The Rotherham Social Prescribing Service for People with Long-term Conditions: A GP Perspective

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Introduction

Social Prescribing aims to prevent worsening health for people with long-term health conditions. It works by enabling GPs to link patients with sources of social, therapeutic and practical support mainly provided by voluntary and community organisations in their local area. There is significant policy support for Social Prescribing from the Department of Health and NHS England who have both promoted referral to the voluntary and community sector as a way of making health and social care more sustainable.

In Rotherham the Social Prescribing Service is delivered by Voluntary Action Rotherham (VAR) in partnership with more than 20 local voluntary and community organisations (VCOs). The Service was first commissioned as a two-year pilot in 2012 and is now funded until March 2018 through the Better Care Fund. It has two core features:

- A team of Advisors provide a **single gateway to voluntary and community sector support** for GPs and Service users: they receive referrals from GPs of eligible patients and carers and assess their support needs before referring on to appropriate VCS services.
- A **grant funding programme** through which **a 'menu' of VCS activities** to meet the needs of Service users is micro-commissioned.

Between September 2013 and March 2016 the Rotherham Social Prescribing Service supported **more than 3,000 local people with long-term health conditions and their carers**, the majority of whom did not have access to opportunities to engage and become active in their local community. They have accessed a range of services and activities including befriending, arts and crafts groups, exercise classes, complementary therapy and counselling. The service covers the whole of the borough of Rotherham and is one of the largest of its kind in the UK. It is embedded in a wider programme of Integrated Case Management commissioned by the CCG.

This thematic summary report explores the benefits and challenges of Social Prescribing from the **perspective of GPs**: it draws on qualitative interviews with 10 GPs and two Practice Managers and a bespoke data extract from one GP surgery. It paints an overwhelmingly positive picture of the impact of Social Prescribing on GPs and patients, and highlights how the Service has quickly become a central component in a GPs options when treating the causes and consequences of long-term health conditions.

How does Social Prescribing benefit GPs?

The qualitative interviews explored GPs views about how Social Prescribing directly benefits them and the work of their Practice. A number of clear themes were evident.

A holistic approach to health

Social Prescribing has enabled GPs to take a holistic approach to meeting patients' health and well-being needs. Whereas before the Social Prescribing Service was developed they had limited options to support patients beyond medical prescribing and referrals for specialist care, now they have options available to meet a patient's social and non-medical needs as well. Emphasis was placed on Social Prescribing as an addition to a range of services already available and broadens their options for treatment, rather than replacing existing treatment pathways.

Awareness of community-level support

GPs do not have the resources to map and understand the range of support available to patients through voluntary organisations and

community groups. Before the Social Prescribing Service was developed some GPs referred patients to community-level support on an ad hoc basis but now could rely on VAR and the Social Prescribing Advisors to maintain an understanding of what support was available, from who, and whether or not it was appropriate for individual patients.

Reduction in workload

There was agreement amongst GPs that for some patients', referral to the Social Prescribing Service could reduce their workload by either reducing the number of repeat appointments, particularly when non-medical issues were a root cause, and enabling them to have shorter and/or better quality consultations with patients.

This finding is borne out in data provided by one GP Practice on a cohort of 30 patients referred to Social Prescribing. In the 12 months following referral:

- 55 per cent of patients had fewer face-to-face appointments and 42 per cent had fewer telephone consultations.
- Face-to-face appointments reduced by 28 per cent and telephone consultations reduced by 14 per cent.

Reduction in medical prescribing

GPs also felt that they were probably prescribing fewer medicines to patients that they referred to Social Prescribing, and/or that patients were using prescribed medicines less. However, they argued that this would be hard to evidence as many patients now had prescriptions on repeat order from the chemist that were probably 'stacking-up' at home[1]. For long term health conditions where prescriptions supported comorbidities, the perception of reduced drug prescriptions resulting from Social Prescribing could be obscured by the need for new drugs. Overall however, GP's felt that there was a reduction of specific drugs for depression or anxiety for example and this was a positive outcome for the patient.

> ***"I feel fairly confident that you would be able to show less GP admissions & attendances…I am just saying that the reductions you manage to show with A&E attendances….you can extrapolate that if they are not attending the GP – they are not going to A&E as much…. they don't feel as unwell."***

How does Social Prescribing benefit patients?

The qualitative interviews explored GPs views about how Social Prescribing directly benefits the patients they refer to the service. Their views mirrored earlier evaluation findings drawn from patients themselves.

Reduces social isolation and loneliness

Many of the patients referred to Social Prescribing are socially isolated and lonely. This is both a consequence of poor mental and physical health and a cause of deterioration in existing conditions. GPs noted that following many patients' referral to Social Prescribing they became more active - both physically and in the community - leading to a marked increase in their confidence and an overall improvement in their general well-being.

> ***"….in South Yorkshire many live on a hill. They'll have steps to get out (of the house) and stairs to go up to the toilet, they become socially isolated because they can hardly get out – and this makes their breathing worse. Here we can improve their breathing by getting engaged in the community, getting them out, getting them to have more exercise. That comes not from a medical perspective, but from a social perspective where what we need is someone who comes along and says 'we're off to the shops', or 'come and do a bit of painting'…..when they are actually engaged and motivated to leave their front door, because even the action of walking down to a car or transport, that's exercise and their breathing should get better."***

Prevents family and care breakdown

Many patients referred to Social Prescribing rely on informal carers, or are informal carers themselves, and are often at imminent risk of care breakdown. Social Prescribing funded services (some specific, some generic) provided an opportunity for these patients and their family members/carers to access additional support to provide respite from their caring role.

Person centred service

GPs were keen to emphasise the importance of the person-centred approach taken by the Social Prescribing Service. This included having a single point of contact following the initial referral (the VAR

[1] NHS Rotherham CCG has recently implemented new procedures for medicine waste management which ought to prevent this from happening in the future.

Advisor), the opportunity to receive support directly in their own home and support to access services in the community, and continuity provided once they have taken-up a service.

Managing symptoms

GPs noted that, as people get older, their needs often change from medical to social. By meeting these social needs GPs felt that Social Prescribing supported patients to manage their symptoms more effectively and enabled them to remain independent and engaged in the community.

> ***“My perception is that you’ve got an alternative…you get to the point where you’re throwing medication at the patient and which is probably of limited value to them. You are just trying to give them things that will help and make their life better…when actually what would make their life better is some more social interaction, or better housing.”***

> ***“There are elements of patient care which are improved by Social Prescribing and also helps elements of our own working style which is much improved from a number of perspectives. We feel that as GPs it has helped our workload and patients have had much better outcomes, especially the ones who seem to go round the ‘revolving door’ – we have been able to stop quite a lot of those ‘cause they weren’t really medical problems and since we started using Social Prescribing we’ve almost put an end to that as well.”***

What are the wider benefits of Social Prescribing?

Throughout the interviews GPs identified a number of wider benefits of the Social Prescribing Service beyond those directly experienced by GPs and their patients.

Social care

A number of GPs argued that Social Prescribing could be an alternative or accompaniment to traditional social care as it provided support for patients to live more independently in their own home and enabled them to access social activities (as specified in the Care Act).

Secondary care

GPs also argued that in some instances Social Prescribing could ease pressure on secondary care - Accident and Emergency attendances and non-elective in-patient stays - by addressing patients’ immediate health related social needs. However, GPs also identified various groups of patients for whom there were unlikely to be secondary care benefits. For example, patients with multiple and complex health conditions, terminally ill patients, Warfarin patients, cancer patients, patients with mental health problems, and patients with alcohol or drug addiction. In these examples it was acknowledged that, given the complex nature of patients’ health problems, they were highly likely to act of their own accord and decide to access emergency secondary care regardless of the medical or Social Prescribing that GPs could put in place.

What are the challenges of Social Prescribing?

GPs identified a number of challenges associated with Social Prescribing: these included challenges for GPs themselves and challenges for patients.

For GPs…

For GPs, there was an initial challenge in getting patients to agree to engage with the Social Prescribing Service. This included ensuring that patients understood the purpose of the service and then accepted it as a viable complementary service to the medical support provided by the GPs. It was acknowledged that some patients are more confident than others to try new approaches to their care. It was argued that all primary care services (i.e. not just the GP) needed to support and encourage patients to engage with Social Prescribing so that the patient was in no doubt of its importance as an alternative source of support.

GPs also felt that is was important to understand the limitations in the type of service available through Social Prescribing and argued that more flexibility is sometimes needed to meet patient needs. They also noted that the ‘menu’ of services was changed on a regular basis and it could be difficult to keep up-to-date with what was on offer without regular updates from Social Prescribing Advisors.

For patients…

The challenges for the patient were primarily connected to their desire to see a familiar GP on a regular long term basis. When presented with an alternative service option many patients were initially resistant.

Similarly, GPs felt that Social Prescribing could be seen as filling a space previously occupied by families, friends and neighbours who have historically provided support for social needs and

30/40 years ago, social support in the form of Social Prescribing was not something the patient would expect to see as a service to be provided by the voluntary sector or the State. Social Prescribing fills the gap of a befriending service for example and some find this disconcerting. However, the GPs interviewed confirmed that people are accepting it to a greater extent than they expected, once these hurdles have been overcome.

> ***"I think the service they are now getting from a formalised social service is what you would have expected them to have got (historically) from their old friends and families. So, some may find that a little disconcerting, they may not want someone to come and 'befriend me', but people are accepting it, better than I thought they would."***

Reflections on the Rotherham Social Prescribing model

GPs provided reflections on the Social Prescribing model in place in Rotherham and their views on whether it worked effectively.

The role of Voluntary Action Rotherham

GPs were keen to highlight the essential role that Voluntary Action Rotherham (VAR) played in ensuring the service functioned effectively. They emphasised how difficult it is for Doctors and Nurses working in primary care to know what voluntary and community sector services are available, either in the local community or across the borough. As such they believed it would be very difficult to maintain an effective Social Prescribing service without the input of an organisation like VAR that could keep *abreast* of and support the *development* of key services at a community level. Linked to this was the importance of having a single organisation in the co-ordination role. This gave GPs the confidence that there was strong oversight of their referrals and meant that referrals could be made efficiently through a straightforward process.

The role of Social Prescribing Advisors

When talking about the Rotherham Social Prescribing model, and the role of VAR, GPs emphasised the importance of the Social Prescribing Service Advisors with who they were in frequent contact. The Advisors were held in high regard by GPs for their reliability and professionalism. The Advisors had up to date knowledge of the range of services and support available to patients which meant GPs and other practice staff did not have to worry about keeping abreast of these. It was argued that in the absence of these Advisors practice staff would not have the resources to keep up to date with which services were available or keep track of referred patients, nor would they be able to support / link patients into Social Prescribing services.

Links to case management

The way that Social Prescribing is embedded in Case Management was also considered important by GPs. A strong sense of shared understanding and expertise in Social Prescribing had clearly developed within the Case Management process, with GPs evidencing the involvement of all members of the Multi Discipline Team (MDT) – emphasis was also placed on the success of the referral process as result of this team working.

The fact that Social Prescribing Advisors were part of Integrated Case Management Teams meant that GPs and other practice staff received ongoing and regular feedback about the patients they had referred to Social Prescribing.

> ***"This is an integral part of it…the MDT meetings include the Social Prescribers and the discussion of the process. The staff do not need prompting, they can keep tabs on the patients, on their caseload and deliver a report back every month. Omitting them from the team would be a disaster."***

Contact

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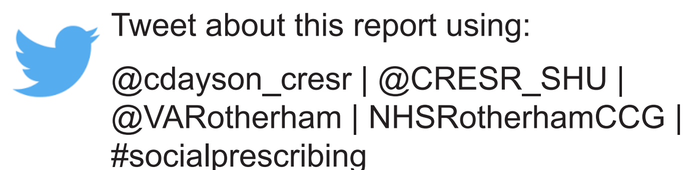

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