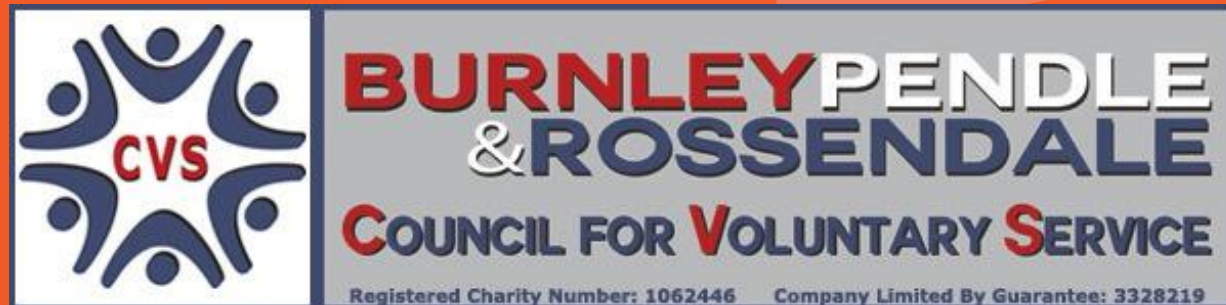


# Social Prescribing MONTHLY REPORT

SEPTEMBER  
2025

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.





# 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.

## 18,937

**Total number of referrals since commencement.**

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

## 7,290,745

**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 18,937 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.

## 227,244

(Average of 2 hours per session x 6 sessions x 18,937)

**Hours of SP Support**

# 01



# 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*

## Group Support & Funding Team



**Heather Starkie**  
*Funding Co-ordinator*



**Tracey Noon**  
*Operations Manager*



**Julie Overson**  
*Project Support*

## Pendle



**James Smith**  
*SP Linkworker (PE)*



**Amy Whitham**  
*SP Linkworker(PW)*



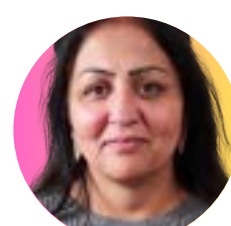
**Zoe Brown**  
*SP Linkworker(PW)*



**Ummul Fayyaz**  
*SP Linkworker (PW)*



**Pam Bailiff**  
*SP Linkworker (PE)*



**Farrah Rafiq**  
*Social Connector*



**Rebecca Hayworth**  
*Social Connector*



**John Verity**  
*Social Connector*

## Children & Young People Team



**Sammie Taylor**  
*SPLW – C&YP (PW)*



**Sylvia Pickles**  
*SPLW – C&YP (PW)*

## Rossendale



**Mandy Richardson**  
*Social Connector*

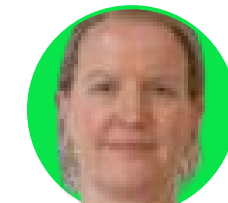


**Jonathan Sheriff**  
*Social Connector*

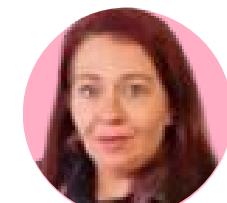


**Julie Heywood**  
*Social Connector*

## Hyndburn & Ribble Valley



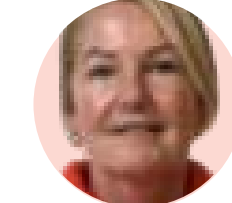
**Susie Edwards**  
*Social Prescribing Lead*



**Alison McGruer**  
*Community Lead*



**Tracey Jones**  
*Social Prescribing Linkworker*



**Shereen Gregory**  
*Social Prescribing Linkworker*



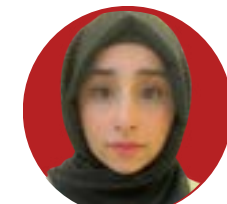
**Fiona Bradley**  
*Green Social Connector*



**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*

# Burnley

**806**

**Referrals so far  
this year**

**28**

**New Connector  
Referrals**

**24**

**Closed Connector  
Cases**

**23**

**Current/Active  
Connector Cases**

**55**

**New Linkworker  
Referrals**

**47**

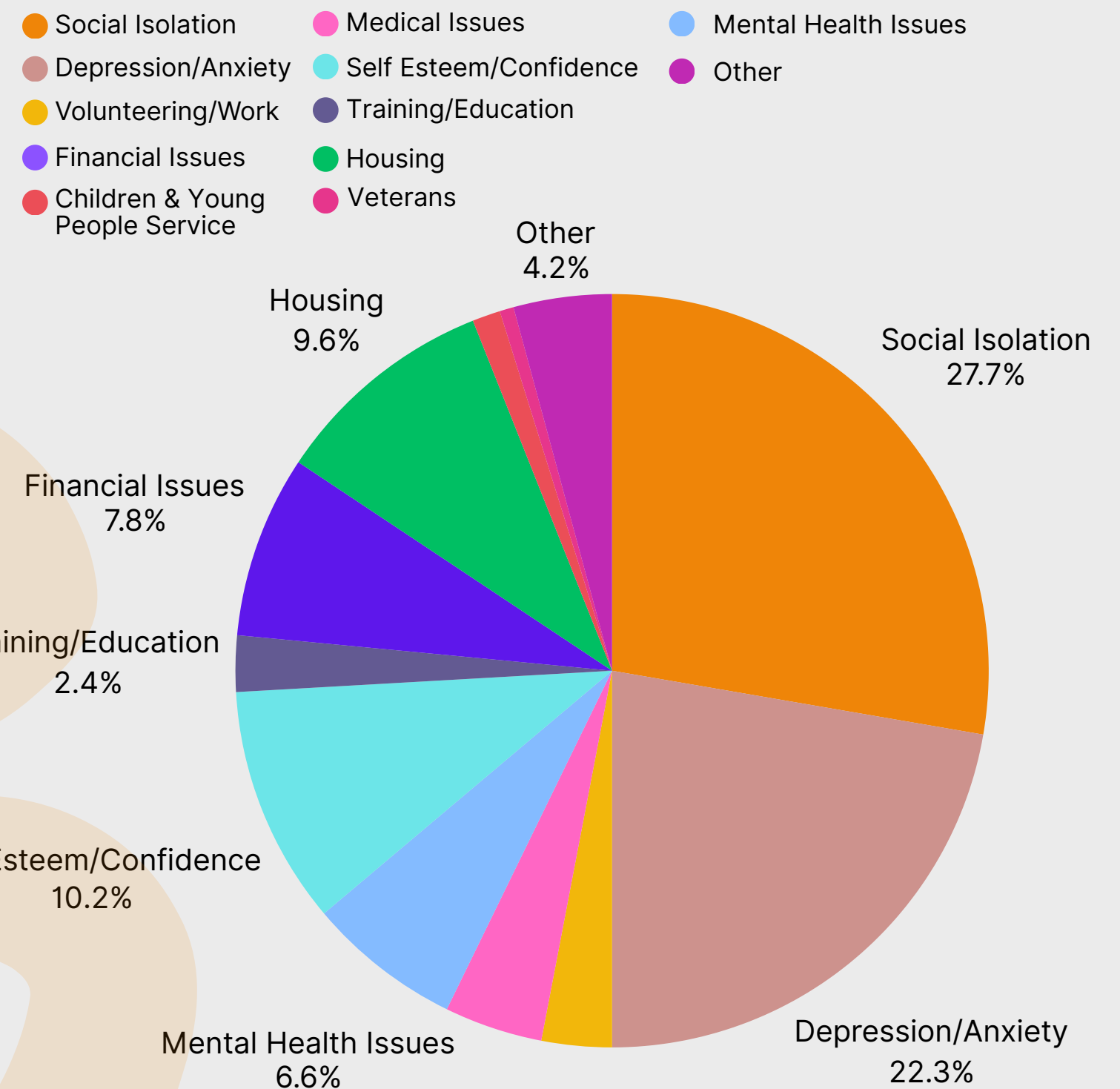
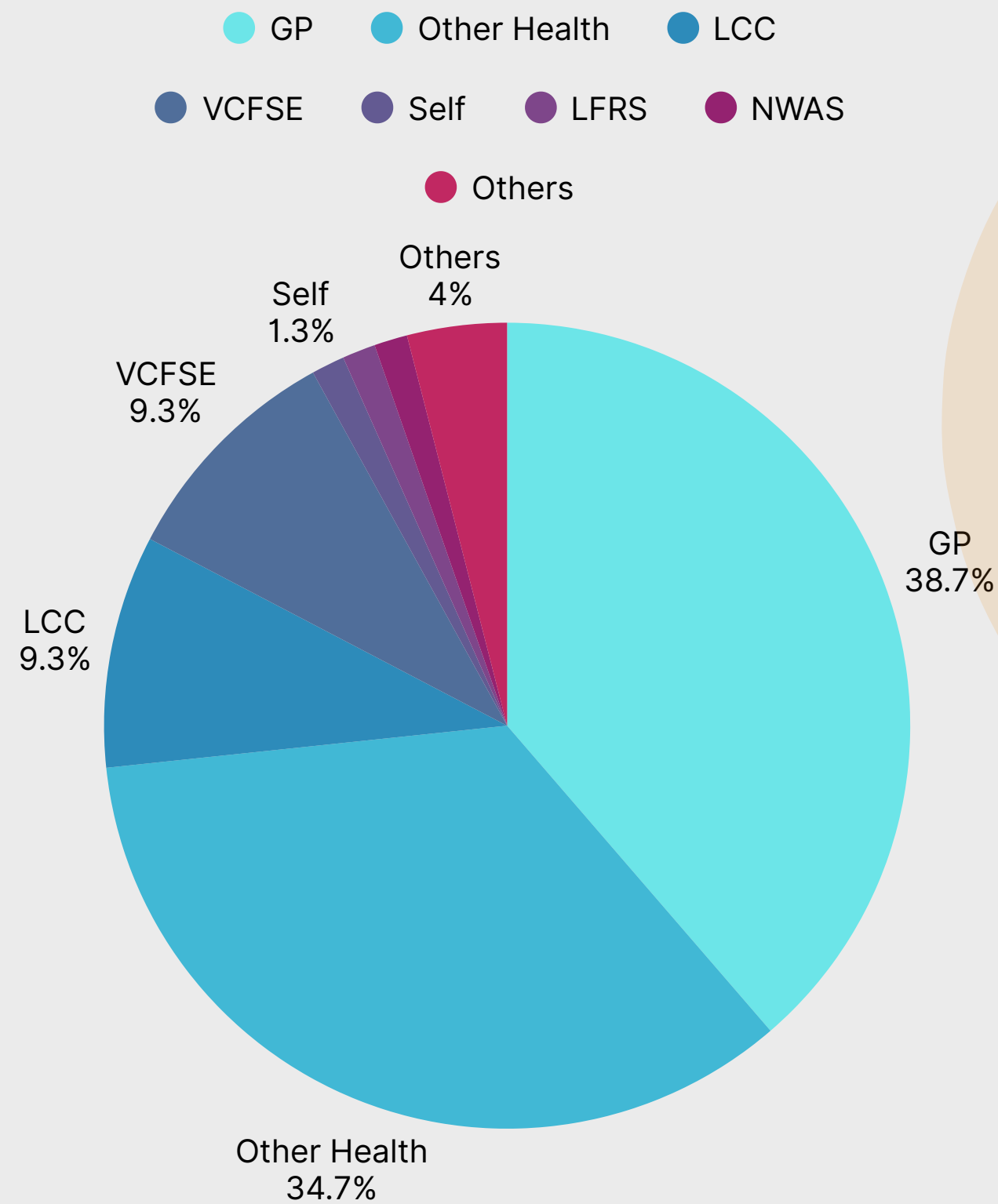
**Closed Linkworker  
Cases**

**131**

**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	53	Unique Groups
Given	121.5	Hours of Group Support
SP Team also attended	55.5	Hours of Meetings
	16	Hours of Learning
SP Team referred into	41	VCF Organisations
	18	Statutory Organisations



# Burnley CASE STUDY NAME GOES HERE

## Reasons indicated on initial referral

MT is struggling with mobility issues, drives but is put off if unable to park nearby to where he is going. Does not have a disabled badge. Struggles with forms. He would appreciate advice.

## Initial Assessment and Support Provided

TMT lives alone in a bungalow. Has Cerebellar ataxia which means struggles with balance, can only walk short distances. At risk of falling. Would like to go to a balance retraining class which he has been to previously and found extremely beneficial. Priority for MT was to get a blue badge which would enable him to go out more. I put MT in touch with LCC telephone appointment service for blue badge applications and referred to Steady on Falls Prevention Service.

## Background of client

MT is a 72 year old male living alone.

## Client Outcomes

MT was seen within 2 weeks at home by Steady On who referred him to DWP visiting service for support with attendance allowance application, signposted to BFC Social group, referred to Community Rehab for physiotherapy input and as a result is now on the waiting list for balance retraining. Completed application for blue badge which has been approved.

## Client Comments

“ I am really impressed with the service, I have been struggling since moved here in 2020 to access anything. I’ve been trying to find out if balance training was available in this area and great news I have found it”



# Pendle

948

Referrals so far  
this year

26

New Connector  
Referrals

13

Closed Connector  
Cases

44

Current/Active  
Connector Cases

63

New Linkworker  
Referrals

47

Closed Linkworker  
Cases

99

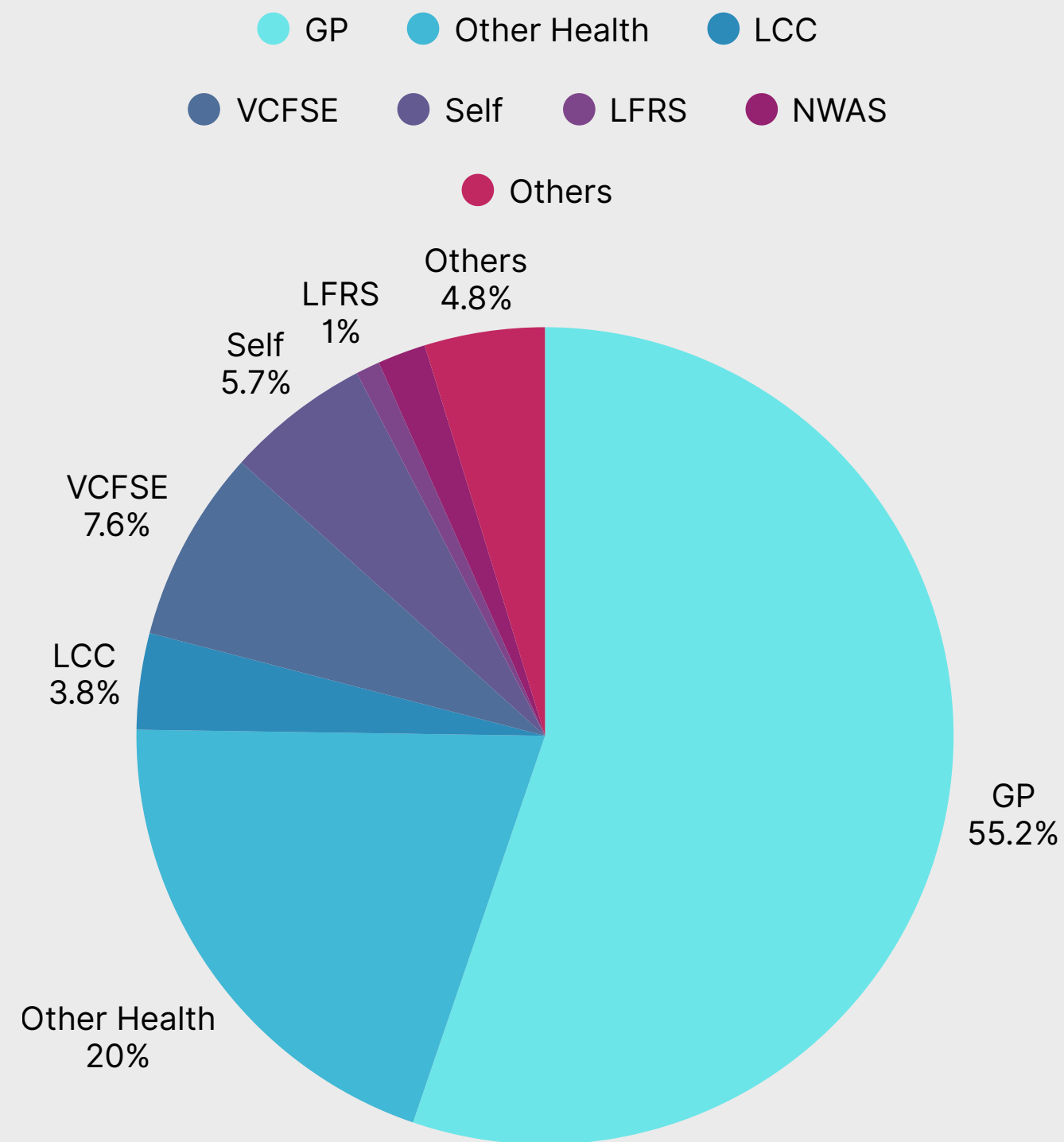
Current/Active  
Connector Cases

Reporting on behalf of Pendle East PCN

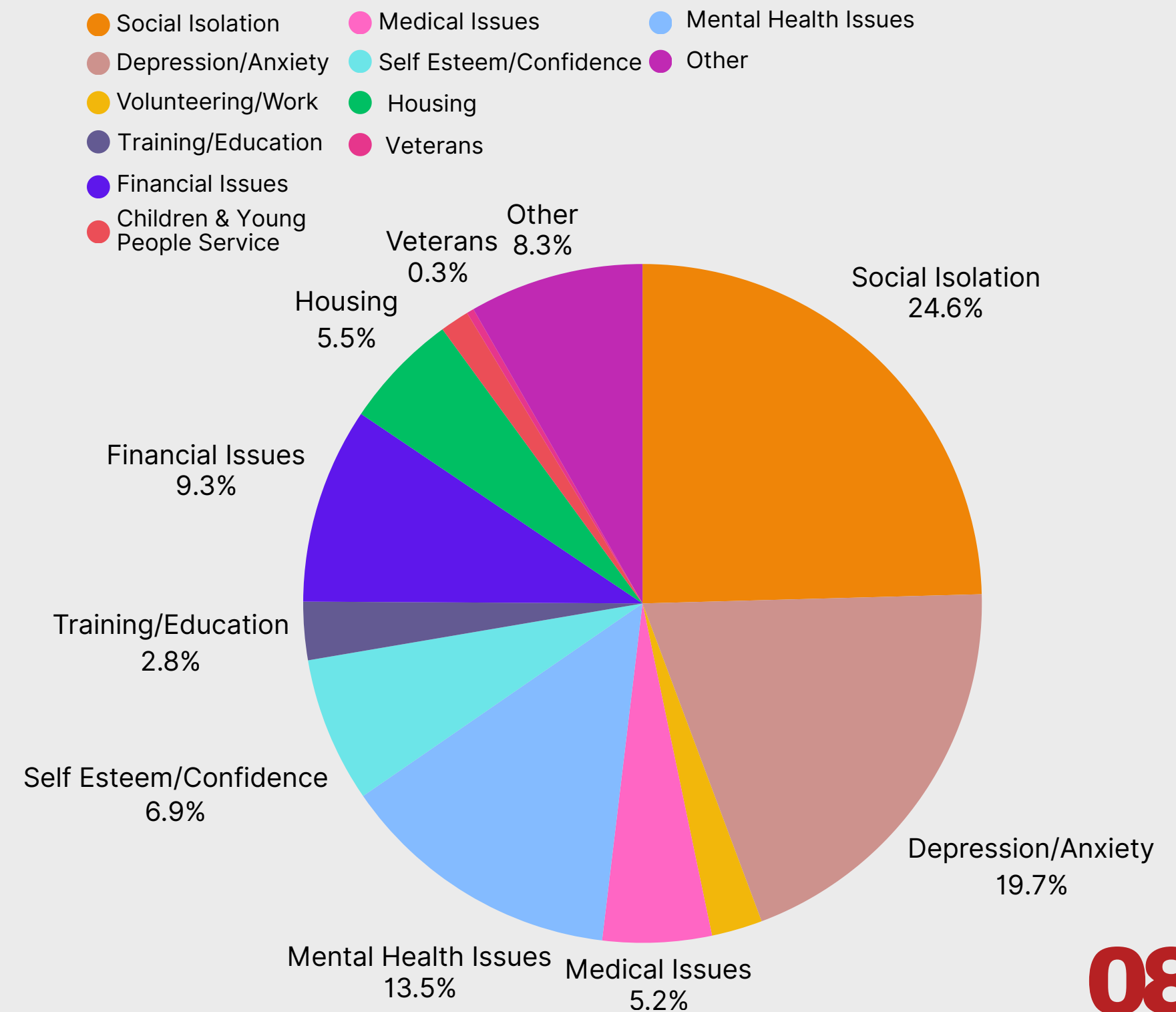
21

New Linkworker  
Referrals

# Pendle Referrals From



# Supporting People With



# Pendle Group Support & Funding Team

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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.

## This Month In Pendle we have:

Supported	<b>36</b>	Groups
Given	<b>54</b>	Hours of Group Support
SP Team also attended	<b>20.5</b>	Hours of Meetings
	<b>16.5</b>	Hours of Training
SP Team referred into	<b>38</b>	VCF Organisations
	<b>23</b>	Statutory Organisations



# Pendle CASE STUDY NAME GOES HERE

## Reasons indicated on initial referral

Referral received from the local Job Centre requesting support with social isolation, depression and anxiety, low self-esteem and confidence.

## Initial Assessment and Support Provided

Client X explained how he found it very difficult to engage with groups of people and would struggle to attend any local groups. He enjoys being outside and has an interest in nature and animals, especially horses. He also has an interest in nature photography. I gave Client X the option of doing some volunteer work at a local Riding for the Disabled centre and he thought this might be something he would enjoy. I contacted the RDA manager and arranged for myself and client X to go and have a look round the centre. Client X thoroughly enjoyed his visit and said he felt 'right at home' with the horses. He has agreed to volunteer for the centre 2-3 days a week. I provided him with the details of a photography course at a local college and it is something he is going to consider for the future.

## Background of client

Client X is an ex-army veteran who for the last eight years has been a fulltime carer for his wife, who sadly passed away. With no local support from friends or family Client X has felt very lonely and isolated.

## Client Outcomes

Is now feeling confident at the leaving the house and spending time at the stables, supporting adults/children with disabilities to enjoy horse riding.  
Has bought a camera and is going to sign up for a photography course.

## Client Comments

Thank you so much for supporting me to find something that I enjoy doing. I feel much more relaxed when I am at the centre and feel a great sense of pride helping others to enjoy horses. It is also great to know that should I need your support again in the future you're not very far away.



# Rossendale

**127 Aug**

**Referrals so far  
this year**

**11**

**New Connector  
Referrals**

**4**

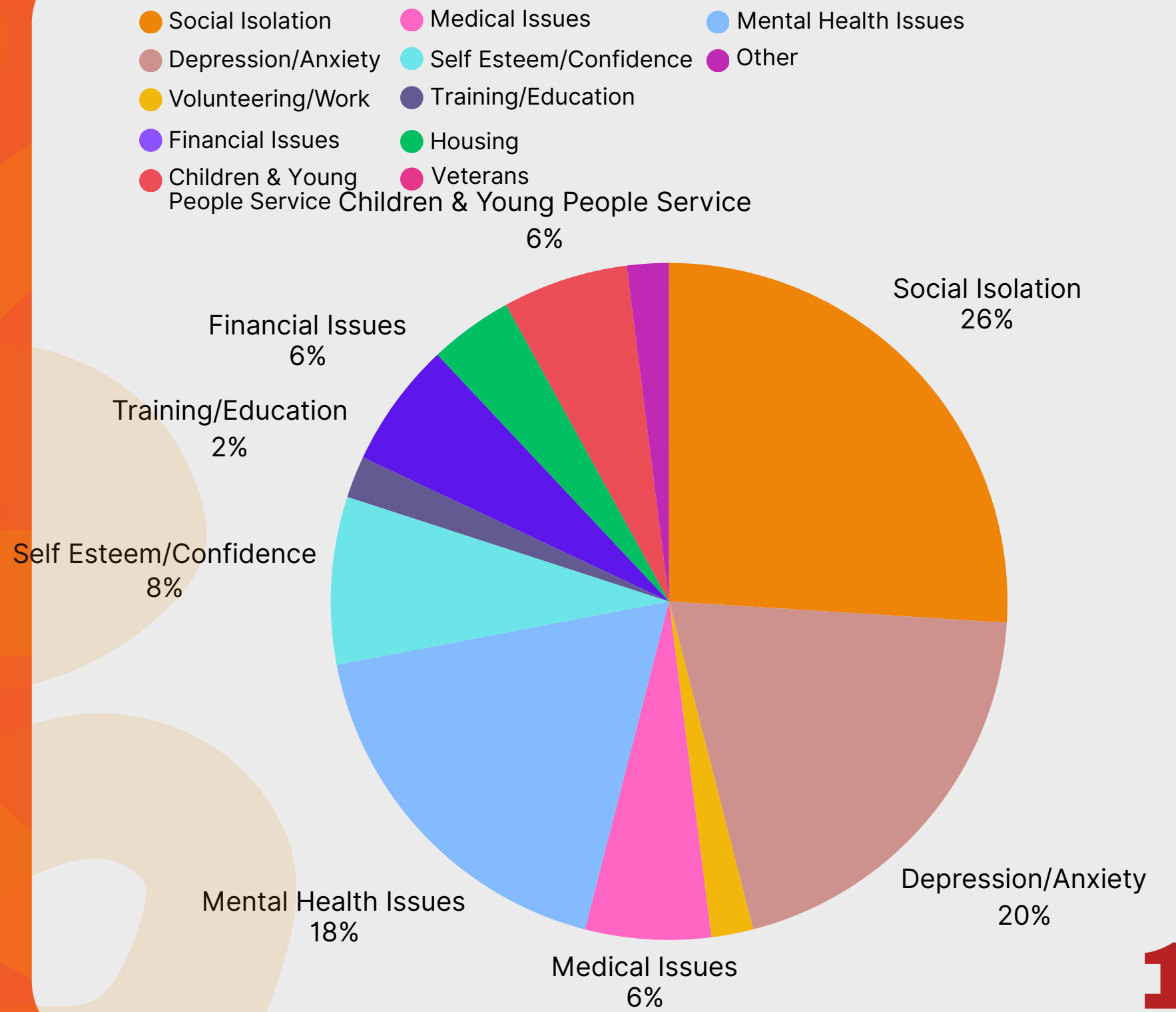
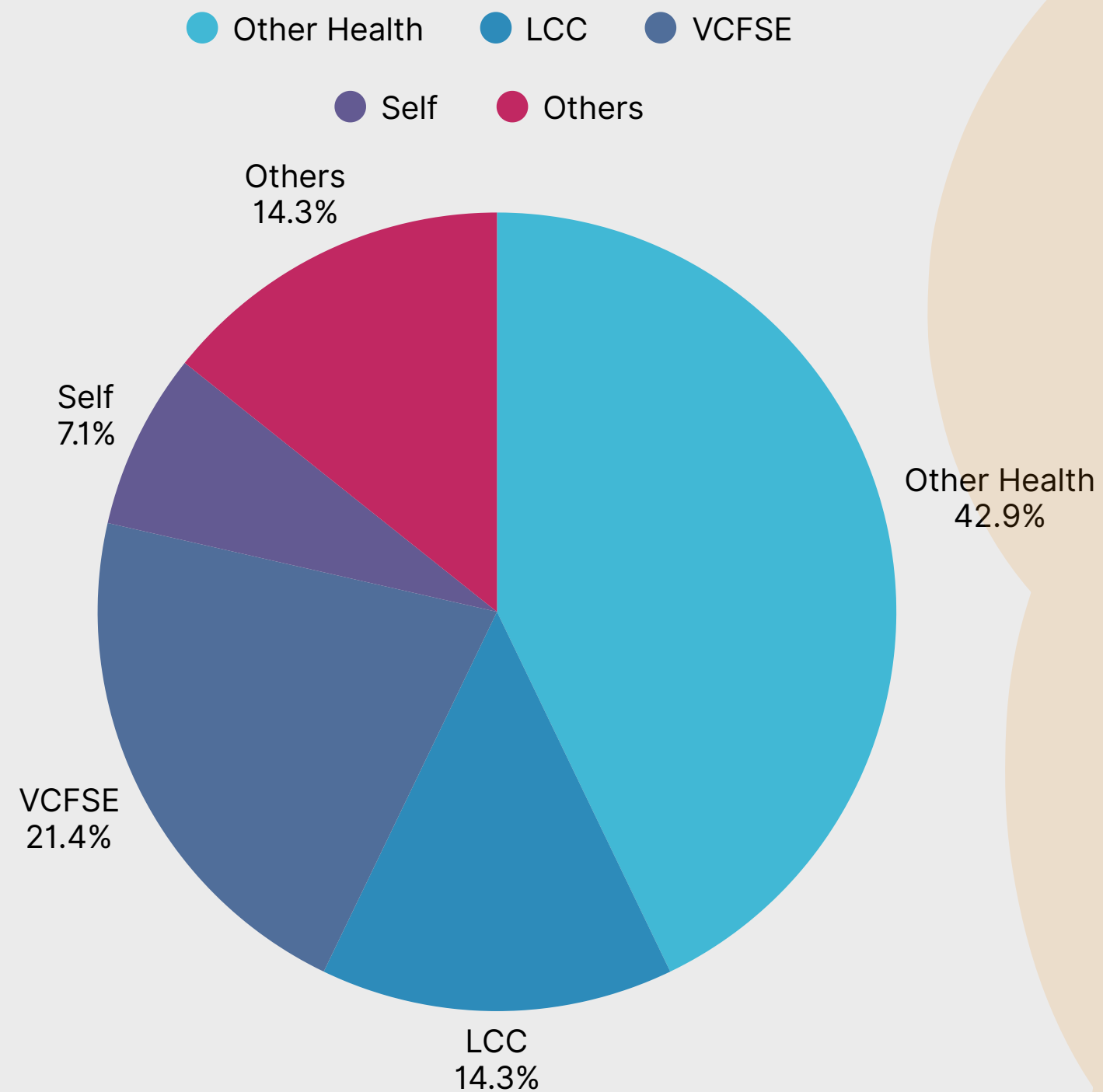
**Closed Connector  
Cases**

**27**

**Current/Active  
Connector Cases**

# Rossendale Referrals From

# Supporting People With



# Rossendale 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 Rossendale we have:

Supported	31	Unique Groups
Given	16.5	Hours of Group Support
SP Team Also Attended	6.5	Hours of Learning
SP Team Also referred into	35	VCFS Organisations
	3	Statuary Organisations

# Rossendale CASE STUDY NAME GOES HERE

## Reasons indicated on initial referral

The client was referred from the Older Adults Community Mental Health Team.

## Initial Assessment and Support Provided

Due to the client's mental illness, she was not initially contactable by phone. However, the use of email and face-to-face meetings has worked effectively.

Key actions:

- Reduce social isolation by identifying a local voluntary group that offers arts, craft and horticulture.
- Build confidence in attending a new group on a regular basis.
- To increase her satisfaction rate with the community mental health nurse at the GP practice; by empowering her to advocate her needs more coherently.

## Client Comments

"Sometimes you just need that additional support and encouragement outside of my family to get involved and keep going. Communication via email helped tremendously in terms of my accessibility needs. Something so simple."

## Background of client

Client (A) is a retired female in her seventies who lives alone. She is diagnosed as schizophrenic and during episodes of poor health can become paranoid. She has two daughters that do not live locally; Dubai and Watford. She has two grandchildren that live in Manchester and Liverpool. She drives and regularly visits her grandson in Manchester. Four years ago, she relocated to Rossendale having lived her whole life in Salford. During this period her daughters have moved away from the Northwest. She is socially isolated, and bouts of hospitalization have eroded her confidence.

She receives regular support from her daughters but via zoom/phone and email. The daughter that lives in the UK undertakes regular visits to her Mum. The daughters take an active role in her care, often taking part in medical meetings whenever possible.

The client would describe herself as 'practical in nature.' She enjoys arts/crafts and woodwork and is physically fit for her age. At the initial assessment meeting she was seeking to build her confidence and a bigger social network. Her daughter's moving away has meant she has become increasingly lonely.

## Client Outcomes

Improve social connection through art/craft or horticulture to integrate into a new friendship group and safe community space.

Attend and undertake the site tour for prospective volunteers at Stubby Lee Community Greenhouses.

Attend Stubby Lee Farm Therapeutic Art Groups on Wednesday and Thursday.

Advocate small changes to the format of the regular meetings with the GP Mental Health Worker; for example: regular inclusion of her daughters via Zoom and trying to go at quieter times so it is less overwhelming.



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

# Social Prescribing for Children & Young People

Pendle West Only

80

Referrals so far this year

9

Closed

5

New Referrals

19

Current Active



Pendle East

4

New Referrals

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 NAME GOES HERE

## Background

- Young person referred into the service by school
- Wanted support in accessing community activities
- Unsure what was available in the area.

## Outcome & Help Provided

- Young person has said they given a couple of activities a go on the action plan independently.
- Young person has increased in confidence.
- Young person is happy to continue trying the activities independently.

## Action Taken

- Initial assessment with both parent and young person to identify need and actions.
- Activity plan was created
- Shared information on local activities available based on what young person and parent had said that young person would enjoy.
- Young person is keen to access the CVS activities to gain new skills and experiences.

## Comments

Young person: Thank you. I didn't know there was so much going on near me.

Parent: Thank you so much for listening and helping us. We didn't know what to do before we spoke with you.



# Hyndburn

**468**

**Referrals so far**

**150**

**Current/Active  
Linkworker  
Referrals**

**80**

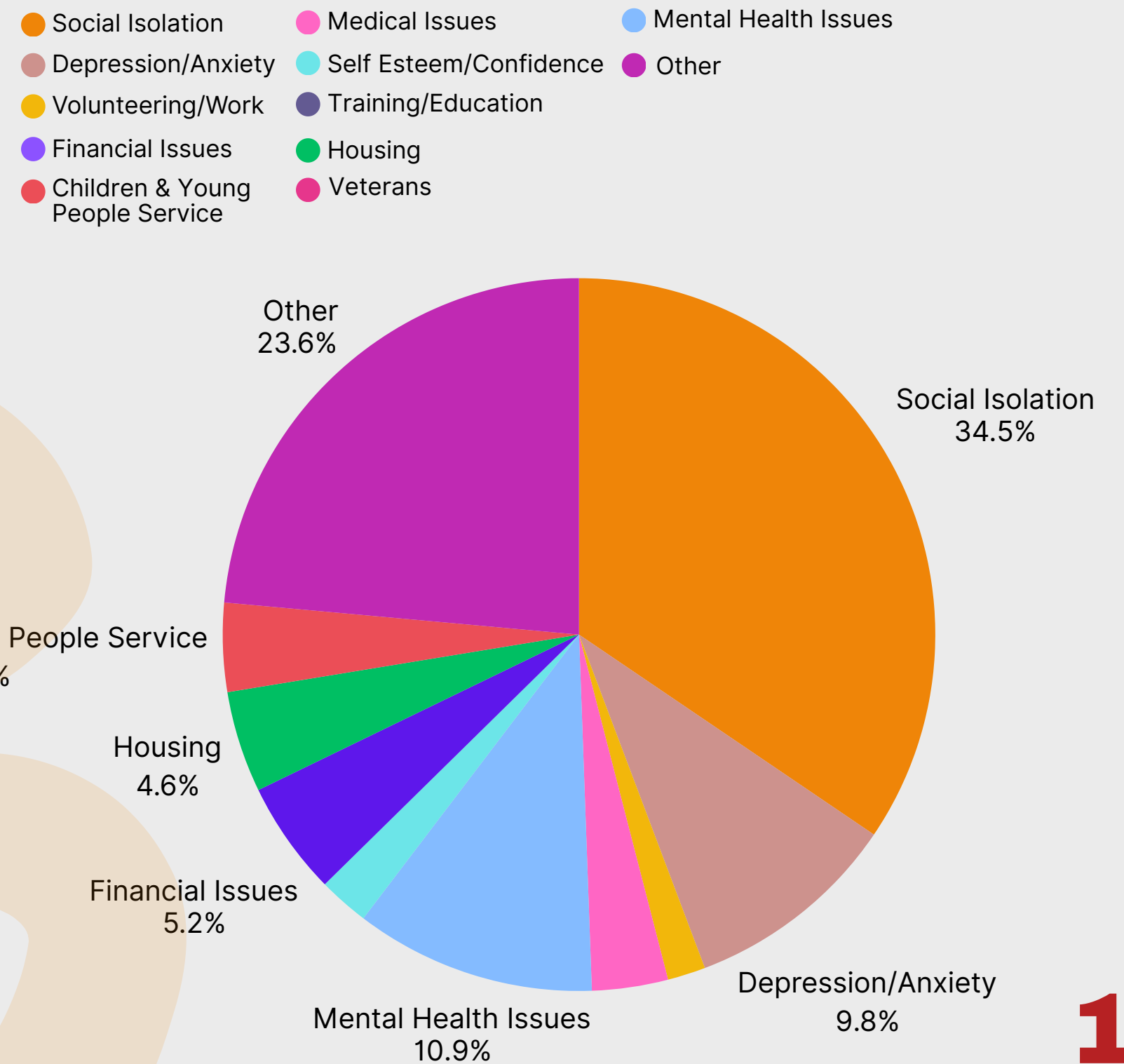
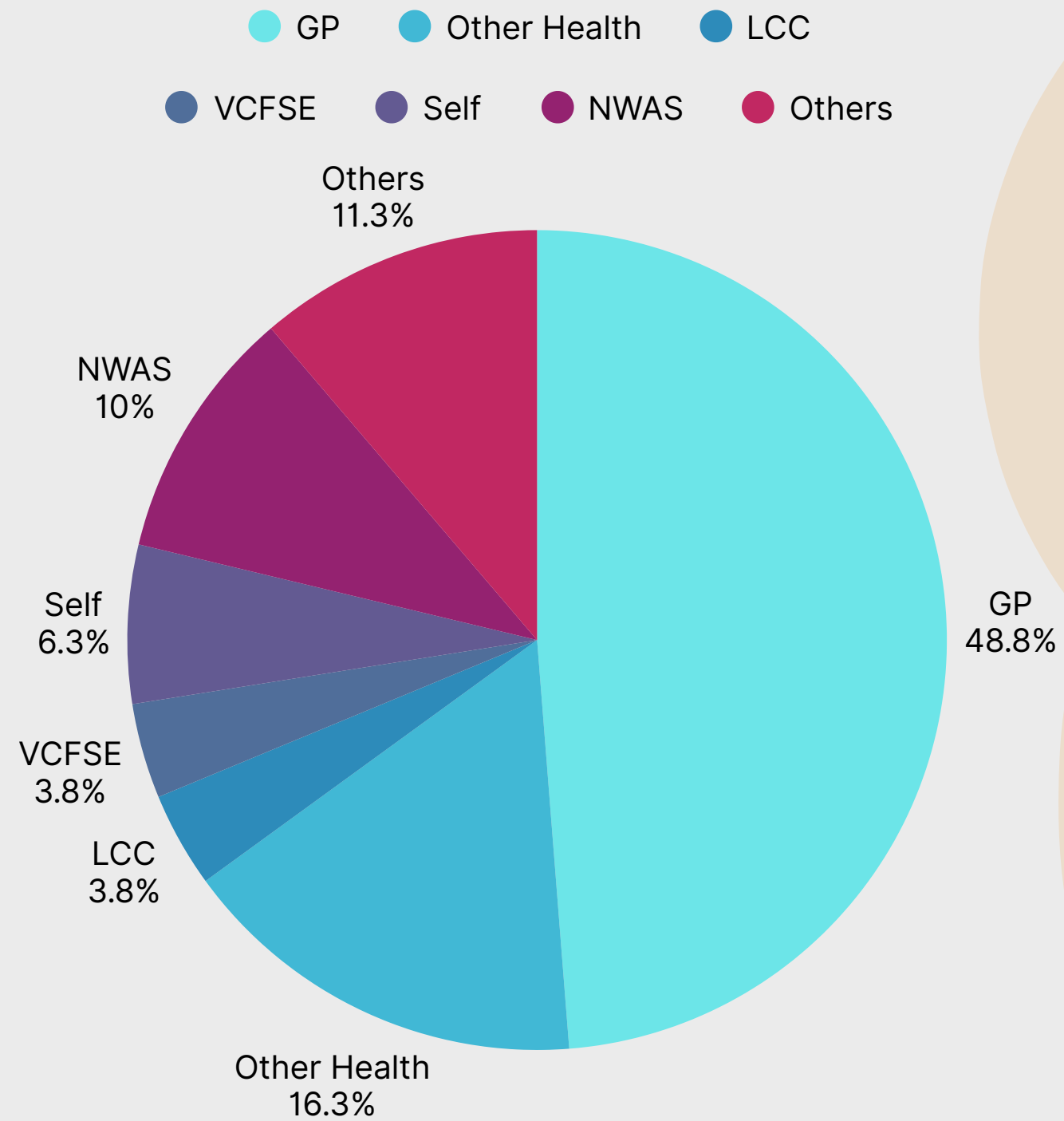
**New Linkworker  
Referrals**

**48**

**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	15	Unique Groups
Given	12	Hours of Group Support
SP Team also attended	26.5	Hours of Meetings
	31	Hours of Training
SP Team referred into	19	VCF Organisations
	2	Statutory Organisations



# Hyndburn CASE STUDY NAME GOES HERE

## Reasons indicated on initial referral

J was referred to CVS by her GP (Lancashire and South Cumbria East Lancashire : Ribble Valley PCN) on 30<sup>th</sup> July 2025, after a period of no mobility from trapped nerves and right gluteal tendinitis. J had completely changed her stature to compensate for the injury which had been affecting her now for a number of months, some of which she was unable to walk.

## Initial Assessment and Support Provided

On our first visit with J, we discussed her fear and some SMART goals. J wants to be able to walk without fear and be able to do simple things. We agreed we would start small and see how we got on, just leaving the house to walk to the lamp post for example. We agreed that regular short walks would be the best way forward. We agreed to aim for two - three times a week.

Longer-term goals were shopping around Clitheroe as she hasn't been able to do that as well as maybe attending groups at Trinity or around any hobbies she has.

On the first day J managed to walk about 25mtrs. J needed no help, and we addressed to slight stoop and that if she starts to topple, she is already unbalanced and to try and stand up straight. J took this on board and informed me on the second visit that she has noticed that she does this at other times during the day and is consciously now standing up straight.

## Background of client

J was slightly stooped, shuffled her feet and was afraid to leave the house and walk anywhere through fear of falling. J had no confidence that she could walk any distance.

## Client Outcomes

We have now done ten walks and J has increased her distance every single time, without fail! She consciously walks with a straighter posture, and the shuffling of her feet has improved as has her speed and distance. J has never needed my help for balance. We take it slowly and J now walks around 200mtrs. J also is realising that although she still has some pain and difficulty, the psychological aspect of the issue is being slowly dealt with as she acknowledges she is improving all the time.

On my last visit J told me that her Neighbours have seen us out walking and have offered to do walks with her also. This is fantastic and J is over the moon about it and will be taking them up on their offer.

# Ribble Valley

**297**

**Referrals so far  
this year**

**66**

**Current/Active  
Linkworker  
Referrals**

**38**

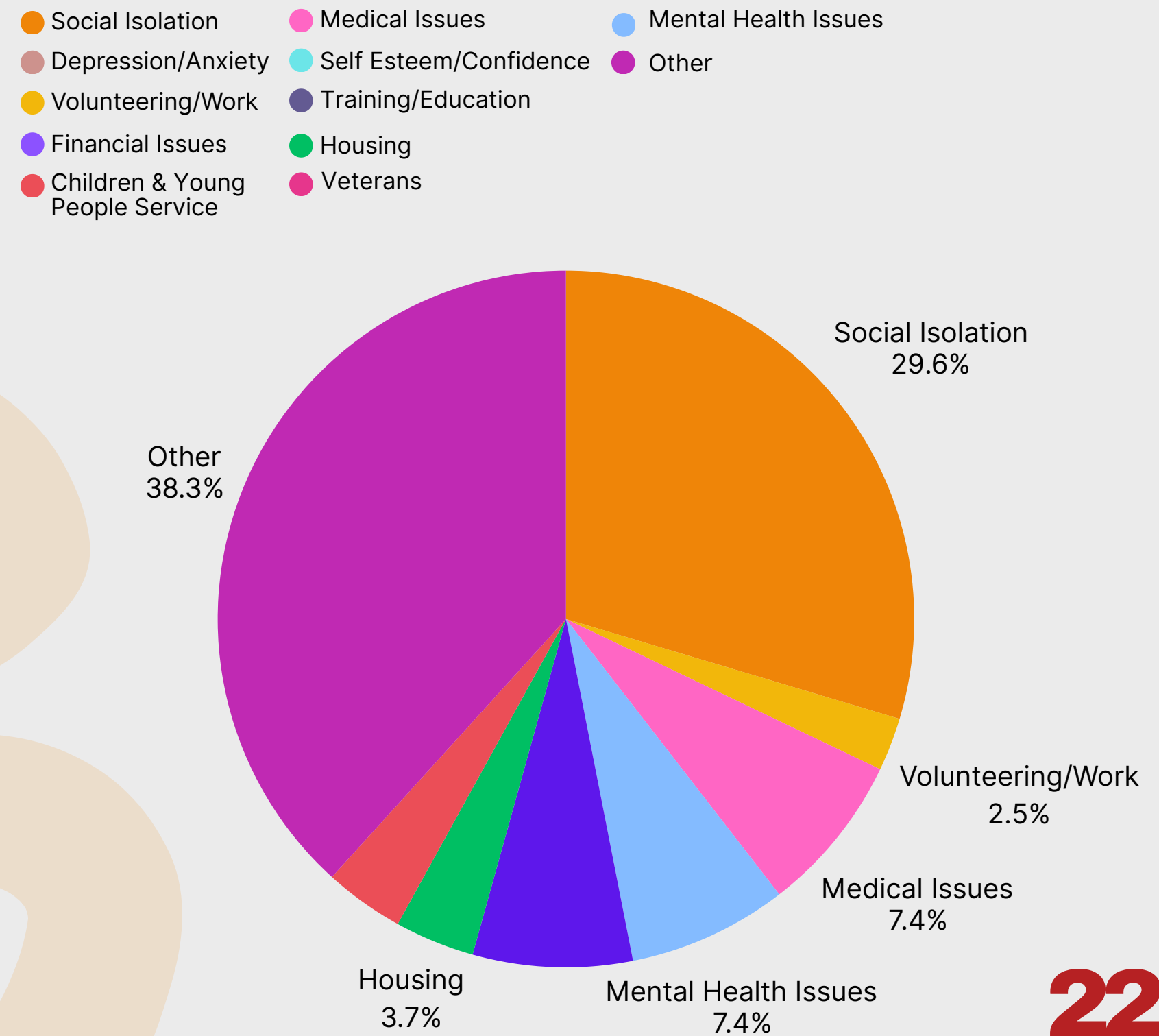
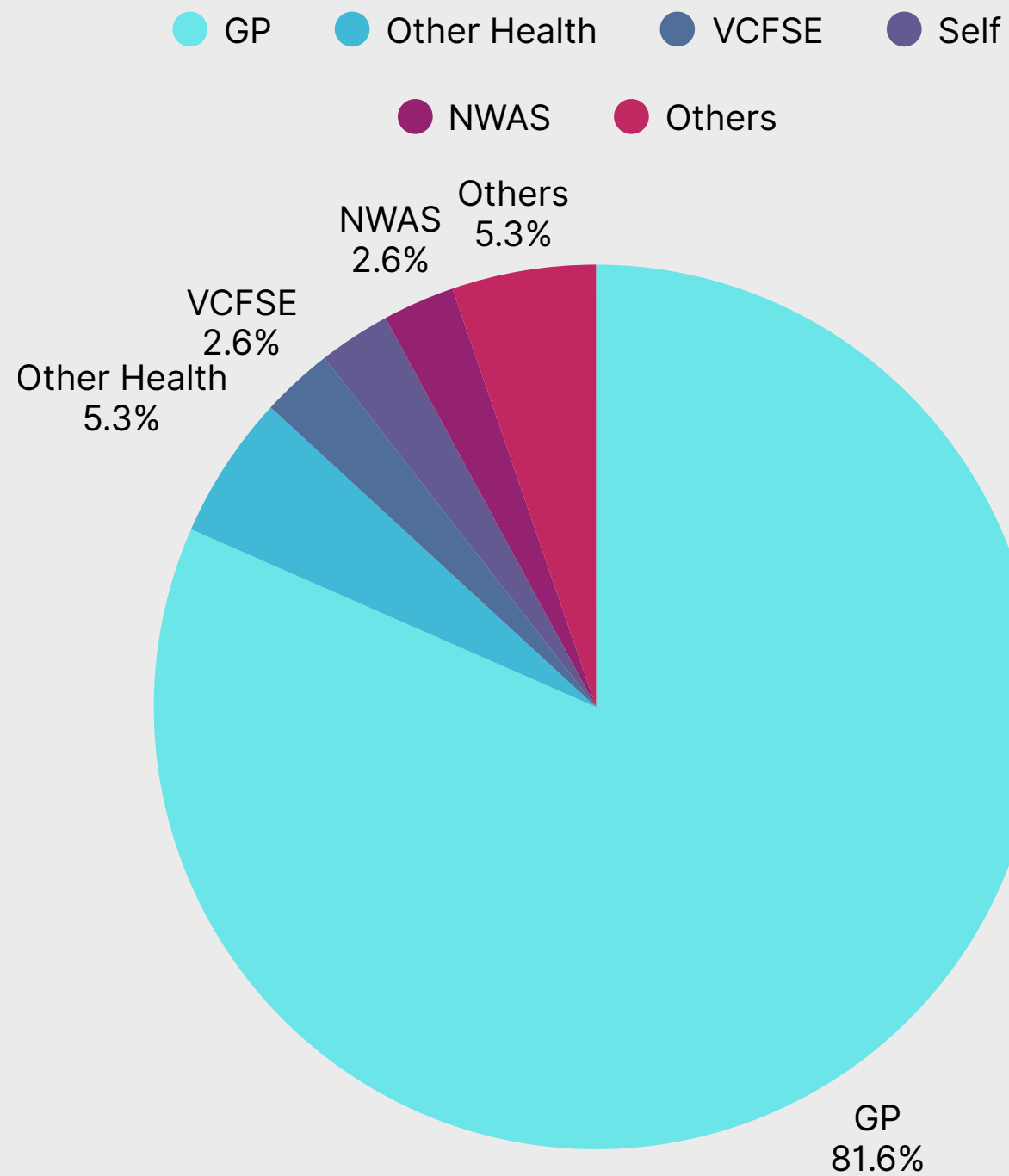
**New Linkworker  
Referrals**

**28**

**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	13	Unique Groups
Given	13	Hours of Group Support
SP Team also attended	28	Hours of Meetings
	1	Hours of Learning
SP Team referred into	20	VCF Organisations
	4	Statutory Organisations



# Ribble Valley CASE STUDY NAME GOES HERE

## Reasons indicated on initial referral

C was referred into CVS via the Ribble Valley PCN. C 72 years old and is registered blind and awaiting a guide dog.

## Initial Assessment and Support Provided

As well as the dog routes, C is very active, and her blindness is a fairly recent thing. C knows and loves the area she lives in and had been part of many groups there. The loss of C's sight is down to a heart defect and C wants to get regular exercise and keep herself healthy now this defect has been addressed.

With all this in mind we began with one of the routes for the dog, and C taught me how to guide her. We walked for over a mile, in the rain and wind and C was so enthusiastic and trusting. It was such a pleasure to help her. We discussed the area and the history and arranged a second walk soon after.

## Background of client

Upon meeting C I found she has no sight at all and has been going through the process of getting a guide dog. C is still about 18 months off getting her own dog.

## Client Outcomes

On our second walk we focused on C getting some exercise for herself, on a route she enjoyed and we talked about the plants and flowers and the buildings along the way. Despite the fact that C had lost her sight recently, she is so enthusiastic. We discussed going for a walk where she could show me the historical sights around the area along side her routes for dog exercise, and places away from the roads and noise so she can enjoy the sounds of nature.

# Working in partnership using the whole system approach.

