

# Good practice in social prescribing for mental health: the role of nature-based interventions

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# 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, it 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'.

The prevalence of mental ill-health is on the rise in the UK with an estimated one in four people experiencing a 'significant' mental health problem in any one year. With prescriptions at record levels and a huge demand for other therapies, health and social care commissioners are examining and commissioning different options. With increasing recognition of the importance of nature and place as a determinant of individuals' mental health, organisations providing nature-based interventions are working with a wide range of vulnerable groups throughout the UK. These nature-based interventions could be part of a new solution for mental health care, however increasing the awareness of, and access to, these interventions is challenging.

This new research builds on the findings from earlier Natural England reports:

- *Expanding delivery of care farming services to health and social care commissioners* (NECR194)
- *A review of nature based interventions for mental health* (NECR204)

These reports reveal that there is:

- Strong evidence of the efficacy of nature-based interventions.
- A growing demand from vulnerable adults for these green care services.
- Underused capacity in existing green care services. And,
- Increasing interest in referring to these types of services from health and social care commissioners.

However, the number of referrals remains small. The reports highlight that it is not an issue of low supply or demand (as both are increasing), but a lack of a consistent delivery method that easily matches supply to demand.

This study engages local authorities and health commissioners to identify best practice in a range of social prescribing services referring people to nature-based (green care) interventions in light of:

- The NHS ambitions to focus on individual and community involvement in healthcare.
- The shift to more local delivery of health and care services.
- The under-utilisation of existing green care services. And
- The vast potential to increase the scale of green care provision.

Options for improving the commissioning of, and referral to, these services as well as scaling-up the provision of nature-based interventions are explored.

This report should be cited as:

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**Further information**

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# Contents

	Page
<b>Acknowledgements</b>	<b>7</b>
<b>List of Abbreviations</b>	<b>7</b>
<b>Executive Summary</b>	<b>8</b>
<b>1. Introduction</b>	<b>13</b>
1.1 Key definitions	13
1.1.1 Social prescribing	
1.1.2 Green care and nature-based interventions	
1.1.3 Nature, health and wellbeing sector	
1.2 Background to the study	13
1.2.1 Social prescribing and mental health	
1.2.2 Changes in health and social care – the relevance of social prescribing	
1.2.3 Policy context	
1.2.4 Nature-based interventions within social prescribing	
1.2.5 Rationale for this study	
1.3 Aims of the study	17
1.3.1 Key objectives	
1.4 Structure of this report	17
<b>2 Methodology</b>	<b>18</b>
2.1 Overview	18
2.2 Phase 1 – Evidence review	18
2.2.1 Engaging the right people	
2.2.2 Evidence gathering and review	
2.3 Phase 2 – Demonstration event	20
<b>3 Green Care</b>	<b>21</b>
3.1 Definition of green care	21
3.2 Types of green care	21
3.3 Distinctions between ‘green care’ and ‘nature-based health promotion’ projects	23
3.3.1 Nature in health promotion and in care	
3.3.2 Referral to nature-based health promotion and to green care interventions	
3.4 Health and wellbeing benefits of green care	25
3.4.1 General health and wellbeing	
3.4.2 Mental health	
3.5 Economic benefits of nature-based initiatives	27
<b>4 Social prescribing – Definitions and models</b>	<b>29</b>
4.1 Definitions and terms in social prescribing	29
4.2 Incorporated activities and service users	30
4.3 Social prescribing models and typologies	30
<b>5. Social prescribing – Evidence review and good practice</b>	<b>33</b>
5.1 Key findings from evidence review	33
5.2 Evidence review	34
5.2.1 Examples of social prescribing	
5.2.2 Collated case study results	
5.3 Organisation of social prescribing schemes	43

5.3.1	Starting motivations	
5.3.2	Scale	
5.3.3	Who runs the service?	
5.3.4	Inclusion of nature-based health promotion and green care interventions	
5.4	Service users	43
5.5	Referral mechanisms	44
5.5.1	The importance of the 'link worker' in social prescribing	
5.6	Funding of social prescribing services	44
5.6.1	Funding sources and mechanisms	
5.6.2	Costs	
5.7	Evidence of effectiveness and cost-effectiveness from social prescribing	45
5.7.1	Benefits	
5.7.2	Evidence of health benefits and reductions in use of services	
5.7.3	Evidence of cost-effectiveness and return on investment for social prescribing	
5.8	Key challenges	47
5.8.1	What is social prescribing?	
5.8.2	Need for cooperation and partnership working	
5.8.3	Engaging GPs and healthcare staff	
5.8.4	Funding for service providers	
<b>6</b>	<b>Social prescribing – Demonstration event</b>	<b>50</b>
6.1	Key findings from demonstration event	50
6.2	The demonstration event	51
6.3	The morning session	51
6.4	The interactive discussions	52
6.4.1	General issues raised	
6.4.2	Priority issues and their solutions	
6.5	Achievements	55
<b>7.</b>	<b>Discussion</b>	<b>56</b>
7.1	Summary of findings	56
7.2	Discussion – Implications for nature-based interventions in social prescribing	57
7.2.1	The evidence question	
7.2.2	Multiple outcomes simultaneously	
7.2.3	Follow-up and longer-term care from nature-based interventions	
7.2.4	Funding implications for nature-based interventions	
7.2.5	Increasing the scale of nature-based social prescriptions	
7.2.6.	Models for best practice for mental health within social prescribing	
7.3	Issues Identified	63
<b>5</b>	<b>References</b>	<b>67</b>
<b>6</b>	<b>Appendices</b>	<b>71</b>

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## List of Abbreviations

ASD	Autism Spectrum Disorder
A and E	Accident and Emergency
CCG	Clinical Commissioning Group
cs	Case study
DoH	Department of Health
GP	General Practitioner
HT	Horticultural Therapy
HWB	Health and Wellbeing Board
IAPT	Improved Access to Psychological Therapies
ICMT	Integrated Case Management Team
LA	Local Authority
LTC	Long Term Condition
NBI	Nature-based Intervention
NHS	National Health Service
PCT	Primary Care Trust
PEP	Patient Empowerment Project
PbR	Payment by Results
STH	Social and Therapeutic Horticulture
SPN	Social Prescribing Network
SROI	Social Return On Investment
SWEMWBS	Short Warwick-Edinburgh Mental Well-being Scale
VCS	Voluntary and Community Sector
WEMWBS	Warwick-Edinburgh Mental Well-being Scale

## Executive Summary

### Background

Social prescribing has been identified by Simon Stevens, CEO of the NHS, as one key way in which the NHS can change from “a ‘factory’ model of care and repair” to one that focuses on much wider individual and community engagement (Five Years Forward View, NHS England, 2014 – henceforth referred to as the Stevens Report). Social prescribing<sup>1</sup> is a way of linking patients in primary care with sources of support within the community – usually provided by the voluntary and community sector, offering GPs<sup>2</sup> a non-medical referral option that can operate alongside existing treatments to improve health and wellbeing.

Social prescribing is used for a wide range of client groups, including people with mild to moderate mental health problems<sup>3</sup>, complex Long Term Conditions (LTCs) and for people with both short term and enduring mental health problems. Social prescribing has been shown to produce positive outcomes, such as emotional, cognitive and social benefits and includes a range of prescribed interventions and activities from online Cognitive Behavioural Therapy courses, community art groups and befriending clubs, right through to green gyms and ‘exercise on prescription’ schemes.

The nature, health and wellbeing sector provides an increasing number of nature-based interventions, comprising both i) **nature-based health promotion services** – providing informal opportunities for people to engage with nature in their community (e.g. community gardening or conservation volunteering) and ii) **green care services** for individuals with a defined health need offering structured therapy, rehabilitation or care, using contexts such as conservation or horticultural therapy projects and care farms.

Green care already integrates health and social care and provides exactly the style of community-based, non-clinical care sought by the NHS in the Stevens Report. However, despite this, the numbers of green social prescriptions remain low.

### Aims

Considering the NHS’s ambitions to focus on individual and community involvement in healthcare; the shift to more local delivery of health and care services; the under-utilisation of existing green care service provision; and the vast potential to significantly increase the scale of green care provision through new services, there was an urgent need to discover how best to engage health commissioners in the promotion and use of nature-based interventions within social prescribing.

The aims of this study were:

- to develop an understanding of the value of nature-based-interventions within social prescribing services for people with mental ill-health;
- to provide suggestions for good practice in social prescribing services for commissioners;
- to provide a resource and support for the providers of nature-based interventions in engaging with primary care

### The work

This work comprised two stages (each of which involved both people who are involved in commissioning or facilitating social prescribing services and people from nature-based interventions providing green care and/or health promotion services):

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<sup>1</sup> sometimes called ‘community referral

<sup>2</sup> Other practice staff and social workers

<sup>3</sup> In this report we have referred to ‘mental health problems’ throughout for consistency



- i) an evidence review (including a search of current social prescribing literature and practice); and
- ii) a demonstration event – to share good practice and to explore steps needed for the scale-up of nature-based social prescriptions in one locality.

The aim of the evidence review was to examine the use of community or voluntary sector based interventions that achieve clinical outcomes for people with mental health problems through non-clinical means. To understand social prescribing and its application, examples ranging from simple local directories to large scale programmes were examined (via publicly available literature and interviews and verifications from key staff involved in the social prescribing services). Twelve social prescribing services were chosen as the focus for this research, showing a mix of scale, purpose and demonstrable effectiveness. The onus was on case studies that have a good track record; operate at scale; that are replicable; and that are in England. However, the intent of this research was not to produce a comprehensive assessment of all social prescribing in England (which is outside of the commissioned scope) or to estimate the proportion of the population currently benefitting from social prescribing.

The demonstration event was held in one commissioning region – Leeds – which was selected because all three local CCGs in the area are providing social prescribing services but are at different stages of development; a range of nature-based interventions are already operating successfully in the area; and the University of Leeds is involved in related research. The event brought together health and social care professionals involved with social prescribing in the three Leeds CCG-led social prescribing services with providers of nature-based care services from the local area to explore practical ways of working together to increase the referrals to nature-based social prescriptions in the Leeds area. 32 people attended the event, 7 people from social prescribing services in Leeds, 6 health or social care commissioners or professionals, 10 people from local nature-based interventions and 9 others (researchers and steering group members).

## Key findings

### The current social prescribing landscape

- There are many different social prescribing models currently operating in England, all using slightly different referral mechanisms, funding arrangements and ways of working. Although this study aimed to focus on social prescribing for mental health, the reality is that most schemes target a range of beneficiary groups, and so this specific focus was not possible. The majority of social prescribing services are therefore generalist<sup>4</sup> or generalist plus mental health.
- All the successful social prescribing services examined in this study have set up an effective primary care referral system providing GPs with a non-medical referral option to enable patients to easily access health resources and social support from outside the NHS. Social prescribing schemes are operated jointly by primary care providers and the third sector, but the social prescription element is predominantly delivered by the third sector.
- The characteristics of a ‘successful’ social prescribing service have not yet been fully researched. However, from the cases examined in this study, good practice in social prescribing depends on good partnerships, high levels of cooperation and joint ownership between a wide range of individuals, groups and organisations with very different organisational cultures. Good communications between the social prescribing service, GPs and healthcare staff, is essential. Social prescribing link workers play a pivotal role in the social prescribing service, as they are responsible for taking referrals and linking the patient to relevant services.

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<sup>4</sup> i.e. not aimed at a specific medical condition but rather a range of conditions, LTSs or for frequent attenders.

- Patients benefitting most from social prescribing often have multiple health-related issues, which individually are insufficient to trigger social or health care payment, but in combination result in frequent GP visits and high service use. Benefits from social prescribing identified in this study include: i) better outcomes for health and social care; ii) improvements in the mental health and wellbeing of patients; iii) cost-effective use of NHS resources; and iv) more effective use of GP time<sup>5</sup>.
- At present, specific inclusion criteria for services within social prescribing options are rare, with no specific accreditation requirements for service-providers. As a result, GPs have expressed concerns about the quality of services and liability.
- Shortcomings with the current referral processes were also highlighted as a barrier to engaging GPs with social prescribing. Reaching agreement between General Practices and the social prescribing provider regarding effective referral routes and appropriate inclusion criteria<sup>6</sup>, is a particular priority.

#### Barriers to the sustainability and up-scaling of social prescribing

- There is no consistent or standardised referral mechanism.
- There is no funding for the social prescription element in the majority of social prescribing services (i.e. no funding to the third sector service providers)<sup>7</sup>.
- **The lack of direct funding for the health care interventions offered through social prescription together with no underpinning referral system are fundamental barriers to the NHS's ambitions to increase the scale of social prescribing in the future.**

#### Nature-based social prescriptions

- Most social prescribing services contain one or two nature-based health promotion initiatives in the suite of available options, but only a small number of services specifically include green care treatment interventions.
- Nature-based options are not actively promoted, compared to other types of intervention within social prescribing, and are generally suggested *only if a patient expresses an interest in being outside*. Patients will not always be aware of nature-based initiatives, what they can offer and their associated benefits.
- In comparison to many voluntary sector initiatives currently included in social prescribing portfolios, the evidence on the effectiveness of nature-based health promotion and of green care is relatively strong. However, the nature, health and wellbeing sector recognises that it is not currently promoting the range of services effectively. Researchers, social prescribers and nature-based intervention providers all agree that there is a need to improve the promotion of these services.

## Issues Identified

#### Maintaining good practice within the current social prescribing landscape

1. **All those involved in social prescribing at both the national level (Department of Health, NHS England, Public Health England) and the local level (CCGs, Health and Wellbeing Boards, GP**

<sup>5</sup> The Social Prescribing network has identified more benefits cited from attendees at their inaugural conference in January 2016 – Page 15 in conference report: <https://www.westminster.ac.uk/patient-outcomes-in-health-research-group/projects/social-prescribing-network>

<sup>6</sup> This is applicable regardless of the social prescribing option i.e. from debt counselling through to care farming

<sup>7</sup> Found both in the literature, in the social prescribing services examined in this study and by participants at the demonstration event

practices, social prescribing services, link workers and local projects) should adopt the terms and definitions recommended by the Social Prescribing Network<sup>8</sup>.

2. **Good partnership working between stakeholders is essential for a successful social prescribing service. Social prescribing service staff and health service referrers (GPs and others) urgently need to improve the systems and processes that support dialogue between these two key groups of practitioners.**

#### *Ensuring long-term sustainability of social prescribing*

In Five Years Forward View (NHS England, 2014) Simon Stevens highlighted the need to change the focus of the NHS to one of much wider individual and community engagement. Increasing the scale of social prescribing in the future is an important contribution to achieving this aim. However, the sustainability of social prescribing in the long term will depend on the voluntary and community sector becoming a more valued and secure element within the social prescribing process, and this requires urgent improvements in the funding arrangements.

3. **Services provided by the individual interventions included in social prescribing schemes should have access to direct funding<sup>9</sup> to ensure the sustainability of social prescribing in the long-term.**

Establishing a referral and information sharing system that is efficient and effective is critical for the success and scaling-up of social prescribing desired by the NHS in the future. It is essential that health workers can give the prescription quickly and easily, whilst also feeling assured that they will be using an appropriate service with real potential to deliver required outcomes.

4. **NHS England should work with Clinical Commissioning Groups, GPs, healthcare staff, social prescribing services and researchers to establish a standardised referral mechanism suitable for the variety of social prescribing services and the range of interventions within them.**

For social prescribing to become accepted as mainstream and expand in the longer term, evidence that it is having a positive impact both on people's lives and on the health service must be provided. Although many social prescribing services are focused on collecting evidence of outcomes (often in conjunction with academic institutions), there is currently a wide variation in methodology, making comparative analysis difficult.

5. **NHS England, Public Health England, and the National Institute for Health and Care Excellence (NICE) should work with social prescribing services and Clinical Commissioning Groups to develop a Standard Evaluation Framework (SEF) for social prescribing interventions – similar to those currently developed for physical activity and obesity – initially focussing on social prescribing for mental health and wellbeing.**

#### *Increasing the scale of nature-based social prescriptions*

6. **The nature, health and wellbeing sector organisations (including: Green Care Coalition, TCV, Care Farming UK, Thrive and Groundwork) should work together with Natural England and Defra to support an expansion in nature-based interventions within social prescribing.**

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<sup>8</sup> **A social prescriber** –any (healthcare) professionals who refer people to a social prescribing service. **A social prescribing service** – the link worker(s) and the subsequent groups and services that a person accesses to support and to manage their needs. **A link worker** – There are many other terms used for these (see page 31). Usually a non-clinically trained person who works in a social prescribing service, and receives the person who has been referred to them. Link workers are responsible for assessing a person's needs and suggesting the appropriate resources for them to access.

<sup>9</sup> Funding to follow clients and/or for infrastructure

- 7. National<sup>10</sup> support organisations and networks for the nature, health and wellbeing sector (such as Green Care Coalition, TCV, Care Farming UK, Thrive and Groundwork) should work together to develop promotional resources to give to CCGs, social prescribing services, link workers and patients that outline why nature-based interventions are so relevant for use in social prescribing and should help nature-based interventions engage effectively with their local healthcare sector<sup>11</sup>**
- 8. Nature-based support organisations and networks need to identify and collate information from individual interventions on how nature-based interventions are providing a quality service that is both effective and cost-effective<sup>12</sup>. Such findings need to be shared with Defra and Natural England through the National Outdoors for All Working Group, so they can be disseminated by partners to a wide range of audiences.**

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<sup>10</sup> And UK-based

<sup>11</sup> both within social prescribing and wider

<sup>12</sup> and/or provide cost benefit

# 1. Introduction

## 1.1. Key definitions

### 1.1.1. Social prescribing

There is currently no universally accepted definition of social prescribing (see section 4.1). In this report, social prescribing is defined as:

*“a mechanism enabling healthcare professionals to refer patients to a link worker, to co-design a non-clinical social prescription to improve their health and wellbeing”*  
(slightly adapted from Social Prescribing Network, 2016).

### 1.1.2. Green care, nature-based interventions and the nature, health and wellbeing sector

#### Green care and nature-based interventions

Green care is defined as:

*“nature-based therapy or treatment interventions – specifically designed, structured and facilitated for individuals with a defined need”* (Bragg and Atkins, 2016)

There are a number of different types of nature-based intervention included under the ‘green care’ umbrella ranging from care farming through to wilderness therapy. Green care is covered in more detail in Chapter 3.

#### Nature-based health promotion activities

There are also a wide variety of projects and community groups offering nature-based activities on a more informal basis for the general population as part of health promotion, healthy lifestyles or ill-health prevention (such as community gardens and food growing projects, community farms, environmental volunteering).

#### The nature, health and wellbeing sector

A collective term used in this report to describe both green care services and nature-based health promotion services.

## 1.2. Background to the study

### 1.2.1. Social prescribing and mental health

The Stevens Report proposed that the NHS needs to change, moving from “a ‘factory’ model of care and repair” to one that focuses on much wider individual and community engagement and social prescribing has been identified as a key way in which this can be achieved.

Social prescribing (sometimes called ‘community referral’) is a way of linking patients in primary care with sources of support within the community – usually provided by the voluntary and community sector – providing GPs, other practice staff and social workers with a non-medical referral option that can operate alongside existing treatments to improve health and wellbeing (Friedli and Watson, 2004; University of York and NIHR, 2015).

Social prescribing has been used for people with mild to moderate mental health problems<sup>13</sup>, for reducing social exclusion in disadvantaged and vulnerable populations, and for people with complex Long Term Conditions (LTCs) and both short term and enduring mental health problems. Social prescribing has been shown to produce positive outcomes, such as emotional, cognitive and social benefits (Bates 2002; Gask et al. 2000; Fredli et al. 2008). Social prescribing includes a range of prescribed interventions and activities from online Cognitive Behavioural Therapy courses, community art groups and befriending clubs, right through to green gyms and ‘exercise on prescription’ schemes.

### **1.2.2. Changes in health and social care – the relevance of social prescribing**

Health and social care in England is in a period of significant structural change with secondary and community healthcare service commissioning now the responsibility of Clinical Commissioning Groups (CCGs) (Bragg et al., 2014). The majority of CCGs are also now responsible for commissioning primary care. CCGs manage most of NHS England’s budget and commission a range of health services, including community health and rehabilitation care.

Integration between health and social care has recently become a particular priority<sup>14</sup>, with regional Health and Wellbeing Boards (HWBs)<sup>15</sup> set up to improve health, mental health and social care provision and delivery by facilitating partnership between the CCGs and local authorities (LAs) – thus increasing the integration between the two services (Local Government Association, 2014). The Department of Health will issue guidance to Health and Wellbeing Boards asking them to ensure that joint health and wellbeing strategies (JHWSs) include action across health, social care, public health and wider services to build strong and effective relationships with general practice services.

The Department of Health have proposed the introduction of social prescriptions for those with long-term conditions (DoH, 2006) with the specific aim to promote integrated health and social care, together with the voluntary and community sector (University of York and NIHR, 2015). With up to 20% of GPs time estimated to be spent on dealing with patient problems that have social causes (Caper and Plunkett 2015), social prescribing may represent a way to manage increasing demands on both the NHS and GPs’ time (Buck, 2016).

NHS England are also promoting access to non-clinical interventions from voluntary services and community groups as a way of making general practice more sustainable (Dyson, 2014). The role of voluntary sector organisations is seen as important in supporting the work of general practice as local models of social prescribing can enable GPs to access practical, community-based support for their patients, including access to advice on employment, housing and debt. In fact social prescribing is presented as number one of 10 High Impact Actions for releasing GP capacity (NHS England, 2016, p52) and NHS England are appointing a new National Champion for Social Prescribing (NHS England, 2016, p33)<sup>16</sup>. The Five Year Forward View for Mental Health (The Mental Health Taskforce, 2016) also highlights the importance of developing new partnerships with the community and voluntary sector in the treatment of mental health conditions.

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<sup>13</sup> In this report we have referred to ‘mental health problems’ throughout for consistency

<sup>14</sup> ‘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.

<sup>15</sup> Set up through the Health and Social Care Act (2012)

<sup>16</sup> The report also highlights a one-off Sustainability and Transformation package of non-recurrent investments over the next 5 years to include training and investment for 3,000 new mental health workers (NHS England, 2016, p56)

The Care Act 2014 requires the provision of information and advice to enable providers of care and support services (such as LAs and CCGs) to advertise their services to people who might need them. CCGs are required to demonstrate that they have a range of mechanisms in place to engage with patients, carers and their communities, and to work in partnership with voluntary/charitable sector groups. Online directories, hubs or portals have been used to provide this 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. However, these directories appear to vary widely in their content, the services that are ultimately publicised and how up to date they are.

### 1.2.3. Policy context

The 2006<sup>17</sup> white paper reviewing the NHS highlighted the importance of people being able to access local services to help improve their mental wellbeing and address the wider determinants of health. It identified social prescribing as a suitable mechanism for integrating health and social care and for ensuring that people with LTCs could access a sufficient range of services and facilities to support their health (Friedli et al., 2007a; The University of York, 2015).

NHS England have also promoted the importance of providing patients with access to non-clinical interventions delivered within the local community to support both patients and general practice<sup>18</sup>, although no NICE guidance has yet been presented regarding what this should entail (University of York, 2015). The Marmot Review highlighted the value of providing social prescribing services, presenting a direct correlation between health inequalities and social, environmental and economic factors (Marmot et al., 2010), and promotes social prescribing as a model to address the wider health determinants (Wilson, 2015).

Current public and mental health agendas and policy narratives are broadly supportive of social prescribing, with prevention and health promotion becoming central tenets of NHS policy and practice (NHS England, 2014; Public Health England, 2015). Asset-based approaches for improving health and wellbeing are increasingly being pursued at the local level in order to utilise local community assets to enable good health and wellbeing – something fundamental to social prescribing (Public Health England, 2015; Wilson, 2015; NHS England, 2016; Mental Health Taskforce, 2016).

### 1.2.4. Nature-based interventions within social prescribing

The nature, health and wellbeing sector provides an increasing number of nature-based interventions, comprising i) **nature-based health promotion services** – providing opportunities for people to engage with nature in their community (e.g. community gardening and food growing, conservation volunteering) and ii) **green care services** for individuals with a defined health need - structured therapy, rehabilitation or care using contexts such as conservation or horticultural therapy projects, and care farms (see section 1.3 for more details on green care).

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<sup>17</sup>Department of Health, White paper. Our health, our care, our say: a new direction for community services, January 2006.

<sup>18</sup>Dyson B. Improving general practice: a call to action. Phase one report. NHS England. <https://www.england.nhs.uk/wp-content/uploads/2014/04/emerging-findings-report.pdf> April 2014. NHS England, 2014; Public Health England, 2015

Green care integrates health and social care and provides exactly the style of community-based, non-clinical care sought by the NHS in the Stevens Report. Despite this, however, the number of green social prescriptions remain low.

### 1.2.5. Rationale for this study

Following the publishing of the Natural England funded work: *'Expanding delivery of care farming services to health and social care commissioners'* and *'A review of nature-based interventions for mental health'* it has become clear that there are three common themes that run across much of the provision of nature-based interventions (green care) for vulnerable adults:

1. **There is underused capacity in pre-existing green care service provision.** Most ably demonstrated in an earlier Care Farming report (Bragg et al., 2014), which found that most care farms (76%) are not currently running at full capacity<sup>19</sup>.
2. **There is a growing demand and appetite for green care services from beneficiaries; and an increasing interest in referring to these types of services from commissioners** (Mind, 2013; Bragg et al., 2015).
3. **The evidence of the efficacy of nature-based interventions in addressing health and social care issues is strong** (Bragg and Atkins, 2016).

What we are facing, therefore, is not simply an issue of supply or demand (as both are present), but rather a lack of a consistent delivery method that easily matches supply to demand. In primary care, GPs surveyed by Mind in 2013 indicated they would like to know more about green care interventions for mental health. However, with rising demands on primary care, there is simply not the capacity or time for GPs or other practice staff to research appropriate local provision.

This study therefore builds upon the foundation work from the previous studies, drawing specifically on two recommendations from the Care Farming Report (Bragg et al., 2014):

*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:*

- i. *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, directory or social prescribing facilitators;*
- ii. *Care farmers should be encouraged to register with local online directories of services and have representation on their local hubs/ directories/ social prescribing facilitators to advertise their services to potential service users.*

And similarly, from the Mind report (Bragg and Atkins, 2016):

- i. *Providers of green care services should be encouraged to register with local online directories of services (or consortia of service providers) and have representation on their local hubs to advertise their services to potential service users*

An initial scan of Local Authority websites indicates this process is being implemented in several different ways (or not at all) and there is therefore an opportunity to support Local Authorities and commissioners in designing the most effective way to engage with voluntary sector services. This

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<sup>19</sup> Although the operating capacity varies, the mean operating capacity in 2014 was 58%. 91% of care farms said that they would be able to offer more sessions if they had additional resources, i.e. financial resources, extra staff and additional land or buildings. From: Bragg et al. 2014).



study explores the use of a range of social prescribing services in referring people with mental ill-health to nature-based (green care) interventions, making suggestions for their scaling.

### **1.3. Aims of the study**

Considering the NHS ambition to focus on individual and community involvement in healthcare, the shift to a more local delivery of health and care services, the under-utilisation of existing green care services provision and the vast potential to significantly increase the scale of green care provision through new services, there was an urgent need to discover how best to engage commissioners in the promotion and use of nature-based interventions within social prescribing.

The aims of this two-phase study were therefore:

- to develop an understanding of the use of nature-based-interventions within social prescribing services for people with mental ill-health;
- to provide suggestions for good practice in social prescribing services for commissioners;
- to provide a resource and support for the providers of nature-based interventions in engaging with health and social care.

#### **1.3.1. Key objectives**

The key objectives for the study include:

- To examine the available evidence on social prescribing services across England for people with mental ill-health and those that include nature-based options within them.
- To recommend good practice within social prescribing services
- To recommend good practice for nature-based service providers in presenting information for directories in social prescribing services
- To raise awareness amongst commissioners and social prescribers of the value of nature-based interventions, through a demonstration event
- To share findings from the research work with local partners to progress and scale up mental health referrals to nature-based interventions in social prescribing in one commissioning area.
- To provide a model for the development of nature-based social prescribing in other areas and with other service user groups

### **1.4. Structure of this report**

This report covers the methodology of this research (Chapter 2) and outlines both green care and social prescribing in the UK (Chapters 3 and 4 respectively). The results of the social prescribing evidence review and good practice are featured in Chapter 5 and details of the social prescribing demonstration event in Leeds are given in Chapter 6. Discussion and issues stemming from the research are given in Chapter 7.

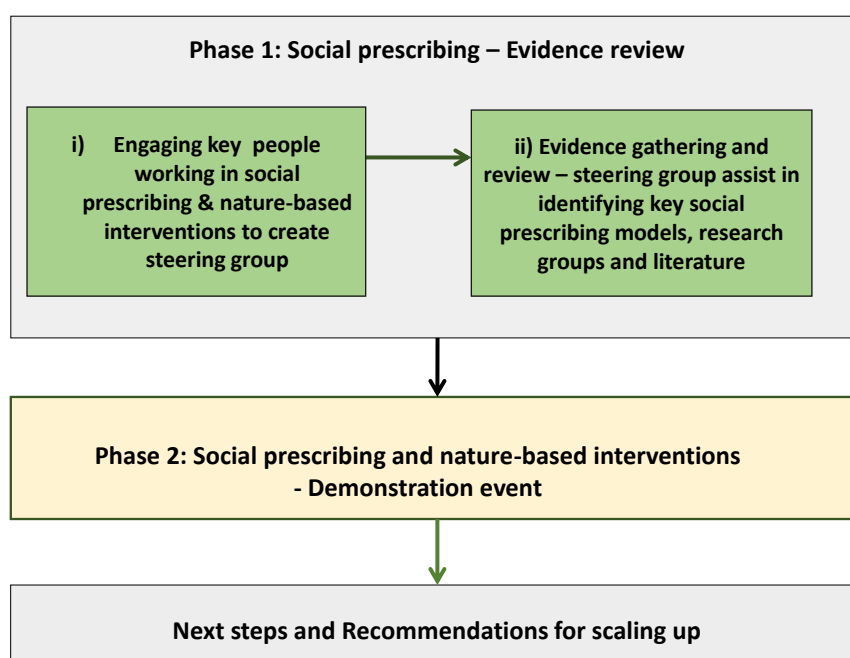
## 2. Methodology

### 2.1. Overview

There were two main stages to this work (see Figure 2.1) each of which involved both representatives of those who are involved in commissioning or facilitating social prescribing services and those providing nature-based health promotion and green care services:

- Phase 1. Evidence review – including: i) engaging the right people (i.e. talking to those who are currently working in social prescribing); ii) evidence review (including a search of current social prescribing literature and practice);
- Phase 2. Demonstration event – to spread any good practice identified in phase 1 and to explore steps needed for scale-up.
- The findings from phase 1 and phase 2 were collated and used to inform suggestions for scaling-up the number of nature-based social prescriptions.

Figure 2.1 Phases of social prescribing research



### 2.2. Phase 1 – Evidence review

Phase 1 focused on reviewing the available literature on social prescribing: identifying current models delivering social prescribing services (and specifically any that cater for patients with mental ill-health); assessing the extent and form of engagement with nature-based interventions within these services and developing an awareness of related opportunities and challenges. However, the aim of this research was not to produce a comprehensive assessment of all social prescribing in England (which is outside of the commissioned scope) nor to estimate the proportion of the population currently benefitting from social prescribing.

### 2.2.1. Engaging the right people

The study aimed to identify key organisations to engage with in the mapping of social prescribing, including:

- Nationally – the Local Government Association, Public Health England and NHS England
- Locally – public health teams and other organisations or consortia already involved in social prescribing; CCGs currently working with social prescribing (such as Bristol<sup>20</sup>)
- Voluntary sector – organisations like TCV, The Wildlife Trusts, Care Farming UK, Age Concern and the Centre for Sustainable Healthcare, interested in this area
- Academics – University of Essex, University of Exeter, University of Leeds, Sheffield Hallam University.

These organisations were contacted to inform them about this study, to ask them to suggest other people working in the field of social prescribing and to signpost researchers to any literature they felt was key to a study of this nature. Individuals from some of these organisations subsequently joined the steering group for the study – for more details of the steering group see Appendix B.

### 2.2.2. Evidence gathering and review

The study examined the use of community and voluntary sector based interventions that achieve clinical outcomes for people with mental health problems through non-clinical means – i.e. social prescribing services. The research aimed to understand social prescribing and its application, from simple local directories through to large scale programmes and supported referral mechanisms. Other models were also examined, for example: i) where the voluntary sector is organised around a single point of contact and seeks specifically to engage people with nature-based service provider(s); ii) services initiated by a sole nature-based service provider with their local CCG; and iii) those provided by holistic health centres that service their own patients and those registered with neighbouring practices.

The aim of the evidence review stage was to provide a number of case studies to represent the range of social prescribing service models operating in England, in order to identify common elements of ‘success’ which could then be considered as good practice. The focus was therefore on case studies that:

- are well established;
- have a good track record in terms of numbers of patients involved;
- have demonstrable success in terms of beneficial outcomes;
- are operating at scale (e.g. with at least one CCG);
- are in England and
- show the diversity of social prescribing models.

#### Evidence gathering process

A template was developed by researchers to give the social prescribing examples a common format and to allow comparison between them. This template (see Appendix C) was reviewed by the steering group and piloted with three organisations before being used for the main study. Questions in the template for social prescribing services included:

- What it is they are doing

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<sup>20</sup> See <http://eprints.uwe.ac.uk/23221/1/Social%20Prescribing%20Report-final.pdf>;  
<http://www.wellspringhlc.org/content/South%20West%20Social%20Prescribing%20in%20Bristol%20A4%204pp.pdf>

- What directories of services they currently have (or are planning in the future)
- How they are organised (by client group, department, needs etc.)
- What information is required to be accepted as a provider, including prior accreditations
- What referral methods and mechanisms they currently have in place
- Scale of uptake from GPs (i.e. the number of referrals given by whom and to whom)
- How they have worked and why
- Key challenges
- What they are measuring or providing as measures of effectiveness
- Criteria for directory inclusion (if applicable, e.g. process, accreditation, costs, vetting process etc.)

The lead researcher completed templates on potential case studies identified both in the literature and by steering group members, using published information. The researchers and the steering group then worked together to choose 12 case studies that they felt were representative of the diversity of social prescribing services in England (see Table 5.1. in Chapter 5, and Appendix D). This process was then validated by contacting each of the 12 chosen social prescribing services and asking them to provide feedback on their case study and to provide any updated information<sup>21</sup>. Nine of the twelve social prescribing services participated in this validation process. The case study templates were then collated and analysed to draw out commonalities, differences and elements of success which could be considered as good practice.

Five of the case studies (operating in Bromley by Bow, Leeds, Rotherham (x2) and Merseyside) were subsequently highlighted in the main report, as the study team and the steering group felt that they were both successful and representative examples of the major types of social prescribing model present in England. These can be seen in Boxes 1-5 in Chapter 5.

### **2.3. Phase 2 – Demonstration event**

Phase 2 consisted of a demonstration event that would bring together health and social care professionals involved with social prescribing and providers of nature-based care services in one area to: i) share the findings of Phase 1, ii) to share experiences and iii) to explore the challenges and opportunities to increase nature-based social prescriptions in the area.

This demonstration event occurred in one commissioning region (Leeds), involved local people and organisations and was targeted specifically at social prescribing for mental health service users. Leeds was selected as all three local CCGs in the area are providing social prescribing services but are at different stages of development; a range of nature-based interventions are already operating successfully in the area; and the University of Leeds is involved in related research.

Relevant stakeholders and potential providers identified via the steering group, researchers and the University of Leeds were invited to explore practical ways of working together to increase the referrals to green care social prescriptions in their area. The aim was twofold:

i) facilitate the first steps of the provision of an integrated offer with a common set of therapeutic goals; and ii) to get the ‘right’ people from one region together, to set about developing a working model which could ultimately be replicated to other areas of England<sup>22</sup> and for other service-user groups in the future. The programme for the social prescribing event in Leeds can be found in Appendix E.

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<sup>21</sup> Key individuals were contacted initially by email or telephone and were asked to arrange a convenient time for themselves (or the most appropriate person) to participate in a telephone interview and to add any additional detail to their case study. This helped to ensure that data are valid, current and fair. The details of the individuals and their organisational roles are also detailed in Appendix D.

<sup>22</sup> And where appropriate in the wider UK

### 3. Green care

#### 3.1. Definition of green care

Green care is one of the two elements that make up the nature, health and wellbeing sector<sup>23</sup>. Green care is defined as: “*nature-based therapy or treatment interventions – specifically designed, structured and facilitated for individuals with a defined need*” (Bragg and Atkins, 2016).

This results in a wide range of interventions, enabling the choice of the most appropriate treatment option for a specific individual as ‘bespoke’ care (Hine et al., 2008b). Although there is much diversity, the different approaches share commonalities, including:

- i) The contact with nature, i.e. using a coherent and deliberate strategy to generate health, social or educational benefits using nature.
- ii) Provision of facilitated, regular and specific interventions for a *particular* participant (or group of service users), rather than simply a ‘natural’ experience for the general public (Sempik et al 2010; Sempik and Bragg, 2013).
- iii) Services which are commissioned by a variety of different commissioning bodies and individuals.

Currently, a wide range of vulnerable groups benefit from such nature-based interventions, including (but not restricted to): people with mental ill-health (particularly those experiencing mild to moderate depression), people with dementia, adults and children with learning disabilities, adults and children with Autism Spectrum Disorders (ASD), those with a drug or alcohol addiction history, disaffected young people, and adults on probation.

#### 3.2. Types of green care

There are many different types of green care intervention currently in use (see Figure 3.1), However, the three most frequently occurring and widely available types of green care in the UK are social and therapeutic horticulture, care farming and environmental conservation (when used as a treatment intervention)<sup>24</sup>.

##### *Social and Therapeutic Horticulture (STH), Horticultural Therapy (HT) and food growing as an intervention*

Essentially, STH is using gardening and plants to help individuals develop wellbeing. This can be achieved through spending time in gardens, participating in gardening activities or doing something more active such as growing food (Mind, 2013). HT has been used as a more formal therapy or as an add-on to therapy for many years and there has been a steady rise since the 1980s in the numbers of garden projects in the UK that offer both STH, HT (Hine et al., 2008a, b) and more recently food growing as a treatment intervention (Schmutz et al., 2014). Social and Therapeutic Horticulture is one of the most successful and popular green care options in the UK, with over 1,000 projects catering for over 21,000 service users each week (Sempik et al., 2003)<sup>25</sup>. Nearly half of the STH projects in the UK provide services for people with learning difficulties; while 40% support people with mental health problems (Sempik et al., 2003).

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<sup>23</sup> The other being nature-based health promotion

<sup>24</sup> For more details on other types of green care intervention see Bragg and Atkins, 2016

<sup>25</sup> This is likely to be an underestimation given that these figures are from 2003. More up to date figures have not been collated.

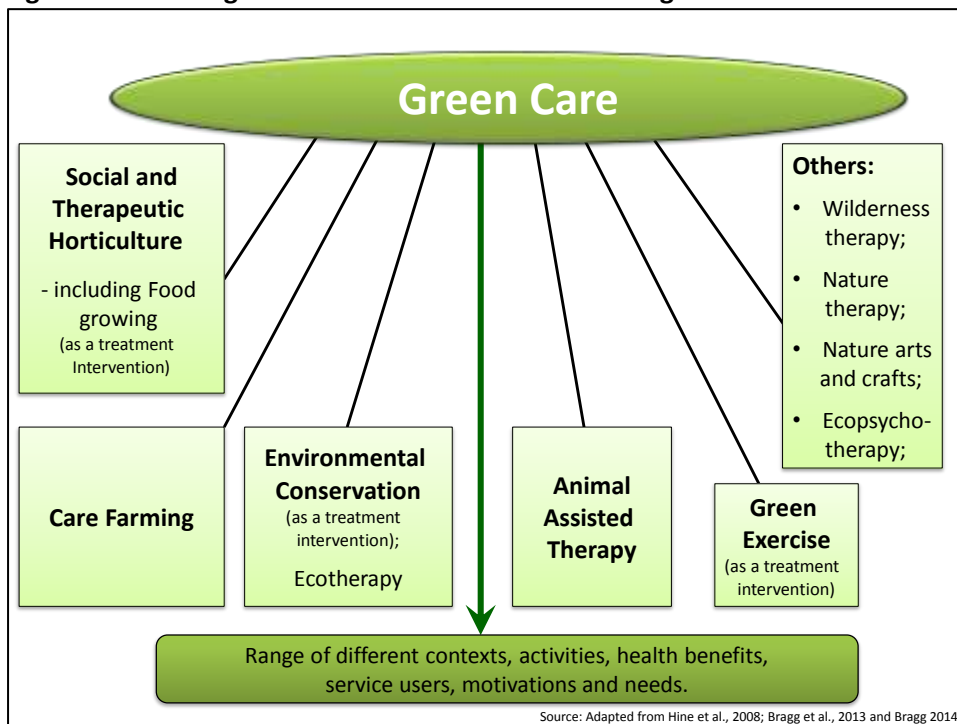
### Care Farming

Care farming (sometimes called social farming) is defined as the therapeutic use of agricultural landscapes and farming practices (Hassink, 2003; Haubenhofner et al., 2010; Care Farming UK, 2016a). On care farms, components of either the whole or part of the farm are used to provide health, social or educational care through a supervised, structured programme of farming-related activities. There are approximately 240 care farms in the UK. Of these, 8 are in Wales, 12 are in Scotland, 15 in Northern Ireland and 205 in England (Care Farming UK, 2016b), with an additional 25 care farms in the Republic of Ireland<sup>26</sup> (SoFab, 2014). Care farms currently provide services for an estimated total of 8,400 vulnerable people per week across the UK (Care Farming UK, 2016b).

### Environmental conservation (as a treatment intervention)

Facilitated environmental conservation work has increasingly been used as a means of delivering various health, wellbeing and social benefits for a variety of marginalised groups (Bragg et al., 2013a), and as commissioned programmes these are considered a form of green care. In these initiatives structured, facilitated activities take place, specifically designed both for the conservation and management of natural places; and for the health and wellbeing of participants. Although the key organisations providing environmental conservation as a treatment collate some data on their own activities, this data varies in format from organisation to organisation making it difficult to estimate a total number of projects providing services and the number of service users.

**Figure 3.1 The range of nature-based interventions in green care**



<sup>26</sup> 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.

### 3.3. Distinctions between ‘green care’ and ‘nature-based health promotion’ projects

#### 3.3.1. Nature in health promotion and in care

In addition to commissioned nature-based interventions designed for use as green care, there are also many projects using nature-based activities aimed at ill-health prevention through promoting healthy lifestyles in the general population. These health promotion projects are typically initiatives run in natural spaces (such as community gardens, nature reserves, woodlands, etc.) or projects offering nature-based activity sessions (community food growing, bush craft, healthy walks etc.). Nature-based health promotion activities are often run in partnership with land management organisations, community groups and schools.

Participants usually self-refer to these types of projects although they are often promoted and recommended by health professionals as opportunities for people to spend time outdoors and to become more physically active and socially included<sup>27</sup>. As these initiatives are designed for the general population or for specific *groups* within the general population rather than as part of a treatment or care package for an *individual* with a defined need, they therefore fall within the realms of public health rather than of ‘care’.

In reality, however, these distinctions are sometimes less clear. Some green care providers also offer nature-based activities for the general population, and inevitably there is some overlap within and between individual projects. In addition, people from the general population attending health promotion initiatives may also be vulnerable but are not attending the project as part of a ‘care package’, and some projects work with participants who are ‘well’ and those who are ‘ill’ simultaneously.

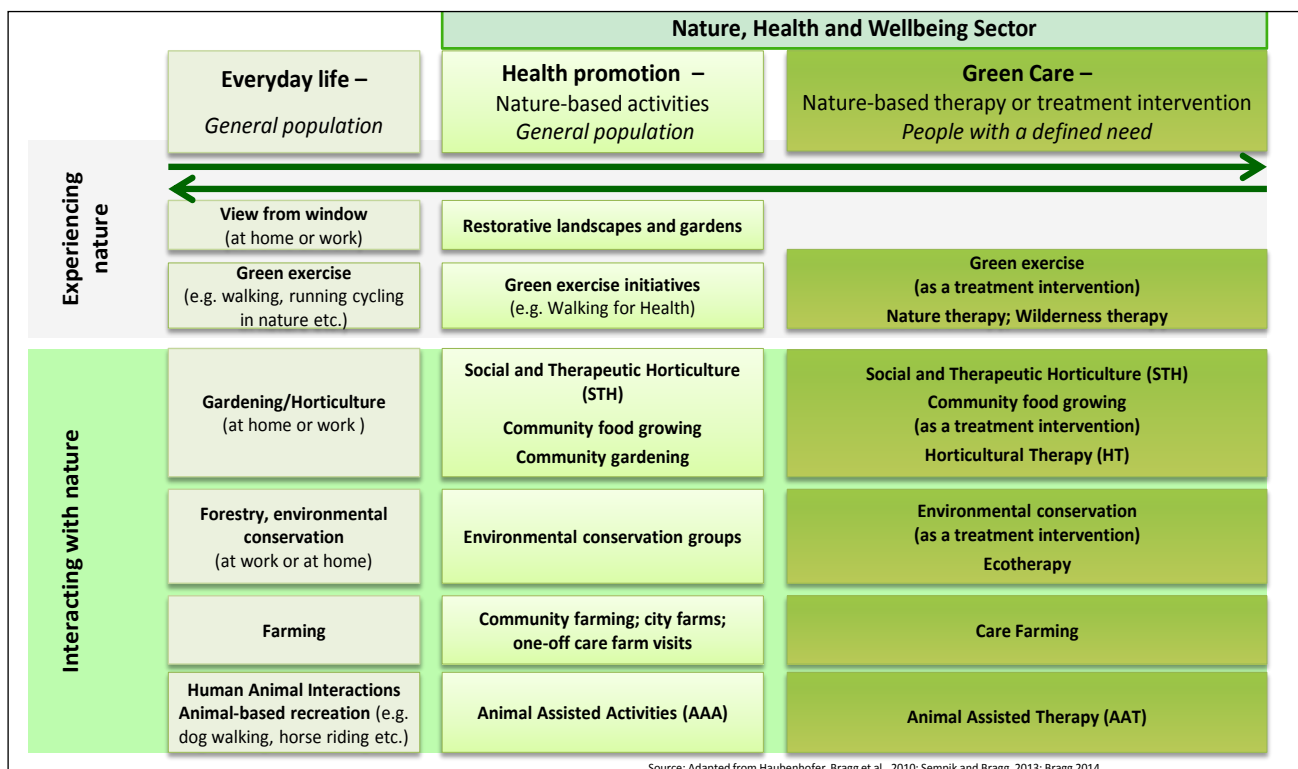
Figure 3.2 further clarifies these distinctions between green care and health promotion by identifying three key levels in which a person may engage with nature:

- i) nature as part of **everyday life**, including both nature-based employment and recreational activities;
- and then the two levels that comprise the nature, health and wellbeing sector:
- ii) nature activities as part of **health promotion**, healthy lifestyles or ill-health prevention; and
  - iii) nature as a therapeutic intervention – **green care**.

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<sup>27</sup> Some social prescribing services also refer patients to these types of projects (See Figure 3.3).

**Figure 3.2 The different contexts in which an individual may engage with nature**



**Explanatory notes:** The three columns represent the different contexts in which an individual may engage with nature. On the left, the ‘*Everyday life*’ column highlights various situations in which an individual engages with nature as part of their normal lifestyle, including everyday leisure or work activities. People usually make a conscious choice to incorporate these nature-based activities into their lifestyle and have the ability and opportunity to do so.

The middle column ‘*Health promotion*’ outlines a variety of existing group projects and initiatives which aim specifically to encourage individuals, communities and disadvantaged groups to benefit from nature-based activities in order to become more active, to have more social contact, to increase wellbeing or in the case of community food growing, to eat more healthily. People who attend these initiatives may not have the opportunity or ability to engage with nature as part of their ‘usual’ lifestyle and can attend these health promotion projects on either a regular or ad hoc basis. They may or may not be ‘vulnerable’ and will have joined the project on their own volition, or have been advised or suggested to join by a health, social or community worker, by a family member or friend. Funding is usually for the project as a whole and may come from public health, local authority grants or from the voluntary or private sector.

On the right, the ‘*Green care*’ column represents the various nature-based interventions that have been specifically commissioned for an individual with a defined health or social need as part of their care or treatment package. People attending these interventions will follow a facilitated and structured programme, on a regular basis; will have defined needs and outcomes; and the service is usually commissioned by health or social care (although service users in receipt of a personal budget may commission their own services). Funding is paid per individual for the care/ treatment service provided by the intervention.

The green arrows show that these three columns are points along a continuum. In moving from left to right from everyday life to green care (the top arrow), the needs of the individual are more acute, the support/care required is more intensive and the cost of the service increases. However, what makes nature-based interventions so powerful is the ability to reverse this trend and move from right to left (as shown by the bottom arrow) as the individual’s wellbeing improves, reducing costs and embedding practices within self-regulated and maintained healthy lifestyles. Different levels of support within projects can (where appropriate) help an individual move on from needing the services of a green care intervention, to maintaining their improved wellbeing state by attending a health promotion initiative, and then to progress further by choosing to incorporate nature-based activities and healthier behaviours into their everyday lives, thus creating a habit for life.

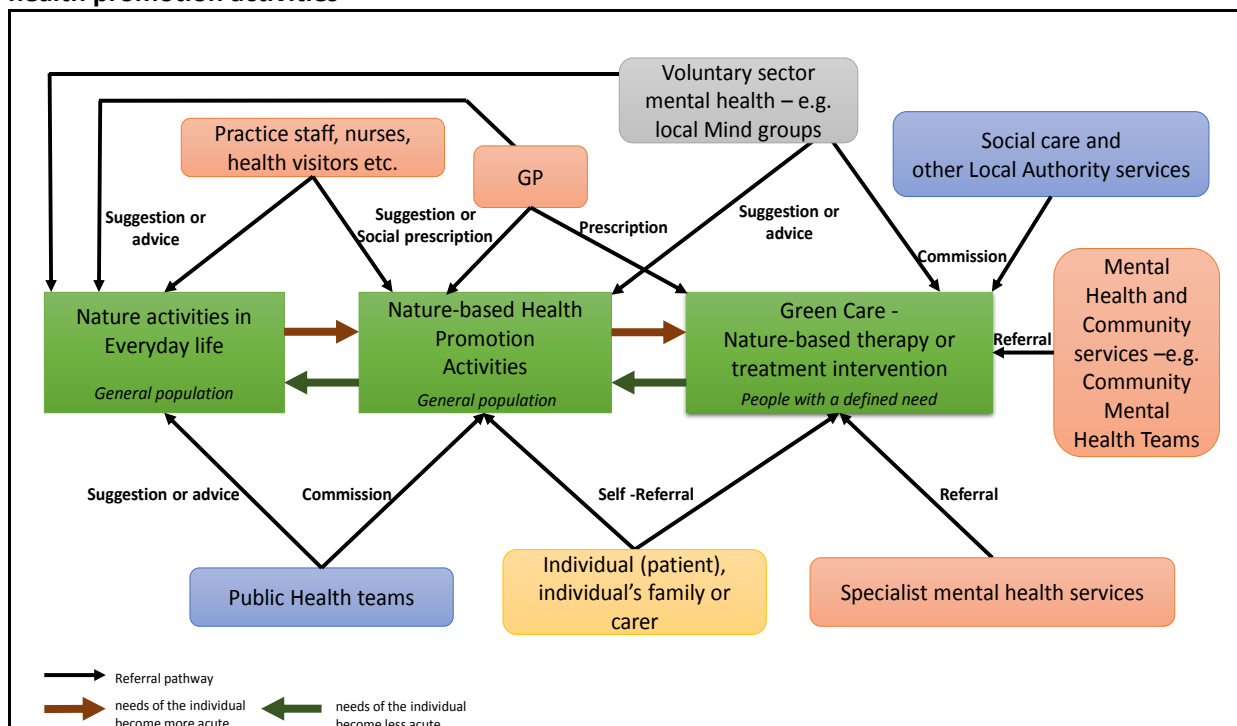


### 3.3.2. Referral to nature-based health promotion and to green care interventions

Making the distinction between green care interventions and nature-based health promotion activities within the nature, health and wellbeing sector is also important, due to the differing commissioning and referral pathways for the two types of service. Bragg and Atkins (2016) highlighted the need for clear communication of the distinctions between green care and nature-based health promotion both to ‘speak the right language’ to the different commissioners and to acknowledge the different referral mechanisms to each type of care.

Figure 3.3 draws on the three ways of engaging with nature shown in Figure 3.2 and highlights the differing health<sup>28</sup> and social care referral pathways present for incorporating more nature activities in everyday life and for the two types of nature-based service.

**Figure 3.3 Mental health and social care referral pathways to green care and to nature-based health promotion activities**



**Note:** There are many other referral pathways to green care interventions such as from: probation services; special education; drug and alcohol rehabilitation commissioners; ex-service personnel organisations and other commissioners. The focus for this figure is on the mental health and social care pathways (as per remit of study).

## 3.4. Health and wellbeing benefits of Green Care

### 3.4.1. General health and wellbeing

There is a convincing evidence base to show that exposure to the natural environment positively affects physical health and mental wellbeing. There have also been several comprehensive reviews of this published in nature, health and wellbeing literature (see for example: Pretty et al., 2006; Bird, 2007; Barton and Pretty, 2010; Pretty et al., 2011; O'Brien and Morris, 2013; Allen and Balfour,

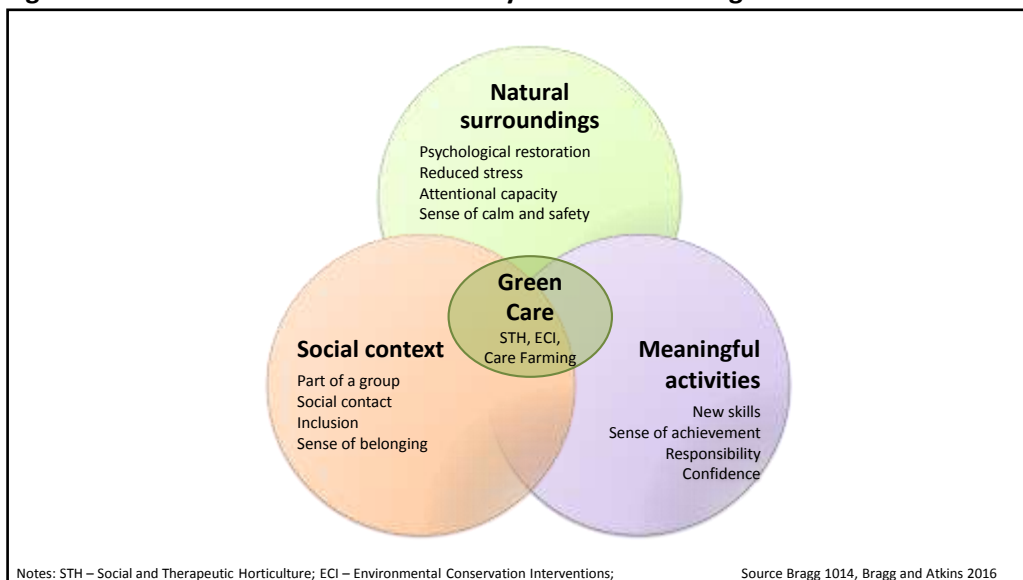
<sup>28</sup> Largely focussing on mental health as per remit of this report – although also applies to physical health too

2014). A recent report by The Kings Fund<sup>29</sup> also highlights the health benefits of gardening and shows that evidence on the impact on health is diverse and complex (Buck, 2016). Although studies that can measure direct cause and effect are relatively few, many other studies are “consistent with a wide range of health impacts across mental and physical health and health behaviours across the life-course” (Buck, 2016, p6). This report also highlights the evidence available for gardening as part of ‘everyday life’, for community gardening programmes as part of ‘health promotion’ and for social and therapeutic gardening as part of ‘green care’.

### 3.4.2. Mental health

A recent Natural England report reviewed the published literature for evidence on the mental wellbeing benefits derived from the three main types of green care: i) care farming, ii) social and therapeutic horticulture, and iii) environmental conservation. The report convincingly highlights a range of mental wellbeing benefits for participants, derived from the interaction between and combination of the three key attributes which define these interventions: i) the natural environment; ii) the meaningful activities; and iii) the social context, – see Figure 3.4 (Bragg and Atkins, 2016).

**Figure 3.4 The interaction of the three key elements within green care**



This interplay between the three attributes have also been echoed in two papers about care farming published after the Bragg and Atkins review (Elsey et al., 2016; Leck et al., 2016). Elsey et al. states: “Although care farming is an overtly practical approach, various theories suggest a sophisticated and subtle web of social, mental and physical interactions providing a potentially potent complex intervention” (Elsey et al., 2016 p99). The authors go on to suggest that care farms (and social and therapeutic horticulture) particularly resonate with the concept of ‘recovery’ in mental illness (Anthony, 1993) and highlight the importance of the increase in social connection, personal growth and physical activity together with the restorative effects of nature after time spent on a care farm programme. Although specifically about care farming, there are many parallels with social and therapeutic horticulture and environmental conservation interventions.

<sup>29</sup> Which included many systematic reviews

From the published literature, the mental health benefits from green care interventions include:

- Psychological restoration and increased general mental wellbeing
- Reduction in depression, anxiety and stress related symptoms
- Improvement in dementia-related symptoms
- Improved self-esteem, confidence and mood
- Increased attentional capacity and cognition
- Improved happiness, satisfaction and quality of life
- Sense of peace, calm or relaxation
- Feelings of safety and security
- Increased social contact, inclusion and sense of belonging
- Increase in work skills, meaningful activity and personal achievement (Bragg and Atkins, 2016)

### **3.5. Economic benefits of nature-based initiatives**

Economic analyses including Social Return on Investment (SROI) have been applied to assess the value provided by several green care interventions and nature-based health-promotion projects.

#### Accessing greenspaces

Accessing green spaces such as urban parks regularly has been shown to save the NHS money by reducing mental health admissions (Wheater et al., 2007; Buck, 2016).

#### Nature-based health promotion

There have been several Social Return On Investment studies for health promotion interventions. One such example is the evaluation of the Master Gardener programme. Master Gardener is one of a number of projects developed by Garden Organic where gardener regularly mentor householders in food growing, for a growing season. The SROI analysis showed that the Master Gardener programme has benefited participants by improving physical health, mental health and wellbeing; by increasing community participation and life satisfaction and by making food more affordable. The SROI ratio calculated indicates that every £1 invested in the Master Gardener programme has generated, on average, £10.70 in social, economic and environmental benefits (Garden Organic, 2014).

The evaluation of The Conservation Volunteers (TCV)<sup>30</sup> Green Gym<sup>31</sup> programme in 2008 estimated that for every £1 invested there would be £2.55 saved in treating illness due to inactivity (Yerrell, 2008). A more recent SROI evaluation in 2014, estimated that for every £1 invested into Green Gyms the social return is £4.02 (NEF and TCV, 2015). This research showed that: i) the physical health of the participants rose an average of 33% (worth £2.6 million); social isolation reduced in 80% of participants (worth over £700,000); and iii) personal wellbeing increased (worth over £400,000) (NEF and TCV, 2015; TCV, 2016). Another SROI conducted at a city farm community garden project run by Georgie City Farm in Edinburgh estimated that for every £1 invested there was £2.35 return (Gorgie City Farm, 2011).

#### Green care

Evidence of NHS savings is also apparent in the economic case studies examined in the Ecominds programme (NEF, 2014). The Ecominds programme was a National Lottery funded scheme for a

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<sup>30</sup> In 2008 TCV was BTCV, British Trust of Conservation Volunteers.

<sup>31</sup> Green Gym is an outdoor exercise programme, designed by TCV to improve people's health and wellbeing and make a positive impact on the local environment. During each session, a leader guides participants through exciting conservation activities which could include managing woodland, food growing, creating wildflower gardens and wildlife ponds. Green Gyms tackle essential conservation jobs in the great outdoors, working together in friendly teams to transform their local area. Participants also pick up new practical skills for life and the workplace, make new friends and improve their overall wellbeing (TCV and NEF, 2016).

variety of green care and nature-based health promotion projects delivering interventions for people with mental health issues, and was managed by Mind. The economic analysis of five people attending a range of green care projects in the programme, conducted by the New Economics Foundation, estimated the value of approximately £7,000 per person<sup>32</sup> as a result of taking part in a green care intervention (NEF, 2014). This value was derived through reduced NHS costs, welfare benefit reductions and increased tax contributions. In addition, a community gardening (health promotion) project in London estimated that potential savings to the NHS for a year could amount to over £113,000 for participants who reported an improvement in their health (Jackson et al., 2012).

Social Return on Investment analyses have also been carried out on green care interventions. A care Farm SROI analysis of the Houghton Project estimated that for every £1 invested there is £3.59 social return (Leck, 2012) and for Nineveh Ridge care farm a £3.39 return (Leck, 2011). For the Houghton Project care farm, only 61% of the total value associated with the care farm was found ultimately to relate to the service users themselves with 18% concerning carers and relatives and 17% in savings to the NHS resulting from reduced use of services (Leck, 2012).

Sydenham Garden in London runs three adult mental health projects and one dementia project for i) people recovering from significant mental health problems; ii) dementia patients; and iii) People living with anxiety and depression. Patients are referred to the project through their GP or keyworker. The programme was commissioned by Lewisham CCG to provide social and emotional learning sessions targeting mental health, on which they calculated an economic pay-off to the NHS of £9.42 per pound (Knapp et al., 2011).

### Conclusions

These studies have been united in presenting a positive return on investment that relates, in large part, to the improved health and wellbeing of stakeholders and associated cost savings (Greenspace Scotland, 2013; Leck et al., 2014, 2016). SROI analyses for nature-based initiatives range from £2.35-£10.70 per £1 invested<sup>33</sup>.

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<sup>32</sup> Ranged from £4,000 to £12,000

<sup>33</sup> Different inclusion parameters exist in different SROI calculations so variations in methodology can cause variation in result.

## 4. Social prescribing – Definitions and models

### 4.1. Definitions and terms in Social Prescribing

Social prescribing (sometimes called community referral) is a mechanism to engage patients with non-medical support services within the community (Brandling and House, 2007; Friedli et al., 2007a). In essence therefore, social prescribing is a framework for supporting people's psychosocial needs, that responds to the increasing recognition of the influence of economic, social, environmental and cultural factors on health (Friedli and Watson, 2004).

Evidence suggests that as little as 20% of health outcomes actually relate to clinical care; 10% are due to the physical environment, 30% relate to health behaviours and the remaining 40% is attributed to socioeconomic factors (Kimberlee, 2014). According to the Low Commission (2015) an estimated 20% of patients consult their GP for social problems and 15% of visits were for social welfare advice (Low Commission, 2015; SPN, 2016.) It is these wider determinants of health that social prescribing is seeking to address by providing a framework for developing alternative, non-medical responses to meet the needs of patients (Brandling and House 2009; The University of York, 2015).

Processes and procedures within social prescribing services vary considerably, there is currently no universally used definition of social prescribing – a recent report from the Social Prescribing Network (SPN) identified 56 variations on terms and definitions of social prescribing. There is also no evidence of a shared understanding amongst health professionals as to what social prescribing entails (Kimberlee, 2013; Kimberlee et al, 2014; Kinsella, 2015):

- Langford et al. describe social prescribing as: *“a clear, coherent and collaborative process in which healthcare practitioners including GPs, practice nurses and community matrons work with patients and service users to select and make referrals to community-based services.... Social prescribing is a tool for clinicians to work with patients to address wider social and lifestyle aspects of their health.”* (Langford et al., 2013, pp. 7-8)
- The Social Prescribing Network<sup>34</sup> states that: *“social prescribing involves empowering individuals to improve their health and wellbeing and social welfare by connecting them to non-medical and community support services. It is an innovative and growing movement, with the potential to reduce the financial burden on the NHS and particularly on primary care”*. However, as a result of an event held in January 2016 the network has since developed a shortened definition: *“Enabling healthcare professionals to refer patients to a link worker, to co-design a nonclinical social prescription to improve their health and wellbeing”* (Social Prescribing Network, 2016).
- Others state that the wider shared intent of social prescribing is to provide a non-medical referral option that can operate alongside existing treatments to improve health and wellbeing and build resilience within communities (Community Action Southwark, 2015; Kimberlee, 2013; The University of York, 2015).

For the purposes of this study, social prescribing is defined as:

*“a mechanism enabling healthcare professionals to refer patients to a link worker, to co-design a non-clinical social prescription to improve their health and wellbeing”*  
(Adapted from Social Prescribing Network, 2016)

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<sup>34</sup> See <https://www.westminster.ac.uk/patient-outcomes-in-health-research-group/projects/social-prescribing-network> for more details

There are other associated terms used to describe aspects of social prescribing, defined by the Social Prescribing Network (2016) and include:

- **A social prescriber** – any (healthcare) professionals who refer people to a social prescribing service.
- **A social prescribing service** – the link worker(s) and the subsequent groups and services that a person accesses to support and to manage their needs.
- **A link worker** – link workers have a variety of names e.g. health advisor, health trainer, facilitator or community navigator. Usually a non-clinically trained person who works in a social prescribing service, and receives the person who has been referred to them. Link workers are responsible for assessing a person's needs and suggesting the appropriate resources for them to access.

These terms will be used throughout this report.

## 4.2. Incorporated activities and service users

The range of activities that are included in a social prescribing service can be extremely varied and can include anything from support groups, physical activities, advice services and learning, to volunteering and outdoor activities (Community Action Southwark, 2015; Friedli et al., 2007b).

Social prescribing can provide benefits in three key fields: improved mental health, enhanced community wellbeing and reduced social exclusion (Friedli and Watson, 2004). Social prescribing can benefit members of various vulnerable or at risk groups, in addition to those with mental health problems and frequent attenders in primary care (Friedli et al., 2007a; Community Action Southwark, 2015; Woodall and South, 2005). GPs are most likely to refer patients to a social prescribing service if they display one or more of the following characteristics:

- A history of mental health problems
- Frequent attenders of GP practices
- Two or more long-term conditions
- Socially isolated
- Untreatable or poorly understood long-term conditions
- Not benefiting from clinical medicine and drug treatment. (Brandling and House, 2009)

The fact that people might often have more than one of these characteristics supports the fact that social prescribing services often have holistic intent that seeks to address wider issues rather than those that might manifest in a single way (Brandling and House, 2007, Kimberlee, 2013).

## 4.3. Social Prescribing models and typologies

The social prescribing mechanisms (models and referral pathways) can vary widely between different social prescribing services in the UK, which further hinders the understanding of what social prescribing involves. To provide some clarity, several typologies of social prescribing have been developed (e.g. Kimberlee, 2013; Community Action Southwark, 2015 – see Appendix F for more details of these).

### Kimberlee typology

From a study of social prescribing in the Bristol area, Kimberlee (2013) presented four models of social prescribing:

- Social Prescribing as Signposting
- Social Prescribing Light

- Social Prescribing Medium
- Social Prescribing Holistic<sup>35</sup>

Southwark typology

Similarly, Community Action Southwark (2015) have identified three models of social prescribing activity:

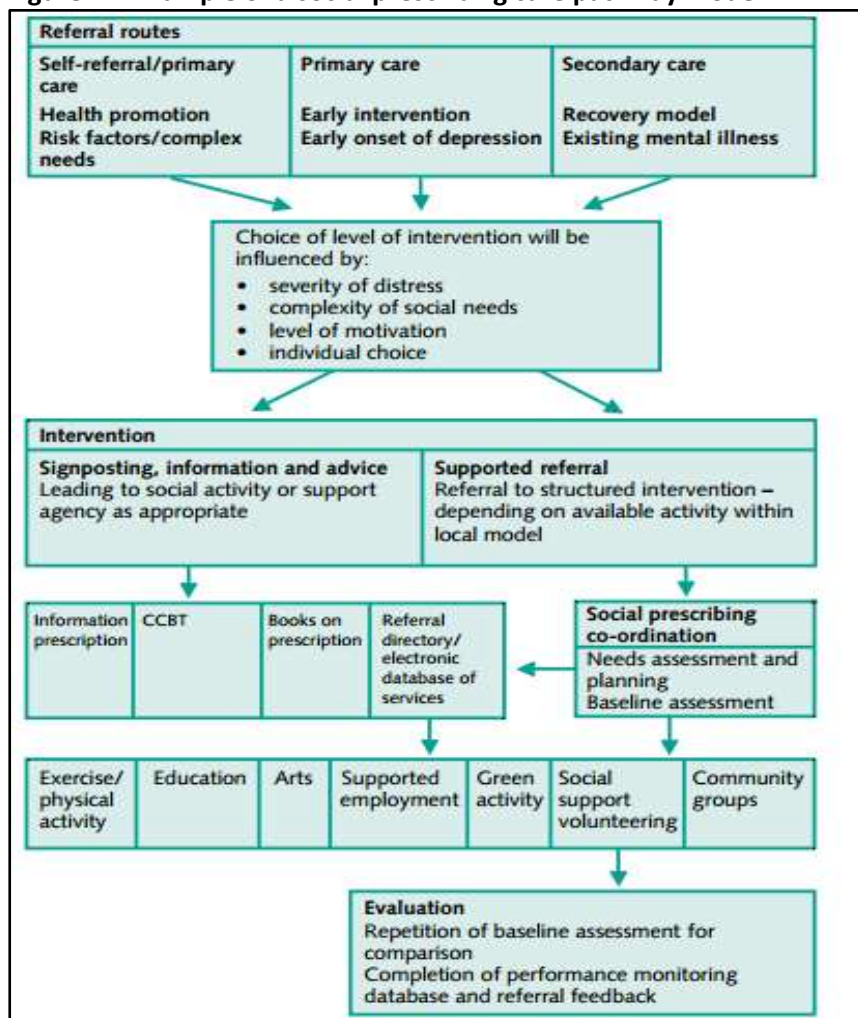
- Direct referral of patient to the organisation that will provide the intervention
- Referral of patients to a lead provider, a link worker then carries out an assessment with the patient and recommends an appropriate service.
- Referral to one of several ‘specialist’ lead providers, a link worker carries out an assessment and recommends an appropriate service.

More details on both the Bristol and Southwark examples can be found in Appendix F.

Freidli model

Freidli et al. (2007a) developed a visual overview of a social prescribing care pathway model (Figure 4.1).

**Figure 4.1 Example of a social prescribing care pathway model**



Source: Friedli et al., 2007a – A model derived from North West demonstration sites

<sup>35</sup> Holistic schemes have usually evolved over time, having been examples of light or medium initiatives previously. They work with people with long-term conditions (LTCs) who are encouraged to play a role in managing their own care and benefit from the participation of GPs who recognise the value of the service provided for meeting the needs of their patients.

#### **4.3.1. Commonalities**

What these typologies and models have in common is that they highlight the existence of different levels of involvement with patients from signposting an individual to a source of information, right through to supported referral with the help of a link worker and accompanied visits to the service provider.



## 5. Social prescribing – Evidence review and good practice

This chapter outlines the key findings of the evidence review before highlighting examples of social prescribing used, the five in depth case studies and the collated results of the 12 social prescribing services examined in this study. Finally, key points from the research are covered in more detail together with key challenges identified. Further information can be found in Appendices D and G-L.

### 5.1. Key findings from evidence review

#### Organisation and activities covered

- All the social prescribing services studied have a primary care referral system in place that provides GPs with a non-medical referral option to enable patients to access health resources and social support from outside the NHS
- Social prescribing services are operated jointly by primary care providers and the third sector, but the social prescribing element is predominantly delivered by the third sector.
- Successful social prescribing depends on good partnerships, high levels of cooperation and joint ownership between a wide range of individuals, groups and organisations with very different organisational cultures.
- Although most social prescribing services seem to contain one or two nature-based interventions in the suite of options, these appear very much in the minority. It is unclear whether this is due to: a lack of nature-based projects in the area; a lack of awareness of the existence of these projects locally; or a limited understanding of the benefits that nature-based initiatives can provide.
- There are usually no specific inclusion criteria for services included as social prescribing options and no specific accreditation requirement for service-providers.

#### Service users

- The target beneficiary group is generalist<sup>36</sup> for the majority of services or generalist plus mental health.
- Patients benefitting most from social prescribing often have several health-related issues simultaneously, none of which are sufficient in their own right to trigger social or health care payment, but that combine to result in frequent GP visits and high service use.
- Most nature-based initiatives included in social prescribing services are nature-based projects (aimed at ill-health prevention through promoting healthy lifestyles), rather than green care interventions (commissioned, bespoke nature-based interventions for individuals with a defined need).

#### Referral mechanisms and funding

- Larger and more successful services typically use link workers with local knowledge<sup>37</sup> – although the level of support given by the link worker varies.
- The link worker plays an important role in social prescribing, as they are responsible for taking referrals and then linking the patient to relevant services. Various evaluations have emphasised the critical importance of their role in relation to the success of a service

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<sup>36</sup> i.e. not aimed at a specific medical condition but rather a range of conditions, LTSs or for frequent attenders.

<sup>37</sup> who are sometimes formally linked to the primary health care settings

- The majority of social prescribing schemes are funded directly by CCGs and are free of charge to the patient
- In the main, social prescribing services fund the operating costs of the service (i.e. link workers and referral mechanisms etc.) but not the service provision. There is rarely direct financial support to service providers<sup>38</sup>

### Benefits

- A range of different patient and service outcome evaluation measures are used in social prescribing services. Benefits from social prescribing include:
  - better outcomes for health and social care;
  - improvements in mental health and wellbeing;
  - cost-effective use of NHS resources; and
  - more effective use of GP time.
- The potential cost savings associated with the Rotherham social prescribing pilot are estimated to be between £1.41 and £3.38 for every £1 invested<sup>39</sup>; and for the Wellspring Healthy Living Centre a return on investment for their social prescribing service of £2.90 for every £1 invested<sup>40</sup>.

### Challenges

- Due to the wide range of services included under the umbrella term of social prescribing, the differing referral mechanisms and the lack of a universally accepted definition, there is therefore a lack of understanding as to what social prescribing entails.
- One key practical challenge is reaching agreement between General Practices and the social prescribing provider regarding effective referral routes and appropriate inclusion criteria<sup>41</sup>.
- Despite 90% of GPs saying that their patients would benefit from social prescribing, and 4 out of 5 thinking it was something that they should be able to access, only 16% of GPs said that they regularly used social prescribing.
- Barriers to engaging GPs and healthcare staff in social prescribing services include: a lack of communication between social prescribing service and the GPs and other healthcare staff; issues with the referral process; worries about liability; and increased workload.

## **5.2. Evidence review and good practice**

The study aim was to examine the use of community or voluntary sector based interventions that achieve clinical outcomes for people with mental health problems through non-clinical means. To understand social prescribing and its application, examples ranging from simple local directories to large scale programmes were examined, via publicly available literature and interviews and verifications from the social prescribing services.

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<sup>38</sup> In 50% of models the CCG or funder pays for social prescribing referral process with limited grant funding available to support the individual service-providers; 33% only fund the referral process (signposting/website/ link workers/ centre); and minority fully fund the service provision.

<sup>39</sup> Dayson and Bashir, 2014

<sup>40</sup> Kimberlee et al., 2014

<sup>41</sup> This is applicable regardless of the social prescribing option i.e. from debt counselling through to care farming

### 5.2.1. Examples of social prescribing

Twelve social prescribing services were chosen as the focus for this research, showing a mix of purpose and demonstrable effectiveness. The onus was on case studies that have a good track record; operate at scale; that are replicable; and located in England. Details of the twelve social prescribing services chosen for this study are shown in Table 5.1.

A template was developed to give the case studies a common format and to allow comparison. All templates relating to the twelve social prescribing services can be found in Appendix D. From the twelve examples of social prescribing services, five representative case studies were subsequently examined in more depth, including:

- Box 1. Leeds West Patient Empowerment Project (Case Study no. 9<sup>42</sup>): Chosen because it is a good example of a CCG funded generic social prescribing referral service to unsupported organisations<sup>43</sup> (i.e. community service providers are not paid for the services they provide)
- Box 2. Natural Health Service (Case Study no. 6): Chosen as it is an example of a specifically nature-based social prescribing service<sup>44</sup>. The organisation covers referral and service and is grant funded (rather than CCG funded).
- Box 3. Bromley-by-Bow Centre (Case Study no. 2): Chosen because it is a holistic centre-based social prescribing service<sup>45</sup>. It is a generic referral and service delivery organisation funded by both the CCG and through charitable funds.
- Box 4. Rotherham Social Prescribing Service (Case Study no. 5): Chosen because it is the longest running social prescribing service; also is a CCG funded generic referral service but to supported organisations (i.e. service providers do receive some financial support for providing services)
- Box 5. Rotherham Social Prescribing for mental health and wellbeing pilot (Case Study no. 5): Chosen because it has grown from the success of the Rotherham social prescribing service and is also a CCG funded referral service to supported organisations but specifically aimed at those with a mental health diagnosis.

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<sup>42</sup> Case studies also referred to as cs

<sup>43</sup> related: Leeds South and East, cs3; Newcastle West, cs7

<sup>44</sup> related: A dose of nature, cs1; Natural Choices, cs11

<sup>45</sup> related: Wellspring, cs8

**Table 5.1 Details of social prescribing services used in study**

<b>Name</b>	<b>Social prescribing service</b>	<b>Area covered</b>	<b>Case study number</b>
A Dose of Nature	Grant funded (not CCG) nature-based referral and service delivery organisation	Cornwall, Devon and Bristol	1
Bromley by Bow Centre	CCG and charity funded generic referral and service delivery organisation	Tower Hamlets	2
Connect for Health	CCG funded generic referral service to unsupported organisations	Leeds South and East	3
Growing Well	Service provider working independently and directly with CCG	Cumbria	4
Rotherham Social Prescribing Service	CCG funded generic referral service to supported organisations also Pilot project – CCG funded referral service for people with mental health problems	Rotherham	5
The Natural Health Service	Grant funded (not CCG) nature-based referral and service delivery organisation	Merseyside	6
Ways to Wellness	CCG funded generic referral service to unsupported organisations	Newcastle West	7
Wellspring Healthy Living Centre	CCG and charity funded generic referral and service delivery organisation	Bristol	8
West Leeds Patient Empowerment Project	CCG funded generic referral service to unsupported organisations	Leeds West	9
Clinks Care Farm	Service provider working independently and directly with CCG	Norfolk	10
The Natural Health Service for Weymouth and Portland / Natural Choices	Grant funded (not CCG) nature-based referral and service delivery organisation	Weymouth and Portland	11
Well Aware	Online directory	South West	12

### **Box 1. Leeds West Patient Empowerment Project**

The Leeds West Patient Empowerment Project (PEP) was developed in 2014 and is a partnership between Leeds West CCG, local voluntary groups, CCG member practices and Leeds City Council. BARCA-Leeds leads the initiative but works in partnership with Leeds Mind, Better Leeds Communities and Touchstone. PEP covers all the GP surgeries in Leeds West CCG and was initiated by the CCG to connect general practice with the voluntary sector to help patients develop the skills, knowledge and confidence to self-manage their condition.

There are no specific patient criteria; clinicians instead refer based on their understanding of the patient's health and wellbeing and what may be of benefit. The focus is on meeting unmet needs, building resilience and providing community-based mental wellbeing solutions.

GPs identify patients they think could benefit from the support of PEP, provide information and, if a referral is agreed, then share relevant information with a PEP link worker who then meets the patient to discuss how best they might be supported. This might take the form of one to one support (average of six sessions) or linking to a group or activity, with PEP staff accompanying them to their first session if required.

PEP was funded on an annual basis for the first two years but funding has now been made available for a further three years (until August 2019) on the basis of positive impact evaluations. 482 patients were referred to PEP between October 2014 and September 2015; 78% came through a GP, 12% were self-referrals, 6% were referrals by other practice staff and 4% were from other organisations. Patients were then referred on by PEP link workers to 987 groups and services that included woodland walks and an environmental conservation group (Johnson, 2015). No financial support is provided to these organisations, and the need to explore associated impact and unintended consequences has been noted.

The impact evaluation identified a statistically significant increase in mental wellbeing scores amongst referred patients, their self-reported wellbeing was also found to have increased as was their perception of their self-efficacy to manage their own health. Furthermore, 80% of GPs indicated that they had seen improvements in patient care since the start of the PEP, 70% that in their opinion the wellbeing of their patients has improved, 100% that it was making a positive difference to their patients and 90% that it was making a positive difference to their local community.

### **Box 2. Natural Health Service, Liverpool**

The Natural Health Service offers health commissioners a social prescribing service specifically using nature-based interventions. The Natural Health Service offers access to a range of these interventions to help tackle a range of health and wellbeing issues. The Natural Health Service is currently working on two programmes: '*Nature for Health*' and the '*Natural Health Service Research Centre of Excellence*'. This consortium of environmental, academic and health practitioners seeks to increase the use of the natural environment to support good health through a single point of access to a range of well-developed and evidence-based services in natural green spaces.

The Natural Health Service coordinates activities and is also involved with delivery of nature-based interventions. Project partners lead on delivery, but they sometimes also involve other local groups in the process. The first Nature for Health placements were provided in September 2013 and £400,000 of lottery funding (2015) will deliver activities over the next three-year period. Partners are funded to deliver programmes as a whole rather than by number of participants.

All activities provided are nature-based and include nature walking, horticultural therapy, forest school, green volunteering, green gym and mindful contact with nature. These last for between eight and sixteen weeks and the intent is to then signpost participants to other services as required. The service is open to all, but it is anticipated that most participants will have mild to moderate mental health problems.

Referral forms can be accessed by post, e-mail or on-line, and participants can self-refer or be referred by any qualified health provider (primary and secondary). No referrals from GPs have been received so far, but it is anticipated that this will occur as the service becomes better established and the evidence base develops. The Natural Health Service Research Centre of Excellence is working with various academic institutions to commission independent evaluations of the Natural Health Service and its products.

### **Box 3. Bromley-by-Bow Centre**

The holistic healthy living centre in Bromley by Bow (built in 1997) has applied social prescribing principles from the outset. Funding from Tower Hamlets CCG since 2013 has enabled the expansion of their social prescribing service to include other local GP practices and in 2016 to the whole Borough. GPs, health care assistants and nurses can refer to the service and it supports 700 out of a total of 25,000 registered adult patients annually. 25% of the Centre's expenditure relates to the provision of GP services and the remaining 75% supports the delivery of non-clinical services. The social prescribing seeks to support the health and wellbeing of all patients through improving the wider determinants of health. It is open to all, but is particularly relevant for those with several conditions – where none are sufficient in their own right to trigger social care payments but which combine to result in frequent GP visits and increased service use.

Link workers regularly ensure that participating practices know about the social prescribing service, and that it is accessible to practice staff and GPs through the electronic referral process. A referred patient can have up to six sessions with the link worker if required, with a balance between receiving the support they require without becoming dependent upon the individual providing that support. GPs receive feedback from link workers about relevant health and wellbeing outcomes.

No formal service directory exists – referrals are to 30-40 organisations. Gardening is one promoted activity and a previously funded therapeutic horticulture programme is now being managed by local people with support from the Centre's wellbeing teams. The aim is for the activities to ultimately become part of patients' lives thus supporting active lifestyles and social interaction, rather than being time limited or dependent on external funding – strengthening communities to become more resourceful, resilient and better able to support their own health and wellbeing.

Although the voluntary sector will not initially receive direct financial support, social prescribing is seen as part of a longer-term shift towards resources for voluntary and community provision if evidence shows monetary savings for the NHS.

### **Box 4. Rotherham Social Prescribing Service**

A social prescribing pilot was initiated in Rotherham in 2012 and is funded to 2018 through the Better Care Fund. Voluntary Action Rotherham delivers the service in partnership with more than 20 local voluntary and community organisations, on behalf of NHS Rotherham CCG. The service works with patients identified as in the 5% most intensive users of services, who have complex long-term conditions (LTCs), are high users of hospital care and are likely to continue to be so in the future. 74% of those involved in the service are aged 70 or over. Participants are referred onto the service by the 36 participating GP Practices or by the Integrated Case Management Team. More than 1,600 patients were referred to the service between 2012 and 2014 and 1,100 of these were then referred on to funded providers. A Project Manager oversees the day-to-day running of the service and grant programme, and five advisors work directly with patients. Advisors carry out home visits and engage in guided conversations (to assess support needs) before referring them to one of the local organisations contracted to provide services.

Unusually, the Rotherham service has 'commissioned' voluntary and community organisations to deliver services (rather than relying on free service provision) – inviting grant applications from local not-for-profit organisations seeking to improve the health and wellbeing of patients with LTCs. One has a gardening project and a local Wildlife Trust is also interested in becoming involved. 44% of the £1 million funding provided for the first two years covered the core cost of developing and running the service, and the remaining 56% funded the 'menu' of voluntary and community sector activities.

The service has been regularly evaluated. Emerging lessons and recommendations for stakeholders and commissioners were identified in 2013 and in 2014 analysis provided cost-benefits and return on investment. In 2016, an updated assessment shows i) reduced non-elective inpatient episodes, ii) reduced A and E attendances, and iii) positive change amongst 82% of participants on at least one wellbeing outcome measure. NHS costs avoided for the full three years of the service were estimated at £536,000 compared to total input costs of £1.65 million (this figure does not incorporate social cost-benefits or related future savings). The Rotherham social prescribing service received the 'Excellence in Individual Participation Commissioner' award from NHS England in 2014 and is part of the NHS 'Improving general practice – a call to action' initiative.

### **Box 5. Rotherham social prescribing for mental health and wellbeing**

As a follow-on from the successful Rotherham social prescribing service highlighted in Box 4, a social prescribing service specifically for people with mental health issues was started as a one-year pilot in Rotherham in April 2015 and has since been extended for another year. Participants are referred to services that already exist in the locality and to those that are commissioned specifically for this pilot. These have included 'Men in Sheds' and services linking people to exercise and the environment.

The local Mental Health Trust identifies patients considered to be sufficiently stable for discharge but for whom social prescribing might improve resilience and the development of support networks to reduce the likelihood of re-admission<sup>46</sup>. The social prescribing organisation are currently in discussions with the Trust about extending social prescribing to other patient groups and linking with the IAPT (Improved Access to Psychological Therapies) service.

Two advisors work specifically on the mental health pilot and referrals occur through both individual and group routes. When mental health workers refer individuals, an advisor then arranges a joint meeting with the worker and the patient to explain the service and the potential benefits. If the patient chooses to engage (96% of those who attend the initial meeting), then this is followed by a more in depth guided conversation between the advisor and the patient. The advisor will then make appropriate referrals whilst also maintaining contact with the patient so they can monitor progress and continue to provide support as required.

The local mental health team have also set up an eight-week transition group for people with whom they are working towards discharge. Advisors join the group in week 6 and, after the last session, will meet individually with people who are interested in taking up the social prescribing service. This group route then operates in the same way as with individual referrals.

Early indicators of impact are positive:

- 83% of starters have completed the programme.
- Of those that have completed, 66% have become more involved in activities, 31% have become involved in learning or training, 17% have started volunteering and 7% have gained employment.
- 96% have reported an improvement in at least one outcome area: 72% feel more positive and 62% feel better able to manage their symptoms.
- Amongst those patients that have had a discharge review meeting with the mental health team, 54% have been discharged.

### **5.2.2. Collated case study results**

Using the templates populated for each of the examples of social prescribing, the results of key elements of the 12 different services were collated to ease comparison and identification of commonalities and differences. These are shown in Table 5.2.

From these collated findings, the key points for social prescribing services are:

- The majority (67%) cover a single CCG area – and the remainder cover two or more CCGs.
- Although some started in 2011 – 42% social prescribing services started in 2014 or later.
- Starting motivation – 67% started social prescribing to widen the range of referral opportunities available by connecting GPs to community/voluntary sector referral opportunities.
- Services are operated jointly by primary care providers and other third sector partners, but the social prescribing element is delivered by the third sector.
- Target beneficiary group – majority 59% are generalist or generalist plus mental health.
- Majority take the form of social prescribing via link worker – although the level of support given by the link worker varies.

<sup>46</sup> The patient groups concerned are mainly cluster 7 and 11 currently; that is those who are suffering from issues associated with long term non-psychotic disorders such as anxiety and depression, and those with a history of psychotic symptoms who have been stable for more than two years. People in this latter cluster can also have long-term dependence issues.

- Most require no specific accreditation or process for service-providers in order to be included in the choice of social prescribing options.
- 67% include referrals to nature-based interventions – but these are minimal (i.e. to one or two projects) or the numbers of nature-based options are unknown.
- In the majority of services, the patient is referred via the GP or health-worker – to the link worker – and then directed to the service-provider.
- Recommended dose or length of time patients attend social prescribing intervention varies but most commonly for 12 weeks.
- Most social prescribing services are free of charge to the patient.
- In 50% of services the CCG or funder largely pays for social prescribing referral with limited grant funding available to support the individual service-providers; 33% only fund the referral process (signposting/ website/ link workers/ centre); and minority (17%) fully fund the service provision.
- No funding directly follows the individual patient.
- A range of patient/ service outcome evaluation measures are used in social prescribing services.



**Table 5.2 Collated case study results for key elements of social prescribing**

Key question	Options	Case studies	
		Number	Proportion (%)
Area covered by social prescribing service	1 CCG	8	67
	2-3 CCGs	2	16.5
	3+ CCGs	2	16.5
When social prescribing service started	Pre 2000	1	8
	2007 - 2010	2	17
	2011 - 2013	4	33
	2014 - 2016	5	42
Starting motivation of social prescribing service	Social prescribing to connect GP to community/voluntary sector referral opportunities	5	42
	To widen/coordinate <i>nature-based</i> patient referral opportunities available to GPs	3	25
	To help patients self-manage and give direct contact with health and wellbeing service providers	2	16.5
	To increase referrals to a single nature-based project	2	16.5
Type of social prescribing project	Online social prescribing directory	1	8
	Healthy Living Centre offering social prescribing	2	16.5
	Social prescribing service	4	33
	Nature-based social prescribing	3	25
	Individual project (care farm)	2	16.5
Target audience/ patient group	Not specified/ generalist	2	16.5
	Generalist plus mental health	5	42
	Mental health	3	25
	Various long-term conditions/ high service users	2	16.5
What form does social prescribing take?	Social prescribing via website	1	8
	Social prescribing via phone call	1	8
	Social prescribing via link worker	7	59
	Social prescribing via 1 project	2	17
	other	1	8
What information/ accreditation or process is required for service-providers in order to be included in social prescribing options	None	5	42
	Base level standards and qualifications / NHS Standard contract for services	2	16.5
	Must be member of SP consortium	1	8
	Compliance with external accreditation/ AQP/ Competency framework to deliver IAPT	2	16.5
	Not applicable	2	16.5

Key question	Options	Case studies	
		Number	Proportion (%)
Nature-based interventions included in social prescribing options?	Yes – all	3	25
	Yes – minimal/ unknown numbers	5	42
	Not known	2	16.5
	Not applicable	2	16.5
Referral mechanism	Find interventions by themselves	1	8
	Referred to website/ phone no	1	8
	Referral form from health-worker – directed to link worker – directed to service-provider	8	67
	Referral form from health-worker – directed straight to service-provider	2	17
Who refers patient to social prescribing?	GP/ health-worker only	4	33
	GP/Health-worker and self-referral	5	42
	GP/ Health-worker, pharmacist and self-referral	2	17
	Self-referral	1	8
Recommended dose/ length of time attending social prescribing intervention	None	3	25
	12 weeks (approx.)	5	42
	12-16 weeks	1	8
	1 year or more	2	16
	Open-ended or varies	1	8
Cost to patient?	Yes (donations or between £2.50 and £5 a session)	2	17
	No	10	83
What aspects of social prescribing service does CCG/ funder pay for?	Providing the social prescribing referral service (signposting/website/ link workers/ centre) only	4	33
	Mainly social prescribing referral but some funds (grants) to support the individual service-providers	6	50
	Funding goes direct to service-provider (individual project case studies)	2	17
Funding follows individual patient	Yes	0	0
	No	12	100
Measures used to assess effectiveness/ outcomes?*	None	2	17
	Informal/ qualitative feedback on patient notes	1	8
	Person centred goals	1	8
	Outcome Star	1	8
	WEMWBS/ SWEMWBS	4	33
	Range of additional standardised measures	2	17
	External evaluator/ academic partner	4	33
	Use of services	4	33
	Social/ economic impact	3	25

Note: \* Percentages may add up to more than 100% where services utilise several evaluation measures/ approaches

### **5.3. Organisation of social prescribing services<sup>47</sup>**

#### **5.3.1. Starting motivations**

- Although some started in 2011 – 42% social prescribing services started in 2014 or later
- Starting motivation – 67% started social prescribing to widen the range of referral opportunities available by connecting GPs to community/voluntary sector referral opportunities.

#### **5.3.2. Scale**

- In this study, the majority (67%) of social prescribing services cover a single CCG area, and the remainder cover two or more CCGs.

#### **5.3.3. Who runs the service?**

- Services are operated jointly by primary care providers and other third sector partners, but in all services the social prescribing element is delivered by the third sector.
- The lead provider is responsible for i) promoting the social prescribing service to the public, clinicians and relevant third sector organisations and ii) for referring patients to appropriate services.

#### **5.3.4. Inclusion of nature-based and green care interventions**

##### Numbers

- With the exception of the three services specifically focused on offering nature-based options for social prescribing, most social prescribing services seem to contain one or two nature-based interventions but these appear very much in the minority.
- It is unclear whether this is due to: a lack of nature-based projects in the area; a lack of awareness of the existence of these projects locally; or a limited understanding of the benefits that nature-based initiatives can provide.

##### Green care or health promotion?

- With the exception of the care farming social prescribing examples (cs4, cs10), the vast majority of nature-based initiatives currently providing services for social prescribing services are nature-based projects aimed at ill-health prevention through promoting healthy lifestyles, rather than commissioned, bespoke nature-based interventions designed for use as green care for individuals with a defined need.

### **5.4. Service users<sup>48</sup>**

- The original aim of this study was to identify social prescribing services for people with mental health problems. However, the remit was widened due to the small number of social prescribing services that focus solely on mental health.

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<sup>47</sup> For a more detailed account of the organisation of social prescribing models, see Appendix G.

<sup>48</sup> For more details of the service users in the social prescribing schemes, see Appendix H.

- Target beneficiary group – majority (59%) in this study were generalist or generalist plus mental health
- One group perceived to be particularly suited to social prescribing are people with mild to moderate mental health problems (cs1, 3, 4, 6, 8, 10, 11); and one organisation has recently initiated a pilot service solely for people dealing with mental health problems (cs5).
- Several other services highlighted comorbidity of target health issue group with mental health problems.
- Those benefitting most from social prescribing are often dealing with several health-related issues, none of which are sufficient in their own right to trigger social care payment – despite their combining to result in frequent GP visits and an increased future health bill (cs2).

## **5.5. Referral mechanisms**

- Patients are most commonly referred to a social prescribing service by a GP or practice nurse, but some participants come through other routes or by self-referring. (Langford et al., 2013; Community Action Southwark, 2015).
- Where GPs make referrals to a large generic social prescribing project, a link worker will make contact, meet the patient in person and accompany them to their first session if required (cs9).
- Other services often use different referral methods such as electronic referral forms, direct contact or signposting only.

### **5.5.1. The importance of the link worker in social prescribing**

- The link worker plays an important role in social prescribing, they are employed by the social prescribing service and are responsible for taking referrals and then linking the patient to relevant services. They will often undertake an initial assessment with the patient before referring them on, adopt a case management role and monitor the patient's progress. Various pilot evaluations have emphasised the critical importance of their role in relation to the success of a service (Community Action Southwark, 2015; Langford et al., 2013).
- The level and extent of the link workers' involvement with patients can differ greatly – from one-off, or remote signposting through to link workers accompanying the service user to the activity.
- It is beneficial for link workers to attend practices regularly to provide the opportunity to engage directly with both the health service providers and users (cs2), and to develop a thorough understanding of needs.

## **5.6. Funding of social prescribing services<sup>49</sup>**

### **5.6.1. Funding sources and mechanisms**

- The majority of social prescribing services in this study were funded directly by CCGs.
- Nature-based intervention specific services were funded by one-off grants (research council, cs1; national lottery, cs6) or through funding from a combination of statutory health and social care providers and the third sector (cs11).

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<sup>49</sup> See Appendix I for more details

- Most social prescribing services fund the operating costs of the service (link workers and referral mechanisms etc.) but not the service provision.
- A minority of social prescribing services may provide some sort of grant funding for the service providers but not on a payment per individual basis.

### 5.6.2. Costs

- The Rotherham pilot cost approximately £1m over the first 12-month period and economic analysis estimated that this would be recouped after between 18 and 24 months (Dayson and Bashir, 2014). This has been presented as comparable with other research that has found similarly that services need to run for at least this length of time to generate a positive return on investment (Kinsella, 2015).
- One of the more recent services has adopted an alternative and innovative funding mechanism that effectively accesses payment based on results; the money to initially provide the social prescribing service has been obtained from a social investor but it is intended that this debt will be serviced through outcome-based payments from the CCG, the National Lottery and the Cabinet Office (cs7).

## 5.7. Evidence of effectiveness and cost effectiveness from social prescribing services

An overview of the evidence base for the effectiveness of social prescribing services can be found in Appendix J.

### 5.7.1. Benefits

The RAISE network have suggested that the following five benefits can result from social prescribing<sup>50</sup>:

- better outcomes for health and social care;
- improvements in mental health and wellbeing;
- cost-effective use of NHS resources;
- more effective use of GP time; and
- an opening up of the provider base and increase in the range of services offered (diversification of the marketplace)

Furthermore, social prescription services have been said to benefit third sector service providers by enabling increased engagement with clinical services and providing the opportunity to demonstrate suitability for meeting non-medical need (Community Action Southwark, 2015).

### 5.7.2. Evidence of health benefits and reductions in use of services

- The social prescribing pilot evaluation in Rotherham (Dayson and Bashir, 2014) identified reductions in inpatient admissions (-21%), outpatient appointments (-21%) and Accident and Emergency attendances (-20%) among the 559 patients of the total 1,500 patients who were followed up.
  - Analysis of an additional cohort of patients (n=280) who provided comparable wellbeing measures after a period of 3-4 months found that 83% had experienced

<sup>50</sup> <http://www.raise-networks.org.uk/wp-content/uploads/Social-Prescribing-briefing-paper.pdf>

positive change in at least one measured outcome area (e.g. feeling positive, managing symptoms better etc.).

- Three of the voluntary and community sector service providers to which referrals were made received additional funding as a result of the social prescribing grant they received from the CCG, and 11 of the funded services reported total additional income of at least £10,000 from social prescribing patients accessing additional services through self-funding or the use of direct payments or personal budgets.
- A more recent evaluation report of the Rotherham social prescribing service (Dyson et al., 2016) provided an updated assessment of the social and economic impact between September 2012 and March 2015:
  - non-elective inpatient episodes had reduced by 7%
  - non-elective inpatient spells had reduced by 11%
  - Accident and Emergency attendances reduced by 17%
  - Younger service users saw greater reductions in their use of urgent care than older service users.
  - Service users who completed their grant-funded referral activity within the VCS experienced a higher degree of positive change than those who did not.
  - And those who continued to engage in the VCS once this activity had concluded showed the greatest amount of change.
  - Overall, 82% of Service users experienced positive change on at least one wellbeing outcome measure<sup>51</sup>.
- Several social prescribing services have collected data relating to clinical, wellbeing and economic outcomes (cs9). The services that engaged with patients directly (as opposed to providing an online directory of potentially relevant services) recognised the importance of evidencing outcomes (cs2, 3, 6), with many already working with academic institutions (cs1, 4, 5, 6, 8, 10) or other independent third party organisations (cs9).
- Baseline and follow-up assessments have also been undertaken, that incorporate various validated scales to measure wellbeing (most commonly WEMWBS) and self-reported health-related behaviour change (cs1, 2, 4, 9).
- However, there was concern that the continuous drive for a more 'robust evidence-base' and RCTs to demonstrate social prescribing's efficacy was overshadowing the fact that plenty of evidence is already available to show both that social prescribing can be successful and that there are problems and issues with the current system of health and social care. Several case studies felt that social prescribing requires significantly less resourcing than is required to maintain the current overstretched system.

### **5.7.3. Evidence of cost effectiveness and return on investment for social prescribing**

- Social Return on Investment (SROI) analyses seek to take account of all material outcomes – social, environmental and economic, intended and unintended, positive and negative – and have been applied successfully to help demonstrate the wider value provided by some of the social prescribing services analysed for this study (cs5, 8). These studies measured reductions in NHS costs as a result of the service and an analysis of GP contact times suggested these had reduced in relation to 60% of participants (cs8).

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<sup>51</sup> The Social Prescribing Service measured users' progress towards social outcomes through a wellbeing measurement tool developed specifically for the Service.

- Dayson and Bashir (2014) suggested the potential cost savings associated with the Rotherham social prescribing pilot could be anything between £1.41 and £3.38 for every £1 invested.
- NHS costs avoided for the full three years of the Rotherham social prescribing service have been estimated to translate to an annual return of 33 pence for each pound invested (Dayson et al. 2016). The estimated return on investment from wellbeing benefits for the full three years of the Service was between 78 pence and 85 pence per pound invested<sup>52</sup>.
- Kimberlee and colleagues (2014) presented a return on investment related to the social prescribing service provided by the Wellspring Healthy Living Centre of £2.90 for every £1 invested.
- Reviews conducted by Kimberlee (2013) and the University of York (2015) found only one RCT assessing the cost effectiveness of a social prescribing project (Grant et al., 2000). This early study related to 90 patients who were referred to a voluntary organisation and identified clinically important benefits compared with usual general practitioner care with regard to managing psychosocial problems – but their care was found to cost more than routine care and their contact with primary care was not reduced. However, the study is highlighted as having failed to consider long term savings or compare costs associated with referral to secondary care (Kimberlee, 2013; The University of York, 2015).
- Looking at the value of nature-based interventions in a slightly different way, that of the costs per quality adjusted life year (QALY), Willis et al. (2016) found that social prescriptions for woodland health promotion activities for those with mental health problems in Scotland<sup>53</sup> suggested a cost of £8,600 per QALY. When compared to other similar health interventions, this is considered ‘highly cost effective’ for a health intervention by NICE benchmarks (Willis et al., 2016; Buck, 2016).

## 5.8. Key challenges facing social prescribing services

Several challenges to social prescribing have been identified both by the published reviews on social prescribing and by the examples used in this study. Four key challenges identified include:

- lack of clear understanding of what social prescribing comprises;
- the need for cooperation and partnership working;
- engaging GPs and healthcare staff; and
- funding for service providers.

Further detailed information on social prescribing challenges can be found in Appendix L.

### 5.8.1. Lack of clear understanding of social prescribing

There is a common misconception is that social prescribing refers to one specific practice which is the same all over the country. However, in reality, the range of services that are included under the umbrella term of social, the differing referral mechanisms and the lack of a universally accepted definition, show that this is not the case. Furthermore, inconsistencies in the way that the term

<sup>52</sup> However, it is noteworthy that the Year 1 figures were not considered to have provided an accurate reflection of the likely social cost-benefits of Social Prescribing over a longer period.

<sup>53</sup>see the Scottish Branching Out programme

'social prescribing' is interpreted has led to much confusion as to what social prescribing comprises (Friedli et al., 2007b).

### **5.8.2. Need for cooperation and partnership working**

Successful social prescribing depends on good partnerships, high levels of cooperation and joint ownership between a wide range of individuals, groups and organisations with very different organisational cultures.

It is essential that all parties are i) able to work effectively with one another and ii) have a shared understanding of those who might benefit from social prescribing, the services that are available and that sufficient capacity exists to meet demand (Community Action Southwark, 2015; Kimberlee, 2013; Langford et al., 2013). The Rotherham social prescribing programme has a long history of effective partnership working between health and voluntary and community services (Wilson, 2015).

One key practical challenge is reaching agreement between General Practices and the social prescribing provider regarding effective referral routes and appropriate criteria, given that these often evolve over time (Kimberlee, 2013).

### **5.8.3. Engaging GPs and healthcare staff**

Differing levels of take-up of social prescribing services by GPs have been reported. One study showed that although 90% GPs thought that their patients would benefit from social prescribing, and 4 out of 5 thought it was something that they should be able to access, only 16% of GPs indicated that they regularly used social prescribing and only 9% of patients reported having been given a social prescription (Langford et al., 2013).

Barriers to engaging GPs and healthcare staff in social prescribing services include:

- Insufficient communication
- Referral process
- Liability
- Increased workload

Appendix J contains a risk analysis conducted by one CCG prior to initiating their own successful social prescribing service, detailing challenges and how they were tackled and effectively overcome.

#### Insufficient communication

For social prescribing to be successful, the importance of getting GPs 'on-board' is apparent in this study (cs2). For maximum engagement, effective and repeated contact between social prescribing service staff and healthcare professionals is paramount. This serves to ensure GPs are aware of why a social prescription might be needed; and to understand that frequent-appointment and high use patients may need additional support to help them access voluntary support services that are available (cs2).

As well as communication from social prescribing services to healthcare staff, communication the other way – to services from GPs – is also important. Referrals from health workers do not always include information about the patients' backgrounds, medical history or additional support or treatment that they are receiving. A more transparent or effective approach to sharing patient data whilst retaining confidentiality might also be required (Community Action Southwark, 2015).



### Referral processes

When GPs are having to complete a referral form (particularly a paper copy that may need downloading and posting) this can be time-consuming (cs10). Some larger services avoid this issue by having link workers, but this could present challenges for smaller and less well-resourced services.

In addition, not all social prescriptions are taken up by patients and it unclear what happens to those who do not and that this is not reported to or by referring GPs (Kimberlee, 2013).

### Liability

Some GPs have said that they are concerned about their liability when referring a patient to a social 'prescribing' project, and that they would prefer to use the term 'referral' rather than prescription to demonstrate an end to their responsibility in terms of related care provision (Kimberlee, 2013).

Despite the importance given to receiving feedback on patient outcomes as a result of social prescribing, this is not always sought by GPs. In one service, when GPs 'clicked' to refer someone to social prescribing they could also click to specify whether they required feedback (cs2). If this was provided, it could give GPs confidence about efficacy and that their referrals were followed up and acted upon (cs2).

### Increased workload

The implementation of a social prescribing service in the initial stages is likely to increase the workload of GPs because of the need to develop and maintain new partnerships and referral routes. Although social prescribing is likely to lead to reduced appointments and reduced ongoing costs, participating GPs need to recognise and accept that this will take time. GPs appeared to increasingly support social prescribing as the service becomes better established.

Another issue related to workload of those running the social prescribing services is that there can also be capacity issues around maintaining up-to-date information on relevant service providers and their surplus capacity (Kimberlee, 2013).

#### **5.8.4. Funding for service providers**

The majority of Voluntary and Community Service providers within the social prescribing services in this study do not receive payment for the services that they provide. The Rotherham service is the only identified example of a social prescribing service developed explicitly to fund both the core cost of providing the prescribing service and the cost of delivering the 'menu' of prescribed activities<sup>54</sup>. A few other services have some small, one-off grants available but the majority do not.

Many of the voluntary and community organisations that provide social prescribing interventions are grant-funded on a short-term basis and have to regularly secure funding in order to run their service. These organisations therefore may not be able to incorporate costs associated with an increased level of service delivery (Community Action Southwark, 2015; Kimberlee, 2013). The funding challenge is likely to be an important issue to address for long-term sustainability and scaling-up of social prescribing services.

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<sup>54</sup> This benefits service providers, and it is noteworthy that the scheme received the 'Excellence in Individual Participation Commissioner' at the 2014 NHS Excellence in Participation Awards (cs5).

## 6. Social prescribing – Demonstration event

### 6.1. Key findings from demonstration event

- The demonstration event in Leeds brought together people involved with social prescribing in the three Leeds CCG-led social prescribing services with local providers of nature-based care services. The purpose of the event was to invite the commissioners, the social prescribing services and the nature-based service providers to explore practical ways of working together to increase the referrals to green care social prescriptions in the Leeds area. 32 people attended the event.
- Overviews of the health and wellbeing benefits of green care interventions and of social prescribing and key findings of this study were given before views of social prescribing from the social prescribing services and from the nature-based interventions were highlighted. The afternoon workshop discussed key issues facing social prescribing and possible solutions.
- General issues raised can be grouped into four main categories, i) Communicating the benefits of nature-based interventions; ii) Evidence gathering and evaluation of interventions; iii) Quality assurance and logistics; and iv) Funding.
- Key issues identified included:
  - a lack of funding for service providers;
  - a need to share information about who we are and what nature-based interventions do, and for whom;
  - shortcomings with referral processes;
  - what happens to clients after the 12-week social prescribing period ends?;
  - not enough people expressing an interest in nature-based interventions as they are not aware of what benefits they can offer; and
  - distance – who pays for transport to green care interventions in rural areas?
- Suggested solutions included:
  - CCGs and/or social prescribing link workers supporting and working with local service providers to secure grants or funding from a variety of different sources;
  - ensuring nature-based interventions get on the portfolio of possible social prescribing interventions that are on offer;
  - highlighting benefits to patients;
  - standardising the referral mechanism across social prescribing needs.
- A need was identified to determine what social prescribing is being used for?, i.e. a long-term condition or a short-term crisis. A study was suggested looking at what types of people are accessing social prescribing and for what sorts of conditions, to inform expectations of progression from both patient and GP.
- After the demonstration event, green care and nature-based health promotion providers said that they had learned much more about social prescribing in general and about how their local social prescribing services operated.
- Social prescribing facilitators said they had learned something new about green care and what and who it could be used for, and that they needed to take this information back to other link workers and staff.
- Social prescribing staff and nature-based intervention providers recognised the distinctions between green care services for individuals with a defined need and nature-based health

promotion services. Nature-based intervention providers agreed that these distinctions would make it easier to explain what services they provide to potential commissioners. Most agreed that social prescribing referral and funding mechanisms currently support nature-based health promotion rather than green care services.

- Green care and nature-based intervention providers recognised that they were not currently selling their service well. Researchers, social prescribers and nature-based intervention providers all agreed that there was a need to say something very simple about the evidence base for green care because it is an unconventional intervention. Particularly given that in comparison to many VCS initiatives currently included in the social prescribing portfolio, the evidence on the effectiveness of green care is quite strong

## 6.2. The Demonstration Event

A demonstration event was held in Leeds that brought together health and social care professionals involved with social prescribing in the three Leeds CCG-led social prescribing services with providers of nature-based care services from the local area. This event occurred in one commissioning region which was selected as all three local CCGs in the area are providing social prescribing services but are at different stages of development; a range of nature-based interventions are already operating successfully in the area; and the University of Leeds is involved in related research. 32 people attended the event, 7 people from social prescribing services in Leeds, 6 health or social care commissioners or professionals, 10 people from local nature-based interventions and 9 others (researchers and steering group members).

The purpose of the demonstration event was to invite the commissioners, the social prescribing services and the nature-based service providers to explore practical ways of working together to increase the referrals to nature-based social prescriptions in the Leeds area. The aims of the event were to:

- i) get the 'right' people from one region together, to develop a working model which could be replicated to other areas of England<sup>55</sup> and for other service-user groups in future.
- ii) share the findings from Phase 1,
- iii) share experiences and to explore related challenges and opportunities.
- iv) facilitate first stages of the provision of an integrated offer with a common set of therapeutic goals;

## 6.3. The morning session

In the morning session of the demonstration event, an overview of the health and wellbeing benefits of green care interventions<sup>56</sup> was given followed by an overview of social prescribing and key findings of this study<sup>57</sup>. The local Leeds social prescribing context was then outlined by link workers from the three different social prescribing schemes in Leeds<sup>58</sup> before they explained what they are looking for in service provision, from a Leeds link worker perspective – “*Social prescribing, what we are looking for*”. The view from a nature-based intervention involved in social prescribing as a service provider was then given for balance<sup>59</sup> – “*Social prescribing, what we provide*”. The full programme for the event can be found in Appendix E.

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<sup>55</sup> And where appropriate in the wider UK

<sup>56</sup> Dr Rachel Bragg, Care Farming UK

<sup>57</sup> Dr Chris Leck, University of Worcester

<sup>58</sup> Sharon Williams and Samantha Clewley (Leeds W); Chaitan Parmar (Leeds S & E); Nat Lindo (Leeds N);

<sup>59</sup> John Preston, Hollybush TCV.

## 6.4. The interactive discussions

The afternoon session was designed to be interactive, to share experiences from all the different stakeholder perspectives and to identify the best way forward by exploring how to overcome barriers and fulfil needs of patients, social prescribers and green care service providers. The delegates were split into two mixed stakeholder groups and firstly asked to identify the challenges for increasing the number of nature-based social prescriptions in the area, secondly the groups were asked to decide on three key challenges and then thirdly to suggest possible solutions for these key challenges.

### 6.4.1. General issues raised

The issues raised can be grouped into four main categories, i) Communicating the benefits of nature-based interventions; ii) Evidence gathering and evaluation of interventions; iii) Quality assurance and logistics; and iv) Funding.

#### *i) Communicating the benefits derived from nature-based interventions to social prescribers*

- Social prescribing is one potential source of service users for nature-based interventions. This implies that there is evidence of need
  - NBIs need to promote and share information on how these needs can be met through accessing a nature-based initiative.
- Getting the message across
  - There is a lack of clarity amongst social prescribers about what green care can do for people
  - NBIs are not communicating these benefits to social prescribers and health and social care professionals.
  - There is much evidence of effectiveness already – how do we translate that into a coherent and relevant message? Achieving this will benefit all levels of the social prescribing system.
- Nature-based interventions provide multiple outcomes simultaneously (physical and mental health benefits from being active in nature, social inclusion and meaningful activities) therefore wider than a clinical intervention.
  - need to sell the uniqueness of nature-based interventions and what they can offer
  - need to raise understanding and awareness of the cross-cutting nature of these types of interventions
- Need to also emphasise the importance of these nature-based interventions as providing an ‘anchor’ for patients.
  - importance of having somewhere to go to, with meaningful activity
  - many offered volunteering opportunities after the 12-week period of social prescribing has finished.
  - Highlight the spectrum of NBIs ranging from green care through to health promotion.
- *‘People want to be people, not defined by their illnesses’*
  - despite social prescribing being about ‘social’ and community interventions even the services themselves tend to adopt silo medical thinking
  - Social prescribing hubs and services often receive funding to set up services where they identify a gap – for example setting up a diabetes group and older person’s group, i.e. thus continuing the medical model of thinking.
  - There is no evidence that these types of groups achieve anything (although social support is linked with better mental health)

- For people who don't want to live their lives defined by their conditions these sorts of groups put them back into this.
- Green care is unconventional in this sense as the interventions cater for mixed client groups – so doesn't provide a natural fit with the 'clinical' model
- Communications – need to make commissioners and social prescribing link workers aware of what nature-based interventions are available in their area and what green care can offer to patients.
  - Look at existing projects and present them to CCG as an example of social prescribing

ii) Evidence gathering and evaluation of interventions

- Evaluations and evidence – how much information is actually needed to demonstrate effectiveness?
  - There are inconsistencies between social prescribing services. It seems to vary from a requirement for traditional clinical type evidence (RCTs) to prove that the intervention works to no requirement at all for interventions to evidence outcomes.
  - if social prescribing is a 'non-clinical' community referral why is clinical based evidence being asked for?
- Outcome measures used to measure effectiveness vary widely.
  - Each of the three CCG social prescribing services in Leeds use different outcome measures. Identified need for collective consensus.
  - Is there scope for some other way of gathering info or standardising outcome measures?
- Need for large-scale partnerships to gather big data

iii) Quality assurance and logistics

- Level of professionalism in the 3<sup>rd</sup> sector needs to be highlighted – essential in gaining trust and recognition from GPs for example.
- Rigour – how 'good' are the projects in the portfolio of social prescribing options? The majority of social prescribing services have no eligibility criteria.
  - What about policies and procedures to ensure good practice and safe running?
  - Do they need to be CQC accredited for example or is this not appropriate for 'non-clinical' community interventions? There is confusion from clinicians regarding this.
- Information sharing – different organisations have different client information and data systems. The prescribers and referrers are likely to have secure networks and need to keep health data protected, whereas VCS organisations may not. This could lead to data protection issues when referring to community and voluntary organisations without these systems.
- GPs and other 'prescribers' – social prescribing services – service delivery partners. It is essential to have some understanding of what is needed at all stages of the social prescribing service in order to provide the right information
  - Importance of spending time developing relationships for partnership working highlighted
- Possible dilemma between the development of an efficient social prescribing *process* versus the freedom to provide an effective *individual journey* – can social prescribing provide both?

iv) Funding

- Where is the funding for the third sector who are delivering these projects coming from? There is no money from social prescribing going directly to those delivering the service.
  - this is not a sustainable model for the long term.
  - potential of developing contracts with providers (as in the Rotherham model?)
  - Potential for pilot projects?

## 6.4.2. Priority issues and their solutions<sup>60</sup>

### Priority issue 1: Lack of funding for service providers

#### Suggested solutions:

- *At the local level* – the importance of working together in partnership was highlighted. Discussions focused around the potential for CCGs and/or social prescribing link workers supporting and working with local service providers to secure grants or funding from a variety of different sources, in order to be mutually beneficial
- *At the national level* – Sharing and identifying successes in terms of both how these nature-based interventions are effective and are cost-effective and/or provide cost benefit. This could have a knock-on effect in securing top-down funding at a national level. Highlighting the lack of funding for service providers may also help social prescribing services allocate some funds to paying the service providers for their services.

### Priority issue 2. Need to share information about who and what nature-based interventions do.

#### Suggested solutions:

- Ensuring nature-based interventions get on the portfolio of possible social prescribing interventions that are on offer – onus on the individual project.
- Highlight benefits to patients
- Also talking to GPs and other health staff and practice managers directly about referral mechanisms for these projects and benefits for their patients
- Need to talk about the quality of nature-based interventions. Recognition and roll out of Care Farming UK's care farming Code of Practice – uniform templates for policies for example.

### Priority issue 3. Shortcomings with referral processes

#### Suggested solutions:

- The referral mechanism across social prescribing needs to be standardised; it must be robust; must sort out the differing data protection requirements from the different partners (clinical/ voluntary); it needs to be suitable across the wide range of projects in the social prescribing portfolio; and needs a standardised evaluation.
- Need to talk on a national level – to NHS England, PHE and NICE, etc. about evidence of effectiveness and about a standardised referral and evaluation mechanism for social prescribing

### Priority issue 4. What happens to clients after the 12-week social prescribing period ends?<sup>61</sup>

#### Suggested solutions:

- Need to determine what the social prescribing is being used for? Is it to help tackle a long-term condition or to help someone out of a short-term crisis?
- Suggest a study looking at what types of people are accessing social prescribing and for what sorts of conditions to inform expectations of progression from both patient and GP.

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<sup>60</sup> Two groups identified 3 key issues and associated solutions in the interactive sessions. These have been amalgamated but the first priority issue for each group was the same so there are 5 rather than 6 issues in this section.

<sup>61</sup> Ethics of leaving people stranded after intervention has finished; What happens to people long term?

**Priority issue 5. Not enough people expressing an interest in nature-based interventions as they are not aware of what benefits they can offer**

**Suggested solutions:**

- Taster sessions at nature-based interventions for potential service users and social prescribing link workers.

**Priority issue 6. Distance – who pays for transport to green care interventions in rural areas?**

**Suggested solutions:**

- Collaboration of projects – i.e. joint bid by nature-based interventions for assistance with travel costs.

## **6.5. Achievements**

- There was agreement from participants at the demonstration event that the day had been useful and that networks and new partnerships had been formed as a result.
- Green care and nature-based health promotion providers said that they had learned much more about social prescribing in general and about how their local social prescribing services operated.
- Social prescribing link workers from two of the social prescribing services said they had learned something new about green care and that they needed to take this information back to other link workers and staff.
- Social prescribing staff and nature-based intervention providers recognised the distinctions between green care services for individuals with a defined need and nature-based health promotion services. Providers agreed that these distinctions would make it easier to explain what services they provide to potential commissioners. Most agreed that social prescribing referral and funding mechanisms currently support nature-based health promotion rather than green care services.
- Green care and nature-based intervention providers recognised that they were not currently selling their service well. Social prescribing staff suggested the type of advertising information that they would need, i.e. something visual and simple, perhaps including some quotes from patients or service users.
- Researchers, social prescribers and nature-based intervention providers all agreed that there was also a need to say something very simple about the evidence base for green care because it is an unconventional intervention. Especially given that in comparison to a lot of VCS initiatives in the social prescribing portfolio, the evidence on green care is quite strong.

## 7. Discussion and Issues Identified

### 7.1. Summary of findings

#### **The current social prescribing landscape**

- There are many different social prescribing models currently operating in England, all using slightly different referral mechanisms, funding arrangements and ways of working. Although this study aimed to focus on social prescribing for mental health, most schemes target a range of different beneficiary groups, and so this focus was not possible. The majority of social prescribing services are therefore generalist<sup>62</sup> or generalist plus mental health.
- All the successful social prescribing services examined in this study have set up an effective primary care referral system providing GPs with a non-medical referral option to enable patients to easily access health resources and social support from outside the NHS. Social prescribing schemes are operated jointly by primary care providers and the third sector, but the social prescription element is predominantly delivered by the third sector.
- The characteristics of a ‘successful’ social prescribing service have not yet been fully researched. However, from the cases examined in this study, good practice in social prescribing depends on good partnerships, high levels of cooperation and joint ownership between a wide range of individuals, groups and organisations with very different organisational cultures. Good communication between the social prescribing service, GPs and healthcare staff, is essential. Social prescribing link workers play a pivotal role in the social prescribing service, as they are responsible for taking referrals and linking the patient to relevant services.
- Patients benefitting most from social prescribing often have multiple health-related issues, which individually are insufficient to trigger social or health care payment, but in combination result in frequent GP visits and high service use. Benefits from social prescribing identified in this study include: i) better outcomes for health and social care; ii) improvements in mental health and wellbeing of patients; iii) cost-effective use of NHS resources; and iv) more effective use of GP time<sup>63</sup>.
- At present, specific inclusion criteria for services within social prescribing options are rare, with no specific accreditation requirements for service-providers. As a result, GPs have expressed concerns about the quality of service and liability.
- Shortcomings with the current referral processes were also highlighted as a barrier to engaging GPs with social prescribing. Reaching agreement between General Practices and the social prescribing provider regarding effective referral routes and appropriate inclusion criteria<sup>64</sup> is a particular priority.

#### **Barriers to the sustainability and upscaling of social prescribing**

- There is no consistent or standardised referral mechanism.
- There is an absence of funding for the social prescription element in the majority of social prescribing services (i.e. no funding to the third sector service providers)<sup>65</sup>.

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<sup>62</sup> i.e. not aimed at a specific medical condition but rather a range of conditions, LTSs or for frequent attenders.

<sup>63</sup> The Social Prescribing network has identified more benefits cited from attendees at their inaugural conference in January 2016 – Page 15 in conference report: <https://www.westminster.ac.uk/patient-outcomes-in-health-research-group/projects/social-prescribing-network>

<sup>64</sup> This is applicable regardless of the social prescribing option i.e. from debt counselling through to care farming

<sup>65</sup> both in the literature, in the social prescribing services examined in this study and by participants at the demonstration event



- The lack of direct funding for the healthcare interventions offered through social prescribing together with no underpinning referral system are fundamental barriers to the NHS's ambitions to increase the scale of social prescribing in the future.

### **Nature-based social prescriptions**

- Most social prescribing services contain one or two nature-based *health promotion* initiatives in the suite of available options, but only a small number include specific *green care* treatment interventions.
- Nature-based options are not actively promoted compared to other types of intervention in social prescribing services and are generally suggested *only if a patient expresses an interest in being outside*.
- In comparison to many voluntary sector initiatives currently included in social prescribing portfolios, the evidence on the effectiveness of nature-based health promotion and of green care is relatively strong. However, the nature, health and wellbeing sector recognises that it is not currently promoting the range of services effectively. Researchers, social prescribers and nature-based intervention providers all agree that there is a need to improve the promotion of these services. A systematic review of what nature-based social prescribing approaches work for people with mild to moderate depression, and in what circumstances has recently started (being led by a team at The European Centre for Environment and Human Health<sup>66</sup>; Husk et al., 2016). This study is likely to provide a fuller insight into the benefits of the nature, health and wellbeing sector for social prescribing.

## **7.2. Discussion – Implications for nature-based interventions in social prescribing**

The aims of this study were threefold:

- i) to develop an understanding of the value of nature-based-interventions within social prescribing services for people with mental ill-health;
- ii) to provide suggestions for good practice in social prescribing services for commissioners;
- iii) to provide a resource and support for the providers of nature-based interventions in engaging with primary care.

This study has been successful in developing an understanding of the value of nature-based interventions within social prescribing services in general and has highlighted the fact that many of the social prescribing services in the study although catering for a generalist audience are in fact also addressing mental health issues. This is due in part to the comorbidity of mental health with other conditions. Only a minority of social prescribing services are specifically catering for people with mental ill-health (the new Rotherham pilot project for example).

This report, together with the learning and outcomes from the Leeds demonstration event form a useful resource and support for nature-based health promotion and for green care providers to facilitate engagement with primary care. Good practice in social prescribing services is outlined in section 7.2.6, and suggestions for scaling-up nature-based interventions within social prescribing are given in section 7.3.

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<sup>66</sup> <https://beyondgreenspace.wordpress.com/2016/06/10/social-prescribing-review-nature-based-interventions-for-mild-to-moderate-depression/>

### 7.2.1. Funding implications for nature-based interventions within social prescribing

The lack of funding for third sector interventions providing the social prescription element in social prescribing is undoubtedly a significant challenge to the sustainability of social prescribing services (as identified from the good practice scan, the demonstration event, and in other related forums (South West Peninsula CLAHRC, 2016; Social Prescribing Network)). In the majority of services, the funding goes to support the running of the social prescribing service, i.e. to pay for the link workers and referral mechanisms. Only a very small minority of social prescribing services either pay directly for the social prescription provided to the patients by the voluntary sector interventions or support them indirectly through the allocation of small grants.

Regardless of whether the options provided in a social prescribing service are nature- or non-nature-based, given that the service providers in social prescribing are from the voluntary and community sector, it seems unrealistic and unsustainable in the long-term for commissioners or prescribers to expect to be provided with a free service, for which the provider gets no recompense.

*“Currently when a voluntary sector organisation or group helps someone via a social prescription, this is undertaken as part of their existing commissioned or charitably funded activity. In contrast, a medical prescription comes with costs and funding attached. This needs monitoring and further attention over time, especially given the pressure on funding and budgets experienced by the VCS”<sup>67</sup>*

A collaboration between 26 English environmental conservation organisations recommended that, by 2018, 1% of the public health budget should be invested in using the preventative and restorative value of nature to provide cost effective health solutions. (Response for Nature, 2015). Only a very small proportion of this would be required to support social prescribing to nature-based health promotion or green care services on a national level.

The funding issue will impact on the relevance of social prescribing to many nature-based health promotion and green care operations that are dependent on accessing funding in order to provide the service. It is reasonable to assume that some unused capacity may already exist, but this may not always be the case and increased levels of social prescribing may alter this situation.

### 7.2.2. Health promotion or green care?

Although a few social prescribing services (such as the two care farming examples) are offering green care services as part of a treatment or therapy programme, this study - and other ongoing studies<sup>68</sup> - have found that the majority of nature-based initiatives included in social prescribing services currently are nature-based health promotion projects<sup>69</sup> (aimed at ill-health prevention through promoting healthy lifestyles), rather than green care interventions (commissioned, bespoke nature-based interventions for individuals with a defined need).

Many nature-based organisations offer both health promotion opportunities and green care programmes. Clarification is needed from social prescribing services as to which of the two types of programme they are looking to refer patients to, so that the relevant nature-based service providers can be involved. This will then shape how the providers frame the services they offer and what evidence of effectiveness is required.

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<sup>67</sup> <http://www.movingforward-northeast.co.uk/wp-content/uploads/2015/08/Social-Prescribing-Mental-Health-Report-13.10.14.pdf>

<sup>68</sup> see for example South West Peninsula CLAHRC, 2016

<sup>69</sup> Patients are referred to a nature-based group rather than it being a specific part of their treatment or therapy programme.

Costs per individual generally increase from health promotion to green care as a more formal service is provided, as the needs of the patient are more acute. Social prescribing services need to provide community support for all patients with applicable health conditions. This could involve referrals to freely available local community groups when appropriate. But it would be unrealistic to assume services that are free to access will always be able (or willing) to accommodate or support people dealing with complex long term issues and needs.

#### Green care service providers

For green care providers, in particular, the current models of social prescribing may not be appropriate for two reasons:

Firstly, funding for green care services usually follows the individual as part of their therapy, care or special education programme (i.e. payment per person from a care package or personal budget for example) and this type of funding is not usually available through social prescribing. Unless alternative methods of paying for services can be identified (grant funding, bulk payments etc.) providers of green care are unlikely to be paid for services through social prescribing.

Secondly, most social prescribing services<sup>70</sup> appear to be looking for health promotion type services rather than green care services, so what they offer may not be appropriate.

#### Health promotion service providers

For organisations providing health promotion type nature-based interventions, social prescribing may be more suitable, as these projects are usually grant-funded rather than taking payment per individual and may have the capacity to accommodate the extra service users through social prescribing – at least in the short term. The fact that many social prescribing services have small grants that can be accessed could also pay for some proportion of the service they are providing. In addition, providing health promotion services appears to be what social prescribing services are looking for in their portfolios.

#### Providers of both health promotion and green care

For nature-based organisations who deliver both green care and health promotion initiatives, it may be appropriate to register and provide some services under social prescribing if there is unused capacity in their health promotion projects. Being involved in social prescribing in this way may lead to green care commissions in future as the service becomes more widely known and utilised.

### **7.2.3. The evidence question**

A reasonable body of evidence exists which suggests that green care interventions and nature-based health promotion initiatives result in improved health and wellbeing. However, this evidence rarely meets the same standard of proof as traditional health interventions, because the research studies required have not yet been funded to the same degree. Randomised controlled trials (RCTs) for example, are often prohibitively expensive, harder to design and to apply than in more traditional health care settings that apply more ‘discrete’ treatments (Bragg, 2014; Cupitt, 2015; Buck, 2016;).

Previous studies (specifically Bragg and Atkins, 2016) have, nevertheless, called for the greater use of pre- and post-intervention measurement of health and wellbeing outcomes (using standardised outcome measures) wherever possible. This has been aimed primarily at green care service providers, in order for them to demonstrate effectiveness, if not necessarily causality<sup>71</sup>. Due to the

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<sup>70</sup> Only two social prescribing services in this study included green care services (care farming) which were being commissioned (i.e. paid for) directly by the social prescriber;

<sup>71</sup> That is, moving level of evidence up from level 1 to level 2 in the Nesta levels of evidence (See Puttick and Ludlow, 2013 for more information on this)

less formalised approach in nature-based health promotion interventions this type of evaluation may not always be practical or deemed necessary.

Nevertheless, this 'gold standard' RCT evidence is also absent from many other health intervention activities, without it leading to questions about their acceptability or being used to justify their exclusion.

*"So while there is always room for stronger study designs, we have to ask the practical question: how much and what type and strength of evidence is 'enough' to guide action and policy? .... Our own view is that while more RCTs would definitely be helpful, we also need to put into practice what we already know"* (Buck, 2016, p20 - 42).

In addition, social prescribing interventions are by definition, designed to be delivered in non-clinical ways, by community and third sector organisations rather than by health professionals. This further brings into question what type of evidence of effectiveness is appropriate for social prescribing options – given that they are not designed to be traditional healthcare options.

Indeed, at the recent launch of the Kings Fund report on the health benefits of gardening projects<sup>72</sup>, Health minister Jane Ellison<sup>73</sup> said that the same level of scientific evidence does not apply to gardening and health research as to clinical research:

*"For me, there is a different evidential bar in something like social prescribing for people to get out doing gardening than there is for a vastly expensive new cancer drug"*<sup>74</sup>

She then urged local public health commissioners within local government to commission gardening interventions after following *"common sense instincts"*.

This certainly echoes sentiments of attendees at the demonstration event in Leeds who felt that in addition to evaluating effectiveness of their own services, the nature, health and wellbeing sector<sup>75</sup> should also be collating and disseminating the evidence that has already been gathered – in a way that is accessible and relevant to health<sup>76</sup> and social care commissioners, social prescribing services and patients.

In addition, just as the distinction between green care services and nature-based health promotion initiatives means that each approach has different commissioning, funding and referral pathways, it seems logical that the standard of evidence required, how the services are promoted and to whom are also likely to be different.

#### **7.2.4. Raising awareness of the value of nature-based interventions within social prescribing**

The demonstration event in Leeds, emphasised that green care and nature-based intervention providers recognise that they were not currently promoting their service effectively. This echoes wider discussions within the nature, health and wellbeing sector, where it has been noted that a clear and coherent communication of the benefits to the service user, to health and social care and of the cost-effectiveness is needed (e.g. Bragg et al., 2014; Bragg and Atkins, 2016).

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<sup>72</sup> Buck, 2016

<sup>73</sup> MP and Parliamentary Under Secretary of State for Public Health

<sup>74</sup> <http://www.hortweek.com/national-gardens-scheme-report-pushes-health-agenda/parks-and-gardens/article/1395179>

and <http://www.theguardian.com/society/2016/may/17/doctors-should-prescribe-gardening-for-patients-more-often-says-report>

<sup>75</sup> and the nature-based health promotion sector

<sup>76</sup> Both primary and secondary healthcare

The awareness and depth of the evidence base concerning the efficacy of nature-based interventions is undoubtedly growing, but further promotion is required amongst NHS commissioners, frontline health workers, social prescribing link workers and patients alike. In social prescribing the role of the link worker is an important element of a successful service and the demonstration event in Leeds found that direct contact with link workers to inform them of nature-based interventions in their area and what services they can offer is a good place to start with raising awareness.

Patients will not always be aware of all the types of support services – such as nature-base initiatives – in the menu of options available to them. Similarly, patients are likely to be unaware of what these types of interventions could offer and the associated benefits that they could gain from attendance. Patients therefore rely on guidance from their link worker and so it is imperative that link workers are not only informed about what nature-based interventions are available in their area but of the multiple benefits to the patient from attending such interventions.

Link workers and other social prescribing staff at the demonstration event in Leeds said that they currently suggest attendance at a nature-based intervention only if the patient specifically requests that they would like to do something outside. This means that many people don't know of the existence of these interventions, of the benefits they offer and the availability in their area currently and therefore miss out on the opportunity to attend.

In addition, it emerged from the demonstration event that one result of not knowing what nature-based interventions were present in their area and what they could achieve, was that social prescribing services were setting up new groups to allow patients to get together. These groups appeared to be relying on a 'clinical' model i.e. mainly set up as a support group for people with a specific illness or condition rather than the more 'social' model that tends to define social prescribing. Green care and nature-based health promotion are unconventional in this sense as the interventions cater for mixed client groups – and so doesn't provide a natural fit with the 'clinical' model. One of the benefits of taking part in a nature-based intervention (as highlighted by service users) is that the participant is not defined by their illness or condition but rather as a member of a group taking part in meaningful activity outside, thus breaking down barriers and allowing people to feel more 'normal' and socially included.

In conclusion, unless link workers actively promote nature-based health promotion and green care projects to patients, the usage within social prescribing is unlikely to increase. In the same way, the nature, health and wellbeing sector needs to ensure that services they can provide within social prescribing and the unique benefits to patients are more widely publicised and more actively promoted to link workers (and to other health and social care staff).

#### **7.2.5. Unique characteristics of nature-based health promotion and green care interventions**

##### ***Follow-on care opportunities from nature-based interventions***

One of the unique features of the nature, health and wellbeing sector is the idea of a continuum or spectrum of care from nature-based health promotion through to green care (as outlined in Section 3.3 and Figure 3.2). This is likely to be of particular relevance for the provision of longer-term mental health and wellbeing support (Clatworthy et al., 2013; Bragg and Atkins, 2016).

The increasing number of community gardens, city farms, and food and gardening groups; together with the abundance of managed nature reserves and greenspaces (all keen to increase and scale-up their community and volunteer approaches) could provide a useful route for enabling people to

continue accessing nature-based activities and the associated positive effects once their green care service or their 'social prescription' has ended. Indeed, many nature-based interventions currently offer volunteering opportunities after the 12-week period is over. This goes some way to relieve concerns raised by GPs relating to what happens to patients at the end of their programme. Continued involvement across the continuum in this way can often help participants go further and incorporate nature activities into their regular routines and behaviours, thus embedding a healthier lifestyle. The availability of such longer-term opportunities is another of the unique features of nature-based interventions promoted to commissioners, referrers and patients alike.

### **Delivering multiple outcomes simultaneously**

Another of the 'unique' features of nature-based interventions are the benefits derived from the combination of the three key elements – the natural surroundings, the meaningful activities and the social context. Nature-based interventions provide multiple outcomes simultaneously and can help to increase mental health and wellbeing, increase physical activity levels, decrease social isolation, provide opportunities for learning and positive behaviour change and re-connect patients to other people – all this takes place in the natural environment, which in itself is known to provide additional mental health benefits.

It is known that the indirect economic costs of mental ill-health<sup>77</sup> are systematically higher than the direct service costs<sup>78</sup> (McCrone et al., 2008; Vardakoulias, 2013; Trautmann et al., 2016). Deriving multiple outcomes from one intervention in this way is therefore likely to favourably impact on cost-effectiveness. Nature-based interventions that address both the direct and indirect costs to society from mental health are therefore likely to produce both higher cashable and non-cashable benefits (avoided losses) than other interventions that do not (Vardakoulias, 2013).

Green care interventions can be used not only help to address a clinical problem (e.g. anxiety, mild to moderate depression) through facilitating emotional resilience for example, but can also help with the social problems that 20% of patients consult their GPs about (The Low Commission, 2015). Promoting this fact more widely to commissioners and patients alike is likely to lead to an increase in the scale nature-based referrals in social prescribing.

### **Quality of service provision**

In the literature and case studies examined in this research, one of the factors preventing more GPs engaging with social prescribing is the issue of liability and quality assurance. At present, there are rarely specific inclusion criteria or quality assurance for the options for patients available in the social prescribing portfolio. Even if the argument that standards and requirements of clinical interventions should not be imposed on non-clinical interventions is left to one side, the desire for some kind of quality assurance requirement to ensure that the GP's patient is attending a safe, well-run and ethical service, is understandable.

Nature-based health promotion interventions (such as TCV's Green Gyms for example) often have a standardised way of working, a set evaluation method and a whole suite of policies and procedures to ensure participants are in safe hands. Similarly, in order to take referrals from commissioners, green care interventions will have a wide range of safeguarding, health and safety and other policies and procedures in place and will employ trained staff. Some organisations are already accredited (through the Care Quality Commission for example<sup>79</sup>) and in care farming, Care Farming UK, has

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<sup>77</sup> Associated 'invisible costs' such as income losses due to mortality, disability, seeking care, work absence and early retirement for example (Trautmann et al., 2016)

<sup>78</sup> The 'visible' costs associated with diagnosis and treatment within the healthcare system (Trautmann et al., 2016)

<sup>79</sup> There are many accreditations that different green care interventions adhere to but these vary with client group catered for

developed a care farming Code of Practice<sup>80</sup>, to support the requirements of commissioners, clients and other authorities by providing them with a level of quality assurance.

### 7.2.6. Models of best practice for mental health within social prescribing

Social prescribing services vary widely and models have differing budgets and resources, work with different foci, use different methods, at different levels and with different organisations leading the service. Therefore, it is not appropriate to identify one model as ‘best’ practice, as there are aspects of several services that work well and others which are less successful. It is more useful to outline the key ingredients of a good scheme, such as:

- a shared understanding of what social prescribing is to be used for and for whom;
- an effective partnership and regular communication between stakeholders;
- a simple and effective referral system which is not time consuming for GPs and suitable for a wide range of interventions;
- assurance that all options in the social prescribing portfolio are safe, high-quality interventions;
- the presence of well-informed link workers to support patients in their choice of social prescribing intervention;
- financial support for service provision for the interventions within the social prescribing portfolio.

The Rotherham social prescribing service has many of the ingredients for good practice highlighted above, and was awarded the ‘Excellence in Individual Participation – Commissioner Award’ by NHS England in 2014. This service is also contributing to the NHS ‘Improving general practice – a call to action’ initiative that is seeking to support the transformation of local community services and to support GPs to improve outcomes and tackle inequalities. The Rotherham service currently only caters for people with complex Long Term Conditions, who are also often elderly. In the last year however, the Rotherham service has developed a service specifically for people with mental ill-health and it will be interesting to see the outcomes of this scheme in future. The social prescribing service in Rotherham also appears to be one of the few able to support – in financial terms – the provision of nature-based interventions within it, and the relevance, suitability and efficacy of this service needs to be promoted.

## 7.3. Issues Identified

The main issues are numbered but each contains several key actions (shown as bullet points below each issue)

### Maintaining good practice within the current social prescribing landscape

1. **All those involved in social prescribing, at both the national level (Department of Health, NHS England, Public Health England) and the local level (CCGs, Health and Wellbeing Boards, GP practices, social prescribing services, link workers and local projects), should adopt the terms and definitions recommended by the Social Prescribing Network<sup>81</sup>.**

<sup>80</sup>See <http://www.carefarminguk.org/about-us/care-farming-code-practice> for more details

<sup>81</sup> **A social prescriber** – any (healthcare) professional who refers people to a social prescribing service. **A social prescribing service** – the link worker(s) and the subsequent groups and services that a person accesses to support and to manage their needs. **A link worker** – There are many other terms used for these (see page 31). Usually a non-clinically trained person who works in a social prescribing service, and receives the person who has been referred to them. Link workers are responsible for assessing a person’s needs and suggesting the appropriate resources for them to access.

**2. Good partnership working between stakeholders is essential for a successful social prescribing service. Social prescribing service staff and health service referrers (GPs and others) urgently need to improve the systems and processes that support dialogue between those two key groups of practitioners.**

- Regional networks of providers, commissioners and others need to be established to develop shared understanding of what is needed, best practice, challenges and research findings.

**Ensuring long-term sustainability and upscaling of social prescribing in future**

The Stevens Report highlighted the need to change the focus of the NHS to one of much wider individual and community engagement. Increasing the scale of social prescribing in the future is an important contribution to achieving this aim. However, the sustainability of social prescribing in the long term will depend on the voluntary and community sector becoming a more valued and secure element within the social prescribing process and this requires urgent improvement in funding arrangements.

**3. Services provided by the individual interventions included in social prescribing schemes should have access to direct funding to ensure the sustainability of social prescribing in the long-term.**

- Services provided for intensive users of NHS services (and for those who are considered likely to become so in the future) are particularly important for the NHS to manage costs.
- This funding could come through grants (from or in conjunction with the social prescribing service), direct commissioning (perhaps in conjunction with local authorities, NHS England and Public Health England); or directly from patients who are given personal budgets to buy services to help manage long term conditions.
- Highlighting the lack of funding for service providers may help social prescribing services allocate some funding to pay the service providers to continue their services.

Establishing a referral and information sharing system that is efficient and effective is critical for the success and scaling-up of social prescribing as desired by the NHS in the future. It is essential that health workers can give the prescription quickly and easily whilst also feeling assured that an appropriate service with real potential to deliver required outcomes will be used.

**4. NHS England should work with Clinical Commissioning Groups, GPs, healthcare staff, social prescribing services and researchers to establish a standardised referral mechanism suitable for the variety of social prescribing services and the range of interventions within them.**

For social prescribing to become accepted as mainstream and expand in the longer term, evidence that it is having a positive impact both on people's lives and on the health service must be provided. Although many social prescribing services are focused on collecting evidence of outcomes (often in conjunction with academic institutions), there is currently a wide variation in methodology, making comparative analysis difficult.

**5. NHS England, Public Health England, and the National Institute for Health and Care Excellence (NICE) should work with social prescribing services and Clinical Commissioning Groups to develop a Standard Evaluation Framework (SEF) for social prescribing interventions – similar to those currently developed for physical activity and obesity – initially focussing on social prescribing for mental health and wellbeing.**



- In addition, the Social Prescribing Network have identified a need for research on comparative effectiveness of social prescribing versus standard care options (SPN, 2016).

### **Increasing the scale of nature-based social prescriptions**

#### **6. The nature, health and wellbeing sector organisations (including: Green Care Coalition, TCV, Care Farming UK, Thrive and Groundwork) should work together with Natural England and Defra to support an expansion in nature-based interventions within social prescribing.**

- Key messages:
  - Communicate how nature-based interventions meet the changing needs of the NHS.
  - Highlight that nature-based interventions support three key health programmes outlined in the NHS Five Year Forward View: New Models of Care; Healthy New Towns; and Social Movements for Health.
- Promoting different levels of service:
  - Distinguishing between green care services for individuals with a defined need and nature-based health promotion services is crucial in giving a clear explanation of the different levels of service available from the nature, health and wellbeing sector. Nature-based service providers should use these distinctions more widely to make it easier to explain what services they provide to potential commissioners – including those within social prescribing.
  - Ask social prescribers what level of service they are looking for from the interventions in their social prescribing portfolio.
- Promoting the unique benefits of nature-based interventions:
  - Ensure the unique benefits to patients from nature-based interventions are more widely publicised and more actively promoted to social prescribing link workers (and other health and social care staff) and also to patients.

#### **7. National<sup>82</sup> support organisations and networks<sup>83</sup> for the nature, health and wellbeing sector (such as Green Care Coalition, TCV, Care Farming UK, Thrive and Groundwork) should work together to develop promotional resources to give to CCGs, social prescribing services, link workers and patients that outline why nature-based interventions are so relevant for use in social prescribing and should help nature-based interventions engage effectively with their local healthcare sector<sup>83</sup>**

- Promotional materials:
  - A Standard Advertising Framework (SAF) for mental health and nature-based interventions could be developed – similar to one from the Centre for Sustainable Healthcare shown in Appendix M.
  - Guidelines for clinicians showing what nature-based interventions can offer for different user groups.
  - Posters showing the benefits of nature-based interventions for a range of user groups to display at GP surgeries.
  - Taster days at nature-based interventions for potential service users and social prescribing link workers.
- Engaging effectively with the health care sector:

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<sup>82</sup> And UK-based

<sup>83</sup> both within social prescribing and wider

- More demonstration events in different localities will help nature-based interventions make connections and to 'sell' their service.
- Support for individual organisations within the nature, health and wellbeing sector to determine whether social prescribing in its current forms is appropriate.
  - For nature-based health promotion providers with spare capacity and core funding, social prescribing is likely to be relevant way of securing more participants onto their projects because they fit with the type of health promotion type services predominantly used in social prescribing services.
  - For green care providers, unless their local social prescribing service offers direct funding for the services provided to patients, social prescribing may not currently be the best referral route for service users.
  - For green care providers who also deliver health promotion activities becoming involved in social prescribing could act as a stepping stone to increased commissioning of green care services, once awareness of their existence and of what they can also provide, grows.
- If local providers of nature-based health promotion and green care services conclude that social prescribing is relevant for them they:
  - should collaborate to make single, comprehensive offers of services available to CCGs – not only for social prescribing but also for other mechanisms of health and social care referral.
  - should register with local online directories of services, regularly update link workers and other social prescribing staff about the services they can offer and for whom and work with their local social prescribing service to advertise their services to potential service users.

**8. Nature-based support organisations and networks need to identify and collate information from individual interventions on how nature-based interventions are providing a quality service that is both effective and cost-effective<sup>84</sup>. Such findings need to be shared with Defra and Natural England through the National Outdoor for All Working Group, so they can be disseminated by partners to a wide range of audiences.**

- Quality Assurance:
  - Highlight the existence of quality assurance initiatives within the nature, health and wellbeing sector (such as the Care Farming Code of Practice for example) for ensuring quality services.
- Effectiveness and cost effectiveness:
  - Nature-based interventions should collect data on patient outcomes (including pre and post intervention health and wellbeing outcomes using standardised outcome measures where possible) to demonstrate both the effectiveness and financial impact of their services on patients and on the NHS.
  - Collation of cost benefit data could help secure top-down funding for nature-based interventions at a national level or grant funding at a local level.

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<sup>84</sup> and/or provide cost benefit

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## 9. Appendices

### Appendix A – Research Team involved in the study

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

#### 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) Mind

Mind provides advice and support to empower anyone experiencing a mental health problem and campaigns to improve services, raise awareness and promote understanding of mental health problems. Mind's network of over 140 local Minds provides support to over 400,000 individuals across England and Wales and delivers services rooted in their local communities.

Between 2009 and 2013, Mind funded 130 ecotherapy (green care) projects across England with £7.5m support from the Big Lottery Fund. Over 12,000 people used the projects to look after their mental health by doing gardening, farming, food growing, exercise, art and craft, or environmental conservation work – supported by trained professionals. In October 2013 Mind launched their 'Ecotherapy Works' campaign at The King's Fund where they called upon the people who plan, commission and deliver health and social care services to look at the evidence for green care and consider how it can be provided locally to improve our health and wellbeing.

Mind remains active in promoting green care as a cost effective way to improve both physical and mental wellbeing, which is accessible and inclusive. Currently at least half of all local Minds provide some form of green care.

## **Appendix B – Steering group for this research**

The advisory group for this research comprised:

Gavin Atkins, Mind;  
Ian Egginton-Metters, Care Farming UK and FCFCG;  
Dr Rachel Bragg, Care Farming UK;  
Dr Chris Leck, Independent researcher;  
Dr Dan Bloomfield, University of Exeter;  
Robin Asquith, Botton Village (Camphill Trust care farm);  
Sarah Preston, Natural England;  
Dr Kerryn Husk, Plymouth University;  
Rachel Stancliffe, Centre for Sustainable Healthcare;  
Dominic Higgins, The Wildlife Trusts;  
Craig Lister, TCV;  
Dr Helen Elsey, University of Leeds;  
Dr Jenni Murray, University of Leeds;  
Stephanie Jackson, GP and Kernow CCG;  
Rachel Murray, Kernow CCG.



## Appendix C – Case study template

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**1. Name of case study and key contacts:**

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**2. Area/ region**  
(e.g. Leeds – 3 CCGs; CCG; County-wide; national scheme etc.)

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**3. What is the main purpose /key starting motivation of the initiative?  
And who started it?**  
(e.g. started by a local GP to increase non-clinical choices for patients/service users; started by public health dept. of LA to increase activity levels)

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**4. How is it organised?**  
(i.e. by client group (e.g. children, mental health, learning disabilities) by type of provider (e.g. consortia of nature-based interventions; providers of services for looked after children) by department, by type of needs etc.)

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**5. What is it and when did it start?**  
(i.e. is it an online directory or a social prescribing pilot? Or something else?)

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**6. Who is it targeting?**  
(i.e. frequent GP attendees? public health? Specific medical conditions? All encompassing?)

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**7. What directories of service providers does it have? And what form does this take?**  
(e.g. online hub of service providers; list of service providers; brokerage service)

- 

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**8. What information/ accreditation / process is required to be accepted as a provider?**  
(e.g. only open to service providers registered with the LA; service providers need to be CQC approved; have to pay a joining fee; have to pass a vetting process etc.)

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**9. Are any nature-based interventions currently included within the list of service-providers? If so how many? Or what proportion?**  
(i.e. some hubs have no NBIs; some just have green gyms; some are purely nature-based etc.)

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**10. How are patients referred?**  
(i.e. What referral methods and mechanisms they currently have in place?)

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**11. Who is / or is able to refer to services?**  
(e.g. only GPs; nurse practitioners; health prevention teams; LAs; CMHTs; voluntary organisations; families; personal budget holder self-referral etc.)

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**12. What is the scale of uptake?**  
(i.e. number of referrals given by whom and to whom – e.g. 400 GP referrals and 30 LA social service referrals per year)

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**13. How are they measuring effectiveness of the services provided?**  
(What they are measuring or providing as measures of efficacy? Are they measuring success at all? – does the GP or referral agency get feedback?)

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**14. Is there a recommended ‘dose’ or typical length of programme for people referred to these services?**  
(i.e. are they prescribed 12 week of treatment at a care farm? or is it open ended? Or a certain no of

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sessions?)

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**15. Is there a cost to the patient? Is there funding following the patient/ service user?**

**Who actually pays for the service?**

*(i.e. does the service provider receive direct payment from NHS or LA for the individual place at the intervention?)*

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**16. Conclusion about financial viability?**

*(i.e. is this a model that could work – is it funding the programme through grants rather than the running costs or costs per service user? Is it viable for our nature-based interventions??)*

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**17. Successes**

*(i.e. what has worked and why?)*

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**18. Challenges**

*(What hasn't worked and why? Limitations?)*

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**19. Further information**

*(i.e. associated reports and where to find them; evaluations? websites; other resources?)*

## Appendix D – Case studies

### Case Study 1 A Dose of Nature (Cornwall, Devon and Bristol)

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#### 1. Name of case study and key contacts:

- A Dose of Nature
- Dan Bloomfield, Research Fellow, University of Exeter (Penryn campus): D.Bloomfield@exeter.ac.uk / 07986 511883

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#### 2. Area/ region

*(e.g. Leeds – 3 CCGs; CCG; County-wide; national scheme etc.)*

- Seven separate pilot schemes initiated in Cornwall, Devon and Bristol.

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#### 3. What is the main purpose /key starting motivation of the initiative?

##### And who started it?

*(e.g. started by a local GP to increase non-clinical choices for patients/service users; started by public health dept. of LA to increase activity levels)*

- The initiative has been funded by the Natural Environment Research Council (NERC) to investigate how natural spaces can support nature prescription.

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#### 4. How is it organised?

*(i.e. by client group (e.g. children, mental health, learning disabilities) by type of provider (e.g. consortia of nature-based interventions; providers of services for looked after children) by department, by type of needs etc.)*

- Dose of Nature has been organised as a disaggregated network of pilots, each a partnership between GP surgeries and local environmental partners. Services are provided to patients generally as well as for specific diagnoses.

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#### 5. What is it and when did it start?

*(i.e. is it an online directory or a social prescribing pilot? Or something else?)*

- Nature-based social prescribing pilot(s). Started in autumn 2014 and running until autumn 2016 at least.

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#### 6. Who is it targeting?

*(i.e. frequent GP attendees? public health? Specific medical conditions? All encompassing?)*

- All encompassing, although some groups focus on mental health. The majority of participants are required to be referred through their GP
- Some pilots include self-referrals or secondary referrals from other partners, e.g. Mind.

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#### 7. What directories of service providers does it have? And what form does this take?

*(e.g. online hub of service providers; list of service providers; brokerage service)*

- In the absence of a hub-based model, the intention was to develop self-sustaining projects in each locality and use an overarching co-ordinator to distribute funds, develop best practice and ensure a balance between independence and common standards. Patient referral is therefore not centralised.

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#### 8. What information/ accreditation / process is required to be accepted as a provider?

*(e.g. only open to service providers registered with the LA; service providers need to be CQC approved; have to pay a joining fee; have to pass a vetting process etc.)*

- Providers were identified following local partners searches, and developed their model of care over time alongside, and with, local GPs. At the same time they were required to meet base-level standards and qualifications.

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#### 9. Are any nature-based interventions currently included within the list of service-providers? If so how many? Or what proportion?

*(i.e. some hubs have no NBIs; some just have green gyms; some are purely nature-based etc.)*

- All NBIs. A broad network of nature-based practitioners and participating organisations has been established.

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#### 10. How are patients referred?

*(i.e. What referral methods and mechanisms they currently have in place?)*

- Telephone referrals or via completion of a form. Course facilitators then contact the patient / client.
- Referral via an existing social prescribing Hub.

- Secondary referral via on-going sister groups and projects.

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### 11. Who is / or is able to refer to services?

(i.e. only GPs; nurse practitioners; health prevention teams; LAs; CMHTs; voluntary organisations; families; personal budget holder self-referral etc.)

- Participants were either referred onto the project through their GP (Roseland, Bristol, Exeter, St Austell) or self-referred (Wadebridge, Bodriggy / Stennack, Newquay).

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### 12. What is the scale of uptake?

(i.e. number of referrals given by whom and to whom – e.g. 400 GP referrals and 30 LA social service referrals per year)

- 39 patients completed courses to date. Estimated total by June 2016 will be 75.
- Total referrals is greater (estimated total by June 2016 = 130).

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### 13. How are they measuring effectiveness of the services provided?

(What they are measuring or providing as measures of efficacy? Are they measuring success at all? – does the GP or referral agency get feedback?)

- Evaluations are being provided in relation to all pilot schemes that include qualitative and quantitative outcome data. WEMWBS is completed pre- and post- participation.

Pilot (total n=39)	Average before intervention	Average after intervention	Change
Roseland (n=7)	34.5	53	18.3
St Ives / Hayle (n=9)	28.9	43.7	14.8
Wadebridge (n=7)	28	48.4	20.4
St Austell (n=4)	22.2	51	28.9
Newquay (n=12)	24.3	36.8	12.5
MEAN	27.6	46.6	19

- Three more groups still to run in 2016.

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### 14. Is there a recommended 'dose' or typical length of programme for people referred to these services?

(i.e. are they prescribed 12 week of treatment at a care farm? or is it open ended? Or a certain no of sessions?)

- 12 sessions are recommended in the best practice guidance, but the Roseland walks took place over 10 sessions (2.5 hours) and the Bodriggy / Stennack activities over 9 sessions (4 hours).
- New groups for 2016 will all be 12 weeks long, with a minimum of 2.5 hours.

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### 15. Is there a cost to the patient? Is there funding following the patient/ service user? Who actually pays for the service?

(i.e. does the service provider receive direct payment from NHS or LA for the individual place at the intervention?)

- In the region of up to £5,000 funding is provided by NERC to support the provision of each programme.
- Costs per patient have averaged at £317 so far.

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### 16. Conclusion about financial viability?

(i.e. is this a model that could work – is it funding the programme through grants rather than the running costs or costs per service user? Is it viable for our nature-based interventions??)

- Not sustainable over the long-term in its current form.
- Partners are examining new models alongside Kernow CCG and Cornwall Council (H&WBB).
- Some groups have continued in a self-organised way.

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### 17. Successes

(i.e. what has worked and why?)

- Has received additional funding to extend the operation of the scheme until October 2016.
- Success based in in-depth and local partnership building, aimed at securing trust of referrers.
- Tied in with on-going interdisciplinary research programmes at the University of Exeter and University of Plymouth, which

has helped the project by providing administrative and background support services as well as by lending credibility.

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### 18. Challenges

*(What hasn't worked and why? Limitations?)*

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### 19. Further information

*(i.e. associated reports and where to find them; evaluations? websites; other resources?)*

- Website and report in draft as at Feb 2016.

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### 20. Conclusion

- Providing valuable evidence of the efficacy of NBIs and supporting the development of effective delivery models.
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## Case Study 2 Bromley by Bow Centre

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### 1. Name of case study and key contacts:

- Bromley by Bow Centre (a healthy living centre). General enquiries: 020 8709 9700
- Dan Hopewell – Director of Knowledge and Innovation. Formerly Director of Strategy and (previously) Director of Services: 07545 255095

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### 2. Area/ region

*(e.g. Leeds – 3 CCGs; CCG; County-wide; national scheme etc.)*

- Principally Tower Hamlets – 1 CCG. The CCG is divided into 8 practice networks (on geographical basis), each of which cover approximately 1 square mile. Their network contains 5 practices, 2 of which are part of the Bromley by Bow Health Partnership (they manage a total of 3 practices). All of the five practices in the network are part of the 'core' social prescribing service.
- Their recently initiated social prescribing project with Macmillan Cancer Support also encompasses 3 additional London CCGs: City and Hackney, Newham and Waltham Forest.

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### 3. What is the main purpose /key starting motivation of the initiative?

**And who started it?**

*(e.g. started by a local GP to increase non-clinical choices for patients/service users; started by public health dept. of LA to increase activity levels)*

- The Bromley by Bow Centre was founded in 1984, and in 1997 it build a health centre as part of its integrated model and sought to apply social prescribing principles from the outset. It was one of the country's first healthy living centres and doctors located within the Centre have always referred patients to the programmes and projects provided by the Centre.
- Approximately 75% of the Centre's expenditure relates to the delivery of non-clinical services and 25% covers the cost of providing GP services – this broadly reflects figures provided by the Marmot review suggesting that about 30% of health outcomes are determined by clinical interventions, and the remaining 70% by socio-economic factors.

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### 4. How is it organised?

*(i.e. by client group (e.g. children, mental health, learning disabilities) by type of provider (e.g. consortia of nature-based interventions; providers of services for looked after children) by department, by type of needs etc.)*

- Distinctions are drawn sometimes in relation to client group and type of need (e.g. cancer support and mental health), but social prescribing is also used more widely to support the health and wellbeing of all patients, and to improve their wider determinants of health.

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### 5. What is it and when did it start?

*(i.e. is it an online directory or a social prescribing pilot? Or something else?)*

- Essentially an established holistic health centre that provides a social prescribing service for its own patients and those from 5 neighbouring practices. Since 2013 they have received funding from Tower Hamlets CCG to further develop their social prescribing work on-site and expand the application of their model to include other local health centres (St Andrews Health Centre, Stroudley Walk Health Centre, St Pauls Way Medical Centre and Merchant Street Practice).
  - They also operate 2 additional social prescribing schemes: their social prescribing service for people living with and beyond cancer (funded by Macmillan Cancer Support) started in 2015 and they provide a social prescribing scheme based in one practice (St Paul's Way) associated with the Healthy Cities project that engages with families with children aged under 5.
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- PoLLeN (funded through Ecominds) started in 2010 and applied a social prescribing model whereby health professionals referred patients to the project either as a treatment in itself or alongside other treatments.

#### 6. Who is it targeting?

*(i.e. frequent GP attendees? public health? Specific medical conditions? All encompassing?)*

- The wider scheme is all encompassing, although specific medical conditions / populations are targeted by the two other social prescribing services provided.
- Dan suggested that those who might benefit most from social prescribing will often be dealing with various relevant issues, none of which are necessarily sufficient in their own right to trigger social care payment despite their combining to result in frequent GP visits and an increased future health bill. He differentiated their social prescribing model from that in Rotherham (for example) by the fact that his understanding was that Rotherham focus more on top 3-5% of patients in terms of associated primary and secondary care costs – e.g. those with co-morbidity – rather than being a generalist approach like theirs.

#### 7. What directories of service providers does it have? And what form does this take?

*(e.g. online hub of service providers; list of service providers; brokerage service)*

- No formalised internal directory exists. About 1,100 voluntary sector organisations operate across the Borough, but they tend only to make referrals to between 30 and 40 organisations that they have found (on basis of support sought and subsequent feedback) to help meet the needs and enable the sort of outcomes desired. A comprehensive directory is already available elsewhere in the Borough if required, and Dan suspected that creating an exhaustive directory and trying to map all local provision before starting a social prescribing scheme is both unnecessary, and potentially will act as a barrier to getting the scheme up and running. What is critical is on the ground local intelligence of core, predictable service need, (e.g. community activity groups, social welfare advice etc), and then the referrals will start to shape an understanding which services are needed.

#### 8. What information/ accreditation / process is required to be accepted as a provider?

*(e.g. only open to service providers registered with the LA; service providers need to be CQC approved; have to pay a joining fee; have to pass a vetting process etc.)*

- There is no formalised process, with Dan suggesting that it is neither realistic nor perhaps necessary to fully vet all the organisations that people might be referred to – social prescribing often supports people accessing local community groups and in doing so should avoid being over-formalised or over-regulated.

#### 9. Are any nature-based interventions currently included within the list of service-providers? If so how many? Or what proportion?

*(i.e. some hubs have no NBIs; some just have green gyms; some are purely nature-based etc.)*

- They previously operated PoLLeN (People, Life, Landscape and Nature) therapeutic horticulture project (Ecominds) but this has ended.
- In 2014 they initiated a new therapeutic horticulture programme called Roots East, initially funded for one year, this continues as a therapeutic horticulture programme managed by local people with support from the Centre's wellbeing teams. **ACTION** Dan to investigate further.
- Gardening is promoted as an available activity in relation to the generalist social prescribing scheme and the new social prescribing project with Macmillan Cancer Support.
- **ACTION:** Dan agreed to provide numbers and further detail if available.

#### 10. How are patients referred?

*(i.e. What referral methods and mechanisms they currently have in place?)*

- Initially took the form of GPs informally walking around the Centre with the patient and introducing them to services offered internally. In 2010 they introduced an electronic referral form for GPs to complete and forward to person in 'link worker' role. Since 2013, the other 4 practices in their network (and their other practice outside the network) have also had access to this mechanism. The referral form on their computer system (populated by EMIS) allows them to directly prescribe services such as health training, debt or legal advice, or alternatively to make a referral to the social prescribing coordinator who will either make an onward referral to an appropriate service or meet the patient to get a better understanding of their needs.
- The link worker also regularly attends all 5 surgeries in the network to ensure that they are known to the practice staff and can be personally and directly accessed by both GPs and patients.
- A referred patient's first meeting with the link worker tends to last between 30 and 60 minutes and the link worker might

have up to about 6 sessions with the person concerned if required. Dan stressed the importance of getting the balance right so they can receive the input required between support and enabling them to move on without becoming dependent upon the support of the link worker.

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### 11. Who is / or is able to refer to services?

*(e.g. only GPs; nurse practitioners; health prevention teams; LAs; CMHTs; voluntary organisations; families; personal budget holder self-referral etc.)*

- People were referred to PoLLeN, Roots East and our successor gardening groups by their GPs and health professionals, but some people attended after hearing about it from others (so essentially self-referral).
- GPs, health care assistants and nurses can refer currently to the social prescribing scheme, but Dan highlighted the fact that it is potentially advantageous if this can also be done by pharmacists (as has sometimes previously occurred) and surgery receptionists (who often have very different conversations with patients). He suggested that it might also be advantageous if referrals could also be made by people working in housing, schools etc. in addition to self-referral.

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### 12. What is the scale of uptake?

*(i.e. number of referrals given by whom and to whom – e.g. 400 GP referrals and 30 LA social service referrals per year)*

- Between January 2013 and January 2014 the Centre's social prescriber project supported over 700 local people.
- Dan indicated that about 700 people continue to be referred to the social prescribing scheme annually out of a total of about 25,000 adults registered.
- The Ecominds PoLLeN case study detailed the following, but no time period was provided: 97 people were referred by GPs or health professionals and 64 people attended more than one session.

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### 13. How are they measuring effectiveness of the services provided?

*(What they are measuring or providing as measures of efficacy? Are they measuring success at all? – does the GP or referral agency get feedback?)*

- Feedback processes have been set up to ensure GPs receive outcome letters for all patients they have referred with information on outcomes. This is to ensure best practice and to encourage further referrals.
- Dan thought that link workers at some social prescribing schemes (perhaps including Hackney) might now be able to directly write on patients' GP surgery notes and presented this as a positive strategy.
- External evaluations of PoLLeN were conducted in 2012 and 2013. Both made use of qualitative and quantitative data; the full version of WEMWBS was used in the first study and the second included the short form of the Clinical Outcomes in Routine Evaluation questionnaire (CORE10) and the shortened version of WEMWBS.
- Dan acknowledged the importance of evidencing outcomes and impact but also observed that people can sometimes be over-concerned with the criticality of having a robust evidence-base to demonstrate social prescribing's efficacy; he points out that the evidence shows that the current health system is not working\* and that, at a cost of say £5,000,000 pa, social prescribing does at least require significantly less resourcing than is required to maintain the current – failing – system.
- Currently, health professionals essentially have three options, to give the patient some advice, to prescribe a course of treatment, or refer to a specialist. In future years it will come to be recognised as absurd that clinical staff had no means by which they might refer their patients to non-clinical support. If establishing social prescribing across the UK cost £11.5 million, that would only represent 0.01% of the NHS budget

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### 14. Is there a recommended 'dose' or typical length of programme for people referred to these services?

*(i.e. are they prescribed 12 week of treatment at a care farm? or is it open ended? Or a certain no of sessions?)*

- *No information was found.* **ACTION:** I suspect that this will not / cannot be the case but please could you confirm Dan. The reality is that people will adjust the amount of support they access around about managing their Long Term Health condition, or adopting healthy lifestyles according to what they continue to benefit from, similarly with support around increasing skills, employability, work experience or getting a job. Similarly with welfare advice, debt advice and support with managing their money. Sometimes such support, for instance with access to a community gym, or a walking group becomes, quite rightly, part of people's lives. Similarly with the many community groups that people are referred to, such as gardening, arts programmes and dance groups, it is precisely the intention that these become part of people's lives, supporting active lifestyles and social interaction. In many instances those who are social prescribed because of their needs, very quickly become the resource that supports those who are subsequently referred. Indeed that is one of the functions of social prescribing, the strengthening of networks within communities, and the building of a more resourceful community.
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- In terms of the support from the link worker themselves, many social prescribing programmes incorporate a coaching and support function within the role of the link worker, in Bromley by Bow's case our link worker is a trained counsellor, and whilst her role isn't to be a counsellor, many of the skills such as motivational interviewing are important to the role. Our link worker will have up to six on hour sessions over a mutually agreed period of time with someone who have been referred. And potentially the same people may be referred more than once. The link workers at Ways to Wellness in Newcastle will support people for up to 24 months, with 21 months being an average. It is recognised by many social prescribing schemes that one to one support is critical in supporting the needs of many of those referred, including around long term behaviour change.

#### 15. Is there a cost to the patient? Is there funding following the patient/ service user? Who actually pays for the service?

*(i.e. does the service provider receive direct payment from NHS or LA for the individual place at the intervention?)*

- No funding is directly associated with individual referrals. The additional services / activities they directly provide internally or to which patients may be referred externally are generally grant funded; for example the PoLLeN project was funded by **Ecominds** and the **J P Getty Jnr Charitable Trust**, and the Roots East project was funded by the JPMorgan Chase Foundation.
- The cost of the social prescribing service itself is funded by the local network of five GP practices together with the Tower Hamlets Clinical Commissioning Group.
- Dan suggested that social prescribing should be about supporting the development of a vibrant and resourceful communities and that a danger of providing funding in a manner in which it follows individual referrals was that this might promote a silo mentality wherein clinicians became the gatekeepers to accessing services. I.e. only patients who had been referred by clinicians could access certain services, and those who sought them out through self-referral would be turned away, or directed to seek an appointment with their GP, in order to access, for example, a community walking group. This would discourage the community from engaging in supporting its own health and wellbeing. However, he felt also that social prescribing can highlight gaps in what is available in the community already and that funding is sometimes needed to fill these gaps, but with this funding the service rather than being associated directly with individual referrals. In Bromley, for example, they had been aware that the CAB were already overwhelmed and any social prescribing service would need to consider the potential volume of un-met demand for welfare advice. He also felt that the funding for service providers associated with the Rotherham scheme was helpful for the whole sector as it helped highlight the fact that the voluntary sector is often already poorly funded and may not be able to accommodate all those referred effectively and appropriately.

#### 16. Conclusion about financial viability?

*(i.e. is this a model that could work – is it funding the programme through grants rather than the running costs or costs per service user? Is it viable for our nature-based interventions??)*

- Although the local GP network and CCG fund the social prescribing link worker, the actual projects to which patients are referred are often largely grant dependent. No funding attached to the social prescriber is available to support internal services or external service providers to whom referrals are made.

#### 17. Successes

*(i.e. what has worked and why?)*

- Tower Hamlets CCG are now intending **to support the introduction of social prescribing across the whole borough and all their GP Networks in 2016. They will be** putting extra funding into each of the GP Network Areas in Tower Hamlets to pay for a co-ordination function to make assessments and make referrals to suitable voluntary sector provision, and to provide some follow up. No extra funding will be available immediately to pay the voluntary sector but social prescribing is being presented as part of the longer-term shift towards valuing the contribution of the VCS in delivering health & wellbeing outcomes and a corresponding rebalancing of resources towards voluntary and community provision. The CCG has suggested it might further fund socially prescribed activity in the future if evidence from an evaluation shows that social prescribing yields cashable savings from NHS budgets.

#### 18. Challenges

*(What hasn't worked and why? Limitations?)*

- *No information was found.*

#### 19. Further information

*(i.e. associated reports and where to find them; evaluations? websites; other resources?)*

- Dan highlighted the importance of getting all involved GPs and other clinical staff on-board in order for social prescribing to be successful. This requires effective and repeated engagement to ensure they're aware of why it is needed, the



voluntary support services might be available, but the sort of people who might be repeatedly and overly using GPs will often benefit from support with accessing these.

- Dan described a scheme being initiated in Southampton that would involve the link worker conducting the interview with the referred patient aided by the use of software to identify and record someone's level of social capital and the sort of things that are important to them. The results are then fed directly into a database to identify potentially suitable / appropriate referral opportunities. He is interested in seeing if this could be applied in Bromley (it's based on an open-access IT platform – Genie).
- Dan outlined the Nuka health care system that they are researching with regard to considering the incorporation /translation of aspects of it in Bromley: he described this Alaskan model as a relational form of primary care, with multi-disciplinary team working with all family members to enable behavioural change (with GP salaries accounting for a much smaller percentage of overall health spending than is the case in the NHS). According to the internet, *The main elements that differentiate the Nuka System of Care from other healthcare systems .... include terminology, citizen-set priorities, a commitment to same-day access, holistic health and partnership with customer-owners to deliver improved population health. These elements are supported by an organisational value system that includes stable long-term leadership, value-based recruitment and the transparent use of outcomes data. Overall, the Nuka System of Care claims to deliver excellent value for money, improved health outcomes and vastly improved patient experience.*
- Information about their social prescribing service: <http://www.bbbc.org.uk/news/336/social-prescriber>
- Information about their social prescribing training activities: (<http://www.bbbc.org.uk/-social-prescribing-seminars--201>)
- Ecominds case study <http://www.mind.org.uk/media/1393809/ecotherapy-pollen-health-professionals.pdf>
- Clift, S., Cunningham, L. and Winczewska, N. (2013) *PoLLeN. People, Life, Landscape and Nature. An evaluation 2012-2013*. Canterbury: Sidney De Haan Research Centre for Arts and Health, Canterbury Christ Church University. ([file:///C:/Users/Owner/Downloads/PoLLeN\\_2013\\_Evaluation\\_Report.pdf](file:///C:/Users/Owner/Downloads/PoLLeN_2013_Evaluation_Report.pdf))

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## 20. Conclusion

- This appears to be an excellent example of an established health service provider that effectively supports the health and wellbeing needs of patients in a holistic and individually-focused manner. Incorporated activities have previously included green care and volunteers still provide gardening activities. However, they appear to remain dependent on accessing grant funding to support the individual projects they deliver rather than these being enabled directly via the social prescribing funding that is received from the CCG. External service providers do not currently receive funding in exchange for the provision of their services.
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## Case Study 3 Leeds South and East

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### 1. Name of case study and key contacts:

- Connect for Health. Delivered by a consortium of local charities led by Leeds Mind.
- Helen Kemp, Chief Executive of Leeds Mind (general enquiries: 0113 305 5800)

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### 2. Area/ region

(e.g. Leeds – 3 CCGs; CCG; County-wide; national scheme etc.)

- Leeds South and East (1 CCG – but North Leeds CCG has also been approached to become involved).

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### 3. What is the main purpose /key starting motivation of the initiative?

#### And who started it?

(e.g. started by a local GP to increase non-clinical choices for patients/service users; started by public health dept. of LA to increase activity levels)

- The CCG initiated the scheme to enable GPs to utilise local community support services (it was felt that GPs didn't have sufficient in-depth knowledge or resources to refer / signpost patients to relevant community groups and activities operating in the area).
  - The Connect for Health service is intended by the CCG to provide signposting rather than on-going support, but, if considered appropriate, workers can accompany referred patients to their first few sessions.
  - The service is being delivered by a consortium of local charities: Leeds Mind, Touchstone, BARCA, Leeds Irish Health and Homes, Hamara and Better Leeds Communities (BLC). They were selected following a rigorous tender process assessed by a panel of health experts and patient representatives.
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#### 4. How is it organised?

(i.e. by client group (e.g. children, mental health, learning disabilities) by type of provider (e.g. consortia of nature-based interventions; providers of services for looked after children) by department, by type of needs etc.)

- No information was found.
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#### 5. What is it and when did it start?

(i.e. is it an online directory or a social prescribing pilot? Or something else?)

- A social prescribing service that was launched in November 2015.
  - An online portal (not yet operational) will allow patients to access information and refer themselves directly.
  - The Connect for Health team will work with individuals to find support that meets their personal needs.
- 

#### 6. Who is it targeting?

(i.e. frequent GP attendees? public health? Specific medical conditions? All encompassing?)

- All encompassing. The programme is not condition specific, but evidence from the Leeds West programme is suggested to show that between 60-70% of referrals are likely have a mental health problem.
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#### 7. What directories of service providers does it have? And what form does this take?

(e.g. online hub of service providers; list of service providers; brokerage service)

- It is not yet apparent how they will identify / access relevant service provider, but is stated that the first task for appointed workers will be to map all possible signposting opportunities across South and East Leeds.
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#### 8. What information/ accreditation / process is required to be accepted as a provider?

(e.g. only open to service providers registered with the LA; service providers need to be CQC approved; have to pay a joining fee; have to pass a vetting process etc.)

- No information was found.
- 

#### 9. Are any nature-based interventions currently included within the list of service-providers? If so how many? Or what proportion?

(i.e. some hubs have no NBIs; some just have green gyms; some are purely nature-based etc.)

- No service providers are yet listed but it is anticipated that this will be the case; suggested range of activities include walking groups and dance classes, healthy cooking classes and gardening groups, social groups for older people and debt and housing advice.
- 

#### 10. How are patients referred?

(i.e. What referral methods and mechanisms they currently have in place?)

- Patients will be able to access the service via the phone or website. A phone or face to face to meeting (dependent on need) will then be arranged and they will be signposted to a service that is identified as potentially suitable.
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#### 11. Who is / or is able to refer to services?

(e.g. only GPs; nurse practitioners; health prevention teams; LAs; CMHTs; voluntary organisations; families; personal budget holder self-referral etc.)

- All patients registered with GP practices in Leeds South and East will be eligible and will be able to self-refer or via a referral from a health professional.
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#### 12. What is the scale of uptake?

(i.e. number of referrals given by whom and to whom – e.g. 400 GP referrals and 30 LA social service referrals per year)

- Not yet fully operational
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#### 13. How are they measuring effectiveness of the services provided?

(What they are measuring or providing as measures of efficacy? Are they measuring success at all? – does the GP or referral agency get feedback?)

- Targets and outcomes have not yet been formalised but the chief executive of Leeds Mind suggests it will be based on the number of referrals and reduced GP usage, with the CCG having responsibility for monitoring.
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#### 14. Is there a recommended 'dose' or typical length of programme for people referred to these services?

(i.e. are they prescribed 12 week of treatment at a care farm? or is it open ended? Or a certain no of sessions?)

- No information was found.
- 

#### 15. Is there a cost to the patient? Is there funding following the patient/ service user? Who actually pays for the

**service?**

*(i.e. does the service provider receive direct payment from NHS or LA for the individual place at the intervention?)*

- The pilot scheme will receive £1.5 million from the CCG over three years that will provide for 12 Wellbeing workers covering the 42 GP surgeries in the area.
- It is not yet clear whether service providers might be funded through the scheme: *'Some of the groups and services that we may recommend will charge or ask for donations. We will discuss potential costs with you whenever we are aware of these, taking into consideration your income and ability to pay.'*

**16. Conclusion about financial viability?**

*(i.e. is this a model that could work – is it funding the programme through grants rather than the running costs or costs per service user? Is it viable for our nature-based interventions??)*

- The funding appears to relate principally to the provision of a signposting service rather than to support the operation of the services to which patients are referred.

**17. Successes**

*(i.e. what has worked and why?)*

- *No information was found.*

**18. Challenges**

*(What hasn't worked and why? Limitations?)*

- *No information was found.*

**19. Further information**

*(i.e. associated reports and where to find them; evaluations? websites; other resources?)*

- Connect for Health literature for patients indicates that there are different models for social prescribing and describes their offering three levels of support:
  - ☐ Level 1 – We will provide information by phone or e-mail to help you understand what support is available in your local community.
  - ☐ Level 2 – We will arrange a meeting with a Wellbeing Co-ordinator to help better understand your health and wellbeing needs and what you hope to improve. The Co-ordinator will then provide you with information and advice on local services and community groups that you could access.
  - ☐ Level 3 – We know that some people will not be able to access local community groups or services without some additional support. This might be because of high levels of anxiety or you are new to the area. We will provide up to 6 sessions to support you to access appropriate support. This might be attending a group with someone for the first couple of visits for someone who is especially anxious or accompanying someone on public transport to a new venue.
- The Leeds Mind chief executive has suggested that a future role could be to inform commissioners about gaps in provision based on where people want to be signposted and availability etc.

**20. Conclusion**

- It is currently unclear what, if any, funding will be assigned to support the costs of the services accessed.

## Case Study 4 Growing Well (Cumbria) Case Study

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### 1. Name of case study and key contacts:

- Growing Well, Cumbria: Therapeutic Community.
- Beren Aldridge – Therapeutic Coordinator – 015395 61777 - [beren@growingwell.co.uk](mailto:beren@growingwell.co.uk)

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### 2. Area/ region

(e.g. Leeds – 3 CCGs; CCG; County-wide; national scheme etc.)

- Cumbria – 1 CCG

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### 3. What is the main purpose /key starting motivation of the initiative?

#### And who started it?

(e.g. started by a local GP to increase non-clinical choices for patients/service users; started by public health dept. of LA to increase activity levels)

- The Therapeutic Community scheme was initiated by the care farm.
- GPs also refer into Growing Well's core service though CCG don't offer any funding to our core service.

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### 4. How is it organised?

(i.e. by client group (e.g. children, mental health, learning disabilities) by type of provider (e.g. consortia of nature-based interventions; providers of services for looked after children) by department, by type of needs etc.)

- The therapeutic community meet and work together every Friday, combining a mixture of practical activities, group therapy and managing the business of how the community operates.

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### 5. What is it and when did it start?

(i.e. is it an online directory or a social prescribing pilot? Or something else?)

- The Therapeutic Community started in 2014
- It operates effectively as a social prescribing scheme but the care farm therapeutic coordinator does not consider it is necessarily perceived as such within the CCG.

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### 6. Who is it targeting?

(i.e. frequent GP attendees? public health? Specific medical conditions? All encompassing?)

- People with mental health problems.

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### 7. What directories of service providers does it have? And what form does this take?

(e.g. online hub of service providers; list of service providers; brokerage service)

- n/a

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### 8. What information/ accreditation / process is required to be accepted as a provider?

(e.g. only open to service providers registered with the LA; service providers need to be CQC approved; have to pay a joining fee; have to pass a vetting process etc.)

- n/a

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### 9. Are any nature-based interventions currently included within the list of service-providers? If so how many? Or what proportion?

(i.e. some hubs have no NBIs; some just have green gyms; some are purely nature-based etc.)

- n/a

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### 10. How are patients referred?

(i.e. What referral methods and mechanisms they currently have in place?)

- People who contact them are enabled to visit the farm and then asked to complete a short application form.
- If a community mental health team is already involved with the individual concerned then they are asked to support the application; GPs are otherwise approached to fulfil this role.

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### 11. Who is / or is able to refer to services?

(e.g. only GPs; nurse practitioners; health prevention teams; LAs; CMHTs; voluntary organisations; families; personal budget holder self-referral etc.)

- People can refer themselves or others but are then required to provide a mental health reference, usually completed by a member of the community mental health team or a GP.

**12. What is the scale of uptake?**

(i.e. number of referrals given by whom and to whom – e.g. 400 GP referrals and 30 LA social service referrals per year)

- There were 10 participants in the Therapeutic Community when it was initiated in 2014; in April 2015 6 of this number remained and 5 others joined (11 total).

**13. How are they measuring effectiveness of the services provided?**

(What they are measuring or providing as measures of efficacy? Are they measuring success at all? – does the GP or referral agency get feedback?)

- During 2014 the therapeutic community members collected data about their experiences and worked with a researcher from the University of Salford to evaluate the project using quantitative (WEMWBS) and qualitative data (see below for link).
- The CCG agreement requires that they deliver on a series of ‘key performance indicators’ (KPIs) in relation to participants and outcomes.

**14. Is there a recommended ‘dose’ or typical length of programme for people referred to these services?**

(i.e. are they prescribed 12 week of treatment at a care farm? or is it open ended? Or a certain no of sessions?)

- At least 0.5 days a week. The duration of participation is not predetermined and the care farm tries to access / divert alternative funding if necessary to allow it to continue for as long as it is sought / required.

**15. Is there a cost to the patient? Is there funding following the patient/ service user? Who actually pays for the service?**

(i.e. does the service provider receive direct payment from NHS or LA for the individual place at the intervention?)

- There is no cost to the patient. 40% of the funding for the first pilot year of the therapeutic community was provided by the CCG, and the perceived success of the project during the first year of operation resulted in their fully funding the service during 2015. 2016: the therapeutic community continues to be fully funded by NHS on a rolling one-year contract.

**16. Conclusion about financial viability?**

(i.e. is this a model that could work – is it funding the programme through grants rather than the running costs or costs per service user? Is it viable for our nature-based interventions??)

- The CCG are now fully funding the programme but this remains on an annual basis.

**17. Successes**

(i.e. what has worked and why?)

- The therapeutic coordinator considers their social prescribing pilots to have been successful and to have resulted in about a 50% increase in referrals.

**18. Challenges**

(What hasn't worked and why? Limitations?)

- 

**19. Further information**

(i.e. associated reports and where to find them; evaluations? websites; other resources?)

- Understanding the impact of Growing Well: <http://www.growingwell.co.uk/downloads/49/understanding-the-impact-of-growing-well.ashx>

**20. Conclusion**

- The relative success of the current scheme appears to be underpinned by the presence and engagement of the therapeutic coordinator who has developed effective links with local health and social care service managers / decision-makers over a sustained period.

**Case Study 5 Rotherham****1. Name of case study and key contacts:**

- Rotherham Social Prescribing Service
- Social Prescribing Project Manager (Voluntary Action Rotherham): Barry Knowles Tel: 01709 723098. Mobile: 07714 560092. Email: [barry.knowles@varotherham.org.uk](mailto:barry.knowles@varotherham.org.uk)
- Adult Health and Social Care Development Officer (Voluntary Action Rotherham): Linda Jarrold (Barry's line)

manager).Tel: 01709 834449. Email: [linda.jarrold@varotherham.org.uk](mailto:linda.jarrold@varotherham.org.uk)

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## 2. Area/ region

(e.g. Leeds – 3 CCGs; CCG; County-wide; national scheme etc.)

- The borough of Rotherham – 1 CCG.

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## 3. What is the main purpose /key starting motivation of the initiative?

### And who started it?

(e.g. started by a local GP to increase non-clinical choices for patients/service users; started by public health dept. of LA to increase activity levels)

- Pilot first initiated as an element of a GP-led Integrated Case Management (ICM) initiative that provided investment in the community during the transition from the PCT to the CCG.
- Intended to increase the capacity of GP practices to meet the non-clinical needs of patients by enabling people with long term conditions to be referred through case management teams to sources of support in their community.
- The service is delivered by Voluntary Action Rotherham (VAR), in partnership with more than 20 local voluntary and community organisations (VCOs), on behalf of NHS Rotherham CCG.

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## 4. How is it organised?

(i.e. by client group (e.g. children, mental health, learning disabilities) by type of provider (e.g. consortia of nature-based interventions; providers of services for looked after children) by department, by type of needs etc.)

- A core team consisting of a Project Manager and five Voluntary and Community Sector Advisors (VCSAs) is employed by VAR.
- The Project Manager oversees the day-to-day running of the Service, including management of the grant programme, and acting as a liaison between VCS providers and wider NHS structures.
- The VCSA role provides the link between the Service and the multidisciplinary ICMTs. The 5 advisors work with patients referred from 36 participating GP surgeries who are judged to be at risk of unplanned hospital admission.
- They have recently started a mental health pilot.

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## 5. What is it and when did it start?

(i.e. is it an online directory or a social prescribing pilot? Or something else?)

- An established social prescribing scheme.
- The original social prescribing pilot started in April 2012 with funding for 2 years. An additional year of funding was then obtained and 3 more years funding has now been provided from the Better Care Fund (so currently funded until April 2018).

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## 6. Who is it targeting?

(i.e. frequent GP attendees? public health? Specific medical conditions? All encompassing?)

- Patients with complex long-term conditions (LTCs) who are already high users of hospital care and assessed as being at high risk of accessing unplanned hospital care in the future and needing non-clinical support to improve their health and wellbeing.
- A risk stratification tool is used to identify the five per cent most intensive users of services: these patients and their carers are eligible for case management and can access social prescribing.
- The majority of the patients referred to the Service are elderly: 6% under 50, 8% 50-59, 14% 60-69, 30% 70-79, 35% 80-89, 9% 90 or over (Dayson et al., 2016).

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## 7. What directories of service providers does it have? And what form does this take?

(e.g. online hub of service providers; list of service providers; brokerage service)

- The advisors connect people with one of the local voluntary and community sector organisations contracted to provide services. On occasions where these are judged unable to meet a particular need or goal, advisers are able to identify and spot-purchase more appropriate solutions. Referrals are also made to unfunded services.
  - The service also acts as a gateway to the groups and activities available in the wider voluntary and community sector and acts as a care navigator for public sector services.
  - The Social Prescribing Service has provided grants to local VCS organisations across a number of phases:
    - Autumn 2012: 10 voluntary and community organisations (VCOs) were commissioned to deliver initial suite of pilot services.
    - Spring 2013: a further 13 VCOs were commissioned to deliver pilot services.
    - April 2014: 27 VCOs were commissioned to deliver a revised menu of 32 services under the new Better Care Fund contract.
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- April 2015: the menu of services was updated, with 17 VCOs commissioned to deliver 20 different services.

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### 8. What information/ accreditation / process is required to be accepted as a provider?

*(e.g. only open to service providers registered with the LA; service providers need to be CQC approved; have to pay a joining fee; have to pass a vetting process etc.)*

- Rotherham Social Prescribing Service invited grant funding applications from all local not-for-profit voluntary and community sector organisations and groups that could provide services to improve the health and wellbeing of patients with long term conditions.
- Organisations or groups applying for £5,000 or more were required to complete an initial Pre-Qualification Questionnaire (PQQ) before an application for grant funding was considered. Grant applications of less than £5,000 do not require completion of a PQQ but they still complete a quality check as part of their application.
- Funded providers are required to demonstrate compliance with an externally validated quality assurance framework (*no further information found*).

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### 9. Are any nature-based interventions currently included within the list of service-providers? If so how many? Or what proportion?

*(i.e. some hubs have no NBIs; some just have green gyms; some are purely nature-based etc.)*

- 1 of the 26 funded organisations (Kimberworth Park Community Partnership) continues to offer a gardening project as one of their suite of services.
- Rotherham United Community Sports Trust receive funding through the new mental health SPS pilot to provide a walking group amongst other things.
- YAWR Services were supported in 2014 (but this appears to have ended) to provide a gardening service
- Sheffield Wildlife Trust have been in touch recently with regard to becoming a commissioned service provider.

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### 10. How are patients referred?

*(i.e. What referral methods and mechanisms they currently have in place?)*

- Participants have to be registered with a Rotherham GP Practice and are referred after having been identified using the previously detailed risk stratification tool.
- GP refers to the ICMT, they refer to the VCSA and they then refer to a funded or non-funded activity.
- VCSAs carry out home visits and engage in guided conversations to assess their support needs and help patients identify the areas of their lives they would like to change/improve before then referring them to the most appropriate service available.
- VCSAs also form part of the ICMT and attend meetings when service users are discussed.

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### 11. Who is / or is able to refer to services?

*(e.g. only GPs; nurse practitioners; health prevention teams; LAs; CMHTs; voluntary organisations; families; personal budget holder self-referral etc.)*

- Participants are referred onto the scheme by their GP Practice or members of the ICMT.

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### 12. What is the scale of uptake?

*(i.e. number of referrals given by whom and to whom – e.g. 400 GP referrals and 30 LA social service referrals per year)*

- 2012-14: 1,607 patients were referred to the service, of whom 1,118 were referred on to funded VCS services. In parallel, more than 200 referrals were made to non-funded VCS provision and more than 300 referrals were made to statutory services (Dayson and Bashir, 2014).
  - Between September 2012 and March 2015 the Service received referrals from 35 (out of 36) GP practices in Rotherham. Overall, 1,991 Service users were actively engaged by the Social Prescribing Service (Dayson et al., 2016).
  - Over the course of 2012-2015 there were 4,702 onward referrals of 722 individual users (many had more than one onward referral) to funded VCS services.
  - Regarding Community based leisure and social activities, 87 referrals were made 2012-2013, 374 in 2013-2014 and 253 in 2014-15 (Dayson et al., 2016).
  - 61% of users referred-out to grant-funded provision through the Service were referred to more than one service. (Dayson et al., 2016).
  - 38% of Service users were referred to the wider pool of VCS provision available in the borough rather than to VCS services in direct receipt of funding through the Social Prescribing Service (Dayson et al., 2016).
  - In the past three years the Service has engaged with more than 2,000 local people with long-term health condition (Dayson et al., 2016).
  - The target for the new mental health pilot to engage with 250 people in the first year; the overall target for the social prescribing scheme is currently 1,300 - 1,400 people p.a.
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- **How are they measuring effectiveness of the services provided?**

*(What they are measuring or providing as measures of efficacy? Are they measuring success at all? – does the GP or referral agency get feedback?)*

- Since its inception as a pilot in 2012, the Rotherham Social Prescribing Service has been the subject of evaluation by the Centre for Regional Economic and Social Research (CRESR) at Sheffield Hallam University.
- An interim pilot evaluation report (December 2013) identified emerging lessons and provided a series of recommendations for stakeholders and commissioners
- A final pilot evaluation report (September 2014) provided an assessment of its social and economic impacts with more detailed analysis of cost-benefits and return on investment, including assessing the potential cost savings and efficiencies to the NHS.
- An evaluation report published in January 2016 (and intended to be annual) provided an updated assessment of the social and economic impact of the Rotherham Social Prescribing Service between September 2012 and March 2015. This was informed by analysis of client management and monitoring data collected by VAR, analysis of hospital episodes data for a cohort of Service users between 2012 and 2014 and service user case studies. Summary of findings (Dyson et al., 2016):
  - The average number of non-elective inpatient episodes reduced by 7%
  - The average number of non-elective inpatient spells reduced by 11%
  - The average number of non-elective inpatient bed days increased by 28%
  - The average number of Accident and Emergency attendances reduced by 17%
  - Younger Service users generally recording greater reductions in their use of urgent care than older Service users.
  - Service users who completed their grant-funded referral activity within the VCS experienced a higher degree of positive change than those who did not.
  - Service users who completed their grant-funded referral activity and continued to engage in the VCS once this activity had concluded exhibited the greatest amount of change.
  - The Social Prescribing Service measured users' progress towards social outcomes through a well-being measurement tool developed specifically for the Service. Overall, 82 per cent of Service users experienced positive change on at least one outcome measure.
  - NHS costs avoided for the full three years of the service were estimated as £536,000 compared to total input costs of £1.65 million. This translates to an annual return of 33 pence for each pound invested. The estimated return on investment from well-being benefits for the full three years of the Service was between 78 pence and 85 pence per pound invested). However, it is important to note that the Year 1 figures do not provide an accurate reflection of the likely social cost-benefits of Social Prescribing over a longer period.

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**13. Is there a recommended 'dose' or typical length of programme for people referred to these services?**

*(i.e. are they prescribed 12 week of treatment at a care farm? or is it open ended? Or a certain no of sessions?)*

- The desire appears to be that participants leave, self-fund or are funded externally after the first 3-month period.

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**14. Is there a cost to the patient? Is there funding following the patient/ service user? Who actually pays for the service?**

*(i.e. does the service provider receive direct payment from NHS or LA for the individual place at the intervention?)*

- The annual funding agreement covers the core cost of delivering the Service alongside a grant funding pot for a 'menu' of VCS activities that have been specifically developed to meet the needs of Service users.

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**15. Conclusion about financial viability?**

*(i.e. is this a model that could work – is it funding the programme through grants rather than the running costs or costs per service user? Is it viable for our nature-based interventions??)*

- The scheme appears to have been funded appropriately and effectively; 44% of the £1 million funding that was provided for the first two years covered the core cost of developing and running the scheme and the remaining 56% funded the 'menu' of VCS activities.

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**16. Successes**

*(i.e. what has worked and why?)*

- Patients who accessed the service were reported as generally being more satisfied with the support they received to manage their condition than had previously been the case.
  - In March 2014 the Pilot received the 'Excellence in Individual Participation Commissioner' award at NHS England's Excellence in Participation Awards 2014.
  - The scheme has been influential in the development of NHS policy at a national level and is part of the NHS' 'Improving general practice – a call to action' initiative, which aims to support action with the potential to transform services in local
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communities and support general practice to improve outcomes and tackle inequalities.

## 17. Challenges

(What hasn't worked and why? Limitations?)

- The pilot scheme was commissioned in April 2012 but the majority of VCS services did not commence until January 2013 or later due to the amount of time it took to establish the scheme's operational form. This included staff recruitment; developing relationships with GP practices and Case Management Teams, including raising awareness of the Pilot and the benefits of social prescribing for patients and carers; developing programme management systems, including a commissioning framework and grant monitoring systems; working to understand need and gaps in existing provision; and identifying and developing partnerships with the range of potential VCS providers across the borough
- The volume of referrals has varied considerably by GP practice. 4 practices referred more than 100 patients, five referred between 50 and 100 patients, 12 referred between 25 and 49 patients and ten referred less than 25 patients (including three that referred less than 10) (Dayson and Bashir, 2014).
- Some additional indirect costs (inputs) have been borne by organisational stakeholders:
  - Voluntary Action Rotherham and the CCG had to invest a significant amount of time prior to the commissioning of the pilot to research the need for the service, develop the service model and specification, and consult with GPs and voluntary sector organisations.
  - The Foundation Trust supported the development of the complex client management system through which referrals in to and out of the service were monitored and reported on.
  - Volunteers: many of the services provided through the Pilot were provided with considerable support from volunteers. They input their own time, without which the direct costs of delivering the scheme would have been increased.

## 18. Further information

(i.e. associated reports and where to find them; evaluations? websites; other resources?)

- <http://www.varotherham.org.uk/social-prescribing-service/>
- Dayson, C., Bashir, M. and Pearson, S. (2013) *From dependence to independence: emerging lessons from the Rotherham Social Prescribing Pilot*. Centre for Regional Economic and Social Research, Sheffield Hallam University. <http://www.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/rotherham-social-prescribing-summary.pdf>
- Dayson, C. and Bashir, M. (2014) *The social and economic impact of the Rotherham Social Prescribing Pilot. Main Evaluation Report*. Centre for Regional Economic and Social Research, Sheffield Hallam University. <http://www.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/social-economic-impact-rotherham.pdf> (A representation of their model is included in this report).
- Dayson, C., Bashir, N., Bennett, E. and Sanderson, E. (2016) *The Rotherham Social Prescribing Service for People with Long-Term Health Conditions. Summary Report*. Centre for Regional Economic and Social Research, Sheffield Hallam University. [http://www.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/rotherham-social-prescribing-summary-report-2016\\_7\\_0.pdf](http://www.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/rotherham-social-prescribing-summary-report-2016_7_0.pdf)
- Dayson, C., Bashir, N., Bennett, E. and Sanderson, E. (2016) *The Rotherham Social Prescribing Service for People with Long-Term Health Conditions. Annual Evaluation Report*. Centre for Regional Economic and Social Research, Sheffield Hallam University. [http://www.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/rotherham-social-prescribing-annual-eval-report-2016\\_7.pdf](http://www.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/rotherham-social-prescribing-annual-eval-report-2016_7.pdf)

## 19. Conclusion

- The Rotherham model appears to effectively support both patients and service providers and to be suited to the delivery of NBIs.
- The fact that many of those referred are quite elderly might have to be taken into account when designing interventions.

For Social prescribing risk analysis conducted by Rotherham CCG before initiating the scheme see Appendix K.

## Case Study 6 Natural Health Service (Merseyside)

### 1. Name of case study and key contacts:

- Natural Health Service (The Mersey Forest ).
- Paul Nolan: 01925 816217 [info@naturalhealthservice.org.uk](mailto:info@naturalhealthservice.org.uk) [paul.nolan@merseyforest.org.uk](mailto:paul.nolan@merseyforest.org.uk)

### 2. Area/ region

(e.g. Leeds – 3 CCGs; CCG; County-wide; national scheme etc.)

- The Natural Health Service is based at The Mersey Forest Offices in Warrington (1 CCG) but the consortium also covers Merseyside (6 CCGs) and Cheshire (4 CCGs?).

### 3. What is the main purpose /key starting motivation of the initiative?

#### And who started it?

*(e.g. started by a local GP to increase non-clinical choices for patients/service users; started by public health dept. of LA to increase activity levels)*

- The Natural Health Service is the coordinator of activities and is also involved with the actual delivery of programmes.
- The Natural Health Service was initiated by The Mersey Forest, a network of 21 organisations made up of seven local authorities, Natural England, the Forestry Commission, the Environment Agency, landowners, businesses and local communities.
- Seeking to help coordinate environment bodies and their offer to the health and social care sector to increase the use of the natural environment to support good health and to develop targeted health products that make use of the Natural Environment as a key element of health care or improvement.
- To provide a single point of access to a range of well-developed and evidence based services in natural green spaces.

### 4. How is it organised?

*(i.e. by client group (e.g. children, mental health, learning disabilities) by type of provider (e.g. consortia of nature-based interventions; providers of services for looked after children) by department, by type of needs etc.)*

- A consortium of environmental, academic and health practitioners, coordinated through a Steering Group

### 5. What is it and when did it start?

*(i.e. is it an online directory or a social prescribing pilot? Or something else?)*

- A social enterprise supporting social prescribing.
- They are currently working on 2 programmes: Nature for Health and the Natural Health Service Research Centre of Excellence
- The first Nature for Health placements were offered in September 2013.
- Nature for Health: £400,000 of lottery funding was accessed towards the end of 2015 that is intended to deliver activities targeting health inequalities for a 3-year period.

### 6. Who is it targeting?

*(i.e. frequent GP attendees? public health? Specific medical conditions? All encompassing?)*

- All encompassing, but with priority being given to those in the local area.
- It is anticipated that most of those who are engaged with will be facing mild to moderate mental health problems.

### 7. What directories of service providers does it have? And what form does this take?

*(e.g. online hub of service providers; list of service providers; brokerage service)*

- All 6 original involved partners remain very keen to be involved with service delivery and there is no intention yet to involve additional service providers (this may change in the future).
- Partners do work with local groups to deliver health interventions

### 8. What information/ accreditation / process is required to be accepted as a provider?

*(e.g. only open to service providers registered with the LA; service providers need to be CQC approved; have to pay a joining fee; have to pass a vetting process etc.)*

- Need to be a member of the consortium.

### 9. Are any nature-based interventions currently included within the list of service-providers? If so how many? Or what proportion?

*(i.e. some hubs have no NBIs; some just have green gyms; some are purely nature-based etc.)*

- All included are nature-based. The range of activities on offer in 2013 included walking, horticultural therapy, forest school, green volunteering and green gym, mindful contact with nature.
- 2016: the intent currently is to continue to provide these products and to then signpost participants to other services if required.

### 10. How are patients referred?

*(i.e. What referral methods and mechanisms they currently have in place?)*

- A referral form is made available by post, e-mail or on-line.

### 11. Who is / or is able to refer to services?

*(e.g. only GPs; nurse practitioners; health prevention teams; LAs; CMHTs; voluntary organisations; families; personal budget holder self-referral etc.)*

- Self-referral or any qualified health provider (primary and secondary).

### 12. What is the scale of uptake?

*(i.e. number of referrals given by whom and to whom – e.g. 400 GP referrals and 30 LA social service referrals per year)*

- Self referrals, as yet not a referred service, though there are close links to the Countess of Chester Hospital for the Nature4Health project that is being delivered in partnership with the hospital, Cheshire West and Chester, TCV and the Land Trust
- The 2013 business plan included the aim of achieving an annual delivery of 1000 units of treatment by 2018.

### 13. How are they measuring effectiveness of the services provided?

*(What they are measuring or providing as measures of efficacy? Are they measuring success at all? – does the GP or referral agency get feedback?)*

- The intent from the outset was to work with a range of institutions to commission independent evaluations of the products and the Natural Health Service.
- The Natural Health Service Research Centre of Excellence has been developed with this in mind and is proving popular. They are working currently with Liverpool University, John Moores University, Exeter University and are engaged with 2 PhDs and several master's degree students.

### 14. Is there a recommended 'dose' or typical length of programme for people referred to these services?

*(i.e. are they prescribed 12 week of treatment at a care farm? or is it open ended? Or a certain no of sessions?)*

- The business plan indicated that they intended initially to provide 16 sessions of activity with each session able to accommodate ten people. However, it also stated that the course of treatment may last anywhere from 4 to 16 weeks depending on the products and the needs of the clients. 2013 promotional materials indicated that they hoped participants would attend at least 12 sessions.
- The current intent is for programmes to last for between 8 and 16 weeks.
- Intent to continue to provide 6 previously described products as 8 to 16 week programmes and will then signpost participants to other services if required. They will be funding partners to deliver the interventions / programmes themselves rather than on basis of number of participants.

### 15. Is there a cost to the patient? Is there funding following the patient/ service user? Who actually pays for the service?

*(i.e. does the service provider receive direct payment from NHS or LA for the individual place at the intervention?)*

- They will be funding service providing partners to deliver the interventions / programmes themselves rather than on basis of number of participants.

### 16. Conclusion about financial viability?

*(i.e. is this a model that could work – is it funding the programme through grants rather than the running costs or costs per service user? Is it viable for our nature-based interventions?)*

- Currently viable as a result of National Lottery funding to provide services for the next 3 years.

### 17. Successes

*(i.e. what has worked and why?)*

Consortium has focussed attention on a few products to help to achieve a high standard delivery  
Links to universities has delivered excellent analysis of the outcomes of delivery to date

### 18. Challenges

*(What hasn't worked and why? Limitations?)*

- As yet, no referrals from GP's, still early days in the delivery of data from the interventions, things may improve as the evidence develops
- In some cases, maintaining attendance over an extended (up to 16 weeks) period of time

### 19. Further information

*(i.e. associated reports and where to find them; evaluations? websites; other resources?)*

- They are currently working on a new website to promote (and provide information about) the work they are doing and the services they offer.
- About the Natural Health Service: [http://www.naturalhealthservice.org.uk/about\\_the\\_nahs.pdf](http://www.naturalhealthservice.org.uk/about_the_nahs.pdf)
- Business Plan (Executive Summary): [http://www.naturalhealthservice.org.uk/naturalhealthservice\\_execsum.pdf](http://www.naturalhealthservice.org.uk/naturalhealthservice_execsum.pdf)
- Guidance for referral organisations: [http://www.naturalhealthservice.org.uk/referral\\_guidance.pdf](http://www.naturalhealthservice.org.uk/referral_guidance.pdf)

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## 20. Conclusion

- A model that involves only nature-based service providers and provides funding to these to actually deliver interventions (but dependent on accessing grants).
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## Case Study 7 Ways to Wellness, Newcastle West

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### 1. Name of case study and key contacts:

- 'Ways to Wellness' is the scheme currently operating in Newcastle West. It follows two previous pilot social prescribing projects in the West of Newcastle. These are interrelated but have been enabled via different funding streams. Tara Case, Chief Executive, [info@waystowellness.org.uk](mailto:info@waystowellness.org.uk)
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### 2. Area/ region

*(e.g. Leeds – 3 CCGs; CCG; County-wide; national scheme etc.)*

- Newcastle West: this was formerly 1 CCG but has now amalgamated with 2 other CCGs to become Newcastle Gateshead CCG. However, Newcastle West remains the focus of the initiative.
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### 3. What is the main purpose /key starting motivation of the initiative?

#### And who started it?

*(e.g. started by a local GP to increase non-clinical choices for patients/service users; started by public health dept. of LA to increase activity levels)*

- *Phase 1* was funded by NESTA's People Powered Health programme and was intended to develop a linkwork service within existing voluntary organisations to enable health professionals to refer patients to non-clinical community services and networks, to raise awareness and equip health professionals to be able to use the service and to develop and maintain a comprehensive web-based information resource to support the project. A multi-agency group of 5 local voluntary and community organisations were involved in the initial project design and each of these identified a link worker through whom health professional referrals could be channelled.
  - *Phase 2* (Supporting Social Prescribing for Mental Health) was concerned with investigating challenges that arose during the previous Social Prescribing Pilot and ascertaining how best to address these.
  - *Ways to Wellness* was incubated by VONNE (The Voluntary Organisations' Network North East – but now operates completely independently) and supported by the CCG, the Big Lottery Fund, the Cabinet Office, [Department of Health Social Enterprise Investment Fund](#) (SEIF) and ACEVO (the Association of Chief Executives of Voluntary Organisations). *Ways to Wellness* holds a seven-year contract with the CCG whereby the CCG, the Big Lottery Fund and the Cabinet Office have agreed to pay for the provision of social prescribing services to their patients in return for *Ways to Wellness* demonstrating the value to patients and a reduction in their use of NHS resources. *Ways to Wellness* has contracted four service provider organisations (2 year contracts) to deliver the service. Each service is responsible for providing link workers to provide services to patients referred from a portion of the 18 General Practices in the west of Newcastle.
  - *Ways to Wellness* has raised money from a social investor, Bridges Ventures, in order to fund the service before outcome-based payments are generated from the CCG, the Big Lottery Fund and the Cabinet Office. If the targets are achieved, *Ways to Wellness* should demonstrate an economically sustainable case for intensively scaling up social prescribing for people with LTCs.
- 

### 4. How is it organised?

*(i.e. by client group (e.g. children, mental health, learning disabilities) by type of provider (e.g. consortia of nature-based interventions; providers of services for looked after children) by department, by type of needs etc.)*

- By client group and needs
- 

### 5. What is it and when did it start?

*(i.e. is it an online directory or a social prescribing pilot? Or something else?)*

- Social prescribing (pilot and scheme).

- *Phase 1*: August 2011 - March 2013

*Phase 2*: February 2013 - Feb 2014

*Ways to Wellness*: launched in April 2015.

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### 6. Who is it targeting?

*(i.e. frequent GP attendees? public health? Specific medical conditions? All encompassing?)*

- Phase 1: vulnerable people with LTCs and mental health problems
- Ways to Wellness: Targeting people with the following LTCs:
  - Chronic breathing difficulties (COPD) or Asthma
  - Diabetes (Type 1 or Type 2)
  - Heart Disease
  - Epilepsy
  - Thinning of the bones (osteoporosis)
  - Any of the above with depression and/or anxiety

#### **7. What directories of service providers does it have? And what form does this take?**

*(e.g. online hub of service providers; list of service providers; brokerage service)*

- Four non-profit or social enterprise service providers are contracted by Ways to Wellness to hire Link workers who deliver the one-to-one aspect of the Ways to Wellness service.
- Link Workers signpost clients to existing community services, as appropriate and aligned to client goals.

#### **8. What information/ accreditation / process is required to be accepted as a provider?**

*(e.g. only open to service providers registered with the LA; service providers need to be CQC approved; have to pay a joining fee; have to pass a vetting process etc.)*

- The 4 contracted service provider organisations (who provide the link workers) were selected following a procurement process.

#### **9. Are any nature-based interventions currently included within the list of service-providers? If so how many? Or what proportion?**

*(i.e. some hubs have no NBIs; some just have green gyms; some are purely nature-based etc.)*

- Patient goals determine this – Ways to Wellness data will be fully analysed after 1 year of service delivery; preliminary data analysis indicates that this is not a significant area of focus for patients (<0.1% of goals).

#### **10. How are patients referred?**

*(i.e. What referral methods and mechanisms they currently have in place?)*

- Link workers receive referrals from GPs and practice nurses; they then assess people's needs and develop personal goals and provide buddying and signposting into local activities and networks and sources of information, advice and support.

#### **11. Who is / or is able to refer to services?**

*(e.g. only GPs; nurse practitioners; health prevention teams; LAs; CMHTs; voluntary organisations; families; personal budget holder self-referral etc.)*

- GPs and other GP surgery health workers.

#### **12. What is the scale of uptake?**

*(i.e. number of referrals given by whom and to whom – e.g. 400 GP referrals and 30 LA social service referrals per year)*

- *Phase 1:* 124 referrals were made over an 8-month period by six general practices (86% of referrals came from 2 surgeries).
- *Ways to Wellness:* aiming to reach up to 3,500 patients per year. April – January 2015: engaged with 811 patients.

#### **13. How are they measuring effectiveness of the services provided?**

*(What they are measuring or providing as measures of efficacy? Are they measuring success at all? – does the GP or referral agency get feedback?)*

- *Phase 1:* Monitoring data (based on 11 completed records) showed 69% of patients experienced an increase in SWEMWB score and 64% achieved an increase in confidence in managing their LTC.
- *Ways to Wellness; Two outcome measures generate outcome-based payments:* (1)The Well-being Star (version of the Outcomes Star by Triangle Consulting) will measure patients' self-reported change in well-being across eight domains. (2) Reduction in secondary care (hospital) costs in comparison to a matched cohort.

#### **14. Is there a recommended 'dose' or typical length of programme for people referred to these services?**

*(i.e. are they prescribed 12 week of treatment at a care farm? or is it open ended? Or a certain no of sessions?)*

- *Phase 1:* Participating service providers appear to have offered time-limited link worker support based on the payment they were receiving for taking part in the pilot.
- *Ways to Wellness:* It is envisaged that patients will remain on the scheme for an average of 21 months and will be supported by their dedicated link worker throughout this period.

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### 15. Is there a cost to the patient? Is there funding following the patient/ service user? Who actually pays for the service?

(i.e. does the service provider receive direct payment from NHS or LA for the individual place at the intervention?)

- *Phase 1*: No cost to patient but many of the link worker organisations and those to whom they referred patients could ultimately only deliver the service due to funding received from elsewhere.
  - *Ways to Wellness*: No cost to the patient. Social Impact Bond funding is invested at risk by social investor, which is repaid if patient improvement targets are met, generating outcome based payments. **Funding does not automatically follow patients in terms of any services they might be signposted to. Funding exists to help with services that might become over-subscribed due to Ways to Wellness patients.**
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### 16. Successes

(i.e. what has worked and why?)

- *Phase 1*: Referral forms were praised for being simple to complete.
  - *Phase 3 (potential)*: Ways to Wellness is applying a social impact investment solution that is presented as removing the risk to the CCG and the restrictions presented by annual commissioning cycles.
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### 17. Challenges

(What hasn't worked and why? Limitations?)

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### 18. Further information

(i.e. associated reports and where to find them; evaluations? websites; other resources?)

- <http://waystowellness.org.uk/>
- ERS Research and Consultancy (2013) *Newcastle Social Prescribing Project. Final Report.*
- *Phase 2: Social Prescribing for Mental Health* (<http://www.movingforward-northeast.co.uk/wp-content/uploads/2015/08/Social-Prescribing-Mental-Health-Report-13.10.14.pdf>)

Identified the following strategies for improving engagement rates:

- Health and care professionals knowing and applying selection criteria in order to identify only those patients for whom SP is appropriate
- Link worker making first contact through home visit
- Link worker contacting referrer to gain better knowledge and understanding of patients' needs, wants and anticipated outcomes
- Financing the various phases:  
*Phase 1*: NHS Newcastle West CCG received £100,000 from NESTA (National Endowment for Science, Technology and the Arts) to plan and deliver a pilot social prescribing project for people with long-term conditions (LTCs). The project received a further grant of £50,000 from the North East Health Innovation Education Cluster.

*Phase 2*: Funded through £32,500 'Mental Health Bundle Monies' from NHS North East (the Strategic Health Authority at the time).

*Ways to Wellness*: In the development phase, VONNE secured £130,000 of development funding from the Department of Health Social Enterprise Investment Fund (SEIF). In addition, ACEVO (Charity Leaders Network) pledged £15,000 in cash and in-kind support. In January 2014, a further £150,000 of technical assistance funding was secured from the Big Lottery Fund. This funding was used to develop the Ways to Wellness service model (financial and operational) and to build capacity.

The Ways to Wellness Trust is a registered charitable foundation, and Ways to Wellness Ltd is the trading arm, which holds and manages contracts with service providers, social investors and the pre-existing Newcastle West CCG (now part of Newcastle Gateshead CCG). Bridges Ventures are providing £1.65 million of Social Impact Bonds to support the establishments of the Ways to Wellness service ahead of performance measures being achieved and payments being received from the Newcastle West Clinical Commissioning Group (now part of Newcastle Gateshead CCG). This is the first time such a funding structure has been used. The contracts are structured on an 'outcomes payment' basis, so investors will only be paid by the CCG if Ways to Wellness can demonstrate achievement of performance measures that demonstrate the value to patients and a reduction in the use of NHS resources. The Big Lottery Fund Commissioning Better Outcomes Fund and the Cabinet Office Social Outcomes Fund have also agreed to pay up to £2 million and £1million, respectively, in outcome-based funding.

- *Phase 2* (Social Prescribing for Mental Health) sought to improve the effectiveness and take up of social prescribing for people with mental health problems. Recommendation 4 related to the need to consider funding service provider
-

organisations despite *phase 3* not appearing to have acted on this:

*‘Currently when a voluntary sector organisation or group helps someone via a social prescription, this is undertaken as part of their existing commissioned or charitably funded activity. In contrast, a medical prescription comes with costs and funding attached. This needs monitoring and further attention over time, especially given the pressure on funding and budgets experienced by the VCS’ (p. 7).*

## Case Study 8 Wellspring Healthy Living Centre (Bristol)

### 1. Name of case study and key contacts:

- Wellbeing Programme delivered by the Wellspring Healthy Living Centre.
- Head of Services: Rhian Loughlin. Tel: 0117 911 9831. Email: [rhian.loughlin@wellspringhlc.org](mailto:rhian.loughlin@wellspringhlc.org)

### 2. Area/ region

*(e.g. Leeds – 3 CCGs; CCG; County-wide; national scheme etc.)*

- Inner-City and East Bristol, with a focus on the Lawrence Hill ward

### 3. What is the main purpose /key starting motivation of the initiative?

#### And who started it?

*(e.g. started by a local GP to increase non-clinical choices for patients/service users; started by public health dept. of LA to increase activity levels)*

- Wellspring Healthy Living Centre is a community-run charity that was founded in 2004 by a group of local residents.
- Incorporated services include a G.P. surgery, dentist, complementary therapies, arts project, learning kitchen and garden.
- They adopt a social prescribing approach that is intended to support individuals in such a way as to encourage them to play a central role in managing their own care.

### 4. How is it organised?

*(i.e. by client group (e.g. children, mental health, learning disabilities) by type of provider (e.g. consortia of nature-based interventions; providers of services for looked after children) by department, by type of needs etc.)*

- On an individual basis.
- The provided service is described as ‘holistic’ social prescribing (as opposed to ‘light’ or ‘medium’) wherein they seek to address the beneficiary’s personal needs in a holistic and individual way.

### 5. What is it and when did it start?

*(i.e. is it an online directory or a social prescribing pilot? Or something else?)*

- The social prescribing project has been operational since 2007. It was initially funded by New Deal for Communities, and then in 2010 jointly funded by Tudor Trust and Henry Smith charities.

### 6. Who is it targeting?

*(i.e. frequent GP attendees? public health? Specific medical conditions? All encompassing?)*

- They work through Improved Access to Psychological Therapies (IAPT) with those who have low to moderate common mental health disorders – depression and anxiety. This is based on PBR (payment by results) as part of the Any Qualified Provider (AQP) framework adopted by Bristol CCG for its IAPT provision.
- We also work with those who have long-term conditions physical health conditions as this also impacts on mental health and wellbeing.

### 7. What directories of service providers does it have? And what form does this take?

*(e.g. online hub of service providers; list of service providers; brokerage service)*

- They have a ‘library’ of leaflets, but use monthly staff share meetings to update workers on what is available along with line management and clinical supervision from an outside agency. Workers will ask Wellspring’s Senior Wellbeing Practitioners for information on service providers or will use the internet and the database Wellaware (*another of our case studies*).

### 8. What information/ accreditation / process is required to be accepted as a provider?

*(e.g. only open to service providers registered with the LA; service providers need to be CQC approved; have to pay a joining fee; have to pass a vetting process etc.)*

- They are an AQP and have developed a competency framework for practitioners to deliver psycho-social support for IAPT.

- They are part of a city-wide alliance which is developing a standard for the delivery of Kitchen on Prescription (healthy-eating courses) in Bristol.

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**9. Are any nature-based interventions currently included within the list of service-providers? If so how many? Or what proportion?**

*(i.e. some hubs have no NBIs; some just have green gyms; some are purely nature-based etc.)*

- They have made some referrals to the Barton Hill Walled Garden and occasionally make referrals to a very small group of volunteers who look after the courtyard garden and the beds surrounding the building.

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**10. How are patients referred?**

*(i.e. What referral methods and mechanisms they currently have in place?)*

- In-house – the Healthy Living Centre that delivers the scheme contains a GP surgery.
- They also take referrals for the IAPT service directly from the assessors of the Bristol Wellbeing Therapies and take referrals from G.P.s across Inner-City and East Bristol for an Assisted Referral into the Bristol Wellbeing Therapies assessment process. The Assisted Referral intervention consists of a 40 - 50 minute session where people are supported to make an appointment for an assessment.

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**11. Who is / or is able to refer to services?**

*(e.g. only GPs; nurse practitioners; health prevention teams; LAs; CMHTs; voluntary organisations; families; personal budget holder self-referral etc.)*

- GPs, but anyone can make a referral to the Bristol Wellbeing Therapies service, including self-referrals. The client is then assessed, and the assessor makes the referral to the psycho-social intervention.

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**12. What is the scale of uptake?**

*(i.e. number of referrals given by whom and to whom – e.g. 400 GP referrals and 30 LA social service referrals per year)*

- No information was found or provided.

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**13. How are they measuring effectiveness of the services provided?**

*(What they are measuring or providing as measures of efficacy? Are they measuring success at all? – does the GP or referral agency get feedback?)*

- They have developed their own tool (in conjunction with Richard Kimberlee, UWE and using established measurement scales) to measure various elements relating to health and wellbeing and identify change (pre and post intervention). They use PHQ -9, GAD-7, phobia scale and Work and Social Adjustment Scale – the prescribed minimum dataset for IAPT.
- Data analysis identified statistically significant improvements three months after a beneficiary's induction on the intervention in measures of: depression, anxiety, isolation, wellbeing, perceived economic wellbeing and physical activity.
- Analysis of GP contact times suggested that for 60% of beneficiaries there was a reduction in their GP attendance rates in the 12 months post intervention compared to the 12 months period prior to referral. For 26% of beneficiaries it stayed the same and for 14% it increased.
- A Social Return On Investment ratio of £2.90 : £1 was calculated (UWE, 2014).

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**14. Is there a recommended 'dose' or typical length of programme for people referred to these services?**

*(i.e. are they prescribed 12 week of treatment at a care farm? or is it open ended? Or a certain no of sessions?)*

- 12 weeks of one to one support followed by 12 months of group support around a particular activity was promoted initially but they are limited in the number of sessions by IAPT. The client is permitted to have 6, with the potential for supplementing this number with up to 2 more depending on the likelihood of those supplementary sessions moving the client into 'recovery'. They present the mean average as 8 – 9 sessions.

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**15. Is there a cost to the patient? Is there funding following the patient/ service user? Who actually pays for the service?**

*(i.e. does the service provider receive direct payment from NHS or LA for the individual place at the intervention?)*

- This initiative was initially funded by the Henry Smith and Tudor Trust, but now have funding based on PBR from Bristol CCG.

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**16. Successes**

*(i.e. what has worked and why?)*

- No information was found or provided.

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**17. Challenges**

*(What hasn't worked and why? Limitations?)*



- No information was found or provided.

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### 18. Further information

(i.e. associated reports and where to find them; evaluations? websites; other resources?)

- Kimberlee, R. (2013) *Developing a social prescribing approach for Bristol. Project Report*. Bristol Health & Wellbeing Board, UK. [https://www2.bristol.gov.uk/committee/2013/ot/ot049/1128\\_7.pdf](https://www2.bristol.gov.uk/committee/2013/ot/ot049/1128_7.pdf)
- Kimberlee, R. (2014) *Proving our Value: Measuring the economic impact of Wellspring Healthy Living Centre's Social Prescribing Wellbeing Programme for low level mental health issues encountered by GP services*. The University of the West of England, Bristol. [http://wellspringhlc.org/content/POV%20Final%20Report%20March%202014%20\(2\).pdf](http://wellspringhlc.org/content/POV%20Final%20Report%20March%202014%20(2).pdf)
- Wellspring's social prescribing scheme is described as being characterised by the following elements:
  1. Holistic: person-centred and non-prescriptive with consideration of an individual's physical, mental and spiritual needs and wellbeing
  2. Co-production: recognising and supporting clients to manage their own recovery.
  3. Key-worker model and goal setting: the client, together with their key worker, identifies and sets realistic goals. The worker then supports the client to achieve these goals.
  4. The use of a range of therapeutic tools.
  5. Addressing the wider, social determinants of health: referral to agencies that can address those issues that contribute to poor mental health.
  6. Partnership working and embedded referral pathways.
  7. Asset-based approach: a) referral to activities and services, in the individual's local community, that support good mental health; b) facilitation and support for peer-support groups and activities based in the community; c) Volunteer Befrienders who themselves have experienced poor mental health, but who are ready to support others in their recovery.
  8. Based on Five Ways to Wellbeing: connect, be active, take notice, keep learning and give.

### 19. Conclusion

- Feels like an effective and well-thought out service that seems to work well. However, it involves only one health centre (that enjoys full buy-in from GPs) and it does not appear that any funding follows patient referrals.

## Case Study 9. Leeds West Patient Empowerment Project

### 1. Name of case study and key contacts:

- West Leeds Patient Empowerment Project (West Leeds PEP)
- Mark Fuller, GP Clinical Lead for Public Health [mark.fuller1@nhs.net](mailto:mark.fuller1@nhs.net)
- Sue Wilkinson, Commissioning and Development Manager [sue.wilkinson5@nhs.net](mailto:sue.wilkinson5@nhs.net)
- Joe Kent, Assistant Operations Director (Health, Wellbeing & Adults, Barca-Leeds) [Joe.kent@barca-leeds.org](mailto:Joe.kent@barca-leeds.org)
- PEP telephone no.: 0113 279 5870

### 2. Area/ region

(e.g. Leeds – 3 CCGs; CCG; County-wide; national scheme etc.)

- West Leeds – 1 CCG (37 GP surgeries)

### 3. What is the main purpose /key starting motivation of the initiative?

#### And who started it?

(e.g. started by a local GP to increase non-clinical choices for patients/service users; started by public health dept. of LA to increase activity levels)

- The Patient Empowerment Project (PEP) was developed in 2014 using a co-production approach in partnership with Patient and Clinical Leaders from NHS Leeds West Clinical Commissioning Group (CCG), local voluntary groups, CCG member practices and Leeds City Council.
- The PEP service creates a formal means of enabling general practitioners to refer patients with social, emotional or practical needs to a variety of holistic, local community services through referral to one of the community based PEP workers, thus expanding the range of options available in a GP consultation. Patients can also self refer.
- Initiated by West Leeds CCG to connect general practices with the voluntary sector. "To improve the wider health and well-being of patients by providing a referral route between GP practices and local voluntary sector organisations, activities, groups and services". Referred patients are supported on a one-one basis or in a group, to help them to develop the skills, knowledge and confidence to self-manage their condition.

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#### 4. How is it organised?

(i.e. by client group (e.g. children, mental health, learning disabilities) by type of provider (e.g. consortia of nature-based interventions; providers of services for looked after children) by department, by type of needs etc.)

BARCA-Leeds (an independent, multi-purpose organisation providing specialist services to children, young people, and adults) lead the initiative, but working in partnership with Leeds Mind, Better Leeds Communities and Touchstone.

- PEP is implemented in all practice areas in NHS Leeds West CCG, tailored to the needs of local practice communities aiming to provide better health outcomes and reduce health inequalities.
- 

#### 5. What is it and when did it start?

(i.e. is it an online directory or a social prescribing pilot? Or something else?)

- Essentially a social prescribing project.
  - Started in September 2014 with funding for a 12-month period. Further funding was obtained for a further 12 months on evidence of impact with current contract ending August 2016. 3 year contract out to tender March 2016 following successful evaluation.
- 

#### 6. Who is it targeting?

(i.e. frequent GP attendees? public health? Specific medical conditions? All encompassing?)

- All encompassing (examples provided include those dealing with long term health problems, depression, mild-moderate anxiety and those who are recently bereaved, socially isolated, marginalised, disadvantaged or vulnerable)
  - There is no patient criteria for member practices to adhere to when referring patients to the PEP service. The clinician refers on the basis of how they feel the patient may benefit from the support provided by the PEP service based on their understanding of the patient's health and well-being.
  - The focus is on identifying and meeting unmet need, building resilience and innovative community based solutions to prevent mental health problems and promote mental wellbeing
  - PEP enables patients and communities to actively self-manage their health issues, improving patient experience and outcomes.
- 

#### 7. What directories of service providers does it have? And what form does this take?

(e.g. online hub of service providers; list of service providers; brokerage service)

- PEP has access to Leeds Directory of Services and CVFS online directories
  - A total of 987 groups and services were signposted or referrals made to by the PEP coordinators to 482 enrolled patients (n=484) between October 2014 and end September 2015 (Johnson, 2015).
- 

#### 8. What information/ accreditation / process is required to be accepted as a provider?

(e.g. only open to service providers registered with the LA; service providers need to be CQC approved; have to pay a joining fee; have to pass a vetting process etc.)

- Fully adhere to the terms and conditions of the NHS Standard Contract for Services <http://www.england.nhs.uk/nhs-standard-contract/>
  - Detail the systems and processes they will have in place to outline the standards of support provided for advice givers, the nature of that advice, when and how to escalate issues to a professional, or their line manager
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#### 9. Are any nature-based interventions currently included within the list of service-providers? If so how many? Or what proportion?

(i.e. some hubs have no NBIs; some just have green gyms; some are purely nature-based etc.)

- Included at least one 'Walk in the woods', with this having been highlighted for praise by a patient in the associated evaluation.
  - Referrals made to local conservation group
- 

#### 10. How are patients referred?

(i.e. What referral methods and mechanisms they currently have in place?)

- GPs identify patients they think could benefit from the support of the West Leeds PEP. They provide information about the project and, if a referral is agreed, PEP make contact and meet the patient to discuss how best they may be supported by available services (one to one support or linking to a group or activity).
  - PEP staff provide personal support for patients to attend their first session according to patient need.
- 

#### 11. Who is / or is able to refer to services?

(e.g. only GPs; nurse practitioners; health prevention teams; LAs; CMHTs; voluntary organisations; families; personal budget holder self-referral etc.)

- 78% of referrals have been by a GP, 12% self-referrals' 6% are referrals by other practice staff and 4% are referrals from
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other organisations or from other BARCA and partners services (Johnson, 2015)

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### 12. What is the scale of uptake?

*(i.e. number of referrals given by whom and to whom – e.g. 400 GP referrals and 30 LA social service referrals per year)*

- January 2015: 115 referrals
- November 2015: 703 patients had been referred into the PEP service. Conversion rate of referral to enrolment total of 69% means that within the first 12 months of PEP a high proportion of those in most need of a social prescription are being supported by PEP.
- The number of patients in receipt of the PEP service was far greater than the 150 that was anticipated for the first year as a service in development.
- Referrals have been received from all NHS Leeds West member practices (n=37).

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### 13. How are they measuring effectiveness of the services provided?

*(What they are measuring or providing as measures of efficacy? Are they measuring success at all? – does the GP or referral agency get feedback?)*

- The evaluation by the Yorkshire and Humber Commissioning Support (YHCS), Health Economics Evaluation and Evidence Service (HEEEs) uses an approach with four key domains; clinical outcomes, economic outcomes, staff acceptability and feasibility and patient experience.
- They undertook an impact evaluation that was informed by questionnaires completed by patients, volunteers and staff, interviews with patients and case studies
- A baseline survey was completed on first appointment with the PEP client and then a follow-up assessment survey was completed three months after or on leaving the service.
- Following support from PEP the PEP cohort of patients (n=115) mental wellbeing (SWEMWBS) and self-reported well-being has improved as has their perception of their self-efficacy to manage their own health.
- The PEP cohort mean mental well-being score (SWEMWBS) at baseline assessment is 18.46. After support from PEP this increases to 20.62. This is a statistically significant finding ( $P < 0.05$ ) thus establishing a proxy measure of clinical effectiveness of mental health for this cohort of patients
- Office of National Statistics well-being measurement provides a national context and following support from PEP the positive increase in response to these questions show a statistically significant positive change ( $P < 0.05$ )
- When asked “How confident are you that you can do all things necessary to manage your illness on a day to day basis?” Those reporting not at all confident has dropped from over 30% to less than 15% following support from PEP
- Dichotomised EQ5D5L results for the PEP cohort including LTCs show a positive shift of 7% from problems to no problems in both self-care and depression
- Patient experience rating 7.9/10
- There is a 11.5% decrease in those who self-report that they smoke and a 6% increase in those self-reporting that they are trying to smoke less or are trying to stop smoking.
- Case studies evidence that individuals have received personal solutions to their individual needs, such as being enabled to return to work or start voluntary work.
- Following support from PEP 80% of patients indicated they would seek community based solutions rather than accessing the health system.
- GP feedback: 70% said that patient care was better coordinated since the start of the PEP, 80% that they had seen improvements in patient care since the start of the PEP, 70% that in their opinion the wellbeing of their patients has improved, 100% that it was enhancing their patients’ experience, 100% that it was making a positive difference to their patients and 90% that it was making a positive difference to their local community.

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### 14. Is there a recommended ‘dose’ or typical length of programme for people referred to these services?

*(i.e. are they prescribed 12 week of treatment at a care farm? or is it open ended? Or a certain no of sessions?)*

- Driven by patient need – an average of 6 contacts per patient is noted in the contract but this is expected to vary according to the individual holistic plan agreed with each patient

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### 15. Is there a cost to the patient? Is there funding following the patient/ service user? Who actually pays for the service?

*(i.e. does the service provider receive direct payment from NHS or LA for the individual place at the intervention?)*

- Free at point of access

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### 16. Conclusion about financial viability?

*(i.e. is this a model that could work – is it funding the programme through grants rather than the running costs or costs per service user? Is it viable for our nature-based interventions??)*

- The PEP is funded by the CCG until August 2016 and a 3 year contract out to tender March 2016 following successful

evaluation.

- No additional funding provided for those who deliver the services / activities to which people are referred.
- Indicative cost per QALY supports PEP as a cost effective service for commissioning purposes; project findings have been shared with NICE regional colleagues as part of the developing evidence base on Social Prescribing.

### 17. Successes

(i.e. what has worked and why?)

- Associated outcomes from the first year of the service delivery were presented as having been the cause of Leeds West CCG providing a second year of funding that also allowed additional link workers to be employed.
- Following dissemination of key findings, Leeds City Council Housing and Councillors have invested in a PEP Housing worker to tackle social issues and improve mental health in 4 High Rise flats in a deprived part of Leeds.

### 18. Challenges

(What hasn't worked and why? Limitations?)

- Gaining feedback from groups and services signposted and referred to had a poor response rate and this will be built on in year 2.
- High complexity of initial referrals meant slower start to development of peer led groups.

### 19. Further information

(i.e. associated reports and where to find them; evaluations? websites; other resources?)

- <http://barca-leeds.org/health-and-wellbeing/west-leeds-pep-patient-empowerment-project>
- Project evaluation: <http://www.leedswestccg.nhs.uk/content/uploads/2015/02/Patient-empowerment-project-presentation.pdf>
- Johnson, S. (2015) *NHS Leeds West Clinical Commissioning Group Patient Empowerment Project (PEP) Final Year One Report*. Yorkshire and Humber Commissioning Support.  
*'The survey of community providers revealed little in the way of impact by the PEP service on their groups and services. The response rate was low and not fully representative of the broad range of groups and services that received signposts and referrals from the PEP service. In future years the Leeds West CCG through the PEP service needs to build a way to obtain this feedback in order to better understand impact/unintended consequences on these groups and services.'* (Johnson, 2015)

### 20. Conclusion

- Effective link service but seeming to link patients with providers that do not require funding.

## Case Study 10 Clinks Care Farm (Farming for health)

### 1. Name of case study and key contacts:

- Farming for health (Clinks Care Farm – 01502 679134)
- Doeke Dobma

### 2. Area/ region

(e.g. Leeds – 3 CCGs; CCG; County-wide; national scheme etc.)

- Great Yarmouth and Waveney CCG (although were also in dialogue with neighbouring CCG – South Norfolk)

### 3. What is the main purpose /key starting motivation of the initiative?

#### And who started it?

(e.g. started by a local GP to increase non-clinical choices for patients/service users; started by public health dept. of LA to increase activity levels)

- Initiated by the care farm to increase use of the care farm.

### 4. How is it organised?

(i.e. by client group (e.g. children, mental health, learning disabilities) by type of provider (e.g. consortia of nature-based interventions; providers of services for looked after children) by department, by type of needs etc.)

- 

### 5. What is it and when did it start?

(i.e. is it an online directory or a social prescribing pilot? Or something else?)

- Started as a social prescribing pilot in Oct 2010 and continues to operate as an effective example of small-scale social prescribing (1 CCG: 1 care farm).

#### 6. Who is it targeting?

(i.e. frequent GP attendees? public health? Specific medical conditions? All encompassing?)

- Initially patients with mild to moderate mental health problems but also seeking to engage with those with physical health issues.

#### 7. What directories of service providers does it have? And what form does this take?

(e.g. online hub of service providers; list of service providers; brokerage service)

- n/a

#### 8. What information/ accreditation / process is required to be accepted as a provider?

(e.g. only open to service providers registered with the LA; service providers need to be CQC approved; have to pay a joining fee; have to pass a vetting process etc.)

- n/a

#### 9. Are any nature-based interventions currently included within the list of service-providers? If so how many? Or what proportion?

(i.e. some hubs have no NBIs; some just have green gyms; some are purely nature-based etc.)

- n/a

#### 10. How are patients referred?

(i.e. What referral methods and mechanisms they currently have in place?)

- GPs make referrals by downloading and completing a referral form that is then sent to the farm. The care farm then contacts them to arrange a suitable date and time for them to visit the farm.

#### 11. Who is / or is able to refer to services?

(e.g. only GPs; nurse practitioners; health prevention teams; LAs; CMHTs; voluntary organisations; families; personal budget holder self-referral etc.)

- GPs

#### 12. What is the scale of uptake?

(i.e. number of referrals given by whom and to whom – e.g. 400 GP referrals and 30 LA social service referrals per year)

- Over 40 people attended the pilot; slower than anticipated take-up of placements resulted in the original 12-month pilot being extended for a further 6 months.
- Currently funded to provide 8 weekly placements.

#### 13. How are they measuring effectiveness of the services provided?

(What they are measuring or providing as measures of efficacy? Are they measuring success at all? – does the GP or referral agency get feedback?)

- Appropriate goals are agreed with the patient during the first session, and these are then reviewed at the end of the 6<sup>th</sup> and 12<sup>th</sup> week.
- Working with the University of East Anglia to evaluate outcomes.

#### 14. Is there a recommended 'dose' or typical length of programme for people referred to these services?

(i.e. are they prescribed 12 week of treatment at a care farm? or is it open ended? Or a certain no of sessions?)

- 12 weeks, 1 day a week

#### 15. Is there a cost to the patient? Is there funding following the patient/ service user? Who actually pays for the service?

(i.e. does the service provider receive direct payment from NHS or LA for the individual place at the intervention?)

- The PCT originally provided £90,000 to fund for 1 year (8 placements, 1 day a week). The CCG have continued to fund but at a lower rate (2015: £25,000).

#### 16. Conclusion about financial viability?

(i.e. is this a model that could work – is it funding the programme through grants rather than the running costs or costs per service user? Is it viable for our nature-based interventions??)

- This has proven to be financially viable but has been enabled by the presence of a proactive care farmer and an engaged individual within the CCG.

- This is the only pilot project funded by the PCT in 2010 that remains operational so has proven to be more financially viable than many alternative schemes.

### 17. Successes

*(i.e. what has worked and why?)*

- There is no formalised requirement to provide feedback to referring GPs, but, at the end of the 12-week period, GPs are sent a letter outlining outcomes / achievements. This feedback has been found to be appreciated and positively received. Indeed, maintaining such contact with GPs is presented as a critical element of their relative success at maintaining the scheme.

### 18. Challenges

*(What hasn't worked and why? Limitations?)*

- Until 2014 there were mental health link workers present at GP surgeries and the GPs used to refer patients to them to signpost to relevant activities such as this. Since these posts have been cut they are now more dependent on GPs referring directly; filling out a 2-page referral form is challenging for GPs who only have 10 minutes for each patient.

### 19. Further information

*(i.e. associated reports and where to find them; evaluations? websites; other resources?)*

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### 20. Conclusion

- Works reasonably well but labour-intensive for the care farmer; would be greatly facilitated by a link worker being available (GP – patient – care farm).

## Case Study 11 The Natural Health Service for Weymouth and Portland (NHSWP)

### 1. Name of case study and key contacts:

- The Natural Health Service for Weymouth and Portland (NHSWP)
- LiveWell Dorset: 0800 8401628 / 01305 233105

### 2. Area/ region

*(e.g. Leeds – 3 CCGs; CCG; County-wide; national scheme etc.)*

- Natural Choices is open to anyone living in Dorset (1 CCG)

### 3. What is the main purpose /key starting motivation of the initiative?

#### And who started it?

*(e.g. started by a local GP to increase non-clinical choices for patients/service users; started by public health dept. of LA to increase activity levels)*

- The NHSWP evolved from a GP led initiative. The Dorset Coast Forum set up the scheme with funding from the Dorset CCG and Dorset County Council, RSPB and the Olympic Legacy Fund.
- The intent of the Natural Choices scheme is to identify and promote activities in the local natural environment to widen the patient referral opportunities available to GPs.
- They are seeking to establish a process within the current GP referral system to include a broader range of activities and to create a standardised application form to enable new activities/outdoor offers to be added to the referral list.

### 4. How is it organised?

*(i.e. by client group (e.g. children, mental health, learning disabilities) by type of provider (e.g. consortia of nature-based interventions; providers of services for looked after children) by department, by type of needs etc.)*

- By type of provider (nature-based)

### 5. What is it and when did it start?

*(i.e. is it an online directory or a social prescribing pilot? Or something else?)*

- A service signposting people to a range of activities in the natural environment that go under the umbrella name of Natural Choices.
- Launched on the 10th June 2015.

### 6. Who is it targeting?

*(i.e. frequent GP attendees? public health? Specific medical conditions? All encompassing?)*

- Patients aged over 18 with low risk physical and mental health problems.
- Provides information, support and onward referrals for weight management, smoking cessation, physical activity and alcohol.

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**7. What directories of service providers does it have? And what form does this take?**

*(e.g. online hub of service providers; list of service providers; brokerage service)*

- Those who contact them / access their resources are provided with details of relevant activities.

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**8. What information/ accreditation / process is required to be accepted as a provider?**

*(e.g. only open to service providers registered with the LA; service providers need to be CQC approved; have to pay a joining fee; have to pass a vetting process etc.)*

- No information was found, but the LiveWell Dorset website provides a contact number for service providers who are interested in getting involved with the scheme (01305 233106).

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**9. Are any nature-based interventions currently included within the list of service-providers? If so how many? Or what proportion?**

*(i.e. some hubs have no NBIs; some just have green gyms; some are purely nature-based etc.)*

- All the activities promoted through 'Natural Choices' are nature-based activities that involve exercise outdoors. These are sailing, gardening, conservation volunteering, natural health walks, mindfulness in the natural environment

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**10. How are patients referred?**

*(i.e. What referral methods and mechanisms they currently have in place?)*

- The suite of activities is promoted amongst GPs and Pharmacies. Signposted patients are then required to contact LiveWell Dorset who then signpost them to Natural Choices.
- A specially trained wellness advisor then assesses people over the phone and provides a brief intervention designed to support healthy behaviour choices. Where required, they will offer a programme of support to help people make and sustain changes to their lifestyle and signpost them to other services.

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**11. Who is / or is able to refer to services?**

*(e.g. only GPs; nurse practitioners; health prevention teams; LAs; CMHTs; voluntary organisations; families; personal budget holder self-referral etc.)*

- GPs, pharmacies and self-referral.

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**12. What is the scale of uptake?**

*(i.e. number of referrals given by whom and to whom – e.g. 400 GP referrals and 30 LA social service referrals per year)*

- No information was found.

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**13. How are they measuring effectiveness of the services provided?**

*(What they are measuring or providing as measures of efficacy? Are they measuring success at all? – does the GP or referral agency get feedback?)*

- They have conducted research to identify people's preferences for activities and the motivations and barriers to getting involved.

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**14. Is there a recommended 'dose' or typical length of programme for people referred to these services?**

*(i.e. are they prescribed 12 week of treatment at a care farm? or is it open ended? Or a certain no of sessions?)*

- It is recommended that patients complete an initial 12 sessions.

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**15. Is there a cost to the patient? Is there funding following the patient/ service user? Who actually pays for the service?**

*(i.e. does the service provider receive direct payment from NHS or LA for the individual place at the intervention?)*

- Average costs are between £2.50 and £5 per session; It does not appear that any funding is available to meet such costs.

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**16. Conclusion about financial viability?**

*(i.e. is this a model that could work – is it funding the programme through grants rather than the running costs or costs per service user? Is it viable for our nature-based interventions??)*

- Appears to be dependent on patients self-funding.

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**17. Successes**

*(i.e. what has worked and why?)*

- No information was found.

### 18. Challenges

(What hasn't worked and why? Limitations?)

- No information was found.

### 19. Further information

(i.e. associated reports and where to find them; evaluations? websites; other resources?)

- [https://www.dorsetforyou.com/media/205848/Natural-Health-Service-Weymouth-and-Portland-Survey-Report/pdf/Natural Health Service Weymouth and Portland Survey Report.pdf](https://www.dorsetforyou.com/media/205848/Natural-Health-Service-Weymouth-and-Portland-Survey-Report/pdf/Natural%20Health%20Service%20Weymouth%20and%20Portland%20Survey%20Report.pdf)

### 20. Conclusion

- Seems a rather convoluted process that is dependent essentially upon GPs initiating referrals or individuals finding out about the service for themselves. In both instances, prospective patients are required to pursue for themselves, with this being promoted as a way of encouraging those concerned to take personal responsibility for initiating change. When I tried phoning the Natural Choices number there was no answer or opportunity to leave a message!

## Case Study 12 Well Aware, the South West

### 1. Name of case study and key contacts:

- Well Aware.
- Carmen Arnaiz (project manager) 0808 808 5252

### 2. Area/ region

(e.g. Leeds – 3 CCGs; CCG; County-wide; national scheme etc.)

- Bath and North East Somerset, Bristol, Somerset and South Gloucestershire (3 CCGs and 4 LAs).

### 3. What is the main purpose /key starting motivation of the initiative?

#### And who started it?

(e.g. started by a local GP to increase non-clinical choices for patients/service users; started by public health dept. of LA to increase activity levels)

- To enable contact between health and wellbeing service providers and users
- Four local authority partners: Bath & North East Somerset Council, Bristol City Council, South Gloucestershire Council and Somerset County Council. 3 CCG partners: Bath and North East Somerset, Bristol and South Gloucestershire.
- The lead provider is The Care Forum, a health and social care voluntary organisation providing a mixture of frontline services and support to individuals, groups and organisations.

### 4. How is it organised?

(i.e. by client group (e.g. children, mental health, learning disabilities) by type of provider (e.g. consortia of nature-based interventions; providers of services for looked after children) by department, by type of needs etc.)

- By type of intervention.

### 5. What is it and when did it start?

(i.e. is it an online directory or a social prescribing pilot? Or something else?)

- An online directory that is searched using key words.
- June 2015

### 6. Who is it targeting?

(i.e. frequent GP attendees? public health? Specific medical conditions? All encompassing?)

- All those providing or seeking health and wellbeing services.

### 7. What directories of service providers does it have? And what form does this take?

(e.g. online hub of service providers; list of service providers; brokerage service)

- The service provided is an online directory of health and wellbeing service providers and events.
- In October 2015 the directory contained the details of over 6000 organisations.
- Service providers are required to maintain their own records but they are contacted every six months to remind them of this requirement.



**8. What information/ accreditation / process is required to be accepted as a provider?**

(e.g. only open to service providers registered with the LA; service providers need to be CQC approved; have to pay a joining fee; have to pass a vetting process etc.)

- None: free to register and access. Well Aware does not vet or check those on the database but investigates complaints and deletes services if appropriate.

**9. Are any nature-based interventions currently included within the list of service-providers? If so how many? Or what proportion?**

(i.e. some hubs have no NBIs; some just have green gyms; some are purely nature-based etc.)

- Yes: searching the term 'Care farm' provides details of 21 services (including CFUK).

**10. How are patients referred?**

(i.e. What referral methods and mechanisms they currently have in place?)

- Self-referral

**11. Who is / or is able to refer to services?**

(e.g. only GPs; nurse practitioners; health prevention teams; LAs; CMHTs; voluntary organisations; families; personal budget holder self-referral etc.)

- Self-referral

**12. What is the scale of uptake?**

(i.e. number of referrals given by whom and to whom – e.g. 400 GP referrals and 30 LA social service referrals per year)

- No information was found.

**13. How are they measuring effectiveness of the services provided?**

(What they are measuring or providing as measures of efficacy? Are they measuring success at all? – does the GP or referral agency get feedback?)

- No information was found.

**14. Is there a recommended 'dose' or typical length of programme for people referred to these services?**

(i.e. are they prescribed 12 week of treatment at a care farm? or is it open ended? Or a certain no of sessions?)

- No information was found.

**15. Is there a cost to the patient? Is there funding following the patient/ service user? Who actually pays for the service?**

(i.e. does the service provider receive direct payment from NHS or LA for the individual place at the intervention?)

- Start-up funding for the Well Aware project was provided by the South West Improvement and Efficiency Partnership.
- Service users are responsible for accessing funding when selected services require it.

**16. Conclusion about financial viability?**

(i.e. is this a model that could work – is it funding the programme through grants rather than the running costs or costs per service user? Is it viable for our nature-based interventions??)

- No cost to service providers for advertising service, but no associated funding unless service user is able to access / provide this.

**17. Successes**

(i.e. what has worked and why?)

- No information was found.

**18. Challenges**

(What hasn't worked and why? Limitations?)

- No information was found.

**19. Further information**

(i.e. associated reports and where to find them; evaluations? websites; other resources?)

- Website: <http://www.wellaware.org.uk/>

**20. Conclusion**

- On-line directories such as this promote social prescribing opportunities but can only really support NBIs indirectly by helping to raise awareness of their existence amongst potential service users and others who access the resource.



## Appendix E: Programme for the social prescribing demonstration event in Leeds

### Social prescribing in Leeds: is 'Green Care' an option?

#### Programme

- ▶ 9.30 Coffee and Registration
- ▶ 10.00 Welcome and overview of the health and wellbeing benefits of green care interventions - Dr Rachel Bragg
- ▶ 10.35 Overview of social prescribing and our research - Dr Chris Leck
- ▶ 11.00 Overview of Social Prescribing in Leeds - Sharon Williams (Leeds W); Chaitan Parmar (Leeds S & E); Nat Lindo (Leeds N);
- ▶ 11.30 Coffee
- ▶ 11.55 Social prescribing, what we are looking for - Leeds facilitators' perspective - Sharon Williams (Leeds W); Chaitan Parmar (Leeds S & E); Nat Lindo (Leeds N);
- ▶ 12.20 Social prescribing, what we provide - a Leeds green care provider's perspective - John Preston, Hollybush Conservation Centre, TCV
- ▶ 12.45 Questions and comments from participants arising from the morning sessions
- ▶ 1.15 Lunch
- ▶ 2.00 Interactive session - The way forward - how to overcome barriers and fulfil needs of patients, social prescribers and green care service providers
- ▶ 3.00 Reporting back
- ▶ 3.20 Conclusions and close
- ▶ 3.30 A green care intervention - optional tour of Meanwood Valley Urban Farm

## Appendix F Social prescribing models

From a study of social prescribing in the Bristol area, Kimberlee (2013) presented four models of social prescribing:

- *Social Prescribing as Signposting* – serves *only* to direct patients to a network or organisation that may be able to support their wellbeing. GPs may refer patients to a project, or a link worker may be based at a surgery but have no formal links with GPs, and the patient is then responsible for contacting and accessing relevant services.
- *Social Prescribing Light* – at risk or vulnerable patients are directly referred to a specific programme in order to address a specific need or meet a specific objective.
- *Social Prescribing Medium* – a link worker will see referred patients and promote self-care as well as signposting them to relevant voluntary organisations or self-help groups. The initiative does not explicitly seek to address needs holistically but instead aims to address a particular need or behaviour.
- *Social Prescribing Holistic* – has the following features: a clear GP/Primary Care referral process to an external provider exists (generally taking the form of a letter, form, phone call or on-line application); a local remit and knowledge of supportive organizations and events in the area; a jointly developed, sustained intervention (between the primary care provider and the social prescribing provider); addresses patient needs holistically (they may initially be referred in relation to a specific issue but consideration is also given to wider needs); no limit to the number of sessions a patient can spend at a social prescribing project, although time parameters may be applied; whilst seeking to improve wellbeing but recognising that mental health needs will also often be present.

Holistic schemes have usually evolved over time, having been examples of light or medium initiatives previously. They work with people with long-term conditions (LTCs) who are encouraged to play a role in managing their own care and benefit from the participation of GPs who recognise the value of the service provided for meeting the needs of their patients.

Similarly, Community Action Southwark (2015) have identified three models of social prescribing activity:

- A GP refers patients directly to the organisation that will provide the intervention / service. No 'middle man' is required, and costs may therefore reduce, but busy GPs need to remain aware of relevant local community services and they may not be ideally suited to deciding that which might be most appropriate.
- A GP refers patients to a lead provider, a link worker/ facilitator then carries out an assessment with the patient and recommends an appropriate service. The lead provider liaises between health professionals and voluntary and community service providers and link workers can fully assess patient needs, agree outcomes and monitor related progress.
- A GP refers patients to one of several 'specialist' lead providers working in different areas of social commissioning such as mental health, social isolation or in managing a specific LTC. A link worker will then once again carry out an assessment with the patient and recommend an appropriate service but the management of the system is not in this case the responsibility solely of a single lead provider.

## Appendix G Organisation of social prescribing services

- The relationship between the lead provider and other service providers can be formal or informal and this can impact on the availability of outcomes data (Community Action Southwark, 2015).
- Two models with a pre-designated lead provider, had made this a formal arrangement (cs3, 5) and another had a designated lead provider but their role was to manage an online directory that patients were responsible for accessing and wherein records were maintained by service providers who were not vetted (cs12).
- Despite there not always being a formalised lead provider, there was evidence of coordinating organisation sometimes fulfilling a similar function (cs6, 11) or an organisation having been specifically developed to fulfil the social prescribing development and service delivery role (cs9).
- Social prescribing schemes were most commonly primary care-based projects referring patients to a specific programme, although many schemes were also operated by primary or secondary health care staff as signposting services that linked patients with information and support available in the voluntary and community sector (Friedli et al., 2007a).
- With regard to the larger and more generic schemes that were assessed, one had been initiated by the CCG, developed in conjunction with local practices, councils and community groups and was delivered by a service initiated for this specific purpose (cs9). Another scheme had similarly been initiated and funded by the CCG but was delivered by a consortium of local third sector organisations with an assigned lead (cs3). In another instance, the CCG were only going to provide funding for the social prescribing scheme once pre-determined outcomes had been delivered, and an organisation developed specifically for this purpose had contracted four other organisations to provide the associated link workers (cs7). One of the health centres that operated a social prescribing service were funding this through an Improved Access to Psychological Therapies (IAPT) programme that was financed via the CCG (cs8).
- Schemes that were seeking specifically to engage people with nature-based activities, did not always receive formalised input from primary care providers, despite their sometimes making referrals (cs1, 6), although one had been initiated by GPs and the signposting service itself was funded (in part) by the CCG despite the activities themselves needing to be self-funded by those referred (cs11). With regard to the schemes applying to a single green care service provider, these had both been initiated by the care farmers but they were in receipt of funding from the CCG to provide a certain number of placements (cs4 and 10). However, it is worthy of note that one of those concerned suggested that the CCG did not necessarily perceive themselves funding a social prescribing service despite it effectively operating as one (cs4).

## Appendix H. Service users

Some schemes suggested that social prescribing was particularly relevant for people dealing with certain health conditions with regard to other issues, with these sometimes being fairly generic and in other cases being more specific. These included low level physical health issues (cs10, 11), weight management, smoking cessation, alcohol and physical activity (cs11).

Other schemes were presented as all-encompassing (cs1, 2, 3, 9) despite also sometimes highlighting potentially relevant conditions such as long term conditions (LTCs), social isolation, disadvantage and vulnerability (cs9). The focus was on one occasion presented as relating to meeting currently unmet needs more broadly rather than meeting pre-defined needs (cs9). Another scheme indicated that they also engaged with those who had long-term physical health conditions but highlighted the fact that these were often accompanied by mental health and wellbeing issues (cs8). Similarly, another scheme sought only to engage with people with LTCs, but highlighted the fact that these might be accompanied by mental health issues (cs7). In one instance two additional social prescribing schemes were provided alongside the more generic scheme, with these relating solely to people with cancer or families with children aged under 5 five years (cs2).

Distinctions were on this occasion drawn between the generalist approach incorporated within their social prescribing model and that adopted by cs5 which was perceived as focusing primarily on the top 5% of patients in terms of associated primary care costs, with these tending to be those with co-morbidities (cs2). The data collected for this study supported this assertion, with those concerned always being required to have complex LTCs that had resulted in their already being high users of hospital care (cs5). Perhaps not surprisingly, the majority of referrals were in this instance reported as being elderly (cs5).

## Appendix I. Referral mechanisms and funding

In one instance, for example, 78% of referrals were made by a GP, 12% by self-referral, 6% by other practice staff and 4% from other organisations (Johnson, 2015). This was similarly found to be the case in relation to many of the case studies, with GP referrals often being sought (cs1, 5, 6, 7, 11), and sometimes being required (cs10), but with self-referral also sometimes being accepted (cs1, 3, 6, 8, 11) or referral by any surgery health worker (cs7), qualified health-care provider (cs2, 3, 6), pharmacist (cs11) or member of the Integrated Case Management Team (ICMT) (cs5). It was also suggested as potentially beneficial for surgery receptionists also to be able to make referrals to social prescribing schemes given that they will often have very different, albeit equally informative, conversations with patients (cs2). One scheme had not yet actually received any GP referrals despite their seeking such input (cs6).

With regard to the schemes provided by individual care farms, one of these enabled people who contacted them to visit and an application form was then completed with them before their GP or supporting health worker was approached to support this (cs4), whilst in the other instance GPs would complete a referral form, send this to the farm and they would then contact the individual concerned to arrange a time for them to visit the farm (cs10). In the case of one of the schemes that support only nature-based services, referrals could be made either by telephone or completion of a form and the course facilitator then contacted them directly as no link workers were available to fill this role (cs1). Although health centre social prescribing link workers might have only one meeting with a referred patient if this were sufficient, up to six sessions could be provided if deemed necessary (cs2). Both the holistic health centres were also now in receipt of funding to take referrals to their social prescribing scheme from specific neighbouring practices (cs2, 8).

There was evidence that some GP practices were utilising electronic referral forms that allowed GPs to directly and immediately refer patients to specific social prescription providing services (cs2). Furthermore, a new social prescribing scheme was described as currently being developed that would take the form of an IT programme essentially conducting an interview (in the presence of a link worker) to identify someone's level of social capital and the sort of things they value. The results would then be fed directly into a database to identify potentially relevant referral opportunities. The individual who described this scheme felt that it might be beneficial and worthy of consideration for wider implementation (cs2).

Contact with patients varies greatly, one scheme presented the following three options as being available with regard to the level of engagement between link worker and patient: phone / email detail about potentially suitable available services; a face to face meeting followed by information about potentially suitable available services; or up to six sessions with referrals to support them in actually accessing the service (cs3). In some instances, they assessed people over the phone after the patient had contacted them directly and then referred them to a service identified as potentially beneficial (cs11). Alternatively, contact could occur by telephone or face-to-face dependent on the needs of those concerned (cs3), might always take the form of a home visit (cs5) or was not specified (cs7). When the patient was responsible for initiating contact, this was presented as being intentionally applied to ensure they are engaged with what they are doing and are personally responsible for taking the first steps to initiate change (cs3, 11).

Furthermore, an investigation into social prescribing challenges conducted in association with one scheme suggested that link workers having direct contact with referrers was important for allowing them to develop a thorough understanding of the patients' needs and sought outcomes from the outset and their then making their first contact with those referred through a home visit was presented as a valuable strategy for improving engagement rates. (cs7). Some GP practices had

previously had mental health workers in attendance who had sometimes essentially operated as link workers to the benefit of less well-resourced or smaller social prescribing type schemes but these had now been removed (cs10).

Funding was sometimes provided to enable a programme's delivery, but this was allocated to deliver the specific programme rather than on the basis of numbers of participants (cs1, 6). On another occasion the funding provided related solely to the signposting service which referred people to programmes that generally required a small (£2.50 - £5) payment to then be made (cs11). With regard to health centres that actually provided services internally for patients referred to these via their social prescribing service, these were generally grant funded on a case by case (in terms of the actual service rather than the user) basis (cs2), but one was also in receipt of PBR funding to support their service provision (cs8).

Operational costs for more generic schemes were often being met with CCG funding, with this generally being provided for a 1-year period in the first instance but sometimes being extended to 3 years once it had become established and been positively evaluated (cs9). There was also evidence of schemes receiving 3 years of CCG funding from the outset (cs3) and others where funding was received on a rolling one-year contract assuming KPIs had been met (cs4).



## Appendix J. overview of the evidence base for the effectiveness of social prescribing services

Social prescribing services are generally perceived as being successful but supporting evidence is currently limited with insufficient evidence of effectiveness, impact or value for money (Friedli et al., 2007b; Langford et al., 2013; The University of York, 2015; Kimberlee, 2013). Some studies are seen as being of poor quality, involving insufficient numbers of participants, short follow up times and lacking comparability in the outcomes measured (University of York, 2015). Reports on social prescribing often refer to the same examples and that this has had the effect of suggesting a momentum for social prescribing that is not yet actually evident or evidenced (Kinsella, 2015; University of York, 2015). Nevertheless, a recent study of gardening and health that acknowledged such realities still highlighted social prescribing as a relevant and noteworthy strategy given ‘... *the knowledge that much of what determines and supports our health is rooted in social and economic factors*’ (Buck, 2016, p7).

Despite acknowledging that there are limitations in individual studies and methodological approaches, other studies (including Wilson (2015)) found the University of York review unnecessarily harsh. Wilson pointed out that standardised, quantitative measures of health and wellbeing outcomes are often applied (including the General Health Questionnaire, the Warwick-Edinburgh Mental Wellbeing Scale and the Global Quality of Life Scale), and that an increased use of cost benefit research (such as Social Return on Investment) and the value associated with complementary approaches has been incorporated in more qualitative studies.

Agreement is expressed regarding the need to collect data on patient outcomes in order to monitor financial costs and savings and the effectiveness of the social prescribing programme, with the quality of this being dependent, in part, on the feedback received by the lead service provider and the way in which this organisation applies their case management role (Community Action Southwark, 2015). Furthermore, insufficient follow-up research for 12 months after patient having left a social prescribing scheme (Kimberlee, 2013).

Relevant outcomes for social prescribing service users include an increased awareness of the sort of skills, activities and behaviours that support positive mental wellbeing, increased social networking amongst marginalised and isolated groups, reduced use of antidepressants and reduced need to visit GPs (Friedli et al., 2007a).

CCG requirements sometimes required that the social prescribing scheme delivered on a series of key performance indicators that relate to both numbers of participants and outcomes (cs4, 7). One of these schemes will receive payment on the basis of 2 pre-determined outcome measures, namely wellbeing change identified by applying the Outcomes Star and reduced secondary health care costs compared to a matched cohort (cs7). In other instances, the service provider recognises the value in providing relevant feedback to the referring GP and has proactively elected to do this (cs10). Despite no evidence always being available of outcomes being researched, one of the services that provided signposting solely to nature-based activities did indicate having researched those which were preferred and associated motivations and barriers (cs11).

An evaluation of qualitative data relating to a pilot social prescribing scheme in Bradford found the scheme was considered acceptable, relevant and appropriate by both service providers and users alike (Woodall and South, 2005). The scheme was found to have provided an effective link between primary care and the voluntary sector, with all patients interviewed identifying positive outcomes resulting from the referral.

GPs who were interviewed by Kimberlee presented the holistic social prescribing projects that they engaged with as having a positive impact on the health and wellbeing of referred patients.

### Conclusions

Social prescribing in England is still in its early stages, but early research findings are generally positive and the evidence base is expanding as new schemes are implemented and those that are already operational become better-established. Further and more sustained evaluation of schemes is required, but this is an on-going process and currently available evidence suggests that social prescribing can result in a range of positive outcomes for patients, the clinical and the third sector. These encompass improvements in patients' health and wellbeing, financial savings through reduced use of statutory health services and the potential for voluntary and community organisations to become more economically sustainable as a result of more structured integration with the clinical sector.

## Appendix K. Social Prescribing Risk Analysis (cs5)

Risk	Impact	likelihood			Response
		low	med	high	
Insufficient number of providers available with appropriate skills and acumen to deliver effective services	Inadequate range and availability of services to meet non-clinical needs of patients	*			Scoping exercise carried out prior to submission of business case.  Lead organisation to channel funding to providers to fill identified gaps in the menu of services available
Providers unable to cope with increase in referrals	Providers not able to respond to referrals within timescales. Providers stop taking new referrals		*		Demand management and contingency plans developed with each provider Additional funding available on a tariff basis to services experiencing higher than expected volumes of referrals
Providers unable to demonstrate the quality of their service provision	GPs do not make referrals due to lack of confidence in the quality of the service		*		Lead organisation checks that providers are able to demonstrate compliance with an externally validated quality assurance framework e.g. IIP, CQC registration, Supporting People QAF
Providers unable to meet information management requirements	GPs do not get effective feedback about the outcome of their referrals and stop referring to services. Lead organisation unable to comply with outcome reporting requirements.		*		Comprehensive data sets, outcome measurement tools and reporting requirements agreed at outset.  Lead organisation provides support to smaller organisations to set up and maintain information management systems
Lack of "buy in" from GPs – therapeutic value of VCS interventions not understood / GPs do not remember to refer people	Project unable to fully integrate with GP case management pilot, impacting on potential outcomes and efficiency savings.		*		Recruit GP champion(s). Ensure assessment and care planning procedures for people with LTCs include non-clinical needs, and provide training to case managers on the value and scope of social prescribing. Named care co-ordinators assigned to each practice to build trust and understanding.
Lack of „buy in“ from patients e.g. not seeing relevance of service to their needs or not having the confidence to try new activities	Patients refuse referrals to the service or fail to engage with the service / service providers selection of the menu of activities offered		*		Involve patients in the design of the care coordinator service and provide menu of interventions and information about services / examples of how patients have benefited. Recruit care co-ordinators who have advanced social and motivational skills and the ability to engage and develop relationships with clients. "Handholding service" – care co-ordinator or volunteers accompany patient to initial appointments or activities to overcome practical or anxiety barriers.
Project drift – failure to establish project within agreed timelines	Project fails to demonstrate desired outcomes / efficiency savings		*		Establish strong stakeholder steering group to maintain drive and motivation, and develop robust implementation plan with milestones to monitor progress Recruit project manager to oversee implementation of the project and provide support to smaller providers to help them establish systems/services
Difficulties finding effective ways to demonstrate outcomes that are meaningful to both people with LTCs, GPs and commissioners	Project is perceived as not achieving outcomes / sufficient efficiencies – project funding is not sustained			*	Agree evaluation framework with all stakeholders at outset NHSR/GPs will need to provide the baseline and outcomes data on patients (pre-and post-intervention) in order that commissioners can decide on the validity and cost effectiveness. Evaluation to be carried out by external party to improve validity and credibility

## Appendix L. Challenges to social prescribing

### Funding

From the breadth of social prescribing programmes evidence suggests that the most successful when they involve organisations from beyond the NHS (Langford et al., 2013).

Various funding strategies have been applied to support service providers by different social prescribing schemes, with funding coming from local authorities, CCGs, and, in the case of Newcastle, social investment (Community Action Southwark, 2015). In Rotherham, over the first two years that the service was provided, £610,597 of grants were made to 24 organisations to provide 31 different prescribing services, with this having accounted for 56% of the total project budget (Dayson and Bashir, 2014).

However, and appearing to be more commonly the case, other social prescribing schemes provided no support funding to the organisations to whom they referred (cs9) or suggested that this might be the case depending on the personal circumstances of the individual being referred (cs3) or if services became over-subscribed as a result of social prescribing (cs7).

It was also suggested that the CCG had indicated funding for actual service providers might be made available in the future if evidence demonstrated that social prescribing was yielding cash savings for NHS budgets (cs2). There was only one identified service that was able to directly fund services to provide social prescribing and also spot-purchase alternative intervention if these were judged to be more appropriate by link workers, but this service applied a risk stratification tool that resulted in the social prescribing scheme being accessible only the most intensive users of health services (cs5). In this instance, the current three-year funding for the service had been provided via the Better Care Fund (cs5).

One of those engaged with providing a social prescribing service suggested that social prescribing should be primarily about supporting vibrant and resourceful communities and that a danger of providing funding to follow individual referrals was that this might promote a silo mentality wherein they started acting effectively as gatekeepers rather than allowing the community to engage in supporting its own health and wellbeing. Nevertheless, they went on to highlight the fact that social prescribing can show gaps in what is available in the community already and that funding is sometimes needed to fill these gaps, but with this funding the service rather than being associated directly with individual referrals (cs2). He also felt that the funding for service providers associated with cs5 was helpful for the whole sector as it helped highlight the fact that the voluntary sector is often already poorly funded and may not be able to accommodate all those referred effectively and appropriately (cs2)

Appendix M. Prescribing Green Space Flyer



Prescribing Green Space - why it is important?

1 of 2

Early Deaths UK



Physical inactivity now rivals smoking as one of the nation's biggest health problems and is responsible for 17% of early deaths in the UK.

The Cost of physical inactivity:

The overall costs to the economy of physical inactivity in England are estimated to be £8.2 billion per year.<sup>1</sup> As a result the value of encouraging the people to be active is huge, simply "reducing the sedentary population by one percent could reduce both morbidity and mortality rates valued at £1.44 billion a year".<sup>2</sup>

If Central Bedfordshire encouraged 10% of its population to exercise through access to good quality green space it would save an estimated £2.9m in healthcare costs.<sup>3</sup>



GPs understand the benefits of exercise but there are barriers to prescribing it.<sup>5</sup>

What is so important about green space and its role in healthcare?

Green space has huge benefits to both physical and mental health<sup>6</sup> and also significant social benefits.<sup>7</sup>

Being in green space can improve mood and result in a decrease in blood pressure and muscle tension.<sup>8</sup>

The availability of good quality green space in a neighbourhood can lead to higher physical activity levels and people living in close proximity to good quality green spaces enjoy better health and live longer.<sup>9</sup>

Improving access and use of green space can help to reduce health inequalities in key priority health areas.<sup>10</sup>



Green space is important for prevention and for reducing rates of some chronic disease: e.g. Trees improve air quality and asthma rates in children are found to be lower when there is more tree cover.<sup>11</sup>

Exercising outdoors in natural and green spaces is more beneficial to health and wellbeing than indoor exercise.<sup>12</sup>



Physical activity can offer benefits to those receiving cancer treatments and can reduce the likelihood of recurrence breast and bowel cancer.<sup>13</sup>

How can GPs improve their patients' health through green space? - Green prescriptions

6-8 months after receiving their green prescription, 63% of patients are more active than they were before and 46% have lost weight.<sup>14</sup>



To find out more about green prescriptions contact: The Centre for Sustainable Healthcare - info@sustainablehealthcare.org.uk



www.shhsfnet.org



Prescribing Green Space - why it is important?

2 of 2

Endnotes

<sup>1</sup> Allender, S, Foster, C, Scarborough, P, Rayner, M. 2007, 'The burden of physical activity-related ill health in the UK: J. Epidemiol Community Health, 2007, 61:344 – 348' 'No change? Valuing the natural environment', Natural England 2009 -www.naturalengland.org.uk/publications

<sup>2</sup> 2005 CJK Consulting, Willis, K., Osman, L., 2005. 'Economic benefits of accessible green spaces for physical and mental health: scoping study'. Forestry Commission

<sup>3</sup> There are 4 million households in England and Wales and 264,500 households in Central Bedfordshire. If every household in England were provided with good access to quality green space it could save an estimated £2.1 billion in health care costs. If Central Bedfordshire encouraged 10% of its population to exercise through access to good quality green space it would save an estimated £2.9m in health-care costs. Taken from Natural Fit, Dr William Bird, 2004.

<sup>4</sup> Serl N. Physical inactivity and its impact on healthcare utilization. Health Econ 2009, 18:885–901.

<sup>5</sup> Research by the Mental Health Foundation found that 42% of GPs would try exercise as one of their top three strategies if they themselves became depressed but only 5% prescribe exercise to their patients. [ref (Up and Running, © Mental Health Foundation 2005)]

<sup>6</sup> Two reports, sponsored by RSPB, published in 2004 and 2007 outlined the benefits to physical and mental health arising from contact with the natural environment. These included the reductions in obesity, heart disease, diabetes, cancer, stress, ADHD, aggression and criminal activity, amongst others. Bird, W (2004) 'Natural Fit', RSPB - www.rspb.org.uk/images/natural\_fit\_full\_version\_tcm9-133055.pdf/Bird, W (2007) 'Natural Thinking', RSPB - www.rspb.org.uk/images/naturalthinking\_tcm9-161858.pdf

<sup>7</sup> Participation in a range of green exercise activities leads to significant health and social benefits. Self-esteem levels are significantly improved and feelings of anger, confusion, depression and tension all significantly improve post-activity. Pretty J, Griffin M, Peacock J, Hine R, Sellens M and South N. 2005.

<sup>8</sup> Jules Pretty, Murray Griffin, Jo Peacock, Rachel Hine, Martin Sellens and Nigel South 2005. A countryside for Health and Well-Being: The Physical and Mental Health Benefits of Green Exercise, Countryside Recreation Network

<sup>9</sup> Van den Berg, A.E., Koole, S.L., and van der Wulp, N.X. (2003). 'Environmental preferences and restoration: (how) are they related?' Journal of Environmental Psychology 23, 135-146.

<sup>10</sup> Natural solutions for tackling health inequalities Jessica Allen and Reuben Balfour UCL Institute of Health Equity

<sup>11</sup> This report includes lots of useful case studies. Natural Solutions for Tackling Health Inequalities Jessica Allen and Reuben Balfour, UCL Institute of Health Equity,

<sup>12</sup> Columbia University researchers found asthma rates among children aged four and five fell by a quarter for every additional 343 trees per square kilometre. Lovell, G., Quinn, J., Neckerman, K., Perzanowski, M. & Irande, A. (2008) 'Children living in areas with more street trees have lower prevalence of asthma.' Journal of Epidemiology & Community Health, 62(7), pp. 647-649.

<sup>13</sup> Macmillan Cancer Support (2011) The Importance of physical activity for people living with and beyond cancer: A concise evidence review

<sup>14</sup> Dose of Nature Evidence report, Dan Bloomfield 2014 <http://www.health.govt.nz/our-work/preventative-health-wellness/physical-activity/green-prescriptions/green-prescription-research/green-prescription-patient-survey>

To find out more about green prescriptions contact: The Centre for Sustainable Healthcare - info@sustainablehealthcare.org.uk