Whither, social prescribing?

Social prescribing is a wicked term. The post-modern, angst driven, conceptualization of social phenomena as: ‘wicked,’ first emerged in the field of social planning in the 1960’s. A phenomenon labelled wicked meant it was something whose social complexity means that it has no determinable form or stopping point. Moreover, because of complex interdependencies, the effort to solve or understand one aspect of any wicked phenomena may in fact reveal or create more problems inimical to further understanding and development. This is true of social prescribing.

What is social prescribing? As others more famous than me have said: ‘where to begin’? On a simple level social prescribing can be seen as a process where patients in primary care are linked with sources of support within their community. It has been perceived as allowing GPs, and more recently all primary health care professionals, with an option to prescribe a non-medical option as opposed to or in addition to a medical one. This can operate alongside existing treatments to improve patient well-being. As time as moved on from the pioneering days of the Bromley By Bow Centre in the 80s many interventions, projects, initiatives and health professionals have begun to adorn the mantle of social prescribing to describe their work. Some of these can now be found in secondary care, many others have prospered in the community and voluntary sector and may in fact have no direct or formal connection to health services at all e.g. a local gardening project.

Around the UK, and indeed across many nation states social prescribing is growing in fact the Work Foundation declared that it had gone ‘viral’! In a recent review of social prescribing initiatives for the Department of Health researchers from the Social Prescribing Network determined at least six different models of social prescribing and noted that the Department of Health and NHS England preferred the ‘link worker’ model of social prescribing where the prescriber works with a referred person, ‘to co-design a nonclinical social prescription to improve their health and wellbeing.” This is more than simply signposting and will clearly demand more skills than those offered by a ‘community navigator’. I have argued elsewhere, that the ‘link worker’ would need to work with a referred patient ‘holistically’. Holistic social prescribing services are interventions that have evolved from simpler models over a period of years. The worker is external to the practice but co-locates with the local health service. The social prescriber provider has a clear local remit and draws on local knowledge of local services and networks to connect patients to important sources of support and aid. The social prescribing intervention has also usually been developed and sustained jointly over time and in its present form represents a product of joint partnership working between the primary care provider, the social prescribing provider and the patient. The social prescriber provider addresses the patient’s needs in a holistic way be it around budgetary advice, nutrition, addiction, loneliness, access to employment, onward referral etc. There are no limits to the number of times a patient is seen and indeed the relationship is contingent on the patient’s needs.

But why is social prescribing going viral now? It is clear that the NHS is in crisis. A victim of its own success, it now faces the growing demands of: an ageing population, the growth of lifestyle diseases, the demise of mental health services and the realization that growth in antibiotic resistance could lead to what the chief medical officer for England (Dame Sally Davies) calls ‘the end of modern medicine’. Leaving the poor and the vulnerable, who are wreaking the consequences of the broader collapse of the welfare state; to become increasingly propelled to take their social problems and individual concerns into the last, sole, universal, welfare service free at the point of entry: the NHS. A NHS which is still bounded by a belief that a bureaucratic structure constitutes the most efficient and rational way in which health services can be organized and that systematic processes and organized hierarchies are necessary to maintain the natural order, maximum efficiency, and effective delivery of services to the patient. However, in an age of increasing diversity and individualism, unfettered bureaucracy in fact mounts a threat to creativity and prevents the ability of local professionals to respond flexibly and holistically to individual patient needs.

The NHS was developed in a different time where collectivism and shared responsibility was the national hegemonic consensus that underpinned its universal paternal top-down approach. Deindustrialization and the growth of a service sector based on principles of individual consumption and ‘seduction’ persuades individuals to increasingly pursue their dreams and experiences in the market place. In response to consumer indifference and demand overload in health services key players in different locales have independently evolved ‘bottom-up’, partnership approaches, frequently bespoke, to help improve local wellbeing. ‘Social prescribing’ is often seen as an intrinsic answer. With no agreed definition and heterogeneity in its promulgation different social prescribing alliances are carving out and delivering programmes through the development of varying alliances of counter-hegemonic partners from public, third sector and even private sector partners. The state still maintains the 'spontaneous consent' of the populous through a negotiated construction of a political and ideological consensus around the NHS but it is increasingly considering less dominant ideas as perhaps solutions. In the past we have accepted the consensus of a universal funded health service because we had a reason to believe in it and gain from it. It appeared to be ‘common sense’. However social prescribing is being nurtured and sustained by new funded coalitions which respect the autonomy of the movement to which they contribute.

Despite social prescribing being highlighted as one of ten key outcomes highlighted in the *General Practice Forward View* (2016) as an important mechanism to support more integration of primary care with wider health and care systems to help reduce demand on stretched primary care services there is still no direct funding or universal fund to support its development. There is no ‘top-down’ instruction from the NHS or any other national body as to what should be done, how it should be done which has allowed existing social prescribing schemes to emerge organically ‘from the bottom up’ through local leaders from different sectors; pioneering a way forward into developing a universal social prescribing service provision linked to every GP practice in their area e.g. Gloucestershire, Rotherham. In both cases transformative change took several years and started from small beginnings. My own research suggests that local partnerships are emerging to creatively evolve their own local, ‘link worker’, social prescribing schemes to suit their need, despite the NHS. Thus initiatives are being funded in a variety of ways: half of existing initiatives are supported by Clinical Commissioning Group and/or local authority funding partnerships. However others use public health money, grants and trusts from various organizations including the Big Lottery, a few use social impact bonds, one local council has raised the precept on their Council Tax and a couple are supported by local philanthropists for various reasons.

Its viral growth and inherent localism makes assessment of social prescribing’s impact difficult to assess. The NHS mantra of demand reduction in GP attendance and A and E usage (attendance and admissions) appears to be being met. For the most part, social prescribing seems to have a protective effect on service demand according to a recent review of 94 studies. But this evidence only applies to a cohort of patients referred, patients who failed to engage fully with social prescribing have sometimes been shown to have much higher rates of health service use both before and after referral. But, the quality of current evaluation data means that impact needs to be interpreted with caution. None of the studies were randomised controlled trials (the gold standard of evidence for NIACE) and very few were peer reviewed. Evidence’ in a medical setting is related to the concept of evidence-based medicine. This is an approach to making the best clinical decisions based on what is perceived to be the most rigorous clinical research data and experience. Because the impact of social prescribing is often beyond the perspective of the NHS, the dominant paradigmatic approach of Health Economics in informing NIACE and NHS decision making means the social and personal gains for social prescribing patients are frequently seen as not relevant to NHS policy makers managing tight budgets and seemingly increasing demand. Thus the social impacts of, for example, enabling debt management, improved sense of wellbeing and improved physical activity are not seen as pertinent to health commissioners. Also most of the evaluations conducted hitherto are often based on small numbers of patients, short time scales, subject to high drop-off rates at follow-up meaning their studies frequently lack the power to show a statistically significant outcome. Clearly a huge challenge because social prescribing like any other innovative and transformative approach to address broader population’s needs are ushering in a variety of local cultures of change and at the same time trying to account for itself using performance indicators set by others and intended for other disciplines.

We are a long way from 1948, when we recall that 85% of BMA members voted against the establishment of the NHS six months prior to its launch. At the timer one Dr. Alfred Cox’s examination of the bill led him to conclude that with the NHS the government was taking a large step towards national socialism as practised in Nazi Germany and that the medical service was being put under the dictatorship of a medical fuhrer! Clearly, despite claims to objectivity, rational planning, and performance led policy development what counts as policy in the NHS is and always has been subject to interpretation and struggle. The social prescribing movement spearheaded by the 1500+ members of the Network who are in reality providing an informed and experiential counter hegemonic view and values that suggest that our health services should not be delivered by a top-down, silo service that can only offer reactive support detached from the very civil society that supported its establishment.

The political and practical implications of social prescribing are thus profound because around the country unique, local partnerships and coalitions are emerging in a sort of ‘war of position’ in the struggle over ideas and beliefs, of how best to address specifically the crises in the NHS and more broadly how to evolve an open, enabling, health service to encourage holistic approaches to health. It reveals that health and wellbeing services per se have developed through contested knowledge and social constructs that continue to be challenged and challenging today as they were seventy years ago. Social prescribing is building civic capacities to think differently about local wellbeing and to challenge assumptions and norms, and articulate new ideas and visions for future generations.

The future shape of our wellbeing services will continue to be contested. But it is important that key values and ideas as to what our health services are for and how they should be delivered needs to be and will be continually contested. In July this year Tudor Hart the radical, Welsh GP, inventor of the Inverse Care Law and advocate of the routine use of blood pressure checks in GP counsultations outlined nine important principles on which our health service was originally founded. There is insufficient space here to fully explore all the principles but given the rise of social prescribing it is important to reflect on our values as we build the future going forward. Hart principally said that we should recognise that the NHS’s most important inputs and processes are the personal interactions between lay and professional people. Its staff and component units should not be expected to compete for market share but to cooperate to maximize useful service. And its local staff and local populations believed that they had moral ownership of and loyalty to their neighbourhood NHS units and services. In the face of budget collapse, the unforeseen consequences of Brexit, the possible privatisation of health services because of diminishing budgets means that local social prescribing partnerships need to continually encourage cultural change in our wellbeing services. Whatever the context social prescribing is providing a holistic framework for responding to the wider social, cultural, environmental factors that impact on health and wellbeing and it invites people to respond holistically to the causes of poor health.

Polley, M., Bertotti, M., Kimberlee, R., Pilkington, K., and Refsum, C. (2017) Reviewing the evolution of social prescribing practice in England, University of Westminster/Social Prescribing Network

Richard Kimberlee is a Senior Research Fellow at the University of the West of England (Bristol) and the South West lead for the Social Prescribing Network.