GreenSPring Project Report and Evaluation

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Derby and Derbyshire's GSP Pilot (Jan 2021-March 2023)

Contents

Abbreviations

ARRS	additional roles reimbursement scheme
AV	Amber Valley
CCG	clinical commissioning group
CIC	community interest company
CMHT	community mental health team
CYP	children and young people
DCC	Derbyshire County Council
DCHS	Derbyshire Community Health Services
DEFRA	Department for Environment, Food & Rural Affairs
DHCFT	Derbyshire Healthcare NHS Foundation Trust
GP	general practitioner
GSP	green social prescribing
HP	High Peak
ICB	integrated care board
ICS	integrated care system
LG	GreenSPring's leadership group
LIO	local infrastructure organisation
MH	mental health
NASP	National Academy for Social Prescribing
NBA	nature-based activity
NED	North East Derbyshire
NFC	National Forest Company
NHSE	National Health Service England
OHID	The Office for Health Improvement and Disparities
OT	occupational therapist

PCN	primary care network
PDNP	Peak District National Park
SD	South Derbyshire
SDDC	South Derbyshire District Council
SHU	Sheffield Hallam University
SPAG	Social Prescribing Advisory Group
SPLW	social prescribing link worker
ToC	theory of change
VCSE	voluntary, community and social enterprise

Acknowledgments

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To the Leadership Group (detailed membership in Figure 1, p.12), GSP Programme Manager Sam Alford, Professor Chris Dayson from Sheffield Hallam University, and the other national partners from NHSE, Natural England, DEFRA, Sport England, NASP and OHID.

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Background and national picture

In 2020, a project aimed at preventing and tackling mental ill health through Green Social Prescribing (GSP) was announced by the then environment secretary, George Eustace. An expression of Interest (EOI), and then a full application, was completed by a group of organisations in Derby and Derbyshire. This two-year, £7 million project was funded and supported by multiple partners, including: Department of Health and Social Care, Department for Environment, Food and Rural Affairs, Natural England, NHS England and NHS Improvement, Public Health England, Ministry of Housing, Communities and Local Government, National Academy for Social Prescribing and Sport England.

The aim of the project was to test how to embed GSP into communities 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.

Each of the seven 'test and learn' sites selected received £500,000 to test the ways in which connecting people with nature can improve mental wellbeing. The objectives of the GSP test and learn sites were to:

- understand and address system barriers to scale up effective GSP across England
- understand actions and behaviours required from different stakeholders to sustainably embed effective GSP 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 GSP and how this could be measured
- implement targeted and co-designed interventions to scale up GSP
- 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

Green Social Prescribing (GSP), as defined by the national evaluation team is: the practice of supporting people to engage in nature-based interventions and activities to improve their mental health. Social Prescribing Link Workers (SPLW) (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 Social Prescribing 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.

Local context and definitions

Nature-Based Activity

Any nature-based activity (NBA), which did not include sporting or physical activity that happens to take place outdoors (i.e., a connection with nature was vital) was considered to be relevant to GSP. Providers taking part in the network sessions and testing came from a range of sectors, mostly from the VCSE, but also included the public sector, sole traders and companies limited by shares.

Benefits to nature

Though it is considered implicit in the work of most providers of NBA, quantifying and measuring the benefits separately were not the focus of this pilot.

Social Prescribing

In this report, and with reference to all related work (with some nuance in the provider collaborative model, described in that section), the term social prescribing means ANY health professional that could make a 'referral', formal or otherwise, into a nature-based activity. This includes, but is not limited to: SPLW, occupational therapists (OTs - usually from Community Mental Health Teams (CMHT)), community psychiatric nurses, community connectors, housing officers, job centre staff, GP surgery staff, and other Voluntary Community and Social Enterprise (VCSE) sector providers. Some of these roles have titles which are duplicated across more than one organisation (this fact highlights the complexity and lack of connectedness across the system, discussed later). Self-referrals were also accepted.

The term social prescriber in the context of the Derbyshire pilot (including Derby City for the purposes of this project) means anyone who can refer into NBA, through a formal or informal referral. It quickly became clear that, in some parts of the system, there was little understanding that there is no formal process for making or receiving referrals, no existing resource to deliver these activities in communities and, therefore, no agreed set of standards, monitoring or regulating of delivery available, or to be expected.

GSP

Whilst this project was specifically focussed on nature-based wellbeing activity, it was acknowledged that much of the work and examples are pertinent to the full breadth of community-based wellbeing activity. The Green Provider Network (see p77) recognised the similarities and challenges facing VCSE members of all sectors, and decided early on that the network would welcome any organisations with a 'green' ethos in terms of sustainability and collaboration.

Referral
Describes the process of an ‘onward referral’ from a person in a support role, e.g. SPLW, into a community-based activity for wellbeing, e.g. a NBA.

The local landscape

Derbyshire’s embedded researcher from Sheffield Hallam University (as part of the national evaluation consortium), Dr Katie Shearn, was assigned to support the local test and learn programme and attended a number of Leadership Group (LG) meetings, as well as holding workshop sessions with that group and the project management team, particularly in order to develop the Theory of Change (ToC) that was adopted for the programme.
As part of the national evaluation team’s work in the national pilot, Dr Shearn held several sessions with the LG to develop and review the ToC, upon which the approach to the local evaluation was predicated. The national evaluation team reported that the: 'high level programme theory' developed by the national team was informed by literature (Garside et al., 2020) and was refined through consultation with Derbyshire stakeholders. It was potentially a way of framing Derbyshire's impact re: a) actively trying to address known barriers and challenges in systemic working, and b) adoption of this model by other embedded researchers and informing of the national evaluation. Dr Shearn also held interviews, at various stages, with a number of local stakeholders to support the wider national evaluation.

Institutions

Changing local system – Integrated Care System (ICS)

Over the lifetime of the GreenSPring programme, there was a significant system journey for health in Derbyshire with the CCG (Clinical Commissioning Group) forming into the Derby & Derbyshire Integrated Board (ICB). This journey began in April 2019 with four CCGs merging to create one for Derby and Derbyshire. In July 2022, the Derby and Derbyshire ICB was established and throughout 2022-23 this was strengthened, and new ways of working in an integrated, shared, collaborative way were proposed. NHS Trusts, Primary Care, Local Authorities, District and Borough Councils, VCSE sector, non-NHS organisations and Derby and Derbyshire ICB began to establish how they would work together, and the ICS strategy was published.

Local Authority
At the time of the initial GSP call, Derbyshire County Council (DCC) and Public Health (PH) were exploring community wellness and social connectedness, and connecting people through involvement in green activities, which was relevant to the GreenSPring approach. The 'green agenda' also cross-cut other local council initiatives such as active travel and countryside services so it was important to ensure both PH and DCC had a stake in the work.

Of the partners not directly involved, departments within DCC were initially very interested to connect their work into GSP, however, once they realised the testing approach was not focussed on the benefits of NBA they struggled to see how they could get involved and interest

dropped off. Similar to other partners, DCC seemed to turn their attention back to other things, not least because of the ongoing impact of the pandemic, plus a system-wide recruitment challenge.

As time progressed, it became evident that there was a lack of spaces and opportunities to feed back information being found through the testing. There were no systematic reporting mechanisms within PH or into DCC, and it became hard to raise the profile of the work and its findings. Attempts were made to gain the support of the Director of PH, but this was also challenging as the findings from the work were challenging for existing individuals, structures and workflows within the system to hear and there seemed to be no single or obvious identifiable entity or entities to promote the work, even for those 'bought in' and interested in supporting it.

NHS/Mental Health

The publication of the Community Mental Health Framework (CMHF) in 2020 by NHS England heralded the start of widespread community mental health transformation work. In Derbyshire, a collaborative approach to this work between health, social care and VCSE was launched, called "Living Well" in the County and "Derby Wellbeing" in Derby City. The principles behind these projects were to co–produce with the people receiving the services so that they receive easily accessible care at the right time, that health social care and VCSE organisations work together to wrap around the person to support them to live well in their local community, and that the person feels connected to their community and the people around them. This coincided with the Derbyshire GreenSPring project, and the hope was that these two work streams would interconnect as part of the collaborative approach, and drive support for green health and social prescribing opportunities to become sustainable, robust resources to effectively work with people with mental health conditions.

However, due to the way the funding had to be used, it was not possible to secure the requisite resources to support smaller providers to safely work with people in their local communities. The funding stream was designated for the employment of additional staff to implement the new model of working, thereby excluding any possibility of channelling some of the transformation monies into the voluntary organisations that will be expected to support people with mental health conditions in the community as part of the CMHF.

<u>VCSE</u>

When discussing social prescribing with public sector partners and VCSE members alike, the project management team noted that SPLW roles were the focus and point of reference for understanding social prescribing, including of the Social Prescribing Advisory Group (SPAG). In the wider VCSE, non-Primary Care Network (PCN) - based SPLWs are employed by infrastructure organisations. This, coupled with the SPLW focus, also confuses the broader understanding of the diversity of the VCSE, of social prescribing, and what (and how) NBA is delivered in communities.

The intention of the pilot was to understand existing NBAs and create a referral-ready sector, rather than design new activity and duplicate provision, and anyone with an interest was welcome to join the conversation. In this project and the wider network, most green providers are charities, micro-entities or community groups and part of the VCSE sector. Additionally, there are local authority, private sector, and larger charities with objectives relating to human wellbeing (e.g. the RSPB), which also deliver NBAs. The need to create inclusive pathways and options for investment is relevant to all 'providers', not just the pathways through the SPLWs hosted by infrastructure organisations.

With the emergence of the ICS during this project, a VCSE Alliance was created; this group continues to grapple with the challenge of 'representing' a sector encompassing myriad groups and organisations, of all scales and areas of interest.

Current Arrangements for Social Prescribing

At the time the GreenSPring application to the national pilot was written, the number of whole time equivalent (WTE) roles (which include SPLWs) filled through the Additional Roles Reimbursement Scheme (ARRS) available to PCNs were as follows:

2020/21 – 55.11 WTE
2021/22 – 58.30 WTE
2022/23 – 78.52 WTE

The precise number of other social prescribing type roles across sectors is unknown, highlighting the disconnect in delivery of services across health, social care and other local authority initiatives. However, stakeholders were clear that the process of social prescribing had been happening in Derbyshire for more than a decade prior to the National Health Service England (NHSE) -funded initiative.

At the time of application to the GSP pilot, approx. 40% of the ARRS positions were presumed to be SPLWs based in Local Infrastructure Organisations (LIOs). In addition, Derbyshire PCNs employ 13.5 WTE Health & Wellbeing Coach positions and 130 WTE Care Coordinator positions through ARRS roles.

A 'Link Worker Manifesto', produced in 2021 in collaboration with Arts Derbyshire, brought together nine SPLWs' perspectives on what social prescribing is and how well it was functioning, and set out the challenges facing SPLW in Derbyshire at the time of the project. These included proper pay and conditions such as contractual arrangements; a place to work; appropriate kinds of support and supervision; robust systems, policies and procedures; and access to equipment and resources (Social Prescribing Network, 2022). At the beginning of the GreenSPring project, SPLW representation comprised SPLWs, including the Chief Executive Officer of a local infrastructure organisation (LIO) with a SPLW staff team. Capacity for

Leadership Group participation became an issue, and social prescriber engagement from then on was: via SPAG; through subgroup meetings (particularly in relation to the GreenSPring Levels); at a local level through each piece of commissioned testing; by setting up a training session around nature-based provision (summary in Testing, p.72); and through network sessions at some green provider sites (see individual delivery summaries), which enabled a wide range of link workers to talk to others in similar roles.

The perspectives gathered during this phase can be summarised using elements of the ToC and were subsequently tested throughout local and county-wide work.

Perspectives on current arrangements

There is a lack of mutual understanding and awareness of different parts of the system and how they operate - the desire from referrers was for an easy access map or database of provision, but relationship building was prioritised to ensure better referrals and outcomes for patients, including feedback loops back into the system.

Non-existent and/or inappropriate referral to GSP - referrers expressed concerns about the ability and credibility of organisations or groups, not usually resourced to 'deliver' (n.b. not all 'providers' consider themselves as such, or desire 'referrals' into an activity).

Users are not actively engaged in GSP Processes and High user drop out of the GSP system at multiple points in the pathway - a lack of understanding of the nature and content of NBAs was cited as a reason for low numbers of onward referrals, as were the challenges the individuals were facing, often mental health related, which meant they were not ready to be referred into an activity.

The network of providers, link workers, referrers and funders is fractured and dispersed - further to this, there was a perceived shortage of 'appropriate' interventions, leading to SPLW setting up their own groups, particularly desirable for efficiency when teams have heavy caseloads and, generally, lack the time (or permission in some cases) to attend activities with potential participants.

Green providers are funded piecemeal and unsustainably resulting in sector fragility and competition - providers, who have usually sought funding themselves to deliver an NBA, reported low numbers of referrals and were, therefore, unable to access sustainable investment on the grounds of 'evidencing' need.

NBA Sector Landscape

As mentioned, the NBA providers engaged with GreenSPring were predominantly VCSE micro-organisations. Therefore, funding for NBAs mostly comes from efforts of the organisations and groups themselves, often in the form of short-term grants. The project team carried out an audit

of the funds available, and the majority of these were one-off micro grants (at a local level) with some larger regional or national pots available as part of competitive processes. Levels of monitoring and evaluation vary, both within the social prescribing workforce and NBA providers (see Quantitative Data summary, p.69). In the providers' case, this impacts groups' or organisations' ability or capacity to seek funding from various sources, and the majority of VCSE providers focussed on a specific type of intervention, such as NBAs, find accessing contracts, commissions or frameworks such as Adult Day Services, prohibitive to participate in.

Sustainable investment

In the broader (health and public sector) system, there was an assumption that referrals flowed freely through existing channels, e.g. into PCNs, through to SPLWs and onwards, without obstacle, into groups and organisations which were ready to offer activities and services. There was also a perception that if there were a readily accessible database or 'marketplace' of providers awaiting referrals, the challenges observed throughout this project could be overcome. This led to a dual purpose for test and learn activity: evidence gathering to elucidate the broader practical and logistical challenges of a person's journey to good mental health through access to nature, but also highlighting the complex interrelations between sectors, organisational cultures, and financial factors.

Project Leadership and Governance

The GreenSPring LG (see Figure 1) comprising mental health specialists, Local Authority, NHS partners, Social Prescribing Link Worker, 'Green' providers, VCSE Infrastructure, Clinical Commissioning Group and Public Health professionals, met on a regular basis throughout the programme and interacted, either through GreenSPring subgroups or in other fora, with a range of local partners and groups, e.g. the Social Prescribing Advisory Group (SPAG). The membership of this group changed through the duration of the project.

A mental health sub-group was established to inform the work of the project team, and meetings were held with the social prescribing workforce (anyone working in this capacity in the county or city was invited to these meetings). A network of green providers was established as a key outcome of the work and is discussed in the Green Provider Network Development Summary (p.76).

The LG intended that a project manager and three 'green advocates' would be recruited to deliver the project, employed through Derbyshire County Council (DCC). Three green advocates (project officer roles) were initially recruited, with two leaving before the end of 2021. An arrangement for project management support by LG members (from three 'green' organisations and one local authority) was agreed on an interim basis until the project management post was recruited to. However, recruitment of this post was unsuccessful, and it was agreed that from 01/09/21 the existing arrangement (representatives of the three 'green' organisations) would become substantive until the end of the project in March 2023. Further project support of one

day per week was offered by Natural England, and one of three individuals that occupied this role supported the project at various times throughout the project period.

During the programme period, the project team provided monthly update reports to NHSE; quarterly reports, which were accompanied by meetings with national partner organisations and GreenSPring LG members; attended national collaborative sessions; and participated in test and learn site project management meetings.

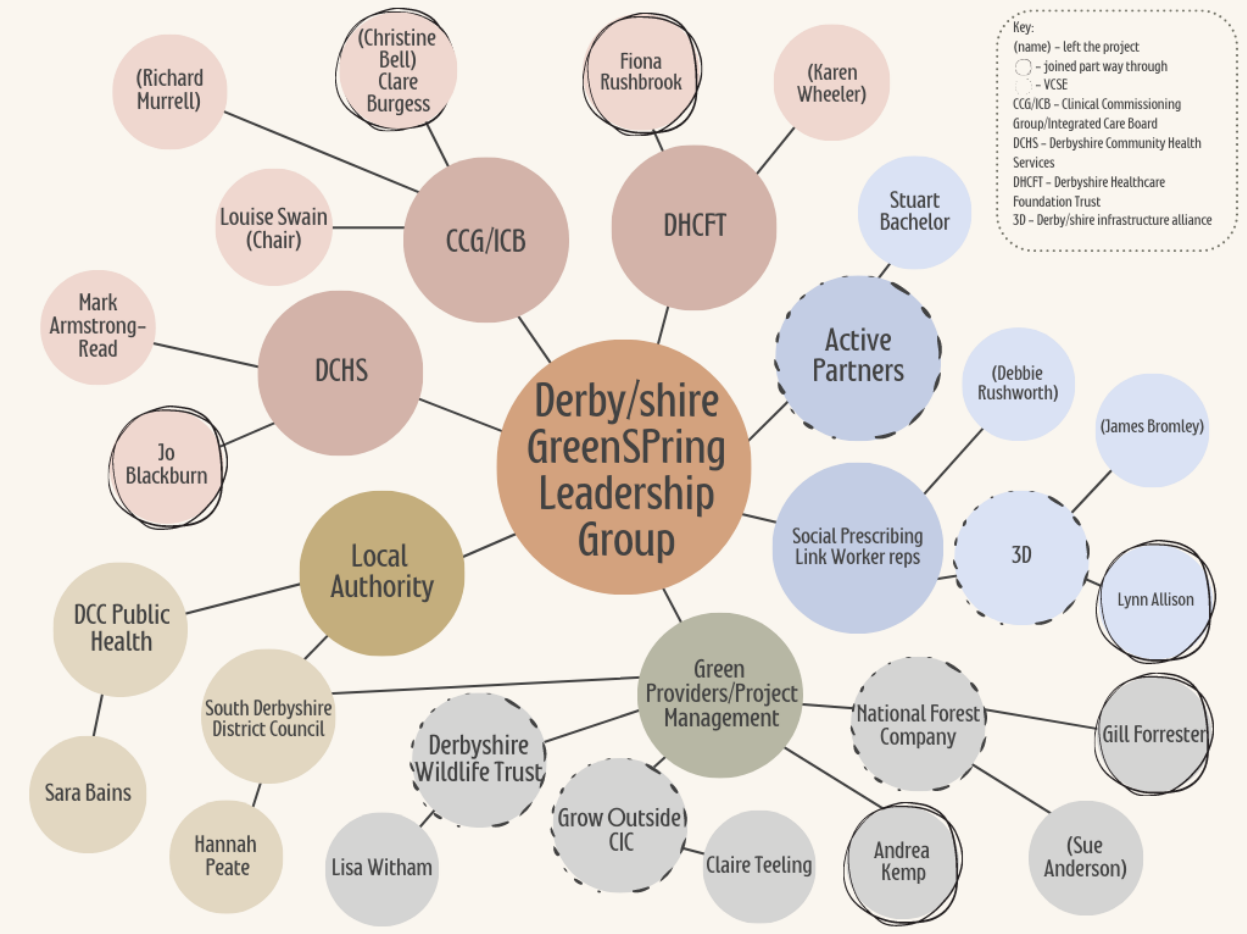


Figure 1. Leadership Group membership. Circles represent organisations and representative roles/named members.

Local data were provided to the national evaluation consortium in the form of monitoring data, e.g. numbers of referrals, wellbeing data from delivery of projects, as well as any available SPLW referral data, information on project costs and commissioned delivery, and two providers submitted data to be used in a value for money analysis.

The commissioned testing work in each of the districts and boroughs was developed iteratively, based on insight and contributions from relevant stakeholders, and each site was allocated a ‘site lead’, either from the project team or from local organisations in the relevant

district/borough. Their reflections form part of the evaluation and were used to compile the project summaries (from p.25).

Shared Vision

Through work in partnership, via the LG and with other stakeholders in the Derbyshire system, it became clear that wider work was required to reach a shared understanding before any delivery or testing could commence. Part of the challenge was the specified aim to investigate the need for system change to enable effective NBA for citizens, as opposed to offering grant funding to the green provider sector to prove its efficacy. It also highlighted that working practices across and within sectors were siloed, rather than reflecting a holistic view of addressing mental health and inequalities. For example, the regular and continued requests for transactional information about dates, times and locations of NBAs from referrers, rather than self-reflection about what is required to deliver system-wide effective mental health benefits through nature.

This pilot represented an abstract concept for many and, therefore, was difficult to explain at online network events and through traditional presentations and agenda items (the majority of which were virtual). A set of slides was created and used by some of the members of the LG, aiming to build understanding and consensus around the aims of the project. Its call to action was for participation and input, rather than delivering information. Relatively little progress was made taking this approach.

A county-wide (which included the Nottinghamshire GSP pilot) provider session was convened by the Active Partners Trust early in May 2021, to engage green providers in the upcoming testing work, as well as the green provider network, and to give stakeholders the opportunity to hear about the work of the Derbyshire programme. Throughout the project period, numerous boards, groups and system partners received presentations on the work of the pilot. Progress updates were requested from very early on and this created a tension between engaging people in the work and obtaining buy-in, and delivering snippets of data, which would not lead to ownership or any meaningful change.

A set of FAQs was made available and continuously updated in order to provide information on the work and these were shared, along with any relevant ways to engage, e.g. the provider survey, with interested stakeholders. Individuals were usually referred to the project team to have this information shared, rather than being engaged by partners in a discussion at the first point of contact.

Approach to testing

Aims

GreenSPring aimed to:

- develop a Derbyshire-wide collaborative framework to bring existing and new partners together to create a sustainable scaled–up model that better connects social prescribers and providers, accelerating and expanding the work, so more people can be helped to access local greenspaces;
- learn lessons about shared policy and delivery and identify barriers, ways of improving outcomes for citizens;
- create a referral ready sector with capacity and confidence to deliver this.

The full GreenSPring application to the national programme stated that 'understanding the factors which impact the implementation of social prescribing will support the development of a common framework for practice'. GreenSPring proposed that it would build effective, mutually beneficial long-term partnerships with the VCSE sector; increasing access to funding to deliver additional projects and services, providing wider benefits for residents of Derbyshire; whilst developing and evaluating sustainable models of remuneration for services provided by the sectors referring to and providing those interventions. 'Gaps and existing conventional barriers mean that routes to achieving this are not clear. Many VCSE groups are unable to access NHS-funded provision and frameworks due to their size and minimum contract levels. By capacity building this sector and providing training and support we will be able to expand this high-quality delivery to more people, and beyond this funding. Identifying and embedding appropriate referral routes from referring organisations to intervention providers will be a key outcome for this project.'

Target audience

At the early stages of the project, the target groups were proposed to be:

- people in areas adversely impacted by wider determinants of health and wellbeing where Covid appears to be having a greater negative impact on jobs, opportunities and mental health
- Children, young people and families across Derbyshire

During development of the project, it became clear that the need to establish a shared understanding of GSP was a greater challenge than anticipated. It was decided that having an additional focus on children and young people, as well as the adult social prescribing system, was beyond the scope of this project. However, a related piece of work carried out by DCHS in conjunction with the LIO, Derbyshire Voluntary Action, recruited a Children and Young People's (CYP) SPLW for one year to understand the viability and potential for such roles in the system.

Further, providers already delivering NBA in communities reported that multiple structural inequalities faced a majority of existing participants, so segregating potential users by specific

categories risked downplaying the complexity, impacting the mental health needs that many of the NBAs existed to address.

Developmental evaluation

The GreenSPring programme adopted a developmental approach to the local evaluation. As a test and learn programme the project team decided, along with researchers from the national evaluation team, to adopt an approach that avoided answering questions early in the process, which could restrict progress and a way to learn from the project, instead using developmental evaluation to encourage the open-ended enquiry of the themes and issues that arose as the work progressed. It is a method that encourages trial and error rather than focussing on the 'realising' of pre-established goals (Patton, 2016).

Developmental evaluation is focused on learning and adaptation, and it is typically conducted in collaboration with the people who are developing or implementing the program. In this case, the project lead was responsible for the evaluation process and, working with the team implementing the work, used participatory decision making and collecting data on the experiences and perspectives of stakeholders. This ensured a continuous flow of information about the work and areas of focus and kept activity in line with the agreed principles of the testing; all elements essential of a developmental evaluation (Dozois et al., 2010). It required trust, good communication, and a clear understanding of the approach and overall intended aims.

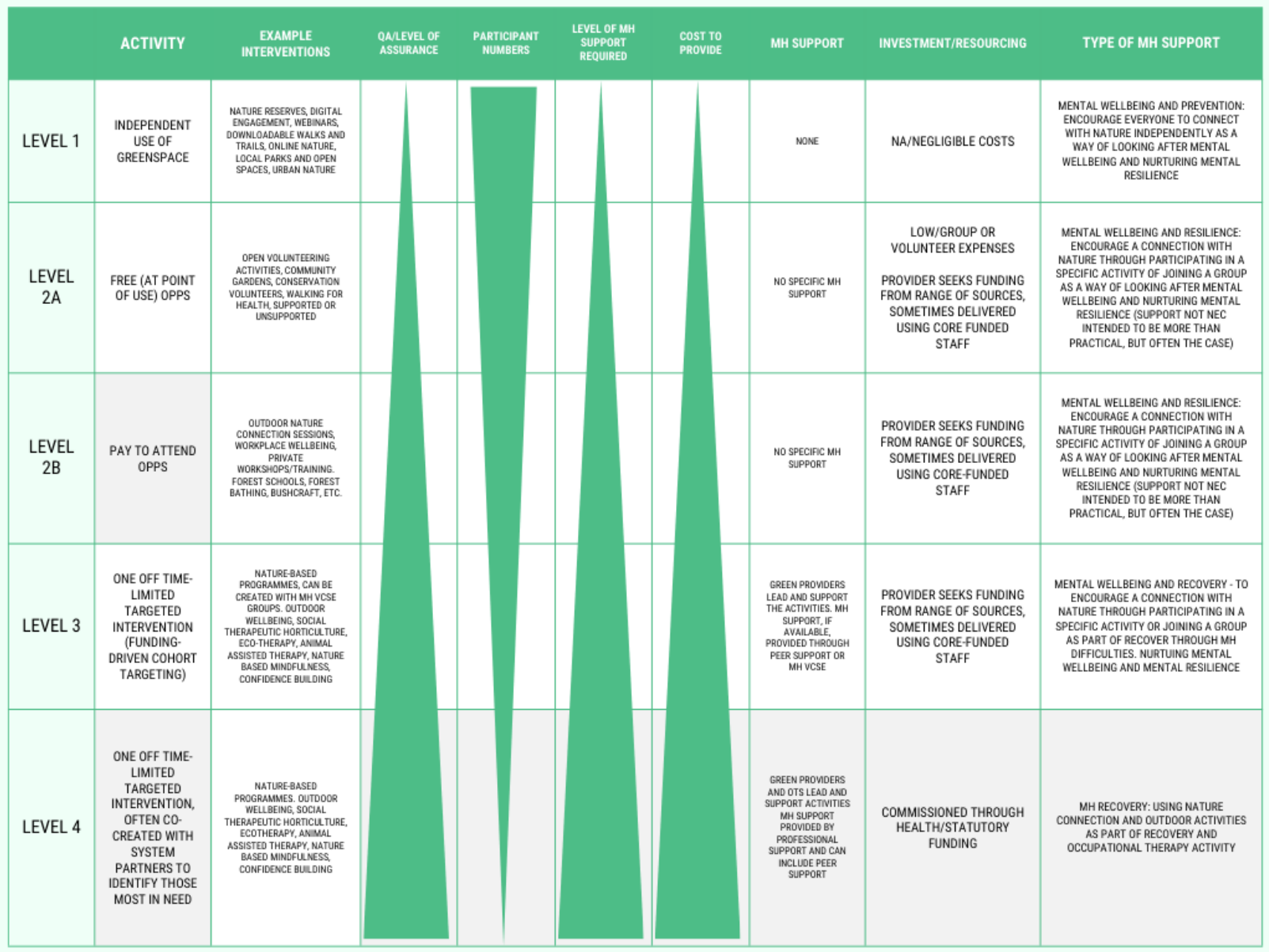
As with all evaluation methods, the issue of bias in this approach was an important factor to consider. Having site leads working directly with each provider, supporting any changes to the project plan and gathering reflections helped to ensure fidelity and check for bias. Also, the summaries presented (from p.25) were compiled either by a project team member who was not a site lead, or they were reviewed by a non-lead, before being reviewed again by the main evaluator. The process was discussed with Dr Shearn, Professor Dayson of the national evaluation team and Sam Alford, programme lead from the national team at NHSE.

'Levels' of green wellbeing activity/intervention

To address some of the differences in understanding and interpretation of what NBA could support which MH needs, and to help define the range of green provision in the sector, the 'green providers' in the LG began to create a set of 'Levels' at the application stage. A chart was developed to define the types of activity available, explain the factors impacting providers' capacity, and begin to address appropriateness of different NBAs for people with a mental health support need (see Figure 2, p.17). This was continuously refined, updated and modified according to discussion with providers, referrers, the mental health lead and subgroup, and other stakeholders working in the area of social prescribing.

The levels describe the range of NBA, from self-supported and independent use of greenspace that requires little input, other than signposting to an opportunity, through to supported activity,

often with some form of input from a mental health professional. The latter tend to be short term and funded by a more formalised part of the health system or budget but are dependent on existing relationships or access to resources and networks. Smaller numbers of participants are supported as the levels increase, but a greater expectation of quality, capacity and mental health expertise is found. See Case Study A in Appendix 5 for further detail.



	ACTIVITY	EXAMPLE INTERVENTIONS	QA/LEVEL OF ASSURANCE	PARTICIPANT NUMBERS	LEVEL OF MH SUPPORT REQUIRED	COST TO PROVIDE	MH SUPPORT	INVESTMENT/RESOURCING	TYPE OF MH SUPPORT
LEVEL 1	INDEPENDENT USE OF GREENSPACE	NATURE RESERVES, DIGITAL ENGAGEMENT, WEBINARS, DOWNLOADABLE WALKS AND TRAILS, ONLINE NATURE, LOCAL PARKS AND OPEN SPACES, URBAN NATURE					NONE	NA/NEGLIGIBLE COSTS	MENTAL WELLBEING AND PREVENTION: ENCOURAGE EVERYONE TO CONNECT WITH NATURE INDEPENDENTLY AS A WAY OF LOOKING AFTER MENTAL WELLBEING AND NURTURING MENTAL RESILIENCE
LEVEL 2A	FREE (AT POINT OF USE) OPPS	OPEN VOLUNTEERING ACTIVITIES, COMMUNITY GARDENS, CONSERVATION VOLUNTEERS, WALKING FOR HEALTH, SUPPORTED OR UNSUPPORTED					NO SPECIFIC MH SUPPORT	LOW/GROUP OR VOLUNTEER EXPENSES PROVIDER SEEKS FUNDING FROM RANGE OF SOURCES, SOMETIMES DELIVERED USING CORE FUNDED STAFF	MENTAL WELLBEING AND RESILIENCE: ENCOURAGE A CONNECTION WITH NATURE THROUGH PARTICIPATING IN A SPECIFIC ACTIVITY OF JOINING A GROUP AS A WAY OF LOOKING AFTER MENTAL WELLBEING AND NURTURING MENTAL RESILIENCE (SUPPORT NOT NEC INTENDED TO BE MORE THAN PRACTICAL, BUT OFTEN THE CASE)
LEVEL 2B	PAY TO ATTEND OPPS	OUTDOOR NATURE CONNECTION SESSIONS, WORKPLACE WELLBEING, PRIVATE WORKSHOPS/TRAINING. FOREST SCHOOLS, FOREST BATHING, BUSHCRAFT, ETC.					NO SPECIFIC MH SUPPORT	PROVIDER SEEKS FUNDING FROM RANGE OF SOURCES, SOMETIMES DELIVERED USING CORE-FUNDED STAFF	MENTAL WELLBEING AND RESILIENCE: ENCOURAGE A CONNECTION WITH NATURE THROUGH PARTICIPATING IN A SPECIFIC ACTIVITY OF JOINING A GROUP AS A WAY OF LOOKING AFTER MENTAL WELLBEING AND NURTURING MENTAL RESILIENCE (SUPPORT NOT NEC INTENDED TO BE MORE THAN PRACTICAL, BUT OFTEN THE CASE)
LEVEL 3	ONE OFF TIME-LIMITED TARGETED INTERVENTION (FUNDING-DRIVEN COHORT TARGETING)	NATURE-BASED PROGRAMMES, CAN BE CREATED WITH MH VCSE GROUPS. OUTDOOR WELLBEING, SOCIAL THERAPEUTIC HORTICULTURE, ECO-THERAPY, ANIMAL ASSISTED THERAPY, NATURE BASED MINDFULNESS, CONFIDENCE BUILDING					GREEN PROVIDERS LEAD AND SUPPORT THE ACTIVITIES. MH SUPPORT, IF AVAILABLE, PROVIDED THROUGH PEER SUPPORT OR MH VCSE	PROVIDER SEEKS FUNDING FROM RANGE OF SOURCES, SOMETIMES DELIVERED USING CORE-FUNDED STAFF	MENTAL WELLBEING AND RECOVERY - TO ENCOURAGE A CONNECTION WITH NATURE THROUGH PARTICIPATING IN A SPECIFIC ACTIVITY OR JOINING A GROUP AS PART OF RECOVER THROUGH MH DIFFICULTIES. NURTUING MENTAL WELLBEING AND MENTAL RESILIENCE
LEVEL 4	ONE OFF TIME-LIMITED TARGETED INTERVENTION, OFTEN CO-CREATED WITH SYSTEM PARTNERS TO IDENTIFY THOSE MOST IN NEED	NATURE-BASED PROGRAMMES. OUTDOOR WELLBEING, SOCIAL THERAPEUTIC HORTICULTURE, ECOTHERAPY, ANIMAL ASSISTED THERAPY, NATURE BASED MINDFULNESS, CONFIDENCE BUILDING					GREEN PROVIDERS AND OTS LEAD AND SUPPORT ACTIVITIES MH SUPPORT PROVIDED BY PROFESSIONAL SUPPORT AND CAN INCLUDE PEER SUPPORT	COMMISSIONED THROUGH HEALTH/STATUTORY FUNDING	MH RECOVERY: USING NATURE CONNECTION AND OUTDOOR ACTIVITIES AS PART OF RECOVERY AND OCCUPATIONAL THERAPY ACTIVITY

Figure 2. GreenSPring ‘Levels’

Theory of change

Having the freedom and flexibility to test and, potentially, fail was a challenge for some stakeholders. A considerable amount of time was spent by the LG understanding the culture and norms that prevented individuals from feeling confident to have open discussions about the barriers, as well as the opportunities, that could emerge from the project. This extended to green providers, for different reasons, and is discussed in the site lead summary (p.78).

To alleviate these concerns, illuminate the multiple opportunities, and attempt to create broad understanding and a shared purpose and vision for the possibilities of GSP, the LG participated in several sessions with Dr Shearn as embedded researcher. Through the initial phase of internal consultation, ToC development and sense-making, and through the work of Dr Shearn and the national evaluation team (via interviews and interaction with local stakeholders), the challenges and key concepts set out in the following section emerged and formed the basis of the test and learn work.

The development of this work used the concept of logic and dyslogic models developed by Garside *et al.* (2020) and built on stakeholders' perspective that the local green social prescribing system currently aligned most closely with the dyslogic model. A wide range of stakeholders were engaged in this process and the resulting outputs from online collaborative tools provided a framework to use to structure the testing phase (Appendix 2). The sections of the framework relevant to identified challenges in boroughs or districts were used to design each of the commissioned pieces of testing work, and those connections are referred to in each summary (p.25).

In Derbyshire and across all seven of the national test and learn pilots, a common set of barriers and blockers were identified. This highlighted areas for improvement that each test and learn site might explore within their unique contexts.

1. **New commissioning arrangements:** *if* we have new commissioning arrangements and agreements, *then* we will ensure that nature-based providers are embedded within the delivery and wider social prescribing landscape.
2. **Power and influence directed to support GSP:** *if* political and strategic power and influence is directed to support GSP, *then* there will be shifts in policy and budgeting.
3. **Priority actions to drive legitimacy:** *if* we gain agreement on priority actions, *then* we will drive legitimacy and buy-in to GSP.
4. **Harnessing nature-based assets:** *if* we grow or harness nature-based assets, *then* there will be a range of appropriate, diverse, geographically spread opportunities for service users.
5. **Creating aligned structures:** *if* we remove perceptual and structural barriers and create aligned structures, *then* we will have coherence and clarity of roles and responsibilities across the system.

6. **Creating compelling evidence:** *if* we gather and share routine data in the GSP system, *then* this will build confidence in the efficacy of GSP to support people with mental ill health.
7. **Improving networks to support connectivity:** *if* we enhance processes to support information flow and feedback loops within the system between the network of providers, link workers, referrers and funders, *then* we'll have better connected, efficient and effective pathways.
8. **Mutual accountability and shared problem solving:** *if* we want mutual accountability and shared problem-solving to enhance service use the experiences, *then* we need to build trust and respect so that people understand and awareness of how different actors in the system may operate.
9. **Improved access to GSP:** *if* we build referrers, capability, opportunity and motivation to refer to GSP, *then* we have improved access to appropriate green opportunities.
10. **Equitable access to GSP:** *if* you want equitable access to appropriate green opportunities, *then* decision making must be made through an inequalities and intersectional lens.
11. **Person-centred GSP:** *if* we want a GSP system that is person-centred, *then* the user voice is important to illuminate the changes across the pathway.
12. **GSP plausibly contributes to improvements in referrals:** *if* we want referrals to be fulfilled, *then* users must have a positive experience across the GSP pathway.
13. **GSP plausibly contributes to improvements in the management of mental health:** *if* we want nature-based activity to contribute to improvements in management of mental ill health, *then* people need to be able to access nature-based opportunities in ways that are meaningful and they value.

A lack of shared understanding of the widest definitions of social prescribing and its related challenges was recognised early in the project, so the plan for testing was formed and informed throughout the first year of the project via meetings, workshops, discussions, consultation through surveys and engagement events. The first phase of the work required a significant investment of time to understand the full spectrum of opinion, perspectives, roles and delivery of GSP in Derby and Derbyshire. The local picture is presented here in relation to the above areas for improvement and formed the basis of the district-specific and county-wide testing. While all areas listed are relevant to Derbyshire, some themes were stated more clearly at the outset, and others emerged throughout the project. To support these findings, relevant examples have been drawn from the national evaluation team's interim report (Holding et al., 2023) and used to highlight some of the above statements.

1. New commissioning arrangements

Stakeholders in system leadership positions, e.g. health, expressed a feeling of being unable to make change or address systemic blockages such as a lack of investment in social prescribing activity provision, and this led to a reliance on the 'green provider' members of the LG to drive the change required and investigate (without wider knowledge of existing commissioning and investment priorities) alternative routes to investment.

Feedback from an interim report to the LG, noted that:

> *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.*

Whilst acknowledged, and a clear element of the project aims, the LG and wider stakeholders were unable to make progress in addressing this.

A commissioning compact was created with the intention to map the funding and investment routes already in existence, to then identify additional opportunities in the system. Little progress was made in completing this, besides listing some of the short-term grant funding opportunities available and already mapped. During the project, conversations were held in relation to seeking investment from: mental health transformation funding, existing commissioned delivery for mental health (specifically already commissioned from the VCSE sector), discharge funding, the Better Care Fund, personal health budgets, existing investment in delivery through the VCSE sector by what was the CCG and the County Council, the ICB's Green Plan and any associated opportunities. This is a significant gap in investment in the social prescribing pathway in Derby and Derbyshire, and it continues to be highlighted as a critical part of embedding NBA in the wider social prescribing system.

2. Power and influence directed to support GSP

This was identified as a cross-cutting theme throughout testing and delivery work and is addressed in the Outcomes section (p.81) alongside the other themes.

4. Harnessing nature-based assets

The development of the GreenSPring 'Levels' has helped (members of the public sector, in particular) to understand and describe the range of NBA available. So far, the Levels have mostly been used in dialogue to explain the diversity, rather than to understand expectation and awareness of the needs to deliver these levels of provision effectively, particularly related to capacity building for 'providers' (providers of NBA in the lower levels are often unlikely to describe themselves as 'service providers', and often do not desire or request 'referrals', and this is a key factor to be understood in the SP referral pathway).

An initial survey, which remained open throughout the project, was shared across the city and county in order to gather input from a broad range of providers of NBA. Given the acknowledged challenges of bringing about change in the wider system, and alongside testing to elucidate the breadth of activity and issues relating to social prescribing, the project also aimed to support the part of the currently unfunded and often unsupported and informal part of the SP system. Through survey and consultation, providers reported that they would value support to develop a

'green' network, particularly to have their voices heard and reduce the repetitive self-promotion required to be visible, as well as resources and mutual support to be 'referral ready'.
"[Derbyshire] 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." (Holding et al., 2023).

7. Improving networks to support connectivity
Early meetings with SPLW and a wide range of referrers were held to discuss GSP and awareness of the range of NBA, also to discuss the developing GreenSPring 'Levels'. Many referrers were surprised to see each other in the same setting, some had not heard of GSP and indeed were unaware that there were NBAs to refer patients into for mental health and wellbeing.

Concern was repeatedly expressed over the suitability of organisations and providers' ability to support people with mental health needs. It was acknowledged that a lack of consistent investment meant that a cliff edge was likely for patients when programmes, or entire businesses or projects, run out of funding. Some SPLWs and other referrers admitted that this prevented them from making referrals in an attempt to 'protect' the patient. The same issue arose when a paid opportunity was presented, with free activity identified as the most common type of referral made through social prescribing (this feedback was from both referrers and providers - it was felt that the majority of patients seen through SP services could not afford to pay for NBAs).

Although certain forms of benefit and personal budget are available and already granted in many cases specifically for this use, using them for wellbeing activity in general is not common. The lack of awareness, and willingness, amongst support staff who could enable the patients to obtain and use funds in this way are a barrier to accessing NBA for wellbeing.

"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. [Derbyshire]"

"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 (GSP pilot site T&L7). [Derbyshire] 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." (Holding et al., 2023).

Some of the concerns in making onward referrals related to the ability of the provider group or organisation having the skills, capacity and safeguarding experience. Providers reported that they felt equally frustrated in not having clear communication channels, including an often distant referral-making workforce with a high turnover and lack of consistency in knowledge sharing.
"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 [Derbyshire]." (Holding et al., 2023).

8. Mutual accountability and shared problem solving
During initial stages, the myriad roles (formal and informal) and stakeholders engaged with the broader concept of social prescribing were poorly understood. Further, in some cases, the validity and acceptance of those roles as part of social prescribing were not acknowledged. The particular role that NBAs (in contrast to other forms of community activity, e.g. arts projects) play in this process is also not widely understood, and this can impact on the likelihood of onward referrals into NBAs. The national evaluation's interim report noted that "*there is a lack of a basic understanding, and valuing, of social prescribing and/or GSP and/or nature-based provision among stakeholders such as health care workers [Derbyshire]" and "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." (Holding et al., 2023).*

The imbalance in power felt in the 'green' part of the LG was discussed and broadly recognised but, despite revisiting the conversation on a regular basis in LG meetings, this became one of the barriers to progressing work through the LG, leading to the project team feeling somewhat isolated in leading the project.
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 [Derbyshire]. (Holding et al., 2023).

As part of the work to uncover the range of perspectives in social prescribing, discussions with VCSE infrastructure representatives (with dual roles as service providers and LIOs) sought to broaden the focus (particularly at SPAG meetings) away from just the SPLW workforce and onto the broader SP landscape, locally. However, the lack of awareness and shared understanding in health system leadership and across sectors continued to be a challenge for the duration of the project.

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 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. [Derbyshire]] (Holding et al., 2023).

Commissioning test and learn projects in the 'nine sites'

Preliminary testing set out to understand and demonstrate the dissonance in understanding SP in Derby and Derbyshire; this was done through testing referral pathways in three districts around the city and county (p53). Along with a lack of shared understanding of the overall concept, the transferability of any testing carried out raised concern with wider stakeholders, unconnected with the project. To mitigate this, it was decided that the project would attempt to identify factors pertinent to each borough and district in Derbyshire, taking account of any locally-relevant features, e.g. geography, demography, and other socio-economic factors.
In order to achieve this, insight was sought from within the LG and its partners, to identify key themes or challenges, pertinent to delivery of nature-based wellbeing for mental health in each area. The rationale for what was tested in each area is described in each summary (from p.25), as it relates to the ToC. Little input was obtained from the wider system but, through discussion and following suggestions provided, project team members investigated themes and leads in each area to understand the most pressing issues to test.

Once available insight was gathered and local connections had been made, provider groups and organisations that had expressed an interest in being involved (and were providing some form of nature-based wellbeing activity already), and that could fulfil the requirements of the testing, were then commissioned to deliver activity.

The planning of testing work was discussed with members of the LG at its regular meetings and on an *ad hoc* basis. A set of general (see agreement template in Appendix 3) terms were established by the project team and shared with the LG, including agreed rates to be paid for delivery. Two of the green providers' summaries reference what would have been the actual project costs (though they accepted the day rate offered to contribute to the work) and a breakdown is included. All providers were asked to write a report summarising their experience in line with what they were asked to test as part of the ToC; also, to use some form of quantitative wellbeing measure, where possible and relevant. In some cases, primarily because of the GreenSPring level the intervention related to, this was not possible. All providers were also asked to collect monitoring data (for both local and national evaluations) and qualitative information, e.g. case studies, where possible, and to submit their own reflections on the process at regular intervals to their site lead or the project team.

The testing summaries in the following section contain additional contextual data submitted on a regular basis by the provider and by the relevant ‘site lead’ - a member of the project team overseeing the commissioned projects. Thereby, also contributing to the developmental evaluation process.

Standards/expectations

In order to maintain the flexibility and responsiveness inherent in micro VCSE providers, a light touch approach to commissioning delivery was favoured. Members of the LG and project team established a set of common policies and practices in line with community-based NBA delivery to request from providers (see Appendix 3). As part of the agreement between GreenSPring and delivery providers, a set of procedures and processes were suggested. Providers confirmed these were in place, however, there was no requirement to provide these documents to the project team. One potential provider, inadvertently, divulged that they felt this process could be exploited. It is anticipated that, in time, the Green Spring Network might create and endorse its own set of self-managed requirements for delivery, as members of the provider collaborative model are now doing.

Outputs - delivery and testing reports

The projects commissioned across the nine districts and boroughs of Derby and Derbyshire are as listed in Table 1 below. A report on each piece of commissioned delivery is included in Appendix 4, and below are summaries of those, plus information on preparatory work that did not come to fruition, and testing of different elements of the system, with comments on, if and how they were concluded.

Table 1. Test and learn delivery providers, areas and documentation.

Test site/provider	District/borough	Report+Summary or only Summary
Bolsover (general)	Bolsover	S
Buxton Civic Association	High Peak	S
Community Growth CIC	Chesterfield	RS
Craft Wood CIC	Amber Valley	RS
Derby City (general)	Derby City	S
Derbyshire Wildlife Trust/DHCFT	Derby City	RS
Elephant Rooms CIC	Erewash	S
Green Thyme and Derby West Indian Community Assoc.	Derby City	RS
Green Thyme and DHCFT allotment	Derby City	RS
Grow Outside CIC	Amber Valley	RS
High Peak (general)	High Peak	S
Hunloke Community Garden	Chesterfield	RS
Kenning Park Forest School and North Wingfield Community Garden	North East Derbyshire	RS
Referral Routes testing - Grow Outside CIC, DWT and Rosliston Forestry Centre	High Peak/Derby City/South Derbyshire	RS
SDDC's Environmental Education Programme	South Derbyshire	RS
Spiral Arts	Derby City	RS
Wellies CIC and Wild Roots Creative CIC	Derbyshire Dales	RS
Whispering Trees CIC	South Derbyshire	RS
Lived experience	County-wide	S
Buddy volunteering	County-wide/Amber Valley	S
Personal health budgets	County-wide/Amber Valley	S
Quantitative data/wellbeing outcomes	County-wide	S
Social prescriber engagement/training	County-wide/Amber Valley	S
Provider Collaborative	County-wide	S
Green Provider Network	County-wide	S

Summaries

Bolsover (general)

The Bolsover site lead connected with Visit, Sleep, Cycle, Repeat (VSCR) through Derbyshire County Council at Bolsover, whose project lead attended sessions of the green provider network. The GreenSPring site lead also attended a visioning and marketing workshop for this work in Bolsover. More details can be found on the Derbyshire County Council website (DCC, 2022). However, following the initial round of workshops for VSCR, no further updates on the project or progress were received.

Green Provider: Bolsover Woodland Enterprise (BWE)

Project outline: To support with impact and evaluation measures which will help BWE with their impact data for funded projects and demonstrate local need for their services.

Initial rationale for testing (linked to Theory of Change):

- organisational structures (e.g. policy, objectives, governance, record keeping) are not aligned.

Related elements (of the ToC):

- green providers are funded piecemeal and unsustainably resulting in sector fragility and competition.

Summary of outcomes:
Due to the nature of BWE's funding from Derbyshire County Council (DCC) they do not have a clear framework to measure success against. They receive rolling funding but often with last minute notice. DCC has implied that they see progression from BWE as a desired outcome of the funding, however BWE has approximately 40 participants (called Team Members) who are in meaningful activity delivering practical land management and contracts with local landowners. They have long standing team members who have greatly benefitted from their services over many years, often 10+ years. In order to demonstrate the impact that BWE has on its team members, GreenSPring supported outcome and impact measurement tools. An initial meeting took place to find out how BWE could connect with and benefit from GreenSPring. A further meeting was held with staff and a Trustee who has experience of using outcome measures and a range of possible measurement tools were considered. These included: a barometer graphic to show how far along their journey a team member was; a bespoke outcomes star to plot changes in team members' behaviour, confidence etc; and simple pictorial measures such as faces or leaves. We also discussed learning and development needs of team members who have gained practical skills such as health and safety or using tools and equipment and how these can be highlighted through individual case studies.

A range of measurement tools, plus examples and templates, were left with staff for them to decide on the best measure to use. BWE were also waiting to hear about their new contract from DCC so it was agreed that the range of measurement should be discussed with DCC in case they had any specific requirements that would be added to the new contract. Despite chasing BWE several times and offering support there was no follow up meeting with GreenSPring.

Learning:

- Green Providers and VCSE groups use a broad range of evaluation and impact measures and it is difficult to know which one to invest in;
- there are a number of wellbeing measures available 'off the shelf' such as outcomes stars and WEMWBS, but some have a cost particularly for analysing the data on behalf of an organisation;
- bespoke measurement tools work well as each organisation knows its participants and their aims and progress. However this makes it difficult for funders and commissioners to compare the impacts from one provider to another;
- there is a lack of capacity within organisations to create these types of impact tools due to staff time and delivering.

Summary/areas for further learning:

- conversations with funders and commissioners on what they consider to be good outcomes for participants, and more guidance from funders on frameworks and impact measurement;
- this is a good example of a mismatch between a funder who believes that progression from a programme into work is the desired outcome for the participant, and the provider who believes that their team members are exceeding their potential by staying with them.

Green provider: Buxton Civic Association

Project outline: Buxton Civic Association runs its own, self-funded (through grants) programme of woodland wellbeing/GSP sessions. As part of the GreenSPring project, the team shared their experiences and reflections regarding engaging with the local system in and around Buxton and highlighted the referral routes into their sessions.

Initial rationale for testing (linked to Theory of Change):

- there is an insufficiency of appropriate Green providers *[feedback from SPLW in HP].*

Related elements (of the ToC):

- the network of providers, link workers, referrers and funders is fractured and dispersed;
- there is a lack of mutual understanding and awareness of different parts of the system and how they operate;
- non-existent and/or inappropriate referral to GSP;
- high user drop out of the GSP system at multiple points in the pathway;
- users are not actively engaged in GSP processes.

Summary of outcomes

One highly engaged social prescribing link worker with an existing personal interest in green led to a good number of successful referrals, initially. However, with a change of staff came less engagement, leading to a drop in referral numbers. Often the success of referrals into green provision is greatly influenced by the individuals in post. If they have a personal interest, engagement is good, but as green health is not specifically written into referral agencies' job descriptions, it can easily be missed altogether for those without a that interest.

Referrals can require a high level of input and follow-up before they result in successful face-to-face attendance. For example, reassurance, coaxing and support to take the first steps to attending the session. Buxton Civic Association have tried to support as much as possible with this process but are at their maximum capacity and do not always have the time available for this step. If referral agencies are also unable to provide this initial support, due to workload, referrals will often fail. The most successful outcomes are where referrers can the service user to attend until they feel comfortable accessing provision for themselves.

Buxton Civic Association is keen to build a feedback loop between themselves and referral agencies, so that if a participant stops attending sessions there is a follow-up and the client can be supported back to an activity (either at Buxton Civic Association or another form of community provision more appropriate for the individual). Unfortunately, this is currently unachievable because cases are closed once the referral is made with, potentially, no opportunity to follow up. Meaning that, even if the initial referral is successful, a service user could be lost from the system if they stop attending community-based provision, or if the programme is limited in length, or funding ceases. Potentially leaving the individual without

support and cycling back into the system that SPLW roles were designed to alleviate pressure on.

Learning:

- a feedback loop between providers and referral agencies and ongoing support for service users would likely increase positive outcomes;
- referral into green provision currently largely relies on the personal approach of each individual referrer, rather than a set process across the board. This results in fluctuating referral numbers, correlated with inconsistency of staffing (which is a widespread problem, especially with SPLW roles), and frequently results in low referral numbers to green provision.

Summary/areas for further learning:

- green wellbeing activity needs to be embedded in social prescribing, broadly, not seen as an add on, if considered at all;
- although green provision may not suit everyone, it could be introduced into initial conversations to ensure those who would benefit are aware of the opportunities;
- the element of building in ongoing support and feedback loops could be an area for further learning and development for the wider social prescribing sector;
- explore nature buddies/volunteers to help people to initially get engaged in GSP provision.

Green provider: Community Growth CIC

Project outline: Working with referral agencies to develop a set of clear suitability criteria to facilitate appropriate referrals to green activities. This was completed via a series of focus groups and questionnaires, gathering intel from referral organisations, green providers and service users. A criteria 'postcard' promoting each activity was developed and shared with referral agencies clearly stating the need-to-know information about each activity and who it would be suitable for. This approach was then tested by inviting referrals for taster sessions of various green activities.

Number of referrals: DCC community connector (1); DVA (Derbyshire Voluntary Action) (4); SPLW (6); OT (EI Team) (11); self-referral (2) (these are instances of referrals across four discrete sessions so could represent the same person more than once).

Wellbeing measures used: own 'growth tree' measure

Initial rationale for testing (linked to Theory of Change):

- non-existent and/or inappropriate referral to GSP (focus on inappropriate referrals).

Related elements (of the ToC):

- there is a lack of mutual understanding and awareness of different parts of the system and how they operate;
- the network of providers, link workers, referrers and funders is fractured and dispersed;
- users are not actively engaged in GSP processes.

Summary of outcomes
The suitability criteria postcards helped referral agencies understand what each activity actually involved, and which of the patients/clients it would be suitable for. This was especially helpful for those referrers who were unfamiliar with green provision.

However, the level of prior understanding and experience of the referrer still impacted whether or not they would recommend an activity to a client. Those who had personally experienced a similar session and fully understood what would be involved were more likely to make a referral.

Referral agencies found the postcards easy and efficient to access, and useful to share with their colleagues and patients/ clients.

The postcards helped to provide useful information for referred clients, and boost the appeal to attend. However, 1:1 support at the first session provided by the referrer was still desirable and led to a higher rate of attendance. Where this support was unavailable, attendance levels were lower.

Learning:

- despite increased interaction, improved relationships and setting out suitability (inclusion/exclusion) criteria for participants, referrals numbers were not improved compared to usual running of this CIC;
- the postcards show a model of good practice for how green provision can be promoted effectively to referral organisations. The postcards are quick and memorable to read and accessible for professionals and service users to make use of;
- referral organisations found the guidance from the postcards useful to establish what the green activities would involve and which of their clients the activity would be suitable for. This led to 5 out of 5 successful appropriate referrals to the taster sessions;
- referrals into green provision often rely on the personal opinions of each individual referrer. Those who believe in the effectiveness of green provision are much more likely to make referrals. If that individual staff member leaves, connections are lost.

Summary/areas for further learning:

- one barrier regularly cited is lack of knowledge of green provision available and what these types of activities may involve. They are still seen as quite ‘alternative’. More work could be done to address this issue and work towards green activities becoming mainstream;
- although the suitability criteria postcard did reduce barriers to referrals in terms of knowing what green provision involves and who it is suitable for, there are other barriers preventing referrals. The range and causes of the barriers to referrals warrant continued investigation and discussion.

Green provider: Craft Wood CIC

Project outline: Providing 12-week blocks of woodland based, 'Level 3' intervention, with the expectation that by the end of the program attendees will feel confident in engaging with nature independently at 'Level 1' activities.

Number of attendees: 19 in total, not all at one session.
Number of referrals: 25. Self-referral (23), CMHT(2).
Wellbeing measures used: UCL wellbeing umbrella at pre and post sessions, only small numbers between two and four participants at each session completed these.

Initial rationale for testing (linked to Theory of Change):

- green providers are funded piecemeal and unsustainably resulting in sector fragility and competition.

Related elements (of the ToC):

- nature-based assets are grown, nurtured or harnessed to provide a range of appropriate, diverse, and geographically spread opportunities for service users;
- referrers and link workers have the capability, opportunity and motivation to refer to GSP which improves access to appropriate green opportunities;
    - [both commissioned activities in Amber Valley were funded for a period of 6+ months in order to address the 'cliff edge' participants' experience through short term funding, and significant promotion was undertaken with referrers out to ensure awareness of the opportunities].

Summary of outcomes:

- the vast majority of participants self-referred;
- participants that did attend showed an average increase in positive emotions and an average decrease in negative emotions;
- extensive pre-session contact with participants helped to increase attendance. This included offering familiarisation visits and sending personalised check in emails before the session with information about weather forecast and upcoming activities, plus post session emails with photographs of the session and a thank you for participants' hard work;
- opportunities were provided to encourage participants to 'move on' from this initial six week programme. This included signposting to other activities, advising on how to make/source materials to continue activities at home and providing a range of free resources.

Learning:

- although all activities were open to all, the activity focus led to a gender split: females focusing on art, males gravitating to woodworking and woodland craft. Gathering around

a fire for drinks and lunch was a key feature of bringing everyone together to socialise, which made the activities more diverse;
- participants benefited from being able to stay on in the project and act as ‘buddies’ for the next cohort;
- all participants were appropriate for the level of experience and intervention from the provider;
- green activities benefit from having a central ‘hub’ to the session where all participants can mix, helping to create diverse and appropriate opportunities for service users.

Summary/areas for further learning:

- referrals from professionals into this project were near non-existent (apart from one referral from the CMHT) – the range and causes of the barriers to referrals warrant continued investigation and discussion;
- length of intervention, short term (six-week) programmes as compared with continuous provision in a nearby programme running at the same time (Grow Outside in Amber Valley). The latter may have helped with visibility and understanding from social prescribers;
- the uptake of progression opportunities was not measured, so it is not clear how many participants ‘moved on’ from Level 3 interventions to Level 1 opportunities as a result of the program. This is an area that warrants further investigation.

Derby City (general)

Project outline
To test the following:

- connectivity of existing Derby Social Prescribing network;
- representation of activities culturally appropriate to the diversity represented in the geographical area;
- developing provider capabilities by looking at expanding referral opportunities into
- signposting out of activities and different providers.

Initial rationale for testing (linked to Theory of Change):

- there is an insufficiency of appropriate green providers. *This was the initial focus resulting from feedback from SPLW and other social prescribers in the City.*

Related elements (of the ToC):

- the network of providers, link workers. referrers and funders is fractured and dispersed;
- there is a lack of mutual understanding and awareness of different parts of the system and how they operate;
- non-existent and/or inappropriate referral to GSP;
- users are not actively engaged in GSP process.

Summary of outcomes:

- green providers unable to commit extra time or resources to participate fully in new opportunities (see Green Thyme/DWICA);
- evidence of an unofficial 'green network', with some providers signposting between themselves, but with evidence of gatekeeping and based on personal rather than professional relationships;
- it is very difficult for new providers with no contacts in the 'established green network' to become part of it (see Spiral Arts testing);
- referral rates were low, despite direct targeting of social prescribers and health care professionals.

Learning:

- social prescribing pathway in Derby changing with new 'Derby Wellbeing Collaboratives network' through the Living Well programme;
- some social prescribers do not make formal referrals, instead encouraging people to self-refer, meaning there is no way of accurately recording where a referral comes from, and no opportunity for a feedback loop;
- feedback from social prescribers is that community activities were not what their clients needed. Mostly they need advice on money matters;
- the Derby Health Inequalities Partnership Board Co-production Group sees 'inclusive' as being 'for the community by the community', with culturally specific provision being

thought of as most desirable, but there may not be the resource amongst these groups to deliver (see Green Thyme/DWICA);
- providers believe their provision to be inclusive, but this does not equate to diverse, and participants are not necessarily representative of the local community;
- evidence of gatekeeping and siloed working practices;
- some members of a local green network chose to opt out of delivering activity for the test and learn pilot due to bad experiences with the NHS as staff members;
- Local Authority staff feel that they are providing a type of social prescribing service through their local area coordinators teams. They believe that 'sitting the money with GP surgeries is problematic as it only reaches a certain aspect of the wider community', that their teams are better suited to recognising and responding to need in the community.

Summary/areas for further learning:

- clearer information and pathways of communication are needed for new providers to be able to engage with the existing networks;;
- clearer information sharing, role definitions and signposting between organisations could be explored to address gatekeeping and siloed working practices;
- co-production is the key to providing culturally appropriate provision, and work needs to be done to clarify the role of diversity, inclusion, and cultural appropriateness, especially for funding bids;
- developing standardised referral practices would be effective for efficient monitoring of referral routes and create better relationships between referrers and providers;
- better relationship building across organisations. Derby Wellbeing collaboratives network would be worth monitoring to see if it manages to fulfil this role. At a leadership level, numerous conversations have taken place to understand and make the case for providers as part of the Living Well workforce, through MH Transformation. To date, no progress has been made, and the focus is on providers promoting themselves as part of a 'marketplace' of opportunities, rather than having them embedded as part of the holistic support system on offer to patients.

Green provider: Derbyshire Wildlife Trust (with DHCFT - Level 4 testing)

Project outline

- co-design a programme with mental health professionals and service users;
- deliver a 10-week programme to increase nature connection and wellbeing (12 weeks delivered);
- create wildlife and habitat features to benefit the local community.

Developed through building relationships with staff at Kingsway Unit Derby, understanding the needs of the patients and service users, and looking at potential progression routes for participants. Testing related to Level 4 of the GreenSPring levels and benefitted from programme co-design with mental health specialists.

Maximum number of participants: The facility provides support for up to 25 patients
Number of attendees: sessions attended by between three and eight participants
Number of referrals: na

Wellbeing measures used: DWT wellbeing ladder and steps towards a tree for nature connection measure, but were limited by several factors detailed in DWT's full report.

Initial rationale for testing (linked to Theory of Change):

- there is a lack of mutual understanding and awareness of different parts of the system and how they operate. *This piece of work related to increasing participation of patients in the mental health service at the unit, to encourage nature connections whilst in journey recovery and through into community activity – testing across levels.*

Related elements (of the ToC):

- there is an insufficiency of appropriate green providers;
- evidence for GSP efficacy is limited and/or not compelling and/or not sufficiently rigorous to wider system partners;
- users are not actively engaged in GSP processes.

Summary of outcomes:

- the group cohesion and comradery built over the weeks and a lot more smiles and positivity from the patients were observed. Many wildlife features were made, including bird boxes, butterfly homes, bird feeding stations, sensory planting and bird feeders;
- flexibility and adjustments were required each week to suit the patients and how activities were carried out. Adaptability was required to ensure suitability for different levels of interest and ability, and weather;
- health professionals were particularly interested in the work; the sessions were co - designed with occupational therapists. Staff at the unit requested ongoing work to

improve the internal spaces of bungalows with images of nature etc, they commented that the work was valuable and wanted it to continue;
- positive client feedback and experience; some patients encouraging others to participate.

Learning:
- evaluation needs to be as simple as possible. Individuals giving great verbal feedback and a positive change in their behaviour can be observed, but this is not translating into written evaluation. Many of the participants struggled to concentrate by the end of the session or had to leave early as an hour was too much for them. Written evaluation, therefore, doesn't seem to capture the full picture;
- there was insufficient monitoring data due to inconsistent attendance by participants;
- much seems to depend on the attitudes of staff - often the success of projects is due to the particular interest of individuals, rather than job role. Some OTs were very keen on GSP, some don't see it as something they can fit into their workload;
- co-design of sessions helps build understanding, trust and relationships and ensures suitability of activity at Level 4.

Summary/areas for further learning:
- commissioning and funding opportunities need exploring with the NHS for this sort of intensity (level) of work to become sustainable. Work should be framed in the context of the financial and monitoring demands of the Trust;
- further work to consider progression of participants through to community activity;
- evaluation tools developed with service users could be investigated.

Green provider: Elephant Rooms CIC

Project outline: Elephant Rooms is a social enterprise, in the heart of Draycott near Derby that provides a diverse range of natural holistic health and well-being therapies, classes and workshops. The aim was to engage with the social prescribing, community wellness networks and green providers in Erewash and test the GSP referral pathway in a live project.

Elephant Rooms was asked to provide GreenSPring with first-hand insight into navigating the social prescribing and public health system by acting as a single point of access for those seeking to refer service users into GSP activity throughout Erewash. By taking referrals for individuals interested in engaging with green activity and conducting a simple assessment to decide where best to place the individual, the aim was to understand if this resulted in increased referrals to green providers. Where green interventions were unsuitable or unavailable, the individual could be referred back to the original referral agency and the action recorded. Elephant Rooms also continued to help develop the network of green providers in and around Erewash, encourage green providers to link in with their local Community Wellness Network.

Initial rationale for testing (linked to Theory of Change):

- non-existent and/or inappropriate referral to GSP.

Related elements (of the ToC):

- there is an insufficiency of green providers;
- the network of providers, link workers, referrers and funders is fractured and dispersed;
- there is a lack of mutual understanding and awareness of different parts of the system and how they operate.

Summary of outcomes:

- mapping and partnership building work undertaken to understand provision in the area received a positive response from green providers;
- referrals were still made directly to green providers, rather than via this single point of contact but these were very few within the timescale io the test and learn;
- mapping and connections attempted with possible referrer agencies, but difficult to identify all relevant services and to obtain responses;
- the testing provoked concern from the local infrastructure organisation about overlapping remit;
- the lack of referrals within the allotted time of four months meant that full evaluation of the approach was not possible;
- there was some initial concern from the LIO regarding overlap, prior to significant discussion with Elephant Rooms of aims and explanation of how referrals would operate. However, communication with the LG indicated some initial consternation and resistance from the LIO.

Learning:

- the resulting lack of referrals could indicate a lack of understanding of the available green providers and what they are offering or a poor understanding of the benefits of green provision;
- working with the LIO to enhance the referral pathway is vital;
- identification of which referral agencies are likely to need the services of green providers is critical;
- promoting the understanding of green provider services, the benefits and how to access them is important.

Summary/areas for further learning:

- further work is required for health system stakeholders to understand the breadth of provision and diversity within the VCSE in Derbyshire, in order for mutual trust and good relationships to be established (including within the VCSE sector); Elephant Rooms subsequently became the lead provider in the south/east, Personalisation-funded provider collaborative model, in particular, to pursue the development of this model;
- there is a need for green providers to understand the constraints and priorities of the referral services;
- it is important to encourage referrers to visit green provider facilities to understand the nature of the services;
- the range and causes of the barriers to referrals warrant continued investigation and discussion.

Green provider: Green Thyme CIC and Derby West Indian Community Association

Project outline: For an established green provider to provide support for a community group representing ethnic minorities who are interested in setting up a GSP activity. For the ethnic minority community group to train the green provider in what would make a culturally appropriate green activity.

Initial rationale for testing (linked to Theory of Change):

- users are not actively engaged in GSP processes.

Related elements (of the ToC):

- the network of providers, link workers. referrers and funders is fractured and dispersed.

Summary of outcomes:

- the two ethnic minority community groups who engaged did not appreciate how much time and effort it takes to create and maintain a safe productive allotment/space for delivering GSP. Although both community groups approached already had allotment sites and requested support, the first group withdrew from the project because they did not have anyone from the community who wanted to lead the project. The second group did not have a regular time for carrying out allotment work, it being referred to as '*ad hoc*';
- it was reported that ethnic minority community groups want activities for the community by the community but may not have the resources to implement this;
- upkeep of outside green activities is challenging in the winter but using nature-based crafts linked to the allotment, like making clay plant markers, is a good way of keeping people connected with nature indoors;
- cultural appropriateness training was not delivered for two reasons. The initial ethnic minority group pulled out of the testing, and the second group were from the same ethnic minority community as the green provider.

Learning:

- although the test parameters were clear in the agreement and clarified in emails as well as conversations, the green provider did not collect all the data requested and the final report did not reflect the testing requirements;
- the provider felt the sessions at DWICA were seen less as wellbeing opportunities for the children, more as an opportunity for free childcare;
- ownership of the site of delivery is important to the ethnic minority community groups;
- both the ethnic minority community groups were primarily focused on food growing for their green activity and were not aware of the health and wellbeing benefits of 'green'.

Summary/areas for further learning:

- there appears to be a need for capacity building within ethnic minority community groups. Could this be done by building better relationships and using the skills already available in the wider VCSE sector?;
- increased information sharing amongst ethnic minority communities about the benefits of ‘green and blue’ provision for health and wellbeing.

Green provider: Green Thyme and DHCFT, Psychiatric forensic outpatients

Project outline: An established green provider will deliver sessions with an NHS outpatient Occupational Therapist led allotment session, with the intention of network building to be able to signpost out of the NHS sessions into the community (linked to DWT testing at Kingsway, intended to be a further potential progression route for participants, ie an onward connection to community NBA).

Wellbeing measures used: The provider was asked to collect quantitative data, but they decided instead to use qualitative data collection, having conversations with the participants. This was in part because they were guests of an already established group, which already has its own procedures in place. The occupational therapist who runs the sessions was asked for more information but did not supply the requested data.

Initial rationale for testing (linked to Theory of Change):

- there is a lack of mutual understanding and awareness of different parts of the system and how they operate.

Related elements (of the ToC):

- the network of providers, link workers, referrers and funders is fractured and dispersed.

Summary of outcomes:

- beneficiaries of the allotment were also encouraged to attend NHS-led walking groups. No information was provided (it was requested) to suggest that there is any referral out of NHS provision to community-based provision;
- having a discrete project to work on gave the beneficiaries clear objectives and goals, this was valued by participants, who stated that it made them feel more positive about the project and that they felt listened to and part of the process. The participants had not had the opportunity to co-produce a project before;
- one participant had attended a community allotment group before their hospital admission, but since discharge they have attended the NHS one instead.

Learning:

- the green provider felt that it took time to gain the confidence of the allotment beneficiaries;
- the beneficiaries of the allotment are referred there after being discharged from a forensic psychiatric hospital. It is part of their recovery process, and the beneficiaries state that they knew that if they could motivate themselves to get there (the allotment), they would feel better.

Summary/areas for further learning:

- in this instance, the NHS has clear referral routes for supporting people out of the hospital into NHS supported activities. Further investigation could focus on what it would take to create the trust needed to refer outward again from the NHS led sessions into community-based ones, with open communication for the opportunity for ongoing support;
- could this kind of support be rolled out for other long-term conditions?

Green provider: Grow Outside CIC, Amber Valley

Project outline: Grow Outside was commissioned to provide a period (over six months) of on-going community gardening sessions to test whether a long-term offer increases the number of referrals, participant take up and participant retention. Amber Valley referral agencies actively contacted regularly to encourage referrals.

Maximum number of participants: 14 per session
Number of attendees: 24
Number of referrals: 27 in total. Self-referrals (11), DCC Health and Wellbeing Coaches (4), SPLW (2), health and wellbeing coaches (5), job centre event attended by the facilitator (2), following a Futures Housing community volunteering day (1).
Wellbeing measures used: UCL wellbeing umbrellas

Initial rationale for testing (linked to Theory of Change):

- green providers are funded piecemeal and unsustainably resulting in sector fragility and competition.

Related elements (of the ToC):

- non-existent and/or inappropriate referral to GSP;
- there is a lack of mutual understanding and awareness of different parts of the system and how they operate;
- high user drop out of the GSP system at multiple points in the pathway.

Summary of outcomes:

- received positive feedback from participants, about looking forward to sessions all week;
- those that did attend enjoyed it and showed improved wellbeing scores but generating referrals was difficult, with limited referrals from SPLW routes;
- communicating with referral agencies took a lot of time and effort. Referral agencies were invited to come and visit, which some did, but some were unable to leave their bases;
- initial interest from referral agencies when first discover the provision and garden that then seemed to dissipate;
- significant turnover of users/volunteers throughout the six months, although some attendees did continue to consistently attend the provision.

Learning:

- observing the sessions highlighted the skills, empathy, adaptability needed to use the outside space to help nurture people. A lot happens that is unseen by referrers and the system – we need to understand and report this further, to help people understand the value of specially designed wellbeing-based sessions;

- ongoing sessions are not yet resulting in long term attendance; participants come along for a few weeks, seem to enjoy themselves and being part of the community, a group bonds, but then participants fall away and the whole cycle starts again;
- long term offer of GSP hasn't significantly increased referral numbers, especially from SPLWs;
- GreenSPring project team members presented to Amber Valley's Place Alliance, with positive reactions. Interestingly, GPs attending commented they were unsure how to use social prescribing resources properly. There was a recognition that the SP system is not as effective as it could be.

Summary/areas for further learning:

- understanding how to encourage more referrals – speaking the language of referral agencies so they can understand the benefits – e.g. framing activities using the five ways to wellbeing;
- buddying pilot- this was explored but very difficult to source volunteers, this is an area to explore further and put specific focus on. Local OTs identified several service users who would benefit from a buddy to attend sessions with. Having a buddy would support participant to attend, feedback from social prescribers consistently shows that they lack capacity to address this significant barrier;
- service user perspective and voice are needed to more fully understand their journey and reasons they attend or stop attending;
- the range and causes of the barriers to referrals warrant continued investigation and discussion.

High Peak (general)

Project outline: Information gathering from various organisations about access to green provision across the High Peak area. Organisations spoken to included:

- Townend Community Garden
- Peak District National Park
- Shift Together
- The Bureau
- High Peak CVS Social Prescribing Link Worker team
- Buxton Civic Society

Initial rationale for testing (linked to Theory of Change):

- there is an insufficiency of appropriate green providers *(reported by SPLW in HP - waiting lists/limited available places are reported).*

Related elements (of the ToC):

- the network of providers, link workers, referrers and funders is fractured and dispersed.

Summary of outcomes:

- due to the geography of the High Peak District, communities are dispersed and distant from each other with their own strong identities. It can be very difficult for participants to travel between projects and locations, and often they do not wish to leave their own communities;
- green provision in the High Peak needs to be place-based and designed to suit each community and its individual identity. What may work in one community may not work in another;
- the Nature Prescriptions pilot from RSPB and PDNP may provide resources (if continued) to enable participants from across the district to access some shared nature-based provision by using their own gardens and local green spaces. This pilot is yet to be completed and evaluated.

Learning:

- the geography and lack of transport in rural areas is a barrier to accessing green provision. It cannot be assumed that living in an area close to natural spaces guarantees accessibility;
- provision within such a rural district with widely dispersed communities needs to be place-based and designed to suit the community in which it sits.

Summary/areas for further learning:

- strong sense of place for individuals, may prevent travel across even local borders. Transport, as with Derbyshire Dales testing, is an issue but masks other interconnected barriers;

- there might be issues with perception and access to resources such as the PDNP, when not all potential participants have the social capital required to access nature independently.

Green provider: Hunloke Community Garden

Project outline: Hunloke Community Garden is a registered charity, run by a small group of volunteers with a board. Many of the people who are on the board are founders of the project which was a Millennium commission funded project. To understand the appropriateness of and appetite for GSP at the Garden, a project worker from GreenSPring worked alongside the charity volunteers to develop pathways of referral for 'GSP' as a 'Level 2a' provider. The aim was to explore what information and support individuals referred might need by following the journey of new volunteers within the project, if the charity considered themselves 'providers' of GSP activity and looking at new ideas – or revisiting past practices – to support sustainability of within the project, if formal referrals were desired by the Charity.

Maximum number of participants: na (volunteers sought)
Number of attendees: ten in total
Number of referrals: 14. Self-referral (2), SPLWs (6), Health and Wellbeing Coaches (2), Volunteer Centre (1), CMHT OTs (2), Youth Hub (1).
Wellbeing measures used: N/A

Initial rationale for testing (linked to Theory of Change):

- non-existent and/or inappropriate referral to GSP (referrals defined as volunteers at this site/level, not participants accessing a service).

Related elements (of the ToC):

- there is an insufficiency of appropriate green providers;
- the network of providers, link workers, referrers and funders is fractured and dispersed;
- there is a lack of mutual understanding and awareness of different parts of the system and how they operate.

Summary of outcomes:

- the profile of the garden has been raised locally both with the public and referral services. A range of referral and support agencies have visited the garden are hoping to work more collaboratively with them, including: SPLW, Volunteer Centre, community development workers, and OTs;
- the project has refreshed and reviewed policies with support from the Volunteer Centre, including introducing a volunteer registration form, enabling the project to liaise with the volunteer/participant and the referrer from the beginning in a more relaxed, assured way;
- there were 14 volunteers introduced via referral between August and December 2022. The direct communication channels between PCN-based SPLW and the project has enabled a more personalised approach with people and the possibility to follow up if they have not attended;
- personal stories from some of the volunteers show the benefits of being part of Hunloke Community Garden and the positive impact it has had on their health and wellbeing;

- retention of volunteers is an issue- only 3 of the volunteers introduced during Aug -Dec have continued to attend, their reasons for no longer attending were varied.

Learning:

- the need for continued support, funding and marketing for projects like this to continue and grow does not seem to be appreciated or understood. A discussion with a local councillor, supporting the development of a new community garden on the next street, highlighted a lack of awareness of the support Hunloke requires to continue, because it's seen as an existing community facility;
- it is imperative to work with those on the ground who feel most ownership for the space/delivery, in terms of development and change. The current small team of volunteers are very passionate about their project and it was important to work with them closely with all ideas;
- the need for specific wellbeing/support structures to enable the project to meet client needs adequately;
- need for funding and paid coordination to achieve full potential for the use of the space for wellbeing. Many partners who visited the project had ideas where new projects could work with Hunloke, e.g. Active Derbyshire, DVA Feeling Connected project, DVA project with Derby University. However, they all required someone to lead this from within Hunloke project without funding or support, and Hunloke does not have the capacity, or possibly the desire, to do this.

Summary/areas for further learning:

- there are opportunities for a variety of volunteer roles within the project to support the project lead who currently does all the tasks. They plan to contact the Volunteer Centre for support with this idea and also for support with funding applications;
- still unclear if Hunloke see themselves as a formal 'service' provider of green activities;
- this project shows the need for clear aims and objectives within a community organisations and that those are aligned to the promotion of any potential 'service';
- the range and causes of the barriers to referrals warrant continued investigation and discussion.

Green provider(s): North Wingfield Community Garden and Kenning Park Community Forest School

Project outline: Testing models of public greenspace use by green providers.
North Wingfield Community Garden shared their experience of using Parish Council land for their community gardening project. Kenning Park Forest School piloted an 11-week programme of green wellbeing activities within Kenning Park, a Parish Council owned park in Clay Cross, which is managed by Kenning Park Community Group.

Number of attendees: 15 in total
Number of referrals: 15, were self-referral(10), SPLWs (3), GP (1), and DCC (1)
Wellbeing measures used: N/A

Initial rationale for testing (linked to Theory of Change):

- there is an insufficiency of appropriate green providers.

Related elements (of the ToC):

- non-existent and/or inappropriate referral to GSP.

Summary of outcomes:

- the land accessed via both Parish Councils was fit for purpose;
- local management of the land allows for good flexibility and adaptations, e.g. easy to change dates and times of sessions. This is especially true where the green provider is given responsibility for a space, e.g. the North Wingfield Community Garden and the Forest School area in Kenning Park;
- Kenning Park Forest School benefitted from extra support from North East Derbyshire District Council. The use of public space for wellbeing fitted well with the Council's own agenda;
- the above use of Parish Council land enabled the development of new green provision in the area;
- despite the suitability, familiarity and accessibility of both green spaces, referrals from professional organisations were few.

Learning:

- public green spaces that are locally managed can provide accessible, welcoming, affordable venues for green providers to facilitate activities within communities – bringing green activity into the heart of communities;
- using known community spaces might support participants' attendance at green provision.

Summary/areas for further learning:

- the Kenning Park sessions were particularly well attended. There is scope for further investigation into the reasons for this. For example, might the use of a known local park to support a participant's attendance (already a familiar, trusted place), likewise the facilitator being a familiar face in the locality? Did endorsement from North East Derbyshire District Council, which might be seen as a trusted organisation, give the session credibility?;
- despite enthusiasm and interest from local organisations, referrals to both projects were limited. The range and causes of the barriers to referrals warrant continued investigation and discussion.

Referral routes testing
Green provider(s): Grow Outside CIC, Rosliston Forestry Centre, Derbyshire Wildlife Trust

Project outline: All three organisations were commissioned to run a six-week programme of activities within locations across Derbyshire to test local referral routes into green provision. Grow Outside CIC ran a pilot in High Peak, Rosliston Forestry Centre planned to deliver in South Derbyshire, and Derbyshire Wildlife Trust planned to deliver in Derby City. All organisations promoted the sessions to referral organisations within their geographical boundary.

Maximum number of participants: 12
Number of attendees: eight in total
Wellbeing measures used: UCL Wellbeing Umbrellas

Initial rationale for testing (linked to Theory of Change):

- non-existent and/or inappropriate referral to GSP.

Related elements (of the ToC):

- there is an insufficiency of appropriate green providers;
- the network of providers, link workers, referrers and funders is fractured and dispersed;
- there is a lack of mutual understanding and awareness of different parts of the system and how they operate.

Summary of outcomes:

- neither Rosliston Forestry Centre nor Derbyshire Wildlife Trust received any referrals, so their pilot programmes did not run;
- referrals to the High Peak project were made by New Mills Volunteer Centre, RemediUK and Zinc CIC. A further self-referral was made via Youth Matters on Facebook;
- referrers did not provide information on participants' background/suitability, so it was not possible to risk-assess participants prior to attendance or assess suitability. None of the referrers asked if there was a referral form or formal process. Participants' personal information was gathered by the delivery organisation, but it is unclear with whom this responsibility sits;
- no referrers asked for risk assessment, public liability insurance details, skills/experience in delivery, etc.;
- only one referrer followed up to find out about attendance;
- only one referring partner used secure transfer of personal data and accompanied the individual to the first session;
- one potential referrer enquired whether support to attend would be provided by the delivery organisation;
- participants were referred on the basis that the programme was for adult mental wellbeing but participants had a complex range of physical, mental and social/personal issues, common in these types of interventions;

- all participants had a positive response to all sessions and activities, and many requested (and even anticipated) a repeat or longer version of the programme.

Learning:

- many green providers and community mental health support workers report repeat attendees seeking this sort of activity and 'cycling' through community groups; providers often go to great lengths to make different programmes available to the same people to avoid facing a 'cliff-edge' when short-term funding and, therefore, support ends;
- transport is often cited as a barrier to attendance, however, even though transport was provided for this programme, the effort required (early start, travelling into a different locality) was sometimes too great and participants declined the transport offer and chose not to attend. Having a buddy or someone to accompany the participant could potentially help with this. The minibus collecting individuals did make a difference to attendance for some participants;
- there is evidence of unidentified barriers to referral into green provision across the county;
- there is a lack of a formal referral process between referral organisations and green providers.

Key recommendations/ areas for further learning:

- further learning about referral agencies' approaches, processes, responsibilities and expectations is required;
- it could be beneficial to create clear guidance that could be universally used across the county to bridge the gap between referrer and green provider. For example, development of a referral form gathering necessary participant information, clear guidance on who is expected to provide support for participants, and what level this support needs to be etc.;
- the range and causes of the barriers to referrals warrant continued investigation and discussion.

Green provider: South Derbyshire District Council's Environmental Education Programme

Project outline:

1. Analysing participation in South Derbyshire's Free Tree scheme to assess why people engage with the programme, what supports them to get involved or what barriers prevent participation.
2. Gathering insight from local referrers as to any barriers preventing their clients from participating. Using learning to gather ideas that could inform co-production opportunities in the future.

Number of respondents: 374

Initial rationale for testing (linked to Theory of Change):

- users are not actively engaged in GSP processes/inequalities in access to nature.

Related elements (of the ToC):

- the network of providers, link workers, referrers and funders is fractured and dispersed;
- non-existent and/or inappropriate referral to GSP.

Summary of outcomes:

- the results of the questionnaire used with this project suggest the participants already engaging with the free tree scheme are largely already connected with nature. However, this could be bias; those already connected to nature wishing to positively contribute to a nature study by replying to the questionnaire;
- those engaging with the free tree scheme showed increased levels of wellbeing and are aware that engaging with nature is good for their health;
- conversations with local Health and Wellbeing Coaches suggest that they are looking to set up specific groups for their clients, rather than referring to existing provision (such as that listed in the 'Get Active in The Forest' brochure). However, they have no budget to do this;
- barriers to making referrals for Health and Wellbeing Coaches include lack of knowledge about what is available locally (despite the Get Active in The Forest resource), differing remits between Health and Wellbeing Coaches based at different surgeries and changes in staff;
- feedback from the Practice Manager at Swadlincote Surgery regarding prescription costs/ free prescriptions:
- GSP/SP is usually free to the patient but doesn't always have to be provided free. For sessions which need to be paid for, there is a possibility that in some cases the patient will pay. In cases where the NHS will pay (to fund physical health interventions, e.g. funded through PH programmes such as Live Life Better Derbyshire), patients can be given/emailed a code to be given to the provider. The provider can then invoice, e.g. for a six-week course such as weight loss. Unclear from this and the whole programme

whether the appetite for sustainable investment will extend to green health and wellbeing activities;
- Quality Outcomes Framework – there is a process for prescribing GSP would be expected to come through to the surgery via that pathway;
- links between the surgery, Integrated Care Board (ICB), Primary Care Network and GSP (pilot) are not clear at surgery level;
- health professionals consulted are open to joint working but were previously unaware of GreenSPring and the GSP. This suggests lack of awareness is still a major barrier (this was the second round of testing in South Derbyshire, the first aimed specifically at raising the profile of GSP and green providers – see Whispering Trees' report (SD));
- the perennial problem of funding remains. Seeking to refer clients to become 'volunteers' still incurs costs to the provider.

Learning:
- lack of awareness (and relationships) remains a major barrier to GSP; and
- there are systems within surgeries to pay for prescriptions e.g. weight loss sessions, which could in theory be used to pay for green activities.

Summary/areas for further learning:
- further work is required to find the best ways to increase awareness about GSP and what provision is available locally;
- work is required to identify (and discuss) barriers to participation and how to engage those not already connected with nature;
- additional work is required to understand prescribing systems and flow of funding with patients, and how surgeries could include green provision in their prescription offer;
- this project has acted as a catalyst to spark initial conversations between green providers and local health organisations. Could this work and continued relationship building result in increased referral numbers across the breadth of local green provision, or lead to new opportunities for co-production?

Green provider: Spiral Arts, Derby City

Project outline:
Spiral Arts ran nature-based arts sessions based in Derby Arboretum. They were advertised through a range of local and community routes. A particular aim was that people would be encouraged to get involved by volunteering with the friends of Derby Arboretum community garden after the craft sessions are finished.
This tested referral pathways including Living Well Derby (now Derby Wellbeing), and the effectiveness of engaging people with indoor based activities throughout the autumn and winter months. Spiral Arts emphasised the sessions as 'nature-based' and avoided the label of 'wellbeing' in case this put anyone off.

Maximum number of participants: ten per session

Number of attendees: 15, but not all in the same session, and seven people only attended once (four self-referrals, six friends and family referrals, five VCSE organisation referrals, zero social prescriber referrals) *Note: Although the client did not turn up to the activity, the social prescriber who was supporting them did and stayed for the whole session. Three trainee social prescribers also attended one session as part of their induction (with prior agreement). None of the social prescribers were recorded in the figures for the purpose of this project.*

Number of referrals: 19 in total, nine from referral agencies, nine self-referrals/friends and family, one from social prescriber. NOTE: These figures are not an accurate picture. Informal post-project feedback from SPLWs to the provider was that they had made referrals but relied on the clients to contact Spiral Arts themselves. This resulted in clients who did enquire about the project being recorded as self-referrals, or else they did not contact Spiral Arts. We have no way of knowing due to GDPR.

Cost: Spiral Arts estimate that it costs them £250 to run a session. This cost covers staffing, rent, heating, insurance, materials, advertising, time spent planning, risk-assessing, delivering and evaluating. It does not include time spent promoting and attending Living Well and other relevant VCSE meetings and keeping up to date with the sector trends and funding opportunities to carry on with the work in a professional manner.

Wellbeing measures used: The provider did attempt to record quantitative data in the form of a scored wellbeing questionnaire. Unfortunately, because the attendees of the sessions varied from week to week, and because only one participant attended every session, there was not enough data to produce meaningful results. Note: See 'Evaluation summary' for more insight into the overall evaluation process for all tests.

Initial rationale for testing (linked to Theory of Change):

- the network of providers, link workers, referrers and funders is fractured and dispersed.

Related elements (of the ToC):

- non-existent and/or inappropriate referral to GSP;
- high user drop out of the GSP system at multiple points in the pathway.

Summary of outcomes:

- it was difficult to establish contact with the key SPLWs and main health contacts for referrals, and navigate the health websites for contact information;
- slow progress to engage meaningfully with the Living Well team;
- low numbers/limited SP referrals - new link workers attended a session as part of their induction but did not bring clients along with them;
- sessions ran successfully, with participants (mainly from Spiral Arts usual channels), who enjoyed and valued the sessions, supporting the premise that nature-based activity can successfully take place in any season;
- participants were interested in returning for more craft activities but did not show an interest in joining the gardening session at the same location.

Learning:

- links to SP teams and Living Well take time and energy to build relationships, understanding and trust;
- it is difficult to map the journey of participants without a shared formal process in place. This makes it difficult to identify barriers to participation or learn why some referrals fail;
- participants selected which sessions to attend according to the activity on offer. They did not appear committed to attending the sessions for wellbeing's sake. The data collected for the national evaluation supports this. Only one of the participants had mild to moderate mental health needs, with the others recorded as ‘no mental health needs’. SPLW feedback indicated that the needs of patients referred into social prescribing could not be met by a community-based wellbeing activity, e.g. housing, financial needs were more pressing.

Summary/areas for further learning:

- taster sessions for SPLWs and other health staff may increase understanding and trust;
- further exploration with health providers such as living well and SPLWs as to what the barriers to making referrals to GSP provision are; what is needed, what would help?;
- having a process in place to follow a client’s journey and provide support where necessary may help to generate more successful referral outcomes;
- at the start of this project, the decision was made by the provider not to use terms like wellbeing to advertise it, as they believe that puts people off. This is a comment that has been reflected by other people interviewed over the two years of the test and learn pilot. Is this assumption true? Did not labelling it as a wellbeing activity put social prescribers

off from referring into it? More work is required to understand how discuss GSP activities to attract appropriate clients and to give confidence to the referrers;

- the range and causes of the barriers to referrals warrant continued investigation and discussion.

Green provider: Wellies CIC and Wild Roots Creative CIC

Project outline: Two programmes of six green activity sessions, provided in two venues, testing different modes of transport. One programme delivered from Wellies CIC using the organisation's minibus to pick up participants from Ashbourne town centre. A second programme delivered by Wild Roots CIC at the Whitworth Centre in Darley Dale, to test feasibility of relying on public bus service and/or community transport to access provision, both of which serve this venue.
In both sites, private transport options were offered, and taken up, to encourage subsequent public transport options.

Number of attendees: Wellies: six
Number of referrals: Wellies: 11
Actual cost per day for Wellies: (included here because this differs from funded day rate of £325)

2 staff @ £25 per hour x 6 hours = £300	Venue hire £150
2 hours admin @ £14 = £28	Food and materials £100
1 hour project management @ £30	Contribution to central
Minibus costs £100	overheads/contingency £100

Total £808

Wellbeing measures used: Both providers attempted to use UCL Wellbeing Umbrellas

Initial rationale for testing (linked to Theory of Change):

- there is an insufficiency of appropriate green providers *[Feedback from SPLWs and referrers in the Derbyshire Dales was that (due to rurality and dispersed populations in this district), insufficient green provision is available to make effective referrals].*

Related elements (of the ToC):

- non-existent and/or inappropriate referral to GSP
- high user drop out of the GSP system at multiple points in the pathway.

Summary of outcomes:

- use of community transport was not feasible. Barriers to using community transport included:
    - unavailable at the times required and unable to provide any flexibility (school runs taking up a large portion of their availability). Some services only run on set days
    - not possible to travel across geographical boundaries between community transport providers
    - one participant felt uncomfortable being seen to use community transport – 'felt stigmatised'

    - if the journey is not part of an existing subsidised community transport contract, the cost is prohibitive for individuals
    - where community transport does exist in this area and is free of charge for those with a gold card (£2.50 fare otherwise), its reliability in terms of regular transportation and the restricted area covered means this is not, currently, a transport solution;
- even when available, participants did not wish to use public bus transport. Barriers included:
    - all participants had high anxiety when asked to use public transport. This was due to number of people on the bus, reliability, waiting times
    - the length of journey times and level of comfort
    - limited independence and flexibility, e.g. not being able to leave sessions and travel at any time to suit the participant
    - taxi transport was most successful, as it allowed for flexibility and reduced user anxiety, travelling door to door
    - some participants felt they may be able to use public transport once their confidence increased and they felt comfortable with the setting. The programme finished before this progression could be tested;
- the cost of taxi transport would be prohibitive to individuals, and was successful due to transport funding through the GreenSPring project;
- the WELLIES project minibus was successful in transporting individuals from Ashbourne to their rural location. However, transport to Ashbourne was problematic, with some requiring a taxi for the first part of the journey.

Learning:

- siting green activities within easy reach of public and/or community transport does not provide a quick solution to enable access for all participants;
- many participants are facing other complex barriers preventing them from attending activities, not just lack of transport availability;
- the current public and community transport schemes tested do not provide sufficient services to be a viable alternative to taxi or own transport.

Summary/areas for further learning:

- the assumption that transport is a standalone issue that, if resolved, would lead to effective referrals is a distraction from the complexity surrounding a lack of referrals;
- further research into transport provision is required;
- a possible area for further learning would be to assess the feasibility of collaboration between green provider and community transport to co-design a solution to enable participants to access provision;
- the range and causes of the barriers to referrals warrant continued investigation and discussion.

Green provider: Whispering Trees CIC, South Derbyshire

Project outline: Whispering Trees provided GreenSPring with first-hand insight into navigating the public sector, VCSE, and health (e.g. local health partnership/Place Alliance) and social prescribing system as a provider of GSP activity, through the design, promotion and delivery of a curated “Care to connect” six-week programme.

Maximum number of participants: ten
Number of attendees: seven
Number of referrals: seven: five of these were self-referral and two from SPLW in Erewash Voluntary Action, taster session also agreed for six P3 service users.
Wellbeing measures used? None used

Initial rationale for testing (linked to Theory of Change):

- green providers are funded piecemeal and unsustainably resulting in sector fragility and competition.

Related elements (of the ToC):

- the network of providers, link workers, referrers and funders is fractured and dispersed;
- organisational structures (e.g. policy, objectives, governance, record keeping) are not aligned;
- there is a lack of mutual understanding and awareness of different parts of the system and how they operate;
- non-existent and/or inappropriate referral to GSP.

Summary of outcomes:

- large amount of energy and resource went into building positive connections with services, agencies and SPLWs (from Erewash and Derby City) but very few referrals received;
- the social prescribing system in South Derbyshire is not set up or functioning properly;
- the group programme went ahead and was very well received by participants who came via historical self-referral; with positive peer support growing and a positive difference in behaviour and wellbeing.

Learning:

- social prescribing system not fully operational in South Derbyshire which results in a fragmented and complex system that is hard to access and navigate. This has led to Whispering Trees looking to wider networks and geography for referrals;
- the continued need to follow up initial connections is very time and energy consuming when busy with other projects;
- referral agencies seem to be at capacity dealing with complex and crisis cases, they do not have the time or capacity for preventative work. This results in very little follow up on green activities which are seen as ‘nice to have’ rather than ‘need to have’;

- the local system is perceived to be a closed shop, hard to get into and then navigate.

Summary/areas for further learning:

- Whispering Trees continue to market themselves and the opportunity for GSP – and have had some contact with social workers who are looking for sessions funded through a personal budget – as yet this has not materialised, but this could be a good way of sustainably delivering their services;
- the range and causes of the barriers to referrals warrant continued investigation and discussion.

Test and Learn project summary – Learning from lived experience

Project outline: Gathering learning and insights from those seeking solutions to overcome barriers to accessing nature. Feedback was gathered from individuals who have overcome barriers themselves and organisations who support individuals to access nature.

Initial rationale for testing (linked to Theory of Change):

- users are not actively engaged in GSP processes.

Related elements (of the ToC):

- non-existent and/or inappropriate referral to GSP;
- high user drop out of the GSP system at multiple points in the pathway.

Summary of outcomes:

- this seems to be a pioneering area of work within Derbyshire. Several organisations are working to identify and overcome barriers to accessing green spaces, particularly for BAME communities. Organisations including Derbyshire Wildlife Trust, Derbyshire County Community Trust and Derbyshire BME Forum were approached to share their learning with GreenSPring. Initial insights have been shared, but the slow pace of working with communities means that projects are still in their infancy at the end of GreenSPring;
- Derbyshire BME Forum has a busy agenda focusing on access to health care. GreenSPring was originally added to one of their meeting agendas, but was then removed when more pressing issues needed to be addressed within the short time frame;
- we were able to gather some insights from engaged individuals. However, those who have engaged are those who are already connected to nature. We have been unable to engage with non-connected individuals within the timeframe;
- initial conversations gathering lived experience insights highlighted the following:
- a feeling of safety is vital for people to feel comfortable accessing nature. If they do not feel safe, they will not engage;
- cultural uses of green space can clash and cause a barrier. For instance, accessing a park where dogs could be off a lead is a big barrier. Some groups would ask for culturally specific requirements such as women only sessions;
- not being able to use greenspaces in a culturally appropriate way is a barrier, e.g. not being able to host gatherings around a BBQ in a public space;
- accessibility is a barrier. This could include transport to the site or access to the site itself, e.g. quality and accessibility of footpaths;
- accessing information about greenspace is a barrier. This includes finding out about where green space exists, how to access it, what activities can be done there, etc.

Learning:

- a wide variety of barriers need to be addressed and overcome to ensure nature is accessible to everyone;
- co-production with communities and green providers could provide a solution, but this requires time and investment in addition to that of the provision itself.

Summary/areas for further learning:

- further co-production work with trusted organisations already working within communities would be beneficial to reach those not already connected with nature. This could be done by co-produced interventions and local green space design that helps to overcome barriers, making nature more accessible.

Test and Learn project summary – buddying support to attend green wellbeing activities

Project outline: Consistent feedback from referrers and providers was that the lack of face-to-face support to attend a session is a barrier to participation, and the majority of SPLW do not have the capacity to do this. We proposed to test whether providing a ''buddy' volunteer' to accompany patients accessing Community Mental Health Team services (working with occupational therapists) to green wellbeing sessions would result in increased attendance.

Initial rationale for testing (linked to Theory of Change):

- high user drop out of the GSP system at multiple points in the pathway.

Related elements (of the ToC):

- non-existent and/or inappropriate referral to GSP.

Summary of outcomes:

- although co-production work to develop a new volunteer role took place, we were unable to source volunteers and match them to a suitable client requiring a 'buddy' during the time limit;
- Rethink Mental Illness' 'Derbyshire Recovery Peer Support Service' and Amber Valley CVS were approached to source a suitable volunteer but, due to their low volunteer numbers and limited capacity, this was not possible within the time available;
- initially, clients interested in green health activities in general were sought, but more detail on what (and where) was available was required before suitable participants could be identified;
- one match was made between client and provider during the testing period;
- a list of existing providers, running already funded sessions in Amber Valley (that were appropriate and willing to receive referrals) was shared with CMHT and client was identified;
- one volunteer was eventually identified (at the end of the testing period) through another green provider (this person was a participant themselves who expressed an interest in a 'buddying'/befriending role to the green provider);
- the volunteer was not able to sit within the Occupational Therapy team, and we were unable to identify and engage a voluntary organisation with suitable experience and knowledge to lead on this work.

  [N.B: there may be scope to host the volunteer within the green provision that a patient is interested in accessing. To date, the Physical Activity and Wellbeing Project Officer at Amber Valley Borough Council has been contacted to see if their project could support the 'buddy' volunteer identified. Contact details have been shared between this Project Officer and an OT in the CMHT.]

Learning:

- although a 'buddy' volunteer is frequently suggested as a solution to support attendance at community-based provision, it is not clear whose responsibility it is to host a volunteer;
- providing volunteer support requires infrastructure and investment. Hosting volunteers is not ‘free’ or without cost; they require support, coordination, and management. The volunteer would need to sit within an organisation that can provide appropriate levels of insurance, policies and procedures, and guidance and support.

Summary/areas for further learning:

- green provision must be consistently available to make such matches a possibility, and then deliver them to reach a positive outcome for both the client and 'buddy' volunteer;
- where is it best to host a 'buddy' volunteer? Each green provider could host their own 'buddy' volunteer, although this may result in challenges with inconsistency between different buddies, and would require investment;
- test further whether providing a 'buddy' to accompany service users to provision would increase attendance.

Project summary - Personal Health Budgets (PHBs)

Green provider: various

Project outline: To test the feasibility of using personal health budgets to fund green activities as part of a personalised care plan. Referrers were invited to submit expressions of interest with a patient case summary, to then be matched to a green activity. Referrers were then to test the ease and practicality of filling in relevant forms with the clients. The intention was to then test the PHB process for applicability.

Initial rationale for testing (linked to Theory of Change):

- green providers are funded piecemeal and unsustainably resulting in sector fragility and competition.

Related elements (of the ToC):

- organisational structures (e.g. policy, objectives, governance, record keeping) are not aligned;
- non-existent and/or inappropriate referral to GSP;
- users are not actively engaged in GSP processes.

Summary of outcomes:

- despite targeted promotion of the opportunity, number of referrals was low (three enquiries in total);
- multiple barriers were identified to using PHBs to fund green health activity; these included trust in providers and suitability of provision, concern for patient wellbeing in an uncertain process; timescales and priorities of stakeholders; the overall time taken to identify a suitable referral who the social prescriber was willing to refer and for them to be considered in the PHB application process;
- the paperwork necessary would have been difficult and not wholly relevant, in this scenario, for the referrer (support worker) to fill in with the client. There was also a requirement for the referrer or another responsible person to monitor progress.

Learning:

- clear timelines and dates for review boards need to be in place to build confidence and efficiency in the system, and to make sure that people being referred are aware of the time it may take before they get into an activity through the PHB route;
- the paperwork is complex, requiring information that even the beneficiaries of the PHB may not know themselves;
- there is a limited number of green providers who can receive spot payments to support clients;

- cost of activity is a barrier to access as is the existing funding environment (ie no funding for consistent or long-term provision), which prohibits suitable charging structures from being created.

Summary/areas for further learning:

- further work is required to establish why referral rates were so low;
- recommendation to seek ways to streamline bureaucratic processes in order to remove this as barrier applying for a PHB;
- for mental health purposes, those entitled to Section 117 aftercare are ideal candidates for this form of financial support, to access services to reduce the risk of returning to hospital. This process would be an ideal way of testing sustainable provision for such patient;
- short-term funding leads to short term projects. Referrers do not feel confident or that it is appropriate to refer into a project that is time limited.

Project summary - Quantitative data/wellbeing measures review

Green provider: various

Project outline: To ask all test and learn projects to collect and analyse quantitative data. To test the capability and willingness of providers to collect and analyse quantitative data. Full explanations and examples of quantitative data analysis for wellbeing were shared with the providers, as well as full support from the Greenspring team.

Wellbeing measures used: All test and learn providers were given the UCL museum wellbeing measures toolkit, which explains how, when and why to use wellbeing questionnaires and wellbeing umbrellas. They were encouraged to use the wellbeing umbrella if they did not feel confident that they used a suitable quantitative data collection method for wellbeing. All providers were asked at least monthly if they needed extra help. It was left up to the providers to determine whether they used the wellbeing umbrellas or another outcome measurement tool of their own choosing. The providers were also given a copy of a written report to use as a template for their own report, if desired. The example report used the wellbeing umbrella method and used simple descriptive statistics, demonstrating how the data could be analysed.

Rationale for test: It is argued that there is not enough robust quantitative evidence in support of GSP activities. Commissioners, funding bodies and statutory organisations often require providers to capture quantitative data as a condition of the grant/contract. Are providers able and willing to do this?

Summary of outcomes:

- five out of the nine providers asked to collect quantitative data did so;
- only two of the five providers that collected data analysed it in a meaningful way and presented the findings in their final report;
- one provider collected data using methods that they designed themselves, but only collected it for one session;
- one provider only collected the data after the first and sixth session;
- one provider chose to use a wellbeing questionnaire from the tool kit. Instructions were not followed correctly regarding when the questions could be used despite being pointed out by participants, suggesting that little importance was placed on the monitoring of the activity;
- in general, providers prefer to use qualitative methods and case studies to record progress of beneficiaries;
- providers did not ask for help carrying out the wellbeing evaluations even though it was offered regularly.

Learning:

- there is not one ‘catch all’ evaluation tool;

- it is more meaningful to use an evaluation tool that suits the organisations and their ability to analyse the data, simple tools can still be valuable;
- high quality qualitative data that produces meaningful insights versus poorer quality quantitative data that the providers do not know how to analyse;
- there is a belief amongst providers that commissioners do not use the data that providers collect for them on their behest. This makes providers feel it is a waste of their time collecting the type of data that commissioners want, and instead they prefer to gather data that helps themselves and helps them better improve their services, rather than second guessing what funders want and ending up with lots of data they can't use;
- different commissioners prefer different evaluation methods to be used. Some are more open to qualitative methods as evidence than others;
- health-related metrics may be used for monitoring purposes in relation to a legal framework, international guidance or benchmarking activities. Some funders also require/recommend the collection of certain metrics as part of their overall evaluation objectives;
- providers see collecting quantitative wellbeing data as intrusive to the sessions and counterproductive to the therapeutic nature of the sessions they are delivering;
- beneficiaries resented having to spend time filling out forms pre and post activity, this led to people not listening to the instructions, rushing to fill in the forms and answering the wellbeing scale in reverse (1 being circled for ‘all of the time’ instead of 5, and vice versa);
- providers commented that individuals' journeys for their mental health and wellbeing is not a linear process and as such cannot be measured accurately with short term quantitative data methods (their intervention does not have a ‘standalone’ impact on a person’s mental health).

Summary/areas for further learning:
There are already papers and guides for supporting organisations to collect and analyse data appropriate to health and wellbeing. Most of the green providers participating in this project demonstrated that they did not have the skills or motivation to carry out rigorous monitoring for evaluation. Providers, especially smaller providers, often deliver activities which either only just break even, are run by volunteers, or that they are not able to recover full costs for, so it is unlikely that without financial support providers are unlikely to have the time required to participate in training and research to upskill in this area. Mandating organisations to collect quantitative data as a requirement of funding at best creates a barrier to smaller providers accessing the funds, at work it results in spurious data. Providers reported that the amount of time it would take to collect and analyse the data requested by some funders prevented them from applying for the funding; the alternative is to carry out the work in their spare time and at their own cost.

- The purpose of the data collection needs to be made clear to the provider, so they understand the reason for it and how it will be used.

- Different commissioners like different evaluation tools, some are more open to qualitative case studies than others. It would be helpful to discuss with commissioners what their expectations are before the project commences so that suitable evaluation methods can be built in from the start.
- Social prescribers use various methods to collect wellbeing scores, would it be useful to develop a universally acknowledged method that can be used by social prescribers and providers as well?
- Better information sharing between funders/commissioners and providers would help to build trust, so that providers know why and how the data they have collected is used.
- If commissioners and funders ask for a particular type of data collection method, it would be in their best interest to have a compulsory workshop for the providers to attend to make sure that they have a full understanding and the skills to carry it out.
- If the data collected is expected to be presented in reports, a spreadsheet template with formula already in place to calculate the required outcomes would be useful to ensure standardisation.

Project summary – GSP training delivered for Derbyshire-wide Social Prescribers.

As with all GreenSPring pilot activity, here the term 'Social Prescriber' is used in its broadest sense to include any individual who might refer in to green activity.

Project outline: Sheffield and Rotherham Wildlife Trust was commissioned to deliver a training workshop for 'social prescribers' representing geographical areas across Derbyshire and Derby City, from as many referral agencies as possible. During the workshop participants were introduced to the concept of GSP and were asked to identify barriers and solutions to referring in to green provision.

Maximum number of participants: 20
Number of attendees: 18

Initial rationale for testing (linked to Theory of Change):

- there is a lack of mutual understanding and awareness of different parts of the system and how they operate.

Related elements (of the ToC):

- non-existent and/or inappropriate referral to GSP.

Summary of outcomes:

- a range of referral agencies attended the training including Social Prescribing Link Workers, Occupational Therapists, Living Well Wellbeing Coach and Peer Workers based at Rethink, Derbyshire Federation for Mental Health, New Mills Volunteer Centre and P3;
- participants' prior knowledge and experience of green provision was wide-ranging, with one participant previously being unfamiliar with the term GSP and unaware of the benefits of nature on mental wellbeing. We anticipated that attendees would already be familiar with GSP, and able to start identifying barriers to referral straight away, but this was not the case;
- the main barriers to referral highlighted were transport, lack of awareness of activities taking place and poor understanding of green provision.

Learning:

- the knowledge, awareness and desire to engage with green provision varies widely across individual providers;
- the providers each have their own systems and processes which also vary across teams;
- transport is seen as a key barrier to referral;
- lack of awareness and understanding of green provision is a key barrier to referral.

Summary/areas for further learning:

- further work is required to embed ‘green’ within the existing social prescribing system. It is currently seen as an addition that is ‘nice to have’ for those with an interest, but access to green health activities should be available and accessible to all;
- had time allowed, the project team had intended to talk to the social prescribers about other barriers, including personal ones resulting from a lack of trust and confidence in provision (something that was described as a concern early in the project);
- ideally, GSP would be included in initial training and induction processes so that all referrers are aware of the impacts of green provision and how to refer their clients.

Provider Collaborative Modelling

Project outline:
To model effective and efficient systems and processes for sustainable social prescribing in Derbyshire and Derby. To work directly with and build capacity within and across grassroots enterprises who are best placed to deliver local, meaningful, personal and health promoting activities (see Case Study B in Appendix 5).

Initial rationale for testing (linked to Theory of Change):

- green providers are funded piecemeal and unsustainably resulting in sector fragility and competition.

Related elements (of the ToC):

- the network of providers, link workers, referrers and funders is fractured and dispersed;
- there is a lack of mutual understanding and awareness of different parts of the system and how they operate;
- organisational structures (e.g. policy, objectives, governance, record keeping) are not aligned.

Summary of outcomes:

- following a successful proposal to the JUCD Personalisation budget for £100k, two geographical sites were selected for the 12-month modelling work; Bolsover District and Erewash/South Derbyshire, based on their readiness to progress with this approach;
- in Bolsover, the coordinating organisation is Bolsover CVS who have taken on the monitoring and evaluation role. There are three providers committed to developing the model:
    - Bolsover Woodlands Enterprise
    - Rhubarb Farm
    - Pleasley Pit Country Park
- in Erewash/South Derbyshire the coordinating organisation is Elephant Rooms with providers including:
    - Whispering Trees
    - Blue Tonic
    - Long Eaton Community Garden
    - Elephant Rooms
    - Helping Hooves
- scores of participants have engaged in a range of opportunities through the networks and have benefitted from the diversity of settings, activities and people involved;
- Erewash/South Derbyshire Collaborative is now connected to the local PCN.

Learning:

- a successful provider collaborative requires time, space and conditions which allow for and encourage authentic relationships and collaboration;
- building personal relationships and fostering regular face to face interaction seems to lead to increased referral numbers. Having a representative from the collaborative to build this relationship on behalf of all providers within the collaborative increases successful connections between referrers and providers;
- including a range of providers within the collaborative who deliver interventions at different levels ensures there is suitable provision for referrals to be made in to;
- the collaborative provides a valuable space for providers to access valued peer support.

Summary/areas for further learning:

- the provider collaborative model is generating interest from system partners and plans are emerging in Chesterfield and Amber Valley for similar models through the Place Alliance and/or Health Partnership;
- transport remains a key issue, with participants struggling to reach providers;
- the collaborative model may help to alleviate the issue of inappropriate referrals, for the participant and provider. A well-resourced collaborative network across a locality will ensure that participants are not 'held onto' for reasons other than their wellbeing. Ideally, individuals can move on when it's right for them and the provider; continue accessing the same project with options for progression, appropriate for their needs; or can develop skills to become a volunteer or even move into paid work (within the collaborative's activities or elsewhere).

Green Provider Network Development

Project outline:
Bringing green providers together in a peer support network to pool resources, share skills, knowledge and best practice, generate a shared voice and create a platform for increased collaboration.

Initial rationale for testing (linked to Theory of Change):

- the network of providers, link workers, referrers and funders is fractured and dispersed.

Related elements (of the ToC):

- there is a lack of mutual understanding and awareness of different parts of the system and how they operate;
- organisational structures (e.g. policy, objectives, governance, record keeping) are not aligned.

Summary of outcomes:

- the network grew to a core membership of approximately 12 green providers who regularly attend meetings and contribute to the development of the network, with a wider reach of 83 individuals receiving the network newsletter and engaging variously with funding opportunities promoted, responding to shared surveys, attending other system meetings when shared directly with them, e.g. SPAG;
- the network came together aiming to:
    - create change by developing a shared understanding of the potential contribution nature-based enterprises can offer as part of a joined-up health and care system
    - provide a collective voice for nature-based social innovators and spark collaborative action
    - identify and advocate the social and economic value of nature-based activity
    - promote high quality operating standards
    - lobby for resources to be channelled closer to participants and provision
    - share knowledge and good practice
    - encourage and enable mutual support between providers;
- the network tested none-hierarchical self-managing structures including the use of ‘circles’;
- a prospectus was developed to showcase green provision and its impact on health and wellbeing across Derbyshire. This can be viewed at https://greenspring.org.uk/greenspring-network/
- ‘hot topic’ online bitesize information sharing sessions were set up to benefit network members.

Learning:

- there is a desire from green providers to work differently with the system. The vision is to move away from competing for small pots of short-term funding towards collaborative long term funded projects that all green providers involved can benefit from. Long-term funding is required to enable ongoing long-term provision to be available;
- through collaborative work, there is scope to share good practice and provide consistent guidance for organisations on appropriate policies, procedure and training to enable them to become delivery ready for health and wellbeing initiatives;
- it would be helpful to hold a repository of sign-posting information for green providers so that all have access to shared information and support;
- the network enabled providers to connect formally and informally, to share practice and ideas for future work, e.g. Winter Wellbeing, plus a way to offer moral support to one another during uncertain times. Providers have also talked of emotional burn-out and compassion fatigue as issues often unrecognised in the sector;
- green provision still sits outside of the main 'social prescribing' landscape. It is unclear how to shift perspectives to ensure green becomes mainstream for all social prescribers.

Summary/areas for further learning:

- there is scope for the provider network to continue in its development. Further insight into what will entice members and what the network can offer to best benefit members would be beneficial;
- there is a need for a more cohesive strategy to link health professionals with providers and ensure that referrals made are appropriate;
- a network could also offer opportunity for green providers to make onward referrals to further support for participants where appropriate;
- there is a need for longer term funding to enable long term provision to remain available. There needs to be a recognition that green provision is not free to deliver.

Site leads and reflections

As previously described, the contributions of the site leads were integral to the planning, delivery, monitoring and evaluation of the testing. The reflections of site leads informed testing decisions and they consulted repeatedly with local stakeholders. Testing work was iterated and modified throughout the project, especially if a provider was already working in a particular community, and at times the sessions were modified part way through, e.g. with a changed focus, dates, or promotion method (exemplified in both AV and both SD pilots).

This section is a summary of a workshop session with the site leads once testing was complete. Their reflections helped to produce the summaries in the previous section, and synthesised here are their experiences of supporting the commissioned delivery, in the context of overseeing testing and supporting the providers in their local systems.

Outline:
Area site leads were designated to ensure test and learn projects remained on track to test the Theory of Change elements assigned to them. Site leads were also able to add valuable reflections centred around both the test and learn project itself and the wider system in which it operated.

Summary of outcomes
At times, it was challenging to keep green providers on track to test the ToC. Some testing was expected to lead to low uptake due to the barriers identified, but accepting failure did not sit well with providers, and this could sometimes lead to the project veering off track and attempts to seek solutions, rather than an acceptance that failure could lead to learning and was 'permitted'. There was concern that providers themselves would be judged for low numbers, rather than the barriers of the wider system. This fear is understandable within the current culture, where providers are encouraged to compete for limited funding pots and work opportunities, and must outcompete their competitors, even if this means masking the barriers experienced by service users who would benefit most from provision.

The site leads team were able to gain a valuable birds-eye perspective across the system. They found that at grassroots level there was energy and appetite to experiment and trial new ways of collaborative working. A culture of honesty was developed when all providers were reimbursed for their time independent of outcomes, and when all were seen as equal. This enabled a true picture of life as a green provider to emerge, rather than the positive gloss often portrayed for the sake of gaining funding.

The site leads team observed inconsistencies and barriers within the wider system across Derbyshire. The lack of a consistent approach between social prescribing organisations and, at times, social prescribing roles, made it difficult to engage and plug 'green' into existing systems, as the systems were not there to access. The test and learn project has helped to raise the profile of the benefits of green, and it is now on the radar of more prescribers, but this is due to

an individual prescriber's personal interest and willingness to engage. If an individual leaves their post, this knowledge leaves with them and there is nothing to ensure it is taken up by the new member of staff taking on their role. Site leads spent a lot of time trying to seek out the right individuals to engage with, and were often set back when staff changes took place.

Social prescribing organisations have their own set of systems and policies, and can be unwilling or unable to make changes to support collaboration with the green sector. When seeking solutions in response to feedback from social prescribers, such as the instigation of a single point of referral for green provision that can then make onward referrals to any green providers in the area, resistance was met and it took time for the new service to be understood. This was possibly because it worked outside of their current procedures and crossed over into the realms of 'referrals' which was seen as sitting within the remit of the social prescribing organisation. The new approach did not fit with the existing system and was not immediately accepted. This experience suggests that work is required to smooth the interface between green providers and referral organisations in a way that suits both sectors' ways of working.

The site leads observed that the number of referrals in all geographical areas was low (see Table 2, p.80) Additionally, there is no consistent definition of what is classed as a referral from social prescribing organisations. At times, participants attended green provision after being sign-posted by social prescribers (which relied on participants disclosing or being aware of this information). The social prescriber may have classed this as a 'referral', but the green provider might call this as a 'self-referral'. With no process in place between provider and referral organisation, it was not possible to track the progress of individual participants.

Main learning points:

- communication was one of the biggest challenges experienced within this work. The test and learn approach was difficult to explain as it was a new way of working for the majority of stakeholders involved. Many system partners wanted to be kept updated with information, but this information did not lead to action. It is unclear why this was the case or what different approach would lead to people being galvanised into action. It was difficult to create shared understanding between everyone involved and avoid assumptions being made;
- traditional, passive organisational structures provided a barrier to change. An attitude of short-termism, coupled with a lack of accountability, lack of courage/ability to experiment and lack of investment led to inertia, a lack of action and, therefore, lack of change. It was very difficult to attempt to lead change when not in charge and not able to hold anyone accountable and this was felt consistently by the project team;
- it was difficult to collect consistent and good quality monitoring and evaluation data from across the green provision. Providers across the county commented that their participants struggled using the UCL wellbeing umbrella, and data analysis approaches varied across green providers, with no other meaningfully quantitative measure adopted (see Quantitative data/wellbeing measures review in previous section).

Summary/areas for further learning:

- identifying evaluation tools that can be used to produce comparable high-quality data across all green provision would be an area for further investigation;
- further investigation into the barriers leading to low referral numbers is required;
- there is a need for further work across the system to build a culture of reciprocity and equity, regardless of role or position.

Table 2. Overall referrals across all testing pilots

Total number of known referrals to GSP activities	137
Total number of people taking up GSP activities	119
No. people referred by PCNs (ie SPLWs attached to PCNs)	22
No. people referred by SPLWs (not attached to PCNs) NB includes informal/signposting referrals	2
No. people referred by Community Mental Health Teams	15
No. people referred by other means (including self-referral)	91

Test and learn evaluation outcomes

Learning from district-specific and county-wide testing has highlighted areas for further work in relation to the challenges identified at the outset of the project. Alongside the research from the national team, a Masters' student thesis based on the GreenSPring project, and reflective processes of the project team, site leads and evaluator, it has also led to identification of additional barriers and opportunities, both for the local system and for delivery of NBAs for health and wellbeing in Derbyshire. The outcomes of test and learn work are discussed below in the context of some of the Theory of Change statements (p.18).

Power and influence directed to support GSP

The inability to raise the profile of GSP within the health system, and the lack of positional power felt by many without an 'official' role in social prescribing or the health system more broadly is something the pilot struggled to address.

New commissioning arrangements

Value For Money analysis

A report from the work of the national evaluation team found that:

"Emerging evidence from the national GSP evaluation suggests that the average cost per participant in nature-based activities is £507 but costs range from £97 to £1,481. Compared with other interventions for people with mental health needs such as behavioural activation (£231- £250 for 10 sessions), CBT (£1,060 for 10 sessions), early intervention for psychosis (£4,043 year one) and collaborative care for depression Type II diabetes (£858 over 6 months), nature-based activities appear to be a relatively cost-efficient way to support people across a wide spectrum of mental health needs. It is important to recognise, however, that for many people, the most appropriate course of action to support their mental health will be to access different types of intervention in combination."

"National evidence also indicates that the average cost of a social prescribing link worker referral ranges from £145-£163. This means the 'full cost' of making GSP referral (the combined cost of a GP appointment, link worker referral and participation in nature-based activities) is estimated to range from £284-£1,686. This wide range reflects the broad spectrum of mental health needs that these activities cater for, with those offering universal access or catering for people with predominantly mild mental health needs tending to cost less to deliver per person than those for people with moderate and more severe needs. Looking across the GSP pathway, the evidence suggests that GSP can be considered a relatively cost-efficient intervention when compared to other types of support for people with similar mental health needs." (Holding et al., 2023).

Certain forms of state benefit and personal budget are available and already granted in many cases specifically for use in provision of wellbeing activity. However, their use for NBA and subsequent referrals on this basis are not common. There appeared to be a lack of awareness,

and willingness, amongst support staff who could enable patients to obtain and use funds in this way. Although testing the potential for uptake of PHBs did not result in any delivery of NBAs through the GreenSPring project, there is potential to pursue this as a way of funding NBAs, particularly through the provider collaborative where there is a mechanism for dispersing funds from a centrally managed budget. Investigation of Mental Health Act Section 117 aftercare for this purpose is an additional option for consideration for DHCFT.

Provider collaborative models can demonstrate the benefits of NBAs but require investment from the system (see Case Study B in Appendix 5). Also, there might be opportunities through mental health transformation and Living Well, if the concept of workforce can be expanded to include those in informal payment and delivery models and not recruited via the health system or only in larger VCSE organisations.

Evidence of testing and from the green providers show that a range of models have benefits for different target groups, and this benefit can be quantitatively demonstrated when appropriate measures are used. As described in two of the delivery summaries; a flat rate for delivery across a spectrum of expertise and mental health provision was not sufficient to cover the costs to ensure safe and effective NBA for those with greater mental health needs.

Identifying barriers and creating compelling evidence

When discussing the demonstration of the benefits of NBAs, health partners sought to find standardised, quantitative monitoring measures, regardless of the type or level of intervention. Organisational drivers and priorities tend to prevent progress through providers not being able to deliver what is expected, and commissioners not being able to compromise, particularly regarding barriers and quality issues relating to quantitative data and certain monitoring, e.g. an automatic expectation of sustainability.

Quality standards/readiness, quality, monitoring

Quality standards and governance relating to acceptance of NBAs as more formally delivered services are something that the green provider network could consider and are being self-managed through the provider collaboratives. This represent an opportunity for local discussion, e.g. through Place Alliances, and could lead to better representation and increased mutual understanding and awareness, especially to address the types of need that can be addressed through NBAs.

Similarly, members of formal health structures and commissioners often seek umbrella or anchor organisations which are perceived as more responsible and guaranteeing standards and quality. This makes sense financially and for efficiency, but smaller groups and organisations are also able to ensure good quality practices and processes, regardless of stature. Therefore, there are risks of a dependence on the same organisations and individuals in the system being commissioned, potentially increasing resentment and mistrust in organisations seemingly part of the sector but behaving like statutory bodies.

Nature-based providers and groups engage in communities to address an observed need, and so that they can deliver at ground level and have the relative freedom to pursue their aims in a way that larger organisations often cannot, and often without being 'controlled' by those larger bodies. However, small providers expressed concern that they are 'propping-up' services while large organisations are then setting up additional green programmes and accessing contracts, because the smaller groups do not have the relationships, networks or financial scale to participate through traditional service delivery mechanisms.

Despite some concern being expressed by referrers about the ability and capacity of providers, none of the providers reported being asked by referrers for credentials, risk assessments, insurance, etc. and there was no follow up about engagement reported. This represents a disconnect between the needs of a health system preoccupied with risk and compliance, and the experience of providers feeling outside of a system not currently funding NBA provision. In GreenSPring testing, participants were referred on the basis that the programme was for adult mental wellbeing but individuals often had a wide range of physical, mental and social/personal issues, a common occurrence for these providers, and it was generally assumed that the provider could support a range of complex needs without further investigation by the referrer.

Improving networks to support connectivity

The numbers of referrals from SPLW into nature-based activity were lower than might be expected and, despite some delivery being commissioned to run over several months, a longer term offer of GSP did not significantly increase numbers of referral, especially from SPLWs. This is, potentially, not only a matter of understanding of NBA activity but also the many roles and organisations involved in the support of patients who might benefit from it. In numerous fora and interactions throughout the project, e.g. SPAG via SPLW and link worker employers, it was made that the primary focus of the role is not about onward referral into communities, but tackling immediate health and social needs, not necessarily the remit of the SPLW role. This could be due to the case load pressures and inconsistent employer policies but managing numbers and short term needs of potential participants, as opposed to 'social prescriptions', was reported as the focus, further preventing productive discussion about the wider SP system in Derbyshire.

"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 Derbyshire, Link Worker data was provided from one of the four localities involved in the T&L (test and learn) site. Of the 686 onward referrals, data provided for 56 (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." (Holding et al., 2023).

Derbyshire GreenSPring testing demonstrated that engagement of the referrers is paramount and is helped if the individual has an awareness of the benefits of NBA, an understanding of the

VCSE provider organisations and groups, e.g. through the 'Levels', and believes that the final referral into community provision is beneficial and essential to social prescribing.

The work that goes into a successful referral, from internal 'health system' referrals through to delivery in communities, must be understood by both the provider and the referrer. For example, attrition, or even a successful attendance, is a challenge with several causes. Providers report that much interest in their activity is received by referrers, some even attending NBAs themselves, but these often do not result in participant attendance. It was felt that a lack of a professional or mental health focus is the reason for no onward referral, but social prescribers report a range of reasons for this. Many are unable, due to capacity or employer policy, to accompany a potential participant once to an intervention, not to mention the multiple attendances that might be required to instil the confidence and familiarity needed by a person experiencing anxiety.

Who should be supporting the participant has also been questioned throughout GreenSPring testing. Many SPs expect a provider to support prior to and during an activity, including providing transport in some cases, whereas providers report that they are not resourced or enabled to provide this. All stakeholders agree, however, that having support to attend even the first NBA session is more likely to result in successful participant outcomes. Onward progress from an activity has also emerged as a factor in success of NBAs, with some providers wanting to offer ongoing support until the individual no longer requires it, and others preferring (and often being expected to evidence) progression for patients through their service and into other meaningful activities, sometimes volunteering or work.

Accessibility and transport

Transport is often cited as a barrier to attendance, however, even though transport was provided for some GreenSPring delivery projects, the effort required (early start, travelling into a different locality) was sometimes too great and participants declined the transport offer and chose not to attend. Having a minibus collecting individuals did make a difference to attendance for some participants, although community provision of this type of transport is not consistent in all districts. For example, there is little flexibility or routes outside of local boundaries and vehicles are often booked for specific purposes at times, e.g. school transport. Also, the cost of alternative travel options is often prohibitive. However, even when transport was provided or made easier to access, there are a number of reasons why it did not increase the likelihood of attendance. These include the mental health of the individual, time taken and of the day, a sense of independence, confidence, etc.

In communities facing economic disadvantage, including some ethnic minority communities, where greenspace might not be easily accessible, different barriers arose. Information about the space itself was felt to be important, e.g. facilities, location of footpaths, knowing whether dogs were likely to be present, whether it would feel safe, and whether a site could be used for a range of specific activities, such as barbecues.

Mutual accountability and shared problem solving

GSP is still perceived by many as niche provision, with some system stakeholders feeling that NBAs would not be able to address loneliness and isolation or low-level MH challenges. However, at a local level and with stakeholders who have been part of the project in some way, reciprocal relationships were formed and focussed activity, such as the training sessions with different types of referrer, helped to increase appreciation for GSP and understanding of the factors influencing successful outcomes. Clear organisational policy (e.g. inclusion/exclusion criteria - for SPs as well as providers) and mutual respect are required in order to have accountability and problem solve effectively, and respectfully.

Results from testing pilots found that feedback loops between referrer and provider are vital for success, as is ongoing support around mental health needs and information sharing, especially for safeguarding purposes.

Speaking the language of the health system and referrers was noted to be important by providers, so that the benefits of NBAs can be understood and building in the time to nurture relationships and spend time in communities is vital for social prescribing roles to work effectively.

Harnessing nature-based assets

Whilst the GreenSPring 'Levels' have been broadly welcomed and requests to share were frequent, the risk was that, as all GSP activity promoted, information on the content of an NBA is all that is requested, as per a newsletter or directory entry, rather than full understanding of the group or organisation and the NBA itself. The levels are a useful tool in helping to explain the variety and requirements, and can help with making appropriate referrals, but there is a risk of missing the nuance, as a shortcut to 'processing' patients into an activity in a transactional manner. The same behaviour can be seen with each new 'mapping' initiative, and serves to leave providers, often unsupported, without a right of reply or feedback loop to express or escalate concerns in the interest of patient wellbeing.

Not all providers were able to engage with the social prescribing landscape to the same extent. Many reported working in isolation, feeling disconnected (especially as a micro-provider) and not being able to access local support networks or funding. The Whispering Trees summary (p.62) provides details of how a new organisation, even though relatively well resourced, found it difficult to engage with the local health partnership and access support.

Key learning and considerations for future action

The themes that have emerged through GSP test and learn activity are like many reported in system change programmes. A range of actions were taken forward to begin to understand and demonstrate the changes that were required and possible, within the system. Progress has been made and is used here to describe potential next steps and recommendations.

Through testing, a collaborative framework to fulfil project aims could not be developed in one part of the system alone, and without equitable input from all parts of the social prescribing landscape. As per the pilot objectives, GreenSPring has learned lessons about the need for shared policy and delivery and has identified barriers and ways of improving outcomes for citizens. To illustrate the relevance of this work for the wider system, some of the Theory of Change areas have been explored in more detail with recommendations provided below.

Collaboration/Power and Influence

Development of a Derbyshire-wide joined up approach to green social prescribing was central to the aims of the pilot and, in many ways, the cornerstone of the work. Collaboration across providers, particularly smaller enterprises, has been successful with the creation of a green provider network yielding many benefits to partners. This will be covered in further detail later.

However, collaboration between new and existing partners has been more difficult to foster and a common theme emerging throughout the pilot was a lack of mutual understanding of the conditions experienced by stakeholders across the system - between partners, between referrers and providers, and between organisers and participants. In the planning phase, a lack of mutual understanding amongst partners such as NHS, Local Authorities, VCSE organisations, and VCSE infrastructure organisations meant that the partnership fell short in fully committing to a shared purpose and collective action, resulting in slow progress in driving forward change.

The low levels of mutual understanding between referrers and providers (for example relating to roles, responsibilities, resources and expectations) led to difficulties matching the needs of participants to the provision available. As well as limited awareness and understanding of partners' conditions, evaluation of the test and learn sites revealed poor connectivity and 1s of trusted feedback between the referrers and providers during and after activities which appeared to further inhibit progress and led to opportunities for improvement being missed. Providers find it difficult to be honest and open about capability and capacity for fear of missing opportunities, but also because there is not a clear understanding of what they offer by prescribers and providers do not want to miss out on the possibility of a referral.

At a leadership level, there were few spaces for sharing honest, open reflections, data, feedback, information and aspirations. The convenor role was taken on by the Project Team who, whilst part of the leadership, were also deemed to have the best connections and overall understanding of the work. This style of organising is considered helpful in tackling complex

issues as illustrated in Figure 3, but it became problematic during the work when the leadership group often defaulted to traditional, hierarchical delivery and reporting mechanisms which served as blockers and slowed progress.

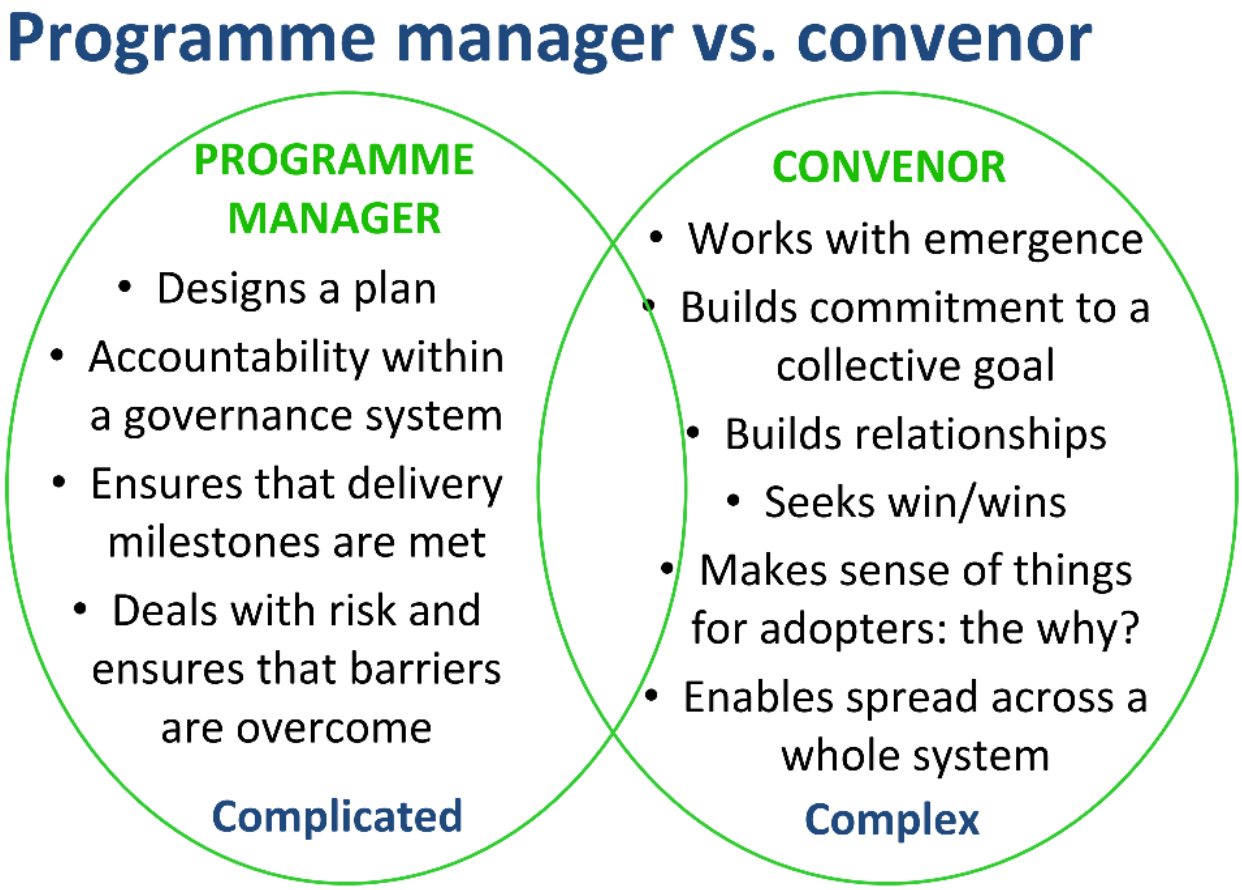


Figure 3. Traits of conveners and managers (Bevan, 2023).

Further work is also required to fully understand and engage participants and service users in the planning and delivery of green social prescribing to make sure it reflects the diversity of the communities served, is accessible and fit for purpose. Whilst this pilot aimed to take account of and embed an ethos of personalisation (a person-centred approach), enabling the participant voice to be heard at every stage of the pilot was deeply challenging.

The need to shift power away from statutory partners and towards citizens and communities has long been recognised within national 'system change' programmes and initiatives. By bringing together new and existing partners as well as small providers, it was hoped that the pilot would generate a change in the power dynamic which would lead to meaningful action closer to the needs of citizens.

Progress was slow, and it was often difficult to create opportunities for honest conversations and get to the heart of the issues and barriers which emerged during the pilot. Many system partners wanted to be kept updated with information, but this information did not lead to action. The Leadership Group was newly formed for the purpose of GreenSPring and the relationships between VCSE providers, NHS and Statutory colleagues took a long time to develop and required deeper levels of trust than were present to enable partners to reveal vulnerability.

Whilst the Leadership Group benefited from broad stakeholder representation, there was a high turnover of members and varying levels of engagement over the course of the work. Despite much early interest in the programme, with short term funding and a lack of national political leadership, it was difficult to leverage Derbyshire-wide strategic commitment and traction.

Frustrated by a slow pace of change, energy was channelled towards developing the green provider network and 'Provider Collaboratives' at a local level, with the intention of influencing from the ground up and out.

The Provider Collaborative modelling was an additional piece of work emerging from the pilot which complimented each of the aims, particularly 'creating a referral ready sector with capacity and confidence to deliver'. Focussing on Bolsover and Erewash/South Derbyshire, resources were channelled to the grass roots where small community-based providers came together to share experience, knowledge, aspirations, capacity, reflections and plans to engage more people in nature-based experiences to improve mental health and wellbeing. In both settings, referrals have increased, there have been reported improved health outcomes by participants and new capacity has been created in the form of volunteers, skills, confidence and connectivity. Further investment has been secured in Erewash to enable subsidised transport for participants who were struggling to access activities. A separate report is available detailing the outcomes of this work.

Recommendations:

- *identify and support convenors of and conditions for mutual understanding, reciprocity, shared purpose and collective action amongst stakeholders involved in implementing systemic initiatives such as green social prescribing*

- *actively promote data sharing, risk sharing, peer support, honesty and reciprocity across networks*

- *pay particular attention to involving participants and service users in planning, delivering and reviewing initiatives at every stage*

- *further work is undertaken to resource the development of 'provider collaboratives' across Derbyshire and Derby, focussing on a personalised approach to social prescribing in its*

widest sense, and making optimal use of opportunities to build capacity within the voluntary and community sector

- *support the formation of networks of people with a keen interest in the work as well as leverage and energy to make a difference, rather than identifying representatives from partner organisations.*

New commissioning arrangements

The pilot revealed that consistent and proportionate methods of collecting data and evidencing impact are critical to creating a sustainable scaled up model and for nature-based providers to be embedded in delivery. The study of the test and learn sites found that the expectation from the system of what is required to evidence is not always appropriate for the activity being delivered, and the intended outcomes and extent of the funding acquired are often misaligned.

Collecting and analysing data from vulnerable people struggling with their mental health can be incredibly difficult and was raised as a concern by several of the national and local test and learn sites. Lengthy questionnaires are felt to be counter-productive when participants arrive for the first time at an activity, many of whom have overcome fears and barriers to attend and may have already been surveyed about their wellbeing. Many providers adapted data collection to meet the needs of the participants, but this can compromise commissioners' requirements and leave providers caught between doing a good job and collecting necessary data. Further work is required by commissioners, providers and participants to understand and agree on data requirements, collection and analysis to optimise the use of data provided without putting undue pressure on participants and providers. In addition, clarity is sought by providers as to how data is used to inform policy and decision making in the wider system.

Many providers lacked experience of high-quality data collection, handling and reporting. The pilot revealed a general lack of consistency when it came to qualitative and quantitative data collection and analysis and most programmes did not allow sufficient time and resource for monitoring and evaluation leading to scant evidence of the impact and value for money of this type of intervention.

Support for both providers and commissioners is required if data collection and evidencing of impact are to be improved, particularly around aligning aims and agreeing achievable outcomes. Further clarity is required around data management and quality, where and how it is used, and who will collect it.

Recommendations:

- *a holistic review of commissioning including data collection, analysis, and evaluation. Co-production of procurement processes and proportionate monitoring/evaluation tools that can be used effectively, demonstrably and with accountability across the system*

- *measure success by outcomes rather than processes, involve providers and participants in aligning aims, methods and evidencing progress. This should be an ongoing cycle of feedback, informing and improving policy, and would result in an integrated upskilled workforce with consistent approaches to data collection, handling and reporting*.

Identify Barriers/Improve Networks

One of the main aims of the programme was to identify barriers to accessing nature-based activities and explore ways of improving lives for citizens.

The route forward for a person who has identified themselves as struggling with their mental health is known as a 'pathway'. Pathways include routes into and out of formal mental health services, social prescribing pathways and communication across and between the range of referrers. The pilot found that the myriad roles and responsibilities are not clear across the public sector, nor within the VCSE. Input from Derbyshire's Social Prescribing Advisory Group and the GreenSPring mental health subgroup highlighted that the referral processes into a social prescribing service are not always clear and are not consistent across the county. Nor is the expectation of ability or capacity of the social prescribers to deal with the complexity when a patient is presented and, in turn, the patients' ability to then be integrated into a community-based activity.

Despite the challenges in testing the model through GreenSPring, buddying programmes might help to encourage participation in NBAs. However, relationships with other organisations, public sector or VCSE, are vital to ensure volunteers in the position of supporting a participant are also supported with aims and mutual understanding.

Given the complexity of the pathways, the pilot sought to unravel several of the strands and simplify the route to better mental health for more citizens. At times, participants attended green provision after being sign-posted by social prescribers (which relied on participants disclosing or being aware of this information). The social prescriber may have classed this as a 'referral', but the green provider might call this a 'self-referral'. With no process in place between provider and referral organisation, it was not possible to track the progress of individual participants.

During the programme a workshop was offered to health professionals and SPLWs to better embed GSP into areas of work and explore conversations about nature-based interventions. Several sites met with their local SPLWs, Occupational Therapists and other social prescribers to discuss the pathways and referral processes and build up relationships with local health professionals.

Following training and the social prescriber network meeting, feedback highlighted that if there were more reciprocal, trusting relationships between Social Prescribers and providers, then this

might enable more successful onward referrals. Better connections and capacity would reduce duplication and setting up new provision and activities.

As a result of the workshop, participants also reported better understanding of the range of social prescribing roles and acknowledged that this awareness could improve efficiency, reduce duplication and create more opportunities for collaboration and mutual support across SP provider organisations. Where a programme was co-produced with health professionals, it helped build understanding, trust and relationships and ensured suitability of activity.

The set of intervention 'levels' that were developed through the GreenSPring programme can be used to understand the type of activity on offer and its appropriateness for people with a range of mental health challenges. The costs to provide activity and the expectation of what support can be provided can also be clearly defined using the framework. Ideally, it would be used in conversations between prescriber and provider when the referral is taking place, but also at a planning and strategic level to understand the breadth and diversity of the VCSE sector (especially when considered more widely than 'green' health) and what must be in place for effective relationships to be developed. Once a basic understanding is reached, additional barriers, such as transport and physical support to attend can be addressed.

If the 'levels' were used for information sharing and setting clear boundaries, potential gaps in provision could be identified. When the full range of activities available are understood, this will also result in increased connections, and greater efficiency. Social prescribers will not need to set up their own activities because they will have a greater awareness of what is already available in communities and be able to make appropriate referrals.

Throughout the programme low referral numbers were reported and by working to understand why this was the case and developing testing work accordingly, it emerged that the main barriers to attendance were:

- a lack of awareness of activities taking place
- poor understanding of green provision
- deeper disconnects across the range of social prescribing pathways.

Other important and compounding factors included support to access and readiness to use modes of available transport; motivation, confidence and agency; and physical and cultural accessibility of nature-based activities.

During the testing, providers themselves were concerned they would be judged over the low number of referrals. One site designed inclusion/exclusion postcards demonstrating how green provision can be promoted effectively to referral organisations. The postcards are quick to read, memorable and accessible for professionals and service users to make use of.

The geography and lack of transport in rural areas is a barrier to accessing green provision. It cannot be assumed that living in an area close to natural spaces guarantees accessibility;

Several providers used a minibus or taxi service collecting individuals and taking them to their sites which did make a difference to attendance for some participants. However, despite attempts to remove transport barriers, successful attendance at those activities was not guaranteed and the wide range of barriers, e.g. motivation, confidence and support to attend must be addressed in full.

As noted, better understanding of existing activities would release the additional capacity of referrers required to make physically supported referrals into nature-based activities. Testing activity demonstrated that providing transport and removing tangible barriers was not sufficient to ensure a successful (short- or long-term) engagement in an activity. Most potential participants required support to attend at least the first session, often from their front door, until a connection was made, and they felt confident and comfortable. This was the primary reason found for the low number of referrals.

Recommendations:

- *investment in prevention, ie provision of nature-based activities, and addressing structural inequality to improve motivation, confidence and agency*

- *foster better relationships between Social Prescribers and providers, focussing on improving awareness of activities and understanding of green provision and improving clarity of referrer roles*

- *allow adequate time to support patients into and during activities*

- *investment in accessible, nature-based activity to allow for practical support, e.g. clothing, transport, etc.*

Referral Ready Sector/Harnessing Nature-Based Assets

The pilot aimed to create a referral ready sector with capacity and confidence to deliver. Current conditions of short-term funding, statutory sector heavy partnerships, low referral numbers and a lack of awareness of the range of opportunities available lead to competition between providers and a culture of fear and low trust, often resulting in poor outcomes for citizens.

The test and learn sites found that, for the sector to be referral ready, there needs to be:

- long-term financing of the provision of activities supplied as part of a joined up social prescribing system
- acknowledgement of the value of nature-based activities contributing to improved mental health
- better understanding and acceptance of the issues around accessibility to nature
- better data collection and analysis leading to evidence of impact
- better collaboration and relationships between commissioners, referrers, providers and participants

- better procurement – inclusive and equitable practices
- a coherent voice for the sector included in the Integrated Care System
- an emphasis on relational over transactional ways of working.

As previously noted, if delivery of nature-based activities was invested in through a wider prevention agenda, existing short-term and one-off funding (e.g. community grants, PHBs) resources could be targeted to tackle the secondary barriers faced, e.g. transport, equipment, clothing.

Creating conditions which reduce competition and enhance collaboration significantly assist with becoming 'referral ready'. The Provider Collaboratives spent time and energy creating a culture of honesty and accountability and agreed that for the modelling work, all providers would be reimbursed for their time regardless of outputs. Collaboration and equity of provision appears to reduce competition and encourage innovation which then optimises use of local nature-based assets.

Mutual understanding between providers and referrers also addresses barriers and improves conditions to become referral ready. Better understanding of what providers are offering, as well as the constraints and priorities of the referral services aid relationships and smooth the referral pathway for participants. At one provider site run with volunteers, many partners who visited the project had ideas about how new initiatives could work. However, they all required someone to lead this from within the site and without funding or support, and the provider did not have the capacity for this.

Several providers delivered from publicly accessible green spaces such as local parks or community gardens. Local management of the land allows for good flexibility and adaptations to sessions if needed. This is especially true where the green provider is given responsibility for a space which can also benefit a local authority or district council with their wellbeing and parks agendas. For this to happen, relationships need to be built up between providers and local authorities which can be slow to build due to capacity and bureaucracy.

When the challenges described above are acknowledged and tackled in partnership, the green provider sector already in place will be supported and valued in ways that allow better collaboration and more innovation to be learned from and incorporated across the wider system. The mounting benefits of working this way are being demonstrated through the provider collaborative modelling and the wider green provider network. This work requires tangible support and long-term investment if it is to continue and grow.

Recommendations:

- *invest in the ongoing modelling work and find meaningful ways to collaborate and include a wider range of voices and create mechanisms for including and co-producing with (VCSE especially), nature-based activity providers*

- *capacity-building for nature-based activity providers based on need and understanding of the broad range of activities, structures and challenges facing a modern VCSE sector*

- *through the establishment of mutually respectful and equitable relationships, create opportunities to use the wide and varied green spaces available across Derbyshire for the benefit and wellbeing of residents*

- *open up opportunities for green providers to be part of the decision-making forums and partnerships, e.g. health partnerships and place alliances.*

Overarching recommendations:

- ***build a culture of reciprocity and equity across providers, referrers and system leaders, enabling better collaboration to prevent and address mental health illness***

- ***further investigation into the causes of low referral numbers into social prescribing activity in communities***

- ***co-produce procurement processes and proportionate monitoring and evaluation tools that can be used effectively, demonstrably and with accountability across the system.***

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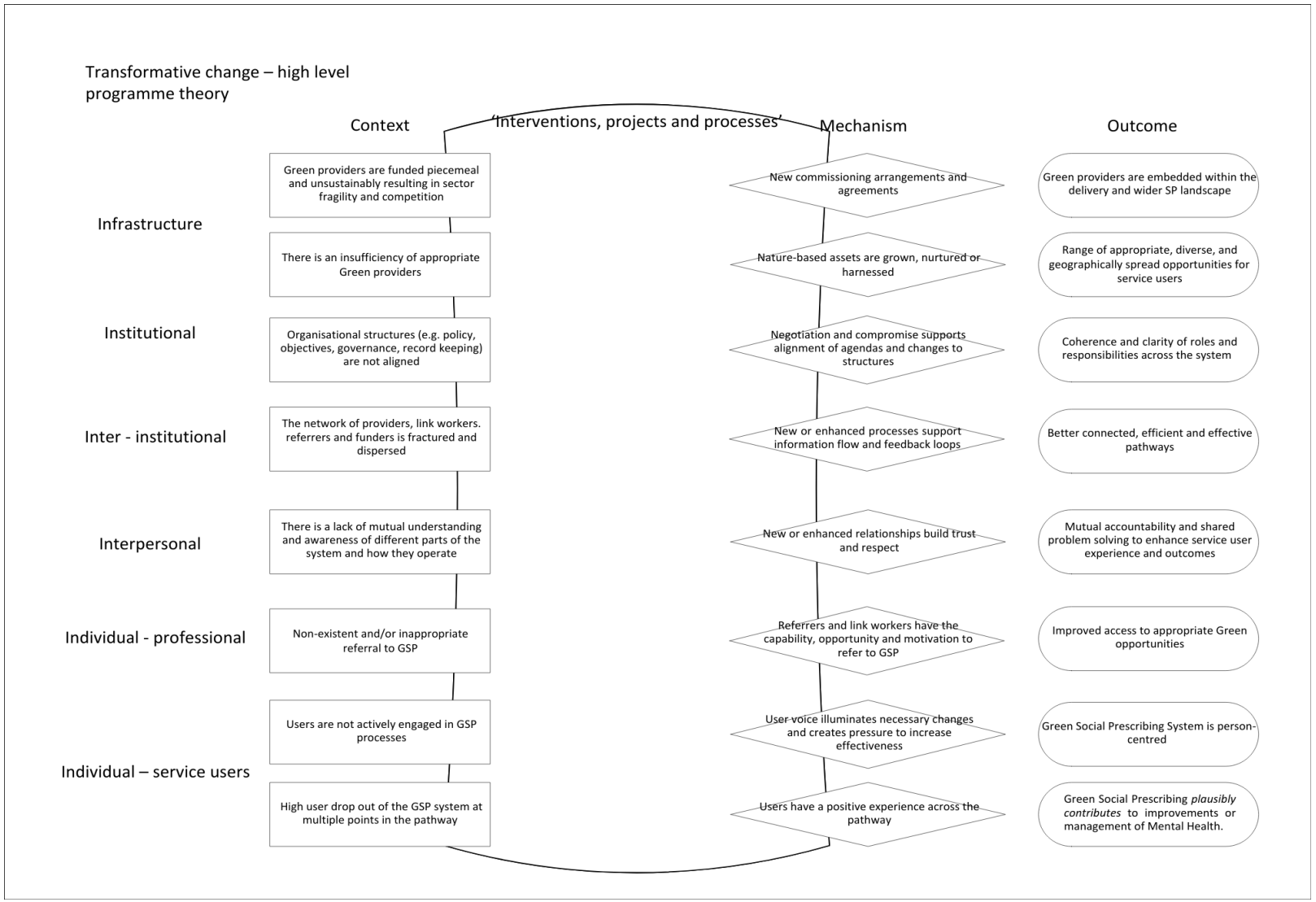
Appendices

Appendix 1 List of green providers delivering test and learn projects

Provider name	Website
Buxton Civic Association	www.buxtoncivicassociation.org.uk/stronger-roots/
Community Growth CIC	www.communitygrowthcic.co.uk
Craft Wood CIC	www.craftwood.org.uk
Derby West Indian Community Association	https://mail.dwica.co.uk/index.html
Derbyshire Wildlife Trust	www.derbyshirewildlifetrust.org.uk
Elephant Rooms (Draycott) CIC	www.elephantrooms.co.uk
Green Thyme	https://greenthyme.wixsite.com/green-thyme
Grow Outside CIC	https://growoutside.co.uk
Hunloke Community Garden	www.hunlokecommunitygarden.co.uk
Kenning Park Community Forest School	https://www.facebook.com/profile.php?id=100079631091702
North Wingfield Community Garden	https://www.facebook.com/northwingfieldcommunitygarden/
SDDC Rosliston	www.roslistonforestrycentre.co.uk
Spiral Arts	www.spiral-art.blogspot.com
Wellies CIC	www.welliesproject.org.uk
Whispering Trees CIC	www.whisperingtrees.org.uk
Wild Roots Creative CIC	www.wildrootscreative.org

Appendix 2 Programme framework



Appendix 3 Commissioning agreement

Commissioning agreement
GreenSPring Partnership Agreement
Organisation name:

Lead contact name and details:

1.0 Summary
This agreement is to deliver elements of Derbyshire's GSP Test and Learn site programme. The agreement will cover working with the GreenSPring project management team and partner organisations to test a variety of approaches and measures against project outcomes and deliverables as part of the GreenSPring project plan.

2.0 Project Background
Seven new test and learn sites, based across England, will focus on communities hardest hit by coronavirus. This could include those living in deprived areas, people with mental health conditions or BAME communities. Since the coronavirus pandemic, when many people have experienced distress, loneliness or anxiety, there has been an increased public awareness of the benefits of regular access to green spaces. This programme has been funded by the Department of Health and Social Care, Department for Environment, Food and Rural Affairs, Natural England, NHS England, Office for Health Improvement and Disparities, Sport England, Department for Levelling Up, Housing and Communities and the National Academy for Social Prescribing. Joined Up Care Derbyshire are the Lead Partner for GreenSPring.
The sites each explore and bring together opportunities for communities to get involved in their natural environment through GSP which is the practice of supporting patients to engage in nature-based activities.

3.0 Timetable
The project is running from April 2021 through to April 2023 and all project delivery testing will be completed by 1st March 2023.

4.0 Deliverables
This agreement is for **** to deliver:
-
Regular updates and reporting to the GreenSPring project management team will be required to contribute to national reporting and evaluation measures. There will also be some further information requested on support and capacity building requirements.

5.0 Minimum requirements
Necessary policies/processes
· Equality, Diversity and Inclusion

- Safeguarding
- GDPR
- Risk assessment for site and activity
- Public Liability insurance, including employer's liability if relying on volunteers for delivery (the latter is advisable but up to the provider)
- DBS
- First aid
- To keep a record of the individual, including next of kin/emergency contact, and personal health information required by the provider, emergency services, etc. Plus, any necessary consent, e.g. appearing in photos.

Advisable
- Volunteer policy

6.0 Information Available
Information on the GreenSPring project is available at https://greenspring.org.uk/. A theory of change document and delivery plan developed by the project management team and wider leadership group is informing delivery of the testing sites and project partners based on issues, challenges and opportunities across the county.

7.0 Copyright
Copyright and intellectual property rights in any works, methods or revisions created by this contract shall rest with the commissioning body or as agreed when discussing the delivery methods.

8.0 Payment

8.1 Fixed Price
There is a fixed price for undertaking this commission of £*** (including VAT). This is based on *** days comprised of ***. (delivery of GSP is chargeable at £325 per day; the fee for admin, planning, evaluation and other project related activity is £250 per day. Breakdown to be agreed with the project team).

8.2 Payment Terms
Payment will be made using the following schedule:

[Invoicing instructions varied, depending on the stage of the project]

Appendix 4 Green provider reports see Green Spring (2023)

Appendix 5 Case studies

Case Study A

Derby City and Derbyshire (Case Site 4)
Levels
Programme theory 7 and 8

Summary: Providers highlighted that referrals that they do receive from health pathways and/or link workers were inappropriate. The Project Management group devised a 'Levels' system which outlined the level of support needs and the level of provision available. Although the team accept the full potential for the Levels has not yet been realised, successful trials of the idea have led to awareness raising and more appropriate referrals.
The idea: The Green Provider network reported a consistent pattern across Derbyshire of limited and inappropriate referrals. Whilst this is a complex problem, one element of the problem was that there was a mismatch in client needs and provision available. Providers are often unable to support people with higher mental health needs because a) they are not remunerated adequately to do so and b) their staff and volunteers do not necessarily have the skills, expertise, capacity or interest to do so. This means that some clients were referred but without adequate support which can be distressing for the client, the provider staff and volunteers and any other people attending the group.

The project management team developed, in consultation with the Green Provider Network and Leadership Group, a simple table which highlighted the 'types' of activity available and their relative suitability for mental health support needs, the cost and risks associated as well as some detail about funding and evaluation and monitoring.

This was used by Leadership Group and Project Management teams to circulate to potential referrers to assist them in understanding what was appropriate. Observations highlighted that any investment into further delivery was assessed against what 'level' it was to fulfil. Observations also illuminated that the team recognised limited availability of provision at level 3 and 4 and invested directly into new projects and provision.

Where next: The Levels are a simple way of raising awareness and knowledge among healthcare professionals and social prescribers. This and other collateral may help to increase suitable referrals. They could also be used more strategically to audit provision and tailor investments in developing appropriate Green / Nature-based opportunities. The Provider Collaboratives are using the Levels to support the development of a funding model.

	ACTIVITY	EXAMPLE INTERVENTIONS	QA/LEVEL OF ASSURANCE	PARTICIPANT NUMBERS	LEVEL OF MH SUPPORT REQUIRED	COST TO PROVIDE	MH SUPPORT	INVESTMENT/RESOURCING	TYPE OF MH SUPPORT
LEVEL 1	INDEPENDENT USE OF GREENSPACE	NATURE RESERVES, DIGITAL ENGAGEMENT, WEBINARS, DOWNLOADABLE WALKS AND TRAILS, ONLINE NATURE, LOCAL PARKS AND OPEN SPACES, URBAN NATURE					NONE	NA/NEGLIGIBLE COSTS	MENTAL WELLBEING AND PREVENTION: ENCOURAGE EVERYONE TO CONNECT WITH NATURE INDEPENDENTLY AS A WAY OF LOOKING AFTER MENTAL WELLBEING AND NURTURING MENTAL RESILIENCE
LEVEL 2A	FREE (AT POINT OF USE) OPPS	OPEN VOLUNTEERING ACTIVITIES, COMMUNITY GARDENS, CONSERVATION VOLUNTEERS, WALKING FOR HEALTH, SUPPORTED OR UNSUPPORTED					NO SPECIFIC MH SUPPORT	LOW/GROUP OR VOLUNTEER EXPENSES PROVIDER SEEKS FUNDING FROM RANGE OF SOURCES, SOMETIMES DELIVERED USING CORE FUNDED STAFF	MENTAL WELLBEING AND RESILIENCE: ENCOURAGE A CONNECTION WITH NATURE THROUGH PARTICIPATING IN A SPECIFIC ACTIVITY OF JOINING A GROUP AS A WAY OF LOOKING AFTER MENTAL WELLBEING AND NURTURING MENTAL RESILIENCE (SUPPORT NOT NEC INTENDED TO BE MORE THAN PRACTICAL, BUT OFTEN THE CASE)
LEVEL 2B	PAY TO ATTEND OPPS	OUTDOOR NATURE CONNECTION SESSIONS, WORKPLACE WELLBEING, PRIVATE WORKSHOPS/TRAINING. FOREST SCHOOLS, FOREST BATHING, BUSHCRAFT, ETC.					NO SPECIFIC MH SUPPORT	PROVIDER SEEKS FUNDING FROM RANGE OF SOURCES, SOMETIMES DELIVERED USING CORE-FUNDED STAFF	MENTAL WELLBEING AND RESILIENCE: ENCOURAGE A CONNECTION WITH NATURE THROUGH PARTICIPATING IN A SPECIFIC ACTIVITY OF JOINING A GROUP AS A WAY OF LOOKING AFTER MENTAL WELLBEING AND NURTURING MENTAL RESILIENCE (SUPPORT NOT NEC INTENDED TO BE MORE THAN PRACTICAL, BUT OFTEN THE CASE)
LEVEL 3	ONE OFF TIME-LIMITED TARGETED INTERVENTION (FUNDING-DRIVEN COHORT TARGETING)	NATURE-BASED PROGRAMMES, CAN BE CREATED WITH MH VCSE GROUPS. OUTDOOR WELLBEING, SOCIAL THERAPEUTIC HORTICULTURE, ECO-THERAPY, ANIMAL ASSISTED THERAPY, NATURE BASED MINDFULNESS, CONFIDENCE BUILDING					GREEN PROVIDERS LEAD AND SUPPORT THE ACTIVITIES. MH SUPPORT, IF AVAILABLE, PROVIDED THROUGH PEER SUPPORT OR MH VCSE	PROVIDER SEEKS FUNDING FROM RANGE OF SOURCES, SOMETIMES DELIVERED USING CORE-FUNDED STAFF	MENTAL WELLBEING AND RECOVERY - TO ENCOURAGE A CONNECTION WITH NATURE THROUGH PARTICIPATING IN A SPECIFIC ACTIVITY OR JOINING A GROUP AS PART OF RECOVER THROUGH MH DIFFICULTIES. NURTUING MENTAL WELLBEING AND MENTAL RESILIENCE
LEVEL 4	ONE OFF TIME-LIMITED TARGETED INTERVENTION, OFTEN CO-CREATED WITH SYSTEM PARTNERS TO IDENTIFY THOSE MOST IN NEED	NATURE-BASED PROGRAMMES. OUTDOOR WELLBEING, SOCIAL THERAPEUTIC HORTICULTURE, ECOTHERAPY, ANIMAL ASSISTED THERAPY, NATURE BASED MINDFULNESS, CONFIDENCE BUILDING					GREEN PROVIDERS AND OTS LEAD AND SUPPORT ACTIVITIES MH SUPPORT PROVIDED BY PROFESSIONAL SUPPORT AND CAN INCLUDE PEER SUPPORT	COMMISSIONED THROUGH HEALTH/STATUTORY FUNDING	MH RECOVERY: USING NATURE CONNECTION AND OUTDOOR ACTIVITIES AS PART OF RECOVERY AND OCCUPATIONAL THERAPY ACTIVITY

Case study B

Derby City and Derbyshire (Case Site 4)
Provider Collaborative
Programme theory 1, 4, 6 and 7

Summary: Two Provider Collaboratives have been developed as part of GreenSPring and through capacity building funding drawn from *Personalisation Budgets*. The Provider Collaboratives have been developed by grassroots organisations who are geographically close to one another. With the help of a facilitator, they have co-designed the governance structure and other processes that would enable them to work together. Each collaborative has a different structure and focus which has been driven by the local partners. This has enabled a diversity of provision, cross-organisational support, and cross-organisational referral. There is interest in developing the model in another district and beyond just 'Green' providers.

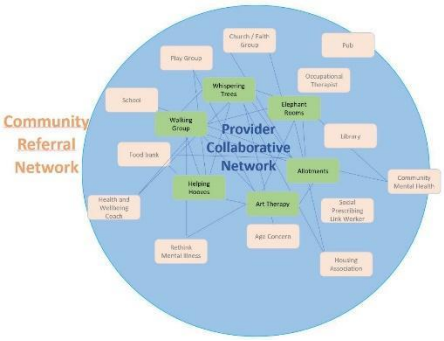
The idea: In many places across Derbyshire, there are lots of small nature-based organisations (Green Providers) but they are not sustainably funded and lack coordination. Some are interested in core/sustainable funding to secure their initiatives, but they do not / cannot engage with the 'bigger players' (e.g. Primary Care Networks, County Council, Borough Council, Active Partnership, CVS). There is recognition that bureaucracy surrounding this impenetrable and/or weighted towards larger organisations, and they lack the skills and capacity to undertake the administrative burden associated with use of public funds. Most organisations have their own projects, volunteers, local networks and are connected, in some cases, to local infrastructure organisations. Some recognise that lack of coordination can mean that some of their clients are not supported as best as they could be.

Brought together by attending the GreenSPring Green Network sessions some providers identified an opportunity to build on what worked on the ground during the pandemic in Mutual Aid Networks. There was a recognition that they shared similar values. There was a desire to offer holistic, person centred and relational rather than clinical as it helps people get more control over their healthcare, to manage their needs and in a way that suits them.

Concurrently, GreenSPring identified an opportunity with the Personalisation Programme Manager to secure £100k additional funding to build capacity, in the collaboratives, to co-design the governance and collaborative arrangements. Each of the two 'hubs' received £35k and the remainder supported co-ordination and facilitation. The processes under which these collaboratives come together are co-produced. This means that the organisations themselves decide how they will work together, make onward referrals, share knowledge and insight, gather monitoring and evaluation data, and offer peer review and reflections on each other's work. The larger (lead) organisations, in the collaborative, which have more core capacity, supports the development of the governance and accountability framework on behalf of the rest.

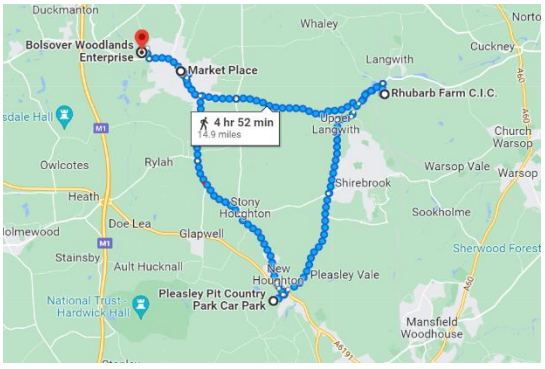
Do things in a way that's quite hierarchical. It's structured, it's ordered, there's strong reporting upwards. There are steering groups there are, you know, very rigorous mechanisms for organising money, organizing an activity. And I just don't think that they are helpful in every setting.

Community building and enabling things to grow from the ground…It I think it's helpful to grow networks which are less formal. More about relationships and more about what people want to do together and then follow that wherever it goes and to allow that to grow, but to grow from itself and to be accountable to itself and to share what that what that network is doing within, but also outside and to kind of influence from the inside out. (DB1)



Provider Collaborative #1 Five core organisations, link with each other and several other individuals and organisations including schools, foodbanks, local community mental health teams, mental health support charities, the church, the library, the housing association, and social prescribing link worker. These links reflect the multi-dimensional network of relationships which enable help and care for members of the community to support their wellbeing, not just a single pathway. Interventions across the providers range from facilitated walking, community gardening, and peer support groups to structured activities such as 'social and therapeutic horticulture' to one-to-one therapies e.g. animal assisted therapy. Lots of examples of individual referral success and additionally, connections were made between a community development organisation and an organisation hosting 400 refugees. This has led to an integrated provision building individual skills but also community cohesion.

Much effort was put into building referral routes by one of the organisations, social media, invitation to site visits, connection to various ICB strategic networks and groups. Referrals were not forthcoming until the very end of GreenSPring (indicating that the referral network may lack capacity, opportunity, and motivation to refer, but also that timescales for change are relatively long).



Provider Collaborative #2 In this area, there is more limited voluntary sector provision. Five local organisations, led by the local VCSE, have organised themselves to improve outcomes for participants, build relationships between themselves and other organisations in the area and demonstrate the value of a community-based model. They recognised and shared insight about the unsuitability of some of the funded programmes (e.g. 12 weeks) for people with complex needs. The collaborative developed a 'trail' on which all their organisations could be found. This allowed them and clients to experience a wider range of support which could be discovered within a relatively small geography. The trail would allow them to identify and/or develop new groups, with a budget aligned to supporting set up.

Where next: The Provider Collaboratives will continue with the existing funding until the end of 2023. There are potentially opportunities for further development and learning with the newly formed Place Alliances. Commissioning structures need to be supportive of these types of collaboratives to change the Green Provider landscape in the long term.

*"I'm thinking specifically about the people who are leading grassroots organisations in communities. They totally care. They care about each other, they care about themselves, they care about their work. They care about the environment and that gives me huge confidence and hope that what they're doing will happen, whether or not the system helps it". DB*1