Social Prescribing

MONTHLY REPORT

AUGUST 2025

Working in partnership in East Lancashire

BURNLEY PENDLE & ROSSENDALE COUNCIL FOR VOLUNTARY SERVICE
Registered Charity Number: 1062446 Company Limited By Guarantee: 3328219

Lancashire County Council

NHS Lancashire and South Cumbria Integrated Care Board

CVS HYNDBURN & RIBBLE VALLEY Community Voluntary Support

Social Prescribing is a person-centred, holistic approach to health and wellbeing that connects individuals to non-clinical sources of support within their community.

What is Social Prescribing?

Social prescribing offers a way to access non-medical support within the wider community. It connects people with local services, groups, and activities that help address emotional, social, and practical challenges recognising that issues like loneliness, housing problems, or financial stress can all affect our health and wellbeing.
Referrals are open to everyone and can come from schools, councils, health and care professionals or you can refer yourself.
Social prescribing can help people to:

- Build confidence and reduce feelings of isolation
- Manage mild to moderate mental health needs
- Access community services and peer support
- Take part in volunteering, training, or employment
- Improve quality of life and regain independence

By addressing the broader factors that influence health, social prescribing works alongside traditional medical care. It reduces pressure on NHS services, provides early intervention, and empowers individuals to take greater control of their wellbeing.

In East Lancashire, BPRCVS and HRVCVS deliver high-quality social prescribing in partnership with Primary Care Networks (PCNs), the voluntary sector, and other local partners. This work is supported by Integrated Care Board (ICB) and Lancashire County Council Adult Social Care (LCC ASC) funding, and relies on the strength and diversity of our local community groups.

18,733

Total number of referrals since commencement.

Includes HRVCVS figures from Jan 2020 to March 2020 and again from March 2022 excluding May 2022.

7,212,205

Approximate saving in GP appointment costs

Average GP = £64 per patient per 10-minute face to face appointment.
Average 6 visits per patient = £385 x 18,733
NB: this is GP time only taken from https://www.pssru.ac.uk/pub/uc/uc2020/2-communityhcstaff.pdf and does not take into account all other NHS services, other statutory services, etc.

224,796

Hours of SP Support

(Average of 2 hours per session x 6 sessions x 18,733

Photo - Park Social

Meet The Team!

Lynne Hargreaves-Walker

Health & Wellbeing Programme Manager

Burnley

Louise Howorth
Full time SPLW (BE)

Vicky Ogretmen
Full time SPLW (BE)

Lois Metcalfe
Full time SPLW (BE)

Christina Howarth
Social Connector

Vacant
Social Connector

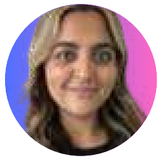
Joanne Green
Social Connector

Pendle

James Smith
SP Linkworker (PE)

Amy Whitham
SP Linkworker(PW)

Zoe Brown
SP Linkworker(PW)



Ummul Fayyaz
SP Linkworker (PW)

Pam Bailiff
SP Linkworker (PE)

Farrah Rafiq
Social Connector

Rebecca Hayworth
Social Connector

John Verity
Social Connector

Rossendale

Mandy Richardson
Social Connector

Jonathan Sheriff
Social Connector

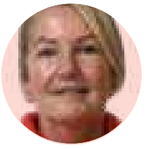
Julie Heywood
Social Connector

Hyndburn & Ribble Valley

Susie Edwards
Social Prescribing Lead

Alison McGruer
Community Lead

Tracey Jones
Social Prescribing Linkworker



Shereen Gregory
Social Prescribing Linkworker

Fiona Bradley
Green Social Connector

Dorothy Parsons
Project Support

Zoe Yates
Social Prescribing Linkworker

Maria Malik
Social Prescribing Linkworker

Chelle Simpson
Social Prescribing Linkworker

Ian Targett
Social Prescribing Linkworker

Julie Mallinder-Smith
Social Prescribing Linkworker

Group Support & Funding Team

Heather Starkie
Funding Co-ordinator

Tracey Noon
Operations Manager

Julie Overson
Project Support

Children & Young People Team

Sammie Taylor
SPLW – C&YP (PW)

Sylvia Pickles
SPLW – C&YP (PE)

Burnley

723

Referrals so far this year

22

New Connector Referrals

27

Closed Connector Cases

27

Current/Active Connector Cases

58

New Linkworker Referrals

61

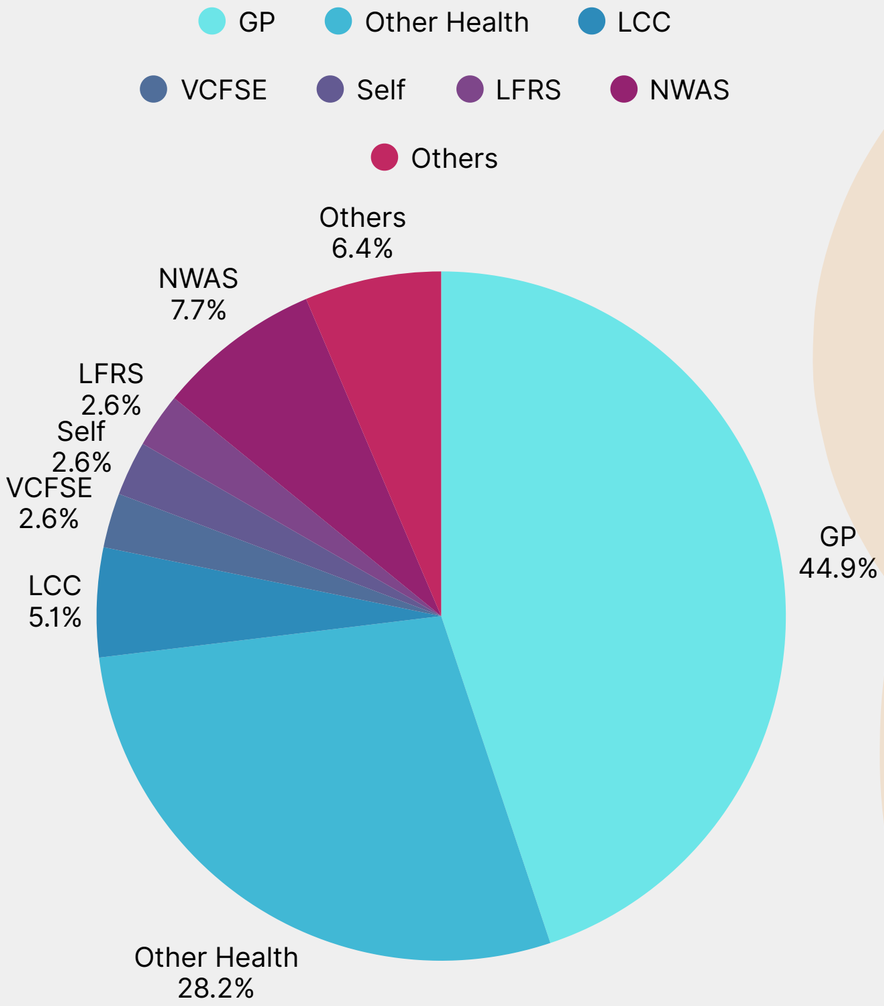
Closed Linkworker Cases

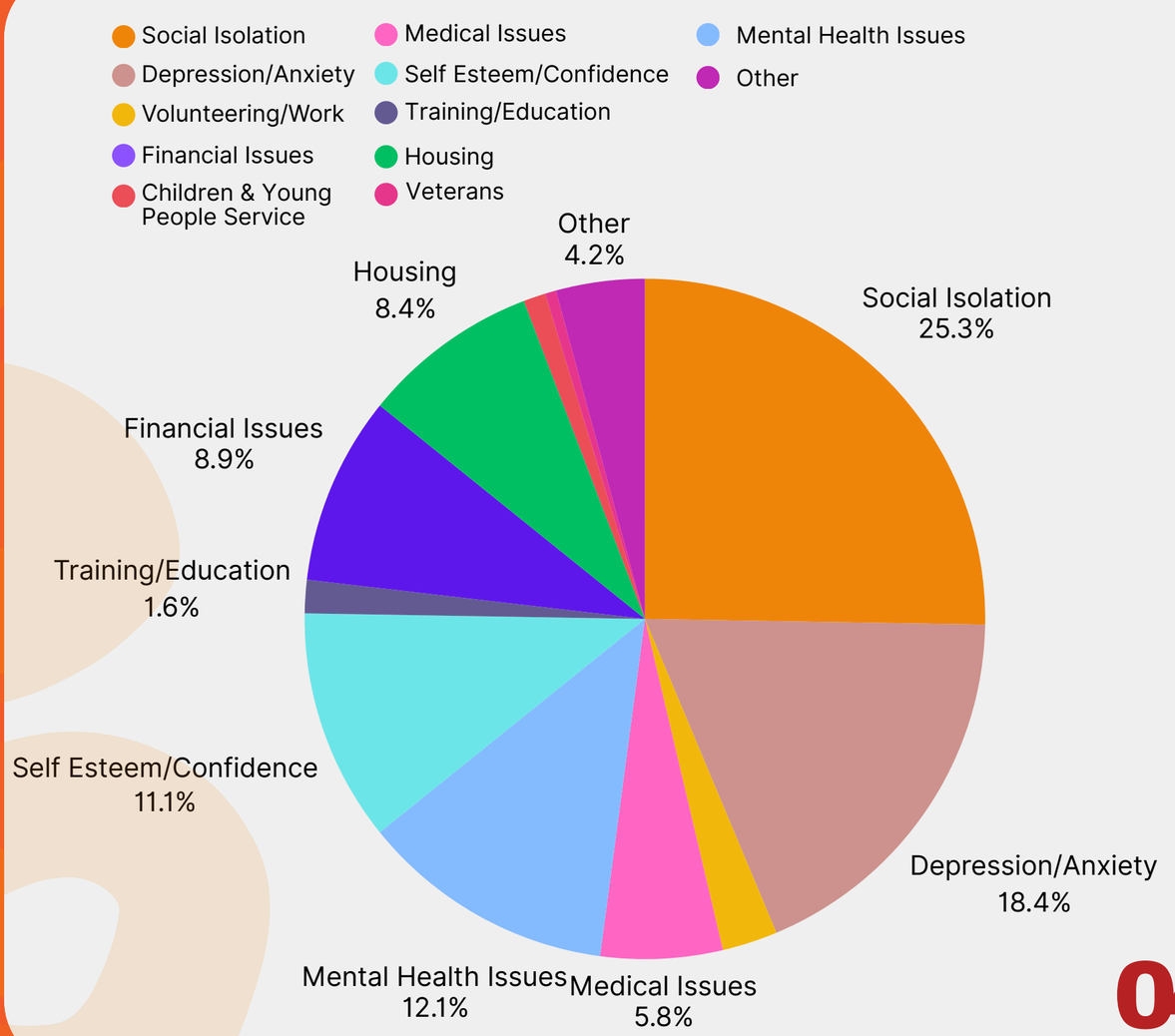
124

Current/Active Connector Cases

Burnley Referrals From

Supporting People With





Burnley Group Support & Funding Team

East Lancashire is very lucky to have ICB funding for small community organisations – without which our SP Team would not have any destinations for the people we help.

As well as supporting individuals the SP locality teams work closely with the wider BPRCVS & HRVCVS Teams to support vital community groups who provide the valuable services that support the people we support.

This Month In Burnley we have:

Supported	**52**	Unique Groups
Given	**76.5**	Hours of Group Support
SP Team also attended	**69**	Hours of Meetings
	15	Hours of Learning
SP Team referred into	**36**	VCF Organisations
	22	Statutory Organisations

Burnley CASE STUDY Diane

Reasons indicated on initial referral

Social Isolation, Depression/Anxiety, Self-esteem / Confidence, Medical
Referral from the clients GP Surgery stated that the client was socially isolated, not getting out of bed, and struggling getting out of the house due to long term anxiety and depression. She hadn't been out of the house on her own for years.

Background of client

Client is a woman in her 50's who was receiving mental treatment.

Initial Assessment and Support Provided

When I first contacted the client, she had been temporarily admitted to a nursing home for care after a recent fall at home. I met her at the nursing home, and she said had been taking part in some activities whilst staying there and enjoying it. I explained that there are similar activities she can attend in the local community once she is recovered and back at home.
I gave her some information about local groups/activities & gentle exercise classes to look through in her own time.I also offered to attend something with her initially if she felt anxious about going on her own.
She was discharged and back home a few weeks later. I contacted her and she was keen to try a seated exercise class at a venue near her home. I met her there the next week and supported her to attend the seated exercise class.

Client Outcomes

Client said she enjoyed the class, and she went again the week after on her own and even went for coffee afterwards with some of the others in the group.

Pendle

838
Referrals so far this year

31
New Connector Referrals

10
Closed Connector Cases

47
Current/Active Connector Cases

38
New Linkworker Referrals

29
Closed Linkworker Cases

81
Current/Active Connector Cases

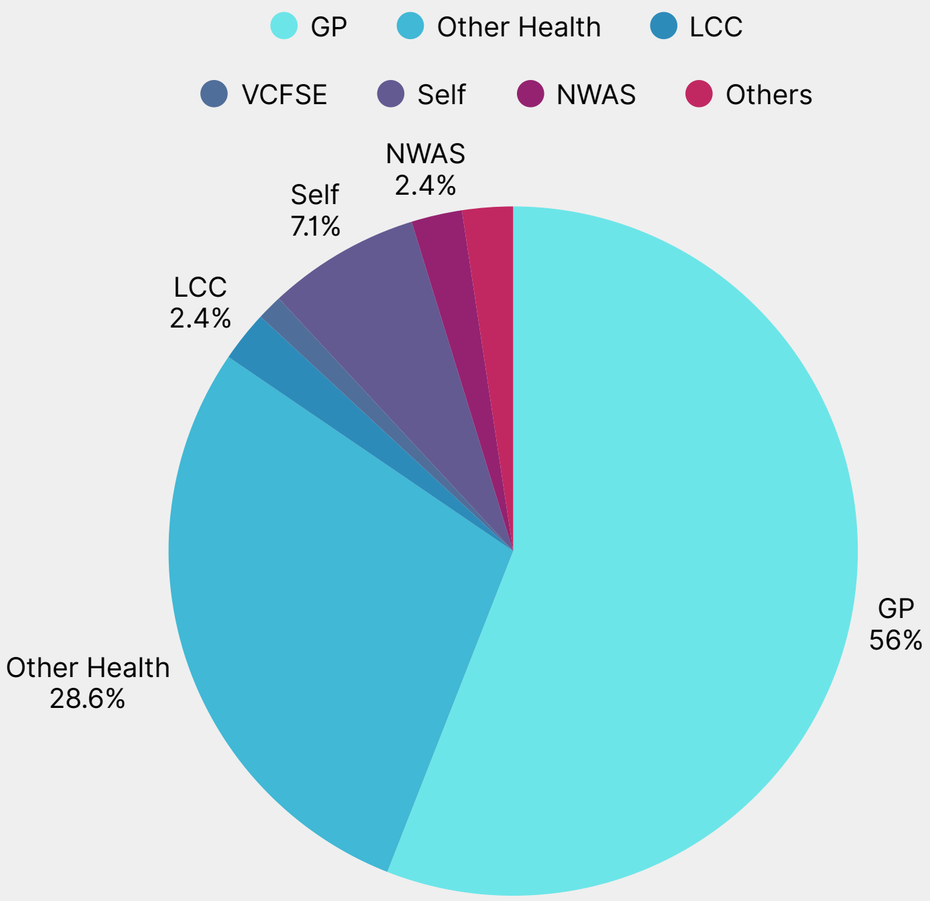
Reporting on behalf of Pendle East PCN

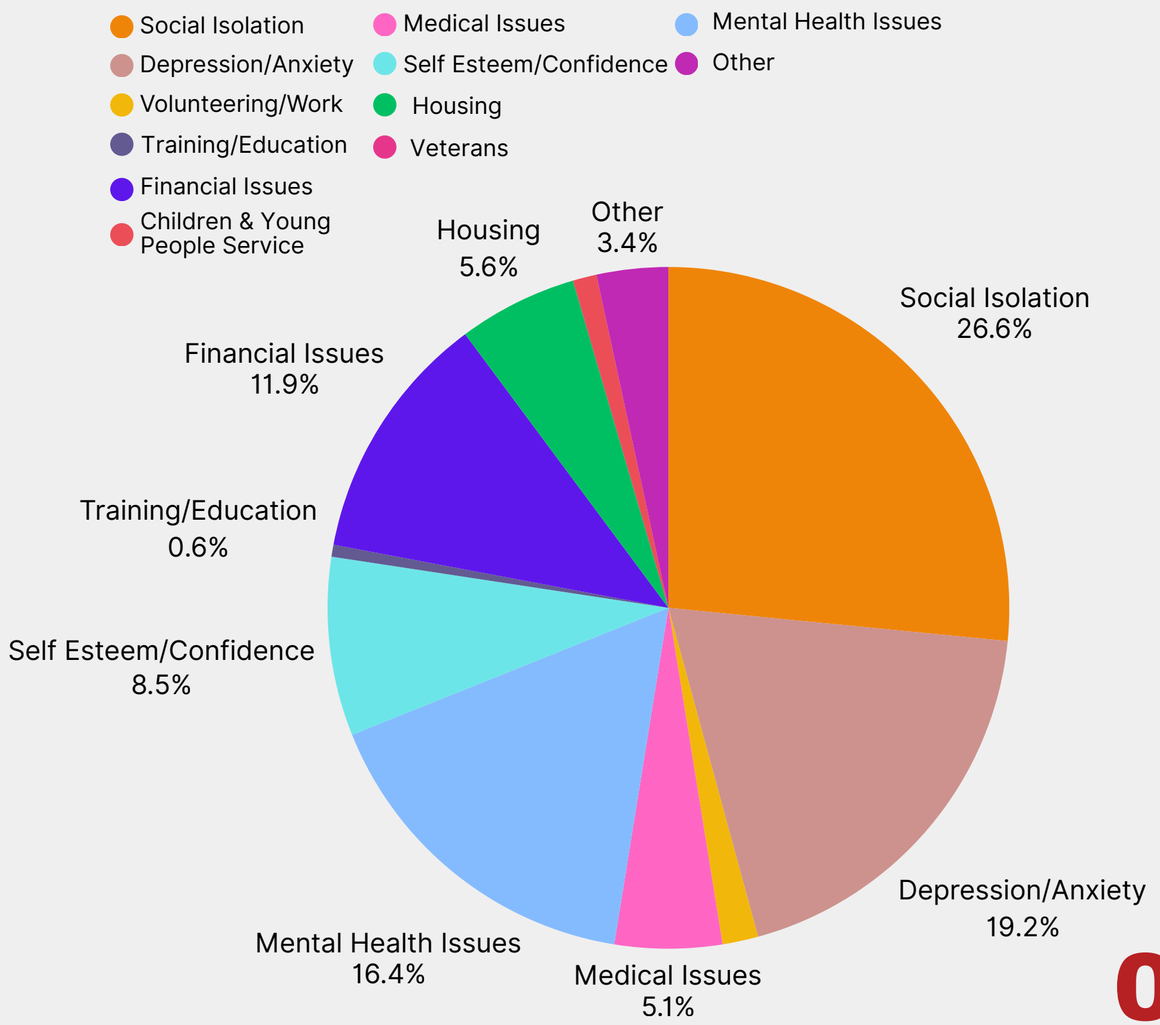
31
New Linkworker Referrals

5
Closed Linkworker Cases

Pendle Referrals From

Supporting People With





Pendle Group Support & Funding Team

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This Month In Pendle we have:

Supported	**23**	Groups
Given	**65**	Hours of Group Support
SP Team also attended	**32**	Hours of Meetings
	49	Hours of Learning
SP Team referred into	**48**	VCF Organisations
	20	Statutory Organisations

Pendle CASE STUDY Hussain

Reasons indicated on initial referral

The client would like to be supported to access activities and meet new people in the community who can speak the same language as him. He was really struggling with PTSD, suicidal thoughts and self-harm. Needs support from the Muslim/Urdu speaking community as his English was very limited.

Initial Assessment and Support Provided

- The client required support in finding things in the community that mattered to him. He was looking for groups and activities in the local community. The client was self-motivated and eager to start the intervention.
- He was experiencing isolation and low confidence, lacks community connections and meaningful activities.
- English is not his first language; speaks Urdu
- Client was interested in counselling sessions due to the trauma he had endured with his ex-partner.
- The client was interested in gardening groups, ESOL classes and financial support.

Background of client

- The client is 31 years old.
- Fled domestic violence and abuse from wife's family.
- Currently residing in a safe house.
- Struggles with his Mental Health and would like to access support/groups to integrate into the community.

Client Outcomes

Client was engaging and attending groups/service for support promptly. We started attending Food for All together which has helped his financial situation as he does not have to spend much money on food anymore. This was difficult for him to get used to initially as he was not aware that he, as a Muslim, cannot purchase certain foods. He was shown how to detect vegetarian/halal food on packaging. This got easier with time as we attended weekly, he now attends independently and has built the confidence to ask the volunteers for support when he is unsure.

He has started attending gardening groups in the area as this was closest hobby to his line of work in Pakistan. He has made some friends at the safe house, and they all attend the groups together.

He has also been referred to an ESOL class which starts in September.

The client has been receiving counselling sessions and is currently still accessing the service. He has found this beneficial and there has been a shift in mood since, he has become a lot more talkative about his past experiences as well as his current situation.

Rossendale

127

Referrals so far this year

22

New Connector Referrals

2

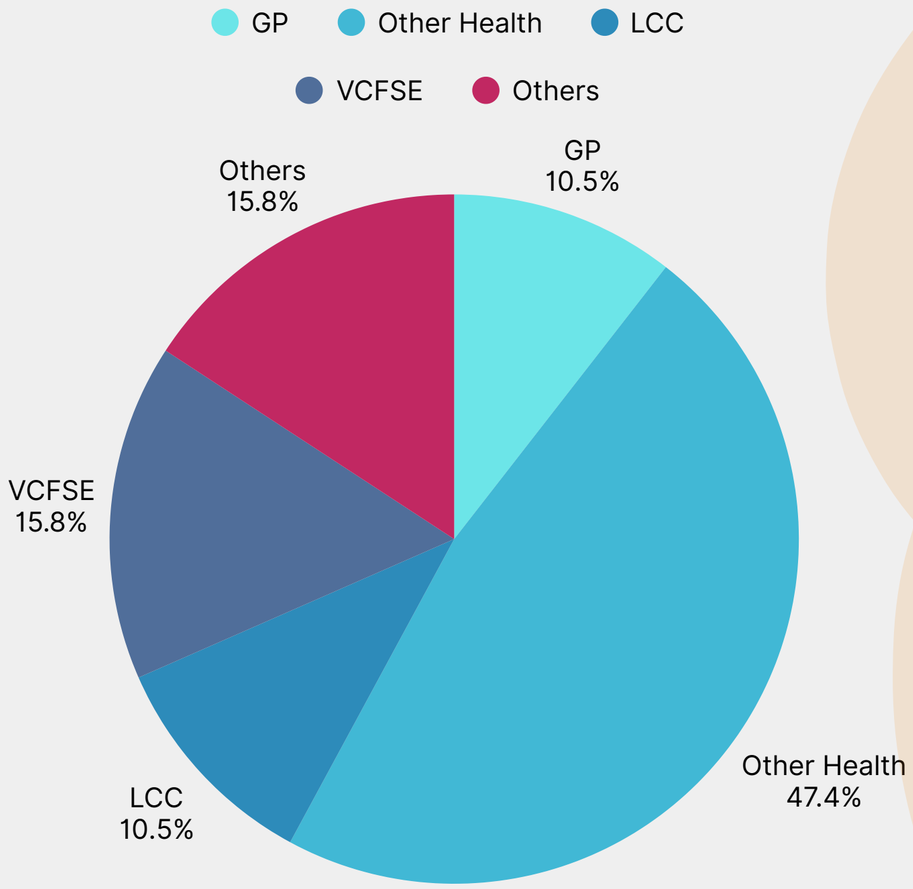
Closed Connector Referrals

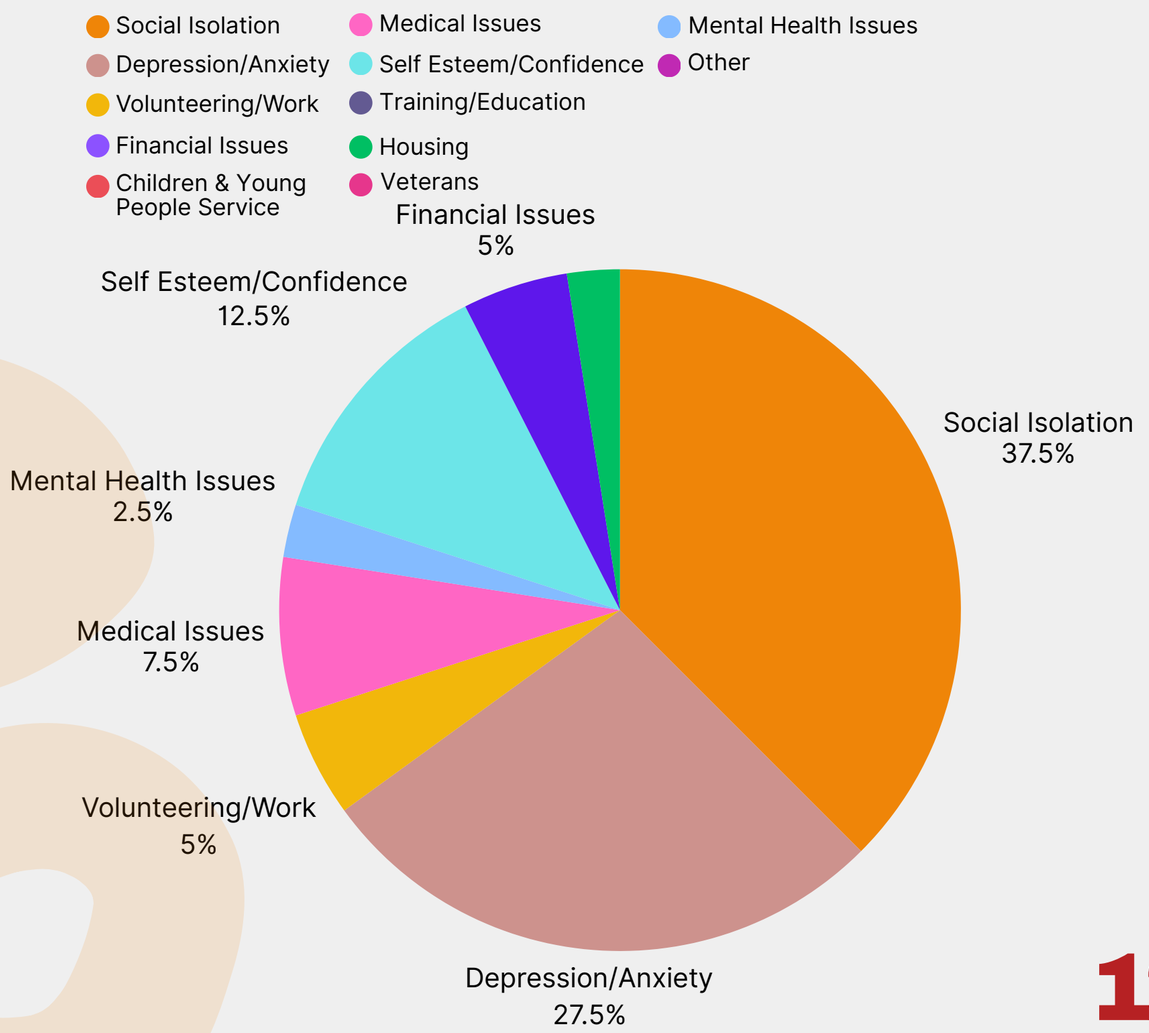
28

Current/Active Connector Cases

Rossendale Referrals From

Supporting People With





Rossendale Group Support & Funding Team

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This Month In Rossendale we have:

Supported	25	Unique Groups
Given	31	Hours of Group Support
SP Team Also Attended	22	Hours of Meetings
	6	Hours of Learning
SP Team Referred into	12	VCF Organisations
	1	Statutory Organisations

Rossendale CASE STUDY Edward

Reasons indicated on initial referral

The client was referred due to difficulties with mobility, falls, and ongoing housing challenges. He also reported significant pressure from the Department for Work and Pensions (DWP) regarding work capability despite complex health issues.

Initial Assessment and Support Provided

At first contact, the client described his pain and mobility issues, and the emotional impact of repeated falls. He expressed frustration at the lack of suitable housing and fear of further accidents.
Key actions:
Housing: Worked with his daughter to contact Together Housing and ensure medical evidence was included on his file. Encouraged resuming bidding for ground floor properties and advised on contacting Adult Social Care to increase his housing banding.
Benefits: Explored his Universal Credit status, encouraging discussion with Citizens Advice to review his Work Capability Assessment and challenge unnecessary work demands.
Health & Safety: Referred into the Steady On! Falls Prevention service. Signposted to the Samaritans for emotional support given his low mood. Encouraged consideration of careline alarm options.
Family Support: Coordinated with N, who helped manage communication with services on the clients behalf due to his difficulties with technology and paperwork.

Background of client

Client is an older male who lives alone but receives regular support from his daughter and son. He has multiple long-term health conditions, including bulging discs, arthritis, and spondylitis after decades of heavy manual work. These cause severe pain and frequent falls, which he cannot always recover from independently. He has received some support from Adult Social Care (e.g. rails and adapted furniture), but his current upstairs housing is unsafe given the fall risk.
A receives Personal Independence Payment (PIP) and Universal Credit but has been receiving monthly DWP calls that feel like pressuring him to return to work, which he finds highly stressful. He would like to work but recognises this is no longer possible. His main goal was to move to a ground floor or adapted property through Together Housing.

Client Outcomes

The client was linked in with Steady On! for falls support and provided with clearer pathways for housing and benefits advocacy. Housing and Adult Social Care discussions are ongoing. He has more consistent support from his daughter in navigating services and now has details for emotional support (Samaritans).
Although his surgery and recovery remain uncertain, the client expressed relief that someone had helped him to make sense of the system and begin moving things forward. The case is now closed with the option of re-referral once he is further along in his recovery.

Social Prescribing for Children & Young People

BPRCVS Trustees have had to make the difficult decision to pause referrals for all areas for this service apart from Pendle West. Trustees have funded this service for a number of years out of reserves – this could not continue. Pendle West PCN is at the vanguard of providing a social prescribing service for children & young people by funding 2 x 30 hours linkworkers. Please contact tracey.noon@bprcvs.co.uk should you have any questions

Pendle West

71
Referrals so far this year

8
New Referrals

20
Current Active

Pendle East

2
New Referrals

11
Current Active

Although numbers of referrals are relatively low in comparison with the adult SPLWs, the complexity of issues being experienced by the young people (and their families) referred into our service is increasing. This means more time is being spent keeping young people safe and ensuring they have all they need to lead happy, healthy, empowered lives.

Family CASE STUDY Karen

Parents Comment

'Hi Sammie, I want to thank you for the incredible support this group has had on my child. Whilst working with the service, the encouragement, care and opportunities offered by the group have made a real difference in their life.

They have been able to take part in different activities and gained new experiences. These activities have been so much fun, they have helped build confidence, make new friends and feel part of a supportive community.

As a parent it means everything to see them so happy and supported and seeing the positive impact on their emotional wellbeing.

Thank you.'

Hyndburn

388

Referrals so far

109

Current/Active Linkworker Referrals

44

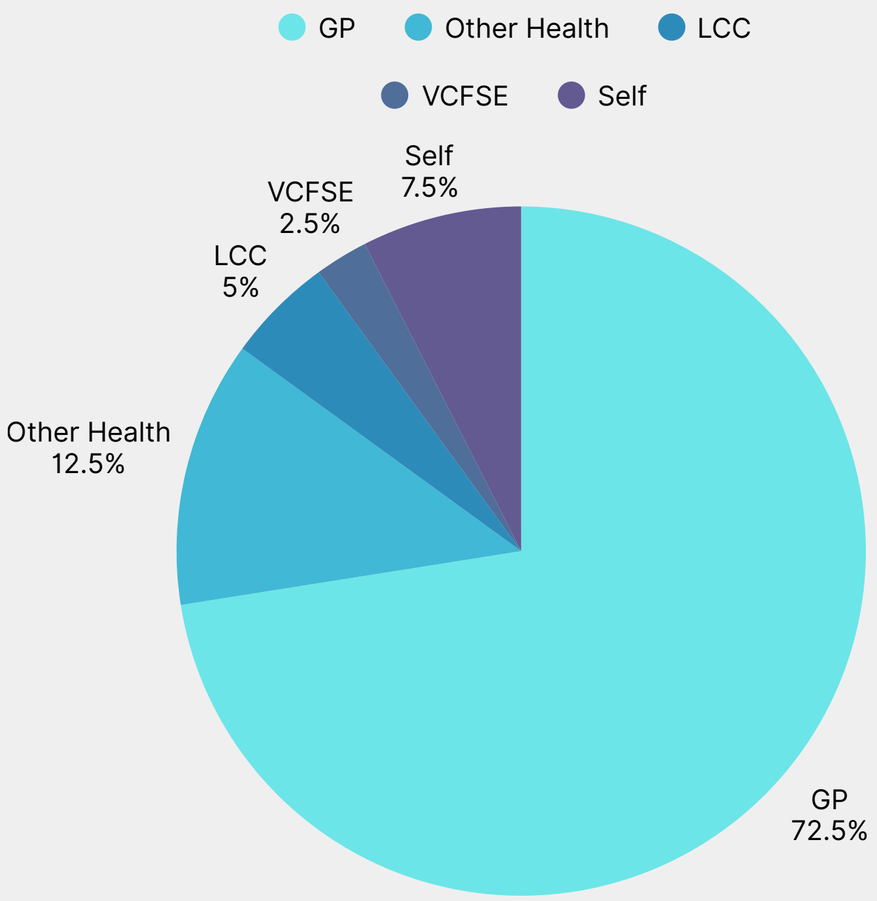
New Linkworker Referrals

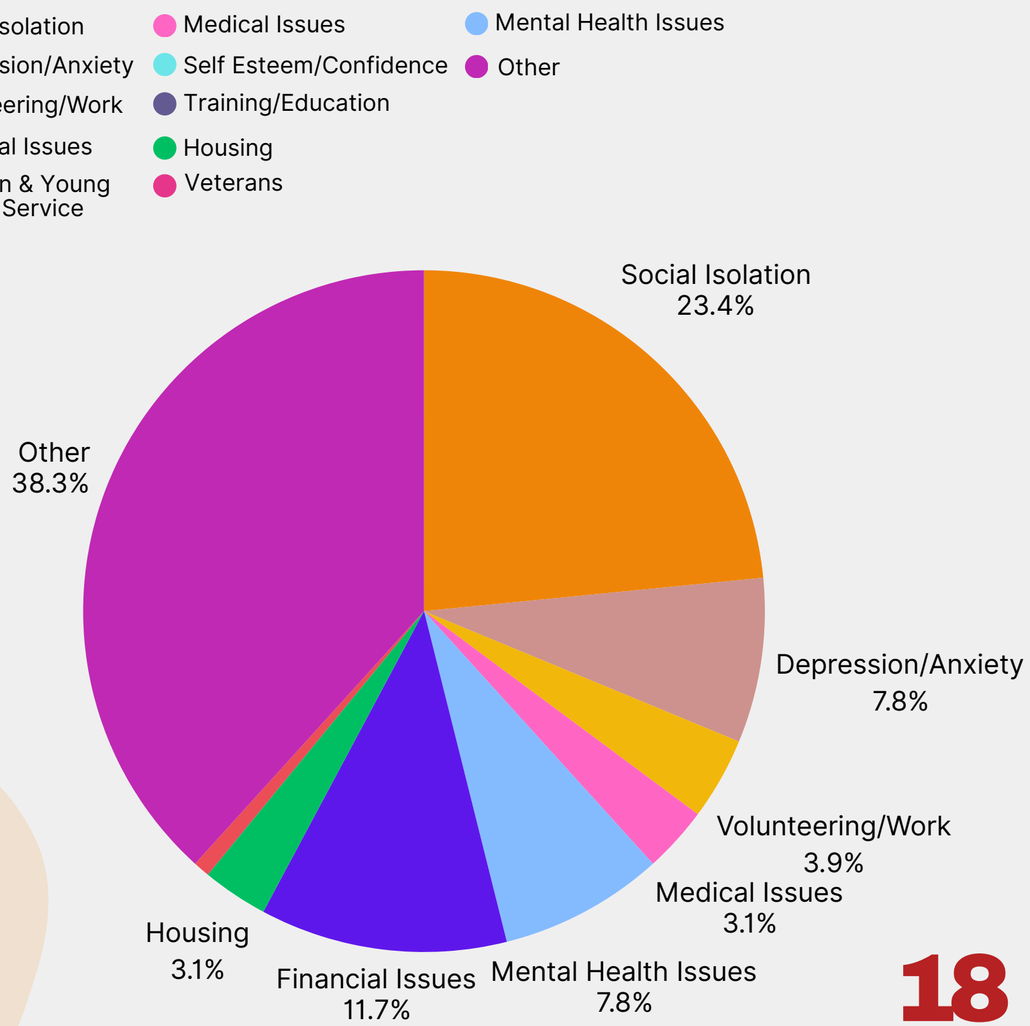
60

Closed Linkworker Cases

Hyndburn Referrals From

Supporting People With





Hyndburn Group Support & Funding

East Lancashire is very lucky to have ICB funding for small community organisations – without which our SP Team would not have any destinations for the people we help.

This Month In Hyndburn we have:

Supported	**23**	Unique Groups
Given	**40.5**	Hours of Group Support
SP Team also attended	**71**	Hours of Meetings
	14	Hours of Training
SP Team referred into	**38**	VCF Organisations
	6	Statutory Organisations

Hyndburn CASE STUDY Adam

Background of client

We had a referral from North West Ambulance Service for a 60 year old male who had suffered a head injury. He had been homeless for 2 weeks following a relationship breakdown and needed help with accessing housing support

Initial Assessment and Support Provided

On initial telephone conversation he had contact from the Emerging Futures team and was waiting an appointment. He also had an appointment with Red Rose Recovery as he is alcohol dependent. He was given information about Maundy Relief and their community lunches and services. He said he had been and used their services for a shower and change of clothes. They discussed Ernest Street Community Café which he didn't know about, they arranged to meet there the following week. It was very busy when they arrived so Ian the pastor arranged for a drink to be brought out for him as he felt too overwhelmed to go in, he did not want anything to eat. He was having good support from Red Rose Recovery and feels the small groups they offer are giving him a daily routine and he does not feel judged by anyone there as they have all experienced addiction so have lived experience. He was also going to see Inspire to help him work on reducing his alcohol. He seemed very committed to improving his situation despite his homelessness and alcohol issues. He had been given a pod to sleep in and feels the area he is in is safer than some, as the homes around him look out for him. He was given information on other places he could access for things like a haircut or shave and agreed to do regular check ins with him.

Client Outcomes

Shereen continued to check in with him and things gradually moved forward. Three months following the first contact with him he responded to a check in text
Things have moved on since we last spoke, I've got a room in Rishton. I'm volunteering at BHF and at Ernest Street Church, Who'd have thought?
Things are looking up, I've nearly given up drinking now as well

Ribble Valley

259

Referrals so far this year

49

Current/Active Linkworker Referrals

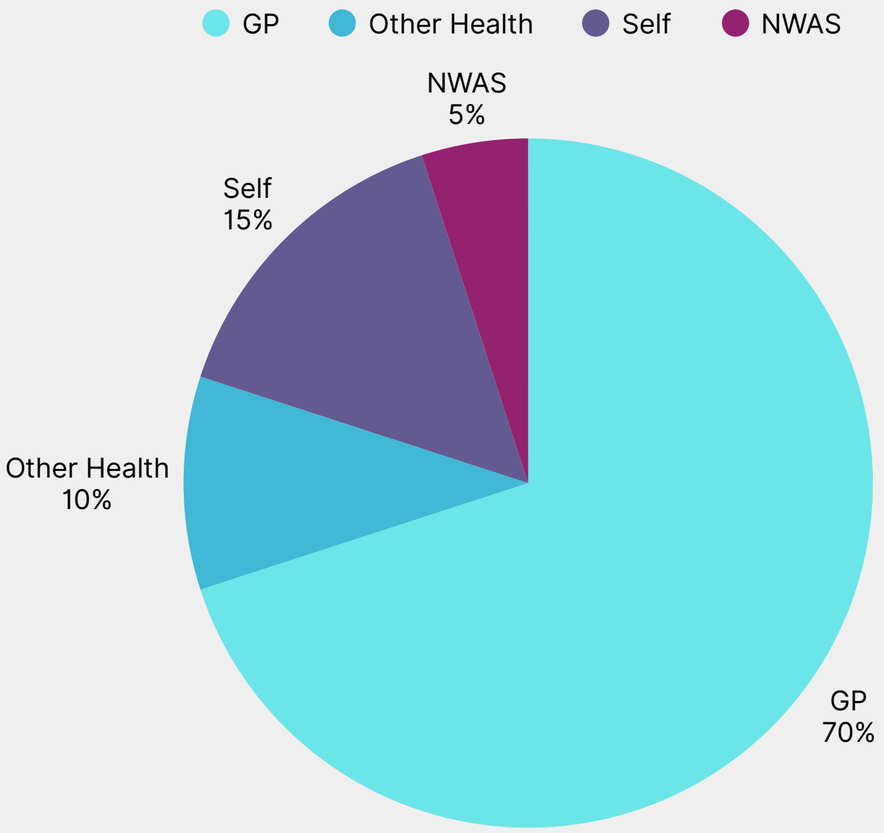
20

New Linkworker Referrals

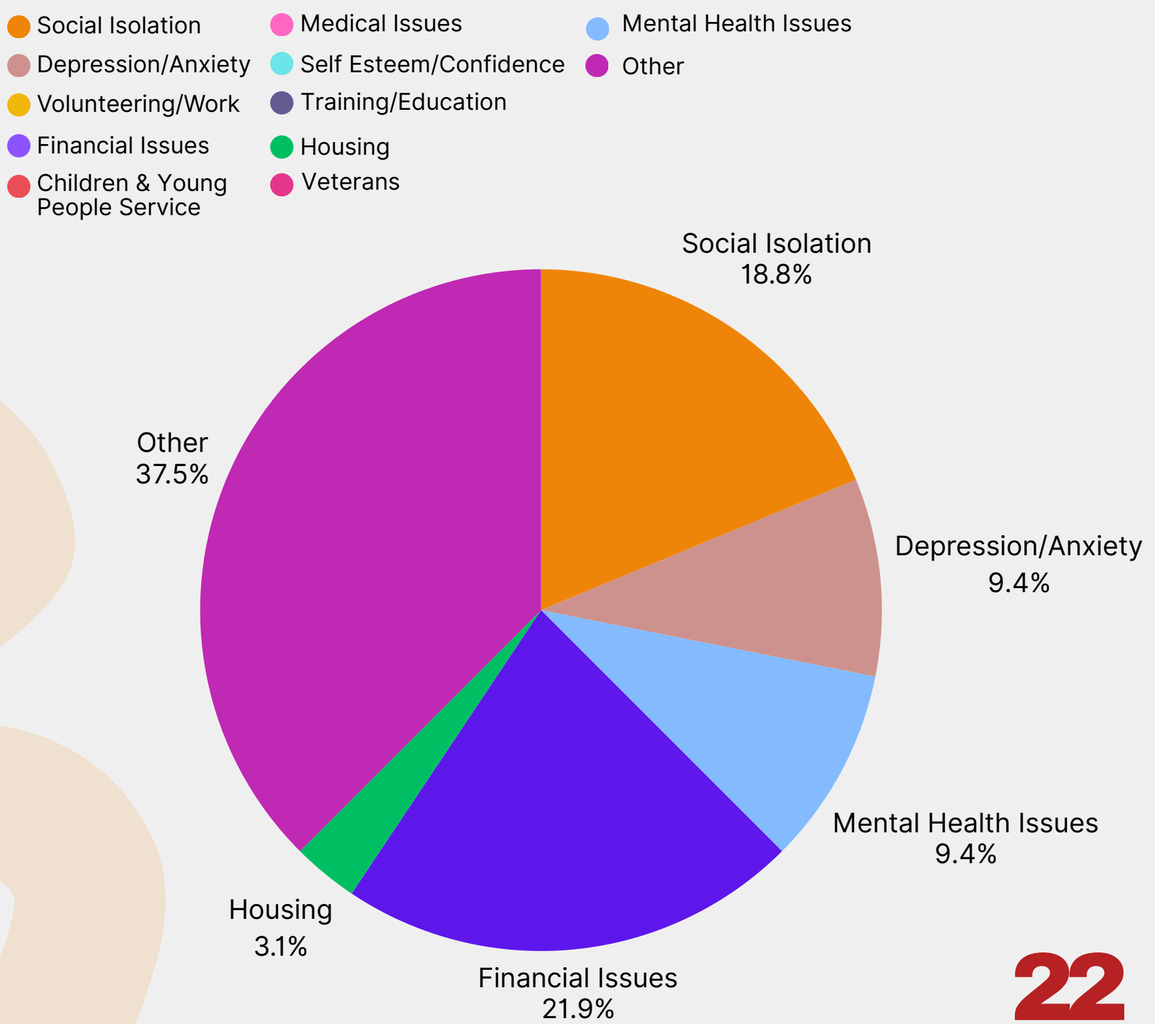
30

Closed Linkworker Cases

Ribble Valley Referrals From



Supporting People With



Ribble Valley Group Support & Funding

East Lancashire is very lucky to have ICB funding for small community organisations – without which our SP Team would not have any destinations for the people we help.

This Month In Ribble Valley we have:

Supported	**8**	Unique Groups
Given	**8.5**	Hours of Group Support
SP Team also attended	**65**	Hours of Meetings
	7	Hours of Learning
SP Team referred into	**12**	VCF Organisations
	4	Statutory Organisations

Ribble Valley CASE STUDY NAME GOES HERE

Reasons indicated on initial referral

Client reports feeling lonely since the loss of her husband. She is struggling to manage with technology and integrating to her local community due to motivation and having no one to turn to”

Background of client

- Female aged 65 years old.
- Lives alone and is in remission from breast cancer.
- Her only daughter has recently had a premature baby who was in hospital.
- She has 2 small dogs who she doesn’t like to leave for longer than 4 hours.

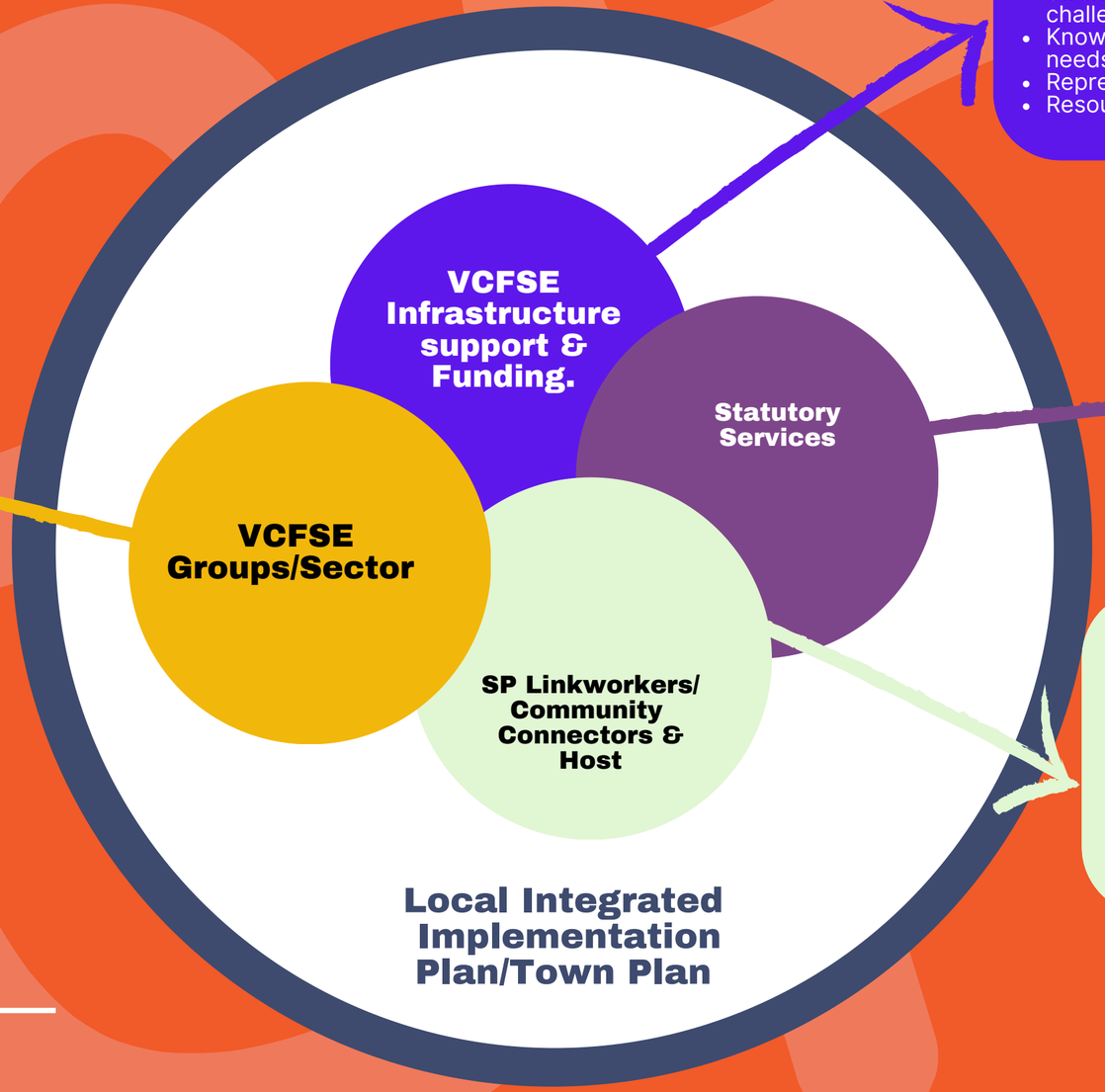
Initial Assessment and Support Provided

She shared that she was lonely and wanted to get more involved with her local community.

Client Outcomes

I met her at the Trinity Hub and helped her to use her phone to access Facebook and her emails. I signposted the library to get more help in “getting online”
She agreed to a referral to Age UK plus is being supported by “Inspire”. She attends their group at the Salvation Army every Wednesday.
I helped her to complete her application form to volunteer for the YMCA shop and St Vincent de Paul Befriending.
She now attends R and E Fitness every Wednesday and Friday at Clitheroe Rugby club.
I signposted the Shop of Hope and we attended a craft session together there. She made a wreath with cardboard and wool, which she planned to add leaves to.
She has been referred to Up and Active to access the gym, the range of classes and their community walks.
I have signposted u3a as she is interested in History and they offer a group in West Bradford. I have given her the information about the “Friendship Lunch” at her local church.

Working in partnership using the whole system approach.



Needs:

- Strong links to all partners
- Strong links with VCFSE offer & knowledge of challenges & opportunities.
- Knowledge & experience of flow in/out of community needs & community offer.
- Representation at all levels.
- Resources to deliver the support needed by VCFSE

Needs:

- Strong links to all partners
- Strong links with VCFSE offer & knowledge of challenges & opportunities.
- Knowledge & experience of flow in/out of community needs & community offer.

Needs:

- Access to funding & other resources to deliver.
- Support from infrastructure around capacity building, resources, etc to adapt, develop and sustain Knowledge of demand/need flowing from local priorities.
- Representation at all levels.

Needs:

- Appropriate management, training & supervision resource.
- Strong links to all partners including the wider VCFSE
- Knowledge of flow in/out of community needs and challenges.