Name of case study: DL, isolated and living in poor conditions (Granta Medical Practices)	
Brief description of the client's/patient's issue	Nursing team visited 95-year-old patient in assisted living to dress legs (with appropriate PPE). Patient usually had cleaner who was isolating so flat had mouldy food including maggots around. Patient had weekly essentials delivery from Local authority but could not unpack so was spoiling in the entrance. Nurses contacted Social prescribing team who worked with patient to identify needs. Nurses also identified that patient was living off Credit card which had been stopped as he hadn't been out to pay monthly statements. Patient was also just living off Marmalade sandwiches. No family.
Summary of the support provided	Nurses and social prescribers liaised with warden who disposed of spoiled food and was trying to get food deliveries stopped and was now redistributing goods to other residents until then. Social prescribers worked with patient to source meals on wheels provider and work out payment options. We also worked with patient to get building society to generate a cheque to pay credit card statement giving him access to money.
Summary of outcome and impact (including quotes)	Having a hot 2 course meal delivered each lunchtime meant that the patient had a nutritious hot meal daily with no food laying around and as credit card was addressed he could order milk etc as and when he needed from his village shop to be delivered. The old food was removed and sorted by the warden and the nursing team help with a little washing up etc when they visit. Until the patient's cleaner can return. Situation is still not ideal but in light of current restrictions the patient is a lot happier and in a healthier environment to promote healing than they were. Patient called reception at surgery to say "just spoken to this patient, wanted to thank you for getting things organised so quickly, having dinner brought tomorrow" and from nursing team "PT really appreciate and enjoys the meals that are delivered. Can you please get this to be continued".
Tips for others or future plans (optional)	In the current restrictions we cannot fix everything but we can work with patient, clinical teams and local authority to reach a better healthier outcome for patients for the here and now. Do not underestimate the small things and the impact they can have. A simple thing like having a hot meal delivered once a day means risk of mouldy food is mitigated and patient is receiving nutritious meals that will aid his healing and the knowledge that he is valued from people caring improves his mental health.

Name of case study: Isolated/Bereaved/Life Event (Granta Medical Practice)	
Brief description of the client's/patient's issue	Pt. was referred by her GP Pt has a history of depression and is on medication. GP can increase this but is running blood tests first to check there is no underlying cause for pt's extreme tiredness. GP stated pt is lonely at this time of Covid., she explained pt. has also been recently bereaved in the last two weeks. Family do not live local. GP tasked us to see if there is anything, we can do to ease patient's loneliness at this time.
Summary of the support provided	When I called pt, she was very grateful and instantly talkative, she asked me after a few minutes if I had the time to talk which I replied yes [as social prescribers we have more time to spend with patients]. She said, in her own words, that the "constant nothingness, no end in sight" is affecting her significantly. She is "so tired all the time" she could "curl up and go to sleep at any time". Pt explained she had been bereaved by her sister and a friend whom she has known since primary school. They died two weeks ago in the space of two days of one another. But, the bereavement does not seem to be her main preoccupation at present. Her son who lives in Dorset would like her to move down there. He has found a property for her which is a short walk from his house. He is calling her and asking her if anyone has been around to view her house which is currently on the market and is keen for her to make a move. Pt is not sure that a move is the right thing to do. She is not keen on having people in the house doing viewings and feels "caught". She explained her son and his partner are "lovely and he means so well" but she is not sure she can manage the upheaval and managing the move itself which will largely be by herself. She says she is keen to support him as his business is not doing so well and she could walk the dog for example and support him financially. Although, she acknowledged she could also support him financially remotely also. [I am conscious of this comment in a safeguarding capacity, and will keep hold of this in my future conversations with the pt.]

	I listened to her concerns and suggested that perhaps she writes a list of pros and cons for both options. I went on to ask her about a referral to Age UK Hertfordshire's InTouch service because it exists for older people who are experiencing large life events at present (the move and bereavement) and may be able to help her consider her options from a neutral perspective. We also spoke about her day-to-day routine, she says she "dreads the day" when she wakes up, she finds it hard to remember what day it is. I asked her what her normal routine was pre-Covid and she explained she had several groups she would go to in the villages. I asked her what she thought might make the days easier now and she explained she used to enjoy writing stories, she said perhaps she could do that again and start to document her days. She also enjoys taking a cup of tea and sitting in her garden and she has purchased a travellator and is taking herself on short walks. We talked around the fact that she would have to establish friendships and social circles if she moved (we didn't touch on how difficult this may be if she needed to continue to self-isolate) and that although she may be nearer her son he is still working. Her son lives in a town and she lives in a village which is very quiet and rural meaning she can get out to walk but also she has the confidence to drive here and used to take herself into the nearby town which she may not have when she moves. As regards the practicalities of Covid, I have established she is doing her own shopping online with Tesco via an ipad which her family have trained her to use, she is on their priority list. I have tasked the GP reception team to see if they can call the pt to register her to order her medication online. She collected her medication herself at the pharmacy today, I have informed her of the local Covid group. She has consented to one of the coordinators calling her to make an introduction and I have spoken with the coordinator to ensure this occurs over the bank holiday weekend.

Summary of outcome and impact (including	This case is ongoing but pt. very much appreciated the opportunity to speak with someone who was not friend or family and could support her in a neutral manner – whilst providing some input into practical solutions which it is hoped will start to ease her isolation at this time and help her with making a significant life event at this difficult time. Thereafter it may be that we provide support to help her grieve for her sister and lifelong friend - if required.
Tips for others or future plans (optional)	In a peer support meeting this week with social prescribers from across the CPFT, we discussed how working together we could possibly work together to obtain funding for projects. In particular, a project/s to reduce patient's isolation by increasing their skills with technology was discussed. We will look to take this further at the next supervision.

Name of case study: H Carer/AA/CA/Dementia (Granta Medical Practice)	
Brief description of the client's/patient's issue	Pt referred by receptionist at surgery. Pt was working at a children's care facility but had to stop work because her husband had received a letter telling him he was required to shield. Her husband has dementia and as well as the risk that she would pose to him whilst continuing to work, as a result of having to shield, his care arrangements had broken down. Pt was very distressed because she had to leave a job that she really loved, she had been working 4 bank shifts every week but had not been paid for the last 4 weeks as she was on a 0 hours contract. She really wanted to be furloughed because she hopes that she will be able to return to her job in due course but her employer was very reluctant. Her employer told her she could not be furloughed unless her husband was in receipt of Disability Living Allowance (DLA).
Summary of the support provided	Pt was keen that she should have a letter from the doctor to explain that her husband was unable to self-care independently and requires regular prompting. I was able to task the GP for this to be arranged. We discussed the issue surrounding DLA. Husband is aged over 65 and I explained that he may be eligible for Attendance Allowance (AA) at the Higher Rate which is the equivalent benefit for retired persons. Thereafter she could be assessed for Carer's Allowance. Patient agreed to a referral to Age UK Hertfordshire which I completed. I also wrote to the patient with the details for Citizens Advice Bureau whom she could contact if she felt she needed further support around her employment contract.
Summary of outcome and impact (including quotes)	I spoke to pt and she wanted me to say to the GP "thank-you very much for the lovely letter". She was delighted with it. She said that she has sent it to her employer and "Age UK have been absolutely brilliant" in terms of getting her husband's AA forms filled in. She said the service she has received was "Amazing" and thanked me very much for helping to make it happen.

Tips for others or future plans (optional)	I asked if there was anything else for which pt required support. I explained the local Covid response group would be able to assist her with shopping and medications. I have placed their details in the post to her with a GMP newsletter. I have also sent her information on Carers in Hertfordshire and Hertswise support for Dementia. I will follow-up in a couple of weeks to see if she has received notification of the Attendance Allowance but also discuss with her the benefits of seeking support from the above two organisations.

Name of case study: SK anxiety and suicidal thoughts (Granta Medical Practices)	
Brief description of the client's/patient's issue	Referred from GP for isolation and extreme anxiety regarding coronavirus. Husband in care home, family support via telephone. Anxiety over returning to work. On medication and known to mental health team, admits to suicidal thoughts.
Summary of the support provided	Telephone call to introduce myself and establish contact. Very anxious and we discussed measures she had made to keep herself safe. Agreed on daily phone call including weekends and Bank holidays for support and as a protective factor. Patient called mental health line for support and gave half her medications to a neighbour for safe keeping. Lots of discussion over following days to identify triggers and coping strategies. One example was patient mentioned feeling out of body and thinking she should end her life after high intensity exercise. I asked her to identify her eating patterns to which she realised she was eating after these sessions and that her blood sugar maybe low. On identifying this she started to eat beforehand and the feeling reduced. Patient also started to work with employer on positive adjustments to working environment, so they felt able to return.
Summary of outcome and impact (including quotes)	Patient is feeling more positive and has made progress, fewer contacts now needed but aware may relapse and better at identifying triggers and coping mechanisms. Has also built up a routine and started wellness classes online. No recent thoughts of suicide reported. Patient emailed practice to say "Thank you for all the help, one of your Social Prescribers has been giving me over the last months with my anxiety/depression, she always brightens me up and, I think, has gone above and beyond even ringing me at weekends to make sure I am OK."
Tips for others or future plans (optional)	Suicide prevention training was invaluable in this situation and it gave me the confidence to have those conversations with patient. Also knowing they had spoken to GP and medications were in hand and GP was happy we could support gave confidence to the process. Be aware of agreeing to something

	that isn't sustainable and have a plan for reducing need as soon as you start so patient knows they have your support without becoming over reliant on you. Also, if you do not feel confident you should communicate this to your manager instead of compromising your own mental health.