Joined Up Care Derbyshire

March 2022 newsletter

Joined Up Care Derbyshire is the name for Derby and Derbyshire's Integrated Care System (ICS).
This newsletter is produced bi-monthly; past editions can be found here.

Derbyshire Shared Care Record Goes Live

The new electronic shared care IT system for residents of Derbyshire and Derby, known as the Derbyshire Shared Care Record (DSCR), went live last month after many months of preparation by local NHS and social care organisations. The DSCR joins up different records, including GP, hospital, and social care records, to create a more comprehensive and up-to-date record for citizens as patients and service users. Click here to read more about the DSCR.

You can see how the DSCR works with our series of short animations here.

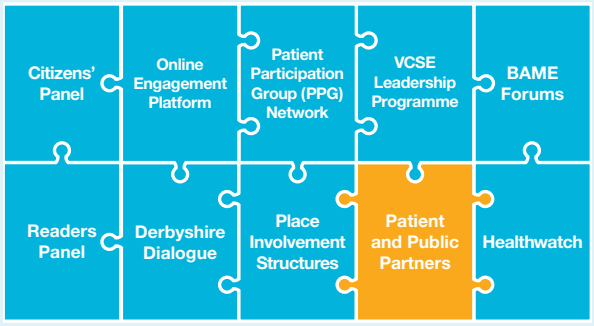
DERBYSHIRE County Council

NHS

Derby City Council

Embedding strong engagement with people and communities

Embedding strong engagement with people and communities at the heart of decision-making around system transformation work has always been a priority for Joined Up Care Derbyshire. In the November 2021 issue of our newsletter, we introduced our 'Continuous Engagement Framework' and spoke about our Readers Panel. In our January 2022 issue, we spoke about our Citizens' Panel and Online Engagement Platform. In this issue, we would like to introduce you to some of our Patient and Public Partners.



Patient and Public Partners

Patient and Public Partners are lay members who want to be involved in improving health and care. They have extensive experience either as a patient, family member or caregiver; others have been part of the health system in a professional manner.

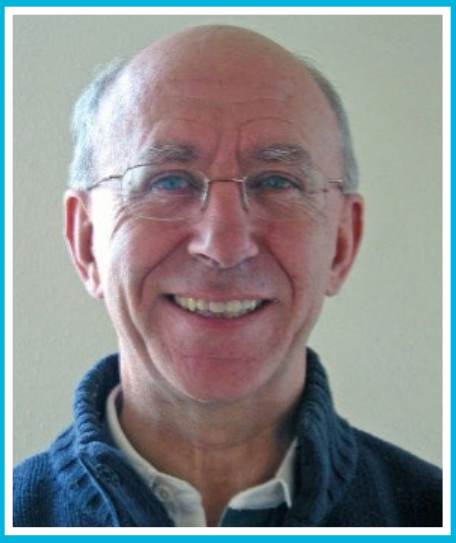
Our partners get involved in various aspects of work in the Integrated Care System to help develop and improve services.

They provide:

- Important insights and ideas for quality improvement efforts
- Improve communication between patients and health care providers, leading to improved patient and provider satisfaction
- Help health care providers embrace potential changes, as they can see them from the patients' perspectives
- Help to ensure that patients are full participants in decisions that affect them
- Contribute to meaningful changes to health care services.

We currently have 14 Patient and Public Partners. Here's the experience of a few of them:

Trevor Parkerson



My name is Trevor Parkerson, and I am a 75-year-old Anglican priest. For the last seven years, I have worked as a Hospital Chaplain, first at Queens Hospital, Burton, and then at Royal Derby and Florence Nightingale Community Hospital. In 2020 I underwent major cardiac surgery and received excellent cardiac rehabilitation care from the team at Queens Hospital, Burton. From my work as a Hospital Chaplain, I had learned that cancer patients do not always receive a consistent level of rehabilitation, that is if they receive any at all. I was very pleased to have the opportunity to join the Living with Cancer workstream and I was surprised to learn that the provision of Cancer prehabilitation and rehabilitation is not mandatory in the NHS.

The workstream group is very diverse and involves people with many different roles, some within the NHS but others who work for community groups who are key to providing support for people living with cancer. I have received excellent support from Sheree who leads the group and Lisa who works alongside Sheree. We normally meet monthly using MS Teams and before each meeting, the Patient and Public Partners are invited to attend a pre-meeting to discuss any issues. The Patient and Public Partners in our group have a wide range of backgrounds and experience and can comment objectively at the meetings. It is still early days for the group, and it will continue to develop ideas to improve the aftercare offered to cancer patients with set objectives and dates already agreed.

Professor Paula J Holt MBE

I was keen to become a Patient and Public Partner for the Diabetes Board, as I have learned through my many years as a nurse, and as an academic responsible for educating our Nursing and Allied Healthcare workforce, that the voice of service users/patients is the most important in the health and care system. Over the past couple of years, I have been the recipient of care for long term conditions that were completely unexpected. I have had fabulous care physically and psychologically from experienced health professionals that have helped me navigate and adapt to a new way of living and given me the confidence to deal with my wellbeing - with support available if needed. During this time, I have experienced occasions of not so great care, and though I have not been afraid to address this I am aware for others raising concerns does not come easy. I am engaged in a wide network of people with long term conditions through friends, family and social media support groups. We share dialogue on what is going well or not so well in our care, and what makes the pursuit of wellbeing and self-management more difficult for some, particularly lack of resources, support or education. I wanted to be a Patient and Public Partner representative to advocate for patients and reflect their lived experiences, to champion care that is kind, innovative and equitable, and to promote the need for care that is holistic. It remains a frustration that having more than one health need necessitates the involvement of different groups of health professionals that don't always seem to collaborate or communicate effectively to ensure joined-up care for the individual, but with more patient voices articulating their lived experience I hope that truly integrated care becomes a reality. I can honestly say that in the few meetings I have attended so far, I have been treated as an equal and valued participant, and I would encourage others who are keen to represent the patient experience to consider how they can contribute to making a positive difference to our healthcare system.

Jo Blackburn, Personalisation Programme Manager for Joined Up Care Derbyshire, has this to say about the Patient and Public Partner initiative:

"The Living with and Beyond cancer workstream is the best meeting I attend because there are people in attendance that have lived experience of cancer. They are good at challenging some of the conversations and relating them to what it's like having to live with a condition, something we really can't understand. At many meetings, they challenge the use of all the acronyms which often, other participants don't even understand the meaning of (but are afraid to ask). All services should have people with lived experience participating, it makes such a positive impact."

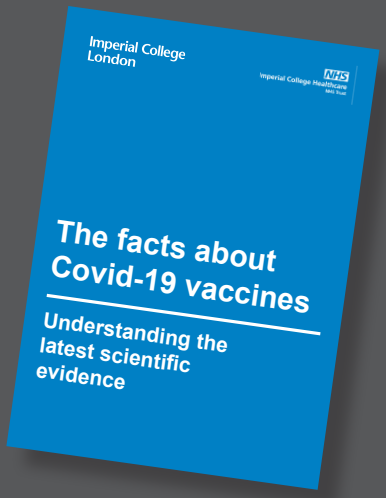
If you are interested in recruiting Patient and Public Partners for a Board, Committee or Workstream you facilitate, please get in touch with Karen Lloyd karen.lloyd24@nhs.net who can support you.

Still unsure about Covid-19 Vaccination?

Imperial College London is one of the most respected and trusted clinical research institutions in the world.

This document lays out the facts about the Covid-19 vaccines to help you navigate the shifting sands of misinformation and misunderstanding and help you make an informed decision about being vaccinated.

Click here to read it.



Are you at risk of Type 2 Diabetes?

Find Out Your Diabetes Risk Level Today

Find out in just two minutes whether you are at risk of developing Type 2 diabetes:

www.lwtcsupport.co.uk/know-your-risk-tool

SCAN ME

Individuals found to be at risk of developing Type 2 diabetes will be able to access free support

72% Achieved weight loss at an average of 5kg → **6%** Average body weight lost on programme → **65%** Programme completion rate - the highest in the country!

LW TC Living Well Taking Control | NHS HEALTHIER YOU NHS DIABETES PREVENTION PROGRAMME

Winning Streak for the Diabetes Education Team

For the second year running the fantastic Diabetes Education Team at Derbyshire Community Health Services NHS Foundation Trust have won the X-PERT Health award for The Best Patient Experience 2021. This was based on their results of delivering 105 programmes with an 81% completion rate and a participant satisfaction score of 95% between January 2019 - December 2020.

This is a national award and compares the results of 64 providers from across the UK. The achievement is even more special given that the team have had to adapt the X-PERT programme to be delivered virtually during the Covid-19 pandemic.

X-PERT Diabetes is a 6-week programme for people with Type 2 diabetes that aims to increase your knowledge, skills and understanding of your condition and help you to make lifestyle choices to manage your blood glucose levels more effectively. An overview of the X-PERT Diabetes Programme can be found here.

If you have Type 2 diabetes and would like to attend a course, please speak to your GP surgery.


X-PERT Diabetes Programme Summary

This programme is delivered over six sessions, which are outlined below. If you have purchased or been given this handbook but are not attending a programme all of the key messages from these sessions are still covered. If you require additional support our free online forum (accessible at www.xperthealth.org.uk/forums) is open to everyone.

Session 1: What is Prediabetes and Diabetes?
Digestion, carbs and blood glucose control
Insulin and insulin resistance
The 7 Lifestyle Factors for optimal health
Health results - what do they mean?
Setting goals: my health results

Session 2: Nutrition for Health and Fat Awareness
Limitations with "eat less, move more"
Nutrition for Health - food groups and portions
Dietary approaches - one size doesn't fit all
Fat Awareness
Setting goals: my dietary approach

Session 3: Carbohydrate Awareness
Carbohydrate and blood glucose levels
Assessing the amount of carbohydrate
Considering the type of carbohydrate
How good am I at estimating carb content?
Setting goals: my carb intake

Session 4: Psychology of Eating, Food Labels and Physical Activity
Psychology of eating and causes of hunger
Nutritional information on food packaging
Physical activity - why, what, when and how?
Setting goals: my foods and activity

Session 5: Possible Complications
Low and high blood glucose levels
How can diabetes affect long-term health?
Prevention of complications
Work, driving, insurance, travel and illness
Stress, meditation and sleep
Setting goals: reducing my risk

Session 6: Recapping and the Way Forward
"Are you an X-PERT?" game (group programme only)
Revisiting my health profile
What's next?
Maintaining any benefits
Recipes for different dietary approaches
Setting goals: my health goals for the future

www.xperthealth.org.uk

Thriving Places - Guidance on the development of place-based partnerships

Integrated Care Systems (ICSs) received a whole range of guidance in the later months of 2021 aimed at supporting systems to develop effective partnership working. All the guidance can be found here.

In this issue of the newsletter, we'll be summarising Thriving Places: Guidance on the development of place-based partnerships as part of statutory integrated care systems

This guidance looks at how as an Integrated Care System (ICS) we can make decisions based on a shared understanding of the local population and how people live their lives, to promote better health and wellbeing and address health inequalities. The Thriving Places Guidance seeks to support all partner organisations in ICSs to define their place-based partnership working and to consider how they will evolve to support the transition to the new statutory ICS arrangements, anticipated from July 2022 (for more information about this transition, see page 1 of our January Issue here). The intention is to support partners to build on existing arrangements, not to disregard partnership approaches that are already working well.

This work is critical to the establishment of our ICS, as health, care and other public and voluntary services people use are predominantly delivered within the community or 'places' where they live or work. Almost 80% of people's interactions with the NHS occur in their own homes, their GP practices, community pharmacies, dentists or local health centres, and the vast majority of social care services are delivered at home or in the community. In Derbyshire, we have been operating with 8 local place-based arrangements for some years now and as a result have already established good partnership working between local government, the NHS, social care providers, the voluntary, community and social enterprise sector and other community partners, and these arrangements will provide a strong foundation for further work to co-ordinate and integrate services further.

As we face the challenge of social, economic, and public health recovery from the Covid-19 pandemic and look to tackle the inequalities and vulnerabilities it has exposed, the case for multi-agency working is strong. We know now more than ever the shared strength and resilience of our local communities and the opportunities that utilising and investing in our shared social infrastructure can bring to prevent ill health and promote wellbeing. If we are serious about promoting better health and wellbeing and addressing health inequalities, we must take collective decisions based on a shared understanding of the local population and how people live their lives. We must look beyond health and care services to the wider determinants that influence the health of our populations – early years support, housing, leisure, transport, skills and education, employment support and the environment.

To do this, the Thriving Places guidance asks the following of ICSs:

To agree on the configuration, size, and boundaries of the ICS's Place-Based Partnerships

In Derbyshire it has been agreed that we will have two Place Partnerships for the City and County, coterminous with our Local Authority boundaries, this will facilitate alignment of priorities and resources.

To agree on the purpose and role of Place-Based Partnerships – i.e., what functions and responsibilities should be carried out at place level.

Work to agree on the purpose and role of the partnerships has been developed through partnership sessions and high-level functions and programmes of work have been agreed upon. They include:

- Understanding and working with communities
- Joining up and co-ordinating services around people's needs
- Addressing social and economic factors that influence health and wellbeing, and
- Supporting quality and sustainability of local services.

To agree the planned governance model for place including:

- Membership
- Place-level decision-making arrangements, including any joint arrangements for statutory decision-making functions between the NHS and local government
- Representation on, and reporting relationships with, the ICP and ICB.

In JUCD delivery will be through two Place Partnership Boards (one City and one County) and an Integrated Place Executive. These will be co-chaired between the NHS and Local Authorities. The membership has been agreed and plans are underway with the ambition of holding the first meetings during April. There will be a Place Partner member on the Integrated Care Board (ICB) and the Integrated Care Partnership (ICP) arrangements are still under development. Membership includes NHS organisations, local authorities (reflecting both tiers in the County) general practice and the voluntary sector.

Agree on leadership roles and capabilities - There is a range of leadership roles that may be fulfilled at place, and they will depend on the responsibilities the place-based partnership has agreed to undertake together. Partnerships may choose to have an overall lead for the place, its vision and plan, which will likely comprise the role of convening the partnership but may also include responsibility for managing delegated statutory functions. This will typically be accompanied by other leadership roles in the partnership for defined functions or programmes of work.

A workshop was held on the 20th January 2022 to develop and agree on proposals that will now be implemented. Ensuring clinical and professional leadership is seen as a key element. Work has also been done looking at leadership capabilities and behaviours; ensuring leaders embody a commitment to collaboration and partnership working.

Whilst there are some formal elements in response to Thriving Place's guidance in terms of new structures and governance there is a strong commitment to building on the existing strong foundation of local place-based working and the principles that have underpinned success. The guidance recognises the need to 'learn by doing' and anticipates that there will be a need to adapt as the implementation of all of the components of the ICS progress. This gives an exciting opportunity to think differently and work collaboratively to get the best approach for Joined Up Care Derbyshire and improve care and outcomes for our population.

On the 9th February 2022 a further white paper, 'Health and social care integration: joining up care for people, places and populations' was published, which goes further in setting out the expectations for health and local government to jointly deliver for local communities.

Including Glossop in the Derbyshire Integrated Care System - UPDATE

The government announced in summer 2021 that Glossop healthcare services should not move into the Greater Manchester ICS but instead move to the Derby and Derbyshire's Integrated Care System to enable closer joint working. Since then we have been working to keep Glossop residents informed and also to listen to their questions and concerns. On 27 January 2022, we held a listening event that included a brief update from senior leaders at Derby and Derbyshire Clinical Commissioning Group, Tameside and Glossop Clinical Commissioning Group, Derbyshire County Council and the Glossop Primary Care Network.

In response to the feedback received at the event and through our engagement activities, we were able to provide reassurance that people in Glossop will continue to receive their care in the same way that they do now and that we do not propose to make any changes for the next 12 months. We provided further assurance that this decision to move healthcare to Derbyshire will not impact any individual patient's right to choose, or to use services outside of the Integrated Care System.

From a cross-systems perspective, we are all working together to make this change as seamless as possible in a way that also builds on the great work and learning developed as part of the Greater Manchester Integrated Care System. More listening events for our public, patients, staff and stakeholders are planned over the coming months and beyond the formal transition date which is now confirmed as 1 July 2022.

If you would like more information:

- Go to our Joined Up Care Derbyshire website here for more information and responses to frequently asked questions
- Email our enquiries service at ddccg.enquiries@nhs.net
- Call Healthwatch Derbyshire, your independent local health and social care champion on 01773 880786
- Attend one of our information sessions where you can also ask questions. You can find out when these are taking place and see recordings of previous events here. You can also ask questions on this platform and download a summary of themes from discussions that have already taken place.

Men, is it time to talk?

Mentell

Mentell provides circles for men aged 18+ to talk in a safe and confidential space, free from advice and judgement.

Due to Covid-19 circles are currently online, and can be accessed for free, every Monday at 7 pm.

To sign up click here.

Become a facilitator

Derbyshire is looking to recruit new facilitators to run local circles, if you are interested you can find more information here.

Turn Your Business Blue - Support men's mental health

Turn Your Business Blue is a campaign running across the United Kingdom, open to all businesses that want to raise awareness of men's mental health. You can find out more information by clicking here. This initiative has had a huge impact on referrals to Derbyshire's local circle.

You can hear from Christian, who has used Mentell here.

Men's Sheds UK

Have you heard about Men's Sheds? Men's Sheds are kitted out community spaces where men can enjoy practical hobbies. They're about making friends, learning and sharing skills. Many men go along just for the tea and banter, everyone is made to feel welcome. Men's Sheds have been shown to improve men's mental health and happiness. Each Shed is different, and they are based all over the world! If you would like to find out more and find out where your nearest Shed is then take a look on the Men's Sheds website (menssheds.org.uk) or follow them on Twitter: @UKMensSheds

Support network created by Men's Shed in Swanwick

Tucked away on a farm in a lesser-known area on the outskirts of Swanwick something amazing is happening.

With their slogan, "make friends - make something in wood," Swanwick Men's Shed provides a safe, friendly place to meet and join in a variety of projects – from building garden benches, planters and obelisks to making picture and mirror frames and reviving old furniture.

And despite its location, the Men's Shed is at the centre of the community. People venture up with donations of tools and wood, put in requests for things to be made and there are many links with others in the community like local schools and charities.

But what's clear here is the Shed is providing a lifeline to local men (and women) who would otherwise be socially isolated or suffering with poor mental health. With the Government's Loneliness Strategy stating lonely people were more likely to be admitted to hospital or have a longer stay, visit a GP or Emergency Department, and enter local authority funded residential care, the opportunities provided by this small community group are huge.

Tackling social isolation

Charles Parkes helped to set up the Men's Shed in 2017 through Valley CIDS and it's since won regional and national awards. It's aimed mainly at men but is open to both men and women over 18.

He explains: "The original idea was to deal with isolation for older males. A lot of men who've finished work for whatever reason - whether they've retired, been made redundant or finished due to ill health - don't have the social network that their wives would probably have through schools, playgroups, WI and all sorts of things.

"We've had a few people move into the area and then become widowed so they're in a new place with no social contact at all. They have found new friends and a family in the Shed. They enjoy coming and helping out, making items for their grandchildren or cooking the sausages on a Saturday.

"We get new members to buddy up with a shedder on a project. It is good to see them smiling and enjoying the banter. It's something to do and keeps them physically fit and mentally active."

Feeling valued

The Shed is primarily a woodworking and hobby workshop, but the value people take from it is hugely varied.

Charles said: "Some come to utilise their skills, some come with a particular purpose to make something, the majority come just to do something, whatever that is. I think the main thing is they can still be useful, by fetching and carrying and holding and screwing and helping someone a bit more able.

"We have a lady who comes, she's 75 and not really done anything practical all her life but she makes all the garden trellis and she's really taken that on board. So she's found new skills and she works in a team with one or two others.

"We've got people who've got dementia, at various levels. Being at the Shed provides a respite and free time for their carers.

"Dementia sufferers can have a short attention span so we have to find tasks they can manage. One shedder put together one of our bird box kits that we make for schools and conservation groups. He presented it to his wife and that was a huge success for them as a couple. She's got the nest box in the garden."

Building family and support

The friendships formed through the Men's Shed have spread far beyond the confines of the shed itself.

Charles explains: "We've found friendship, I think that's the thing. We come to the farm, have a bit of banter, go and feed the animals, have a sausage cob, be useful.

"We support each other. We've got two or three at the moment who've got health problems within their family and we're rallying around speaking and supporting each other. We closed over Christmas and we kept in contact with people who needed contact and help.

"I get a lot of satisfaction out of it in terms of what we've achieved. When you hear their stories it's great to see the effects it's had on other people being there.

"We've got people there who would relatively openly admit it's saved their lives."

How can you help Swanwick Men's Shed?

There are lots of costs involved in running Swanwick Men's Shed so we are always on the lookout for donations of wood and tools. We are currently in desperate need of good quality timber to fulfil a request from a charity shop to make some gardening crates. If any local businesses can help, please contact Charles at charlieparkes@gmail.com

Find out more via their website here

Communities beginning to benefit from new home visiting services

Team Up Derbyshire

An acute home visiting service is where different professionals from across health and social care, working together as a team, provide person-centred, timely, responsive care for vulnerable individuals. The service is part of the Ageing Well and Team Up Derbyshire approach to improving care for the housebound population.

Team Up Derbyshire is an ambitious programme in Derby and Derbyshire that aims to create one team across health and social care who see all housebound patients in a neighbourhood. This team is not a new or 'add on' service – it is a teaming up of existing services – with general practice, community, mental healthcare, adult social care and the voluntary and community sector all working together.

As well as the home visiting service, Team Up Derbyshire also incorporates three initiatives of the national Ageing Well programme. These are community urgent response (providing crisis response and reablement care), enhancing health in care homes (providing comprehensive support to care homes and their residents), and anticipatory care (working proactively with patients to maintain or improve health and wellbeing).

Shown here are two case studies of new home visiting services that are currently being set up in Derbyshire – by Arch Primary Care Network (PCN) and Derbyshire Dales PCN.

Arch PCN spans the gap in care for the housebound

Following the success of a pilot acute home visiting scheme in Arch PCN, the service is now being expanded this year.

The service pilot ran in Arch PCN in September and October 2021 and saw a total of 84 people visited by a PCN team member rather than the individual GP practice sending a clinician out. Arch PCN covers Alfreton, Ripley, Crich and Heanor and has nine GP practices working in three neighbourhood areas. The PCN is based at Church Farm Primary Care Centre in Ripley.

The pilot service ran one day a week from 10 am to 4 pm, overseen by clinical lead Dr Natalie Craven. Eight pilot days were completed achieving an average of 10.5 visits per day and an average visit length between 15 and 30 minutes. Only two referrals were rejected as being inappropriate. Several lessons were learnt from the pilot including the need to improve IT systems and boost staff recruitment.

With additional staff now in place (two community GPs, three advanced care practitioners and two admin support roles), the PCN plans to run a five-day-a-week service from spring 2022. The service would run 8 am to 6.30 pm on those days, increasing to a 12-hour day to 8 pm when staffing allows.

A small multi-disciplinary team (MDT) was launched during the pilot, including a community GP, care coordinator, community matron and social prescriber. This was found to be beneficial for onward referrals and discussion of complex patients with frequent contact with multiple health and care agencies. The MDT is due to re-start in line with the expanded service.

Future plans for Arch PCN include taking on responsibility for the care of residents in care homes from the individual GP practices.

Becky Tomlinson, Operations Manager, Arch PCN, said: *"GP practice staff have said they are grateful for the extra support that we can provide, and the informal feedback has all been very positive; staff have been asking when we are going to run the acute home visiting service again.*

"Patients have also appreciated the extra time and attention we can give them, not only addressing their immediate needs but being able to look at their situation holistically, liaising with services such as pharmacy, social care and housing. We have spoken to patient participation groups (PPGs) at the GP practices and the feedback has been very supportive."

Alongside this scheme and other activities, Arch PCN is committed to being a training and educational environment for staff in both formal academic settings and day-to-day learning opportunities. This includes drop-in and shadowing days for trainees to gain exposure to acute visiting and community geriatrics. One member of staff is to be supported through a three-year MSc programme for advanced nursing while working within Team Up Derbyshire. Both Dr Natalie Craven and Becky Tomlinson are also undertaking Affina professional coaching qualifications.

For further information about Arch PCN, please contact Becky Tomlinson, Operations Manager, via email r.tomlinson2@nhs.net

Team Up Derbyshire in action – a case study courtesy of Dr Natalie Craven of Arch PCN

Team Up received a referral for a patient aged in their late 90s suffering from acute vertigo. The person lived alone in a ground floor flat and had a package of care twice a day. In the 48 hours before the visit, the patient had been seen by three other teams – East Midlands Ambulance Service, out-of-hours GP and the surgery GP.

Team Up was able to assess the individual, chase up the delayed prescription for the vertigo symptoms and also discuss advanced directives regarding her care. This involved the completion of a 'Respect' form not previously considered or completed. The Team Up community GP was able to speak to the person's family regarding this conversation as they were not living in the local area.

The patient's neighbour had been staying with her all day and overnight for the last 48 hours as the patient was unable to walk to the toilet independently. Team Up liaised with the community access point and arranged an urgent therapy response for assessment, and delivery of a walking frame and commode, meaning the patient was able to safely remain at home while symptomatic. This was achieved within two hours of the Team Up community GP visit. The care coordinators also received a referral.

The individual was booked for follow-up support from Team Up to optimise their blood pressure and was forwarded to the multi-disciplinary team for an increased package of care. The patient made a full recovery within a week of starting medication and was managing independently at home with their new care package.

New Dales community GP to lead innovative home visiting service

Derbyshire Dales PCN is setting up a new home visiting service which will see a multi-disciplinary team supporting housebound patients.

Overseeing the new service, set to launch from May 2022, will be clinical lead and new community GP, Dr David Munkenbeck, who joined on 1 February, having worked previously as a salaried GP in Sheffield. The service will initially run for between two to three days per week and will expand over the coming years.

The Derbyshire Dales home visiting service is initially set to feature four paramedics who will receive a comprehensive induction programme to support their transition from the ambulance service to primary care.

Alex Guevara, Operations Lead for Team Up Derbyshire Dales, who has worked as a paramedic and clinical practitioner, says: *"Paramedics are an obvious choice to play a key role as they are already very capable of providing a high standard of care to those in their own home. Our new service allows them to spend more time with patients in order to identify needs other than the more obvious medical care."*

The community GP and the multi-disciplinary team providing the service are to be based at Whitworth Hospital, Matlock, where they will be integrated with local care partners such as local authority social care and Derbyshire Community Health Services which already provide some of the services that Team Up will be focused on.

Alex adds: *"This hub at Whitworth Hospital will allow us to bring everyone together under one roof. The different members of the team will be able to talk about the care that the patient requires and refer to different services. This is linked into the holistic perspective of the service where someone can take the time to sit down with a person and identify all the areas in which they might need support – it could be the need for a walking frame, a befriending service because they're lonely, or maybe support with finances and filling in a form for benefits. Back at the hub, there will be colleagues from areas like social care, occupational therapy and community matrons who can help. It is so much easier to do this in the hub rather than pinging emails about."*

For further information about Derbyshire Dales PCN, please contact Alex Guevara, Operations Lead, via email alex.guevara@nhs.net

Find out more
Team Up Derbyshire has a section on the Joined Up Care Derbyshire website which now includes a monthly bulletin of news. You can also read more news stories and interviews on the Team Up Derbyshire blog.

Joined Up Careers supporting a new cohort of 'Wellbeing Enablers'

A new, free training programme has been set up for people in and around Chesterfield to become 'Wellbeing Enablers'.

The three-week scheme is providing an introduction to skills such as workplace behaviours, workplace health and wellbeing, coping with change, and developing confidence.

It is being delivered by Joined Up Careers Derbyshire, a partnership of local health and care organisations covering the city and county, and Chesterfield College. Wellbeing Enablers is funded by Health Education England.

The programme aims to boost the mental health and wellbeing support available to local people and provide skills training to members of the workforce who may have been made redundant, furloughed or who are simply looking to re-skill in a new career.

A total of 30 places have been made available for the pilot training programme commencing on Monday 28 February 2022 with applications inbox remaining open to capture interest for future cohorts. To register your interest in future programme's, apply here.

Susan Spray, programme lead, for Joined Up Careers Derbyshire, said:
"This is a 'fast track' training programme aimed at supporting individuals in local communities to live well and stay well. People who complete the training programme will also be in a good position to then take up paid roles in the health and care sector. It could be that it opens up doors for roles in care homes, children and adult mental health services, or in areas such as social prescribing, supporting people with lifestyle support and advice. We could see Wellbeing Enablers eventually working in varied roles in the NHS, social care and the voluntary sector."

David Malone, Deputy Principal at Chesterfield College, explains:
"As a college at the heart of the community, we're excited to play a key role in the delivery of programmes such as the Wellbeing Enabler. We're delighted to be able to not only boost participants' wellbeing but also hopefully kickstart career pathways in the NHS and key services such as mental health to support the wider community. This programme is a fantastic way for anyone to reskill and get a foot on the ladder in working in the health and care sector."

People who complete the programme will be given a certificate as evidence of their participation – a useful addition to someone's CV. They will also have the opportunity of progressing onto a special Step Into Work programme.

Step Into Work is a six-week, accredited, pre-employment training programme to prepare unemployed adults aged 19+ for employment in the health and care sector. It can be offered in conjunction with the Pathways to Health and Social project, also delivered by Joined Up Careers Derbyshire, that provides additional one-to-one career advice, guidance and support.

In need of advice and support?

In Derby City

The Derby Poverty Commission maintains a list of some of the support services and mechanisms that are currently available in Derby city.

If you need support and don't know where to turn then a good first point of contact is the Community Hub which provides a single front door to many of the support mechanisms whilst also providing low-level support itself. The Community Hub can be accessed by calling 01332 640000 - option 5.

You can find further information here about the support available.

Energy Support:

Household Support Fund (closes 31/03/22)

- A one-off payment to support with food or fuel
- Must be in receipt of benefits and in financial hardship
- To apply go to https://myaccount.derby.gov.uk/en/service/Household_Support_Fund

Stay Warm and Well This Winter

- Advice or support with cold homes, energy bills, energy efficiency, financial hardship, food shopping, homelessness or eviction, home maintenance, winter flue jab, Covid-19 support.
- Call 01332 640000 – Option 5

Rent Support:

Single Discretionary Award Scheme

- Financial support made up of Discretionary Housing Payment, Council Tax Hardship Payment, support for moving to cheaper accommodation, goods for the home.
- Apply online at https://derby.ecinfo.org.uk or call the council on 01332 640000

Vulnerable Renters Fund

- For private renters on low-incomes in rent arrears who are at threat of eviction.
- Payment is made direct to your landlord to top up your rent account.
- Access via referral. Call the Community Hub 01332 640000 option 5.

Derby Money Advice Team

- For Derby Homes tenants who are struggling to pay their rent. Provides benefit entitlement support, financial planning support, debt support and more.
- Contact via email to money.adviceteam@derbyhomes.org or phone 01332 888777

Housing Advice:

Derby City Council Housing Options

- If you are homeless, threatened with homelessness, or need advice about your housing situation.
- Call 01332 888777 – option 5, or email housing.options@derby.gov.uk

Direct Help & Advice

- Provide specialist advice, advocacy, and representation for families and individuals facing crisis, to prevent and alleviate homelessness, debt, and housing difficulty.
- Call 01332 287850, email info@dhadvice.org, or visit Housing and Debt Advice, Phoenix Street, DE1 2ER

Food Support:

Derby Food 4 Thought Alliance

- Supports people experiencing food poverty through food provision, signposting, education, and advice.
- Call 01332 640000 – option 5

Debt Advice & Support:

Derby City Mission – Jubilee Project

- Free debt advice, walk in sessions, no appointment needed
  - Tuesdays 10.15am-12.15pm, St Peters Church DE1 1NN
  - Wednesdays 10am-12pm, St Augustines Church, Normanton, DE23 8BP
  - *Alternate* Thursdays 9.30-11.30am, Allenton Osmaston Sure Start Centre, Allenton, DE24 8XB
  - *Alternate* Thursdays 12-1.30pm, Davenport Road Evangelical Church, Osmaston, DE24 8AX

In Derbyshire

People across Derbyshire may have concerns about the impact that recent cost of living increases may have. There is a lot of support available to help Derbyshire residents, and outlined below are some of the support channels that people can access to get the help they need.

Welfare and Benefits Advice

The welfare rights team can help you to find out about the benefits you may be entitled to and how to claim. You can email the team at welfarebenefits@derbyshire.gov.uk or telephone 01629 531535.

For more information visit Welfare benefits - Derbyshire County Council

Derbyshire Discretionary Fund

The Derbyshire Discretionary Fund (DDF) can provide grants or emergency cash payments if you are in urgent need of financial help following a crisis or disaster and support you to continue to live independently or cope with exceptional pressure when you have no other source of funding.

The fund may support you to resolve your immediate difficulties and also put you in touch with other support and services so it's less likely to happen again. You can apply for the grant by telephone on 01629 533399.

For more information visit Derbyshire Discretionary Fund (DDF) - Derbyshire County Council

Household Support Fund grants

Households facing financial hardship can apply for a grant for help towards their food, energy, and essential living costs.

A maximum of 2 payments can be made worth £64 per household plus an extra £20 will be provided for each partner/spouse and any dependent children.

All payments must be made before the fund closes at the end of March 2022.

Please telephone: 01629 533399

Council Tax

You can claim help with your council tax bill from your local district and borough council. You may be able to reduce your bill by applying for a discount on your bill, for example, if you live alone or if someone who lives with you is permanently disabled. Discounts are based on your circumstances, not your income or savings.

You may also be able to claim means-tested council tax support if you are on benefits or another form of low income. In exceptional cases of hardship, your local district or borough council may be able to give additional discretionary help.

For further information. Please contact your local borough or district council.

Housing

If you are worried about not being able to pay your rent this can be a big concern. Citizens Advice have information about rent arrears here - Dealing with rent arrears - Citizens Advice

There is also advice on our website around preventing homelessness - Preventing homelessness - Derbyshire County Council

Legal Advice

Derbyshire Law Centre are available to provide free, confidential legal advice over issues around housing, debt, immigration, employment, and discrimination.

For more information on their service, please visit their website - Derbyshire Law Centre® or telephone 01246 550674

Advisory Services

Citizens Advice can offer free, confidential, impartial, and independent advice and information on a wide range of subjects including debt, income maximisation, energy, employment, and housing problems. Support is available over the telephone, at local Citizen Advice offices, a range of community Venues and GP surgeries. Derbyshire County Council is a partner in this service.

Visit Derbyshire Citizens Advice (derbyshirecab.org.uk) and click on your local office for more information.

Food

The Feeding Derbyshire Partnership aims to improve accessibility to good quality affordable food and reduce the negative impact of hunger by ensuring projects are inclusive to all and reach those who are in need. Work is supported by Public Health and coordinated by Rural Action Derbyshire

For more information visit Feeding Derbyshire | Rural Action Derbyshire or call 01629 592978

You can find a list of food banks across Derbyshire here Foodbanks in Derbyshire | Rural Action Derbyshire

To check if your child qualifies for free school meals please visit Free school meals - Derbyshire County Council

Energy Support

Warmer Derby and Derbyshire

If you are looking for impartial advice and practical tips on how to stay warm at home and cut your energy usage, you can call the 'Warmer Derby and Derbyshire' service free of charge. Residents can call for advice about their energy bills, how to make their homes more energy-efficient and how to apply for grants for heating systems and insulation. Just call 0800 677 1322 – there are no charges for this call.

Derbyshire Healthy Homes

The Healthy Home project offers people with long-term health conditions help with cold homes. The project helps improve home insulation and heating to keep your home warm and keep you healthy.

To find out if you're eligible for the project email: healthyhome@derbyshire.gov.uk

Winter Pressures Single Point of Contact (professionals only)

The Winter Pressure Single Point of Contact is a service for professionals only, to support them to refer and signpost vulnerable residents to essential services and self-help advice this winter. It includes support and advice with cold homes, financial hardship, energy bills, homelessness, food insecurity. This is open until the end of March 2022 and is a single point of contact if you are unsure where to refer someone currently. This service is open to all health professionals, social care practitioners, district/borough stakeholders and voluntary sector partners. For more information, please go to:

Winter Pressures - pathway for professionals - Derbyshire County Council

Or email: healthandwellbeing@derbyshire.gov.uk

Mental Health

For many people, the pandemic has had an impact on their mental health. Feeling anxious, worried, or overwhelmed is normal. The good news is that there are lots of things you can do to look after your mental health and wellbeing. The link below has lots of information and sources of support that you can access

Emotional health and wellbeing during the coronavirus outbreak - Derbyshire County Council

Live Life Better Derbyshire

Live Life Better Derbyshire is Derbyshire County Council's healthy lifestyles service that aims to help people make structured, long term changes to improve their health. This includes free support to stop smoking, lose weight and get more active. Home - Live Life Better Derbyshire

For more information, please visit www.derbyshire.gov.uk/moneyandadvice

Population Health Management in Derbyshire

Whilst lots of us live long and healthy lives, many local people are dying younger than they should from preventable diseases. Also, more local people are living with long-term conditions like asthma, diabetes, and heart disease, and are doing so from a younger age. There are also huge inequalities in the health outcomes for people across Derby and Derbyshire.

Improving population health is a core aim of our Integrated Care System with an ambition to increase life expectancy and healthy life expectancy and to reduce health inequalities. To do this we are taking collective action to 'turn the curve' on long-term challenging issues like smoking, obesity and harmful drinking that increase the risk of living with a long-term condition or of dying prematurely as well as things like housing and poverty.

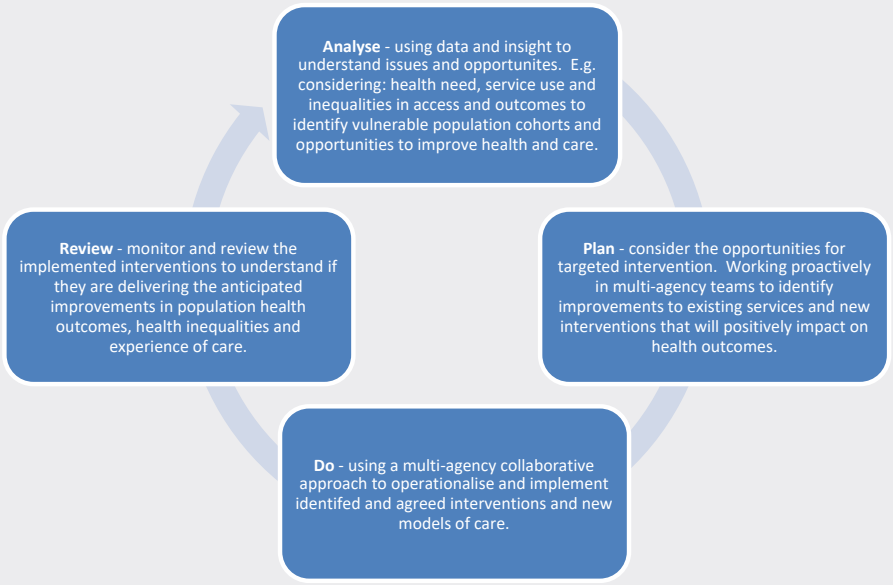
You can watch an animation here that explains a 'population health' approach.

Population Health Management (PHM) is a way of working to help planners and frontline teams understand current health and care needs and predict what local people will need in the future.

This will help us better tailor care and proactively support communities and individuals with more joined-up and sustainable health and care services, tackle the wider determinants of health and make better use of public resources.

PHM uses data and insight to understand the factors driving poor outcomes in different populations. This helps us proactively improve existing care and design new models of care to improve the health and wellbeing of local people today as well as in the future.

The PHM approach is perhaps best considered as a cyclical process that supports change and transformation:



To support us in building our Population Health Management capacity and capability, we are taking part in two nationally funded Programmes that will help us at the system, place, and neighbourhood level:

- The Population Health Management Development Programme (PHM DP)
- The ICS Population Health and Place Development Programme (PDP)

The Population Health Management Development Programme (PHM DP) has three aims:

- To develop and build PHM capacity and capability across our workforce.
- To advance our PHM infrastructure.
- To support efficient and effective use of our resources.

The PHM Development Programme works across system, place, and neighbourhood, shaping and supporting the operationalisation of our strategic intentions.

The cornerstone of the PHM approach is the use of linked data providing insights across individuals and communities rather than just activity across organisations or points in time. This will give us better insight into the complexity of need and service use enabling holistic and impactful interventions for individuals, cohorts, and communities.

The PHM Development Programme will develop the capability of both our analytical and wider workforce, developing understanding and interpretation of data but also on designing approaches for intervention design.

In addition, we are also taking part in the national ICS Population Health and Place Development Programme (PDP) which will accelerate the development of place-based approaches to improving population health.

The PDP will work at Place with clinical and care leaders, analysts, primary and secondary care, local government, social and community services, and the voluntary and charity sector. It will provide practical support to give us the tools, techniques, and approaches to enable us to deliver effective Population Health Management (PHM).

Whilst there are system-wide events, we have some specific Places and Primary Care Networks (PCNs) actively participating in these programmes too.

The two programmes are fully complementary and will embed a consistent approach to PHM building up the skills and infrastructure we need to improve population health.

Finally, in addition to these programmes, JUCD will be hosting a Health Education England funded Population Health Fellowship. The Fellowship is for healthcare professionals interested in population health and health inequalities and will be part-time for one year hosted by Derby City Council. The Fellowship will offer yet more capacity and capability to support our work on population health.

Personalisation - What Matters to me

Personalised care is based on a 'what matters to you' conversation. It supports people with choice and decision making; harnessing the expertise of people, professionals and the health and care system and provides a positive change in power and decision making that enables people to feel informed, have a voice, be heard, and be connected to each other and the community in which they live.

In previous editions of our newsletter, we have covered Personal Health Budgets and Shared Decision Making. In this edition, we look at the Social Prescribing component of Personalisation.

Social prescribing

Social prescribing has been happening in communities for many years. The NHS is now building on the approach, supporting a way for local agencies to refer people to a link worker. Link workers give people time, focusing on 'what matters to me' and taking a holistic approach to people's health and wellbeing. They connect people to community groups and statutory services for practical and emotional support.

In some cases, link workers (as well as existing social prescribers in communities) can support community groups and service providers to be accessible, and help people to start new groups, working collaboratively with all local partners.

Social prescribing works for a wide range of people, including people:

- With one or more long-term conditions
- Who need support with their mental health
- Who are lonely or isolated
- Who have complex social needs which affect their wellbeing.

When social prescribing works well, people can be referred to social prescribers from a wide range of local agencies, including general practice, pharmacies, multi-disciplinary teams, hospital discharge teams, allied health professionals, fire service, police, job centres, social care services, housing associations and voluntary, community and social enterprise (VCSE) organisations. Self-referral is also encouraged.

Social prescribing complements other approaches, such as active signposting. This is a light-touch approach where existing staff in local agencies provide information to signpost people to services, using local knowledge and resource directories. Active signposting works best for people who are confident and skilled enough to find their own way to services after a brief intervention.

Social prescribing link workers

In the Long-Term Plan, NHS England committed to building the infrastructure for social prescribing in primary care. It stated that were would be 1,000 new social prescribing link workers in place by 2020/21, with significantly more after that, so that at least 900,000 people will be referred to social prescribing by 2023/24.

Social prescribers are becoming an integral part of the multi-disciplinary teams in primary care networks alongside voluntary organisations, who can support social prescribing provision, to help reduce health inequalities.

This is the biggest investment in social prescribing by any national health system and seeks to reinforce, invest in, and promote community-based care and support alongside medical treatment as part of personalised care.

Derby and Derbyshire's Green Social Prescribing Project – GreenSPring

Background

GreenSPring is one of seven government funded 'Test and Learn' pilot areas tasked with investigating 'preventing and tackling mental ill-health through green social prescribing'.

Green social prescribing is the practice of supporting people to engage in nature-based activities to support their health and wellbeing. This can include activities such as walking, cycling, community gardening and food-growing projects, as well as practical conservation tasks such as tree planting. An example includes prescribing appropriate physical activity to people living with long-term conditions to manage their conditions and improve their mental wellbeing.

We are working to define the system change needed to realise the potential of green social prescribing. GreenSPring aims to test how to embed green social prescribing into communities.

To achieve the following outcomes for individuals:

- improved mental health
- reduced health inequalities/inequalities in access to quality greenspace
- reduced demand on the health and social care system
- reduced isolation and loneliness (especially in relation to Covid-19)
- developing best practice in making green social activities more resilient and accessible.

Work so far

GreenSPring began in Spring 2021 and will continue to Spring 2023. Over the last year we have been:

- Recruiting 'Green Advocates' who will help create support for the work at the grassroots level and will be a key route for informing social prescribers, community health staff and green providers to understand the referral processes and benefits of the nature-based wellbeing activities
- Seeking baseline information from Social Prescribing Link Workers (and other social prescribers) around current signposting to green opportunities
- Talking to providers of green social prescribing activities to find out what's working and what's not working so well, and any relevant information on the current experience of the system.

Where we are now:

We are initiating a network of green providers to understand the support required and willingness to participate and contribute to the development of an independent, mutually supportive network of green providers.

We are also evaluating our first round of testing following setting up delivery programmes in High Peak, City and South Derbyshire. Of these three pilots, only one programme ran due to lack of referrals, low numbers of participants, and unclear referral routes.

Next:

The next phase will be district/borough-level testing in all nine localities, with the approach tailored to each locality and informed by cross-sector intelligence of need and existing provision.

Beginning with three areas:

- Best practice modelling of an established green social prescribing activity. What can we learn to benefit other green providers in Derby City?
- How do green providers interact effectively and input strategically with the existing Local Authority and health partnership in South Derbyshire?
- How does a grassroots community network access and engage with local system structures and partnerships in Amber Valley?

Don't worry if you aren't from one of these areas! We will be running other testing activities in different areas across Derbyshire.

If you are a green provider or provide nature-based activities and want to know more, you can complete our survey here

If you are an individual with lived experience of mental health issues and would like to tell us of your experiences of using nature and green spaces to improve your wellbeing, please contact us at hello@greenspring.org.uk to be part of our focus group.

New Treatment Offered to Vulnerable Covid Patients in Derbyshire

Vulnerable patients in Derbyshire are being offered a new treatment by DHU Health Care to reduce the risk of complications for people with Covid-19.

Sotrovimab, a neutralising monoclonal antibody (nMAB), can be given to reduce the risk of serious illness that can arise amongst vulnerable people testing positive for Covid-19.

It's the first time the medication, provided at two DHU Health Care sites, has been widely offered to patients in Derbyshire.

Kirsty Osborn is Deputy Director for Urgent Care at DHU Health Care, she said: *"It's fantastic news for our patients and another weapon we have in the fight against this pandemic. We will use it for those patients returning a positive PCR test who have underlying health conditions that could put them at risk of hospital admission.*

"A member of our Urgent and Emergency Care Team will identify and contact patients who we feel meet that criteria and discuss the possibility of them being offered a treatment to enable them to make an informed choice. The treatment needs to be provided within 5 days of a positive PCR and symptoms. It's a significant step towards reducing the number of anticipated hospitalisations at a key time in the country's fight against Covid-19."

The treatment is currently being provided at DHU sites within Derby Urgent Treatment Centre and Ashgate Manor in Chesterfield, only by referral, following a positive PCR test. It is administered intravenously for antibody treatment and in tablet form as an antiviral medication.

Emma Harrison, from Chesterfield, has Crohns and Ulcerative Colitis, was shielding from Covid-19 during the various lockdowns and is immunosuppressed so can't build up her antibodies. She received the antibody treatment at Ashgate Manor after a positive PCR test.

Emma said: *"Because of my condition, my Specialist Nurse was kept informed in case I ever tested positive and developed symptoms. I was registered as a priority for this treatment, contacted very early to assess my suitability and booked in the following day for treatment.*

"Kirsty administered the treatment, and she was fantastic, she made it as comfortable and reassuring as possible, explaining exactly what was happening and what to do if I had any side effects. I did experience some sickness so contacted 111 who booked me an Out of Hours GP appointment very quickly. I was prescribed some anti-sickness tablets and that took care of my symptoms.

"There was the potential for me to be very ill with Covid and end up in the hospital due to my condition, but the symptoms subsided very quickly after this treatment. I have been vaccinated and boosted but this is another way of ensuring that I don't become seriously ill and I'm grateful that it's ready and available so quickly for people like me."

Kirsty added, *"This is not a substitute for vaccinations. We would still encourage everybody who hasn't already done so to book their vaccination as soon as possible. It remains the best way of putting up a barrier against Covid-19 for you and those around you. But for those who do become infected and are vulnerable, these treatments will help reduce symptoms, speed up recovery times and could mean fewer people are admitted to the hospital.*

"At DHU Health Care, we're proud once again to be working alongside NHS Derby and Derbyshire CCG, and other key system partners in playing a vital role in protecting the public and ensuring that we're doing our bit to help protect all resources within the NHS and the wider health community. By doing what we can to prevent serious illness, we reduce hospital admissions and help to alleviate the pressure on our NHS services at a critical time."

Dr Steve Lloyd, Executive Medical Director for NHS Derby and Derbyshire CCG added: *"The provision of nMABS and oral antivirals for the most clinically extremely vulnerable people in Derbyshire has been another shining example of our partnership approach to tackling the Covid-19 pandemic. In addition to the vaccination programme, patients now have a further line of defence against the virus, and we are pleased to be making such excellent progress with providing access to this medication for our population."*

East Midlands Ambulance Service (EMAS) secures volunteer charitable funding to improve local community services

East Midlands Ambulance Service has been successful in securing funding through two separate volunteer funding opportunities to support the expansion of existing and new volunteer initiatives across the region, including Derbyshire.

NHS England Funding – Supporting Winter Pressures

This funding will provide for the following three programmes:

1. Enhancement of Community First Responder (CFR) Volunteer Provision

Expansion of Community First Responder dispatch points and introduction of new schemes in communities most in need to enhance the Community First Responder volunteer function across the region. The main purpose of our volunteers is to attend emergency calls within their clinical scope of practice which include resuscitation, defibrillation, cardiac arrest, stroke, non-injury falls service, minor injury and other non-injury calls such as concern for welfare. CFR's can often arrive on the scene before an ambulance with the view to prevent unnecessary activations of EMAS crews.

2. Introduce Volunteer Community Resilience Trainer role (VCRT) to deliver a bystander CPR Community Programme

To recruit 30 dedicated volunteers for this role who will deliver a rolling bystander/mass citizen CPR training programme in all communities and support the placement of more public defibrillators, carry out and support CPR training, Community Public Access Defibrillator (CPAD) management, Community CPR Events, local NHS support initiatives (i.e., vaccine rollout programmes) and CPR education to secondary school PHSE leads.

For volunteers to educate members of the public and patients when it is right to call 999 and to signpost to other services in primary care when it is not a life-threatening emergency so our crews can get to the patients who vitally need us.

3. Introduce a Volunteer Operational Support Worker role (VOSW) to support front-line operational pressures

To support immediate front-line Accident & Emergency and Patient Transport Service operational and winter pressures at hospitals, support ambulance stations logistics and supplies and fleet (moving vehicles).

NHS Charities Together Funding

The funding from this charity will cover four programmes:

These initiatives will result in a measurable improvement in health outcomes for communities or services adversely affected by Covid-19; reducing hospital admissions by facilitating the right care in the right place; increasing the capacity of the current community response and providing direct support to the network of Community First Responders.

1. Starting eight new Community First Responder (CFR) schemes in currently under-served areas in the East Midlands.

2. Providing 14 new Community First Responder fully electric multi-capability cars which include a falls response service to speed up community response to patients in remote locations.

3. Introducing 90 new Community Public Access Defibrillators (CPADs) predominantly in rural overlooked communities and under-served areas where there are above average occurrences of chest pain, hypertension, and sudden cardiac arrest.

4. Providing state of the art equipment for our Volunteer Doctor Critical Care Car to provide an enhanced critical care response to patients requiring support across the East Midlands. The car would be an additional resource to enable more people to be treated and would be used for training new volunteer doctors.

Healthcare evidence and knowledge are now a simple search away

NHS professionals make millions of health and care decisions every single day. The challenge of ensuring these decisions are based on the latest insight married with decades of evidence and research is being met head-on with the arrival of a brand-new online search.

The Health Education England funded NHS Knowledge and Library Hub brings together a vast range of databases, journals, NICE guidance, and other support tools in one place. Designed to give quick and easy access through a secure online platform, we hope this will help practitioners, trainees and students with their professional development and evidence-based care.

It's particularly useful for students on health-related courses (medicine, nursing, dentistry, allied health professions) who go on placement in NHS Trusts. Content of the easy-to-use platform includes:

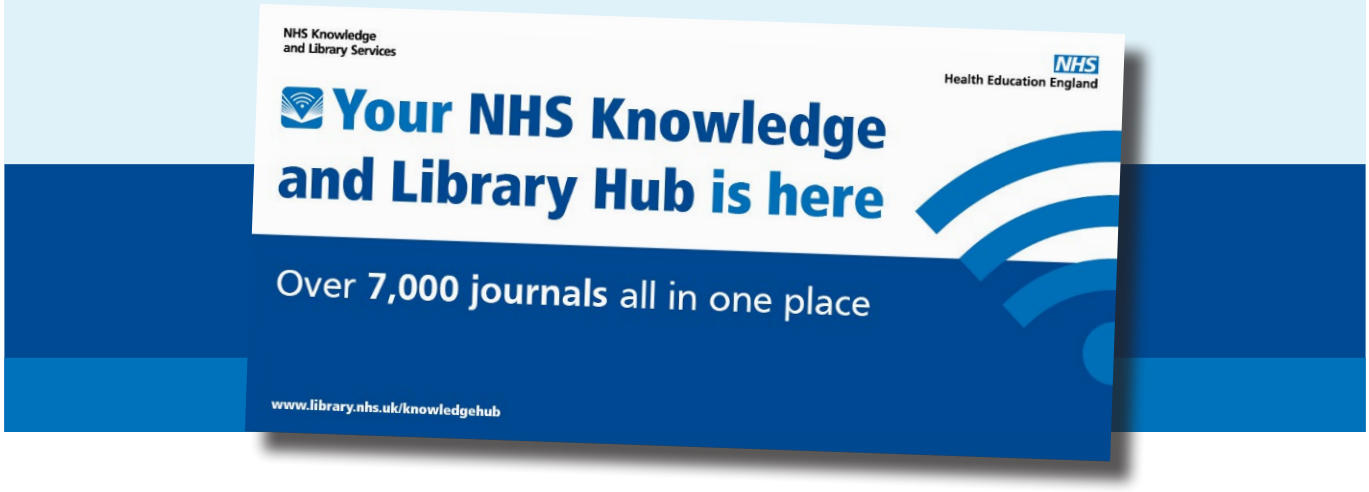
- Over 7,000 journals
- Books and e-publications, including OUP handbooks
- One-click access to full-text, request a copy or contact an NHS library
- Clinical decision support tools such as BMJ Best Practice
- NICE pathways and guidelines
- Databases like Medline, EMBASE, CINAHL and PsycInfo.

Streamlining the search for knowledge means that professionals only need to look in one place, rather than scouring multiple resources to find answers to the questions they face.

Offering an intuitive search experience for both quick and in-depth study, the Hub provides access to nationally and locally funded knowledge and evidence resources. It is also anticipated that content will grow significantly and at pace from launch.

The Hub provides free access to all the HEE core content. This means that, once they have signed in, users can tap into the same system wherever their placements and future career takes them.

Start your search here.



Non-Executive Members appointed to new NHS Board

Four local people have been appointed as Non-Executive Members Designate of the new NHS Integrated Care Board (ICB) for Derby and Derbyshire. Acting as independent members of the new board, the roles will help shape the long-term plan for the local NHS.

The NHS Derby and Derbyshire ICB, due to be established on 1 July 2022, will be the NHS organisation with responsibility for planning to meet local health needs, allocating resources, ensuring that services are in place to deliver against ambitions, and overseeing the delivery of improved outcomes for their population. Tackling inequalities in health outcomes, the ICB will be part of the Joined Up Care Derbyshire Integrated Care health and care system, continuing to work with partners in local authority, the voluntary sector and others, helping the NHS to support broader social and economic development.

To view further details, click here.

Health and wellbeing at the touch of a button

Did you know you can get quality assured health and wellbeing apps at the touch of a button?

Derbyshire County Council is working with Orcha - The Organisation for the Review of Care and Health Applications - to provide an online library of digital health and wellbeing support.

From support for long-term health conditions to apps that can help you to stop smoking, sleep better and improve your mood, there are 100s to choose from.

Each app has been assessed against a wide range of criteria including clinical assurance, ease of use and data protection.

Click here to search and download apps.

Contact Joined Up Care Derbyshire

Visit the website: joinedupcarederbyshire.co.uk
Email: joinedupcarederbyshire@nhs.net

If you would like to sign-up to receive the Joined Up Care Derbyshire newsletter, please email karen.lloyd24@nhs.net

If you would like to know how you can get involved click here.

Joined Up Care Derbyshire
DERBYSHIRE County Council
NHS
Derby City Council