Ben Gilchrist, Deputy CEO, Action Together

I am going to be deliberately mischievous: I will make the argument that social prescribing is failing three key tests on: 1) being radical, 2) being equal partners and 3) values.

First, the radical test – social prescribing is fixated on the NHS, but the NHS is an obsolete hierarchical structure. Where are the solutions, it should be focused on the economy.

Second, the equal partners test – when you boil it down, when you get in the room with people from the public sector (and private), we [the VCSE sector] get treated poorly, we are not the equal partners we should be, especially in the context of the NHS Long Term plan. There is a lack of funding for the voluntary sector provision that is being subscribed to, so it risks destabilising the very sector it is relying on. And, let's not duplicate voluntary sector work already out there – if GPs say "yes, we'll let you employ them", the model is for us paying for the Link Workers and all their costs. If you went to your NHS provider and said "we can do it cheaper, can we use the surplus?" they will say no and want the extra money back.

Third, the values test – at least theoretically, the battle we have fought for decades that the person matters, the person-centred approach, that battle is won. But social prescribing fails that test because it is dependent on GP referral. So if the first port of call is GP, rather than the Link Worker, it fails because the person can't choose.

So social prescribing is failing on these three tests – my mischievous take on it!

Sophie Glinka

I have a slightly different take, thinking about roots, I'm a person within the community with a passion for where I live but have felt disconnected from it at different times of my life as a teenager for example, and as a mum. I've spent time working in the probation service, and for me the answer is people, and connections to people. So when the opportunity came up to work for a very small charity in my hometown, I jumped at it, I knew we could make a difference to the people who are most lonely, get them connected and then help them reach out to others too.

The charity has been doing social prescribing for 40 years, but only formally as social prescribing for the last 2½ years. Formalisation gives an opportunity for future change, and opportunities for the sector and ourselves to be seen as experts in our field. We are not going cap in hand, because they need us, we have the expertise as the VCSE sector that they don't have. The battle is not yet done on sharing the funding but it is a start. Social prescribing is a catalyst. Deciding which battles to fight is key, and I'm pleased social prescribing is happening at scale now across the UK. I wouldn't choose it this way but the battle is won, social prescribing is there in long term plans.

Michelle Howarth, University of Salford

I'm coming at this from a very different perspective, a nursing background in the NHS. There are 690,772 registered nurses, small percentage of whom are working in the community but few knows what it is about, and what social prescribing really is. When I started nursing I was taught a very impersonal system, patients were known by bed numbers, not their names – so I have a very personal view on why we change people into patients. I am an optimist. Social prescribing is built into a long term approach and there is a commitment to shifting our thinking, our paradigms, from a medical model into a personal approach. It's not "what is the matter with you", it's now "what matters to you". Changing mind-sets, thinking about a new whole system approach, social prescribing leads to this and it is fortunate that this is happening across Greater Manchester. Organisations I work with have used asset-based approaches for years and this needs to be recognised.

The other part of this is thinking that social prescribing is the system itself, and so doesn't describe what happens at the end, the ecosystem there and what happens. The optimist in me thinks there are services out that there we need to tap into and that collaborative work will bring about changes.

Reflection from participant

Whilst I largely agree with Ben, I think we have taken a different approach in Salford and we have been careful to put the extra funding in to support that. I know it's not perfect yet but with the infrastructure for each of the five neighbourhoods, I feel confident it will tie in. We tend to be ahead of the game in Salford we are doing it differently, there is a buzz. I'm not saying we've got it right but the CCG and VCSE sector are there working together.

Q & A Session

I'm here because I want a better understanding of how social prescribing works in practice. How does it work from GP?

Wendy replied, we were awarded transformational funding, and one part of project covers this, there are five anchor organisations in each neighbourhoods, linking into work that is already happening. Linking into GP practices, who are working very closely with the Community Connectors. Referrals are made from primary care to the Community Connector, and they then work closely with them to access provision in their local neighbourhood.

So if I know someone who needs support, who is very lonely, under the GP, and on medication. How would this work for them – what happens next? Do I refer them to the Community Connector?

Wendy replied, under this current model we are unable to take referrals from VCSE organisations as we can only accept referrals from pre-set referral channels. The current model for Salford has been developed to link in specifically with primary care.

The NHS Long Term plan which was released earlier this year states that social prescribing should be open to everyone and has benefits for everyone, regardless of where they are up to in terms of their health and wellbeing. But our resourcing means that any referrals need to be in line with what we need to evidence at the end of the programme, which includes evidencing a reduction in demand on primary care.

Sophie responded, The NHS Long Term plan is that it should be 1 Link Worker per 10,000 people, so it should improve but this is where we are now due to finite resource. At some point in the future, you should be able to self-refer; this is just where we are at the moment. We are all pushing for that, and we don't have to accept that this is enough. The NHS England plan is great and we are doing it already, but also the organisations doing it are under resourcing constraints.

Ben responded, these projects are a test of change, and we are all taking learning forward for future development.

In layman terms, can you explain how it works and the timeline?

Sophie responded, there are three steps [might be slightly different for Salford, as programmes run differently across the country]:

1) Referral. Where referral currently happens depends on location, in Glossop we take referrals from everywhere, we have funding for this; in Salford, referrals are made by GPs. It should be from all statutory services. How do we develop and grow this? Without this, it doesn't work.

2) Two: Link Workers: they are the bridge for this.

3) Community activity is the third step, the third step has the structure to help

Does there have to be special criteria for referral?

Wendy responded, each scheme will have its own; ours doesn't have a set criteria, it is more open – based on a conversation between the GP/health service and the patient. We are working with them to think differently about this and where they could refer. We are giving them feedback regularly on the work done and the impact on each individual referred.

Only one Link Worker in a borough of 30,000, so there must be some referral criteria? So how would someone make a decision to refer?

Wendy responded, It is linked very closely in Salford with primary care, so a GP will make a decision, e.g. if someone attends their GP with low mood. The finite resource is why social prescribing is only open to GPs for referral at the moment.

But there must be lots of people with low mood who could be referred by their GP?

Wendy responded, we're at a starting point with GPs, so it isn't the case that we have suddenly got inundated with referrals – this is a new scheme

Michelle responded, this is a leap of faith for GPs, who don't know about the brilliant work that has been going on. As the system grows and more people become alert to it, obviously there will be a pinch point.

So then it will be working at capacity and then you will be looking to recruit?

Wendy responded, once Primary Care Networks (PCN's) have been established and Link Worker locations set. But as far as the NHS England plan is concerned, it should be open to everyone. This is a challenge that has not yet been fully thought through, and NHS plan is clear on what funding will be allowed.

The NHS Long Term plan is one 1 link worker per 10,000?

Sophie responded, 250 referrals per year is the plan. It's not the link worker that does the work it's about how that person refers into the community. Some people will need more support when they are referred, some need less.

Is there an opportunity for someone like me who is not medically trained but can recognise where some people will benefit, can I contact GP to suggest, or ask them to go to GP and ask for SP?

Wendy responded, we don't want people to have unnecessary GP appointments. But GPs have care navigators, so someone can speak to them and they can make referral themselves.

GPs are very aware of local services, so is this something new?

Michelle responded, no, but the term "social prescribing" is new and is used to get people like GPs to buy into it. In nursing, we used to call it community referral. In a series of research and report documents, the term has grown and has been given leverage. 30% of people go to a GP for social reasons… it's not new. It's the NHS recognising that the medical model doesn't always work, that is the new thing.

Ben responded, the voluntary sector has led this work for decades and should be championed. The new badge is not just that we have a developing language but is also around the developing GP relationship. The system has disabled them from doing what they want and should be doing. It's doing what we should have been doing all along, especially in the GP interaction. We have drawn out some key messages and are championing holistic social prescribing, because I agree with Sophie and Michelle [about the value of social prescribing], and I agree that Salford is doing exactly the right things. I think there is something new, and that's the route in. It's very different in different places. The three steps are very helpful to describe what is diverse across Greater Manchester and across the UK.

I run a CIC for arts and crafts. How do these referrals come to me?

Wendy responded, Community Connectors are doing work to find out what is happening locally, so you will need to speak to Nicola Spiby about this.

Nic Spilby responded, Community Connectors will link people with you, and they can also attend with individuals and can ensure that they have a friendly face there for the first session. One GP said that they could refer but individuals wouldn't know how to get there, how to dress etc, so a Community Connector takes them through all that. They tease out what activities they like and would like to try. The Link Worker then has the conversation with the GP.

That practical support is really good to hear about. Knowing people who can't even get to their GP to pick prescription up, that level of support is what is needed?

Nic responded, we still have work to do with primary care but we are not duplicating work if we know they have a Social Worker etc.

How successful are you with getting GPs on board?

Doing quite well in Salford, high proportion of practices are set up to refer. A GP doesn't always know the area, or live there, so don't know what community assets are available. We can be that expertise.

John Phillips, We are one of the anchor organisations. We worried initially that we were not getting referrals at all, but we are now getting referred people with complex needs. Need to talk with GPs about this.

Sophie responded, the power of social prescribing is how do we map this and say "look this many people are falling through the gaps, so something needs to be done for them", and tracking it to feed it back. We know it will be tricky but, in the long term, it should be a powerful tool in filling these gaps.

Participant -Fundamental challenge, how do we make this as easy as possible for GPs? We bombard them with new initiatives, constantly pushing them, as we try to create more community-based models. We need to find how to support them.

Threshold: we deliver early intervention services, but not early really, complex needs. Good to hear that there is money being put into organisations but there are gaps to plug and social prescribing threshold could be used to mask this. Needs to ensure the level of intervention is where the need needs to be met. A research base needs to be established. People being referred to something that is not appropriate is not helpful.

Empower the community to know about social prescribing and to understand what is available to them.

Wendy responded, some work is being done about this, for example to get posters into GP surgeries, but on a small scale so far, so that people become more aware and can ask to be prescribed in. But at the moment we aren't able to accept self-referrals and we don't want to create additional GP appointments. This is a pilot, so

the evaluation will capture this and we will reflect on what that model will look like. Self-referral and education of the public is further along that continuum. System change, GPs having different conversations, people expecting different things we can't realistically achieve it now but it is for the future.

Mike responded, we are supporting with our evaluation. It's the "you need us line" the commissioners need to know why they need us. Sophie, your Glossop model is more open and a more interesting model, is there any evaluation? And is a membership model better than bottlenecking through GPs?

Sophie responded, no single evaluation covering the whole programme it is expensive and boils down to small pieces of work being evaluated due to small pots of funding. The wider academic evaluation doesn't feel within reach. After transformational funding, I'm not sure who else will fund it.

Ben responded, I am very adamant that we shouldn't be apologetic around the evaluation base, because there is lots of evidence that our work works. Where is the evidence base for the current dysfunctional system working? Do we feel it? And we've got that evidence, we should push it.

Michelle responded, GPs want to know about the evidence base, we need to confidence that you have the support to provide. We don't know what doesn't work because we haven't evaluated it. Maybe funding individual organisations to evaluate their work could help.