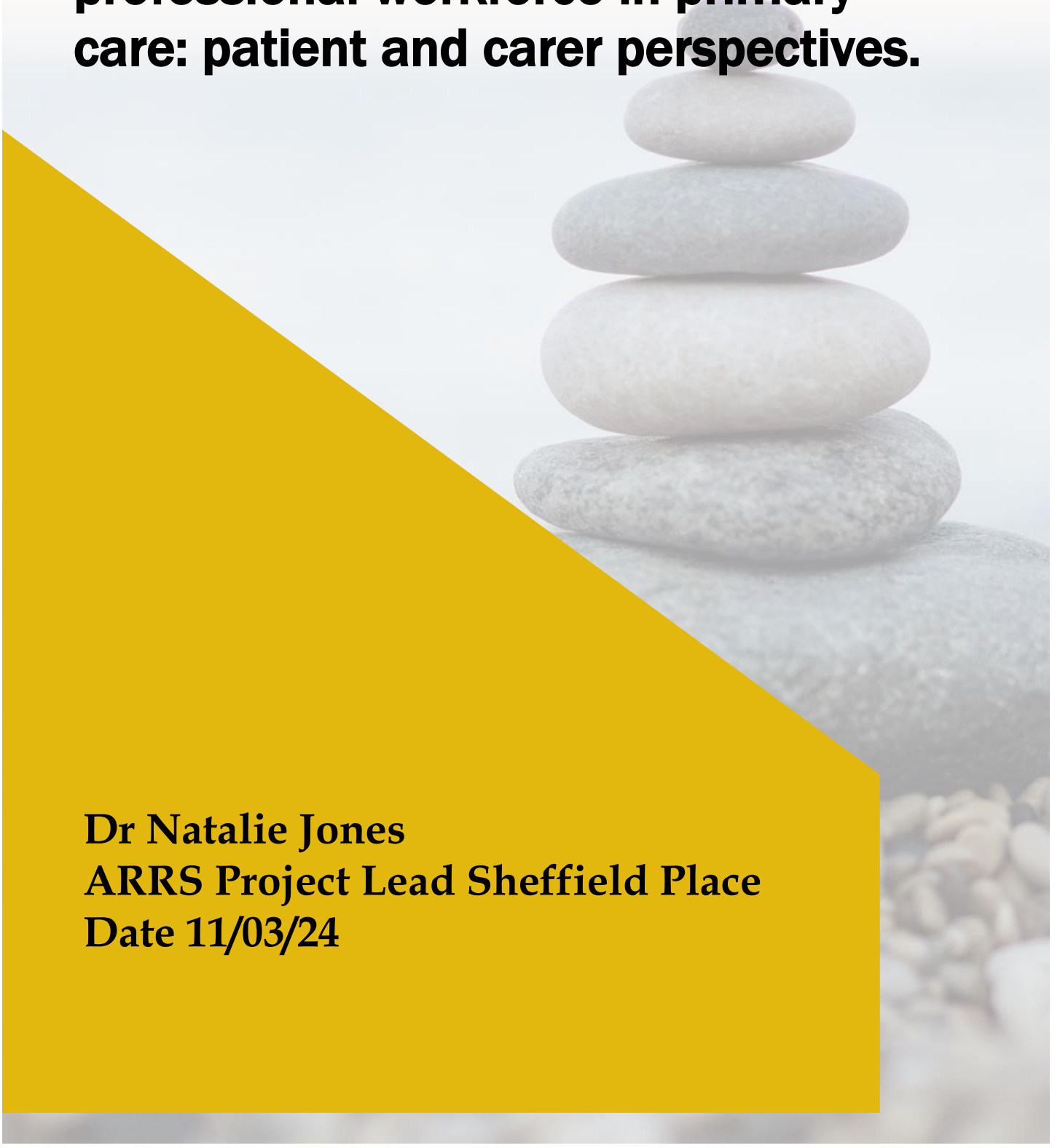
South Yorkshire and Bassetlaw
Integrated Care System

Understanding the impact of the multi-professional workforce in primary care: patient and carer perspectives.



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Acknowledgements

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The audience for this report

This report will be of interest to the following:

- Integrated Care Boards
- GP Federations
- Primary Care Practitioners
- Primary Care Networks.
- NHS England, Scotland, Wales, Department of Health Northern Ireland.
- Independent Policy Units
- The public (A lay summary has been prepared for service users, carers and family members).

Executive Summary

This report seeks to explore the influence of the multi-professional workforce in primary care. Active involvement of service users in evaluation processes and engaging patients in service design have the potential to enhance care quality by incorporating feedback on processes, accessibility, and overall experience, thus shaping and improving future developments.

Twenty participants were interviewed for this project to explore their interactions with the multi-professional workforce and how they perceive its impact. This report will summarise the main discoveries and present notable insights obtained from the narratives of patients and carers concerning their firsthand experiences of the multi-professional workforce.

Furthermore, it presents a framework for measuring impact and a logic model that sheds light on the inputs, activities, and anticipated outputs of multi-professional roles. This report reflects a small number of perspectives from patients and carers who volunteered to be interviewed. The contents are derived from the lived experiences and personal views of participants as well as the author's in-depth analysis.

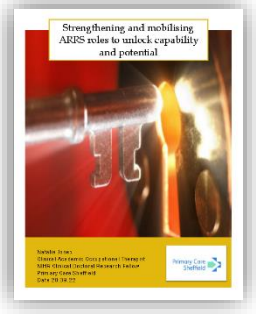
Background

In 2019, as part of the NHS Long Term Plan, the Additional Roles Reimbursement Scheme (ARRS) was introduced in England through the Network Directed Enhanced Service Specification. The primary aim of the ARRS workforce was to provide additional appointment capacity as well as address local health inequalities. The bold ambition was to expand the primary care workforce to support general practice. This new funding facilitated the recruitment of familiar roles in primary care such as pharmacy and physiotherapy, as well as new personalised care roles (NHS England, 2021). The ambition to diversify the workforce and integrate 26,000 extra staff into general practice by 2024, was embraced by Primary Care Networks.

Utilising ARRS funding, PCNs could finance their salaries and additional expenses associated with hiring and overseeing these new roles. To date, PCNs have a selection of 17 roles available to choose from.

A review of ARRS roles in Sheffield in 2022 led by the author of this review describes some of the considerable challenges associated with workforce transformation, embedding, and retaining this new workforce.

Click here to read more
Strengthening and mobilising ARRS roles to unlock capacity and potential



ARRS Roles

Advanced Clinical Practitioner
Care Coordinator
Dietitian
Digital and Transformation Lead
Enhanced Nurse
General Practice Assistant
Health and Well-being Coach
Mental Health Practitioner
Nursing Associate
Occupational Therapist
Paramedic
Pharmacist
Pharmacy Technician
Physician Associate
Physiotherapist
Podiatrist
Social Prescribing Link Worker

John's Story

John's care coordinator advocated for him with a housing association after his mum suddenly passed away. John explained that in three weeks' time he will get his tenancy agreement for his home, where he lived with his beloved Mum and dog. John describes this as his safe place, a place that holds memories. John explains that he knows the neighbors and they know him. When he doesn't go out because he is feeling low, they notice and knock on his door to check he's OK. He knows that he could go to them if he were in difficulty and this thought provides him with comfort. These things matter to John and this is why staying in his own home is important to his mental health and wellbeing.

Care Coordinator Role.

Introduction

For most patients, their first point of contact with a health service is with a general practitioner. Patients often have multiple complex health conditions which impact their physical, psychological, and social well-being. The essence of the Additional Roles' Reimbursement Scheme was to provide a coordinated and personalised approach to care, particularly for people who manage chronic health conditions and to promote health and well-being with specific interventions. Research tells us that patients want to feel involved in their healthcare decisions, have a choice, continuity of care and a personalised approach, and improved accessibility to appointments with a skilled and trained workforce (NHS 2019, Sanderson 2019). These attributes are also described by the Kings Fund Innovative Models in General Practice report which summarises the key attributes that patients desire and general practice want to provide to deliver high-quality care (Figure 1).

The integration of these new roles signals a burgeoning recognition within the primary care workforce of the advantages brought by increased capacity, leading to the emergence of novel care models. A trend towards collaborative, multi-professional teamwork is evident. Nevertheless, comprehensive data regarding the effectiveness of these roles remains scarce. Furthermore, the persistent hurdles of recruiting and retaining this new workforce continue to pose challenges for Primary Care Networks (PCNs).

Figure 1: The core attributes of general practice taken from Baird et al., 2018.

Project Aims and Objectives

A service evaluation was initiated to examine the interactions between patients and caregivers who have utilised the multi-professional workforce employed and funded by the Additional Roles Reimbursement Scheme. While the acronym 'ARRS' has gained widespread recognition nationally to refer to this emerging workforce, the preferred terminology, 'multiprofessional worker or workforce,' will be utilised consistently throughout this report.

Aim: To understand the impact of the multiprofessional workforce in primary care.

1. **Interview people with lived experience of multi-professional workforce in primary care.**
2. **Identify the types of interventions being deployed.**
3. **Understand the impacts resulting from contact and intervention.**

Data Analysis

The qualitative data collected from this project was uploaded to NVivo (a qualititaive data anylysis software package). Nvivo is used specifically for anlaysis of unstructured text. This was used to drill deeper into the analysis of the lived experience data and develop key themes from the patterns, similaries and differences.

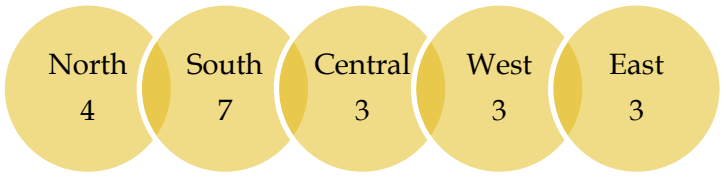
Method

To understand the impact of multi-professional roles in primary care, the primary care network staff were invited to participate in a service evaluation. They were asked if any patients from their current caseloads would be open to sharing their personal experiences with the author. Those who expressed interest were informed about the project's objectives, and their verbal consent was obtained for a 30-minute in-person or telephone interview. Before the interview, each volunteer participant engaged in a pre-interview discussion with the author, to address any project-related inquiries and understand how their stories and experiences would be utilised. They were informed that their stories would be anonymized and pseudonyms would be used. Additionally, participants were made aware that a shortened version of their stories would be included in this report. All participants willingly disclosed the decade of their birth, the area of Sheffield where they reside, and their ethnic origin. Furthermore, a majority of participants agreed to share a summarised anonymized version of their narratives in the appendix of this report.

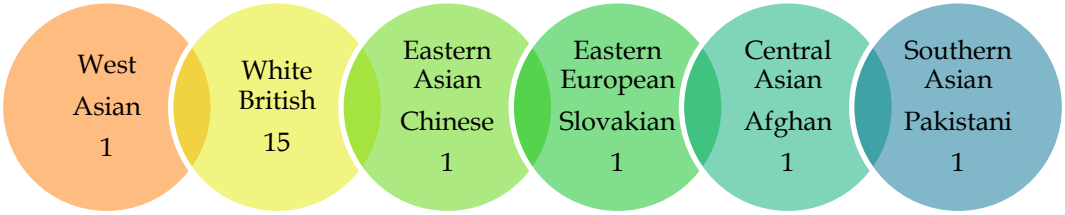
Objective 1: Interview people with lived experience of the multi-professional workforce in primary care.

Participant Characteristics

Participants were distributed amongst Sheffield Primary Care Networks (PCNs), with the south of Sheffield having the highest number of participants. This disparity could be attributed to the presence of two PCNs in this area, each equipped with large multi-professional teams that were more proactive and effective in recruiting participants.



There were an equal number of female and male participants, with ten individuals of each gender agreeing to an interview. Six distinct ethnicities were represented.



Sixteen patient participants ages ranged from 20-95

20-30	30-40	40-50	50-60	60-70	70-80	80-90	90-100
4	1	1	5	2	1	1	1

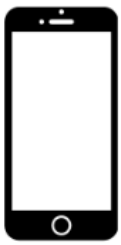
Carers

30-40 1
60-70 1
70-80 2

Four participants were carers agers ranged from 30-75

Nine multiprofessional roles were represented in the patient stories

Care Coordinator	5
Occupational Therapist	4
Physicians Associate	3
Paramedic	2
Social Prescribing Link Worker	2
Advanced Clinical Practitioner	2
Mental Health Practitioner	1
Health and Wellbeing Coach	1
Dietician	1



Sixteen participants were interviewed over the telephone

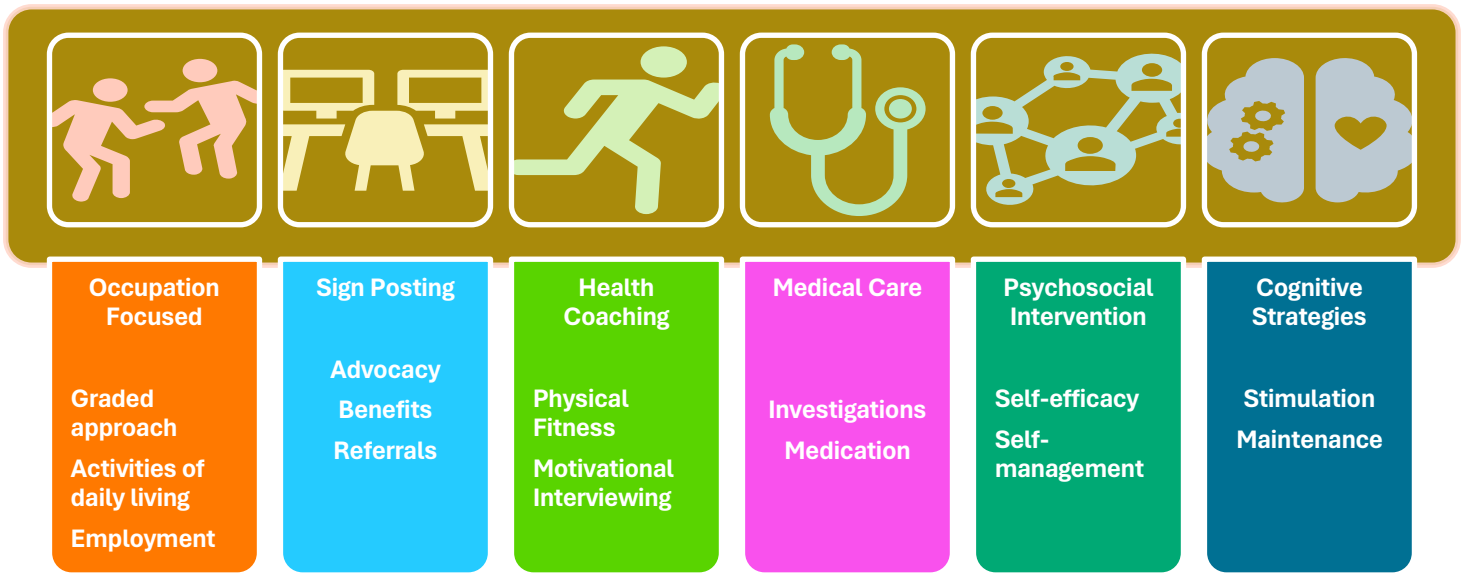
Four participants were interviewed in person

Due to language difficulties, some of the details provided by the patients were checked with the multiprofessional worker to ensure the details were correct post interview.

Three additional participants consented to provide written lived expereince stories rather than be interviewed. Their own words and experiences were documented by the multiprofessional worker and this additional data was also analysed during this evaluation.

Objective 2: Identify the types of interventions being deployed.

Figure 2 describes Six types of intervention that were implemented, with most patients receiving multiple interventions, and the majority of patients were referred to additional services.



Occupation Focused Interventions

Seven patient narratives encompassed a holistic assessment of their occupations, which included activities of daily living, hobbies, creative pursuits, and employment. These patients detailed how changes in their physical and/or mental health had affected their engagement in activities and vocational roles. Through interventions aimed at enhancing confidence and providing support to pursue voluntary work, three patients were able to initiate a plan to return to paid employment. Emma describes her experience ***'I feel better, my health is so much better, my diabetes control is so much smoother, I'm not just sitting all day, I am doing things all of the time. I was taking anxiety medication which I no longer take, and I have reduced my antidepressants". Role Health and Wellbeing Coach.***

Additional examples of occupation-focused interventions encompass providing equipment and home adaptations to facilitate increased physical activity and engagement in hobbies and activities. June recounted her troubled upbringing and childhood traumas, which have had lasting effects on her mental well-being into adulthood. She recalled how, before the pandemic, she regularly participated in church gatherings, crafting groups, and knitting sessions. However, the onset of the pandemic exacerbated her mental health struggles, leading to increased hoarding tendencies and agoraphobia. Upon consultation with her GP, June was connected with a care coordinator who arranged for her to receive a rollator frame, aiding her mobility within her home. Furthermore, she was referred to talking therapies and supported in attending church services online. Motivated by the proactive approach of her Care Coordinator, June began venturing out again, noting improvements in both her mobility and mental health. Her aspirations for the future include rejoining crafting groups and decluttering her home.

Occupation Focused Interventions Continued

Neil was undergoing treatment with a mental health professional as part of his journey toward recovery from alcohol and substance addiction. Upon recommendation from the Mental Health Practitioner, Neil was referred to a Social Prescriber to explore new avenues of occupation. During their initial meeting, Neil expressed his interest in learning to play a musical instrument. Discovering a mutual enthusiasm for Sheffield's music scene, Maya introduced Neil to drumming classes offered by Sheffield Flourish. With Maya's encouragement, Neil attended three sessions before gaining enough confidence to participate independently. Additionally, Neil was introduced to a gardening group and an outdoor walking group, providing crucial opportunities to discuss his mental health and his strategies for maintaining sobriety. Neil said ***'I have not used alcohol since late December. In addition, just before Christmas, I successfully applied for a voluntary position with the Salvation Army working in the shop and carrying deliveries twice a week'.***

Emma's story, 'I went to see the GP and was put on antidepressants and anxiety medication. The GP suggested that I have an appointment with a Social Prescriber to see if they could help. Socially I didn't see anybody at all, my mum used to visit, and I didn't go out at all, I didn't go shopping or see anyone. Now I volunteer at the social café once a fortnight for a full day, I do well-being Wednesdays and support the menopause café once a month.' Social Prescriber Role.

'I was also referred to a Health and Well-being Coach. James helped me to take up other activities. I have started to do badminton and Tai Chi. I also volunteer at the wildlife trust and gardening group. We have developed some pocket allotments at two GP surgeries, and we have been putting in plants and doing mindfulness at the same time. My life is full now I need more days in the week, I am making up for lost time.' Health and Wellbeing Coach Role.

Signposting

Ten patient narratives included signposting and onward referral, such as directing individuals to mental health services, voluntary sector organisations, assistance with benefits, housing departments, and various health and care professionals.

Annie, in her carer's story, recognised the vast knowledge and network of contacts possessed by her mother's Occupational Therapist. Leo shared his experience of receiving support through a referral to befriending services via his Dietitian.

Hamza and his young family were living in very poor conditions in a privately rented house with a significant damp problem. His Care Coordinator understood his concerns and advocated for him with the housing departments and the landlord. This resulted in new carpets being laid and they were able to move out of the house while some repairs were completed. The Care Coordinator was able to work with other agencies that could help Hamza and his family. Hamza describes her perseverance 'She just would not stop; she went everywhere until something was done to help us'. Care Coordinator Role.

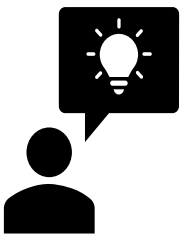
Health and Well-being Coaching

In June's account, she describes how her care coordinator utilised coaching techniques to assist her in addressing her hoarding tendencies. June remarks, ***"She has aided me in organising some of my belongings in the house and categorising others".*** The care coordinator also guided her towards adopting a more optimistic outlook, particularly concerning the future. June elaborated on how the mental health support provided by her Care Coordinator has heightened her mindfulness regarding her lifestyle, resulting in recent positive health outcomes.

In Leo's narrative, he faced challenges in losing weight one year after being diagnosed with diabetes. Leo collaborated with Zara to establish goals, which included weight loss and striving for diabetes remission. He recounts that upon receiving the diabetes diagnosis, he promptly implemented changes, such as discontinuing fizzy drinks and cutting back on sweets, including a nightly habit of consuming an entire bag. Additionally, he reduced portion sizes and made several minor adjustments, yet he was disappointed to find no weight loss and only a slight reduction in his HbA1c levels one year later. Leo underwent lifestyle coaching, was referred to a weight loss program, and had his medication adjusted by his GP. After a year on the program, Leo reports a reduction in his HbA1c levels, a loss of 10 lbs, and a decrease in his BMI, attributing these positive changes to Zara, his Dietition. Her help and support has been instrumental in his progress toward achieving his goals. These findings correlate with research that has also shown positive impacts associated with embedding Dietitans in primary care (Mitchell et al., 2017, Howatson et al., 2015, Razaz et al., 2019).

Zara reports '***Patients value attending an appointment closer to home, especially those with health anxieties. We have had some excellent patient feedback and most of them said they would recommend the service to relatives. I do a lot of onward referrals to other services such as befriending services. I had some lovely feedback from the sister of a patient who had diabetes and learning disabilities. She said that I made her comfortable and explained things brilliantly.' Dietitian Role.***

Neil's narrative also includes Health and Well-being Coaching. With the assistance of the Social Prescriber, he engaged in self-directed learning about the health consequences of alcohol abuse and the ramifications of social isolation on long-term health. This newfound understanding served as a driving force for Neil to persist in his recovery journey.



Medical Care
Eight interviews recounted instances of medical care being integrated with other interventions. This encompassed a spectrum of actions, including vaccinations, blood tests, investigations, and adjustments to medication. Among these interviews, three involved individuals who had consulted with a Physician Associate, while two involved interactions with Paramedics. Hence, medical interventions were evident, but there was also an indication of GPs and various multi-professional roles working closely together to aid patients. An illustration of this collaboration is found in Marie's account, where the Occupational Therapist collaborated with the GP to procure appropriate nutritional supplements, facilitating Marie's recovery and her ability to resume daily functional activities.

Lived experience stories involving Physician Associates (PA) included interventions for both physical and mental health. The narratives demonstrate how a PA can complement medical care, providing timely access and continuity of care which supports the view of Van den Brink, et al., (2021) and Drennan, et al. (2015).

Carrie's Story 'If it wasn't for Ayesha's perseverance this would not be happening. She may have caught the cancer early. She kept asking questions and took swift action. She was kind, sympathetic and informative. She explained everything carefully and was there for each step. She acted without hesitation and put my mind at ease. It was a personal thing for me to be examined intimately but she wasn't fazed or embarrassed she just got on with it. I could not thank her enough.'

Physician Associate Role.

Chen's story 'Lyra sent me for blood tests, and I started on antidepressant medications; I thought I would give it a try. She also sent me for an ECG for ADHD medication. She referred me to the mental health crisis team, and I saw a community mental health worker. I was having suicidal thoughts.'

Lyra explains that during the period of getting assessments and starting new treatments, she saw Chen for ongoing support to review treatments and keep an eye on his mental health. Chen says 'I appreciated the rapport we had and that she listened'. Lyra explained that in the beginning, she booked double appointments to address multiple issues, the first appointment took 40 minutes 'we needed to make a plan to address the suicidal thoughts and impulsive behaviours that Chen was experiencing'.

Lyra explained that she had a named GP whom she could debrief with and write the prescriptions. Chen explains that he developed a rapport with Lyra and this built trust so that he could share his concerns. He is feeling better on the treatment and is receiving mental health support. He doesn't need to come as often and is grateful that he is getting assessments for ADHD and Autism.

Physician Associate Role.

Two narratives featured paramedics, with both detailing lived experiences involving medical interventions for acute illness, followed by interventions for end-of-life care and advanced care planning. Steve shares his perspective as a carer in one of these stories. He recounts how Sean, the Paramedic, responded when Tom suffered a fall, resulting in a laceration on his arm. Given that Tom was on blood thinners and the bleeding wouldn't cease, Steve was understandably worried about his father needing hospitalisation. Steve elaborates that after administering first aid, the Paramedic and the GP worked together collaboratively to devise a plan aimed at avoiding hospital admission. ***'Sean and the GP had an extensive conversation to discuss a plan. The GP suggested that there was only one type of treatment that might be suitable and if this didn't work Dad might have to be admitted to hospital due to the complexities of his kidney failure. Without the GP and Paramedic working together in a joined-up way the outcomes could have been a lot worse. The GP was researching in the background what medications would work and Sean was assessing the situation with Dad and relaying this back. By working together they avoided Dad having a long wait for an ambulance and they prevented Dad from going to the hospital'.***

Tom expressed reluctance to go to the hospital due to concerns about leaving his wife alone. Steve was impressed by the collaborative effort to navigate this complex scenario. Tom underwent treatment for a urinary tract infection in addition to the arm injury. Steve emphasised the significance of Sean's visit, acknowledging that without it, his father would likely have been hospitalised. He commended the decision-making process that led to preventing hospital admission and sparing the need for an ambulance. Tom was grateful for the opportunity to remain at home, prompting Steve to reflect, ***"We would have been utterly lost without this service."***

Paramedic Robin initially attended to Nina when she was unwell with a chest infection, and it was during this visit that he broached the topic of advanced care planning. Kira explains 'Mum has never wanted to talk about what would happen when she dies. My dad was dying, and Mum didn't want to talk about that, death just didn't exist. So we have never talked about anything much. Having Robin come to the house to talk about advanced care planning enabled Mum to talk about it. Robin introduced it thoughtfully; he asked the right questions. Mum made all the decisions about where she wanted to be and how things would be in the end. As a catalyst from this, she then went on to do a will and we got in place a lasting power of attorney for health and finances and now we are all sorted. It opened the door to those conversations and since then she has told relatives about it, and she talks about it more openly and now everybody knows where we are with things. Now we have a plan for what will happen if Mum becomes unwell. She's recently had pneumonia and a GP did a home visit. She asked if Mum wanted to go into hospital. Mum was in a position to say 'no' she could do what we wanted to do, stay at home. The power of the document is that it's all written down. Unless she changes her mind. She was confident in saying a blank 'no' I don't want to go, there was no pressure to go as we had the plan. Mum was confident about that decision. We know it can change but she can also be managed at home and that's the best place for her to be, she doesn't go out, and she's not been out in three years so going to the hospital would be a trial. She can stay at home where things are familiar to her and there is no risk of her falling.

Psychosocial Interventions
Self-confidence building was highlighted in five patient narratives. Patients described how, with assistance, they regained the confidence to engage in group activities, socialise, and pursue employment. Additionally, they noted the correlation between self-confidence and the inclination to participate in sports and activities aimed at enhancing physical fitness.

Fourteen patients and carers discussed the importance of emotional support for their mental health and well-being. This included bereavement support, coping with a change in health status, crisis support, and help navigating mental health services. Two patients talked specifically about the support they received after close family bereavements (Allie and John). John recalled, ***"I lost my mum, I lost my dog and without these people here I wouldn't be here, I would be six feet under".***

Patients also discuss the importance of encouragement, human connection and building a trusted relationship (Chen, Joyce, Nina), where they can talk about their worries and fears and receive emotional support to make lifestyle changes. Several patients described how they were motivated to make positive changes following their appointments (Neil, Marie, June).

In Joel's account, he sought help from his GP due to feelings of anxiety and depression stemming from losing his job and remaining unemployed for several months. Consequently, Joel was directed to a Social Prescribing Link Worker.
Joel has now got a position volunteering in a local GP practice. He is going to help people with the electronic check-in process and do some administrative jobs as well as welcome patients. Joel said 'Before I met Molly, I felt quite stuck, I didn't know what to do and I was feeling very low. I now feel more confident, and I really appreciate having someone help and support me to find work. Knowing that there is support has really helped me feel better.' Social Prescriber Link Worker Role.

Allie's Story 'Susan was bereavement support, she helped with the simplest of things as we couldn't function. She provided support in those early days when I couldn't think straight, she guided us and helped us to make a plan. She was like a breath of fresh air. I don't know what I'd have done without her. She helped us to think about the funeral, suggested bereavement counselling which Dad has taken up, helped us with sorting out benefits he was entitled to and contacted adult social care about some extra care.' Care Coordinator Role

Jake's Story, 'If it wasn't for Suki, I would honestly not be alive today. When I went into crisis I talked to Suki, and she passed me to the crisis resolution team and then I went to crisis house and the people there were really helpful. She helped me with managing my mental health and talked to me about strategies. Suki was an advocate for me, working between me and services. I cannot give her enough praise for what she has done for me and what she is trying to do for me. She has signposted me to charities for mental health. She has been there for me in crises, getting me help when I need it. From the start, she has understood about my autism and mental health and how they have impacted each other. She's a sounding board to help with questions and things I don't understand. Suki is a godsend, and I don't use that term lightly.' Mental Health Practitioner Role

Social Isolation
Four narratives addressed social isolation and the effects on mental health and well-being, as observed in the experiences of Neil, Marie, John, and Emma. Common themes included social isolation arising from alterations in physical health and self-imposed isolation due to mental illness.

In all four accounts, a phased program was implemented to reintegrate social activities and foster connections with others. For example, in Emma's narrative, this process entailed meeting her at a nearby shopping centre and assisting her in leaving her vehicle. Patients acknowledged the advantages of expanding their social networks and the resulting positive influence on their mental health and well-being.

In John's narrative, he began attending drop-in sessions organised for residents by the Care Coordinators at a nearby community centre. Despite describing himself as 'a loner' and 'not very social,' John finds value in simply being in the company of others. At times, he prefers to observe from the sidelines, but he enjoys having people nearby.

John said, 'Since coming to the drop-in I have noticed that I am feeling better about myself'. John attends the drop-in most months and reluctantly he joins in the chair exercises, but he makes a joke about this suggesting he secretly enjoys joining in.
Care Coordinator Role.

Cognitive Strategies
Three narratives highlight the implementation of cognitive strategies, as evidenced in the experiences of Melissa, Joyce, and Flora. Melissa emphasised the significance of cognitive stimulation for care home residents, noting how Occupational Therapy facilitated activities to engage patients with cognitive decline in stimulating and socially interactive tasks, thereby enhancing residents' moods. Additionally, Occupational Therapists administered diagnostic cognitive assessments to facilitate onward referral bringing care closer to home (Bolt et al., 2019, Davies et al., 2023). In another account, Flora received Occupational Therapy assistance in adopting strategies to bolster the retention of crucial information. These narratives showcase cognitive strategies aimed at stimulating and preserving memory skills or providing compensatory techniques for individuals experiencing memory decline. These findings echo Occupational Therapy services in Lanarkshire where proactive models of prevention interventions are also proving effective (Kochar and Geer 2022).

The multi-professional roles served diverse populations encompassing individuals with both mental and physical illnesses.

Complex and multiple health conditions
Social Isolation
People living with trauma
People living with addiction
People living with learning difficulties
People living with the impacts of neurodiversity
People living with long-term health conditions
People living with frailty
Whole Families
People experiencing health inequalities
Young adults
Refugees and asylum seekers
Non-English speakers
Housing issues

Key aspects of multi-professional working.

The interview data was analysed to understand the lived experience of patients and carers and what they valued and appreciated most about the multi-professional roles. There were six prominent themes. Whilst timely access to health and care professionals held significance, it was not the most commonly cited aspect of appreciation. Instead, the majority of the patients expressed appreciation and gratitude for the demeanour of the individual, their communication style or their professional competencies. The relationship between patients and healthcare professionals was highly valued for its quality, continuity of care and resulting outcomes. Above all the personalised approach and therapeutic relationship were deemed the most valued aspects of care.

Six Themes: What do patients value when they engage with multiprofessional roles?

- **Timely access**
  Direct access to the individual without the need for GP involvement.
  Flexibility of access.
  Available in a crisis.
- **Relational qualities**
  Developing a rapport and trusted relationship.
- **Continuity of care**
  Consistently seeing the same individual for ongoing support over time.
  Supportive approaches.
- **Personalised care**
  The approach was tailored to the individual and their specific needs.
  The goals were specific and meaningful.
  Promotes independence and self-management.
  Listening skills and empathetic approach.
- **Professionalism**
  Professional approach.
  Their access to other services, onward referral, and networks.
  Appreciation of advocacy skills.
- **Group interventions**
  Opportunity to connect with other patients and local communities.
  Interventions to reduce social isolation.

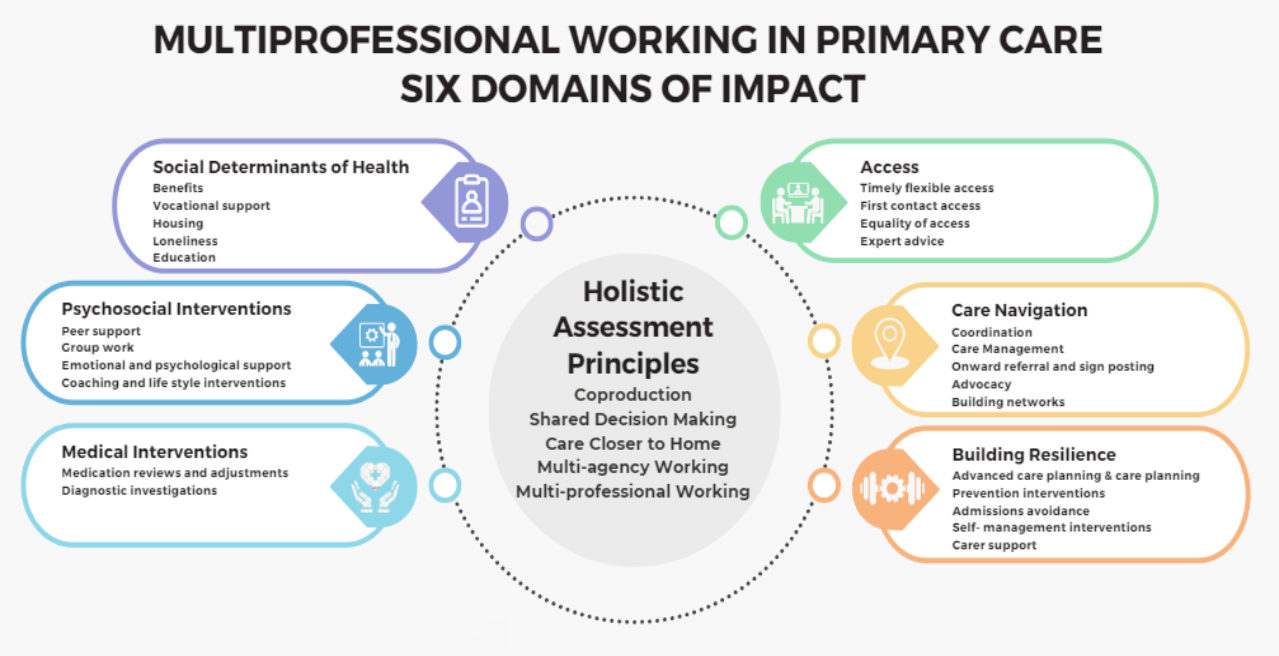
Objective 3: Understand the impacts resulting from contact and intervention.

Six distinct impact domains were identified each with a subset of characteristics. Figure 3 illustrates these six impacts with the circle representing the interconnected relationships between domains.

At the heart of the illustration lies a holistic assessment, which entails a detailed understanding of the individual's health and well-being and how these aspects are influenced by both physical and mental health. Key features of the multi-professional worker's assessment include collaboration with the patient and assisting them in enhancing their ability to self-manage.

Additional features encompass discussing options and engaging in joint decision-making or supporting the individual in making autonomous decisions. Moreover, the assessment involves collaborating across various domains and sectors, as well as working closely with other multi-professional roles.

Figure 3: Six domains of impact



The following sections of this report will delve into each domain in-depth, offering examples and examining the subset of additional aspects within each domain.

Access

Five participants highlighted the advantages of direct access to multi-professional workers, bypassing the need to involve a GP. They valued the promptness of onward referrals to other healthcare professionals, such as Mental Health Practitioners, Occupational Therapy and medical investigations. Echoing the findings from an evaluation of Mental Practitioner roles in Kent (Hotham 2015). Flora expressed, ***"It is reassuring that we can request the OT's involvement in the future."*** Seven narratives depicted the multi-professional worker offering advice and guidance. Participants described this as educational (Leo), reassuring (Marie and Philip), and characterized by kindness and compassion (Carrie and Ashante)

Annie's Story, 'Chloe's approach from her very first involvement was a significant breakthrough in terms of the support she was able to provide, both herself and through her extensive knowledge and network of contacts. I was impressed with several things, most notably her genuine caring approach, professionalism, and the aforementioned experience, knowledge, and networks. Through talking with Chloe and the Parkinson's Nurses, I now have a much better understanding of how Mum sees things and the triggers that cause her to have relapses and episodes where she hallucinates, and she believes she is in a different place. Dad has struggled with this as he is with Mum 24 hours a day and is clearly under some pressure. As a result, on her most recent visit, Chloe arranged for a colleague to visit to further assess Mum's cognition, and work with Dad to help him understand the impact of Mum's Parkinson's on her thinking processes and speech etc. This is another clear example of Chloe recognising the wider issues and working collaboratively to address and resolve them.' Occupational Therapy Role.

Care Navigation

In most accounts, the multi-professional worker assisted individuals in accessing additional services and facilitated coordination among various agencies. Advocacy support encompassed tasks such as drafting supportive letters, interfacing with agencies on behalf of the patient, and collaborating with both the individual and agencies to secure necessary support. Hamza's Care Coordinator played a pivotal role in coordinating across multiple agencies and advocating on behalf of him regarding housing issues and damp conditions. Similarly, Jake recounted how his Mental Health Practitioner, Suki, served as his advocate. ***'Suki was an advocate for me, working between me and services. I cannot give her enough praise for what she has done for me and what she is trying to do for me. She has signposted me to charities for mental health. She has been there for me in crises, getting me help when I need it.'***

Signposting to other services features in ten stories. Types of services accessed through their multiprofessional worker included counselling, asylum seeker specialist support, housing agencies, mental health services, weight management programmes, Physiotherapy, and Social Prescribing.

Neil's Mental Health Community Connector referred him to housing organisations but also acted as a sounding board for him to discuss and plan a strategy on how to approach his landlord.

Connecting patients to other services seemed to help them develop wider networks of support or access specialist assessment. Annie's story illustrates this from a carer's perspective she emphasises the importance of the multi-professional worker knowing the health and care system. In addressing the complexity of patients' needs, the multi-professional workforce frequently engages in coordination and care navigation. They manage cases until it becomes appropriate to conclude the episode of care. This typically entails multiple sessions, with the intervention being time-limited, contingent upon goal attainment or completion of an action plan.

Building Resilience

Care planning and advanced care planning feature in several narratives. Nina's story involves advanced care planning for end-of-life care with a paramedic. Nina's daughter Kira explained how through these conversations the family were able to talk more openly about end-of-life care and they also went on the put in place lasting power of attorney and a will. Kira said that advanced care planning gave Nina the confidence to make decisions about going into the hospital when she became unwell and that the whole family were now aware of her wishes. This also supports the findings in recent research that deploying primary care Paramedics can avoid unnecessary admissions to hospital (Arden and Ge 2023, Mahtani et al., 2018)

Specifically avoiding admission to hospital was evident in two stories (Nina and Philip), however, it was also evidenced in stories that involved Occupational Therapy (Marie, Flora, Melissa and Joyce) where preventative interventions were evidence such as falls prevention interventions, provision of mobility aids, strengthening work, providing equipment and adaptations.

Three individuals acting as caregivers participated in this review, and their accounts underscore the significance of involving and supporting unpaid caregivers. Steve (Paramedic), Annie (Occupational Therapist), and Allie (Care Coordinator) each shared a distinct narrative highlighting the imperative for multi-professional workers to engage with and collaborate with family networks. This collaboration is crucial for understanding caregivers' perspectives, supporting them, and acknowledging their stresses. Allie found herself thrust into the role of a caregiver following the sudden passing of her mother. Her Care Coordinator offered practical assistance and support during this challenging period, which included arranging care and supporting Allie's father, while also tending to Allie's needs as a new caregiver.

Medical Investigations

Several roles had more emphasis on medical interventions such as adjustment of medications, investigations (Paramedic, Physician Associate and Advanced Clinical Practitioners) and diagnostic skills. Although these roles involved medical interventions they also included a holistic assessment and the patient stories reflect that psychosocial

health was considered and assessed. Although the Advanced Clinical practitioner in Idrak's story used diagnostic tools to diagnose his back pain she was also considering the psychosocial impact and his psychological health including the impact of trauma on his physical health.

Psychosocial Interventions

Psychosocial interventions treat or address symptoms of mental illness and seek to improve psychological and social aspects of well-being. There were thirty-seven references to emotional and psychological support in the twenty patient/and carer narratives. Multi-professional workers were dealing with sensitive intimate health issues (Ashante- ACP), end-of-life care (Nina-Paramedic), bereavement (Allie- Care Coordinator), suspected cancer diagnosis (Carrie- Physician Associate), substance abuse and alcohol recovery (Neil- Mental Health Community Connector), life-changing disability (Nazim- Care Coordinator) and severe mental illness (Jake- Mental Health Practitioner).

Emotional support was the most prevalent theme and was highly valued by the patients. Social interventions included social prescribing, specific interventions to address social isolation and vocational interventions. Several stories included interventions to support lifestyle changes (Neil, Joel, Marie and Leo). These ranged from interventions to increase physical activity, improve nutrition as well as increase socialisation. There was evidence of grading activities (Marie and Emma) and gradually building confidence (Neil, Joel, June, Leo). Patients also identified the importance of not feeling alone, peer support and being part of a group. Social isolation is thought to be a determinant of health and social prescribers have been successful in addressing these types of issues as found in the Thamesmead Peabody Report (2022).

Social Determinants of Health

Multiprofessional workers were supporting patients to access benefits (Allie, Joel, Joyce). Nazim's story illustrates how his Care Coordinator helped him to receive financial help which had a life-changing impact.

Nazim's Story, following a cancer diagnosis Nazim had life-changing head and neck surgery. During a hospital admission, he found himself homeless and was discharged to hostel accommodation. During this time his health rapidly deteriorated. He was losing weight and his mental health was suffering due to the antisocial behaviour he was exposed to in the hostel. Ruby helped Nazim get the benefits he was entitled to, which meant he could move out of the hostel into council accommodation. Ruby helped Nazim furnish the property and arranged for him to have specialist support from a Dietition. Nazim started to put on weight. He received some help with benefits to ensure that he could pay the rent and buy food. Ruby also arranged some home adaptations and support from adult social care. He talks about 'feeling alive gain'. He attends the Care Coordinator's weekly drop-in where he can socialise with other residents. He says that everyone is very nice and explains that he has a strong faith and when he prays, he prays for the people that have provided him with the help that he needed especially Ruby. Care Coordinator Role.

Three patients, namely Emma, Neil, and Joel, received assistance in securing volunteer positions to ultimately obtain paid employment. Notably, Neil has achieved success in securing paid employment since then. Emma extended her involvement in volunteering and was actively participating in several projects within the local community, including those supported by the organisation that funded her social prescribing link worker. Joel expressed pride in his role as a volunteer within a GP practice, where he assists patients in accessing services. While the financial aspect of employment was deemed significant, the social aspects of volunteering and the importance of meaningful occupation were also clearly evident.

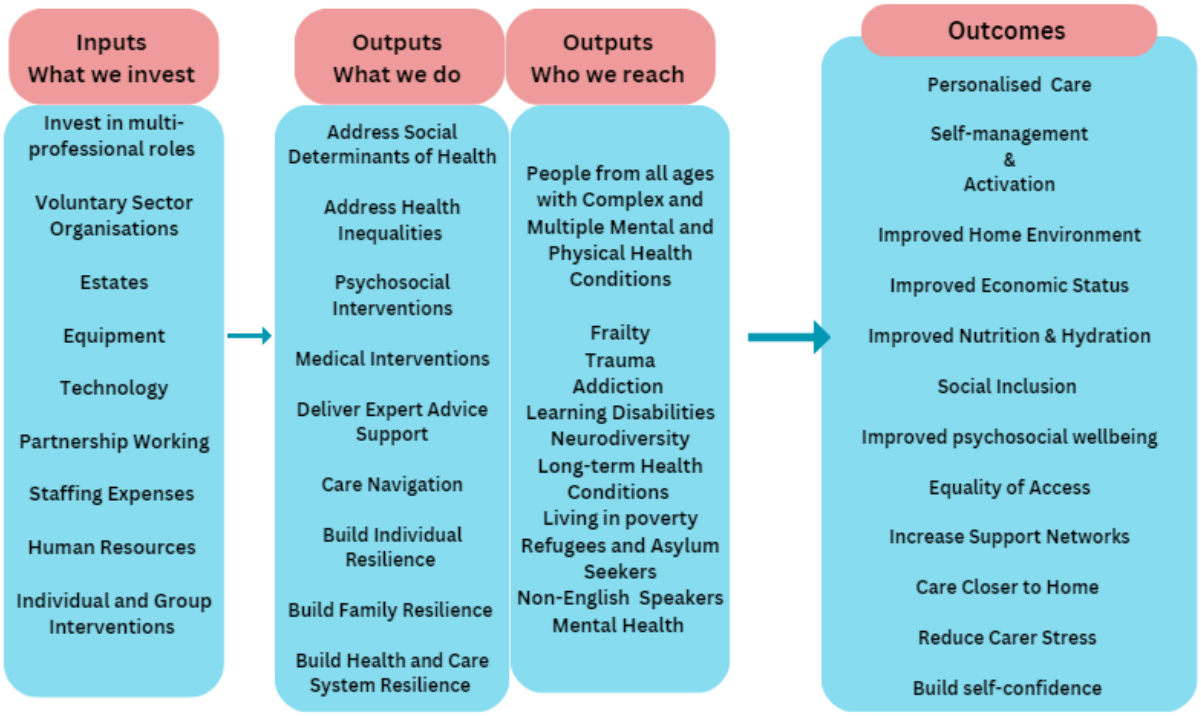
Housing and health we inextricably linked. Housing support included writing letters of support (Hamza, John, Jake), obtaining soft furnishings (Hamza, Nazim) and white goods (Nazim), and supporting landlord negations (Hamza, Neil, Jake). Patients needed assistance with managing neighbourhood antisocial behaviour, rehousing and home improvements. John's story is particularly moving. Following the sudden death of his mother he found himself facing eviction from his home. Unable to mediate with the housing association and manage the paperwork due to a learning disability he was nearing the stage of eviction. One day he found himself on a bridge ready to take his own life. A passerby managed to talk him down and pursued him to visit his GP where he was referred to a Care Coordinator. The Care Coordinator advocated for John with the housing association and as a result of her actions, John was awarded a tenancy agreement.

The data highlighted the significant role of multi-professional workers in identifying social needs and facilitating connections to voluntary sector organisations that offer services to address social isolation. Additionally, they were involved in health promotion and education, as well as supporting individuals in self-management. For example, Neil received support from his Social Prescriber to address his addiction issues, while Leo learned about cooking and nutrition to manage his diabetes and achieve weight loss goals.

Developing a logic model.

A logic model is a structured approach to visualise and understand the relationships between the available resources, intended activities and the anticipated change or results. To understand the mechanisms for change associated with multi-professional roles, the author has developed a logic model to describe the inputs, outputs, and outcomes of multi-professional workers. This model has been formulated from the data and insights derived from the patient and carer narratives. Figure 4 illustrates the theory of change by describing the key components: what Primary Care Networks (PCNs) invest in the multi-professional workforce, the functions and deliverables of the roles, and the populations they serve. The outcomes articulate the potential impacts of the multi-professional workforce thereby providing primary care leaders and commissioners with a model to understand the types of outcomes they can anticipate.

Figure 4: Logic model for multi-professional roles



The utilisation of this logic model enables the planning of workforce developments by defining the resources, activities, and anticipated outcomes of multi-professional roles. Both the six domains of impact framework (Figure 3) and the logic model (Figure 4) serve as aids for contemplating how to measure outcomes. Despite variations in experience, qualifications, and skills among the roles, each lived experience story revealed strong common features such as the deployment of multiple psychosocial interventions.

These project outputs could support ongoing research and evaluation of multi-professional roles while also conveying expectations regarding role fulfilment. The author intends to use this as a basis for developing a tool to gauge the effectiveness of multi-professional roles. This model demonstrates that multi-professional roles meet the core attributes of general practice (Figure 1) desired by patients, encompassing access, continuity, coordination, and community focus (Baird et al., 2019).

Limitations of the Review:

The participants in this evaluation were self-selecting. Notably, no dissatisfied participants came forward. Multi-professional workers were encouraged to recruit willing volunteers potentially resulting in a selection bias towards people with positive experiences.

Some patients faced communication challenges necessitating verification of their details with their workers. While this constitutes a small sample size and not every role was represented this project offers compelling narrative stories to illustrate the impact of

multi-professional roles which can serve as a foundation for future evaluation and research.

Although this review identifies that multi-professional roles are working together, it does not delve into how they collaborate, what mechanisms are at play and the outcomes of collaborative working. The impacts of multi-disciplinary teamwork and personalised care teams were not explored in this review but are important considerations for future reviews.

Despite efforts to be inclusive, several ARRS-funded roles were not included in this review. Further reviews should include the impacts of Digital and Transformation Lead, GP Assistant, Nursing Associate, Physiotherapy, Pharmacy roles, Podiatrist and the newly added Enhanced Nursing role.

Considerations for future evaluations and research:

Recruiting participants willing to share their stories posed a challenge. Initially, the goal was to recruit a patient who had experience with each multi-professional ARRS role. However, despite extensive efforts to advertise the project and offer flexible engagement options, this objective proved unattainable. Future evaluations should strive to recruit more children and young people who have received support from multi-professional roles. Future reviews should explore the availability of quantitative data to complement the qualitative narratives, thereby providing a broader understanding of impact.

Summary

The findings of this report indicate that multi-professional roles are beginning to instigate a shift towards a more holistic approach to primary care, echoing the sentiments outlined by Dr Claire Fuller (2022) in her report on integrating primary care and advancing towards a psychosocial model of care. This shift involves a focus on supporting the overall health and well-being of communities and aligning the broader health and care system with a population-based approach (Fuller 2022). While this report offers insights into the experiences of patients and carers, these developments are still in their early stages, and there remains much to be discovered about multi-professional working in primary care. This domain of clinical practice necessitates further workforce development, innovation, and rigorous clinical research.

Recommendations:

- The majority of the patients were not aware of the multiprofessional role in primary care before they were introduced to it. Raising patient awareness about the role of multiprofessional workers in general practice could improve patient acceptance and utilisation of these services.

- A clear definition and understanding of each role within the primary care team are essential to ensure effective collaboration. Information on the patient website would also support awareness and acceptance of these roles.

- The six domains of impact could be used to develop a data collection tool to capture qualitative and quantitative data on the impact of multiprofessional roles.

- The logic model developed could be utilised to explore the mechanisms for change and to test out theories of how these roles impact patient health and well-being and population health.

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Appendix

Allie's Story: Care Coordinator Role

Allie explains that her mum was taken unexpectedly ill and went into hospital. Her dad has epilepsy and required constant supervision. Susan the Care Coordinator was asked by the GP to provide Allie with some support for getting care in place for her Dad while her mum was in hospital. Sadly Allie's mum passed away unexpectedly in hospital.

Allie had to take over as carer for her Dad who was registered disabled. She explains that he can't go out alone, and he has to wear protective headgear outside, 'this is normal for us but for everyone else they panic, there is very little knowledge about his condition. When Mum was alive, he had round-the-clock care, although he strives to be independent. When Mum was in hospital, he was alone as I was working full time.'

Susan tried to get emergency care for Dad as he was used to living with someone and it was unsafe. 'We wanted to put this carer in place ready for when mum came out of the hospital as mum would need extra care as well.'

Allie explains 'Susan was a bereavement support, she helped with the simplest of things as we couldn't function. She provided support in those early days when I couldn't think straight, she guided us and helped us to make a plan. She was like a breath of fresh air don't know what I'd have done without her. She helped us to think about the funeral, suggested bereavement counselling which Dad has taken up, helped us with sorting out benefits he was entitled to and contacted adult social care about some extra care.'

Allie explained 'I can't be there 24 hours a day he needs support Susan helped us to get city-wide alarms in place. Which gives me some reassurance when Dad is alone. I didn't know about any of these things. She helped us to get support from adult social care- expediting things and advocating on our behalf. She provided emotional support as well as practical help. This service is fantastic - I had no idea you could get this help from the GP. '

'In the early days, I could hardly string a sentence together, we were both grieving we didn't know what to do, suddenly, I had to take on another household and sort out finances and, in the midst, we were grieving. Susan was an ear, someone to listen, she came to see us at home, and she was just wonderful. I can't speak highly enough of her. She helped more than I think she will ever know.'

Annie: Occupational Therapist

Annie is the daughter of Joyce and Ted. 'I first met Chloe earlier this year when she began visiting my mum who has Parkinson's disease. For several years following her diagnosis, Mum coped well but has more recently started to struggle. Our local GP practice therefore suggested Chloe and the Occupational Therapist visit Mum to see how she could support her. Up until this time, my dad had coped well supporting Mum, but following Mum's progressive change, Chloe's support was vital as Dad was also in poor health and was beginning to struggle himself.'

'Chloe's approach from her very first involvement was a significant breakthrough in terms of the support she was able to provide, both herself and through her extensive knowledge and network of contacts. Chloe fully understood Mum's situation and quickly gained her and my own, full confidence. Unfortunately, Dad can on occasion be a little over-controlling and, although he means well, this can detract from the real issues and Mum's actual needs. Chloe picked up on this immediately and would discreetly take Mum into the kitchen for the two of them to have a 'proper' chat. Annie described how she attended one of Chloe's early visits. Mum and Dad were struggling to let me know what had happened during Chloe's visits. On meeting Chloe, I was impressed with several things, most notably her genuine caring approach, professionalism, and the aforementioned experience, knowledge, and network of support agencies/groups. Annie explains 'This skill base combined with Chloe's listening, understanding and empathy has proven to be invaluable to my family, particularly given the complexity of Mum's situation. Chloe has kept in regular contact with me, before and after her visits with Mum, keeping me up to speed and jointly agreeing on the best way forward. She has also recognised and dealt with some of the complications caused by my dad's approach which is largely based on a lack of understanding.'

One particular example of Chloe's professionalism and integrity is in the supporting statement she wrote for an unsuccessful Attendance Allowance claim. Chloe was concerned at the decision and together with a colleague drafted a letter of appeal on Mum's behalf. Annie says 'Chloe has been a 'rock' in supporting mum, dad, and myself in dealing with what has been an unprecedented and difficult few months for us. I am genuinely grateful for her support and advice and look forward to working with her in the coming weeks and months. Dad can often be a little overbearing and difficult to grasp a clear understanding of the situation and Mum's actual needs. A good example is Mum's medication which it recently became apparent she was failing to take regularly. I had discussed this with my dad on several occasions and he hadn't fully grasped the importance of the situation.

Annie describes a conversation she had with Chloe 'She has diplomatically approached the subject with Dad and spoken to me about potential options for 'escalating' things if there is no immediate improvement. Chloe suggested setting reminders through Alexa, ART involvement, and ultimately a potential care package. I see this as an example of Chloe's ability to acknowledge and diplomatically challenge a potentially difficult situation without making Dad feel as though he is failing in any way.'

Annie describes another way that Chloe has gone 'above and beyond through talking with Chloe and the Parkinson's nurses, I now have a much better understanding of how Mum sees things and the triggers that cause her to have relapses and episodes where she hallucinates, and she believes she is in a different place. Dad has struggled with this as he is with Mum 24 hours a day and is clearly under some pressure. As a result, on her most recent visit, Chloe arranged for a colleague to visit to further assess Mum's cognition, and work with Dad to help him understand the impact of Mum's Parkinson's on her thinking processes, speech etc. This is another clear example of Chloe recognising the wider issues and working collaboratively to address and resolve them.'

Ashante's Story: Advanced Clinical Practitioner Role

Ashante is in her 20's. She came to the UK on a student visa and has claimed asylum. She attended the practice for a new arrival appointment which involves screening refugees and asylum seekers.

She was assessed by Tinika an Advanced Clinical Practitioner (ACP). Who commended screening for blood pressure, plus weight, height and body mass index. This also includes screening for lifestyle factors such as alcohol intake, smoking, diet and dental issues. There are also other screening processes for transmittable diseases, sexual health and a deep dive into past medical history. Ashante said she was claiming asylum due to her sexual orientation.

Ashante explained that her periods had started when she was 10 years old and she had irregular and painful periods. She has a muscular build and acene and other clinical discussions started to build a picture of the potential diagnosis of polycystic ovaries. To rule out diabetes a blood sugar test was completed which was within normal limits.

Ashante shared that this was the first time anyone had talked to her about her health problems, and she recalled 'I didn't think I was a real woman'. She decided that she and her sister when of a similar build and shape and that their mother was the opposite petite. She said her sister could not conceive and that they felt like freaks. As an ACP Tinika can make referrals to ultrasound so she discussed with Ashante that she could make a referral for some investigations and there was also a possibility that she may need to see an endocrinologist or gynaecologist for further testing based on her history and examination findings if the diagnosis of polycystic ovaries was not confirmed.

The results indicated raised testosterone levels, normal ultrasound and an urgent referral to endocrinology was made. Endocrinology Consultants have subsequently confirmed a diagnosis of a rare inherited condition called congenital adrenal hyperplasia where the body is missing an enzyme which organises the release of hormones. This can cause complications with fertility and requires lifelong medical treatment.

Ashante will continue to be cared for by Tinika while she remains in the city. Her sister in Africa had been sent information on the condition and genetic testing had been recommended.

Tinika says 'I use advanced level decision-making skills to aid my clinical reasoning when dealing with differentiated and undifferentiated individual presentations and complex situations but effective communication and gaining the trust of Ashante was vitally important to ensure a positive outcome. Although the working diagnosis was not confirmed the tests, I had requested were pertinent to initiating an urgent referral to the endocrinology team and thus led to a correct diagnosis for Ashante.'

Carries Story: Physician Associate

Carrie is in her 50s she has had irritable bowel disease most of her life and in the last two years has been struggling with menopause symptoms. She explains 'Around Christmas time I was having difficulty going to the loo, I felt a pressure in the back passage, and I was feeling hot-sick and sweaty. I have endometriosis but have not had a period for two years. I just wasn't feeling right. I thought it might be my IBS so I went to see the doctor and I saw a physician associate called Ayesha. She explained she wasn't a doctor, and she explained the difference between her role and that of a doctor. I told her that it didn't feel right when I had a poo, I felt a funny kind of pressure. She asked me lots of questions and then examined my back passage and tummy.

'She felt up there and said there is no blockage but I can feel internal and external haemorrhages I didn't know I had internal ones but it put my mind at rest. She prescribed some treatment and said to come back if I wasn't feeling right.'

'After a few weeks, I still wasn't right, so she sent me to the hospital for some blood tests and I did a poo test which I had never done before. She explained everything carefully. I went for the tests. I had an ultrasound and at this point, I was experiencing excruciating pain.'

'The hospital consultant explained that it might be several things, from fibroids to ovarian cancer. The blood tests showed that my HC125 was high, so this is a sign that there is something sinister. Through all this Ayesha has been there, talking me through things. She explained I would be fast-tracked because of suspected cancer.'

'I went to the hospital and had a vaginal probe, and I was due to have a biopsy but it got cancelled at the last minute. The consultant explained that the lining of my womb is thicker than it should be. I have come off the HRT so the night sweats are back, but it could be feeding cancer so that's what I must do. I am now waiting for an MRI scan under general aesthetics. If it wasn't for Ayesha's perseverance this would not be happening. She may have caught the cancer early. She kept asking questions and took swift action. She was kind, sympathetic and informative. She explained everything carefully and was there for each step. She acted without hesitation and put my mind at ease. It was a personal thing for me to be examined intimately but she wasn't fazed or embarrassed she just got on with it. I could not thank her enough.'

Chen's Story: Physician Associate

Chen is in his 20's he is a student at the university. He went to see Lyra the Physician's Associate because of low mood. He didn't want to go to the doctors, but his girlfriend May had seen Lyra a few weeks ago and had convinced Chen that Lyra would be sympathetic to his issues.

Chen explains that he has had a difficult childhood. He has seen many doctors for his health issues, and he has not found it helpful. He finds it difficult to trust health professionals and it was feeling reluctant to see someone about his mood.

Chen explains that at first there were some things he needed physically, low vitamin D and blood tests. He explains that he feels depressed and has a low mood. He is concerned that he might have ADHD and is awaiting a diagnosis of autism.

Lyra explains there is more awareness of these conditions which has reduced the stigma. Chen says that his parents never addressed it and that some of his mental health problems are related to family trauma.

Chen says 'Lyra sent me for blood tests and started recommending I start on antidepressant medications; I thought I would give it a try. She also sent me for an ECG for ADHD medication. She referred me to the mental health crisis team, and I saw a community mental health worker. I was having suicidal thoughts.'

Lyra explains that during the period of getting assessments and starting new treatments, she saw Chen for ongoing support to review treatments and keep an eye on his mental health. Chen says 'I appreciated the rapport and that she listened. Lyra explains 'In the beginning, I booked double appointments to address multiple issues, the first appointment took 40 minutes – we needed to make a plan to address the suicidal thoughts and impulsive behaviours that Chen was experiencing. Lyra explained that she had a named GP who she could debrief with as needed and write prescriptions.

Chen explains that he has developed a rapport with Lyra and this has built trust so that he can share his concerns. He is feeling better on the treatment and is receiving mental health support. He doesn't need to come as often and is grateful that he is getting assessments for ADHA and Autism.

Emma's Story: Health and Wellbeing Coach

Emma is a white British lady in her 50's. Emma describes herself as being in a bad place mentally. She explains that she has been through a lot of different things in her life which gradually led to her stop going out. She was alone, she didn't leave the house for five years. She went to see her GP and she was put on antidepressants and anxiety medication. The GP suggested that she have an appointment with a social prescriber to see if they could help her.

Emma referred herself to the local voluntary sector organisation that was providing the GP with social prescribing like workers. This is where Emma met James and started to receive support for her mental health and well-being. From this Emma was referred to Claire a Health and Wellbeing Coach.

Emma explains 'I had a car but when I went out in the car I got to a place, and I couldn't get out. Claire would meet me at locations and support me to get out of the car and we would go and do something together like shopping or other activities. Emma explains how gradually she became more confident with this until she was able to do it herself. She goes on to say how she now volunteers at the charity herself. 'I was doing all of the activities, and they kept saying, 'Would you be a volunteer and help out', I wasn't sure if I could. They put the paperwork to apply to be a volunteer in an envelope but said don't open it until you are ready. Then one day I felt ready.'
Emma explains 'Claire and James have given me my life back. I have been through a lot of bad things, and I just shut down and then I couldn't open again. It was hard to do anything, but they helped me to open up.

'They were very patient with me, not pushing me too much, gentle and persuasive. James said to me right at the beginning, we will put in all the support but there is only one person that can do it and that's yourself. Even now I still get the feeling I don't want to do it and I think back and say, 'You're not going back there again'.
'Socially I didn't see anybody at all, my mum used to visit, and I didn't go out at all, I didn't go shopping or see anyone at all. Now I volunteer at the social café once a fortnight for a full day, I do well-being Wednesdays and support the menopause café once a month.'

'Feel better, my health is so much better, my diabetes control is so much smoother, I'm not just sitting all day, I am doing things all of the time. I was taking anxiety medication which I no longer take, and I have reduced my antidepressants. I have started to do badminton and Ti Chi. I also volunteer at the wildlife trust and gardening group. We have developed some pocket allotments at two GP surgeries, and we have been putting the plants in and doing mindfulness at the same time. My life is full, now I need more days in the week, I am making up for lost time.'

Flora's Story: Occupational Therapy

Flora is in her 80's. A few months ago she visited her GP following a nasty fall outside. She broke her arm and had cuts and bruises. Flora had started to have difficulty walking around due to osteoarthritis.

Flora's GP referred her to Rosie the Occupational Therapist because they were concerned about her memory. Rosie assessed Flora's needs in her own home. First of all Rosie introduced herself and looked at the more physical difficulties and building a rapport. A follow-up visit was agreed to look at the memory issues. Flora was appreciative of this as Rosie could have a close look at the things Flora was struggling with.

'Rosie provided me with toilet equipment, and she was very nice, she looked at what I needed and thought of things that could help me. Since having the raised toilet I am managing much better, and I can do more on my own.' We discussed the use of a walking stick for outdoors, which I am already doing, particularly as I live in a hilly part'.

Flora has also been experiencing some memory problems, so Rosie completed a memory assessment. Which resulted in the GP referring Rosie to the memory clinic for further assessment. Rosie also suggested some things that might help such as putting labels on the cupboard doors. Other things suggested were to use a weekly, clearly visible calendar for appointments, the use of reminders on my mobile phone to take my medication.

Rosie discussed the importance of routine and suggested that as a family we create some family books. Something our daughter had done for our wedding anniversary. We are looking forward to doing this together with our children and grandchildren as this is something we have routinely done for our holidays. It is re-assuring to know we can request Rosie's involvement in the future.

Hamza's Story: Care Coordinator

Hamza is in his 30's he lives with his wife and children in rented accommodation, English is not his first language. He fled his home country to give his family a better life and talks about being 'very appreciative' of being able to live in the UK. Hamza's house has significant damp issues which he has been struggling to manage and this is having a detrimental effect on his health and that of his family.

His wife is due to have a major operation and he is very worried about bringing her back to the property afterwards. Hamza has asked for help to address the damp issues. The GP and midwife have all written letters to help him and although the council have been involved, he is still living in poor conditions. His Care Coordinator understood his concerns and helped him by acting on his behalf and liaising with relevant agencies. She also helped him to get letters of support. This resulted in carpets being laid and they were able to move out of the house while some repairs were completed. The care coordinator was able to work with other agencies that could help Hamza and his family. Hamza describes her perseverance 'She just would not stop; she went everywhere until something was done to help us'.

The care coordinator Farah says 'At the time that I met this family Hamza's wife was pregnant, they were brought to my attention by a nurse at the practice who was looking after Zahara. I did a home visit and saw how bad the dampness in the house was. Water was literally running down the walls, there was black mould everywhere. The pillows, mattress, and bedclothes were all damp and mouldy. The smell was horrendous. As you came to the door of the property you could smell the damp". Farah explained 'Hamza had worked for the British in Afghanistan and was brought over as a refugee when Britain allowed people over who had worked for them. I spoke to the resettlement team, as they were the ones looking after them. After much back and forth I was able to get them out of the flat for a weekend to allow the flat to dry out and be painted. But, within weeks the damp was back. I asked the nurse, midwife, and GP to write letters supporting the family to get them out of this property as I could see it was having a detrimental effect on the young child and Zahara's health. I got several agencies involved and after a team around the person meeting, the family was moved from the property into temporary accommodation.

By this point, Zahara had given birth to the baby and the dampness was affecting the baby's health, I could see he wasn't thriving and there had been several A&E visits. The health visitor like the midwife had flagged her concerns to their relevant teams but things were not moving fast enough. I contacted Housing Solutions from the Council and after explaining the situation they removed the family and put them into temporary accommodation. The family's health improved whilst in the temporary accommodation. They were in temporary accommodation for two months and in the end, had to go back to the flat. During the summer months, things were fine but as winter approached the damp came back. The family are now on the priority list for rehousing. I contacted the local Councillor to get the family some support, there has been some local press on their story, and this has helped move them to the priority list".

Idrak's Story: Advanced Clinical Practitioner

Idrak is in his 20's. Born in Iraq he speaks Kurdish Sorani and is an asylum seeker. He speaks little English so an interpreter is required. He lives in a hotel and on his first appointment with the practice disclosed details of his father's brutal murder. He presenting problem is low back pain. Idrak lived in a tent in France for the first months after leaving his country until he crossed the channel and was placed by the home office in a hotel.

There was no previous medical history of low back pain, he was nervous to attend the surgery but he explained that he had back pain for approximately two months which was preventing him from sleeping. He was unable to purchase medication for this due to having very little money. Charlotte was the Advanced Clinical Practitioner (ACP) in the clinic that day and she assessed Idrak's back pain symptoms and explored his concerns and worries.

Through the interpreter Charlotte was able to gain a measure of pain, as well as clinical observations she assessed for red flags that might suggest more serious conditions. For this Charlotte was able to rule out possible red flags indicating further investigation. She also conducted a physical examination to add to the clinical picture. She palpated the spine for tenderness and performed the straight leg test advocated as part of a spinal examination. No serious pathology was suspected, and further examination indicated a possible muscle strain.

Charlotte reflects 'We both agreed that reducing his pain was a priority and after re-establishing he had no known drug allergies or contraindications to analgesia.' Charlotte proposed that Idrak commences on regular paracetamol and ibuprofen, and these would be prescribed due to Idrak's financial situation. Charlotte reflects 'I booked Idrak for a two-week review to ensure his symptoms were improving and to screen him for depression and we discussed a possible referral to the local physiotherapy department if he remained symptomatic.

I consulted with the GP afterwards who suggested that at the next review, I might consider a differential diagnosis of ankylosing spondylitis if he remains symptomatic and book him in for bloods to check his vitamin D level and inflammatory markers to rule out infection or inflammatory arthritis. Deficiency of vitamin D is commonly reported in asylum seekers such Idrak and can present with a history of bone pain, proximal muscular weakness, change in gait, or fatigue.'

Charlotte reflects that low back pain is a common presentation in primary care and the biopsychosocial model is a helpful tool to reflect on with the asylum seeker population to explore potential causes other than physical pathologies.

Jake: Mental Health Practitioner

Jake is in his 40's he has autism and a long-standing mental illness. Jake describes mental health difficulties that started when he was a teenager. He explains 'Since then lots of GPs have been trying to get me proper psychological help, I ended up being homeless until a friend helped me to get a bedsit, but my mental health had never been right, my first memory of things going wrong was in nursery school.' Over the years Jake has had several counsellors but describes this as 'Tying to put a sticking plaster on a major wound, lots of things happened in my life'. Jake says that he was diagnosed with post-traumatic stress disorder after having a stillborn child and issues with a previous partner.

Jake explains that when he was diagnosed with Autism, he thought things would improve however 'The mental health problems were compounded as you are no longer one service's responsibility, adult autism said, we don't do support, we only do assessment and diagnosis. During COVID there was a service from the GP surgery, that was helpful. It was every few weeks and I could call when I needed help in between appointments.' Jake describes how he bounces between services and doesn't quite fit in any. Jake met Suki a Mental Health Practitioner during COVID. He says 'If it wasn't for Suki I would honestly not be alive today. She has been seeing me on and off for about 13 months, it was just supposed to be short-term but as I couldn't get into any other services, I started to see Suki.

'I had a panic attack in a car park while out shopping and I sent her a message and she rang me back. Between her and the GP, they have really helped me. After I attempted suicide, I talked to Suki. Suki is the only stable help that I've had, so I am so grateful for her help. Suki helped people to understand what I have been through, and she believed my story.'

'When I went into crisis I talked to Suki and she passed me to the crisis resolution and then I went to crisis house and the people there were really helpful. She helped me with managing my mental health and talked to me about strategies.'
'Suki was an advocate for me, working between me and services. I cannot give her enough praise for what she has done for me and what she is trying to do for me. She has signposted me to charities for mental health. She has been there for me in crises, getting me help when I need it.'

'I am currently having issues with the antisocial behaviour of a neighbour, noise and disturbances, drug use and property damage. I have had to call the police and deal with housing officers, and I am trying to get rehoused with my family. Suki has helped me deal with this'.

'When my ability to cope has crumbled she has been there for me. All roads led to Suki. From the start, she has understood about my autism and mental health and how they have impacted each other. She's a sounding board to help with questions and things I don't understand. Suki is a godsend, and I don't use that term lightly'.

Joel: Social Precriber

Joel is in his 20's and has been out of work for a few months. He visited his GP after feeling low in mood. He was feeling anxious and depressed related to being out of work. Being out of work was having a significant impact on his mental health. The GP referred Joel to Molly a social prescriber. Molly contacted Joel to find out how she might help him. Joel was reluctant to consider benefits as he thought this would have had a negative effect on his ability to get work and, he felt that it was admitting defeat. Molly convinced Joel that getting some benefits would be helpful for him, so he agreed, and she talked him through the process of how to apply for universal credit. He has received this benefit, and he is so appreciative as he feels it is helping him with his quest to find work. He has applied for a few jobs and is hopeful of getting employment soon.

Molly also suggested that Joel try getting some voluntary work, she suggested that work experience would be good for his CV and also this could help him when applying for jobs. Molly worked with some local GP practices to see if Joel could do some volunteer work in the practice.

Joel has now got a position volunteering in a local practice. He is going to help people with the electronic check-in process, and some administrative jobs as well as welcome and help anyone who attends the practice.

Joel said "Before I met Molly I felt quite stuck, I didn't know what to do and I was feeling very low. I now feel more confident, and I really appreciate having someone help and support me to find work. Knowing that there is support has really helped me feel better".

John: Care Coordinator

John is 54 years old. He has been unemployed for some time after losing his job when the company he worked for went bust. John has enduring mental health illnesses which were exacerbated by recent bereavements. Within the space of a few weeks, John's mother unexpectedly passed away followed by his close companion Fed his pet dog. When John gets low, he takes himself off for a bike ride and admits that he drinks alcohol to help himself feel better. Not long after losing his mum, he found himself looking over a bridge and thinking about taking his own life. An off-duty police officer noticed him and went over. They had a chat about getting some help and following this John decided he was going to visit his GP.

John went to see his GP about anxiety, depression, and suicidal thoughts and in particular his concerns about being made homeless. Although John had lived with his mother for a long time, he wasn't a tenant and although they had discussed joint tenancy this was not put in place before his mother passed away. After losing his mum John tried to complete the paperwork for the Housing Association to take on the tenancy. He found this difficult due to some unexpected issues and this process was causing him a great deal of stress and anxiety. The GP suggested that John have an appointment with the care coordinator.

This is where John met Polly. She took time to get to know John. She had time to listen to his concerns and to find out what help he needed. Polly supported John in completing the relevant paperwork and she became an advocate for John with the housing association. John was in danger of getting an eviction notice so Polly dealt with some of the communication herself and asked the GP to write a supporting letter. John explained that in three weeks' time, he is going to get tenancy to the property where he has lived with his mum and his beloved dog. John describes this as his safe place, a place that holds memories. John explained that he knows the neighbours and they know him. When John hits a low spot he tends to stay at home and hunker down. The neighbours noticed that John hadn't been out and about and they knocked on his door to check that he was okay. John feels that he could go to the neighbours if he were in difficulty and finds comfort in having people around him who know him. These are the things that matter to John, and this is why staying in his own home is important to his mental health and well-being.

John said that when he met Polly he was broken and through the help that she provided he has been given a new lease of life. 'I lost my mum, I lost my dog and without these people here I wouldn't be here, I would be 6 feet under'. John started to attend the drop-in sessions which happen weekly for local residents. Although John describes himself as 'a loner' and 'not very social', he appreciates just being around other people. Sometimes he just sits on the sidelines and watches, but he likes the idea of having people near. John said, 'Since coming to the drop-in I have noticed that I am feeling better about myself'. John attends the drop-in most months and reluctantly he joins in the chair exercises, but he makes a joke about this suggesting he secretly enjoys joining in.

June: Care Coordinator

June is in her mid-60's she describes herself as a 'collector of things'. She openly talks about her 'troubled past', difficult childhood as well as experiencing toxic adult relationships. She describes how this has led to her being a 'bit of a hoarder' and how this has recently 'gotten out of hand'. June was referred by her GP to a care coordinator who worked with June to figure out how to improve things in her life. The care coordinator recommended that she try some talking therapy and supported her to get a referral for some mental health support. June has talking therapy through online sessions which she finds very helpful as she doesn't like to go out and describes herself as agoraphobic.

June explains that the care coordinator has helped her put away some of her things in the house and sort other things into categories. She says the care coordinator has helped her to look more positively at things, especially the future. She says that the mental health support has helped her to become more 'mindful' of her lifestyle and how this has recently been affecting her health.

She thinks about going out in the warmer weather and would like to attend events at her local church. She joins the 'zoom' services but would really like to attend events in person. June explains that before COVID she spent a lot of time knitting and crafting. She likes to write stories and used to attend a knitting circle and a craft group. Unfortunately, these stopped during COVID-19, and they haven't started again.

The care coordinator arranged for June to have a rollator frame to help her walk. She uses this to get around her bungalow and has been outside nearer the house with it. She feels panicked about going out and being away from home but aspires to do this when the weather is better. The care coordinator arranged a hospital bed on loan which makes getting in and out of bed and moving around in bed much easier. June says that both of these pieces of equipment have made a difference to her well-being.

June says that the psychological therapy has helped her to think differently about things and 'put to bed' some of the things that were affecting her health. June says that the care coordinator was good company and friendly. She appreciated her positive attitude which helped June to feel more positive. June says that she has grown in confidence and has started to think about her problems differently she attributes this to the help she has received and being inspired by her care coordinator's 'can do attitude'.

Leo: Dietition

Zara is a Dietition in a primary care network. She works with patients who are type l or type ll diabetic and those in a pre-diabetes stage. She also works with people who have diabetes with additional needs such as learning disabilities. Zara visits patients in their own homes and runs clinics in GP surgeries.

Leo is 28 years old. He has type II diabetes and asthma; he was referred by a practice nurse for dietary information, he describes himself as eating too many carbohydrates. His HbA1c (provides a measure of average blood sugar levels over a period of time) at diagnosis was 75 and one-year post-diagnosis was 73. He was taking 500mg of metformin twice a day.

Leo was working part-time as a cleaner in the evenings. He describes himself as eating a lot of carbohydrates. For breakfast, he would have 4 slices of toast with butter and squash with no added sugar, didn't eat during the day but drank 900ml of squash, and his evening meal consisted of pasta after work which could be as late as 10pm. He didn't eat any vegetables or salad and snacked on pot noodles with a couple of slices of bread or a cheese sandwich with four slices of bread.

Leo set some goals with Zara which included weight loss and aiming for diabetes remission. He explains that when he was diagnosed with diabetes, he immediately made some changes which included stopping fizzy drinks and reducing sweets such as eating a full bag of wine gums every night. He also reduced portion sizes and made a few small cutbacks but he was dismayed one year later not to have lost any weight and his HbA1c had only reduced by a couple of points. On his first appointment with Zara, he received some dietary education. Following this he decided to swap to whole grain and seeded bread and he looked at ways to reduce carbohydrate intake and add in more veg. Zara advised him to have a light lunch to even out his meals and try to incorporate 10-15 minutes of activity after eating to help with glycemic control and weight loss.

Leo and Zara discussed the NHS low-calorie dietary programme (path to remission), a full explanation of what they entailed and what commitment was needed for the 12-month programme was considered. Leo decided to enrol in the programme, and he gave consent for Zara to complete the application.

Zara was referred back to the GP for some medication changes as the programme required stopping the metformin medication to commence a low-calorie diet. Zara explains that now she is a non-medical prescriber this is something she can do without referring to the GP.

Leo reports that after one year on the programme, his HbA1c has reduced to 53, 9 months after starting the programme. He has also lost 10lbs and reduced his BMI making some positive lifestyle changes. He is pleased to be well on track for achieving his goals and this can be credited to the help and support of Zara.

Marie: Occupational Therapist

Marie was in her 70's. She had recently seen her GP who had suggested she see Sophie the Occupational Therapist because she was not going out any more. 'I've got osteoporosis and I had broken my pelvis. It was a horrible time. I'd not been out of hospital that long, a few weeks. I was feeling low'.

Marie explained 'Even on days I didn't want to go out I would remember what Sophie said we slowly moved forward, so I went out by myself and walked a bit further each time until I could get back to the local grocery shop'. Marie explained 'I thought, you can do it, I've got to push myself and not just sit in the chair all day'.

Marie looked forward to the Occupational Therapist's visit. 'We always had a nice little chat and we've covered all sorts of things. Sophie showed me how to get up out of my chair, stand up and wait a few minutes while I was feeling a bit dizzy. Sophie told my doctor about that. So I know how to get out of a chair and strengthen my muscles, be safer, and wait a few minutes. I do the same getting out of the car, she told me about that too'

Marie explained 'I wasn't eating much when I came out of hospital. I'd lost weight. Sophie sorted it so I got these drinks (pointing to Fortisip) to help build me up and we talked about what I wanted to eat; and how to eat more. I think too, there's this (Marie points to where she had a previous wrist fracture) which never healed properly. We've been over everything that it affects, and Sophie helped me with cutlery and ways to do things easier with getting dressed and things in the kitchen'.

Marie talked about how Sophie had given her confidence. 'When I'm sat here, Sophie says 'you are doing well'. We look at the positives. Sophie does tell the truth. She talks to me and doesn't talk down to me. It gives me a boost. I've got her number and if I need to see her, I can ring her rather than the doctor's. I know we've talked about groups, but they aren't my thing. I see people when I walk along the road and I'm out and about. I sound like an old woman! but we've also talked about how to cope with my back pain, that's helped too. But most of all, I have got my confidence back'. Marie concludes by saying 'Sophie helped me to get my confidence back'.

Melissa: Occupational Therapy

Melissa is a Care Home Manager. She shared her experiences of working with a primary care occupational therapist and a personalised care team. 'One of the major benefits is the care planning, the primary care staff will meet with family and care home staff. They gain in-depth information about our residents, they think about their outcomes and what things will improve their quality of life.'

'The Occupational Therapist reviews all resident's work with our care planner to find things that are of benefit to the residents. One chap was having a lot of falls and the OT suggested buying a helmet, it is not something we would have thought of.'

'One of the biggest impacts has been having the Occupational Therapy students. They do activities with residents. They developed activities which were sustainable after the students left. An example is the Tree of Life project. They used this bark wallpaper to develop a tree of life and we decorated it with all sorts of things. In the winter we made snowflakes. All the things that can be made and put on the tree to move around. It was great for the well-being of the residents. Before that, we had two other OT students who focused on music and movement. Residents were really engaged by it. We have an activities coordinator, who also gets involved with residents and she works with the students.'

'The care coordinators are another team that comes in and speaks to residents and their families. They provide a link to the GP. They have a preparation sheet thing to talk about individual residents and their needs. They pick up on things like eating and drinking, whether residents moving enough and do they need support with their behaviours.'

'One chap had a painful shoulder. The OT did an assessment and made a referral to physiotherapy. She suggested different ways to transfer to the resident, so he was not in pain, and this reduced some agitated behaviour. Another good thing about having the Primary Care team is the mobile book library. They have arranged for a library to come with actual books big print or audio for those that can't read. The library is an activity, that everyone can get involved with. Residents can choose a book and it gets everyone talking. One of the positives of working with the OT and her team is that we can bounce ideas and concerns together. They get to know the residents in a more intimate way, and this makes it easier for the GPs when they come.'

Nazim: Care Cordinator

Nazim is 53 years old. He came to the UK in the 1980s following a military career in Pakistan and he had several jobs but his last employment was working as a taxi driver for special needs children. Two years ago Nazim was diagnosed with head and neck cancer. He had major life-changing surgery on his face and jaw and is currently in remission from the cancer. While Nazim was in hospital recovering from surgery he became homeless.

On leaving the hospital he was lodging in a shared house with other single gentlemen and he was rapidly losing weight due to difficulties with eating and drinking. The accommodation had kitchen facilities but the hygiene standards were low and Nazim did not have the will or energy to cook food for himself. His friends were bringing him food but this wasn't enough. The shared house had issues with antisocial behaviour, people shouting and playing music loudly and banging on Nazim's door at all hours of the day. He was struggling to cope with his life and adapt to the consequences of the cancer surgery. Nazim was also missing hospital and GP appointments.

Nazim visited his GP and it was suggested he meet with a care coordinator to see what help was available. He met with Ruby and explained that his living conditions were impacting his health. Ruby reported the antisocial behaviour to the council and spoke to him regularly to ensure he was eating enough. Ruby helped Nazim get some advice from a Dietition who changed his medication and nutritional supplements. Ruby supported Nazim in getting rehoused and he moved to a rented property that had kitchen facilities where he could cook his own food.

The new property has very little in the way of furniture, furnishings and white goods, so Ruby is currently working with the council and local charities to get the house kitted out with everything he needs. As a result of getting this support, Nazim has started to put on weight. He no longer misses hospital or GP appointments. He has received some help with benefits to ensure that he can pay rent and buy food. Ruby is also helping to arrange some home adaptations and social care.
Nazim explains how much she appreciates the help he has received. He talks about 'feeling alive gain'. He goes to the care coordinator's weekly drop-in where he can socialise with other local residents. He says that everyone is very nice. He explains that he has a strong faith and when he prays he prays for the people that have provided him with the help that he needs especially Ruby.

Neil: Mental Health Community Connector / Social Prescriber

Neil is in his late 50's. He was referred to the Social Prescribing following an appointment with a Mental Health Practitioner. Neil had a history of alcohol and substance misuse but aspired to be alcohol-free. He had some physical health issues and wished to improve this as well as reduce social isolation. Neil had recently started to attend some groups at a local charity providing support for drug and alcohol recovery.

Neil spoke to Maya a Social Prescriber before meeting face to face. Neil and Maya realised that they shared a passion for music. They had a long discussion about the history of Sheffield bands and clubs. Although several options were explored, the one thing that Neil said he had always wanted to do was to learn to play drums, however, he didn't know where to start.

Maya told him about the Tuesday morning drumming classes at Sheffield Flourish, so they planned an initial taster session together. Neil thoroughly enjoyed the initial session, and they attended three further sessions together. Neil had connected well with the other musicians and started to look at Oasis gardening and other activities run by Flourish. Neil was getting ready to begin the phased withdrawal of Maya's help and support, so plans were put in place for him to begin attending with a greater degree of independence.

Maya explains 'A key part of each session was the prior meeting and walk to Flourish. Neil used this opportunity to discuss ongoing issues around his tenancy and although he understood the limits of my role, I was happy to signpost him to relevant supporting organisations and act as a sounding board for him to discuss and plan a strategy on how to approach his social landlord'. Additionally, these conversations helped to motivate Neil to talk about his substance misuse. He started to do self-guided research into the impacts of alcohol and social isolation on cognitive function in later life.

As a result of Neil's attendance at the groups, he was able to learn a new and complex musical skill. Neil says 'I have not used alcohol since late December. In addition, just before Christmas, I successfully applied for a voluntary position with the Salvation Army working in the shop and carrying deliveries twice a week'. Neil completed his first shift in the week in January and found it very rewarding. Maya says 'This is great news, and this success suggests there is a potential opportunity for a discussion and referral to Good Work before our work together finishes'.

Nina: Paramedic

Nina is in her 90's she came to the UK from Slovakia with her family. Robin a paramedic came to see Nina as she was unwell with a chest infection. He arranged for her to get a prescription for antibiotics and then he asked if she had thought about plans to support her at home. Nina's daughter Kira explained that this was when Robin introduced the idea of advanced care planning. He asked if Nina and her family would be interested in discussing this further. Robin came back to visit when Nina was feeling better. Kira says, 'he was such a lovely man I liked him, he was thoughtful, he took his time and he explained everything before we agreed to do anything.'

Kira explains that Mum has never wanted to talk about what would happen when she dies. 'My Dad was dying, and Mum didn't really want to talk about that, death just didn't exist. So we have never talked about anything much. Having Robin come to the house to talk about advanced care planning enabled Mum to talk about it. Robin introduced it thoughtfully; he asked the right questions.'

Kira went on 'Mum made all the decisions about where she wanted to be and how things would be at the end. As a catalyst from this, she then went on to do a will and we got in place a lasting power of attorney for health and finances and now we are all sorted. It opened the door to those conversations and since then she has told relatives about it and she talks about it more openly and now everybody knows where we are with things. When we go on holiday my children, and everyone know what Mum's wishes are- it is one of the best things that we could have done. Robin was so brilliant with her, she trusted him. After getting the will and power of attorney sorted, we updated the plan. Robin came to our house this week Mum was so pleased to see him even though she was ill with pneumonia. He makes a little joke and honestly, her face lights up.'

'Now we have a plan what will happen if Mum becomes unwell. We all talked about it as a family and everyone agreed that it was a good decision, she's recently had pneumonia. The GP did a home visit and he asked if Mum wanted to go into hospital. She was in the position to say 'no' she could do what we wanted to do, stay at home. The power of the document is that it's all written down. Unless she changes her mind. She was confident in saying 'a blank 'no' I don't want to go, there was no pressure to go as we had the plan.'

Steve: Paramedic

Tom is the main carer for his wife Shelia who has Parkinson's Disease. Shelia has carers four times a day. Tom also has complex health conditions. This story is told by Steve, Tom's son. Tom has problems with his heart, lungs, and kidneys. One night he started to become unwell. He called 111 and an emergency GP visited him at home. He was prescribed antibiotics for a urinary tract infection. After a week he didn't seem to be getting better they were getting worse. That evening Tom had a fall at home and cut open his arm. He takes blood thinners, so the wound bled quite a lot. He managed to bandage his arm and went to bed thinking he would feel better in the morning. The next morning he called Steve his son to tell him what had happened. Steve went over straight away and was shocked to see the wound. Tom was in bed pale and experiencing confusion and fatigue.

The GP was called, and they told Steve that Sean a Paramedic from the practice would do a home visit. Sean arrived soon after and gave Tom a comprehensive assessment. Sean said that the antibiotics for the urinary infection had not worked, and he needed to consult with the GP Pheobie about which medications would be suitable to treat the infection given that Tom had kidney failure. Sean and Pheobie had an extensive conversation to discuss a plan. The GP Pheobie suggested that there was only one type of treatment that might be suitable and if this didn't work Tom might have to be admitted to hospital due to the complexities of his kidney failure. Steve said ' without the GP and Paramedic working together in a joined-up way the outcomes could have been a lot worse. The GP was researching in the background what medications would work and Sean was assessing the situation with Dad and relaying this back. By working together they avoided Dad having a long wait for an ambulance and they prevented Dad from going to the hospital'.

Tom didn't want to go to hospital. He had been admitted to hospital previously for urinary infections and he preferred where possible to be treated at home. In hospital, he was worried about Shelia. Steve said 'as I see it the GP and Sean worked together in a joined-up way, Sean was a great chap, surely this is a good use of resources? He had the right skills and experience to assess the situation and the GP advised on the treatment, it was teamwork'. Steve explained that the cut on Tom's arm actually looked worse than it was and although it had bled a lot the urinary tract infection was the main priority. The medication was prescribed by the GP. Tom explained 'It was crystals in water, only one dose and I took them straight away'. Steve phoned his dad the next day and he was 'bright as a button' feeling much better.

Steve commended the GP and Paramedic for their professionalism, and teamwork he said, 'Without a doubt if Sean had not visited my dad he would have ended up in the hospital, they made the best decisions they could based on the facts, and they prevented hospital admission and saved an ambulance coming'. Tom was appreciative of being able to stay at home and Steve remarked 'We would be lost without this service'.

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