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

Interim Report - September 2021 to September 2022

January 2023

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September 2021 to September 2022

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

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List of Abbreviations

CCGs	Clinical Commissioning Groups
CICs	Community Interest Companies
COVID-19	Coronavirus Disease 2019
Defra	Department for Environment, Food & Rural Affairs
DES	Network Contract Directed Enhanced Service
DPIA	Data Protection Impact Assessment
G/B S	Green/Blue Space
GP	General Practitioner
GSP	Green Social Prescribing
The project	The Preventing and Tackling Mental Ill Health through Green Social Prescribing Project
ICS	Integrated Care System
IMD	Index of Multiple Deprivation
HCP	Health Care Professional
HSC	Health and Social Care
HWB	Health and Wellbeing
MH	Mental Health
NBSP	Nature-based Social Prescribing
NHS	National Health Service
NHSE	National Health Service England
PCNs	Primary Care Networks

QoL	Quality of Life
ScHARR	The School of Health and Related Research
SHU	Sheffield Hallam University
SP	Social Prescribing
SPSS	Statistical Package for the Social Sciences
T&L (site)	Test and Learn (site)
ToC	Theory of Change
UNEX	The University of Exeter
VCSE	Voluntary, Community and Social Enterprise
VFM	Value for Money
WP	Work Package

Contents

1. **Introduction** **1**
1.1. The Preventing and Tackling Mental Ill Health through Green Social Prescribing Project 1
1.2. Green social prescribing 2
1.3. Purpose and content of the interim report 3
1.4. Methods and progress 4
1.5. Synthesised findings across work packages 8

2. **Synthesis of the Aims and Theories of Change of the Test and Learn sites** **9**
2.1. Vison 9
2.2. Change 9
2.3. Medium and long-term outcomes 10
2.4. GSP as a complex system 12

3. **Theme 1: Relationships and connections across the GSP system** **13**
3.1. Inclusion of stakeholders 14
3.2. How connections are made 15
3.3. Alignment and interconnectedness of systems and practices (buy in) 16
3.4. Roles, capacity, and interconnectivity 17
3.5. Flexibility, adaptability and robustness of the system 18

4. **Theme 2: Test and learn site project delivery** **20**
4.1. National project management and leadership 21
4.2. Alignment of ambitions and aims 22
4.3. Use of T&L funds 23
4.4. Project progress 24

5. **Theme 3: Use of Test and Learn funds to build GSP system and support activity delivery** **25**
5.1. Priorities and strategies for use of the T&L funds 26
5.2. Community involvement in use of T&L funds 28
5.3. Collaboration with system partners in use of T&L funds 29
5.4. Data collection, systems, infrastructures and priorities linked to T&L funds 31

6. **Theme 4: Integration of GSP in the health system** **35**
6.1. Cohort and eligibility priorities for GSP within the health system 36
6.2. Embedding and perception of GSP 36
6.3. Coordination and provision of services 37
6.4. Pressures within the health system 37

6.5. Commissioning and funding ... 38
6.6. Perspectives on reliability, trustworthiness and effectiveness of green social prescribing in the health system ... 39
6.7. Evidence ... 39
6.8. Relevance to inequalities in health ... 40

7. Theme 5: Link Workers and Referral Processes ... 41

7.1. Priorities for social prescribing / green social prescribing ... 42
7.2. Link Worker referrals to nature-based activities ... 43
7.3. Locally trusted organisations and accreditation systems ... 43
7.4. Referral pathways and processes ... 44
7.5. Referral and Link Worker location ... 45
7.6. Referral workforce ... 45

8. Theme 6: Nature-based system and providers ... 47

8.1. Priorities in delivery ... 48
8.2. Understanding of, and access to, social prescribing system/s ... 50
8.3. Funding availability and needs ... 51
8.4. Availability and accessibility of delivery settings ... 54
8.5. Support and resources ... 56
8.6. Capacity for delivery ... 57
8.7. Nature-based providers and data collection ... 58
8.8. Experiences of referrals and referral systems ... 60
8.9. Experiences of delivery of activities ... 62
8.10. Experiences of working with people with MH needs ... 62

9. Theme 7: Targeting of GSP for particular groups ... 64

9.1. Priority and underserved groups, their identification and agreement ... 65
9.2. Decision making between stakeholders ... 65
9.3. Targeting approaches ... 66
9.4. Recruitment and referrals ... 68
9.5. Barriers to engagement and strategies to improve engagement ... 70

10. Theme 8: Referral experiences ... 72

10.1. Referral experiences ... 72
10.2. Activity experiences ... 73
10.3. Perceptions of suitability, benefits ... 73
10.4. Accessibility ... 75

11. Theme 9: System Data Collection Practices, Information Flows ... 76

11.1. Barriers to collection of robust data ... 77
11.2. Access to data ... 78
11.3. Remit of different stakeholders to collect data ... 78
11.4. Outcomes ... 78
11.5. Summary of the monitoring data ... 79
11.6. Link Worker provided data ... 80
11.7. Nature-based provider data ... 82

12. Theme 10: Developing sustainable GSP systems and delivery ... 85
12.1. A focus on sustainability ... 86
12.2. Funding and resources for sustainability ... 88
12.3. Policy and strategy for GSP sustainability ... 90
12.4. Developing a sustainable system ... 92
12.5. Evidence and intelligence to support a sustainable GSP system ... 92
12.6. Training and capacity development for sustainability ... 93
13. Conclusions and implications ... 95
13.1. Conclusions ... 95
13.2. Quantitative data challenges ... 97
13.3. Targeting under-served populations ... 97
13.4. Implications ... 98
13.5. Next steps for the evaluation ... 113
14. References ... 114

List of Tables and Figures

Table 1: Individual work package methods and progress ... 4
Figure 1: Synthesised local Theories of Change ... 11
Figure 2: Test and Learn strategies ... 27
Figure 3: Plurality of patient pathways to GSP activities for hypothetical T&L site ... 32
Table 2: Monitoring data received from Link Workers and providers ... 80
Figure 3: Draft National Theory of Change ... 87
Table 3: Table of Implications ... 108

Introduction

1

1.1. The Preventing and Tackling Mental Ill Health through Green Social Prescribing Project

The 'Preventing and Tackling Mental Ill Health through Green Social Prescribing' Project is part of a two-year £5.77m cross-governmental initiative focusing on how systems can be developed to enable the use of nature-based settings and activities to promote wellbeing and improve mental health. Partners include: Department of Health and Social Care, Department for Environment, Food and Rural Affairs, Natural England, NHS England, NHS Improvement, Public Health England, Sport England, Department for Levelling Up, Housing & Communities and the National Academy for Social Prescribing. The project is testing how to embed green social prescribing into communities in seven test and learn sites in England in order to:

- Improve mental health outcomes.
- Reduce health inequalities.
- Reduce demand on the health and social care system.
- Develop best practice in making green social activities more resilient and accessible.

In 2020 Integrated Care Systems (ICS) and Sustainability and Transformation Partnerships (STPs) were invited to become 'test and learn' sites for the project. The aims were to '*establish what is required to scale up green social prescribing at a local system level and take steps to increase patient referrals to nature-based activities.'* The pilots, and the evaluation (to which this interim report relates), were to help identify what works in shared policy making and delivery across multiple sectors and scales, and to clarify how barriers to delivery could be overcome and which enablers help improve outcomes of better mental health and 'value'.

The programme was promoted to ICS and STPs with ambitions to: Provide opportunities to work collaboratively to embedded green social prescribing within the wider developing social prescribing at individual, community and whole systems levels; address the 'under-utilisation' of greenspaces for health outcomes; opportunities to 're-frame' how greenspaces, and the activities run in them, can support better health and wellbeing; and finally, to scale up provision of greens social prescribing, aid recovery form Covid-19, and health reduce inequalities in health.

The objectives of the Test and Learn pilot programme were to:

- Understand and address system barriers to scale up effective green social prescribing across England.
- Understand actions and behaviours required from different stakeholders to sustainably embed effective green social prescribing delivery models as part of the wider health and care landscape.

- Develop four location specific plans which set out the activities, support and resource required to scale up green social prescribing and how this could be measured.
- Implement targeted and co-designed interventions to scale up green social prescribing.
- Increase patient referrals to nature-based activities to help people's mental health.
- Increase join-up, collaboration and shared learning between the health and environment sectors.
- Inform the development of national and local implementation strategies for social prescribing.

Successful applicants who got through the Expression of Interest stage were invited to set out their relevant experience. They were then asked to articulate how, through whole system partnership approaches, their proposal would help to address health inequalities and support Covid-19 affected populations. Applicants were also asked to make clear: how the pilot would be systematically embedded, and how it would be further developed and expanded beyond the Test and Lean programme; how applicants had identified communities of need (primarily relating to high deprivation, health inequality, and/or Covid-19 impact); how they would track progress on the delivery and measure outcomes; the extent of partnership working and how this would be maintained and governed; and finally, their commitment to evaluation and learning through the programme.

1.2. Green social prescribing

In this project, green social prescribing (GSP) is the practice of supporting people to engage in nature-based interventions and activities to improve their mental health. Social prescribing Link Workers (and other trusted professionals in allied roles) connect people to community groups and agencies for practical and emotional support, based on a 'what matters to you' conversation. There are four 'pillars' of social prescribing that Link Workers connect to: physical activities, arts/cultural activities, debt and other practical advice, and nature-based activities. There are many different types of nature-based activities and therapies that people may reach through a social prescription and include: conservation and other hands-on practical environmental activities; horticulture and gardening; care farming; walking and other exercise groups in nature; and more formal talking therapies based in the outdoors.

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

Evaluation is taking place throughout the project, led by the Department for Environment, Food and Rural Affairs (Defra) on behalf of the national partners. The evaluation is assessing processes, outcomes and value-for-money, in order to inform implementation and future policy and practice. It will improve understanding of what works, for whom, in what circumstances and why. The project includes in-depth evaluation in the Test and Learn (T&L) sites together with lighter touch evaluation of green social prescribing in a range of other locations, to provide comparison and learn more about how green social prescribing can be scaled up in a wider range of contexts.

The evaluation contract was awarded in April 2021 and will run to June 2023, to a consortium led by University of Sheffield working with University of Exeter, University of Plymouth and Sheffield Hallam University. This document reports on interim data collected from September 2021 to June 2022 and draws on initial scoping work undertaken March 2021 - July 2021. The four specific aims of the evaluation are:

- **Aim 1**: To understand the different systems, actors and processes in each T&L site and how these impact on access to, and potential mental health benefit from, GSP.
- **Aim 2**: To understand system enablers and barriers to improving access to GSP, particularly for underserved communities.
- **Aim 3**: To understand how GSP is targeted at particular groups, including underserved communities.
- **Aim 4**: To improve understanding of how to successfully embed GSP within delivery and the wider social prescribing policy landscape.

1.3. Purpose and content of the interim report

This report details the initial synthesis of data gathered by the national Evaluation Team on the Test and Learn project.

It details the activities, constraints and challenges faced by those who are working to promote and scale up GSP which the Test and Learn project is seeking to address, as well as the initial impacts of these changes. It focuses primarily on aims 1-3 of the evaluation as a whole, with more detailed learnings about how to embed GSP to be produced for the final report in summer 2023.

The report draws on ongoing work from Work Packages 2-6 and is structured into the following sections:

- Evaluation methods and progress.
- Thematic synthesis of the key findings across work packages, organised by 10 interconnected themes:
    1. Relationships and connections across the GSP system.
    2. Test and learn site project delivery.
    3. Use of Test and Learn funds to build the GSP system and support activity delivery.
    4. Integration of GSP in the health system.
    5. Link Workers and referral process.
    6. Nature-based system and providers.
    7. Targeting of GSP for particular groups.
    8. Referral experiences.
    9. General data collection practices, information flows.
    10. Developing sustainable GSP systems and delivery.
- Conclusions and implications.

Additional and separate documents are provided as Appendices with more extensive reporting of the methods and findings of each individual Work Package activities.

1.4. Methods and progress

Table 1: Individual work package methods and progress

WP Number and name	Activity and methods used	Data collected to date (i.e., no of questionnaires returned, interviews, observations, workshops etc.)	Location in detailed report	Next steps (i.e., type of data to be collected, timescales)
WP2. Evidence synthesis	Collaborative workshops	• Individual Theories of change for each T&L site. • Synthesis of local Theories of Change.	Further detail on ToC in Appendix 1.	Revisiting ToC with T&L sites for discussion and update.
	Targeted evidence searches	Research on whole systems approaches to interventions and evaluation.		Ongoing responsive evidence synthesis (ad hoc).
WP3A. Mixed Methods Evaluation: Quantitative	Action research to improve the quality of data monitoring across sites. Regular meetings with the individual Project Manager/s. Workshops and advice sessions with Link Worker teams and nature-based activity providers to develop monitoring data systems and use of questionnaires to evaluate T&L sites.	Development of core outcomes and guidance on capturing data e.g., agreement on how to record whether a user has mental health issues.	Detailed interim report of WP3A in Appendix 2, part a. monitoring and evaluation data; part b. questionnaire results; part c. Link Worker and NBA delivery questionnaires.	Ongoing support of T&L sites to develop their monitoring systems.
	Collation, cleaning and analysis of monitoring data.	Monitoring data received and cleaned from Link Workers: • Site 1: n=69. • Site 2: n=88. • Site 4: n=393. • Site 5: n= 393. Data received and cleaned from nature-based activity providers: • Site 1: 69 service users. • Site 2: 540 service users. • Site 3: 33 service users. • Site 4: 0 (not focus of T&L delivery). • Site 5: 453 service users. • Site 6: 196 service users. • Site 7: 434 service users.		Continue to support T&L sites with collecting monitoring data. Undertaking of further subgroup analysis to meet needs of T&L sites. A further cohort of data will be analysed in Spring 2023 to feed into the next evaluation report.
	Questionnaire to Link Workers and	• 122 Nature-based activity provider responses.		Development of follow up Link Worker and

WP Number and name	Activity and methods used	Data collected to date (i.e., no of questionnaires returned, interviews, observations, workshops etc.)	Location in detailed report	Next steps (i.e., type of data to be collected, timescales)
	nature-based activity providers.	• 91 Link Worker responses.		nature-based provider questionnaires to administer in Spring 2023.
WP3B Mixed Methods Evaluation: Qualitative	Embedded Researcher reflections.	Extensive immersion in the local T&L system. Including attendances at meetings to build links and relationships as part of becoming 'embedded' in local T&L site.	Detailed interim report of WP3B in Appendix 3.	Continued embedded researcher informal reflections will be collected throughout the project and further reflections reported on in the autumn report.
	Interviews Observations	Total: 67 formal interviews, and 43 formal observations[1]. • T&L1: 9 interviews. • T&L2: 12 interviews. • T&L3: 10 interviews. • T&L4: 5 interviews. • T&L5: 10 interviews. • T&L6: 11 interviews. • T&L7: 11 interviews. Across all T&L sites, interviewees included: • 20 project managers. • 3 mental health service system leaders. • 7 clinicians. • 5 social prescribing leads. • 20 green activity providers. • 1 local authority manager. • 5 commissioners. • 2 Link Workers. • 1 local evaluator. • 3 NHS strategic level employees. • 1 service user representative.		• Proposed additional interviews / focus groups with service users and key stakeholders Winter 2022/23. • Requested case studies from sites. These will be analysed and included in the final report.
WP4. Light touch evaluation outside pilot sites	7 non-T&L sites.	Interviews with 9 stakeholders.	Detailed interim report of WP4 in Appendix 4.	Follow-up interviews and workshops, Autumn 2022.

[1] In addition to formal observations, a large number of informal conversations, email exchanges and meeting attendances have also been undertaken to enable the researchers to embed in the system and develop deeper contextual understandings of the Test and Learn sites.

WP Number and name	Activity and methods used	Data collected to date (i.e., no of questionnaires returned, interviews, observations, workshops etc.)	Location in detailed report	Next steps (i.e., type of data to be collected, timescales)
WP5. National Partnership	Stakeholder interviews.	Interviews with 12 stakeholders.	Interim report of WP5 ToC workshops and interviews in Appendix 5.	Follow-up interviews, Autumn / Winter 2022.
	Theory of Change workshops with stakeholders.	3 workshops.		Prioritisation and planning of further workshops for ToC development.
WP6. Value for Money	Value for money costing tool: site and provider level.	Site level tool completed by 4 sites for Financial Year 21/22 (3 outstanding).	Interim report of WP6 in Appendix 6.	• Site level tools to be completed by 7 sites for Financial Year 22/23 (March 23 onwards). • Provider level tools (n=14-21) to be complete during autumn-winter 22/23. • Stakeholder workshops to establish meaningful cost comparators and 'typical' care package costs.
WP7. Integration and synthesis of findings	Synthesis, using realist informed methods, of findings from WPs3-6.	N/A	Forms main body of the Interim Report.	• Further refinement and use of explanatory analytic framework.

Methods for integration and synthesis of findings

This Interim Report represents an initial thematic analysis of the findings, to date, from across all work packages of the Test and Learn Evaluation and synthesised through work package 7.

The objectives of this stage of the analysis are to:

- Organise and describe the findings of each work package (see separate Appendices for detailed reports of each work package).
- Integrate and synthesise across work packages.

- Provide initial analytic interpretation of findings.
- Initiate the development of programme theories to inform the final stages of data collection and subsequent analysis.

We are guided by realist informed approaches to evaluation of complex systems and have sought to use a whole system framing of our understanding of what is being attempted through the Test and Learn pilot project (see detail under Theme 1 below). We have not sought to take a comparative approach to analysis, rather we are trying to understand rich detail about the activities, challenges and achievements of the sites in context. The relative 'success' of each site has not been assessed. This is due to the recognition that each T&L site is operating within its own unique set of circumstances and have each taken a very different approach to developing the systems and facilitating increased GSP. Furthermore, 'success' is a difficult concept to define when taking a whole systems approach. Instead, we are working towards identifying the factors within each context that have or could contribute to facilitating equitable GSP. In the final report the analysis will enable us to produce a set of statements about what works, for whom and in what circumstances and as such we will be able to reflect on unique circumstances and commonalities within and across sites.

We took the following steps to producing the integrated synthesis of findings detailed in this document.

Initial theme categories were identified through a synthesis of key objectives and research questions as stated in the project proposal and agreed with the national funding partners. These were integrated with additional themes that were emerging from the initial descriptive analysis of the findings of, predominantly, work packages 3A (the quantitative work) and 3B (the embedded qualitative work), with additional insights from work packages 2 (local Theories of Change), 4 (information from non-test and learn sites) and 5 (national partnership working). Details of the methods and interim findings from each work package are shown in the appendices. As the Value for Money assessment is in early stages of data collection, this is not reported here, but details can be seen in Appendix 6.

Ten interconnected theme categories were defined:

1. Relationships and connections across the GSP system.
2. Test and learn site project delivery.
3. Use of Test and Learn funds to build GSP system and support activity delivery.
4. Integration of GSP in the health system.
5. Link Workers and referral process.
6. Nature-based system and providers.
7. Targeting of GSP at particular groups.
8. Referral experiences.
9. General data collection practices, information flows - including quantitative data collected through work package 3A.
10. Developing sustainable GSP systems and delivery.

These ten themes were then broken down into a total of 65 sub-themes. Initially this structure was developed by the University of Exeter team, it was then discussed and further refined at a whole group meeting in Sheffield in July 2022.

Evaluation Team members were then asked to provide reflections on their findings for each of these sub-themes (as appropriate). This was done in a spreadsheet - which was organised according to work package and, for WP3B, by T&L site - in order to bring a structured and systematic approach to analysis. The high-level reflections in the spreadsheet were then analysed according to theme by members of the University of Exeter team. Additional, often more specific data was integrated at this stage (e.g., from T&L application documents; site information summaries; T&L high level site and quarterly progress summaries; and steering group and advisory board minutes). The written thematic synthesis was iteratively drafted by the University of Exeter team, with multiple waves of sense checking and verification by the wider Evaluation Team.

The next stages of the analysis will be iterative. Key areas of analytic focus will be prioritised, candidate theories of 'what worked, where and for whom' will be further clarified and then tested through the final waves of data collection. The aims will be to explore:

- The relevance of different systems, actors and processes in each T&L site context and how these impacted on increasing access to, and mental health benefit from GSP.
- Key system enablers and barriers to improving access to GSP, particularly for under-served communities.

The following questions will then be addressed to inform future GSP strategy:

1. How can the complex system/s be influenced to enable, embed and sustain GSP?
2. What are the key, pragmatic and achievable leverage points to enable and sustain GSP?

1.5. Synthesised findings across work packages

The following chapters present a synthesis of the aims and theories of change of the test and learn sites followed by thematic synthesis of the key findings across work packages, organised by 10 interconnected themes:

1. Relationships and connections across the GSP system.
2. Test and learn site project delivery.
3. Use of Test and Learn funds to build GSP system and support activity delivery.
4. Integration of GSP in the health system.
5. Link Workers and referral process.
6. Nature-based system and providers.
7. Targeting of GSP for particular groups.
8. Referral experiences.
9. General data collection practices, information flows – including summary of quantitative data collected.
10. Developing sustainable GSP systems and delivery.

2 Synthesis of the Aims and Theories of Change of the Test and Learn sites

Theory of Change (ToC) models were co-produced for each Test and Learn site and for the national partners. They describe the vision, current status and needed changes, resources, activities, and aims regarding medium- and longer-term changes. Theories of Change for each test and Learn site are shown in Appendix 1. These site based ToCs were synthesised to create a generic ToC model that describes the shared vision, current status and required changes, resources, activities, and aims regarding medium- and longer-term changes Figure 1.

2.1. Vison

Most T&L sites wish to affect systems change to join up health and social care systems with nature-based providers, to connect more people from more diverse populations with nature and reduce health inequalities. Most are also keenly aware of the need to ensure that GSP is sustainable, particularly in relation to the mechanisms of funding for nature-based activities and providers. Only one site explicitly includes ambitions to reduce health service burden in their vision (although this is raised by others in terms of impact).

2.2. Change

Changes needed to achieve successful GSP systems identified by the Test and Learn sites included: generating better (clinical) evidence as a mechanism to influence more clinician buy in; building links (within the health system and beyond it), and aligning with broader organisational structures and cultures, strategies and programmes (within the health system and beyond it), in order for GSP to be embedded; clarification of referral pathways and more effective connection between Link Workers and providers; increased capacity in nature-based activity provision; raising awareness among communities about nature-based activities and ensuring equitable access through addressing barriers such as childcare and transport.

2.3. Medium and long-term outcomes

Sites identified a range of medium- and long-term outcomes for the system, the community and the individual including: establishing trusting relationships and partnerships within the system, and enabling ongoing collaboration around GSP; GSP becoming better understood, accepted and valued as a viable option (particularly for prevention) by health care professionals and the healthcare system leading to greater likelihood of it being embedded in health systems; sustainable funding (including direct commissioning) contributing to improving capacity; improving service user pathways; increasing awareness and understanding leading to equitable uptake of GSP offers by the community; and GSP practices becoming environmentally sensitive. Several sites aim to increase understanding, awareness of, equitable use of, and connectedness with, local green and blue space, with the aim of improving mental health outcomes. Focusing on the upstream determinants of mental ill-health – particularly in terms of inequalities in access and in health – is seen as a key mechanism through which GSP can impact mental health outcomes. The sites intend that this will lead to empowered and resilient communities.

Figure 1: Synthesised local Theories of Change

2.4. GSP as a complex system

Green Social Prescribing (GSP) consists of complex, nature-based interventions operating within complex health and voluntary sector systems. Complex interventions are those that contain several interacting components (Craig et al., 2008). They are often “dependent on the behaviours of those delivering and receiving the intervention, there are a range of possible outcomes, or there is a need to tailor the intervention to different contexts and settings.” (Rodriguez et al., 2020). It has been suggested that recognising the nature of complex systems is key to ensure that such programmes are properly delivered and evaluated (McGill et al., 2021). Complex systems exhibit a number of features, such as their dynamic nature, interacting components within the interventions, adaptive responses within the system to interventions, emergent qualities, and feedback loops.

> *When we use the word 'system' we do not use it in the sense of a fixed organisational structure such as a benefits system or hospital. Rather, we use it to mean something that assembles itself around a shared sense of purpose. (Plamping et al., 1998)*

Within a health care context, for example, systems exist in multiple, interacting ways, including organisational (relating to the administrative or managerial systems with given functions), relating to structures of service delivery (such as primary care systems), topic based clusters of healthcare need (systems aimed at preventing and tackling mental ill-health) or the way in which such activities are driven (through local area agreements, for example, or strategic documents). Similarly complex systems also exist for Local Authorities, the Voluntary, Community and Social Enterprise (VCSE) sector and other relevant bodies. GSP is attempting to work across and within these systems, to try and embed and scale up GSP in order to prevent and tackle mental ill-health. One of the key challenges is how the various entities (institutions, organisations, providers, networks, individuals, communities etc.) which constitute 'the GSP system' assemble and interact in order to work towards this common goal.

> *When we work in a whole system way, the purpose of our interventions is to release the potential for finding creative solutions which already exist within the system. This contrasts with the model of expert solutions being imported from outside. (Plamping et al., 1998)*

Each of the T&L sites has designed its own approach to the challenge of embedding GSP across their systems. This is in line with a whole systems approach where local solutions to complex challenges are to be encouraged. It is the *function* of the activities which is standardised in a whole systems approach (in this case, trying to embed GSP), rather than the *form* (the exact nature of activities that aim to achieve this). (Garside et al., 2010). It also fits with a 'test and learn' approach as systems can adapt to changing circumstances and to accumulated understandings about what supports or hinders the project.

Building and supporting relationships is key. A central concern of systems working is to harness and facilitate the power of individual and organisational relationships between those working within a system (Attwood et al., 2003; Hawe et al., 2009; Plsek, 2001; Pratt et al., 2005; Stacey, 1996). It also recognises that knowledge about current working, and possible problems may be localised across the system. In order to develop solutions to these problems, access is needed to as much tacit and formal knowledge, from all parts of the system, as possible through relationships within and between organisations, and a recognition that answers are always subject to alteration and improvement. (IDeA, 2007; Senge, 1993)

3

Theme 1: Relationships and connections across the GSP system

This section describes how relationships and connections across the GSP system have been developed and supported. It discusses: the inclusion of stakeholders; how these connections are made; the alignment and interconnectedness of systems and practices (buy in); roles, capacity, and interconnectivity; and the flexibility, adaptability and robustness of the system.

Key Findings from Theme 1: Relationships and connections across the GSP system

- T&L Sites have undertaken huge amounts of work to engage stakeholders from across the GSP system, through creating networks, stakeholder groups, workshops and management structures. Involvement in the GSP system was typically more complete than in the non T&L sites. Some gaps in active involvement remain in some sites, particularly at a strategic level, including representatives from mental health trusts, nature-based delivery organisations (particularly from smaller organisations), Link Workers and those with lived experience of mental ill-health. Capacity to attend, or not feeling like their input had an impact may be issues influencing this.
- Where existing networks, such as those for nature-based activity providers, already existed, this has facilitated sites moving more quickly to delivering nature-based activities through GSP. Elsewhere it has taken longer to understand the local landscape and develop these networks. There is a risk that overreliance on existing networks may exclude some groups and reinforce existing more dominant voices.
- Many sites report strong support and buy-in for GSP from stakeholders. However, they report that some remain unaware or sceptical of GSP benefits (including some clinicians), or are unconvinced of its relevance for specific groups (such as those with more serious or complex mental health conditions).
- Dedicated Project Managers have a central and critical role in developing and promoting GSP, including providing leadership, coordination, strategic development, relationship and network development, and identifying additional funding streams.
- Power imbalances between statutory and VCSE sectors remain, with the latter not always feeling valued as equal partners, or able to influence project direction. They may be expected to be flexible in responding to need, where statutory partners may have less agility and flexibility.

3.1. Inclusion of stakeholders

The GSP system includes a wide range of possible stakeholders: those in the health services (primary care practitioners, mental health practitioners, managers, commissioners, hospital and community trusts etc.), those in the Local Authority (such as public health practitioners, planners, infrastructure, parks management etc.), arm's length governmental agencies and advisers (such as Natural England, Sports England etc.), Link Workers (who may be employed through GP surgeries, other parts of the NHS, voluntary sector etc.), nature-based providers (from the voluntary and community sectors), other VCSE organisations (such as Age Concern, Citizens Advice, mental health charities etc.) and members of the community. The exact combinations, and their role or position, may vary from site to site, but a range of those interested and influential in adopting and embedding GSP need to be involved.

At the start of the project, nature-based providers often felt unconnected to the health system, and to the project and were not clear how to get involved, with some feeling that it was a '*closed shop*' or not knowing how to get themselves '*on the radar*' (as evidenced in the questionnaire responses for WP3A, interviews WP3B). Efforts made by one T&L site (T&L4) has supported those involved to gain a greater understanding of the health system and arrangements for provider participation in decision making. In addition, Link Workers were not always aware of the GSP offers in their locality. Sites have tried to address this information asymmetry through developing networks, training, and direct provider funding.

While all the sites involve a range of relevant stakeholders in their management/planning meetings, some notable absences include service user members/ people with lived experience of mental ill health (present in only one site), Link Workers (at the time of writing, Link Worker representatives were only present in two sites, and in several cases interviewees commented on the complexities of fragmented Link Worker employment and lines of accountability, which hindered communication), mental health services (present in four sites, and technically part of the group but rarely attending in a further two), primary care/GPs (present in four sites) and nature-based providers – particularly those representing smaller or local organisations rather than network or national green organisations (present in three sites). Smaller nature-based providers may not be resourced to spend time in meetings where they are not paid to attend (interview/obs data T&L4), and may have small numbers of paid workers in their team, reducing capacity to take on additional roles and activities. Where they do attend, the issues they raise may not be addressed (T&L4). In one case, Link Workers were initially part of the management team but had to step back due to lack of capacity/workload. Similarly, one site did initially include a service user member on their management group, but they did not feel heard and subsequently left:

> *So we failed there I think and that's something we should reflect on [T&L1]*

One site reported involvement through a local service user co-production group, but it was felt that their input was limited. Another site reported that their wish to treat service users who sat on committees as colleagues, and to pay them accordingly, was initially resisted by larger public sector organisations in the partnership, although this was ultimately resolved. Being able to model alternative approaches, such as those favoured by the VCSE sector, and to present this as part of a test and learn ethos was seen as positive. See section 5.2 for more detail on involvement in allocating funds within sites.

Previous research has highlighted the need for partner organisations to feel a sense of ownership and involvement in strategies and policies for successful whole system working (Pearson et al., 2010), and this may not be possible where key partners do

not attend key decision-making fora. This can be challenging and, even where all partners are, in theory, “at the table”, invitees may be unable to attend, unable to attend regularly, or may not feel they influence decisions where they do attend. Crucially, this may lead to limited understanding of the challenges faced by key partners and may not allow decision makers to draw on the knowledge and experience of these partners to address these issues.

In the non-T&L sites (WP4), involvement in the GSP system was typically less complete than in the T&L sites, where the dedicated resources afforded by the project facilitated more activity and greater visibility of GSP. Where previous investment in GSP was present in non-T&L sites, this site was able to do more, but this investment was less system focused and more project based. In addition, individual enthusiasts might bear more responsibility for driving GSP, rather than there being more focus on the wider system.

3.2. How connections are made

GSP needs to be embedded across and within existing systems, themselves already complex, as well as developing new pathways and connections to other parts of the system (and connected systems). In addition to developing new networks and management structures within localities, the sites have been positive about the opportunities offered through NHSE for the National GSP Project to come together and share experiences between sites.

In many of the sites, established existing partnerships and networks have been used and built on to leverage GSP work in the locality including VCSE, social prescribing, and nature-based provider and interest group networks including, in some areas, the Local Nature Partnerships (LNPs). Where these networks were already reasonably well developed this has allowed the sites to proceed relatively quickly to supporting specific nature-based providers to develop and deliver projects to local populations (e.g., T&L7 where networks among nature-based providers (such as through the LNP and its health-related sub-groups) and those for SP were both already in existence, and the project has supported linkages between these). Other sites have had to, or chosen to, spend longer developing these networks and systems prior to focusing on intervention delivery – recognising that robust systems are more likely to lead to sustainability of GSP in the longer term (e.g., T&L4; T&L3; T&L2). Developing green networks (between a range of nature-based activity providers), and linkages to other VCSE groupings (such as those supporting mental health) was seen as an important way for the test and learn sites to become more aware of the capacities and capabilities across their locality which would support better link up and use of local resources. Building relationships across diverse partners and systems can be time consuming but is essential to develop trust and support agency across the system.

While leveraging existing networks and partnerships may be effective in quickly drawing together and strengthening activities across relevant sectors, there is also a risk that this results in reliance on existing connections. This may contribute to the exclusion of important but unconnected parts of the system and specific actors within it (such as smaller nature-based providers), reinforce existing organisations status as the '*go to*' for support (T&L4) or include only those groups who were already delivering nature-based activities in a social prescribing context rather than expanding the number of offers available through Social Prescribing (T&L2). It may also contribute to continued exclusion of some voices, and participation of some groups, as noted above (T&L5). In a whole systems approach, the groundwork of bringing people together to develop, and organise around, a shared sense of purpose is critical to success and in itself forms a key part of the process of 'delivering' GSP. However, elsewhere across a number of T&L sites, the project has been instrumental in expanding existing networks, systems and interconnectivity. For example, where strong existing Social

Prescribing structures had not previously engaged with grass roots nature-based organisations, and where providers have been connected in an emergent GSP Alliance model (T&L4).

While formal meetings, governance and systems for engaging across partners were common, it was noted in some areas that systems were connected primarily through personal knowledge and connections rather than more formal structures (T&L3). In practice, both formal and informal connections will be important to facilitate whole system working. It was noted at one site that formal meetings and networking events themselves facilitated the development of more informal discussion and networking between partners (T&L7).

Working with complex systems requires recognition that knowledge about current working, and possible problems may be localised across the system. In order to develop solutions to these problems, access is needed to as much tacit and formal knowledge as possible through relationships within and between organisations, and a recognition that answers are always subject to alteration and improvement (IDeA, 2007; Senge, 1993). By relying on existing networks and structures, some parts of the system, which may hold key understandings about the system and problem solving within it, may not be heard. It was also noted that such reliance may cement formal lines of communication, and that these may be very hierarchical, particularly within NHS structures. Critical tacit knowledge, gleaned through expertise by experience or within volunteer and professional groups with less access to decision making fora, may remain unheard.

3.3. Alignment and interconnectedness of systems and practices (buy in)

Views of the nature and goals of the GSP system, and the SP system generally, vary and can be contested between partners. Despite the 'what matters to you' rhetoric, health services may focus on NHS partners and processes, as well as aims to reduce workload/ demand on health services (T&L4), while other partners may view SP in a more holistic, person-centred way with the aim of improving individual health, wellbeing and nature connection.

While some sites reported positively on buy-in for GSP across the system (T&L5), several sites noted challenges. For some, these challenges related to a lack of a robust and deep understanding, amongst a range of stakeholders, of what is needed to significantly shift the balance of control and structures (practices, processes, roles and resources) in order to build and embed new systems. In other cases, there is a lack of a basic understanding, and valuing, of social prescribing and/or green social prescribing and/or nature-based provision among stakeholders such as health care workers (T&L4). Two sites have worked to build an accredited or trusted provider scheme for nature-based providers to try and ensure that health professionals and Link Workers feel confident to refer for nature-on-prescription (T&L3; T&L6) (see Theme 10 for more detail).

In some cases, green partners, or the voluntary sector generally, did not feel they were treated as equal partners in the GSP system, or that it had taken a long time for them to be treated as such (T&L1). It was also noted that, despite considerable work by the project to engage with mental health trusts, this could be challenging with many in the sector having a '*healthy scepticism*' of GSP. GSP could be seen as '*nice to do,*' but not important given other priorities and challenges in mental health services (T&L5; T&L2) or the (perceived) dominance of a more biomedical model (T&L1):

> *I certainly don't think it is up there from mental health... from a mental health perspective, it is certainly not seen or not viewed as important. And, you know, I*

even went and spoke to the key leads for mental health – it's certainly not on their agenda. [T&L5]

It was noted that buy-in might be achieved at an individual level but was also required at a team level to be successful. Elsewhere, increased understanding and enthusiasm for GSP engendered by the project has not translated in action – for example with some Link Workers not increasing their referrals to nature-based providers (T&L2).

Where all the core T&L management team come from the same body, such as the local authority, this may facilitate early work as ways of working and expectations are familiar, but it may also reduce opportunities for building the interconnections with other sectors, as needed for systems change.

Questionnaire data (WP3A) showed that there were initially some concerns about communication about the project within sites from both Link Workers and nature-based providers, meaning they didn't feel informed about what was going on in their locality. Some who had attended meetings about the project reported a lack of subsequent follow up, or there was not sufficient communication amongst partners such as letting people know what activities were happening. Whilst valuing the potential of the project, they could be discouraged from further involvement if they hadn't heard whether the time they invested to participate led to change. This highlights the importance of keeping enthusiastic people in the system informed about activity and progress, and feeling valued to avoid partners feeling disconnected and limiting partner buy-in.

National partners have noted that, despite working well together, issues are not always resolved and some – such as the focus on individual level mental health impacts and the need for corresponding monitoring data – were returned to for repeated discussion, without seemingly being resolved (WP5). Addressing these challenges and building consensus around points of contention within the partnership, has become a key focus of WP5, and a series of workshops to develop the national theory of change for the roll-out of GSP have gone some way to resolving these issues.

However, this perceived inconsistency early in the project was transmitted to the sites themselves, particularly around the priorities for systems building, intervention delivery and targeting and monitoring impact on mental ill health. It was noted by some T&L sites that a lack of national direction at the start of the project and a shift in focus hindered project planning and delivery.

Interviews with stakeholders in the non-T&L sites (WP4) suggested that buy-in to GSP was affected by short term funding models. Some felt that it was not worth engaging with activity that was unlikely to be maintained in the longer term. This highlights the importance of sustainable funding models for involvement across the system.

3.4. Roles, capacity, and interconnectivity

The role of the Project Manager(s) at all sites is pivotal in providing leadership, direction and influencing the culture of GSP within the locality. The absence of resources for leadership roles was also noted as a key limitation in developing and expanding GSP work in non-T&L sites (WP4). Most T&L sites have a single Project Manager, but one has shared this role across four Project Managers, each with distinct specialities/ remits, and another uses a project management group. Across a large urban site, there is a single Project Manager, but the T&L site has effectively been split into a number of smaller sites, holding their own funding and each operating slightly differently, and having different strengths and maturity in existing networks and collaborations. While other sites haven't formally split the patch like this, they also contain different areas (such as urban and rural areas) that are also working with different types of infrastructure, systems and networks, such as across multiple CCGs

which were operating independently. With changing organisational structures, such as ICSs whose remit requires formalised partnership working across health, local authorities and the VCSE sector, this may help to increase engagement and breakdown silos.

The organisation that 'hosts' the Project Manager/s may impact on their influence. In one site where the Project Manager is hosted through a small VCSE organisation (T&L4), there is a sense of disempowerment not experienced by those sites where being employed and hosted by a local authority or ICS gives a greater sense of strength (e.g., T&L2, T&L5, T&L7). However, in the two other sites where Project Managers are from the VCSE sector, there is a longer history of joint work between health and the VCSE sector and a greater sense of support for the sector among key people in the health system. At the time of reporting, the relative lack of power experienced in T&L4 had been recognised and work in the leadership group to redress this is ongoing.

The range of Link Worker models (for example whether hosted and employed through primary care, other parts of the NHS, Local Authorities or within the VCSE) – both within and between sites – can influence the extent to which Link Workers are connected to the GSP system. In some localities, GSP was working with one type of Link Worker set up, but not with Link Workers in others (for example working with those employed by the NHS, or in one VCSE organisation, but not with others).

Link Worker capacity is clearly under strain, with high levels of referrals as well as reports of inappropriate referrals, including those who may have serious mental health needs, and those experiencing critical social and economic issues. In some cases, Link Workers felt they were perceived as a '*dumping ground*' for people with difficult and serious needs due to pressures elsewhere in the health system and a lack of other suitable options to refer them to (WP3A, questionnaire data). GSP is one pillar of the four available as an SP 'what matters to you' offer, which limits the number of people they can refer to GSP and therefore their engagement.

In some sites, power imbalances between partners remain, particularly between nature-based providers and system leaders (especially in health). Where support is requested, this is not consistently acted on, and the VCSE tends to perceive a lack of genuine influence, despite in some cases having formal roles and responsibilities within the GSP system (T&L4). The establishment of a 'trusted green provider' system (T&L3) is seen as a way of creating more equitable relationships.

3.5. Flexibility, adaptability and robustness of the system

In order to be successful, systems need to be able to adapt to changing circumstances and respond flexibly to challenges (Garside et al., 2010). Statutory agencies may have less flexibility than the VCSE sector in terms of hierarchies and ways of working, and there are also budgetary constraints (with funds to be spent on particular things or within the financial year for example). Where funds to support GSP can be managed within the VCSE sector, this may allow more flexibility in this regard.

Statutory bodies, and particularly NHS structures, are seen as limited in their ability to change and adapt. There is also the perception that there is a greater expectation that the VCSE sector should adapt to NHS systems and ways of working, but not *vice versa*. Green providers may be more used to being flexible because of the constant need to adapt in response to changing funding landscapes. However, reliance on the VCSE sector could be a system fragility:

> *Currently, community-based activity provision is largely resourced through the goodwill and initiative of the micro VCSE providers. There can be no expectation*

of data quality, processes, standards, etc. until that changes and valued and trusting relationships are established. [T&L4]

One site noted that there was not, as yet, what could be thought of as a single GSP system – but a series of nested systems, some disconnected. Other sites noted that some historical divisions, such as Clinical Commissioning Groups (CCGs) and other organisational structures persisted. This meant that systems and infrastructure across the patch may be at different levels of maturity, including the levels of prior development in SP programmes and available nature-based provision.

4

Theme 2: Test and learn site project delivery

This theme discusses the ways in which the test and learn sites reflected on the nature of the delivery challenges, including national project management and leadership; alignment of ambitions and aims; use of test and learn funds and project progress.

Key Findings from Theme 2: Test and Learn site project delivery

- Support from the national GSP project (particularly through NHSE staff support, and generating national policy conversations) and has been highly valued by the T&L sites both to support delivery, as a catalyst for action, and as a way of providing legitimacy for the project and facilitating local buy-in.
- Perceived lack of clarity and shifting priorities from the national partnership were found to be unhelpful and, in some cases, thought to negatively impact the potential of the sites' success (for example, through focusing on generating evidence of individual level mental health impact early in the project, while this is reliant on embedding GSP in local systems).
- Sites are still working to align the vision, aims and priorities of stakeholders in relation to GSP. Where there is clear communication of goals, processes for agreement and the development of networks, these help to address this.
- Sites are very positive about what has been achieved by the GSP project (such as building relationships, funding activities and opening up access, reaching communities in need), despite some feeling they have not done as much as they hoped to by this time point, about halfway through the project. This may be due to the inherent challenges, and the time-consuming nature, of attempting to affect systems change, as well as the project operating in the context of the Covid pandemic, and concurrent health system reforms. Sustainability planning is an increasing focus of site activity.
- The timescale of 2 years is recognised as insufficient for the ambition of the project to affect systems change.

4.1. National project management and leadership

Many of the sites agreed that support from the National GSP project through NHSE and the national project manager was very helpful, offering a range of valued support from strategic input to assistance arranging and joining meetings with specific key individuals locally. In one site (T&L3) the input of Natural England was also highlighted, noting that they were also closely involved, and regularly attending project meetings. The national conversation raising the importance of GSP and providing funding were seen as critical and catalytic:

> *I think policy decisions and commitments from NHS England nationally is so important and so meaningful. Because when you've got that written in policy in a mandate from the government or NHS England nationally you can then start having those conversations and making those decisions much more easily because you know that's the future direction of travel. [T&L5]*

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

The national level leadership was considered to have been an important component of getting wider buy in:

> *I know locally, when I'm talking to kind of providers and services with the, you know, the individual NHS trusts. As soon as I say NHS England, you know, little ears go up! And they're listening. So, I think, but whether that's not them providing any action, that's just kinda got the interest in the first place [T&L5]*

However, there were also concerns. The focus of GSP project was seen to have shifted away from a more flexible initial focus on issues such as tackling health inequalities, supporting communities hit by Covid-19, loneliness and wellbeing, as a route to supporting mental health, to focus more exclusively on mental ill-health, which was seen as only part of the original rationale at national level. Sites also perceived there to be a more specific focus on primary care referral routes than originally intended. This led to a lack of fit between projects as conceived and planned in the sites' original bids, and the current ambitions of the GSP Project at a national level. In addition, it was felt that the emphasis shifted from system change to embed GSP, to more urgency to deliver nature-based programmes locally and for these to demonstrate mental health impact. As the project enters its later stages, a further shift toward prioritising sustainability has been noted:

> *The lack of national clarity on the programme and to be honest, slightly moving goalposts has been a challenge. As an example, when the opportunity was publicised, it linked green prescribing to mental health but ... I read it as quite open you know, supporting mental health and wellbeing kind of message. As the months went ... it felt like that message sharpened significantly to 'we're interested in people with severe mental ill health'. You know, it's more that than the preventative and I felt that that message did move and wasn't that helpful. [T&L]*

Sites experienced pressure from the national team to start delivering nature-based interventions through the project more quickly than they had been planning to, and felt that this might be detrimental to their ultimate success:

> *There's this enormous time pressure from NHS England, 'You need to be delivering right now because we need to be collecting data from January.' And*

*we're like, 'Sh*t. Well, you know, that means we need to like, do engagement' and it just all felt very, very rushed. And in an ideal world, it would have, you know, taken a lot longer and whatever, it might have been better quality. [T&L]*

As many sites wanted to develop meaningful engagement activities with nature-based providers and/or to co-produce interventions with local communities, these time pressures may have prevented best practice in these activities. Previous research has found that targets or funding attached to narrowly defined areas of health impact, and short timeframes, may limit the ability to take a whole systems approach (Garside et al., 2010), a tension that is evident in the T&L project. In addition, perceived shifts in national project emphasis towards delivering green interventions and monitoring outcomes, may limit sites' ability to focus on the necessary relationship and trust building prior to moving to intervention delivery.

This perceived shift in project emphasis has led to some sites feeling frustrated that they were expected to deliver on specific tasks rather than pursue locally developed strategies to develop and embed GSP. Some sites felt there was a drive towards standardisation of approaches to developing GSP, which didn't fit with the local agency required to respond to local need, and to work with local systems.

In addition, there was a perception that the National Partnership was keen to prioritise positive messages, particularly focusing on some sites, or on particular activities (such as funded green interventions), which could affect morale in other sites, and was felt to undermine local efforts to embed GSP.

Findings from the evaluation of national partnership working undertaken for WP5 suggests that partners are aware that some of the challenges experienced within the partnership did have potentially negative consequences for the sites and have taken steps to address this (section 3.3 above). It was felt that there had been a lack of leadership early on in the project after key personnel who developed the GSP project left, leading to issues with defining, agreeing and acting on the aims of the project. Initial '*norming and storming work*' to clarify the vision and purpose of the project was not undertaken so, for example, no theory of change for the project intentions overall was developed and agreed among partners at the start.

4.2. Alignment of ambitions and aims

Sites differ in the extent to which the overall aims of the GSP T&L site, and the priorities for action, are aligned across the system and among members of the project management meeting groups. While local management and partnership groups appear to have strong buy in for GSP, some appear to lack agreement about the core purposes, and priority actions for the T&L site, and so also whether appropriate progress toward goals is being made (e.g., T&L4, T&L1):

I think everybody's bought into it and we are all very congratulatory of what's happening….I am not sure that everybody fully understands where we should be at or feels knowledgeable enough to challenge if we are not. I am not sure if we are all just a group of people that have come together every month. [T&L1]

Given the scale of change required, it is perhaps not surprising that stakeholders may differ in terms of what they see as priority actions. Whilst there is agreement about the overall vision for the GSP, there have been some challenges in agreeing and communicating the purpose of the pilot, specifically.

Other sites had a strong sense of direction, for example about the centrality and targets for their funding strategy for nature-based providers, or through clear agreement and communication of project goals [e.g., T&L3, T&L7]. Elsewhere, investment in

developing networks for local nature-based providers to support networking and partnership building (identified as a priority through early co-development work) was seen as key to allow better connections and alignment between the VSFCE and health sectors [T&L2].

Some differences in priorities between local sites and the national project have already been noted above. Where members of the national management team join local T&L meetings, this was seen to skew conversations towards the mental health focus of the national partnership, potentially stalling conversations about other issues on which the local management team wanted to focus. One site also noted that the focus of the national project on mental health outcomes meant that they felt restricted in their funding choices for nature-based provider projects, leading to a focus on those they thought could deliver monitoring data, rather than having the freedom to use broader criteria for selecting projects to support. This was also noted in some T&L site Theory of Change workshops, where individual level mental health impact was brought up by NHSE, having not been spontaneously mentioned by the sites themselves as the focus of their planning. This highlights the different perspectives that remained between some sites and National Partners and different perceptions about the emphasis of the project.

4.3. Use of T&L funds

The way in which funds have been deployed across the GSP system by the sites reflects their understanding of local priorities and of original national priorities which sites responded to in their applications (see Appendix 6 WP6 for initial findings on funds allocated to strands of activity, and Section 5 below for more detail on delivery considerations). Funding has been used for: specific management, coordination, and networking staff; mapping the GSP system across the site; supporting networks; direct funding to nature-based providers; developing referral networks; local evaluation activities; training, continuing professional development and information/dissemination materials; support for local infrastructure, such as allotments; and equipment (such as outdoor clothes and equipment) to support participation in green activities, particularly among disadvantaged groups (see Section 5.1 for more detail). Where these did not previously exist, a number of sites have used funds to set up and support networks of nature-based-providers, and partnership building across the GSP system. Staff to coordinate such activities is key, as fostering partnerships and sustaining referral pathways can be very time consuming and requires different approaches for different organisations. Other sites have prioritised co-design work for green activities, and grants panels to award funding to nature-based providers.

Personnel appointments, in addition to Project Managers to lead the work, have included green advocates (T&L4), with specific roles to support partnership and engagement working in the patch (T&L5).

Project Managers have also worked to enhance the project funding through leveraging money from other budgets (such as the ICS or local Sports foundations), and garnering support by partnering with other sectors, such as education. While budgets from statutory agencies may be restricted in terms of how and when they can be spent, partnering with the VCSE sector potentially allows funds to be transferred to these areas where such restrictions may be less rigid (T&L7) and allows philanthropy funding to be brought in to support GSP activities.

Sites are already seeking funding for specific activities beyond the period of the existing grant, for example existing project management, or supporting green networks to work with voluntary sector mental health providers to focus on support for specific participant groups (such as those with poor mental health) (T&L7, T&L4). Some sites want to move away from short term, piecemeal funding for nature-based providers to

longer term investment, which would allow nature-based providers to become more financially sustainable and develop more appropriate services. However, they recognise that such long-term investment from the health service may not be forthcoming (T&L3).

Some in the green sector felt that insufficient funds were being invested in providers to support delivery (WP 3A, questionnaire), however some sites reported that the NHS was ill-equipped to provide funding to multiple small nature-based providers, leading to a focus on larger organisations or network support instead. Some (T&L1, T&L2) have formed partnerships with local grant making organisations to overcome the challenges associated with making small grants to VCSEs from within the NHS

4.4. Project progress

Some sites are very positive about what has been achieved through the GSP project, and are advanced in their planning for legacy activities (e.g., T&L7). Others, on the other hand (T&L4, T&L5) recognise that not as much progress has been achieved in the time frame as they had hoped, and that changing the system to embed GSP is taking time. However, learning through project activities has also precipitated new initiatives (such as the development of a collaborative alliance model, and hyperlocal testing of approaches in T&L4).

Where focus has been strongly on co-design for the project, these sites have been slower to progress to funding nature-based activity providers, but these activities have been the result of extensive co-design work with communities and is integral to the development of governance and support structures for the project.

Predictably for test and learn activity, some planned features have not worked out as planned. For example, quantitative data collection was planned through SP software, but this has yet to materialise and requested features have not been accommodated by software managers, limiting the amount of relevant data collected in T&L7.

The national partnership has also expressed some concern about the progress, although this was also seen as inevitable, given the scale of the change required:

> *This is a change management programme in the context of enormous system change in a global pandemic. I don't think partners know and understand that…Two years is quite a short time to demonstrate 'system change' – if you think about a systems approach, something that requires a cross sector transformation, you're talking at least 3-5 years strategy [WP5].*

Support for the project through NHSE was valued, but some National Partners felt that information about what was happening was guarded, and wanted more open feedback from NHSE to other partners about how delivery was going, and more formalised interaction between a wider range of national partners and the Test and Learn sites. (WP5).

5

Theme 3: Use of Test and Learn funds to build GSP system and support activity delivery

This theme focuses on exploring what we have learnt regarding the use of T&L funds to build the GSP system and support activity delivery in each of the pilots, and the influence of the National Partners on this work. First, the priorities and strategies for the use of the funds are addressed, including clarifying the different models of progress. Then the involvement of 'communities' of location, or of lived experience or interest in the use of the T&L funds is described. This is followed by details of what we know about collaboration with professional stakeholders such as the wider health sector and structures such as ICSs. Finally, issues of data collection, systems, infrastructures and priorities linked specifically to the use of the T&L funds are discussed. This relates to sections elsewhere in the report, such as Theme 9.

Key Findings from Theme 3: Use of Test and Learn funds to build GSP system and support activity delivery

- The Test and Learn funds have been used in a myriad of ways depending on the local contexts and needs, the priorities identified by project management and through co-development processes and in response, for some, to the need to adapt to shifts in requirements (such as data requirements) as the project has developed.
- The development of Integrated Care Systems (ICSs), and their processes and structures, have provided systems change opportunities with which to align the T&L project.
- Different approaches and sequences were taken to the pilots, these can be clustered into three types: A) Initial system building and strengthening with direct funding of activities at a later stage of the project; B) Parallel system building and direct funding of activities and/or awarding of funds to address factors that prevent uptake; and C) Primarily system building and strengthening with relatively little to no direct funding of activities or other factors.
- All areas have used substantial proportions of funds to develop the 'system', including for project management and coordination roles; network building activities; and collaborative and participatory governance. Most areas have also used funds to support GSP development and delivery, or to tackle barriers to participation.
- In many areas the T&L project and funds have leveraged additional funding, in some cases this is significant (e.g., close to £400,000 in one T&L pilot site).

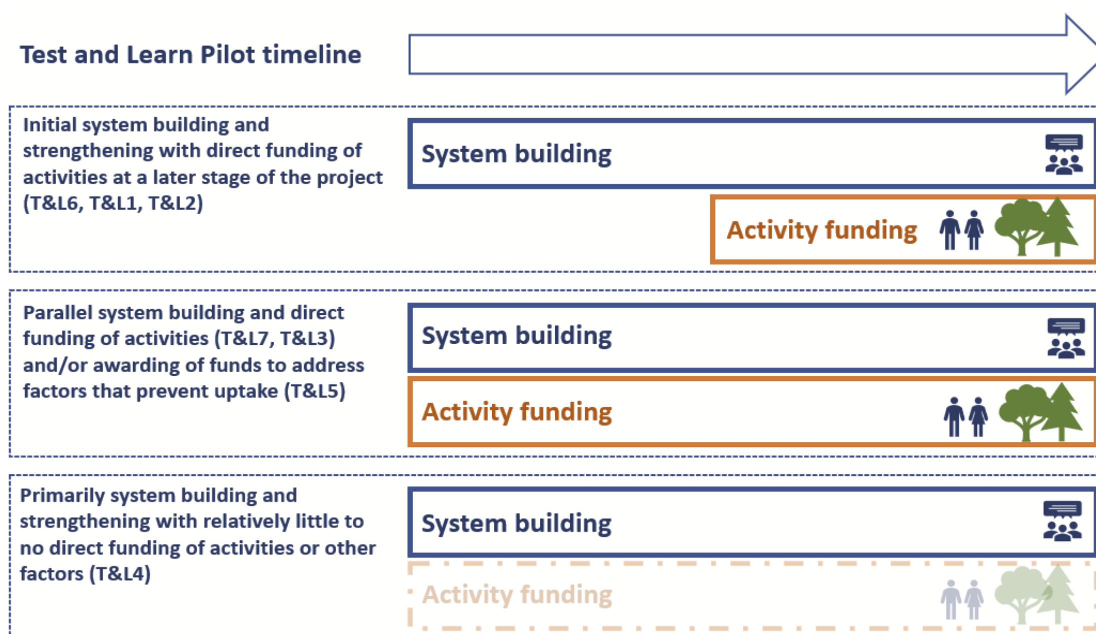
- The importance of involving communities and service users was acknowledged by most sites. Some sites have strengthened their approaches through acting on local and lived experience knowledge to inform aspects of delivery such as priority areas for investment and how to engage with certain communities. Others were struggling to find meaningful ways to include communities and service users.
- All sites have worked with wider professional sectors to determine how best to use funds. The extent, nature and experience of collaboration varies. Certain organisations, such as Mental Health Trusts or organisations delivering mental health services in the statutory/health sectors and VCSE, have successfully been involved in some areas but have been more difficult to engage and work with elsewhere.
- There was a lack of clarity, initially, regarding the data requirements that were associated with the use of T&L funds. The T&L project as a whole and many of the local pilots were not, arguably, designed in such a way to deliver the data requirements (whether the monitoring or outcomes data) that developed as the projects progressed.
- The plurality and complexity (in terms of the range of stakeholders, funding mechanisms, priorities, capacities and so on) of the GSP system as a whole, and especially of individual patient pathways, was not adequately recognised or considered when data requirements associated with the use of T&L funds were being developed.

5.1. Priorities and strategies for use of the T&L funds

The funding that was made available to successful sites was inherently flexible and could have been used in a number of different ways depending on local context, identified needs for developing GSP across the area, and in relation to differing priorities regarding what was perceived to be key to creating longer term sustainability. As such, there are a plurality of different overarching strategies for the use of the T&L project funds (Figure 2):

- Initial system building and strengthening with direct funding of activities at a later stage of the project (T&L6, T&L1, T&L2).
- Parallel system building and direct funding of activities (T&L7, T&L3) and/or awarding of funds to address factors that prevent uptake (T&L5).
- Primarily system building and strengthening with relatively little to no direct funding of activities or other factors (T&L4).

Figure 2: Test and Learn strategies



Those sites which have directly funded nature-based activities have taken different approaches. Two sites have focused on a small number of key providers with whom they are working closely to develop the activities. Others have taken an open funding approach, where priorities have been shared and local delivery organisations have bid for funding to deliver activities or support access. These different approaches can help explain why there is such a difference in the number of nature-based projects funded between sites (from two to 52) and should be noted when interpreting the outcomes data.

In a small number of sites, funds have been used on GSP infrastructure such as allotments. Where funds have been used to try and address barriers to uptake a range of activities have been reported - this includes one site where no providers have been directly funded. These include buddy systems, for both patients support to join activities, as well as between referrers and activities providers), funding resources such as coats and wellies, and transportation. In addition, funding has gone to organisations that support training for nature-based providers, or to support a trusted provider programme.

Where funds have been used to build or strengthen systems again there are a plurality of different approaches taken. In most cases funds have been used for costs for project management and a range of support posts. Other activities include funding:

- Leadership positions.
- Funding for staff for project coordination.
- Governance mechanisms.
- Participation of community members, people with lived experience, or priority group representation in delivery.
- Evaluation, evidence and best practice reviews.
- System mapping and strengthening including building referral pathways.
- Key priority group mapping, needs assessments.
- Set up or strengthening practitioner (Link Worker or nature-based provider) networks.

- Data systems.
- Trusted provider schemes.
- Communications and marketing.
- Training.
- Future planning and proofing activities, succession plans.

In some sites additional funding has been secured to extend or complement the activities of the T&L project, in some cases this is significant (e.g., close to £400,000).

Typically, the sites appear to be using the funding as was intended and articulated in their project plans. However, there were reports that some sites, particularly those which had taken a staggered approach - with early months focusing on co-production, and system building and strengthening before commencing the direct funding of activities - had felt pressure to modify their plans (see Theme 1 and 2 for more detail). The pressure from the national project partners to produce data on the outcomes of taking part in GSP activities had resulted in some bringing forward the direct funding of activities in order to comply with requests.

5.2. Community involvement in use of T&L funds

The importance of working directly with communities and service users within the programme was acknowledged by most sites. The nature and intensity of co-production and collaboration differed. Several sites made significant efforts to avoid tokenism and had early co-design stages to the T&L project design and delivery (T&L2, T&L6). Community members, priority group related organisational representatives, and/or people with lived experience were involved in prioritisations and funding decisions:

> *For the project's funding under the T&L pilot, service users from the [local T&L pilot team] for disabled people were involved in workshops to decide funding priorities, and were equal panel members for the project funding interviews. This was explicitly designed by a member of the project team with [T&L locality] to be meaningful co-design, rather than tokenism. …They were paid for their time, their title was a project support officer, and they very much sat next to us in this workshop rather than just a sort of addition to ask some type of questions from time to time. [T&L6]*

In some sites, co-production of nature-based activities with communities has been emphasised, so bids for delivery funds which evidenced this were prioritised and more likely to receive funding in the open calls (T&L2). Co-production with communities and delivery professionals at another site had helped clarify the nature of issues that could be addressed through the T&L project. In this case a commonly held perception (that people lack basic resources such as coats and shoes to attend) was not actually the key issue that needed addressing, instead it related more to anxiety and a need to focus on support for access. Co-production methods were also used by nature-based activity delivery organisations to develop contextually and culturally appropriate activities (T&L2).

However, in some sites there appeared to be little co-design, co-creation or collaboration in project management, delivery or governance. Several sites reported that although there are good links with communities (of practice or need), there was little meaningful involvement in influencing the priorities or strategy of the programme, how it was managed, or how funds were used. In one case, a user group is represented on the steering group and while they contribute to meetings this usually

involves detail rather than strategic decisions. However, an interviewee said: *'I feel extremely welcomed and part of a team when I'm doing the Zoom meetings' (T&L3).*

This perception of community or lived experience members who had a role in governance being somewhat tokenistic or marginalised was echoed by reports from several sites, with one stating '*Where we failed is around the patient involvement.'* *(*T&L1*)*.

Specific issues that prevented meaningful collaborations related to low capacity to collaborate on T&L from all stakeholders and related to differentials in allocation of funds within the system; mismatches in expectations; challenges of geography and accessibility of collaborative opportunities; and communication issues. It is not yet clear whether a focus on co-creation leads to better outcomes for participants or enhances the process of embedding GSP.

5.3. Collaboration with system partners in use of T&L funds

Reflecting the cross-sectoral nature of green social prescribing, all sites are working collaboratively with other professional sectors. The collaborative element was identified as core and fundamental to the Test and Learn project. The collaboration relates both to working with more diffuse 'systems' such as the 'social prescribing system' as well as with specific named organisations, or between individuals. The extent, nature and experience of collaboration varies across the sites. Certain organisations such as Mental Health services have successfully been involved in some areas, whereas in others they have been more difficult to engage and work with.

The development of Integrated Care Systems (ICSs), and their processes and structures, have provided systems change opportunities to align the T&L project with. Most sites explicitly commented that the project is well linked into the ICSs, both with the core structures and institutions, as well as with the more peripheral organisations, enabling communication and opportunities for collaboration.

There appears to be a spectrum of factors which prompt collaboration:

- Explicit commitment to collaboration as driving motivation for involvement in the T&L project.
- Shared ambitions, or alignment of strategies between different sectors or organisations.
- Additional opportunities for funding through collaboration.
- Recognition of opportunities for efficiencies and cost saving:

  Our green social prescribing programme will bring together environment and health and care sector commissioners to explore where commissioning efficiencies could be found. [T&L7]

As noted previously T&L funds and resources have been used to enable collaboration. Most sites are using a plurality of different approaches to building and maintaining collaboration:

- Collaborative, cross-sectoral/institutional leadership.
- Cross-involvement on different strategic leadership boards.
- Individuals taking on explicit responsibility for ensuring collaboration:

The PM in this site is also working at a systems level within the ICS and has assured links between the GSP project and the ICS throughout the programme. This has been instrumental in understanding what is happening at a systems level so that the project can be appropriately embedded within wider systems priorities. [T&L2]

- Secondments and individuals taking on dual roles.
- Involvement of existing, or creation of new inter-and intra-sectoral networks.
- Co-development and -creation activities.
- The explicit 'use' of national or local policies and strategies such as local Care Pathways, Climate, Biodiversity Net Gain, Levelling Up, Planning, and Community development plans as 'hooks' to bring together different sectors and facilitate collaboration. This instrumental use of policies and strategies is being used to embed the project and its legacy:

  We are exploring the NHS Net Zero carbon emissions agenda and how this could be used as a hook to promote further inclusion of nature-based opportunities within clinical settings. We are already exploring how on-site horticultural programmes could contribute to the agenda within an acute hospital site, and we will be developing ideas about how improved patient outcomes could be achieved as a dual benefit from net zero activity. [T&L7]

- Alignment of shared performance indicators.
- Information sharing and outreach.

The benefits of collaboration were recognised by all, both in terms of the T&L project specifically, but also in relation to addressing wider system level challenges and needs. One of the work areas where this can be most clearly seen is in relation to data collection. In one site (T&L2) challenges with coordination of and acting on the motivation and capacity of stakeholders from across the different sectors involved was recognised as a barrier to the collation of data. Collaboration with the (non-GSP) social prescribing steering group allowed the T&L team to recognise the wider context of the system level issues in data collection and flows. Participants described how being involved in the test and learn pilot has surfaced issues within the wider system, and has '*enabled a conversation*' (T&L2) to develop collective strategies to overcome them. The shared need to address these wider issues has prompted the establishment of a working group to consider data issues and options to improve data across the system.

The collaborative approaches adopted by T&L sites are bringing additional cross-sectoral funding into the system for many of the sites. One site detailed ten additional discrete funds that had been attracted to the project with a further set of funding proposals and resources, such as access to sites, under discussion. However, integrating with the new statutory role for ICSs, and particularly where they are new or undergoing change, has posed a challenge for some sites. Identifying who has responsibility or relevance, maintaining relationships, and making links between programmes of work has been problematic:

Resources are being put into conversations with referrers and Link Workers in order to help build a sustainable system. But this is time-consuming and difficult. (T&L3)

These findings highlight the scale and range of collaborative work that needs to be untaken to embed GSP, and the challenges of doing so within systems that are themselves undergoing change.

5.4. Data collection, systems, infrastructures and priorities linked to T&L funds

As will be discussed elsewhere in this report (see theme 9), there are challenges to data gathering and interpretation in relation to the funded activities. These issues are complex and multi-faceted.

First, and as noted in Theme 1 and 2, there was a perceived lack of clarity over what data was needed and for what purposes by the National Partners. This led to confusion amongst the T&L sites and the need to adapt plans as those needs became clearer:

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

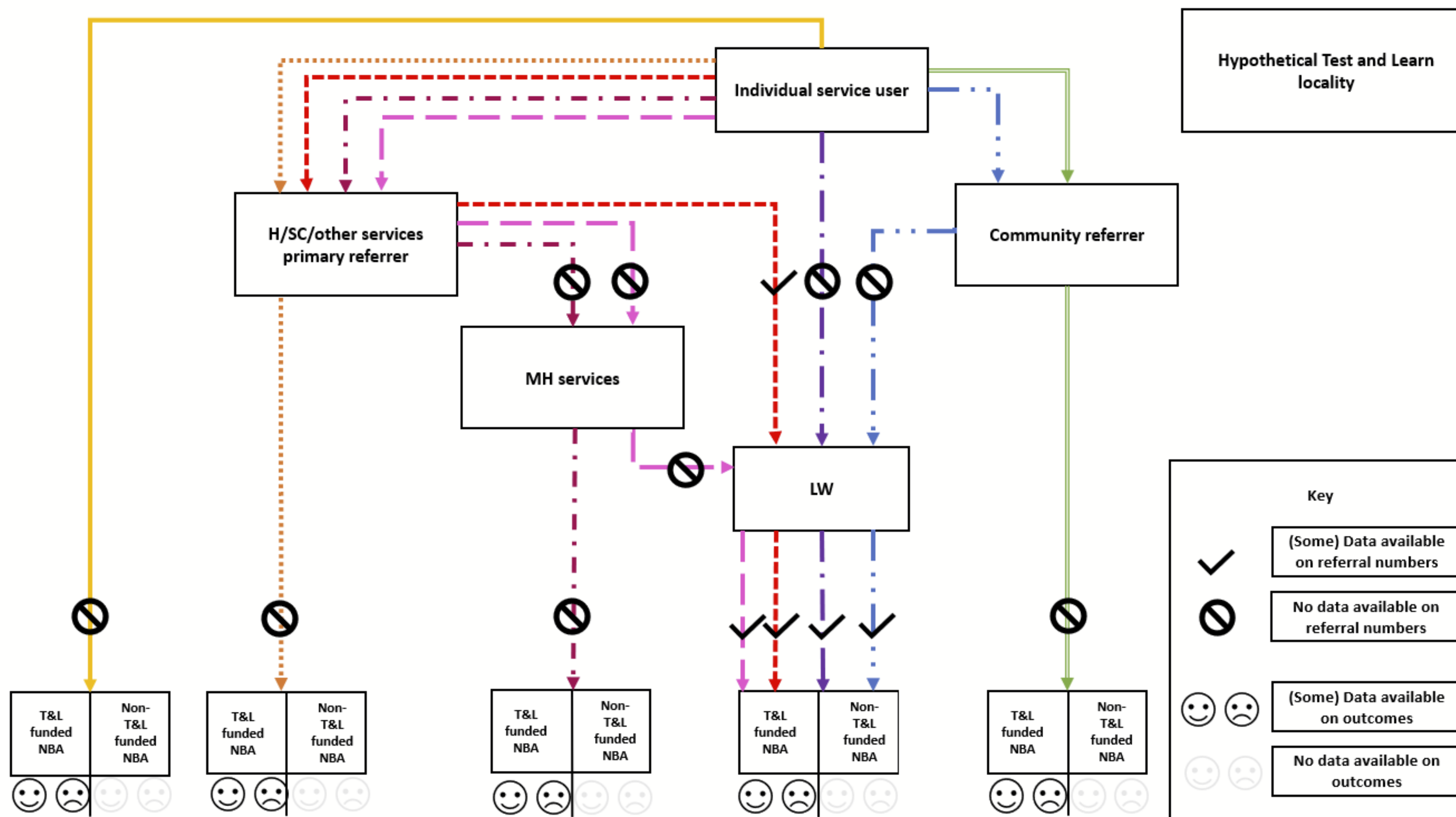
It did not appear to be made clear to the T&L sites that there would be a significant emphasis on collecting robust and comprehensive referral numbers and, more importantly, there was a lack of clarity over the requirements to collect outcomes data from participants in nature-based activities. There was concern from one site that the need to adapt the T&L plans to enable referral and outcomes data meant that they were having to choose between:

> *…having projects running to supply the data required for the national programme versus trying new and innovative approaches that may take longer to establish and not provide the required data set within the funded period. This is creating a pressure to choose between what may be a more effective model and what is easily deliverable.*

The T&L project as a whole and many of the local pilots were not, arguably, designed in such a way to deliver the data requirements that developed as the project progressed.

Second, there appears to have been a lack of understanding of, or recognition of and then adaptation to, the plurality of the individual pathways into nature-based activities by some stakeholders. As the hypothetical site illustrated in Figure 3, individuals can reach nature-based activities through numerous pathways within a given locality. Data may not be reasonably collectable from many of these pathways or providers (e.g., as indicated by the strike through or tick for section of each pathway, or the greyed out or bolded face in the relation to outcomes). This may be because those pathways or providers are not directly involved in the T&L, the activities may not have been directly funded, or there is a lack of capacity or infrastructure necessary to collect and share data. Further, within each locality, there is variation within each of those pathways. This complexity has contributed to the partiality of the data that has been collected on referrals and outcomes that is discussed in Theme 9.

Figure 3: Plurality of patient pathways to GSP activities for hypothetical T&L site



Third, there is a significant diversity of activities within GSP. This makes collecting data difficult and leads to questions about the comparability of any data that is collected. During the scoping phase, the Evaluation team worked with stakeholders to identify a suitable outcome measure with consensus reached on using the ONS-4. However, it was accepted that given the diversity of populations involved in GSP, it would not be possible to find a measure that suited everyone's needs. For example, concerns have been raised about the suitability of ONS-4 for people with learning disabilities and translation conceptually to some cultures. Furthermore, some stakeholders question whether outcome measures should be used at all. In one T&L site, it was found that there was an overwhelming consensus that the use of medical/NHS type outcome measures is not appropriate for green social prescribing or social prescribing more widely. For people who held this view, it could undermine their motivation to collect data. These challenges about finding a suitable outcome measure and concerns about their applicability are not exclusive to GSP and are common concerns raised by the VCSE sector in relation to community based social connection activities.

Fourth, there has been a failure to identify appropriate ways to encourage, facilitate, mandate or leverage systematic and comprehensive (to whatever degree is needed) data collection throughout the system linked to the GSP T&L programme. Neither the GSP, nor the wider SP system, is set up for capturing monitoring data that systematically and comprehensively clarifies a) referrals and b) outcomes as a total, or in relation to the T&L project. Some of the reasons for this are simple, for example some providers are collecting data as handwritten notes, which had to be processed by the Evaluation Team, a time-consuming task. Other issues related to capacity and proportionality. There was a perception that the relatively small contribution to delivery made by the T&L project did not justify the data collection requirements that followed the money. One provider asked: '*You've only given us £5k, is it really worth it*?' There were concerns with data collection and case study fatigue in some T&L sites.

Other issues related to the complexity and variation in systems of data collection. The systems are not joined up and not able to coordinate and make data collection more efficient. Within T&L sites there are multiple, and not necessarily compatible, setups including different referrers, organisations, databases and data systems. Monitoring systems and protocols also differ within and between T&L sites creating '*fragmentation of data and sometimes different versions of the truth*' (T&L2). The proprietary systems that were invested in to aid data collection have, for the most part, failed to meet expectations. In one T&L site, the problems with the data systems were thought to have exacerbated the problem of under participation of micro providers as negative findings may have a disruptive impact where overall numbers of attendance are low, and where they may also be more subject to inappropriate referrals which many also generate negative findings without any context for this being available.

The national core dataset had to be balanced with local priorities, with, for example, certain localities making decisions about adapting the type of data being collected. The time and capacity needed at project management level to agree and collate the data required was a significant challenge for many T&L sites. It takes considerable investment of time from the Project Manager to support organisations to collect data including developing systems and supporting organisational culture change. At the activity delivery level, some organisations were better placed to collate the data than others. However smaller organisations or those less experienced, do not have the necessary capacity or skills to collate and produce the data required. More flexibility and support were needed to help the smaller providers.

Finally, a full picture of how T&L sites are progressing is also difficult because of the differences in motivations and balance of priorities at the project management level. Certain areas have a more comprehensive data picture, and arguably better-quality data, because of the prioritisation of data in the pilot plans, the greater interest in data

collection by Project Managers, and the greater buy-in from project partners. In some areas concerted work has focused on trying to understand the issues and identify solutions.

In one T&L area funds were made available to help cover the costs of data collection and to encourage onward engagement. Despite this, not all areas applied for the funding due to issues with capacity and infrastructure (e.g., for invoicing) or because they were a large PCN organisation and felt they did not need it. Where funding was given, this resulted in organisations providing data where they may have previously struggled to do so. The funding provided VCSE organisations with capacity to collectively discuss issues related to data collection and generated a larger discussion across the system about barriers and needs. Providing backfill payment was seen as integral for recognising the important role of the VCSE sector and to support VCSE capacity for participation in system work.

In areas where the funding was not taken up, other options to increase engagement have been explored, including holding focus groups to understand specific barriers to data collection and identify potential solutions. Backfill payment was also offered for focus group attendance. In turn, this T&L site has also offered ongoing one-to-one support and several workshops in order to provide training and support around data collection. The level of investment this site has given to support data collection illustrates the time consuming and intensive nature of such activities, especially given the varied challenges that different providers face.

Theme 4: Integration of GSP in the health system

6

> *Even those bits which might have been a bit more sceptical several years ago and thinking, well, that looks like a waste of money to us, are now thinking actually they're not, now we've got ourselves a space, actually that's, yes we'd still like some more money but we can see actually it's not a stupid investment. [T&L1]*

This theme details the complex relationship GSP has with the health system. The ways in which people described links with or connections to the health system fell into eight main categories:

- The fit of GSP to health systems in terms of the eligibility of cohorts for treatment using these pathways.
- How GSP might be embedded into health systems and how health perceives GSP.
- How GSP services and other elements of the health system work together or are coordinated.
- Pressures across both systems.
- How commissioning might work or be adapted.
- How the health system views GSP in terms of reliability or quality.
- The evidence needed to increase those perceptions of reliability.
- How GSP links to health inequalities across the health system.

Further detail around these themes can be found in Appendix 3. This theme has clear links with other areas, for example relationships across the GSP system (Theme 1), and Link Workers and referral routes (Theme 5).

Key Findings from Theme 4: integration of GSP in the Health System:

- The skills, training and expertise to deal with (often more complex) cohorts of people linked to GSP are different across the health system and VCSE; with the latter (not being MH providers) often lacking the required skill mix – or resources to acquire - to engage those with serious mental illness.
- GSP is gaining significant traction but viewed by some in the health system as a 'nice to do' and additional service, rather than a viable and wholly embedded option for specific cohorts. More clarity about the GSP offer, when it is appropriate and for whom should be made available to all.
- Given the diversity and diffuseness of organisations, individuals, and roles delivering GSP, coordination was often challenging and a limiting factor.
- The commissioning of GSP poses multiple challenges, from who qualifies for each stream, and how committed that stream is to existing organisations, to the bias towards larger organisations in funding applications. Ensuring fair access to funding and sustainable investment by small and micro-organisations is central.
- Addressing health inequalities is seen as a priority and in some areas concerted efforts have been made to use approaches which may help lessen unintended consequences of exacerbating inequality, or to reduce inequalities through highly targeted provision. However, how to structure the system and design or deliver nature-based activities to reduce inequalities more systematically is still being addressed.

6.1. Cohort and eligibility priorities for GSP within the health system

Sites reported differences in those engaged or those eligible for GSP, but with an overriding understanding that these were not hard lines ('*you are never too ill for treatment*' T&L7). There was a priority for those experiencing mild to moderate mental ill health, but this has shifted during the project to include those on the more severe end of these categories. Indeed, it '*feels like it may have broadened for some areas*' (T&L7). Target groups for each site are shown in the site-specific Theories of Change (see Appendix 2) and further discussed under Theme 7.

The inclusion of those with more complex symptoms raised concerns. There was a feeling that some in the voluntary sector lacked the skill mix compared to sectors where people may have undertaken specialist training and have the resources to engage these cohorts.

6.2. Embedding and perception of GSP

Embedding GSP across multiple and linked systems was a core component of the work described by sites. This process features multiple distinct phases and was summarised by T&L6 as; an initial set up phase, developing operating procedures, building cross-sectoral relationships, understanding the existence of nature-based opportunities, co-designing and offering community grants, as well as evaluating progress and impact.

Progress has been positive but slower than expected in some areas:

> *ICS currently does not, sufficiently, mention the contribution of green health/wellbeing activity or GSP. [T&L4]*

Though there is an ambition amongst many to spread the message of GSP, and buy in and enthusiasm from many quarters (see Theme 1), there is also sometimes a '*fear of GSP*' or SP more broadly at some levels (non-T&L sites, WP4). Some of this lack of traction was assigned to poor shared understanding across organisations within the system or wider mental health structures. Engagement with mental health services has been particularly challenging, owing to ongoing pressures in systems, pressures which are not the preserve of green social prescribing but the primary care and social prescribing landscape more generally.

More generally, T&L reported that GSP was often a '*nice to do*' (T&L5) option rather than being appropriately embedded, and that (given the increase in severity) for a section of referrals, a GSP intervention is not seen as appropriate. T&L4 also related that GSP can be viewed as quite a narrow pathway currently and to further embed there was a need to raise awareness (T&L2) about how GSP can become part of other distinct offers. Challenges around translating from overall buy-in and enthusiasm into action were also raised, often being limited by people's capacity.

6.3. Coordination and provision of services

Sites reported multiple and interacting entry points into activities, as well as multiple geographies across which programmes are being implemented: '*something of a patchwork of organisations that are interested in GSP or have capacity*' (T&L3). Coordination can be challenging (T&L7): individual nature-based activity providers are, understandably, taking different approaches, and local teams across districts offer things in different ways. In addition, there are large numbers of Link Workers involved (nine organisations in one T&L site, for example, with 75 Link Workers across 20 PCNs).

However, coordinated approaches were seen to be key to achieving more embedded sustainable GSP:

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

6.4. Pressures within the health system

It is clear that sites, organisations within sites, and individuals within organisations are all under significant and increasing pressure. These come from a wide range of sources but commonly reported are demand related pressures around caseload numbers and changing severity of need. Clearly there have also been impacts related to the pandemic, with clinical capacity to engage with social prescribing more broadly, and GSP specifically, reduced due to increased pressures of Covid-19 and the vaccination programme (noted by T&L3). More recently, the cost-of-living crisis is being discussed, with patients at crisis point and presenting with urgent financial, housing and energy cost pressures. These critical and immediate needs also impact on the capacity, and appropriateness, of engaging with GSP for both practitioners and patients. On a human level, the pandemic has simply exhausted individuals within the system so that:

> *even quite rudimentary things that we might want to do at the moment are quite hard work. [T&L7]*

Sites reported that given the existing pressures on staffing and funding in mental health services, and the impact on existing interventions, there was a feeling that working alongside the VCSE was important to mitigate the impact of these pressures (T&L5). There was also interesting discussion around the comparative availability and pressures related to what have been referred to as the four 'zones' of social prescribing, of which GSP is only one (the others being physical activity, arts and culture, and financial, housing or other advice services). These zones often operate largely separately, despite there being clear overlap, but given the pressures reported above there has been a shift towards financial advice referrals. This shift meant fewer referrals in other zones, but GSP was – in some cases – filling the gaps and often leading the way.

6.5. Commissioning and funding

Funding in general was a feature in many of our discussions involving commissioning, including which organisations fund GSP and on what time scales for which these funds were intended. Frequently reported was a specific issue around which organisations and activities qualified for which particular streams of funds, and what '*comes under the banner of GSP*' (T&L7). Relatedly, there was also uncertainty around what the evidence requirements relating to the effectiveness of GSP were for different funders, and how best to communicate any emerging evidence. More generally, T&L3 raised the longer-term issue of whether GSP should be an NHS or public health function, given the spread across both prevention and therapeutic activities.

More practically speaking, there was a feeling that commissioning systems lacked resources of any sort, but particularly any spare resource for new approaches including GSP (T&L7). This was despite recognising that Link Workers were a relatively low-cost role for the potential benefits accrued. In terms of staffing, a deficit in trained nurses, therapists and others in mental health services was reported meaning that engagement of the VCSE is imperative (T&L5).

The equality of the GSP offer was seen across most of our themes, however there were particular concerns around the bias inherent in the commissioning process. Sites reported feeling that larger VCSE organisations were dominant in the funding process and that funds were often not evenly distributed. Partly this was considered to be a function of larger organisations' ability to engage with funding processes and absorb financial risk, while it was also noted that there are simply large numbers of smaller VCSE providers. It was suggested that viability might be improved if smaller and larger providers worked together more robustly. It is worth noting that this challenge is not unique to this project. There is a wider evidence base that documents the challenges facing small local VCSE organisations in public commissioning processes. Often these organisations are crowded out by large (often national and regional organisations) who offer perceived efficiencies of scale. It is widely argued that commissioning practices need to be reformed to more effectively capture the value of smaller organisations with local roots who can often be more responsive and flexible in the face of complex needs (Dayson et al, 2022). Collaborative approaches linking small and large organisations are being tested in the project (e.g., T&L3, T&L4, T&L5) which may provide a viable future model for developing collaborative funding bids. Already in T&L3, T&L4 and T&L5 there have been several discussions around onward sustainability of the programme and using the collaboration to pool resources, capacity and expertise to support smaller scale organisations to apply for further funding and develop their infrastructure. In turn, these sites' model of using a larger (infrastructure) organisation to link with smaller green providers has given them access to funding and support which they would have been unlikely to access independently due to a lack of capacity.

6.6. Perspectives on reliability, trustworthiness and effectiveness of green social prescribing in the health system

Targets relating to throughput, engagement numbers or completions (often locally agreed), and regardless of the intended outcome, have encouraged increased referral rates to social prescribing (T&L6) and, whilst this may be positive for many reasons, it also reduces capacity for already pressurised providers. There was no consensus around what outcomes were most important for GSP (or for social prescribing generally) and, given that GSP is a heterogeneous approach, there was agreement that each individual's engagement would cost a different amount, impact on service use in different ways, and that 'success' would also be different. In the non-T&L sites (WP4) broader outcomes were included, with less of a focus on narrow mental health measures.

There was concern overall about the level of rigour needed in terms of quality assurance:

> *reassurance…is needed as to the quality, safety, and effectiveness of community-based support. [T&L6]*

It was considered important for smaller nature-based organisations to reach a certain level of quality and safeguarding as well as meeting a community level for trust and diversity (T&L7). T&L4 felt this was particularly important given the perceived (or actual) complexity and variability of the offers available, which *'does cause some hesitancy'* in terms of health system confidence in those activities.

6.7. Evidence

There were multiple reports of expectations amongst health care workers for specific types of evidence requirements:

> *…theorised that referrals/buy-in from GPs may be lower due to a 'healthy scepticism' around the value of green social prescribing from some clinicians working from a 'pharmacological model' where prescription of treatment is based on many trials and this kind of evidence. [T&L1]*

In the absence of such evidence, it was felt that some practitioners would only see GSP as an additional element rather than a viable alternative to more standard treatments. The key aim for the evidence base, argued T&L1, '*is identifying the circumstances and situations in which GSP is both accessible and effective*'. However, sites reported that it may be that concerns about evidence needs of clinicians are less important than knowledge of, and confidence in, local nature-based activities by Link Workers and others connecting people with these activities. GPs may not have these conversations with patients when they are referred for a social prescription, leaving the detail of what is appropriate for a patient to emerge through conversations with the Link Worker.

Many also highlighted that the national partners, and in particular the current GSP Project has raised awareness and surfaced issues around evidencing both partnership working and SP more broadly, that would otherwise have remained hidden (e.g., T&L2). This has allowed conversations to start that may not resolve within the life of the project but which are making progress towards enabling integration into the health system.

6.8. Relevance to inequalities in health

Some of our surveyed Link Workers (WP3A) raised concerns about whether nature-based referrals were suitable for all those individuals with high levels of need that they are seeing, and this raises the important question of inequalities. The stated aim and potential for GSP is to engage those most in need and to put in measures to assess the breadth of offers. However, there was some concern that it was not yet clear whether there are (or how to identify) particular groups that would benefit (in terms of outcomes) from a specifically green referral. There were positive stories, with T&L7 reporting individuals with English as a second language being well supported by community services and rapid language support available.

7

Theme 5: Link Workers and Referral Processes

This theme is concerned with the role of the Link Worker and other community connector roles as it relates to GSP, and the entire referral process by which individuals find themselves at a Link Worker considering GSP as an option for health. For the perspectives of nature-based providers on referrals and referral processes, see section 8.8. Unsurprisingly, given their central role in the process, Link Workers and other community connectors were a key feature of many of our discussions with sites. Below we outline these findings, broken down into six sub themes we felt most represented the data: firstly was the issue of the priorities for both social prescribing and also GSP specifically, who was eligible and for what reasons; secondly the way that information flowed through the system accessible by Link Workers or referral organisations, including data; thirdly the organisations that Link Workers felt appropriate to refer to, and how these were collated; fourthly the actual pathway people experienced, where had they come from and how; fifth the physical location of the Link Worker role, whether that was in the health system or elsewhere; and lastly the resilience, function and wellbeing of the Link Worker workforce. Given the current importance of Link Workers to social prescribing, this theme has relationships with virtually all the others reported.

Key Findings from Theme 5: Link Workers and referral process:

- Link Workers are central to the function of GSP, however given the stress faced by the health service, and increasing acuity of those arriving, it is a role under ever increasing pressure. Decreasing caseloads, increasing Link Worker numbers and empowering Link Workers to decline referrals best managed elsewhere would all be beneficial.
- GSP is only one of many options available for Link Workers to connect people to (others may relate to arts-based activities, physical activity and practical support like debt advice). Communicating in what ways, for whom, and when GSP can be most appropriate is essential to increasing referrals.
- Multiple points of entry to the GSP system are needed, so assessing and managing self-referrals as well as referrals from diverse community organisations is important and also (given these would bypass primary care) of value to the NHS.
- For a range of reasons, the Link Worker role is an overworked one, with individuals working extra unpaid hours common. To prevent burnout and to meet targets, being realistic about the caseload of Link Workers (particularly of those managing higher complexity cohorts) is critical.

7.1. Priorities for social prescribing / green social prescribing

One of the recurring themes in conversations with sites around the Link Worker role and referral process, was the complexity of need and relevance of the cohorts that they were seeing. It was frequently reported that there was increasing mental health need, often of high severity, with lots of complex, urgent issues that needed addressing prior to further engagement. Practically speaking, for clinicians:

> *if someone is presenting at their GP practice in crisis around some of the social elements of their life can they really wait for a referral for a social prescriber? [T&L3]*

Some of these referrals were considered high-risk and potentially not appropriate for social prescribing, and it was also questioned whether activity providers would have the skills to support such populations. Given these priorities, and as described above, this potentially places GSP options further down the list for those making onward referrals (T&L2). From Link Worker monitoring data provided (WP3A), in T&L4 less than 10% of referrals from Link Workers were to a nature-based provider, although this was higher in other sites (see Section 11.5 and Appendix 2 for more details). In T&L4, 56 of 686 onward referrals were to nature-based activities (8.2%). Some Link Workers felt social prescribing was being used as a 'dumping ground' for people with a range of, some acute, needs (questionnaire data, WP3A). Given this, Link Workers were having to prioritise getting people support with more urgent needs such as referring to financial support organisations. One strategy to help address this lower rate of referrals was suggested: that providers construct and circulate a paragraph explaining what each project is to SP Link Workers. Since the interviews were conducted this strategy is now under development or being implemented in some sites. In one (T&L3) a directory of green activities and providers has been developed showing what is available to Link Workers and other referrers in each locality. It may also be the case that alternative routes into nature-based activities need to be optimised to ensure those who may benefit can access these.

Our understanding of referrals to nature-based activities is in its early stages. We received limited monitoring data on nature-based activities from one Test and Learn site, so the initial exploration may not be representative of the GSP project. This single site indicated that 70% of referees were recorded as experiencing moderate or severe mental health needs that have a detrimental impact on their daily lives. The majority came from more socio-economically deprived communities and, while people from ethnic minority backgrounds were being referred to nature-based activities, the majority were white. See section 11.5 for more detail across the sites.

The issue of severity is compounded by an opaqueness in the system that means it is often unclear, or the system not sufficiently coordinated, for common priorities to emerge or to understand if there are a common set of mental health conditions being referred to Link Workers (T&L3).

Whether GSP was perceived as relevant to client need, may be dependent on the personal experience and preferences for nature-based activities among Link Workers (T&L2 and 5):

> *every Link Worker has their own particular areas that they are more passionate about and have personal interest in. [T&L2]*

Importantly, given that referrals have to be appropriate to client need, perceived as useful and to address the presenting need, it is not possible for Link Workers to make guarantees to the project in terms of numbers or timings of referrals to nature-based activities (T&L1).

Referral pathways in the non-T&L sites (WP4) were largely similar, however there was more of a focus on fewer (funded) green projects, as there had often been one or two investments that were well known amongst staff. As with the T&L sites, referral numbers were often patchy.

7.2. Link Worker referrals to nature-based activities

It appeared that a minority of Link Worker’s onward referrals were to nature-based activities, partly due to a lack of knowledge about nature-based activities. From the questionnaire analysis, we found that only 12% of Link Workers (from our questionnaire WP3A) stated that at least half of their onwards referrals were to nature-based activities, with 50% saying that less than a quarter were to nature-based activities. Around a quarter stated they did not feel sufficiently informed about GSP. There were also points raised in our free-text responses around uncertainty about what would actually change for people as a result of GSP referrals, or how their involvement would lead to change.

Keeping up to date with the constantly shifting landscape of activities was challenging (T&L3). In addition, personnel in Link Worker roles also changed frequently, so the match between the two was difficult to keep track of: '*So it feels sometimes like you’re working in a bit of a fog*' (T&L3). The referral pathway between Link Workers and nature-based activity providers is more established in some Test and Learn sites than others (questionnaire data, WP3A). For about half of Link Worker questionnaire respondents, less than a quarter of the referrals they made were to nature-based activities (which may be wholly appropriate given the diversity of needs reported). In the Test and Learn site from which we received monitoring data (T&L5), entry to a nature-based activity via a Link Worker pathway accounted for just under a quarter of participants received by nature-based providers (23%). This figure may be higher because this specific site had embedded Link Workers with the nature-based activities. T&L sites are seeking to raise the profile of nature-based activities amongst local Link Workers including through webinars and taster events. The follow-up questionnaire in early 2023 will explore this issue with Link Workers to understand if their knowledge has improved.

This was also true of the non-T&L sites (WP4), where relationships with nature-based providers was more patchy, due to there being fewer of them engaged with the system.

7.3. Locally trusted organisations and accreditation systems

There is a great deal of discussion about how activities are collated for Link Workers to select from here was also repeated discussion around Link Workers having a sub-set of activities that were locally trusted and that they preferred to refer to known quantities rather than new and less well-known providers:

> *[There are] partnerships in place with existing organisations and it was safer to refer to these organisations [T&L5]*
>
> *because that’s what they have done historically, and you know traditionally. That’s just their go to and I think it’s just going to take time to break that [T&L2]*

Nature-based activity providers themselves wanted greater referrals from Link Workers. Over 80% of nature-based activity providers reported having capacity to receive more referrals (total nature-based activity provider responses = 122, WP3A). This was surprisingly high, and indicates no overall lack of nature-based provision, but rather a need to improve referral routes and funding to support providers with tailoring

and sustaining their provision. Nature-based activity provider respondents often found referral routes were difficult to understand and access:

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

In one of the non-T&L sites (WP4), there was an 'approval model' similar to the locally trusted organisation model, where the local authority provided approval status to organisations based on prior experience working with specific cohorts.

One of the sites is testing a collaborative model within the programme, whereby infrastructure organisations provide the link to smaller green providers. Within this model some organisations act as both a delivery partner and a referral organisation, linking referrals to appropriate activities. This has worked particularly well in one area where the large organisation is collocated with smaller green providers and is aware of their remit and activities, so can triage referrals effectively. In turn, when a person finishes an activity but requires further support, the infrastructure organisation is able to refer them onto other local activities, creating a feedback loop to reduce the chance of people going back into the NHS system unnecessarily. Before this partnership was in place, interviewees described how individuals who were at the end of their support but who were still unwell would either regress in their condition and stop engaging, and/or would re-enter the NHS system. Although emerging findings suggest this assists smaller scale organisations to navigate referral pathways, similar issues in relation to the complexity of pathways and a lack of Link Worker referrals has still been identified by some of the infrastructure organisations in this site, suggesting pathways between Link Workers and providers need to be strengthened across the system.

7.4. Referral pathways and processes

We report above on the relevance of referrals, however more practically speaking there were conversations around the reasons for, scale and source of referrals. Most referrals to Link Workers came from primary care (Link Worker questionnaire, WP3A), however there were a significant number from other routes including self-referrals. This was discussed as problematic in many of the sites:

> *Interviewer: How is it currently set up to support the flow of people who might want to access nature-based activities from healthcare through into nature-based provision?*
>
> *Participant: I think it's a mess to be perfectly honest, I don't think it is at all joined up…people are working in their own silos within their own organisation or their own setting even, even the setting within the organisation even, and some clinicians have good links with some local providers, and if they've developed a programme together then they will go to those same people, but they won't necessarily go anywhere else because there's the whole, there's often the problem with information sharing and data agreements, and some more complex things like that [T&L4]*

Different stakeholders disagreed on the definition of the GSP 'referral system'. For some it related to a narrow clinical pathway, for others it was a broad spectrum of different routes, some facilitated by Link Workers or equivalent, on to a nature-based activity. As a result, several sites have explicit streams of work around self-referral, to ensure organisations in the local area understand and can assist with those seeking to self-refer.

T&L7 reported a high number of re-referrals (the same individual referred multiple times to the same Link Worker, to either the same or another NBP), currently 1 in 5 are re-referrals which involve people with more complex, ongoing needs. There was also considerable concern that social prescribing often was subject to inappropriate and too many referrals given the intended breadth of programmes. That said, there were also a small number of Link Workers who reported they struggled to get sufficient numbers (Link Worker questionnaire WP3A).

In terms of coping strategies, T&L2 reported Link Workers setting up peer-support groups to discuss and help manage complex cases. Elsewhere it was suggested that some Link Workers would benefit from '*further skills and training around supporting mental health across the spectrum of need*' (T&L5).

7.5. Referral and Link Worker location

In keeping with other research on broader social prescribing, the location of Link Workers (both physical and organisational) was an important factor affecting pathways. Our questionnaire showed that just over half of Link Workers (52%) were hosted in voluntary sector organisations (total Link Worker responses = 91). The remainder were employed by other sectors including primary care, and mental health services. The majority of referrals to Link Workers appear to come from primary care although pathways are diverse.

Link Workers reported benefits to being co-located in GP surgeries, for example building relationships and understanding primary care systems, but that in some cases this was not possible and community spaces provided workarounds (T&L7). Overall, Link Worker co-working arrangements were felt to be working well.

There was a preference for in-person appointments (T&L7) but, with limited availability, other digital methods of communication were also useful; and some cohorts preferred phone consultations.

We know less about those who do not attend, or drop out, than those who engage with activities. There was a reported "*issue with people not picking up the phone to Link Workers trying to arrange appointments" [T&L7].*

Once people engaged,

> *Link Workers' involvement is inconsistent due to high workloads and staff turnover…some participants do not show up…they may be insecure or worried. [T&L3]*

One proposed solution to this is the 'green buddy' model, to help participants engage and embed into new activities (see Section 8.5 for more detail).

7.6. Referral workforce

Issues related to the Link Worker role and social prescribing workforce generally were frequently raised. All Link Workers reported being overworked, with personnel gaps where people had not been replaced, meaning that almost half had worked additional unpaid hours (Link Worker questionnaire WP3A). Many Link Workers reported they were working at capacity or were overwhelmed:

> *I have over 150 referrals waiting to [be] booked in I have a 3-4 month waiting list I think, I'm told to just ignore the amount of referrals coming in and do what I can do by my manager, this isn't good enough as patients are being left and*

vulnerable....My own mental health and now physical health has been affected by all the stress of carrying such a huge workload [WP3A questionnaire]

The workforce was described as *"overworked and overstretched, under-resourced, under-valued"* and *"misunderstood in what they do and the service that they provide."* [T&L5]

As previously described, this is impacted by workers having a higher caseload than practicable and an increasing severity of client need (T&L3).

More specifically, Link Workers reported feeling they were being measured against:

throughput which doesn't facilitate them (a) getting to know the patients and (b) getting to know the provider landscape. [T&L4]

These targets also do not realistically match the level of capacity provided through directed enhanced service (DES) funded Link Workers (i.e., those Link Workers funded as part of the NHS Long Term Plan, in each Primary Care Network) (T&L6). This potentially creates a situation where services are forced to choose between a more effective model and what is easily deliverable. Link Worker services are also tendered services, so any change in the tender results in relationships having to be rebuilt, even if the staff remain the structures and management often shift.

In one of the non-T&L sites the Link Worker workforce was supported and supplemented by an aligned cohort of workers with a less defined role, but still with a caseload. This was intended to remove pressure from the Link Workers, but of course the Link Worker role was, in itself, intended to remove pressure from primary care. This suggests that the pressures may simply be passed along the system.

8

Theme 6: Nature-based system and providers

There is no single nature-based provider system. Instead, each of the seven T&L sites have systems characterised by pre-existing networks, links of history, geography, need, connections linked by individuals or clusters of power brokers, and funding structures. This complexity is discussed at the system level within Theme 1: relationships and connections across the GSP system.

Within this Theme, nature-based systems are the specific focus within the context of those who provide nature-based activities either to those referred by GPs and Link Workers, or through direct self-referrals. These people and organisations provide a breadth of activities, often targeted towards specific populations, using a range of delivery means and mechanisms. The findings presented under this theme address: priorities in delivery for nature-based systems and providers, including alignment with system needs; understanding of, and access to, SP systems; funding availability and needs; availability and accessibility of delivery settings; support and resources; capacity of delivery; data collection, systems, infrastructures and priorities; experiences of referrals and referral systems; experiences of delivery of activities; and experiences of working with people with MH needs.

Key Findings from Theme 6: Nature-based system and providers:

- Preventing poor mental health, and maintaining good mental health, were commonly seen as important outcomes by nature-based providers. However, most providers also recognised clear benefits of nature-based activities for everyone regardless of condition, rather than being limited to specific health conditions or needs.
- It is currently unclear whether the myriad challenges faced by providers and Link Workers across the nature-based system are due to lack of availability, capacity or connectivity. It is currently unclear if this is an issue of lack of availability or capacity, or a lack of connectivity, and what factors contribute to this variation across the system.
- The scale and spread of organisations providing or able to provide nature-based activities is not necessarily known by those who may be able to make referrals, such as NHS social prescribing teams.
- Relationships between Link Workers and provider organisations are often the method by which referrals are made, but individual connections are fragile, and risk being lost when people move on, change roles or external pressures change priorities within the system.

- For many T&L sites, access to the local social prescribing system is through self-referral or other community organisation referral, rather than via Link Workers.
- Precarious, short-term funding cycles and lack of system level support for the VCSE sector is a barrier to sustainability and embedding GSP within statutory systems.
- There was a high degree of variation across T&L sites in terms of both availability and accessibility of delivery settings. Some sites report sufficient nature-based activities, while some report not enough specialist providers for issues such as higher mental health needs or requiring more expert support.
- Many nature-based providers felt that 'it is very hard to demonstrate the impact of preventative interventions,' which they see as at least part of their core role, such as GSP within short commissioning cycles, and the types of data typically used by nature-based providers to measure interventions (such as case studies and self-reported outcomes) are less valued by central commissioning structures which creates a mismatch in expectations and delivery.

8.1. Priorities in delivery

Across all T&L sites, priorities for the delivery of nature-based activities focused on addressing groups most affected by systemic health inequalities. Identified groups commonly included people from ethnic minority backgrounds, people with disabilities (physical, learning, and autism), older people, people with identified mental health needs, people living with dementia, carers, and geographical communities experiencing higher levels of social deprivation particularly since the start of the Covid-19 pandemic. This was aligned with the original call for pilot sites, which stated:

> *The test and learn site aims to test how to increase use and connectivity to green social prescribing in England in order to:*
>
> - *improve mental health outcomes*
> - *reduce health inequalities*
> - *reduce demand on the health and social care system*
>
> *[source: https://www.gov.uk/government/publications/green-social-prescribing-call-for-expressions-of-interest]*

These aims had remained consistent at the level of the T&L sites since the start of the funded project. Nature-based providers across T&L sites have shown flexibility in who they support, with some providers having specific criteria for the people they would target, and many being non-selective in their criteria. Preventing poor mental health, and maintaining good mental health, were commonly seen as important outcomes by nature-based providers. Many providers across sites perceived clear benefits of nature-based activities for everyone regardless of condition, rather than being limited to specific health conditions or needs.

One provider described how making their activities open to different groups where appropriate has positive outcomes for all participants over time. For example, providers found that opening up their groups which were initially focused on people in recovery from substance abuse helped to de-stigmatise this issue:

> *We started off with [X] days for the substance recovery people, and [X] days for general, but we've actually mixed them, and it's worked really well. And we like that model because it de-stigmatises people who have addiction problems.*

Because our philosophy on that is that an addiction, whichever addiction you happen to have, is a symptom of some other problem, it's not their problem, it's how people cope with their problem, so, from that point of view the underlying problem people have will have some similarity to everybody else's problems and that's the bit we want to get at, so that has actually worked really, really well, and we are massively proud of that. [T&L1]

Similarly, young adults working alongside people with disabilities had positive outcomes, with the young people developing relationships and empathy with people with disabilities:

So, we do merge where we can but we're still very careful and cautious about that, but when we do mix, if it's done properly, so I worked with a group of four young men who were excluded from all the local secondary schools, they were lively, really lively lads, they just wanted to lay bricks, build things and they mix on a [day] with a group of adults from the local care home with really complex, long term conditions. When the lads first got there all they did was snigger and laugh and you know, say comments under their breath like weirdo, and one lad would say to me I don't want to be with them, it makes me feel sick, I can't, so that was week one, week two. Week eight, nine, ten, the lads turned up on the farm and they were chopping up dinner for some of these people, one of them was tying shoelaces for somebody, and I said to, we had a bit of a debrief and I said, at the beginning you wouldn't go anywhere near this group of gentlemen, now you're almost support working them and one of the lads said to me, well yes they're just like us really, you know. One of the other lads said to me, I've never met a disabled person before but they're alright aren't they, so they're developing identity skills, it's really, really powerful I think and yes, learning, learning about each other's uniqueness. [T&L1]

One of the strengths of T&L4 has been in the development of a network for nature-based providers which is predominantly made up of smaller providers. This has been developed in response to what those involved in running smaller organisations perceive to be systemic under-participation in regional and sub-regional policy and funding decision making settings. A network led by these smaller organisations themselves was thought to be able to better represent their unique needs and secure a more equitable route to funding opportunities, than the current and planned arrangements via a VCSE coordinating group. A network of nature-based providers across districts has met several times and helped to develop a model being currently tested.

Through the light touch evaluation of non-T&L sites (WP4), providers have shown that they are keen to support green social prescribing through leveraging their particular expertise. For example, one organisation centred around nature conservation has developed specific GSP activities around this and related outcomes such as nature connectedness. Another organisation is a charity involved in sustainable food production. Their key outcomes have wider reach, such as increasing community cohesion, enhancing health and wellbeing, increasing biodiversity, and making more inclusive local economies. By focussing on these aspects of delivery, they feel they have plenty to offer green social prescribing.

Alignment with system needs

There is common agreement across T&L sites that an appetite for green social prescribing exists. Many activities across sites are designed to meet some of the system requirements, and particularly those that have seen an increase since the pandemic such as mild to moderate mental health problems, isolation, and loneliness. Across many sites, priorities aligned well with the system needs in the original call.

Sites purposefully designed their project to meet the call objectives with mental health as part of, but not the only, focus of the call.

We found consensus across T&L sites that GSP is a useful mechanism to meet some of the system needs. What is often perceived to be missing is the means by which the system can be joined up and operate effectively. There were apprehensions around the position of GSP with mental health services, with one site reporting a consensus from those working within MH services that GSP-type interventions were inappropriate for people in crisis, and that the service would be better placed in the VCSE sector. In some areas, GSP is seen as part of the process of '*embedding personalisation across the system*' [T&L3].

It is currently unclear whether GSP is meeting cross-system demand for nature-based services. Across many T&L sites, large numbers of organisations bid for funding, but some funded projects have reported low numbers of referrals from Link Workers, with some projects closing early due to low demand. In other areas, activities are consistently oversubscribed with waiting lists for future activities. There is a perception in some areas of the NHS that there are not enough nature-based providers for social prescribers to refer to. The breadth and variation of challenges reflected here by nature-based providers within T&L sites are echoed in the Link Worker responses to the questionnaire circulated in January 2022 as part of WP3A. It is currently unclear if this is an issue of lack of availability or capacity, or a lack of connectivity. It is also unclear what factors contribute to this variation across the system.

The scale and spread of organisations providing nature-based activities (or able to provide these activities) is not necessarily known by those who may be in a position to make referrals, such as NHS social prescribing teams. One nature-based provider acknowledged the need to continuously maintain relationships and connections with partners who may be able to provide referrals. Relationships between individuals are often the method by which referrals are made, but these individual connections are fragile, and risk being lost when people move on, change roles or external pressures change priorities within the system.

Non-T&L sites (WP4) highlighted a lack of development or promotional funding, or support on how to tailor nature-based activities to fit a social prescribing offer. It was suggested many existing activities may just need a few tweaks, or some extra training to be able to offer these to more people through social prescribing. Another organisation reported that they did not apply for test and learn funding as GSP was at an early stage of development, and they wanted to ensure their work would be complementary to other providers and within the system.

8.2. Understanding of, and access to, social prescribing system/s

T&L sites reported that understanding of, and access to, social prescribing is mixed, with some providers using existing networks and links to make great use of the GSP activities and support through this project, and some providers asking for more support than the T&L site GSP project can offer. However, in T&L7 the project team has leveraged further funds from elsewhere for these providers (who either applied for but did not receive funding, or who have gone back to ask for more funding) to ensure all applicants are supported in some way. In T&L6, a nature-based project which requested more funding was offered constructive help to access funds elsewhere, or to scale the project so it was better aligned with the GSP project aims.

For many T&L sites, access to the local social prescribing system is through self-referral or referral from a range of other agencies, rather than via Link Workers. A common bottleneck reported by sites is the capacity and availability of Link Workers. Link Workers across sites are reporting higher demand than before the pandemic, with

particularly high demand across the system for people seeking support with housing, debt, domestic abuse, child abuse and safeguarding issues. More Link Workers are being recruited in many areas, but demand often outstrips capacity.

These findings on Link Worker capacity are also reflected within data from the questionnaire carried out earlier in the project under WP3A. Many nature-based providers had capacity to support more referrals. However, some nature-based providers struggled with moving people onto other activities, which restricts how many new referrals they can accept, indicating an issue with support needs of users, and an inability to progress on through the system, especially in the context of short term offers. Nature-based providers described hesitancy from users about accessing less intensive support, and/or there not being opportunities to support people to access other nature-based activities (questionnaire WP3A). From this perspective, there is a continuum of nature-based support and consideration needs to be given about how to support people along the pathway, for example, someone may initially attend a horticultural course and then be supported to become a volunteer at a community allotment. The significant burden on small organisations to design, fund, promote, and deliver complex mental health programmes was repeatedly highlighted. The questionnaire also identified a heavy reliance on volunteers within this sector, raising concerns around governance and levels of responsibility particularly when working with people with complex and more severe mental health problems (WP3A).

Greater understanding of existing GSP structures, as well as the benefits of GSP both within the healthcare system and among nature-based providers, has been high on the agenda for many T&L sites. Activities such as festivals to raise profile and awareness, publications and videos for demonstrating availability and benefit across the system, and appearances in local media have been promoted in several T&L sites.

Within the light touch evaluation of non-T&L sites (WP4), one interviewee was uncertain who the key Link Worker employers were, and whether they were funded through GP practices or voluntary organisations.

8.3. Funding availability and needs

Nature-based providers across many T&L sites consistently raised the issue of precarious funding. Short-term funding contracts are not conducive with the delivery of ongoing support and activities. Service users may need ongoing and flexible support in order to see a long-term positive impact, rather than time-limited, overly structured activities. This is particularly important for those with mental health issues and it makes it difficult for organisations to provide suitable and beneficial activities.

One common problem raised is the lack of long-term investment and system level support for the VCSE sector which has impacted on the GSP project but also the wider social prescribing system. Difficulties on relying on short term commissioning cycles and the impact this has on long term sustainability of VCSE organisations as well as the need for long term financial support was noted by several participants. Nature-based providers also shared concerns over sustainability and what would happen to vulnerable clients who became dependent on their services:

> *And this is part of the battle is, once you've got somebody ready it's got to be the right thing for them otherwise all that work you've just spent building them up just disappears overnight. So it's got to be, and it's got to be consistent and it's got to be regular and especially in mental health it has to be available and it has to be every week at a certain time, so there has to be some consistency there. [T&L1]*

Many nature-based providers are small voluntary organisations and the need to frequently apply for funding is very time-consuming and takes away resources which

could otherwise be used for delivering activities. The significant burden on small organisations to design, fund, promote, and deliver complex mental health programmes was also repeatedly highlighted within the questionnaire carried out earlier in the project as part of WP3A. Providers in interviews frequently described their income as coming through piecemeal funding/fundraising from a range of sources and the need to constantly be applying for more:

> *it's just a question of as and when grants come up, we apply for them, […] So, it's bits and pieces here and there, which makes it very, very difficult. [T&L1]*

There was a sense from nature-based providers (primarily voluntary sector organisations) that much of the investment into GSP was being targeted further upstream and they were not receiving enough funding to be able to deliver services:

> *within the social prescribing network that's developing is that a lot of funding is going in to the start up the NHS administration, the research teams like yourselves, the program, like [name] runs, and actually on balance, looking at [that] all the funding that's available, actually very little is going into the green providers […] it's a fraction of actually what we need for the project. Now, [name] told me that he got – what did he say? – a hundred and fifty thousand pounds [to award] and four hundred and fifty thousand pounds worth of applications so he got three times the amount of applications for funding available. So what that says to me straight away, the sector needs more funding. [T&L1]*

Across many sites, there is a severe concern that social prescribing, and GSP specifically, is often where many people are directed because of a lack of support elsewhere. The lack of long-term funding and system level support for the VCS and community sector has impacted on the green social prescribing project but also the wider social prescribing system. Some nature-based providers described how '*expectations to do more social prescribing*' had increased '*but not necessarily the levers or the financial backing to support it*' [T&L5].

It was clear that long term monetary investment in the project was seen as integral for continued sustainability. One interviewee felt that a lack of investment directly into organisations diminished the quality of interventions on the ground:

> *I think it is under-invested and under-resourced and as time progresses, GPs and kind of other strategic organisations and NHS England at large really I think are pushing more and more onto social prescribing for it to achieve more and to address wider issues. Which it's well set up to do through what you can achieve through social prescribing but it's not getting any investment in the resources it needs to do those things as well. So Link Workers are overstretched, have way too many cases and individuals that they work with, as well as being drawn into other areas of work as well. And all of those things diminishes and reduces the quality of the actual interventions. [T&L5]*

Although funding was a challenge for all, issues for long term sustainability of funding may be particularly pertinent for larger scale, more specialist groups. Smaller groups have fewer costs (such as seeds and equipment for planting) and so may manage smaller pots of funding, whilst others have, for example, several paid members of staff that are integral to the coordination of activities. Onward funding for specialist provision is viewed as integral for GSP to be recognised as a viable alternative to treatment and for provision to embed into the wider system. Even with smaller nature-based organisations, realistic expectations need to be set around onward sustainability. Some nature-based provider interviewees were concerned about the future sustainability of their job roles and what would happen to the momentum of GSP if their role was to cease:

If we're looking at that big kind of hefty weight of destinations like [name of organisation] ...there's got to be that funding there to support staff. And, we've survived so far, you know, we keep on, we keep on going for it. But, it's not, it's not gonna be seen as a trusted, embedded part of the healthcare system unless we can guarantee that we're gonna be here in two years. You know, that, otherwise, why the, you know, we're never gonna see those real kind of weighty referrals coming in, numbers are coming through and people benefiting until we can demonstrate there's longevity to it. And how do we demonstrate this longevity if all we're relying on is all these little- they're not little pots of funding, you know, like [name of grant] is a hundred thousand, the [name of grant] was, you know, kind of a bit more than that. [T&L5]

It was clear that, whilst many current funding opportunities were short term and piecemeal, nature-based providers were used to this way of working and had found ways to adapt (such as applying for small pots of funding or levering 'in kind' funding from the CCG and other sources) – although this did cause stress and pressure on delivery teams. Creating sustainability of their activities was a key motivation for applying for the T&L funding for some nature-based providers. One T&L site project management team had found ways to secure longer term funding by redirecting funds through a VCSE organisation which allowed for greater flexibility in spending requirements and could hold money across financial years and fund projects over a longer period.

In one T&L site, funding is not being provided for nature-based project delivery, but some funding is provided for participation in networks and contribution to strategic meetings. In another T&L site, funding is being used to directly support a limited number of projects. Other nature-based providers are supported through an accreditation process, with the intention that ultimately money should flow through the referral system and support a more sustainable model.

One T&L site highlighted how commissioning cycles created competition. For many, the short-term nature of commissioning cycles within the NHS and local authorities were not conducive to preventative interventions. Some participants spoke about how this creates competition across the system:

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

In non-T&L sites (WP4), interviewees reported that funding is considered to be very *ad hoc*, with an awareness of money available through the PCNs, from central government for certain activities, and for active travel feasibility studies. However,

there wasn't a clear method of allocation, which was hindering attempts to secure further funding to improve Link Worker training and support. Another interviewee reported that social prescribing is still seen as new and poorly understood and that this was linked to a lack of funding, with lots of talk of funding but little evidence of it being made available.

One interviewee reported that funding that comes from the local authorities, a mental health VCSE organisation, and PCNs for social prescribing also covers the GSP roles, and a key aspect of their role is to access other pots of funding. Another interviewee noted that there appears to be sufficient funding through the CCG for social prescribing. For GSP, sustainability and long-term funding were cited as challenges, with short-term commissioning models not helping this - there is a need for funding to show a longer commitment. Another organisation highlighted wider concerns about funding and the short-term nature of smaller pots of funding and short-term contracts. There is a need for more sustainable large-scale funding (e.g., from statutory services who will benefit from GSP) to fund GSP providers.

8.4. Availability and accessibility of delivery settings

There was a high degree of variation across T&L sites in terms of both availability and accessibility of delivery settings. Some sites have found there are sufficient nature-based activities available in their locality, referring to a wide breadth and diversity of activities for different groups. Most were viewed as catering for people with low to moderate mental health needs. However, in some cases there are not enough specialist providers for issues such as higher mental health needs or requiring more expert support, and these providers can experience being 'locked out' of some of existing referral pathways.

Findings from one of the observations indicated that specialised nature-based provision for people with more complex mental health needs were receiving a large number of referrals in some areas, which perhaps indicates a need to increase this type of provision. One nature-based provider interviewee described 'struggling for capacity' in terms of dealing with specialist referrals:

> *And then the other side is having the organisations with this devised skill set based on the needs of the individuals. So, we've mentioned before that mental health is a huge, huge spectrum of what mental health is. And individuals sit on that and know what their need is and what stage they're at. So it's having the right organisations that can provide the interventions based on what support an individual needs...And obviously you've got like that upside down triangle, so would that actually be just a normal triangle. The basis being most people [are] probably low level. That's where you've got the biggest numbers. That's probably where the most amount of organisations that can cater to those skills. But it's also the easiest to get organisations to that level. But higher up in terms of the needs chain you get less people there but they're individual needs and support become much more intensive to … the support that you need to provide becomes much more specialised…So that is something that we need to make sure that we have ready so that we can cater to anyone but we've got the organisation depending on what they need and support that we need to provide for them but I don't think we are there yet. We are certainly at that lower level at the moment. We have got organisations in our Programme that can provide that high level of support but it's much more resource intensive and skill sets are specialised. And you do need someone that's probably trained for years that can provide it. [T&L5]*

In addition, although participants discussed an abundance of activities, some raised a lack of green/blue assets in the centre of areas and barriers to accessing green/blue space, such as lack of transport. One participant discussed how this requires nature-

based providers to have more conversations with land managers, such as the council, to explore using different assets:

> *It's making sure there's enough offers and appropriate offers, I think. So, where we've had [a] challenge to, you know, like I said, the biggest barrier being travel and transport, of going, OK, well, you know, we've set up this [name of green organisation]. [name of green organisation] is there already, [the service user] might already be a member there, or, you know, using like a service. So that's one step, building confidence. Because they know, they know its familiarity. But, it's also a step towards, um, it's right on a [transport] stop, you know, on the [transport] stop…it's right in the centre of places. So it's maybe, looking at different green assets. So, those parks that I talked about that are barren for biodiversity and they're just associated with sport, recreation, you know, sports recreationally, or a picnic. Looking at what, if there's any groups or infrastructure that we can develop there, so talking with councils. [T&L5]*

Aligned with these supply and demand issues is uncertainty around the flow of participants and funding through the system, which can cause issues for referrers and nature-based providers, particularly given previous points made around precariousness and lack of continuity of support.

Accessibility of nature-based activities is a challenge raised by some sites, with some activities not accessible by public transport. Where public transport is available, some participants lack the confidence in using public transport. T&L3 is working with a regional transport provider to train volunteer drivers who can take participants to activities. Even with volunteer drivers, costs of vehicle hire, and insurance must still be covered. Navigation is an issue for many both in terms of finding the general intervention location, and in finding the specific site once in the right areas (such as a specific allotment space in a large allotment complex).

In other sites, general agreement amongst participants was that there were sufficient green and blue activities available due to there already being a strong infrastructure for SP and GSP in place across the region. Some participants discussed how T&L2 had good and accessible green and blue assets, including a national park. However, one participant questioned whether there was enough specialist green provision but hoped this would develop as part of the project:

> *I suppose the one thing in [name of area] is because our generic community organisations do a lot of green, there probably isn't strong connection between social prescribing and specialist green provision. And some of this might develop, and actually when you look at the list of grants, I know some of them are being led by specialist green organisations but in conjunction with community organisations. And I think if you were to describe a gap you know our community anchors are just getting on and doing low-level. They are doing green prescribing within the context of a generic community organisation and the skills that they have. There is nothing wrong with it. It is great and that's what's going to be the long-term out there. What they are not necessarily doing is connecting in with say a specialist organisation building those links etc., and through this hopefully some of that will be developed. [T&L2]*

Whilst there was an abundance of green assets in the area, some participants discussed barriers to access such as concerns for safety due to high levels of crime. A lack of nature-based provision within areas of high deprivation was recognised as another consequence of, and mechanism for, further entrenching health inequalities, with the recognition that access issues such as safe and inclusive spaces for women, those with young families, and ethnic minorities are often overlooked in planning activities.

Participants discussed how there could be a multitude of reasons why someone may not engage with GSP, including issues with the quality of green space:

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

8.5. Support and resources

All the T&L sites have training programmes at various stages of scale and development. T&L7 has a well-developed training programme jointly created between the T&L pilot project and the local nature partnership, with a large number of free courses available and advertised through a newsletter every two months. This training is directed towards nature-based providers, Link Workers and referrers but - in most cases – is open to anyone. Example courses include mental health-focused training on listening skills, suicide awareness, mental health first aid, and mental health safety planning. This site also invites one or more funded projects to talk about their activities at the beginning of each Project Board meeting to ensure Project Board members gain a real understanding of where the funds go and who they benefit. Members regularly comment this is a highlight of their regular oversight and governance activities, and really helps to embed understanding of the range of GSP activities being supported.

In T&L5, nature-based providers have support through the site's strategic level programme meetings, monthly meetings with the ICS, free training and resources, and are also welcomed to the SP Link Worker workshops. Locally the lead delivery partners also act as the central point of resource.

All sites have slightly different structures for directly supporting nature-based providers, but most involve a facilitated network which aims to generate new partnerships, develop cross-sectoral relationships, share experiences and best practice, and support smoother referrals through greater understanding of different existing systems and requirements. T&L6 has a nature-based provider network with around 120 members, a monthly newsletter advertising opportunities and a substantial training programme for nature-based providers, referrers, and Link Workers.

Within T&L1, many nature-based providers talked about the importance of peer support for their beneficiaries and having others to talk to who may have gone through similar experiences, which was seen as different to other healthcare interventions. Although participants came along to do the activities, it was often the peer support surrounding the activities which was thought to provide benefits. Some participants had gone on to become volunteers following participation in GSP programmes:

I think the main thing is like just speaking with someone else and like being a part of something, being a part of a little family if you like, community. Because pre-session people come in and we'll have a little chat and then we'll set up jobs and tasks or whatever they're doing, like 10 minutes before the session ends we all sort of sit around, have a drink, have a chat. That sort of thing. And some of them have become friends outside of the garden as well. [T&L1]

In T&L3, one of the key support needs identified through the T&L pilot is for participants to be accompanied or supported into activities to ensure referrals are taken up. With

the support of Natural England and NASP a 'green buddy' scheme has been prototyped in which volunteers are trained to help referrers by supporting or accompanying participants into activities. The scheme is currently being piloted with a view to being expanded across the T&L area.

From the questionnaire conducted earlier in the project as part of WP3A, just under a third of nature-based activity provider respondents to the questionnaire said their organisation had received funding through the Test and Learn project. A similar number had not applied for funding (32%) whilst others said there were not relevant opportunities, or the grants offered were not suitable for them. Providers felt that inadequate financial resources were available through the Test and Learn project.

8.6. Capacity for delivery

From the questionnaire of nature-based providers earlier in the project (WP3A), most reported capacity to receive more referrals (>80%) and wanted to improve referral routes. However, there were also some providers who had waiting lists. Often organisations were struggling with getting referrals and wanting to improve signposting routes to support more people to access the activity. Some people discussed how if they were supporting specific users, capacity could be an issue e.g., if they needed more intensive support. Capacity issues are also related to the onward movement of participants through and out of nature-based programmes or moving on to other forms of nature-based provision.

Inappropriate referrals were commonly reported by providers, involving those with a high level of mental ill-health, or social care needs. Some users were presenting with urgent needs, for example food insecurity or debt advice support. Stakeholders felt that these users were referred to social prescribing because there was a lack of other services to which professionals could refer people. In other cases it was because there was a lack of understanding about the remit of social prescribing as it is a relatively new service development.

This mixed picture is reflected across all the sites, with some providers at or over capacity, and some reporting low numbers of referrals with lower than predicted engagement from Link Workers and referrers. Some sites report a gap for capabilities and capacities to work with people with more serious mental ill health needs which need tailored 1:1 support. In terms of mental health need, some providers were keen to accommodate whoever they were approached by but had clear boundaries of who they would not take based on their own risk assessments. One provider had limits on the number of people with dementia they would take, although demand has increased significantly over the last few years - because people with dementia had higher needs for supervision and care, they didn't have enough staff to accommodate more than two or three people, and often the carers also needed support and respite which they were not getting while they were in their role as carer.

There is a perception amongst some nature-based providers that GSP money is available, but appears to be focused on the Link Worker level to enable the ‘prescribing’ to happen rather than funding for providers to support delivery of activities and services.

From the non-T&L sites (WP4), one nature-based provider reported that the VCSE sector may not have the capacity or expertise (in terms of mental health support) to deal with referrals from NHS/clinical commissioning. More broadly, despite high demand for nature-based activities there are limiting factors in the shape of high workloads and a lack of resourcing. Voluntary organisations in particular have voiced concerns around inequity of GSP funding, with greater allocation made to health and NHS organisations for Link Worker support, and less money going to support delivery by third sector organisations. A visible lack of long-term commitment needed to grow

and scale local systems, through ongoing and persistent use of short-term commissioning models, is an ongoing issue for many. A lack of capacity building stymies growth of the GSP system, which both contributes to, and is exacerbated by, high staff turnover. In turn, this increases challenges in relationship building, inward investment, awareness raising, and training.

Capacity constraints of nature-based providers are widely noted and understood by the National Partners (WP5). However, they argue that most funding decisions should be made locally, and should mainly flow locally through ICS commissioning rather than national sources, if GSP is to be sustainable. National partners do have an influence however, as they can set strategy and priorities, and raise awareness of effective practice and learning from the GSP project across the country through their support for the roll-out and scale-up of GSP.

8.7. Nature-based providers and data collection

Most sites report they have started the T&L pilot with piecemeal and fragmented systems for data collection and management (see section 11 for more detail), and as part of the pilot are working with funded nature-based providers to embed more consistent data collection approaches. Often, data collection systems are oriented to the immediate needs of people attending services, rather than using validated tools to assess outcomes.

In many sites, there is a general consensus that '*it is very hard to demonstrate the impact of preventative interventions*' such as GSP. Many providers see primary and secondary prevention of mental ill health as at least part of their core role. It was felt that the short-term nature of commissioning cycles was not conducive in measuring the impact of social interventions. In particular, the types of data that providers typically used to measure such interventions, such as case studies and self-reported outcome measures, are not high up within the NHS hierarchy of evidence, creating a 'mismatch' (T&L5) with delivering a complex and heterogeneous programme such as the GSP project. Despite some challenges in collecting data, interviewees acknowledged the importance of creating data systems so that nature-based providers can demonstrate impact and apply for further funding at the end of the project.

Across sites, there are pockets of good practice which tend to be where individuals have a particular passion for SP and have '*gone out of their way to build relationships with local green providers*'. Where there is a high turnover of staff, connections are easily lost.

Networks between nature-based providers were seen as important in improving the GSP system. One interviewee spoke about setting up a forum open to social prescribers and providers to ensure that everyone was aware of what was available and could signpost and refer across the city between providers (T&L2).

In one area of one T&L site, GSP is being managed through the local Public Health team, who deliver a lot of services and work with communities but also have strong links with the NHS, and have a good understanding of and access to clinical systems. This was thought to work well as the infrastructure for sharing information both ways between nature-based providers and prescribers was already in place – primary care could see how this was reducing pressure on them. This may be more difficult for VCSE organisations to achieve.

Nature-based providers tended to seek qualitative feedback from their participants on how their service was working for them and how they could improve, and they often avoided formal outcome measures, as these were perceived as off-putting for participants or too generic for specific programmes. They often focused on 'softer

outcomes'. One nature-based provider had invested in the social return on investment engine[2] in order to provide evidence for funders. Some had adapted existing measures (e.g., Warwick-Edinburgh Mental Wellbeing scale) or evaluated using their own methods:

> *I have what I call my evaluation box … It's literally, and this we've had for years, it's a shoe box and then there's loads of questions all around it, like what made you happy today, what made you laugh, what did you learn, you know, more kind of just broad and I'll just take the box out at various sessions and we just have little cards and bits of paper and people will just answer a question. But that has been so insightful. What new groups would you like to see, you know, anything you can recommend […] I'm just thinking of like random examples, don't mix the ginger nut biscuits with the jammie dodgers. Very funny things, but actually really important things that people feel listened to, subtle that you wouldn't capture otherwise. So, so I do my shoe box. [T&L1]*

T&L6 have commissioned an evaluation of previous nature, health and wellbeing pilots and fixed term projects delivered in the locality to capture all previous learning and create a recommendation of best practice to inform project activity. They are currently scoping a partnership with their regional university to support on-going evaluation.

Across several sites there is strong consensus amongst participants that the use of "*medical/NHS type outcome measurements is not appropriate for nature-based social prescribing*" [T&L2] or social prescribing more widely. Often the impact is much more small scale and long term – such as making new friends, feeling happier one day to the next and building confidence, which '*you can't measure*' (T&L2) through traditional methods. The consensus that it is '*very hard to measure the worth and value of the preventative stuff'* (T&L2), particularly when existing data systems don't allow for a good baseline measurement. The importance of undertaking qualitative research alongside quantitative methods was highlighted.

Some nature-based providers felt they were being asked to collect outcome measurements without being paid to do this type of work. Collecting measurements is time consuming and challenging, particularly for smaller scale services. Some felt strongly that the level of outcome measurement required is not conducive to the size of grants or services offered. One participant at management level felt that the measurements reduced nature-based providers' ability to do anything innovative and reduced their confidence. This threatens their future sustainability by *'putting people off'* (T&L2) applying for further pots of funding. One manager discussed nature-based providers not being aware at the start of the process of the level of measurements which were required.

All of the sites have struggled with data collection, for a range of reasons. T&L2 has found issues with one area due to the large number of different organisations employing Link Workers, resulting in differing levels of experience and capacity. There is a lot of interest in sharing data and developing data systems locally but there are many challenges which may not be overcome in the current project. Rather than supplying data, it has been suggested here that Link Workers and SP provider managers join a focus group so the site can understand the challenges. They will be offered the backfill payment for their attendance.

Questionnaire data gathered within WP3A earlier in the project highlighted that T&L site Project Managers have incorporated the need for nature-based activity providers to collect monitoring data into their funding award contracts. However, sites have taken different approaches to how prescriptive they have been, typically not mandating which

[2] https://socialvalueengine.com/

specific monitoring data and mental wellbeing measures are to be collected. Despite contractual obligations to provide data - such as demographic data or using an outcome measure of their choice, and the availability of some support - nature-based activity providers are struggling to collect information. This may be due to: the reliance on a volunteer workforce; lack of robust integration of monitoring data collection processes; and disproportionate data collection requirements for the scale of funding received. This has resulted in considerable missing data. Project Managers, in conjunction with the Evaluation Team, are undertaking work to improve the quality of data capture such as providing one-to-one support and running site-based workshops.

Amongst the National Partners, there is understanding that the data ask of providers is a big one but is being asked for anyway, which is illustrative of the power imbalance within the project. (WP5) Ultimately, the National Partners set-out requirements that Test and Learn Sites need to follow.

8.8. Experiences of referrals and referral systems

Many of the nature-based providers who responded to the questionnaire early in the project, said they did not receive many referrals through social prescribing pathways (WP3A). People felt that Link Workers did not contact them or refer people to them, even though there was a need. Nature-based providers perceived that referral routes were restricted and difficult to access, and thus providers could not reach those in real need. Nature-based providers did not know how to get on the Link Worker databases of community activities, indicating that schemes like the 'trusted provider' need to be transparent. Conversely, Link Workers do not always know what nature-based activities are available or how suitable they are for people with mental health needs. Many nature-based providers suggested that where Link Workers took part in a visit to understand the activity, they found this very beneficial in understanding what was required by providers and what was involved for participants. Given Link Worker capacity and workload issues noted in previous sections, this may be increasingly difficult to arrange.

Across several T&L sites, participants felt that the introduction of the project had encouraged networking between different organisations which has strengthened referral pathways and increased connectivity between different parts of the system. Participants acknowledged that groups, organisations and referral pathways existed prior to the test and learn pilot but were often not as well connected to each other. It was acknowledged that developing effective partnerships across the sites was integral for ensuring strong referral pathways. Building up trust is integral to reducing inappropriate referrals. Despite increased investment in partnership working and a perceived buy-in across the system, some nature-based providers have not received the amount of referrals they were expecting or have the capacity to support.

Referrals also seem dependent on specific people who have buy-in for the project or links with different organisations. Relying on specific people becomes problematic when key people leave the organisation, contributing to fragility in the system. Although some nature-based providers expected more referrals, others felt that referrals had increased since the start of the project and that this was linked to greater awareness of the benefits of GSP.

There was acknowledgement by some participants of a '*disconnect*' or fragmentation between '*providers and suppliers and the intermediaries like Link Workers*' (T&L5). It was acknowledged that referral pathways are complex and that set up has not been as straightforward as first envisioned (for example, it is not as simple as a doctor makes a referral and then a Link Worker picks this up). Lots of work has been undertaken by sites to understand the barriers and how to connect people to the correct places. Ensuring service users and Link Workers are aware of the nature-

based activities available is key but remains an ongoing challenge. Increasing awareness across different stakeholders requires a lot of monetary and workload investment. Examples of awareness raising activities by nature-based providers and other stakeholders include developing online networking and holding meetings, delivering in-person launch events, providing free taster sessions of activities to referrers and Link Workers, as well as creating flyers, toolkits, websites and other communication materials. Some places within T&L sites have used project funding to directly fund members of staff to develop connections between referrers, nature-based providers, Link Workers and service users. Through funding specific posts dedicated to partnership working, the T&L pilot has allowed for increased capacity to foster connections which would not have been possible prior to the project.

Some nature-based providers report that they struggle to get referrals, despite repeated efforts to contact and engage with social prescribers and/or GPs and sharing information about activities, although this appears to be changing with referrals slowly starting to come through in some places:

> *I can only presume the staff are just so busy or just don't have that capacity to then follow that up when actually it could save them quite a lot of time. But there's just something about that, just that relationship building, whether they don't have time for that, I don't know, it just seems to the green organisation, they feel a little bit dismissed or not listened to I suppose and then kind of give up. [T&L1]*

Currently there are issues in terms of two-way communication, for example if a GP makes a referral they may not follow up or hear back about what happened. If they are not aware of whether there was a positive outcome, they don't know whether to continue making the referrals. GP's knowledge and awareness of GSP was cited as a barrier by a number of interviewees in terms of both the concept itself, and knowledge of specific services available in the area although, as noted before, this may reflect a lack of understanding about where referral to a specific activity or service occurs, which is not usually direct from the GP. Other nature-based providers report that they receive some inappropriate referrals, but they send these back. This happens regularly with some referrers. The impact on the individuals is not clear.

Within T&L2, despite much investment in partnership working through various activities such as a Green Task Group (project management group) and the Green Network group (network bringing together nature-based providers), it was acknowledged that further work was needed to strengthen the relationship between Link Workers and nature-based providers. As with T&L5, some nature-based providers had expected more referrals from the GSP project from both Link Workers and GPs. One participant discussed how they had only received self-referrals so far of which only two were new people not already involved in other activities.

One key challenge identified by WP4, focussing on non-T&L sites, is the description of SP and GSP systems as fragmented, disjointed or lacking clear coordination. A result of this is poor awareness of the availability of services and a limited 'core set' of activities offered by referrers. High numbers of PCNs, provider overlap with different contracts and confusing geographies of some of the strategic and regional bodies was highlighted as contributing to this fragmentation and confusion around lines of report and responsibility. This challenge was highlighted across areas where SP and GSP were both new and established.

8.9. Experiences of delivery of activities

There was less information across T&L sites on nature-based provider delivery experiences. In T&L4, this was not within the scope of their activities at the time of writing.

Across other sites, there is clear buy-in and passion from nature-based providers on the importance of green/blue activities and many were already established providers before the GSP T&L project. Many described GSP as their 'bread and butter' and have really enjoyed delivering activities. Some shared concerns over the sustainability of activities and issues around long-term funding which are common issues within the VCSE sector but have found ways to adapt, such as applying for small pots of funding or obtaining match funding from other sources such as the CCG/ICS. Further detail is given in site updates within Appendix 3. We will also explore issues of delivery activities further in the next round of data collection when sites will have made more progress.

T&L6 carried out a provider survey on the use of green spaces and has conducted a policy and practice review on the use of nature in care pathways within the locality.

Within T&L1, one provider articulated how nature-based activities could support people in different ways through peer support and sharing lived experiences which contributes to a more holistic experience. Providers were very passionate about the benefits of their activities and the benefits that many individuals could experience through participating whether through formal GSP referrals or more informal routes:

> *That's how we're different, because [...] we're not saying 'we're experts in what's happened to you', we're saying 'this is what's happened to us, this is how we deal with it, this is what's been helpful for us, take that or leave it', and opened it up to the rest of the group and say 'what helps you?', and you can then take whatever you want out of that experience, or not. So, it's not about somebody telling you what you should do, it's about sharing an experience, and that's what makes it not like a health intervention. [T&L1]*

Nature-based providers were keen to highlight the informal and flexible nature of their activities and described how participants were encouraged to try new things as well as ensuring that they had the choice to take part in their own way and do activities that they felt most comfortable with:

> *We like to say we leave labels at the gates, so we're you know, not really that bothered [apart from] health and safety whether you've got other issues or whether or not you've assaulted somebody, you know, let's take it at face value, leave the diagnosis at the gate and find out what you're interested in and we'll adapt our activities. [T&L1]*

8.10. Experiences of working with people with MH needs

Some sites are collecting this data through case studies.

In T&L5, there are varying levels of nature-based provision aimed at those across the spectrum of mental health needs. Two sub-localities have described having direct experience of working with, and supporting, vulnerable service users with complex mental health needs. Issues relating to supporting those with mental health needs were rarely specifically mentioned, which may indicate nature-based providers feel comfortable providing this provision.

T&L 1 reported that sometimes nature-based providers struggle to fill positions for staff and volunteering roles which could be an issue in terms of being able to provide activities. Interviewees highlighted the importance and challenge of needing to have staff and/or volunteers who are appropriately qualified to understand and support the needs of people referred through GSP (for example level of risk, safeguarding, clinical knowledge, connections with mental health teams for support, accessibility). Some providers were concerned that they were not equipped or qualified to provide the support that some people being referred might require:

> *[Some people] need more help than they get and we are happy to help them but we are not really qualified, well we are not qualified social workers. But we have sort of helped on a few occasions with filling stuff in and making calls to people but you know they almost get lost in the system and they are really quite vulnerable. But it'd be good if we had somebody to contact and say what do we do, how do we handle this situation, do you know what I mean? I don't know how possible that is but that's, because to me that should be like a social worker's job but one of these people that I am talking about, he's been discharged from his mental health team and to me he's still got problems that you know – he's not, he's compos mentis and everything but he has, you know what I mean and we've helped him with a few things just by that, just by talking to people and then suddenly realise he's not right.' [T&L1]*

In the non-T&L site interviews (WP4), one provider flagged concerns with 'opening the floodgates' of the project to people with more complex needs. They stated that they are often approached by community mental health workers, youth offending teams, etc. who wish to refer clients, and sometimes clients do come through with greater need (as the project is very open). They do the best they can, but the national project funding would have given them the capacity to employ someone with the right experience to support those with greater need. They are hoping to provide this in future, but the environment is difficult funding-wise.

Theme 7: Targeting of GSP for particular groups

9

Under this theme there are a range of particular groups highlighted by different T&L sites, reflecting a diversity of geography, regionality, economy and devolved policy making. All T&L sites identified specific groups of people to be targeted for GSP within their original bids in order to address health inequalities, underserved geographical communities, and populations disproportionately affected by Covid-19. Findings presented under this theme address: priority and underserved groups (see also local Theories of Change in Appendix 1 for target groups for each site), their identification and agreement; decision making between stakeholders; targeting approaches; recruitment and referrals; and barriers to engagement and strategies to improve engagement.

Key Findings Theme 7: Targeting of GSP for particular groups:

- T&L sites have purposefully engaged service users with lived experience of mental ill health in different ways to inform the design and delivery of GSP programmes.
- Working directly with target groups is sometimes constrained or guided by the focus of funders and funding opportunities, where restrictions are placed on e.g., geography, timescale or age grouping.
- There are many examples within the project of T&L sites successfully reaching marginalised groups with focused interventions. For example, one site undertook further work to plug gaps in provision and increase grant applications from underserved communities. Where grant funding wasn't allocated in the first round further work was undertaken alongside providers to coproduce new applications, resulting in further applications from providers targeting people from ethnic minority backgrounds, those with severe mental health issues and disabilities. Another site has had success in getting more people from their 'Health Inequalities' populations to connect with nature with an ongoing goal to support more delivery leaders from within these communities. Other sites have carried out engagement work to increase referrals, such as identifying and bringing diverse groups and community leaders together to understand barriers and needs, focusing activities on known areas of deprivation, translating literature into different languages, actively funding members of staff to develop referral pathways or providing taster sessions for nature-based activities.
- However, significant barriers to engagement remain. Overcoming barriers such as poverty, digital and physical access, fluctuations in mental health, language, and cultural differences, requires time, effort and representation such as working with trusted gatekeepers.

9.1. Priority and underserved groups, their identification and agreement

Much of the initial T&L7 work has focused on addressing health inequalities, targeting specific communities, and also work linked to primary care. For the remaining period of the project, they are looking to create stronger links to secondary care, starting with the regional mental health partnership and building more nature-based provision into standard practice. The regional mental health partnership has several nature and health projects running but is still quite ad hoc rather than an overall approach for the organisation. The aim now is to build green care into the standard practice of clinical workforces.

This ambition to extend into more severe mental health issues, as well as targeting specific populations such as ethnic minorities with a mental health focus, is a key focal point for several T&L sites. Specific geographical focuses within T&L sites are targeting their own communities, for example one T&L site was doing specific work around those living in poverty, who are homeless or at risk of homelessness and most affected by Covid-19, all with a mental health focus.

In one site, which is running a clinical cohort, their work has not yet engaged with any people from ethnic minority backgrounds and low numbers of people from these communities are currently accessing SP. However, NHS Charities-funded work will concentrate on developing and supporting organisations delivering green/blue activities for ethnic minority groups. Physically visiting these organisations has been beneficial in promoting engagement.

From the questionnaire conducted earlier in the project (WP3A), T&L sites identified a range of target groups who may be more at risk of experiencing mental ill health including those with a diagnosed mental health condition, as well as those from a broader demographic who are known to be subject to greater health (including mental health) inequalities, such as people from ethnic minority backgrounds, people with learning disabilities and those living in areas of high deprivation. Within the same questionnaire, nature-based activity providers reported a mix of different intentions regarding targeting. Some created highly targeted activities, while others offered activities for the general population.

In non-T&L sites (WP4), a key priority is engaging diverse groups and understanding why green and blue spaces are less used by certain groups. An example provided was from the Sikh community who described inherent cultural concerns around going outside, going out in the evening, and taking part in sports. The aim is to help change those views and demonstrate the value.

9.2. Decision making between stakeholders

Currently we have less information from sites about how decisions are made about targeting activities. This may change as the embedded researchers focus on participant experiences in the final months of the project. All T&L sites have project boards with membership across key stakeholder groups and some sites, such as T&L7, facilitate groups specifically targeted at GSP Link Workers within the locality.

Within T&L5, focus on people from ethnic minority backgrounds was due to evidence showing that these communities experience the greatest disadvantages from health inequalities, with huge variation of experience even within local authorities. Further to this, delivery partners and the T&L team centrally have been working to engage community groups that represent those communities at a neighbourhood level to increase engagement and uptake.

In T&L3, decision-making has not emerged as an issue as the approach of working through 'trusted green providers' was agreed at the outset. The challenge is feeding this through into a fragmented referral system.

T&L6 has developed a specific 'co-design protocol' which sets out clear stages and opportunities for people with lived experience of mental ill health to inform the design and delivery of the project. The protocol was based on a site-wide survey with the aim of understanding the specific needs and challenges within each priority community within the locality. Lived experience consultants were recruited as colleagues of equal status to support on-going project delivery, and the plans of each provider applying for funding under the GSP project were reviewed by a person with lived experience of mental health concerns. This made for a richer discussion and a more genuine approach to creating an offer accessible to people with mental health concerns. Alongside the survey, T&L6 carried out formal engagement with user-led networks and ongoing attendance at key regional meetings such as the Learning Disabilities Partnership Board and Mental Health Transformation Programme. This site is also developing a programme to champion health and wellbeing, which provides training to equip people from ethnic minority backgrounds to promote health and wellbeing messaging within their own communities. The training is co-designed with people from ethnic minority backgrounds and representative organisations.

Within the work with the National Partners (WP5), an initial lack of clarity regarding who owns and/or should drive GSP policy led to a degree of stasis and extensive debate about the aims of the GSP project and wider policy... This picture has become clearer more recently: in-keeping with the cross-Governmental focus of the project, it is jointly owned by the health and environmental sectors and progress has been made to embed it in a range of health and environment policies which ought to filter down to local policy in the longer term.

9.3. Targeting approaches

All T&L sites have an implicit or explicit target of activities being set in, or carried out for people who live in, areas of deprivation.

T&L7 explicitly aims to create more green leaders from communities identified as being particularly adversely affected by health inequalities. By their own assessment, they have had good success in getting more people from their 'Health Inequalities populations' to connect with nature. Much of the delivery, however, is still run by people from outside these communities so an ongoing goal is to support more people from within these communities to lead sessions within their community. In an original approach, T&L7 are running a 'mystery shopper' programme, where an independent mental health charity has been commissioned to carry out mystery shopper activities on funded nature-based projects. Nine members of the charity, who are experts by experience, will attend funded projects as genuine participants and will feed back to the project board in order to inform local service improvement, carry out monitoring and evaluation, and form an independent view of how programmes are running in practice.

More detailed reflection on targeting approaches for specific populations was given by T&L5, where it was clear that reaching such communities was time consuming and required sustained effort. The T&L sites had undertaken different pieces of engagement work to increase referrals, such as identifying and bringing diverse groups and community leaders together to understand barriers and needs, translating literature into different languages, actively funding members of staff to develop referral pathways or providing taster sessions for nature-based activities. The importance of meeting people in person to build trust and confidence, as well as working directly with communities to understand their needs, was acknowledged. In turn, the importance of

changing the language around social prescribing to be less medical was discussed by some participants. Removing medical language and working closely with communities by actively involving those with lived experience of mental health issues in the project was seen as extremely important for engaging hard to reach groups:

> *And you know another big one that comes up is the language sort of stuff. So, language barriers in terms of you know accessibility if English isn't your first language. That's just you know a very easy no brainer one. I mean it's something we are trying to look at now but it's trying to find somewhere that could translate our literature and things like that but then also on site … So that's a barrier but then also and we are trying to address this as well through the network meetings because we invite you know commissioners, but we will also invite service users to those meetings. It's everybody on the whole spectrum of social prescribing are invited. And it's like changing the language of social prescribing because it's like ……clinical which it almost needs to be, because otherwise are you going to sell it to people who are clinically minded you know. But it's like how can we meet in the middle? And so, there's that and there's also trust. There's an us and them mentality sometimes from people if they feel like they, if they've experienced health inequality and they feel like they've not been heard, and they've not been able to access services which you know people do report that. You know that they feel like they've been passed from pillar to post. All those kinds of things come out of conversations and some things are medicalised. Ooh it's not for me that, it's not for me that you know. [T&L5]*

One site highlighted that they were sometimes constrained or guided by the focus of funders and funding opportunities. For example, the test and learn project funding was initially only focused on participants under the age of 65. However, following feedback from providers, T&L1 are reviewing this limit and have asked their steering committee for permission to revise this.

T&L6 targeted four geographic communities in regions of higher deprivation, and four thematic communities (people with mental ill health, people with learning disabilities, people with dementia, carers). To engage and collaborate with these communities, the site offered dedicated funding specifically for communities of deprivation, providing small grants to a number of community groups to help them to make further use of nature as a health and wellbeing asset. This fund was used to leverage engagement and helped to identify active citizens and potential co-producers from within the focus communities. This site also agreed a co-design protocol to set out some clear stages and opportunities for people with lived experience of mental ill health to inform the design and delivery of the project. An initial step was a user survey to understand the specific needs and challenges within each target community. The survey platform automates the collection, collation and reporting of data so provided easy to understand results and insights without requiring a huge amount of time or resource from the project. Lived experience consultants were recruited to support on-going project delivery and take part in workshops so that the plans of each provider could be reviewed by a person with lived experience of mental health concerns. This made for a richer discussion and a more genuine approach to creating offers for this population.

T&L6 also created a fund to target their thematic and geographic communities of focus, establishing specific opportunities for people with learning disability, dementia, mental health needs, or from areas of deprivation or people from ethnic minority backgrounds to access nature-based opportunities. Examples include a walking group for people with learning disability, wild swimming for carers, and a climate change and environmental group for Muslim women and girls. Alongside this they carried out formal engagement with the user-led networks, for example attending the Learning Disabilities Partnership Board and Mental Health Transformation Programme. T&L6 secured matched funding to develop a health and wellbeing champions' programme

for people from ethnic minority backgrounds to provide training based on Making Every Contact Count to equip them to promote health and wellbeing messaging within their own communities. This training will be tiered, with entry level training enabling residents from ethnic minority backgrounds to reflect on their own health and wellbeing, increasing to more intensive training that would connect them into the NHSE Peer Health Leadership programme. This training will be co-designed with people from ethnic minority backgrounds and representative organisations. Other initiatives to target groups of interest include a universal promotional campaign to promote the use of nature for health and wellbeing benefit amongst all residents with a view to catching those who would not be known to services but who may benefit. The project is working with nature-based providers to collect data collection on uptake. Other initiatives are focused on place-based community engagement and co-production, wider than GSP but including nature-based activities.

T&L2 has good coverage of projects targeting different cohorts and using a range of approaches. In some localities, not all funding was allocated, so further work was undertaken by place partners alongside providers to coproduce new applications that met the project objectives and plugged gaps in provision. For example, further work has been undertaken in one area to target those experiencing severe mental health needs as well as blue activities due to a gap in provision. The social prescribing lead in the area has contacted groups to encourage participation and through this work the panel received two more applications – one from a blue activity provider targeting severe mental health as well as another blue activity which has prior experience of engagement work with those with disabilities. In one locality, whose original focus was the clinically vulnerable and those who are shielding, findings from workshops with stakeholders revealed the need to focus on ethnic minority communities. The local nature-based organisations are working alongside local authority colleagues to carry out some specific work targeting these groups, which has resulted in another application from an organisation with a track record in engaging with ethnic minorities. The benefit of this was illustrated by an interviewee who described how the codesign work had increased applications from ethic minority community groups but also improved connections and relationships:

> *There's also some work, I am thinking specifically here about [name of area] where by virtue of a funding pop ups in [name of area] we wasn't getting enough applicants from BAME communities and so [through] a bit of co-design work and good conversations between BAME groups in that place had happened. That's actually I think going to have a long term benefit... [T&L2]*

For National Partners (WP5), most respondents were clear that the GSP project was targeting people with mental health needs, rather than the general public. The aims (as explained by one partner) are to ensure access to GSP for people across the continuum of mental health need (from self-identified low-level needs e.g., loneliness, mild depression through to those with more serious and enduring illness). However, how this vision should be put into practice by Test and Learn sites was not initially clear, documented, or possibly agreed amongst the partners, nor was it the vision clearly communicated to interested sites in 2020. Whilst there now seems to be clarity across the national partnership, the issue continues to cause difficulties as sites have developed projects that responded to a wider brief - and it is difficult to shift at this late stage.

9.4. Recruitment and referrals

There were initially concerns that, in some T&L sites, there were issues within some localities about numbers of referrals from ethnic minorities. For many, it was *'a key objective to reach these groups'* (T&L5). Current monitoring data is encouraging, but further work needs to be done to explore ethnicity profiles for different localities in order

to better understand how well GSP is serving local need. People reflected that there was still '*a lot to do here to reflect the target audience we are trying to reach, including improving the quality of data, foster and create trust*'. Despite this, most interview participants felt they were reaching the people who would benefit from the project most (such as those with mental health issues not accessing medical services), although some sites did have capacity to take on more referrals:

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

It was clear that reaching such communities was time consuming and required sustained effort. The T&L sites had done different pieces of engagement work to increase referrals, such as identifying and bringing different groups and community leaders together to understand barriers and needs, translating literature into different languages, actively funding members of staff to develop referral pathways or providing taster sessions. The importance of meeting people face-to-face to build trust and confidence as well as working directly with communities to understand their needs was acknowledged:

> *So, it was realising that actually what we need to do is much more strengthen the localities. So, we went out to adverts and… for basically VCSE leaders from across those [x] localities. And we also basically looked at leaders from what we saw as those different communities of experience, communities of interest and communities of, of culture, and saying, well we actually need to bring in that, because we also have a number of communities who run laterally across the longitude of localities. So the Jewish community is a really good example of that. They actually sort, you know, they don't actually exist in one of it, and they wouldn't say, oh we, you know, we're from, there are the Jewish community. And I don't actually see or recognise those, those boundaries. So we brought those groups together and said, OK, you know, let's actually have the leaderships first, and then we then work out where the representatives go, rather than take it the other way round. [T&L5]*

T&L5 has made strong links with the Jewish community in their localities by working with leaders to understand gaps in provision and to develop new activities by linking them into local green space.

In T&L3, the challenges of working with Link Workers suggests that there may be some issues in terms of participation reflecting target groups, but data are not available to verify this.

9.5. Barriers to engagement and strategies to improve engagement

Within T&L5, interview participants described many barriers to accessing GSP for underserved groups, such as one interviewee who discussed how GSP caters to the middle class and that those from vulnerable groups need further support to access such services. In turn, linked to previous discussions, this interviewee felt that reducing poor mental health was not a realistic aim for the project, particularly in the context of poverty and the financial crisis:

> *Some of it I just think looking across the board, we need to be careful about what it's been brought in for, so if you're clear at the beginning… it's about being more precise in our definition rather than just a general improvement around mental health, I think that will fail, and if I'm honest that's also our target of social prescribing as well, not just as a general thing, like I say, that won't read well, the middle class will routinely go for it more obviously, they always do, and that's because that's the way the system is, but the folk who might most need it actually will need brokers and help around that one, but they could do with, you know, a couple of quid extra to pay for bits and pieces, especially in the financial crisis we're heading into. [T&L5]*

The concern around improving access for underserved groups was also reflected by T&L6, who - in response to increasing pressures around health and care capacity - are exploring self-referral models and smoothing access pathways for people who, for example, have difficulty in accessing primary care services. Part of this approach involves exploring how to support alternative referral points who may be in a position to identify mental health needs. This site also explicitly recognised the challenges in competing priorities given the greater focus on health inequalities experienced by ethnic minorities precipitated by the Covid-19 pandemic. This increase in activity has led to higher demands for representative groups to engage and support various activities and agendas focussed in this area.

Other barriers suggested by participants included poverty and financial issues, lack of access to transport and appropriate kit (linked to finances), lack of access to internet and social media, fluctuations in mental health issues and confidence, issues with language and the need for translations or differences in culture - for example, seeing nature-based activities as work rather than a recreational activity:

> *there's a few different points. So, historic. So, particularly talking about … with the BAME groups, that historic is, you know, when their kind of grandmas' generations came over, it was a luxury, they didn't have time and availability of green space. And although a lot of people, you know, when I've talked to them, have massive connections back in their original home, you know. Like, a lot of people around Pakistan that they did work the land and, you know, that, that was their job. Erm, and already have that massive nature connection. It just wasn't realistic when they came over to England because it was a real luxury to have that time…So, a really interesting one was around, um, how language, the language that we use. So, growing, food growing and gardening is very much seen in certain cultures, erm, as… laymen's work. It's not, you know, it's kind of not, for us it's recreational and it's something fun, but for that it's kinda looked down on a little bit. [T&L5]*

The stigma around mental health, particularly for people from ethnic minority backgrounds, was mentioned by some participants.

In T&L2, some participants described the difficulty in engaging with underserved populations within the project and questioned whether they were reaching those who would benefit most from the project. Participants in interviews and observations

described several barriers to engaging underserved communities such language barriers for those for which English was not their first language, issues with kit and transport linked with poverty and financial issues, stigma associated with mental health (particularly amongst people from ethnic minority backgrounds) , lack of representation of the workforce (for example, many Link Workers are white), lack of trust, mobility issues and lack of access for wheelchair users, lack of confidence/ anxiety, and lack of access to social media and digital exclusion and racism/lack of representation in the workforce:

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

A lack of transport and availability/accessibility of green activities in local spaces was a key barrier within several test and learn sites. To mitigate this, one T&L site (T&L5) was exploring working with local community groups, land managers and the council to develop green activities in underutilised green space closer to local areas or in spaces traditionally used for sports or other activities:

> *It's making sure there's enough offers and appropriate offers, I think. So, where we've had challenge to, you know, like I said, the biggest barrier being travel and transport, of going, OK, well, you know, we've set up this [name of green organisation]. [Name of green organisation] is there already, [the service user] might already be a member there, or, you know, using like a service. So the, that's one step, building confidence. Because they know, they know it's familiarity. But it's also a step towards, um, it's right on a met stop, you know, on the tram stop…it's right in the centre of places. So it's maybe, looking at different green assets. So, those parks that I talked about that are barren for biodiversity and they're just associated with sport, recreation, you know, sports recreationally, or a picnic. Looking at what, if there's any groups or infrastructure that we can develop there, so talking with councils [T&L5]*

Within this site, a number of strategies to improve engagement with underserved communities was discussed, particularly the importance of identifying and working with a trusted gatekeeper within that community. In T&L3, the project has sought to recruit volunteer drivers to help participants access activities.

Other suggestions made by participants included ensuring activities were culturally appropriate (such as using correct clothing, doing exercise and other activities '*within cultural norms'* (T&L2) and free at the point of access, using project funds to remove barriers such as providing transport, working directly with communities to share information about activities (for example through trusted gatekeepers and word of mouth), increased information sharing with GPs and Link Workers, working with health professionals to help them better support and understand the needs of underserved groups, utilising different communications strategies such as videos, capacity building with community groups in targeted areas to help them write bids and create governance structures, and encouraging those living in areas of high deprivation to see and utilise the green and blue on their doorstep. A key part of this is about changing attitudes and the acceptance of GSP activities which participants acknowledged would take a long time to develop.

Theme 8: Referral experiences

10

Within this theme, user experiences are reflected across all the T&L sites from a range of sources, including interviews, observations, theories of change and site-generated information. A further piece of work is planned for Autumn 2022 under WP3B to talk directly with service users and capture their experiences of GSP. An explicit aim within this piece of work is to explore a diversity of viewpoints, reflecting opportunities for learning about successes and challenges for service users within GSP systems, and eliciting further insights from findings to date. Under this theme we report: referral experiences; activity experiences; perceptions of suitability and benefits; and accessibility.

Key Findings Theme 8: Referral experiences

- Initial experiences of referral may be negative due to long waiting times to see Link Workers.
- High levels of service user drop-off between referral and joining an activity signals a need for additional contact and support. Proposed peer support models may help this issue, such as the buddying system being tested.
- Nature-based providers and health care professionals within the GSP system emphasised the importance of a person-centred approach, where individual choice was paramount. There are concerns that a medicalised model of prescription and associated language may undermine user buy-in.
- Most providers reported the single biggest challenge was getting users to the first session – once this had happened, people generally return and engage positively.

10.1. Referral experiences

In T&L4, user experience is a core focus and case studies may provide insights in the coming months. Across the T&L sites a key challenge was the workload of Link Workers who were perceived as ‘*overworked and overstretched’* which impacted on referral experiences. For example, T&L3 reports long waiting times to see Link Workers, so the initial experience of referral may not be positive. There are high levels of drop-off between referral and joining an activity, which highlights the need for additional contact and support. There is a proposed buddying system that may go some way to addressing this issue.

Within the non-T&L sites (WP4), interviewees emphasised the importance of informed choice, acknowledging that not everybody needs to be referred to activities - not just because they are already heavily loaded, but because some people are capable of self-referring.

One provider highlighted the importance of GSP being user-centric and expressed concerns that outcomes and impact of activities may be undermined when the activity becomes ’prescribed’. The term GSP could be off-putting and they flagged that it shouldn’t be clear where people have been referred from (if they have) and that this should be a thoughtful and private process.

10.2. Activity experiences

T&L1 reported that providers described broadly similar processes for working with patients/participants once they had been referred to their organisation. They would usually have one-to-one conversations (over the phone or in-person) to find out what the person was interested in, what they might like to work on and ease them in gently, giving them options and support throughout the process. Most said that, for participants who are suffering with mental ill-health, the biggest challenge was getting people there but once they had attended they usually carried on coming back:

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

Similarly, T&L3 reported that those who do participate in activities generally have positive experiences, though much of this information is from providers' reports rather than through detailed data collection. The fact that many participants want to continue with nature-based activities beyond the initial 12 weeks suggests they are providing important social and health benefits for participants.

Within the non-T&L sites (WP4), users reported that it was good to have a buddy to go with people to activities. when anxiety is high or confidence is low. A buddy is usually a volunteer befriender who will accompany people to an activity and support them to build confidence. This site used NHS volunteers who had initially signed up to help with Covid-19 vaccination centres but were now looking at other ways to continue volunteering.

10.3. Perceptions of suitability, benefits

Several sites reported positive stories of service user journeys, with providers stating that they had seen improvements in service user wellbeing, confidence, physical health (through walking and eating healthier food) and knowledge about nature. Interviewees from T&L5 also discussed how attending the groups provided peer on peer support for service users which can be particularly important for people with mental health issues:

So, I think social isolation is absolutely up there. Confidence building is another really big one in that you know we've had people come through who, and this is across the programme we've done, not just gardening… but then you know now a couple of months into the programme, they are doing that. You know very kind of informal at the minute peer support with other people and with new people coming in you know just showing them how to do stuff. Showing them the ropes, that sort of stuff you know. Taking them under their wing a bit because they've built that confidence up over them couple of weeks by being in that regular group and it's easy and it's relaxed and stuff like that. And we now have people who've come through that and got on the training and want to deliver stuff and have got the support to do it. So, that confidence building and anxiety reduction as well is massive. And I think the other thing it was feedback that we get from what people always, always say is it gives them something to do with their time and it gives them a sense of purpose. So, I think for anyone, if people are looking for, it's really difficult isn't it this because if people are looking for a sense of purpose and identity you know. [T&L5]

I think, yeah, anyone that I've spoken to that has been a, that is a front recipient and they've told me some of their outcomes of the people in, like, just some of the really informal case studies that we've talked about. They've been really great and, like, life-changing erm, especially for communities that don't get to go outside that often, or don't get to use these really beautiful spaces in [name of place] that often. But it's just, it's just a shame that it's taken the NHS so long to, to want to fund these types of activities. Cos, people have been crying out for this for the longest time, even before Covid. [T&L2]

Some service users taking part in GSP go on to volunteering or develop their own groups. It should be noted that many of these stories relate to groups that were previously set up, rather than new ones developed as part of the GSP pilot.

Within T&L3, there are some concerns with the suitability of some nature-based activities for people with severe needs (particularly where participants may be deemed a risk to others - for example, because of a history of offending). Reports from service providers suggest those who do participate benefit from the social interaction and connections with nature that are stimulated through GSP activities. However, these benefits have to be balanced against the real or perceived risks to other service users.

T&L5 discussed the complexity of service users' experiences and journeys. Alongside mental ill-health, service users are often dealing with a multitude of other issues such as food and financial insecurity:

So, I suppose when we look at the reasons for people being referred in, we see you know we see a significant proportion of those, say eighty-five percent thereabouts for, their mental health reasons. But when you break it down, actually when you look at those conversations, it's not that, it's about sixteen to twenty percent may have an emotional health need. Most of those immediate presentations are dealt with if you get the person to the right level of support. Often it is about benefit and support, housing, food. Food's a big, increasingly big one. Then we are starting to see more people presenting with mental health, low level mental health, anxiety, depression, low mood, and I suspect that is going to continue for a good while given the failure of the economy. [T&L5]

10.4. Accessibility

One interviewee in T&L7 discussed mental health for people in secure units and talked about the importance of accessibility for the most marginalised people:

> *I: What do you think… by the end of this project, what do you think will be the thing you are proudest of from the [T&L7] test and learn pilot? P: ...the accessibility for the most disenfranchised people, really. So you know, it is probably often going to be men, they are probably going to have a forensic history, they are probably going to have a history of substance misuse. They probably have a history of some violence and that, and you know, those really unpopular people that I have spent my life hanging around with, but how do we… is it all available for them as well? I think I have kind of asked that in meetings before and been reassured, but I guess I am just sat here wondering if there is more we need to be doing still and maybe we need to be pumping a bit more in those areas...? So say we…have an allotment group running successfully in our medium secure unit, that then means there's fewer barriers then when that person is leaving the secure unit to go and live somewhere supported in the community, where they could possibly going to the allotment group in the secure unit for the last six months, so they are going to be much more readily welcomed into the allotment group in the community, because we've already kind of done that, so, you know, what do we need to do? [T&L7]*

In T&L5, participants described the different barriers service users face for engaging in nature-based activities, such as low mood and confidence, and practical issues such as access to transport or clothes/shoes to take part in activities. One participant described how barriers can emerge over time, for example at the beginning it may seem anxiety is an issue, but other more practical issues emerge such as financial difficulty or lack of equipment and kit. Once such practical barriers are removed often service users can engage despite their mental health issues. Working with the individual to understand their personal barriers is important for ongoing engagement.

For T&L1 geographical accessibility was raised as an issue. For example, in more rural areas provision was more piecemeal.

The precarity of funding of VCSE sector organisations was highlighted as a potential barrier. Most nature-based providers were very open in terms of the people they hoped to support. However, some activities were reported as unsuitable for certain groups, e.g., ecotherapy for people suffering from dementia. Also, some providers felt unable to support people with more severe mental illness due to perceived lack of expertise to provide adequate support:

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

11

Theme 9: System Data Collection Practices, Information Flows

Most of our conversations, with sites, Link Workers, nature-based organisations, and others, included reference to data; in terms of both its the capture and use of myriad data elements. Largely these conversations fell into four subthemes: barriers to collecting and collating data; who has access to any data from different parts of the system; the remit and scope or scale of any of these data; and the outcomes reported in any dataset. This theme has clear links with (4) the health system, (5) the Link Worker and referral process, and (6) the nature-based provider theme.

It was suggested that many of the barriers raised would be addressed by the inclusion of an appropriately senior, resourced post specifically to focus on data systems and collection. Importantly, many sites noted the additional input from the Evaluation Team in collecting data. The Evaluation Team has spent considerable time supporting the T&L sites, and individual organisations within them, to collect data requested for this project. This has included running training events, meeting most months with each Project Manager, ad hoc meetings, developing the monitoring data variables, and supporting individual nature-based activity providers. This could be seen as an intervention in itself. While this has improved the sites' ability to collect data, there remain challenges with the quantity, completeness and quality of data available.

Key findings Theme 9: System Data Collection

- Collecting robust, accurate and accessible data is one of the key challenges faced by social prescribing and by the GSP project. Barriers include the spread of data across multiple organisations (and often requiring a common unique identifier and complex data sharing agreements), data remit (covering different sections of the individual's journey through services), lack of resource to collect or collate data, and a lack of agreed standardisation.
- One potential way to improve capacity at individual site level could be having an appropriately senior, dedicated role responsible for data collection, collation and reporting.
- Social prescribing software offers potential solutions to some of these issues but has not always translated into practice.
- There is debate about how to measure whether there are benefits from GSP, given that programmes seek to address such diverse and broad mental, physical and social health needs. Sites sought guidance from the existing literature, the evaluation team, national partners and further afield; but there was often a lack of consensus between sources and for different audiences, as well as a disconnect between prioritised measures and the practicality of data collection.

11.1. Barriers to collection of robust data

Unsurprisingly, there were myriad barriers reported for collecting, collating, and processing the most appropriate data. We detail many of these in this section; all were considered important by different actors in different ways and taken together hopefully allow for constructive conversation around how to improve data collection, or perceptions of data collection. Importantly, one site noted that the GSP project itself has provided '*an impetus to collectively overcome these barriers*', feeling that the GSP has been a catalyst to exploring data issues relating to social prescribing and VCSE activities more generally. This site added that the ability for their Project Manager to then sit on a national group relating to data issues was a key positive step.

Many sites identified that consistency was tricky to achieve in terms of data. This was partly linked to sheer volume of data, '*how much information they feed back to Link Workers*' (nature-based provider questionnaire, WP3A), however this was also viewed positively in other contexts:

> *we have a fantastic system…which collects and provides…primary care data…we can see social prescribing referrals, we can see ethnicity…and that's fantastic. [T&L3]*

There was also optimism within the sites about new ICS structures and the consistency they have the potential to bring to data structures (T&L5). The T&L local project management team recognise this challenge and are engaged in designing solutions

More generally, there were barriers relating to some service users not wanting to be part of research/evaluation studies. This is not specific to GSP, or even SP, but health services in general. Sites felt that mitigation strategies such as reducing the length of study documentation had been effective. T&L1 did note that the service users who do provide data, do not necessarily reflect the service wide GSP populations. T&L7 reported that the overall burden of data collection was a barrier. Relatedly, the capacity, and will, of nature-based providers to collect data was raised by interviewees and in the questionnaire. There were many reports of insufficient skills or expertise to collect, collate and share data. In addition, some felt this would interfere with the relationships with participants, or did not think the amount of data requested was proportional to the size of grants received.

Social prescribing software had been adopted for sections of the pathway (most often for referrals to Link Worker) or was in the process of being adopted in at least two sites. There were clear benefits that such systems would bring, however the implementation often did not match expectations. Practical problems with software included cluttered interfaces; difficulty navigating; lack of connection to GP systems, and, more generally, some felt these software solutions slowed down the Link Workers (T&L7). The plurality of different data capture systems was highlighted as a significant issue:

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

There was optimism that these problems were in the process of being solved by software providers. However there was some concern that any technological solution would exacerbate the problem of under-participation by micro-providers (T&L4).

In non-T&L sites (WP4) data collection and collation was much less developed and, in some cases, non-existent. The ability of these sites to report and communicate evidence relating to their programmes was impacted by the lack of resources put into

data collection. Data that were collected also had a narrower remit. This demonstrates that the investment in the T&L sites is a significant step forward, even if that investment relating to data should be increased.

11.2. Access to data

Access, or even '*getting Link Worker data sets available*' (T&L7), was a common discussion within the sites. T&L1 summarised a main concern in that there are a '*large number of Link Worker employing organisations*' and therefore working with existing (siloed) systems is often complex. An important point related to the myriad systems, is that the sites are outside formal NHS structures and so lack the leverage to collate data in many cases and have to find alternative methods. Respondents to our Link Worker questionnaire also noted that some still use paper records or even no records at all. For nature-based providers, while there was potentially more leverage to get data from projects that were directly funded by GSP funds, some providers were reluctant to pressure participants to complete these for fear of damaging relationships, while Project Managers may also be reluctant to disengage providers through being over-demanding. Generally, sites have tried to be supportive, rather than mandating data collection, encouraging partners to provide what was feasible and recognising that some would not be able to provide data.

11.3. Remit of different stakeholders to collect data

Sites discussed the extent to which data are captured, what is happening and for which parts of the system. Link Workers felt it should be straightforward to identify where they had made referrals in terms of the name of organisation referred to but further coding would be needed to classify whether it was a nature-based provider (Link Worker questionnaire WP3A). As described above, many of the referrals to nature-based providers were self-referrals, which obviously fall outside the remit of many data systems (although individual nature-based providers may collect some information), and tracking these individuals poses a greater challenge.

Moving one step away from Link Workers, identifying the exact referral types (nature-based, financial, physical, etc.) was considered much more difficult by at least one site (T&L3). Whatever data were captured, most felt it was important to communicate these back to referrers (often GPs) and other key parts of the system. Broader still:

> *the main thing that threatens my mind is…not having…the data…to show why the voluntary sector…needs to be resourced. [T&L2]*

Importantly for the project, multiple sites raised the idea of leverage; where there was a funded (or otherwise resourced) lever, this was likely to better enable data to be collated (such as from nature-based providers who received project funding). However, for the GSP project, this excluded key parts of the system, such as Link Workers, in many areas.

11.4. Outcomes

In common with the wider literature on social prescribing, the outcomes that sites or systems prioritised varied greatly. Given the project aims, there is a 'focus on mental health and wellbeing' (T&L1), including the Hospital Anxiety and Depression Scale and ONS-4 scales. However standardised measures like ONS-4 are not always appropriate (T&L3).

About half of Link Workers in our survey (questionnaire data, WP3A) reported using outcome measures regularly (48%) whereas only a quarter of nature-based activity

providers reported using such measures. There was considerable variety in which Patient Reported Outcome Measures (PROMs) were collected, although the ONS-4 was the most common; used by 30% of Link Workers and 19% of nature-based activity providers who completed the questionnaire.

It was noted that project 'outcomes' are not simply quantitative measures or bounded metrics, leading to interest in alternative evidence for impact, such as case studies (T&L1). T&L7 added that in places there had been inconsistent use of self-reported measures, impacting on data quality.

As noted in section 8.7, there were arguments for using broader, less health orientated measures which were seen as too 'medicalised' by some.

T&L7 argued that whatever measures were used should aim to capture the 'messiness' of day-to-day practice and capture the whole system, although this may involve both more data collection, and also different types of data collection, including qualitative.

Also considered important were the outputs (rather than outcomes) of systems, such as relatively basic service use figures relating to referral numbers and referral routes (T&L2). T&L7 also suggested that funding could be aligned to these sorts of performance measures.

Linking data across the system, particularly to individual outcomes relating to the culmination of people's journeys was considered difficult by at least one commissioner (T&L3). T&L5 also noted that updating outcomes measures in existing systems was challenging.

Tensions were raised between the benefits of having a national agreed core dataset, which most agreed was a positive step forward, and the need for locally specific data to address local priorities.

11.5. Summary of the monitoring data

As noted above, there have been considerable challenges to generating monitoring data. Thus, the analysis summarised here (see Appendix 2 for more extensive reporting of WP3A monitoring data) provides a partial snapshot of who may be accessing GSP, their journey and potential impact. We do not know the total numbers of people being supported by Link Workers or GSP and it is unknown how representative the data that we received is in terms of capturing who is accessing GSP. For example, in one site less than a third of funded nature-based organisations provided service user data. Further, there is inconsistency in the data that was provided by sites, with differing types and amounts of data collected. Additionally, datasets returned by providers were typically not fully completed, with differing levels of missing data for each variable. Within the data received, there is a danger of double counting some individuals where organisations provided both individual level and aggregated data to Project Managers.

Table 2: Monitoring data received from Link Workers and providers

T&L site	Monitoring data from Link Workers	Monitoring data from providers
1	69 service users	69 service users
2	88 service users	540 service users
3	No data	33 service users
4	393* service users	No data
5	393* service users	453 service users
6	No data	196 service users
7	No data	434 service users

* Please note, n=393 for both T&L4 and T&L5 is correct

11.6. Link Worker provided data

NB - T&L5 is reported separately throughout due to differences in the system structure (see Appendix 2 for more explanation).

Demographics of people accessing support from Link Workers

- **Gender:** Across the sites providing this data (T&L1, T&L2 and T&L4), more women have been supported (58.5%, n=255/436) compared to men (41.3%, n=180/436).

  In T&L5 (which is reported separately) 60% of service users supported by Link Workers identified as women (57.5%, n=185/322). This gender imbalance across sites reflects other social prescribing evaluations.

- **Age:** In T&L1, T&L2 and T&L4 Link Workers are supporting people from across the age spectrum but there appears a greater proportion of service users amongst the older age groups. Half of people supported were aged over 65 (50.7%, n=268/529).

  In T&L5 the Link Workers supported both working age and older adults. For example, 10.5% (n=32/305) of service users accessing support were aged 18-24 and 10.8% (n=33/305) were aged 60-64.

- **Ethnicity:** Link Workers were predominately supporting people of White British ethnicity (T&L1, T&L2 and T&L4). In the data provided, over 90% of service users were White British (93.8%, n= 196/209). A small number of people from other ethnic groups were supported including those from Pakistani and Black Caribbean ethnicities.

  In T&L5 the majority of service users were White British (73.1%, n=231/316), over 10% of service users identified as Pakistani/British Pakistani (11.7%, n=37/316). There will be some differences in ethnic profiles because of differences within localities.

- **Socioeconomic deprivation:** Link Workers supported some service users from the most socioeconomically deprived neighbourhoods (nearly 20% came from the three most deprived deciles) (n=94/493, 19%). But of the data received, a greater proportion of service users were from the least socioeconomically deprived neighbourhoods (but this may be reflective of which localities provided data) (n=252/493, 51.1%). In T&L5 over two-thirds of service users lived in the top third

most socioeconomically deprived neighbourhoods (69.2%, n=234/338). This highlights the work of the site in having specific nature-based Link Workers to support the site's target populations into nature-based activities.

- **Employment and Education status:** Within the one site that collected data on employment and education, it appeared that service users accessing Link Workers had a higher level of unemployment and lower level of qualifications than the UK average (n=10/69, 15% were in employment).

Mental health needs

A substantial proportion of people accessing Link Workers in T&L 1&2 that provided this data appeared to have mental health needs which had a detrimental impact on their daily lives. The proportions differed between areas, however. In T&L2, over 90% (96.4%, n=81/84) of service users were recorded as having mental health issues, which varied between pre-determinants of mental ill health (such as loneliness), to acute issues (including psychosis). In Site 1, the population on average was classed as having moderate levels of anxiety based on the Hospital Depression and Anxiety Scale (11.53, SD: 4.82). Service users from T&L1 reported a range of health conditions including physical impairments, sensory impairments and learning difficulties. Over two-thirds of the service users from T&L1 reported felt that their day-to-day activities were limited because of physical and/or mental health conditions.

In T&L5 the majority of service users, for whom data was provided, were categorised as having mental health issues (83.5%, n=81/97). However, this data needs to be treated with caution due to missing data potentially skewing the percentages.

Referral routes and rates

Healthcare professionals appeared to be the primary referral source to Link Workers. In T&L2, the main referral source was primary care where just over half of referrals were from GPs (55.2%, n=48/87) and other primary care professionals such as Practice Nurses (16.1%, n=14/87). In T&L1, almost half of referrals were from mental health teams (47%, n=32/69). Other key sources were self-referrals (19%, n=13/69) and GPs (16%, n=11/69). However, T&L1 was recruiting specifically to a cohort study so it is unknown how representative the findings are.

In T&L5 over a third of service users were referred by Primary Care Link Workers (38.5%, n=141/366). Self-referrals were the other prominent source of referrals (34.7%, n=127/366).

Extent of Link Worker support provided

There was considerable variation in the length of support that service users received from Link Workers in the two sites that provided relevant data (T&L1 and T&L2). T&L2 provided data on 24 service users, with support ranging from a one-off session to a service user being supported by a Link Worker for up to six months. The mean length of Link Workers support was 9.7 weeks (SD:7.5). It is not clear at what stage of receiving Link Worker support that people are referred to nature-based providers.

In T&L5 of the 60 service users for whom we have data, over half received between 2-5 sessions (53.3%, n=32/60). A further third received between 6-10 sessions (25%, n=15/60).

Referrals to nature-based activities

From the small amount of data received, it appeared approximately 5-10% of Link Worker onward referrals were to nature-based activities. For example, in T&L4, Link Worker data was provided from one of the four localities involved in the T&L site. Of the 686 onward referrals, data provided for 56/683 (8.2%) were to nature-based activities. These proportions reflect the findings of the questionnaire. It was not possible to explore whether service users being referred to nature-based activities are representative of the general Link Worker service user population.

In one of the sites (T&L2) to provide relevant data, Link Workers referred service users (total n=91) to a range of nature-based activities including community allotments and gardening projects (25%, n=22/91), conservation projects and nature-based physical activities (25%, n=22/91). The most common onward referral route was to nature-based organisations who would then determine what specific activities the service user would access (n=25/91, 28.4%). In T&L4, 56 referrals were made to 19 different activities.

In T&L5, which as previously noted operates a different model of Link Workers, with some situated in nature-based providers, over two thirds of service users had been referred to nature-based activities (68.7%, n=270/393). Of the referrals made, the most common was to horticultural activities (46.6%, n=126/270) followed by nature-based craft focused activities (21.1%, n=57/270).

11.7. Nature-based provider data

Number of people accessing nature-based activities

We do not have accurate figures relating to the number of people supported through nature-based activities associated with the GSP T&L project. This is because of the different methods used to record monitoring data and different return rates for each nature-based activity. Based on the data returned, there were at least 3525 cases supported through nature-based activities. This does not mean that 3525 individual service users accessed support as some may have accessed more than one nature-based activity. This figure is likely to be an underestimate as data were only received from some funded providers. For example, T&L7 received data from less than a third of funded providers. Further, our data was collected to mid July 2022, and monitoring data collected from the test and learn sites suggest that more than 6000 people had accessed nature based provider activities by the end of September 2022.

Demographics of people accessing funded nature-based activities

- **Gender:** Across the sites there is a relatively even proportion of men (46.7%, n=885/1898) and women (52.2%, n=990/1898) being supported by nature-based providers. A small number of people identified as 'non-binary' and 'other'.
- **Age:** Sites appeared to support people across the age spectrum including under 18s, people of working age and older people. Overall, around a fifth of service users were over 65. Only some sites supported under 18s, which may require further consideration in the future.
- **Ethnicity:** Across the sites, 68% (n=753/1107) of the people accessing nature-based activities were reported to be White British. A greater proportion of service users from ethnic minority backgrounds than the national population average were reported to be accessing activities. This may be due to some highly targeted provision.

- **Socioeconomic deprivation:** Although there was significant variation between T&L sites (reflecting local geography), overall over half of service users being supported by nature-based providers lived in the most socioeconomically deprived neighbourhoods (Deciles 1-3) (61.7%, n=501/812).
- **Sexuality:** In the one site to collect relevant data (T&L7) over 5% of service users identified as LGBTQ+ (6.2%, n=18/290), a proportion higher than the national average.
- **Health status:** In the one site to collect relevant data (T&L7) over a third of service users being supported by nature-based providers self-identified as having a disability or long-term health condition (37.1%, n=111/299).

Mental health needs

Across the T&L sites to provide relevant data (T&L 2, 5 & 6), three quarters of service users being supported by nature-based providers were categorised as having mental health issues (74.8%, n=591/790). However, proportions varied between sites. In T&L6 less than half of service users were recorded as having mental health issues whereas in the two other sites that provided data, the proportion was over 80%. GSP was supporting people with differing levels of mental health needs ranging from having pre-determinants to more severe mental health issues. Approximately a quarter of service users were considered as having pre-determinant mental health issues including experiencing loneliness (24.2%, n=191/790). The most common category was moderate mental health issues including service users experiencing depression (39%, n=308/790). A small proportion of service users were considered as living with serious mental illness e.g., psychosis (11.6%, n=92/790). There may be a number of reasons why not everyone was categorised as having a mental health issue. One reason will be that people may not disclose the difficulties they are experiencing as it can take time for people to build up trust with providers. Secondly, some of the providers will be supporting people at higher risk of experiencing mental health issues such as experiencing socioeconomic deprivation, reflecting the preventative element of GSP.

Source of referral to nature-based activities

There was considerable heterogeneity in referral routes to nature-based providers between the T&L sites reflecting local systems. Self-referral was the most common access route, with 29.8% of service users accessing nature-based activities through self-referral (n=431/1447). Link Workers were also a common source of referral (27.2%, n=343/1447). Less than 5% of service users were referred to nature-based activities through mental health services.

Delivery of Nature-based activities

Of the data received, the most common types of nature-connection activities were bushcraft (18.1%, n=527/2906) and horticultural activities (15.5%, n=451/2906). Exact numbers of attendances at activities was difficult to assess. Of the data received, service users had received between 6-10 interactions to date, but the range was one to over 20. Many people were still attending activities, so the number of interactions is likely to increase. T&L1 provided data on frequency of attendance; the majority of service users attended the nature-based activity weekly (86%, n=24/28).

Change in mental wellbeing

Where data were provided, it appeared that service users experienced improved mental wellbeing when accessing nature-based activities. There are considerable differences in the extent of change between sites and whether the change was

statistically significant. This is likely due to measurement issues and sample sizes. At this stage, the cumulative data across sites was analysed as population change within the domains of the ONS-4. Samples vary per ONS-4 domain, but the maximum sample size was Pre: 543 people and Post: 473 people. Part of the reason for small amounts of data was that some sites were in the earlier stages of delivery and many users were still attending activities. Of the ONS-4 data received, amongst the sample there was an increase in the proportions of people with higher levels of wellbeing and lower levels of anxiety:

- The proportion of people having a very high or high life satisfaction increased from 17.4% (n=38/219) to 78% (n=128/164) after people accessed nature-based activities.
- The proportion of people having a very high or high level of feeling life is worthwhile increased from 20.6% (n=45/218) to 64.7% (n=106/164) after people accessed nature-based activities.
- The proportion of people having a very high or level levels of happiness increased from 38.7% (n=210/543) to 84.2% (n=398/473).
- The proportion of people experiencing high levels of anxiety reduced from 33.6% (n=179/532) to 9.5% (n=44/463) after people accessed nature-based activities.

The data provided was from a range of activities of various lengths, accessed by people with different demographics. This heterogeneity means that the mental wellbeing data cannot be used to definitively say whether GSP works but indicates that service users do appear to have improved mental wellbeing from accessing GSP. In addition, support received will differ for each person in a similar way to when a patient consults a GP - the nature of support provided will vary considerably. However, GSP does build upon the wider evidence base on the effectiveness of specific nature- based interventions.

Nature-connectedness

The evidence was mixed on whether people's nature connectedness improved following attendance at nature-based activities. Of the two sites to provide this data, one site reported an improvement (T&L2) however the other (T&L6) showed a statistically significant deterioration. This needs further exploration.

12

Theme 10: Developing sustainable GSP systems and delivery

The final theme focuses on the sustainability of the T&L project and of GSP more generally. First, the focus on sustainability is briefly noted, before focusing on how funding and resources associated with the T&L project is being used to prepare for the future. Next, we examine how the T&L sites, as well as the National Partners, are working to embed GSP across many different policies and strategies as a means to ensure the longer-term legacy of the T&L project. The development of the structure and nature of GSP within the T&L localities is discussed next. Finally, the relevance of data and evidence, as well as building capacity to ensure longer term sustainability is focused on.

Key Findings from Theme 10: Developing sustainable GSP systems and delivery

- Sustainability was a core component of the T&L pilots from initial design of the strategy, through to efforts to identify emerging opportunities to embed ways of working as the systems developed.
- There is a common aim to try to break the ‘cycles of innovation’ that have dogged previous efforts to address intractable ‘wicked’ issues.
- The apparent maturity of the GSP and wider SP systems, and progress in ensuring sustainability, is mixed across (and within) the T&L sites.
- Several sites have secured additional funding to contribute to the sustainability of progress made in developing the green social prescribing system. In some cases, this is significant (e.g., close to £400,000).
- Embedding GSP within wider, but related policies and strategies, as well as within relevant structures is a key approach to longer term sustainability taken by all sites and the National Partners. There is variability in how well this has been achieved to date, however this is a component of many of the T&L sites’ end stage use of the funds and may develop further.
- There are concerns about post T&L project sustainability as some key factors such as nature-based activity delivery funding are to some degree outside of the control of those involved in the local pilots.
- There are also concerns that progress made will be lost as attention shifts to other programmes, or due to system pressures such as the cost-of-living crisis.

12.1. A focus on sustainability

All sites have sustainability as a core ambition and, as such, have designed their programmes to work towards a coherent and maintained maturity of the system that has been nurtured. Those pathways to sustainability differ depending on the context, resources available, and priorities and motivations of stakeholders. Despite this variability there is a common aim to try to break the 'cycles of innovation' that have dogged previous efforts to address intractable 'wicked' issues:

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

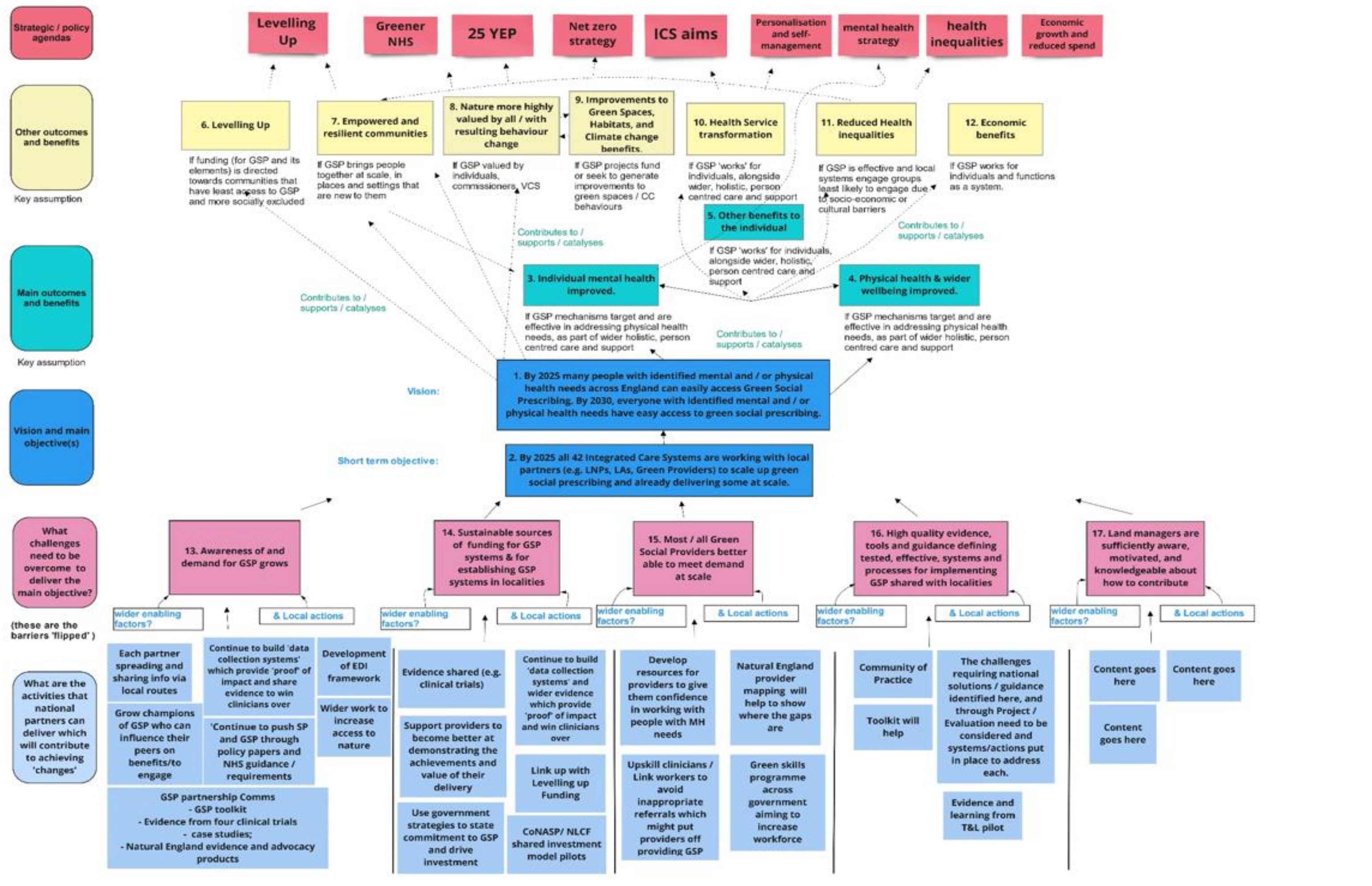
There was a perception that an awareness of, and a system wide confidence in, the sustainability of GSP would contribute to its very sustainability. However, sustainability is also about ensuring that the services are needed and fit with wider systems as discussed elsewhere (e.g., section 8.3).

The findings of this first wave of interviews with the National Partners (WP5) also concerned the central goal of embedding and sustaining GSP. Shared understanding of the wider system/s was thought to be core to achieving this. Four areas of shared understanding appeared to be particularly important in this regard:

1. Agreeing what the project needs to achieve, and the order of priority. This includes navigating the tension between whether the project focus should be outcomes and impact on issues such as mental health or generating learning about how GSP can be embedded in different contexts. This tension was then mirrored in National Partner's differing priorities for this evaluation.
2. Developing a shared understanding about how the work being undertaken – for example the Test and Learn sites, their Evaluation, and the National Research programme – is expected to contribute to the agreed project goals, and over what timescales.
3. Identifying what the main local and national barriers to embedding GSP and making it sustainable are, and the ways in which these can be overcome at different spatial levels and in different contexts.
4. Agreeing and prioritising the key policy tools and objectives through which the goal of embedding and sustaining GSP can be achieved in the future.

Figure 3 illustrates a provisional Theory of Change relating to the future strategy of the National Partners for the national scale up of GSP following the completion of the GSP Project in 2023. This was developed over a series of workshops with National Partners.

Figure 3: Draft National Theory of Change



12.2. Funding and resources for sustainability

Many sites have concrete and well-developed plans for post T&L project phase sustainability. Just one (T&L3) appears to have less well-developed plans, despite their T&L steering group having sustainability of the GSP pilot and future funding as a permanent agenda item, and at present no concrete proposals for future funding are under consideration.

Several sites have secured ongoing funding. In one site this includes money from four Local Authorities, to support a coordinator post beyond the 2023 end of the T&L pilot project funding. This has been a plan since early in the project and is seen as a significant success for sustainability and legacy planning. This site has also made plans for a local environmental network, who have been partners on the T&L site project to take over locality-wide network meetings from September 2022. At another site additional funds from the ICS have been allocated to support some of the existing grant holders to extend their delivery. The funding would be framed as a short- term extension to offer providers more time to think about and implement their long-term sustainability plans. Plans for how this will be allocated and how applications will be scored are currently being developed, but it is likely that projects will be judged on: whether there is there scope to strengthen social prescribing and mental health pathways; better engagement with target cohorts; or to increase their green or blue connection. The scope and focus of project extensions are also likely to be codesigned with place leads, the Project Manager and the project team.

In the T&L site which has primarily focused on systems change - using funds for the development of networks and pathways - the long term, beyond the life of the T&L funding, has been the core focus. As such this site, despite facing challenges in prioritising and agreeing how to make this happen and in achieving key components of its ambition, has been able to build new partnerships and provider collaboratives that are hoped to outlive the current GSP project. The ambition is that these collaboratives will attract NHS investment in an alliance.

Sites have used a variety of approaches to address longer term sustainability. These include: workshops held regularly with the leadership teams to reflect on progress and identify actions needed to ensure the longevity of what is achieved; proactive identification and addressing of anticipated challenges to the GSP system through focused task forces; exploration and application of complementary and additional funding streams; training and support for wider partners on how to ensure sustainability in their respective processes and components of the system; exploring technological options e.g., to support payments to a subsidised nature on prescription partnership with current providers.

The ambition for most T&L sites is that the systems they have created are self-sustaining:

> *Ultimately what we're looking to see in at the end of the 2 years is a self-sustaining system that doesn't need pump priming, that doesn't need that kind of additional funding that it's had already, the £500 grand it doesn't need topping up again. It might need a bit of assistance or support but ultimately you know particularly the green grants can help, communities you know, maximum 10k for a community project you know to kind of get some essential stuff but it's not gonna be of a magnitude of £500k for you know or £100k for an individual project. It's just erm, I think that the main concern there and it's that we do end up with something that is self-sustaining at the end of the 2 years. [T&L5]*

The quote came from a member of the Local Authority, but other stakeholders, including Project Managers, share these concerns about the sustainability of GSP,

access to funds and resources, and the need for evidence to show commissioners if and how it is saving money in other parts of the system. Most had concerns that despite the significant (and often successful) efforts to modify or build systems that enabled GSP pathways, the absence of certainty about sources of and access to funding – for both core administrative functions, as well as to deliver activities - may jeopardise the progress made. Similar attitudes were expressed by other stakeholders, such as the nature-based providers, who raised the precarity and uncertainty of funding availability as a fundamental challenge.

The availability of and access to long term funding (and other forms of system support) whatever its origins, is a key priority that was considered to be outside the agency of most Project Managers and T&L partnerships:

> *We want that commitment financially for five years to progress this with a view of, early on in the fifth year we review it to another five years progress, the service for another five years, and I think that is what needs to be done. Someone needs to like take the bull by the horns and say right I believe this will work, here's my commitment, but it has got to be from the people above. It's sorry fart arsing around with little bit of funding here, a little bit of funding there you know the growing cycle like a say is a year for a bit of wasteland, it could be a year before it's ready but how do you get those people in as part of their recovery and own that project and be proud of what they are doing and to be able to shout about it. [T&L4]*

Although a key element of the sustainability strategies of most sites, applications to key mechanisms, such as funding via the ICNs, had not been confirmed for some. It was noted that '*expectations to do more of social prescribing'* had increased '*but not necessarily the levers or the financial backing to support it*' (T&L5). The perceived lack of support from the NHS, in particular, was considered to be 'disappointing', with negative perceptions of the previous and likely future allocation of funding. One site is attempting to address such issues by developing an 'alliance model' which will address NHS commissioning small/micro VCSE sector organisations.

Within the sites, there appears to be real concern that without the corresponding commitment to enable sustained funding streams, the gains made through the T&L project will go the way of previous short-term funded projects and time-limited initiatives, where knowledge and connections are lost within months of the project end. There were also concerns raised about the suitability of data being collected to a) understand the progress made, b) what is working, where and for whom, and c) to make strong arguments to potential funders. On the latter point, it was thought that commissioners will want to see whether GSP is saving money in the health and social care system. An interviewee at one site (T&L3) reflected that they are concerned that the difficulties in collecting robust data about referrals and, especially, regarding longer term clinical outcomes could affect commissioners' long term decision making on funding allocations, threatening the sustainability of all that has been achieved. However, for some it was felt that is not necessarily the ambition of GSP, further, in many sites, the data that is being collected is not thought to be appropriate to make this argument robustly. In one T&L area this is explicitly recognised, and steps are being taken to talk to commissioners about exactly what data is needed to make the case for further funding.

More generally there are serious concerns that external pressures, including the cost-of-living crisis will undermine the progress made. One site suggested that although there is a lot of interest and goodwill towards green social prescribing, the cost-of-living crisis is taking up more and more attention from everyone in the system:

It may be that resources we could have secured end up going to address this issue. We are trying to support GSP as part of the solution as a cost-effective way to help people cope at a time of challenge. [T&L7]

The non-T&L sites (WP4) reflect similar concerns regarding access to funding and resources. Many non-T&L participants expressed the need for more sustainable large-scale funding (e.g., from statutory services who will benefit from GSP) to fund GSP providers. There was a perception that there is funding for Link Workers but none for the providers delivering activities in the local community. There appears to be an expectation that the 'third sector will pick up the slack'.

These participants felt that the sector needed to be assertive in communicating their need for more resource. In particular, development funding to support applications for funding for nature-based providers would be helpful, and that it could help to ensure that the design phase (which is fundamental to the project outcomes) is as effective as possible and facilitates collaboration. For this group there was a strong feeling that there is a need to ensure the financial model is sustainable, there was hope that a systems approach to improve health and wellbeing will be adopted. There are ambitions to tap into future funding streams that may be coming online, such as Environmental Land Management Scheme (ELMS) and Public Health payments.

Findings from the work with National Partners (WP5) suggests that although there is recognition of the significance of funding and resource allocation for sustainability of the GSP, and in regards the legacy of the T&L project itself:

In order to embed SP as a viable option we need to work with the supply end of the equation – we need to be sure that the green sector is competent and confident to deliver mental health solutions across the continuum of mental health needs. What lies behind that is an understanding about continuity of funding wherever that might come from because in order to make those service improvements and extend their models they need to have that certainty of investment to be able to invest in their businesses. (WP5 NP)

There is still a lack of clarity and agreement about how the GSP system should be supported. One participant stated:

…there are differences of opinion in terms of who pays for GSP – that was raised at one of the advisory boards – an assumption that NHS has money. But in fact the NHS wouldn't see itself paying for this…other than through joint funding around the specialist end'.

However, another argued:

[The SRO] very clearly, and very strongly, made the case for funding, essentially health funding, because she said explicitly it's the NHS that has the money and the health sector that has the money in this scenario, she very clearly made the case for money to flow to the, often small, environmental organisations who are providing services, and providing activities for people to be prescribed to, and from a system point of view…that is absolutely crucial. (WP5 NP)

12.3. Policy and strategy for GSP sustainability

Embedding GSP within related policies and strategies, as well as within relevant structures, is a key approach to longer term sustainability taken by all sites. For instance, in T&L5 the Project Manager is in regular discussions with the ICS to ensure GSP is embedded within wider system priorities (integration with local ICNs is key to most T&L site sustainability strategies.). At this site SP is written into the ICS Green

Plan and the ICS Population Health Strategy with the ambition for continued policy commitment to GSP. There are also discussions about aligning GSP within external policies such as the [regions] council's wide 5-year environmental plan and the health promotion plan. The integration with wider policies was reflected on at another site:

> *we've got links into the various sort of strategies that dictate how health and social care operates in [T&L locality]. Both within sort of [T&L locality], [T&L locality] County Council, [T&L locality MH trust], some of the various sort of green sector partnerships and boards that sit. We have access into those, we are your sort of… we are telling them what's going on with our program. They're familiar with green social prescribing, but it's such early days at the moment that we haven't yet been able to sort of impact on the actual strategy that they're writing. And a lot of them, I don't know if it's… I… I don't know why, it may just be coincidental, but a lot of them are currently writing a strategy for the future of whatever their… their organisation or their… their partnership is. And so, we're trying to make sure that whilst that's being written, we're feeding into them about the results of our program to make sure that the green… green social prescribing gets mentioned in it. So, I think that will change at a system level. [T&L6]*

There remains some lack of clarity about policy that corresponds to the 'whole system' in some sites, with differing options (and opinions) about where GSP should 'sit'. For one site community health partners distinguish strategic levels from front-line priorities, seemingly underplaying the strategic nature of safeguarding a thriving and appropriate provider network:

> *Shouldn't a main output by the end of the project be a report around what are the strategic issues and the possible solutions to those issues to create a viable long-term Social Prescribing system across [region]? This report needs to be at a strategic system level rather than a front-line activity level; e.g., infrastructure, communication, finance, technology, resources, policies, processes, etc. [T&L4]*

At a national level, the interviews conducted as part of WP5 suggested that there are also ambitions to integrate GSP into relevant plans and policies such as the forthcoming Mental Health strategy. The interim report is seen by several national partners as a key stepping off point in future policy development, with a possible extension (business case being submitted to HM Treasury on 4th November, which the evaluation leads are contributing to, to help shape the evaluation aspect), which is seen as a key period in the development of policies and associated 'toolkit'.

The interviews with National Partners through WP5 indicated that the scaling up or out of GSP is dependent, to some degree, on the development of Integrated Care Systems. However, at the time of the interviews there appeared to be limited acknowledgement that timescales for this will far exceed the timelines for the current scale of the T&L project. Beyond this the National Partners discussed a number of strategies to the ongoing development of GSP:

- Demonstrate value, communicate that value and secure buy in from potential external partners.
- Advocate for long term sustainable funding, specifically to cover costs of local providers.
- Understand what each partner's levers are (stakeholders, language, expertise) and identify who is best to engage at which levels.
- Broaden the cross-department approach to consider more strategic shared goals and how partnership can deliver on those e.g., health of the nation, tackling biodiversity loss, tackling climate change etc.

12.4. Developing a sustainable system

The maturity of the GSP and wider SP systems, and progress in ensuring sustainability is mixed across (and within) the T&L sites. In some T&L pilots there appears to be evidence of system integration (see Theme 1 and 2), some examples of well-developed GSP pathways (see Theme 3, 5 and 6). Most have made significant efforts to increase capacity and develop the tools which can help ensure future investment in GSP, such as in relation to data collection and skills development. However, in some cases progress is fragile, with reliance on one-to-one relationships between individuals rather than collaboration being embedded in the system. Therefore, when people change roles or move on, progress can stall or be lost. In one site, the T&L leadership are actively working to embed GSP within the ICS and related systems. The key challenge in this context has been to provide a workable infrastructure for a process that all parties agree should happen (referral of patients via Link Workers or connectors into appropriate green activities). This requires a solution to the problem of fragmented employment (such as the short-term nature of Link Worker contracts) and pressure of work within the health system and in particular for Link Workers, or an effective and consistent workaround.

The short-term nature of the T&L project appears to be a concern for many T&L sites leadership teams. As noted previously many felt that achieving systems change is a long-term activity and there is concern about whether they will have progressed far enough to ensure sustainability:

> *there is now only 9 months of the programme left and there is a feeling that things are just getting going and we risk a significant reduction in resource before work is fully embedded. We do have a local approach to sustainability and this mitigates part of that risk but there is still a fear that current progress will be lost once the GSP team ceases in April 2023. [T&L7].*

There were concerns that key milestones, such as evidence of *'system level buy in'* that had translated into longer term funding commitments (T&L5), had not yet been achieved.

At the national level (WP5) some felt that the project needs to prove GSP 'works' first before decisions about roll out can be made. Currently the priority is taking action to raise the profile of the T&L project and its ambitions and to sustain momentum, while making plans for how to implement roll out. There is some discussion as to the approach to raising the profile of GSP, and in particular the way in which it is 'branded':

> *calling it GSP is not helpful. It's not an easy comms thing. You almost have to understand 'social prescribing' and then try to understand 'green' social prescribing. It takes a bit of explaining around what it means – compared to just saying 'nature-based interventions to support your mental health. [WP5]*

There are also concerns that there is still work to be done on the 'acceptability of' a GSP offer for both primary referrers such as GPs and Link Workers, as well as reception of a referral by the public: '*you've got the person that walks into the doctors surgery and says, you know, here's my condition, the doctor says, what you need to do is go and spend some time in the natural environment and the person thinks they are being fobbed off.*'

12.5. Evidence and intelligence to support a sustainable GSP system

Evidence is being used to plan for beyond the T&L project in different ways between the sites. In one T&L site there is emerging evidence and insight about how the system is not working which is being shared with stakeholders and is beginning to add to a

weight of evidence for the need to work differently and at a place-level and not in organisational silos (T&L4). Efforts to align the data collected and the platforms used is another key strategy common to several sites.

In another site case studies and evidence in various forms (personal stories and quantitative data) are being gathered to support the case for continuity:

> *I'm trying to get pieces of information. So whether it be the data, whether it be some of those key case studies, and then feed it back to what I would say are the most – perhaps most influential in each of the place-based partnerships. [T&L5]*

At the national level (WP5) evidence and data, including the project evaluation is important to reflexively and iteratively modify the project to ensure longer term sustainability:

> *…there is the need for the project to be thinking all the time, about how it uses that learning to effect that change… I think this was actually picked up from right at the top of government when the Secretary of State launched this project, he was really clear in saying, I want to see learning coming from this project, all the time, I do not want to receive a report, an evaluation report at the end of the project, telling me what the project has or hasn't achieved. I want it to be growing and amplifying and replicating itself through the life of the project. And I think we must not get distracted by the day-to-day operational challenges that are constantly in the project and forget to do this really, really important function. [WP5]*

A number of evidence related actions were identified by the National Partners including: further supporting Communities of Practice; developing GSP Toolkits; and dissemination of evidence and learning from the T&L pilot and evaluation; developing resources for providers to give them confidence in working with people with mental health needs.

12.6. Training and capacity development for sustainability

Training, resource hubs and capacity development are common strategies for sustainability and legacy across most T&L sites, as well as for those who were spoken to as part of the wider evaluation. This includes creation of training plans, delivery of bespoke local co-produced training, and use of third-party training and CPD. Training that is planned relates to a range of different skills and capacities and includes training on partnership working and on evaluation. T&L6 has extensive and well developed CPD plans in development. The site will build on the support it has already given to allow 112 professionals to take up relevant CPD by securing match funding with the locality mental health trust, and through corporate sponsorship via the locality's social value marketplace to extend the offer.

GSP specific training, targeting different stakeholders including providers as well as referrers, such as good practice in design and delivery of activities, and on the wider nature-health evidence base is also being developed or provided. A key area of deficit in skills relates to routine work with people with more severe mental health need. One area identified a need to provide resources to those delivering nature-based activities to improve the accessibility, diversity, and inclusion. This site is also considering scoping a quality standard and the associated training that may be required to support this.

Demonstrating the 'quality' of the nature-based provision is a key concern for many sites and is being built into sustainability plans. This is driven by a perception that greater trust in the activities - that they are safe and will achieve what they intend to achieve without unnecessary risks to those participating – that are available to

referrers, particularly those in the mental health system, will help address some of the identified challenges to the GSP pathways such as low referrals:

> *there are tensions in those local organisations and sort of charities who have been chasing money for years, year on year, who… who see the arrival of, you know, green social prescribing money and sort of chase after these short grants. But they know that it's not enough to embed sustainable long-term projects… I think there's tensions around quality, around not so much accreditation but, you know, what do we mean by a good enough provision? [T&L7]*

At the National level the need to enhance the skills and capacity for high quality delivery were identified as important next steps. Potential actions to achieve this include: upskilling clinicians and Link Workers to avoid inappropriate referral and the development of a green skills programme across government aiming to increase the workforce. T&L2 invested in training for Link Workers and the wider workforce to upskill and raise confidence to refer and raise awareness of GSP activities. Although training was well received, engagement and referrals from Link Workers were still lower than anticipated due to pressures within the wider system and issues relating to Link Worker capacity. This shows that increased investment in training and capacity building does not remove barriers within the system.

Conclusions and implications

13

13.1. Conclusions

This interim report presents synthesised findings from across the evaluation work packages to explore our current understandings of:

- The different systems, actors and processes in each T&L site and how these impact on access to, and potential mental health benefit from, GSP.
- The system enablers and barriers to improving access to GSP, particularly for under-served communities.
- How GSP is targeted at particular groups, including underserved communities.

Aligning local and national GSP priorities: For complex projects such as GSP, with competing national and local policy priorities, clearer alignment and shared understanding of local and national priorities from the outset is likely to give projects the best chance of success. There are three components to this: alignment within local areas; alignment between local areas and the national partnership; alignment within the national partnership. Arguably, and perhaps not unusually for large scale cross sectoral system change projects, it has taken the project 12 months to recognise and attempt to resolve this, but tensions still exist. There remain some uncertainties, locally and nationally about, for example, where the boundaries of GSP lie (such as whether self-referral to nature-based activities is considered part of the GSP system) or whether the project focus should be about the impact on individuals, or the impact on systems. These are clearly interlinked, with individual impact at scale dependent on the systems to enable this, and examples of impact potentially reinforcing the systems change required to achieve this. However, such uncertainties may impede progress locally. It was argued that national partners may need to cede more power to local areas to ensure they have sufficient autonomy in the delivery of their project to respond to local needs and contexts.

Importance of Shared Outcomes funding: Undertaking projects which aim to affect systems change is challenging, and takes time. National Shared Outcomes Fund investment however, has had a powerful and catalytic effect. We have shown that it facilitates getting stakeholders around the table, and allows this to occur more quickly than it would otherwise. It has also enabled leverage of other local and national resources. Many of the challenges encountered by the projects are also present in other, non-Test and Learn areas, but the resource provided by the GSP project has enabled the Test and Learn sites to explore how these can be overcome, which is generally not happening in other areas.

Embedding a system-level understanding of GSP: For the project to successfully enable GSP to scale and become sustainable, there is a need to have a systems level understanding and prioritisation of GSP: what is it, what are the benefits, how well integrated is it within the wider health system and what resources are needed to enable it to be sustainable? Arguably this is underway but takes time (more time than the currently available in a two-year GSP project). Securing buy-in has been crucial but this is difficult with potential partners who were less centrally involved in the inception of the project, or those who become distant from the project over time and as the amount of key actors grows. We found that spending time engaging with key actors in different parts of the system (geographically and disciplinarily) about GSP is key.

Challenges facing the VCSE sector: The VCSE are critical partners in social prescribing. There is general agreement that funding for these partners - often small scale and short term - is a core issue, and one that is key to the sustainability and roll-out of GSP at scale. However, there appears to be no consensus about solutions. While scarcity of resources within and beyond the health system is the biggest issue, a shift in thinking towards prevention, investment and long-term solutions may help. Commissioning GSP providers by the local NHS is a potential (contributory) solution that is being explored by some sites. New statutory guidance from the NHS about how ICS should proactively engage with VCSEs represents an important step-forward in this regard, but it is recognised that even if this does increase commissioning of VCSEs, additional resources will need to be drawn in from elsewhere to enhance the involvement of nature-based providers (for example from philanthropic funders or social investment).

It is also important to acknowledge that there is a major power imbalance between the statutory sector system and VCSE nature-based activity providers. The latter have the least power, and yet the onus seems to be on them to be most flexible, and to find solutions to resource issues (and to the data challenges described below). Co-created solutions in which there is flexibility on both sides may ultimately be more effective and will help ensure that small local providers are not crowded out of GSP by larger national ones.

Tailoring referrals more effectively: Although current understanding of the type and extent of nature-based provision, and of referral pathways through the GSP pilots is still evolving (in terms of routes to referral, who participates in specific activities etc.), there is some suggestion that tailoring and targeting support is very important, alongside a mixed ecosystem of nature-based providers. For example, smaller community organisations may be better equipped to deliver universal activities suitable for those with less complex needs, or preventative interventions, provided they are not overwhelmed by referrals. For more complex cases or more severe needs, larger organisations or those with specialist skills may be better able to provide the expertise required to support these people appropriately (safeguarding, trauma informed practice etc.). This has implications for future 'scale up' or 'scale out' strategies.

Improving referral pathways: Referral pathways are key but have been recognised to be challenging. Sites recognise they need to be underpinned by mutual understanding and strong relationships between Link Workers and other social prescribers, and nature-based providers. Key enabling factors include:

- Awareness amongst Link Workers and other referrers of the benefits of nature-based provision.
- Understanding amongst Link Workers and other referrers of the range availability of nature-based provision in their area.
- Nature-based providers are aware of and connected to Link Works and other referrers.

- Community-referral and self-referral are accepted and promoted as a mechanism for accessing nature-based provision.

Where these conditions are in place the GSP system seems to be working best; where they are missing, referral numbers can be very low. The Test and Learn sites are trying to build the connections necessary to address this, but the scale of the challenge means this will take time, and many factors can disrupt the process.

Pressures affecting the social prescribing model: There are signs that current social prescribing models in general are under strain - particularly in terms of the scale of demand for Link Workers, and the severity of need among those they are seeing. This is likely to become even more acute through the cost of living crisis. GSP is nested within this wider social prescribing system, and relies on a functioning social prescribing model if it is to work. This is a critical issue for social prescribing. Policy, nationally and locally, should consider how to achieve the appropriate caseload balance between a) the quantity of throughput (as Link Workers have less time, their approach may become more transactional) and b) supporting fewer people sufficiently to achieve outcomes (with more time available, Link Workers can take a more relational approach, as indeed was originally developed and intended in many parts of the country). Alternative approaches to accessing beneficial nature-based activities, including self-referral and alternative routes to providers, should also be explored and promoted where appropriate.

13.2. Quantitative data challenges

A major tension within the GSP project is around quantitative monitoring data. We are starting to better understand the myriad of issues that affect the availability, quantity and quality of data available. These include:

- Capacity of Link Workers and nature-based provides to collect data from participants. Individual-level follow-up data about outcomes and referral destinations is a particular challenge.
- Capability with the whole system - from commissioners through to Link Workers and providers - to record, collate, link and analyse data in a systematic way across referral pathways.
- Philosophical concerns amongst some nature-based providers who are not convinced that this should be a priority for them, as it detracts from their distinctive offer and has implications for what they can achieve through GSP.

It should be noted that there are also data challenges within parts of the health system that are more used to these types of requirements (such as primary care). These findings reflect similar lessons from multiple projects within and beyond health. In order to maximise data collection there should be efforts to co-identify the data that needs to be collected across the system with the end goal of aiming to measure a few things and measure them consistently; improve and align systems of data collection, collation and analysis – including ensuring findings are fed down as well as up.

13.3. Targeting under-served populations

As outlined above, at this stage we are aware that the quantitative data is not fully representative of the population of people referred to nature-based provision through GSP. As the project progresses, and the quality and quantity of monitoring data improves, we hope to be able to draw some firmer conclusions about the extent to which the GSP project has reached under-served populations. From the monitoring data we currently have, however, it appears that the Test and Learn sites have been

able to reach populations that are currently under-served by social prescribing. Link Workers in the GSP project are generally seeing more older, white women from less socio-economically deprived neighbourhoods. Currently, more people arrive at nature-based activities through self-referral, than through Link Workers and, by contrast, nature-based providers are seeing similar proportions of men and women, and people from across the age spectrum. In some areas a greater proportion of people from ethnic minority backgrounds than the national population average are also participating (though it is not yet clear if this reflects local population distributions), this may be due to successfully targeting activities. More than half lived in the most economically deprived neighbourhoods, again reflecting effective targeted funding. Sites have used a number of strategies to achieve this, including co-production, co-design and collaboration activities with local communities and VCSE groups, addressing practical barriers to participation, funding specific projects to plug identified gaps in provision, and targeting activities and materials to needs of specific groups or within specific localities. Sites recognised that while such work could be challenging and time consuming it is valuable and necessary. The need to engage with underserved populations and reduce inequalities is a key aim of the overall programme and a policy priority and concern of the NHS and other partner organisations. The difficulties identified through the project in engaging with underserved communities is not new and is not specific to the GSP programme but across the system as a whole.

13.4. Implications

- Implication 1: There is a need for clarity of, and agreement on programme aims and objectives, and for means of achieving them.
- Implication 2: There is a need to support and enable local flexibility.
- Implication 3: There is a need to address investment mechanisms for nature-based providers.
- Implication 4: There is a need to address Link Worker capacity and workload.
- Implication 5: Recognising the plurality of the pathways to accessing nature-based activities is key.
- Implication 6: GSP should build on and extend efforts to target under-served communities, and expanding specialist provisions to support people with more severe needs.
- Implication 7: The importance of ongoing investment in system-level work to embedded progress made and extend learning beyond the GSP project needs to be recognise.

Implication 1: There is a need for clarity of, and agreement on programme aims and objectives, and for means of achieving them

Context

- The GSP T&L programme is a complex and large programme with hundreds of different stakeholders each with differing needs and expectations. We found that views of the nature and goals of the GSP system vary and, in some cases, differ between partners. This is not surprising or a failure.
- Green Social Prescribing project funding, strategy and leadership, and funded project manager posts in T&L sites, have been catalytic for scaling up and embedding GSP in the pilot sites.
- There remain some uncertainties, locally and nationally about, for example, where the boundaries of GSP lie (such as whether self-referral to nature-based activities

is considered part of the GSP system) or whether the project should focus on the impact on individuals, or the impact on systems. These are clearly interlinked, however, such uncertainties may impede progress locally.

- We found that there is a lack of a robust and deep understanding, amongst a range of stakeholders both locally and nationally, of what is needed to significantly shift the balance of control and structures (practices, processes, roles and resources) in order to build and embed new systems.
- Power imbalances between statutory and VCSE sectors were evident, with the latter not always feeling valued as equal partners or feeling able to influence project direction. The VCSE sector may be expected to be flexible in responding to need, where statutory partners may have less agility and flexibility. The onus currently seems to be on the VCSE sector to be most flexible, and to find solutions to resource issues.

Why this is important

- For complex projects such as GSP, with competing national and local policy priorities, clearer alignment and shared understanding of local and national priorities from the outset is likely to give projects the best chance of success.
- When trying to bring about systems change, the groundwork of bringing people together to develop, and organise around, a shared sense of purpose is critical to success and in itself forms a key part of the process of 'delivering' GSP. National funding has supported this in T&L sites. Building relationships across diverse partners and systems can be time consuming but is essential to develop trust and support agency across the system.
- The commitment, motivations and capacities of different actors will affect whether or not the aims and objectives can, or will be achieved. Appropriate approaches to achieving the aims and objectives of the programme can only come about when the commitment, motivations and capacities are understood and acted upon.
- Co-created solutions in which there is flexibility on both sides may ultimately be more effective and will help ensure that small local providers are not crowded out of GSP by larger national ones.

What needs to be done

- Commitment to and time/capacity for co-creation is important- working with complex systems requires recognition that knowledge about current working, and solutions to possible problems, may be localised across the system and that relationships and networks within and between organisations are key. Time needs to be taken to clarify and find agreement on the aims and objectives of the programme, how they are to be achieved, and to agree on the order of priority. This includes navigating the tension between whether the project focus should be evidence about outcomes and impact on issues such as mental health, and evidence about or generating learning about how GSP can be embedded in different contexts.
- Agreeing and prioritising the key national and local policy tools and objectives through which the goal of embedding and sustaining GSP can be achieved in the future.
- Raising awareness – locally and nationally – of GSP, including what it is, what the benefits are and for whom, and the resource implications, is an ongoing process, but is vital to secure buy-in and win the hearts and minds of key stakeholders.
- The evident power imbalances within the GSP system need to be articulated and, where possible, addressed.

- Efforts need to be made to keep enthusiastic people in the system informed about activity and progress of the T&L programme (though equally this applies to wider GSP system development efforts), and feeling valued to avoid partners feeling disconnected and reducing commitment.

Implication 2: There is a need to support and enable local flexibility

Context

- The purposes of the T&L programme were to clarify what was needed within local contexts to develop and sustain green social prescribing; to understand and address system barriers to scale up and understand actions and behaviours required from different stakeholders to sustainably embed effective green social prescribing delivery models as part of the wider health and care landscape.
- The T&L sites developed locally relevant plans that were responsive to their specific stage of GSP development and co-identified needs.
- The support offered by the national partners to local sites was considered to be critical, with key individuals offering a range of valued support from strategic input to assistance arranging and joining meetings with specific key individuals locally.
- However, the perceived shift in focus by the National Partners to a greater focus on mental ill health was felt to have constrained the strategy of some local Test and Learn sites. There was a perceived lack of fit between projects as conceived and planned in the sites' original bids, and the current ambitions of the GSP Project at a national level.
- Prioritising specific areas through targets relating to narrowly defined outcomes, may limit the sites' ability to take a whole systems approach and their ability to focus on the necessary relationship and trust building.

Why this is important

- For the T&L process to be successful the sites, arguably, need time and space to focus on responding to local needs and contexts. These contexts vary by area and within areas, and could include:
  - Local population needs - links to health, social and economic inequality and exclusion.
  - Maturity/connectedness of an ever-changing SP system.
  - Health system delivery/foci/priorities.
  - Capacity of green providers, and availability and quality of green and blue space.
  - Embeddedness of VCSEs within ICS/ICB.
- Local flexibility is essential to respond to these and there is no one size fits all approach.

What needs to be done

- There is a need to ensure that the top-down national requirements of the partners do not erode the ability of each Test and Learn site's ability to respond to pre-existing strategy and emergent local needs and contexts.
- This requires flexibility in the interpretation and application of the requirements of the Shared Outcomes Fund and an understanding that GSP priorities, and outcomes, will vary by area as a result.

- It was argued that national partners may need to cede more power to local areas to ensure they have sufficient autonomy in the delivery of their T&L project to respond to local needs and contexts, whilst remaining an active participant in those discussions.

Implication 3: There is a need to address investment mechanisms for nature-based providers

Context

- Investment in and funding for the development and delivery of nature-based activities is ad-hoc, short term, unsustainable, and difficult to predict.
- The lack of long-term investment and system level support has impacted on the GSP project, as well as on the wider SP system.
- Seeking and securing investment or funding is a considerable burden on the VCSE sector. The challenge is felt differently by different scales of providers. Smaller scale providers find it challenging to find time and capacity to continually seek funding. Many nature-based providers are small voluntary organisations and the need to frequently apply for funding is time-consuming and takes away resources which could otherwise be used for delivering activities. Larger scale and more specialist providers may need access to more sustained funds that can support infrastructure and specialist staffing.
- Despite these challenges, many providers are skilled at identifying and gaining funding from a range of sources to develop and continue their work and being agile and flexible in the ways they work.
- Despite the lack of systematic investment in the provision of activities due to the priorities of the T&L programme as a whole or local site strategy, VCSE providers are under huge pressure due to the size, complexity and severity of caseloads.
- There was frustration from some that T&L funds were perceived to have been directed upstream and they were not receiving enough funding to be able to deliver services, undermining commitment to the programme.

Why this is important

- The current funding landscape results in short termism, unnecessary competitiveness and has implications for capacity of providers to deliver.
- The availability of and access to long term investment (and other forms of system support) whatever its origins, is a key priority and crucial to scaling up and out of GSP.
- Alleviating the fund seeking burden on small delivery organisations would avoid loss of providers from the system.
- The funding challenges may be affecting the quality of provision, with current models offering few opportunities to undertake meaningful co-development with communities or other stakeholders, or to develop evidence-based practice. Further, the reduced capacity of providers has implications for other processes such as engaging with Link Workers or sufficient monitoring and evaluation activities.
- Unless this is addressed, it poses a major risk to the sustainability of GSP and social prescribing more generally.
- New statutory guidance from the NHS about how ICS should proactively engage with VCSEs represents an important step-forward, but it is recognised that even if this does increase commissioning of VCSEs, additional resources will need to

be drawn in from elsewhere to enhance the involvement of nature-based providers (for example from philanthropic funders or social investment).

- As yet, there appears to be no consensus about solutions to the funding challenge.

What needs to be done

- Review the investment and funding landscape, clarify key mechanisms, identify key actors with agency to address barriers, and act on barriers relevant to different types of providers.
- Clarify what is needed to develop an investment mentality; to reframe providers as a form of social infrastructure to be invested in as a key pillar of the system. Explicitly shift thinking towards prevention, investment and long-term solutions.
- Commissioning GSP providers by the local NHS is a potential (contributory) solution. This is being explored by some sites. Development funding to support applications for funding for nature-based providers would help ensure that the design phase (which is fundamental to the project outcomes) is as effective as possible and facilitates collaboration.

Implication 4: There is a need to address Link Worker capacity and workload

Context

- Link Workers and other community connectors are an important component of social prescribing, however the role is under ever increasing pressure. This is also true for other parts of the health service.
- Link Workers are under pressure because of the numbers of referrals and the severity and complexity of need, and due to personnel gaps. Link Workers told us they are working at capacity.
- We were told that the Link Worker system, and Link Workers themselves are 'undervalued and under resourced'.
- Some Link Workers are receiving referrals for people who are high risk due to ill health, including mental ill health, and have acute needs such as housing, debt advice, refuge from domestic violence etc. We heard from some Link Workers who felt they were being put in dangerous situations.
- We heard that types of immediate needs that people are coming to Link Workers with (e.g., in relation to housing, finances, food etc.) mean that GSP is further down the list of options for those making onward referrals. It takes time and it is important to address basic needs and create stability first, only then may some people be ready for a green social prescription.
- Link Workers told us they have little capacity to proactively learn about the nature-based activities in their area.

Why this is important

- The current levels of pressure are likely to increase as the cost-of-living crisis becomes more acute over the winter.
- Increased pressure on Link Workers to address basic needs and crisis situations may mean that options such as GSP are seen as less relevant to the population being seen.
- The pressure on Link Workers is threatening the underlying philosophy of social prescribing of the relational approach which provides time for people to co-identify the most appropriate solutions for their particular needs.

- The pressures have led to high turnover, and staff loss among Link Workers.
- GSP is nested within the wider social prescribing system, and relies on a functioning social prescribing model if it is to work. Finding solutions to this should be the responsibility of the whole of the social prescribing system locally and nationally, not just health partners.

What needs to be done

- National and local social prescribing policy makers need to consider how to achieve the appropriate balance between a) the quantity of throughput (a more transactional model) and b) supporting fewer people sufficiently to achieve outcomes (a more relational model, as indeed was originally developed and intended).
- There may be a need to increase the capacity of Link Workers within the wider SP system, through for example, increasing the workforce, improving triage at initial referral.
- Recognise the plurality of the referral/access pathways (community connectors, VCSE routes, self-referral) and facilitate these other routes to nature-based activities (see below).

Implication 5: Recognising the plurality of the pathways to accessing nature-based activities is key

Context

- We found that there are different operational definitions of the GSP 'referral system'. For some it relates to a narrow clinical pathway, for others it is a broad spectrum of different routes, including access via self-referral.
- Although it is uncertain due to data challenges (and data was collected at the beginning of the T&L programme so the situation may have changed), a relatively low proportion of Link Worker referrals are to nature-based activities.
- Again, although it is uncertain due to data challenges (and data was collected at the beginning of the T&L programme so the situation may have changed), nature-based providers reported to us that the majority of people are accessing their services via routes other than via Link Workers.
- Although the conditions that can facilitate effective Link Worker referral systems are generally understood and the Test and Learn sites are trying to build the connections necessary to address this, but the scale of the challenge means this will take time, and many factors can disrupt the process.

Why this is important

- Clarity is needed for strategy to develop effective and appropriate systems. Narrow conceptions of the referral pathway potentially risk missing opportunities to scale up and out GSP.
- Building on SP routes beyond Link Workers may lead to a wider variety of people accessing GSP – our (limited) monitoring suggests that more people from ethnic minority backgrounds, more disadvantaged neighbourhoods, and a wider range of age groups are accessing green activities than are being seen by Link Workers.
- Certainty and agreement over what constitutes the GSP pathway is important for understanding the outcomes of T&L, for clarifying what monitoring and evaluation data need to be collected and by whom, and for addressing questions about the completeness of data collected.

- The potential of GSP to address inequalities in health is closely linked to the nature of the referral and access pathways.
- Referrals also seem dependent on specific people who have buy-in for the project or links with different organisations. Relying on specific people becomes problematic when key people leave the organisation, contributing to fragility in the system.

What needs to be done

- Build mutual understanding of the plurality of the GSP 'system' and strong relationships between Link Workers and other social prescribers, and nature-based providers. Developing effective partnerships across the sites is integral for ensuring strong referral pathways.
- Community-referral and self-referral are accepted and promoted as a mechanism for accessing nature-based provision.
- Explore the implications of, and ways to achieve a robust self-referral system and community to community connection referrals.
- If self-referral is recognised as an important pathway there is a need to explore the profile of self-referees and this differs from Link Worker and other referral sources; clarify what motivates/activates people to self-refer; and explore how people find out about the opportunities they access.

Implication 6: GSP should build on and extend efforts to target under-served communities, and expanding specialist provisions to support people with more severe needs

Context

- There are still important questions about how GSP is delivered appropriately, equitably and in such a way that does not inadvertently exacerbate inequalities. However, early indications are that a wider range of people are participating in nature-based activities in the T&L sites (more men, and wider age range, more people from ethnic minority backgrounds and more people from disadvantaged neighbourhoods) than are typically offered social prescribing.
- More people arrive at nature-based activities via self-referral than via Link Workers. This and other community links may be important routes for GSP.
- Many people are accessing the GSP system who have more specialist mental health needs, which may mean in some cases the needs of both participants and providers are not sufficiently met in more general groups
- Many providers feel ill-equipped to deal with the types of mental health difficulties faced by people being referred to them, with some referrals considered high-risk and potentially not appropriate for social prescribing.
- Consistency is needed in how GSP can be used to reduce socio-economic and demographic inequalities in health, as well as incorporating the systems to support GSP for these underserved communities.
- The need to engage with underserved populations and reduce inequalities is a key aim of the overall programme and a policy priority and concern of the NHS and other partner organisations.

Why this is important

- There is a need for greater understanding of how to tailor and target GSP interventions effectively, safely and with suitable protections in place for all parts of the system.
- Existing examples of providers that work successfully with people who have more severe mental health highlight successes in investing in training and support, staffing levels and education.
- It is clear there is not a one size fits all approach, and a targeted and tailored, mixed ecosystem of universal and specialist provision is needed.
- It is too soon to say what types of provision work, for whom and in what circumstances. The final evaluation report ought to provide more insights in this regard, but it is likely that more detailed evidence on this topic will need to be collected beyond the lifetime of the GSP project and its evaluation.

What needs to be done

- Where T&L sites, or other non-GSP programme providers, have been successful in attracting a greater proportion of people from ethnic minority backgrounds than the national population average to participate in GSP activities, there needs to be greater understanding of a) whether this reflects local population distributions, and b) how sites and providers are targeting activities successfully.
- Develop and support an ecosystem of providers. Smaller community organisations may be better equipped to deliver universal activities suitable for those with less complex needs, or preventative interventions, provided they are not overwhelmed by referrals. For more complex cases or more severe needs, larger organisations or those with specialist skills may be better able to provide the expertise required to support these people appropriately (safeguarding, trauma informed practice etc.). This has implications for future 'scale up' or 'scale out' strategies.
- Co-production, co-design and collaboration with local communities and VCSE groups can help to overcome practical barriers to participation.
- Fund specific projects to plug identified gaps in provision and tailor activities and materials to needs of specific groups and/or within specific localities.
- Further work is needed to understand how to overcome connected challenges to participation relating to poverty, digital and physical access, fluctuations in mental health, language, and cultural differences.
- Green buddy systems or peer support may help overcome some barriers to participation for underserved communities.

Implication 7: Consistency of understanding around data requirements and responsibilities across the system

Context

- There are major challenges associated with collecting, accessing, collating and analysing quantitative data across the social prescribing system. These findings reflect similar experiences from multiple projects within and beyond health.
- Collecting robust, accurate data and then making it accessible is one of the key challenges faced by those in the GSP system.

- Some nature-based providers felt they were being asked to collect outcome measurements without being paid to do this type of work, or lacked capacity, or motivation to use what were sometimes seen as inappropriate measures.
- NHSE isleading work to develop a social prescribing minimum data set and data standard. The GSP project has itself provided impetus and focus to try and address some of these challenges.
- Some sites have invested time and resources to support nature-based providers through workshops to understand challenges to data collections, and then designing training to address these, with funds to back fill attendance.

Why this is important

- Good quality, consistent data which allows understanding of who is accessing various parts of the GSP system, who is dropping out, and assessing impact on individuals, is needed to understand who is utilising and benefiting from GSP.
- In order to maximise data collection and understand how GSP is working there should be efforts to co-identify the data that needs to be collected and then requirements should aim to measure a few things and measure them consistently; improve and align systems of data collection, collation and analysis – including ensuring findings are fed down as well as up.

What needs to be done

- Resolving the data challenges of the T&L programme and of the wider GSP system should be a priority and the NHSE-led work to develop a social prescribing minimum data set and data standards are an important development in this regard. However, implementing the change needed will require ICS/ICB prioritisation and investment. Some areas recognise this and are taking the steps necessary, but others have not yet made substantial progress.
- A system wide approach which prioritises, and invests in, data collection is required for both the T&L programme and the wider GSP system.
- Clarity is needed about what data is needed and for what purposes, and this should be communicated clearly to all those who will need to act on the requirements.
- Different types of data are valued by different parts of the system, and co production, capacity building and appropriate resourcing (including to attend any training) may be needed to try and reconcile these differing perspectives and support sufficient data collection.
- Local investment to support capacity building, and flexibility to support smaller providers.
- The onus for data collection should be on the GSP system as a whole, and not the VCSE sector.
- Depending on the needs, data requirements may need to be clarified at the design stage and not left to evolve through the programme.
- Capacity of stakeholders needs to be considered, recognising that smaller providers may need more support and flexibility in this regard.

Implication 8: The importance of ongoing investment in system-level work to embedded progress made and extend learning beyond the GSP project

Context

- Many of the challenges encountered by the project are also present in other, non-Test and Learn areas, but the resource provided by the GSP project has enabled the Test and Learn sites to explore how these can be overcome.
- Undertaking projects which aim to affect systems change is challenging and takes time. In this context the National Shared Outcomes Fund investment has had a powerful and catalytic effect on GSP nationally and within the Test and Learn Sites. It has facilitated getting stakeholders around the table more quickly than would otherwise have been the case. It has also enabled leverage of other local and national resources to support implementation.
- However, the GSP project is being implemented in a relatively short time period (two years) to bring about system change and to understand what works, where and for whom. It seems likely that more time will be needed to ensure that lasting change is achieved.
- Other non T&L areas have not had access to similar levels of investment and have struggled to develop or embed GSP at the same rate as the Test and Learn sites.

Why this is important

- An extension to the national funding would give the national partners and Test and Learn Sites additional time to learn about what is working (and what isn't), raise awareness of the benefits of GSP, and make the changes necessary to embed GSP for the longer term.
- Additional investment would also provide opportunities to increase understanding of how to target underserved and structurally disadvantaged communities and increase the likelihood of achieving lasting system level change.
- Other areas or stakeholders interested in scaling-up and embedding GSP beyond this project should recognise that this will require investment of time and resources in project management, relationship building, system and process mapping, and the capacity and capability of Link Workers and nature-based providers. It is unlikely that such investment will be forthcoming nationally, meaning local level responses drawing on available resources will need to be developed.

What needs to be done

- An extension to the GSP project is key to ensuring the learning and system-level changes achieved so far can be embedded, enhancing the prospects for these to lead to lasting change.
- If an extension to the Shared Outcomes funding is not received, the Test and Learn sites will need to consider alternative approaches and sources of investment to continue their work and embed change.
- Beyond the GSP project, areas interested in scaling-up and embedding GSP should make this a system level priority and secure investment in the resources needed to undertake systems change. Where possible they should draw on the learning from the GSP project and invest in activities that are most needed and most likely to have an impact in their local context.

Table 3: Table of Implications

Implication	Context	Key actions
1. There is a need for clarity of, and agreement on programme aims and objectives, and for means of achieving them	• The GSP T&L programme is a complex and large programme with hundreds of different stakeholders each with differing needs and expectations. We found that views of the nature and goals of the GSP system vary and, in some cases, differ between partners. This is not surprising or a failure. • GSP project funding, strategy and leadership, and funded project manager posts in T&L sites, have been catalytic for scaling up and embedding GSP in the pilot sites. • There is a lack of a robust and deep understanding, amongst a range of stakeholders, of what is needed to significantly shift the balance of control and structures to build and embed new systems. • Power imbalances between statutory and VCSE sectors were evident. The VCSE sector may be expected to be flexible in responding to need, where statutory partners may have less agility and flexibility.	• Commitment to, and time/capacity for co-creation is important- knowledge about current working, and solutions to possible problems, may be localised across the system and relationships and networks within and between organisations are key. Time needs to be taken to clarify and find agreement on the aims and objectives of the programme, how they are to be achieved, and to agree on the order of priority. • Agreeing and prioritising the key national and local policy tools and objectives, early in the process, through which the goal of embedding and sustaining GSP can be achieved in the future. • Raising awareness – locally and nationally – of GSP, including what it is, what the benefits are and for whom, and the resource implications, is an ongoing process, but is vital to secure buy-in and win the hearts and minds of key stakeholders. • The evident power imbalances within the GSP system need to be articulated and, where possible, addressed. • Efforts need to be made to keep enthusiastic people in the system informed about activity and progress, and feeling valued to avoid partners feeling disconnected and reducing commitment.
2. The is a need to support and enable local flexibility	• The purposes of the T&L programme were to clarify what was needed within local contexts to develop and sustain green social prescribing; to address system barriers to scale up and understand actions and behaviours required to sustainably embed effective GSP delivery models as part of the wider landscape.	• There is a need to ensure that the top-down national requirements do not erode the ability of each Test and Learn site's ability to respond to pre-existing strategy and emergent local needs and contexts. • This requires flexibility in the interpretation and application of the requirements of the Shared Outcomes Fund and an

Implication	Context	Key actions
	• The T&L sites developed locally relevant plans that were responsive to their specific needs. • The support offered by the National Partners to local sites was considered to be critical. • However, the perceived shift in focus by the National Partners to a greater focus on mental ill health was felt to have constrained some local strategy. There was a perceived lack of fit between projects as conceived in sites' original bids, and the current ambitions at a national level. • Prioritising specific areas through targets relating to narrowly defined outcomes, may limit sites' ability to take a whole systems approach and to focus on necessary relationship and trust building.	understanding that GSP priorities, and outcomes, will vary by area as a result. • It was argued that national partners may need to cede more power to local areas to ensure they have sufficient autonomy in the delivery of their T&L project to respond to local needs and contexts, whilst remaining an active participant in those discussions.
3. There is a need to address investment mechanisms for nature-based providers	• Investment in and funding for the development and delivery of nature-based activities is ad-hoc, short term, unsustainable, and difficult to predict. • The lack of long-term investment and system level support has impacted on the GSP project, as well as on the wider SP system. • Seeking and securing investment or funding is a considerable burden on the VCSE sector. Smaller scale providers may find it particularly challenging to find time and capacity to continually seek funding. More specialist providers may need access to more sustained funds that can support infrastructure and specialist staffing. • Despite these challenges, many providers are skilled at identifying and gaining funding from a range of sources to develop and continue their work and being agile and flexible in the ways they work. • Despite the lack of systematic investment in the provision of activities due to the priorities of the T&L programme as a	• Review the investment and funding landscape, clarify key mechanisms, identify key actors with agency to address barriers, and act on barriers relevant to different types of providers. • Clarify what is needed to develop an investment mentality; to reframe providers as a form of social infrastructure to be invested in as a key pillar of the system. Explicitly shift thinking towards prevention, investment and long-term solutions. • Commissioning GSP providers by the local NHS is a potential (contributory) solution and is being explored by some sites. Development funding to support application development would help ensure that the design phase (is as effective as possible and facilitates collaboration.

Implication	Context	Key actions
	whole or local site strategy, VCSE providers are under huge pressure due to the size, complexity and severity of caseloads. • There was frustration from some that T&L funds were perceived to have been directed upstream and they were not receiving enough funding to be able to deliver services, undermining commitment to the programme.	
4. There is a need to address Link Worker capacity and workload	• Link Workers and other community connectors are an important component of social prescribing, however the role is under ever increasing pressure. • Pressure comes from: numbers of referrals; severity and complexity of need; personnel gaps. Link Workers are working at capacity. • We were told that Link Workers are 'undervalued and under-resourced'. • Some are receiving referrals for people who are high risk and some felt they were being put in dangerous situations. • People's immediate needs include housing, finances, food etc.). It takes time to address this and create stability first, only then may some people be ready for SP. • Link Workers may have little capacity to proactively learn about the local nature-based activities.	• National and local social prescribing policy makers need to consider how to achieve the appropriate balance between a) the quantity of throughput (a more transactional model) and b) supporting fewer people sufficiently to achieve outcomes (a more relational model, as indeed was originally developed and intended). • There may be a need to increase the capacity of Link Workers within the wider social prescribing system, (e.g., increasing the workforce, improving triage at initial referral). • Recognise the plurality of the referral/access pathways (community connectors, VCSE routes, self-referral) and facilitate these other routes to nature-based activities (see below).
5. Recognising the plurality of the pathways to accessing nature-based activities is key	• There are different operational definitions of the GSP 'referral system'; from narrow clinical pathway, to a broad spectrum of different routes, including access via self-referral. • A relatively low proportion of Link Worker referrals are to nature-based activities (NB uncertain due to data challenges, & data collected at the beginning of programme). and Nature-based providers reported the majority of people are accessing their services via routes other than via Link	• Build mutual understanding of the GSP 'system' and strong relationships between Link Workers and other social prescribers, and nature-based providers. Developing effective partnerships across the sites is integral for ensuring strong referral pathways. • Community-referral and self-referral are accepted and promoted as a mechanism for accessing nature-based provision.

Implication	Context	Key actions
	Workers (NB uncertain due to data challenges, & data collected at the beginning of the programme). • The conditions that can facilitate effective Link Worker referral systems are generally understood and sites are trying to build the connections necessary to address this, but the scale of the challenge means this will take time, and many factors can disrupt the process.	• Explore the implications of, and ways to achieve a robust self-referral system and community to community connection referrals. • If self-referral is recognised as an important pathway there is a need to explore the profile of self-referees and how this may differ from other referral sources; clarify what motivates/activates people to self-refer; and explore how people find out about the opportunities they access.
6. GSP should build on and extend efforts to target under-served communities, and expanding specialist provisions to support people with more severe needs	• There are questions about how GSP is delivered appropriately, equitably and does not inadvertently exacerbate inequalities. However, early indications are that a wider range of people are participating in nature-based activities in the T&L sites than is typical. • More people arrive at nature-based activities via self-referral than via Link Workers. This and other community links may be important routes for GSP. • Many people are accessing the GSP system who have more specialist mental health needs, which may not be sufficiently met in more general groups • Many providers feel ill-equipped to deal with the types of mental health difficulties faced by people being referred to them. • The need to engage with underserved populations and reduce inequalities is a priority.	• There needs to be greater understanding of if and how sites and providers are targeting activities successfully. • Support an ecosystem of providers: smaller community organisations may be better equipped to deliver 'universal' or preventative interventions. For more complex cases or more severe needs, larger organisations or those with specialist skills may be better able to support these people appropriately. This has implications for future 'scale up' or 'scale out' strategies. • Co-production, co-design and collaboration with local communities and VCSE groups can help to overcome practical barriers to participation. This needs to be funded. • Further work is needed to understand how to overcome challenges to participation relating to poverty, digital and physical access, fluctuations in mental health, language, and cultural differences.
7. Consistency of understanding around data requirements and responsibilities	• There are major challenges associated with collecting, accessing, collating and analysing quantitative data across the social prescribing system. These findings reflect similar experiences from multiple projects within and beyond health.	• Resolving the data challenges of the T&L programme and of the wider GSP system should be a priority. • A system wide approach which prioritises, and invests in, data collection is required for both the T&L programme and the wider GSP system.

Implication	Context	Key actions
across the system	• Collecting robust, accurate data and then making it accessible is one of the key challenges faced by those in the GSP system. • Some nature-based providers felt they were being asked to collect outcome measurements without being paid to do this type of work, or lacked capacity, or motivation to use what were sometimes seen as inappropriate measures. • NHSE is-leading work to develop a social prescribing minimum data set and data standard. The GSP project has itself provided impetus and focus to try and address some of these challenges. • Some sites have invested time and resources to support nature-based providers through workshops to understand challenges to data collections, and then designing training to address these, with funds to back fill attendance.	• Clarity is needed about what data is needed and for what purposes, and this should be communicated clearly to all those who will need to act on the requirements. • Different types of data are valued by different parts of the system, and co-production, capacity building and appropriate resourcing (including to attend any training) may be needed to try and reconcile these differing perspectives and support sufficient data collection. • The onus for data collection should be on the GSP system as a whole, and not the VCSE sector.
8. The importance of ongoing investment in system-level work to embedded progress made and extend learning beyond the GSP project needs to be recognised	• Undertaking systems change projects is challenging and takes time. The National Shared Outcomes Fund investment has had a powerful and catalytic effect on GSP nationally and within the Test and Learn Sites. • The resource provided by the GSP project has enabled the T&L sites to explore how these challenges can be overcome. • The GSP project is being implemented in a relatively short time period to bring about system change and to understand what works, where and for whom. • Other areas have not had access to similar levels of investment and have struggled to develop or embed GSP at the same rate as the Test and Learn sites.	• An extension to the GSP project is key to ensuring the learning and system-level changes achieved so far can be embedded, enhancing the prospects for these to lead to lasting change. • If an extension to the Shared Outcomes funding is not received, the Test and Learn sites will need to consider alternative approaches and sources of investment to continue their work and embed change. • Beyond the GSP project, areas interested in scaling-up and embedding GSP should make this a system level priority and secure investment in the resources needed to undertake systems change; draw on the learning from the GSP project; and invest in activities that are most needed and most likely to have an impact in their local context.

13.5. Next steps for the evaluation

WP2 Further collaborative workshops with T&L sites to reflect on and refine the Theories of change. Responsive to evidence needs as required by the Evaluation Team.

WP3A Ongoing support of the Test and Learn Sites to develop their monitoring systems. Further data collection will include: Link Worker and nature-based provider monitoring data (Spring 2023); a further round of questionnaires to Link Workers and nature-based providers (Spring 2023). Additional data cleaning and analyses.

WP3B Continued Embedded Researcher informal reflections will be collected throughout the project. Key meeting observations. Further interviews with users, T&L stakeholders Winter 2022/23. Analysis of case reports from sites. Further analysis, to include explanatory understandings derived from the project.

WP4 Follow up interviews planned for Autumn 2022. Analysis for the final report.

WP5 Follow up interviews/ workshops Winter 2022. Analysis for the final report.

WP6 Follow up meetings with sites and further data collections, analysis for the final report.

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14

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