Prime Minister's Challenge Fund
Warrington Health Plus: Warrington

National Evaluation Report: March 2016

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About the scheme

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The Prime Minister's Challenge Fund[1]

In October 2013, the Prime Minister announced a new £50 million Challenge Fund to help improve access to general practice. The Challenge Fund is designed to stimulate and test innovative ways of providing primary care services. A total of 254 expressions of interest were received from groups of practices across the country. Of these, 20 were selected to act as 'wave one' pilot sites, covering 1,100 general practices and 7.5 million patients.

The independent national evaluation

The wave one pilots are now over a year into delivery of their plans and the first overall evaluation report, which looks at progress at a programme level was published in October 2015. In addition, a second evaluation report has now been published and alongside this are 20 pilot evaluation papers which review the individual PMCF programmes in more detail. These case study papers review innovations that each pilot site has introduced and discuss how their projects have contributed to the national Challenge Fund objectives. This paper is one of this series and focuses on Warrington, Health Plus.

It should be noted that the national evaluation was commissioned to understand the impacts of the Challenge Fund at programme level. As such the individual papers are not intended to provide a full cost-benefit analysis or detailed evaluation of all of the projects introduced by the pilots. However, they do provide the opportunity to showcase pilot activities in more detail, understand which interventions have proved most successful and explore the reasons for this.[2] It is important to note that this individual report should be read in conjunction with the overall evaluation report with particular reference to the 'assumptions and limitations' section on page 7.

Pilot summary

Warrington Health Plus (WHP) included 28 practices and covered a patient population of 218,000. The pilot used Challenge Fund investment to support their transformation of primary care through the design and establishment of seven Primary Care Home (PCH) clusters. The pilot's specific local PMCF objectives were focused on:

- creating collaborative clusters for integration and care coordination;
- establishing relational working, engagement and culture change; and
- responding to the ten locally identified priorities for primary care.

[1] Hereafter referred to as PMCF or the Challenge Fund.
[2] The pilots were encouraged by NHS England to undertake local evaluations, which looked at specific local data and metrics, to complement the national evaluation.

In order to achieve these objectives the pilot organised its activities into a number of workstreams:

Transforming primary care through collaborative clinical leadership and relational working

The development of PCH clusters around populations of c30,000 was the foundation to delivering transformational change in primary care across Warrington. This approach was based on the Medical Home Model on which there is international evidence on the benefits of a senior physician led care model supported by an extended MDT (multi-disciplinary team).[3] The model was similar to that of a Multispecialty Community Provider as defined within the Five Year Forward View.[4] PMCF investment enabled the practices to develop cluster working at scale and pace with the establishment of seven PCH clusters enabling collaborative working, delivery of projects, and working beyond the practice walls. The formation of the clusters was established through clinical leadership and extensive GP engagement as well as consideration of geographical location, travel infrastructure and public health information on the demographic profile or disease burden of the local population. All clusters were involved in projects that were co-designed around 10 priority areas for primary care.

All practices were also part of a Community Interest Company (CIC) which was formed in July 2014. This was set up as a not-for-profit social enterprise and was led by a Board which had representation from GP federations, clusters, and lay members (as well as representatives from local commissioners (Clinical Commissioning Group (CCG) and Local Authority) during the PMCF period). Clusters were required to submit a business case for each project to the CIC Board for scrutiny and approval.

System alignment around clusters to promote care coordination and integration

Using the established clusters, WHP worked with system partners to design the integrated teams that sat around the collaborative clusters (the Primary Health and Social Care Teams for clusters). This alignment was phased as clusters matured. Community and district nursing teams were realigned during the second half of 2015 alongside the expansion of care coordination. In parallel, from September 2015, social care was incorporated in a phased approach within cluster working. This involved the introduction of new posts such as Link Workers and Social Care Assistant Practitioners working across health and social care. Initial planning work is also underway on the longer term alignment of public health, mental health, secondary care and wider third sector services.

Care coordination

Central West cluster developed and tested an approach to care coordination and shared the learning with a working group to agree an approach that could be rolled out to all clusters. The cluster initially targeted this support to patients who have dementia or who have had a stroke, are housebound, have had 3 or more GP home visits in the last 12 months or who are highlighted within the risk stratification tool. The model of care was designed to provide patients with:

- a comprehensive and holistic nurse-led assessment;
- a named coordinator who provided the link between the patient, their carer and the wider care team; and
- an action plan to meet their needs, made in partnership with the patient and their family.

[3] Warrington GP Federation (2014) Expression of Interest
[4] http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

The first evaluation of this project was presented and will inform the town-wide care coordination work programme. A town-wide care co-ordination model is being developed by a multi-agency working group led by WHP, for consideration against Better Care Fund monies, which will sustain and embed care co-ordination into all clusters through phased implementation.

Extended access

WHP, working in partnership with Bridgewater Community Healthcare NHS Foundation Trust, implemented two developments to enhance access to consultations:

- An evening and weekend non-urgent service which provided routine pre-bookable GP appointments at a central location in Warrington, extending access to 8pm from Monday to Friday and 8am – 8pm at weekends. This service was live from the beginning of November 2014 and all registered patients in Warrington had access to the service.

- A core hours service which offered access to same day appointments for patients with certain conditions. This service was delivered by a GP and nurse on certain days of the week (Mondays, Tuesdays and Fridays). The service was operational in the Central West Cluster from May 2015 and the Central North Cluster from July 2015.

WHP were keen that extended access developments did not just offer "more of the same". It was therefore intended that in providing these additional contacts, practices would have increased capacity within their core operation to provide longer appointments or continuity of GP for complex patients. Technology was also used to facilitate access.

Through the Challenge Fund, half of practices had access to a web-based demand and capacity tool and this is being rolled out to all practices to help improve utilisation and demand management in GP practices. In addition a GP-led triage system and self-care technology were being rolled out. A Warrington-wide booking system was also developed to allow practice patients to 'choose and book' for certain cluster services such as cardiology (through a heart failure project).

Care homes

WHP delivered a multi-disciplinary team care home project and through PMCF tested a model of care in which cluster based health services were shaped to provide support to the 1,600 nursing and residential home beds across Warrington. Key features of the care model were as follows:

- Each PCH cluster was linked to a number of local care homes;

- The cluster based care home team was led by a care home lead GP, and a care home nurse, supported by a medicines management team;

- As well as providing more traditional reactive primary care services, the care home team provided proactive care, undertaking holistic assessments and developing care plans for residents including advanced care planning and end of life care; and

- Technology was used to support the monitoring and delivery of care. Five care homes tested a telehealth tool called "My Clinic" which enabled remote monitoring of clinical observations and video conferencing with the care home. In this project each GP and care home nurse had a tablet which allowed remote access to clinical information on GP systems.

Other targeted initiatives

Across the seven clusters within WHP, a number of other projects were trialled. These included:

- Guided care which was implemented in two clusters (East and North). This project was based on the 'guided care model' (developed at John Hopkins Bloomberg School of Public Health) and was designed to manage patients with more than one long term condition more proactively. This took the form of a single holistic medical, social and psychological nurse led assessment and provided patients with a person-centred care plan which also linked patients to support within the community and promoted self-care; in partnership with local leisure and public health providers.

- A heart failure pathway was implemented in the Central East Cluster. This project remains under development and will enable the testing of an integrated pathway for newly diagnosed patients with heart failure between primary and secondary care. More widely, this project was an opportunity for the testing of a model of alignment of secondary care to PCH clusters. A cluster PPG meeting was undertaken in September to gain views from patients. The first clinics were held in mid-October.

- Paediatric ambulatory care, an innovative primary care project for children was implemented within Central North Cluster in Warrington. Two paediatric nurses were employed to provide 5000 additional appointments, which saved GP time and provided both proactive child and family preventive work and medical see and treat.

- A software-based referral and clinical utilisation tool was tested in some clusters. This assisted with referrals to the most appropriate care setting, audited current referrals, and helped identify gaps in service provision.

Underpinning the delivery of these projects, an information governance framework was developed, and a wide range of enabling IM&T projects were implemented e.g. technology for remote working to support the care-co-ordination project and nursing home projects. The Risk Stratification Patient Portal was also procured and embedded across Warrington practices.

Meeting the national programme objectives 2

Objective one: To provide additional hours of GP appointment time

What did the pilot deliver?

Of the 28 practices in Warrington, 18 offered extended hours prior to the introduction of PMCF (at least one day per week outside of non-core hours). These services were available to 120,533 patients (57% of the patient population). Only a few practices offered weekend GP appointments.

All 28 practices were able to access and book their patients into an evening and weekend non-urgent service which offered additional routine pre-bookable GP appointments at a central location. These extended hours were available to 218,000 patients registered at practices covered by WHP; this represents 100% of the pilot patient population.

In two clusters, an extended access core hours service was also tested which offered access to same day appointments for patients with certain conditions. The service is being evaluated and the knowledge gained being used to inform future model development.

How did the pilot deliver additional hours?

The evening and weekend non-urgent service was delivered by GPs at a central location in Warrington, from 6pm – 8pm Monday to Friday and 8am – 8pm at weekends. This service was live from the 3rd November 2014. The additional core hours service was delivered by a GP and nurse on certain days of the week (Mondays, Tuesdays and Fridays in response to trends in demand). The service was operational in the Central West Cluster from May and the Central North Cluster from July 2015.

How many additional GP hours were provided and used?

As of September 2015, a total of 12,600 additional cluster based extended access appointments were provided. The level of provision rose through the months with the weekly average additional extended access contacts rising from 204 between February - May 2015 to 392 between June - September 2015. In terms of hours, a total of 2,100 additional hours were provided.

In June 2015, an average of 295 hours per week of extended access were provided; representing a rate of 1.4 hours per 1,000 practice population.

As well as increasing the number of appointments available to patients, wider benefits were also considered to include the provision of more suitable and convenient appointments for patients, as well as continuity of care.

In implementing the non-core extended access service, Sunday appointments were available from April 2014. WHP found that there was limited demand for these appointments and, despite promoting this service through targeted marketing, found that demand remained low (although it built slowly). In trying to enhance Sunday utilisation, WHP launched a targeted communications campaign. This involved sending targeted communication materials to working age people though large employers, to working parents of small children through nurseries, as well as targeting existing available networks such as groups that support carers – however, Sunday utilisation remained low, and local data analysis also revealed a reduction in patients booking appointments on a Saturday afternoon. The extended access benefits demonstrated by the PMCF will be taken forward locally with the Primary Care Strategy.

Local evaluation of the extended access service provided in evenings and weekends over its first six months of operation highlighted that the types of patients who used the service were as expected in terms of age and

presenting condition. Those within the 31-50 years age bracket were the most common users of the service, followed by those aged 19-30 years, those aged 51-70 years and children aged 1-10 years. The most common condition treated was chest infections accounting for just under 50% of patients.

To support greater utilisation of this service a centralised support facility was established for any GP Practices with a concern or query about a patient consultation, providing a written reply within 48 hours. The service also introduced a new service for patients whom Did Not Attend (DNA's). GP practices were notified about individual DNA's and a text service reminded patients in advance that they had an appointment booked with the service.

By June 2015, a total of 88,500 appointments had been made available within core working hours across the pilot. This equates to 14,800 additional hours. This represents an increase of 2% from the June 2014 baseline, approximately 300 additional hours. Core hours utilisation remained consistent with the baseline (88%), at 85% in May 2015 and 87% in June 2015. Utilisation for extended hours increased from 75% to 83% in May 2015 and 79% in June 2015.

Objective two: To improve satisfaction with access to general practice

The national evaluation also took into consideration the impacts of the programme on patient and staff satisfaction:

Improving patient satisfaction

83% of respondents to the National GP Patient Survey rated their satisfaction with the overall experience of the GP surgery as 'very good' or 'fairly good'. Comparing this data with the previous year, there was little change in this rate.

In considering satisfaction with opening times, there was little change over this same period; with 92% of respondents reporting satisfaction with the convenience of the appointment, 68% being satisfied with opening hours (3% lower) and 70% of respondents reporting that the GP surgery is currently open at a convenient time.

When asked about additional opening times that would make it easier to see or speak to someone, there was a 4% reduction in respondents indicating a preference for additional access during lunchtime and in contrast, a 9% increase of respondents indicating a preference for this additional access on a Sunday (a total of 44% of respondents).

There was a 3% increase in the frequency of patients seeing their preferred GP (57% of respondents).

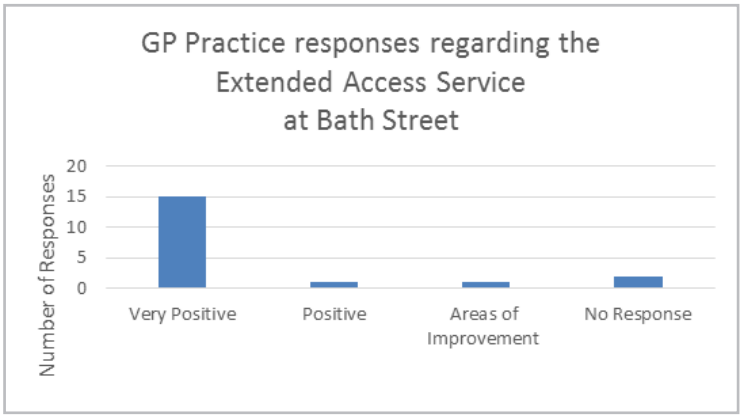
Locally, patient satisfaction feedback regarding operation of the extended access service at evenings and weekends was collected through patient feedback forms from February 2015 to October 2015.

The results of this local evaluation indicated that:

- 88% of patients would be extremely likely to recommend the service to friends and family and a further 12% would be likely to recommend the service;
- 88% of patients were very satisfied with the service and 9% of patients were satisfied; and
- 83% of patients were very satisfied with waiting times and a further 12% of patients were satisfied.

Improving staff satisfaction

WHP undertook its own online survey of staff delivering the extended access services. Its survey was sent out to all the practices participating in the Extended Access Service - 19 responses were received, due to the low response it is difficult to develop conclusive findings, but overall, the Extended Access Service was received very positively, as the chart below shows.



Key positive comments revolved around the Extended Access Service being a very useful alternative for patients, including those who work long hours. Staff were happy that local GPs staffed the clinics and reported that the service gave much needed capacity when their own service/ practice was under pressure.

A number of responses detailed areas where improvements could be made to the service, these focused around general operational issues, booking process and appointments and are detailed in the box below:

- **Operational** – some patients were seen at the extended access service who were then asked to see their own GP the next day. The onward referral process needs tightening up in terms of ensuring there is adequate information on notes, similarly some consultations are being marked private so not visible to the GP and additional training is required for some GPs and new members of staff on how to use the system;
- **Booking process** – it would be easier for GPs to directly book into the system, the old process of having passwords in advance is preferable to the new system of having a weekly password; and
- **Appointments** – a greater number of midweek appointments would be an improvement, and the first come first served process was not always helpful, potentially leading to an unfair distribution of appointments.

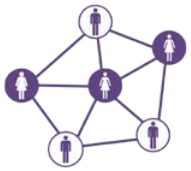
Objective three: To increase range of contact modes

Using technology

Through its extended access workstream four practices went live with tools which streamlined access and enabled GPs to differentiate patients with complex and acute needs and offer different appointments on this basis. A further five undertook baseline work towards implementing this. One cluster also considered using this clinical triage tool as part of a single point of access for the whole cluster. Early local evaluation of this development from one practice, Springfield Medical Centre in another local case study, showed that since the introduction of a GP-led triage system in July 2014, an additional 37% of patients were supported each week ,with a 42% reduction in the number of face-to-face consultations (due to increased telephone consultations). The data submitted as part of the national metrics, when comparing June 2014 to May 2015, showed that available telephone consultations in core hours increased from 13% to 17% across all practitioners, and from 15% to 21% for GPs. In non-core hours, GP telephone consultations increased from 1% to 16%.

Other developments included the installation of patient check-in and call-in screens in practices and the trialling of information kiosks in two clusters to provide information on self-care and signposting.

Using other practitioners



- **Care co-ordination**: In phase 1 of the care coordination project in the Central West Cluster (25th March to 2nd July 2015), over 140 assessments were completed either during home visits or practice appointments. Over a 2 month period, a further 84 medication reviews were undertaken. Staff reported that care coordination enhanced their patients' experience through the identification, communication and coordination of support available for patients and their carers. A full local evaluation of the scheme is being finalised in late February 2016, but there is evidence from the medicines review, case studies, staff and patient/carer survey responses of both the need for intervention and the impact of those interventions. The medicines review demonstrated benefits, but also the potential for greater benefits, if acceptance rates of findings by GP practices could be increased, and whilst the data on patient and carer views was limited, it was overwhelmingly positive.

- **Care homes**: The care home service model was implemented in five clusters and over 750 holistic MDT assessments were completed. Medicines management support to care homes was also put in place, and telehealth care was piloted.

Wider learnings from the programme

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Transformational and sustainable change

Prior to PMCF, practices worked individually or within existing Federations that were not geographically based. With the support of PMCF investment, seven PCH clusters were rapidly established in parallel, alongside the formation of the CIC. All practices from across Warrington were involved in clusters and co-designed projects. Clusters are still developing and maturing but detailed work is underway on alignment of services around the clusters (such as community nursing, care coordination) and new ways of working. Local commissioning intentions from the CCG and Local Authority were aligned to this, supporting this as a sustainable model.

The relationships between practices within clusters and also across clusters were considered to be lasting and GPs have reported positively about the increased interaction opportunities. There are examples of where this collaboration drove further change; for example, one cluster considered the use of Doctor First as a single point of access for all member practices.

WHP reflected that relationships at every level were important. For example, cluster meetings were attended by each Practice; the practice manager community had regular practice manager meetings as shared learning sessions (with the NHS IQ Productive General Practice resource available to all Practices supported by PMCF funding). From these, there was a naturally emerging buddying approach to offering support to each other and this in turn created capacity and capability in the system. These relationships were essential in supporting change in primary care.

The formation of the CIC as one organisation to represent the GP body in Warrington was effective, enabling it to shape the supply of primary care going forward as well as being represented in whole system discussions on health, social care and transformation. The CIC developed a set of 'principles of practice'[5] designed to guide the behaviour, decisions and practice of CIC members and GP colleagues involved in WHP. These principles included:

- Act for the wellbeing of patients, practitioners and the health and care economy
- Engage
- Follow through on commitments
- Share and learn in every interaction
- Turn scarcity into creativity
- Practice adaptive action

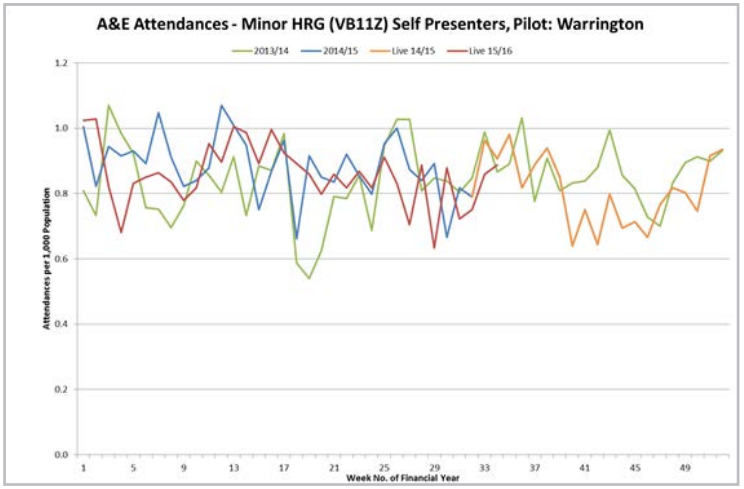
A process of review was agreed to support the implementation of these behaviours and to seek to measure cultural change, with all practices being asked to complete a 360 degree assessment on an annual basis. Wider system partners (including providers and the local authority) also found these principles useful and undertook a workshop session together to help them translate these principles into relevant behaviours within their own context. It is felt that these principles provided a useful foundation which allowed barriers such as data sharing to be worked though. WHP also looked to different available tools in which to measure relational impacts.

The programme was mindful of the need to establish a sustainable model. Commissioners from both the CCG and local authority worked with the CIC Board since its creation. This meant that commissioning intentions reflected the creation of PCH clusters and the future integration of services around these. Supporting this, WHP received a commitment from the CCG to fund the maturity of clusters throughout 2015/16 through the Primary Care Commissioning Strategy and the Better Care Fund. From 2016/17, the Primary Care Strategy will support the sustainability of this model of care.

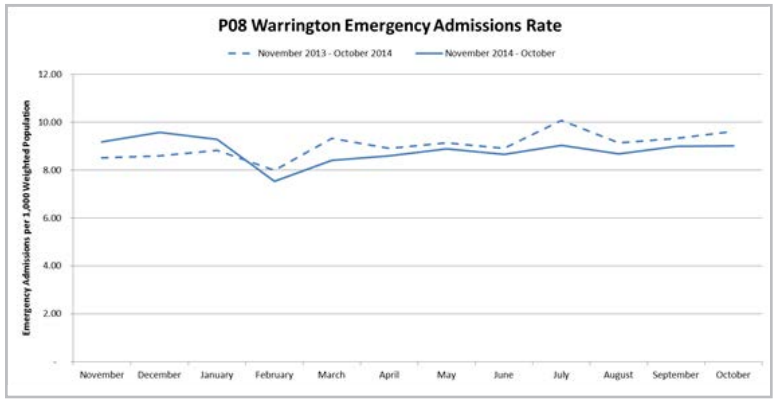
[5] http://www.warringtonhealthplus.org/#!principles-of-practice/c1px4

Reducing demand elsewhere in the system

Analysis of minor A&E attendances[6] up to the end of November 2015 showed that during the time that the pilot was live with its initiatives there was a statistical reduction in these attendances compared to the same time period in the preceding year; equiavlent to an annual reduction of 570 attendances (6% reduction).[7] A local comparator group of GP practices in Halton CCG had also seen a 6% reduction in attendances in this same time period.



Profile of emergency admissions



In terms of the pilot's impact on emergency admissions, since going live, there has been a 2% reduction in admissions compared to the same time period in the preceding year.[8]

However, as recognised in the summary report, attribution of impact to the Challenge Fund pilots is inherently difficult to prove since many other initiatives were implemented locally. These findings should therefore be interpreted with this in mind.

[6] Minor A&E attendances defined by HRG code VB11Z.
[7] Note that the data for the latest months in 2015/16 may be subject to amendment or revision through the financial year.
[8] Note that the data for the latest months in 2015/16 may be subject to amendment or revision through the financial year.

Facilitating learning

WHP valued the learning and support from NHS Improving Quality and felt that they would benefit further from additional access to this input as part of their ongoing developments. This support was valuable in building the engagement and relational working required to support the local transformation programme.

The programme also took part in national PMCF events and had individual conversations with other wave 1 pilots to share learning around common issues such as information governance. WHP was committed to sharing learning with others and this includes sharing findings of its longer term local evaluation.

Models which can be replicated in similar health economies

WHP reflected that the cluster based PCH model was based on the primary care medical home evidence base, and so has the potential to be replicated across other health communities. It was noted that Warrington as a health community could be regarded as a 'typical' small town population with a District General Hospital and a traditional mix of GP community. In terms of delivery at scale, the model was also considered to be valuable as the development of clusters has not required changes to the configuration of existing practices' partnerships or Federations; rather, it was fostered on collaboration.

Whilst the model itself may be replicable, a number of key factors must be considered in order for it to be successfully tailored and embedded into another health community. These include: the approaches taken in Warrington to extensively engage GPs and stakeholders; creating protected time for relationships to develop; to implement strong processes and enable clinical leadership.

The approaches taken to individual work streams such as the care homes model are also considered to be replicable in other health communities. Local engagement may be required however to tailor these to the local context.

Financial evaluation

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As part of the Challenge Fund and through matched funding, the pilot reported a spend of over £5.2 million up to the end of November 2015. Of this, the pilot spent over £1.3 million to support extended access services with a further £1.87 million on other wrap around initiatives and £2 million on enabling activities such as IT, project management and training. Of these enabling activities, programme management costs were £560,000.

Whilst the pilot scheme provided some practice level data whilst it was operational with its initiatives, this still remains too limited a dataset on which to assess and comment on the value for money and return on investment of its extended hours services.

As well as supporting the establishment and delivery of the extended access developments, Challenge Fund investment was used to mobilise WHPs wider transformation agenda. The pace of this large scale change programme would not have been achieved without this funding. In interpreting value for money in the local context, it is important to recognise that this funding has been used to set up and invest in the mechanisms to effect change across the whole system.

In terms of impact on A&E services, the annual reduction of 570 minor attendances (6%) would represent a cost saving of £33,000.

What enabled innovation and change? 5

- Engagement and clinical leadership was embedded throughout the change programme. This began in 2013 through a GP membership survey and whole-town events which facilitated a consistent and shared understanding of the challenges facing primary care in Warrington. Leadership was provided from a GP-led primary care programme group established through the CCG. Engagement was embedded throughout the cluster approach and was reflected in the sustained engagement evident within clusters and through the whole system approach being undertaken on work streams. For others embarking on similar programmes of change, engagement with clinicians should begin as early in the process as possible and it is important to recognise that relationships are critical. The programme must also have clarity of communication when dealing with different stakeholders.

- The structures developed were inclusive of stakeholders. All practices were represented on their own Cluster Board. Each Cluster had a lead GP and the practice manager from each practice in the cluster. Every cluster and federation had a GP member of the CIC Board.

- The programme set clear expectations as to timescales around implementation, creating space for these relationships to develop and embed, which was considered to be crucial. Clusters were given the flexibility to continue to evolve naturally; for example one of the smaller clusters merged with another neighbouring area.

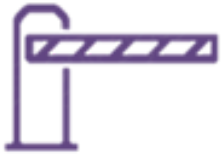
- Effective 'relationship managers' or facilitators played an important role in maintaining sustained engagement with practices and in helping members to see opportunities for change. These roles required individuals who understand both primary care and the health policy agenda and have the facilitation skills to challenge practices in a supportive and developmental manner.

- Organisational development was an important aspect in generating cultural change; the support provided by NHS Improving Quality has delivered "real benefit". The NHS change model reflected the factors WHP considered to be essential to the success of the programme.

- Practices did not have 'spare capacity' and in order to mobilise programmes of this scale, it was necessary to invest in a programme team who were able to provide support.

- The approach taken also meant that projects were designed and tested in a phased way. This allowed for evaluation and learning to be embedded in developments as they were rolled out more widely across Warrington. Phasing also allowed clusters to focus on projects which were most relevant to their local population, which generated a sense of ownership. Information was used to support change. For example, activity data was reviewed in designing the core hours extended access service. WHP also sought to invest in technology to provide practices with information to support system redesign, for example identifying trends in access.

What barriers and challenges were faced? 6



- Data sharing was the biggest challenge due to fragmentation and complexity of the existing system. To overcome this, WHP had to invest time and resource and consider that it was important to give practices time to be confident in agreeing to these data sharing agreements. Presentations at the CIC Board were also used as a mechanism to build sign-up and gaining support from 'opinion leaders' in practices was also important. Nationally, more awareness and support is needed regarding the complexity of data sharing agreements.

- Agreeing appropriate legal agreements was also a key challenge. Complex legal inter-practice agreements (e.g. alliance contracts) were required to enable cluster and town-wide working across practice boundaries.

- Clinical indemnity for nurses with new roles and working across clusters also emerged as an issue with implications in terms of timing and costs.

- Information management and technology (IM&T) challenges impacted on nearly all projects and the issue was exacerbated through the three different practice clinical systems used in practices within Warrington, and through transitional CSU arrangements. Key challenges were around: the functionality to share records; mobile remote working; developing a single care plan to be held on the GP record; and the implementation of the risk stratification tool requiring data warehousing from CSU (CSUs ownership of access). PMCF required pace and scale that has created pressure in the system and the IM&T issues were complex and time consuming. To avoid significant delays to the programme, WHP directly appointed technical agencies to provide support which had cost implications. In resolving some of these barriers around data sharing, WHP liased with other PMCF pilot areas such as Herefordshire about their approach to information governance and with the local IT Partnership Group.

- Recruitment of GP resources and wider specialist nursing staff was a challenge. With regards to GPs, there were challenges in recruiting GPs as well as GPs with certain skills such as advanced care planning. Supplementing this, the CIC was clear that in recruiting additional GP and nursing resources, WHP must not destabilise the local system. Providing appropriate clinical supervision was also a challenge in the recruitment of specialist community matrons and nurse practitioners. WHP and Bridgewater Community Healthcare NHS Foundation Trust are therefore looking to develop partnership arrangements to provide this clinical supervision and to consider the use of secondment arrangements. This partnership approach also overcame some of the wider employment barriers (such as the ability to advertise on NHS Jobs or continuity of NHS terms and conditions of employment) which may have deterred potential applicants. Most recently, WHP undertook a successful recruitment exercise for paediatric ambulatory care nurses, advertising roles directly through the paediatric nursing network; this is an approach they will look to use going forward.