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"Social prescribing has been prioritised by the NHS. Is this support appropriate given current pressures? Discuss." Word count = 1475

Social prescribing is becoming extremely à la mode in the circles of integrative medicine, general practice and the NHS in general. A modern-day general practitioner (GP) will spend around 20% of their time dealing with social issues (1). Does this rise in social issues therefore require a rise in social solutions? This essay will discuss what social prescribing is, and whether its use is justified in the face of current pressures within the health system. In particular, this essay will focus on financial, time/workload, and disease-related pressures and how social prescribing fits or doesn't fit within this landscape.

Social prescribing – what, why and how

Social prescribing happens in different ways across the country, but mostly via a link worker. This is an individual who works with GP practices and sees patients referred by their GP who are struggling with complex social problems, multiple chronic diseases, loneliness or social isolation, and mental health problems (2). The link worker will see these people and offer an array of services aiming to improve their quality of life through non-medical means. This could be prescribed exercise classes, group education, arts classes, legal advice, healthy cooking classes, gardening, and much more (3). This service acknowledges that many things contribute to our health including social, emotional, physical, and spiritual matters. It is encouraging to see the NHS embracing this model of care – otherwise known as integrative medicine. Integrative medicine acknowledges that true healing requires a holistic view that treats the whole person, not just their isolated symptom (4). Commissioners believe social prescribing can improve patient satisfaction, quality of life and reduce the workload of GPs.

Multiple pilot models of social prescribing in the UK provide useful case studies to observe its cost and impact. The 2014 pilot in Rotherham showed improved patient satisfaction, wellbeing and mental health outcomes (5). Furthermore, the 1400 patients that engaged in the study spent less time in hospital compared to previous years (5). A similar study in Bristol from 2013 found improved anxiety levels and overall wellbeing scores, as well as reduced number of GP appointments being used by those who engaged in social prescribing (6). Despite some benefits in small pilot studies, a systematic review of 15 trials concluded that "current evidence fails to provide sufficient detail to judge either success or value for money" (7). This was mainly due to studies having multiple bias issues and being small in sample size. Therefore, it is clear more robust studies are needed to

effectively evaluate social prescribing. This will become more possible as it begins to be introduced as part of the NHS Long Term Plan (8).

The NHS Long Term Plan outlines the intention that GP surgeries across the country will become part of 1400 Primary Care Networks (PCN) (8). A PCN is a hub which connects multiple small and large local GP practices, allowing all to have access to the same level of services. As part of the new team within each PCN will be a link worker, with 1,000 new link workers being introduced from July 2019 (2). NHS England state they will fund salaries for these new link workers as part of the new £4.5 billion service model that is encompassed in the NHS Long Term Plan (2). For the first time in NHS history there is a promise that "investment in primary, community and mental health care will grow faster than the overall NHS budget" (2). How much exactly the social prescribing element of this will cost is unclear. This essay question asks if the support for social prescribing is appropriate, given current pressures. The 'current pressures' can be split into financial, time/workload, and disease-related pressures.

Financial pressures

From a financial standpoint, the question remains – is it financially viable to roll out across the country? A recent NHS England social prescribing scheme in Leeds cost £1.5 million to introduce in one CCG (9). Quite how the already over-stretched NHS can afford to implement this new model of health provision is unclear. One could argue that GPs should already be signposting those with complex social needs to appropriate services, without the need for a new NHS employee. The government seem confident social prescribing will reap long-term savings as those with complex social issues engage in fewer GP appointments, A&E visits and medical prescriptions (2).

Despite this, a social prescription can only prescribe something that actually exists (1). Alongside the NHS Long Term Plan there needs to be a halt to the significant local authority cuts (10). For example, regional art galleries are suffering huge slashes in public funding despite being asked to run extra arts classes as part of social prescribing schemes (11). If the public organisations providing the 'social prescriptions' don't have sufficient funding it is irrelevant how many link workers there are, or how robust the social prescription infrastructure is within the NHS.

Time and workload pressures

GPs are facing a larger and more complex workload than ever before (12). Many newly qualified GPs are opting for portfolio careers with just over 10% of GP trainees planning to do full-time clinical work 5 years after qualifying (12). These factors combined with an ageing population, increasing social problems, and patients with complex needs result in an overstretched primary care service.

Social prescribing, 59% of GPs believe, could reduce their workload (13). As described above, pilot studies have shown reduced hospital and GP use by those who engaged in social prescribing (8, 10).

The 10-minute appointments allocated for GPs are inadequate to explain the full extent of services available to an individual, describe which benefits someone is entitled to, or to make a referral for swimming classes or legal advice (3). By having a link worker or similar staff member with real expertise in these areas available for referral it could save precious time in a GPs day, whilst still leaving patients feeling their concerns have been validated and listened to.

Disease pressures

50% of adults have a chronic illness related to poor diet or lack of exercise (14). This increase in chronic diseases is one of the biggest challenges facing the NHS at the moment. The increase in diseases such as obesity, irritable bowel syndrome, depression, and chronic pain and fatigue syndromes is continuing despite public health advice (14). Clearly our way of preventing these *largely* preventable conditions isn't working. Could social prescribing allow a more direct and targeted way of accessing those most vulnerable in society? By enrolling those with social issues in healthy cooking classes could we reduce the risk of cancer and chronic disease? A more personalised way of introducing patients to a healthy diet, or exercise programme must be more likely to work than a billboard in the street.

Conclusions

When evaluating any new medical intervention, one must look at the cost-effectiveness, benefits and risks. The cost-effectiveness is hard to untangle as it is being introduced as part of an overhauling of the NHS primary care system. One key point is that funding must also be made available for the public sector organisations providing the 'social prescription'. In terms of benefits, a key systematic review commented it could not judge social prescribing's "success or value for money" (7). There is a clear need for more robust studies investigating the benefits of social prescribing. Furthermore, there is still uncertainty about exactly how it will all work, and the role of link workers. Despite this, the theory and intentions behind social prescribing are appealing. Qualitative evidence indicates that social prescribing is liked by both patients and doctors and leads to higher all-round satisfaction (15).

Finally, one must look at the risks of social prescribing. The side effect profile or *lack of* with regards to social prescribing is something that will liberate healthcare professionals and patients. Instead of adding a benzodiazepine to a cocktail of drugs to treat mild anxiety, why not try an art class? Social prescribing is personalised, simple, and safe. In truth, good general practitioners have

been using these techniques for years – local and practical social advice to help those most vulnerable in society. Formalising this into a reproducible framework that can be used across the country will of course cost money and draw criticism. However, it will also allow more of those with complex social needs to receive safe and simple interventions, all whilst being listened to by someone who cares and has the time to give. Primary care in the UK needs to adapt to the increase in chronic diseases and strain on NHS services. Overall, I believe the recent priority given to social prescribing is justified in. Years of austerity and a changing social landscape are creating new challenges. These new social challenges require new social solutions, with social prescribing being a simple, safe and holistic starting point.

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