Northumbria Research Link

Citation: Bradley, Gemma and Scott, Jason (2021) Social prescribing nomenclature, occupational therapy and the theory of Institutional Work: Creating, maintaining and disrupting medical dominance. Occupational Therapy in Health Care. ISSN 0738-0577 (In Press)

Published by: Taylor & Francis

URL: https://doi.org/10.1080/07380577.2021.1926046 <https://doi.org/10.1080/07380577.2021.1926046>

This version was downloaded from Northumbria Research Link: http://nrl.northumbria.ac.uk/id/eprint/46097/

Northumbria University has developed Northumbria Research Link (NRL) to enable users to access the University's research output. Copyright © and moral rights for items on NRL are retained by the individual author(s) and/or other copyright owners. Single copies of full items can be reproduced, displayed or performed, and given to third parties in any format or medium for personal research or study, educational, or not-for-profit purposes without prior permission or charge, provided the authors, title and full bibliographic details are given, as well as a hyperlink and/or URL to the original metadata page. The content must not be changed in any way. Full items must not be sold commercially in any format or medium without formal permission of the copyright holder. The full policy is available online: http://nrl.northumbria.ac.uk/policies.html

This document may differ from the final, published version of the research and has been made available online in accordance with publisher policies. To read and/or cite from the published version of the research, please visit the publisher's website (a subscription may be required.)

Northumbria University NEWCASTLE

CUSTOMER SERVICE EXCELLENCE CSE UniversityLibrary

Commentary

Social prescribing nomenclature, occupational therapy and the theory of *Institutional Work*: Creating, maintaining and disrupting medical dominance

Key words: social prescribing, occupational therapy, institutional work

Abstract

Social prescribing is a process of helping people to access non-medical activities and services which address health and wellbeing needs. The process is frequently (although not exclusively) initiated by primary health care professionals and often involves prescribing activities or initiatives provided by community and voluntary organizations. To occupational therapy, the links between activity, social-connectedness and health are clearly not new, although there are emerging international examples of social prescribing initiatives, and examples of newly developed roles, processes and funding opportunities, all of which are creating momentum behind the agenda.

In this commentary, we draw upon the theory of *Institutional Work* to examine how the language of 'prescription', and the purposive action of policy-makers and practitioners, is shaping thinking and action in relation to activity and health. Arguably, this language has helped to translate the recommendation of activity to meet a range of health needs in to an accessible and implementable concept. However, it has also potentially contributed to positioning the concept within a medical model of health, upholding medical dominance, and leaving occupational therapy on the margins of the debate.

Social prescribing connects people with social and voluntary organizations to access non-clinical activities (The Kings Fund, 2017). Internationally, there are different models of social prescribing, but many involve referring a patient to a link worker who works with the patient to access activities and programmes such as volunteering, physical exercise, befriending, or group learning. The primary role of the link worker is to work in a person-centered way, finding out what issues are affecting the health and wellbeing of the individual and connect people with activities which could enable control, help to learn or develop skills, give time to others, or engage interests which have known health benefits such as exercise or being outdoors (NHS England & NHS Improvement, 2020). An example of one social prescribing initiative in the United Kingdom (UK) is presented in box 1.

[Box 1 near here]

Social prescribing is promoted as a key part of personalised care across health and care systems and there is evidence of positive health benefits for a range of people including those living with long term conditions, those who need support to maintain good mental health and those with complex social needs or experiencing isolation (Bickerdike et al, 2017). There is also evidence to suggest that social prescribing can reduce pressure on General Practice and other health services (Polley et al, 2017), such as in pre-hospital urgent and emergency care (Scott et al., 2021). For these reasons, it is high on the health and care agenda in the UK with emphasis in both the General Practice Forward View (NHS England, 2016) and the NHS Long Term Plan (NHS England, 2019).

Although the interest and discourse surrounding social prescribing has recently accelerated, it is clearly not new. Firstly, the links between activity-based social connectedness and wellbeing have a clear historical and philosophical basis (Wilcock & Hocking, 2015) and the ideas are given prominence in much earlier international models of

social determinants of health (e.g. World Health Organization, 2003). Secondly, such links are central to the profession of occupational therapy, which has a long history of recommending the therapeutic benefits of activity for people living with long term health conditions (Meyer, 1922). Theories from occupational therapy and occupational science – such as the conceptual framework of doing, being, becoming, belonging (Wilcock, 2006) – emphasise, amongst other elements, the importance of being meaningfully engaged in activities and the value of social connectedness as people 'do'. Furthermore, such values are fundamental tenets for many community organizations, who perhaps would not relate these connections with professionally-led processes or theories, but instead to more organic and community-centred approaches.

In this paper we examine how the practice of choosing, using and recommending activity as a means to improve health has been relabelled as social prescription. We also consider how the lexicon of *'prescription'* has positioned the agenda within a medical model of health, and enabled mimicry of established medical practices which have unarguably increased opportunities for funding and profile while contributing to challenges and critical questions for occupational therapy. We locate this discussion against a backdrop of policy and practice in the UK, however interest in healthcare organizations meeting social needs and the medicalisation of these social needs and interventions are global themes (Gottlieb, Wing & Adler, 2017), for example with similar community referral initiatives reported in the United States (Cartier, Fichtenberg & Gottlieb, 2020), Australia (Bartholomaeus et al., 2019) and Scandinavia (Jensen et al., 2017). The debate about how language is influencing, and being influenced by, policy and purposive action, is of international significance and interest as these initiatives develop and gain further traction.

We have noted parallels between social prescribing and the theory of *Institutional Work* (Lawrence & Suddaby, 2006) and will use this framework to explore issues within this

commentary, many of which we suggest stem directly from the language of *prescription*. Whilst others have reflected on the language of social prescription and alignment with a medical model (Phizackerley; 2019), the theoretical lens of *Institutional Work* advances this discussion to examine the purposive action which has enabled this positioning. *Institutional Work* outlines categories of action by individuals and organizations aimed at creating, maintaining and disrupting institutions. Lawrence and Suddaby (2006) synthesise nine distinct practices through which individuals and organizations can create and influence new institutions. *Defining, vesting and advocacy* are examples of overtly political work to reconstruct rules and boundaries that may lead to access to material resources; *constructing identities, changing norms and constructing networks* are actions where belief systems are reconfigured; and finally, *mimicry, theorizing, and educating* include actions designed to alter abstract categorisations, thus changing the boundaries of meaning systems. A brief summary of how Instititutional Work categories are applied to social prescribing is provided in table 1.

[Table 1 near here]

What's in a name?

If we accept that the premise of facilitating connections between individuals and heath-giving activities is not new, it is the label of 'social prescription' which is more recent and has coincided with increased interest and profile. The origin of the term within professional language and policy is unclear, although it was highlighted as a strategy for community services and for supporting those with long term care needs in UK policy in 2006 (Department of Health, 2006) and has also been noted, albeit to a lesser extent, in international examples (Gottlieb et al, 2018; Aggar et al, 2020).

Alongside the unclear origins, there is also an absence of one accepted definition of social prescribing (Bickerdike et al., 2017) and the term is used in different ways, interchangeably used to describe a process within a pathway which makes links between individuals and community resources, or actual activities and interventions to address social needs (Health Education England, 2016). One definition from The Social Prescribing Network (2020) defines the concept as enabling healthcare professionals to refer patients to a link worker, and to co-design a non-clinical social prescription to improve their health and wellbeing. The language of *enabling healthcare professionals* and the action to *refer* is terminology indicative of a process where responsibility lies with professionals and is aligned with a traditional medical paradigm.

Institutional Work Actions (1) - Reconstructing rules and boundaries

Since the emergence of the term social prescribing, there has been increasing *advocacy* to raise its profile. For instance, one of the key actions to advocate and share best practice in the UK was the appointment of a General Practitioner (GP) as a national clinical champion for social prescribing, arguably representing allegiance to the traditional roles and responsibilities of *prescribers* and thus creating a firm footing for the social prescribing agenda inside a traditional medical model. Whilst this can be beneficial – particularly for the advocacy of social prescribing – it does means that medicine will likely retain its dominance as it has with the distribution of other forms of prescribing (Weiss, 2020).

Through the Institutional Work of *defining*, new roles have emerged for link workers to facilitate the referral process, as described in the example in Box 1. Additionally, the Institutional Work of *vesting* has conferred property rights to Primary Care Networks, Clinical Commissioning Groups and, to a lesser extent, Local Authorities. Whilst Local Authorities are

seen in name as key stakeholders, the language of their own policy describing social prescribing as *'Just what the doctor ordered'* (Local Government Association, 2016) once again is suggestive of deferral to medically-led decision-making. Potential implications of these rule-creating actions are that hierarchies within primary care are preserved, roles of link workers (and any evolving roles of supervisors, coaches or educators) may be more accessible to disciplines such as medicine and nursing who already have a firm footing within primary care, and perhaps more significantly, people accessing services are defined in 'patient' roles (NHS England, 2016).

At face value, the rhetoric of contemporary policy to construct or reconstruct rules and boundaries does use language which promotes personalised models and encourages new partnerships and cross-sector working. Such values are once again highly familiar to occupational therapy philosophy and practice (WFOT, 2010; RCOT 2016). However, such policy is clearly orientated towards an audience within statutory services (such as the General Practice Forward View, 2016 and the NHS Long Term Plan, 2019) and critical voices suggest that funding opportunities have primarily opened up within these traditional areas (Thirdsector, 2018). Routes to access additional resources for community groups who are expected to respond to referrals are unclear and the language of policy and guidance risks missing or alienating such key stakeholders.

Institutional Work Actions (2) - Reconfiguration of identities, relationships and belief systems

Once rules are established and material resources are accessed, the next set of Institutional Work practices suggest that identities, relationships and belief systems are configured. Significantly, definitions of social prescribing as a means of enabling GPs, Primary Care

Practitioners, and other frontline healthcare professionals to refer patients to a link worker, with a surrounding discourse as something 'the doctor orders', have now set in motion rules about how the process should happen and the identities of those responsible. Although one of the cited goals of social prescribing is to relieve pressure on GP services (NHS England, 2016), the language suggests that knowledge and action continues to lie with GPs, with an associated workload for gatekeeping and referral. Outcomes from comparable initiatives to reduce pressure, but where the professional has remained as a gatekeeper within a pathway, suggest work has been delegated rather than substituted, the desired reduction in workloads has been questionable, and maintenance of power and privilege has been prioritised (Currie et al, 2012). This continued involvement and oversight by GPs is not unique to social prescribing; Cooper et al. (2012) noted that nurse and pharmacist prescribing initiatives experienced similar medical dominance.

The construction of social prescribing as a professionally-led activity, which has attracted funding within contracts for General Practice (NHS England, 2019) aiming to reduce pressure on services, has inevitably influenced the direction of measuring outcomes. The evidence base to measure the effectiveness of social prescribing represents potential *changing normative associations* and is perhaps shaping, or reshaping how those involved with social prescribing connect these activities with the foundations of their organizations. Within evidence published to date, there are examples of disparate measurement of changes in wellbeing, user-experience, service uptake and healthcare usage (Bickerdike et al, 2017).

Community organizations involved in delivering activities may have not traditionally evaluated outcomes in these ways, but will now likely be directed to do so via the recently developed common outcomes framework for social prescribing (NHS England, 2020), which includes impact on the person, impact on community groups and impact on the health and social care system (see Table 2). Arguably, if wider professions, community organizations

and those who use services had been involved in earlier stages of advocacy, defining and vesting, then the language of measuring outcomes may have been different. But with this outcomes framework, the success and speed with which professions and organizations can respond is likely to be critical to securing their place within *normative networks*.

[Table 2 near here]

Institutional Work Actions (3) - Altering and sustaining meaning systems

The final set of practices involves altering meanings and categorizations to establish and normalise institutions. *Mimicry* describes practices which leverage existing sets of taken-for granted actions or beliefs to associate the new with the old and ease the adoption of a new institution or construct. The word 'prescribing' is undoubtedly significant here, helping people to associate a new concept with an established practice. Such mimicry has potentially eased the adoption by GPs and perhaps a prescription-in-hand has made the concept more understandable to the public. In contrast, the word prescription may have distanced the agenda from practices which feel familiar to occupational therapy and others.

Mimicry of the prescription template is likely to have deeply layered consequences some of which may not be easily understood. It could over-simplify solutions to highly complex issues and make people feel more incompetent if they do not respond well to, or adhere to, the prescription. There is therefore a need for stronger *theorizing*, and we urge a joined-up effort towards developing a more robust evidence base which explores causality chains associated with patient and service outcomes.

There is also potential oversimplification of this juxtaposed new and old template for GPs and health professionals who may be looking for the 'BNF' (British National Formulary – a pharmaceutical reference book) equivalent to aid social prescription. The NHS Directory of Services contains information about a wide range of national health and social care services but many services involved in social prescribing are not commissioned statutory services, and information is not easily accessible. Local directories exist, and some services use digital platforms which list verified community services (as outlined in Box 1) although keeping on top of services which emerge, restructure and discontinue at a frequent rate is a major challenge.

Educating, the final Institutional Work practice, is significant here. Once again, the earliest voices were perhaps heard from within medicine, with explicit calls for the concept of social prescribing to feature in undergraduate medical curricula (Chiva-Giurca, 2017) although we would encourage a more collaborative and nuanced approach. This will not only support understanding of the local landscape but, more broadly, assist a multi-dimensional understanding of social prescribing to emerge. Education can provide transformative opportunities for the future of social prescribing and bring opportunities for alignment with a different model of health and wellbeing but it must involve partnerships which transcend traditional disciplines and sectors.

Discussion

Occupational therapy, with its focus on holistic person-centered care, enabling self-management and working across health and care organizational boundaries, has a clear fit with primary care and community health (AOTA, 2020). However, it is internationally recognised that the contribution of occupational therapy within primary care is under-utilized

and the role is poorly defined and understood (Dahl-Popolizio et al, 2017; Chamberlain et al, 2019). Limitations in understanding and utilization of occupational therapy may have contributed to the emergence of social prescribing to fill a perceived void in how services can respond to patients' individual needs that are shaped by social determinants of health, and the institutional work practices described above to create processes, resources and profile to build on the foundations of the established medical norm of prescribing.

We propose that recent purposive action, influenced by the language of prescription, has contributed to the idea of recommending activities and social connections as a means to improve health now being an accessible, and implementable concept in primary care. This language is also contributing to the attraction of material resource, realising an increased profile, and easing the adoption of practices which centre around social activities in the UK, and this in turn presents an exemplar as social prescribing receives greater attention internationally. On a positive note, some of these actions have arguably been instrumental in placing social prescribing as a means to addressing social determinants of health firmly on the healthcare agenda. As occupational therapists are obvious partners in the development of social prescribing initiatives (Royal College of Occupational Therapists, 2020) both the profession, and the people and communities served, can benefit from the momentum.

But this also leads to the contrasting acknowledgement that, whilst the language of occupational therapy has similar aims, it has not had the same level of impact. Frameworks such a 'doing, being, becoming, belonging' (Wilcock, 2006) have a solid foundation within the profession, but have perhaps not provided a language which achieves a wider reach. We note parallels with the suggestion from Laposha and Smallfield (2019) that where momentum builds behind growing population health needs but where occupational therapy is not fully engaged in the conversation, the profession may miss the opportunity for a central and influencing position in the debate. To those inside the profession, values of activity and

connectedness as a means to maintain and improve health are synonymous with occupational therapy, although those outside of the profession perhaps remain unconvinced or unaware. And in essence, these same values have been through a renaming and rebranding drive that is now social prescribing, but with occupational therapy on the margins of the agenda.

Call to Action

Occupational therapists can build on the growing momentum behind social prescribing whilst influencing the future direction of this agenda. We argue that reflections on the purposive actions to date, utilising the theory of institutional work, can assist with goal-orientated actions of the occupational therapy profession going forwards.

Firstly, the language used to date has placed social prescribing primarily within a medical model of health and illness and we encourage occupational therapists to promote the agenda, and hence the profession, from a different perspective. We must acknowledge language that occupational therapists have previously used may not be recognized amongst those now working in social prescribing, and we may need to adapt our language for occupational therapy to capitalize on the social prescribing agenda by joining and helping to drive the debate.

The language of activity and occupation can still be central to shaping identities and measuring outcomes, the latter of which have been recognised to be poorly captured in previous research on social prescribing (Bickerdike et al, 2017). Supporting link workers to understand the links between meaningful occupation and health to evaluate outcomes in terms of the changes that are meaningful to individuals and communities can help to develop a stronger evidence base for social prescribing that is currently lacking (Husk et al, 2020).

Furthermore, although there are many health benefits of engaging with community activities there are also unquestionable challenges and risks which may emerge when there is incompatibility or imbalance between the person and their capabilities, the demands of the activities and the influences within dynamic community environments. Occupational Therapists can give a language to such aspects of practice and can educate gatekeepers and link workers about recognising risks and referring to occupational therapy practitioners for complex cases (RCOT, 2019)

Stakeholders have also begun to advocate from within the occupational therapy profession (RCOT, 2020), making arguments that not only support social prescribing as a concept, but also occupational therapy as an essential partner. Occupational therapists could also look for opportunities to enable those from diverse backgrounds and services to be advocates for the links between occupational therapy and social prescribing, proposed as an essential requirement for championing this agenda as it moves forwards (Drinkwater, Wildman & Moffatt, 2019). Diverse voices could also help to develop a deeper understanding of any consequences of the language of prescription.

Through occupational therapy and occupational science research, the profession is already making an essential contribution to theorizing *practice*; that is to say, understanding why occupation and a sense of community belonging have health benefits, for whom, and under what conditions (Bromann Bukhave & Creek, 2020). However, it is also important to theorise the *organisation of practice* and its relationship to occupational therapy. To be more precise, organisational theory and the more specific theory of Institutional Work (Lawrence & Suddaby, 2006) as applied in this paper provide a theoretical basis for understanding the macro-level context in which processes and organisational structures operate and influence *practice* itself. Ongoing contributions to this evidence base are therefore vital to (re)building

theory and vocabulary - such as evaluating the influence of referrers and gatekeepers, occupational therapists and link workers within this macro context.

The concepts that we have discussed and critiqued in this paper are of course presented without empirical data, and therefore there is a pressing need for research on social prescribing to investigate how language influences how and where it is embedded in practice, and especially to reflect on medical dominance. The final Institutional Work practice of *education* is also in its infancy but another area where occupational therapists can influence the future direction. Looking ahead, education will take many forms, from links with existing curricula, development of formal educational programmes for link workers, and also provision of mentoring and supervision. We would urge occupational therapists in a range of clinical, managerial and academic roles to be alert to, and indeed seek out, such opportunities. Education of those who deliver, refer to, commission and strategize the actions of connecting people with health-enhancing activities is likely to have far-reaching power to influence the direction of the current social prescribing agenda and address some of the challenges raised in this paper.

Conclusion

The theory of Institutional Work has allowed us to examine how the language of 'prescription', and the purposive action of policy-makers and practitioners, is shaping social prescribing. This language has helped to translate the recommendation of activity to meet a range of health needs in to an accessible and implementable concept. However, it has also potentially contributed to positioning social prescribing within a medical model of health, upholding medical dominance, and leaving occupational therapy on the margins of the debate. As social prescribing gains traction internationally, occupational therapy could play a

more significant role in supporting and evaluating social prescribing activities, as well as educating those involved in provision of activities.

Acknowledgements:

We would like to thank Simply Connect Solutions Ltd for giving permission to adapt the case study used in Box 1.

Thanks also to Dr Tom Sanders and Dr Phillip Whitehead for their review of this manuscript.

References

Aggar, C., Caruana, T., Thomas, T., & Baker, J. (2020). Social prescribing as an intervention for people with work-related injuries and psychosocial difficulties in Australia. *Advances in Health Behaviour.* 3(1); 101-111.

American Occupational Therapy Association (2020). Role of Occupational Therapy in Primary Care. *American Journal of Occupational Therapy,* 74. https://doi: 10.5014/ajot.2020.74S3001

Bartholomaeus, J. D., Van Agteren, J. E., Iasiello, M. P., Jarden, A., & Kelly, D. (2019). Positive aging: The impact of a community wellbeing and resilience program. *Clinical gerontologist*, 42(4), 377-386.

Bickerdike, L., Booth, A., Wilson, P., Farley, K., & Wright, K. (2017). Social prescribing: less rhetoric and more reality. A systematic review of the evidence. *BMJ Open*: 7; e013384.

Bromann Bukhave, E., & Creek, J. (2020). Occupation through a practice theory lens. *Journal of Occupational Science.* https://doi: 10.1080/14427591.2020.1812105

Cartier, Y., Fichtenberg, C., & Gottlieb, L. (2020). Implementing community resource referral technology: facilitators and barriers described by early adopters. *Health Affairs:* 39(4); 662-669.

Chamberlain, E., Truman, J., Scallan, S., Pike, A., & Lyon-Maris, J. (2019). Occupational therapy in primary care: exploring the role of occupational therapy from a primary care perspective. *British Journal of General Practice*: 69 (688); 575-576.

Chiva-Giurca, B. (2017). *Report exploring the need to formally introduce social prescribing within the undergraduate medical school curriculum*. College of Medicine. https://collegeofmedicine.org.uk/wp-content/uploads/2018/01/official-report-2017-social-prescribing-withing-the-undergraduate-and-postgraduate-medical-school-curriculum.pdf.

Cooper, R. J., Bissell, P., Ward, P., Murphy, E., Anderson, C., Avery, T., James, V., Lymn, J., Guillaume, L., Hutchinson, A., & Ratcliffe, J. (2012). Further challenges to medical dominance? The case of nurse and pharmacist supplementary prescribing. *Health: 16*(2), 115-133.

Currie, G., Lockett, A., Finn, R., Martin, G., & Waring, J. (2012). 'Institutional work to maintain professional power: recreating the model of medical professionalism'. *Organisation Studies:* 33(7): 937-962.

Dahl-Popolizio, S., Rogers, O., Muir, S. L., Carroll, J., Manson, L. (2017). Interprofessional primary care: the value of occupational therapy. *The Open Journal of Occupational Therapy*: 5(3). https://doi.org/10.15453/2168-6408.1363

Department of Health (2006). *Our health, our care, our say: a new direction for community services.* HM Government. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/272238/6737.pdf.

Drinkwater, C., Wildman, J., & Moffatt, S. (2019). Social Prescribing. *British Medical Journal*; 364: l1285.

Gottlieb, L., Cottrell, E., Park, B., Clark, K., Gold, R., & Fichtenberg, C. (2018). Advancing social prescribing with implementation science. *Journal of the American Board of Family Medicine.* https://doi: 10.3122/jabfm.2018.03.170249

Gottlieb, L., Wing, H., & Adler, N. (2017). A systematic review of interventions on patients' social and economic needs. *American Journal of Preventive Medicine:* 53(5); 719-729.

Health Education England (2016). *Social prescribing at a glance: North West England.* https://www.hee.nhs.uk/sites/default/files/documents/Social%20Prescribing%20at%20a%20glance.pdf

Husk, K., Blockley, K., Lovell, R., Bethel, A., Lang, I., Byng, R., & Garside, R. (2020). What approaches to social prescribing work, for whom, and in what circumstances? A realist review. *Health and Social Care in the Community*. 2020; 28: 309– 324.

Jensen, A., Stickley, T., Torrissen, W., & Stigmar, K. (2017). Arts on prescription in Scandinavia: a review of current practice and future possibilities. *Perspectives in public health*, 137(5), 268-274.

Laposha, I., & Smallfield, S. (2019). Examining the occupational therapy definition of self-care. A scoping review. *Occupational Therapy in Health Care.* 34(2); 99-115.

Lawrence, T., & Suddaby, R. (2006) 'Institutions and institutional work'. In Clegg, S., Hardy, C., Lawrence, T. & Nord, W (Eds.). *The SAGE Handbook of Organization Studies (second ed.)*. London: Sage Publications Ltd, pp. 215-254.

Local Government Association (2016). *Just what the doctor ordered: social prescribing – a guide for local authorities*. https://www.local.gov.uk/sites/default/files/documents/just-what-doctor-ordered--32e.pdf.

Meyer, A. (1922). The philosophy of occupational therapy. *Archives of Occupational Therapy*: 1(1); p1-10.

NHS England (2016). *General Practice Forward View*. https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

NHS England (2019). *NHS Long Term Plan*. https://www.longtermplan.nhs.uk/

NHS England (2020). *Social prescribing and community-based support: Summary guide.* https://www.england.nhs.uk/wp-content/uploads/2020/06/social-prescribing-summary-guide-updated-june-20.pdf

NHS England and NHS Improvement (2020). *Social prescribing link workers: reference guide for primary care networks.* https://www.england.nhs.uk/wp-content/uploads/2020/06/pcn-reference-guide-social-prescribing-june-20.pdf

Phizackerley, D. (2019). Social prescribing: right idea, wrong name. *Drug Therapeutics Bulletin*. 57(9); 130.

Polley, M., Bertotti, M., Kimberlee, R., Pilkington, K., & Refsum C. (2017). *A review of the evidence assessing the impact of social prescribing on healthcare demand and cost implications.* https://westminsterresearch.westminster.ac.uk/item/q1455/a-review-of-the-evidence-assessing-impact-of-social-prescribing-on-healthcare-demand-and-cost-implications.

Royal College of Occupational Therapists (2020). *Informed View: Social Prescribing.* https://www.rcot.co.uk/node/2381

Royal College of Occupational Therapists (2019). *Occupational Therapy's Role in Social Prescribing.* https://www.rcot.co.uk/news/occupational-therapy-role-social-prescribing

Royal College of Occupational Therapists (2016). *Reducing the pressure on hospitals: a report on the value of occupational therapy in England.* https://www.rcot.co.uk/file/3209/download?token=Q6kpX7Jp

Scott, J., Fidler, G., Flynn, D., Monk, D., & Heavey, E. (in press) Social prescribing in pre-hospital emergency and urgent care: A qualitative study. *Health and Social Care in the Community*.

Simply Connect (2021). *GP-based social prescribing service.* https://www.simplyconnectsolutions.co.uk/wp-content/uploads/2019/09/CONNECT-WELL-WEST-KENT.pdf

The Kings Fund (2017). *What is Social Prescribing?* https://www.kingsfund.org.uk/publications/social-prescribing?gclid=EAIaIQobChMI1N31_YXF6wIVM4BQBh3BgwftEAAYASAAEgJj1fD_BwE

The Social Prescribing Network (2020). *What is Social Prescribing?* https://www.socialprescribingnetwork.com/

Thirdsector (2018). *Social prescribing is not always a win-win.* https://www.thirdsector.co.uk/social-prescribing-not-always-win-win/local-action/article/1460014

Weiss, M. C. (2020). The rise of non-medical prescribing and medical dominance. *Research in Social and Administrative Pharmacy*. https://doi.org/10.1016/j.sapharm.2020.05.015

Wilcock, A. (2006). *An occupational perspective of health – second edition*. Thorofare, New Jersey: Slack Incorporated.

Wilcock, A. & Hocking, C. (2015). *An occupational perspective of health – third edition*. Thorofare, New Jersey: Slack Incorporated.

World Federation of Occupational Therapists (2010). *Client-centredness in occupational therapy.* https://wfot.org/assets/resources/Client-centredness-in-Occupational-Therapy.pdf

World Health Organization (2003). *Social determinants of health: the solid facts – second edition.* https://www.euro.who.int/__data/assets/pdf_file/0005/98438/e81384.pdf.

Box 1 – An example of a social prescribing initiative in the UK (Simply Connect, 2021)

General Practices in the Kent region of the United Kingdom have an established pathway for social prescribing. This pathway is primarily targeted to adults with one or more long term health conditions, those who need mental health support, those who are lonely or isolated or people with complex social needs. Using a digital referral platform (Simply Connect Solutions Ltd, Sheffield), General Practitioners (GPs) or other Primary Care professionals can refer people into the social prescribing service which leads to the allocation of a Link Worker. Link Workers meet the person, discuss their individual circumstances and needs and work alongside the person to identify suitable support services and activities. The same digital referral platform is used to record responses to built-in measurement tools (such as standardised wellbeing questions), to directly refer in to verified community services and to alert both staff and service-users to upcoming events or appointments. The Link Worker can also provide ongoing tailored support to review the impact of support and activities.

Table 1: Types of Institutional Work, definitions and application to social prescribing (adapted from Lawrence &Suddaby, 2006)

Purpose of Actions	Type of Institutional Work	Definition	Application to social prescribing
Reconstructing rules and boundaries	*Advocacy*	Mobilisation of political and regulatory support through direct and deliberate techniques of social suasion.	Development of policy and regulation for social prescribing, as recognised in the General Practice Forward View (2016) and NHS Long Term Plan (2019). A national champion identified from inside the medical profession.
	Defining	Construction of rule systems that confer status or identity, define boundaries of membership or create status hierarchies within a field.	Link worker roles developed with a clear hierarchy in primary care. Status hierarchies are still being defined, with link workers consisting of non-professional roles (e.g. receptionists) to professional roles (e.g. nurses).
	Vesting	Creation of rule structures that confer property rights.	Development of Primary Care Networks and other commissioning vehicles. The 2019 GP contract awards General Practice funding for social prescribing roles with a stated aim of reducing pressures and addressing workforce demands.
Reconfiguration of identities, relationships and belief systems	*Constructing identities*	Defining the relationship between actor and the field in which the actor operates.	GPs act as primary gatekeepers to socially prescribed services with the routine task of referral delegated to link workers.
	Changing normative associations	Re-making connections between sets of practices and the moral and cultural foundations for those practices	Indicators of success are influenced by a medical model and include cost effectiveness, target numbers and impact on other services such as Accident and Emergency (A&E) and GP consultations.
	Constructing normative networks	Constructing of inter-organizational connections through which practices become normatively sanctioned and which form the relevant peer group with respect to	NHS England (2020) have developed a common outcome framework for social prescribing (table 2), and it is unclear whether community and voluntary sector (CVS) organizations are able to implement this.

		compliance, monitoring and evaluation	
	Mimicry	Associating new practices with existing sets of taken-for-granted practices, technologies and rules in order to ease adoption	Prescribing terminology mimics existing primary care practice terminology, but may require new technologies and rules.
Altering meaning systems	*Theorizing*	Development and specification of abstract categories and the elaboration of chains of cause and effect	Causal chains for people with complex health and social care needs are unknown, but efforts are now being made to establish the underlying theory.
	Educating	Educating of actors in skills and knowledge necessary to support the new institution	As social prescribing becomes more prominent, there is a need to educate all actors; patients (to enhance uptake and adherence), clinicians (to inform appropriate referrals), commissioners (to facilitate suitable quality assurance and payment structures) and CVS organizations (to help navigate unfamiliar processes and maximise potential for meaningful partnerships)

Table 2: Common outcome framework for social prescribing (adapted from NHS England, 2020)

Common outcome	Outcome variables	Measurement tools
Output measures	• Number of people referred • Uptake and rejection of referrals • Patient characteristics (age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation • Referral criteria (e.g., long term conditions or receipt of social care) • Referral process and pathway • Number and nature of community groups referred to • Number of personalised support plans co-produced • Number of link workers • Number of volunteers • Average amount of time spent with each person • Total investment in the social prescribing connector scheme (input measure)	• None specified
Impact on person	• Feeling in control of own health and wellbeing • Physical activity • Ability to manage practical issues such as debt, housing and mobility • Connectedness to others; reduction to isolation and loneliness • Employability*	• Existing tools already in use • Patient activation measure** • Office National Statistics wellbeing scale** • Short Warwick-Edinburgh Mental Wellbeing Scale**
Impact on community groups	• Resilience (including changes to number of volunteers, capacity to manage referrals and what support is needed to make social prescribing sustainable)	• 'Confidence' survey*
Impact on health and social care system	• Number of GP consultations • A&E attendances • Number of hospital bed days • Volume of medication prescribed • Morale of staff in general practice and other referral agencies	• Mixed methods survey***

* NHS England reportedly plan to co-design these measurement tools
** NHS England are reportedly currently obtaining feedback on the use of these measurement tools.
*** No further detail provided