Newsletter Date:
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Hinckley and Bosworth Social Prescribing Link Worker PCN Newsletter

Inside this issue:

A day in the life of a Social Prescribing Link Worker :

08:30am Arrive at the surgery, answer any queries from day before, review and respond to a variety of service emails, and set up login to all systems for day planning.

09:15am– Multi Team Meeting– liaison with professionals across community service offer-including: Mental health Matters workers, Care Coordinators, Health & Wellbeing workers, Recovery Workers, & LAC's Creating links and sharing Community Mapping Resource creation & service liaison.

10:15am– Home Visit to Patient with dementia & family, following decline in memory, Practice Nurse referred to SPLW To support family with local activities, services and community offer to support patient at home and to increase socialisation opportunities. Also to support carer's with carer's support links and services.

11:30am SPLW Clinic at surgery: F2F Appointment with patient following GP referral for patient with LTC, and socially isolated/Low Mood.

12:30pmTelephone call to patient to follow up on previous actions and support with SPLW regarding signposting to carer's links & Support

13:45pm SPLW attending new Social Hub in community Church— meeting volunteers, sharing information, active signposting for patients, sharing SPLW role and be the active link between VCS to PCN

3pm Meeting to plan and co-produce SPLW Presentation of service for PCN, and create /explore SPLW Newsletter creation

4:30pm Telephone Consultation with Patient to review social housing needs, and offer onward referral to services to support her impending eviction to ensure patient is well supported & reduce risk of homelessness.

Social Prescribing News:

National News Stories on the benefits of Social Prescribing:

https://www.wired.co.uk/article/social-prescribing

https://www.kingsfund.org.uk/publications/social-prescribing

QR CODE For SPLW Facebook Page:

SPLW PATIENT STORY

Referral From: Patient self-referral request to SPLW via Surgery reception.

Referral Message: This patient was wondering if they could get a call off you– patient has seen the Social Prescriber information in the surgery, is really struggling with anxiety, after a recent job loss at the moment and thinks you may be able to help. Thank You.

SPLW first contact and what patient wanted:

Patient initially referred due to loss of income/job due to covid- which had led to financial strain, low mood, and patient identified themselves as isolated and lonely- no family locally or friendships. SPLW created person centred care plan with patient to focus on their Mental Health Support, Social Isolation, and financial supports.

During initial contacts with patient, the patient sadly lost a friend to suicide. This then evolved the support needs and added to their care plan with a need for further support.

Multidisciplinary team working with referrals by SPLW to:

- Mental health matters- to support patient's anxiety and routine/building structure to day and working with to support social anxiety
- Link to the voluntary service for Befriending for friendship and to improve social isolation.
- Referral to HBBC welfare support officer to support patient with financial debt, benefits Assessments and grants eligibility
- SPLW Referral into Food banks and food parcels
- Liaison with voluntary sector services to support with household items so patient has bed to sleep in—via local SPLW connections with locally based voluntary supports.
- Referral by SPLW to Physical Exercise Service via HBBC for walking buddy.
- SPLW alongside Welfare Support Officer connected to HBBC housing Officer to review supports on offer with financial aspects.
- Signposting to Cruse bereavement support and Suicide based charities to support people impacted by the loss of someone to suicide.
- Signposted to step change debt charity to support reductions and reviews of patient debt, Referral completed to Clockwise Credit union to support the setup of a budgeting account.

Outcome:

Mental Health

Patient was supported for 12 weeks with the MHM Team to support management of social anxiety— SPLW Worked with MHM service with regular reviews with MH Professional to share best practice and service collaboration. Patient engaged and completed programme and began to leave their home again feeling more confident and able to manage their anxiety symptoms.

Patient reduced MH Reviews with GP from 2 weekly to 6 weekly.

Socialisation:

Patient due to restrictions had the support of a telephone befriender which helped grow their confidence in speaking to new people.

As restrictions eased Patient was connected to community physical exercise programme and began going for walks with a volunteer to build their confidence and increase social interaction gradually, whilst also benefiting their MH with regular exercise.

Finances:

Patient with the support of HBBC welfare service was assessed for benefit eligibility and awarded a grant to help with utility billing.

Patient was supported by SPLW to apply for PIP.

Step change debt charity helped patient with debt support.

Housing Officer following referral by SPLW applied for help from the Big Difference scheme with Severn Trent and they have helped patient with reducing water rates and debt.

PATIENT VOICE AND FEEDBACK

"Thank you so much for all your help and onward supports, I honestly don't know where I would be now without it"

SPLW ACTIVE SIGN POSTING AND SERVICE INFORMATION SHARING

National Eye Health Week Sept 20th-26th

vista
Improving lives of people with sight loss

SPLW Case Study—Supporting Sight Loss
Local Connections with wider services to support patients:

SPLW had a received referral via a GP for an elderly patient living alone, Patient was suffering with declining sight loss. This was impacting patients ability to care for their self safely and fully. There was a potential of health decline due to a risk of falls in the home, and the patient was unable to cook for self as unable to see the cooker dials. The patient expressed their love of cooking, and how this decline in sight had "taken away my one love"

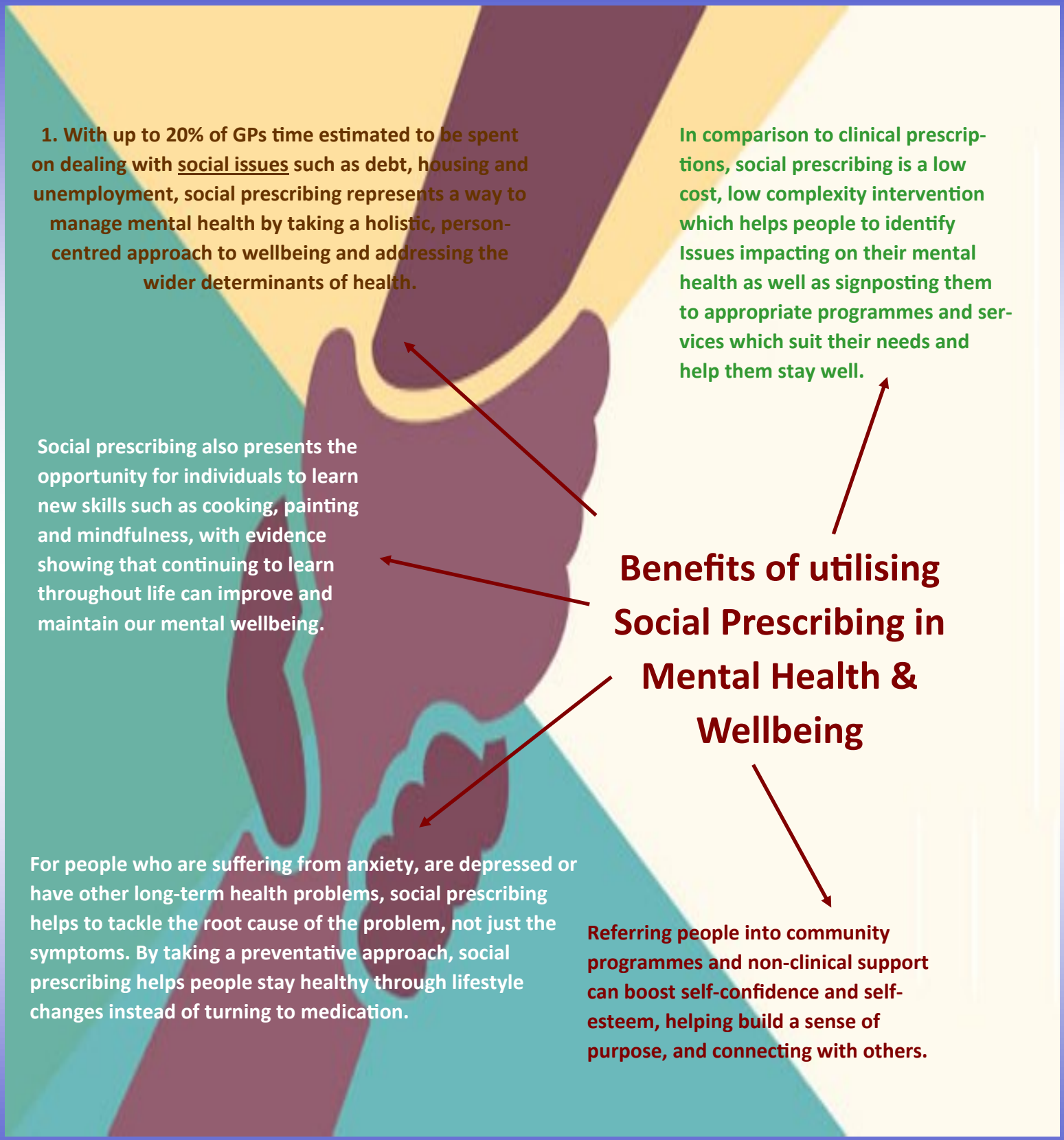
The SPLW contacted the patient, and arranged a home visit to talk through areas of need, difficulties and to review wellbeing. The patient was keen to maintain independence, but their declining sight was preventing this which was making patient feel low in mood and "fed up."
After an assessment with the patient, and care plan created, the SPLW contacted the Vista Sight Service, and completed a Tel referral for the patient. VISTA have since contacted the patient, and have completed a home visit to look at minor adaptions and sight supporting equipment in patients home to support patient so they can remain independent and safe.

A new cooker magnifier was installed—as cooking with oven was difficult as could no longer see the dials, and therefore wasn't eating well as was reliant on microwave meals. The patient is now able to cook for again and patient reports they feels they have their enjoyment back.

This contact with patient also reduced risk to patient of onward admission as the support offered reduced the risk in the home for trips, falls and potential burn injuries.
Enquiries about our services and support available for people with sight loss.

0116 249 8839 and info@vistablind.org.uk

Social Prescribing & Mental Health and Wellbeing



Benefits of utilising Social Prescribing in Mental Health & Wellbeing

1. With up to 20% of GPs time estimated to be spent on dealing with social issues such as debt, housing and unemployment, social prescribing represents a way to manage mental health by taking a holistic, person-centred approach to wellbeing and addressing the wider determinants of health.

In comparison to clinical prescriptions, social prescribing is a low cost, low complexity intervention which helps people to identify Issues impacting on their mental health as well as signposting them to appropriate programmes and services which suit their needs and help them stay well.

Social prescribing also presents the opportunity for individuals to learn new skills such as cooking, painting and mindfulness, with evidence showing that continuing to learn throughout life can improve and maintain our mental wellbeing.

For people who are suffering from anxiety, are depressed or have other long-term health problems, social prescribing helps to tackle the root cause of the problem, not just the symptoms. By taking a preventative approach, social prescribing helps people stay healthy through lifestyle changes instead of turning to medication.

Referring people into community programmes and non-clinical support can boost self-confidence and self-esteem, helping build a sense of purpose, and connecting with others.

New Community Groups, Activities & Supports

Newbold Verdon Community Social Hub

Where: Baptist Church

When: Every Wednesday 9am—5pm

(breakfast & Lunch offer free, with tea and coffee, including a variety of activities across the session.)

Afternoon Tea at Newbold Verdon library

Last Thursday of each month 3pm-4.45pm on 28.10.21, 11th, 28th and 9th Dec with guest speakers and activities at each session.

2nd Thursday of the month 3pm-4.45pm on: 9th and 30th Sept, and 14th October .

Pathways Community Café– Hinckley

Our café is open to the community on Thursdays, during term-time, from 10am-2pm.
We serve cooked meals and light lunches all freshly prepared to order.
Sit and relax by yourself or join your family and friends in a warm and welcoming environment. We also have a lift for anyone with disabilities.

Hinckley Baptist Church, Baptist Walk,
Hinckley, Leicestershire LE10 1PR

Dementia Support Services in Leicester & Leicestershire

World Alzheimer's Day 21 September and is part of World Alzheimer's Month. This year, we're talking about dementia – and urging everyone to join in the conversation by becoming Dementia Friends.

For more information please contact us:
0116 223 7363 Open weekdays between 08:30 - 17:30
dementia.support@ageukleics.org.uk

- **VASL Support For Carers: 01858 468 453**

- **Forget Me Not Social Group**
- **Starting from Thursday 16th at St Martins Church Hall 10.30am to 12 noon. The group is run by volunteers, for those with a diagnosis of Dementia, memory impairment or brain injury and their carer. There is a cost for the carer of £3 for refreshments but there is a real opportunity to spend time with other carers who may well have a shared life experience.**