

Social Prescribing MONTHLY REPORT

JULY
2026

Working in partnership in
East Lancashire



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



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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.

21,823

Total number of referrals since commencement.

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

8,401,855

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 21,823 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.

261,876

Hours of SP Support

(Average of 2 hours per session x 6 sessions x 21,823)

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)



Zoe Bell
Social Prescribing
Linkworker (PW)



Julie Holden
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



Mandy Richardson
Social Connector

Rossendale



Rebecca Nolan
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)



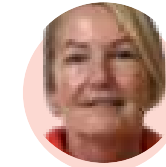
Sania Farzana
Social Prescribing
Linkworker – C&YP
(PW)
currently on maternity
leave



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



Social
Prescribing Lead



Social
Prescribing
Linkworker



Green Social
Connector



Social
Prescribing
Linkworker



Dorothy Parsons
Project Support



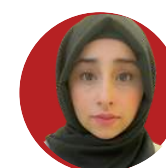
Administration
Officer



Admin &
Marketing
Apprentice



Social
Prescribing
Linkworker



Social
Prescribing
Linkworker



Social
Prescribing
Linkworker



Social
Prescribing
Linkworker

Burnley

613

**Referrals So Far
This Year**

23

**New Connector
Referrals**

28

**Closed Connector
Cases**

30

**Current/Active
Connector Cases**

66

**New Linkworker
Referrals**

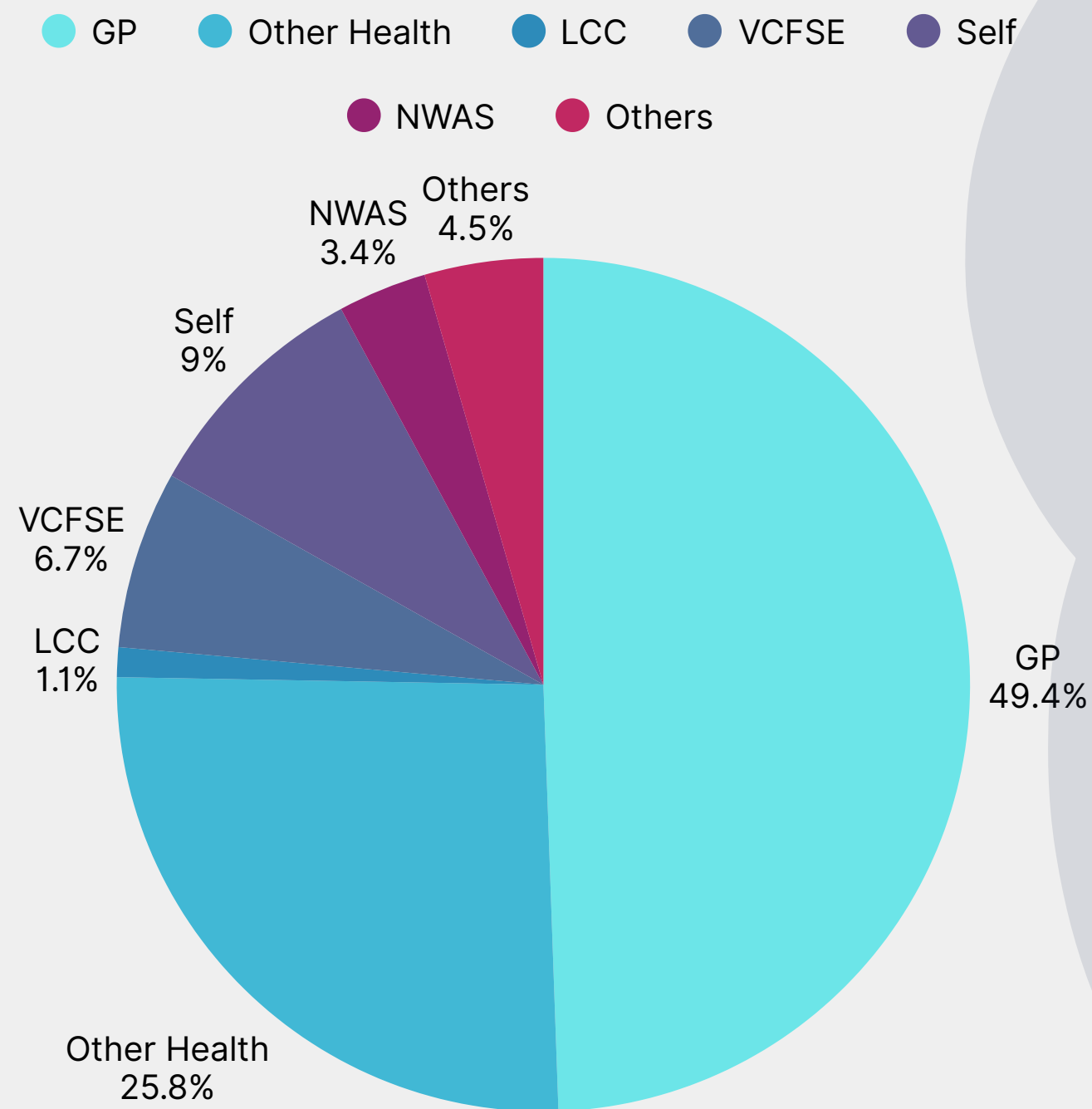
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**Closed Linkworker
Cases**

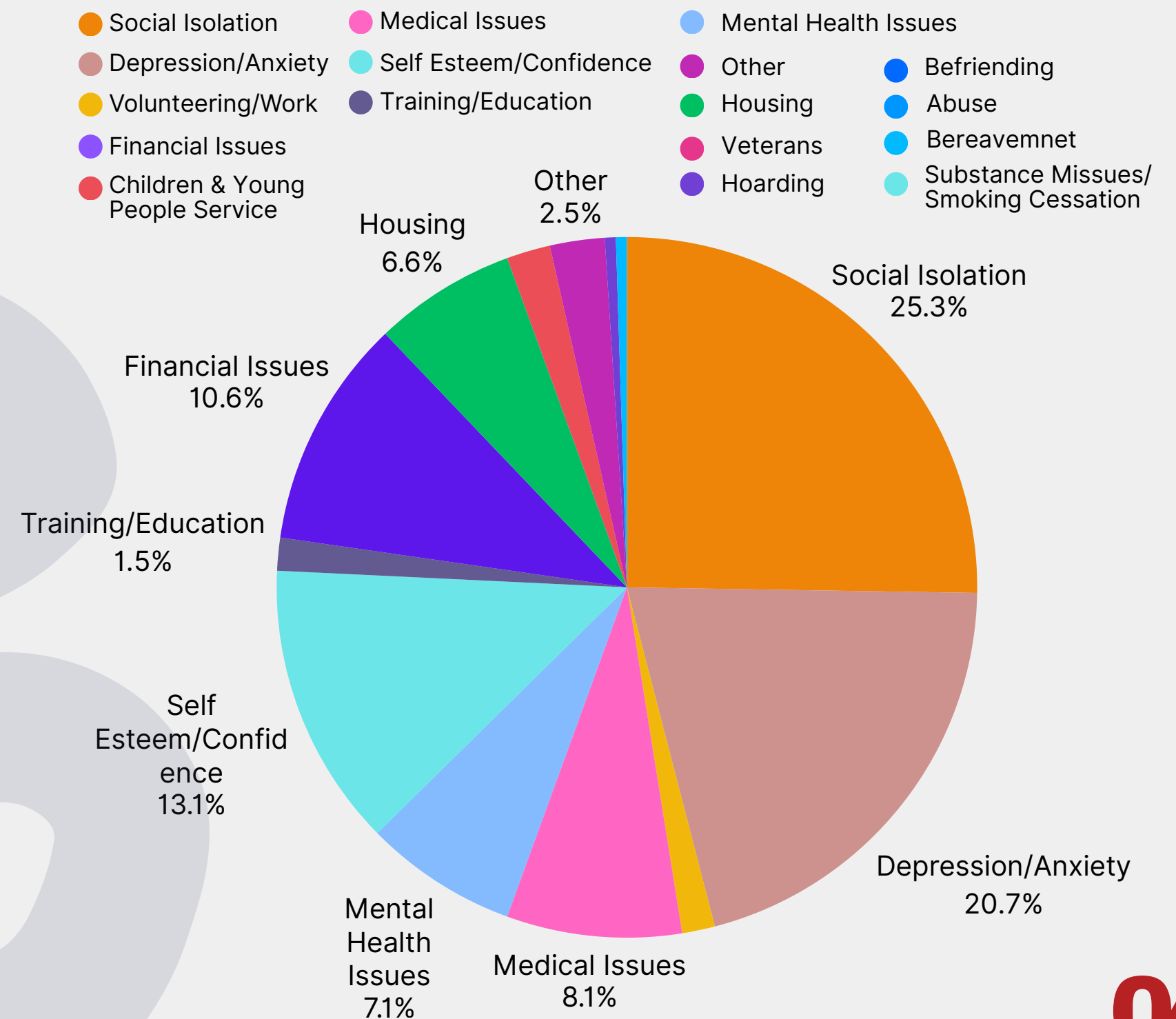
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**Current/Active
Linkworker Cases**

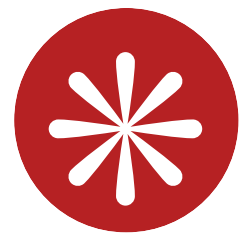
Burnley Referrals From



Supporting People With



Burnley Group & Volunteer Support Team



Burnley		Group Support
Supported	52	Unique Groups
Support Given	157.5	Hours of Group Support
SP Team Attended	48.5	Hours of Meetings
SP Teams Referred into	33	VCFS Organizations
SP Teams Referred into	16	Statutory Organisations
Burnley		Volunteering
Enquiries Recieved	21	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 would have carried on until my head exploded

ONS4	Life Satisfaction	Worthwhile	Happiness	Anxiety
Initial	6	7	6	7
Final	8	8	7	7

Reason Indicated for Referral

Social Isolation, Depression/Anxiety, Self-esteem/Confidence, Financial Issues, Housing

Background of Client

Rachel lives with her Dad Robert, she has a limited social network and would benefit from information about groups/activities in the local area. Rachel requires information about support available to apply for housing, she does not wish to do this currently but would like the information available to her. Rachel requires support to apply for a bus pass. Rachel is being referred to CAB to assist with applying for PIP.

Initial Assessment and Support Provided

During the Initial assessment Rachel wanted support to find groups where she could make friends. I told her about Art from the heart and met her there. I signposted to ICANN to apply for PIP as CAB hadn't been in touch. I supported her to apply for a bus pass. I also referred her to Workwell as she was having difficulties at work.

Client Outcomes

Rachel goes to the art group weekly and has made some friends. She has applied for PIP and for a bus pass. She has regular appointments with Workwell.

Client Comment

I would have carried on until my head exploded and ended up in hospital like it did before.

I felt very comfortable with you and you helped me sort my problems out.

Thank you

Pendle

587

**Referrals So Far
This Year**

17

**New Connector
Referrals**

17

**Closed Connector
Cases**

24

**Current/Active
Connector Cases**

43

**New Linkworker
Referrals**

38

**Closed Linkworker
Cases**

88

**Current/Active
Linkworker Cases**

Reporting on behalf of Pendle East PCN

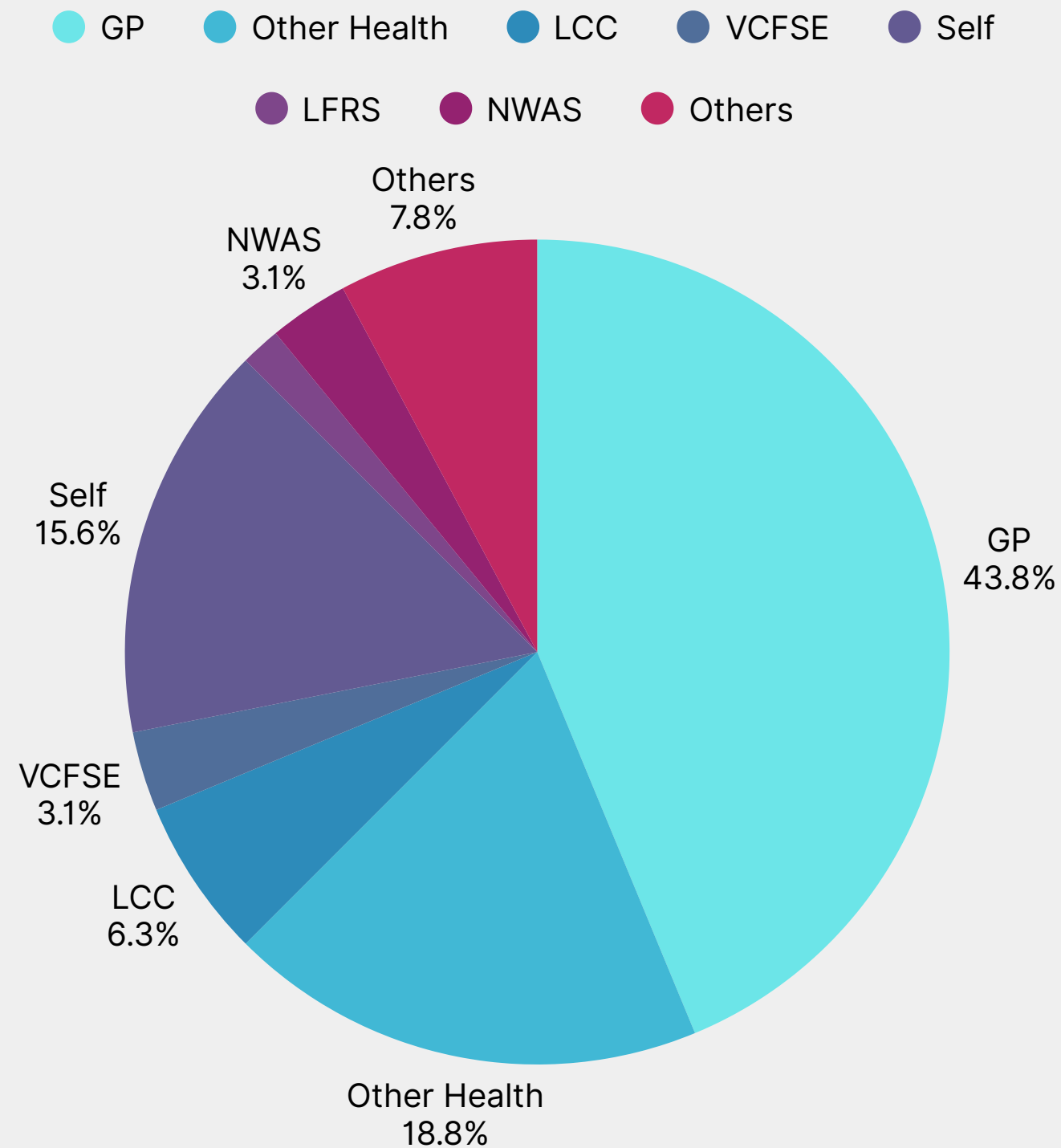
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**New Linkworker
Referrals**

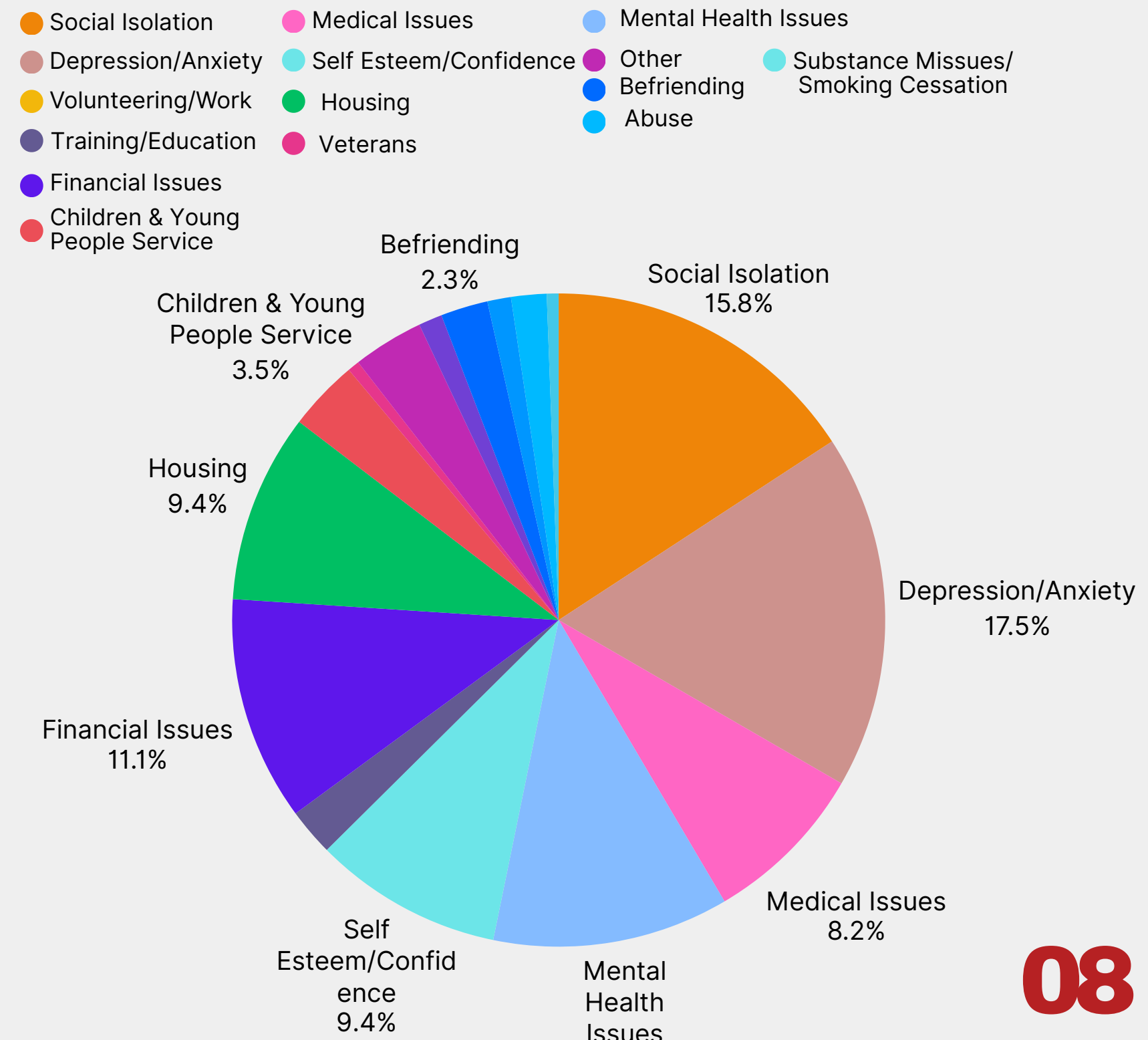
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**Closed Linkworker
Cases**

Pendle Referrals From



Supporting People With



Pendle Group & Volunteer Support Team

Pendle		Group Support
Supported	25	Unique Groups
Given	42	Hours of Group Support
SP Teams Also Attended	27.5	Hours of Meetings
Sp Teams Referred Into	46	VCFS Organisations
SP Teams Referred into	23	Statutory Organisations
Pendle		Volunteering
Enquiries Received	9	Individuals
Currently Volunteering	5	Individual

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Pendle

I didn't know where to turn

Reasons Indicated on Initial Referral

Housing Support and Anxiety

Background of Client

Young lady who has been the victim of domestic violence and is currently sofa surfing. Highly anxious and in need of rehousing as soon as possible

Initial Assessment and Support Provided

Divorced from her husband she is having to manage family conflicts in addition to having no fixed abode and dealing with high anxiety levels in addition to language barriers.

Having approached the council she was offered shared accommodation but due to social anxiety she feels unable to accept this and given vulnerabilities was at high risk of experiencing further abuse.

Following the initial assessment a referral to Be Free for support around the domestic violence was made. I submitted another statement to Pendle Housing Needs to declare imminent risk of homelessness and filled in a B-With-Us housing application.

This was banded at 5 but following another conversation with housing was changed to a 2.

I then supported the client to place bids on the B-With-Us site until they were successful.

Following this success, I worked with local organisations to secure the basic equipment needed to set up a home. A referral was also made to Talking Therapies to support with mental health needs.

ONS4	Life Satisfaction	Worthwhile	Happiness	Anxiety
Initial	1	2	2	10
Final	6	5	7	5

The ONS4 final scores show a marked improvement from the initial scores.

Client Outcomes

Client is now looking to make a fresh start free from the threat of violence and is able to concentrate on her mental wellbeing.

Client Comments

Client expressed gratitude for the support given and expressed that before Social Prescribing input she did not know where to turn to for support.

Rossendale

134

**Referrals So Far
This Year**

21

**New Connector
Referrals**

40

**Current/Active
Connector Cases**



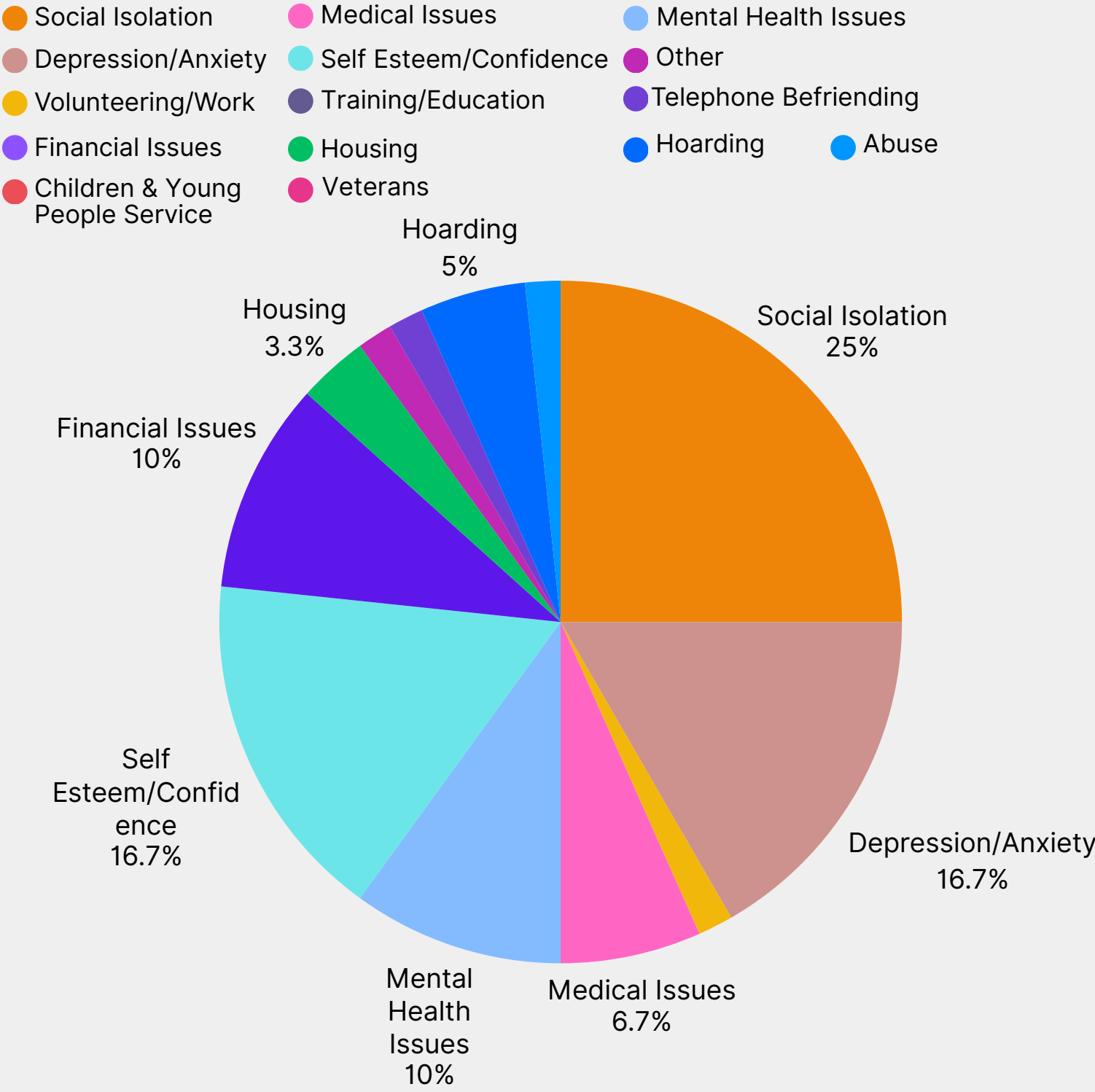
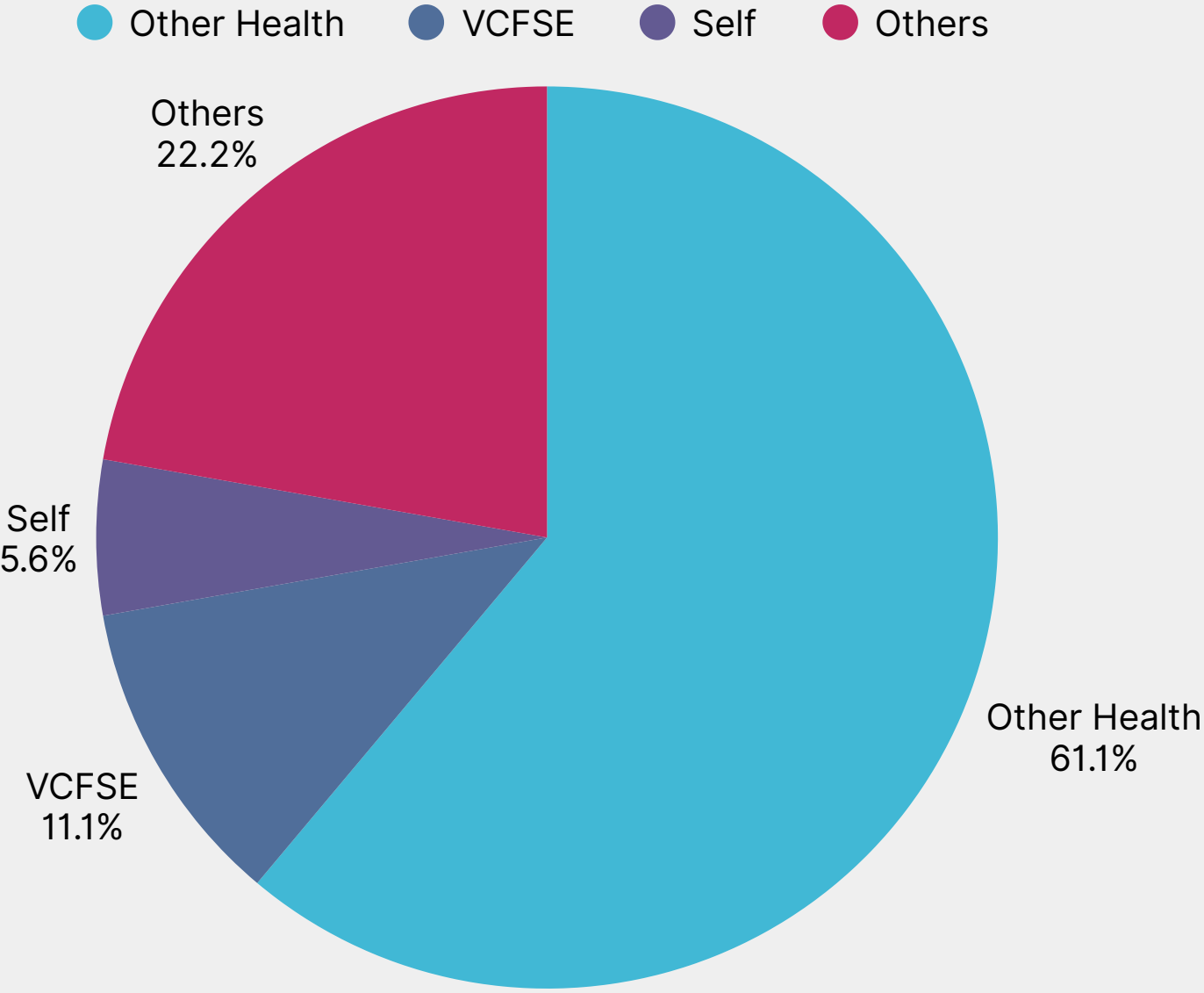
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**Closed Connector
Referrals**

11

Rossendale Referrals From

Supporting People With



Rossendale Group & Volunteer Support Team

Rossendale		Group Support
Support	34	Unique Groups
Given	77	Hours of Group Support
SP Teams Also Attended	6.5	Hours of Meetings
SP Teams Referred into	13	VCFS Organisations
SP Teams Referred into	3	Statutory Organisations
Rossendale		Volunteering
Volunteer Enquiries	5	Individuals
Currently Volunteering	1	Individuals

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Rossendale

When I feel lonely I call an ambulance

Reasons Indicated on Initial Referral

The patient is suffering with social isolation especially at night resulting in ambulances being called out. She has tried to socialise with neighbours but they won't interact.

Background of Client

Client is a female 85 yrs old, lives in social housing alone.

Initial Assessment and Support Provided

- Has carers attending 4 times a day .
- Has regular contact with children and grandchildren.
- Client has limited mobility and uses mobility aids around the house.
- Client needed a necklace fall/panic button replacing as it had broken and she had lost it.
- Client shared that she needed a dentist due to some tooth ache
- Client shared that she didn't have any additional needs as she is happy where she is and doesn't need anything.
- Running theme with client that neighbours are not sociable.
- Client shared that she hasn't called the ambulance in weeks.

Client Outcomes

- Made 3 home visits and 4 calls
- Was able to arrange a replacement fall/panic button for client.
- And sourced a dentist and an emergency dentist and contact number should the client require it.
- Made an adhoc visit to client after calling and no answer. Was concerned as I knew the client at the time had no panic button- visited and all was well. Client was very happy to see us.

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

Social Prescribing for Children & Young People

Pendle West

69
Referrals So Far This Year

14
Closed

15
New Referrals

15
Current Active

53
Accessing Activities

Pendle East

1
New Referral



STOP PRESS * STOP PRES

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

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.

15

Pendle

I didn't want to engage

Background

YP was referred in for social and emotional wellbeing support in May 2025. Case closed in November 2025. Open to activities for upto 18 months.

Actions Taken

Sent through lots of activities to parent. Parent called and we explained our activities. Parent booked YP for our activity. Space became available on more activities, YP was invited and attended all activities.

Needs

No engagement from parent. YP did not attend any of our activities. Case reopened (referral came through for same YP for support with accessing activities) in May 2026. Completed YP IA and action plan and progress reviews again. YP was excited to attend our activities, but again no engagement from parent.

Outcomes

YP has made new friends, learnt new skills, had lots of fun socialising with other young people outdoors, and is excited to attend more activities.

Rational

This case study highlights the length of time we support our young people, building positive relationships with parent and child. Parent is now fully engaged with our service, YP is no longer missing out. YP's case is currently still active (open for progress reviews).



Hyndburn

491

**Referrals So Far
This Year**

101

**Current/Active
Linkworker
Referrals**

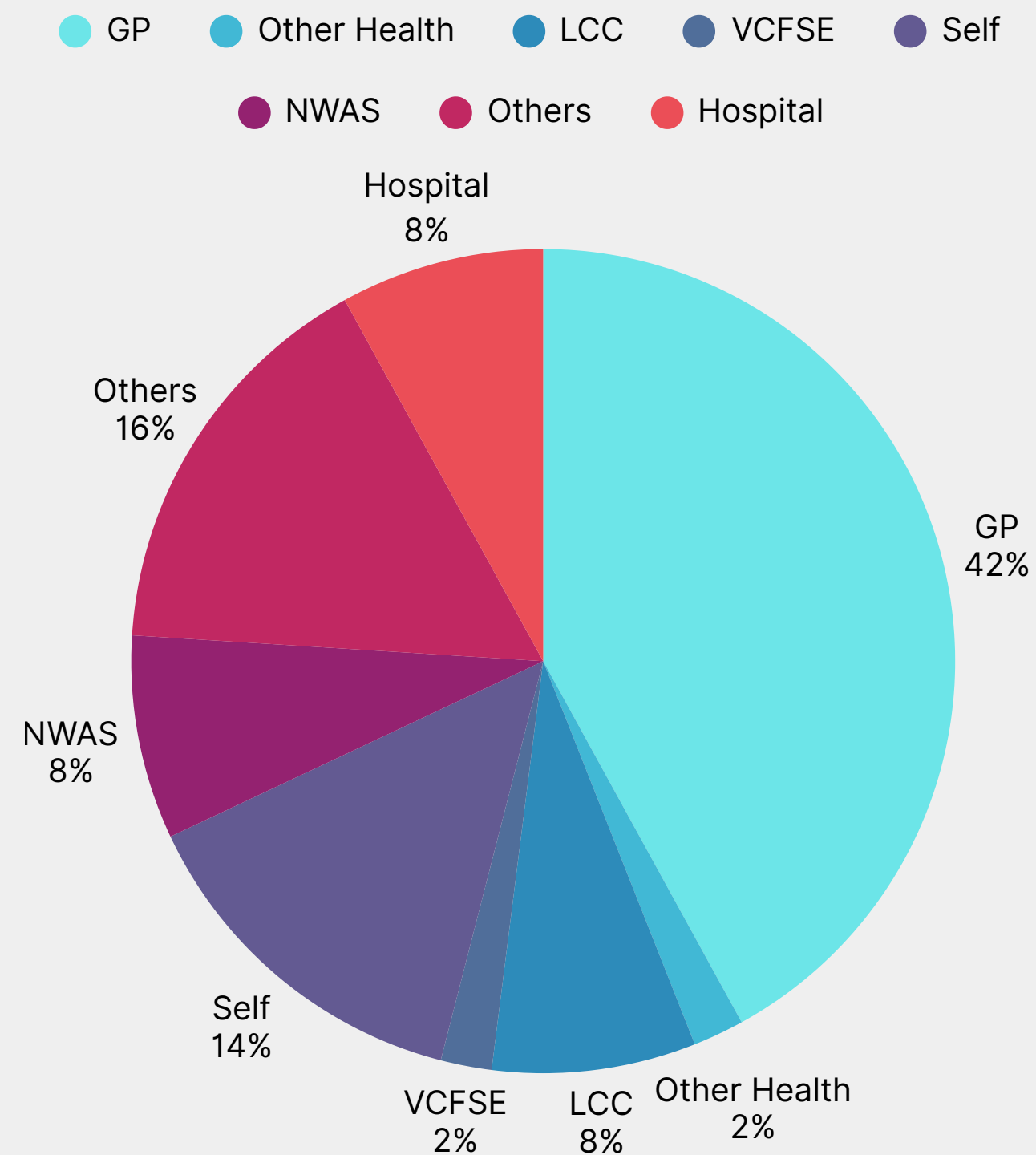
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**New Linkworker
Referrals**

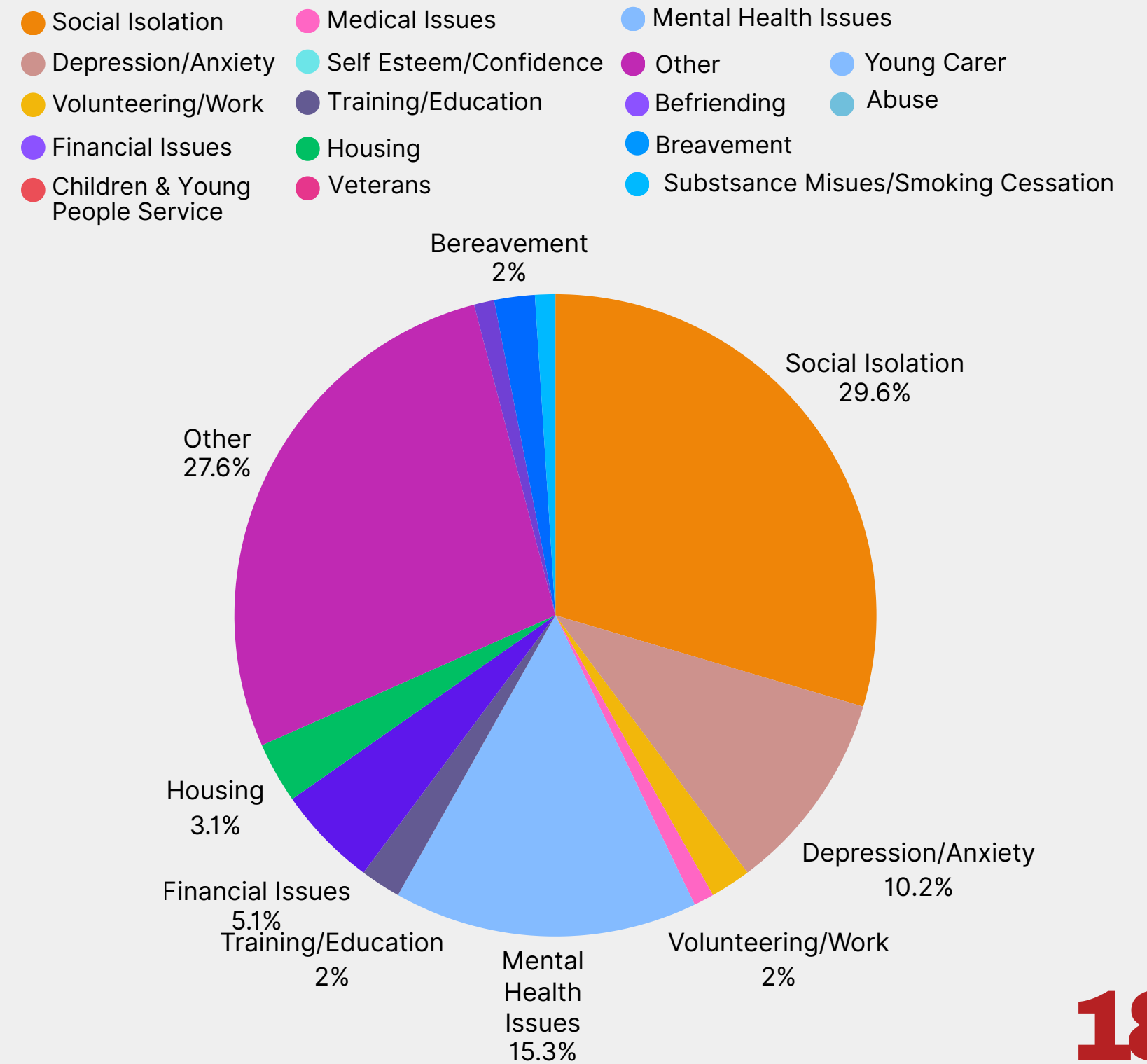
68

**Closed
Linkworker Cases**

Hyndburn Referrals From



Supporting People With



Hyndburn Group & Volunteer Support Team



Hyndburn		Group Support
Supported	18	Unique Groups
Given	27.5	Hours of Support
SP Teams also Attended	31	Hours of Meetings
SP Teams Also Attended	46	Hour of Training
SP Teams Referred into	39	VCFS Organisations
SP Teams Referred into	10	Statutory Organisations
Hyndburn		Volunteering
Volunteers	21	Seen or Supported
Volunteer Opportunities	2	Completed

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Hyndburn

I feel so alone

Reason For referral

His two sons do not live locally and he has no social network. One of his sons orders food online to be delivered to him. He was previously very independent, he has had a decline in his physical health and mobility which is impacting him and he has become increasingly lonely and isolated. His mobility means it has become difficult to go out of his house so he is spending a lot of time at home alone. He struggles getting through to the GP for appointments and has had some recent input from Occupational therapy team who have put some equipment in place and has telecare.

Initial Assessment Support Provided

He would like information about local activities and community transport as well as benefits advice to check he is in receipt of everything he is eligible for. We assisted Brian with setting up a GP appointment as his legs are very swollen and not been reviewed by his GP. We referred him into the Integrated Neighbourhood Team so they could review his physical health and also discuss other options that may help him with his mobility. He has had a lot of hospital appointments and his son has supported him. They have got him a cleaner who is coming fortnightly. His mood has been impacted by the loneliness and isolation caused by his mobility.

Client Outcomes

We managed to get him a community befriender from Brave Church which is very close to his house. We did a handover visit with the befriender so that they understood the client's needs. The visit went well, he had a good rapport with him and it is hoped they can engage well with him and attempt to bring him to some of their social groups at the café at the church to ease his loneliness

Ribble Valley

288

**Referrals So Far
This Year**

72

**Current/Active
Linkworker
Referrals**

44

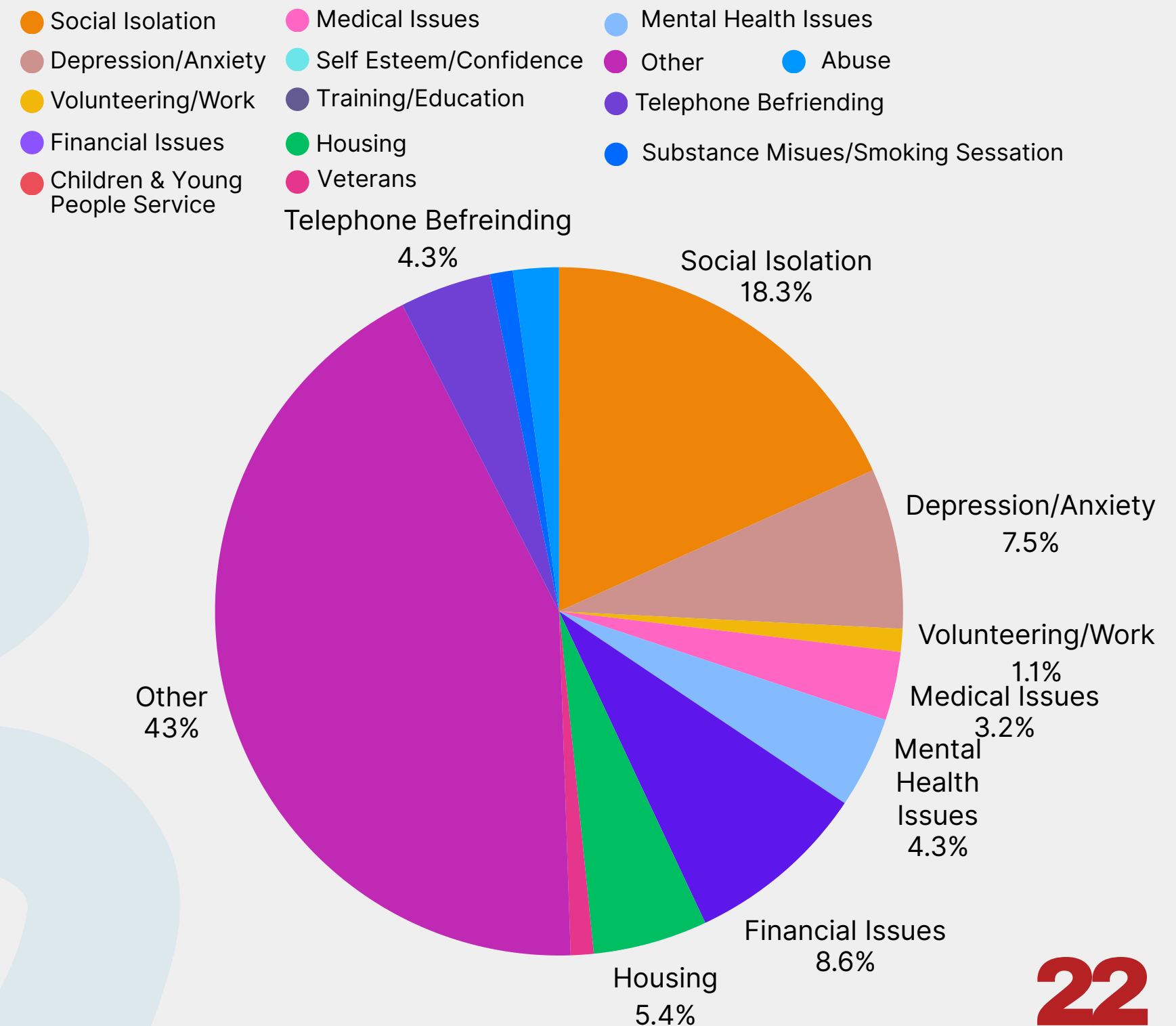
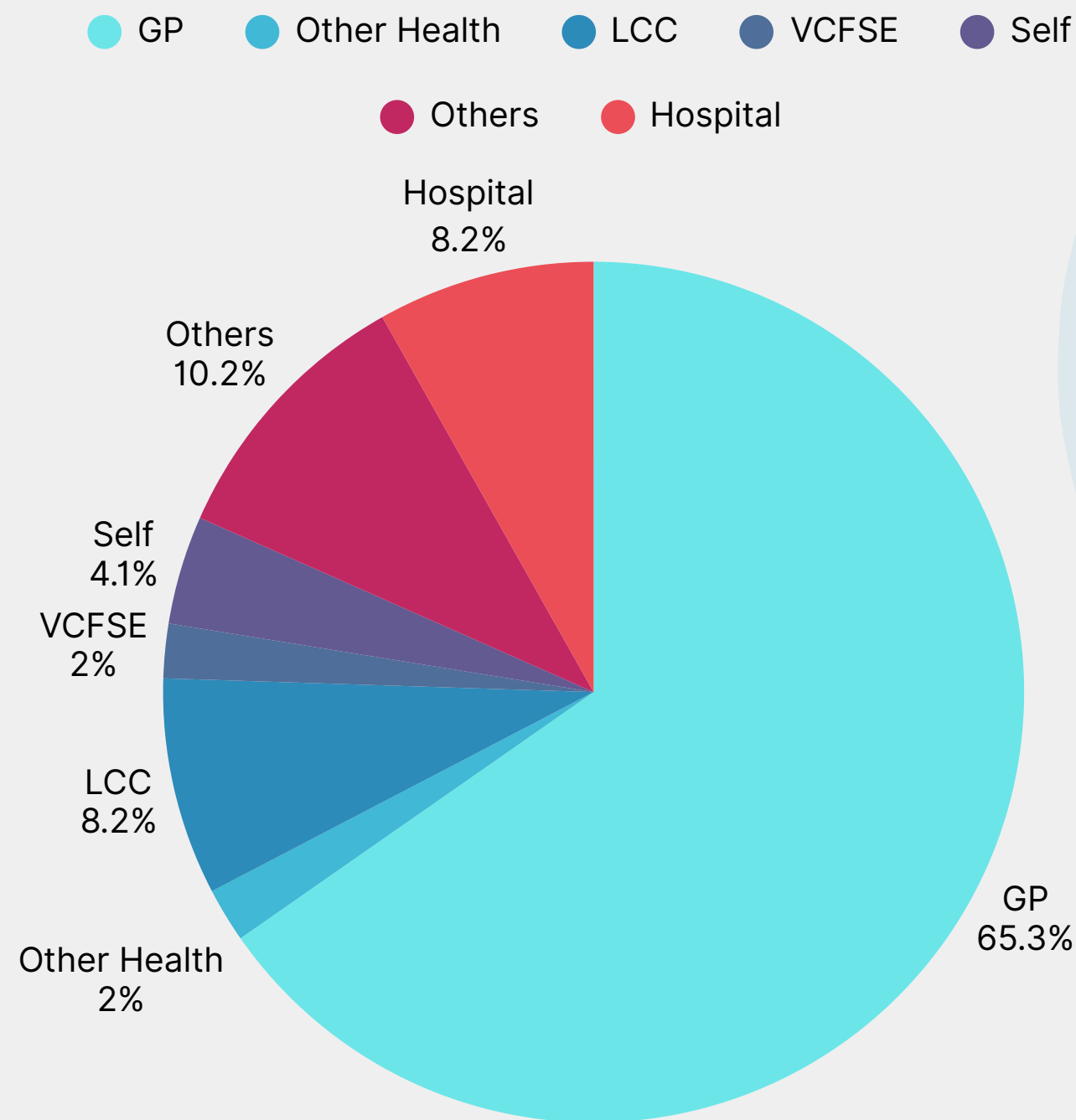
**Closed
Linkworker Cases**

46

**New Linkworker
Referrals**

Ribble Valley Referrals From

Supporting People With



Ribble Valley Group & Volunteer Support Team



Ribble Valley		Group Support
Supported	18	Unique Groups
Given	33.5	Hours of Group Support
SP Teams also Attended	18	Hours of Meetings
SP Teams also Attended	30	Hours of Training
SP Teams Referred into	27	VCFS Organisations
SP Teams Referred into	5	Statutory Organisations
Ribble Valley		Volunteering
Volunteers supported	17	Individuals
Volunteers Opportunities	2	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

You made it so simple for me

Reasons Indicated on Initial Referral

Client has recently moved to Clitheroe from Blackburn with her partner. Client has low confidence, depression and anxiety. She is wanting to know about local activities that she can attend in the area- to potentially make new friends and have the opportunity to get outdoors more. She used to attend social groups and wellbeing sessions in the area she used to live in and found it beneficial. She struggles being around a lot of people but can cope with small groups

Background of Client

Female client – 61 yrs old – referred in by Disability employment advisor at the job centre

Initial Assessment and Support Provided

The first appointments she had with our team client was accompanied by her partner as felt she needed his support. She expressed an interest in craft and knitting groups and was given information about various groups. Arranged to meet her at the craft group at Clitheroe library as it is a low key, smaller group so would suit her needs. She attended the group with her partner initially, she engaged with the group and felt confident enough for her partner to leave and go off and do errands and she was happy to stay. Attended the group with her another couple of times until she was happy to attend on her own. At this stage she had built up a good rapport with the group leader

Client Outcomes

For this client, making it simple and focusing on one group and attending with her has helped her to get comfortable with attending that group. This has been a positive way to help her start to build friendships and build her confidence with socialising without getting overwhelmed. This has been a good way to help this client engage with our service and move forwards

Working in partnership using the whole system approach. ✨

