Natural England Commissioned Report NECR194

Expanding delivery of care farming services to health and social care commissioners

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NATURAL ENGLAND

Foreword

Natural England commission a range of reports from external contractors to provide evidence and advice to assist us in delivering our duties. The views in this report are those of the authors and do not necessarily represent those of Natural England.

Background

The Natural Environment White Paper "The Natural Choice: securing the value of nature" (Department for Environment, Food and Rural Affairs, 2011) sets out the need to strengthen the connection between people and nature. However, the White Paper also acknowledges that the opportunities to benefit from spending time in the natural environment are currently not open to everyone, which can contribute to health and other inequalities. Natural England is committed to increasing the number and range of people who can experience and benefit from access to the natural environment, and through the Outdoors for All Programme is leading the Government's ambition that 'everyone should have fair access to a good quality natural environment'.

Care farms provide health, social and educational care services through supervised, structured programmes of farming-related activities for a wide range of people, including those with learning disabilities, people with Autism Spectrum Disorders, those with a drug history, people on probation, young people at risk and older people, as well as those suffering from the effects of work-related stress or ill-health or mental health issues. Care farming is a specific commitment within the White Paper which Natural England supports through the Higher Level Stewardship Educational Access option. See **Environmental Stewardship: educational access visits on your land**.

In 2014, Natural England engaged Care Farming UK to undertake a review of the care farming sector in order to better define the full range of services provided. The findings in "Care farming: Defining the 'offer' in England - NECR155" (Bragg *et al*., 2014) identified a significant under-utilisation of existing care farming services and made a number of recommendations for action to encourage further development of the sector.

This report presents a follow-on research study for Natural England, which aims to develop an understanding of how care farmers are currently engaging with health and social care commissioners; to discover the key information needed by those commissioners to enable larger scale commissioning of care farming services; and to determine the best means of providing this information at both local and national levels.

The findings of this collaborative project between Care Farming UK and the University of Essex will be used to improve awareness of care farm services and ease of access to those services for both individual users and health care commissioners.

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Natural England Project Team - Jim Burt, Principal Adviser, Outdoor Learning and Outdoors for All Programme **jim.burt@naturalengland.org.uk** and Sarah Preston, Senior Adviser, Outdoors for All Programme **sarah.preston@naturalengland.org.uk**

Contractor - **Care Farming UK Project Team** – Ian Egginton-Metters, Company Secretary, Care Farming UK **ian@carefarminguk.org.uk**; **University of Essex Project Team** – Dr Rachel Bragg, Senior Research Officer, Green Exercise Research Team, School of Biological Sciences, University of Essex **rebragg@essex.ac.uk** and Dr Carly Wood, Research officer, Green Exercise Research Team, School of Biological Sciences, University of Essex **cjwood@essex.ac.uk**; **Independent researcher** – Dr Chris Leck (affiliated to the University of Worcester) **c.leck@worc.ac.uk**.

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Further information
This report can be downloaded from the Natural England website: **www.gov.uk/government/organisations/natural-england**. For information on Natural England publications contact the Natural England Enquiry Service on 0845 600 3078 or e-mail **enquiries@naturalengland.org.uk**.

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List of Abbreviations

ASD	Autistic Spectrum Disorder
CCG	Clinical Commissioning Group
CFUK	Care Farming UK
GP	General Practitioner
HWB	Health and Wellbeing Board
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
NHS	National Health Service
PCT	Primary Care Trust
PHE	Public Health England
QIPP	Quality, Innovation, Productivity and Prevention
RCT	Randomised Controlled Trial
SoFab	Social Farming Across Borders
SOUL	Soft Outcomes Universal Learning

Executive Summary

Background:

Care farming is one of a number of approaches which are more generically described as 'green care'[1]. Care farms provide health, social and educational care services through programmes of farming-related activities for a wide range of vulnerable people including those with learning disabilities, people with Autism Spectrum Disorders (ASD), those with a drug history, or on probation, disaffected young people and elderly people, as well as those suffering from the effects of work-related stress or mental health issues.

There are approximately 230 care farms in the UK (194 of these are in England) (Care Farming UK, 2014) with an additional 25 care farms in the Republic of Ireland (SoFab, 2014). A wide range of commissioning organisations currently commission care farm services, but the majority of farms have clients referred to them by social services, Community Mental Health Teams and education services; together with clients who are self-referred, referred by family or referred from 'other' sources (Hine et al., 2008; Bragg, 2013).

In 2014, Natural England engaged Care Farming UK (CFUK) to undertake a review of the care farming sector in order to better define the full range of services provided. The findings from the 2014 review of the care farming sector, "*Care Farming: Defining the 'offer' in England*"[2] (Bragg et al. 2014) identified a significant under-utilisation of existing care farming services and made a number of recommendations for action to encourage further development of the sector.

Aim:

This report presents a follow-on research study for Natural England, which aims to develop an understanding of how care farmers are currently engaging with health and social care commissioners; to discover the key information needed by those commissioners to enable larger scale commissioning of care farming services; and to determine the best means of providing this information at both local and national levels.

Key findings:

- A total of 29 commissioners took part in the study, representing a range of commissioning roles and contexts including those: from Clinical Commissioning Groups (CCGs, 4); with a health care role (5); from Local Authorities (adult social care, mental health and drug and alcohol services) (9); and from public health (11). Twenty four care farmers (representing all the English regions) took part in the study;
- Healthcare commissioners are still largely unaware of care farming and those who have heard of it often do not fully understand either the concept or the potential benefits;
- There are three main routes to commissioning care farm services through health and social care:
    a. Commissioning bodies (CCGs and LAs) for small-scale or individual contracts;
    b. Commissioning bodies (CCGs and LAs) for large-scale contracts;
    c. Individual service users with personalised health or social care budgets;
- All care farms examined in the study have service users referred through Local Authority teams but only 17% care farmers received referrals through their CCG - in

[1] also include interventions such as social and therapeutic horticulture, animal-assisted activities, ecotherapy, wilderness therapy and facilitated environmental conservation
[2] http://publications.naturalengland.org.uk/publication/6186330996342784

the form of ‘social prescribing’ or something similar (route a); 2 of the care farms in the study are currently accessing clients through large scale contracts as a result of being part of a consortium (route b); but increasing numbers of service users come through personal social care budgets (route c);

- Commissioners supported the development of consortia to allow greater commissioning to care farms, but felt that these would be best comprised of organisations offering a range of different types of care for a particular user group. Many care farmers are already operating in such partnerships (both formally and informally) and the majority said they would be interested in developing links in order to provide a range of opportunities or a larger ‘offer’;
- The commissioners in the study support care farmers adopting the Care Farming UK Code of Practice as a minimum standard in order to demonstrate a consistent standard across the sector. Similarly there was broad support for the Care Farming UK Code of Practice from care farmers;
- Commissioners highlighted the importance of collating both generic and care farm specific evidence of a broad range of care farming outcomes including clinical and generic health, wellbeing, social functioning outcomes, evidence of reduced service use and also cost-benefit analysis. All of the care farmers agreed that commissioners were placing an increased and more explicit focus on outcomes and recognised the need to evaluate effectiveness (but were unclear about how they might evidence, quantify or value such outcomes).

Discussion:

The findings of this study have demonstrated that the changes in the health and social care landscape are impacting on commissioners, service providers and service users alike. Changes in public spending have led to reductions in available resources for the delivery of community-based health and social care, and there is also an increased requirement to engage with individuals who are commissioning their own services through the personalisation agenda. Commissioners are reducing transaction costs by awarding fewer, larger scale service contracts, whilst seeking simultaneously to support more innovative services. Developing an understanding of these changing processes and associated local priorities combined with providing care farm services which target these priorities, should enable care farmers and other nature-based providers to engage and deliver services effectively.

Many CCGs are still in the process of assessing the type of service provision they require rather than having reached the point where they are actually looking at commissioning new services. The use of direct payments has changed the commissioning landscape in relation to Local Authority services, and personalisation in healthcare might similarly impact on future contract commissioning on the part of CCGs and other healthcare provision.

Increasingly, consortia are seen as a way to enable third sector service providers to engage with larger health and social care tendering opportunities and are thought to be particularly beneficial for relatively small service providers. These relationships are likely to help all participating care farmers to enable them to access the larger contracts that are out of the reach of individual providers, particularly if consortia are for services that engage with particular client groups.

This study has identified three main routes to commissioning care farm services through health and social care:

i) **Through commissioning bodies (CCGs and LAs) for small-scale or individual contracts**. These are contracts for small numbers or for individual service users; currently the most common contracts for care farming services from LAs; also

sometimes derived from specific grant funding to support innovative practices such as social prescribing (Box 5.1);

ii) **Through commissioning bodies (CCGs and LAs) for large-scale contracts.** These are contracts/tenders for larger numbers of service users increasingly preferred by CCGs; such large contracts are not currently accessed by care farmers; there is a need for care farmers to develop partnerships and consortia to enable large-scale provision;

iii) **Through individual service users with personalised health or social care budgets.** These are contracts for care for an individual; currently some care farm services are provided for those in receipt of personal social care budgets; as yet, not many through personal health budgets; there is a need for care farmers to engage with individuals, their families and their support workers to facilitate these contracts.

Commissioners in this study expressed a desire for a consistent quality of service across the care farming sector and supported the uptake of the care farming Code of Practice. Care farmers also identified the need to ensure that those who provide a care farm service are operating to a comparable and acceptable standard. Care Farming UK introduced the care farming Code of Practice and CEVAS training to address this issue and care farmers widely support these initiatives.

The emphasis on the integration of health and social care through CCGs and Local Authorities is likely to provide excellent opportunities for care farms, which already focus on providing integrated care. Typically care farms provide a holistic service that delivers multiple outcomes for people with a wide range of personal needs - a fundamental strength of care farming. Highlighting this will help to raise awareness of the suitability of care farms in providing the sort of integrated service desired by both policy makers and service commissioners.

Recommendations:

Raising awareness of care farming

Although Local Authorities in some areas are commissioning care farming services, many health and social care commissioners remain unaware of care farming and the associated benefits at the strategic and operational level. In addition, the general public, including many current and potential service users and their families, are also unaware of the benefits of care farming or even of its existence as a treatment option:

1. **Care Farming UK, needs to work with other supporting organisations to significantly improve the promotion of care farming services at a national level to:**
   - **the general public** (including potential service users, carers and their families);
   - **to strategic health and social care commissioning agencies** (such as: NHS England, Public Health England and the Local Government Association);
   - **to patient representation bodies and specialist advice organisations** (e.g. MIND, Alzheimer's Society) **and should also support regional or county networks of care farmers to promote care farming at the local level to potential service users and commissioners.**

Promoting care farm services to commissioners

There are three main types of health and social care commissioning contract available for care farm services: i) small-scale or individual contracts through CCGs and LAs; ii) large-scale contracts through CCGs and LAs; and iii) personalised health or social care budgets through individual service users. Care farmers therefore need to align their business strategies to one or more of these three types of contract if they want to effectively engage commissioners and service users:

2. **Care Farming UK should develop a range of online resources for care farmers and brigade these products and services under the 3 commissioning pathways to enable care farmers to promote the care farming sector at the local level;**

3. **Care Farming UK should provide guidance to care farmers on how to access relevant information on local health and social priorities and on how to market their care farming offer to address these needs.**

A lack of information on available placements was identified by commissioners in the study as a barrier to care farm commissioning, therefore up to date information on available care farm placements needs to be widely available:

4. **There is an urgent need for Care Farming UK to make information on all care farms in the UK available on their website, to enable commissioners to locate care farms in their area, and to see their capacity and what services they provide;**
5. **Care Farming UK should compile an annual 'care farming offer' report, publish this on its website, and communicate its availability as widely as possible to commissioners and public health officials;**
6. **Care farmers should take responsibility for providing and maintaining information on services provided and surplus capacity that will be publicised on the CFUK website and used in the 'care farming offer' report.**

Increasingly, Local Authorities and some CCGs are developing local online directories of services and service providers as a cost-effective way of publicising the local offer:

7. **Care Farming UK should work with LAs, CCGs, and supporting organisations to create a list of online directories currently in existence in order to signpost care farmers to their local hub;**
8. **Care farmers should be encouraged to register with local online directories of services and have representation on their local hubs to advertise their services to potential service users.**

<u>Accessing large scale contracts</u>

Commissioning of health and social care services through fewer contracts for larger numbers of service users is an increasing trend that has been highlighted in this study. Care farmers need therefore to consider working in partnership with providers who offer services for a specific client group, to increase their ability to engage with these larger commissioning tenders:

9. **There is an urgent need for Care Farming UK to undertake a large scale demonstration project to trial and evaluate new approaches to large scale, integrated service delivery through consortia;**
10. **Care Farming UK should signpost care farmers to information on local large scale tendering opportunities;**
11. **Care Farming UK should support care farmers to work in partnership with other care farmers or other service providers in order to access larger scale health and social care contracts.**

<u>Quality of service - Care farming standards</u>

Commissioners in this study expressed a desire for a consistent quality of service across the care farming sector and supported the uptake of the care farming Code of Practice as a minimum standard:

12. **By 2018, Care Farming UK should ensure all care farmers have adopted the care farming Code of Practice;**
13. **Care Farming UK should promote the benefits to care farmers from implementation of the care farming Code of Practice and support care farmers in completing the Code by providing additional resources to help them compile the evidence required;**
14. **In order to encourage more established care farms to complete the care farming Code of Practice, Care Farming UK should investigate a potential fast-track option;**

15. **Care Farming UK should build on the current self-assessment and support system of the Code and investigate the viability and practical application of the adoption of an externally verified accreditation system.**

Evidence of effectiveness

Commissioners are increasingly requiring evidence on health and wellbeing outcomes and of cost-benefit from care farming, and expressed a need for both generic evidence of the effectiveness of care farming and evidence specific to individual care farms:

16. **Care Farming UK should work with organisations such as Natural England, the National Outdoors for All Research Group, and Public Health England to compile and widely disseminate generic evidence of the effectiveness and cost-benefit of care farming;**
17. **Care Farming UK and Natural England should continue working towards recommending a set of standardised outcome measures, in order to enable care farmers to evidence effectiveness.**

1. Introduction

1.1. Background to the study

In 2014, Natural England engaged Care Farming UK (CFUK) to undertake a review of the care farming sector in order to better define the full range of services provided. These services include support for people with learning difficulties, autism, mental illness and dementia as well as skills training and support for disaffected young people and offenders. Care farming is one of a number of approaches which are more generically described as 'nature-based interventions' or 'green care'. Nature-based initiatives encompass all activities that utilise elements of nature specifically to help vulnerable people to achieve positive outcomes (Sempik et al., 2010). Such interventions include social and therapeutic horticulture, animal-assisted activities, ecotherapy, wilderness therapy and facilitated green exercise or environmental conservation. Whilst the process and forms of delivery can vary considerably between the different types of nature-based interventions, their linking ethos is that through structured, supervised contact with nature, coherent and deliberate strategies are used to generate health, social or educational benefits (Bragg et al., 2013).

The findings from the 2014 review of the care farming sector, "*Care Farming: Defining the 'offer' in England*"[3] (Bragg et al. 2014) identified a significant under-utilisation of existing care farming service provision and made a number of recommendations for action to encourage the further development of the sector. Actions included the need to raise awareness of the sector and to develop a greater understanding of the priorities of potential and existing commissioners in terms of:

i) evidence of client benefits from care farming;
ii) the location of care farms with unused capacity (and if specific to client groups); and
iii) any other information required by commissioners to enable the commissioning of more services to utilise the spare capacity identified.

The need for research to determine the ways in which care farmers could provide this information effectively and ensure that they can be seen to be delivering appropriate services, was also identified.

This report presents a follow-on research study by the research team (See Appendix A) for Natural England, investigating the key information needed by health and social care commissioners in order to enable and facilitate further commissioning of care farming services and the actions required by care farmers in order to effectively engage commissioners. There are currently a wide variety of commissioning organisations which contract care farming services, but including all commissioners in the study was considered beyond the remit and resources of this research. As a result, one sector was chosen to represent 'commissioners' in this research, with the expectation that:

i) many of the key issues and recommendations from one commissioner type would be transferable to other sectors; and
ii) a similar study for other commissioners could be undertaken in future.

This study therefore specifically focuses on health and social care commissioners and the information and evidence required for them to more extensively utilise care farming services.

This research was undertaken at a time of change in the health and social care commissioning landscape. This presents both challenges and opportunities for the uptake of care farm services in England, but it is hoped that the provision of an enhanced awareness of the sector will help to ensure that care farms can engage effectively within this new landscape.

[3] http://publications.naturalengland.org.uk/publication/6186330996342784

The research for this report was conducted in two phases with two cohorts of participants. Phase 1 consisted of a scoping study with both commissioners and care farmers from three counties, whilst phase 2 represented a wider study with both commissioners and care farmers from throughout England. The results from the scoping study (phase 1) were used to shape the questions utilised in the wider study (phase 2) and the results of both studies were used to inform the next steps and recommendations.

1.2. Care Farming

Care farms provide health, social and educational care services through supervised, structured programmes of farming-related activities for a wide range of vulnerable people (Care Farming UK 2014). These vulnerable people include those with learning disabilities, people with Autism Spectrum Disorders (ASD), those with a drug history, or on probation, disaffected young people and elderly people, as well as those suffering from the effects of work-related stress or mental health issues.

There are approximately 230 care farms in the UK (194 of these in England) (Care Farming UK, 2014) with an additional 25 care farms in the Republic of Ireland[4] (SoFab, 2014). In the UK, care farming has largely stemmed from the agricultural sector, with links made with health and social care, special education, probation services and others, although a minority of care farms have also emerged as a response to a specific need identified by health, education or religious organisations (Bragg 2013; Leck et al., 2014). In Ireland the context appears to be slightly different, as a survey in 2007 estimated there were around 10 private care farms and around 80 institutional farms or sheltered workshops offering care farm type services (McGloin and O Connor, 2007).

There are a number of regional and national care farming organisations which provide supporting services for care farmers in the UK and Ireland and which promote and facilitate the development of care farming. Care Farming UK is a charity which supports care farmers across the UK. Care Farming UK has strong links with Care Farming Scotland, which supports care farmers in Scotland and the Social Farming Across Borders (SoFab) project, which supports care farmers in Northern Ireland and in Eire. Other more informal groups exist in Wales and regional and county groupings and networks are operating in some parts of England, all of which are supported by Care Farming UK. Care Farming UK have also developed a Code of Practice intended to support the requirements of commissioners, clients and other authorities by providing them with some degree of assurance that care farms which adhere to the code are safe, professional and efficient[5] (See www.carefarmingUK.org for more details).

A wide range of commissioning organisations currently commission care farm services, but the majority of farms have clients referred to them by social services, Community Mental Health Teams and education services; together with clients who are self-referred, referred by family or from 'other' sources (Hine et al., 2008; Bragg, 2013). Funding sources for care farms therefore vary extensively: care farms access client fees originating from personal budgets; from Local Authority social services; self-generated funds; charitable trust

[4] This number includes a very small number of farms in Northern Ireland, but as the focus of the research was on the ROI, a comprehensive survey of NI was not included in the study.
[5] Care Farming UK are encouraging all care farmers to adopt this and in order for individual care farms to be identified as meeting this Code of Practice they must submit a self-assessment detailing how they meet each section of the code, which is then assessed by a panel of experts.

donations and philanthropy, and some care farmers also receive funding for care farm visits through Educational Access payments as part of Higher Level Stewardship (Bragg, 2013).

1.3. Health and social care in England

1.3.1. Overview

Health and social care in England is in a period of significant structural and financial change. Between 2010 and 2015, £20 billion of efficiency savings have been delivered through the Quality, Innovation, Productivity and Prevention (QIPP) programme (Bennett, 2014). Social care and community services have been experiencing comparable budget changes, with councils delivering savings of £3.53 billion to adult social care since 2010 with demand having increased by 14% over the same period (Bennett, 2014).

1.3.2. Recent changes to integrate health and social care commissioning

Integration between health and social care has been sought for many years, but it has recently become a particular priority. 'Equity and Excellence: Liberating the NHS' (2010) set out the government's long-term vision for the future of the NHS and emphasised the need for health and social care services to be better integrated at all levels of the system.

As part of the Health and Social Care Act (2012), a number of significant changes in health and social care mechanisms have been applied. Since April 2013, public health specialists from more than 70 organisations have been brought together into a single public health service under the newly formed Public Health England (PHE) (PHE, 2014). PHE sets out the strategic priorities for public health but much of the responsibility for implementing public health has now been passed to local authorities (LAs).

In addition, secondary and community healthcare services commissioning is now the responsibility of newly formed clinically-led organisations called Clinical Commissioning Groups (CCGs) (Bragg et al., 2014). CCGs are responsible for managing the majority of NHS England's budget (£65.6 billion out of a total of £95.6 billion) and for commissioning a range of health services, including community health and rehabilitation care. Despite tight controls over some elements of their design, the internal structures of individual CCGs and the nature of their relationships with other commissioning bodies (including LAs and neighbouring CCGs) vary, and governance arrangements can be complex.

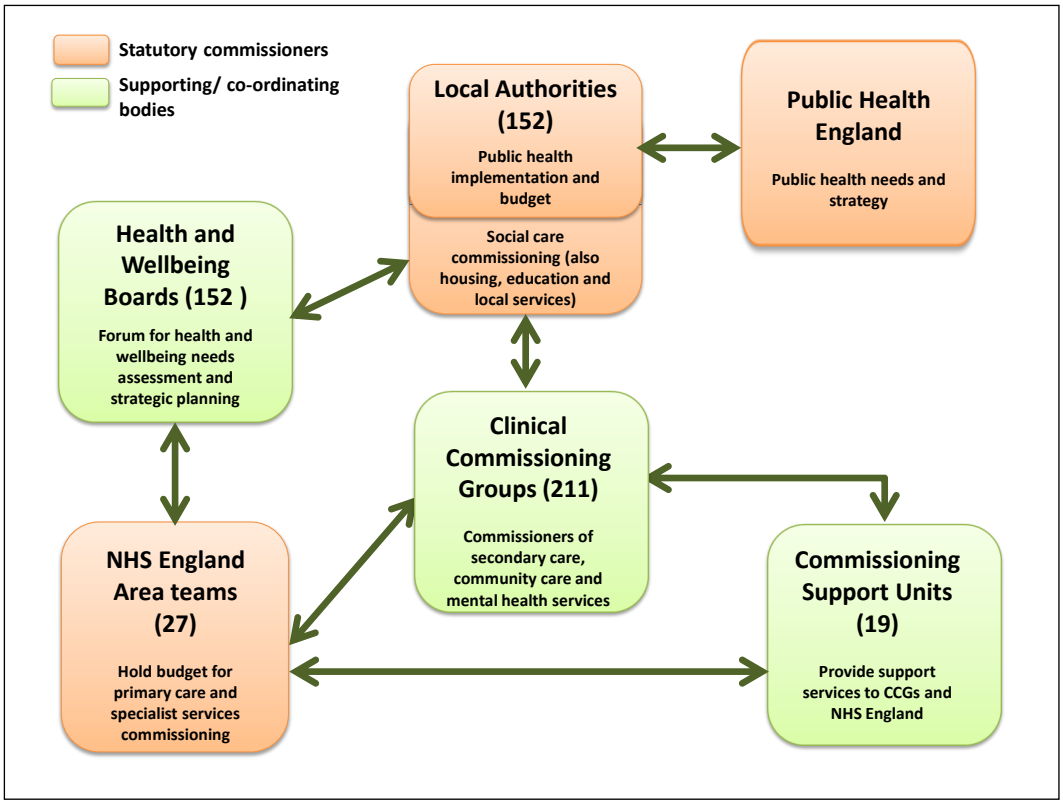
The majority of CCGs are presented as having developed structures to support GP engagement and local priority-setting, and some have developed some form of partnership arrangement or alliance with other CCGs that can include the development of joint commissioning plans. All GP practices are legally required to be part of a CCG (Naylor et al., 2013), but in reality, CCGs across England vary enormously in terms of developmental stage.

When CCGs became responsible for managing the majority of the NHS budget, the remaining commissioning functions that had previously been the responsibility of the Primary Care Trusts (PCTs) were split between a further two organisations (Naylor et al., 2013). Public health commissioning budgets of £2.7 billion were transferred to the 152 top-tier Local Authorities in England (county councils and unitary authorities) and NHS England (formerly the NHS Commissioning Board) became responsible for commissioning primary care (£13 billion) and specialist services (£12 billion) through its 27 area teams. These area teams also have a role in holding CCGs to account and providing them with support (Bragg et al., 2014).

In addition, as part of the Health and Social Care Act (2012), a network of regional Health and Wellbeing Boards (HWBs) has been established in England. Each top tier and unitary local authority has its own HWB. The role of these HWBs is to improve health, mental health and social care provision and delivery by facilitating partnership between the CCGs and LAs and thus increasing the integration between the two services (Local Government Association, 2014). By conducting a joint health and social care needs assessment of their area population and subsequently developing a health and wellbeing strategy, the aim is to encourage coherent, joined-up and more effective commissioning, prioritise local activity (short, medium and longer term) and influence commissioning behaviour (Allen and Balfour, 2014; Ham et al., 2015).

HWBs therefore consist of strategic commissioners of both health and social care from CCGs and LAs respectively. It was intended that the newly developed HWBs, convened by local authorities, would co-ordinate the activities of these various commissioning groups (Naylor et al., 2013). Therefore, although the new commissioning landscape reduces upward accountability to NHS England, this was accompanied by increased outward accountability to the HWB and inward accountability to the membership of the CCG. Details of the links between the various health and social care organisations in England are shown in Figure 1.1.

Figure 1.1. The new health and social care commissioning system in England



Source: Bragg et al., 2014b; Adapted from Naylor et al., 2013b.

As yet, reorganisation in both NHS England and commissioning support units since the implementation of the Health and Social Care Act (2012) does not appear to have changed the structure of CCGs. However, there are plans to reduce direct commissioning of primary care and specialised services by NHS England in order to devolve more responsibility to CCGs. These reforms reflect increasing concern that previous changes have fragmented commissioning responsibility, with population-based budgets being split between CCGs, NHS England and LAs (Ham et al., 2015). Whilst it is too early to identify the benefits of new commissioning arrangements, it is hoped that they will enable CCGs to work more closely

with LAs and that transferring responsibility for public health to LAs will allow for a broader approach to health promotion.

1.3.3. Information on providers of care and support services

The Care Act 2014 requires the provision of information and advice to enable providers of care and support services to advertise their services to people who may need them. Online directories, hubs or portals are one such way to provide relevant information and to highlight the services and service providers available in an area. Some higher tier local authorities have these online directories in place and others are developing them. Some voluntary sector organisations are collaborating to publicise voluntary sector providers, and in other cases environmental organisations in an area are doing the same. There is likely to be some overlap.

These directories appear to vary widely in terms of information is required for inclusion and what services are ultimately publicised. Some directories only allow one service (or client group) to be publicised at a time; some vet applications prior to featuring them on a directory, whilst other directories rely on user feedback to ensure quality control. In addition, search facilities are more effective if the enquirer knows what they are looking for but are less effective for browsing through potential services.

1.3.4. Personalised budgets

In addition to the structural changes to increase integration between health and social care commissioning, the introduction of personal health budgets (in conjunction with increasing numbers of personal social care budgets) has been highlighted as providing an ideal opportunity to further develop integration (Forder et al., 2012). Personalisation is central to funding changes that are accompanying reductions in public spending and is likely to have a significant impact on the commissioning landscape. Personal budgets relating to social care funding have been available since 2007 (Bennett and Stockton, 2012), but personal health budgets are now also being promoted. The government has committed to rolling out personal health budgets for patients who are eligible for NHS Continuing Healthcare[6].

The take up of budgets in relation to adult social care initially proceeded more slowly than was originally proposed, but, by the end of March 2014, 648,000 people in England (62% of eligible individuals), were accessing care and support through a personal budget (Health and Social Care Information Centre, 2014). However, only 23.6% currently manage their personal budget personally through a direct payment, with the remainder being managed by councils on their behalf or taking the form of Individual Service Funds (Bennett, 2014). The extent to which personal budgets are currently being applied varies significantly between different councils, with figures of over 90% applying in some areas whilst others remain at less than 25%. A similar degree of disparity is evident in relation to the relative take up by people with differing primary needs; more than 80% of people with a learning disability have a personal budget as compared to less than 30% of people with a mental health problem (Bennett, 2014).

It is not yet clear how integrated health and social care packages and payments will develop, evaluations of current schemes (see Appendix B) have suggested further developments will be required to increase the diversity of opportunities and to increase the scale of uptake

[6] Individual budgets have also been proposed in relation to young people with special educational needs, with the aim to increase the involvement of children, parents and carers in the commissioning process and to place an increased emphasis on outcomes. Pilots are currently underway to extend the use of individual budgets for young people to those in residential settings (Bennett, 2014).

(Bennett, 2012; Forder et al., 2012). Commissioners will also need to implement new methods of quality assurance that are appropriate to a wider range of service providers. A 'dual carriageway' approach, trialled in some areas, allows contributory organisational structures to remain in place whilst simultaneously enabling the individuals concerned to benefit from integrated support (NHS Confederation, 2012). The Care Act (2014) will start to be implemented in 2015 which is intended to empower individuals to take responsibility for choosing the care and support they receive rather than this being controlled by commissioning organisations. It places an emphasis on early intervention, prevention and enablement, promotes increased integration between health and social care, provides for a new national assessment framework and further promotes the application of personal budgets (Bennett, 2014; SCIE, 2013).

1.4. Aims of the study

In light of the changes to the health and social care commissioning environment and the under-utilisation of existing care farm service provision, there is a need to discover how best to engage commissioners in care farming. The aims of this two phase study were therefore to develop an understanding of how care farmers are engaging with health and social care commissioners, to discover the key information needed by those commissioners in order to enable larger scale commissioning of care farming services and to determine the best means of providing this information.

The key objectives for the study are separated into those for commissioners and those for care farmers.

1.4.1. Objectives: Commissioners

Awareness of service:

- To assess the extent to which health and social care commissioners are aware of and utilise care farm services;
- To explore whether care farming is perceived currently as an appropriate service by health and social care commissioners.

Key information and evidence of outcomes:

- To clarify the key information and the format in which it is required across the range of different health and social care commissioners, to support their decision-making and enable them to engage with appropriate service providers;
- To determine the type of evidence of client and service benefits (outcomes, economics) that commissioners are requiring to be made available to demonstrate efficacy; and to identify the extent to which commissioners seek the provision of specific client outcomes when they commission these services.

Commissioning processes:

- To determine whether commissioners (e.g. CCGs) perceive particular benefits of being able to commission services from groups of service providers rather than on an individual basis (e.g. from consortia);
- To develop an awareness of any additional ways in which commissioners think the care farming offer could be packaged to meet their requirements effectively.

1.4.2. Objectives: Care Farmers

Current commissioning of care farming services:

- To determine which care farms still have unused capacity and whether this applies across their offer or to specific clients groups;
- To determine the extent to which care farmers currently engage with commissioners and access clients;
- To explore the challenges that care farmers face when engaging with commissioners and the strategies that they have adopted to overcome them.

Offering services in partnership:

- To determine the extent to which, and processes through which, care farmers currently engage with one another and other service providers;
- To develop an understanding of care farmers' willingness, and ability, to provide services on consortia basis; determine whether brokerage is desired (and who should provide it); and ascertain how such developments might be managed and delivered most effectively.

Further support:

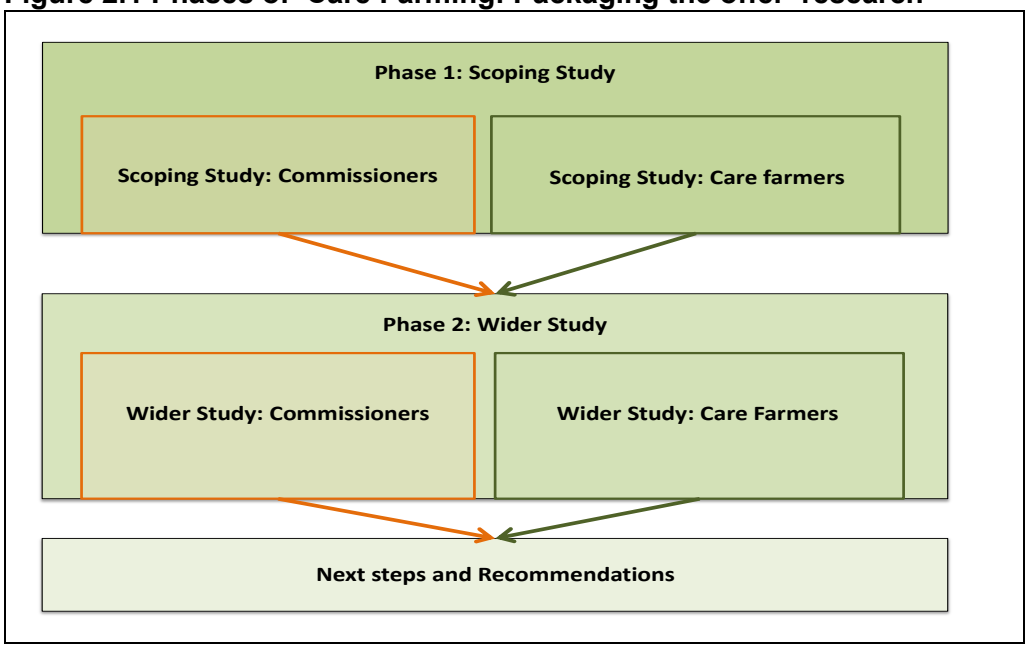
- To identify further ways in which care farms might reasonably be supported to provide a service that meets the needs and requirements of health and social care commissioners;
- To identify the extent of the information relating to services and excess capacity that care farmers want publicised via the Care Farming UK website; and assess willingness to take responsibility for providing and updating this information;
- To cost the subsequent database, website and mapping developments required to meet the above objectives and to assess the resources needed (staff and funds) to ensure suitable support in the future.

2. Methodology

2.1. Overview

This study was structured in two phases, each of which took place with both care farmers and commissioners (Figure 2.1). Phase 1 was a scoping study which sought to engage care farmers and commissioners in three pre-determined counties: Dorset, Suffolk and Worcestershire. These counties were selected on the basis that they contained reasonable numbers of both established and recently constituted care farms, included urban and rural areas and were reasonably geographically diverse. Phase 2 followed on from phase 1 and consisted of a wider study with commissioners and care farmers throughout England. The results from phase 1 were used to inform the design of phase 2. The findings from phase 1 and phase 2 will be used to inform the next steps in terms of engaging health and social care commissioners with care farming services.

Figure 2.1 Phases of 'Care Farming: Packaging the offer' research



2.2. Commissioners

2.2.1. Phase 1: Scoping study

Participants

For the scoping study, health and social care commissioners in the counties of Dorset, Suffolk and Worcestershire were approached. Nineteen emails were sent to request the participation of commissioners with health and social care commissioning responsibility from all relevant county councils and CCGs[7]. Emails were followed up with phone calls, to avoid generic organisational email addresses and to identify the most appropriate person for participation and to encourage participation. All commissioners who agreed to participate provided verbal consent and took part in a telephone interview at a mutually convenient date and time. The consent included permission for the interview to be digitally recorded.

[7] A list of CCGs was obtained from the Health and Social Care Information Centre, which indicated that Dorset has one CCG, Suffolk two CCGs and Worcestershire three CCGs.

Method
A questionnaire and supporting structured interview were developed based upon the outcomes of the *Care Farming: Defining the 'offer' in England* (2014) report which identified a need to raise commissioner awareness of care farming and develop a greater understanding of the needs of commissioners in order to enable greater commissioning of care farming services; and after discussions with the external advisory group (See Appendix C). The questionnaire asked commissioners about their current commissioning of nature-based interventions and care farms, the process of commissioning services and the ways in which they would prefer to commission services (Appendix D). The purpose of this questionnaire was to explore how care farm services were perceived and accessed by service commissioners. A focus was placed on identifying key data concerning commissioning requirements and processes to develop an appreciation of strategies that might potentially be applied to enhance the relevance of the care farming offer.

Interviews were conducted by an experienced researcher and were sufficiently flexible in style to allow lines of particular interest to be identified and pursued. Interviews lasted between 20 and 60 minutes and all interview data were transcribed into a Microsoft Excel spreadsheet for sorting and analysis. Independent researchers analysed the data using thematic analysis techniques. A coding structure was devised initially to refine the open categories created by the research questions and additional categories were then incorporated to accommodate further information that was provided. No predetermined proportion of the data was required to evidence a particular theme; the guiding principle was that it captured something of relevance to the research aims. Quotations from interviews have been included to illustrate identified topics and themes. A comparable strategy was applied in relation to the analysis and reporting of qualitative data provided by care farmers.

2.2.2. Phase 2: Wider study

Participants
For the wider study, health and social care commissioners throughout England were approached. A total of 448 commissioners, including those from the 192 UK CCG's, 152 Health and Wellbeing Boards and Public Health England, were subsequently emailed a covering letter and link to the online survey in December 2014. Reminder emails were sent out in January 2015 and followed up by a telephone call or standardised telephone interview with a selection of commissioners. All commissioners who agreed to participate provided their verbal or written consent to do so.

Method
An online questionnaire was developed based on a refined version of questions used in phase 1 of the study (Appendix D). The questionnaire sought to determine whether those with responsibility for commissioning health and social care services were currently commissioning nature-based interventions, whether they are aware of care farming and its services and what would be required in terms of evidence and accreditation in order to encourage CCGs to commission placements to care farms. The questionnaire also asked whether CCGs would prefer to commission care farming services via consortia and how this could best be structured. Questions were also included about partnership working between both service providers and CCGs. Questionnaire data were collated by Survey Monkey in a series of Microsoft Excel spreadsheets. Independent researchers from the University of Essex exported the data and transferred it to an SPSS database for sorting and analysis. Thematic analysis techniques were applied in order to analyse the data.

2.3. Care Farmers

2.3.1. Phase 1: Scoping study

Participants
All 29 care farms listed on the CFUK database as operating within Dorset, Suffolk and Worcestershire were invited to participate in the study via email. The 15 care farmers who agreed to participate took part in a telephone interview with the researcher and provided verbal consent to do so.

Method
A questionnaire and supporting structured interview were developed based upon the outcomes of the *Care Farming: Defining the 'offer' in England* (2014) report which identified that in addition to the need for a greater understanding of the commissioner requirements, there is also a need for research to determine the ways in which care farmers can provide the information required by commissioners and to ensure that they can be seen to be delivering appropriate services.

The questionnaire asked care farmers about organisations currently commissioning their services, how they promote their services to commissioners and work in conjunction with other care farms (Appendix E). Interviews also obtained information about excess capacity on care farms and how care farmers felt they might be supported in providing a service that met the requirements of relevant commissioners. All interview data were entered into a database for sorting and analysis. Independent researchers from the University of Essex analysed the data using thematic analysis techniques.

2.3.2. Phase 2: Wider study

Participants
All 15 care farmers who had contributed to the first phase of the study were contacted by email to request their participation in a telephone focus group in January 2015 (nine subsequently took part). Nine care farmers (one representing each of the eight English regions and one from London), were also invited to take part in semi-structured interviews. The CFUK database and data on current care farm provision provided by the 2014 'Defining the offer' survey (Bragg *et al*., 2014) were consulted to ensure that a sufficiently diverse sample was incorporated. All the care farmers who were contacted consented verbally to take part in the interviews.

Method
For focus groups with care farmers, a list of interview topics was developed based upon the findings of the scoping study. These topics and a summary of the results of the first phase of the study was sent to all prospective participants a week before groups were scheduled to take place; a reminder containing the same background information was also sent on the preceding day. The purpose of the focus groups was to facilitate an open discussion of the key issues that had emerged during the first phase and to consider further how the care farming offer might be most effectively presented and promoted to support the needs of service providers, users and commissioners. The interviews with care farmers who had not been involved in phase 1 of the study addressed a number of topics including current commissioning of their services, partnerships with other care farms and whether farms had evidence of their outcomes. The care farmers were informed about the purpose of the study but were not provided with data from the previous phase. Focus group and interview data

were collated in a series of Microsoft Excel spreadsheets. Independent researchers applied thematic analysis techniques in order to analyse the data.

3. Commissioner results

3.1. Commissioners study: Key findings

- A total of 29 commissioners took part in the study, representing a range of commissioning roles and contexts including 4 from Clinical Commissioning Groups; 5 with a health care role; 9 from Local Authorities (adult social care, mental health and drug and alcohol services); and 11 from public health;
- Thirteen commissioners indicated that they were currently commissioning placements to nature-based interventions and 10 of these said they are currently commissioning care farm services. However, healthcare commissioners are largely unaware of care farming and those who have heard of it often do not fully understand either the concept or the potential benefits;
- There are 3 main routes to commissioning care farm services through health and social care:
    a. commissioning bodies (CCGs and LAs) for small-scale or individual contracts;
    b. commissioning bodies (CCGs and LAs) for large-scale contracts;
    c. individual service users with personalised health or social care budgets;
- Few commissioners currently use online hubs or directories to promote available local services and to increase accessibility. Although most felt that this was a good idea it was not something that they would have the resources to provide;
- Commissioners would encourage care farms to go into partnership with other service providers and to do so according to client group or geographical area, as this is likely to be of most relevance. Commissioners also supported the development of consortia to allow greater commissioning to care farms, but felt that these would be best comprised of organisations offering a range of different types of care;
- Commissioners highlighted the importance of collating evidence of a broad range of care farming outcomes including clinical and generic health, wellbeing, social functioning outcomes, evidence of reduced service use and also cost-benefit analysis. Commissioners felt that there would be value in having generic evidence from care farms, in addition to any evidence from specific or individual care farms. A comprehensive evidence base would therefore engage the greatest variety of commissioners;
- The commissioners in the study support the idea of care farmers adopting the Care Farming UK Code of Practice in order to engage commissioners and to demonstrate that they have the appropriate knowledge and experience to work with vulnerable people, and that the relevant safeguarding is in place.

3.2. Commissioners results

This section of the report details the data that were collected from the health and social care commissioners who were interviewed for the both the first and second phases of the research. The results are organised in the following sections:

- Commissioners in this study;
- Current awareness of and commissioning to care farms;
- Benefits and barriers to commissioning care farm services;
- Commissioning processes: Access, promotion and partnership working;
- Evidence requirements;
- Care farm standards.

Additional comments from commissioners in the study can be found in Appendix F.

3.3. About the commissioners

A total of 29 commissioners took part in the study, representing a range of commissioning roles and contexts including 4 from CCGs; 5 with a health care role; 9 from Local Authorities (adult social care, mental health and drug and alcohol services); and 11 from public health.

In phase 1, ten commissioners were interviewed. Four of these commissioners were representatives of different CCGs, whilst the remaining six were commissioners within LAs. None of the commissioners who were interviewed for this first phase of the study were actually members of the Health and Wellbeing Board, but one was required to attend their meetings (Head of Public Health) and others (working in both health and social care) said that they were working with the priorities of the HWB in mind. In phase 2, a total of 19 commissioners completed the online survey. Of these, 11 had a public health role, 5 a health care role and 3 a social care role.

3.4. Current commissioning of nature-based interventions

Commissioners were asked if they currently commissioned placements that involved nature-based interventions. The 28 commissioners who responded to this question were evenly split as to whether they currently commissioned nature-based services or not, with 13 (46%) commissioning placements that involved nature-based interventions, and 14 (50%) not commissioning these services[8]. Placements commissioned included care farming, walking, gardening and horticulture, forest skills, equine therapy and courses at local agricultural colleges. However, these had always been commissioned on an individual basis and some respondents indicated that the commissioning of such activities was reducing due to funding cuts.

3.5. Current commissioning of care farming services

3.5.1. Awareness and commissioning of care farming services

The commissioners who took part in the study had a varied awareness and knowledge of care farming with the majority (79%) having heard of care farming, and 21% who had not. All ten commissioners who took part in phase 1 reported that they had heard of care farming, perhaps unsurprisingly given that care farming is fairly well established in these counties. Four of those concerned were known already to be involved with commissioning placements on care farms and others may have been directed to take part in the study on the basis of their prior knowledge.
Despite the commissioners in this study being aware of care farming, it was suggested that this was not necessarily the case amongst other commissioning colleagues. This was backed up by the findings from phase 2 where only five of the 19 phase 2 commissioners reported that they were familiar with care farming services, whilst most said that they had heard about it but didn't know much about it. *"Care farming is….still relatively new in terms of how it works into the wider health and social care offer in this county and England more generally."*

Only around a third (n=10) of commissioners interviewed were currently commissioning care farming services. However, the majority (58%) said that they would like to find out more about care farming.

[8] One commissioner was unsure

3.5.2. CCG commissioning

The CCG commissioners involved in the study appeared to be less aware of care farming as a potentially relevant intervention than their LA counterparts. However, one of the interviewed commissioners had played a key role in the implementation of a 'Farming on Prescription' scheme to enable people with mental ill-health to be referred by their GP for sessions at a care farm. Whilst this was successful for the patients who chose to engage, the GPs needed regular reminding to refer to the service. The CCG commissioners in the study were not aware of similar schemes at other care farms, but expressed interest in the development of such schemes in future.

Commissioners said that they were limited in the extent to which they could commission 'new' services, as they were required to honour existing contracts inherited from the PCT. Some commissioners did point out that contracts were starting to come to an end, which might enable services such as care farms to participate in future tendering opportunities. Whilst care farming was presented as potentially being suitable for commissioning through CCGs, it was also highlighted as advisable to avoid contracts that were being transferred from other providers as a result of TUPE[9] requirements regarding the transfer of responsibilities relating to the former provider.

Box 3.1 Comments from CCG commissioners

"I'm kind of aware of them as a concept and I find them quite interesting and really it would be great to sort of understand…it's not something that's really come up on the radar to be honest."

"I think we have to permanently remind GPs that the service is there because they have such high volume workloads these days that when someone goes to them feeling low with symptoms of anxiety or depression the easiest thing is to write a prescription…."

"The fortunate thing is the procurement rules changed this year….We have to tender…..it will give us some other opportunities for some innovation and that might open up the care farm type approach to things."

3.5.3. Local Authority commissioning of social care services

All LA commissioners whose primary role was social care indicated that increasing numbers of people now had control of personal budgets that resulted in them taking over commissioning responsibilities. These commissioners indicated that some people were choosing to spend their personal budgets attending local care farms and related activities.

Box 3.2 Comment from Local Authority commissioners

"*We can't contract….because the money we'd spend on the contract we've given to people with personal budgets. That's the big shift that both providers and sometimes clients struggle with….The county council role is more now promoting than commissioning."*

3.6. Benefits of commissioning care farm services

Some commissioners highlighted that they perceived care farming as an activity that had specific benefits for people with particular needs, but others recognised that it might also serve a wider population. The overall benefits of commissioning placements at care farms were identified as improved physical and mental health, development of skills relevant for

[9] Transfer of Undertakings (Protection of Employment) regulations (TUPE). Further information is available at https://www.gov.uk/transfers-takeovers/overview

employment, enjoyment, physical activity and social interaction (see Box 3.3).
Commissioners who had 'placed' service users on care farms indicated that they had found them to provide an effective service, attributed to a number of factors:

- the specific farm context;
- the wider opportunities provided;
- participation enables clients to engage with a wider range of people, in terms of their personal circumstances and needs.

Box 3.3 Benefits to commissioning care farming services - as highlighted by commissioners

"In a rural county like Shropshire, farming and farming related industry are key sources of employment, therefore care farming provides an opportunity for vulnerable people to access training, expertise and support"

"I am from a farming background and am fully in agreement to the benefits that the service can provide to service users which encourages confidence and ability, whilst allowing them to learn and be more self-aware"

"People really enjoy attending such sessions"

"General wellbeing outcomes of physical activity, mental wellbeing, reduction in isolation and possible skills development. Also a sense of job well done and taking people out of their day-to-day environment into something new"

"When society works well it's through a mixed model and actually to segregate people in any shape or form hinders their development.…It's about the impact and the outcome rather than their diagnosis."

"Care farming is something that can be tailored to support the needs of those with mild, moderate and more severe mental health needs. Because it's an environment based support system, I think it can probably do a raft of different things for a different range of clients."

3.7. The barriers to commissioning care farming

Commissioners were also asked to identify barriers currently preventing them from commissioning care farming services. These included health and safety issues, lack of funding and transportation, and the access issues for more remote care farms. Commissioners were aware that the provision of appropriate evidence could provide particular challenges for operations such as care farms particularly for those who favoured better established health-related intervention strategies. Some commissioners also identified the fact that care farms catered for a wide range of client groups as a potential difficulty. Further comments relating to perceived barriers of commissioning are shown in Box 3.4.

Box 3.4 Barriers to commissioning care farming - as highlighted by commissioners

Funding, infrastructure and access:

"Funding, conflicting agenda, political context and climate" "Lack of infrastructure that is friendly to this type of intervention" "Financial barriers with current budget cuts" "Availability of placements"

"Accessibility is often an issue if the service is off the public transport route and the bus provided is full, if the service user has mobility problems" "Shortage of funding and geographical proximity of service providers"

Client groups

"Eligibility as a barrier to services. Services are very popular as people wish to attend and may not fit the eligibility criteria if they are low or moderate needs" "What I had to get over to our people, was when talking about the provision was that, no, it wasn't a learning disability provision or a mental health provision or a dementia provision, but rather they welcomed all and everyone."

Health and safety

"Health and safety worries including infections and injuries" "…There is an element of danger which

would be a risk to anyone who is working within the farming environment which as a result could unnerve service users if they are exposed to any incidences…."

Awareness

"Knowledge about the farms and resources that they provide" "Clinicians are very curious about how these things work, especially if it's a social model. They are more used say to therapies like CBT and reluctant to engage with alternatives." "Most people don't have it in their list of things they would prescribe."

Contracts:

"Some of our contracts are rather large so you need to have that financial capability behind you to be able to be capable of delivering those services that last for between 3 and 5 years."

"Care farming caught us right in that transition period. If it had come in 5 years previous to that we probably would have block contract funded it."

3.8. Commissioning processes: Access and promotion

3.8.1. Directories of service providers

In phase 2 of the study, commissioners were asked whether they currently use online directories or hubs in order to highlight the services and service providers available in their area, in order to increase accessibility. Whilst the majority of commissioners (94%) deemed online hubs to be necessary and a good idea; only 6% are currently using them. The majority (79-83%) of commissioners are not currently developing an online hub and are not currently considering using one. Most commissioners (83%) also felt that although a hub was a good idea, they were unable to provide the service at this time.

However, commissioners did identify that IT was often being used to enable both commissioners and service users to develop an awareness of service providers in their area, with many commissioners also using E-tendering to both inform people about the availability of tenders and to enable them to apply. Furthermore, a commissioner representing a LA outlined an IT scheme (due to be launched April 2015) to enable people in receipt of personal budgets to develop their packages online. The logistics of this scheme were presented as work in progress, but it was thought that there would be two levels at which service providers could be registered, to distinguish those who are accredited from those who are not.

Box 3.5 Comments from commissioners on online directories

"We've got electronic my life portals and what have you that staff can use to source, you know, resources in their local area."

"If you go onto our CCG website, all the procurements that are coming up, it's all in the public domain."

"What the council's doing at the moment is setting up a marketplace….where people with personal budgets will be able to get on and see exactly what's available and I would imagine other councils will be going down the same route as well."

3.8.2. Promotion of care farming services to commissioners

Many commissioners emphasised the fact that care farmers would benefit from proactively promoting and publicising their services, particularly with regards to engaging health service providers such as GPs and CCGs. It was suggested that many of these commissioners are currently unaware of care farming as a service, the target groups reached and the potential benefits. Several commissioners stated that this proactive behaviour was already evident, with some care farmers, having successfully researched commissioning priorities in their locality and clearly demonstrating how their service can support these local priorities. Given that commissioning priorities change, commissioners felt that it is also important for care farmers to keep up to date with the changes to ensure that they can continue to provide relevant services.

3.8.3. Changing needs of health and social care commissioning

Given the changing expectations of those accessing health and social care services, the commissioners in the study felt that there was therefore a need for alternative operating models. Some LA commissioners indicated that care farms were the sort of operations that were less likely to receive block contracts from core budgets in the future, others stated that as they were still controlling funds, they would be continuing to administer block contracts and would work promoting services, operating preferred provider lists, managing targeted funding streams and administering budgets on behalf of individuals.

LA commissioners also highlighted that they were keen to help third sector providers to access relevant funding (either as grants from independent sources or Government funding for a specific purpose or to engage with a specific target group), a factor likely to have increasing relevance with further reductions in care budgets. This would provide opportunities for LAs to operate in partnership with care farms rather than purely as service commissioners. Furthermore, since the more traditional service providers are not always willing or able to engage with the changes in health and social care commissioning, LA commissioners felt that there were increased opportunities for commissioning alternative forms of provision, such as care farms.

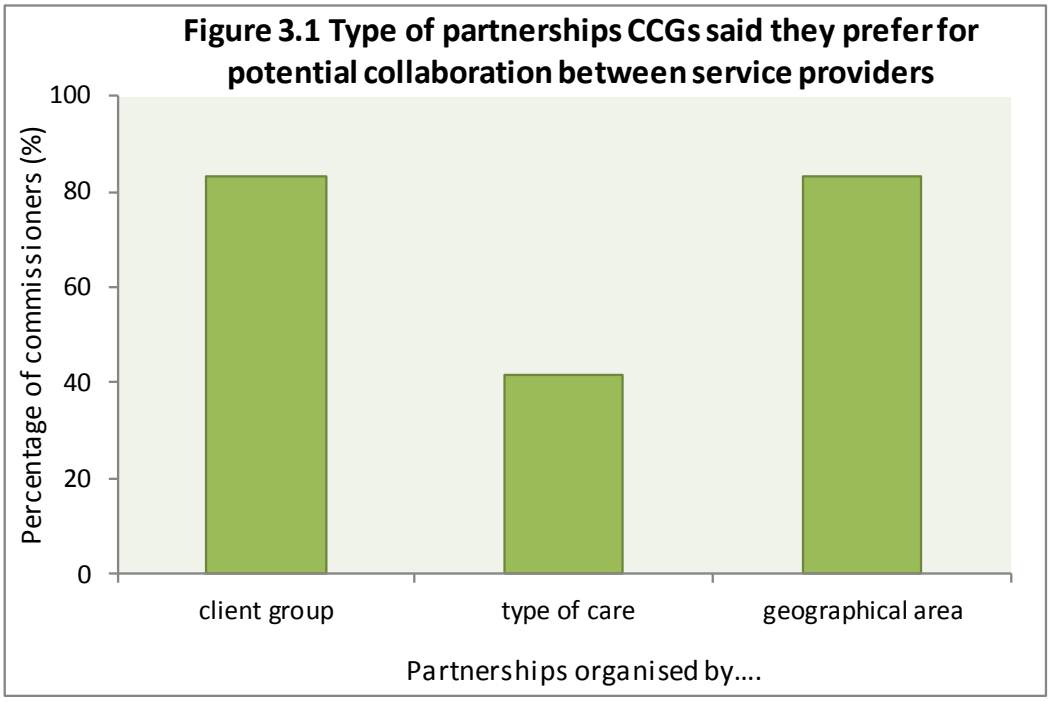
3.9. Commissioning Processes: Working in partnership

3.9.1. Types of partnership

Commissioners were asked about potential partnership working, both between service providers and between commissioners in different areas. Regarding partnerships between different service providers, commissioners were asked whether they would find it most useful for such partnerships to be based on:

i) the client group catered for;
ii) the type of care provided; or
iii) geographical area.

The majority of commissioners said that they would prefer partnerships to be based on either the client group or geographical region, with fewer requiring partnerships based upon the type of care (see Figure 3.1).



Regarding commissioning services in partnership with other commissioners in neighbouring regions, the majority of commissioners were supportive, with 41% already doing so, 18% looking into doing so and 12% interested in developing such partnerships[10]. When asked about the benefits of partnerships between commissioning groups, the majority of commissioners reported that partnerships could be used for economy of scale (79%), use of existing structures/good practices (86%) and for integrating service delivery (86%). More than half of commissioners also reported that partnerships could be used for better dissemination of information about service provision (57%).

Commissioners are sometimes already in partnership with other health and social care service providers in relation to Section 75 of the National Health Services Act (2006). These partnerships can involve NHS Trusts, CCGs and LAs and can result in commissioning responsibilities relating to mental health being shared or redeployed. Although the value of integration between health and social care has been talked about for many years, commissioners stated that it is now starting to be applied in practice - a new reality likely to favour the commissioning of holistic care services such as care farms.

Box 3.6 Comments from commissioners about partnerships

We commission most of our mental health services through the local NHS Trust and then some of the joint commissioning we do; we have a pooled fund joint with the county council."

"I think the whole health and social care framework is quite dynamic.…It's moving at the moment and there is a stronger emphasis on integration across the piece."

[10] 29% were not interested in developing such a partnership

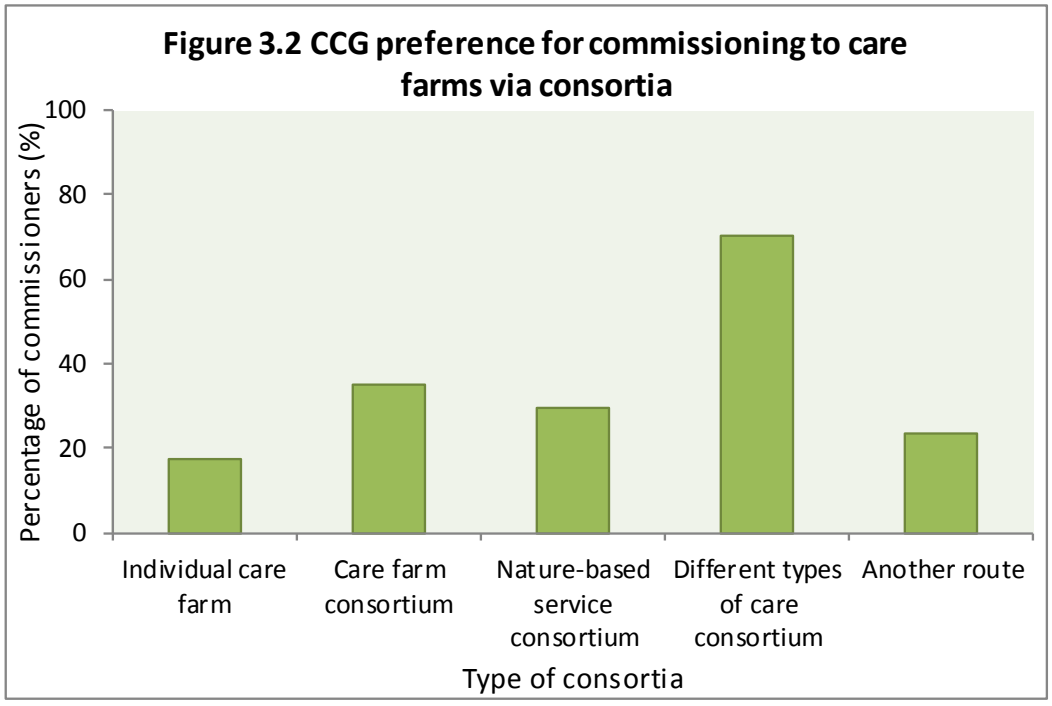
3.9.2. Commissioning through consortia

Commissioners were asked about their preferences for commissioning via consortia[11] or individual service providers. Approximately 70% said that working in consortia could be a suitable, effective and worthwhile model, likely to be:

i) beneficial for relatively small providers (given the size and longevity of some of the contracts for which they sought tenders);
ii) beneficial to be operating from under a shared umbrella (Box 3.7).

In phase 2 commissioners were asked more specifically about the structure of such consortia and whether they would prefer to commission via:

i) an individual care farm;
ii) via consortium of care farms;
iii) a consortium of nature-based interventions;
iv) a consortium of organisations able to offer a range of different types of care, or
v) via some other route (Figure 3.2.).



The majority of commissioners (67%) said that they would prefer to commission services from a consortia of organisations able to offer different types of care; 33% through a consortium of care farms and nature-based interventions; 17% would commission from an individual care farm; whilst 22% would use another commissioning route such as "*a provider that they know…"* and that their commissioning route *"depends on the contract…"*

Commissioners recognised that consortia could adopt different ways of working, but that the inclusion of a broader range of services in a consortium (rather than care farms alone) would help members to more successfully integrate their particular strengths and would increase choice. However a central requirement of such systems was the existence of a primary person or organisation with whom they could engage.

[11] Groupings of organisations set up for a common purpose

Commissioners value consortia as a less well established, but nevertheless potentially innovative approach, with service providers being able to engage with tenders from which they would otherwise be excluded (as a result of not having an established track record). Not all commissioners in the study supported operating within consortia and one suggested that care farmers might not be suited to the associated inter-dependencies. Other commissioners suggested that consortia were actually becoming less applicable in the current climate. This opinion was expressed by council representatives rather than those representing CCGs, but this distinction may change if personal health budgets start to impact on contracting requirements (see Box 3.7 for more comments).

The Dorset Continuum was given as an example of an operational consortium that encompassed local care farms, intending from the outset to facilitate the involvement of local organisations that provided services for young people in contracting processes. The Local Authority provided funding to support its development and initial operation, in part at least, because they perceived it as a helpful vehicle for sharing information. However, it also proved successful in obtaining contracts that would have been beyond the reach of its constituent parts.

Box 3.7 Comments from commissioners regarding commissioning through consortia

"There's something very lovely about being an individual care farm that does its own thing but actually I think in today's climate of governance and risk sharing and having agreed procedures in place that are needed to make something a viable service you would probably find that you would be more successful as a larger group."

"What we tend to do is have a primary provider who will coordinate or sub contract commissioning for various different support services ….I think the way that commissioning is going is much fewer smaller contracts with lots of different people and moving towards much bigger contracts which cover wider areas."

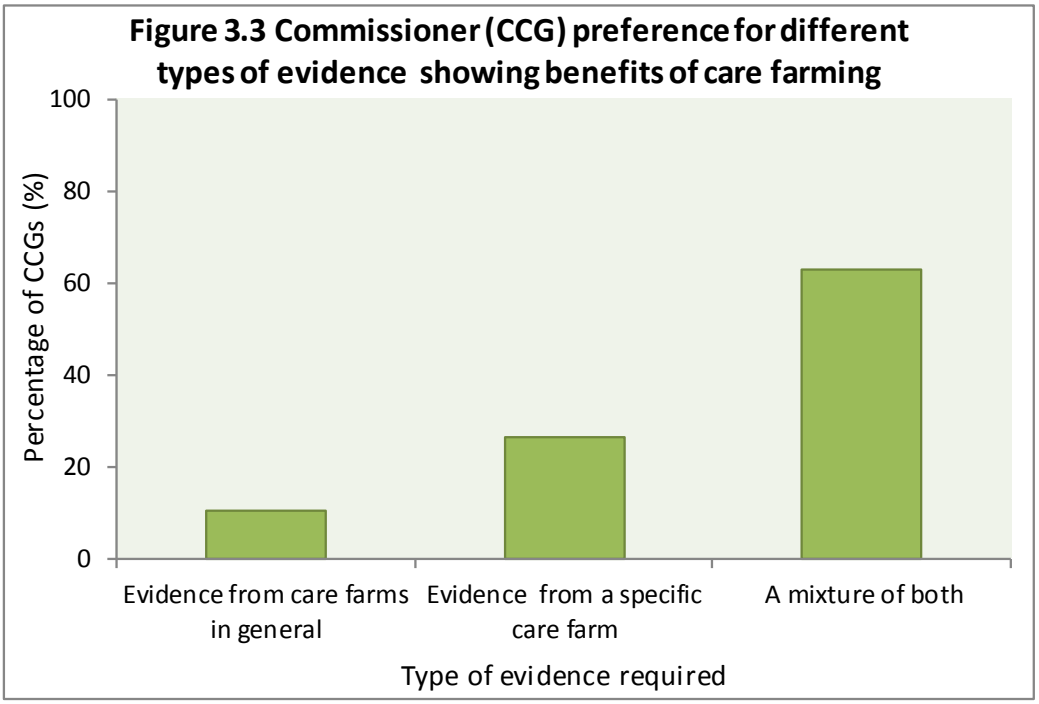
"Not everyone wants the care farm approach ….What you want is as much of a range of choice as possible. The key thing though is that each of them can deliver our particular outcomes that we are saying we want."

"The aim is to get to personal budgets and for people to support themselves in getting care so we're not really looking at block contracts through consortia."

3.10. Evidence requirements for commissioning to care farms

Commissioners indicated that there was an increasing requirement for service providers to evidence outcomes and articulate associated change for service users. Some commissioners said that they had not been focused on this previously, but this was changing, with the majority indicating that they now required service providers to identify and evidence appropriate outcomes. In fact, all commissioners indicated that evidence of care farm outcomes needs to be measured formally with 88% stating this was 'very important' and 12% as 'fairly important'.

The type of outcomes required varied both according to the needs of the individual and according to local priorities. Broadly, commissioners felt that evidence of wellbeing, social functioning and clinical health outcomes; alongside reduced service use, evidence of personal recovery and skill development were of importance. Some commissioners also reported that a social return on investment or cost benefit analysis would also be useful.



Commissioners indicated that whilst evidence of outcomes is increasingly required from all interventions, the fact that care farming is considered a relatively unproven treatment option means that it is particularly important to be able to show its efficacy. Commissioners suggested that it would be helpful to be provided with evidence relating to care farming more broadly and also that which related more specifically to the particular care farms with which they might engage (Figure 3.3).

There was recognition that some of the evidence might relate to other countries within which care farming was more widely established, but this was still presented as relevant and helpful. Psychometric scales and physical tests could be applied further to collect meaningful quantitative data to measure change and that qualitative data were also helpful to help understand the impact of any changes. Box 3.8 gives further comments from commissioners regarding the evidence of care farming outcomes.

Box 3.8 Comments regarding evidencing care farming outcomes

"I think that, on the individual level, when I've visited care farms you can see some really significant impacts….Their contribution is, I think, easily discernible."

"I think it's about being sure what the health outcomes are because nobody will commission anything in health these days unless there are associated health outcomes."

"It's very hard now to get commissioners to part with money without there being a form or sort of evidence that it's really improving quality or it makes efficiency savings. It's the brutal world that I'm living in now."

"My advice to CCGs would be to look at your clinical evidence base, of which there is quite a bit now, to support the outcomes. Not only in this country but further afield where it's been more engrained."

"We're as interested in narrative based outcomes, as we are in statistics."

"*How does it sit with the wider service offer.…How could it be positioned so that actually it supports people in moving, in taking on more of a preventative essence to it ….How does care farming, and the essence of care farming, work with ….the commissioning market ….Where does it take its place and how does it show itself as being something which can be quite dynamic as well as kind of therapeutic in a softer sense…. How is it really supporting the move on of individuals rather than it becoming, a kind of day service....which are out of fashion."*

3.11. Care farm service standards

3.11.1. Care Farming UK Code of Practice

Commissioners were asked if they would be more likely to commission to care farms which had adopted a Code of Practice. All commissioners supported the existence of the care farming Code of Practice developed by Care Farming UK and felt that it helped to:

i) demonstrate that care farms were providing a shared standard that suitably served and protected vulnerable clients; and
ii) that care farms were aware of the shared standards that they needed to provide (see Box 3.9).

Care farms being signed up to the Code of Practice was seen as beneficial by commissioners regardless of whether their organisation had an internal accreditation process that would also apply. It was also felt to be beneficial for people who were in control of their own personal budgets or managing them on behalf of a third party. Commissioners suggested that the provision of an associated kite mark might help all concerned to recognise from the outset that appropriate quality standards were in place and that it was helpful for people who provided similar services to be subject to internal as well as external scrutiny. However, it was also suggested by the majority of the consulted commissioners that from their perspective, as commissioning organisations often have their own accreditation processes in place, further external monitoring is probably unnecessary.

Box 3.9 Comments from commissioners regarding care farming standards

"It gives you peace of mind that you're buying into a certain quality."

"If you could come to a CCG and say we are now accredited, you know, it just makes it sound much more credible doesn't it. It adds gravitas to it."

"If you want to get into the business of attracting individual customers with a personal care budget then I think having accreditation of some sort would be a good thing to aspire to."

3.11.2. Additional accreditation

A number of commissioners did say that further accreditation needs were required in order for them to commission care farming services (see Box 3.10). These needs include knowledge of the client group and their needs and appropriate safeguarding. There was recognition on the part of some commissioners that care farm service providers had often come from different sectors, with some being perceived as having a background in agriculture and others as having been more directly involved with caring for people. It was acknowledged that both were relevant, but there was concern from some commissioners that farmers in particular might not necessarily be aware of, or capable of delivering, an appropriate standard of care.

In some cases preferred service provider lists are in place, which include service providers who have undergone internal accreditation. This accreditation is often required before a service provider could even apply for a tender. Although being a preferred provider was identified as preferable, this was more so the case for commissioning of services by LAs as opposed to CCGs. Even if this was not the case, experienced providers are often favoured. Commissioners identified that lists which included non-accredited service providers were used to signpost people who were in receipt of personal budgets. Many commissioners also suggested that services providers need to be accredited with organisations responsible for commissioning.

Whilst accreditation was thought by commissioners to ensure an appropriate standard of care, the process was recognised as being time-consuming and complex. It was also pointed out that obtaining accreditation could present particular challenges for new service providers as a result of their not being able to evidence their capability.

Box 3.10 Comments from commissioners regarding additional accreditation

"That they adhere to the appropriate safeguarding requirements"

"It is an unregulated activity in terms of the Care Quality Commission. Local government do their own checks and monitoring to ensure all is well e.g. barring checks"

"…..Have to become a registered provider to be accredited"

"Anyone that we commission care services from needs to be accredited with the county council…."

"it has to go to formal tender and then anybody could apply for that as long as they could fulfil the criteria."

"You have to produce evidence to show you're ok to be accredited, but if you're a new service you haven't got evidence. Some providers have had first to work just with people on personal budgets to gather evidence."

"I think things like social care tend to have a really robust provider list, but I don't think health tends to, or we don't as an organisation."

4. Care farmer results

4.1. Care farmer study: Key findings

- A total of 24 care farmers (representing all the English regions and London) took part in the study. All care farms examined in the study have service users referred through Local Authority teams but only 17% of care farmers received referrals through their CCG - in the form of 'social prescribing' or something similar (route a); 2 of the care farms in the study are currently accessing clients through large scale contracts as a result of being part of a consortium (route b); but increasing numbers of service users come through personal social care budgets (route c);
- Care farmers in the study agree that many commissioners are still unaware of care farming (particularly healthcare commissioners and those in areas of the country with fewer care farms) and that others do not fully understand either the concept or the potential benefits;
- The majority (92%) of care farmers proactively engage with commissioners (in various ways) and highlighted the effectiveness of organising visits to the farm by potential commissioners and service users. Many care farmers are included in online directories of service providers for their geographical area, but have not yet received new service user referrals as a result;
- All of the care farmers have had some contact with other care farms, but the extent and type of relationships vary greatly. Meeting up with other care farmers for networking and support was considered valuable, longer term engagement was not so clear cut – but 63% of care farmers said they would consider operating in conjunction with other local care farms in future;
- Similarly many care farmers are already operating in partnership with other service providers (both formally and informally) for a particular service user group and the majority said they would be interested in developing links with other service providers who engaged with the same client group in order to provide a range of opportunities or a larger 'offer'. The majority of care farmers (67%) also said that they would consider developing relationships with other nature-based service providers in future if this was likely to provide access to further funding opportunities and clients;
- All of the care farmers agreed that commissioners were placing an increased and more explicit focus on outcomes and on 'progression' amongst service users, often requiring evidence of health benefits and cost savings. Care farmers recognised the need to adopt strategies that would help them demonstrate change (but were unclear about how they might evidence, quantify or value such outcomes most effectively);
- There was broad support for the Care Farming UK Code of Practice – particularly for new care farms - to raise standards and to manage associated risks. Seven care farmers were either signed-up or in various stages of submission, three said they intended to go through the process at some point (but did not consider it a priority); three were uncertain; and a further four said they were unlikely to participate. Care farmers who had successfully completed the Code of Practice said that they had found it to be a useful and reasonable process;
- The majority of care farmers (88%) indicated that they would be supportive of the Care Farming UK website providing information about service user vacancies on their care farm and felt that they could take responsibility for keeping the information up to date, if they were to receive an electronic reminder at appropriate times.

4.2. Care farmer results

This section of the report details the data collected from the 24 care farmers who contributed to the study. The results are organised in the following sections:

- Care farmers in the study;

- Current commissioning of care farm services;
- Commissioning processes: Access, promotion and partnership working;
- Evidence requirements;
- Care farm standards;
- Maintaining up to date information on care farm capacity.

Additional comments from care farmers in the study can be found in Appendix G.

4.3. About the care farms in the study

In total, 24 care farmers took part in the study. Fifteen care farmers were interviewed individually during the first phase and eight of these also participated subsequently in focus groups. Care farmers were from a range of geographical areas, including in phase 1: Suffolk (6), Dorset (4), Worcestershire (3) Staffordshire (1) and Norfolk (1)[12]. The nine remaining care farmers were interviewed during the second phase of the study to provide input from each of the eight English regions and Greater London.

4.4. Current commissioning of care farm services

4.4.1. Awareness of care farming amongst commissioners

Care farmers in the study felt that many commissioners are still unaware of care farming, particularly health care commissioners and in areas of the country where care farms were less well represented. One care farmer said that 'lack of awareness' had been stated explicitly as the reason why they had been unsuccessful with their application for CCG funding. Even amongst those commissioners who were already theoretically aware of care farming, care farmers felt that they did not necessarily grasp what it actually entailed or the potential benefits.
Other issues affecting commissioning in general included possible misconceptions of the term 'care farm' and the extent and significance of the differences between the modus operandi and expectations of care farmers and service commissioners.

Box 4.1 Comments from care farmers regarding commissioner awareness

"You're bringing together two completely different cultures and expecting somehow for them to work without any facilitated process."

"I still think there is a gap in the seriousness with which people see a provision of this sort."

"I'm sure there are a lot of people on that board who have never heard of care farming."

"I think there's a huge lack of knowledge out there and that's where we suffer greatly from not having Care Farming UK beating the drum nationally."

4.4.2. CCG commissioning as 'social prescribing' or 'farming on prescription'

Nine of the 24 care farmers (38%) indicated that they had experienced direct contact with their local CCG. However, five of these were just attending meetings and although others had engaged with individual GPs, they had gained a shared impression that funding was not currently available -regardless of the efficacy of services. Four care farmers had submitted

[12] Farmers from Staffordshire. and Norfolk were included because members of the research team had been invited to meet with members of Staffordshire CC and a CCG was known already to be commissioning placements at the care farm in Norfolk.

funding bids to a CCG; three of these had proven successful but the other left with the impression that different criteria, priorities and processes were applied by different CCGs.

Case Study 1: Farming on Prescription Scheme

One of the CCG funded care farm services concerned a scheme called 'Farming on Prescription', which had been initiated with the PCT but had continued to operate under the CCG, albeit with reduced funding. GPs referred patients with mild to moderate mental health issues for 12 sessions at the care farm and goals were agreed with the patient during the first session. GPs were increasingly concerned with health-related outcomes such as weight loss, improved appetite and reduced medication, although other outcomes included social activities and improving personal wellbeing. The care farmer indicated that there was no formalised requirement to provide feedback to the referring GPs, but that they always provided this because they saw it as a critical factor with regard to keeping them engaged with the scheme.

The care farmer stressed the importance of having someone within the CCG who 'got' care farming and suggested that it might be harder to implement in areas where CCGs were more inclined to outsource their commissioning. Furthermore, although the CCG provided funding, it was his responsibility to ensure that sufficient referrals were forthcoming and this required proactive and repeated engagement with the CCG and individual GPs.

Funding cuts created further challenges, with the mental health link workers who GPs had used previously to engage patients with the care farm no longer operating within surgeries. The completion of a fairly detailed referral form was time-consuming for GPs (as compared to writing more traditional prescriptions) and the care farmer was currently assessing how this process might be streamlined. The care farmer concerned was also currently in dialogue with another local CCG about a scheme that he hoped would involve additional care farms and patients with a wider range of needs. He highlighted the fact that this CCG appeared to operate differently and to have different priorities to its neighbour, and stressed the importance of having an awareness of the local agenda and desired outcomes from the outset, to ensure that a relevant service could be offered.

For the CCG funded care farm services, this had taken the form of social prescribing, whereby GPs referred people to the farm as an alternative to medical prescribing. One care farmer had received support for a specific three year project (40% funded by the CCG and the remainder obtained from a regional trust) and an additional fixed payment relating to their core service. The three year project was now ending and the care farmer was awaiting a decision from the CCG about whether they would fund its continuation. Another care farmer who had also obtained funding for a three year pilot programme said that initially they had struggled to obtain the required GP referrals. Indeed, all three of the care farmers funded through the CCG presented it as having been necessary for them to proactively and repeatedly engage with the CCG, individual GPs and potential service users in order to operate.

Two care farmers in the phase 2 study were also in similar social prescribing schemes and another was aware of this being trialled in their locality. The awareness of social prescribing varied amongst the care farmers in the study with some involved in such schemes and others being unaware of the term. However, all the care farmers who had successfully obtained such funding via a CCG had proactively initiated the development of the scheme and presented it as providing a valuable income stream.

Box 4.2 Comments from care farmers regarding CCG commissioning

"The CCG has been in disarray I would say. No one really knows what's happening, what they're doing....even the people in the NHS would say they're only just getting it together themselves."

'We took the time to go to the shadow CCG boards and be part of that process.....there is a directive to be involved in the voluntary sector....I don't know if it's just that we happened to put ourselves in the right place at the right time."

"The funds from the CCG have been forthcoming because we have been expanding our outreach into GP surgeries and that has been the main contributor to our increased service usage because the GPs are now referring to us."

"The social prescribing pilot has been enormously successful and has led to, as I said, probably led to a good 50-60% increase in our referrals."

"What we learnt is the importance of good communication with the doctors who refer their patients to the farm."

"Other care farms will need to be really geared up to what commissioners expect to deliver and how they will provide the required outcomes if they're going to do something like Farming on Prescription."

"I keep an eye on their strategy, their wellbeing strategy….so that when I do have those conversations with people I'm able to talk their language and understand what their priorities are."

"That's the only way you really get any money, if you can solve a problem for somebody."

4.4.3. Local Authority commissioning

All of the care farmers interviewed had service users attending who had been referred via the Local Authority through various LA teams. Historically LAs have engaged with care farms to a much greater extent than their health care counterparts, however there was a general consensus that LA commissioning was currently varying with changes in funding and the implementation of the personalisation agenda. Funding challenges seem to be affecting most LA teams - people with mental health issues are perceived to be facing greater difficulties in accessing funding than those with learning disabilities, and the two care farms that had previously had contracts with LA drug and alcohol treatment teams had been informed that such funding would no longer be available. Six of the care farmers (40%) worked with young people (group and individual commissions), and their participation was not yet being affected by funding. In addition, reductions in LA funding have resulted in some existing service providers having to close, providing care farmers opportunities to engage with people who need to access alternative services as a result.

Care farmers often develop effective working relationships with individual council employees (who personally appreciate the benefits of care farming services) but this is not necessarily the case for the organisation as a whole.

Box 4.3 Comments from care farmers regarding Local Authority commissioning

"It's so difficult, particularly with the council, with all their cuts and staffing cuts and things. And sometimes you think you knew what they were doing and they've either disappeared completely or they've been moved to a different part of the county."

"It depends on the social worker that comes out and whether they actually get care farming....or whether they prefer a more traditional inside activity."

"Things are moving very rapidly into decline in terms of the amount of care they're offering, the council. I think we're being invited more to things at the council where we get told about what's out there and what we can apply for."

4.4.4. Personalised budgets

Although LA commissioners are still seen as relevant in commissioning processes and successful engagement with service users, the increased use of personal budgets for funding adult social care, has changed the extent of their influence. For two care farmers, all of their service users are now funded through personal budgets and others suggested that the personalisation agenda had resulted in it being more important to engage with key workers supporting service users rather than with strategic commissioners within the LA.

Some care farmers stressed the need to engage directly with potential service users from the outset, but others considered it important also to continue to engage with more strategic commissioners to promote services and to stay informed about local priorities and processes.

Box 4.4 Comments from care farmers regarding Personal Budgets

"Actually the days of commissioning are gone. They're on the way out. We are part of the virtual high street of day opportunities that people will choose to attend and they'll use their personal budgets."

"It would seem to depend how determined that individual social worker is to fill in the paperwork."

"I know, because I've sat in on the council side, what the personal budgets are supposed to be for and how they're supposed to work. But some social workers seem to think the budgets should be spent on specific things rather than giving the client the freedom that they should have."

"It's very difficult to plan because you don't know how big personal budgets will be and the number of days attendance it will cover."

"Now we are looking at people with very severe needs and very challenging emotional and behavioural issues as well. The people we had coming through 6 years ago, I think they're just not commissioning services for them anymore."

Some care farmers in the study expressed concerns that their LA contracts would not necessarily be renewed when current arrangements came to an end. Others pointed out that some of the people currently attending their farms were still not clear about whether they would continue to receive financial support, or had already had to stop attending as a result of reduction or withdrawal of funding. These care farmers now need to engage with new client groups such as those with more complex needs in order to access direct budgeted support. The ability to access a personal budget was sometimes seen to relate more to the commitment and perception of relevant *key workers* than the needs of the *individual* concerned; and even after a personal budget had been allocated, service users and key workers did not necessarily understand the extent to which this allowed them to exert influence regarding choice of services. Such uncertainties and associated logistical challenges were presented as having impacts on both service users and service providers.

4.4.5. Integrating health and social care commissioning

Several care farmers felt that the increasing focus on greater integration between health and social care in policy and practice would provide new opportunities for a service such as care farming which is already delivering services in both spheres. Integration is perceived to be only apparent within mental health, with care farmers indicating that they were not always certain whether associated funding and related input originated from the LA or CCG. Care farmers suggested that the 'Better Together' initiative[13] and forthcoming legislative changes meant that integration might now be translating into policy and practice - which could more widely promote and value care farming services, many of which already centre upon the provision of holistic care.

4.4.6. Alternative commissioning and funding options

The majority of care farmers interviewed (80%) also have people attending their farm who are not referred through statutory services, but rather through a wide range of local or national voluntary and community organisations (charitable and otherwise). Some of these agencies commission block contracts and others provide funding on an individual basis. Furthermore, many care farmers indicated that they often applied for grant funding (from BIG

[13] Further information available at: https://www.dorsetforyou.com/better-together

Lottery for example) to support the participation of those who were unable to access personal health or social care funding. Indeed, this income stream, often used to support the provision of services and infrastructure, was seen by some as fundamental to their continued operation in the face of funding challenges. One care farmer also highlighted the fact that it was always worth applying to individual local councillors for grant funding from the budgets in their control which are allocated annually but are sometimes returned unspent.

4.5. Commissioning processes: Access and promotion

Nearly all of the care farmers (92%) seek proactively to promote their services to commissioners. However, the longer established care farmers, having built up their reputation over a sustained period of time, said that key workers often contacted them directly to arrange referrals and that 'word of mouth' between social workers, carers and service users generated more new service users than did commissioner interactions. Of those farmers who do not promote to commissioners one said he was at capacity and another felt that it had become a *"waste of time and resources"*. Some care farmers however felt that they were possibly not approaching the most suitable person or not approaching them in the most appropriate way. Although many care farmers engaged with commissioners at the more strategic level by attending events or by inviting them to visit the farm (thus promoting their services), they did not perceive this as something that necessarily translated into service user referrals.

In terms of promoting care farming more widely, some care farmers in the study felt that whilst Care Farming UK's recent lack of funding was likely to have hampered the promotion of care farming at the national level; care farmers had a shared responsibility for promoting care farming at the local level. A number of different strategies were identified that care farmers in the study used for promoting their 'offer' to both commissioners and service users and these are shown in Box 4.5.

Box 4.5 Different strategies used by care farmers to promote their services to commissioners and service users

- Representation on directories of service providers/ online portals
- Leaving leaflets in GP surgeries, care homes and community centres / public spaces
- Contacting GPs directly and giving presentations at their meetings
- Press releases and advertising in relevant publications
- Joining voluntary and statutory provider groups and sharing information about services and events
- Organising and attending care farm conferences and events
- Maintaining an internet presence: websites, blogs and Facebook pages
- Participating at careers evenings for vulnerable young people
- Providing feedback (to carer, referrer and referring agency)
- Publishing a care farm newsletter
- Attending local service provider events with 'trade stand'
- Providing care farm open days
- Providing taster sessions
- Building partnerships with other groups

The importance of organising visits to the farm by both potential commissioners and service users was stressed by care farmers - especially if current service users were present[14]. Many care farmers offer free taster sessions and suggested that marketing these effectively could increase engagement, by helping people to recognise that these have real value and are part of a wider scale provision. For example, one successful care farm described how

[14] This is likely to be more of a challenge for newer care farmers who are still developing their client base.

their marketing leaflet contained a voucher (of a stated financial value) reflecting the cost of attending the care farm for a one-day session.

4.5.1. Directories of service providers

All nine of the care farmers interviewed for the second phase of the study are represented on an electronic portal that covers their geographical location. Some felt that inclusion on these databases and electronic market places was only available for service providers who had received formal accreditation through the Local Authority, but others said they were open to anyone who chose to register[15]. Despite this representation, there was a shared feeling amongst care farmers in the study that they had not yet proven to be a useful tool for promoting their services.

One care farmer described the Local Authority as having recently initiated what was intended to be a user-friendly portal to help those in receipt of personal budgets finding service providers, but he was unaware of any care farmers actually having obtained new service users via this route. Other care farmers were concerned that service users and their families might have limited or no use of the internet, and unless they were aware of care farming, they would be unlikely to recognise its potential for meeting their personal needs or to locate it via an electronic portal.

Box 4.6 Comments from care farmers on online directories

"As far as I'm aware that's been a complete and utter disaster - the e-market place - and we haven't had any referrals from it."

"To be honest the online portal for the county council is not much more than a database and unless you know what you're looking for its very hard to find."

4.6. Commissioning processes: Working in Partnership

4.6.1. Types of partnership

Care farmers in the study were asked about the different ways in which they could work in partnership with other organisations, including working:

i) with other care farms;
ii) with other nature-based service providers;
iii) with other care providers for a particular client group; and
iv) with a brokerage service.

Some care farmers felt that the development of consortia[16] (regardless of specific composition) as having particular relevance in the current commissioning landscape. The majority (79%) of care farmers supported the idea of increased partnership working and considered that operating within consortia could help them to access the larger tenders that were otherwise outside their reach. However, others highlighted the breadth of challenges associated with working together such as: different service providers operating in different ways, competition between providers and being unable to present a sufficiently united front. Such challenges have resulted in failed consortia attempts in the past, but there were also instances in which these had been successfully overcome. Care farmers in the study

[15] This is confirmed research for this study whereby a number of portals across the country were accessed and examined.
[16] Groupings of organisations set up for a common purpose

concluded that consortia would be beneficial for all parties if an effective and robust operational form were agreed and implemented from the outset.

Box 4.7 General comments on working as consortia

"I agree that the CCG do like the consortium idea but, from our point of view, it's very difficult to see how it would actually work."

"An awful lot of consortia break down quite quickly, with possibly disastrous results, because it is difficult to align your business with others."

There's a general desire to work together. Obviously the practicalities are always difficult ….You've got to have such a good legal framework to do it….I think it's something we're going to have to look at more."

"I think it would need a great deal of consideration. However I'm definitely up for the idea of collaborative working."

"It's actually very profitable. The downside is there's a hell of a lot of paperwork attached to it."

4.6.2. Partnerships between care farmers

All of the care farmers who participated in the study have had some contact with other care farms, but the extent, form and perception of associated relationships varied greatly. Some service users attend more than one care farm, some care farms have service users engaging in activities on each other's farms and others outlined more formalised arrangements relating to the provision of accredited training. However, for some the only contact with other care farmers comes through events organised by Care Farming UK.

In some areas of the UK, regional care farmer networks have emerged – for example in the West Midlands, Dorset and East Anglia[17]. However, these groups were sometimes seen as being too broad to serve the needs of members who were located in different counties with different commissioning processes and priorities, and as a result many areas have developed county networks instead (e.g. Suffolk, Norfolk and Essex). Networking groups were felt to be valuable for a number of reasons – for awareness-raising, mutual support and sometimes in accessing service users. Challenges regarding care farmers' network meetings included: lack of time to travel and attend meetings; meetings of unequal value for participants[18]; and concerns about competing for the same clients[19].

Meeting up with other care farmers for networking and support undoubtedly has value, but care farmers felt it was unrealistic to imagine that social interaction alone was sufficient to assure longer term engagement. When asked if they would consider operating in conjunction with other local care farms in future, 63% of care farmers said they would do so and suggested initiatives such as jointly marketing regional care farms to relevant commissioners; developing comparable price structures; or jointly selling produce. Other care farmers said they would consider all forms of collaboration if they thought that it would increase service user numbers.

Those who had reservations felt that: the existing networks (including Care Farming UK) sufficed; funding would not be available; the care farm offer was not sufficiently 'standardised' to warrant or support closer collaboration; or that such a partnership might not

[17] External input supported the initial development in all instances - Care Farming West Midlands had received grant funding from the Regional Development Authority to proactively develop care farms and support service providers in Worcestershire, Suffolk CC had provided grant funding to support the development of local care farms and a Dorset Land Network has been developed and facilitated by the LA.

[18] new/ less experienced care farmers seeking too much support from more experienced care farmers

[19] although care farmers who were in fairly close geographical proximity felt they provided sufficiently distinct opportunities/cohorts to enable them to co-exist satisfactorily

always be practical or desirable (for example in areas where there are low numbers of care farmers or where excessive numbers of care farms created competitive challenges).

Care farms enhance wellbeing by enabling people to spend a sustained period of time engaging with agricultural places and activities, but the context can vary widely. Although the diversity of the activities and approaches included under the care farming umbrella can sometimes be seen as a challenge, most care farmers in the study felt that this diversity creates opportunities for care farms to work together, rather than being competitors.

Box 4.8 Comments on care farmer partnerships

"We are all of us small businesses and we suffer the implications of that in terms of the amount of time we have available to engage with each other."

"We agreed that we'd actually work in county groups because that's where commissioning happens."

"We're passionate about what we're doing and we can get burnt out with trying. It's about pooling those resources and being stronger as a body as opposed to an individual."

"We weren't a cooperative that shared business, we were a cooperative that strategically marketed our sector….Now we're individually promoting what we do and moving forward."

"The bid was well received, but, because it didn't cover all of the county, it was no good. If we had bid with other farms in the county it might have worked."

"You are relying on other farms to deliver their side of the contract. Farmers I think, rightly, are very reluctant about that. It's not an established model. So, while I think one might be interested, I can't see many people signing up for it."

"We definitely don't see ourselves in competition with anybody."

"I suppose we exist in this bubble of....competitive collaboration."

4.6.3. Partnerships between different nature-based care providers

The only evidence of care farmers engaging with other nature based service providers that emerged during the first phase of the study concerned the Dorset Land Network. This had been initiated and managed by the LA, but was on the point of losing this support and its continued existence was presented as uncertain. Care farmer members of the group said that the breadth of services included in the network posed challenges (with regard to adequately serving their needs) but others painted it in a more favourable light.

Many care farmers (67%) said that they would consider developing relationships with other nature-based service providers in future if this was likely to provide access to further funding opportunities and clients. Some care farmers were already members of local groups that incorporated a range of nature-based activity providers, but none of these had been successful in accessing joint funding. One care farmer described discussions having taken place with regard to seeking to jointly bid for contracts, and agreement having been reached about this being potentially worthwhile, but none of the members had been willing or able to take responsibility for taking this forward. Another group was presented as having started the process of developing a joint bid but various challenges had resulted in this never having been submitted.

4.6.4. Partnerships of care providers for a specific client group

Many care farmers are already operating in partnership with other service providers (both formally and informally), but with the shared interest being service user or client group. For example, two care farmers described being part of a consortium of service providers that engaged with children and young people to facilitate engagement with contracting mechanisms. The initiation of this consortium had been supported by the LA; it had now been operational for about a year (after two to three years of development) and was presented as already having successfully tendered for contracts and generated referrals. Other care farmers indicated that they had considered joining local third sector bidding consortia but that they had not yet actually done this as a result of concerns about how such operations could work in practice.

All nine of the care farmers interviewed for the second phase of the study indicated that they would be interested in developing links with other service providers who engaged with the same client group to provide a range of opportunities to cater for their personal requirements.

Box 4.9 Comments on partnerships by client group

"We work in partnership. That has increased our numbers. It has increased our reputation and our viability rather than worked against us."

"I'm more interested in operating in collaboration with other sort of service providers than other care farms …I want people who can actually bring something to the party."

"There was a bidding process and the consortium won that bid because they had this variety of offerings in the consortium... it looks quite innovative. That's what the great strength of it is."

4.6.5. Commissioning through brokerage

When asked whether brokerage services[20] were seen as a strategy for enabling care farmers to engage with larger contracts, 67% of care farmers asked said they would consider this if it actually translated into service users attending the farm. However most care farmers said they had insufficient surplus income to fund such a service or felt that developing consortia was perhaps a more effective strategy for generating new commissions. Those who did not support brokerage suggested that it was unnecessary, would not produce sufficient benefits or felt that the challenges would be prohibitive.

Those who expressed interest in the idea of brokerage had several ideas regarding who might best provide such a service, with some favouring an independent third party such as Care Farming UK. Others felt that brokerage would be better managed by care farmers themselves or by one of their representatives. There was much debate regarding the form that such brokerage should take, with some care farmers suggesting that it should be about supporting the provision of shared operational quality and rigour (rather than directly providing placements); whilst others felt that Care Farming UK might usefully provide a form of brokerage that disseminated information about funding opportunities and liaised with interested care farms.

[20] Brokerage services in this sense – where an independent agent or third party acts as the 'middle-man' between those wanting to commission a service and those who are providing a service – i.e. matching clients to care farms. A broker would likely charge a fee from one or both parties for providing the service.

4.7. Evidence requirements for commissioning to care farming

All of the care farmers agreed that commissioners were increasingly focused on outcomes and on 'progression' amongst service users although one care farmer did not feel that this had yet translated into an explicit requirement for provision of evidence. Several care farmers felt this presented new challenges that they did not necessarily feel able to address, but it was suggested that CEVAS training might help care farmers to put appropriate strategies in place. The majority (88%) of care farmers already had some evidence of outcomes that they could share with commissioners, but the form very much depended upon the individual service user to whom it applied and often took the form of case studies. Commissioners increasingly require evidence of health benefits and cost savings and care farmers recognised the need to adopt strategies that would help them demonstrate change (but were unclear about how they might evidence, quantify or value such outcomes most effectively).

Care farmers described various tools that they used to collect data, including:

- a range of questions that they had compiled themselves (sometimes encompassing SMART goals) to obtain subjective perceptions of relevant change (social, mental and physical);
- various externally devised and validated scales;
- the health section of the Client Services Receipt Inventory;
- Soft Outcomes Universal Learning (SOUL) record;
- Outcome Stars[21].

Care farmers agreed that no one particular method of measuring outcomes was sufficiently flexible to apply universally to such a varied client base, whose personal needs and aspirations differ enormously.

Several farmers said that their greatest challenge concerned the collection of data that would be perceived as sufficiently objective by service commissioners. Only two of the care farms had evidence that had been undertaken by external organisations (a university and a research consultancy), but such studies are likely to exert the greatest influence on commissioners. One care farmer is currently collaborating in a three year project with a local university to conduct a Randomised Controlled Trial (RCT) and another is using pedometers to measure increased participant physical activity when attending a care farm.

Box 4.10 Comments on evidence of outcomes

"We're starting at very different levels with each of the individuals that we work with....Each person you're trying to take on a completely different journey."

"Recently I've had clients commissioned with outcomes that they'd like to see, which is really interesting. Before we used to just get clients and that was it."

"We evaluate everything that we do and the effect it's having on people but it's largely been a subjective process and, the trouble with commissioners is, they want objective outcomes and it has to be up to them, I think, whether we like it or not."

"What we've been told is we have to be able to demonstrate, on an on-going basis, whether or not we achieve any cost savings to the NHS."

"What we don't have (and I don't know quite how we could get it to be honest), is the kind of financial effectiveness proof because it's really hard to quantify."

[21] Outcomes Stars were highlighted repeatedly as having been applied and adapted successfully to measure change that took place whilst people were attending the care farm, but due to copyright issues and prohibitive costs it was not deemed appropriate for all care farms.

4.8. Care farm service standards and the Care Farming UK Code of Practice

4.8.1. Views on the Care farming Code of Practice

A broad appreciation for the Care Farming Code of Practice, developed by Care Farming UK was expressed from care farmers in the study. This voluntary Code of Practice has been developed and implemented for a number of reasons – primarily to promote a minimum set of standards to which care farms should comply in order to raise standards and to manage associated risks. Many care farmers in the study raised concerns about service providers being able to promote themselves as care farms without being required to meet any sort of quality standards[22] and wondered if the Code of Practice could also include a physical check in future. In fact some care farmers advocated an even more rigorous accreditation process to further demonstrate that they were providing an appropriate and legitimate standard of care. They suggested Care Farming UK as an appropriate organisation for delivering such a scheme but acknowledged that considerable funding and resources would be needed to support its operation.

Other care farmers felt that more formalised inspections were unnecessary and impractical, pointing out that although positive outcomes could result from the adoption of the code, significant numbers of care farmers would need to sign up for such a scheme in order for it to gain sufficient credence. Whilst the code was seen as being particularly helpful for new care farms, some felt that the additional workload could present particular challenges for care farmers who are already operational or who are required to undergo other accreditation processes (often linked to specific commissioners). The majority of care farmers in the study (76%) are already accredited by at least one external commissioning organisation (including Local Authorities, Ofsted and the Care Quality Commission) in order to deliver care farming services to clients.

Some Local Authorities in particular only commission services from those on an approved provider list or who have undergone some form of internal or LA accreditation process. Although this process can be arduous, care farmers have found it ultimately beneficial for providing both credibility and potential customers. One care farmer indicated that their LA was currently seeking proactively to engage smaller local providers in tenders but that only those they had previously accredited were entitled to register interest[23]. Furthermore, another care farmer who had recently completed an LA accreditation process highlighted the fact that this had already resulted in their receiving a large number of new referrals.

Many elements of the Code of Practice are similar to those required under different schemes, but care farmers felt that completion of the CFUK Code of Practice could help to ensure they had the necessary documentation in place - but acknowledged that pulling all the elements together is a time consuming process and as yet there is little formal recognition of the code from commissioners. It was also suggested that the code was more easily accessible by people from a care or business management background rather than from an agricultural background, but other care farmers pointed out that CEVAS[24] training was available to provide relevant support and document templates.

[22] one care farmer highlighted a provider that they already considered to be operating inappropriately under the care farming 'banner'

[23] The intent was that the LA would select a lead supplier from amongst interested local third sector groups and they would then manage a contract encompassing other local service providers.

[24] CEVAS - Countryside Educational Visits Accreditation Scheme. A nationally recognised accreditation scheme offers training for individuals who are working – or plan to work – with groups of school children, young people or clients with additional needs – i.e. education or care farming http://www.visitmyfarm.org/cevas-farmer-training

4.8.2. Uptake of the Code of Practice

In terms of how many care farmers in this study were currently signed up to the Code of Practice, seven care farmers (41%) were either signed up and completed (2), in the process of submission (4) or had started the process (1); three said they intended to go through the process at some point (but did not consider it a priority); three were uncertain; and a further four said they were unlikely to participate[25]. Care farmers who had successfully completed the Code of Practice said that they had found it to be *"a useful and reasonable process"*. Others indicated that if something were put in place that resulted in their no longer needing to complete alternative commissioner processes then they would engage with the Code of Practice.

Box 4.11 Comments about the Care Farming UK Code of Practice and accreditation

"The Code of Practice is excellent and I think everyone should be encouraged to do it."

"I think we need some sort of care farm inspection and standard. I know a lot of care farms are wary about this but farms are dangerous places, we are working with challenging people and it only takes one thing to go wrong…."

"I think there needs to be a central national accreditation for care farms. If we're all going to go under that umbrella there needs to be a minimum care standard that we're all sticking to."

"Any Code of Practice is going to overlap with existing statutory things …so I never saw the point of it, although in principle it sounds like a good idea."

"We have to provide the evidence of a whole range of areas of our provision in order to be able to go onto the preferred suppliers list so that really became our priority."

"I think it's particularly good for people coming into care farming. It gives you something to work through."

"What that actually does, selfishly, it gives us a kite mark I suppose. Yep, we've ticked the boxes. We use that a lot on our marketing material."

"I really do think in all honesty that somehow we should be accredited or regulated….It's all too easy for people to start doing something like this and not know what they're doing."

"It's funny because probably early on I was one of the ones who was pushing for a kite mark - we need to get something out there. But the more you go into it....it's just ticking another box and we still need to meet all their other requirements as well to achieve those standards."

"We feel a little bit inspected to death....the prospect of more inspections wouldn't appeal to me. ...I can't really see the benefit to be honest."

4.9. Maintaining up to date information on care farm capacity

In 2014, a review of the care farming sector (Bragg et al. 2014) was undertaken in order to better define the full range of services provided. In order to elaborate on and possibly map the identified unused capacity on care farms by user group, care farmers in this study were asked to check the information about their service currently held on the Care Farming UK database. Due to the dynamic nature of service user placements, the information on the database regarding surplus capacity was found to have changed for approximately half (54%) of the care farmers in the study.

There were a number of changes, either: there was no previous data available (2); numbers of service users had increased and farms were now operating at full capacity (2); overall capacity had increased (both numbers of service users and surplus capacity) (4); numbers of service users had increased but still some surplus capacity (5); numbers of service users

[25] one felt the associated requirements were excessive

had decreased (2). Surplus capacity per specific client group was available for only 2 of the 24 farms.

The majority of care farmers (88%) said that they would be supportive of the Care Farming UK website providing information about service user vacancies on their care farm (as long as this did not give the impression that because they had unused capacity, they were in some way failing). One farmer was undecided and the other two indicated that as their capacity was flexible it was not appropriate to state specific numbers (as they are sometimes able to make additional space if required).

All of the care farmers who were supportive felt that they could take responsibility for keeping the information up to date, but suggested that it would be helpful to receive an electronic reminder about this at appropriate times[26].

[26] Care farmers in phase 2 were then provided with information about how to access and amend (if required) their surplus capacity details on the CFUK database and two of the farmers who updated their details said that they had found this to be a straightforward process.

5. Discussion and Recommendations

5.1. Discussion

5.1.1. Addressing study aims

Due to the recent changes within the health and social care commissioning environment and the under-utilisation of existing care farm service provision, a need to discover how best to engage commissioners in care farming was identified. The aims of this study were therefore to develop an understanding of the key information needed by those commissioners to enable increased commissioning of care farming services, and to determine the best means of providing this information at both local and national levels.

The findings of this study have demonstrated that the changes in the health and social care landscape are impacting on commissioners, service providers and service users alike. Changes in public spending have led to reductions in available resources for the delivery of community-based health and social care, and there is also an increased requirement to engage with individuals who are commissioning their own services through the personalisation agenda. Commissioners are reducing transaction costs by awarding fewer, larger scale service contracts, whilst seeking simultaneously to support more innovative services. Developing an understanding of these changing processes and associated local priorities, combined with providing care farm services which target these priorities, should enable care farmers and other nature-based providers to engage and deliver services effectively.

The intention of this study was to enhance understanding of healthcare commissioning with a view to increasing the uptake of referrals to care farms. Although Health and Wellbeing Boards do not have a direct commissioning role, their membership includes representatives of LAs and CCGs and they are responsible for formulating a Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS). Despite their importance in the promotion of an integrated health and social care agenda, the impact and influence of individual HWBs varies greatly and many do not yet appear to be fully achieving this (Humphries and Galea, 2013).

Similarly, whilst there is some evidence of limited growth in the use of non-NHS providers for the provision of community and mental health services (Ham *et al.,* 2015), Clinical Commissioning Groups are in different stages of operational development. Many CCGs have contracts inherited from their PCT predecessors; some are finalising their procurement and tendering rules; whilst other CCGs are still in the process of assessing the type of service provision they require (rather than having reached the point of commissioning new services).

5.1.2. Health and social care commissioning

The overwhelming majority of care farm placements are currently funded through education and social care budgets that are controlled by Local Authorities, rather than through healthcare budgets. LAs have also seen funding changes in recent years and increased personalisation is reducing their direct commissioning responsibilities. Nevertheless, LAs are interested in partnerships with local third sector organisations (to access additional grant funding) and can be influential in promoting the care farm offer more widely.

The use of direct payments has changed the commissioning landscape in relation to Local Authority services, and personalisation in healthcare might similarly impact on future contract

commissioning for CCGs and other healthcare provision. It is possible that the relevance and prevalence of larger scale commissions will reduce further as the personalisation agenda gathers momentum. Although CCGs might not currently be commissioning significant numbers of care farm placements, commissioners in this study suggest that it has potential as an appropriate service in the future.

Increasingly, consortia are seen as a way to enable third sector service providers to engage with larger health and social care tendering opportunities and are thought to be particularly beneficial for relatively small service providers. Care farmers are likely to benefit as a result of engaging with consortia, but will need to ensure that they are accompanied by appropriate forums and processes that support shared decision-making and accountability. The newer and currently under-subscribed care farms potentially have the most to gain (in the more immediate term at least) from the development of closer working relationships between care farmers. These relationships will help all participating care farmers if it enables them to access the larger contracts that are out of the reach of individual providers.

Contracts tendered by CCGs (and Local Authorities) generally focus on a specific client group with particular needs rather than seeking to engage with a specific form of service provision (Addicott, 2014). This was backed up by the findings in this study, suggesting that potential partnerships and consortia are likely to be most useful for services that engage with particular client groups rather than those that provide similar services. Consortia working can be beneficial, but it is essential that all parties support and are fully aware of both the model that is adopted and their associated responsibilities and risks. Care farms are innovative in their own right, but equally might enhance their offer further through targeted integration with related service providers.

Local Authority commissioners in this study suggested that ‘e-market places’ are being developed in some areas and that these were likely to become increasingly evident as commissioners seek to provide a brokerage facility to enable people with personal budgets to identify and select services of their choice. Although care farmers were not aware of anyone having used one to access their services, these online directories are likely to become more important as commissioners move to provide the information required after the Care Act is implemented in April 2015. Furthermore, these online markets enable relatively small providers such as care farmers to publicise themselves alongside larger and more established traditional service providers.

This study has therefore identified three main routes to commissioning care farm services through health and social care:

i) **Through commissioning bodies (CCGs and LAs) for small-scale or individual contracts**. These are contracts for small numbers or for individual service users; currently the most common contracts for care farming services from LAs; also sometimes derived from specific grant funding to support innovative practices such as social prescribing (Box 5.1);
ii) **Through commissioning bodies (CCGs and LAs) for large-scale contracts.** These are contracts/tenders for larger numbers of service users increasingly preferred by CCGs; such large contracts are not currently accessed by care farmers; there is a need for care farmers to develop partnerships and consortia to enable large-scale provision;
iii) **Through individual service users with personalised health or social care budgets.** These are contracts for care for an individual; currently some care farm services are provided for those in receipt of personal social care budgets; as yet, not many through personal health budgets; there is a need for care farmers to engage with individuals, their families and their support workers to facilitate these contracts.

The emphasis on the integration of health and social care through CCGs and Local Authorities is likely to provide excellent opportunities for care farms, which already focus on providing integrated care. Typically care farms provide a holistic service that delivers multiple outcomes for people with a wide range of personal needs - a fundamental strength of care farming. Highlighting this will help to raise awareness of the suitability of care farms in providing the sort of integrated service desired by both policy makers and service commissioners.

Box 5.1 Grant funding from CCGs

Despite currently appearing to be the exception rather than the rule, some CCGs were found to be providing grants to support care farm provision. Only three of the 24 care farms (13%) that contributed to this study were receiving grants to enable activities such as social prescribing, and all those concerned had directly approached and engaged with the CCG to enable their initiation rather than through wider strategic intent. However, similar schemes are now operating successfully in an increasingly large number of areas - Heywood, Middleton and Rochdale CCG are, for example, now in the third year of providing a Social Investment Fund that a service commissioner has presented as successfully reducing health inequality and supporting the development of more resilient communities.[1] This fund provides grant support to local groups and consortia who deliver innovative interventions that support the CCG's priorities. Furthermore, they have developed a commissioning model that is intended specifically to support service providers who might not be experienced at engaging with formal tenders.

5.1.3. Quality of service and evidence of effectiveness

An increasing number of LA commissioning teams operate some form of preferred provider or accreditation scheme, although associated requirements and outcomes vary. This situation currently appears to relate less to CCG commissioners, but this may change, particularly in light of the expansion of personal health budgets and the more effective integration of health and social care.

Care farmers identified the need to ensure that those who provide a care farm service are operating to a comparable and acceptable standard. Care Farming UK subsequently introduced the care farming Code of Practice and associated CEVAS training to support this. Care farmers widely support these initiatives, but some have suggested that they are insufficient, and that further accreditation is required (one that involves some sort of physical inspection). However as the majority of care farms are already required to be accredited by commissioning organisations in order to deliver services to clients, some care farmers saw complying with the Code of Practice as a lesser priority[27].

Care farming will become more widely applicable if it can demonstrate that it can deliver particular health outcomes and can facilitate cost-savings. The majority of care farmers in the study are now providing evidence concerning outcomes and progression, but this generally takes the form of internal individual assessments and case studies rather than something that can be shared with commissioners to provide a broader picture of potential outcomes. Care farms are likely to benefit from undertaking evaluations that articulate the sort of progression that is evident amongst care farm participants. Commissioners indicated that they would value evidence of effectiveness from specific farms as well as generic

[27] It is possible that all services might now be required to be seen to be providing the quality of care that is sought by the Care Quality Commission (CQC). The Care Act that comes into force in April 2015 increases the CQCs regulatory responsibilities to include the registration and increased inspection of all social care providers (Ham *et al*., 2015).

evidence. Therefore raising awareness of the research evidence base nationally and locally is likely to help facilitate increased commissioning.

5.2. Recommendations

Recommendations stemming from this research have been organised under the following headings:

- Raising awareness of care farming;
- Promoting care farm services to commissioners;
- Accessing large scale contracts;
- Quality of service - Care farming standards;
- Evidence of effectiveness.

5.2.1. Raising awareness of care farming

Although Local Authorities in some areas are commissioning care farming services, many health and social care commissioners remain unaware of care farming and the associated benefits at the strategic and operational level. In addition, the general public, including many current and potential service users and their families, are also unaware of the benefits of care farming or even of its existence as a treatment option:

1. **Care Farming UK), needs to work with other supporting organisations to significantly improve the promotion of care farming services at a national level to:**
   - **the general public** (including potential service users, carers and their families);
   - **to strategic health and social care commissioning agencies** (such as: NHS England, Public Health England and the Local Government Association);
   - **to patient representation bodies and specialist advice organisations** (e.g. MIND, Alzheimer's Society) **and should also support regional or county networks of care farmers to promote care farming at the local level to potential service users and commissioners.**

5.2.2. Promoting care farming services to commissioners

There have been many recent changes in the health and social care commissioning infrastructure, with an increased emphasis on integrating health and social care and on personalised budgets. This has been coupled with changes in public funding, and a desire for fewer, larger scale contracts. As a result, there are three main types of health and social care commissioning contract available for care farm services: i) small-scale or individual contracts through CCGs and LAs; ii) large-scale contracts through CCGs and LAs; and iii) personalised health or social care budgets through individual service users**.** Care farmers therefore need to align their business strategies to one or more of these three types of contract if they want to effectively engage commissioners and service users:

2. **Care Farming UK should develop a range of online resources for care farmers and brigade these products and services under the three commissioning pathways to enable care farmers to promote the care farming sector at the local level;**
3. **Care Farming UK should provide guidance to care farmers on how to access relevant information on local health and social priorities and on how to market their care farming offer to address these needs.**

Care Farming UK should therefore collate best practice and supporting resources for each contract type and could include: examples of successful engagement strategies for commissioners and service users, effective marketing strategies, advice, documents, web resources and workshops etc. In order to achieve this, care farmers need to be willing to

share examples of successful strategies[28] to engage commissioners and service users with personal budgets.

A lack of information on available placements was identified by commissioners in the study as a barrier to care farm commissioning, therefore up to date information on care farm placements needs to be widely available:

4. **There is an urgent need for Care Farming UK to make information on all care farms[29] in the UK available on their website, to enable commissioners to locate care farms in their area, and to see their capacity and what services they provide.** It is hoped that the CFUK database will be more widely accessed by service users and commissioners as awareness of care farming increases and as individuals have greater personal choice and control over their care;
5. **Care Farming UK should compile an annual 'care farming offer' report, publish this on its website, and communicate its availability as widely as possible to commissioners and public health officials;**
6. **Care farmers should take responsibility for providing and maintaining information on services provided and surplus capacity[30] that will be publicised on the Care Farming UK website and used in the 'care farming offer' report.**

Increasingly, Local Authorities and some Clinical Commissioning Groups[31] are developing local online directories of services and service providers as a cost-effective way of publicising the local offer. Although these hubs are currently not being used to their full potential, it is likely that they will become effective tools for engaging with the small-scale or individual CCG/LA contracts as more CCGs become aware of care farming; and engaging with personalised health or social care budgets as numbers of individual service users with personal budgets increase:

7. **Care Farming UK should work with LAs, CCGs, and supporting organisations to create a list of online directories currently in existence in order to signpost care farmers to their local hub.** Care Farming UK should also seek to publicise case studies where care farms have benefitted from directory-associated promotion;
8. **Care farmers should be encouraged to register with local online directories of services and have representation on their local hubs to advertise their services to potential service users.**

5.2.3. Accessing large scale contracts

Commissioning of health and social care services through fewer contracts that provision larger numbers of service users is an increasing trend that has been highlighted in this study. Assuming that these larger scale contracts[32] are here to stay, this creates particular challenges for smaller scale service providers such as care farms. Care farmers need therefore to consider working in partnership[33] with providers (nature-based or otherwise)[34] who offer services for a specific client group, to increase their ability to engage with these larger commissioning tenders:

[28] Anonymised as required
[29] This will be done in discussion with care farmers and will include only non-commercially sensitive information
[30] A collective agreement, or clear statement to explain what 'surplus capacity' means, will be required for clarification
[31] As well as voluntary sector umbrella organisations
[32] often for well over 200 service user places per week
[33] A National Consortium of Social Enterprises provides a free service to support commissioners and social enterprises in engaging effectively with one another if more localised schemes are currently unavailable
[34] See for example, the Natural Health Service in Merseyside http://www.naturalhealthservice.org.uk/

9. **There is an urgent need for Care Farming UK to undertake a large scale demonstration project to trial and evaluate new approaches to large scale, integrated service delivery through consortia;**
10. **Care Farming UK should signpost care farmers to information on local large scale tendering opportunities;**
11. **Care Farming UK should support care farmers to work in partnership with other care farmers or other service providers in order to access larger scale health and social care contracts.**

5.2.4. Quality of service - Care farming standards

Care Farming UK has been working with care farmers to raise the standard of care farming in the UK and has developed the care farming Code of Practice as a baseline standard to provide commissioners, clients and other authorities with some degree of assurance that care farms which adhere to the code are safe, professional and efficient[35]. Most care farms already have extensive risk assessments in place (in order to comply with the requirements of commissioners and insurance companies), and health and safety protocols are included in both the Code of Practice and CEVAS training.

Commissioners in this study expressed a desire for a consistent quality of service across the care farming sector and supported the uptake of the care farming Code of Practice as a minimum standard. It is therefore essential that the greatest possible number of care farmers complete the care farming code of practice in order to promote care farming as a quality service to commissioners:

12. **By 2018, Care Farming UK should ensure all care farmers have adopted the care farming Code of Practice;**
13. **Care Farming UK should promote the benefits to care farmers from implementation of the care farming Code of Practice and support care farmers in completing the Code by providing additional resources to help them compile the evidence required.** Such resources could include the development of workshops[36] and seeking funding to provide additional CEVAS courses across England (at an affordable price to meet demand);
14. **In order to encourage more established care farms to complete the care farming Code of Practice, Care Farming UK should investigate a potential fast-track option.** A future 'fast-track' option could be developed for care farms that already have accreditations that cover specific elements in the code, with a view to the recognition of existing accreditation;
15. **Care Farming UK should build on the current self-assessment and support system of the Code and investigate the viability and practical application of the adoption of an externally verified accreditation system.**

5.2.5. Evidence of effectiveness

Health and social care commissioners are increasingly requiring evidence on health and wellbeing outcomes and evidence of cost-benefit from care farming, and expressed a need for both generic evidence of the effectiveness of care farming and evidence specific to individual care farms. Health and social care commissioners need to be made aware of the

[35] Care farmers who have met the requirements of the Code have the use of a specific logo or kite mark available for the care farm to display on its own website and other publicity to demonstrate their completion of the CFUK Code of Practice.
[36] Different, distinct workshops are likely to be needed for existing and prospective care farmers

existing international and national evidence base in order that they may be convinced of the efficacy of care farming for many client groups:

16. **Care Farming UK should work with organisations such as Natural England, the National Outdoors for All Research Group, and Public Health England to compile and widely disseminate generic evidence of the effectiveness and cost-benefit[37] of care farming to care farmers, commissioners and other bodies of health and social care professionals.**

Some care farmers in this study suggested that they needed support in providing the care farm specific evidence of effectiveness required by commissioners. Care farmers therefore highlighted the need for standardised tools to enable them to evidence a wide range of outcomes for service users[38]. Such tools should ideally be suitable for use by care farmers to effectively measure the health and wellbeing of different user populations, to enable better understanding of associated outcomes, on an individual, organisational, regional or national level:

17. **Care Farming UK and Natural England should continue working with other organisations and researchers towards recommending a set of standardised outcome measures, in order to enable care farmers to evidence effectiveness.**

[37] Including Social Return on Investment

[38] This mirrors a similar need recently identified by several other green care service providers - for example the Green Care Coalition, Social and Therapeutic Horticulture practitioners, Growing Health, Food Collaboration Research and many individual nature-based interventions.

6. References

Addicott, R. (2014). *Commissioning and contracting for integrated care.* London: The Kings Fund.

Alakeson, V. and Rumbold, B. (2013). *Personal Health Budgets: Challenges for commissions and policy makers*. London: Nuffield Trust.

Allen, J. and Balfour, R. (2014). *Natural solutions for tackling health inequalities.* London: Institute of Health Equity and National Outdoors for All Working Group.

Bennett, S. (2014). *Getting serious about personalisation in the NHS*. Think Local Act Personal.

Bennett, S. and Stockton, S. (2012). *Personal health budgets guide. Integrating personal budgets – early learning*. London: Department of Health.

Bragg, R. (2013). *Care Farming in the UK- Key Facts and Figures*. Summary report for Natural England. Colchester: University of Essex.

Bragg, R., Wood, C. and Barton, J. (2013). *Ecominds effects on mental wellbeing: An evaluation for MIND.* London: Mind

Bragg, R., Egginton-Metters, I., Elsey, H. and Wood, C. (2014a). *Care Farming: Defining the 'offer' in England.* Natural England Commissioned Reports, Number 155.

Bragg, R., Wood, C., Barton, J. and Pretty, J. (2014b) Wellbeing benefits from natural environments rich in wildlife: A literature review for The Wildlife Trusts. Newark: The Wildlife Trusts.

Care Farming UK. (2014) Website: http://www.carefarminguk.org/

Forder, J., Jones, K., Glendinning, C., Caiels, J., Welch, E. Baxter, K., Davidson, J. et al. (2012). *Evaluation of the personal health budget pilot programme.* London: Department of Health.

Ham, C., Baird, B., Gregory, S., Jabbal, J. and Alderwick, H. (2015). *The NHS under the coalition government. Part one: NHS reform.* London: The King's Fund.

Health and Social Care Act 2012. Available at: http://www.legislation.gov.uk/ukpga/2012/7/pdfs/ukpga_20120007_en.pdf

Health and Social Care Information Centre. (2014). Adult Social Care Outcomes. Available from: www.ascof.hscic.gov.uk/Outcome

Hine, R., Peacock, J. and Pretty, J. (2008). Care Farming in the UK: Contexts, benefits and links with therapeutic communities. *Int. Journal of Therapeutic Communities,* 29(3): 245-260.

Humphries, R. and Galea, A. (2013). *Health and wellbeing boards: One year on.* London: The King's Fund.Ipsos Mori Social research Institute (2011). *Users of Social Care Budgets: Ipsos MORI report for the National Audit Office Study on the Department of Health's regulatory oversight of care markets.* London: National Audit Office.

Leck, C., Evans, N. and Upton, D. (2014). Agriculture – who cares? An investigation of 'Care Farming' in the UK. *Journal of Rural Studies*, 34: 313–325.

Local Government Association (2014). Website: http://www.local.gov.uk/health/-/journal_content/56/10180/3510973/ARTICLE

McGloin, A. and O Connor, D. (2007). *An overview of Social Farming in Ireland: The state of the Art.* Report for the SOFAR Project.

Naylor, C., Curry, N., Holder, H., Ross, S., Marshall, L. and Tait, E. (2013a). Clinical commissioning groups: supporting improvement in general practice? London: The King's Fund. Available at: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/clinical-commissioning-groups-report-ings-fund-nuffield-jul13.pdf

Naylor C, Imison C, Addicott R, Buck D, Goodwin N, Harrison T, Ross S, Sonola L, Tian Y and Curry N. (2013b). Transforming our health care system: Ten priorities for commissioners. London: The Kings Fund. Available at: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/10PrioritiesFinal2.pdf

NHS Confederation (2012). *Joint personal budgets: a new solution to the problem of integrated care?* Briefing issue 251. London: The NHS Confederation.
Public Health England (2014). Webpage: http://www.gov.uk/government/organisations/public-health-england/about .
Sempik, J., Hine, R. and Wilcox, D. eds. (2010). *Green Care: A conceptual framework, A report for the working group on the health benefits of green care, COST Action 866, Green Care in Agriculture.* Loughborough: Centre for Child and Family Research, Loughborough University.
Social Care Institute for Excellence (2013). *Fair access to care services (FACS): prioritising eligibility for care and support.* London: SCIE
SoFab (2014). *Social Farming Across borders*. Per. Commission. 30th March 2014.
The Audit Commission (2010). *Financial management of personal budget.* Available at: http://archive.audit-commission.gov.uk/auditcommision/sitecollectiondocuments/auditcommissionreports/Nationalstudies/20101028financialimplicationsofpersonalbudgets.pdf
The Audit Commission (2011). *Improving value for money in adult social care*. Available at: http://www.audit-commission.gov.uk/2011/06/improving-value-for-money-in-adult-social-care/

7. Appendices

Appendix A – Research Team involved in the study

This Natural England commissioned research involves two key organisations: Care Farming UK and the Green Exercise Research Team at the University of Essex; and input from a freelance researcher affiliated to the University of Worcester Further details of the organisations can be found in the sections below.

The wider steering group for this work comprised: Gavin Atkins (Mind); Carol Cartwright (Linking Environment and Farming (LEAF)); Dr Helen Elsey (University of Leeds); Sarah Hambidge (University of Bournemouth); David Marshall (Associate, The Bulmer Foundation) Dr Jenny Mercer (Cardiff Metropolitan University); Dr Joe Sempik (University of Nottingham); Dr Heema Shukla (Public Heath England).

1) Care Farming UK

Care Farming UK is a professional charitable company accountable to its members; and a network which provides a voice and supportive services for care farmers, to inspire decision makers and to develop policies and actions that will support care farming in the UK. Care Farming UK is led by care farmers and care farming experts, and has four strategic objectives to:

- Support care farmers - improvement in the quality and provision of services provided by care farms and to support the development of a community of practitioners;
- Develop networks - enabling care farming networks to develop across the UK that will support the practice and capacity of individual care farms and facilitate relationships with local commissioners;
- Raise the profile - increasing the profile and awareness of the impact of care farming at both a UK and national level; and
- Expand the evidence - developing the evidence-base for the effectiveness of care farming, and to disseminate this evidence.

More information on the work of Care Farming UK, including case studies and the Code of Practice are available on the Care Farming UK website, alongside details of care farms, country and regional networks, and research evidence.

2) The Green Exercise Research Team at the University of Essex

The Green Exercise Research Team involved in this study forms part of the Essex Sustainability Institute (ESI) at the University of Essex. There is growing empirical evidence to show that exposure to nature brings substantial mental health benefits and at the same time, physical activity is known to result in positive physical and mental health outcomes. Over the last 11 years at the University of Essex, these ideas have been combined into a programme of research on ‘green exercise’ (activity in the presence of nature) and ‘green care’ (therapeutic applications of green exercise and other nature based interventions). These address current concerns about the adverse health effects of modern diets, sedentary lifestyles and a disconnection with nature, along with growing evidence that stress and mental ill-health have become substantial health problems for many people in industrialised societies. This cross-disciplinary University of Essex project team is engaged in primary research on:

i) the health benefits of green exercise – investigating the mental and physical health benefits of physical activities under exposure to different rural and urban environments;
ii) measuring connection to nature; and

iii) evaluating a wide variety of green care options in varying contexts (including care farming, facilitated green exercise, ecotherapy and wilderness therapy); and; and is currently leading research in this field.

The Green Exercise Research Team were also involved in conducting the original research that supported Mind's Ecotherapy campaign in 2007 and the Ecominds Programme from 2008-2013. More information on this research can be found at the Green Exercise website.

Appendix B – Evaluation of personal budget schemes

Evaluations of personalisation in social care have highlighted that this is a cost-effective approach, which offers the service user more choice and control over their care (The Audit Commission, 2010, 2011; Ipsos Mori, 2011). The evaluation of the national pilot programme on personal health budgets also indicated that it *"was associated with a significant improvement in the care- related quality of life and psychological wellbeing of patients"* (Forder et al., 2012. P10).

However, the implementation of personal health budgets was found to require further development in order to increase diversity of opportunities and engagement with personal health budget holders and their families (Bennett, 2012; Forder et al., 2012). Furthermore, commissioners will need to implement new methods of quality assurance that are appropriate to a wider range of service providers. Quality assurance mechanisms will need to be adopted that ensure personal safety and quality service provision whilst also encouraging the provision of a range of innovative services (Forder et al., 2012; Alakeson and Rumbold, 2013).

Appendix C – Advisory group for this research

The advisory group for this research comprised:

Gavin Atkins, Mind
Carol Cartwright, Linking Environment and Farming (LEAF)
Caroline Drummond, Linking Environment and Farming (LEAF)
Dr Helen Elsey, University of Leeds
Sarah Hambidge, Bournemouth University
Dr David Marshall, Associate, The Bulmer Foundation
Dr Jenny Mercer, Cardiff Metropolitan University
Dr Joe Sempik, University of Nottingham
Dr Heema Shukla, Public Health England

Appendix D – Commissioner questions – Phases 1 and 2

Phase 1:

1. What is your role within the CCG / Council?
2. Are you a member of the HWB?
    i) Yes
    ii) No
3. Is your organisation currently commissioning care farm placements?
    i) Yes
    ii) No
    iii) Not sure

If yes, please indicate why care farming is considered to be a suitable activity

If no, please select from the following:

    i) Not aware of care farming
    ii) Not aware of local placement availability
    iii) Not considered suitable

If not considered suitable, what are the barriers that you perceive as negatively influencing the suitability of CF placement commissioning?

If not aware, would you consider commissioning care farm services?

    i) yes
    ii) no

If no, what are the barriers that you perceive as negatively influencing the suitability of CF placement commissioning?

4. Are you currently commissioning placements that involve any other sort of green care or ecotherapy?
    i) Yes
    ii) No
    iii) Not sure

If yes, please describe the activity and indicate why this is considered to be a suitable activity

If no, please indicate why this is the case by selecting from the following:

    i) not aware of green care activities
    ii) not aware of local placement availability
    iii) not considered suitable

5. How do you identify services that are taken into consideration when making commissioning decisions?
6. What process is applied to select the services that are commissioned?
7. Are there particular outcomes that are prioritised?
    i) Yes
    ii) No

If *yes,* please describe

8. Do you keep a list of preferred service providers?
    i) Yes (formal)
    ii) Yes (informal)
    iii) No

If *yes*, what would care farms and other green care services need to do to become included?

9. Do you think there are any gaps in the services you currently commission?
    i) Yes
    ii) No

If *yes,* please describe

10. If you were to commission care farm or other green care placements, would you prefer to do this on a consortia basis or to deal with individual providers?
    i) Consortia

ii) Individual

If on a consortia basis would you prefer to use an independent third party to access care farm placements or to deal directly with a representative of the service providers?

i) independent third party
ii) service provider

11. What, if anything, else could be done to improve the care farm offer from your perspective?
12. Would you or any of your colleagues be interested in visiting a local care farm?

Phase 2:

1. Is your commissioning role / remit to do with:
   i) Public health
   ii) Health care
   iii) Social care
2. Are you currently commissioning placements that involve nature-based interventions such as care farming?
   i) Yes
   ii) No
3. Are you aware of care farming?
   i) Yes – I am familiar with care farming and the services it provides
   ii) Yes – I have heard the name but I don't really know much about it
   iii) No
4. Would you like to find out more about care farming?
   i) Yes
   ii) No
5. What do you consider are the benefits of commissioning care farming services?
6. What do you consider are the barriers to commissioning care farming services?
7. Many care farms provide evidence of outcomes based upon the requirements of existing commissioning bodies or individual clients. How important is it to you that these outcomes are measured formally?
   i) Very important
   ii) Fairly important
   iii) Not very important
   iv) Not at all important
8. The outcomes of care farming have been measured internationally, nationally and by individual care farms. Current evidence suggests that care farming can provide multiple health, wellbeing and social benefits to participants.
   In order to commission care farming services, would you require:
   i) Evidence regarding the benefits of care farming in general?
   ii) Evidence from the specific care farm from which you were considering commissioning services?
   iii) A mixture of both?
   iv) Neither
9. In commissioning care farming services would you need evidence of: (you may tick more than one box)
   i) Clinical health outcomes
   ii) Generic health outcomes
   iii) Wellbeing outcomes
   iv) Social functioning outcomes
   v) Reduced service use
   vi) Other- *Add Box*
10. Most care farms already ensure that their services meet specified standards and Care Farming UK is currently encouraging members to adopt a Code of Practice. Would you

be more likely to commission placements from a care farm that had adopted the CFUK Code of Practice?

i) Yes
ii) No

11. Is there anything else that you would need in terms of accreditation in order to commission care farming services?
    i) Yes
    ii) No
12. In your area, would you prefer to commission care farming services from:
    i) Individual care farm
    ii) Consortia of care farms
    iii) Consortia of nature-based interventions
    iv) Consortia of organisations able to offer a range of different types of care
    v) Other – please tell us – *add box*
13. In order to increase accessibility, in some regions Health and Wellbeing Boards, Clinical Commissioning Groups, or Local Authorities provide online directories (hubs) of available services in their locality.
    Is an online 'hub' something that you:
    i) Are currently doing (please provide link)? *add box for this.*
    ii) Are in process of developing
    iii) Are considering doing?
    iv) Think is a good idea?
    v) Think is a good idea, but are unable to provide this service (due to lack of time or resources)?
    vi) Someone else is already providing (name) *add box for this*
    vii) Don't consider necessary
14. Throughout the country, collaborations and partnerships are forming between service providers in order to facilitate the process of commissioning. Would you find it useful for these partnerships to be based upon: (*you may tick more than one box)*
    i) The client group catered for (e.g. all available services for mental health)
    ii) The type of care provided (e.g. all available nature-based interventions)
    iii) Geographical or regional area (e.g. all available services in the region)
    iv) Other- *Add box for comments*
15. Some commissioning of services is undertaken in partnership between regions.
    Are you:
    i) Currently doing this - *add box for further information*
    ii) Looking into doing so
    iii) Not in partnership but interested in developing a partnership
    iv) Not interested in developing a partnership
16. Would you use these commissioning partnerships for: (you may tick more than one box)
    i) Economy of scale
    ii) Use of existing structures/good practice
    iii) Integrating service delivery
    iv) Better dissemination of information about service provision

Appendix E – Care farmer questions phases 1 and 2

Phase 1:

1. Does the information currently held by CFUK (obtained in previous survey) about your operation (relating to client groups and surplus capacity) remain correct?
2. Does any surplus capacity relate to specific client groups?
    i) Yes
    ii) No

If *yes,* which groups

3. Do any CCGs currently commission placements on your farm?
    i) Yes
    ii) No

If *yes,* name of CCG and contact individual, number of placements, client groups concerned and form / requirements of contract

If *no,* have you had any contact with your local CCG?
    i) Yes
    ii) No

If *yes,* please name contact and describe form / outcomes

4. Have you had any contact with your local HWBB?
    i) Yes
    ii) No

If *yes,* please name contact and describe form / outcomes

5. Do any Council departments / directorates currently commission placements on your farm?
    i) Yes
    ii) No

If *yes*, name of Council, relevant departments / directorates and contact individual(s), number of placements, client groups concerned and form / requirements of contract.

If *no,* have any Council departments / directorates previously commissioned placements on your farm?
    i) Yes
    ii) No

If *yes,* please describe the form it took and why it ended

6. Do any other organisations currently commission placements at your farm?
    i) Yes
    ii) No

If *yes*, name of organisation and contact individual(s), number of placements, client groups concerned and form / requirements of contract.

7. How else do you access referrals? (if CFUK don't already have this data)
8. Who do you perceive as potentially relevant local commissioners that are not currently accessing your services (if have contacted previously, associated outcomes and challenges)
9. Do you actively promote your services to health and care commissioners?
    i) Yes
    ii) No

If *yes*, to whom, how have you done this and what methods have you found to be particularly effective or otherwise?

10. Are you in regular contact with other CFs in the County?
    i) Yes
    ii) No

If *yes,* what forms does this take:
    i) Regional network
    ii) Informal conversations
    iii) Informal cooperation

iv) Formalised cooperation
v) Other

11. Would you consider operating in conjunction with other local CFs?
    i) Yes
    ii) No
    iii) Not sure

If *yes,* which of the following aspects of the service you provide do you think might be usefully shared?

i) Marketing
ii) Placement pricing structures
iii) Engaging with commissioners
iv) Commissioner contacts
v) Service level agreements
vi) Activities
vii) Examples of good practice
viii) Other

12. Would you consider engaging with some sort of brokerage facility if this supported you in obtaining commissioner contracts?
    i) Yes
    ii) No
    iii) Not sure

If *no,* why not

If *yes,* why and which of the following do you think would be most suitable to provide this service:

i) Included care farmers
ii) CFUK
iii) Other third party
iv) Other

What percentage of associated income might you consider paying in return for this service?

i) None
ii) 1-2%
iii) 3-5%
iv) 6-10%
v) >10%

13. Please indicate if you are willing for the following data about your care farm to be available online:
    i) Services provided
    ii) Client groups
    iii) Surplus capacity
14. Would you be prepared to take responsibility for ensuring these data were kept up-to-date?
    i) Yes
    ii) No
15. Would you be willing to support this study further by joining a CF sub-group?
    i) Yes
    ii) No

Phase 2:

1) Have you been able to access the data held by CFUK relating to client groups and surplus capacity at your care farm to check remains correct / update?
    i) Yes
    ii) No

If *yes*, are you happy for data to be available online via CFUK website (if have surplus, days, client groups), any issues and are you prepared to take responsibility for checking remains up to date every few months?
If *no*, why not (*won't have time / not able to do / not prepared to do*)

2) Do any CCGs currently commission placements on your farm?
    i) Yes
    ii) No

If *yes,* name of CCG and contact individual, number of placements, client groups concerned, length of commission and form / requirements of contract.
If *no,* have you had any contact with your local CCG?
    i) Yes
    ii) No

If *yes,* please name contact and describe form / outcomes

3) Have you had any contact with your local HWBB?
    i) Yes
    ii) No

If *yes,* please name contact and describe form / outcomes
If *yes* or *no*, do you think there is likely to be value in your engaging with HWBB and why (not)?

4) Do you actively promote your services to health and care commissioners?
    i) Yes
    ii) No

If *yes*, to whom, how have you done this and what methods have you found to be particularly effective or otherwise?

5) Are you aware of any resources being available in your local area to help you to engage with service users and commissioners?
    i) Yes
    ii) No

If *yes*, please describe
If *no*, online portals are now provided in some areas to allow personal budget holders and other service commissioners to identify local service providers. Do you think this would be helpful for you?
    i) Yes
    ii) No

6) Do you know if 'social prescribing' has been trialled in your locality?
    i) Yes
    ii) No

If *yes*, please describe

7) Do you have any evidence regarding the effectiveness of your care farm that you could share with commissioners?
    i) Yes
    ii) No

If *yes*, what form does this take:
    i) Report
    ii) Case study
    iii) Personal testimony
    iv) Other

Was this undertaken internally or externally?
What sort of outcomes does this evidence?

i) Improved mental health
ii) Improved physical health
iii) Increased social engagement
iv) Improved employability through the development of skills
v) Personal fulfilment
vi) Reduced use of statutory services
vii) Other

8) Are you in regular contact with any other cfs?
i) Yes
ii) No

If *yes,* what forms does this take?
i) Regional network
ii) Informal conversations
iii) Informal cooperation
iv) Formalised cooperation
v) Other

9) Do you see yourself as being in competition with other local cfs?
i) Yes
ii) No

10) Would you consider operating more closely with other local cfs?
i) Yes
ii) No
iii) Not sure

If *yes,* what form might this take (examples below)?

11) Would you consider operating in a consortium with other nature based service providers in the area if this enabled you to tender for additional contracts?
i) Yes
ii) No
iii) Not sure

12) Would you consider operating in a consortium with other service providers in the area who engage with the same client group if this enabled you to tender for additional contracts?
i) Yes
ii) No
iii) Not sure

13) Are you intending to complete the Care Farming UK Code of Practice?
i) Yes
ii) No
iii) Not sure
iv) Don't know about it

14) Would you consider having your care farming service externally accredited in order to attract commissioners?
i) Yes
ii) No
iii) Not sure

Appendix F – Additional comments from commissioners in the study

Commissioning

"We constantly have to keep momentum going on plugging the service and the benefits and the outcomes….It's time consuming because it's not a traditional service. Most people don't have it in their list of things they would prescribe."

Benefits

"Could be valuable for physical and mental health"

"Learning skills, work experience, work preparation, working with other people"

"Obtaining new skills in different environments and a sense of achievement in those activities"

"Getting people engaged in something important whilst providing them with a purpose and potential future career"

Therapeutic interventions"

"Health and education benefits" "Physical activity and social interaction"

"I think that, on the individual level, when I've visited care farms you can see some really significant impacts….Their contribution is, I think, easily discernible."

"It's one of those projects where you totally personally believe in what they are doing."

Challenges

"There is a danger of it seeming to be a very 'old school' segregated/paternalistic approach. Often lacks the integration/community focus"

"Cost"

"People's prejudices"

"Providers- The line of sight to keep budget from social care and would want to see a preventative saving for the budget and the relationship with that budget…"

"We haven't got money knocking around. If they're going to spend money on something new they've got to take it out of the existing thing and that's hard to find."

Partnership working

"It's antithetical really because the type of person who gets involved with care farming, and is committed to it, is probably the very type of person who wouldn't want to be involved in a consortium."

"….we don't commission on the basis of outputs, we commission on the basis of outcomes and we leave it for the providers to tell us their path to those outcomes."

"Often, in the past, we've always thought about maintaining, but I'm in the business now of being able to evidence progression, whatever that might mean."

How does the care farming industry network with the wider farming industry and is there scope for people to move on to voluntary opportunities. Is it well harnessed to local education providers....

Evidence of effectiveness

"We don't just want you to be different but also to be more effective….It's nice to have a bit of diversification, I think that's great, but I want also to see costs cut."

"Staff who have knowledge and experience of working with vulnerable adults i.e. re safeguarding, medication management, support personal needs etc."

"Where farms which work with particular clients e.g. drug misusers, then assurance that they have the knowledge and skill sets to do so…"

"Evidence of positive outcomes from other NHS or social care organisations who had commissioned services" from the farm"

"Are they safe to handle basic clinical needs e.g. disability and mental health awareness, basic first aid and resuscitation (maybe an enhanced "offer" if certain groups to be covered in addition e.g. managing diabetic hypoglycaemia)"

"It would depend on the client groups- these would need to be clearly specified"

Appendix G – Additional comments from care farmers in the study

Commissioning

"When I've spoken to the GPs they've all said yes we love it but they don't have access to that amount of money to be able to pay for people to come."

Integration of health and social care

"I think when the two are integrated, because our service is very much an integrated service, it stands right at the crossroads of health and social care, I think it will benefit us."

"Health has always argued that care farming is about a social activity and it's not about health and, however much we've argued with them about how people feel better by coming to them, they've had that argument, but with the Better Together programme that's supposed to be starting up in all areas that should change."

"I am beginning to see some light because the commissioning process surrounding integrated healthy living is a demonstration of what we've been waiting for. So I don't think we should get despondent."

Promotion of services

"I think it's something that somehow needs to be marketed but it's a very difficult thing of knowing where to start or where to go."

"If you don't go you don't know what you might miss, but if you do go sometimes you think, well I've got better things to do with my day really."

"How long do you knock on a door that's locked?"

"….most of the time it isn't going in at the top where you get your leads and your positive outcomes, it's by going in at ground level."

"People with money and clout don't tend to come out."

"As we all know, until you come onto a care farm you can't really appreciate it."

"People send the people because they trust us and they know we've got a lot of experience in that area."

"I think the system at the moment seems to be a bit unwieldy and well confusing really."

"I like the idea of going out to promote but is it directly to the commissioning people or is it to the people at the coal face?"

"Even though they're not directly commissioning placements you still need to know where they're going, their thought processes, what their needs are, because then we can shape our business around what they need to do."

Partnerships and standards

"At area meetings people just wanted their hand holding through the whole process. They just wanted to know who we got referrals from and things."

"….we reorganised and we followed the lead given by the LEPs, the local enterprise partnerships….in order that we could align ourselves to where the new funding streams are most likely to emerge."

"In terms of what they expect, in terms of targets and outcomes, [these] are quite unrealistic if they think of the setting we're working in."

"We need some tools don't we? We need some generic tools that are perhaps used nationally or at least county wide to do these measurements."

"We got about half way through and then put it aside just because there wasn't time for something that no one was asking for."

"I was quite concerned that there were so many people setting up and doing care farming but they had no policies or anything in place. It only takes one to go down and we're all going to go down."

"Any business is about how much resource I can put in for how much money I make out of what I'm doing, and there isn't enough money coming into those businesses care farming to make it possible for people to invest in quality."

"It's a very difficult thing to regulate."

"I think it's a very open and transparent kind of industry so I think to regulate it now would stifle it."

"There's no requirement to be regulated at all and it's frightening....the potential for things to go wrong is significant."