Wellbeing prescription

August 2023 Review

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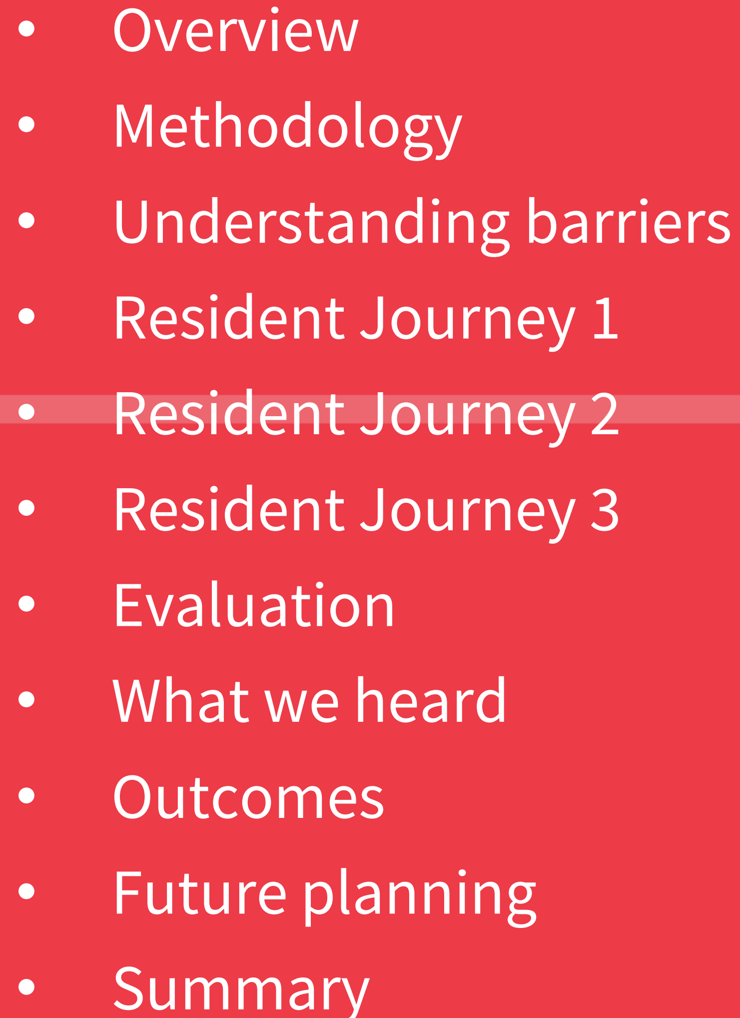

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Overview

Over the last 6 months, a partnership between Life Leisure, Public Health/Stockport Council, Age UK Stockport, Viaduct Care CIC and Brinnington Surgery have introduced a Wellbeing prescription.

The wellbeing prescription is an additional tool to support Viaduct and the surgery to integrate patients and residents into community services. Through the wellbeing prescription, this currently connects the patients to one of the Community Supporters, Danny from Age UK Stockport, who encourages and guides individuals into community activity. Danny calls, meets the individual in a social space and meets them at the community provision, to act as an “ice-breaker” to social activity and groups in Brinnington.

The addition of the Wellbeing prescription gives an opportunity that increases the number of ways to connect to community provision and enhances the social prescribing model currently in Brinnington. Over the last 6 months this has taken positive steps forward, where we hope to demonstrate in this review the journeys of three clients and a report of the outcomes up to August 2023.

Methodology

How?

- Creation of the Wellbeing prescription and the Community Supporter – enhance the connectivity to community services and provision.
- Work towards an increase of services, and an increase in engagement and trust building.
- Focus on the Community Supporter demonstrating the understanding of barriers and why they haven’t accessed provision.
  - Where are potential blockers?
  - How can we “accurately” meet the needs of the residents?
- Creating and enhancing the resource available in the community:
  - Social settings impact and the “ice breaker” provision.
  - Review the type of activity available and how we introduce people who have low-confidence or low self-esteem.
  - Beginner type sessions and the messaging key to engagement into programmes.

Resident Journey 1

How were they referred?

- **Self-referral**
- Motivation: Pre-diabetic, had to change lifestyle.
- Practice nurse gave options – decided on self-referral.
- Connected to Community Supporter through dropping a completed wellbeing prescription in the post box (reception at Brinnington surgery).

01

How active were they before?

- Activity levels were zero.
- Minimal engagement with local community groups, sessions and services.

02

Activities/provision they accessed

- Met with the Community Supporter at Brinnington Park Leisure complex (BPLC).
- Attended "bingo" session at BPLC.
- Attended Confidence Walk at BPLC.
- Attended Social Gym session at BPLC.
- Attended Chair-based exercise session at Lighthouse centre.

03

Outcomes

- Complete change to their lifestyle – healthier BMI.
- Went from 0 active minutes a week to over 3 hours minimum a week.
- Maintained activity and engagement with provision since January 2023.
- The individual encouraged two sons and daughter to attend sessions – big motivation for continued access.

04

Resident Journey 2

How were they referred?

- **Practice Nurse referral.**

- COVID-19 impacted weight including impact on their knees and physical limitations.
- No confidence in gym which affected weight-gain.
- Connected to Community Supporter through practice nurse advice/referral.

01

How active were they before?

- Not active at all – zero participation.
- A social person but weight gain and low-confidence significantly impacted the individual to attend a gym or similar setting.
- Barriers with cost – affordability of the gym or similar services.

02

Activities/provision they accessed

- Met with the Community Supporter at BPLC to attend the Confidence Walk provision in mid-July.
- Attended Chair-based exercise at local community centre.
- Attended breathing exercise classes at local community centre.

03

Outcomes

- Significant engagement with community provision and growth in confidence.
- The catalyst of connecting with the wellbeing prescription and local activity is something the resident has embraced and allowed them to increase activity to over 5 hours a week.

04

Resident Journey 3

01 How were they referred?

- **Viaduct social prescribing referral.**
- Viaduct Link worker felt the Community Supporter had more information about what's available locally.
- Community Supporter able to prescribe differently to meet the clients' needs.

02 How active were they before?

- Not active at all – zero participation.
- Full-time worker, Monday to Friday.
- Lived in Brinnington 11 years – isolated.

03 Activities/provision they accessed

- Met with the Community Supporter at BPLC following a phone call.
- Attended BOOST sessions (supporting mental health and wellbeing).
- Signed up to PARiS scheme in June.
- Attended Evening Walking session held at BPLC.

04 Outcomes

- As the individual was isolated, although many services would be suitable, most are during the day.
- The access to the provision mentioned has supported her to improve mental health and engagement locally with social activities.
- Increased social engagement.

Evaluation

Through the wellbeing prescription, we received 20 referrals who have accessed the free access through our collective provision. This includes access to the coffee mornings, social group sessions, Confidence Walk, Social Gym drop-in and other physical activities. The free access suggests that cost is impacting on physical activity, however offering a free space has opened more routes.

10 of the referrals now attend the PARiS scheme, which is something we hadn't anticipated as part of this work, but it contributes to the growing routes in which patients take to access physical activity.

So what? What have we done differently?

- Knowledge and understanding of the activities and diverse offer (social sessions, physical activity, leading on sessions).
- The "right" community supporter and their knowledge, expertise and positive personality.
- Community decision making and ownership.
- Build up trust in the process of the wellbeing prescription and built on the relationships between services.
- Sustainability with the individual/resident – **creating their own networks.**
- Evaluating the story telling differently – the implementation of theory of change.

What we heard….

Client 1 was diagnosed as prediabetic by the local GP. Upon leaving a surgery, they noticed the wellbeing prescriptions in the reception area and decided to complete the form.

Client 1:

“I have found new information regarding activities going on in the Brinnington area. With this information and support, I have been able to attend multiple physical and mental well-being sessions. My favourite is the community walk on Monday mornings. It's a great way to start the week."

Client 2 visited her local GP surgery, after a conversation with a practice nurse. Client 2 was informed about the well-being prescription and the benefits to sessions they could attend.

Client 2:

“I have been living in the Brinnington area for 20 years but always work a 9 to 5, so I really struggled to make new friends. Since enquiring on the social prescription, I have been attending the evening community walk. This has been a great way to meet new people. We are planning to move the evening walk to a weekend at the end of September which will make it more inclusive to people working full-time."

Outcomes

Impact

- Reduced BMI.
- Accessing more social community provision.
- An increase in social connections.
- Positive impact on wellbeing (both physically and mentally).
- Increased physical activity levels (to meet national guidelines).

Learnings

- Simplistic marketing and communications for routes into physical activity and social activity.
- Further developments of services: Evening provision and access to improve/enhance (from Resident 3).
- Navigating mental health needs….
- Precise referral route – avoid complicated processes.

Considerations

Has this resulted in a reduced access to GP services?

Has this reduced cost on health services?

Do Link Workers have the knowledge and confidence to navigate physical activity conversations and match clients to suitable provision?

Are Link workers aware of the full range of benefits physical activity can offer (e.g. physical health, social connectedness and mental health)?

Do providers measure PA levels, mental well-being etc?

Do Link Workers measure PA/PH outcomes?

Who monitors the outcomes?

Do providers measure physical activity levels, mental well-being, social connectedness and other relevant outcomes?

Future planning

- Confirmed – we have an additional Community Support now part of the programme (Lisa from Life Leisure).
- Grow on the connections to other local provision – using our evidence to share the success of the programme.
- Future guidance: government guidelines on physical activity (150 minutes moderate exercise per week).
- Diversify the offer through providers.
- Our continued alignment with social prescribing goals is key for this to benefit the patients.

Summary

The wellbeing prescription is still in its early days, but the initial implementation has been very promising. The wellbeing prescription has created more routes into social and community activity, with the opportunity to expand on community supporters and what provision individuals' access.

It is important that the opportunities for residents' access to activity continue to increase, based around their individual needs. By our key community connectors supporting each individual, it has helped expand the community offer to support those who are disengaged.

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