Social Prescribing has been prioritised by the NHS. Is this support appropriate given current pressures? Discuss.

What is social prescribing? The current context

Social prescribing is a means of improving the holistic wellbeing of patients by making links between the patient and the opportunities around them, including activities such as sports clubs, art classes, and local libraries. NHS England has chosen to make social prescribing a priority through its inclusion in the NHS Long-Term Plan, setting out its importance for the next decade. This priority status most notably takes shape through its commitment to employ one thousand new link workers over the next two years, who will act as facilitators of social prescribing by referring patients from primary care into local community services, as well as developing services of their own (NHS England, 2019).

The NHS is currently under unprecedented pressure. A funding crisis over the last five years has led to poor staff morale, leading to a recruitment and retention crisis. Now almost 40,000 nursing posts lie empty, and remaining staff bear the burden of the deficit. Waiting time targets are consistently missed across the country, leading to delayed care for patients (Anandaciva and Ward, 2019). In addition, there is increasing pressure to fund bigger and better technologies, including expensive cancer drugs, cutting-edge robotics, and artificial intelligence. Moreover, the population is not getting any healthier: an obesity crisis, increasing numbers of lonely elderly people with complex care needs, and a burgeoning mental health epidemic all appear to be on the horizon, amongst other pressures (Public Health England, 2018). There seems to be no end to the drain on NHS finances. Surely, this healthcare system cannot justify throwing money towards a novel scheme such as social prescribing when even its most basic structure is creaking?

Yet social prescribing promises solutions to many of these problems (The King's Fund, 2017). In response to the mental health crisis and loneliness of the elderly, it claims to bring people together through community initiatives and create social capital which improves mental wellbeing. It hopes to improve the determinants of physical health too, through initiatives such as walking groups, exercise classes, and simply getting housebound people out of their front doors. It is an approach with the whole person at its core, seeing people in their social contexts and not only as a physiological being. Social prescribing targets the most vulnerable patients, and thus some of the most frequent attenders to

general practice and A&E departments. This has led to claims that it could even reduce the number of presentations to NHS services and result in financial savings. It is no wonder that NHS England is so keen to implement this programme - it seems there is nothing worth having that social prescribing does not deliver.

Neither is social prescribing new. Whilst a nation-wide scheme like that contained within the NHS Long-Term Plan has not been rolled out before, it has been explored in a variety of ways and contexts. These include link workers for the homeless population in Glasgow, where some participants reported improved wellbeing, felt emotionally supported by their link workers, and wanted to give back to the community, amongst other soft outcomes (Hanlon et al., 2019). At the Artlift project for mental health in Gloucestershire, participants described the programme as an escape from their normal everyday lives and enjoyed the chance to be with others (Redmond et al., 2018). In Nottingham, an Arts on Prescription scheme was found to give participants new aspirations, including educational, and there were positive social and relational outcomes (Stickley and Eades, 2013). These individual projects seem to have seen success, which could be replicated on a larger scale across the NHS.

Where is the evidence?

Given the scale of the NHS support for social prescribing, perhaps we need more than simply participants' feedback, however heart-warming, to justify it. A recent systematic review of the literature on social prescribing schemes found that the published evidence was primarily small-scale evaluations of projects, with poor methodology and a high risk of bias (Bickerdike et al., 2016). Much of the data available on social prescribing is sourced from the grey literature, such as reports from charities to demonstrate and justify their use of funding. Where more rigorous scientific methods have been applied to examine the outcomes of social prescribing, the results tend to give a mixed picture of its effectiveness; a case-control study of the Connect programme in Cumbria, not dissimilar to the programme being adopted nationally, was one of the only trials to study financial returns. It found no significant financial savings between patients in a social prescribing programme and those who were not (Maughan et al., 2015). Cost-effectiveness may not be the outcome of primary importance when it comes to patients' well-being, but this study is just one example of the mixed peer-reviewed evidence on social prescribing schemes.

Some of the reasons for the lack of quality evidence were explored in a recent editorial article by Husk et al. (2019). One key reason for the lack of published evidence is the number of organisations, often small charities, who are part of one social prescribing scheme. These would all need to be engaged in data collection in a standardised fashion in order to produce high quality data for research – no small feat. In addition, it is ethically challenging to run randomised controlled trials in social prescribing as it would mean vulnerable patients in deprived areas missing out services if they were to be placed in the control group. These difficulties mean it would be complicated, time-consuming, and potentially costly to design ethical trials and collect meaningful data on social prescribing. But we cannot simply dismiss the need for evidence, either. We certainly would not allow large-scale NHS funding of a new technology on the basis of social prescribing's existing evidence base – NICE, the body which reviews the clinical evidence and cost-effectiveness of treatments, has a careful appraisal process (NICE, 2018). Why bend the rules for social prescribing?

The NHS is to some extent aware that the available evidence on social prescribing does not guarantee its success across the country. Thus, NHS England has proposed its own Common Outcomes Framework within its guidance on social prescribing, to measure its effectiveness and justify its funding (NHS England, 2019). This measures the outcomes in three areas: the well-being of the individual person, the resilience and confidence of community groups accepting referrals, and the impact on the overall health and care system – for example, the volume of medication prescribed and changes in staff morale. Codes have been created for electronic records in primary care, which hope to track GP referrals to social prescribing across the board, allowing for consistent data collection.

Whilst the Common Outcomes Framework does appear to be a step towards filling the literature gap, it is likely that much of the evidence generated from these evaluation exercises will again go into NHS reports and not through the thorough process of peer-review. This evidence is still not strong enough to stand up against the quantity and quality of peer-reviewed literature which supports other projects, drugs and technologies vying for NHS money.

Conclusion

In conclusion, I believe that social prescribing is worth prioritising, but only with investment into rigorous research to secure its future. Despite obvious gaps in the peer-reviewed literature to prove its efficacy, the UK's looming loneliness and mental health crises make it a priority to invest in community

services which bring people together – sooner rather than later. But alongside the money being spent on link workers and community organisations, more money needs to be set aside for research into its effectiveness, in particular its financial value, to defend and secure this spending into the future. The grey literature currently relied upon on will not be good enough in the coming years to justify social prescribing when pitted against NHS pressures to spend on technologies which have the data on their side. If those who champion social prescribing are truly convinced of its usefulness, they will champion evidence too.

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