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Signposting services in the UK: enhanced support or service diversion for people with health and social care needs: a rapid realist synthesis

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Abstract

Purpose – In the UK signposting services can be developed as enhanced support for people with health and social care needs or service diversion to help primary and urgent care services manage their workload. This review considers these two conflicting purposes.

Design/methodology/approach – The review used a realist approach, initial searches to identify theory; we then selected 22 publications and extracted programme theories, from which we developed questions from three viewpoints: the service user, the front-line service provider and the commissioner. A rich sample of studies were found from purposive searching. To optimise the applicability of synthesis findings predominantly UK studies were included.

Findings – Users value signposting service that understand their needs, suggest a range of options and summarise potential actions. People with complex health and social care needs generally require extended time/input from signposting services. Front-line providers require initial and ongoing training, support/supervision, good knowledge of available services/resources and the ability to match users to them and a flexible response. Commissioned signposting services in England are diverse making evaluation difficult.

Originality/value – Meaningful evaluation of signposting services requires greater clarity around roles and service expectations. Signposting services alone fulfil the needs of a small number of users due to the unreconciled tension between efficient (transactional) service provision and effective (relational) service provision. This is underpinned by competing narratives of whether signposting represents diversion of inappropriate demand from primary care and other urgent care services or improved quality of care through a joined-up response encompassing health, social care and community/voluntary services.

Keywords Signposting, Health and social care, Realist review, Service users, Service evaluation, Commissioner, Service provider, Community sector, Voluntary sector, Primary care, Urgent care, UK

Paper type Research paper

Introduction

Signposting put simply means pointing people to potentially useful sources of information, help or advice. By implication, it refers to an initial contact for orientation and transmission of information that may or may not require detailed extensive follow-up and support. The UK health and social care system is complex and many people are unaware of the services

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available. Therefore, users may require signposting from a first point of contact with the service (often a general practice or generic service provided by receptionists) to other sources of information and support. Many members of health and social care staff include signposting within their roles, with its increased importance accompanying the development of social prescribing, as an alternative or add-on to conventional medical treatment. The need for signposting recognises that demand for many services exceeds the available supply, potentially leading to long waiting lists and frustration on the part of patients.

Against this shifting background, signposting may be defined as "new roles and support for navigators, health trainers and advisors who help patients and service users understand, access and navigate community-based services that will improve their health" (Nesta, 2013). Typically, signposting "involves practitioners providing information, with the process of contacting the service (self-referral) undertaken by the individual" (White *et al.*, 2022, p. e5106).

However, the diversity of approaches to signposting is illustrated by a survey of clinical commissioning groups (CCGs) in England (Tierney *et al.*, 2019).

Of 195 CCGs approached, 162 provided useable data and 147 provided a "care navigation" service in primary care. Services were delivered by practice staff, dedicated paid employees and volunteers in various combinations. Seventy-five different titles described the role, with "care navigator" and "link worker" being most common. Most services were available to all adult patients ("generic" services), particularly when delivered by receptionists or other members of practice staff. However, some signposting services were only available to users meeting particular criteria such as older people or those with a long-term health condition. Further variation exists in the methods of referral into, or contact with, the signposting service. Referral was commonly by a primary care or community health professional, others self-referred or initiated contact via a GP surgery (Tierney *et al.*, 2019). Increasingly, the delivery of signposting services can be through multiple channels: face to face, by phone, virtually, by technology assisted by humans or by technology developed to deliver signposting.

A prioritisation exercise by Health and Care Research Wales in 2020 identified an evidence gap around signposting, particularly beyond primary care to include acute and social care services. The original research questions ("What approaches improve signposting to services for people with health and social care needs? What works best, for whom, in what circumstances and why? Do benefits accrue from implementing options in combination"?) strongly indicated the need to employ a realist review approach (Pawson *et al.*, 2005). The review team, commissioned by the National Institute for Health and Care Research (NIHR) Health Services and Delivery Research Programme, initially identified programme theories (explanations for how services work) from a review of theoretical and empirical literature. Subsequently, we sought to address these initial programme theories by synthesising evidence from the distinct perspectives of the service user, the front-line providers of signposting services and the commissioner/funder.

Methods

We undertook a focused realist review as we were seeking to explore how the different approaches to signposting work, for whom in what circumstances and why (Pawson *et al.*, 2005). The methodological approach for this review is set out in detail in the published protocol (available at: https://fundingawards.nihr.ac.uk/award/NIHR135661) which was developed with input from commissioners and patient and public involvement representatives. The review comprised two phases: in the first phase, we identified evidence specifically relating to signposting for identifying theory for developing programme theories in the form of IF (Context) –THEN (Mechanism) –LEADING TO (Outcome) statements (CMO Configurations). From the programme theories identified we developed three priority questions. The second phase was identification, analysis and synthesis of evidence to address these questions.

Searches

We conducted two phases of evidence retrieval, one for each stage of the review. The searches were developed by an Information Specialist/Reviewer (AC) with input from the other reviewers.

First phase searches. An exploratory search was conducted on Medline to find terms and related concepts for signposting. This search guided the development of the first phase searches to identify programme theory/ies. The theory search included synonyms and related terms for signposting combined with terms for programme theory and relevant study types. We then conducted searches on Medline, CINAHL and SSCI restricted to research published in English from 2016-current. This cut-off date was used because interest in signposting increased after publication of the NHS England General Practice Forward View (https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf).

The search strategy, databases and dates of search are provided in the supplementary materials. Exported search results were uploaded and deduplicated using Endnote X9.

Second phase searches. The second phase of searches was purposive due to time constraints and aimed to provide a rich sample of studies to address the three priority questions. Targeted searches of the Endnote database identified key items relating to the three perspectives. Additionally, one reviewer conducted "context sensitive" searches of article full-text using the scite tool (https://scite.ai/) and Google Scholar (via Publish Or Perish https://harzing.com/resources/publish-or-perish).

Study selection

Study selection from first phase searches. One reviewer (AB) experienced in realist reviews selected studies from the first phase searches to use for theory identification.

Study selection from second phase searches. Selection of studies for the realist synthesis was prioritised to optimise richness, relevance and rigour. Each reviewer led on one of the review questions and selected included studies that address their question sharing any studies relevant to the other perspectives. Predominately including UK studies helped optimise the applicability of synthesis findings to the Health Services and Delivery Research Programme.

Data extraction

Data extraction was undertaken in the first and second phase, more detail follows.

First phase data extraction. For the first phase we extracted CMO configurations in the form of IF (Context) –THEN (Mechanism) –LEADING TO (Outcome) statements (CMO Configurations). The extracted data related to IF (WHO? DO WHAT? FOR WHOM?) THEN (THE RESPONSE IS) LEADING TO (WHAT OUTCOMES? FOR WHOM?).

Second phase data extraction. The second phase data extraction covered study characteristics, study context and study findings to address the three priority questions. Data extracted for study characteristics: author, year, study country/countries, study design, study sample, sample size, population age, population gender, health condition. For signposting context, we extracted setting, generic or specialist, signposting features, by whom, types of resources required and length of interaction. For study findings, we extracted outcomes measured, main findings and key messages including limitations.

Analysis and synthesis

Realist synthesis was used to answer the three key questions. The importance of CMO theory was considered in the analysis and synthesis of evidence.

Results

Search results

The search results are described for each phase.

First phase search results. The broad search retrieved 857 references and the focused search 35 references. Before deduplication there were 892 references and after there were 747 unique references, 716 from the broad search and 31 from the focused search. One reviewer (AB) reviewed the references and twenty-two studies were selected to use for theory identification.

The team prioritised complete (i.e. three-element) CMO configurations, whenever possible. A limited number of two-element CMO configurations were included when they provided unique insights, for completeness. The CMO configurations were checked to ensure that the configurations were complete, in a standard format and that agency (i.e. who was the agent for action) could be identified. The initial programme theories were discussed within the review team and the need to address the complementary perspectives of the service user, front-line service provider and the commissioner/funder was identified. Priority question were constructed to match each perspective.

(1) Question one (Value and Usefulness of Signposting) considers the service user perspective: What do people with health and social care needs require from a signposting service to believe it is a valuable and useful service?

(2) Question two (Required Resources) considers the perspective of the front-line provider of the signposting service: What resources (training, directories/databases, credible and high-quality services for referral) do providers of front-line signposting services require to confidently deliver an effective signposting service?

(3) Question three (Specification, monitoring and evaluation) considers the viewpoint of the commissioner/funder: Under what circumstances should commissioners commission generic or specialist signposting services?

Second phase search results. The second phase searches identified 270 records from a targeted search of the Endnote database and 12 records through context sensitive searches using the scite tool and Google Scholar. After removal of one duplicate 291 references were assessed for eligibility. To address the three questions, 27 items were included in the review. This consisted of 4 reviews and 23 studies; some of the included studies provided information for more than one of the questions. Two hundred and seventy six studies were excluded from the review. The review findings will be presented for each question then the discussion synthesises the results from the three perspectives. CMO configurations were extracted for the included studies and can be found in the supplementary material.

Question 1 (value and usefulness of signposting)

For question 1, 19 items of evidence were reviewed including 4 reviews and 15 individual items reporting UK studies or service evaluations. The majority of studies were qualitative or mixed-methods with just one quantitative study.

People accessing signposting services value a joined up response that helps them to navigate resources offered by different organisations and/or sectors (Wildman *et al.*, 2019). Key features from a service user viewpoint are an understanding of their needs, presentation of options (together with alternatives if required) and a summary of the recommended action to be taken. This needs to be supported by appropriate matching of opportunities to their needs and resourced provision and capacity so that they can pursue these opportunities (Brunton *et al.*, 2022; Wildman *et al.*, 2019). Above all, a signposting service must reduce the "patient burden" (the extent to which the patient has to "push" themselves through their

interaction to achieve appropriate options and choices) encountered in contacts with formal health services when trying to pursue options and alternatives (Stokoe *et al.*, 2016). A key consideration is whether signposting services are conceived to operate in isolation or whether they form the front-end of an integrated pathway of care with multiple routes and outcomes.

The needs of only a small proportion of those targeted by signposting services are met by signposting services alone (Brunton *et al.*, 2022; Wildman *et al.*, 2019; Harris *et al.*, 2020). Where people with complex needs interact with signposting services, interaction may require extended time or multiple interactions. Alternatively, they may perceive that the brief intervention did not completely meet their needs. Effective use of signposting, which requires a clear, and often detailed, understanding of service user needs, may operate against a programme theory that conceives signposting as an efficient brief intervention to divert service users away from formal health services towards wider resources in the community (Brunton *et al.*, 2022).

Question 2 (required resources)

In addressing this question, 14 items of evidence were reviewed including 1 review and 13 individual items reporting UK, US or Canadian studies or service evaluations. A scoping review aimed to understand the effectiveness of linking schemes in improving the health and well-being of people with long-term conditions (Mossabir *et al.*, 2015). The other studies were qualitative or evaluation of signposting services or training programme.

To provide an effective signposting service front-line providers need appropriate training and ongoing support and supervision (Brunton *et al.*, 2022; Gauthier *et al.*, 2022; Donovan and Paudyal, 2016; Toal-Sullivan *et al.*, 2021). They require good knowledge of relevant health, social care, community, voluntary or other agency activities and opportunities to which they feel empowered to refer service users (Farr *et al.*, 2021; Bertotti *et al.*, 2018; Brunton *et al.*, 2022; Gauthier *et al.*, 2022). Connected to this is whether front-line providers are confident that there are sufficient appropriate, high quality resources available. This is important especially in times of resource constraints. To match a service user to appropriate resources can take time, a number of interactions and the creation of trust between the front-line provider and the service user. Front-line providers of signposting services need to provide a flexible response in order to meet very diverse levels and types of individual needs. Requirements may also differ according to differing levels of availability of complementary services (e.g. where separate health and social care signposting services co-exist or not).

Question 3 (specification, monitoring and evaluation)

To answer question 3, four items of evidence were reviewed; data from a survey of CCGs in England (Tierney *et al.*, 2019), two service evaluations and a qualitative study of a new care model in Child and Adolescent Mental Health Services (CAMHS) (Farr *et al.*, 2021). The service evaluations were for a social prescribing service (Dayson *et al.*, 2016) and a primary care diabetes care navigation service (Allen and Drabble, 2017).

The reviewed evidence supported the diversity of commissioned signposting services in England (no studies were from Wales or Northern Ireland) in terms of client groups, staff delivering the service, referral routes and how the signposting role is defined (Tierney *et al.*, 2019). This is a potential barrier to evaluating and commissioning services (Tierney *et al.*, 2019). The evidence indicates that the evaluation of signposting service is uncommon which is a potential barrier to the commissioning of services.

In times of resource constraints the lack of availability of services in the voluntary and community sector (VCS) may limit the effectiveness of signposting services in primary and secondary care and their potential to reduce urgent care use and improve wellbeing in service

users. The importance of the availability of quality well-resourced services was identified in relation to the provider perspective.

Brief signposting interventions are sufficient for some service users. Others require intensive support to help them overcome barriers to engagement with either the care signposting/care navigation process or, subsequently, to engagement with services to which they are referred. This was identified in relation to the service user and provider perspective (Farr *et al.*, 2021; Dayson *et al.*, 2016).

From the commissioner perspective, it is important that referral processes provide intensive support to those most likely to benefit in the longer term.

Discussion

The three perspective (service commissioner, service deliverer and service user) approach that the team employed for the review yielded multiple benefits. Previous realist work suggests that a single narrative offers too simple an evaluative lens when data can sustain;

> "multiple explanations … sometimes contradictory explanations and sometimes perverse, artefactual explanations" (Taylor *et al.*, 2021, p. 454).

The outcomes of a signposting intervention are influenced by context. More typically, multiple stakeholders for a complex intervention *(context)* advance different explanations for what is intended *(outcomes)* (Steenkamer *et al.*, 2017). This is more than simply a difference in preferred *outcomes* but can be fundamental to the whole conception of the intervention. We identified certain arguments, justifications and supporting evidence for signposting as an efficiency intervention, with *outcomes* of diverting inappropriate use away from formal health and social care services. Conversely, we identified arguments, justifications and supporting evidence for signposting as a service enhancement, with the *outcome* of filling a deficiency in current health and social care provision. This deficiency could variously relate to the need to identify sources of support, the need for assistance in navigating the complexity of the health and social care systems or the need to develop self-management resources, or some combination of these needs. Typically, this service enhancement is packaged as a means to deliver "holistic" care (Kimberlee, 2015). Of course, this tension between efficiency intervention and service enhancement does not represent an either/or decision. Each service needs to decide how it will manage these competing priorities in terms of both service focus and resources.

The *context* in which the service is provided is important. Underpinning these assumptions or intended *outcomes* are different models for who delivers the signposting. The "diversion" model sees administrative staff providing a signposting service with the *outcome* of reducing demand on front-line clinical services. Assuming that these staff are able to deliver a satisfactory response and that they do not spend an inordinate amount of time delivering the signposting service this represents a potential efficiency *(outcome)*. However, this would assume that the administrative staff are currently underutilised and/or that their involvement in signposting is of greater benefit than their role in performing traditional routine administrative functions. Less apparent is where clinical staff are required to deliver a signposting service in addition to their usual role. Potentially, this may add to the time spent for each patient contact – unless staff members are already delivering signposting invisibly within their current interactions. In fact, extended contact may well be the norm if service users expect to be able to discuss their preferences, barriers and beliefs about the ability of the service to meet their presenting needs and to build a trusting relationship (Featherstone *et al.*, 2022). Legitimising signposting in this *context* holds the merit of making what was previously invisible apparent but holds little other advantage. Where signposting is expected to coexist alongside other clinical roles, health professionals may find it challenging to remember the available options, requiring frequent reminders and prompts (White *et al.*, 2022). Finally, largely within the service enhancement model, comes the prospect of adding an extra value-

added service whereby administrative and/or clinical staff offer a signposting service not previously delivered. Service enhancement may particularly be a driver where a signposting service targets a specific client group rather than providing a general contact point. Of course, if this service can be delivered either by voluntary agencies or by commercial enterprises a service enhancement could be achieved for no extra health or social care expenditure.

We therefore found ourselves unearthing different, and in some way competing, narratives as to what signposting is intended to achieve. Multiple perspectives of the same phenomenon have fruitfully been explored in other types of research (Swinglehurst *et al.*, 2010). However, it is overly simplistic to attribute one perspective to one particular group of stakeholders. Commissioners and service providers would share commitment to the needs of service users. Most service users appreciate that demands upon public or voluntary-funded services need to be bounded within reasonable resource limits of both time and finance. Shorter individual signposting sessions increase availability of services and extend the coverage to more users. Staff involved in signposting do not simply require knowledge of available resources or services. They also need to believe that the service user will respond to the recommendation and that they have the potential to benefit from the service. Signposting also occupies an interim space when individual circumstances do not require immediate referral (for example, when an individual is not experiencing acute illness, hospitalisation or crisis) but when circumstances are sufficiently flexible to allow for preferred and optimal timing (White *et al.*, 2022). Evidence also suggests that repeated or multiple instances of individuals not acting upon signposting may transform the health professional to adopting an active role of direct referral (White *et al.*, 2022).

The above issues focus on delivery of the signposting service itself. Although this can variously harness existing resources or demand new additional resources this may not represent the only expenditure. For signposting to operate, and to be viewed, satisfactorily requires that the signposting service be underpinned by an appropriate level of resources for the support or activities to which the service user is being referred. A low-cost model would simply catalogue and direct towards resources already available in the local community, whether through public services or voluntary services. A high-cost model would require the large-scale funding of numerous missing resources to which the signposting could redirect and divert service users. An intermediate model would use the creation of a resource directory to support local signposting as an opportunity to stocktake and replenish current community resources. In other words, it is not sufficient merely to "clean the shop window" (the signposting) but the service also needs to ensure that the shop is "stocked" by "mapping local community groups and services into electronic health directories" (Kimberlee, 2015, p. 106 populated with the activities and resources required to meet service users' needs and to ensure repeat visits where necessary (Kimberlee, 2015).

What we found lacking when conducting the review was a fundamental and explicit articulation of the needs of the service user. We could not determine the extent to which the rationale for the service is for the one-off user with a single knowledge deficit to be addressed by a signposting service or for a repeat user whose original need is satisfactorily met on the first instance and therefore returns to attempt to satisfy similar, but essentially different, additional needs. Similarly, is the service primarily seeking to acquire more and more use until its lack of access and delayed response drives users away or is it seeking to make the service user independent and therefore no longer needing the service. Would satisfied service users be expected to recruit others to the service by means of referral or would they move on, through evolution of need and personal development such that they are no longer in contact with the service? Finally, unlike social prescribing which carries a stratified expectation of type of contact (for example ranging through signposting, light, medium and holistic) (Kimberlee, 2015), signposting does not seem to have reconciled very different service user needs. These can range from the brief encounter where success is measured by the brevity of the contact (Bertotti *et al.*, 2018) before successful referral to an appropriate alternative source of support to a

more intensive, extended and possibly repeat consultation where the person signposting gains a detailed case history of the service user and works through multiple, complex issues until each individual case is resolved. It feels unsatisfactory to define signposting only as the first stage of the social prescribing process when satisfactory signposting can take place (in some cases up to 30% of instances) without proceeding to other more intensive forms of social prescribing. Indeed one study on social prescribing is labelled with the title "more than signposting" (Kimberlee, 2015). Although brief information provision and signposting can function as.

"catalysts for change" (White *et al.*, 2022, p. e5112) there is recognition that significant behavioural change requires longer time, beyond signposting, in helping service users to "work out where they want to go next" (Bertotti *et al.*, 2018, p. 238).

Strengths and limitations

Our review was commissioned for a UK audience and therefore appropriately privileged evidence derived for UK-based services. In privileging relevance, the review was able to evaluate services that were delivered to a typical NHS and UK social care population. Our realist study complements realist explorations of social prescribing that suggest that factors such as the quality of relationship with health staff, the accessibility and location of services and the quality of staff training can all influence outcomes (Elliott *et al.*, 2022; Husk *et al.*, 2020). However, instead of focusing on the key stages of enrolment (referral), engagement (initial uptake) and adherence, signposting appears to be based on access (to inquiry point), direction (to appropriate resources) and follow through (to referral to services).

Initiatives such as "signposting" often develop ahead of formal definitions and service specifications. A review team can formally anchor the review topic to the precise term but risk omitting useful examples that have been labelled differently. This is a particular issue when the terminology is as diffuse as revealed by the above mentioned survey (Tierney *et al.*, 2019). Alternatively, they can produce a working definition of characteristics for inclusion, irrespective of service label used, but risk accumulating a heterogeneous collection of interventions that share little in the way of common and transferable lessons learned. This latter approach could also result in the arbitrary omission of a useful initiative or evaluation because of the presence (or absence) of a contested feature. Our team decided that interventions that referenced signposting would yield sufficient diversity, without necessarily having to label their specific initiative as such. This represented an optimal and pragmatic approach to study identification and heterogeneity.

Our team faced a further challenge in that at the time of our review signposting was developing rapidly as a concept within primary care services whereas the motivation for the review question came from elsewhere, namely social care, voluntary services and acute hospitals. An instrumental delineation of scope would exclude primary care services. However, within a theory-led review method an argument could be made for including services regardless of sector.

Recommendations

Working within an exploration of signposting, from the reverse direction of a study of social prescribing, we concur that further research is needed "to gain quantitative insights into the numbers of people requiring 'more than signposting', and how practitioners make decisions about which approach to use" (White *et al.*, 2022, p. e5112).

Conclusion

To enable evaluation of signposting services there needs to be greater clarity around the roles and service expectations. For users with complex health and social care more intensive and repeated support is required from specialist services equipped with specific knowledge and

situational understanding. Thus, signposting services need to be flexible to meet the specific needs of the individual service user. For some service user this will be a brief information giving exercise while for other users with more complex needs it will involve the development of a relationship over time and could include potential support with taking forward the potentially useful services and resources.

There is an underlying tension between the efficient (transactional) service provision with brief referral and effective (relational) service provision, which requires detailed understanding of individual service user needs, remains unreconciled. This is underpinned by competing narratives of whether signposting represents "diversion of inappropriate demand from primary care and other urgent care services" or "improved quality of care through a joined-up response that encompasses health, social care and community/voluntary services".

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Supplementary Material
The supplementary material for this article can be found online.

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