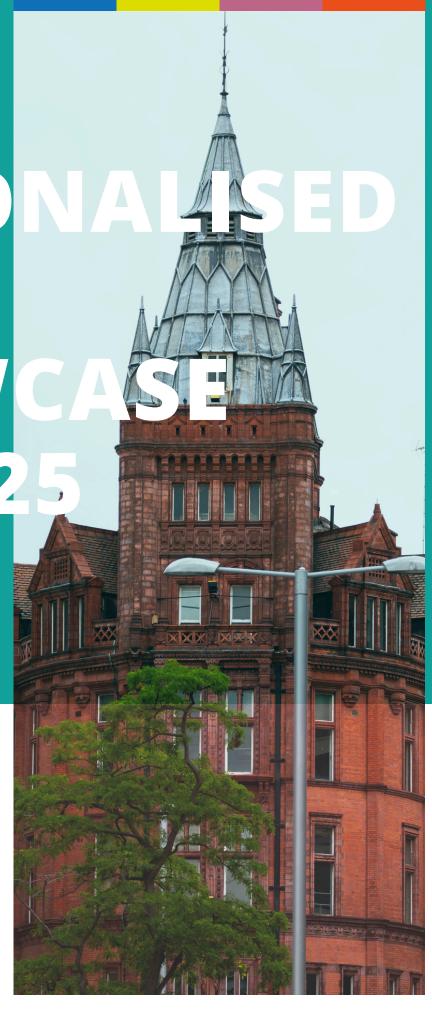


PERSO NO CARE
SHOW CARE
Q4 2025



Nottingham City General Practice Alliance



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# MELANIE PINNOCK

I'm Mel, a Social Prescribing Link Worker for Clifton & Meadows PCN, supporting patients to reconnect with their community and find hope beyond the traditional clinic walls. What drives me every day is seeing how social prescribing can transform lives, not just by addressing medical symptoms, but by tackling the loneliness, stress, and practical struggles that weigh people down.

Many patients I meet feel invisible, overwhelmed by challenges like isolation, mental health struggles, or housing worries — issues that medicine alone can't fix. Social prescribing gives them a lifeline; a trusted space to be heard, and a path to meaningful activities and support that can help with purpose and connection. I've seen people go from feeling lost and alone to finding new friendships, confidence, and a reason to get out of bed in the morning.



#### **Melanie Pinnock**

SOCIAL PRESCRIBING LINK WORKER
CLIFTON AND MEADOWS PCN



Working in Clifton & Meadows PCN, I'm privileged to serve a diverse community where pockets of deprivation mean these needs are urgent. Clifton's green spaces like Clifton Grove offer calm and wellbeing, while The Meadows, with its strong community spirit and accessible transport, provides vital hubs for support. Our team runs weekly exercise groups, craft sessions, coffee mornings, and drop-ins at places like the Salvation Army and Hope Centre, creating safe spaces where people can rebuild their lives.

One patient told me how a simple invitation to a craft group helped her overcome crippling anxiety and rediscover joy. Another found warmth and dignity through our winter support programme when heating bills felt impossible. These moments remind me that social prescribing is about more than signposting, it's about walking alongside people through their toughest times, helping them reclaim control and hope.

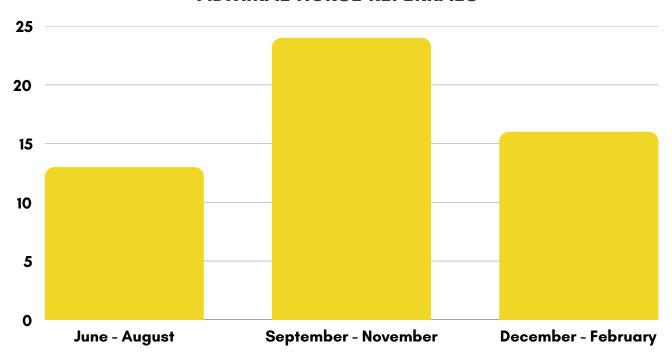
The impact can be very deep for me as a social prescriber and people we are helping: social prescribing complements clinical care by addressing the social and emotional roots of ill health. It's about healing the whole person, not just treating symptoms. In Clifton & Meadows, I'm proud to be part of a change in approach that restores connection, reduces health inequalities, and changes lives for the better—one conversation at a time.

I hope you enjoy the showcase, and the great work my colleagues are delivering across the city.

# BULWELL & TOP VALLEY



#### ADMIRAL NURSE REFERRALS



### **Admiral Nurse Service**

As dementia specialists, admiral nurses help families manage complex needs, considering the person living with dementia and the people around them. They provide information, advice and emotional support to families affected by dementia.

Complex needs may include issues such as the carer struggling to cope, complex family dynamics, high level of distress, changes in the presentation of the person with dementia, complex decision making, comorbidities and end of life.

The Bulwell and Top Valley PCN
Service went live in October 2023.

**Dementia**UK



# Bulwell and Top Valley Admiral Nurse

Between December 2024 and February 2025 the admiral nurse has had a huge impact for the PCN:

- 418 clinical contacts made.
- 959 clinical interventions delivered.
- Helping to **reduce** carer stress.
- Strong GP engagement and multidisciplinary liaison.
- Complex case management.

### Feedback on the service

"The admiral nurse has helped me with my health problems, and mental health especially. I found I was no longer able to cope with my wife's Alzheimer's and became depressed. She helped me to get the right help and steered me through the process of seeking care for my wife, and ultimately, going into permanent care for her. Her support has been invaluable."

- Carer

"She has been anchor for me in a storm of emotions, reassurance what I am experiencing is normal when dealing with someone who has dementia. She has reminded me I need look after myself as well, she has taken time to listen to me and made suggestions that may help dealing with certain situations. Personally, I don't know how I would've handled the last few months without her." - Carer

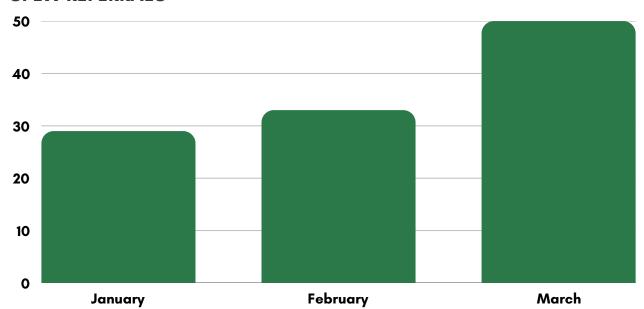
#### **Dementia Action Week**

This event, scheduled for 19 May, aims to raise awareness about dementia, including its modifiable risk factors, common signs and symptoms, and the support available through the admiral nurse service. It will also involve participation in health and wellbeing events to promote understanding of dementia and highlight the important role of admiral nurses in supporting those affected.

# BESTWOOD & SHERWOOD



#### SPLW REFERRALS



## **Social Prescribing Case Study**

An 82 year old woman, previously a full time carer for her late husband, experienced significant anxiety, low mood, and mobility challenges following his death, leading to isolation and a loss of independence. Physical health issues, including a weak heart and osteoarthritis, compounded her difficulties, while her reluctance to accept support equipment limited her daily functioning.

Patient said:

With the help of a social prescribing link worker (SPLW) and the Integrated Reablement Service, she received mobility aids, began doing regular supported walks, and gradually regained confidence, eventually achieving her goal of walking independently to the local shop. She also secured higher rate of Attendance Allowance, enabling her to fund practical help and transport, easing her son's caregiving burden and allowing for quality time together.

"I am thrilled to bits with the help given to me by my social prescriber. I am so happy with how things have changed."

With additional support, including digital assistance from AbilityNet, she now manages her finances via a new smartphone, reconnects with friends, and participates more actively in her community. The intervention significantly improved her physical and mental health, restored independence, and enhanced her social wellbeing.





# January Health and Wellbeing Hub

January 2025 Community Health and Wellbeing Hub was attended by a staggering **100** patients!







14 organisations attended to provide information, advice and support on a wide range of healthcare and wellbeing topics.

In total they captured a total of **334** conversations with patients, 58 patients were signposted to alternative organisations for specific support and they made 28 direct referrals/follow ups into their services from the event!

### Better Off Together (beyond the referral)

Our Better Off Together (BOT) sessions continue to thrive, with an average of 11 participants joining each week. These friendly, informal gatherings offer ongoing support beyond social prescribing, giving attendees the chance to reconnect with a social prescribing link worker, share experiences, and build new friendships.

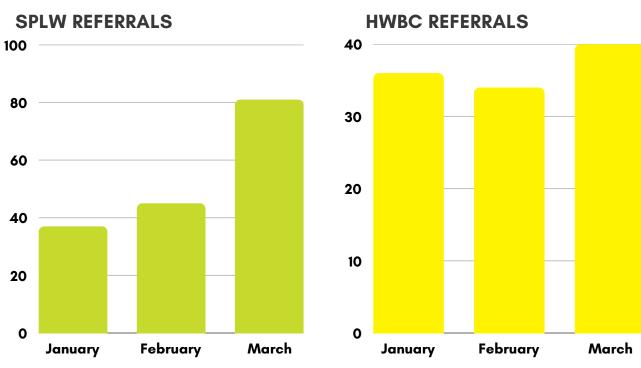


BOT has become a valued space where people feel supported, connected, and empowered. A recent highlight was a session led by the DESMONDS service (Diabetes Education and Self Management), focusing on health, wellbeing, and local service was so well received that he'll be returning soon with a talk on nutrition and basic health checks, in response to popular demand.

As BOT continues to grow, we remain committed to creating inclusive, welcoming spaces that help people stay engaged, informed, and involved in their community.

# NOTTINGHAM CITY EAST





## **Social Prescribing Case Study**

A patient, aged 50, was referred to social prescribing due to experiencing feelings of loneliness and isolation. During the initial conversation, the patient shared an interest in participating in group activities, particularly those involving gardening. After exploring suitable options, they were referred to a local gardening project at the St Ann's allotments. At first, the patient was reluctant to attend alone, so a direct introduction was arranged with the project manager to provide a warm welcome and ease any anxieties.

Patient said:

"Thank you for all your help!"

This support helped the patient feel more comfortable and confident about attending. Since then, the patient has begun attending the allotment group weekly on their own and has made several new friends. Over the course of the six week intervention, the patient experienced a noticeable improvement in their mood, confidence, and general mental wellbeing. They have become more socially engaged, and they are going out more often, and report no longer feeling isolated.





Empowering patients through lifestyle support and education Nottingham City East 'Living Well with Diabetes' group is a six week course designed to support patients who have recently been diagnosed with type 2 diabetes.

The programme focuses on helping individuals understand their condition and make sustainable lifestyle changes to improve their overall health and wellbeing. Sessions are delivered by the PCN 6 team of health and wellbeing coaches, alongside Dr Hughes, a GP with a special interest in lifestyle medicine. Together, they provide a supportive and informative environment where patients can learn practical tools to manage their diabetes with confidence.



The response to the programme has been overwhelmingly positive, with patients reporting improvements in their physical health, mental wellbeing, confidence, and social connection.

"Since starting the wellbeing class, I have felt much better both physically and mentally. The classes have given me more confidence and a purpose to get out and meet people."

> "I enjoyed the wellbeing group even though I joined partway through. I especially liked the relaxation activities and discussions about food and nutrition."

"The sessions helped my arthritis by maintaining flexibility with exercise. The advice I received has made it easier to live independently. I'm grateful for the support it's made a real difference."

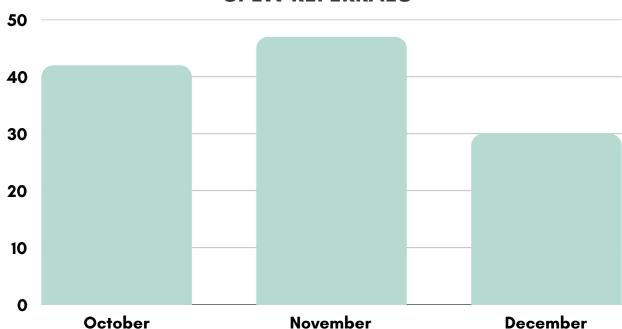
> "The exercises helped with my osteoarthritis. I've even started using the meditation techniques at home. These sessions were a real benefit to both my mental and physical health."

"Attending the group helped" me get out of the house and socialise. After each session I felt less anxious, and it became easier to come back each week. I'd love the sessions to continue and include some anxiety techniques."

# CITY SOUTH



#### **SPLW REFERRALS**



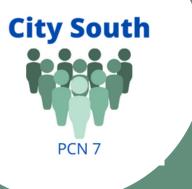
## **Social Prescribing Case Study**

The social prescribers first met the patient through a cancer care review, where it became clear that he was facing financial difficulties, experiencing low mood, and struggling with social isolation. As he was actively seeking employment but finding the process disheartening due to limited success, he was referred to the social prescribing service for additional support. The patient expressed a strong desire to return to work to improve both his financial situation and his social engagement, though he required a role that wasn't too physically demanding due to the lasting effects of his cancer treatment.

Through the social prescribing intervention, he was referred to Working Well East Midlands for employment support and is now in the final stages of several job interviews, meeting with the service weekly. He was also referred to Beyond Diagnoses for a benefits review to address financial concerns. Additionally, he attended the Winter Warmth event, where he received a free winter warmth pack and engaged with various services and attendees. There, he connected with SFICE and showed interest in volunteering at their soup kitchen. He has since begun volunteering, which he finds fulfilling and beneficial both socially and emotionally.

Patient said:

"Very
professional staff
member, thank
you so much for
your support."







City South PCN won funding this year from the city council to provide support for patients living in fuel poverty. This funding allowed them to put on three warm spaces around the PCN, provide patients with a hot meal, drink and if they qualified, they were able to give them a free winter warmth item such as an air fryer, slow cooker or electric blanket.

The social prescriber's also collaborated with multiple local services such as Thriving, Sfice, Green Doctor and Radford Care Group. These events also identified many patients who needed onward social prescribing support.

#### DEMENTIA AND CANCER CARE REVIEWS

The social prescribers have now completed the dementia reviews for two of their practices' patients, which is a big achievement. They have also started the cancer care reviews for their practices. The team are enjoying supporting these patients.

#### Dementia reviews completed:

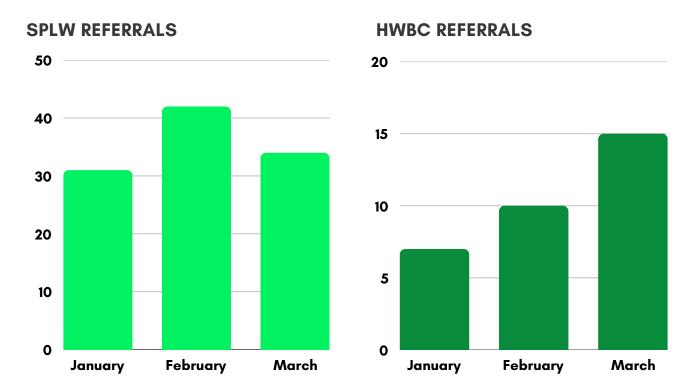
Jan	Feb
12	13

#### Cancer care reviews completed:

Jan	Feb Marcl	
10	12	20

# CLIFTON & MEADOWS





## **Social Prescribing Case Study**

A patient was referred into the social prescribing service as they are experiencing significant stress and burnout due to caring for his son, who has a rare genetic condition and complex needs. His wife is currently a student, placing most family and home responsibilities on him. The difficult transition of his son to a special needs school further exacerbated the strain. As a result, the patient had to take time off work due to extreme stress, though his employer has been supportive.

The social prescribers has help the patient by referring them to Notts Talk, where he began an online CBT course through Silverline, which he found helpful as the course was online and he will always have the material to read again. He has also been connected with Angelman UK for additional support.





On March 19, 2025, PCN 8 Clifton and Meadows proudly hosted an inspiring event at the Queens Walk Community Centre in honour of Social Prescribing Day. With **98** patients attending, this special occasion highlighted the incredible impact of neighbourhood integrated working, demonstrating how it effectively unites services and the community to foster health, wellbeing, and holistic support.

The afternoon was filled with engaging activities, information, discussions, and opportunities to learn about the various services available in our neighbourhood, all aimed at enhancing the quality of life for residents. From health checks to volunteering, the event showcased the power of collaboration in addressing the diverse needs of our community.

Thank you to all who attended and contributed to making this event a success. Together, we are building a healthier, more connected community!

## **PCN 8 WINTER SUPPORT**

Thanks to a Winter Support Grant, the PCN 8 personalised care team launched a practical and compassionate response to help Clifton and Meadows residents in the winter. They identified high risk patients and sign posted them to a weekly drop in sessions which were held at the PCN 8 practices or a coffee morning. Patients then could speak with social prescribers about their needs.

#### **Impact**

- **53** patients received warm clothing items.
- **43** patients were also given energy efficient products.

For patients who couldn't attend in person were called, assessed, and had items dropped off at home — with guidance on how to use them if needed.

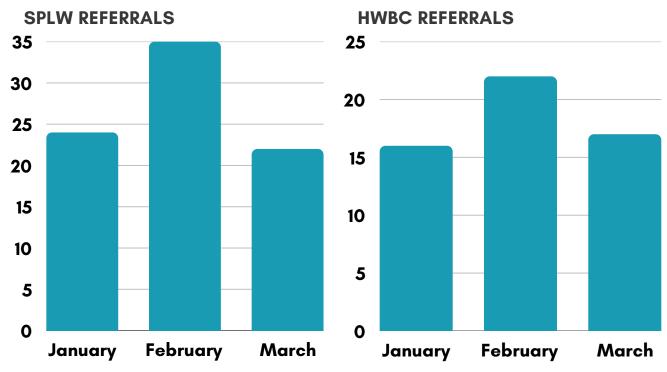
"I'm not thinking about how to keep warm; the stress is less. Not worried so much about bills. These are things to keep me warm without having heating on."

#### Patients say:

"Better quality of life for my 94 year old mother – keeping her warm is one of our main concerns."

# ASPIRE





## **Social Prescribing Case Study**

The patient is a 45 year old woman referred for support with ongoing depression and a complex medical history, including a past stroke, ADHD, PTSD, bipolar disorder, sciatica, hearing loss in one ear, tinnitus in the other, and menopause related symptoms. She is also under significant emotional strain as she supports her daughters, who have their own mental health challenges. She prefers one to one conversations over group settings, especially when discussing past trauma.

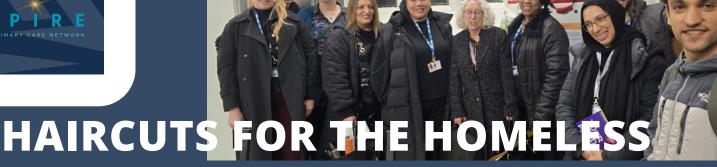
Practical issues, such as maintaining a large garden, reapplying for PIP, and the desire to move to a more manageable two bedroom home contribute to her stress.

Patient said:

"Thank you for helping me."

Social prescribing interventions have included referrals to Talking Therapies and Autism East Midlands, financial support with PIP, water based exercise to suit her physical needs, and help with her garden and housing search. She has also been signposted to a menopause and aromatherapy course for further support.





On 13 February 2025, The Aspire social prescribing team collaborated with the Sfice Foundation to host the "Haircuts for the Homeless" event, coinciding with their Social Café.

The Social Café provides essential services, including a three course meal, showers, and laundry facilities, to individuals experiencing homelessness, such as refugees, asylum seekers, and those without access to public funds.

In collaboration with various partners, we distributed essential items to attendees:



**Winter warm packs:** 10 packs containing hats, scarves, gloves, socks, and blankets, funded by the PCN.



**Personal hygiene products:** Sanitary items, deodorants, and baby wipes donated by Asda.



**Toiletries:** Shaving cream, toothpaste, body soap, and face soap provided by Lush.



**Sexual health packs:** Condoms, lubricants, and dental dams supplied by The Health Shop.



#### 'CERVICAL CANCER' OUTREACH PROJECT

During National Cervical Cancer Awareness Week, the social prescribing team, supported by their care coordinator, visited PCN practices and local businesses to raise awareness about the importance of cervical screening (smear tests).

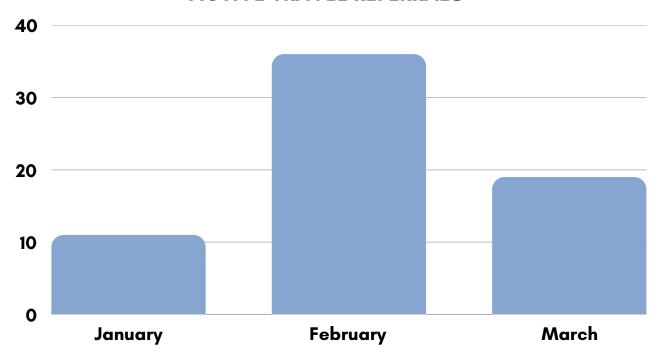
During their visit they engaged with women through conversations about their experiences and barriers to screening. They also distributed **50 leaflets** to inform and educate and handed out **50 wellness packs** to encourage selfcare and build positive health habits.



# ACTIVE TRAVEL



#### **ACTIVE TRAVEL REFERRALS**



## **Active Travel Case Study**

A patient was referred to the Travel Well project as they did not have the confidence to ride a bike and felt uncomfortable with riding and struggled to coordinate the pedals.

She began cycling with Women in Tandem, a Travel Well service provider. With consistent support and encouragement, she started riding in small group sessions. These group rides offered a safe, welcoming space where she could build confidence and connect with other women from diverse backgrounds across Nottingham.

As her confidence grew, she joined a bike maintenance class, learning to repair and care for her bike. Building on her progress, she went on to ride to raise funds for the National Forest, took part in a women's cycling weekend in the Peak District, and became actively involved in the local cycling community.

Patient said:

"This has truly been a behaviour change, I now commute by bike without using a car—it saves money and keeps me active."

Her experience sparked a passion for supporting others. She began volunteering with Women in Tandem, helping at workshops and encouraging more women to cycle. Her commitment led to her becoming a Volunteer Coordinator in Women in Tandem, guiding others on their own cycling journeys.





# BULWELL MARKETEVENT

Active Travel attend the Bulwell marketplace every third Wednesday of each month to promote the service.

They have had a fantastic time speaking to visitors by giving them expert advice on walking and cycling, along with Dr Bike services, a free bike MOT offering check-ups and basic repairs to help ensure a smoother, safer ride on the road.

#### What vistors have said:

The free bike MOT was amazing and so helpful!"

The free bike maintenance at the marketplace was so convenient. I don't drive. so it was hard to get my bike checked, this really helped."

### **NEW YEAR HEALTH EVENT**

Travel Well took part in the Aspire PCN 'New Year Health Event'.

During this event they raised awareness about the benefits of the active travel project and how it aims to help support people to build activity into their daily lives for lasting healthy changes.

