The Hub
DERBYSHIRE

QI Projects for Fellowships

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MSK Fellowship - Rheumatology component

Date:May 2025

Author: Dr Rachel Hamilton-Cruse

1 Introduction

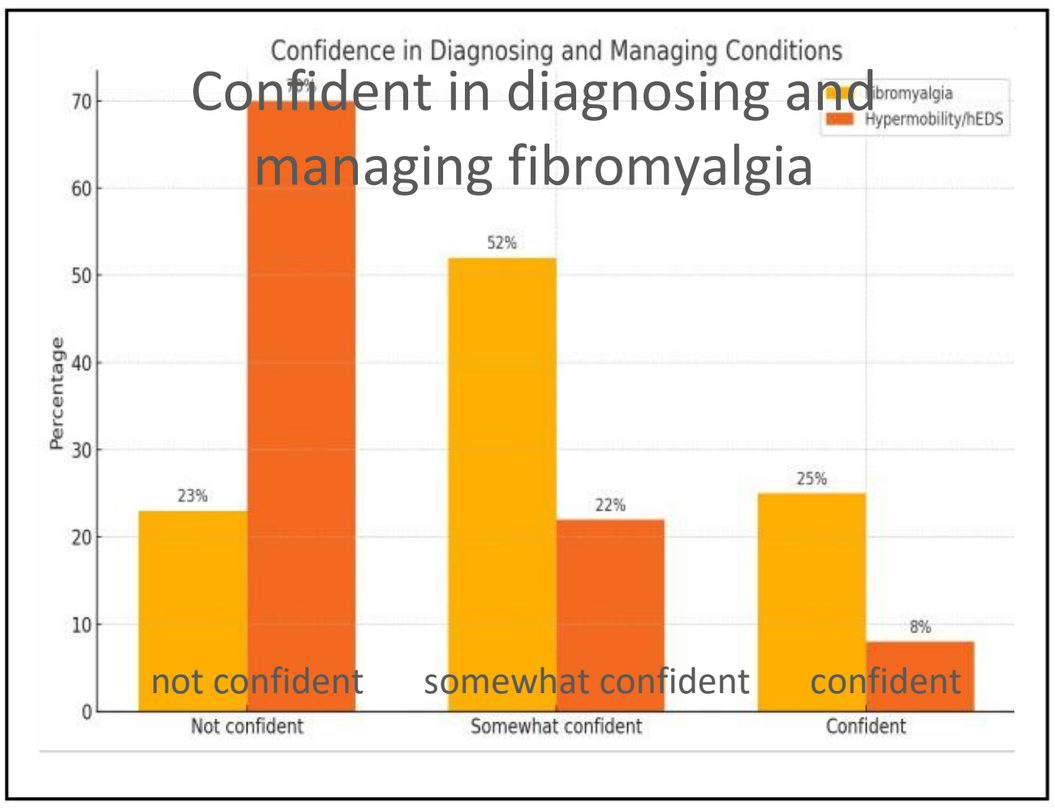
My project involved collaborating on various MSK related workstreams alongside the GPPB MSK fellows and ICB MSK team. After Q2, I shifted focus completely to rheumatology workstreams and this poster outlines that aspect of my work. My rheumatology project looked to identify ways to help address long waiting times for new patient referrals to rheumatology via collaboration with rheumatology and primary care colleagues.

2 Method

- An early theme that emerged was the implementation of NHS England (NSHE) and Getting It Right First Time (GIRFT) national mandates to reduce non-inflammatory referrals to rheumatology. While this shift is expected to improve waiting times, it also has important implications for the diagnosis and management of non-inflammatory musculoskeletal conditions in primary care.
- To better understand the current landscape, I designed and distributed a questionnaire aimed at assessing:
- Awareness of the national pathway changes
- Confidence among clinicians in diagnosing non-inflammatory conditions and existing community-based service provision
- In parallel, I began collaborating with the UHDB Rheumatology Department to enhance Pathfinder templates, improve access to clinical advice, and expand educational support. This included working with the local tertiary Ehlers-Danlos Syndrome (EDS) service to co-develop and deliver an education evening for GPs and AHPs.

3 Results

Results from the GP questionnaire revealed generally low confidence in diagnosing and managing non-inflammatory conditions in primary care. Notably, only 1 out of 18 Primary Care Networks across Derbyshire currently has access to a specialist service for managing patients with chronic primary pain. These findings were shared with rheumatology teams and ICB MSK colleagues. However, there was limited appetite at the ICB level to pursue service development in this area. Notably, a pilot study for an MDT clinic for fibromyalgia has already been undertaken by UHDB with outcomes demonstrating clinical effectiveness and cost effectiveness with results shared at ICB level but attempts to continue and expand the service have been stopped due to funding constraints.



In response, I shifted focus toward improving education and clinical resources. I also spent time with the UHDB rheumatology team in outpatient clinical setting, gaining clinical experience of frontline rheumatology services.

4 Impact and benefits

Over the past 15 months, the original aims of my project have evolved significantly. This shift initially stemmed from a decision to concentrate solely on rheumatology, moving away from a dual focus on rheumatology and FCP work. Subsequently, I encountered several challenges at the ICB level that limited progress in areas such as fibromyalgia and Ehlers-Danlos Syndrome. These difficulties appeared to be due to differing priorities at the ICB level.

In response, I redirected my efforts toward gaining clinical experience with the Derby Rheumatology team, alongside contributing to rheumatology education through initiatives such as the Hub Plus education sessions and the development of Pathfinder advice and guidance documents.

5 Conclusion

Challenges remain regarding the appropriate setting for the diagnosis and management ofnon-inflammatory con diti ons National guidelines advocating a shift of responsibility from secondary to primary care risk placing additional financial and clinical strain on an already overburdened primary care system. Patients with conditions such as fibromyalgia and hypermobile Ehlers-Danlos Syndrome (hEDS) are particularly vulnerable to poor outcomes due to the ongoing lack of dedicated services. This issue remains unresolved and will require a strategic shift in focus at the Integrated Care Board (ICB) level to drive meaningful change.

Primary Care Cancer Education Fellowship

Date: 28/03/2025 Author: Dr Jennifer Pickard

1

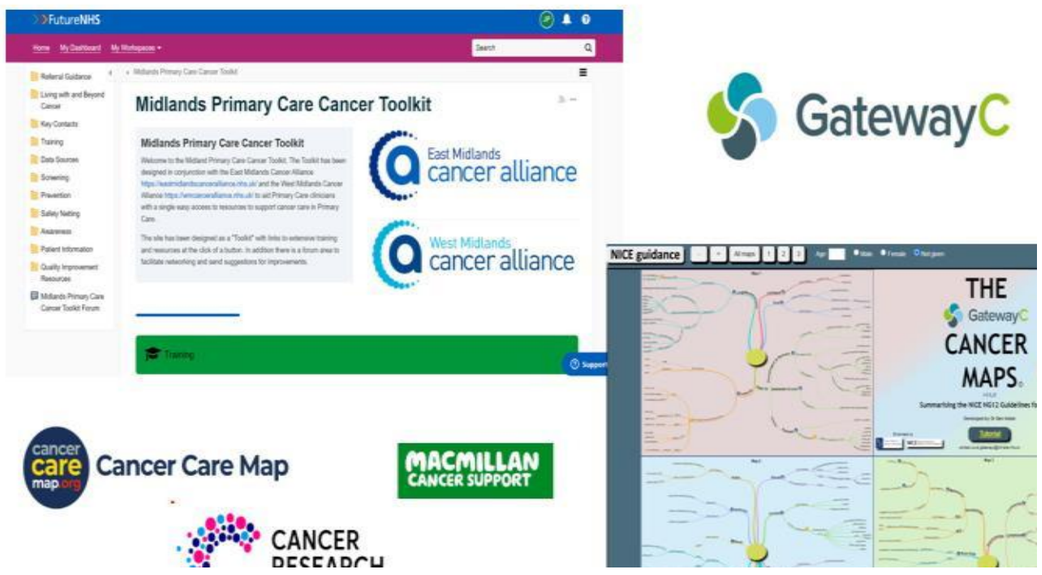
Part of a pan-Midlands collaboration, this 12 month fellowship aimed to promote existing cancer educational resources for all primary care staff and patients and development of material which addresses any training gaps. There was a focus on identifying addressing health inequalities/hard to reach patient groups, to improve prevention and early diagnosis of cancer.

A toolkit has been developed on the NHS Futures Toolkit to host resources.

2 Method

1. **Identify materials to be stored on NHS Futures toolkit** The initial phase involved researching available educational resources, both locally from across the Midlands and nationally, with particular focus on Core20PLUS5 patient groups to address health inequalities.
2. **Promote training currently available eg Gateway C, Macmillan**
   Many opportunities taken to promote the fellowship and existing resources, particularly Gateway C – primary care nursing conferences, CRUK GP trainers event, various PCN events, East and West Midlands Cancer Alliance meetings.
3. **Stakeholder engagement to identify pathway/training gaps**
   Meetings with numerous stakeholders including Midlands ICB cancer leads, EMCA and WMCA primary care leads, public health and voluntary sector organisations to identify training needs.
4. **Development of resources which can be recorded for future use** training event presentations and two webinars developed as a result of above extensive research and networking.

3 Results



RESOURCES:

1. **NHS Futures Midlands Primary Care Cancer Toolkit:** https://future.nhs.uk
2. **EMCA Primary Care Training Academy:** https://eastmidlandscanceralliance.nhs.uk/professional/emca-training-and-education-academy-register
3. **East Midlands Breast Pain Pathway webinar:** https://www.thehubplus.co.uk/course/499
4. **Trauma Informed Cancer Care Webinar:** https://www.thehubplus.co.uk/course/439

4 Impact and benefits

The NHS futures toolkit provides a platform for hosting educational resources for staff and patients and links to EMCA, WMCA, Macmillan and CRUK resources amongst others, providing easy access from one dashboard for staff.

The webinars address training gaps and are applicable to clinical and non clinical staff. The trauma informed cancer webinar effectively utilises a patient with lived experience and a pathway developed elsewhere to enhance the impact of this emerging field. Example of feedback: ***'Excellent training session, very insightful and motivating to improve patient care.'***

5 Conclusion and Recommendations

Wider aim of improving access to cancer educational resources across primary care is to improve prevention and earlier diagnosis of cancer, to improve overall outcomes.

Challenge: it was difficult access public participants to engage in development of educational resources. I think this is key to effectively target hard to reach patient groups and tackle health inequalities and would recommend this as a future focus.

Quality Improvement in General Practice

Date: 26/02/2025

Author: Dr Weronika Tobiasiewicz

1 Introduction

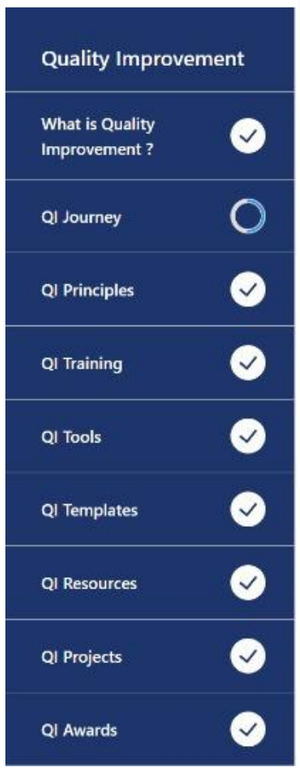
Continuous Quality Improvement can ensure better patient outcomes and experiences as well as higher service efficiency and better staff experience.

The aim of my project was to support the evolution of QI in General Practice in Derbyshire by promoting a system wide approach to QI and increasing awareness of education, training, and resources as well as creating opportunities to share best practice, in the hope that we could start to make QI a part of everyday practice for all.

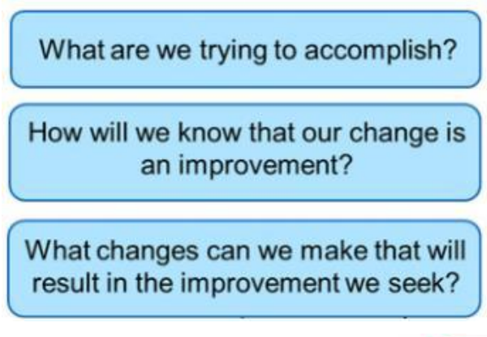
2 Method

1. Assessed existing QI resources in GP in Derbyshire
2. Researched what worked well in other areas
3. Designed, created and launched Derbyshire GP QI Portal
4. Delivered Introduction to QI Training for clinicians & non-clinical staff
5. Collated QI initiatives across GP in Derbyshire into a virtual library
6. Launched Derbyshire GP QI Awards
7. Collaborated with other organisation to develop higher level expertise in QI in GP ie QSIR training
8. Built links with other organisations to help revive the JUID Network & Exchange

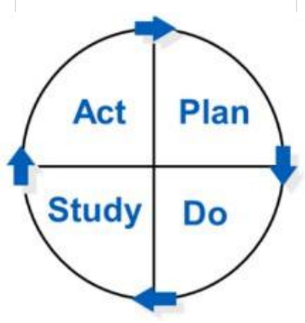
3 Results



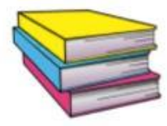
The Model for Improvement



PDSA Cycles



QI Resources



How to get started in QI https://www.bmj.com/content/364/bmj.k5437

How to Lead a QI Project https://www.bmj.com/content/346/bmj.f113

The Health Foundation: What everyone should know about health care quality improvement.

https://www.health.org.uk/sites/default/files/QualityImprovementMadeSimple.pdf

RCGP Leading effective and sustainable Quality Improvement within a Primary Care Network

https://www.rcgp.org.uk/getmedia/7eb16993-d107-4346-bb81-04039f23606e/QOF-QI-PCN-how-to-guide-RCGP-2021.pdf

The QI Journey

QI Templates

4 Impact and benefits

The Derbyshire GP QI Portal gives all frontline staff the opportunity to access the training and resources they need to participate in QI activity.

QI Principles set the foundations for building a culture of continuous improvement.

Creating a directory of QI training and signposting to available QI resources across the system means we will all be speaking the same QI Language.

Promoting a simple methodology and easy to use templates for recording learning enables both clinicians and non-clinical members of staff to make QI a part of their everyday work.

Creating the GP QI Library allows learning from QI initiatives to be shared more easily across a wider geography increasing the impact of each QI.

Derbyshire GP QI Awards mean that QI can be recognised and celebrated as well as outcomes of the most impactful projects being clearly articulated and more widely shared.

5 Next steps

Creating a culture of continuous improvement and collaboration requires engaged Leadership. We now need to increase awareness of resources and keep QI on the agenda.

Ideas for further development include:

QI at every QUEST relevant to the topic that month.

Working with the JUID Network to promote QI activity eg. National QI week.

Derbyshire GP QI Conference and QI Champions in each practice or PCN (NB doesn't have to be someone clinical).

Dermatology Fellowship: Improving Referral Pathways and Education in Primary Care

Date: 2024-2025
Author: Azeez Pervez

1 Introduction

The Dermatology Fellowship aimed to enhance primary care dermatology services by improving referral pathways, fostering collaboration between primary and secondary care, and developing educational resources for clinicians and patients. This initiative was driven by the need to reduce unnecessary referrals, enhance diagnostic confidence, and improve overall dermatology care within primary care settings.

2 Method

1. **Stakeholder Engagement** – Collaborated with Dermatologists, GPwSIs, and healthcare leaders across Derbyshire, Nottingham, and Chesterfield.
2. **Needs Assessment** – Identified barriers in dermatology referral pathways and challenges in GP training.
3. **Curriculum & Resource Development** – Designed educational materials, with a focus on skin cancer recognition and dermatoscopy use.
4. **Education Delivery** – Conducted multidisciplinary teaching sessions for PCN clinicians, incorporating specialist input and patient resources.
5. **Evaluation & Impact Assessment** – Reviewed referral patterns and educational effectiveness while exploring sustainable improvements.

3 Results and Analysis

Stakeholder Engagement & System Understanding

- Mapped dermatology service variations and referral inefficiencies.
- Identified resistance to GPwSI integration in Derbyshire despite its success in Nottingham and Chesterfield.

Referral Pathway Improvements

- An audit had been conducted, revealing frequent incorrect 2WW referrals. Majority of incorrect referral were from non-GPs referring.
- Advocated for additional training to standardise referral processes.

Education & Training

- Delivered dermatology teaching sessions covering common lesions and skin cancer recognition.
- Partnered with the East Midlands Cancer Alliance and a skin charity to enhance educational resources.
- Began development of a dermatology reference guide for potential use in general practice.

Technology Exploration

- Investigated AI tools like ‘Skin Analytics’ for improving triage efficiency, noting both potential benefits and implementation challenges.

Challenges Encountered

- Difficulty securing financial support for sustainable educational programs.
- Scheduling constraints and stakeholder alignment slowed progress.
- Lack of formal accreditation for existing dermatology education resources

4 Conclusion and Future Recommendations

This fellowship successfully highlighted the role of education in improving dermatology referrals and clinical confidence. While systemic changes (e.g., integrating GPwSIs) faced resistance, structured education emerged as a feasible and impactful strategy for short term changes with hopeful long term impact.

Key Takeaways:

- **Primary care dermatology education should be expanded** with structured, recurring training sessions.
- **Collaboration between primary and secondary care** is crucial for improving referral efficiency.
- **AI and digital tools offer potential** but require further evaluation and integration into clinical workflows.
- **Future dermatology fellows can build upon this work**, particularly by formalising dermatology teaching programs and securing funding for long-term sustainability.
  HUB+ to seek regular teaching sessions with Dermatology Registrars, this would be of mutual benefit

By continuing this initiative, primary care clinicians will be better equipped to manage dermatological cases, reducing unnecessary referrals and enhancing patient outcomes

Core Immunisation and Vaccination Training

1 Introduction

The primary aim of this project was to create an engaging inclusive 2 day core Immunisation and Vaccination training package. The training package was to include the 12 core areas of the National Minimum Standards and Core Curriculum and be able to be delivered both face to face or online. The package was to be interactive, informative and fully inclusive of a variety of learning styles for new vaccinators.

2 Method

Planning the project entailed meetings and discussions between Kerrie and the local Screening and Immunisation team (SIT) the integrated Care Board (ICB) and Kerrie also reached out and networked with the De Montfort University Immunisation and Vaccination Lead. The 12 Core areas of immunisation knowledge helped to shape the design of the training package and Kerrie was able to research each of the core elements in depth for inclusion in
a structure way.
A variety of sites were used to gather evidence based and up to date information and all are referenced and inclusive in the slide set presentation so the new vaccinators can also access them.
Kerrie has embedded and catered for a variety of learning styles in the presentation.
Over the timespan of one year and the changes to the immunisation schedule ment the presentation would need to be updated multiple times.
Once created the final presentation has been presented to the SIT team to ensure all key factors have been included and are clear and concise and the presentation is ready for delivery.

3 Results

Over 500 slide presentation to be delivered over 2 days

12 Core areas of immunisation knowledge

Ice breaker

Visually pleasing backgrounds and slides

Multiple informative videos

Pictures and sounds

Links and Hyperlinks to key learning platforms

Case Studies for additional group learning

Electronic anonymous participation via Mentimeter

4 Impact and benefits

Vaccination saves lives and protects people's health. It ranks second only to clean water as the most effective public health intervention to prevent disease. Through vaccination, diseases that were previously common are now rare, and millions of people each year are protected from severe illness and death.
Immunisation and Vaccination training is a key essential part of the training new vaccinators are required to complete before completing there competencies. The course is over two days and contains extensive in depth information.

New vaccinators need to have a sound and robust understanding of all aspects covered in the training package so they can be competent knowledgeable practitioners in the wider community and also promote vaccina tion uptake.

5 Conclusion

Curating the presentation is only the beginning for this training package, it will need continual updating as schedules and society changes. It is however, a visually pleasing fully adaptable user friendly presentation for a variety of new vaccinators
in our diverse population.

Rural and Agricultural Health – a hidden inequality

The scale of the issue:
9.7 million defined as 'Rural' – VERY mixed group. Pockets of poverty hidden in relative affluence.
This population is older (average age 58 vs 45), lower educational levels and lower income this process is accelerating.

Research:
Literature review – local and national.
Farmer interviews. Agricultural centre visits.
Trailblazer educational sessions.
Meetings with various stakeholders – nursing drop-in clinic at agricultural centre, the farming life centre, rural domestic abuse charities, rural chaplaincy, local veterinary practices, social care, TeamUp, clinical lecturer in rural medicine and more.
Conferences – EURIPA rural health forum, Rural Services Network conference.

Current health situation.
Cancers present much later.
Much greater burden of musculoskeletal disease.
Much higher rates of cardiovascular disease.
Higher rates of poor mental health.
Suicide rate DOUBLE national average.

Why is this the case?
Healthcare increasingly centralised – closing branch surgeries and community hospitals
Worsening of already poor public transport / much further to travel
Less educated / poor digital literacy / poor health literacy
Very physical and isolated work – no concept of holidays / sick leave / occupational health
Stigma of illness / weakness / mental health and particularly others in community knowing
Suspicion of outsiders / professionals – cultural independence

Project outcomes.
Making it easier to find remote farms - What3Words coordinates for System One to help practices and Team Up
Raising awareness – discussed with clinicians and raised at LMC, PCN, QUEST, PLACE
Posters featuring our clinicians who are involved in agriculture to display at farmers market and in practices to show we are interested in helping.
Supportedinsetting upamentalhealth practitioner atagriculturalmarket.
Personal learning and development – research, networking, lobbying, applications.

Health page with resources NHS and third sector on the website of the Farming Life Centre.

Tutorials for GP registrars working in rural area. Outreach / education – doctor visits to local rural nursery (mostly farming families)

Next steps.

Continue to raise awareness of 'Rurality' as an inclusion group to consider.
Try to improve outreach and integration with other services.

Tarquin Bertram

Structured Medication Reviews in the Care Home Population

Date: 18/09/2024

Author: Oliver Bedford

1 Introduction

I work within the frailty team within Team Up in Erewash. Care home residents are often frail, with complex care needs and a high pharmacy burden with increased risk of adverse side effects.

Alongside PCN pharmacists we wanted to look at ways to reduce polypharmacy and ensure care home residents are having appropriate timely structured medication reviews.

Aim: Reduce polypharmacy and ensure appropriate and safe prescribing in the ~~care~~ home population.

Objectives:

I. Offer all care home residents regular structured medication reviews.
II. Reduce pharmacy burden in the care home population.
III. Have a pathway to raise medication queries to the PCN pharmacy team.

2 Method

I reviewed how many residents within a care home had had a structured medication review within the past 12 months coded on SystmOne.

Following this, the team implemented a structure for PCN pharmacists to offer regular medication reviews to all care home residents in our PCN. I provided a supporting document outlining this structure and providing guidance on reviewing medications within the care home population.

The PCN pharmacy team also created an email pathway for the frailty team to raised medication concerns to the pharmacy team.

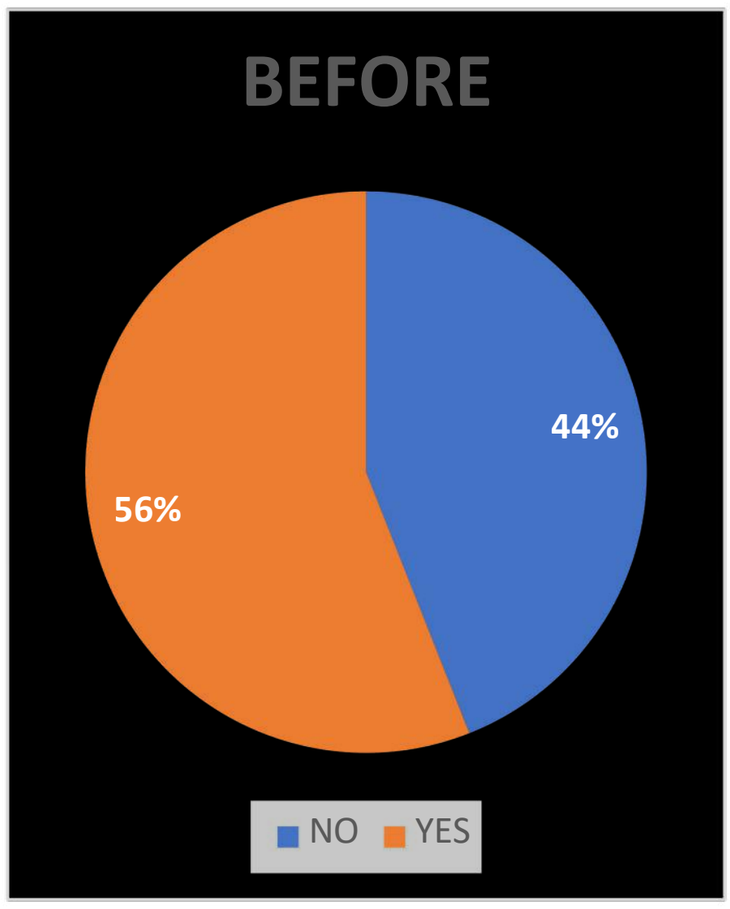
Following the implementation of the above I re-audited the same care home to review how many residents had had a structured medication review.

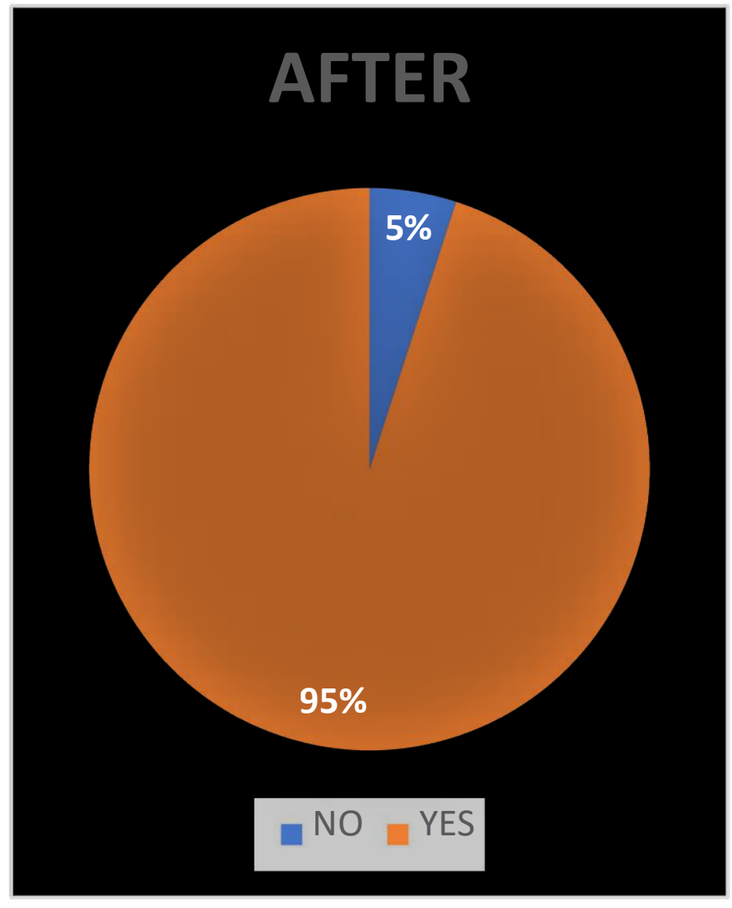
3 Results

Prior to implementation of PCN pharmacists and a review structure, 34 out of 61 residents within a care home in our PCN had had a medication review coded on SystmOne within the past 12 months.

6-months after implementation 60 out of 63 residents within the same care home had had a medication review coded within SystmOne within the past 12 months.

Staff from the frailty team, pharmacists and care home nurses have all fed back how useful this exercise has been and how they have noticed a reduction in medications being administered.





4 Impact and benefits

Setting up a structure for medication reviews to happen regularly within our care homes has resulted in more residents having timely reviews. This has likely had further benefits which have not been specifically measured including:

- Reduced polypharmacy and resultant complications.
- Reduced burden on care home staff in administering medications.
- Reduced hospital admissions secondary to medication adverse effects.
  Cost saving through cessation of unnecessary medications.
  Improving QOL for patients by reducing tablet burden.

Moving forward this is something we aim to maintain as in care homes there are new residents moving in regularly. This is something that could be mirrored in other PCNs who have a pharmacy team working regularly with care home residents.

5 Conclusion

This project has resulted in a greater number of care home residents having a timely review of their medications by an appropriate healthcare professional.

I believe this project has resulted in improved patient care within the local care home population. Reducing polypharmacy has the potential for other benefits in addition to improved patient care, including reduced cost and reduced workload for care home staff.

Engaging various stakeholders has helped the implementation of regular structured medication reviews. The PCN pharmacists have been involved throughout the process and have fed back that they now feel better supported and utilised in their role within the frailty team.

Trailblazer Fellowship: To Improve the Experience in Primary Care for patients who are Autistic and/or have a Learning Disability

Date: 12/10/2024

Author: Zohra Jafri

1 #u]j;

Patients who are autistic and those who have a learning disability experience significant health inequality.

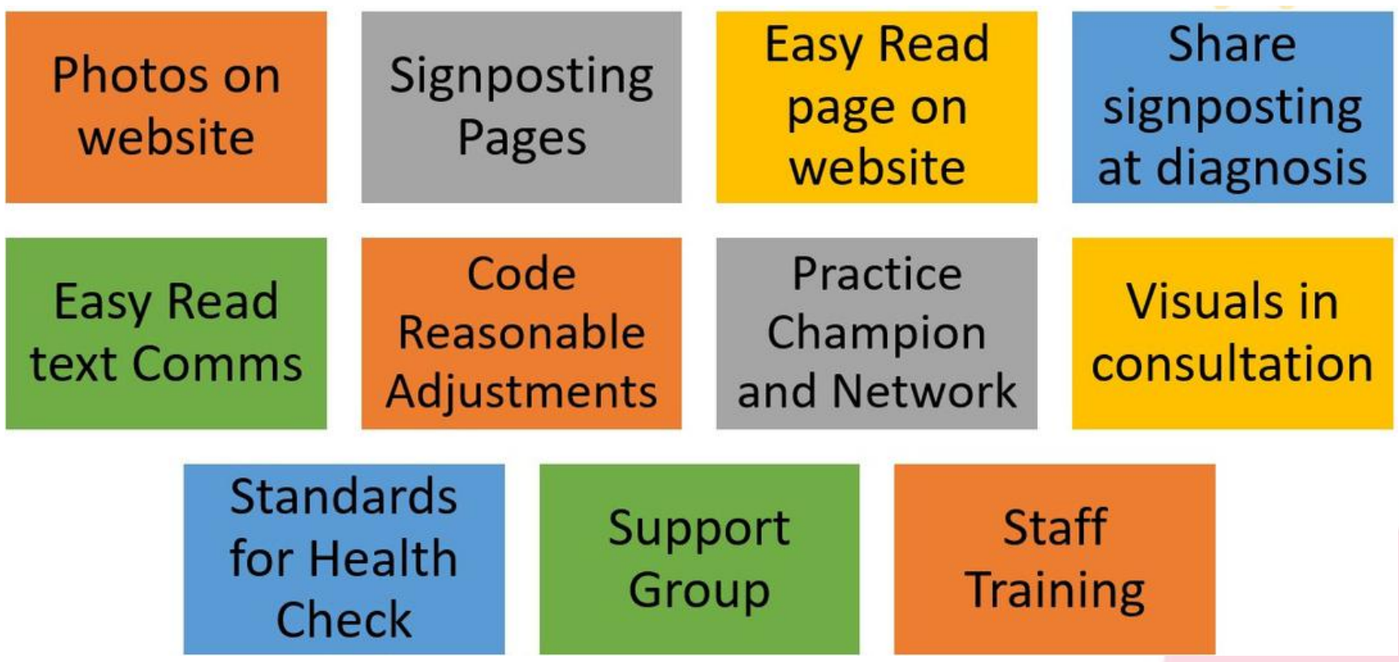
People with a learning disability die 20 years earlier than the general population and 42% of these deaths are avoidable.

I completed a GP Taskforce/Hub Plus Fellowship in 2023. This involved collating over 150 pieces of feedback from patients who are autistic and/or have a learning disability, their parents and carers. This led to an Action Plan of how to improve the experience at the GP.

The aim of the Trailblazer Fellowship was to put the Action Plan into practice at a GP surgery.

2 Method

The Action Plan is below:

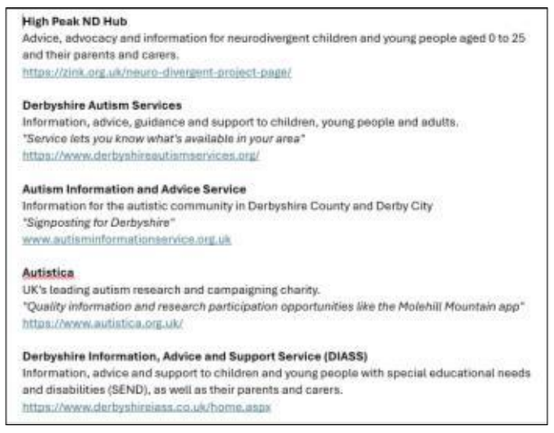


I worked with a focus group of patients and parents, GP colleagues, and professionals from local VCSE organisations to put this plan into practice.

3 Results t ##################U

Photos on website:

Signposting pages:



High Peak ND Hub
Advice, advocacy and information for neurodivergent children and young people aged 0 to 25 and their parents and carers.
https://zink.org.uk/neuro-divergent-project-page/

Derbyshire Autism Services
Information, advice, guidance and support to children, young people and adults.
"Service lets you know what's available in your area"
https://www.derbyshireautismservices.org/

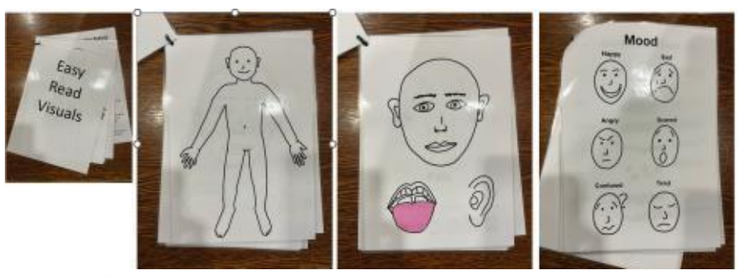
Autism Information and Advice Service
Information for the autistic community in Derbyshire County and Derby City
"Signposting for Derbyshire"
www.autisminformationservice.org.uk

Autistica
UK's leading autism research and campaigning charity.
"Quality information and research participation opportunities like the Molehill Mountain app"
https://www.autistica.org.uk/

Derbyshire Information, Advice and Support Service (DIASS)
Information, advice and support to children and young people with special educational needs and disabilities (SEND), as well as their parents and carers.
https://www.derbyshireiass.co.uk/home.aspx

Easy Read:

Visuals in Consultations:



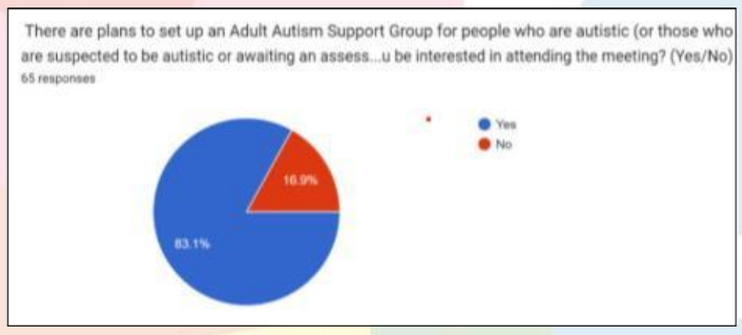
Autism and LD PracticeChampions:

Patient Support Group:

- Zink-started as High Peak food bank 'to provide a holistic approach to supporting people and families towards better futures'
- New Mills Volunteer Centre
- Patient focus group
- Questionnaire to patents (adults who are autistic)

4 Impact and benefits

Adult AutismSupport Group-extracts from questionnaire feedback



"To meet new people who I may finditeasier to connect with due to both having autism. Share struggles and feelless alone."

"To get advice on how to motivate myself to do things and think positively."

"Need a safe space to be myself"

"To share experience and support others."

5 Conclusion

The action plan contains various actions that can be taken in Primary Care to improve the experience for patients who are autistic and/or have a learning disability.

I plan to continue ongoing work to achieve practice standards.

I am sharing the Action Plan more widely (within the local PCN, across Derbyshire and regionally)

There is scope to develop a practice accreditation.

The overall aim is to improve patient experience and enable health equity.

Becoming an educator.

Date: 28/08/2024
Author: Matthew Morgans

1 Introduction

Throughout my medical training I have always enjoyed teaching more colleagues, both my peers and my junior colleagues. For my new to practice project I aimed to use that time to train up with the eventual goal of becoming a educational lead at my practice.

2 Method

Planned to develop as an educator through a meeting with the senior partner to discuss and plan how this could be achieved at the practice. Agreed plan of step-wise approach building up to potentially doing the Educational Supervisor's course. Initially planned to debrief trainees, then complete the clinical supervisor's course with a view to becoming educational lead at the practice. Arranged regular reviews to assess how to move forwards, gradually taking on more responsibility from an educational lead point of view.

3 Results

1. Completed the clinical supervision training for both Foundation year doctors and GP registrars and been added to the GMC list for approved clinical supervisors. This has allowed me to work as a clinical supervisor for 2 FY2 trainees and currently supervising a GP registrar in her second year of training.
2. Developed and delivered an induction tutorial for incoming registrars and foundation year doctors which covered both mandatory topics such as zero tolerance policy and a multi-faceted clinical case discussion about a patient with vague abdominal symptoms allowing discussion regarding 2ww criteria, mental health issues, involvement of other members of the clinical team such as social prescribers. Recently led this for 3 FY2 clinicians and 5 GP registrars.
3. Have become prescribing mentor (DPP) for practice pharmacist as they undertake the pharmacist independent prescribing at the University of Derby. This involved completing the prescribing practice supervision course and will involve supervised debriefs over a 6 month period.
4. Currently undertaking work looking into the feasibility of expanding capacity for medical students at the practice with another NtP GP.

4 Impact and benefits

Key benefits:

1. To the practice:
    a. Gained a clinical supervisor helping to facilitate the training and development of trainees.
    b. Potential for additional income streams through extra trainees/ medical students
2. For me:
    a. Enjoyed adding another strung to my bow as a trainer developing my skills in teaching and education.
    b. Received fantastic feedback as a helpful and approachable supervisor who helped facilitate completion of mandatory supervised learning events.

5 Conclusion

In conclusion, the new to practice scheme has really helped to allow me to develop as an educator. I have facilitated this on multiple fronts as a clinical supervisor, pharmacist supervisor and lead for tutorials. This is something I will continue to develop in the years ahead such as work with medical students and eventual goal of educational lead.

Project Summary: Developing End of Life Care at Lister House Surgery and Beyond

31/07/2 024 Dr Julia Mason

1 Introduction

The majority of End of Life Care (EoLC) is provided in the primary care setting and most general practice (GP) staff come into contact with patients receiving this care on a regular basis. The aim of my project was to become more involved in EoLC on a practice and locality level and make improvements in patient care along the way.

2 Next Steps

The project started with lots of networking, which included the following.

- Becoming part of the End of Life Operational Group
- Spending a day with the Palliative Care Urgent Response Service
- Becoming part of the Derbyshire Alliance for End of Life Care Group
- Meeting the Community Palliative Care team nurse for the practice
- Meeting the practice district nursing leads
- Meeting all team leads within the practice to specifically discuss EoLC

I was subsequently asked to be palliative lead at my practice and set about finding out the current processes in place for providing end of life care for our patients. Qualitative feedback was received from staff about what worked well and what didn't, as well as what they would like to see happen. I carried out retrospective death audits to identify areas in patients care that went well and didn't, as well as being involved in any significant events or complaints involving any aspect of EoLC, to review and implement changes. I chaired palliative meetings to receive feedback from staff, give feedback on findings and discuss changes. The outcomes of changes would then be discussed and reviewed in subsequent meetings.

3 Out comes

As a result of the networking and qualitative data collection many changes and actions were made which have been listed below.

1. All staff providing EoLC in surgery moved to using the Electronic Palliative Care Coordination System (EPaCCS) template
2. Training and instruction manuals on the use of EPaCCS and associated forms
3. Blue prognosis coding added to the EPaCCS template for all Derbyshire practices to benefit from
4. The development of clinician and admin palliative practice protocols
5. Improvement of the care plan standard operating procedure
6. Regular practice palliative meetings with better turnout of the multi-disciplinary team and engagement from all staff
7. Implementation of training for all new GP's and registrars starting at the practice on our palliative protocols
8. Involvement in updating the Symptom Management in the Last Days of Life guidelines – giving a GP perspective
9. Input into changes to be made on the Derbyshire Alliance End of Life Toolkit
10. Involvement in a project to increase patients understanding of the role of the GP in End of Life Care in Derbyshire, Nottinghamshire and Birmingham areas
11. Attendance at an advanced communications course, learning then shared with the practice and at training of new staff

4 Impact and benefits

As a result of the changes made our patients are receiving more standardised EoLC regardless of who they see and the practice team is more engaged and confident in managing these patients.
The palliative practice protocol has increased staff confidence in providing EoLC and has supported better communication between the whole practice team in caring for these patients. The use of the EPaCCS template ensures that the most up to date version of the ReSPECT and Care Plan forms are always used and EoL

Derbyshire Task force Fellowship in Respiratory Medicine

Dr. Kate Stonier

Aims

To start working towards developing a specialist interest in Respiratory Medicine. To work under the supervision of Consultant Dr Sally Davies, in the Respiratory outpatient department at Chesterfield Royal Hospital. To identify areas of how the care of respiratory disease can be improved in the community setting and increase integrated working between Primary and Secondary Care.

Objectives

- Spend time with all members of the North Derbyshire Respiratory team. Including; community and hospital Respiratory Nurses, Respiratory Physiotherapists, Specialist Oxygen Nurses, Pulmonary Rehabilitation clinicians and Respiratory consultants.
- Increase my knowledge in Respiratory Medicine by reading relevant guidelines, attending courses and conferences.
- To understand the current North Derbyshire Respiratory services and their referral pathways.
- Undertake audits in the Primary Care setting. To include an audit on the management of patients attending with frequent COPD exacerbations, and an audit reviewing the referrals made to the community and secondary care respiratory teams.
- Attend a weekly hospital outpatient clinic assessing patients under the supervision of Dr Davies.
- Invite specialist colleagues to spend time shadowing my working day in General Practice. To better understand how respiratory patients are managed in the community and the challenges faced in Primary Care.
- To start a community respiratory clinic for patients registered to Royal Primary Care Chesterfield, to manage patients with respiratory disease in the community and reduce the rate of hospital referrals

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NHS PILOT LIFESTYLE MEDICINE CLINICS AT MACKLIN STREET SURGERY

Dr Sally Giovannelli Dip IBLM/BSLM FRCGP

1

Through the lens of inner-city practice, we witness the pernicious impact of unmitigated social deprivation and inequality on health. The need for high quality, evidence-based, Lifestyle Medicine (LM) input, has never been greater in the communityweserve. Utilising knowledge from Diplomas in LM and Coaching, I wished to provide Lifestyle Medicine Clinics. A 360º person centred approach. Clinics being GP led, in conjunction with a multidisciplinary team. All 6 pillars being reviewed at each consultation, incorporating coaching techniques, working in ***partnership with patients to make***sustainable, health behaviour changes.

AIMS

1. Toreduce(andpotentiallyreverse)theriskof chronic disease and adverse health outcomes.
2. Toimprovephysical,andpsychologicalwell-being; **'Fitter, Healthier, Happier'.**

2 Method

A patientsearchwasperformed(Systmone)forpatientswithBMI>30,±Pre-Diabetes± Hypertension and aged 35-55 years (anticipating a potential family 'ripple effect'). Poster invites outlining the benefits of Lifestyle Medicine were sent to the identified patients via text.

12 Patientsattendedclinics.Aninitial1:160-minuteGPassessmentusingthe **BSLM baseline questionnaire** with 30-minute follow up's at approximately 1, 3, 6 & 9 months. At each appointment, all 6 pillars of LM were reviewed with behaviour change coaching, motivational interviewing and positive psychology being employed. SMART goals set, workingin ***active partnership*** with the patient.Followupmotivational text messages were sent. Eachpatientwassignposted tothe **Dietician**, local **Physical Activity (PA) provider,** and if required the **Social Prescribing Team.**

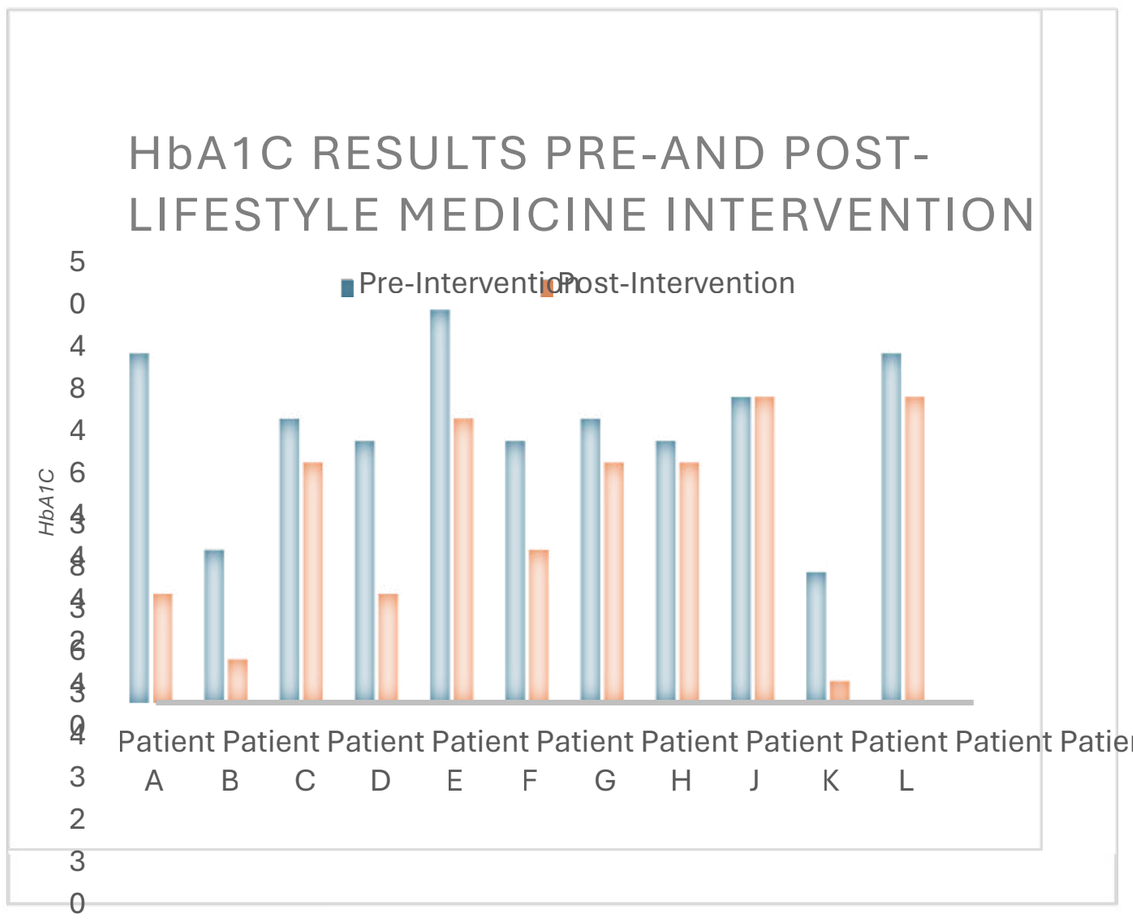
Each patient received a handheld record of their metrics and documented their **WHY?'** ***i.e. their reason for change.***

A 'One-Stop'onlineLifestyleMedicineInformationbookletwasdeveloped(Link below), Including integral behaviour coaching questions, signposting to local, and national Lifestyle support. Patients were also offered the opportunity to 'Walk and Talk' with me, at our localParkrun/Walk.

Metrics were compared pre and post LM intervention. These included BP, Weight, BMI, GAD-7(anxiety), PHQ-9 (depression), Self-rating (SR) 'wellness scale', PA level & HBA1C.

3 Results

OUTCOME MEASURE	Patients losing	Percentage		Mean Improvements
weight	Patients reducing BMI	Patients achieved	91%	91% 8.2 Kg
reducing BP	Patients improving PHQ9	100%	66.6%	2.34 Kg/m2
Patients improving GAD7	Patients improving HbA1C	77.7%	90% 86%	17.7/9.7
Patients improving health and wellbeing rating	Patients increasing Physical Activity	100%	90% 18%	4 points
Physical activity meeting CMO Guidelines	Antihypertensive deprescribed	75%		8.2 points
Reversal of Pre-diabetes				4.38 mmol/l
				25%



4 Impact and benefits

Patients who engaged with the Lifestyle Medicine Clinics really appreciated the 360-degree approach to their health and the reduction of risk of adverse health outcomes.

" The process and attention I have received has made me much more confident in myself and I have already seen the benefits"

"The whole process has been good, I have noticed a good deal of change in my health and lifestyle, it has been well worth attending clinic"

"100% helpful"

'Thank you for your significant support and the major changes that your input has initiated in my health and wellbeing'

Of note, one patient bought Mounjaro privately for 10 weeks, but stopped due to cost and side effects. Importantly, the patient continued to lose weight & increase physical activity after discontinuation, with sustained Lifestyle changes.

https://www.thehubplus.co.uk/files/Resource%20Library/Lifestyle%20Medicine%20%E2%80%93%20Improving%20your%20Health%20and%20Wellbeing.pdf

5 Conclusion

Lifestyle Medicine Clinics with a multidisciplinary and coaching approach can be transformational for patient's physical and psychological health.

This approach has delivered significant improvements in weight loss and blood pressure, reduced anxiety and depressive symptoms, reduced HbA1C levels, reversed pre-diabetes, and facilitated deprescribing of antihypertensives.

Patients have been given the tools to empower themselves to make long term sustainable changes, reducing their risk of chronic disease and adverse health outcomes. To be **'Fitter, Healthier, Happier'.**

Perinatal Mental Health Fellowship.

Date: 28/08/2025
Author: Dr Runveer Singh

1

Perinatal Mental Illness is among the most common issues faced by expectant mothers and yet it is undervalued and under recognised. This project was able to focus on this and spread awareness within all sectors of primary care, clinical and none clinical enabling everyone to gain a better knowledge of this subject in order to help any patient who in need.

2 Overview

Initially this project teamed up with the Coventry and Warwick training hub as they received the majority of the funding to deliver training across the whole of the midlands. This included online Teams sessions in the different areas of the midlands as well as 2 full day face to face events, one in the north and one in the south of the region.

We collaborated on creating a presentation to deliver to all members of primary care and I was able to conduct multiple online sessions where people had booked onto from before. This included clinical and none clinical members of staff.

After the Coventry and Warwick training hub completed their project, I was able to build on this project further.

By attending the stakeholders meeting, I was able to network and link up with the local Psychiatrists. We were able to discuss ways of disseminating the information further and also the sort of patients they were keen on seeing in clinic. I was also able to talk to the mental health support workers and they were keen to promote themselves in our GP practice to our ethnically diverse patient population.

After the completion of the first year, I was able to extend this project further. This allowed me to conduct more online sessions during dedicated PLT training time. This enabled me to reach out to further members of the primary care team and as this was PLT time, all clinical and none clinical members were able to attend and so I could tailor the presentation to everyone who joined. I was also able to present this information to the staff at my own practice which all of which was very well received.

3 Online learning

With the help of the team at HUB PLUS, I have been able to create an online learning resource for anyone registered to complete. This builds on the presentation and gives the freedom for the learner to access material in their own time at a pace of their choosing. This will help promote perinatal mental health even after this project ends.
The link for this training resource is:
https://thehub.continuumlearn.com/course/661

4 Resources

As part of the project, one aim was to look at resources in different languages in order to spread awareness to patients of different ethnicities. Below are links for these.
Postnatal depression in Urdu:
https://www.rcpsych.ac.uk/mental-health/translations/urdu/postnatal-depression
Post Partum Psychosis leaflets in various languages:

https://www.app-network.org/postpartum-psychosis/insider-guides-in-other-languages/

5 The Future

I feel the work completed within this project has been very valuable and beneficial to primary care across Derby and Derbyshire. By promoting Perinatal Mental Illness, all staff are now more aware of what to look for and what questions to ask their patients. This will provide better care to these vulnerable patients and lead to better outcomes earlier.
Even though this fellowship is ending, I will look to continue promoting Perinatal Mental Health with ad hoc presentations and am proud that the online resource is available for everyone to access.

Aspiring Clinical Leader Fellowship
Derbyshire General Practice

Date: 31/08/2025

Author:DrWeronikaTobiasiewicz

1

There is no single clear leadership pathway in GP and yet strong GP leadership is vital for high quality, cost-effective and patient-centred care. GPs need to be able to develop the knowledge and skills required to lead within and beyond their practice and need to be able to understand the systems in which they operate.

This fellowship gave me the opportunity to develop my leadership knowledge and skills so that I am better placed to lead within and beyond my practice in future.

2 Method

3 Aspiring Clinical Leader Fellows were appointed one to each of the GP Leadership Organisations in our ICS JUCD; GPPB, The Hub+ and DDLMC.

I shadowed the Chief Executive & Medical Director of DDLMC. I was given the opportunity to attend system meetings: GP Ops, GP Leadership group, Primary Care Sub-Group, the Clinical & Professional Leadership Group, Digital Steering Group, Primary & Secondary Care Interface, GPPB and DDLMC as well as Task & Finish working groups for clinical pathways such as the introduction of Medical Examiners and the A&G pathway, as well as attending LPC (Local Pharmacy Committee) and the JUID Network. I also attended the National England LMC Conference and UK LMC Secretaries Conference as well as having the opportunity to engage in Coaching & Mentoring, Action Learning Sets and having time for self-directed learning including recommended reading, TED talks, webinars & reflection for self-development.

3 Results

- Participated in the NHS East Midlands Leadership and Management Programme.
- Became DDLMC Representative for Erewash.
- Delivered Respiratory Teaching in person and online.
- Represented GP at the JUID Network.
- Gave a speech and presented the QI awards at the New to Practice Celebration Evening.
- Applied for the Lead GP Role for the local Lung Cancer Screening Programme.
- Courses: QI, Civil Leadership, Courageous Conversations, Psychological Safety & Leading with Purpose.
- Used the Scope for Growth & NHS Leadership Framework for personal development.
- Worked with DDLMC & GPPB on Comms & Engagement.
- Worked with The Hub+ on a Leadership offer.
- Worked with GPPB on HIN Respiratory Transformation Programme Funding bid.
- I did a lot of reading (meeting papers, books, BMA Guidance, NHS 10-year plan, NHS Confed publications)
- And I learnt the meaning of innumerable acronyms! :o)

4 Impact and benefits

The ACL Fellowship gave me the opportunity to connect with people at all levels across the system, to develop professional relationships, work within teams I hadn't previously known existed and engage in projects I would not otherwise have had the time to pursue. I gained a real appreciation of the complex interface between providers within the system alongside an increased ability to navigate this.

My knowledge around system level working grew more than I could have imagined. My better understanding of the GP GMS contract, LCSF, PCN DES as well as the upcoming changes around Single Neighbourhood and Multi Neighbourhood contracts as outlined in the 10-year plan allowed me to start thinking strategically and appreciate the bigger picture. Attending LMC Conferences increased my knowledge and understanding of how health policy is formed and influenced.

I had the unique and rare opportunity of time to reflect on my own leadership style, to develop self-awareness and emotional intelligence as well as increasing my confidence. The ACL Fellowship gave me real time and practical insight into how the NHS functions beyond a GP practice and how GP fits into the wider healthcare system.

5 Next steps

I now feel ready to be more proactive and take the lead in initiatives that require both vision and collaboration knowing I have the skills to lead on projects and influence change.

I will take with me a sense of connection to the wider healthcare system as I continue working at a system level through my role on the LMC and will continue to develop my Respiratory Lead role in my practice, throughout my PCN and wherever opportunity takes me.

I can whole heartedly recommend this fellowship opportunity to any GP – it offers a unique and rare opportunity to gain insight, foster connections and better understand the system in the ever-changing world of healthcare.

System One Optimisation Guide

Author: Dr johnWilliams

1

My project was to develop a guide for the optimisation and efficient use of System One, which is the predominant patient record program used in Derbyshire and in my own GP Practice.

I have presented this to my colleagues at LGMC and they have found this guide to be very helpful.

2 Method

1. Planning and Research

I ascertained what areas of System One are under utilised by my colleagues by discussing this with clinicians at my GP practice and with New to Practice GPs and in my mentoring sessions.

2. Design and Development

I designed my guide to include information that was not so basic as to be already obvious to all users but to also avoid very complex topics that would not likely be useful to most readers of the guide.

3. Testing and Evaluation

Ipresented my work to my colleagues at my GP practice to determine if the guide was pitched at the correct level and to ensure that it contained information that was both useful to others yet not overwhelming.

3 Results

I received informal feedback from my colleagues in regards to my project and the overall consensus was positive.

The range of options for the individual tips and modifications that are highlighted in the guide allows for users of all experience levels with IT to improve their System One experience.

Conversely there were some areas that staff found to be a little complex and not relevant to their use-case however I expected this to be the case.

4 Impact and benefits

There is now a standardised guide that is available to our clinical staff to refer to for help with System One optimisation.

This is useful for current staff and for new staff and trainees joining the practice.

5 Conclusion

Having created my guide to be a general approach to optimising System One with easily removable sections that reference how this works in my own practice I can produce an edited guide to be circulated to NTP members/other interested parties if required.

Does an increase in promotion of health inequalities training have the potential to reduce gaps in health inequalities?

Problem

Health inequalities are now widely recognised as a problem in society. Healthcare has a role in this. But even now, many people working in primary care know nothing about it – so how can we change this?

Project Aim

To assess awareness of current health inequalities training and create better health inequalities training in Derbyshire

BACKGROUND

Health inequalities are "differences in health across the population, and between different groups in society, that are systematic, unfair and avoidable" [1].

Primary care has influence in 50% of the contributing factors through clinical care, access to care, health promotion and disease prevention[3].

Life expectancy (years)	Male	Female
National	73.5-83.2	78.3-86.3
Derby City	77.5	81.6
Derbs. County	79.1	82.4

Table showing life expectancy variation across the country – between the most and least deprived areas [4,5,6]

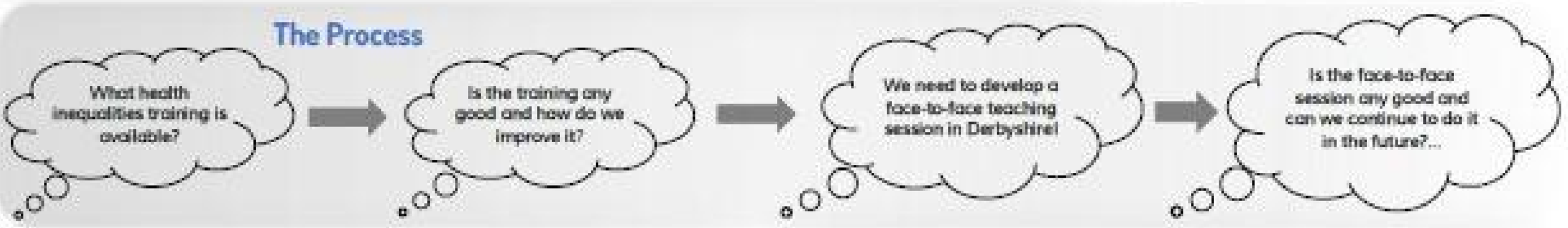
Core20PLUS5 is a national NHS England approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort and identifies "5" focus clinical areas requiring accelerated improvement. [2]

What did we initially find?

Derby & Derbyshire Health Inequalities Quality Improvement Questionnaire

- 31 respondents across Derby City, Derbyshire North and South
- 65% were non-clinical staff
- The average confidence in their understanding of health inequalities was 3.8 out of 5 (1 low, 5 high)
- 48% had never done any formal health inequalities training
- Only 29% had heard of Core20PLUS5

The Process



Feedback from the newly developed face-to-face teaching sessions

Session 1:

- Confidence (out of 5) in understanding of health inequalities increased from a mean of 2.75 to 4.44 (62% increase).

Session 2:

- Confidence (out of 5) in understanding of health inequalities increased from a mean of 2.05 to 4.03 (97% increase)

50% of attendees across the two face-to-face sessions reported intent to change their practice as a result of the session

Conclusion and Reflection

- Basic educational session "Introduction to Health Inequalities" can have a significant impact on primary care professionals understanding and awareness of health inequalities
- There is potential for an increase in promotion of health inequalities training to begin to reduce gaps in inequalities.
- There was not enough time during the fellowship to evaluate whether colleagues who underwent training will implement change in their practice following the session

Recommendation

More funding should be available to allow face-to-face teaching on health inequalities to continue in the future.

References

1. NICE and health inequalities. *National Institute for Health and Care Excellence*. Updated: not known. Available at: https://www.nice.org.uk/about/what-we-do/nice-and-health-inequalities (Accessed: December 2023).
2. Core20PLUS5 (adults) – an approach to reducing healthcare inequalities. *NHS England*. Updated: not known. Available at: https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/ (Accessed: December 2023)
3. Healthy Lives Resources Guide. *The Health Foundation*. Updated: January 2017. Available at: https://www.health.org.uk/sites/default/files/HealthyLivesResourceGuide.pdf (Accessed: December 2023)
4. What is happening to life expectancy in England? *The King's Fund*. Updated: 10/08/2022. Available at: https://www.kingsfund.org.uk/insight-and-analysis/long-reads/whats-happening-life-expectancy-england (Accessed: December 2023).
5. Local Authority Health Profiles. *Fingertips, Public Health Data*. Updated: not known. Available at: https://fingertips.phe.org.uk/profile/health-profiles/datafpage/1/at/302/are/E06000015 (Accessed: December 2023).
6. Local Authority Health Profiles. *Fingertips, Public Health Data*. Updated: not known. Available at: https://fingertips.phe.org.uk/profile/health-profiles/datafpage/1/at/302/are/E10000007 (Accessed: December 2023)

Dr Allie Hill, GP

Derbyshire Health Inequalities Fellow 2023

Trailblazer Fellowship 2024/5
Children & Young People's Mental Health (CYPMH)

By Catherine Bell

Background

- **CYPMH is a priority** - CYPMH was identified as a key clinical area in the Core20PLUS5 approach to reducing health inequalities (NHSE, 2022)

1 in 5 CYP aged 8-25 have a probable mental health condition

(NHSE Digital, 2 023)

- **CYPMH problems are a common presentation in general practice** - 55% of 16-25 year-olds surveyed by Young Minds in 2020/21 had visited their GP about a mental health concern at some point in their lives
- **But there are other services available in Derbyshire to support CYP** - 67% of CYP surveyed would prefer to access MH support without going to their GP, but only 53% were aware of other routes

Aims

My aims included somepractice-level goals to improve the experience of CYP accessing our practice, and some county-level goals to work towards improving links between GPs and existing services for CYP.

How can services work together more effectively to signpost CYP to the right support..?

Practice-level goals

- Learnabout how CYP use our practice - through audit
- Improve links with existing local services for CYP
  - Start a youth patient participation group
  - Look at how to make our practice more 'youth friendly'

County-level goals

- Conduct a survey of GPs
- Share results with key stakeholders
- Discuss how to improve links between services
- Arrange a training event

GP Survey

- In Feb 2025, Derbyshire primary care clinicians whose role involves supporting CYP <18yrs with their mental health were invited to complete an anonymous online survey.

These consultations always leave me feeling a little bit **hopeless**... ...I think **we let these children down**

- The survey highlighted feelings of **confusion**, **frustration** and **helplessness** amongst many primary care clinicians as they try to support CYP with mental health problems...

...and revealed that **many GPs are not aware of existing services** available to support CYP with their mental health.

Working together

Compass Changing Lives is the main provider of early intervention emotional wellbeing and MH support to CYP in Derby & Derbyshire

Specialist CAMHS community advisors (SCAs) provide early intervention support and advice to professionals

As part of the project, I:

- Invited our local SCA to attend our practice **MDT** once a month to advise on CYPMH cases. Produced
- **SMS templates** to help signpost CYP/parents to Compass, Kooth and other useful resources. Connected
- SCAs & Compass with The Hub Plus for a **training update** for GPs on MH pathways in July 2025.

NextGen Care Project

- The **NextGen Care Project** is a collaboration between The Valleys Medical Partnership and Eckington High School.

I didn't know you could see a GP without a parent...

- In July 2025, we gave an assembly to **Year 12 students** inviting them to be a part of a **youth engagement project** with the aim of improving the experience of CYP registered with The Valleys. Students decided to focus on **raising**
- **awareness of confidentiality** for young people, to empower them to book and attend GP appointments independently. We hope to use the results of their year group survey to inform an **awareness**
- **campaign** in Spring 2026.

Personal development

The Trailblazer Fellowship has given me the **time and resources to develop** knowledge and skills that I can use in my existing clinical and educational roles, as well as **my future career in GP.**

As a Fellow, I was able to access funded development opportunities, including:

- 'The Track' **strengths-based leadership coaching** programme
- ILM 5 **Certificate in Effective Coaching & Mentoring**
- **Presentation skills** training
- Red Whale GP **update courses**