GREATER PETERBOROUGH NETWORK

ANNUAL REPORT

2023 - 2024

Greater Peterborough Network

NHS

FOREWORD

Dr Neil Modha

Chair

This has been a year of change and challenge for Greater Peterborough Network (GPN). We have further strengthened the clinical and managerial team and brought in some expertise to support our teams. I am delighted that many of our newer GP Members to the board have settled well in the organisation and are providing leadership within our sub-committees. My thanks to Dr Daniel Nlewedim and Dr Rupert Bankart alongside our longer serving directors supporting our committees - Dr Esther Green and Dr Sundeap Odedra.

There have been some changes in the clinical leadership within the organisation and I am delighted to announce that Dr Sundeap Odedra has been appointed as Medical Director. Many of our GP board Members have taken on leadership of our respective services. We thank Dr Harshad Mistry for his tenure in Greater Peterborough Network and wish him the best for future endeavours.

Greater Peterborough Network has continued to look at adding value to our patients and the care system in the space between the Hospital and General Practice. Call Before Convey, Virtual Wards and Wrap Around Services have become business as usual as we look to explore other opportunities to enrich our patients' lives.

We have started sharing patient stories at our board meetings. Some of which, we will be sharing at our Annual General Meeting. These are humbling, and we should be really proud of what we have created, the people we have recruited and the difference they have made to our people. Dr Ruth Beesley is an exemplar of leading by doing and creating a culture of understanding, empathy and excellence and I thank her for her contributions to the organisation with a focus on mental health and improving the lives of the homeless and vulnerable.

A recent trip to Hull showed some amazingly simple work that we feel will really make a difference to our community in Peterborough and I am looking forward to seeing what we can do by providing improved care for the most vulnerable and frail individuals. I am grateful to Dr Rhiannon Nally for her leadership in this area.

Continuing to improve our health system and pushing to make things better keeps us united. Thank you to our colleagues in General Practice and in the health system for their support.

GPN is nothing without our teams. We have so many team members who go above and beyond on a daily basis. We appreciate their flexible approach and their desire to make a difference to people. As a board we have celebrated the work of our teams and some star individuals too.

We hope here at GPN we are seen as the team with a can-do attitude that you can rely on. We commit to continue with our three objectives - supporting our Members, influencing the system and making a difference to our community.

FOREWORD

Mustafa Malik

Chief Executive Officer

This year in 2023-24, GPN has worked diligently on behalf of our Members, consistently striving to enhance the support and services we offer to our Member Practices, our staff, our partners and the patients we serve. This year, we have further expanded the range of services and support offers available to our Practices. Our Human Resources and Information Governance support has been particularly well-received, with many Members sharing how valuable these resources have been in navigating their challenges. The practice teams have found the wellbeing fund to be a valuable opportunity for staff to enhance how they make the most of precious break times.

Throughout this report, you will see examples that we have tried to take every opportunity to support our Members and our patients where possible. However, there is always more to do, and we commit to keep striving on the journey of support and service delivery.

Over the past 12 months, some of our most significant achievements together include supporting with Home Visiting services for housebound patients, where we were able to provide 10,668 home visits, to delivering Extended Access through the GP Hub, and our Menopause Clinics, which our colleagues have fed back this has helped them remain at work. We continue to provide services not only at scale across general practice, such as the GP Hub and Home Visiting Service, but wider across the system which has a positive impact for colleagues across all areas of the local health and care system such as our Call Before Convey and the Virtual Ward. This helps keep patients at home, but also helps us to support our Members by having the calls answered centrally, keeping the calls away from primary care.

We recognise the workforce pressures on general practice and through another successful year of the ARRS programme, where we were able to leverage our collective scale and make available a further £1.1m for staff costs over and above the national allocation. This was made possible through a collaboration between the Peterborough PCN Clinical Directors, the Cambridgeshire & Peterborough ICB and GPN. As a result of this, Peterborough Practices were able to recruit a further 220 staff. This funding helps create teams with a wide range of skills to better support our Member Practices.

As we look forward to the year ahead, I am filled with excitement and optimism. The achievements of this past year would not have been possible without the dedication of our staff, the engagement and support of our Member Practices, and the invaluable support from colleagues across the healthcare system. I am humbled and grateful for the collective effort that has brought us to this point.

Together, I believe we can continue to make a meaningful difference. With the same energy, commitment, and collaboration, we can build on our successes, support our Practices, and improve the health and well-being of the patients, their carers, our staff and the communities we serve.

Thank you to each and every one of you for your dedication, compassion, and hard work. Here's to a bright and impactful future ahead in 2025.

BOARD OF DIRECTORS

The GPN Board of Directors are elected by the shareholders to set the strategy and represent the interests of shareholders and Members. 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 forum which help the Board discharge its duties in a robust and structured manner.

Mustafa Malik
Chief Executive Officer

Dr Neil Modha
Chair

Angela Bright
Non-Executive Director

Dr Sundeap Odedra
Medical Director & Vice Chair

Dr Ruth Beesley
Mental Health Services

Dr Rhiannon Nally
Frailty

Dr Esther Green
Finance Auditing

Dr Harshad Mistry
Board Director

Dr Rupert Bankart
Finance Auditing & Long Term Conditions

Dr Daniel Nlewedim
Communications & Quality and Patient Safety Committee

A WORD FROM OUR MEDICAL DIRECTOR
Dr Sundeap Odedra

GPN continues to provide a wide array of services for our Member Practices and patients. These include Extended Access appointments provided through the GP Hub, Home Visiting HCAs, physical health checks for patients with Severe Mental Illness, Homeless Health, Virtual Ward, Call Before Convey and several others. Day to day, I see the industrious and dedicated work from our clinical and non-clinical teams which are reflected in some of the case studies I encourage you to read later in this report. Over the next year we are determined to maintain a focus on improving quality, launching new services and consolidating our position to ensure we can continue to provide long term support for our Member Practices and patients.

ABOUT GPN

WE ARE

- A **not for profit GP Federation** owned and run by the shareholding Member Practices.
- Governed by a **Board of elected GP Directors**, with a Chief Executive Officer and Non-Executive Director.
- An ambitious **at-scale primary care organisation** with a passion for integration and innovation.

WE DO

- Recruitment, induction and support of workforce through a team dedicated to **supporting Primary Care Networks**.
- Deliver at scale services to **improve the health and wellbeing** of the populations we serve.
- Connecting General Practice with the wider health and care system, operating as a **"network of networks"** for our PCNs, representing Member Practices at system and place level meetings.

OUR PRINCIPLES

- To act as the foundation stone for our Members: **supporting them to deliver high quality healthcare.**
- To attract **innovation and investment** into primary care.
- To be dynamic: **always seeking out new opportunities** for our Practices and PCNs.
- To be the **primary care provider at scale:** supporting delivery of services at place level that benefits our patients and Members.
- To **engage our clinical community:** identifying local clinical leaders to drive service redesign and delivery across our place.
- To face challenges head on, **working collaboratively** to deliver solutions.

OUR AMBITIONS

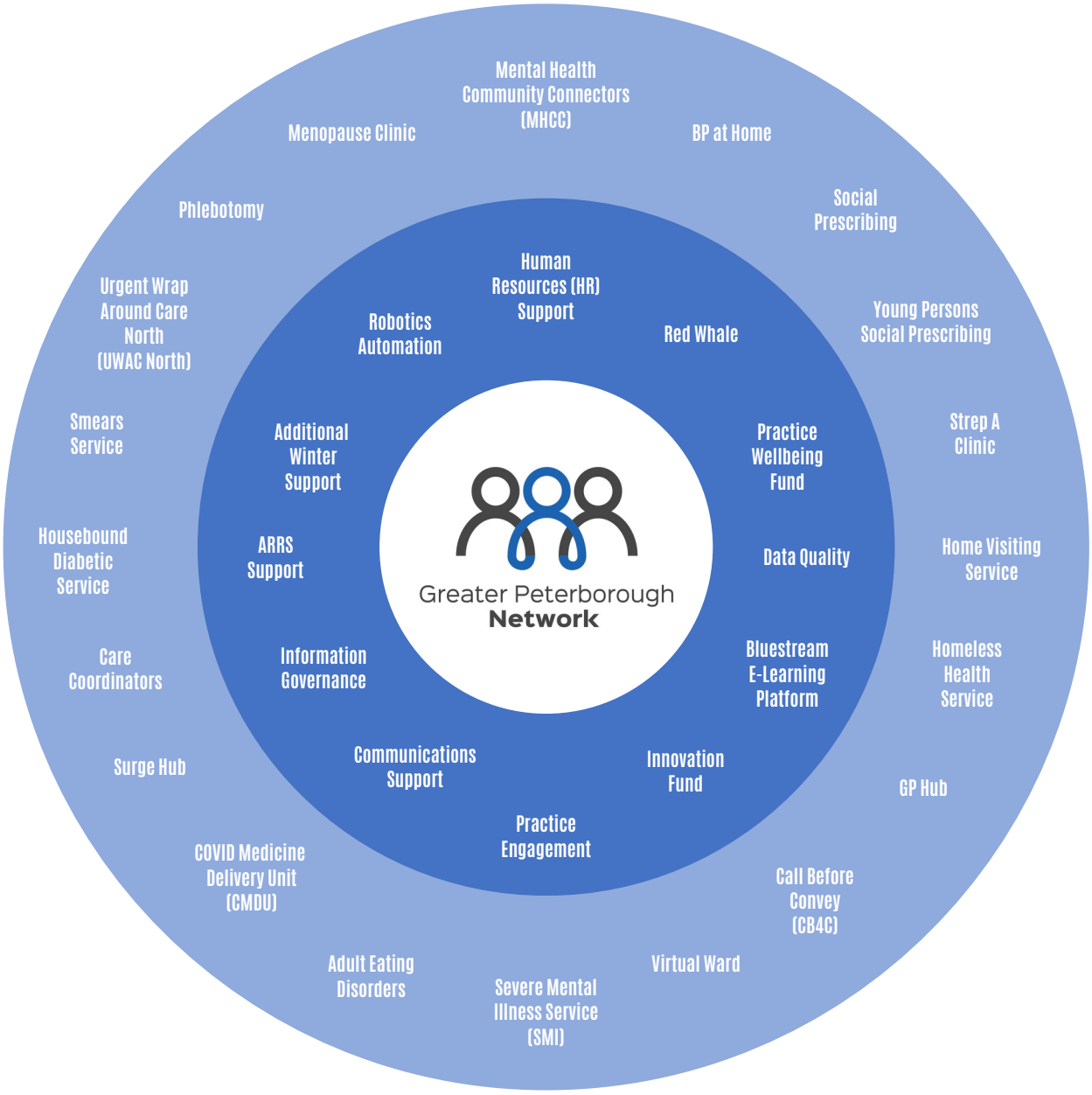
- To become the **leading GP Federation** that continues to support and provide services for our Member Practices.
- Deliver **community based services** that address existing gaps.
- Working closely with our **partners and commissioners** to improve healthcare and health outcomes for our population.

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.



OUR PEOPLE & SERVICES

THIS SECTION HIGHLIGHTS THE BREADTH OF SERVICES WE PROVIDE

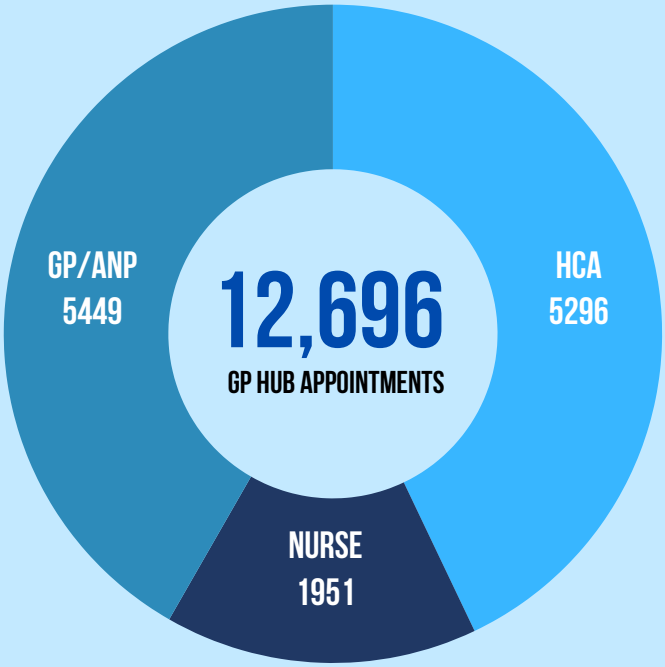
Throughout 2023 and 2024, we have strengthened our commitment to fostering collaboration among our Member Practices and partners. By actively supporting these partnerships, we have been able to enhance the quality of care provided to our communities.

During this period, **we are proud to have delivered a total of 20 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 2023-24

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. **Below is a brief snapshot of some of the data collected in 2023-24:**



116.5% OF CONTRACTED EXTENDED ACCESS HOURS DELIVERED

26,172 PHLEBOTOMY PATIENTS PROCESSED AT THE CITY CARE CENTRE

10,668 TOTAL VISITS FROM THE HOME VISITING SERVICE

3,860 UNIQUE HOUSEBOUND PATIENTS VISITED THROUGH HOME VISITING SERVICE

811 SMEARS DELIVERED

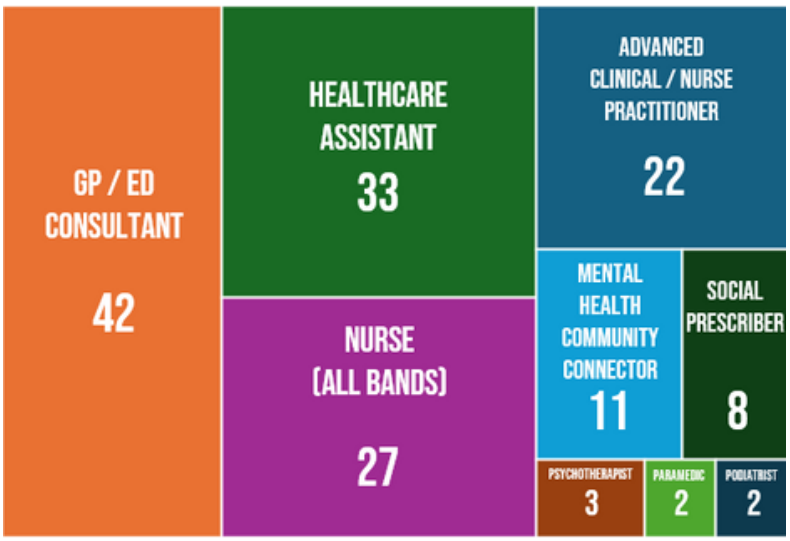
15,851 SMS APPOINTMENT REMINDERS SENT VIA ROBOTIC AUTOMATION

594 VISITS TO BP AT HOME PATIENTS

97.6% OF PATIENTS ASKED (6826) WOULD RECOMMEND GPN SERVICES TO THEIR FRIENDS AND FAMILY

150 CLINICAL STAFF WORKED ON GPN SERVICES: 19% MORE THAN 2022-23

INDIVIDUAL GPN CLINICAL STAFF 2023-24



A YEAR IN DATA 2023-24

3,226
TOTAL SEVERE MENTAL ILLNESS HEALTHCHECKS

5,825
SMI PATIENTS CONTACTED

58.3%
OF ALL PATIENTS ON THE SMI REGISTER HAD THEIR HEALTH CHECK VIA GPNS SERVICE

133,396
MILES COVERED BY OUR VISITING TEAMS.
THAT'S 5.36 TRIPS AROUND THE EQUATOR!

338
PSYCHOTHERAPY SESSIONS FOR HOMELESS HEALTH PATIENTS

436
GP APPOINTMENTS FOR HOMELESS HEALTH PATIENTS

1878
PATIENTS TRIAGED BY CMDU SERVICE

835
CMDU PRESCRIPTIONS ISSUED

2,666
PODIATRY APPOINTMENTS

9790
BED DAYS SAVED ON GPN'S VIRTUAL WARD

5891
BED DAYS SAVED ON GPN'S UWAC SERVICE

8258
PATIENTS SUPPORTED THROUGH CB4C

81.6%
OF VIRTUAL WARD PATIENTS WERE DISCHARGED SUCCESSFULLY AFTER CARE AT HOME, AVOIDING READMISSION TO HOSPITAL

85.9%
OF UWAC NORTH PATIENTS WERE DISCHARGED SUCCESSFULLY AFTER CARE AT HOME, COMPLETELY AVOIDING ADMISSION TO HOSPITAL

82.9%
OF PATIENTS SUPPORTED THROUGH CB4C AVOIDED ADMISSION TO HOSPITAL

5.2
AVERAGE LENGTH OF STAY FOR GPN UWAC PATIENTS

7.7
AVERAGE LENGTH OF STAY FOR GPN VIRTUAL WARD PATIENTS

GP HUB

The Extended Access GP Hub, located at the City Care Centre on Thorpe Road, offered routine appointments operating from 6:30pm to 9:30pm, Monday to Friday and 8:30am to 6:30pm on Saturday.

In 2023-24, this service was for patients registered with a participating Peterborough GP Practice. GPN supported the delivery of extended hours for PCNs that subcontracted to GPN, either in full or in part.

The number of appointments offered are based on each PCN's patient population and are ringfenced to each PCN to ensure equity for all Practices. GPN work collaboratively with local GP Practices to understand population needs and to offer the services required to meet those needs for patients and Practices. The GP Hub provides access to dedicated GPs, Advanced Nurse Practitioners (ANP), Registered Nurses, and Health Care Assistants (HCA), ensuring enhanced access to high-quality primary care services. Additionally, **the ability to offer wound dressings outside of practice core hours ensures patients are treated in the appropriate environment rather than the Emergency Department.**

Peterborough has a highly diverse population with appropriately diverse access requirements. The working population can often struggle to attend health appointments during the day resulting in health disengagement or inappropriate use of other NHS services that are open out of hours, furthering the health inequalities that we see across our city. As a result, GPN offer hours outside of the core Extended Access requirements to make sure that access is available to all of our population.

GPN offer the Extended Access service to all patients registered with a Peterborough Practice ensuring equality of access and increased capacity. **For 2024-25, all Practices across Peterborough have access to the Hub offering additional hours to specification to cater for patients and practice needs.**

97.1%

OF PATIENTS ASKED (2157) WOULD RECOMMEND TO FRIENDS AND FAMILY

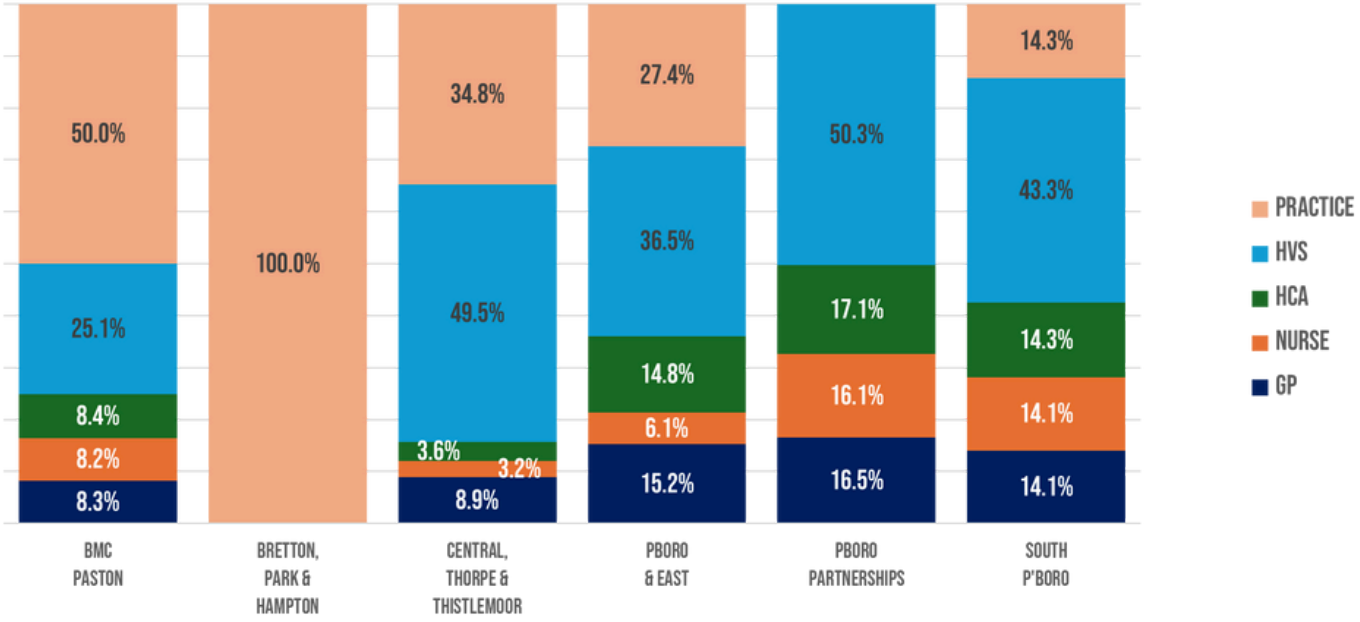
"The treatment I have received at the GP Hub has been exemplary. Staff are so friendly, courteous, knowledgeable and professional. The GP Hub is a wonderful resource. Long may it continue."

"Amazing service, very thorough, efficient and professional staff. Excellent to have evening hours for people with families and who work during the day."

GP HUB

1 IN 24 OF PETERBOROUGH REGISTERED PATIENTS USED THE GP HUB IN 2023-24

PETERBOROUGH EXTENDED ACCESS COVERAGE: 2023-24



GP/ANP: 1690 HOURS PROVIDED (6760 APPTS)

NURSE: 1194 HOURS PROVIDED (4776 APPTS)

HCA: 1600 HOURS PROVIDED (6400 APPTS)

HOME VISITING SERVICE

The Home Visiting Service supports patients and Practices across Greater Peterborough by providing in-home observations for housebound patients.

Practices can refer patients for services such as phlebotomy, blood pressure checks and height / weight measurements, helping to gather necessary information for informed care decisions.

For urgent needs, GPN can see patients within 48 hours, enabling timely interventions.

Peterborough has a large aging population with a cohort of housebound patients who are often vulnerable, isolated and unable to access the same level of care. Practices have often struggled to find community services with capacity to refer patients to for observations and investigations.

Barriers of inclusion criteria have often reduced the access to healthcare for our housebound patients. These barriers can often lead to restricted access of treatment, furthering health inequalities in our city.

GPN worked with Healthwatch who endorse this service and agree this is much needed for our population.

99.3%

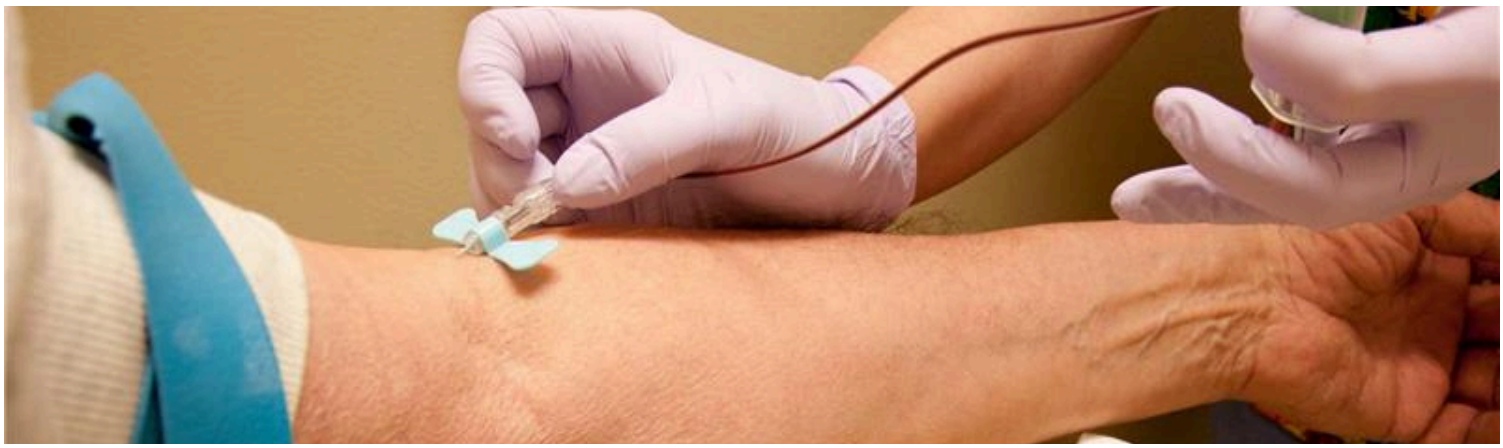
OF PATIENTS ASKED (2052) WOULD RECOMMEND TO FRIENDS AND FAMILY

"Fantastic, no bruises. Very efficient & polite, a really good HCA and a credit to the service."

"Very good, very nice HCA. No bruises, you wouldn't even know that I had a blood test."

"Amazing, really lovely HCA. Scared of needles but she really helped and put me at ease."

HOME VISITING SERVICE



99.3% OF URGENT REFERRALS VISITED SAME / NEXT DAY

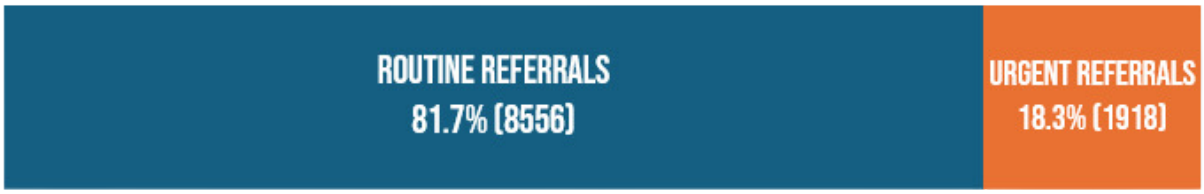
96.8% OF ROUTINE REFERRALS VISITED INSIDE 21 DAYS

96.9% PHLEBOTOMY SUCCESS RATE

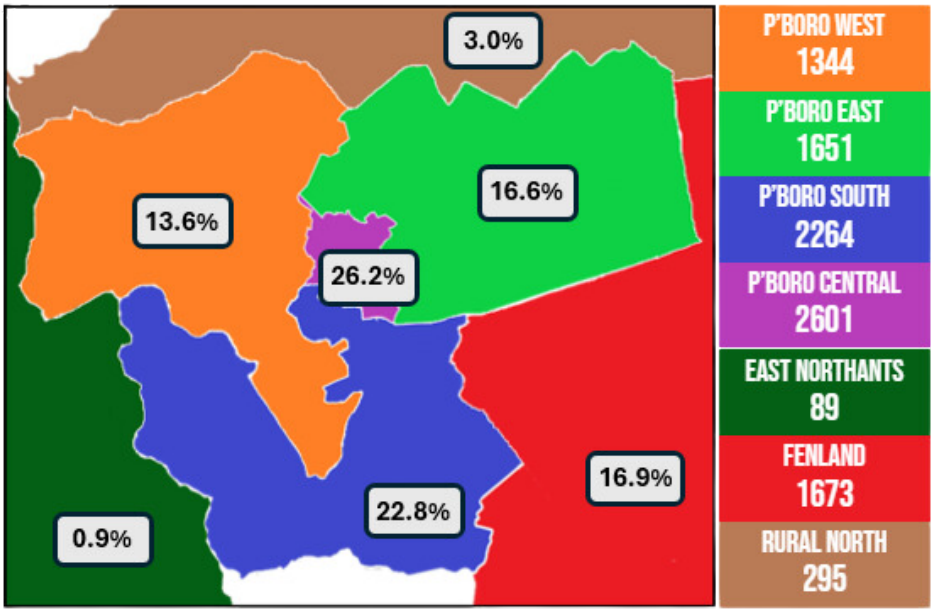
37,095 MILES TRAVELLED BY HCAS

81.2 AVERAGE PATIENT AGE

107 OLDEST PATIENT VISITED



DISTRIBUTION OF HOME VISITING SERVICE APPOINTMENTS BY WARD



HOUSEBOUND DIABETIC SERVICE

In collaboration with Cambridgeshire and Peterborough ICB, funding was provided to offer a diabetes service for housebound patients. All Peterborough Practices could refer patients for annual health checks, including phlebotomy, blood pressure, urine specimens, BMI calculation, and foot checks, followed by management plans. **During the diabetes appointments, 42% of patients needed an escalation for results outside the normal parameters**, for example high blood pressure and the need for podiatry. Detecting abnormalities decreases the risk of deterioration and increases patient quality of life.

The population of Peterborough has a high prevalence of patients with diabetes, with some of the poorest patient outcomes. Many patients are housebound, leading to difficulties in accessing care, poor diabetes management, and increased health inequalities. Practices across Peterborough have been enabled to monitor their housebound diabetic patients with more precision, offering better long-term condition care to their patients. This project saw an increase in diabetic checks completed across Peterborough demonstrating the value of the service.

Unfortunately, the Diabetes Home Visiting Service has not been further commissioned for the upcoming 2024-25 period, however, GPN are proud of the positive impact this service had for Practices and patients.

Although this service is no longer commissioned, **as a not for profit organisation GPN have agreed to continue this service to support our patients and our Members due to the positive impact this service has delivered.**

1,334 COMPLETED PATIENT VISITS

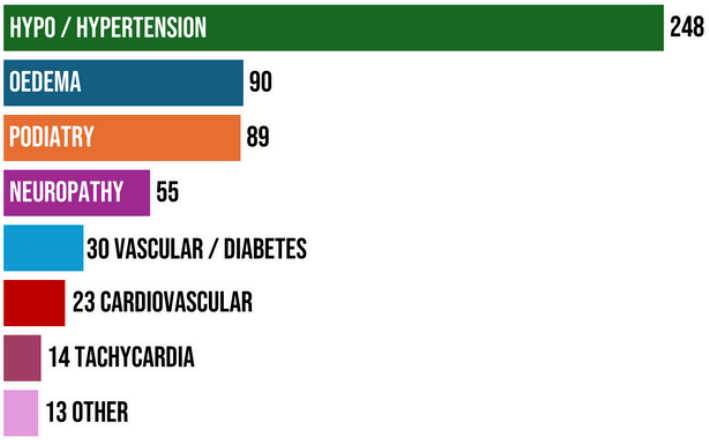
562 CLINICAL ESCALATIONS

"Many thanks for coming to see me for a diabetes review. HCA was great, pleasant, thank you."

"Went very well, just got off the phone to a doctor who was following up from the review. Thank you for the service."

"Amazing service, I was able to have my diabetes checked in my own home. I am unable to leave my home so this was really helpful"

CLINICAL ESCALATIONS



WHY DO WE ESCALATE BACK TO THE PRACTICE?

Escalations occur when the visiting HCA identifies areas of concerns around the patient's health and wellbeing. Escalations can occur for:

- Foot surveillance
- BP concerns (such as Hypertension)
- Vascular issues
- Safeguarding
- Mental Health or other social care concerns
- Other physical health concerns

BP AT HOME SERVICE

In addition to the Housebound Diabetic service, GPN also developed a BP at Home service for patients registered with a Peterborough practice. Patients were referred to the service by their GP practice and issued with a BP monitor which was delivered to their home, with a HCA on hand to assist patients that may not be used to taking their own measurements or using equipment.

Patients provided BP readings using a method convenient to the patient, for example, text message, phone calls or email for up to three weeks. These readings were collated by the GPN team and escalated to the patients Practice if necessary. These readings were logged into SystmOne for full clinical visibility and a graph was sent to the Practice showing the trend of readings over the monitoring period.

Due to the demographics of Peterborough, many patients have uncontrolled hypertension (high blood pressure) or undiagnosed hypertension. As many as five million adults in the UK have undiagnosed hypertension and don't know they are at risk (British Heart Foundation, 2024). As a result, patients may not be medicated correctly, and Practices are unable to support their long-term condition management as effectively as they would wish to. **This service supported and encouraged patients to submit their readings via a preferred method leading to better recording compliance.**

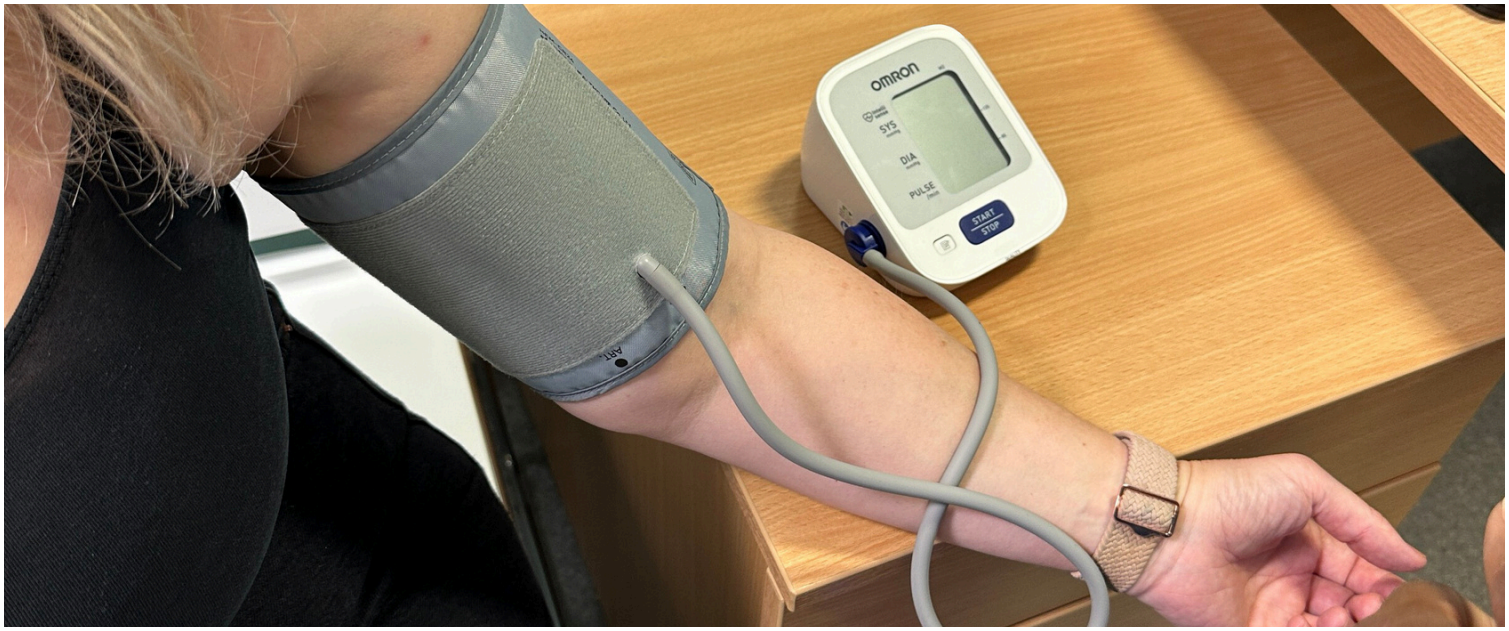
Undiagnosed or uncontrolled hypertension can lead to heart attack or stroke. If left untreated it can also lead to complications such as kidney failure, heart failure, problems with sight and vascular dementia (British Heart Foundation). Being able to identify these patients reduces these risks.

Unfortunately, the BP at Home service has not been further commissioned for the upcoming 2024-25 period, however, **GPN are proud of the positive impact this service had for Practices and patients.**

13,053
BP MEASUREMENTS LOGGED

2,166
CALLS TO PATIENTS

271
PATIENTS ASSESSED



MENTAL HEALTH SERVICES

Severe Mental Illness

GPN have completed another successful year in the Severe Mental Illness (SMI) Service. This 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 needed.

The SMI service is commissioned to deliver to 74 Practices from Peterborough, Wisbech and Cambridge, either at the patients registered Practice through an arranged clinic, a visit to the patient's home or in extended hours at the GP Hub. This provides good equity of access and ensures that an inability to visit their Practice is not a barrier to patient wellbeing.

Adults with an SMI are statistically more likely to die prematurely (before the age of 75) than adults who do not have an SMI (Department of Health, 2023). 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.

Additionally, this cohort of patients can often be hard to reach and to engage in health services. Having a team dedicated to the SMI patients ensures all patients on the register are contacted and supported to attend appointments.

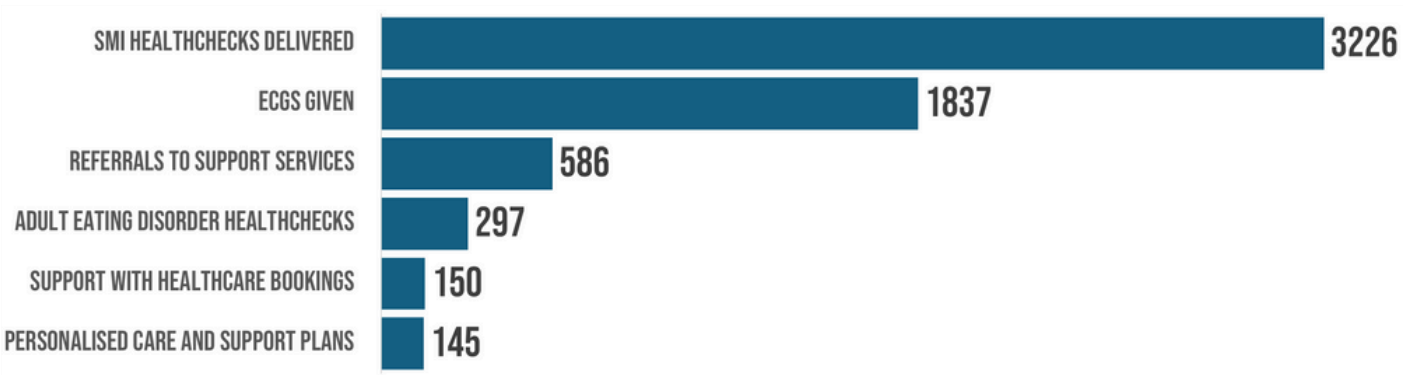
As a result, the Did Not Attend (DNA) rate for hard-to-reach patients has remained lower than the national expectation.

82.9%
ATTENDANCE RATE

707
CLINICS HELD

38,292
MILES COVERED BY TEAM

368
PATIENT IN-HOME VISITS



MENTAL HEALTH SERVICES

Adult Eating Disorder

GPN work in collaboration with Cambridgeshire & Peterborough Foundation Trust (CPFT) to support patients in Peterborough, Cambridge and Wisbech with a mild to moderate eating disorder. Health appointments include phlebotomy, blood sugar test, Blood Pressure, Body Mass Index (BMI) calculation and temperature checks. In 2024-25 this will also include Huntingdon patients, offering equity across Cambridgeshire & Peterborough. Patients with eating disorders can harm the heart, digestive system, bones, teeth and mouth and can lead to other diseases (National Eating Disorders Association 2022).

Patients with eating disorders often have their health care support through either the hospital or primary care. This can be daunting for patients with a risk of patients slipping through the gaps in the system.

The Adult Eating Disorder service ensures patients are monitored between primary and secondary care, are on a consistent case load, allowing a better monitoring system of attendance and engagement. The team are then able to escalate any deterioration directly through to CPFT. This eases Practice workload and ensures patients are receiving the right care at the right time in the right place.

"Good listener of my issues and challenges that I have been through."

"She really understood when I was talking about my mental health. She was lovely."

"The healthcare assistant was punctual, polite, friendly, efficient and made me at feel completely at ease."

PERSONALISED CARE

Care Coordinators

GPN Care Coordinators have a diverse role within Practices, with a primary focus on supporting PCN care homes to facilitate virtual and face-to-face ward rounds, multi-disciplinary teams and to coordinate with care home staff to gather patient information and handle urgent cases by triaging and directing to appropriate services.

This includes Learning Disability and Dementia reviews, supporting PCN projects such as:

- **Healthy You weight management referrals**
- **CVD initiatives**
- **Type 2 Diabetes pathway to remission**

Care Coordinators also complete Personalised Care and Support Plans (PCSPs) for care home residents and patients with long-term conditions, supporting patients and their families to ensure that care and support is tailored to their individual needs.

Practices support many care homes, and the ability to have this coordinated alleviates time for the Practices and encourages collaborative working.

COMMUNITY GARDEN PROJECTS: PROMOTING IMPROVED MENTAL & PHYSICAL WELLBEING AND SOCIAL INTERACTION

Social Prescribers

GPN Social Prescriber Link Workers are based in PCNs and support patients to improve their own health and wellbeing determined mostly by social, economic, and environmental factors.

Social Prescribers seek to address peoples' needs in a holistic way and supports individuals to take greater control of their own health.

Patients across Peterborough have diverse needs and required tailored support packages to increase engagement and receive the aspects of care not always available through the GP Practice.

Personalised Care has proven to benefit patients by reviewing a patient's wellbeing needs using a holistic approach.

HOMELESS HEALTH OUTREACH

The Homeless Health Outreach service offers vital psychotherapy and mental health GP support to those in need. **This service operates through key partner organisations and the dedicated homeless health outreach bus, bringing healthcare directly to the community.**

The Homeless Health Outreach service offers three weekly GP health sessions with a focus on mental health. These flexible, drop-in clinics are designed to help individuals transition into mainstream healthcare without the need for prior appointments. Psychotherapy is tailored for individuals who are homeless or at risk of homelessness. GPN's psychotherapists also offer specialised trauma-informed training to key partner organisations.

Homelessness is prevalent in Peterborough resulting in poor physical and mental health outcomes. People who are homeless or at risk of becoming homeless require a partnership approach to support with their mental, physical and environment needs. **Providing community-based interventions earlier in the patient's journey ensures a reduction in deterioration.** GPN have collaborative working partnerships with key organisations such as Peterborough City Council Rough Sleeper Outreach Team, The Garden House, Outside Links, Dual Diagnosis Outreach Team (CPFT), Boroughbury Medical Centre, Aspire, and other homeless services in the city.

25

EVENING CLINICS HELD ON THE HEALTH OUTREACH BUS

"Totally different to any other therapy that I have previously received. [Psychotherapist] interacts with me and I feel really happy as she has taught me a lot. I am a million miles from where I use to be. "

106

VULNERABLE INDIVIDUALS SUPPORTED WITH ACCESS TO HEALTHCARE

"I cannot thank the psychotherapy service for the support which has been a beacon of light during such a challenging time. I will be eternally grateful for the encouragement and understanding and that's not to mention this great toolbox which I have taken away to help in the future."

MENTAL HEALTH COMMUNITY CONNECTORS

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 by the individual. Patients can 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.

Examples of what a MHCC could support with:

- **Housing issues**
- **Isolation and loneliness**
- **Benefits**
- **Drug/alcohol/gambling addiction**
- **Goal setting**
- **Connecting with activities in the community**

Only PCNs signed up to the service can refer. The current PCNs are: Peterborough Partnerships, Boroughbury & Paston and Fenland. Referrals are made through the Joy app on SystmOne. Many patients living with complex mental health needs lack social, economic and environmental support. Coordinating social issues alongside the support already given by their GP or Mental Health team can increase their overall wellbeing. As a result of additional support for many patients, there has been a reduction for the need of GP appointments.

"Invaluable support the MHCC was easy to talk to. They helped me get back into the community by attending groups on the first visit with me. I didn't realise how far I had come until we did the scoring questions. 10 out of 10!"

"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."

96.1%

OF PATIENTS ASKED (183) WOULD RECOMMEND TO FRIENDS AND FAMILY

MENTAL HEALTH COMMUNITY CONNECTORS

24,175

CONTACTS WITH PATIENTS BY MHCC STAFF

6.95

AVERAGE SESSIONS PER PATIENT

527

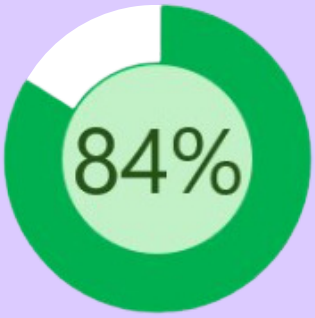
ONWARD SUPPORT REFERRALS FOR PATIENTS

1,395

REFERRALS FROM PRACTICES INTO THE SERVICE

REFERRAL NUMBERS ACROSS THE REGION

NORTH	SOUTH
890	505



OF PATIENTS RECORDED IMPROVEMENTS IN THEIR WELLBEING AFTER SUPPORT FROM THE SERVICE

34%

AVERAGE IMPROVEMENT IN PATIENT ONS4 SCORES UPON DISCHARGE FROM THE SERVICE

ONS4: WHAT IS IT AND WHY DO WE USE IT?

The ONS4 refers to a set of four questions developed to measure personal well-being.

These questions are part of the broader Measuring National Well-being (MNW) Programme, which aims to provide a comprehensive view of the nation's well-being beyond traditional economic indicators.

The ONS4 questions are designed to capture three types of well-being: evaluative, eudemonic, and affective. Here are the four questions:

- **Life Satisfaction:** *"Overall, how satisfied are you with your life nowadays?"*
- **Worthwhileness:** *"Overall, to what extent do you feel that the things you do in your life are worthwhile?"*
- **Happiness:** *"Overall, how happy did you feel yesterday?"*
- **Anxiety:** *"On a scale where 0 is "not at all anxious" and 10 is "completely anxious", overall, how anxious did you feel yesterday?"*

These questions are used to measure well-being because they provide insights into how people perceive their own lives, which can be more telling than objective measures alone.

By asking individuals to rate their own experiences, the ONS4 captures subjective well-being, reflecting what truly matters to people in their daily lives.

YOUNG PERSONS SOCIAL PRESCRIBING

The Young Persons Social Prescribing service (YPSP) was provided by Greater Peterborough Network, covering the geographical area of Peterborough City. **This one-year project was funded by Peterborough City Council as part of their Health Inequalities, Tackling Prevention and Supporting Community Engagement Grant** and sadly closed on the 31st August 2024.

The YPSP connected young people aged 11 to 18 with local activities, groups, and services, effectively addressing health inequalities, social and emotional needs, and enhancing youth provision in Peterborough. The service demonstrated a positive impact on young people's health and well-being reducing health inequalities.

In partnership with PCNs across Peterborough City, as well as voluntary organisations, family workers, public health teams, and the Healthy Schools Programme, we engaged with young people in several secondary schools. This service aimed to support those who may have limited access to primary care or other health-related services. The service worked collaboratively with the Youth Parliament, to identify areas of support in communities. This was achieved by working with Peterborough's Young Persons committee to seek their views on what matters to them and what they felt was required for young people across the city. **Listening to young people's voices is crucial for identifying the support they need and for shaping and improving the service effectively.**

Peterborough has several deprived areas where young people frequently face challenges due to limited community resources, leading to unmet social and mental health needs. **Early intervention is essential to support these young individuals as they transition into adulthood, helping to reduce the need for medical and social interventions later in life.**

100%
PATIENT SATISFACTION

77%
IMPROVEMENT IN PATIENT WELLBEING FOLLOWING APPOINTMENTS

69
PATIENTS SUPPORTED THROUGH THE SERVICE

"Thank you so much for all the support you gave to me. I can actually see a light at the end of the tunnel and that's thanks to your caring, down to earth, professional approach."

"[Patient] is coming on amazingly! I cannot believe we have managed to get her back into the education setting, we couldn't have done it without your support."

SMEARS CLINIC SERVICE

Endorsed by the local authority and Cancer Alliance, GPN supported patients and Practices across Peterborough to increase access and awareness of cervical screening tests.

Creating additional dedicated smear clinics in the evenings and weekends enabled patients to have flexible access to appointments, with the ability to book these online. By using Eclipse data, we identified patients with previous abnormal smear results who had not returned for follow-up. This targeted approach ensured that these individuals received the necessary follow-up tests and care.

The uptake of cervical smear appointments in Peterborough has historically been low, partly due to limited clinic access and varying cultural differences towards preventative screening within our diverse communities. Additionally, many patients with previous abnormal results had not returned for follow-up. They were at risk of missing early referral to specialist services for further investigation.

By working collaboratively with Practices, GPN have been able to contact and educate patients, resulting in the completion of a high number of cervical screenings which otherwise may have been missed.

811

SMEARS DELIVERED

99.3%

OF PATIENTS ASKED (191) WOULD RECOMMEND TO FRIENDS AND FAMILY

VIRTUAL WARD

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, GPN care for patients in their own homes.

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, Nursing Associates, Urgent Care Technicians and Health Care Support Workers. Supported by an Operational team coordinating the service, GPN can offer several interventions including ongoing extended clinical assessments, observations, bloods, ECGs, bladder scans and dressings.

The Virtual Ward operates every day from 8:00am to 8:00pm, 365 days a year.

GPN, in partnership with NWAngliaFT, manage the patient's care plan and treatment until they are medically well enough to be discharged back into routine primary and community care.

GPN were originally funded for 19 Virtual Ward beds, but increased to 40 beds in November 2023.

Patients who are admitted to an acute hospital bed are at risk of further deterioration including healthcare-acquired infection and deconditioning. When patients are admitted to acute wards, their care packages are often stopped, which complicates the discharge process for patients. 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. Delivering hospital care in a patient's home enables patients to have a recovery and care plan coordinated by the Virtual Ward team. This alleviates pressures on primary care and increases the availability of acute care beds for those who cannot be treated at home.

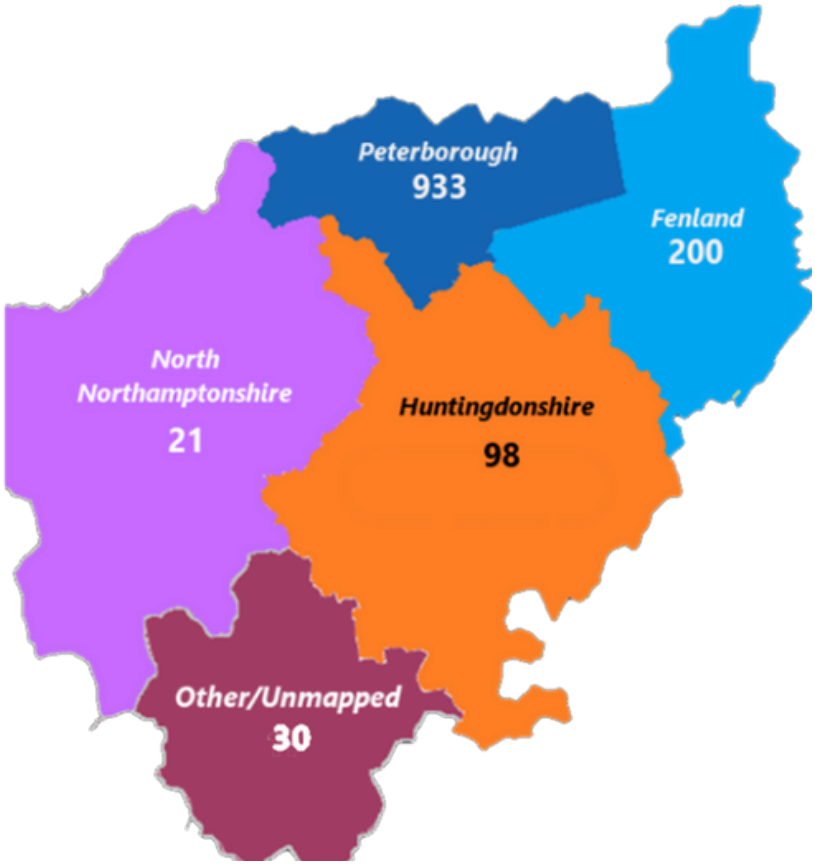
VIRTUAL WARD

"Wish I could stay on our service forever... Really thankful!"

"Brilliant service, felt really looked after. Very VERY grateful!"

"Really happy with service. Happy that within a difficult week myself and my wife had support"

PATIENT LOCATIONS



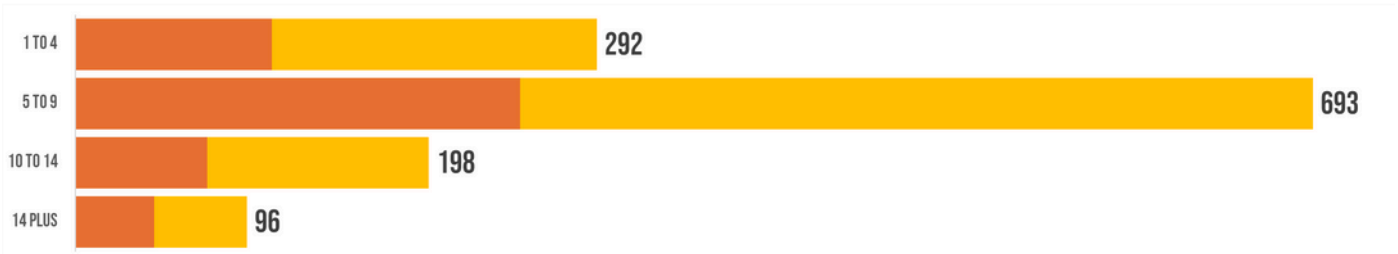
1279 PATIENTS CARED FOR BY GPN VIRTUAL WARD TEAM

97.6% OF PATIENTS ASKED (711) WOULD RECOMMEND TO FRIENDS AND FAMILY

MOST COMMON SYMPTOMS OF ONBOARDED PATIENTS

- FRAILTY RELATED SYMPTOMS
- RESPIRATORY ISSUES
- CIRCULATORY ISSUES
- EXTERNAL INJURY
- DIGESTIVE ISSUES

PATIENT LENGTH OF STAY BEFORE DISCHARGE



PATIENT SPLIT ACROSS GPN VIRTUAL WARDS

URGENT WRAP AROUND CARE NORTH

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

Operating daily from 8:00am to 8:00pm, 365 days a year, the service accepts referrals from ambulance crews, the Call Before Convey service, NHS 111, and other community healthcare teams. It is available to patients aged 18 and over who are registered with a GP in Cambridgeshire or Peterborough. 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 now consisting of Advanced Clinical Practitioners, Urgent Care Practitioners, Paramedics, Nursing Associates, Urgent Care Technicians and Health Care Support Workers. The team can take several interventions including ongoing extended clinical assessments, observations, bloods, ECGs, bladder scans and dressings. Working collaboratively with the East of England Ambulance Service (EEAST), UWAC North will also support intercepting patients on 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 who are admitted to an acute hospital bed are at risk of further deterioration including healthcare-acquired infection and deconditioning. When patients are admitted to acute wards, their care packages are often stopped, which complicates the discharge process for patients. As a result, patients often need further support when discharged through secondary, community, primary and social care.

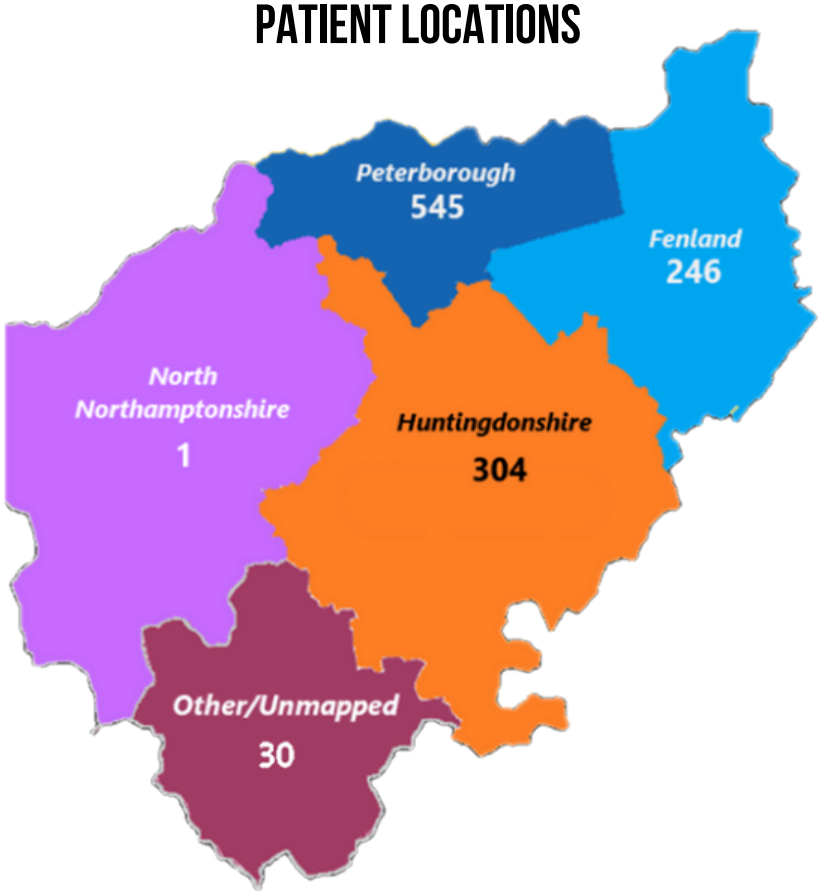
Patients recover more quickly in familiar home surroundings, reducing the separation from support systems outside the hospital. Delivering hospital care in a patient's home enables patients to have a recovery and care plan in place coordinated by the GPN team, alleviating pressures on primary care and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

URGENT WRAP AROUND CARE NORTH

"The team went above and beyond. I think the service is an excellent idea as it keeps people out of hospital and gives reassurance that people are being looked after. The alternative would have been going to ED and waiting for hours and hours."

"No improvements, service is excellent, can't fault it. Very very good and helpful team - the team went out of their way to help, collected meds, excellent treatment so far and I am very pleased."

PATIENT LOCATIONS



1126 PATIENTS CARED FOR BY GPN UWAC TEAM

98.8% OF PATIENTS ASKED (362) WOULD RECOMMEND TO FRIENDS AND FAMILY

MOST COMMON SYMPTOMS OF ONBOARDED PATIENTS

- EXTERNAL INJURY
- RESPIRATORY ISSUES
- GENITOURINARY ISSUES
- CIRCULATORY ISSUES
- DIGESTIVE ISSUES

PATIENT LENGTH OF STAY BEFORE DISCHARGE

PATIENT SPLIT ACROSS UWAC NORTH ONBOARDING SOURCES

HSJ AWARDS FINALIST

CALL BEFORE CONVEY

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.

"I have used Call Before Convey numerous times whilst working on an ambulance and it is brilliant to have a service that you can discuss patients with and seek senior clinical support. We are able to make a shared decision to come up with an appropriate care plan for patients and get them the right care at the right time. Call Before Convey is now my go-to when a patient does not need hospital conveyance to formulate an appropriate care plan, preventing unnecessary hospital admissions."

The service's innovative approach was recognised as **a finalist for the Data-Driven Transformation Award at the 2023 Health Service Journal (HSJ) Awards**, highlighting its significant impact on healthcare delivery.

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, achieving an impressive 99.83% annual success rate in meeting the Key Performance Indicator (KPI) of answering all calls within 20 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.

CALL BEFORE CONVEY

HSJ AWARDS FINALIST

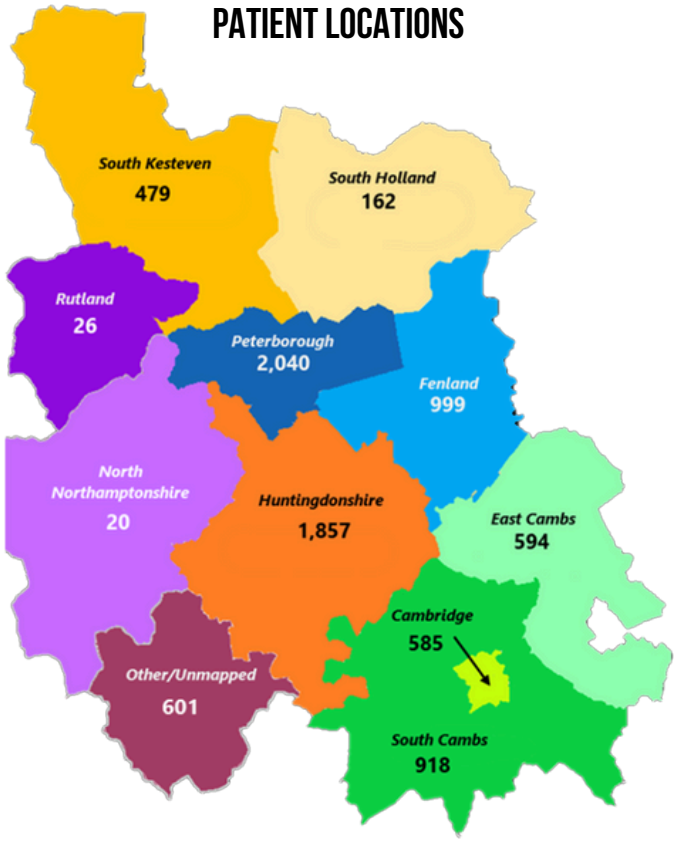
946

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

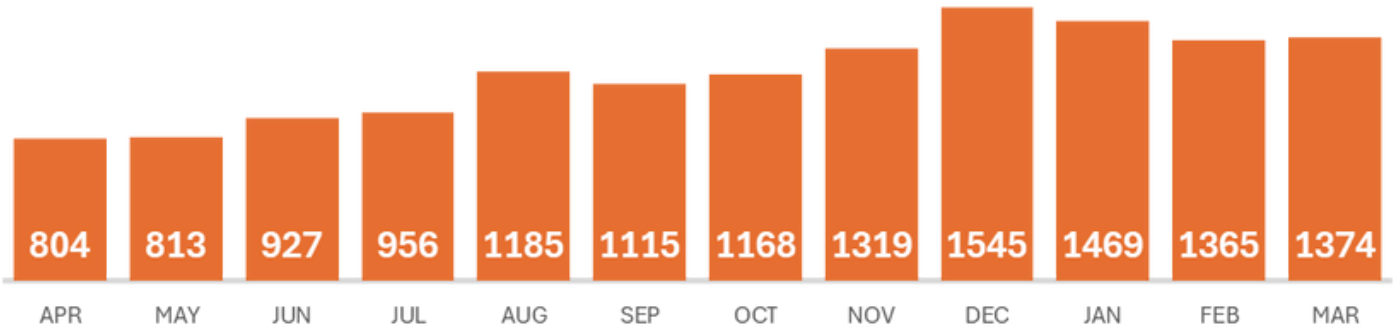
8,149

HOURS OF SUPPORT DELIVERED

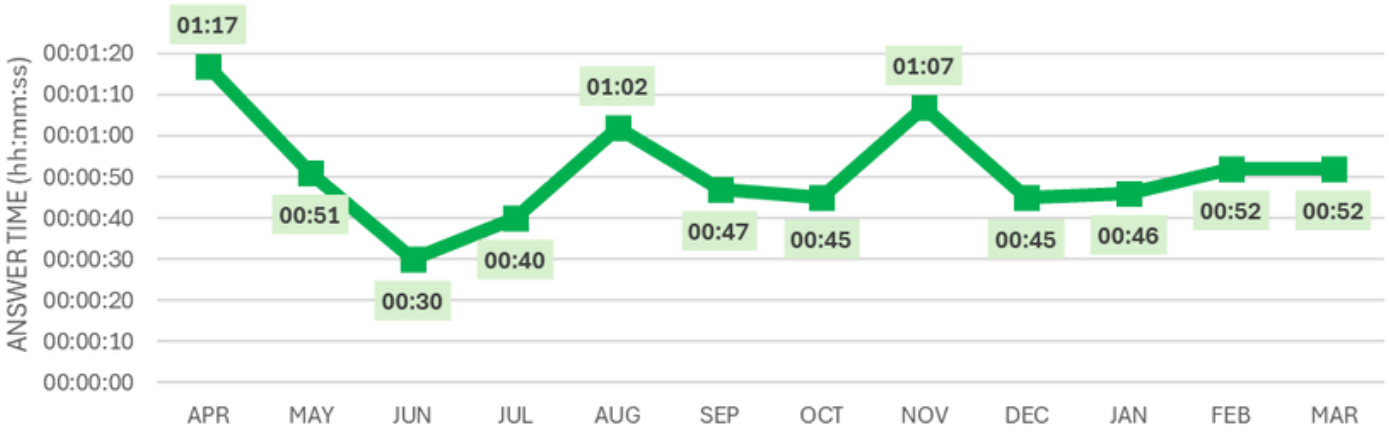
PATIENT LOCATIONS



CALLS ANSWERED PER MONTH



AVERAGE CALL ANSWER TIME



COVID MEDICINE DELIVERY UNIT

The COVID Medicine Delivery Unit (CMDU) provided Cambridgeshire and Peterborough patients, in the highest-risk clinical groups, with access to antiviral medications, both oral and intravenously, to support their recovery from COVID-19. **During the Winter peak of 2023, the service experienced exceptional demand, with 288 referrals received in December 2023.**

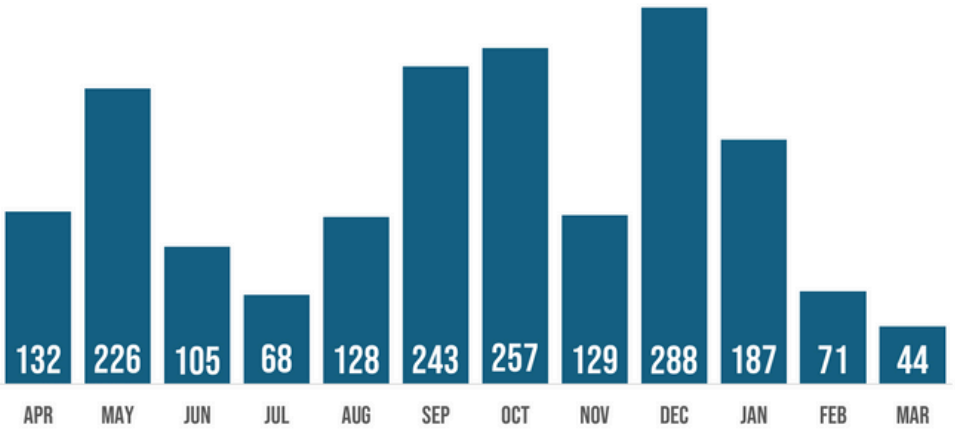
In response to increase in demand, all service areas increased operations to seven days a week. In early 2024, GPN supported ICS colleagues with transferring the service to general practice in line with national direction.

Patients with specific underlying conditions are more vulnerable to severe illness, hospitalisation and long-term complications when contracting COVID-19. CMDU was previously delivered in hospital, putting patients at higher risk of contracting other ailments and the risk of the spread of COVID-19 in hospital.

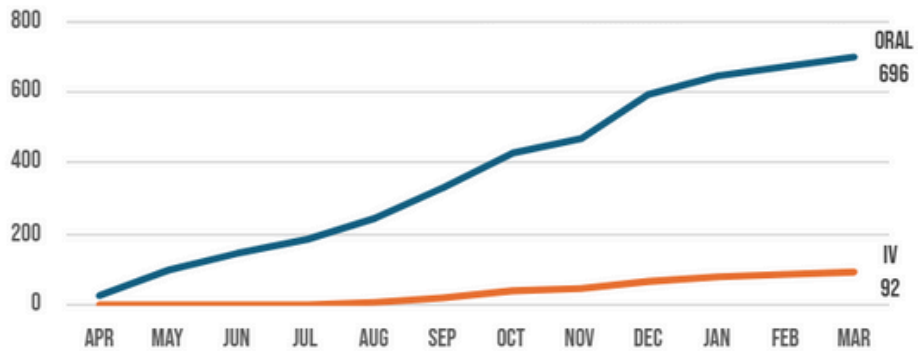
Providing this service in the community enabled patients to receive the right treatment, either via oral or intravenous antivirals, to support their recovery and prevent deterioration.

With the complexity of the prescribing and the increased demand GPN's service allowed for Practices to focus on Winter pressures reducing additional workload.

PATIENTS TRIAGED BY CMDU SERVICE IN MONTH



MEDICATION PRESCRIBED BY CMDU SERVICE



"The Nurse made my husband and me welcome and carried out the infusion with care and professionalism, explaining everything clearly."

"The Nurse was very professional, kind and reassuring. The treatment was quick and efficient."

"Team delivering IV were superb, and communication was excellent. Very grateful for the service."

PRACTICE SUPPORT

Additional Role Reimbursement Scheme (ARRS)

GPN worked on behalf of the Membership with the Cambridgeshire and Peterborough ICB to continue the additional guaranteed ARRS funding programme from 2022-23 into 2023-24. This has been a successful scheme and **provided an additional £1.1m of workforce funding directly into Peterborough PCNs**, giving all PCNs up to £26.56 per weighted patient to use towards valid roles for the ARRS scheme, ensuring that the usage of national funding was maximised across the region.

GPN are reviewing the options available to continue support into 2024-25, with the aim of supporting our Members and maximising the ability to build a stronger local workforce in Peterborough for our patients.

£7.3M

TOTAL ARRS FUNDING UTILISED IN GREATER PETERBOROUGH

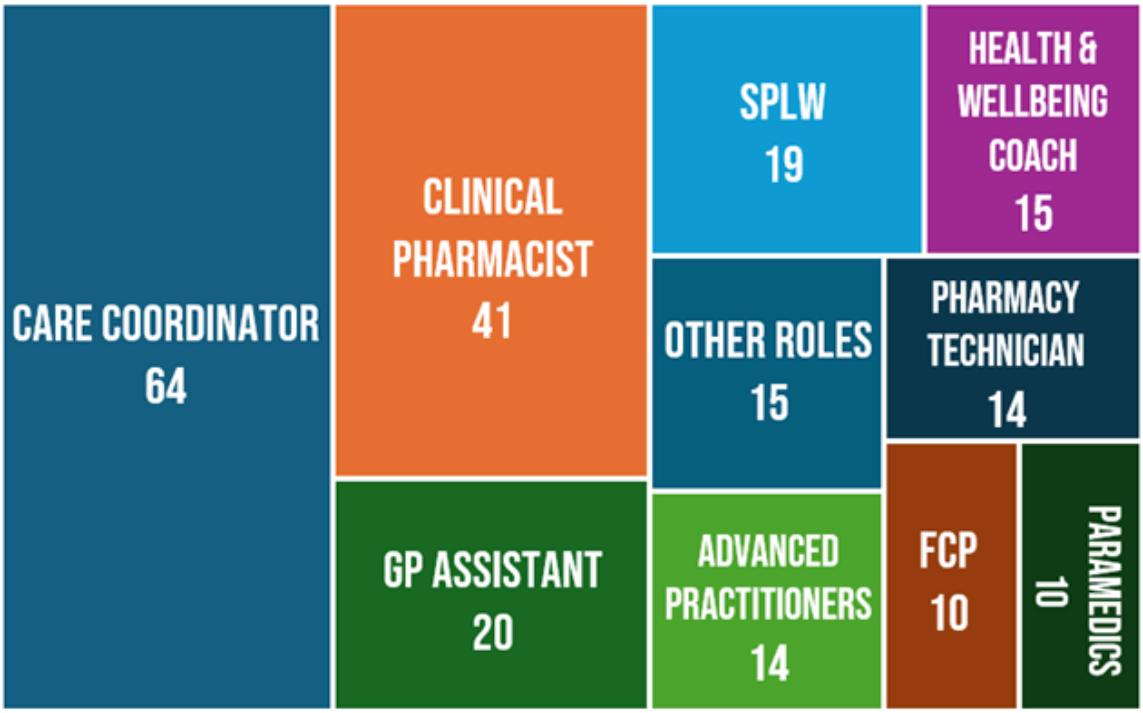
£1.1M

ADDITIONAL FUNDING FOR PETERBOROUGH WORKFORCE

220

ARRS ROLES EMPLOYED ACROSS GREATER PETERBOROUGH

TOTAL HEADCOUNT OF ARRS ROLES ACROSS GREATER PETERBOROUGH



PRACTICE SUPPORT

Wellbeing Fund

Staff retention in the NHS and staff wellbeing are extremely important to ensure our Practices have a consistent healthcare team ready to deliver high quality services to our patients.

In recognition of staff across the whole Membership who work tirelessly to provide excellent care to our population, GPN distributed £1,000 per Practice to use for staff wellbeing projects.

Some examples of how this money was used to benefit local staff:

- the purchase of outside furniture for staff to take their breaks away from computer desks
- the purchase of a staff water cooler
- organised social events such as Ten Pin bowling.

Menopause Support Clinic

As part of GPN's commitment to supporting primary care, the GPN Menopause Support Clinic was introduced in 2023. This clinic provides primary care staff within the GPN Federation access to a GP specialising in menopause, offering advice and treatment, with the aim of improving their workday while managing symptoms.

Women constitute a substantial portion of the primary care workforce:

General Practitioners (GPs): Approximately **57%** are female**.**
***Nurses*:** Around **90%** of primary care nurses are female**.**
***Admin/Non-clinical Staff*:** Females make up about **80%** of this workforce**.**

Supporting staff to receive the treatment plan they need reduces sickness rates and early retirement.

"This was an amazing service. Feel like me. Hadn't realise how much symptoms had affected my life. They had affected my ability to think and drive. Every person with menopause symptoms should have access to this level of information and detail. I tell everyone not to delay and it's given me a new lease of life."

29

PRIMARY CARE STAFF HAVE BEEN SUPPORTED BY THE CLINIC IN THE PAST YEAR

PRACTICE SUPPORT

Additional Winter Support

GPN worked in partnership with the Member Practices to address the increased winter demands by **extending Surge and Strep A clinics through to Spring 2023**. GPN provided additional funding for patient access support to allow Members to offer increased appointments at peak times.

At scale solutions such as the Surge and Strep A Hubs offered an increase in appointments and additional Hub sites for equity of services.

GPN have offered practice-based funds which have supported Practices to purchase additional capacity based on their population need. Offering both services increased capacity and reduced practice staff fatigue.

Winter pressures are a perennial problem for primary care and patients alike. Colder conditions force people inside where infections are more easily spread, this combined with lower immunity levels leads to higher infections. More access is consistently needed so patients can receive timely treatment, to help reduce deterioration which can lead to hospital admissions. A lack of access can often lead to inappropriate use of secondary care services such as ED, adding to additional pressures in the system.

Podiatry

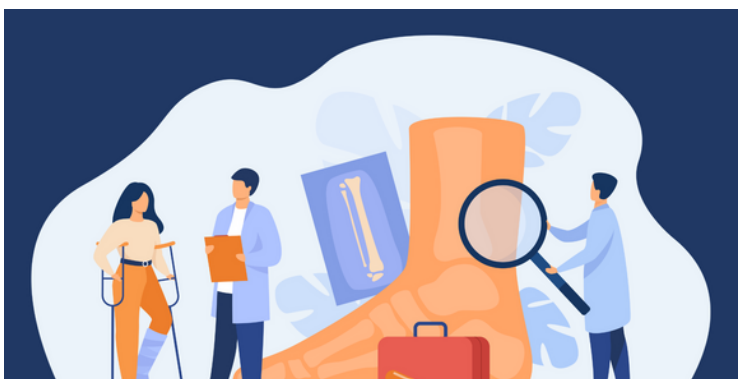
GPN's Podiatry Service, which ran throughout 2023-24 was accessible to all Peterborough Practices who could directly book their patients in for appointments either in the daytime, or in a weekly evening clinic.

This valuable service relieved pressures for Practices, and reduced waiting times significantly for patients awaiting Podiatry services and treatment.

Delays in addressing foot and ankle care needed can lead to a range of complications, from ongoing and increasing pain, to the need for surgery or even amputation.

Through GPN's diabetes work and reporting, Podiatry escalations were also identified as the second most common cause of concern, highlighting the real need for this additional GPN service to support our Members.

The service offered 2,666 appointments in 2023-24.



PRACTICE SUPPORT

PRACTICE SUPPORT AND ENGAGEMENT ARE AT THE HEART OF THE FEDERATION, ENCOURAGING CONSISTENCY ACROSS PRACTICES IN PETERBOROUGH AND OFFERING SPECIALITY SUPPORT.

DURING 2023-24 GPN OFFERED A VARIETY OF SUPPORT INCLUDING:

Information Governance (IG)

Information Governance (IG) underpins the NHS ensuring patient information is secure, confidential and collated in a transparent way. IG is a very specialised topic requiring compliance with legislation underpinned by the need to have effective systems and process in place to protect patient data which is paramount. **GPN offer an IG expert to support Members with their IG compliance issues.**

Data Support

Data Support, at 10 hours per Practice site, was available to Members to support in a broad range of SystmOne and data quality related tasks including;

- Identifying coding issues
- Income maximisation through correct coding for QOF and IIF reports
- CQRS related queries
- Facilitating use of SystmOne templates and tools to develop PCN shared staff
- Audits of GPAD appointment configuration and data

Engagement With Members

GPN hold Practice Manager forums, Clinical Director and Member meetings to encourage shared learning, identify current issues and gain feedback from the Members to improve service delivery and patient care. These meetings are multi-format and can be held face-to-face or as lunchtime Teams sessions.

GPN also have a Members group available on WhatsApp and a monthly newsletter keeping our Members up to date with our latest developments.

Human Resource (HR) Support

Practices have been offered up to 15 hours of access to an independent HR advisor who is able to assist with employment law queries, policies and procedures including staff disputes.

Practices accessed over 200 hours of this support in 2023-24, saving them both time and money.

PRACTICE SUPPORT

Communications Support

Communications Support encompasses a range of efforts aimed at improving practice websites, creating posters, and producing promotional material for practice services. A key element of this support is the production of monthly GPN newsletters, which keep Practices informed of service updates and changes. These communications have been well-received, helping Practices enhance their engagement with patients.

Examples of print and digital media created include posters developed in collaboration with Practices and PCNs to showcase key services and roles within primary care and across system partners. These materials highlight the exceptional contributions of healthcare teams to improving healthcare delivery.

Additionally, social media posts and website notices have been crafted to support Practices and PCNs, covering a variety of topics such as training day announcements and recruitment efforts. **By working closely with each Practice, tailored content is developed to meet their specific objectives.** Logos have also been designed upon request, with a collaborative process that involves multiple design drafts to ensure alignment with the organisation's vision.

LOGO EXAMPLES

SOCIAL MEDIA POST EXAMPLES

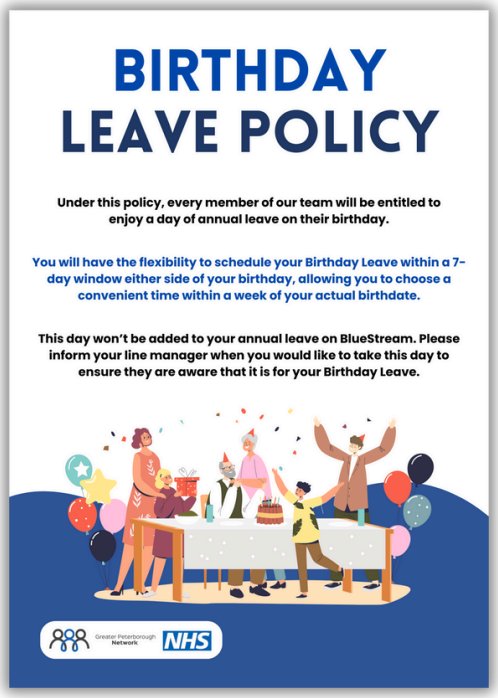
POSTER EXAMPLE

ORGANISATIONAL DEVELOPMENT

As a Federation, we continue to grow our HR support for our teams across our network. Bethan Billington continues to provide HR consultancy advice for our Practices, whilst we have introduced dedicated HR support for our growing workforce to deliver on both our HR and organisational development commitments.

Supporting our teams and ensuring a positive workplace culture has been a key focus during 2023-24. Our key focus has been ensuring positive steps are taken towards looking after our team's health and wellbeing.

We have reviewed our working culture within GPN by carrying out listening sessions with our HR Consultant and promoting a collaborative team approach with the implementation of our staff suggestion box – this is reviewed monthly. All suggestions are fed back to the team via our operations meeting, identify the action taken against each one.



In continuing to support wellbeing and improving team benefits, **we have implemented a 'Birthday Day Off'** for all GPN staff , which gives our team the confidence they can take the day off to celebrate their special day. **We have also given additional health and wellbeing support in implementing a monthly wellbeing hour**, where our team can take an hour when it best suits them, and their team, and taking a well-earned hour to focus on what is important to them. **We have also enrolled our substantive staff/training hub staff into an employee assistance programme** providing company funded benefits through our external provider, UK Healthcare. Staff have the additional benefit of increasing their cover by personal contribution.

Focusing on staff morale, **in January 2024 we launched Employee of the Month**, asking our team to put forward their nominations and asking our board to provided impartial agreement on the monthly award. This year, we also see the the introduction of our staff celebration – ***An Afternoon Full of Stars***, an awards afternoon celebrating our teams across Greater Peterborough Network.

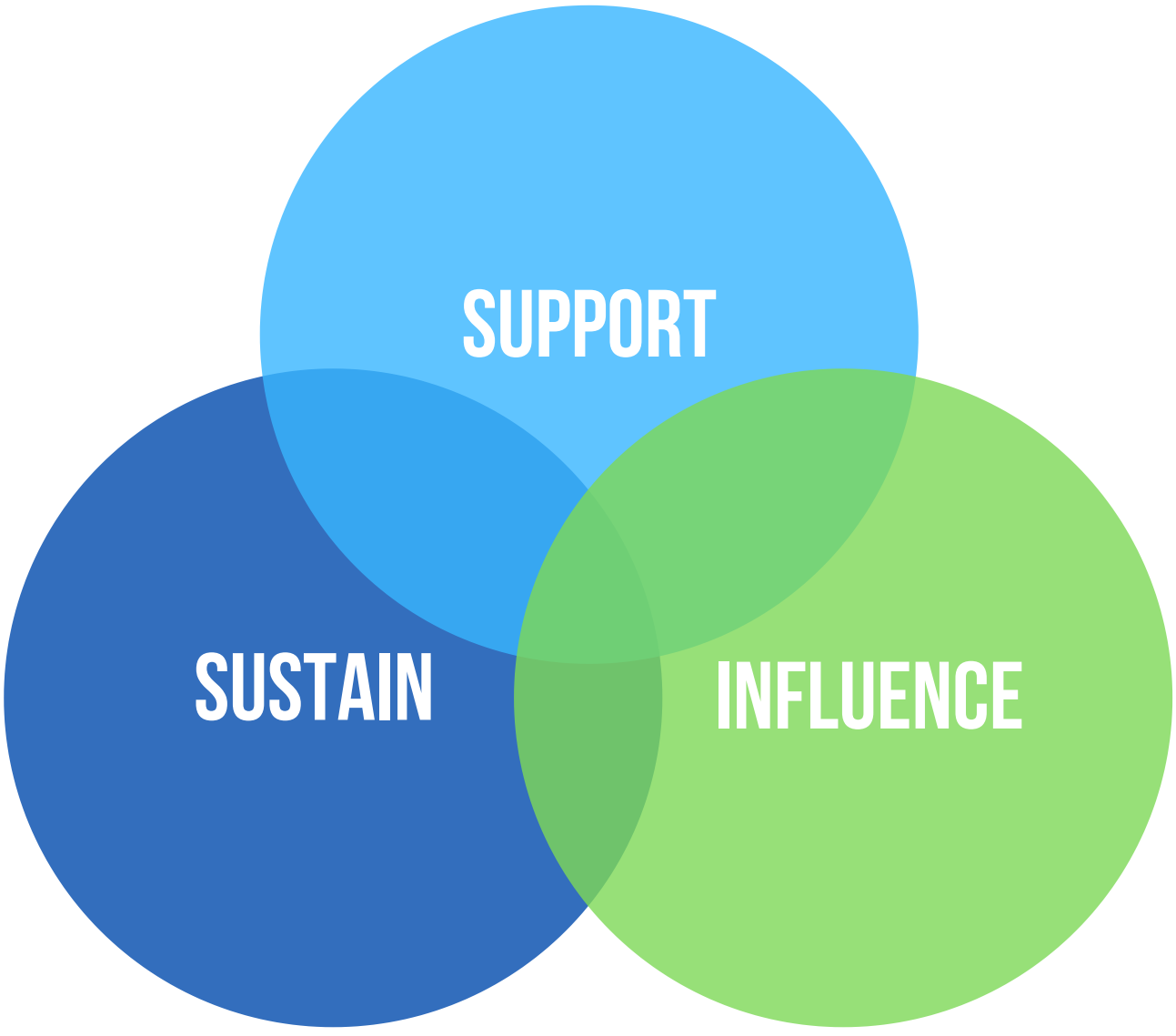
Moving forward we will be developing our Organisation Development plan to support team development to reflect Greater Peterborough Networks overall vision, strategic goals and objectives. It frames the development of our workforce capabilities, skills and competencies, whilst combining cultural factors. **We will also focus on keeping our strategy updated and in line with employment compliance.**

LOOKING AHEAD

BUILDING ON OUR SUCCESSES, FOR OUR 2024-25 STRATEGY WE WILL CONTINUE TO WORK WITH AND ON BEHALF OF OUR MEMBER PRACTICES TO BETTER SERVE OUR PATIENTS AND COMMUNITIES THROUGHOUT THE COMING YEAR AND BEYOND

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



PLANS FOR 2024-25

SUPPORT

Primary Care

- Ongoing support for Extended Access in Practices, including home visiting for housebound patients, addressing health inequalities in Primary Care in Peterborough.
- Exploring further at-scale primary care solutions such as long-term condition services to reduce demand on primary care and increase patient contact.
- Assessment of decommissioned services to identify and bridge service gaps.
- Dedicated GPN Primary Care Team supporting with innovation and practice ideas.
- Information Governance, HR and communications support.

Patients

- Improving access to healthcare outside core hours.
- Supporting patients to receive the right treatment at the right time in the right place.
- Embracing our cultural diverse population, ensuring consistent care that meets the needs of our population and reduces health inequalities and barriers to access.
- Supporting hard to reach communities to access healthcare through initiatives such as Homeless Health and Severe Mental Illness health checks.

System

- Working with the system to explore innovative ways of providing patient care to alleviate pressures in other parts of the system.
- Bridging the gap between primary care and secondary care.
- Being an integral part in the system, supporting new ways of working to improve healthcare systems.

Partners

- Supporting integration of services for seamless patient care.
- Collaboration with partners on Urgent Community Response and Virtual Wards to reduce unnecessary hospital admissions.
- Proactively encouraging shared systems of working, including IT systems and clinical governance, resulting in resilience and higher visibility of patient records.

Workforce

- Support workforce with additional training and opportunities to increase workforce satisfaction and increase skill set within GPN.
- Create an Organisational Development strategy to review staff needs and ensure they feel valued.

PLANS FOR 2024-25

SUSTAIN

Primary Care
- Explore potential service opportunities for primary care to offer patients the best services possible.
- Using the Clinical and Operational Group, Quality Patient Safety Committee and Board sessions to ensure clinical and operational safety of services.

Patients
- Recruiting the right clinical and operational workforce to deliver safe and effective services.
- Work to streamline services and reduce double handling of patients. Supporting patients to tell their story once and have the coordination of care handled for them.

System
- Continue to enhance services and contracts delivered by GPN, ensuring consistency of services and care for patients.
- Explore potential opportunities for our system to offer patients the best services possible.
- Implement a data-driven, cost-effective approach to clinical services.

Partners
- Continue to build working relationships to integrate and combine services, strengthening service pathways.
- Share successes and challenges with our partners to have a transparent working relationship and learn from each other to institute universal best Practices.

Workforce
- Review workforce strategies and employment support.
- Create a clear Human Resources Organisation Development strategy that supports our people to have good personal and professional harmony.

INFLUENCE

Primary Care
- Transform the structure of primary care through automation and digital enablement.
- Collaborate with our Members to develop innovative models of care and new services.

Patients
- Ensure patients receive the right care in the most appropriate setting.
- Continuously innovate services to meet the evolving needs of our patients.

System
- Working with our system to establish and implement ‘New Care Models’ so patients can receive the most appropriate care, reducing excessive waiting times.
- Implement the use of digital monitoring for patients on the Virtual Ward and UWAC.

Partners
- Sharing data and outcomes with partner organisations to review any changes needed in service pathways.
- Continue to share system access with partners to enable open and transparent care.

Workforce
- Continue to work with the ICB on options to support Practices with the ARRS scheme to maximise workforce across Peterborough.
- Using an Organisational Development approach to ensure GPN is rated an excellent place to work and improve staff wellbeing.

PRACTICE SUPPORT FOR 2024-25

Support For Practices

Membership support is a priority for GPN, and we are continuously finding ways to alleviate practice pressures. The federation is here to support all our Member Practices and patients in a multitude of ways. **We pride ourselves on providing at scale solutions** containing patients treatment plans through Virtual Ward, Urgent Wrap Around Care North and Call Before Convey reducing the demand on primary care. Independent support for HR and Information Governance will continue through 2024-25 ensuring all Practices have seamless access to both specialities.

Internal communications support will continue throughout this year offering support for communication development and showcasing exemplary work.

GPN commit to increasing Membership communications with a communications plan created with the Board and Membership Engagement team. Plans for site visits and regular touchpoint meetings will be implemented.

Extended Access

GPN is committed to providing access to the Extended Access services for all our Member Practices and patients of Peterborough through 2024-25. Supporting the extension of Practices using a variety of clinicians preventing practice staff burn out and the difficulty of filling rotas.

Tackling health inequalities across Peterborough by ensuring all patients have access to evening and weekend appointments. Providing a Home Visiting service for all Members assisting the care of vulnerable housebound patients within Peterborough.

Additional Role Reimbursement Scheme (ARRS)

Working with the ICB, the ARRS scheme enabled the Membership to bring in new work force to support the ever-growing demand in primary care. This has been a successful scheme, resulting in an additional £1.1m of workforce into primary care roles in 2023-24.

GPN intend on reviewing the support we can give for this year's ARRS scheme to continue to build a stronger workforce in our area.

Additional Winter Support

GPN commit to supporting Member Practices and patients during Winter and will work with Practices to review patient demand and identify any areas needing additional capacity.

Automation and Technology

GPN are committed to finding ways to utilise both our existing tools and new developments in technology to maximise the efficiency of our organisation and our Member Practices. Over the last 12 months, we have successfully utilised Robotic Process Automation (RPA) scripting to automate thousands of repetitive tasks such as SMS appointment reminders, task management and daily reporting. The next step for this development is to work with Practices to identify and develop candidates for RPA in their own daily workflows, as well as continuing to find other ways to simplify the systems available to our Members, such as protocols and pathways via the "pink button" on SystmOne and external initiatives that could be utilised at scale.

PLANS FOR 2024-25

Long Term Conditions (LTC)

As part of the Boards strategy plan, a subset of the board is working with the Engagement and Operational team to design services that support patients with LTCs at scale. As a result of the positive practice and patient impact of the Diabetic Home Visiting service, GPN will commission this service for 12 months to ensure consistent care is given to our vulnerable patients and our Member Practices. The LTC group are currently working on phase 2, reviewing comorbidity data and practice engagement surveys to consider further at scale LTC services.

39.9%

OF PATIENTS THAT VISITED THE GP HUB IN 2023-24 HAVE AT LEAST ONE LONG TERM CONDITION, WITH 14.7% HAVING TWO OR MORE

41.7%

OF PATIENTS THAT WERE VISITED BY OUR HOME VISITING TEAM HAVE TWO OR MORE LONG TERM CONDITIONS

Frailty Service

In readiness for Winter 2024-25, GPN has being working with ICS partners to develop a frailty service. The service aims to proactively identify patients at risk of deterioration and extended use of healthcare services, initial screening will be based on patients with a certain frailty score and one or more risk factors or regular ED attendances. GPN will continue to work with ICS partners on this service.

HOSPITAL AT HOME PLANS 2024-25

Following on from the successes of 2023-24, GPN have worked to optimise three of their services into a singular entity, delivering benefits for patients, our Members and the system through six key principles of design.

SAFETY COMPETENCE EFFICIENCY FLEXIBILITY FORESIGHT DATA DRIVEN

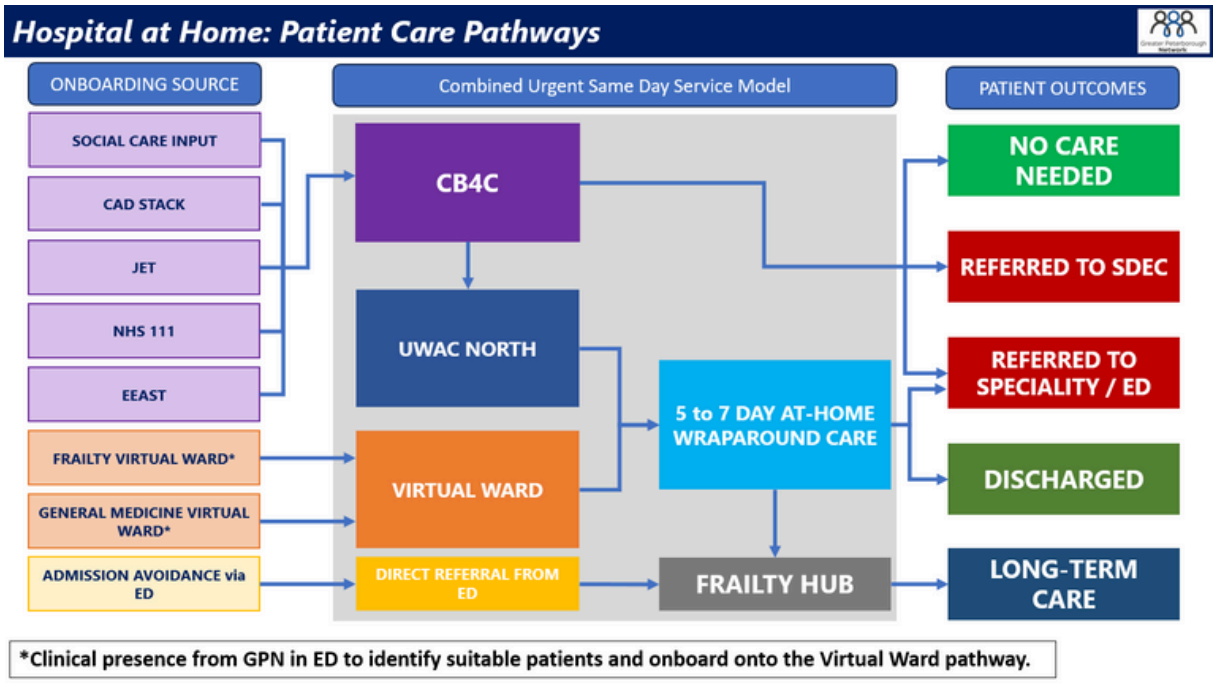
WHAT ARE THE BENEFITS OF A SINGULAR APPROACH?

By unifying services under a singular delivery model of "Hospital at Home" GPN will:

Deliver a singular patient-centred pathway where the professionals rotate around the individual as opposed to the patient being passed through services in a piecemeal and transactional referral-based manner.

Streamline services to:

- Provide a single coordination Hub where "one call does it all", incorporating Call Before Convey, UWAC North and Virtual Wards, with scope for the seamless integration of Frailty related services into the pathway.
- Reduce duplication of work by minimising clinical handovers and transfer of care between services.
- Have fewer patient handovers between services, saving clinical time and reducing bureaucracy.
- Use a single trusted assessor model.
- Have senior clinical decision makers overseeing the service and determining the care plan for the patient with a daily identified clinical lead.
- Unify a singular workforce increasing productivity as working 8:00am – 8:00pm, 7 days across all pathways and services.
- Use a singular operating model to maximise efficiency and operational oversight, with a singular suite of standard operating procedures, clinical policies and service level agreements.
- Minimise underutilised capacity across the services by allowing capacity and support to be leveraged up or down in each of the elements where demand requires, delivering efficiencies.
- Maximise the potential for performance adjustments, forecasting and financial controls by bringing together multiple services into a singular suite of reporting and internal dashboards, whilst still providing localised contractual reporting for each of the singular services.
- Standardised GIRFT (Get It Right First Time) model, making every contact count with a single multi-disciplinary team.



OUR SENIOR MANAGEMENT TEAM

Our Senior Management Team (SMT) is made up of experienced leaders who guide the company with a focus on growth, efficiency and the delivery of safe and responsive patient care across our city.

Each Member of the SMT is the owner of their domain and lead their teams to deliver the principles and ambitions of the organisation, as well as the positive results that are expected for our Members.

They work collaboratively to ensure seamless daily operations and to make key decisions that support the company's goals and long-term success, with a focus on delivering results for our staff, our Members and the patients of Greater Peterborough.

Mustafa Malik
Chief Executive Officer

Helen Lord
Director of Operations

Ben Mather
Head of Information and Performance

Sarah Shah
Associate Director of Nursing

David Monk
Associate Director of Allied Health Professionals

Sinead Atkinson
Finance Manager

Jillian Hall
Personalised Care Lead

Ian Weller
Programme Director

Heather Wilmer
Human Resources and Organisational Development Business Partner

WE ARE HERE TO SUPPORT YOU.

We are dedicated to providing unwavering support to our Members in every way possible. Your ideas, suggestions, and feedback are invaluable to us, and we encourage you to share them. Please don't hesitate to reach out to our Senior Management Team, who are always available to listen and collaborate with you.

Together, we can continue to grow and improve.

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

"Exceptional service delivered in a friendly professional manner."

"Perfect. Evening appointment was great and on time. Nurse was experienced and helpful."

"The Nurse was very pleasant, professional & knowledgeable. I found the whole experience very helpful!"

"Very happy with service, don't need to improve anything visiting team was amazing. Overall experience was great!

"Efficient & friendly visit. Last year I did need other services, which I was successfully directed to. Thank you."

Contact

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Greater Peterborough Network

NHS

*Some patient quotes may have been edited for grammar and length