Phil - We’ve got someone who has spent five or six years with us on the project but who is now migrating over to the health side of things so a really fascinating overlap that will inform our thinking even more.

Cormac, Yes, well, as Phil says I have been working here at Radio Regen for five and a half years but for the last four months, I have been working in the university of Salford as well, so splitting my time between the two organisations on a piece of work specifically around social prescribing and what I have done, is set up the Social Prescribing hub and we are looking at social prescribing and how to make it better, basically. It is a research project, I am exclusively working on that, I am not teaching at the university, I do have an academic background, not in this world (laughter)...I should say, I am also working in the Directory of Occupational Therapy, so it’s very interesting to have an occupational therapist in the room...but my background is not in occupational therapy whatsoever, so it’s interesting that I am learning the language of two disciplines, I am learning the language of social prescribing, because I don’t have a massive background in social prescribing and also don’t have any background in occupational therapy and so I’m learning two disciplines at the same time, I don’t have a background in social prescribing but the reason that I got the job was partly because of the work we are doing in Radio Regen in terms of on the heath, but also because I am on the board of another organisation in east Manchester that does horticultural gardening and learning, working with people low self-esteem, social isolation, poor mental health - called Debdale Eco Centre, so we are working on a social isolation on a project funded by Macc - so my route into this has been through the voluntary sector really and also shaped by my work here in Radio Regen and it’s with that sensitivity that I do my work, so hoping to share some insights from that work and hoping to have that conversation now but also in the afternoon as we said, we are going to have some workshops to possibly nail this down in some more detail.

So, Claire has done a better job than I could’ve at painting the national picture but I am still going to put some of that in front of you again. What we are talking about is that perhaps only 10% and that number does change, but 10%-10% of our health is medical and the rest is non-medical, so what we are talking about is this key phrase - and Claire used this - “the social determinants of health” it’s a really key phrase and so learning this language, being able to speak to commissioners, to funders, to partners, is a key driver to be able to deliver this work, being seen as a legitimate partner, being someone they would want to fund, they would want to support and again, it’s thinking about placing ourselves in that world; how can we have those conversations with funders - it’s talking the language, so that is one of the key phrases. And the other is personalisation, you know, personalised healthcare - as Claire said, she painted the whole picture. So the Marmot review there of health inequalities - that many communities are ridden with as we know, many marginalised groups and it’s often those people who are most isolated, most disenfranchised, this review put that problem centre of stage and said this is what we need to need to be addressing as the national picture, but also the drain on the NHS is such that it’s been decided - the NHS has clearly seen that they need to do things differently and some of it has come from a financial incentive so that there is a big drain on the system - maybe I don’t really like that language so much - but it is the acknowledgement that a lot of people go to the GP without a health condition whatsoever. Sometimes people go to the GP because they are feeling a bit lonely or they need some advice and this report said that 15% of GP visits are for social welfare advice.

Claire - does anyone know what that is in Manchester? Guess the percentage of GP appointments that are for non-medical and clinical issues? 40! Almost have say it’s nothing that a GP can help with.

Cormac - and so this is part of a driver of this thing that I want to get into today which is to talk about social prescribing which has become a very popular phrase and it’s also a key element of the picture of personalisation and making healthcare more effective. Cost effective but effective at helping the person. There are various definitions of social prescribing - not one that I find particularly useful but one that has come from - this report is very good but I still feel this definition is a bit clunky but they have defined it as “enabling healthcare professionals to refer patients to a link worker to co-design a non-clinical social prescription to improve their health and wellbeing.” So that was a focus group that came together to say what is social prescribing and that is what they came up with.

Cormac - exactly, you’ve got it in a nutshell - it’s basically health professionals referring people to a community based solution rather than prescribing a medical solution - it’s about community activities, rather than medications.

Q - some of those surely should come through the community - the person on the road that knows everything - who has the t-shirt - we have been members of support groups where they were facing a difficult time but someone in the group had already been there a year before and whatever….

Cormac - there is an element of resistance in the voluntary sector - for good reason - of this word/term and this agenda because a lot of people say this “ this is what we’ve always been doing or why is there a need for this to be done?” and I want to get into that maybe by showing how some people might be resistant to some things and how some processes might be put in place.

* Or cynical like me!
* I don’t think it’s cynical by the way

But actually one of my colleagues in the world in Tameside - part of the community of practice, he says that what it is it’s a bridge between the voluntary sector and - community connection and taking the clinicalised approach away from it.

Maybe I’ll show that video but I think it might be better to get through a few key points and then we’ll maybe come back to some points. So, as I said, it is flavour of the month; everyone is talking about social prescribing, and in a way that’s an opportunity and in a way that’s a bit of a challenge because you’ve got a lot of people muscling into this world. Some people know more of what they’re talking about than others. But it’s to say that there is a real appetite out there for this work and that there is a real desire to do thing differently genuinely, it’s not just about saving money, although, if it does that then that’s probably a good thing from the NHS’s and the funders’ point of view. The other thing to say is that it looks different in different parts of the country. I’ll give you a few models today, though there isn’t sort of one way to do social prescribing or one way that it looks, it looks different according to who’s funding it and who’s delivering it and you know, where it is and that is partly do with the devolved landscape in some senses and partly do with every region having their own policies and their own strategic organisations. And some structures just don’t exist, there aren’t CBSs everywhere in the country and those kinds of things. So those are things to bear in mind, but maybe two very different models of how it works, and I will get into this in more detail, sometimes it’s as kind of lightweight if you like, as a GP receptionist signposting a person to a community activity, so it could be literally that you walk into a GP practice (chats with audience)...I think there is an awful lot of problems for someone to say what’s wrong with them in an open forum to a receptionist, to even reveal that level of detail of what’s going on for you and then the receptionist is meant to signpost you to community activities, directed through a database, generally they will have a database of activities out there but there is all sorts of problems with that. Probably a better model in my view and actually really shared more broadly, is that it’s based around relationships with a link worker - but basically the issue here is that a GP, as we probably know, has ten minutes with you, in fact probably less, probably more like seven and for them to be able to get to know you and to get to know you and to get to know everything that’s going on with you, and to be able to say you know, what might be beneficial to you, is going to be very difficult, so what the link worker, the role they play is to provide that listening ear - often they’ll spend more like an hour in the first instance and more like several hours over the course of a period, again that changes according to who’s funding it and all of that - but the link worker is a key role her and I’ll get into that in a bit more detail.

To continue with the overview, yes, there is an increasing evidence base - you’re asking about things that we can give you to say ‘does this work?’ yes it does! Depending on what level of evidence you want, do we want randomised control trials and all this kind of stuff and some people speak that language more people are becoming sensitised to a different kind of language and I will show you some of the different models and frameworks that are being used - the evaluation frameworks - and the tools that people are using and actually some of them are very accessible - so there is an increasing evidence base for this working and yes, as Claire said, - the background here is this person-centred personalised model for healthcare. This is a bit of an intimidating pyramid that no-one can really read but it’s just to say that this is an NHS view of personalisation but I find this useful to show that it’s basically in terms of complexity of needs, so recognising that we have a whole population of people with different levels of complexity of needs and this end of the pyramid is the whole population - in a 100% of people with long-term physical and mental health conditions, 30% of people of the population with complex needs, 5% - OK we can play around with those definitions and those numbers, but the basic point is that there is a model that incorporates the universal side of healthcare which includes things like social prescribing which is directed towards wellness - staying well and community resilience.

* Phil - It’s actually worth reading that supporting people to stay well and building community resilience - enabling people to make informed decisions and choices when their health changes - if that doesn’t speak to us, I don’t know what does.

Cormac - When I share the slides with you, you’ll be able to read this in more detail. This comes from a presentation from James Anderson who is the head of personalised care in NHS England….the other thing to say is that social prescribing is in the landscape of medical care - there is obviously the need for more specialist care and I think - and part of what I do actually in Salford is try to say ‘well social prescribing actually isn’t the answer to everything, it’s clearly not - there is a lot of people in this world who is actually like a dog and bone kind of thing, it’s like social prescribing is the thing we need to do; everyone needs to be doing social prescribing…’ but that potentially risks taking the focus away from the person, what is it that the actual person needs? You know, we can’t treat or pose a solution without knowing what is going on for them, what they want you know. And to just wrap up this intro, in terms of the language (to Claire - you’ve set it up already) “Asset-based approach” - thinking about people and their assets rather than their problems, focus on wellness, not illness, and the importance of personal choice and control in achieving and maintaining wellbeing - that’s social prescribing in a glance and again, I can share a load of references on these slides as well….

But I just wanted to break off from my presentation to basically rip off in entirety, a section from a presentation done by William Bird, who’s a doctor who gave the keynote at the first international social prescribing conference that was held in the University of Salford earlier this year. So these slides are directly taken from him but he has given us the authority, the OK to do so, it’s on that idea of personal choice and the doctor’s and the patient’s choice, so, meet Bob, in Liverpool. The doctor’s brief is ‘let’s get Bob active’ so as you said, they’re thinking about exercise, what is it that we actually need to do - what’s the end goal, so you know, we can give him an NHS treatment. Bob - why don’t you get off the bus and walk a bit more...Bob you really should take the stairs and lift, come on Bob. Bob, why don’t you go try a keep fit class on Tuesday? Have you tried cycling to the shops? But the thing that actually got Bob moving was linking him in with the group of supporters who walked two miles to Anfield every week so, this was the key to getting Bob actually walking was connecting him up to this group of people who connect him the thing that he actually loves which is football. As William Bird says, to Bob - that is not exercise or health - physical activity is now hidden behind a much greater experience for Bob, it’s invisible to him, it’s a means to an end, not the end in itself, the end is now getting to Anfield and finding this greater value for each person. But the point he is making is that we are connecting and tapping into what is meaningful for the person and that is connecting up with what I am doing in Salford which is applying occupational therapy to this world - looking at meaningful activity. In a way, it’s worth reflecting on this because the doctor said - here is something we think that will be good for Bob - exercise - he has prescribed an activity by stealth - he has embedded this prescription in this activity quite adeptly so we can maybe challenge it in the sense by saying - was this Bob’s choice? Maybe it wasn’t entirely. But Bob, actually probably is going to take up this activity on a more regular basis - it’s embedded into his life, it’s invisible to him, it’s not seen as a chore - actually seen as something that he loves, and it’s connecting into that thing of connecting with what people love doing. What people like doing - that’s the key….

Phil - Affinity groups overlaps with that as well - then there is an existing affinity.

Dave - then there is a the fact that you’re walking to the match with a load of pals, and possibly walking back there is also that social connection where it might be better walking but suddenly he’s got something to talk about where he is sharing how he feels…

I think it’s about finding that meaningful activity for the person - it’s always about understanding what is actually meaningful for them. And that can be a range of different things so social prescribing - getting to the nub of it - is referring people to community based activities - those activities could be any number of things. I’ve just selected four here you know, going to a fitness group which may or may not work for some people, it may be that it’s more of an embedded activity - you can get exercise by gardening but could also do many things - it can connect you with other people - it can also connect you with nature, there’s all sorts of evidence about all these different things. Don’t know how many of you are familiar with those activities, but they’re big and really popular and really seen to be worthwhile, beneficial and there’s this thing called community radio which, I don’t know, maybe some people have heard of and everyone’s happy in community radio, right!? But putting community radio in that landscape of activities...so basically, social prescription is activities on prescription. That’s what we’re talking about and all of the words that have on the left are used in a phrase that you can Google - like ‘art on prescription’, ‘books on prescription’, ‘exercise on prescription’, ‘learning on prescription’, ‘gardening on prescription’ there is whole load of different phrases that are recognised by healthcare people as good things - the arts on prescription is maybe the thing that dovetails most closely with community radio; community radio stations often explicitly say that we are an arts-based organisation, not all of us actually label ourselves like that but it certainly dovetails nicely but in practice, arts on prescription activities tend to be delivered by museums, they tend to be workshops that the museums run and you come in and you learn about painting or whatever, you do something that’s around the culture or the ethos of the museum, so to my knowledge, I don’t know of any community radio stations that are actually doing arts on prescription but I think it’s one of the phrases...I guess, implicitly here I am creating the gap - where is radio on prescription? We could actually add that to the list and put that on the phrase chart.

Phil - another thing to think about is where you have a sector or organisation that is already well versed in this and have those connections, maybe a way to try your involvement with it you could go down the road to a museum that’s already doing it and say ‘ok you’re doing the craft or whatever day - what about a little bit of blending some community radio into that will take a group of those participants through a process to make a report, a community radio programme about what’s been going on. So, in some cases, you can actually boost your capacity by partnering up with an organisation to do that sort of thing. They’ll recognise the extra oomph/benefit they’ll get from that and who knows what comes down from that?

Dom - Creativity Works which are an arts-based charity that very much works with people with postnatal depression and all sort of things

Cormac - we can make some more of those practical links and agendas in our local areas when we get into the workshops.

\*\*\*

I wanted to give you a quick overview of social prescribing - how it works. This is one model really but it’s just a visual model for a pathway so it’s basically the person - it doesn’t always have to be a visit to a GP - that’s not the only way that social prescribing is initiated - I’ll come back to that point but in this model, let’s keep it simple, it’s about a person visiting their doctor, the doctor recognises that “I don’t have enough time in this seven minute engagement to understand what all the things going on are or what all of the benefits that may be out there are, so I’m going to refer you to a social prescribing service that exists. So the social prescribing service will look differently according to the different place that it’s in - sometimes it will be located in a GP practice, sometimes the actually link worker will actually be located in the GP surgery/practice, sometime they will be funded by another organisation like a CBS or a CCG and they will exist in their separate organisation but the point is the GP makes a referral to those people, the social prescriber person and the person assesses the needs and then in that one hour conversation and then refers to a range of community services, so that’s where we come in in the voluntary sector - so we are over here in the learning and skills - this pathway was created by the Work Foundation, so this particular model of social prescribing is very much about work. So it’s about social prescribing as a means to getting people more employable...and maybe part of the larger conversation or ideas that we can bounce around are about the overlaps between health and employability.

Basically, it’s about referral to a range of different organisations - I’ve just been giving you a small picture of those - literally they could be anything - I have heard of people being prescribed petting horses, or some really bizarre dance routines, actually I think pole-dancing was on one person’s social prescribing routines. So you know, it really can be any number of activities, it’s all about what the person actually wants to do - what’s gonna be meaningful to them, what’s gonna be actually motivate them to make them get out of the house for the first time and make those connections. And the outcome is improved health and wellbeing and perhaps work-opportunities.

* Dave - can I ask where the money runs out - because the GP gets paid, the link worker gets paid, but then…North Manchester and Oldham, we could set up a radio on prescription project and if we got ten people coming along, we could get some money but where do we then get that money?

Cormac - it’s a big problem - it’s a big question and to be honest to answer the question, there is no easy answer and the money that’s being saved by the NHS isn’t necessarily being translated into more funding for the voluntary sector but it should be and that’s one of the things that within this world/sector, we need to put those messages back and they have been pushed back quite forcefully to say ‘if you are asking us to take on people with complex needs and to manage someone’s health in a way that we haven’t necessarily been trained to do - where is the support for us?’

Phil - bottom line, it aint gonna happen without money.

Helen - well this was my question - what happens when we can’t actually support the person?

Dom - it seems to me is that what is actually happening here today so we are being given the tools to demonstrate the needs and this end bit, the community groups - that’s what we are - we’re here to help but you’re giving us the tools to make applications to enabling charities who will enable us to do the doing. And that’s what we are doing here, isn’t it?

We’re not gonna get state-funding for this but we are gonna get third sector funding if we go about it in the right way.

Cormac. I’ll talk about funding in a bit but it hasn’t been cracked yet but we are being seen - the voluntary sector is being seen more and it’s not just about a language shift, there’s a whole culture shift about partnership working and the voluntary sector is seen as a legitimate partner in the world of healthcare so I think that is the leader to funding although has it happened yet - I’ll give you one example we still have a way to go until the voluntary sector is properly put into the picture here and properly resourced to do all of the things that are actually being put on the agenda by the funders and the commissioners…

Phil - but Helen’s point is spot on - you must never be in a position to offer a service you can’t provide, across the board - safeguarding etc etc - all has to be in situ and so we have to be clear about what we are offering and so it might just be the chance to have your thing broadcast and then it’s all done at a more specialist organisation that can offer that support….or it can be the whole package - it will depend on our capacity to do that.

Dave - sometimes where the radio station is promoting another organisation, they’re the ones that are going to do the work and this radio station would not want to be taking that on - specialist knowledge etc in that area and that, I think maybe at time causes a bit of confusion from elsewhere because there are some things we can do for nothing...and that we do that and I think we passionately do want to do that but you’re not doing it just for the money but you’re doing it because the end product helps people and unfortunately those people pushing people into the queue to start this process confuse the fact that your volunteers for radio aren’t the volunteers for the walking group.

Cormac - exactly, so it’s thinking about the implications of your organisation taking on different referrals, if you want to enter into this world then it will have implications for the way you work, the way you train your volunteers, the way you set up your policies as an organisation…

Dave- the people instigating it in different areas, there are different amount of expertise, one community radio station may well be able to do something with blind people etc and another one may say we can’t do that.

Phil - it’s horses for courses but it’s all valuable.

\*\*\*

The link worker is a really key role and I think in some cases it’s knowing the organisations that do social prescribing and knowing the link worker will sometimes be the key driver in terms of you being able to be on the radar of social prescribing. The link worker does play this key role as the person who listens to the person, who’s their champion, who is keeping them going, to be on their side when often no one else is, these are quotes that I have taken from the many link workers over the course of the project I have been working on and they are great, really fantastic people but they also play a key role not just in understanding the person but also in referring out there and sometimes they play that pivotal role and if they don’t know that you exist then they’re never going to refer out to you in the first place so sometimes it’s about being on their radar as much as on the funder’s radar so they are a key role for us too.

Dave - Is there a lot of occupational therapy in there?

Cormac - yes!...

But yes, they do play this key role but they are more of a nurturing role and this quote here is lovely from service users:

“She has got the ability to make me feel really special, before she came, I was like a car with a flat tyre; I was getting nowhere fast”

...and also:

“ I just expected her to introduce me to the gym and that would have been it and if it had just have been that I would have turned around and gone in the opposite direction but because of the way I was gradually, really professionally linked into different things, I felt I’d floated into it rather than being shoved from behind”

... it’s that idea of them just nurturing you along and going on a journey with you - they are great people.

Looking at the whole structure of social prescribing, how it works, how it’s funded, who does what, the CCGs are the key players, generally - it does vary but they will be the body that holds the funds and they will direct a social prescribing project or initiative. Sometimes that’s in partnership with the local authority or CVS - Council for Voluntary Services...like MACC and all the key umbrella organisations in directing or being partners in actually funding the work but sometimes being people who engage/liaise with these kinds of structures and being very useful bodies for you to keep in touch with. But sometimes housing associations play a role here in this landscape of funding and then a whole myriad of grants and so on to enter the funding picture. I did mention that it’s not just GPs who initiate social prescribing, sometimes it’s another health professional....sometimes it can be very different people - it can be the ambulance or the fire service because they are the people that enter into people’s homes and recognise that there is whole load of different issues going on here and ‘I can’t deal with them where I am now’. In fact, my colleague who is an an occupational therapist spent a day with the ambulance service and at no point did they actually treat anybody medically, they fixed somebody’s radiator and cleaned up their house...that person needs something, somebody else. Social workers are key areas for referring you into the system but everyone gets funnelled into this system which is a social prescribing service. They are called different things in different areas, Community Navigators, Wellbeing Coordinators...and more. But sometimes it’s about advice, about how to manage debts or housing situations because they are the things that will determine wellbeing. ‘I’m so depressed or so anxious because I can’t pay the rent.’ It’s often about accessing other kinds of services and also all of those areas are on prescription. Or it can be referring back to a health professional - that’s the interesting part of the picture, there is actually a need for an occupational therapist or a physiotherapist or somebody - a mental health professional - who actually does need to take this person on and so that’s the other thing that we shouldn’t lose sight of.

The work I am doing in Salford is about being person-centred - that we recognise the person’s needs and what is meaningful to them which is where occupational therapy comes in…

Dom- The social prescribing issues could actually formulate a part of how our planning develops; there is an issue there that we might be a part of the solution of.

Cormac - That’s a really good point - thank you - we are a part of the solution here - the problem is that sometimes people are lacking in motivation; they don’t have something to engage them. A lot of social prescribing services for whatever reason in their communities there just aren’t the opportunities for engaging activities to refer out to, so again, the landscape, the social fabric of each community is different - the variety of activities that someone can prescribe to can vary from place to place. But we as community radio people know that we have something of real value, of real meaning and it’s about putting that in the head of the person who is activating this.

Faheem - Community radio could be the place that signposts people to other places.

Phil - and it goes back to the notion of the community radio station as a community centre. And different stations have different relationships ongoing with participants but many stations have relationships with their volunteers that go beyond the programme and there is a unique ability to connect there.

Cormac - so just to touch a bit on the voluntary sector - GPs might see this a way to get a load of free stuff, and if that’s what we are being seen as then we are devalualing ourselves; we need to recognise that we do have value and don’t let ourselves get bunched in with that picture of just something people can get for free; it’s more about valuing our service. The other point made by Janet Wheatley who heads up a very interesting social prescribing model in Rotherham - I think it’s a beacon for the voluntary sector - she says the last thing you want to do is to send the sector loads of extra referrals when you just don’t have the resources to cover it. Just to pick up on Rotherham as a model - Janet Wheatley is their chief exec - so they deliver two social prescribing programmes on behalf of the CCG and then what they do is micro-commission activities so they pay the voluntary sector organisations to deliver whatever programme of healthcare that is determined as appropriate by the link worker - so what that does is then provides funding for frontline voluntary community organisations. She says it’s a resource intervention rather than just signposted already overstretched VCS services. THat’s a nice little model that hasn’t been replicated everywhere but it is being seen as a very successful programme and so it’s the kind of model people are seeing as successful and because the voluntary sector have already got that message out - though we need to get it out even more - we can’t be free partners in this whole world - we need to be valued and recognised then the Rotherham model is a good one to point people to.

...Just to say also that ‘social prescribing’ isn’t a phrase everybody’s happy with - it rubs some people up the wrong way….’don’t call it social prescribing’, call it ‘community building’ and don’t situate it in the doctor’s surgery, make that one of many points of entry - the neighbourhood is the unit of change, place-based stuff, not the waiting room. I think the indtering thing here is that we are starting to see a shift in not just seeing the person as the problem - the individual’s health - and actually talking about the community’s health and if funders start seeing that shift and funding that idea then we as voluntary sector organisations as

have the potential to play a key role in being partners of maintaining community wellbeing so again, learning the language, I think those are the kinds of messages I think we should, as a collective sector, be shouting about to the funders. The message is getting out there but it needs to be made more forcefully.

...

But really just the final point to make is that I think we should get on the radar of funders and that is about learning the language and speaking the language by running a pilot and evidencing outcomes - something we could potentially start today, actually developing something that shows the benefits of community radio for health outcomes and then proves to other people that your organisation can deliver health outcomes so that's a a key driver is that you then have the evidence to deliver that kind of work. Social media, sometimes with community radio, we don't often celebrate the work we do and make it visible and it's key to make our organisations look like legitimate partners to the people who want to fund outcomes. It is a particular landscape in Greater Manchester and there are particular opportunities - accessing the GMHSC - as a collective we should be getting on the radar of the community of practice and be involved in that conversation. I know Claire said not to speak to the local GP but I think it wouldn't do any harm at least to have a conversation with the GP to figure out what they're doing and figure out what you could do as a point of referral from them because some GPs get it and some don't, some are resistant and some are massively passionate - do test it - it's worth having the conversation.

END