

JOURNAL OF

holistic healthcare

Re-imagining healthcare



Social prescribing



- Social prescribing now
- SP – where next?
- Gathering the evidence
- Compassionate Frome
- The self-caring community
- A layman's perspective
- SPEAR in Bristol
- Evaluating social prescribing
- The Tenofus choir
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ISSN 1743-9493

Published by

British Holistic Medical Association
West Barn, Chewton Keynsham
BRISTOL BS31 2SR
journal@bhma.org
www.bhma.org

Reg. Charity No. 289459

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Design

www.karenhobden.com

Cover illustration

The healing tree by Maya Cockburn
www.mayacockburn.com

Printing

Spinnaker Print Ltd

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Editorial



David Peters
Editor-in-Chief

Building a bigger primary care toolkit

The biomedical model is a fine tool, but it has no cures for many kinds of everyday suffering. Necessary though it might be in chronic disease, seldom will it be sufficient. Tackling complex long-term health problems requires an expanded holistic approach that is rarely possible in routine primary care. When doctors have to work under pressure, and all that is to hand is a (biomedical) hammer, everything will have to look like a nail. And so life's problems are given medical labels. As surgeries fill with people whose problems don't fit the medical box so well, doctors are realising they need a bigger toolkit; and ideally the time to make use of it.

What are GPs to do, for instance, when in the cut and thrust of a packed day's work every fifth patient arrives with a non-medical issue – a relationship problem, housing and unemployment concerns or work-related issues? In 2015, these accumulating slots cost the NHS nearly £400m a year (Citizens Advice, 2015). Add to this workload chronic health problems rooted in lifestyle, long-term psychosocial issues and socio-economic deprivation, plus patients whose medically unexplained symptoms signal medically unexplored stories, and it's easy to see why hard-pressed doctors are loath to open the much-feared 'can of worms'.

Medication won't catch the slippery contents of a patient's can full of loneliness, loss and old trauma, let alone pay their rent arrears. Yet with GPs' and patients' stress levels ramping up year-on-year, time-poor GPs' patience is wearing ever thinner. Unless they have more time and a bigger toolkit, the temptation to medicalise every kind of suffering is likely to increase, even though over-diagnosing and over-treating can be ineffective, costly and dangerous. Worse still, the conspiracy of silence about the causative (but 'unfixable') roles of lifestyle, deprivation, emotions and relationships while letting the doctor – and society as a whole – off the hook (for a while at least), leaves patients – unless they have what it takes to make these links for themselves – dangling and helpless. For doctors this kind of doublethink is demoralising, and its undercurrents of defeat and hopelessness may well contribute to GP burnout.

Thankfully medical practice has begun joining up the biopsychosocial dots. Where once overstretched doctors might have settled for a pragmatic unsatisfying short-term biomedical fix, instead, with social prescribing, they can drop a line to a link worker – a community connector who knows the local voluntary sector, and can meet up with a patient to find out what's needed and 'prescribe' appropriate contact, company and support. As one leading early adopter of social prescribing reminds us, building social capital and community cohesion is health-generating and may create a virtuous circle (Branding and House, 2009).

Social prescribing, whatever else its merits, provokes conversations about non-medical options for improving health and tackling long-term illness. Now the cat is out of the bag, the demand is bound to grow, and though its effectiveness on a large scale has yet to be established, early adopters like its common sense appeal. Researchers suspect that patient engagement is the key factor for success (Moffatt *et al*, 2017) – which of course is the case with almost any complex holistic personalised intervention, but it makes social prescribing a square peg in the round holes of randomised trials and rigid forms of evidence-based medicine. This could become a stumbling block to its more widespread adoption. Another would arise if social prescribing initially required more consultation time, although it's good to learn that patients in more affluent areas who have multi-morbidity get longer more patient-centred consultations, and greater GP empathy. However, those with complex needs who live in deprived areas get little extra attention (Mercer *et al*, 2018). It would be a travesty if SP became the preserve of the better off, yet if the twin blades of GP overstretch and economic austerity do cut back social prescribing's green shoots, the inverse care law will once again have been proven irrefutable.

By reconnecting patients who have non-medical needs with community resources that can better meet them, complex care could become less doctor-dependent. This is an obvious selling point for social prescribing, but for it to succeed and spread, the indispensable community organisations it depends on will need funding, and skilled link workers to help weave them into primary care. So crucial determinants are integration and engagement: GPs' willingness and capacity to be gate-openers to new and unfamiliar styles of referral, patients with a growing sense of enablement, and local grass roots leadership in well-resourced voluntary organisations. Happily and for many years – often in deprived areas – communities have been sprouting examples of what can be done when holistic primary care staff work in harmony with local health champions and the voluntary sector. Our journal's archives bear witness to that. JHH (bhma.org/journal) has been ahead of the game in shining a light on many of them.

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Social prescription: coming up for air

Michael Dixon

Chair, College of Medicine



Social prescription has become a social movement whose ultimate aim is to create communities that make us healthy rather than ill. Its astonishing progress has been due in part to the altruism and passion of those who have been developing programmes throughout the UK. But it is also due to a growing recognition within the biomedical world that our current medical model is unable to solve the exponential increase in obesity, diabetes, stress, depression and even cancer. Social prescription represents 'the other way'. Our second national conference on social prescription on 6 November is titled *Social Prescription – Coming of Age*. For the cause of holistic medicine and all that this journal represents, it is a final and irreversible 'coming up for air'.

As a national and international movement, social prescription was born three years ago somewhere around Reading on a train journey from Devon to Paddington. At our GP centre in Devon, Marie Polley, now co-chair of the National Social Prescribing Network, had just finished researching the effects of providing a social prescription to patients who were diabetic or at risk of diabetes. After nine months a third of them had converted to no longer being either diabetic or at risk of diabetes. 'What next?' we asked ourselves.

Ten years into general practice, I was burnt out. Swamped by patients presenting with a range of problems from chronic tiredness, frequent minor infections, irritable bowel, headaches and back pain to stress, loneliness and sheer misery. Discovering complementary medicine gave me back my professional life and radically altered my views on how to heal and the importance of balancing the perspective of clinician and patient. The College of Medicine advocates an open-minded approach to health and healing that includes complementary medicine and other non-biomedical interventions such as the arts and healthy eating, which are being increasingly offered under the umbrella of 'social prescription', which is another college-led initiative.

We had been working alongside the Bromley by Bow Centre in Tower Hamlets, London, over several years to develop and provide social prescription but funding had always been difficult and frequently had to be sought through private sponsors. It was time to make the world – patients, professionals and media – aware of social prescription and to get it universally recognised and funded.

Our first step was to bring together all those that we already knew were pushing the boundaries. We turned to innovators like Professor Chris Drinkwater in Newcastle West; Dr James Fleming and his Green Dreams project in Burnley; the work under way in centres at City and East London in Rotherham; Gloucestershire and of course Bromley by Bow. We formed a self-elected leadership group of around 12 clinicians and academics. Our next step was to invite anyone who might be interested or involved in social prescription to a meeting in London in January 2016. Having secured a Wellcome Trust seed award and support for a meeting from AbbVie, we speedily arranged a conference in central London, expecting at most around 30 or 40 people to come.

In spite of minimum publicity 150 people applied but we had to limit it to 100 because of space. It is a pattern

that has repeated itself over the past two years with every conference or meeting on social prescription being oversubscribed many months in advance. It became very clear before, during and after that first meeting (of what was to become a nascent National Social Prescribing Network) that all over the country patient groups, clinicians (especially GPs), clinical commissioning groups and local authorities were looking outside the biomedical box when it came to both care and improving the health of their local population.

These initiatives had one thing in common – they were linking people to local voluntary and community groups. The initiatives varied from fishing clubs, knit-and-natter groups, singing, dancing, reading and theatre groups to green exercise, gardening clubs and yoga/Tai Chi. Remarkable projects with remarkable results came pouring out of the woodwork. Clearly an enormous wealth of pent-up energy had been working below the radar and was about to explode on to the national stage. By the time of our House of Commons launch two months later the national network had grown to 300 strong, and it has grown to well over 2,000 today.

At our House of Commons launch in March 2016, Dr Sarah Wollaston, Chair of the Health Select Committee

was due to chair. Family illness kept her away so Stephen Dorrell (the previous Secretary of State for Health and current Chair of the NHS Confederation), affirming his own commitment to social prescription, stepped in. Janet Wheatley, from Rotherham CCG, launched an ongoing debate when she said simply 'it's just common sense'. Her view represents those who find it obvious that social prescription and non-medical interventions can improve health using available volunteer and voluntary resources. At the other extreme, a more traditional NHS lobby keeps potentially effective interventions at bay for decades pending double blind placebo-controlled evidence.

It became very clear that patient groups, GPs, CCGs and local authorities were looking outside the biomedical box

Something extraordinary happened at the launch. A remarkable dialogue and relationship between the College of Medicine and the University of Westminster had started the ball rolling for social prescription. There had been some discussion already with NHS England as to whether it would take an interest in social prescription. All too often Whitehall takes a good idea from the front line, magnifies and mistranslates it and then drops it on already overstretched clinicians and organisations. But this time NHS England was both courageous and correct in deciding to join to work hand in glove with the front line to enable social prescription to develop a united vision together with the National Social Prescribing Network, the College of Medicine and University of Westminster. To maximise knowledge, commitment and passion I was appointed national clinical lead for social prescription and the University of Westminster was commissioned to research the current state of play and the economic implications of social prescribing (Polley, Bertotti *et al*, 2017; Polley Bertotti *et al*, 2017).

There is hardly a single social prescribing project that could be said to be financially sustainable

Today we are defining social prescription as involving a prescriber, a link worker and a menu of activities and interventions the link worker can offer. And we now have a commitment to roll out social prescription from Simon Stevens, chief executive at NHS England, who said in the national press that he would like every GP to be able to offer it; the Mayor of London has incorporated social prescription in his health strategy; it is now being offered in a number of clinical commissioning groups and in

South Yorkshire's Sustainability and Transformation Plan. Some form of social prescribing is going on in almost half of clinical commissioning groups, where the normal model is co-funding between the local clinical commissioning group and local authority.

There are two main challenges ahead. The first is how we create a sustainable funding model that makes social prescription an intrinsic part of the NHS and its funding flows. This is especially needed to enable voluntary and community groups to plan sustainable provision of initiatives. At present there is hardly a single social prescribing project that could be said to be financially sustainable beyond two or three years. The second challenge will be to keep social prescription faithful to the principles of those who have pioneered it and to avoid it being dumbed down to mere signposting, or a one-size-fits-all process. Research on how and where it works best will also help to determine its future direction.

Meanwhile, much needs to be done. NHS England with its regional networks, mapping initiative, creation of a common framework for data collection and other support will be leading the implementation of social prescription in England. Its close connection to those who have led the process to date and those who are currently leading social prescription at the front line should ensure that the process of universalisation proceeds without hitting the rocks. Meanwhile, there is a pressing need for independent research to guide the progress of social prescription. Following a booked out international conference on social prescribing research at the University of Salford this summer, the National Social Prescribing Network is evolving as leader and co-ordinator of such future research. There is also increasing interest among the other three UK nations, with Scotland in particular advancing social prescription rapidly. Health and social care partnerships have submitted primary care improvement plans to recruit and allocate 250 link workers, to support Scotland's most deprived communities and tackle inequalities. In early 2018 Wales formed an all-Wales social prescribing research network and Ireland and Northern Ireland are collaborating with their own Social Prescribing Network Ireland. With increasing invitations to speak abroad, the College of Medicine, University of Westminster and National Social Prescribing Network are at the head of an emerging international movement, led by the UK, whose first international conference will be held in London in June 2019. Great Britain with its unique National Health Service, free at the point of delivery, is the ideal seedbed for an idea whose time has certainly come.

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Social prescribing and the development of the 'evidence base'

Marie Polley

Senior Lecturer in Health Sciences and Research; Co-Chair, Social Prescribing Network



I started my career studying biomedical sciences, and gained a PhD investigating the molecular components of cancer development – I've always been fascinated by DNA. While completing my PhD, I trained in Usui Reiki as I wanted to do something that would help to support my own health. I then practiced Reiki while carrying out my molecular biology research. After a post-doc contract in the Department of Cancer Cell Biology, Imperial College, I felt more called to work directly with people and I became an embedded researcher at Breast Cancer Haven where I evaluated the service providing complementary therapies for women with breast cancer – a great way to marry up my interest in complementary medicine, research and cancer. Through this position and in collaboration with Penny Brohn Cancer Centre, the Measure Yourself Concerns and Wellbeing (MYCaW) tool was developed and validated, a tool used internationally today. Over the past 15 years I have been pioneering ways to promote a more integrated approach to caring for people.

After several years of working steadily with my co-chair Dr Michael Dixon, and the Social Prescribing Network steering committee, alongside regional leads, special interest group leads and research collaborators, I can now say that we all feel heartened by the evident progress social prescribing is making.

When we originally won seed award funding from The Wellcome Trust, our aim was to research social prescribing outcomes, but also to understand the theoretical basis underpinning health creation in this context and to bring together a stakeholder network. I had in mind at the time a network of researchers who were undertaking pragmatic mixed-methods approaches to data collection, and to share how they were doing things. However, growth of the network has been so rapid that only in the last year have we started to turn our attention seriously to research.

As my background is broadly as an academic and a researcher, I felt it was crucial to bring the research

community together to review our findings, hear one another's challenges and explore the research methods that were working and find out about those that weren't. So, we held the first International Social Prescribing Network Research Conference at the University of Salford in June 2018: 15 presentations, 30 posters, a superb keynote from Dr William Bird, and all of this rounded off with a choir! Interactive feedback captured during the conference highlighted sustainable funding of social prescribing as the biggest concern, and realist mixed-methods research as the best working approach. Presentations and posters and a report from the conference are all available on our website (www.socialprescribingnetwork.com/resources).

Views on what 'evidence' is needed to support the expansion of social prescribing seems to be broadly determined by professional background, though not always so. Below I briefly examine the changing research paradigm we are living through, and

the challenges that researching social prescribing present.

The changing theoretical model of care

The NHS Five Year Forward View envisions a more primary care focused service, in which, as The King's Fund has commented, reducing health inequalities will be crucial. Such a shift in emphasis towards prevention (and wellbeing) implies a less biomedical, more biopsychosocial model of care that attends to the overlapping dimensions of human life. This is great news, though it presents many challenges for the worlds of research, policy and commissioning.

- 1 In the (bio)medical world, the dominant model is evidence-based medicine (EBM). EBM proposes a hierarchy of evidence depending on the designs and methods used to collect and analyse data. This implies that the method at the top

of the pyramid is best 'evidence' for the effect of an intervention. In the case of a pharmaceutical drug, the term 'efficacy' directly links a cause (the drug) with an effect (usually a quantitative outcome) using a research design (usually a randomised controlled trial) that rules out bias and extraneous variables, and in which people can be randomly assigned to active 'blinded' treatment or control groups. Randomised controlled trials (RCTs) have for many years been seen as the 'gold standard' of evidence for pharmaceutical and clinical biomedical research. However, social prescribing is not like a drug, and the experimental rigours of an RCT are neither practical nor appropriate when evaluating a complex biopsychosocial approach for supporting people, at a time when they may be at their most vulnerable. See Greenhalgh (2014) and Greenhalgh and Papoutsi (2018) for more discussion on the issues associated with EBM and randomised controlled trials.

“The experimental rigours of an RCT are neither practical nor appropriate when evaluating a complex biopsychosocial approach”

Using realist and pragmatic approaches

When researching complex interventions such as social prescribing, we have to move away from the notion that RCTs are the *only* source of the types of 'credible data' required to inform policy and investment. In reality a range of research methods and designs are more relevant to the biopsychosocial field than RCTs. Nonetheless, research funders, policymakers and commissioners tend to expect evidence to be based on RCTs. Yet on the ground, researchers are finding that realistic and pragmatic methods are more successful ways of collecting the kind of data that's actually relevant, because they set out to observe and understand what is working best, for whom and why (Pawson and Tilley, 1997): for example action-research designs, mixed-methods and qualitative research, case studies and interviews focusing on an individual's experience. These approaches can enrich and complement the available quantitative data and help us understand the 'why' and 'how' of the outcomes achieved. Furthermore, action research, by feeding back data to service users and stakeholders who provide social prescribing (SP) schemes, can improve the implementation of new and make existing schemes more effective.

Challenges for current and future social prescribing research

All research fields have interesting challenges to overcome, and SP is no exception. These are briefly explored below (in no particular order).

- Social prescribing, though it's been around for quite a while, is still an emerging research field, with no sustainable funding behind it. Despite this, nearly all social prescribing schemes understand they need have some associated evaluation or research. Views vary – depending on the perspective of the professional you are talking to – as to what sort of data will satisfy commissioners and funders. My research group at the University of Westminster, in collating and researching all outcomes associated with social prescribing, has already extracted data from as many research papers and evaluation reports as we could access in the public domain. We have noted that in many of these reports, outcomes associated with debt, welfare, legal advice, employability and housing are not consistently included. To get a fuller picture of these under-represented areas we have begun consulting with stakeholders and link workers to establish a consensus, so that we will know the relevant outcome measurement tools to use.
- Social prescribing has few associated funding streams. Funders are now starting to review their strategies so they can properly consider supporting research on social prescribing. This positive move will only bear fruit however, if funders see the value of research designs other than controlled clinical studies, and if applications are appraised by reviewers with appropriate knowledge of these research methods and their relevance to SP.
- It typically takes 12–18 months to set up a social prescribing scheme from scratch. The first year is primarily spent developing relationships between the professional sectors involved. To guide and refine such emerging schemes, they have to be studied, using realistic and pragmatic approaches, as they are being developed and rolled out. The initial stages of developmental research such as this don't produce traditional patient or service outcomes; they only come along a few years later once the service is fully established.
- It can be difficult to establish a baseline measure of a person at the point before they enter a social prescribing project; at the point of first referral would be ideal. But even if a person experiencing mental health episodes, or food poverty, or who is about to be evicted from home, saw the relevance of taking part in a social prescribing research project, who would carry this data collection out? If link workers were to be involved at this stage it would add an additional dimension of training and support. Practical as that could be, in reality the link worker is doing a crucial and careful job of building a relationship with the

client, and getting entangled with research questions could get in the way of this process. So it will be crucial to find ways to discreetly capture relevant early data without burdening participants.

So where does this leave the 'evidence base'?

From a (bio)medical perspective there are too few RCTs for a meaningful systematic review. However, the growing number of mixed-methods evaluations being carried out are capturing change in wellbeing or quality of life, health system usage and more specific outcomes. A range of research projects using action research are working on understanding how to implement social prescribing efficiently, and other studies are seeking to understand what we need to be measuring, when and how.

Unexpectedly good progress is already being made in this emerging field, even though it lacks sustainable

funding, has very few dedicated funding streams, and the need to study biopsychosocial healthcare using pragmatic as well as traditional approaches is only slowly being understood. But Rome wasn't built in a day, and plenty of engaged researchers are now prepared to submit grants for research into social prescribing. I predict a real shift in understanding of social prescribing over the next five years thanks to all the researchers and evaluators who have contributed to the evidence base to date. Viva la social prescribing!

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COLLEGE OF MEDICINE AND INTEGRATED HEALTH

Join our two-day College of Medicine Foundation Course 15th and 16th November 2018

This two-day course led by Professor David Peters and Dr Michael Dixon will provide an introduction to integrated health and care. It is open to all clinicians and therapists but should be particularly helpful for GPs and nurses who are interested in looking beyond the conventional biomedical box.

Limited spaces still available.

When:	Thursday 15th–Friday 16th November 2018
Where:	Diorama Arts Centre, London
Tickets:	College of Medicine members £250, non-members £350

The course will include sessions on lifestyle approaches, social prescribing, mind/body therapies and cover most mainstream complementary therapies.

The aim of the course is to demonstrate our healing potential beyond prescribing and referral, to provide information that will be useful in discussing non-conventional treatment options with patients and to teach some basic skills that can be used in clinical practice.

Our foundation course will be held at the Diorama Arts Centre in London – an educational charity supporting the arts and the community of the London borough of Camden. There will be a chance to hear national experts speak on their particular areas of integrated medicine and an opportunity for all those attending to create their own plans for future clinical practice.

Full details and booking information can be found at
<https://collegeofmedicine.org.uk/events/#!event-list>

Compassionate Frome – working towards a more connected community

Helen Kingston

GP



Our project sought systematically to identify people who might need a particular kind of support. As we found ways to work as one team strong supportive networks have developed across the different parts of the NHS social care and voluntary sector in our community. Having a team with shared values has given us confidence and energy to continue to try and make a difference. The savings suggest that this way of working improves quality of care, and offers us the possibility of a sustainable self-financing new model.

I set up the Compassionate Frome project with Jenny Hartnoll in 2013. As the project has grown and expanded across the Mendips, I also worked closely with compassionate communities. The project was designed to better connect and support patients and improve working lives for those in healthcare. It has also demonstrated cost savings as a by-product of this patient-centred approach. In July this year I was awarded a Point of Light award by the Prime Minister on behalf of the team for the work and its achievements.

Our project began in 2013, partly as a response to patients whose problems required more than medication, but in an environment where clinicians were ever more expected to rely on linear algorithms for single diseases. Each of us is, after all, so much more than a list of our diseases, and these constraints seemed increasingly to distract from what was most important to the individual.

In each one of us there are qualities to love and admire: some of us are more extrovert, more confident and more able to take the opportunities that life may provide us. Our sometimes contradictory emotions, and the history of how we have become who we are today, are what makes us human. We need to understand each other's frailties and imperfections and find acceptance, because the connections we make with our fellow human beings are an essential part of what makes life worth living.

When faced with a simple problem most of us can make the right decision. However, someone faced with a complex mix of conflicting emotions, previous adverse experiences and a lack of self-confidence might well struggle to move forward. To help someone in this predicament to make progress we must first understand their perspective and what is most important to them. This will require

empathy, listening skills and time to connect and understand. Professionals can help but equally friends, neighbours and family members also have these abilities. and they in turn may be best placed to offer these gifts. By building a more connected community everyone benefits, but in particular those who lack connectedness, some of whom are among the most vulnerable in our community.

Reaching out

Our project sought proactively and systematically to identify people who might need this kind of support. For instance we contacted anyone discharged from hospital after an emergency admission, and we set out to identify anyone who – whether at a home visit, or at an appointment – had appeared to be at a crossroads or indeed in crisis. We believed that in such vulnerable times, networks of support either became visible or were most obviously needed, and that the impetus to make a change in the pattern of life could become more activated.

A hub team working within our GP surgery has time protected for carrying out this important work and to offer support. To link up concerns and co-ordinate the care of those most in need, our hub nurse is available for

case discussions with hospital staff, ambulance teams and community colleagues. This will not happen if liaison activity has to be squeezed between consultations and phone calls in the normal busy working day. The role provides her the space and time needed for implementing a proactive approach. This allows us to work systematically across our whole population to ensure that we provide consistent care to those at higher risk. We have sought to avoid criteria and thresholds for our service however, and have been able to offer this holistic approach to others not in crisis and who may not have such high immediate needs.

And of course the health services are only a very small part of individuals' lives. We are touchpoints for some but not all of our community. Last year our website had over 45,000 hits. With the support of the Frome town council we were able to appoint a volunteer co-ordinator who set up a training programme for interested members of our community to become community connectors. These are individuals who know about the resources we have on our website and the health connections service and are able to signpost family, friends and neighbours and those they meet in day-to-day life. Each community connector may have on average 20 conversations each year but with nearly 700 community connectors doing this, it means 14,000 conversations annually.

Having a database of community resources at our fingertips has been a key enabler to different kinds of conversations. Sometimes the preferred solution to a problem might lie within an individual's existing network of support, so a discussion about the options will enable or precipitate a conversation with loved ones. Where individuals need more support our team of health connectors can work one-to-one with individuals. Sometimes this can be a nudge that allows clinical staff to have structured consultations around what matters, and has led to an exploration of possibilities.



So what have our patients said?

The improvements we have been able to measure tell us that patients experience greater wellbeing, and feel more supported and connected.

Health Connections Mendip 2016/17 statistics

- 81% of (HCM) patients saw an improvement in wellbeing (WEMWBS)
- 83% of patients saw an increase in PAM score (patient activation)
- 93% of patients said they felt more able to access support in the community
- 92% of GP practice staff felt confident that their patients benefit from being signposted to HCM

2017/18 snapshot of patients over a week

- 95.6% said they have more connections/friends as a consequence of using the service
- 87% said their emotional wellbeing had improved since using the service
- 82.5% said they felt more connected to the community
- 56.5% said they felt they have visited the GP less frequently as a result of using the service.

In the three years of a fully embedded model, the Compassionate Frome project has shown year-on-year reductions in the number of patients being admitted as emergencies to hospital.

Frome medical practice has seen a decrease of 160 emergency admissions (-6.2%) when comparing the full 2017/18 year with the baseline (2013/14). During the same

time periods the rest of our community in Somerset has seen an increase of 13,997 emergency admissions (+26.6%) across the patch.

The savings suggest that not only does this way of working improve the quality of care provided, but that it offers us the possibility of a sustainable self-financing new model of care.

We set out to improve care. We wanted to understand each individual's strengths and weaknesses and adapt the care provided to their needs and priorities. These savings have been achieved by allowing the individual to prioritise what is right for them and by treating each individual as a whole rather than narrowly focusing on what would be the least costly option for a named disease or condition. This is not just the right thing to do but our results suggest it is also more cost-effective, and it has begun to change the kind of the conversations I have in my consultations from being about 'what are you going to do for me?' to conversations about 'this is what I am planning to do next about my situation'. Patients who might formerly have come with a list of problems hoping to get answers now come with a clearer sense of their priorities and of next steps for improving their lives. As clinicians we have a sense of making a difference to what really matters and with that comes a sense of pride and satisfaction in the work that we do.

There has been a transformation too in the relationships across our local health service. We are now working as one team by building trust and developing strong supportive networks across the different parts of the NHS social care and voluntary sector in our community. We now have a culture of co-operation and

pragmatism that comes from a unified goal to do what is right. I feel supported by colleagues in our health connections team, in community services, in social care and voluntary organisations such as Citizens Advice. By nurturing supportive relationships across the wider team, this collaborative working feels safer, more effective and more sustainable.

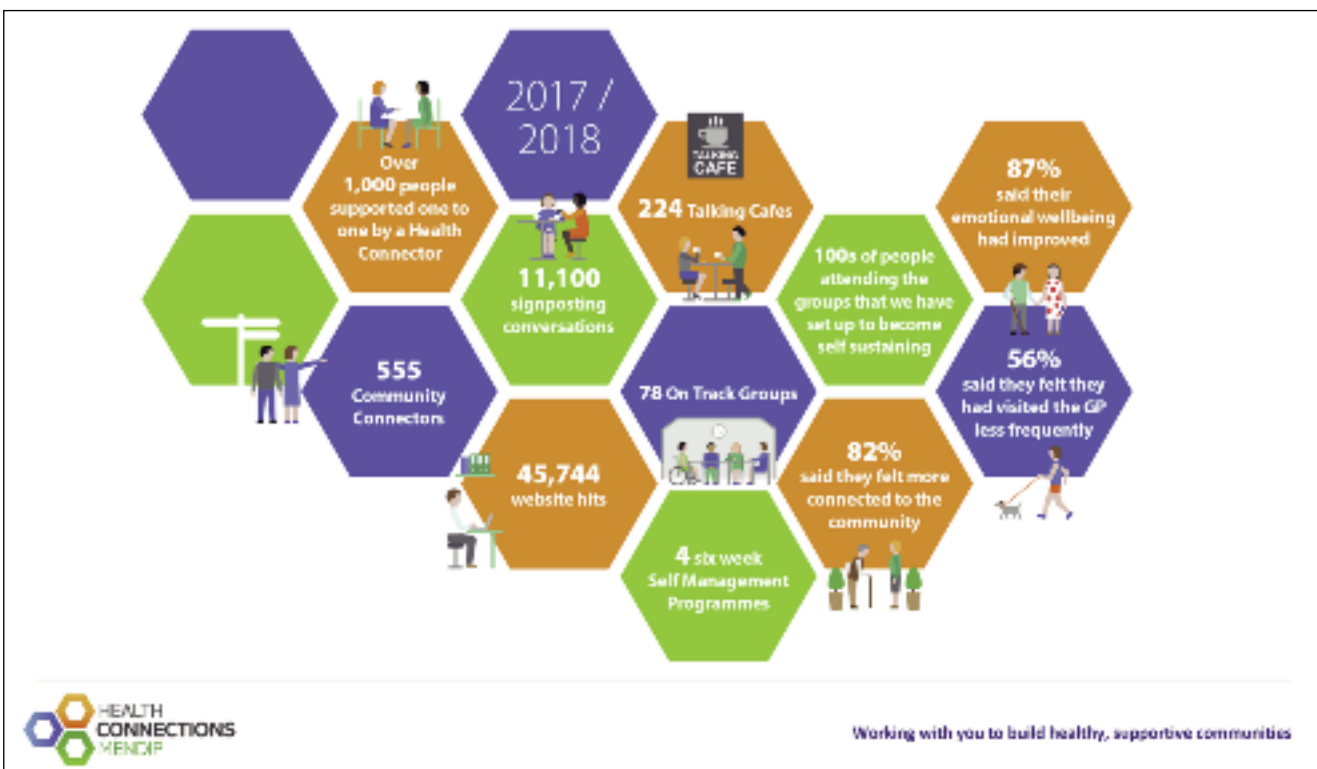
There has been a great deal of discussion about resilience training to help staff withstand the pressures of rising workloads, rising patient expectations and the blame culture of modern society. Speaking personally, our project has nurtured me and provided a supportive framework that helps me withstand some of the moral distress of working in a service that no longer has the capacity to manage what is expected and needed (Oliver, 2018). It offers hope that the art of my profession can be respected and valued as well as its scientific basis. It is giving us back time to care.

Connectedness helps us all. Together we are stronger, and having our team gives me confidence and energy to continue to try and make a difference. I draw strength from seeing the impact that our project has made on my patients' lives. In the same way I have felt the impact of belonging to a supportive team with shared values.

We are grateful to Somerset CCG and to the partners of Frome medical practice who have funded this project and allowed it to flourish. With support from Compassionate Communities UK, the model is now being considered in other health communities.

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The true potential of social prescribing

Marion Steiner

GP; Self-Care Lead for Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group



Vulnerable patients with non-medical needs may feel the safe space of a familiar general practice is the only place to turn to. A range of support stretches from simply signposting someone who is isolated, to options in the community (potentially by reception staff), all the way to in-depth work with a link worker using a holistic asset-based approach tailored to a patient's individual ideas, needs and resources. Their skill seems to be a key to making sustainable improvements in wellbeing. To succeed SP needs to involve minimum GP referral effort and maximum feedback on outcomes.

A cycle ride through parkland is a good start to my day at work – birdsong, the murmur of water and wisdom of trees. During 30 years as a GP, I've learnt what I need to maintain therapeutic energy. Drawing on many sources to broaden knowledge and nourish my consultations, I seek to be an integrative doctor. Over years, treatments and lifestyles have become more sophisticated, life expectancy has lengthened, and the need for perspective, balance and shared decision-making has grown.

A visit to the GP

Mrs Chowdry, an 81-year-old widow, notices the smell of blossom as she walks up the path. She can hear a group of people laughing in the Living Well practice kitchen as they learn how to make cordial from the flowers they've picked on their weekly walk, led by a patient volunteer.

At the welcome desk, she's greeted by a health navigator, measures her own blood pressure – nice and low – and sits down to read *Poems in the Waiting Room*. She looks forward to picking up her quarterly copy, and afterwards sharing it with an elderly neighbour, who she met at Pilates for Pensioners. The waiting room is looking fresh, with a bright new Five Ways to Wellbeing display, and a young mother is using the exercise bike while she waits for her postnatal check, her baby asleep in its pram.

Mrs Chowdry is here for a medication review. She had her blood results sent to her mobile phone. It's been adapted for her arthritic fingers, and she finds it a really useful way to get answers to her questions and communicate with family, friends and her long-term conditions nurse. The text message sent out by the practice about this appointment included some simple questions to help her make the most of her time with her GP.

She feels she's doing pretty well, especially after going to Fun Food for Health classes run by local sixth form

science students helped by the community diabetes champion. She was bored with cooking the same things for herself every week, and is glad of new recipes and new friends to try them out on. But she'd like to take fewer tablets and she's worried about feeling a bit wobbly at times...

Dr Simon, her GP, is feeling ready for his first patient. He has cycled to work along the Green City cycle route, avoiding traffic jams and arriving in time for a whole team breakfast, organised by the practice manager who has recently run a mindfulness course. It was Simon's turn to bring the bread as he'd surprised colleagues by taking up baking: kneading dough, he found, was an excellent way to work off frustrations with the NHS, and much better than kicking the cat. They also shared some of the first raspberries from the community garden, sited on a previously derelict plot of land behind the practice.

Simon's relationship with Mrs Chowdry has evolved over several years. He used to feel his irritable bowel stirring up at the prospect of morning surgery dragging on interminably. Back then he was always glad that she was happy simply to listen to what he had to say, accept her prescription, and leave. As far as he was concerned 'shared decision-making' was a load of politically correct twaddle, wasting time better spent on improving QOF achievement to maximise practice income.

The true potential of social prescribing

But he had to admit that things had changed after the social prescribing training. He found he was enjoying being a GP again, and that somehow patients like Mrs C seemed to have changed the way they talked to him too; he didn't feel so responsible for everything and could even enjoy a joke or two. He felt a glow of pride in statistics showing how locality numbers for A&E attendances and admission rates had fallen by about 20% over the two years since the social prescribing system had started. Of course, the practices didn't take all the credit. Casualty staff and social workers now understood that regular attenders with lots of health issues came back less often if social prescribing co-ordinators unpacked their underlying problem. Lately even junior doctors had begun coming to the community hub for a week during their training.

Mrs C's consultation flows along. They discuss results noticing that he has let go of his old impulse to control her diabetes too tightly. They agree that she'll stop one of her tablets, and after listening carefully to her worries about unsteadiness, he examines and reassures her that there are things she could do that might help. They discuss the options and she decides to try a strength and balance class at the local youth centre. She was hoping he'd suggest this, as she's heard they're good fun.

After she's left, he pauses for a moment to enjoy the satisfactory list of drugs she's been able to stop... Mirtazapine, Amlodipine, Pioglitazone – poetic almost. Better for her, for the NHS budget, and for the otters in the river.

This is a fictional story, but it's only a stone's throw from reality – all of its elements are happening here and now, just not all in the same place, at the same time. It's a story that has been slowly but surely emerging as part of a creative and wholesome solution to the many problems of an overburdened system that depletes patients and clinicians of their power and energy.

'Social prescribing', a term coined decades ago, has meant many things in different contexts.

Social prescribing and self-care

When I first trained as a GP, we had got as far as acknowledging that psychosocial factors had to be taken into account in the consultation, and that the way doctors communicate exerts a crucial influence on medical treatment outcomes. So far so passive! Several steps on from this, we now see that patients too are critically involved in this process, that what *they believe* they need in order to feel better is a huge factor, as is their way of life and their access to relationship and community. All are vital elements in the wellspring from which true health derives.

It is our responsibility not to get in the way of this connection, for it allows a flow towards what we might call self-care. The 'first do no harm' principle of the

Henleaze Lake, Bristol, site of a wellbeing course run by Southmead Development Trust as part of its Healthy Alternatives Social Prescribing Project.

Photographer: Mark Thompson



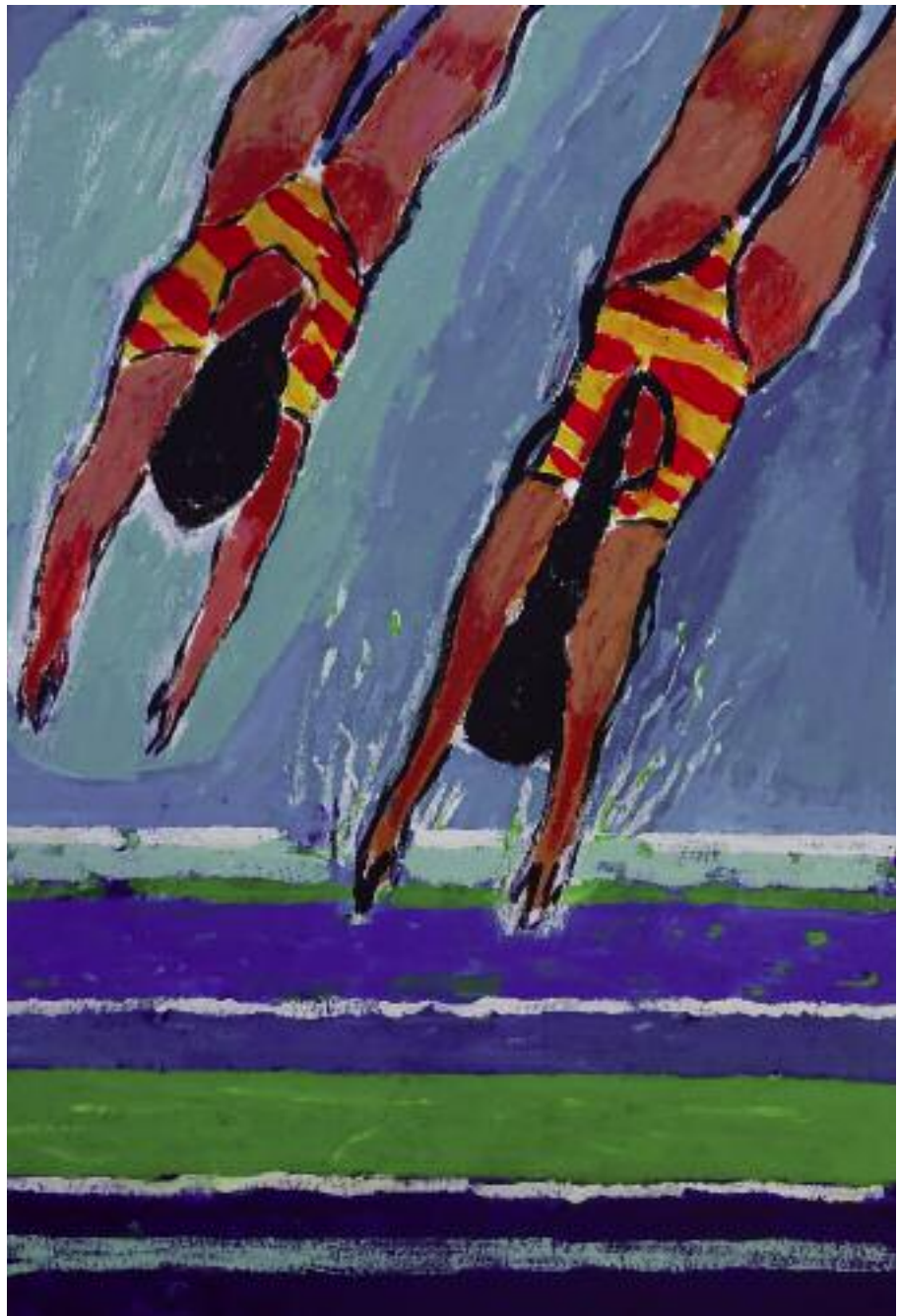
Hippocratic Oath should apply not only to treatments such as drugs or surgery, but also to the way we engage with patients across the healthcare system. My, as yet unproven, hypothesis is that all the ways in which we engage with patients, through public health messages, making appointments, referral letters, discharge summaries... play an important part in how much they feel involved or are 'activated'. This is the official term, as judged by Patient Activation Measures (Hibbard *et al*, 2004), licenses for which have been purchased by NHS England in recognition that patients experience better outcomes when they are activated and that they cost the health and social care systems less.

Social prescribing and the environment

A project on medicines waste (Gibbs, 2016) in Bristol's European Green Capital year looked at the problem from many different perspectives and asked what might change. The annual cost of primary care prescription medicines waste in the Bristol CCG area alone was estimated as at least £5.7 million. An estimated 972 tonnes of Bristol medicines waste is going into landfill each year, costing £443,926.68 for its disposal. Among the factors that emerged during focus groups with over 1,000 patients was that a large majority would like to use more non-medical resources to support health. Reducing waste is an imperative for the environment and could save millions for the NHS, which could be invested in community social prescribing initiatives across the whole country.

Social prescribing and the community

Disadvantaged communities in particular can benefit from a primary care approach that, by inviting the community in and allowing the practice to step outside, breaks down barriers between organisations supporting health. Nationally, there are several excellent examples of this, the Bromley by Bow Centre in London being the trailblazer.



Divers: Maya Cockburn www.mayacockburn.com

The Bromley by Bow model grew from its community, and aspires to create 'vibrant and healthy communities, person by person' The approach supports and builds on personal and community assets that are a renewable and sustainable resource. Over 30 years later it remains a thriving project in an area of deprivation and diversity: this success relates closely to the carefully nurtured roots from which it has grown, and the spirit and joyful commitment of those involved ('Unleashing Healthy Communities: researching the Bromley by Bow model' (Stocks-Rankin *et al*, 2018) is very relevant reading).

Another example of innovative change that benefits both community and general practice, is the *Altogether Better* health champions programme.

'Health champions are people who, with training and support, voluntarily bring their ability to relate to people and their own life experience to transform health and well-being in their communities' (Altogether Better, 2018).

GP practices can benefit from incorporating health champion patients into their team to support patients and staff, and practices that have done this have tended to grow and thrive despite the ongoing challenges of reduced funding and limited clinical manpower.

Social prescribing and primary care

'Enabling healthcare professionals to refer patients to a link worker to co-design a non-clinical social prescription to improve their health and wellbeing.'

This shortened definition emerged from the Social Prescribing Network Conference Report 2016, and is contained in the University of Westminster's guide *Making Sense of Social Prescribing* (Polley *et al*, 2017).

Some people can access resources directly, but many vulnerable patients choose to bring their (often non-medical) needs to the safe space of a familiar general practice. Therefore an access framework which allows different levels of support is obviously needed. In my experience, to be successful, it should involve minimum GP referral effort and maximum feedback on outcomes. This ranges from a signposting role, for which reception staff can be trained, to what has been called a 'holistic' approach in which a social prescribing link worker meets the patient for a number of sessions. The skill of the worker in using an 'asset-based approach', building on resources patients may have in their life, seems central to sustainable improvement in wellbeing.

A case study

Stan is a 77-year-old man whose GP referred him for support for improving his diet by learning to cook. At initial assessment with our social prescribing link worker, it emerged that he was very low because his wife, who did all the cooking, had left him three years ago, after 53 years of marriage. He had made since three serious suicide attempts and had been drinking very heavily. He was noted to be very tearful, expressing deep loneliness and dejection.

He was very reluctant to access local addiction support services because he felt that this was just for young street drinkers and drug takers. He was helped and encouraged to make an initial appointment despite these worries. He eventually attended weekly and began to cut down on his drinking, but continued to need link worker support to develop an honest and trusting relationship with the addiction counsellors.

Stan, though he had previously rejected the idea of any sort of mental health treatment, then started to attend

weekly support group sessions. There he was noted to be particularly valued for his re-emerging sense of humour and, as he developed relationships with others in the group, he found the confidence to join the life recovery group.

Stan mentioned that he had previously been referred to a chronic obstructive pulmonary disease (COPD) exercise course. He only been only once, due to his very low mood, but remembered enjoying it and felt he could have got a lot out of it. He was re-referred to the programme, and through this he started better breathing classes and the supported exercise sessions at the gym. The improvement in his exercise tolerance and confidence meant that he no longer felt the need to apply for a disability parking permit; something he had discussed during initial meetings.

Stan comes to the centre most days now to use the gym, take part in walking football classes, and chat in the café. Many people have noted how very different he seems to the unkempt, downcast man he was, and more formal evidence for this comes from the improvement in his Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS). Nor has he needed any medication to reach this place. And now he is cooking for himself.

Sadly, just at a time when he feels that he has a lot more to live for, Stan has been diagnosed with a terminal cancer. He came to the centre as soon as he found out, seeking the support of a volunteer counsellor. He knows that whatever the future holds, he's in a much better place to face it, and he won't be alone.

With thanks to Colette Brown, of Healthy Alternatives, Southmead Development Trust, for this case study.

And finally, possibly the first social prescribing-inspired Haiku.

Pain flows deep and dark
Need to find my precious light
Guide me to my spark

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Social prescribing – a layman's perspective

Peter Donnebauer

Layperson trustee of the BHMA; pioneering moving image artist and media entrepreneur



Social prescribing looks at patients' wider social needs and makes referrals to community-based non-clinical services. 35 years after the BHMA was born, it can celebrate SP as a sign that holistic healthcare has at last gone mainstream. Crucially SP signals the fact that many problems can't be solved by money or pills, and implies the possibility that (with help where needed) we can (and should) be more fully engaged with maintaining or recovering our own health and wellbeing. To make this possible GPs will need to be supported by liaison staff.

I have been interested in alternative approaches to drug-based 'treatments' since being prescribed tranquillisers for random panic attacks in my teens in the 60s. My instinct then told me that this was not treating the cause(s) of my condition; this was verified some five years later when I was one of the first people in the country to be officially diagnosed with hypoglycaemia. A week after the six-hour blood sugar test I had changed my diet accordingly and that was the last time I needed help from the medical profession for my 'symptoms'. Medical understanding has moved on since then, and the internet is a powerful source of patient information, but my instinct remains to use drugs only as a last resort. I have been a layperson trustee of the BHMA for the past few years as it remains the only organisation committed to promoting a person-centred rather than a symptom-centred approach to 'illness'.

Social prescribing IS holistic healthcare in practice

An article in Pulse broke the surprising news that health regulator NICE is calling for GPs to signpost patients at risk from loneliness and isolation to local singing, arts and crafts and walking groups, to help them stay healthy and keep living independent lives. General practice could receive an extra £1 per patient towards improving access to social prescribing by 2017/18 according to NHS England's clinical champion for social prescribing (Wickware, 2016).

Social prescribing (SP) is all about looking at patients' wider social needs in order to make referrals to community-based non-clinical services, ideally with the GP being supported by liaison staff. So, 35 years after the BHMA was born, it has cause to celebrate this as a sign that holistic healthcare has gone mainstream!

SP is holistic even though its name comes straight out of the medical model in which the dispassionate professional observes, analyses, diagnoses and *prescribes*. Yet this raises an issue for me, because we 'patients' have too easily and for too long accepted that the doctor is

someone who knows more than we do about our ill-health or dis-ease, and can diagnose – ie tell us what is wrong, and then *prescribe* something for us, and then tell us what we need. Thankfully – and SP is a sign of this – there is at last a growing acceptance that the 'something prescribed' doesn't have to be a drug. This is great news for patients, and possibly for doctors too. However, even if the doctor *is* correct about what we need, the *social prescription* is going to demand a lot more from the patient than a trip to the chemist and a prescription charge!

No more magic bullets?

The fact is that many problems can't be solved by money or pills. This is in itself a crucially important message. Instead, SP relies on the possibility that (with help) we can (and should) be more fully engaged with our own health and wellbeing. The social prescription moreover requires us to be actively involved in activities within our local community: a double whammy in that it will probably benefit not just the individual, but the community too, and the NHS as well of course. As a report published by the

Social Prescribing Network (a group dedicated to supporting SP at local and national levels) says: 'Social prescribing could help reduce pressure on health and care services by referring patients seeking help for non-medical issues to community based non-clinical services...since... around 20% of patients consult GPs for problems that are primarily social rather than medical, and dealing with these needs is important because social and economic factors affect health outcomes' (Torjeson, 2016).

“ SP is holistic even though its name comes straight out of the medical model ”

Of course not everyone, including drug companies, will celebrate if doctors are required to push us to live more active and engaged lifestyles. The nation ought to applaud though, because the government exhorting us to eat five a day or to take 10,000 steps a day has not worked. Is this because the UK population is not yet well-educated and wealthy enough to make health-enhancing lifestyle changes? Perhaps we need the leadership and support of a new kind of primary care organisation or emphasis, and less that of celebrity culture and *The Daily Mail*.

Social prescribing is holism by the back door

Or perhaps it's via the front door but in disguise! It *is* holistic in the sense that it does not focus on simply eliminating symptoms. Instead SP is interested in boosting resilience by asking what the individual can do to better manage their own dis-ease and promote wider wellbeing. Even though it might not appear to the doctor, or even the patient themselves, to be holistic, the prescribed activity will probably have improvements beyond symptomatic relief. And there will be other side-benefits if SP allows hard pressed GPs to offer something for those patients who are 'repeat visitors' without conventionally 'treatable' medical issues. What's more, SP reinforces the role of GPs as a central part of the local community. Potentially at least, SP supports the financial health of the local community too, by encouraging people to spend time and money locally; and it saves the NHS money on medicines that may not even be taken by the patient, for it is well known many patients do not like to take drugs, or take them erratically.

SP usually depends on secondary advisors and supporters who take some time pressure off GPs, allowing them to use their professional time more effectively for attending to medical issues that they can treat 'conventionally'. And, in the longer term, it will hopefully discourage passivity from patients and empower them to realise that they can have a positive impact on their own health.

Unspoken aspects of the doctor-patient consultation

Social prescribing illuminates something important about the doctor-patient consultation. I see this as a 'two person game' with particular social rules – a kind of play-acting of accepted social roles – where authenticity is probably the exception rather than the rule; the unspoken and assumed conventions contextualise and define the situation. I have known many people who go to doctors for a diagnosis, and leave the consultation with a prescription for drugs that they have little or no intention of ever using, unless their condition was serious or life-threatening. It is not authentic for the patient to pretend to accept the doctor's unspoken rules and conventions where the expected outcome will most usually be the prescribing of drugs.

Perhaps this reluctance to be honest about why they consulted is to do with a misplaced English sense of politeness. But with the necessary feedback loop broken, the doctor has no information about what the patient actually wanted, nor any reason to do things differently. One expensive result is overprescribing, which I tackled in an earlier JHH article about my osteoporosis (Donnebauer, 2015). Researchers found that in 2013 overall, around a quarter to a third of patients either failed to take their prescribed medications or didn't take them as directed. The estimated cost to the NHS in the UK is more than £500 million every year (Langley and Bush, 2014). One should then add in the potential human loss of an authentic interaction, the unintended side-effects of drugs, the cost pressures on the NHS and the ineffective use of GPs' time, which is in short supply, with many burning out or retiring early. 'Knee-jerk' prescribing undervalues the benefits of GPs' human-to-human role. With the predicted rise of robot competition in the form of AI diagnosis and prescription one can see many compelling reasons why the GP consultation could do with a fundamental makeover.

Social prescribing is the chink in the armour of evidence-based medicine

Does evidence-based medicine actually underpin current consulting practice and GP action? Research by Peter Gotzsche (2016) referred to in the *British Medical Journal* blog suggests that prescription medicines are the third largest killer of patients after heart disease and cancer.

This is why I hope SP will be a seed, whether consciously or not, for the practice of holistic healthcare. Whatever its many intrinsic benefits for individuals, it will open up debate about what holistic GP consultations and extended services can achieve. This is clearly important in an ageing population with complex healthcare needs and the ever-increasing financial and resource pressures on the NHS. And surely, in an age when everyone can access so

much varied information about medical matters on the internet, SP just feels more 'modern'.

Are there any downsides?

The only downside I can foresee is that it moves the patient out of the GP surgery environment into potentially unregulated areas. Even so, the kinds of non-medical engagement recommended under SP surely need regulating far less than do doctors and medicines. Presumably doctors will be aware if a patient is vulnerable from reduced mental capacity for example, and good practice would anyway have the patient return for GP review.

It may only be a small beginning, but holistic healthcare is going mainstream.

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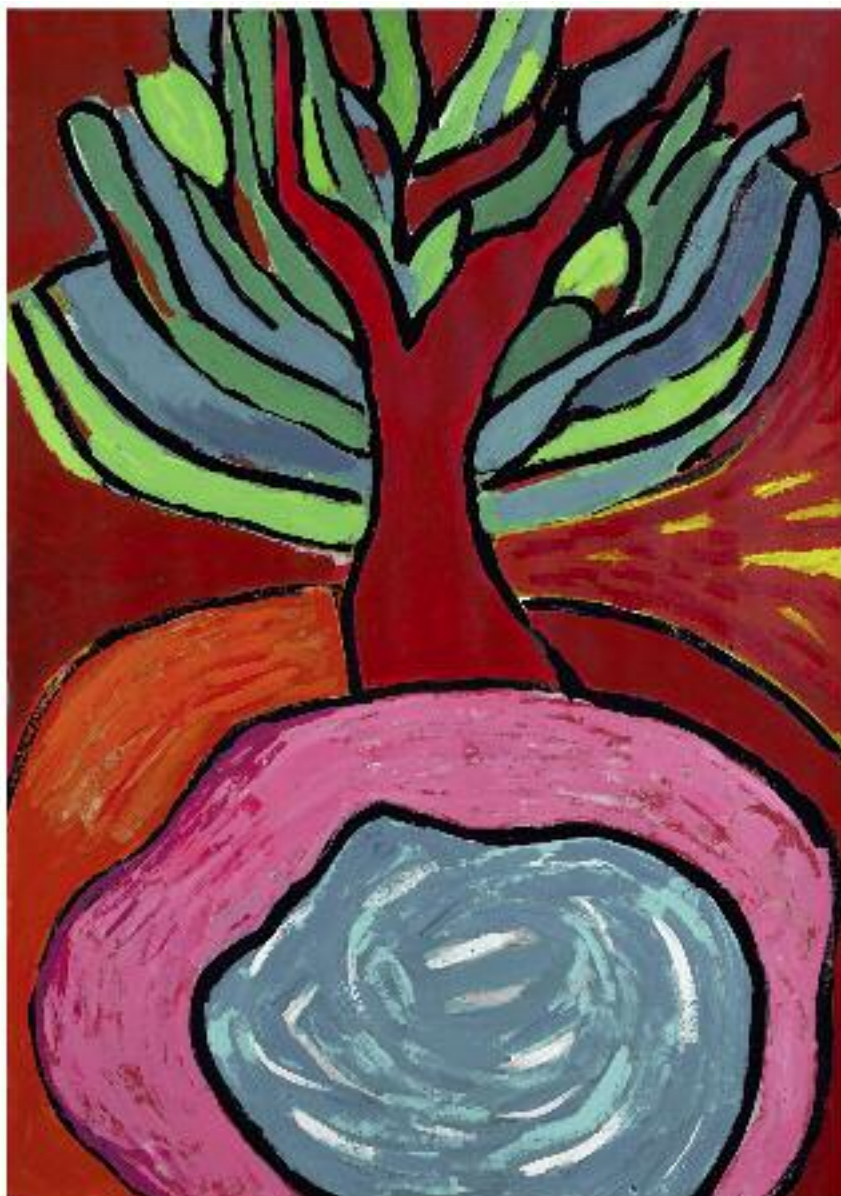
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Tranquility by Maya Cockburn www.mayacockburn.com

Social prescribing for equality and resilience: the SPEAR project

Collette Brown

Social Prescribing Co-ordinator, Southmead Development Trust



SPEAR is a holistic social prescribing model operating across Bristol's areas of highest social deprivation and health inequity. It is a partnership between four community anchor organisations based in geographically discrete areas. Individuals are mostly referred to SPEAR by a health professional, but they can also self-refer. They then meet a social prescribing link worker for an initial one-to-one session. This article explores the ways the communities in which SPEAR operates have determined the shape that the project has taken, showing the context specificity of social prescribing.

After leaving the Bristol student bubble in 2012, my eyes were opened to the stark inequality faced by the city's residents. Volunteering played a big part in this – from the niggling feelings of discomfort during my internship with Oxfam where my walk to work took me past people who were struggling with homelessness, to facilitating peer support groups for people struggling with their mental health. The former saw me campaigning for equality overseas (while we seemingly ignored our own country's failures in this area) and the latter brought home just how much cuts to mental health services were affecting everyone, but especially those living in more deprived areas of Bristol. I'm passionate about challenging inequality in all its forms and yearn for a more equal society in which labels will only be used for packets of food.

'We can only provide the dancefloor. It's up to individuals how, or even if, they dance.'

Michael Marmot, 2015

In the interview for my job as social prescribing co-ordinator a few years ago, I told a story – a story that I felt reflected the idea of the way in which social prescribing would support people; that it was about the individuals that we were helping, rather than about saving the world. The story goes like this:

A man was walking along a beach, and he saw someone dancing in the distance. As he got closer, he saw that it was a young boy and he saw that he wasn't dancing – he was eagerly throwing starfish back into the sea, one by one, as they had become stranded on the beach. 'What are you doing?' he asked the young boy curiously. Without looking up, the boy replied 'I'm saving these starfish. If they aren't thrown back into the sea then they'll die.' The

man laughed. 'But there are thousands of starfish on this beach, and only one of you! What difference can you possibly make?' The boy picked up a starfish, tossed it into the water and, turning to the man replied, 'I made a difference to that one'.

From: Eiseley(1978)

And this is how a lot of people see social prescribing. Someone is really struggling with something visible, they go to their GP, and their GP suggests a non-medical activity to that person – gardening, for example. And the individual attends merrily with no barriers, feels their life has purpose once more, feels able to participate in self-care and reduce their use of NHS resources. But, as I began to design our holistic social prescribing model, and actually began to support people one-to-one in a truly person-centred way, I realised just how far away from holistic social prescribing this analogy was.

It's not about just throwing starfish back into the ocean. It's about finding out why they've become stranded in

the first place, and equipping them with tools to reduce the likelihood of them getting stranded again. It's about building resilience, increasing knowledge of self-care, and exploring the underlying reasons for the individual's struggles, then supporting them to address these underlying reasons before (and also often alongside) making steps towards accessing wider groups, activities and support. And with these groups, activities and wider support often come significant barriers – particularly in areas of multiple deprivation: money worries linked to welfare benefit and debt, caring responsibilities, physical and mental health problems and disabilities. If we threw many of the people we work with back into the ocean they would drown. Or in a few weeks' time they would be back on the beach, waiting to be rescued again. So this isn't about rescuing people. It isn't about saving people. It's about building skills and resilience within people to save and help themselves. And it's about building a community so that it's ultimately that community looking out for one another, rather than 'service providers' providing services.

SPEAR (Social Prescribing for Equality and Resilience) operates across Bristol. SPEAR focuses on the areas of highest deprivation scattered across the city. They are among the most deprived 10% of communities in the UK. Each SPEAR partner organisation (Knowle West Healthy Living Centre, Southmead Development Trust, Wellspring Healthy Living Centre and The Care Forum) is embedded in its local community. This is about person-centred, place-based health. We've been working in our areas of benefit for many, many years. We are trusted by our local communities. We have the assets of community centres. People are happy to meet a link worker at, for example, The Greenway Centre (a community hub), because their friend Beryl goes to the strength and balance class there, and Heidi from down the road works in the café. It's a safe place – like their GP surgery. But it's in, and of, the community.



The Greenway Centre, a community hub

Individuals are mostly referred to SPEAR by a health professional, but they can also self-refer. They then meet with one of our social prescribing link workers for an initial one-to-one session, which involves exploring why they feel they were referred and what support they feel they need rather than relying on their GP reasoning – the two are often different. This session also involves goal-setting – thinking about what difference that individual would like to see in their life. And this is all with the aim of supporting and equipping the individual to access what are deemed as non-medical sources of support in the community – gardening groups, exercise groups, art groups – of which there are hundreds.

Wouldn't it be great if people just came to us wanting to know where a local knit and natter group was, and then popping along to it regularly and declaring that all of their longstanding needs were now met? But, as you can probably imagine, it doesn't quite happen like this. Most people who access our service need what we call a 'supported referral'. This is invariably due to them being negatively affected by their social situation – the social determinants of their health. This results from being born (by the luck of the draw) into an area of multiple deprivation. When people have massive 'fires' burning in their lives – welfare benefits, debt, caring responsibilities, lack of education – just giving them a leaflet for an art group and arguing that this will have a massive positive benefit on them won't have much impact.

So this supported referral involves us working with the individual to help address some of these social determinants – be it form-filling, access to education, housing support or additional barriers that are preventing the individual from taking steps towards self-care. It is only when these blocks are addressed by walking alongside the individual that a relationship of trust starts to build and real and lasting change begins to happen. These individuals can then be supported to access our structured programmes – art, cooking, volunteering, physical activity and walking for health – which are each led by partner organisations. These are supported, themed groups which act as a stepping stone to community-based support and take people a step closer to taking control of their own health and wellbeing.

We work to a holistic, person-centred link worker model – tailored by each partner to the community they work in. We firmly believe that there is not a one-size fits all approach to social prescribing. The model needs to be bespoke to each community – even those communities within SPEAR. Yes, there needs to be universal social prescribing coverage across all areas, but what this coverage looks like will differ in each area according to need, demographic, level of health and wealth inequality to name but a few distinguishing features.

Some areas will need more of a community development approach – particularly areas of Bristol such as Stockwood where activities and groups to support people to access are few and far between. Others, like Southmead, will need link workers who are very skilled in welfare benefits support due to the cuts to local provision of information, advice and guidance services. Lawrence Hill will need specialist Somali-speaking link workers to ensure that the Somali families who make up a significant percentage of its demographic are able to access the support. In Greater Fishponds, community spaces are scarce and so the social prescribing project is not able to operate out of a community centre. They have adapted the model so that link workers can visit individuals in their own homes, meet them in a café or any other space where they feel safe.

As such, SPEAR is a locality model – working with the strengths in each of our partner's communities. Hence the model differs in each area of benefit. The asset of Southmead Development Trust's community gym means that supported, specialised exercise sessions for individuals with specific long-term health conditions is something that we can much more easily provide than the other SPEAR partners. However, the key asset of Wellspring Healthy Living Centre is a community kitchen and art room, with associated staff. This enables frequent provision of healthy cooking and wellbeing arts courses tailored to a variety of different cultures which make up their local community. Knowle West Healthy Living Centre's asset is their walking-for-health trainer, who can offer walk leader training and support to set up new walking groups. The Care Forum has established and matured volunteer projects within Greater Fishponds and is able to build on this to support their clients to progress to volunteering for SPEAR, working one-to-one with people who are referred to SPEAR, helping those people to access supported community activity whilst continuing to build on their own skills and resilience.



Knowle West Healthy Living Centre

Something which is common to all areas that SPEAR works in is the level of deep-rooted trauma suffered by individuals and that sometimes the link worker is the first person an individual has spoken to about this. Again, the approach is different between localities depending on available provision and level of need. Indeed, for three of SPEAR's partner organisations (Wellspring Healthy Living Centre, The Care Forum and Southmead Development Trust), the supported referral follows a psychosocial approach. This is reflected in the skillsets of the link workers and the greater number of referrals for individuals struggling with their mental health. Many of these troubled residents would have previously met the threshold for NHS secondary care mental health services.

“Something which is common to all areas is the level of deep-rooted trauma suffered by individuals”

Knowle West Healthy Living Centre similarly receives a significant number of referrals for people with mental health issues, and will refer to local community based mental health services or through referrals to Bristol Wellbeing Therapies or others. They also see a greater number of clients with lifestyle challenges. Due to their longstanding reputation for lifestyle support, their workers have additional training in food and nutrition and in developing peer support work.

Perhaps the draw for individuals, who might in the past have been shoehorned into other statutory services, is the truly holistic, person-centred approach that all our link workers take. For us, it's not about sticking diagnoses on people; nor is it about fitting people into the neat little boxes that society has constructed. This invariably means 'cutting bits off people', that is, reducing them to a set of problems that match a service offer.

Inevitably those unwanted bits that don't fit the service tend to be the very parts that make up the essence of their being – their individuality, their spark. The most important thing link workers have is *time to spend with people – to listen to them, to bear what they truly want and need*. Added to this, the worker must have a genuine desire for people to live the best life that they possibly can.

This ties into the asset-based approach that SPEAR partners follow. Along with asset-based community development (ABCD), which is part and parcel of our work, we also look for the strengths or 'assets' of the individuals themselves. Some of the first questions our link workers ask people are: 'What's good about your life at the moment?'

What do you enjoy doing? What works well? What's worked in the past?' Often this takes people back, because they're fully expecting to talk about all the things that are going wrong for them at the moment. But we don't see people as what they are lacking. We don't define people as 'well and able to contribute to society' or 'ill and never going to amount to anything'. Everyone has something to give to society. Everyone has a spark within them: it's about finding that spark and running with it.

Here is an example of an older woman I was working with who I supported to access our wellbeing arts programme. As a result of her getting out of the house for the first time in many months, she rekindled her love of creativity and started attending a local art group. She also began writing poetry again, and asked why I didn't set up a writing group. However it was important to our model, and to this person, that I didn't entertain this idea. Instead, I asked her why she couldn't set one up herself. Her response? 'People like me can't go around setting up groups!' 'People like you?' I asked. 'Yes, old people, people who don't have any qualifications, people from Southmead.' I challenged this. We discussed the barriers; we discussed the fear that was underlying this; we discussed the support I could provide. And now her writing group takes place every Tuesday morning and they're planning a spoken word event. As such, the work of the link worker is also about challenging the *status quo*. It's having difficult conversations with people, and showing that just because things have always been done a certain way, this doesn't mean that things have to continue to be done that way. It's asking: 'Why not?'

What is essential in all communities is that the importance of the 'pill end' of social prescribing is acknowledged, and appropriately funded. Supporting activities in the local community that people can access (along with the plethora of small, local community groups and activities) is integral to any social prescribing model. Someone once said to me 'you wouldn't expect a GP to give a patient a medical prescription then send them to an empty pharmacy. There need to be sweets in the sweet shop'. The time a link worker spends with someone is just as important as what they are ultimately supported to access. Both are essential for long-term and sustained behaviour change.

For SPEAR, this means that we invest in structured programmes. Each SPEAR partner has a specialism – wellbeing arts, kitchen on prescription, physical activity, walking for health groups and volunteering. However it also means that our co-ordinators and link workers dedicate time to community development work – be it supporting smaller organisations to apply for funding, or



Wellspring Healthy Living Centre

supporting local residents to set up new groups where there may be gaps. This also relies on strong networking between other community-based organisations and 'on the ground' workers – to share resources, knowledge and to avoid duplication.

So what does this all actually look like in practice? The story of Brian

Brian's GP referred him to our Healthy Alternatives SPEAR project. Initially Brian found it difficult to engage with the service. Our link worker phoned and left messages several times before Brian responded, saying it was unusual for him to answer as he wasn't speaking to anyone at the moment. Brian described feeling very stuck and low, and unable to motivate himself, however after the phone call with the link worker he agreed to meet her at the Greenway Centre.

At Brian's first session he described feeling very depressed, and suicidal during the winter months. He described anger issues and debt problems, and he had served several spells in prison. Brian wasn't sleeping well due to a noisy neighbour, was unhappy with the state of his flat, and mentioned that bad things had happened to him as a child but that he couldn't talk about them. Brian also had a recent diagnosis of diabetes which scared him as a family member had lost limbs due to diabetes.

With the link worker's encouragement, Brian considered the things he was appreciative of in life: his dogs, being outdoors, and his skill at darts playing. He was very keen to get out of his flat, and agreed to try our weekly gardening group, and take part in a local community cooking workshop. Brian attended these and really enjoyed the gardening group, committing to weekly attendance and building a good relationship with the facilitator, helping her at other gardening projects in the area.



Wellspring Healthy Living Centre

In further sessions the link worker supported Brian to address the practical issues of his debt and housing, alongside establishing more social activities. The link worker helped Brian apply for a charity grant for new flooring, a bed and a cooker; to fill in forms for an occupational therapist assessment for bathroom adaptations; to engage with a financial advice agency to make a Debt Relief Order; and to organise his utility and household bills so that he makes regular, manageable payments. The link worker gradually encouraged Brian to make phone calls himself. Initially he was worried about becoming angry or abusive with call staff, which was his usual reaction when stressed, but he overcame this through practising anxiety management skills. The link worker also provided foodbank vouchers when Brian's finances were tight.

“ The work of the link worker is also about challenging the status quo ”

After additional encouragement by the link worker, Brian made an appointment with a diabetic nurse to discuss his fears around his diabetes. This led to him making an appointment with Southmead Development Trust's exercise on referral co-ordinator to explore ways in which he could better manage his condition through improved diet and exercise.

Brian was keen to do more outdoor activities, and joined the supported open water swimming and social group run by Healthy Alternatives. There he met a local fisherman who encouraged him to get a licence, and offered to share kit and advice with Brian. Brian expressed

how encouraged and grateful he felt for the kindness and welcome of the people he met at the activities. Building on these successes the link worker encouraged Brian to think about volunteering, and he began voluntary work at the Greenway Centre, and has become involved with a local group setting up a new city farm.

As Brian became more confident with the link worker, he spoke about the childhood trauma which he saw as the root of his mood problems. Despite stating that he didn't want counselling or support for this, over subsequent sessions he admitted how helpful he found it to 'open up' to someone, and the link worker discussed options for ongoing support for him to continue 'opening up'. Brian engaged with a local trauma and substance abuse charity, and is on the waiting list for counselling.

“ The time a link worker spends with someone is just as important as what they are ultimately supported to access ”

Ultimately, this is about relationships. It's about believing in people, increasing their feeling of self-worth and enabling them realise that life can be different. It's about building resilience. And it's about empowerment, which means not doing anything for people that they can do for themselves. And sometimes this means people not doing what we really feel is the right thing for them. Because we don't have the right to say what the right thing is for anyone. It's up to individuals to make decisions for themselves – it's up to us to ensure that they are equipped with the knowledge that enables truly informed decisions.

“ It's about believing in people, increasing their feeling of self-worth ”

So by all means, let's throw starfish back if they're stranded. But for any sort of long-term change and prevention we also need an understanding of why they got stranded in the first place so we can make sure they don't get stranded again. Often this will involve building relationships and the facilitation of self-care that are central to a strong, person-centred, holistic social prescribing model.

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parkrun: stories of inspirational people

Simon Tobin

GP, Norwood Surgery, Southport; parkrun ambassador for health and wellbeing



parkrun is a collection of five-kilometre running events that take place every Saturday morning in 20 countries across five continents. My local parkrun has, quite simply, changed my life. The truly amazing and inspirational people I've met have transformed both my clinical practice as a GP and me as a human being. My hope in sharing these wonderful stories is that others may appreciate the phenomenal potential of parkrun to change lives. For those that have never been to a parkrun, I'd be thrilled if you registered with your local parkrun and tried it just once – run, walk or volunteer. It might transform your life too.

I've been an NHS GP and trainer in Southport for 25 years. My interests include diabetes, lifestyle medicine and deprescribing. I worry a lot about overprescribing, overdiagnosis and doctors who slavishly follow guidelines without asking the person in front of them what matters to them. I love offering lifestyle change as a possible alternative to medication. Fell-running was my passion until a tragic knee injury (walking up a flight of stairs!) ended what promised to be at best a decidedly mediocre career. I now swim in beautiful lakes instead of limping around them. I am an unpaid parkrun ambassador for health and wellbeing.

Eileen's story

'I did it!' declared the triumphant text below a photo of a Lycra-clad Eileen beaming from ear to ear at the finish of the Great North Run. The message continued: 'From feeling very low to a half marathon via parkrun and an excellent GP. Thank you so much'. This was only the second time I had ever given my mobile phone number to a patient of mine but I was excited to hear how Eileen had got on.

A year previously, she had come to see me at the surgery to ask for my help. She told me 'I feel broken'. I've known Eileen for 20 years since she moved to Southport and have always been fond of her. She has a broad Geordie accent and a wonderful, warm nature. Life has been challenging for her as a lone parent and moving across the country with a young daughter but she has worked tirelessly and done everything possible to make a good life for the two of them. Eileen's father suffered from severe shell shock during the Second World War and was 'never the same' after the war ended. She vividly recalls how terrifying it was to visit him in hospital during his admissions for electro-convulsive treatment.

She and I have met many times over the years to discuss her recurrent issues with stress, anxiety, depression

and low self-esteem. Periodically she has used alcohol as a coping mechanism and has been on and off antidepressants for many years. This time though she seemed different. She told me that she had stopped drinking two weeks previously and that she was fed up with the constant cycle of feeling bad about herself, needing medication, getting better for a short while only to relapse a few months later. She wanted my advice on how she might be able to change things permanently. I was thrilled that she'd come to discuss this with me and after applauding her brilliant efforts with the alcohol, asked her if she did any kind of physical activity. She said that she didn't, so we chatted about whether feeling physically fitter might help improve her mental health too.

That was two years ago, when Southport parkrun had just launched, so I asked Eileen if she might be interested in coming down to see how she got on. 'But I'm not a runner' was the reply. I explained that roughly a quarter of people who come to parkruns across the country don't run, they often walk or sometimes do a mixture of walking and jogging – either way, everyone was welcome. I promised her that she wouldn't come last – every parkrun has volunteer tail walkers so nobody has to suffer that indignity. Interestingly, Eileen said that



Southport parkrun

a couple of friends at work had been encouraging her to come along with them and she was up for giving it a go. She and I agreed to meet at the park that Saturday, 15 minutes before the start. Fascinatingly, she told me recently saying that when I mentioned parkrun what she had actually thought was: ‘What? Is he f...ing joking?’

Over the past two years I have ‘referred’ more than 100 patients to parkrun, with some tremendous results. parkruns are free 5 kilometre events that take place in parks and open spaces across the UK every Saturday morning, at 9am in England and Wales and 9:30am in Scotland and Northern Ireland. From humble beginnings in Bushy Park, London, in 2004 with just 13 runners and five volunteers, there are now 540 parkruns around the country and that number is increasing every week. parkruns are open to everyone aged four and over. Additionally, 2k junior parkruns on Sunday mornings for 4–14 year-olds are also booming. There are currently 230 weekly events, with more events starting every Sunday. Participation is rising rapidly with more than 150,000 walkers, joggers, runners and volunteers getting involved every weekend at parkrun and junior parkrun across the country. 1.6 million people have taken part, including more than 53,000 people who identified themselves as inactive at the point of registration.

My local parkrun in Southport sits right in the middle of the catchment area for my surgery where I’ve worked as a full-time, NHS GP for 25 years. Our first Southport parkrun two years ago attracted just 24 walkers, runners and volunteers. This summer we set a new attendance record of 510 finishers and 36 volunteers.

Our course is flat and fast yet when I look at the finish times for parkrunners at Southport I’m delighted to see that the average finish time is considerably slower when compared with other parkruns across the country. That tells me that we’re getting a higher proportion of the

slower runners and walkers coming along. Getting these folk to increase their exercise really excites me in terms of making a real difference to the health of our communities. The quicker runners would be out running somewhere whether or not there was a parkrun but without the cheering marshals and team at our local parkrun to support and welcome the slower participants, I suspect that many would just have stayed at home.

“ Without my local parkrun to inspire and motivate me my numbers would not be as good as they are ”

I was delighted to see Eileen with her friends at the start of the parkrun that Saturday and thrilled to see her cross the finish line to a huge cheer from our marshals and the other runners, with a huge smile. She said to me later: ‘Those first scary weeks when the team at the finish cheered and encouraged me, I felt like a superstar’.

Eileen has now become a regular at Southport parkrun and as her times have come down, her confidence has risen. She’s now completed several 10k races and I was so proud of her when she said that she had entered the Great North Run in her home town of Newcastle. She told me that never in her wildest dreams had she thought that running in this iconic race was achievable for her. That was something other people did.

There’s been a fascinating change in Eileen since she started at parkrun, a newfound confidence and a noticeable rise in her self-esteem. She showed me some photos of her taken recently on a charity trip to Malawi, surrounded by laughing children. She told me that she had always wanted to get involved with this project but had repeatedly declined invitations because she had lacked the confidence. She worried that she would let



Eileen in Malawi

them down. She certainly hasn't and has plans to go back again. Eighteen months since starting at parkrun Eileen has transformed her life – she feels in control and has not needed antidepressants for nearly two years.

Gary's story

One day last year, 47-year-old Gary came to chat to me at Southport parkrun and wanted to share his story. He had been diagnosed with type 2 diabetes in 2015. He was overweight at 96kg (15 stone), a smoker, his cholesterol was up and his blood pressure very high at 185/118. Following his diagnosis Gary hit a major low patch but eventually decided he wanted to try to turn his life around. He told me that his big motivation for change was his love for his young son – he wanted to be around to see him grow up, get married and to be there to see his grandchildren. Sensibly, Gary decided to start by tackling his smoking and with extraordinary willpower he managed to quit. He then began to think more seriously about his diet. He had been offered metformin to control his high sugar levels but worried about the high risk of side-effects such as abdominal pain, bloating and diarrhoea. Gary was determined to avoid medication if possible. Interestingly, I have been offering many of my patients a choice over recent years. I've asked them whether they prefer to take lifelong medication or to consider lifestyle change.

Fascinatingly, almost all opt for the latter. That phrase 'lifelong medication' is a wonderfully powerful motivator.

Gary looked at dietary change and realised that reducing his intake of sugar and starchy carbohydrates was the way forward for him. He began to lose weight and as he did so he began to move more. His brother was a regular at Southport parkrun and encouraged Gary to come down and give it a go. Despite his apprehension he gave it a try and loved it.



Gary Rimmer (centre)

So how's Gary getting on now? In short, fantastically well. He weighs 20kg less than in 2015 and his waist is 15cm smaller. His high cholesterol and blood pressure are now fine. He remains off cigarettes and his diabetes is perfectly controlled without the need for medication. Gary told me: 'When my results came in I was applauded by the diabetic nurse. Without my local parkrun to inspire and motivate me my numbers would not be as good as they are and I don't believe that I would be running'. He has now gone on to complete several 10k races and half-marathons. He now considers himself 'a runner'. All this has been achieved because he chose lifestyle change rather than lifelong medication.

Fascinatingly, I've noticed a change in Gary over the time I've known him. He's developed more confidence and his self-esteem has risen. He has shared his amazing success story with other diabetics and become a parkrun ambassador for diabetes. I believe that his perception of himself has changed too – from someone who felt that he was a victim of a long-term condition to seeing himself as a real success, a father to make his son proud and a role model for others with diabetes. All of this is hard to measure of course but I have no doubt that parkrun coupled with a positive attitude have made this possible.

Kelly's story

I was chatting to Kelly, another patient of mine, a couple of years ago. She's an inspirational woman, a lone parent in her early 40s. Kelly has been blind since birth but has never let this stand in her way. She got a degree in performing arts and then went on to study journalism (she is fluent in Braille), working all her adult life and still being a wonderful mum. One day at the end of an appointment she told me that she was fed up with her gym class – when they went outside for a run they put her on the rowing machine so that she 'wouldn't come to any harm'. She felt patronised and frustrated. People with disabilities are half as likely as non-disabled people to be active (Sports England, 2014). I asked Kelly if she would be interested in coming along to Southport parkrun that Saturday. By coincidence I had just trained as a guide runner and was desperate for someone to practice on. To my surprise Kelly was up for it and didn't seem put off by my inexperience. This wasn't the first time her feisty determination would amaze me. I picked her up from her house and we managed to get around the course without falling or bumping into anything. We needed to stop and walk three times for Kelly to get her breath back which, in retrospect had more to do with all the new sensations hitting her much more rapidly than normal, making her feel slightly panicky. She had never, ever run before, something that I had completely failed to appreciate.

After we finished, I asked Kelly for her thoughts. She told me: 'It's really difficult to describe to anyone who can see, just what it feels like to suddenly not have a cane in your hand – the sense of achievement it gives you when you do take that leap of faith. It's such a lovely experience



Kelly with guide runner Simon

to be running through the park on a Saturday morning, feeling the fresh air hit my face'. She then went on to say that she was disappointed with her finishing time. She was frustrated that she had needed to walk and knew that she could cover the course more quickly. So she came back and had another crack at it the following week, managing to complete the course two minutes faster. In fact, Kelly came back to Southport parkrun for 13 successive weeks and set 13 successive personal bests – I've never heard of any runner doing that. Her time over 5k has dropped from 45 to sub-25 minutes. Like Eileen, Kelly has gone on to bigger and better things, several 10k races and half-marathons and to my delight, completing the London Marathon with her guide Mike earlier this year. I asked Kelly recently what difference starting at parkrun had made to her life and she told me that it had given her an amazing boost of self-confidence to realise that she was capable of achieving anything that she put her mind to.

There are few people who would disagree with the importance of physical activity for good mental and physical health but I believe that the positive aspects of volunteering at parkrun and other social prescribing ventures are not given enough consideration. A patient of mine in her 60s who has issues with anxiety recently told me that volunteering at parkrun had 'revolutionised' her life. I'm beginning to realise that there are huge benefits from simply bringing people together and helping to build communities. parkrun is in a wonderful position to involve people who may be hard to reach and those who are on or beyond the periphery of our communities.

Alfy's story

I was very moved by the story of Alfy Kirkley, a young man who was serving time in HMP Haverigg, one of three

prisons where parkrun UK has recently set up events. Clearly there are logistical challenges to setting up a parkrun inside a prison but there is tremendous potential for improving the health of both staff and inmates. Alfy was a regular at the prison's Black Combe parkrun before his release earlier this year. One can only imagine what it must be like to leave prison. Previous relationships may have broken down, you may be living in new accommodation and perhaps lack a supportive community around you. Well, as a parkrunner that was different for Alfy. parkruns around the country are exactly the same – just register once only, print off a barcode to enable your results to be processed and turn up on a Saturday morning. So that's what Alfy did following his release. He had a community to go to, one where he knew the system, felt comfortable and was welcomed and encouraged. I was astonished to see a tweet from Barrow Police saying:



Follow

Heard from Haverigg prison that their best "Park Run" runner has been released and competed in his 1st local Park Run. He came 2nd. He says Park Run changed his life. That's the power of sport. @parkrunUK

Particularly moving was Alfy's response, in his own words: 'I feel i av found a new life. i can't change what i av done but I can try an make amends. thanks everyone especiallymy new family. this is a lifesaver n I'm only gona improve. it's all about pbs now. thank u all again'.

When I think about what I look forward to each Saturday, it's meeting up with a group of people who I care about, catching up, having a natter. The exercise is a great addition but it's the social connections that make it so enjoyable. I know that there are people at my parkrun whose only significant social interaction each week occurs at parkrun. The importance of this cannot be underestimated. I was shocked to read that loneliness has been linked to a 30% increase in premature death (Holt-Lunstad *et al*, 2015). The NHS spends millions of pounds each year on tablets that have a relatively small



Alfy (left) at Black Combe parkrun

impact on reducing the risk of heart disease or stroke yet we talk very little about loneliness, social isolation and the benefits that might come from addressing this.

Elisabeth's story

Elisabeth lives in a residential care home near Bushy Park, home of the first ever parkrun. Her daughter Lucy is a keen parkrunner and decided one day to bring Elisabeth along to watch the event. Elisabeth loved sitting in her wheelchair alongside the course, cheering the runners and walkers and high-fiving the children.

Elisabeth has now become a regular volunteer at Bushy Park and the team has awarded her honorary marshal status and presented her with her own hi-vis vest which she proudly wears each Saturday. I know that both Elisabeth and Lucy were deeply touched by the enormous number of Christmas cards she received last year from local parkrunners. Atul Gawande, in his wonderful book on ageing, *Being Mortal*, stresses the need for all humans to have a purpose as we approach the end of our lives. I know that parkrun has given Elisabeth this.

parkrun has the power to transform lives not just in terms of physical health but also mental and social benefits. It's free, local and helps to build and strengthen communities. I have no doubt that as a result of coming along to parkrun many of my patients have taken control of their health and need fewer medications as a consequence. Side-effects are less likely to occur as a consequence and the NHS saves a fortune in unnecessary medication. My patients feel great about this, it's given them a real sense of hope.

Recently parkrun has linked up with the Royal College of GPs to set up parkrun practices. GP practices across the UK that establish links with their local parkrun and encourage patients to go along will be certified by the college. Interested GPs can find out more from the RCGP website. The response has been overwhelming with more than 100 practices signed up in the first two weeks. It's wonderful to see so many healthcare professionals embrace the importance of physical activity and the benefits of social prescribing.

There are now 1,550 parkruns across the world with nearly 300,000 participants each weekend, and such is the demand that the number of events will double in just the



Lucy and mum Elisabeth



Kelly completes the London Marathon with guide Mike

next two years. There seems to be a real interest in the enormous potential benefits of social prescribing. Developing links between the NHS and parkrun makes perfect sense. It's the best and the cheapest medicine there is.

One final story. A few years ago a middle-aged GP was feeling frustrated with his career. He worried that he spent too much time telling his patients to take preventative medications that they didn't want and that he didn't really believe in. He knew that he should be encouraging physical activity but simply nagging his patients to start running or join a gym didn't seem to work. Getting involved with parkrun has transformed his life. His circle of friends has widened and he has met some astonishing and inspirational people from all walks of life. All of a sudden he feels that there is a form of physical activity out there that will appeal to his patients and he is enthusiastic about inviting them to come along in any capacity. He enjoys meeting them on a Saturday morning and now regards many as friends as well as patients. Connecting with his patients outside the surgery has been a wonderful revelation for him. It has deepened and strengthened his relationship with many of them. He feels so much happier and energetic about general practice too. 'Prescribing' parkrun has given both him and his patients a new lease of life. I'm sure you've guessed who the GP is. Perhaps the same thing could happen to you?

For more parkrun information visit www.parkrun.org.uk.

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Research summaries



Thanks to James Hawkins <http://goodmedicine.org.uk/goodknowledge>

BHMA chair threw down the gauntlet

This article from 2009 (by our now-chair) says continuing to medicalise society's problems is unsustainable. Social prescribing has been shown to help some individuals and is an option we should embrace. But can it also help society? On the face of it, empowering our communities to attend to some of our more intransigent health problems seems to be an obvious approach and is in line with stated government policy, including joint projects between health and social care. Building social capital and community cohesion is health-generating and so may help to create a virtuous circle. We could even take social prescribing to mean treating society as the patient for whom we prescribe. This requires a shift in medical culture towards a closer identification with the public health of the local community.

Brandling J, House W (2009) Social prescribing in general practice: adding meaning to medicine *Br J Gen Pract.* 59(563): 454–456. www.ncbi.nlm.nih.gov/pmc/articles/PMC2688060

Engagement counts

Findings suggest that tackling complex and long-term health problems requires an extensive holistic approach not possible in routine primary care. Link worker social prescribing programmes comprise personalised support to identify meaningful health and wellness goals, ongoing support to achieve agreed objectives and linkage into appropriate community services. This model of social prescribing, which takes into account physical and mental health, and social and economic issues, was successful for patients who engaged with the service. Future research on a larger scale is required to assess when and for whom social prescribing is clinically effective and cost-effective.

Moffatt S et al (2017) Link worker social prescribing to improve health and well-being for people with long-term conditions: qualitative study of service user perceptions. *BMJ Open* 7(7): e015203. www.ncbi.nlm.nih.gov/pmc/articles/PMC5541496

Who is SP effective for?

The use of non-drug, non-health service interventions has been proposed as a cost-effective alternative to help those with long-term conditions manage their illness and improve their health and wellbeing. Interventions typically involve accessing activities run by the third sector or community agencies and may also be described as non-medical referral, community referral or social prescribing. To be effective, patients need to be 'transferred' from the primary care setting into the community and to maintain their participation in activities. However, it is not currently known how and why these approaches enable which people under what circumstances to reach community services that may benefit their health and wellbeing.

Husk K et al (2016) What approaches to social prescribing work, for whom, and in what circumstances? A protocol for a realist review. *Syst Rev.* 3:5:93 www.ncbi.nlm.nih.gov/pubmed/27255362

How to change practice and commissioning?

Although social prescribing shows significant potential for the benefit of patients and primary care, several challenges need to be considered and overcome, including 'buy-in' from some GPs, branding, and funding for the third sector in a context where social care cuts are severely affecting the delivery of healthcare. With its emphasis on context and mechanisms, the realist evaluation approach is useful in understanding how to identify and improve health interventions, and analyse in greater detail the contribution of different stakeholders. As the SPC is central to social prescribing, more needs to be done to understand their role conceptually and practically.

Bertotti M et al (2018) A realist evaluation of social prescribing: an exploration into the context and mechanisms underpinning a pathway linking primary care with the voluntary sector. *Prim Health Care Res Dev.* 19(3): 232–245. www.ncbi.nlm.nih.gov/pmc/articles/PMC5904290

SP and austerity

The Link Worker Programme (LWP) is a social prescribing initiative in areas of high deprivation in Glasgow, Scotland, designed to mitigate the negative impacts of the social determinants of health. Although the LWP appears to be a fruitful approach to collaborative case management, integration initiatives such as social prescribing cannot be seen as 'magic bullets'. In the context of economic austerity, such approaches may not achieve their potential unless funding is available for community organisations to continue to provide services and make and maintain their links with primary care.

Skivington K et al (2018). Delivering a primary care-based social prescribing initiative: a qualitative study of the benefits and challenges. *Br J Gen Pract.* 68(672): e487–e494. www.ncbi.nlm.nih.gov/pubmed/29784868

The methodology problem

This mixed method evaluation approach used patient surveys with matched control groups and a qualitative interview in a mixed socio-economic, multi-ethnic, inner city London borough with socially isolated patients who frequently visited their GP. The intervention was implemented by 'social prescribing co-ordinators'. Outcomes of interest were psychological and social wellbeing and healthcare resource use. Changes in general health and wellbeing following referral were very limited and comprehensive implementation was difficult to optimise. Although GP consultation rates fell, these may have reflected regression to the mean rather than changes related to the intervention. However, it should be noted that the control (n = 302) and intervention groups (n = 184) differed in three ways. The control group were more likely to be living with others (63% vs 40%), in paid work (47% vs 9%) and had been in full time education for longer (61% vs 43%).

Carnes D et al (2017) The impact of a social prescribing service on patients in primary care: a mixed methods evaluation. *BMC Health Serv Res.* 17: 835. www.ncbi.nlm.nih.gov/pmc/articles/PMC5735927

Social prescribing in London – a GP perspective

Tom Coffey

GP; Mayoral Health Advisor, London



I joined the mayor's office as senior health policy advisor to the mayor in 2016. I continue to work as a GP, am clinical lead for mental health and children's services at Wandsworth CCG and the joint-clinical lead for emergency care NHS England (London). I also work in A&E in Charing Cross Hospital and am GP advisor to the Battersea Healthcare social enterprise. My remit at City Hall includes providing health policy advice to the mayor and working closely with the mayor's statutory health adviser on matters relating to health policy. However I still find time to use my season ticket for Chelsea FC.

Overall SP access in London is patchy. Although many statutory and voluntary organisations want to develop more opportunities for access to social prescribing projects, this is not happening in a systematic way. A social prescribing vision for London, which is being developed by the Greater London Authority, NHS England, Healthy London Partnership and the London Social Prescribing Network will focus on four priority areas that can make the most difference: workforce development including the role of volunteers; evaluation, outcomes development and sharing good practice; improving digital connectivity; and the provision of specialist legal advice.

Why GPs need social prescribing

As a GP working in Tooting, south London, many of my patients come to me about problems I cannot solve. Despite continuing advances in medical treatment, there is no pill I can prescribe for many of the reasons patients come to me – for social problems like debt, loneliness, housing issues, family troubles, unemployment or work problems – even though these predicaments are clearly affecting their physical and mental health.

Patients come to my surgery with complex challenges – often they have several health and social concerns, exacerbating each other and making each day a challenge. Finding their own solutions can be very difficult.

And I am not alone – it's estimated that one in every five patients visit their GP for non-medical reasons (Toriesen, 2016).

In fact, this figure should probably be much higher: the Low Commission reported that 15% of all GP visits were for social welfare advice (Low Commission, 2015), let alone the many other issues that affect the quality of people's lives.

So how can I, as a GP, support patients with such complex and multiple non-medical needs? In my experience, social prescribing can play an important role.

The first thing social prescribing does is offer a listening ear, the opportunity for a patient to tell me what's really concerning them. It allows me to recognise it, validate it, and then vitally allows me to offer them something to help with it – a referral route to advice and support beyond (though often alongside) the medical advice that I provide.

Social prescribing offers me an opportunity to provide my patients with a wider range of support. It enables me to help people to improve their quality of life and to feel better. It is a way of bringing together a patient's health, care and social needs, and addressing the issues they identify as important to their health and well-being – and to their lives – through access to support and services in the community.

The varieties of social prescribing

There is no single model of social prescribing, but there are many

different examples across London and the country of how services are developed and provided.

The Bromley by Bow Centre is one example. Linked to 18 medical practices in the area, it offers holistic support with a full range of services, including working with Macmillan Cancer Support to offer social prescribing for people living with and beyond cancer (see www.bbbc.org.uk/services/get-support-for-issues-affecting-your-health).

In the London borough of Bexley adults can register with Community Connect to access a range of services, including active lifestyles and befriending and support groups. This borough-wide service is run by Bexley Voluntary Service Council in partnership with Mind (see <http://mindinbexley.org.uk/community-connect>).

It's estimated that one in every five patients visit their GP for non-medical reasons

And in my own surgery, Citizens Advice provides weekly appointments. Appointments can be made by self-referral or a GP may suggest it. The service is for any patient who needs advice, information or practical support with a wide range of issues including housing, debt, legal and welfare benefit problems.

And it is not just GPs that can use these services – there are many examples of other health and care professionals, such as drug and alcohol services and housing associations, building this approach.

All these services are different; social prescribing services work best when developed with individual needs and local services in mind. But core is referring patients to a friendly, capable person, someone who can take the time and has the skills to listen, work with the individual to understand their needs and to empower them to take control of their own health and wellbeing.

Crucial too is a strong and vibrant voluntary and community sector (VCS) that can provide the appropriate services. Long before the term social prescribing came along they had been providing community services, connecting locally to help people manage and improve their health and wellbeing. The VCS is best placed to reach out and provide appropriate support to the most vulnerable members of the community, in a way they can engage with.

Nurturing social prescribing

For social prescribing to grow the VCS sector needs to be an equal partner with NHS and local authority commissioners in developing and delivering social prescribing services. The sector needs adequate and sustainable financial support to play its part, especially with the increasing pressures facing the health and care sector.

Today, more and more people are recognising the value of social prescribing. While it has been well understood within the clinical community for some time that 'you can't drug people into being healthier' this obvious fact is increasingly being recognised by patients and as this happens demand for non-medical, holistic solutions is bound to grow.

For the NHS today, social prescribing features as a key driver within the Five Year Forward View and many sustainability and transformation plans, including all of those covering the London area. Social prescribing has been identified as a means for implementing a range of person-centred approaches based on preventative initiatives and community-based assets. Social prescribing also shares the values that underpin the wider personalisation movement within health and social care.

We know from the evaluations of various social prescribing projects that it also saves the NHS money; by reducing the amount of times people visit their GP and A&E departments. For example, the 2016 evaluation of the Rotherham social prescribing service carried out by the Centre for Regional Economic and Social Research at Sheffield Hallam University showed that A&E attendances of those taking part in the scheme fell by 17%. The estimated total NHS costs avoided between 2012–2015 were more than half a million pounds: an initial return on investment of 43 pence for each pound invested.

Benefits are wide-ranging: social prescribing also leads NHS healthcare professionals into developing wider relationships with their communities and the third sector, and vice versa.

But the most important benefits are that this approach helps people take control of their own health and wellbeing, thus improving quality of life and helping reduce health inequalities.

The London challenge and vision

Though social prescribing is available in London, access is at best variable. Some areas have services available to the whole population and meet a wide range of needs for individuals. Other areas are much less advanced, developing these services at different speeds and as part of different strategies. Although we know that many statutory and voluntary organisations are keen to develop more opportunities for patients to access social prescribing projects, this is not happening in a systematic way in London.

The mayor of London recognises this challenge, and that is why in his new London Health Inequalities Strategy (Greater London Authority, 2018), he has stated an ambition to ensure social, non-medical services are available to all who need or want them, and particularly the most vulnerable Londoners. Still, across London's boroughs there is variation in ambition, capacity and crucially resource. For example, we know that there is significant variation between boroughs in terms of how much investment goes into social prescribing, and in

where this investment comes from. In the recent mapping of social prescribing services across England carried out by NHS England 47% of services in London received funding from clinical commissioning groups, 29% from local authorities and the rest from other sources.

The mayor wants to understand what can be done to better support areas where social prescribing is less well developed. We have been working with the voluntary, community and social enterprise sector (VCSE), local authorities, and the NHS to explore their different roles, and what the challenges and opportunities are for each sector – including in terms of developing digital solutions.

“We know from the evaluations of various social prescribing projects that it also saves the NHS money”

This work has informed the development of a social prescribing vision for London. This is being developed by the Greater London Authority, NHS England, Healthy London Partnership and the London Social Prescribing Network in collaboration with several partners across the local authorities and the VCSE sector to support the scale and spread of social prescribing across London.

In developing our social prescribing vision, we sought the views of over 100 social prescribing stakeholders – from a range of services users, including young Londoners, to link workers, commissioners and service providers.

The vision will focus on four key priority areas where we think that we can make the most difference to the growth of social prescribing in London; workforce development including the role of volunteers; evaluation, outcomes development and sharing good practice; improving digital connectiveness; and the provision of more specialist legal advice (debt, housing, welfare, employment etc).

Underpinning this vision is the acknowledgement that for social prescribing to be successful it has to be developed and delivered within an effective and equal partnership between local authorities, NHS organisations and the VCS. The vision is intended to support the link between individuals who have healthcare and support needs with the services offered by the VCS.

The longer term goal is that every Londoner, but especially those in disadvantaged groups with multiple

complex needs, will be able to access social prescriptions from the cradle to the grave, so that their needs can be met as their life and circumstances change.

“For social prescribing to be successful it has to be developed and delivered within an effective and equal partnership between local authorities”

There is no ‘one size fits all’ solution to this – in fact, that’s the very point, that each individual patient’s needs are different and will require a solution tailored to their own needs, and therefore that services need to be developed locally by commissioners, providers and service-users themselves.

For me, as for many other health and care workers – both in statutory services and in the VCS, social prescribing provides an opportunity to improve health and improve lives; working together across London, we can make this happen.

Note: The social prescribing vision for London will be published in Autumn 2018

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Love by Maya Cockburn www.mayacockburn.com

SOCIAL PRESCRIBING STRATEGY

MAYOR OF LONDON Healthy London Partnership 

 the Mayor and I were both born in Tooting!

He recognises that health is **A PRIORITY** across all London



Children's health

 Marie Pelley

the SOCIAL PRESCRIBING NETWORK promotes sharing and people involvement

Formed of **15,000 PEOPLE** a DIVERSE range of stakeholders



people centred

5 AREAS TO FOCUS ON...

- mental health
- healthy habits
- healthy places
- healthy communities

IT'S ALL ABOUT **RELATIONSHIPS**



it takes **TIME** to align schedules...

use it wisely!

Sharing standards measures

RECOGNIZE THAT WORKING IN A GP IS NOT ONLY ABOUT PRESCRIBING MEDICINES

SOCIAL PRESCRIBING

IMPACTS COMMUNITIES AS WELL AS GPs

An equal and cohesive system

- the Mayor NEEDS:
- LOCAL ADVICE
 - WORK TRAINING
 - INFRASTRUCTURE SUPPORT
 - DIGITAL OFFERING

 Dr Jagun John

I see so many patients that I want to help but I can't because of the lack of resources

SHARE your experience and expertise

 HLP

I work for HLP

I have been told to play football!

we want **PARTNERS** across London **WORKING BETTER TOGETHER**

 Bev Taylor

to make Social Prescribing work we need to **test**, look into **culture change** and **Mindset...**

Evidence based

the evidence shows that the effects of social prescribing are **REAL!**

NO health models

"PEOPLE" WORKS for "PEOPLE"



LET'S USE EACH OTHER!



Visual Minutes by CreativeConnection.co.uk

Visual minutes from a social prescribing conference held at London City Hall in February 2018

Sing with Us – the benefits of arts and social prescribing

Iwan Jones

Head of Wellbeing, Tenovus Cancer Care



Social prescription has risen to prominence in recent years and with it the crucial role that third sector and community services or activities could and should play. The arts in particular are a well-researched and proven vehicle to facilitate social prescription – so how can that link between healthcare and social interventions be strengthened and improved? Sing with Us is a service provided by Tenovus Cancer Care for people affected by cancer and provides a perfect case study to explore some of the themes, benefits and issues that surround bringing social prescription to life.

A desire for a more rewarding and fulfilling job led me to the opportunity to work for Tenovus Cancer Care, leaving behind the world of retail distribution. One of the major draws to this role was having the opportunity to manage services that are all designed to support people in need, including an arts-based service. In my younger years the arts, particularly singing, were an incredibly influential and important part of my life – and music still is. Getting the opportunity to combine one of my personal passions and supporting people in original ways in one role is a rare opportunity, and one I had to take. Since then I have developed my knowledge of cancer and I've also been able to further appreciate just how important the third sector can be in supporting people in a variety of ways, while helping them cope with a difficult time in their lives. One area I am particularly interested in is how third sector and community-based services can support the health sector in an increasingly tough and demanding environment.

Introduction

In 2018, Tenovus Cancer Care is celebrating its 75th birthday. The charity started in 1943 with 10 businessmen in south Wales who came together to fund small projects to help people in need of support in their community. In the 1960s, the charity began to focus on cancer research, which led to the building of the Tenovus Institute in Cardiff, which continues to house cancer research. Tenovus Cancer Care continues to research and fundraise towards a future without cancer, while offering a range of support services to help people who have been affected by cancer.

Sing with us

Tenovus Cancer Care has six distinct services, each created to provide support to people affected by cancer. This is combined with promoting lifestyle choices and behaviours that can help people to prevent the development of cancer in the first

place. These services include mobile support units offering treatment to people closer to home, a support line where dedicated nurses can provide advice and comfort to anyone dealing with cancer, and Sing with Us, a network of choirs that offer support, social integration and, of course, fun.

Sing with Us has the potential to play a part in the local social prescribing scheme – a holistic framework that allows arts, social and community activities to overlap with primary healthcare provision. In early 2018 I was lucky enough to witness the idea of social prescription becoming a physical and tangible concept. Members of my team were invited to attend a conference on social prescribing in Bristol, where one of our Sing with Us choirs was also asked to perform. At this event, it was clear that there was a strong desire and appetite to use the benefits of social prescribing in the broader sense – making socially prescribed interventions and activities a more robust and practical referral method. This

type of event will hopefully become more commonplace as it proved that many of the potential barriers can be overcome.

A brief history of Sing with Us

Sing with Us was born from the initial set-up of a choir in Pontypridd, south Wales in 2010. A couple of years later an opportunity arose for Tenovus Cancer Care to be part of a television programme about a group of cancer patients who sing together. The programme was called *The Big C* and was part of Channel 4's early venture into the Stand Up to Cancer campaign. The focus of the programme was to explore the stories of these very individual people, how they came together as a choir and how the choir and the group they were part of helped and supported them. This was the original idea for what Tenovus Cancer Care wanted to achieve with Sing with Us. It continues to be an essential part of the ethos of the choir. In 2012, Tenovus Cancer Care got funding to grow the Sing with Us family in Wales, taking the total of choirs from one up to 15 over the following three years. Since then further funding has allowed the charity to add one choir in Wales and two choirs in England, expanding Sing with Us to the network of 18 choirs it has today.

The primary purpose of Sing with Us is to support people affected by cancer in a fun, fulfilling and supportive manner. This opportunity provides a social setting where people affected by cancer can meet and create friendships while they learn to sing together as a collective group. As a holistic support service, Sing with Us also offers a pathway for those involved to receive further support from other areas of the charity if needed.



We believe in the power of singing!

Sing with Us is open to anyone who has been affected by cancer, including but not limited to, patients, survivors, carers, healthcare workers, family, and friends. The choirs have been designed to be inclusive of everyone regardless of singing experience or lack of it. Each choir meets every week for an hour-and-a-half rehearsal session which is made up of two dynamically different sections. The first half an hour is dedicated to socialising, including welcoming any new members and having an all-important cup of tea! This social part of the session is vital to the choristers as it allows them to integrate into the choir and get to know each other, with many friendships continuing beyond the choir sessions. This helps to create one of the really special things about Sing with Us; it becomes a self-perpetuating entity as the people who are initially supported by the charity go on to support the people around them who join later – one of the many reasons we consider them as a family. At any session, there is no pressure for anyone to share their personal experience of cancer with anyone else, but they know that others are there in solidarity with them and they can talk if they want to. The hour making up the second part of a session is then dedicated to singing. It will typically involve some warm-ups, learning a new song and running through older songs at the end of the session to end on a figurative, and often literal, high note. All the songs that are covered by the choirs are chosen and arranged with the aim of being uplifting, meaningful and/or fun. Each session is run by one of the charity's very talented team of choir leaders, who are all professional musicians, who together help to decide on the new tracks, record them, and then teach them to their respective choirs.

Sing with Us has earned a significant place at the charity through its somewhat unique ability to both support the people who use it and to also support the charity in its continuing work to raise awareness of cancer. Integral to this are the choristers, who themselves come to be some of the greatest advocates and spokespeople for the cause. Many of the members of the choirs go on to do so much more for the charity: whether they fundraise individually or as part of one of the Friends of Tenovus groups – perhaps volunteering for bucket collections or participating in gigs – they play a crucial role in helping the charity to achieve its aims.

Gigs, a term used to refer to any concerts or events at which a choir is invited to perform, are a great way to publicly showcase the ability of these fantastic choirs, to increase awareness of the charity's work and to raise vital funds which allow the charity to run these brilliant services in the first place. Also,

many of the choristers share their personal stories with the charity's storyteller, offering a unique insight into how cancer has affected them and how they have moved past it, often positively contributing to the support Tenovus Cancer Care has been able to give them.

Sing with Us now boasts an active membership of approximately 1,400 people with more than 900 regularly attending a weekly session through the year.

There has been a longstanding perception that singing improves your wellbeing, as do a range of other arts and social activities, and this is very much at the heart of Sing with Us. While this perception has existed for a while, through Sing with Us there was an opportunity to research this idea further. Exploring this perception and ideology is key to understanding the role that arts-based opportunities can play within social prescription.

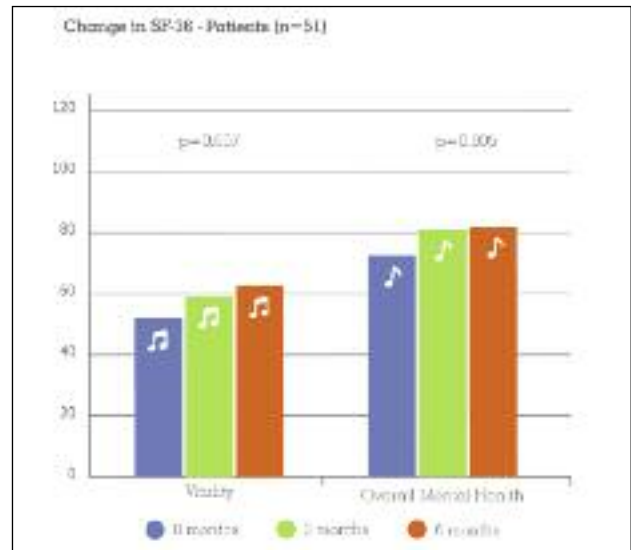
Research and Sing with Us

Research has always been at the forefront of what Tenovus Cancer Care does, and this certainly applies to researching the effects of singing through Sing with Us. Since its inception in 2010 the charity's own research team, along with a number of key stakeholders and partners, has conducted a wide range of research projects on the service in an effort to add evidence to the perceived power of singing and to help to develop Sing with Us, making it so much more than just singing.

The research started with The Big C choir and a preliminary study conducted by Cardiff University demonstrating a reduction of anxiety and perception of pain following an hour-long choir session. Following this, a quantitative study was completed in conjunction with the university involving more than 1,000 choir members completing validated questionnaires (the Short Form 36 and Hospital Anxiety and Depression Scale) on joining the choir, three months after joining and six months after joining.



Tenovus Cancer Care Sing with Us choir



Preliminary research showed a reduction of anxiety and pain following a choir session

This research, along with further qualitative data capturing, led to an opportunity to work with Imperial College London and the Royal College of Music who were pioneering the use of saliva to test for biological changes in response to musical activities. This study examined 193 choir members from five Sing with Us choirs, taking saliva samples from before and after a one-hour choir rehearsal with the aim of investigating any biological changes that occurred. The study showed numerous beneficial biological effects from the hour-long session including the reduction in cortisol levels and an increase in endorphin and oxytocin levels. These exciting findings provide evidence for a beneficial effect in terms of reducing the body's inflammatory response, which has been linked to an increased ability to fight serious illnesses – including cancer!

Following this initial breakthrough, there was a desire from all three parties to undertake a more detailed and expansive study into the long-term effects of singing in a choir on specific groups of people diagnosed with cancer. This proposal was accepted and led to a further partnership study, adding the Royal Marsden Hospital as a partner. This has been conducted over the last two years and the results are expected to be published in late 2018.

Social prescription and Sing with Us

Social prescribing has become an increasingly popular and crucial option when looking at the shape of healthcare in the future – especially given the financial constraints that are increasingly affecting the NHS. Social prescribing (or community referral) emerges from the recognition that people's health is very significantly influenced by a range of

social, economic and environmental factors. So it makes good holistic sense to address these powerful health determinants. In simple terms, social prescribing makes it easy for all primary care professionals (GPs, nurses, etc) to refer their patients to other local non-medical opportunities. These can be provided by any of a growing number of community groups, third sector services or work-provided opportunities. The idea is to help an individual to improve their health and wellbeing with less reliance on medication or other medical interventions, and great self-reliance. These schemes can provide a much more sustainable long-term resolution for a patient.

While the idea of social prescription makes logical sense, and many separate studies have shown it to be effective on some level, social prescribing will not be able to cure disease and it will not always be the most appropriate form of support. Further, it almost always requires a higher level of engagement, commitment and effort from the individual to get the most out of it. The role of the 'prescribing' professional is also a critical part of the jigsaw. It requires their judgement to make a recommendation that is right for that patient at that time. The more confidence that can be given to healthcare professionals, and the more they can determine the benefits of these interventions for themselves, the more it will allow a method of social prescription to reach its full potential.

Another critical factor that could severely impact the movement towards social prescribing is consistency – or the potential lack of it. Social prescription has been spoken about at length in various corners of the UK, but progress has been relatively slow in adopting the approach and finding a joined up, coherent method of referral is an issue. There are many factors that affect this, including the way GP practices and the NHS in general are set up (or split up). Different health boards, practices, geographical locations, and individuals will probably have different approaches and priorities based on location or circumstance. However this mixed-methodology means that trying to apply social prescribing across all these areas is a considerable challenge.

A great future for social prescribing?

As these barriers are overcome, and as the method of social prescribing becomes more widely accepted by healthcare professionals, the focus will swing to those organisations that are able to provide services and activities that patients can be referred to. In a general sense, the arts and activities that involve the arts tend to be a very acceptable and suitable export for social prescription. As an established arts-focused service for people affected by



Sessions are led by a choir leader who are all professional musicians

cancer, Sing with Us is a perfect example of what is available in the broader environment to support social prescribing. The evidence that has been built up with the research and evaluation of Sing with Us in its eight years of existence strongly suggests significant health-related benefits for people who are involved in this arts-related activity. Hopefully these findings, along with the evidence from the wider research field, will be enough to demonstrate the real benefits of these types of activity and enable healthcare professionals to be comfortable with referring their patients to them. Beyond that research is the human element of these activities, where people who come from all walks of life and backgrounds can be brought together to unite and help them cope with a difficult time in their lives. In this way, through becoming committed and engaged, Sing with Us enables individuals to play their part in creating a new self-sustaining support network. This aspect of social prescribing is a crucial element to keep in mind because that is where the more significant and extended benefits of social prescribing come into effect. The advantage of these activities being provided by external organisations is that they can be supported by other activities offered by the organisation. Using Tenovus Cancer Care as an example, the members of the Sing with Us choirs can benefit from the other support services the charity offers, such as the money advice service. In this way, by referring to third sector organisations, individuals are often supported on multiple fronts.

Tenovus Cancer Care is aiming to reach and support as many people as possible to continue to give hope and to help people cope, working towards a future without cancer. In line with this vision, Sing with Us as a service will continue to support people affected by cancer long into the future.

For more information about Tenovus Cancer Care, Sing with Us and any of the other services and research from the charity, see: www.tenovuscancercare.org.uk; facebook.com/tenovuscancercare; twitter.com/tenovuscancer.

Rediscovering human–nature connectedness through social prescribing

Craig Lister

Green Gym Managing Director, The Conservation Volunteers



I had some challenges during my childhood and left school with few qualifications, which I now consider a valuable experience. Deciding I needed to take control for myself I joined the RAF at 17 and immediately benefited from the camaraderie and support and drive the military gives. Fast forward 12 years post military, I retrained as an exercise physiologist aligned to my sporting activities, but found a passion to help others help themselves, particularly those with complex obesity and chronic back pain, the latter being the subject of my postgraduate research degree. This evolved into national roles within public health and exercise referral where I developed an interest in evolutionary physiology and the underpinning components of a healthy, happy life.

We evolved and excelled in the natural world, overcoming challenge through collaborative effort, sharing success and failure as communities to the point where we became the world's dominant species. Over the past 30 or 40 years have we consistently expected more from the NHS as well as 'suffering' from a wholesale shift in activity levels and an increase in isolation, often to a point of learned helplessness. Social prescribing reminds us of the power of community, demedicalising many treatments and providing an opportunity for us to be central to our own health and wellbeing.

The biomedical model continues to provide wonderful outcomes for many people. But for many human problems technological and pharmaceutical options are neither appropriate nor effective. It seems unlikely that the NHS will be able to serve an ageing population with complex needs without fundamental system change. As this realisation dawns on policy-makers worldwide, I am becoming more optimistic that through social prescribing we may rediscover what we once knew so well about health and wellbeing: something we lost, or that was taken from us inadvertently, or in some cases deliberately.

'The art of healing comes from nature, not from the physician. Therefore, the physician must start from nature, with an open mind.'
(Paracelsus, 1493–1541)

As an exercise physiologist I have helped many people with complex obesity and chronic pain to achieve their goals. Often, they were people for whom the normal biomedical model had proved unsuccessful. I got much better at helping them make progress once I realised that the

physiology component was (relatively) the straightforward part. By far the bigger challenge I faced was in how to support behaviour change. Having taken additional training in this area, I found that by using motivational interviewing methods I could engage more effectively within this psychosocial space.

As I spent more time in the voluntary sector, my understanding of the breadth of what constituted health and wellbeing evolved further. Out in this arena I met many wonderful (usually unsung) people, who help their communities every day, through their selfless, compassionate and direct support.

Wired for nature

If we compress human evolution into 24 hours, then for around 23 hours and 58 minutes – more than 99% of our time as the human species – we lived and worked in the great outdoors. In this wild and wonderful but mostly challenging environment, despite the lack of medicines, technology, far-ranging communications, and our relative weakness and vulnerability to many predators, homo sapiens

became the planet’s dominant species, largely I believe through collaborative effort. As a group-living species it was by supporting each other, and by sharing and learning through adversity and successes, that humans evolved extraordinary resilience. People everywhere demonstrate this every day.

Humans are group animals by nature, gathering information from body language, facial expressions and spoken language, seeking support from trusted others in time of need, sharing success and challenge. Tending and befriending are in our DNA. Neurochemical changes from positive group engagement support enhance bonding, reduce aggression and dull perceptions of pain. In most cases I believe that humans are also altruistic, within boundaries and given the opportunity, particularly where they feel their actions have lasting impact.

As a hunter-gatherer species we co-evolved with the natural environment; the human body produced its own self-regulation pharmacy, for instance the range of myokines triggered by physical activity and temperature changes, that help regulate inflammation, oxidation and control a wide range of metabolic functions. Physical activity it would seem is a basic requirement for our species. It regulates blood sugar, builds muscular and



Hedgelaying in Regent’s Park

skeletal strength, returns blood from the extremities, and improves mood. Yet compared with former times, in today’s deskbound workplaces and with our homes crammed with labour-saving devices, we have little need to exert ourselves. Whereas until quite recently our diet varied with the seasons and was produced without chemicals, the transport industries, agri-business and Big Food have changed all that. Yet people who are less well-off are disproportionately disadvantaged when it comes to choosing to eat foods the body can thrive on.

The list of challenges our species had to overcome and shared as we evolved is a long one. In particular our mind and body had to adapt to the rigours and pleasures of the natural world, which may explain why simply being in green spaces can boost mental wellbeing. There is growing evidence of biological benefits too, for instance a joint project in autumn 2017 involving the BBC, The Conservation Volunteer’s (TCV) health programme Green Gym and the University of Westminster demonstrated improved cortisol awakening response (CAR) as well as reduced anxiety, in an eight-week conservation scheme management (ie group-based physical activity with a purpose) that at the same time enhanced biodiversity (BBC2, 2017). Players from the People’s Postcode Lottery support TCV to gain further evidence of the positive impact of Green Gym on health and wellbeing.

Evidently we have a symbiotic relationship with the natural world, and it’s one we break at our own, and its, peril. But when, as in the above example, we work collaboratively, *and* in nature (which reconnects us to being active and also has inherently two-way healing effects) we go *with* the grain of human nature. My 85-year-old father who suffers from Parkinson’s and other ailments is a case in point. He finds great solace in green spaces and in engaging with people. So by volunteering to greet visitors at Hampton Court Palace, his social



Participants at the Trust Me I’m a Doctor Green Gym in Regent’s Park

prescription allows him to socialise, feel useful, get active and spend time in green space: four-way health creation! He, of course would wryly observe that what I am proposing would have been ‘everyday common sense’ when he was younger.

Over the past 20 years and more, we have witnessed the scope of the NHS expanding, along with people’s ever-increasing expectations of the breadth and speed of care it should deliver; in parallel we have seen individuals’ growing disconnection from their own health-creating processes, perhaps exacerbated by consumer culture, live-now-pay-later values, and the ubiquity of lawyer-fuelled legal claims. I suspect the modern world’s disconnection from nature contributes to these high levels of learned helplessness: that the Smiths’ song Ask (1986) gets it right: ‘Nature is a language, can’t you read’. It seems we have lost our ‘natural’ nature-literacy and forgotten the fundamental roots of health. Yet social prescribing has enormous potential to restore some of this missing sense of self, of belonging, connection to place and (my particular focus) links with the other than human world. Where SP succeeds is when it helps a person own the challenges they face, celebrate their achievement in tackling adversity and be motivated to sustain an upward spiral of wellbeing and participation.

‘Natural forces within us are the true healers of disease’

(Hippocrates, 460BC–370BC)

TCV’s Green Gym is as an example of one kind of provider within social prescribing. It works with colleagues from charities with a similar ethos such as The Land Trust. Together with almost 1,000 small community groups we

enable more people to experience the benefits of group-based activity in green spaces. Aligned to components of social action theory and the five ways to wellbeing (connect, be active, take notice, keep learning, give), achieving things as a group within natural surroundings has clear health benefits. Other newer programmes such as Good Gym and parkrun use our altruistic nature and the outdoors to help others in a similar manner.

Something like social prescribing has been happening in many guises, under many names and for a long time. Now though, with social prescribing at a critical stage, there is potential to move it forwards with support from the NHS, which will be a crucial for its spread and long-term success. But let us never forget that social prescribing is about people and communities first; the communities that deliver the bulk of the provision whether in green spaces, through art, safe and affordable housing, debt support, help with relationships, loneliness. We are fortunate that the Big Lottery Fund supports TCV and many others to develop the social prescribing agenda.

There is an immediate need to ensure the sustainability of these active community groups, and NHS support will help of course. Never forget though, that social prescribing is a diversity of approaches all of which must be embedded in the communities they arise from. So is there a danger that the NHS, with the best of intentions, by bringing social prescribing into ‘the system’, could inadvertently erode the community roots that have to respond sensitively to local needs? Without this spontaneity will SP lose its essence?

I believe aspects of social prescribing work particularly well in nature and green spaces. It is powerful because it reflects our nature as group-living mammals, who are evolved to help each other and who want to feel valued, empowered, optimistic and enabled to seek help. Social prescribing has the potential to remind us that we are responsible for our own health, or at least to share responsibility with others who can help us build resilience. It tells us that it’s OK to ask for and receive support.

There is more evidence to be gathered of course, but let’s not dismiss what we instinctively know to be true about the positive impact of social support; that after all it’s not rocket science, it’s (human) nature.

‘The noblest art is that of making others happy.’

PT Barnham (1810–1891)

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Participants on the Camden Green Gym which celebrated its 10th anniversary in October 2017

Arts on prescription – five steps to success

Tim Joss

Chief Executive and founder of Aesop



The UK has a world class arts sector. Its potential to contribute to social prescribing is enormous but, to quote an All Party Parliamentary Group report (2017), only ‘a small modicum of the potential contribution’ has so far been realised. Thanks to the energy and imagination of many people in both health and the arts, there is new momentum ‘at the forefront’. Five steps to success are recommended, starting with stronger communication, respect and understanding between the health and arts sectors.

I’m a social entrepreneur. Looking back over the organisations and initiatives I led or founded, ‘bridge building’ has been a common theme. Four years ago, I left the privileged position of directing one of the larger charitable foundations to found Aesop Aesop (arts enterprise with a social purpose) and play my part in connecting the arts world with other sectors including education, international development and criminal justice. Behind this stood a conviction that the arts have not realised their massive potential to improve the lives of people and communities. We decided that health would be the first focus.

A new bridge

Social prescribing creates a new bridge between health and the arts – arts on prescription as it is now known. As social prescribing grows, there is every chance that trust, confidence and collaborations between arts and health professionals will grow too, leading to many patients’ improved health and wellbeing.

Social prescribing offers an opportunity to leave behind the depressing conclusion of a major report of 2017. *Creative Health*, the result of a two-year inquiry commissioned by the All Party Parliamentary Group on Arts, Health and Wellbeing, found that ‘the United Kingdom is still very far from realising more than a small modicum of the potential contribution of the arts to health and wellbeing’.

Thanks to many energetic and imaginative people in health and the arts, things are moving now. Aesop’s contributions have included the first evaluation framework for arts and health (commissioned by Public Health England, 2016), two sell-out national arts and health showcases for health decision-makers in partnership with the College of Medicine, and a survey of health professionals’ attitudes to the arts. Aesop commissioned ComRes to survey more than 1,000

GPs. The results were heartening: 66% agreed that public engagement with the arts can make a significant contribution towards preventing ill-health among the public. 44% also agreed that arts-based interventions can be a cost-effective way to deliver primary care to the public and improve health outcomes. 62% agreed that art-based interventions can make a significant contribution to improving the health and wellbeing of NHS staff.

The big question now is how to make the most of this new momentum and the opportunities that social prescribing offers. Here are five recommended steps to arts on prescription’s success.

Step 1 – Build stronger communication, respect and understanding between health and the arts

These sectors think and do things differently.

Arts activity is project-based. Whether a community arts workshop or a Hollywood film, the activity is time-limited, of its time and place, and project-funded. Health activity on the other hand is service-based, aims to be universally available and requires sustainable funding.

‘Is this arts programme available in my area?’ is a common question asked

by GPs. At present, almost all arts programmes are projects. No arts programme is universally available across the country.

Taking arts programmes to scale deserves to be a priority. There will be different ways of achieving this. It can mean delivery by one organisation such as National Museums Liverpool's 'House of Memories' programme supporting people to live well with dementia, or by many collaborating such as the groups within the growing Dance for Parkinson's UK Network.

On health sector attitudes to the arts, the Aesop survey of GPs generated more positive responses than expected. But for many in health the arts are treated as a 'nice-to-have' and 'fluff', not a core service. For instance, Norfolk and Norwich University Hospitals NHS Foundation Trust says on its website 'All our [arts] projects are funded by grants from organisations and charitable donations, no money is taken from healthcare budgets'. This needs to change.

There is also a problem with arts sector attitudes to health. Arts professionals believe passionately in the transformative power of the arts but fear being 'instrumentalised'. What they mean is a fear of being thought of as just additions to the health workforce, denied scope to be artistically creative and not respected as artists. Without this scope and respect, long-term engagement of artists will be a challenge.

This fear can be overcome. Aesop runs Dance to Health, a falls prevention dance programme for older people. The initial pilot programme showed that dance artists could be trained to smuggle evidence-based falls prevention exercises into creative, sociable dance activity and dance artists found the requirements artistically stimulating, not restrictive.

Developing a shared language will be crucial. Aesop's latest contribution is the Active Ingredients Project, a

collaboration with leading arts consultancy, BOP Consulting. It consciously draws on a health term and applies it to the arts, aiming to deepen our understanding of how arts interventions in health and social contexts actually work, and improve the ways these are designed and their impacts measured. The Active Ingredients model asserts that any wider utility of the arts is rooted in a core artistic and cultural experience. Those interested in the outcomes of arts in health need therefore to invest in that core artistic and cultural experience; it is not something that can be 'value engineered' out of the picture.

An example of an active ingredient is the arts' ability to change the way someone thinks about themselves, moving them from a negative health identity to a positive artistic identity. As one Dance for Parkinson's participant said, 'I used to think of myself as someone with Parkinson's. I now think of myself as a dancer'.

Step 2 – Harness passion and evidence

Approaches to evidence are very different in the arts and health. For example, while health has many widely used outcomes frameworks, the arts has none.

There are signs that convergence is under way. Social prescribing is one indication of health's looking beyond the biomedical model. Public funding pressure, scrutiny and demands for accountability mean that passionate belief in the benefits of the arts is no longer enough. The Arts & Humanities Research Council's Cultural Value Project is developing understanding of why the arts and culture matter and how we capture the effects that they have, and the evidence base for the arts achieving health improvement is growing.

However, more work is needed to bring research and practice closer together. The innovation foundation Nesta has made an important contribution with its standards of evidence (2013). There are five levels,

progressing from 'You can describe what you do and why it matters, logically, coherently and convincingly' (Level 1) to 'You can demonstrate causality using a control or comparison group' (Level 3) to 'You have manuals, systems and procedures to ensure consistent replication and positive impact' (Level 5).

Step 3 – Develop standards and ethics

A link worker advising a patient on local arts opportunities must be confident that any chosen activity has suitable standards and ethics such as safeguarding policies and procedures. With small local groups, this will not always be the case.

There is limited evidence that artistic quality and health improvement go hand-in-hand. Encouragingly, Aesop's experience with Dance to Health is that they do. It has been highly rewarding, effective and



Dance to Health, a falls prevention dance programme for older people. Photo: Helen Murray.

cost-effective to work with leading dance organisations already expert in working with older people.

More generally, measures for artistic quality are not established in the arts sector although Arts Council England has supported a quality metrics pilot which used self, peer and public assessment to capture the quality of art and cultural work.

Step 4 – Don't make health inequalities worse

In its '10 facts on health inequities and their causes' the World Health Organization (2017) says, 'There is ample evidence that social factors, including education, employment status, income level, gender and ethnicity have a marked influence on how healthy a person is. In all countries – whether low-, middle- or high-income – there are wide disparities in the health status of different social groups. The lower an individual's socio-economic position, the higher their risk of poor health.'

As social prescribing link workers engage with their local communities they will find another inequality. A Third Sector Research Centre paper by Professor John Mohan (2011) concludes, 'The broad picture is very clear: there are over 2.5 times as many organisations who say they work at the neighbourhood scale in the most prosperous neighbourhoods in the country compared to those in the most disadvantaged areas'.

Taken together, this means those with higher risk of poor health will have fewer social prescribing opportunities.

In the particular case of arts contributions to social prescribing, the inequalities may be even greater. Two reports by GPS Culture (2013, 2014) analysed distribution of arts funding. As Melvyn Bragg said in his endorsement 'This report is timely, urgent and damning of an increasingly centralised funding process. London is simply eating up the resources, which are limited, and is therefore starving the rest of the country. This is wrong, short sighted and undoubtedly unfair'.

The answer has already been recognised by the social prescribing movement: health must invest in social prescribing in disadvantaged communities. In the case of the arts, this can be helped by arts/health funding partnerships.

Step 5 – Don't underestimate the power of the arts

We have a world class arts sector built on three big pillars: the creative industries such as book publishing and the music and film industries; the voluntary arts sector with over 49,000 groups and 9.4 million people taking part; and the publicly funded sector which widens access and invests in innovation and the national's cultural heritage.



Members of East London Dance's older people's dance group, Leap of Faith, at the Southbank Centre. Photo: Helen Murray.

Fulfilling the arts' potential to contribute to social prescribing is just base camp. The arts can go much further in support of health. Aesop's national showcases have featured arts programmes which can be more effective and cost-effective than existing health provision – for example, the Raw Sounds music programme for aiding the rehabilitation of young people with severe mental illness. The arts have an important contribution to make to medical training as the Clod Ensemble's Performing Medicine programme (www.clodensemble.com/learning/performing-medicine/) has shown. And by helping patients express their experience of treatment (artist Bobby Baker's Diary Drawings – <https://dailylifeld.co.uk/our-work/diary-drawings> for example), the arts help the health system reflect on how to humanise and improve its services.

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The beauty of being an 'outsider'

An action research evaluation of the creativity, resilience, enablement and wellbeing (CREW) programme facilitated by Outsider Gallery London

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CREW is a pilot art and music programme for people who have experienced distress, madness and/or mental health services in north London. It was hosted by Outsider Gallery, facilitated at Clarendon Recovery College and ran from 2016–2017.

My decolonising and feminist commitments have emerged from my collaborations with community groups in Aotearoa New Zealand, New York and London toward mad, racial, gender and educational justice. These collaborations have also led me down an at times otherworldly path of participatory, embodied and creative methods in my research and teaching, as put forth in my forthcoming book with Routledge, *Psycurity: Colonialism, Paranoia and the War on Imagination*.

In our evaluation of CREW we found it makes a space for participants to experience expression, imagination and collectivity, and for service-providers and community members to experience and appreciate community, creativity and healing. It is an empowering, de-stigmatising and transformative programme with the potential to make a remarkable therapeutic and social impact. It should be enabled to continue.

'Everyone deals with their mental health very individually, so two people with bipolar would be two very different people... and you throw creativity into the mix with that as well and it's very difficult to determine, "Right that's your box, that's your box, that's your box and that ticks it all".'

(Ben, CREW facilitator)

When describing the aims and process of CREW (creativity, resilience, enablement and wellbeing) in an interview facilitators Ben Wakeling and Jon Hall spoke of four core elements. These four elements – a responsive *space*, the expression of *self*,

relationality and *support* and the telling of *stories* – enable CREW to sustain an ethical and engaged practice without imposing a standardised 'model' that would otherwise threaten the therapeutic and innovative essence of the programme. The evaluation that follows sought to explore how this approach affected individuals, services and the community.

Three groups of adults and young people chose to participate in the programme. Each was guided through weekly, one-hour one-to-one and group sessions for 10 weeks before being invited to showcase their art and music to the community through an evening of exhibitions and performances.

In our assessment we used a mixed-methods ethnographic action research evaluation to collect both quantitative and qualitative data. We simultaneously participated in the programme and reflecting on how to improve the evaluation process (Kagan *et al*, 2011; Cleary *et al*, 2016; Teo, 2010). Our final report drew on data collected from 75 post-session responses from CREW participants, 11 interviews with CREW participants

and 113 reflections from service providers and community members who attended the showcases. The findings focused on organising this data into recurring themes (Braun and Clarke, 2006), summarised below, alongside exemplar quotes from participants, service providers and community members. A concerted effort has been made to prioritise these voices over our own.



How are individuals affected by their experiences in CREW?

Expression

'Poetry has a very deep power, letting you see into your sub-conscious mind and real feelings.'
(CREW participant)

'To be able to sit down with a piano, just mess about with some chords and create something that sounds like a song, that made my confidence soar.'
(CREW participant)

'I have drawn a lot of things that I am really proud of.'
(CREW participant)

'It just helped me as a person really. I felt more confident with myself and I felt more confident with my creativity.'
(CREW Participant)



Top and above, members of the public at the open evening, Outsider Gallery

'What I've enjoyed, I'm guessing that they enjoyed, a lot is just the freedom to actually musically express yourself.'
(CREW participant)

'Like you don't have to be an artist to make art. It's just self-expression really.'
(CREW participant)

'It was a nice release from a lot of tension.'
(CREW participant)

'Other people like me with creative minds who have been through some stress and are trying to harness the creativity as opposed to let the creativity take over them.'
(CREW participant)

'It's just so accessible and comfortable and it's just comforting really. If anyone is like, 'I need to do something, feeling shit', come here and you'll feel way better.'
(CREW participant)

'I had absolutely nothing to do and basically CREW gave me a way to enjoy my time. And to be freer really. It doesn't matter, it's just enjoy your time while you are here, it doesn't matter, don't worry about small stuff, don't worry about this that and the other. Don't lose hope really.'
(CREW participant)

First, CREW made a space for participants to experience expression. The creative process led to feelings of confidence, pride and enjoyment along with a sense of productivity and accomplishment. It afforded the opportunity for self-expression within a context of clinically-led services that might otherwise limit experiences. In turn, participants spoke powerfully about the programme's capacity to positively intervene on, if not prevent, their feelings of distress and madness.

Imagination

'You don't necessarily have to do anything or bring anything to the table. They sort of... open your drawers and get all the pens and pencils out and paper and... it's all inside you. They just get it out'
(CREW participant)

'I found that I was able to do more than I would have given myself credit for being able to do.'
(CREW participant)

'At the end of the 10 weeks I have an album basically and that's such an accomplishment. It's actually more of an insight to who you are than it is as an accomplishment to others.'
(CREW participant)

'It's helped me to be more outgoing, it's helped me to talk and make my voice heard.'
(CREW participant)



Second, CREW made a space for participants to experience *imagination*. Enabled to get 'outside' of their everyday, people could reimagine themselves and the role and potential of their voice in the world. This opened their sense of what they and the world could be – including mental health services. Participants consistently requested for more CREW, or similar programmes, in which they were made to feel like an integral part of the therapeutic process for both themselves and others.

Collectivity

'Everyone was included, like actually everyone. Everyone pushed each other. I just thought it was just so beneficial to have that. It's like a youth club for adults but you actually learn stuff.'
(CREW participant)

'This provides something more than just the courses. I think it is somewhere that people can be and who might otherwise be alone.'
(CREW participant)

'It's nice to be surrounded by people that are understanding because they may not have exactly the same problems in their lives or the same unwellness, but if somebody's having a bad day, people are quite accepting of that and these people are nurtured.'
(CREW participant)

Third, CREW made a space for participants to experience *collectivity*. Participants spoke at length about the positive effects of the friendships and camaraderie developed over the programme. Also of a sense of being part of something bigger than themselves. They considered this to be

particularly significant given their experiences of distress and madness that could otherwise lead to isolation. Moreover, as their participation took on diverse forms while working towards a shared project, participants expressed a sense of their own uniqueness and agency within this collective.

How are services and the community affected by the work of CREW?

Community

'The whole thing is so brilliant!'
(Community member)

'It makes me want to become more involved with these kind of events.'
(Community member)

'How good it is to be a person and how a genuinely functioning community exists.'
(Community member)

'Life! How hard it is until you meet the right people to help see you through.'
(Community member)

'Made me aware of the importance of recognising and accepting any mental health.'
(Community member)

'How important it is to publicly celebrate recovery. How important it is to have lots of people alongside you, do it with you.'
(Community member)

'How great we could be as a society, if we all embraced events such as The Outsiders.'
(Community member)

'The power of bringing people 'inside', the magic of love and attention. I LOVE the 'normalness' of this work as an intervention.'
(Community member)



Top, above and page 47: paintings at the exhibition: Participants agreed to their pictures being used anonymously

Fourth, CREW made a space for service providers and community members to experience and appreciate *community*. People expressed immense enjoyment during the CREW showcases and spoke of a supportive atmosphere that allowed them to reflect on the importance of community in mental health and in general. In turn they engaged their own social responsibility as well as the value of difference and diversity – especially with regard to the humanity of experiences of distress and madness.

Creativity

'It was incredible how much talent was on show that would have otherwise gone unnoticed.'

(Community member)

'I just find it really astounding to keep being amazed by the music, by the poetry, by the art and also the fact that I'd stay here for 3 hours and talk to people about mental health, about art.'

(Community member)

'How important & vital creativity + self-expression is for wellbeing – for individuals and communities and the whole world!'

(Community member)

'How powerful it is to create our way out of mental distress.'

(Community member)

Fifth, CREW made a space for service providers and community members to experience and appreciate *creativity*. People consistently made references to the quality of the art and music on show, thus engaging with the artists and musicians as artists and musicians. This interrupts the focus on distress and madness that can otherwise dominate perceptions of people who use mental health services.

Healing

'Got me straight in the heart.'

(Community member)

'Thank you for this, made me reflect, feel very emotional and drained me of a lot of stuffs I need to get rid of, it was amazing!'

(Community member)

'Healing.'

(Community member)



'Feelings of quiet reflection.'

(Community member)

'...it makes you realise that mental health is one of those things that isn't talked about a lot, but actually it's out there, it's everywhere, and lots of people you might know have gone through it.'

(Community member)

'Bravery. How damn scared so many of us are to show vulnerability or anything raw and real.'

(Community member)

'I am really proud of the clients that I referred because it's really changed them.'

(Service provider)

'I'm just hoping that this sort of approach to mental ill health can be mainstreamed.'

(Service provider)

Sixth, CREW made a space for service providers and community members to experience and appreciate *healing*. People's connections with, and reflections on, the art and music suggested that the CREW showcase enabled them to not just witness but feel things that might usually be unspoken in or silenced by society. In turn, they expressed a recurring respect for the artists and musicians while simultaneously making them reflect on their own relationship to distress and madness. It followed that people commented on the need for CREW to continue as a unique alternative to clinically-led services, thought to not only improve but save lives while simultaneously promoting and relieving the other NHS providers.

The beauty of being an 'outsider'

Together, the above findings suggest that CREW participants:

- experience confidence, pride and enjoyment, including a sense of accomplishment
- feel free to, and comfortable with, expressing themselves
- are able to see their own and each other's capacity and potential
- come to know that their voice matters
- make friends, support each other, work together and feel part of a collective
- happily become actively involved in the process.

In addition, the findings suggest that through their encounter with CREW service providers and community members:

- have their expectations challenged
- commit to community
- value diversity
- see people as more than their diagnoses
- respect people who experience distress and madness
- witness and feel unspoken or silenced experiences
- do not 'other' people who experience distress and madness.

These lists suggest that CREW offers something distinct from clinically-led services. CREW creates an alternative space where participants are invited to explore and explode who they are and could be, rather than accepting a medical account of their experiences. Moreover, CREW creates a collective space that invites people to dialogue across differences; to see that things do not have to be 'this way'; to imagine that another world is possible and to collectively move towards it. Allowing these experiences of expression, imagination and collectivity, CREW promises a unique and effective form of empowerment in line with 'psychologies of liberation' (Baro, 1994) – which contributes to both individual and social wellbeing (Kagan *et al*, 2011).

Further, by making a space for service providers and community members to reflect on and connect with experiences of distress and madness, CREW offers an alternative to mainstream mental health campaigns. Feeling discomfort *and* safety are a necessary pathway for sustained personal and social change (Lorde, 1984; Anzaldúa, 1987). The capacity of the showcases to gently nudge and stretch emotional boundaries in a supportive setting suggests that CREW is striking a complex and powerful balance for affecting how people relate to distress and madness.

There is a growing body of evidence that anti-discrimination campaigns centring on a medical model actually increase stigma and social exclusion (Read *et al*, 2006). In contrast CREW enables a form of public engagement that *decentres* pathology and *recentres* community, creativity and healing. Simultaneously respecting the strength, contribution and humanity of

people's experiences, this potential to challenge discrimination also alleviates the suffering associated with distress and madness (Cromby and Harper, 2009). In addition, by explicitly valuing an 'outsider' status – both for participants and for the programme itself – CREW welcomes the contributions of diversity and marginality (Hooks, 1994), reframing efforts for 'inclusion' toward not simply transforming individuals but transforming society.

In sum, by making a space for participants to experience expression, imagination and collectivity, and for service providers and community members to experience and appreciate community, creativity and healing, CREW is an empowering, destigmatising and transformative programme with the potential to make a remarkable therapeutic and social impact. It is highly distinct from other clinical services. Like the participants, service providers and community members quoted above, we therefore strongly recommend that CREW be resourced to continue and to expand. However in doing so we acknowledge that the potency of CREW comes from its capacity to be responsive and participatory, as well as its capacity to create reflections on existing knowledge and services. This is nourished by the programme's own status as an 'outsider' to existing institutions. Any attempts to grow it must respect and sustain this dynamism by respecting and sustaining its independence and authenticity. CREW needs to be able to continue to walk the talk about 'the beauty of being an "outsider"'.
Following more than 50 years of scholarship and activism, including by people with a psychiatric diagnosis and/or using psychiatric services, we choose to use the words 'distress' and 'madness' in order to interrupt the dominance of the medical model (including its associated inaccuracies and injustices) and witness the politics of both people's experiences and psychiatric interventions.

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Health creation and social prescribing ... what's the difference?

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The Health Creation Framework has been developed through listening carefully to people. It works because it is based on the experience of disadvantaged people whose lives have been changed for the better and those who work closely with them. They have told us that the key things that made the difference to them were listening and responding, truth-telling, strengths-focus, self-organising and power-shifting. Health creation comes about when local people and professionals work together as equal partners and focus on what matters to people and their communities.

My main professional expertise lies in housing policy and practice but I often describe myself as a sector-bridger since much of what I do lies at the interface between traditional professional domains. My passion is to bring congruence between public services and the reality of people's and communities' lives – which requires health, housing, social care and other services to work together and focus on what it is that makes people well. I've worked with and advised many organisations including The King's Fund, NHS England, the National Housing Federation, Housing LIN, the Local Government Association, De Montfort University and the Royal Town Planning Institute.

Social prescribing is increasingly being recognised as offering health and wellbeing benefits to patients beyond the consultation interaction alone. By recognising that people's health is primarily determined by a range of social, economic and environmental factors, it seeks to address people's needs in a more holistic way.

According to The King's Fund (2017) there are more than 100 social prescribing schemes in the UK – there may be many more. They are supported by the Social Prescribing Network and NHS England's national clinical champion for social prescribing which advocates for this more holistic intervention.

Another approach to addressing the unmet health and wellbeing needs of people and their communities is through the practice of health creation. This is being championed by New NHS Alliance and its members.

Simply put, health creation is a route to wellness. It comes about when local people and professionals work together as equal partners and focus on what matters to people and their communities. Health creation is complementary to, and can enhance, social prescribing. However, there is

still some confusion as to how health creation fits within the overall scheme of things.

Wellness is an active process of becoming aware of, and making choices toward, a healthy and fulfilling life. Wellness is more than being free from illness, it is a dynamic process of change and growth.

University of California (undated)

Health creation and social prescribing

New NHS Alliance was recently asked, on twitter, to clarify the relationship between social prescribing and health creation – as espoused by the alliance and its members.

We felt that the best way to respond might be to set out not just one but several illustrations of how the relationship works. We expect different perspectives to be helpful to different people depending where they sit within the health and care system. And we value your feedback – so please feel free to tweet your thoughts @nhsalliance.

Health creation and social prescribing ... what's the difference?

The first thing to say is that social prescribing is an excellent first step in the journey to adopting health creating practices. If you're a general practitioner, a practice manager, a practice nurse or anyone else supporting general practice, and you've not already adopted social prescribing, then the emerging evidence for its benefits indicates that you should seriously consider doing so. Adapt and respond.

Social prescribing opens up a wide-range of possibilities for social interventions, alongside medical ones. It is a move away from the biomedical approach to a holistic person-centred partnership and it starts the process of culture change among the workforce and patients. Having a community navigator who can spend more time listening and working with individuals to find appropriate solutions to their ailments or troubles will certainly help more people to better health than the traditional model of the 10-minute consultation.

Health creation is a route to wellness

To be well, people need sufficient

Control over the circumstances of their lives and the things that affect them.

Contact with other people that is enjoyable, meaningful and purposeful.

Confidence to see themselves as an asset able to have a positive impact on their own and others' lives.

The second point is that, while any general practice that is adopting health creation is likely to have social prescribing as part of the mix, it should not be assumed that they are

therefore 'doing' health creation. Among the many social prescribing models some are going to work better than others in terms of enhancing wellness. Our community-informed framework suggests that the most health creating forms of SP would be characterised in abundance by these five features – *listening and responding, truth-telling, strengths-focus, self-organising and power-shifting*. (For more information about the five features of health creating practices see www.nhsalliance.co.uk). Those that have two or three of these five features will offer benefits although they may not be meeting their full potential.

The third point is that general practice can adopt a wide range of practices that can be health creating, not just social prescribing. Group consultations are a good example. Where they are done well, peer learning and support (aka self-organising) becomes a bigger part of the patient experience. In one study in Croydon, type 2 diabetes patients reported learning more compared with one-to-one consultations. This included improved understanding of their diabetes and how to manage it. Supportive friendships that are forming through the group sessions come with more acceptance of the need for lifestyle change. Not only that but having attended such meetings patients then engage with local social prescribing and report they wouldn't have gone to SP events on their own. New NHS Alliance recently found evidence of high levels of health creating practices in hospital discharge schemes, initiatives that support people with mental health difficulties within the community and social clubs for older people, to name just a few.

And finally, social prescribing is a specific practice, albeit one with many variations. It is 'a means of enabling

Health creation happens ...
... when communities and professionals work together as equal partners and do what matters to communities



People need



Control
Contact
Confidence
... to be well

The 5 features of health creating practices

- Listening and responding
- Truth-telling
- Strengths-focus
- Self-organising
- Power-shifting



New NHS Alliance is calling for ...

1. The adoption of health creating practices
2. System reforms to support Health Creation
3. Enhanced education in Health Creation

Professionals can ...

- Adapt their current practices
- Adopt whole new practices
- Disrupt by working with communities to produce whole new solutions

Become a partner in Health Creation
<http://www.nhsalliance.org/becomeamember>

GPs and other frontline healthcare professionals to refer patients to a link worker – to provide them with a face-to-face conversation during which they can learn about the possibilities and design their own personalised solutions, ie ‘co-produce’ their ‘social prescription’ – so that people with social, emotional or practical needs are empowered to find solutions which will improve their health and wellbeing, often using services provided by the voluntary, community and social enterprise sector’ (defined by the first Social Prescribing Network conference in 2016).

Health creation is, by contrast, a way of working at the front line that is not the preserve of healthcare professionals. It requires asset-based skills characterised by the five features of health creating practices. When these five features are working, it provides the conditions for people to gain **control**, make meaningful **contact** with others and build **confidence**. People need enough of the 3Cs of health creation to be well.

It is the equal partnership and the ability of people to work together with others to address the long-term issues that matter to them and their community that makes for lasting change in people’s and communities’ lives. Communities play roles, professionals play roles, and what gets done revolves around what matters to the communities. If done well, there is a positive impact on the workforce as well as on the community.

The five features of health creating practices

Listening and responding: effective, genuine listening to the reality of people’s and communities’ lives is essential. As is acting differently on what is heard, and not just reverting to the established systems. Listening can also enable truth-telling when there is sufficient trust for people to open-up about matters they might find it difficult to face up to.

Truth-telling: when people and practitioners face the truth and can identify and acknowledge what holds them back from creating health, rather than treating illness, they can start to get to the root causes of problems.

Strengths focus: health creation happens when attention is paid to what people can do for themselves or others. Making people aware of their strengths, and finding opportunities for them to employ them, unlocks their potential and builds confidence for creating health.

Self-organising: putting people in touch and helping them to connect meaningfully with others makes it possible for them to find solutions and take actions together. When people start to value, trust and help each other and work together, they are more likely to find purpose in their lives and this drives wellness. Over time, people become less reliant on health and care services.

Power-shifting: lasting health creation happens when the features above result in a power shift from practitioners to people and communities. When people’s expertise and strengths are recognised and valued, they can make good decisions about things that affect them and their environment. Services can then adapt and respond.

Health creation is a route to wellness. It comes about when local people and professionals work together as equal partners

The route to health creation

Social prescribing is one route into health creation. As well as providing a connection between the medical and social models of health, it also helps to create a bridge between primary care, other local services and communities. Those who adopt community-led versions of social prescribing and continue to develop them by fully embedding the five features of health creation practice within them have the greatest potential to improve population health. Other sectors and parts of the health system will take different routes into health creation. For many, *making every contact count* (MECC) is part of the journey. For others the adoption of reflective practice and psychologically informed environments is the route to take. What is most important is that we all go on the journey, that we all recognise the efforts of others who may be taking different routes, and that we are all open to learning from each other along the way.

General practice can adopt a wide range of practices that can be health creating, not just social prescribing

It is heartening to see that social prescribing has been widely taken up by general practice despite the lack of a robust evidence base. This is unusual. It is also absolutely necessary if we are to stand a chance of embracing either social prescribing or health creation. Trying new practices, incrementally building the evidence base, sharing our learning and strengthening our collective confidence as we go along are all essential to bring new practices to the mainstream. This needs to become the new normal, applying as it does as much to health creation as to social prescribing.

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Whither social prescribing?

Richard H Kimberlee

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June 2018 saw the Social Prescribing Network host its first International Research Conference at the University of Salford. I was hoping to discuss the ideas presented here but illness prevented it. The NHS in England is in crisis; a victim of its own success? In response to this crisis key leaders, in different locales, have independently evolved 'bottom-up', partnership approaches, frequently bespoke, to respond to this crisis and have constructed them as social prescribing. But whither will this go? In this paper I outline the first of three alternatives for the future of social prescribing: war of position.

My interest in what I call 'holistic' social prescribing has been lifelong. I grew up in a small town in Worcestershire where my mother was the practice manager of a local surgery. In the 1960s, engagement with GPs were more than nine-minute encounters. They knew their patients and their families and worked tirelessly to evolve and engage local resources to promote communal wellbeing. Working as a public health economist today we see local people trying to recreate these transformative intentions to achieve a more effective approach to promote wellbeing.

Social prescribing is a wicked term. The post-modern, angst-driven, conceptualisation of social phenomena as 'wicked' first emerged in the field of social planning in the 1960s. 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 providing GPs, and more recently all primary health care professionals, with an option to prescribe a non-medical opportunity 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 London in the 1980s many interventions, projects, initiatives and health professionals have begun to don 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, for example 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'! A recent review of social prescribing initiatives commissioned by the Department of Health and undertaken by researchers from the Social Prescribing Network revealed at least six different models of social prescribing (Polley *et al*, 2017). It was 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 non-clinical 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 often interventions that have evolved from simpler models over a period of years. The worker is external to the clinical 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 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 realisation that growth in antibiotic resistance could lead to what the chief medical officer for England (Dame Sally Davies) calls 'the end of modern medicine'. This leaves the poor and the vulnerable, who are reaping 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. But this universal NHS is still bounded by a belief that a bureaucratic structure constitutes the most efficient and rational way in which health services can be organised and that systematic processes and organised hierarchies are necessary to maintain the natural order with maximum efficiency, and effective delivery of services to the patient. However, in an age characterised by increasing diversity and individualism, unfettered bureaucracy actually 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. De-industrialisation 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 (SP) is often seen as an intrinsic answer. With no agreed definition of SP there is heterogeneity in its promulgation, with different social prescribing alliances carving out and delivering programmes through the development of varying alliances of counter-hegemonic partners from public, third sector and even the private sector. The state still assumes the 'spontaneous consent' of the populous by virtue of the negotiated construction of a political and ideological consensus around the NHS. But communities are 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 often being nurtured and sustained by new coalitions of funders which respect the autonomy of the movement to which they contribute.

“ A recent review of social prescribing revealed at least six different models ”

Social prescribing was being highlighted as one of 10 'high impact actions' in NHS England's *General Practice Forward View* (Varnum, 2016) They see it 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. However, 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 or how it should be done. This has allowed existing social prescribing schemes to emerge organically 'from the bottom up' through local leaders from different sectors. For instance, this pioneering of a way forward is happening in Gloucester and Rotherham, even developing into a universal social prescribing service provision linked to every GP practice in these areas. 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 hierarchy. Thus initiatives are being funded in a variety of ways: half of existing initiatives are supported by the local clinical commissioning group and/or local authority funding partnerships. However others use public health money and grants from various organisations including The Big Lottery, and a few use social impact bonds. One local council has raised the precept on its 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. The NHS mantra of demand reduction in GP attendance and in A & E usage (attendance and admissions) appears often to have been fulfilled. For the most part, social prescribing seems to have a protective effect on service demand according to a recent review of 94 studies (Polley *et al*, 2017). But this evidence applies only 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 NIHCE) 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 NIHCE 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 timescales, and are subject to high drop-off rates at follow-up. This means their studies frequently lack the power to show a statistically significant outcome. This is clearly a huge challenge. Social prescribing, like any other innovative and transformative approach to addressing broader population's needs, is 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!

Its viral growth and inherent localism makes assessment of social prescribing's impact difficult

We are a long way from 1948, when we recall that 85% of BMA members voted against the establishment of the NHS six months before its launch. At the time, 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 1,500+ members of the Social Prescribing Network is, in reality, providing informed and experiential counter-hegemonic understandings and values that suggest that our health services should not be delivered by a top-down, silo service capable only of reactive responses 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. This is about 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. Experience so far reveals that health and wellbeing services per se have developed through contested knowledge and social constructs that continue to be as challenged and challenging today as they were 70 years ago. Social prescribing is building civic capacities to think differently about local wellbeing, and to challenge assumptions and norms, and to 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. Among the extraordinary achievements of the radical Welsh GP, Julian Tudor Hart, who sadly died aged 91 in July this year, was an account of the 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. 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 rather to co-operate to maximise useful service. These local staff and local populations need reason to believe that they have moral ownership of, and loyalty to, their neighbourhood NHS units and services. We are facing some years of particular uncertainty in this respect. The unforeseeable consequences of Brexit, and the possible privatisation of health services because of diminishing budgets, mean 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 and environmental factors that impact on health and wellbeing. Social prescribing invites people to respond holistically to the causes of poor health.

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The Fife Shine programme

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Health and social services in the UK are groaning with the strain of seemingly inexorable rises in pressure on hospitals, care homes and home care with growing numbers of older people and people with chronic health conditions needing support. Such deep systemic challenges suggest the current pattern of care in unsustainable. This paper describes how one small area of Scotland (Fife) has used fresh thinking to co-design bespoke solutions with patients and their families. While there is still further to go, there are signs that a more resilient and responsive pattern of care is emerging.

I have spent more than 20 years as a specialist in public health in NHS Fife, a Scottish health board which serves a population of 370,000 people. During this time, I realised the thinking which had led to huge gains in population health over 150 years was not proving powerful enough to tackle 21st century health challenges. Since the early 2000s, my links with International Futures Forum have enabled me to meet people with multiple perspectives, willing to share their thinking, which offered better possibilities. This led to work with public health colleagues called The Fifth Wave.

Introduction

The White Paper Liberating the NHS in 2010 from Andrew Lansley, newly arrived as Secretary of State at the Department of Health, was a missed opportunity. With flatline budgets for the NHS for the foreseeable future, increases in an elderly population with chronic and complex conditions and declining morale in the workforce, something radical was needed. Instead, the White Paper set out plans to increase marketisation in the NHS and became enshrined in law in 2013 as the Health and Social Care Act.

Today, the NHS in England endures the consequences of these decisions, struggling with waiting times, staff vacancies, deep financial deficits and a fragmented system with multiple providers and complex commissioning arrangements. Might there yet be hope that something different could emerge in Scotland, which abolished the purchase-provider split in 2003, yet is still facing many of the same challenges in terms of finance, workforce and changing patterns of disease? Might there be a way to sustain vital elements in the current system while growing a new one, better suited to the current and future operating environment? This paper sets out an example – the Fife SHINE Programme – from one health board area which aims to do just this.

Three horizons thinking

To understand how a different system can emerge, it is necessary to think about how patterns of activity rise to dominance, subsequently decline, and new ones take their place. We also need to consider how to manage the transition from an old system to a new one in ways which sustain the viability of the whole over time. One way of exploring this territory is to use the three horizons framework (see Figure 1). The framework describes three different patterns of activity taking place simultaneously to create a complex adaptive system.

The **first horizon** – H1 – is the dominant pattern at present. It represents 'business as usual'.

The **third horizon** – H3 – emerges as the long-term successor to business as usual and is much better fitted to the world that is emerging than the dominant H1 system.

The **second horizon** – H2 – is a pattern of transition activities and innovations, people trying things out in response to the ways in which the landscape is changing.

Without the 'pull' of H3 and a transition strategy to navigate the turbulence along the way, H2 innovation will inevitably be assimilated into the existing system. This might extend the life of H1 for a while, but increases the scale of the necessary

transition before H3 can become the new dominant pattern.

Three horizons for healthcare

The origins of the Fife SHINE programme can be traced to a three horizons conversation in 2009 on winter planning for NHS Fife. The concern was a familiar one to many working in the NHS today, not just in the winter but the whole year round. It was noted that hospital pressures were high with older people in particular subject to delays in their discharge as they awaited suitable care at home. These delays led to further concerns about adverse health impacts: reduced scope for active rehabilitation, staying longer than necessary in unfamiliar surroundings, being exposed to risks of infection and falls. Added to these concerns was acknowledgment that staff were feeling worn down by the seemingly inexorable rise in demand at the front door of the hospital. These concerns represented the signs that the H1 dominant pattern of healthcare was under strain and unlikely to be sustainable through many more winters in its current form.

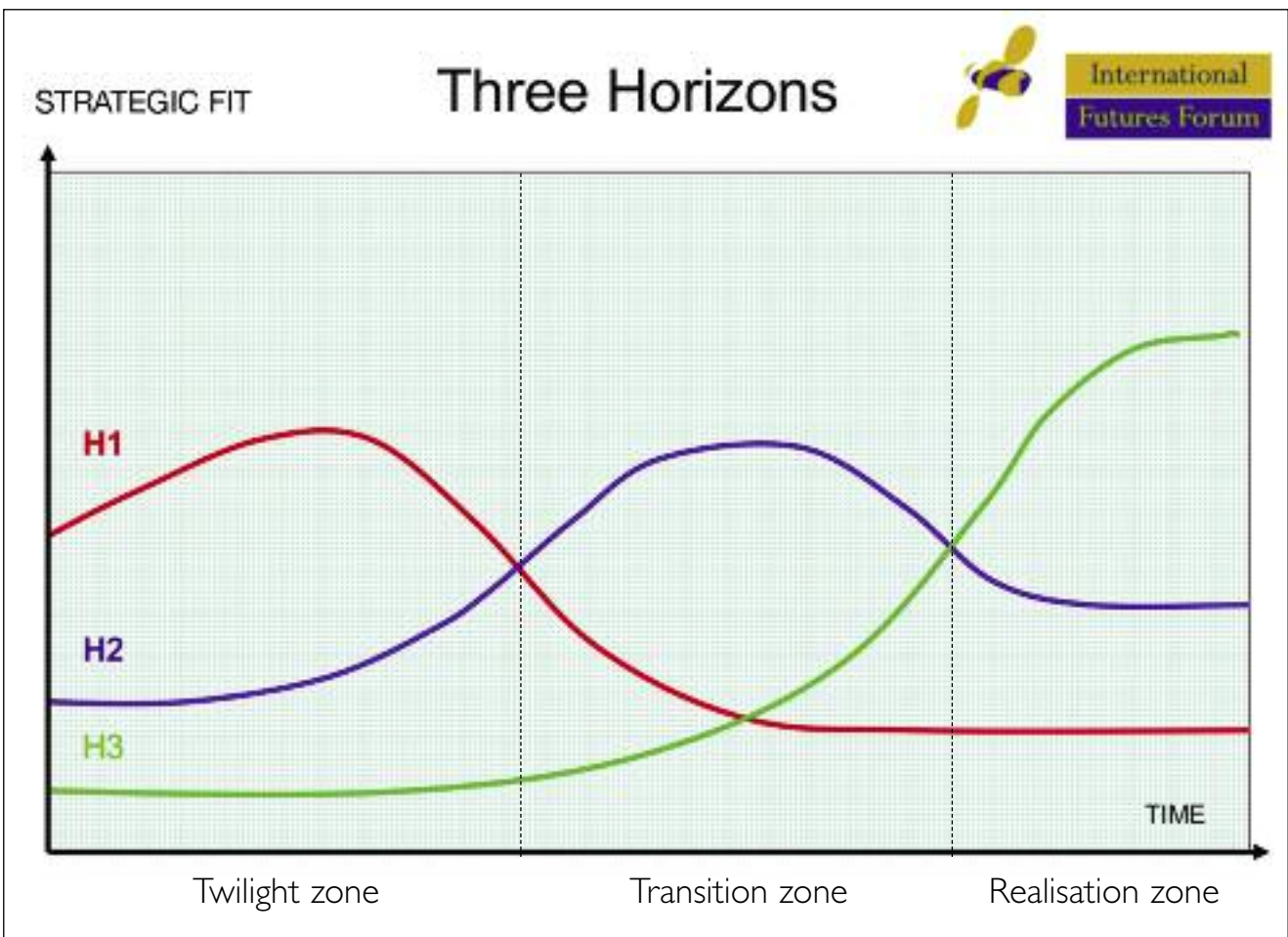
The conversation also revealed an aspirational vision (H3) of a very different, all-pervasive pattern of care, based on an understanding that solutions were to be found outside the conventional system, driven by what people needed in their lives to ‘help them thrive, not just survive’. The Nuka system of care in Alaska was identified as a living

example of this vision operating at scale (H3 in the present). The word Nuka means a large living system and describes the system developed by the Alaskan Native people to create a pattern of healthcare shaped by the quality of relationships between its participants. Deeper study of the approach convinced the pioneers in Fife that the shift in culture they had imagined was indeed possible in practice and at scale (Hannah, 2014).

Changing the conversation

The Fife SHINE Programme began by changing the conversation with older people to focus on life and relationship rather than infirmity, and to identify what it would take to enable them to thrive at home. Community health and care staff (including third-sector providers) were introduced to the concept of personal outcomes – allowing people to describe what was important to them in their lives. They were trained to use a solution-focused approach (good conversations) with patients who had been discharged from hospital or referred by their GP for additional home-based support. In these conversations they explored ways in which personal outcomes could be achieved. That frequently involved reconnecting with friends, family, neighbours and the local community.

In addition, the programme aimed to identify and stimulate a new network of local ‘micro-providers’ of support to cater to the range of personal and bespoke



needs revealed in the process. These micro-providers were small-scale and local (up to five people working in them) and ranged from purely voluntary activity such as lunch and sports clubs to formal social enterprises such as shopping services or community transport operators.

In 2010 The Health Foundation opened a grant programme called Shine inviting innovative 'invest to save' proposals. Fife won one-year funding and began its work in 2011.

From small beginnings

It was very slow work at the beginning. In the first year just six older people completed the process from engaging in a different conversation to identifying and achieving their personal outcome, often involving local micro-providers in the process.

However the small number disguised the fact that the families and staff involved were amazed. Stories such as, 'You're the first person who has really listened to mum', from her daughter; 'I feel human again' from a patient, and 'You forget your aches and pains when you are involved in something worthwhile' from a micro-provider suggested something remarkable was taking place. The approach seemed to be life-enhancing for those willing to give it a go.

“ The H1 dominant pattern of healthcare was under strain and unlikely to be sustainable ”

Over the next five years, the programme has scaled by a factor of 10 each year and now reaches more than 30,000 people in Fife across different services and agencies. A shift in the pattern of care has gathered strength year by year and is now, at least in the area of older people receiving care in the community, almost pervasive. After the funding from The Health Foundation ended, the work kept going hand-to-mouth. The part-time programme manager and clinical champion roles were eventually funded from mainstream budgets. During this time, beyond the NHS, social work has also funded several community link workers (local area co-ordinators); created an online directory of local voluntary sector activity (On Your Doorstep) which is used by staff when they are having personal outcome conversations; and provided a small-scale voluntary projects (Small Sparks) fund.

Managing the turbulent transition

What kept the small team of innovators going? After all, by any standard measures the first year results failed to demonstrate any tangible impact on service or funding pressures. The answer lay with the stories from patients

and families about achieving life goals in ways that surprised them and their professional carers. People were not looking for extravagant outcomes, but worthwhile activities which helped them feel connected, able to reciprocate in some way and feel valued as human beings. Staff and families were creating small pockets of the third horizon pattern in the midst of the first horizon system.

“ The programme aimed to identify and stimulate a new network of local 'micro-providers' ”

Breaking out of the old pattern meant questioning assumptions about evaluating success and about spreading and scaling innovation. Growing a new pattern had to take into account the ongoing changes in the old pattern (H1 decline), opportunities for gathering momentum and building alliances (H2 activity) and challenges from alternative versions of H3, out of line with the aspirations of local people. Fundamental to success was a requirement to learn at every level of the programme, from reflective practice for individual staff members, peer support for teams and services, gathering patient stories using routine processes, annual learning events for stakeholders and working with researchers and evaluators interested to come alongside the programme as fellow learners.

Gradually, local systems have begun to adapt and shift to support the new pattern. Standard documentation includes personal outcomes and processes for the regular review of progress. Care pathways have evolved to create opportunities for this personal outcomes approach when the patient or client's needs are too complex for a single disease or service response. Examples include patients referred to musculo-skeletal physiotherapy with chronic issues, patients attending neurology clinics with functional symptoms and 'high health gain' patients requiring complex case management.

Patterns shift when mindsets change

This is not just about scaling up an innovation. The change is more profound. For the third horizon to grow beyond the work of a small team of innovators, the whole mindset of people working in the system needs to change. After three years of working in this new way, it became clear that people involved were thinking differently as shown in Table 1, overleaf.

Such a deep shift in mindset can only come through lived experience of working in a different way, supported by others, reflecting and learning with them and seeing the transformation in people's lives that results.

Table 1: Changes in thinking	
Belief in the past	Belief now
Patients have to change, not us.	We have to change first in order to facilitate change in the people we support.
We need more staff.	We do not need any more staff but we need to work differently, often in a more integrated way and in real partnership with our community.
We provide healthcare but are being asked to provide social, psychological and spiritual care.	We can't provide healthcare without attending to social relationships and exploring meaning and purpose and what gives us joy in our lives for our patients and ourselves.
We are person-centred.	We need more encouragement, opportunities for development and clear permission to provide continuity and relational care and less emphasis on tasks and activities.
Only if we are doing something are we providing healthcare.	Good quality conversation is itself a health intervention.

Outcomes for Fife

While it is impossible in such a complex, dynamic change process to attribute cause and effect, it is worth noting that NHS Fife is today, in spite of testing circumstances familiar across the UK, a high-performing health board with top quartile performance for waiting times across most indicators. More importantly perhaps, during the last severe winter, with flu pressures to contend with and the acute challenge of the ‘beast from the east’, the system as a whole has shown its resilience in bouncing back quickly to its previous high performance levels.

A comprehensive case study of the SHINE programme has recently been published by International Futures Forum (Leicester, 2018). It explores the conceptual architecture that underpins this conscious initiative in systems change, records the progress year by year and the lessons learned at each stage of the journey. It concludes

with general lessons derived for practitioners in health and social care interested in following this approach to shifting the dominant pattern and policy-makers or funders wishing to encourage and support such approaches.

Most interesting, however, might be the chapter on ‘the last mile’ – an exploration of what it might take at this point to make this H3 innovation, which started at such small scale back in 2011, the new dominant H1 pattern. At that point this innovation in the system will become an innovation of the system and proof positive that even as the NHS struggles we do have a plausible Plan B. There is hope. Watch this space.

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Two Rocks Shouting at Each Other by Maya Cockburn www.mayacockburn.com

Social prescribing – are drugs or people the better cure?

Thomas Christie

Medical student



The title for the 12th BHMA student essay competition was Social Prescribing – are drugs or people the better cure? Students were asked to radically and critically consider the future of healthcare in the context of social prescribing. Thomas Christie was awarded the £250 prize for his 'clear and direct style of writing' and also his 'decision to borrow from Michael Marmot to ground the complex issues that familiar individual experiences entail'. Judges were impressed by his emphasis on the necessary balance between understanding and working with the complexity of human communities, and the very different kind of complexity of pharmaceuticals.

I am a fifth-year medical student at the University of Oxford, Green Templeton College. Outside of medicine I enjoy rugby and rowing, and am also a keen writer, currently working on this year's medical school pantomime. The reason I wrote this essay is largely due to the way the medicine course is organised at my university. The first three years of our course are almost entirely lecture based, with a major focus on reviewing scientific papers, and understanding the molecular underpinnings of different diseases and the drugs that treat them, but often neglecting the impacts of disease, and other avenues of treatment. The idea of social prescriptions was something that I did not really encounter until my fourth year, when we had our first hospital and community placements. The argument in my essay, that all treatments should be evaluated equally based on outcomes instead of separated by method (with drugs given priority), is based on my experience in general practice, where the importance of other forms of treatment became apparent to me. I hope you enjoy reading it.

I recently read the book *The Healthcare Gap* by Michael Marmot (2015), and one passage in particular stuck with me. It is a conversation between a patient with relapsing depression and her physician.

Patient: Oh doctor, my husband is drinking again and beating me, my son is back in prison, my teenage daughter is pregnant, and I cry most days, have no energy, difficulty sleeping. I feel that life is not worth living.

Doctor: Let's try swapping the blue pills you were taking for these red ones.

Though this passage refers to a single conversation from over 30 years ago, anyone involved in healthcare today will recognise it. It is a conversation that represents the limits of medicine; doctors do not always have a cure. This position of powerlessness is something that has haunted doctors since the beginning of the profession, and will continue to until its death.

The phrase 'we did all we could' is of no comfort to anyone.

The last century offered doctors some of the first truly effective weapons in the fight against disease, effective medication. Drugs like antibiotics and chemotherapy agents, and more recently antibody therapies and antidepressants, have provided proven and effective treatments for many diseases that were virtually untouchable before. Drugs such as Imatinib and cisplatin have reduced the mortality rates of certain cancers by orders of magnitude, and vaccines have wiped out some diseases entirely, and have reduced others to vanishing scarcity.

Drugs have not, however, by any stretch of the imagination cured all illnesses. Medicine lacks treatments entirely for many diseases, and the available therapies for others are often only marginally effective and can be burdened with side-effects. Most would agree that for the case above, new and improved antidepressants are

Social prescribing – are drugs or people the better cure?

unlikely to help this woman; at best, they would treat the symptoms, but not the causes, of her condition. Unfortunately, this is the case for the majority of patients that we try to treat. Drugs are not equipped for the infinite complexities of the human condition. Antibiotics can treat infections – but when we look beyond the infection we might see that it occurred in a 77-year-old woman recovering from a hip operation. Investigating further we find she broke her hip when she fell down the stairs in her house, she has glaucoma and can't see well. And we discover that she was found only by chance hours later, her husband had recently died and she now lives alone. As the complexities of this case increase, we begin to appreciate how limited antibiotics alone are in their ability to improve the life of this patient.

“Medicine lacks treatments entirely for many diseases, and the available therapies for others are often only marginally effective”

Luckily drugs, referrals and operations are no longer the only tools in a doctor's arsenal; medicine has branched out. Instead of waiting for a frail patient to come into A&E with a fractured hip, we can send them to a falls clinic. Instead of treating the injuries of a young adult who self-harms, we can send them for counselling and involve social services. Instead of trying a depressive patient on more and more antidepressants, we can assign them CBT or light therapy. Even better, these methods seem to work with and enhance the effects of drugs; studies have shown that light therapy and antidepressants both improve depression, but a combination of the two is better than either treatment alone (Lam *et al*, 2016).

Another set of resources can be found in what is known as social prescribing, a term that refers to local non-medical services that can serve to better one's life. This rather broad classification normally refers to activities such as volunteering, art activities, and sports, but can also encompass things such as legal aid and nutritional advice.

Schemes for which studies have been conducted do seem capable of having positive effects on health and well-being. A study in Bristol (Kimberlee, 2013) found that social prescriptions resulted in decreased levels of anxiety and better reported health, and another in Rotherham (Dayson and Bashir, 2014) showed that these schemes reduced the hospital admission risk of patients after four months. As a consequence of these results, and off the back of some NHS policy papers (NHS, 2014), some forms of social prescription are being accepted as valid forms of treatment, and are being prescribed with increasing regularity in the UK. It is important to note that many current therapies started outside the field of medicine, and gradually joined with it as their effectiveness was

proven; psychiatry and physiotherapy, to name just two.

Despite the potential benefits of social prescriptions, they are far from perfect. The detractors of social prescribing often describe them as ineffective, unproven, and expensive. While many may see these criticisms as unfair, they are difficult to argue against, as so few trials exist for these treatments. In order to be comfortable prescribing these therapies, GPs and others in primary care need to be sure that they work. One of the most commonly prescribed social therapies for alcoholics is a recommendation to attend Alcoholics Anonymous meetings. This organisation claims that its famous 12 step programme results in a 75% cure rate for participants, and it currently has over 2 million members worldwide. However, the actual rate of 'cure' has been estimated to be closer to 5–8% (Dodes and Dodes, 2014), and AA actually ranks 38 out of 48 methods for alcohol addiction treatment (Glaser, 2015). Imagine how many more people could have been cured if they had been sent to the other, better programmes, instead of to the most popular one. Even worse, unproven therapies may have damaging side-effects, in the same way as drugs. For years people experiencing traumatic events were treated with psychological debriefing (talking back through a traumatic event in its immediate aftermath), in order to decrease their risk of developing PTSD. Both doctors and patients thought it was incredibly successful, and it became widely practiced. Later, however, several RCTs revealed that this therapy actually increased the risk of developing PTSD compared to controls (Rose *et al*, 2002).

“A study showed that these schemes reduced the hospital admission risk of patients after four months”

We need these therapies to undergo comprehensive evaluation so doctors can determine their usefulness, otherwise we risk wasting the patient's time, the NHS's money, and potential QALYs (quality adjusted life years). For these therapies to be thought of in the same way as drugs, they will have to go through the same review process.

There has traditionally been a large amount of resistance to the prescribing of these types of social therapies, from within medicine and outside it. The main reason for this is perfectly demonstrated by the question around which this essay is based. *Are drugs or people better?* This title immediately raises two assumptions. The first, that only one can be chosen – there is no potential for collaboration – and the second, that the two things are fundamentally different. And this is how they are regarded within medicine, as a second option to try if the drugs don't work, or more often, as treatment for the mind,

where drugs are treatment for the body.

This division is artificial – the mind and body are not separate entities; what affects one affects the other. In the age of holistic medicine, we should be regarding drugs and social prescriptions both simply as treatments, and should be evaluating them not by the medium in which they are delivered, but by how effective they are. This means that not only should these social prescriptions be treated with the same significance as drugs, they should be subject to the same degree of scrutiny. Randomised controlled trials, producing unbiased results, are needed to determine the uses and limitations of these therapies as treatments, in the same way as drugs are evaluated.

This is not to say that these therapies will replace drugs. They could, however, be another piece of equipment in a doctor's toolbox, prescribed in the same way as drugs are now, by their effectiveness. A future in which social prescriptions are given alongside drugs would offer more opportunities for patients to be effectively treated, and give doctors more tools with which to do their jobs. Returning to that opening conversation, imagine how it would look in a brave new world where drugs and social therapies are valued the same and prescribed together.

Patient: Oh doctor, my husband is drinking again and beating me, my son is back in prison, my teenage daughter is pregnant, and I cry most days, have no energy, difficulty sleeping. I feel that life is not worth living.

Doctor: Let's try swapping the blue pills you are taking for these red ones. I'll also put you in contact with the local legal counselling service to see what we can do about your husband. There is a mother and daughter pregnancy counselling service you could attend as well. There's also a new trial that I might be able to get you on, looking at the impact of art therapy on people with relapsing depression. Would you be interested?

Medicine is about preserving people's health and wellbeing. By accepting social prescriptions as another method with which to achieve this goal, medicine will expand its ability to treat patients in need, and doctors will have to face situations in which they have nothing to offer less and less.

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Swimming with Fish by Maya Cockburn www.mayacockburn.com

Whither social prescribing



William House

Retired GP; Chair of the BHMA

My interest in social prescribing (SP) started in the late 1990s. I had been a full-time GP for about 15 years, practising in Keynsham near Bristol – long enough to be frustrated with the weaknesses of ‘fix-it’ healthcare. One day we had a visit from a somewhat eccentric and certainly charismatic woman named Victoria Orah. She wanted us to send her some of our patients who we thought might be helped by getting involved with the community. She seemed to know a lot about what was going on ‘out there’, and certainly a great deal more than we did in our cocoon of scientific promises, intricately woven by Big Pharma. So we said we would. Victoria’s work became known as the Amalthea Project, from the nurturing goddess in classical Greek mythology. My life began to change at the moment our goddess, Victoria, walked into our surgery!

Amalthea blossomed and many grateful residents need us less often. But the blossom would soon wither and fall away. A group of researchers at the University of Bristol set out to evaluate the project through a randomised controlled trial – supposedly the gold standard evaluation of an intervention (Grant *et al.*, 1999). This bureaucratic research process was like a damp blanket over the project. Our goddess fell ill; the project limped along to the end of the research, but Victoria could carry on no longer and Amalthea was no more. So ended my SP mark 1, killed for its own good.

SP mark 2 started in 2006 with a phone call from the local public health department wanting practices to help with public health. Conversations followed with a far-sighted local council senior manager, a group of people active in the community and another researcher (this time qualitative). After a preparatory qualitative study we launched a more organised form of SP with skilled and paid facilitators, proper support and light touch evaluation. We called it ‘New routes’. It gave us a much deeper, richer and ‘holistic’ understanding of what we were doing (Brandling and House, 2009) but it remained a poor relation at the edge of healthcare and finally fell victim to austerity.

By this time I had retired from the practice and had more time. I wanted to understand what SP actually does. I could see that medicine is limited by its dominant linear understandings of living systems, and from my long interest in complexity I knew the living world is not simply linear but rather complexly circular – it is an ecosystem. I realised too that the name ‘social prescribing’ looks in two directions. ‘Social’, evoking ‘society’ and ‘community’, is resolutely complex: a world of relationships and stories. ‘Prescribing’ is often complicated, but (providing you avoid the politics) it is mostly not complex. It is basically linear:

Illness > medical diagnosis of disease > prescription for disease

We at the BHMA believe that prescribing must encompass at least some of the complexity of the individual and the society to which they belong. The pioneer in the understanding of complex systems, Gregory Bateson, argued that the linearity of medical knowledge comes from the scientific basis of the medical model (Ward, 2017). SP challenges this linearity. It’s just a pity about the name. The young GP in Bromley, south London, who is credited with inventing the name ‘social prescribing’, told me she regretted it soon after it had caught on. Of course, it caught on because it is easy for medics, managers and politicians to understand. She had realised at some level that ‘social prescribing’ is an oxymoron – it contains an inherent contradiction. Our wonderful living world is overwhelmingly complex, so treating it as if it were simple and linear is doomed. This problem becomes acute when we begin to look at relationships – in this case between a patient and the community of which they are a part – in the ecology of this social system.

So after my retirement as a GP in 2010 I found a group of residents with similar interests (some my ex-patients) and formed a small community organisation we called Keynsham Action Network (KAN). It was launched in 2011 to explore the empowerment of the people: putting them in control, so perhaps, ‘social empowerment’ is a better name. In this experiment, SP is removed from the shackles of the NHS and reinvents itself in the same community where I was once a GP. This has emerged as SP mark 3 (House, 2018). It is a version of London’s now famous Bromley by Bow project, but for a middle class community with endemic loneliness. So what does KAN do? For me, KAN’s most inspiring and exciting intervention so far concerns the nature of conversations within the community. This recognises that they are the golden thread that nourishes connection and belonging. For this we are adapting a conversational technique very successfully pioneered in the Fife Shine project in Scotland (see page 55). We are in the early stage of training as many as possible of those who care in the community (including NHS staff) to use this conversational form in their everyday work. Since we are intervening in an ecosystem, we will be studying the impact on the entire community, but with a very light touch. Watch this space.

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Reviews

Sapiens: a brief history of humankind

Yuval Noah Harari

Vintage, 2011

ISBN 978 1 84655 823 8

Sapiens – a brief history of humankind is a writer's force of nature. It presents as a large book – nearly 500 pages – yet this is remarkably small for a work of such historical scope and intellectual variety. These, together with literary panache, yield us both a tardis and Aladdin's cave of ideas.

Yuval Noah Harari is an academic in world history and his quest here is to offer an evolutionary history of humankind. This he does by constructing an often speculative narrative, taking us from our mindless biological roots to (his) imagined future scenarios of robots, cyborgs and humans, where our triumphant intelligence has rendered us:

Self-made gods with only the laws on physics to keep us company, we are accountable to no one. We are consequently wreaking havoc on our fellow animals and on the surrounding ecosystem, seeking little more than our own comfort and amusement, yet never finding satisfaction.

Is there anything more dangerous than dissatisfied and irresponsible gods who don't know what they want?

This bleak possibility and stark question are, in fact, the book's very last passages – Harari's dark coda to end a vivid, varifocal and often brilliantly orchestrated (his)story.

*

Even before we start, the book's back cover offers an alluringly sharp synopsis signposting the trenchant writing within.

100,000 years ago, at least six human species inhabited the earth. Today there is just one.

Us. Homo sapiens.

Why did our foraging ancestors come together to create cities and kingdoms?

And what will our world be like in millennia to come?

Harari sources his myriad evolutionary streams to three major transitions: the cognitive revolution (language, writing and abstract thought), the agricultural revolution (domestication; the concepts of property, time investment and instrumentalism; the harnessing of nature), the scientific revolution (investigative knowledge; the control of nature; the growth of industry, capital, empire and social control).

These panoramic explorations are not confined to the relative safety of *what* probably happened, but extend to the riskier *why*. Harari builds his formulations from a wondrously wide range of original source documents, art and artefact, and established disciplines – archaeology, anthropology, biology, physics, agriculture ... all of these bulk-out the 'what'; sociology and a wise choice of psychologies humanise the 'why' and lead to the book's unusual and engaging qualities: this is also an

experiential history. So Harari portrays what he imagines was the likely day-to-day social and subjective experience of our forebears. When he then weaves in parallel descriptions of religious or political developments he often anchors these in humankind's deeper, rarely directly articulated, fears and hauntings. In this way he auras the pith of likely facts with the ever-present spiritual and existential, as he understands them. Such balance between academic rigour and inter-subjective imagination is probably something of a doomed high-wire act in academia.

Inside the front cover is another brief array of visual soundbites; I imagine Harari help crystallise:

FIRE gave us power; GOSSIP helped us cooperate; AGRICULTURE made us hungry for more; MYTHOLOGY maintained law and order; MONEY gave us something we can really trust; CONTRADICTIONS created culture; SCIENCE made us deadly.

Maybe no one has yet termed 'holistic history', but here must be a supreme example: a creative unification of the apparently disparate and unconnected. The resulting synthesis hums with new life.

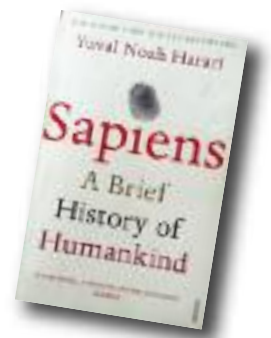
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Sapiens was published in 2011 and quickly gathered critical acclaim and brisk sales. Starting to read it six years later, I looked forward to a bracing whirlwind tour of history. What I did not anticipate was how relevant, illuminating and galvanising I would find all this – this enormous tapestry – in how I perceive and conceive my immeasurably smaller area of interest: our current public welfare and its conundrums.

Harari's notions of long-vanished worlds are often startlingly relevant to what we struggle with today: this is painfully true of our welfare. Of course this could be dismissed as merely a twenty-first century projection onto all else. Equally, yet more important, it may signal our perennial impasses and follies, and then the truth of the adage: the most reliable lesson from history is that we do not learn from history.

Many of the book's passages convey this so well as to merit extended quotes. Healthcare's current escalating traps and follies – industrialisation, monetisation, marketisation, commodification, reification of the abstract and ideological, the tragic fate of the simplistic – all are present in this sampling. The reader can surely identify apposite examples from our current political, social and welfare predicaments:

- *Most human cooperation networks have been geared towards oppression and exploitation. The peasants paid for the burgeoning cooperation networks with their precious food surpluses, despairing when the tax collector wiped out an entire year of hard labour with a single stroke of his imperial pen.*
- *This is why cynics don't build empires and why an imagined order can be maintained only if large segments of the population – and in particular large segments of the elite and security forces – truly believe in it ... How do you cause people to*



believe in an imagined order such as Christianity, democracy or capitalism? First, you never admit that the order is imagined. You always insist that the order sustaining society is an objective reality created by the great gods or by the laws of nature.

- There is no way out of the imagined order [of intersubjective myth]. When we break down our prison walls and run towards freedom, we are in fact running into the more spacious exercise yard of a bigger prison.
- The most important impact of script on human history is precisely this: it has gradually changed the way humans think and view the world. Free association and holistic thought has given way to compartmentalisation and bureaucracy.
- Writing was born as the maidservant of human consciousness, but is increasingly becoming its master. Our computers have trouble understanding how homo sapiens feel and dream. So we are teaching homo sapiens to talk, feel and dream in the language of numbers, which can be understood by computers.
- Such [human and societal] contradictions are an inseparable part of every human culture. In fact, they are culture's engines, responsible for the creativity and dynamism of our species. Just as when two clashing musical notes played together force a piece of music forward, so discord in our thoughts, ideas and values compels us to think, re-evaluate and criticise. Consistency is the playground of dull minds.
- When the natives questioned Cortés (the conquering Spanish conquistador of Mexico in 1519) as to why the Spaniards had such a passion for gold, the conquistador answered, 'Because I and my companions suffer from a disease of the heart which can be cured only with gold'.
- When everything is convertible, and when trust depends on anonymous coins and cowry shells, it corrodes local traditions, intimate relations and human values, replacing them with the cold laws of supply and demand ... Human communities and families have always been based on belief in 'priceless' things, such as honour, loyalty, morality and love. These things lie outside the domain of the market, and they shouldn't be bought or sold for money ... As money brings down the dams of community, religion and state, the world is in danger of becoming one big and rather heartless marketplace.
- Treating living creatures possessing complex emotional worlds as if they were machines is likely to cause them not only physical discomfort, but also much social stress and psychological frustration ... The tragedy of industrial agriculture is that it takes great care of the objective needs of animals, while neglecting their subjective needs.
- This [capitalist-consumer ideal] is the first religion in history whose followers actually do what they are asked to do. How, though, do we know that we'll really get paradise in return? We've seen it on television.
- Yet all of these upheavals are dwarfed by the most momentous social revolution that ever befell humankind: the collapse of the family and the local community and their replacement by the state and the market.
- In the last two centuries, the intimate communities have withered, leaving imagined communities to fill the vacuum.

*

Some might find Harari's bold speculations too unprovable, too reckless, to assimilate and take seriously. Yet I was heartened to find a broad historical view that seemed to grasp the human heart and mind of our long stories and struggles. This relief contrasts strongly with recent years' contact with medical colleagues, managers, planners, academics and politicians who seem to me dishearteningly increasingly out of touch with the human heart and mind in healthcare. Indeed, such evisceration of the human mind and heart is a deliberate preliminary in our burgeoning and mandatory 'systems' that now predicate the entire span of our activities, from personal consultations to the political manoeuvring of our largest institutions. It has become cultural.

How has this happened? How have we devised systems of human welfare that attempt to refine themselves by jettisoning the primacy of understanding better our nature's vagaries? Some of the sampled notions of this historian can help us here: the cognitive inhibitions of writing (and its computerised developments), the destruction of natural bonds and ecosystems in systematised farming, the destruction of human bonds from ideologically driven marketisation. No, Harari is not intending to write about healthcare: he is attempting to map large historical currents. But his big picture captures clearly so much of importance that we recurrently do not, or will not, see. We instead become in thrall to our own culture, and then are conscious only of the detail of its inner mechanisms; its larger working and directions lie beyond our depth of field.

*

Harari quotes from a 1942 German biology textbook:

The battle for existence is hard and unforgiving, but is the only way to maintain life. The struggle eliminates everything that is unfit for life, and selects everything that is able to survive ... These natural laws are incontrovertible; living creatures demonstrate them by their very survival. They are unforgiving. Those who resist them will be wiped out. Biology not only tells us about animals and plants, but also shows us the laws we must follow in our lives, and steels our wills to live and fight according to these laws. The meaning of life is struggle. Woe to him who sins against these laws.

Marie Harm and Hermann Wiehle (1942) *Lebenskunde für Mittelschulen – Fünfter Teil. Klasse 5 für Jungen.*

Such was the banal yet malign fare from a grotesquely dark regime now almost beyond the horizon of living memory.

Today we live in relatively beneficent times, surely?

Yet let us say you are an employee of our now competitively marketised NHS. You have provided trusting, loving vocational care for many years. But this is hard to measure and your NHS Trust is small, economically pusillanimous and liable to be deemed 'economically unviable. For closure under our *Sustainability and Transformation Plan ...*'

The above passage will send through you a chill of recognition.

*

History is like some of our great music: our many interwoven themes have many guises, variations and returns.

History is not just for historians.

David Zigmond
Retired GP and physician in psychological medicine

holistic healthcare

Re-imagining healthcare

About the BHMA

In the heady days of 1983 while the Greenham Common Women's Camp was being born, a group of doctors formed the British Holistic Medical Association (BHMA). They too were full of idealism. They wanted to halt the relentless slide of mainstream healthcare towards industrialised monoculture. They wanted medicine to understand the world in all its fuzzy complexity, and to embrace health and healing; healing that involves body, mind and spirit. They wanted to free medicine from the grip of old institutions, from over-reliance on drugs and to explore the potential of other therapies. They wanted practitioners to care for themselves, understanding that practitioners who cannot care for their own bodies and feelings will be so much less able to care for others.

The motto, 'Physician heal thyself' is a rallying call for the healing of individuals and communities; a reminder to all humankind that we cannot rely on those in power to solve all our problems. And this motto is even more relevant now than it was in 1983. Since then, the BHMA has worked to promote holism in medicine, evolving to embrace new challenges, particularly the over-arching issue of sustainability of vital NHS human and social capital, as well as ecological and economic systems, and to understand how they are intertwined.

The BHMA now stands for five linked and overlapping dimensions of holistic healthcare:

Whole person medicine

Whole person healthcare seeks to understand the complex influences – from the genome to the ozone layer – that build up or break down the body–mind: what promotes vitality adaptation and repair; what undermines them? Practitioners are interested not just in the biochemistry and pathology of disease but in the lived body, emotions and beliefs, experiences and relationships, the impact of the family, community and the physical environment. As well as treating illness and disease, whole person medicine aims to create resilience and wellbeing. Its practitioners strive to work compassionately while recognising that they too have limitations and vulnerabilities of their own.

Self-care

All practitioners need to be aware that the medical and nursing professions are at higher risk of poor mental health and burnout. Difficult and demanding work, sometimes in toxic organisations, can foster defensive cynicism, 'presenteeism' or burnout. Healthcare workers have to understand the origins of health, and must learn to attend to their wellbeing. Certain core skills can help us, yet our resilience will often depend greatly on support from family and colleagues, and on the culture of the organisations in which we work.

Humane care

Compassion must become a core value for healthcare and be affirmed and fully supported as an essential marker of good practice through policy, training and good management. We have a historical duty to pay special attention to deprived and excluded groups, especially those who are poor, mentally ill, disabled and elderly. Planning compassionate healthcare organisations calls for social and economic creativity. More literally, the wider use of the arts and artistic therapies can help create more humane healing spaces and may elevate the clinical encounter so that the art of healthcare can take its place alongside appropriately applied medical science.

Integrating complementary therapies

Because holistic healthcare is patient-centred and concerned about patient choice, it must be open to the possibility that forms of treatment other than conventional medicine might benefit a patient. It is not unscientific to consider that certain complementary therapies might be integrated into mainstream practice. There is already some evidence to support its use in the care and management of relapsing long-term illness and chronic disease where pharmaceuticals have relatively little to offer. A collaborative approach based on mutual respect informed by critical openness and honest evaluation of outcomes should encourage more widespread co-operation between 'orthodox' and complementary clinicians.

Sustainability

Climate change is the biggest threat to the health of human and the other-than-human species on planet Earth. The science is clear enough: what builds health and wellbeing is better diet, more exercise, less loneliness, more access to green spaces, breathing clean air and drinking uncontaminated water. If the seeds of mental ill-health are often planted in an over-stressed childhood, this is less likely in supportive communities where life feels meaningful. Wars are bad for people, and disastrous for the biosphere. In so many ways what is good for the planet is good for people too.

Medical science now has very effective ways of rescuing people from end-stage disease. But if healthcare is to become sustainable it must begin to do more than just repair bodies and minds damaged by an unsustainable culture. Holistic healthcare practitioners can help people lead healthier lives, and take the lead in developing more sustainable communities, creating more appropriate models of healthcare, and living more sustainable ways of life. If the earth is to sustain us, inaction is not a choice.

Journal of Holistic Healthcare

"The Journal of Holistic Healthcare...
a great resource for the integration-minded,
and what a bargain!"

Dr Michael Dixon

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ISSN 1743-9493

PROMOTING HOLISTIC PRACTICE IN UK HEALTHCARE