NHS
Nottingham and Nottinghamshire
Integrated Care Board

Social Prescribing across Nottingham and Nottinghamshire
Briefing for Nottinghamshire Health Scrutiny Committee
November 2025

1 Introduction

The purpose of this briefing is to provide the Nottinghamshire Health Scrutiny Committee with an update on social prescribing, specifically:

a. The strategic context and link to personalised care.
b. The activity that has been delivered to date.
c. The emerging plans to embed social prescribing into Integrated Neighbourhood Teams.

For the purpose of this paper it should be recognised that NHS funded Social Prescribing Link Worker roles and social prescribing activity are not the same. This paper focuses specifically on social prescribing within the NHS England Universal Personalised Care framework and the Primary Care Network (PCN) model, where SPLWs are funded through the Additional Roles Reimbursement Scheme (ARRS). These link workers are part of the PCN workforce, providing holistic, non-clinical support to address individuals' social, emotional, and practical needs by connecting them with community resources.

The paper does not cover non-NHS-funded social prescribing activity type roles, that include community connection and signposting activities. Such activities, delivered by voluntary or specialist commissioned services, these may still involve referrals from health, social care, or community organisations, but will not be covered in this paper.

2 Strategic Context

As part of the NHS Long Term Plan (2019), there was an expectation to roll out a Personalised Care Model[1] across England, reaching 2.5 million people by 2023/24 and then aiming to double that again within a decade.

Personalised care is centred on what matters to individuals, recognising their unique strengths, needs, and preferences. It ensures that people living with long-term conditions have equal choice and control over their mental and physical health. This approach is one of the five key practical changes introduced by the NHS to transform care delivery. The Universal Personalised Care Model is being embedded as a business as usual approach across the transformational programmes, supporting the shift towards a more holistic personalised care services.

Personalised Care across the Nottingham and Nottinghamshire Integrated Care System (ICS) aimed to maximise independence, good health, and wellbeing across the lifespan, shifting the focus from 'what is wrong with you' to 'what matters to you'.

The Personalised Care Model has six components:

- Shared decision making

[1] NHS England » Comprehensive model of personalised care

- Personalised care and support planning
- Enabling choice, including legal rights to choice
- Social prescribing and community-based support
- Supported self-management
- Personal health budgets and integrated personal budgets

Nottingham and Nottinghamshire Integrated Care Board (ICB) hosted the Programme Team for the Universal Personalisation Programme to lead the System-wide delivery of the nationally set targets for delivery all six components.

Although national funding (from the NHSE Universal Personalised Care Programme) for social prescribing ended in March 2023, delivery has continued to allow Nottingham and Nottinghamshire ICB to embed social prescribing and its related components across the System footprint, to maximise learning, strengthen integration, and ensure sustainability of this holistic model of care.

By the end of the nationally funded programme, Nottingham and Nottinghamshire ICB successfully met all targets outlined in its Memorandum of Understanding. Social Prescribing Link Workers (SPLW) were fully embedded within local services, contributing to a more integrated approach to personalised care. Delivery had matured within the Primary Care Network (PCN) workforce, supporting sustainability and alignment with neighbourhood-level health priorities.

SPLWs are part of the Primary Care Network (PCN) personalised care workforce, working alongside Health and Wellbeing Coaches and Care Coordinators to deliver holistic, person-centred support.

PCNs are collaborative groups of general practices that work in partnership with local health and social care providers to deliver integrated services tailored to the needs of their local populations. Under the PCN Directed Enhanced Service (DES) specification (the nationally agreed primary care contract) PCNs are required to ensure patients have access to social prescribing (Appendix 1). However, it is the responsibility of each PCN to use population health data to determine the most appropriate roles and services to meet the specific needs of their communities.

Social prescribing services may be delivered either through direct employment of SPLWs or via sub-contracted arrangements with external providers. The development and delivery of localised social prescribing plans are shaped by several strategic priorities, including:

- Population Health Management (PHM) data, which informs targeted interventions based on local health needs.
- The PCN Maturity Matrix, a self-assessment tool used by practices to evaluate their progress towards becoming a fully integrated network.
- Place-based priorities, which reflect broader system-level goals and community needs.

Together, these elements ensure that social prescribing is not only available but also responsive, sustainable, and embedded within the wider personalised care agenda.

3 Defining and provision of Social Prescribing

Social prescribing is a cornerstone of Universal Personalised Care, offering a holistic approach that connects individuals to community-based activities, groups, and services. It

addresses the practical, social, economic, and emotional factors that influence health and wellbeing, moving beyond clinical interventions to support the whole person.

At its core, social prescribing involves referrals from local agencies, such as charities, health services, and social care, to a Social Prescribing Link Worker (SPLW). These professionals take a personalised approach, giving people time and space to explore what matters to them, rather than focusing solely on what's the matter with them. Together, they coproduce a personalised care and support plan tailored to individual needs.

Across 23 PCNs in 2024-25 there were over 16,400 referrals into social prescribing. There are 82 full time equivalent staff employed via General Practice, General Practice Federations or the voluntary sector on behalf of PCNs

Example Social Prescribing Pathway

1. **Identify a patient who needs non-medical support.** The GP or another practice staff member (nurse, pharmacist, receptionist) recognises that a patient's problem is partly social or emotional, not purely medical. A patient presents repeatedly with low mood, isolation, or mild anxiety, but medication isn't the right answer.
2. **Make a referral to the SPLW.** The GP sends an internal referral to the Link Worker. E.g. "Refer to SPLW for support with loneliness and housing concerns."
3. **SPLW contacts the patient directly.** The SPLW spends time understanding the person's needs, goals, and barriers. They might meet the patient in the surgery, at home, or in the community.
4. **Develop a personal plan.** Together, they create a plan focusing on what matters to the person, not just their symptoms. E.g., "Join local walking group," "Apply for housing support," "Attend carers' support sessions."
5. **Connect to local services / community assets.** The SPLW helps the person connect with relevant groups, charities, or public services. Food banks, debt advice, physical activity sessions, peer support, volunteering opportunities.
6. **Feedback to the GP.** SPLWs document outcomes and progress in the GP record, so the clinical team stays informed. "Patient attending weekly art therapy group — mood improved."

SPLWs are embedded within multi-disciplinary teams and work closely with the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector. They identify and connect people to suitable community groups and services, ensuring safe and appropriate referrals. Social prescribers visit new community groups to assess accessibility, noise levels, and suitability for patients e.g. with sensory sensitivities or anxiety.

SPLW work very closely with their local community assets through joint working and collaboration with communities. This includes voluntary sector organisations, local area coordinators and community development workers. SPLW provide the link between general practice and local community activity through contacts and networking. SPLW use online platforms such as 'help yourself Notts' or 'The Big Green Book' to understand local offers within their local areas.

People with Severe Multiple Disadvantage are less likely to engage initially, but through partnership with trusted VCSE organisations, culturally competent link workers, and flexible, person-centred approaches, social prescribing can become a key part of improving health equity and inclusion.

Where gaps exist, SPLWs help individuals establish new groups and activities, fostering inclusive and sustainable community networks. In Mid Nottinghamshire the Best Years Hub

by Your CVS has developed for people over 65 who are experiencing social isolation, offering social activities, health advice, and support is supported by SPLWs.

SPLWs manage their own caseloads, and offer support around the wider determinants of health, such as housing, employment, and financial wellbeing. In Rosewood PCN SPLW are central to the Connect 2 Work pilot to enhance job prospects and better health outcomes. This enables them to respond to the specific needs of the local population.

Through social prescribing, patients may feel more connected to community resources, reduced social isolation and noticeable improvements in both physical and emotional wellbeing.

Social prescribing is accessible through both primary and secondary care, as well as community-based organisations. It supports a wide range of individuals, including:

- People with one or more long-term conditions
- Those experiencing mental health challenges
- Individuals who are lonely or socially isolated
- People facing complex social needs that impact their wellbeing

GPs and PCNs are responsible for implementing tailored communication strategies. These teams use population health data to proactively identify patients who may benefit from as social prescribing. This proactive approach includes direct referrals to SPLWs and discussions in multi-disciplinary team meetings involving clinical, social, and non-medical colleagues to determine the most appropriate support for each patient. There is high demand, with waiting lists being a common occurrence.

Waiting lists for social prescribing exist due to high demand and the capacity of SPLWs. Each PCN manages its own waiting list, and approaches vary. In some cases, SPLWs continue to support individuals while they await access to other community or mental health services, which can contribute to waiting times. Some PCNs have developed group models to help manage demand. The specifics of waiting list management and length are determined locally by each PCN.

This reflects both the effectiveness of targeted communication and the perceived value of the offer among patients. PCNs have developed alternative ways of delivery including Social Prescriber led group models which bring people with similar needs together to connect with local support and help manage waiting times.

4 Green Social Prescribing: Case Study

Green Social Prescribing (GSP) is an innovative, non-clinical approach that enhances physical and mental health by connecting individuals with nature-based activities. As a key component of the broader Universal Personalised Care model, it empowers people to take control of their wellbeing through tailored, community-based support.

This approach is particularly effective in addressing mental health challenges, social isolation, and health inequalities. It complements traditional healthcare by focusing on the wider determinants of health and encouraging meaningful engagement with the natural environment.

GSP involves referring individuals to activities in natural settings, such as:

- Community gardening and conservation projects
- Local walking groups and green gyms
- Outdoor arts and cultural activities
- Nature-based mindfulness and relaxation sessions

- Blue prescribing activities like open water swimming or canoeing

These interventions are facilitated by SPLWs or other trusted professionals. They engage individuals in “what matters to you” conversations, coproducing personalised care and support plans that reflect each person’s needs and preferences.

From 2021 to 2025, the Green Social Prescribing Programme – GreenSpace was led by Nottingham Voluntary Community Service (NCVS), becoming the strategic lead for system learning across the Nottingham and Nottinghamshire ICS. Nottingham was one of seven national “Test and Learn” sites, running a two-year pilot from April 2021 to March 2023.

Key outcomes from participant reviews showed:
- 66% were able to think more clearly
- 64% felt more optimistic
- 55% felt more relaxed
- 36% felt more useful
- 36% were better able to deal with problems

The percentages cited are drawn from participant feedback collected during the Green Social Prescribing pilot programme (2021–2023), led by Nottingham CVS as part of a national 'Test and Learn' initiative. These figures reflect qualitative outcomes from participant reviews. Unfortunately, the raw numerical data (i.e., total number of respondents) is not held by the ICB and is not accessible to us currently

The programme has evolved to include:
- Eight targeted cohorts, including people with serious mental illness, dementia, neurodiversity, and young people with mild mental health issues.
- Strengthened partnerships and improved data-sharing to measure impact and ensure safe referrals.
- Tools like the Big Green Book and Mini Green Book, which serve as directories of nature-based activities and support resources.
- National recognition through contributions to the Green Social Prescribing Toolkit, developed by the National Academy for Social Prescribing.

Since the conclusion of national funding for Green Social Prescribing in April 2025, efforts have continued to embed the programme’s learning into local initiatives. Across Nottinghamshire, numerous green spaces are maintained by volunteers from VCSE organisations and are still part of SPLW community referral pathways. These groups remain actively engaged in seeking both national and local funding to sustain and expand their green space initiatives, for example, Feel Good Gardens[2] and Cotgrave Community Garden[3]. These established community gardens across Nottinghamshire continue to provide natural environments that people can access, to benefit their physical, emotional and social wellbeing.

5 Emerging Integrated Neighbourhood Teams (INTs) across Nottingham and Nottinghamshire

The Lord Darzi[4] review set the direction of travel towards a neighbourhood health service and Neighbourhood Health Guidelines[5] were issued in January 2025. The 10 Year Health

[2] Home | feelgoodgardens.org
[3] Get involved - Cotgrave Community Garden
[4] Independent investigation of the NHS in England - GOV.UK
[5] NHS England » Neighbourhood health guidelines 2025/26

Plan for England[6] subsequently set further direction and implementation requirements for its delivery.

The Health Plan has put neighbourhood health and wellbeing front and centre of its proposals to reform the National Health Service (NHS). This is with the aim of delivering a model of care that is preventative and better supports those most in need. The ambition is to put an end to 'hospital by default' through establishing a neighbourhood health service, with the intention of providing more personalised and coordinated care within local communities, reintegrating healthcare into the social fabric of places and leading to better and more cost-effective patient outcomes.

Integrated Care Systems have been asked to initially focus on supporting people of all ages with complex health and social care needs who require support from multiple services and organisations.

Nottingham and Nottinghamshire is working with health and social care professionals to bring together the implementation of Integrated Neighbourhood Teams (INTs) in a phased roll out across the system working together to provide joined-up, community-based care for defined populations, typically around 30-50,000 people. These teams aim to improve population health, reduce health inequalities, and ensure people can access the right care closer to home by bringing together services from primary care, social care, mental health, community care, and voluntary sectors. INTs are designed to improve efficiency, share knowledge, and provide a holistic approach to care by better understanding local needs and coordinating support for individuals, families, and communities.

Our focus is to:

- **Improve health outcomes:** Focus on preventing ill health and supporting individuals to live healthier lives within their community.
- **Reduce health inequalities**: Address the social determinants of health and provide targeted support for communities with greater need.
- **Enhance access to care:** Make it easier for people to access a range of services, including primary and community care, in a convenient local setting.
- **Promote joined-up working:** Break down traditional barriers between health and social care services, fostering better collaboration and knowledge sharing.
- **Deliver person-centred care:** Involve patients and communities in decisions about their health and involve them in the design of services.

In 2025/26 across Nottingham and Nottinghamshire the focus is on supporting citizens identified with Frailty and/or Long-Term Conditions, to support improvement management of health and care, reducing acute demand, and providing support close to home.

Implementing INTs offers numerous benefits to both individuals and communities. For residents, it means receiving the right care at the right time, closer to home, without the need to navigate multiple services. This approach reduces the burden on acute healthcare services by promoting preventive care and early intervention. For professionals, working within an INT enhances collaboration, reduces administrative tasks, and provides access to a broader network of support, ultimately leading to more efficient and effective service delivery.

INTs bring together a diverse range of professionals and organisations from different sectors, including:

[6] 10 Year Health Plan for England: fit for the future - GOV.UK

- **Primary Care Networks (PCNs):** GPs, Nurses, PCN additional staff including SPLWs, Occupational Therapy, Health and Wellbeing Workers Pharmacists etc.
- **Community Health Services:** District nurses, allied health professionals.
- **Social Care:** Adult Social care teams.
- **Mental Health Services:** Community Mental Health teams.
- **Voluntary and Community Sector:** Local charities and community organisations.
- **Wider Primary Care Services:** Community Pharmacy Community Optometry and General Dental Services
- **Other Local Authority Services:** Including Housing, Public health and potentially other services like the Fire service.

Non-medical interventions are crucial for the success of INTs with a view to addressing the social determinants of health, such as housing, loneliness, and lack of physical activity, improving overall quality of life and preventing further illness. These non-clinical approaches, often through social prescribing and community resources, reduce demand on acute services, lower costs, and offer more personalised, holistic care by focusing on individuals' broader social and emotional wellbeing.

With this in mind the development of INTs has involved the voluntary and community sector and wider partners to ensure that the non-medical approaches are captured and supported as the INTs are developed across the system. This short film showcases the work of the Small Steps to Feeling Great partnership in Warsop. It features contributions from colleagues at the local community organisation Vibrant Warsop and PCN additional colleagues from the local PCN. Together, they reflect on what it means to work differently and share the positive impact this approach is having on residents in Warsop. This example highlights how integrated working with community partners can deliver meaningful improvements in wellbeing and engagement, reinforcing the value of embedding non-medical models within INT development.

6 Social Prescribing – What's Working Well / Key Challenges

What's Working Well

- **Established Practice at PCN Level:** Social prescribing is well embedded and maturing at the Primary Care Network (PCN) level, with roles tailored to local health inequalities and social needs.
- **Workforce:** There are 96 Social Prescribing Link Workers (SPLWs) employed via the ARRS scheme, plus additional ICB-funded mental health link workers. (*84 April 2025*)
- **Proactive Approaches:** SPLWs use population health data to identify cohorts most impacted by health inequalities and proactively target interventions (e.g., respiratory conditions, dementia, winter checks).
- **Personalised Care:** SPLWs build shared plans with patients and connect them to community support, with average caseloads of 30–40 people at any one time.
- **Community Investment:** Some localities (e.g., Bassetlaw CVS, GreenSpace) have adopted sustainable investment models for the VCSE sector, supporting grants and contract-based commissioning

Challenges

- **Data Gaps and Inconsistency:** There is a lack of consistency in outcomes monitoring and impact data. Data interoperability between digital and data systems is limited.
- **Digital Platform Fragmentation:** Multiple digital platforms are in use, but they are not interoperable. No single system-wide approach exists, making data sharing and analysis difficult.
- **Burden on SPLWs:** Logging data is time-consuming, and SPLWs often lack space and access to digital systems in surgeries. Some still use local spreadsheets.
- **Limited Use of Outcomes Data:** Outcomes data is not consistently used to drive service growth; decisions are often based on case studies and patient feedback rather than robust data.

7 Recommendations

Nottinghamshire Health Scrutiny Committee is asked to:

- Note the contents of this briefing.

Appendix 1: Primary Care Network Directed Enhanced Service (PCN DES)

The Primary Care Network Directed Enhanced Service (PCN DES**)** is a key component of the NHS Long Term Plan, designed to encourage collaboration between general practices to deliver services at scale. Under the PCN DES, groups of GP practices—known as Primary Care Networks—work together with community, mental health, social care, pharmacy, hospital, and voluntary services to provide more integrated and proactive care for local populations, typically covering 30,000–50,000 patients. There are 24 PCNs across the Nottingham and Nottinghamshire system (15 in the County).

The PCN DES is commissioned nationally by NHS England as an enhanced service under the GP contract, but it is locally delivered through Primary Care networks that sign up to the DES via their practices' Medical Contract.

Funding for PCN services is provided through a series of specifications and payment components, for SPLW this is the Additional Roles Reimbursement Scheme (ARRS).

Performance and delivery are monitored and reported through a variety of mechanisms such as enhanced access delivery claims and self-declarations.

The PCN Clinical Director is accountable, on behalf of member practices, for:
a) ensuring that the PCN delivers the requirements set out in the Network Contract DES for its registered population, including by:
    i. effective allocation of funding and ARRS capacity across the Network
    ii. ensure that all constituent practices are operating the Modern General Practice Access Model and are continuously working to improve patient experience.
b) informing the Commissioner of PCN delivery against the Local capacity and access criteria;
c) working with local partners to support establishment of INTs and ensure PCN participation within its INT.

As part of contract monitoring for PCNs in 25/26 is a requirement to submit a PCN Workforce plan for ARRS. This describes how PCNs will provide access to a social prescribing service to those who may benefit, to help meet the practical, social and emotional needs that can otherwise affect health and wellbeing. No additional information is required.

The provider position for SPLW across Nottinghamshire and further information links:

Provider	PCNs included	Website
Partners Health Ltd	Rushcliffe PCN	https://www.rushcliffehealth.org/social-prescribing/population-health-management
Primary Integrated Community Services	Nottingham West PCN Arnold and Calverton PCN Arrow Health PCN Byron PCN Mansfield North PCN Rosewood PCN Ashfield North PCN Ashfield South PCN Newark PCN Sherwood PCN	Primary Care Network Services - Primary Integrated Community Services Ltd

Bassetlaw Community Voluntary services	Lawood and Bawtry PCN Newgate PCN	Social Prescribing | Bassetlaw CVS
Retford and Villages PCN	Retford and Villages PCN	Retford & Villages Primary Care Network - PCN | Facebook
Synergy PCN	Synergy PCN	Synergy PCN Social Prescribers | Nottingham | Facebook