

## Dr Michael Dixon GP, LVO, OBE, National Clinical Lead for SP, NHS England & NHS Improvement. Chair, College of Medicine. Co-Chair, International SP Network.

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What an amazing morning this has been! I feel I have been amongst prophets and world experts this morning. Much to attribute to Veronica for having been an absolutely tireless proponent of the arts and dementia over the past few years, and also, to Muir. Muir has this wonderful title, he did have, as Director of Knowledge for NHS. It is nice to see him still living up to that repository of knowledge. Brian, I so much enjoyed your presentation just now. As you say, social prescription (SP) is very well developed in the UK, with two or three SPLW in every group of GP practices or PCN. But we have now formed the Global Alliance within the National SP Academy (NASP), and that includes the United Nations (UN), World Health Organisation (WHO) and about 25 other countries. Very rapidly SP is becoming a global movement, even in the Republic of Ireland, where the minister there is quite committed to making it global there. So, a lot of things are happening in SP.

This morning I want to talk about its role in early dementia. I do not suppose anyone from what they've heard over the last two days doubts that social prescription has a role in dementia, but what I want to argue is that it has an equally central role for people where there is even the mildest suspicion of dementia or memory problems. My argument over the next ten minutes will be: firstly, because that will make social prescription more effective in the long run, secondly because it will delay the deterioration of that person's memory; and thirdly, that even in those where they are not proven to have dementia eventually, there are endless benefits for social prescription having been offered.

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Let's first look at the argument for social prescription being more effective if intervention is early. As GPs we often see people at these very early stages, and often the patient and the relative may suspect something is going on, but our tests do not prove that. It is more difficult often in general practice these days, because often we do not know our patients quite as well as we used to. So, there is that suspicion as it were. Sometimes that leads to a referral, and often there are compounding factors, particularly during COVID19, such as loneliness. You probably know this, but 2.6 million people in the UK, according to the Office of National Statistics, said that they were lonely all or most of the time during Covid, [\*Mapping loneliness during the coronavirus pandemic\*](#) (2021). Of course, that obfuscates the diagnosis. I have no doubt that at that stage, when people are thinking of a referral, as GPs, or have actually referred, social prescription has a crucial role.

That is because the SPLW will see the person, and find out what they are like, find out what their beliefs, what their hopes, what their fears, what their challenges are. Then help them to take on a number of interventions, such as the arts, or outside group activities which will work for them. The point of getting them to do this at an early stage is because the person concerned can then get to know a group of people, and become familiar with a particular activity, and create routines and activities that will be putting them in good stead for the future.

An important part here is confidence. We know that for instance, if you look at socially isolated people, there is something called the paradox of loneliness. Scientists have shown, that if you are a lonely person, you have twice as much suspicion of a stranger than an un-lonely person. There is a paradox, those who are most lonely and want to socialise find it most difficult. That is where social prescription comes in, that's where social prescription in the early stages of dementia can give people that boost in confidence, that socialisation which is so crucial. Not to mention Dominic's word 'joy', and not to mention Brian's word 'hope', which can be offered in these early stages. I would say that there are endless reasons why any suspected case of dementia should be referred by their GP, occupational therapist or anyone else concerned, for SP, indeed by the carer themselves. Do not forget the carers, because during COVID, three-quarters of carers said that they felt more stressed, [\*GMB Union\*](#) (2021). So, we must think about them as well and offer them an early opportunity for the person they are caring for to get help.

Quite apart from people getting rooted in activities in an early stage being a good thing, the other issue is the extraordinarily powerful effect that social prescription can have in delaying and mollifying the effects

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of dementia itself. Muir Gray has already referred to this. Take social interaction, we know that having social interactions itself makes your chances of dying 25% less, [\*Social Relationships and Mortality Risk: A Meta-analytic Review\*](#) (2010). That is not only social activity, but often with social prescription we are talking about greater physical activity, often healthy diet, improved mood, all these things can delay the progression and mollify the main effects of dementia. Of course, Muir mentioned the words 'sense of purpose'. Sense of purpose itself, and also the feeling that you're actually doing something, almost whatever you're doing, activating that patient will itself have a beneficial effect.

Thirdly, what about those for whom the diagnosis of dementia turns out perhaps not to have been right, or even, the suspicion. In general practice you see lots of people with, for instance pseudo-dementia, where the person's memory and cognition has deteriorated, but it is due to something else, particularly depression. Of course, with depression, surely if social prescription can help that progression, that is going to be better for the patient concerned than giving them a tablet, and far more sustainable, because they have got something ongoing that will sustain the recovery. Ditto for the other issues that bring people to surgery to see me with suspected cognitive decline. Often it is actually relationship breakdown, sometimes it's a specific disorder like low thyroid. In all cases, I think social prescription can offer a solution, even if that final diagnosis isn't dementia. Maybe we shouldn't be too hung up on this diagnosis, suddenly someone not having dementia and then having dementia. Maybe we should see it as progression, we should see that social prescription can help at all stages. Daisy Fancourt at UCL has shown that if you take up a hobby you are three times more likely to come out of a depression, [\*COVID19 Social study\*](#) (2020). How powerful an effect is that, compared to an antidepressant which often have rather marginal effects.

In my own [\*NHS surgery\*](#), we offer a whole range of interventions, some of which are specific for patients with dementia, such as the memory clinics, but most of them are for anyone who is lonely, elderly, has early stages of dementia, and these are things like art and craft classes, knit and knatter groups, patient walks. We have three, coming onto five different gardens that people can enjoy, work in and socialise in. These various interventions are relevant for people with a whole range of problems, we don't have to necessarily feel that we're targeting patients with dementia, and in the early stages we don't even need to label them. I think social prescription is clearly not something we aim at dementia; we aim it at the person who may be suspected of having it. Providing

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someone with a reason to live matters whether or not the final diagnosis is proven. It is totally crucial for anyone who becomes a dementia patient in the end. How we achieve that? Well, I'd love to go onto that, but I see that's the subject of the next session! Thank you.

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