'Social prescribing for better health and happiness

Newsletter update - Social Prescribing Update 11/8/2017

We are now over two months into Social Prescribing and our referrals have reached over 90. We are focusing on those at risk of falls and supporting carers. Below we have included some case studies with regards to these outcomes. We have been successful is preventing admissions and enabling patients to remain at home.

In this update: more case studies and how social prescribing is developing community support

Supporting a patient to remain at home

I received a referral from the patient's GP outlining that the patient required some more social support and was also depressed (currently known to CMHT). I rang the patient and agreed to visit her home the following week as the patient had low mobility and lives on her own.

The patient is a self-funder and also has people to places transport arranged (TAPS service - £100 a year free travel and subsidised thereafter). I discussed with the patient what she enjoyed which included creative arts, comedy, learning about psychology and socialising. There is currently a volunteer that goes round once a week for an hour which the patient looks forward too. The patient stated that she would like more of this kind of interaction so I put a referral into the royal voluntary service to find another volunteer that could visit her. She was also unsure as to the benefits she receives and should be receiving so I have arranged a home visit by citizen's advice bureau to support her with this which has been confirmed for within the next few weeks. There were other concerns about the amount of interaction she was receiving from other services which I was able to discuss with her GP and support following up with. I am currently discussing with the education manager at Norden Farm the opportunities with supporting the patient access some of their art classes or comedy with people to places providing transport.

Whilst I was round the patient's home she had an epileptic seizure whereby she appeared to stop breathing. I called 999 and was asked to start administering CPR after some initial questions by which point the paramedics arrived and took the required checks (heart rate, blood pressure etc.) and started to prepare to take the patient to hospital however the patient started to come out of her seizure. They asked if she would like to go to hospital to which the patient replied 'No' and had expressed earlier to myself how she wanted to remain at home. The patient disclosed that she has 4 fits a day however there wasn't any 24 hour monitoring in place so I raised this to social services and will follow up accordingly. I also followed up with the patient's GP who expressed that the patient is a complex case and had been under her care for 8 years with various medication reviews. The patient is isolated, frustrated and essentially bed bound 7 days a week however is able to travel with a carer and has transport arranged therefore over the next 12 weeks the patient's wellbeing should improve once the appropriate services are accessed.

Supporting a carer

The patient was referred by her GP as she is elderly and looking after her husband who is terminally ill. The patient came into surgery to discuss her situation. She hadn't had a revision of her carer's assessment for over 4 years and her role had changed from when her husband first became ill. This prompted me to request a review of his package of care and her carers assessment via RBWM from which she will receive more finical support towards her caring role. The patient is also going into hospital herself to have a procedure and has booked her husband into respite but is concerned about how she will manage post op. I gave her information regarding the STS&R team that would be able to support her with p/care on her discharge. I suggested a Carebank referral which would allow her to go out when they are present and keep her husband company as he likes to talk to people even though he can no longer go out. We also discussed the SWIFT service to support the cared for whilst the carer has a break and my patient would like to be able to access this service once she has had her operation as she would benefit from having a night away in a hotel and then she can go shopping in the morning and not have to worry about her husband.

Developing community support services

We have also been assisting to develop community support/services;

We have increased the SMILE classes in Ascot. We are liaising with one of the local Churches and the Fire Station in Ascot to allow groups to use their spaces for example computer classes for those who wish to learn more about using a PC. The space can also be used for Physiotherapy appointments

We have introduced SMILE classes into one of the new private sheltered housing in Maidenhead.

We are currently introducing a new App to RBWM which supports patients with high anxiety, acquired brain injury, autism, learning disability etc. with coping mechanisms to allow them to go about their daily routine.

There is a new pilot service which RBWM are funding and can only be accessed via social prescription at present - The SWIFT service which is providing carers with a break overnight including 6 hours either side of this break plus a night away in a hotel if they wish .

The Social Prescribers are assisting the GP's with their projects and visions around a homeless clinic and falls prevention and attending flu clinics.

Caroline, Katie and Ryan