PERSONALISED CARE SHOWCASE Q3 2025

Nottingham City General Practice Alliance

CONTENTS

MIKE CROWE

Mike Crowe

CLINICAL DIRECTOR
BESTWOOD AND SHERWOOD PCN

Spring is in the air, finally, after what seems to have been a particularly long winter. As the days become a little brighter, I have been considering the changes and growth in our healthcare communities. We have many opportunities to nurture budding reform in our patch, as well as across the NHS and wider care system. The Personalised Care Team roles and the development of the Neighbourhood Health Service are emblematic of fresh direction.

Neighbourhood initiatives are fundamental to public health and, as we well know, it is not enough merely to keep up as our communities evolve. We have a responsibility to embrace reform daily as it evolves with our patients, and to prepare for the coming seasons.

Current NHS policy emphasises change along three main areas:

- **From hospital to community** – Providing better care close to, or in, people's homes, helping them to maintain their independence for as long as possible and only using hospitals when it is clinically necessary.
- **From treatment to prevention –** Promoting health literacy, supporting early intervention and reducing health deterioration or avoidable exacerbation of ill health.
- **From analogue to digital** – Greater use of digital infrastructure and solutions to improve care.

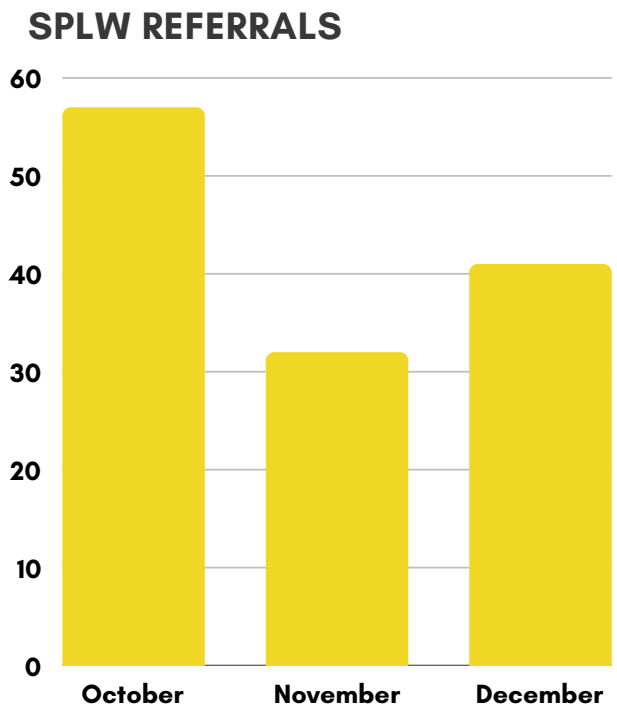
Community-focused care, public health and illness prevention are inherent to these initiatives. For example, around one in five GP appointments are not strictly medical, with patients presenting with loneliness, housing and debts concerns, and all the pressures of society. The Personalised Care Team is already making meaningful changes at local level, to support and promote success of the NHS policies.

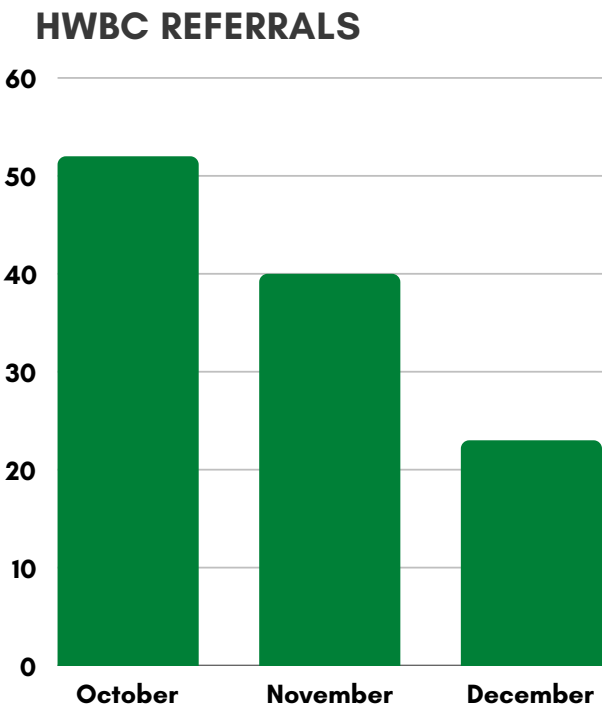
- In the **community** our colleagues have been working proactively to improve care for frail patients; and to make dementia reviews more accessible and easier to navigate for patients and families.
- Focussing on **prevention**, our community hub, the cardiovascular prevention programme, the concerted team support for cancer screening and flu vaccination is resulting in greater uptake.
- The **digital** inclusion course was entirely devised by the team. It proved popular in helping patients learn how to use tech to access health services. Digital and technological advancement happens at pace. There is clear eagerness to bring our organisations up to the standards we expect from our own personal tech/IT.

It takes patience to plant the seeds of change and tend to them until they take root. We are indisputably overworked, and can feel undervalued sometimes. In these moments it can be challenging to recognise the fruits of our labour. Our teams have a real and significant impact not only in our own communities and neighbourhoods, but for the public health of the country. I am so proud of the innovation and dedication of the Personalised Care Team, the values and commitment to reform in my own network and across our region.

BULWELL & TOP VALLEY

Bulwell & Top Valley
PRIMARY CARE NETWORK





Social Prescribing Case Study

The patient, who previously experienced homelessness, has been staying with his brother and sister-in-law but wants to live independently due to mobility issues, partial deafness, and feeling low after recent falls and isolation. His living situation was difficult, as his family was unkind, limiting his access to food, heating, and mobility aids. Although he reconnected with his estranged daughter, who helped by preparing meals, he often went hungry as others in the household took his food. Support from Social Prescribing made a big difference, connecting him with services like Adult Social Care for mobility support, discounted transport, housing assistance for a suitable home, and the Red Cross for equipment advice.

Patient said:

"Jane helped me feel like a human being, she had lots of patience and is very supportive."

The patient has received additional support, including access to a community centre for hot meals and social activities, a new walking stick and sight badge, and help from a community protection officer. A social worker is actively securing a local flat for him, and he now receives pension credit, increasing his income by £305 per month. Nottingham City Council is assisting with white goods for his new home, with manageable repayment options. His daughter has been helping with paperwork, packing, and setting up his home. He is also attending life skills courses on budgeting and cooking, improving his independence, well-being, and social connections.

Bulwell & Top Valley

PRIMARY CARE NETWORK

THE BOCCIA PROJECT

This project was ran by the Health and Wellbeing team in November and December 2024. This has been renewed thanks to funding from the Get Out, Get Active project.

The PCN 1 Health and Wellbeing team will be identifying patients from their caseload and Social Prescribing caseload who would like to engage in inclusive sport but have faced barriers preventing participation. A new cohort will be formed to start in early March.

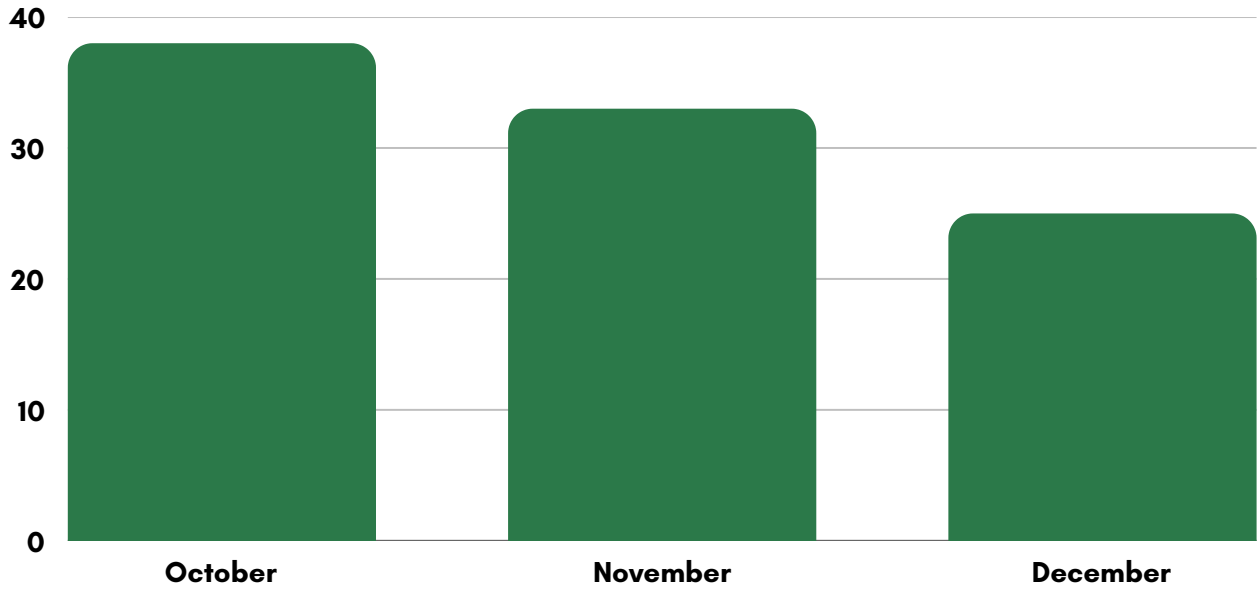
In addition to this success, there is now a commitment to establishing a regular Boccia group at Ken Martin Leisure Centre, starting in the spring/summer. As a service, they have also created inclusive materials, including an easy-read leaflet and booklet.

INTERNATIONAL DAY OF PERSONS WITH DISABILITIES

On 17th December, PCN 1 held an event in support of 'International Day of Persons with Disabilities'. On the day, 15 health checks where completed.

A range of services attended, providing information and support.

BESTWOOD & SHERWOOD



Social Prescribing Case Study

A 58-year-old woman was referred to the Social Prescribing team with mental health and housing issues. She was self-harming and using alcohol. The patient was also under secondary mental health care. The patient felt isolated but was reluctant to socialise. Her housing was unsuitable due to poor mobility.

The SPLW team collaborated with Homelink and supported her in attending social groups, though she hesitated to go alone. They engaged the Framework stabilisation team for additional support and provided brief alcohol interventions. She was referred to the Adult Social Care reablement team and assigned a support worker.

Patient said:

"The SPLW team was such a good service, she had not heard of it before and felt everyone needs to know about it"

Upon discharge, she praised social prescribing, wished more people knew about it, and reported stopping drinking.

Community Health and Wellbeing Hub

This hub is coordinated by Bestwood and Sherwood care coordination team and showcases the collaboration between the PCN, practice teams, patient volunteers and community partners.

In October's Wellbeing Hub the PCN successfully engaged 98 patients. This resulted in 325 patient conversations with 25% of them consenting to direct referrals into internal and external services.

53% of patients were also signposted to additional support pathways, demonstrating the program's significant and sustained impact and success.

Community Health and Wellbeing Hub wins PMA Award!

In October the Community Health and Wellbeing Hub for patients in Bestwood and Sherwood has won the 'Innovation in General Practice 2024' category at the 2024 PMA Awards!

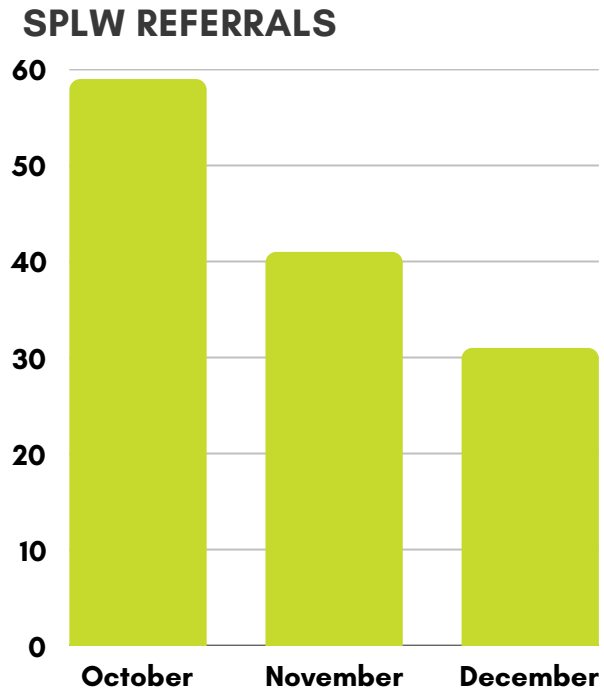
Digital Literacy Programme

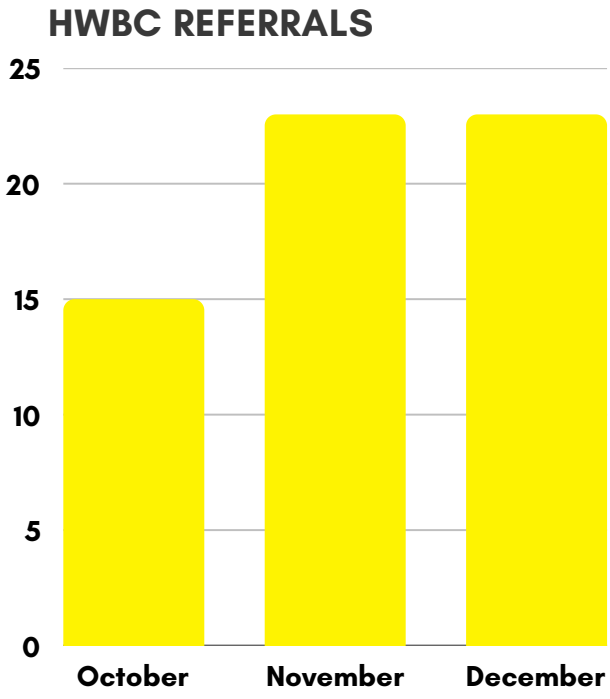
The Personalised Care Team successfully completed a **Digital Literacy Programme** for Sherwood Rise Medical Centre patients.

Key outcomes:

- NHS App Adoption: 86% registered and can now access NHS services independently.
- Email Usage: 100% now have an active email.
- Online Appointments: 57% initially unsure can now book confidently.
- Social Media Awareness: 100% improved understanding of its impact on health.
- Online Safety: 100% demonstrated better online safety knowledge.

NOTTINGHAM CITY EAST





Coffee Morning Case Study

Patient aged 64 struggled to socialise and make new friends, he was a regular visitor to his Surgery and spent most of his time at home alone.

Initially he found it very difficult to commit to attending any social groups or activity due to fear and anxiety. A face-to-face appointment was arranged at the surgery and at this meeting he committed to attending the weekly coffee morning the following week.

Patient said:

"He felt welcomed by the group, the environment was relaxed and he enjoyed the quiz!"

The patient now feels comfortable attending on his own and attends every week! He socialises with other and gets involved in the activities. He continues to develop his confidence and is now looking at attending other social groups

WEEKLY COFFEE MORNING

Community Hub Sneinton

Nottingham East PCN's weekly coffee morning has been running for two years. During the past year, they have welcomed approximately **80** people to the coffee mornings and have around **20** regular attendees.
On 17th December they hosted their annual Christmas Social. They provided a light buffet, games, crafts and a quiz.

The weekly coffee morning continues to make a difference to PCN 6 patients and the community by:

- Addressing social isolation.
- Providing a warm space.
- Opportunity to make new friends.
- Having direct access to Social Prescribing Link Workers, Health and Wellbeing Coaches and the Financial Social Prescriber.
- Getting the brain cells working with the quiz.

PCN 6 POOL EVENT

PCN 6 pool event has experienced significant growth since its inception, expanding from a small group of 4 participants to a consistent attendance of 12-14 people per session. Throughout this journey, their has been remarkable personal and social development among the regular attendees.

Participant Growth and Development

Mark's journey

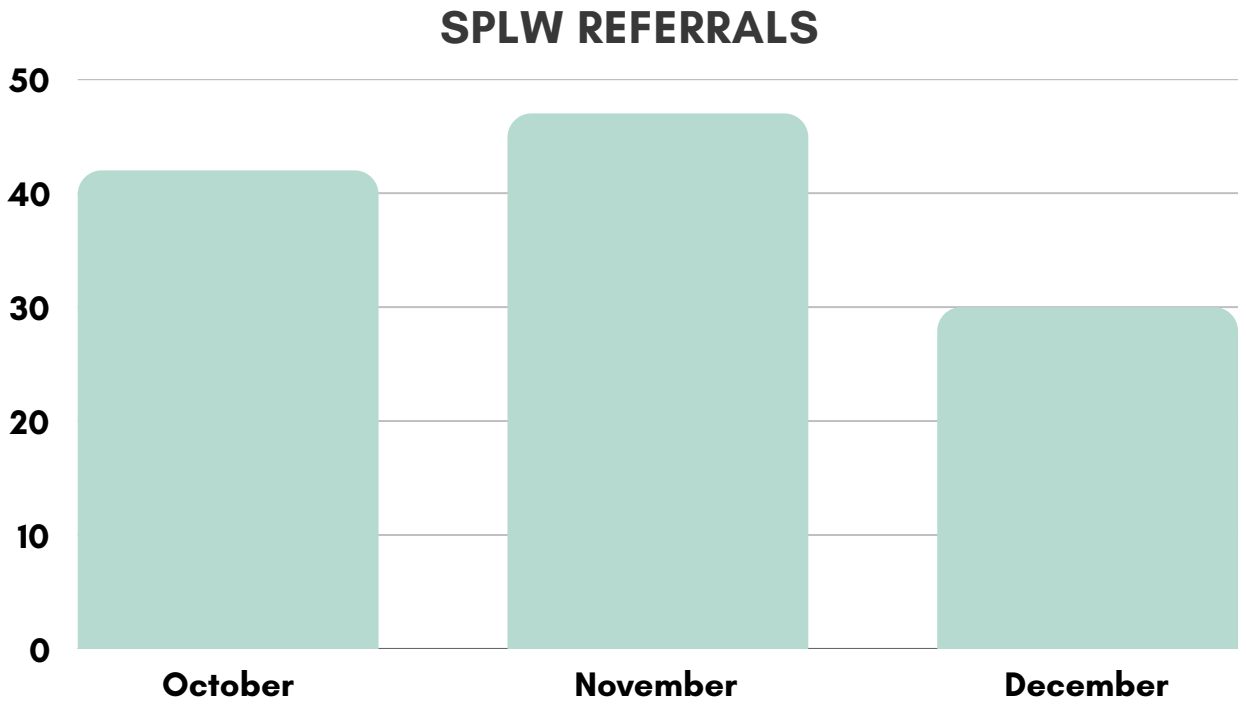
Mark first attended Riley's with his social worker before joining our group a few weeks into the programme. Since then, he has become a regular attendee, showing improved mood and confidence. Mark has expressed gratitude for the staff and the event, highlighting the importance of practising social skills and being part of a supportive community in his personal growth

Judah's transformation

Judah was referred to the pool event by Futures as a way to enhance his social skills. Initially, he was very reserved and unfamiliar with the game of pool. However, with encouragement and guidance from the staff, Judah gradually built his confidence. Over time, he became more engaged and is now an integral part of the group, never missing a session since he joined.

CITY SOUTH

City South PCN 7



Social Prescribing Case Study

A 61-year-old woman living alone with her dog, was referred to the Social Prescribing Link Worker (SPLW) by her GP due to multiple ongoing health issues, low mood, and social isolation following a recent family bereavement and years of physical and mental pain. Although her health conditions were being supported by various services, delays and unclear waiting times caused her significant frustration and anxiety. The patient had become socially isolated, rarely leaving her home or engaging with others.

Patient said:

'Thank you for helping me to sort out the health programmes. I am looking forward to starting them which I hope will also reduce my anxiety.'

The SPLW provided emotional and practical support by assisting her with navigating referrals, contacting organisations, and finding social activities. This intervention helped the patient secure a place in a 12-week support program after her referral had been lost and facilitated the start of her remote CBT for PTSD through Talking Therapies.

Additionally, the SPLW supported her with a discretionary housing payment application, provided information on independent living options, and signposted her to the Law Centre for PIP tribunal assistance. By helping her connect with relevant services and encouraging her to engage socially, the SPLW's support improved the patient's confidence and provided hope for better management of her mental and physical health.

City South

PCN 7

SOCIAL PRESCRIBING HUBS

City South social prescribers have recently started their own community hubs at Grange Farm Medical Practice.
Their aim is to support patients with holistic needs such as social isolation, housing queries, finance, and health and wellbeing.
Each month will have a different focus, and they will also be inviting other services to collaborate with them.

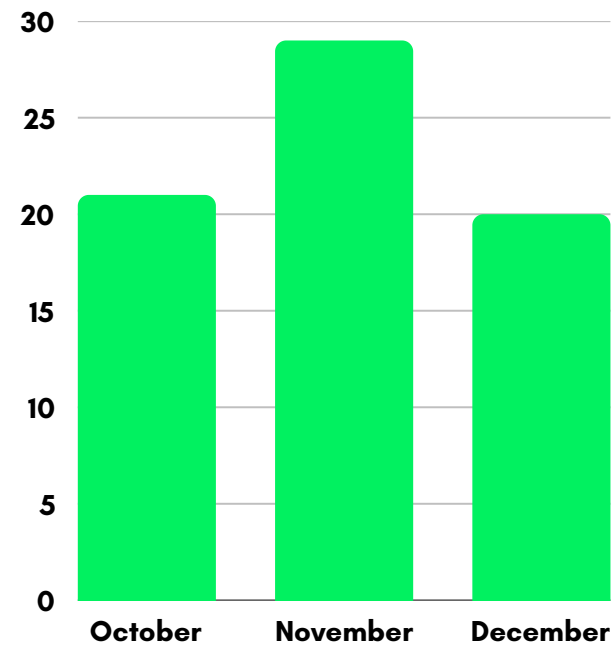
DEMENTIA REVIEWS

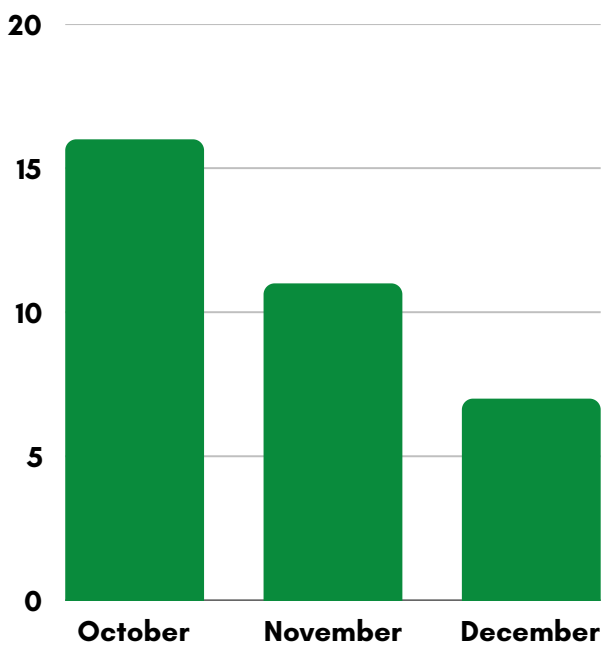
The Social prescribers are now supporting all practices in the PCN with dementia reviews. The team are enjoying supporting these patients, and it is working well with the Social Prescribing interventions.

Dementia Reviews Completed:

Oct	Nov	Dec
17	13	11

CLIFTON & MEADOWS





Social Prescribing Case Study

A patient was referred to the Social Prescribing Link Workers who was struggling with low income and needed support with his finances and priority debts.

The SPLW supported him by referring him to the food bank and secured an appointment at Citizens Advice for debt management.

He felt supported and had peace of mind over his situation.

Patient said:

"I am so grateful for the support my social prescriber has given me, she really took the time to listen"

COFFEE MORNING

The Social Prescribers for Clifton and Meadows regularly have up to 29 people coming to their coffee mornings every week to either join in on Nick's exercise class or sit down and chill with some knitting, colouring and a cup of tea.

They have had lots of visitors recently, including colleagues from other PCN's who came to get some inspiration for their networks, visits from the local firemen to give out basic first aid training and a special visit from an African drum teacher.

The local fire department attended and gave a course on CPR and fire safety. They joined in with Nick's exercise class and joined in for a game or two of dominoes.

WOMEN'S MONTHLY MENOPAUSE GROUP

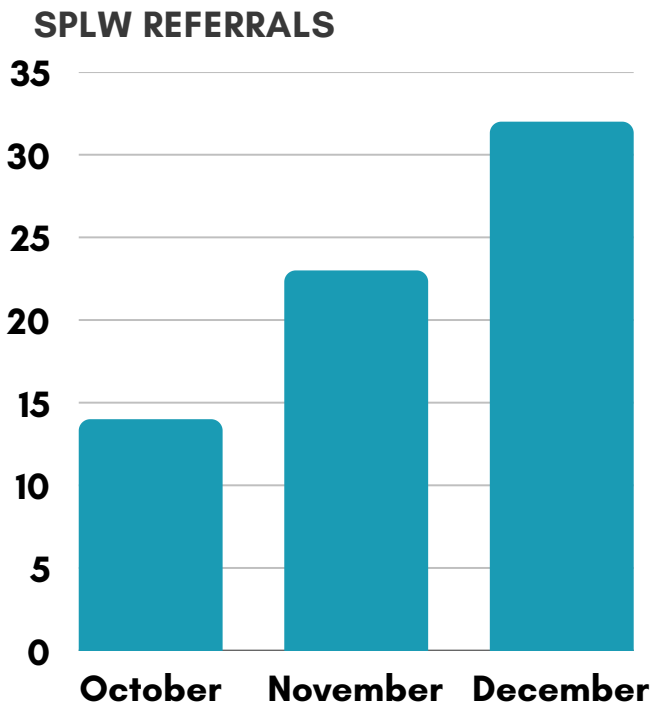
The personalised care roles for PCN 8 hosted monthly menopause sessions, each with a specific theme. These sessions featured mindfulness practices during menopause, diet and nutrition exercises, and outings to the Green Gyms. These sessions concluded in December. Below is some feedback they received.

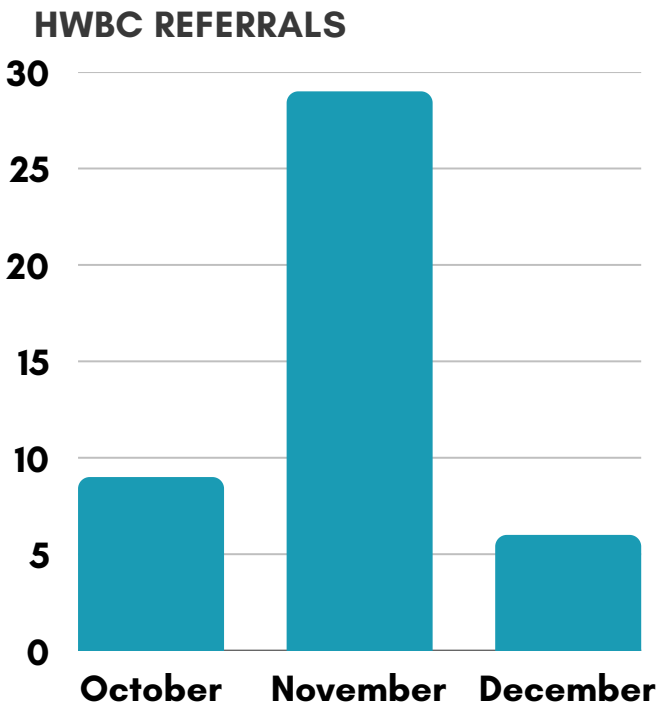
"It has been great getting to meet people who are experiencing the same things as you are"

"It was brilliant!"

"We have received some really valuable support and information"

ASPIRE





Health and Wellbeing Case Study

A patient with a low income faced challenges accessing health resources while managing hypertension and frequent body pain. She aimed to lose weight and improve blood pressure control but needed structured support.

Health and Wellbeing Coaches (HWBC) invited her to a six-week workshop on hypertension, obesity, and anxiety, providing essential health management knowledge. She then received 12 weeks of continued support, which helped her stay motivated and adopt positive lifestyle changes. She also won a free three-month gym membership, removing financial barriers to exercise.

As a result, she lost over 3kg, became more mindful of her eating habits, and significantly improved her mental wellbeing.

Patient said:

"Patient reports feeling much more motivated to continue her health journey"

6 WEEK HYPERTENSION, OBESITY AND ANXIETY SEMINAR

This six week workshop was designed to provide participants with knowledge and practical strategies to manage hypertension, obesity, and anxiety through lifestyle modifications. The sessions covered topics such as nutrition, exercise, stress management, goal setting, and the impact of smoking and alcohol on health.

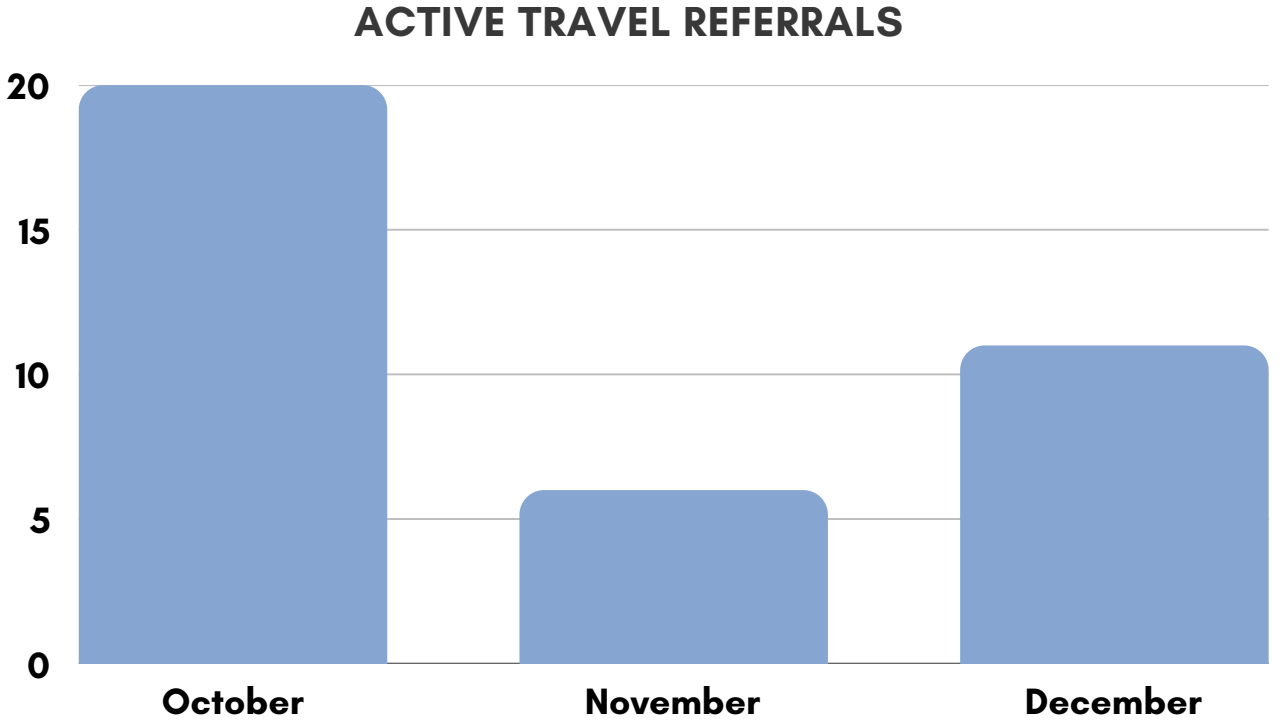
The aim was to equip participants with the tools and support needed to make sustainable changes that improve their overall health and wellbeing. This workshop aims to empower individuals with tools to manage these interconnected conditions through sustainable lifestyle modifications.

The workshop successfully provided participants with practical tools and alongside success in education to improve their health. While challenges like maintaining motivation were present, the majority of participants showed progress in managing their conditions. We showed significant improvements in patients mental wellbeing scores alongside increases in motivation to adopt healthy lifestyle changes to improve upon disease management.

Patient from the workshop said:

"After going to the workshop sessions, I won a three month gym pass. This helped me use what I learned in a practical way. Now, I go to fitness classes all the time and focus on eating better and improving my mental health. It's fun! And I've lost 3kg! I would recommend this workshop to anyone—not just for the chance to receive a gym pass, but for the high-quality information on managing my hypertension in different ways."

ACTIVE TRAVEL



Active Travel Case Study

A patient who had been struggling with isolation and anxiety remained at home, afraid to go out due to a lack of confidence. This isolation had a impact on her mental health and overall wellbeing.

Through a one-to-one active travel buddy support program, she was paired with a walker leader who carefully planned a suitable route, picked her up, and walked her back home. They walked at a comfortable pace, engaging in meaningful conversations in a relaxed and supportive environment.

The leader ensured she felt safe and encouraged throughout the journey. After just two walks, she gained the confidence to step outside on her own and she successfully applied for and secured a new job, marking a significant milestone in her personal growth.

Patient said:

"The one-to-one buddy walks played a crucial role in reducing her anxiety and improving her mental health."

COMMUNITY WELLBEING WALK

The Active Travel Team conducted a wellbeing walk in Nottingham City East PCN to support the Community Health Hub event on the 21st October 2024 from The Cherry Lodge to the St Ann's Advise Centre.

The walk provided a great opportunity for participants to engage in light physical activity to support mental and physical wellbeing, connect with others in the community in a relaxed setting and learn about the benefits of active travel and accessible routes. With an incredible turnout, the event showcased the power of walking as a simple yet effective way to enhance overall health and wellbeing.

VOLUNTEER WALK LEADER TRAINING WORKSHOP

The Volunteer Walk Leader Training Workshop, held on 20 November 2024, brought together volunteers from diverse backgrounds, including community organisations and individuals interested in leading community walks in their neighbourhoods.

The workshop provided training on conducting safe and effective health and wellbeing walks, helping people reconnect with walking to reduce social isolation and improve their mental, emotional, and physical health. It covered all essential aspects that a Volunteer Walk Leader would expect in terms of quality and content, equipping them with the skills, knowledge, and confidence to lead guided walks in local neighbourhood settings.
This workshop will hopefully encourage more volunteers to lead community walks, fostering healthier and more connected communities