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Haywood, A. orcid.org/0000-0002-5824-3043, Dayson, C., Garside, R. et al. (13 more authors) (2023) National Evaluation of the Preventing and Tackling Mental Ill Health through Green Social Prescribing Project. Report. Department for Environment, Food & Rural Affairs (Defra).

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National Evaluation of the Preventing and Tackling Mental Ill Health through Green Social Prescribing Project

Appendices to Interim Report - September 2021 to September 2022

January 2023



National Evaluation of the Preventing and Tackling Mental III Health through Green Social Prescribing Project

Appendices to Interim Report

September 2021 to September 2022

Prepared for the Department for Environment, Food & Rural Affairs (Defra).

This appendices document, and the accompanying briefing, summary and full interim report, are published by Defra (Defra Project Code BE0191) and are available from the Department's Science and Research Projects Database at <https://randd.defra.gov.uk>. Whilst the research was commissioned by Defra, the views expressed reflect the evaluation findings and the authors' interpretation; they do not necessarily reflect Defra policy.

Please cite as:

Haywood, A^{*1} Dayson, C^{*2} Garside, R^{*3} Foster, A^{*1} Lovell, R^{*3} Husk, K^{*4} Holding, E^{*1} Thompson, J^{*1} Shearn, K^{*2} Hunt, H.A^{*3} Dobson, J^{*2} Harris, C^{*2} Jacques, R^{*1} Northall, P^{*2} Baumann, M^{*2} Wilson, I^{*2}. **National Evaluation of the Preventing and Tackling Mental III Health through Green Social Prescribing Project: Interim Report (Appendices) – September 2021 to September 2022.** *January 2023.* Department for Environment, Food and Rural Affairs (London).

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Appendix 1: Work Package 2. Local Theories of Change

A1

A1.1. Methods overview

In each site, a round of workshops were held (online) with key stakeholders and facilitated by the evaluation team. These workshops followed a relatively straightforward logic-model style approach to developing theories of change, whilst recognising the challenges inherent in understanding complex systems in community settings. The proforma used was an adapted version of a model devised for past work by members of the team (Dayson et al., 2018). For two sites, previous work done locally to develop their test and learn sites was not repeated, but we draw on that work, which may be presented in a different format, below.

A1.2. Test and Learn site 1

Vision and ambition for the project

Participants identified some key areas that characterised the overarching ambition for the project:

- Maximise the opportunities to use green and blue spaces for social prescribing by joining-up and connecting existing activities, networks and systems around a common goal.
- Enable more funding/resources to flow through to frontline providers of green activities to support them to become more sustainable.
- Make greater use of the natural environment as a mechanism for improving mental health and wellbeing.
- Supporting/enabling people to be active socially, physically and mentally.

What needs to change?

Participants reflected upon what needs to change for ambition for the project to be achieved:

- Increasing awareness and accessibility of green provision a) within communities and, b) within the health and system (and professions).
- Improving the evidence base about the value and benefits of social prescribing and green space to meet the expectations of health professionals.
- A greater focus within the health system towards prevention.

- Closer working between link workers and green providers to make GSP more embedded and accepted as an option for patients.
- Ensure equity of access to green space and green providers amongst key communities of place and interest.
- Support more people to have positive feelings about existing green spaces.

Participants also reflected upon some of the drivers of change:

- The need to convince ‘detractors’ of the benefits of SP/GSP.
- The COVID-19 pandemic has exacerbated existing health inequalities.
- Resource and time pressures within and beyond the health system mean there is a need for more ‘affordable’ options for patients.
- No one part of the system can achieve the change needed on their own – there is a need to work together.
- Changing philosophies within mental health services mean GSP may be seen as a more acceptable option.
- The climate crisis – understanding our impact on the natural environment is more important than ever.
- The move to an Integrated Care System = an opportunity to increase engagement and involvement of VCS in health; also an opportunity to take some ‘risks’.

Enablers and barriers to successful green social prescribing

Participants identified a number of enabling factors and barriers associated with successful green social prescribing that will need to be overcome if the project is to be successful. These are summarised in the table below.

Table A1.1: Enablers and Barriers

Enablers	Barriers
Advocates for SP/GSP throughout the health system	Keeping people connected and engaged with the project – risk if current momentum is not maintained.
High levels of stakeholder involvement and engagement – good coverage across [locality]	Transport to/from green activities and green spaces.
Understanding of lived experience within the programme	Funding tends not to flow through to providers and patients.
Lots of people to engage in GSP and multiple routes through which to engage them	Engaging people who do not yet see the value of GSP.
Diverse funding and investment opportunities	Not reinventing the wheel – build on what exists.
	Need to raise awareness amongst providers - insufficient good quality applications to NHS Charities GSP funding opportunity. Short-term nature of funding may have been a barrier, along with capacity to bid for funding.

Medium-term outcomes

Participants identified a range of outcomes that they hoped to see during the lifetime of the project linked to the work undertaken. They were keen to emphasise that realistic expectations were needed for 2-year project:

- GSP is more embedded within local SP systems and the wider health and care system.
- There is a better understanding of what works and what doesn't in relation to GSP.
- Behaviour changes amongst individuals so that they make more and better use of green and blue spaces.
- More focus on community development in relation to GSP.
- Improvements in health and wellbeing and self-management – follows through into reductions in demand for crisis care (but unsure how to measure this and there is a need to improve data and records).
- Resources are shifted within the system towards prevention.
- Improvement in clinical MH outcomes amongst key groups.
- VCSEs/green providers are better equipped to measure outcomes.
- Green providers are more engaged in SP and wider health and care system.

Long-term outcomes

Participants were also asked to identify a range of outcomes that they hoped to see beyond the lifetime of the project:

- GSP is properly embedded in the SP/health and care system and well coordinated, building on learning from this project.
- Advocates of SP/GSP act on their instincts by investment more in GSP/green activity and embed it in key strategies etc.
- Relationships and networks developed through this project are maintained and built upon – networks of learning exist around SP/GSP.
- More integrated commissioning of SP/GSP and green providers.
- Have a better understanding of what doesn't work and don't repeat mistakes of the past.
- Well-developed referral pathways and a sustainable menu of providers to refer to.
- Patient experience of GSP is better understood.

Success

Finally, participants were also asked to think about what main successes they would like to see from the project:

- There is a 'baseline' or minimum level of GSP provision across [locality].
- Everyone in [locality] has access to GSP.
- GSP is accepted by the public and health professions as a legitimate intervention and part of the clinical 'toolbox'.
- GSP is rolled-out beyond mental health.

- Nationally, the test and learn sites have demonstrate how and why GSP works (and for whom).

A1.3. Test and Learn site 2

Vision: What is the issue we need to address?

- 1. System change:** to join-up existing green activities, assets and providers with the [locality] social prescribing 'system(s)' and wider systems of health and social care within the ICS to provide a platform for a wider range of outcomes to be achieved. This requires a better understanding referral pathways and other access routes to green providers.
- 2. Access to green space:** to improve access to green space through GSP for all communities, but with a focus on equity of access for target communities (BAME communities; children and young people; areas of social and economic deprivation; areas most adversely affected by the COVID 19 pandemic).
- 3. Evidence and understanding:** to gain greater recognition of the impact and benefits of green space/assets, GSP and SP more generally within health professions
- 4. Capacity and resources:** to improve the capacity and sustainability of green providers

Where are we now?

Built up a strong green social prescribing network who are keen to drive change forward. Undertaken a mapping exercise of GSP provision. Current barriers; fragile system and issues of long term sustainability, buy in from GPs and other health professionals, pressure on link workers, service user engagement

What will success look like?

Green social prescribing embedded within the wider system. Sustainability outside of current programme including long term funding and therefore confidence and buy in from stakeholders across the system.

What resources will we use?

- Existing: There is already a strong infrastructure for social prescribing in the region to build upon (rather than duplicate). There is a real opportunity to take something that is already being done in other places but give it strength by connecting it to the people and communities who really need it.
- Inputs: financial support from the [green VCFSE], ICS and [sports org]
- Outputs: The main resources will be:
- Staff time; Link workers, health professionals, project management team

What will we need to change or do?

- For individuals and communities:
 - Programmes need to be accessible and appropriate- we need to support people to attend activities by removing specific barriers (e.g. by befriending, outreach work, childcare and transport)
- Within the health and care system:
 - Need better clinical evidence of effectiveness to ensure buy in from clinicians and other stakeholders
 - Need to create clear referral pathways (i.e. primary care, mental health) to social prescribing and or green activities, and better understanding of the benefits of activities by individuals and health professionals
 - Funding: access to mainstream funding; funding for prevention; a mixed economy of funders supporting GSP

How are we going to do this?

- Small, medium and large scale grants to support overall aims and priorities of the programme (e.g. by prioritising applications which demonstrate they connect people with the outdoors, which support people with mental illhealth, improve access to green prescribing for communities by Covid-19, and which prioritise place based activities)
- Workforce development – training on green SP for LWs and other allied health professions
- System engagement around GSP to raise awareness and improve processes and pathways etc
- Community development, co-design and engagement with GSP providers
- Delivery of communications and engagement strategy
- Development of sustainability plan to ensure sustainability outside the lifetime of the programme
- Promote the use of open and green spaces by all sectors for physical/mental health

What change will we see in the medium term?

- For individuals and communities:
 - Individuals remain engaged with the programme and continue to practice nature connectedness
 - Individual behaviour change – service users see the value in nature and can support friends and families to engage in green and blue activities
 - People and communities become more interested in nature and begin to demonstrate pro environmental behaviour – e.g. awareness of littering etc
 - Objective/subjective improvement in mental health and wellbeing used validated measures
- Health & care system:
 - Prioritisation of resource for GSP across the system
 - Increased capacity of referral agencies to receive more GSP referrals
 - GSP providers able to adapt current activities to mitigate health inequalities
 - Linked to the above: use inequalities lens to target people across the spectrum of mental health issues (pre determinants of mental health)

What change will we see in the longer term?

- For individuals and communities:
 - Those most affected by health inequalities and who need services most are accessing them
- The environment:
 - Benefits for the environment/nature, evidenced through increased in pro environmental behaviour
 - Promotion of safe and accessible spaces
- Health & care system:
 - A change in funder and commissioner behaviour in support of GSP
 - GSP embedded within existing SP infrastructure
 - Long term sustainability of VCSE sector, green providers and green activities
 - Reduction in health inequalities and inequity of access

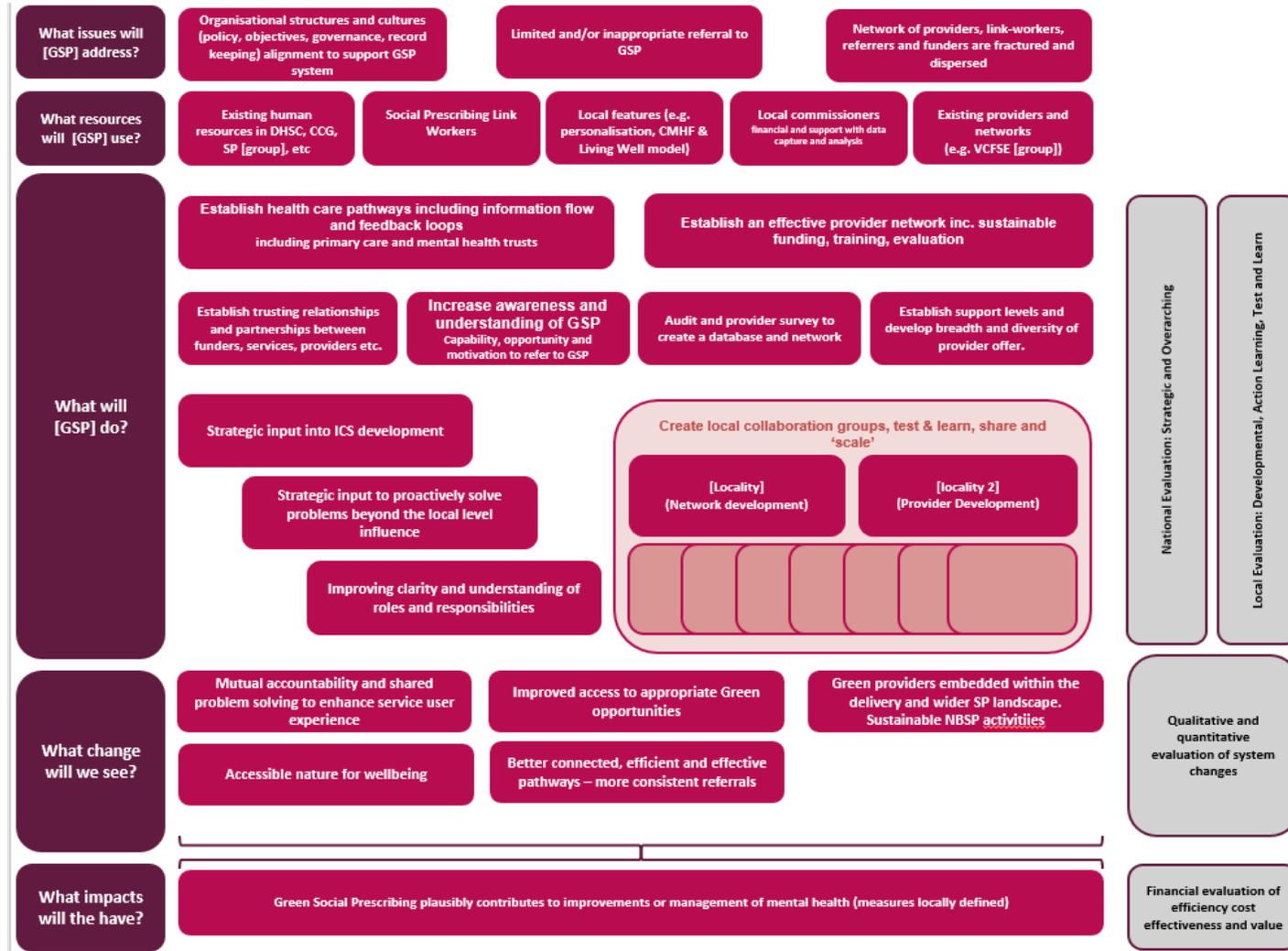
A1.4. Test and Learn site 3

What are the issues we want [GSP] to address?	Vision and Ambition for [GSP]	What needs to change for the Vision and Ambition to be achieved?
Tackling and preventing mental ill-health for people living in [locality]	[GSP], a two-year test and learn programme, looks to improve the mental health and wellbeing of communities, in particular those hardest hit by the Covid-19 pandemic and those experiencing the greatest health inequalities, by connecting local people with nature-based activities and green community projects and initiatives in [locality].	Sustainable funding of the green community and voluntary sector in order to meet the demand (and anticipated increase) from green social prescribing
		Referrals into community and voluntary sector need to be appropriate and supported
Embedding green social prescribing into local health systems and be seen as an intervention of choice		Conjoining/linking together of providers in place
		Easy to access, up to date information for LWs and other social prescribers about green providers that have been accredited/checked
Improve the sustainability of local green and nature based providers		Direct access to LWs for patients - not having to go through GP to get access to LW
		Other prescribing/referral pathways (than LWs)
Improve the engagement of people - especially those from deprived areas, BAME communities and disadvantaged backgrounds to experience the benefits of nature and the outdoors.		Easier and more equitable access to green spaces/assets and activities for everyone
		A clear understanding of the patient journey through green social prescribing which informs the design of the prescribing pathway and what is required to connect people to these activities
Improve the access to green spaces/assets and activities for the widest range of people which leads to the opportunity of being connected to nature		Improvement in the (including perceived) safety and the quality of parks and open/green spaces
Building reciprocal understanding between the community and voluntary sector and the health system		Personalised care budgets able to be used for SP and GSP Green providers considering inclusivity and the needs of diverse audiences in their offer
	Increased awareness of the benefits of connectedness to green and nature based	

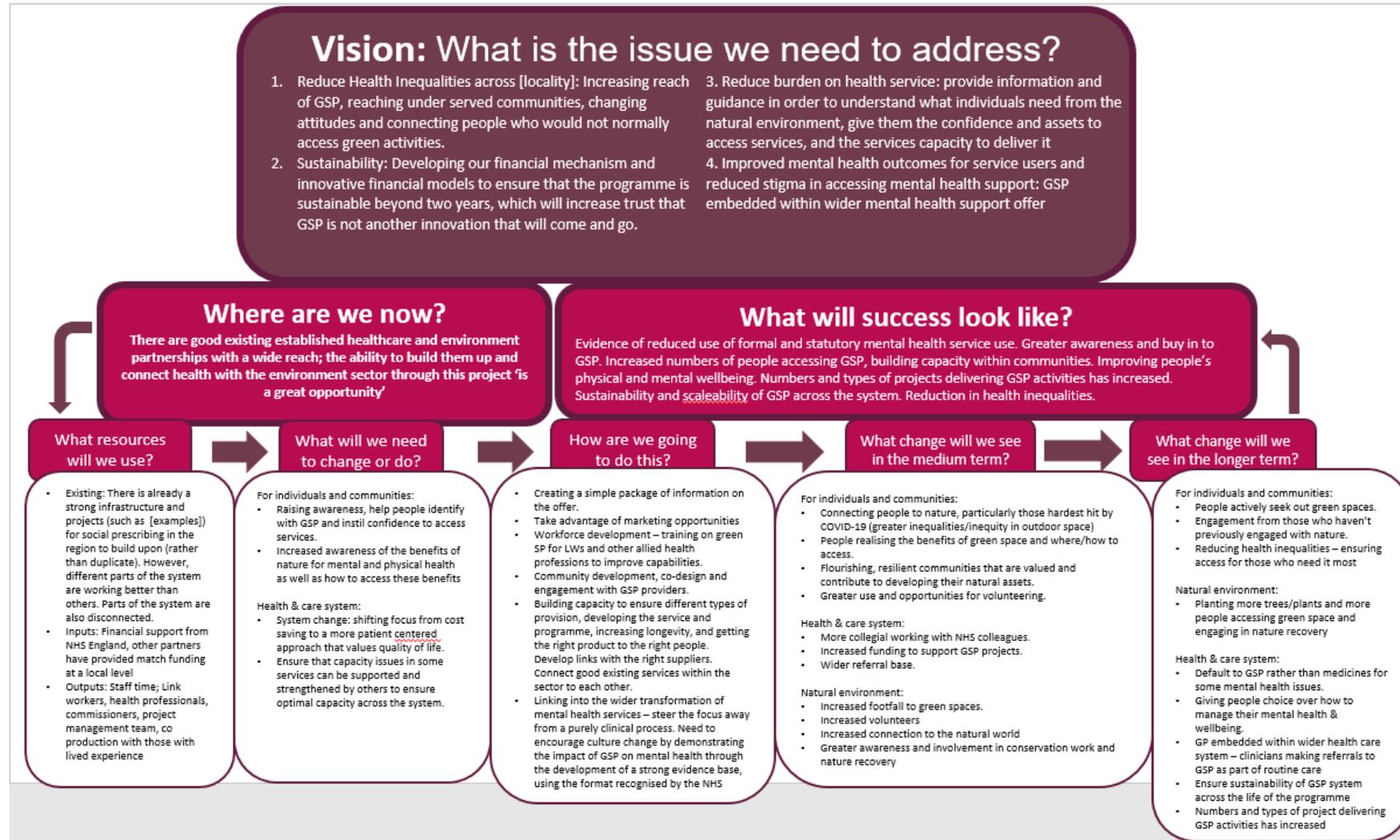
Medium term outcomes - 2 year life of Test & Learn project		Longer term outcomes - 3 to 5 years		Measures of success
	Participant Outcomes		Participant Outcomes	
MT1	Increasing nature connectedness and social interaction among participants: becoming part of everyday life	LT1	A contribution to reducing health inequalities in target communities	GSP is an intervention of choice for health professionals working across our local mental health system
MT2	Improving mental health outcomes	LT2	Improving mental health outcomes across the widest range of people	GSP contributing to the transformation of mental health services in the city
MT3	Improvements in quality of life	LT3	A more diverse paid and volunteer workforce in green and nature based industry	Appropriate and effective GSP pathways in place that work well locally for prescribers, participants and providers
MT5	Enhanced connection to and sense of community	LT4	A mixture of hyperlocal, local, city wide and county wide opportunities for people to engage with nature	A green eco-system that is connected and collaborative supporting a hyper-local, city and county network of GSP providers and enablers.
MT6	Developing confidence and knowledge to gain and retain employment	LT5	Equitable, personalised intervention and recovery	A GSP offer that meets the varying needs of our vibrant and diverse communities
MT7	Non-judgemental inclusive and positive patient experience	LT6	Improvements in our local urban outdoor environments making them more conducive to walking and cycling for recreational and active travel	Changes in the mental health outcomes for our communities through engagement with nature and green activities
MT8	Improved knowledge and awareness of local green assets, providers and benefits of engagement		Increased use of and involvement in green spaces/nature-based activities by certain communities who feel this is for them and have the confidence to access	Access to green spaces and assets is easy and equitable
MT9	Better choice and variation of local green and nature engagement		Clear line of sight and contribution from GSP to local priorities and ambitions for city and county (eg [council environ initiative], Mental Health Transformation, ICP and ICS priorities)	Green providers are fit for purpose and well placed for commissioning by ICP/ICS
MT10	Empowerment and ownership of work by service users and partners			

Enablers	Barriers		Health/Mental Health System Outcomes		Health/Mental Health System Outcomes
Green buddies/befrienders	Multiple employers of SPLWs across city and county	MT13	People in the health system value and understand green social prescribing	LT	Improved Population Health
Robust data capture across all areas of the system		MT14	Understanding of what is needed (critical factors) to ensure a change in the existing local system/s in order to embed GSP	LT	Reduced unemployment and universal credit
Role of [locality VS org] as trusted intermediary between VCSE and health sectors		MT15	Improved system partnership in the awareness and benefits of green social prescribing		Reduction in inappropriate primary, secondary and social care usage
Increase in capacity across supply side (providers)		MT16	Enhanced and formalised pathways to green social prescribing - wider referral base across mental health services		
Adoption of validated measurement tools by green providers		MT17	Workforce development in relation to green and mental health		
Standardisation of data capture across SPLW (ONS4) including baseline and follow-up		MT18	SPLW and other SPs confidently prescribing green and nature-based activities		
Green advocates across all levels of the system			Community/Voluntary Sector		Community/Voluntary Sector
Qualitative examples of impact of GSP at PCN and GP level		MT19	Reduction in the stigma around mental health		A conduit for future green social prescribing investment
Person centred approach- co-creation of activities and opportunities with people who want to use them.		MT20	Enhanced capability and capacity within the community and voluntary sector in relation to GSP		Connected web of green and nature based providers offering a range of GSP opportunities across all mental health levels
Balancing demand and supply		MT21	Empowered communities		A network of VCSE green providers offering health/mental health system interventions that help tackle mental health through a social rather than a clinical model
		MT22	Increase in sustainable, resilient green community and voluntary sector		

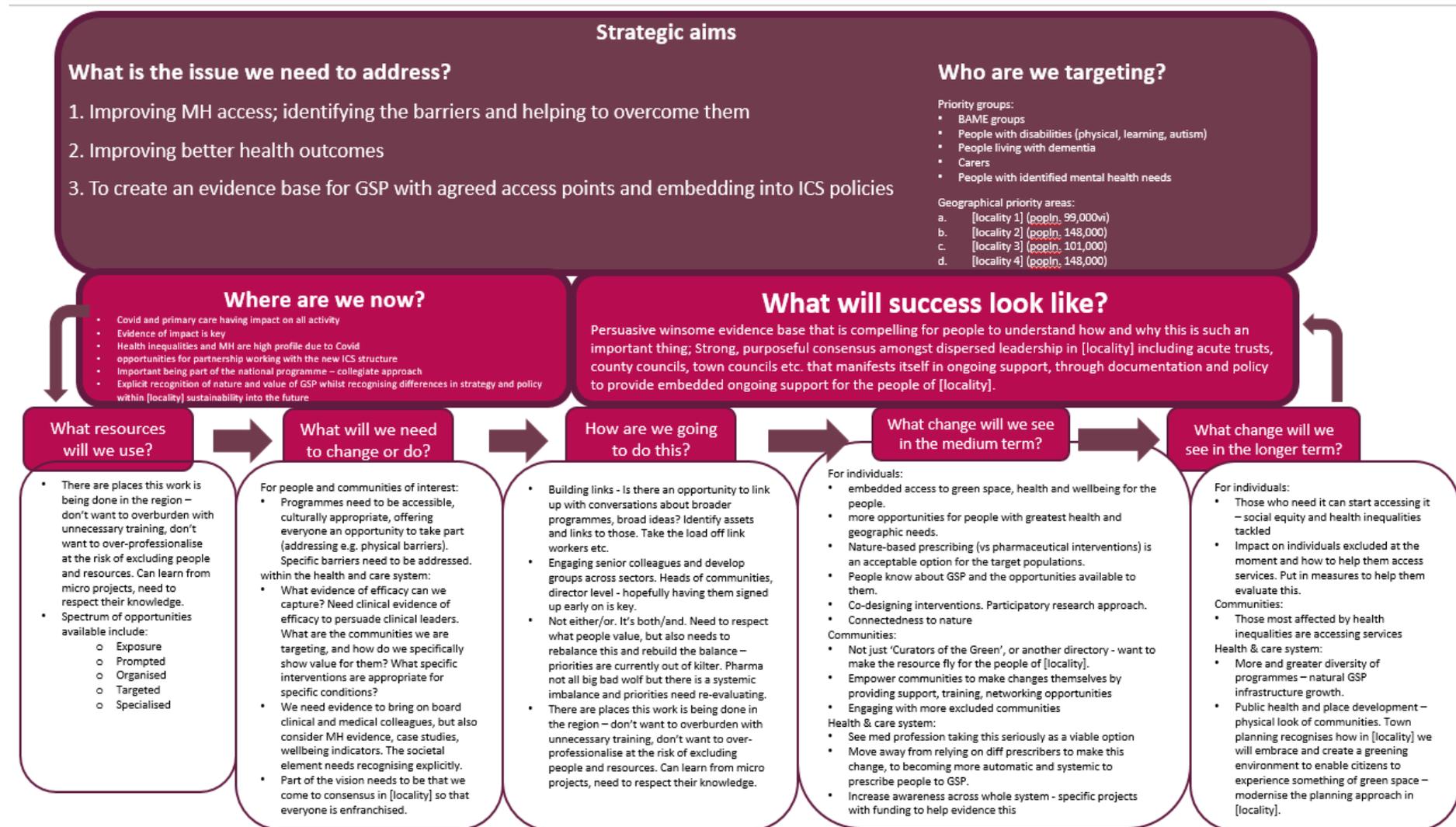
A1.5. Test and Learn site 4



A1.6. Test and learn site 5



A1.7. Test and Learn Site 6



A1.8. Test and Learn site 7

Vision: What are the issues we need to address?

1. How to ensure GSP is embedded as part of the (wider) nature, health and SC systems and strategies – Key Driver
2. How to ensure GSP is a sustainable practice and movement – Key Driver
3. GSP is not viewed by people and communities as something they can access freely via multiple routes
4. The need to move away from seeing a nature as just e.g. field, and towards it being a community asset.
5. Inequalities in health and wellbeing

Where are we now?

Lots of energy and momentum desire to harness this for long term cohesive sustainable change: High levels of current activity that it recognised: A desire to not reinvent the wheel: Recognition that GSP isn't going to work for everyone but that it should be inclusive and equitable in availability.

What will success look like?

High quality capacity in the system for supporting community activity – especially for people from priority populations (Core 20 plus 5): Formal H&SC routes are connected to community routes so GSP are welcoming, safe and relevant for local communities: People feel that GSP is connected to communities, not a service: Individuals have formal (e.g. supported) and informal (e.g. self-directed) opportunities to access nature to improve their health: Engagement from key communities/populations: Diversity in delivery: Greater awareness of benefits more widely: Integrated 'nature' and H&SC systems. via leadership support, strong local evidence base, referral pathways and robust funding.

What resources will we use?

- The providers, such as [healthy lifestyle service], which are linking communities to providers outside of the standard health and social care system.
- Grant funding and diverse match funding
- Cross-sectoral leadership collaboration and partnerships
- The [green network] and existing community organisations, [green provider], nature therapy practitioners, local expertise, existing guides, Strategy Groups
- Educational/academic resources
- The ICS
- [H&SC SE] strengths assessment of green assets in the community; local council ([locality] parks strategy etc.)

What will we need to change or do?

- For people and communities of interest:
- Reduce inequalities in access and individuals have formal (e.g. supported) and informal (e.g. self-directed) opportunities to access nature to improve their health
 - Green network and broader community needs to understand what local assets are available, when, where and for whom.
 - More join up needs to be achieved between assets within the systems and communities.
 - Linkage and support from existing health & social care structures to grass roots organisations to reach level of quality for safeguarding, etc. alongside the need for community level contributions for trust and diversity
 - Actions and interventions that promote links to communities are needed to help people understand and take advantage of the health opportunities.
- Across/within system/s there is a need to:
- Build sustainability in systems (beyond initial funding)
 - Integrate nature and H&SC systems
 - Embedding these GSP activities within wider strategies (e.g. green plans)
 - Advocacy for better environmental quality/protections
 - Explore funding and resourcing constraints and solutions such as enabling funds to follow patients to the delivery agents of GSP, without making those agents part of the NHS system; feasibility of 'GSP' block contract from the CCG (or its successor) to add to the critical mass of what is offered.
 - Sustainable, flexible and pragmatic monitoring and evaluation that enables the system.

How are we going to do this?

- Generate high quality infrastructure
- Measure the impacts of that (quant/qual)it
- Use that to generate the long term buy in from the systems, inc. embedded referral pathways and resourcing, advocacy
- More activity, join up and connection.
- Building on the cohesive and 'recognised (e.g. by the health services) nature of the 'movement'
- Consistency and coherence and establishing a process for funding and future sustainability
- Finding ways for equity of access to opportunities for all communities in the region
- Co-creation and use of place-based programmes that are more integrated.
- Clarifying what evidence is needed, and whether national evidence is sufficient (or not) for local implementation.
- Recognise and measure social value as well as ecological and aesthetic value of this investment
- Being open-minded about what constitutes 'evidence' – going beyond RCTs etc. Valuing different ways of knowing
- Use the educational/academic resources
- Maintaining and advocating for the widest interpretation of 'health' – keeping it broad, holistic, beyond a narrow clinical interpretation
- Focus on protective factors

What change will we see in the medium term?

- For individuals:
- Increase in/formal access to nature, health and wellbeing resources
- Communities:
- Equal access to in/formal access to nature, health and wellbeing resources for all communities
 - Uptake of community based asset approach
 - Understanding and recognition of local assets
 - Networked human assets
 - Co-created and place-based programmes integrated into GSP system
- Health & care/nature system:
- Better GSP/nature infrastructure
 - Wider recognition of GSP
 - GSP accepted into the mainstream prescribing system.
 - Increased awareness of and use of evidence of effect at a national level and its relevance at a local level
 - Health and social care commissioners helping unlock funding across the system
 - Health and social care leaders recognising impact measures relevant to the community
 - Initial collaboration between groups, between public/private - e.g. experts in delivering nature based activities and expertise in the communities in which they're delivering.

What change will we see in the longer term?

- Cross-sectoral joined up approach to GSP – collaboration between public/private/third sector – continually evaluated and improved, ensuring an established, grounded approach to encourage and nurture future opportunities, skills development and capacity building.
- For individuals:
- Equitable opportunities to access nature and improve health, formally and informally
- Communities:
- Actions and interventions that promote links to communities so they are able to understand and take advantage of the health opportunities
 - Integrated management plans with additional organisations.
- Health & care system:
- Sustained infrastructure beyond end of GSP programme
 - Sustainable and flexible ways in which funds move through systems that do not make delivery agents part of the NHS system.
 - The number of patients and their outcomes sufficiently monitored
 - Culture change, particularly in terms of the health and social care system valuing and investing in non-clinical approaches to improve health.

A1.9. References

Dayson, C., Pearson, S. and Bennett, E. (2018) *Evaluation of the Early Action Neighbourhood Fund: Learning Update - Revisiting the Programme Theory of Change*. Sheffield, CRESR, Sheffield Hallam University. Available at https://static1.squarespace.com/static/5613a0eee4b097682dbdc243/t/5caf6290419202fc2215fed6/1554997909700/EANF+Theory+of+Change+Learning+Report+2018_FINAL.pdf

Appendix 2: Work Package 3A- Utilising questionnaires and monitoring data to evaluate the Test and Learn Sites

A2.1. Summary of Appendix 2

This appendix focuses on Work Package 3A (WP3A). WP3A involves utilising questionnaires and monitoring data to evaluate the T&L sites. Over the course of this document we:

- Describe the methods used within WP3A.
- Discuss the facilitators and barriers to collecting monitoring data.
- Explore the findings from the baseline Link Worker and Nature-based providers.
- Present the statistical analysis of the monitoring data.

A2.2. Initial questionnaires of Link Workers and nature-based activity providers- Justification and methods

We are undertaking a questionnaire across the seven T&L sites to explore both delivery and perceptions of GSP and to capture how these may change over the course of the project. The questionnaire is aimed at both Link Workers and nature-based activity providers as key stakeholders within the GSP pathway. To date, we have undertaken the initial questionnaire and include the findings from this within the interim report. In this section we outline the methods underpinning the initial questionnaire. The second questionnaire will be undertaken in February 2023 with a focus on exploring what has changed during the GSP delivery period.

Rationale

The rationale for undertaking a questionnaire alongside the Embedded Researchers was to enable us to sample a wider number of people, identify themes for the Embedded Researchers to explore further and to provide contextual information regarding delivery and perceptions about GSP (Mathers et al, 2009). Some T&L sites had already undertaken mapping work and distributed their own questionnaires. However, it was felt utilising one standardised questionnaire across all seven sites would provide a more consistent data set.

The questionnaires were developed based on the findings of the scoping report and the research questions and outcomes stakeholders were interested in (see scoping report for further information). One version was developed for completion by people in Link Worker related roles (referred to as Link Workers below for simplicity). Another was developed for nature-based activity providers. Whilst there are multiple stakeholders involved within GSP, Link Workers and nature-based activity providers are two key parts of the pathway and within their roles can provide perspectives on other parts of the pathway. For example, Link Workers may discuss the engagement of primary care practice staff.

The questionnaires were developed in conjunction with national partners, with draft questionnaires being circulated several times to obtain feedback. We piloted the questionnaire with contacts known to the National Evaluation team who did not work within the T&L sites. Through the piloting process, we improved the clarity of some of the questions as well as adding an additional question about whether delivery was in rural or urban settings. Another suggestion was to embed the Participant Information Sheet within the questionnaire, which was a useful piece of feedback and something that we did. The feedback from piloting was reassuring, with people feeling that the length of the questionnaire was appropriate and the questions answerable.

To encourage completion, we had to minimise the length of the questionnaire, prioritising key information that could be generated from the questionnaires rather than from other parts of the evaluation. We used a mixture of open and closed questions to build up both a quantitative understanding of the issues whilst also providing the opportunity to receive more descriptive feedback. The questionnaires are available [here](#) and [here](#).

Questionnaire recruitment

The questionnaire was developed within an online management system (Qualtrics) so that people could complete the questionnaire online. Qualtrics was used because it is a piece of approved software for the University of Sheffield. It meets the required data security and information governance process standards needed to undertake health research. Through using Qualtrics, an online link was generated. People clicked on the link to complete the questionnaire.

Project Managers at the T&L sites were sent an introductory email and the questionnaire links in January 2022. The Project Managers were asked to circulate this amongst their networks. The Project Managers were kept updated about the questionnaire response rates for their sites and asked to recirculate the information two weeks later, targeting any specific gap in responses. Officially, the recruitment window was open between 7th January to the 18th February 2022. However, we did not close recruitment until 8th March 2022 to enable further responses from two sites that had delayed circulating the questionnaire to fit in with other activities.

The questionnaire was used to complement data being collected in the other parts of the T&L evaluation e.g., by the Embedded Researchers. Thus, we used an opportunistic sampling technique rather than utilising a representative sampling framework. This means it is unknown how representative the responses are, especially as people may be more likely to complete free-text comments if they have specific feedback they want to give.

People completed the questionnaire online. However, if they preferred, they were given the opportunity to complete the questionnaire over the telephone or as part of an online meeting. Should they have any queries, potential responders were provided with the National Evaluation team's contact details (Alexis Foster).

A Participant Information Sheet was provided both with the introductory email and embedded within the questionnaire. People were asked to read this and tick a box within the questionnaire to consent to participating. It was also explained that completion of the questionnaire was deemed as providing consent. None of the questions were mandatory, so respondents only needed to complete the questions that they wanted to. Therefore, there are differing response rates for each specific question.

Questionnaire responses

We received 91 responses to the Link Worker questionnaires across the seven sites. There were 122 responses from people representing nature-based activity providers. The responses varied considerably between sites, for example for the nature-based activity provider questionnaire the range was 3-28. The different response rates were partly due to the different configurations of the T&L sites and demands on peoples' time. For example, in one site they were undertaking similar mapping work. In another site, the focus had been on engaging a small number of larger delivery providers.

Due to the opportunistic sampling methods, it is unknown how representative the responses to the questionnaire are. However, this is not a critical issue because the purpose of the questionnaire was exploratory rather than definitive. We were using the questionnaire to understand current practice and opinions, using the findings to identify arising issues that are then explored by the Embedded Researchers. For example, transport was highlighted as a barrier within the questionnaire, so this issue has been explored further by the Embedded Researchers.

Analysis of the questionnaire

Each questionnaire was downloaded from Qualtrics into an Excel file. The Evaluation Team undertook data cleaning of the responses so that the dataset was ready for analysis. Descriptive analysis of the fixed-answered questions was undertaken in specialist statistical analysis software packages (SPSS and Stata) (Field, 2013). For example, calculating percentages of people who delivered activities within rural or urban settings. Subgroup analysis on a specific site-level was not undertaken because this led to small samples, which made it difficult to explore patterns within the data. Furthermore, the purpose of the questionnaire was to understand issues arising generally across the GSP project, with the Embedded Researchers responsible for focusing on drilling down issues on a site-specific basis. As a collective, the Evaluation Team is using the learning from individual T&L sites to build up a more general understanding of the delivery of GSP rather than comparing sites for which works best. Where there are specific issues arising from T&L sites, the Embedded Researchers explore the issues further through their site-specific research.

We had intended to undertake some relationship analysis, for example exploring whether there were differences in capacity between certain types of organisations. However, generally we did not undertake this relationship analysis because the sample was not large enough. Rather, we undertook narrative reflections of relationships between the data, using the free-text responses to build our understanding of arising issues. The open-ended questions have been initially analysed using simple thematic approaches guided by the conceptual model developed in previous work (Garside et al., 2020). The responses were tabulated and evidence relevant to the key themes were extracted. Elements of commonality and contradiction were sought to address the key research questions.

Follow-up questionnaire

We will be conducting a further questionnaire in Spring 2023 to understand what has changed during GSP and to explore factors relating to the sustainability of the project. We anticipate a similar sample size of approximately 100 questionnaires completed per stakeholder group. This will be sufficient given the questionnaire is seeking to capture arising issues which can be explored further by the embedded researchers.

A2.3. Methods for utilising monitoring data

Alongside primary data collection such as questionnaires, the Evaluation Team also supported sites to develop monitoring data processes. Providers will often record data on service-users such as their demographics, referral routes and outcomes, partly for their own case management reasons but also to collect information on behalf of commissioners for performance management reasons (Foster et al., 2020). The Evaluation Team sought to collate and analyse this information. However, because historically Link Workers and nature-based activity providers had their own monitoring systems and requirements for information, there was little consistency in what was being collected nor established variables for GSP. Therefore, the Monitoring data work package became an action research project (Foster et al., 2022), where the Evaluation Team supported local sites and individual Link Workers and nature-based activity providers to develop a GSP consistent monitoring system. This has required considerable investment of time from the National Evaluation Team, who have gone beyond the resourcing of the contract to ensure that T&L sites are supported.

Developing a GSP Monitoring dataset

The first few months of the evaluation was spent developing a GSP monitoring dataset. This involved multiple conversations and feedback cycles with national and local partners. It was decided to focus on collecting monitoring data from Link Workers and nature-based providers as these are key parts of the pathway and where there was more scope to influence data monitoring systems.

The data was not mandated from sites but rather viewed as best practice and what sites may need to collect to understand who is accessing GSP, what is being delivered within GSP and the potential outcomes of the project. In a separate appendix we provide more detail on the process of developing data monitoring systems and the variables being collected. Below, we focus on the National Evaluation Team's processes on receipt of the data.

Receiving and cleaning the data

Where relevant, the Project Managers sent data in Excel spreadsheets. Due to a lack of resources at the individual T&L site level to collate and clean the data, this task was undertaken by the Evaluation Team. For example, many of the sites sent individual spreadsheets for each nature-based activity provider including handwritten data. Whilst this was not planned, the Evaluation Team were willing to undertake the additional data co-ordination and cleaning work because of the pressures that Project Managers were experiencing. For example, we had to spend a considerable amount of time cleaning data and collating it across different organisations. In Site 1, they were not able to provide the individual level data because of the data protection issues. In this case, the local evaluation team undertook the descriptive analysis themselves and provided us with the results.

Project Managers sent AF (based at the University of Sheffield) the spreadsheets by email, in a password protected file. Upon receipt, the researcher saved the files to the secure drive and deleted the emails and attachments.

As part of the data cleaning process, an individual Master File was produced for each relevant site, where individual organisation data was collated within the Site-Specific Master file. Data cleaning was undertaken of the files in Excel. This included ensuring that any data made sense e.g., addressing any potential data anomalies. A key part of cleaning was replacing postcode data with IMD deprivation codes. This involved recording postcodes with the IMD deprivation decile to understand whether service users were living in areas of socio-economic deprivation (MHCLG, 2019) after cleaning, the data was transferred into R (statistical analysis software) for analysis.

Analysis of the monitoring data

Summary statistics were used to describe the characteristics of the people accessing GSP and their journey. Statistics were undertaken on both a site specific and GSP project level to provide both site specific and overall statistics. For categorical variables the frequency and percent of participants was presented. Continuous variables such as the time between referral and receiving support were summarised using the mean and standard deviation, median and Interquartile Range (IQR) and range.

ONS-4 outcome measures (Life Satisfaction, Worthwhile, Happiness, Anxiety) were summarised at baseline and follow-up. The distribution of each score was described by reporting the number and percentage of participants who recorded each possible value on the outcome scale. The average score was described using the mean and median and the variability was described using the standard deviation and interquartile range. For those participants with both a baseline and follow-up score, the change in score was described using a paired samples t-test, reporting the mean change, 95% confidence interval and P-Value. These enabled us to explore how mental wellbeing had changed both across the population but also on an individual service user level (the latter was only possible for service users who had completed a pre and post measure).

Some sites used the Nature Connectedness Index. This was analysed using a similar approach to the ONS-4 outcome measures. However, a Wilcoxon signed rank test was used to compare the scores between pre and post timepoints due to the skewed distribution of the difference in scores.

One site collected binary outcomes on a change in physical activity in the last 7 days. This was a binary measure of Yes/No. We used McNemar's test for paired data to compare people's physical activity levels pre and post accessing GSP.

Summary

To summarise, WP3A has consisted of utilising questionnaires and monitoring data to explore the delivery of GSP within the T&L sites such as the demographics of service users accessing GSP. This has required the National Evaluation Team to invest significant amounts of time to support the Project Managers, Link Workers and nature-based providers to develop systems for collecting and processing monitoring data. The emerging findings will be synthesised with findings from other work packages to develop our understanding of GSP.

References

Field, A. (2013) *Discovering Statistics Using IBM SPSS Statistics (4th ed.)*. London: SAGE Publications Ltd.

Foster, A., O'Cathain, A. and Harris, J. (2020) How do third sector organisations or charities providing health and well-being services in England implement patient-

reported outcome measures (PROMs)? A qualitative interview study. *BMJ Open*, 10, e039116.

Foster, A., O’Cathain, A., Harris, J., Weston, G., Andrews, L. and Andreeva, O. (2022) Using co-production to implement patient reported outcome measures in third sector organisations: a mixed methods study. *Journal of patient-reported outcomes*, 6 (1), pp.1-10.

Garside, R., Orr, R., Short, R., Lovell, R., Husk, K., Mceachan, R., Rashid, R. and Dickie, I. (2020) *Therapeutic Nature: nature-based social prescribing for diagnosed mental health conditions in the UK*. Final Report for DEFRA. DEFRA.

Mathers, N., Fox, N. and Hunn, A. (2009) *Surveys and questionnaires*. The NIHR Research Design Service for Yorkshire & the Humber. www.rds-eastmidlands.nihr.ac.uk Available at https://www.rds-yh.nihr.ac.uk/wpcontent/uploads/2013/05/12_Surveys_and_Questionnaires_Revision_2009.pdf

Ministry of Housing, Communities and Local Government (2019) *The English Indices of Deprivation 2019: Frequently asked questions*. Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/853811/loD2019_FAQ_v4.pdf

A2.4. Developing and collecting monitoring data within the GSP system to understand who accesses services, what they receive and the impact of GSP (Evaluation Aims 1 and 4)

Introduction

In this section, we present the learning from supporting the development and collection of monitoring data from the seven T&L sites. We describe how we have worked with the sites, the challenges faced and potential solutions.

A key aim of Work Package 3A is to undertake quantitative analysis of monitoring data to understand delivery of GSP including who accesses support and the referral pathway. Given the evaluation is not a formal effectiveness study, we are not trying to establish whether GSP ‘works’.

GSP focuses on supporting people to access nature-based activities which meet their specific needs. Consequently, it involves multiple organisations, from different sectors seeking to support people to engage in nature-based activities. For example, a person may see their GP, be referred to a voluntary sector employed Link Worker and then be supported to access a nature-based activity run by another voluntary sector organisation. This makes collecting monitoring data challenging, as there is never a single organisation collecting data detailing a person’s whole journey but rather each organisation may capture a part of the journey. Furthermore, each person’s GSP journey will not be uniform, it will involve different referral pathways, organisations, and nature-based activities. Different organisations involved within the GSP have differing priorities and are at different levels of maturity in respect of capturing monitoring data. For example, some organisations may utilise a data management system and have capacity to extract reports for funders. On the other hand, other organisations may be run by volunteers and collect purely paper-based attendance registers. Consequently, there has been a (and is an ongoing) need to support the T&L sites to develop monitoring systems which reflect the multi-faceted nature of GSP.

Given the need to develop capacity, we have been working with each T&L site to develop their own locally appropriate solutions to data monitoring. Consequently, establishing robust data monitoring processes has itself become part of the evaluation

including exploring the feasibility of monitoring processes. Thus, the aim and remit of WP3A has evolved from not purely analysing monitoring information but also supporting T&L sites and organisations within each site to embed systems which can be sustained to provide local intelligence on GSP to inform delivery and development beyond the evaluation.

The National Evaluation team has built upon experience gained from our studies about supporting organisations to implement monitoring information (Foster et al., 2018; Foster et al., 2020; Foster et al., 2022)

To date, the priority has been on developing monitoring systems in specific parts of the GSP pathway, which captures parts of a person's experience. At present, most organisations' systems are not sufficiently connected to track people throughout their GSP journey. This is discussed in more depth later in this document.

We have targeted collecting monitoring data from both Link Workers and nature-based providers, as both are key parts of the GSP pathway. The reason being that Link Workers may be able to collect data on people's journey to that point of the system and Link Workers have a key role in potentially signposting people to nature-based activity. There is also currently considerable development of policy and resources associated with Link Workers including developing their monitoring systems. Nature-based providers were prioritised given that they deliver green activities. Furthermore, given that in some sites nature-based providers were commissioned to deliver activities there was a contractual arrangement which could be used as leverage to collect monitoring data.

Data Monitoring Framework

Through consultation with national partners and individual T&L sites, the National Evaluation team developed a framework of variables (data monitoring framework) that could be collected to demonstrate:

- Who is accessing support?
- Referral routes.
- The support provided.
- Potential impact of parts of the GSP approach.

For example, given the focus of the project on mental health, we had to develop a way of assessing people's mental health needs. We did this by asking the organisations collecting data to record whether a service user had mental health needs that were having a detrimental impact on their daily lives.

Our data monitoring framework was not mandated but rather is a toolkit of recommended data for stakeholders to explore who was accessing GSP, their GSP journey and the potential impact of GSP on people's mental wellbeing, nature connectedness and physical health. The monitoring framework provided a useful platform for discussing data needs and gaps. T&L Sites were encouraged to collect the data but with the caveat of appreciating local preferences. Thus, many of the sites operationalised the toolkit to reflect local priorities and delivery of GSP. For example, in one site they wanted to collect two of the four ONS-4 questions to reflect local commissioning preferences. In another T&L site, commissioned nature-based activity providers were allowed to choose which mental wellbeing outcome measure they were collecting as part of their contracts.

The Evaluation Team developed detailed guidance and Excel monitoring templates to support organisations within T&L sites (Defra, 2022). Accompanying this, the

Evaluation Team has undertaken significant capacity building work with individual sites to support referring organisations- especially Link Worker services and nature-based activity providers. Many of the T&L sites have provided positive feedback about our approach, appreciating the collaborative approach and our willingness to invest time in supporting sites to overcome barriers rather than there being an expectation that data would simply be collected. This has required the Evaluation Team to invest significant time which was beyond the resource of the evaluation contract. This needs to be considered in terms of future resourcing of GSP monitoring data. Examples of support include:

- Speaking with individual nature-based providers to help them develop their monitoring processes.
- Running workshops at a number of different sites with nature-based providers to develop data monitoring capacity.
- Supporting sites with collating and cleaning data such as writing up hand-written data notes.

Unsurprisingly, there have been considerable barriers encountered to collecting data, at different levels of the GSP pathway for a myriad of reasons. Consequently, there is less monitoring data collected than anticipated especially from Link Workers. This highlights the challenges of developing GSP monitoring systems and is reflected in the Social Prescribing Maturity Framework. This social prescribing specific framework highlights that data monitoring systems may be fairly new and evolving rather than established and mature (NHS England, 2022).

Changes in Mental Wellbeing measured by utilising Patient Reported Outcome Measure

A key aim of GSP has been to prevent and improve mental health issues. Given this, it was important to identify a measure to capture change in mental health. Through extensive consultation during the scoping phase of the evaluation, it was decided to encourage stakeholders to use the ONS-4, which is a mental wellbeing Patient Reported Outcome Measure (Office for National Statistics, 2018). Importantly, this was considered acceptable by many stakeholders because it is relatively short (4 questions), uses relatively lay language, is free to use and is widely used. It is also one of the core outcomes measured for Link Workers.

Given the diversity of populations accessing GSP, the ONS-4 is not suitable for everyone accessing support (nor would any measure). For example, people with learning disabilities may struggle to comprehend the questions. Some sites are undertaking work on developing measures to utilise with specific populations including one T&L site working with a learning disability charity to develop an appropriate wellbeing measure. Furthermore, some of the ONS-4 domains do not translate well to some people from ethnic minority backgrounds. For example, the domain 'anxiety' is considered stigmatising because it is associated with being classed as 'mad'.

There are some key caveats to using the ONS-4 to understand the impact of GSP on people's mental wellbeing, with resulting data needing to be contextualised. Firstly, within this specific GSP evaluation, there is no control or comparison group and so it is not known whether any improvement is because of GSP or whether an alternative intervention (or no intervention) may have been better.

Secondly, whilst we can establish whether the extent of change is statistically significant, it is unknown what level of change is considered meaningful amongst stakeholders including commissioners. For example, what level of mental wellbeing improvement would be deemed a success - 50% of people experiencing an

improvement, people moving to a lower level of wellbeing to a higher level or is it about a percentage change? These are criteria likely to be decided by local commissioners when funding programmes.

Thirdly, the GSP is not one intervention and different amounts of changes may be anticipated depending on the type, length, and intensity of the referral route and/or nature-based activity. Fourthly, consideration needs to be given of whether outcomes data is being collected from a representative sample. For example, it may be nature-based providers working with certain populations that are not utilising measures. Finally, even if pre-support measures are collected, organisations can struggle with collecting measures after service users have received support. Organisations have given different reasons for this including:

- A service user who stops attending an activity before the point of collecting the measure (often referred to 'dropping out' or an 'unplanned ending').
- A service user may be continuing to attend an activity and there is not an established timepoint to collect a measure.
- A service user is referred onto other activities and thus is continuing to receive support from other providers.

Alongside mental wellbeing, the National Evaluation Team also suggested ways of measuring changes in relation to nature. If T&L sites wanted to use a nature related measure, we suggested a question from the Nature Connectedness Scale (Richardson et al., 2019)

I feel part of nature 1 (completely agree)-7 (completely disagree)

Key learning on outcome measures:

The ONS-4 and a question from the Nature Connectedness Scale has been recommended for use within GSP.

However, it is not useful or possible to mandate collection of these measures as stakeholders need to take account of local contexts and specific populations- for an intervention as diverse as GSP there is not one universally suitable measure.

Further consideration is needed by commissioners about what constitutes meaningful change, that they would want to see demonstrated in outcome measures to consider GSP as having a successful impact on improving mental wellbeing. With the absence of control groups or a powered sample, this will depend on individual commissioners deciding upon performance monitoring criteria.

A2.5. Different parts of the GSP Pathway

GSP is a multi-stage pathway, involving different organisations and services. This multi-stage pathway creates challenges for data monitoring, with each encounter facing specific barriers for capturing data. At present there are no methods to capture monitoring data for people across the whole of their GSP journey. An exception is in one site where they are running a cohort study. This involves people consenting to be part of the research study and the Link Work tracking people's journey and changes in their mental wellbeing. Despite funding Link Workers to undertake the cohort study, there have still been challenges of the Link Workers having sufficient time to undertake data collection, staff retention and attrition in the study. This highlights the challenges of capturing data even with significant dedicated resource.

We have encountered differences in approaches between T&L sites in both developing GSP and data monitoring systems. These differences are seen as an important part of the T&L process. It reflects that each site was commissioned to develop their specific GSP project rather than each being funded to deliver the same set of activities. However, this has implications for the data monitoring as some of the T&L sites that have taken a commissioning approach to nature-based activity will have greater leverage than in other T&L sites, where the focus has been on developing partnerships rather than on contractual relationships. Below, we detail some of the complexities at different parts of the GSP pathway in collecting monitoring data.

Project Management Team

The characteristics of the Project Management team have an influence on the monitoring data being collected. Developing and collecting monitoring data has required a considerable investment of time for Project Managers, alongside multiple other priorities. Some Project Managers view monitoring data as key to evidencing the impact of GSP to secure future funding and this has motivated them to be proactive in setting up and collecting data. Key learning from the roles of the site-specific Project Management teams include:

- **Having dedicated resource to focus on data monitoring-** The development and collection of monitoring data requires considerable time and commitment which may not always be a priority for Project Managers given their multiple responsibilities. Some Project Managers have invested resource in grant management organisations or with a Monitoring Officer to focus on data. It is recommended that in future, dedicated resource is allocated for data monitoring so that the sole responsibility is not on Project Managers, who are having to undertake data related tasks alongside other pressures on their time.
- **Contractual relationships-** Project Managers found that they had greater leverage with organisations that were being commissioned to deliver activities through GSP such as nature-based providers. Furthermore, some stakeholders struggled or believed it was inappropriate to seek data from organisations not being given funding. This is discussed further throughout this document but highlights the feasibility of what can and cannot be attributed to GSP.
- **Ensuring capacity for analysing and utilising monitoring data-** Some of the sites have not had the resources to process, collate and analyse monitoring data. Consequently, they have been reliant on the Evaluation Team to undertake this function. This needs consideration going forward to ensure that there is capacity for T&L sites to perform this function. For example, one site proposes that this requires the equivalent of an NHS Agenda for Change Band 6 Data Officer.
- **Developing locally appropriate data monitoring systems-** Some Project Managers have engaged with commissioners from an early stage to design monitoring data systems which are compatible with and meet local needs. For example, using outcome measures which reflect measures used on other wellbeing initiatives in the locality. Given the place-based concepts of the ICS and different commissioning approaches, there is likely to be some variation between localities.
- **Feeding back data to inform local decision making-** A key issue for Project Managers has been being able to use data collected through the evaluation to inform local decision making. Whilst this is part of wider discussions about the purpose of the evaluation, it is an important learning point for future monitoring and evaluation work. Project Managers and stakeholders need to be able to utilise the information to influence practice within their locality.

Healthcare and social care use

Referrals to GSP may initially start from health and/or social care services such as mental health services or primary care. From the beginning of the evaluation, it was agreed that data would not be collected from this part of the system because of the complexities of accessing patient medical records. However, stakeholders have discussed wanting to understand whether support through GSP has led to changes in healthcare service use. Given the multiple healthcare services involved it would be challenging to rely solely on healthcare records to measure changes. Thus, to explore changes in service-use, a study would be required that involved getting users to complete Health Service Resource Questionnaires. This method is often used within health economic studies (Leggett et al., 2016).

Collecting monitoring data from Link Workers

Link Workers are a key part of the GSP system because of their role in supporting people to access nature-based activities. This is complex, as there is considerable heterogeneity in how Link Worker roles are embedded within the wider health and care system. Each T&L site is dealing with multiple Link Workers employed by different organisations throughout the localities. This heterogeneity is the result of SP developing through placed-based strategies alongside the more recent NHS England Link Worker policy structure (NHS England and NHS Improvement, 2019). This heterogeneity means that within each T&L site, there will be multiple Link Workers, each recording (and having access to) different types of monitoring data, in different ways. Furthermore, the GSP project is not funding these Link Workers, so there is no contractual obligation for the Link Workers to record relevant data or provide this to the GSP Project Managers. Detailed below are some of the different types of Link Workers and how that impacts on the collection of monitoring data.

Primary Care Employed Link Worker- Some Link Workers are employed by Primary Care Networks embedded within GP practices. They will usually record user information on healthcare patient record systems like EMIS and System1. The nature of data they record is decided by each employing organisation such as whether or not they need to use an outcome measure. There will often be one or two Link Workers in each Primary Care Network which means within each T&L site there are multiple 'lone' Link Workers'. It can be difficult to extract information from the healthcare patient record systems to inform monitoring reports and it would require considerable time to extract the data to populate any monitoring data forms. Furthermore, Link Workers have expressed concern about whether they have sufficient permissions in place to pass on information to the GSP project.

Voluntary sector employed Link Workers- In some areas, voluntary sector organisations have been commissioned to provide social prescribing. These have been commissioned through different funding arrangements and been mandated by these different commissioners to record different monitoring information through different methods. In some organisations, they have used data management systems, organisation specific data management systems or spreadsheets. Again, there are challenges in terms of the inconsistency of data recorded and whether information can be passed onto the GSP project. For example, in one site where information was extracted from Link Worker specific data management software, there was no linkage between user's demographics and the onwards referral information.

GSP Related Link Workers- In one site Link Workers were funded through the GSP project. This facilitates the use of monitoring data because these Link Workers are part of the GSP project and thus have full access to and are contractual obliged to provide monitoring data.

Key issues about collecting monitoring data from Link Workers

Key issues have emerged from seeking to collect monitoring data from Link Workers:

- It is more difficult than nature-based providers because the Project Managers do not have any contractual relationship with Link Workers.
- For Link Workers, the GSP is only one part of their work and they are facing unprecedented pressure because of the cost of living and related crises that are impacting on the needs of clients.
- Developing the monitoring systems of Link Workers is part of a wider local and national conversations beyond GSP such as the work being undertaken by NHS England.
- There was more scope to develop data monitoring systems when one organisation was contracted to deliver Link Worker provision within a locality than when there were multiple organisations involved. For example, within one site there are some localities with one Link Worker provider which has made it easier to obtain monitoring data than in another part of the locality where multiple different community anchor organisations provide Link Worker services.
- Instability of commissioning- The Link Worker landscape is continually changing because service contracts are generally short-term. For example, in one site, the lead organisation was decommissioned, and another provider contracted to provide the social prescribing service. The Project Manager had to re-develop relationships with the new providers, who had different monitoring systems.
- In a couple of sites, organisations have been offered payment to develop data monitoring systems or to pay for Link Worker time to support the collection of monitoring data. For example, one site offered Link Worker organisations £750 (negotiable if they needed more money) in recognition of the time and resource it may take to amend data management systems. Whilst this commitment was important to ensure that organisations were sufficiently resourced, offering payment did not solve the issues. Firstly, not many organisations took up the offer of payment because they had other priorities. Even when Link Worker time was funded, their time could still be taken up by other priorities which meant they were unable to dedicate the necessary time to undertake data monitoring.
- Link Workers used different data monitoring systems. This may be Excel spreadsheets, organisation-based data monitoring systems or specialist data management software e.g., Elemental and Joy. Some areas are interested in using this specialist software because it is viewed as a way of co-ordinating data and linking it with other systems. However, data management is only one part of implementing monitoring information and will not solve all the issues. For example, in one site they have been unable to get data on referral routes to be linked with demographics from the Link Worker specialist software, reducing the usefulness of the data.
- A key aspect of learning for the GSP project is having a non-manual method of identifying which people have been referred to a nature-based provider. In most scenarios, at present it would require manual identification based on the name of the organisation. This is resource intensive and not feasible if there are a large number of service users or different geographical locations. We recommend that systems are developed so that there can be a tick box to indicate when a service user has received a nature-based activity referral. Indeed, this tick box function could be applied to different types of referrals beyond nature-based e.g., arts, heritage, welfare advice to enable a consistent analysis of onward referrals.
- Most sites have been unable to collect Worker data because they did not have a contractual relationship with organisations. There are national developments of

Link Worker data that longer-term GSP may be able to link in with and thus benefit from.

- Link Worker Providers tended to provide data purely on people referred to nature-based activities rather than all of their service users. This means that it is not possible to ascertain the proportion and how representative service users referred to nature-based activities compared to overall caseloads.
- Given the limited Link Worker data received and the range of published studies focused on Link Workers generally alongside work being undertaken by initiatives such as the Oxford Observatory (Clinical Informatics & Health Outcomes Research Group et al., 2021) utilising this data alongside specifically collected Link Worker data for GSP may be beneficial.
- Whilst we only received limited data from some sites in respect of Link Workers, of the sites that sent data there were some variables which were more complete than others. This indicates what data may be feasible to collect through data monitoring processes and which variables may need to be sourced through other means. For example, demographic data and source of referral data was relatively well completed. In contrast, there were relatively few service users with outcome measure data and there were quality assurance issues with date related data.
- Although the National Evaluation has not received as much data as hoped, the Project Managers have utilised the GSP program to have local conversations on collecting and utilising Link Worker/social prescribing data. For example, in one site they are developing local Link Worker data monitoring standards and looking to invest in specific software. In another site they have set up a working group to develop local data monitoring standards for Link Worker services.

Table A2.1: Summary of Link Worker data received

We summarise below the Link Worker data received from sites in July 2022.

Site	Link Worker data
1	<ul style="list-style-type: none"> • Data being collected through a cohort study with Link Workers recruiting participants on behalf of the local evaluators. • Participants are people that are referred to nature-based activities. • Data was provided on 69 participants but limited by the variables and categories decided by the local evaluators which differ from the National Evaluation. • Data was more complete because of the data being specifically collected for a research study rather than routine monitoring.
2	<ul style="list-style-type: none"> • Data collected on many of the Evaluation variables on some service-users (n=88). • Provided data on people who are referred onto nature-based activities rather than service-users generally. • Data drawn from some localities but not all parts of the site. • Demographic data was more complete than date or outcome data.
3	<ul style="list-style-type: none"> • No Link Worker data provided as the site was focused solely on nature-based activity providers.
4	<ul style="list-style-type: none"> • Some demographic and referral data provided from one locality, but the different variables are not linked (issue with SP software) which meant it was not possible to explore patterns within the data. For example, whether nature-based referrals differed by demographics. • Sample was relatively large (n=393) but a limited number of variables were collected. • No outcomes data or date related data was provided.
5	<ul style="list-style-type: none"> • Site operates nature-based Link Workers, where people referred to nature-based activities will be supported by a Link Worker to engage in nature-based activities alongside more generic Link Worker. • Data was primarily from nature-based Link Workers. • Sample was relatively large (n=393) with data collected on a range of variables.
6	<ul style="list-style-type: none"> • No Link Worker data provided as the site experienced difficulty getting permission for providers to share the data with the GSP project.
7	<ul style="list-style-type: none"> • No Link Worker data was provided because the Project Manager is working with other stakeholders in the region to develop data monitoring systems through a technology platform and agreeing a region wide core data set. They may work with NHS England on this.

The sample of Link Worker data received has increased considerably from the April 2022 report with the evaluation receiving data from a number of sites with information on different variables.

Collecting monitoring data from Nature based activity providers

There appears greater opportunity to influence data collection by nature-based activity providers that have been funded directly through the GSP project than Link Workers and nature-based organisations that have not received funding. Project Managers have incorporated the need for organisations to collect monitoring data into contracts and grant agreements. However, they have taken different approaches to how prescriptive they are. For example, in one site they have prescribed the variables to be collected whereas in another they have been more pragmatic depending on the organisation. It is less feasible to get monitoring data from nature-based providers operating in a T&L site who have not received funding because there is no contractual obligation to provide this data and these organisations will need to prioritise providing monitoring data to their own commissioners/funders.

Despite contractual obligations, providers lack sufficient capacity to collect and process monitoring data. This is despite receiving funding and considerable support. For example, in one site the Project Manager received monitoring data from less than a third of funded projects. In one T&L site, there is considerable missing data in terms of demographics and outcome measures, highlighting that some nature-based activity providers may not be in a position practically or culturally to collect the type and quality of monitoring data the system 'needs' (and in some cases collecting this type of data may not be appropriate). This highlights how providers are at different levels of maturity in terms of data collection. Key learning has been:

- There was more scope to collect monitoring data from those organisations who were provided with funding to deliver GSP.
- Organisations had different levels of experience and infrastructure to be able to collect monitoring data. There is a need to provide support to organisations with less experience or infrastructure to collect monitoring data. Some of this support has been provided by Project Managers. The evaluation team has also provided considerable support to individual providers.
- Some nature-based activities are more amenable to measurement than others. For example, different types of monitoring data can be collected for a fixed-term closed group course than open access, drop in events.
- Organisations need support with developing their monitoring data infrastructure and this can take time.
- Organisations need intrinsic motivation in the form of feedback on the data they are collecting. Without feedback organisations can feel this is a 'tick box' exercise.
- Some of the organisations rely on volunteers or run activities purely outdoors, which can make it harder to collect data.
- There is a developing evidence base on the impact of nature-based activities so future use of monitoring data needs to consider what the data is going to be used for and whether there is already a sufficient evidence-base available, so what does the monitoring data add?
- Organisations are more experienced at collecting some types of monitoring data like demographics data than other types including date related data, outcomes data and onward referral. Thus, there could be more reliance on organisations to collect certain types of data and identify other methods to collect the types of data organisations may struggle with. Date related data such as number of sessions or date between referral and completing an activity often have significant data quality issues.

- Some organisations provided both aggregate and individual-level data but for different numbers of people with some duplication of service users. This meant it was difficult to use both the aggregate and individual level data.

Table A2.2: Summary of nature-based activity provider data received

Site	Nature-based activity providers
1	<ul style="list-style-type: none"> • Data is collected through a cohort study through Link Workers recruiting participants on behalf of the local evaluators. • As Link Workers track information it is difficult to fully separate the Link Worker and/nature-based activity data (n=69). • Data variables e.g., age categories were chosen by the local evaluation so some differences to the National Evaluation. • Pre and post ONS-4 data collected for 27 service users • Data sharing agreement was not processed in time by the university of the local evaluation team, so the local evaluators conducted the analysis and provided the findings rather than providing the National Evaluation team with raw data. Consequently, at times the data cannot be collated with other sites.
2	<ul style="list-style-type: none"> • Data collated on service users accessing GSP funded nature-based activity providers (n=540). • Site collected the Evaluation variables and some additional variables including caring status. • Pre and post ONS-4 data collated on 15 service users. • Site provided individual organisation spreadsheets so required considerable resource investment from the evaluation team to collate and clean because of capacity issues at the site.
3	<ul style="list-style-type: none"> • Some variables provided on 33 service users mainly related to demographics. • Not provided linked pre and post data so it was not possible to explore whether individuals have experienced a change in their mental wellbeing.
4	<ul style="list-style-type: none"> • No data provided on nature-based providers because they have only recently started delivery because they have been focussing on system change.
5	<ul style="list-style-type: none"> • Data provided on service users accessing funded nature-based activity providers (n=453). • Data provided on many of the Evaluation variables including demographics and support received. • Completed pre and post ONS-4 outcome data for 39 service users.
6	<ul style="list-style-type: none"> • Data provided on service users accessing GSP funded nature-based activity providers (n=196). • Data provided on many of the Evaluation variables including demographic and support received. However, there is an issue that some missing data has been categorised which impacts on reliability of the data e.g., whether it is an appropriate referral, missing data has become coded as a 'no' which changes the nature of the frequencies. • Pre and post ONS-4 outcomes data collected for 105 service users.
7	<ul style="list-style-type: none"> • Data provided on service users accessing funded nature-based activity providers (n=434). • Data returned for less than a third of funded nature-based activities. • Data provided aligns with sites' own data monitoring decisions e.g., people from ethnic minority background or not, Under 18, 18-65, over 65 etc rather than the National Evaluation variables. • Pre and post ONS-4 outcomes data collected on 299 service users (for 2 of the questions). • Collating the data has required considerable input from the National Evaluation team as site returned individual spreadsheets per provider including handwritten notes (Evaluation team did this as site did not have capacity)

The amount of monitoring data has increased considerably since the previous report. For the April 2022 report, we received nature-based provider data from one site and less than 10 pre and post outcome measures. For this report, 6 of the 7 T&L sites have provided monitoring data, with us receiving data on over 1500 service users and some further additional higher level aggregate data. We are continuing to support sites, with the expectation being that data quality and completeness will increase. For example, more organisations returning data. Furthermore, the number of service users will increase as GSP continues to support people. Thus, it is likely that there will be a much larger amount of data available for analysis for the final report.

Supporting the collecting and use of monitoring data

Whilst the national evaluation has identified a number of challenges, through working with the T&L sites, we have also identified some potential solutions that future GSP projects may wish to incorporate.

Utilising a grant monitoring organisation: One site has commissioned a grant monitoring organisation to manage the nature-based provider grants including supporting organisations with collecting monitoring data. The advantage of this is that the grant management organisation will be experienced at undertaking the work and it reduces the time the Project Manager has to spend on coordination and monitoring. The challenge is that it does cost money.

Investing in a data manager: Developing, managing, and utilising monitoring data is challenging and can be difficult for Project Managers to prioritise given the multiple, competing responsibilities they have. Investing in a standalone role to be responsible for data monitoring may be a feasible approach for sites. Many of the sites have required the Evaluation team to provide a significant amount of support and thus there is a need to have site-based personnel who can perform this function if the GSP project is rolled out with monitoring data requirements.

Providing training and support for nature-based providers: Rather than there being an expectation that nature-based providers can collect monitoring data, many of the T&L sites have given considerable support to individual organisations to help them with this. For example, the National Evaluation team have run workshops and provided individual support to organisations to support specific queries.

Regular meetings between Project Managers and providers: Some of the Project Managers had regular monitoring meetings with nature-based providers. This provided an opportunity to identify data monitoring issues in sufficient time to address potential problems rather than discovering issues on receipt of monitoring data returns.

Reviewing data collected and providing feedback: It was useful to ask organisations to provide regular data returns and the Project Manager reviewed them to identify any issues with completeness and quality and provide feedback. For example, in one site the evaluation team developed a learning paper on common data issues to help nature-based providers improve their practice.

Sites need resource to provide tailored support to smaller organisations: There were some organisations that attempted to collect the data but did this through recording data on paper records. For the National Evaluation, the team supported organisations with utilising this data. However, this is another resource that would need to be accounted for as some organisations will require considerable support to develop their data monitoring capacity.

Focusing on nature-based activities which have been allocated funding: T&L sites have invested significant amounts of time trying to generate monitoring data for

Link Workers and the wider green network. However, without a contractual obligation for agencies to provide the monitoring data it has been rather futile at times. There is also the dilemma when services are stretched, whether a priority of their time and resources is to provide GSP with data when they are not receiving any funding from GSP. Consequently, GSP projects could prioritise data collection from nature-based projects that are being funded through GSP. Over time, there should be a more national evidence base on the Link Worker element of social prescribing that could be drawn upon as an evidence base.

Resourcing data management software: A key challenge is that providers utilise different data management systems or may not have access to a system. Consequently, sites may want to consider investing in a data management system that can be utilised by providers. Albeit it must be noted that these will not solve all the data quality issues but may facilitate the collection and use of monitoring data.

Analysis capacity: Whilst sites are collecting monitoring data, some sites have spoken of not having the skills or capacity to analyse the data. In this evaluation, the National team has undertaken the analysis on behalf of sites. However, it raises questions about longer-term capacity and skills to ensure that collected monitoring data is analysed appropriately.

External researchers: Understandably, despite best intentions, organisations struggled to collect monitoring data beyond demographic data. The cohort study in one site which relies on Link Workers has also struggled with engagement. Thus, it feels that for a comprehensive collection of individual level data to explore who is accessing GSP, the users' journey and the impact of the service would require investment in an external research project. This would require the resourcing of significant research assistant time who would undertake data collection directly from service users to ensure consistency and completeness of data collected. For example, the study may utilise a health care resource use questionnaire to explore the impact of GSP in healthcare use.

Summary

Through WP3A to date, we have developed a GSP Monitoring Dataset which consists of variables that partners feel are important to understand who accesses GSP, the support they receive and potential impact of the programme. Project Managers and the national evaluation team have invested significant time and resources into developing GSP data monitoring systems. Some of this has enabled monitoring data to be collected but organisations have not collected the data as comprehensively as envisaged for a number of different reasons. This process has consequently identified issues but also potential solutions for facilitating the collection of monitoring data. Alongside, Project Managers have used the data monitoring framework as a catalyst to have local conversations and begin changing practice in respect of systems collection and resourcing of monitoring data throughout the wider social prescribing system. This is especially relevant given the evolving situation of ICS and social prescribing policy.

References

Clinical Informatics & Health Outcomes Research Group, Nuffield Department Of Primary Care Health Sciences, University Of Oxford. (2021) *Social Prescribing in Primary Care*. ORCHID:Oxford. Available at: [Social Prescribing in Primary Care | ORCHID :: Oxford-RCGP RSC](#)

DEFRA (2022) *National Evaluation of the Preventing and Tackling Mental Ill Health through Green Social Prescribing Project: Light Touch Interim Report*. Appendices. Internal report. Defra. Unpublished.

England N.H.S. and Improvement N.H.S. (2019) *Social prescribing Link Workers: Reference guide for primary care networks*. Available at: <https://www.england.nhs.uk/publication/social-prescribing-link-workers-reference-guide-for-primary-care-networks-technical-annex/>

Foster, A., Croot, L., Brazier, J., Harris, J. and O’Cathain, A. (2018) The facilitators and barriers to implementing patient reported outcome measures in organisations delivering health related services: a systematic review of reviews. *Journal of patient-reported outcomes*, 2(1), pp.1-16.

Foster, A., O’Cathain, A. and Harris, J. (2020) How do third sector organisations or charities providing health and well-being services in England implement patient-reported outcome measures (PROMs)? A qualitative interview study. *BMJ Open*, 10, e039116.

Foster, A., O’Cathain, A., Harris, J., Weston, G., Andrews, L. and Andreeva, O., (2022) Using co-production to implement patient reported outcome measures in third sector organisations: a mixed methods study. *Journal of patient-reported outcomes*, 6(1), pp.1-10.

Leggett, L. E., Khadaroo, R. G., Holroyd-Leduc, J., Lorenzetti, D. L., Hanson, H., Wagg, A., Padwal, R., Clement, F. (2016) Measuring Resource Utilization: A Systematic Review of Validated Self-Reported Questionnaires. *Medicine*, 95(10), p e2759 doi: 10.1097/MD.0000000000002759. Available at https://journals.lww.com/md-journal/fulltext/2016/03080/measuring_resource_utilization_a_systematic.10.aspx

NHS England (2022) *Social Prescribing Maturity Framework: A Draft Quality Improvement Tool for Integrated Care Systems*. Draft Report (NHS England). Unpublished.

Office for National Statistics (2018) *Personal well-being user guidance*. Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/methodologies/personalwellbeingsurveyuserguide>

Richardson, M., Hunt, A., Hinds, J., Bragg, R., Fido, D., Petronzi, D., Barbett, L., Clitherow, T., White, M. (2019) A Measure of Nature Connectedness for Children and Adults: Validation, Performance, and Insights. *Sustainability*, 11(12), p. 3250. doi:10.3390/su11123250. Available at <https://www.mdpi.com/2071-1050/11/12/3250>

A2.6. Analysis of the nature-based activity provider questionnaire

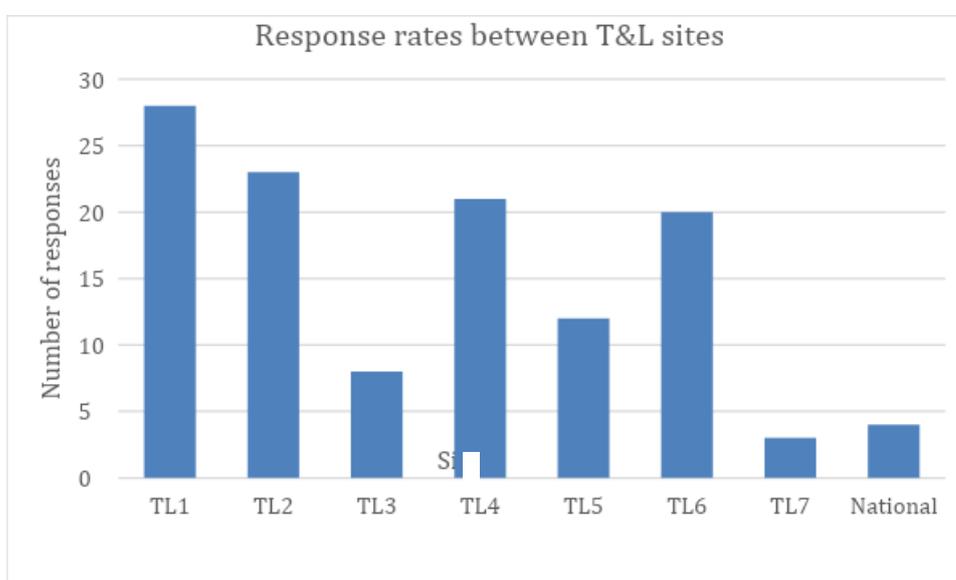
Responses to the nature-based activity provider questionnaire

There were 122 responses from people representing nature-based activity providers. The responses varied considerably between sites from 3-28 (Table A2.3, Figure A2.1). The different response rates were partly because of the different configurations of the T&L sites and demands on peoples’ time. For example, in one site they were undertaking similar mapping work. In another site, the focus had been on engaging a small number of larger delivery providers. There were a small number of responses from people who worked for national organisations across the different sites.

Table A2.3: Response rate of nature-based activity providers by site

Site	Response (n=119)
TL1	28 (23.5%)
TL2	23 (19.3%)
TL3	8 (6.7%)
TL4	21 (17.6%)
TL5	12 (10.1%)
TL6	20 (16.9%)
TL7	3 (2.5%)
National	4 (3.4%)

Figure A2.1: Response rates between T&L sites

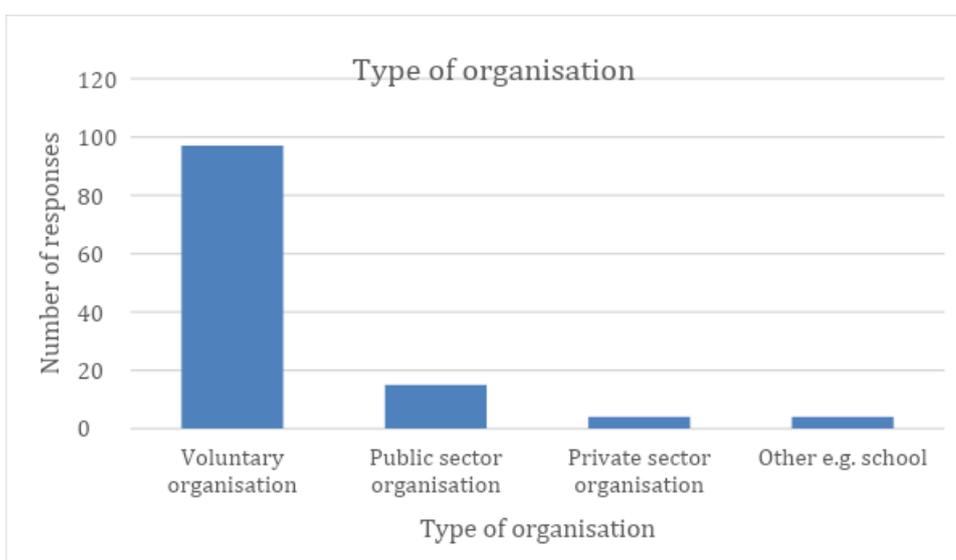


Type and size of organisation (Answered by 120 people)

The majority of respondents were from voluntary sector organisations (n=97/120, 80.9%) (Table A2.4, Figure A2.2). Fifteen (12.5%) were from public sector organisations. Four represented private sector organisations (3.3%) and a further four people (3.3%) were from different types of organisations including a school and a freelancer. These responses demonstrate how nature-based activities are predominantly provided by voluntary sector organisations which has implications for funding, data system flows and sustainability.

Table A2.4: Type of organisation

Type of organisation	Response (n=120)
Voluntary/community sector organisation	97 (80.9%)
Public sector organisation	15 (12.5%)
Private sector organisation	4 (3.3%)
Other e.g., school	4 (3.3%)

Figure A2.2: Type of organisation

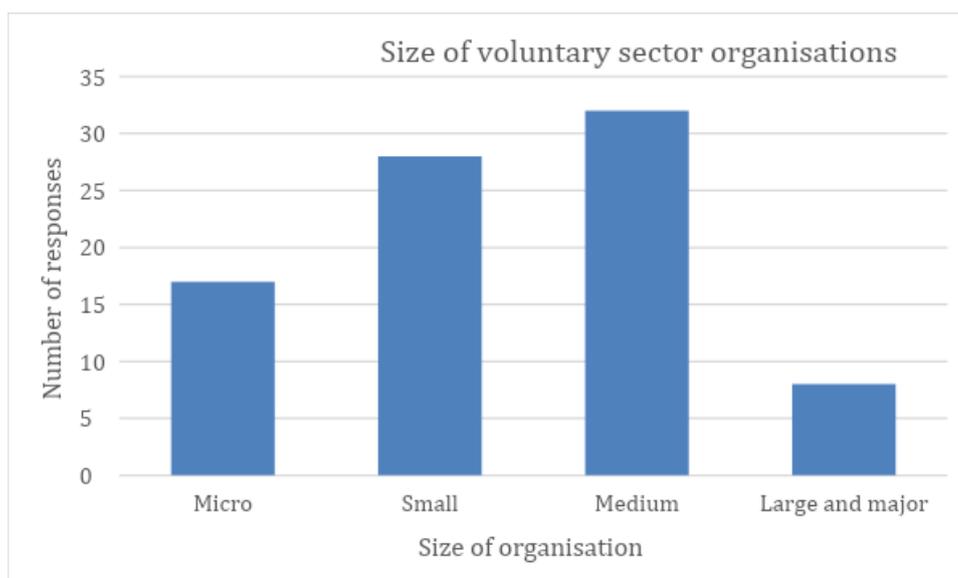
Respondents represented a variety of sized voluntary sector organisations (Table A2.5, Figure A2.3). About half were from smaller sized organisations, having an annual income of less than £100,000 (n=45, 52.9%). This has implications in terms of funding, infrastructure, capacity and sustainability. Just over a third represented medium sized organisations with an annual income of £100,000-£1 million (n=32, 37.7%). Less than 10% represented organisations that had an income of more than a million but less than £100 million (n=8, 9.4%). Interestingly, the respondents worked for larger organisations than the UK average- where 80% of voluntary organisations are smaller organisations with an income less than £100,00¹. This indicates that there may need to be further consideration of what role smaller, less formalised organisations could have within the GSP pathway.

Table A2.5: Size of voluntary sector organisations

Size of voluntary organisation	Response (n=85)
Micro (Annual income of under £10,000)	17 (20%)
Small (Annual income of £10,000-£100,000)	28 (32.9%)
Medium (Annual income of £100,000 to £1 million)	32 (37.7%)
Large and major (Annual income of £1-£100 million)	8 (9.4%)

¹ See [NCVO Almanac 2021: The latest findings on the voluntary sector and volunteering | NCVO Blogs](#) for more info

Figure A2.3: Size of voluntary sector organisations



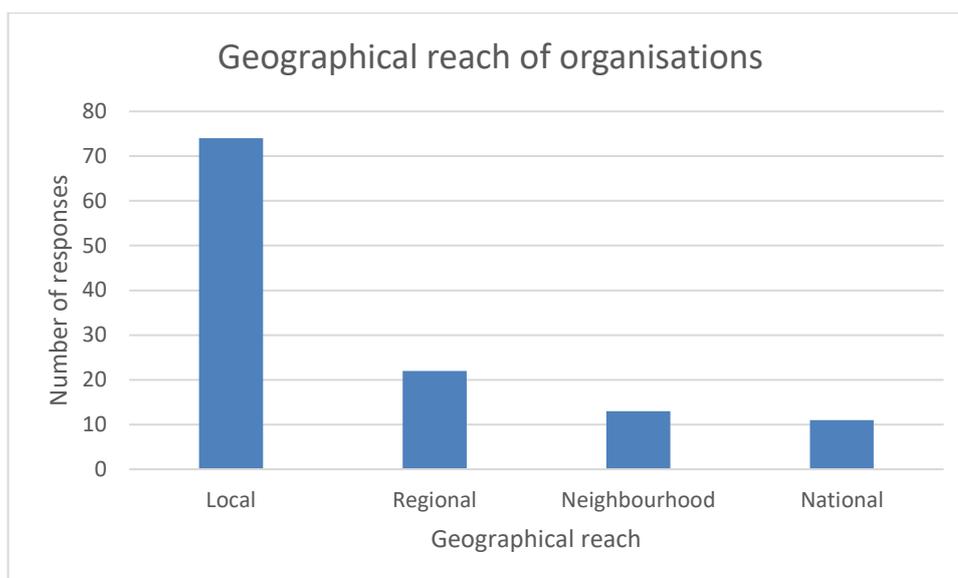
Geographical scope (Answered by 120 people)

The majority of the respondents were from organisations with a geographical scope of a specific town or local authority area (n=74, 61.7%) (Table A2.6, Figure A2.4). Just under a fifth operated on a regional basis (n=22, 18.3%). A similar proportion of around 10% of respondents represented neighbourhood-based organisations and national organisations. With almost three quarters of respondents being from organisations in one town or neighbourhood (n=87, n=72.5%), it indicates that nature base activity providers are tailored to the local context, building upon the idea of GSP being a placed-based offer.

Table A2.6: Geographical scope of nature-based activity providers

Geographical reach	Response (n=120)
Local- based in one town/ city	74 (61.7%)
Regional	22 (18.3%)
Neighbourhood-based	13 (10.8%)
National	11 (9.2%)

Figure A2.4: Geographical scope of organisations



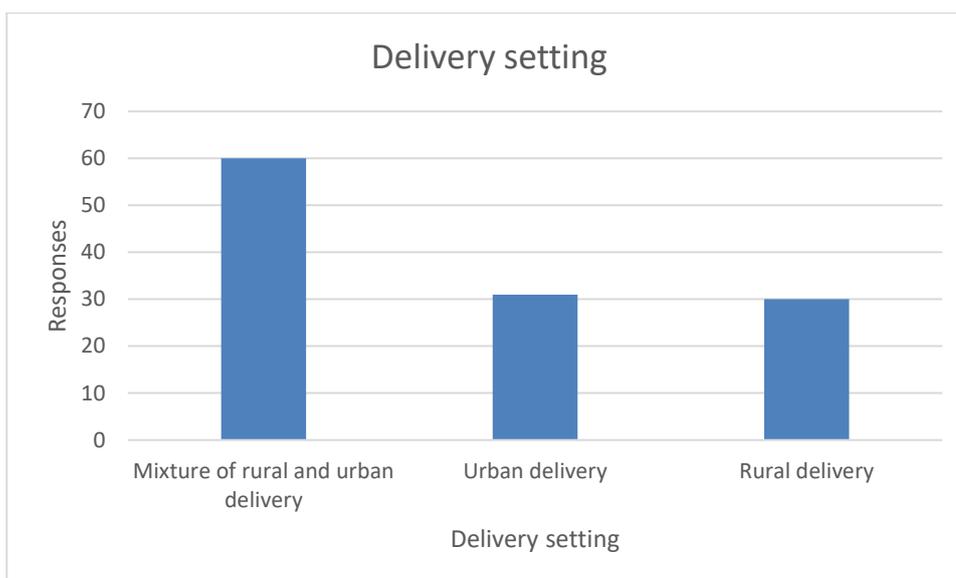
Delivery of services within rural or urban settings (Answered by 121 people)

About half of respondents represented organisations working across both rural and urban areas (n=60, 49.6%) (Table A2.7, Figure A2.5). The remaining were split equally amongst delivery in purely rural and urban areas. This mix may have implications for service delivery, with stakeholders feeling that there may be different barriers such as transport in rural areas, this will be explored further by the Embedded Researchers.

Table A2.7: Delivery setting

Delivery setting	Response (n=121)
Mixture of rural and urban delivery	60 (49.6%)
Urban delivery	31 (25.6%)
Rural delivery	30 (24.8%)

Figure A2.5: Delivery setting



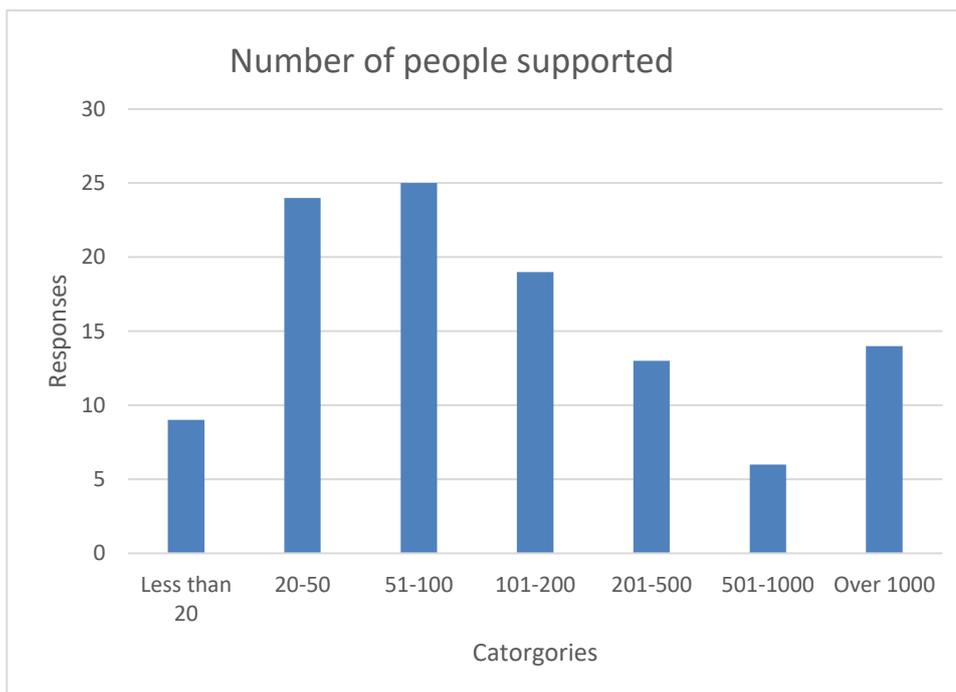
Number of people supported per year (Answered by 110 people)

There was considerable heterogeneity in the number of people each organisation delivered nature-based activities to (Table A2.8, Figure A2.6). The median number was organisations supporting 51-100 people per year with nature-based activities. However, there were also organisations at the other end of the spectrum, from supporting less than 50 people to supporting over 1000 people per year. This highlights the differences in scale of nature-based activities and may have implications for funding and scalability. We also know from talking to providers that there is also a difference between how many people are supported and the amount of support provided- some organisations may provide significant support to a small number of people whereas another organisation may deliver a one-off programme to a large number of people. As with the other questions, this highlights the heterogeneity of nature-based activity providers involved in GSP and the complexity of exploring opium service delivery.

Table A2.8: Number of people supported by nature-based activity providers

Number of people supported annually	Response (n=110)
Less than 20	9 (8.2%)
20-50	24 (21.8%)
51-100	25 (22.7%)
101-200	19 (17.3%)
201-500	13 (11.8%)
501-1000	6 (5.5%)
Over 1000	14 (12.7%)

Figure A2.6: Number of people supported per year by nature-based activity providers



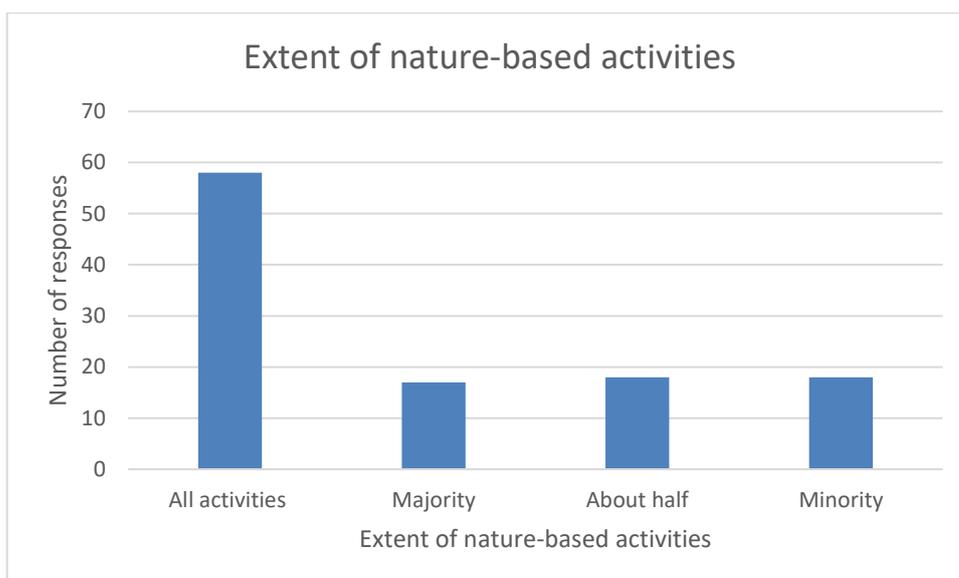
Extent organisations deliver nature-based activities (Answered by 111 people)

About half of respondents said their organisations purely delivered nature-based activities (n=58, 52.2%) (Table A2.9, Figure A2.7). The other respondents were split evenly amongst the other categories: most activities being nature-based, about half and only the minority of delivery. This means there is a considerable mix of providers involved in GSP. This heterogeneity has implications for the delivery of GSP such as the service-user journey.

Table A2.9: Extent organisations' deliver nature-based activities

Role of nature-based activity	Response (n=111)
All our activities are nature-based aimed at improving an individual's health and wellbeing.	58 (52.3%)
The majority of our activities are nature-based but we provide some other types of activity e.g., debt advice or lifestyle coaching	17 (15.3%)
About half of our activities are nature-based and about half are other types of activity e.g., debt advice or lifestyle coaching.	18 (16.2%)
The majority of our activities are not nature-based	18 (16.2%)

Figure A2.7: Proportion of activities that are nature-based



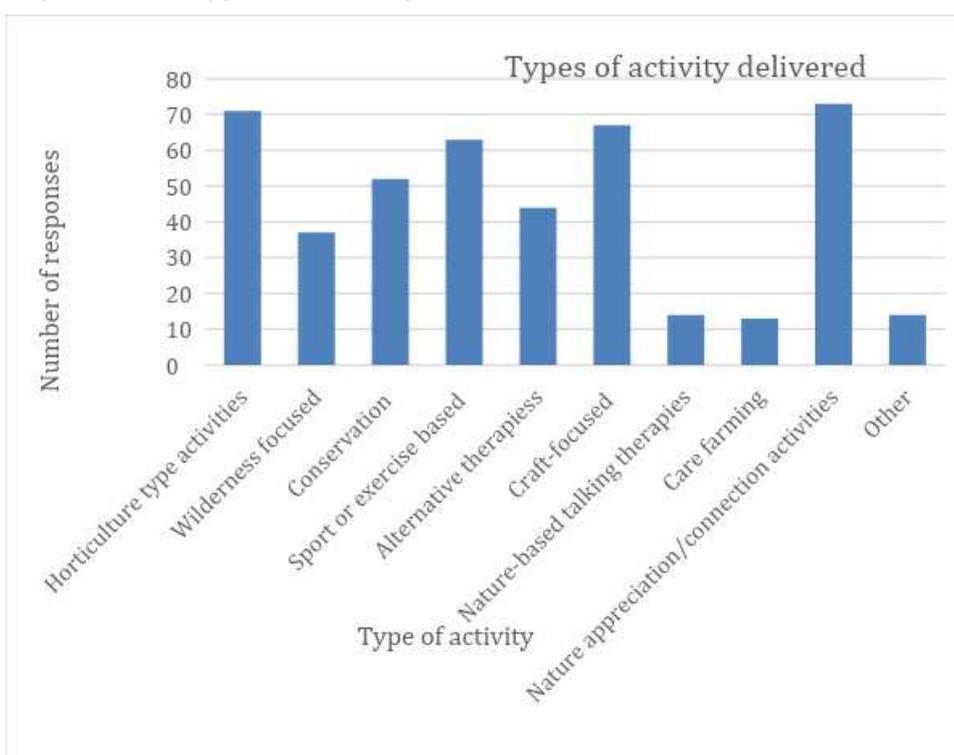
Types of nature-based activities delivered (Answered by 111 people, multiple responses could be provided)

Different types of nature-based activities were being delivered by providers. The most common were activities which included either a nature appreciation/connection component or horticulture activities (Table A2.10, Figure A2.8). Over half of the respondents delivered activities with the following components: nature appreciation/connection activities (73, 65.8%) horticulture type activities (71, 58.7%) craft-focused (67, 60.4%) and sport or exercise based (63, 56.8%). In contrast there was a considerably smaller number of respondents delivering nature-based talking therapies e.g., (n=14, 12.6%) and care farming activities (n=13, 11.7%). Most respondents explained that their organisations offer a range of nature-based activities which had different components. Only one fifth of respondents reported delivering activities which only feature one component such as sport-based activities (n=24, 19.8%) This indicates that many of the providers involved in GSP are delivering a range of activities.

Table A2.10:² Types of activity delivered

Type of activity	Response (n=111)
Nature appreciation/connection activities e.g., engaging with nature, citizen science	73 (65.8%)
Horticulture type activities e.g., growing and caring for plants	71 (58.7%)
Craft-focused e.g., arts and crafts activities using natural resources	67 (60.4%)
Sport or exercise based e.g., green gyms, health walks	63 (56.8%)
Conservation e.g., tree planting or scrub clearance	52 (46.8%)
Alternative therapies e.g., mindfulness activities, spiritual retreats	44 (39.6%)
Wilderness focused e.g., visits to more remote places or bushcraft	37 (30.6%)
Nature-based talking therapies e.g., mainstream talking therapies such as CBT delivered in a natural setting	14 (12.6%)
Other	14 (12.6%)
Care farming e.g., caring for animals	13 (11.7%)

Figure A2.8: Types of activity delivered



² Percentages total over 100% as multiple responses could be provided.

In terms of ‘other’ activities, respondents discussed delivering the following activities:

- Water based activities.
- Self-led access to nature.
- Pet-assisted walks.
- Eco-therapy days.
- Curriculum linked activities to improve learning and engagement.
- Self-led access to nature.

This range of activities again shows the heterogeneity of GSP provision. A couple of people explained that they were developing a programme of work to fit within the GSP programme. This indicates that GSP may be supporting development of new provision within areas, rather than purely supporting existing provision.

Population groups supported (Answered by 113 people, multiple responses could be provided)

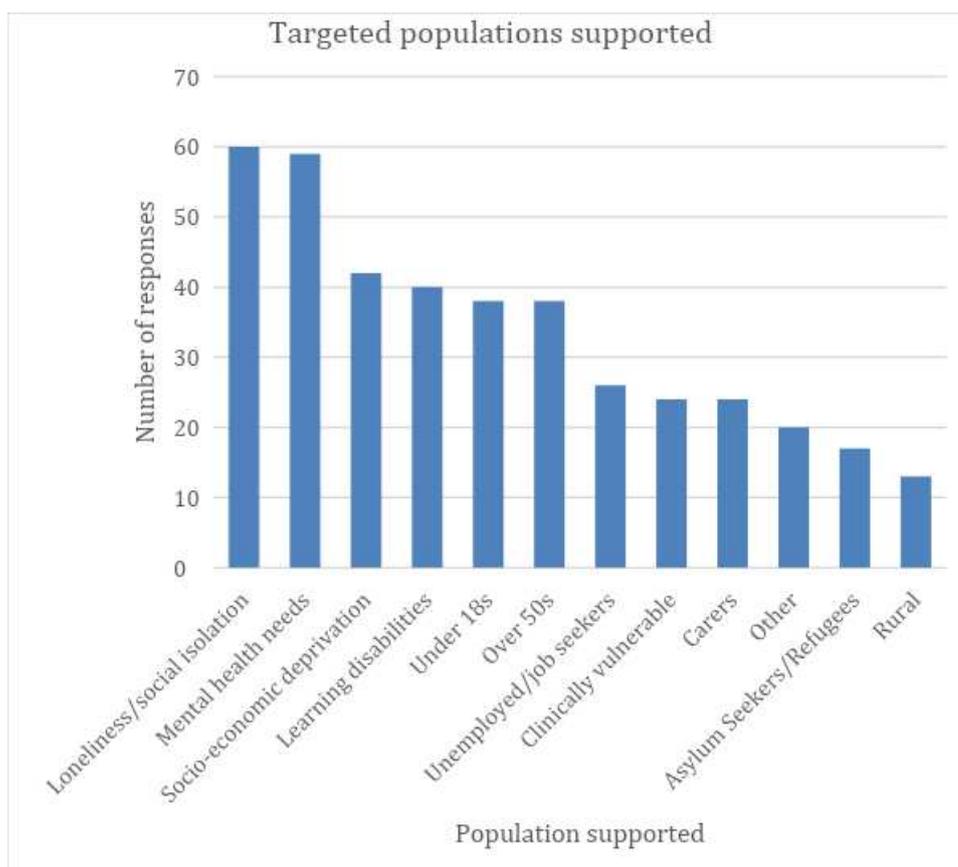
Almost half of respondents delivered a mixture of generic activities and activities that were targeted at specific populations (n=49, 43.4%). Almost a third of respondents represented organisations that served a specific population (n=35, 30.9%). The remaining organisations supported the general population such as those living in the locality (n=29, 25.7%). Organisations targeted their activities at a variety of populations (Table A2.11, Figure A2.9). The most common were activities aimed at people experiencing loneliness and people with mental health needs such as people referred through secondary mental health services. This reflects the scope of the GSP project.

Table A2.11:³ Targeted population group

Targeted population group	Response (n=113)
People experiencing loneliness/social isolation	60 (53.1%)
People with mental health needs e.g., referrals through Community Mental Health Teams	59 (52.2%)
People living in areas of socio-economic deprivation	42 (37.2%)
People with learning disabilities	40 (35.4%)
People under 18 years old	38 (33.6%)
Older adults (over 50s)	38 (33.6%)
People who are unemployed/job seekers	26 (23%)
People who were considered clinically vulnerable during the pandemic e.g., people shielding	24 (21.2%)
People who are carers	24 (21.2%)
Other	20 (17.7%)
People classed as Asylum Seekers/Refugees	17 (15%)
People living in rural areas	13 (11.5%)

³ Percentages total over 100% as multiple responses could be provided.

Figure A2.9: Targeted populations



Alongside, several respondents provided information on other targeted populations they worked with. This included:

- Young people aged 16 – 25.
- People living with their dementia and their carers.
- People experiencing autism.
- People living with physical disabilities.
- People living with sensory disabilities.
- People living with any type of disability (be it physical, mental, or developmental).
- People living with dementia.
- People with limited mobility or at risk of falls.
- People who are leaving care.
- Veterans.
- People who have been part of the criminal justice system e.g., ex-offenders.
- The elderly.
- People from Black, Asian, and other ethnic minority communities.
- Recovering substance misusers.
- Men.
- Women.
- People experiencing homelessness.

- Adults at risk of cardiac condition.
- Children in care or at risk of going into care.
- Children struggling with mainstream education.

The range of specific populations supported highlights the heterogeneity of nature-based activity provision. The range also raises questions about the balance of activity provision for general versus targeted populations and the implications of the different approaches such as in terms of availability of services, accessibility, funding and sustainability.

One person notably commented that they adapt their provision depending on requirements of grant funding. This was because their organisation relies on grants. This response highlights the precariousness of many of the organisations delivering nature-based activities and how the GSP programme may shape provision in an area through funding decisions.

Some organisations delivering more generic nature-based activities raised concerns that certain population groups such as people with accessibility needs or people from ethnic minority groups may feel activities are not welcoming or as inclusive as they could be. A small number of respondents built upon this, feeling that there was a need to ensure communities had positive role models who engaged with nature to encourage involvement from peers.

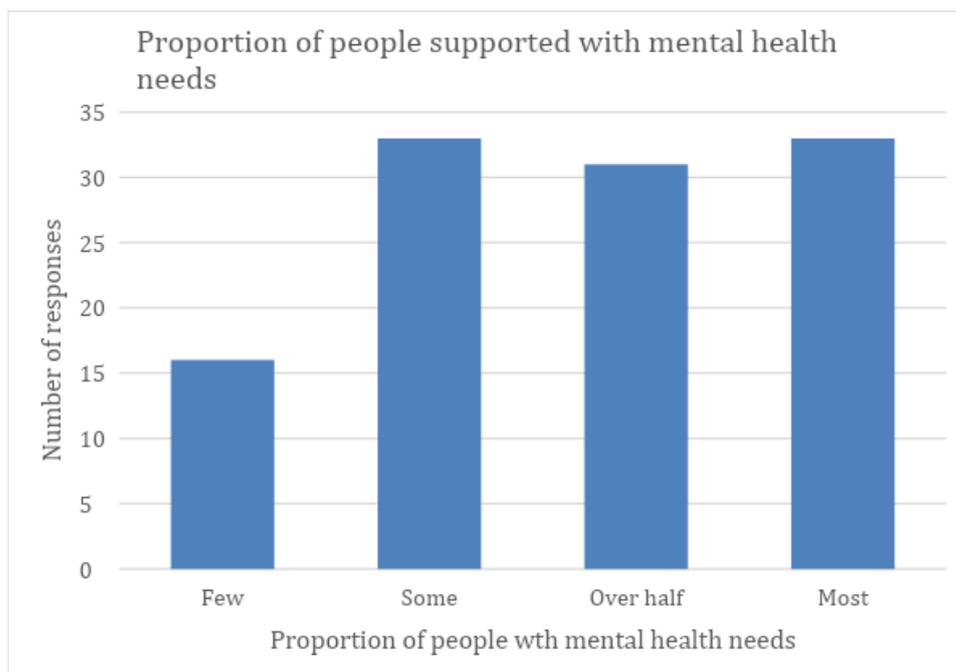
Proportion of people supported with mental health needs (Answered by 113 people)

Generally, nature-based activity providers appeared to support a significant number of people who had mental health needs which had a detrimental impact on their day to day lives (Table A2.12, Figure A2.10). Over a quarter of respondents felt that at least three-quarters of the people they supported had mental health needs which had a detrimental impact on people's lives (n=33, 29.2%). Just over half of responders felt that at least half of their service-users had mental health needs (n=64, 56.6%), A further 33 respondents believed at least a quarter of people had mental health needs (n=33, 29.2%). Only a small number of respondents felt that less than a quarter of their service-users had mental health needs that were detrimental to their day to day lives (n=16, 14.2%). This indicates that people with mental health needs are accessing nature-based activities within the T&L sites.

Table A2.12: Proportion of people supported who have with mental health needs

Proportion of people supported with mental health needs	Response (n=113)
Few (Less than a quarter of people)	16 (14.2%)
Some (A quarter to half of people)	33 (29.2%)
Over half (Half to three quarters of people)	31 (27.4%)
Most (More than three quarters of people)	33 (29.2%)

Figure A2.10: Proportion of people supported with mental health needs



Challenges supporting people with mental health needs (Free-text response)

People reported challenges with supporting people with mental health needs especially in terms of the barriers people can face attending activities and the additional staff resource required to support people to engage and attend. For example, people with chaotic lives needed additional staff support to build up rapport and support service users with attending. The additional staff resource either needs to be funded or a trade-off has to be made to support few service users. For example, one person discussed how their organisation had developed a trauma-informed, person centred induction process. Concerns about supporting people with mental health needs was reflected in requests for mental health centred training such as in terms of suicide prevention (discussed later in the document).

The main challenge is actually getting people to attend, people are often anxious about meeting other people, just getting them through the gates is a result. Sometimes people find it hard to participate in something that takes them out of their comfort zone.

People expressed challenges about working with people with anxiety and unpredictable adherence. There was also the perception from some providers that there were risks supporting people with higher mental health needs including issues building up relationships and safeguarding. Several providers reported high levels of interest and sign-up not translating into regular participation for example due to sleep issues or substance misuse.

One challenge was the reliance of volunteers on delivery whilst also supporting people with higher levels of mental health needs. They felt this could create additional demands on volunteers and the organisations needed to ensure that they provided sufficient volunteer supervision and training, which requires resource.

People also expressed challenges of supporting people with mental health needs to move on from their provision to alternative providers. For example, when the activity was finishing or if the person's needs had changed. Some respondents discussed how this created bottlenecks, preventing the organisation from providing support to new referrals.

Poverty was a factor mentioned by many providers as affecting uptake and adherence to the activities they offered. People experiencing poverty may contribute to mental health needs but also if one is struggling to work due to mental health needs, this can then contribute to financial struggles. Poverty created considerable barriers to engaging in activities including not being able to afford transport or the necessary clothing. So even if activities are free, GSP projects may need to consider how to fund other costs service users experience related to accessing nature-based activities.

Referral routes (Free text response)

Many responders discussed that at present they did not receive many referrals through social prescribing pathways. People felt that Link Workers did not contact them or refer people to them, even though there was a need. Respondents perceived that referral routes were restricted and difficult to access, and thus providers could not reach those in real need. Some of the challenges that were commonly mentioned included raising awareness of their provision with Link Workers, issues with understanding the system and how to raise their profile generally, and how to secure referrals. Many providers raised issues regarding difficulties with promoting their offer and getting on the Link Workers' databases:

The main challenge is having access to referrers or Link Workers. No one from the NHS or [Link Worker provider] has ever put our organisation onto a database. People have found us by accident. I learned from another project that we were expected to find our own clients, which is unethical.

There was a perception by some responders that it was a closed shop, especially in areas where they have used GSP to develop an approved provider list. People felt it was opaque about how to get on this list and people relied on information from other providers to get involved.

Volunteers (Answered by 102 people)

Over 90% of providers utilised volunteers within their organisation. Ninety-two of 102 respondents described the role of volunteers within their organisations (90.2%). Only 10 people (9.8%) stated that volunteers did not have a role within their organisation. This high proportion of organisations utilising volunteers reflects the involvement of voluntary sector organisations within GSP but also has implications for the economic impact and sustainability of GS. For example, the viability of delivery if the organisation had to pay staff rather than utilise volunteers.

People were concerned about their reliance on volunteers especially in terms of capacity and reliability. Some people discussed that their provision was only feasible because of reliance on volunteers but this required investment of training and something offered in return such as qualifications, which had cost implications. Additional concerns raised included a lack of appropriately skilled volunteers, skills deficits, training needs, confidence of volunteers and the reluctance of people to provide 1-1 support. There was concern about the use of volunteers when supporting people with higher level needs, especially relevant given the focus of GSP on mental health.

Information flows

We explored within the questionnaires how nature-based activity providers may record data, their use of outcome measures and good practice they have experienced in terms of information flows with referrers. This will help inform the capacity building needed for Work Package 3A.

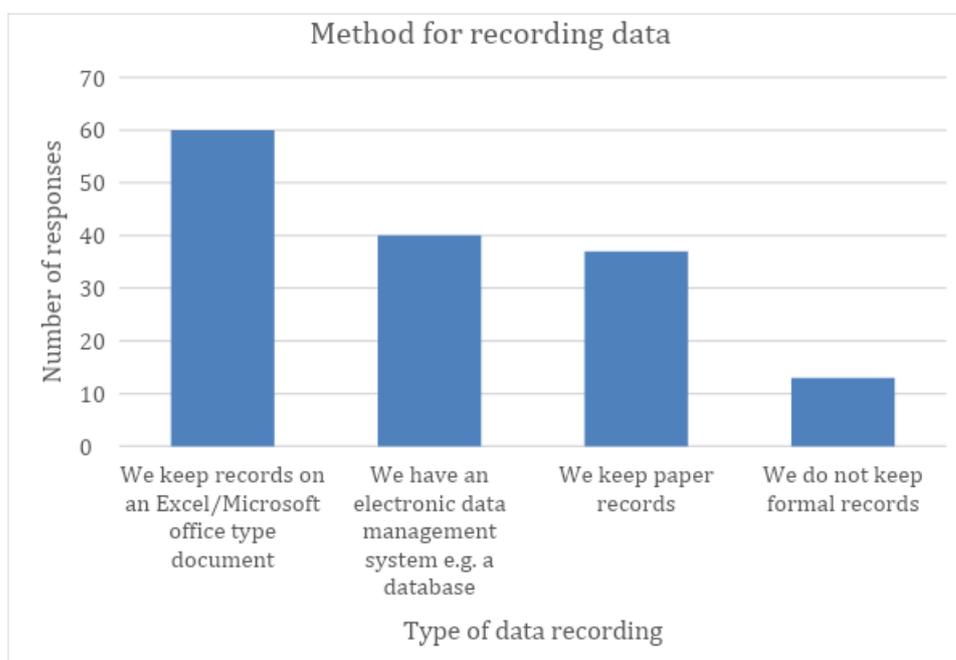
Recording data (Answered by 112 people, multiple responses could be provided)

Nature-based activity providers recorded their data in different ways including using different systems within the same organisation for different projects (Table A2.13, Figure A2.11). The most common method was using software like Excel to record data on their service users. Half of respondents reported using this method (n=60, 53.6%). Just over a third of organisations appear to utilise electronic data management systems (n=40 35.7%). A further third of organisations rely on paper records within some of their activities (n=37, 33%). Furthermore, a small number of organisations are not keeping any formal records for some of their nature-based activities (n=13, 11.6%). This variety of methods demonstrates that nature-based providers are at different stages of being able to capture information. People raised the challenges of being able to demonstrate their activity and impact to make the case for funding. Organisations spoke about needing support and investment to be able to collect information to inform both GSP and to use more generally to generate funding.

Table A2.13:⁴ Method of recording service user data

Method of recording service- user information	Response (n=112)
Use a Excel/Microsoft office type document	60 (53.6%)
Use an electronic data management system	40 (35.7%)
Use paper records	37 (33%)
Don't keep formal records	13 (11.6%)

Figure A2.11: Method of recording service-user data



Collection of Patient Reported Outcome Measures (Answered by 109 people)

Almost half of respondents said that their organisations do not currently collect Patient Reported Outcome Measures (PROMs) (n=53, 48.6%) (Table 2.14, Figure 2.12). PROMs are a tool used within health and social care to measure changes in someone’s health and wellbeing that they may experience when receiving support. This lack of use amongst nature-based providers indicates that there are significant

⁴ Percentages total over 100% as multiple responses could be provided

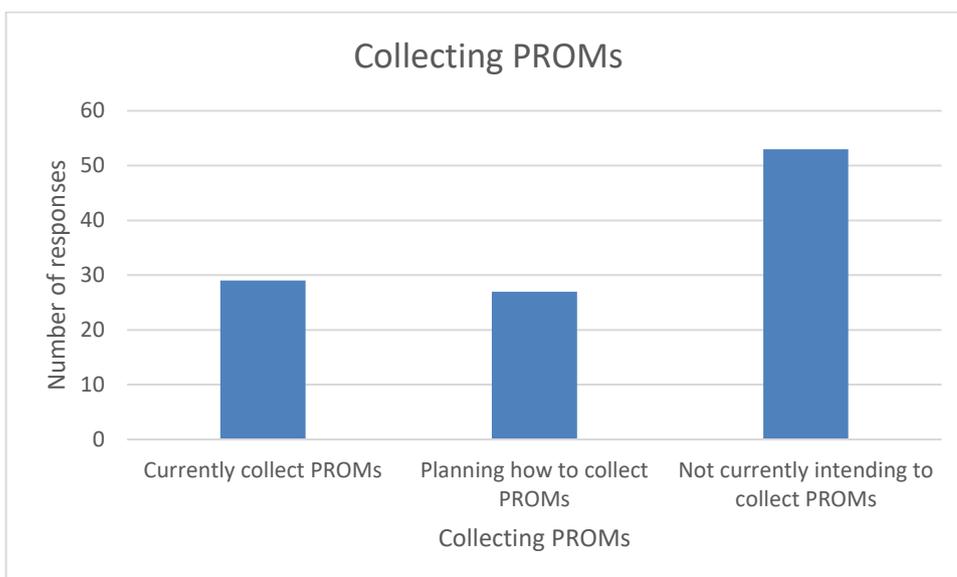
gaps within the system to measure changes in service users' health and wellbeing. It takes time and the investment of resources to implement outcome measures, indicating that there needs to be capacity building within GSP to encourage this. It also means that there may be lower use of PROMs within the routinely collected data to inform WP3A than anticipated when scoping the evaluation.

Building upon this, there is a quarter of organisations planning how to implement PROMs, indicating that providers are interested in utilising measures and there may be improved use of measures during the evaluation (n=27, 24.8%). A quarter of responders said their organisations are currently collecting PROMs (n=29, 26.6%) within their nature-based activities.

Table A2.14: Collection of Patient Reported Outcome Measures

Whether collect PROMs	Response (n=109)
Currently collect PROMs	29 (26.6%)
Planning how to collect PROMs	27 (24.8)
Not currently intending to collect PROMs	53 (48.6%)

Figure A2.12: Whether providers collect PROMs



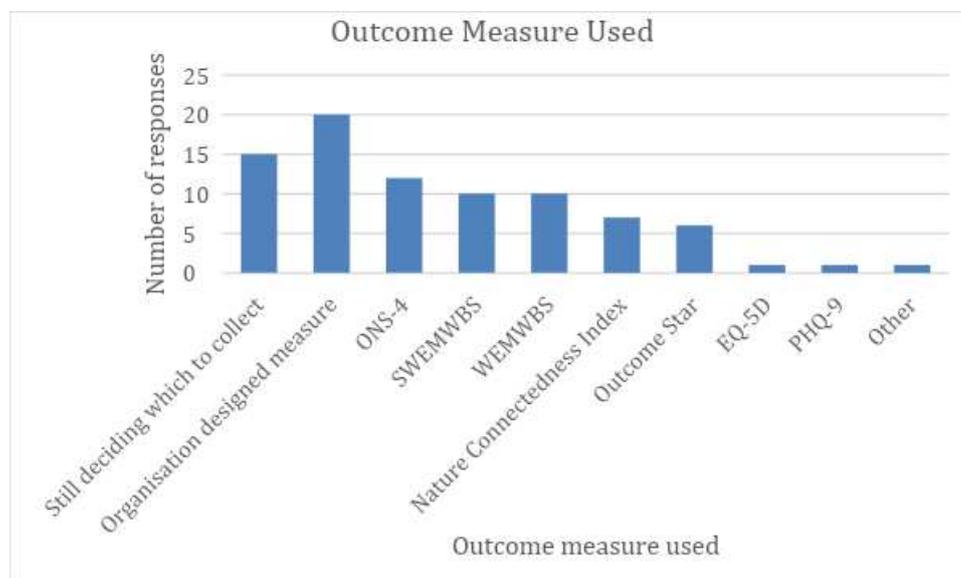
There is a lack of consistency in which PROMs are used by nature-based activity providers. Some organisations were using more than one measure, either because they wanted to use multiple measures or because they were using different PROMs for different activities. Some people provided responses about measures they were planning to collect. About a third of organisations were using a measure that the organisation had designed (n=20, 31.7%). These bespoke measures are likely to differ and not be validated but will be considered acceptable and thus usable within the organisations themselves. Some respondents were still deciding which measure to collect (n=15, 23.8%), indicating that there is interest in adopting measures and potential chances to influence which specific measures are used. Amongst people collecting standardised PROM, the most common type were mental wellbeing measures. The ONS-4 (n=12, 19%) was the most common followed by the full and short Warwick Edinburgh Mental Wellbeing Scales (WEMWBS, SWEMBS) (n=10, 15.9%, each). A small number of organisations used the Nature Connectedness Index (n=7, 11.1%). Only one respondent described their organisation using a specific mental health measure, in this case the PHQ-9 which measures depression. Only one

organisation collected a quality-of-life measure: EQ-5D. Due to the heterogeneity of nature-based providers, it is unsurprising that there is variety in measures collected and this reflects other types of wellbeing activities. However, it also presents challenges for developing a collated evidence base such as performing meta-analysis. It is useful that the most used measure is the ONS-4 because this reflects guidance from NHS England on social prescribing services to use ONS-4, so over time there could be scope at measuring how a person's wellbeing has changed during their GSP journey.

Table A2.15: Type of PROMs used

Outcome Measure	Response (n=63)
Still deciding which measure to collect	15 (23.8%)
Organisation designed measure	20 (31.7%)
ONS-4	12 (19%)
SWEMWBS	10 (15.9%)
WEMWBS	10 (15.9%)
Nature Connectedness Index	7 (11.1%)
Outcome Star	6 (9.5%)
EQ-5D	1 (1.6%)
PHQ-9	1 (1.6%)
Other	1 (1.6%)

Figure A2.13: Measures being used by nature-based activity providers



Feeding back to referrers (Free-text question)

There were some indications of poor information flows between referral organisations and activity providers. In some cases, delivery organisations reported being given very basic, often insufficient information provided by Link Workers (or equivalent) to nature-based activity providers. People wanted further information on service users' specific needs. There were mixed reports of information flows from provider back to the referrer. Some people reported providing feedback to Link Workers or other referral sources. However, other people were more hesitant because of confidential issues. The lack of good practice indicates that T&L sites could explore creating locally tailored templates

of both referral and feedback information processes which ensure sufficient information is shared but which complies with good practice on information sharing.

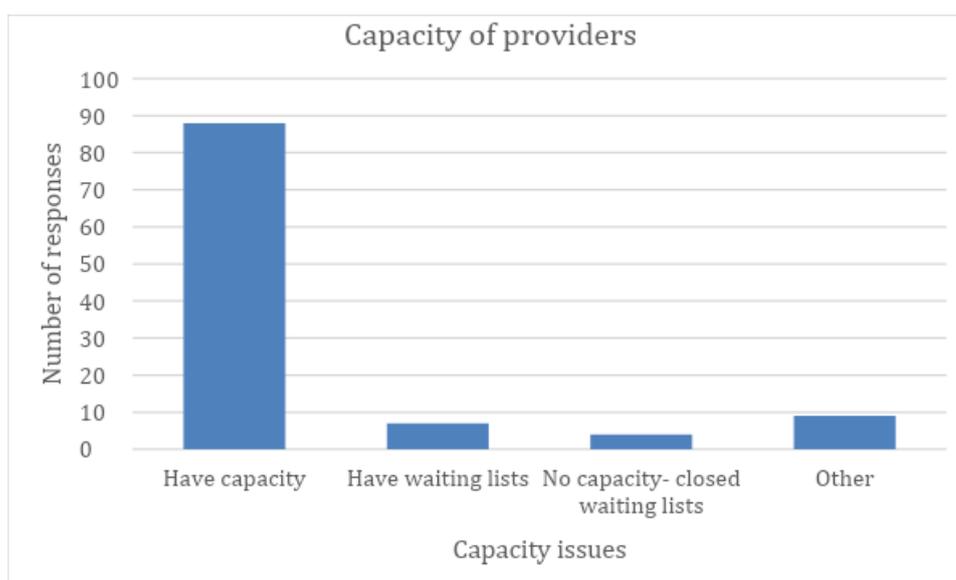
Capacity (Answered by 108 people)

Generally, there appears capacity within the system to increase referrals to nature-based activity providers. A large majority of respondents said their organisation has capacity to accept referrals (n=88, 81.8%) (Table A2.16, Figure A2.14). This demonstrates that there is scope for increased referrals through GSP. A small number of responders said their organisation is currently operating waiting lists (n=7, 6.8%). A few organisations have no capacity to accept referrals and have had to close waiting lists (n=4, 3.7%). The sample was not large enough to explore statistical significance but there appeared a trend that it was smaller organisations supporting less than 50 service-users a year who had capacity issues. This will be explored further by Embedded Researchers because it highlights the potential scalability of GSP when working with smaller providers, especially those that provide targeted activities such as intensive support with young people. A few people added additional comments that they are about to advertise their provision which may impact on capacity whilst another said they were currently expanding capacity. One person commented that Covid-19 and having to have social distancing measures in place reduced capacity. A key part of the follow-up questionnaire will explore the implications of improved partnerships and referral routes within GSP and how these impact on capacity.

Table A2.16: Capacity of nature-based activity providers

Whether providers have capacity	Response (n=108)
Have capacity for people to access our activities	88 (81.5%)
Currently at capacity and have waiting lists	7 (6.5%)
Have no capacity and have closed waiting lists	4 (3.7%)
Other	9 (8.3%)

Figure A2.14: Capacity of providers



Reports regarding current capacity were mixed. There were many reports of no issues with capacity. For some providers they were running under capacity, struggling to attract people to attend. Some providers discussed this related to the poor or non-existent relationships with Link Workers and lower than expected referrals. One

provider suggested that poor connections with Link Workers is a factor in their capacity issues:

We are not connected at all with Link Workers and social prescribers in any adequate or meaningful way. We work with school groups mainly but could take on other work and service users.

Other providers linked lower than expected referrals to accessibility and transport. These issues also arose within the Link Worker questionnaires in terms of barriers of making referrals. So, availability of nature-based activity provision is itself not enough, it needs to be within the context of there being wider infrastructure to enable service users to access support. For example, someone said that their location was difficult for service users to attend on public transport.

Another responder discussed that uncertainty and variable referrals and arrivals is limiting their organisation's ability to deliver:

Yes recently opened up for an additional day and the referrals that were on the waiting list didn't translate into places so we have left the additional day for now. St other times we don't get enough referrals even though we have added other client groups, for example, people with learning difficulties. I have been told by a Social Worker contact that within social services, staff tend to refer to organisations who have contracts with the local authority. That is a problem for us as well as for appropriate referrals for people who would benefit from a good fit rather than a referral to an organisation purely based on contractual status.

A common capacity issue related to funding including being able to extend support to different areas or populations groups. People recognised that having to limit capacity to specific groups due to funding restrictions could contribute to inequity such as provision between parts of a national park.

We are close to being at capacity and this due to demand for activities supporting individuals with more complex needs. To provide more interventions, we would need more funding.

Alongside funding, there were other constraints to developing capacity including staff, the size of site or availability of equipment. People discussed being limited in capacity because of not having sufficient staff or because more staff are needed to meet service users' specific needs. One respondent reported that their staff were not skilled or necessarily willing to deliver GSP. Other comments related to the multiple demands on staff time and skills. There were many mentions of staff being overstretched. Some reported that more staff were needed for mixed ability/needs groups to accommodate and care for everyone's individual needs.

Offering specialist support such as to people with learning disabilities also had a detrimental impact on capacity. This was because the more intensive support meant fewer people could be supported. For example, due to safeguarding processes or not being able to introduce new attendees because current service users struggled with the group changing.

Capacity issues are also related to the onward movement of participants through and out of nature-based programmes or moving on to other forms of nature-based provision. Respondents from all sites reported this as an issue:

Our main difficulty is to move participants on to other providers. We have had to re-evaluate the time participants have access to our activities from 6 months to 9 months. We are aiming to review where participants are at 6 months and actively

encourage them to think about follow on activities over the following 3 months. We introduce them to other providers but there is some anxiety about moving to other providers. Some form of support to do this would be extremely helpful. 'Green Buddies' are planned.

This indicates that there is a need for T&L sites to not just think about provision per se but how the support fits together through a service-users journey especially taking account of mental health needs which may not follow a linear trajectory.

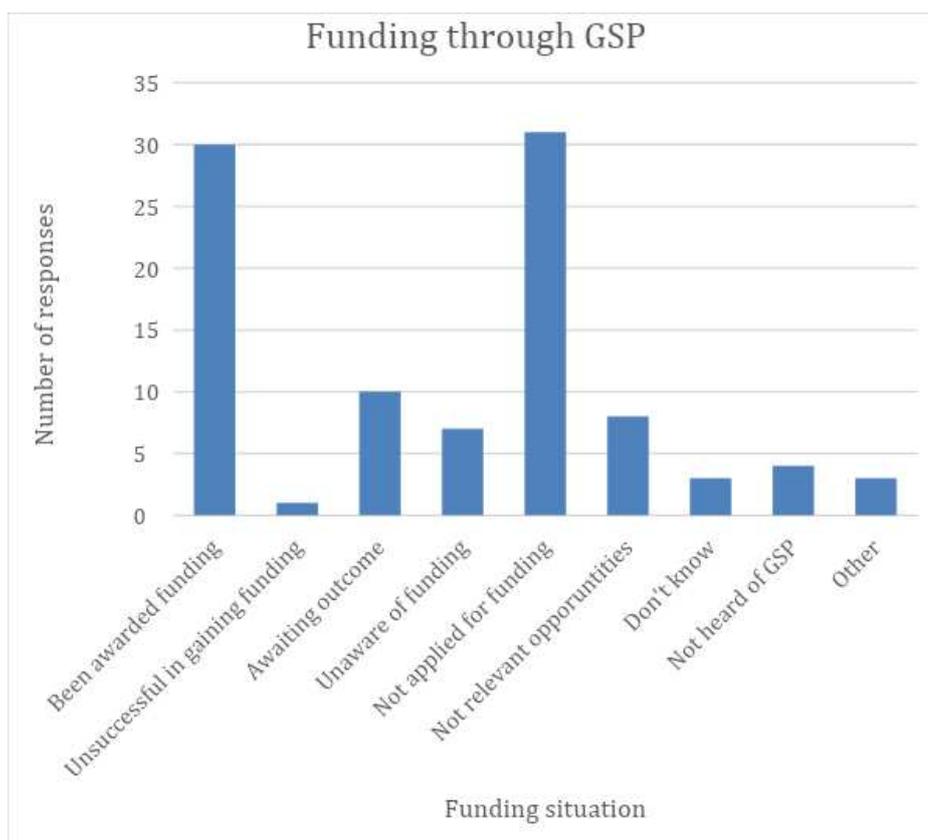
Funding through GSP (Answered by 97 people)

Just under a third of respondents said their organisation had received funding through the GSP programme (n=30, 30.9%) (Table A2.17, Figure A2.15). A similar number had not applied for funding (n=31, 32%). There were some people who were awaiting a funding outcome (n=10, 10.3%). Other providers had not been aware of funding (n=7, 7.2%) or there had not been relevant opportunities to apply (n=8, 8.2%). This is to be expected given the diversity of nature-based activity providers involved and the different approaches T&L sites have taken to funding. Only one respondent had been unsuccessful in applying for funding. This raises questions about whether there are providers who are perhaps less engaged since being unsuccessful in their applications and the need to ensure that their voices are heard in the evaluation. Some respondents provided other experiences. One person was disgruntled because they had been trying to find out about potential funding through GSP and did not feel anyone could provide them with information on this and that they were fobbed off. One organisation had received funding through a similar programme being run in one site that was linked to GSP. Finally, another respondent said that their organisation had been subcontracted by an organisation that had received funding. This sub-contracting of services reflects the wider management of voluntary sector contracts.

Table A2.17: Whether organisations have received funding through GSP

Funding through GSP	Response (n=97)
Have been awarded funding	30 (30.9%)
Awaiting outcome	10 (10.4%)
Funding was unsuccessful	1 (1%)
Not aware of funding through the project	7 (7.2%)
Not applied for funding	31 (32%)
Not been relevant opportunities to apply for	8 (8.2%)
Don't know	3 (3.1%)
Not heard of GSP	4 (4.1%)
Other	3 (3.1%)

Figure A2.15: Whether organisations received funding through GSP



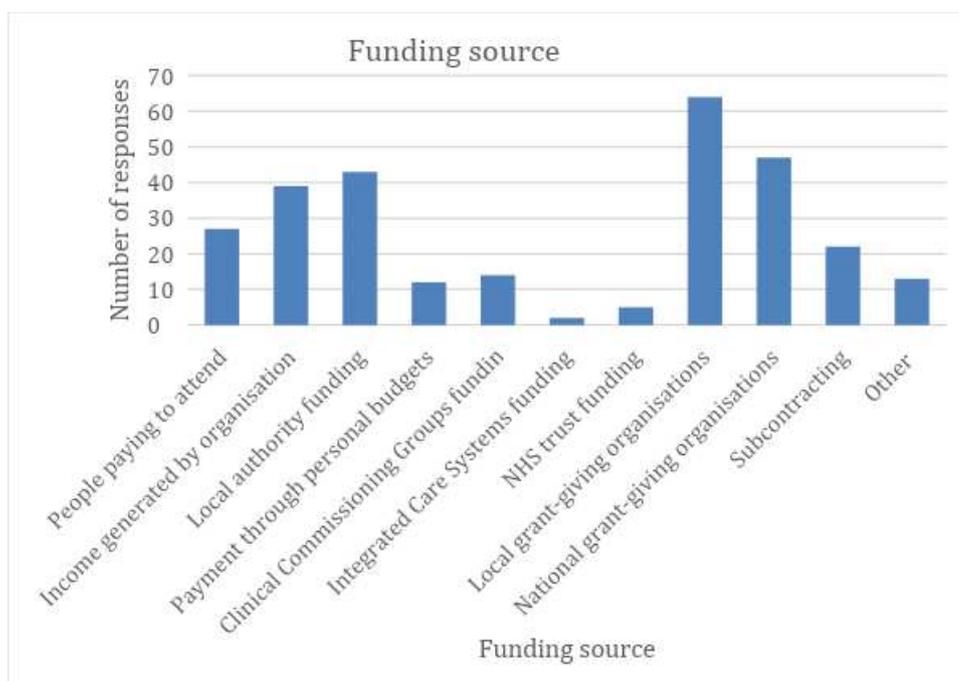
Funding sources (Answered by 105 people, multiple responses could be provided)

Nature-based activity providers generally have a mixed funding model, being funded by different sources to deliver their GSP related activities (Table A2.18, Figure A2.16). Just under three quarters of organisations were funded by two or more funding sources (n=70, 72.2%). This mix is partly because of how many of the nature-based providers were voluntary sector providers, who may draw upon a range of funding sources to sustain their operations. The most common source was local grant giving organisations (n=64, 61%). The next two most prominent sources were national grant giving organisations such as the lottery (n=47, 44.8%) and funding from local authorities (n=43, 41%). Despite the focus of GSP being on supporting people with mental health needs, only a fifth of responders said their organisation received any funding from NHS mental health or acute trusts (n=5, 4.8%) and/or NHS commissioning bodies (n=16, 15.2%). Some organisations charged people to attend some of their activities, which provides income (n=27, 25.7%). In terms of 'other' responses, some people explained that they have no funding at present and any provision is purely delivered by volunteers. Another responder said that they had recently registered their organisation with the charity commissioner to provide opportunities to then apply for grants. One person discussed that their provision was funded by several start-up grants. The mix of funding and the fixed term nature of funding such as through grants highlight that the nature-based provision is precarious, which may create challenges for the creation of ongoing pathways and sustainability of GSP. This issue was raised within the free-text questions, respondents expressed concern about the insecurity of funding. They felt that it was getting harder to generate grant funding. However, people felt that they would struggle to get participants to pay for attendance, raising questions about how to sustain provision.

Table A2.18:⁵ Sources of funding

Funding Sources	Response (n=105)
Funding from local grant-giving organisations	64 (61%)
Funding from national grant-giving organisations	47 (44.8%)
Funding from the local authority (grant or commissioned services)	43 (41%)
Income generated by the organisation e.g. renting properties, fund-raising	39 (37.1%)
Income generated from people paying to attend	27 (25.7%)
Funding from being subcontracted to deliver work	22 (21%)
Funding from Clinical Commissioning Groups (grant or commissioned services)	14 (13.3%)
Other	13 (12.3%)
Income generated from people paying to attend through arrangements like Personal Budgets	12 (11.4%)
Funding from NHS acute or mental health trusts e.g. the local hospital	5 (4.8%)
Funding from Integrated Care Systems (grant or commissioned services)	2 (1.9%)

Figure A2.16: Sources of funding



Aspirations for being involved (Answered by 109 people, multiple responses could be provided)

People were asked about their aspirations of being involved in the GSP project. Almost half of the respondents ticked all of the options for aspirations of being involved (n=46, 42.2%) (Table A2.19, Figure A2.17). This indicates that people hoped being involved would enable their organisation to increase the number of service-users they supported, access funding, establish new referral routes and networks, share learning,

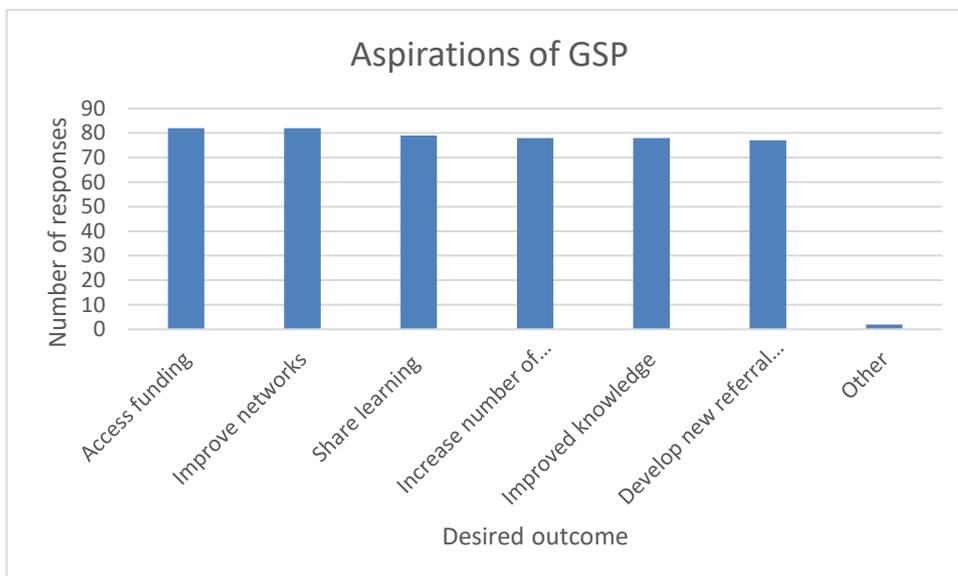
⁵ Percentages exceed 100% as multiple responses could be provided.

and increase their knowledge of GSP. This wide range of aspirations indicate that there are considerable expectations from nature activity providers about GSP. More generally, there were a similar number of respondents for all the aspirations- indicating that nature activity providers may have different aspirations but as a collective they are similar in relation to improving partnerships, increasing service-users, improving sharing of good practice and increasing funding. There were also a handful of other aspirations given including wanting to work with secondary mental health services and raising the importance of having a healthy environment. This range of responses highlight that people value the potential partnership opportunities and sharing of practice from being involved in GSP, the GSP project is not solely viewed as a funding programme. In the follow-up questionnaire, we will explore whether these aspirations have come to fruition and how that may impact on the people's perspectives and engagement with GSP.

Table A2.19:⁶ Aspirations of nature-based activity providers for being involved in GSP

Aspirations	Response (n=109)
Access funding	82 (75.2%)
Improve networks	82 (75.2%)
Share learning	79 (72.5%)
Increase number of service-users	78 (71.6%)
Improved knowledge on GSP	78 (71.6%)
Develop new referral routes	77 (70.6%)
Other	2 (1.8%)

Figure A2.17: Aspirations for being involved



Skills and knowledge (Answered by 109 people)

Two-thirds of respondents felt they had sufficient skills and knowledge to support the development of the GSP project in their locality (Table A2.20, Figure A2.18). Of the 109 respondents, 18 strongly agreed with the statement (16.5%) and 56 people agreed (51.4%). A small number of people disagreed (n=11, 10.1%) and 24 people neither

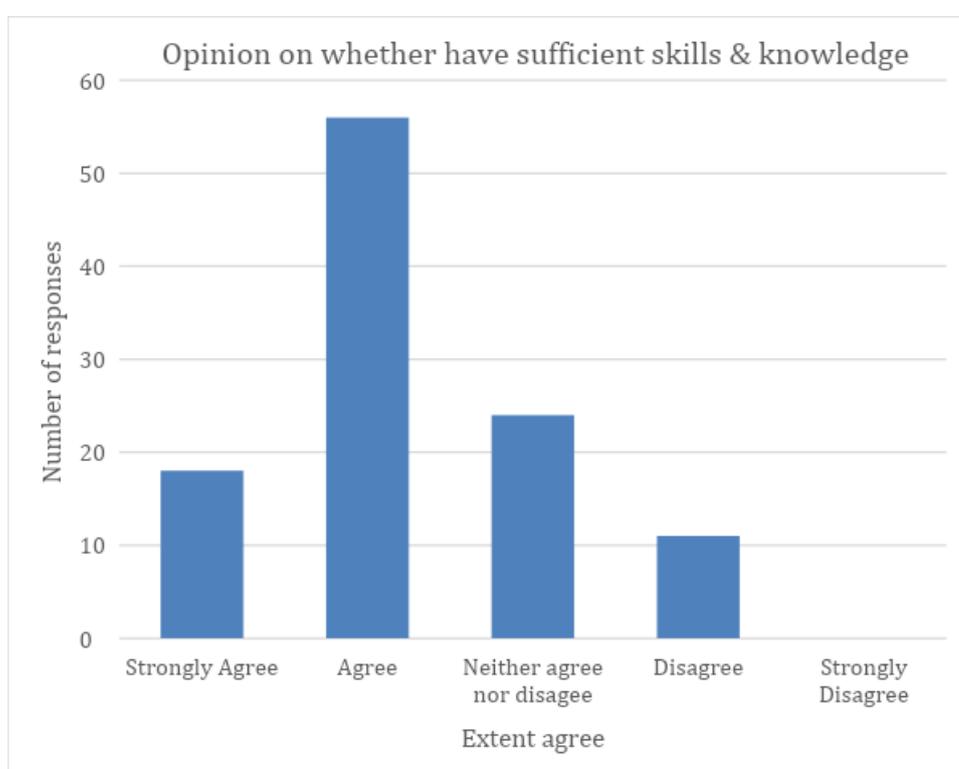
⁶ Percentages exceed 100% as multiple responses could be provided.

agreed nor disagreed (n=24, 22%). This indicates that generally people do feel sufficiently skilled in delivering GSP.

Table A2.20: Extent people feel they have sufficient skills and knowledge about GSP

Opinion	Response (n=109)
Strongly agree	18 (16.5%)
Agree	56 (51.4%)
Neither agree or disagree	24 (22%)
Disagree	11 (10.1%)
Strongly disagree	0 (0%)

Figure A2.18: Extent people feel they have sufficient skills and knowledge about GSP



Although respondents felt they had general skills and experience in GSP, a number of people suggested specialist training that they needed. This included:

- Monitoring and evaluation including outcome measures.
- Understanding and gaining entry to the system, funding and commissioning processes.
- Mental health first aid, best practice working with individuals with mental health needs, counselling, conflict resolution, advanced communication, negotiation skills, suicide prevention.
- Safeguarding.
- Practical activities in terms of delivery of mental health activities outdoors.
- Business mentoring.
- Networking, connection with other community services.
- Staff and volunteer training and support.

- Site development.
- Community engagement in deprived areas.

Some of these relate to providing more specialist support to people with mental health needs, reflecting the focus of GSP. Other training relates more to the development of the GSP pathway such as links between organisations. Some training related to nature-based providers specifically. These suggestions for training highlight that people do value the GSP programme running training and development opportunities.

Opinions on the GSP project to date (Numbers answering varied on specific question)

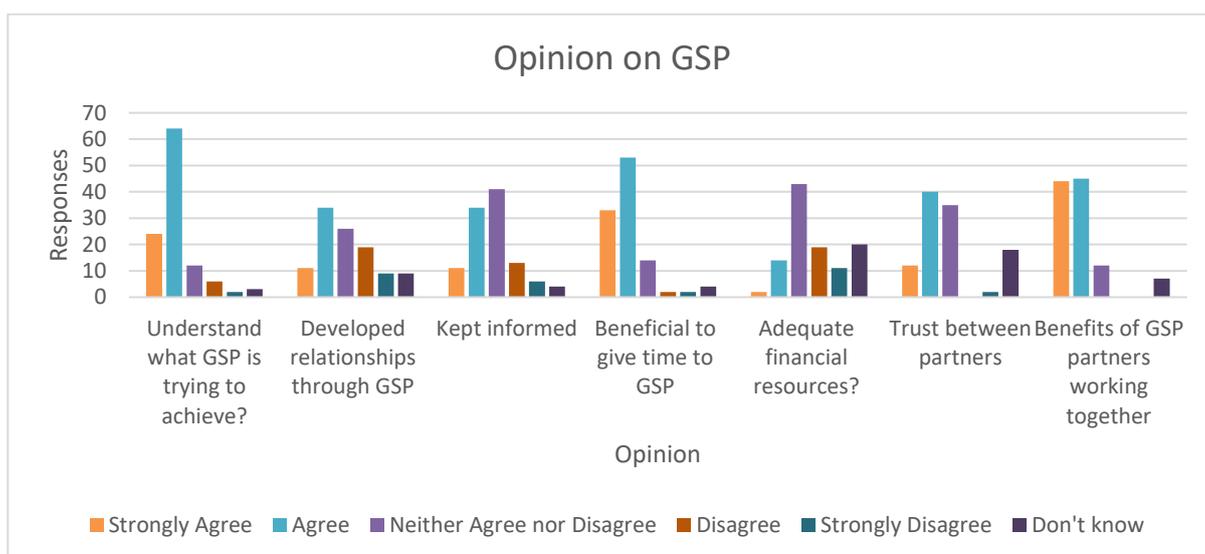
Based on a Likert Scale, respondents were asked a series of questions about whether they agreed or disagreed about statements relating to the GSP project (Table A2.21, Figure A2.19). Generally, people agreed with the statements that investing time in GSP was a worthwhile experience, there was trust between partners and there were benefits of people working together. People had more mixed responses in terms of whether they had developed relationships through being involved in GSP and whether they felt they were adequately kept informed. Respondents also gave more mixed responses about whether there were adequate financial resources associated with GSP. This indicates that T&L sites may need to do more to proactively communicate with relevant stakeholders and organise opportunities for people to build up partnerships. The financial resource question indicates that many respondents felt that there are not sufficient financial resources within GSP, this will be further explored by the Embedded Researchers.

Generally, people expressed considerable enthusiasm for the GSP programme. Some respondents welcomed the opportunity to network, share knowledge, skills and experiences. However, some people expressed low awareness of the purpose of the GSP especially in terms of the benefits for activity providers like themselves. Other people said they had yet to become involved or that it was too early yet to have an opinion of whether it was working or not. Some people felt that to date, the GSP programme had not engaged with their organisation in a meaningful manner. This highlights a challenge for T&L sites in terms of which providers they do and do not reach and the implications within the sector if some but not other organisations are involved.

Table A2.21: Opinions on the GSP project

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Don't know/ Don't have an opinion
Understand what GSP is trying to achieve? (Answered by 111 people)	24 (21.6%)	64 (57.7%)	12 (10.8%)	6 (5.4%)	2 (1.8%)	3 (2.7%)
Developed relationships through GSP (Answered by 108 people)	11 (10.2%)	34 (31.5%)	26 (24.1%)	19 (17.6%)	9 (8.3%)	9 (8.3%)
Kept informed (Answered by 109 people)	11 (10.1%)	34 (31.2%)	41 (37.6%)	13 (11.9%)	6 (5.5%)	4 (3.7%)
Beneficial to give time to GSP (Answered by 108 people)	33 (30.5%)	53 (49%)	14 (13%)	2 (1.9%)	2 (1.9%)	4 (3.7%)
Adequate financial resources? (Answered by 109 people)	2 (1.8%)	14 (12.9%)	43 (39.5%)	19 (17.4%)	11 (10.1%)	20 (18.3%)
Trust between partners (Answered by 107 people)	12 (11.2%)	40 (37.4%)	35 (32.7%)	0 (0%)	2 (1.9%)	18 (16.8%)
Benefits of GSP partners working together (Answered by 108 people)	44 (40.7%)	45 (41.7%)	12 (11.1%)	0 (0%)	0 (0%)	7 (6.5%)

Figure A2.19: Perceptions of GSP



What is working well and what is not working well? (Free text question)

Respondents were asked to describe what they felt was and was not working well, with a range of responses given. Some of the positive feedback included:

- The opportunities for awareness raising, networking, shared learning.
- Training provision.
- Opportunities to support delivery.
- Availability of grants.
- Responsiveness of Project Managers to providers.
- Information on monitoring and evaluation.
- Sharing information on impact.

Alongside the positive feedback, there was a range of feedback provided about what was not working well, some of which was the mirror opposite of the positive feedback. This highlights that providers will have different experiences of GSP especially given the heterogeneity of nature-based activity providers. Some of the feedback was quite negative, indicating that there perhaps needs to be more opportunities within the T&L sites for providers to be able to share criticism so that this can be used to improve the programme. Many of the comments relate to people feeling that engagement has been disjointed, they have not been kept updated about what is happening and there has not been an increase in referrals from social prescribing pathways. Ultimately some people felt that the GSP is failing in its mission as it had not yet generated any further referrals to them. Key feedback included:

- Uncertainty regarding the necessity or rationale for the division of GSP from other forms of social prescribing.
- Lack of support for new entrants into the GSP system.
- Lack of awareness of funding opportunities and how to access to funding over longer time periods, lack of guidance on factors such as alternative funding routes and how to become an approved supplier.
- Poor communication e.g., cancelled meetings or people not aware how can become part of meetings.
- Inability to engage sufficiently- people were concerned about being able to engage in the co-creation process as there is a large numbers of meetings/workshops.
- Lack of recognition of existing knowledge- people felt there were already people and organisations within the system with significant knowledge. They would like greater value to be placed on this and more opportunities to gain learning from organisations doing this well.
- People felt that the GSP programme needed to be longer because it takes considerable time to develop relationships, pathways, and systems.
- There needs to be more support for overcoming challenges such as how to engage Link Workers.
- Inadequate focus on improving the referral pathways including contact between Link Workers and providers.
- People were concerned that there is not sufficient wider infrastructure in place such as transport to support people to attend activities. Responders described how purely funding providers is not sufficient as there are other barriers.
- Issues with delivery of activities such as being able to find sufficient land to expand provision and how that may be detrimental to the GSP pathway.
- Feeling that there needed to be greater opportunities to network.

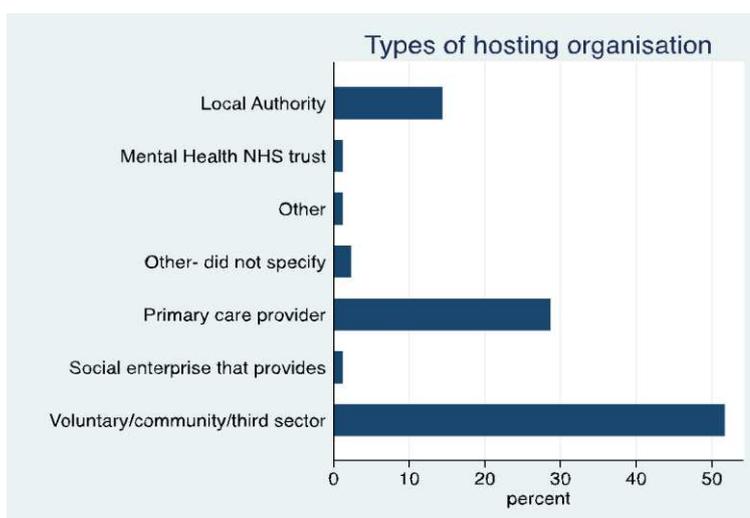
Summary

The questionnaires provided a valuable opportunity to collect feedback from a range of Link Workers and nature-based activity providers. There is considerable heterogeneity of providers in the system and the activities provided which creates complexity in terms of GSP pathways. There needs to be improved referral pathways between Link Workers and nature-based activity providers as there is capacity for more service users to access nature activities. Consideration needs to be given to the whole GSP pathway such as people not only accessing nature-based activities but between providers, such as to less intensive support. GSP activities are providing considerable support to people with mental health needs, but this requires more staff resource, who need specialist training. The reliance on volunteers and grant-based funding means there is considerable precariousness. People hope that GSP will enable the sharing of good practice, development of partnerships and enable more service users to access nature-based provision. The follow-up questionnaire early in 2023 will enable an exploration of whether these aspirations have been met and the sustainability of GSP.

A2.7. Analysis of the Link Worker Questionnaire

Link Worker survey – interim descriptive analysis

We received 91 responses. These were across 7 sites. The majority (n=47) were hosted in voluntary sector organisations, the remainder spread across primary care, mental health and other providers:



Closed questions results

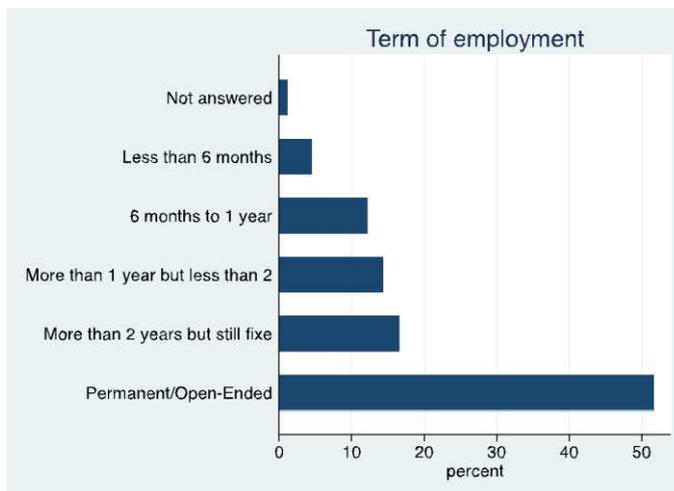
Of all respondents, 87% (n=79) reported offering 'generic' support as opposed to 'targeted' (13%, n=12). The majority of respondents (56%, n=51) stated that their work covered both rural and urban areas, with 37% (n=34) working only in urban areas, and only 7% (n=6) solely rural areas. Our sample was experienced, with the majority (34%, n=31) having been in their role for longer than 2 years:



Almost all (78%, n=71) of respondents worked over 30 hours a week, 8% (n=7) worked between 22.5 and 30 hours, 10% (n=9) worked between 15-22.5 hours and the remainder working fewer than 22.5 hours a week in this role.

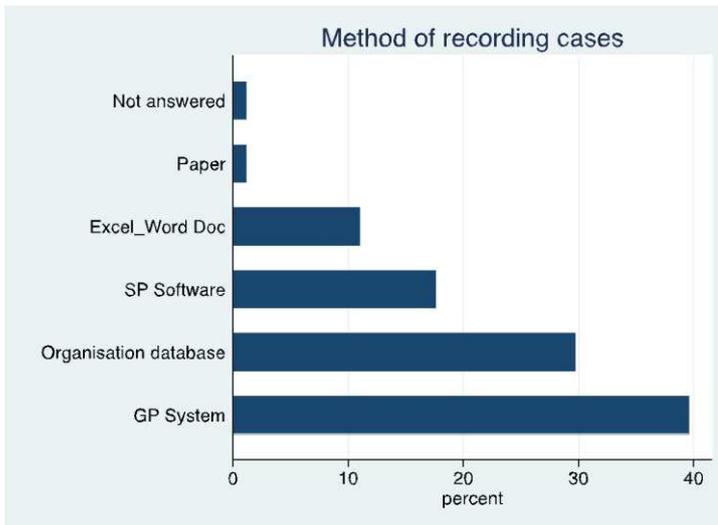
Importantly, 45% of the sample had worked unpaid hours – either occasionally (33%, n=30) or regularly (13%, n=12). Fifty-two percent (n=47) did not work additional unpaid hours.

The majority 52% (n=47) were on permanent or open-ended contracts with their employing organisation:



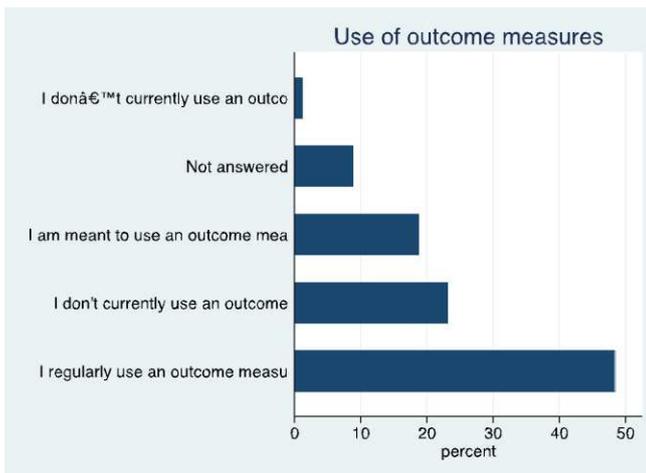
Methods of working

Of our respondents, 77% (n=69) did not have any support from volunteers to deliver their service (either accompanying individuals directly or delivering leaflets etc.). In terms of recording cases, the majority (40%, n=36) used a GP system of some sort:



In terms of identifying where Link Workers were referring people, the majority (70%, n=64) felt it would be 'straightforward' to identify where people went, with 18%, n=16 feeling it would be difficult but possible. The remainder felt it would not be possible to get that information or did not answer.

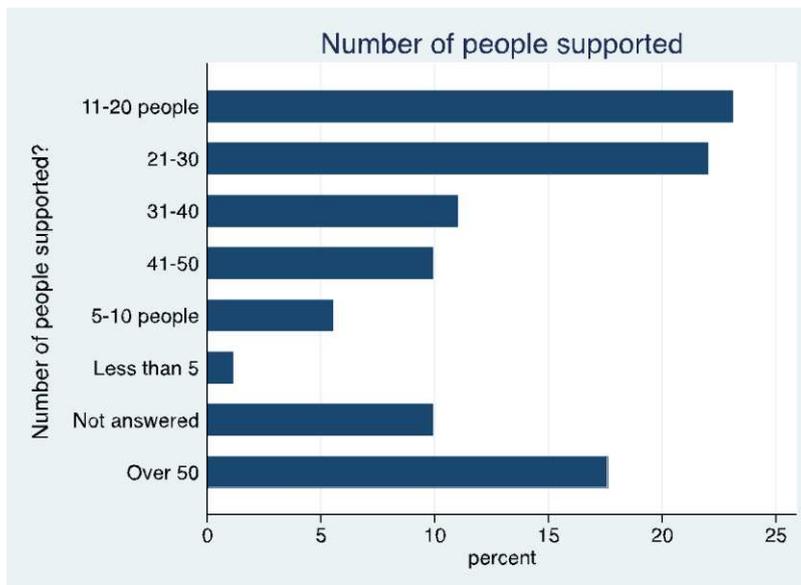
In terms of using outcomes, there was diversity, however, the majority (48%, n=44) did regularly use outcome measures:



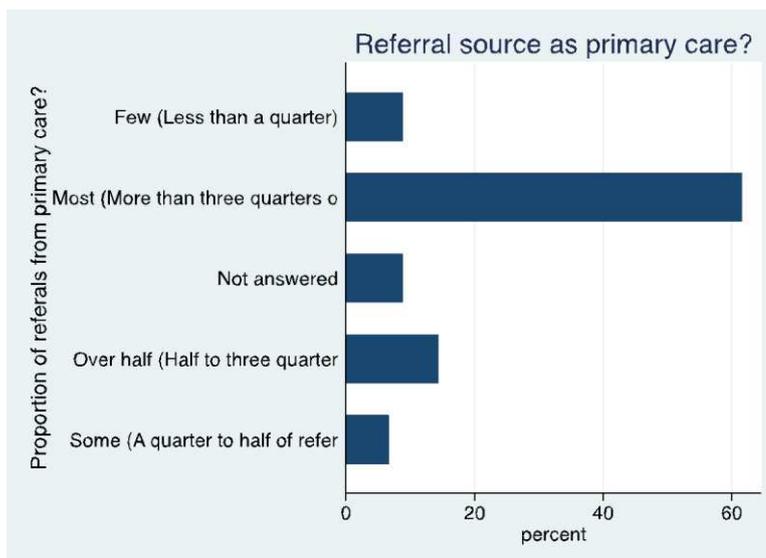
Outcomes measures used were diverse. Of those collecting that information, most commonly used on their own were ONS-4 (30%, n=27), followed by Outcome Star (10%, n=9); however, combinations of ONS, PAM, and WEMWBS were also reported.

Cohort supported

In terms of who the Link Workers were supporting, there was a relatively broad spread reported:



The referral route for these individuals (i.e., from where they were referred to the Link Worker) was, for the most part, from Primary Care (with 62%, n=56 stating that 'most, over ¾' came from that route):



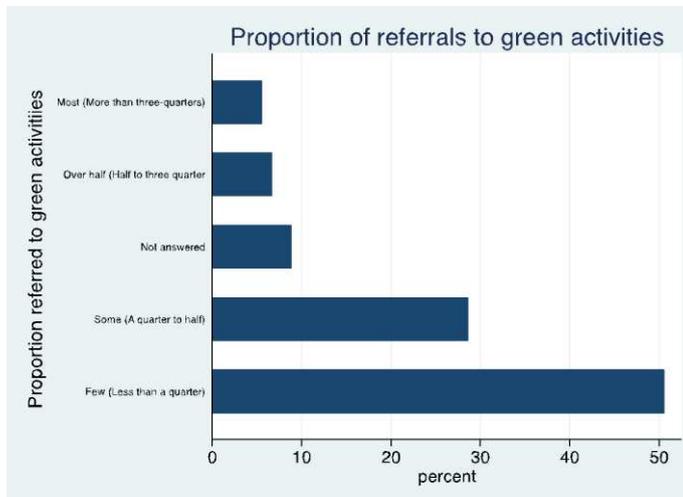
Interestingly, of those we surveyed, 80%, (n=73) reported over half of their referrals as being related to mental health.

Proportion of referrals with mental health needs?	Freq.	Percent	Cum.
Few (less than a quarter of referrals)	2	2.20	2.20
Most (More than three quarters of referrals)	50	54.95	57.14
Not answered	8	8.79	65.93
Over half (Half to three quarters of referrals)	23	25.27	91.21
Some (A quarter to half of referrals)	8	8.79	100.00
Total	91	100.00	

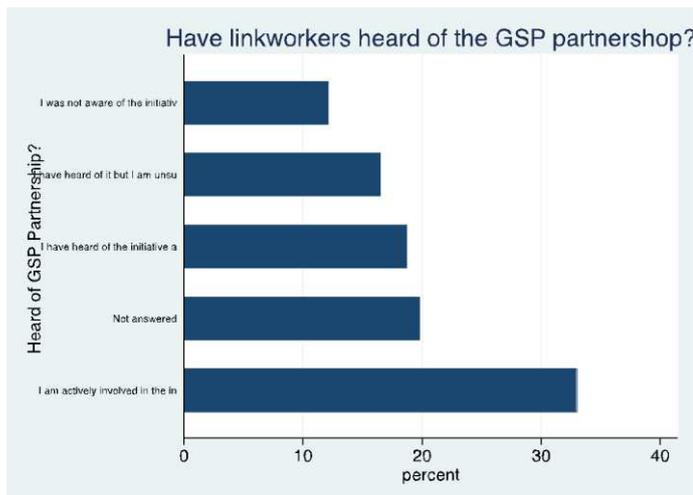
Green Social Prescribing elements

Whilst all our respondents were answering based on their involvement in the green social prescribing programme and so all preceding answers are framed in that context, we did also include variables that specifically relate to green social prescribing activity.

Firstly, we were interested in what proportion of referrals Link Workers made onwards to green activities. For most (51%, n=46) green activities comprised fewer than a quarter of their referrals, with 29% (n=26) reporting that under half of their referrals were green. Only 12% (n=11) reported over half their referrals being to green activities.



Our sample were, mostly, actively involved in the GSP partnership (33%, n=30). A further 19%, n=17 had heard of and understood the aims of the partnership; however 28%, n=26 had either not heard of or were unsure what the partnership aims were.



More broadly, but relatedly, 60% (n=55) of our sample felt that they understood what the hopes for GSP were, with only 21% (n=19) reporting that they did not, or were not sure, what those hopes were.

I understand what GSP hopes to achieve?	Freq.	Percent	Cum.
Agree	34	37.36	37.36
Disagree	3	3.30	40.66
I don't know/I don't have an opinion	2	2.20	42.86
Neither agree or disagree	14	15.38	58.24
Not answered	17	18.68	76.92
Strongly agree	21	23.08	100.00
Total	91	100.00	

Thirty percent of our sample (n=27) felt that they had developed relationships through GSP. Fourteen percent (n=13) disagreed that they had developed relationships through this route, with the majority (36%, n=33) unsure or having no opinion.

Thirty-four percent (n=31) of our respondents either strongly agreed or agreed that they felt sufficiently informed about GSP, with 26% (n=24) disagreeing or strongly disagreeing that that was the case. Twenty-one percent (n=19) were unsure.

Almost two-thirds (62%, n=56) of responding Link Workers felt that it was beneficial to spend time on GSP. Only 19% (n=17) were unsure.

Only 15% (n=14) of our sample felt there were sufficient financial resources available relating to GSP. Slightly more (15%, n=16) disagreed and felt there were insufficient funds, but mostly (48%, n=44) Link Workers were unsure.

Lastly, in relation to partnership working, the vast majority (73%, n=66) felt there were benefits to partners working together in relation to GSP. Only 42% (n=38) though felt that there was trust amongst partners, with a similar amount (37%, n=34) unsure.

Initial exploration of relationships

Analysis is ongoing; however, we are exploring the relationships between key variables in our dataset and present initial findings below.

Firstly, we were interested in the relationship between referral to GSP rates (proportion referred to green) and other Link Worker characteristics. We re coded the GSP rate variable into binary (over half, under half of referrals) for ease.

There was no evidence to support a relationship between green referral rates and type of base organisation:

What type of organisation is your employer?	RECODE of EProportionreferredto greenact (Proportion referred to green activitiie		Total
	Under Hal	Over Half	
Local Authority	11	1	12
Mental Health NHS tru	1	0	1
Other	1	0	1
Other- did not specif	2	0	2
Primary care provider	22	1	23
Social enterprise tha	1	0	1
Voluntary/community/t	34	9	43
Total	72	11	83

Pearson chi2(6) = 4.8075 Pr = 0.569

Nor was there evidence of differential rates of green referral by knowledge of the GSP partnership:

Heard of GSP Partnership?	RECODE of EProportionreferredto greenact (Proportion referred to green activitiie		Total
	Under Hal	Over Half	
I am actively involve	25	4	29
I have heard of it bu	13	2	15
I have heard of the i	14	3	17
I was not aware of th	11	0	11
Not answered	9	2	11
Total	72	11	83

Pearson chi2(4) = 2.2059 Pr = 0.698

We were also interested in the relationship between mental health referrals and green referrals – though the missing data meant collapsing both into binary variables. There was no direct relationship between these two binary variables however:

RECODE of EProportio nreferredt ogreenact (Proportio n referred to green activitiie	RECODE of EProportionofreferals withment (Proportion of referals with mental heal		Total
	Under Hal	Over Half	
Under Half	10	62	72
Over Half	0	11	11
Total	10	73	83

Pearson chi2(1) = 1.7371 Pr = 0.188

Stata code

```
**Link worker survey – Defra 2022**
import excel "/Users/kerryn/Desktop/Defra L_W Survey/Link worker questionnaires 2022.xlsx", sheet("Link worker qu
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*** ENCODE***
foreach v of var Site Whattypeoforganisationisyou Genericortargaetedsupport Ruralorurbanareas LengthoftimedoinSPt
    encode `v', gen(E`v')
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drop Site Whattypeoforganisationisyou Genericortargaetedsupport Ruralorurbanareas LengthoftimedoinSPtyperol Worki
***
replace ESite = 2 in 3
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replace ENumberofpeoplesupported = 9 in 10
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*graph hbar (percent), over (EUsePROMs, sort(1)) title (Use of outcome measures)
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recode EProportionreferredtogreenact (1 5 = 1 "Under Half") (3 = .) (2 4 = 2 "Over Half"), gen (Eproptiongreencol
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Free text response results

Link Worker perceptions of what is working well in the Test and Learn pilots

Very few responses, many ‘don’t know’s’ or commenting they are too new to the project etc. from the Link Workers.

Positive impressions were expressed by one Link Worker:

Increased communication between Link Workers and Green social prescribing organisations / services. Patients who attend seem to keep going, allowing them to make new friends & contacts. (27)

What needs improving in the Test and Learn pilots

Again, very few responses and many ‘don’t know’s’ responses to this question.

Several Link Workers commented that they have a poor understanding of the Test and Learn programme and of local Green Social Prescribing options:

Clearer aims and objectives of the Green social prescribing project required. More targeted information required for each task group. Do task groups still exist? I have had nothing since the first task group meeting. More direction. More consolidated approach required. More regular updates, even if minimal. I have been involved in meetings from the beginning but still if I am asked what Green social prescribing is I find it hard to define what the aims are yet full understand the concept and I can't share any work that is really being done other than information gathering which we have been asked to do several times in various ways. (36).

One Link Worker commented they do not understand how the project will translate into delivery of more Green Social Prescribing

I am aware we have [test and learn project name] but at present this appears to be some form of networking event with stakeholders- not sure how this actually translates to delivering more nature-based interventions or making them accessible and well publicised. (3)

In another area a Link Worker stated:

I 100% support this project but am finding a lack of support groups in my locality that focus on tackling specific mental health issues other than a general 'this improves mental wellbeing and can reduce anxiety etc'. Is more training needed to existing charities/ groups on how to set this up to remove perhaps health and safety fears? Or is it a perceived need of equipment therefore cost or transport to and from green spaces? (10).

One Link Worker expressed concern about the long-term sustainability of the project:

Fear of the funding that currently supports our projects ending (33)

One Link Worker commented that there is a need for more information on the Test and Learn programme and better communication:

Need more information. We were involved in a meeting about green social prescribing then sent an email saying we were to be involved in the project without anyone asking us what our capacity is like, what our thoughts were on it etc. (20).

Similar issues were raised in other sites:

Communication about what the project is, who is running it, who it's for etc...

Some Link Workers questioned the availability of local Green Social Prescribing projects with the perception there are few options:

Availability, some services are not available locally or have not expanded enough to cater yet for individual referrals from our service. This will take time and not necessarily a negative. (64).

Perceptions of the Link Workers regarding issues with receiving referrals

Referrals to the Link Workers seem to be coming from a variety of sources: General Practitioners, mental health services, community practice nurses, substance misuse organisations, Social Workers, 3rd sector, Job Centres, Community Care Workers.

There were a great many responses indicating inappropriate referrals is a significant issue for Link Workers. Inappropriate for the severity and complexity of issues faced by the referee, including alcoholism and drug use; the Link Worker is not equipped to deal with the issues being presented; lack of onward services to refer to; Link Workers being put in dangerous situations:

Where to begin... Inappropriate referrals yes some have high mental health needs and require more support than a primary service can offer, a fair amount MASH referrals made as GP have highlighted self-neglect and requested I make this referral for them. Not enough information around pt being put on referrals, my safety could have been compromised a few times and has been because of this with police involvement as in I shouldn't have seen them on my own but didn't find out till after and found out during a consultation that this is an inappropriate referral.

There were some mentions of inappropriate referrals because referrers 'do not understand the nature of social prescribing'

Perception from some Link Workers that social prescribing is inappropriate for people with more severe MH challenges:

Some referrals are inappropriate as the patient may have high level mental health needs that social prescribing won't meet.

There was a perception that Link Workers and social prescribing being treated as a dumping ground:

Some agencies see us as the referral of last resort. (8)

There were many mentions of problematic referral rates. For some Link Workers there are too few referrals:

I cover 7 Practices and the referrals are not evenly spread (even as a % of size of patient population for each Practice). Some Practices do not refer at all.

However, for more of the Link Workers, there are too many referrals to cope with:

I receive far too many referrals on a monthly basis and do not feel I am giving the patients the full service they deserve as I just don't have time. I do 99% of my referrals over the phone again due to time constraints undergoing a home visit.

Several mentions of 'batch referrals' swamping the Link Workers. Mentions of long waiting times for referees to see Link Worker. Indications of some Link Workers suffering with case load and the system within which they are working:

I have over 150 referrals waiting to be booked in i have a 3-4 month waiting list i think, I'm told to just ignore the amount of referrals coming in and do what i can do by my manager, this isn't good enough as pt's are being left and vulnerable, this adds more pressure on me, there is no sign of getting any support with more staffing as statistics need to be shown across north west {test and learn area} as whole before they can see a need for this. My own mental health and now physical health has been affected by all the stress of carrying such a huge workload and pressure from all my four practices with a me first attitude, far too many referrals, but they are getting financial incentives for sending referrals into the overworked underpaid social prescriber with no support for our workloads.

There are a few mentions of Link Workers feeling unable to do their job adequately, typically due to overburden in their caseload:

I receive far too many referrals on a monthly basis and do not feel I am giving the patients the full service they deserve as I just don't have time. I do 99% of my referrals over the phone again due to time constraints undergoing a home visit.

There were a few mentions of poor information flows e.g., Link Workers having very little info on referees; referees not knowing why they have been referred to Link Workers.

Link Workers' perceptions of the challenges of supporting people with mental health needs

Transport was by far the most commonly mentioned issue. This was often linked to the financial situation of referees (e.g., On benefits); transport is too expensive. Also linked to the availability of transport to the destination, or the time it takes. Some

referees are overwhelmed by the idea of taking public transport to an unknown destination.

Anxiety, whether general or specific social anxiety, was also a very common issue mentioned. Some Link Workers reported being concerned that referring people with social anxiety to social programmes is inappropriate:

A big challenge is the increase in people presenting with social anxiety; as a social prescriber, I don't want to encourage people into social situations if they do not have coping mechanisms to manage their social anxiety.

The Link Workers report that referees can be disengaged with their health, with low motivation to take up any social prescribing offer:

Often so disengaged with their own health they can't answer the questions 'what would you like to be doing, what's important to you, what would help. (13).

Challenges with maintaining contact with these referees:

It can be difficult to maintain consistent engagement with them, e.g., Missing social prescribing appointments or not attending appointments with services they are connected with due to mental health deterioration, or the impact of mental health being disorganisation. (1).

One Link Worker mentioned a lack of time available to build trust with referees:

It takes time to build trust, safety and a relationship with all of those who I come into contact with. This is a Link Worker's biggest challenge. (5).

Other related issues included language barriers.

Some Link Workers reported feeling ill-equipped to deal with and advise referees with specific needs such as those related with learning disabilities (including memory), or with more severe mental health needs. Either there were not the options available, or they do not have the training/skills:

The level of their support needs goes beyond the social prescribing role.

Some Link Workers mentioned not having appropriate clinical supervision and feeling unqualified to deal with the severity of issues people are facing:

... I am not qualified enough to deal with these people effectively and fear that it will only get worse the more I get referred people with mental health needs. (77).

The lack of wider systems of care and support (including long waiting lists) was raised by a number of the Link Workers:

Accessing IAPT referral; People tell me they are struggling to connect with crisis tele services; Many counselling services are full and not taking referrals right now, CRUSE being one locally for Selby. (6).

The impact of the combination of the factors discussed here was raised by one Link Worker:

Lack of appropriate services, especially for people with severe or complex mental health needs that aren't suitable for primary care mental health services. In primary care mental health teams the support they offer is great but often have very long waiting lists which can leave the patient in limbo and causing social

prescribing Link Worker's to pick up the slack in the meantime - for me my background is in mental health and crisis so I am confident in this, but I am aware other social prescribing Link Worker's feel we don't have adequate training to support patients in these situations. (86)

One Link Worker reported the situation they find themselves in as:

...the fear that they will commit suicide and that it will be somehow my fault. That I will not get to them in time to make a difference. That I will have to close their case before any of the agencies that I have referred them to will have had a chance to pick them up. (45)

Link Workers' perceptions of the barriers to referring people with mental health needs to nature-based activities

Again, transport was by far the most commonly mentioned issue. The costs were primary, but also the confidence needed to get on a bus, leave home area, navigate multiple forms of transport etc. to the locations of the nature-based activities. Linked to these issues related to seasonality were cited as barriers, especially for older people not wanting to go out in winter. Facilities and accessibility of the sites was also raised as an issue, particularly for people with mobility challenges. Lack of services such as toilets at Green Social Prescribing sites.

There were several comments on poor availability of options and perceptions of the quality of those options:

There just are not any to refer to, and the ones that are available are quite poor, as in either led by peers, or too far away and patients are unable to source transport to get to them. (16)

Again, anxiety was a primary concern:

People are often not at a stage where they are able to leave their house. (9)

Additional health issues were also raised as a challenge by several Link Workers:

Health concerns which make them worry about their abilities to carry out the conservation task, so for example, bad backs, hips, legs, feet, diabetes, eczema, epilepsy, learning disabilities, obesity. Autism & ADHD. (45)

Getting referees to 'turn up' was listed as an issue across the sites. This was linked to low motivation, anxiety and a range of other barriers.

A further issue was linked to a perception of a lack of referees' experience of natural environments and perception of potential benefit:

...lack of understanding/belief of the positive impact that nature-based activity has on health... (50) and

Refusal to consider getting out and trying nature-based activities citing no motivation/not for them/ can't afford travel/ too physically impaired. (32).

Lack of time to build trust and relationships was also mentioned. Lack of access to the support systems that some may need to take up a Green Social Prescribing offer:

Some people feel they need someone to go with them regularly to activities, due to lack of confidence or other mental health issues. Finding a free service to

support with this is difficult and some people are not successful in a PIP application to help pay for a PA. (72)

The administration burden was cited as a challenge by several Link Workers, this also related to issues regarding adequate knowledge of the safeguarding needs of referee and provider:

So much paperwork now (e.g., Risk assessments) etc that certain services we cannot refer into any more - for example Nature in Mind. Service is great but we do not have capacity to do all that and are not qualified to decide on risk status - ours is currently a phone only service so we do not even visit these patients in their homes prior to referring. (66)

Good practice in referrals for people with mental health needs

Typically, these questions were left blank.

There is not much of this at the moment. (5)

Key good practices included:

- Maintaining ongoing contact with the client:

I follow up with the service-user to identify if they have engaged with services I have sign posted or referred them to. If they haven't, I explore with them the reasons why they haven't and try to overcome any obstacles they have with engaging. Sometimes this means following up with the organisation I've referred to or working with the service user to devise a plan to overcome obstacles that suits them. (72) and

- Sufficient understanding of the service:

As a social prescriber I always scope out a service before I refer a patient to that service. I check the safeguarding policies as well. (16)

- Monitoring and evaluation of practice:

Outcome measures are taken. Client satisfaction assessments are carried out. We write case studies although not as often as we would like because this is time consuming. Sometimes we take videos and photos to share on social media. (37).

- Sharing case studies.
- Person led decision making approaches, time to listen and understand, creation of a support plan:

I always give the clients space they need to talk, and feel safe to do so. I just listen and wait and collect key points along the way to see what level of activation they are at and also pick up on positive language around likes...Build on that more to engage service sign posting relevant to likes. (12)

- Coordination with other services:

One of the GP practices I work with have a mental health review meeting. This once a month and we will discuss high priority patients gathering information from services the person has been referred to. The meeting involves a Mental health Nurse, Nurses, GP's Focus Care Worker and social prescribing Link Worker. This detail is all added to EMIS. I also attend Huddles where nurses, Link Workers and

social workers discuss individual patients to measure progress. These happened everyday but I attend one a week. (33)

- Feedback on progress from provider.
- Additionality of green social prescribing options:

I closed support for a couple of clients where a referral into the nature-based intervention was "the cherry on the cake" of the support and the client had made significant improvements and felt confident to complete the activity on their own. (50)

Training and support needs for Link Workers

- Green Social Prescribing practices generally and for specific groups. Several Link Workers commented on their need for greater understanding of availability of and good practice in Green Social Prescribing:

A general understanding of best practice when using Green social prescribing would be useful. Knowledge of what works, for which type of mental health and in what circumstance would be helpful in developing my knowledge and therefore make the referrals I make more beneficial. (10).

- Experience of the activities was mentioned by a number of Link Workers:

I found most useful visiting sites of service provisions to see first-hand the activities or facilities they have. This helps better understand the service and therefore appropriately signpost the appropriate service user to the service.

- Green Social Prescribing effectiveness, cost reduction
- Local options and their entry criteria:

A comprehensive website or list of services that are available to access green social prescribing, simple ways to refer and a single point of access for referrals and questions. (52)

- More information on the Test and Learn programme.
- Training in mental health challenges and treatment options.
- Mental health training.
- Overcoming barriers to health improvement.
- Motivational techniques.
- Trust building.
- Good quality training:

The training I have had so far has been terrible.

A2.8. Findings arising from the WP3A monitoring data

Introduction

We present the quantitative analysis of the monitoring data in this section. As discussed, there have been considerable challenges generating monitoring data. **Thus, the analysis provides a snapshot of who may be accessing GSP, their journey and potential impact. It is unknown how representative the data is of who is accessing GSP and certainly the data does not provide us with information on the total numbers of people being supported by GSP.** For example, in one site under a third of funded nature-based organisations provided service user data. We present findings from two parts of the GSP system: Link Workers and nature-based activities. Below we describe the data we received and then present the analysis, initially from Link Workers, followed by the nature-based activity data.

Monitoring data from Link Workers: We received community Link Worker data from 3 sites (Site 1,2 and 4). Site 1 comprises people recruited to a cohort study so may not be representative of those who would generally access Link Workers. Site 2 and 4 provided Link Worker data from a proportion of their Link Worker services. For example, Site 4 provided data on one locality within the site. Additionally, Site 5 provided data on their GSP Link Workers, which included Link Workers based within the nature-based providers. We received the following data:

- Site 1- 69 service users.
- Site 2- 88 service users.
- Site 4- 393 service users.
- Site 5- 393 service users.

We have presented the Link Worker data on Site 5 separately because Link Workers were configured differently within the site compared to other T&L sites. Differing amounts of data were provided on each variable, per site. For example, demographic data was relatively well completed but there was much less data provided on the number of interactions. Consequently, each variable analysed involves a different number of service users with different amounts of missing data.

Monitoring data from nature-based activity providers: We received individual level nature-based activity data from 5 sites. Additionally, we also were able to use some of Site 1's cohort data in respect of nature-based activity providers. In total there was a sample of 1725 service users:

- Site 1- 69 service users.
- Site 2-540 service users.
- Site 3- 33 service users.
- Site 5- 453 service users.
- Site 6- 196 service users.
- Site 7- 434 service users.

The datasets were not fully completed, with differing levels of missing data for each variable. Additionally aggregate data was provided by Site 1 (n=173), Site 2 (n=995) and Site 5 (n=632). However, much of this aggregate data was not complete so is primarily included within the narrative rather than including it within the data tables. Furthermore, there is a risk that there is some duplication between individual and aggregate level data with some service-users being recorded in both. Whilst we have

done what we can to clean the data to address this issue, it may remain from some organisations and is an issue to feedback to T&L sites.

Completion rates of each variable varied considerably, with demographic variables relatively well completed but destination and outcomes data less well completed. The service users were from nature-based activities funded through GSP. The information is also only from a proportion of funded nature-based activities, and (as is often the case with broader social prescribing data) it is unknown how representative these data are. For example, there is an indication that GSP is supporting a significant proportion of people from minority ethnic backgrounds, however it is unknown whether this is a true reflection or relates more to which specific nature-based organisations returned data. Despite these concerns, the monitoring data is useful for identifying emerging patterns which can be explored further in other work packages through triangulation. For example, some of the emerging findings from the monitoring data reflect the questionnaire findings.

Link Worker data

Demographic of people accessing support from Link Workers

The demographics of people receiving Link Worker support are provided in Table 2.22

Gender: Across the sites, more women have been supported (58.5%, n=255/438) compared to men (41.3%, n=180/438). The exception is in Site 1, however this may relate to service users being recruited to the cohort study. Other social prescribing schemes have reported supporting a greater proportion of women than men (Foster et al, 2020; NASP, 2022). This indicates that there is a wider issue within social prescribing about ensuring men are both referred and supported by Link Workers. Interestingly, this gender difference is not present in terms of accessing nature-based providers (described later). This indicates that there may be other referral avenues that are more successful at supporting men to access nature-based activities.

Age: Link Workers are supporting people from across the age spectrum but there appears a greater proportion of service users amongst the older age groups. There are less than 1% of Under 18s being supported. This may be reflective of the Link Workers who provided data to the evaluation but raises questions about the role of Link Workers in supporting younger people (and matches demographic analyses on SP more generally (NASP, 2022)). Interestingly, a number of nature-based providers did support younger people indicating that other referral routes are being used to engage people Under 18 into nature-based activities. **Half of people supported were aged over 65 (50.7%, n=268/529), indicating that Link Workers are predominately supporting older people. Consequently, Link Workers may need to ensure that younger people of working age are also supported through social prescribing.**

Ethnicity: Link Workers were predominately supporting people of White British ethnicity. In the data provided, over 90% of service users were White British (93.8%, n= 196/209). A small number of people from other ethnic groups were supported including those from Pakistani and Black Caribbean ethnicities. On the data received, it appeared there was a disproportionate number of White British people supported (which is again in keeping with recent work conducted by the NASP academic collaborative (Tierney et al., 2022)). However, it is acknowledged that there are different ethnic profiles within each T&L site so it may relate to the specific sites which provided data. **This issue needs further consideration to ensure people from minority ethnic backgrounds are being supported by Link Workers. Interestingly, amongst the nature-based providers, there was a higher proportion of people**

from ethnic minorities, indicating that other referral routes are proving more relevant in terms of supporting people to access nature-based activities.

Socioeconomic deprivation: Link Workers appear to be reaching people living in deprived socioeconomic areas. However, the proportion of people being supported varies between sites which reflects the different geographical configurations (and matches what we have seen from the SP Observatory reports (Jani et al., 2021)). For example, one site only provided Link Worker data from a relatively affluent area.

Employment and Education status: Within the one site that collected data on employment and education, it appeared that service-users accessing Link Workers had a higher level of unemployment and lower level of qualifications than the UK average. Site 1 collected information on the employment status of people accessing Link Workers. It appeared that Link Workers were primarily supporting people not in work. Only 15% (n=10/67) were in work which is a considerably lower proportion than the national average. Furthermore, 39% (n=27/67) of service users were unable to work due to disability or ill health. In terms of education levels, 4.5% (n=3/67) of service users had a degree of higher-level qualification which is lower than the UK population average of 20%. Whilst this is just one site, where people were recruited to a cohort study and thus not necessarily representative, it does highlight that Link Workers may be reaching people who are more likely to be unemployed than the UK average.

Table A2.22: Demographics of service users being supported by Link Workers

Variable	Characteristics	Site 1 (n=69)	Site 2 (n=88)	Site 4 (n=393)	Cumulative total across sites (numbers vary depending on each demographic)
Gender	Women	24 (35)	58 (65.9)	173 (62)	255 (58.5)
	Men	44 (64)	30 (34.1)	106 (38)	180 (41.3)
	Other	1 (1)			1 (0.2)
	Missing			104	
Age category	< 18	0 (0)	4 (4.6)	1 (0.2)	5 (0.9)
	18 – 24	7 (10)	5 (5.7)	12 (3.2)	24 (4.5)
	25 – 29	15 (22)	13 (14.9)	18 (4.8)	59 (11.2)
	30 – 34		4 (4.6)	9(2.4)	
	35 – 39	8 (12)	3 (3.4)	6 (1.6)	30 (5.7)
	40 – 44		2 (2.3)	11 (2.9)	
	45 – 49	18 (26)	6 (6.9)	9 (2.4)	60 (11.3)
	50 – 54		6 (6.9)	21 (5.6)	
	55 – 59	12 (17)	5 (5.7)	19 (5.1)	83 (15.7)
	60 – 64		9 (10.3)	38 (10.2)	
	65 – 69	5 (7)	4 (4.6)	19 (5.1)	65 (12.3)
	70 – 74		10 (11.5)	27 (7.2)	
	75 – 79	1 (1.5)	4 (4.6)	57 (15.2)	111 (21)

Variable	Characteristics	Site 1 (n=69)	Site 2 (n=88)	Site 4 (n=393)	Cumulative total across sites (numbers vary depending on each demographic)
	80 – 84		6 (6.9)	43 (11.5)	
	≥ 85	3 (4.5)	6 (6.9)	83 (22.2)	92 (17.4)
	Missing		1	19	
Ethnicity	Any other Asian background				
	Any other Black, African or Caribbean background				
	Any other ethnic group		5 (5.7)		5 (2.5)
	Any other Mixed or multiple ethnic background				
	Any other White background				
	Arab				
	Asian – British				
	Asian/Asian British – Chinese				
	Asian/Asian British – Indian				
	Asian/Asian British – Pakistani		1 (1.1)		1 (0.5)
	Black/Black British – African		1 (1.1)		1 (0.5)
	Black/Black British – Caribbean		2 (2.3)		2 (0.9)
	Mexican				
	Other	2 (2.5)			2 (0.9)
	Polish				
	White – English, Welsh, Scottish, Northern Irish or British	65 (95)	78 (89.7)	53 (100)	196 (93.8)
	White – Gypsy or Irish Traveller				
	White – Irish				
	White and Asian				
	White and Black African	2 (2.5)			2 (0.9)
	White and Black Caribbean				

Variable	Characteristics	Site 1 (n=69)	Site 2 (n=88)	Site 4 (n=393)	Cumulative total across sites (numbers vary depending on each demographic)
	Missing	0	1	340	
Socioeconomic deprivation of neighbourhood resided in (IMD Decile)	1 (Most Deprived)	27 (43)	28 (51.9)	10 (2.8)	65 (13.3)
	2	8 (13)	8 (14.8)	1 (0.3)	17 (3.5)
	3	6 (9.5)	4 (7.4)	2 (0.5)	12 (2.4)
	4	6 (9.5)	2 (3.7)	0 (0)	8 (1.6)
	5	2 (3)	2 (3.7)	24 (6.4)	28 (5.7)
	6	2 (3)	6 (11.1)	56 (15)	64 (13.1)
	7	6 (9.5)	2 (3.7)	36 (10.5)	44 (9.0)
	8	3 (5)	0 (0.0)	86 (23.1)	89 (18.2)
	9	2 (3)	0 (0.0)	103 (27.6)	105 (21.4)
	10 (Least Deprived)	1 (1.5)	2 (3.7)	55 (14.7)	58 (11.8)
	Missing	3	34	20	

Mental health needs

Unsurprisingly given the aims of the programme, a substantial proportion of people accessing Link Workers appeared to have mental health needs which had a detrimental impact on their daily lives, albeit the proportions varied between sites. These statistics are in relation to the proportion of service users who were considered as having mental health issues rather than necessarily the reason for referral. In Site 2, over 90% (96.4%, n=81/84) of service users were recorded as having mental health issues which varied between pre-determinants such as loneliness to acute issues including psychosis.

Site 2 provided a break-down of the types of mental health needs people presented with. The most common being people having pre-determinants of mental health issues including loneliness and financial stresses. By pre-determinants, these are issues that may be having a detrimental impact on a person's mental wellbeing but the person is not experiencing a clinically diagnosable mental health illness. The dominance of people with pre-determinant mental health needs highlights the potential role of GSP in supporting people to reduce the risk of escalating mental health issues. Around a fifth of people were experiencing more moderate mental health issues including depression. Less than 5% of service users had more severe mental health issues such as psychosis. Precise numbers have not been provided because there was considerable overlap in the categories utilised by Link Worker providers. **However, the data provides initial findings that Link Workers appear to be supporting people with mental health needs which may range from pre-determinants to more acute needs.** It will be important in later stages to explore with Link Workers whether they feel there are sufficient nature-based activities available to meet people's different needs. For example, Site 2 proactively sought to commission nature-based

activities aimed at people with moderate/severe mental health issues because the Site had identified that there was a gap for this population within the GSP provision.

Despite significant numbers of service users reporting mental health issues, the mental wellbeing measures were more complex. On the ONS-4, for Life Satisfaction, Happiness and Feeling Worthwhile domains, the samples were categorised as having a ‘Medium’ level of mental wellbeing. This may reflect that Link Workers are supporting people with pre-determinant mental health needs as well as people with clinically diagnosable mental health conditions. In Site 1, there was indication that people had higher levels of anxiety and were experiencing mild depression. The sample of 69 was categorised as experiencing Mild Depression (8.92, SD:4.74) on the Hospital Anxiety and Depression Scale and moderate levels of anxiety (11.53SP SD: 4.82) (Site 1 was the only site measuring these constructs). Whilst Site 1 was recruiting people to a cohort study it indicates that there will be some service users with higher levels of mental health needs.

Table A2.23: Levels of mental wellbeing before receiving Link Worker support

Domains	Site 1 Mean (SD) (n:69)	Site 2 Mean (SD) (n=15)
Overall, how satisfied are you with your life nowadays?	5.5 (2.2) Medium	4.6 (2.0) (Medium)
Overall, to what extent do you feel that the things you do in your life are worthwhile?	5.7 (2.5) Medium	4.9 (1.7) (Medium)
Overall, how happy did you feel yesterday?	5.3 (2.7) (Medium)	4.8 (2.5) (Medium)
Overall, how anxious did you feel yesterday?	6.3 (3.0) (High)	5.4 (3.0) (Medium)

Impact of health conditions on daily life

Service users reported a range of health conditions including physical impairments, sensory impairments and learning difficulties. Whilst this data was from Site 1 and linked to their cohort study, it indicates that Link Workers are supporting people who have a range of health conditions. These different health issues need to be taken account of when considering referrals to nature-based activities as some activities may be more suitable than others. For example, it could be difficult for someone with mobility issues to access a community allotment. **The issue needs further exploration in later stages to explore how people’s different physical and mental health needs can be supported to ensure that GSP is inclusive.**

Table A2.24: Physical health issues amongst Link Worker service users in Site 1

Impairments or Health Conditions	Health conditions (n=122) (people may have multiple health conditions)
A physical impairment e.g., reduced mobility	11 (9)
A sensory impairment e.g., blindness	5 (4)
A mental health condition e.g., depression	50 (41)
A learning difficulty/cognitive impairment e.g., Down's syndrome	7 (5.5)
Dyslexia or an autistic spectrum disorder	18 (15)
A long-term health condition e.g., cancer	7 (5.5)
Any other long-term illness or health condition that has lasted for more than 12 months	24 (20)

In Site 1's cohort study, over two-thirds of service users sampled felt that their day-to-day activities were limited because of physical and/or mental health conditions. Site 1 explored this issue, and over a quarter of service users felt that their health had a substantial impact on their day to day lives (29%, n=20/69). Over half of responders felt their health did limit their day-to-day life to some extent (52%, n=35/69). Whilst this cohort may not be representative, it does indicate that GSP is supporting people with a range of mental and physical health needs which needs to be taken into account in terms of accessing and attending nature-based activities.

Referral routes and rates

Link Worker referral routes

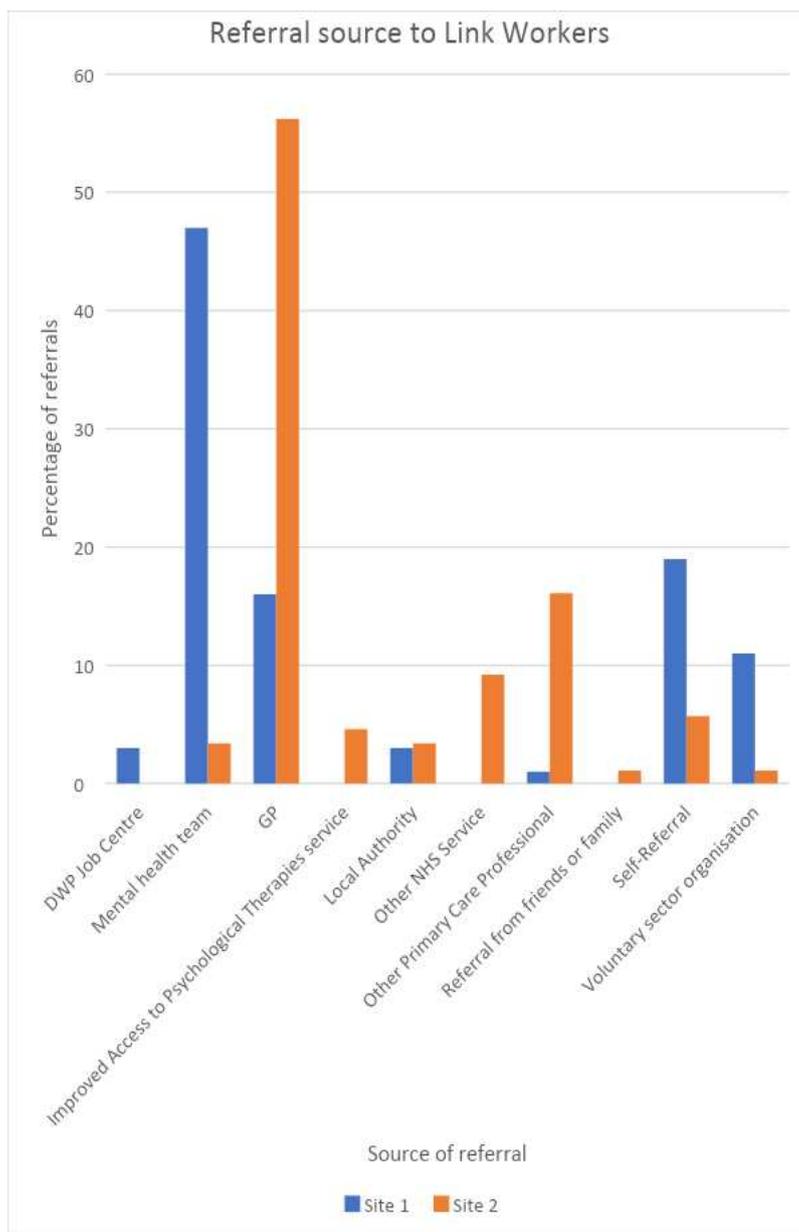
Healthcare professionals were the key referral source to Link Workers, however the specific type/location of healthcare professionals differed between sites. In Site 1, almost half of referrals were from mental health teams (47%, n=32/69). Other key sources were self-referrals (19%, n=13/69) and GPs (16%, n=11/69). Whereas in Site 2, the main referral source was primary care where just over half of referrals were from GPs (55.2%, n=48/87) and other primary care professionals such as Practice Nurses (16.1%, n=14/87). The different models may be due to Site 1's cohort study. Whilst healthcare professionals were a dominant source, there is a need to enable referrals from other sources, such as self-referral, partly to facilitate engagement. What is not known from this data is the range of healthcare professionals engaging within a service, for example whether it is all or only some GPs within a specific GP practice. This needs further reflection because it is an issue highlighted within the questionnaire. It may also be useful to develop further referral routes outside of the NHS such as through the Department for Work and Pensions and Local Authorities. Whilst these other services only made a small number of referrals, it indicates that there is scope to consider how GSP may link with other statutory agencies. However, a challenge raised in the questionnaire was capacity so if greater referral routes are developed that may increase referrals, Link Worker and provider capacity would need to be expanded to accommodate demand.

Table A2.25: Referral routes to Link Workers⁷

	Site 1 (n=69)	Site 2 (n=87)
Source of Referral		
DWP Job Centre	2 (3)	N/A
Mental health team	32 (47)	3 (3.4)
GP	11 (16)	48 (55.2)
Improved Access to Psychological Therapies service	N/A	4 (4.6)
Local Authority	2 (3)	3 (3.4)
Other NHS Service	N/A	8 (9.2)
Other Primary Care Professional	1 (1)	14 (16.1)
Referral from friends or family	N/A	1 (1.1)
Self-Referral	13 (19)	5 (5.7)
Voluntary, Community or Social Enterprise Organisation	8 (11)	1 (1.1)

⁷ No total calculated because each site configured their referral routes differently which is a key finding.

Figure A2.20: Referral source⁸ to Link Workers



Appropriateness of referrals Questionnaire responses highlighted concerns about Link Workers receiving referrals outside of their remit. From Site 2 that collected this variable, there does not appear to be an issue. Over 90% of referrals were recorded as appropriate (97.7%, n=85/87). However, this site only provided data on people that had been referred to nature-based activities so they would have only included service users that accessed Link Worker support and thus were probably appropriate referrals. **Given this, it is not possible to quantify whether in the GSP project there is an issue of inappropriate referrals to Link Workers.**

Extent of Link Worker support provided

We sought to explore the length of time between a referral being made and support from a Link Worker starting. This is because within the questionnaires, Link Workers raised concerns about having to operate waiting lists. However, in the data we received, the date of referral and date support started were often the same. Consequently, it

⁸ Referral source as a percentage of Link Workers to demonstrate the differences between sites and to allow for differences in the number of service users.

was difficult to establish waiting list times. **Of the data we received, the waiting list times ranged from 0 days to almost 4 weeks. It is unknown how this compares to other Link Worker services and whether there are implications if service users experience delays accessing Link Workers.**

The data quality issues made it difficult to establish the exact number of monthly referrals however numbers did vary, reflecting findings from other evaluations.

There was considerable variation in the length of support that service users received from Link Workers. Site 2 provided data on 24 service users, with support ranging **from a one-off session to a service user being supported by a Link Worker for up to six months.** The mean length of Link Workers support was 9.7 weeks (SD:7.5). However, **the large standard deviation reflects the wide variation and demonstrates how Link Workers often tailor their support. What is not known is at what stage of receiving Link Worker support are people referred to nature-based providers and how the two parts of the pathway may overlap.** For example, a Link Worker may support someone to access a nature-based provider and continue supporting the service user for a month afterwards as the service user becomes settled into the activity.

Onward referrals

Referrals to nature-based activities

From the small amount of data received, it appeared approximately 5-10% of Link Worker onward referrals were to nature-based activities. For example, in Site 4, Link Worker data was provided from one locality. Of 686 onward referrals, 56 were to nature-based activities which equates to 8.2%. Whilst this is limited data and not necessarily representative, the figure matches the questionnaire findings in that only the minority of Link Worker service users will be referred to nature-based activities. **This raises questions about whether there is scope to increase referrals from Link Workers to nature-based activities such as through raising awareness of available activities. However, it could indicate that going forward, any GSP needs to include other referral routes such as developing links with mental health teams, the voluntary sector and allowing for self-referral.** In the questionnaire, Link Workers discussed having to support service users with crises such as debt management and thus a nature-based referral would not be a priority whereas it could be more appropriate at other parts of a person's service pathway.

As most Link Worker data related to people who received a nature-based referral, it was not possible to explore whether service users being referred to nature-based activities are representative of the general Link Worker service user population or whether there are specific differences. For example, are there differences in the age profile of people being supported by Link Workers and people who are then referred onto nature-based activities? This highlights a challenge for GSP of how to get this data. It may be fruitful to collaborate with other studies/ registries focused purely on Link Workers who may be able to report more extensively on Link Worker service users and whether nature-based referrals are representative of the general Link Worker service user population.

Types of onwards referrals

Link Workers referred service users to a range of nature-based activities including community allotments, conservation projects and nature-based physical activities. In Site 2, the main type of nature-based referrals was to community gardening/horticulture programmes (24.2%, n=22/91) and nature-based physical activities such as health walks (24.2%, n=22/91). Interestingly in Site 2, the

most common onward referral route was to nature-based organisations who would then determine specific support (n=25/91, 27.5%). This links into the work another site is undertaking in terms of having Link Workers based within nature-based organisations to provide a triage function (Site 5, described below). In Site 4, 56 referrals were made to 19 different activities. This highlights that Link Workers do refer to a range of activities. However, interestingly over a third of referrals were to health walks, indicating that Link Workers may have 'go to' activities that they refer service users to (35.7%, n=20/56). This indicates that there could be scope to increase Link Workers knowledge of the range of nature-based activities available in a locality.

In Site 2, we explored whether there were gender differences in the types of nature-based referrals Link Workers made. Whilst this was one site and the sample size was insufficient to ascertain whether it was statistically significant, there did appear to be some differences. Men were less likely to be referred to nature-based arts and crafts programmes (10% compared to 22.4% of women). However, in respect of conservation programmes, men were more likely to be referred (Men: 33.3%, Women: 20.7%). Whilst there may be genuine differences in the interests of different genders, it will be important to explore this further to firstly ensure sufficient activities are available that are appealing to people of different genders. Further, we need to ensure that there is not an unconscious bias, where Link Workers are potentially making assumptions based on gender about which nature-based activities a service user may want to access.

Table A2.26: Onwards referrals to nature-based activities from Link Workers in Site 2

Type of nature-based activity	Number of service users (n=91)*
Referred to green activity provider (they will decide support)	25 (27.5)
Community gardening and horticultural programmes	22 (24.2)
Nature-based physical activity or sports programme	22 (24.2)
Nature-based arts and crafts programmes	16 (17.5)
Environmental conservation programmes	5 (5.5)
Other	1 (1.1)

*Based on 91 onward referrals as service users could be supported to access multiple nature-based activities.

Table A2.27: Onward referrals to nature-based activities from Link Workers stratified by gender in Site 2

Type of nature-based activity	Gender	
	Women (n=58)	Men (n=30)
Community gardening and horticultural programmes	12 (20.7)	10 (33.3)
Environmental conservation programmes	4 (6.9)	1 (3.3)
Nature based arts and crafts programmes	13 (22.4)	3 (10)
Nature based physical activity or sports programme	13 (22.4)	9 (30.0)
Other	1 (1.7)	0 (0.0)
Referred to green activity provider (they will decide support)	15 (25.9)	10 (33.3)

GSP Triage Link Workers

Site 5 operated a mixed model of Link Workers which alongside generic Link Workers based in GPs and voluntary sector organisations, they also had GSP specific Link Workers who were responsible for supporting people to access nature-based activities. These Link Workers support people to access appropriate nature-based activities, which may or may not be in the organisations that they were working within. This model appears to address one of the issues in Site 2, where people were referred to providers so they could support the service user to decide which nature-based activities to access.

Given these differences in operationalisation and because the site primarily received data from nature-based Link Workers rather than generic Link Workers, we report the findings separately in the sections below.

The organisations providing data were based in different sectors and included a walking group, generic community organisations and GP practices. In this site, the Link Workers provided data relating to 393 service users. The data presented highlights how this model is reaching a diverse cohort of people with a higher proportion having mental health needs and is supporting them to access nature-based activities.

Service user demographics in Site 5

In Site 5, the Link Workers supported both working age and older adults. For example, 10.5% (n=32) of service users accessing support were aged 18-24 and a further 10.8% (n=33) were aged 60-64. **The age diversity indicates that within Site 5, GSP Link Worker are reaching people at different stages of their life course.** There were very few under 18s supported (1.6%, n=5) indicating that this is not a target service user group within Site 5. This highlights the variation within sites where some are supporting Under 18s and others are not. There appeared to be a disproportionate number of women supported compared to men, with almost 60% of service users identifying as female (57.5%, n=185). **This gender difference continues in this site in terms of nature-based activities indicating that Site 5 may want to consider how to recruit more males to GSP. GSP Link Workers appear to be supporting people from a range of ethnicities.** Whilst the majority of service users were White British (73.1%, n=231), people from minority ethnic backgrounds were also supported. For example, over 10% of service users identified as Pakistani/British Pakistani (11.7%, n=37). This reflects that Site 5 is more ethnically diverse than some of the other T&L sites. Service users were typically living in more socioeconomically deprived neighbourhoods. **Over two-thirds of service users lived in the top third most socioeconomically deprived neighbourhoods (69.2%, n=234).** This indicates that the site is reaching people who may typically be experiencing health inequalities.

Table A2.28: Demographics of service users accessing GSP Link Workers in Site 5

Demographic	Variable	Number of service users (n=393)
Age	< 18	5 (1.6)
	18 – 24	32 (10.5)
	25 – 29	21 (6.9)
	30 – 34	23 (7.5)
	35 – 39	42 (13.8)
	40 – 44	18 (5.9)

Demographic	Variable	Number of service users (n=393)
	45 – 49	28 (9.2)
	50 – 54	32 (10.5)
	55 – 59	17 (5.6)
	60 – 64	33 (10.8)
	65 – 69	19 (6.2)
	70 – 74	17 (5.6)
	75 – 79	7 (2.3)
	80 – 84	8 (2.6)
	≥ 85	3 (1.0)
	Missing	88
Gender	Women	185 (57.5)
	Men	132 (41.0)
	Non-Binary	4 (1.2)
	Other	1 (0.3)
	Missing	71
Ethnicity	Any other Asian background	8 (2.5)
	Any other Black, African, or Caribbean background	2 (0.6)
	Any other ethnic group	1 (0.3)
	Any other Mixed or multiple ethnic background	10 (3.2)
	Any other White background	8 (2.5)
	Asian/Asian British – Indian	1 (0.3)
	Asian/Asian British –Pakistani	37 (11.7)
	Black/Black British – African	7 (2.2)
	Black/Black British – Caribbean	4 (1.3)
	White – English, Welsh, Scottish, Northern Irish or British	231 (73.1)
	White – Irish	2 (0.6)
	White and Asian	3 (0.9)
	White and Black African	1 (0.3)
	White and Black Caribbean	1 (0.3)
	Missing	77
Socioeconomic deprivation of neighbourhood resided in (IMD Decile)	1 (Most Deprived)	113 (33.4)

Demographic	Variable	Number of service users (n=393)
	2	67 (19.8)
	3	54 (16.0)
	4	34 (10.1)
	5	19 (5.6)
	6	10 (3.0)
	7	12 (3.6)
	8	20 (5.9)
	9	6 (1.8)
	10 (Least Deprived)	3 (0.9)
	Missing	55

Mental health issues in Site 5

The vast majority of service users were categorised as having mental health issues (83.5%, n=81/97). Although, due to missing data, it is unknown if the numbers have been inflated because of what appears to be missing data. It could be that some of the missing data is actually because someone does not have notable mental health needs, but rather than record 'no', the Link Worker just left that category blank.

People had a variety of mental health issues which ranged from pre-determinants to more severe mental health issues. Almost a quarter of service users had early/pre-determinant mental health needs (23.7%, n=23/97) such as people experiencing loneliness. This category is used to indicate people who have issues in their lives which may be detrimental to their mental wellbeing but they are not necessarily experiencing a clinically diagnosed mental illness. A significant proportion of service users had moderate mental health needs, which entailed their lives being somewhat detrimentally impacted by mental health issues (40.2%, n=39/97). This was the largest group of service users. Compared to other sites, there was a significant proportion of service users in Site 5 with severe mental health issues such as psychosis (19.6%, n=19/97). **The data does indicate that GSP Link Workers are supporting people across the spectrum of mental health issues.**

Table A2.29: Proportion of GSP Link Worker service users with mental health issues

Type of mental health needs	Number of service users (n=97)
No mental health needs	16 (16.5)
Early/pre-determinants of mental health needs	23 (23.7)
Moderate mental health needs	39 (40.2)
Severe mental health needs	19 (19.6)
Whether someone has mental health needs	
Yes	81 (83.5)
No	16 (16.5)

People had a medium level of mental wellbeing across all 4 of the ONS-4 domains (n=39):

- Life satisfaction: 5.1 (SD: 2.1)
- Worthwhile: 5.8 (SD: 1.9)
- Happiness: 5.7 (SD: 2.3)
- Anxiety: 5.2 (SD: 2.4)

Within each domain there was a range of scores highlighting that Link Workers are supporting people with different levels of mental wellbeing for example, some service users were categorised as highly anxious. If service users have a medium or higher level of mental wellbeing, then the focus of GSP may be on supporting service users to maintain their mental wellbeing rather than necessarily improving wellbeing.

Source of referral in Site 5

As with generic Link Workers, there were diverse referral routes to GSP Link Workers. Over a third of service users were referred by Primary Care Link Workers (38.5%, n=141/366). Self-referrals were the other prominent source of referrals (34.7%, n=127/366). **This highlights the importance of having both formal referral routes with healthcare and other services but also has the scope for people to self-refer.** It may be useful to explore within the site whether having the second layer of Link Workers supports primary care-based Link Workers in their work.

Table A2.30: Referral routes to GSP Link Workers

Source of Referral	Number of service users (n=366)
Community Mental Health Team	9 (2.5)
GP	4 (1.1)
Local Authority	3 (0.8)
Other NHS Service	16 (4.4)
Other Primary Care Professional	9 (2.5)
Primary care based Link Worker/Social Prescriber	141 (38.5)
Referral from another part of the organisation	2 (0.5)
Referral from friends or family	7 (1.9)
Self-referral	127 (34.7)
Voluntary, Community or Social Enterprise Organisation	47 (12.8)
Voluntary/Community/Social Enterprise based Link Worker/Social Prescriber	1 (0.3)

Support provided by GSP Link Workers in Site 5

A small amount of data were provided on the number of support sessions people received from GSP Link Workers. Of the 60 service users, over half received between 2-5 sessions (53.3%, n=32/60). A further third of service users received between 6-10 sessions (25%, n=15/60). No-one received more than 15 sessions. **This indicates that GSP Link Workers provide fairly short-term support, reflecting their role as a triage type service.**

GSP Link Worker onward referrals in Site 5

At the point of providing data, over two thirds of service users had been referred to nature-based activities (68.7%, n=270/393). This was considerably higher than amongst the generic Link Workers, where the proportion was less than 10%. This higher rate is expected given that the focus of the GSP Link Workers was to support people to access nature-based activities rather than them have a generic function. It was not possible to identify why some people in Site 5 had not been referred to nature-based activities.

Of the referrals made, the most common was to horticultural activities (46.6%, n=126/270) followed by nature-based craft focused activities (21.1%, n=57/270). Referrals to conservation focused or alternative therapy sessions were less common. It is not known whether this is because service users are less interested in these activity types, or they were not available in their locality. This issue will be further explored by the Embedded Researchers in terms of how T&L sites are addressing issues such as the availability of different types of nature-based activities, how organisations decide which activities to deliver and whether these choices are provider or service user driven?

Table A2.31: GSP Link Workers onward referrals

Type of nature-based referral	Number of service users (n=270)
Alternative Therapies (e.g. mindfulness activities)	5 (1.9)
Conservation Focused	15 (5.6)
Craft Focused	57 (21.1)
Exercise Focused	34 (12.6)
Horticultural Type Activities	126 (46.6)
Nature Connection Activity	33 (12.2)

Destination following support in Site 5

Although based on small numbers (n=38), it appeared that there was a potential issue of people having an unplanned ending when accessing GSP Link Worker support (26.3%, n=10/38). This needs further exploration to understand whether there is an issue trying to engage people in nature-based activities. Over a quarter of people were referred onto activities within the same organisation (26.3%, n=10/38) and a proportion were referred onto other organisations (15.8%, n=6/38). Over a quarter of people being referred within the organisation, reflects the model of GSP Link Workers supporting people to access nature-based activities and highlights the potential benefit of people being able to engage in activities within an organisation they already have a relationship with.

Table A2.32: Destination following GSP Link Worker support in Site 5

Destination following support	Number of service users (n=38)
Accessed further activities within the same organisation	10 (26.3)
Continuing to attend the activity	8 (21.1)
Dropped-out of the activity before completing planned support	10 (26.3)
Finished in the organisation and referred to other organisations	6 (15.8)
Finished in the organisation with no onward referral	4 (10.5)

Analysis of nature-based activity provider monitoring data

Number of people accessing nature-based activities

As previously discussed, it is difficult to identify the precise number of people supported through GSP because of the different methods used to record monitoring data and different return rates for each nature-based activity to Project Managers. Based on the data returned, there were at least **3525 nature-based activities delivered**. This figure is likely to be an underestimate because not all of the T&L sites were able to collect monitoring data from all their funded nature-based activities. For example, Site 7 received data from less than a third of providers. Furthermore, sites generally did not collect data from providers that they did not fund. Given the context of some nature-based providers and the different monitoring systems used, it is unlikely that the GSP project will ever be able to fully capture the number of people accessing GSP. This is evident by the gaps and nuances in the monitoring reports returned to the national partners, highlighting the challenges capturing activity. Furthermore, some of the service users accessing GSP will be captured in both the Link Worker and nature-based activity but at this stage it is not possible to track and link people throughout their journey, so it is unknown how representative the data from nature-based activity providers and Link Workers is in terms of capturing common GSP journeys.

Demographics of people accessing funded nature-based activities

A diverse range of people are being supported by nature-based providers. This includes a significant proportion of people with mental health issues. Furthermore, nature-based providers are supporting service users including people living in socioeconomically deprived areas and people from ethnic minority backgrounds.

Gender: Across the sites there is a relatively even proportion of men (46.7%, n=885/1895) and women (52.2%, n=990/1895) being supported by nature-based providers. A small number of people identified as 'non-binary' and 'other'. It is important that GSP focuses on creating an inclusive environment so may want to reflect on whether there is more that is needed to be done in respect of gender inclusivity.

Age- Sites appeared to support people across the age spectrum including under 18s, people of working age and older people. However, there were differences in supporting under 18s between T&L sites. In some sites a significant proportion of service users were under 18, ranging from 20% to 40%. This highlights the potential role of GSP in respect of younger people, but it has implications for how GSP can fit within existing service pathways and the commissioning of nature-based activities. However, in other sites under 18s were not supported and this is an issue to consider for the future direction of GSP. Around a fifth of service users were over 65, this included people in their 60s as well as those in their 70s and 80s. However, the proportion of over 65s varied between sites, some had only small numbers whereas over a quarter of service users were over 65 in other sites. Across the sites, a significant proportion were of working age including people in their 20s and 50s. The heterogeneity of the ages of service users indicates that GSP is supporting people across the age spectrum. However, further consideration is needed in respect of the role of GSP in supporting people who are under 18.

Ethnicity: Nature-based providers are supporting people from a range of ethnicities. **Generally, the sites are supporting a greater proportion of service users from ethnic minority backgrounds than the national population average.** For example, across the sites, 68% (n=755/1110) of service users were White British. This is lower than the national average of 78.4% (Office for National Statistics, 2021). The data

indicates that GSP is potentially reaching people from ethnic minority backgrounds, however the precise ethnic profile in each T&L site differed, which is likely to reflect local demographics. Some sites have proactively funded nature-based activities aimed at people from specific ethnic communities which is positive and is reflective in the data. However, Project Managers raised concerns that other activities were struggling to recruit people from ethnic minorities.

Socioeconomic deprivation: There was heterogeneity in the proportion of service users that live in neighbourhoods classed as socioeconomically deprived between sites (measured by the IMD as described in the methods appendix). This is reflective of the different localities of the T&L sites but also reflects that within each site, there will be multiple types of neighbourhoods. **Over half of service-users lived in the most socioeconomically deprived neighbourhoods (Deciles 1-3) (61.7%, n=501/812).** This is important given concerns raised within the questionnaire about whether this cohort would access nature-based support. Building upon this, service users also lived in areas of medium and low socioeconomic deprivation highlighting that GSP was operating across different types of neighbourhoods.

Sexuality: Emerging data indicates that GSP is engaging people who identify as LGBTQ+. Site 7 collected monitoring data on sexuality. Within the site, over 5% of service users identified as LGBTQ+ (6.2%, n=18/288). This is higher than the national average (Kampen et al., 2017; Office for National Statistics, 2021). Whilst this is only one site, it is an important issue for the Embedded Researchers to explore further on whether GSP is supporting people who identify as LGBTQ+, especially given the higher rates of mental health issues within the community.

Health status: Emerging data indicates that GSP is supporting people who consider themselves as disabled or as having a long-term health condition. In Site 7 (the only site collecting this information), over a third of service users self-identified as having a disability or long-term health condition (37.1%, n=111/299).

Clinically vulnerable to Covid-19: Site 2 wanted to ensure that people who were clinically vulnerable to Covid-19 were supported through GSP because of the impact of the pandemic on this population such as having to shield. **Just under half of people supported within this site were classed as clinically vulnerable, indicating that GSP is reaching this population (46.8%, 116/248).**

Caring status: The GSP project appeared to be supporting people who either had carers or were informal carers. Site 2 collected information on caring status and identified that 20% of service users considered themselves as having a carer (n=59/295). The GSP project was also engaging people who considered themselves to be informal carers (8.8%, n=26/295). This is just above the national average of 6% of the population being informal carers (Foley et al., 2022). This indicates that within the specific site, the GSP project is reaching people who are impacted by caring.

Table A2.33: Demographics of people accessing funded nature-based activities

Variable	Characteristic	Site 1 (n=173)	Site 2 (n=659)	Site 3 (n=33)	Site 5 (n=453)	Site 6 (n=196)	Site 7 (n=434)	Cumulative total across sites (n=1948)
Gender	Women	109 (70.3)	346 (52.5)	25 (75.8)	233 (55.6)	103 (52.6)	174 (40.1)	990 (52.2)
	Men	46 (29.7)	300 (45.6)	8 (24.2)	179 (42.7)	93 (47.4)	259 (59.7)	885 (46.7)
	Other		13 (1.9)		3 (0.7)			16 (0.8)
	Non-binary				4 (1.0)			4 (0.2)
	Prefer Not to Say						1 (0.2)	1 (0.05)
Age	< 18		147 (22.9)		5 (1.4)	80 (40.8)	Site used different age categories	232 (18.7)
	18 – 24		76 (11.8)		36 (9.9)	9 (4.6)		121 (9.8)
	25 – 29		38 (5.8)	1 (3.0)	28 (7.7)	12 (6.1)		79 (6.4)
	30 – 34		35 (5.4)	2 (6.1)	27 (7.4)	3 (1.5)		67 (5.4)
	35 – 39		43 (6.7)	2 (6.1)	50 (13.7)	8 (4.1)		103 (8.4)
	40 – 44		45 (7)	2 (6.1)	25 (6.9)	8 (4.1)		84 (6.8)
	45 – 49		37 (5.8)	4 (12.1)	34 (9.3)	20 (10.2)		95 (7.7)
	50 – 54		40 (6.2)	2 (6.1)	35 (9.6)	17 (8.7)		94 (7.6)
	55 – 59		41 (6.4)	2 (6.1)	21 (5.8)	10 (5.1)		74 (6)
	60 – 64		43 (6.7)	8 (24.2)	37 (10.2)	14 (7.1)		102 (8.2)
	65 – 69		31 (4.8)	7 (21.2)	22 (6.0)	4 (2.0)		64 (5.2)
	70 – 74		21 (3.3)	2 (6.1)	19 (5.2)	4 (2.0)		46 (3.7)
	75 – 79		32 (5)	1 (3.0)	10 (2.7)	6 (3.1)		49 (4)
	80 – 84		9 (1.4)		9 (2.5)	1 (0.5)		19 (1.5)
	≥ 85		5 (0.8)		6 (1.6)	0 (0.0)		9 (0.7)

Variable	Characteristic	Site 1 (n=173)	Site 2 (n=659)	Site 3 (n=33)	Site 5 (n=453)	Site 6 (n=196)	Site 7 (n=434)	Cumulative total across sites (n=1948)
Age category	<18						82 (22.1)	
	18-65						176 (47.4)	
	>65						113 (30.5)	
Ethnicity	Any other Asian background		18 (3.2)	1 (3.0)	8 (2.1)	0 (0)		27 (2.3)
	Any other Black, African or Caribbean background		10 (1.8)		2 (0.5)	1 (0.5)		13 (1.2)
	Any other ethnic group		1 (0.2)	1 (3.0)	3 (0.8)	1 (0.5)		8 (0.7)
	Any other Mixed or multiple ethnic background		2 (0.4)		12 (3.2)	2 (1.0)		16 (1.4)
	Any other White background		3 (0.5)		9 (2.4)	24 (12.2)		41 (3.7)
	Arab		40 (7)					43 (3.9)
	Asian – British		3 (0.5)					3 (0.3)
	Asian/Asian British– Chinese		3 (0.5)			4 (2.0)		7 (0.6)
	Asian/Asian British– Indian				1 (0.3)	17 (8.7)		18 (1.6)
	Asian/Asian British– Pakistani		22 (3.9)		43 (11.4)	4 (2.0)		94 (8.5)

Variable	Characteristic	Site 1 (n=173)	Site 2 (n=659)	Site 3 (n=33)	Site 5 (n=453)	Site 6 (n=196)	Site 7 (n=434)	Cumulative total across sites (n=1948)
	Black/Black British– African		14 (2.5)	1 (3.0)	7 (1.9)	1 (0.5)		24 (2.2)
	Black/Black British– Caribbean		4 (0.7)		5 (1.3)			9 (0.8)
	Mexican		1 (0.2)					1 (0.1)
	Polish		1 (0.2)					1 (0.1)
	White– English, Welsh, Scottish, Northern Irish or British		430 (75.3)	26 (78.8)	275 (73.1)	125 (63.8)		755 (68)
	White – Gypsy or Irish Traveller		8 (1.4)			6 (3.1)		14 (1.3)
	White – Irish		6 (1.1)		4 (1.1)			10 (0.9)
	White and Asian		2 (0.4)	1 (3.0)	3 (0.8)	8 (4.1)		15 (1.4)
	White and Black African			1 (3.0)	1 (0.3)	1 (0.5)		3 (0.2)
	White and Black Caribbean		3 (0.5)	1 (3.0)	3 (0.8)	2 (1.0)		9 (0.8)
Ethnic minority or Not	Yes						241 (60.6)	
	No						157 (39.4)	
Socioeconomic deprivation of neighbourhood resided in (IMD Decile)	1 (Most Deprived)		154 (50.0)	4 (15.4)	122 (31.3)	0 (0.0)		280 (34.5)

Variable	Characteristic	Site 1 (n=173)	Site 2 (n=659)	Site 3 (n=33)	Site 5 (n=453)	Site 6 (n=196)	Site 7 (n=434)	Cumulative total across sites (n=1948)
	2		40 (13.0)	4 (15.4)	78 (20.0)	0 (0.0)		122 (15)
	3		29 (9.4)	0 (0.0)	69 (17.7)	1 (1.1)		99 (12.2)
	4		11 (3.6)	4 (15.4)	39 (10.0)	26 (29.5)		80 (9.9)
	5		18 (5.8)	2 (7.7)	22 (5.6)	4 (4.5)		46 (5.7)
	6		19 (6.2)	4 (15.4)	13 (3.3)	5 (5.7)		41 (5.0)
	7		15 (4.9)	1 (3.8)	13 (3.3)	12 (13.6)		41 (5.0)
	8		10 (3.2)	1 (3.8)	23 (5.9)	8 (9.1)		42 (5.2)
	9		7 (2.3)	2 (7.7)	7 (1.8)	9 (10.2)		25 (3.1)
	10 (Least Deprived)		5 (1.6)	4 (15.4)	4 (1.0)	23 (26.1)		36 (4.4)
LGBTQ+	Yes						18 (6.2)	
	No						270 (93.8)	
Disability / Long-term health condition	Yes						111 (37.1)	
	No						188 (62.9)	
Clinically Vulnerable to COVID-19	Yes		116 (46.8)					
	No		132 (53.2)					

Variable	Characteristic	Site 1 (n=173)	Site 2 (n=659)	Site 3 (n=33)	Site 5 (n=453)	Site 6 (n=196)	Site 7 (n=434)	Cumulative total across sites (n=1948)
Caring status	Does not have a carer/Is not a carer		210 (71.2)					
	Has a carer		59 (20)					
	Is a carer		26 (8.8)					

Mental Health Issues

The majority of people accessing nature-based activities reported mental health issues and T&L sites were reaching people with different levels of need ranging from pre-determinants to people living with serious mental illness. Throughout we use the term pre-determinants for people who may be experiencing issues that could be impacting on their mental health including people experiencing loneliness or debt that may be having a detrimental impact on mental wellbeing. However, these people would not be necessarily categorised as someone meeting a clinical diagnosis of a mental illness such as depression. This term alongside the classifications of mental health needs used within the National Evaluation was developed with the national partners.

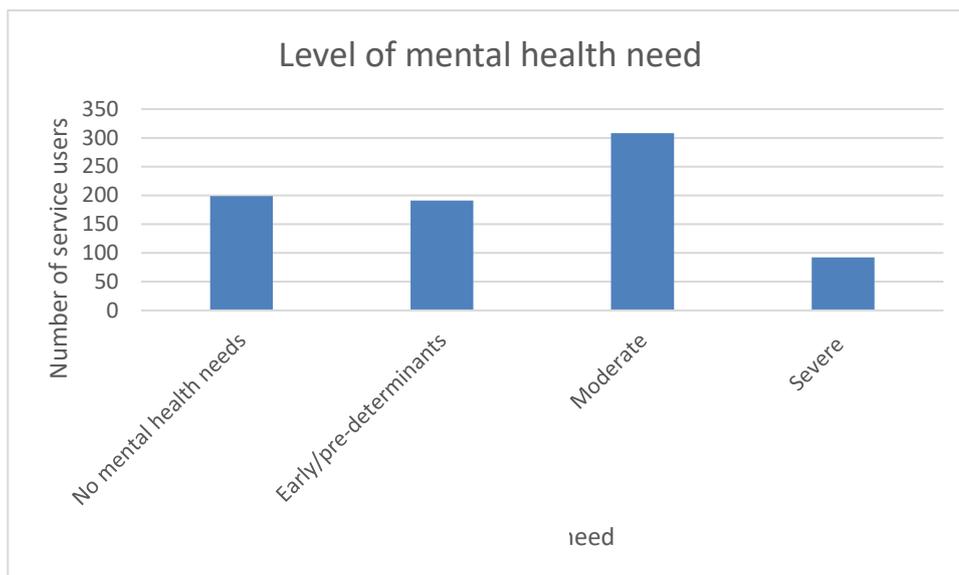
Across the T&L sites, three quarters of service users were categorised as having mental health issues (74.8%, n=591/790). However, proportions varied between sites. In Site 6 less than half of service users were recorded as having mental health needs whereas in the two other sites that provided data, the proportions were over 80%. GSP was supporting people with differing levels of mental health needs ranging from having pre-determinants to more severe mental health issues. Approximately a quarter of service users were considered as having pre-determinant mental health issues including experiencing loneliness (24.2%, n=191/790). The most common category was moderate mental health issues including service users experiencing depression (39%, n=308/790). A small proportion of service users were considered as living with serious mental illness e.g., psychosis (11.6%, n=92/790).

Some of the nature-based providers used mental wellbeing measures which indicated that GSP was a broad offer, supporting people with both lower and higher levels of mental wellbeing. In Site 3 they used the Short Warwick Edinburgh Mental Wellbeing Scale. Of the 33 people that completed the measure, the mean was 23.2 which was comparative to the UK population mean (Ng Fat *et al.*, 2017). However, people's scores ranged from 8-35, highlighting that the level of mental wellbeing of people accessing nature-based activities varies considerably from having low levels of mental wellbeing but also those with average or higher levels of mental wellbeing. A similar finding occurred in respect of the ONS-4 data, collected in a number of sites. The ONS-4 data is discussed later in the document in respect of the impact of nature-based activities.

Table A2.34: Mental health needs of people accessing nature-based providers

	Site 2 (n=437)	Site 5 (n=157)	Site 6 (n=196)	Cumulative total across sites (n=790)
User has mental health needs which infringe on daily life				
No mental health needs	78 (17.8)	24 (15.3)	97 (49.5)	199 (25.2)
Early/pre-determinants of mental health needs	120 (27.5)	40 (25.5)	31 (15.8)	191 (24.2)
Moderate mental health needs	201 (46)	65 (41.4)	42 (21.4)	308 (39)
Severe mental health needs	38 (8.7)	28 (17.8)	26 (13.3)	92 (11.6)
Mental Health Needs				
Yes	359 (82.2)	133 (84.7)	99 (50.5)	591 (74.8)
No	78 (17.8)	24 (15.3)	97 (49.5)	199 (25.2)

Figure A2.21: Nature of mental health needs of service-users accessing nature-based activities



Source of referral to nature-based activities

There was considerable heterogeneity in referral routes between the T&L sites. Referrals were from a wide range of sources including Link Workers, self-referrals, and referrals from voluntary sector organisations. Link Workers were the most common source of referral, with just over a quarter of service-users being referred to a nature-based activity via a Link Worker (27.2%, n=393/1447). Link Workers were based in different sectors including primary care and the voluntary sector. Across the sites, self-referral was a prominent referral source. **A quarter of service users accessed nature-based activities through self-referral (29.8%, n=431/1447).** Sites are developing mixed-referral models with variation between T&L sites about how large a role Link Workers play. For example, in Site 7, 8.8% of nature-based referrals are from Link Workers whereas it is over half within Site 6 (54.3%). Whilst some of these differences may be attributed to which organisations returned data, the statistics indicate that T&L sites may have developed different GSP configurations to reach people who can benefit from nature-based activity. In sites where the numbers of referrals from Link Workers are relatively low, there is potential to increase Link Worker referrals.

Other sources of referrals included voluntary organisations or from other parts of an organisation delivering nature-based activities. **Healthcare professionals such as mental health services or GPs made a small number of referrals.** Less than 5% of service users were recruited through mental health services, indicating potential scope for GSP projects to work closely with mental health services to develop more established referral routes. The variety of referral routes underpins the need to have multiple referral routes to reach as many people as possible who could potentially benefit from nature-based activities.

Table A2.35: Referral route to nature-based activities

Source of referral	Site 2 (n=590)	Site 3 (n=32)	Site 5 (n=426)	Site 6 (n=92)	Site 7 (n= 307)	Cumulative total across sites (n=1447)
Department for Work and Pensions					2 (0.7)	2 (0.1)
GP	10 (1.7)		4 (0.9)		14 (4.7)	28 (1.9)
Local Authority	17 (2.9)		4 (0.9)			21 (1.5)
Mental health teams e.g. Community Mental Health Team	27 (4.6)		9 (2.1)	2 (2.2)	5 (1.7)	43 (3)
Other NHS Service	15 (2.5)		35 (8.2)	4 (4.3)		54 (3.7)
Other Primary Care Professional	1 (0.2)		9 (2.1)			10 (0.7)
Primary Care				15 (16.3)	13 (4.4)	28 (1.9)
Primary Care Based Link Worker/Social Prescriber	70 (11.8)		148 (34.7)	11 (12.0)	4 (1.4)	233 (16.1)
Private sector referral	118 (20)		5 (1.2)			123 (8.5)
Referral from another part of the organisation	82 (13.9)	1 (3.1)	2 (0.5)			85 (5.9)
Referral from family/friends	42 (7.1_)	6 (18.8)	7 (1.6)	11 (12.0)	2 (0.7)	68 (4.7)
Self-referral	77 (13.1)	8 (25)	137 (32.2)	9 (9.8)	200 (67.8)	431 (29.8)
Social prescriber (sector not specified)		2 (6.2)			22 (7.5)	24 (1.7)
School					13 (4.4)	13 (0.9)
Voluntary, Community or Social Enterprise Organisation	36 (6.1)	15 (46.9)	64 (15.0)	1 (1.1)	19 (6.4)	135 (9.3)
Voluntary sector based Link Worker/Social Prescriber	95 (16.1)		2 (0.5)	39 (42.2)		136 (9.4)
Other					13 (4.4)	13 (0.9)

Figure A2.22: Source of referral to nature-based providers

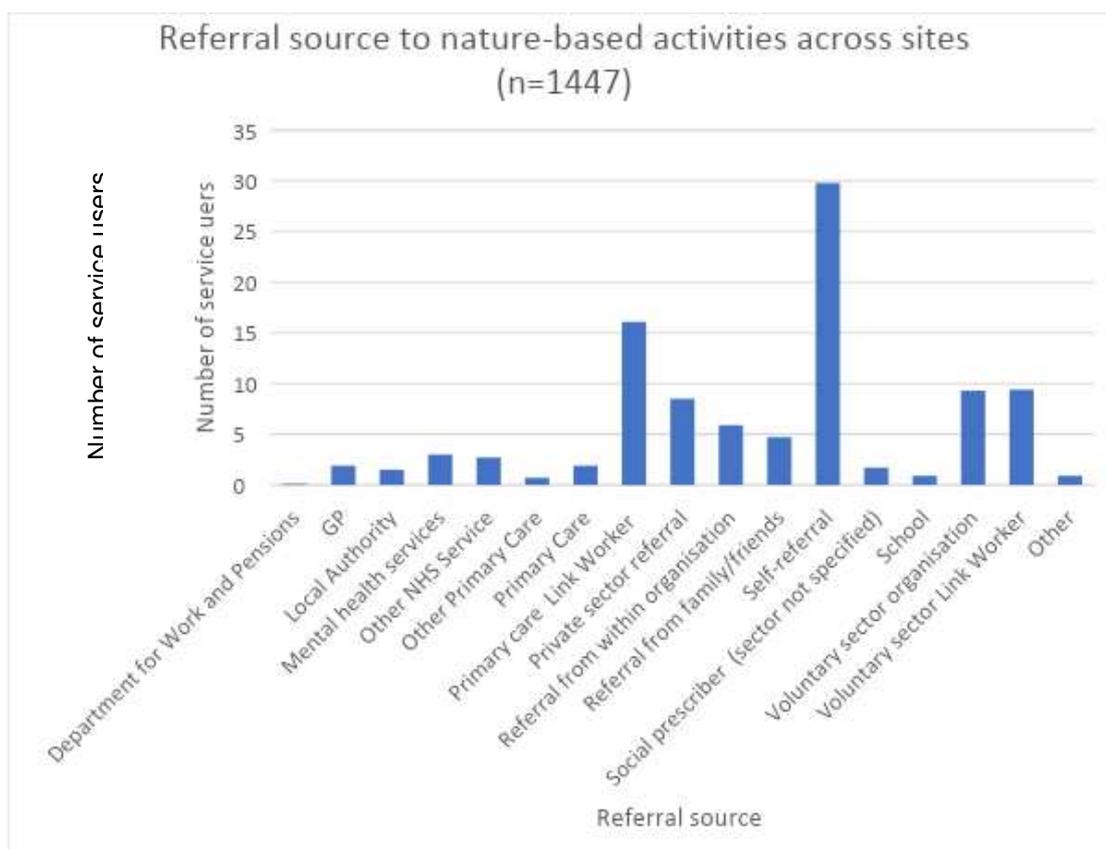


Table A2.36: Proportion of Link Worker referrals to nature-based providers (based on nature-based provider detail)

	Site 2 (n=590)	Site 3 (n=32)	Site 5 (n=426)	Site 6 (n=92)	Site 7 (n=307)	Cumulative total across sites (n=1447)
Proportion of referrals from Link Workers irrespective of specific employment sector	165 (30)	2 (6.3)	150 (35.2)	50 (54.3)	26 (8.5)	393 (27.2)

Whether referrals received nature-based support

The majority of people referred to nature-based activities appeared to receive support. In Site 5, over two-thirds of service users received nature-based support (67.3%, n=268/397). Less than 10% of service users did not receive nature-based support (7.3%, n=29/397). Whilst there will always be some people who do not access support, it could be useful to identify if there are issues that need addressing to increase engagement. A quarter of people were awaiting support (25.4%, n=101/397). This may be because of waiting lists due to capacity issues or people are waiting for an activity to start.

Delivery of Nature-based activities

There was a wide variety of nature-based activities delivered ranging from horticulture type of activities, craft focus and nature connection activity. Of the data received, the most common types were nature connection activities such as bushcraft (18.1%, n=527/2906) and horticultural activities (15.5%, n=451/2906). Less common were wilderness activities, talking-therapies and nature-based arts and crafts activities. There was a large number of service-users attending 'other' activities, but this was largely due to one provider in Site 2. This provider ran drop-in activities within a park and had 869 people accessing the activity.

The types of activity varied between sites reflecting local commissioning preferences (albeit it may also be the product of who returned data monitoring). The wide range of activities highlights the importance of having different types of nature-based activity on offer to appeal to as many people as possible. It is not possible to assess, from reported data, the optimum nature-based activity mix that T&L sites may want to fund and whether some types of activity may be more effective than others in terms of supporting mental wellbeing. There is also the issue of how the specific type of activity influences commissioning decisions. For example, is the specific activity less important than ensuring having activities targeting specific demographics. Cost and resources may also be relevant, for example it may be cheaper to offer health walks than sustain a community allotment. There was considerable variation in the number of service users supported by each project, ranging from less than 10 to over 800, reflecting the different scope of activities.

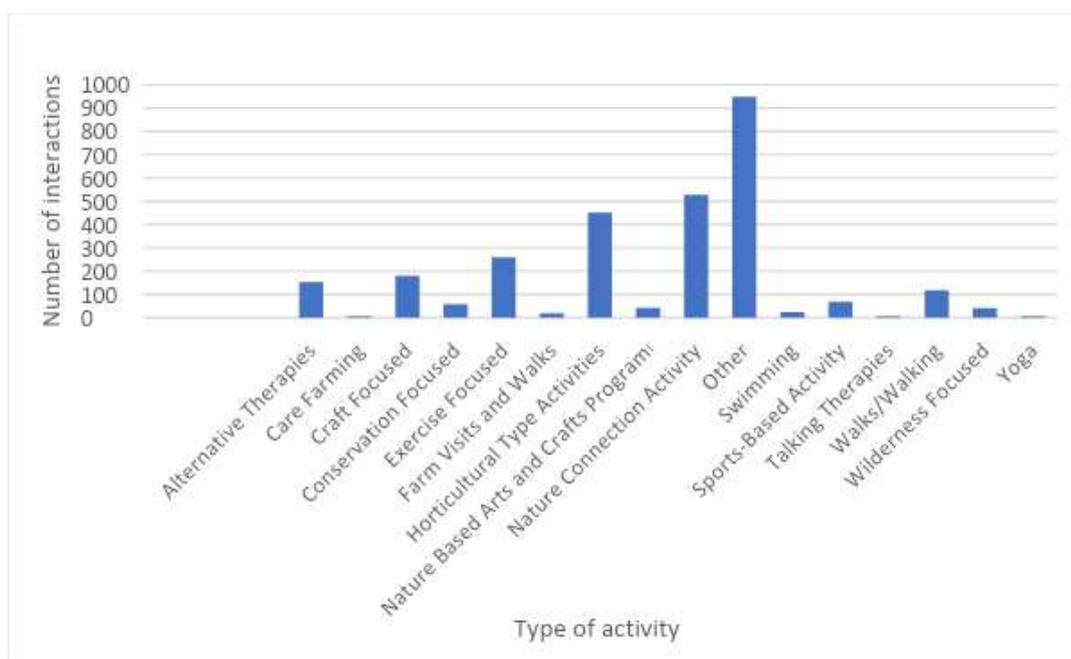
Table A2.37: Type of nature-based activity (data from nature-based providers)

Type of nature-based activity	Site 1 (n=32)	Site 2 (n=1776)	Site 5 (n=331)	Site 6 (n=464)	Site 7 (n=303)	Cumulative total across sites ⁹ (n=2906)
Alternative Therapies (e.g. Mindfulness Activities, Spiritual Retreats)		138 (7.8)	5 (1.5)	10 (2.2)		153 (5.3)
Care Farming (e.g. Caring for Animals)		6 (0.3)				6 (0.2)
Craft Focused		45 (2.5)	60 (18.1)	75 (16.2)		180 (6.2)
Conservation Focused		30 (1.7)	16 (4.8)	12 (2.6)		58 (2)
Exercise Focused	6 (18.8)	125 (7)	40 (12.1)	88 (19)		259 (8.9)
Farm Visits and Walks					19 (6.3)	19 (0.7)
Horticultural Type Activities	22 (68.7)	135 (7.6)	139 (42)	111 (23.9)	44 (14.5)	451 (15.5)
Nature Based Arts and Crafts Programmes		22 (1.2)			20 (6.6)	42 (1.4)

⁹ Numbers greater than total of service-users because individuals could attend more than one nature-based activity. Percentage is of numbers of activities delivered.

Type of nature-based activity	Site 1 (n=32)	Site 2 (n=1776)	Site 5 (n=331)	Site 6 (n=464)	Site 7 (n=303)	Cumulative total across sites ⁹ (n=2906)
Nature Connection Activity e.g bushcraft		254 (14.3)	62 (18.7)	115 (24.8)	96 (31.7)	527 (18.1)
Other e.g family open days in parks	4 (12.5)	923 (52)	4 (1.2)	17 (3.6)		948 (32.6)
Open water swimming				12 (2.6)	12 (4.0)	24 (0.8)
Sports-Based Activity		42(2.4)		5 (1.1)	21 (6.9)	68 (2.3)
Talking Therapies Delivered in a Natural Setting		3 (0.2)		3 (0.6)		6 (0.2)
Walks/Walking		33 (1.9)			85 (28.1)	118 (4.1)
Wilderness Focused		20 (1.1)	5 (1.6)	16 (3.4)		41 (1.4)
Yoga					6 (2.0)	6 (0.2)

Figure A2.23: Types of nature-based activities delivered



Date of referrals and support

There was breadth in the number of service users accessing nature-based activities each month. Sites provided information on the date of referral and the dates that service users received support. However, the high number of errors within the data meant we were unable to utilise it meaningfully. For example, the date of referral was often the same as the date recorded for when support began, or dates were in the future. However, despite this, it was evident that the number of service users both referred and supported appeared to vary each month. This indicates that there is not a consistent pattern of referrals which can make planning capacity and estimating appropriate caseloads challenging.

Amount of support received

Exact numbers of interactions received from providers were not fixed and difficult to assess, given a lack of consensus on 'completion' and the fact a large proportion continue to attend activities at the time of data collection. Of the data received, the most frequent experience was service users receiving between 6-10 interactions to date. However, the number of sessions range was 1-20. It is likely that the people being recorded as having one session are primarily people who attended one-off taster nature-based events. The 6-10 interactions will include people who were attending fixed-term activities such as horticulture courses but also service users attending ongoing activities. People attending a greater number of sessions may be accessing ongoing nature-based activities. The number of interactions raises questions whether GSP funding should be focused on fixed-term activities which may act as a gateway to other non-GSP funded nature-based activities or whether GSP funds ongoing nature-based activities that a service-users may continue to attend.

Site 1 recorded how frequently sessions were. In that site, the majority of service users attended the nature-based activity weekly (86%, n=24/28). A small number of service users attended more than once a week and 1 person attended fortnightly and another monthly. Whilst this was one site, it indicates that service users generally attend weekly nature-based activities.

Destination following nature-based support

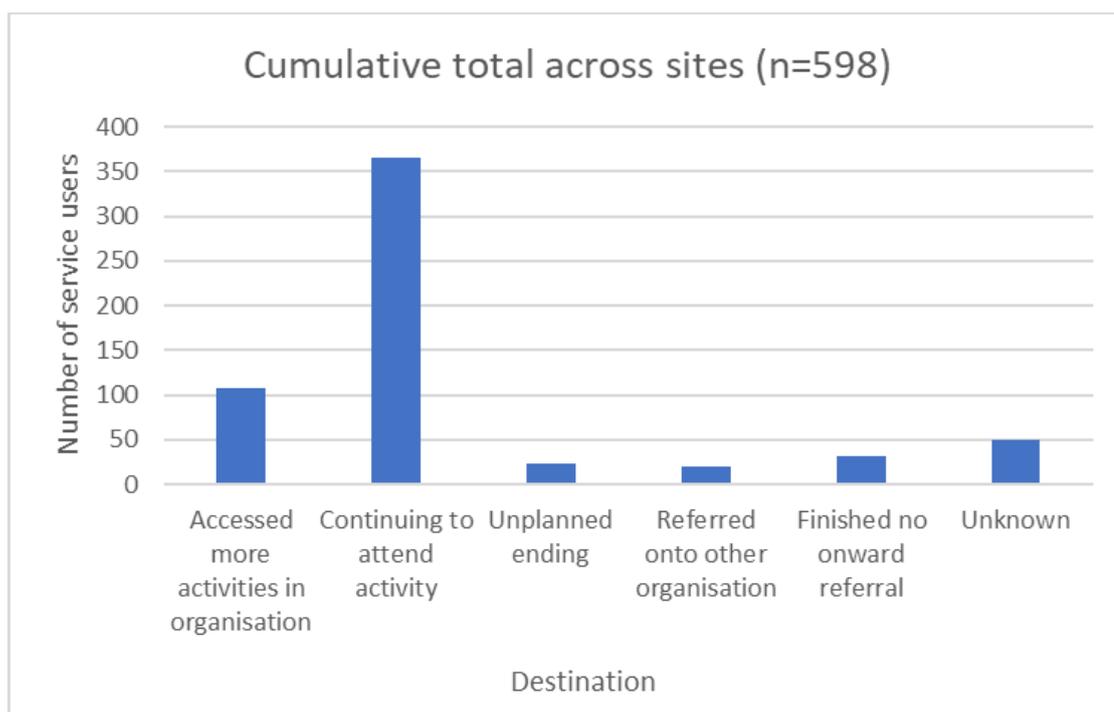
Service users had different destinations when attending nature-based activities. Firstly, the proportion of service users having unplanned endings appeared relatively low. For example, people who stopped attending a course before the last session. **Across the sites it appeared less than 5% of people had an unplanned ending (3.3%, n=24/598).** This is relatively low compared to other social prescribing related activities (Foster et al., 2020). It is also positive given that GSP is supporting service users who may have complex needs which could be detrimental to attendance. However, it is unknown how representative the data is and further exploration will be undertaken with nature-based providers.

Over half of service users were continuing to attend activities (61.2%, n=366/598). This potentially raises capacity issues in terms of accepting new referrals, as highlighted within the questionnaires. Nature-based providers also have a signposting role themselves, supporting some service users to access further activities within the organisation (17.9%, n=107/598), or with other organisations (3.3%, n=20/598). This indicates that in terms of a service user journey, there can be multiple nature-based encounters stemming from a single referral.

Table A2.38: Destination following nature-based activity

Destination following nature-based activity	Site 2 (n=349)	Site 5 (n=82)	Site 6 (n=167)	Cumulative total across sites (n=598)
Accessed further activities with the same organisation	79 (22.7)	19 (23.2)	9 (5.4)	107 (17.9)
Continuing to attend the activity	183 (52.5)	25 (30.5)	158 (94.6)	366 (61.2)
Unplanned ending (e.g. stopped attending the activity before completing planned support)	13 (3.7)	11 (13.4)		24 (4)
Finished in the organisation and referred to other organisations	13 (3.7)	7 (8.5)		20 (3.3)
Finished in the organisation with no onward referral	26 (7.4)	5 (6.1)		31 (5.2)
Unknown	35 (10)	15 (18.3)		50 (8.4)

Figure A2.24: Destination following nature-based activity



Change in mental wellbeing when accessing nature-based activities

Service users experienced improved mental wellbeing when accessing nature-based activities. There are considerable differences in the extent of change between sites and whether the change was statistically significant. This is likely due to measurement issues and sample sizes. Overall, people who completed both a pre and post ONS-4 when accessing nature-based activities experienced an improvement in their mental wellbeing. Below, each question on the ONS-4 is presented. **Due to the diversity of activities and number of interactions, it is unclear what nature-based activities are having the greatest impact on mental wellbeing.** For each question we present average change for service users who

completed both a pre and post ONS-4 measure. We also consider the proportion of population change. This latter measure includes anyone who has completed a pre and/or post ONS-4 measure (analysis explained within the earlier methods section).

Life satisfaction

Service users experienced an improvement in their life satisfaction when accessing nature-based activities. Whilst the extent of change varied, the change appeared statistically significant (Table 2.39). Of particular note, is that the proportion of service users identifying as having high or very high life satisfaction increased from 17.3% (n=38/2194) to 78%, (n=128/164) after accessing a nature-based activity (Table A2.40). This highlights how GSP is supporting an improvement in people's life satisfaction.

Table A2.39: Extent of change in life satisfaction when accessing nature-based activity providers

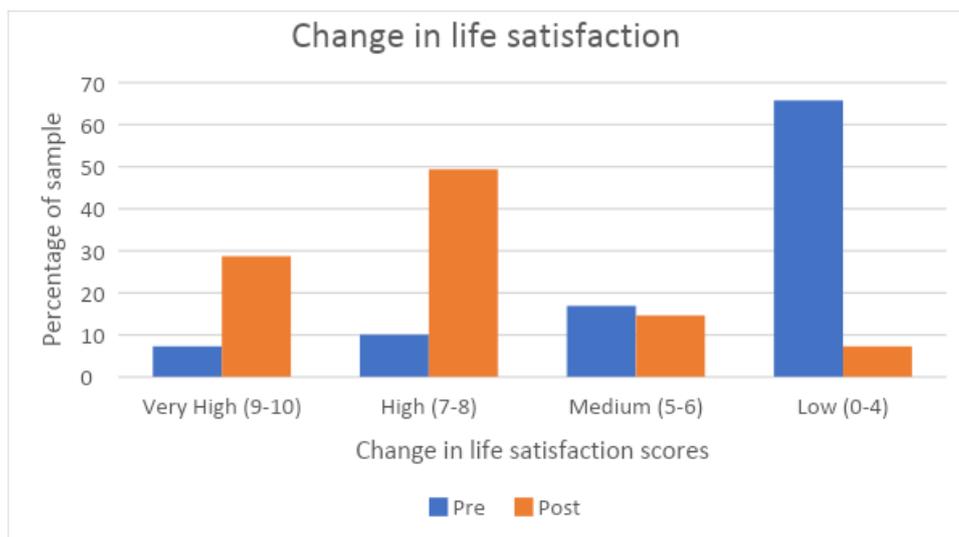
	Pre score (SD)	Post score (SD)	Mean Change	95% Confidence interval	Significant change?
Site 1 (n=27)	4.7 (2.6) (Low)	7.2 (1.8) (High)	2.44		<0.001
Site 2 (n=20)	6.8 (2.7) (Medium)	7.6 (2.0) (High)	0.8	0.1-to 1.4	0.036
Site 5 (n=39)	5.1 (2) (Medium)	5.8 (1.7) (Medium)	0.7	0.1 to 1.2	0.018
Site 6 (n=105)	2.3 (0.8) (Low)	8.0 (1.0) (High)	5.7	5.5 to 6	<0.001

Table A2.40: Change in life satisfaction when accessing nature-based activity providers

Category	Site 2 (Pre) (n=37)	Site 2 (Post) (n=20)	Site 5 (Pre) (n=58)	Site 5 (Post) (n=39)	Site 6 (Pre) (n=124)	Site 6 (Post) (n=105)	Cumulative total across sites (Pre) (n=219)	Cumulative total across sites (Post) (n=164)
Very High (9-10)	10 (27)	7 (35)	5 (8.6)	1 (2.6)	1 (0.8)	39 (37.1)	16 (7.3)	47 (28.7)
High (7-8)	5 (13.6)	6 (30)	11 (19)	16 (41.1)	6 (4.8)	59 (56.2)	22 (10)	81 (49.4)
Medium (5-6)	11 (29.7)	6 (30)	21 (36.2)	13 (33.3)	5 (4.1)	5 (4.8)	37 (16.9)	24 (14.6)
Low (-0-4)	11 (29.7)	1 (5)	21 (36.2)	9 (23)	112 (90.3)	2 (1.9)	144 (65.8)	12 (7.3)

Not received the information broken down from Site 1.

Figure A2.25: Change in life satisfaction amongst service users when accessing nature-based activity



Change in whether life is worthwhile

Emerging findings indicate that service users do feel their life is more worthwhile after accessing nature-based activities. Whilst the extent of change and whether the change is statistically significant varies between sites, the findings indicate that nature-based activities are having a positive impact on people’s mental wellbeing. For example, in Site 1, the mean

score increased from 4.9 to 7.3. Across the sites, there was a notable increase in the sample having improved wellbeing. Before receiving support, 20.6% of service users had a high or very high score in terms of considering their life worthwhile (n=45/218) and this increased to almost two thirds of service users post support (64.7%, n=106/164).

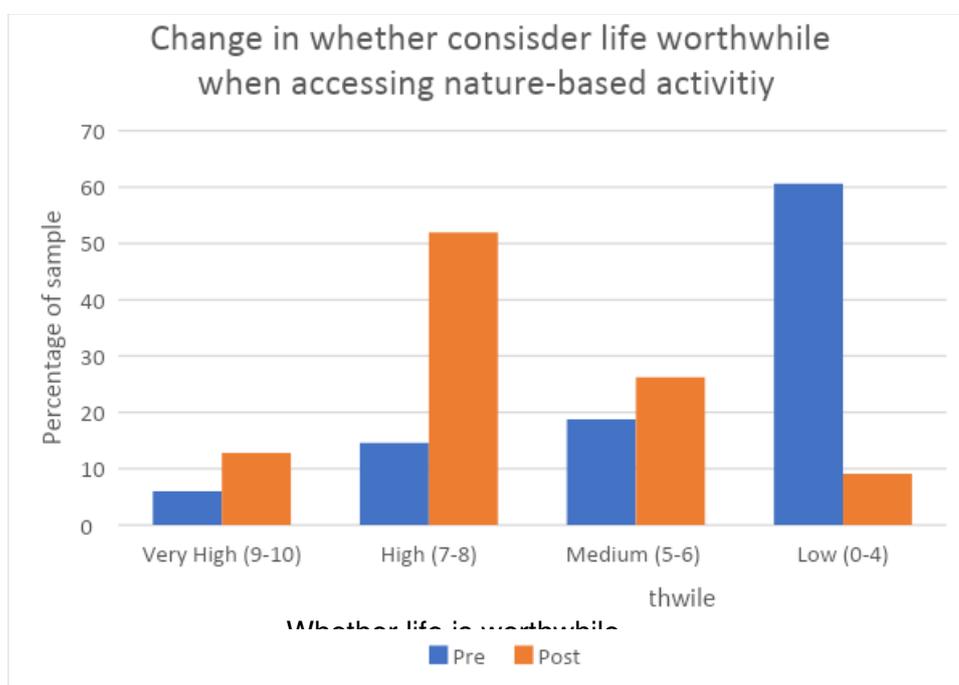
Table A2.41: Extent of change in whether life is worthwhile when accessing nature-based activity providers

	Pre score (SD)	Post score (SD)	Mean Change	95% Confidence Interval	Significant change?
Site 1 (n=27)	4.9 (3.0)	7.3 (1.9)	2.37	N/A	<0.001
Site 2 (n=20)	6.7 (2.2)	7.3 (2.6)	0.7	-0.3 to 1.6	0.189
Site 5 (n=38)	5.6 (2.0)	6.0 (2.0)	0.4	-0.3 to 1.0	0.2
Site 6 (n=105)	3.1 (0.5)	7.1 (1.2)	4	3.8 to 4.3	<0.001

Table A2.42: Change in whether life is worthwhile

Category	Site 2 (Pre) (n=37)	Site 2 (Post) (n=20)	Site 5 (Pre) (n=57)	Site 5 (Post) (n=39)	Site 6 (Pre) (n=124)	Site 6 (Post) (n=105)	Cumulative total across sites (Pre) (n=218)	Cumulative total across sites (Post) (n=164)
Very High (9-10)	8 (21.6)	9 (45)	4 (7.1)	2 (5.1)	1 (0.9)	10 (9.5)	13 (6.0)	21 (12.8)
High (7-8)	8 (21.6)	3(15)	17 (29.8)	12 (30.8)	7 (5.6)	70 (66.7)	32 (14.6)	85 (51.9)
Medium (5-6)	12 (32.4)	5 (25)	22 (38.5)	16 (41)	7 (5.6)	22 (21)	41 (18.8)	43 (26.2)
Low (-0-4)	9 (24.4)	3 (15)	14 (24.6)	9 (23.1)	109 (87.9)	3 (2.8)	132 (60.6)	15 (9.1)

Figure A2.26: Change after accessing nature-based activities in whether service users feel their life is worthwhile



Change in happiness

Service users generally experienced increased happiness when accessing nature-based activities and this was a consistent finding across sites. The finding was statistically significant except in Site 2. However, Site 2 shows positive change but it was a small sample which may account for the finding not being statistically significant. Across the sites, there were improved levels of happiness, for example people categorised as having high and very high levels of happiness increased from 38.7% (n=210/543) to 84.2% (n=398/473).

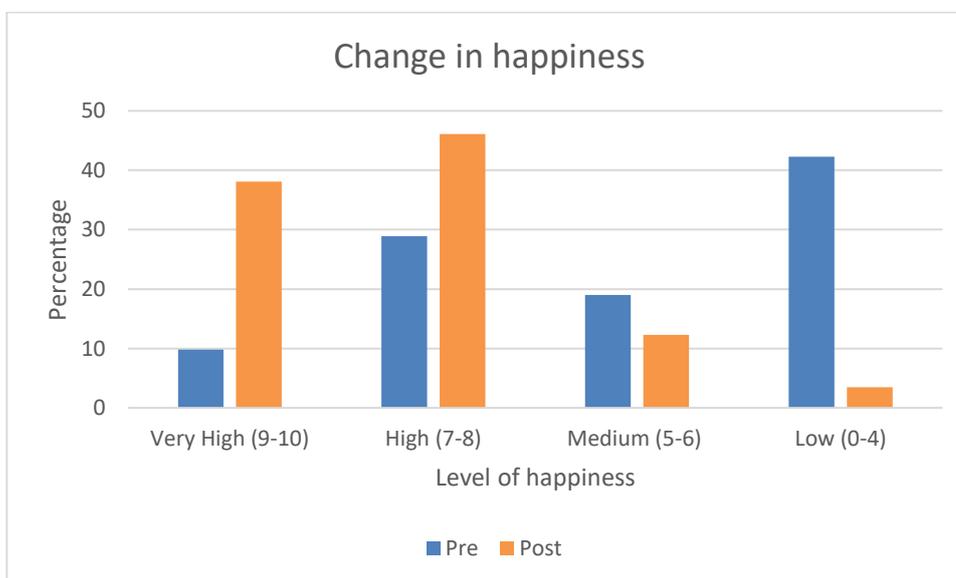
Table A2.43: Extent of change in whether people have improved happiness when accessing nature-based activity providers

	Pre (SD)	Post (SD)	Mean Change	95% Confidence Intervals	Significant change?
Site 1 (n=27)	4.3 (2.7)	7 (2.2)	2.7	N/A	<0.001
Site 2 (n=20)	7 (2.7)	7.4 (2.5)	0.4	-1.2 to 1.9	0.648
Site 5 (n=39)	5.5 (2.9)	6.5 (1.9)	1	0.4 to 1.6	0.003
Site 6 (n=105)	2.3 (0.9)	7.6 (1.1)	5.3	5.0 to 5.6	<0.001
Site 7 (n=308)	6.1 (2.2)	8.2 (1.4)	2.1	1.9 to 2.4	<0.001

Table A2.44: Change in happiness

Category	Site 2 (Pre) (n=37)	Site 2 (Post) (n=20)	Site 5 (Pre) (n=57)	Site 5 (Post) (n=39)	Site 6 (Pre) (n=124)	Site 6 (Post) (n=105)	Site 7 (Pre) (n=325)	Site 7 (Post) (n=309)	Cumulative total across sites- (Pre) (n=543)	Cumulative total across sites- (Post) (n=473)
Very High (9-10)	12 (32.40)	7(35)	6 (10.5)	8 (20.5)	1 (0.8)	26 (24.8)	34 (10.5)	139 (45)	53 (9.8)	180 (38.1)
High (7-8)	7 (18.9)	5 (25)	12 (21.1)	12 (30.8)	7 (5.6)	62 (59)	131 (40.3)	139 (45)	157 (28.9)	218 (46.1)
Medium (5-6)	10 (27.1)	6 (30)	18 (31.6)	14 (35.9)	7 (5.6)	16 (15.2)	68 (20.9)	22 (7.1)	103 (19)	58 (12.3)
Low (0-4)	8 (21.6)	2 (10)	21 (36.8)	5 (12.8)	109 (88)	1 (1)	92 (28.3)	9 (2.9)	230 (42.3)	17 (3.5)

Figure A2.27: Change in happiness amongst service users before and after accessing nature-based activities



Change in anxiety

There is some indication that service users accessing GSP are experiencing a reduction in their anxiety, however this was not a consistent finding across sites. The anxiety scale is analysed in reverse to other questions, meaning a decreased score indicates a reduction in anxiety and thus is an improvement. Not all sites showed a statistically significant change, which may be due to the sample sizes. In Sites 6 and 7, both sites demonstrated a statistically significant reduction in anxiety after accessing

nature-based activities. Both these sites had sample sizes of over 100. This gives some indication that GSP potentially can contribute to reductions in anxiety. Across the sites, there was a general decrease in anxiety. For example, there was a considerable reduction in the proportion of service users having high levels of anxiety from 33.6% (n=179/532) to 9.5% (n=44/463).

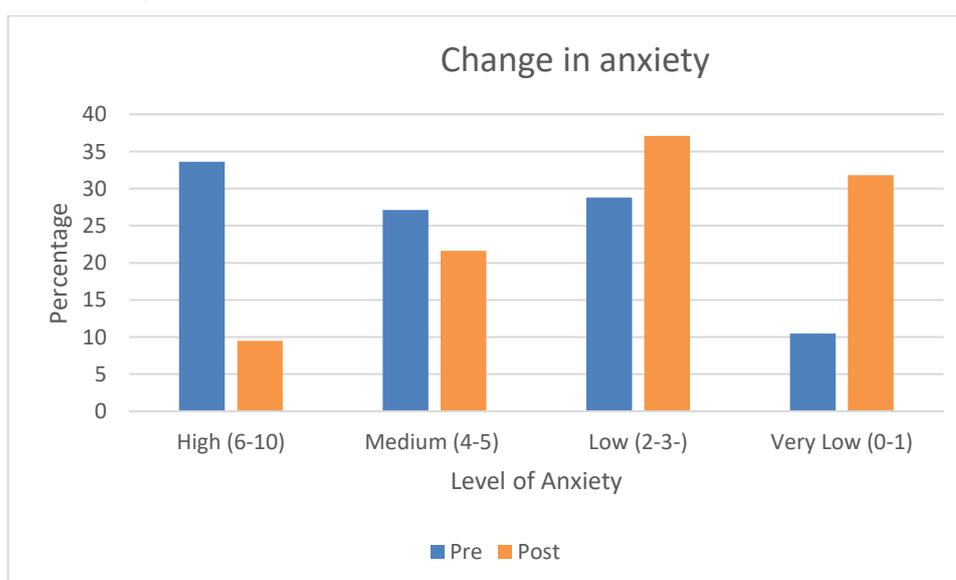
Table A2.45: Change in anxiety when accessing nature-based activities

	Pre score (SD)	Post score (SD)	Mean Change	95% CI	Significant change
Site 1 (n=27)	5.7	3.6	-2.1	N/A	.016
Site 2 (n=20)	3.9 (3.1)	4.7 (3.5)	0.8-	-1.6 to -3.1	0.512
Site 5 (n=38)	4.8 (2.3)	4.3 (2.0)	-0.5	-1.3 to 0.3	0.187
Site 6 (n=105)	2.2 (0.9)	1.8 (1.2)	-0.4	-0.7- to -0.2	<0.001
Site 7 (n=290)	5.2 (2.4)	2.9 (2.07)	-2.3	-2.5 to -2.0	<.0001

Table A2.46: Change in anxiety when accessing nature-based activities

Category	Site 2 (Pre) (n=37)	Site 2 (Post) (n=21)	Site 5 (Pre) (n=57)	Site 5 (Post) (n=38)	Site 6 (Pre) (n=124)	Site 6 (Post) (n=105)	Site 7 (Pre) (n=314)	Site 7 (Post) (n=299)	Cumulative total across sites (Pre) (n=532)	Cumulative total users across sites- (Post) (n=463)
High (6-10)	9 (24.3)	7 (33.3)	25 (43.8)	9 (23.7)	9 (7.3)	1 (1)	136 (43.3)	27 (9)	179 (33.6)	44 (9.5)
Medium (4-5)	9 (24.3)	2 (9.5)	16 (28.1)	15 (39.4)	17 (13.7)	15 (14.3)	102 (32.5)	68 (22.8)	144 (27.1)	100 (21.6)
Low (2-3-)	7 (18.9)	6 (28.6)	9 (15.8)	9 (23.7)	82 (66.1)	27 (25.7)	55 (17.5)	130 (43.5)	153 (28.8)	172 (37.1)
Very Low (0-1)	12 (32.5)	6 (28.6)	7 (12.3)	5 (13.2)	16 (12.9)	62 (59)	21 (6.7)	74 (24.7)	56 (10.5)	147 (31.8)

Figure A2.28: Change in anxiety amongst service users before and after accessing nature-based activities



Physical health improvements when attending nature-based activity

Site 6 collected outcome measure data on whether people’s physical activity increased when accessing nature-based providers. Of the 124 service users who completed the information, there were 6 people from a sample of 17 whose physical activity changed from not regularly doing activity to undertaking regular activity. The analysis found that 86.3% (n=107/124) of participants did sport, a fitness activity or dance in the last 7 days before the nature-based activity and this increased to 90.3% (n=112/124) after the activity. McNamar’s test comparing the paired data shows this is not statistically significant ($p=0.131$) but this may be due to sample size. **Thus, the evidence provides some indication that GSP may support people to increase their physical activity, but it will not benefit everyone. The sample is too small to explore whether the impact on physical activity varies between nature-based activities. Also relevant is that the majority of people were relatively physically active before engaging in nature-based activities which may indicate that GSP is reaching people who are already active.** There may need to be further consideration of whether people who are not physically active will be receptive to nature-based referrals. Whilst this is all speculative at the stage because of the small sample size, the issues will be explored further within the evaluation.

Table A2.47: Change in physical activity when accessing nature-based activities in Site 6

		Physically active after activity		Total
		Yes	No	
Physically active before Activity	Yes	106 (85.5)	1 (0.8)	107
	No	6 (4.8) ¹⁰	11 (8.9)	17
Total		112	12	124

Nature-connectedness

The evidence was mixed on whether people’s nature connectedness improved when accessing nature-based activities. One site demonstrated an improvement, and one site demonstrated a decline. In Site 6, there was a statistically significant improvement in people’s nature connectedness score when attending nature-based activities (n=115). Amongst the 115 people sampled, the average score increased from 4 to 5 out of 7. In contrast in Site 2, there appeared to be a statistically significant deterioration. The pre-score was 6 and the post score was 4. However, it is a relatively small sample (n=28). Furthermore, not all the activities being funded through GSP are aiming to improve nature-connectedness. For example, an outdoor swimming group may be aiming to increase exercise. Given the mixed findings and potential caveats, the issue of nature connectedness will be explored further within the evaluation especially in terms of service-users’ trajectory of ongoing engagement with nature-based activities and the relevance of nature-connectedness to different parts of the GSP project.

¹⁰ Green- Demonstrates an improvement; Red- Demonstrates no improvement or a deterioration.

Table A2.48: Changes in nature connectedness

	N	Pre score		Post score		P-Value
		Median	Inter Quartile Range	Median	Inter Quartile Range	
Site 2	28	6.0	6.0 – 7.0	4.0	4.0 – 4.0	<0.001
Site 6	115	4.0	3.0 – 5.0	5.0	4.0 – 5.0	<0.001

Summary

Whilst the collected monitoring data only captures a snapshot of activity from the GSP project, it has highlighted some important findings. There is considerable breadth in who is accessing GSP, their GSP journey and the types of activity being delivered. In terms of service users, it is evident that the sites are managing to engage people who typically experience health inequalities such as people living in socioeconomically deprived neighbourhoods and people from minority ethnic backgrounds. GSP is reaching people with differing levels of mental health needs. A range of nature-based activities are being delivered through GSP ranging from exercise in nature, bushcraft, and horticulture activities. Whilst in some sites, Link Workers are a key referral source, it is also evident that GSP comprises a range of referral routes including self-referral and referrals from the voluntary sector. Having these multiple referral routes appears important to facilitate access. Many people remain attending the nature-based activities or are supported to access other activities within the same organisation indicating that GSP may have a gateway function. There is some evidence the nature-based activities are having a positive impact on people's mental wellbeing.

References

Cartwright L., Burns L., Akinyemi, O., Carder-Gilbert, H., Tierney, S., Elston, J., Chatterjee, H. [On behalf of the NASP Academic Partners Collaborative]. (2022) *Who is and isn't being referred to social prescribing?* London: National Academy for Social Prescribing. Available at <https://socialprescribingacademy.org.uk/wp-content/uploads/2022/04/Evidence-summary-who-is-accessing-social-prescribing.pdf>

Foley, N., Powell, A., Clark, H., Brione, P., Kennedy, S., Powell, T., Roberts, N., Harker, R., Francis-Devine, F. and Foster, D., (2022) *Informal carers*. House of Commons Library Briefing Paper no. 7756. London: House of Commons Library. Available at <https://researchbriefings.files.parliament.uk/documents/CBP-7756/CBP-7756.pdf>

Foster, A., O'Cathain, A. and Harris, J. (2020) How do third sector organisations or charities providing health and well-being services in England implement patient-reported outcome measures (PROMs)? A qualitative interview study. *BMJ Open*, 10, e039116

Foster, A., Thompson, J., Holding, E., Ariss, S., Mukuria, C., Jacques, R., Akparido, R. and Haywood, A. (2021) Impact of social prescribing to address loneliness: A mixed methods evaluation of a national social prescribing programme. *Health & Social Care in the Community*, 29(5), pp.1439-1449. Available at <https://onlinelibrary.wiley.com/doi/full/10.1111/hsc.13200>

Jani, A., Liyanage, H., Okusi, C., Sherlock, J., Hoang, U., MCGagh, D., Williams, J., Joy, M., Ferreira, F., Yonova, I., Pika, G., Krajenbrink, E., Victor, W., Mcguinness, J. and De Lusignan, S. (2021) *Health inequalities and personalised care in England April 2017-March 2021*. Available at <https://orchid.phc.ox.ac.uk/wp->

[content/uploads/2021/08/Health-inequalities-and-personalised-care-in-England-Apr-2017-Mar-2021.pdf](#)

Kampen, Van S.C., Lee, W., Fornasiero, M. and Husk, K. (2017) The proportion of the population of England that self-identifies as lesbian, gay or bisexual: producing modelled estimates based on national social surveys. *BMC research notes*, 10(1), pp.1-6. Available at <https://bmcrsnotes.biomedcentral.com/articles/10.1186/s13104-017-2921-1>

Ng Fat, L., Scholes, S., Boniface, S., Mindell, J. and Stewart-Brown, S. (2017) Evaluating and establishing national norms for mental wellbeing using the short Warwick–Edinburgh Mental Well-being Scale (SWEMWBS): findings from the Health Survey for England. *Quality of Life Research*, 26(5), pp.1129-1144. Available at <https://psycnet.apa.org/record/2016-56433-001>

Office for National Statistics UK, (2021). *Population estimates by ethnic group and religion, England and Wales: 2019*. Available at <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/populationestimatesbyethnicgroupandreligionenglandandwales/2019>

Office for National Statistics UK. (2021) *Sexual orientation, UK: 2019*. Available at <https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2019>

Tierney, S., Cartwright, L., Akinyemi, O., Carder-Gilbert, H., Burns, L., Dayson, C. and Chatterjee, H. [On behalf of the NASP Academic Partners Collaborative]. (2022) *What does the evidence tell us about accessibility of social prescribing schemes in England to people from black and ethnic minority backgrounds?* London: National Academy for Social Prescribing. Available at: <https://socialprescribingacademy.org.uk/wp-content/uploads/2022/04/Evidence-summary-BME-accessibility.pdf>

Appendix 3: WP3B

Qualitative data

A3.1. Overarching questions

1. What are the key characteristics of each intervention system?
2. What are the different delivery/services/interventions trying to achieve? What is their measure of 'success'?
3. To what degree are systems and success reliant on specific elements of the local context? What are these elements?
4. How well are the expectations/needs of each actor met within each system?
5. Are the active components of each intervention consistent within, and across areas?

A3.2. Methodology

The qualitative data collection and analysis is broadly informed by realist evaluation methods (Pawson & Tilley, 1997) using an embedded researcher approach. The work seeks to understand 'what works for whom in what circumstances' by exploring the context, interventions, mechanisms, and outcomes of the seven Test and Learn sites. Initial programme theories based on the literature and the scoping stage of the evaluation informed the first stage of data collection. These initial programme theories are subject to change as data collection develops. We present in this section, our analysis of initial findings against our initial programme theories.

A3.3. Methods

The data is collected via an embedded researcher approach who is responsible for data collection within their Test and Learn site(s) (Gradinger et al., 2019; Hazeldine et al., 2021). Whilst embedded researchers have been collecting data within their own Test and Learn site, regular meetings have been held to discuss data collection and initial findings.

The primary sources of data collection are:

1. Observation, documentary analysis and informal conversations:

The embedded researchers are engaging in ethnographic data collection activities including observation of T&L site meetings and informal conversations and analysing T&L site reports and documents. Embedded researchers keep field work diaries, making notes in the field and writing up fuller notes following observation and completing an observation template informed by the evaluation

research questions. Data collection and analysis is an iterative process. Whilst each embedded researcher is thematically analysing their own field notes, the wider embedded researcher team meets to discuss findings, developing programme theories and next steps in data collection. We have undertaken 43 formal observations.

2. Realist informed interviews:

Realist informed telephone/online interviews are being conducted with key stakeholders (GSP providers, programme management staff, referrers, Link Workers, volunteers) across the 7 Test and Learn sites for the duration of the evaluation. An initial interview schedule and guide was derived from the programme theories. Based on this, a first set of interviews were conducted by the embedded researchers between January and May 2022.

- 9 interviews completed for T&L1
- 11 interviews completed for T&L2
- 10 interviews completed for T&L3
- 5 interviews completed for T&L4
- 10 interviews completed for T&L5
- 11 interviews completed for T&L6
- 11 interviews completed for T&L7

A second wave of interviews with key stakeholders will be undertaken in early 2023. These interviews will explore specific aspects of the programme theory.

3. Secondary analysis of Test and Learn site case studies (to be conducted early 2023):

Each Test and Learn site is committed to collecting at least one service user case study each quarter. We will undertake secondary analysis across the service user case studies in the first quarter of 2023 in order to further refine and develop programme theory and to develop cross site learning about the service user experience.

A3.4. Findings

A coding framework was developed based on the programme theory and initial realist interviews. Ten thematic areas were identified that reflect areas of the programme theory:

1. Sustainability.
2. Sufficient green activities & assets.
3. Structures & processes.
4. Interconnectivity (between funders & providers and between referrers and providers).
5. Mutual awareness & understanding.
6. Buy in (from referrers & Link Workers).
7. User influence (in structures & processes).
8. (User) Pathway experience.

9. Data & measuring impact.

10. Underserved populations.

We will take each of these findings in turn, considering them at both the local T&L site level and also at a higher overarching level to inform the development of the medium programme level theories.

Before this, we provide an update on each of the Test and Learn sites.

Site updates¹¹

South Yorkshire & Bassetlaw

Since the last report this site has undertaken a number of delivery activities. Many of these activities have revolved around developing partnerships and networks as well as providing support to grant recipients and developing and strengthening referral pathways. Grant recipients are in different stages of delivery, with some activities beginning in April and others over the summer due to the nature of the activities provided. Delivery activities since the last report include:

- Delivering workshops alongside national/local evaluators to support grant recipients with the data ask as well as offering one to one support sessions.
- Delivered training to Link Workers which has now been evaluated and has been well received.
- Undertaken engagement work with Allied Health Professionals to raise awareness of GSP.
- Undertaken further codesign work to increase referrals in underserved communities by working with community leaders to encourage applications from the target cohorts.
- Received match funding from ICS for project extensions. Developed a plan for this focusing on extending projects where there is there scope to strengthen social prescribing and mental health pathways, better engage target cohorts, or to increase their green or blue connection.
- Continued to offer support to grant recipients through the Green Network as well as the Community Practice meetings, bringing green providers together to network and support each other and learn best practice.
- Held workshops on sustainability both in the Task Group, Green Network and Community of Practice meetings to help support grant recipients think about sustainability of their activities beyond the life of the programme.
- Project manager now sits on a system wide task group to mitigate challenges in social prescribing data which has relevance to issues emerging from the GSP programme (see below).

Greater Manchester

Since the last report this site has focused on delivery of green activities in line with the warmer weather, with each mini-T&L site focusing on different aspects of delivery. In turn there have been lots of internal discussions about sustainability beyond the life of the programme including the delivery of an engagement sustainability workshop with

¹¹ Throughout the synthesis and during the interviews we have anonymised sites by number. However, in this section, we have elected to name sites to enable meaningful description and also because some of the information may facilitate the identification of the anonymisation codes.

NHS, council and wider partners to share opportunities, and best practice and discuss sustainability. This site has also focused on county wide training and since the last report has developed and launched a GM wide training plan and website focused on Link Workers, green providers and the wider workforce. Several events have taken place as part of this including a green provider collaborative launch event in Salford which was attended by over 100 people. In turn, the site continues to focus on developing and strengthening referral pathways and targeting underserved communities, including holding workshops and training on equality and diversity. Targeted engagement with the existing Link Worker network continues with specific training and awareness raising happening in each locality where delivery capabilities exist.

Nottingham

Since the previous report, the Test and Learn pilot has now expanded into Nottinghamshire as planned. There are good relationships with Mid and South Nottinghamshire councils and with Link Workers.

Derbyshire

Since the previous report, the pilot has developed mini Test and Learn sites across the different districts. This is complemented by cross-county initiatives. Most recently there has been a development in the green provider network who have developed an alliance model to pilot in the remainder of the GreenSpring pilot to get over the seemingly intractable issue of the NHS commissioning small/micro VCSE sector organisations. Several of these mini test-and-learn and cross-county initiatives are bearing interesting findings and insights.

Humber & North Yorkshire

Since the previous report, this site has awarded funding to VCFSE projects to deliver GSP projects. They have commissioned the University of York to evaluate the project and Link Workers are administering the HADS and ONS-4 before individuals take part in GSP activities and again after approximately 12 weeks. A broad range of projects have been funded (both geographically and in terms of focus) with some funding going towards new projects (Grow Your Own) and some supporting existing work.

Surrey Heartlands

Since the last update, the pilot site has directly funded a number of projects across the locality covering a range of talks, walks, courses and activities that take place outdoors in both rural and urban public green spaces, 12 week courses on mindfulness for teenagers with mental health issues within areas of higher deprivation, nature connection courses for Muslim women and girls at risk of mental health issues, wild swimming for people from minority ethnic backgrounds at risk of mental health issues, online nature workshops for people at risk of mental health issues, accessible green space courses for people with communication needs and learning disabilities, and at risk of mental health issues, and community gardening activities for people within areas of higher deprivation and at risk of mental health issues. The site has also supported healthcare professionals with CPD training in GSP, with plans in train to extend this offer further through match funding with the locality mental health trust, and through corporate sponsorship via the locality's social value marketplace. The site has developed county-wide training for many GSP-related courses, alongside an active green health and wellbeing network. The T&L site is developing plans with the regional mental health trust to run a pilot project developing outdoor therapeutic space and introducing nature as a therapeutic setting, alongside staff training and development

and awareness raising and evaluation of pilot for its effectiveness and viability as an additional health asset for an NHS mental health trust.

Bristol

This pilot site has funded projects across the locality, with specific projects supporting ethnic minorities, refugees, non-EU migrants and asylum seekers, ex-offenders and people on probation, people on low income and experiencing food poverty, people with long term health conditions, people with postnatal MH issues, groups of people with East African heritage, marginalised communities, people with autism, people with learning disabilities, people with dementia and their carers, and children and young people. Within regular Project meetings, there is no explicit inclusion of intervention participants. Link Workers are also absent at these core team meetings, although the Link Worker network meetings are active and well attended by Link Worker managers from across the locality. This site has a clear focus on legacy planning, and as part of this has secured ongoing funding from several key partners across the locality and beyond (into the wider region) to support a coordinator post beyond the 2023 end of the T&L pilot project funding. This has been a plan since early in the project and is seen as a significant success for sustainability and legacy planning. This T&L pilot site has solid training plans, with a current offer for providers and referrers (although inclusive for anyone who wants to attend), but ongoing plans for future training offers - and host sites - are being developed as part of the legacy plans.

A3.5. General site challenges

Issues around data collection and monitoring, partly due to problems with the commissioned software, partly because it is a bigger job than many had anticipated.

Some sites are receiving less referrals than anticipated and so are thinking of ways to remove barriers such as removing the age limit of 65.

A3.6. Thematic analysis based on programme theory

Theme1: Sustainability

There is an underlying issue of piecemeal, uncoordinated short-term and project based, time limited funding for green providers and activities. This has a negative impact on future sustainability.

Across all seven Test and Learn sites, stakeholders raised concerns about sustainable funding and the pressures this placed to continually plan and apply for small pots of funding. Unsurprisingly, it was felt that this had a knock-on impact on future planning and the ability to embed GSP within systems and led some providers to feel sceptical of the initiative. Although not a specific issue to the GSP project, some sites felt that a lack of long term investment in the VCSE sector and a continual reliance on short term, insecure funding represented an absence of system level buy-in for the community led projects. It was clear that creating sustainability of the programme was a priority for the sites and much work had been undertaken to collectively discuss potential opportunities.

We want that commitment financially for five years to progress this with a view of in the early on in the fifth year we review it to another five years progress the service for another five years and I think that is what needs to be done. Someone needs to take the bull by the horns and say right I believe this will work here's my commitment, but it has got to be from the people above. It's sorry fart arsing around with little bit of funding here, a little bit of funding there you know the

growing cycle like a say is a year for a bit of wasteland, it could be a year before it's ready but how do you get those people in as part of their recovery and own that project and be proud of what they are doing and to be able to shout about it. [T&L4, Interview 2]

There's a massive, long history of sort of stuff like this money comes into the system, absolutely welcome [...] two years, three years, four years down the line money disappears, the core system says I haven't got the money to fund that, I've got to fund the city hospital [...] So ... the system hasn't, isn't able to reorientate its long-term funding and then it withers doesn't it until the next block of money comes along and it's not called green spaces it's called blue spaces or turquoise spaces [T&L3 Interview 7]

I think the most important thing we can take away from this is how you can create something that's sustainable. That in... in my opinion is above and beyond all the other stuff that we're trying to do. It is to create something that's actually going to last after us. What we don't want to be doing is creating all of a sort of excitement and energy and movement around bringing social prescribing in [T&L locality] for a year, a year and a half, two years, and then our program team disappears, funding stops, and then green social prescribing just sort of falls apart, everything that we might have created just sort of, yeah, disappears into nothing. [T&L6, Interview 3]

Some data from the T&L sites suggests that short term funding is particularly problematic for small scale nature organisations such as gardening, which require longer time scales to see the benefits. On the other hand, other data suggests that the long-term funding issues were more pertinent for larger scale specialist groups that have higher running costs and overheads. Fundamentally, frequently applying for grants is time consuming and takes dedicated person time away from other aspects of core business.

...it takes you away from what I think is the most important thing which is doing the job. I'd much rather be out there doing that than you know. But hopefully like I say with this lottery bid if we can get that, that will take the pressure off for sure. [T&L1 Interview 6]

Data suggests that sustainable funding is problematic for providers but also has knock on adverse effects for those seeking support. This can be seen both in terms of restricting the formation of trusting and supportive relationships but also in terms of ensuring adequate activities to refer to. Some participants suggested that referrer organisations were less likely to refer to organisations which they felt may not be available in the future:

I think the fear is sustainability, and I think that's a fear of everyone who's working in the project, so Link Workers I imagine, don't want to become really reliant on something that may, may or may not still be there. [T&L2, Interview 10]

The European Social Fund (ESF) provides 5 years' worth of funding, which is unusual for providers in this space. As this fund draws to a close, sourcing similar funding continuity is also a concern for providers:

They've been very, you know, sustainability has been a big part of that, but I know like from kind of bits and pieces of conversations that I have had with fundraising, you know, what we're doing, we're doing it well, we know it works and so in terms of when we do apply for funding, you know, we want to sell what we're doing now, we don't want to just, you know, a big song and dance about something totally different, totally new, and only get it for a year, and then have to change and

dance, and do something different to get another pot of funding for a year. I think where we're at, we just... we know what's working and we just want to continue doing that and if sustainability is a big part of fundraising and funders then, you know, we've been here for a long time doing this, and just let us carry on doing what we are. [T&L6 interview 10]

Building on this there was a strong feeling that working in organisational silos was part of the problem. The importance of partners such as the NHS, community sector and local authorities working together at a systems level to tackle issues (such as environmental issues through the GSP project) was acknowledged.

Everyone works in silos. You know? Money is in the silos as well. And if you're not close enough to that silo, you don't get any of the money. [T&L3, Interview 4]

I've been in the mental health services a long time, to know that things have come and gone, come and gone, and people need that confidence to know it's there, and it's going to stay there. I mean how we do that I've no idea, but by joining things a bit more together you would hope the very different streams that maybe could come and match each other, or things like that, to help that, that would be nice to see, but as people, for it to be offered on an equal footing to a medication. [T&L4, Interview 3]

Further, other findings highlight concerns that GSP funding may remove funding from other over stretched services, or that the short-term nature of current funding systems create potential competition within organisations again illustrating the need for a system approach.

I think when green social prescribing and the whole concept of social prescribing sort of was emerging, I think there's a real hope for the third sector that there'd be some funding behind it - and I'm still in the mindset that for me, I don't see it as a means to funding by, through the NHS or Public Health - yes, some funding would be amazingly brilliant, of course it would, but actually the short-term commissions that you get are just quite frankly useless...and, you know, it's so competitive, as well, particularly within [Placename 2], in [Placename 1], it's really, really brilliant third sector scene. It's so competitive that that kind of commissioning process I felt as though we were competing against, trying to get funds from services, you know, Adult Health and Social Care Services that were just - I'm not saying what we do isn't important, it's really important, but why are we competing with these other services that are doing such an amazingly crucial job to people who are in absolute dire need? So all of that felt and feels wrong...I don't think that the health sector has money. I think there's a whole way that local authorities could work better with Public Health and the NHS to think about investment in green spaces and activities, don't get me wrong - but I think there was a bit of a thing that it would be some sort of, you know, new funding stream and I, I just I don't think it is, I think it's a pathway. [T&L5, Interview 3]

Another concern voiced around sustainability is continuity of key people in current GSP roles, such as T&L site project managers or other champions, who currently 'hold the agenda' and act as active and engaged brokers between different parts of the system. Sites have emphasised the importance of sustaining such roles past the funded programme to avoid slippage across transitional phases.

I think there is a reality that we often talk about sustainability in the sense of getting everybody to kind of do stuff, but having someone whose job it is to do stuff is often rightly, or wrongly, and I... you know, I probably manage things... I tend to be perhaps a bit too paternalistic in getting stuff done, but sometimes just having someone to just get on and do it, is a good way of getting it done rather than

thinking everybody will just do it, because it's the right thing to do. [name #3] has been absolutely fantastic, and obviously really believes in it, and that is the main reason I think we are looking at the successes we are, so yeah, I would think that some type of, it might not be project management, but some type of coordinating function. You know, someone to fly the flag for it, keeping reminding people of the opportunities, I think is really important, particularly when we are talking about such a dispersed kind of... otherwise the leadership of it is so dispersed, isn't it? It's someone in [local area #1] that's into swimming and someone in [local area #2] that's into, I don't know, hill farming, and you know, you need someone to kind of hold that together, I think. [T&L7, Interview 11]

Allied to this point is the need for sustainability within the provider networks, both in financial and workforce terms. One T&L site is paying particular attention to provider sustainability as a core part of their programme activities.

Another one is the... our sustainability workstream, and that has sort of two different parts to it. One part of it is the sort of system sustainability where we're looking at having green space, nature, green social prescribing sort of recognised as a genuine sort of valued health asset within the [T&L locality] health and social care system. So, that includes a lot of... a lot of involvement in the various sort of boards or panels or steering groups or strategy groups that all meet within sort of the health and social care sector to try and make sure they're recognising green social prescribing and recognising the benefits of sort of being outside within nature. The other side of it is more sort of local provider sustainability. So, when you have these... these providers who are offering a... a green social prescribing opportunity, we want to make sure that those are sustainable providers. And I mean that not just in the financial sense, but in every other sense, really. So, sort of a... a sustainable workforce, making sure you're look after their... the... the workforce wellbeing, making sure you have a method for recruiting and retaining both staff and volunteers, having a sort of supervision framework. All bits and pieces like that to make sure those individual providers don't just sort of exist for the time that they're funded for, but also have plans to be able to exist in... into the future and continue providing green social prescribing. So, that... that's my role within that workstream, is to try and ensure that there is sustainability at the local provider level as well as trying to create it at the system model. [T&L6, Interview 3]

Theme 2: Sufficient green activities and assets

We require a range of appropriate nature-based activities and opportunities for service users. People can easily access green and blue space. Inequalities are considered in the provision of GSP.

Across the T&L sites there is a clear appetite from providers for GSP. This was reflected in the high degree of competition for the grants that was reported across the sites. Some Test and Learn sites are also drawing on well-developed infrastructure. A key challenge for many T&L sites has been how to join up activities that are already in place to create a network of GSP, rather than independent activities.

...you know we are stronger together. None of us have the answer for everything... So, you know we can't in isolation do everything, but together we can do it. So, we need to be looking at partnership. We need to be pulling in all those different expertise so we can widen what offer we've got and just make it easier for people. We are also making sure, because a lot of the barriers for service users again it was not knowing what's available. Not knowing if it was for them, which is also a bit of a confidence issue for those people. You know if they don't know about it, they are not going to go. If they don't feel confident to go, it's never

going to happen. So, it's like well actually how do we better support people in different services and make them feel like it's just a next step. You know it's not something different, it's part of what we are already doing. So, if we say as an example someone coming down to our community garden. Rather than us saying well you know if you are interested in you know cycling, we could put you in touch with a cycling group. We'll find one for you. Making a phone call and then saying there you go, right there's the details, off you pop. [T&L5, Interview 9]

Further some T&L sites felt that capacity might become an issue if their referrals increased rapidly and in some cases T&L sites already feel that demand is higher than can be provided for:

We are at capacity at the moment with what we offer and provide, and we get a lot of requests, a lot of "oh, we have this group of refugees who need this, that, and the other", or "we have this group of workers, key workers, this, that", it's a lot of requests we get and we have to be very clear, we only have one wellbeing coordinator ... and I need to protect her time. [T&L3, Interview 2]

Interviews highlighted difficulties accessing some of the green activities:

Sometimes there is not a green space there, quality of green space, competency in using the green space, understanding that that green space is for you, that you've got agency or ownership over it. So you might have a park that's right next to your community but it's over a massive road and that whole community are worried about that road, and that park will never get used by that community, or a park is seen as a place that's anti-social behaviour... definitely the safety in our communities and the safety of people in parks is so worrying for people, understandably, you don't want your kid to play somewhere where you've got drug needles on the floor for example. [T&L2, Interview 10]

Quality of GSP providers was assessed during the application phase. One Test and Learn site uses a 'trusted provider kitemarking scheme' to assess the quality of green providers. This has received positive feedback:

I think the trusted provider scheme has really been really valuable in us being able to have those conversations, in-depth conversation with providers, to understand where they are, where we can provide support. We deliberately haven't gone down a funding application process because that just for us just perpetuated what we're still complaining about. [T&L3, Interview 3]

An interviewee at another site identified assessing the quality of providers as a challenge for the future, where competition for funding and judging provision to be 'good enough' will become even more important:

There are tensions in those local organisations and sort of charities who have been chasing money for years, year on year, who... who see the arrival of, you know, green social prescribing money and sort of chase after these short grants. But they know that it's not enough to embed sustainable long-term projects. So, there's a big tension around that proper funding of community-based provisions that ensures sustainability beyond, you know, bits of trial test and learn... you know, the city farms for example, all of that that the... the green social prescribing hasn't answered that long-term, robust funding question. I think there's tensions around quality, around not so much accreditation but, you know, what do we mean by a good enough provision? [T&L7, interview 2]

Theme 3: Structures & Processes

When structures and process are not aligned the system does not work.

Across the T&L sites there appears to be wider support for the GSP pilot, especially as it connects to different personalisation and prevention agendas. Many participants report positively about partnerships that have been established during the pilot. However, in a few T&L sites this is potentially undermined by what appears to be a lack of depth of understanding amongst the wider system partners within some T&L sites, strategic leads and some of the leadership groups of what may be necessary to significantly shift the balance of control and structures (practices, processes, roles and resources) to support it.

The GSP pilot has played out at the same time as significant bureaucratic and governance reorganisation stimulated by the Integrated Care System (ICS) formation. This has created challenges in forward planning due to a lack of clarity on where GSP fits within wider system priorities and funding streams.

So, this is a move to a patient-centred approach ... based on what matters to them, and developing specific pathways for patients rather than them being lost within a system and being driven by the services; it's being driven by the system which fits into the personalisation agenda. [T&L3, Interview 3]

Strategic support NHS England was often highlighted as being vital for raising the profile of the pilot and the importance of GSP, although there were some concerns about what would happen once the pilot comes to an end.

I think policy decisions and commitments from NHS England nationally is so important and so meaningful. Because when you've got that written in policy in a mandate from the government or NHS England nationally you can then start having those conversations and making those decisions much more easily because you know that's the future direction of travel. Whereas where things change so quickly and so easily that you are never sure where your investment's going or what's important nationally. [T&L5, Interview 1]

I think from the national partners, you know, relationship with NHS England, great support from them, happy with that. Natural England as well, you know, working closely with them, actually having somebody locally that is on the team as well. [T&L3, Interview 3]

And, I think part of this project what's been really different about it, is that we have, there's been a really good presence from NHS England. So I know [name of person] has been to loads of our meetings and he's really listening and, and, you know, kind of having you guys there is such a big thing, and I didn't realise the scale. I knew it was a big evaluation, but not quite that big! But there's some big, big clout behind this. Erm, so I think that's where the difference is. We're kinda getting, as green groups, we're coming together to shout. And then, we've also now got the backing with NHS England. I know locally, when I'm talking to kind of providers and services with the, you know, the individual NHS trusts. As soon as I say NHS England, you know, little ears go up! And they're listening. So, I think, but whether that's not them providing any action, that's just kinda got the interest in the first place. [T&L5, Interview 4]

The involvement of NHS England has inevitably influenced how T&L sites fund projects, particularly in relation to data collected. This has in turn affected funding decisions made by T&L sites, by requiring them to focus on projects ready to collect the outcome measures required by NHS England:

I think we felt a little bit pressured by NHS England to start producing data from our project to start giving results on the sort of active lives measure, or, you know, ONS4 or the Nature Connectedness Index. So, we instead had to start choosing some that were more ready to start providing the service. I don't... but I don't think that has necessarily meant that we have sort of poorer quality of projects. I think all of them are still very good projects, but we did have to start choosing some that were in a more ready position. [Unspecified site, Interview 3]

Within T&L site 4 whilst there is associated VCSE Alliance work, green providers report that this does not appear to have grasped the opportunity to engage very small providers. Within Y&L 4, but potentially reflected in the other T&L sites the leadership group perceive that the Mental Health Transformation programme has a limited understanding of the input and value of the VCSE and no mechanism to fund the provision:

...even the community mental health transformation, which [name removed] sits so beautifully with ... because it's all about that individual and wrap it round what makes, keeps that individual well... but how to fit it in, because it's not already there, is another challenge as well. [T&L4, Interview 3]

Building on this, across some T&L sites there were some concerns about how embedded GSP is within mental health structures, particularly when dealing with people in crisis as GSP does not currently 'fit' within the NHS clinical model:

I think part of the problem of it is, the person who was, you know, sort of pushing this at a [name of area] level has now gone. The person who was then pushing it above has now gone...it's lost its champions, it's lost its, and it's just sitting there. And, if, you know, and I certainly don't think it is up there from mental health... from a mental health perspective, it is certainly not seen or not viewed as important. And, you know, I even went and spoke to the key leads for mental health – it's certainly not on their agenda. [T&L5, Interview 2]

Whilst other T&L sites report stronger links with mental health services, particularly as a result of COVID-19:

They saw the impact of what was happening with the pandemic and the impact on people's mental health, so that was concerning the healthcare trust. And then – and this is my understanding of it – and then the mental health transformation work started in the city and the county. So it seemed a bit like a perfect opportunity, really, to be another part of that – of wanting to be at the forefront of social prescribing in the country, after the vanguard work and the commitment to it. [T&L3, Interview 3]

There was widespread agreement that integration takes time. Improving knowledge and information sharing across the wider sector, along with better evidence of the benefits of GSP was considered important to aide integration:

I think it will always take a long time to completely embed something in the system, so it's not necessarily consistent across [this area] where people you know GPs are going yeah actually, I could easily get someone into a walking group. There's still some disconnect there but it's I think that awareness that's been going on and the fact that certainly using the pilot as a model you know. They are going out to the surgeries and doing gardening in the surgeries, doing an arts and crafts session. All those things have massively increased that buy in from those surgeries... And you think well it's there and it's on your doorstep and you can see it, that's the game changer. That's what helps to support it becoming embedded, because it's you know you are not having to be reminded because

there's someone out the front gardening. There's somebody out there at the minute. There's somebody in the community, both surgeries have like developed a community room within the surgeries to be able to deliver surgeries you mentioned where there is still this disconnect. Why do you think that's still there, do you think? What can we do to overcome that and get them more engaged? [T&L5, Interview 9]

Further, it was reported that GSP had helped to 'expose' issues within the wider system and enabled conversations about how the system works as a whole:

I think there's probably, my sense would be that there is with any time you get kind of national funding that's got a lot of attention on it, like you say, because I think it's such a fantastic opportunity, then there is an impetus to move quickly. But there are some enablers that aren't quick fixers because if they were you would have fixed them already. I think, looking at the positive side, I think green social prescribing will be a really good catalyst actually for social prescribing generally and it forces light on the issue like the system integration issue. [T&L2, Interview 3]

There was also some discussion about 'systems fit' in terms of where GSP is placed within the wider system:

I go back to something I said before, I don't think it's quite sitting in the right place. I don't think it quite knows what it wants to be. Whether it wants to sit inside the mental health...I think it is an issue with staffing. It's an issue of opinions. It's an issue of all of those bits and pieces. It's also an issue of showing that it bloody works. So, the mental health structure will always default to a clinical approach because that's what's done for the last, you know, twenty, thirty, years, that that's, NHS, NHS is clinical. Whether we like it or not, it's based on clinical staffing. And I'm not, you know, I, I come from very much a social [background]...But I've also have to realise the system that I work within, and I work within a very clinical system, that actually, you are not going to tear down, as much as you disagree with it, because it's so ingrained in everything, in that transaction...So if we look at IAPT, you know, for me, has been a bit revolution of that. But even IAPTs has been clinicalised beyond it's, you know, all it is a very now structured thing....So there is an argument for me about, actually, do we want green social prescribing to actually become, you know become structured into the system, it will be sanitised and structured in the same way that IAPTs has been...I would probably argue that, actually, we shouldn't, you know, be careful what you wish for, it might come true. You know, green social prescribing, if it becomes structured in there, will become very structured because that's the way the system works, the system can't quite understand it. So, there is a line, I think, about, you know, where does, does, there's almost green social prescribing want to be systemised or want, does it want to sit outside and be revolutionary?... Because, actually, one of the beautiful things about the voluntary sector and what the voluntary sector does, is the voluntary sector doesn't necessarily have to be part of the system. The voluntary sector can actually sit outside and allow people to, to access it, and that's, that's part of its beauty. [T&L5, Interview2]

Theme 4: Interconnectivity

Referral pathways/interconnectivity between parts of the system is crucial. We want better connected referrers, providers, and pathways.

Some of the T&L sites reported that the pilot had contributed towards greater interconnectivity by getting key players into the same room. Despite this, there were a number of challenges reported around referrals into the system, both in terms of

ensuring that they receive the referrals from providers, that they aren't pushed beyond capacity and that referrals are appropriate and can be supported. One participant suggested that referrers being able to track people that have been referred into the system would be useful:

...there's probably something about I suppose you know tracking it through so that we can follow people up so make sure that it has had that difference so there'd be some sort of handover from the referrer and then handed back. [L&L4, Interview 2]

An interviewee from one site highlighted how workload pressures for Link Workers have meant GSP may have to take second place to more pressing issues, particularly when supporting people unlikely to attend a local GP:

There are lots of people out there in our community that need help that are not even going to their GP. So they are not going to their GP, they are not going to get referred to the Link Worker or they are not going to self-refer to the Link Worker so they are going to be even in the health system, but yet we know that those people are socially isolating and are the ones that would need it most. So it's working out who are the people that have touch points with that people. Some of that might just be family and friends, just the neighbour. You might know me, but the next door neighbour never leaves their house and is really struggling, and won't go and seek support. So, it's the whole community. That's social prescribing in its widest ethos, isn't it? I think there's a lot of pressure put on the investment into Link Workers, like they are the be-all-and-end-all of social prescribing, and it's like, no, they have a clear role to play, but they can't... they are not responsible for the whole of social prescribing as an ethos. It's like, they just have a... you know? So I think there is a lot of demand put on the Link Workers, and of course they've had massive capacity issues, workforce issues, all of that going on as a backdrop to this as well, and are seeing people with much more high level of mental health support need as well, and they have got nowhere else to signpost them to, so they are dealing with more complex cases, where actually community wellbeing activities like nature and physical activity just end up being dropped down the agenda because they've got no housing, they are struggling, they are in debt. There's a lot of stuff they've got to get through. [T7L7, Interview 8]

Other T&L sites reported a lack of clarity and consistency in the referral systems:

Interviewer: How it is currently set up to support the flow of people who might want to access nature-based activities from healthcare through into nature-based provision?

Participant: I think it's a mess to be perfectly honest, I don't think it is at all joined up...people are working in their own silos within their own organisation or their own setting even, even the setting within the organisation even, and some clinicians have good links with some local providers, and if they've developed a programme together then they will go to those same people, but they won't necessarily go anywhere else because there's the whole, there's often the problem with information sharing and data agreements, and some more complex things like that. [T&L4, Interview 3]

Within one T&L site, it would seem that the pilot has further exposed different viewpoints on what the referral system is. The interview data suggests that some NHS colleagues focus on a narrow and defined pathway with critical referral points between the healthcare practitioner and provider potentially via the SPLW or a software enabled 'market-place' – highlighting this pathway as the fulcrum of the referral system:

I think initially one of our key aims was, we need something to make sure that there's a system in place that links what's going on with the activity providers and what's going on with the social prescribers, so I think it's almost like a market place type thing, so if you think something like eBay where someone who you want to buy something or you want to find out what's available you go onto eBay and you put in your search and say 'I want x, y, z', and you can tell and see all the people who are selling it. [T&L4, Interview 4]

Others suggest a more complex and broad referral system which is intended to position the person at the centre of their holistic care. This difference may be both ideological and structural. This difference in perspectives has potentially contributed to some dissonance in the leadership group about the priorities for the pilot.

On a similar theme, one interviewee highlighted the need to approach each of the components of the whole system differently and individually, tailoring the relationship to suit their particular demands and requirements:

There is an element of our work that is absolutely to do with training sort of local health and social care professionals. And then a last one that I mentioned is our... the local mental health trust, [locality MH partnership]. So, there's a piece of work I'm doing at the minute that we're seeing as falling under the thematic community workstream that I'm leading on and where I'm trying to develop a relationship with [locality MH partnership] to strengthen their ties into the green sector and then to green social prescribing providers. So, each... like how we develop the relationship with each one of these routes integrating social prescribing, we've had to look at the separately, and because each one of them... like, so each... each part of this whole network, if you see it as a whole network of social prescribers, GPs, mental health professionals, they all operate very differently. So, we can't use this blanket approach to develop a relationship with them. We're having to sort of approach each of them separately and think, 'Right, how can you maybe first convince this person of the value of green social prescribing, and then second, make sure that they're educated about it and then make sure that they know of the opportunities for green social prescribing in their... in their area or across [T&L locality] as a whole, and then how do you make sure there is then a clear referral pathway for that specific person into green social prescribing?' And how you... I think that was four things that I mentioned there, maybe five. How you approach each of those is also different between each person that you're trying to do that for. [T&L6, Interview 3]

Theme 5: Mutual awareness and understanding

Focus on interpersonal relationships. Are people talking to each other about GSP?

Some T&L sites felt the strong focus on mental health was overly restrictive for wider parts of the GSP system:

I think it's been presented very much as being primarily mental health focused. [T&L3, Interview 2]

Across all T&L sites there were identified challenges in cross-sectoral working, navigating the system and understanding the roles of their counterparts in other organisations:

I can ... say from my own experience I have no idea how the public sector, health sector, works, really, and I just, I'm still baffled by all the acronyms and all the different groups and then they change their name all the time which isn't helpful... [T&L3, Interview]

There's a question of, you know, who owns the people who are doing it? So, within [locality] for instance, you've got local boroughs, you've got [locality] County Council and you've got health as a separate entity, [locality T&L site] which is not part of [locality] County Council. Even within [locality] County Council I would argue, and recent conversations have really emphasised this in my mind, there's a distinction between [locality] County Council and public health which sits within [locality] County Council but seems to have its own agenda and identity, and nobody in public health seems to talk to anybody else in [locality] County Council. So, you... you've got all sorts of people who are ploughing their own furrow, so to speak, and yet you've got to try and bring them together in... in a way that makes them as effective as possible. So, where... where the ownership sits longer term with green social prescribing, where it fits within this mass of activities which are there, if you like, I suppose to improve people's wellbeing at heart. Too early days, but... but I think important topic for the future. [T&L6, Interview 1]

It was felt that this was often compounded by a constant turnover of staff:

You can go to a team meeting and explain what you are, what your referral process is from your client, what it's aimed at, what are the outcomes you're hoping to achieve. They'll have a staff turnover and then, you know, nobody really knows about you nine months later. [T&L3, Interview 4]

In some cases, it was suggested that better understanding by Link Workers of what activities they are referring into was needed:

So, the people that are referring have to have a real understanding of what we offer. So, possibly going in and talking to groups. Like I've been and talked to local mental health services. At the beginning, I did manage to get into a couple of GP surgeries. But I know I've had a social prescriber referral, a lovely lady who needed to come; didn't like sitting in the sun, was terrified of insects, and was really struggling being outside. And it was such a shame, because she wanted to be there, but she simply had... she was going to be so strung out the whole time. So, then you just think, 'Why did you refer her, because that's left her with a sense of failure?' You know, and... and that's not kind, that's not kind. And she'd struggle to get on the bus and was really pleased with herself about that. And we were talking about how she'd done, but... so, there has to be a real appreciation of what's on offer, and that has to be some sort of... the thing that is also quite tricky. [T&L7, Interview 3]

However, as discussed above, interviews from a couple of T&L sites suggested that the pilot had actually served to improve networking, communication and relationships between different stakeholders. In particular, it has raised the agenda of GSP and facilitated conversations between partners about what is and isn't working within the system. Further, some T&L sites highlighted areas of good practice to improve mutual understanding, such as an initiative that brings together different professionals and the Green Network creating a collegiate space to bring together green providers. Both have received good feedback thus far and will be an interesting case study to follow:

Where I think there maybe has been a change is in the recognition and the sort of connection to networking within various green social prescribing providers within [T&L locality]. Whereas, before a lot of them that are separate from each other and weren't familiar what with... what each other were doing. I think what we have been able to do is create a network of green social prescribing providers... I think there's probably at least 100+ who are part of this network now. So, I think we maybe have gone some way in bringing all of those people together, and hopefully sort of helping them to develop relationships with each

other and share learning, perhaps even share resources with each other. So, that is something where I think perhaps there has been some change. But I expect more change to come over the next sort of three, four, six months. [T&L6, Interview 3]

Theme 6: Buy in

Referrers and Link Workers are convinced of the benefit of green activities. Referrers and Link Workers have the capacity, capability, opportunities, and motivation to refer to appropriate GSP if they exist.

On the whole, there appears to be clear widespread buy-in from stakeholders on the importance and benefits of GSP. However, a number of interviewees from different T&L sites suggested that some mental health professionals regard GSP as a 'nice to do' (T&L5, Interview 2) but it is not yet appropriately embedded within the wider offer. Some participants felt this is because MH services are dealing with people in crisis for which a GSP intervention is not appropriate. For most MH services participants felt that GSP was not 'seen or viewed as important' (T&L site 5, Interview 2). Others suggested that referrals/buy-in from GPs may be lower due to a 'healthy scepticism' around value of green social prescribing from some clinicians working from a 'pharmacological model' where prescription of treatment is based on many trials and this kind of evidence:

Some practitioners will probably see it as a nice addition, rather than as a viable alternative. [T&L1, Interview 2]

However, others reported that over recent years there has been growing enthusiasm and positivity:

...even those bits which might have been a bit more sceptical several years ago and thinking well that looks like a waste of money to us, are now thinking actually they're not, now we've got ourselves a space, actually that's, yes we'd still like some more money but we can see actually it's not a stupid investment. [T&L3, Interview 7]

On a fundamental level, it was noted at one site that the terminology of Green Social Prescribing was problematic and off-putting for the general public:

I have to say, as a phrase and particularly as a member of the public phrase, green social prescribing is ugly in the extreme...And should be scrapped as quickly as possible. ...But it does also come back to, you know, what is the real purpose and what is the linkage between green and social prescribing. Social prescribing as a term, by the way in my view, is just awful. It... it... is it, apart from anything else, it... it has... the sense of it is about doing things to people and telling people what they should be doing in terms of prescribing how they should be. And if... I cannot think of a bigger switch off to most people than... than Big Brother's going to come and tell me what I ought to be doing. [T&L6, Interview 1]

It was suggested that operational and individual buy-in could be improved through better consistency and less silo working:

...if you're talking about getting somebody to, I don't know, a gardening project, then social prescribers could potentially be doing that, but also occupational therapists or other mental health clinicians could be doing that as well. If we're all doing it for the same person and we duplicating that, or we're actually assessing differently, we're assessing because we're mental health practitioners and somebody needs more level four support, but the social prescriber's only

seen them on two occasions and is trying to introduce them to level one support, that person's not, you know, it's about the system working together, so it's given that conversation about what that needs to be. And then just the awareness that social prescribers are there because like I say they're not, they're a brand-new workforce and they're sitting in different part of a system, they're not mental health practitioners, but a lot of the people that are coming through to them have got mental health needs. [T&L4, Interview 3]

T&L4 has attempted to address this problem by developing training resources to explain the green activities and associated benefits. T&L5 has also offered taster sessions of green activities to encourage referrals from other sources whilst T&L2 has implemented training for the wider workforce to increase knowledge of GSP. This is ongoing and will be worth exploring in future interviews.

Theme 7: User influence

Users are actively engaged in the design of activities and there are formal mechanisms in place. User influence also considers health inequalities.

Within T&L2, service users were involved in the codesign element as well as the grants panels. Findings from the codesign workshops which were undertaken at the start of the project to map the barriers and needs of different stakeholders across the programme were used to directly influence the programme – such as the target cohorts for each area. Several promotional videos have also been created with service users. The importance of user influence and the programme being based and tailored to the needs of communities was acknowledged. Successful GSP projects were seen as ones that are ‘very much driven by service users’:

I think that's one of [the programmes] main strengths is that it's based in co-design, so erm, it's based in, the community have been involved from the beginning, and the voluntary organisations have been involved from the beginning, and the green network is a, erm, a clear, sort of result of that, so that enables then, if everyone's had buy in then everyone's taken on a journey together, you haven't created something and then gone oh by the way can you refer, or by the way do you want to join in, so I think huge investment in ownership in this project by the co-design element of it. [T&L2, Interview 10]

T&L6, has also looked to use the programme to test how they meaningfully involve service users in all aspects of GSP support, including funding decisions.

So, there was an organisation... called [T&L locality] [name of organisation] for disabled people. And... and they... I don't want to misrepresent them. But I... I... I believe they see themselves as a... a voice for people with mental health concern and disability in all the local conversations around health and social care. And they are a bit of a... a bit of a leader in sort of co-design as in where they are real sort of champions for co-design within the whole [T&L locality] network. And, we went to them and said, "Would you be able to support us with how we introduce co-design into our program?" And we ended up commissioning them to find co-designers for us, recruit co-designers, and then provided to co-designers who were... they were the two that then joined us within our workshops. But the capacity in which they joined us was essentially as a colleague, rather than as someone who's just sort of helping us out for the day. They were... they were paid for their time...and they very much sort of sat next to us in this... in this workshop rather than just a sort of addition to ask some type of questions from time to time.

... it was a really interesting bit of the project to get involved in, of how do you genuinely involve co-designers in a... in a meaningful way rather than just in a tick-box kind of way. And there... there was a bit of challenge, I think internally around paying co-designers for their... for their time and their support, because it's not the way that things have been done before. And that... that is always a challenge in these sort of big organisations, particularly in public sector organisations of changing the way that things have been done. And when you're saying, "I want to pay..." who would previously be seen as a... as a volunteer and you're saying, 'I want to pay them as a colleague' and it ruffles a few feathers.

...the argument they [name of organisation] and I had for doing this towards the Yes, this hasn't been done before, but this is a fantastic opportunity to do it under the heading of a Test and Learn site. And we can test the value of paying pro-producers, co-designers for their time with our program. [T&L6, Interview 3]

However, across the other sites the user influence appears to be somewhat limited:

Where we failed is around the patient involvement. So, we actually tried to get somebody involved who got lived experience but he didn't feel it was really, he was really being heard and it was addressing his issues. But there wasn't anything he really could add. So we failed there I think and that's something we should reflect on. [T&L1, Interview 2]

Theme 8: Pathway experiences

User experiences across the pathway and reasons why they do and do not stick with GSP activities.

This theme will be explored in more detail in the service user interviews that will be undertaken in Autumn 2022. However, some broad issues arose from the stakeholder interviews.

A number of stakeholders said that with participants who are suffering with mental ill-health the biggest challenge was getting people there. Once they did attend, they usually carried on coming back:

Yes, I mean sometimes getting them in is the hardest, not obviously the people that just walk in on their own but some people they will ring you and say they want to come and then they put it off a bit. So getting the more serious mental health service users if you like is probably the hardest part. But once we get them in, obviously we do an induction and all that stuff and, but we sort of like ease them in really slowly, give them a really easy job and we'll ask them if there's something they particularly like to do. And we like to sort of talk to people and observe them and see what their capabilities are if you like. See where their strengths and weaknesses lie. And what they want really because me and my colleague are big on it's what they want and not what we want you know. Very sort of people led if you like. They might just want to come in and sit and have a chat with us in a nice space. And we are happy to do that. [T&L1, Interview 6]

I think the challenge sometimes is about actually just turning up ... it seems to work better with the community connectors who have the time to actually take people to their actual activity and go along with them for the first time, which obviously Link Workers don't have the capacity to do, so this idea of green buddies I think, I'm really hopeful that this will support some of those initial things. [T&L3, Interview 2]

In addressing barriers, one interviewee commented on the importance of understanding people's individual journeys and barriers to participation, and working to overcome these barriers through small changes like making sure people have enough information about what's involved:

One of the issues in general with community development in the broader sense is actually two things. One is creating awareness of what is available, and the second thing is mechanisms for enabling entry to those activities. So, my favourite one... so, we're involved in a... a very detailed and ambitious project in one of the most deprived areas in [locality], and... based around the social capital model that I talked about, and the... the... one of the examples I use tends to be, somebody says "Well, I've... you know, I've always fancied playing Badminton, but I don't really know how to do badminton, or... or... where... you know, do I have to have my own racquet when I go along for the first time? What clothing should I wear? I'm not going to know anybody who's doing it, you know, I'm going to, you know, feel really lost". So, there are... one of the things that we're focusing on is actually good quality information about what you need to do a particular activity, but we're also exploring the area of buddying, where you actually get somebody who's already doing the badminton to say, "Okay, if you'd like to start, I'll talk to you before you go, I'll... I'll join you in the first session, introduce you to other people, etcetera, etcetera", and help people get over that hurdle of actually getting involved in the activity. And I think that could well apply to... to quite a lot of green social prescribing. So, before Christmas for instance, we did... as... as a... as a team at work, we... we did some forest bathing. And forest bathing was very new to most of us and, you know, words are very interesting, but you know, the whole image of what forest bathing is all about on its own is not necessarily very helpful and illustrative. And... and... but even with that, I noticed that I was unsure, what clothing should I wear? What sort of shoes should I take with me? What happens if it's raining? You know, all those sort of thing. I mean, how far am I going to have to walk? You know, do I have to be fit to do it? You know, all that surround... even for somebody like myself, there were quite a lot of issues around there. [T&L6, Interview 1]

One interviewee highlighted how labelling programmes as 'mental health' focused was problematic in many ways for service users, and it was important to reflect the broad range of experiences that many interventions can address:

Now, when you look at the prevention and early intervention agenda, one of the things that comes through very clearly is that that... you cannot... well, you will not be effective if you actually focus on mental health alone. For a start, most people don't want to engage in a preventative way in talking about their mental health, and one of the things I really like about green social prescribing is what it is about is getting people doing activities which will support their mental health and wellbeing, but without it sort of being rammed down their throat, if you like. [T&L6, Interview 1]

Leading on from this, stakeholders discussed how service users' experiences and journeys were often fairly complex. Alongside mental health service users are often dealing with a multitude of other issues such as food and financial insecurity:

So, I suppose when we look at the reasons for people being referred in, we see you know we see a significant proportion of those, say eighty-five percent thereabouts for, their mental health reasons. But when you break it down, actually when you look at those conversations, it's not that, it's about sixteen to twenty percent may have an emotional health need. Most of those immediate presentations are dealt with if you get the person to the right level of support. Often it is about benefit and support, housing, food. Food's a big

increasingly big one. Then we are starting to see more people presenting with mental health, low level mental health, anxiety, depression, low mood, and I suspect that is going to continue for a good while given the failure of the economy. [T&L5, Interview 8]

One T&L site introduced a specific barriers fund to help alleviate some of the difficulties identified (e.g. buying appropriate footwear if required) which shows the importance of having dedicated funds to support the complex array of challenges a service user may face.

Theme 9: Data and measuring impact

Possible mismatch in system demands for data compared to what is feasible and appropriate leads to difficulties in measuring impact.

There were definite challenges to collecting data and measuring impact identified across the T&L sites. These included inconsistent and uncoordinated data sources, sites using their own data collection systems, feelings that some outcome measures are inappropriate for GSP and the additional burden of collecting data on top of their day-to-day activities:

And they all have different ways of – and different processes in place. And that can be, you know, different IT systems, different data management systems. So, getting a consistent definition of what green prescribing is, is challenging... So, I think in the area of data management it's extremely challenging. [T&L3, Interview 3]

We've got our own systems where we are recording measures of impact like the ONS for kind of measures or those kind of things. But then there's increasingly an ask for, we see the differences and the similarities because we span a few different geographies. But I think there is an appetite from primary care networks for things to be easier for them to refer within clinical systems but then unless there is a way of us having visibility out of that being able to report back impact, then when it comes to things like green social prescribing, then it's quite hard to say because you have got a fractured version of the truth where you are recording some things in sub-clinical systems and some things in our own systems and stitching it all back together is not necessarily going to be the easiest...Then a real world challenge of today and again one is decided on ok I can provide you with the data that I know about, that I can see myself but understand our data is factored in multiple places and I can't command anything about how system one is set up and what data is recorded. What you can and can't record within a GPs system. [T&L2, Interview 2]

For some providers, there is an issue of having sufficient expertise and resource within the team to collect standard outcome measures, or collect data in a standardised way as required by the GSP programme funders. In one example, the T&L site project management team has worked hard to try and create flexibility in the system to allow support of less conventional activities:

I suppose what... what we're trying to do within our program is...quite sort of innovative or... or experimental. And so, we do end up working with...these organisations or these groups who maybe don't do things in the more sort of conventional way of clients turned up, you run a session with them. If you get some measures, they get home, they come back and rinse-repeat next week and thereafter. There are some like that, absolutely. And like that is a model that... that works, has been proven to work time and time again. But there are others that perhaps don't quite follow that model, and so do pose some issues when it

comes to data collection. But with them being the more sort of experimental and... and innovative, those are the kind of things that we want to try to see if... if those do work. ...So, one of the projects, for example, is from [national nature charity] who one of the things that I'm quite looking forward to... to testing with them is that they're... they're a green provider that are trying to provide a green social prescribing opportunity, whereas most of the others are sort of health and social care providers. ...But ... the actual project itself that they're running is, they're trying to livestream nature feeds from their phone, ...in two dementia care homes. ...So, we're trying to see exactly what that looks like at a minute, but that is not a sort of straightforward one where you can say, 'Right, we'll collect measures at this point pre and then this point post.' It causes... at major speed that they're just of ongoing, live stream of... with sort of community TV, for example. So, it's not like there is a... there is a section that is run, it may just be more of a sort of ongoing thing that provides an element of nature connectedness within that care. So, that is... is one of those little more experimental ones where it seems like such a great opportunity to test the sort of... the... the borders between sort of digital and green and green social prescribing from [national nature charity]. Like such a great opportunity hasn't come across before. ..like we're going to have to try and work out how you collect data from this. But like I was saying before, so that's something that we're willing to like... we're willing to work with and find a way of doing it. And... and it may be that the data isn't perfect, it may be sort of, I don't know, cobbled together somehow, but the opportunity itself, it seems like such a great one that we're not going to not to do it for the sake of, 'Oh, it's too hard to collect data from it. [T&L6, Interview 3]

Other difficulties were highlighted with measuring impact and outcomes for nature-based interventions more broadly, in ways that are meaningful to participants and providers but that are equally acceptable to the NHS and clinicians:

I think there's that kind of buy in barrier and evidence barrier. ... I think the buy in is much better than it was a few years ago, from say GPs and Link Workers. But I think there's still more work to do. I think there's probably a tendency for nature and health to be seen as a bit of a fluffy option I imagine for some people. Understandably, because it's very hard to disentangle the benefits of going for a walk in a green environment, from is it the green environment? Is it the social aspect? Is it just getting out and doing something? Does it really matter? It probably does when you're prescribing something. But I think the difficulty of obtaining really precise and rigorous evidence, and what the perception of the sector is, are going to be potential barriers". [T&L7, Interview 1]

Theme 10: Underserved populations

Which target populations are the pilot sites focused on? How are they reaching them and what are the challenges?

Each T&L site has a clearly identified aim to target different under-served communities, although in practice most providers are open to supporting a range of populations. For a couple of sites this is being met through working with local voluntary and community sector organisations in order to identify those most at need. Whilst there was a feeling that they were making good inroads towards this goal, some participants reported that more could be done and engaging underserved communities remained an onward challenge:

Working in a core city which is mostly deprived, has some of the most deprived super output areas in the country, undoubtedly there are some communities where you know, they're the seldom heard type of communities, they're seldom heard where we need to do more work. That's both in some of the areas where

we'll see huge diversity and that's obviously, there are some cultural norms that we need to work out... [T&L3, Interview 7]

There are practical challenges I am not sure that we've necessarily fully overcome. They may pop back up again of transport and people lacking funds and resources to take part in the activities. [A: Yeah] And I think that's something that advises us or flagged already that might be challenges. Ok you've got these activities but the person that I am supporting is in a wheelchair and its very difficult for them to get there or they can't afford to pay for a taxi or to take two buses or whatever. So, I think there are some kinds of practical challenges beyond awareness that where the investment can really make a difference as well. [T&L2, Interview 2]

One site conducted outreach activities into their underserved communities at the beginning of the project using their wider network, and were successful in attracting groups that had previously not engaged with statutory funding bodies:

...it felt like an important step to be addressing the imbalance in who engages with nature and health or [the] natural environment for wellbeing, and look... you know, sort of face the inequalities in that. So [we] set... up the special interest group for diversity in nature and health, and as... and part of that was to unders... to be able to be supportive of people who are coming into the [T&L site] pilot who are from communities who aren't familiar with this territory, who don't, you know, have a context for it, and to... it... it was an opportunity to be there, to reach out and be a point of support or for them to discuss anything that they were finding confusing or challenging, or, you know, could do with that extra support. [T&L7, Interview 4]

Whilst some T&L sites reported positive stories of meeting the needs of those with mental health issues, others did not feel they had the expertise to adequately support them:

As for life's stresses and things like that you know in this particular case it's somebody who's got psychosis and the diagnosis of schizophrenia and has recently become homeless. And he's previously managed to hold down a job and things like that but now he finds himself, due to a relationship breakdown, finds himself in this situation. And actually, all he needs is just some way of being settled again and getting supported. And we are able to offer really good wrap around support in lots of different avenues. It's a massive, massive benefit and you see those on a daily basis, but I think those are the people that you know really need to be reached. Especially at a time when services are really struggling because of Covid and things like that. There might not be as much support out there and you know mental health services are stretched more than ever, aren't they you know? So, where we could support in other ways, I think it's helping those higher risk groups, you know people who might end up back in hospital if they don't have somebody supporting them out in the community. [T&L5, Interview 9]

What we're looking for, in terms of referrals, is anybody from the local community who's got depression, anxiety, people who are isolated, lonely, low level mental health, because we're not experts so we don't take people who've got bi-polar disorders, or personality disorders, those sorts of things, because they're too complex, so we wouldn't touch on those sorts of things. So, really just those people who are, you know, feeling a bit down, feeling a bit lonely, before they start to escalate into having a more serious problem, it's that early intervention that we want to be able to do. [T&L1, Interview 7]

Within some interviews, it was clear that reaching underserved communities was time consuming and required sustained effort. T&L5 has done different pieces of engagement work to increase referrals, such as identifying and bringing different groups and community leaders together to understand barriers and needs, translating literature into different languages, actively funding members of staff to develop referral pathways or providing taster sessions. The importance of meeting people face-to-face to build trust and confidence as well as working directly with communities to understand their needs was acknowledged. It will be useful to explore the impact of this work in future interviews.

A3.7. Next Steps

- Full team meeting in October to discuss and finalise the next round of data collection and explore the developing programme theory.
- Final data collection to be conducted Jan/Feb 2023.
- Secondary analysis of 1-2 case studies from each of the 7 T&L sites Jan/Feb 2023.
- Individual analysis of T&L data Feb 2023.
- Embedded researcher team meeting end of Jan and Feb 2023 to explore data.
- Qual data synthesis across T&L sites March 2023.

A3.8. References

Gradinger, F., Elston, J., Asthana, S., Martin, S. and Byng, R. (2019) Reflections on the Researcher-in-Residence model co-producing knowledge for action in an Integrated Care Organisation: A mixed-methods case study using an impact survey and field notes. *Evidence & Policy: A Journal of Research, Debate and Practice*, 15(2), 197–215. <https://doi.org/10.1332/174426419X15538508969>

Hazeldine, E., Gowan, G., Wigglesworth, R., Pollard, J., Asthana, S. and Husk, K. (2021) Link Worker perspectives of early implementation of social prescribing: A 'Researcher-in-Residence' study. *Health Soc Care Community*, 00, 1–8. <https://doi.org/10.1111/hsc.13295>

Pawson, R. and Tilley, N. (1997) *Realistic Evaluation*. London: London: Sage Publications.

Questions for topic guides

Interviews with key stakeholders

The following questions will be further developed and incorporated into separate topic guides for each key stakeholder. The language may also be adjusted depending on the target audience. Each Test & Learn site will develop over time, and accordingly the theories of change and underlying assumptions will change as the stakeholders develop their ideas. We will adjust the questions, in line with these emerging findings and themes.

For ease, we have included a separate topic guide for service users (please see attached documents)

Research question	Participant(s)
BACKGROUND	
<ul style="list-style-type: none"> What is your current job role? <i>Prompts: who do you work for, how long, how many hours worked, etc?</i> 	Referrers, GSP providers, project management team, link workers, service commissioners and other health professional stakeholders identified through embedded activity if appropriate
<ul style="list-style-type: none"> Which town/location are you based in? 	Referrers, GSP providers, project management team, link workers, service commissioners and other health professional stakeholders identified through embedded activity if appropriate
INVOLVEMENT IN WIDER SOCIAL PRESCRIBING SYSTEM	
<ul style="list-style-type: none"> What is your role within the social prescribing system? <i>e.g. whether referrer, provider or other stakeholder</i> How effective is the current system and why? In your experience, does green social prescribing sit comfortably within the wider social prescribing system? Expand depending on yes/no 	Referrers, GSP providers, project management team, link workers, service commissioners and other health professional stakeholders identified through embedded activity if appropriate
INVOLVEMENT WITH GSP	
<ul style="list-style-type: none"> When did you get involved with the green social prescribing test and learn pilot? How did you first hear about it and why did you want to get involved? What is your role within the GSP system? <i>e.g. whether referrer, provider or other stakeholder.</i> What is GSP trying to achieve? <i>Why is GSP needed? What 'problem' is GSP addressing?</i> What do you think about nature based activities as an alternative to other mental health treatment? What/who is good for? What currently works in the GSP system to help achieve those aims, and what gets in the way? How do you feel the communication is working within your T&L site? Do you feel you know what is happening within your site and beyond? <i>Do they feel part of it?</i> 	Referrers, GSP providers, project management team, link workers, service commissioners and other health professional stakeholders identified through embedded activity if appropriate

Research question	Participant(s)
<ul style="list-style-type: none"> • What would you describe as the key characteristics or components of the Test & Learn? • Why was this test & learn project developed and what do you hope to achieve? • How and why might the characteristics or components you have developed help to meet those aims? To what extent are all the partners in agreement about the aims and ambitions of the Test & Learn pilot? • <i>Prompts: what is your overall vision for the Test & Learn? (can link this to Theory of Changes for each site)</i> • To what extent do you think it is meeting its goals and why/why not? 	<p>Referrers, GSP providers, project management team, link workers, service commissioners and other health professional stakeholders identified through embedded activity if appropriate</p>
<ul style="list-style-type: none"> • Can you tell me about the service you provide? Is this a new service that was created for the GSP project or have you been running this service for a while? • <i>Prompts: Types of support, numbers of participants, who are they targeting, when did it launch, when do they meet, if not through GSP, how else do users/clients find their services?</i> • If existing service: did you modify the existing service to fit in with the project specification? • How is the service currently funded? • How do you plan to fund the service after the current project finishes? • <i>Prompts: are there any concerns over future service sustainability</i> 	<p>GSP providers</p>
<ul style="list-style-type: none"> • How did you find the application process for the service? Did you encounter any barriers to applying for the funding and if so how were these overcome? 	<p>GSP providers</p>
<ul style="list-style-type: none"> • How many service-users have you supported in the past year? • How do you record your data? <i>Prompts: what systems do they use, what information do they collect</i> • Are you able to identify GSP referrals within your systems? How easy or difficult is this? • How often do you signpost people to green/nature-based activities? Are there certain types of people you refer more to this type of support and why? <i>Prompts: e.g. those with mental health issues</i> • Are there certain population groups you struggle to engage with and why? • In general, do service users stay engaged with the project or is disengagement an issue? If so, for whom? • Linked with above: are there issues with referrals reentering the system? (e.g. revolving door) 	<p>Link workers</p>
<p>PERCEIVED CHANGES TO THE GSP SYSTEM</p>	
<ul style="list-style-type: none"> • What, if anything, has changed as a result of the Test & Learn pilot? <i>Prompts: These might be</i> 	<p>Referrers, GSP providers, project management team, link workers,</p>

Research question	Participant(s)
<p>changes in awareness, attitudes and behaviours, connectivity, relationships, processes, practices availability of resources, roles and responsibilities.</p> <ul style="list-style-type: none"> • How do you know that it has changed? • How have those changes come about? What has contributed to those changes? • What has gotten in the way of change? Why have these things inhibited change? 	<p>service commissioners and other health professional stakeholders identified through embedded activity if appropriate</p>
<ul style="list-style-type: none"> • What works to support the involvement of green providers in the project to date, under what circumstances and why? Can you give examples of when it has worked or hasn't? • What factors affect the participation of green providers in the social prescribing system? • In your opinion, are there enough GSP providers within the system to meet demand? 	<p>Referrers, GSP providers, project management team, link workers, service commissioners and other health professional stakeholders identified through embedded activity if appropriate</p>
<ul style="list-style-type: none"> • What factors enable or prevent service users from participating in the project? Who can influence these and how? • What difficulties or challenges are associated with users' experience of GSP? How can these be overcome? 	<p>Referrers, GSP providers, project management team, link workers, service commissioners and other health professional stakeholders identified through embedded activity if appropriate</p>
<ul style="list-style-type: none"> • How do service users experience GSP? What opportunities do they have to influence it? What choice/control do they have over their journeys? 	<p>Referrers, GSP providers, project management team, link workers, service commissioners and other health professional stakeholders identified through embedded activity if appropriate</p>
<ul style="list-style-type: none"> • What factors enable or prevent successful referrals? Why do these factors enable or prevent and how? Who can influence these and how? 	<p>Referrers, GSP providers, project management team, link workers, service commissioners and other health professional stakeholders identified through embedded activity if appropriate</p>
<ul style="list-style-type: none"> • What institutional barriers do green providers/funders/referrers etc have to overcome? Who can influence these and how? What skills and capabilities are required, and from whom? • Examples of when barriers were overcome – what made this happen. • What happens when barriers cannot be overcome? 	<p>Referrers, GSP providers, project management team, link workers, service commissioners and other health professional stakeholders identified through embedded activity if appropriate</p>
<ul style="list-style-type: none"> • What factors are important in the relationships between the different people involved in the green social prescribing system? And why? How can those relationships work most effectively? 	<p>Referrers, GSP providers, project management team, link workers, service commissioners and other health professional stakeholders identified through embedded activity if appropriate</p>

Framework for potential theories to test - exact activities and interventions to be inserted for each T&L site.

Situation	Context	Activities and interventions that aim to alter the context to trigger mechanisms (to be filled in below – these will be different for each T&L site)	Mechanism	Outcome
Infrastructure	Green providers are funded piecemeal and unsustainably resulting in sector fragility and competition		New commissioning arrangements and agreements	Green providers are embedded within the delivery and wider SP landscape
	There is an insufficiency of appropriate Green providers		Nature-based assets are grown, nurtured or harnessed	Range of appropriate, diverse, and geographically spread opportunities for service users to access green spaces
Institutional	Organisational structures and processes (e.g. policy, objectives, governance, monitoring, evaluation and record keeping)) are not aligned		Negotiation and compromise supports alignment of agendas and changes to structures	Coherence and clarity of roles and responsibilities across the system to support GSP
Inter-institutional	The network of providers, link workers, referrers and funders is fractured and dispersed		New or enhanced processes support information flow and feedback loops	Better connected, efficient and effective pathways
Interpersonal	There is a lack of mutual understanding and awareness of different parts of the system and how they operate		New or enhanced relationships build trust and respect	Mutual accountability and shared problem solving to enhance service user experience and outcomes
Individual - professional	Non-existent and/or inappropriate referral to GSP		Referrers and link workers have the capability, opportunity and motivation to refer to GSP	Improved access to appropriate Green opportunities
Individual – service users	Users are not actively engaged in GSP processes		User voice illuminates necessary changes and creates pressure to increase effectiveness	Green Social Prescribing System is person- centred
	High user drop out of the GSP system at multiple points in the pathway		Users have a positive experience across the pathway	Green Social Prescribing <i>plausibly contributes</i> to improvements or management of Mental Health.

Topic guide

Service user interviews

Introduction

Thank you for agreeing to take part in this research project.

We are interested in finding out your experiences of the Green Social Prescribing service and any impact the service has had on you. I will be asking you a few questions, and we are really interested in your views.

- Everything you say will be completely confidential. No names will appear on any reports and you will not be able to be identified.
- With your permission, I will record the interview.
- If there are any questions you do not wish to answer then you don't have to
- You can stop the interview and withdraw from the study at anytime
- Anything you do say will not affect the support you receive from the service or the hospital

Do you have any questions?

Before we start, I need to ask you to complete a consent form to confirm that you understand what is involved and you agree to take part in the interview. *Participant completes consent form (either written or verbal, depending on mode of interview).*

Background

- So that I can understand a little more about you, please could you tell me a little about yourself and what a typical day is like for you?

Prompts: age, where they live, who do they see, where do they go, health issues, medications etc.

Involvement with social prescribing

- Have you been referred to any social prescribing activities in the past that are not explicitly green social prescribing? Prompts: give examples, such as exercise referrals, befriending groups, art therapy etc.
- Was GSP an option? If so, was there a clear reason you did not take this route?
- How do you find the social prescribing referral process? Is it easy/tricky to navigate?

Prompts: is there a standard process; who referred you (e.g. GP, LW), for what reason, how long did it take

Involvement with GSP service

- Can you tell me how you came to be referred to the green social prescribing activity (if GSP activity is not recognised use link worker name, provider name or another name they are familiar with)?

Prompts: did you discuss your health issues/needs with a health professional and what happened next? who referred you, why did they refer you, what was the process, what happened next? Note if they did not come via a health route - e.g. social work referral.

- How did you feel about this referral? *Prompts: how did you feel about this as an approach to managing your health issues?*
- What activity/activities have you attended as part of the GSP project? *Prompts: type of activity, e.g. walking/gardening etc.*
- What impact, if any, do you think the service has had on you? *Prompts: on mental health/wellbeing, on relationships etc.*
- What impact, if any, do you think the service has had on your relationship with nature? *Prompts: usage of nature, appreciation of nature, whether nature was a previous interest/ source of solace or new through the SP etc.*
- Has the service affected the way you use other health services? *Prompts: less visits to doctor, medication, admissions to hospital, increased use of voluntary or community groups or support at home, etc.?*
- Did you experience any barriers to accessing the GSP support, how were these overcome or not? *Prompts: e.g. transport*
- Is there anything about the way you get support that doesn't currently meet your health needs and how could it be improved?
- Would you recommend the GSP to others who are experiencing similar issues and why? Do you recommend further funding for these types of activities and why? If so, where might funding/support be taken from, is this service more important than others?

Anything else?

Remind participant what will happen to the results of the research

Thank you for taking part in this research project

Appendix 4: Work package 4 – Initial Findings from Light Touch Evaluation in Non-Test and Learn Sites

A4.1. Introduction

Work package 4 comprises a light touch evaluation of GSP systems and activities in a number additional non-test and learn sites (i.e., areas and projects not in receipt of funding through the Green Social Prescribing Project). The purpose of this work is to develop an understanding of the added value of the project and to identify the transferability of key learning from the pilot sites (and vice versa). By understanding the variety of systems, interventions, activities, funding and commissioning models, capacity and capabilities associated with GSP in areas that have not been involved in the national programme, and therefore not had access to additional resources and support to develop GSP, the evaluation will be able to capture important contextual information that will help inform the scaling up of GSP.

The evaluation questions for this work package are:

- What is the make-up of the local GSP system in each area?
- What key strategies and development plans are there around GSP in these areas?
- What local data is being collected on the scale, scope, reach and outcomes of GSP activity in these areas?
- How do these sites GSP systems evolve and develop relative to the test and learn sites?
- What barriers and enabling factors exist in these areas and do they compare/contrast with areas that are part of the GSP programme.

A4.2. Sampling and Methods

Work package 4 utilises a qualitative research design involving interviews with key actors in the sample locations. Locations were identified through a purposive sampling strategy supported by the national partners. Criteria included:

- Areas that had applied for national Test and Learn funding but had been unsuccessful.
- Areas where the national partners were aware of organisations or groups seeking to or interesting in growing or rolling out GSP.

- Areas where the Evaluation Team were aware of organisations or groups seeking to or interesting in growing or rolling out GSP.
- Examples of other sources of investment in GSP (for example through NASP Thriving Communities, or the National Lottery Community Fund).

Other sampling considerations included geography (including areas not covered by the programme such as London), demographic and economic characteristics. The seven areas selected as case studies are summarised in table A4.1 overleaf.

Table A4.1: Case study overview

Case Study	Area	Data collected
1	North-west region	Interview with local sport and physical activity partnership lead
2	Midland city	Interview with health and wellbeing lead for local sport and physical activity partnership
3	Midland county	Interview with green social prescribing lead within local wildlife trust
4	East of England	Interview with social prescribing provider organisation
5	London (two boroughs)	Interview with parks and health partnership manager within local authority
6	National charity	Interview with nature and wellbeing project manager
7	Local charity, East of England City	Interview with charity founder (nature-based provider)

To date, nine interviews have been conducted in seven areas with a lead green social prescribing stakeholder from that area. Interviewees represented a range of organisations including local sport and physical activity partnerships, local authorities, national nature charities and local charities who were green social prescribing providers. Findings from each area have been analysed and written-up as case studies (presented in the following section) and key themes identified (Case study themes).

A4.3. Case study write-ups

Case study 1: North-West Region

a) The local social prescribing system

The existing social prescribing system is characterised as fragmented and uncoordinated and is driven by isolated individuals who have made it their mission to build their own awareness of what is available and to pass on that knowledge where they can. This is despite the system having been in place for a long time. Recent investment helped to install a number of new link workers, but without coordination between them there is still confusion and a lack of awareness over what activities are available and who is responsible for what.

This confusion and coordination is not helped by different footprints of regional bodies, with the delivery organisation interviewed providing support for six different local authority areas, but the new Integrated Care System (ICS) expected to cover a total of nine local authority areas. This is due to be implemented from July and there is some concern around how this transition from the Clinical Commission Groups (CCGs) will go, particularly in relation to the impact on the better-established social prescribing areas.

In relation to those better-established areas, one local authority in the region does have a variety of communication channels and activities in place that help to get the relevant stakeholders talking and builds awareness of what is available. This includes a network of partners, including the mix of Primary Care Network (PCN) and Voluntary and Community Sector (VCS) employed link workers, with regular meetings to discuss problems and training. There is also someone in the CCG who is specifically responsible for integration and coordination of social prescribing. However, it was suggested that this authority and activity was the exception, with the coordination in the rest described as “poor” and it being recommended that the network model be replicated across the region.

Regional leads for physical activity, employed by the Active Partnerships, have also been helpful in coordinating activity at the regional level. Their work included surveying link workers to build a regional picture of activity and to outline a number of recommendations for action – this was considered to be best practice, but it was acknowledged that the focus was on physical activity. Despite this activity the number of link workers in the area was not clear, and it was suggested that no one, not even the CCG, would have that information or full picture of activity. Addressing the poor coordination and improving training and awareness for link workers was cited as the main challenge to overcome. A database of activity/providers would help, and they believe that the NHS has this information but that they are unable to share it. However, the already high workload of link workers was also noted as a challenge.

Funding is considered to be very ad hoc, with an awareness of money available through the PCNs, from central government for certain activities, and for active travel feasibility studies. However, there wasn't a clear method of allocation, which was hindering attempts to secure further funding to improve link worker training and support.

Social prescribing is well regarded and understood locally and is expected to be a priority for the ICS due to the huge emphasis on mental health and because this is a Marmot Community. However, it was unclear how well green social prescribing was already embedded into this system, with the sense that it was not strong at the moment. Existing links are likely to be organic and based on impromptu relationships rather than a concerted, or systematic approach.

b) Green Social Prescribing in the area

Green Social Prescribing (GSP) was defined as being “any activity that involved being outdoors in a green or blue space”. And ideally, it would be linked to walking, cycling or active travel [because their focus is on physical activity].

This area did submit multiple applications to be a test and learn site, however, the process was not well thought through. The opportunity was sent out by “someone senior in the ICS” but it went to many random partners, which led to a “free for all”. Instead of one coherent and joined up application there were three disjointed bids. One did go through the first round but was ultimately rejected. It was acknowledged that they were not set up properly at this time, but if the process was repeated now, they would have a much better chance. Notably, since this occurred there has been

specific activity to coordinate green partners, which involved one of the local VCS infrastructure organisations and the Thriving Communities Programme.

No aim for GSP was yet apparent, but a focus on decarbonisation and reduction of carbon footprints was discussed as a strategic priority and why GSP would be of interest locally. It was also hoped that objectives would include link workers referring into park and woodland activities, with one forest project highlighted, and an active travel programme that runs across two of the local authorities. Other local priorities for GSP included the high demand by existing social prescribing users for physical activity and meditative activities; how GSP might galvanise people to use local green space and counter the selling off of parks; and whether the impact of covid on activity could be better understood i.e. was the initial rise in activity during lockdowns maintained long term?

No key people or organisations were identified. The ICS were considered to be keen on the idea but no one had been identified as leading any activity yet. Some roles in sustainability and environment were highlighted in NHS trusts and CCGs, and they were pushing walking and cycling, but as with social prescribing generally, there was a lack of coordination. It is hoped that this will be improved when the ICS is properly established.

Similarly, no specific funding was identified. The ICS's green plan was discussed, and the inclusion of GSP in this, but it was not believed to have any funding attached. In terms of existing activity, it was admitted that there hadn't been much yet that was considered best practice. At grassroots level some VCS activities were considered to have been "incredible" – walking groups, gardening and allotments, Nordic walking – very well attended and with high demand. There was also an awareness that it is not just about the activity, but that the social interaction and connectedness to place was of equal importance. It was therefore felt that the offer is right, but strategically it is disjointed and there is a lack of capacity for the providers. So whilst it is hoped that there would be more referrals, there was recognition that the resources aren't yet there to deliver on this, and there needs to be investment in scaling up and linking in to the existing social prescribing system in order to improve access.

Case study 2: Midland City

a) The local social prescribing system

Currently feels a bit disjointed – there are approximately 30 PCNs and many different providers with different contracts, which creates difficulties keeping everyone in the loop about what is available. There is a high turnover of social prescribers making relationship building even more difficult – high workloads were suggested as the cause for this turnover. Training of prescribers is also an issue – there is a focus on physical activity with mental health only recently added to the core offer.

There are a number of key local players including a sport partnership, family services VCS organisation, and a wellbeing society – the latter having its own team of social prescribers and a contract to deliver approximately 40% of services in the area – but it has been hard to make contact with everyone. Sport England has an active local link worker and the mental health foundation trusts were also highlighted for their good relationships with local users and effective social prescribing role.

Social prescribing is still seen as new, with many still not fully understanding it. This was linked to a lack of funding, with lots of talk of funding but little evidence of it being made available. It is hoped that when the ICS is up and running from June that this will change and that they will determine allocation levels. It is unknown whether social

prescribing will be a priority for the ICS, but it has been championed by local partners and there is hope that it will be.

Examples of good practice include a project using sport/physical activity as part of the recovery pathway for individuals with severe mental health issues i.e. regular users of mental health services. This has adopted social prescribing principles without actually having a link worker yet. They have also brokered relationships with neighbouring link workers through a mental health training and upskilling package. Difficulties have focussed on partnership working and developing shared understandings and timeframes. There is also a real lack of awareness by local social prescribers of the local clubs and providers that are available. Conversely, there is a lack of understanding by the clubs of what social prescribing is and how they can support it.

b) Green Social Prescribing in the area

There are currently lots of green activities included in the social prescribing system thanks to the number of parks and green spaces available. Activities include walks in parks, Nordic walking, fishing, outdoor yoga, tai chi – though not many ‘blue’ activities. This represents a good opportunity for GSP but there needs to be a piece of work that could marry up link workers to these opportunities.

GSP is considered to involve “the use of nature and the outdoors to boost health and wellbeing” and would include activities such as walking, cycling, gardening, or outdoor meditation. It is not thought to be a well understood or shared definition locally, with only those already active in that area being aware - and a question was raised as to whether or not social prescribers would fit in that bracket.

It was uncertain if there was an application to become a test and learn site, with suggestions that another regional body may have submitted an unsuccessful one. The primary ambition for GSP at the moment is to get a better understanding around it and to spread that message. It was suggested that there is still a “fear” of GSP, though this also still existed in relation to social prescribing broadly so may need to focus on that first. Developing awareness of social prescribing was expected to naturally lead to improved promotion of GSP. Once that understanding is achieved then a key aim would be to increase utilisation of parks and green spaces and to link GSP to the “five ways to wellbeing” approach, promoting the benefits of being outside and in nature.

In terms of key organisations, a specific green social prescriber was highlighted in one active partnership, but it was acknowledged that there may be more that they were not aware of. It was highlighted that respective organisations and roles are still to be determined but that they will need to be strategic in who is included in their offer - “we can’t include every Tom, Dick and Harry as that would dilute the offer”.

Initially there was no acknowledgement of any funding for GSP, but some recent Sport England funding is expected to include support for both GSP and social prescribing activities. The green elements of the previously highlighted project were again outlined as good practice, with the diversity of participation championed i.e. women fishing, men at yoga, across all ages - “not all blokes at the football”. They expected more resistance from people with severe mental health issues but there wasn’t any and it “wasn’t a hard sell”.

Current challenges come back to overcoming that disjointedness – with many silos apparent due to different providers working with different contracts. To achieve this, they need to empower providers to have the conversations around GSP, but the benefits far outweigh the risks. They also need the right tools, and it was recommended that upskilling of social prescribers was undertaken to give them “a good handle on

the spectrum of people and issues that they will be dealing with”. This could give them the confidence to signpost the right people to the right activities.

Case study 3: Midland County

a) The local social prescribing system

The system is operated completely differently by two different local authorities:

In one, social prescribing has been established for a number of years and is all delivered through the authority with a prescribed number of hours per GP. Social prescribing is linked in through three community connectors who find activities or organisations that prescribers can use as part of the pathway. The connectors provide a level of quality assurance on the providers, with key organisations including Age UK and Mind.

The other authority is much newer to social prescribing. Primary Care Networks were given money to bring in a prescriber. Money was also given to the local Mind to commission activity – this covered 25 personnel (a combination of full and part time staff) including councillors, health and wellbeing practitioners and one full time social prescriber. Another avenue is through the largest GP, who is also a PCN and has their own social prescriber. There are no community connectors, in this authority, instead users are assessed on a case-by-case basis to find most relevant activities for them, rather than having a list provided for them to choose from.

Funding comes through the two local authorities, the local Mind, and the PCNs. Despite this, social prescribing doesn’t seem to be high up the priority list for the newly formed ICS (from 1 April). The focus of the previous two CCGs that came together was in the community resource centres and the work of Mind.

Elements of both systems represent good practice, with a combination seen as the ideal system. The use of the community connectors looking for services on the ground and offering a level of quality assurance of providers - signing them up to Memorandums of Understanding etc – is useful for the larger providers, but makes inclusion of some of the smaller groups e.g. knit and natter or chess groups, much harder. They are unlikely to want to go through this process. For those organisations, the other system offers benefits as they can be part of an individually focussed and assessed offer of services. This combination – some connection and light quality assurance, combined with individual tailoring – would be preferred.

The main challenge is how busy and fully loaded the social prescribers are and the impact this has on raising awareness of the offer – “heads are down so there is no time to see what other options are out there”. This leads to a tendency to lock in a list of providers and then stick to it, which may not be beneficial to certain clients.

Whilst there are lots of diverse ad hoc funds that can be accessed for to start up local projects (water company, jubilee, mental health, and climate change funds were all discussed), there was nothing in the way of development or promotional funding, or support on how to tailor activities to fit a social prescribing offer. Many existing activities may just need a few tweaks or some extra training and they would be able to offer these to more people through the social prescribing system.

b) Green Social Prescribing in the area

The level of GSP in the system currently is very low and is limited to paid activities from organisations like National Trust or the odd walking group. This is hoped to change as both authorities now have green social prescribers as well, with a focus on

encouraging use of green space but also to understand the barriers to accessing green space and identify gaps in provision.

GSP is considered to be “about using greenspaces (including water sports) and outside activities to improve the mental health and general wellbeing of people”. Use of the term ‘nature connectedness’ was also common in this area and similarly defined.

This area did not apply to be a test and learn site as the current green social prescriber project had already been developed prior to the call. The ambition of this, and GSP locally, is to raise awareness. This is initially being achieved by talking to people – social prescribers already know the value of greenspace for health and wellbeing, but are less familiar about where people can actually go and what spaces/activities are available. The ambition is not about massive changes, but about gentle changes – not about signposting to long-distance walking groups, but about recognising the value of your garden or local park. A key priority is engaging diverse groups and understanding why they don’t use green spaces as much. An example provided was from the Sikh community who described hereditary concerns around going outside, going out in the evening, and doing sports. The aim is to help change those views and demonstrate the value.

Vital activity that is being undertaken includes introductions and awareness raising with the social prescribers. Natural England have helped here, developing a presentation on the value of greenspaces that is guiding those conversations, and they have arranged some taster days for potential users – this gives people the chance to experience greenspace, not just hear about the benefits, which was seen to be very important. Other positive activity includes when bigger organisations, or local councillors, have come forward to highlight greenspaces that they want people to use, or have worked with communities to understand how they would like to see a space used – really positive for GSP.

GSP is considered important in helping to address the recent deterioration of mental health during Covid lockdowns. There are also a number of targeted areas of physical inactivity that are a focus locally, so trying to combat inactivity and those struggling to access greenspace/activity are key. They are also keen to connect groups into other aspects of wellbeing e.g. thinking about jobs and skills and linking to Department for Work and Pensions (DWP) advisors etc.

The main partners include the local authorities, primarily their public health departments, the active partnership, and the local wildlife trust. The funding that comes from the local authorities, Telford Mind, and the PCNs for social prescribing also covers the GSP roles, and a key aspect of this job is to access other pots of funding. As highlighted above, there are many ad hoc funds that could be accessed that aren’t specific to social prescribing or GSP activities, and they are only targeting amounts of money that are quite small – “a couple of hundred quid to hire venues and equipment, refreshments etc”.

The major challenge is time, due to excessive workloads. From the user perspective, it is also good to have a buddy to go with people to activities – anxiety is high, confidence is low – a volunteer befriender to go with people to allow them to build confidence could help significantly and they started to use NHS volunteers who had initially signed up to help with covid vax centres but were now looking at other ways to continue volunteering. They also want to be able to give people informed choices and acknowledge that not everybody needs to be referred to activities - not just because they are already heavily loaded, but because some people are capable of self-referring.

Case study 4: East of England Region

a) The local social prescribing system

The local system can be traced back to 2014, with the first scheme developed with the county council. Since then, it has become quite common and it can be seen in all of the long term plans and is championed across GP practices. Social prescribing is considered a flagship programme and their project is contracted to deliver in specific geographical areas and includes a team of staff and volunteers based in 20 GP practices and at the discharge hub at one of the main town hospitals. Pilot activity also includes end-of-life social prescribing with the local hospice. Key partners include the CCG, the Health and Wellbeing Alliance, the county council, and the active partnership (where GSP has also been started).

There does seem to be sufficient funding through the CCG, with the project turning over around £200,000 revenue a year. However, they expect the costs to increase and they have already seen large fluctuations in demand e.g. they dealt with an average of 5,000 conversations per year, but this went up to 8,500 during the pandemic. From the providers point of view, there is a large number but “they aren’t tripping over each other for funding” at the moment.

Due to this activity there is a clear understanding and acknowledgement of the value of social prescribing locally and within the ICS. However, their work is trying to focus on pre-GP interventions, so that people don’t need to visit their GP as often, but the local model and long-term plan seems to be much more clinically based. This gap between understanding and action on social prescribing needs to be addressed i.e. people are aware of the value of non-clinical interventions but then there is little evidence of action to support this approach.

Good practice was demonstrated by their ability to adapt quickly and deliver vital support during the high demand of the pandemic but want to build this support more systematically into neighbourhoods and are in the process of developing neighbourhood teams. These will have greater reach into communities, and outside of traditional clinical settings, being able to go to people where they are and ensure they have control over their outcomes.

Challenges relate to the clinical approach taken. In clinical settings the partners want to “measure the life out of things”, but social prescribing is about early, and often low level, interventions e.g. “the art of the conversation”, and demonstrating the impact and value of this can be a challenge. There is a need to work with clinical partners to support people to remove some of the clinical aspects needed and to truly integrate so that we can support each other and be considered a partner not just a provider.

b) Green Social Prescribing in your area

Within this system, GSP is relatively new, having been piloted in 2018 – which was only a small pilot that has had to subsequently grow itself organically. Activity is still limited though there has been a lot more focus on physical activity, and in non-traditional forms e.g. allotments.

Definitions of GSP are quite broad at the moment, focussing on “connecting people to outdoor activities”. It was also considered to be about understanding the benefits of nature and having a better connection to your local place and people, with the benefits this brings for mental health and wellbeing and raising awareness of what is actually on people’s own doorstep.

The target audience is to work with people who undertake less than 30 minutes of activity per week, but often they work with a wider audience. Their programme aims to both increase physical activity and connect people to place by developing neighbourhood level activities. But the ambition is not just about signposting. There is also a community capacity building element e.g. training local walk leaders/motivators, and this capacity building is considered to be part of the gap to clinical partner understanding. The walk motivator programme is delivering “outcomes from stealth” i.e. not just physical improvements but also that connectedness, social, and training outcomes. This delivers on a key objective of supporting people to be active but also to be able to support each other to be active. Success is also not measured in terms of content e.g. length, number etc, it is always focussed on attendance and the self-sustainability of activities. There has never been any Key Performance Indicators (KPIs) set for physical activities even though this is a key outcome, which does create some difficulty for some of their physical activity led partners. However, they all understand how this increases inclusivity and helps with community capacity building, which in turn drives the activity. Specific positive outcomes for people include a gentleman at a weight management session who had previously had a heart attack and needed a knee operation – interventions helped remove the need for his knee operation. The good participation rates across activities also demonstrates the “stickiness” of their programme and shows that the approach is working.

GSP is a priority due to the high levels of obesity locally and particularly to support the aim of addressing inactivity in young people. There is also “the long shadow of covid” and being able to build confidence, particularly in older people, to get out and be active again. GSP also benefits place, increasing people’s understanding of what assets are available locally, and in turn, helping to support the ongoing existence of those local assets. For example, activities at the local arboretum provided much needed funding to sustain the arboretum and demonstrated a form of Asset Based Community Development.

Key partners on GSP are the district council and the active partnership, with Local Delivery Pilot funding made available to scale up the original programme into another town. Options are also being explored to roll out some aspects of this programme across the whole county and it is hoped this approach can be built into, and supported by, the ICSs. However, there is still some uncertainty over the timeline for the new ICSs and current work in the two towns will be split between two different ICSs, despite being in the same county.

This may cause a challenge but the main concern at the moment is “stopping people interfering” i.e other agencies often want to refer in to their programme and also have their own ideas around what the programme should/could be, potentially leading to mission drift if not firm about the approach. Strong partnership working and co-design aspects, with everyone knowing their roles and spaces, helps to avoid this kind of mission drift. Sustainability and long-term funding is also a challenge and short-term commissioning models don’t help this. There is a need for funding to show a longer commitment.

Case study 5: London (two local authorities)

a) The local social prescribing system

The local social prescribing system is described as being well-developed and established across the two neighbouring local authorities in London. The CCG commissions social prescribing services and they are delivered by the council targeted at particular areas of need in one LA and geographically according to PCNs in the other LA. Organisations providing services are often health-related and a small number of (generally) large third sector organisations oversee delivery. A partnership

manager is in place to oversee GSP in this area and work between the parks departments in the council, health services and GSP providers. The interviewee was uncertain on how link workers were generally funded (e.g. through GP practices or voluntary organisations).

The four social prescribing themes in this area operate fairly separately despite some overlap, e.g. GSP and physical activity. Although the interviewee was only involved in the GSP theme, they speculated that perhaps the financial theme was more developed whilst the physical activity and arts and culture themes were less well-developed. GSP seemed to be leading the way in terms of social prescribing in these local authorities.

b) Green social prescribing in the area

The interviewee was unsure why they had not received test and learn funding. They think the bid was building on work they were already doing, and they have been able to continue this through funding for another project by National Trust. This NT project was the beginning of GSP work in this area. Heads of parks services in the councils and Public Health worked together as they felt it was a good opportunity to make parks part of the health agenda, and for the council's parks departments to be less siloed and inward looking. Other funding for GSP came through funding of a co-design pilot by Defra. Funding was also received from Public Health England for the parks service more generally (rather than GSP specifically). The interviewee felt that GSP has helped to bring in funding for parks but was not necessarily the sole reason they got it.

GSP is organised in this area through the councils' approaching organisations and asking them to open up their activities for GSP referrals. They are provided with information about the benefits of GSP (for participants and their organisation) and how to access support. They describe what GSP is and share research. Organisations are asked to complete a form including basic information about the activity, where it is held, contact details, payment information and any other relevant information, such as how they support and welcome people and any health and safety procedures. Once the organisation is approved, referrals can then be made to them through the NHS and/or mental health services. This process is only in place across GSP rather than social prescribing as a whole. This process appears to be working well and the council, voluntary organisations and health sector are well-connected through this work.

GSP is happening across all parks in both boroughs. Link workers can refer people to a park for informal activities (e.g., meeting a friend, going to a café, kicking a ball around) or organised activities taking place in the park. Most activities already existed but the council are also creating and funding a handful which they hope will continue past the end of the National Trust funded project. They are aiming for GSP to become embedded as 'business as usual' for the councils. The interviewee described how they saw GSP as a great opportunity for parks services across the country and the National Trust funding had given them space to explore how to make it work. GSP will now be a priority for parks teams in councils which would not have been the case two years ago.

GSP is felt to be well-embedded in this area, with real improvements in understanding of GSP over the last couple of years and good links and partnerships with ICS and CCG teams. However, the interviewee reported that there was still work to be done. The ambition for GSP in this area is to increase the number of GP surgeries referring people via a social prescribing link worker to a park or activity. By 2031, they aim to ensure that link workers are situated in all GP surgeries. They also hope to have conducted evaluations and have evidence to show that the people's health has improved as a result of GSP.

This area was at an early stage of measuring outcomes of GSP activities. They were currently collecting case studies and considering following up with people who had undertaken activities to see if they had experienced any benefits. Additionally, they were considering trying to ascertain whether there had been any changes in the numbers of referrals by link workers.

Case study 6: National charity

This organisation has a strong focus on nature conservation and part of their vision relates to people power and taking action, so GSP is seen to fit well with the organisation's strategic objectives. This organisation is beginning to look at how Green Social Prescribing can fit into their overall strategy and have employed a Nature and Wellbeing Project Manager to embed GSP in their work across the country.

This organisation considered putting in a bid for the test and learn funding but decided against it due to timescales and GSP being at an early stage of development in this organisation. They wanted to ensure that their work would be complementary to work already being done by social prescribers, ensuring they were filling a gap rather than duplicating or competing.

GSP activities will be focused in nature reserves managed by the organisation. The organisation plan to offer a range of GSP activities, including self-led (e.g. mindfulness) and staff/volunteer facilitated (e.g. nature walks, pond-dipping). The focus will be on connecting people to nature as this is their area of expertise. However, they would be keen to make links and develop partnerships with health and wellbeing providers who could use their nature reserves for GSP activities with clients. They are also keen to utilise their connections in urban areas to 'take nature to people' and encourage peer support for people who may be lonely or isolated.

The organisation is exploring and considering options for GSP, through running a number of trials in different areas and building partnerships. GSP is a relatively new area of interest for the organisation. They are evaluating as they go along and will consider the benefits. GSP in the organisation is at quite an early stage of development and they are exploring it with an open mind, with the only constraints being that activities must fit in with the remit and skillset of staff and volunteers. They are happy to be guided by what people need. It feels like an exciting process and there is enthusiasm from staff in the organisation but they are being cautious not to overload staff with already busy workloads.

The organisation has started to develop a number of partnerships in different areas of England. For example, in one area they are partnering with a provider of GSP activities who work with people with complex mental health needs. The organisation gives the provider free access to their nature reserve and supports practical activities and courses, such as woodworking and toolmaking. The interviewee described multiple and mutual benefits for the organisation as well as the clients (in terms of self-esteem and confidence). In another area, the organisation had partnered with a mental health trust who ran a day centre, to develop and deliver a programme of activities running over 8 weeks for clients, including photography, nature walks, making bird boxes, etc. The organisation has also researched and contacted social prescribing services in urban areas and set up meetings with link workers to develop partnerships. They are trying to build relationships with social prescribers and show them activities so that they are aware of what the organisation can offer and to ensure they receive appropriate referrals. They are also exploring the potential for partnerships with the NHS.

The interviewee highlighted other considerations in terms of how they would receive referrals. They were keen to stress that they were using a broad definition of GSP and

wanted to highlight the benefits of GSP activities for everyone. They were expecting that GSP referrals would come from a range of sources. Nonetheless, the organisation's key focus is on nature-connectedness, whereas social prescribing services are more likely to have an explicit focus on health and wellbeing. The organisation is also considering how they would measure changes in nature-connectedness and any impacts of this.

Currently the organisation is exploring a number of options for funding their GSP activities, including applying for pockets of local grant funding, and exploring whether they could be part of the ICS commissioning cycle. The interviewee acknowledged wider concerns about funding in terms of the short-term nature of smaller pots of funding and the need for more sustainable larger-scale funding (e.g. from statutory services who will benefit from GSP) to support GSP providers.

Case study 7: East of England City

This interview was with the founder of a charity aimed at bringing people together in local communities and getting them involved in growing food and sustainable food production (co-farming). The charity's key outcomes are focused on increasing community cohesion, enhancing health and wellbeing, increasing biodiversity, and making more inclusive local economies.

The organisation is also interested in influencing the national food strategy. Alongside their co-farming activities, they hope to 'prescribe' food too, to promote healthier diets. The organisation donates to eight community food hubs across the city, and last year produced and donated 12 tonnes of food worth over £52,000 from a piece of land of 1.5 acres. They also had 500 volunteers who donated 8,150 hours. The organisation is running the first pilot of co-farming in a deprived ward in a city in England and if this is successful, they hope to scale up.

a) The local social prescribing system

The interviewee had the sense that social prescribing was not well-embedded in the area. They highlighted issues relating to people employed in the NHS / clinical commissioning who may be keen to refer people but perhaps has the perception that the voluntary sector did not have the capacity or expertise (in terms of mental health support) to deal with this. The interviewee was aware that social prescribing link workers were employed within GP surgeries and the CCG but was unsure of who they referred patients to.

b) Green social prescribing in the area

The organisation is part of a sustainable food partnership working with others in the local area and connected to a national programme. They are keen to work with national bodies (e.g., Defra) to become more sustainable. The organisation had been part of a consortium bidding for the test and learn funding, which included health partners and other providers. They haven't continued to meet since they didn't receive the funding. However, the interviewee feels that everyone would 'be keen to get back around the table' if other opportunities arose. However, they highlighted the difficulties of putting together applications which require a lot of work, particularly when the organisations coming together tended to have low levels of capacity. They suggested that development funding to support applications would be helpful, and that it could help to ensure that the design phase (which is fundamental to the project outcomes) is as effective as possible, facilitating collaboration.

The organisation is well-embedded in the local community. They ran a year-long process of co-design with around 200 local residents to design the farm and became

incorporated in October 2020. The Covid-19 pandemic created logistical challenges and also had an impact on funding. For example, the National Lottery was only providing emergency funding which they were not awarded. Their key aim is to make the activity sustainable and scalable, making sure the financial model is sustainable and taking a systems approach to improve health and wellbeing. They are hoping to tap into future funding streams coming online.

The interviewee highlighted the importance of GSP being user-centric. They expressed concerns that outcomes and impact of activities may be undermined when the activity becomes 'prescribed'. They felt that the term GSP could be off-putting and they flagged that it shouldn't be clear where people have been referred from (if they have) and that this should be a thoughtful and private process.

The interviewee flagged concerns with 'opening the floodgates' of the project to people with more complex needs. They stated that they are often approached by community mental health workers, youth offending teams, etc. who wish to refer clients, and sometimes clients do come through with greater need (as the project is very open). They do the best they can, but the test and learn funding would have given them the capacity to employ someone with the right experience to support those with greater need. They are hoping to provide this in future, but the environment is difficult funding-wise. It appears that there is plenty of funding for link workers in the NHS but none for the providers delivering activities in the local community. There appears to be an expectation that the 'third sector will pick up the slack'. The interviewee felt that the sector needed to be assertive in communicating their need for more resource and ensuring vulnerable people are safe and being referred appropriately.

The interviewee also flagged the challenges of measuring impact and are currently using light-touch methods (short questionnaires).

A4.4. Case study themes

A number of key themes were identified across the seven case studies. These are highlighted below and framed as challenges and opportunities associated with the development and implementation of GSP.

Challenges

- i. **Fragmentation:** Both the SP and GSP systems were commonly described as fragmented, disjointed or lacking in clear coordination. This resulted in a poor awareness of what was available with prescribers locking in limited lists of activities. The high number of PCNs, overlapping providers on differing contracts, and confusing geographies of some of the strategic and regional bodies was said to be contributing to this fragmentation and confusion around who was responsible for what. And this issue was not just cited in areas that considered SP to be less well established.
- ii. **Funding / capacity:** Overall, despite high demand for GSP in some areas, high workloads and lack of resource across the system is a limiting factor. Voluntary sector organisations have concerns about inequity of funding for GSP, with greater funding being allocated for NHS/health for providing link workers, and less to support third sector organisations with delivery. Where funding was available concerns still existed with regards to the length of funding available, and a general lack of long-term commitment – demonstrated by short-term commissioning models - that would be needed to grow and scale local systems. Further difficulties in growing the system arose from a lack of capacity, which was both exacerbated by, and contributed to, a high turnover of staff. This made relationship building, awareness raising, and training very hard to achieve.

- iii. **Duplication / competition:** There are concerns about ensuring that the right people are delivering GSP services and avoiding creating duplication or competition. There is a sense of uncertainty over what is already being provided between and within different parts of the system. In some cases this is due to differing footprints of commissioning bodies (e.g. LAs, ICSs, VCS, etc.) which lead to overlapping offers or different approaches in different areas.
- iv. **Impact of Covid-19:** The impact of Covid-19 has created ongoing increases in demand and stresses on already limited resources and services, especially on the NHS/health, but also across the system. It has also affected the confidence of many people, particularly older people, to go out and use their local green spaces, with much work needed to rebuild this confidence.
- v. **Safeguarding:** Voluntary sector organisations have concerns about providing GSP activities for individuals with more severe or complex mental health needs. Consideration needs to be given to ensuring that referrals are appropriate for the level of support that individuals need and that providers are able to deliver.
- vi. **Evaluation and data:** There are challenges in monitoring the impact of GSP activities. Providers of GSP may have differing priorities to social prescribers or those working in the health sector. For example, one interviewee described how their organisation was focused on nature-connectedness and highlighted the challenges in measuring this, as well as the challenges of measuring health-related outcomes that social prescribers may be looking for.

Opportunities

- i. **Collaboration:** SP/GSP appears to be more embedded where there is effective collaboration across different parts of the system, for example, between local government, health services and third sector organisations. Working together creates efficiencies across the system. There also appears to be opportunities for innovation and creating new partnerships through GSP which a number of interviewees are exploring.
- ii. **Wider impact:** Whilst many areas cited obesity or inactivity crises as priorities for developing GSP, it was also aligned to other opportunities and policy priorities beyond physical and mental health, such as climate change, the response to Covid-19, the queen's jubilee, etc. For example, one interviewee highlighted that GSP aligned with their aims and strategy in part due to their focus on improving access to nature, increasing biodiversity and protecting the environment. Another area was engaging with more diverse groups to understand why their use of green spaces was limited and to provide activities that would help to address this.
- iii. **Funding / Development:** Linked to the wider impact of SP/GSP activities described above, the applicability/fit of GSP within wider agendas could sometimes facilitate access to varied funding streams. For example, one interviewee described how their local councils had become more involved and invested in GSP through their parks and green space departments and through identification of clear opportunities to embed parks in the wider health agenda. They have received funding from National Trust and Public Health England to develop and embed these ideas and ways of working. Another area was working with providers to access smaller pots of funding from these wider agendas e.g., Queen's Jubilee, as the sums of money needed to deliver activities was relatively small. Similarly small pots of development or promotional funding, or support on how to tailor activities to fit an SP/GSP offer, would also enable many existing providers to make the minor adjustments they

need to be able to offer their activities to more people through the SP/GSP system.

- iv. **Impact of Covid-19:** Whilst the pandemic has created ongoing challenges, it has also created some opportunities, for example, through highlighting the value of parks and green spaces, physical activity and improving and supporting mental health, which in turn gives support for SP/GSP. There was also an influx of NHS volunteers during the pandemic who have subsequently transitioned into supporting GSP activities, with one provider keen to use them as activity buddies. There is also interest from providers to better understand the impacts of Covid-19 and to identify whether increases in activity have been maintained after the pandemic.
- v. **Neighbourhood-level working:** Whilst the fluctuation in demand that the pandemic created was managed in the short term by fast adaptation and firefighting, one area wants to have a more systematic response and is now developing neighbourhood teams. These will have greater reach into communities, and outside of traditional clinical settings, and will go to people where they are.
- vi. **Developing local community assets:** GSP provides an opportunity for developing and maintaining local assets (i.e., Asset Based Community Development). Signposting and referral to organisations providing these activities could have health benefits for the individual whilst also enabling organisations to become more viable and sustainable through increased engagement. Raising awareness of what is on people's doorsteps has increased use and was said to contribute to a stronger connection to place. One area highlighted activities at the local arboretum as providing much needed funding to sustain that asset.

A4.5. Next steps

Each of the case study areas has agreed to be interviewed again and will be followed-up in early 2023. Each area will also be offered the opportunity to participate in an area level focus group of key stakeholders to develop themes further, facilitated by the evaluation team (we anticipate holding 3-4 focus groups). In addition, in spring 2023 we will bring the areas together to participate in a national workshop to share learning from their work and the wider test and learn programme.

Appendix 5: Work Package 5 - National Partnership Working: Reflections and Theory of Change Development

A5.1. Introduction

This appendix provides the Evaluation Team's initial findings and reflections on the functioning of this unique partnership. It draws on work package 5 has two main components:

1. Qualitative interviews (n=10) with representatives of the national partners undertaken between December 2021 and January 2022.
2. A series of three two-hour workshops to develop a Theory of Change for how the National Partnership can support roll out Green Social Prescribing nationally – making use of the learning and evidence about how to scale GSP in an area generated through this project.

This programme of evaluative activity aimed to provide a facilitated learning environment in which national partners could receive and take stock of the learning from the project on an ongoing basis. This was felt to be important as the Shared Outcomes Fund requires Government departments and wider partners to work differently from 'business as usual'. As such it is hoped that the findings of this work will also provide evidence and learning on the experiences and outcomes of cross-sectoral partnership working that can be shared with other Shared Outcomes Fund projects and across Government more widely.

A5.2. Key Findings from the National Partner Interviews

Project governance and the benefits of partnership working

Partners provided overall reflections on the governance of the project and the benefits of partnership working. Overall, there was agreement that relationships across the partnership were positive despite the complex nature of the project and the issues it is aiming to address. Participants felt a strong sense of collaboration, and everyone was committed to making the project a success. There was general recognition that this is a complex project, and, in that context, there had been some considerable achievements. These included:

- **Clarity of roles:** there is a clear understanding of what role each partner plays, and their strengths and weaknesses; no missing roles were identified.
- **The governance is well developed:** the project has a clear governance structure with sub-groups that enable the day-to-day operation of the project.
- **Shared learning:** the cross-department, multi-partner approach enables learning to be shared through new relationships that probably wouldn't have been formed (as deeply) through traditional, siloed working.

Challenges for partnership working

Although participants were able to reflect positively on a number of aspects of partnership working, they tended to focus more on the challenges and the implications these have for the delivery of the project. Indeed, whilst governance was highlighted as a positive feature of the project, some partners felt that there might be too much, or that it was too unwieldy for a project of this size (i.e., relatively small and short-term) and that this could be detrimental to effective and efficient decision making. Linked to this, were concerns that the pace of delivery, the necessity of holding meetings online during the COVID-19 pandemic, and staff turnover, had at times hindered the development of the relationships needed to implement the project. Some respondents felt they did not have the time or resources to contribute what was needed - whether that is attending meetings, commenting on papers or engaging staff in their own departments.

Looking beyond the governance of the project, a number of other challenges were also identified by partners.

i. Complexity, and wanting 'too much' from the project

Partners are aware that the project is complex and seeking to do a great deal - and that this reflects the fact that the project has so many partners. For example, across the partners there are ambitions to:

- Test and learn how GSP can be embedded in mental health systems and pathways.
- Test and learn how green providers can be supported to provide the scale and quality of services needed.
- Determine/prove the impact of nature/access to nature /GSP on mental health, wellbeing and wider inequalities.
- Understand how change in mental health is created, how it is generated and whether it is a 'viable alternative' to therapy / medicines...or for some an 'additional' solution that is part of a broader 'package'.
- Broaden access to interventions and understand the role GSP can play in addressing health inequalities.
- Ensure physical activity is part of the (green) social prescribing offer and understand the part GSP can play in supporting people to increase activity levels.
- (Potentially) test whether GSP impacts on people's sense of custodianship and engagement with nature.

The wide range of ambitions outlined is perhaps inevitable given they are drawn from a range of partners and their specific positions within the policy landscape. However, it does pose problems for the project in terms of developing a shared vision and agreement on how this should be evaluated (as outlined below).

ii. The purpose of and priorities for evidence (evaluation and research)

We found that there is not yet full agreement on the emphasis or sequencing of how the evidence and learning from the project will inform the future roll-out, scaling and spreading of GSP. Whilst for some partners it was felt that the project must provide evidence about the *effectiveness* of GSP (i.e., the extent and type of outcomes) before future decisions could be made, for other partners, the case for GSP has already been made, and this project is largely about clarifying *how* to embed it in local health systems in ways that are sustainable.

iii. Limited understanding of different operating environments

The project partners come from a range of different policy traditions and disciplines within Government which each have deeply entrenched norms and practices. Some respondents felt that the lack of mutual understanding of these different operating environments had had an impact on the partnership and that sometimes, the lack of a shared language meant partners could find themselves talking at cross-purposes.

iv. Different ideas about who GSP is for

Most respondents are clear that the current GSP project was targeting people with mental health needs, rather than the general public (health and wellbeing promotion). The aims (as explained by one partner) are to ensure access to GSP for people across the continuum of mental health needs (from self-identified low-level needs e.g., loneliness, mild depression through to those with more serious and enduring illness). However, there was some concern that the other two foci set out in the original project documentation – to mitigate the effects of the COVID-19 pandemic and to address health inequalities, had become a secondary concern. This was considered to be problematic by a number of partners because several of the test and learn sites were less focussed on mental health, and acute mental ill-health in particular, than they had expected.

v. Timescales for delivery

Partners recognised that the timescale for delivery of the test and learn site element of the project – two years – was very short given the scale of the task (i.e., to embed GSP and demonstrate effectiveness in a complex system that is itself undergoing significant change). However, there was concern that the scale of the task and level of effort required was not fully understood across the partnership.

vi. Who should pay for GSP

There are differences of opinion amongst the partners about who should pay for which parts of GSP and at what spatial level. For some, the health system should pay, and there is an assumption that it has the money to do so. In reality, the NHS, beyond its existing national investment in Link Workers, may only be able to fund specialist support at a local level through commissioning (and joint commissioning). Some partners recognised this and felt that other parts of the public sector should also pay for GSP, particularly where it can benefit wellbeing and the wider social determinants of health. What partners did agree on was the need to ensure, somehow, that the cost burden of GSP did not fall on small green providers in the local voluntary and

community sector, and there was recognition that their work did require additional and sustainable financial investment from somewhere.

Why has the partnership experienced these challenges?

Collaboration and partnership working is never easy, and it often takes time to develop the relationships and understanding necessary to develop effective partnerships. Throughout the interviews partners reflected on why these challenges had emerged and how they could be overcome. Some of the factors proposed to explain these challenges included:

- **Leadership:** whilst there had undoubtedly been strong leadership to get the project funded in the first place, a number of senior leaders had moved on and left operational staff to pick up the baton.
- **Staff turnover:** linked to leadership, it was felt that those responsible for project implementation were not those who had designed it, perhaps leading to differences in interpretation and a shift in priorities.
- **Lack of ‘norming and storming’:** following staffing changes, people new in roles were not afforded the time to engage other partners and agree a shared vision and common purpose for the project.
- **No overarching project theory of change:** although there is an implicit theory of change within the original business plan, this was never developed or made explicit, meaning there isn’t a shared understanding of what the project is doing, what each activity will lead to, or the overall aim or vision.

A5.3. Recommendations following the national partner interviews

The findings of this first wave of interviews with the national project partners highlights the importance of developing a shared understanding in a number of areas if the project is to achieve its goal of embedding and sustaining green social prescribing across the country. Four areas of shared understanding appeared to be particularly important in this regard.

1. **Agreeing what the project needs to achieve**, and the order of priority. This includes navigating the tension between evidence about outcomes and impact, and evidence about how GSP can be embedded in different contexts.
2. **Developing a shared understanding** about how the work being undertaken – for example the Test and Learn sites, the Evaluation, and the National Research – is expected to contribute to the agreed project goals, and over what timescales.
3. **Identifying what the main local and national barriers** to embedding GSP and making it sustainable are, and the ways in which these can be overcome at different spatial levels and in different contexts.
4. **Agreeing and prioritising the key policy tools and objectives** through which the goal of embedding and sustaining GSP can be achieved in the future.
5. Since completing the interviews and disseminating the findings to the national partners the evaluation has become an important resource for supporting the national partners to address these issues. Three theory of change workshops have been used to support partners to begin to develop the shared understanding and possible solutions needed to develop a strategy for spreading, embedding and sustaining GSP beyond the life of this project. Following the workshop initial progress has been made to co-develop a theory of change for partners to utilise as part of this process (see following section for a full discussion).

A5.4. Draft Theory of Change for the national roll-out of GSP

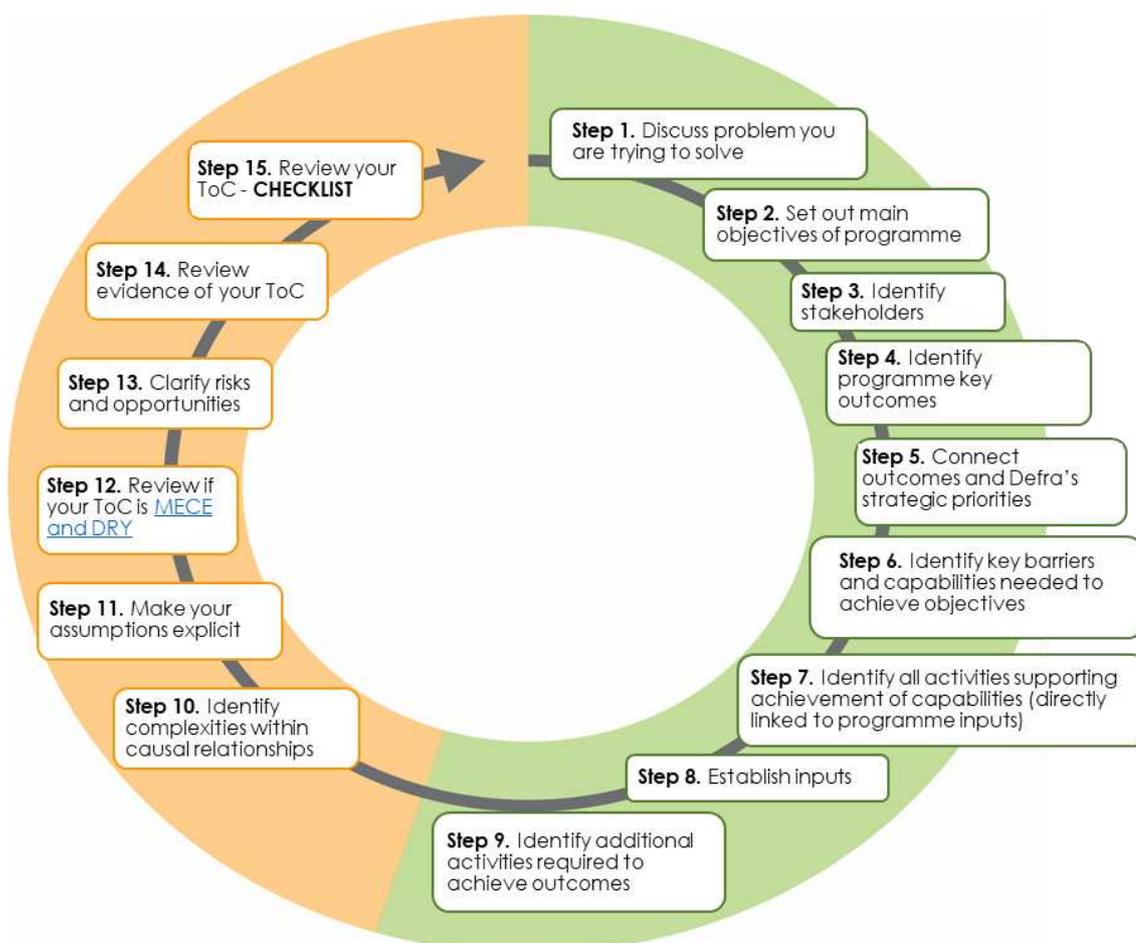
Introduction

This section of the appendix provides a very early draft of that Theory of Change (based on three two-hour workshops) and an accompanying narrative as well as setting out proposals for next steps and further development of the Theory of Change.

Methods

The Defra ToC tool¹² has been used to underpin our approach to the development of the Theory of Change. Key steps in the approach are set out in the figure below. The tool emphasises a collaborative and participatory approach to the development of Theory of Change. This ensures that differences of opinion, priorities, and different assumptions about how a programme might work in practice can be worked through and as far as possible, resolved. **We have used most, but not all steps in phase 1. We have not yet progressed through to phase 2 steps. We anticipate working through a second iteration of phase 1 steps later in the Project, as well as reaching steps in phase 2.**

Figure A5.1: Defra ToC tool step by step process



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<http://randd.defra.gov.uk/Default.aspx?Menu=Menu&Module=More&Location=None&Completed=1&ProjectID=20910>

The draft Theory of Change for roll out set out below is in **outline form** and builds on initial interviews (n=10) with representatives of the national partners and document review that was followed by three two-hour ToC focussed workshops with National Partners. Workshops have been used to discuss, rehearse and agree:

- The definition of the GSP.
- The timeframes for the ToC.
- The main objective and vision for roll out including the primary target group for GSP.
- Primary and secondary benefits and outcomes, along with some of the dependencies and assumptions.
- Responsibilities for decision making about health inequalities and other tailoring of GSP locally to local priorities.
- Policy on routes into GSP.

The workshops have also had **preliminary** discussions covering:

- The stakeholders involved in or likely to be affected by roll out of GSP.
- Resources available to support roll out.
- Key barriers and challenges that need to be addressed for roll out objectives and vision to be realised.
- Actions and activities that National Partners say they plan to deliver, which are expected to contribute to overcoming **each** of the barriers, as well as additional ideas for actions which could be undertaken.

As the workshops were undertaken during the early / middle stages of the Project, there is very little detail in these latter issues – what National Partners will or can do collectively or individually to support roll out are at an early stage of development.

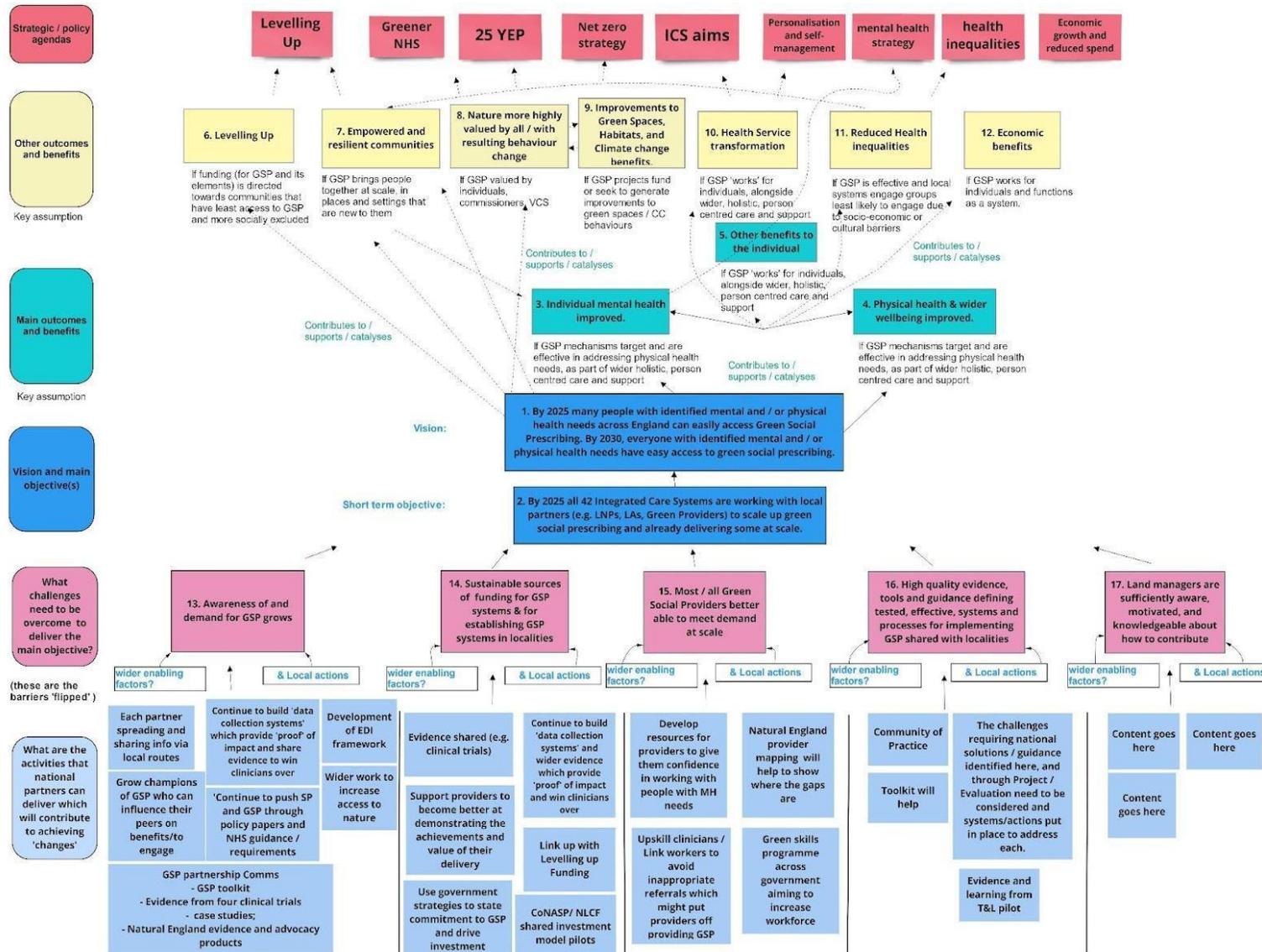
It is also important to note that there has been limited opportunity to date to ensure that the Theory of Change is informed by Partners' engagement with the emerging evidence from the evaluation and other work streams – however there will be an opportunity to do more of this collective interrogation and critical interpretation of the evidence and learning, and subsequent evolution of the Theory of Change in workshops we propose for the Autumn, Winter and Spring of 22/23 as the various programme and evidence workstreams provide interim or final outputs.

Outline Theory of Change for roll out

This section sets out the elements outlined above that have been discussed and agreed with National Partners through the three workshops. The ToC diagram is presented overleaf, followed by a summary narrative. The narrative focuses on the issues that have been covered in the theory of change workshops to date – as noted elsewhere a fuller write up of the ToC will be possible only as partners begin to make decisions about the detailed arrangements to support national roll out.

The ToC diagram includes any activity that partners themselves said are 'planned' but this requires further verification. It doesn't include partners 'ideas' for what **could** be done as these have not been agreed or discussed in the workshops. These are however included in the tables for reference and knowledge management purposes. The ToC does not include any actions of regional or local actors but plans / ideas for these could potentially be included in future iterations of the ToC as evidence emerges from the evaluation about how pilot sites have 'scaled' GSP locally.

Figure A5.2: Draft ToC for Roll Out of GSP



The definition of GSP

National partners agreed that the definition of GSP used in the ToC should be informed by / based on the definition set out in the Evaluation Scoping Report. The following 'evolved' definition has been drafted for consideration by national partners and is informed by the scoping report and workshop discussions.

Defining GSP

What GSP involves, and how it works is likely to vary considerably. However, Green social prescribing is the act of enabling people with a need (identified by the individual or a health professional), to reach nature-based activities and services based in or using the natural environment and typically, provided by the voluntary and community sector. GSP referrals are made by social prescribing link workers (or sometimes other practitioners known to the person) who build a relationship with people based on a "what matters to you" conversation and an offer of practical and emotional support. GSP services are designed or intended to benefit mental, emotional, physical or social health.

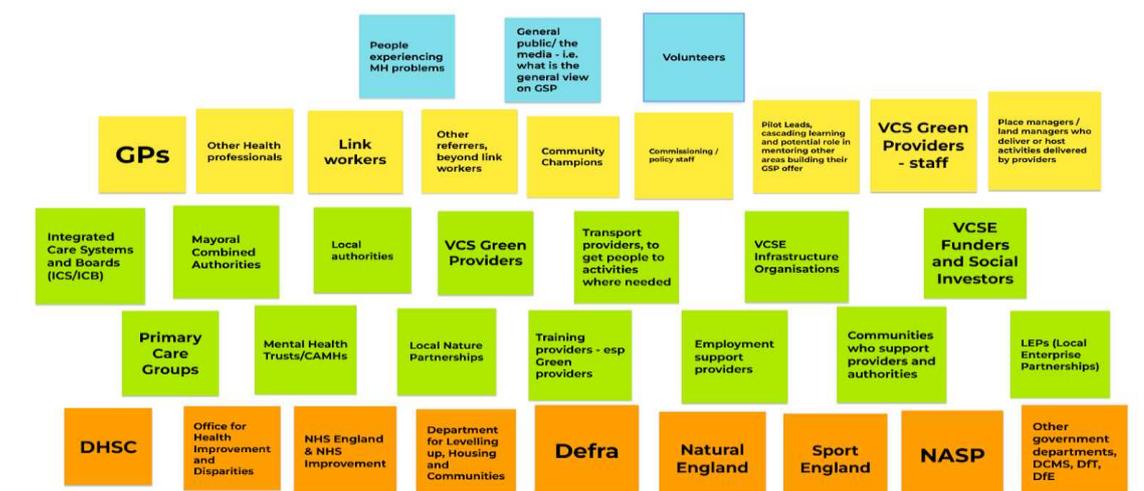
Green social prescribing is situated within a wider system of social and health care, infrastructure and provision; green social prescribing may be one offer amongst many for people with identified mental health needs. These additional services / wider systems of social and health care include social prescribing more generally, a range of public health and primary / secondary physical health and / or psychological services, services that support people with their relationships, services to encourage self-management, others that can help with finances and financial management, others that provide job coaching / support, as well as support around housing. Access to GSP may therefore be part and parcel of a wider package of support that an individual may be accessing. The wide range of services that might be required by individuals with mental health needs is a recognition of the fact that people may be facing several interrelated issues at the same time.

Partners also agreed that multiple routes into GSP would be encouraged including through **link workers** funded by NHS, Local Authority, and charitable sectors. It was acknowledged that to cope with demand, referrals via other workers (allied health professionals and other workers in the wider health and community services) would be acceptable. However, the criteria for whether or not these staff should be entitled to play this referring role would need to be linked to whether they were able to hold a 'what matters to you' conversation and their knowledge of locally available services and green opportunities. Local decision makers would be responsible for this.

Stakeholders

A wide range of stakeholders were identified. These are shown in the figure below. In terms of roles, National Partners (in the bottom layer) are setting the framework and ambition for roll out. Delivery will be led locally by Integrated Care Systems, involving local partners (including all the agencies and individuals in the middle three rows).

Figure A5.3: stakeholders



Gaps and issues: It would be helpful as part of detailed barrier analysis and strategic action planning, for national partners to unpack the potential stakes and roles of each stakeholder in any national roll out – including understanding what they are likely to gain or lose as part of any roll out. This in turn would contribute to the development of a more robust Theory of Change. This is something that could be undertaken in future workshops proposed later in this Appendix (p174).

The detailed roles of each of these stakeholders and local processes will not be covered in the national Theory of Change as these are expected to be covered as part of the wider work to build local theories of change.

Timeframes for the ToC

Partners agreed that the focus and detail of the ToC should be on the short term (i.e., to 2025) but that there should be a clear link to the longer term represented in it.

Resources available to support national roll out

Plans and arrangements for partners to work together beyond the pilot are not yet clear, however, at the time of writing national partners were able to confirm that:

- The Cross government social prescribing task force will have a role.
- There is a possibility of a project extension.

Wider resourcing commitments that will support roll out include:

- NHS regional personalised care teams.
- NASP multi-agency regional teams.
- Sport England Investment and Collaboration with Active Partnerships.
- Levelling up Parks Fund.
- Social prescribing schemes in ICSs.

Gaps and issues: The content here would benefit from review and elaboration (to understand these contributions more clearly). Any other resources available should be incorporated. It would be helpful, in future workshops, to link these resources to one or more of the specific barriers.

Vision and main objective for roll out including the primary target group for GSP

The vision for GSP roll out, agreed amongst National partners in the workshops is:

By 2025 many people with identified mental and / or physical health needs across England can easily access Green Social Prescribing. By 2030, everyone with identified mental and / or physical health needs have easy access to green social prescribing.

The agreed, short-term objective for GSP roll out is:

By 2025 all 42 Integrated Care Systems are working with local partners (e.g. LNPs, LAs, Green Providers) to scale up green social prescribing and are already delivering some at scale.

These are set out **in the centre of the ToC** diagram above.

The focus is on people with *identified* mental health needs – this includes needs which are self-identified or identified by an informal carer, as well as those identified by a professional (GP, allied health professional, or community / VCS staff). However, national partners also recognise that GSP has the potential to benefit – through a potential range of different mechanisms – the mental and / or physical health of people with physical health needs, regardless of whether they have presented to ‘the system’ with identified mental health needs. Therefore, national partners agreed that people entering the social prescribing system with primarily physical health needs should also be encouraged to access Green Social Prescribing.

Gaps and issues: What is not yet clear from the workshops is what ‘scale up’ means in an area when combined with access ‘by many people’. These are important for ensuring national partners are clear about the scale of change sought, and for ensuring the ToC (and any future delivery plans) are founded and resourced on the basis of clear definitions of ambition. Additionally, this will help to underpin any future evaluation of roll out. Future workshops could be used to discuss and define these.

Responsibilities for decision making about health inequalities and tailoring to local priorities

National Partners agree that within the primary focus area (identified mental health needs), GSP should be available to all socio-economic and health groups. However, local decision makers would be advised to use the NHS Core20plus5 guidance¹³ to undertake any further prioritisation and targeting necessary to better support those groups most likely to be experiencing health inequalities to participate. Further support may also be required to support those least likely to feel able to participate and therefore at risk of self-exclusion from GSP opportunities.

Primary and secondary benefits

Below we set out the primary benefits that are expected to flow from successful roll out nationally – the number linked to each benefit refers to the box number in the ToC.

¹³ See

<https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/>

It will be for local stakeholders for example to tailor their GSP strategy to achieve local priorities. The benefits presented here are those which are feasible as a result of delivering GSP locally. In practice, which benefits are achieved, for whom, and with what impact will depend on what GSP activities look like in each area, the level and extent of any efforts to reach and support specific groups who may be experiencing health inequalities, and / or may be less likely to take part for various reasons despite the potential benefits that may accrue to them. These local strategies and prioritisation are not considered as part of the TOC for national roll out.

Table A5.1: Primary benefits

Primary benefit / outcome area (and relevant policy agenda)	Further details	Assumptions
Individual mental health improved (mental health strategy)	<ul style="list-style-type: none"> Definitions of the types of mental health improvements cannot be given here – they will depend on the needs of the individual, their circumstances, and the nature of the support provided, which will be determined at a local level. 	<ul style="list-style-type: none"> GSP mechanisms target and are effective and delivered alongside, and as part of any wider holistic, person centred care and support that might be needed to reduce mental distress, Other internal or external circumstances that might affect mental health do not get worse. Short term benefits arising from participation could be sustained through continued participation in nature-based activities.
Physical health and wider wellbeing improved (Long term NHS plan)	<ul style="list-style-type: none"> Definitions of the types of improvements to physical health that might result cannot be defined here – they will depend on the needs of the individual, their circumstances, and the nature of the support provided, which will be determined at a local level. 	<ul style="list-style-type: none"> GSP mechanisms target and are effective and delivered alongside, and as part of any wider holistic, person centred care and support that might be needed to reduce mental distress, Other internal or external circumstances that might affect mental health do not get worse Short term benefits arising from participation could be sustained through continued participation in nature-based activities.
Other benefits to the individual (various)	<ul style="list-style-type: none"> Improved ability to work Resilience and reduced risk of relapse (physical / mental ill health) Reduced carer burden Encourages wider self-management behaviours and capabilities 	

Rolling out GSP is additionally expected to contribute to the achievement of a wider range of secondary benefits, linked to key government commitments on health and the environment. As noted above, which benefits are achieved, for whom and with what

impact will depend on the detailed priorities, strategy and arrangements for effective delivery within local systems, as well as local circumstances and contexts including wider service environment. Each of these wider benefits is set out below. The number (to the left) relates to the number in the ToC itself.

Table A5.2: secondary benefits

Secondary benefit / outcome area (and relevant policy agenda)	Further details	Assumptions
Levelling up (levelling up)	<ul style="list-style-type: none"> Those with limited access and opportunities benefit from relatively greater access and opportunities. 	<ul style="list-style-type: none"> If funding (for GSP and its elements) is directed towards communities that have least access to GSP and more socially excluded.
Empowered and resilient communities	<ul style="list-style-type: none"> 'Bridging' social capital enhanced. Increased safety of formerly inhospitable green spaces due to increased use and any funded improvements. Community health & wellbeing. 	<ul style="list-style-type: none"> If GSP Roll out brings people together at scale, in places and settings.
Nature more highly valued by all / with resulting behaviour change (25 YEP)	<ul style="list-style-type: none"> Enhanced use of natural community assets. Independent access and use of green spaces - no need for prescribing green activity. Increased pro-nature behaviours (e.g., volunteering). NHS / VCS more connected with nature. More public / stakeholder support for nature policy (25 YEP) and awareness of need for nature recovery. 	<ul style="list-style-type: none"> If access to nature catalysed by GSP results in individuals, commissioners, VCS valuing nature more highly.
Improvements to Green Spaces, Habitats, and Climate change benefits (25 YEP, Net Zero Strategy)	<ul style="list-style-type: none"> Contributes to nature recovery. More climate change related / nature-based projects taken forward. 	<ul style="list-style-type: none"> If GSP projects fund or seek to generate improvements to green spaces / climate change behaviours.
Health Service transformation (Greener NHS, personalisation, prevention and tackling health inequalities)	<ul style="list-style-type: none"> Encourages wider self-management behaviours and capabilities. Reduces GP consultation for non-medical issues. Enhances effectiveness of other MH measures as part of self-management agenda. Clinicians and commissioners more confident to use VCS/ Social prescribing. Generates positive support for and efficacy of the wider social prescribing and personalisation agenda. 	<ul style="list-style-type: none"> If GSP 'works' for individuals, alongside wider, holistic, person centred care and support.

Secondary benefit / outcome area (and relevant policy agenda)	Further details	Assumptions
Reduced Health Inequalities (Public health)	<ul style="list-style-type: none"> How health inequalities are addressed will depend on how local social prescribing systems manage Green Social Prescribing and their strategic approach to prioritisation and support (Core20PLUS5). 	<ul style="list-style-type: none"> If GSP is effective and local systems engage groups least likely to engage due to socio-economic or cultural barriers.
Economic benefits (economic growth, reduced cost to public purse)	<ul style="list-style-type: none"> More people are able to work / return to work due to recovery or reduced caring role. New jobs in the GSP sector. Healthier / more resilient and more productive workforce resulting from staff using GSP. Cost savings to the health sector through reduction / avoidance of ill health and reduced use of GP time for needs which are 'non-medical'. There may also be reputational benefits if businesses contribute funding to GSP. 	<ul style="list-style-type: none"> If GSP works for individuals and functions as a system. If businesses contribute funds to GSP.

Key barriers and challenges that need to be addressed

A number of barriers or challenges must be overcome to achieve the main objective of roll out and to enable the flow of benefits and outcomes outlined in tables A5.1 and A5.2 above. Five key barriers to roll out were discussed with National Partners. These are outlined in table 5.3 below. Further details of the barrier are given – these are tentative suggestions for what defines or perpetuates the barrier, based on comments made by national partners as well suggestions made in associated project documentation, and related research.

In the ToC these barriers have been ‘flipped’ from the negative (barrier) to the positive i.e., they become a ‘sub-objective’ to be achieved rather than a barrier. Both the negative (original barrier) and the positive framing (the sub-objective) are shown in the table.

Table A5.3: Details for Barriers

Flipped barrier (i.e., sub-objective)	Original Barrier	Further details of barrier
Awareness of and demand for GSP grows	Lack of awareness of GSP and its benefits / lack of demand for GSP	<p>Leadership, comms & learning mechanisms are underdeveloped:</p> <ul style="list-style-type: none"> • Prior to the GSP Project there has not been any national action to stimulate or support GSP. • Availability of GSP is patchy. • There are few if any opportunities or fora in which to share knowledge and good practice about GSP. <p>Public perceptions and requirements are not aligned with 'scaling up GSP':</p> <ul style="list-style-type: none"> • Most people already access green spaces (70%) and most think it helps them (IFF Research). • Those not already accessing are the least likely to accept offer / take up referral (according to IFF research). • Also, according to IFF research some people would prefer 'traditional' treatment options rather than social or green social prescribing. <p>Buy in across the clinical pathway is lacking:</p> <ul style="list-style-type: none"> • Medics are not always aware of or supportive of GSP – the evidence base / the case for GSP has not been adequately shared (according to Evaluation findings in T&L sites). • Some national partners believe that the bio-medical model of health dominates in the health system, the bio-social elements have not yet been accepted and incorporated into practice. <p>Other actors do not have enough information:</p> <ul style="list-style-type: none"> • Link workers are not always aware of GSP services – referrers lack information about suitable nature-based services in their area
Sustainable sources of funding for GSP systems & for establishing GSP systems in localities	Lack of (sustainable) funding for GSP systems & activities and for establishing GSP systems in localities	<p>A range of factors are thought to be behind the lack of funding and may stand in the way of progress.</p> <ul style="list-style-type: none"> • Prior to the GSP Project there has not been any national action to stimulate or support GSP. • There is a lack of coordination of supply and demand at national and local level. • Funding for scaling GSP has cost up to £1m in T&L sites. It is not clear how other sites will find the resources to set up systems and processes and establish oversight of scaled up GSP systems. • Potential commissioners have not been convinced that spending public money on GSP is defensible. A compelling business

Flipped barrier (i.e., sub-objective)	Original Barrier	Further details of barrier
		<p>case and evidence base has not been presented.</p> <ul style="list-style-type: none"> Quantified unit costs and benefits of GSP are not known due to the heterogeneity of services and clients accessing them, and the challenges of evaluation. It is not clear or agreed who (which agency) should pay for (or at least contribute to) different elements within the GSP service / pathway. All public services and VCS are under pressure and do not have additional funds to invest. There are many existing demands on limited, diminishing pots of money.
Most / all Green Social Providers better able to meet demand at scale	Some Green Social Providers would currently not be able to meet demand at scale	<p>A range of issues were suggested:</p> <ul style="list-style-type: none"> There has not previously (and is not currently) sustainable, long-term funding for green providers which makes it difficult for them to expand. Labour / supply chain issues – some providers may find it difficult to recruit. There are no established skill sets for GSP, nor models of career progression, this makes running a GSP organisation more costly and finding and retaining staff more challenging. Providers don't always see themselves as providing 'GSP' and there aren't always links between providers and referrers. Some providers may not feel able to cater for health or mental health needs of some of the patients referred to them – particularly where they have high or fluctuating needs. Some providers find it difficult to access health systems to find a 'footing' and establish relationships.
High quality evidence, tools and guidance defining tested, effective, systems and processes for implementing GSP shared with localities	Lack of evidence, tools, systems, and processes on / for workable local models of GSP to share with localities	<p>A range of capabilities need to be developed at a local level to support 'scale up of GSP. There is a need for guidance and support around:</p> <ul style="list-style-type: none"> Governance: How to establish locality wide 'governance' systems. Client data sharing protocols and systems: How to get the right client level data collected and shared across system actors (monitoring plans, arrangements, progress and outcomes). i.e., what data does each agency need from each other, what is each agency able to collect and share? How can data collection and sharing be improved? Referrals: how to establish referral systems and access arrangements and how to open up referral processes to other actors (i.e., not just Link workers). Relationships: how to develop and manage relationships across the range of actors.

Flipped barrier (i.e., sub-objective)	Original Barrier	Further details of barrier
		<ul style="list-style-type: none"> • Evidence for commissioning: how to develop a commissioning strategy for GSP – including evidence about which types of strategies and activities work in terms of outreach, prescribing and delivery, for different populations. • Raising awareness & building demand: how to raise the profile of GSP amongst range of actors and establish an appetite for GSP. • Strategy for reaching those who could benefit most: Developing and implementing effective targeting and support in line with NHSCORE20PLUS5. How to reach and convince people most likely to benefit but least likely to access that taking part is a good idea? • Inserting GSP in a dynamic, and challenging context: How best to manage the interface with other systems (such as social prescribing itself and health service) when these are either in development or in crisis themselves. • Workforce: how to manage workforce development across the system to support effective delivery
Land managers are sufficiently aware, motivated, and knowledgeable about how to contribute	Some land managers / owners are not sufficiently aware or motivated, and / or don't know how or what to do	No further details available on this.

Gaps and issues: Future workshops with national partners will aim to clarify further details and fill in gaps in the tables above. The GSP evaluation, the research that Defra has commissioned and the research that Defra plans to commission could provide further insights on these barriers as well as identifying additional barriers. Further confirming and clarifying these barriers will help to sharpen up the focus for the ToC enabling national partners to determine more conclusively **what activities and inputs are** needed to address these barriers and which should ideally be included to support national roll out. All these issues will be considered in future workshops as learning and outputs from research continue to be shared with national partners.

Actions and activities that National Partners will deliver to support roll out

National Partners proposed a range of activities that would or could be delivered to help overcome these barriers during the workshops. In the table below, the proposed activities have been clustered and connected to the barrier that they are most clearly associated with.

The table includes activities that partners say they plan to deliver and in addition, their ideas for actions / activities that are being, or could be, actively considered.

Table A5.4: Actions & ideas for actions

Flipped Barrier (i.e., sub-objective)	Planned national actions to take (and any details provided)	Further ideas for what national partners could do
Awareness of and demand for GSP grows	<ul style="list-style-type: none"> • Each partner spreading and sharing information via local routes. • Grow champions of GSP who can influence their peers on benefits / to engage. • Continue to build 'data collection systems' which provide proof' of impact and share this evidence in order to win clinicians over. • Continue to push SP and GSP through policy papers and NHS guidance / requirements. • Development of EDI framework. • Wider work to increase access to nature. • GSP partnership Comms (GSP toolkit, evidence from up to four clinical trials, case studies, evidence and advocacy products provided by Natural England). 	<ul style="list-style-type: none"> • More training and awareness raising for link workers.. • Continue through our networks to help connect existing and pilot providers with local systems • More emphasis on comms and support is needed to raise awareness. • Engage more with national bodies and orgs that have credibility - e.g., royal colleges. • Community of practice would help to spread learning. • Work collaboratively to ensure the VSCE sector is linked into the ICS boards to influence and support sustainable funding and build trust to support appropriate referrals. • Complete the scale up plan and use that to plan/prioritise actions. • We hope the evaluation plus NASP/other research will answer the questions ICS chairs etc need answers to be able to take up GSP. • Listen to local systems to understand the barriers from their perspective (e.g. is it lack of buy-in/demand? lack of resources? etc).
Sustainable sources of funding for GSP systems & for establishing GSP systems in localities	<ul style="list-style-type: none"> • Evidence shared (e.g. clinical trials). • Support providers to become better at demonstrating the achievements and value of their delivery. • Use government strategies to state commitment to GSP and drive investment. • Continue to build 'data collection systems' which provide 'proof' of impact and share this evidence in order to win clinicians over. 	<ul style="list-style-type: none"> • Provide and/or leverage additional funding and ensure funding reaches providers. • Ensure GSP is embedded in system transformation and part of local priorities. • Work with private sector to secure funding, e.g. from CSR budgets, already had interest from Arup. • Joined-up, place/system-based approaches to investment, drawing on

Flipped Barrier (i.e., sub-objective)	Planned national actions to take (and any details provided)	Further ideas for what national partners could do
	<ul style="list-style-type: none"> • Link up with Levelling up Funding. • NASP / NLCF shared investment model pilots. 	<p>inputs from multiple funders with an interest in GSP.</p> <ul style="list-style-type: none"> • Continue to explore options for shared outcome funding. • Encourage ICS to make investment in green providers, wider VCSE and community assets a priority (but is the possible in resource constrained context?). • Explore new funding models, e.g., match funding pots. • Encourage investors to consider green providers (and wider VCSE) as something for systems to invest in, rather something that is dependent on system resources to operate. • Commission further GSP research to assess VFM.
<p>Most / all Green Social Providers better able to meet demand at scale</p>	<ul style="list-style-type: none"> • Develop resources for providers to give them confidence in working with people with mental health needs. • Upskill clinicians and link workers to avoid inappropriate referrals which might put providers off providing GSP. • Natural England provider mapping will show where the gaps are. • Green skills programme across government aiming to increase workforce. 	<ul style="list-style-type: none"> • Support VCSE providers to understand and be able to demonstrate Value for Money to their commissioners (effectiveness; economical and efficiency). • Develop a demand and capacity model (this is a standard approach for traditional NHS services). • Consider workforce modelling to enable scale. • Continue to value hyper-local providers and ensure systems include support for them to continue to be engaged. • Deep dive to understand the reasons behind this and what can be done about it. • How much does this matter? We must value hyper local and larger providers and ensure that between them the breadth of need is covered. • More resources for providers showing how they can join up with the health system and start to receive referrals etc.

Flipped Barrier (i.e., sub-objective)	Planned national actions to take (and any details provided)	Further ideas for what national partners could do
		<ul style="list-style-type: none"> • Important to connect into the system existing established providers in addition to those in pilots.
High quality evidence, tools and guidance defining tested, effective, systems and processes for implementing GSP shared with localities	<ul style="list-style-type: none"> • Community of Practice. • GSP Toolkit. • Evidence and learning from the T&L pilot / evaluation. • The challenges requiring national solutions / guidance identified in table 3, and through Project / Evaluation need to be considered and systems/actions put in place to address each. 	<ul style="list-style-type: none"> • NASP and others are commissioned to strengthen the evidence base with further summaries to come. • Change of mindsets around what 'good' or reliable evidence is. • GSP directories of green providers.
Land managers are sufficiently aware, motivated, and knowledgeable about how to contribute	No actions have been identified for this 'flipped' barrier.	No ideas were generated on this flipped barrier.

Gaps and issues: The content in the 'activities' column is the content shared by individual participants in the workshops. At present there is little more detail other than the title of each activity.

Future workshops should:

- Confirm these actions with National Partners.
- Generate further details for what the activities are, how much will be delivered, when and for how long, who will deliver them and *how* they are expected to contribute to achieving each sub-objective.
- Clarify whether the 'ideas' suggested are agreed or not.
- Clarify any wider 'enabling factors' or relevant 'local activities' that contribute to the sub-objective.

Risks and issues

Risks to the successful delivery of the programme, including internal delivery and external factors that might jeopardise the achievement of the objective and realisation of different benefits have not yet been considered due to the early stage of this work. Consideration of risks and issues would be undertaken with partners when the ToC has been more fully developed.

A5.5. Next steps

Detailed suggestions for further development of the Theory of Change have been noted in the main body of the text above. In summary further work may include:

- Incorporate partners' views on and details of the key barriers that have been clarified further through the research and evaluation.

- Further crystallise and clarify the details for what programme activities will be delivered, and how, and how these activities are expected to contribute to overcoming key barriers and challenges.
- Clarify and incorporate wider enabling factors, and details for local actions.
- Review and clarify assumptions.
- Undertake a collective risk assessment of the ‘theory of change’ for future roll out.

We propose to complete this work and a first full draft of the Theory of Change for roll out through three further workshops – each resulting in refinements and evolution to this early outline draft. Ongoing work by National Partners to set the vision and document the strategy will also be reviewed and will directly inform the Theory of Change when available.

Dates proposed below are suggestions that have been built around timing of evaluation and research outputs. However, we are keen to ensure that deliverables from this workstream are generated in time for key decisions or funding applications, and these dates could easily be revised.

Table A5.5: Further workshops

Workshop date	Evidence that partners will be able to make use of in the development of the ToC.
Workshop 4 – January 2023	<ul style="list-style-type: none"> • Interim evaluation report • final report of IFF perceptions research • Natural England’s capacity assessment final report
Workshop 5 – March 2023	<ul style="list-style-type: none"> • Progress updates from the evaluation ahead of the final report due in May 2023

Appendix 6: Work package 6 update – Preliminary value for money interim findings

A6.1. Introduction

This appendix provides an interim analysis of data for Work Package 6 (WP6) which aims to complete an in-depth **Value for Money assessment of the Green Social Prescribing Project** with a focus on the work of the seven Test and Learn sites. As part of this WP6 will:

- Evaluate the unit costs of GSP activity to understand the types of costs that are involved, to whom costs fall and whether support is provided at the best cost.
- Assess whether costs are preventative rather than reactive and create capacity across different systems, such as primary and secondary health care.
- Quantify the average cost of the supporting people to participate in nature-based activity in each site through the GSP project (cost efficiency) in each site and identify the factors that affect variation in support costs.
- Explore the extent to which it is possible to quantify effectiveness - contribution to outcomes for stakeholders - including the average cost of different types of outcomes and the factors associated with variation in effectiveness.
- Value (where possible) fiscal, financial and societal outcomes.
- Consider equity i.e., whether the test sites are addressing social and economic inequalities.
- Provide evidence and a cost tool to support the rollout of GSP.

Costs will be considered from four perspectives: the overall costs of delivering the GSP test and learn projects; green/blue providers delivering nature-based interventions; link workers; and the cost of associated care packages provided to GSP service users. The approach to assessing costs and benefits is outlined in the following section.

It is important to note that it is reasonable to expect the cost per service user engaged in nature-based activity to vary considerably by Test and Learn site. As noted in the main body of this report, the foci of the seven sites are very different and this will have a bearing on the numbers of referrals made. Where funded activity has focussed primarily on system building and strengthening with relatively little to no direct funding of activities or other factors (T&L4); or initial system building and strengthening with direct funding of activities at a later stage of the project (T&L6, T&L1, T&L2); we would expect the cost per service user to be relatively high. Where funded activity has focussed on parallel system building and direct funding of activities (T&L7, T&L3) and/or awarding of funds to address factors that prevent uptake (T&L5) we would

expect the cost per service user to be lower. Indeed, in sites where direct funding of activities is not a priority it may be necessary to reflect on whether it is fair or meaningful to provide per-beneficiary costs.

A6.2. Limitations of the analysis presented

It is important to caveat the analysis presented by highlighting a number of limitations.

- First, only four of the seven sites provided data, meaning that the picture presented is only partial.
- Second, the current data only covers the early stages of the project (the first 12-15 months). Given that different sites have prioritised different aspects of delivery during this period (as discussed above), comparison between sites is inadvisable. Third, we are uncertain as to the completeness of the data provided about the number of people supported to access nature-based activity through the GSP project in each site. This data requires further verification with sites and triangulation with other data sources (such as that provided for WP3b).
- Third, this data represents only the first stage of value for money assessment. As the project moves toward completion more complete data from a wider range of perspectives will become available, enabling a more holistic assessment to be presented. Given these limitations, at this stage **we would caution strongly against using this data to inform project management, policy or strategy decision.**

A6.3. Methodology

Our approach to understanding the value for money of the Green Social Prescribing project is based on the principles of the HM Treasury Green Book. However, given the complexity of the project (highlighted elsewhere in the appendices to this Interim Report), a bespoke methodology comprising a range of data collection tools has needed to be developed. Each data collection tool is outlined below.

Cost of managing and delivering green social prescribing projects and nature-based interventions (the Test and Learn Sites)

Establishing the costs of managing and delivering the GSP projects and nature-based interventions is essential to assess their economic case, as well as informing commissioners on their resourcing requirements. To ascertain these costs, two cost surveys have been developed which will be completed by:

- The seven **Test and Learn sites**: to build a detailed and robust evidence base on the costs and staffing of the establishment, management, organisation and delivery of the GSP projects.
- A sample of **nature-based providers** in receipt of GSP referrals: to provide further and more nuanced detail on the scale and nature of delivery costs and staffing associated with nature-based interventions.

The information to be gathered covers actual financial (excluding VAT) and staffing information over the lifetime of the GSP project. It includes: income sources, capital costs, set up cost, staffing costs and numbers, operational costs and monitoring and local monitoring and evaluation.

To date, only the Test and Learn site cost survey has been completed (in four sites) and only for the early stages of the project (the first 12-15 months). A follow-up test and learn site survey will be completed at the end of the project to capture costs for

the full duration. The survey of nature-based providers will be completed in late 2022/early 2023 to ensure the data covers the widest possible time period of delivery.

An initial pilot of the nature-based provider survey identified practical issues associated with the capacity of provider organisations. In response, additional support will be provided during the main data collection period. Researchers from the national evaluation team will work with three providers from each Test and Learn site to complete the tool. Initially working with their existing financial monitoring and then following up with short conversations and queries to complete the cost tool, enabling comparison of standard and consistent data across providers.

Cost of link workers

Additional data collection is required to collate information not covered by the Test and Learn and Provider cost surveys (described above), but which is important to understand the full cost of link worker activity associated with GSP. This data will be derived from existing sources including: the NHS Direct Enhanced Service contract (DES) which codifies the NHS funded link worker role within Primary Care Network; published evidence on link worker costs (e.g., local evaluation reports); and data from commissioned social prescribing services in test and learn sites (where available). This data will be combined with data collected through Evaluation Work Package 3A to assess the likely range of costs associated with a link worker making a green referral (referral to a nature-based provider).

Cost of care packages

Understanding the cost of care package that GSP beneficiaries are in receipt of provides important context (and equality information) about people accessing nature-based activities through the GSP project. It will also support estimates of the savings that could be associated with GSP. To date the evaluation has explored different methods to determine these costs and assesses that the following data are required: the range of care services that are accessed, the level of usage of each care service, the change in usage that can be attributed to GSP and then the unit cost of care package services to compute the financial cost and savings.

As highlighted in Work Package 3A (Appendix 2), access to quantitative data which would provide the highest standards of evidence is limited for this evaluation. This would require a more detailed and extensive individual level data access and an impact evaluation beyond the scope of this study. To address these limitations, we plan to run a workshop with each Test and Learn site in Autumn 2022 to establish expected costs. This will be based on developing 'High', 'Mid' and 'Low' cases from the monitoring data on GSP beneficiaries. We will then work with workshop participants to estimate 'typical' care package costs before, and after, GSP. This will be based around a template which sets out the structure of the workshop and enables as much work as possible to be done in advance. Finally, after the workshop we will draw on evidence from PSSRU's health and social care cost database to estimate and validate the costs of care packages.

A6.4. Progress update

Thus far WP6 has sought to gather interim data about costs from the seven Test and Learn Sites. To date the cost survey has been completed by four Test and Learn sites¹⁴. The survey gathered evidence on the costs and staffing of the establishment,

¹⁴ Each site was requested to complete the tool by September 2022, but to date only four have been returned. This limits the completeness of the analysis presented.

management, organisation and delivery (at an aggregate level) of the GSP Test and Learn projects. Therefore, the interim analysis presented in this chapter is narrow in its content. It assesses income as well as set-up, management and coordination costs and staffing at the site level. The final evaluation report will contain a more comprehensive and detailed analysis from across the system. As well as a finer grain analysis of the costs involved this will include the cost of link workers, the delivery costs of Green Social Prescribing by green providers in receipt of GSP referrals, and the alternative health care costs that GSP *may* reduce.

All seven Test and Learn Sites were asked to complete a cost survey for their site. Typically, this was completed by the project manager in conjunction with the financial lead for the site.

Four responses were received by the cut off for the interim report analysis. The survey aims to build up a detailed evidence base on the costs and staffing at a site level. The information gathered covered actual financial (excluding VAT) and staffing information for the sites, broken down by a series of headings. To ease completion for the sites they were able to identify the time-period for their data. The projects were also asked to provide the number of service users who had participated in nature-based activity through their project over the same time-period to enable costs per service user to be calculated.

It should be noted that the data provided from the sites is self-reported within the guidelines provided. Thus far it has not been possible to verify the accuracy of the responses received so the analysis presented here is done so in good faith. We will however seek to verify and discuss the results with the sites in the next phase of the evaluation.

The remainder of this appendix provides analysis of these responses.

A6.5. Data overview (interim¹⁵)

What income did the Test and Learn sites receive?

The financial resources coming into the Test and Learn sites are considered in this subsection. Table A 6.1 shows the total income received by the four Test and Learn sites was just under £1,900,000, equating to approximately £2,400 per service user supported to participate in nature-based activity the GSP project. Of this amount:

- 71 % (£1,349,596) was Shared Outcomes Fund Green Social Prescribing Project funding.
- 24 % (£451,841) comprised own and/or partner financial commitment to deliver GSP project, including matched funding commitments.
- 5% (£87,811) was in the form of own and/or partner cost of in-kind staffing commitments.

This means that for every £1 of Shared Outcomes Fund funding an additional 40 pence had been levered in from other sources. This latter amount included 33 pence from own/partner commitments and seven pence in the form of in-kind staffing commitments.

In this context it is also important to note that a number of the national partner organisations also ‘matched’ the Shared Outcomes Fund money, representing further

¹⁵ When interpreting this analysis please note the caveats identified in section A6.2 of this appendix.

leveraged investment. Following the initial commitment of £4.27 million by the Shared Outcomes Fund the national partner funding commitments were as follows:

- NHS England: £500k.
- NASP: £500k.
- Sport England: £500k.

Table A6.1: Sources of income

	Income (£)	Income per service user engaged in NBA (£)	Percentage of total income (%)
SOF*: GSP funding	£1,349,596	£1,687	71
Own/partner financial commitment	£451,841	£565	24
Own/partner in-kind commitment	£87,811	£110	5
Total	£1,889,248	£2,362	100

* Includes national partner contributions

Table A6.2 demonstrates the breakdown of sources of income by the four test and learn sites who provided data. Across the four sites the average income per service user engaged in nature-based activity was £2,362. This value varied greatly between the sites from £12,739 to £1,287 per service user. The reasons for this variation are complex and related to the project context and will be explored further in the next phase of the evaluation. However, it can in part be explained by the period accounted for by the data as well as differences in the set-up approach taken by the four sites. For example, and as outlined in Appendix 3 focussing on Work Package 3B, whilst some sites prioritised referrals to nature-based providers early-on in their delivery, others have prioritised other activities such as systems engagement and co-production. Those that have prioritised referrals will inevitably have recorded a high number of service users engaged in nature-based activity than those that prioritise other activities.

Table A6.2: Sources of income by Test and Learn site

	T&L1		T&L2		T&L4		T&L5	
	<i>Income</i>	<i>Income per service user</i>						
SOF: GSP funding	£500,000	£1,109	£358,686	£2,916	£240,910	£10,474	£250,000	£1,232
Own/partner financial commitment	£206,453	£458	£234,138	£1,904	£0	£0	£11,250	£55
Own/partner in-kind commitment	£0	£0	£35,714	£290	£52,097	£2,265	£0	£0
Total	£706,453	£1,566	£628,538	£5,110	£293,007	£12,739	£261,250	£1,287

The overall costs of providing the projects

This section considers the site level expenditure by the four Test and Learn sites that completed the cost tool in the respective period covered by the data collection. These are presented as a total and per service user amount. The latter is important given the variation in the numbers of service users that each project has worked with, and the time-period covered.

The total expenditure of the four Test and Learn sites was £1,451,640 for the periods covered by the data. This means that the average site level cost per service user participating in nature-based activity was £1,815¹⁶ (in evaluation terms this is the average cost efficiency).

However, site level expenditure varied from £951 in T&L1 and £1,287 in T&L5 to £5,063 in T&L4 and £5,243 in T&L2 (Table A6.3). The context for these variations has been discussed above and will be explored in more depth in the next phase of the evaluation. As well as seeking to understand the variation in costs per service user participating in nature-based activity across the Test and Learn sites the final report will seek to:

- Compute and compare average costs for service user outcomes.
- Compare the average costs of GSP against NHS care package costs.

The next section considers in more detail the costs of the four Test and Learn sites.

Table A6.3: Expenditure by Test and Learn site

	Expenditure (£)	Expenditure per service user engaged in NBA (£)
T&L4	£116,453	£5,063
T&L5	£261,250	£1,287
T&L1	£429,103	£951
T&L2	£644,835	£5,243
Total	£1,451,640	£1,815

Composition of project costs

This section considers the types of expenditure for the four Test and Learn sites (Table A6.4).

The Cost Information Tool asked the Test and Learn sites to break their costs down by categories of the expenditure. A list of more detailed categories was provided to assist the sites in completing this information under a series of nine broad expenditure types. The focus of this analysis are the broad categories of expenditure due to the wide variation in the more detailed categories at an individual site level.

¹⁶ total cost reported divided by the number of beneficiaries that they had supported.

Table A6.4: Expenditure by type of activity

	Expenditure (£)	Expenditure per service user engaged in NBA (£)	Percentage of total expenditure (%)
Capital	£3,699	£5	0
Set-up	£32,665	£41	2
Staffing	£329,545	£412	23
Operative	£1,004,933	£1,256	69
Monitoring & evaluation	£69,788	£87	5
Other costs	£11,010	£14	1
Total	£1,451,640	£1,815	100

As is expected operative costs¹⁷ account from the vast majority of expenditure: £1,004,933 or 69% of overall expenditure. The average operative cost across the four Test and Learn sites was £1,256 per service user engaged in nature-based activity. This ranged from £4,215 per service user to £0 per service user at a site level. A more detailed understanding on the cost of delivering GSP will emerge from the delivery partner work which will take place in the next phase of the evaluation.

Just under a quarter of expenditure over the period was accounted for by staffing costs £329,545 (£412 per service user engaged in nature-based activity on average; or 23% of total expenditure). Operative staffing costs were by far the largest type of staffing expenditure: on average £264 per service user or 15% of total expenditure. GSP set-up staffing costs were the second largest type of staffing costs: £136 on average per service user (7% of total expenditure).

All other types of costs accounted for 5% or less of total expenditure.

Project staffing and staff costs

The Cost Information Tool also asked Test and Learn sites to provide their average full-time equivalent (FTE) staffing inputs, broken down by type of activity (set-up, operative, monitoring or other activity) and staffing role (managerial/leader, supervisor/middle manager, Link worker, frontline delivery staff, administration/support/other staff and temporary/agency staff). This section provides analysis of the responses received.

The four Test and Learn sites collectively drew on an average of 9.2 FTEs staff per month. This translates to on average 1.15 FTEs staff per month per 100 service users engaged in nature-based activities. However, it is worth stressing that this number is for the central site teams so does not include staff in external link workers, nature-based delivery partners or commissioned organisations. T&L1 had the largest number of FTE staff: 4.9 FTE per month on average. Whereas T&L2 had the lowest number of FTE staff (0.6 FTE per month on average).

Analysis of FTE staff by their role reveals 'Managerial/Leader' staff accounted for 45% of staff time. This is expected given the sites have a largely management and coordination role for the GSP projects, as opposed to delivery. Of the remainder, 29%

¹⁷ Operative costs are costs associated with the day-to-day delivery of the GSP sites and support to beneficiaries. This also included payments and grants to organisations delivery partners.

of FTE staff had a 'Link Worker' role and 26% had an 'Administration/Support/Other staffing' role. Again, this is explained by the role played by the sites.

Considering the sites individually reveals 'Manager/Leader' staff comprised over 90% of staffing FTEs in T&L5 and T&L2. In T&L4, FTE staff were split evenly between 'Managers/Leaders' and 'Administration/Support/Other staff' categories. Whereas, in T&L1 'Link Workers' comprised the largest staff grouping (55%), with 'Manager/Leader' comprising 24% of their FTEs and 'Administration/Support/and other staff' making up 20% of their FTE staff. A point to explore through the evaluation is whether this allocation of staff time has contributed to T&L1's high number of service users engaged in nature-based activity.

Summary

This chapter has presented an interim analysis of WP6. In particular it has analyses of responses by Test and Learning sites to a 'Cost Information Tool' which seeks to gather detailed information on the income, costs and staffing of the sites. The data provided from the sites is self-reported within guidelines. Thus far it has not been possible to verify the accuracy of the responses received so the analysis presented here is done so in good faith. We will however seek to verify and discuss the results with the sites in the next phase of the evaluation. This will also enable the evaluation to understand and explain the results that emerge – including why differences emerge between the Test and Learn sites.

The following findings emerged, which should be treated as interim and tentative at this stage due to the limitations highlighted in section 2:

- The total income received by the four Test and Learn sites equated to approximately £2,362 per service user engaged in nature-based activity. Of this amount 71% (£1,687 per service user) was Shared Outcomes Fund Green Social Prescribing funding, including funding committed to the project by national partners. This means that for every £1 of Shared Outcomes Fund Green Social Prescribing funding an additional 40 pence had been levered in from other sources.
- The average site level cost of engaging a given service user in nature-based activity was £1,815 (in evaluation terms this is the average cost efficiency).
- Operative costs¹⁸ accounted for the vast majority of expenditure: £1,004,933 or 69% of overall expenditure. Just under a quarter of expenditure over the period was accounted for by staffing costs £329,545 (£412 per service user engaged on average; or 23% of total expenditure).
- The average cost per service user engaged, categories of expenditure, level of staffing and composition of staffing teams all varied across the four Test and Learn sites.
- 70% of FTE staff were either 'Managerial/Leaders' (45% of staff FTEs) or in a 'Administration/Support/Other staffing' role (26%). This is expected given the sites have a largely management and coordination role for the GSP projects, as opposed to delivery.
- The data presented is limited and partial, so should not be used to make decisions at this stage.

¹⁸ Operative costs are costs associated with the day-to-day delivery of the GSP sites and support to beneficiaries. This also included payments and grants to organisations delivery partners.

A6.6. Next steps

The final evaluation report will contain a more comprehensive and detailed analysis of the costs of delivery of Green Social Prescribing Projects, engaging service users in nature-based activity, and the alternative health care costs that GSP *may* reduce. The process for collecting this data has been outlined in the Limitations of the analysis presented section. In summary, key activities and timescales are as follows:

- Completion of 2-3 green provider cost surveys per Test and Learn Site: autumn/winter 2022/23.
- Desk based research to establish the cost of link workers and link worker referral to green providers: winter 2022/23.
- Workshops and desk-based research to establish care package costs: winter 2022/23.
- Completion of year 2 project level cost survey by seven Test and Learn sites: spring 2023.
- Data analysis: spring 2023.