

1st April 2026

NHS Glos.

ICB Newsletter

NHSE SW Digital Neighbourhood webpage relating to the **Digital HOPE Programme** offer - funded 10,000 places for Southwest registered patients to access a course which seeks to empower people living with LTC/MH conditions, by providing them with knowledge, skills & confidence to improve their health & wellbeing.



Live Better to Feel Better Online

Are you living with a diagnosed long-term physical health condition(s), registered with a Gloucestershire GP and over 18?

This 6-week self-management course is co-facilitated by our Peer Support Workers - all of whom have a long-term health condition. Topics covered include:

- The mind body connection
- Adapting to change
- Assertiveness and looking after me
- Problem solving and decision making
- Mindfulness and breathing for relaxation
- Communication and working with health professionals and services
- Managing pain
- Sleep and fatigue
- Self-care and compassion

Tuesdays 14th April - 19th May

Time: 10:30am – 12:30pm

Closing date for applications Monday 23rd March



For further details, scan the QR code
www.ghc.nhs.uk/other-areas/ghwb-college
Email: ghwc@ghc.nhs.uk
Telephone: **0300 421 4414**





Gloucestershire Health and Care
NHS Foundation Trust

Live Better to Feel Better

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- Self-care and compassion

Wednesday 3rd June – 8th July 2026

Time: 1:00pm-3:00pm

Place: Churchdown Community Centre, Parton Rd,
Churchdown, Gloucester GL3 2JH

Closing date for applications Monday 11th May



For further details, scan the QR code
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Email: ghwc@ghc.nhs.uk
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'Personalised Conversations – Health Coaching Part 1 training' for
'frontline clinical/non-clinical' staff accredited with the
Personalised Care Institute (PCI).

Click link to register: *Personalised Conversations and Health Coaching Courses Accredited Training – Fill out form*

Expression of Interest

2026-2027

Personalised Conversations & Health Coaching Skills Training - Part 1 Enrolment

ICB Funded Course - 16 hours = 4 half-days run over 4 successive weeks - facilitated learning held on MS Teams

Course Overview

Through this course, you will develop **practical health coaching** and **person-centred communication skills** that empower people to take greater control of their health and wellbeing. Focusing on personalised care, you will learn how to tailor your support to individual needs, recognising wider social factors that influence wellbeing and self-management.

This training combines practical exercises, skills practice, peer feedback, and reflective learning to help you build confidence and improve both the experience and outcomes for the people you support.

Module 1

- Raise awareness on NHS Universal Personalised Care Model
- Provide context of Communication skills for good coaching conversations
- Enhance understanding on the Wider Determinants of Health

Module 2

- Identify Health Coaching Skills
- Explore the Stages of Change Model
- Identify a person's Capability, Motivation, Opportunity & Activation changes
- Explore Communication Skills – Directive / Non-Directive

Module 3

- Discuss tailoring support to a person
- Raising awareness on Equality, Diversity & Inclusion and unconscious bias
- Applying strategies and tool for working with resistance and ambivalence

Module 4

- Exploring changes in Practice
- Identifying and responding to Unhelpful health beliefs
- Analysing the balance of Rapport verse Challenge
- Raising awareness of the 'Drama Triangle'
- Skills practice and opportunity for reflection

Transforming Care, Transforming Communities

WHY are we doing this?

- To deliver the ambitions set out in the NHS Long Term Plan (2019) superseded by the 2025 publication to increase the number of staff with personalised care competencies.
- To enable frontline clinical and non-clinical workforce to gain core skills that support prevention, supported self-management, shared decision-making, effective conversations around personalised care and support planning, identifying motivations, managing resistance and adapting approaches to readiness and activation levels.
- To create system sustainable capabilities through accredited trainers as part of the Southwest Health Coaching Collaborative using course materials accredited with the Personalised Care Institute.

WHAT do we want to improve?

- Increase job satisfaction through continued personal development of our workforce.
- Reduce people presenting in a health crisis adopting joined up proactive personalised care approach.
- Increase Patient Activation, Reported Experience and Outcome Measures.

HOW will we do this?

- Offer free training fully accredited with the Personalised Care Institute.
- Provide opportunities through the 'Train the Trainers' model to expand sustainable capabilities and capacity to deliver health coaching training across our county.
- Establish Communities of Practice action learning sets to provide continued support and mentoring to our workforce.

WHO can enrol?

- All frontline clinical & non-clinical health and care staff employed in Gloucestershire
- Social Prescribers, Health & Wellbeing Co-ordinators, Care Co-ordinators, Nursing & Midwives, Allied Health Professionals, Social Workers, Care Sector Staff & VCSE Partners.

Training Dates: 2026-27 – Qtr1

Personalised Conversations:
Health Coaching Skills 1

Please click on link to register onto the 'free' Part 1 course held online:

Personalised Conversations and Health Coaching Courses Accredited Training – Fill out form

Contact: lisa@nhs.net for any further details.

Cohort Dates:

Part 1 – Module 1	22-04-26
Part 1 – Module 2	29-04-26
Part 1 – Module 3	06-05-26
Part 1 – Module 4	13-05-26
Part 1 – Module 1	30-04-26
Part 1 – Module 2	07-05-26
Part 1 – Module 3	14-05-26
Part 1 – Module 4	21-05-26
Part 1 – Module 1	02-06-26
Part 1 – Module 2	09-06-26
Part 1 – Module 3	16-06-26
Part 1 – Module 4	23-06-26

Southwest Integrated Personalised Care Awards (SWIPC)
Awards scheduled in Nov-26 hosted by the **Coalition for Personalised Care**.

Click on link to access details about entry criteria.

One Glos 'Personalisation into Practice' Our People Stories

All it took was to ask... What matters to me...

Sandy
Secondary Breast Cancer Patient

Justine Crew
Secondary Breast Cancer ANP

1. Tell us about how it happened, and why you are proud of it.
My role involves supporting patients who have a diagnosis of secondary breast cancer. All of the patients I support will not be cured but often, with multiple treatment options now available patients can, potentially live well for many years. Evidence has shown that, although the ReSPECT process has opened up conversations regarding broader treatment options, CPR recommendations will remain a focus in a lot of conversations. I was keen to help improve our patient's current experience through the ReSPECT process. The aim of the project was to provide a personalised approach through a future care planning clinic using the ReSPECT process and documentation. By holding 'what matters to me' conversations facilitated by a nurse-led clinic and, by working alongside interdependent projects, including shared decision-making about medical interventions based on needs, wishes and preferences. We are proud to be jointly working across the system with true integration and, most importantly for the patient to be at the forefront of what we do.

2. Tell us, who did you work with?
The GHFT Oncology team worked with NHS Glos ICS, GHFT Consultant Oncologists, GHFT Junior Drs, Oncology ANPs, Specialist Palliative Care Team, ReSPECT working group, Business Information, Macmillan Volunteers, Macmillan next steps, Sue Ryder therapy team and day centre, Maggie's, bereavement advisors, Primary Care A&Ps roles, GOC's Equipment services, Sandy and her son Jason.

3. Tell us, how you did it?

4. Tell us, what was the impact on the person?
As Sandy has so eloquently written producing her personalised care and support plan (PCSP), which included a ReSPECT conversation enabled her to focus on 'what mattered' to her the most; that was her quality of life and well-being, getting through her 'bucket list' and most importantly living well.

5. How did working in a personalised care way make you feel?
Developing a rapport and an understanding of our patients' priorities for their care is invaluable in the work that we do. Establishing those therapeutic relationships early on in their trajectory enables us to engage and have conversations that are both explanatory and meaningful.

6. What could health and care leads do to help make that happen?
Ongoing support of future care planning clinics enabling the right environment to hold 'what matters' conversations. Digital interoperable between system partners to reduce duplication helping to create integrated working.

“ My name is Sandy, I'm 68 years old and I was diagnosed with secondary (advanced) breast cancer in October 2023. Initially I was advised that it had spread to my bones and my lungs but with treatment I could live well for a 'good few years' ahead. I felt very lucky that I had time on my side. Unfortunately, following an MRI on my head, the results showed that the cancer had also spread to my outer and mid skull. The prognosis therefore changed to 6 months (based on data produced averages). The news was a shock, especially after losing my husband unexpectedly 2 years previously and my mother just a few months prior to my diagnosis. I had asked for my revised prognosis as it was important to me, my son, who is 33 years and my extended family, for me to be able to plan my ongoing care and support and particularly my 'end of life' care. I also needed to sort out finances, admin and my Will. This would give me back some control over my life with clinicians and my family knowing and understanding my wishes. Justine Crews, my Advanced Nurse Practitioner understood how I felt and invited my son and I to meet with her to have a 'what matters to me' conversation. The outcome from this was producing together my personalised care and support plan as part of my future advance care planning. Justine also signposted me to Sue Ryder for physio support at home having suddenly lost my mobility, further impacted by a partial hip and femur replacement, due to two pathological fractures. Two months later I was able to walk again with a stick for support. I was so happy. Although I was fully aware that I had a life-limiting diagnosis, what mattered to me was that I looked as normal as possible. I didn't want to look poorly. So, with Justine's guidance I decided to buy a wig. Wearing the wig gave me the newfound confidence that I had been hoping for. All my care plans were now in place but to complete what matters most to me was my quality of life and my well-being. I didn't want to sit and wait to die. So, my son and I decided to put a bucket list together, of events, holidays and time with family and friends. We have had such fun following the bucket list and I feel so well a year after my initial diagnosis and prognosis. Treatment is ongoing and I am now also attending more advanced fitness training through Macmillan Next Steps and Tai Chi at Maggie's. Although I am living with stage 4 cancer, I am living well and making the most of every single day. This all began with that first conversation I had with Justine a year ago, when she asked, 'what matters to me'..... Thank you, Justine. **”**

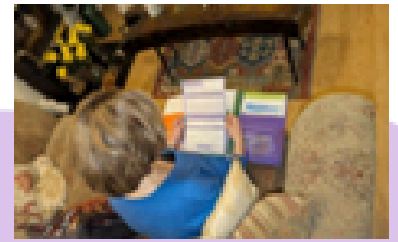


One Glos 'Personalisation into Practice' Our People Stories



Gloucestershire Hospitals
NHS Foundation Trust

All it took was to ask... What matters to me...



Sandy

Secondary Breast Cancer Patient

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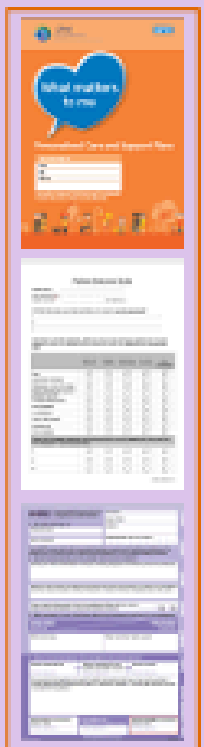
Justine Crewe, my Advanced Nurse Practitioner understood how I felt and invited my son and I to meet with her to have a 'what matters to me' conversation.

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Justine Crewe

Secondary Breast Cancer ANP

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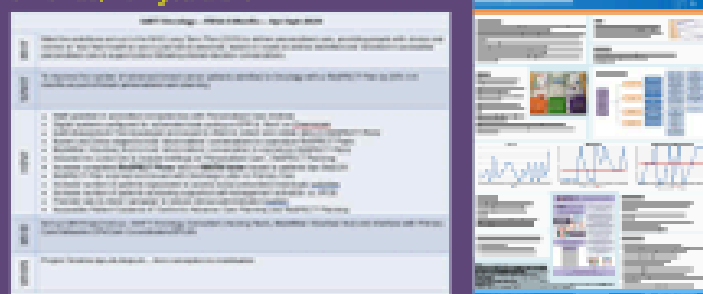
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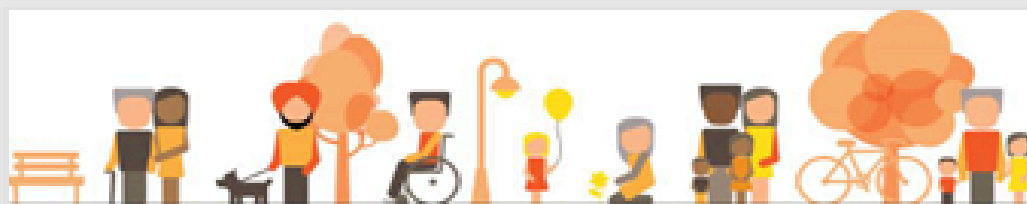
5. How did working in a personalised care way make you feel?

Developing a report and an understanding of our patients' priorities for their care is invaluable in the work that we do. Establishing those therapeutic relationships early on in their trajectory enables us to engage and have conversations that are both exploratory and meaningful.

6. What could health and care leads do to help make that happen?

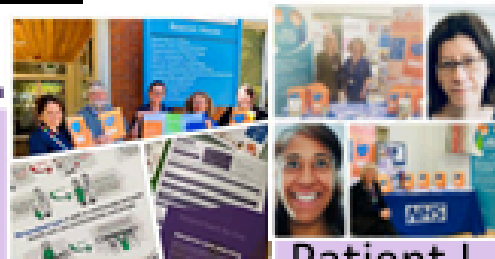
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One Glos 'Personalisation into Practice' Our People Stories

All it took was to ask... What matters to me...



Patient L

Secondary Breast Cancer Patient

Sam White

Clinical Lead - Specialist Palliative Care



1. Tell us about how it happened, and why you are proud of it.
Working together differently is at the heart of the specialist palliative care (SPC) service. Since the pandemic, the community SPC team (CSPCT) have adjusted our ways of working to manage increasing referral numbers, higher complexity of patients and mirroring countryside allocation of primary care resources into Primary Care Networks (PCNs). We have developed an electronic patient record and established robust data sharing agreements with GHC NHSFT. This has enabled consistent person-centred coordinated care, illustrated through the following case.

2. Tell us, who did you work with?

The GHFT CSPCT team worked with L and her family to co-ordinate care, GHFT acute and community SPC, GHCHNSFT District Nurses, Primary Care GP & Great Oaks hospice @ home service.

3. Tell us, how you did it?

Working differently has required a number of changes to service delivery, to increase partnership working. This was recognised at the PEoL Care Awards in 2024. Since 2020 CSPCT have created daily virtual Clinical Review Meetings (CRMs), that enable real time senior clinical decision-making around complex cases.

All new patients referred to CSPCT are discussed, as well as those patients who have more challenging and complex issues and symptoms. Similarly to the principles of a virtual ward, changing a 1.0 WTE Palliative medicine job plan, has created a greater efficiency in oversight of patients known to CSPCT. In 2024, a total of 2,333 patient episodes were discussed, averaging 194 patient episodes a month. We will have had a "What Matters to Me" conversation with an estimate that most have a completed ReSPECT Plan.

4. Tell us, what was the impact on the person?

L's treatment was personalised to her priorities. Through personalisation, a medical plan was co-produced, with L at the centre making informed choices about what medication she wished to try. Personalised care requires multi-agency collaboration to ensure complex needs are met. CSPCT aim to offer advice around alternative ways to manage complex and distressing symptoms. These can be distressing for a person to experience, whilst creates moral distress for those providing care if they are not optimised. Options on how to manage this should never be linear, viewed more of a tube map, allowing people to stop at which ever station they wish to, whilst supporting them to get to their destination, however turbulent the journey.

5. How did working in a personalised care way make you feel?

As a system lead, empowering the team to work to a personalised care model, creates improved patient outcomes (as evidenced above), as well as allowing staff to work in a way that gives them job satisfaction.

6. What could health and care leads do to help make that happen?

Consider how our CRMs could be adapted to become a sustainable virtual ward model. Recognise that personalised care delivery requires skilled team, with a culture shift in relationship between professionals and people, valued as equal partners to collaborate and manage the highest complexity and significant risk. 10% of people who die in Gloucestershire have contact with the CSPCT. We see an emerging theme of increasing need for non-malignant conditions, and we would welcome opportunity to develop research and innovation around how the SPC needs of this population are met.

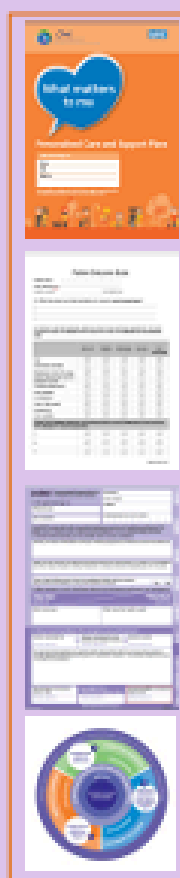


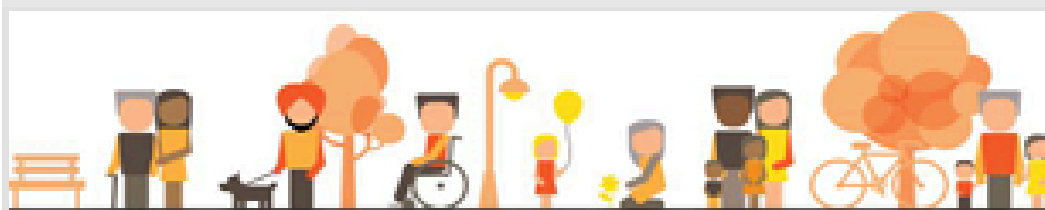
L, a 59 year old lady, has lived with metastatic breast cancer for 12 years. In the autumn of 2024, she presented in the acute hospital with 2 back-to-back admissions with increasing shortness of breath. This culminated in her discharge home, in recognising she may be starting to die and did not wish to be in hospital. Once home, her condition improved.

In co-production with L and her partner, the community palliative care CNS was able to ascertain that L was not happy with the suggested medication changes recommended by other healthcare practitioners. L was experiencing pain, nausea, and a degree of confusion. Routine "just in case" medications were offered on top of the syringe pump that was running.

By having a "What matters to me" conversation, the community palliative care CNS was able to establish that L had always preferred to use non-pharmacological means to manage her symptoms in the time that she has been unwell. L was also able to express that being cognitively alert was a strong priority to her and she felt increasing morphine doses had exacerbated her symptoms. This was a challenge to staff caring for her, as they wished for her to be as comfortable as possible.

By working collaboratively, CSPCT were able to offer alternative advice and guidance around L's symptom management. L was sick enough to die at the point of discharge, but through a period of intensive management, her CNS recognised that her condition stabilised. The CSPCT helped direct L's pharmacological management, recommending drugs that would not be routinely used by other HCPs. This included removing the syringe pump L was requiring, as well as L accepting alternative drugs to manage her symptoms. L is planning a midweek getaway, focusing on making memories for her and her family. This would not have been possible if CSPCT had not adjusted her medication and made the swift changes.





One Glos 'Personalisation into Practice' Our People Stories

All it took was to ask... What matters to me...

Dr Ann Cooper

GP, North Cotswold PCN

1. Tell us about how it happened, and why you are proud of it.

Patient X presented at the practice raising concerns about cognitive impairment during 2016, following a holistic assessment with the Memory Assessment clinic was diagnosed with Posterior Cortical Atrophy Dementia. In Nov-2023 supported by the Personalised Care Programme Manager set up a home visit to hold a 'what matters' conversation with Patient X and his wife to understand their needs, wishes, preferences on how he wishes to manage his physical, psychological, and social needs recorded in personalised care and support plans. A 1-off Frailty & Dementia Personalised Wellbeing Budget has now been offered commencing in June-24 to support Patient X for 6-12 months, administered by AgeUK Glos.

2. Tell us, who did you work with?

Myself together with Patient X and his wife, Primary Care Frailty Mgmt, Adult Social Care, GHC's Dementia Service & Memory Assessment Specialist Nurses, GHFT's Neurologist, Pharmacist, Cotswold Friends, SSAFA, Blind Veterans UK, AgeUK Glos, NHS Glos ICB, Local Gym.

3. Tell us, how you did it?

North Cotswold PCN pledged commitment with other system partners to onboard with the 'What Matters to Me' project to distribution the WTM folder, holding personalised care and support plans owned by registered patients. Staff have upskilled in Personalised accredited competencies and through MDT discussions have proactively supported Patient X and his wife reviewing their issues and discussing steps to meet their goals. We are determined to relieve the burden for Patient X and his wife by working collaboratively with our health & care partner. Working with AgeUK Glos who are managing the 1-off Personal Wellbeing Budgets.

4. Tell us, what was the impact on the person?

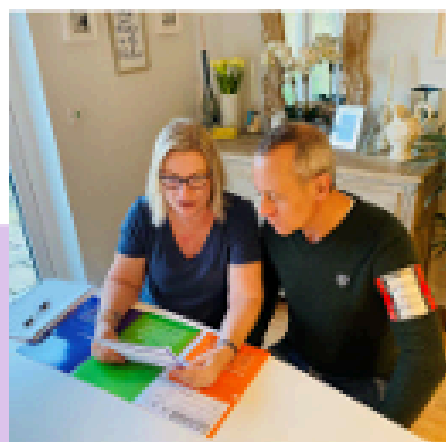
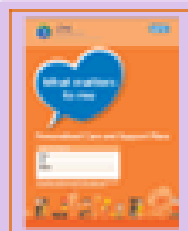
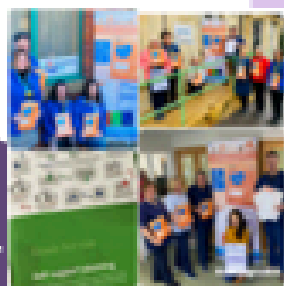
Patient X was on a downward trajectory to becoming deconditioned and socially isolated, impacting his physical and mental health deterioration. Working with ALMG he has secured non-recurrent funding to access a local gym which has made reasonable adjustments to support people with disabilities. Patient X becomes animated when he talks about exercising to avoid muscle wastage, has a sense of purpose and satisfaction that he can still keep fit.

5. How did working in a personalised care make you feel?

The way I work has changed, providing time to hold 'what matters' conversations and the ability to work in collaboration with other agencies to tailor support for our registered patients.

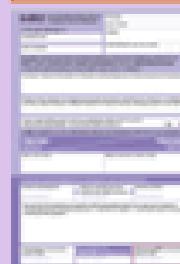
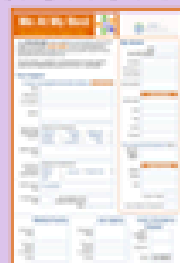
6. What could health & care leads do to help make that happen?

Time allocation for personalised care consultations to be held to build trust and truly understand the whole person's needs and wishes, digital interoperability to liaise with other teams, and access to personal wellbeing budgets to act at pace to support people's needs.



Patient X

"I'm 64 years old, and in 2016 my life changed forever following a diagnosis of Posterior Cortical Atrophy (PCA), a rare young form of Dementia. Living with my 'new reality' resulted in the loss of my job, my car, our family home, and has adversely impacted on the mental wellbeing of my wife. We feel shunned by our community and becoming increasingly isolated and lonely as we don't have family support around us.



Dr Ann Cooper has supported me and my wife by holding a 'what matters' conversations to assist us both to determine what our needs, wishes, fears and preferences are to manage living our 'best life' with such a debilitating long term health condition.

What's important to me is maintaining my independence and dignity, which includes my physical health. As a veteran I've always been disciplined to keep in good physical condition and through SSAFA and the Blind Veterans UK secured funding to access a local gym, once a week for 50 mins, that has made reasonable adjustments for people like me with visual impairment and spatial awareness issues through 1-2-1 physical training. These facilities have created an environment which is quiet and spatially safe for me to navigate equipment with an instructor's guidance helping me to avoid becoming deconditioned. A change in my daily routine, relieves my mental health issues of frustration, anxiety, isolation, boredom.

It also offers respite for my wife who has her own mental health issues managed by medication. My wife has created an armband to alert people to my condition to help them readjust their interaction with me, as I stumble with my words these days.

I'm afraid of becoming a burden to the wider healthcare system through frequent use of services and reliance on medication. Accessing a social prescribed activity that has made reasonable adjustments to support me using a 1-off Frailty & Dementia Personal Wellbeing Budget, managed by Age UK Glos has helped me avoid physical and mental health deterioration during the past 6 months. I've noticed I'm less reliant on visiting my GP. "



One Glos 'Personalisation into Practice' Our People Stories

All it took was to ask... What matters to me...

Sharon Renouf-Preece

Stroke Early Supported Discharge (ESD) Flow and Wellbeing Co-ordinator



1. Tell us about how it happened, and why you are proud of it.

Seeing Me has been a key focus for the Stroke Early Supported Discharge (ESD) Team at Gloucestershire Health & Care NHS Trust. During the past 12 months my new role was created to provide a case management approach to promote personalised care. This included linking acute and community services to promote independence and proactive care planning to help patients navigate the Stroke Pathway and access appropriate care aligned with community and voluntary services. I'm now able to visit people in their own home to get to know them, their wider family network and facilitate 'what matters to me' conversations recorded in their personalised care and support plans to explore supported self-management options.

2. Tell us, who did you work with?

I worked with Gloucestershire Hospital NHS Foundation Trust (GHFT) Stroke Unit team, Gloucestershire Health & Care (GHC) Trust Community Stroke Rehabilitation team including Occupational Therapists and Physiotherapists, Primary Care's GP Practice Care Co-ordinator, Gloucestershire County Council (GCC) Social Care Team, Pharmacy Team, Voluntary Community Sector agencies including PeoplePlus, Age UK Glos, Mrs RB and her husband.

3. Tell us, how you did it?

Proactively connecting up with NHS providers in the County and other agencies through telephone calls and emails to ensure Mrs RB & husband received practical and integrated personalised care. I spent a total of 10hrs with Mrs RB and her husband to provide a holistic needs assessment and our therapist and rehabilitation assistants visited the couple 4 times a week for 8 weeks to provide therapeutic support. Further follow-up contacts were established between 6-12 months by the Community Stroke Co-ordinator to ensure the couple's supported self-management was working well.

4. Tell us, what was the impact on the person/system?

Mrs RB had prompt joined-up health and care from numerous providers, as well as ensuring her husband's wellbeing was part of the personalised care discussions. As health support staff and professionals we can see a change towards 'integrated neighbourhood team' working to create better efficiencies for the system, reducing duplication of activity and better patient experiences.

5. How did working in a personalised care way make you feel?

A privilege to have the flexibility and agility to tailor care to a person's needs and wishes as part of an 'out of hospital' rehabilitation approach whilst supporting the person holistically.

6. What could health and care leads do to help make that happen?

Enable a single interoperable digital personalised care & support plan that can be accessed by any OneGlos system partner and printable copies held in the 'What Matters to Me' folder owned by the person.

Seeing Me.....Mrs RB (Stroke Patient)

I'm Mrs RB, aged 83 and in 2025 I was taken to Gloucestershire Hospitals NHS Trust Stroke Unit for medical care. After spending some weeks in hospital, the Hospital Discharge Co-ordinator explained to me and my husband that Sharon from Gloucestershire Health & Care NHS Trust, 'Community Stroke Early Supported Discharge' (ESD) team would co-ordinate additional support for me and my husband to return home safely.

Sharon quickly arranged a home visit, advising she would carry out a wellbeing and safety check and to hold a **personalised care** conversation with me and my husband to help us identify 'what matters' to us to best cope with my new health needs following my Stroke. I was helped to record information into my Personalised Care and Support Plan now held in my 'What Matters to Me' folder. Sharon advised she had also contacted my GP practice for support to complete my ResPECT Plan. Details about my needs and goals based on my Stroke symptoms to help improve my daily activities had been recorded separately onto the community stroke teams 'About Me' digital system for clinical note recording.

Sharon conducted a second home visit to give further assistance with onward referrals and then organised visits from the Stroke ESD team Occupational Therapist, Physiotherapist, Rehabilitation Assistants and my GP's Ageing Well Team.

She also helped us with:

- Ordering equipment to support independence & safety.
- Understanding medication and dosage to administer.
- Financial support to access benefits with hospital parking & mileage.
- Obtaining a Blue Badge to support poor mobility and disability rights UK for a Radar Key.
- PeoplePlus Carer register for my husband to support with domestic activities.

What can I say, just a huge thank you for the support and care from everyone involved to get me back to living my best life.



Integrated Working - Universal Personalised Care

What Matters?

A shift in relationship between health & care professionals & people

"being sociable", it's about enjoying at home, it's making me become engaged, less tired and feeling relaxed, accessing people that I can rely on, I feel more open with my partner or health condition"

... **"being active"**, my mobility is compromised due to my symptoms, I can't walk a mile but find it difficult to get about independently, it's a chore going to the bathroom or checking the door but I've been out of bed for 3 months"

... **"being healthy"**, I use to go to the local allotment, it was my favourite hobby as I loved growing my own vegetables and cooking healthy meals, but these days I can't drive, walk properly and I feel tired and fatigued, I'm not making progress any more but know I need to manage my diabetes"

... **"being independent"**, I've alone, my daughter lives out of area and visits every 3 weeks. My neighbour has kindly offered to do my shopping as I can't use my car anymore. I need help with cleaning and gardening, it's all becoming too much for me now. I've made my Will and Lasting Power of Attorney in case I become negatively impacted and want my daughter to be able to make decisions on my behalf"



Define
What Matters in Life

Produce
Goal Setting Targets

Implement
Health Planning Support

Sustain
Quality & Experience



Social Prescribing / Creative Health
 • Dementia Clubs • Choirs, Music, Paint
 • Arts & Crafts Therapy Groups
 • Walk, Run, Swim, Golf, Bowling Groups

Support of Self-Management
 • 24/7 Digital Support • Telehealth
 • Peer Support • Digital HCPs
 • Health Coaching • MFP
 • Patient Activation • MyCall
 • Patient Activation • Dialog

Social Prescribing Plans/Local Activity / Creative Health
 Supported Self-Management Health Coaching
 24/7 Home Assisted Technology
 Personal Health Budgets / Local Wellbeing Budgets

Digital Technology / Equipment
 • Virtual Visits
 • Telehealth

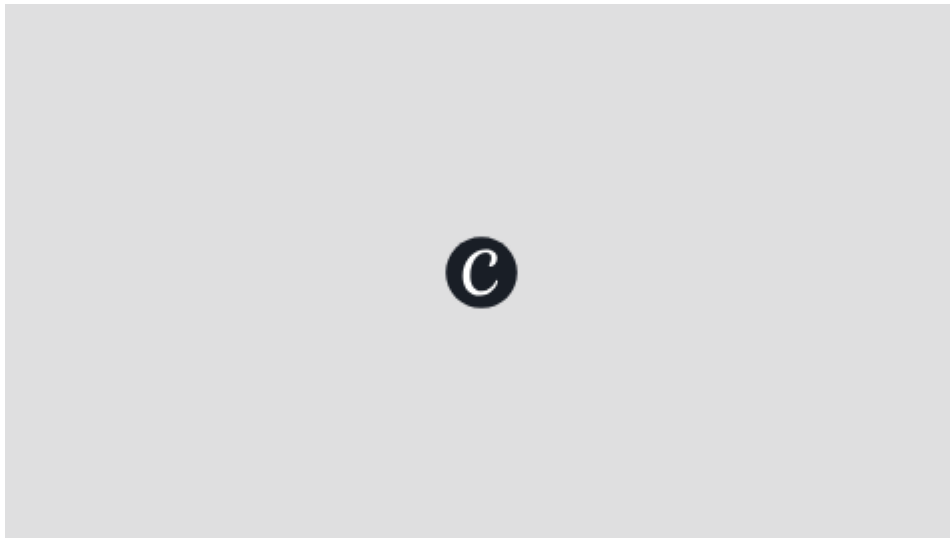
Personal Health Budgets
 • Children's Continuing Care
 • Adults Continuing Healthcare
 • NHS 24/7 24 hours
 • 11688
 • Care Support Budgets
 • One-off Personal Wellbeing Budgets



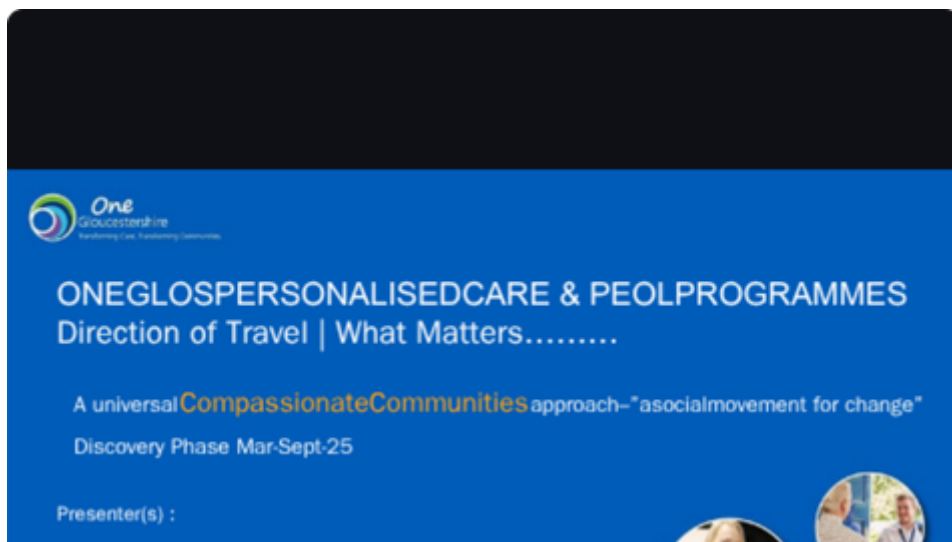
Examples of KPI Metrics to track Patient Experience and System Sustainability

Personalised Care Support Plans ↑ 10% Increase 88% of people with CHDs have a complete personalisation plan and support plan and it is their preference in their wellbeing journey.	Personal Health Budget ↑ 10% Increase 88% of people with CHDs have a complete personal wellbeing budget in place. There are 1000 in place of health and social care.	Supported Self-Management ↑ 10% Increase 88% of people with CHDs are using their wellbeing budget to support wellbeing and self-management of their condition.	Reduced Hospital Readmissions ↓ 10% Decrease 88% of people with CHDs reduce emergency calls and ambulance responses, supported through digital/physical health care.	Engaged Health Teams ↓ 10% Decrease 88% of people with CHDs have a complete digital support plan in place to reduce risk.	Healthcare of the Future ↓ 10% Decrease 88% of people with CHDs reduce the length of their care journey supported by digital and physical health care.
Social Prescribing ↑ 10% Increase 88% of people with CHDs are using local resources to support wellbeing and self-management of their condition.	Wellbeing Coaching ↑ 10% Increase 88% of people with CHDs are using local resources to support wellbeing and self-management of their condition.	Shared Decision Making ↑ 10% Increase 88% of people with CHDs are using local resources to support wellbeing and self-management of their condition.	Hospital Readmissions ↓ 10% Decrease 88% of people with CHDs reduce emergency calls and ambulance responses, supported through digital/physical health care.	Wellbeing Support ↓ 10% Decrease 88% of people with CHDs have a complete digital support plan in place to reduce risk.	Healthcare of the Future ↓ 10% Decrease 88% of people with CHDs reduce the length of their care journey supported by digital and physical health care.

PERSONALISED CARE ROLES



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(double click powerpoint to view powerpoints)





Naturewell

Nature based health and wellness support

Naturewell enables participants to explore their own personal self-care for positive mental health and wellbeing through the 5 Pathways to Nature Connectedness.

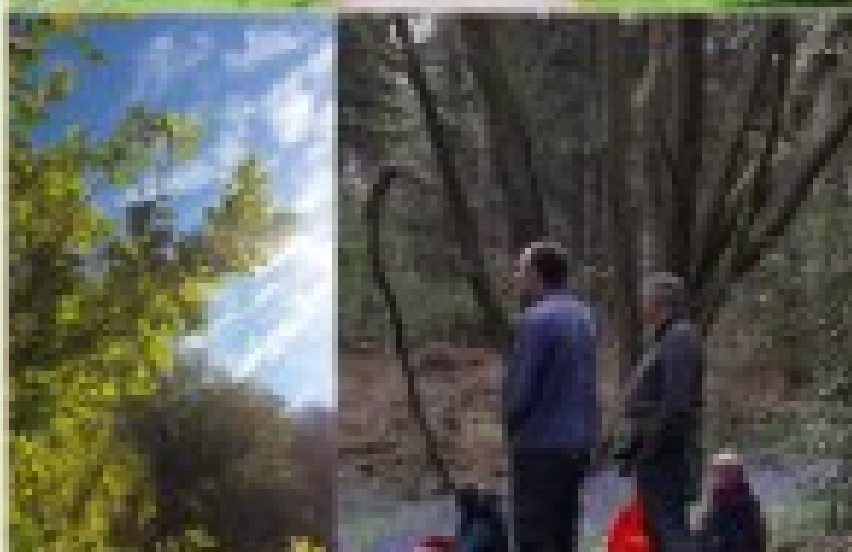
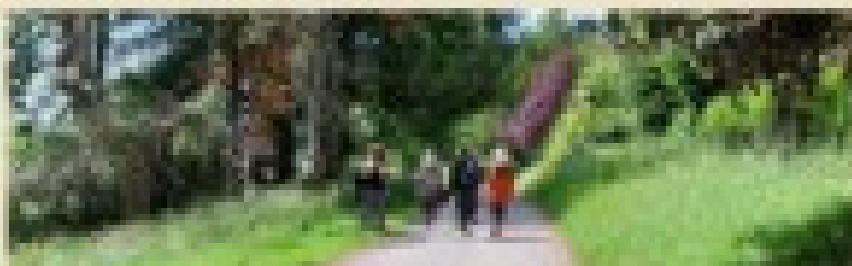
Naturewell supports:
Inclusion
A sense of belonging
Emotional awareness
Meaning and purpose

Naturewell builds on social cohesion through the gentle peer support of the group

To Relax

To Restore

To Revitalise

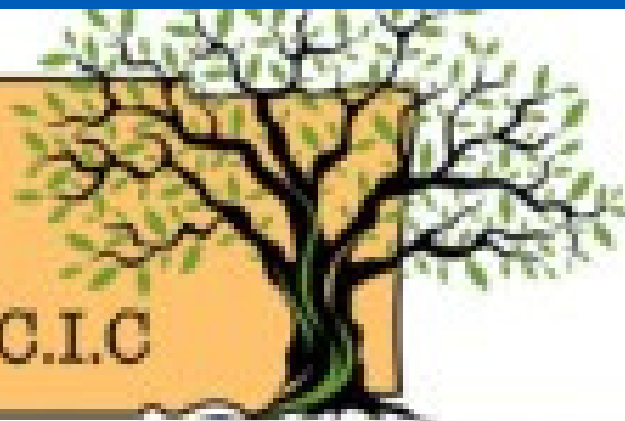


Through facilitated solo time and group reflection the nature-based practices support a personal approach to mental health and wellbeing.

Naturewell is now recognised as a model of practice for nature-based interventions across the UK



The Place Outside C.I.C



We provide facilitated 6-week Naturewell courses;

- to foster a deep connection with nature
- to support positive mental wellbeing through nature-based practice and nature-inspired activities.
- making nature accessible for all.

Our groups offer an opportunity to connect with ourselves and others and foster a sense of belonging to the natural world.

"It has made me realise how important it is to prioritise spending time in nature. Each week I have left the course feeling better as a result of the time spent in nature and the feeling of hold and being part of a such a safe and gentle group"

Contact Lorraine,
All or Wicky at

barn
wood

info@theplaceoutside.co.uk
theplaceoutside.co.uk

PERSONALISED CARE PEER SUPPORT GROUP



Experts by Experience Programme

Keeping service users and carers at the centre of developments at our Trust

Experts by Experience are people who have personal knowledge of our services in Gloucestershire. This could be their own use of our services, or through caring for someone who has used them.

We believe that in order to understand and meet the needs of our service users, their families and carers, we must involve and learn from people who have experience of our care.

Experts by Experience are involved with our Trust in numerous ways and we are always keen to recruit more.

What can I get involved in?

There are lots of different ways to be involved, depending on your interests and preferences. Here are some of them:

- Taking part in staff recruitment
- Project work, co-producing the planning, design, delivery, development and review of services
- Evaluating services and quality assurance
- Staff training
- Peer training in Recovery College
- Engaging with the public at events or co-delivering a workshop
- Attending meetings to give feedback
- Taking part in research

We understand that over time your interests might change - and that's completely fine.

Why might I want to get involved?

Here are some reasons our Experts by Experience have given us:

"The wonderful team I help do such valuable work with the most vulnerable in society, and both need and appreciate my help."

"I feel that I'm giving back to the system, I feel that I am worthy and helpful and have a purpose in life."

"I like to pass on my knowledge and to help others going through similar experiences."

"The Trust was there for me in my darkest time. I like to give something back."

How will you support me to become an Expert by Experience?

You can register your interest by completing and returning our Application Form. Once we've received this, a member of the Partnership Team will contact you and arrange to meet with you.

We will ask you about yourself and the activities you would like to be involved in. We will also go through our Agreement Form with you.

Once Experts by Experience are registered with us, we contact them by email or telephone when new opportunities are available, to see if they might be of interest.

We provide training for certain roles (for instance recruitment training). We also arrange for any reasonable adjustments people need, to help ensure that opportunities are open to as wide a group as possible.



What happens if I become unwell or don't want to continue with the role?

Please do not worry as we fully understand that this may happen. You can opt out, or take a break from the programme at any point.

We want you to feel able to let us know. However, the Partnership Team will be in regular contact with you throughout your involvement.

Will I be able to claim expenses?

Yes. You will be paid an honorarium fee of **£25.00** for up to four hours involvement. If you travel by car, you can claim your mileage and any parking expenses. If you travel by public transport, you can claim your fare.


A claim form will be given or sent to you by the Partnership Team for you to submit after each involvement and we ask you to provide receipts for any fares / parking.

What do I need to do to get involved?

If you have a Care Co-ordinator, you can let them know, or you can contact the Partnership Team directly for an application form. For more information, **our contact details are:**

 **0300 421 4889**

 **partnership@ghc.nhs.uk**

 **Partnership Team**

Gloucestershire Health and Care NHS Foundation Trust
Edward Jenner Court, 1010 Pioneer Avenue, Gloucester Business Park, Brockworth,
Gloucester, GL3 4AW

For general enquiries or if you would like further information, additional copies or would like to receive this leaflet in another language, large print or on audio format, please contact the **Trust Communications Team** at the above address.

 **0300 421 8100**

 **ghccomms@ghc.nhs.uk**

BIG HEALTH 2026

Scan me!



Or visit
www.ghc.nhs.uk
and search for
'big health day'

An inclusive event to promote health and wellbeing

Big Health Day

Thurs 11 June 2026
9.30am-2pm

Oxstalls Sports Park, Plock Court,

Tewkesbury Road, Gloucester, GL2 9DW

An annual event for people with a physical or learning disability, sensory loss or mental health needs

Sports
and
games



Be active
and have
fun



Health checks, wellbeing information and signposting.

Directions and Facilities



Oxstalls Sports Park, Plock Court, Tewkesbury Road, Longford, Gloucester, GL2 9DW.



Entrance on A38 Tewkesbury Road, Longford – follow sign to Tennis Centre

*Availability of accessible parking for Blue Badge users, first come first served.



Use 97 bus from Cheltenham / Gloucester or 71 from Tewkesbury.



FREE parking on-site plus accessible parking*



Accessible toilet facilities inside plus mobile accessible toilets outside



130+ volunteers to help you



Bring a packed lunch or food can be purchased on the day



Dedicated quiet area outside



Only assistance dogs are welcome



working together | always improving | respectful and kind | making a difference



(double click powerpoint to view powerpoints)

working together | always improving | respectful and kind | making a difference

A different Mindset

Has someone close to you received a Dementia diagnosis? This can be challenging and upsetting for family members as well as for the person with the diagnosis themselves.

Mindset for family members is an 8-week course for people who are supporting someone who has received a dementia diagnosis within the last 2 years.

This support course is run by a skilled therapist who will cover a range of topics, and you will also have the opportunity to meet and talk to others who are going through similar experiences.

Our next course is at:

Great Oaks Hospice, Coleford. GL16 8QE

Every Friday morning, 10am – 11:30am for 8 weeks.

from the 10th of April 2026

To join this course please contact:

Maggie Grady on: maggie.grady@mindsong.org.uk (07889 286684)

Mindset also runs courses for the person with the diagnosis. For more information, please contact Amanda Chappell on:

amanda.chappell@mindsong.org.uk (07506 646975)

mindsong

NHS



Great Oaks
HOSPICE