

Hub Plus Fellowships Programme

Primary care teams face growing demand, workforce pressures and increasingly complex patient needs.

The Hub Plus Fellowship Programme gives clinicians protected time to explore challenges, develop solutions and test new ways of working that improve care, strengthen teams and support the future of primary care across Derbyshire.

This Year's Fellows Have:

- Improved frailty and falls prevention
- Developed new approaches to supporting people living with chronic pain
- Strengthened care for care home residents
- Supported GP retention and career development
- Reduced health inequalities
- Increased research and quality improvement capability
- Enabled digital innovation and safer adoption of new technologies
- Created proactive, neighbourhood-based models of care

Plus, much more

Why It Matters

Developing people.

Building leadership, confidence and capability.

Creating sustainable services.

Testing ideas that can be adopted and scaled across primary care.

Improving care.

Delivering better outcomes and experiences for patients.

From personalised frailty care plans and workforce support networks to research readiness, digital transformation and community-based prevention programmes, fellows are helping primary care teams thrive through innovation, collaboration and practical improvement.

Scan the QR Code and discover the collection of Hub Plus Fellowship projects and the difference they are making across Derbyshire primary care.

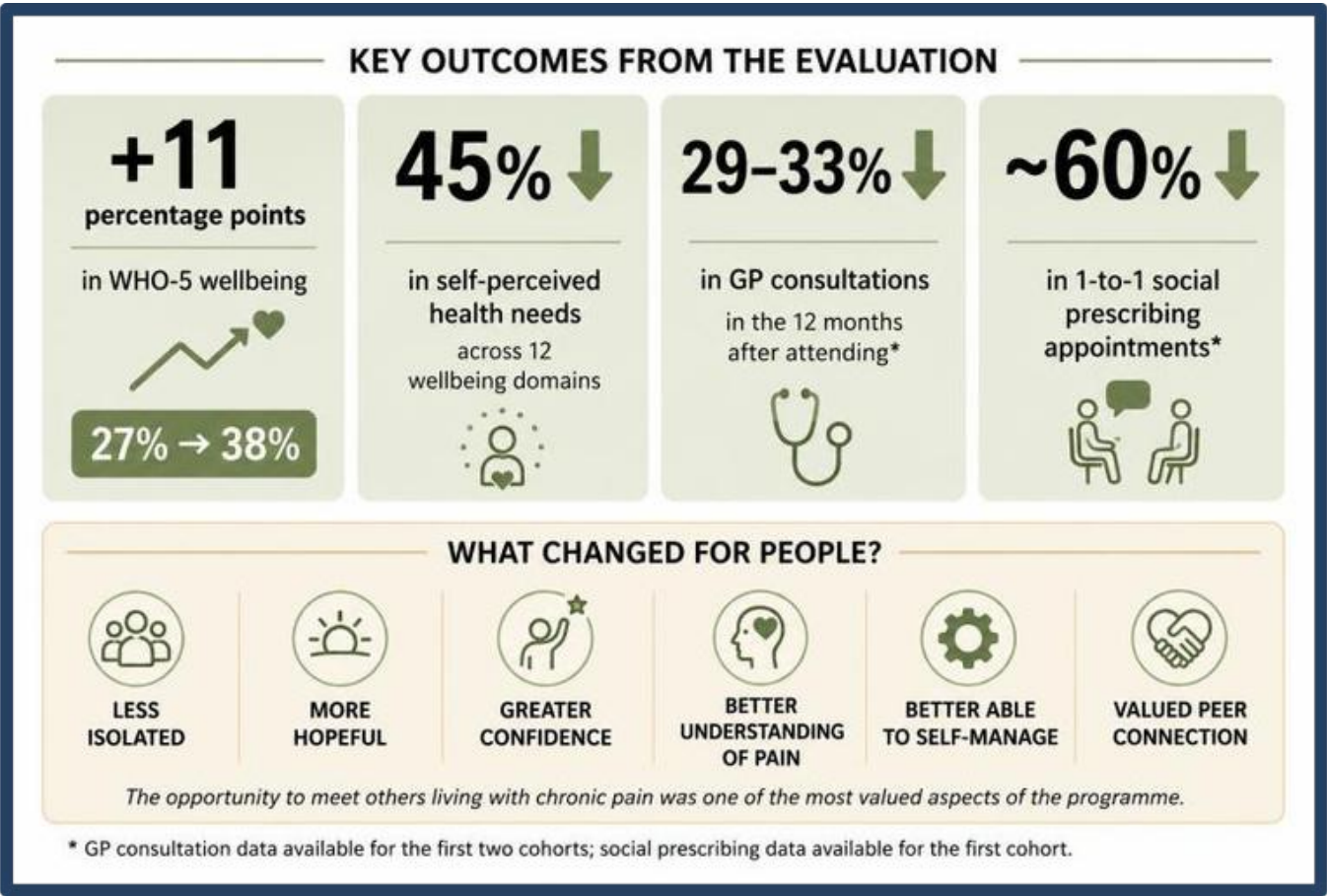


Developing better support for people living with chronic pain in Belper and across Derbyshire: a work in progress



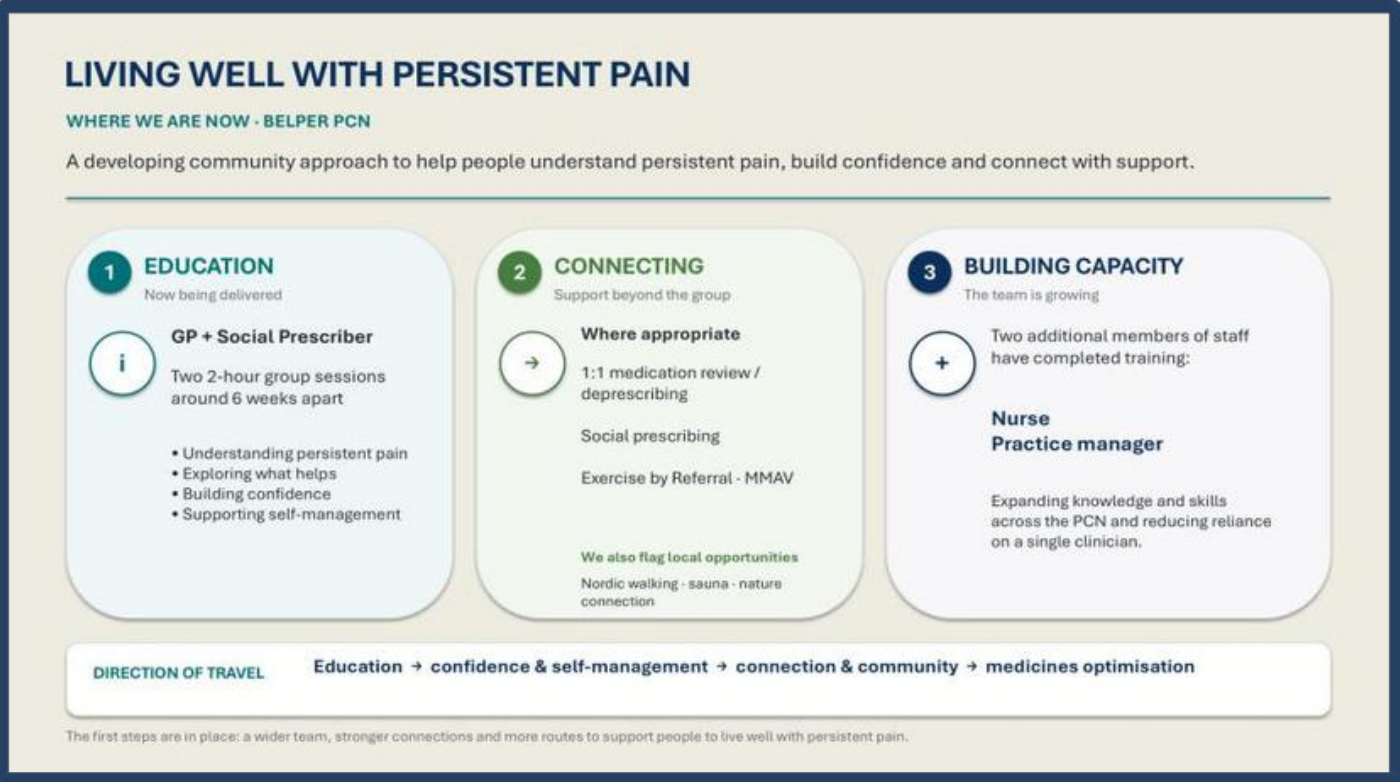
Dr Jane Packer | hosted and supported by Belper PCN

As many as 1 in 3 people live with chronic pain #1 cost to primary care among 32 long term conditions studied*
15 consultations/ year for the average patient identified with chronic pain
~ 50% of GP consultations include discussion about pain 1 in 8 live with high-impact chronic pain



I had already done a lot of groundwork on setting up the Belper PCN pathway in 2024/2025 with my social prescribing colleague, Jude Kelf.

Our work is 2 years old this September and we're about to welcome our 8th cohort. What we do has evolved and developed over this time and especially in the last 6 months. **See below for where we are now:**



I've had time to do a more detailed service evaluation, which has led to some positive findings for anyone looking to do similar work. **See above for highlights.**

The last 12 months for me personally has been much more about:

- ✓ Understanding and mapping the landscape across Derby & Derbyshire
- ✓ Developing wider networks
- ✓ Starting to look at how support in this space could all be more joined up
- ✓ Considering what commissioning in this area might look like going forwards and attending the MSK steering group
- ✓ Creating a patient friendly space on the Belper PCN website
- ✓ Joining the British Pain Society and I am an active member of the Community SIG
- ✓ Creating a Derby & Derbyshire network of professionals and lay people with an interest in chronic pain and we held our first meeting on 1st September



This infographic to the left shows the potential scale of the impact of this project.

Doing things differently takes time, patience and courage. It won't always go as planned.

But there can be a negative cost to carrying on doing things the same way we always have.

- What else happened?**
- ✓ 1st prize Footsteps to Change Conference 2025
 - ✓ 1st Prize Early Career GP Conference Poster Competition 2025
 - ✓ 1st Prize Hub+ QI Awards for Patient Experience
 - ✓ Developed a nature based therapy proposal
 - ✓ Began adapting chronic pain self-management learning for prison settings



The infographic on the left shows the current landscape.

The infographic on the right shows what my ideal would be for Belper PCN.



Join the growing community of clinicians with an interest in chronic pain in Derby and Derbyshire: jane.packer1@nhs.net

Hub Plus fellowships find out more:



*Shetty S, Scuffell J, Aitken D, Ashworth M. Chronic pain: prevalence, demographic inequalities, and healthcare utilisation. A primary care database analysis. BJGP Open. 2025 Oct 27;9(3):

Support and Retention of GPs in Derby and Derbyshire

Dr Joanne Marval | May 2026



Introduction

The GMC Barometer Survey reported significantly higher levels of dissatisfaction, burnout and expressions to leave, amongst GPs when compared to their hospital colleagues. I wanted to gain information on the experience, challenges and support needs of local GPs to identify what works well and where additional resources are needed to improve satisfaction and retention. I would focus on 2 main groups:

- senior GPs towards the end of their clinical career
- the newly qualified and salaried GP career journey.

Methodology

I consulted with Clinical Directors from several PCNs to establish their thoughts, challenges, ideas and current initiatives around GP satisfaction and retention.

I connected with support leads in Lincolnshire, Nottinghamshire and Staffordshire to discuss their current and future projects, and the challenges and success they had experienced.

I wrote and distributed a questionnaire to all GPs enquiring about the positive and negative aspects of their role and GP practice, and what support proposals they would welcome.

Through the questionnaire GPs were invited to attend a short online interview to answer the following questions:

- What are the best 3 attributes about your GP practice?
- What 3 things would you change?
- Do you have a portfolio role? And if so, why?
- What advice would you give to ST3 doctors finishing their training?
- Where do you want to be in 5 years' time?

Results

52 Questionnaires were returned and 17 GP interviews were completed. 94% of GPs had at least 1 portfolio role.

Best Practice Attributes:

Supportive team ethos with a sociable daily connection
Flexible working – appointments/hours/sessions
Training/education environment

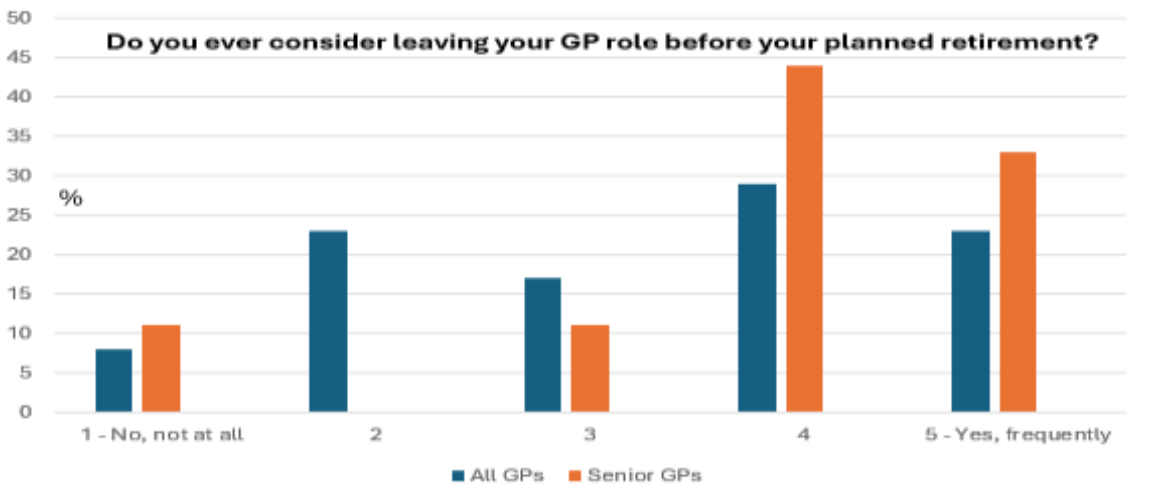
Areas for Change:

Partner/salaried hierarchy
Working in isolation with ineffective communication
Unequal opportunities for salaried GPs

Top Tip Advice for ST3 Doctors:

Wait for the right job to align with strengths and values
Take opportunities – for portfolio roles and networking
Seek and accept support – Early Practice Support Scheme

17% of responses were from senior GPs



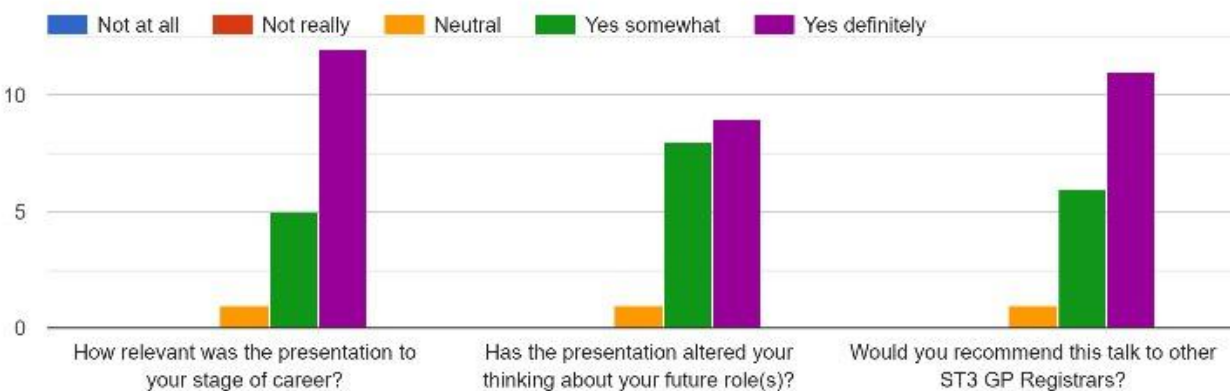
Which support ideas would you be interested in?

	1st	2nd	3rd
All GPs	Networking with career stage	Flexible sessions	Coaching at career intervals
Senior GPs	Flexible sessions	Coaching at career intervals	Networking with career stage

Impact and Benefits

The 'Top Tips' PowerPoint presentation was introduced to ST3 doctors in Chesterfield and Derby

What was your rating of GPs before a session?



Conclusion

This fellowship created a platform for GPs to communicate their success and challenges of working in primary care in Derby and Derbyshire. The results enabled me to produce a 'top tips' presentation and document to support ST3 doctors which were well received, relevant, informative and altered their thinking about their futures roles and career. For senior GPs, the results highlighted the need for flexible clinical sessions, coaching at career intervals and networking opportunities. I have created 2 proposals to The Hub Plus to address these needs as potential future projects.



Beyond Reactive Care: Improving Outcomes for Frail Patients

Dr Amelia Saunders | May 2026

Introduction

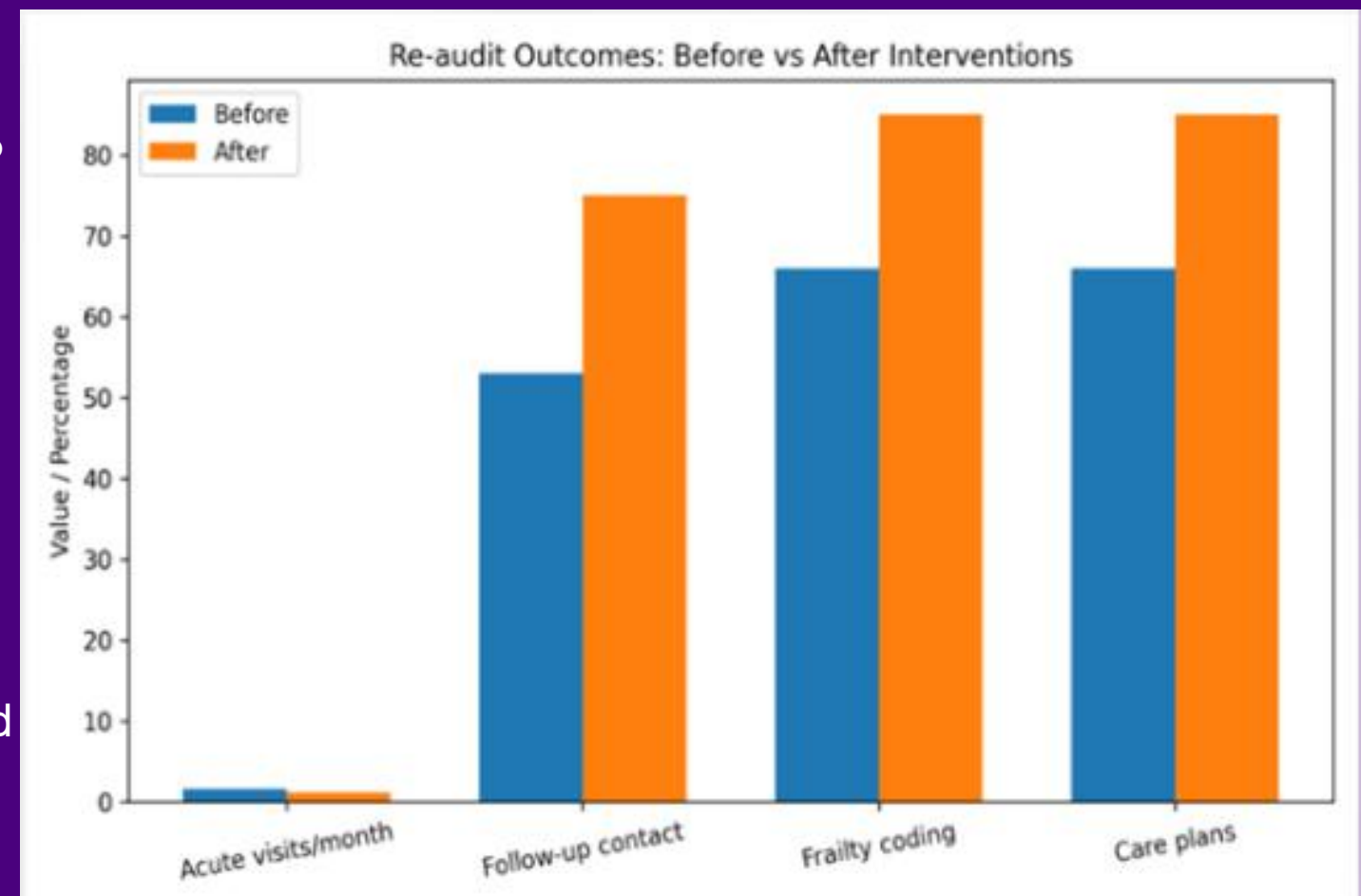
Frailty drives repeat home visits and emergency department attendances, reflecting gaps in proactive, coordinated care. Within Belper PCN, challenges in data quality, coding, and care planning limit effective management of high-risk patients. This project aims to improve identification of frail patients, strengthen multidisciplinary team (MDT) working, and enhance clinician engagement. By targeting high-frequency service users, it seeks to reduce acute demand and improve personalised, community-based care and patient outcomes.

Aims

- Improve frailty identification
- Strengthen multidisciplinary team working
- Reduce acute demand through personalised care

Results

- Identified gaps in frailty identification, care planning and follow up, with poor continuity of care.
- Demonstrated low ED admission in this cohort despite high complexity, with significant patient deterioration over time (26% mortality in first audit: 47% in re-audit cohort).
- Delivered frailty education sessions across the PCN and Derbyshire GP network on frailty identification, coding and CGA.
- Implemented RAIDR risk stratification, identifying that frequent ED attendances are associated with complex needs rather than frailty.
- Established an MDT approach for high-intensity/ complex patients
- Delivered the Ageing Well Belper frailty prevention event in partnership with PCN and neighbourhood organisations, promoting preventative and community-based ageing well support.
- Re-audit demonstrated reduced acute visits (1.6 → 1.2/ month), improved follow-up (53% → 75%), increased frailty coding and care planning/ RESPECT forms (66% → 85%), and better continuity of care.



Impact and Benefits

- Improved proactive identification and management of frail and high-intensity patients across the PCN. Increased frailty coding, follow-up contact, care planning, and MDT working, supported more coordinated and anticipatory care delivery.
- Clinician engagement and education improved awareness of frailty identification and coding processes, while proactive Team Up visits reduced reliance on reactive acute demand. Also highlighted the importance of addressing wider health inequalities within high-intensity service users.
- A scalable model for proactive community care, supporting long-term reductions in avoidable acute demand, improved continuity of care for vulnerable patients, and potential cost savings through reduction in avoidable hospital admissions and wider acute system pressures.

Conclusion

This project demonstrated that proactive identification, education, and MDT working can improve the management of frail and high-intensity patients. The fellowship supported improvements in frailty coding, continuity of care, advance care planning, and proactive follow-up.

The work highlighted that high-intensity service use is often associated with wider health inequalities, rather than frailty alone. The project provides a scalable model for proactive neighbourhood working across PCNs, with potential to improve patient outcomes, reduce avoidable hospital utilisation, and support more sustainable use of healthcare resources.





“I DIDN’T REALISE I COULD”

A PRIMARY CARE PILOT: BUILDING STRENGTH AND CONFIDENCE IN PATIENTS WITH LEARNING DISABILITIES

DR BEN TYLER

GP AT NEWBOLD SURGERY

ben.tyler@nhs.net

July 2026

INTRODUCTION

As part of my Trailblazer Fellowship, focused on reducing health inequalities, I aimed to improve physical health literacy within Newbold’s practice population. A starting point was patients with learning disabilities (LD), 42% of our patients with LD are living with obesity. Resistance training twice weekly is a CMO guideline, yet only 7% of adults meet it compared to 67% who meet aerobic guidelines, it’s almost forgotten about. Strength training reduces mortality, improves mental health and reduces risk of cardiovascular disease, cancer and diabetes.

Drawing on my background as a Team GB Handball coach and former athlete, alongside my recent completion of the FSEM Exercise Medicine Diploma, I developed a pilot to redesign the LD annual review around goals and movement, then deliver sessions on three lifestyle medicine pillars, with a dedicated resistance training component.

REDESIGNING THE ANNUAL REVIEW

The previous annual review consisted of data collection, without any goal setting or measure of functionality. I wanted to turn the review itself into the first intervention. We added grip strength and a 30-second sit-to-stand test as practical proxies for functional strength, alongside the SWEMWBS wellbeing scale, and days active per week.

The addition that changed the character of the encounter most was a single question: *“What’s something you’d love to do if your body felt stronger?”*

Drawing on motivational interviewing’s ‘looking forward’ technique and Nancy Kline’s concept of the incisive question, a question designed to replace a limiting assumption with a liberating one, this shifts the annual review from passive surveillance to an active conversation.

Patients who expressed interest were then invited to the group sessions. I do recognise that this is perhaps compounding inequality, the patients without the motivation to attend likely have the most to gain. Understanding how to reach them is harder and an important next step.

WITHIN THE INDIVIDUAL:
Once the four movements feel comfortable, add resistance, two bottles instead of one, progressively overloading.

SCALABILITY

ACROSS THE PRACTICE:
We are beginning to offer this flyer as part of all patient annual reviews, following the same track as the LD pilot, a shift from health checks that measure, to health checks that start encouraging behaviour change.

PART 1: EDUCATION

We asked patients during their LD annual review what they’d like to learn about, and designed three educational sessions around their responses. These covered three lifestyle medicine pillars:

SLEEP / NUTRITION / MOVEMENT

Group sessions held in a local community hall used pictures, open questions, and motivational interviewing techniques to promote problem-solving from patients themselves:

How could this apply to your life, this week?

4 MOVEMENTS TO IMPROVE YOUR WELLBEING

Do each movement **10** times. Have a rest. Repeat **3** times in total.

1. PICK UP



Pick up and carry something
Like Healthcare, Mandy

2. STAND UP



Stand up from your chair
Like Dr Bhatia

3. PULL



Pull something towards you
Like Nurse, Sarah

4. PUSH



Push something away from you
Like Secretary, Jane



Want more support?
Scan to explore other ways to get active

Live Life BETTER
DERBYSHIRE

Dr Ben Tyler

Newbold Surgery

PART 2: RESISTANCE TRAINING

The second half encouraged movement and resistance training. Sessions opened with a handball-inspired warm-up to music chosen by the patients to set the tone, and shift from clinical to fun. Carers joined-in, alongside patients, and this mattered a lot. The four movements **PICK UP / STAND UP / PULL / PUSH** map to fundamental human movement patterns. They also underpin independence: carrying shopping, getting out of a chair, opening and closing a door.

Everyone was laughing, smiling, and engaged, and that was important. Positive memories of movement make repetition more likely. We also started with very light resistance to avoid delayed onset muscle soreness, a painful first session is one of the most common reasons people don’t come back.



RESULTS

This was a small pilot study of four patients, too small for statistical conclusions, but suggestive that *confidence*, not *capacity*, limited movement for these patients.

All patients improved their sit-to-stand score with one patient going from zero sit-to-stands at their annual review, to eleven after the final session. The capacity was always there, but the belief that it was safe, possible, and relevant to them was not. Feedback received:

“I didn’t realise I could make my back pain better by moving more.”

“Confidence to move my body.”

“I liked doing it with my own doctor.”

“Feel more confident speaking to people and going out”

100% of participants reported moving more at the end of the programme than at the start. Two patients are now engaged with a local activity partner.

WHERE NEXT

- Roll out to other interested LD patients with the goal of a local activity partner representative attending the final session
- Investigate barriers for those who declined to attend through a COM-B lens Re-audit in 12 months to track change at a cohort level
- Bring learning from this to all HCA annual checks at the practice, moving from purely data collection to goal setting and behaviour change
- Extend the programme to patients on the tirzepatide obesity programme Explore whether this model can be extended PCN wide, aligning with the NHS 10 Year Plan’s neighbourhood health model

Derbyshire International Medical Graduate (IMG) Support

Dr Sheila Owusu | June 2026



Introduction

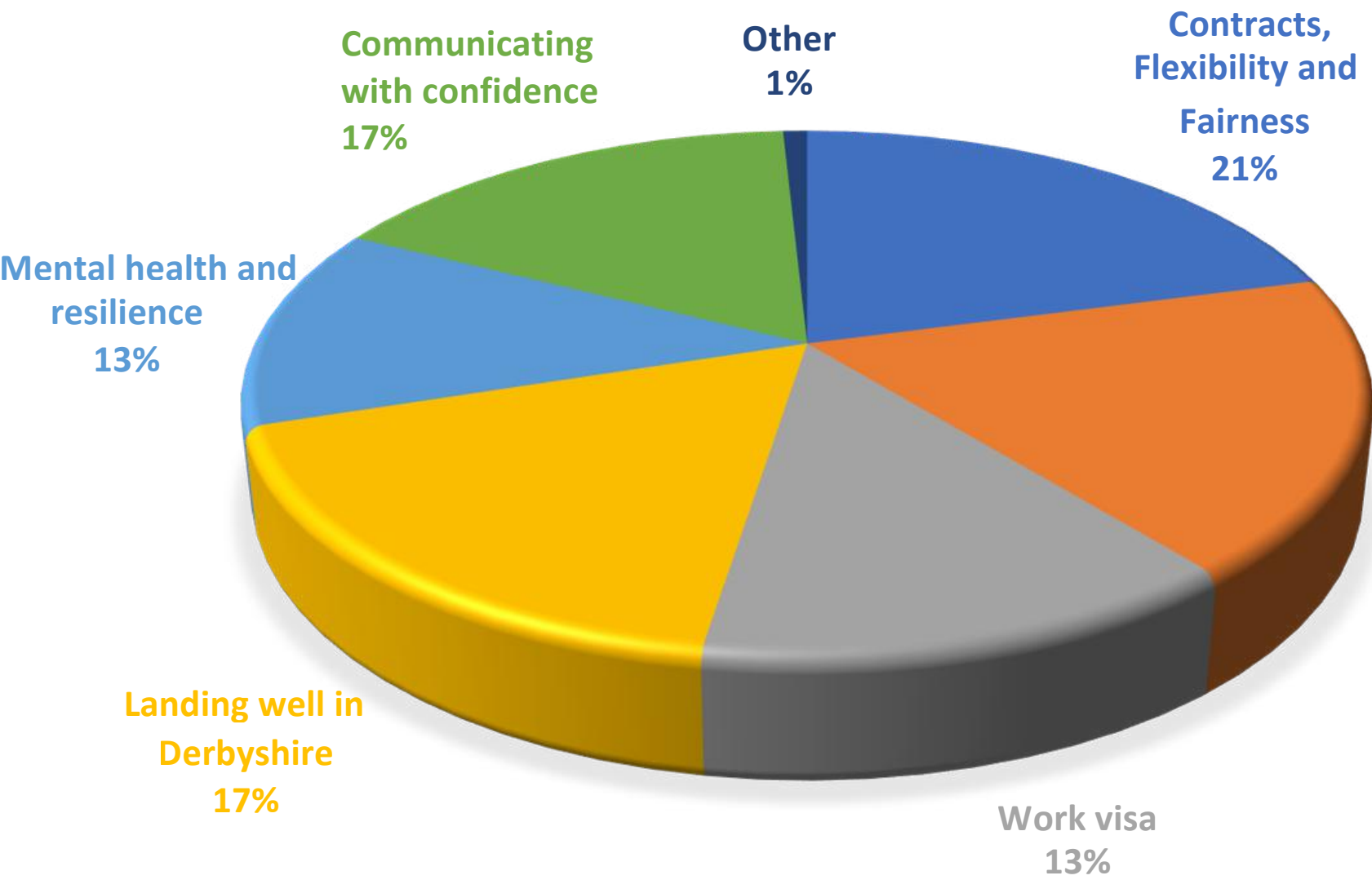
IMGs have become an indispensable part of UK's healthcare workforce. IMGs account for about 42% of the UK medical workforce. The BMA, GMC and the RCGP have stated in various reports, the need to sustain IMG retention especially in general practice. My fellowship sought to find challenges of IMGs in Derbyshire and ways to address some of them improve retention, job satisfaction and patient care outcomes.

Methodology

1. A Microsoft office survey was sent out to identify the IMG GPs in Derbyshire and to ascertain the areas they faced challenges and needed support. This was sent via email to the derby and chesterfield training office to be circulated to IMG trainees, to individual IMGs to circulate to their networks and via other established GP WhatsApp groups for IMG members to fill in.
2. Based on the findings from the survey two top areas were identified and virtual webinars via teams were organised to address the issue of contracts, flexibility and fairness and leadership, research and teaching. External speakers were invited to address these areas, A BMA representative for the first topic and four GPs with expertise in leadership, research and teaching for the second topic.
3. A visa sponsorship survey was also sent out to the GP group formed from the earlier survey to identify IMG GPs to ascertain the challenges needing and searching for a work visa posed.

Results

Survey results - IMG support needed



Visa sponsorship Survey

- 67% felt searching for a visa sponsor has affected their mental health
- 67% felt pressured to accept the jobs roles regardless of preferences, pay or location.
- 100% did not feel confident negotiating contracts due to need for visa sponsorship
- 67% have considered leaving derbyshire due to need for visa sponsorship.
- 100% did not want to leave general practice as a result of their need for a visa sponsor.

Impact and Benefits

Feedback after Webinar
What did you enjoy most about the webinar?

- "Hearing about the various journeys of colleagues and the available opportunities to explore leadership."*
- "Really interesting and sometimes deeply sad to hear about the journeys people took to get to where they are now. I found the final Q and A perhaps the most useful part."*
- "The inspiring personal journey of each facilitator, it was challenging and motivating."*
- "Overall, it was a rich experience with speakers with a diverse and robust experience."*

Conclusion

The cohort of Derbyshire IMGs captured in this fellowship found the support given inspirational and beneficial. Other areas that have been highlighted for further support include:

- Focused session on preparing and presenting oneself for an interview
- GP roles-partner, salaried, locum from an IMG perspective.
- Support for GP practices to get visa sponsorship license to ease stress of job search for IMGs



Making research workable in busy General Practice: Interim learning from a non-medical clinical research fellow

Carmen Villegas-Galvez | Advanced Clinical Pharmacist and Clinical Lead, Long-Term Conditions,
Inspire Health | Sept 2026



THE FELLOWSHIP QUESTION How can protected fellowship time translate into sustainable research capability across a practice, PCN and wider Derbyshire?

Why this matters

- General practice has access to diverse populations and continuity of care, but research competes with intense operational pressure.
- Interest does not automatically become capacity: staff need time, confidence, clear routes and practical support.
 - Research activity can remain dependent on a small number of enthusiasts or external teams.
 - Pharmacists, nurses and other non-medical clinicians bring detailed knowledge of workflow, long-term conditions and quality improvement.
- AIM** Develop and test a practical support model that helps practices become research-ready and research-active without treating research as a separate “extra”.

Fellowship design: learn → embed → spread

12 MONTHS / 96 SESSIONS Protected time to move from observation and skills development into PCN delivery and Derbyshire-wide sharing.

1 LEARN Apr–Jul 2026	Immerse in a Level 4 research center: GCP, site initiation, screening, consent, monitoring and mapping commercial workflows.
2 EMBED Aug–Nov 2026	More involved with commercial trial (delegation list). Test PCN support offer: opportunity triage, practical protocols/SOPs, “quick wins” and coaching for practice teams.
3 SPREAD Dec 2026–Mar 2027	Refine Derbyshire starter resources, share learning and support another site/team to take its next step in research activity.

Progress so far

- Completed core research training and observed study set-up and delivery, including a commercial site initiation visit, Ongoing involved with commercial trial.
- Mapped the research journey, roles, hand-offs and common friction points from opportunity to delivery.
- Built links across practice, PCN, an experienced commercial research center, and Derbyshire research leadership.
- Developed a proposed PCN support trial focused on enablement rather than simply conducting visits.
- Started exploring an AI-supported “research and QI coach” concept, with governance checks and clinicians retaining responsibility.

Early learning

- Protected time is infrastructure** — Without it, research remains optional and is displaced by immediate clinical pressures.
- Research must fit the workflow** — The practical question is not only “Which study?” but “Who notices, decides, contacts, records and follows up?”
- Bridge roles are valuable** — A clinician who understands practice systems can translate between research teams and frontline staff.
- QI can be the gateway** — QI builds confidence with data, testing change and multidisciplinary working—skills that can lead into research.
- Support should be proportionate** — Practices need different offers: awareness, a first low-burden study, or infrastructure for more complex delivery.

Emerging value

PRACTICES Clearer routes, reusable processes and less reliance on one enthusiast.	WORKFORCE A broader research skill mix, enabling pharmacists, nurses and other non-medical clinicians to contribute to research delivery and increasing practice capacity.
SYSTEM COLLABORATION A distributed model that links practices to PCN and experienced research hubs.	PATIENTS More opportunities to hear about and take part in research closer to home.

Next tests and measures

- Run and evaluate the proposed PCN support trial.
- Explore barriers and opportunities for practice/PCN pharmacists to participate in research delivery.
- Support implementation of current starter pack: roles, routes, SOPs, opportunity triage and signposting.
- Measure opportunities shared, staff confidence, readiness milestones, studies supported and sustainability.
- Connect research support with the emerging Derbyshire QI community and refine the research/QI coach concept

LET’S TALK

- What would make research easier in your practice?**
- ☐ Named contact
 - ☐ Protected time
 - ☐ Templates/SOPs
 - ☐ Opportunity digest
 - ☐ Coaching
 - ☐ Something else

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.

Methodology

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

Results

Quality Improvement

What is Quality Improvement ?

QI Journey

QI Principles

QI Training

QI Tools

QI Templates

QI Resources

QI Projects

QI Awards

The Model for Improvement

What are we trying to accomplish?

How will we know that our change is an improvement?

What changes can we make that will result in the improvement we seek?

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

Creating Conditions

Developing Aims

Implement

Understanding Systems

Testing Changes

Spread

Leadership and Teams

Project Management and Communication

Measurement

QI Templates

Hub Quality Improvement in Primary Care

Hub Quality Improvement in Primary Care

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.

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).

TeamUp: a rolling frailty MDT for care home residents

Dr Andrew Goddard | June 2026

Introduction

Care home residents are among the most complex patients in the neighbourhood, but care has been reactive and organised practice by practice, with inconsistent care planning and RESPECT review. The NHS Neighbourhood Health Framework requires 95% of people with complex needs to have a personalised care plan by 2027.

Aim: a structured monthly MDT and medication review giving every resident a current, coded care plan to improve holistic care in the care setting.

Methodology

Delivered within the community frailty service for Erewash, providing acute and proactive visits to care home patients.

The model has four layers:

- Weekly care home check in call / short ward round.
- Fortnightly ward round with GP presence.
- Monthly structured MDT with rolling medication review, rather than annual
- Coded CGA based review for every resident

Pilot: two nursing homes, 69 residents. MDT membership: Community GP, ACPs, PCN pharmacist, care home staff, care coordinators and district nursing.

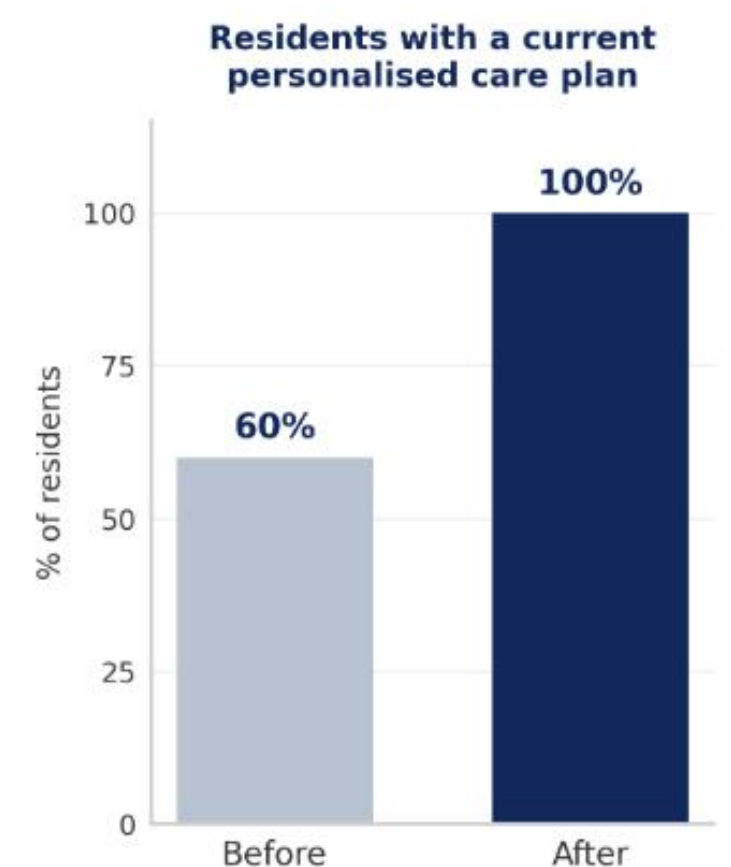
A structured template was built in SystmOne covering legal and administrative status, interim events, Clinical Frailty Scale scoring and the CGA domains. Care plans are accurately coded so they count towards the national target, with other codes added to exempt from routine monitoring.

Results

Two nursing homes, 69 residents.

- 100% had a current personalised care plan after the first MDT cycle, up from 60% at baseline.
- All 69 residents had a RESPECT form at baseline, but 40% had not been reviewed within the previous 12 months.
- Average reduction of 1.1 regular medicines per resident.
- Routine blood monitoring stopped in a further 18% of residents.

Admission avoidance and EMAS attendance data are still being collected.



Impact and Benefits

- Every resident in the pilot homes now has a current, coded care plan, meeting the 2027 national standard three years early.
- Fewer medicines and less routine venepuncture means less burden and less distress for frail residents.
- Care home staff have a predictable monthly point of senior clinical contact, rather than ad hoc calls to the community frailty team.
- Review is anticipatory rather than crisis driven, which is the mechanism by which admissions avoidance is expected to follow.
- Coded, structured recording makes the caseload visible for QOF, exception reporting and service evaluation.
- Delivered within existing staffing.

Conclusion

A structured monthly MDT delivered complete care plan coverage in the pilot homes and reduced medication and monitoring burden.

This is a small pilot over a short period with no control group. A coded care plan is a process measure, not yet evidence of better outcomes, and the admissions and EMAS data are awaited.

Upcoming plan out to the remaining Erewash care homes, then extend the model to housebound patients.



Technology with Purpose: Improving Care, Supporting Staff, Enabling Innovation

Dr Jack Baskerville – Hub Plus Digital Fellow

Digital innovation is not about technology for technology's sake. It is about solving real problems, improving patient care, reducing unnecessary workload and creating more time for what matters most.

Over the past year, practices, PCNs and system partners across Derbyshire have worked together to develop a single **GP-led Digital Strategy for Derby and Derbyshire[SB1]**. The strategy was created in response to challenges raised directly by frontline teams and focuses on practical solutions, workforce support and sustainable innovation.

Our Vision

A digitally enabled, innovative General Practice system that supports our workforce, safely improves access and experience for patients, and enables proactive population health.

What Matters Most?

The Derbyshire strategy identifies six priorities:

- Get the Basics Right
- Empower Practices, Not Block Them
- Use Digital to Give Time Back
- Safe, Scalable Innovation
- Better Use of Data
- Joined-Up Systems

Derbyshire's Top Five Digital Priorities This Year

1. Population Health Management Identifying patients proactively and supporting neighbourhood-based care.
2. Clinical Safety Officer (CSO) Support Providing practical clinical safety and AI support across practices and PCNs.
3. Automated Pathology Filing Using automation to save time and improve consistency
4. Supporting the Transition to NHIS Helping practices navigate future digital infrastructure changes.
5. Leadership and a Collective Voice for Primary Care Ensuring digital developments reflect the realities of frontline practice

Innovation in Action Across Derbyshire

Across Derbyshire, clinicians, practices and PCNs are already leading a wide range of digital innovation, quality improvement and transformation projects:

- ✓ Creation of the Derby & Derbyshire General Practice Digital Strategy
- ✓ Clinical Safety Officer (CSO) programme supporting safer adoption of digital technology and AI
- ✓ Development of shared clinical safety and information governance resources
- ✓ Digital needs surveys helping identify and address frontline challenges
- ✓ AI education programmes supporting safe and intentional use of emerging technologies
- ✓ Growing digital communities of practice across Derbyshire through WhatsApp, Teams and peer networks
- ✓ Fellowship projects helping turn ideas into practical improvements across the county

AND MUCH MORE



Alcohol Related Harm in Amber Valley

A Case for Change

Amber Valley is a national and regional outlier for alcohol related harm.¹

Worryingly, the trends suggest the harm is increasing and worsening.

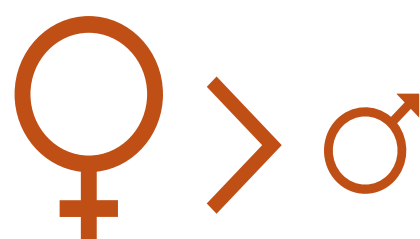
3rd Highest Nationally and Highest in the East Midlands



Admission episodes for alcohol related conditions in women aged 40-64



Admission episodes for alcohol related liver disease in women



Higher levels of harm in women, contrary to national trends



These conditions disproportionately affect the most deprived deciles

The continuing upward trend in alcohol-related hospital admissions, alongside increasing demand on health and social care services, means that action is required now to prevent further escalation of harm and associated costs. Without intervention, alcohol-related harm is likely to result in further reductions in healthy life expectancy, poorer quality of life for residents, and increasing pressure on health and social care services.

A better understanding the unique challenges and conditions in Amber Valley that has led to these outcomes is needed to inform effective strategy. Patient engagement, insight and lived experience are essential to developing any equitable interventions

Opportunity exists in several areas that will rely on good partnership across statutory and voluntary services:

Increasing awareness

Early identification

Chronic disease management

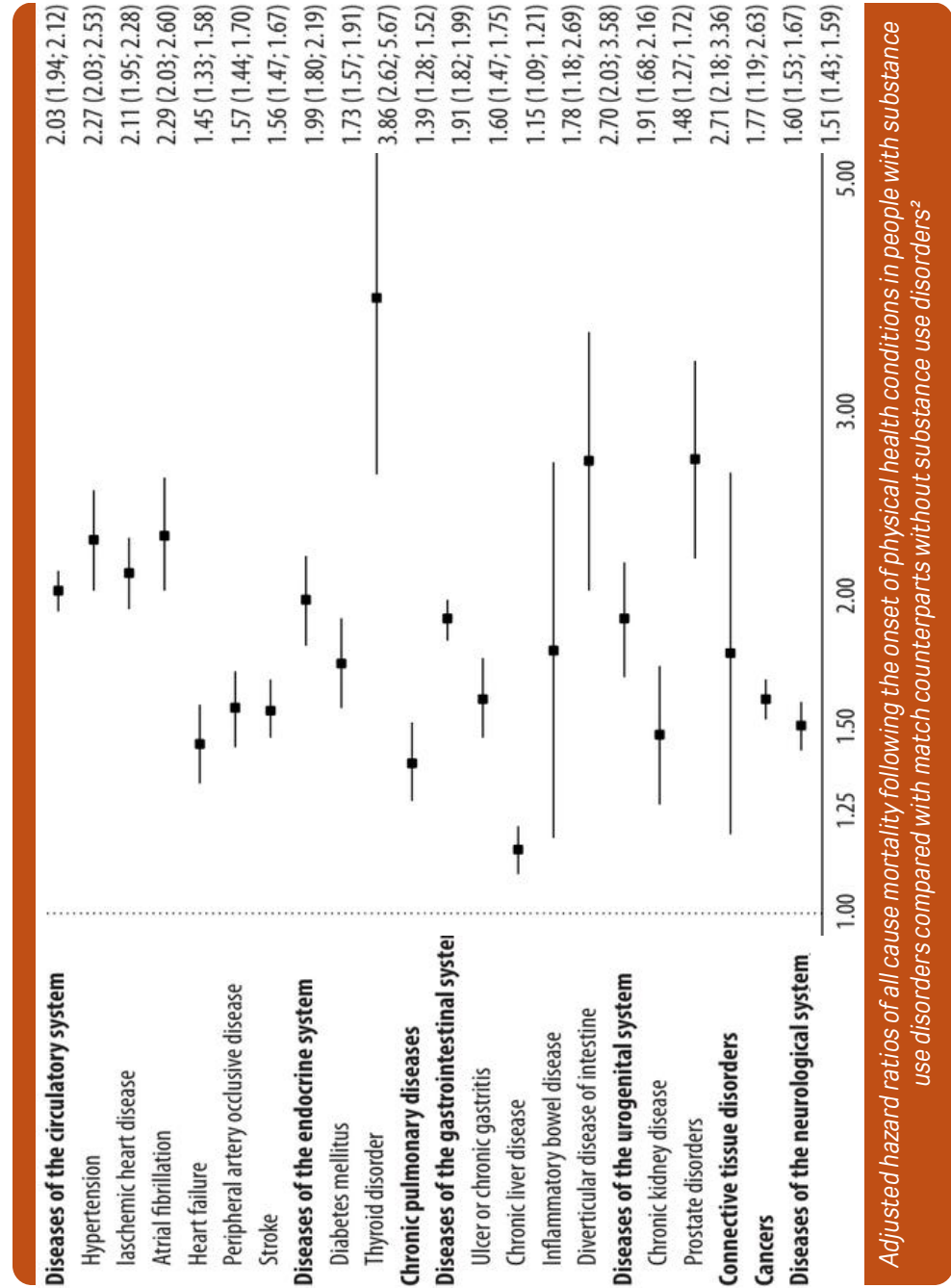
The aim of any intervention is to reduce alcohol-related harm in Amber Valley, leading to fewer hospital admissions, improved health outcomes, and a narrowing of the inequalities disproportionately experienced by women and people living in deprived communities. Success will be demonstrated through measurable reductions in alcohol-related harm and downward trends in admission data over time.

As a result, residents of Amber Valley would experience improved quality of life, increased healthy life expectancy, and more equitable health outcomes.

GP Co-location in the Substance Use Service

A trailblazer project addressing the inequitable health outcomes of those affected by substance use

As highlighted in a systematic review, “There is strong evidence to support inequalities in medical care disadvantaging those who have a psychiatric illness or a substance use disorder. Despite promising approaches to shared care there is a substantial gap in routine medical care for many individuals with mental illness or substance use disorders.”⁷¹ The forest plot below demonstrates that those with substance use disorder have a significantly higher burden of disease related mortality compared with matched counterparts. They experience higher levels of morbidity too. It is the inequity in outcomes that I aim to tackle in my project. Moving the GP to the service users, removing barriers of inequitable access and improving long term outcomes of those affected by substance use.



CASE EXAMPLE

46, male. Discharged 6 months ago having presented with Hb 64 and ischaemic pain. Significant ulceration with PAD, ex-IVDU on methadone. Since then, poor engagement with GP: 4 MIU/ED attendances and 2 DNA GP appointments and missed 2^{ww} appointments. Seen in this clinic and re-engaged with health. Repeat bloods arranged at the clinic, liaison with GP practice re dressings and chronic pain management plan implemented including deprescribing. Bloods identified raised QRISK, Non-diabetic hyperglycaemia and has been engaging with follow up.

THE PROJECT

- I have set up a weekly GP clinic at the substance use base in Ripley as a pilot for 6 months
- This followed liaison with Public Health, PCN and the substance use service provider, DRP, in Derbyshire
- Patients are referred in by their key worker or identified by the 'health improvement nurse' following an initial assessment at referral to the service
- Appointments are 45-minutes allowing for holistic, bio-psycho-social review with a GP
- I aim to address current concerns and developed a template, mimicking a comprehensive geriatric assessment, due to the multimorbidity often experienced.
- Acute concerns are addressed alongside a proactive approach to healthcare to reduce long term morbidity
- Follow up arranged to provide continuity
- I work collaboratively with base GPs, key workers and other professionals involved with the patient.

EARLY OUTCOMES

100% Had unmet health needs

Icon: A large orange circle with a white plus sign inside.

73% Age range 37-72

Icon: A bar chart with three bars of increasing height, followed by a line graph showing an upward trend.

73% Required investigation

Icon: A white line graph with a sharp upward peak on a dark background.

45% Not seen a GP in >1 year

Icon: Two stylized human figures, one in white and one in dark blue, standing side-by-side.

73% BMI >25

Icon: A white silhouette of a person with a large orange circle containing a white plus sign overlaid on their torso.

100% Had medication reviews

Icon: A white clipboard with a checklist and a pencil, set against a dark background.

100% Recommend the service

Icon: A white checkmark inside a dark circle, which is itself inside a larger white circle.

NEXT STEPS

- Keen to develop respiratory input +- spirometry due to due impact of crack and heroin smoking and development of COPD
- Could this approach be applied to other inclusion healthcare groups to improve access and reduce health inequity?

PERSONAL OUTCOMES

- Avicenna professionals national conference attended
- Joined Derbyshire Drug and Alcohol Death Review Board
- Sense of professional fulfilment
- Development of project management skills
- Leadership coaching course completed

References: 1. <https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/quality-of-medical-care-for-people-with-and-without-comorbid-mental-illness-and-substance-misuse-systematic-review-of-comparative-studies/9BC796E14FC587988F1B829CE296D46>
2. <https://iris.who.int/bitstream/handle/10665/377960/97892940096745-eng.pdf?sequence=1>



Dr Lucy Bradley
GP, Trailblazer Fellow
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The stigma I have experienced stops me going to the doctor. This is a really good idea.

-Clinic Attendee

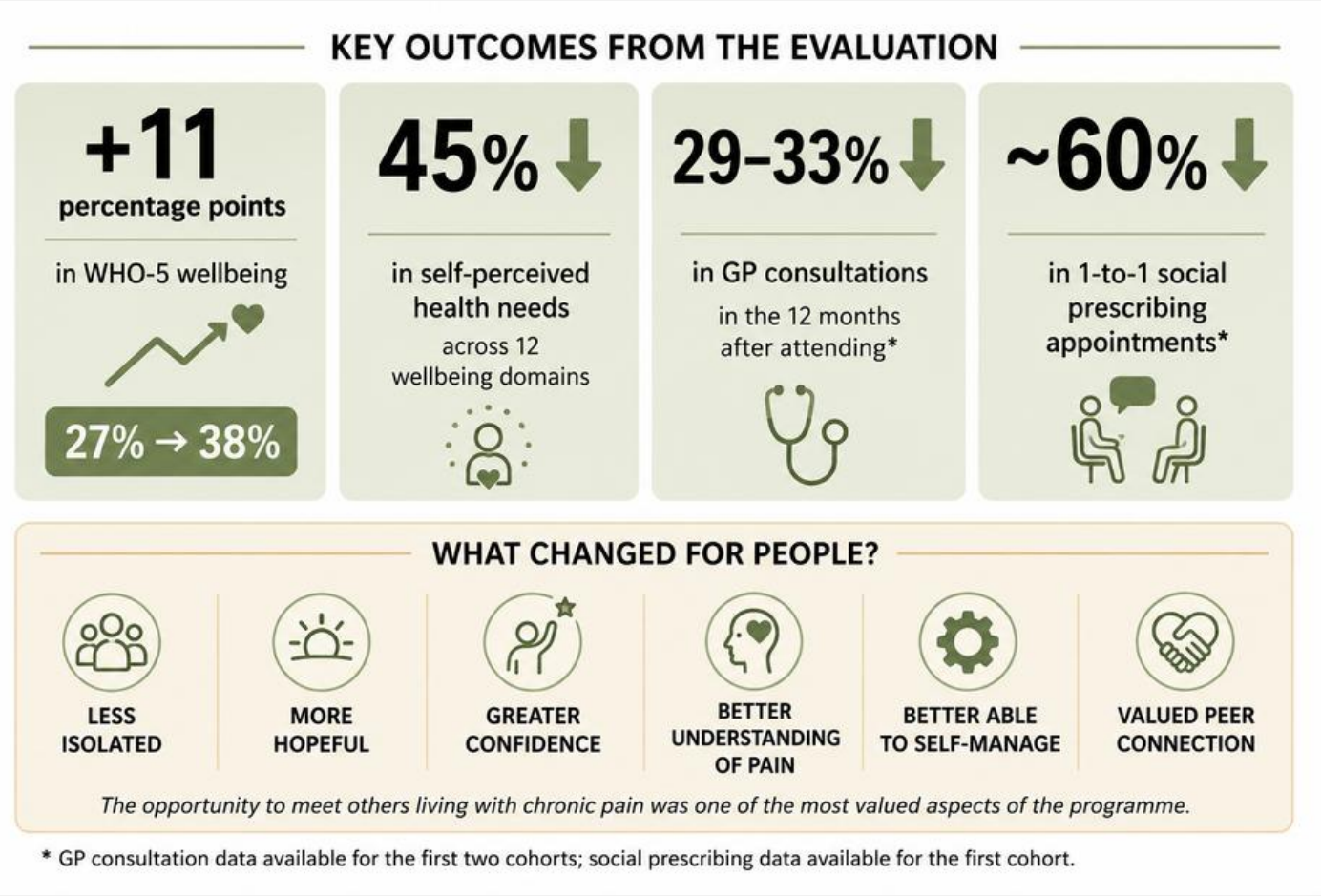
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Developing better support for people living with chronic pain in Belper and across Derbyshire: a work in progress

Dr Jane Packer | hosted and supported by Belper PCN

As many as 1 in 3 people live with chronic pain 1 in 8 live with high-impact chronic pain ~ 50% of GP consultations include discussion about pain

15 consultations/ year for the average patient identified with chronic pain #1 cost to primary care among 32 long term conditions studied*



Creatives in Place

Connecting primary care, communities and creativity

This Arts Derbyshire led initiative uses a relationship-centred bridging model that builds the conditions for creative health to grow locally. Bringing creative people, with curious, creative minds into local communities around General Practices to support health and wellbeing.



The strongest achievement is not simply the activities delivered, but the trusted relationships, networks, confidence and collaborative capacity created around them.

WHAT THE ROLE MAKES POSSIBLE

- GP practices & PCNs
- Social prescribing
- Creative practitioners
- Community organisations
- Residents

CiP connects existing assets rather than duplicating services.

FIVE CORE BENEFITS

- STRONGER NETWORKS**
New and deeper links across health, creative and community sectors.
- CONFIDENCE & CAPACITY**
More people able to contribute ideas, test approaches and lead.
- CREATIVE HEALTH AWARENESS**
Growing understanding of creativity in wellbeing, engagement and prevention.
- LOCAL INNOVATION**
Listening, experimentation and co-production shaped place-responsive work.
- ADVOCATES & CHAMPIONS**
Participants and partners moved from recipients to contributors.

The CIP pilot was run in partnership with Hannage Brook Medical Centre (Wirksworth), Littlewick Medical Centre (Erewash) & Erewash PCN with support from The National Lottery through Arts Council England, Derbyshire County Council, Peter Sowerby Foundation & The National Lottery Community Fund



CREATIVE HEALTH IN PLACE



A trusted connector between systems and communities

EXAMPLES BROUGHT TO LIFE

- Wellbeing tasters & journals
- Live artwork in GP waiting rooms
- Music and Memory Matinees
- Menopause theatre
- Creative smoking cessation
- Prescription for Happiness
- Puppetry for diabetes communication
- 30 Days Creative campaign

HOW CHANGE HAPPENS



The role evolved from delivering activities to:

listening • facilitation • relationship-building
reflection • systems thinking



EARLY SIGNS OF IMPACT

- WELLBEING**
Welcoming spaces helped participants pause, connect and report immediate subjective improvements.
- OPPORTUNITY**
Additional funding, commissions, conference involvement and continuation interest.
- INFLUENCE**
Greater visibility in primary care, public health, local government and community conversations.



WHAT THE EVALUATION TELLS US

PROMISING, BUT EARLY
The pilot has built foundations for change, but it is too early to demonstrate sustained health outcomes or system change.
Evidence is indicative; some activity is resource-intensive; the system remains reliant on CiPs as catalysts.

PRIORITIES FOR THE NEXT PHASE

- Strengthen strategic relationships
- Capture and share practical learning
- Support community ownership
- Embed tested approaches in existing systems
- Continue building robust evidence
- Protect time for evaluation and reflection

Photos by Lamar Francois.

THE OPPORTUNITY: turn early momentum into sustainable, locally owned ways of working.

Creating an Integrated Pathway Between Perth House and the PHD Complex Care Team

Primary Healthcare Derby LTD

Supporting people to transition safely from rehabilitation to independent living through neighbourhood-based multidisciplinary working

THE CHALLENGE

People leaving Perth House can have ongoing clinical, social and practical needs. Without coordinated support, there is a risk of fragmented care, unmet need and avoidable deterioration after discharge (including readmission)

The pilot aimed to develop an integrated pathway between Perth House and the **Primary Healthcare Derby** Complex Care Team to support a smooth transition to home.

AIM

- Create an integrated referral pathway
- Improve discharge planning
- Support independence at home
- Reduce fragmentation between services
- Strengthen neighbourhood working
- Reduce readmission

Outcomes

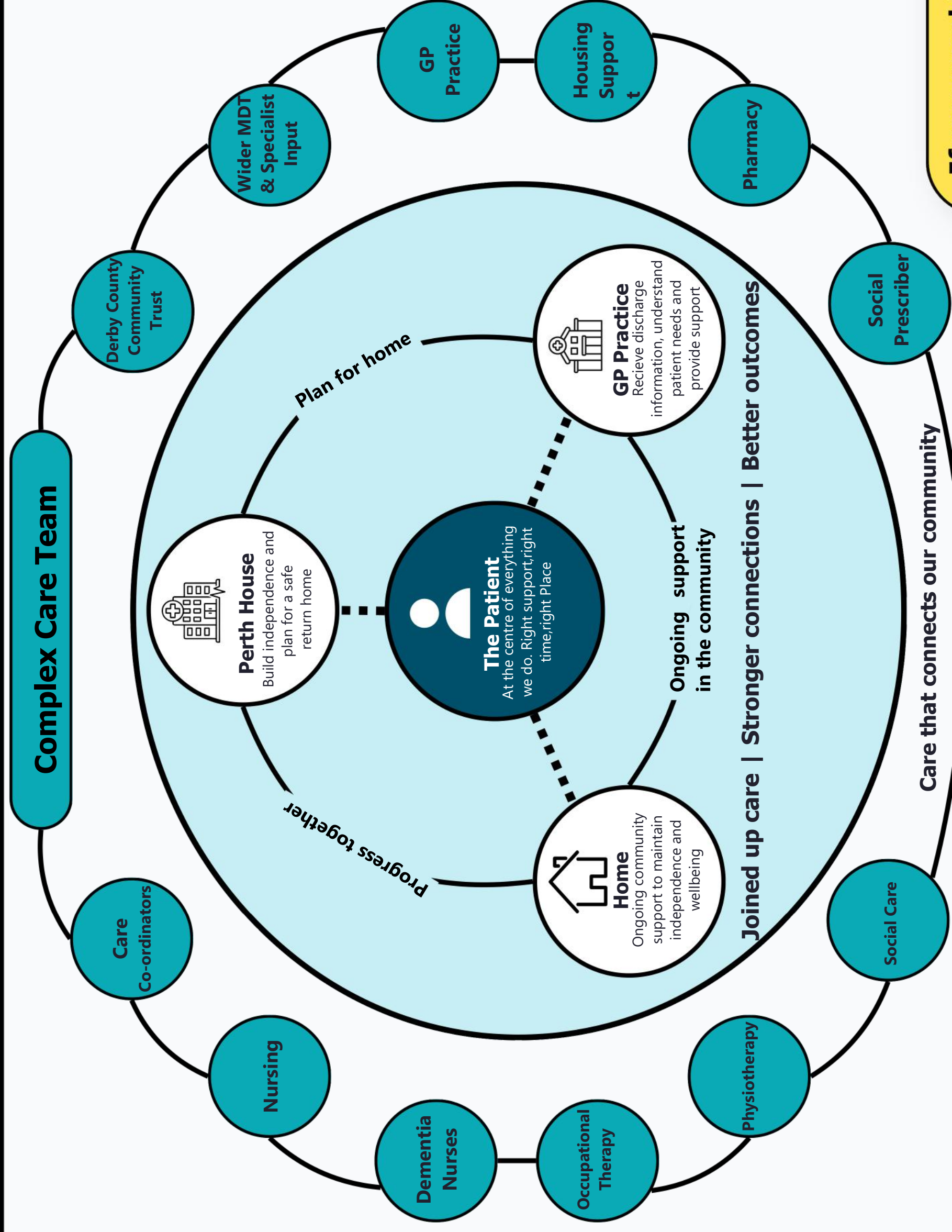
The pilot demonstrated how core therapy, primary care, social prescribing, pharmacy, adult social care and community/voluntary organisations can work together around the individual, to provide timely person-centred continuity of care enabling people to live healthy, independent lives at home for as long as possible

Key Learning

MDT working, building relationships and trust are the foundations of integrated care.

Future Development

Expand provision across the county



If you would like to read more of our case studies or to find more information

please scan :



or please contact

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CASE STUDY: JAMES

James was involved in a road traffic collision where he fractured his back. He was then discharged from hospital to Perth House for rehabilitation where he met with the Complex Care Team Co-ordinator and established his goal to return to hiking.

When James returned home the Complex Care Team identified several challenges at home and acted quickly to resolve these, including enabling access to a phone and internet, arranging a falls response pendant (via care link) and resolution of medication concerns, ensuring insulin and medicines were administered safely.