Social Prescribing

APRIL 2026

MONTHLY REPORT

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.

Accrington Stanley
Extra Time Ladies Group

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.

20,947

Total number of referrals since commencement.

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

8,064,595

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 20,947 patients.
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.

251,364

Hours of SP Support

(Average of 2 hours per session x 6 sessions x 20,947

Meet The Team!

Lynne Hargreaves-Walker
Health & Wellbeing Programme Manager

Tracey Noon
Operations Manager

Burnley

Louise Howorth
Social Prescribing Linkworker (BE)

Vicky Ogretmen
Social Prescribing Linkworker (BE)

Lois Metcalfe
Social Prescribing Linkworker (BE)

Christina Howarth
ASC Social Connector

Carol Driver
Social Connector

Joanne Green
Social Connector

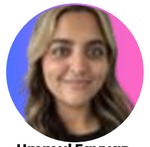
Annie Anderson
ASC Social Connector Hording all areas

Pendle

James Smith
Social Prescribing Linkworker (PE)

Amy Whitham
Social Prescribing Linkworker (PW)

Zoe Bell
Social Prescribing Linkworker (PW)



Ummul Fayyaz
Social Prescribing Linkworker (PW)

Pam Bailiff
Social Prescribing Linkworker (PE)

Farrah Rafiq
Social Connector

Rebecca Hayworth
ASC Social Connector

John Verity
Social Connector

Rossendale

Mandy Richardson
Social Connector

Jonathan Sheriff
Social Connector

Julie Heywood
ASC Social Connector

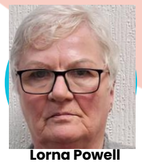
Group & Volunteer Support Team

Heather Starkie
Funding Co-ordinator

Rebecca Nolan
Group Support & Training

Julie Overson
Project Support

Salma Liaqat
Admin Support



Lorna Powell
Admin Support

Caroline Littleworth
Volunteering & Group Support Co-Ordinator

Kim Procter
Volunteering for Wellbeing & Community Hub Project Support Worker

Children & Young People Team

Sammie Taylor
Social Prescribing Linkworker – C&YP (PW)

Sania Farzana
Social Prescribing Linkworker – C&YP (PW) currently on maternity leave

Sylvia Pickles
Social Prescribing Linkworker – C&YP (PE)

Hyndburn & Ribble Valley

Susie Edwards
Social Prescribing Lead

Shereen Gregory
Social Prescribing Linkworker

Fiona Bradley
Green Social Connector

Julie Mallinder-Smith
Social Prescribing Linkworker

Zoe Mount
Social Prescribing Linkworker

Maria Malik
Social Prescribing Linkworker

Chelle Simpson
Social Prescribing Linkworker

Ian Targett
Social Prescribing Linkworker

Dorothy Parsons
Project Support

Burnley

354
Referrals So Far This Year

21
New Connector Referrals

12
Closed Connector Cases

46
Current/Active Connector Cases

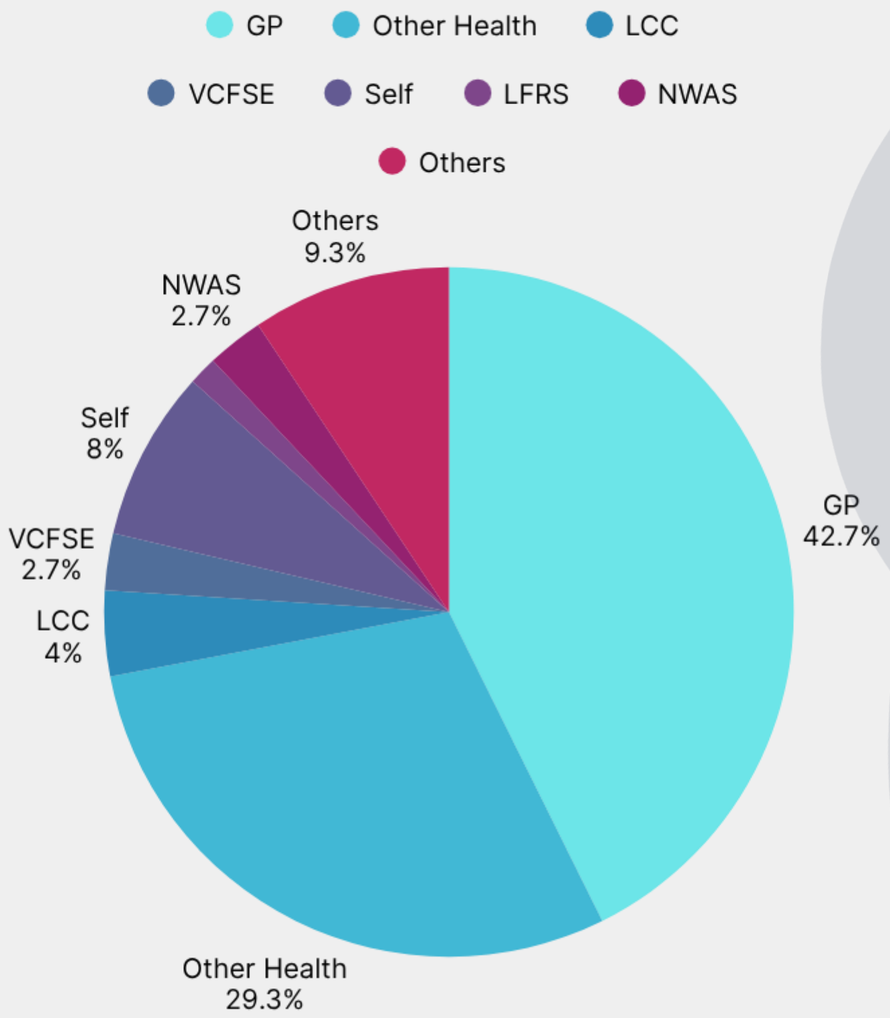
57
New Linkworker Referrals

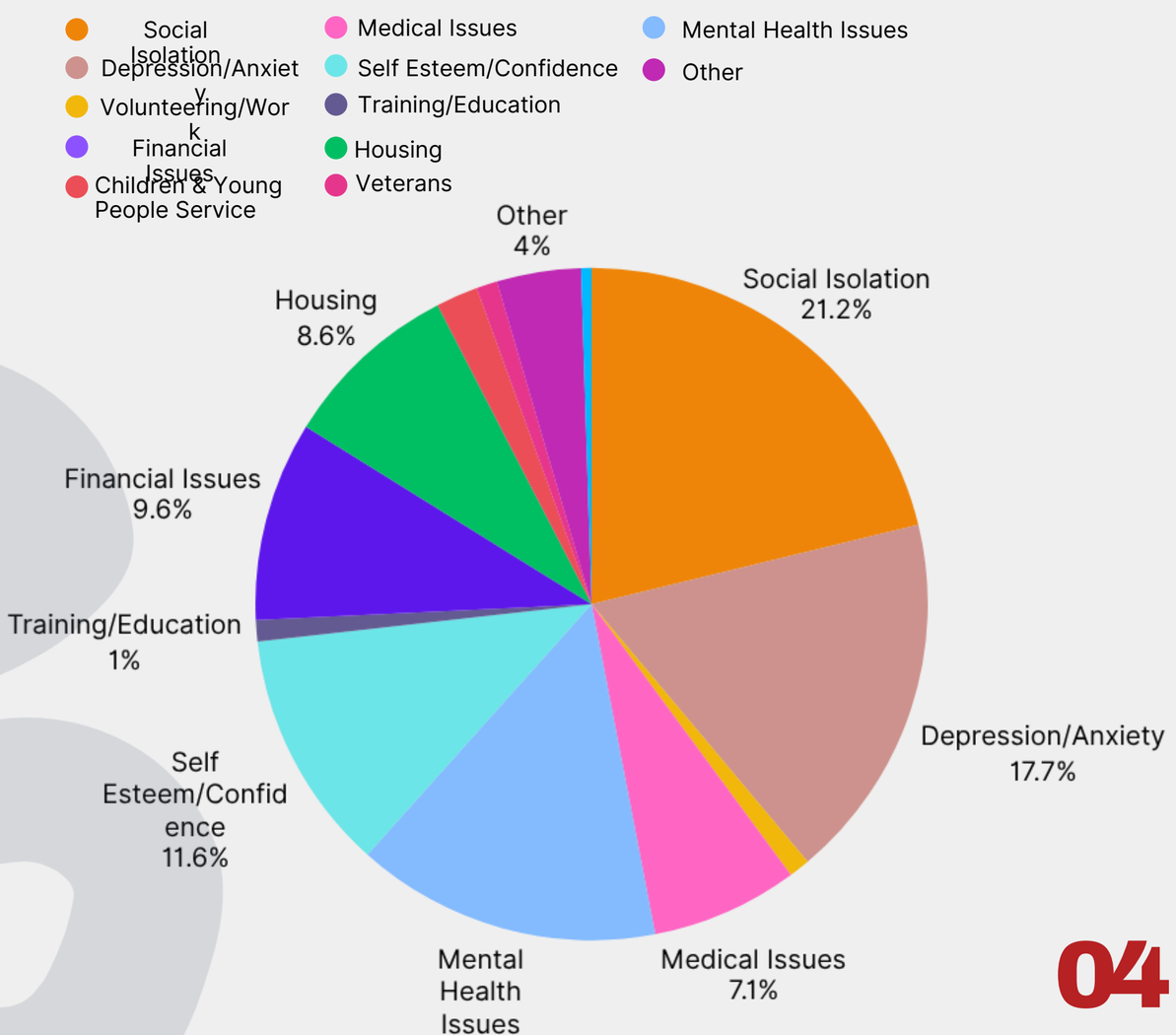
48
Closed Linkworker Cases

68
Current/Active Linkworker Cases

Burnley Referrals From

Supporting People With





Burnley Group & Volunteer Support Team

This Month In Burnley we have:		Group Support
Supported	34	Unique Groups
Given	104:40	Hours of Group Support
SP Team also attended	61	Hours of Meetings
	6	Hours of Learning
SP Team referred into	39	VCF Organisations
	12	Statutory Organisations

This Month In Burnley We Have:		Volunteering
Enquiries Recieved	13	Individuals
Signed Up For Training	7	Organisations
Currently Volunteering	48	Individuals

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.

Burnley Case Study Ben

Client Comment

Language barrier with client but throughout support client has always profusely thanked me for me support and said he doesn't know what she would have done without my help. Feels he can see the end goal now and he is making progress.

Reasons Indicated on Initial Referral

Referred in for social inclusion and housing support by GP surgery

Background of Client

41 y/o non English speaking male

Initial Assessment and Support Provided

1 Currently homeless, sofa surfing
2 Wanted legal advice around access to his children
3 Wanted to know if he is entitled to any benefits
4 Wanted support with his immigration

Client Outcomes

1 Application made to bwithus and to housing needs – now has live account, is in the correct priority banding and is actively bidding on properties.
2 Attended solicitor drop in with client, he was advised that he needs to approach mediation services in the first instance. Then supported client to refer to mediation services and provide evidence needed. Court process now ongoing.
3 Attended citizens advice drop in with client – full benefits assessment done, unfortunately wasn't entitled to anything currently but was informed that once he secures a property he will then be eligible for UC for housing costs.
4 Liaised with Immigration specialist solicitors who encouraged the client to make a formal complaint to the Home Office – then linked client in with New Neighbours Together for support around this – complaint submitted which should now mean an outcome will be provided soon.
Client continues to access New Neighbours Together which has in turn has provided social inclusion – wasn't keen on accessing social groups.

Pendle

363
Referrals So Far This Year

16
New Connector Referrals

17
Closed Connector Cases

22
Current/Active Connector Cases

70
New Linkworker Referrals

23
Closed Linkworker Cases

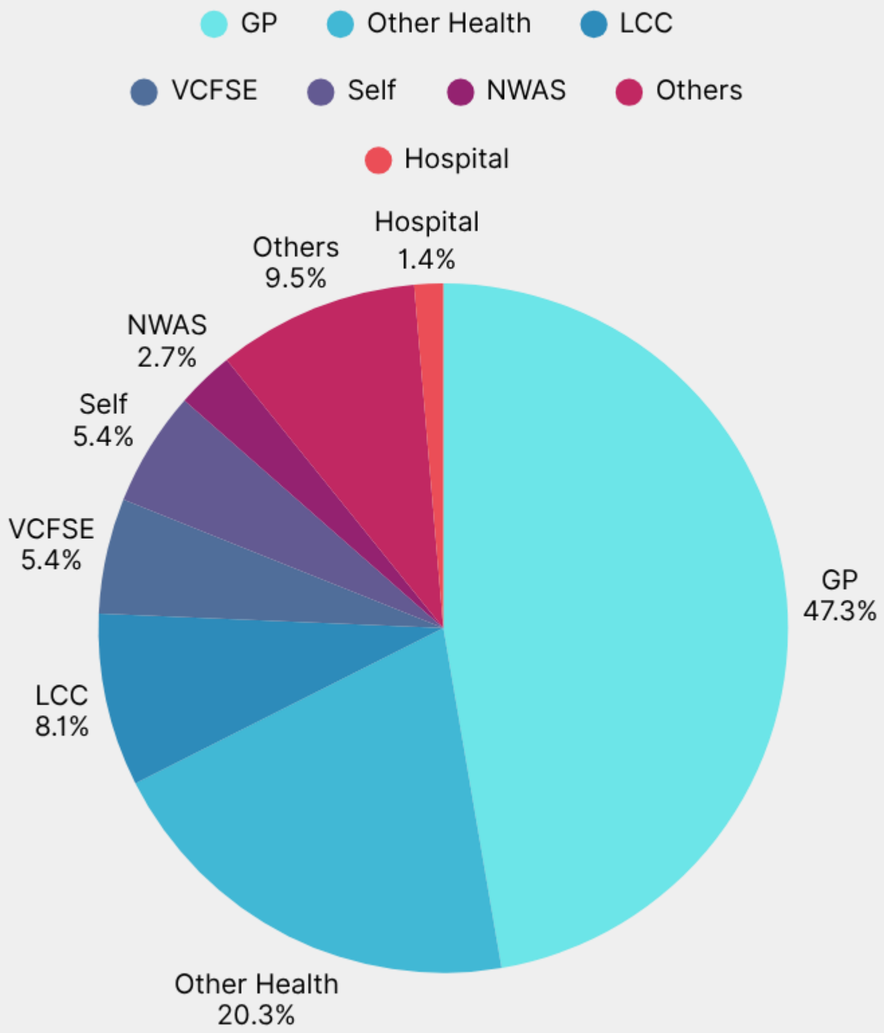
132
Current/Active Linkworker Cases

Reporting on behalf of Pendle East PCN

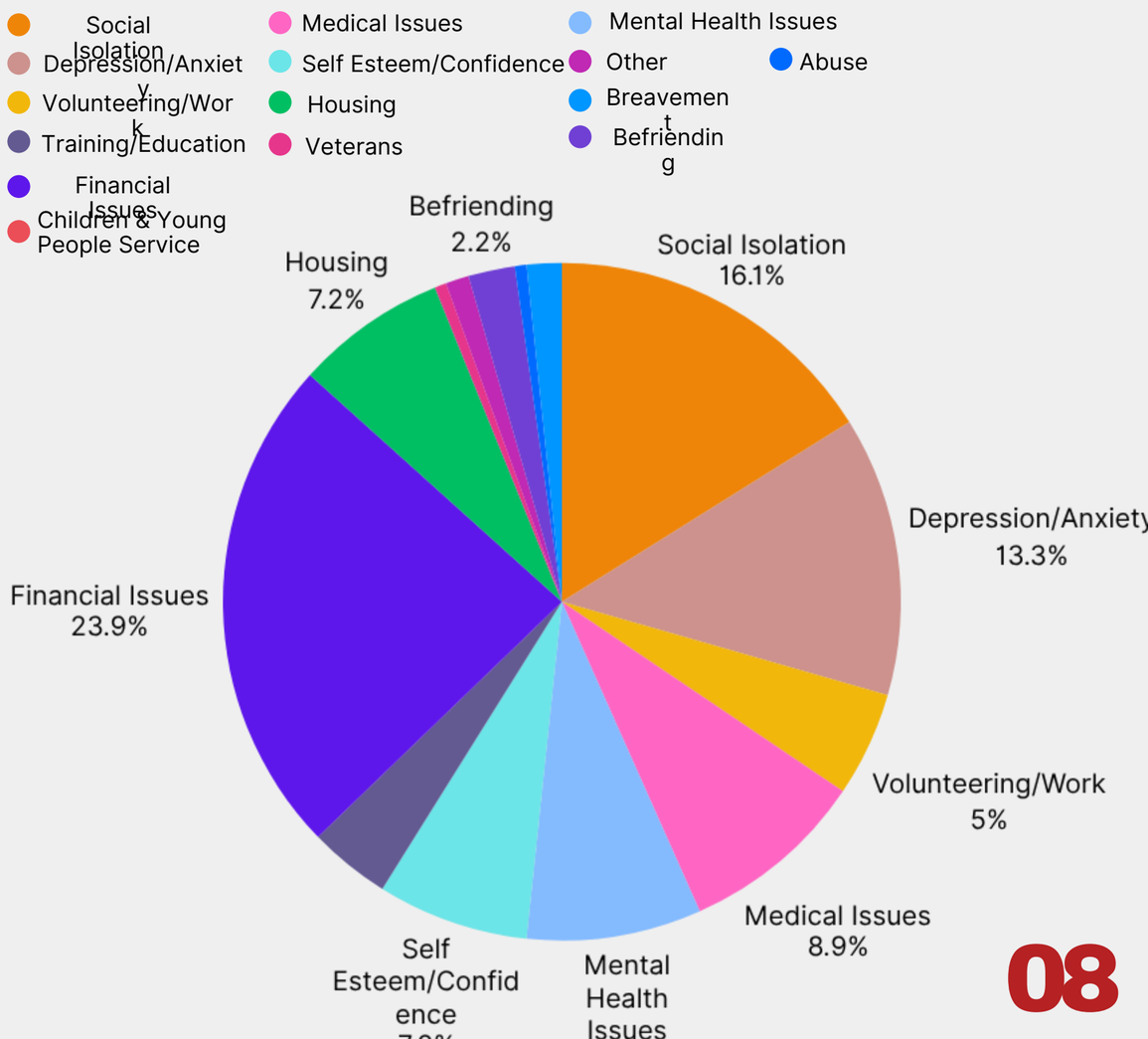
17
New Linkworker Referrals

6
Closed Linkworker Cases

Pendle Referrals From



Supporting People With



Pendle Group & Volunteer Support Team

This Month In Pendle we have:		Group Support
Supported	9	Unique Groups
Given	12.5	Hours of Group Support
SP Team also attended	10.5	Hours of Meetings
	17.5	Hours of Learning
SP Team referred into	39	VCF Organisations
	21	Statutory Organisations
This Month In Burnley We Have:		**Volunteering**
Enquiries Recieved	5	Individuals
Signed Up For Training	1	Organisation
Currently Volunteering	7	Individuals

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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.

Pendle Case Study Patrick

ONS4	Life Satisfation	Worthwile	Happiness	Anxiety
Initial	5	6	4	4
Final	6	7	6	5

Reasons Indicated on Initial Referral

The client would like to be supported to access various services. He has been homeless for quite some time with his wife in Manchester.

Background of Client

The client is 61 years old.
He has multiple health conditions and struggles with his mental health due to his situation.
Client disclosed that he was sleeping on the streets of Manchester with his wife, they have both struggled since coming from Africa.
Client needed support in accessing a food bank as well as household appliances as he moved into his new rented accommodation.

Client Comments

The client was very thankful for all the support he had received and was very complimentary of the service. He has also contacted the referrer to show his gratitude and feels as though he has been supported throughout his move to Pendle.

Initial Assessment and Support Provided

-The client required support in finding things in the community that mattered to him. He was looking for support from the local community that would allow him to start his new life in Pendle with his wife. He has been eager to get this support and was motivated throughout. His wife has also been able to access the social prescribing service for herself.
-He was not aware of the groups and support services in the area that he could access for free.
- The client also wanted to receive mental health support for himself and his wife as their financial situation and living on the streets really affected them.

Client Outcomes

Client and his wife were engaging with social prescriber throughout the intervention.
Client was supported with registering with a food bank. He now attends this food bank weekly.
Client has also accessed counselling through the PCN counsellor.
He was also supported in creating an application to under one roof for household appliances.
Curry on the Street were able to support the couple in accessing household goods for his new home.
They delivered beds for them as they had been sleeping on the floor in their new property which has affected their health further.
The client has also started to receive benefits to support paying the rent.
He now has furnished his home; his mood was elevated once he had achieved this and he was very thankful.
The client continues to attend things in the community and is aware that he can contact the social prescribing team directly if he requires further support in the future.

Rossendale

64

Referrals So Far This Year

11

New Connector Referrals

28

Current/Active Connector Cases

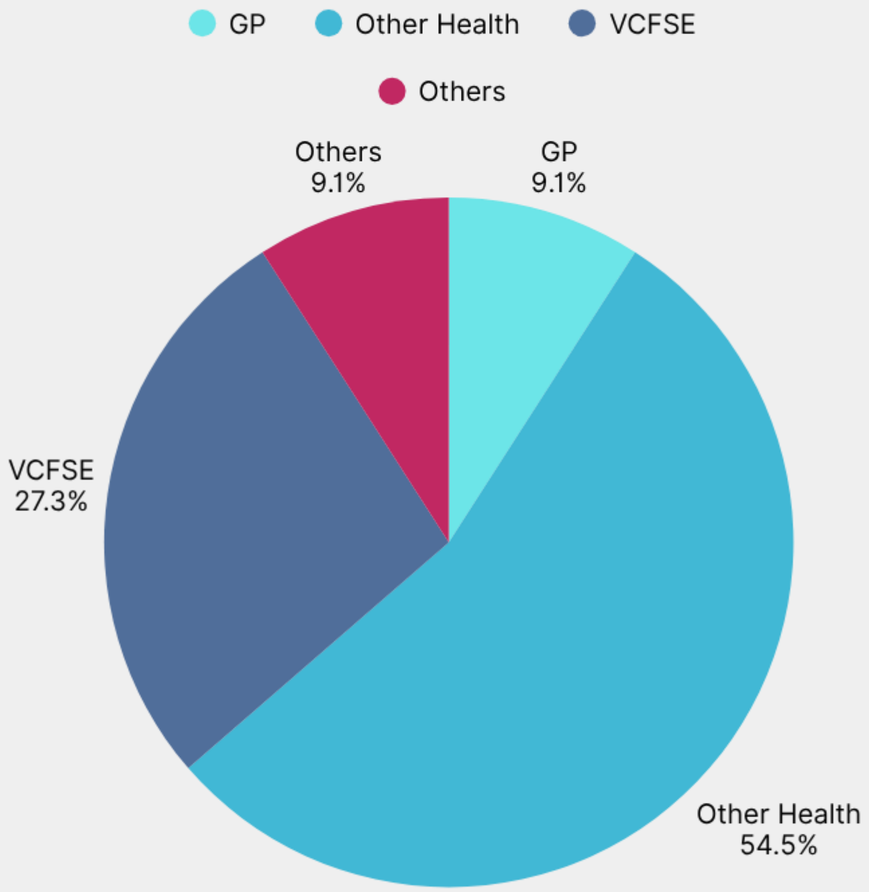
12

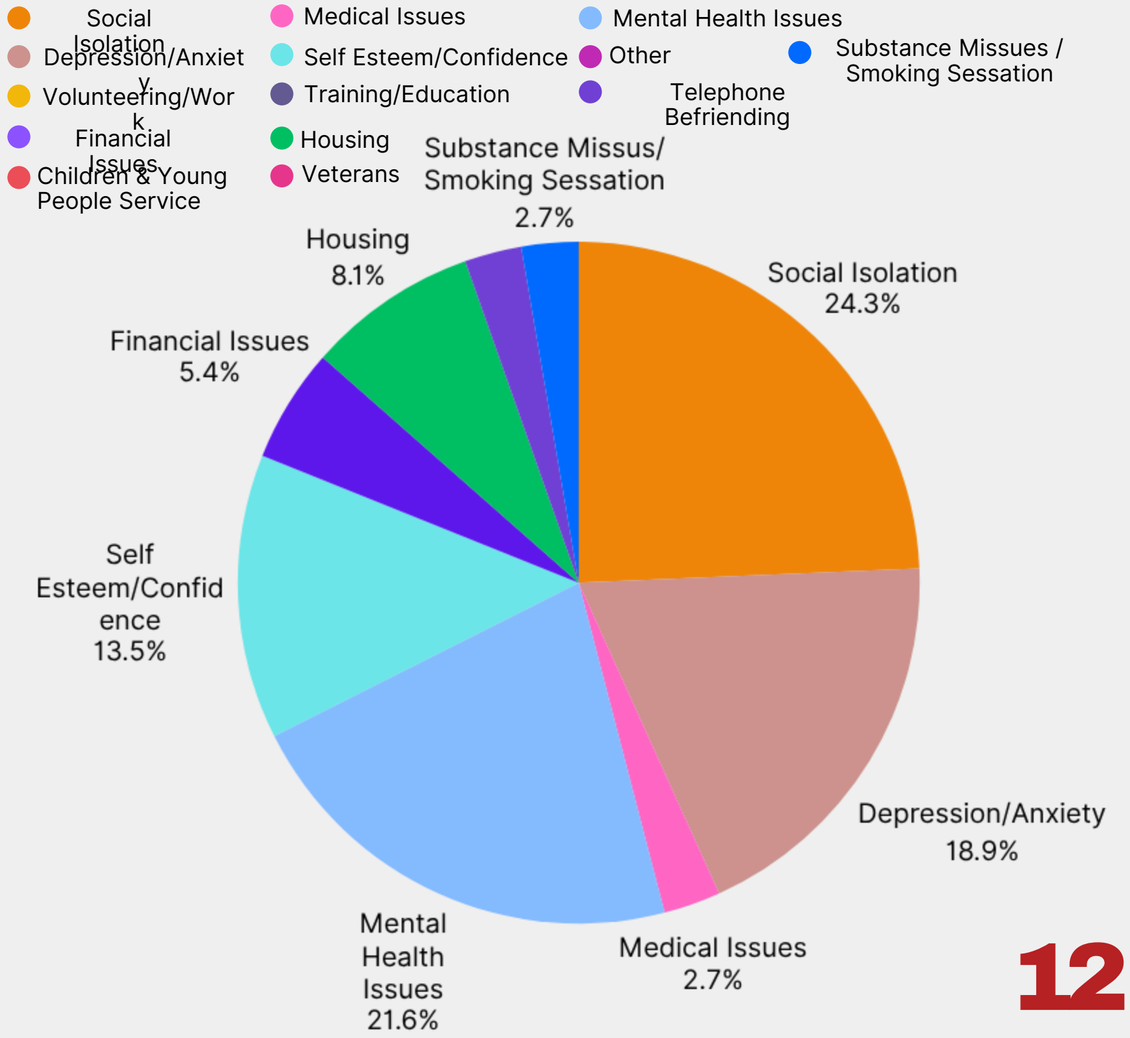
Closed Connector Referrals

Our Rossendale Team was assembled in the summer of 2025 following Carole Williams' retirement. The team is currently out in the community, introducing themselves and working to boost referrals.

Rossendale Referrals From

Supporting People With





Rossendale Group & Volunteer Support Team

This Month In Rossendale we have:	Group Support
Supported	16 Unique Groups
Given	17 Hours of Group Support
SP Team also attended	1.5 Hours of Meetings
SP Team referred into	10 VCF Organisations
	3 Statutory Organisations

This Month In Rossendale We Have:	Volunteering
Enquiries Recieved	3 Individuals
Signed Up For Training	2 Organisations
Currently Volunteering	1 Individuals

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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.

Rossendale Case Study Rosa

ONS4	Life Satisfation	Anxiety	Worthwile	Happiness
Initial	2	9	2	2
Final	5	5	6	5

Reasons Indicated on Initial Referral

Client was referred to the Social Prescribing service by emergency services following concerns around worsening mental health, suicidal ideation, self-harm, housing conditions, and significant emotional distress. She reported feeling unable to cope, described her home environment as unsafe, and was struggling to engage effectively with housing and support services.

Background of Client

Client is a woman in her 30s living alone in Rossendale. She has experienced longstanding mental health difficulties and described feeling overwhelmed, isolated, and emotionally exhausted following the removal of her child from her care. She reported low motivation, anxiety regarding her physical health and living environment, financial hardship, food insecurity, and increasing difficulties managing day-to-day tasks.
At the point of referral, client was in rent arrears and facing the risk of eviction. She described periods of not eating, significant emotional distress, and feeling unsupported whilst attempting to navigate multiple systems including housing, mental health services, and welfare support.

Initial Assessment and Support Provided

Initial work focused on stabilisation, emotional containment, and connecting client with practical support. Support included:
·Emotional support and regular welfare check-ins by telephone and email.
·Discussion around crisis support pathways, including encouraging contact with NHS mental health crisis services and Community Mental Health Team support.
·Signposting to emergency food provision including RAFT and local community food resources.
·Referral to Lancashire Women for therapeutic and wellbeing support.
·Signposting to Home-Start and local family support services.
·Advice regarding housing concerns, homelessness risk, and engaging with housing-related services.
·Encouragement and support around responding to contact from tenancy and income teams to reduce further housing risk.
·Identification and escalation of possible safeguarding concerns internally where appropriate.
·Ongoing encouragement to engage with Adult Social Care and wider statutory support.

Throughout the intervention, the approach centred on building trust, reducing overwhelm, and helping the client access support incrementally rather than expecting her to manage multiple complex tasks alone whilst in crisis.

Client Outcomes

Over the course of support, the client began engaging more consistently with services. Adult Social Care became involved regarding her housing and environmental difficulties, and she reported feeling that some progress was finally being made.
The client accessed therapeutic support, food provision, and practical advice around housing and finances. By the point of closure, she described feeling more supported and more hopeful that her circumstances could improve.
The case was closed collaboratively once key statutory services were involved and the client felt clearer about how to access ongoing support independently if required. Information regarding additional community and family support resources was provided to help maintain longer-term stability.

Social Prescribing for Children & Young People

Pendle West

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

34
Referrals So Far This Year

3
Closed

7
New Referrals

26
Current Active

53
Active for Activities

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 Anders Family

Background

Family has multiagency support; parent has multiple health needs and there are a few children in the home of different ages and needs.

Actions Taken

Mum referred into wellbeing support.
Action plan developed for the children who are being supported by our service.
Further information regarding groups in the community shared for those children who are not accessing our service.

Outcomes

Parent is now accessing wellbeing support regularly.
Family attended some of our parent and child activities in the school holiday together.
Children are also accessing their local guiding and scout clubs.

Needs

Support for children to access activities in the community.
Wellbeing support for parent.

Comments

It was nice coming to the activities as a family; it was good because we could have fun together.

Hyndburn

272

Referrals So Far This Year

115

Current/Active Linkworker Referrals

57

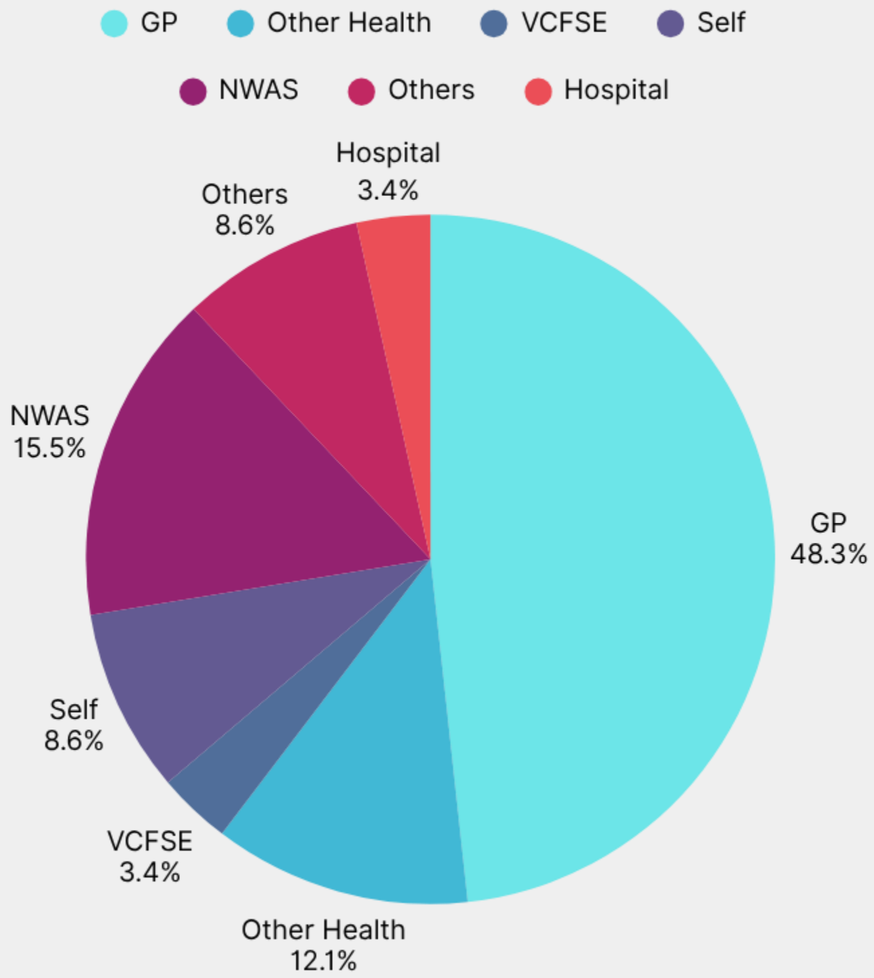
New Linkworker Referrals

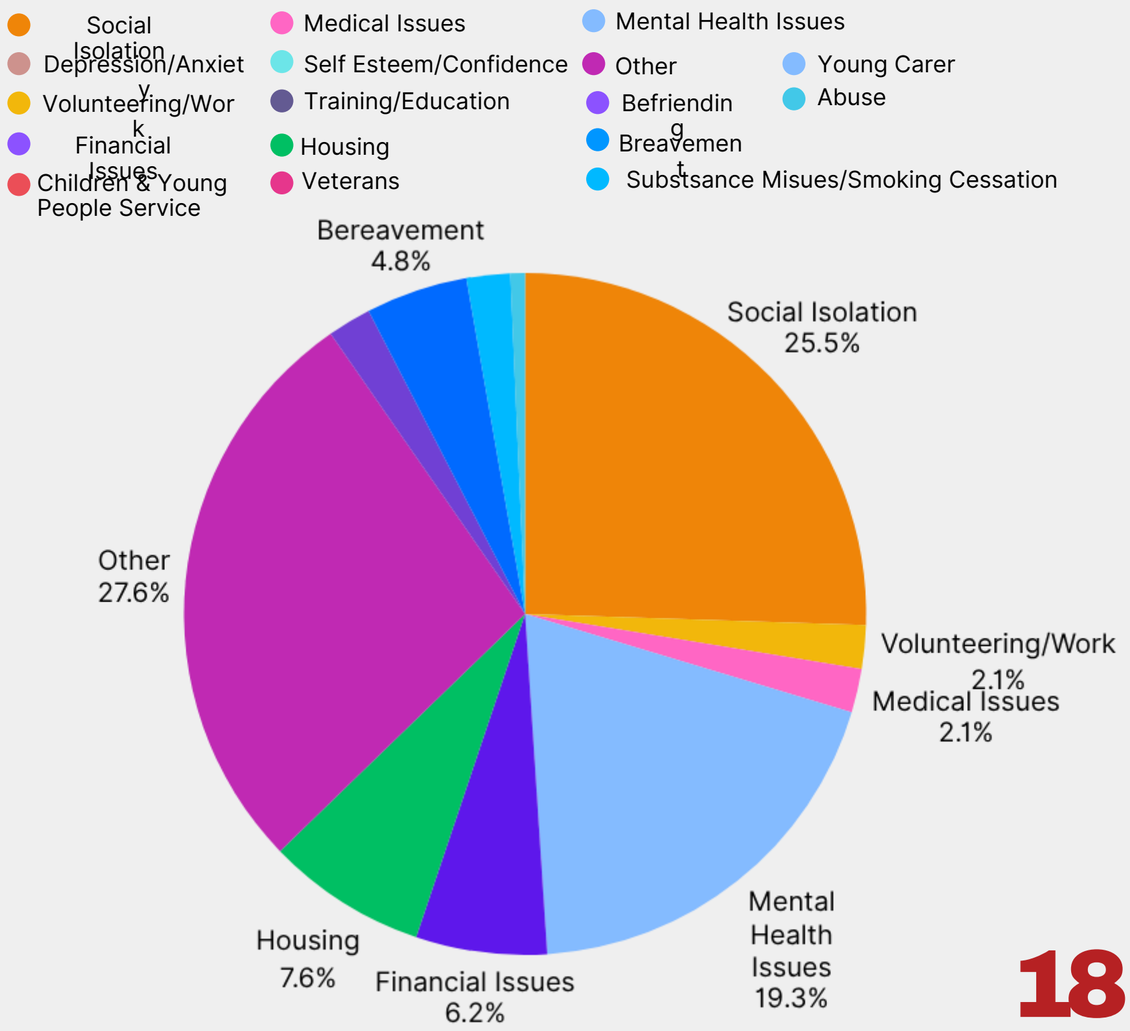
63

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: Group Support

Supported	16	Unique Groups
Given	25.5	Hours of Group Support
SP Team also attended	42.5	Hours of Meetings
	18	Hours of Training
SP Team referred into	42	VCF Organisations
	10	Statutory Organisations

This Month In Hyndburn we have: Volunteering

Volunteers	14	Seen or Supported
Volunteers Interviewed	17	

Hyndburn Case Study Accrington Stanley

Group Support

TOur case study this month is for a group that we have supported since it launched just over two years ago at Accrington Stanley. Accrington Stanley Extra time ladies group

Group Launch & Client Support

When the group launched in March 2024 it took some time to get going as it was a new group. We supported and promoted the group for them. We signposted clients to the group and accompanied clients to the group. We also attended the group and spoke to the people attending to support them to build the group up. It took a while to build up a regular group of attendees and there were some changes to the staff who facilitate the group.
As we are known in the group this has led to taking referrals for people who attend. A woman who attends the group approached us to speak about her son who she was worried about. He had poor mental health and had struggled with this for a significant length of time. This had impacted his work, he was unable to maintain employment. We worked with him and connected him with IPS which was successful at getting him back into work.

About

The group is aimed at over 50s women and compliments the over 50s men's group they have. The group is a social group at Accrington Stanley Sports Hub. It is a modern accessible space and there are facilities for sitting down with a coffee and playing cards, dominoes etc, dart boards, table tennis, an additional room with lots of sports resource

Group Outcomes

We have continued to support the group and it has been rewarding to see how much of a difference the group has made to clients we have introduced to the group as they are still attending it. Our links to the group have resulted in referrals being made into our service for any help or advice as we are well known amongst the people who attend.
It is a welcoming and friendly group and we are very pleased to see how the group has developed into a valuable resource that has positively impacted the wellbeing of the women who attend. The member of staff works really well to bring them together and it has increased to be a what's app group and connections have developed outside of the group as well. It feels like a lovely supportive network that welcomes new people in with a positive atmosphere.

Ribble Valley

168

Referrals So Far This Year

49

Current/Active Linkworker Referrals

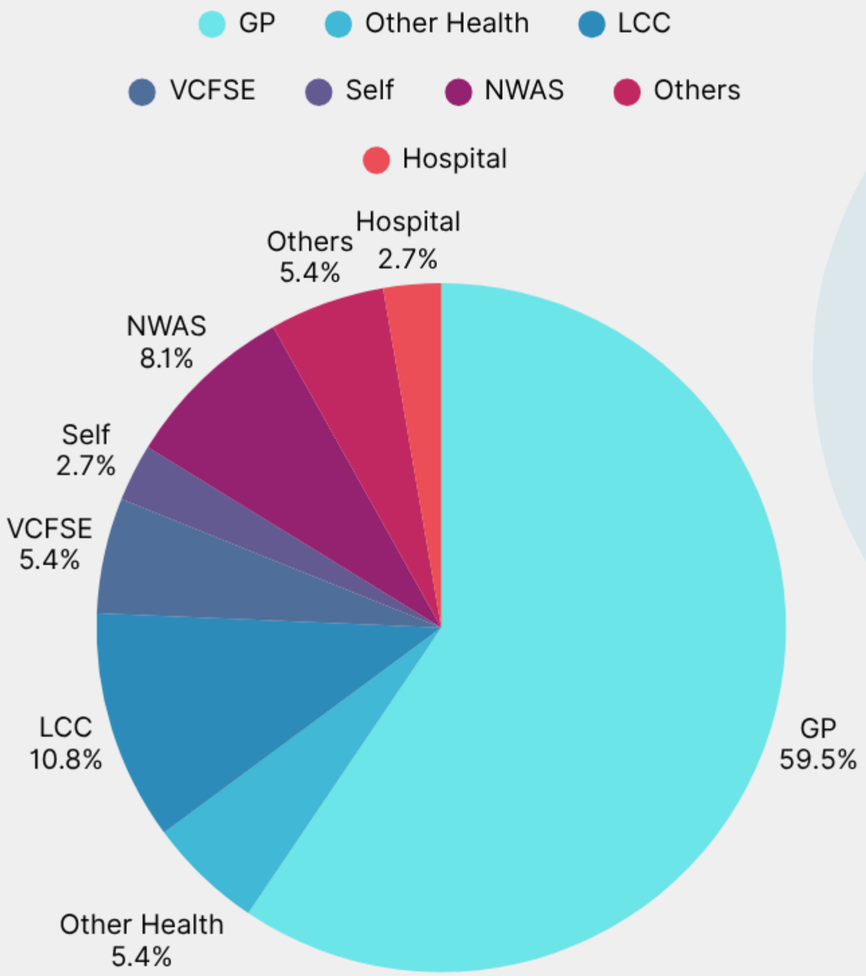
37

New Linkworker Referrals

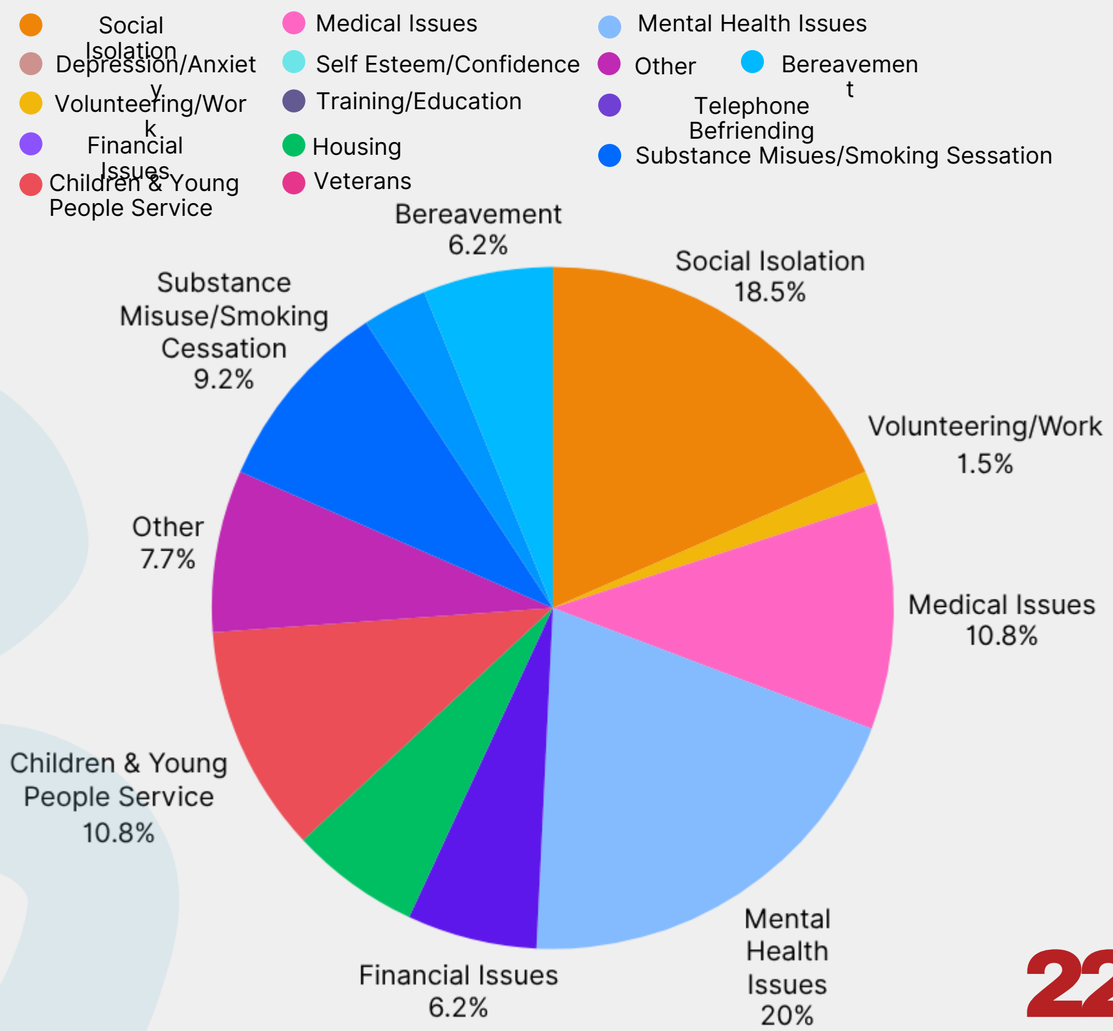
73

Closed Linkworker Cases

Ribble Valley Referrals From



Supporting People With



Ribble Valley Group Support & Funding

This Month In Ribble Valley we have: Group Support

Supported	16	Unique Groups
Given	20.5	Hours of Group Support
SP Team also attended	16	Hours of Meetings
	16	Training
SP Team referred into	31	VCF Organisations
	8	Statutory Organisations

This Month In Ribble Valley we have: Volunteering

SN Campions	17	Individuals
NVolunteers supported	19	Individuals

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.

Ribble Valley Case Study Robert

Reasons Indicated on Initial Referral

We have had a 94 year old client referred in by telephone call to our office from his daughter as she had heard about CVS and wondered if we could help him

Initial Assessment and Support Provided

Ian visited him at home and they built a good rapport and talked about lots of different interests the client has. He did talk about his wife and how sad he was that now he can't drive it is limiting how much he can see her. His mood visibly lifted in the time he was there the more they talked. He was not keen on the idea of going to a group but said he would think about the befriending service. Ian updated his daughter and they agreed that Ian would go again and talk again with him and see how he felt about a befriender and leave the idea of going to groups as she did not feel he would ever be able to do that.
Ian made enquiries with the befriending service as to whether they would have capacity to take him on before his next visit with him so that he wasn't promising something that couldn't be done. He was a bit confused initially on this visit and they talked about a doctor's home visit he had recently. They are monitoring him and he admitted that being on his own so much was impacting him. As the conversation progressed his mood and speech did improve and he said he would be interested in giving the befriending service a go. Ian helped him sort out some issues he was having on his computer and put some shortcuts on his computer so he could easily access documents and emails, he appreciated this help. It was clear he had enjoyed having the interaction with somebody.

Background of Client

He lives in a small village in the Ribble Valley and his daughter lives over 2 hours away, his wife moved into a care home a few months ago after a deterioration in her health and is now bed bound. They have always been a very close couple and not socialised much as they enjoyed spending their time together on their own which has also been facilitated by them living in a rural location. This has worked well for them until his wife's health started to decline. His daughter was not concerned about him being able to look after himself as he is fit and well and able to cook and clean for himself. She orders his shopping online so he has all his needs met except she feels he is now feeling lonely and has a worry that this will impact his health going forward. She visits regularly and takes him to see her mum but would like somebody to see what socially he might engage with if we could visit him. I discussed the option of a befriending service that might be an option.

Client Outcomes

Ian has visited again with a befriender which went really well. The befriender lives in the village and they got on really well. They established a good rapport and agreed a plan that the befriender will call in when he is passing regularly and the client was happy with this. He is keen that Ian still goes again which he will do until the befriending is established before discharging him.
The couple had a lot of input from adult social care in the build up to his wife eventually having to go into a care home and they attempted to engage him with some social activities but he had previously not wanted to engage with anything. The good relationship we have built with a local befriending service run by a local catholic organisation combined with our role as a social prescribing service based in the community means we have been able to visit this client at home and give him time to talk with no agenda. This has given this client the time to be able to make a decision for himself. The opportunity to connect with a befriender who lives in his village is hopefully going to lead to a positive outcome for him and he is able to continue to live at home which is what he wants and will ease his feelings of loneliness and isolation.

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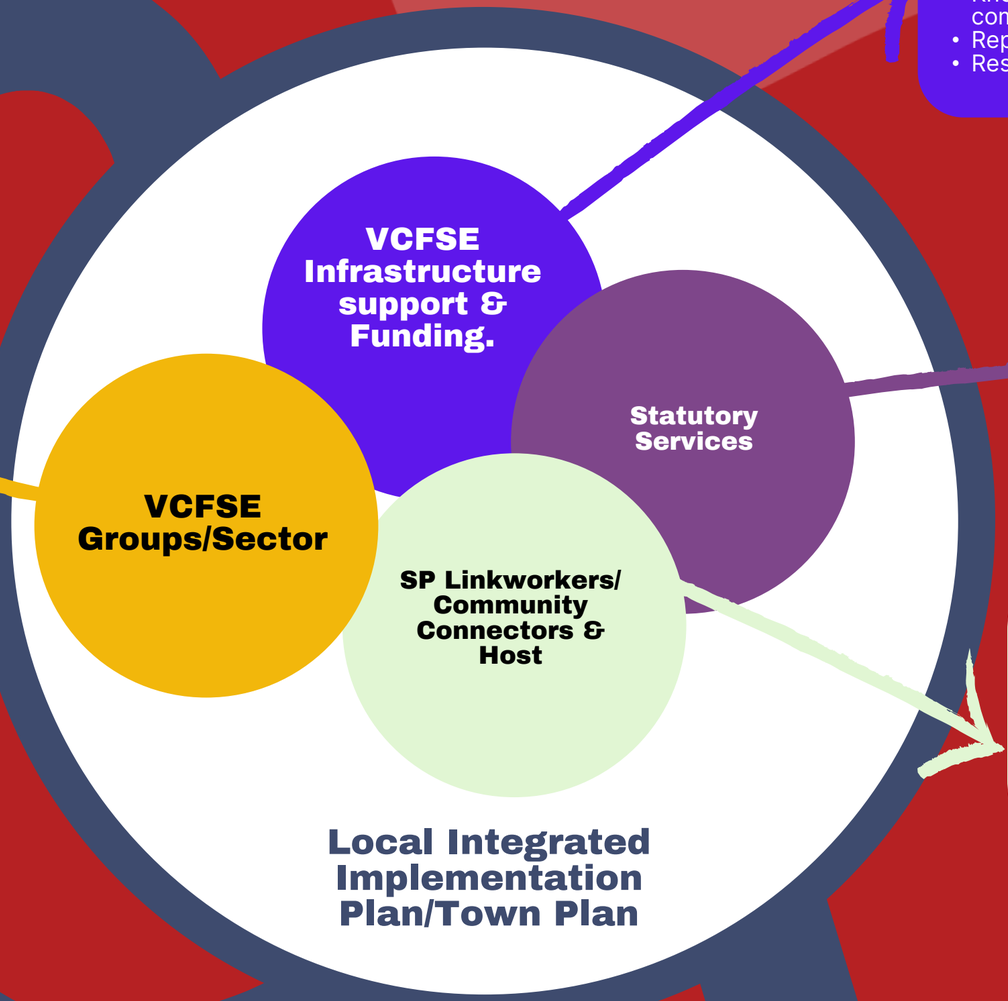
Working in partnership using the whole system approach.



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.