

We Connect Social Prescribing Service

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NHS
Cheshire and Merseyside

Wellbeing
enterprises

We Connect

Background

We Connect¹ is a social prescribing service provided by Wellbeing Enterprises CIC (WE) a UK based health and wellbeing social enterprise and funded by NHS Cheshire & Merseyside. We Connect serves the adult population of Halton (aged 18 years and over) who are registered with a Halton GP Practice.

Social prescribing is a key component of Universal Personalised Care². A team of Wellbeing Link Workers provide one to one support to help people overcome practical, social and emotional challenges using a three-step helping approach:

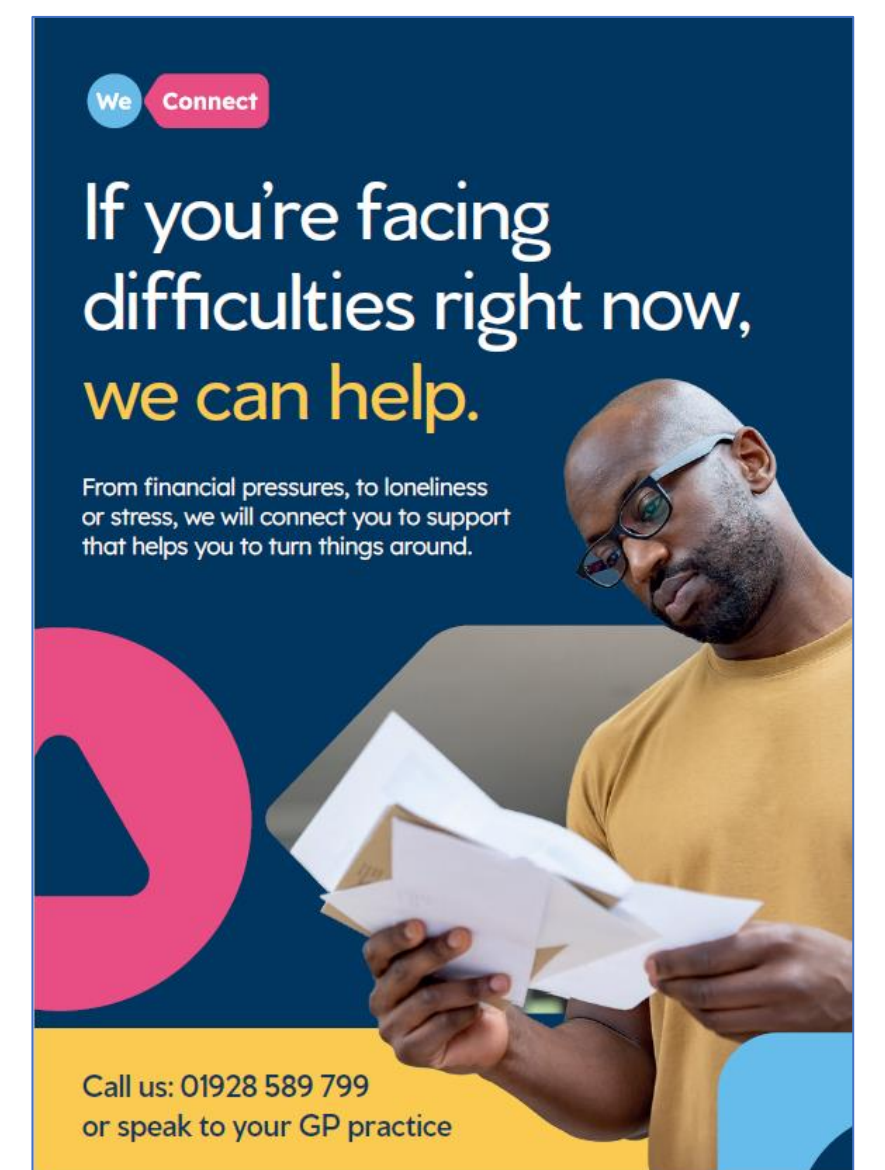
1. Talk - we will listen and understand what is going on for you right now
2. Make a plan - together we will make a plan to get you on the right path
3. Take action – we will help you take control of your health and connect you to people and services that will help you move forward

Social prescribing works particularly well for people who have one or more long term conditions, those who need support with low level mental health issues, people who are lonely or isolated and those who have complex social needs which affect their wellbeing³.

We Connect Service Enhancements

We Connect builds on earlier iterations of social prescribing provision in Halton. Service enhancements include:

- A fully EMIS interoperable data management system enabling real time referrals, snomed coding and patient record updates and associated outcomes reporting.
- Accessible provision including telephone and online support, face to face consultations and home visits for patients with identified needs.
- Extended opening hours 8.00am - 5.30pm Monday to Friday, including bank holidays and some evening and weekend provision.
- Access to wellbeing resources: educational courses, self-help groups, health apps, bibliotherapy and cost of living resources e.g. food, fuel and Highstreet vouchers.

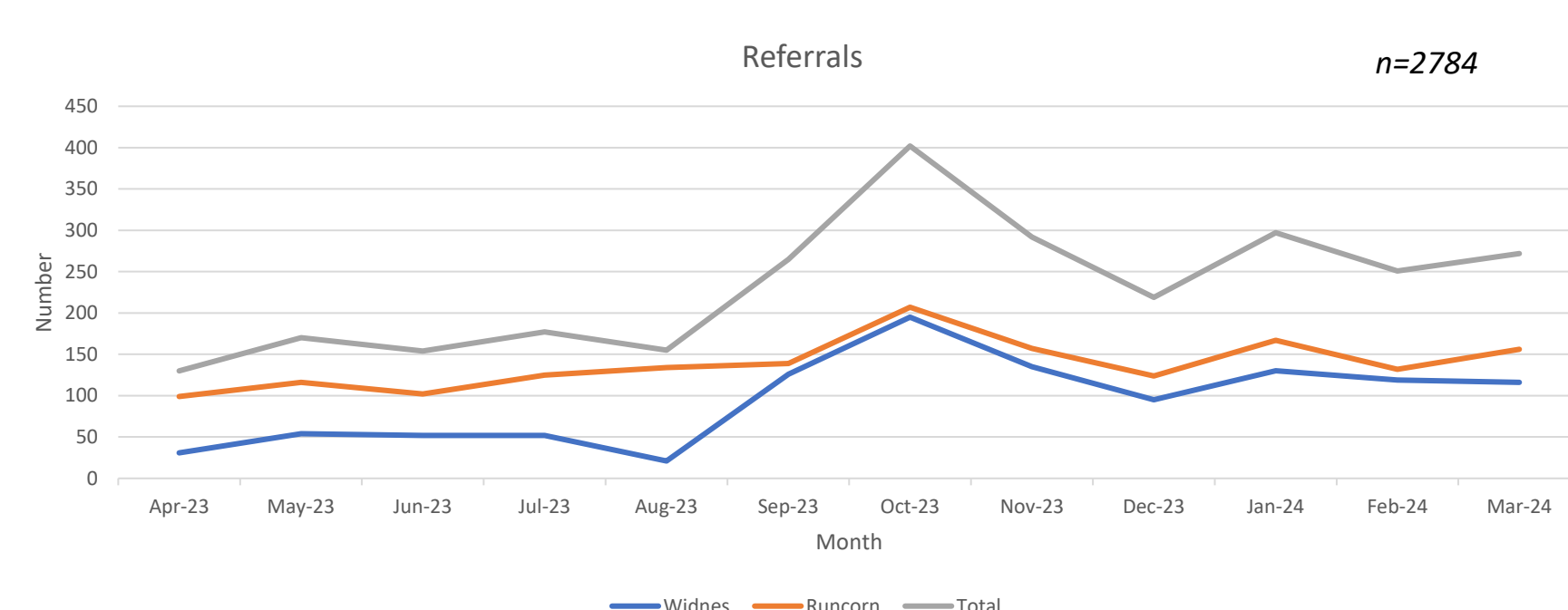


We Connect

Methods & Results

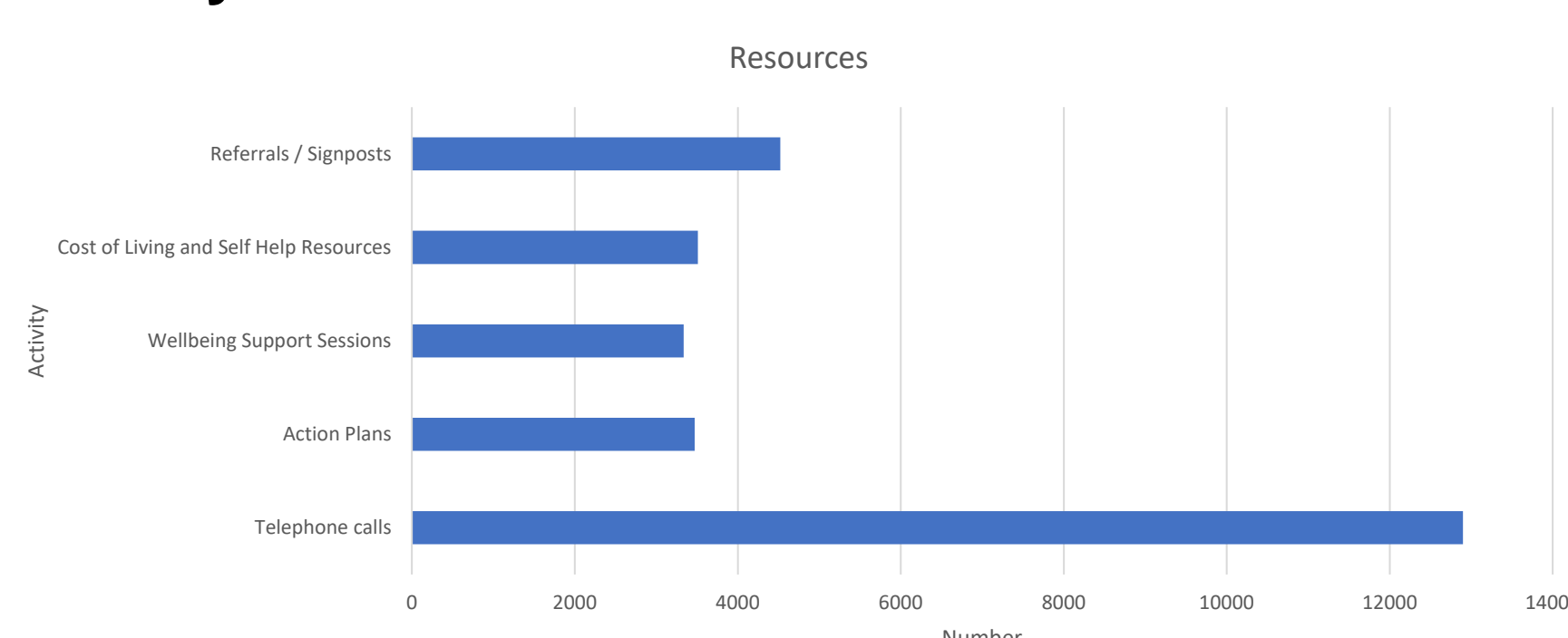
An analysis of data collected over 12-months from 1st April 23 until 31st March 24 was undertaken.

Referral data



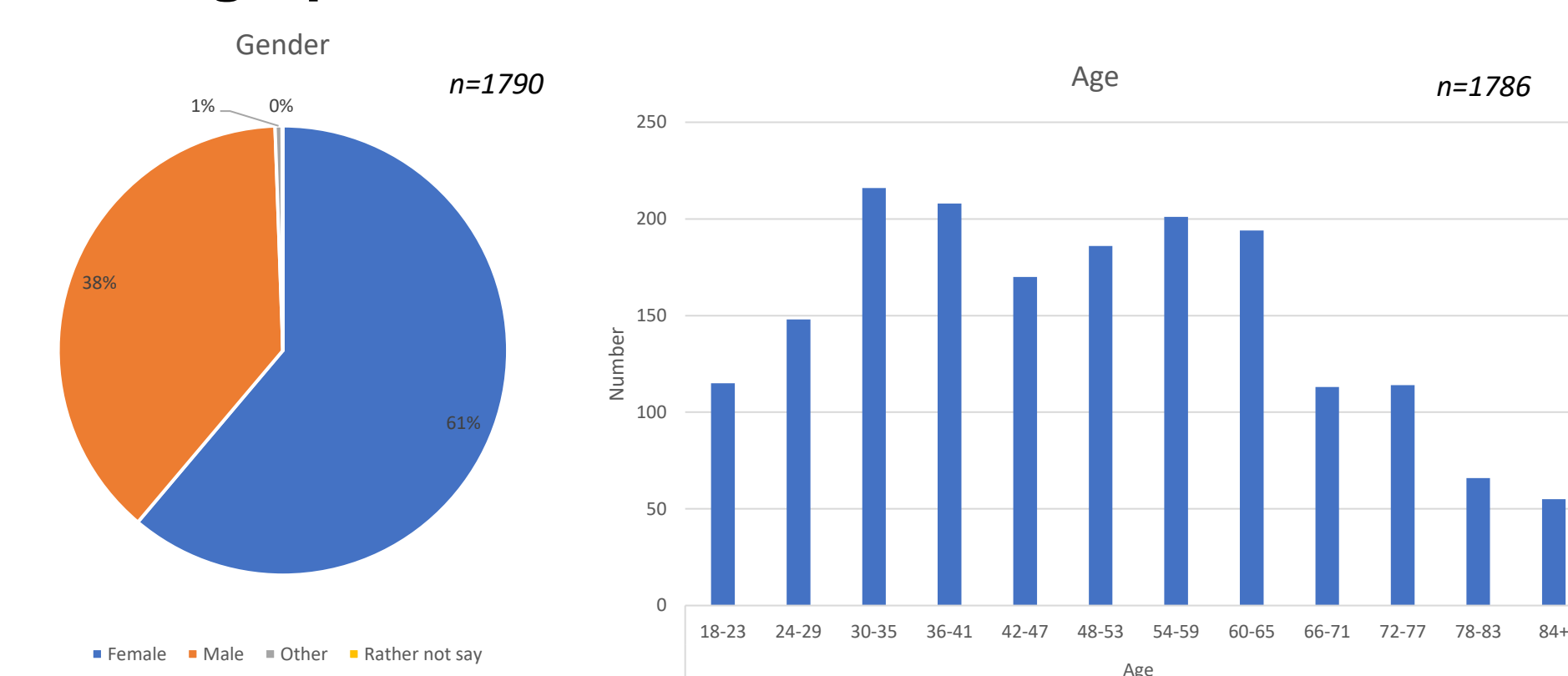
The highest monthly referrals was 402 in October 23.

Activity data



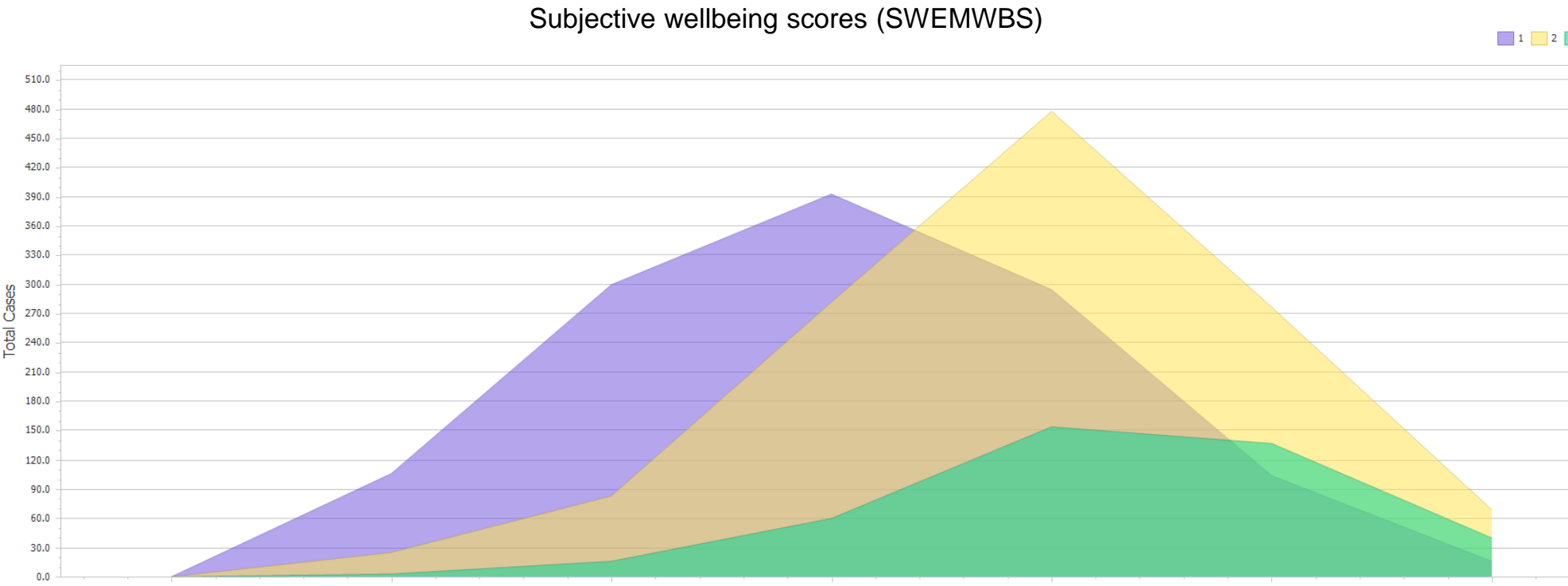
3335 wellbeing support sessions were undertaken.

Demographic data



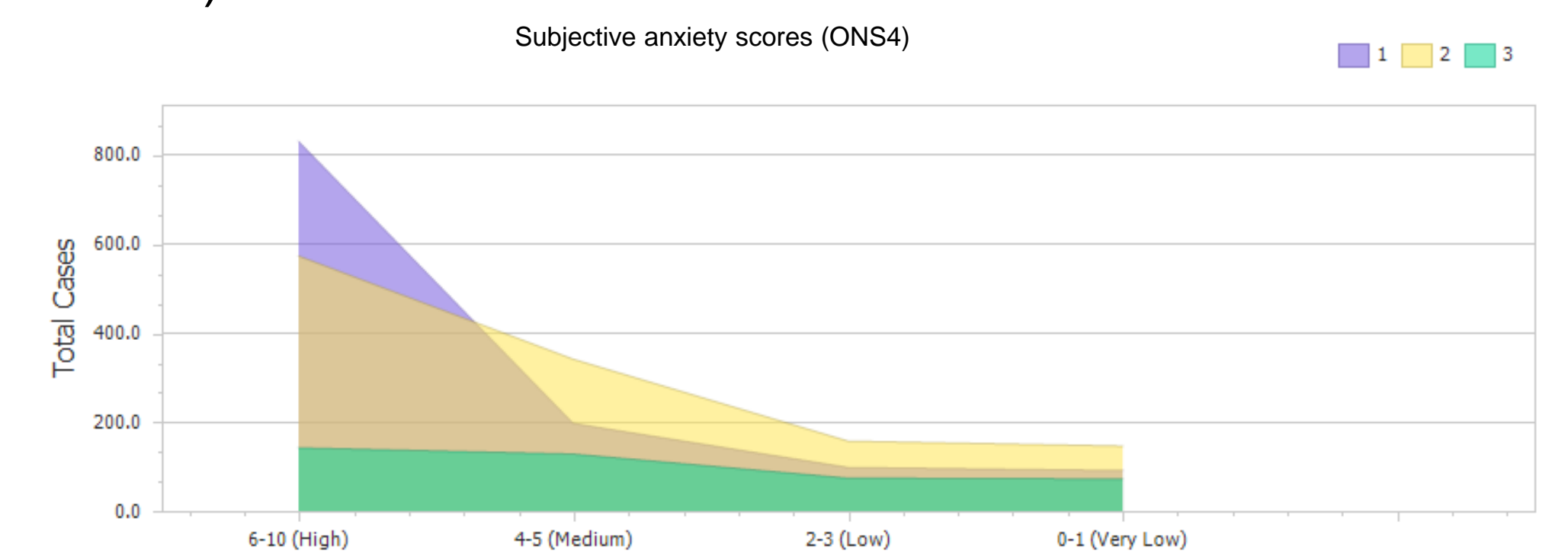
38% were male 61% were female with a wide age range.

Outcomes data



87% improved subjective wellbeing (SWEMWBS) scores. The mean pre SWEMWBS score is 18.1, the post score is 22.5. Shift = +4.4 (n = 1247, p = 0.01). Post 4-week mean

SWEMWBS scores increase further to 24.3 (n = 454, p = 0.01).



67% reduced anxiety (ONS4) scores. The mean pre score is 6.45, the post score is 5.20. Shift = -1.25 (n = 1254, p = 0.01). Post 4-week mean anxiety (ONS4) scores reduce further to 4.42 (n = 465, p = 0.01).

Patient satisfaction ratings for the service is 98%.

"At the time I was referred I was feeling very low and alone. I didn't think anyone cared. Now I feel calmer and listened to. I know there's so much support out there and people care about me" (Patient).

"I am impressed with the service, and the speed with which you contact the patients." (Clinician)

Partnership and asset-based approaches

WE has excellent partnerships with public, voluntary, community and social enterprise (VCSE) organisations in Halton. We've partnered with 168 agencies over the last 12 months to co-deliver community events and wellbeing drop-in sessions at GP practices, flu clinics and other venues. Wellbeing Link Workers attend MDT and PPG meetings at practices and community networks like Partnerships in Prevention (PIP).

We have delivered 79 educational courses and wellbeing activities over 12 months including life skills training sessions, confidence classes, wellbeing walking groups, alpaca farm visits and self-help groups like the Long Covid Support Group. We're also providing volunteering and work experience placements to patients and the public who want to have a hands-on role.

We carry out focus groups and surveys to canvass people's views about how the service can be enhanced. Our extended opening hours is a good example of how we have listened and acted on feedback.

We have recently undertaken a series of community consultation events across Runcorn and Widnes to canvass citizens views about what it is they want and need to live a good life. WE is working with the community to realise these aspirations.

Conclusion

The We Connect service has supported a sizeable number of patients in this 12-month reporting period, with referrals into the service growing by 195% when compared with the previous 12-month period. The service has received positive feedback from patients, public and professionals alike. The service is proving to be a lifeline for those facing practical, social and emotional challenges, especially during a cost-of-living crisis. It is also helping to reduce demand on primary care services.

References

1. <https://www.youtube.com/watch?v=qzwuySKAdr0>
2. <https://www.england.nhs.uk/personalisedcare/comprehensive-model/>
3. <https://www.england.nhs.uk/personalisedcare/social-prescribing/>

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