

The Hub



SOCIAL PRESCRIBER SPOTLIGHT

Supporting our General Practice family
on their Primary Care journey



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Introduction

Social Prescribing work often goes under the radar, not recognised or highlighted, we want to change that narrative by:

1. Giving them the opportunity to showcase their work
2. Demonstrate with real examples and case studies, how SPs reduce pressure on clinical staff
3. Opportunity to make contributions really visible across Derbyshire
4. Be recognised as integral members of the multidisciplinary team

That is why a part of our Social Prescriber Programme we are publishing 4 spotlights, once a quarter, that have been written by the Derbyshire Social Prescribers to share experience.



Around 1 in 5 medical appointments are used for non-medical issues that the clinicians are not aware on how to best support. These can include loneliness, debt, benefits, housing and more. A patient of mine was referred for low mood and struggling with their chronic pain. Whilst working with them, I connected them with the Pain Support Group and a Fitness Programme. This has resulted in him managing his long-term conditions better, attending the GP less and significantly improved his mental wellbeing.

Social prescribers can improve patient outcomes by adding value to the work of their other colleagues. They can visit people in their own home, where they can assess things such as compliance with medication, issues around housing, how well people are living or if they have other needs which are not being met. I visited a person at home who was experiencing very low mood, the home visit showed that they were not taking medication as prescribed (stored in a bag tucked away) and had housing problems including extreme damp which exacerbated existing physical conditions.

Demonstrate the value of Social Prescribing to primary care colleagues

Sometimes, simply having a friendly chat and being truly listened to can greatly ease someone's burden. This approach not only improves wellbeing but also reducing pressure on appointments, letting clinicians focus on medical care. I recently supported an elderly patient with a learning disability enrol on a local reading and writing course, who before was sat at home reading children's books to learn and barely left the house due to limited mobility. I also secured him a transport grant to allow him to easily access the group.

Social Prescribing has so many benefits for clients accessing the service. It reduces isolation, supports community engagement, eases financial pressures and supports overall positive mental health. For primary care colleagues, it reduces GP appointments and colleagues feel comfort that patients are being supported. For one young person, with ASD, selective mutism and acute anxiety, who was unable to leave the house, social prescribing gave them time to build a trusting relationship. The young person now attends a conservation group and is volunteering at their local foodbank.

Normalising Challenge and Complexity in Social Prescribing

In primary care, Social Prescribers increasingly support patients whose needs are shaped by complex social determinants of health. For many, this complexity is not the exception but the daily reality of the role.

Normalising this landscape and acknowledging the pressures it creates is essential for sustainable practice and effective multidisciplinary working.

Complex cases require Social Prescribers to balance competing priorities, manage risk and respond to emotional intensity while maintaining person-centred care. These demands can feel heightened when caseloads are high.

Recognising that complexity is inherent to the role rather than a sign of failure, helps build resilience and fosters realistic expectations across teams.

A clearer understanding of the social prescribing model can also improve referral quality and shared care planning.

By openly recognising the demands of the role multidisciplinary teams can foster shared responsibility, mutual respect and ultimately better outcomes for the patients who need us most.

While a GP may focus on clinical urgency, a Social Prescriber often works through a relationship-based approach, taking time to explore root causes, empower patients and connect them with community support that complements clinical care.

Social Prescribers regularly work with individuals experiencing financial hardship, insecure housing, caring responsibilities, trauma, mental health challenges, substance misuse and social isolation. Alongside this they navigate system-wide pressures: overstretched services, long waiting lists, referrals that are not picked up and patients who may not respond due to chaotic life circumstances or digital exclusion.

Despite these barriers, Social Prescribers continue to work with professionalism, adaptability and a strong commitment to person-centred care.

Normalising these challenges does not mean accepting flawed systems. It means acknowledging the realities of holistic work and strengthening communication, improving referral processes and protecting time for supervision.

What a good referral looks like

- Clearly explains why the client needs Social Prescribing
- Shows the referrer understands what our service does
- Includes the client's current situation and what support has already been tried
- Explains why the referral is being made now
- Manages expectations about what Social Prescribing can and cannot offer
- Benefits from strong relationships with partner organisation
- Good contact details

Why collaboration makes my role easier

- Reduces workload and brings in different expertise
- Leads to better outcomes when needs fall outside our remit
- Involves working with healthcare teams, social care, Job Centres, schools, and more
- Helps build a fuller picture of the client's situation
- Reduces the need for clients to repeat their story
- Increases the offer and intake of referrals
- Good communications with surgeries and staff
- Be part of the induction process
- We can have an input in the local area through locality work

What helps us do our best work

- Transparency between client, referrer, and Social Prescriber
- A shared understanding of what the service can offer
- Clear information about the client's needs and circumstances
- Clients who are motivated and ready to take steps forward
- Strong knowledge of local services and community groups
- Clients who are willing to engage, especially when needs are complex
- Trusting relationships / building rapport
- Time to talk and understand allow patients space to talk as they need
- Having the flexibility to meet people where they feel more comfortable (green spaces and community settings)

What I want other Social Prescribers to know or try

- Be confident setting boundaries and saying no when something is outside our remit
- Direct clients to the most appropriate service to protect wellbeing and effectiveness
- Encourage clients to build independence and confidence
- Consider giving team members specific areas of expertise
- Allocate referrals based on those strengths when appropriate
- Recognise gaps in services and help fill them.

Boundaries I have learned to hold

Reply 1: I have developed my skills and knowledge through life experiences and training that have allowed me to physically manage myself in relation to my workload by setting boundaries particularly around time management. I make plans that include setting work related tasks that are time limited, that avoid working over at the end of the day and during my lunch break, alongside identifying and not taking on tasks that are beyond my capabilities to prevent feeling overwhelmed resulting in burn out. I have struggled to recognise on occasions, that I need to remember I can't `fix` the problems people have, but support and contribute to assisting people to identify and wherever possible their own solutions.

Reply 2: Recognising that the people we work with do have some levels of resilience and responsibility. Remembering the client has managed up until the point they are engaging with the Social Prescribing service and understanding that we may not be able to fix a client's situation. Recognising the strengths that the client has to be able to support themselves.

Knowing when to let go of a client and understanding when someone's situation is beyond our remit and being honest about this.

Ensuring that we finish work at the end of the day, and not (when possible) continuing to work well beyond our working hours and making sure to have a break and take time out. (if this is a quick walk over lunch, just stopping to have lunch etc)

How I look after myself in this role

Reply 1: I work compressed hours that enables me to only work 4 x days a week which has been good Although it can be challenging, I prioritise my self-care retaining my own emotional energy that is needed to engage with people. I worked later hours plus travel resulted in having no time for any self-care. I recently requested and was granted flexible working hours reducing my day by 1 hour which has given me time to exercise at the local gym near where I work immediately after work. I feel this is making a difference to improving my physical and mental health. I ensure I take regular breaks away from the computer screen and move about to maintain good posture which is something I must remind myself to do.

Reply 2: Speaking to our colleagues and debriefing with our manager when we have had a complicated appointment. We try to not take on the problems the client is facing; however this can be difficult to do as we spend a lot of time with clients, and it takes time to learn how to separate ourselves from their situation and not carry guilt that something hasn't been "fixed".

Doing things outside of work such as going to the gym, spending time with friends, family, pets, having other hobbies can also help to unwind and destress after a particularly challenging situation. Having a toolbox of support available, that we can draw on after working with clients.

Having the confidence understand that we are not here to fix every problem a person may face but provide them with the tools to ease the situation.

Previously, when we had the county wide peer support group, this provided an additional opportunity to seek support from people outside of our own teams- something that doesn't really happen now.

What helps me process or carry difficult stories safely

Reply 1: Having a team of colleagues around me and having the opportunity to bring cases forward. We have a weekly case management meeting where we can come and ask questions about how to support clients, but it also gives us an opportunity to debrief after a particularly difficult appointment. As we are out completing visits independently, we do not always have the chance to see our colleagues during the week, so having the case management meeting built in to our working week gives us that space to catch up with colleagues and how their week has been, but also talk about things outside of work to build on that comradeship between us, which strengthens our relationships.

We also have a manager who is there to support and discuss cases with who we can access whenever we need to. A lot of our work is completed independently, so having a space to come and hear different perspectives can support our own decision-making process.

Reply 2: I reflect on what has been shared when I engage with patients. Many share their lived experiences often including historical trauma. If I need to speak to my colleague or manager to `offload` my feelings and /or get clarity and direction, I have been able to make contact for immediate support including booking time for later date to talk more in depth if required.

Reflections on supervision, resilience or professional identity

Reply 1: I have no direct case supervision. I attend a bimonthly 1 x hour meeting with my SPLW colleague, PCN manager and Clinical Director relating to role development and expectations. I can contact my manager at any time for support or advise if needed. I can also contact duty GP relating to any immediate issues that may arise when I meet patients. I try wherever possible to regularly to meet my colleague face to face or via a telephone call to check in that all is ok and share any issues. This is essential and supports my own mental health.

Reply 2: We have six weekly 1-1's with our manager which provides us a safe place to discuss what successes and challenges we have had. We talk about our cases in depth and decide how to make a plan moving forward.

We have discussed resilience a number of times, we understand the importance of looking after ourselves in order to best support the client. We need to practice what we preach to our clients- you can't pour from an empty cup and understand that although our job is to support people to manage and maintain their own health and wellbeing, we do have to practice this with ourselves.

Professional identity- To us is when we feel competent. It is when we see ourselves reflected in feedback and seeing that the role and work is valued and appreciated.

Having a role within the integrated team approach and that we feel we belong, rather than being an additional thought/add on. We have a close relationship with our VCSE and PCN colleagues which helps us understand the value of our work.

Not working in isolation but feel part of something bigger can help us feel more professionally recognised and regarded. Seeing the impact our work can have on the client and the changes the client can make with our support to improve their lives.

Having the opportunity to come together as a wider cohort and hearing the challenges and similarities we have with other Social Prescribing services

Connection and Visibility



Connection and visibility are two important words in the language of the Social Prescriber. If we aren't visible we won't make connections and if we don't make connections we will cease to be visible.

The Social Prescriber and Social Prescriber Triage role is the connector to all services within the community. We connect our patients to appropriate services, advice centres, social activities, physical activities and mental health support. To be able to do this we need connections with all these services so we know where we are signposting our patients to and what they can expect. In addition to signposting we can also have longer term involvement with our patients who need that extra level of support. In these cases we need to build trusting and effective relationships. We also need to work closely with our community partners such as the mental health services, Local Area Coordinators and our colleagues in the GP practices. Leaflets about social prescribing are always present in GP surgeries. These are available for patients or anyone visiting the surgeries to take away and read in their own time. In High Peak there is also a leaflet for professionals only that the team shares when enquiries are made from other agencies/organisations.

Meet A Social Prescriber

Greater Derby PCN have an annual event that is a drop in day in a central location and all Social Prescribers from the local area, not only that PCN, are invited. Members of the public can come and get information about Social Prescribing in general and the services we signpost to and meet a Social Prescriber face to face.

Chesterfield & Dronfield PCN have 3 "hub" days this year where the Social Prescribers and other services promote a health and wellbeing program at drop in community events

A Day In The Life

Greater Derby PCN had a recent presentation to other Additional Roles (ARRS) in our PCN. We presented A Week In The Life of a Social Prescriber which showcased the diverse range of referrals we get and what input we have. The overriding feedback was, they had no idea what our role involved.

What We Wish Others Knew About Our Role

Delivering presentations to colleagues, drop in sessions for the public and newsletters are all good ways to educate people about our role.

A huge thank you to all Social Prescribers across Derbyshire. Your work changes lives.

You support and help reduce pressure on clinical teams by servicing the local communities and improving wellbeing in ways that truly last.

Social Prescribing is about looking beyond medical needs, it's recognising that health is shaped by our relationships, our environment, and our sense of belonging.

If you are a Social Prescriber working in Derbyshire and would like to be involved in the programme please email ddlmc.thehubplus@nhs.net



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