Name of case study: **RE & CC (Couple) difficulties interlinked** **Barnstaple Alliance PCN (Pre-Covid 19)**	
Brief description of the client's/patient's issue	Presenting situation: • R`s current issues are around low mood, burn out from work, caregiving to partner C and 5 children one with ASD. • Risk of losing Job and employers are pressuring him.  Presenting situation:  • C`s current issues are around unresolved loss (death of 4 close family members in close succession, divorce and health difficulties Fibromyalgia, depression and early childhood trauma. C in pain constantly, has no downstairs toilet so often has accidents when unable to climb stairs. • Both have 5 children 1 needing SEN support (Autism) • Housing unsatisfactory, too small, damp & rot affecting health Asthma & Fibromyalgia • Risk of losing Tenancy- rent arrears • Becoming socially isolated, agoraphobic and dependent on Ray thus adding more pressure for him
Summary of the support provided	• Consent given by R to liaise with employers. Sent information out on DDA (disability employment act). TC to ask for sick note to be extended and request to stop harassing R.Urged Ray not to resign • R to explore claiming UC (universal credit) explore carers support (C & R to make appt with CAB to seek clarity on this • Refer R to Devon Carers for carers support • R to refer himself to Clarity mens group for emotional and peer support • R to schedule pleasurable activities and build structure into his week (Likes keeping pigeons discussed tagging and Pigeon care but also resume fishing) • C to self-refer to Clarity counselling & women's group (information given) • Refer to Onesmallstep- support and symptom management, facilitation of health trainer & guided self help

	• C to link with some of the Fybro support groups I have given her • Refer C to Early help/parent and child support. Liaise with SEN & School. C and R to devise support plan • Refer R & C to Encompass and liaise with ND homes- review of tenancy/alternative housing? facilitate needs assessment • Refer to Wiser money project- Support for Debt management/access budgeting course • Refer R & C to side by side parent and carers group – info given • Explore OT referral- needs assessment for adaptations in home/housing support
Summary of outcome and impact (including quotes)	• R`s employers made reasonable adjustments in the workplace – flexible hours to allow Mental health recovery and carers support • Devon carers support to allow R to establish his interests thus improving his mood * motivation • Safe space established for R to seek emotional support when needed • Benefit awarded to reduce the pressures of earning and caring • C managing her symptoms better through the help of One small step & support groups but pacing herself • Housing sent a surveyor around to do assessment and have put forward case for rehousing • Early help involved weekly along with Special needs /Educational welfare officer • Early help offering parenting support • Funding allocated to both R & C to purchase learning and creative toys through Early help fund

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- Referred on for longer term counselling by myself as waiting list too long for Clarity

Quote “ S has been fantastic in that she has taken the time to help and offer so much to us as a family get back on our feet after being sent from agency to agency and not getting anywhere. She has really listened for the first time to both our needs whereas previously this hasn`t been the case, we both have hope now and feel less overwhelmed and in control of our lives. Thank you, a brilliant service, “

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Tips for others or future plans (optional)

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- Always have a framework/holistic assessment on initial consultation, that way nothing gets overlooked
- Active listening, paraphrasing and being a “Skilled helper”
- Good to stimulate dialogue around personal resilience and capitalise on this ie C`s ability to be a great mum despite being in constant pain but also overcoming real adversity in the past and being brave enough to embrace counselling. R`s ability to let go and embrace some new possibilities and create time and space for himself
- Always good to explore what`s going on for the patient rather than making assumptions especially Chronic health – celebrate “Patient being expert in their own health condition” – be aware of unconscious bias and need to rescue
- Explore person centred support and strength based approached
- Useful to use solution focused techniques esp when one is stuck
- Always important to research what you`re referring the patient to, so determine the service is right for them but also considering quality assurance, safeguarding issues etc.
- Really important to offer impartial nonbiased support
- Good to start with graded plan so not to overwhelm
- Good to work towards discharge maybe 4 sessions in
- Useful to give task & guided self-help to enable a sense of control and responsibility

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Social Prescribing Link Worker Impact Case Study

Name of case study: **Barnstaple Alliance PCN (COVID period)**	
Brief description of the client's/patient's issue	Patient referred to social prescriber as end of life palliative care needing support- Welfare, practical and emotional
Summary of the support provided	• Discussed management of difficult days, pain, distraction techniques • Organisation of medication and food delivery • Liaison and support with daughter who lives out of area • Facilitation of telephone befriending (Live at home scheme & Age UK) • Weekly check in T support
Summary of outcome and impact (including quotes)	• Medication and food sorted- liaison with Hospice nurse • Good communication pathways to allow shared support and any changes in health/needs • Reduced feelings of isolation and fear through befriending
Tips for others or future plans (optional)	• Consistent support important • Important to look at dietary needs of the patient and pain control- Good liaison with HN and GP • Being sensitive and mindful of conversations- ensure supportive