

**Glasgow Centre for Population Health and Glasgow
South East Community Health and Care Partnership**

**AN INVESTIGATION INTO GPs AND SOCIAL
PRESCRIBING**

A Pilot Study

FINAL REPORT

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JAN SWIFT: Research Consultant in Health Development

Contact details for author:

Jan Swift
Freelance Consultant in Health Development

7 Burnside Terrace
Kilbarchan
Johnstone
Renfrewshire
PA10 2EY

01505 703024 / 07733 054744

jan@janswift.freeseve.co.uk

Contact details for Publisher

Glasgow Centre for Population Health
Level 6
39 St Vincent Place
Glasgow
G1 2ER

Phone 0141 221 9439
Fax 0141 221 5749

Web: www.gcph.co.uk

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EXECUTIVE SUMMARY

Introduction and Method

Social Prescribing is a method of impacting on the wider determinants of health such as the social, economic and environmental factors, through linking people with health problems to non-medical sources of help and support in the community, usually referral by primary care. This study was a pilot, the purpose of which was to inform the development of a full proposal for exploring referral practice in primary care in social prescribing. The pilot study tested the methodology, scope and reach for the full proposal.

Qualitative methods were used to gather data to meet the research questions. Several different methods of contacting GPs were used to gather data on referral practice, including open forums, letters of invitation, snowball sampling through personal contact and email. There were difficulties in recruiting GPs to the study with different experiences of social prescribing. There were 9 informants in the pilot study. Two focus groups and two in-depth interviews were conducted.

Findings

The GPs in the study generally took a holistic view of health and supported a social model of health. They all made use of social prescribing / referral to some degree and signposted patients to sources of social support in the community

Referral was the preferred term and this was perceived as a written referral to a social programme, with the responsibility for contacting the patient and giving feedback residing with the organisation. Signposting was interpreted as giving the patient information about a service and expecting them to follow it up for themselves. Signposting was more common than referral with the GPs in this study.

The range of organisations referred to was quite limited and GPs favoured those with a statutory service input – health or social work. Voluntary sector organisations were more likely to be signposted than to receive referrals. Only one regeneration funded project was mentioned.

The GPs felt their level of knowledge of social programmes was limited. The factors influencing this were time to become familiar with the potentially large number of relevant organisations and keeping up to date with the constant changes of projects starting, ending and changing their contact details. They felt there should be some kind of central register with the CHCP taking responsibility for vetting organisations and keeping details up to date. A central resource post was suggested which might maintain a web-site. Personal contact from projects was also favoured.

The GPs duty of care was paramount in whether or not a social programme was viewed as trustworthy to benefit the patient and not harm them. Factors in determining this were:

- Appropriateness for patient
- The line management of the organisation

- For voluntary organisations, to be part of a national organisation with a sound track record
- Feedback from patients, or word of mouth recommendations from a trusted person
- A personal visit to the practice from a representative of the organisation

GPs tended to prefer that patients could self-refer and generally did not see their gate-keeping role as useful for patients. The GPs felt that sometimes their gate-keeping role was unnecessary and they were used as information gatherers. Some referral forms were considered to be unnecessarily complicated and time consuming. The GPs favoured the idea of more primary care team members being able to refer patients.

Characteristics of patients that might lead GPs to make a social referral were:

- High level of motivation – those patients willing to make changes
- Wanting alternative to drugs
- Mild to moderate mental health problems
- People who are socially isolated, unsupported by family, etc.

Discussion

The methodology was appropriate for gathering relevant data, but recruitment was difficult, resulting in the informants all being already involved in social prescribing which would have influenced the data collection. It is suggested the use of incentives might help extend the reach of a further study. Senior practitioner involvement was required to give the study legitimacy.

The informants all appeared to be familiar with a social model of health but it was unclear if they applied to social prescribing practice. The relationship between understanding and applying a social model of health merits further exploration.

Since social prescribing was not familiar term to GPs, its use would have implications in recruitment for further studies and in progressing work in this field. It may be better to use the term 'social referral'. The distinction between the terms 'prescribing', 'referral' and 'signposting' and the implications for referral practice need further study.

Factors about social programmes which influenced GPs referral practice centred on the importance of the duty of care and the permanence of programmes and these require more investigation, as would perceptions of the gate-keeping role and assumptions about the suitability of patients for social prescription. Since there is some conflict with the perceptions from social programmes, this should be subject to further research. There is more potential for social referral to be used by the GPs both for more patients and to a wider range of organisations.

Research Questions for Further Exploration:

1. To what extent is there support for social prescribing among GPs? Are there GPs who are not practising this at all? What influences this?
2. What is effective social referral? How is the effectiveness of the intervention influenced by:

- a. The relationship between the GPs' understanding of a social model of health and its application to the process of social prescribing
- b. GPs' perceptions of:
 - i. The differences between social programmes in the statutory, voluntary and regeneration funded sectors?
 - ii. Characteristics of patients which identify them as appropriate for social referral, or otherwise?
 - iii. Possible benefits to patients?
 - iv. The differences between the processes of prescribing, referral and signposting and how their use is determined?
 - v. Their gate-keeping role and the duty of care?
3. What are the experiences of workers in social programmes wanting to canvas GPs to make referrals?
4. Review the role of the primary care team in social prescribing and explore case studies demonstrating good practice.
5. Explore examples of good practice for social prescribing in the UK
6. Consider the feasibility of a pilot programme to improve links and communication between social programmes and GPs, perhaps linking with STEPS, other Primary Care Mental Health Teams, or other CHCP activity.

INTRODUCTION AND BACKGROUND TO THE PILOT PROJECT

Social Prescribing is a method of impacting on the wider determinants of health such as the social, economic and environmental factors, through linking people with health problems to non-medical sources of help and support in the community. Patients are referred, usually through primary care, to community based groups, which might be in the statutory or voluntary sectors, and which provide opportunities for arts and creativity, physical activity, learning and volunteering, mutual aid, befriending and self help as well as support with issues such as benefits, debt, legal advice and parenting problems¹

The potential benefits from social prescribing lie in three areas;

1. Mental health outcomes
2. Community well being
3. Promoting social inclusion

The groups who are viewed as most likely to benefit are disadvantaged, isolated and vulnerable. Such groups could include those with mild to moderate or severe long term mental health problems, recently bereaved elderly people and people with chronic physical illness. These groups are managed within primary care and GPs could be using social prescribing as a means of improving health outcomes. Recent research by the Mental Health Foundation found that 60% of GPs surveyed would prescribe antidepressants less often if an alternative was available to them².

The GP is a key gatekeeper for patients into community sources of help and support but the pattern of referral is patchy, with some GPs making such referrals and others not. There is some evidence that the factors influencing GPs include their attitudes and beliefs about social prescribing, the lack of agreed referral criteria, concerns about increased workload, evaluation criteria, accountability and liability, maintenance of up to date information and lack of knowledge about community resources³. The lack of understanding between the voluntary sector, particularly community development, and Primary Care can result in cultural and professional barriers to effective referral⁴. This was discussed at a recent conference 'Communities on Prescription'⁵ which also highlighted the need to bring a social model of health directly into primary care, with its predominantly medical model of health. A diverse evidence base and lack of models of good practice were also indicated as difficulties in development of social prescribing projects.

However, the evaluation of a social prescribing project established in Bradford (CHAT) showed a diverse range of patients benefiting from a steady stream of referrals to

¹ Friedli L. Social Prescribing for Mental Health in Scotland – a feasibility study. Unpublished available from the author and the National Programme for Mental Health and Well-being

² Mental Health Foundation (2005) in Friedli L (above) P10

³ Scottish Health Feedback, (1999) Mental Health in Primary Care – a needs assessment. HEBS Edinburgh (now Health Scotland)

⁴ Sykes, 2002 in Friedli L. Social prescribing for mental health in Scotland: a feasibility study – unpublished, available from the author and National Programme for Mental Health and Well-Being

⁵ Edmonds, N. (2003) Communities on Prescription? Primary Care and the Voluntary Sector Working Together in Practice. *Journal of Mental Health Promotion*. December 2003

voluntary sector organisations⁶. A post has been created to link patient, primary care staff and sources of support in the community. The referral is made by a member of the primary care team, or self-referral by the patient, to the worker who then spends time with the patient and identifies the appropriate source of support. More details of this project are attached as Appendix One.

A social prescribing project in Trafford aimed to improve mental health and well-being through patients realising their potential, establishing good quality relationships and achieving a sense of purpose and direction in their lives⁷. It provided creative opportunities, cultural engagement and personal learning and included a web-site with details of the range of opportunities for referral: dance, music, the visual arts, complementary therapies, creative writing, exercise, gardening, women only courses and lifeskills. An electronic referral could be made using a simple form on the web-site.

Social prescribing is aligned to current health policy in terms of partnership with the voluntary and community sectors, promoting social inclusion, the social justice agenda, public participation and patient involvement. Community Health Partnerships have a role in involving local communities in improving population health and social prescribing is an important avenue to achieving this. Programmes such as Healthy Living Initiatives have an important role as they provide a range of appropriate activities.

Glasgow Centre for Population Health funded this pilot study of GPs and social prescribing together with Glasgow South East Community Health and Care Partnership (CHCP). The purpose is to inform a wider study which will provide a better understanding of the referral practice of GPs. This is seen as an important step in helping to inform the development and use of services in the wider community which are beneficial to the needs of patients and which could contribute to increasing community capacity and thus to improving population health.

Aim

The purpose of the pilot study is to inform the development of a full proposal for exploring referral practice in primary care in social prescribing. The pilot study will test the methodology, scope and reach for the full proposal.

Research Questions

1. What social programmes canvassing GP referrals exist in the study area?
2. What knowledge do GPs have of social programmes in the study area?
3. What aspects of a patients condition has led GP respondents to refer or not to refer to a social programme?
4. What makes a social programme attractive to GPs?
5. What aspects of a social programme would make GPs decide not to refer patients?
6. What characteristics of GPs are linked with social prescribing?

⁶ Woodall, J and South, J. (2005) *Evaluation of CHAT Social Prescribing Scheme in Bradford South and West Primary Care Trust*

⁷ bluski.org.uk/referrals

METHODOLOGY

The study required ethical approval and Research and Development Management approval. These were obtained from the Primary Care Division of NHS Greater Glasgow and Clyde (NHSGGC)⁸.

Qualitative methods were used to gather data to meet the research questions. Several different methods of contacting GPs were used to gather data on referral practice.

- 1) An open forum of GPs was held at a health centre with several practices. The purpose was to scope the range of basic data on perceptions of social prescribing and its use, to inform the focus group protocol and to support the recruitment process. Seven GPs participated.
- 2) Two focus group discussions were held with a total of 7 GPs and 1 practice nurse. The discussions were recorded.
- 3) In depth interviews were conducted with 2 GPs, which were also recorded.

A short scoping activity was conducted with key contacts in the CHCP to determine the range of social programmes which existed in the area and which might be appropriate for GP referral.

Recruitment

All the GPs in the CHCP area, 89 in total, were sent a letter of invitation from the researcher to participate in the study as informants at a focus group or interview. An information sheet and consent forms were also enclosed. Three replies were received and of these, two later declined to participate. The Public Health Practitioner made arrangements with one health centre to hold an informal discussion at one of the coffee mornings, which were regular features at the health centre. One GP was recruited for an interview through the coffee morning.

The Public Health Practitioner also contacted three practice managers to request arrangement of a focus group discussion. Three groups were arranged and one was cancelled at a later date. Attempts were made to recruit other GPs directly to the study through snowball sampling, email and telephone and also through practice managers. It proved extremely difficult to recruit GPs. Those that did participate were either involved in the steering group for the study or were known to the Public Health Practitioner. No incentives were offered, other than refreshments at the coffee morning.

It was felt to be important to gather data from different groups of GPs, those who were currently referring to community based organisations and projects, those who express an interest in referring but who do not currently refer and those who neither express interest nor currently refer. However, the informants involved in the focus groups and interviews all came into the first category.

⁸ Research and Development Management Approval: project reference number PN06CHO33
Ethical Approval: REC number 06/S0701/145

Focus Group Protocol and Interview Topic Guide

The same questions were used for the focus groups and the interviews. These were developed from the research questions and the literature prior to obtaining ethical approval and modified slightly after the open forum. The guide is attached as Appendix 3.

Analysis

The data was analysed using thematic analysis. The data were examined in detail and a list of categories and sub-categories drawn up for coding, which is shown in Appendix 4. These categories were based on the research questions and other themes which emerged from close examination of the data. The next stage was to code the data and to cut and paste it into these categories. The information in the various categories was interpreted and summarised. Relationships were explored between the emerging themes, for example, the links between characteristics of organisations and the use of signposting or referral. The theory which emerged was then re-examined and re-ordered in relation to the research questions and presented in relevant sections as findings. Since the study was a small pilot, the amount of data was limited and more in-depth testing of the emerging theory was not possible.

Since the main aim of the study was to pilot the method and explore areas for further research, the analysis included examination of the suitability of the methods and also exploration of the findings for issues which would benefit from further exploration.

FINDINGS

Medical or social models of health?

The GPs involved in the study all demonstrated that they subscribed to a social model of health and a holistic perception of health and illness. When asked about the influences on health of people in their areas they suggested environmental and life circumstances, as well as lifestyle factors and behaviours. These included:

1. Poverty, deprivation and affluence
2. Working, unemployment, work based stress
3. Age, genetic make-up
4. Family factors
5. Immigration, being asylum seekers, multi-ethnicity
6. Access to services, particular language and cultural barriers
7. Bereavement

There was some discussion about the different models and one informant made the point that doctors had to operate with a medical model but as GPs they also worked with a holistic approach with their knowledge of patients and their families over a substantial period of time.

GPs' Perceptions of Social Prescribing, Referral and Signposting

The term 'social prescribing' was not familiar to GPs. When given a simple explanation and examples, the terms referral and signposting were most commonly used. All the GPs in this study made patient referrals to non-clinical organisations which varied from exercise on referral to self-help groups and mental health projects. The term prescribing was not used because it implied the writing of a prescription and this was not the usual method of referral. Although a prescription is written for the exercise on referral scheme, one doctor differentiated it thus: *"We do write a prescription, but we don't define what it is they do. So it's not prescribing, it's referral."*

There was agreement among the informants that referral meant sending a letter to an agency or filling in a form and the agency contacting the person to arrange an appointment. The GP would also expect feedback from the agency on whether or not the patient had attended and what progress they had made.

The term signposting was used to describe the process of recommending to a patient that they might benefit from approaching a particular organisation, such as a self-help group. The GP would give the patient the information and it would be up to the patient to take the initiative to make contact. The responsibility lay clearly with the patient whereas in referral, the GP and the organisation took responsibility. It was suggested by some of the GPs that signposting also empowered the patients in taking more responsibility for themselves. The GPs would follow up with the patient at their next appointment on whether or not the patient had contacted and attended the organisation. The GPs in the study were more likely to signpost than refer patients to sources of social support.

The Referral Process

A common element of the referral process was completion of a referral form, issued by the organisation. There was some ambivalence about the use of referral forms:

"When we've got a referral form, it's a bit of a double edged thing. On the one hand, you know you've done it, you know where to send it, because it's written on the form. It's also a bit of a pain because we've got dozens and dozens of different kinds of referral forms for all different kind of services. It's hard to remember what you've got and where you've put it."

There was considerable discussion about the time consuming nature of some of the referral forms and some of the GPs felt they were being used as information gatherers by the organisations, who could collect the information themselves. There were complaints about triplicate forms which could not be scanned for electronic use and storage, so paper copies have to be stored and these often cannot be found when required. The issue was raised of having to store vast amounts of forms for use with both clinical and social referral. They become out of date and have to be thrown away. There was some discussion about the value of electronic referral or being able to download forms from a web-site when required. Several of the GPs preferred self-referral by patients to be more frequent and did not feel the recommendation of the GP was necessary.

The Range of Social Programmes Used by GPs for Social Prescribing

There was not a clear distinction between clinical and social referral by GPs. Smoking cessation and weight management were two examples of organisations which had an element of both social and clinical referral. Exercise on referral was viewed by the informants as a social referral, and this was the most commonly used. The organisations to which GPs most commonly referred to in the study were:

- Exercise on referral
- Smoking cessation
- STEPS – a new primary care mental health team
- Social work
- Welfare rights
- Weight management
- Community addictions team
- Stress Centre

It is striking that six of the eight agencies listed above have the NHS as key partners. Others which were mentioned less frequently, and tended to be organisations that GPs signposted for patients, were:

- Reading on prescription
- Princess Royal Trust for Carers
- Youth health service
- Tom Allen Centre (a voluntary sector counselling centre)
- A multi-cultural women's project
- Pregnancy advice service
- Pathways to work
- Tak-tent
- Bacup
- Cruise
- Victim support

A number of projects and organisations exist in the area, which are funded through regeneration budgets and these were not mentioned by GPs, other than the Stress Centre, which is also part funded through the NHS. Some of these are not appropriate for GP referral and most are short term. In addition there is a large Healthy Living Centre in the same area as some of the informants and this was not mentioned, although they have a number of programmes particularly suitable for social referral.

Level of Knowledge of Social Programmes in the Area

The GPs in the study agreed that they did not feel their knowledge was adequate about community organisations and sources of social support. Their knowledge tended to be limited to the few organisations and agencies that they used regularly, with a few others they may or may not use occasionally. Several commented they were unaware of the extent of their lack of knowledge – they “*did not know what they did not know*”. The reasons they perceived for their lack of knowledge were concerned with the rate of change with community projects and the difficulties in communicating large amounts of information. One GP summed up:

“I find it very difficult to stay on top of what’s out there and that’s for a variety of reasons. One is what was there yesterday may not be there today. It may be amalgamated, re-branded, renamed, new forms, new addresses, phone numbers, fax numbers. It’s not impossible, you send something off and then some time later you’re told something has changed. Or the information sent to the practice has been incompletely received and responded to and that reflects the paper avalanche that we live under on a daily basis. We have to be incredibly selective about what we do. We have a system for recording and storing information about referral agencies which works more or less well for the regular ones but they become out of date for a variety of reasons as well. It’s a constant challenge.”

Lack of time to access and assess information was the most frequently mentioned factor, as in this situation:

“One lady wouldn’t go into hospital because she had cats. I spent ages trying to find out about help for her. There were loads of facilities for pet sitting. All that information, if it was just there, we could just go right away and get it instead of spending ages trying to find out.”

The short term nature of some projects was a problem. One GP commented “you always get told about a project starting and you never get told about it finishing.” Short term projects tended to be less favoured for referral, which perhaps might be a factor which influenced the lack of referral to regeneration funded projects.

Another important factor relating to the knowledge about potential organisations for social referral was their appropriateness. The GPs felt they needed more than basic information so that they could assess if the organisation was one they felt comfortable using for referral, for example, a pregnancy advice service offering counselling that proved to be anti-abortion. In one focus group a GP expressed her difficulty in understanding the difference between the differing philosophical basis of alcohol treatment organisations – the Glasgow Council of Alcohol and Alcoholics Anonymous.

The GPs in the study were most familiar with the agencies they referred to most frequently. Less often, they would need to identify a specialist agency to help a patient with complicated needs, perhaps requiring support with a rare condition in a language other than English and would find this difficult. A solution to the problem of lacking information was sometimes to refer them to another organisation which would have the relevant information. For example, STEPs, the primary care mental health team was viewed as a gateway to community based sources of support, or Citizen’s Advice. One GP mentioned advising patients to go to the local library which held information on local organisations.

Suggestions for Methods of Accessing Information about Social Programmes

The GPs offered plenty of suggestions for methods of accessing information about agencies for social referral and signposting. They agreed they needed to be kept up to date and they could refer more if they had more information. Time was a pressure in terms of keeping up to date and thus they favoured methods which allocated the responsibility outwith the practice. There was a strong view that this was a role for the

CHCP and they raised the possibility of creating a post which would be a central resource for compiling information about organisations suitable for social prescribing, disseminating it and also vetting them for appropriateness. The most popular method of dissemination was via a web-site through which information could be easily accessed and referral forms and leaflets be downloaded. The site could also indicate which organisations would accept self-referral. Patients could also access the website, so GPs could signpost the website for them and they could self refer. If there could be an interface with the GPs' IT system then electronic referral would also be a possibility. It would be important for the information to be local, as their current experience of trying to access organisations via the internet was to be overloaded with national and even international data.

Another method of dissemination which was suggested was a directory. The informants spoke of directories that had existed in the past, but as is usual, they had become quickly out of date and unusable. It could be useful, if kept up to date by the central resource person, as described above.

The GPs spoke of the need for reminders and a simple list was one suggestion. There was considerable discussion about the difficulties of the practice being swamped with large numbers of leaflets. Most of the practices had some form of storing and recording these, but time for reading them and keeping up to date was a problem.

“Personally, I think the only way is for them to come in and tell us about it, because we get leaflets galore, they arrive in the surgery, you glance at it, scan it and don't sit down and digest it.”

Two practices indicated they welcomed representatives from community based agencies who came to speak to the practice at an agreed time. This also gave the staff the opportunity to “*get a feel for the project*” and assess its suitability. Several GPs highlighted the value of word of mouth recommendations for agencies, either from patients or colleagues. This seemed to be a common way for them to access information.

Making Decisions about whether a Social Programme is Appropriate for Referral

It was apparent that GPs felt a clear duty of care in respect of referring patient to other agencies. It was important that they were sure that the organisation was reputable and could be trusted to benefit and not harm the patients. There were several suggestions for how this assessment was made:

- Where a project is located and line managed: if managed by Social Work or the NHS then GPs were more inclined to refer. The qualifications of the line manager were also thought to be important
- If it is part of a national organisation with a sound track record e.g. Alzheimer's Society
- Feedback from other people – patients and colleagues, word of mouth recommendation
- Personal visit from a representative of the organisation

The informants were more confident about referring to statutory agencies, such as welfare rights, especially those with a health service input. They had more difficulty with voluntary agencies, but felt they were appropriate if there was a recognised national organisation with a good track record. Self help groups were less likely to be used for referral and more likely to be signposted. Alternative therapists were mentioned as unsuitable for referral by several GPs, because of a lack of knowledge and understanding of alternative therapies:

“Traditionally there is a problem with things like osteopathy and chiropractors because they are non-medical. There’s a fair number of doctors who will accept that they have benefits but we don’t get any formal training in it, so it’s very difficult and they are not strictly part of the NHS so we tend not to know sufficient about them to advise our patients. The other one is homeopathy, or herbalism which we don’t know much about at all, unless you go and specialise in it, so it’s difficult to refer because you take on a responsibility there.”

In addition one GP said he had experienced some examples of unreliability, for instance, an alternative practitioner promising to cure ME and charging £200 and confusion over the status of a Doctor of Chinese Medicine.

An interesting example was given from one practice which was asked by a university department to take a trainee counsellor on placement:

“The university department that was responsible, we got some kind of verbal request, and it went on over a wee while we tried to clarify it. We eventually decided we wouldn’t have the trainee, because it simply wasn’t clear where the responsibility lay - was it ours or theirs?”

Elements that would encourage GPs to make social referrals would be:

- Up to date knowledge of what is available and appropriate
- Longer term projects and agencies rather than pilot projects which might disappear
- Located or managed by statutory service
- Could clearly transfer duty of care
- The service is free, confidential and culturally sensitive

Matching the patient with the most appropriate organisation could be a problem. One GP cited the example of the number of care organisations covering one area. He found it difficult to know which one would be most appropriate for the patient.

In one case a wife perceived an organisation to be wholly inappropriate for her husband who had appeared to have been happy with the referral:

“An alcoholic man, who was also depressed, he came into see me and I was explaining about the Tom Allen Centre, how it worked. I then got a phone call from enraged wife saying ‘how dare I refer her husband to a religious organisation’. It’s run by the Church of Scotland. I tend to say to people it’s run by the Church of Scotland, but it’s for everyone.”

Characteristics of Patients that Were Most Likely to be Referred and Benefits to Patients

The kind of patients that GPs were most likely to refer for social support fell into one or more of four categories:

- Those that were motivated to help themselves and recognised the need for change
- Patients with mild to moderate mental health problems such as depression, anxiety
- Patients that are willing to accept an alternative to a prescription for tablets
- Those lacking social or family support, have no other sources of help and support and tended to be isolated and lonely

It was a strong theme in the data that patients who want a *'quick fix and some tablets'* would not benefit from social referral. Similarly frequent attenders at the practice were viewed as unlikely to attend, or to sustain engagement, due to the complex nature of their problems and changing priorities. The GP would be looking for an indicator of motivation such as an expressed view from the patient that they recognised they needed to make changes to their life, or who were looking for help with a specific problem that was outwith the scope of the GP practice.

The benefits were seen as those which could not be offered by the GP but would assist in improving the treatment and health of the patient, such as alleviation of mental distress, improved financial situation through benefits advice, making a lifestyle change. Exercise on referral was mentioned in one group as being of particular benefit. The GPs received feedback and the patients engaged with it and seemed to enjoy it. Doctors did not always receive formal feedback from organisations about whether or not patients succeeded in making a lifestyle change.

GPs as Gatekeepers to Other Sources of Social Support in the Community

The informants in the study tended to see their gate-keeping role as a burden rather than a useful tool for the benefit of patients. They felt that patients tended to view them as a first port of call for information, some of which would be better from other sources:

"Something's wrong, my home situation's bad, so they go to the doctor, at least its free, people see us as a hub. Patients will run to their GP. They won't run to their social worker, they won't run to the community nurse, they run to their GP..... People have no idea who to contact, I get numerous phone calls – how do I get hold of the occupational therapist, my baby's not feeding well, should I change this milk to that milk?"

There was a view that other members of the primary care team could refer, but some organisations insisted on a doctor's signature on the form. In one practice, the Practice Nurse was seen as the person who made most of the social referrals and that she had more knowledge than the GPs about what was available. This point was made very strongly by one informant. He felt that considerable training had been undertaken so the primary care team could act as a team and share responsibility

DISCUSSION

Although the pilot study was small, a number of important issues emerged. The aim was to test the methodology for a more comprehensive in depth study, and some key learning points were indicated in relation to recruitment. The data also indicate some interesting issues and questions which would be important to explore in a further study of GP practice in social prescribing, such as underlying models of health, effectiveness of the intervention, perceptions of the gate-keeping role and factors supporting and discouraging referral to social programmes.

Recruitment was a key issue for the study in that it was difficult to involve GPs. The sample which was recruited reflected those interested in the topic and did not include GPs who did not use social prescribing. In the view of members of the Steering Group for the study, it is possible that the title of the study was off-putting for GPs as the findings indicated that the term 'Social Prescribing' was not one they used or understood well. 'Social Referral' might have been better. Another factor might have been that the letter of invitation was printed on the researcher's headed paper, as a condition of the ethical approval. It was not clear immediately, unless the GPs read the information, that the study was bona fide and being conducted by the NHS / local CHCP. Timing could also be an issue with other important requirements taking precedence – a new computer software system was being installed, for example.

The recruitment process required the use of senior practitioners to give legitimacy to study. Writing to all the GPs in the area and snowball sampling were used to reach GPs, but neither was very successful. These issues are important for a future study and perhaps the use of incentives needs to be considered. The recruitment process influenced the collection of data. The sample was very small in the pilot study, and all the informants were already involved in social prescribing. Thus the level of interest and attitudes might be a reflection of that and other GPs may not hold the same perceptions. However, it was a positive outcome of the study that it did identify that there is support in the primary care system for the practice of social prescribing. Some GPs take a holistic view of health and there was both an interest in the topic and evidence of referring patients to social programmes. The use of focus groups and one-to-interviews were appropriate methods to generate useful data.

There may well be a relationship between applying a social model of health and motivation to refer patients to sources of social support. The GPs in the study appeared to subscribe to a social model of health, but it was not clear whether this influenced their interventions with patients. The use of the medical model is intrinsic to clinical practice. It would be important to know if GPs can apply a social model of health to interventions to benefit the health of their patients, since this is an underlying principle of social prescribing. This requires further investigation. The literature suggests that GPs lack of understanding of a community development model of health improvement, which is based on a social model of health, may prevent them referring to such projects. The social programmes selected by GPs tended to fit in with a medical model and may well have been chosen to strengthen their intervention, such as support to reduce weight and stop smoking in order to help to lower blood pressure. It may be that GPs perceive social prescribing as contributing to their clinical treatment plan for patients. In

comparison, where to refer patients with mental health problems might be less clear, unless there is an obvious cause for the problems such as bereavement.

The study indicated the GPs differentiated between the terms prescribing, referral and signposting, and these were significant for patients accessing social programmes. One informant pointed out that when he prescribed he knew exactly what action and benefit would follow for the patient. This was less clear with referral, where the expectation was that the organisation would take responsibility for contacting the patient and giving some feedback to the doctor, whereas signposting required the patient to take responsibility for contacting the organisation. Since social prescribing is an accepted term in the literature, this differentiation produces an interesting ambiguity which could affect recruitment to research projects and progressing work in the field. It was not clear from the data whether their choice of actions were due to the GPs lack of knowledge of or connection with the social programme, or their perceptions of the motivation of patients. There were some indications that GPs would signpost to organisations for which they were less confident about passing on their duty of care, or knew less about, such as self-help groups. On the other hand some GPs suggested that signposting could have the purpose of empowering patients to take responsibility for themselves.

There were some clear indications of factors which encouraged social referral. These centred around two issues:

- The importance of the GPs duty of care and their confidence in the ability of a social programme to benefit the patients
- The state of permanence of programmes and projects – short term projects were less likely to be used for referral. This may be an important factor for projects funded through regeneration monies. These were not mentioned by the informants in the study. A range of projects were funded in this way, and while some were not appropriate for social referral, others could provide the potential for more extensive referral.

Another interesting and important element in the data was the GPs perception of their gate-keeping role. While community projects might view the influence of the GP as important, for example evaluation data from local smoking cessation projects indicates patients referred by GPs are more likely to turn up and quit than those referred by others, the GPs in the study tended to regard it as unnecessarily burdensome. The GPs had a perception that many referrals required the signature of a doctor, but this may be a mis-perception on their part. The gate-keeping role should be explored further since there appear to be conflicting views of its importance between social programmes and GPs. Referral pathways and the role of wider primary care team are also worth further investigation.

There are suggestions in the literature that those patients who are frequent attenders with complex problems would be appropriate candidates for social referral and this might relieve pressure on the GP practice. There was considerable agreement in the pilot study that GPs take the opposite view. They felt that these patients are not suitable for social referral since they tended to lack motivation, have competing and changing priorities and are unlikely to keep their appointments. This is an assumption which could be tested in further research. Since there is evidence that people with complex social problems such as addictions, mental health and social problems do have difficulty in keeping appointments, perhaps there is the potential for GPs to be linked to services which would support such patients in taking up their GPs referral to a social programme.

There was also an indication in the data that GPs linked social referral with lifestyle changes such as losing weight, taking exercise and stopping smoking.

Lastly, the suggestions from the informants for methods of increasing their knowledge of local social programmes were useful. They viewed the responsibility for taking this forward as a legitimate role for the CHCP. The ideal of a central resource to collate and disseminate information about programmes and to vet them for suitability was strongly favoured. The GPs viewed it as unrealistic and inefficient for practices to achieve this individually. There might be a case for considering such a project as a pilot and there are several examples of good practice in the literature e.g. CHAT (see Appendix 1) and the Trafford Social Prescribing project (see www.bluesci.org.uk)

CONCLUSIONS

The use of focus groups and one to one interviews for the study was appropriate for gathering relevant data but the recruitment process proved limiting in the reach and scope of the informants and this limited the scope of the data collection.

The GPs in the pilot study were all referring and signposting patients to social programmes, but the extent was fairly limited. They did identify it as beneficial for patients suggesting that there might be scope for development through referring more patients to a wider range of agencies.

The perceived barriers to social referral were lack of information about appropriate programmes, workload, time to acquire information and keep up to date and the perceived lack of motivation to attend in some patients.

The GPs identified ways of accessing information which would be most appropriate for them such as a central resource in the CHCP which might involve production of a website and electronic referral. The feasibility of a pilot project would be worth further investigation.

An important factor was the GPs' duty of care and their ability to determine if a social programme was appropriate for referral. At present the range of social programmes referred to tended to be within the statutory sector, while local regeneration funded projects were noticeably absent from those used for social referral, except for the local Stress Centre.

The role of gate-keeping was an issue for the GPs. They held strong views on this role and felt it was misused to some degree. Widening this function to the primary care team was seen as positive as was increasing the extent of self-referral.

Research Questions for Further Exploration:

The key purpose of the pilot study was to identify topic areas which would benefit from further exploration. These are summarised below:

- 1) To what extent is there support for social prescribing among GPs? Are there GPs who are not practising this at all? What influences this?
- 2) What is effective social referral? How is the effectiveness of the intervention influenced by:
 - a) The relationship between the GPs' understanding of a social model of health and its application to the process of social prescribing
 - b) GPs' perceptions of:
 - i) The differences between social programmes in the statutory, voluntary and regeneration funded sectors?
 - ii) Characteristics of patients which identify them as appropriate for social referral, or otherwise?
 - iii) Possible benefits to patients?
 - iv) The differences between the processes of prescribing, referral and signposting and how their use is determined?
 - v) Their gate-keeping role and the duty of care?
- 3) What are the experiences of workers in social programmes wanting to canvas GPs to make referrals?
- 4) Review the role of the primary care team in social prescribing and explore case studies demonstrating good practice.
- 5) Explore examples of good practice for social prescribing in the UK
- 6) Consider the feasibility of a pilot programme to improve links and communication between social programmes and GPs, perhaps linking with STEPS or other Primary Care Mental Health Teams, or other CHCP activities.

Appendix 1

Steering Group members

Pauline Craig, Public Health Programme Manager, Glasgow Centre for Population Health

Monica Currie, Public Health Practitioner, Glasgow South East CHCP

Ali MacDonald, Public Health Practitioner, Glasgow East CHCP

Kathleen McGill, Health Improvement Manager, East Dunbartonshire CHCP

Greg Usrey, Public Health Practitioner, South West CHCP

Phil Wilson, GP and Senior Clinical Research Fellow, Dept of General Practice and Primary Care, University of Glasgow

Stewart Mercer, Senior Clinical Research Fellow, Dept of General Practice and Primary Care, University of Glasgow

Helen Tyrell, Director, Voluntary Health Scotland

Appendix 2

The Social Prescribing Scheme in Bradford South and West PCT

The social prescribing scheme in Bradford South and West PCT works by primary health care professionals referring patients with non-clinical needs to CHAT (Community Health Advice Team). The CHAT worker meets with the patient to discuss their needs and then identifies an appropriate source of support in the community. The CHAT worker facilitates access to community groups or courses and may accompany the patient on their first visit if required. Any member of the primary health care team, including GPs, nurses, health visitors, district nurses and receptionists, can refer patients to the scheme by completing a simple referral form. Alternatively, patients can self refer by completing the tear off slip included in a leaflet which is available from surgery receptions and local pharmacies. A key benefit of the scheme is that the CHAT worker is able to spend longer with a patient than primary care staff are often able to, offering up to three forty-minute appointments. This provides the patients with the opportunity to discuss any issues that they feel are affecting their health and the possibility of exploring a variety of solutions.

Summary of the Evaluation

A pilot social prescribing scheme, CHAT, has recently been set up in Bradford South and West Primary Care Trust (PCT). The aims of CHAT are to broaden service provision for patients with non-clinical needs and to facilitate links between primary care and the voluntary sector. The evaluation focused on the development of the scheme in the Ridge and Royds medical practices and used a case study design to examine the scheme from the perspectives of service users and health professionals. In addition, some data were gathered from key individuals involved in the first pilot scheme delivered by Healthy Lifestyle Healthy Living Centre at Dr Micallef & Partners, Highfield Health Centre. In total, 18 semi-structured interviews were carried out over a ten week period.

The evaluation suggests that CHAT is a valued scheme within the primary health care setting. There has been a steady flow of referrals in both practices and CHAT is being used by a diverse range of patients in terms of age, gender and social problems. The findings from the qualitative data show that the scheme is acceptable, relevant and appropriate from the perspective of staff and service users. Patients and health care professionals perceive the CHAT scheme to be a successful bridge between primary care and the voluntary sector. In the interviews all patients expressed some form of positive outcome as a result of being on the scheme – reduced isolation, increased confidence, and access to non-stigmatised support were a few examples. Patients perceiving CHAT as an individual, caring service, tailored to their own appropriate needs, was a powerful indicator of its success. Staff who took part in the evaluation discussed how the CHAT scheme had the potential to reduce workload and improve the quality of patient / professional consultation. The benefits for staff having a personalised, caring service were frequently cited as being one of the strengths of CHAT.

CHAT provided access to a source of expert knowledge which was welcomed by staff. The benefits of the scheme to general practice were also highlighted by this evaluation. Having the scheme as an extension of primary health care adds further to the holistic work happening in these practices. The current model of the scheme is working well and has been found to be acceptable and relevant. If the scheme was extended and potentially rolled out to other practices in the PCT it would be important that the core elements of the model developed in Bradford South and West were maintained. However, consistent and regular feedback for referrers is currently not being achieved and this is an issue which may need to be considered for future practice.

Appendix 3

FOCUS GROUP and INTERVIEW TOPIC GUIDE

- What do you think are the most important influences on health for your patients?
- Perceptions of meaning of social prescribing, *purpose for patients / GP practice. How does it influence health of patients?*
- What projects do you currently refer to? How does this happen?
- Good and bad experiences of referring patients to community organisations / service from them, *concerns / drawbacks*
- Place in patient pathway / kind of patient who might benefit, possible outcomes for patients – short and medium term
- Best methods of communicating with relevant organisations
- Level of knowledge of local organisations
- Factors contributing to effective referral / what is effective referral
- Ways of monitoring outcomes for patients and practice
- Level of policy / guidance required by GPs for social prescribing, referral criteria etc

Appendix 4

Coding List

- Organisations used in social prescribing
 - Types
 - Frequency of use
- Interpretation and use of terms
 - Signposting
 - Referral
 - Prescribing
 - ◆ Meanings
 - ◆ Disadvantages and advantages
 - ◆ Process
- Perceived levels of knowledge of organisations
- Methods of accessing information
- Factors affecting decisions about referral
 - Organisations
 - ◆ Reputability
 - ◆ Duty of care
 - ◆ Matching with patients
 - Patients
 - ◆ Perceived levels of motivation
 - ◆ Beliefs re drugs, quick fix, etc
 - ◆ Self-confidence
 - ◆ Benefits for patients
- GPs
 - Models of health
 - ◆ Social v medical
 - ◆ Application and interpretation
 - Gate-keeping role
 - ◆ Perceptions
 - ◆ Advantages and disadvantages