Supplementary material File 1: Programme Theory for Signposting

Table 1 - Data extraction of Context-Mechanism-Outcome (CMO) Configurations

IF	WHO?	DO WHAT	FOR WHOM?	THEN	THE RESPONSE IS	LEADING TO	WHAT OUTCOMES	FOR WHOM?	SOURCE
IF	Autism support service	Provides an autism-friendly, low-stress environment	Adults with high functioning autistic spectrum disorder (HFASD)	THEN	Adults with high functioning autistic spectrum disorder feel confident seeking/ accessing information	LEADING TO	Signposting or referral to appropriate services (face-to face, phone, e-mail etc.)	Adults with HFASD	Southby and Robinson (2018)[38]
IF	Autism support service staff and volunteers	Signpost to peer mentors	Adults with high functioning autistic spectrum disorder (HFASD)	THEN	Adults with high functioning autistic spectrum disorder share experiences, including positive aspects of autism	LEADING TO	Service users become tolerant of themselves and other people (with and without HFASD)	Adults with HFASD	Southby and Robinson (2018)[38]
IF	Care navigators	Work with key individuals in LA and manufacturers	Older people needing support at home	THEN	Care navigators and older people develop mutual trust and respect	LEADING TO	Ongoing support at home	Elderly people needing support at home	Macinnes (2020)[39]
IF	Care navigators	Work with key individuals in LA and manufacturers	Older people needing support at home	THEN	Care navigators and older people develop mutual trust and respect	LEADING TO	Ongoing support at home	Elderly people needing support at home	Macinnes (2020)[39]
IF	Care navigators working on behalf of local authorities	Employ an appropriate, holistic and transparent decision-making process	Older people needing support at home	THEN	Service providers make appropriate recommendations and telecare equipment is funded as required	LEADING TO	Ongoing support at home	Elderly people needing support at home	Macinnes (2020)[39]
IF	Care navigators working on behalf of local authorities	Employ an appropriate, holistic and transparent decision-making process	Older people needing support at home	THEN	Service providers make appropriate recommendations and telecare equipment is funded as required	LEADING TO	Ongoing support at home	Elderly people needing support at home	Macinnes (2020)[39]
IF	Communities (within an austerity climate)	Lack community activities especially befriending services	Service users	THEN	Link workers and volunteers are not able to signpost to appropriate activities				

		and transport infrastructure such as public and community transport							
IF	Link workers and volunteers	Encourage service-users to develop relationships and interactions with their family and friends, rather than focusing purely on signposting	Service-users	THEN	Service users are not impacted by barriers to signposting	LEADING TO	Service users to develop longer term strategies		
IF	Dementia advisers	Properly trained	People with dementia or their carers	THEN	Receive appropriate signposting and support	LEADING TO	Access other services, reusing service for support with filling out forms	People with dementia and/or their carers	Hibberd and Vougioukalou (2012)[28]
IF	Dementia advisers	Review action points at end of call and send out written information	People with dementia or their carers	THEN	People with dementia or their carers know they have been listened to and have written information they can refer back to or to show their carer	LEADING TO	Remember what is discussed and services suggested leading to use	People with dementia and/or their carers	Hibberd and Vougioukalou (2012)[28]
IF	Dementia advisers	Provide ongoing support by phone or face-to-face	People with dementia or their carers	THEN	People with dementia or their carers know that they are supported	LEADING TO	Confident to reuse service, ask questions, ask about services	People with dementia and/or their carers	Hibberd and Vougioukalou (2012)[28]
IF	Dementia advisers	Provide support and signposting in venue chosen by person with dementia and/or their carer	People with dementia or their carers	THEN	People with dementia or their carers feel relaxed and that separate to formal environment of Drs or memory clinic	LEADING TO	Somewhere else to access support, signposting	People with dementia and/or their carers	Hibberd and Vougioukalou (2012)[28]
IF	Dementia advisers	Provide support and signposting	People with dementia or their carers	THEN	People with dementia or their carers have information about what is available, how to access services	LEADING TO	Help with navigating care system	People with dementia and/or their carers	Hibberd and Vougioukalou (2012)[28]
IF	Dementia advisers	Properly trained	People with dementia or their carers	THEN	Receive appropriate signposting and support	LEADING TO	Access other services, reusing service for support with filling out forms	People with dementia and/or their carers	Hibberd and Vougioukalou (2012)[28]

IF	Dementia advisers	Review action points at end of call and send out written information	People with dementia or their carers	THEN	People with dementia or their carers know they have been listened to and have written information they can refer back to or to show their carer	LEADING TO	Remember what was discussed and services suggested leading to use	People with dementia and/or their carers	Hibberd and Vougioukalou (2012)[28]
IF	Dementia advisers	Provide ongoing support by phone or face-to-face	People with dementia or their carers	THEN	People with dementia or their carers Know that they are supported	LEADING TO	Confident to reuse service, ask questions, ask about services	People with dementia and/or their carers	Hibberd and Vougioukalou (2012)[28]
IF	Dementia advisers	Provide support and signposting in venue chosen by person with dementia and/or their carer	People with dementia or their carers	THEN	People with dementia or their carers feel relaxed and separate from formal environment of Drs or memory clinic	LEADING TO	Improved access to support, signposting	People with dementia and/or their carers	Hibberd and Vougioukalou (2012)[28]
IF	Dementia advisers	Provide support and signposting	People with dementia or their carers	THEN	People with dementia or their carers receive information about what is available, how to access services	LEADING TO	Help with navigating the care system	People with dementia and/or their carers	Hibberd and Vougioukalou (2012)[28]
IF	Dementia Navigators	Link to non-clinical activities facilitated by third sector organisations including signposting to relevant agencies that offer social support	service users	THEN	Not stated	LEADING TO	Service users experience enhanced community well-being and social inclusion	People with dementia	Hagan (2020)[40]
IF	Dementia Navigators	Link to non-clinical activities facilitated by third sector organisations (including signposting to relevant agencies that offer social support)	Diagnosing medical professionals	THEN	Diagnosing medical professionals respect the roles, knowledge and expertise of non-medical third sector service providers	LEADING TO	Diagnosing medical professionals being confident about social prescribing	Diagnosing medical professionals	Hagan (2020)[40]
IF	Diagnosing Medical Professionals	Lack confidence in social support services	People with dementia	THEN	reallocation of signposting to third	LEADING TO	Appropriate recognition of social support needs	People with dementia	Hagan (2020)[40]

					party, such as dementia navigator offers positive and necessary intermediary approach.		alongside medical needs		
IF	Employers of First Contact Practitioners (FCPs)	Provide suitable training	FCPs working in GP practices	THEN	FCPs deliver brief vocational advice in a single consultation	LEADING TO	Discussion of work issues/plans to improve physical functioning	Patients with musculoskeletal pain	Saunders, et al. (2022)[41]
IF	First Contact Practitioners (FCPs) working in GP practices	Identify complex issues/barriers to return to work	Patients with musculoskeletal pain	THEN	FCPs signpost or refer to alternative setting (e.g. GP or community physiotherapy)	LEADING TO	Further consultation to address identified barriers	Patients with musculoskeletal pain	Saunders, et al. (2022)[41]
IF	General Practitioners (GPs)	Signpost to physical activity	Patients who are inactive	THEN	Patients encouraged to consider non-medical approach to healthier lifestyle	LEADING TO	Appropriate use of community resources	Patients who are inactive	Brandborg, et al. (2021)[42]
IF	GPs	Signpost to physical activity	Patients who are inactive	THEN	Patients are encouraged to consider a non-medical approach to a healthier lifestyle	LEADING TO	No inappropriate use of medical resources	Patients who are inactive	Brandborg, et al. (2021)[42]
IF	GPs	Signpost to physical activity	Patients who are inactive	THEN	Patient expectations of treatment (GPs to perform examination, write prescription for medicine and/or refer to specialised diagnosing and treatment in healthcare system, not signpost to PA) are not met.	LEADING TO	Motivation for participation and engagement may be limited and be a potential barrier to social prescribing	Patients	Brandborg, et al. (2021)[42]
IF	GPs	Signpost to physical activity resources that lie beyond their control	Patients who are inactive	THEN	GPs face anxieties that the physical activities are high quality and safe	LEADING TO	Lack of uptake of social prescribing (and physical activity)	Referring GPs	Brandborg, et al. (2021)[42]

IF	GPs	Hold strong confidence that physical activities improve patient outcomes	Patients who are inactive	THEN	GPs use social prescribing (including signposting)	LEADING TO	Uptake of social prescribing (and physical activity)	Referring GPs	Brandborg, et al. (2021)[42]
IF	GPs	Have access to sufficient and appropriate resources (Physical activities)	Patients who are inactive	THEN	GPs use social prescribing	LEADING TO	Positive patient outcomes	Patients who are inactive	Brandborg, et al. (2021)[42]
IF	GPs	Identify sufficient opportunities to signpost to	Patients who are inactive	THEN	GPs use social prescribing	LEADING TO	Positive patient outcomes	Patients who are inactive	Brandborg, et al. (2021)[42]
IF	GPs	Have access to skilled link workers and volunteers	Patients who are inactive	THEN	GPs use social prescribing	LEADING TO	Positive patient outcomes	Patients who are inactive	Brandborg, et al. (2021)[42]
IF	GPs	Perceive that society stigmatises psychological and social health-issues as less accepted than biological health factors	Patients who are inactive	THEN	GPs do not signpost to physical activities	LEADING TO	Inappropriate use of medical resources	Inactive patients	Brandborg, et al. (2021)[42]
IF	Health services	Offer access to skilled link workers and volunteers	Patients who are inactive	THEN	Patients engage in physical activities	LEADING TO	Positive patient outcomes	Patients who are inactive	Brandborg, et al. (2021)[42]
IF	Health and social services	Refer people needing longer-term support or with complex needs	People suffering from or at risk of loneliness	THEN	Short-term programme may fail to signpost appropriately	LEADING TO	Wasted resources and unmet needs	Service users and link workers/volunteers	Holding, et al. (2020)[43]
IF	Health and social services	Refer people needing longer-term support or with complex needs	People suffering from or at risk of loneliness	THEN	Short-term programme may fail to signpost appropriately	LEADING TO	Wasted resources and unmet needs	Service users and link workers/volunteers	Holding, et al. (2020)[43]
IF	Health planners, decision makers, researchers, care providers and patient partners	Do a community engagement initiative to understand gaps in accessing care	People with frailty, chronic illness and mental health problems	THEN	Can develop a navigation model	LEADING TO	Help to overcome barriers to access community resources	People with frailty, chronic illness and mental health problems	Toal-Sullivan, et al. (2021)[32]

IF	Health planners, decision makers, researchers, care providers and patient partners	Develop a patient navigator training programme	Lay navigators	THEN	Can have appropriate training	LEADING TO	Deliver navigator role to help access community resources	People with frailty, chronic illness and mental health problems	Toal-Sullivan, et al. (2021)[32]
IF	Health planners, decision makers, researchers, care providers and patient partners	Undertake a community engagement initiative to understand gaps in accessing care	People with frailty, chronic illness and mental health problems	THEN	Health planners, decision makers, researchers, care providers and patient partners can develop navigation model	LEADING TO	Help to overcome barriers to access community resources	People with frailty, chronic illness and mental health problems	Toal-Sullivan, et al. (2021)[32]
IF	Health professionals	Signpost early to social care assessment	People with Parkinson's	THEN	Earlier access to good quality social care that meets their needs	LEADING TO	Improved health, quality of life and wellbeing – prevention of infections, symptom deterioration and mental health deterioration	People with Parkinson's	Tod, et al. (2016)[44]
IF	Health professionals	Signpost early to social care assessment	People with Parkinson's	THEN	Earlier access to good quality social care that meets their needs	LEADING TO	Improved health, quality of life and wellbeing – prevention of infections, symptom deterioration and mental health deterioration	People with Parkinson's	Tod, et al. (2016)[44]
IF	Healthcare organisations seeking to implement Patient Navigation Programmes (PNP)	Ensure alignment with organisational objectives; supply appropriate funding; provide multidisciplinary clinical leadership; define Patient Navigation (PN) role and workflow, training and supervision	Patient navigation programme teams	THEN	Stakeholders support implementation of a Patient Navigation Programme	LEADING TO	Successful programme establishment	Adults with complex care needs	Kokorelias, et al. (2021)[45]

IF	Healthcare organisations wishing to implement patient navigation programmes (PNP)	Add PN to care team	Adults with complex care needs	THEN	Access and adherence to treatment improve	LEADING TO	Successful care navigation	Adults with complex care needs and their family carers	Kokorelias, et al. (2021)[45]
IF	Healthcare organisations wishing to implement patient navigation programmes (PNP)	Ensure alignment with organisational objectives; supply appropriate funding; provide multidisciplinary clinical leadership; define PN role and workflow, training and supervision	Patient navigation programme teams	THEN	Stakeholders likely to support patient navigation programme implementation	LEADING TO	Successful programme establishment by patient navigation programme teams	Adults with complex care needs	Kokorelias, et al. (2021)[45]
IF	Healthcare organisations wishing to implement patient navigation programmes (PNP)	Add PN to care team	Adults with complex care needs	THEN	Access and adherence to treatment improve	LEADING TO	Successful care navigation	Adults with complex care needs and their family carers	Kokorelias, et al. (2021)[45]
IF	Lay navigator	Receive ongoing training	People referred/accessing to navigators	THEN	Lay navigator is able to support	LEADING TO	Effective signposting	People referred/accessing navigators	Valaitis, et al. (2017)[46]
IF	Lay navigator	Provide a navigator role attached to primary care practice	People with frailty, chronic illness and mental health problems	THEN	People with frailty, chronic illness and mental health problems are referred to ARC patient navigator	LEADING TO	Plan to address barriers and provide support to reach appropriate community resources	People with frailty, chronic illness and mental health problems	Toal-Sullivan, et al. (2021)[32]
IF	Lay navigator	Provide a navigator role attached to primary care practice	People with frailty, chronic illness and mental health problems	THEN	People with frailty, chronic illness and mental health problems are referred	LEADING TO	Strategies to effectively access resources for future need	People with frailty, chronic illness and mental health problems	Toal-Sullivan, et al. (2021)[32]

					to ARC patient navigator				
IF	Lay navigator	Provide navigator role attached to primary care practice	People with frailty, chronic illness and mental health problems	THEN	People with frailty, chronic illness and mental health problems are referred to ARC patient navigator	LEADING TO	Plan to address barriers and provide support to reach appropriate community resources	People with frailty, chronic illness and mental health problems	Toal-Sullivan, et al. (2021)[32]
IF	Lay navigator	Provide navigator role attached to primary care practice	People with frailty, chronic illness and mental health problems	THEN	People with frailty, chronic illness and mental health problems are referred to ARC patient navigator	LEADING TO	Strategies to effectively access resources for future need	People with frailty, chronic illness and mental health problems	Toal-Sullivan, et al. (2021)[32]
IF	Lay navigators	Provide navigation program		THEN		LEADING TO	Improvements in general health and wellbeing	Patient and caregiver	Valaitis, et al. (2017)[46] Cites Bohman 2011, Bradford 2010, Esperat 2012, Foret 2009, Gimpel 2010, Layne 2012, Linkins 2011, Wolff 2009
IF	Lay navigators	Provide navigation program		THEN		LEADING TO	Improved self-efficacy, self-management or empowerment	Patient and caregiver	Valaitis, et al. (2017)[46] Cites Bohman 2011, Mullins 2012, Natale-Pereira 2011, Spiro 2021, Tataw 2011
IF	Lay navigators	Provide navigation program		THEN		LEADING TO	Patient satisfaction with services for themselves or their children	Patient and caregiver	Valaitis, et al. (2017)[46] Cites Bohman 2011, Mullins 2012, Natale-Pereira 2011, Spiro 2021, Tataw 2011
IF	Lay navigators	Provide navigation program		THEN		LEADING TO	Access to care	Patient and caregiver	Valaitis, et al. (2017)[46] Cites Bohman 2011, Bradford 2010, Ferrante 2010, Layne 2012, McCloskey, 2009, Natale-Pereira 2011, Tataw 2011, Tejeda 2013

IF	Lay navigators	Provide navigation program		THEN		LEADING TO	Follow-up and uptake of screening	Patient and caregiver	Valaitis, et al. (2017)[46]Cites Boyd, 2008, Bradford 2010, Clark 2009, Layne 2012, Linkins 2011, Mullins 2012, Natale-Pereira 2011, Retkin 2013
IF	Lay navigators	Provide navigation program		THEN		LEADING TO	Financial, employment, and health claims addressed	Patient and caregiver	Valaitis, et al. (2017)[46] Cites Gimpel 2010, Linkins 2011, Natale-Pereira 2011, Retkin 2013
IF	Lay navigators	Provide navigation program		THEN		LEADING TO	No difference in employment, hours worked or earnings	Patient and caregiver	Valaitis, et al. (2017)[46] Cites Bohman 2011
IF	Lay navigators	Provide navigation program		THEN		LEADING TO	Non use of emergency room and/or hospital	Health system	Valaitis, et al. (2017)[46] Cites Esperat, 2012, Layne, 2012, Maeng, 2013, Pfeffer, 1995
IF	Lay navigators	Provide navigation program		THEN		LEADING TO	Prevention of premature institutionalizations	Health system	Valaitis, et al. (2017)[46] Cites Mayhew 2009
IF	Lay navigators	Provide navigation program		THEN		LEADING TO	Satisfaction with navigation programme	Navigation Programme Service Provider	Valaitis, et al. (2017)[46] Cites Foret Giddents, 2009, Mullins 2012, Spiro 2012
IF	Lay navigators	Provide navigation program		THEN		LEADING TO	Communication among primary care providers and community services or providers	Navigation programme provider	Valaitis, et al. (2017)[46] Cites Anderson 2009a, Anderson 2009b, Boyd, 2007, Mullins, 2012
IF	Lay navigators	Provide navigation program		THEN		LEADING TO	Navigators empowered in their community advocacy role and promoted in their positions	Lay navigators	Valaitis, et al. (2017)[46] Cites McCloskey 2009, Spiro 2012

IF	Lay navigators	Provide navigation program		THEN		LEADING TO	Improved care coordination	Patient and caregiver	Valaitis, et al. (2017)[46] Cites Anderson, 2009b, Retkin, 2013
IF	Lay navigators	Provide navigation program		THEN		LEADING TO	Improvements in general health and wellbeing	Patient and caregiver	Valaitis, et al. (2017)[46] Cites Bohman 2011, Bradford 2010, Esperat 2012, Foret 2009, Gimpel 2010, Layne 2012, Linkins 2011, Wolff 2009
IF	Lay navigators	Provide navigation program		THEN		LEADING TO	Improved self-efficacy, self-management or empowerment	Patient and caregiver	Valaitis, et al. (2017)[46] Cites Bohman 2011, Mullins 2012, Natale-Pereira 2011, Spiro 2021, Tataw 2011
IF	Lay navigators	Provide navigation program		THEN		LEADING TO	Patient satisfaction regarding services for themselves or their children	Patient and caregiver	Valaitis, et al. (2017)[46] Cites Bohman 2011, Mullins 2012, Natale-Pereira 2011, Spiro 2021, Tataw 2011
IF	Lay navigators	Provide navigation program		THEN		LEADING TO	Access to care	Patient and caregiver	Valaitis, et al. (2017)[46] Cites Bohman 2011, Bradford 2010, Ferrante 2010, Layne 2012, McCloskey, 2009, Natale-Pereira 2011, Tataw 2011, Tejeda 2013
IF	Lay navigators	Provide navigation program		THEN		LEADING TO	Better follow-up and uptake of screening	Patient and caregiver	Valaitis, et al. (2017)[46] Cites Boyd, 2008, Bradford 2010, Clark 2009, Layne 2012, Linkins 2011, Mullins 2012, Natale-Pereira 2011, Retkin 2013
IF	Lay navigators	Provide navigation program		THEN		LEADING TO	Financial, employment, and health claims addressed	Patient and caregiver	Valaitis, et al. (2017)[46] Cites Gimpel 2010, Linkins 2011, Natale-Pereira 2011, Retkin 2013

IF	Lay navigators	Provide navigation program		THEN		LEADING TO	No difference in employment, hours worked or earnings	Patient and caregiver	Valaitis, et al. (2017)[46] Cites Bohman 2011
IF	Lay navigators	Provide navigation program		THEN		LEADING TO	Non use of emergency room and/or hospital	Health system	Valaitis, et al. (2017)[46] Cites Esperat, 2012, Layne, 2012, Maeng, 2013, Pfeffer, 1995,
IF	Lay navigators	Provide navigation program		THEN		LEADING TO	Prevention of premature institutionalizations	Health system	Valaitis, et al. (2017)[46] Cites Mayhew 2009
IF	Lay navigators	Provide navigation program		THEN		LEADING TO	Satisfaction with navigation programme	?Navigation programme provider?	Valaitis, et al. (2017)[46] Cites Foret Giddents, 2009, Mullins 2012, Spiro 2012
IF	Lay navigators	Provide navigation program		THEN		LEADING TO	Communication among primary care providers and community services or providers	Navigation programme provider	Valaitis, et al. (2017)[46] Cites Anderson 2009a, Anderson 2009b, Boyd, 2007, Mullins, 2012
IF	Lay navigators	Provide navigation program		THEN		LEADING TO	Navigators empowered in their community advocacy role and promoted in their positions	Lay navigators	Valaitis, et al. (2017)[46] Cites McCloskey 2009, Spiro 2012
IF	Lay navigators	Provide navigation program		THEN		LEADING TO	Improved care coordination	Patient and caregiver	Valaitis, et al. (2017)[46] Cites Anderson, 2009b, Retkin, 2013
	Link worker	Uses skills and knowledge to act as a catalyst for change	People with 'non-medical' needs	THEN	Patients change mindset	LEADING TO	Willingness to consider new things	People with 'non-medical' needs	Tierney, et al. (2020)[47]
	Link worker	Support and encourage patient to develop social connections/activities	People with 'non-medical' needs	THEN	Patients gain confidence and resilience	LEADING TO	Patients feel able to cope with life	People with 'non-medical' needs	Tierney, et al. (2020)[47]

	Link worker	Creates an atmosphere conducive to patients discussing their needs	Patients with significant physical and/or psychosocial difficulties	THEN	Patients experience emotional relief	LEADING TO	Ongoing need for support due to nature of problems	Patients with significant physical and/or psychosocial difficulties	Tierney, et al. (2020)[47]
	Link worker	Creates atmosphere conducive to patients discussing their needs	People with 'non-medical' needs	THEN	Patients raise previously undisclosed issues	LEADING TO	Possible need for referral to GP or other HCP	People with 'non-medical' needs	Tierney, et al. (2020)[47]
	Link worker	Creates an atmosphere conducive to patients discussing their needs	People with 'non-medical' needs	THEN	Patient may become dependent on seeing link worker	LEADING TO	Possible need for referral back to GP when sessions end	People with 'non-medical' needs	Tierney, et al. (2020)[47]
IF	Link worker	Support and encourage patient to develop social connections/activities	People with 'non-medical' needs	THEN	Patients see range of possible solutions to their problems	LEADING TO	Patients don't see GP as first point of call	People with 'non-medical' needs	Tierney, et al. (2020)[47]
IF	Link workers	Tailor national social prescribing programme to local context	People suffering from or at risk of loneliness	THEN	People able to engage with suggested activities	LEADING TO	Social activity	People suffering from or at risk of loneliness	Holding, et al. (2020)[43]
IF	Link workers	Identify need for longer-term support	People suffering from or at risk of loneliness	THEN	Support may extend short-term signposting (e.g. befriending)	LEADING TO	People don't feel unsupported after end of programme	People suffering from or at risk of loneliness who need longer-term support	Holding, et al. (2020)[43]
IF	Link workers	Tailor national social prescribing programme to local context	People suffering from or at risk of loneliness	THEN	People suffering from or at risk of loneliness able to engage with suggested activities	LEADING TO	Social activity	People suffering from or at risk of loneliness	Holding, et al. (2020)[43]
IF	Link workers	Identify need for longer-term support	People suffering from or at risk of loneliness	THEN	Support may extend beyond short-term signposting (e.g. befriending)	LEADING TO	People don't feel unsupported after end of programme	People suffering from or at risk of loneliness who need longer-term support	Holding, et al. (2020)[43]
IF	Link workers and volunteers	Adopt person-centred approach (empathetic, not making assumptions, having time)	People suffering from or at risk of loneliness	THEN	People suffering from or at risk of loneliness able to engage with suggested activities	LEADING TO	Volume of activity (people referred in and signposted out)	People suffering from or at risk of loneliness	Holding, et al. (2020)[43]

IF	Link workers and volunteers	Adopt person-centred approach (empathetic, not making assumptions, having time)	People suffering from or at risk of loneliness	THEN	People suffering from or at risk of loneliness able to engage with suggested activities	LEADING TO	Volume of activity (people referred in and signposted out)	People suffering from or at risk of loneliness	Holding, et al. (2020)[43]
IF	Local authorities and equipment manufacturers	Provide appropriate training and support	Care navigators	THEN	Appropriate recommendations are made and telecare equipment funded as required	LEADING TO	Ongoing support at home	Elderly people needing support at home	Macinnes (2020)[39]
IF	Local communities and authorities	Support local infrastructure and services, especially transport	People suffering from or at risk of loneliness	THEN	People suffering from or at risk of loneliness able to engage with suggested activities	LEADING TO	Sustainable social activity	People suffering from or at risk of loneliness	Holding, et al. (2020)[43]
IF	Male lay navigators	Provide cancer navigation program	Female breast cancer patients	THEN		LEADING TO	Discomfort with male navigators for female breast cancer care, lack of care continuity and poor navigator follow up	Female breast cancer patients	Valaitis, et al. (2017)[46] Cited: Carroll 2010
IF	Nurse navigators	Act as a 'bridge' between general practice and broader health service	Patients with chronic conditions	THEN	Patients offered co-ordinated multidisciplinary care	LEADING TO	Enhanced access to care responsive to their needs	Patients	McMurray, et al. (2018)[48]
IF	Non-indigenous (immigrant) health care users unfamiliar with organisation of health services	Receive education from trained staff about their health conditions [Health Belief Model]	Immigrants with health conditions	THEN	Patients able to manage their own condition	LEADING TO	Appropriate use of health services	Patients	Dominguez Jr (2017)[49]
IF	Non-indigenous (immigrant) health care users unfamiliar with organisation of health services	Believe that they can change their health behaviours [Health Belief Model]	Immigrants with health conditions	THEN	Patients accept being signposted to primary care provider or urgent care, or navigation to community resource	LEADING TO	Non-utilization of emergency care services	Patients	Dominguez Jr (2017)[49]

IF	Nurse navigators	Promote health literacy though evidence/data-informed discussions	Patients with chronic conditions	THEN	Health literacy	LEADING TO	Ability to make health-related decisions	Patients	McMurray, et al. (2018)[48]
IF	Nurse navigators	Undertake holistic risk assessments and care plan reviews	Patients with chronic conditions	THEN	Proactive response possible without need for GP appointment	LEADING TO	Timely referrals to community services	Patients	McMurray, et al. (2018)[48]
IF	Nurse navigators (Australia)	Refer to under-used programmes	Patients with chronic conditions	THEN	Practice nurses become aware of patient problems	LEADING TO	Referrals to community services	Patients	McMurray, et al. (2018)[48]
IF	Nurse navigators (Australia; Gold Coast Integrated Care Programme)	Navigate patients through care transitions	Patients with complex and co-morbid conditions	THEN	Patients with complex and co-morbid conditions receive adequate referrals and brokerage services	LEADING TO	Timely, effective, adequate and patient-centred care	Patients	Cooper, et al. (2017)[50]
IF	Older people	Are signposted to activities that they find *personally meaningful* (person-centredness)	Older people	THEN	Older people find signposting and accompaniment to the first meeting acceptable	LEADING TO	Uptake of signposting services	Older people with anxiety or depression	Burroughs, et al. (2019)[25]
IF	Older people with anxiety or depression	Are signposted to activities that they consider unsuitable or inappropriate	Older people	THEN	Older people do not find signposting and being accompanied to the first meeting acceptable	LEADING TO	Non-utilization of signposting services	Older people with anxiety or depression	Burroughs, et al. (2019)[25]
IF	Older people with anxiety or depression	Are signposted to activities where they feel they are 'passive recipients' of a service	Older people	THEN	Older people do not find signposting and being accompanied to the first meeting acceptable	LEADING TO	Non-utilization of signposting services	Older people with anxiety or depression	Burroughs, et al. (2019)[25]
IF	Older people with anxiety or depression	Are signposted to activities when they do not feel that loneliness or social isolation are problems for them	Older people	THEN	Older people do not find signposting and accompaniment to the first meeting acceptable	LEADING TO	Non-utilization of signposting services	Older people with anxiety or depression	Burroughs, et al. (2019)[25]
IF	Older people	Engage with services, activities and supports to which people are typically signposted	Older people	THEN	Older people benefit from those services (e.g. creative activities, lifelong learning, befriending,	LEADING TO	Health and wellbeing benefits	Older people	Bauer, et al. (2019)[51]. Cites systematic review in support of NICE guideline.

					volunteering and peer support etc)				
IF	Older people	Engage with the services, activities and supports to which people are typically signposted	Older people	THEN	Older people benefit from those services (e.g. creative activities, lifelong learning, befriending, volunteering and peer support etc	LEADING TO	Health and wellbeing benefits	Older people	Bauer, et al. (2019)[51]. Cites systematic review in support of NICE guideline.
IF	Older adults with anxiety and depression	Are signposted to groups (e.g. computer classes, art groups, 'Men in Sheds', walking groups)	Older people	THEN	Older people do not feel anxious, depressed or socially isolated	LEADING TO	Not stated		Burroughs, et al. (2019)[25]
IF	Older adults with anxiety and depression	Are signposted to other activities (e.g. swimming, walking, bowls)	Older people	THEN	Older people do not feel anxious, depressed or socially isolated	LEADING TO	Not stated		Burroughs, et al. (2019)[25]
IF	Other health and care professionals	Lack understanding of care navigator role and eligibility for funding	Care navigators	THEN	Conflict and loss of trust may arise	LEADING TO	Delayed/prevented access to services	Elderly people needing support at home	MacInnes (2020)[39]
IF	Other health and care professionals	Lack understanding of care navigator role and eligibility for funding	Care navigators	THEN	Conflict and loss of trust may arise	LEADING TO	Delayed/prevented access to services	Elderly people needing support at home	MacInnes (2020)[39]
IF	Paediatricians and other child healthcare providers	Provide information on how to assess and treat illness (especially fever and vomiting), determine illness severity and navigate health system	First-time parents of young children	THEN	First-time parents of young children acquire health literacy	LEADING TO	No more unnecessary emergency department visits	Children with mild acute illness and their parents	May, et al. (2018)[52]
IF	Paediatricians and other child healthcare providers	Provide information on how to assess and treat illness (especially fever and vomiting), determine illness severity and navigate health system	First-time parents of young children	THEN	First-time parents of young children acquire health literacy	LEADING TO	No more unnecessary emergency department visits	Children with mild acute illness and their parents	May, et al. (2018)[52]

IF	Paid link workers alongside volunteers	Develop supportive relationship, assess user needs and provide person-tailored care	Service-users	THEN	Service-users feel confident to socialise and to access appropriate community activities and services (via signposting)	LEADING TO	Utilisation of craft groups, adult learning and leisure facilities	Service-users	Foster, et al. (2021)[15]
IF	Paid link workers alongside volunteers	Spend time developing relationships with statutory and third sector partners	Paid link workers and volunteers	THEN	Paid link workers and volunteers feel able to encourage referrals and identify signposting opportunities.	LEADING TO	Utilisation of craft groups, adult learning and leisure facilities	Service-users	Foster, et al. (2021)[15]
IF	Patient navigators	Communicate appropriately with patients	Adults with complex care needs	THEN	Mutual trust and respect develop	LEADING TO	Successful care navigation	Adults with complex care needs	Kokorelias, et al. (2021)[45]
IF	Patient navigators	Communicate appropriately with patients	Adults with complex care needs	THEN	Mutual trust and respect develop	LEADING TO	Successful care navigation	Adults with complex care needs	Kokorelias, et al. (2021)[45]
IF	Patients being offered physical activity interventions	Perceive that society stigmatises psychological and social health-issues as less accepted by than biological health factors	Patients	THEN	Patients do not participate in social prescribing	LEADING TO	Inappropriate use of medical resources	Inactive patients	Brandborg, et al. (2021)[42]
IF	Patients taking part in community-based physical activity intervention grounded in motivational interviewing	Receive signposting to local PA provision	Patients	THEN	<Mechanism>	LEADING TO	Engagement in physical activity	Patients	Wade, et al. (2021)[53]
IF	Patients taking part in community-based physical activity	Receive signposting to local PA provision	Patients	THEN	<Mechanism>	LEADING TO	Mental well-being	Patients	Wade, et al. (2021)[53]

	intervention grounded in motivational interviewing								
IF	Patients taking part in community-based physical activity intervention grounded in motivational interviewing	Receive signposting to local PA provision	Patients	THEN	<Mechanism>	LEADING TO	Retention at 6 and 12 months compared to social action group	Patients	Wade, et al. (2021)[53]
IF	Patients taking part in community-based physical activity intervention grounded in motivational interviewing	Receive signposting to local PA provision and social action (weekly group support)	Patients	THEN	<Mechanism>	LEADING TO	Physical activity greater for moderate PA than signposting alone	Patients	Wade, et al. (2021)[53]
IF	Patients taking part in community-based physical activity intervention grounded in motivational interviewing	Receive signposting to local PA provision and social action (weekly group support)	Patients	THEN	<Mechanism>	LEADING TO	Improved mental wellbeing	Patients	Wade, et al. (2021)[53]
IF	Patients taking part in community-based physical activity intervention grounded in motivational interviewing	Receive signposting to local PA provision	Patients	THEN	<Mechanism>	LEADING TO	Physical activity	Patients	Wade, et al. (2021)[53]

IF	Patients taking part in community-based physical activity intervention grounded in motivational interviewing	Receive signposting to local PA provision	Patients	THEN	<Mechanism>	LEADING TO	Improved mental well-being	Patients	Wade, et al. (2021)[53]
IF	Patients with chronic and complex health needs (e.g. palliative care)	Receive greater clarity and signposting of services	Patients	THEN	Do not experience lack of continuity of care and stress of accessing different services	LEADING TO	Avoidance of heavy burden of continually having to explain, plan and coordinate their care	Patients with chronic and complex health needs	Green, et al. (2019)[54]
IF	Patients with chronic and complex health needs (e.g. palliative care)	Receive greater clarity and signposting of services	Patients	THEN	Patients experience continuity of care and better communication across services	LEADING TO	Appropriate decisions about when (and when not) to seek emergency care.	Patients with chronic and complex health needs	Green, et al. (2019)[54]
IF	People with dementia and/or their carers	Receive instant phone advice and support from trained dementia advisers	People with dementia and/or their carers	THEN	People with dementia and/or their carers know that someone on the other end of the phone knows what they are talking about and listens to them	LEADING TO	Confidence to reuse service, ask questions feel supported etc,	People with dementia and/or their carers	Hibberd and Vougioukalou (2012)[28]
IF	People with dementia and/or their carers	Receive instant phone advice and support from trained dementia advisers	People with dementia and/or their carers	THEN	People with dementia and/or their carers know that there is someone on the other end of the phone who knows what they are talking about and listens to them	LEADING TO	Confidence to reuse service, ask questions feel supported etc,	People with dementia and/or their carers	Hibberd and Vougioukalou (2012)[28]
IF	People with dementia or their carers	Receive phone advice and support from trained dementia advisers	People with dementia and their carers	THEN	People with dementia and/or their carers know that there is somewhere that they	LEADING TO	Confidence to reuse service, ask questions, feel supported etc	People with dementia and/or their carers	Hibberd and Vougioukalou (2012)[28]

					can get help and support (compare services that use answerphones which for hearing or cognitive problems can be off-putting and difficult to access)				
IF	People with dementia or their carers	Receive signposting from trained dementia advisers	People with dementia or their carers	THEN	People with dementia or their carers know about services – local clubs and activities	LEADING TO	Access local clubs and activities	People with dementia and/or their carers	Hibberd and Vougioukalou (2012)[28]
IF	People with dementia or their carers	Receive phone advice and support from trained dementia advisers	People with dementia and their carers	THEN	People with dementia or their carers know that there is somewhere that they can get help and support (compare services that use answerphones which for hearing or cognitive problems are off-putting and difficult to access)	LEADING TO	Confidence to reuse service, ask questions, feel supported etc	People with dementia and/or their carers	Hibberd and Vougioukalou (2012)[28]
IF	People with dementia or their carers	Receive signposting from trained dementia advisers	People with dementia or their carers	THEN	People with dementia or their carers know about services – local clubs and activities	LEADING TO	Access local clubs and activities	People with dementia and/or their carers	Hibberd and Vougioukalou (2012)[28]
IF	People with dementia	Are signposted by specialist services such as memory clinics to community support initiatives	People with dementia	THEN	People with dementia view these services as valuable	LEADING TO	Appropriate utilization of medical resources	People with dementia	Hagan (2020)[40]
IF	People with dementia	Are signposted by dedicated and sensitive project workers who facilitate referrals to social support	People with dementia	THEN	Diagnosing Medical Professionals do not have to spend time on referrals to social support	LEADING TO	Appropriate utilization of medical resources	People with dementia	Hagan (2020)[40]

IF	Receptionists or other GP surgery staff	Provide information about local sources of help	Patients	THEN	Patients feel confident and able to act on information	LEADING TO	Patients find their own way to services	Patients with confidence/ability to respond to brief intervention	Tierney, et al. (2020)[47], citing NHS England (2019)
IF	Service commissioners	consider social prescribing in wider context of funding community activities including befriending services and transport	Service users	THEN	Service users engage with signposting opportunities.	LEADING TO	Not stated		Foster, et al. (2021)[15]
IF	Service users	Face barriers to accessing signposting opportunities including mobility issues, not being able to afford to attend activities, limited public transport and lack of community activities	Service users	THEN	Service users are not able to act upon signposting received	LEADING TO	Non-utilisation of non-medical services		Foster, et al. (2021)[15]
IF	Signposting services	Are delivered in a resource-poor geographical location	People with dementia	THEN	People with Dementia experience delays between diagnosis and receipt of services	LEADING TO	Impaired ability to benefit from referral		Hagam (2020)Hagan (2020)
IF	Social prescribing link worker	Creates atmosphere conducive to patients discussing their needs	People with 'non-medical' needs	THEN	Patients feel comfortable, valued and listened to	LEADING TO	Willingness to talk openly	People with 'non-medical' needs	Tierney, et al. (2020)[47]
IF	Staff in GP Surgeries, Shopping Centres and Libraries	Signpost to diverse statutory and voluntary sector activities and support	Potentially isolated older individuals	THEN	Older individuals do not feel socially isolated and lonely (By the signposting? By the resources they subsequently access?)	LEADING TO	Improved Mental Well-being	Older People	Bauer, et al. (2019)[51]
IF	Staff in GP Surgeries, Shopping	Signpost to diverse statutory and voluntary sector activities and support	Potentially isolated older individuals	THEN	Older individuals do not feel socially isolated and lonely	LEADING TO	Greater Independence	Older People	Bauer, et al. (2019)[51]

	Centres and Libraries				(By the signposting? By the resources they subsequently access?)				
IF	Staff in GP Surgeries, Shopping Centres and Libraries	Signpost to diverse statutory and voluntary sector activities and support	Potentially isolated older individuals	THEN	Potentially isolated older individuals do not feel a need to use primary or secondary care services: Reduced GP and GP nurse contacts, risk of hospital presenting self-harm, and avoidance of psychological therapy to treat depression.	LEADING TO	Return On Investment [Number of individuals contributing time as volunteers]	Commissioners of Services	[51] Cites McDaid et al (2017) Age UK Cornwall (2014) and Windle et al (2016)
IF	Staff in GP Surgeries, Shopping Centres and Libraries	Signpost to diverse statutory and voluntary sector activities and support	Potentially isolated older individuals	THEN	Potentially isolated older individuals experience acceptable physical health and cognition	LEADING TO	Non use of primary or secondary care services:	Commissioners of Services	Bauer, et al. (2019)[51]. Cites McDaid et al (2017)
IF	Staff in GP Surgeries, Shopping Centres and Libraries	Assess the person's situation, wishes, preferences and interests	All [but including potentially isolated older individuals	THEN	<Mechanism> (Possibly "feel receiving individualised or personalised care")	LEADING TO	No social isolation and loneliness	All [Older people]	Bauer, et al. (2019)[51]
IF	Staff in GP Surgeries, Shopping Centres and Libraries	Provide free information about locally available services and support options	Potentially isolated older individuals	THEN	Potentially isolated older individuals feel that services and support are readily available	LEADING TO	(Service utilisation)	(Local services)	Bauer, et al. (2019)[51]
IF	Staff in GP Surgeries, Shopping Centres and Libraries	Provide emotional support	Potentially isolated older individuals	THEN	Potentially isolated older individuals feel confident and motivated about seeking support	LEADING TO	(Repeat use}	(Signposting services)	Bauer, et al. (2019)[51]
IF	Staff in GP Surgeries, Shopping Centres and Libraries	Signpost to diverse statutory and voluntary sector activities and support	Potentially isolated older individuals	THEN	Potentially isolated older individuals feel that (practical) barriers that prevent them from accessing	LEADING TO	(Service utilisation)	(Local services)	Bauer, et al. (2019)[51]

					services and support have been removed.				
IF	Staff in GP Surgeries, Shopping Centres and Libraries	Signpost to diverse statutory and voluntary sector activities and support	Potentially isolated older individuals	THEN	Potentially isolated older individuals do not feel socially isolated and lonely (By the signposting? By the resources they subsequently access?)	LEADING TO	Improved Mental Well-being	Older People	Bauer, et al. (2019)[51]
IF	Staff in GP Surgeries, Shopping Centres and Libraries	Signpost to diverse statutory and voluntary sector activities and support	Potentially isolated older individuals	THEN	Potentially isolated older individuals do not feel socially isolated and lonely (By the signposting? By the resources they subsequently access?)	LEADING TO	Greater Independence	Older People	Bauer, et al. (2019)[51]
IF	Staff in GP Surgeries, Shopping Centres and Libraries	Signpost to diverse statutory and voluntary sector activities and support	Potentially isolated older individuals	THEN	Potentially isolated older individuals do not feel need to use primary or secondary care services: Reduced GP and GP nurse contacts, risk of hospital presenting self-harm, and avoidance of psychological therapy to treat depression.	LEADING TO	Return On Investment [number of individuals contributing time as volunteers]	Commissioners of Services	Bauer, et al. (2019)[51] Cites McDaid et al (2017) Age UK Cornwall and Windle et al (2016)
IF	Staff in GP Surgeries, Shopping Centres and Libraries	Signpost to diverse statutory and voluntary sector activities and support	Potentially isolated older individuals	THEN	Potentially isolated older individuals experience good physical health and cognition	LEADING TO	Non use of primary or secondary care services:	Commissioners of Services	Bauer, et al. (2019)[51] Cites McDaid et al (2017)
IF	Staff in GP Surgeries, Shopping Centres and Libraries	Assess older individuals' situation, wishes, preferences and interests	All [but including potentially isolated older individuals	THEN	<Mechanism> (Possibly "feel receiving individualised or personalised care")	LEADING TO	No further social isolation and loneliness	All [Older people]	Bauer, et al. (2019)[51]

IF	Staff in GP Surgeries, Shopping Centres and Libraries	Provide free information about locally available services and support options	Potentially isolated older individuals	THEN	Potentially isolated older individuals feel that services and support are readily available	LEADING TO	Utilisation of services	(Local services)	Bauer, et al. (2019)[51]
IF	Staff in GP Surgeries, Shopping Centres and Libraries	Provide emotional support	Potentially isolated older individuals	THEN	Potentially isolated older individuals feel confident and motivated about seeking support	LEADING TO	(Repeat use)	(Signposting services)	Bauer, et al. (2019)[51]
IF	Staff in GP Surgeries, Shopping Centres and Libraries	Signpost to diverse statutory and voluntary sector activities and support	Potentially isolated older individuals	THEN	Older individuals feel that (practical) barriers that prevent them from accessing services and support have been removed.	LEADING TO	Utilisation of services	(Local services)	Bauer, et al. (2019)[51]
IF	Statutory agencies	Discourage establishing of support groups or see them as lesser priority	People with dementia	THEN	UK and NI guidance that states benefits of signposting to supportive community or voluntary services is not being enacted	LEADING TO	Missed opportunities to improve the lived experience of those diagnosed	Persons with dementia	Hagan 2020[40]
IF	Support workers (recruited from local Age UK)	Signpost to third-sector group activities	Older adults with anxiety and depression	THEN	Older adults do not respond positively	LEADING TO	Non-uptake of group activities.	Older adults	Burroughs, et al. (2019)[25]
IF	Support workers (recruited from local Age UK)	Signpost to third-sector group activities	Older men with anxiety and depression	THEN	Older men do not want to be passive recipients of services preferring a reciprocal relationship	LEADING TO	Non-uptake of group activities.	Older men	Burroughs, et al. (2019)[25]
IF	Support workers (recruited from local Age UK)	Receive training and a manual	Support workers	THEN	Support workers deliver support with fidelity	LEADING TO	Likelihood that support workers signpost to third sector resources	Support workers	Burroughs, et al. (2019)[25]
IF	Support workers	Accompany on first visit to third-sector group activity	Older adults with anxiety and depression	THEN	Older adults do not feel social isolation	LEADING TO	No anxiety and depression	Older adults	Burroughs, et al. (2019)[25]

	(recruited from local Age UK)								
IF	Trained volunteers	Provide signposting and navigation	Older adults	THEN	<Mechanism>	LEADING TO	Short-term improved mental health	Older adults	Bauer, et al. (2019)[51] Cites Greaves & Farbus (2006) and Dickens et al (2011)
IF	Trained volunteers	Provide signposting and navigation	Older adults	THEN	<Mechanism>	LEADING TO	Access of social support	Older adults	Bauer, et al. (2019)[51]
IF	Trained volunteers	Provide signposting and navigation	Older adults	THEN	<Mechanism>	LEADING TO	Short-term improved mental health	Older adults	Bauer, et al. (2019)[51] Cites Greaves & Farbus (2006) and Dickens et al (2011)
IF	Trained volunteers	Provide signposting and navigation	Older adults	THEN	<Mechanism>	LEADING TO	Access to social support	Older adults	Bauer, et al. (2019)[51]
IF	Trusted GP or other HCP	Provides clear information about link worker service	People with 'non-medical' needs	THEN	Patients believe service may be worthwhile	LEADING TO	Willingness to engage with link worker	People with 'non-medical' needs	Tierney, et al. (2020) [47]
IF	Volunteers	Deliver signposting services alongside paid link workers	Volunteers	THEN	Volunteers are surprised by how much is required	LEADING TO	Volunteers not being able to fulfil their role and link workers having to do proportionately more.	Volunteers	Foster, et al. (2021)[15]
IF	Volunteers	Provide signposting in the person's home or other easily accessed settings	Potentially isolated older individuals	THEN	Potentially isolated older individuals feel that services and support are readily available	LEADING TO	(Service utilisation)	(Local services)	Bauer, et al. (2019)[51]
IF	Volunteers	Provide signposting in the person's home or other easily accessed settings	Potentially isolated older individuals	THEN	Potentially isolated older individuals feel that services and support are readily available	LEADING TO	(Service utilisation)	(Local services)	Bauer, et al. (2019)[51]