GREATER PETERBOROUGH NETWORK

ANNUAL REPORT

10 YEARS OF SUPPORTING YOU

2025

Foreword

Dr Neil Modha

Chair Of GPN Board

This year marks the 10th anniversary of Greater Peterborough Network (GPN).

A decade of partnership, innovation, and commitment to strengthening primary care across our community.

From the very beginning, GPN has acted as a catalyst for collaboration, bringing together practices and partners to respond to local needs with resilience, creativity, and determination.

One of the reasons I love being part of the GPN leadership team is the chance to work alongside such dedicated colleagues. Every day, I see the passion, expertise, and energy that people bring to improving care for our communities. It's incredibly rewarding to be part of a team that shares a common purpose: supporting patients, strengthening primary care, and building stronger connections across the health and care system.

As we look to the future, our ambition is greater than ever. The health and care system is evolving rapidly, and our role as a trusted community integrator is vital. Our Strategy to 2035 is bold:

- Investing in new models of care
- Harnessing data-driven insights for better decision making
- Embracing emerging technologies to deliver sustainable, patient-centred solutions

Ten years on, our mission remains clear: to build a resilient, responsive network that expands access to high-quality, out-of-hospital care.

We are proud of how far we've come — and even more excited about what lies ahead. Thank you to all our colleagues, partners, and communities for your continued support as we take these next steps together.

Foreword

Mustafa Malik

Chief Executive Officer

Over the past year, Greater Peterborough Network has achieved a great deal through closer collaboration with our Member practices and Partners. Guided by the NHS 10 Year Plan, we are seizing new opportunities to bring care closer to home, improve outcomes, and reduce variation in the quality of care our patients receive.

We are proud to be delivering on the NHS 10 Year Plan's key pillars:

- Shifting appropriate hospital care into community settings, through our Virtual Ward

Analogue to Digital, by embracing digital transformation through:

- Remote monitoring of patients, where patients can record their own observations and these are transmitted live to our clinical team, allowing for more frequent and often real time review of their vital statistics
- Robotic Automation Processes (RPA) where manual tasks are now processed through automation saving time and enabling staff to work on other key priorities

Prevention rather than treatment through:

- Expanding proactive care and prevention programmes with a focus on Frailty and Long-Term Condition management

Together, these initiatives are helping us deliver more accessible care to the patients we serve. Our strategy is rooted in a data-driven population health management approach, ensuring services are tailored to the needs of our diverse communities, while supporting our member practices to navigate both the challenges and opportunities ahead.

As we deepen our partnerships, we remain focused on shaping models of care that not only improve the health outcomes of our patients but importantly are also resilient, equitable, and sustainable.
Thank you for your continued support as we turn this shared ambition into reality.

OUR MISSION

Our practices, Patients & Partners

To provide safe, responsive and clinically effective care provided by compassionate people in order to deliver improved outcomes and reduce inequalities for our patients.

We will achieve this by being an outstanding employer for our people by creating opportunities, supporting innovation and working in partnership to improve local health and support services.

Hear from Our Medical Director:

Dr Sundeap Odedra

SCAN ME

OUR COMMITMENT

Throughout 2024 and 2025, we have strengthened our commitment to fostering collaboration among our Member practices and partners. By actively supporting these partnerships, we have been able to enhance the quality of care provided to our communities.

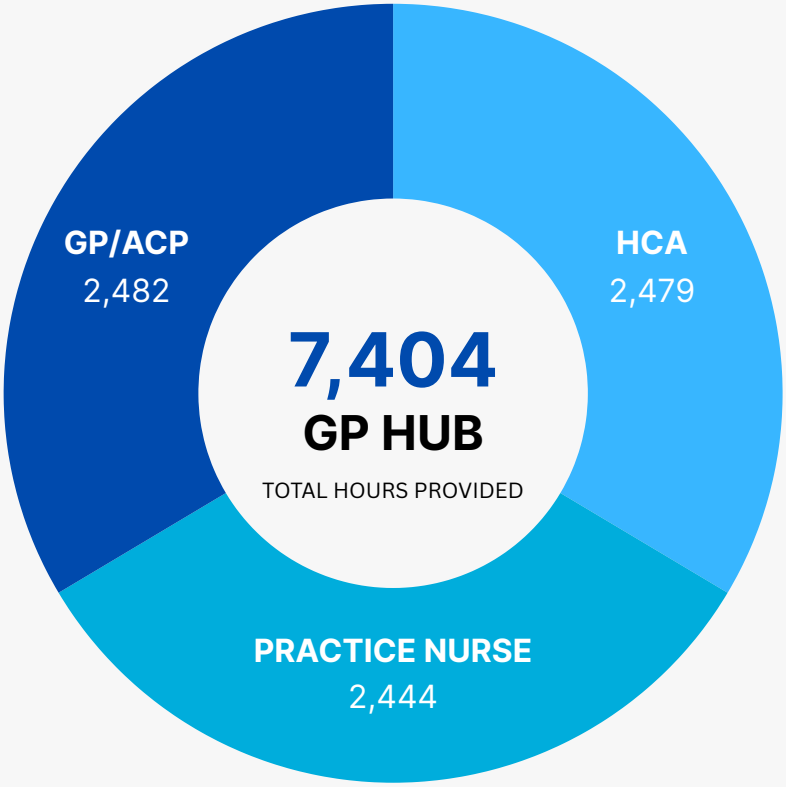
During this period, **we are proud to have delivered a total of 15 services**, all aimed at supporting our patients, partners and members.

The following pages will provide a detailed overview of the various services and initiatives that exemplify our ongoing dedication to delivering exceptional care through collaborative efforts. These examples highlight the impact of our partnerships and demonstrate how, together, we are continuously working to better serve our patients and the communities we are proud to support.

A YEAR IN DATA

2024 - 2025

PLANNED CARE | UNPLANNED CARE | SUPPORT SERVICES



10,370

HOUSEBOUND PATIENTS VISITED AT HOME

95.8%

TOTAL PHLEBOTOMY SUCCESS RATE ACROSS GPN SERVICES

1,030

PATIENTS PROVIDED WITH SAME DAY PHLEBOTOMY IN THE GP HUB

15,163

ENHANCED ACCESS HOURS DELIVERED

Hear from our Head of Performance & Data:
Ben Mather

SCAN ME

97.3%

OF PATIENTS **(7,137)** WOULD RECOMMEND GPN SERVICES TO THEIR FRIENDS AND FAMILY

83.5%

OF UWAC NORTH PATIENTS WERE KEPT AT HOME, COMPLETELY AVOIDING ADMISSION TO HOSPITAL

86.4%

OF VIRTUAL WARD PATIENTS AVOIDED READMISSION TO HOSPITAL

32,309

FINISHED EHANCED ACCESS APPOINTMENTS

75.5%

OF UCR FRAILTY PATIENTS REMAINED AT HOME AFTER DISCHARGE FROM THE SERVICE

75.4%

OF PATIENTS SUPPORTED THROUGH CB4C AVOIDED ATTENDANCE TO HOSPITAL

A YEAR IN DATA

2024 - 2025

GPN is focused on data-driven solutions to enhance every aspect of our operations, ensuring that patient care is always at the forefront. By systematically collecting and analysing vast amounts of data from various sources, we can identify trends, forecast outcomes, and make informed decisions that improve efficiency and patient outcomes. This data-centric approach supports patient care by enabling optimisation of our services, ensuring that our patients receive the best care possible. Usage of data at GPN fosters a culture of continuous improvement and excellence in patient care.

3,403

6-POINT SMI HEALTHCHECKS ACROSS PETERBOROUGH, WISBECH AND CAMBRIDGE

5,496

DIRECT INTERACTIONS WITH PATIENTS ON THE SEVERE MENTAL ILLNESS REGISTER

275

TOTAL VULNERABLE INDIVIDUALS SUPPORTED THROUGH THE HOMELESS HEALTH OUTREACH SERVICE

1,430

TOTAL FINISHED APPOINTMENTS FOR HOMELESS HEALTH OUTREACH PATIENTS

17,984

SMS APPOINTMENT REMINDERS SENT VIA ROBOTIC AUTOMATION

11,278

DAYS OF HOME-BASED CARE PROVIDED TO PATIENTS BY VIRTUAL WARD

10,448

DAYS OF HOME-BASED CARE PROVIDED TO PATIENTS BY UWAC

1,237

OF HOME-BASED CARE PROVIDED TO PATIENTS BY UCR FRAILTY

December 2024 - Starting Date

15,462

CALLS ANSWERED BY THE CALL BEFORE CONVEY SERVICE

12,351

UNIQUE PATIENTS SUPPORTED THROUGH CALL BEFORE CONVEY SERVICE

OUR SERVICES

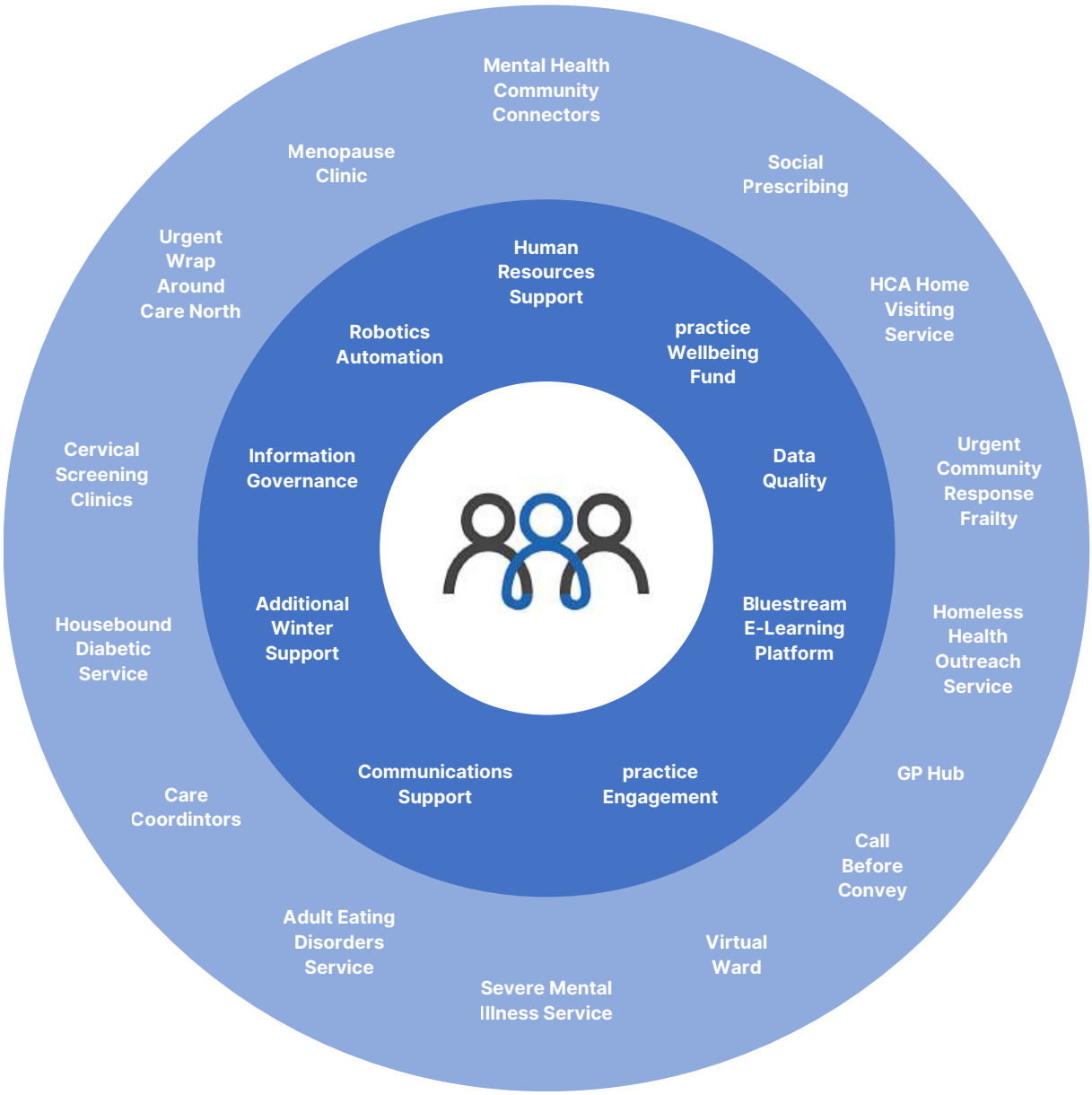
Supporting our members and their patients through the services we offer

Offers to practices:

GPN offers a range of services to our members, from delivering services on their behalf such as Enhanced Access appointments to provide additional capacity, to a range of services from HR, Governance and Data Quality. These offers supplement practice teams, providing expertise as and when required.

Delivery of Services:

We deliver a wide variety of services at scale, to reduce the day-to-day pressure on general practice.



SCAN ME

GP Hub

Service Overview

The GP Hub has continued to provide routine appointments for our member practices outside of their core practice hours, helping to improve access for patients across Peterborough. GPN in partnership with each participating practice provides a multi-disciplinary team of GPs, ACPs, practice Nurses, and HCAs for patients.

Tailored to meet the diverse access needs of Peterborough's population, particularly those who find it difficult to access daytime appointments, the GP Hub aims to reduce health inequalities and prevent avoidable use of urgent NHS services by providing hours beyond the core Enhanced Access specification, to better meet patient demand.

Looking ahead GPN, plans to continue to focus on equitable access and expanding primary care capacity across the city being provided and ensure patients continue to have greater choice and access in getting appointments.

1,383

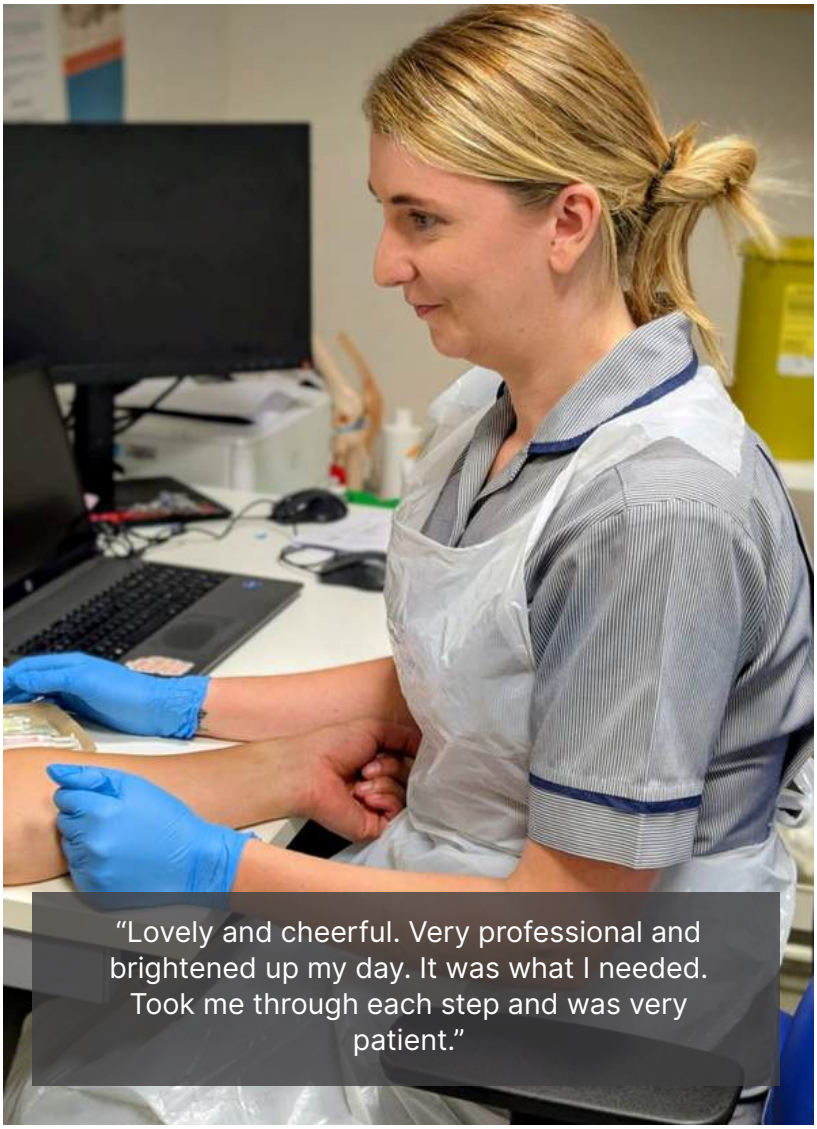
TOTAL NUMBER OF DRESSING & WOUND APPOINTMENTS

25,775

TOTAL APPOINTMENTS DELIVERED

16,487

GP HUB UNIQUE PATIENTS



"Lovely and cheerful. Very professional and brightened up my day. It was what I needed. Took me through each step and was very patient."

HCA Home Visiting

Service Overview

The HCA Home Visiting Service supports patients and practices across Greater Peterborough. Practices can refer housebound patients for services such as phlebotomy, blood pressure checks, height and weight measurements, urinalysis, and stool samples, helping them to gather necessary information to then make informed care decisions, whilst keeping their patients comfortable at home. For urgent needs and referrals, GPN sees patients within 48 hours.

The aim of the Home Visiting Service as well as supporting patients and practices, is to eliminate barriers housebound patients face, and can often lead to restricted access of treatment, furthering health inequalities in our city. This service provides better accessibility to treatment and care.

"Brilliant! Fantastic very understanding. Put me at ease. Got my blood first attempt which is unusual!"

"[HCA] was fantastic. Kind & caring! I can't praise them highly enough."

"[HCA] was lovely! Very kind and very polite to both me and my son. They carried out everything properly."

Hear from our HCA Home Visiting Service Team as they provide insights into how the service runs and showcase its key achievements over the past year.

SCAN ME

8 DAYS

AVERAGE WAITING TIME FOR ALL REFERRALS

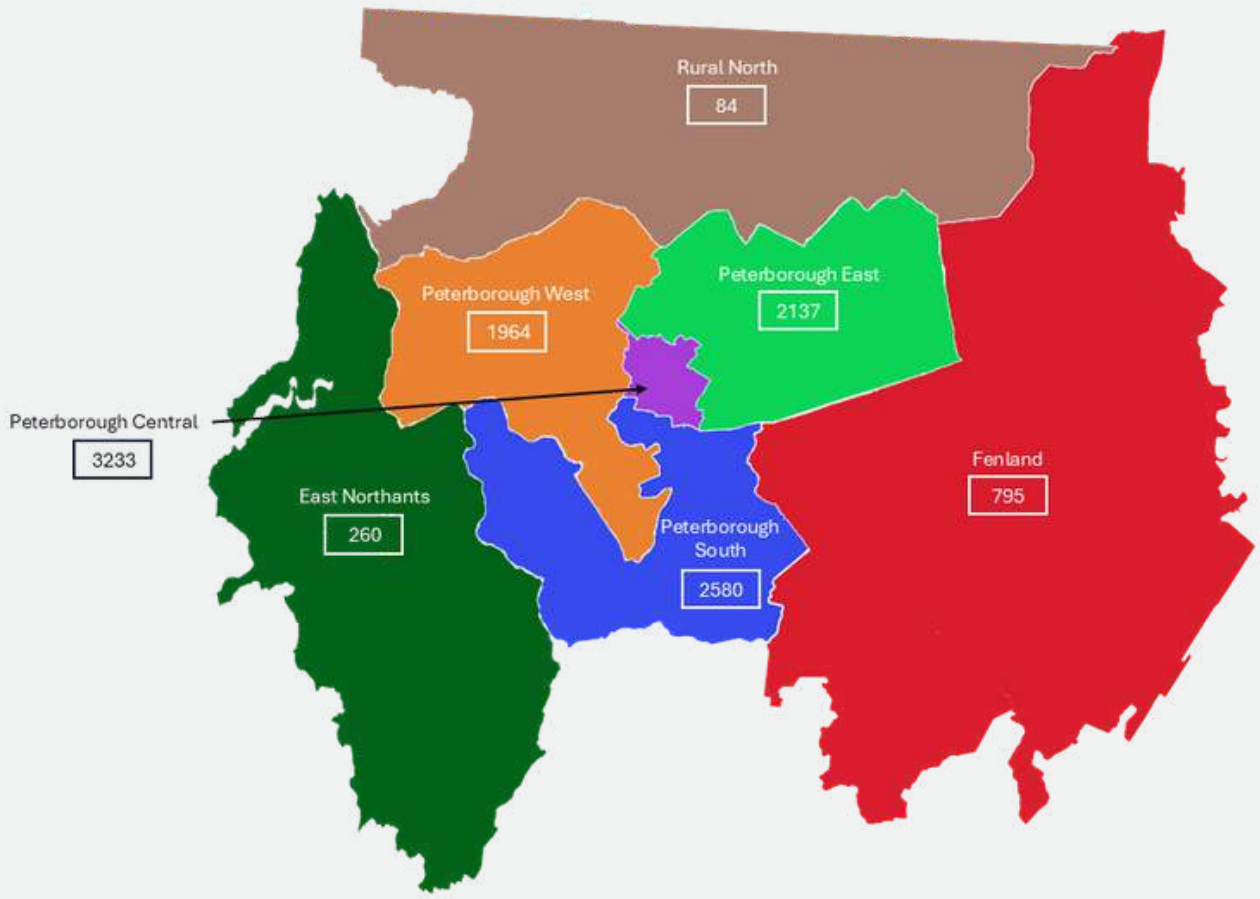
200

HOUSEBOUND PATIENTS VISITED AT HOME PER WEEK ON AVERAGE

97.5%

OF URGENT REFERRALS SEEN WITHIN 24 HOURS

HCA HOME VISITING SERVICE VISITS PER LOCATION



Housebound Diabetic Service

Service Overview

We saw the service end for a short time during the 2024-2025 period due to the service no longer being commissioned, but we are proud to say that the Housebound Diabetic Service is back up and running and has been helping housebound diabetic patients since October 2024.

GPN listened to feedback from our member practices, and heard how sorely this service would be missed and recognised the positive impact this service had on practices, but also how valuable the service was for Peterborough's Housebound Diabetic community.

The service enables GPs across Peterborough and surrounding areas to monitor their patients' health conditions whilst patients remain safe and in the comfort of their own home. Following GPN's home visits, GPs are then able to make informed decisions and provide their patients with the necessary care and treatment required.

GPN's Community Healthcare Assistants are trained to a high level to perform Diabetic reviews, including, essential Blood tests, BP monitoring, BMIs, Foot checks and feedback from the patients. Our team also captures relevant escalations for other health or social well-being concerns.

"Lovely and Cheerful. Very professional and brightened up my day, It was what I needed."

"Very good, explained everything. Very nice Nurse."

"Marvellous! Took me through each step and was very patient."

Hear from our Housebound Diabetic Service Team as they provide insights into how the service runs and showcase its key achievements over the past year.

SCAN ME

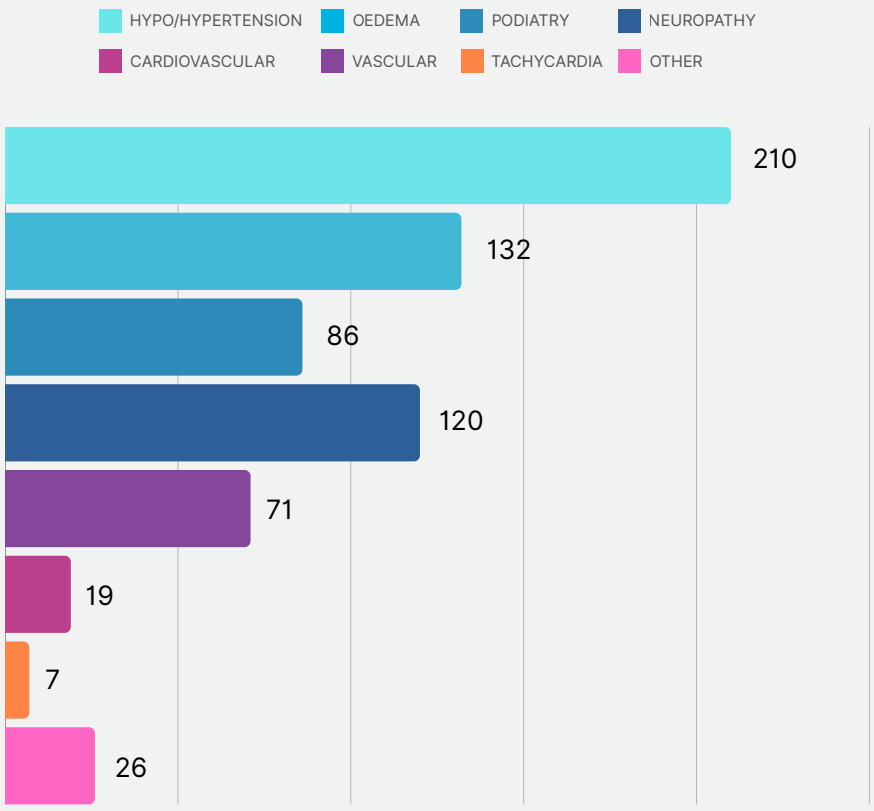
1,005

COMPLETED HOUSEBOUND DIABETIC APPOINTMENTS

885

HOUSEBOUND DIABETICS REFERRED TO THE SERVICE

DIABETES CLINICAL ESCALATIONS



Timely clinical escalations play a vital role in safeguarding the health of housebound diabetic patients.

These issues often go unnoticed for extended periods, and without proactive home visits, they may continue to worsen, potentially leading to serious complications.

By identifying and escalating concerns to the GP, we help ensure that patients receive the necessary interventions before problems become critical, highlighting the essential value of community-based care in preventing harm.

Cervical Screening Service

Service Overview

In January 2025, GPN was approached by North Cambridgeshire & Peterborough Care Partnership to provide a flexible service to enable more cervical smear tests to be undertaken across Peterborough, Fenland, and Huntingdonshire.

As well as being open to members of the public, the clinics also focused on employees of large cooperations operating within the area, with the aim of encouraging patients to attend clinics who were overdue for their screening.

Clinics were provided on the Health Hub Outreach Vehicle where GPN 'took the clinic to the patients' covering sites such as Peterborough City Hospital, Doddington Hospital, and Huntingdonshire Council, as well as supermarket & retail car parks.

Some of these outreach clinics provided at Hospital sites were also provided for the employees of these organisations, offering them some flexibility in completing their screening.

Clinics were offered during evenings as well as on Saturdays and Sundays, providing patients with greater flexibility. It quickly became clear that many people found it difficult to attend screening appointments during standard working hours, often due to childcare or family responsibilities. Clinics scheduled during school holidays were particularly well received, as teachers frequently experienced challenges attending at other times.

"I am a full-time teacher with a family of my own. Having an appointment in half term, in my community has given me a choice to get this done. In term time, I am not able to call the GP surgery at 8am for an appointment due to starting work each day at 8am so to be able to go online and choose a venue best suited to me has really helped."

Hear from our Cervical Screening Service Team as they provide insights into how the service runs and showcase its key achievements over the past year.

SCAN ME

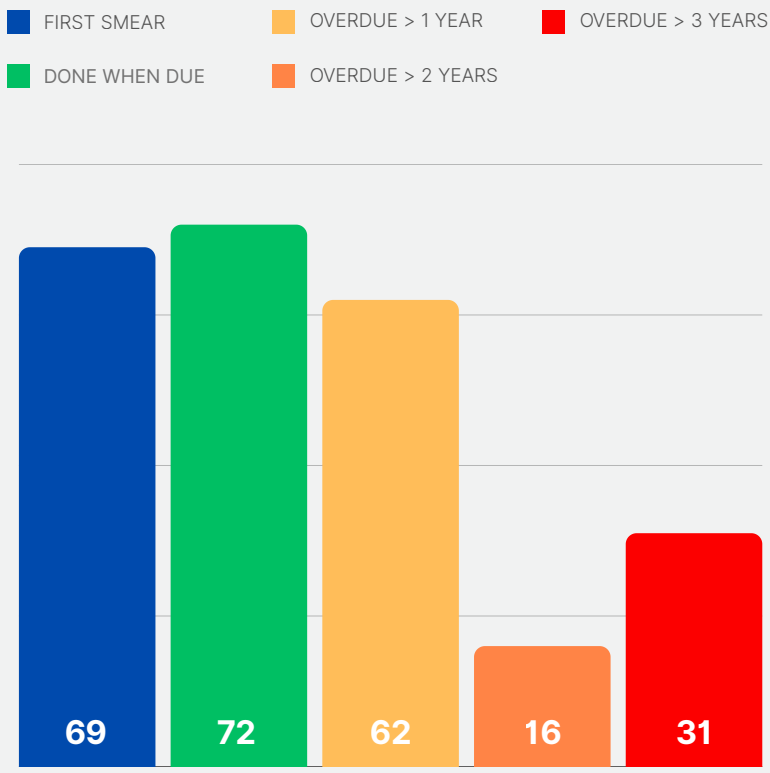
38

ONWARDS REFERRALS TO COLPOSCOPY

For patients who haven't had a smear in many years, referral to colposcopy is crucial.

It enables early detection of abnormal cervical changes that may otherwise go unnoticed, reducing the risk of progression to cancer and ensuring timely, potentially life-saving treatment

BREAKDOWN OF HOW OVERDUE PATIENTS USING THE SMEARS SERVICE ARE



250

CERVICAL SCREENINGS COMPLETED

Homeless Health Outreach

Service Overview

A flexible GP and therapy service to reach some of the most vulnerable in Peterborough with a focus on mental health. Working in partnership with other organisations offering support to those who are homeless or faced with homelessness.

This support not only focuses on access to a GP and therapist but also ranges from support in attending hospital outpatient appointments to ensuring that someone can have access to a healthy diet by issuing a foodbank voucher.

Psychotherapy support offers two types of therapy, short-term signposting support services and tailored long-term therapy, often addressing childhood trauma and the reasons triggering homelessness. This is often linked to work completed by partners in drug and alcohol treatment services.

We are proud of the collaborative working partnerships with key organisations such as Peterborough City Council Rough Sleeper Outreach Team, Outside Links (Sodexo), The Light Project Peterborough, Dual Diagnosis Outreach Team (CPFT), Boroughbury Medical Centre, Aspire, Housing Providers, Charities, Faith Groups, and other homeless services across the city.

> “This is a great service and have saved my life on quite a few occasions and still are. Also, what's more important is I can trust them with everything and that's vital for me.”

> “Years ago, I wouldn't have come and spoke to a counsellor. and now I am actually doing my counselling, and I feel a million times better for talking. I’m getting techniques for when I'm stressed and feeling down. I feel so much better for this service.”

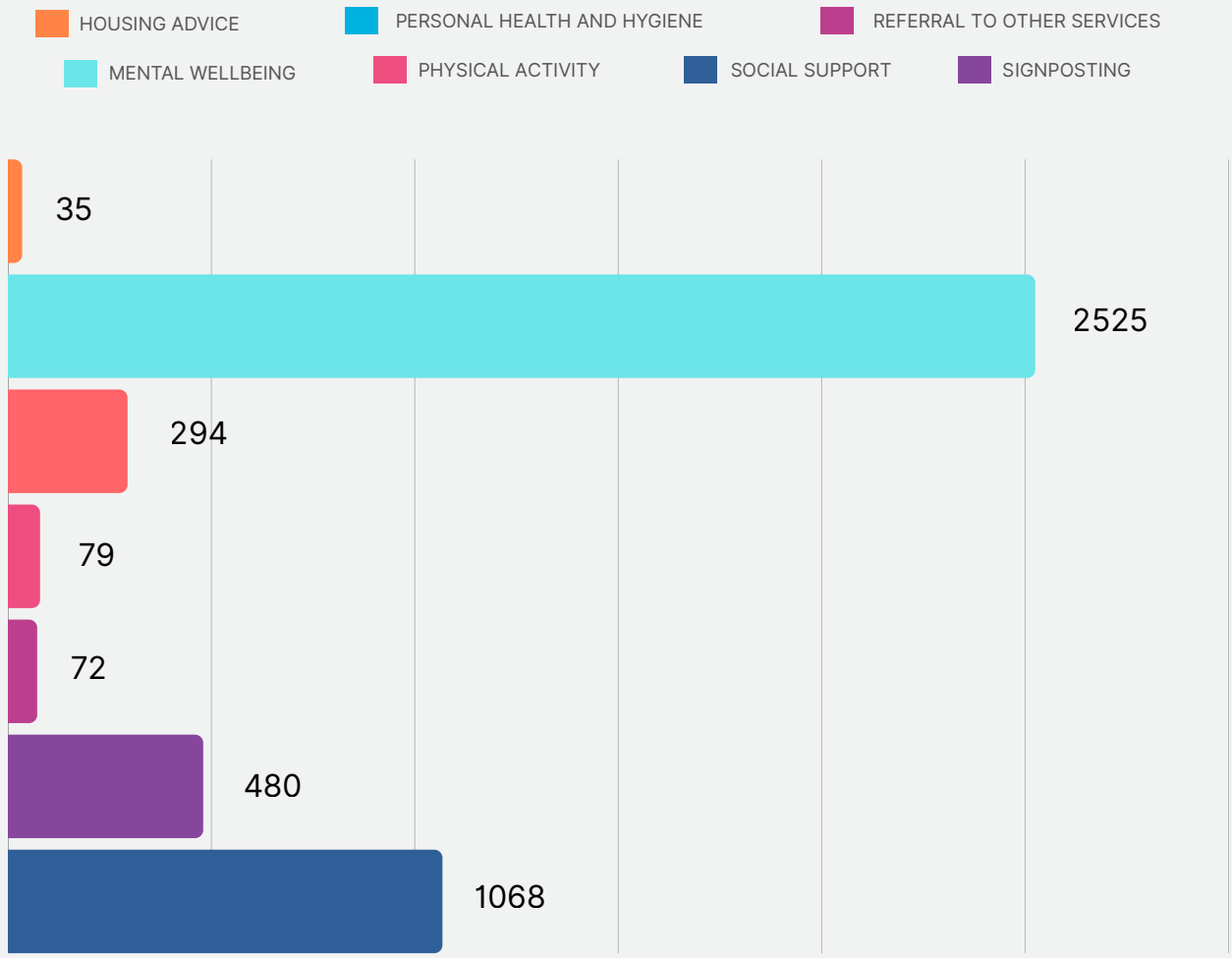
Hear from our Homeless Health Outreach Team as they provide insights into how the service runs and showcase its key achievements over the past year.

SCAN ME

17

EVENING CLINICS HELD
(HEALTH OUTREACH BUS)

ONWARD REFERRALS AND SIGNPOSTING BY THE PSYCHOTHERAPIST



Severe Mental Illness

Service Overview

The SMI service provides annual checks to individuals on the SMI register, supporting patients to receive regular, consistent monitoring and the practices to manage patients' physical health. The SMI health checks include blood pressure, pulse, BMI calculation, checking smoking and alcohol status (including how to seek support), venepuncture, ensuring access to cancer screening (if eligible), and an ECG if required.

Commissioned to deliver to 74 practices from Peterborough, Wisbech, and Cambridge at a variety of flexible locations. This provides good equity of access and ensures that an inability to visit their practice is not a barrier to patient wellbeing.

Patients with SMI frequently develop chronic physical conditions at a younger age, such as obesity, asthma, diabetes, coronary heart disease, stroke, heart failure, and liver disease. Therefore, the annual health checks are vital in identifying conditions early.

Our flexible approach has driven down the Did Not Attend (DNA) rate for hard-to-reach patients.

*Since April 2025, we have provided this service across all of Cambridgeshire and Peterborough.

3,403

SMI HEALTHCHECKS COMPLETED ACROSS PETERBOROUGH, WISBECH AND CAMBRIDGE PRACTICES

406

PATIENTS GIVEN A 6-POINT HEALTH CHECK IN THEIR OWN HOME

16.2%

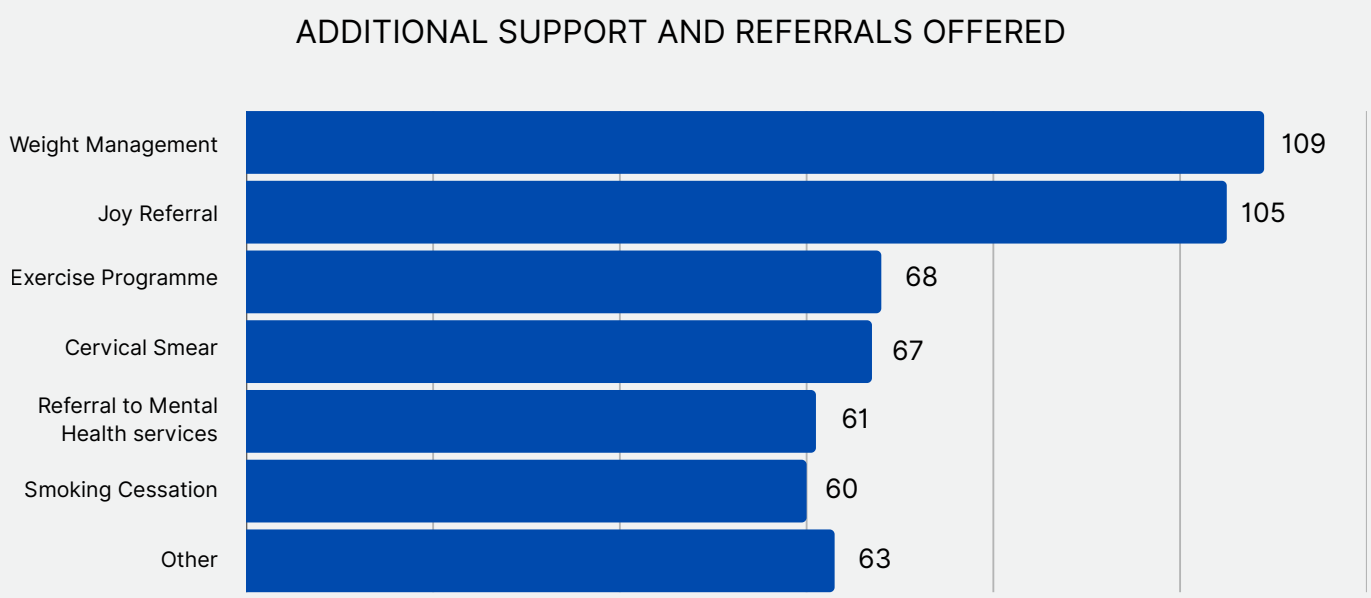
DNA RATE REDUCED FROM A KPI TARGET OF 33.3%

980

TOTAL PATIENTS REFERRED TO OR ESCALATED TO THEIR GP

Hear from our Severe Mental Illness Team as they provide insights into how the service runs and showcase its key achievements over the past year.

SCAN ME



Adult Eating Disorder

Service Overview

Working in collaboration with Cambridgeshire & Peterborough Foundation Trust (CPFT) to support patients with a mild to moderate eating disorder.

The service ensures patients are monitored between primary and secondary care; our collaborative approach with a consistent caseload supports a better monitoring system of attendance. The team escalates deterioration directly to CPFT. This eases practice workload and ensures patients are receiving the right care at the right time in the right place.

Eating disorders can harm the heart, digestive system, bones, teeth, and mouth and can lead to other diseases. Our supportive approach makes accessing healthcare less daunting for patients.

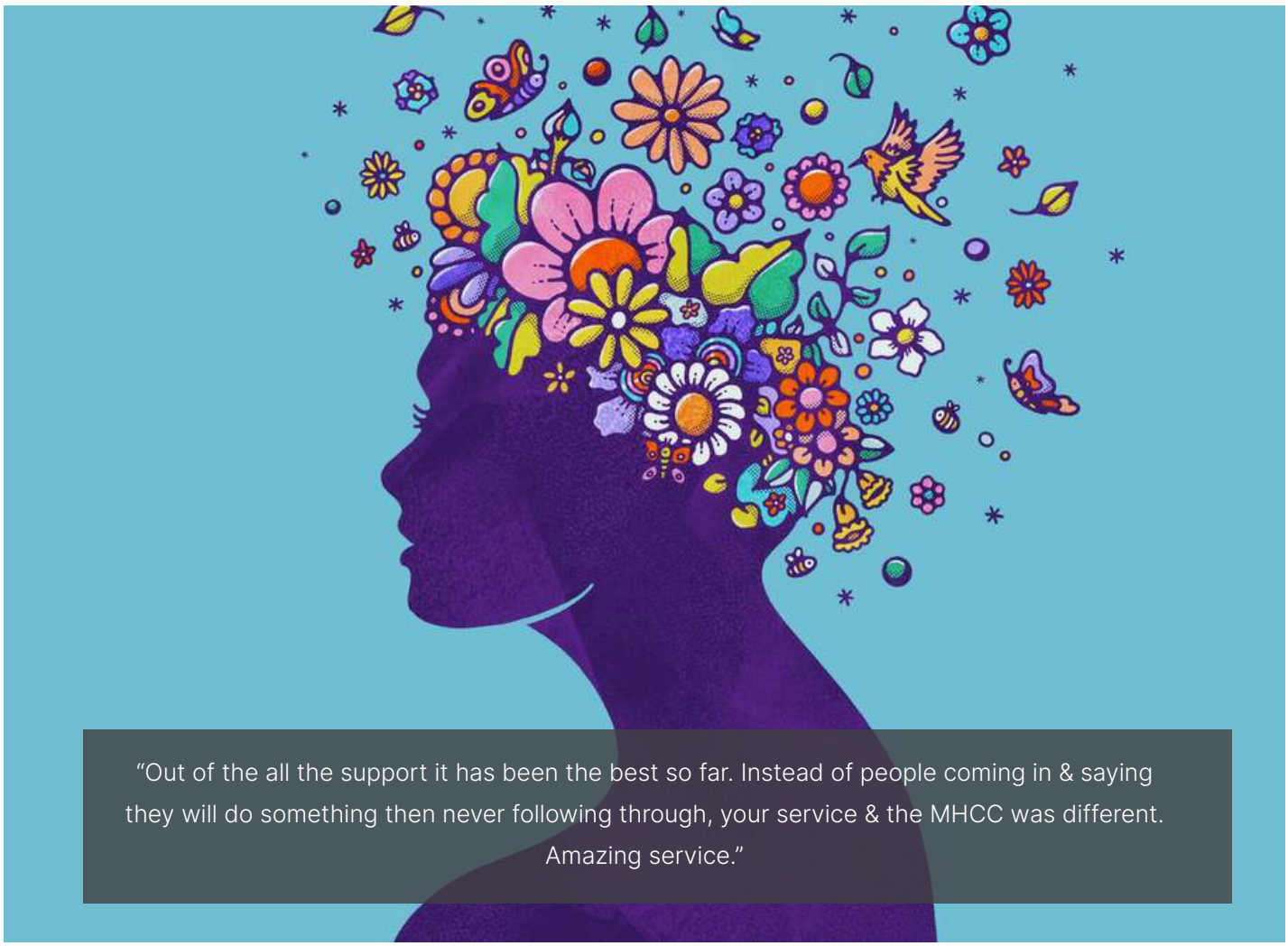
Mental Health Community Connectors

Service Overview

Many patients living with complex mental health needs lack social, economic, and environmental support. The Mental Health Community Connector (MHCC) service supports patients across the North of Cambridgeshire & Peterborough with complex mental health needs to improve their wellbeing. MHCCs will discuss with the patient their needs, set goals with them, and signpost to other services depending on the level of support required.

Patients have 6-8 sessions, based either in the GP practice, over the phone, in the community, or in the patient's own home, removing any barriers to healthcare that may arise when patients are unable to access their practice alone.

Support provided by MHCCs can include housing issues, isolation and loneliness, benefits, drug/alcohol/gambling addiction, goal setting, and connecting with activities in the community. Coordinating social issues alongside the support already given by their GP or Mental Health team can increase their overall well-being. As a result of additional support for many patients, there has been a reduction in the need for GP appointments.



"Out of the all the support it has been the best so far. Instead of people coming in & saying they will do something then never following through, your service & the MHCC was different. Amazing service."

Hear from our Mental Health Community Connector Team as they provide insights into how the service runs and showcase its key achievements over the past year.

SCAN ME

914

TOTAL PATIENTS REFERRED INTO THE SERVICE

451

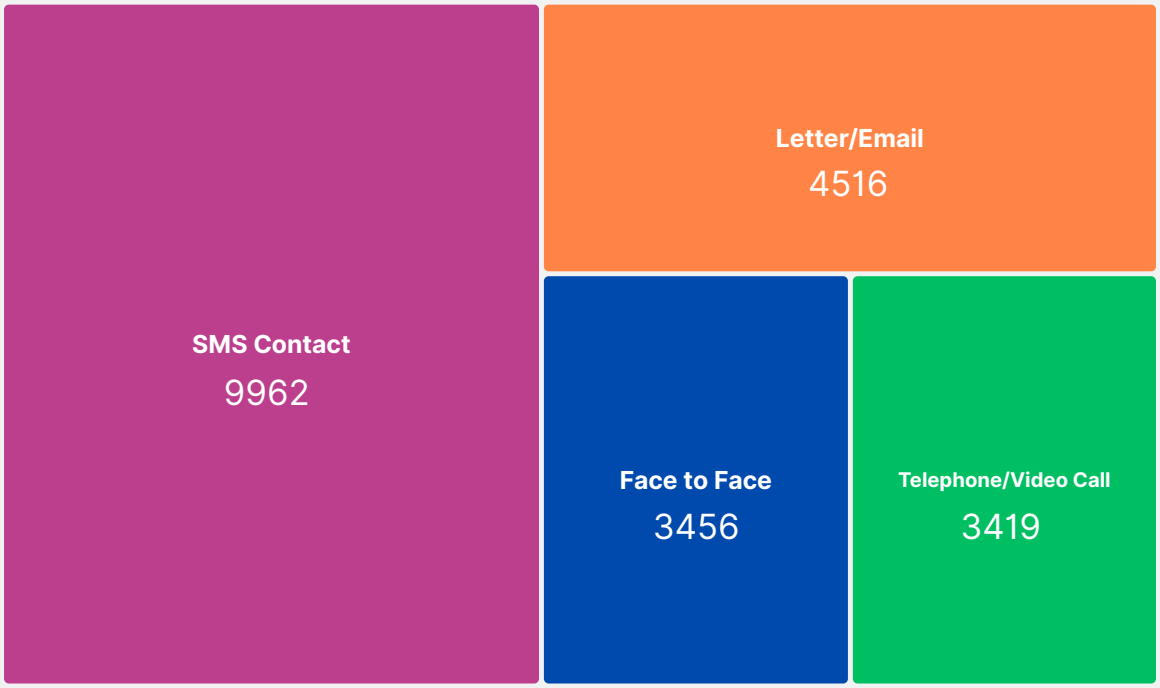
TOTAL ONWARD REFERRALS TO SUPPORT IN THE LOCAL AUTHORITY, COMMUNITY SERVICES AND VOLUNTARY SECTOR

ONS4 BASELINE

51.7%

PATIENTS SHOWED AN INCREASE IN ONS4 SCORE OF 51.7% AGAINST THEIR STARTING BASELINE WHEN DISCHARGED FROM THE SERVICE

PATIENT CONTACTS VIA MHCC SERVICE



Virtual Ward

Service Overview

Patients who are admitted to an acute hospital bed are at risk of further deterioration, including healthcare-acquired infection and deconditioning. Working in Partnership with the North West Anglia NHS Foundation Trust (NWAngliaFT), the Virtual Ward service provides an alternative to hospitalisation for unwell patients whose care can be managed outside a traditional hospital setting.

This service supports patients who have been assessed by hospital teams in the emergency department or assessment units and are deemed to need admission to a hospital ward. Instead of being admitted to a traditional inpatient ward, the GPN team cares for patients in their own homes. GPN manages the patient's care plan and treatment until they are medically well enough to be discharged back into routine primary and community care.

The service is overseen by a GP or Senior Advanced Clinical Practitioner, with our visiting team consisting of Advanced Clinical Practitioners, Urgent Care Practitioners, Paramedics, Urgent Care Technicians, and Health Care Support Workers.

When patients are admitted to acute wards, their care packages are often stopped, which complicates the discharge process for patients and leads to extended hospital stays. As a result, patients often need further support when discharged through secondary, community, primary, and social care.

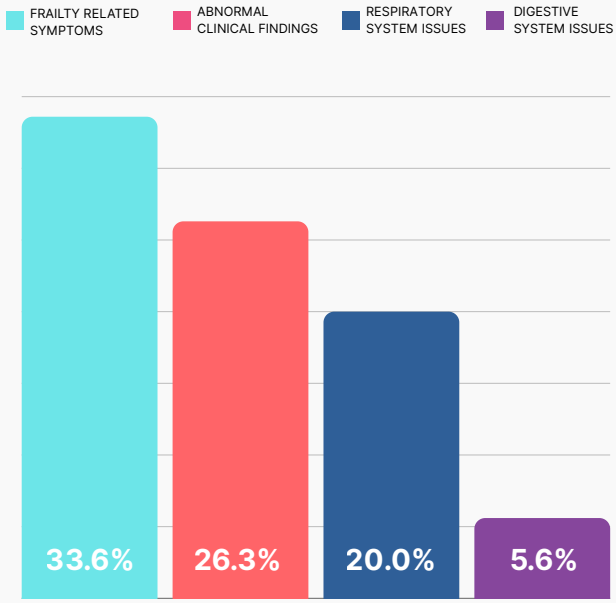
Patients recover more quickly in familiar home surroundings, reducing the separation from support systems outside the hospital, alleviating pressures on primary care, and increases the availability of acute care beds for those who cannot be treated at home.

Hear from our Virtual Ward Team as they provide insights into how the service runs and showcase its key achievements over the past year.

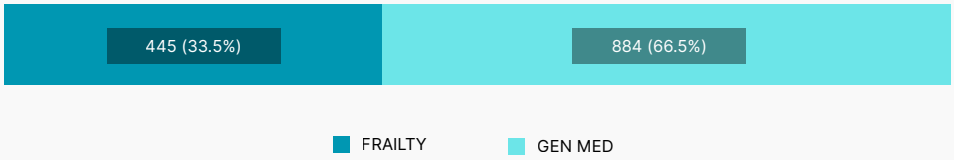
SCAN ME

On average, each patient received 2.5 visits and 1.6 calls from a clinician whilst onboarded to the service providing consistent care, support and reassurance.

THE MOST FREQUENT COMMON SYMPTOMS ON ADMISSION INCLUDE:



PATIENT SPLIT ACROSS GPN VIRTUAL WARD



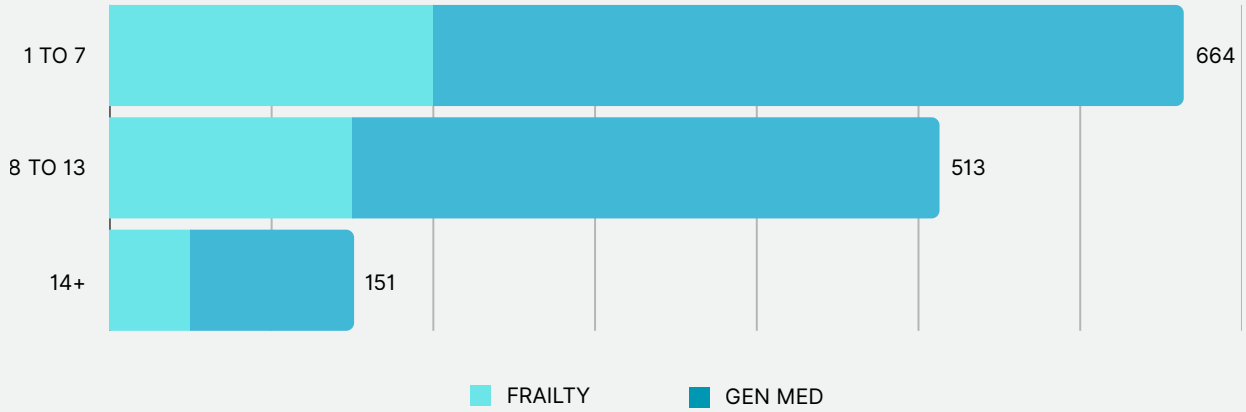
General Medicine: Focuses on acute medical conditions requiring short-term hospital-level care at home, delivered by clinicians and nursing teams.

Frailty: Supports older or vulnerable patients with complex needs, combining acute care with holistic assessment and often requiring more intensive support than those on the general medicine pathway.

PATIENTS BY TOTAL LENGTH OF STAY (DAYS)

Patients are onboarded and remain with us until their symptoms are sufficiently managed or until a higher level of care is required. Individuals discharged from hospital typically have a longer duration of stay than those referred through UWAC/UCR Frailty, as they often present with ongoing, complex conditions that continue to require treatment and monitoring.

8.5 DAYS AVERAGE LENGTH OF STAY



Urgent Wrap Around Care North

Service Overview

The Urgent Wrap Around Care North Service (UWAC North) provides increased care through a range of interventions and support at home for acutely unwell patients, aiming to prevent hospital admissions and promote patient recovery.

The service accepts referrals from ambulance crews, community healthcare teams, and through our call before convey service, as well as referrals from the trusted assessors working within the urgent and emergency care (UEC) hub. Patients can be visited within 2 hours of receiving the referral for a full comprehensive assessment.

The service is overseen by a GP or Senior Advanced Clinical Practitioner, with our visiting team consisting of Advanced Clinical Practitioners, Urgent Care Practitioners, Paramedics, Urgent Care Technicians, and Health Care Support Workers. The team can take multiple interventions, including ongoing extended clinical assessments, remote monitoring, observations, bloods, ECGs, bladder scans, and dressings.

The service is overseen by a GP or Senior Advanced Clinical Practitioner, with our visiting team consisting of Advanced Clinical Practitioners, Urgent Care Practitioners, Paramedics, Urgent Care Technicians, and Health Care Support Workers. The team can take multiple interventions, including ongoing extended clinical assessments, remote monitoring, observations, bloods, ECGs, bladder scans, and dressings.

Working collaboratively with the East of England Ambulance Service (EEAST) and UEC hub, UWAC North accepts referrals from the 999 ambulance STACK to reduce unnecessary ambulance dispatch and admissions. Compliance for ambulance waiting times can often be breached due to a high demand on the service. This can result in patients having long delays for treatment and ambulance crews queuing outside the Emergency Department (ED) for an extended period, reducing efficiency and flow. Intercepting patients who can be treated in the community with a high-level skill mix reduces unnecessary ambulance despatch and avoidable admissions into hospital.

Patients recover more quickly in familiar home surroundings, reducing the separation from support systems outside the hospital. Delivering hospital care in a patient's home enables patients to have a recovery and care plan in place, coordinated by the GPN team, alleviating pressures on primary care and increases the availability of acute care beds for those who cannot be treated at home.

Hear from our Urgent Wrap Around Care Team as they provide insights into how the service runs and showcase its key achievements over the past year.

SCAN ME

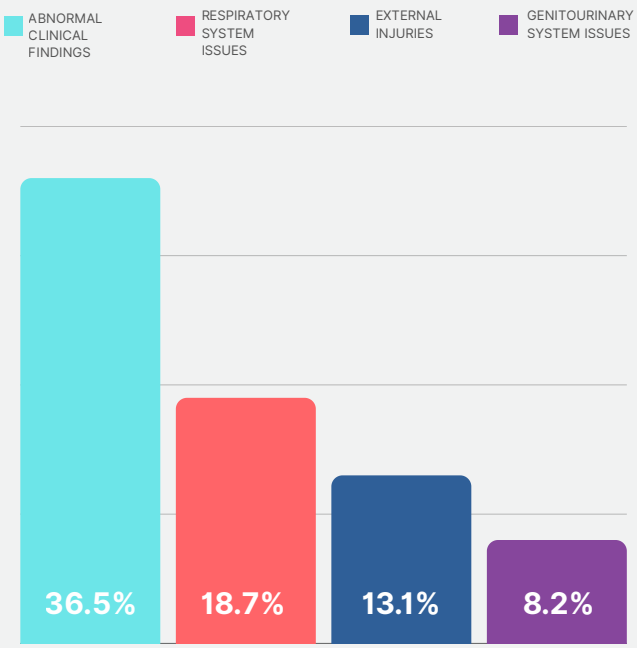
1,973

PATIENTS CARED FOR AT HOME BY GPN UWAC TEAM

ON AVERAGE, EACH PATIENT RECEIVED 2.5 VISITS AND 2.3 CALLS FROM A CLINICIAN WHILST ONBOARDED TO THE SERVICE PROVIDING CONSISTENT CARE, SUPPORT AND REASSURANCE.

COMMON SYMPTOMS ON ADMISSION

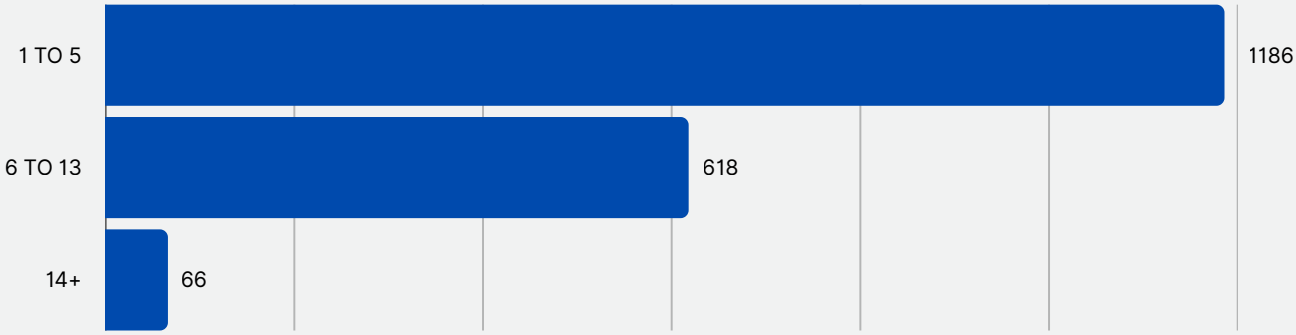
Onboarded patients present with a range of conditions, some of which require longer periods of monitoring than others. The most frequent include:



PATIENTS BY TOTAL LENGTH OF STAY (DAYS)

Patients referred into the UWAC service typically present with lower acuity needs, resulting in a shorter average LOS. Unlike hospital discharges, these patients are drawn from a wide range of referral sources across the community, and their conditions often require less intensive monitoring and intervention. This enables quicker recovery and earlier discharge from the service.

5.6 DAYS AVERAGE LENGTH OF STAY



Urgent Community Response Frailty

Service Overview

Urgent Community Response (UCR) Frailty Service provides increased care through a range of interventions and support at home for acutely unwell frail patients to prevent hospital admissions, which is particularly associated with additional risks and complications for this patient cohort, including risk of falls, deconditioning, delirium, loss of independence, and healthcare acquired infection. For many in this group, hospital admission can often mean that patients never return home with the same functionality, or admission to care becomes inevitable.

The service accepts referrals from ambulance crews and JET community team through our call before convey service. It is available to patients with a Clinical Frailty Score of 5 and over. Patients are visited and assessed by a clinical practitioner who completes an extended clinical assessment and develops a comprehensive care plan.

The service is overseen by a GP or Senior Advanced Clinical Practitioner, with our visiting team consisting of Advanced Clinical Practitioners, Urgent Care Practitioners, Paramedics, Urgent Care Technicians, and Health Care Support Workers. The team can take multiple interventions, including ongoing extended clinical assessments, remote monitoring, observations, bloods, ECGs, bladder scans, and dressings.

In addition, the service supports patients at the end of their life, often in moments of crisis where an ambulance has been called, and ambulance colleagues need support with arranging essential end-of-life medications and other arrangements. This essential support ensures the needs of patients and their families are met at this critical time. The team works with community palliative teams and the palliative care hub to arrange ongoing support.

Hear from our Urgent Community Response Frailty Team as they provide insights into how the service runs and showcase its key achievements over the past year.

SCAN ME

197

HIGH RISK FRAIL PATIENTS, WITH AN AVERAGE AGE OF 85, WERE CARED FOR AT THEIR USUAL RESIDENCE BY GPN UCR FRAILTY TEAM

75.1%

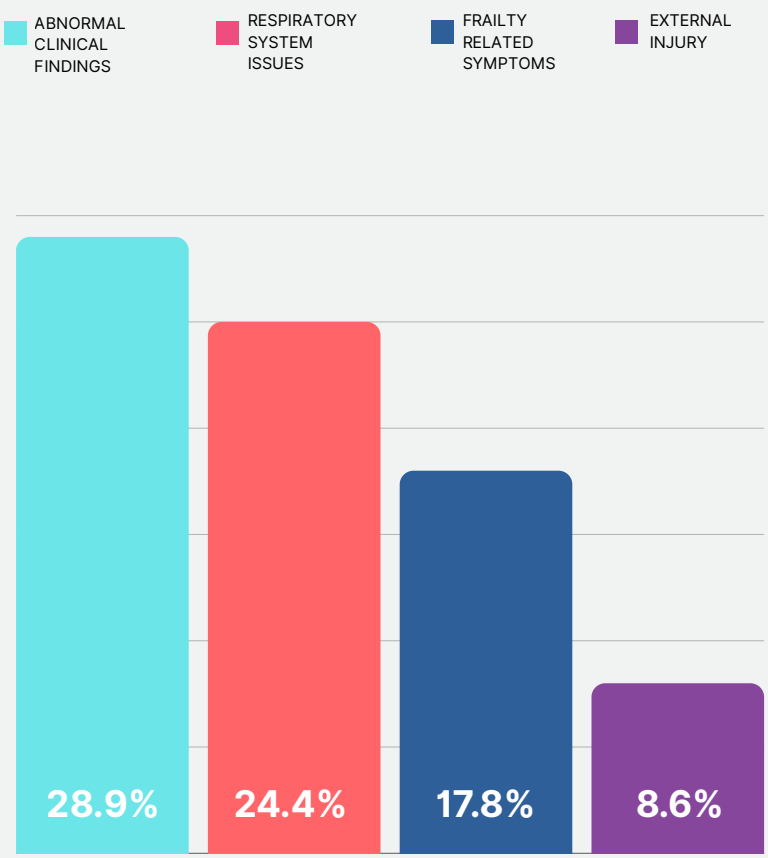
OF PATIENTS SUPPORTED IN THEIR OWN HOME

24.9%

OF PATIENTS SUPPORTED IN NURSING/RESIDENTIAL CARE HOMES

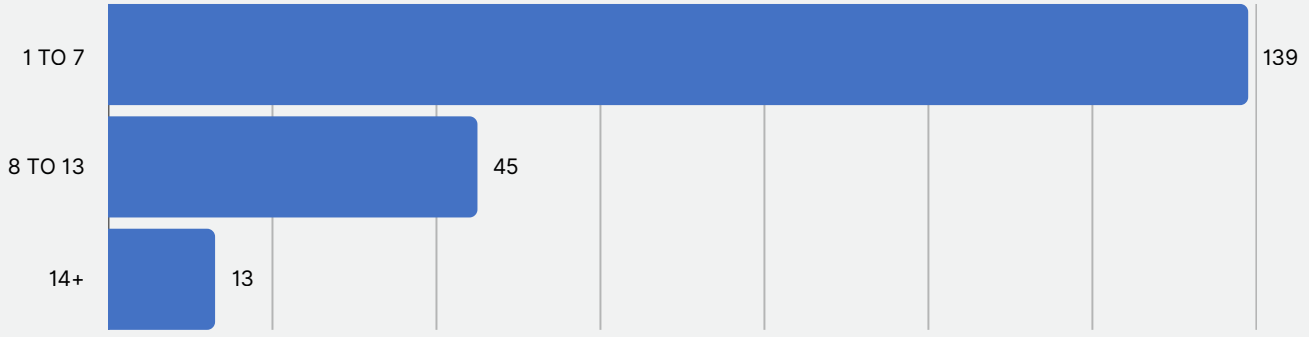
COMMON SYMPTOMS ON ADMISSION

Onboarded patients present with a range of conditions, some of which require longer periods of monitoring than others. The most frequent include:



PATIENTS BY TOTAL LENGTH OF STAY (DAYS)

Patients supported through the UCR Frailty pathway have an average length of stay of 6.3 days — longer than UWAC but shorter than Virtual Ward. This reflects the higher level of frailty within this group, where patients often require more intensive support, longer home visits, and closer monitoring to ensure stability. Recovery is typically slower, with extended input needed to help patients regain function and confidence in the community.



Call Before Convey

Service Overview

The Call Before Convey (CB4C) service enhances patient care by enabling ambulance clinicians to consult with senior clinicians for guidance on patient cases, supporting informed clinical decision-making. This collaborative approach helps optimise patient care and clinical pathways by offering alternatives to transporting patients to the Emergency Department (ED). These alternatives may include referrals to community services, support for self-care, remote prescribing, or referral to hospital specialist teams.

This proactive approach reduces unnecessary ED visits and improves healthcare delivery and patient experience. By collaborating with various healthcare providers, the service helps ease the pressure on EDs, particularly during peak times, ensuring timely, appropriate, and patient-centered care. This approach improves overall health outcomes in the Cambridgeshire and Peterborough regions, promoting quicker recovery by reducing patient deconditioning and enabling them to stay connected with friends and family.

Ambulance crews attending patients who either reside in Cambridgeshire and Peterborough or would be transported to one of the county's three hospitals have access to the CB4C service. Crews frequently consult CB4C, unless immediate hospital admission is required, to seek advice or explore alternative pathways to avoid unnecessary trips to ED. The service also provides senior clinical support, enabling quicker decision-making and allowing ambulances to respond to their next 999 caller sooner, benefiting the wider community.

Previously, paramedics waited an average of 48 minutes to speak with a duty doctor at a patient's practice. In contrast, the CB4C service connects clinicians in an average of just 2 minutes.
The ability to receive advice and collaborative decision-making with senior ED Consultants, GPs and ACPs has enabled ambulance crews to arrange EPS prescriptions to the patient's nearest pharmacy, direct patients to speciality where appropriate, coordinate community services and keep patients at home.

1,621

PATIENTS TRANSFERRED TO CARE UNDER UWAC NORTH DELIVERING A SEAMLESS TRANSFER AND COMPLETION OF PATIENT CARE PATHWAY

9,151

HOURS OF SENIOR CLINICAL SUPPORT DELIVERED TO CREWS TO HELP CHOOSE THE MOST APPROPRIATE PATHWAY FOR THE PATIENT

12,351

PATIENTS SUPPORTED VIA CB4C CLINICAL CALLS

99.6%

CALLS ANSWERED IN UNDER THE 20 MINUTE KPI TARGET AVERAGE OF 1.34 MINUTES TO CONTACT A CLINICIAN

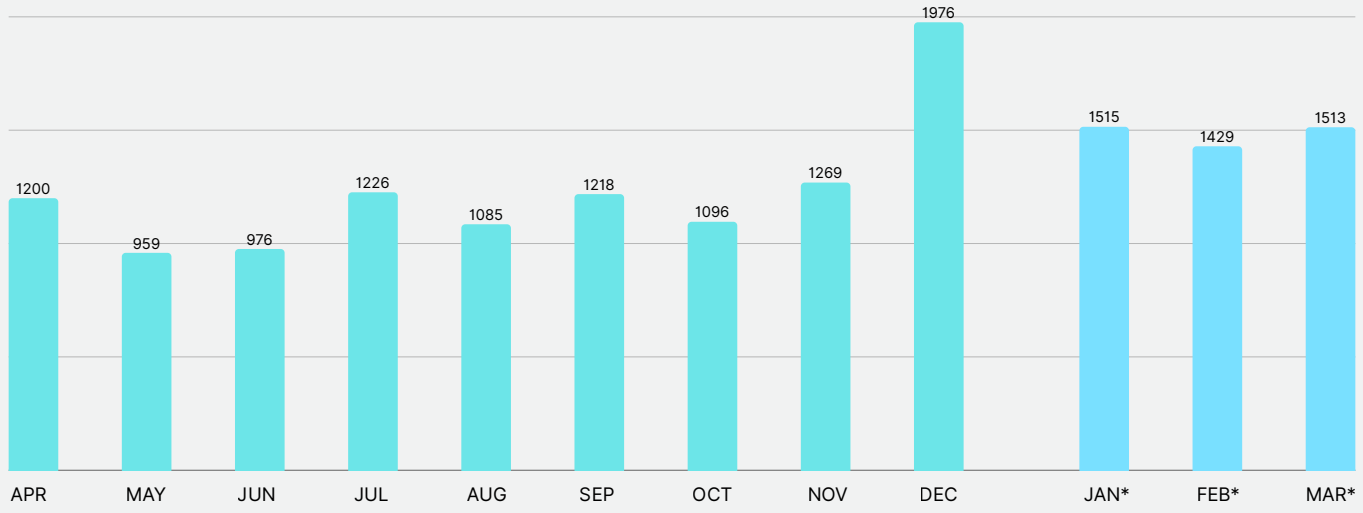
Hear from our Call Before Convey Team as they provide insights into how the service runs and showcase its key achievements over the past year.

SCAN ME

CALLS ANSWERED PER MONTH

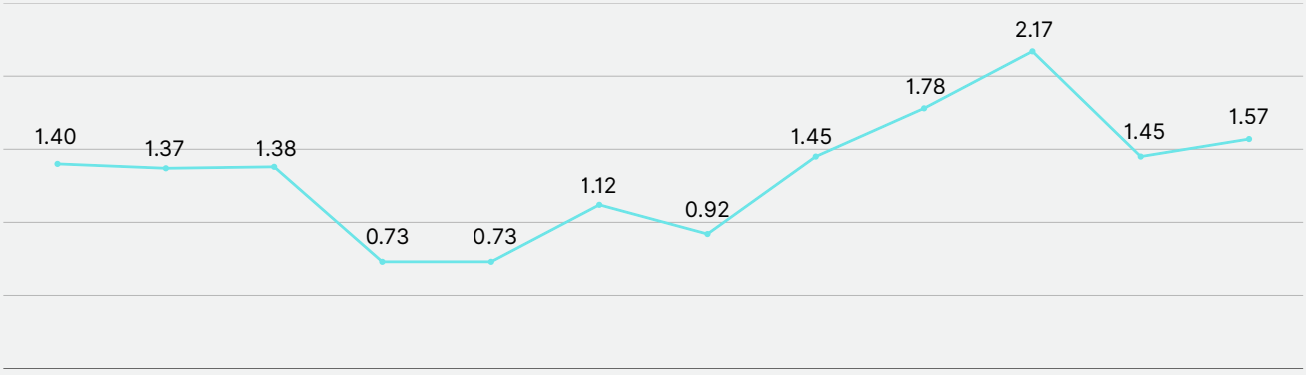
DURING DECEMBER, WINTER PRESSURES DRIVE A SHARP RISE IN THE NUMBER OF CALLS INTO THE SERVICE. THIS INCREASED DEMAND IS MANAGED WITHIN CB4C, WHICH IN TURN HELPS TO REDUCE PRESSURE ON HOSPITALS BY PREVENTING AVOIDABLE ADMISSIONS

*EXTENDED OPERATIONAL HOURS, PROVIDING 345 ADDITIONAL HOURS OF SUPPORT (8 AM – 10 PM)



AVERAGE CALL ANSWER TIME (IN MINUTES)

CONSISTENTLY LOW AVERAGE CALL ANSWER TIMES PROVIDE ASSURANCE TO CREWS THAT SUPPORT IS READILY AVAILABLE, WHILE ALSO REASSURING PATIENTS AND FAMILIES THAT THEY WILL RECEIVE TIMELY ACCESS TO THE MOST APPROPRIATE AND EFFICIENT FORM OF TREATMENT



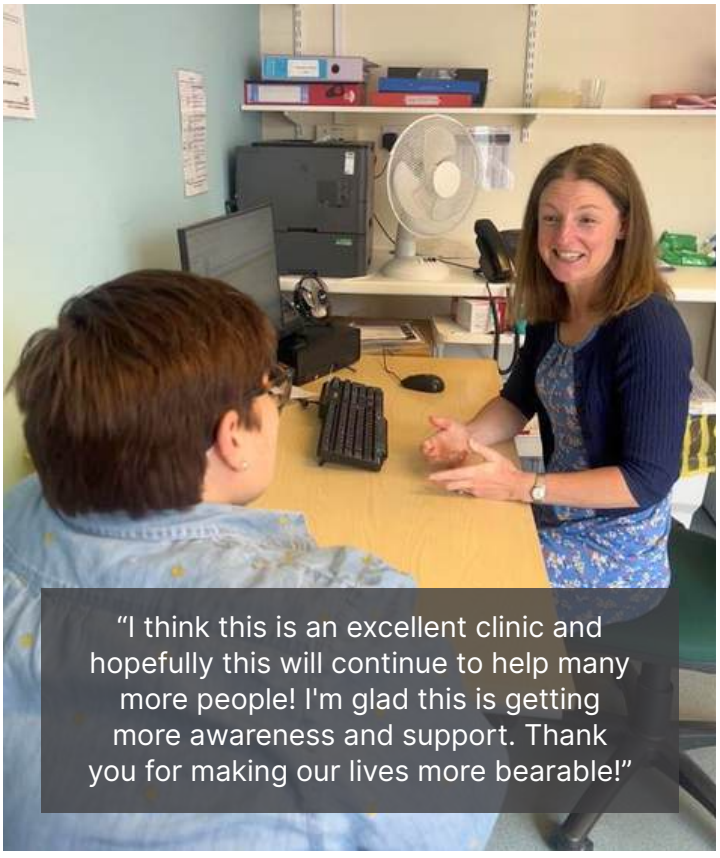
Menopause Clinic

Service Overview

GPN provides a Menopause Support Clinic to the population of the GPN Federation workforce, assisting in reducing staff sickness and improving wellbeing. The clinic has had 100% positive feedback in its friends and family questionnaires.

In the NHS workforce, approximately 1 in 5 women are aged between 45-54 and could be going through the menopause transition.

The objectives of the Menopause Clinic are to host a 6-weekly clinic consisting of one GP session, with regular appointments for either 30-minute consultations for new patients or 15-minute follow-up appointments.



40

LOCAL NHS STAFF GIVEN SUPPORT THROUGH THE MENOPAUSE CLINIC

68

TOTAL COMPLETED APPOINTMENTS FOR PRIMARY CARE STAFF

Hear from our Menopause Clinic Team as they provide insights into how the service runs and showcase its key achievements over the past year.

SCAN ME

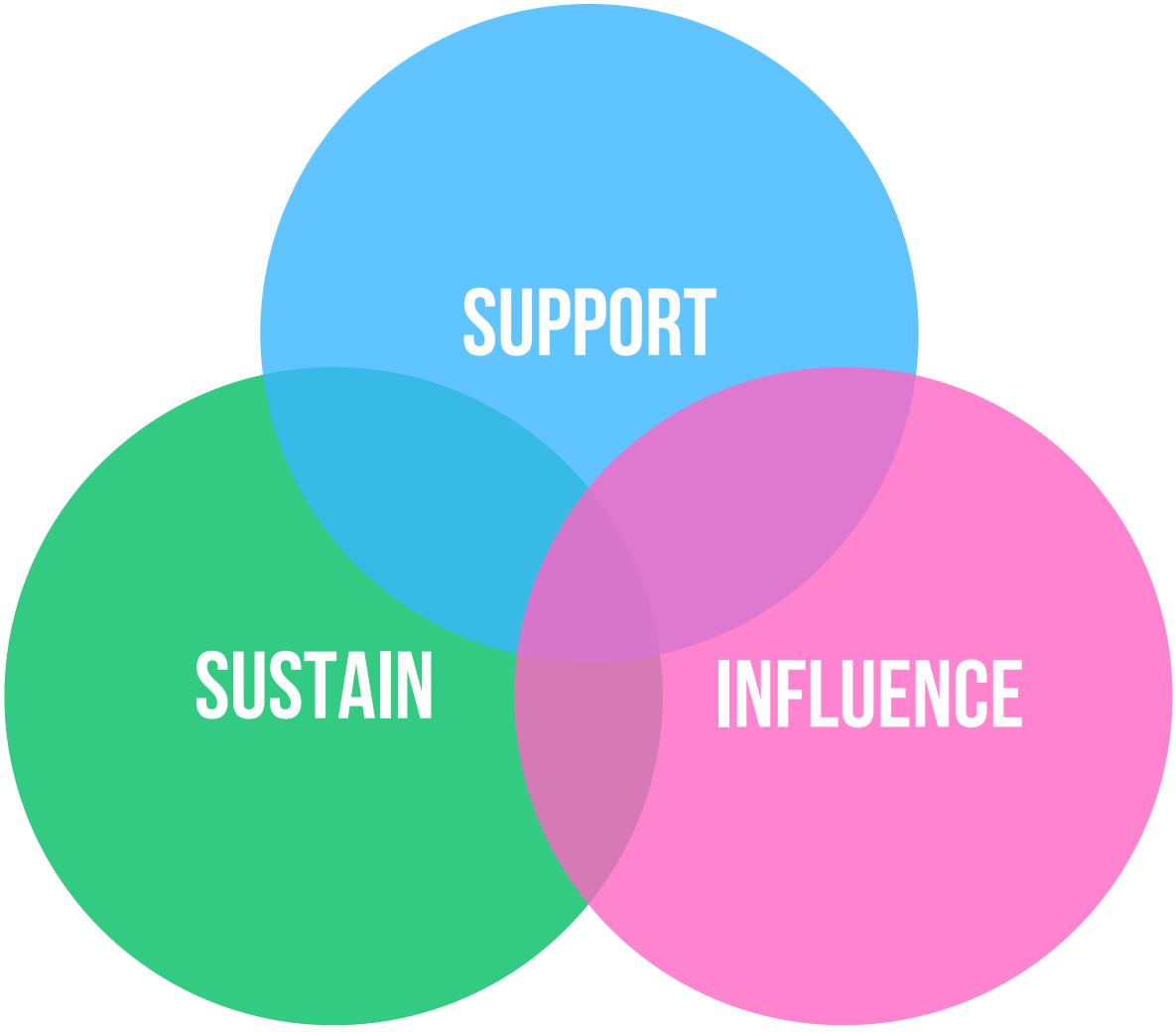
LOOKING FORWARD

At Greater Peterborough Network, our focus is to support practices, sustain high-quality care, and influence the future of primary care delivery.

By combining innovation, collaboration, and patient-centred approaches, we are committed to improving outcomes for our communities and enabling practices to thrive.

There are three key pillars upon which our GPN strategy is built:

- To **SUPPORT** our Member practices and the patients we serve
- To **SUSTAIN** GPN to continue to work with our members as a dynamic and responsive at scale provider of Healthcare Services
- To **INFLUENCE** our system and Regional Partners and Policy Makers in recognising the important role that GPN has in delivery of at scale services



SUPPORT

Our priority is to ensure practices and PCNs are supported to focus on direct patient care. We will achieve this by reducing administrative burdens, strengthening workforce wellbeing, and expanding access for patients.

DRIVING AUTOMATION AND INNOVATION IN CARE

We are embracing advanced tools and automation to transform care delivery. By expanding our tested Robotic Process Automation (RPA) into practices, we can streamline administrative tasks and free up more time for clinical care.

Alongside this, our use of analytics will continue to improve quality, enhance performance, and deliver better population health outcomes.

PRACTICE SUPPORT & OFFERS

To ensure practices have the right foundations in place, we will continue to provide a wide range of support services.

This includes specialist Human Resources support to strengthen workforce management, Information Governance support to maintain compliance and data safety, and Communications support to assist with patient engagement.

Further information is available in our dedicated videos.

In addition, we will offer CQC support through our Clinical & Quality Team and dedicated forums, while also maintaining our commitment to providing ongoing care for Housebound Diabetic patients, ensuring access for some of the most vulnerable individuals in our population. In partnership with the Integrated Neighbourhood Team at NWAFT, GPN has expanded access to cervical screening across Peterborough, Fenland, and Huntingdonshire. By delivering flexible clinics through the Health Hub Outreach Vehicle and offering evening, weekend, and workplace sessions, we have supported patients who may otherwise struggle to attend, helping to increase uptake and reduce overdue screenings.

GPN offers a dedicated Menopause Support Clinic for the workforce within the Federation, designed to improve wellbeing and reduce staff sickness. The service has been extremely well received, achieving 100% positive feedback and demonstrating a clear benefit to both staff health and workplace resilience.

EXPANDING PATIENT SUPPORT AND ACCESS

Improving access and tackling health inequalities remain central to our work, and in the year ahead, we will take further steps to strengthen patient support across our communities. We will continue to build capacity for people living with long-term conditions, recognising the growing needs of patients managing multiple health challenges, and support PCNs to deliver enhanced access so that more patients can benefit from timely and convenient appointments.

Alongside this, we will introduce a new Smoking Cessation Service to promote healthier lifestyles and reduce preventable illness. Crucially, we will also increase co-creation of services through patient forums, ensuring that care is designed around the needs of Peterborough's diverse population.

EXPANDING PATIENT SUPPORT AND ACCESS

Our workforce is the foundation of high-quality care, and we will continue to invest in staff wellbeing and professional growth over the year ahead. Our commitment to our member practices includes maintaining the practice Wellbeing Fund and Staff Benefits Scheme, supporting learning and peer development through dedicated forums for Nurses and HCAs, and providing structured practice learning time alongside targeted winter support to help teams manage seasonal pressures effectively.

SUSTAIN

We are committed to building resilience and ensuring sustainable models of care that meet the needs of both patients and practices, ensuring our commitment to our community.

DELIVERING INNOVATION THROUGH COLLABORATION

NEIGHBOURHOODS

We will continue to strengthen integrated neighbourhood models in partnership with local authority and public health colleagues, playing a key role in the development, delivery and implementation of the National Neighbourhood Health Implementation Programme (NNHIP) as part of the wave 1 pilot site.

PARTNERSHIPS

By embedding a place-based approach focused through PCN footprint delivery, together we can continue to deliver more care closer to our communities. This will further improve the support that GPN offer, so that we can deliver care closer to communities, improve prevention, and support health and wellbeing across Peterborough.

Continuing to deepen our collaboration and partnership working with North West Anglia Foundation Trust through widening our Virtual Ward as well as supporting increasing the number of Frailty beds in the community.

In partnership with the East of England Ambulance Service Trust (EEAST), expanding and building on our Call Before Convey service to support ambulance crews at patients' homes, enabling direct referral to specialist services and reducing unnecessary visits to the Emergency Department (ED). Furthermore, we will be exploring, as part of the national priorities, how we can move activities from the hospital into primary and community care.

BUILDING CAPACITY AND RESILIENCE

Sustainability requires forward planning and innovation. We will expand digital solutions, support workload management, and enable practices to deliver high-quality care over the long term. By developing innovative care models, we are creating a stronger, more resilient system for the future.

INFLUENCE

Greater Peterborough Network plays a vital role in ensuring that the voice of primary care is presented and through unification represent general practice at scale, together our voice is stronger, together our influence is greater. We will continue to represent our practices in system and national discussions, helping shape the future of local healthcare delivery.

SYSTEM LEADERSHIP AND INFLUENCE

Collaboration remains at the heart of our work, with a focus on strengthening system leadership and ensuring the voice of primary care is heard. We will continue to represent practices at both system and national levels so that local priorities are recognised, while also co-creating new models of care with patients and partners to meet the diverse needs of our communities.

At the same time, we will share learning and best practice across PCNs, driving improvements in quality and performance across the network. Working with federation colleagues across the country developing innovative services that others can learn from such as: Call Before Convey and Virtual Ward.

ENGAGEMENT AND GOVERNANCE

We are committed to strengthening relationships with patients, practices, and staff. Over the coming year we will place a strong emphasis on engagement and governance, placing the patient voice at the centre of what we do whilst harnessing local clinical voices and leadership.

This will include creating more opportunities for patient participation in shaping services, delivering data-informed practice visits to ensure care remains responsive to local needs, and providing clear, consistent communication across our network to build shared understanding and trust.

BOARD OF DIRECTORS

The GPN Board of Directors set the strategy and represent the interests of our Member practices and their patients.

Mustafa Malik
Chief Executive Officer

Dr Neil Modha
Chair

Angela Bright
Non-executive Director

Mark Tarry
Non-executive Director

Dr Daniel Nweledim
Vice Chair & Practice Director

Dr Sundeap Odedra
Medical Director

Dr Esther Green
Practice Director

Dr Rhiannon Nally
Practice Director

Dr Rupert Bankart
Practice Director

Dr Rupa Kamath
Practice Director

Dr Nabeel Laliwala
Practice Director

Dr Ruth Beesley
Practice Director

The Board meets fortnightly and is supported by several sub-committees, such as the Quality and Patient Safety Committee, Audit and Financial Processes Committee and the Remuneration Committee which help the Board discharge its duties in a robust and structured manner.

We thank you for your continued support to deliver high-quality care at scale.

“High-quality service delivered with friendliness and expertise.”

“Excellent. My evening appointment started on time, and the nurse was knowledgeable and supportive.”

"The nurse’s professionalism, knowledge, and pleasant manner made the experience very helpful."

"Couldn’t be happier with the service. The team was outstanding, and everything about the experience was positive."

"An efficient and friendly visit. Last year I required additional services, and I was successfully directed to them. Thank you."

Contact

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www.greaterpeterboroughgps.nhs.uk

Greater Peterborough Network NHS