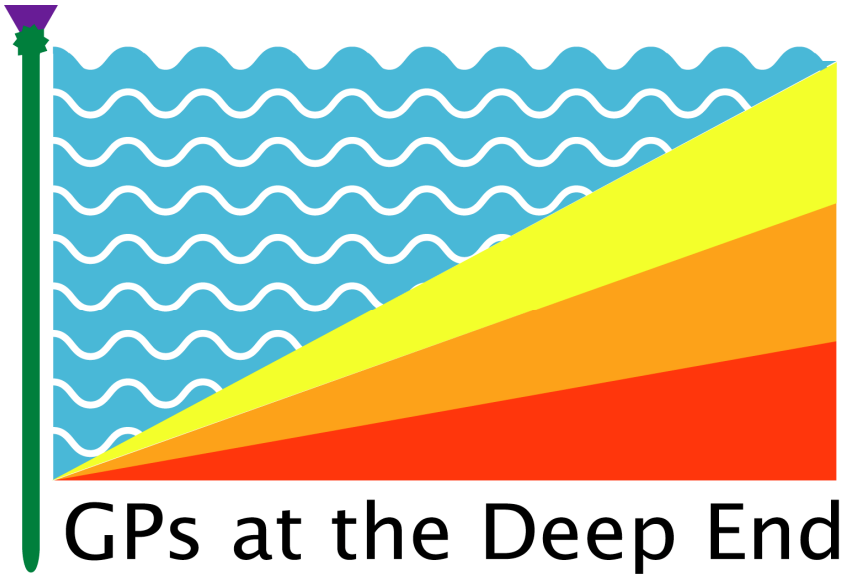


Deep End Report 8

Social prescribing

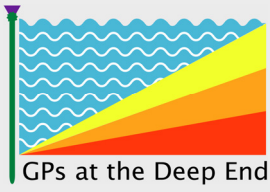
The eighth activity of "General Practitioners at the Deep End"

September 2010

Ten Deep End general practitioners from Glasgow, Dundee and Ayrshire took part in this postal project on social prescribing, by providing reports on their practice's use of non-medical community resources to respond to the needs of their patients.

SUMMARY OF KEY FINDINGS

- GPs in Deep End practices routinely encourage their patients to make use of non-medical community resources to address their health and social needs
- Helping patients to become more self reliant and able to control and improve their own health is a core value for GPs in Deep End practices
- Current processes to distinguish between deserving and undeserving poor on the basis of medical assessments are perceived to produce disability and dependence and to undermine the doctor-patient relationship
- Key interventions that would support more effective social prescribing by GPs are:
  - Benefits reform that reflects the realities of life in Scotland's poorest communities.
  - An internet directory of community resources: if user friendly, locally relevant and kept up to date.
  - More medical and nursing time in consultations to respond to very challenging needs by clear explanation and guidance.
  - Clear guidance for patients and organisations approaching GP practices for reports or advocacy support.
  - Increased funding to voluntary and local agencies in deprived communities.
- GPs with substantial experience of practice in deprived areas also have educational and development needs, requiring new arrangements for protected time and professional support.



"General Practitioners at the Deep End" *work in 100 general practices, serving the most socio-economically deprived populations in Scotland. The activities of the group are supported by the Royal College of General Practitioners (Scotland), the Scottish Government Health Department, the Glasgow Centre for Population Health, and the Section of General Practice & Primary Care at the University of Glasgow.*

Contacts for further information

Paul Alexander *RCGP Scotland* palexander@rcgp-scotland.org.uk
John Budd *Lothian Deprivation Interest Group* John.Budd@lothian.scot.nhs.uk
Petra Sambale *Keppoch Medical Practice, Glasgow* psambale@btinternet.com
Graham Watt *University of Glasgow* graham.watt@glasgow.ac.uk

CONTENTS

PARTICIPANTS

Name	Location	CHCP	Deprivation ranking	List size
Robert Jamieson	Bridgeton HC	GLA (E)	16	2646
Peter Cawston	Drumchapel HC	GLA (W)	59	5313
Donald Gemmell	Mill Practice	Dundee	86*	9317
Christine Grieve	Drumchapel HC	GLA (W)	14	2342
Elizabeth Day	Bridgeton HC	GLA (E)	16	2646
Roger Black	Whitevale St	GLA (E)	65	5563
Hugh Brown	Dalmellington	A&A	90	3682
Gail Henderson	Springburn HC	GLA (N)	37	1386
Emma Shepherd & Joy Rafferty	Easterhouse HC	GLA (E)	5	2430

**Added to top 100 on the basis of SIMD 2009 ranking*

Ten general practitioners participated in this project, completing a questionnaire and report on how their practice makes use of community resources for the benefit of their patients. All quotes are taken directly from the GPs' responses.

The report was compiled by Dr Peter Cawston, general practitioner at Drumchapel Health Centre and Clinical University Teacher at University of Glasgow.

WHAT IS SOCIAL PRESCRIBING?

Social prescribing is the use of non-medical community resources to respond to the needs of patients presenting in a Primary Care context.

- Many patients present to GP Practices with needs of a social nature (e.g. housing, finances, domestic violence, sexual abuse etc). Many more present with medical problems (e.g. anxiety, "stress", addictions, obesity, etc) which have a distinct social dimension.

- Social and medical problems are often not differentiated by patients, who look to GP practices to help them resolve these issues:

  Once you enter my consulting room, as a patient, you have my complete attention, 27 years experience and my empathy. I will do what I can within the limitations of the scenario you bring to me but…I am not a social worker, there are people much better at that job than I, and that's where you should go.

- GPs in deprived communities are a valuable and scarce resource with a specialised expertise to offer. Their effectiveness can be undermined if they are not able to refer patients to appropriate social and community resources, or if these resources are not able to meet those social needs effectively:

  Social prescribing is a very good way of encouraging the patients to help themselves and take ownership of the problem.

- The availability of social resources, however, (such as housing or benefits) is often rationed by medical need. There is therefore a pressure on organisations trying to help clients to obtain legitimacy for claims through medicalisation of needs. This can be detrimental to patients and lead to pressures on GP practices:

  There is a substantial gain to be had through illness in terms of income and resources. The Disability Living Allowance is a gateway benefit.

- Unmet patient expectations, conflict in the doctor–patient consultation, reduced efficiency of the GP service, stress on doctors, and inappropriate use of medical interventions often arise from these social pressures in areas of deprivation.

- Effective social support, on the other hand can bring considerable medical benefits to patients:

  One child had been referred for an operation for undescended testicles which was picked up when he was 6 weeks old. His family kept missing appointments. Since the PACT team got involved he finally had the operation, aged 12.

HOW DO GP PRACTICES CURRENTLY USE SOCIAL PRESCRIBING?

Signposting and referral

- GPs and practice nurses routinely inform their patients of NHS and non-NHS services during consultations.
- ANNEX A **List of community resources accessed by practices** lists some of the non-NHS services signposted.
- There are also NHS resources that GPs refer to which focus heavily on social needs e.g. smoking cessation and addiction teams.
- Most of the GPs who took part have a relatively small number of well established and trusted resources which they signpost regularly and a larger number of more specialised resources which they would draw on occasionally.
- Most would recommend resources in person during consultations. As well as giving contact details, they might give leaflets or promotional material.
- Some GP practices had produced information resources to give to their patients e.g. local directory.
- Assessing the motivation and readiness of the patient to make changes is part of the referral process. Self-referral to an easily accessible service was seen as a useful way to assess whether the patient was prepared to make use of the resource.
- Practices also telephone, write and complete referral forms to assist the referral process.
- Most of the practices refer patients regularly to internet resources.

Medical reports

- All the GPs routinely provide medical reports to government agencies such as the Department of Work and Pensions.
- All of the GPs produce some medical reports and letters of support at the request of patients or organisations acting on their behalf. All felt that this type of activity should be limited. This was the most contentious issue identified and a source of regular stress and conflict:

  I felt there was a conflict between being paid for the report, the patient's expectation of its effectiveness at getting them the award and the doubt as to whether I was exaggerating the disability (or lack of it). My only obligation in this area is to fill up the DWP report for a fee and do a very good job of the reports.

- The effectiveness of this type of activity was questioned by several GPs. Most felt that this had an adverse impact on the medical service they could provide. There was also concern about the impact this has on the local "culture":

These are lists of multiple symptoms and disablements which a GP is asked to sign agreement of and are part of the overwhelming benefits culture.

Advocacy

- Several GPs indicated they are prepared to advocate for social resources on behalf of "selected patients" when there is a pressing medical need.
- However the GPs did not consider advocacy to be a core service that could be expected of them by all patients

Meetings and local contacts

- Some practices have an identified person e.g. practice manager who receives and appraises information offered about local resources before this is used by the clinical staff in consultations.
- Several practices have invited representatives from local resources to speak at a practice meeting.
- Some practices have a patient group or forum. These seem to focus on micro-issues rather than on the wider community and strategic issues.
- Some practices identified the need to have clear boundaries in order to focus on their core functions:

  You can't beat friendly, helpful, cheerful, forward thinking, dedicated people. My practice tries to incorporate these qualities into delivering health care, but that's a big investment. We are a very patient-focussed practice – we can't widen our remit too far. There is also a quality agenda for delivering health care that needs our constant attention.

HOW COULD PRACTICES USE SOCIAL PRESCRIBING MORE EFFECTIVELY?

Recognition of the problems at management & policy level

- Social needs are far more acute and pressing in areas of socio-economic deprivation. GPs working in these areas are very likely to identify a variety of social needs in medical encounters and to receive a high volume of requests for help with social needs.
- GP practices in deprived area routinely face the choice between appearing disinterested in their patients' social problems and becoming swamped by these to the detriment of being able to provide effective primary medical services.
- While there are some mechanisms to reflect the epidemiological distribution of chronic illnesses in the distribution of resources to GP practices, there is no

differential allocation of resources to match the high demand for assistance with these social problems.

- The Local Medical Committee was felt to have an important role in providing guidance to organisations about the role of the GP and in protecting GP practices from inappropriate requests for information.
- Community Health Partnerships could be more effective in providing useful information.

Time to listen and explain

- Many consultations need extra time in order to tease apart the medical and social aspects of the undifferentiated problem being presented by the patient.
- This extra time is not available: as a result social signposting is much less effective than it could be.
- Fifteen minute consultation slots would enable social problems to be responded to in a more effective way:

  The GP could give more and the patients could benefit more but the former becomes stressed and the latter is denied a therapeutic opportunity. This needs extra resources. If the GP is to be a worthy contributor then there needs to be more doctor-time in deprived practices, and the bigger doctor to patient ratio needs funded by government. At present I am a wasted, partially inefficient resource as I am not able to work to my full potential in the consultation. The deprivation/inequality rises but doctor/time has not.

Good practice guidelines for information requests

- Good practice guidelines on seeking medical reports would be of benefit to patients, organisations operating on their behalf, and GP practices.
- The principles behind good practice guidelines might include elements such as the following:
  - Be clear what the problem is: it is disabling to clients to have personal and social problems re-packaged as medical ones.
  - The best source is the client: most of the information about health problems and the impact they have should be provided by the person who has to live with the problem i.e. the patient (or their advocate).
  - Ask doctors medical questions: the role of the medical practitioner is primarily to check the medical information given for accuracy and to clarify and expand on aspects which require professional expertise.
  - Make it simple: a standardised format could be adopted by a wide variety of organisations who require similar types of information.
  - Don’t ask twice: where a report has already been completed for a government agency (e.g. in relation to a disability claim) a second report should not be necessary (e.g. if the patent appeals a decision) unless there has been a significant change in the condition.

- Who's paying? Work undertaken by GP practices utilises a scarce medical resource. Work of this type is not sustainable without detriment to the medical care being provided unless it is resourced.

  An example of good practice: "a medical advisory service housing line application form for patients, where the patient has been given this quite extensive 9 page document and asked to fill this out as far as possible… This new form is standardised; and relates to all the information required. We keep these at the practice, hand them to patients, ask them to fill them out as far as possible then hand them back to us, and we then send them to the medical officer."

Non-medicalisation of social problems

- Many organisations appear to encourage patients to medicalise the problems of life as this legitimises access to social resources (e.g. access to disability benefits:

  We try to resist the urge to medicalise such issues as overwork and not getting on with one's boss."

- From a doctor's perspective, this drives dependency among patients and impacts on the ability of practices to provide care for medical problems.

Up to date sources of information

- Internet directories could be invaluable to patients and to the practice team in giving access to information. These would need to be authoritative, user friendly, and frequently maintained and checked for accuracy and reliability.
- The complexity and number of resources is bewildering to patients and doctors alike. Often resources are short term only, or details change. It is not a good use of medical resource for each GP practice to try and keep up to date.
- Leaflets in a multitude of formats are not helpful to GP practices. Waiting rooms cluttered with posters and leaflets are not effective places to communicate with patients, many of whom are anxious.
- Information resources for doctors to give to patients should be brief and in a format which can be accessibly stored e.g. in electronic format systems to be filed and printed at the point of need, or printed from a web directory.
- Electronic display boards in waiting rooms may be a more effective medium for communication, but this would require careful evaluation before being introduced.
- Local community information points or information managers may have a role to play but would again require careful evaluation of effectiveness
- Local libraries are under-utilised in deprived areas but seem a logical resource to stock local information – this would need to be actively managed and kept up to date however.

Adequate funding for community and support organisations

- Many community resources on which patients rely have uncertain funding. Many others are limited in their capacity. Resources such as stress centres or counsellors have been withdrawn due to lack of funding.
- Primary medical services often plug the gap for many patients: this is an ineffective and expensive use of medical resource:

  Don't really see how we could practice without all these resources…I am worried that cuts in voluntary sector which will have a huge impact on practices in deprived areas and on the poorest /sickest people, especially with addictions or mental health problems.

- Many support organisations are unable to provide local services or are only available for limited periods. This reduces their availability to people with social needs.

  They take 3 months to set up, 3 months to get referrals, run for 3 months then run out of money and take 3 months to close down!

Social networking and relationships with community organisations

- The health visitor is a key member of the practice team who almost invariably develops a network or relationships with other organisations in the practice area
- Other opportunities for networking and personal relationships between the practice team and members of community are more variable
- Personal meetings between practice team members and local organisations are useful in building understanding, but time for this is very limited.
- CHPs could organise regular marketplace events at which all local resources around a particular issue (carers, mental health, young people, healthy living etc) could set up stalls where GP practice representatives could visit, speak to people running the service and collect information.

Accessibility of social support

- Social support organisations need to be readily accessible:

  Often the patients who could benefit most from these services are the least empowered to seek them out. They may find it difficult to phone up new people/go to new places to seek help. Practical things like having no credit on their phone can be a barrier. If they do not get through to someone who can help right away sometimes people are put off.

- Practices often have very little space available. However the key need is for services to be readily accessible in the community.
- Patients in deprived areas are often unable or unwilling to travel distances to access social resources

CONCLUSIONS

All of the GPs taking part recognise social prescribing as an integral feature of their day to day practice and acknowledged the role of non-medical community resources in benefiting the health and wellbeing of their patients. However they also raise concerns about both possible detriment to the patient and threats to the doctor–patient relationship.

Disablement and dependency

Poverty is disabling. GPs in deprived communities are aware of the conglomeration of factors by which many patients can become marginalized from the social benefits of work and material success: low pay, alienating work conditions, low expectations, poor educational achievement, ready access to drugs of addiction, including alcohol and tobacco, a culture of worklessness, poor nutrition, poor physical and mental health. Many of these factors are generational and affect children from the earliest age.

One mechanism in the UK by which scarce social resources can be accessed in deprived communities is by focusing on the disabling characteristics of poverty. The more greatly a patient is affected by their social condition, the greater the possibility of value. Subjective states, such as anxious feelings, unhappiness or morbid ruminations can become objectified for example as “mood disorder” or “suicidal tendencies”. Bereavement, poor housing, homelessness, domestic violence and many other social and political problems can become repackaged as medical ones through the loose usage of terms such as “stress” or “nervous disability”. For many patients this appears to be the only channel available by which to struggle for self betterment or for survival in a hostile environment.

The GP reports portray a picture of communities in which many individuals seem to be locked into dependent relations on authorities – welfare, housing, social work, etc. They are aware that their own relationship with patients could fall into the same pattern. Some express discomfort that by being construed to be the gatekeepers for social resources, under the guise of proving medical need through certificates or reports, they are perpetuating this cycle of dependency. This creates a conflict between seeking to improve the patient’s long term wellbeing and self-efficacy, and responding compassionately to immediate demands for material benefits.

Social prescribing to non-medical community resources may paradoxically also add to this cycle of disablement and dependency. Advocates who seek the immediate welfare of the patient may add political and legal pressure to the construction of their client as a disabled or sick person. In the current climate of widespread withdrawal of illness related benefits, the focus of social struggle by many community organisations is on individuals seeking to prove they are sick, rather than on collective action to change the underlying socio-economic conditions creating and perpetuating cycles of deprivation. It may be that this is their only option.

Emphasising strengths and self-efficacy

The skills that GPs and their practice teams offer- through diagnosis, therapeutic relationships, problem solving, medicines management, improving chronic illness outcomes, etc – are valuable to the communities in which they work. Those taking

part in the social prescribing project readily acknowledge however the limitations of the medical role and the important place of non-medical community resources.

Community resources are most valued by the GPs when they are seen to help people develop the resilience and positive ability to improve their own health. Terms such as “ownership” and “empowerment” are used to express the ability of patients to achieve their own goals and reduce their dependence on others. Medically aligned resources, such as counselling, addictions services, exercise schemes, physiotherapy or carers support are mentioned alongside non-medical interventions such as writing or creative arts groups, volunteering opportunities, employability services or educational opportunities.

On the other hand there is some caution about potential non-medical roles for GP practice teams themselves in the community. The GPs emphasise the need for clear boundaries as to what they have to offer. This seems to arise from an acute sense that constraints on space, time and personnel require a focus on what are seen as core activities in order to maintain standards. There is no strong sense in the GP reports that the practice role is perceived to extend into local development work, direct advocacy, or political campaigning. There is also quite a limited sense of the role of patient participation groups or practice attached voluntary services. There is however a perception that an extension of services attached to GP practices- social worker, benefits / employability advisor or counsellor for example, would be of benefit to patients.

In summary, the GPs who took part in the Social Prescribing Project think it is important to help patients take control of their own health and wellbeing. They see this as a core primary care role, centred on their personal relationships with individual patients. They value other organisations that can further this goal, and regularly point patients in their direction. In keeping with this individual focus they tend to concentrate on individual assistance, rather than on possibilities for action with collective or political goals in the communities where they work.

ANNEX A LIST OF COMMUNITY RESOURCES ACCESSED BY PRACTICES

Please note this list is not exhaustive, but is provided to provide a flavour of the types of organisations mentioned by the GPs in their reports

- Community Addiction Team
- Social Work Office
- Children & Families Team
- Educational Psychology
- Local Schools (phone and discuss children with teachers)
- PACT team (Parent and Child Team)
- Welfare Rights
- Local College Careers Advice service
- School nurse
- McMillan Nurses
- Marie Curie (via District Nurses)
- MacMillian Cancer Support at the Bridge
- Maggie Centre
- Exercise Referral Schemes – eg Live Active
- Weight loss groups
- CRUSE
- Alcoholics Anonymous
- Narcotics Anonymous
- Al Anon
- Community Law Centre
- Stress Centre
- Council on Alcohol
- Marie Curie
- Princess Trust for Carers
- CHiP Van (health information)
- Counselling services eg COPE
- Hospice
- Coeliac Society
- Parkinsons Society
- Insight
- Citizens advice
- Law and Money Advice services
- Live Active
- Regeneration Agencies
- Carer's Trust
- www.patient.co.uk
- "The Internet in general"
- Quarriers
- Gie's a break (including Side by Side respite project and Toffee Club)
- Local Nurseries
- Womens' Aid
- Family Fund, Glasgow Childrens' Holiday Scheme, Buttle Trust, Salvation Army, Renfield Trust, Cash for Kids (all have forms to fill out to get families help with Christmas presents, white goods etc)
- Community Health Shop
- GEAAP

- Citizens Advice Bureau
- Victim Support
- Credit Union
- Volunteer Scotland
- Relate Scotland
- Breathing Space
- H4U
- Disease specific support groups e.g. Alzheimers Scotland, MS Society, Parkinsons Society
- Breast Feeding Network
- Opticians
- Chiropodist
- Sports Physio
- Local MPs, Councillors, MSPs
- Gen R8 (assisted tenancy for young people)
- Housing Associations
- Fare (childrens' club)
- Reed Partnership
- Local churches (asylum seekers)
- One plus (parents with literacy and numeracy issues)
- Furniture Project
- Starterpacks (low cost furniture)
- Writers' Group
- Staff at residential care centres
- Alternative therapies and stress centres (acupuncture, massage, aromatherapy)
- Children's rights advocacy services
- Momentum
- The Green Gym

ANNEX B SOCIAL PRESCRIBING: "I DIDN'T BECOME A GP TO SPEND MY LIFE PRESCRIBING PILLS"

GPs at the Deep End

The 8th activity of "General Practitioners at the Deep End"

A postal project during July and August 2010

Participants are invited for this project, exploring current activity in the area of "social prescribing" i.e. knowing and using community resources to help patients.

Peter Cawston, a GP at Drumchapel Health Centre, describes the reason for the project below. We hope to recruit 10-12 GPs to provide a report of their current experience, activity and views in this area, answering a series of questions, as listed at the end of this flyer.

A half session fee of £105 is available for the two hours it should take to provide such a report. The reports will be combined in a single Deep End report, and used to promote wider discussion about the nature, extent, potential and limitations of social prescribing. The Scottish Government has already expressed interest in the findings. There are no immediate plans for participants to meet, but we expect to convene the group, with locum funding, as part of the next stage.

If you wish to take part, please let Peter Cawston know at P.Cawston@nhs.net.

Social prescribing: "I didn't become a GP to spend my life prescribing pills"

All doctors who work at the so called Deep End of deprived practices are familiar with the long list of psychological and social problems that form the context to ill health and health problems: debts, poor housing, addictions, violence, worklessness, inactivity, a culture of unhealthy eating, to name a few only. Most of us feel that the writing of sick lines and the prescribing of drugs such as statins and antidepressants is a necessary part of what we do, but that they are not adequate responses to the wider problems. What else can and do we offer? This is the subject that is being looked at under the title of 'Social Prescribing'.

Most GPs who work in deprived areas develop some knowledge about other resources within the community that they can refer patients to. Some GP practices go beyond simply informing patients to working more closely with other groups to promote or plan local resources that would be useful to their patients. Examples of these might include local stress centres, exercise schemes, non-NHS counselling services, women's aid, outward bound programmes, benefits or money advice centres, skills workshops (e.g. cycle repair) – the list is again very long.

For many years the literature about General Practice has portrayed the broad generalist approach to health (the much quoted 'bio-psycho-social model') as central to what we do. To take one recent example, the RCGP Scotland 'Essence of General Practice' project listed the whole person approach as an 'essence' of the GP's role. I believe most GPs would identify with this, but it is also the view of patients in deprived areas. Research conducted among patients in the socially deprived housing estate in Glasgow where I work found that the extent to which doctors were able and willing to take into account the "bigger picture" (i.e. the wider daily lives of the patients, behind the presenting problems) was a significant element of what the patients understood to be good quality medical care. A further finding was that patients felt quite socially distant from their doctors, none of whom lived in the area and none of whom were involved to any great extent in local community life outside of their medical practice.

The purpose of the social prescribing report is to try and gather the experiences of GPs who work in the most deprived practices in Scotland to answer three questions:

(1) In what ways do we already use community resources to help our patients?

(2) Are there other ways in which we think better links with the wider community (e.g. voluntary groups, charities, local authority services, police, local businesses, etc) could make us more effective as GP practices?

(3) What ideas do we have that would help our patients make better use of resources in the community?

Interested practices are invited to compile a short report on the role that social prescribing plays in their own practice and on their views about the role they would like to see it playing in the future. Individual practice reports will be aggregated to build up a picture of our experiences and views as GPs working in deprived areas. This will hopefully result in concrete proposals for ways in which GP practices working at the Deep End can be better supported to provide care for their patients.

Dr Peter Cawston

Drumchapel Health Centre
Glasgow

ANNEX C THE PRACTICE SOCIAL PRESCRIBING REPORT

Practice Name and Address	
Practice No	
Person completing this report	
E-mail address	
Date	

You are invited to compile a short report on the role that social prescribing plays in your practice and on the role you would like to see it playing in the future. The individual practice report has two sections, with 4 questions in each section, and is expected to take no more than 2 hours to complete.

Section 1 Current links between the practice and community resources

Please reflect on the current situation in your practice and on relevant examples from the recent past. The types of community resources relevant to this section might include those offered by charities, voluntary groups, local authority services, education, the police, local businesses, patient groups, other government agencies.

Please DO NOT include resources offered by the NHS or by NHS contractors either in secondary care or in the community (for example physiotherapy, primary care mental health teams, dentists and optometrists, etc).

The replies to this section are organised around four possible levels of engagement. Please note that these levels are not hierarchical, but reflect the diversity of roles that we have as GPs, as well as the potential for things to go wrong.

LEVEL A HARMFUL OR NEGATIVE RELATIONSHIPS

Please give examples of any damaging consequences to patient care that have arisen from poor communication and lack of mutual understanding with local community resources. For example these might include the impact that requests for medical support to access resources have on practice workload / the doctor patient relationship, concerns you might have about recommending non-NHS services, or even any reflections on the negative impact we may have as medical practitioners responding to social concerns:

LEVEL B SIGNPOSTING

Please give examples of local services and resources to which your practice refers patients, either by providing information to patients or by direct referral pathways.

How do you provide the information to patients?

How do you make direct referrals?

How effective or otherwise is the process of referring to these external resources?

In what ways (if any) has the care you can provide been enhanced by signposting to other services?

Have there been any examples of patients having encountered problems or being harmed by social prescribing (e.g. breeches of confidentiality, etc)?

LEVEL C COORDINATION

Please give examples where the practice has gone further than simply making referrals or passing information to patients about the service. These might include ongoing personal contact with members of the organisation, inviting a representative to attend a practice meeting, visits by the practice to the organisation, attendance by practice representatives (staff, patients or GPs) at planning meetings etc.

Please discuss whether the Community Health (& Care) Partnership structure has facilitated (or hindered) this process in any way.

Please give examples of any other organisations or structures that have facilitated contact between your practice and the local community bodies (community councils, etc):

LEVEL D JOINT PLANNING

Please give a detailed description of any ways, if any, in which your GP practice has been involved in jointly planning community resources or services to meet patients' needs. These should have a significant input either from the local community (patients, volunteers) or from agencies outside the NHS sector, but in which the practice has played a leadership role. Examples might include services (e.g. prescription collection, befriending) set up by volunteers or local agencies jointly with the practice, or a local forum or meetings facilitated by the practice to promote service development:

Section 2 Possibilities for better links between the practice and the community

Please reflect on your vision for how the practice might be more effective in helping patients to make better use of local resources to meet their health needs:

Please reflect on any ways in which there might be better coordination and communication between the practice and community resources:

Please reflect on any services or resources that you think would function effectively if they were directly attached to your practice:

Please think of some straightforward practical ideas that would make it easier for your practice to use social prescribing more effectively: