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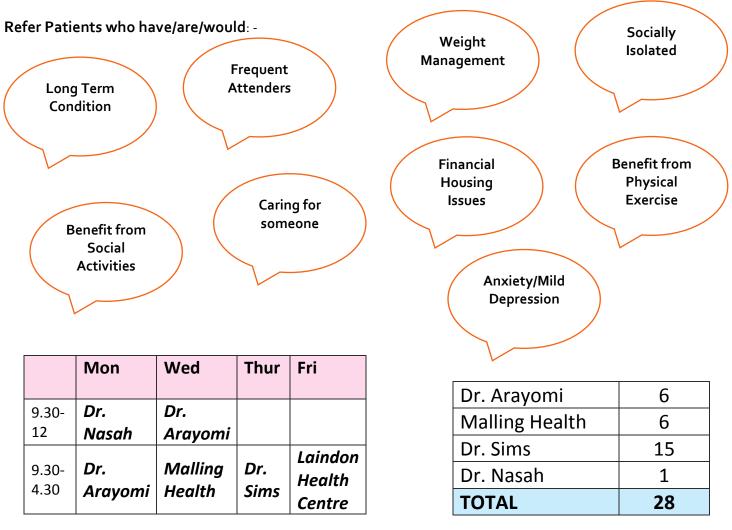
NEWSLETTER

WELCOME TO THE FIRST EDITION OF OUR QUARTERLY NEWSLETTER FOR THE **SOCIAL PRESCRIBING** PROGRAMME BASED IN PITSEA AND LAINDON SURGERIES.



Spring Edition – April 2016

GP's, Practice Nurses, Care Coordinators and Reception Staff at Dipple and Laindon Surgeries are able to refer patients, if they think a Patient could benefit from a confidential, one-to-one meeting with our Social Prescribing Navigators, Jean & Farry. The Navigators will agree an action plan with each patient and signpost and support them along the way to enable patients to access, non-medical local services. Patients can work towards improving their own health & wellbeing



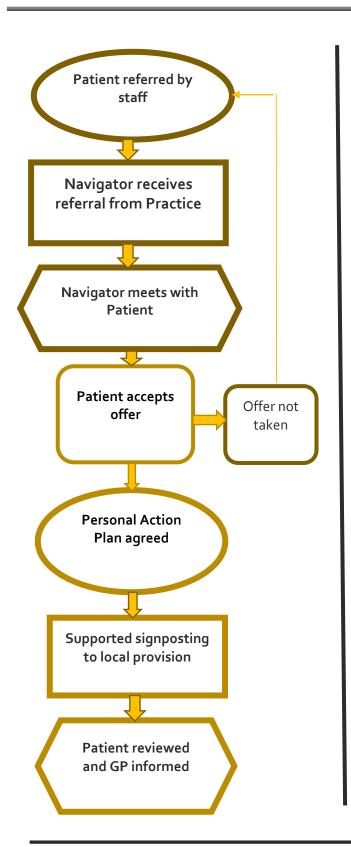








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<u>Case Study 1</u>

Referral reason: Social Activities + Carer + Physical Exercise.

Client has spent many years isolated as full-time carer for her Mother. Mum is aged and has many complex health issues and client lives in Mums house. Outside support from Community Care Team is not in place as Mum can be difficult, mistrusting and does not allow visitors to the house. Client meets most of Mum's needs, has trouble sleeping and suffers from mild anxiety and doesn't want to take anti-depressants. **Outcome/Action Plan:**

Contact local Older Persons Community Group, where various activities daily for Mum. Reassurance that Mum + daughter could initially attend together. Community Transport contacted also to provide access to and from. Befriending service to make contact with daughter and referral to local counselling group also. Recommended local informal Walking Group for daughter to build her confidence and independence. **Follow-up/Review:** Weekly

<u>Case Study 2</u>

Referral reason: Anxiety + Patient off work for past 6 months with recurring knee problem. Recently his Father died suddenly. Usually works abroad and has no family or friends nearby. Sedentary lifestyle caused weight gain. Financial worries as now not working and bills piling up and rent arrears. Very low Literacy level, needs help with form filling.

Outcome/Action Plan:

Assist in contacting Housing Association to address arrears and Benefits Agency to make claim. Contact Community Agents to help with chores.

Follow-up/Review: Fortnightly.

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