



Monthly Newsletter

November 2023

FOCUS: ARRS ROLES

Social Prescribing Link Worker: Abi

Abi is our PCN Social Prescribing link worker (SPLW). Starting in July, Abi has become an integral part of the PCN team.

Responsibilities:

- Working as a Link worker between the surgery, patients and local services in the community reducing the pressure on the surgery for non- medication issues.
- Key component of Universal Personalised care
- Meeting practical, social and emotional needs affecting Patients health and wellbeing
- Holistic approach to addressing patients needs
- Dealing with various support scenarios e.g Blue badges, Bus passes, Transportation for hospital appointments , Financial Support, Benefits advice, Medical devices (wheelchairs) , Housing support and other unmet needs such as food, homelessness, Emotional support
- Mental health support, Family support, Carers support, Domestic Violence, Smoking/ Alcohol abuse , Bereavement, Adult social care, Incontinence etc.



Appointments can be booked with Abi directly into the practice rota. Alternatively, email abimbola.ope-ewe@nhs.net

Wickford PCN Health Event!

The health event was a huge success! We had over 60 recorded names but suspect there were nearer to 100 people through the doors on Saturday 11th November. Carla from Motivated minds gave a brilliant talk on "5 ways to wellbeing".



Abi provided a table with her colleague Yemi and they discussed the social prescribing offer and the variety of services accessible to the patients in Wickford. Abi was also able to give valuable support and advice to carers. Many of the patients have been directed to book an appointment with Abi following the event.

What worked well:

1. The nutritionist was also a great support for the event. Offering healthy snacks and recipe cards to patients to help them on their health journey.
- The texts to patients was a great success as many patients informed us that they came along due to receiving a text from the surgery
- We were able to explore Fibrichk; an AF detection app for FREE for 7 days!

What could we improve next time:

- More clinician support from all practices & planned bookable clinics



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Integrated Neighbourhood team:

Alycia continues to work on the frailty list as the team strives to build connections and develop relationships with our wider stakeholders and community services. The CD and PCN manager met with Lynne Taylor, Head of Integrated care - MSE hospital, to discuss the discharges and frequent attenders lists. We discussed the best way to deal with these and found a useful Ardens template which will now be used when dealing with the discharge patients. ("Ardens discharge review"). The next INT wider stakeholder meeting will be in January.



Health Inequalities Update:

As part of our health inequalities project, as a PCN we set out to target a group of patients with unmet needs, and help support their access to better health care, including social prescribing. Through discussions with our social prescriber, CD and looking at our health inequality data in line with the national focus on 'CORE20PLUS5', the following cohorts were identified:

- Carers and unregistered carers
- Elderly
- Obesity and hypertension

The health event was aimed at providing these groups with opportunistic access to advice, guidance and routine health checks. We have had very positive feedback! :)

What's coming up next?

Next month we will share some exciting advancements on EDATT, our new digital tool to support the Capacity and access plans.