JULY 2026

Wallsend Social Prescribing Team Newsletter

Thank you for reading our newsletter. This month we share a recent group consultation, referrals data and a case study from the team.

Type 2 Diabetes Group Consultation

In July, the social prescribing team facilitated a T2D group consultation with patients in Hadrian Health Centre. Clinicians in attendance included Rachel Hutchinson (Advanced Nurse Practitioner in HHC), Jasmine Wrightson and Amanda Kirtley from the Diabetic Eye Screening Service.

We invited patients with a HbA1c above 60. We had 4 attendees who shared their experiences, which varied from newly diagnosed to 30+ years.

The Diabetic Eye Screening service presented information to patients, and Rachel ANP took the second half of the session to answer patient questions. General themes from this group consultation included medication, lifestyle, diet and managing T2D. Mairi Health and Wellbeing Coach also attended the end of the session, to promote her additional support on offer for T2D management.

We hope to host sessions at Bewicke Medical Centre and The Village Green Surgery next. The diabetic eye screening service is happy to attend again. **If any clinicians have availability and an interest in partaking in the next T2D group consultations, please email Robbie.hall@nhs.net** or **helen.greig3@nhs.net, or send us a task !**

Spotlight: WorkWell Reminder

The WorkWell programme supports people who feel unable to work due to poor health, helping them access the support they need to return to work. **More people in our region are out of work because of poor health than in other parts of the country, with some areas seeing as many as one in three working age adults affected.**

The programme brings together the NHS, councils, job support services, voluntary organisations, and employers to provide joined up support for those who need it most.

Each practice has provided a list of eligible patients, and Sam SPLW also receives direct GP referrals where a patient may need a fit note and is assessed as suitable for the programme.

Please continue to refer.

TyneHealth

Living Well Wallsend Primary Care Network

PCN Data

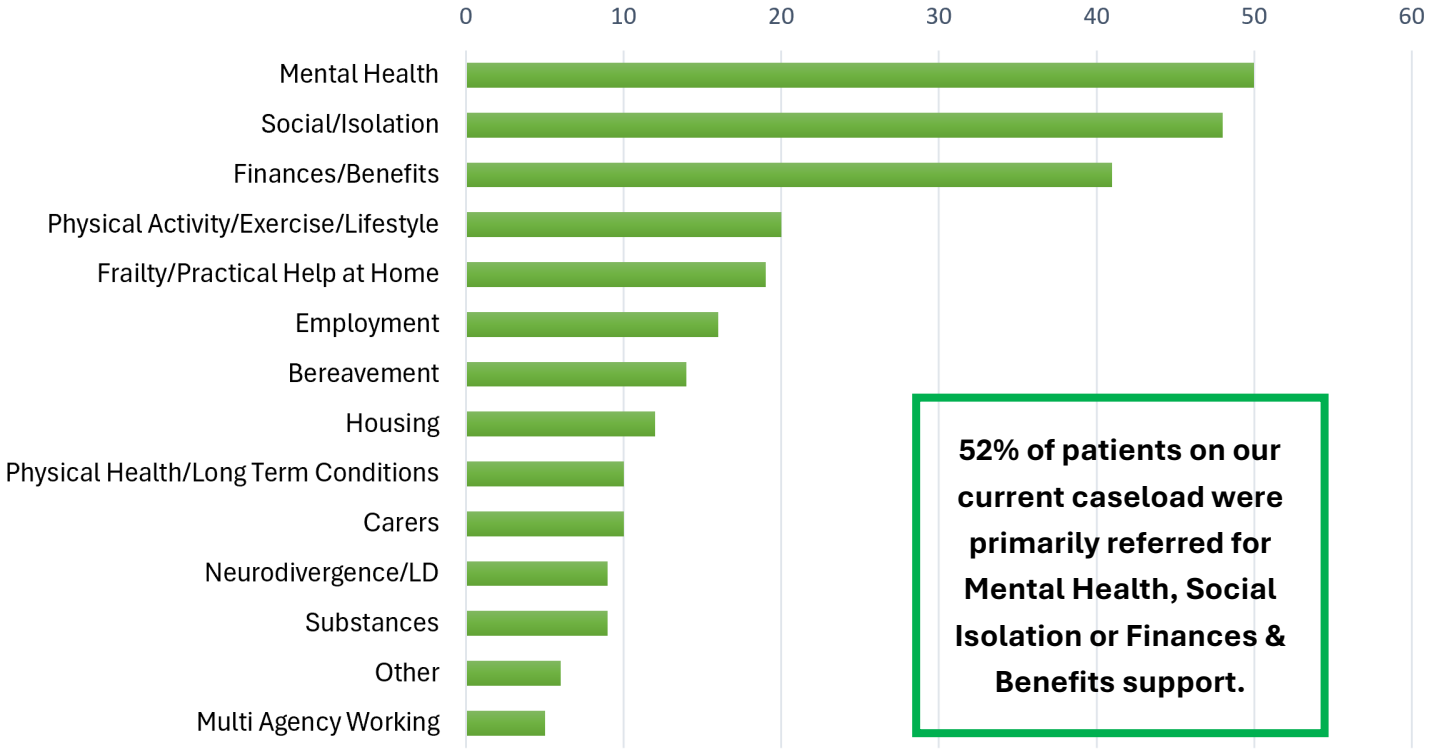
Social Prescribing Team Newsletter

This month, we took a look at the primary reasons patients are referred to Social Prescribing.

Our team manually reviewed the current caseload (269 patients across the service) to identify the **primary reason for each referral.**

While many patients present with multiple interconnected needs, a single primary referral reason was assigned for reporting purposes.

Primary Reasons for Referral to Wallsend PCN Social Prescribing Service



52% of patients on our current caseload were primarily referred for Mental Health, Social Isolation or Finances & Benefits support.

While **Mental Health, Social Isolation and Finances & Benefits make up over half of our current caseload**, the remaining referrals cover a diverse range of needs.

This demonstrates that there is no 'typical' social prescribing patient.

Health and wellbeing can be affected by many different social, practical and emotional challenges. The variety of referral reasons reflects both the complexity of our patients' lives and the wide-ranging support offered by the Social Prescribing Team.

Case study: summary

Who: 51-year-old male

Referred by: GP

Background: Recently separated from a long-term partner and bereaved following the loss of a family member. Supported twice weekly by a support worker but reported limited social connections. Wanted to gain weight and return to playing pool.

Intervention: 13 face-to-face appointments. Explored social isolation, bereavement support and healthy coping strategies. Multi-agency working with his care provider and social care ensured support reflected his preferences and needs. Increased alcohol use was discussed and monitored throughout the intervention, with a focus on healthier coping mechanisms.

Outcomes: Continues to engage well with his support worker and is settled following a change in allocated worker. Regularly accesses community activities, including playing pool, improving social interaction and reducing isolation. Has gained confidence in managing household tasks and living independently, strengthened relationships with his in-laws, and feels in control of reducing his alcohol consumption while knowing how to access further support if needed.