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

Appendices to Final Report - March 2021 to June 2023

January 2024

Department for Environment Food & Rural Affairs | NHS | Office for Health Improvement & Disparities | National Academy for Social Prescribing | NATURAL ENGLAND | THE NATIONAL LOTTERY | SPORT ENGLAND | Department for Levelling Up, Housing & Communities | Department of Health & Social Care

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

Appendices to Final Report

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

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] Witherley, D*[2], Northall, P*[2] Baumann, M*[2] Wilson, I*[2.] **National Evaluation of the Preventing and Tackling Mental Ill Health through Green Social Prescribing Project: Appendices to Final Report.** *January 2024*. Department for Environment, Food and Rural Affairs (London).

University of Sheffield *[1] Sheffield Hallam University*[2], University of Exeter*[3] University of Plymouth*[4]

This report, and the accompanying briefing and summary documents, 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.

Authors

This report was prepared by the GSP National Evaluation Team.

University of Sheffield:

- Annette Haywood
- Alexis Foster
- Eleanor Holding
- Richard Jacques
- Jill Thompson

University of Exeter:

- Ruth Garside
- Harriet Hunt
- Kerryn Husk
- Becca Lovell

Sheffield Hallam University:

- Chris Dayson
- Matt Baumann
- Julian Dobson
- Cathy Harris
- Phil Northall
- Katie Shearn
- Ian Wilson

Acknowledgements

With many thanks to Veronica Fibisan, Merryn Kent, Sarah Ward for administrative support.

Thanks to all the Test and Learn sites for their ongoing engagement with the Evaluation Team, and to all those who provided questionnaire, interview and monitoring data, and participated in workshops. Thanks to the National Partners for helpful comments on a previous draft of this report. Thanks to members of the steering group for useful discussion during the evaluation process.

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Appendix 1: Work Package 3a - Utilising questionnaires and monitoring data to evaluate the Test and Learn Sites

A1.1. Summary of Appendix 1

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:

- Discuss the facilitators and barriers to collecting monitoring data including examples of good practice.
- Explore the findings from the follow-up Link Worker and Nature-based providers questionnaires.
- Present the site summaries of each T&L site monitoring data.

Please note the methods are detailed in the methods section of the main report. `

The overall aim of WP3A was 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).

The presented work builds upon the content of the GSP interim report.

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. Furthermore as a GSP system, data monitoring systems are fairly new and evolving rather than established and mature (NHS England, 2022). 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.

The development of monitoring data systems reflects wider conversations within social prescribing about developing core outcome frameworks (NHS England, 2022). The need to collect monitoring data also reflects a more fundamental debate about commissioners collecting monitoring data from the voluntary sector to justify funding and how that relates to issues such as trust in providers, capacity and resourcing of collecting the data.

Irrespective of these wider debates, due to the pilot nature of the GSP, it was felt important to try and capture monitoring with a focus on 'test and learn' processes to improve collection. Given the need to develop capacity, the Evaluation Team has been working extensively 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 being focused on analysing monitoring information to 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).* It has involved considerable investment of time from the Evaluation Team, beyond the scope of the contracted resource. It is important to acknowledge this because future initiatives need to anticipate the time resource and factor this into service delivery.

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 both on a national and local level. 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. This highlights the tensions between balancing local and national needs.

The Evaluation Team developed detailed guidance and Excel monitoring templates to support organisations within T&L sites (Defra, 2022). We supported sites to develop locally appropriate Excel Templates that captured both local and national chosen

variables. This made collating data across sites more challenging but was important to encourage local buy in.

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 (four 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 use 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. It is not within the scope of this evaluation to explore which interventions may be most effective. Rather we are exploring whether the package of GSP in terms of a variety of nature-based activity supported improvements in mental wellbeing. But types of activity are important in terms of commissioners ensuring they are funding activities which do feature the key mechanisms of nature-based activities). But the different types of activity may have an impact on value for money. This will be explored further through WP6.

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 not collecting further outcome measures 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.
- Activities are not structured e.g., someone may drop into allotment open days so there is not an established time point as such.

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.

A1.2. Developing data monitoring within the GSP pathway

A significant part of WP3A has been to support T&L sites with developing data monitoring systems to try and capture who is accessing GSP, the support they receive and potential impact. 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. We identified that whilst the T&L sites could manage to capture parts of the GSP journey e.g., support from nature-based providers, it was not possible within the current context to combine data from different providers to track people through their GSP journey. For example, there is not a unique ID like an NHS number. Furthermore, our data highlights that whilst Link Workers are a key source of referral there are multiple other referral routes to nature-based providers which again demonstrates the complexity of the GSP pathway. The GSP data monitoring developments are part of a wider context of developing social prescribing systems and some of the learning from GSP have influenced these wider conversations.

In this section we build upon the learning presented in the interim report about some of the challenges faced with collecting GSP monitoring data but also some of the potential solutions that T&L sites tried. We order it in terms of the different stakeholders involved with collecting and using monitoring data. For full information on the data variables selected to be collected and the co-design process, please see the interim report (Haywood et al., 2023).

Significant time investment from the Evaluation Team

The Evaluation Team has undertaken significant capacity building work with individual sites to support PMs, Link Worker services and nature-based activity providers. Investing this time went above and beyond the paid for resource associated with the contract. It is important to acknowledge this because another evaluation team may have not provided this capacity building resource as the contract had been based on a secondary analysis of data. This needs to be considered in terms of future resourcing of GSP monitoring and similar projects as highlights that there does need to be a national role responsible for both developing a potential data monitoring framework whilst also providing support at a local level to support capacity building. This is because many of the nature-based providers are less experienced collecting monitoring data, social prescribing is still establishing data monitoring systems and GSP is a new method of working across multiple systems.

Many of the T&L sites have provided positive feedback about the capacity building approach that the National Evaluation Team has taken. Stakeholders have appreciated 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.

We provided a variety of support including:

- 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.
- Attending meetings between Social Prescribing Managers and GSP managers to discuss development of Link Worker data monitoring systems and how this potential data could be used to inform GSP.
- Being part of local data monitoring tasks forces, to develop local systems for capturing monitoring data.
- Securing additional funding from the University of Sheffield Knowledge Exchange fund which provided some staff with resource to run tailored workshops in two of the local T&L sites including holding 1-1 sessions with individual providers to help them address organisation specific challenges and develop appropriate processes.
- Working with individual providers to identify suitable outcome measures when they are working with specific populations. For example, we worked with a learning disabilities charity to identify a measure suitable for their users because the ONS-4 was not appropriate.
- Developing individual site based monitoring spreadsheets that enable the sites to collect additional variables that are wanted on a local basis. For example, one site wanted to collect information on sexuality and another site wanted to measure changes in physical activity.
- Allowing sites to provide us with individual organisation's spreadsheets that we collated. This was because the Project Managers did not always have capacity to collate the different spreadsheets.
- Undertaking individual site level analysis to provide local insight. This was important so that sites could use the evidence on a local basis.
- Supporting sites to decide future data monitoring systems as part of their development work beyond this GSP funded period to take into account local commissioning processes.

Future GSP projects that want to collect monitoring data need to anticipate that there is a need to undertake capacity building with individual nature-based providers to enable monitoring data to be collected. For example, some of the providers before GSP had simply been collecting paper registers of attendees and did not collect additional information or have any systems for processing the information. It takes time and resources to develop organisational culture to develop monitoring systems and practices.

An alternative to developing and utilising monitoring data is for an external researcher to collect data as part of a research study. The advantage of this is that it reduces the pressure on Link Workers and nature-based providers and can improve the quality of data collected. The challenge is that this requires considerable resource, there would be a need to fund multiple researchers to collect data and it is likely that it would only be possible to capture a few hundred service users across the whole of the GSP pathway. Furthermore, it does not help with developing local intelligence on GSP nor help providers develop monitoring data that they can then use for their own purposes.

Project Management Team

The characteristics of the Project Management team have an influence on the monitoring data being collected and the approaches taken to developing monitoring systems.

Developing and collecting monitoring data has required a considerable investment of time for Project Managers, alongside multiple other priorities. Some Project Managers viewed 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. It appeared to be beneficial if Project Managers could see that monitoring data would be useful to provide local insight rather than purely data to inform a national evaluation. In a previous study, we spoke about the influence of an Implementation Lead but also the external commissioning context (Foster et al., 2020). Both these factors were relevant within GSP.

For example, in T&L sites 7, 5 and 2, the Project Managers were passionate about ensuring that any data collected would be useful for local commissioners to secure follow up funding for nature-based activities. They undertook extensive work locally to develop a local monitoring framework that struck the balance of collecting data for local commissioners but that was manageable for local providers.

At times there was understandably push back from Project Managers about collecting monitoring data. In some cases such as site 7, this was in respect of which specific variables the site would collect. They had already decided the variables they would collect locally and were not willing to collect additional variables suggested by the National Evaluation Team. This is because they had undertaken a local co-design process to decide the local data monitoring process and felt it would be disingenuous to this process to then add additional variables decided at a national level. In other sites, the push back was more related to there being other local priorities, with these Project Managers not feeling the monitoring data was as much of a priority than other aspects of GSP delivery. In these sites, the Project Managers provided the limited amounts of data. These experiences highlight the challenge of balancing the needs of the national GSP programme and local needs.

Many of the Project Managers invested a lot of time developing data monitoring systems locally. The GSP project has highlighted how there are significant gaps in local insight and systems, with people understanding that over time processes need to be developed. The GSP programme has stimulated local conversations with Project Managers in several sites convening data management groups and having wider conversations with social prescribing commissioners and providers to explore longer-term development of data monitoring systems. Although these conversations and initiatives did not necessarily result in improved monitoring data for this evaluation, it will lead to longer-term improvements in data monitoring systems and is reflective of the systems change approach of GSP. This was especially the case with developing monitoring systems of social prescribing generally and how it links to nature-based providers.

In terms of monitoring data for GSP, the Project Managers tried different approaches to improve capture. Some of the approaches which were successful included:

- **Having data management support -** Project Managers benefitted from having additional support with monitoring data. Sometimes this was an in-house resource. For example, site seven received support with collating and cleaning the different spreadsheets from nature-based providers. This was key, as before getting this resource, the Project Manager relied on the support of the National Evaluation Team to undertake the activity. In another site, they had some data

management support at specific points of the evaluation. This was valuable for the Project Manager as freed up some of the time he spent on co-ordinating data to spend on other priorities.

T&L2, contracted a grant monitoring organisation to co-ordinate grants and the monitoring data. This freed up the PM time. It also enabled resource to be invested within a voluntary sector infrastructure organisation. The PM felt this organisation was better placed to manage the grant programme. This was because they were more experienced at contracting relatively small amounts of money with multiple organisations compared to the statutory services. However, the challenge of using a grant monitoring organisation was that the PM had less control over the quality of the data and still needed to spend considerable time working with the grant management organisation. Furthermore, this did cost money to fund the organisation to manage the grants.

Whether in house or external, having data management support does require resource. This is funding which is not spent on direct delivery but arguably could be seen as an investment because by collecting monitoring data and demonstrating impact, future funding may be secured. It is recommended that future projects have ring fenced funding to support data monitoring to ensure that sites can build capacity. Alternatively, when assessing future funding bids, national partners may want sites to provide information on how they plan to undertake data monitoring and resource this.

- **Sharing of experiences** - Irrespective of who is responsible for data monitoring, the T&L sites found it useful when they were able to meet to share experiences and solutions. Future projects should encourage this sharing of practice, especially examples of things that did not appear to work so that other sites can learn from each other.
- **Needing support with analysis** - Many of the sites did not have local support with analysis of the monitoring data. Although the National Evaluation Team sought to provide local feedback, at times their timescales and analysis focus did not fit with the need of individual T&L sites. For example, in one site they wanted provider analysis at a detailed place-based level which was beyond the scope of the National Evaluation. Going forward, GSP Projects need to consider how they can resource analysis capacity to make use of the locally collected monitoring data. For example, whether local Public Health Insight teams can support this. This is especially important as GSP transitions into its next stage.

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). However, there are wider questions whether the purpose of GSP is to decrease healthcare service use. Some argue that it should be about improving the appropriate use of healthcare. For example, nature-based providers may help users to feel more confident to seek healthcare support such as in the case of refugees. So for GSP, there is the need to firstly consider whether changes in healthcare service use is a relevant or realistic outcome for the programme. Secondly, there needs to be consideration of how it would be possible to

measure any changes. Realistically it is likely to need a dedicated research study rather than being undertaken within routine practice.

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 and there is provider/staff turnover. 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. In the interim report, we provided information on the different types of Link Workers and the different challenges this raised with accessing monitoring data. In this report we focus on the developments since the interim report.

Sites have struggled to access Link Worker data for the evaluation. Any data received has been from one or two providers within a T&L site and limited. It highlights that unless there is a contractual obligation to provide funding e.g., as part of a grant agreement it can be difficult to receive data. Furthermore, social prescribing services themselves are relatively immature in terms of data collection with a lot of work being undertaken nationally and locally to decide core data sets and to invest resources in data monitoring processes and capacity building. So, for many social prescribing services, there were not established data monitoring systems especially in terms of identifying nature-based referrals.

The data monitoring processes of Link Workers is part of wider local and national conversations beyond GSP such as the work being undertaken by NHS England. We found that whilst we received limited data from Link Workers, the GSP programme has led to many of the PMs investing time on both local and national initiatives to develop Link Worker data monitoring systems. So, in this sense, GSP has led to systems change. For example, in T&L2, they convened a social prescribing data monitoring group to identify ways of developing data monitoring systems and are trialling the approach in one locality. In another site, they have used the experience of GSP to prompt local investment in specialist social prescribing software.

Although only a limited amount of Link Worker data was received, this was a finding in itself and has highlight some key issues including:

- 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/ variable 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. It is important that this is driven at a national level as well as local level. Without this it is difficult to know whether someone has received a green referral.
- Several of the sites saw the need to improve social prescribing monitoring data generally but did not find the data useful per se for the GSP project. This is

because their priority was data generated from nature-based providers who received grants.

- We identified that GSP referrals came from multiple sources, not just Link Workers. In this sense it may not be a priority to focus on Link Worker data but rather invest time and resources in developing the monitoring data of nature-based providers. Providers recorded referral routes so some Link Worker related data is available from the nature-based providers (e.g., it can be compared whether there are differences between people who are referred by Link Workers and other referral routes).
  - 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. Some sites have since invested in these systems. However, data management is only one part of implementing monitoring information. It still requires significant people resource to implement it, support practitioners with using it and have a lead with the time to process and analyse the data generated from it.
- There are considerable challenges facing Link Workers at present including excess case loads and Link Workers not remaining in their roles. This means that there are other priorities facing services than providing monitoring data to GSP. Again, because there was no contractual obligation to provide data for GSP as they were not receiving funding it was difficult for services to prioritise this.
- 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), the focus for a programme like GSP could be on utilising existing published secondary data.
- 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. Thus, it is recommended that the focus for Link Worker data should be on demographics, whether someone has mental health issues. referral source, onward referral - e.g., whether it was a green referral or something else and baseline ONS-4.
- 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. In another, T&L site, the PM has joined a national group that is exploring the development of Social Prescribing monitoring data, using their experience from the GSP to develop national practice. From that sense, we have supported the development of improved capacity at both a local and national level to capture Link Worker data which is beneficial for social prescribing beyond GSP.

It is recommended that future GSP projects focus on collecting data from nature-based providers as it is challenging to collect Link Worker related data unless GSP provides funding to the Link Workers to support data monitoring as part of the programme. GSP has supported both local and national conversations about improving the quality of monitoring data for social prescribing generally so has had an impact.

Collecting monitoring data from Nature based activity providers

There has been greater scope to collect monitoring data from nature-based providers that have been given funding through GSP. 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. Even with these agreements in place, Project Managers have been flexible, appreciating that nature-based providers have different capacity and skills to collect and provide data. Funding has not been withheld when providers do not provide data, rather they have been supported to develop approaches which are feasible and realistic for them. Sites have generally not sought data from providers who are not funded by GSP.

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:

- There was more scope to collect monitoring data from those organisations who were provided with funding to deliver GSP. However, it is important to note that funding amounts varied, and there is a need to consider proportionality e.g., an organisation being given £5,000 may need to provide different amounts of monitoring data compared to an organisation who was given £20,000.
- Many nature providers are organisations that deliver activities rather than services. For example, running community allotments. There is the risk of formalising nature activity if service users have to provide considerable amounts of information to attend, which loses the concept that people are accessing an activity/hobby to help them.
- Inequality of organisations based on data monitoring skills- There are concerns that data monitoring asks can lead to inequity for organisations, with smaller or less experienced organisations being less able to apply for or benefit from funding because of not having the skills or resources to collect monitoring data. Within GSP this has been taken into account with Project Managers taking a pragmatic approach, anticipating that not all providers will be able to collect monitoring data.

For example, in Site 2, for providers who would struggle with providing individual level data, they provided them the option to return aggregate numbers such as how many people attended the activity. This highlights the need to account for individual providers- not everyone is in the same position to collect monitoring data.

- 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.
- There are challenges with individual circumstances for example if a service user attends multiple activities do they have multiple or a single record? Likewise, if someone returns to a service? These operational challenges highlight that people's journey through GSP is not linear.
- Organisations need support with developing their monitoring data infrastructure and this can take time. Running training sessions, 1-1s and giving feedback on the data helps with developing capacity.
- 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. In some sites, the researchers presented the interim findings to nature-based providers which helped them see how the data was being used. But this did not happen consistently across sites with many providers having not seen the interim report.
- Organisations need to see the benefits to them of collecting monitoring data to provide local insight that they can use rather than viewing it as data purely for the national evaluation. For example, one organisation was able to utilise the data to make a case to access funding from a grant giving organisation. It is important to highlight these examples to providers because that was one of the aims of building capacity so that organisations could benefit from having the monitoring data rather than it just being used to inform the national evaluation.
- Some of the organisations rely on volunteers or run activities purely outdoors, which can make it harder to collect data.
- Organisations need the capacity to develop their systems. For example, one provider spoke about keeping paper registers. However, they have won lottery funding to invest in an operations manager who will be developing the data monitoring systems. This highlights how without dedicated resource, organisations do not have the internal capacity or systems 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. Sites and individual providers could be given more training in how to identify and utilise existing evidence to underpin their work for example through using logic models of the mechanisms of the benefits of nature-based provision.
- 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. So whilst we have data on who accesses GSP and their referral routes, we have little good quality data on the amount of support they received.
- A focus on monitoring data can be detrimental to enabling sites to take more innovative approaches to GSP. It places emphasis on delivery rather than system change. For example, in one site they felt constrained in what activities they

funded as they felt they needed to focus on activities that are amenable to collecting data.

- PMs highlighted how they did not necessarily have the skills or capacity to analyse any collected data. Whilst this was less relevant for the national evaluation, it is an important issue to consider going forward into the next iteration of GSP. For example, in T&L2, they have funded further evaluation activity to undertake the analysis of monitoring data.

The GSP project has supported the development of monitoring data across nature-based providers through investing considerable time in capacity building. However, there are key challenges with many nature-based providers not set up in ways that they can collect data. Consequently, we have only received monitoring data from some funded projects. It has proven difficult to combine individual level and aggregate data because of duplication. PMs often do not have the capacity/skills to make use of the data collected and thus need data management and analysis support at a site level. The data received has enabled us to start to understand who is accessing GSP, referral routes and the impact of nature-based provision. However, it is evident that further capacity building is needed to support nature-based providers. It may be that asking providers to collect aggregate data may be more sustainable longer term in terms of demographics and referral routes.

Longer-term sustainability

It was anticipated that given the time and resources invested, data quality would improve over the course of the programme Whilst there is an increase in the number of service users represented within the data, the quality of the data has not necessarily improved. Indeed site 2's PM felt that the quality of data from nature-based providers was poorer quality in March 2023 than in July 2022. Whilst this is purely an anecdotal comment, it highlights that the implementation of data monitoring systems is not a linear process. Rather it is iterative, with providers needing ongoing training and feedback to support them with improving their data monitoring processes. We have found this in other studies about the need for ongoing support (Foster et al., 2022).

Some sites have been developing legacy approaches to developing data monitoring processes in the next tranche of GSP. For example, we have been supporting site 2 with developing monitoring data processes. This includes:

- Adapting the data monitoring spreadsheet, which included adding additional questions such as whether the provider feels someone has improved and how many activities an individual attends.
- Providing 1-1 sessions with nature-based providers to help them develop their data monitoring processes and to address individual queries rather than purely providing generic advice.
- Supporting an area with testing implementing social prescribing software.
- Commissioning evaluators to undertake further analysis of the monitoring data.

PMs have used the experience of GSP to inform and develop local conversations about monitoring data processes for both social prescribing generally, GSP and VCSE sector generally. This captures the systems change nature of GSP, with sites using the test and learn experience to shape conversations.

Ultimately the experience of GSP has highlighted that the difficulties of capturing monitoring data means that it is not a case of trying harder, but rather different approaches may be more efficient especially given the time and resources required to date. Key issues are:

- It is not possible to capture data on the majority of people accessing GSP through current systems. At best a proportion of people can be captured which may be able to provide some understanding of people's GSP journey and inform local practice.
- It is not possible to track people from the point of referral to a Link Worker to finishing in a nature-based activity through existing data monitoring systems. Some areas are testing approaches in a small locality but it is unlikely to be possible at scale. Consequently, certain variables such as drop out at different points of the pathway are not possible to capture. If it is important to capture this journey, then funding Link Workers or External Researchers to track people is key. Albeit with this approach it will be a case of capturing a proportion of people rather than every user.
- Within the evaluation we sought individual level service user data to be able to explore patterns. Some organisations managed to collect individual level data. But many nature-based providers are not set up to capture data. This is especially the case for smaller organisations or organisations less experienced at providing monitoring data to commissioners. For example, several organisations still keep paper registers and do not have processes in place to utilise this information.
- Even when organisations provide individual level data, PMs then had difficulty collating, analysing and using this data. It indicates that for information relating to demographics and referral routes, sufficient insights would be gained from collecting aggregate data from providers such as the number of male and females. This may improve the extent of data received because it would be more manageable for nature-based providers than the expectations of providing individual level data. However, T&L sites do need to have funded data management and analytic resource to make use of any monitoring data as PMs may not have skills or capacity. For example, working with Public Health Insight Teams.
- Organisations struggled to collect well-being outcome measures. Some sites returned more data than others. Whilst the outcomes data collected has provided some evidence about the impact of nature-based activities and has been used to demonstrate impact, it is questionable how substantial it is to collect longer-term. Furthermore, there was not usually capacity at a local level to analyse the data.
- Future projects need to take into account that for sites to collect, process and analyse data that they need resources to do this. For example, costing in data managers with analysis skills.
- GSP sites benefit from having advice and support from evaluators/researchers. Future projects need to put resource into providing support with developing capacity.

Summary

Through WP3A, 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. On an organisation level, providers have fed up examples of where they had developed their monitoring systems and been able to use the data to make a case for funding from other sources. These experiences have highlighted that it takes significant investment in time and resources to develop monitoring data.

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A1.3. Analysis of the nature-based activity provider questionnaire

Responses to the nature-based activity provider questionnaire (Baseline and Follow-up)

There were 122 responses to the baseline questionnaire and 82 responses to the follow-up questionnaire. Please note that some of the people completing a baseline and follow-up questionnaire may be the same but we were not able to match baseline and follow-up questionnaire responses. So, we are looking at change across the programme rather than whether an individual has experienced changes. Response rates varied considerably between sites, for example for the baseline questionnaire it ranged from 3-28. The different response rates were partly because of the different configurations of the T&L sites and demands on peoples' time. For the baseline questionnaire, there was a small number of responses from people who worked for national organisations across the different sites. There was considerable variation between the proportion of questionnaires represented per site between the baseline and follow-up. For example, TL6 had considerably more engagement in the baseline than the follow-up questionnaire but it was the reverse for TL7. This will have an impact on the findings in terms of change between baseline and follow-up but we are using the questionnaire to identify emerging themes which can be triangulated with other parts of the evaluation rather than as the sole data source. There was less engagement with the follow-up questionnaire because by that stage, people knew that the GSP extension was not happening and were somewhat disillusioned and less engaged in the National Evaluation. Furthermore, there were a number of other similar questionnaires being undertaken which means some people may have felt they had completed a similar questionnaire for a different project. On the questionnaire, none of the questions were mandatory so response rates differed for each question.

In this appendix we focus on the follow-up questionnaire, comparing findings with the baseline questionnaire when appropriate. Please see the interim report for the baseline questionnaire results (Haywood et al., 2023).

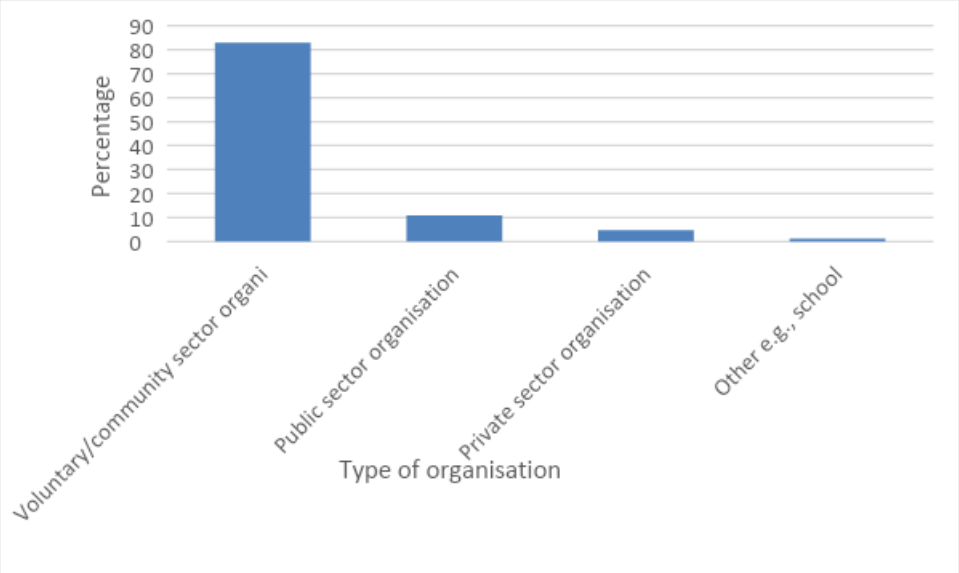
Type and size of organisation

For both the baseline and follow-up questionnaires, over 80% of respondents were from VCSE organisations (Follow-up: n=68/82, 82.9%). There was a small number of responses from public sector or private providers. These responses demonstrate how nature-based activities are predominantly delivered by voluntary sector organisations which has implications for funding, data system flows and sustainability.

Table A1.1*:* Type of organisation

Type of organisation	Baseline Response (n=120)	Follow-up Response (n=82)
Voluntary/community sector organisation	97 (80.9%)	68 (82.9%)
Public sector organisation	15 (12.5%)	9 (10.9%)
Private sector organisation	4 (3.3%)	4 (4.8%)
Other e.g., school	4 (3.3%)	1 (1.2%)

Figure A1.1: Type of organisation at follow-up



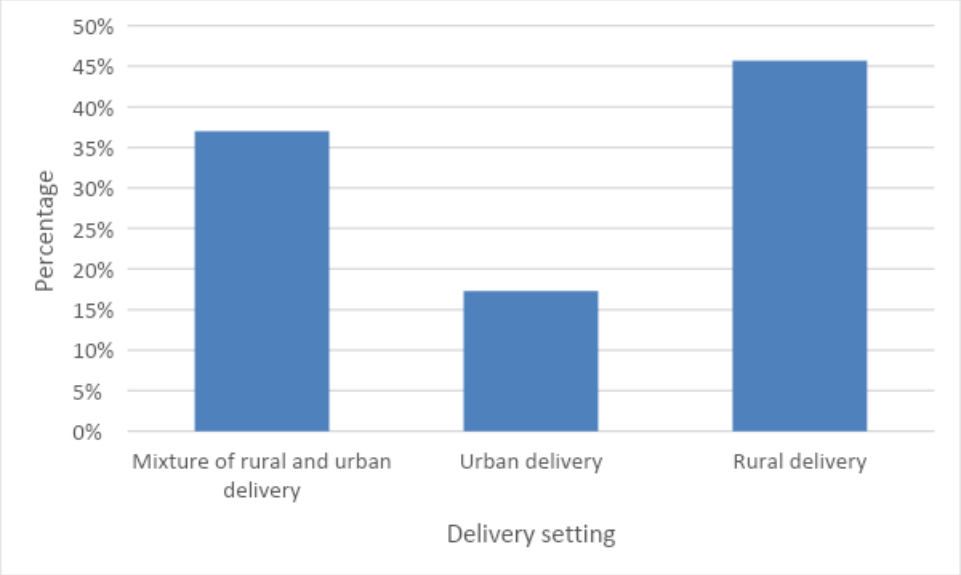
Delivery of services within rural or urban settings

There were differences in whether providers were rural or urban based between the baseline and follow-up responses. In the baseline, about half of respondents represented organisations working across both rural and urban areas (n=60/121, 49.6%) whereas in the follow-up questionnaire, it was 37% (n=30/81). There was considerably greater representation amongst rural providers in the follow-up questionnaire than at baseline (45.7% v 24.8%). This enables us to explore some of the factors facing rural providers because the Embedded Researchers identified that there were specific challenges that they faced.

Table A1.2: Delivery setting

Delivery setting	Baseline Response (n=121)	Follow-up response (n=81)
Mixture of rural and urban delivery	60 (49.6%)	30 (37%)
Urban delivery	31 (25.6%)	14 (17.3%)
Rural delivery	30 (24.8%)	37 (45.7%)

Figure A1.2: Delivery setting



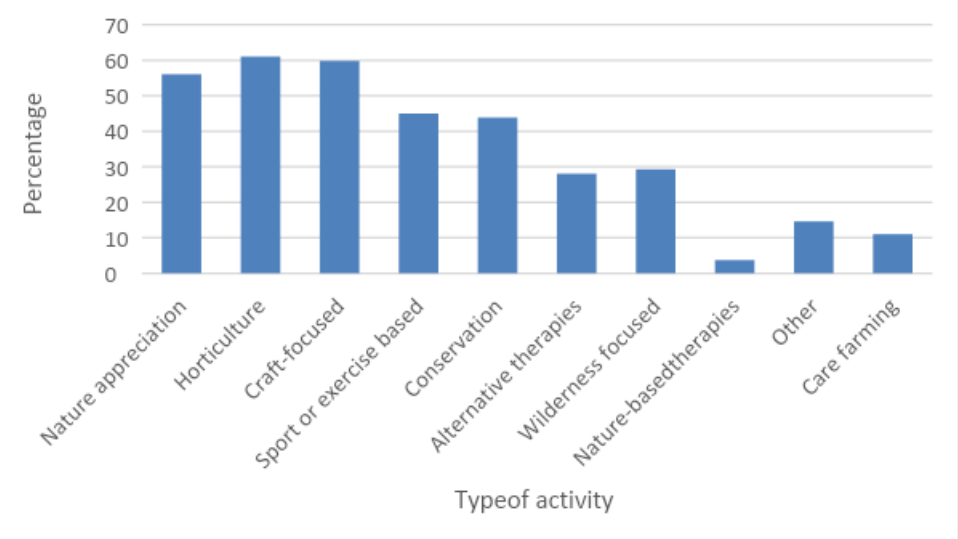
Types of nature-based activities delivered (Baseline and Follow-up questionnaires)

In both the baseline and follow-up questionnaire, it was evident that a variety of nature-based activities were available and the majority of organisations delivered a range of activities or an activity featuring different nature-based components. The most common were activities which included either a nature appreciation/connection component, craft and horticulture activities. There were similar proportions of activity types within the baseline and follow-up questionnaire. Whilst some of this will relate to responses, it indicates that the mix of activities may have remained relatively similar especially as responders indicated that their organisation delivered activities with a mix of components. Interestingly there was only a small proportion of responders delivering nature-based therapy (Follow up- n=3/82, 3.7%). Given the programme is aimed at people with mental health problems, there may be scope to expand this provision.

Table A1.3:[1] Types of activity delivered

Type of activity	Baseline Response (n=111)	Follow-up response (n=82)
Nature appreciation/connection activities e.g., engaging with nature, citizen science	73 (65.8%)	46 (56.1%)
Horticulture type activities e.g., growing and caring for plants	71 (58.7%)	50 (61%)
Craft-focused e.g., arts and crafts activities using natural resources	67 (60.4%)	49 (59.8%)
Sport or exercise based e.g., green gyms, health walks	63 (56.8%)	37 (45%)
Conservation e.g., tree planting or scrub clearance	52 (46.8%)	36 (43.9%)
Alternative therapies e.g., mindfulness activities, spiritual retreats	44 (39.6%)	23 (28%)
Wilderness focused e.g., visits to more remote places or bushcraft	37 (30.6%)	24 (29.3%)
Nature-based talking therapies e.g., mainstream talking therapies such as CBT delivered in a natural setting	14 (12.6%)	3 (3.7%)
Other	14 (12.6%)	12 (14.6%)
Care farming e.g., caring for animals	13 (11.7%)	9 (11%)

Figure A1.3: Types of nature-based activities



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.

[1] Percentages total over 100% as multiple responses could be provided.

- Self-led access to nature.
- Canal maintenance.

This range of activities again shows the heterogeneity of GSP provision. It feeds into emerging themes from other work packages about the key components that nature-based activities need to have whilst also offering variety to appeal to different service users.

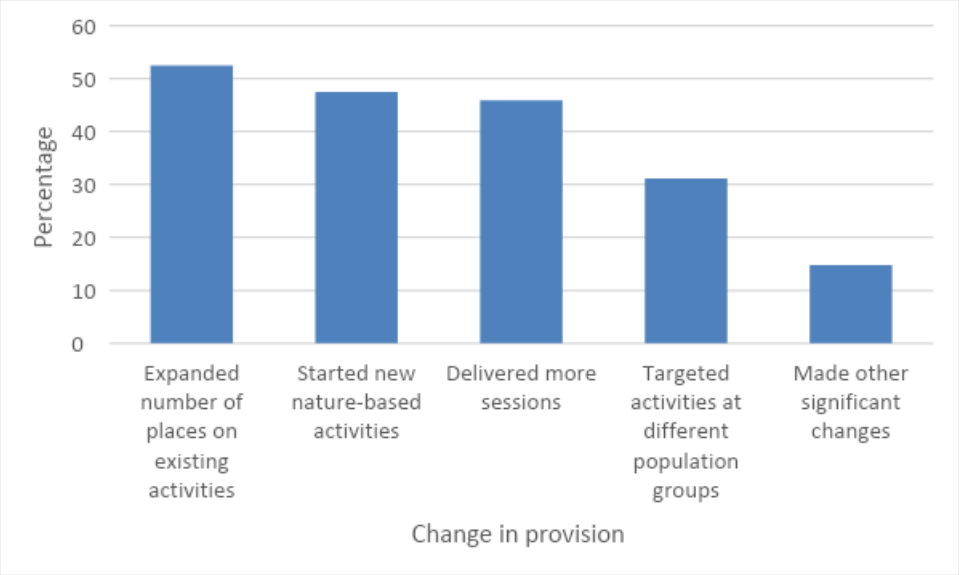
Changes in delivery over the past 12 months

The majority of respondents had made changes to their nature-based provision over the last year, with over half making two or more changes. The most common was providers expanding the number of places they could offer on existing nature-based activities (n=32/61, 52.5%). Almost half of providers had started new activities (n=29/61 47.5%) and others had delivered more sessions such as opening a community allotment more times in a week (n=28/61, 45.9%). Just under a third of respondents had targeted activities at different populations (n=19/61, 31.1%) such as aiming services at people from minority ethnic groups. The responses highlight how GSP has supported the expansion of nature-based provision.

Table A1.4: Change in nature-based provision

Change in provision	Response (n=61)
Expanded number of places on existing activities	32 (52.5%)[2]
Started new nature-based activities	29 (47.5%)
Delivered more sessions	28 (45.9%)
Targeted activities at different population groups	19 (31.1%)
Made other significant changes	9 (14.8%)

Figure A1.4: Change in nature-based provision



Number of people supported

There was considerable heterogeneity in the number of people each organisation delivered nature-based activities ranging from less than 20 to over 1000. Just over half

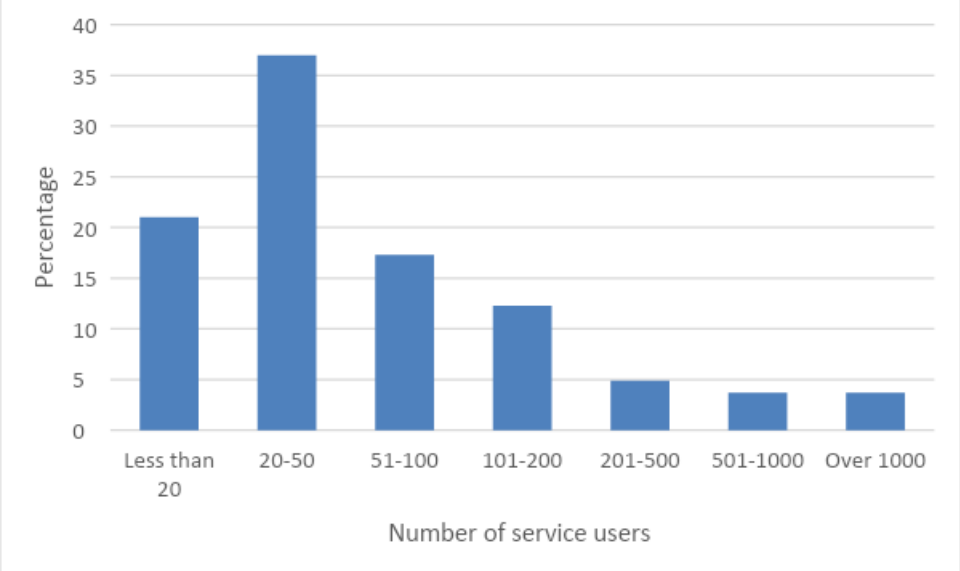
[2] Percentages total greater than 100% as respondents could select multiple answers.

of respondents supported less than 50 people per year (n=47/81, 58%). A further 17.3% (n=14/81) supported between 51-100 people per year. This indicates that three quarters of respondents are supporting less than 100 people per year in their nature activities. 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. This highlights the complexity of GSP and the trade-off between the number of people supported compared to the intensity of support. As many of the respondents were supporting a smaller number of people, it also demonstrates the organisational complexity of GSP in terms of there being multiple providers within a T&L site, each of which will need support from the PM and engagement in GSP. This is more time and resource intensive than when dealing with a small number of providers who are supporting a larger number of service users.

Table A1.5: Number of people supported by nature-based activity providers

Number of people supported annually	Response (n=110)	Follow-up (n=81)
Less than 20	9 (8.2%)	17 (21%)
20-50	24 (21.8%)	30 (37.0%)
51-100	25 (22.7%)	14 (17.3%)
101-200	19 (17.3%)	10 (12.3%)
201-500	13 (11.8%)	4 (4.9%)
501-1000	6 (5.5%)	3 (3.7%)
Over 1000	14 (12.7%)	3 (3.7%)

Figure A1.5: Number of people supported per year



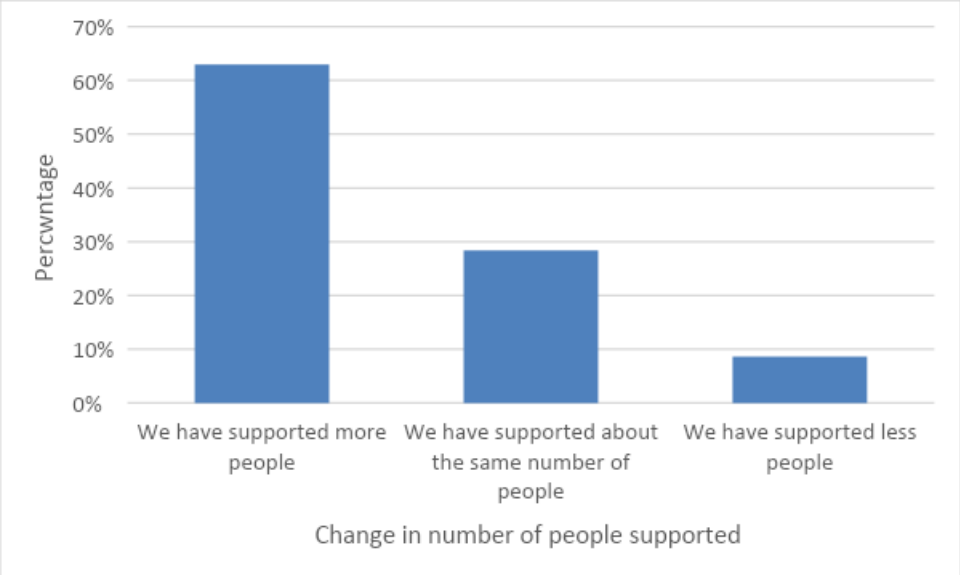
How number of service users have changed over the last year

Almost two-thirds of respondents (n=59/81, 63%) reported an increase in the numbers of service users they had supported over the last year. A further quarter reported that numbers had stayed fairly constant (n=23/81, 28.4%) and a small proportion of providers had found that numbers had decreased (n=7/81, 8%). Some of the respondents made comments that they had supported less service users because of having to reduce activities because of the reduction in funding (see next question). As the majority of providers reported an increase, it indicates that GSP has resulted in an increased number of service users accessing nature-based activities.

Table A1.6: Whether the number of service-users have changed

Whether numbers have changed	Responses (n=81)
We have supported more people	51 (63%)
We have supported about the same number of people	23 (28.4%)
We have supported less people	7 (8.6%)

Figure A1.6: How have number of service users changed over the last 12 months



A1.4. Perceptions on why numbers have changed

Responders gave different reasons for why there was an increase in the number of people accessing nature-based providers. Additional funding provided through GSP was regularly cited as a reason for being able to expand capacity. This included expansion of provision generally, or into new user groups including provision for children and people with dementia. Providers also indicated that getting more staff members and volunteers has enabled them to expand their capacity. increases related to their capacity to deliver have improved, with more volunteers or staff members to support delivery. Additional funding also enabled providers to improve their infrastructure, enabling them to support more people e.g., through opening more parts of the year: "*The numbers have increased because we used the GSP Funding to build shelters, polytunnel a, potting sheds on our allotment which means we can run activities all year round and in all weathers as well as offering drinks on site*." (T&L1).

Improved referral pathways were mentioned by a small number of providers. This is related to the provider's greater capacity to connect with referrers: "*We have added a new wellbeing project as well as increased capacity in the team to connect with referrals and advertise our projects. Being linked in with the Green Social Prescribing group has been beneficial too as it has allowed us to reach more referrers.*" (T&L7). Improved relationships with referrers: "We proactively made links with all the social prescribers in the area and the Occupational Therapists working Community Mental health services" (T&L4). Other providers had worked at raising awareness of GSP amongst refers: *"The workers visited the garden so they were more aware of what we offered & the level of support so they were more informed when introducing people. The feedback from those who did refer was positive and that they felt more confident in suggesting an introduction"* (T&L4).

Raising awareness of GSP was linked to increases in delivery: *"Green social prescribing is more widely known about and accepted as treatment by* people." (T&L7). This had been achieved through a number of routes including advertising: *"We have a range of events/activities on and these are well advertised in the park ad on social media. People opt to attend themselves for their own MHWB [mental health and wellbeing]. We also have a 'Friends of' membership and therefore our newsletter reaches over 1000 people in the local areas, so this also informs people of what is on offer."* (T&L1).

Some providers reported a decrease in numbers. Decreases in provision were linked to factors such as weather, loss of funding, low or no referrals happening in area, or to the ongoing effects of lockdown and Covid: *"We are still recovering from the impact of lockdown and it will take more time for people to return. Also, the winter period is least popular for outdoor activities. We are working on some improvements to our outdoor space and hope that by providing regular sessions twice a week in the garden that more people will return on a regular basis."* (T&L1).

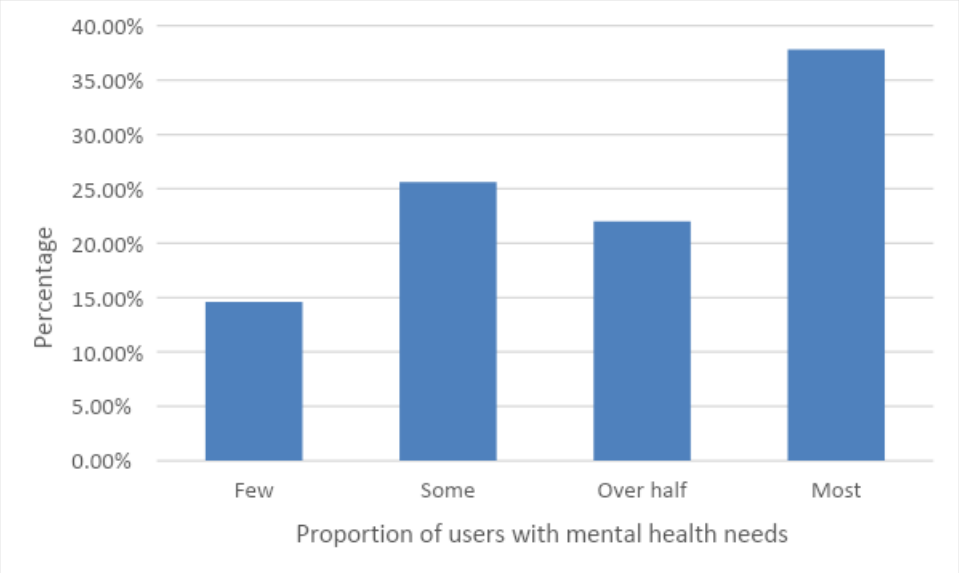
Proportion of people supported with mental health needs

Within the follow-up questionnaire, over half of nature-based providers reported that over half of their service-users had mental health needs which had a detrimental impact on their life (Follow-up: n=49/82, 59.8%). 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. 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-12, 14.6%). This indicates that people with mental health needs are accessing nature-based activities within the T&L sites and that a significant number of service users being supported through GSP do have mental health needs which have a detrimental impact on their lives. The responses were fairly similar to baseline, although as explained in the next question providers do feel they are supporting more people with mental health issues.

Table A1.7: Proportion of people supported who have with mental health needs

Proportion of people supported with mental health needs	Baseline (n=113)	Follow-up (n=82)
Few (Less than a quarter of people)	16 (14.2%)	12 (14.6%)
Some (A quarter to half of people)	33 (29.2%)	21 (25.6%)
Over half (Half to three quarters of people)	31 (27.4%)	18 (22%)
Most (More than three quarters of people)	33 (29.2%)	31 (37.8%)

Figure A1.7: Percentage of service users with mental health needs



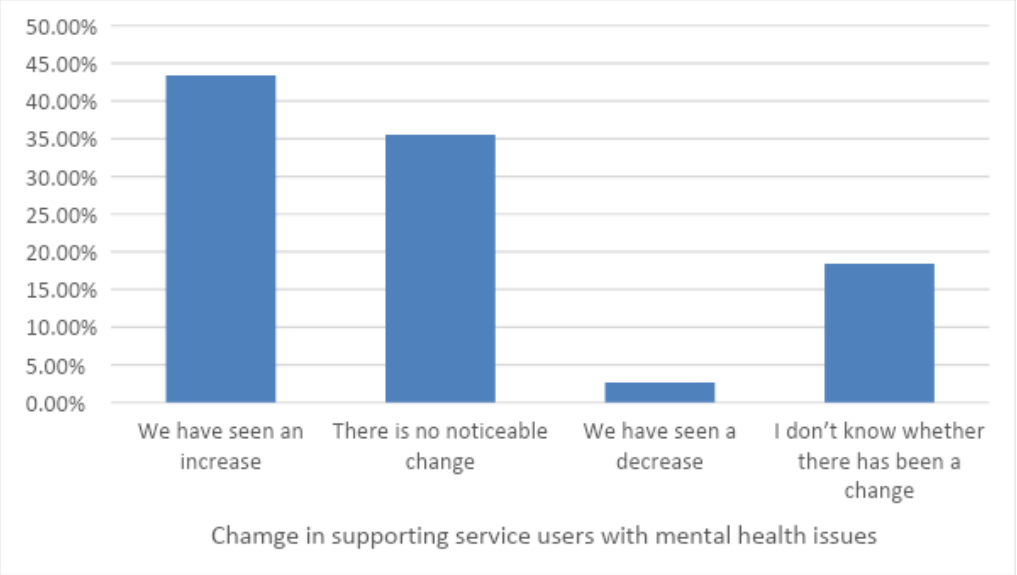
Change in proportion of people with mental health needs

Over 40% of respondents reported that they had had an increase in the proportion of people that they were supporting with mental health needs which were detrimental to their daily lives over the last 12 months (n=33/76 43.42%). About a third of providers reported no noticeable change (n=27/76, 35.5%). Only 2 respondents reported that there had been a decrease with just under 20% not knowing if there had been a change (n=14/76, 18.4%). This indicates that through the GSP, there appears an increase in people with mental health issues accessing nature-based activities.

Table A1.8: Change in proportion of people with mental health needs that are detrimental to their daily lives

Change in proportions	Responses (n=76)
We have seen an increase	33 (43.4%)
There is no noticeable change	27 (35.5%)
We have seen a decrease	2 (2.6%)
I don't know whether there has been a change	14 (18.4%)

Figure A1.8: Change in supporting people with mental health needs



Actions taken to support people with mental health needs to engage with nature-based activities.

Providers highlighted their work to support people with mental health issues to attend including through inviting support workers to attend alongside their clients, developing peer and volunteer support, and holding welcoming sessions. Providers also used ongoing support such as calls and check in 1-1s, tailoring of activities, and ensuring flexibility of both attendance, and in terms of the activities run.

Several providers mentioned they had focused on improving their skills in mental health provision and undertaking relevant training: “Four volunteers have committed to supporting adults with mental health needs and have completed short mental health awareness sessions. Eight volunteers attended a Dementia Friend session.” (T&L5). Some providers reported working with specialist mental health partner organisations.

Furthermore, providers discussed changes they had made to improve accessibility. Primarily this related to transport, however other elements included improving mobility around the site and provision of food.

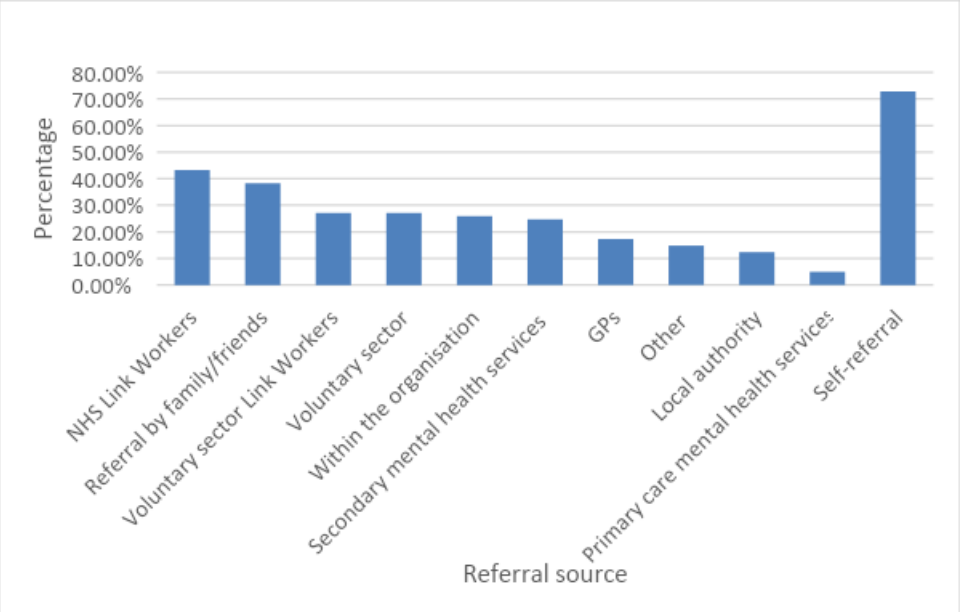
Referral routes

There were multiple referral routes into nature-based activities with almost three quarters of organisations responding that self-referrals are one of their three most common sources (n=59/81, 72.8%). Almost half of providers felt that NHS Link Workers were one of their most common referrers (n=35/81, 43.2%) Other prominent referral rates were family/friends, voluntary sector based Link Workers and from voluntary sector organisations. These highlight that Link Worker referral routes are an important source of referral for some nature-based providers. For over a quarter of respondents, mental health services were a key referrer to their organisation (n=24/81, 29.5%). This indicates that some nature-based providers are well linked into mental health services such as local IAPT services. Further consideration is needed of how these providers have built up referral routes with mental health services as not all providers are managing to develop these routes Some providers responded ‘other’ and discussed other sources including the local job centre and recruiting through social media. Job centres appear an emerging source of referral and are an area for future GSP projects to focus on.

Table A1.9: Referral routes to nature-based providers

Referral Source	Responses (n=81)	Percentage
Self-referral	59[3]	72.8%
NHS based Link Workers/ social prescribing services	35	43.2%
Referral by family/friends	31	38.3%
Voluntary/third sector-based Link Workers/social prescribing services	22	27.2%
Voluntary/third sector/community projects	22	27.2%
From other activities within the organisation I work in	21	26.0%
Secondary mental health services e.g., Community Mental Health Teams	20	25.0%
GPs	14	17.3%
Other	12	14.8%
Local authority/social care services	10	12.3%
Primary care mental health services e.g. IAPT (Improving Access to Psychological Therapies)	4	5.0%

Figure A1.9: Main sources of referral



Proportion of referrals from mental health services

Over half of responders had received referrals from mental health services. The most common was secondary mental health services such as Community Mental Health Teams (n=34/81, 42%). The other common source was GP practice services such as counsellors (n=23/81, 28.4%). Interestingly, IAPT (n=11/81, 13.6%) was only the third most common. This is interesting because of its scope of supporting people with mild/moderate mental health issues, it was anticipated that this may be more common. It indicates that there is scope for GSP to develop better links with IAPT. About 40% of respondents had not received any referrals from mental health services (n=34/81, 42%). This highlights that generally, there is scope for further development of referral

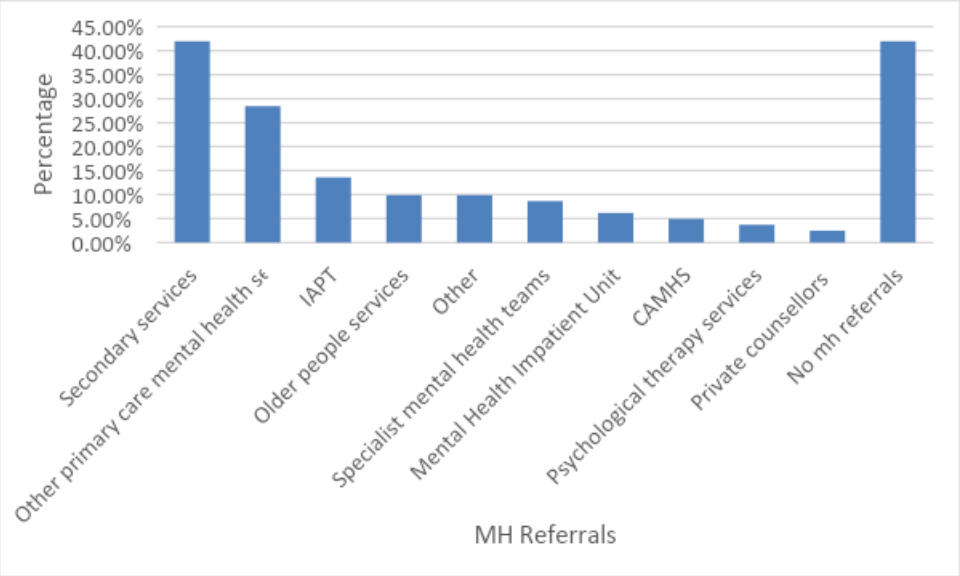
[3] Responses will be over 100% as people were able to make multiple responses.

routes between nature-based providers and mental health services. As some providers have increased their referrals from mental health providers, it indicates that there is learning that could be shared across GSP about doing this

Table A1.10: Referrals from mental health services

Referral source	Responses
None of the above- we have received no referrals from mental health services	34 (42%)[4]
Secondary-care community mental health teams	34 (42%)
Other primary care mental health services e.g., GP practice-based counsellors	23 (28.4%)
Improving Access to Psychological Therapy teams (IAPT)	11 (13.6%)
Older people services	8 (9.9%)
Other (Please specify)	8 (9.9%)
Specialist mental health teams e.g., eating disorder services	7 (8.6%)
Mental Health Inpatient Unit	5 (6.2%)
Child and Adolescent Mental Health Services (CAMHS)	4 (4.9%)
Psychological therapy services e.g. Psychotherapy	3 (3.7%)
Private counsellor/psychotherapist	2 (2.5%)

Figure A1.10: Sources of referral from different mental health services



Proportion of referrals from Link Workers

The majority of providers had few or no referrals from Link Workers indicating that a range of referral routes are relevant for support people to access nature-based providers. Over 40% of respondents had not received referrals from Link Workers (n=34/81, 42%). A similar percentage received some but less than half of their referrals from Link Workers. Almost 20% of respondents received over half of their referrals from Link Workers (n=15/81, 18.4%), These findings highlight that some nature-based

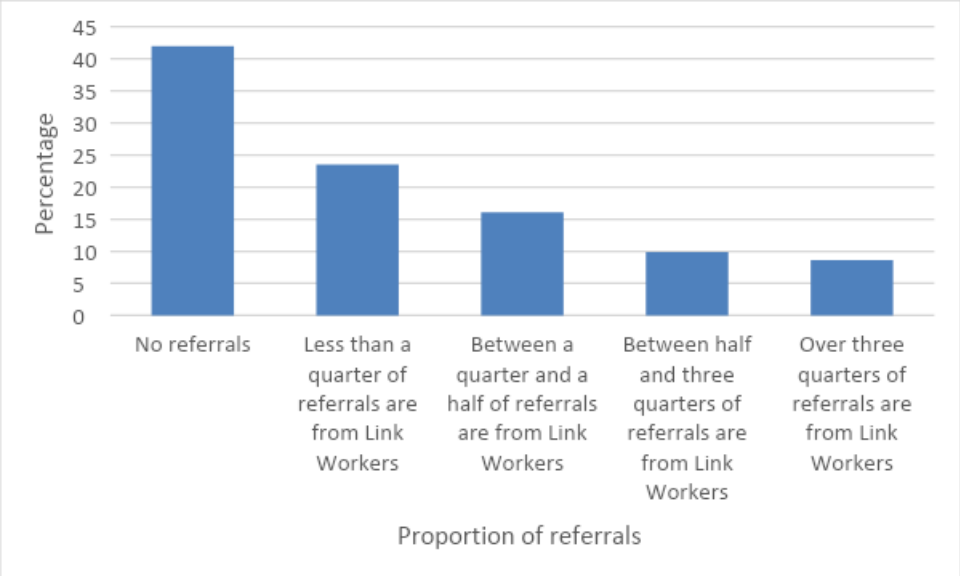
[4] Percentage will total over 100% as multiple responses could be provided.

providers have established referral routes with Link Workers but for others, it is still an area that could be developed.

Table A1.11: Proportion of referrals from Link Workers

Proportion of referrals from Link Workers	Responses (n=81)
We have not received any referrals from Link Workers	34 (42%)
Less than a quarter of referrals are from Link Workers	19 (23.5%)
Between a quarter and a half of referrals are from Link Workers	13 (16.1%)
Between half and three quarters of referrals are from Link Workers	8 (9.9%)
Over three quarters of referrals are from Link Workers	7 (8.6%)

Figure A1.11: Proportion of referrals from Link Workers



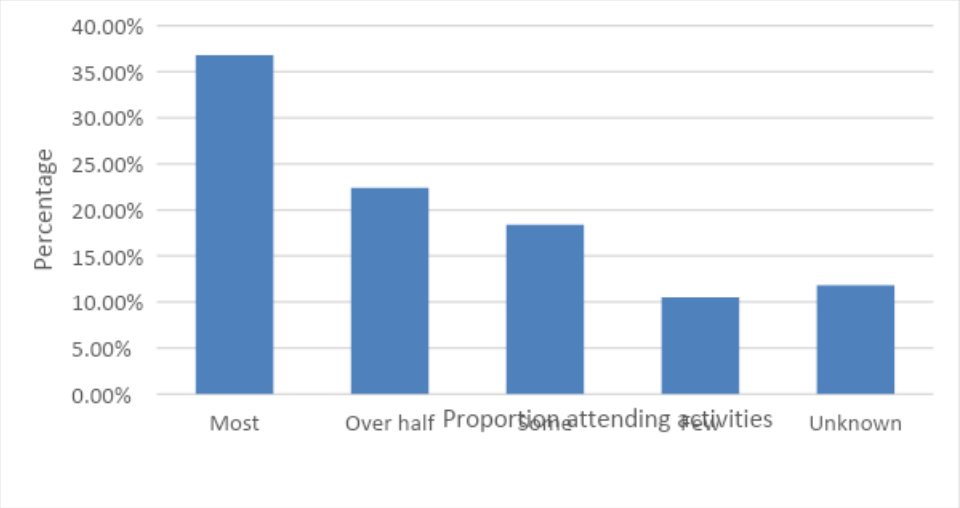
What proportion of referrals attend activities

Within GSP, stakeholders have raised concerns that people referred may not attend the activity. Over 50% of respondents said that over half of referrals did not attend the activity (n=45/76, 59.21%) indicating that it was a significant issue. Some of the GSP sites have been trying initiatives such as buddies and supporting people with transport to address some of the access barriers. It is also important to consider whether it is the responsibility of referrers or the nature-based providers to support people to access the nature-based activity. The high numbers also indicate that referrers are possibly signposting people who do not want to attend the activity but who do not feel able to say no. This indicates that referrers may need training in helping service users with being signposted to activities that they feel they can attend.

Table A1.12: Proportion of referrals not attending activity

Proportion of referrals not attending	Responses (n=76)
Most (More than three-quarters)	28 (36.8%)
Over half (Half to three quarters)	17 (22.4%)
Some (A quarter to half)	14 (18.4%)
Few (Less than a quarter)	8 (10.5%)
I do not know if people attend the nature-based activity	9 (11.8%)

Figure A1.12: Proportion of referrals not accessing services



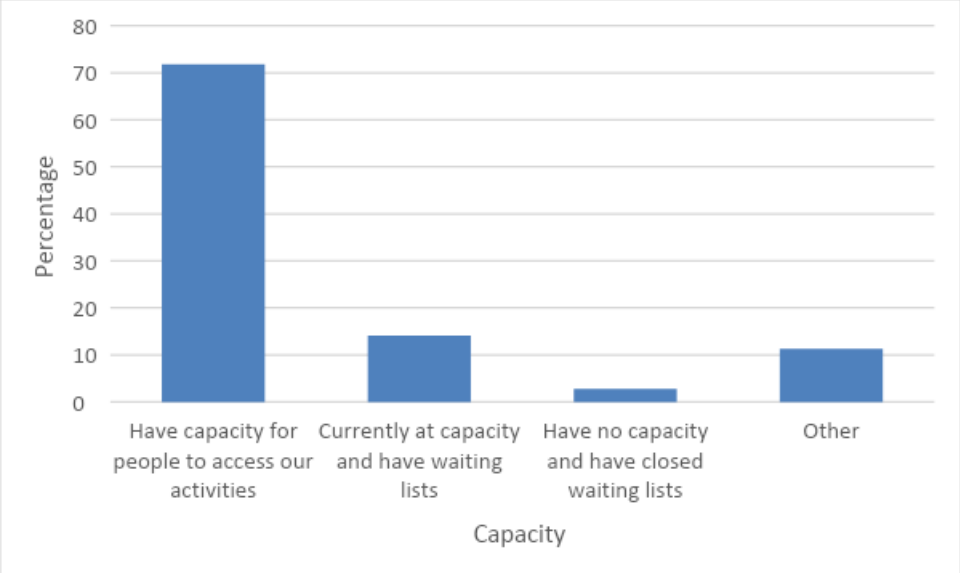
Capacity (Baseline and follow-up)

In the follow-up questionnaire, as in the baseline questionnaire the majority of nature-based providers have capacity to receive more referrals 51 (71.8%). This indicates that the challenge is supporting service users to access activities rather than necessarily provision. Just under 20% of organisations were operating waiting lists or had to close waiting lists. In terms of other comments, respondents discussed how one of their sites was at capacity but the other had places whilst another commented that they had capacity but struggled to receive referrals. The former comment highlights how hyper-local provision is. This is relevant because in WP3B they have found transport can be a barrier and many people prefer local activities. Another 'other' comment related to having capacity but needing funding to be able to continue the activity, which highlights how capacity is dependent on providers having funding to sustain their activities. There being capacity in provision but providers struggling to receive referrals potentially raises bigger questions of whether the activities available meet local people's needs or whether more support is needed to address the barriers that people experience to access nature-based activities It does not appear that GSP has led to a unmanageable increase of referrals which has caused capacity issues generally amongst providers.

Table A1.13: Capacity of nature-based activity providers

Whether providers have capacity	Baseline Response (n=108)	Follow-up response (n=71)
Have capacity for people to access our activities	88 (81.5%)	51 (71.8%)
Currently at capacity and have waiting lists	7 (6.5%)	10 (14.1%)
Have no capacity and have closed waiting lists	4 (3.7%)	2 (2.8%)
Other	9 (8.3%)	8 (11.3%)

Figure A1.13: Capacity of providers



Steps taken to support people to transition to move on from the activities

There were a range of steps taken to support people to transition to move on from the activities. These included progression into other site/organisational based options:

> *We have different projects that people can take part in, people who have attended our wellbeing groups are encouraged to attend our site management volunteering days if that's the right thing for them, they have the opportunity to try out the site management days without losing their place in the wellbeing group they attend. We regularly signpost people to other projects. (T&L7).*

Providers also offered skills training and volunteer development: *"option to train as volunteer walk leaders"* (T&L4), with signposting and support to take up volunteering being a common option: "We do have a volunteer training programme but have more volunteers than we have places for" (T&L4), and *"We are able to support clients with further learning or volunteer training if they are interested in developing their skills/confidence - either by providing this ourselves or finding suitable places for referral."* (T&L1).

Some providers offered mentoring and coaching into training, employment, apprenticeships: *"We have supported a few people into employment where we have mentored and coached them"* (T&L7). Others offered employment in the programme directly: "We have been able to offer part time employment to around six per year and that has worked well, using our services as a stepping stone. The first six months, for many, who have been isolated in bedrooms for 3-5 years, is focussed on attendance, integration and confidence primarily because many have lost the capability to mix and talk and have little to talk about" (T&L7).

However, several providers had no specific progression out of the activities: "Most of our activities are based on long term and maintenance not an objective to move on. We have a hierarchy of mental health services within the organisation from counselling through, therapies, classes and support groups and people access all as they need." (T&L4). For some this was related to challenges of capacity: "We have identified an opportunity to support transition from high support needs to more of a volunteering or independent gardening role, however, this requires additional funding. All projects are challenged with chasing short-term funding so it is difficult to provide long term plans and partnerships." (T&L3).

Funding through GSP

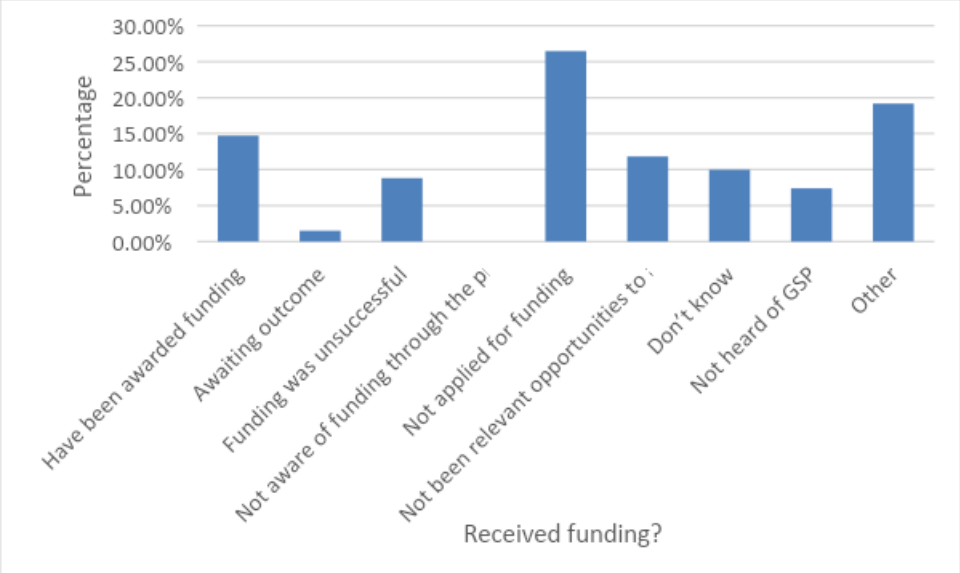
In the baseline questionnaire just under a third of respondents said their organisation had received funding through the GSP programme (n=30/68, 30.9%). This had decreased at the follow-up questionnaire but this could have been due to the sample (n=10/68, 14.7%). Also, some of the people selecting 'other' had received funding but selected this option to explain how the funding had since finished. Furthermore, in a follow-up question, over 30 people responded about what they would do once funding was finished indicating that perhaps more providers received funding than the sample indicates. (Table A1.14, Figure A1.14). Over a quarter of people had not applied for funding n=18/68 (26.5%) or for others there had been relevant opportunities available n=8/68(11.8%). The figures across baseline and follow-up indicate that the majority of nature-based providers had not received funding through GSP. However, many of these were still engaged with GSP highlighting that it is viewed as more than a funding opportunity.

Within the follow-up questionnaire, some people added additional comments. A number of providers felt aggrieved, with people feeling that there were not opportunities for funding for grass root organisations, that the process was not transparent or that they had not had opportunities to apply for further funding. It appears important that for future projects that the funding process is transparent and well publicised so that providers feel it is fair.

Table A1.14: Whether organisations have received funding through GSP

Funding through GSP	Baseline Response (n=97)	Follow-up response (n=68)
Have been awarded funding	30 (30.9%)	10 (14.7%)
Awaiting outcome	10 (10.4%)	1 (1.5%)
Funding was unsuccessful	1 (1%)	6 (8.8%)
Not aware of funding through the project	7 (7.2%)	0 (0%)
Not applied for funding	31 (32%)	18 (26.5%)
Not been relevant opportunities to apply for	8 (8.2%)	8 (11.8%)
Don't know	3 (3.1%)	7 (10.3%)
Not heard of GSP	4 (4.1%)	5 (7.4%
Other	3 (3.1%)	13 (19.2%)

Figure A1.14: Whether allocated funding



Providers who received funding directly through the GSP programme used it for a variety of different purposes:

- Bridging funding.
- Delivery of activities: “We used the funding to provide 31 weeks of community gardening activity called 'Grow Together'. This was a space for anyone to come together, socialise and garden. We tested whether long term ongoing activities aids referrals and retention of participants.” (T&L4).
- Tools and delivery resources including building permanent shelters and resources such as toilets: “£9997 to build a potting/tea shed, polytunnel and outdoor shelter and provide woodworking craft activities.” (T&L1).
- Hiring sites.
- Staffing.
- Training and skills development including developing activity leaders.
- Basic overheads and capacity such as management, insurance.
- Transport.
- Survey work.

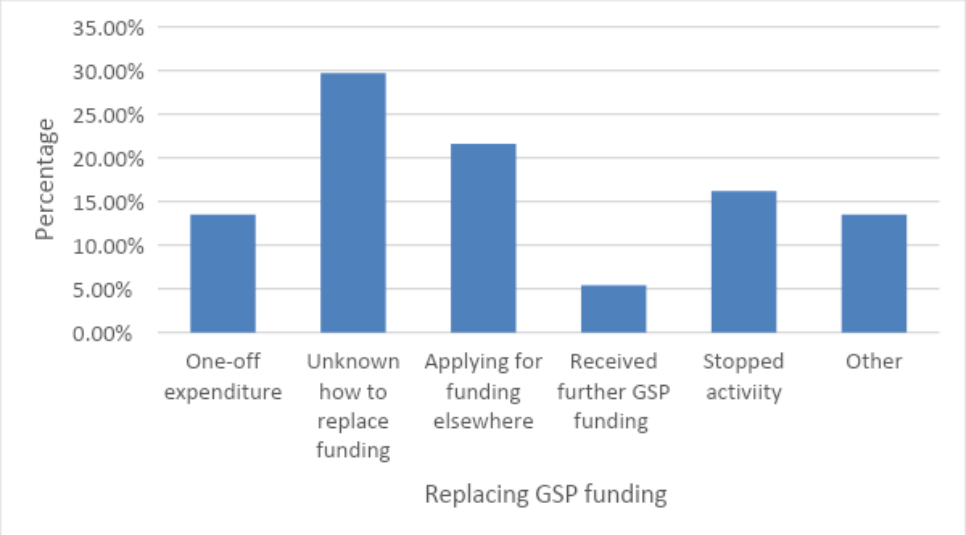
What have providers done once the funding finished?

It appeared that many of the funders were struggling to replace the funding that had been provided by GSP. Over a quarter do not yet know how they will replace the funding (n=11/37, 29.7%) and six felt they will have to stop the activity (n=6/37, 16.2%). Just over a quarter were identifying further funding, had secured funding or received extension funding from GSP. A small number had used the funding for a one-off expenditure so did not require further funding (n=5/37,13.5%). Some of the other comments related to people saying that they would welcome further funding to expand or continue their offer. The responses to this question highlight the challenges of trying to sustain activities after an initial grant period and reflect common challenges amongst voluntary sector organisations.

Table A1.15: What will happen when funding finishes

Action when funding finished	Response (n=37)
The funding was used for a one-off expenditure, so no further funding was required.	5 (13.5%)
We do not yet know how we will replace the funding	11 (29.7%)
We have found/are applying for alternative funding	8 (21.6%)
We have received further funding from the Green Social Prescribing project	2 (5.4%)
We have had to stop/ will need to stop the activity that we used the funding for	6 (16.2%)
Other	5 (13.5%)

Figure A1.15: What nature- activity providers will do when GSP funding finishes



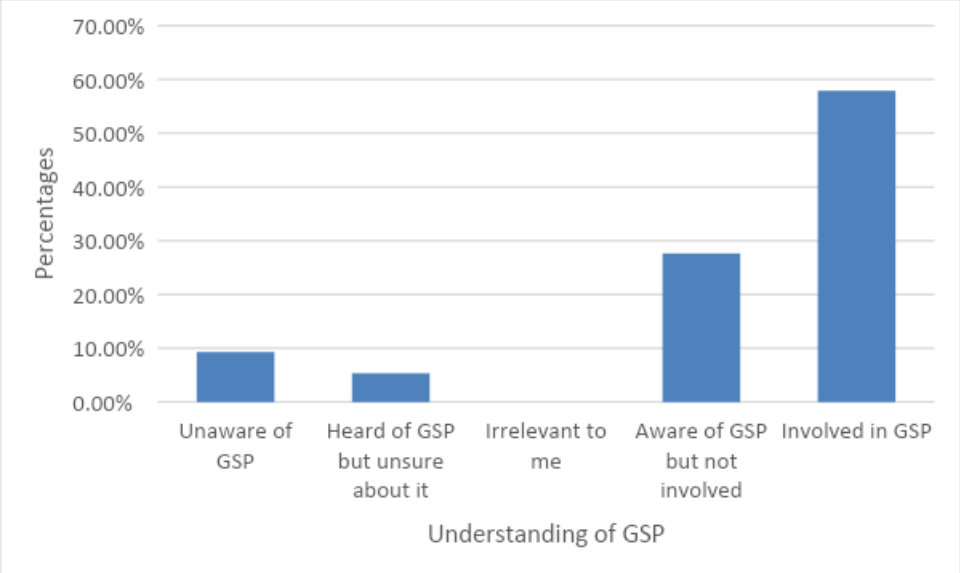
Whether people have heard of GSP

The majority of respondents had heard of GSP and were actively involved in the initiative (n=44/76. 57.9%). A further quarter of people had heard of GSP but not been actively involved (n=21/76, 27.6%). Around 15% of people (n=11/76) had either not heard of the initiative or were unsure what GSP is about. Whilst those likely to complete the questionnaire will be people aware of GSP, it does highlight that people are actively involved rather than purely aware of the initiative.

Table A1.16: Whether people have heard of GSP

Knowledge of GSP	Response (n=76)
I was not aware of the initiative	7 (9.3%)
I have heard of it, but I am unsure what it is about	4 (5.3%)
I am aware of it, but it is not relevant to me	0 (0%)
I have heard of the initiative and what it is about, but I have not been involved	21 (27.6%)
I am involved in the initiative e.g., attending networking events	44 (57.9%)

Figure A1.16: Whether aware of GSP



What aspects of GSP have people accessed

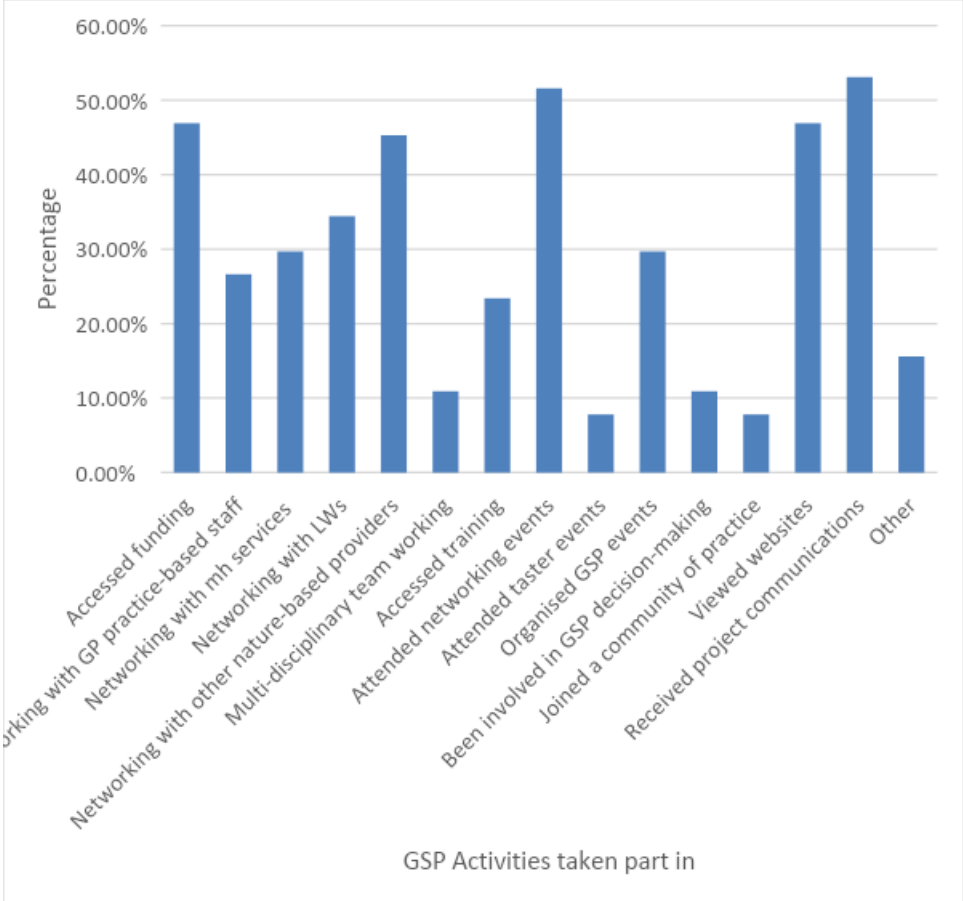
It was evident that responders had accessed a range of GSP activities, with around half of responders having attended networking events and received information about GSP. Interestingly, almost half of responders had accessed funding through the project (n=30/64, 46.9%). This is interesting as for an earlier question, a lot less people had received funding through GSP. Between a quarter and a third of respondents had accessed networking opportunities with GP practices, Link Workers and Mental Health services. Almost 30% of respondents had organised GSP related events themselves which highlights how people are actively engaged in GSP, using it as an opportunity to showcase their work. Smaller numbers of people (less than 10%) had been involved with communities of practice and attended taster sessions. It would be interesting to reflect if this is because people do not find them a useful part of GSP or whether they have not been widely available and are aspects that people would benefit from. One person discussed how whilst they had run a networking event at their organisation, this did not then generate referrals. This is important feedback as it highlights whether there is learning on how to ensure networking does result in improved referral pathways and increased service users accessing nature-based activities.

Table A1.17: Elements of GSP accessed

Element of GSP Accessed	Response (n=64)
Accessed funding through the project	30 (46.9%)[5]
Taken part in activities that have involved networking with GP practice-based staff	17 (26.6%)
Taken part in activities that have involved networking with mental health services	19 (29.7%)
Taken part in activities that have involved networking with Link Workers	22 (34.4%)
Taken part in activities that have involved networking with other nature-based activity providers	29 (45.3%)
Taken part in activities that have involved developing multi-disciplinary team working with other organisations	7 (10.9%)
Accessed training related to green social prescribing	15 (23.4%)
Attended networking events	33 (51.6%)
Attended open sessions/taster events of nature-based activities	5 (7.8%)
Organised or facilitated events for the Green Social Prescribing Project	19 (29.7%)
Been part of a decision-making group for the project	7 (10.9%)
Joined a community of practice	5 (7.8%)
Viewed websites for information	30 (46.9%)
Received project newsletters/correspondence	34 (53.1%)
Other	10 (15.6%)

[5] Please note, percentages add up to more than 100% because people could give multiple responses.

Figure A1.17: GSP activities that nature-based providers have accessed



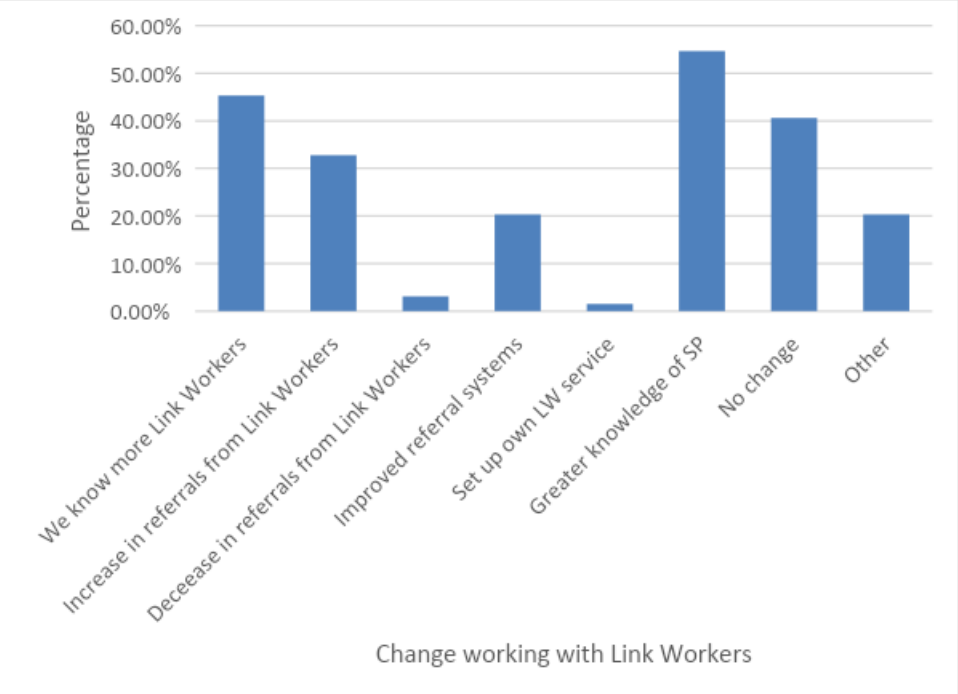
What changes have nature-based providers experienced with working with Link Workers

Just under 60% of respondents reported improvements in their networks with Link Workers and the remainder did not experience any changes (n=26/64, 40.6%). The majority experiencing an improvement highlights how GSP has had an impact on developing social prescribing networks. Just under a third of respondents reported an increase in referrals from Link Workers (n=21/64, 32.3%). About half of respondents reported an increase in awareness of what social prescribing is (n=35/64, 54.7%), Just under half of respondents reported improved networks with Link Workers (n=29/64, 45.3%). Only one respondent said how they had established their own social prescribing service. Of the other comments, one prominent comment was that their local social prescribing service has set up their own community garden for people to undertake nature-activity rather than making an onward referral. This is an interesting reflection and highlights the challenge managing the provision of a variety of providers.

Table A1.18: Changes in working with Link Workers

Changes in working with Link Workers	Responses (n=64)
We have greater knowledge of what social prescribing is	35 (54.7%)[6]
We know more Link Workers	29 (45.3%)
Our nature-based activities have experienced an increase in the number of referrals from Link Workers	21 (32.8%)
Our nature-based activities have experienced a decrease in the number of referrals from Link Workers	2 (3.1%)
We have improved systems for receiving referrals from Link Workers to our nature-based activities.	13 (20.3%)
We have established our own Link Worker service within our organisation	1 (1.5%)
There have been no changes in how we work with Link Workers.	26 (40.6%)
Other (Please specify)	13 (20.3%)

Figure A1.18: Changes in working with Link Workers



Changes in nature-based providers working with mental health services

Over half of respondents reported that their nature-based providers had experienced an improvement in their links with mental health services during the GSP programme. Whereas half of respondents had not reported any changes (n=32/68, 47.1%). Almost a quarter of respondents experienced an increase in the number of referrals they received from mental health services (n=16/68, 23.5%). Respondents also experienced improved networks and referral routes with mental health services. Other people commented that they were starting to develop networks, highlighting how it can take considerable time to build referral links between organisations. Whilst our other data sources indicate mental health services are not one of the most common

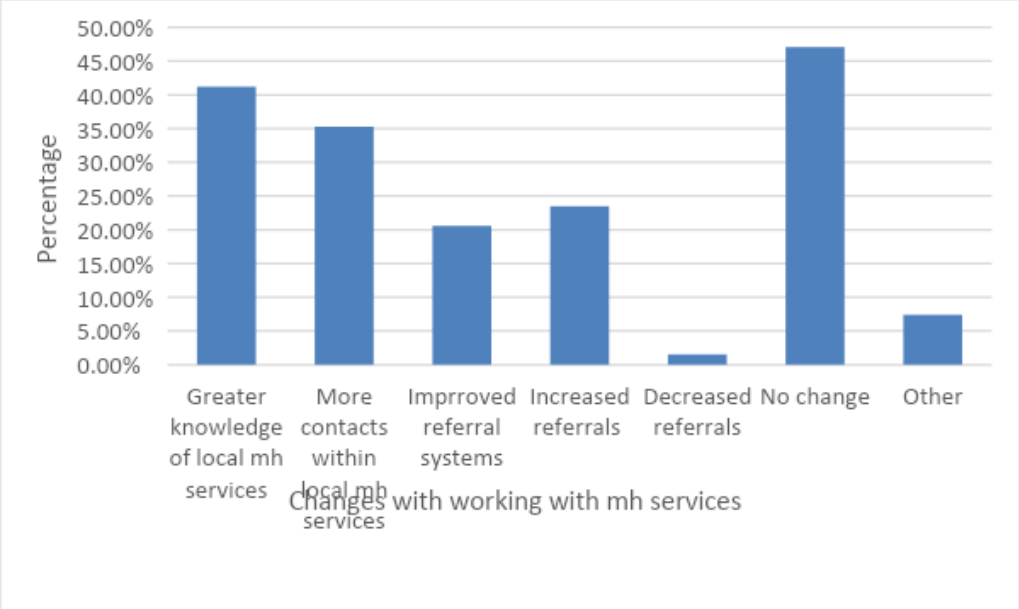
[6] Percentages total more than 100% because respondents could select multiple options.

referrers, the questionnaire highlights how GSP has supported nature-based providers to improve their links with mental health services.

Table A1.19: Whether developed links with mental health services

Developing links with mental health services	Respondents (n=68)
We have greater knowledge of local mental health services	28 (41.2%)
We have more contacts within local mental health services	24 (35.3%)
We have improved systems for receiving referrals from mental health services to our nature-based activities	14 (20.6%)
Our nature-based activities have experienced an increase in the number of referrals from mental health services	16 (23.5%)
Our nature-based activities have experienced a decrease in the number of referrals from mental health services	1 (1.5%)
There have been no changes in how our organisation works with local mental health services	32 (47.1%)
Other (Please specify)	5 (7.4%)

Figure A1.19: Improvements in links between nature-based providers and mental health services



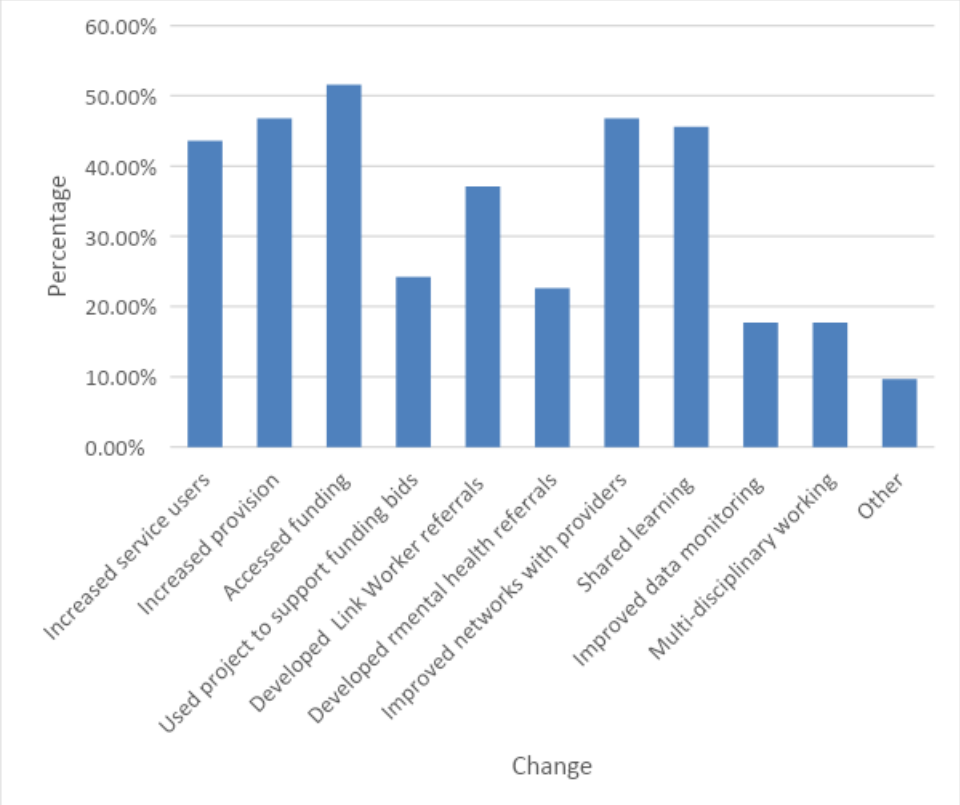
What changes have nature-based providers experienced from the GSP project?

Many of the respondents discussed a range of improvements from being involved in GSP including accessing funding, developing networks, sharing learning, expanding provision and increasing the number of service users that access their organisation. For each of these benefits, almost half of respondents reported them. Over a third of providers reported improved networks with Link Workers (n=23/62, 37.1%) and almost a quarter reported improved links with mental health services (n=14, 22.6%). Other respondents reported developing data monitoring processes and developing multi-disciplinary workers. The range of improvements from GSP highlights how the programme did help nature-based providers with developing networks and provision.

Table A1.20: Changes experienced during GSP

Change experience	Response (n=62) (people could select multiple options)
Increased number of service-users being referred to the organisation	27 (43.6%)[7]
Increased our service provision e.g., set up new activities, run more sessions	29 (46.8%)
Accessed funding through the programme	32 (51.6%)
Referenced the existence of the project within funding applications	15 (24.2%)
Developed referral routes with Link Workers	23 (37.1%)
Developed referral routes with mental health services	14 (22.6%)
Improved networks with other providers of nature-based activities	29 (46.8%)
Shared learning and knowledge with other organisations	28 (45.6%)
Improved data monitoring systems e.g. collecting outcome measures	9 (14.5%)
Undertaken multi-disciplinary working with other organisations	11 (17.7%)
Other	6 (9.7%)

Figure A1.20: Improvements experienced from being involved in GSP



[7] Percentages total over 100% as people could select multiple responses.

Providers provided information on a number of benefits to GSP including:

- Networking.
- Responding to needs in community: “We have been able to respond to a need in the community. Prior to this project and the associated funding, we were unable to provide supported opportunities to engage the community with our gardening. Now, we are able to accommodate a multitude of needs within our supported Gardening Group. By gaining this reputation, we have in turn had social prescribers refer to all of our offerings (art, cookery, lunch club).” (T&L7).
- Greater delivery: Including increase accessibility “Due to the groups we work with being marginalised and minoritised communities it has had an outstanding impact on those people's lives.” (T&L2).
- Raising awareness of GSP.
- Funding: “Receiving a grant helped R&S to move forward in building raised veg boxes enabling people with physical disabilities to join in. Over the year, it has become apparent that we should expand and add a sensory garden.” (T&L1.). Another noted “funding for a whole year that paid us to just do what we do already, not needing to reinvent the wheel, this has been invaluable to us as we have been able to focus more on actual delivery” (T&L1). This is valuable for providers as often grant giving initiatives fund new projects and VCSE organisations report that it can be difficult to access funding that can support existing activities.
- Improved knowledge, skills etc.
- Improved referral routes.
- Improved health of service users.

Opinions on the GSP project (Numbers answering varied on specific question) (Baseline and follow-up)

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. In this description, we only present percentages because it is not possible to compare numbers due to the differing sample size between baseline and follow-up.

There was greater awareness of what GSP was seeking to achieve between baseline and follow-up (Agree/Strongly Agree: Baseline: 79.3%, Follow-up- 88%). Whilst it is appreciated generally people with awareness of GSP will complete the questionnaire, it indicates respondents do understand what GSP is seeking to do.

Respondents felt that GSP had enabled them to develop relationships with other organisations. At baseline, 41.7% of respondents agreed or strongly agreed that GSP had helped them improve relationships. This had increased to 61.2% at follow-up, indicating a substantial increase. It highlights how GSP is making a difference across the system and is more than a grant-giving initiative.

There appeared some issues with respondents feeling kept informed about GSP. Whilst the numbers of people that agreed or strongly agreed with being kept informed had increased from 41.3% at baseline to 50.7%, this was still only half of respondents. It indicates that improved communication is an area that GSP needs to focus on.

Two-thirds of respondents agreed or strongly agreed that it was beneficial giving time to GSP (Follow-up: 66.7%). However, this had decreased from 79.5% at baseline with a greater percentage of people neither agreeing nor disagreeing (Baseline: 13%, Follow-up: 24.2%). Whilst some of the respondents are different and the questionnaire was disseminated after the extension funding had not been awarded, it indicates that

GSP may need to reflect on how to support more nature-based providers to feel giving time to GSP brings tangible benefits to their organisation and/or service users.

There was increased dissatisfaction with the amount of financial resources being allocated through GSP. At baseline, 27.2% of respondents disagreed that there was adequate funding and this had increased to 40.9%. We focus on 'disagreed' in this question compared to the others because respondents that agreed/strongly agreed weren't less than 15% at both baseline and follow-up which was a considerably smaller proportion than for the other questions focusing on purpose and relationships. It indicates that nature-based providers do feel that initiatives like GSP need sufficient funding attached to them to support providers. This is important for considering how GSP may be sustained at a local level without the national funding.

There were relatively high levels of trust amongst partners, with 61.2% agreeing/strongly agreeing at follow-up and this had increased from 48.6% at baseline. This highlights the positive relationships between people involved in GSP.

The vast majority of respondents felt that there were benefits of GSP partners working together. At baseline, 82,4% agreed/strongly agreed and this remained constant at follow-up (80.6%).

The responses indicate that nature-based providers value the opportunities GSP provides in working with partners but there are concerns about whether GSP has sufficient financial resources, whether people feel kept informed and whether a sufficient number of providers feel that spending time on GSP is valuable. The latter highlights the importance of providers feeling there are tangible benefits to their time investment.

Table A1.21: Opinions on the GSP project

	Strongly Agree		Agree		Neither agree nor disagree		Disagree		Strongly Disagree		Don't know/ Don't have an opinion	
	Baseline	**Follow-up**	**Baseline**	**Follow-up**	**Baseline**	**Follow-up**	**Baseline**	**Follow-up**	**Baseline**	**Follow-up**	**Baseline**	**Follow-up**
Understand what GSP is trying to achieve? (Baseline: n= 111; Follow-up: n=67)	24 (21.6%)	26 (38.8%)	64 (57.7%)	33 (49.2%)	12 (10.8%)	5 (7.4%)	6 (5.4%)	1 (1.5%)	2 (1.8%)	1 (1.5%)	3 (2.7%)	1 (1.5%)
Developed relationships through GSP (Baseline: n=108 Follow-up: n= 67)	11 (10.2%)	15 (22.4%)	34 (31.5%)	26 (38.8%)	26 (24.1%)	12 (17.9%)	19 (17.6%)	5 (7.5)	9 (8.3%)	6 (9%)	9 (8.3%)	3 (4.5%)
Kept informed (Baseline: n=109 Follow-up: n=67)	11 (10.1%)	7 (10.4%|)	34 (31.2%)	27 (40.3%)	41 (37.6%)	18 (269%)	13 (11.9%)	9 (13.4%)	6 (5.5%)	5 (7.5%)	4 (3.7%)	1 (1.5%)
Beneficial to give time to GSP (Baseline: n=108 Follow-up: n=66)	33 (30.5%)	14 (21.2%)	53 (49%)	30 (45.5%)	14 (13%)	16 (24.2%)	2 (1.9%)	3 (4.5%)	2 (1.9%)	0 (0%)	4 (3.7%)	3 (4.5%)
Adequate financial resources? Baseline: n=109, Follow-up: n=66)	2 (1.8%)	3 (4.5%)	14 (12.9%)	5 (7.6%)	43 (39.5%)	21 (31.8%)	19 (17.4%)	13 (19.7%)	11 (10.1%)	14 (21.2%)	20 (18.3%)	10 (15.2%)
Trust between partners (Baseline: n=107, Follow-up: n=67)	12 (11.2%)	12 (17.9%)	40 (37.4%)	29 (43.3%)	35 (32.7%)	17 (25.4%)	0 (0%)	2 (3%)	2 (1.9%)	0 (0%)	18 (16.8%)	7 (10.4%\)
Benefits of GSP partners working together (Baseline: n=108, Follow-up: n=67)	44 (40.7%)	25 (37.3%)	45 (41.7%)	29 (43.3)	12 (11.1%)	8 (11.9%)	0 (0%)	2 (3%|	0 (0%)	0 (0%)	7 (6.5%)	3 (4.5%)

Reasons for why there had been no perceived benefits from the GSP programme

There were very few responses to the question which asked if there were no apparent benefits from the GSP project. However, there was a perception that it has not affected the Link Worker or referral pathway: “Link Workers who are not interested or passionate about making a difference are not helpful. We have never been invited to any meeting to network or discuss with them. Attempts to contact the medical centres where they operate fell on deaf ears. Our experience has been fruitless. We receive referrals by word of mouth and have communicated with the rehab, brain injury unit and moved forwards with delivering sessions to their staff and patients, in isolation.” (T&L7). Another noted “There has been no change around working with the associated Link workers - I think this because the role is very niche. Most people prefer to access services directly and social media and other marketing allows for a direct relationship.” (T&L4).

A small number of providers argued there had been failure to address funding (and other resource) challenges and inadequate distribution of the T&L funds: “I feel quite angry that there seemed to be a tendering process for funding which meant only certain organisations benefited from the pilot scheme. We as a very small charity never seem to get a look in, even though we are doing valuable work with the people who attend.” (T&L2) and “Nothing changed considering how much money was available for the project” (T&L4)

Some providers reported that there had been low levels of engagement from T&L teams for two T&L sites (T&L4 and 1).

Provider’s examples of what had changed as a result of the Green Social Prescribing project, be it a positive or negative change

A variety of perceived changes due to the GSP programme were listed by the providers:

- Clarified challenges of GSP: “It has identified a fundamental need for good quality well funded provision. Without provision there can be no GSP.” (T&L4).
- Raised awareness of GSP in others.
- Improved knowledge of practice of GSP “It has allowed us to extend our knowledge of Green Social Prescribing initiatives across the local area and learn about how different organisations facilitate and manage their projects” (T&L7).
- Increased capacity of providers.
- Improved referrals and routes.
- Increased accessibility and equity: “We have been able to train new instructors from ethnic diverse groups within [locality] who in turn are encouraging more people from within their communities to get out and connect with nature.” (T&L7).
- Built links and partnerships: “Better links with community-based organisations, like [organisational name] and [organisational name], who have good links to audiences in their communities that we could never reach without that link” (T&L2).
- Improved participants' lives and prospects.

What activities, context and resources enabled this change to happen?

The types of activities, contexts and resources that enabled the changes to come about through the GSP programme included the support of PM and T&L teams: “It really helped to have a project team to facilitate network meetings, organise behind

the scenes and hold the space. This enabled green providers to come together without it taking up too much of their very limited spare time." (T&L4). The available funding for improved, ongoing or expanded delivery was raised by a number of providers. Changes were also linked to the raised profile of GSP and the momentum associated with a large, high-profile programme.

Opportunities for training were raised by several providers. This was linked to a better understanding of good practice. Development of meaningful connections with others in sector was raised by a small number of providers: "A map of mental health services and contacts shared alongside map of site organisations and the Green Book has been very useful." (T&L3).

What aspects of the Green Social Prescribing project that you feel have worked well and explain why you feel it has worked well?

One of the key, and perhaps most important, ways in which the GSP programme was thought to have worked well was in relation to improving difficult lives: "We have watched significant changes in adults and children. Primarily an increase in confidence and self belief and a willingness to try and have a go. We are a very passionate team and strive to challenge people to move them forward. We have achieved many successes and many people have started through the green social prescribing project and gone on to secure employment and live more fuller lives. In particular we have 4 young people who have worked for us for one year now, all had mental health issues, but were not referred through NHS services, or even recognised as having issues. We have paid for counselling and other therapy privately and each have benefitted immensely and started 'having' a life where they had none. Each of their parents has thanked us for giving back their child or for getting them out of their bedrooms. The change is incredible, they are completely different people from a year ago. Shy, quiet, 19 - 26 years old who struggled to speak, be involved, had no confidence, no goals, multiple issues. They know we believe in them and they have responded to that incredibly positively. We don't believe in giving up on anyone. We find ways for people to move forward, we think outside the box and get outcomes for them." (T&L7).

The GSP programme was also considered to have been of benefit through helping organisations established, funding for provision, and the development of a general sense of momentum. The leadership and sense of support from the project was also felt to be of benefit: "There has been flexibility in terms of how we have spent the grant (we asked for and was granted a small adjustment to our budget). Our request was dealt with quickly, for which we were grateful. The local representative from the Green Social Prescribing fund was very helpful and supportive." (T&L1).

The providers suggested that the GSP programme has helped develop the necessary relationships within the sector, including in relation to referral routes, networking and establishing linkages with others in sector: "The project has also built up a community between partner organisations working around [name of town] so it has been easy and productive working together" (T&L1) and "Our organisation has grown organically with the [local] network and we have greatly benefited from the shared experiences of our colleagues within the network. The relationships had enabled the ongoing development of the system of provision (T&L2): "Other local projects have received green social prescribing funding and used our facilities to deliver their services, this has been brilliant as it means our site is used by more people and those people have had a wider choice of the number and type of activities they attend each week" (T&L1).

What aspects of the Green Social Prescribing project could be improved and why is this important?

The providers felt there were a number of ways in which the GSP programme could have been improved: "Very disappointed in how little has been achieved with the time and money available" (T&L4). It appeared that there had been great expectations of the GSP programme, which, for some it had failed to meet: *"I think the hope of integration into the NHS at this first early stage was unrealistic and perhaps led to undue frustrations. I think local NHS services want to see a project prove itself before feeling it's safe to engage. Unfortunate I don't they are up for sharing the risk of getting a new provision going." D8. Smaller organisations felt excluded: "We want to help, please let us know how!"* (T&L1).

Some felt that there was a need for improved leadership and communication: *"Communication hasn't always been consistent, or it may have been that I missed some of it. It hasn't always been clear who is leading on the project in both of the areas that we have worked with, or who is the main contact. There seems to have been a lot of different staff. For the [locality] one, it has felt quite south [locality] focussed - no meetings have been held in the north of [locality], though online has always been an option. it is a long county [locality]!"* (T&L4).

The factors which needed greater consideration related to further exploration of direct commissioning: *"It would be really good to have been able (as a group) to be able to explore further how projects can be directly commissioned by the NHS or other services where appropriate. When we have worked directly with NHS partners we have been able to provide long-term projects and work closely with health and social care teams as part of their service."* (T&L7).

More, and longer term funding to providers was raised by a significant number of the providers: *"More open communication with providers about funding would be really useful. The mental health crisis is not going away (in fact is getting worse) and as a provider we want to be able to help people. A lot of people who need help, can't afford to fund it themselves and we need to be able to do it for them. We need funding for this to cover our core costs."* (T&L4). *"There needs to be a serious funding strategy so projects can continue the work started, rather than have to tell people it is finishing. Not great for people's mental health, letting them down etc...."* (T&L1*). "I am still unsure as to where funding would come from if GP, Link Workers etc were to refer people to us. We cannot work with people if they don't bring funding with them."* (T&L2).

There is still a need to focus on developing and improving referral pathways: *"Develop better patient pathway for GSP provision with IAPT services, NHS counselling services and Primary care services so that GSP session can help support people on long waiting lists for these services or those people who didn't meet the eligibility criteria to receive support from these services."* (T&L7). *"Building relationships with referral agencies. An ongoing theme for all green providers involved is low referrals from professional agencies. The barriers seem outside of green providers' influence, e.g., service users present with complex needs and are not ready to access community provision, unavailability of transport etc. One barrier that referrers often cite is not knowing about activities or what local providers are delivering. We have tried to help this with regular emails and signing local referrers up to our newsletter, but this has not resulted in any increase of referrals. I'm unsure whether this is because referrers have missed the email due to workload, whether it's easily forgotten or they just don't have clients that would be suitable for the project. We have yet to identify the barriers at play. Identifying these barriers and designing solutions is vital for an increase in referrals and to ensure those who will benefit most can access provision."* (T&L4). *"Referral routes - we feel that we are not reaching everyone who we could help. We target people with enduring problems who have not thrived with traditional medical*

approaches. It is difficult to support some of these to attend - we have heard that referrers have difficulty getting people who would benefit to agree to come along, and we lose people along the way who don't turn up or stop coming. Another level of support to get people to the door would be very helpful to reach those most in need" (T&L2). *"There is a need to understand whether the lack of referrals is a lack of demand or a lack of understanding from the health sector. We need to understand why referrals are not being made."* (T&L4).

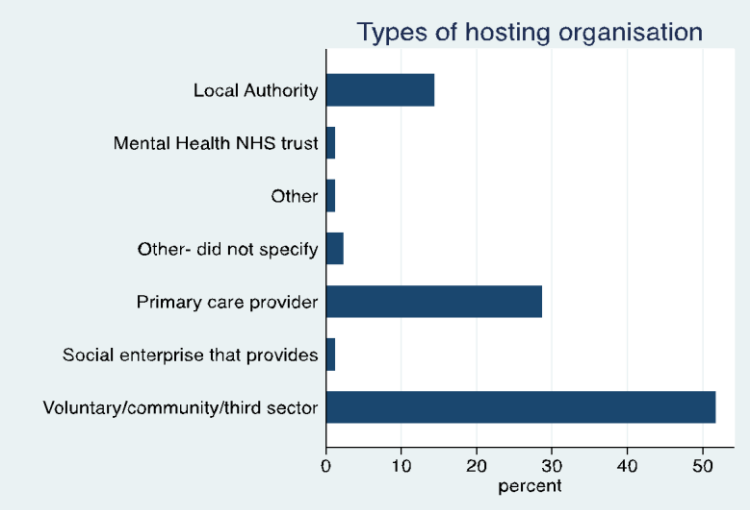
One provider suggested that there is a need to improve the pathway of involvement: *"Develop a patient pathway using GSP groups for those transitioning from in-patient to out-patient. There are many gardening and nature connection groups for patients within hospitals but once they are discharged they are no longer eligible to attend these groups and fall through the cracks."* (T&L7).

Finally, several providers felt that there was a need for more time to develop the networks and relationships necessary for GSP to flourish: *"The organic, co-created and self-led nature of the network requires a pace that takes time." (T&L4) and "It needs to continue, get bigger and ensure that the whole of the county is being represented."* (T&L4).

A1.5. Analysis of the baseline Link Worker Questionnaire

We received 91 responses to the baseline questionnaire. 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.

Figure A1.21: Types of employing organisation



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, a third had been in their role for longer than two years (34%, n=31).

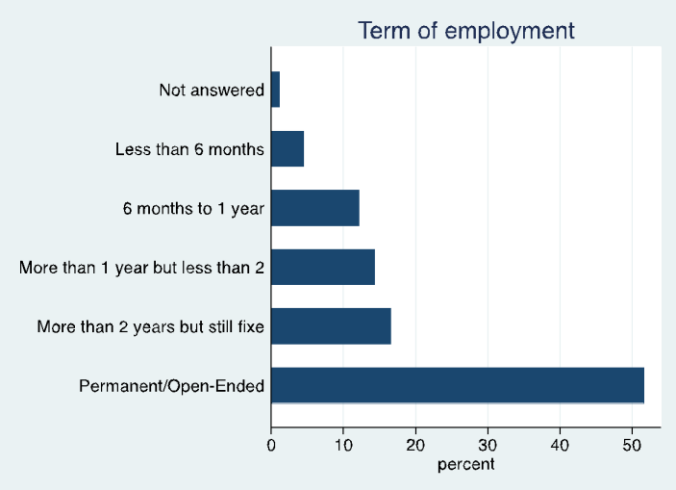
Figure A1.22: Length of time in Link Worker role

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 worked 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.

Just over half 52% (n=47) were on permanent or open-ended contracts with their employing organisation.

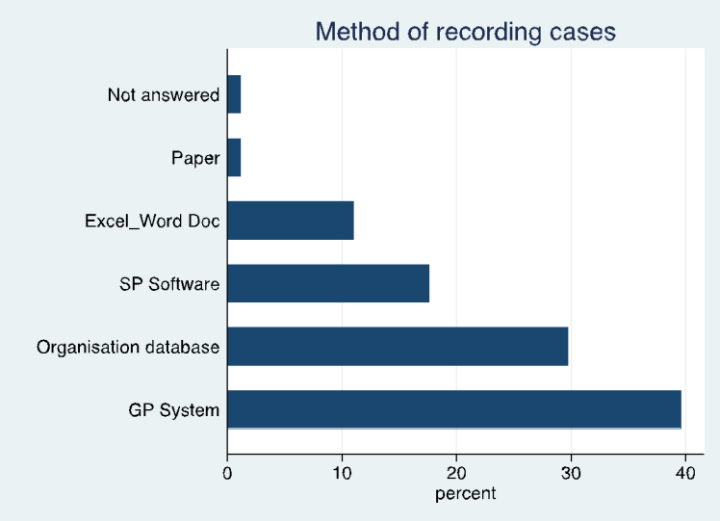
Figure A1.23: Term of employment



Methods of working

Of our respondents, over three quarters (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, 40% (n=36) used a GP system of some sort.

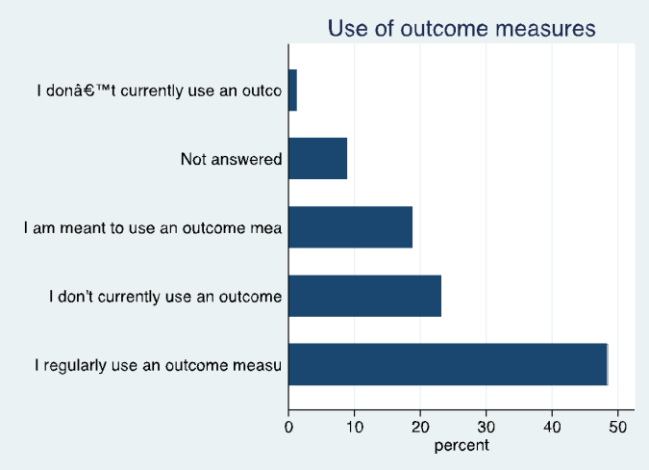
Figure A1.24: Method of recording cases



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.

There were differences in terms of using outcome measures, with just under half (48%, n=44) regularly using outcome measures.

Figure A1.25: Use of outcome measures

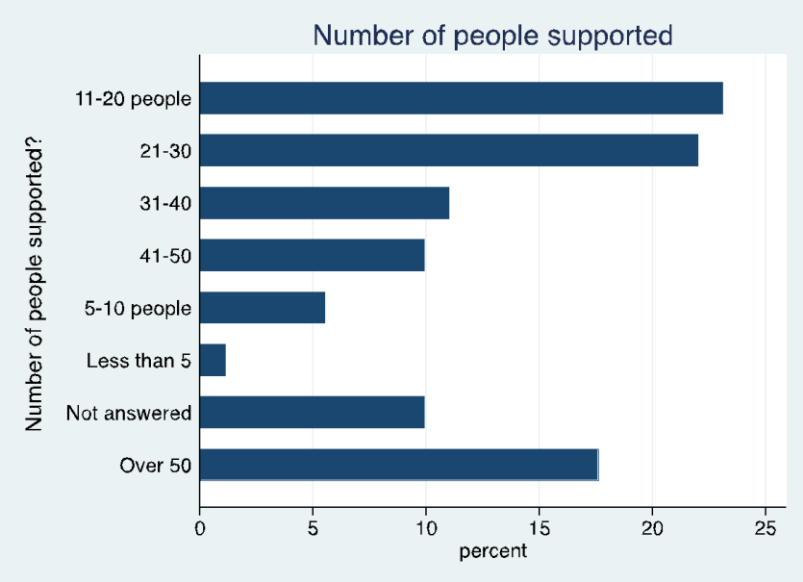


Diverse outcomes measures were used. Of those collecting this information, most commonly used on their own were ONS-4 (30%, n=27), followed by Outcome Star (10%, n=9); however, combinations of ONS, PAM, and WEMWBS were also reported.

Cohort supported

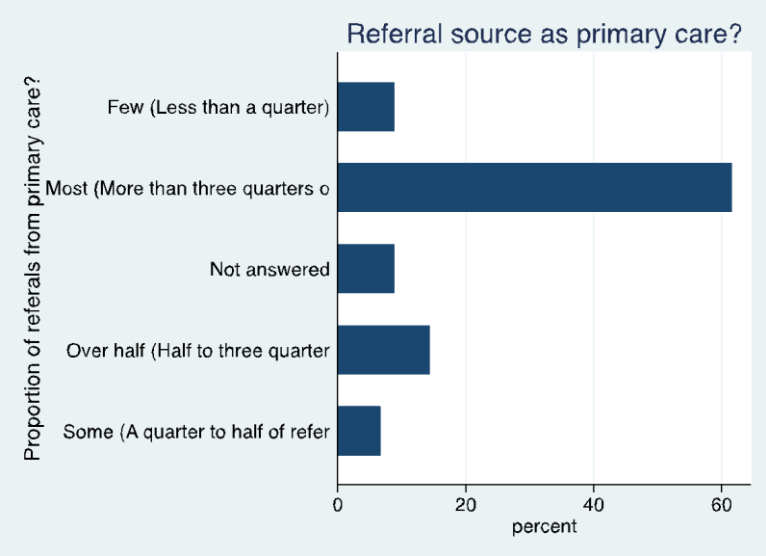
In terms of who the Link Workers were supporting, there was a relatively broad spread reported.

Figure A1.26: Number of people supported



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).

Figure A1.27: Proportion of people referred by primary care



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

Figure A1.28: Proportion of referrals from mental health services

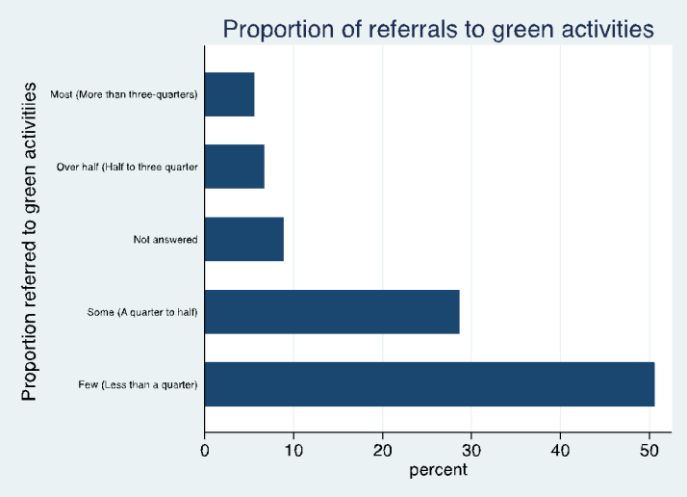
Proportion of referals with mental health needs?	Freq.	Percent	Cum.
Few (less than a quarter of referrals)	2	2.20	2.20
Most (More than three quarters of refer	50	54.95	57.14
Not answered	8	8.79	65.93
Over half (Half to three quarters of re	23	25.27	91.21
Some (A quarter to half of referrals)	8	8.79	100.00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

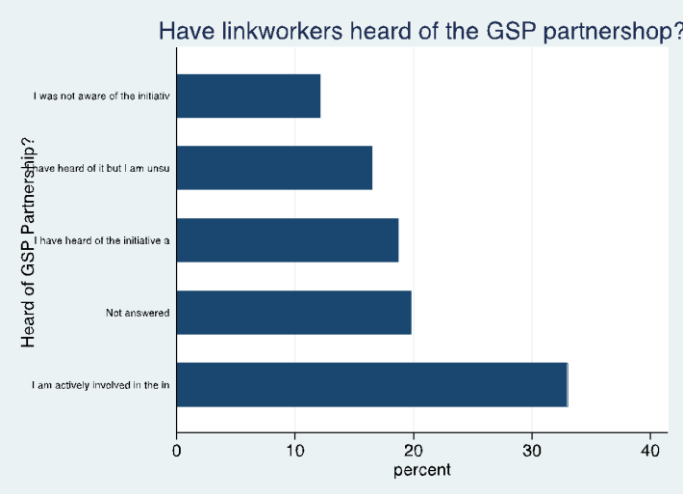
Firstly, we were interested in what proportion of referrals Link Workers made onwards to green activities. For about half of respondents (51%, n=46) green activities comprised fewer than a quarter of their referrals, with 29% (n=26) reporting that under half of their referrals were green. Only 12% (n=11)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

Figure A1.29: Proportion of referrals to green activities



A third were 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.

Figure A1.30: Whether Link Workers have heard of GSP



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.

Figure A1.31: Understand what GSP is seeking to achieve

I understand what GSP hopes to achieve?	Freq.	Percent	Cum.
Agree	34	37.36	37.36
Disagree	3	3.30	40.66
I donâ€™t know/I donâ€™t have an opinio	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 a third (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.

Figure A1.32: Differences in onwards green referrals depending on type of Link Worker employer

What type of organisation is your employer?	RECODE of EProportionreferredto greenact (Proportion referred to green activitiie Under Hal	Over Half	Total
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.

Figure A1.33: Whether a difference between type of Link Worker and whether they had heard of GSP

Heard of GSP Partnership?	RECODE of EProportionreferredto greenact (Proportion referred to green activitiie Under Hal	Over Half	Total
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. However, there was no direct relationship between these two binary variables.

Figure A1.34: Whether differences in nature-based referrals depending on mental health referrals

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

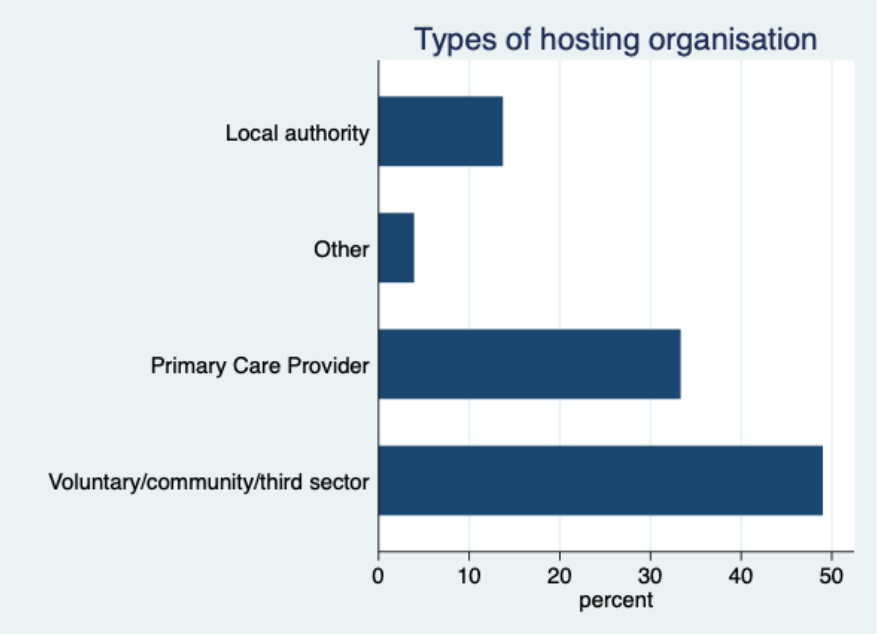
Pearson chi2(1) = 1.7371 Pr = 0.188

Link Worker survey – follow-up analysis

We followed up with a second wave survey to the test and learn sites in March and April of 2023, however importantly this was not necessarily the same individuals and so we present two time-point snapshots of the Link Worker responses rather than within-individual change over time.

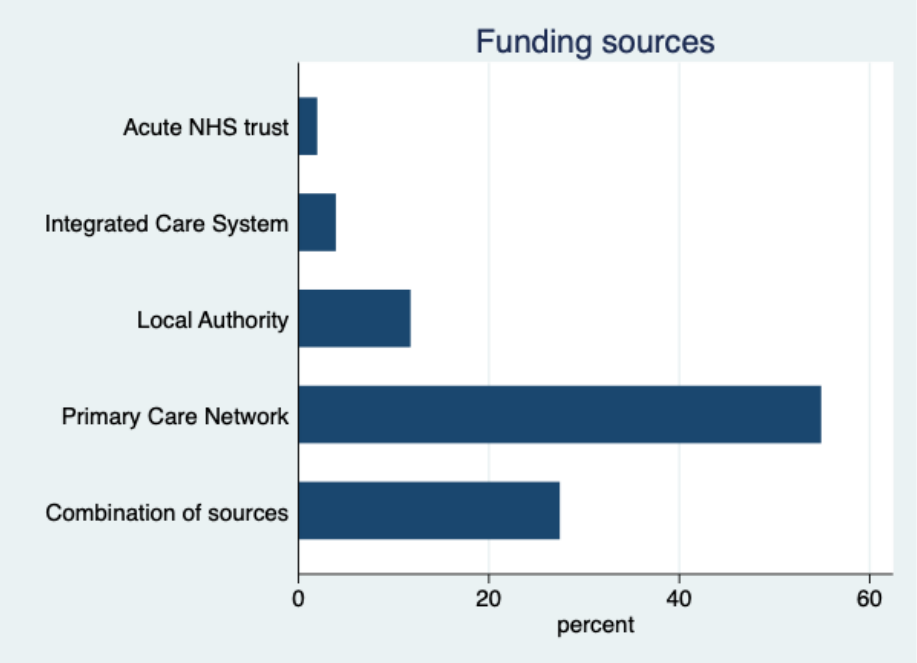
In our follow-up we received 51 responses, 40 fewer than the baseline questionnaire. These were across six of the seven sites, but almost half (47%) were from one site. The most common employment sector was the voluntary sector (n=25, 49%). The remainder are spread across primary care, local authority, and other providers:

Figure A1.35: Type of Link Worker employing organisation



In terms of funding sources, over half of respondents (n=28, 55%) were funded solely through a Primary Care Network or through a combination of sources (such as voluntary sector in combination with statutory health services) (n=14, 27%):

Figure A1.36: Who funds the Link Worker



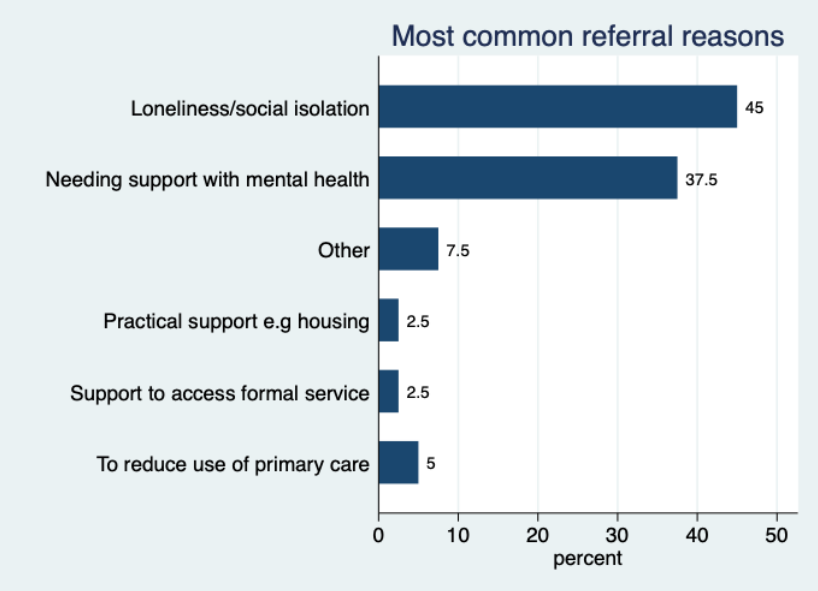
Whilst there was some diversity in job title (not function, but simply the name) the majority reported being titled ‘Link Worker’, ‘social prescribing Link Worker’, or ‘social prescriber’.

Fifty-nine percent (n=30) of respondents reported that they worked in both rural and urban areas, with another 35% (n=18) reporting only working in urban areas and a minority (n=3, 6%) only working in rural areas. **This matches our findings from the baseline survey**. Also, **consistent with the baseline**, our sample was experienced; with the majority (n=29, 57%) having been in the role for longer than two years, and only seven individuals (14%) having been in the post for under six months.

The number of people that were supported by Link Workers varied. The most common response was between 11-20 per month (n=10, 26%), but varied from below 10 (n=5, 13%) to over 50 (n=5, 13%) per month. **Once again, this matches what we found in the baseline survey**. The sources of these referrals was **also unchanged**, with 72% (n=28) coming from a GP or other Primary Care referrer.

In our baseline survey, Link Workers reported the majority of referrals as having some mental health need, **which we also find in the follow-up questionnaire** (n=36, 92% reporting over half their referrals being MH-linked). We wanted more granularity to this aspect of the pathways and in this wave Link Workers reported the following breakdown of referral reasons (figure below) The most common reason is loneliness and social isolation followed by mental health issues. This reflects the focus of GSP.

Figure A1.37: Reason for referral to Link Worker



Perceptions of the Link Workers regarding issues with receiving referrals

Referrals to the Link Workers appear to be coming from a variety of sources: General Practitioners, mental health services, community practice nurses, substance misuse organisations, Social Workers, the VCSE 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: Link workers from all sites reported a number of issues they are currently facing with receiving referrals.

> *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.'

Link Worker in all sites had referrals that were more appropriate for social care and specialist mental health services *"We receive inappropriate referrals from Learning Disabilities, it feels like they refer to us if they are not able to provide a service to the client."* (T&L2). Some referrals were entirely inappropriate: *"Inappropriate referral… i.e., Social Activities for patients with less than 2 weeks to live who are unable to walk and sleep almost 24 hours per day"* (T&L4). However often it was because the referrer had run out of options: *"Sometimes it feels like they are making the referral because they don't know what else they can do"* (T&L2).

A linked issue was the lack of, or poor information relating to referral: *"Lack of detail... omitting safeguarding information or mental health details" (T&L4) and "Some have no or poor risk assessments"* (T&L2).

Link Workers receive referrals of people who are not ready to engage with SP: *"Sometimes GP's will re-refer clients who disengaged with our service, or were not satisfied with the signposting options offered. 9/10 the same thing will happen again, and it takes up time when I already have a high caseload."* (T&L2).

The scale and number of referrals was also reported to be an issue in most T&L sites: *"The area of [name of town] is densely populated and some parts seen as deprived and we receive a very high number of referrals between 2 social prescribers, 50-60 a month"* (T&L2). This has implications for managing waiting lists. However, too few referrals was also noted in T&L4, 5 and 6.

Link Workers worried about their inability to provide quality of service: *"For the last 5 months I was the only Social Prescriber and it was very difficult to provide a quality service to the amount of referrals we were getting. At one point I had 80 patients in my caseload. I believe the figure of 250 patients per year which was set by the NHS is very unrealistic."* (T&L4).

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, so a '*referral of last resort'.*

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 caseload and the system within which they are working:

> *I have over 150 referrals waiting to 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 information on referees or referees not knowing why they have been referred to Link Workers.

These issues with getting appropriate referrals and managing caseloads mean that there are wider issues with addressing problems within the social prescribing pathway beyond GSP. These issues are potentially detrimental to supporting Link Workers to engage in GSP, as their priority may need to be instead on addressing the challenges they are experiencing at the referrals in point of the social prescribing pathway.

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

Transport was by far the most commonly mentioned issue as affecting people with mental health needs to access onward activities. 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. (T&L1).*

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 disorganised. (T&L1).*

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. (T&L4).*

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 mental health 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 am referred people with mental health needs. (T&L1).*

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. (T&L1).*

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. (T&L3)*

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

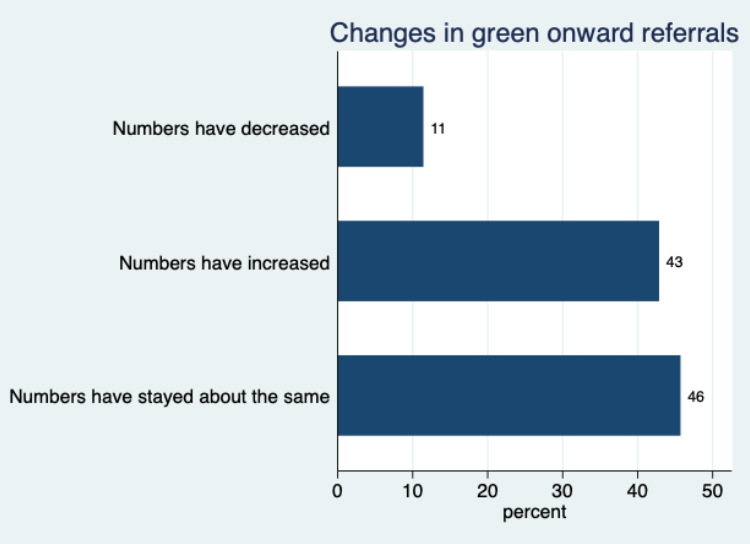
> *…the fear that they will commit suicide and that it will be somehow my fault. That I will not get to them in time to make a difference. That I will have to close their case before any of the agencies that I have referred them to will have had a chance to pick them up. (T&L6)*

Green Social Prescribing Elements

Our follow-up respondents **reported a similar breakdown as the baseline questionnaire** of green social prescribing referrals as a proportion of all onward referrals – just under half reporting that less than a quarter of people received an onward green referral (n=18, 47%). Only six (16%) of our respondents reported that over-half, or most, of their onward referrals were to green activities. This indicates that as a proportion of onward referrals, there has not been an increase in the proportion of clients that link workers on to nature-based activities.

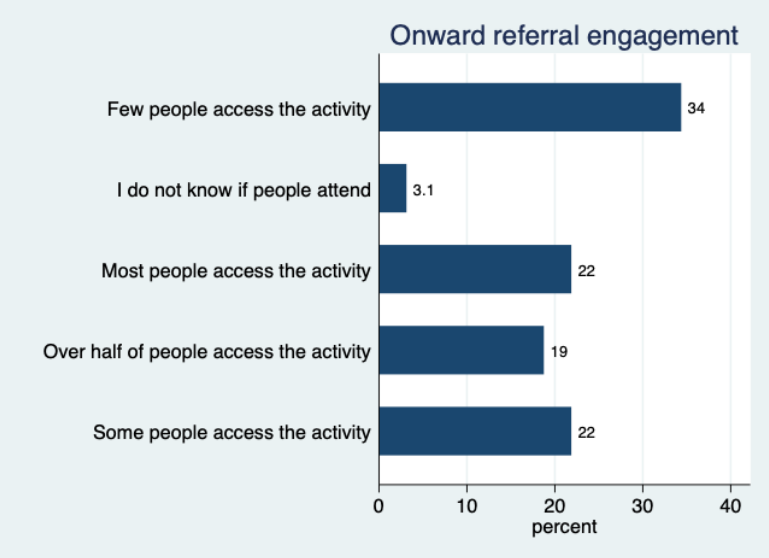
We asked specifically if the number of referrals to green activities had changed over the 12 months since the first survey. Almost half of respondents reported no change **(n=16). Where there had been a change, however, it was mostly an increase** (n=15) rather than a decrease (n=4). This reflects the finding from the nature-based providers, that GSP has not necessarily led to increased referrals from Link Workers to nature-based activities but rather that GSP has enabled improved access to nature-based activities through expanding capacity and enabling referral routes through self-referral and networks with VCSE partners.

Figure A1.38: Where a change in onwards green referrals



Given we are interested in the function of the pathway at each stage – where people move between components, from a referrer to Link Worker and then onwards to activities – we also asked how that onward referral appeared from the perspective of Link Workers (i.e., what proportion of those onward green referrals did they think then actually accessed the activity). Generally 41% of Link Workers felt that over half of people accused activities that they were referred to. However, a third of Link Workers (n=11, 34%), reported that only a few people (less than a quarter) actually accessed the activities that were suggested. This highlights that some Link Workers faced challenges in supporting people to access onward referral opportunities. Further learning is needed at this part of the referral pathway especially in terms of sharing good practice of facilitating onward engagement given the different experiences of Link Workers.

Figure A1.39: Whether people engaged in the onward referral



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

Many factors that act as barriers to a GSP referral for people with mental health issues were mentioned by the Link Workers. These related to the lack of local options to refer people to. A perception that providers of the activities were not necessarily equipped

to deal with people with more severe mental health needs: *"Ensuring a voluntary led community group and members are equipped to support the person with mental health needs appropriately without this becoming more of a support role than a volunteer role"* (T&L5). Another noted that there is: *"Some worry from nature based organisations regarding referring people with mental health conditions - small volunteer led groups"* (T&L2). The inaccessibility of options, relating to factors such as transport and costs was frequently mentioned by Link Workers from all sites: *"nature based activities are usually in the middle of nowhere and hard to get to if you cannot drive"* (T&L2).

The mental health challenges people faced acted as barriers. This includes anxiety around participation: *"Anxiety and inability or unwillingness to leave their homes. Fears creating barriers to stepping out of their comfort zone. Whilst we work with these, it can often take longer than the expected length of time to work with referrals."* (T&L4). Other factors included: worries about safety; Mobility or other physical participation barriers; and uncertainty about what's involved.

"They may be anxious of the unknown, the name 'Forest Bathing' can often give the idea water is involved so a lot of explaining is often necessary." (T&L2). A Lack of equipment to join (e.g., clothing) was mentioned by several Link Worker across the sites: *"Barriers have included the wearing of appropriate/suitable clothing/footwear, the cost of accessing this warm clothing when the weather is harsh."* (T&L6).

The Link Worker also reported that the GSP offer was not necessarily recognised to be potentially of benefit.

> *…lack of understanding/belief of the positive impact that nature-based activity has on health… (T&l2) and*
>
> *Refusal to consider getting out and trying nature-based activities citing no motivation/not for them/ can't afford travel/ too physically impaired. (T&L7).*

They mentioned individuals wanting alternatives such as talking therapies, people's uncertainty about whether nature can help; low motivation to attend; and the short term nature of options makes reduces motivation for commitment: *"Short-term nature of projects makes setting up a new habit unattractive, because people maybe left high and dry afterwards."* (T&L7).

Transport was commonly mentioned as a barrier to supporting people with mental health needs to access nature-based activities. 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 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. For example, people were worried about the lack of facilities like toilets at Green Social Prescribing sites. There were several comments on poor availability of nature-based activity 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. (T&L2)*

Again, anxiety was a primary barrier to people accessing services:

> *People are often not at a stage where they are able to leave their house. (T&L2)*

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. (T&L4)*

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.

Link Workers felt there was a 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.*

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.*

There were some seasonal issues with people less likely to want to take part in outdoor activities in the winter or cold wet weather: *"When I started in May, people were more inclined to get outside and enjoy nature. With it being winter, less people are wanting to go outside/can't get outside due to ill health/frailty. 70%-80% of referrals from the Banstead PCN after over 70 yo."* (T&L2). This was also linked to reduced opportunities: *"In winter I have found there to be little outdoor activities on offer and many of my Service users would prefer to do outdoor activities in spring/ summer time."* (T&L1).

People still had a lot of Covid related poor health and anxiety meaning that they did not always feel able or comfortable accessing group-based activities.

Finally, a key reason was that Link Worker suggested that people often had more urgent needs such as needing debt advice, so referral to agencies that can support these more pressing needs was the priority.

Good practice in referrals for people with mental health needs

Typically, respondents did not provide examples of good practice in supporting people with mental health needs:

> *There is not much of this at the moment. (T&L2)*

Some examples were given including:

- 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.

- 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. (T&L2)

- 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. (T&L6).

- 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. (T&L2)

- Coordination with other services:

  One of the GP practices I work with has 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. (T&L1)

- Feedback on progress of the individual from the nature-based provider.
- Additionality of green social prescribing options:

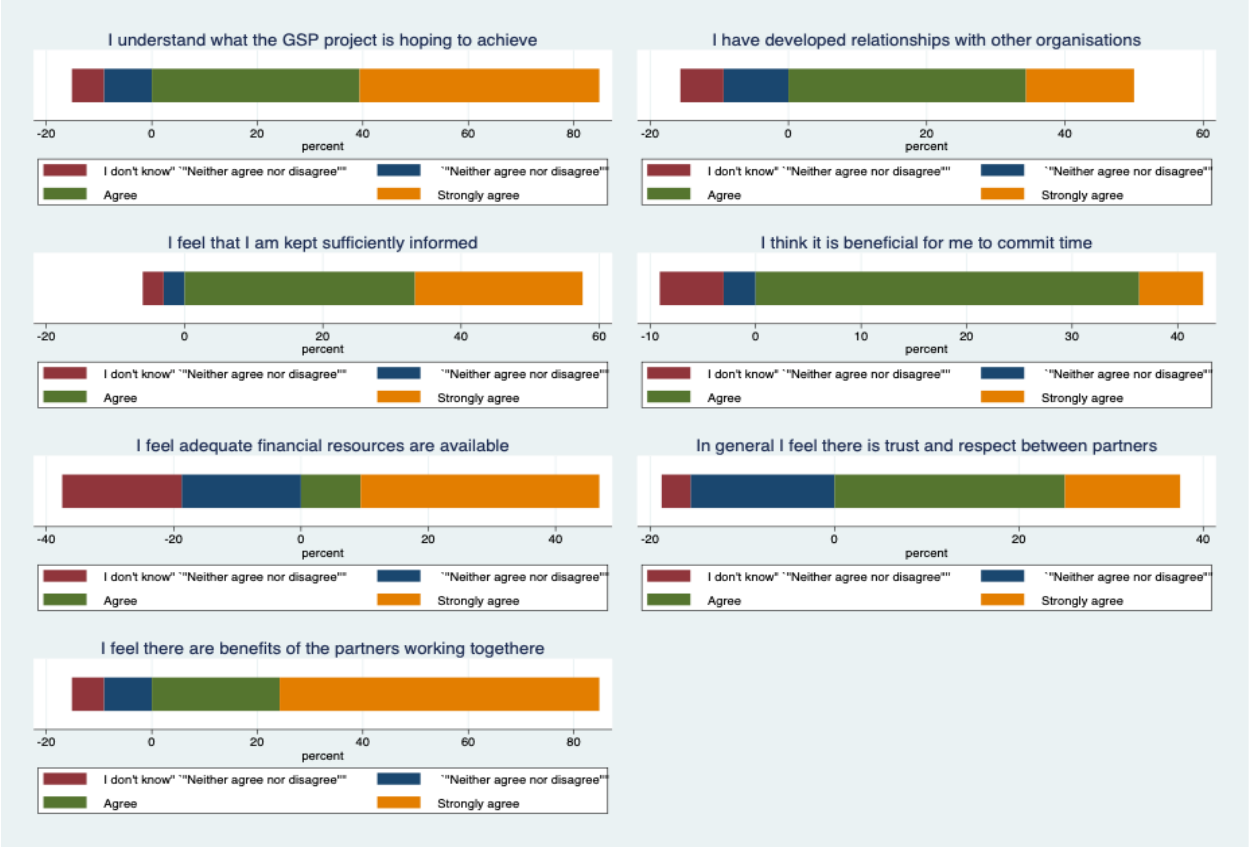
  I closed support for a couple of clients where a referral into the nature-based intervention was "the cherry on the cake" of the support and the client had made significant improvements and felt confident to complete the activity on their own. (T&L2)

Perceptions of GSP

In terms of awareness, **respondents to the follow-up questionnaire were consistent with the results from the first Link Worker survey**; almost half (n=16, 47%) were aware of and actively involved in their local partnership, (n=9) 26% were aware of it and understood the purpose, the remainder were either unaware or unsure of the purpose of the partnership.

Lastly, we included a series of statements relating to the opinions of Link Workers to the overall GSP project.

Figure A1.40: Opinions on GSP



With the caveats that these are responses from different people, and that the sample sizes are small, there are some interesting similarities and differences across the two waves on these statements.

Firstly, compared to the baseline questionnaire, **a greater proportion of respondents strongly agreed that they knew what the GSP programme was hoping to achieve** (23% in wave 1, 45% in wave 2). **A greater proportion of respondents also reported developing relationships through GSP than previously**, with 70% agreeing or strongly agreeing in the follow-up compared to 30% in the baseline.

Again, **almost double the proportion of respondents in the follow-up questionnaire (66% in the follow-up questionnaire compared to 34% in the baseline) either strongly agreed or agreed that they felt sufficiently informed about GSP**. Only 6% (compared to 26% in the baseline) disagreed or strongly disagreed.

A **slightly higher proportion of respondents in the follow-up questionnaire (74%, compared to 62%) reported feeling that it was beneficial to spend time on GSP**. In terms of funding, **slightly more respondents in the follow-up questionnaire (25% compared to 15%) felt there were insufficient funds relating to GSP**.

There was **a slight increase (84% compared to 73%) from baseline to the follow-up questionnaire in the proportion of respondents who felt there were benefits to partners working together in relation to GSP**. Importantly, there was an **increase (68% in the follow-up questionnaire, compared to 42% in the baseline) in the proportion of respondents who strongly agreed or agreed that there was trust amongst partners**.

Training and support needs for Link Workers

Link Workers discussed some of the training needs they had, some training was generic and others were specific to GSP:

- 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. (T&L2).

- 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.

- Wanting information on the evidence base underpinning GSP e.g., its effectiveness so that they can make the case to people they support about the benefits of nature-based activity.
- Information on local nature-based activities 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. (T&L1)

- More information on the Test and Learn programme.
- Training in mental health challenges and treatment options.
- Mental health training.
- Motivational techniques especially in supporting people to overcome barriers they have on addressing improving their health.
- Methods for building trust between clients and Link Workers.
- Improved quality of training on offer.

  The training I have had so far has been terrible.

Gaps in the provision of nature-based activities

The Link Worker identified a number of gaps in local provision. This related to a lack of appropriate offers: *"some great local conservation projects but these do not appeal to all despite being at the weekend (when many people say they are lonesome). Some local estates do some great sessions but these are inaccessible for people with long term complex needs - the people we work with the most. Town in Bloom, woodland bushcraft all there but may be on the wrong day, too far or just too scary or culturally different. Things in local park work better - Park Yoga was fab as is Health Walk. Now we have green gym equipment and ping pong table - looking forward to promoting these in the summer"* (T&L7).

Lack of provision also related to the user group, with a few opportunities for specific groups including younger people, older people, less mobile people, men, and for people with autism or dementia: *"There are a couple of allotment groups which have people of all ages attending but most of the walking groups tend to have older people*

attending. Less younger people (20s) seem to be interested in nature based activities." (T&L7).

The Link Workers also reported an inequity of provision geographically, and in terms of different types of activities, for example, those involving animals, or types which are specifically therapeutic. Finally, there was little provision outside the working week.

What were the greatest benefit to your organisation of the Green Social Prescribing project

A range of benefits were linked to the GSP project. Many Link Workers made positive comments: *"I think Green Social Prescribing is great and I'm glad there are increasing numbers of nature based activities which I can signpost/refer people to. Many people who do attend these activities have found them beneficial with improved mental wellbeing. I will continue to encourage people to attend them, which will be easier now that Spring is nearly here."* (T&L7).

The Link Workers felt that the GSP project had injected energy and momentum into the service. They suggested there was greater interagency awareness and working: *"Greater inter-agency awareness of green social prescribing initiatives. Part of my role involves helping community organisations to apply for funding to run wellbeing sessions, so it has been a really useful way to connect with groups that I have then been able to support."* (T&L7). Link Workers in T&L1 especially but also elsewhere, had greater knowledge of and confidence in options: *"Confidence in knowing the client can remain,10n confident and enjoy being outdoors with support from a volunteer."* (T&L1). A Link Worker from T&L5 commented: *"It has created a stronger connection to other community gardens and strengthened are relationships. We are able to let people know about the garden they can access in their local area. We have been able to support people that may be struggling, provide them with support, knowledge and a space to feel welcome in. It has also enabled us to provide an income to a community garden and offer them support too."* The Link Worker suggested the GSP programme had resulted in better referral routes, more referral options, improved accessibility, and had (potentially) helped some clients with their mental health needs.

Why there had been no benefits from the GSP programme

There were very few responses to the question on why there were no benefits overall. However, the Link Workers who did respond suggested that the GSP had had no or unclear benefits: *"I do not feel there have been any benefits. Patients will not travel to the city centre to access nature. Projects they attend were already in place before the unitive. The walking and photography group at the Learning community was funded through this but I have only had one patient interested in this."* (T&L2). They also felt there were still a lack of options, and that they were unaware of what was being developed and offered.

What changed as a result of the Green Social Prescribing project

The Link Workers suggested that the T&L programme has enhanced motivation for local initiatives: *"We have set up a surgery 'Green Team' to promote recycling/active transport/ green social prescribing to staff for their own wellbeing - this will grow into a longer term cultural change and include more patients eventually I am sure! Start by setting the example and modelling behaviours you want to see?"* (T&L7).

They felt that the programme had resulted in greater local awareness of the benefits of GSP and volunteering, and had enhanced motivation and confidence in system: *"More people in the [locality] now have the opportunity to engage in green social*

prescribing activities than before because there is now more on offer and it is being taken more seriously by NHS staff, providers and users." (T&L2).

A small number of Link Workers ascribed increased delivery to the T&L programme. They suggested that it has supported local grassroots projects and provided another referral route for people with MH difficulties. Further, the T&L programme has facilitated the upskilling of the GSP sector: *"Externally it has enabled the gardens to access training in mental health, create a learning structure with people's needs at the centre whilst also gaining support for their garden."* (T&L5).

Two Link Workers argued that the GSP programme had contributed to patient benefit, and a reduction of demand on statutory MH services: *"Green Social Prescribing supports a reduction on the demand for statutory mental health, health and social care services."* (T&L2).

What activities, context and resources enabled change to happen?

The changes the Link Worker perceived to have happened were linked to the increased resource availability for those running GSP activities. They were also linked to increased awareness, information sharing, team working and networking, and to greater time availability: *"Me having the time to give to project development and going to meet and talk to providers."* (T&L1). A Link Worker in T&L5 suggested that community events had been beneficial: *"Community drop in - enabled us to show people what they could do, indoor activities including seed planting, tree cookies. Word of mouth, encouraging people to talk about what we were doing. Having people who once had joined in actively supported and shared the benefits."*

Aspects of the Green Social Prescribing project that worked well

A Link Worker in T&L2 described the potential of GSP: *"When I work with a client who has tried all other ways to get help either by a GP, medication, mental health teams etc, to be suddenly offered something that is so unexpected, it makes them stop in their tracks. It gives a client something to think about, time out for themselves and purely for themselves, often a time to give their brain a rest from the life they are trying to fit into. So being offered free places and transport takes those hurdles away, takes away reasons people can say 'no'".*

The Link Worker suggested that interagency working had been a particular benefit of the T&L programme: *"…I think multi-agency collaboration and knowledge-sharing has improved in the sphere of 'green' activities as a result, which has been beneficial for organisations and the public."* (T&L7). The programme had also enhanced knowledge of GSP: *"It has opened peoples eyes to the opportunities that Green social prescribing provides. Staff and service users alike."* (T&L1).

What aspects of the Green Social Prescribing project could be improved and why it is important

The Link Workers described a number of ways in which the GSP programme could have been improved. These included more sustained long term GSP projects: *"More focus on long term, local simple projects that can be sustained and attended week after week. Add this in to IAPT timetable as a routine face-to-face local nature option along with a creative option as well as talking option."* (T&L7). More funding for delivery was mentioned by several Link Workers.

The need to improve the accessibility and (geographically) equity of delivery and more funding to address barriers such as transport is also needed.

The Link Workers in a number of sites mentioned the programme would have benefited from more networking opportunities, smaller and more geographically specific subgroups. Involvement of Link Workers and the public was mentioned by several respondents: in relation to Link Workers, one person suggested: *"I think if you want a project to have a better uptake it needs to be located where the link worker is based, maybe involve a link worker from the outset in creating the provision. I have seen great projects that are just in the wrong place, the wrong time of year (people don't want to go out in the cold and damp), unaffordable. Also not knowing they are happening till the last minute at which point it's hard to find participants. Feedback from the projects is always useful, we need to measure the value of the activity."* (T&L6).

Finally, several Link Workers suggested that the programme, and GSP more generally needed to be shouted about more: *"I think it needs to be shouted about more, within the sector people know about it but I feel a lot of GPs might be aware but not actively using the service. Also, it would be good if it was advertised outside of the sector so the everyday person would know about it."* (T&L5).

Perceptions of the Importance of the project

The small number of Link Workers who filled in the question on the importance of the project suggested that it had significant value: *"I think it a really important project. There isn't much support for people struggling with mental health other than going on tablet and going on a huge waiting list for therapy. This is a great way of getting people out of the house, reconnecting to the land and nature."* (T&L5). Another noted that: *"This is a lovely concept that may take time for society to change culture."* (T&L4). This could be addressed, as suggested by a Link Worker at a different site by: *"Make it wider and more integrated into daily life alongside those wonderful special adventurous projects"* (T&L7). Another noted that: *"The GSP test and learn project enabled this [increase in activity around GSP] to happen but only long-term funding from somewhere will allow this to be sustainable"* (T&L6).

A1.6. Individual site summaries

T&L1 Site Summary

Participant Characteristics

Characteristic (N = 224)	N (%)[1]
	Age (Years)
<18	0 (0.0)
18 – 24	24 (10.8)
25 – 34	36 (16.1)
35 – 44	39 (17.5)
45 – 54	52 (23.3)
55 – 64	43 (19.3)
65 – 74	21 (9.4)
75 – 84	3 (1.3)
85+	3 (1.3)
Prefer Not to Say	2 (0.9)
Missing	1
Gender	
Female	131 (58.7)
Male	86 (38.6)
Non-Binary / Third Gender	4 (1.8)
Prefer Not to Say	2 (0.9)
Missing	1
Ethnicity	
Asian or Asian British	1 (0.5)
Black, Black British, Caribbean, or African	0 (0.0)
Mixed or Multiple Ethnic Groups	5 (2.3)
Other Ethnic Group	1 (0.5)
White	213 (96.8)
Missing	4

[1] Missing values are excluded from calculation of percentages

Deprivation

Characteristic (N = 224)	N (%)1
IMD Decile	
1 (Most Deprived)	70 (34.8)
2	21 (10.4)
3	23 (11.4)
4	18 (9.0)
5	12 (6.0)
6	6 (3.0)
7	20 (10.0)
8	10 (5.0)
9	16 (8.0)
10 (Least Deprived)	5 (2.5)
Missing	23

Education and Employment

Characteristic (N = 224)	N (%)[1]
Education	
None	25 (11.3)
GCSE/O-Level or Equivalent	62 (27.9)
A/AS Level or Equivalent	27 (12.2)
Diploma / Foundation Degree or Other Level 5 Qualification	50 (22.5)
Undergraduate Degree with Honours	24 (10.8)
A Higher Degree (e.g., Masters or PhD)	8 (3.6)
Other	9 (4.1)
Prefer Not to Say	17 (7.7)
Missing	2
Employment	
Full-time-paid work (30 hours or more each week)	32 (14.4)
Part-time paid work (under 30 hours each week)	31 (14.0)
In education or training	2 (0.9)
Unemployed	36 (16.2)
Voluntary Work	13 (5.9)
Unable to work because of long-term disability or ill health	63 (28.4)
Retired from paid work	33 (14.9)
Looking after the family or home	7 (3.2)
Other	5 (2.3)
Missing	2

Activities of Daily Life

Characteristic (N = 224)	N (%)[1]
Activities of Daily Life	
Yes – limited substantially	47 (21.1)
Yes – but not limited substantially	132 (59.2)
No	44 (19.7)
Missing	1

Health Conditions

Characteristic (N = 224)	N (%)
Health Condition	
A physical impairment such as difficulty using your arms or mobility difficulties which require you to use a wheelchair or other mobility aid	21 (9.4)
A sensory impairment such as blindness or deafness	8 (3.6)
A mental health condition such as depression or anxiety	165 (73.7)
A learning difficulty/disability or cognitive impairment such as Down's syndrome	17 (7.6)
Dyslexia or an autistic spectrum disorder	38 (17.0)
A long-term health conditions such as HIV, cancer, heart/respiratory condition	19 (8.5)
Any other long-term illness or health condition that has lasted, or is expected to last, at least 12 months	46 (20.5)
Any Health condition (one or more of the above)	179 (79.9)

Reason Referred to SP Service

Characteristic (N = 224)	N (%)[1]
Reason	
Mental Health Condition	163 (74.4)
Physical Health Condition	5 (2.3)
Both Mental and Physical Health Conditions	32 (14.6)
Other[2]	19 (8.7)
Missing	5

[2] Other reasons: Bereavement, Brain Injury, Health and Wellbeing, Joined a Walking Group, Learning New Things, Loss of Confidence, Retired and can't afford courses requiring a fee, social interaction/connection/new to area, social isolation/loneliness

Referral Pathway

Characteristic (N = 224)	N (%)[1]
Pathway	
GP	18 (8.2)
HEY MIND	36 (16.4)
Local Authority Services	3 (1.4)
Mental Health Service	50 (22.8)
Other	9 (4.1)
Other Primary Care Service	5 (2.3)
Secondary Care Services	1 (0.5)
Self-Referral	67 (30.6)
Voluntary or Community Group	30 (13.7)
Missing	5

[2] Other pathways: Age UK, Carers, Citizens Advice, Job Centre, Positive Progression Employment Support, Retreat, SDAVS

Green Activity

Note that the participants may be doing more than one activity.

Activity (N = 224)	N (%)
Bushcraft (e.g. forage, tool making, fire craft)	17 (7.6)
Conservation	4 (1.8)
Crafting	7 (3.1)
Food Growing	1 (0.4)
Gardening	69 (30.8)
Green Exercise	40 (17.9)
Other	34 (15.2)
Yoga or Other Mind-Body Activity	5 (2.2)

Frequency of GSP

Characteristic (N = 224)	N (%)[1]
Frequency	
More than once a week	4 (2.3)
Weekly	135 (78.0)
Every fortnight	3 (1.7)
Every Month	2 (1.2)
Other	29 (16.8)
Missing	51

Duration of GSP

Characteristic (N = 224)	N (%)[1]
Duration	
1 to 4 weeks	56 (32.4)
5 to 8 weeks	63 (36.4)
9 to 12 weeks	54 (31.2)
Missing	51

ONS-4 Summary Statistics (Happiness and Anxiety)

	Pre (n = 224)			Post (n = 224)		
	N (%)	**Mean (SD)**	**Median (IQR)**	**N (%)**	**Mean (SD)**	**Median (IQR)**
ONS-4 Happiness[1]		**5.1 (2.6)**	**5.0 (3.0 – 7.0)**		**6.7 (2.3)**	**7.0 (6.0 – 8.0)**
0 (not at all)	10 (4.6)			2 (1.2)		
1	9 (4.1)			2 (1.2)		
2	24 (11.0)			8 (4.7)		
3	17 (7.8)			8 (4.7)		
4	23 (10.6)			11 (6.4)		
5	49 (22.5)			9 (5.2)		
6	25 (11.5)			23 (13.4)		
7	19 (8.7)			37 (21.5)		
8	18 (8.3)			35 (20.3)		
9	10 (4.6)			24 (14.0)		
10 (completely)	14 (6.4)			13 (7.6)		
Missing	6			52		
ONS-4 Anxiety[2]		**5.3 (2.7)**	**6.0 (3.0 – 7.0)**		**4.1 (2.6)**	**4.0 (2.0 – 6.0)**
0 (not at all)	15 (6.9)			20 (11.6)		
1	10 (4.6)			15 (8.7)		
2	13 (6.0)			17 (9.9)		
3	23 (10.6)			21 (12.2)		
4	18 (8.3)			19 (11.0)		
5	29 (13.3)			26 (15.1)		
6	27 (12.4)			18 (10.5)		

7	30 (13.8)			20 (11.6)		
8	36 (16.5)			11 (6.4)		
9	7 (3.2)			4 (2.3)		
10 (completely)	10 (4.6)			1 (0.6)		
Missing	6			52		

[1] Overall, how happy did you feel yesterday?

[2] Overall, how anxious did you feel yesterday?

ONS-4 Summary Statistics (Life Satisfaction and Worthwhile)

	Pre (n = 224)			Post (n = 224)		
	N (%)	**Mean (SD)**	**Median (IQR)**	**N (%)**	**Mean (SD)**	**Median (IQR)**
Life Satisfaction[1]		**5.1 (2.3)**	**5.0 (3.0 – 7.0)**		**6.7 (1.9)**	**7.0 (5.0 – 8.0)**
0 (not at all)	7 (3.2)			0 (0.0)		
1	8 (3.7)			1(0.6)		
2	17 (7.8)			3 (1.7)		
3	23 (10.6)			7 (4.1)		
4	24 (11.0)			12 (7.0)		
5	45 (20.6)			21 (12.2)		
6	36 (16.5)			27 (15.7)		
7	28 (12.8)			40 (23.3)		
8	16 (7.3)			33 (19.2)		
9	9 (4.1)			19 (11.0)		
10 (completely)	5 (2.3)			9 (5.2)		
Missing	6			52		
ONS-4 Worthwhile[2]		**5.3 (2.4)**	**5.0 (3.0 – 7.0)**		**6.8 (2.0)**	**7.0 (5.0 – 8.0)**
0 (not at all)	6 (2.8)			0 (0.0)		
1	3 (1.4)			1 (0.6)		
2	19 (8.7)			2 (1.2)		
3	30 (13.8)			6 (3.5)		
4	20 (9.2)			16 (9.3)		
5	36 (16.5)			19 (11.0)		

6	31 (14.2)			24 (14.0)		
7	32 (14.7)			32 (18.6)		
8	21 (9.6)			36 (20.9)		
9	9 (4.1)			22 (12.8)		
10 (completely)	11 (5.0)			14 (8.1)		
Missing	6			52		

[1] Overall, how satisfied are you with your life nowadays?

[2] Overall, to what extent do you feel that things you do in your life are worthwhile?

ONS-4 Score (Change)

		Pre		Post		Mean Change	95% CI	P-Value[1]
	N	Mean	SD	Mean	SD			
Life Satisfaction	171	5.1	2.3	6.7	1.9	1.6	1.2 to 1.9	<0.001
Worthwhile	171	5.4	2.4	6.8	2.0	1.5	1.1 to 1.8	<0.001
Happiness	171	5.2	2.6	6.7	2.3	1.6	1.1 to 2.0	<0.001
Anxiety	171	5.3	2.8	4.1	2.6	-1.3	-1.8 to -0.8	<0.001

[1]Paired samples t-test

Overall, 69.6% (119/171) had an increase in life satisfaction score, 64.9% (111/171) had an increase in worthwhile score, 64.3% (110/171) had an increase in happiness score, and 60.8% (104/171) had a decrease in anxiety score.

For life satisfaction, worthwhile and happiness an increase is defined as post > pre. For anxiety a decrease is defined as post < pre.

ONS-4 Worthwhile

Category	Pre (n = 224)	Post (n = 224)
Low	78 (35.8)	25 (14.5)
Medium	67 (30.7)	43 (25.0)
High	53 (24.3)	68 (39.5)
Very High	20 (9.2)	36 (20.9)
Missing	6	52

		After Activity				
		Low	**Medium**	**High**	**Very High**	**Total**
Before Activity	**Low**	17	24	17	5	63 (36.8)
	Medium	6	13	20	11	50 (29.2)
	High	1	4	24	12	41 (24.0)
	Very High	1	2	6	8	17 (9.9)
	Total	25 (14.6)	43 (25.1)	67 (39.2)	36 (21.1)	171 (100.0)

The analysis excluding participants with missing data shows that 36.8% (63/171) had a low worthwhile score before the green activity and this reduced to 14.6% (25/171) after the activity. McNemar's test comparing the paired data shows a statistically significant change (P<0.001).

ONS-4 Happiness

Category	**Pre (n = 224)**	**Post (n = 224)**
Low	83 (38.1)	31 (18.0)
Medium	74 (33.9)	32 (18.6)
High	37 (17.0)	72 (41.9)
Very High	24 (11.0)	37 (21.5)
Missing	6	52

		After Activity				
		Low	**Medium**	**High**	**Very High**	**Total**
Before Activity	Low	18	14	25	9	66 (38.6)
	Medium	6	9	24	14	53 (31.0)
	High	4	7	14	8	33 (19.3)
	Very High	3	2	8	6	19 (11.1)
	Total	31 (18.1)	32 (18.7)	71 (41.5)	37 (21.6)	171 (100.0)

The analysis excluding participants with missing data shows that 38.6% (66/171) had low happiness before the green activity and this reduced to 18.1% (31/171) after the activity. McNemar's test comparing the paired data shows a statistically significant change (P<0.001).

ONS-4 Anxiety

Category	Pre (n = 224)	Post (n = 224)
Very Low	25 (11.5)	35 (20.3)
Low	36 (16.5)	38 (22.1)
Medium	47 (21.6)	45 (26.2)
High	110 (50.5)	54 (31.4)
Missing	6	52

Values are N (%)

		After Activity				
		Very Low	Low	Medium	High	Total
Before Activity	**Very Low**	7	4	2	7	20 (11.7)
	Low	5	9	5	4	23 (13.5)
	Medium	10	8	12	9	39 (22.8)
	High	13	17	25	34	89 (52.0)
	Total	35 (20.5)	38 (22.2)	44 (25.7)	54 (31.6)	171 (100.0)

The analysis excluding participants with missing data shows that 52.0% (89/171) had high anxiety and this reduced to 31.6% (54/171) after the activity. McNemar's test comparing the paired data shows a statistically significant change (P=0.001).

ONS-4 Life Satisfaction

Category	Pre (n = 224)	Post (n = 224)
Low	79 (36.2)	23 (13.4)
Medium	81 (37.2)	48 (27.9)
High	44 (20.2)	73 (42.4)
Very High	14 (6.4)	28 (16.3)
Missing	6	52

		After Activity				
		Low	**Medium**	**High**	**Very High**	**Total**
Before Activity	**Low**	12	24	17	7	60 (35.1)
	Medium	9	19	31	8	67 (39.2)
	High	1	5	14	10	30 (17.5)
	Very High	1	0	10	3	14 (8.2)
	Total	23 (13.5)	48 (28.1)	72 (42.1)	28 (16.4)	171 (100.0)

The analysis excluding participants with missing data shows that 35.1% (60/171) had low life satisfaction before the green activity and this reduced to 13.5% (23/171) after the activity. McNemar's test comparing the paired data shows a statistically significant change (P<0.001).

HADS Score (Change)

		Pre		Post		Mean Change	95% CI	P-Value[1]
	N	**Mean**	**SD**	**Mean**	**SD**			
Anxiety	171	11.1	4.7	8.5	4.0	-2.6	-3.4 to -1.9	<0.001
Depression	171	8.1	4.5	5.6	4.4	-2.5	-3.3 to -1.8	<0.001

T&L2 Site Summary

Participant Characteristics

Characteristic (N = 883)	N (%)[1]
Age (Years)	
< 18	122 (14.7)
18 – 24	91 (11.0)
25 – 29	45 (5.4)
30 – 34	60 (7.2)
35 – 39	52 (6.3)
40 – 44	62 (7.5)
45 – 49	65 (7.8)
50 – 54	54 (6.5)
55 – 59	57 (6.9)
60 – 64	66 (8.0)
65 – 69	43 (5.2)
70 – 74	37 (4.5)
75 – 79	45 (5.4)
80 – 84	23 (2.8)
≥ 85	7 (0.8)
Missing	54
Gender	
Female	522 (60.7)
Male	314 (36.5)
Other	24 (2.8)
Missing	23
Ethnicity	
Asian or Asian British	81 (10.8)
Black, Black British, Caribbean or African	56 (7.5)
Mixed or Multiple Ethnic Groups	7 (0.9)
Other Ethnic Group	19 (2.5)
White	588 (78.3)
Missing	132

Deprivation

Characteristic (N = 883)	N (%)[1]
IMD Decile	
1 (Most Deprived)	205 (35.0)
2	113 (19.3)
3	77 (13.1)
4	29 (4.9)
5	33 (5.6)
6	45 (7.7)
7	29 (4.9)
8	21 (3.6)
9	19 (3.2)
10 (Least Deprived)	15 (2.6)
Missing	297

[1] Missing values are excluded from calculation of percentages

Mental Health Needs

Characteristic (N = 833)	N (%)[1]
User has mental health needs which infringe on daily life	
No mental health needs	109 (14.7)
Early/pre-determinants of mental health needs	306 (41.3)
Moderate mental health needs	237 (32.0)
Severe mental health needs	89 (12.0)
Missing	142
Mental Health Needs	
Yes	632 (85.3)
No	109 (14.7)
Missing	142

[1] Missing values are excluded from calculation of percentages

Referrals

Characteristic (N = 883)	N (%)[1]
Source of Referral	
Community Mental Health Team	17 (2.0)
Friends or Family	60 (6.9)
GP	14 (1.6)
Local Authority	35 (4.0)
Other NHS Service	15 (1.7)
Other Primary Care Professional	6 (0.7)
Primacy Care based Link Worker/Social Prescriber	67 (7.7)
Private Sector Referral	72 (8.3)
Referral from another part of the organisation	141 (16.2)
Self-Referral	198 (22.8)
Voluntary, Community or Social Enterprise Organisation	77 (8.9)
Voluntary/Community/Social Enterprise Based Link Worker/Social Prescriber	166 (19.1)
Missing	15
Referral Appropriate	
Yes	825 (99.2)
No	7 (0.8)
Missing	51

Service User Received Support

Characteristic (N = 883)	N (%)[1]
Service User Received Support	
Yes	613 (74.5)
Awaiting Support	23 (2.8)
No	187 (22.7)
Missing	60

[1] Missing values are excluded from calculation of percentages

Number of Sessions Attended

Characteristic (N = 883)	N (%)[1]
Number of Sessions Attended	
1	247 (37.0)
2 – 5	214 (32.1)
6 – 10	142 (21.3)
11 – 15	30 (4.5)
16 – 20	19 (2.8)
Over 20	15 (2.2)
Missing	216

[1] Missing values are excluded from calculation of percentages

Destination Following Support

Characteristic (N = 883)	N (%)[1]
Destination Following Support	
Accessed further activities within organisation	106 (17.8)
Continuing to attend the activity	237 (39.8)
Dropped-out of the activity before completing planned support	33 (5.5)
Finished in the organisation and referred to other organisations	30 (5.0)
Finished in the organisation with no onward referral	90 (15.1)
Unknown	100 (16.8)
Missing	287

[1] Missing values are excluded from calculation of percentages

Time Variables

	N	Mean (SD)	Median (IQR)	Range
Time from referral to support (weeks)	519	2.4 (5.7)	0.6 (0.0 – 2.3)	0.0 – 57.7
Length of support (weeks)	246	3.7 (6.2)	2.0 (0.0 – 3.4)	0.0 – 29.0

Green Activity

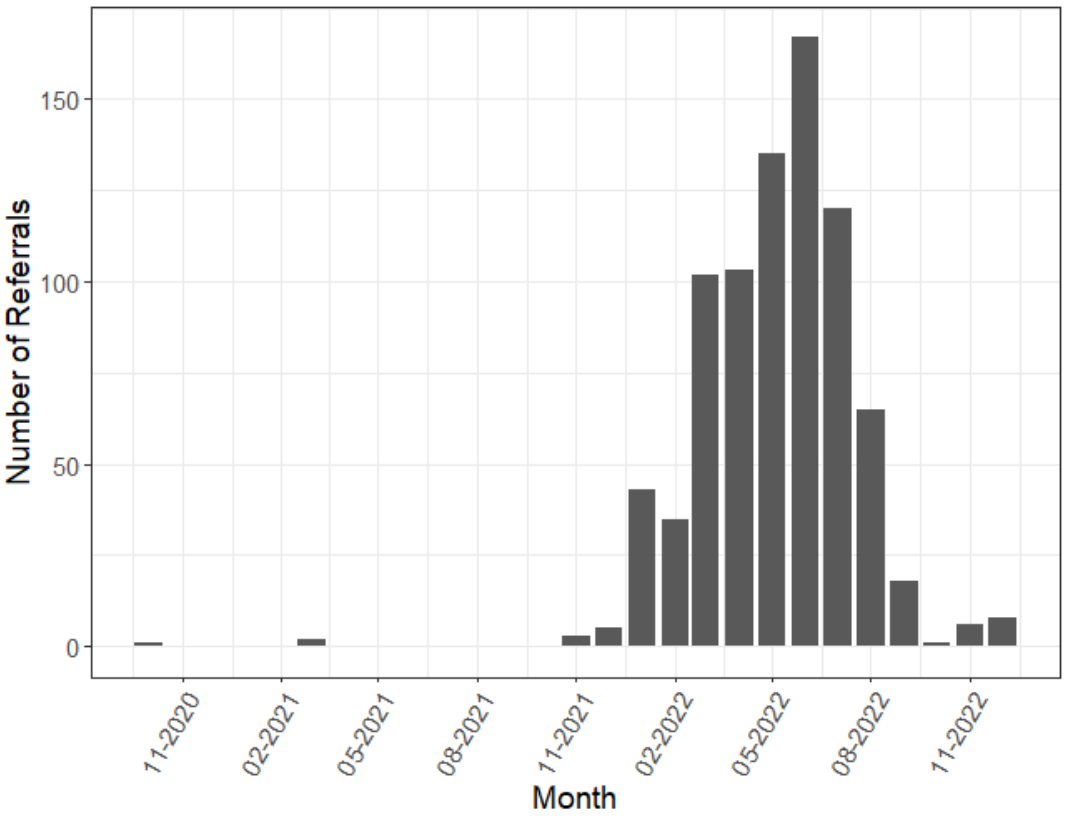
Note that the participants may be doing more than one activity.

Activity (N = 883)	N (%)
Alternative Therapies	188 (21.3)
Care Farming	8 (0.9)
Conservation Focused	23 (2.6)
Craft Focused	100 (11.3)
Exercise	207 (23.4)
Horticultural	157 (17.8)
Nature Based Arts and Crafts	82 (9.3)
Nature Connection	302 (34.2)
Other	46 (5.2)
Photo Walk	39 (4.4)
Sport	31 (3.5)
Talking Therapies	11 (1.2)
Wilderness Focused	72 (8.2)

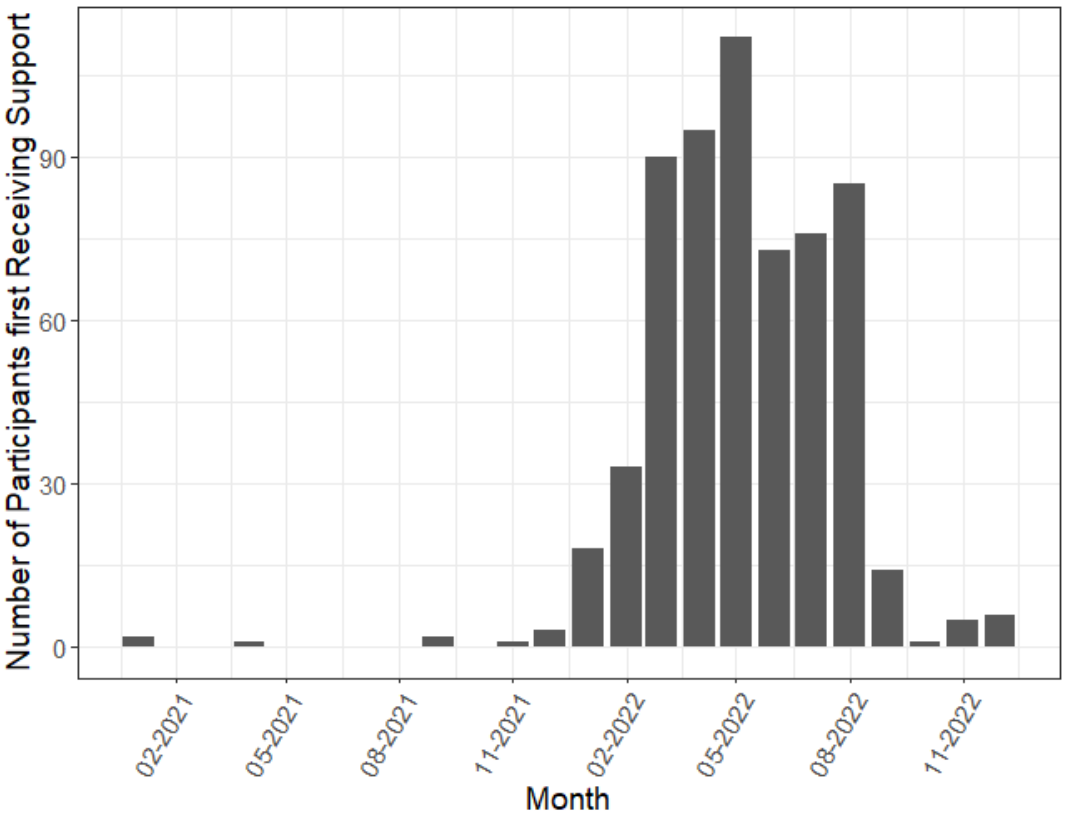
Activity; N (%)	Gender		
	Female (N = 522)	Male (N = 314)	Other (N = 24)
Alternative Therapies	123 (23.6)	53 (16.9)	9 (37.5)
Care Farming	2 (0.4)	5 (1.6)	1 (4.2)
Conservation Focused	16 (3.1)	7 (2.2)	0 (0.0)
Craft Focused	67 (12.8)	24 (7.6)	3 (12.5)
Exercise	124 (23.8)	68 (21.7)	12 (50.0)
Horticultural	87 (16.7)	59 (18.8)	11 (45.8)
Nature Based Arts and Crafts	53 (10.2)	28 (8.9)	0 (0.0)
Nature Connection	206 (39.5)	92 (29.3)	3 (12.5)
Other	20 (3.8)	25 (8.0)	1 (4.2)
Photo Walk	21 (4.0)	18 (5.7)	0 (0.0)
Sport	14 (2.7)	16 (5.1)	1 (4.2)
Talking Therapies	5 (1.0)	6 (1.9)	0 (0.0)
Wilderness Focused	17 (3.3)	54 (17.2)	1 (4.2)

Note that photo walk is 0 for both groups because mental health needs status is missing.

Number of referrals by month



Month Support Started



ONS-4 Summary Statistics (Happiness and Anxiety)

	Pre (n = 863)			Post (n = 863)		
	N (%)	**Mean (SD)**	**Median (IQR)**	**N (%)**	**Mean (SD)**	**Median (IQR)**
ONS-4 Happiness[1]		**5.4 (2.4)**	**5.0 (4.0 – 7.0)**		**7.1 (2.2)**	**7.0 (6.0 – 9.0)**
0 (not at all)	0 (0.0)			0 (0.0)		
1	7 (5.5)			1 (1.6)		
2	8 (6.3)			2 (3.3)		
3	16 (12.6)			1 (1.6)		
4	12 (9.4)			2 (3.3)		
5	28 (22.0)			5 (8.2)		
6	13 (10.2)			11 (18.0)		
7	18 (14.2)			14 (23.0)		
8	9 (7.1)			7 (11.5)		
9	7 (5.5)			7 (11.5)		
10 (completely)	9 (7.1)			11 (18.0)		
Missing	736			802		
ONS-4 Anxiety		**5.5 (2.7)**	**6.0 (4.0 – 7.0)**		**5.1 (2.6)**	**5.0 (3.0 – 7.0)**
0 (not at all)	1 (0.7)			1 (1.3)		
1	17 (11.6)			8 (10.0)		
2	8 (5.5)			7 (8.8)		
3	9 (6.2)			10 (12.5)		
4	11 (7.5)			5 (6.3)		
5	25 (17.1)			14 (17.5)		
6	17 (11.6)			9 (11.3)		
7	25 (17.1)			14 (17.5)		
8	15 (10.3)			3 (3.8)		
9	5 (3.4)			3 (3.8)		
10 (completely)	13 (8.9)			6 (7.5)		
Missing	717			783		

[1] Overall, how happy did you feel yesterday?

[2] Overall, how anxious did you feel yesterday?

ONS-4 Summary Statistics (Life Satisfaction and Worthwhile)

	Pre (n = 863)			Post (n = 863)		
	N (%)	**Mean (SD)**	**Median (IQR)**	**N (%)**	**Mean (SD)**	**Median (IQR)**
Life Satisfaction[1]		**5.3 (2.4)**	**5.0 (3.0 – 7.0)**		**6.9 (1.8)**	**7.0 (5.5 – 8.0)**
0 (not at all)	0 (0.0)			0 (0.0)		
1	5 (3.9)			0 (0.0)		
2	6 (4.7)			0 (0.0)		
3	22 (17.3)			1 (1.6)		
4	13 (10.2)			4 (6.6)		
5	29 (22.8)			10 (16.4)		
6	16 (12.6)			13 (21.3)		
7	9 (7.1)			11 (18.0)		
8	14 (11.0)			11 (18.0)		
9	3 (2.4)			4 (6.6)		
10 (completely)	10 (7.9)			7 (11.5)		
Missing	736			802		
ONS-4 Worthwhile[2]		**5.7 (2.2)**	**6.0 (4.0 – 7.0)**		**6.9 (2.0)**	**7.0 (6.0 – 8.0)**
0 (not at all)	0 (0.0)			0 (0.0)		
1	5 (3.9)			0 (0.0)		
2	5 (3.9)			2 (3.3)		
3	8 (6.3)			2 (3.3)		
4	17 (13.4)			5 (8.2)		
5	26 (20.5)			3 (4.9)		
6	23 (18.1)			12 (19.7)		
7	18 (14.2)			13 (21.3)		
8	10 (7.9)			10 (16.4)		
9	8 (6.3)			7 (11.5)		
10 (completely)	7 (5.5)			7 (11.5)		
Missing	736			802		

[1] Overall, how satisfied are you with your life nowadays?

[2] Overall, to what extent do you feel that things you do in your life are worthwhile?

ONS-4 Score (Change)

		Pre		Post		Mean Change	95% CI	P-Value[1]
	N	Mean	SD	Mean	SD			
Life Satisfaction	60	5.4	2.5	6.8	1.8	1.5	1.1 to 1.9	<0.001
Worthwhile	60	5.5	2.3	6.9	2.0	1.3	0.8 to 1.8	0.001
Happiness	60	5.4	2.5	7.1	2.2	1.7	0.9 to 2.4	0.001
Anxiety	79	5.7	2.8	5.1	2.6	-0.6	-1.3 to 0.1	0.098

[1]Paired samples t-test

Overall, 68.3% (41/60) had an increase in life satisfaction score, 70.0% (42/60) had an increase in worthwhile score, 73.3% (44/60) had an increase in happiness score, and 44.3% (35/79) had a decrease in anxiety score.

For life satisfaction, worthwhile and happiness an increase is defined as post > pre. For anxiety a decrease is defined as post < pre.

ONS-4 Happiness

Category	Pre (n = 883)	Post (n = 883)
Low	43 (33.9)	6 (9.8)
Medium	41 (32.3)	16 (26.2)
High	27 (21.3)	21 (34.4)
Very High	16 (12.6)	18 (29.5)
Missing	736	802

		After Activity				
		Low	Medium	High	Very High	Total
Before Activity	**Low**	3	9	4	4	20 (33.3)
	Medium	2	5	10	5	22 (36.7)
	High	0	0	5	3	8 (13.3)
	Very High	1	2	2	5	10 (16.7)
	Total	6 (10.0)	16 (26.7)	21 (35.0)	17 (28.3)	60 (100.0)

The analysis excluding participants with missing data shows that 33.3% (14/256) had low happiness before the green activity and this reduced to 10.0% (6/60) after the activity. McNemar's test comparing the paired data shows a statistically significant change (P=0.001).

ONS-4 Anxiety

Category	Pre (n = 863)	Post (n = 863)
Very Low	18 (12.3)	9 (11.3)
Low	17 (11.6)	17 (21.3)
Medium	36 (24.7)	19 (23.8)
High	75 (51.4)	35 (43.8)
Missing	717	783

		After Activity				
		Very Low	Low	Medium	High	Total
Before Activity	**Very Low**	4	0	0	5	9 (11.4)
	Low	1	3	4	2	10 (12.7)
	Medium	1	7	6	1	15 (19.0)
	High	2	7	9	27	45 (57.0)
	Total	8 (10.1)	17 (21.5)	19 (24.1)	35 (44.3)	79 (100.0)

The analysis excluding participants with missing data shows that 45.0% (45/79) had high anxiety and this reduced to 44.3% (35/79) after the activity. McNemar's test comparing the paired data shows a statistically significant change (P=0.039).

ONS-4 Life Satisfaction

Category	Pre (n = 863)	Post (n = 863)
Low	46 (36.2)	5 (8.2)
Medium	45 (35.4)	23 (37.7)
High	23 (18.1)	22 (36.1)
Very High	13 (10.2)	11 (18.0)
Missing	736	802

Values are N (%)

Missing values are excluded from calculation of percentages.

		After Activity				
		Low	Medium	High	Very High	Total
Before Activity	**Low**	5	15	3	0	23 (38.3)
	Medium	0	8	11	2	21 (35.0)
	High	0	0	5	4	9 (15.0)
	Very High	0	0	2	5	7 (11.7)
	Total	5 (8.3)	23 (38.3)	21 (35.0)	11 (18.3)	60 (100.0)

The analysis excluding participants with missing data shows that 38.3% (23/60) had low life satisfaction before the green activity and this reduced to 8.3% (5/60) after the activity. No P-value could be calculated.

ONS-4 Worthwhile

Category	Pre (n = 863)	Post (n = 863)
Low	35 (27.6)	9 (14.8)
Medium	49 (38.6)	15 (24.6)
High	28 (22.0)	23 (37.7)
Very High	15 (11.8)	14 (23.0)
Missing	736	802

		After Activity				
		Low	Medium	High	Very High	Total
Before Activity	**Low**	7	7	5	2	21 (35.0)
	Medium	1	7	9	2	19 (31.7)
	High	1	1	8	3	13 (21.7)
	Very High	0	0	1	6	7 (11.7)
	Total	9 (15.0)	15 (25.0)	23 (38.3)	13 (21.7)	60 (100.0)

The analysis excluding participants with missing data shows that 35.0% (21/60) had a low worthwhile score before the green activity and this reduced to 15.0% (9/60) after the activity. McNemar's test comparing the paired data shows a statistically significant change (P=0.005).

Nature Connectedness Index (Pre)

N = 883	N (%)[1]	Mean (SD)	Median (IQR)
Nature Connectedness		**4.9 (1.9)**	**6.0 (3.0 – 6.0)**
1	13 (8.7)		
2	15 (10.0)		
3	14 (9.3)		
4	7 (4.9)		
5	15 (10.0)		
6	62 (41.3)		
7	24 (16.0)		
Missing	733		

[1] Missing values are excluded from calculation of percentages

Nature Connectedness Index (Post)

N = 369	N (%)[1]	Mean (SD)	Median (IQR)
Nature Connectedness		**4.2 (0.9)**	**4.0 (4.0 – 5.0)**
1	0 (0.0)		
2	1 (2.2)		
3	7 (15.2)		
4	26 (56.5)		
5	9 (19.6)		
6	1 (2.2)		
7	2 (4.3)		
Missing	837		

[1] Missing values are excluded from calculation of percentages

Nature Connectedness Index (Change)

		Pre		Post		P-Value[1]
	N	Median	IQR	Median	IQR	
Nature	46	6	5 – 6	4	4 - 5	<0.001

[1]Wilcoxon signed rank test

Caring Status

Characteristic (N = 883)	N (%)[1]
Destination Following Support	
Has a carer	134 (23.6)
Is a carer	38 (6.7)
Does not have a carer / Is not a carer	397 (69.8)
Missing	314

Clinically Vulnerable to COVID

Characteristic (N = 883)	N (%)[1]
Clinically Vulnerable to COVID	
Yes	166 (37.8)
No	273 (62.2)
Missing	444

Reason Not Completed

Characteristic (N = 883)	N (%)[1]
Reason Not Completed	
Attended activity	99 (51.6)
Did not start attending activity	53 (27.6)
Ill health	4 (2.1)
Not able to make activity (e.g. transport, not the right time)	6 (3.1)
Not finding the activity helpful	1 (0.5)
Other	9 (4.7)
Personal commitments	1 (0.5)
Pregnancy	1 (0.5)
Stopped attending because of issues outside the activity (e.g., family commitments)	7 (3.6)
Stopped attending because of mental health issues	6 (3.1)
Stopped attending because of physical health issues	5 (2.6)
Missing	691

T&L 3- Site Summary

Participant Characteristics

Characteristic (N = 117)	N (%)[1]
Age (Years)	
< 18	2 (1.8)
18 – 24	4 (3.6)
25 – 29	10 (9.1)
30 – 34	15 (13.6)
35 – 39	8 (7.3)
40 – 44	9 (8.2)
45 – 49	11 (10.0)
50 – 54	8 (7.3)
55 – 59	7 (6.4)
60 – 64	13 (11.8)
65 – 69	15 (13.6)
70 – 74	4 (3.6)
75 – 79	2 (1.8)
80 – 84	1 (0.9)
≥ 85	1 (0.9)
Missing	7
Gender	
Female	82 (74.5)
Male	25 (22.7)
Non-Binary	1 (0.9)
Prefer Not to Say	2 (1.8)
Missing	7
Ethnicity	
Asian or Asian British	8 (7.3)
Black, Black British, Caribbean or African	7 (6.4)
Mixed or Multiple Ethnic Groups	7 (6.4)
Other Ethnic Group	8 (7.3)
White	79 (72.5)
Missing	8

[1] Missing values are excluded from calculation of percentages

Deprivation

Characteristic (N = 117)	N (%)[1]
IMD Decile	
1 (Most Deprived)	13 (15.1)
2	13 (15.1)
3	11 (12.8)
4	14 (16.3)
5	5 (5.8)
6	8 (9.3)
7	5 (5.8)
8	5 (5.8)
9	3 (3.5)
10 (Least Deprived)	9 (10.5)
Missing	31

Referrals

Characteristic (N = 117)	N (%)[1]
Source of Referral	
Friends or Family	27 (23.3)
GP	3 (2.6)
Local Authority	1 (0.9)
Self-Referral	34 (29.3)
Voluntary, Community or Social Enterprise Organisation	29 (25.0)
Voluntary/Community/Social Enterprise Based Link Worker/Social Prescriber	12 (10.3)
Missing	1

T&L4 Site Summary

Participant Characteristics

Characteristic (N = 99)	N (%)[1]
Age (Years)	
< 18	3 (3.9)
18 – 24	9 (11.8)
25 – 29	4 (5.3)
30 – 34	4 (5.3)
35 – 39	3 (3.9)
40 – 44	8 (10.5)
45 – 49	5 (6.6)
50 – 54	7 (9.2)
55 – 59	14 (18.4)
60 – 64	9 (11.8)
65 – 69	3 (3.9)
70 – 74	3 (3.9)
75 – 79	2 (2.6)
80 – 84	1 (1.3)
≥ 85	1 (1.3)
Missing	23
Gender	
Female	64 (64.6)
Male	35 (35.4)
Missing	0
Ethnicity	
Asian or Asian British	3 (3.8)
Black, Black British, Caribbean or African	0 (0.0)
Mixed or Multiple Ethnic Groups	1 (1.3)
Other Ethnic Group	2 (2.5)
White	73 (92.4)
Missing	20

[1] Missing values are excluded from calculation of percentages

Deprivation

Characteristic (N = 99)	N (%)[1]
IMD Decile	
1 (Most Deprived)	1 (1.5)
2	2 (3.1)
3	5 (7.7)
4	3 (4.6)
5	22 (33.8)
6	8 (12.3)
7	7 (10.8)
8	10 (15.4)
9	5 (7.7
10 (Least Deprived)	2 (3.1)
Missing	34

Mental Health Needs

Characteristic (N = 99)	N (%)[1]
User has mental health needs which infringe on daily life	
No mental health needs	27 (27.6)
Early/pre-determinants of mental health needs	30 (30.6)
Moderate mental health needs	23 (23.5)
Severe mental health needs	18 (18.4)
Missing	1
Mental Health Needs	
Yes	71 (72.4)
No	27 (27.6)
Missing	1

Referrals

Characteristic (N = 99)	N (%)[1]
Source of Referral	
Community Mental Health Team	7 (7.1)
Friends or Family	11 (11.1)
Local Authority	9 (9.1)
Other NHS Service	13 (13.1)
Other Primary Care Professional	3 (3.0)
Primary Care based Link Worker/Social Prescriber	6 (6.1)
Referral from another part of the organisation	5 (5.1)
Self-Referral	31 (31.2)
Voluntary, Community or Social Enterprise Organisation	11 (11.1)
Voluntary/Community/Social Enterprise Based Link Worker/Social Prescriber	3 (3.0)
Missing	0
Referral Appropriate	
Yes	88 (97.8)
No	2 (2.2)
Missing	9

Service User Received Support

Characteristic (N = 99)	N (%)[1]
Service User Received Support	
Yes	60 (82.2)
Awaiting Support	0 (0.0)
No	13 (17.8)
Missing	26

Number of Sessions Attended

Characteristic (N = 99)	N (%)[1]
Number of Sessions Attended	
1	16 (29.6)
2 – 5	19 (35.2)
6 – 10	14 (25.9)
11 – 15	5 (9.3)
16 – 20	0 (0.0)
Over 20	0 (0.0)
Missing	45

Destination Following Support

Characteristic (N = 99)	N (%)[1]
Destination Following Support	
Accessed further activities within organisation	7 (15.2)
Continuing to attend the activity	24 (52.2)
Dropped-out of the activity before completing planned support	8 (17.4)
Finished in the organisation and referred to other organisations	1 (2.2)
Finished in the organisation with no onward referral	6 (13.0)
Missing	53

Time Variables

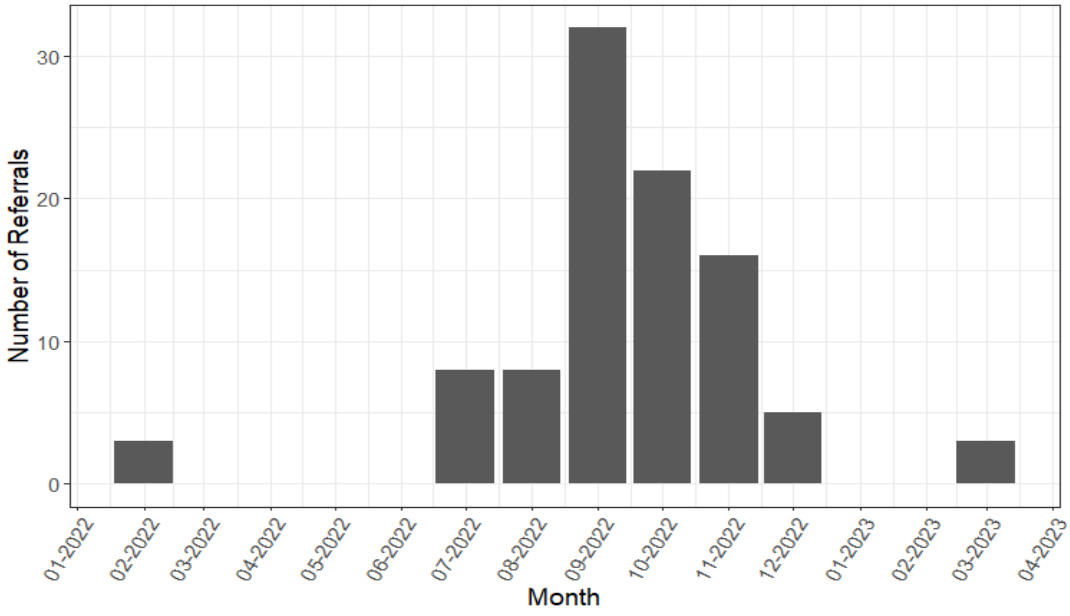
	N	Mean (SD)	Median (IQR)	Range
Time from referral to support (weeks)	25	1.1 (1.2)	0.9 (0.0 – 1.9)	0.0 – 4.1
Length of support (weeks)	3	8.0 (6.0)	11.0 (1.0 – 11.9)	1.0 – 11.9

Green Activity

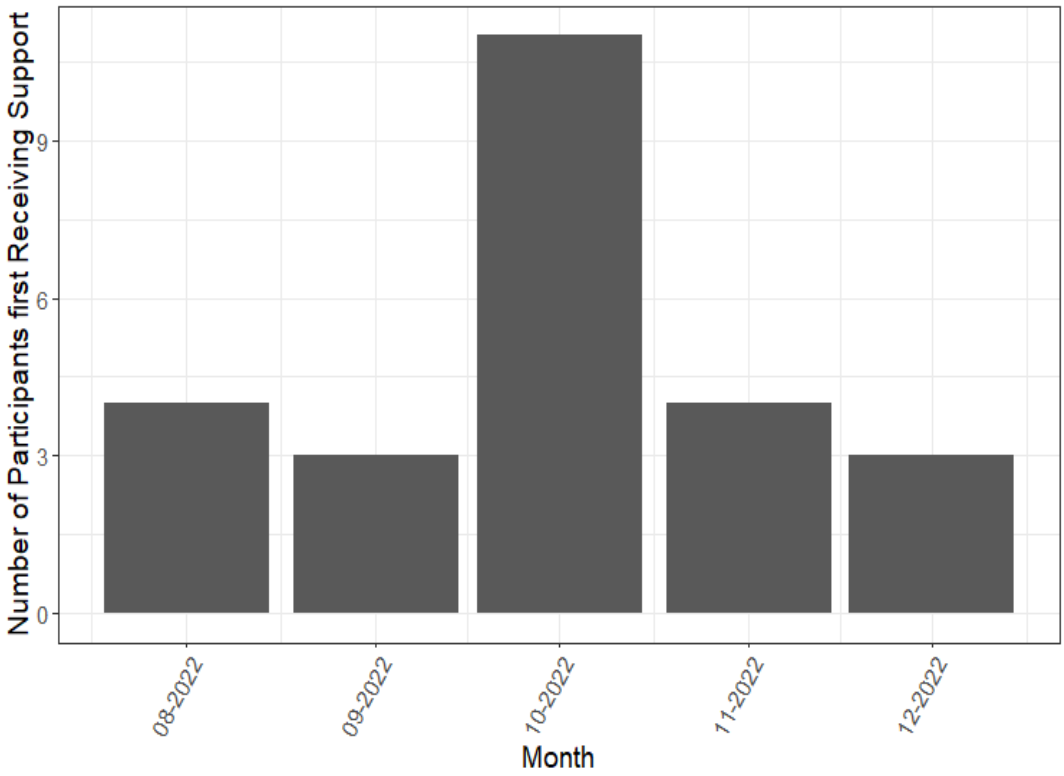
Note that the participants may be doing more than one activity.

Activity (N = 99)	N (%)
Alternative Therapies	16 (16.2)
Craft Focused	42 (42.4)
Horticultural	29 (29.3)
Nature Connection	28 (28.3)

Number of referrals by month



Month Support Started



T&L5 Site Summary

Participant Characteristics

Characteristic (N = 634)	N (%)[1]
Age (Years)	
< 18	6 (1.1)
18 – 24	44 (8.4)
25 – 29	34 (6.5)
30 – 34	34 (6.5)
35 – 39	68 (13.0)
40 – 44	41 (7.8)
45 – 49	48 (9.4)
50 – 54	59 (11.3)
55 – 59	40 (7.6)
60 – 64	49 (9.2)
65 – 69	33 (6.3)
70 – 74	37 (7.1)
75 – 79	14 (2.7)
80 – 84	10 (1.9)
≥ 85	7 (1.3)
Missing	110
Gender	
Female	323 (53.7)
Male	273 (45.3)
Non-Binary	4 (0.7)
Other	2 (0.3)
Missing	32
Ethnicity	
Asian or Asian British	67 (12.8)
Black, Black British, Caribbean or African	22 (4.2)
Mixed or Multiple Ethnic Groups	23 (4.4)
Other Ethnic Group	8 (1.5)
White	402 (77.0)
Missing	112

[1] Missing values are excluded from calculation of percentages

Deprivation

Characteristic (N = 634)	N (%)[1]
IMD Decile	
1 (Most Deprived)	200 (36.9)
2	86 (15.9)
3	98 (18.1)
4	55 (10.1)
5	30 (5.5)
6	15 (2.8)
7	15 (2.8)
8	31 (5.7)
9	8 (1.5)
10 (Least Deprived)	4 (0.7)
Missing	92

Mental Health Needs

Characteristic (N = 634)	N (%)[1]
User has mental health needs which infringe on daily life	
No mental health needs	44 (16.9)
Early/pre-determinants of mental health needs	64 (24.5)
Moderate mental health needs	110 (42.1)
Severe mental health needs	43 (16.5)
Missing	373
Mental Health Needs	
Yes	217 (83.1)
No	44 (16.9)
Missing	373

Referrals

Characteristic (N = 634)	N (%)[1]
Source of Referral	
College	3 (0.5)
Community Mental Health Team	17 (2.8)
Friends or Family	7 (1.1)
GP	6 (1.0)
Local Authority	6 (1.0)
Other NHS Service	56 (9.2)
Other Primary Care Professional	6 (1.0)
Primacy Care based Link Worker/Social Prescriber	206 (33.8)
Private Sector Referral	5 (0.8)
Referral from another part of the organisation	7 (1.1)
Self-Referral	162 (26.6)
Voluntary, Community or Social Enterprise Organisation	73 (12.0)
Voluntary/Community/Social Enterprise Based Link Worker/Social Prescriber	55 (9.0)
Missing	25
Referral Appropriate	
Yes	604 (98.5)
No	9 (1.5)
Missing	21

Service User Received Support

Characteristic (N = 634)	N (%)[1]
Service User Received Support	
Yes	391 (76.7)
Awaiting Support	88 (17.3)
No	31 (6.1)
Missing	124

Number of Sessions Attended

Characteristic (N = 634)	N (%)[1]
Number of Sessions Attended	
1	18 (13.8)
2 – 5	75 (57.7)
6 – 10	30 (23.1)
11 – 15	7 (5.4)
16 – 20	0 (0.0)
Over 20	0 (0.0)
Missing	504

[1] Missing values are excluded from calculation of percentages

Destination Following Support

Characteristic (N = 634)	N (%)[1]
Destination Following Support	
Accessed further activities within organisation	19 (16.8)
Continuing to attend the activity	43 (38.1)
Dropped-out of the activity before completing planned support	11 (9.7)
Finished in the organisation an referred to other organisations	9 (8.0)
Finished in the organisation with no onward referral	12 (10.6)
Unknown	19 (16.8)
Missing	521

Time Variables

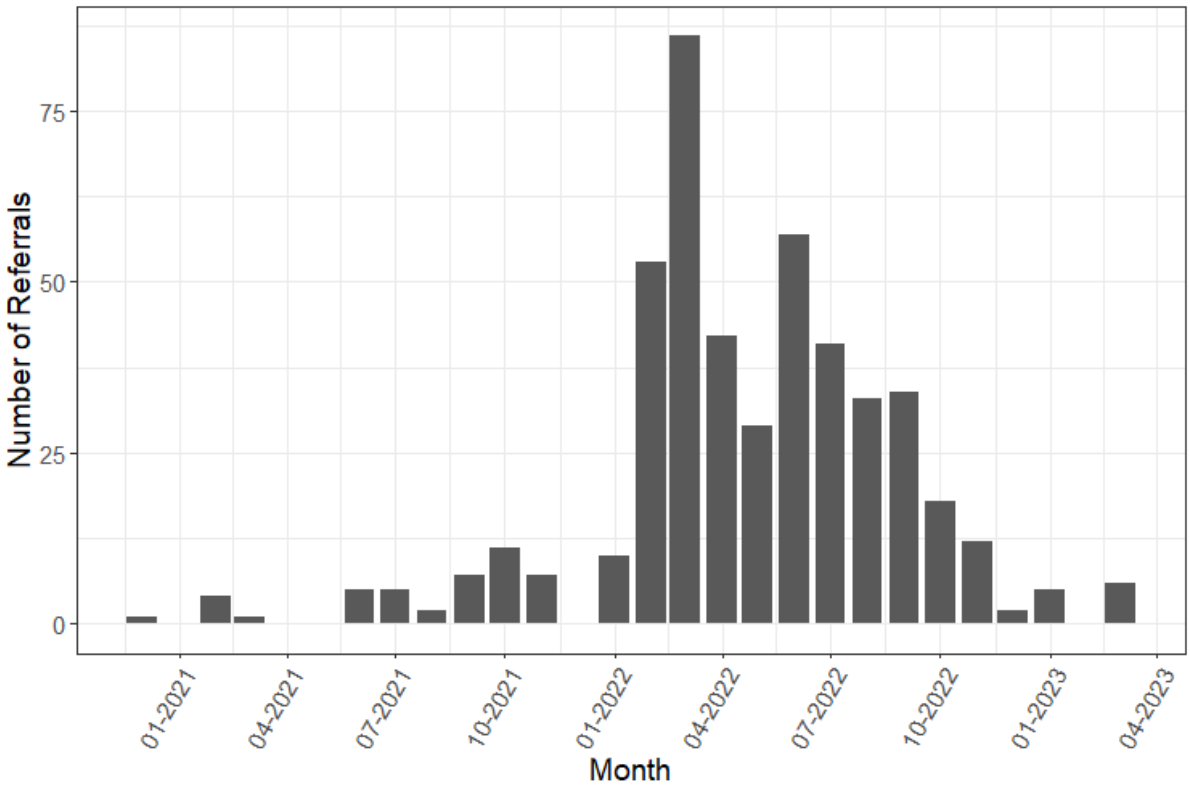
	N	Mean (SD)	Median (IQR)	Range
Time from referral to support (weeks)	150	3.0 (6.7)	0.6 (0.0 – 4.2)	0.0 – 53.7
Length of support (weeks)	67	5.6 (6.9)	4.0 (1.0 – 7.0)	0.0 – 32.1

Green Activity

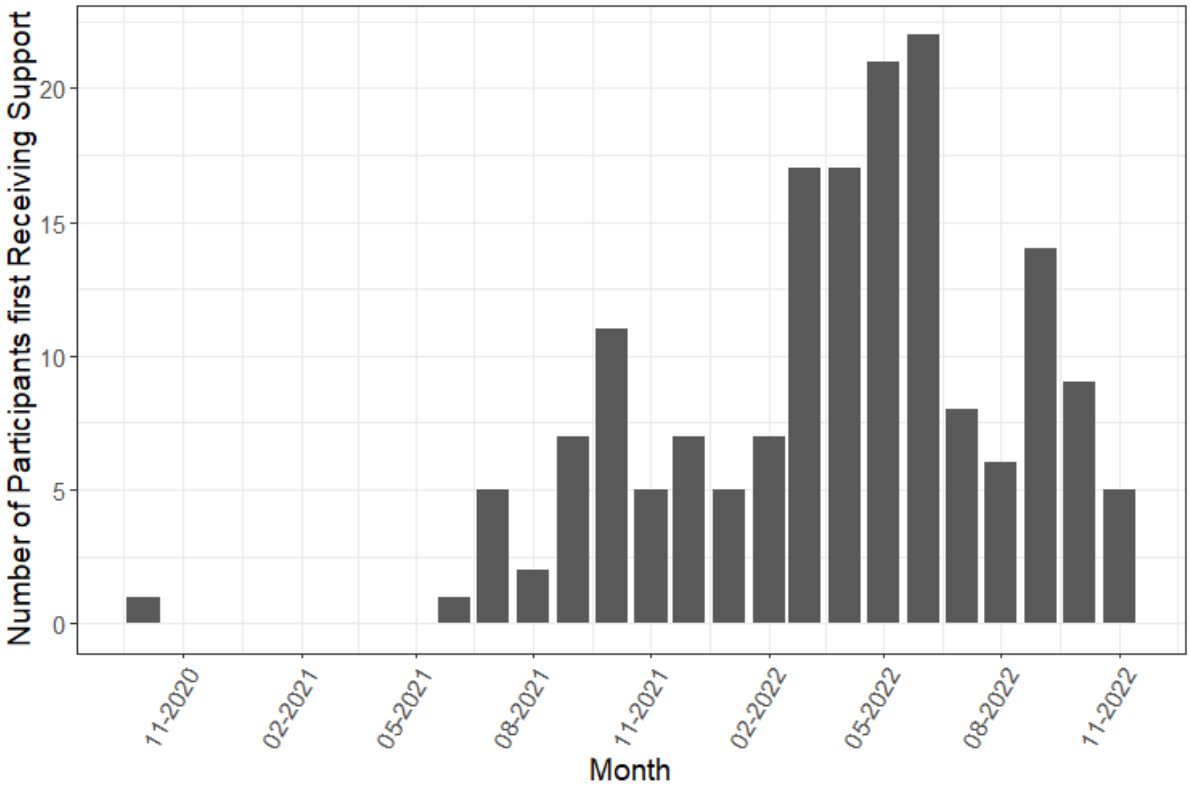
Note that the participants may be doing more than one activity.

Activity (N = 634)	N (%)
Alternative Therapies	10 (1.6)
Conservation Focused	19 (3.0)
Craft Focused	67 (10.6)
Exercise	66 (10.4)
Horticultural	216 (34.1)
Nature Connection	74 (11.7)
Other	16 (2.5)
Sport	8 (1.3)
Wilderness Focused	5 (0.8)

Number of referrals by month



Month Support Started



ONS-4 Summary Statistics (Happiness and Anxiety)

	Pre (n = 634)			Post (n = 634)		
	N (%)	**Mean (SD)**	**Median (IQR)**	**N (%)**	**Mean (SD)**	**Median (IQR)**
ONS-4 Happiness[1]		**5.6 (2.2)**	**5.0 (4.0 – 7.0)**		**6.7 (1.9)**	**7.0 (5.0 – 8.0)**
0 (not at all)	0 (0.0)			0 (0.0)		
1	0 (0.0)			0 (0.0)		
2	4 (5.3)			0 (0.0)		
3	10 (13.3)			2 (4.3)		
4	12 (16.0)			4 (8.5)		
5	13 (17.3)			9 (19.1)		
6	10 (13.3)			6 (12.8)		
7	10 (13.3)			10 (21.3)		
8	9 (12.0)			5 (10.6)		
9	2 (2.7)			8 (17.0)		
10 (completely)	5 (6.7)			3 (6.4)		
Missing	559			587		
ONS-4 Anxiety[2]		**4.9 (2.4)**	**5.0 (3.0 – 7.0)**		**4.1 (2.2)**	**4.0 (2.8 – 5.0)**
0 (not at all)	0 (0.0)			0 (0.0)		
1	10 (13.3)			8 (17.4)		
2	5 (6.7)			3 (6.5)		
3	7 (9.3)			8 (17.4)		
4	7 (9.3)			5 (10.9)		
5	13 (17.3)			12 (26.1)		
6	11 (14.7)			2 (4.3)		
7	11 (14.7)			5 (10.9)		
8	6 (8.0)			2 (4.3)		
9	5 (6.7)			1 (2.2)		
10 (completely)	0 (0.0)			0 (0.0)		
Missing	559			588		

[1] Overall, how happy did you feel yesterday?

[2] Overall, how anxious did you feel yesterday?

ONS-4 Summary Statistics (Life Satisfaction and Worthwhile)

	Pre (n = 634)			Post (n = 634)		
	N (%)	**Mean (SD)**	**Median (IQR)**	**N (%)**	**Mean (SD)**	**Median (IQR)**
Life Satisfaction[1]		**5.5 (2.1)**	**5.0 (4.0 – 7.0)**		**6.1 (1.8)**	**7.0 (5.0 – 7.0)**
0 (not at all)	0 (0.0)			0 (0.0)		
1	1 (1.3)			0 (0.0)		
2	3 (3.9)			0 (0.0)		
3	9 (11.8)			5 (10.6)		
4	12 (15.8)			4 (8.5)		
5	18 (23.7)			11 (23.4)		
6	7 (9.2)			3 (6.4)		
7	15 (19.7)			13 (27.7)		
8	4 (5.3)			8 (17.0)		
9	3 (3.9)			2 (4.3)		
10 (completely)	4 (5.3)			1 (2.1)		
Missing	558			587		
ONS-4 Worthwhile[2]		**5.8 (2.2)**	**6.0 (5.0 – 7.0)**		**6.4 (2.1)**	**7.0 (5.0 – 8.0)**
0 (not at all)	0 (0.0)			0 (0.0)		
1	2 (2.7)			1 (2.1)		
2	4 (5.3)			0 (0.0)		
3	7 (9.3)			4 (8.5)		
4	4 (5.3)			5 (10.6)		
5	15 (20.0)			6 (12.8)		
6	11 (14.7)			6 (12.8)		
7	16 (21.3)			9 (19.1)		
8	10 (13.3)			9 (19.1)		
9	2 (2.7)			5 (10.6)		
10 (completely)	4 (5.3)			2 (4.3)		
Missing	559			587		

[1] Overall, how satisfied are you with your life nowadays?

[2] Overall, to what extent do you feel that things you do in your life are worthwhile?

ONS-4 Score (Change)

		Pre		Post		Mean Change	95% CI	P-Value[1]
	N	Mean	SD	Mean	SD			
Life Satisfaction	47	5.5	2.1	6.1	1.8	0.6	0.1 to 1.1	0.013
Worthwhile	46	6.0	2.1	6.4	2.1	0.4	-0.2 to 1.0	0.148
Happiness	47	5.7	2.2	6.7	1.9	1.0	0.4 to 1.6	0.001
Anxiety	46	4.7	2.4	4.1	2.2	-0.6	-1.3 to 0.1	0.104

[1]Paired samples t-test

Overall, 51.1% (24/47) had an increase in life satisfaction score, 47.8% (22/46) had an increase in worthwhile score, 57.4% (27/47) had an increase in happiness score, and 52.2% (24/46) had a decrease in anxiety score.

For life satisfaction, worthwhile and happiness an increase is defined as post > pre. For anxiety a decrease is defined as post < pre.

ONS-4 Happiness

Category	Pre (n = 634)	Post (n = 634)
Low	26 (34.7)	6 (12.8)
Medium	23 (30.7)	15 (31.9)
High	19 (25.3)	15 (31.9)
Very High	7 (9.3)	11 (23.4)
Missing	559	587

		After Activity				
		Low	Medium	High	Very High	Total
Before Activity	**Low**	4	7	2	1	14 (29.8)
	Medium	1	4	8	2	15 (31.9)
	High	1	4	4	5	14 (29.8)
	Very High	0	0	1	3	4 (8.5)
	Total	6 (12.8)	15 (31.9)	15 (31.9)	11 (23.4)	47 (100.0)

The analysis excluding participants with missing data shows that 29.8% (14/47) had low happiness before the green activity and this reduced to 12.8% (6/47) after the activity. McNemar's test comparing the paired data does not show a statistically significant change (P=0.066). This may be due to the sample size.

ONS-4 Anxiety

Category	Pre (n = 634)	Post (n = 634)
Very Low	10 (13.3)	8 (17.4)
Low	12 (16.0)	11 (23.9)
Medium	20 (26.7)	17 (37.0)
High	33 (44.0)	10 (21.7)
Missing	559	588

		After Activity				
		Very Low	Low	Medium	High	Total
Before Activity	**Very Low**	5	0	0	1	6 (13.0)
	Low	1	4	4	1	10 (21.7)
	Medium	1	4	5	1	11 (23.9)
	High	1	3	8	7	19 (41.3)
	Total	8 (17.4)	11 (23.9)	17 (37.0)	10 (21.7)	46 (100.0)

The analysis excluding participants with missing data shows that 41.3% (19/46) had high anxiety and this reduced to 21.7% (10/46) after the activity. McNemar's test comparing the paired data does not show a statistically significant change (P=0.207). This may be due to sample size.

ONS-4 Life Satisfaction

Category	Pre (n = 634)	Post (n = 634)
Low	25 (32.9)	9 (19.1)
Medium	25 (32.9)	14 (29.8)
High	19 (25.0)	21 (44.7)
Very High	8 (9.2)	3 (6.4)
Missing	558	587

		After Activity				
		Low	Medium	High	Very High	Total
Before Activity	**Low**	6	6	4	0	16 (34.0)
	Medium	2	7	6	0	15 (31.9)
	High	1	1	9	1	12 (25.5)
	Very High	0	0	2	2	4 (8.5)
	Total	9 (19.1)	14 (29.8)	21 (44.7)	3 (6.4)	47 (100.0)

The analysis excluding participants with missing data shows that 34.0% (16/47) had low life satisfaction before the green activity and this reduced to 19.1% (9/47) after the activity. It is not possible to calculate a P value for this.

ONS-4 Worthwhile

Category	Pre (n = 634)	Post (n = 634)
Low	17 (22.7)	10 (21.3)
Medium	26 (34.7)	12 (25.5)
High	26 (34.7)	18 (38.3)
Very High	6 (8.0)	7 (14.9)
Missing	559	587

		After Activity				
		Low	Medium	High	Very High	Total
Before Activity	**Low**	4	5	1	0	10 (21.7)
	Medium	4	6	6	0	16 (34.8)
	High	2	0	10	4	16 (34.8)
	Very High	0	0	1	3	4 (8.7)
	Total	10 (21.7)	11 (23.9)	18 (39.1)	7 (15.2)	46 (100.0)

The analysis excluding participants with missing data shows that 21.7% (10/46) had a low worthwhile score before the green activity and this was unchanged after the activity (although it is not the same ten participants before and after). A P value cannot be calculated.

T&L6 Site Summary

Participant Characteristics

Characteristic (N = 369)	N (%)[1]
Age (Years)	
< 18	92 (26.7)
18 – 24	15 (4.4)
25 – 29	19 (5.5)
30 – 34	16 (4.7)
35 – 39	15 (4.4)
40 – 44	26 (7.6)
45 – 49	27 (7.8)
50 – 54	32 (9.3)
55 – 59	28 (8.1)
60 – 64	29 (8.4)
65 – 69	17 (4.9)
70 – 74	12 (3.5)
75 – 79	15 (4.4)
80 – 84	1 (0.3)
≥ 85	0 (0.0)
Missing	25
Gender	
Female	235 (63.7)
Male	134 (36.3)
Missing	0
Ethnicity	
Asian or Asian British	31 (9.0)
Black, Black British, Caribbean or African	3 (0.9)
Mixed or Multiple Ethnic Groups	21 (6.1)
Other Ethnic Group	1 (0.3)
White	283 (82.3)
Refused	5 (1.5)
Missing	25

[1] Missing values are excluded from calculation of percentages

Deprivation

Characteristic (N = 369)	N (%)[1]
IMD Decile	
1 (Most Deprived)	0 (0.0)
2	1 (0.6)
3	5 (2.9)
4	16 (9.1)
5	5 (2.9)
6	13 (7.4)
7	23 (13.1)
8	18 (10.3)
9	34 (19.4)
10 (Least Deprived)	60 (34.3)
Missing	194

[1] Missing values are excluded from calculation of percentages

Mental Health Needs

Characteristic (N = 369)	N (%)[1]
User has mental health needs which infringe on daily life	
No mental health needs	102 (27.6)
Early/pre-determinants of mental health needs	70 (19.0)
Moderate mental health needs	185 (50.1)
Severe mental health needs	12 (3.3)
Missing	0
Mental Health Needs	
Yes	267 (72.4)
No	102 (27.6)
Missing	0

[1] Missing values are excluded from calculation of percentages

Referrals

Characteristic (N = 369)	N (%)[1]
Source of Referral	
Community Mental Health Team	2 (0.8)
Friends or Family	23 (8.9)
GP	1 (0.4)
Local Authority	2 (0.8)
Other NHS Service	5 (1.9)
Other Primary Care Professional	15 (5.8)
Primacy Care based Link Worker/Social Prescriber	17 (6.6)
Referral from another part of the organisation	6 (2.3)
Self-Referral	24 (9.3)
Voluntary, Community or Social Enterprise Organisation	5 (1.9)
Voluntary/Community/Social Enterprise Based Link Worker/Social Prescriber	157 (61.1)
Missing	112
Referral Appropriate	
Yes	257 (69.6)
No[2]	112 (30.4)

[1] Missing values are excluded from calculation of percentages

[2] Note that only "Yes" was recorded in the data

Service User Received Support

Characteristic (N = 369)	N (%)[1]
Service User Received Support	
Yes	244 (94.9)
Awaiting Support	7 (2.7)
No	6 (2.3)
Missing	112

[1] Missing values are excluded from calculation of percentages

Number of Sessions Attended

Characteristic (N = 369)	N (%)[1]
Number of Sessions Attended	
1	64 (19.4)
2 – 5	97 (29.4)
6 – 10	112 (37.0)
11 – 15	14 (4.5)
16 – 20	3 (0.9)
Over 20	29 (8.8)
Missing	39

[1] Missing values are excluded from calculation of percentages

Destination Following Support

Characteristic (N = 369)	N (%)[1]
Destination Following Support	
Accessed further activities within organisation	81 (28.5)
Continuing to attend the activity	196 (69.0)
Deceased	1 (0.4)
Dropped-out of the activity before completing planned support	1 (0.4)
Finished in the organisation with no onward referral	3 (1.1)
Unknown	2 (0.7)
Missing	85

[1] Missing values are excluded from calculation of percentages

Time Variables

	N	Mean (SD)	Median (IQR)	Range
Time from referral to support (weeks)	193	1.0 (0.8)	0.9 (0.4 – 1.1)	0.0 – 7.0
Length of support (weeks)	40	1.8 (4.9)	0.7 (0.0 – 2.9)	0.0 – 31.1

Green Activity

Note that the participants may be doing more than one activity.

Activity (N = 369)	N (%)
Alternative Therapies	19 (5.1)
Care Farming	7 (1.9)
Conservation Focused	21 (5.7)
Craft Focused	79 (21.4)
Exercise	164 (44.4)
Horticultural	204 (55.3)
Nature Connection	173 (46.9)
Other	17 (4.6)
Sport	5 (4.6)
Talking Therapies	4 (1.1)
Wilderness Focused	22 (6.0)

ONS-4 Score (Change)

		Pre		Post		Mean Change	95% CI	P-Value[1]
	N	Mean	SD	Mean	SD			
Life Satisfaction	256	4.1	2.4	7.1	2.1	3.0	2.6 to 3.3	<0.001
Worthwhile	256	4.6	2.2	6.8	1.8	2.2	1.9 to 2.5	<0.001
Happiness	256	4.3	2.4	7.0	1.8	2.8	2.4 to 3.1	<0.001
Anxiety	256	3.9	2.4	3.6	2.5	-0.3	-0.5 to -0.1	0.004

[1]Paired samples t-test

Overall, 75.0% (192/256) had an increase in life satisfaction score, 68.4% (175/256) had an increase in worthwhile score, 75.8% (194/256) had an increase in happiness score, and 42.6% (109/256) had a decrease in anxiety score.

For life satisfaction, worthwhile and happiness an increase is defined as post > pre. For anxiety a decrease is defined as post < pre.

ONS-4 Happiness

Category	Pre (n = 369)	Post (n = 369)
Low	155 (52.9)	26 (10.2)
Medium	70 (23.9)	59 (23.0)
High	52 (17.7)	118 (46.1)
Very High	16 (5.5)	53 (20.7)
Missing	76	113

Missing values are excluded from calculation of percentages.

		After Activity				
		Low	Medium	High	Very High	Total
Before Activity	**Low**	25	22	67	29	143 (55.9)
	Medium	1	32	21	8	62 (24.2)
	High	0	5	24	9	38 (14.8)
	Very High	0	0	6	7	13 (5.1)
	Total	26 (10.2)	59 (23.0)	118 (46.1)	53 (20.7)	256 (100.0)

The analysis excluding participants with missing data shows that 59.9% (143/256) had low happiness before the green activity and this reduced to 10.2% (26/256) after the activity. McNemar's test comparing the paired data shows a statistically significant change (P<0.001).

ONS-4 Anxiety

Category	Pre (n = 369)	Post (n = 369)
Very Low	33 (11.3)	83 (32.4)
Low	117 (39.9)	57 (22.3)
Medium	48 (16.4)	45 (17.6)
High	95 (32.4)	71 (27.7)
Missing	76	113

Values are N (%)

Missing values are excluded from calculation of percentages

		After Activity				
		Very Low	Low	Medium	High	Total
Before Activity	**Very Low**	22	4	1	2	29 (11.3)
	Low	52	42	12	7	113 (44.1)
	Medium	6	8	14	5	33 (12.9)
	High	3	3	18	57	81 (31.6)
	Total	83 (32.4)	57 (22.3)	45 (17.6)	71 (27.7)	256 (100.0)

The analysis excluding participants with missing data shows that 31.6% (81/256) had high anxiety and this reduced to 27.7% (71/256) after the activity. McNemar's test comparing the paired data shows a statistically significant change (P<0.001).

ONS-4 Life Satisfaction

Category	Pre (n = 369)	Post (n = 369)
Low	166 (56.7)	35 (13.7)
Medium	58 (19.8)	49 (19.1)
High	58 (19.8)	97 (37.9)
Very High	11 (3.8)	75 (29.3)
Missing	76	113

Values are N (%)

Missing values are excluded from calculation of percentages.

		After Activity				
		Low	Medium	High	Very High	Total
Before Activity	**Low**	33	18	63	43	157 (61.3)
	Medium	2	28	6	9	45 (17.6)
	High	0	3	27	16	46 (18.0)
	Very High	0	0	1	7	8 (3.1)
	Total	35 (13.7)	49 (19.1)	97 (37.9)	75 (29.3)	256 (100.0)

The analysis excluding participants with missing data shows that 61.3% (157/256) had low life satisfaction before the green activity and this reduced to 13.7% (35/256) after the activity. McNemar's test comparing the paired data shows a statistically significant change (P<0.001).

ONS-4 Worthwhile

Category	Pre (n = 369)	Post (n = 369)
Low	164 (56.0)	32 (12.5)
Medium	57 (19.5)	67 (26.2)
High	50 (17.1)	114 (44.5)
Very High	22 (7.5)	43 (16.8)
Missing	76	113

Values are N (%)

Missing values are excluded from calculation of percentages.

		After Activity				
		Low	**Medium**	**High**	**Very High**	**Total**
Before Activity	**Low**	31	35	75	13	154 (60.2)
	Medium	0	27	11	10	48 (18.8)
	High	1	5	26	4	36 (14.1)
	Very High	0	0	2	16	18 (7.0)
	Total	32 (12.5)	67 (26.2)	114 (44.5)	43 (16.8)	256 (100.0)

The analysis excluding participants with missing data shows that 60.2% (154/256) had a low worthwhile score before the green activity and this reduced to 12.5% (32/256) after the activity. McNemar's test comparing the paired data shows a statistically significant change (P<0.001).

Continuous walk lasting 10 minutes in last 7 days

Continuous walk lasting 10 minutes in last 7 days (N = 369)	**N (%)[1]**
Before Activity	
Yes	234 (77.5)
No	68 (22.5)
Missing	67
After Activity	
Yes	244 (91.7)
No	22 (8.3)
Missing	103

[1] Missing values are excluded from calculation of percentages

		After Activity		
		Yes	**No**	**Total**
Before Activity	**Yes**	209	1	210
	No	35	21	56
	Total	244	22	266

The analysis excluding participants with missing data shows that 78.9% (210/266) of participants did a continuous walk lasting 10 minutes in the last 7 days before the green activity and this increased to 91.7% (244/266) after the green activity. McNemar's test comparing the paired data shows this is statistically significant (P<0.001).

Cycled in the last 7 days

Cycled in the last 7 days (N = 369)	N (%)[1]
Before Activity	
Yes	24 (7.9)
No	278 (92.1)
Missing	67
After Activity	
Yes	46 (17.3)
No	220 (82.7)
Missing	103

[1] Missing values are excluded from calculation of percentages

		After Activity		
		Yes	**No**	**Total**
Before Activity	**Yes**	14	4	18
	No	32	216	248
	Total	46	220	266

The analysis excluding participants with missing data shows that 6.8% (18/266) of participants cycled in the last 7 days before the green activity and this increased to 17.3% (46/266) after the green activity. McNemar's test comparing the paired data shows this is statistically significant (P<0.001).

Sport in the last 7 days

Sport, fitness activity or dance in the last 7 days (N = 369)	N (%)[1]
Before Activity	
Yes	160 (53.0)
No	142 (47.0)
Missing	67
After Activity	
Yes	184 (70.0)
No	79 (30.0)
Missing	106

[1] Missing values are excluded from calculation of percentages

		After Activity		
		Yes	**No**	**Total**
Before Activity	**Yes**	138	6	144
	No	46	73	119
	Total	184	79	263

The analysis excluding participants with missing data shows that 54.8% (144/263) of participants did sport, a fitness activity or dance in the last 7 days before the green activity and this increased to 70.0% (184/263) after the green activity. McNemar's test comparing the paired data shows this is statistically significant (P<0.001).

Exercise in the last 7 days (walking, cycling, sport, etc)

Exercise in the last 7 days (N = 369)	N (%)[1]
Before Activity	
Yes	252 (83.4)
No	50 (16.6)
Missing	67
After Activity	
Yes	252 (94.7)
No	14 (5.3)
Missing	103

[1] Missing values are excluded from calculation of percentages

		After Activity		
		Yes	No	Total
Before Activity	**Yes**	222	2	224
	No	30	12	42
	Total	252	14	266

The analysis excluding participants with missing data shows that 84.2% (224/266) of participants did exercise in the last 7 days before the green activity and this increased to 94.7% (252/266) after the green activity. McNemar's test comparing the paired data shows this is statistically significant (P<0.001).

Nature Connectedness Index (Pre)

N = 369	N (%)[1]	Mean (SD)	Median (IQR)
Nature Connectedness		**3.7 (1.6)**	**4.0 (3.0 – 5.0)**
1	23 (11.1)		
2	20 (9.7)		
3	48 (23.2)		
4	44 (21.3)		
5	49 (23.7)		
6	15 (7.2)		
7	8 (3.9)		
Missing	162		

[1] Missing values are excluded from calculation of percentages

Nature Connectedness Index (Post)

N = 369	N (%)[1]	Mean (SD)	Median (IQR)
Nature Connectedness		**4.2 (1.6)**	**5.0 (3.0 – 5.0)**
1	18 (10.5)		
2	9 (5.2)		
3	17 (9.9)		
4	41 (23.8)		
5	55 (32.0)		
6	23 (13.4)		
7	9 (5.2)		
Missing	197		

[1] Missing values are excluded from calculation of percentages

Nature Connectedness Index (Change)

		Pre		Post		P-Value[1]
	N	Median	IQR	Median	IQR	
Nature	171	4	3 – 5	5	3 – 5	<0.001

[1]Wilcoxon signed rank test

T&L7 Site Summary

Participant Characteristics

Characteristic (N = 1,178)	N (%)[1]
Age (Years)	
< 18	307 (28.0)
18 – 65	591 (53.9)
> 65	199 (18.1)
Missing	81
Gender	
Female	600 (52.6)
Male	536 (47.0)
Non-Binary	3 (0.3)
Prefer Not to Say	2 (0.2)
Missing	37
Ethnic Group	
Yes	539 (46.9)
No	610 (53.1)
Missing	29
LGBTQ+	
Yes	32 (3.5)
No	878 (96.0)
Prefer Not to Say	5 (0.5)
Missing	263
Disability	
Yes	329 (34.3)
No	629 (65.5)
Prefer Not to Say	2 (0.2)
Missing	218

[1] Missing values are excluded from calculation of percentages

Deprivation

Characteristic (N = 1,178)	N (%)[1]
IMD Decile	
1 (Most Deprived)	2 (5.7)
2	6 (17.1)
3	3 (8.6)
4	2 (5.7)
5	3 (8.6)
6	3 (8.6)
7	5 (14.3)
8	8 (22.9)
9	1 (2.9)
10 (Least Deprived)	2 (5.7)
Missing	1,143

[1] Missing values are excluded from calculation of percentages

Referrals

Characteristic (N = 1,178)	N (%)[1]
Source of Referral	
College	13 (1.4)
Community Mental Health Team	11 (1.1)
Friends or Family	69 (7.2)
GP	45 (4.7)
Local Authority	17 (1.8)
Other	111 (11.6)
Other Professional	119 (12.4)
Primacy Care based Link Worker/Social Prescriber	13 (1.4)
Self-Referral	467 (48.6)
Voluntary, Community or Social Enterprise Organisation	46 (4.8)
Voluntary/Community/Social Enterprise Based Link Worker/Social Prescriber	49 (5.1)
Missing	218

[1] Missing values are excluded from calculation of percentages

Number of Sessions Attended

Characteristic (N = 1,178)	N (%)[1]
Number of Sessions Attended	
1	363 (43.3)
2 – 5	286 (34.1)
6 – 10	116 (13.8)
11 – 15	62 (7.4)
16 – 20	11 (1.3)
Over 20	1 (0.1)
Missing	339

[1] Missing values are excluded from calculation of percentages

ONS-4 Summary Statistics (Happiness and Anxiety)

	Pre (n = 1,178)			Post (n = 1,178)		
	N (%)	Mean (SD)	Median (IQR)	N (%)	Mean (SD)	Median (IQR)
ONS-4 Happiness[1]		**5.7 (2.4)**	**5.0 (4.0 – 8.0)**		**8.0 (1.8)**	**8.0 (7.0 – 9.0)**
0 (not at all)	6 (0.7)			10 (1.4)		
1	11 (1.3)			2 (0.3)		
2	51 (6.0)			1 (0.1)		
3	98 (11.6)			5 (0.7)		
4	127 (15.0)			26 (3.5)		
5	136 (16.1)			27 (3.7)		
6	83 (9.8)			32 (4.4)		
7	84 (9.9)			94 (12.8)		
8	134 (15.8)			228 (31.0)		
9	67 (7.9)			170 (23.1)		
10 (completely)	50 (5.9)			140 (19.0)		
Missing	331			443		
ONS-4 Anxiety[2]		**5.0 (3.2)**	**6.0 (2.0 – 8.0)**		**2.9 (2.5)**	**3.0 (1.0 – 4.0)**
0 (not at all)	142 (17.1)			167 (23.2)		
1	33 (4.0)			73 (10.1)		
2	40 (4.8)			97 (13.5)		
3	63 (7.6)			112 (15.6)		
4	60 (7.2)			98 (13.6)		
5	72 (8.7)			74 (10.3)		
6	78 (9.4)			30 (4.2)		
7	104 (12.5)			33 (4.6)		

8	114 (13.7)			16 (2.2)		
9	94 (11.3)			10 (1.4)		
10 (completely)	32 (3.8)			10 (1.4)		
Missing	346			458		

[1] Overall, how happy did you feel yesterday?

[2] Overall, how anxious did you feel yesterday?

ONS-4 Score (Change)

		Pre		Post		Mean Change	95% CI	P-Value[1]
	N	Mean	SD	Mean	SD			
Happiness	733	5.7	2.4	8.0	1.8	2.3	2.1 to 2.5	<0.001
Anxiety	718	4.9	3.3	2.9	2.4	-2.1	-2.2 to -1.9	<0.001

[1]Paired samples t-test

Overall, 73.4% (538/733) had an increase in happiness score and 64.2% (461/718) had a decrease in anxiety score.

For happiness an increase is defined as post > pre. For anxiety a decrease is defined as post < pre.

ONS-4 Happiness

Category	Pre (n = 1,178)	Post (n = 1,178)
Low	293 (34.6)	44 (6.0)
Medium	219 (25.9)	59 (8.0)
High	218 (25.7)	322 (43.8)
Very High	117 (13.8)	310 (42.2)
Missing	331	443

Values are N (%)

Missing values are excluded from calculation of percentages.

		After Activity				
		Low	Medium	High	Very High	Total
Before Activity	Low	19	24	138	86	267 (36.4)
	Medium	8	24	82	71	185 (25.2)
	High	9	4	100	68	181 (24.7)
	Very High	7	7	1	85	100 (13.6)
	Total	43 (5.9)	59 (8.0)	321 (31.5)	310 (42.3)	733 (100.0)

The analysis excluding participants with missing data shows that 36.4% (267/733) had low happiness before the green activity and this reduced to 5.9% (43/733) after the activity. McNemar's test comparing the paired data shows a statistically significant change (P<0.001).

ONS-4 Anxiety

Category	Pre (n = 1,178)	Post (n = 1,178)
Very Low	175 (21.0)	240 (33.3)
Low	103 (12.4)	209 (29.0)
Medium	132 (15.9)	172 (23.9)
High	422 (50.7)	99 (13.8)
Missing	346	458

Values are N (%)

Missing values are excluded from calculation of percentages.

		After Activity				
		Very Low	Low	Medium	High	Total
Before Activity	**Very Low**	162	1	0	2	165 (23.0)
	Low	30	32	5	13	80 (11.1)
	Medium	14	52	28	16	110 (15.3)
	High	34	124	139	66	363 (50.6)
	Total	240 (33.4)	209 (29.1)	172 (24.0)	97 (13.5)	718 (100.0)

The analysis excluding participants with missing data shows that 50.6% (363/718) had high anxiety and this reduced to 13.5% (97/718) after the activity. McNemar's test comparing the paired data shows a statistically significant change (P<0.001).

Appendix 2: Work package 3B – Qualitative data collection

A2.1. Overarching Questions

The qualitative work package aimed to provide depth and detail throughout the evaluation, both informing and complementing the other work packages. The work package set out to explore the following broad questions:

1. What are the key characteristics of each test and learn (T&L) site?
2. What are the different test and learn sites 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 test and learn site consistent within, and across areas?

A2.2. Methodology

Using programme theory

The qualitative data collection and analysis was broadly informed by realist evaluation methods (Pawson & Tilley, 1997) using an embedded researcher approach. A realist informed approach was considered the 'best fit' to explore the overarching questions, giving us a sense of 'what works for whom in what circumstances' by exploring the context, mechanisms, and outcomes of the seven text and learn sites.

Following a realist approach, initial programme theories, based on the literature and the scoping stage of the evaluation, informed the first wave of data collection *(see table 1).* Programme theories are a set of statements about *what works, for whom and in which circumstances.* Thus, programme theories explore the possible impacts of various mechanisms, or activities in different contexts. Once the initial programme theories were drafted by the ERs, they were used to inform the interview topic guide and schedule (as can be seen in the final two columns of table one).

Embedded researcher approach

An embedded researcher approach (Gradinger et al., 2019; Hazeldine et al., 2021) was chosen to enable the development of trusting relationships between the evaluation team and the test and learn sites. Each test and learn site was assigned a specific embedded researcher (ER) who worked with the T&L site throughout the duration of the evaluation. The ERs worked with the T&L site project managers from the beginning of the evaluation, ensuring clear communication regarding the aims and objectives of the evaluation and feeding evaluation findings back to the project managers and their teams at key points throughout the evaluation. This approach meant that the evaluation was felt to be more of a reciprocal process between the ERs and the T&L sites and ensured that the evaluation team were able to explore issues in depth and detail. One initial step in this process was through the co-development of theories of change (ToC) for each site, with ERs facilitating the workshops, drafting the ToC and meeting with the T&L teams at various points during the evaluation to reflect on how the ToC may have evolved.

Working with specific T&L sites, ERs gained access to team meetings, informal conversations, and site documents (see methods) and were able to collect large quantities of ethnographic data. This was a strength of the approach. However, the approach was also time and labour intensive and generated a lot of data from multiple sources as is later discussed.

ERs met on a fortnightly basis to exchange experiences of data collection and discuss emerging reflections on analysis, next steps and programme theory.

Table A2.1: Initial programme theories

Situation	Context (Q3) also Q4?	Activities and interventions that aim to alter the context to trigger mechanisms (these will be different for each T&L site) (Q1, Q2, Q5)	Mechanism (Q2, Q5)	Outcome (Q2)	Draft research questions	Participants
Infrastructure Definition: the organisations, networks, resources and processes inherent in a place	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	• What factors affect the participation of green providers in the social prescribing system?	Green providers; referrers; service commissioners
	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	• What makes a green provider an appropriate participant in social prescribing? • What factors enable or prevent green providers from participating in the system?	Green providers; service designers and commissioners; external funders
Institutional Definition: the aims, objectives, structures and priorities of	Organisational structures and processes (e.g. policy, objectives, governance, monitoring, evaluation and		Negotiation and compromise supports alignment of agendas and changes to structures	Coherence and clarity of roles and responsibilities across the system to support GSP	• What institutional barriers do green providers have to overcome? Who	Green providers; service designers and commissioners; policymakers; referrers; SPLWs

individual organisations	record keeping)) are not aligned				can influence these and how? What skills and capabilities are required, and from whom?	
Inter-institutional Definition: the aims, objectives, structures and priorities that exist or emerge (shared or disputed) between organisations	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 Definition: the relationships, shared understandings and behaviours apparent between stakeholders	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	• What factors are important in the relationships between the different people involved in the green social prescribing system? How can those relationships work most effectively?	Individuals who operate at the interface between different parts of the system – e.g. link workers, VCS infrastructure organisations, green providers, practice managers
Individual - professional Definition: the knowledge, understandings, capabilities and behaviours associated with a person's professional role	Medical professionals and link workers unaware of and/or unconvinced about the evidence for the health and wellbeing benefits of green activities leading to non-existent and/or		Referrers and link workers have the capability, opportunity and motivation to refer to GSP	Improved access to appropriate Green opportunities	• What factors enable or prevent successful referrals? Who can influence these and how?	

	inappropriate referral to GSP					
Individual – service users Definition: the understandings, capacities, aspirations and behaviours associated with service users' engagement with GSP	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	• How do service users experience GSP? What opportunities do they have to influence it?	Green providers; patient or service user representatives Individual service users (e.g. featured in T&L site case studies)
	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 *plausibly contributes* to improvements or management of Mental Health.	• What difficulties or challenges are associated with users' experience of GSP? How can these be overcome?	

A2.3. Methods

Data collection and analysis was an iterative process, with the first wave of data feeding into an amended programme theory and identifying potential gaps in our knowledge. This was then used to inform the second wave of data collection.

Data were collected via a number of different methods:

- Formal interviews.
- Informal conversations, attendance at meetings and reviewing documents.

Realist informed interviews

Realist informed interviews were conducted with key stakeholders. The key stakeholders to be interviewed were identified from the programme theory (see table one) and in discussion with project managers. They included GSP providers, programme management staff, referrers, link workers, volunteers, and service users across the seven Test and Learn sites. Interviews were conducted at two main points during the evaluation:

- The first wave of interviews were conducted by the embedded researchers between January and May 2022.
- The second wave of interviews were conducted between January and March 2023.

In total 118 interviews were undertaken during the evaluation. Table A2.2 shows the total number of realist informed interviews undertaken within each T&L site during the first and second wave of data collection.

Interviews were primarily undertaken over the telephone/video conferencing for ease of access. They lasted between 20 minutes and one hour. All interviews were transcribed verbatim.

Table A2.2: Number of interviews undertaken by T7L site

T&L site	Wave one	Wave two
T&L site 1	9	6
T&L site 2	12	9
T&L site 3	10	9
T&L site 4	5	5
T&L site 5	10	9
T&L site 6	11	5
T&L site 7	11	7
TOTAL	**68**	**50**

Informal conversations, attendance at meetings and documentary analysis

Throughout the evaluation, the embedded researchers engaged in ethnographic data collection activities including participation and observation of T&L site meetings, informal conversations with T&L site staff and analysis of T&L site reports and documents. Included in the T&L site documents were the T&L site case studies. Each T&L site was committed to collecting at least one service user case study each quarter.

We included review of these case studies in our final analysis with any pertinent data feeding into the refined programme theories.

Data from participating in, or observing, meetings and informal conversations were recorded by the ERs in field work diaries, whereby the ERs would make notes in the field and write up fuller notes following observation or by completing an observation template informed by the evaluation research questions. These activities resulted in large amounts of physical data but, and perhaps more importantly ERs were also able to develop key insights due to the embedded nature of their roles. These key insights were invaluable in the development and refinement of the programme theory as we sought to answer the broader evaluation questions.

A2.4. Data analysis

Data collection and analysis was an iterative, rather than staged process with ERs exploring their data within the context of their own T&L sites and feeding this into subsequent interviews/other forms of data collection. However, there were two key points when collective data analysis was undertaken:

- After the first wave of interview data had been collected ERs met as a team on a number of occasions between May and November 2022 and undertook a collective data analysis exercises and programme theory refinement. This then fed into a whole team meeting to discuss next steps.
- After the second wave of interview data had been collected, ERs met as a team at the end of January 2023 and then at the end of February 2023 to reflect on data and this fed into the final whole team analysis meeting in March 2023.

The data analysis process involved the ERs initially looking at their own site-specific data before coming together to look at patterns and themes across and within sites. Following the first round of interviews, initial transcripts were thematically analysed, and a coding framework developed between the ERs. The initial coding framework covered:

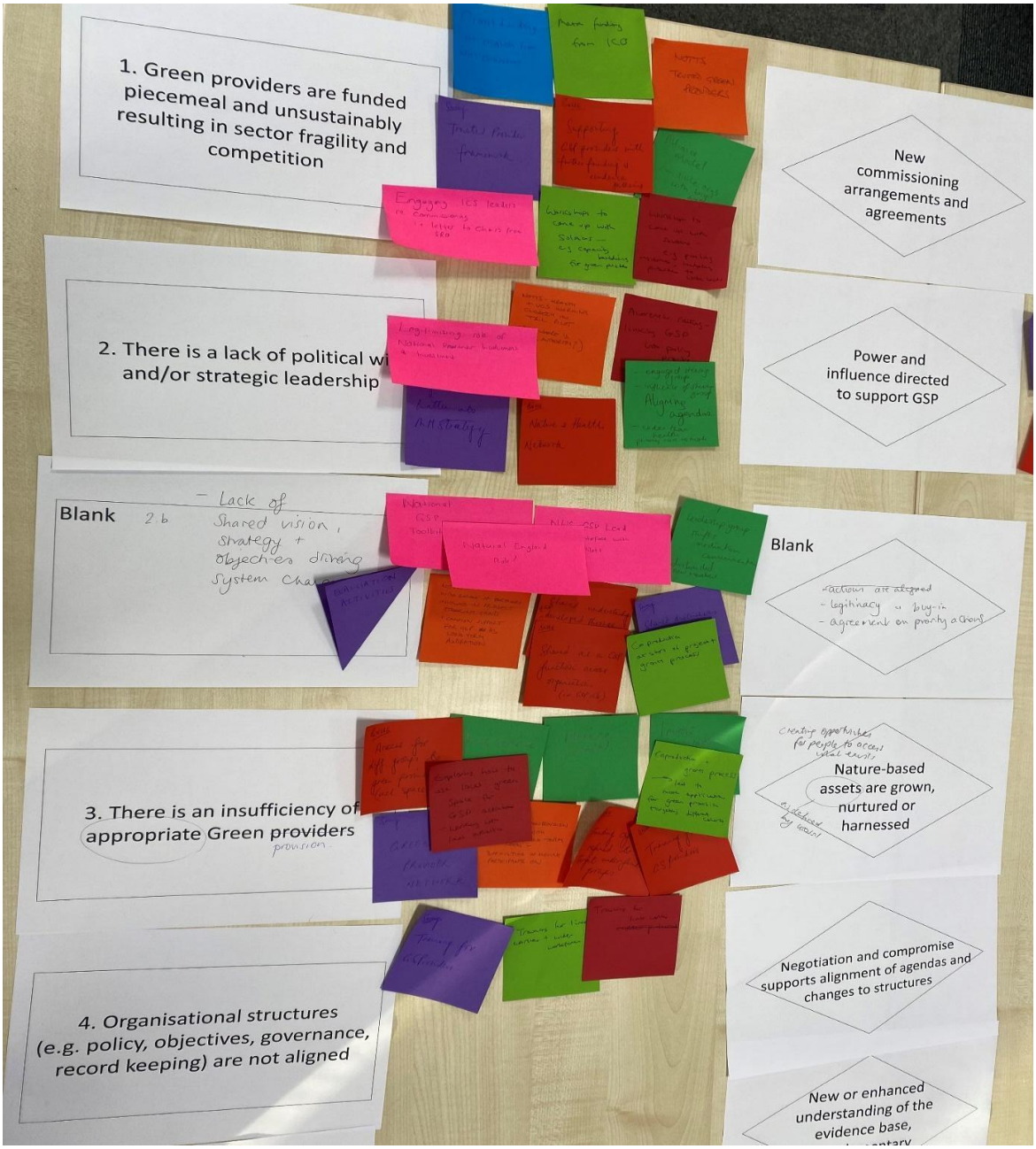
- Sustainability.
- Sufficient green activities and assets.
- Structures and processes.
- Interconnectivity (between funders and providers and between referrers and providers).
- Mutual awareness and understanding.
- Buy in (from referrers and Link Workers).
- User influence (in structures and processes).
- (User) Pathway experience.
- Data and measuring impact.
- Underserved populations.

Following this, ERs analysed the interview transcripts and written observations against the coding framework. The initial findings from this stage of the research are reported in the interim report (Haywood et al., 2023).

The initial findings were then taken to a whole team meeting in December 2022. During this meeting the team undertook participatory analysis of the WP3b findings against the programme theories (see Picture A2.1). This exercise enabled us to identify gaps

in our knowledge, look for threads across and within sites and amend the programme theories. Following this meeting, ERs developed a new interview schedule and questions.

Picture A2.1: Participatory analysis of WP3b data against the Programme Theories



Following the second wave of data collection, interview, observational and documentary data were analysed against the PT framework, culminating in a whole team meeting in March 2023. During the whole team meeting, further participatory analysis was undertaken, linking WP3b data to the programme theory and considering how data from the other WPs may align with this. ERs also reflected on what changes had occurred within their T&L sites that they considered to have had the most significant impacts. ERs then charted their data against individual analysis tables with an example of the headings shown below.

Final analysis table example

Programme theory	Context - why was change needed?	What has happened? Description of change (or lack of)	Activities	What supported change?	What inhibited change?	Evidence of change (or lack of change)	Aspect of programme theory	Quotes

The analysis tables were then used by the synthesis team to develop PT narratives (as shown in chapter 4 of the main evaluation report).

A2.5. Reflections on embedded researcher role

The embedded researchers have reflected on their role and the process, and the following key points can be noted:

- The benefit of an embedded role is providing the sites with a consistent point of contact. This helps to develop trust and rapport with the site team and help to 'open up' meetings and documents with the researcher.

  I believe having substantial time allocated for my role as ER made a significant difference to the level of cooperative engagement I was able to obtain from my sites, as I could invest a substantial amount of time particularly in the early phases of the project in building relationships, having scene-setting conversations and proactively sharing information on the programme (Embedded researcher).

- The long-term nature of the post meant that observation and interactions were continual and helped ERs to pick up on nuances that may have been missed in interviews alone.

  The role of ER in bridging national perceptions and local practice has been invaluable in forming both pragmatic observations and a check on external viewpoints. These perspectives would not have been unearthed through other means, and both the depth of understanding and reflection of nuance were well served using this approach. Both these factors are crucial to understanding the multilevel systemic complexity involved in the structures under evaluation (Embedded researcher)

  Being able to observe meetings and interactions in person and online, over time, was invaluable to really unpick what was happening and the mood/relationships. I think this would have been lost if we were just doing interviews. I was copied into email threads and shared documents they were co-producing and this too highlighted clear differences of opinion in the work (Embedded researcher).

- The ToC and most significant change workshops with sites were seen as a particular positive of the role. This was felt to be more reciprocal and co-productive in nature.
- However, despite the aim to feed back to teams and make the process reciprocal, knowledge mobilisation was at times limited, as sharing of findings was sometimes embargoed.
- ERs also felt that the 'embedded' element of their role was sometimes difficult given that interactions were primarily online.

The main challenge I found was the difficulty of being 'embedded' when your interactions are primarily online and you don't actually visit and experience the places people are talking about (Embedded researcher).

ERs also reflected on some of the opportunities and challenges encountered in recruiting to interviews. Recruitment of most stakeholders was largely considered to have been relatively straightforward. The process was aided by the relationship with T&L site managers and many ERs reflected on the enthusiasm of stakeholders to 'help out' or have a say about GSP. However, a reliance on T7L site project managers also meant that the diversity of interviewees was restricted to those who were known to them.

Recruitment of service users has proven to be more challenging, and ERs have had to proactively engage in different ways to reach service users for interview. These included presenting at programme management meetings, emails to nature-based providers and communities of practice. Frustratingly, one challenge encountered was service users agreeing to interview but then not attending. However, this does reflect the wider health/social care field in terms of the difficulties in recruiting service users to discuss their experiences of services. Despite these challenges, interviews were undertaken with ten service users to reflect on their experiences of the GSP pathway and this data has been explored in collaboration with the T&L case studies.

A2.6. Questions for topic guides

Initial 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.

Research question	Participant(s)
BACKGROUND	
• What is your current job role? *Prompts: who do you work for, how long, how many hours worked, etc?*	Referrers, GSP providers, project management team, link workers, service commissioners and other health professional stakeholders identified through embedded activity if appropriate.
• 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	
• What is your role within the social prescribing system? *e.g. whether referrer, provider or other stakeholder* • 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	
• 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?	Referrers, GSP providers, project management team, link workers, service commissioners and other health

• What is your role within the GSP system? *e.g., whether referrer, provider or other stakeholder.* • What is GSP trying to achieve? *Why is GSP needed? What 'problem' is GSP addressing?* • 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? *Do they feel part of it?*	professional stakeholders identified through embedded activity if appropriate.
• 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? • *Prompts: what is your overall vision for the Test & Learn?* (can link this to Theory of Changes for each site) • To what extent do you think it is meeting its goals and why/why not?	Referrers, GSP providers, project management team, link workers, service commissioners and other health professional stakeholders identified through embedded activity if appropriate.
• 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? • *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?* • 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? • *Prompts: are there any concerns over future service sustainability*	GSP providers.
• 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?	GSP providers.
• How many service-users have you supported in the past year? • How do you record your data? *Prompts: what systems do they use, what information do they collect* • Are you able to identify GSP referrals within your systems? How easy or difficult is this?	Link workers.

• 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? Prompts: *e.g., those with mental health issues.* • 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 re-entering the system? (e.g., revolving door)	
PERCEIVED CHANGES TO THE GSP SYSTEM	
• What, if anything, has changed as a result of the Test & Learn pilot? *Prompts: These might be changes in awareness, attitudes and behaviours, connectivity, relationships, processes, practices availability of resources, roles and responsibilities.* • 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?	Referrers, GSP providers, project management team, link workers, service commissioners and other health professional stakeholders identified through embedded activity if appropriate.
• 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?	Referrers, GSP providers, project management team, link workers, service commissioners and other health professional stakeholders identified through embedded activity if appropriate.
• 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?	Referrers, GSP providers, project management team, link workers, service commissioners and other health professional stakeholders identified through embedded activity if appropriate.
• How do service users experience GSP? What opportunities do they have to influence it? What choice/control do they have over their journeys?	Referrers, GSP providers, project management team, link workers, service commissioners and other health professional stakeholders identified through embedded activity if appropriate.
• What factors enable or prevent successful referrals? Why do these factors enable or prevent and how? Who can influence these and how?	Referrers, GSP providers, project management team, link workers, service commissioners and other health professional stakeholders identified through embedded activity if appropriate.
• 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?	Referrers, GSP providers, project management team, link workers, service commissioners and other health

• Examples of when barriers were overcome – what made this happen. • What happens when barriers cannot be overcome?	professional stakeholders identified through embedded activity if appropriate.
• 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?	Referrers, GSP providers, project management team, link workers, service commissioners and other health professional stakeholders identified through embedded activity if appropriate.

A2.7. Follow up interview topic guide

GSP project

Welcome and introductions

Remind interviewee of purpose of interview (follow up on emerging issues from last time, focused discussion around aspects of change), if participant is happy to proceed go through consent form.

The following questions can be tweaked and personalised depending on specific issues raised in the previous interview.

During our last interviewee we spoke about your involvement in the programme, your vision for what the programme was trying to achieve, and any challenges and facilitators to the programme's success. We would now like to ask some follow up questions to see how things have changed.

We are first going to ask you some generic questions on change within the programme which will help us test our programme theory [remind participant of what programme theory is]:

1. Last time you described your vision for the programme and what you were hoping to achieve which was [insert information]. The interview was fairly early on in the process, but some achievements had been made towards this goal [insert information]. Has this vision changed since the last time we spoke and why? To what extent do you think the programme is meeting its goals and why/why not?
2. What, if anything, has changed as a result of the Test & Learn pilot, and how do you know this has changed? *Prompts: These might be changes in awareness, attitudes and behaviours, connectivity, relationships, processes, practices availability of resources, roles and responsibilities.*
3. How have those changes come about? What has contributed to those changes?
4. What has got in the way of change? Why have these things inhibited change?

We will now ask you some specific questions on aspects of change which we will use to test our programme theory [remind participant what programme theory is].

New commissioning arrangements

5. One key challenge which has been identified across the T&L site pilot is the need for onward sustainability and investment. Different sites have come up with different solutions to this issue. In your T&L site, the following activities had been undertaken or were underway [insert site specific information]. Has any of this led activity led to the development of new commissioning structures, why/why not? are there any new funding models/structures/processes for funding into green organisations? Are there any new bids? Ask for examples of arrangements that have led to any change.

A lack of political will….

6. Do you feel the programme has strategic and political support? Why/why not?
7. Is GSP being considered within wider policy and strategy? How and why have these decisions been made?
8. Is GSP embedded within any policies/strategies? Why/why not?

9. If yes, has this led to any change that goes beyond being written in the policy*? E.g., new commissioning structures, commitment to funding*

Lack of shared vision, strategy and objectives to deliver systems change

10. Do you feel there is a shared vision and strategy to deliver systems change in your T&L site? *E.g., agreed objectives, committee/steering group membership*
11. What system changes have been achieved and how do you know this has changed? If nothing has changed, why not?
12. How has the national partnership contributed to these changes? Are there some organisations who are more engaged than others?
13. What is the role of Natural England in your T&L site?
14. Are the agendas of your T&L site aligned with the national partnership, why/why not? If no, what challenges does this present?
15. Is the agenda of your T&L site aligned to the ICS, why/why not? If no, what challenges does this present?

There is an insufficiency of appropriate green providers and provision (could be partly due to perception and the market there probably isn't enough provision for higher level mental health)

16. Do you feel there are sufficient green providers and provision in your T&L site to deal with demand? If no, what strategies, if any, have you developed to combat this, and what changes has this led to?
17. A lack of provision for more complex needs has been identified as a potential challenge to the programme. Is this an issue in your T&L site, and if so what strategies have you developed to combat this? Has this led to any change?
18. What has your T&L site done to bring together green providers, if anything? What changes has this led to? *E.g. mutual support, capacity building*.

Evidence of GSP efficacy is limited

19. A number of strategies have been delivered within your T&L site to improve the evidence base for GSP, for example…. [provide specific site information].How well have these strategies worked, has this led to the change you were hoping for?
20. We know from speaking with providers that they often use different types of evidence which is not always conducive with NHS measurements. Has there been any concerted communication at a strategic level to accept different types of evidence? *E.g. qual, case studies, etc*
21. How far has the project influenced the types of data commissioning/policy/clinical levels view as important? (could be better worded if someone wants to have a go)
22. Do providers know how to do a good case study? *E.g. what to include/report?*

The network of providers, link workers, referrers and funders is fractured and dispersed

23. How well are providers, link workers, referrers and funders connected to each other. Has this changed since the introduction of the programme?
24. What strategies has your T&L done to increase connections across the system, what changes has this led to? *E.g., green network development.*

25. Are you being engaged across the system, why/why not, if yes, why have people connected? *E.g., shared interest.*
26. Are all actors involved who should be, or is this the same people? How much of this is genuinely new networking with different parts of the system? Consider at an organisational level and provider level.

There is a lack of mutual understanding and awareness of different parts of the system and how they operate

We will now explore specific aspects of change which have been identified as being significant within your T&L site.

A2.8. T&L sites draft observation framework

Site code [Redacted]	
Meeting code [e.g. XX1v (observation meeting 1 virtual)] [N.B. the suffix may be v (virtual) or i (in person)]	
Meeting date [00/00/00] (day/month/year)	
Meeting title	
Meeting purpose/aim	
Attendees (name/role/org if known, Chair if relevant):	
1.	
2.	
3.	
4.	
5.	
Atmospheric observations (brief, descriptive, e.g., constructive; awkward; supportive)	
Meeting activities (what are the talking points/actions/key decisions)	
System impacts: What's working within the system? What's not working within the system?	
Meeting dynamics (brief notes, e.g., [XX] talked for most of the meeting; [XX] not present but was referred to regularly	
Observations for follow up (e.g., talk to X; clarify role of Y; flag Z for interview)	

A2.9. Work Package 2 – Local Theories of Change

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.

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 A2.4: 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 two-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 investing more in GSP/green activity and embedding 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

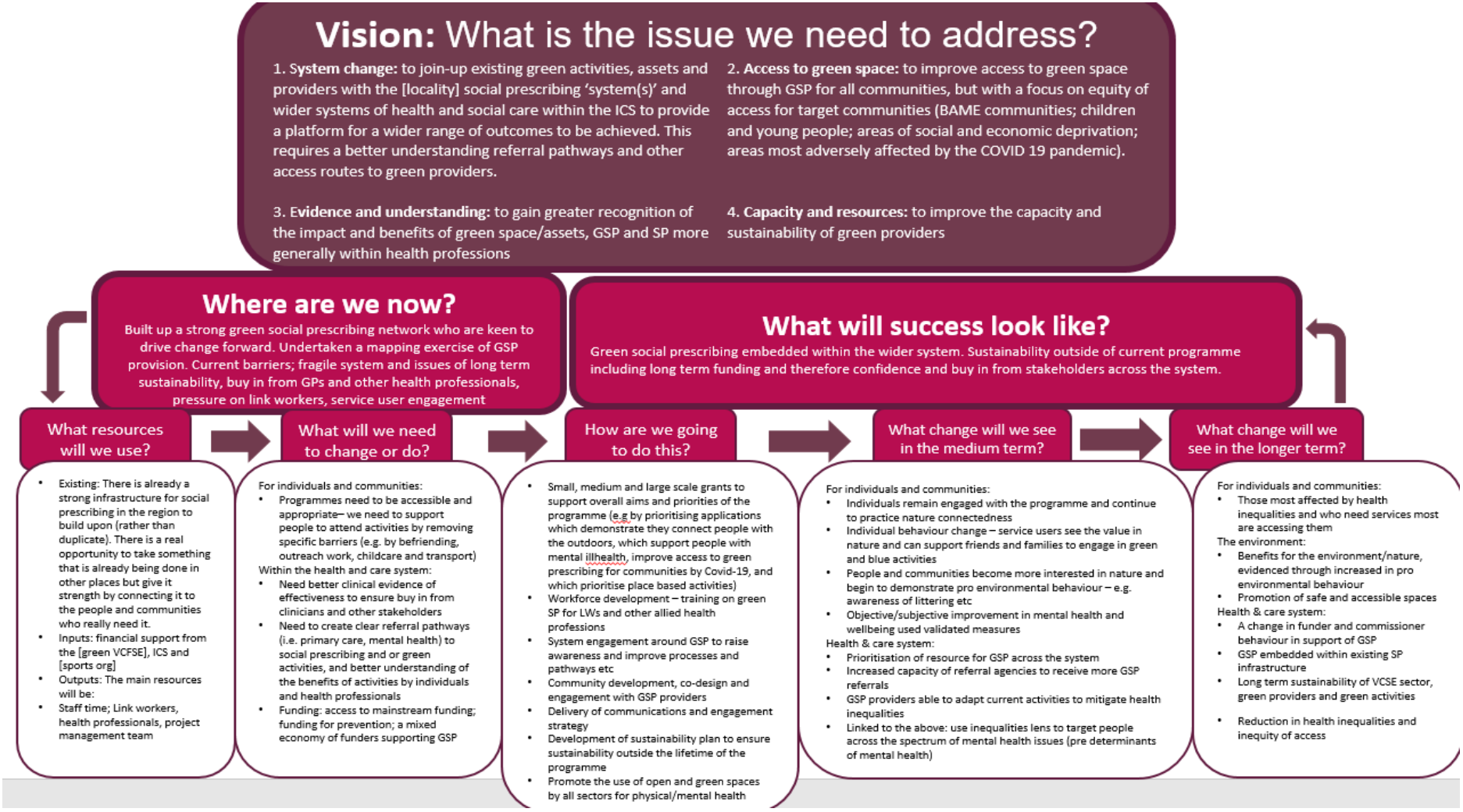
Finally, participants were also asked to think about what main successes they would like to see from the project:

- 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 demonstrated how and why GSP works (and for whom).

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

Test and Learn site 2



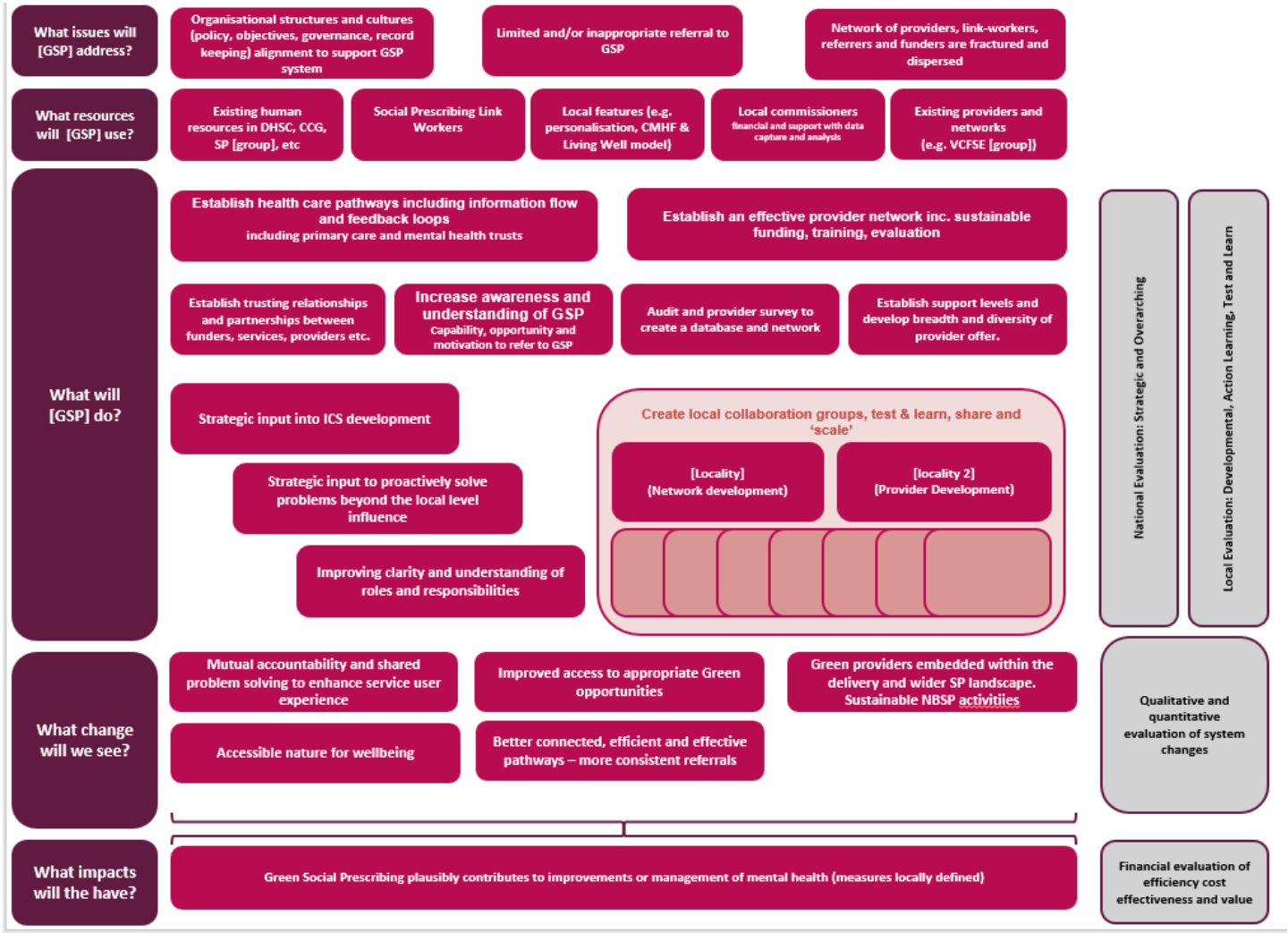
Test and Learn site 3

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
		Personalised care budgets able to be used for SP and GSP
Building reciprocal understanding between the community and voluntary sector and the health system		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

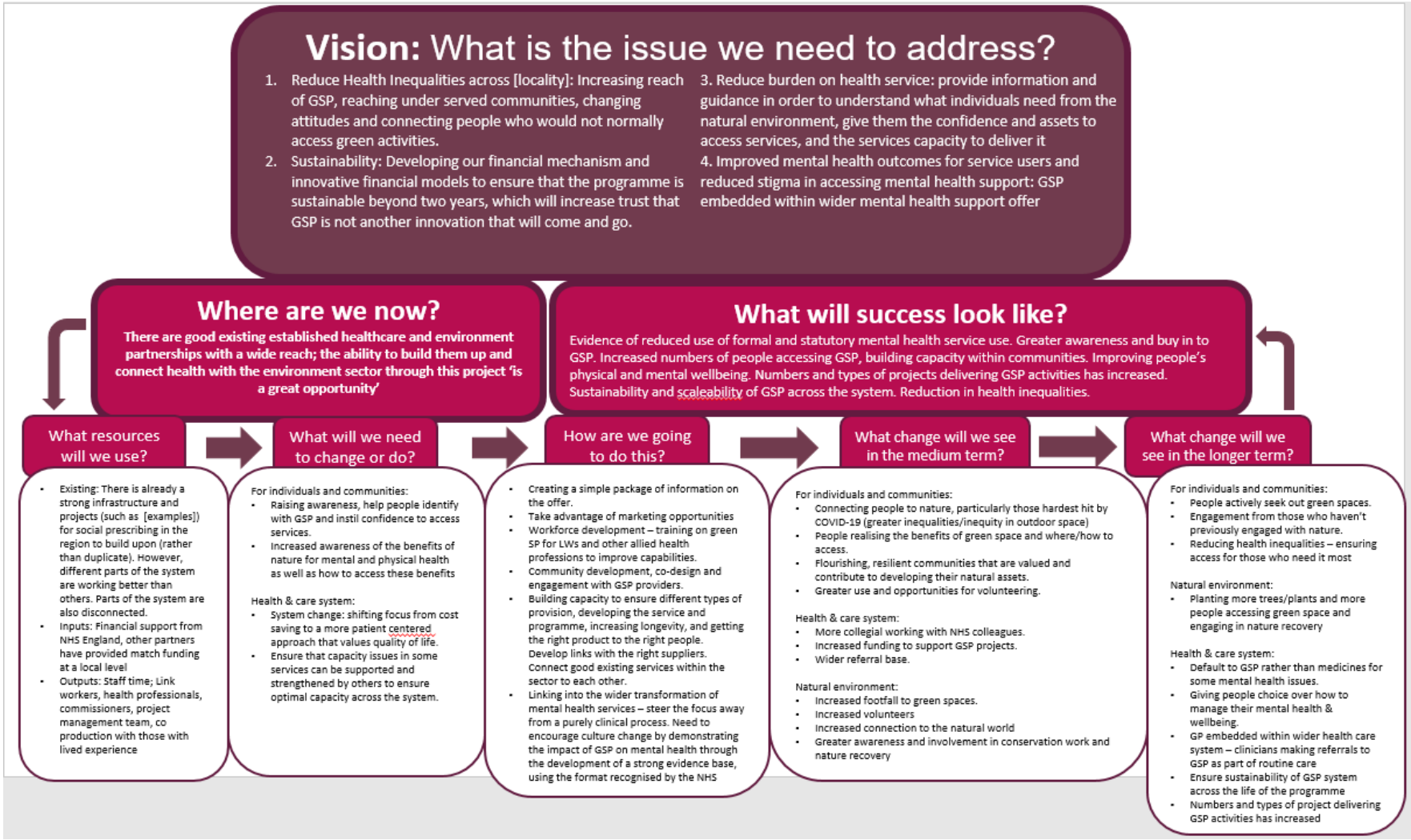
Medium term outcomes - 2 year life of Test & Learn project		Longer term outcomes - 3 to 5 years		Measures of success
	Participant Outcomes		**Participant Outcomes**	
MT1	Increasing nature connectedness and social interaction among participants: becoming part of everyday life	LT1	A contribution to reducing 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 tranformation 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, particiants 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 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		

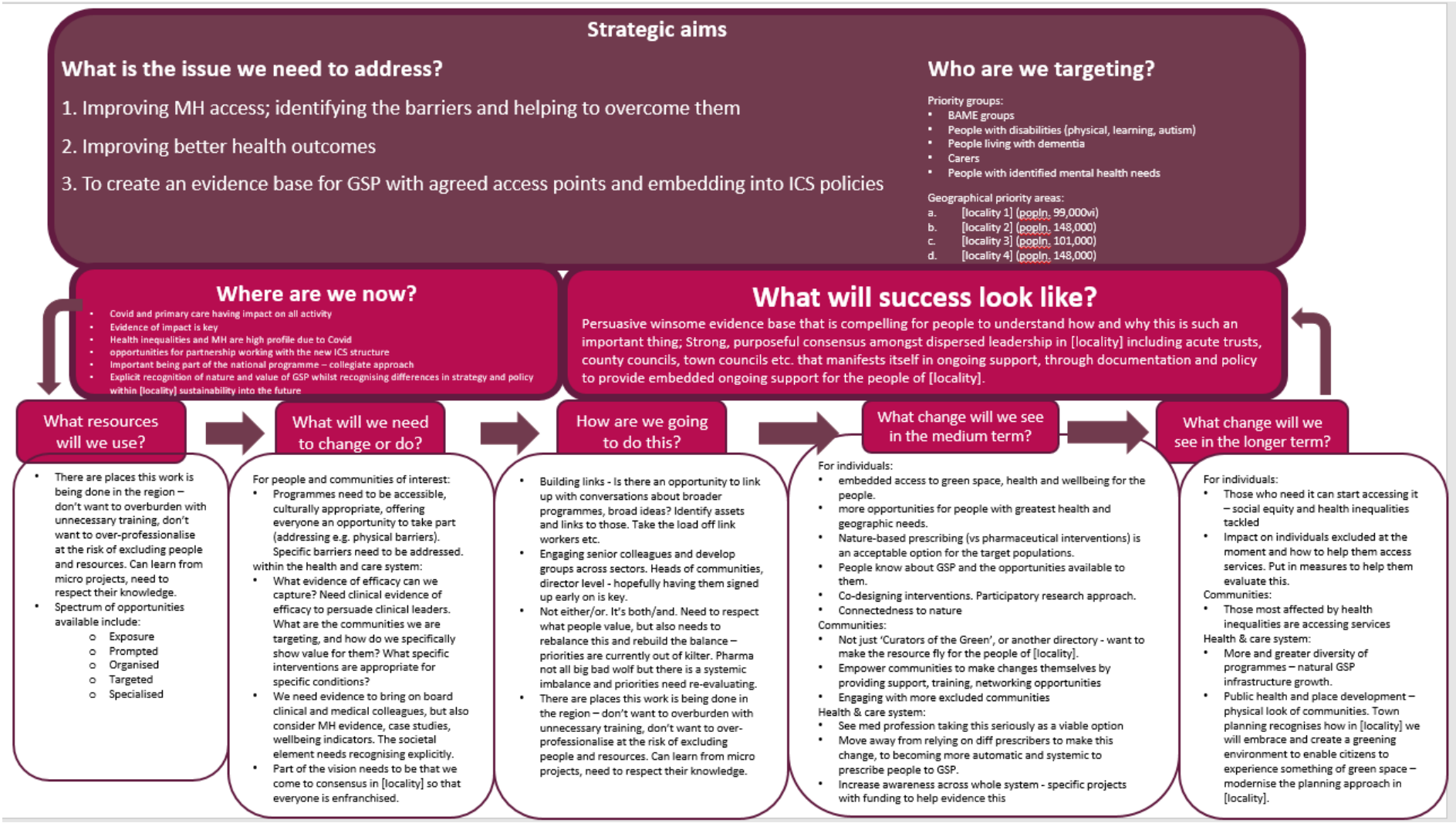
Test and Learn site 4



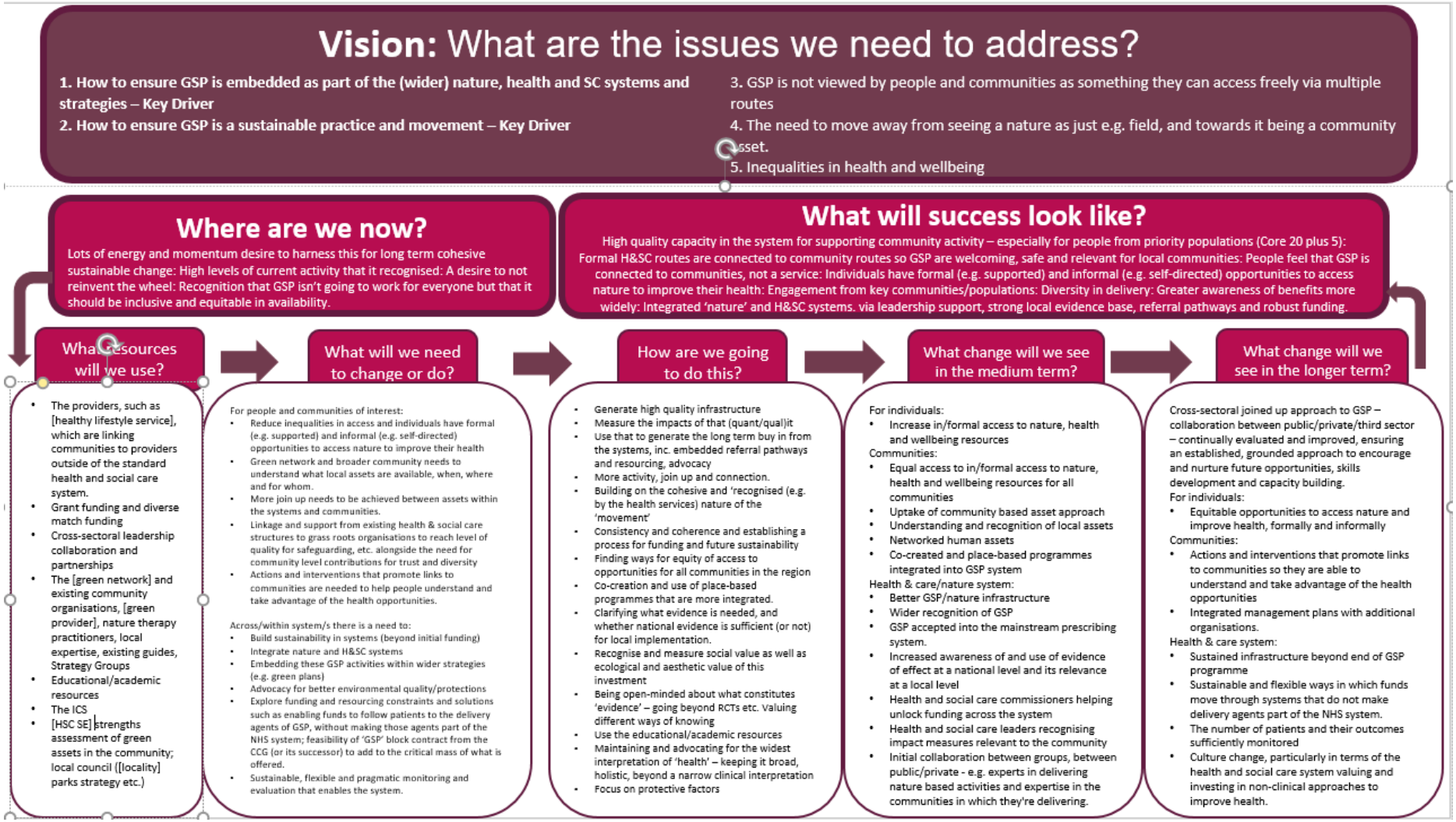
Test and learn site 5



Test and Learn Site 6



Test and Learn site 7



Appendix 3: Work package 4 – Findings from Evaluation in Non-Test and Learn Sites (follow up and new interviews)

A3.1. Introduction

Work package 4 comprises the follow up evaluation of GSP systems and activities in a number of 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.
- What may have changed or what have you learnt over the past year?

Written-up as case studies (presented in section A3.2) and key themes identified (A3.3).

A3.2. Case Study Write-ups

Case study 1: North-West Region – Follow Up Interview

The local social prescribing system

At the first interview, the existing social prescribing (SP) system was characterised as fragmented and uncoordinated, which was causing confusion and a lack of awareness over available activities and who is responsible for what. Poor coordination and improving training and awareness for link workers was cited as the main challenge to overcome.

At the follow up interview, the interviewee explained that the previous CCG structure was all a bit 'higgledy piggeldy', for example having one provider working across multiple PCNs, and other PCNs having multiple providers. But some CCGs developed a really good coordinated approach bringing providers together to deliver learning, training and sharing best practice. The hope that all this great learning, networking and coordination, would come to be upscaled following the NHS restructure moving to an ICB system, where all areas have merged together, has not yet happened reportedly owing to the length of time it takes for a new organisation to bed in, and generally the [NHS] system has been in 'a little bit of chaos'.

Since the first interview, this interviewee has since prepared and released a 'physical activity strategy' for the health and social care sector, that was commissioned by the NHS. The strategy focuses on system change (rather than getting inactive people active), and SP features as a big part of this. It aims to bring together a broad range of stakeholders from different parts of the system to create an advisory group (AHPs, nurses, social workers) and look at what can be done to upskill them around physical activity and how it can be applied in different needs. The next steps and future ambitions are for the groundwork done so far (integration and scaling up) to come to fruition, once the new ICS and ICB structures settle down, and to put in place activities to improve the SP system locally.

At the first interview, pooling data (i.e., database of providers; sharing data on activities) was cited as something that would help and it was considered a challenge to overcome to be able to obtain enough data. At follow-up, this was still an issue in terms of having a standardised approach to collect consistent data for evaluating the effectiveness of interventions and building credibility in SP. Data sharing and collection was seen as clearly being a big challenge and needs someone to collate it with all the right permissions to do it (i.e., considering GDPR etc.).

During the previous interview, the funding allocation for SP was unclear and there was uncertainty around how to secure future funding. At follow up, this interviewee had submitted a bid to Dept. of Transport, but this was rejected, however it helped form partnerships and improve relationships with the combined authority which has lent itself to more opportunities and being better positioned to apply for future funding.

Green Social Prescribing in the area

At the first interview, SP was expected to become a priority, but it was unclear how embedded Green Social Prescribing (GSP) already was in the system (thought not to be strong). At follow up the interviewee was still working towards creating a more coordinated and better designed system – SP is listed as a priority for example the ICS fund a Transformation Board around mental health and SP is included within the strategy as an effective way to reach people, and it was felt that real inroads are now being made to forge the conditions for embedding GSP as well, in terms of building the networks and relationships.

At the first interview, the aim for GSP was not apparent but there were lots of hopes and ambitions to embed it through link workers referring patients to outdoor spaces and building on the existing high demand for SP to galvanise people using green spaces. Whilst the ICS were considered keen on the ideas, there was a lack of coordination to lead any activity or funding to deliver. At follow up, the interviewee had been heavily involved in the physical activity element of the 'Marmot Report' (Sir Michael Marmot's report and approach for the region on tackling health inequalities called 'Altogether Fairer'). Involvement with this has helped to stitch together this interviewee's work/develop their strategy, and they have produced a series of indicators around tackling health inequality, influencing the inclusion of physical activity through active travel as one of the Marmot Report indicators. This was considered to be a really positive achievement as it is seen to create a rationale for if anyone questions why GSP should be funded - that by having this as an indicator it will directly support tackling health inequalities, with the report and prestige of Sir Michael Marmot to back that up.

Case study 2: Midland County – Follow Up Interview

The local social prescribing system

At the first interview, the main challenge noted was how busy and fully work-loaded link workers were and this impacted on raising awareness of the SP offer – leading to a tendency to lock in a list of providers and stick to it, which was not beneficial to some clients. It was further noted that there was no development/promotional funding and a lack of awareness raising of the 'SP offer'. It was also noted that GSP activities were somewhat limited to paid activities from large charity organisations (i.e., National Trust). Link workers and those prescribing SP activities were less familiar with where people could go for greenspace activities for example and the aim was to increase awareness of accessible greenspace, like using your own garden or local parks. Excessive workload was also cited as a major challenge.

Green Social Prescribing in the area

At follow-up, this interviewee's role specifically focuses on GSP activity, and as part of their role responsibilities they have been looking to engage with prospective GSP providers and identify gaps as to why people are not engaging with green social places. This role, with support from other intervention providers (i.e., the smaller groups like gardening, walking, paddle boarding groups that this interviewee has connected in with) have put on a lot of workshops to help with understanding and integrating SP and GSP across link workers. The Local Authority (LA) areas have also done a lot of marketing including leaflets for what SP is for example. A number of new roles have been appointed that this interviewee has connected in with, this includes 'Community Development Officer' roles appointed across each LA area to coordinate relationships between link workers and providers. 'GSP Prescribers' have also been appointed with someone now leading on GSP with their own caseloads. And Children and Young People link workers had begun to be employed in some PCNs to work with children and families which was viewed as going from strength to strength. This interviewee's specific GSP focused role however is due to end at the end of October 2023, so the focus is/has largely been on embedding and making GSP sustainable through fact finding and putting things in place for once this post ends, including the development of a 'road map'/information document for any new green providers interested in becoming a SP intervention – it outlines what SP and GSP is, who they need to contact to get fully constituted, and info re health and safety training etc. This interviewee is also delivering on a campaign before the post ends in October, to inform people across the area of where their top nature reserves are (some are accessible and some are not) – a pdf document is being developed to help link workers and to share with their clients.

At the first interview, it was seen as important for users to have a buddy to go to activities with 'anxiety is high, confidence is low'; having a volunteer befriender and drawing on the NHS volunteers were used initially (who had signed up initially for Covid vaccination centres), and were exploring other ways to encourage volunteering to help build confidence in attendance at GSP interventions. At follow-up, this interviewee is backing the 'green buddy scheme' that the wider area is currently doing and looking to roll it out locally in their locality. This scheme is set up in partnership with the National Association of Social Prescribing (NASP) and Natural England, to help others connect with nature through information, support and activities.

At the previous interview, the aim moving forwards was to engage diverse groups and understand why some groups do not access green space as much e.g., the Sikh community. At follow up, this interviewee had discovered that not accessing nature was very culturally embedded. For example, when parents and grandparents first came to England, there was a lot of racism. The men would go and get a job and when they came home from work, no one would go out again. It became learnt behaviour through the generations to stay at home, but now people want to go out and do things, and this interviewee instigated an initiative with a ladies Muslim group to support this group in learning to ride a bike.

At the previous interview, SP was reported as not being high up on the priority list for the newly formed ICS. At follow up, one of the barriers to embedding GSP was reported as needing to get embedded within some sort of ICS strategy for it to hook into as a bigger picture.

Case study 3: East of England Region – Follow Up Interview

The local social prescribing system

At the first interview, the interviewee reported beginning from a place of strength regarding SP through having had a history of SP being championed within the area, particularly across GP practices. Funding was considered sufficient at the previous interview (through the CCG) and the value of SP was clearly understood. At follow-up, the ICCs have now formed, and it is in the early stages of seeing how this evolves locally. A key development is that they have begun setting up specific PCN roles around 'armed forces SP' as the area has a long history of armed forces resettlement. But this interviewee's work is still mainly hospital based working directly with PCNs.

The focus for the coming year was to be on prevention and helping people upstream before needing to visit a GP, but this was anticipated to be a challenge owing to existing local models and long-term planning adopting a majority 'clinically based approach'. So, whilst the value of prevention and non-clinical interventions is well understood, there was little evidence of action to support this approach. In clinical settings partners want to 'measure the life out of things' rather than taking a conversational and relationship-based approach. At the follow up interview, the ICC's new joint forward plan was reported as including reference throughout to early intervention and prevention as well as place based approaches and SP - it was noted that it remains to be seen how this will manifest into action, and this interviewee considers themselves key to being able to unlocking this potential approach, given their standing and place within the local community.

Green Social Prescribing in your area

At the previous interview, GSP was reported as relatively new with a broad definition on 'connecting people to outdoor activities', with inactivity to be a target focus owing to high obesity levels locally. This interviewee states they were keen not to just be a signposting service and having a community capacity building approach (training walk

leaders/motivators) – this approach was seen as the gap to non-clinical partner understanding. Good participation rates so far demonstrated the 'stickiness' of their programme, showing their approach is working. At the follow up interview, three key developments were reported: link workers are working from the general hospital 6 days a week with the clinical teams – this is helping to unlock conversations around non-clinical aspects of SP; this interviewee continues to link in with 20 GP practices across the area (this is 5 PCNs who have directly commissioned this interviewee's services) - this continues to develop and grow; and the interviewee is based within the centre of town within a 'Community Hub' where the social groups/activities take place, as a central contact point. The benefits are being seen in terms of ensuring they are approachable and public facing in the community which is really helping their organisation to be well embedded in the local systems.

A main challenge reported at the first interview was around 'stopping people interfering' with other agencies referring into this interviewee's programmes with their own ideas on what the programme should/could be doing. This interviewee was keen to avoid 'mission drift' through having strong partnerships and co-design with everyone knowing their roles. At follow up, it was explained that this area has a strategic board that comes together as 'One Community Hub' which is a multi-agency space run by this interviewee as a charity/VCS locally, with SP embedded within it. This is working well and a key strength is that it enables adaptability to focus around the needs of the community and share conversations jointly. It includes working closely with their LA and healthcare partners to support the health and wellbeing of the community through a well maintained and sustained approach. Other agencies have begun working within the GSP space this interviewee recounted it not being as bad as they were anticipating it might be, because this interviewee reported just being pleased to be igniting the GSP school of thought and way of working locally and is keen to maintain conversations/relationships and activities for delivering together, with a joined-up approach moving forward.

At the first interview, sustainability and long term funding was seen as a challenge owing to short term commissioning models, and funding needing to show longer commitments. At follow-up, forward planning was still considered to be missing from the commissioning models, as it is still very reactive. This interviewee was therefore trying to encourage different ways of thinking, working and generating income, e.g., having a community café, renting shared office space to overcome this challenge.

Case study 4: London (two local authorities) – Follow Up Interview

The local social prescribing system

At the first interview, SP was described as being well-developed and established. Organisations providing SP services were often health-related with a few large third sector organisations overseeing delivery. This interviewee was unsure who the key link workers were at this time. At the follow up interview, they continue to work mainly with three SP organisations, Age UK in particular. A close relationship has developed with Age UK whereby they provide feedback on numbers of referrals and follow up work regarding GSP i.e., following up with the patient to see if GSP has had an impact (provided at additional cost). This interviewee reported surprise at the CCG not following up as a matter of course with the organisations they have commissioned to deliver SP to find out if a patient's health and wellbeing has improved since being referred.

Green social prescribing in the area

At the first interview, GSP was one of four key themes of SP for this organisation. Prospective organisations considered suitable for GSP referrals are approached and

asked to open up their activities to receive referrals, and information on GSP is shared with them; this has helped with widening the understanding of GSP. Referrals are made through the NHS and/or mental health services. And GSP is considered a great opportunity to encourage park use. At follow-up interview, it was noted that GSP was included as part of the 'Future Parks Accelerator' work previously where they were testing how GSP might work. Since that project has ended, the focus is now on embedding GSP and making it part of this organisation's regular work, particularly in relation to parks services. A dedicated 'Partnership Manager' post had been recently appointed just to work on green space, GSP and related work. This interviewee noted that they had been 'treading water' since last July as GSP has not had the full time commitment it needs, but going forward it will have that full time commitment now. One piece of work for this new role will be to get 'friends of parks groups' on board, so there are more activities for link workers to refer in to.

At the first interview, the ambition was to increase the number of GP surgeries referring people via SP link workers to parks and related activity. At follow up, this interviewee has created a webpage aimed at health professionals and SP link workers to explain about parks and health benefits and include details of activities happening in the local parks, along with a list of quality approved activities that link workers could refer into – these are to organisations who have agreed to accept referrals. Being approved was seen to add a bit of quality assurance for the SP link workers and the person being referred. Feedback on the website had been positive as people often ask what activities are available and the page seeks to answer this.

Case study 5: East of England - New Interview

The local social prescribing system

There are three different social prescribing approaches within this interviewee's region with emphasis on delivering a 'whole population, all ages' approach, but it was felt there was much work yet to do in the children and young people's arena. Social prescribing was considered more mature within the towns and cities, and less utilised near the coastal and rural areas. People are tending to self-refer themselves through the voluntary sector.

Social prescribing was described as 'the 4 Us' – being **unknown, undeveloped** (in terms of for example the referral system and quality assurance)**, unfunded** and **unequal** (when looking at geographical access and different population groups). Both access to it and awareness of it was considered very different.

Funding for social prescribing delivery was considered insufficient because where funding is pump primed into baseline finances of an organisation for example, when budgetary allocations set aside for resourcing a social prescribing workforce end, there is a real risk to continuing delivery. What is more, where charitable organisations are commissioned to deliver social prescribing activities, once their funding ends, some grass roots charities will cease trading, which is a further risk to the communities and people relying on these organisations for receiving social prescribing to support their health. This interviewee explained that subsequently those people will then end up back in the health sector, where social prescribing is the prevention tool for keeping people from needing to enter it initially. Short-term funding models, i.e. applying for grant after grant for funding, was seen as preventing long term commitment to social prescribing.

This interviewee went on to raise concerns around social prescribing being misunderstood, for example within the health sector, where there is an attempt to fit social prescribing around a medical model and 'that's not what social prescribing is'. This is being mitigated however by 'peer to peer' discussions which was seen to be

soliciting more clout and power for understanding social prescribing and how to develop and implement it more effectively.

Increased collaborative activity between organisations and inclusion of social prescribing within organisational strategies was reported positively by this interviewee, although the operational delivery is 'not quite there yet'. Delivery was seen as requiring a champion and voice to help stabilise it, and this interviewee did report there being a reluctance amongst some grass roots organisations to share knowledge in order to replicate models of success. This was noted as being a result of people working in silos. Having a dedicated post within an organisation therefore, to map out and scope the landscape, encourage conversations, find out who is doing what, to join dots and act as a bridge and link between sectors, was viewed as being positively influential for both social prescribing and green social prescribing (GSP) delivery.

Regarding data on the scale and scope of referrals to both social prescribing and GSP, this was seen to be lacking for this interviewee, with a lot of activity happening at the neighbourhood level that is not being recorded. Many referrals for example are coming in from schools at a neighbourhood level to get involved with GSP activity in particular, but there is uncertainty about where to go and what would be best for them. Opportunities were reported as getting missed due to the volume of people wanting to engage at school level and expand their nature connection opportunities to children and young people. It was also highlighted however that owing to an increased interest in this area of activity with this population group, that to some extent organisations are duplicating one another, which is another issue coming to the fore and calling for a more collaborative and coordinated approach with regards to both social prescribing and GSP.

Green social prescribing in the area

GSP was defined by this interviewee in terms of the different types of green care or nature connection activities, but also coupled to the premise that people do not really stay still, their needs will change and transition over time. For example, where a sensory walk-in nature may be sufficient at one point in time, their needs might develop to require a more directed therapeutic approach at another time.

GSP understanding was considered variable depending on geographical availability and accessibility, with awareness tending to be based on 'you know if you know' (i.e., someone's relative goes to something and you ask about it). Campaigns have been run to raise awareness across both communities, families and other organisations who might be interested in providing support once they know what it is.

Next steps for this interviewee are around strategy development which will involve awareness raising, making GSP more equally available, identifying funding, and developing it further, for example discussion involved creating a 'green care quality mark' for use by social farms and gardens. This helps both the GSP delivery provider and people accessing the service to be recognised as a quality provider.

The Covid 19 pandemic was reported as having raised the whole profile of the benefits of connecting with nature in different ways, and this interviewee explained that considering nature connectedness as 'different shades of green' this might encompass different focuses ranging from health and well being to biodiversity (climate change and food security), which are all shades of an environmental issue or a modern agenda,

> *and if we can find ways of getting people involved in projects and activities that are primarily about one or more of those [nature foci], then they will, invariably get a health and wellbeing benefit from it. For example, if you're out in a conservation*

group planting a hedge, planting trees, you are with a group and there are all sorts of social and mental health wellbeing benefits that come from that sort of participation in a group activity as well as the physical activity. We're trying to become a bit more 'fleet of foot' in terms of spotting those opportunities.

Case study 6: London – New Interview

The local social prescribing system

As a provider of social prescribing, this interviewee admitted to having made certain assumptions about how well developed the social prescribing referral pathways were. After scoping out the pathways themselves, this interviewee noted the varying levels of feedback from people at different points in the system (i.e. link workers, other providers, commissioners) and gathered reports that ranged for example from one provider who ran a community garden who had capacity but not enough people referred to them, through to another more established provider who had longer standing links into the health system and felt their referral pathway and relationships worked well, with a steady stream of referrals coming through. Over time, this interviewee's organisation has begun to get more referrals, but it became apparent that engagement can take time:

> *Obviously, link workers and other health or mental health professionals want some familiarity with the project and the people who are delivering it before they feel comfortable sign posting them there.*

In piloting and testing certain social prescribing activities with a view to upscaling them, this interviewee noted the challenge for people living in cities having to potentially travel to green sites which can impact on uptake of activities.

This interviewee noted the different organisations involved in social prescribing and GSP, with varying organisational structures and employees of link workers, including the NHS, third sector partners, and local authorities for example. They are then deployed in different ways too, which was seen in some ways to make 'intuitive sense' for enabling local autonomy over what works best in response to local need.

Mechanisms for link worker communication was discussed by this interviewee with an example of good practice shared that allowed for information sharing and identifying local activities to refer people in to – a monthly meeting was convened by the local authority inviting link workers from across the borough regardless of the organisation they worked for. The focus was on the borough itself, and all participation was welcomed, even from those on the edge of the neighbouring borough. The aim was to ensure fluid communication and knowledge sharing about local activities.

Funding consistency was cited as a concern, as was the period of time activities were commissioned for. 'Scrambling to get the next tranche of funding in' resulted in a 'patchwork' approach for some providers, with some funds coming from private funders and others from local authorities for example, so it is unclear who is providing the 'lion's share' for social prescribing and GSP activity, which ultimately results in organisations having to compete with each other:

> *obviously large organisations sometimes have, you know, just because they're bigger, have more established processes around accessing funding through grants or corporates or even Commissioners, so just ensuring that smaller organisations have that support in place to apply for things too.*

It was felt that activities delivered locally by organisations with a local community presence were making the most progress for social prescribing working well locally

and gaining community buy-in and support. This led to social prescribing becoming embedded and able to integrate more seamlessly. The activities are also more accessible without people having to travel distances to attend. For example, a local community gardening project is run by local people who have existing relationships in the community, this in turn makes for strong engagement with that project.

Green social prescribing in the area

GSP was defined using Natural England's wider definition relating to the benefit of being in a group of other people/peers and the nature engagement.

This interviewee noted the importance of developing community relationships and the time this takes, in order to develop and deliver both social prescribing and GSP successfully. Link workers were considered vital to developing these relationships for meeting people and gaining trust through experiencing projects for themselves. Good communication allows for 'rapid easy engagement'.

One of the key questions for this interviewee's organisation currently, was around how to support and grow more GSP activity within the local area. Recommendations focused around creating local grassroot forums to help identify what people would like to see in their locality, creating more points for people to engage, and considering what the potential barriers to engagement might be -such as individual preferences and different activities people are comfortable engaging with. The issue of how to resource this was however a concern, although it was stated that perhaps GSP activity would be likely to be more sustainable if created at a community level with more sustained engagement.

The language surrounding GSP was also discussed, for example 'prescribing' was seen to have a medical connotation. Whereas both social prescribing and GSP with its nature engagement, was considered by this interviewee to have the potential for being an upstream/preventative measure, such as in preventing mental health relapses, and thereby relieving pressures on the health system. For example, peer support and nature engagement were seen to reinforce one another and through talking about shared nature experiences, it can 'enhance people's experience of wonder'. GSP was described by this interviewee as providing a 'practice' for people to incorporate within their daily lives, where for example someone may have presented as having an identified 'need' to a health professional, GSP responds, not as a panacea, but it is a practice to keep people slightly better for longer. Helping people to feel empowered to do nature engagement activities themselves is a key aim for this organisation.

Case study 7: Yorkshire and the Humber – New Interview

The local social prescribing system

There are two different social prescribing systems within this locality, with some link workers embedded within NHS PCNs and others within the VCS. The aim of the roles is to link in with communities, and it has been particularly helpful having an additional dedicated facilitator role appointed to help with building up the social prescribing networks, but this role was only a temporary position.

Social prescribing Link Workers would typically look to their local communities to identify activities for social prescribing dependent on what the person they are supporting needs. Where link workers have a background in a certain specialism, for example learning disability services, they tended to support that population more from being able to draw on their existing knowledge.

Link Worker roles in general are now considered to be better understood and valued across multidisciplinary teams. Gaps have been identified however when it comes to offering Link Workers career progression, supervision training, and a permanent base to work out of. There is a requirement for both the capacity and infrastructure to be in place to support the Link Worker roles.

Social prescribing is becoming better understood but there is still work to be done around certain organisations gaining confidence in the role of the link worker and what this role can pick up to support other services. This is perhaps a training need to support the integration of the link worker role and explain their added value as a non-medical part of the workforce.

A question mark existed for this interviewee around whether GPs for example, are the most appropriate roles for supervising and offering provision to Link Workers and whether being more creative with the mix of staff within certain organisations would be better suited for conducting supervision sessions, as this would also feed into retention and ensuring link workers feel valued and supported in their jobs. This interviewee discussed examples of good practice around link workers being given the autonomy to develop their own caseloads and scope out population health data for instance to better support people within their local communities. The National Association of Social Prescribers (NASP) hosted a National Social Prescriber Link Worker Celebration Day which proved an excellent opportunity to showcase what link workers do. Developing a national body, similar to the NMC and GMC for Nurses could be a great way to raise link worker profiles and standards.

Green social prescribing in the area

Being about green spaces, GSP was seen to flourish through activities like walking groups or 'park runs', and this interviewee was aware of the research evidence showing the link to improved health and wellbeing when investing in green spaces.

The interviewee's locality did not receive funding to develop their GSP models and there were disparities in accessing green spaces and nature-based activities, so the region's health sector decided to invest some of its internal funding into a number of GSP specific projects. This resulted in identifying challenges and making recommendations for strategising on next steps for GSP related activity within this locality. Recommendations included identifying and targeting people who would benefit the most from GSP, such as those with mental health issues or adult learning disabilities, and people facing isolation. Challenges were in how to really target and encourage engagement from these population groups, particularly given that those who would access the outdoors are perhaps more motivated to do GSP activities and come anyway, so it was suggested a behaviour change and hand holding exercise trying to get people to attend. Link workers were considered quite key to driving the GSP agenda forward, through their close understanding on the ground to the local population and knowing what activities are available.

Expanding on the point around behaviour change, this interviewee noted how GPs are more medically trained and may naturally look to medicines and writing a prescription. Whereas social prescribing and GSP presents an opportunity for the workforce to marry together, because a social prescribing link worker would look more to the community support. This also enables a personalised care approach and promotes shared decision-making conversations between the provider of support and the person receiving support - 'what matters to me conversations.'

Leadership and co-production with both service users and service providers, were also discussed as an important factor in driving the GSP agenda, as it requires the pulling together of the right people, with shared interests, to influence the work. Also

considered a potential success factor in GSP delivery, was the role social media for example, can play in promoting and creating excitement around certain activities, such as Park Runs, for encouraging attendance through regular activities. There is however always the risk that things are set up and a really good model developed, but it needs funding ultimately.

Case study 8: South East Region – New Interview

The local social prescribing system

Social prescribing was not considered to be a new concept, but the way it is currently being done is new with a revival of reaching out to the VCS to develop it. As a result, it has got bigger and more noticeable. It felt to this interviewee that accessing social prescribing was based more on who you know than in following a structure for how to access it.

Some bigger organisations were seen to be in receipt of funding to develop social prescribing and pull in other VCS organisations. Often flyers would be used to promote initiatives via email for example across multiple organisations, but this wasn't felt to be a cohesive way of working, or for ensuring activities are appropriate to a person's individual needs, or for checking that activities/initiatives are being run appropriately. So, this raised a question mark over who does the recruitment and who does the delivery.

The language surrounding social prescribing was also felt to have a 'Dr emphasis' to it by using the word 'prescription', and this was discussed further in relation to GSP below.

Green social prescribing in the area

It was felt that GSP was not well understood, because the word 'prescription' assumes a medical link with a GP and it being connected with a particular need. GSP can be described in many ways including green care, green interventions, nature programmes for example, with a difference between 'prescribing' and 'intervention'. Confusion might exist around there being an illusion that GSP is prescribed, but not pharmaceutically, so a question remains for some people in understanding what it is, and what is known about what is actually being 'prescribed'.

A model of working that was liked by this interviewee was for VCS organisations to run green programmes/interventions in partnership with NHS Health Teams. The Health Teams bring their expertise around particular needs like mental health issues, and the complimentary VCS organisations bring in their skill set around delivering activities and programmes tailored to those identified needs. The requirement to distinguish between a person's needs was also discussed, because someone with mild mental health needs will need different support to someone with challenging or complex needs, so having the right people both signposting and delivering, with a clear understanding of who GSP is for and how best to deliver it, is important. A concern was raised around it being one thing to fund GSP, but it being another to really understand what you are delivering and dealing with, particularly when it comes to supporting people with mental health needs. And without wishing for it to be policed as it were, there does need to be an awareness around people thinking they are therapists when they are not properly trained or having had life experience of dealing with complex issues related to mental health.

GSP therefore absolutely needs a partnership approach with the right mix of organisations involved with the requisite skills to help support the individual in need.

The VCS was seen as having a key role in this, but to really make a difference, GSP needs to be embedded within the health service.

GSP delivery was currently considered to be quite fractured, which presents problems for driving a cohesive GSP agenda forward. There seems to be multiple agendas, multiple agencies, coming from multiple directions, with an overall tendency for GSP delivery being driven most by people who feel it is important, rather than it being driven by any structural changes.

The evidence base supporting GSP and nature based activity was discussed in terms of the rewarding connection between humans and non-living/non-humans in promoting well-being through being outdoors. There are also opportunities, potentially being missed, for getting involved in GSP activities such as within education to expand learning into well-being and the health of young people, which would combine physical movement with taking education outdoors.

There is a challenge however for GSP providers, particularly smaller organisations, when it comes to attending invited meetings, webinars and events for example, around resourcing and paying for their time to attend, which was suggested to be the case for the wider VCS too. This was reported as problematic as there are ideas around pulling organisations and people together, and some of the bigger organisations are receiving funding to undertake this activity, but smaller organisations are not in receipt of any funding to support GSP roll out and delivery. [MY SUMMARY: In effect therefore they are being asked to provide their time in kind, in addition to having no funding to support their own GSP delivery plans, but expected to contribute to others.]

In discussing what has worked well locally regarding GSP, this interviewee explained that successes had led from employers of GSP providers clearly understanding what their roles are, and being properly supported by their managers, which subsequently leads to providing quality support to the person in need, who has been referred to them. For example, by being allowed to attend GSP programmes/initiatives and experience them first hand alongside their clients. This led to understanding the needs of their clients from seeing them in an everyday space rather than in a room on their own. It was felt that there is a lot that is unexplored about the value of working like this. GSP can work if people understand it.

There is a lot around staff well-being too, with this interviewee having increasingly witnessed staff attending their programmes coming to them and being incredibly stressed. The success comes from having time to explore and remember why they came into the job of being a health worker or a teacher for example in the first place, as otherwise it is so bureaucratic – but the success comes from understanding the different roles for providing GSP and getting to know families or clients' needs in order to support them. A 'person-centred approach' for example enables an organisation to keep in touch with the clients/groups attending the GSP activities. Success comes from the co-production and co-participation to bring about well-being, and the only reason why this works is because it is about building up a relationship.

The successful delivery of GSP comes from there being an understanding between the provider and the client, and that grows, and the more contact you can have with the group/client the absolute better it is. For example, if delivering GSP throughout the seasons, people start to feel more trusting and safe through regularity and familiarity of contact over time, their wellness is in balance and in response to being able to come to a space they feel safe, where they can be themselves, and grow in confidence.

Case study 9: East of England – New Interview

The local social prescribing system

Social prescribing in this area spans the local authorities across different tiers, districts, a unitary county and the combined authority, each with an interest in health, public health and social wellbeing and with differing powers, levers and responsibilities. There is an interest in using parks to improve the health of local communities in the area, with parks largely being run at the district level.

Social prescribing delivery was initially very fractured with multiple layers and multiple players with different responsibilities across authorities, all trying to achieve the same aim but coming at it from very different directions on the local government side. Once the health system was then connected in, not only did you have public health within the local government system and adult social care, there were additional changes happening across the CCG, structurally and in terms of role changes. This resulted in trying to implement social prescribing delivery through a tangled web of local government, identifying who would do what, and factoring in this hugely complex world of the health system. This has resulted in challenges to finding out where the key decision makers are, for driving social prescribing forward and making things happen. The health system had the resources but it interfaced in the care system at the wrong level – 'there were many people in these huge meetings from different roles, but actually no one really held the budget to do things differently. And so that complexity was quite difficult to work through'.

Green social prescribing in the area

The GSP definition is not shared and not well understood. A lot of scoping was undertaken to try and learn from other trial sites and national programmes where GSP was underway to prevent reinventing the wheel for GSP delivery in this area. However, from a GSP delivery perspective, whilst the environment has clearly been identified within the new integrated care plan, and prioritising green space as an important enabler of lots of health outcomes and wider determinants of health, filtering delivery of GSP down through a fractured system where it was difficult to identify the necessary contacts within the health system owing to structural changes in the CCG has been very challenging. A lot of knowledge and capacity was lost through 'churn in the system'.

GSP delivery had been largely dependent on individual initiative rather than being driven by strategy and resource to do it. The types of green intervention have also been very much dependent upon where the link workers saw their impact and their own interests and whilst some were, not all were interested in parks for green prescribing. There was uncertainty over whether GSP was being driven by the data, by the need or actually just driven by the particular expertise in that area.

In terms of funding for GSP this is not sufficient – some early discussions were with 'Neighbourhood Manager' roles situated within the GPs, but they however weren't the budget holders, they were the facilitators between those groups of practises that wanted to do something around GSP. Therefore, finding out how to shape resources in order to shape the vision was a considerable challenge. Where budget did exist for example within local government or the ICB, it was a challenge to explain a request for money being spent to deliver GSP activity on parks. Getting a whole system approach was quite difficult. For example, the process of GSP was explained but how do we then get to the point of understanding the whole chain of decision makers from where the need is identified clearly, and there's a group of people who would benefit from this intervention identified clinically or by the link workers, but how does that then, if it's space or green space you want to use, feed through to those green spaces being

fit for purpose, i.e. what you do when you get there, is there a programme in place, how is it all managed - this has to jump across those different systems in order to get a full chain of events based on the needs of the person receiving delivery on the ground.

Work is underway to try and understand the whole system approach and the chain of events required to deliver GSP in order to prevent continuously reinventing the wheel, so that for example someone sited at a GP practice, or within a GPs group, and who know of people who would really benefit from the outdoors, understand the steps to take and the people to contact to make that happen. In reality a lot of people (GPs etc.) would not know where to start; people on the green space side might not understand what you want if their primary focus is on park maintenance for instance, so when approaching such providers to discuss health for example, they do not understand. There is therefore a lot of stitching together to be done to get people to see the whole picture and then paint a route or a process, which it has taken over a year to establish and scope.

Some really good individual projects were reported on such as healthy walks, volunteering outdoors, dance classes outdoors, all driven by the social prescribing and GSP agendas, but they all relied on closer to the ground initiatives to make the activities happen and they struggled to gain traction further up the decision making chain because of issues around providing enough evidence of results and a reluctance by some senior decision makers because they wanted to see the evidence first. But this is like asking for evidence around education outcomes, it is not linear – people saying they go to the park and subsequently feel much better, is actually difficult to prove it was just the park leading to the improvement as it might be multiple things in a person's life as well as being outdoors every day, that helped to improve their mental health. The park may have been the trigger and played a large part, but it's not the single causal factor. Despite an abundance of evidence at national level showing that the more experience and connection a person has to green space, the better they are both physically and mentally, this lack of evidence at a local level was a problem for some decision makers, albeit not all.

To demonstrate and capture evidence around the benefits of GSP to share locally is expensive to do and difficult to fund, i.e. a longitudinal study over five years on people running, or visiting parks, to help put a value on these interventions for decision makers, but what this interviewee did at a strategic and whole region level, was to demonstrate that by using natural capital they could put a value on health, wealth and the wellbeing contribution of open space by using some of the health indicators and natural capital accounting techniques and tools to show the whole health benefits of parks ('in the region of approx. £280 million over the year'). Some inroads were being made around changing decision makers' views around GSP and trying to put a value on some outcomes that you can't normally. For example, it is possible to put a value on building a new road and saying it will help our local economy, but we don't necessarily think about how building a new park can actually put a value on improvement in health. It seems that decision makers are less used to seeing those types of values i.e. health benefits, than they are the economic values for more traditional types of projects.

> *There's a shift that needs to happen there where those decisions are made with a full understanding, or better appreciation, of the social and environmental benefits as well as the economic benefits.*

Differing political persuasions of the region was also considered a challenge in terms of certain areas being much more environmentally focused than others. Essentially you have two ends of a political spectrum working within the same vicinity trying to get along and agree on how best to manage the local landscape in a way that will benefit

all the communities, and recognising the role of the environment and health, with the landscape having a big role to play in that. As GSP delivery got closer to the ground, it was possible to shape the health environment and see the GSP role as being really important, but fighting through a 'panoply of different players' added to the complexity for delivery:

> *you had this drag on the system, which was the different politics and the different ways that they would articulate what their priorities were, and their inability, to put it brutally, to get on sometimes because of the politics.*

When reflecting back on the work to have been undertaken so far, despite the differences of opinions, there was overall huge enthusiasm to make GSP work. People could see and understand the asset out there in community parks and landscapes that was being under utilised to support people's health. This asset was not really being looked after or its benefits being maximised and recognising this and wanting to do something to change this was recognised. Presentations from individuals with a specific interest in GSP were delivered, chaired by a local GP, with multiple attendees ranging from health organisations, the VCS, the ICS, clinical directors and other GP practices. The willingness is there, but the difficulty and challenge remains for getting a whole systems approach that can be replicated easily. It seems there is an overall lack of resource to do this piece of innovation and actually invest in establishing GSP 'it's like, let a thousand flowers bloom, just chuck it out there and see what happens'.

Case study 10: West Midlands – New Interview

The local social prescribing system

Having been involved in some of the early social prescribing models that pre-dated the national roll out, this interviewee felt better able to shape and create pathways for focusing on integrating social prescribing in the region. Social prescribing was described as a years old system around how to do primary care, but also a way of doing things very differently with a new workforce stipulating a bridge into community, and these two worlds have historically been separate.

Systems were seen as the key factor at a practical level for integrating social prescribing, for example using clinical systems and the barriers that exist to non NHS staff using clinical systems. Social prescribing was seen as a pioneering initiative involved in spearheading buy-in from GPs around the advantages of data sharing, access and input.

> *Integration and collaboration with primary care teams and community care and wider partnerships, gets real when we're talking about data because this is where everything comes literally onto one page.*

Challenges were reported in the first year of integration around having access to GP practice space, improving communication channels and connecting up clinical access. Appointing an administrator with prior experience of working in a large and busy primary care centre in the region was especially helpful in regards to overcoming this challenge, as their familiarity with clinical systems enabled inhouse training for link workers on navigating the clinical systems.

Partnership working across agencies and creating strong links was considered very important. This enables link workers to address the underlying issues that are causing people to come in and out of health services. For example, there might be adverse barriers to improving someone's health because of their housing circumstances, or family and relationship issues. The VCS organisations are able to provide an immediate and essential layer of support for individuals, and for each link worker that

support might look different – it may be a housing provider or an organisation specialising in women's health for example, but together you are linking all the wider determinants of health, such as food poverty, lifestyles, weight management, physical activity opportunities.

Funding is not sufficient. Central funding simply puts a link worker in GPs practices and it is then limited to the salary of that link worker with no incentivisation for VCS organisations to go into social prescribing management, as management costs and on-costs are not written into the national contracts currently. In the VCS, in order to manage this properly and employ a team of link workers, you need a dedicated manager to manage roles and the NHS does not currently cover this cost, which was considered an oversight. In order to top up their budget, this organisation sought to evidence their added value through quality, innovative programme delivery which has subsequently attracted additional project based funding or invites to sit round the table with public health. The concern, however, is that if social prescribing is considered a national programme, are other smaller organisations able to leverage the funding to evidence this. There is therefore a system wide gap in funding to enable the work to start, and central NHS funding is needed in future to support the delivery arm of link workers.

Social prescribing for this organisation is not looked at just through the lens of primary and secondary care but instead thinking through the lens of what a healthy community and healthy society looks like. When using this language it opens opportunities around work, in schooling, and a wider wealth of the community, and it is part of a bigger piece of work to connect into those wider organisations.

Measuring impact and collecting data to evidence the success of both social prescribing and GSP was considered the biggest challenge. If trying to demonstrate a return on investment for the money invested in the programmes, you could for example say that every patient attending a link worker is a patient who has not attended a GP, but obtaining an accurate picture of this is problematic because you could for example count footfall at primary care, but how do you assess whether that patient would continue to be a high frequent user of primary care. There is therefore a mismatch between top-down money coming from the NHS to alleviate pressure from non-medical appointments and non-medical time and being able to measure social prescribing and GSP in a holistic way.

Green social prescribing in the area

Defining GSP depends on the audience. Where it might make sense to GPs, outside this world it is lost on patients:

> *the idea of a 'prescription' is a very personal thing – it's a slip of paper, you go to the chemist and you apply a solution to your health condition, through a 'prescription'. But in the world of SP, it's not prescribing, it's social! So it's a bit of an oxymoron when it comes to applying it in practice, on the ground.*

This interviewee went on to discuss the stigmas attached to words like 'social isolation' and 'loneliness', where no one wants to be made to feel bad through being socially prescribed for, so changing the terminology used and re-branding this has formed a critical part of how this organisation has evolved their service.

GSP and making better use of green space has been a huge part of the work undertaken by this organisation, initially separate to social prescribing, but they have linked the two together by connecting people with a health condition to a green space initiative. This has strengthened the whole programme around the green offer,

widening it to better support people and provide a range of options from walking groups to therapeutic gardening.

One piece of ongoing work is around setting up activities in underutilised and/or neglected garden spaces, such as behind GPs surgeries, and where food is grown in these spaces for example, it then goes back into a community café, which further enables an invite for people to attend both the gardening side and the café. The spaces around the surgeries have been transformed as a result too, GPs also no longer need to pay someone to maintain their gardens. The land is usable, practical, it demonstrates a return on investment, patient's health is improved, and you have a programme needing little input to sustain 'everyone's a winner, everyone benefits'. The creation of a broader programme of green activity like this was considered a future aspirational possibility for implementing across the region, and link workers were seen as being instrumental in shaping and bridging this activity.

Parks were discussed as a great public health resource that are not being utilised enough and owing to a lack of funding to invest in improving access, cleaning them up where they've been fly tipped in, making them usable for people with disabilities, providing benches and improving safety measures, people are discouraged from using them for a walk or a jog as it's not always seen to be the best or most accessible place to do those activities. Linking together with other organisations is therefore vital for identifying who to speak to about what can be done to create better use of green space, to align passions, best practice and create platforms to share evidence for what is working. Also discussed was how other sectors are often being missed from the conversation, such as crime and policing and schools. There's potential funding within these organisations where health won't fund it all. The reality is that any improvements in creating better pathways to improve people's health through green space and to improve the green space environment itself, will also see added value and benefits across other organisations, such as a reduction in crime if parks are more publicly used, and education where putting green into the curriculum is a growing conversation. This could in turn leverage councils to better invest in the improvement of local green spaces.

A3.3. Case Study Themes

A number of key themes were identified across the ten case studies (four follow up interviews and six new interviews). These are highlighted below and framed as challenges and opportunities associated with the development and implementation of GSP.

Challenges

Funding insecurity and consistency

Funding insecurity was commonly cited as a concern, as was the short period of time SP and GSP initiatives and activities were commissioned/funded for. This led to continuous competition between providers who are 'scrambling to get the next tranche of funding in', with the smaller providers seemingly disadvantaged against, owing to some of them having less established processes and resources for bidding for grant funding, despite the very valuable, and much needed work they are doing within communities. There was also an issue raised around VCS organisations being invited to attend meetings of larger, better established organisations who are in receipt of SP and GSP funding, and whilst invites are welcomed, from a funding insecurity perspective, they are in effect being expected to provide their own time in-kind, with no additional funding made available to support their own GSP delivery plans and resourcing needs, whilst being asked to contribute to others. It is therefore unsurprising

that the landscape is promoting a competitive approach, as opposed to one of cohesion.

Strategy and Future Visioning Challenges:

Challenges affecting strategy development for future GSP and SP implementation centred largely around the fractured and disjointed nature of the different systems involved, and the barriers caused by competing for funding. All of which ultimately affect getting a GSP programme in place for the person receiving delivery on the ground. A number of interviewees reported GSP delivery being driven mostly by individuals who personally shoulder the importance of GSP, rather than it being driven by an organisation's structural changes. This has also led to reports of link workers naturally tending to favour initiatives they are interested in and more knowledgeable about, than seeking out a wider range of activities. This subsequently feeds into some providers receiving more referrals than others, resulting in a disproportionate spread of GSP access. As one interviewee noted, accessing SP felt like it was based more on who you know than it following a structure for how to access it.

Organisational structures

Dedicated management roles for supporting link workers working on the ground was considered lacking or not sitting with the most appropriate roles for conducting supervision sessions. As a consequence, link worker retention was affected, as was feeling valued and supported in their jobs. Additionally, it was reported that there was no incentivisation for VCS organisations to branch into SP/GSP management as management costs and on-costs are reported as not being written into the national link worker contracts. Where success stories were however reported, these were in instances where roles were very clearly defined and properly supported by their managers, for example, in enabling and allowing link workers and providers on the ground to manage their own caseloads, to visit provider sites, and to attend sessions with their clients, as opposed to holding meetings in medical rooms.

Data and Measuring Impact

Measuring impact and collecting data was repeatedly reported as challenging by interviews, both owing to the wider issues surrounding data sharing and GDPR, but also because of the holistic and non linear nature of SP and GSP, which is not conducive to being measured using a standardised and consistent approach when it comes to gathering and evaluating data in a cross-comparable way. Interviewees reported on efforts they had made to demonstrate a 'return on investment' with this being the 'language that's mostly understood by decision makers', but overall a shift in thinking as to the most appropriate and realistic way impact could be measured for national programmes like SP and GSP was called for by a number of interviewees. One interviewee for example described SP and GSP as a 'practice' not a panacea – it is something to incorporate into everyday life that will help keep people better for longer by addressing underlying issues that are causing people to come in and out of health services, but recording causal factors in well-being when multiple factors in a person's life can contribute to this is obviously problematic. As another interviewee stated 'GSP can work if people understand it', therefore trying to shoehorn data and evidence into a model typically set up for quantitative measurement is a challenge to be overcome.

Opportunities

User drop out and retention – presenting both challenges and opportunities for a 'person centred' approach

A reported challenge exists around targeting and encouraging continuing engagement across people most likely to benefit most from GSP activity, or those less likely to access it, as per the existing records for attendance at activities. This includes for example certain religious groups or people with mental health needs. As one interviewee discussed, those who would access the outdoors are perhaps more motivated to do GSP activities and come anyway, therefore some 'hand holding' may be needed to further encourage engagement. This may be where potential opportunities exist for link workers to provide the support that other interviewees identified when discussing having clearly defined link worker roles and being well supported by their supervisory teams to meet with their clients and undertake GSP activities together to help with better understanding their client's needs and encouraging attendance. This type of 'person centred' approach was discussed by a number of interviewees as a positive opportunity to promote partnership working across multiple agencies who share a common interest in looking to community support prior to, or alongside, medical interventions to support an individual's mental health and well-being. This was where the VCS was reported as having a key role to play in SP and GSP delivery, alongside it being embedded within the health service.

Partnership working and collaboration

A common theme emerging throughout the interviews was the potential for increased collaborative activity and information sharing between organisations, with shared strategic objectives and developing a forum to share knowledge in order to replicate models of success for GSP and SP roll out. Partnership working could provide scope for sharing a common understanding for the role of link workers and gain confidence in how these roles are developing. Additionally, shared interests across multiple organisations can be pooled to influence driving forward the GSP agenda and expand the learning for supporting the infiltration of GSP into other sectors that were seen to potentially benefit from GSP and SP activities, such as in education for expanding well-being through nature based activities. Building the right relationships across multiple organisations was reported as a potential opportunity for really embedding and growing GSP integration.

Understanding GSP – language and evidence

A strong theme emerging throughout the interviews was reference to the language used around SP and GSP, with concerns that the word 'prescribing' is more fitting to a medical model with a 'Dr emphasis' to it, thereby leading to an ambiguous understanding for what GSP and SP is and aims to do. Opportunities were therefore reported to exist for raising awareness across communities and organisations in the form of campaigns or locally delivered activities to demonstrate the upstream and preventative nature of GSP, such as for preventing mental health relapses. Or for promoting GSP through social media in an attempt to create excitement and encourage participation in activities such as Park Runs, and for keeping in touch with potential attendees around regularity of activities.

Strategy and Future Visioning Opportunities

Looking out for and spotting opportunities to evolve GSP delivery, integration and standards was a common recurring theme across interviews, with strategy development discussed for including for example increased awareness raising, making GSP equally available across populations, identifying future funding,

establishing ‘quality standard marks’ to reassure service recipients that they are accessing a quality provider. Further suggestions included establishing a national body for link workers, similar to the NMC for nurses, as a way of raising link worker profiles and standards.

Opportunities to involve other organisations such as education and the police were reported as currently being missed, where these relationships could forge a cohesive whole systems approach if a shared vision and focus for driving SP and GSP was through the lens of what a healthy community and healthy society looks like as a whole. It was apparent throughout the interviews that huge appetite and enthusiasm exists for what GSP and SP has to offer, with lots of great examples for initiatives shared and success stories of making a difference to people’s lives, such as through setting up activities in underutilised or neglected garden spaces and bringing communities together.

When discussing a whole systems approach and understanding the chain of events required to deliver GSP, opportunities were discussed around what best practice toolkits might look like, such as providing website lists of approved quality providers (with the local authority cited as the potential organisation who might be responsible for such vetting activities); having a step by step process written down linking support organisations to people in need of support along with a database of key contacts for setting up new initiatives and bringing partners on board; and providing instructions on how to replicate certain activities and initiatives in order to avoid time wasted in duplicating efforts. However, a major challenge remains here that wherever competition for funding exists, it naturally suppresses enthusiasm for adopting such an approach.