

# Social Prescribing MONTHLY REPORT

**AUGUST  
2026**

Working in partnership in  
East Lancashire



**BURNLEY PENDLE  
& ROSSENDALE**  
COUNCIL FOR VOLUNTARY SERVICE

Registered Charity Number: 1062446 Company Limited By Guarantee: 3328219



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



|           |                                                   |           |                                                |           |                                       |           |                                                        |
|-----------|---------------------------------------------------|-----------|------------------------------------------------|-----------|---------------------------------------|-----------|--------------------------------------------------------|
| <b>01</b> | Overview of Social Prescribing in East Lancashire | <b>09</b> | Pendle Group Support & Funding Team            | <b>17</b> | Hyndburn Referrals                    | <b>24</b> | Ribble Valley Case Study                               |
| <b>02</b> | Meet The Team                                     | <b>10</b> | Pendle Case Study                              | <b>18</b> |                                       | <b>25</b> | Working in Partnership Using the Whole System Approach |
| <b>03</b> |                                                   | <b>11</b> |                                                | <b>19</b> | Hyndburn Group Support & Funding      |           |                                                        |
| <b>04</b> | Burnley Referrals                                 | <b>12</b> | Rossendale Referrals                           | <b>20</b> | Hyndburn Case Study                   |           |                                                        |
| <b>05</b> | Burnley Group Support & Funding Team              | <b>13</b> | Rossendale Group Support & Funding Team        | <b>21</b> |                                       |           |                                                        |
| <b>06</b> | Burnley Case Study                                | <b>14</b> | Rossendale Case Study                          | <b>22</b> | Ribble Valley Referrals               |           |                                                        |
| <b>07</b> |                                                   | <b>15</b> | Social Prescribing for Children & Young People | <b>23</b> | Ribble Valley Group Support & Funding |           |                                                        |
| <b>08</b> | Pendle Referrals                                  | <b>16</b> | Family Case Study                              |           |                                       |           |                                                        |

# 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.

## 22,042

**Total number of referrals since commencement.**

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

## 8,486,170

**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 22,042 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.

## 264,504

**Hours of SP Support**

(Average of 2 hours per session x 6 sessions x 22,042)

# 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  
Hoarding all areas

## Pendle



**James Smith**  
Social Prescribing  
Linkworker (PE)



**Julie Holden**  
Social Prescribing  
Linkworker (PW)



**Zoe Bell**  
Social Prescribing  
Linkworker (PW)



**Amanda Nowell**  
Social Prescribing  
Linkworker (PW)



**Pam Bailiff**  
Social Prescribing  
Linkworker (PE)



**Farrah Rafiq**  
Social Connector



**Rebecca Hayworth**  
ASC Social Connector

## Rossendale



**Rebecca Nolan**  
Social Connector



**Jonathan Sheriff**  
Social Connector

## Group & Volunteer Support Team



**Heather Starkie**  
Funding Co-ordinator



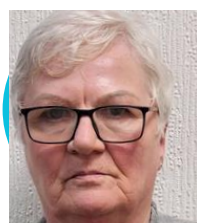
**Rebecca Nolan**  
Group Support &  
Training



**Julie Overson**  
Project Support



**Caroline Littleworth**  
Project Support



**Lorna Powell**  
Admin Support



**Salma Liaqat**  
Admin Support

## Children & Young People Team



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



**Sania Farzana**  
Social Prescribing  
Linkworker – C&YP (PW)



**Andrew Robinson**  
Social Prescribing  
Linkworker – C&YP (BE)



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

## Hyndburn & Ribble Valley



Social  
Prescribing Lead



Social  
Prescribing  
Linkworker



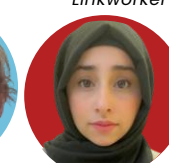
Green Social  
Connector



Social  
Prescribing  
Linkworker



Social  
Prescribing  
Linkworker



Social  
Prescribing  
Linkworker



Social  
Prescribing  
Linkworker



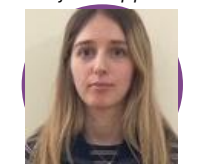
Social  
Prescribing  
Linkworker



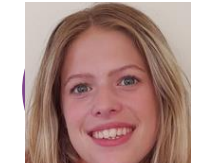
Social  
Prescribing  
Linkworker



**Dorothy Parsons**  
Project Support



Administration  
Officer



Admin &  
Marketing  
Apprentice

# Burnley

**682**

**Referrals So Far  
This Year**

**26**

**New Connector  
Referrals**

**27**

**Closed Connector  
Cases**

**38**

**Current/Active  
Connector Cases**

**43**

**New Linkworker  
Referrals**

**37**

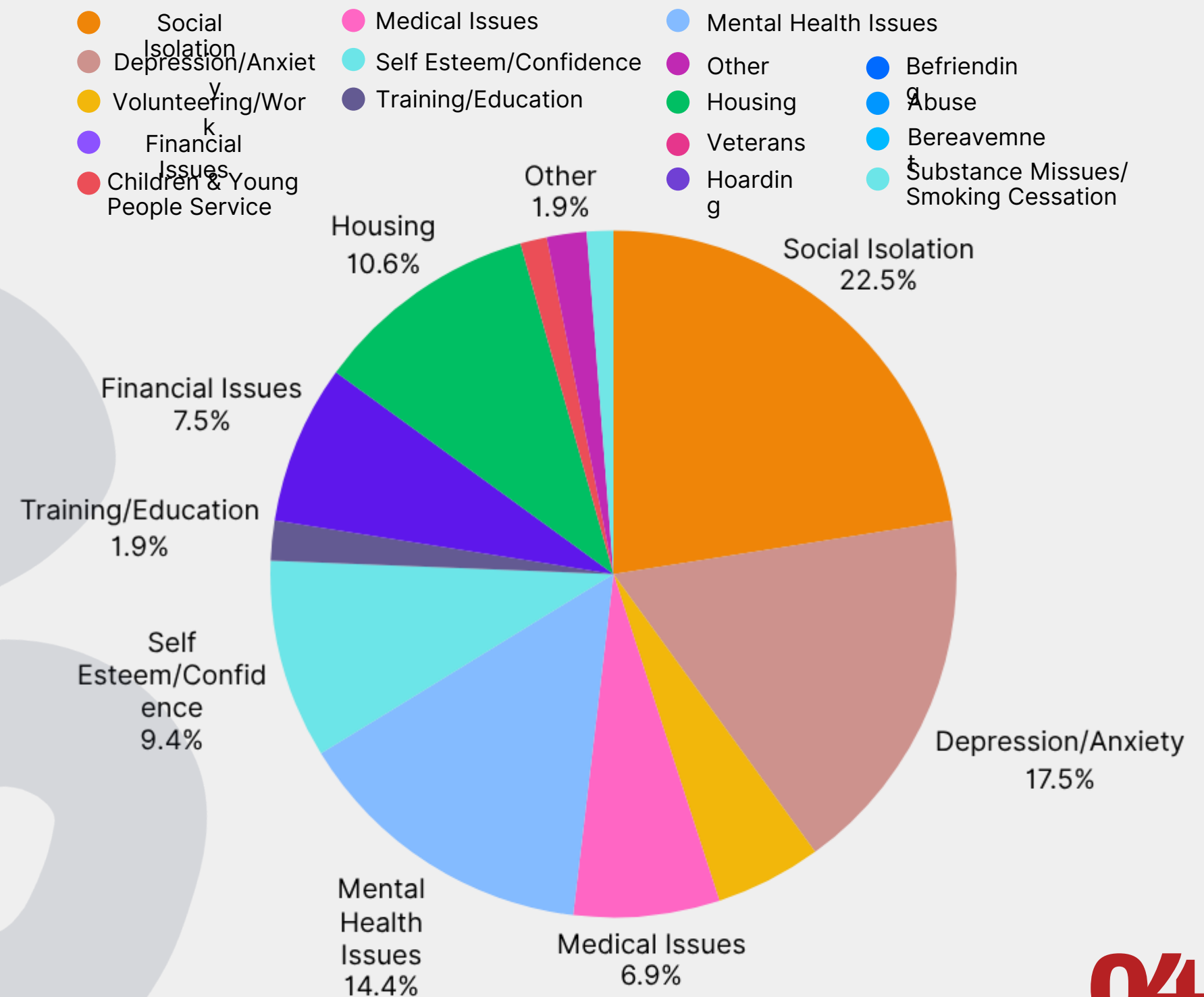
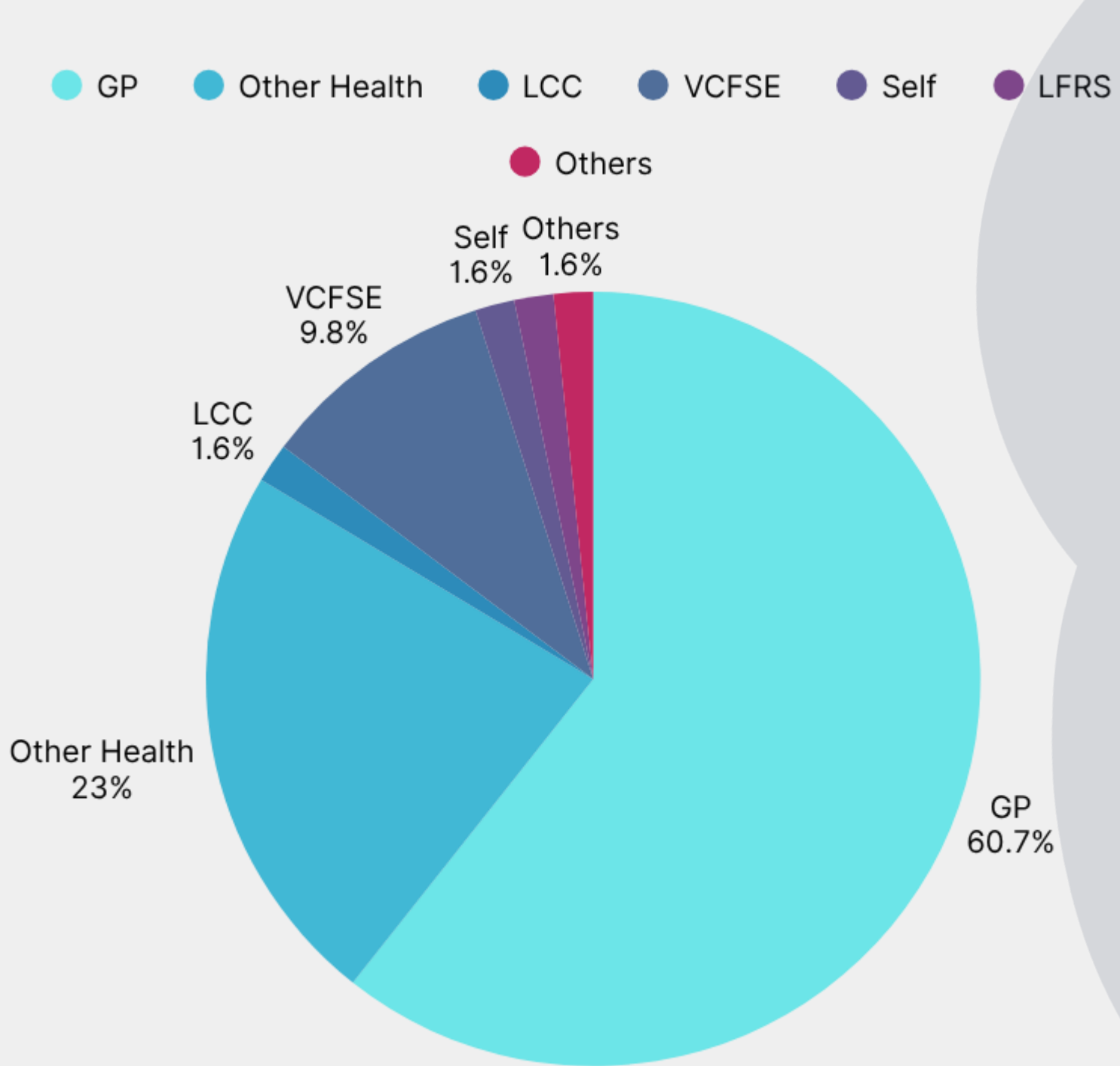
**Closed Linkworker  
Cases**

**81**

**Current/Active  
Linkworker Cases**

# Burnley Referrals From

# Supporting People With



# Burnley Group & Volunteer Support Team



| Burnley                |       | Group Support           |
|------------------------|-------|-------------------------|
| Supported              | 36    | Unique Groups           |
| Support Given          | 29:40 | Hours of Group Support  |
| SP Team Attended       | 57.5  | Hours of Meetings       |
| SP Team Attended       | 3     | Hours of Training       |
| SP Teams Referred into | 34    | VCFS Organizations      |
| SP Teams Referred into | 14    | Statutory Organisations |
| Burnley                |       | Volunteering            |
| Enquiries Recieved     | 17    | Individuals             |
| Currently Volunteering | 30    | 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:

## I hope my story helps someone else

### Reasons Indicated on Referral

Referred by GP for support with social isolation, worsening anxiety and needing support with self-esteem/confidence

### Initial Assessment and Support Provided

Client initially said she would prefer 1-1 support and feels anxious in groups. She agreed to meet me at Park Social group which my colleagues and I run. I met her at the park, and we had an initial 1-1 chat and then introduced her to others in the group. I also took her to see her the Limitless Cycling in the park that's on at the same time

| ONS4    | Life Satisfaction | Anxiety | Happiness | Worthwhile |
|---------|-------------------|---------|-----------|------------|
| Initial | 5                 | 9       | 5         | 5          |
| Final   | 7                 | 7       | 7         | 7          |

This client has shown improvement accross the board

### Background of Client

client is a woman in her 30's who has a learning disability and physical disability.

### Client Outcomes

Client has now been attending Park Social group and and said she likes coming and she also loved the cycling. She said that with having a disability she didn't think she would be able to ride a bike and said she really enjoyed it.

### Client Comment

Client said she would said she would never have tried these activities without Social Prescribing support. She said she hopes that this case study will help someone else who has a disability know that they can also do things like this. Said she plans to attend the sessions regularly now.

# Pendle

**667**

**Referrals So Far  
This Year**

**23**

**New Connector  
Referrals**

**6**

**Closed Connector  
Cases**

**32**

**Current/Active  
Connector Cases**

**34**

**New Linkworker  
Referrals**

**26**

**Closed Linkworker  
Cases**

**83**

**Current/Active  
Linkworker Cases**

**Reporting on behalf of Pendle East PCN**

**23**

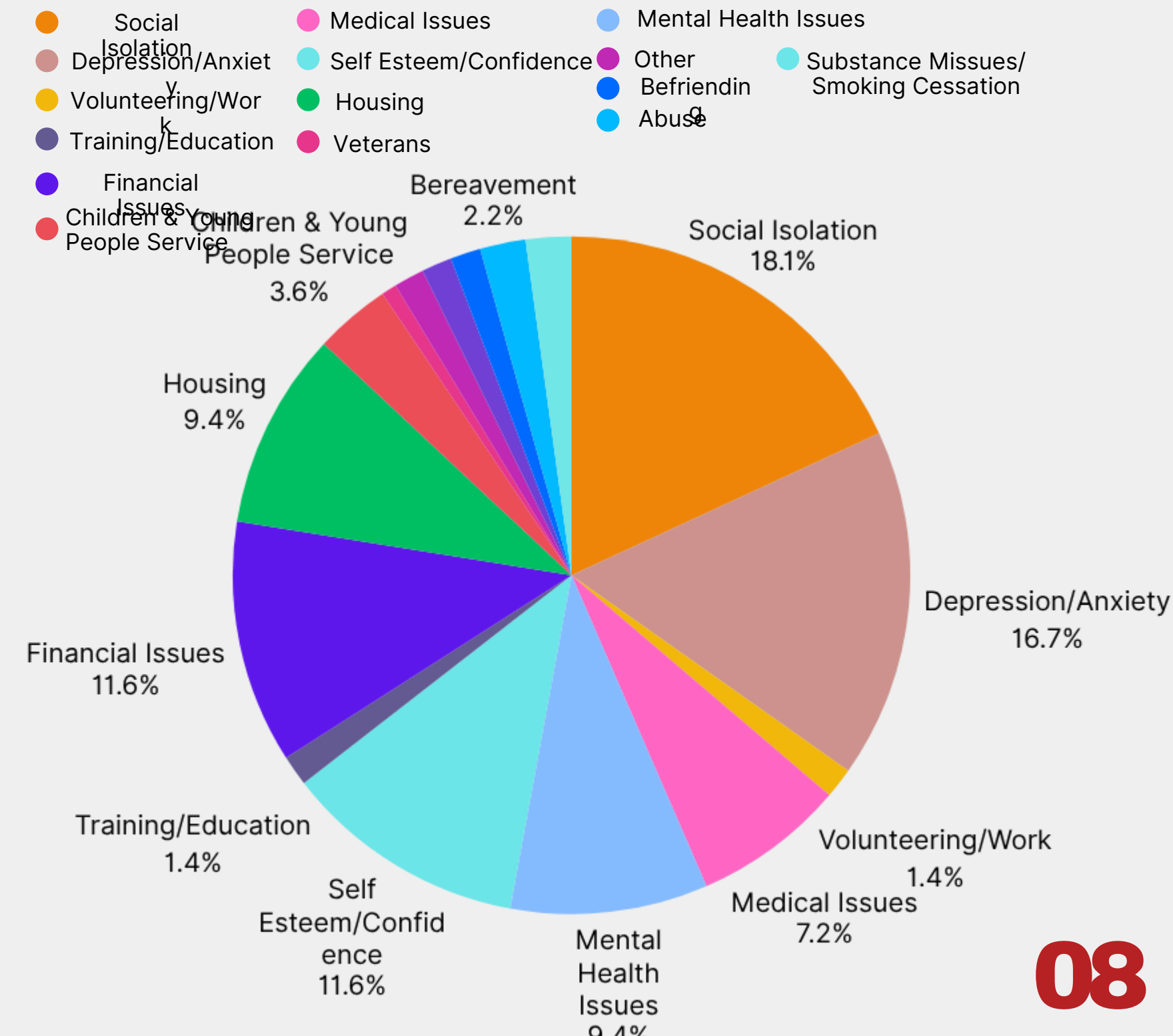
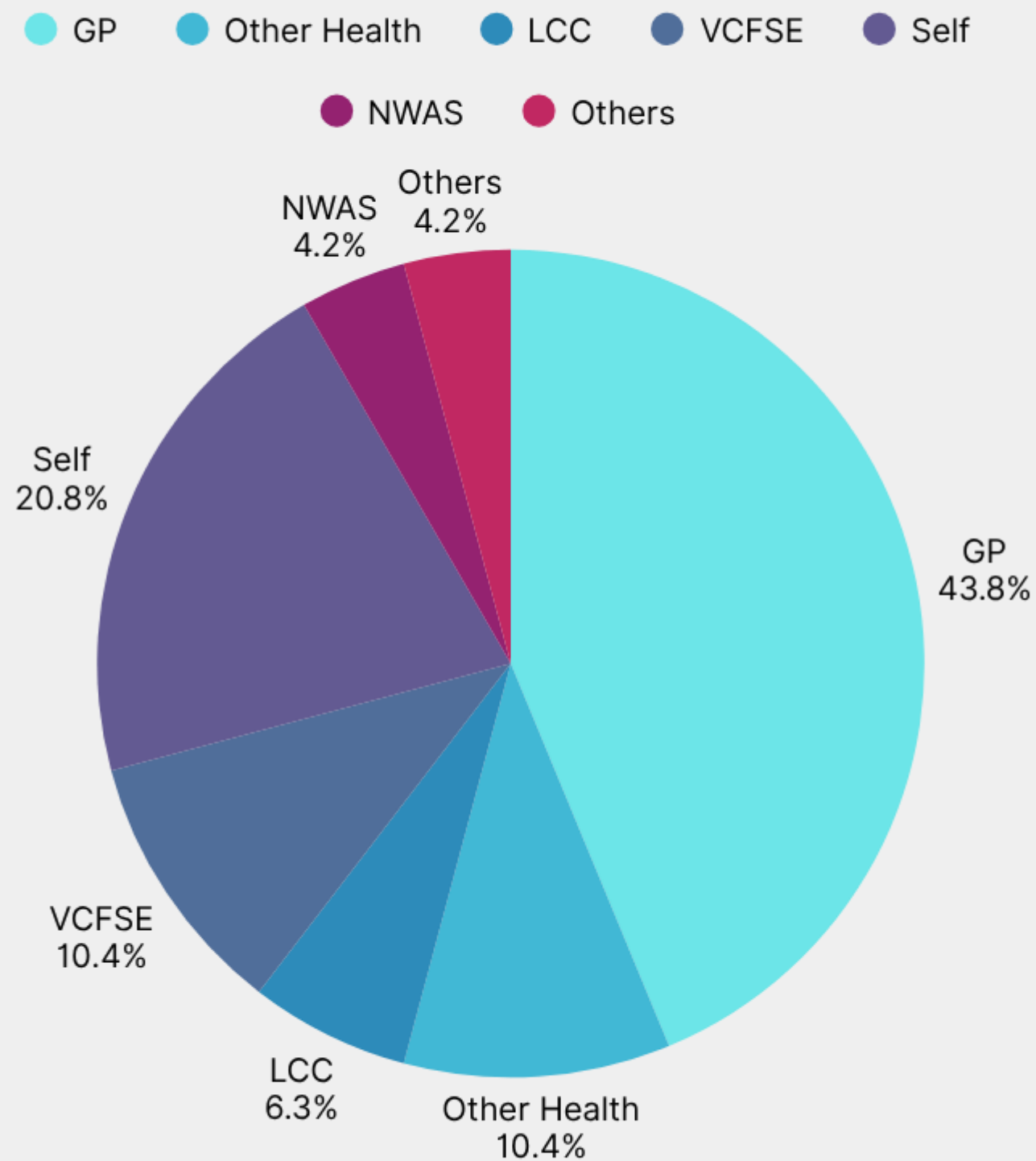
**New Linkworker  
Referrals**

**1**

**Closed Linkworker  
Cases**

# Pendle Referrals From

# Supporting People With



# Pendle Group & Volunteer Support Team

| Pendle                 |     | Group Support           |
|------------------------|-----|-------------------------|
| Supported              | num | Unique Groups           |
| Given                  | num | Hours of Group Support  |
| SP Teams Also Attended | num | Hours of Meetings       |
| SP Teams Also Attended | num | Hours of Training       |
| Sp Teams Referred Into | num | VCFS Organisations      |
| SP Teams Referred into | num | Statutory Organisations |
| Pendle                 |     | Volunteering            |
| Enquiries Received     | num | Individuals             |
| Signed up For Training | num | Organisations           |
| Currently Volunteering | num | Individual              |

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# Pendle: I didn't know which way to turn

## Reasons Indicated on Initial Referral

Client A was referred into the service for support with financial difficulties.

## Background of Client

Client is female aged 39 years old. She lives at home with her 3 children. Her ethnicity is Pakistani and her main language is Urdu. She has remarried but is separated from her husband. She lives in a privately rented property and is struggling to pay the bills and rent.

## Initial Assessment and Support Provided

Client A was suffering with her mental health and feeling isolated. She was feeling overwhelmed and was concerned about being deported back to Pakistan. She was receiving death threats from her first husbands' family. She was worried about the impact this was having on her children. Financial worries.

| ONS4    | Satisfaction | Worthwhile | Happiness | Anxiety |
|---------|--------------|------------|-----------|---------|
| Initial | 5            | 5          | 5         | 8       |
| Final   | 6            | 7          | 5         | 6       |

An improvement is shown in 3 areas

## Client Outcomes

Referrals made to The Ansaar Project for support with finances and asylum status. Referral to Food for All, food bank. Referral to friendship forum. Referral to Yes Hub for teenage child.

## Client Comments

Thank you so much for all your help. I didn't know which way to turn. I appreciate you coming to my home and I am grateful that you have helped with my children. I am receiving support and I have a support worker who speaks Urdu.

# Rossendale

**150**

**Referrals So Far  
This Year**

**16**

**New Connector  
Referrals**

**18**

**Current/Active  
Connector Cases**

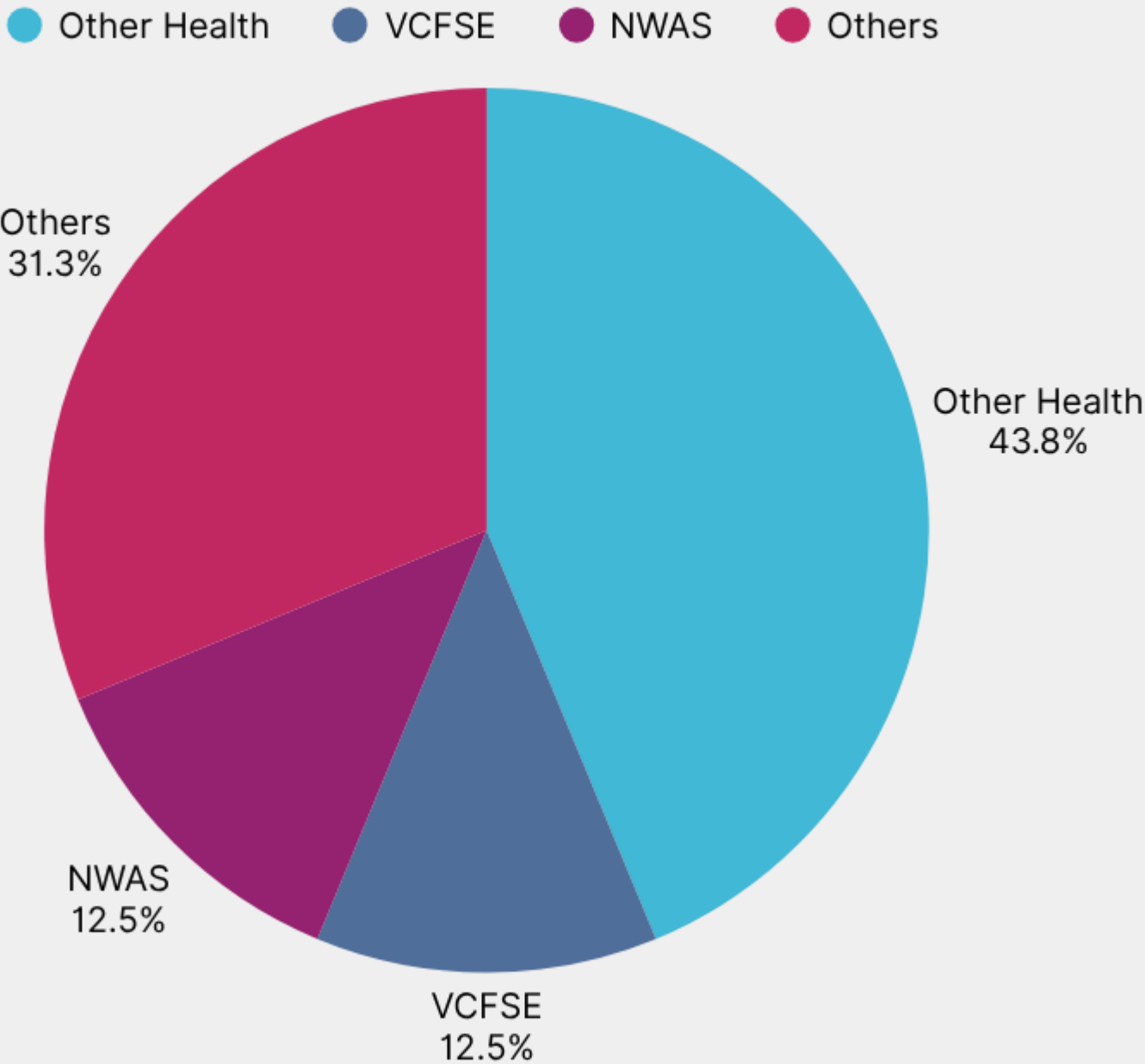


**5**

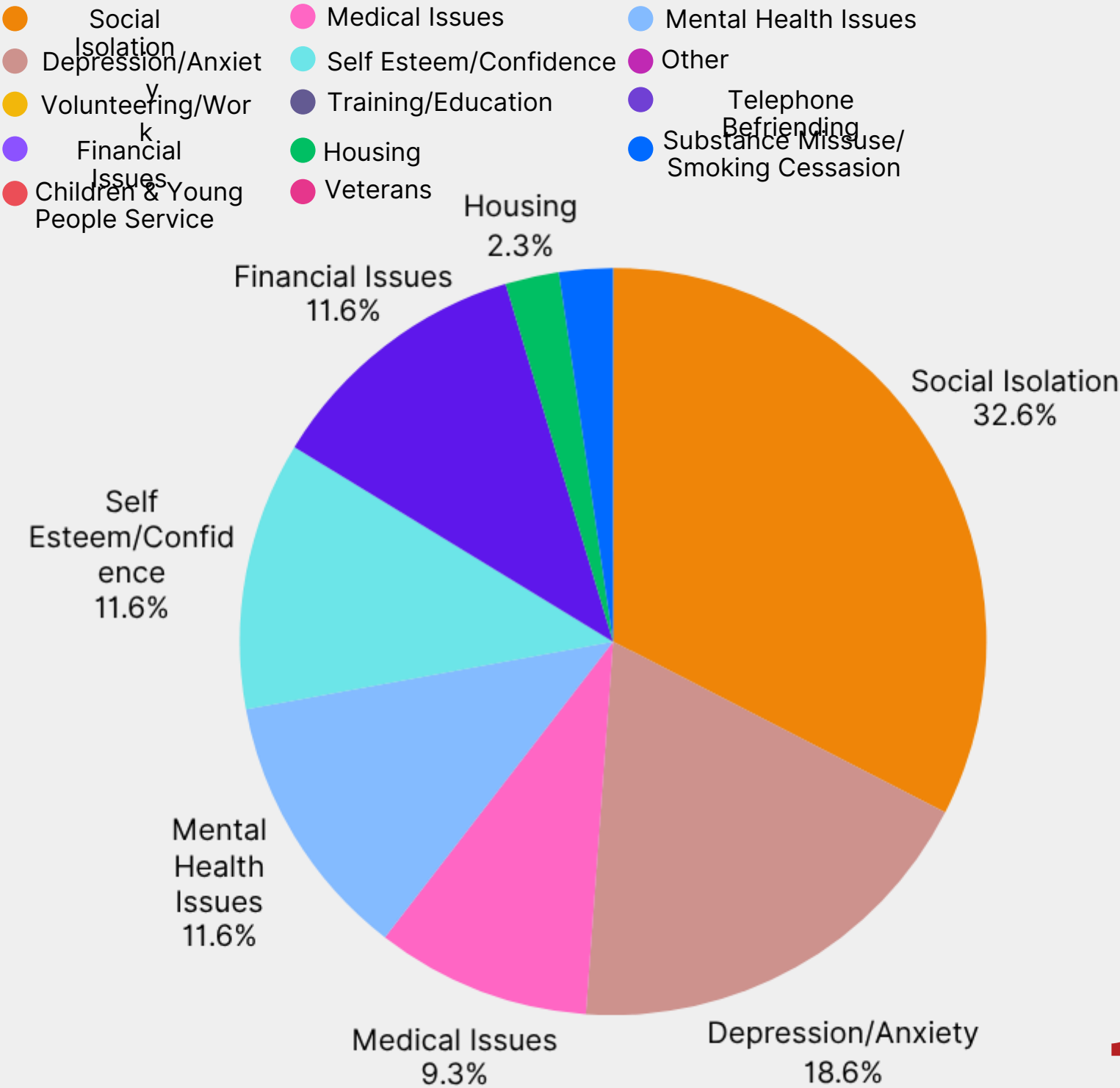
**Closed Connector  
Referrals**

**11**

# Rossendale Referrals From



# Supporting People With



# Rossendale Group & Volunteer Support Team

| Rossendale             |     | Group Support           |
|------------------------|-----|-------------------------|
| Support                | 25  | Unique Groups           |
| Given                  | 20  | Hours of Group Support  |
| SP Teams Also Attended | 2.5 | Hours of Meetings       |
| SP Teams Referred into | 13  | VCFS Organisations      |
| SP Teams Referred into | 7   | Statutory Organisations |
| Rossendale             |     | Volunteering            |
| Volunteer Enquiries    | 2   | Individuals             |
| Currently Volunteering | 1   | Individuals             |

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# Rossendale

## I am confident in being a good mum now

### Reasons Indicated on Initial Referral

Substance Misuse / smoking

### Background of Client

Gender: Female  
Age: 26 – 39  
Client is a single mother to 2 boys. Has limited contact with family. Has a couple of friends.  
Lives alone in social housing

### Initial Assessment and Support Provided

- Recent relationship breakdown
- Recently come out of hospital due to rapid substance withdrawal.
- Experiencing low mood- at first meeting had been sober for 6 weeks
- Multiple health conditions due to long term substance use which is causing isolation.
- Client wants support accessing support for her alcohol misuse, accessing activities and support for self especially during the school holidays which were approaching.

| Happines<br>s | ONS4    | Satisfaction | Worthwhil<br>e | Anxiety |
|---------------|---------|--------------|----------------|---------|
| 5             | Initial | 4            | 6              | 7       |
| 9             | Final   | 8            | 9              | 8       |

Has show significant improvement accross three areas

### Client Outcomes

- Client had very low self-esteem and confidence. When initially suggested to meet in the community she was resistant – made 2 home visits.
- Had numerous conversations including the initial assessment where she identified her needs: Wants to be a good mum, alcohol use support, wants some adaptations to home to support her physical health (fibromyalgia), doesn't want to be isolated.
- Was able to give lots of praise and support client in reframing her thoughts about herself, and her situation. Many discussions around positive parenting strategies which she later reported she had used with the boys and was seeing results including a daily timetable for the half term holidays that the children could follow.
- Was able to signpost and support client in accessing Inspire, Homestart, adult services, Rossendale family hubs.
- Client reported many times that she wanted to show her boys that she was getting better and so was able to initially go for small walks with the boys to build up confidence. Client would go to familiar places like the GP but would not venture further than that independently.
- Had regular check ins with client to offer encouragement and support. Client was able to self-refer to Occupational Health for an assessment for adaptations to her home which was successful. She accessed Inspire and continues to do well with her sobriety.
- Client reported that she felt so much empowered and confident especially in her parenting role and this was evident in her being able to travel from Whitworth to Rawtenstall with her children on the bus and go shopping, lunch and even went to the Rawtenstall family hub to find out information about the half term holiday activities.
- Was able to signpost client to Rossendale council for children's activities. Client reported that she accessed local park activities was able to entertain the children and spend quality time.
- Outcomes were strong for this client from initial findings over being very isolated to venturing out into the community accessing services and activities confidently and independently whilst performing her parenting role

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@bprcv.co.uk](mailto:tracey.noon@bprcv.co.uk) should you have any questions

# Social Prescribing for Children & Young People

**Pendle West**

**73**

**Referrals So Far This Year**

**3**

**New Referrals**

**27**

**Current Active**

**54**

**Active for  
Accessing Activities**

**1**

**New Referrals**

**Pendle East**

**STOP PRESS \* STOP  
PRES**

Burnley East PCN has recently provided funding for a Children's and Young People's SPLW who joined us in August - watch this space



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: We Love Your Service

## Background

A child was referred into our service for support around accessing school. Mum was not engaging with school due to her own concerns with the school, resulting in the child missing out on their education. Mum did not have a positive relationship with the school.

## Actions Taken

Completed parent initial assessment, child's initial assessment and progress reviews with Mum present. We built a positive relationship with Mum and child, and supported both while child transitioned to a different school.

## Outcomes

Mum loves our service. A lot of progress has been made since we met Mum. Child accesses all of our activities, Mum attends the parent and child activities. Child attended all of our summer activities. Child has settled well in the new school. Mum engages really well with our service.

## SP Comment

This case study highlights the rapport built between us, the parent, child and school.



# Hyndburn

**558**

**Referrals So Far  
This Year**

**94**

**Current/Active  
Linkworker  
Referrals**

**67**

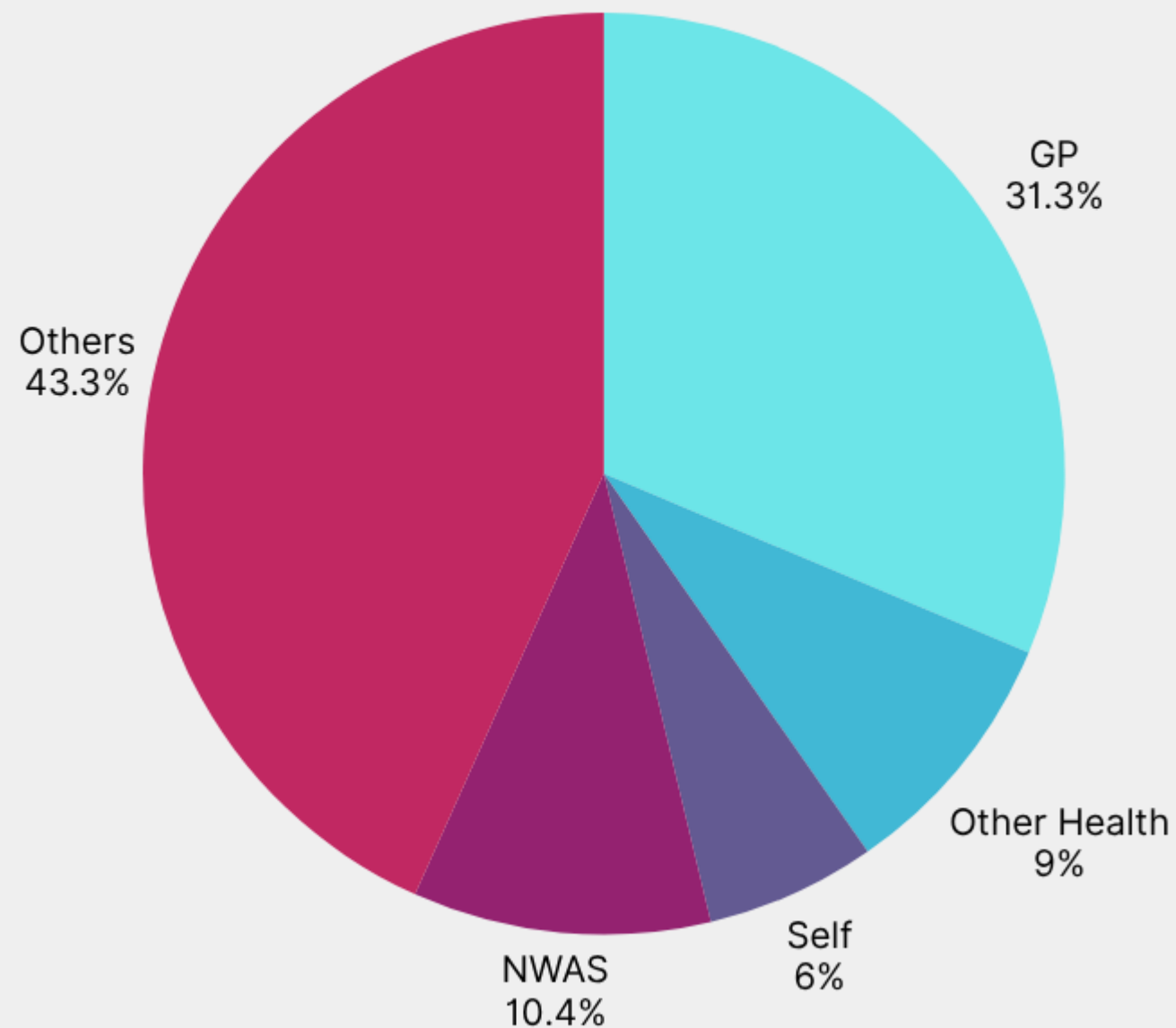
**New Linkworker  
Referrals**

**70**

**Closed  
Linkworker Cases**

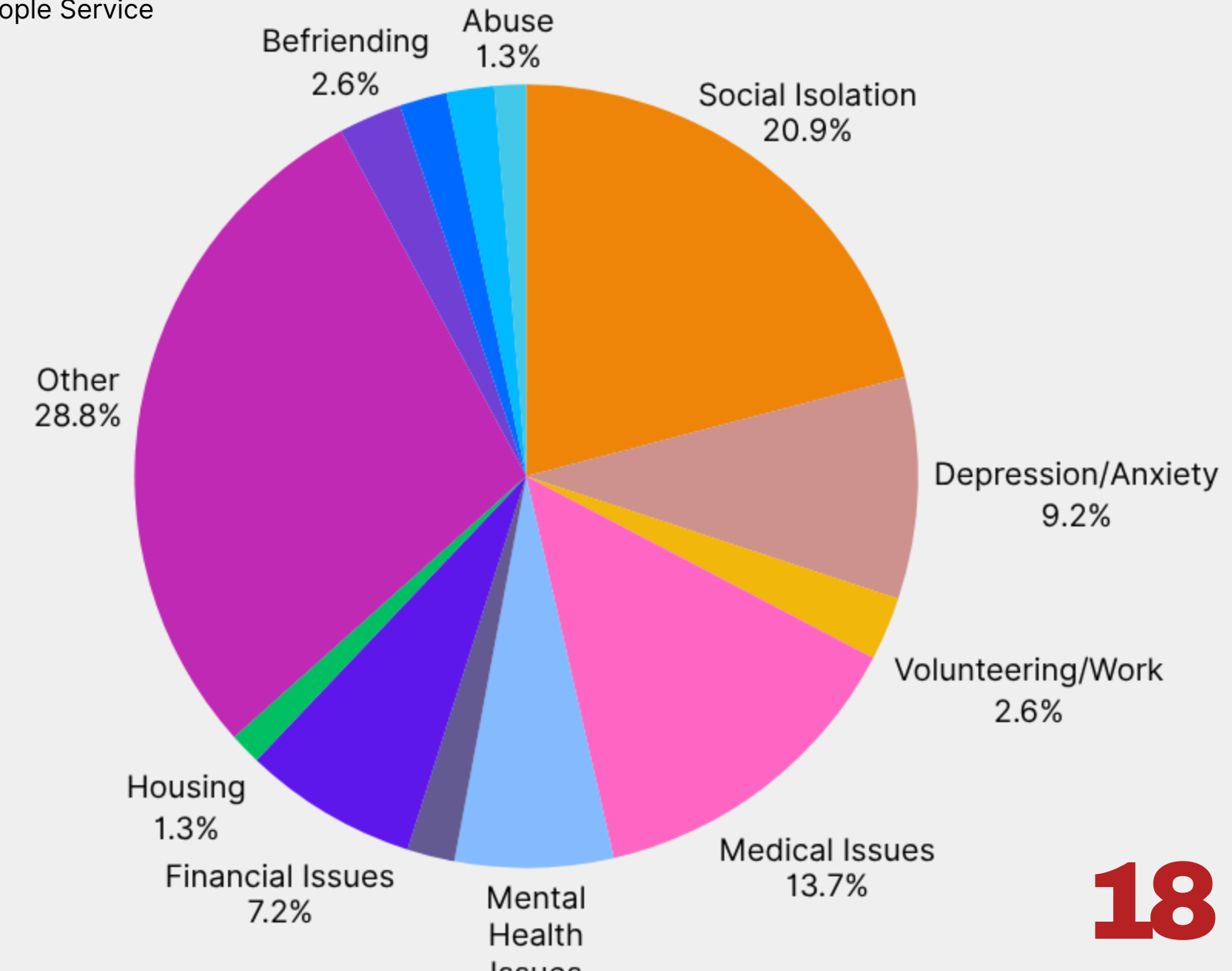
# Hyndburn Referrals From

GP Other Health Self NWAS Others



# Supporting People With

Social Isolation  
Depression/Anxiety  
Volunteering/Work  
Financial Issues  
Children & Young People Service  
Medical Issues  
Self Esteem/Confidence  
Training/Education  
Housing  
Veterans  
Mental Health Issues  
Other  
Young Carer  
Befriending  
Abuse  
Bereavement  
Substance Misuse/Smoking Cessation



# Hyndburn Group & Volunteer Support Team



| Hyndburn               |      | Group Support           |
|------------------------|------|-------------------------|
| Supported              | 12   | Unique Groups           |
| Given                  | 20.5 | Hours of Support        |
| SP Teams also Attended | 10   | Hours of Meetings       |
| SP Teams Also Attended | 8    | Hour of Training        |
| SP Teams Referred into | 34   | VCFS Organisations      |
| SP Teams Referred into | 10   | Statutory Organisations |
| Hyndburn               |      | Volunteering            |
| Volunteers             | 26   | Seen or Supported       |
| Volunteer Hours        | 26   | Completed               |

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# Hyndburn

## I feel very supported and able to move forward now

### Reason For referral and Background

20 yr old male – living in a tent in Hyndburn, homeless for 1 month, no family support, he has registered with the council when he was sofa surfing and was put on a waiting list and heard nothing else

When we called him he was in the hospital after the ambulance service took him in to have some tests to establish why he couldn't stop vomiting. It was during the heatwave and he said he had not eaten properly for a few weeks.

### Initial Assessment

### Support Provided

Initially connected him with the free community lunches and community support in Hyndburn and sent him information by text and arranged to contact him again when he was out of hospital

We kept in touch with him by telephone and text. He said he felt like the council were fobbing him off and he was also worried that he was going to have his universal credit stopped as he had received a text that said they were going to visit him, he hadn't informed them he was homeless. Established that he was in Accrington town centre, explained to him that he needed to go and get some advice otherwise his fears that his money may be cut off may be realised. Explained to him that Maundy Relief could support him with benefit advice and support and also for housing and strongly encouraged him to go, advised I would let them know he was coming. We spoke with the manager of the drop in service at Maundy relief and she said she would look out for him coming in. We contacted him again 2 weeks later, he said he was thankful for all the support we had given him. He said us ringing him to check in had felt very supportive and is what moved him forward. Maundy Relief had helped him and he had now been housed. He was very grateful for our support. He said he didn't need any other immediate help but encouraged him to contact us in future if he needs support with connecting with an organisation or social needs

### Client Outcomes

This is a good outcome for this client who was in desperate circumstances. Giving him the right level of support that worked for him and sharing our knowledge of local services with him helped him. Our relationship with local organisations and churches providing food support and housing advice has given him the support he needs to start rebuilding his life

# Ribble Valley

**318**

**Referrals So Far  
This Year**

**38**

**Current/Active  
Linkworker  
Referrals**

**30**

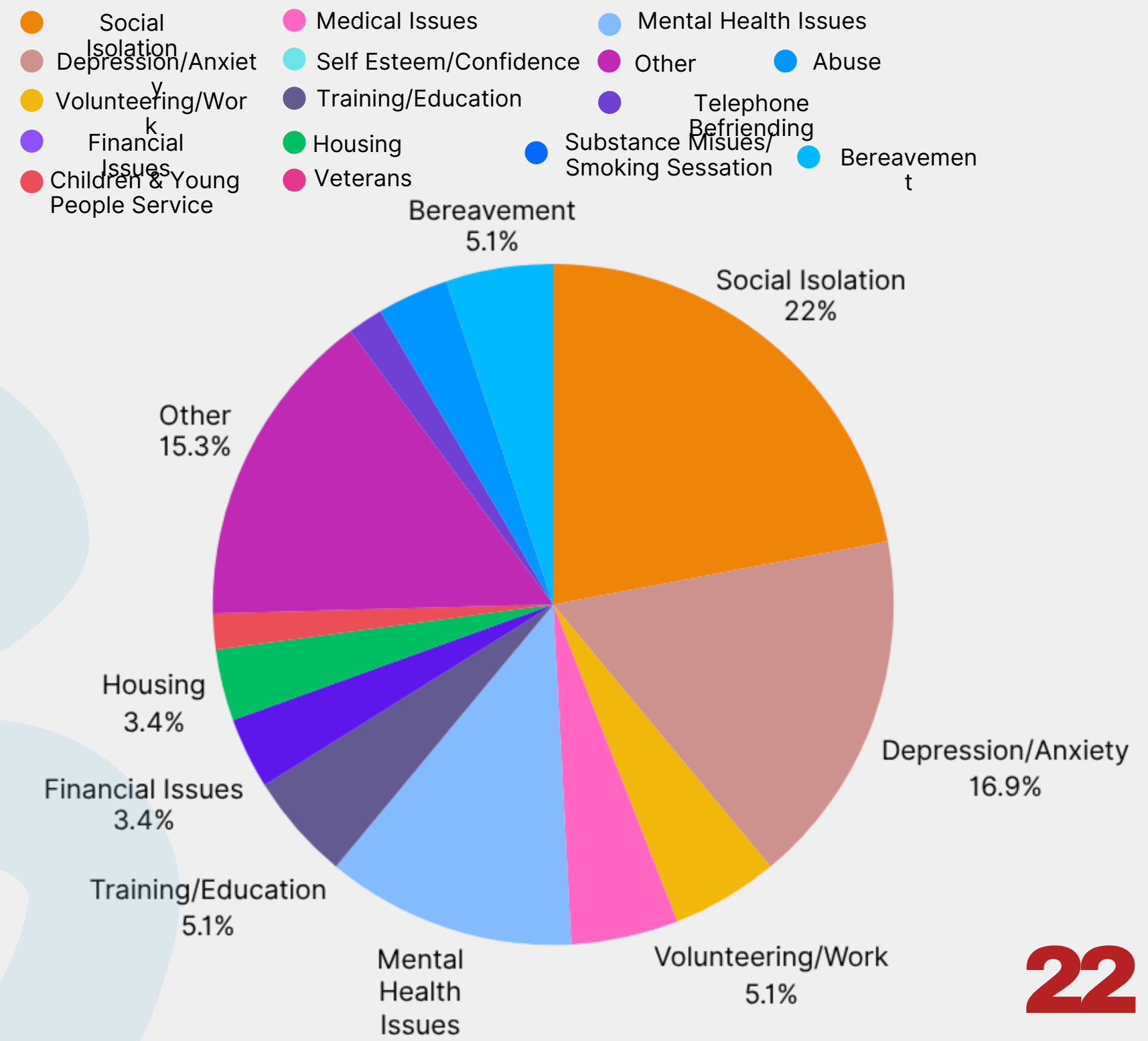
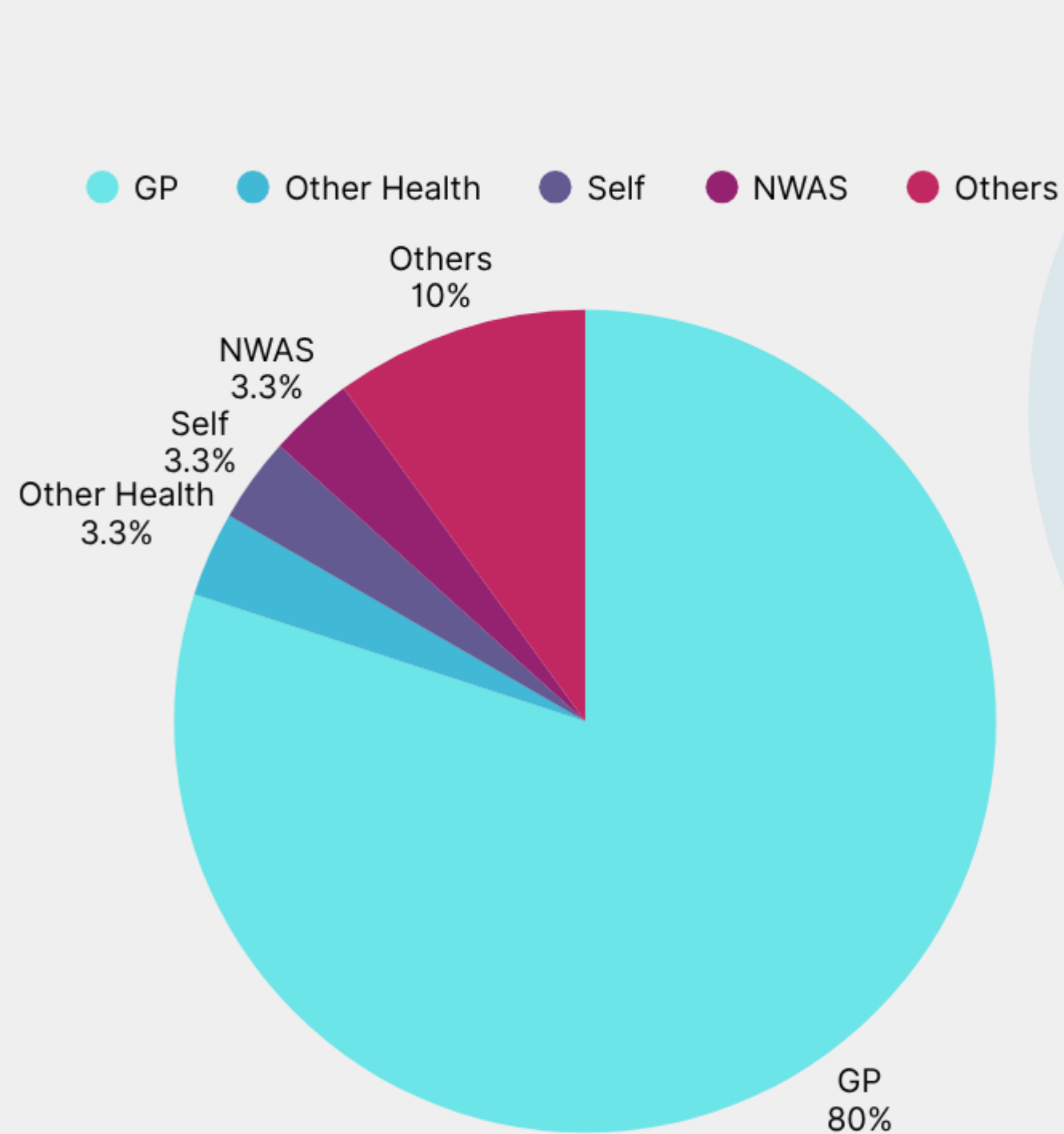
**New Linkworker  
Referrals**

**58**

**Closed  
Linkworker Cases**

# Ribble Valley Referrals From

# Supporting People With



# Ribble Valley Group & Volunteer Support Team



|                          |     |                         |
|--------------------------|-----|-------------------------|
| Ribble Valley            |     | Group Support           |
| Supported                | 15  | Unique Groups           |
| Given                    | 19  | Hours of Group Support  |
| SP Teams also Attended   | 6.5 | Hours of Meetings       |
| SP Teams also Attended   | 6   | Hours of Training       |
| SP Teams Referred into   | 28  | VCFS Organisations      |
| SP Teams Referred into   | 5   | Statutory Organisations |
| Ribble Valley            |     | Volunteering            |
| Volunteers supported     | 19  | Individuals             |
| Volunteers Opportunities | 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

## I didn't think I needed help

### Reasons Indicated on Initial Referral

Referral received from GP practice – 78 yr old male

We have had multiple referrals for him in the past as he has lots of physical health conditions COPD and suspected dementia and services struggle to engage with him as he is a strong character and bats services off saying he doesn't need anything, he lives alone and he doesn't go out other than medical appointments.

The GP referred him in for food assistance as he is not eating regularly and this impacts him as he is on a lot of medication

### Initial Assessment and Support Provided

He was visited at home, his health has deteriorated since their last contact and he is in more pain and has been struggling to arrange further medication with his pharmacy. He said he has food but doesn't have the energy or motivation to cook for himself so ends up not eating much. They discussed a home delivery service that deliver meals that just need heating up so it would make it easier for him and gave him a brochure

At the next visit he was again in a lot of pain and having problems with his phone so had not organised the food delivery service. Assisted him to sort out his phone and contacted his provider for him as he was once again struggling to contact his pharmacy.

A follow up visit was done as he had lost the brochure for the food delivery service and did not know how to contact them. A brochure was given to him with clear instructions so he will now be able to order his food delivery service which will improve his wellbeing when he is eating regularly again.

### Background of Client

He was last supported by our service a year ago and built a good relationship with Ian in our team.

### Client Outcomes

The time taken to build a rapport with this client and visit in his home where he feels comfortable has made a big difference for our ability to engage him. We have been able to assist him with his needs at the pace he needs it which has helped to move this client forward.

# Working in partnership using the whole system approach.

