Social prescribing in rural areas

Background and purpose

Over the last ten years the concept of 'prescribing' a variety of non-pharmaceutical interventions to meet individual's health needs has gradually gained acceptance throughout the health and care system of the UK.

The origins of the use of the term are uncertain but, as with many good things, success has many parents. GPs, voluntary & community organisations, public health professionals and social care practitioners all contributed to an awareness that there were often better alternatives to a growing drugs bill needing to be met by the NHS.

Over the same ten years the ACRE Network, often in partnership with other voluntary organisations, was developing networks of Village or Community Agents. The Agents' precise role differed around the country, but one common strand was working within health and care systems to re-connect individuals in rural areas with both voluntary and statutory services that would improve their well-being and quality of life. In this respect they should be seen as both pre-cursors and deliverers of social prescribing.

This short policy note is intended to help develop an agreed ACRE Network vision for the delivery of social prescribing in rural areas and how this can most effectively integrate with Village/Community Agent programmes. To this end, it is starting out with a small number of key points rather than an exhaustive policy position.

1. The model: inclusive and welcoming communities

It is sometimes said that the first objective for charities should be to remove the need for their own existence! The same must be true of social prescribing. It should be unnecessary for someone who would benefit from more exercise, social contact, intellectual stimulation, friendship, or a better diet to have these 'prescribed' by a medical practitioner. Communities of all kinds (but especially rural ones where other services may be inaccessible) can be active, inclusive, and welcoming places where this kind of prescription is not needed.

Delivery of active, wider, community development with place-based communities of all kinds should be seen as part of a rich pattern of support that helps achieve the same overall health objectives as social prescribing. Many of those who will benefit from involvement in their community will not, in the first instance present with a medical need. This does not mean their health will not benefit in the long term from doing so. 'Social prescribing' cannot, therefore, operate in isolation from wider community development.

2. Variety and local solutions

The delivery of social prescribing is dependent on the development and maintenance of a local 'infrastructure' of active organisations, groups, volunteers, and opportunities for local engagement. This is intrinsically local and will necessarily vary from place to place. Centralised national, County or even district direction is less appropriate and potentially counterproductive because this will detract from local ownership, commitment and thus sustainability. Support for local solutions and development of very local groups and services is essential. In this respect, pluralism and variety is a strength, not a source of weakness.

Often statutory agencies first encounter the rich variety of community organisations that exist in many villages and urban communities, at a single point in time and assume it is always thus. In fact, organisations such as lunch clubs, good neighbour schemes and Village Hall based activities are in constant flux and need support, advice and guidance if they are to be sustained. Those commissioning social prescribing services need also to commission development support for the groups to which individuals will be prescribed. Without this the social prescribing model will not evolve or be capable of being sustained.

3. Application of available resources

As soon as the DHSC and NHSE allocated significant national resource to social prescribing, the whole concept was taken much more seriously by local NHS, Public Health and Social Care management. Approximately £50k was initially allocated to each Primary Care Network and used, almost without exception, to employ new staff either within the statutory sector or commissioned by it. The resulting "link" workers or "connectors" tended to support a single cluster of GP surgeries.

Almost none of the resources dedicated to this initiative reached the small, local, VCS organisations to whom individuals started to be 'prescribed'. This is rather like devoting the NHS drugs budget to employing an army of additional doctors who can prescribe treatments whilst also telling the pharmaceutical industry that it must now provide the prescriptions for free. This urgently needs to change if the social prescribing model is to become sustainable.

One of the blockages to positive change may arise from the different cultures and partnership expectations in the NHS, local government and the VCS. NHS England, as a centrally resourced public body, may have limited understanding of system spend and limitations from other partners in local Integrated Care Systems or what this spend is aiming to achieve. There is a need to be more explicit about resources being required for transformation and development in local areas, not simply used in a transactional way.

4. Roles for national VCS organisations

National recognition of the principles of social prescribing, community development and a thriving/inclusive local civil society is, of course, very welcome. For all the reasons set out above it is essential that those who promote social prescribing at a national level do so with a keen eye to subsidiarity *and sustainability.* The strength of the approach, and the potential to improve people's lives – especially in relation to mental health and well-being – lies at a local level and in the local connections made between individuals, families and the rest of their community.

An important national role would be to commission research from health economists that can place the value of social prescribing on an equal footing to similar research commissioned by the pharmaceutical companies for their products.

5. Rural delivery

The model that has been used for link workers and connectors has tended to be based on the urban context where a single, usually full-time, link-worker can be based in a single location alongside other health professionals. This approach may work in these locations, especially if the urban VCS is similarly organised and can be co-located, by may not be the right solution in a rural area.

In rural areas the available resources for the 'link worker role' may be much better used in other ways to overcome the additional costs of delivering services to dispersed populations. Where other public sector services share a single Village Agent style of outreach to small communities it makes much more sense to integrate the link-worker role into this same network.

Finding economies of scope across multiple services in rural areas is one of the fundamentals of rural proofing service delivery and should be applied in this case. All system partners will find themselves either wasting money or failing to reach people with needs in rural areas if they do not collaborate with very local partners, community groups, good neighbour schemes, Village Agents, transport providers etc.. The ACRE Network and its local members can help to achieve this.

One approach to delivering socially prescribed services in rural areas that is often suggested is to do so digitally. Whilst this may be a useful adjunct for some activities and services it cannot be seen as a complete solution in its own right and, in some rural areas, will be impossible, unaffordable for the individual or require extensive support.

Afternote re. National Academy for Social Prescribing (NASP)

Members of the ACRE Network have been involved in the NASP Thriving Communities Programme, and the Network has recently been involved in discussions with NASP over the setting up of an 'Innovate Community of Practice'. Experience of Thriving Communities has varied, but some aspects have been a common concern amongst those involved. These have been:

- The regional geography that has been set up by NASP has not been helpful, especially since key relationships in this area are being forged at a much more local and, generally, county level in rural areas.
- The overall objective of the programme has not been very clear to participants and the activities / events have not seemed to add value to what is happening locally.
- There seems to be an underlying philosophy to create a large scale, national, approach to social prescribing. This is at odds with the need to build on local activities happening organically in local communities.
- There does not seem to be much willingness to accept the importance of 'subsidiarity' to local areas given that resources for social prescribing are delegated down to ICS level within the NHS.

Overall, the ACRE Network is keen and willing to engage with NASP's 'Innovate' initiative but is equally keen to help NASP avoid some of the design and perception issues that have affected Thriving Communities.

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