RICHMOND SOCIAL PRESCRIBING SERVICE

Ruils Independent Living

Annual Report: April 2024 – March 2025

ruils
independent living

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Introduction

"I think this is a very important service, as when you are informed you have a life changing illness you do not know what to do next. The GP does not have the time to help you get the right you need, and you do not have the energy to find out what is best and available to you. Social Prescribing has been great and I know if I need more help, they will try and get it" Erin - Richmond Medical Group

Social Prescribing is a vital service for primary care health professionals and clients. We support people with non-medical needs and address problems caused by the wider determinants of health. It is a key component of Universal Personalised Care and is underpinned by the national directive to build meaningful connections between individuals, groups, communities and services.

This report provides an update on the service delivery from 1st April 2024 to 31st March 2025.

The service continues to take referrals from 25 GP Practices that make up the 5 Primary Care Networks (PCNs) within Richmond. GP Practices and Extended Access Hubs using EMIS are able to refer electronically to Joy. Those using Medicus are emailing referrals directly to Link Workers within the PCN which are processed manually.

The team continue to receive referrals from Kingston and Richmond NHS Foundation Trust, NHS Talking Therapies and Kingston and Richmond Assessment Team.

Link Workers continue to take self-referrals from previous clients, which reduces the need for the surgery to be contacted for non-medical reasons.

The number of Social Prescribing Link Workers across Richmond General Practice Alliance (RGPA) has decreased from 16 to 11. Each PCN has agreed the number of Link Workers required to meet their needs and this is frequently reviewed to support their patients.

Ruils continues to play a crucial role in helping residents navigate the evolving health and social care landscape. Through working closely with voluntary sector partners and co-producing action plans, the team remains resilient and adaptive. They are committed to addressing the broader social factors that impact health and wellbeing.

Referral Overview

There have been 2,057 referrals received to Social Prescribing. 380 additional referrals were received from East Twickenham PCN, where lists of patients were identified as part of their tackling health inequalities project to support unpaid carers.

This totals 2,437 referrals from 1st April 2024 to 31st March 2025.

There has been a decrease in referrals in comparison to previous years. Teddington and Richmond PCN have limited their referrals due to a reduction in staff throughout the year. Link Workers typically hold an annual caseload between 200 - 250 clients, depending on complexity. The current capacity within Social Prescribing in Richmond is 9.7 FTE.

Figure 1: Social Prescribing Referrals 2024-2025

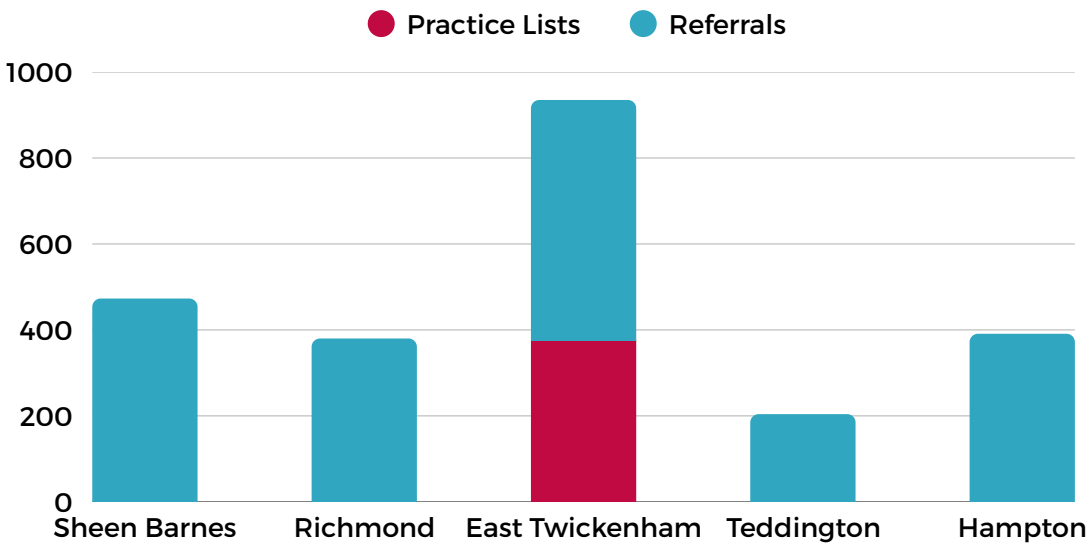
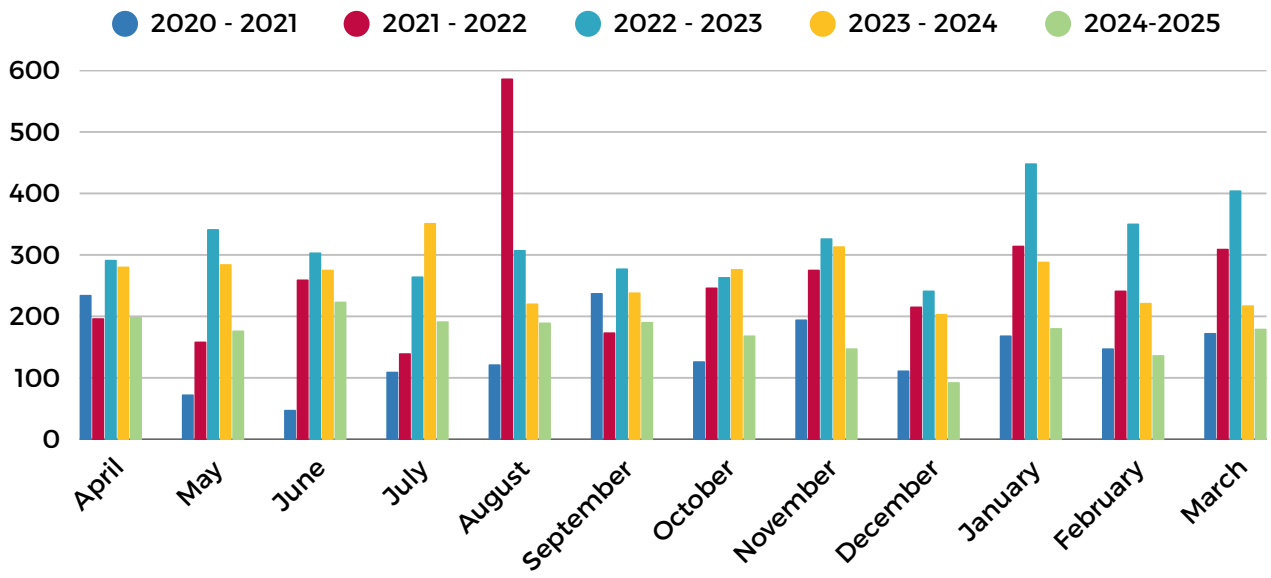


Figure 2: Social Prescribing Referrals 2020-2025



Of the referrals received, 1% were deemed inappropriate for Social Prescribing. These cases are discussed with the referrer and surgery. Reasons for patients not being accepted on to the service include: patient under the age of 18, patient had been incarcerated since the referral, patient had moved into a care home since the referral, patient has uncontrolled addiction and/or acute mental health or social crisis.

During the initial contact and engagement process, 3% of clients declined support from a Link Worker. Reasons for clients declining support included experiencing a significant life event, such as becoming medically unwell, or wishing to focus on engagement with current specialist professionals actively supporting them. Sometimes, clients had taken steps independently to support their health and wellbeing whilst waiting for contact. On occasion, clients could not remember the referral being made to the service and did not wish to engage when contacted.

Those who decline are provided with a clear explanation of the service during initial contact. Link Workers aim to discuss the information provided with the referral and explore how the service could support them. Clients are offered to contact the Link Worker directly in the future should their situation change or they wish to engage with the service.

7% of clients could not be contacted despite multiple attempts to make meaningful contact through different methods of communication over a number of weeks. This figure is consistent with previous years.

At the time of reporting, 61% of referrals have been successfully discharged from the service. An additional 17% engaged initially, including attending appointments, provided with onward referrals and signposting, but became uncontactable before their action plans could be reviewed and the case closed. The remaining 6% of clients are either actively engaged with a Link Worker, with a further 4% awaiting their initial appointment.

Reasons for Referral

The main reasons for referring to Social Prescribing were:

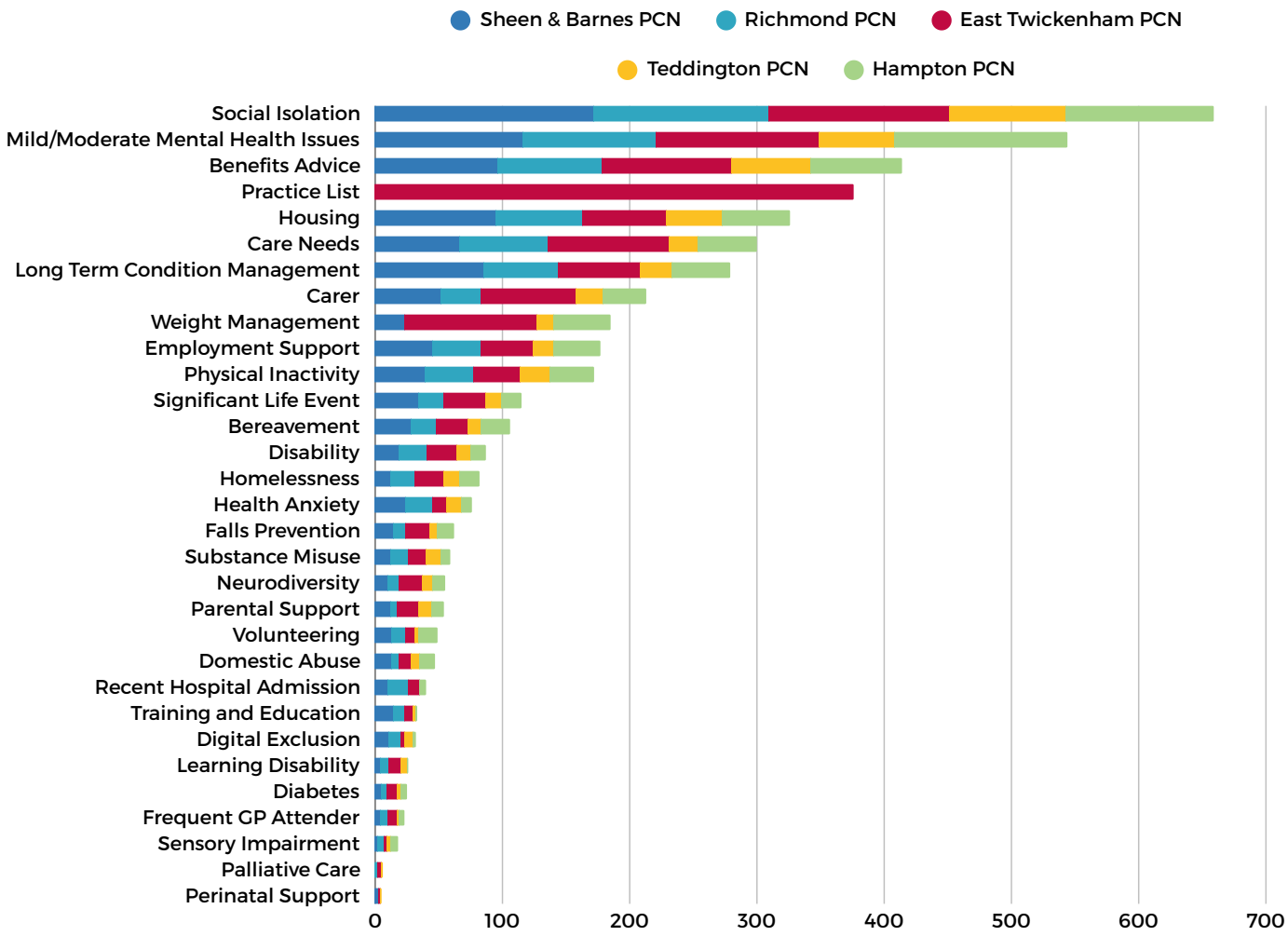
- Social Isolation (659)
- Mild to Moderate Mental Health Issues (544)
- Benefits Advice (414)
- Housing (326)
- Care Needs (300)

The team continues to receive a high number of referrals for mental health and social isolation, which remains consistent with previous years.

Following the Cost of Living increases in August 2022, we have continued to see an increase of referrals for benefits advice. There has also been an increase in referrals to support neurodivergent clients in comparison to last year.

Weight Management referrals were a prominent reason for referral in East Twickenham PCN, and housing referrals were high in Hampton PCN compared to other areas.

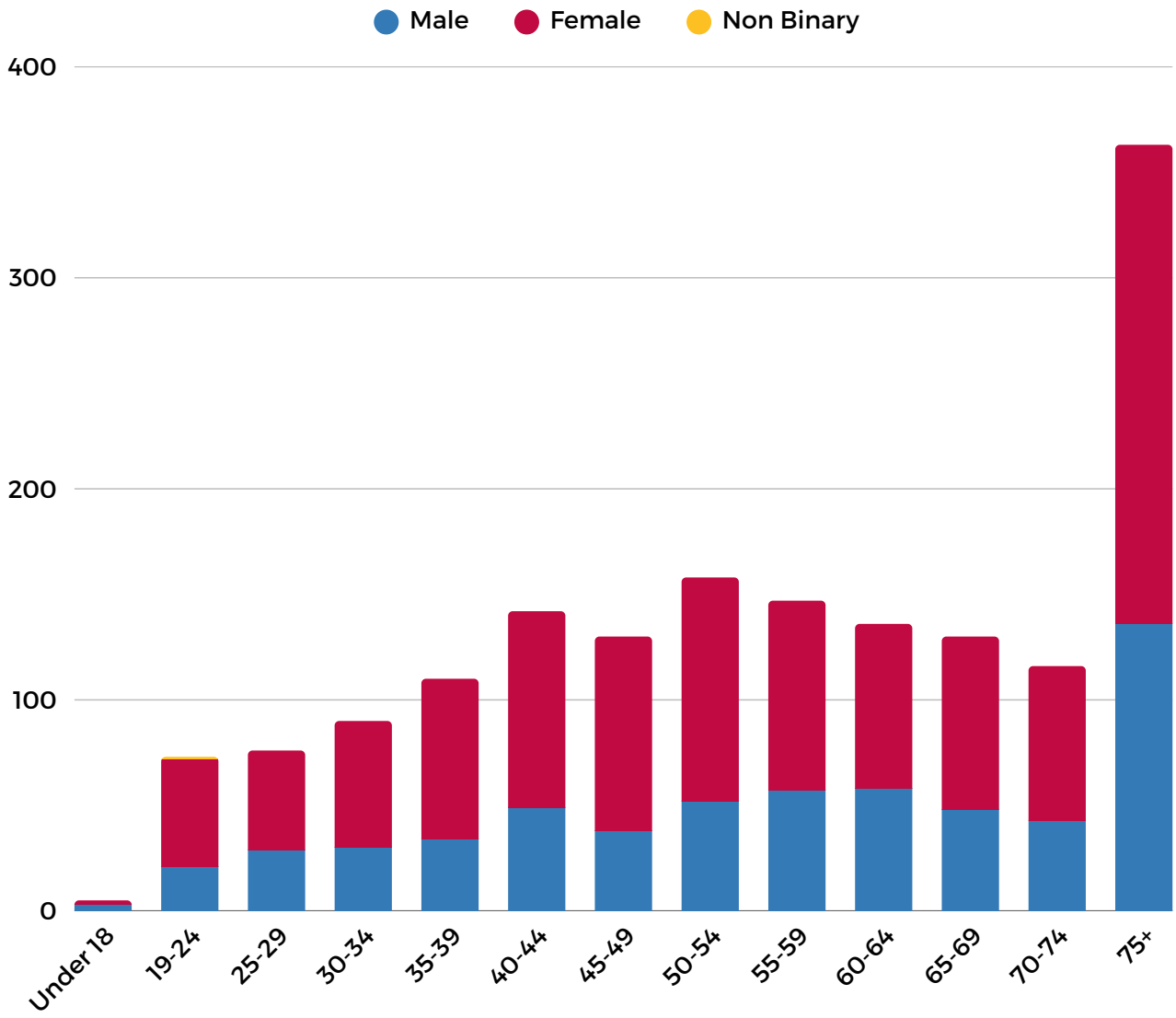
Figure 3: Reasons for Referral



Age and Gender of Clients

The majority of clients referred into the service identified as female (59%), and a breakdown of age shows the majority of clients are aged over 75. This remains consistent with previous years.

Figure 4: Age and Gender of clients



"I am very grateful and impressed with this holistic approach. The Link Worker was capable of listening to the complexity of my needs and understood me as a person before referring me to services"

Ivy – Cross Deep Surgery

Service Intervention

The number of contacts varies per client and depends on the complexity of the referral, number of issues and the individual's motivation to engage with services.

A small number of clients only require one telephone appointment to discuss their needs and are able to navigate the systems themselves with information on local services and sources of support provided by the Link Worker. The majority of clients, however, have complex or multiple needs and receive up to 12 contacts in a variety of communication methods. For example, Link Workers meet clients in surgeries, homes or within community venues to provide coaching, goal setting and co-produce action plans.

Overall, Link Workers completed:

1186 **in-person appointments**

8259 **telephone appointments**

15,330 **follow up contacts**

Link Workers use emails, texts and letters to communicate with clients, discussing their research, options and obtaining further information. Link Workers have signposted and referred a total of 4,315 times to 762 different organisations, groups and local services and activities.

Richmond Aid (Benefits Advice) was the most referred to service (173), followed by Citizens Advice Richmond (141) who also offer benefits and financial advice. Despite a decrease in referrals, onward referrals for benefits advice have increased. This may be as a direct result of local campaigns that have been encouraging those eligible to apply for pension credit and people being contacted to make the transfer from legacy benefits to Universal Credit.

Link Workers have been invited to attend weekly meetings with voluntary and community sector organisations to understand more about what they can offer clients, discuss current cases and ask questions. This has developed their understanding of the support available to ensure onward referrals are appropriate.

Outcomes

Link workers work with clients to achieve personal outcomes, some of which include:

- Successfully supporting a client with complex health needs and hoarding behaviour to engage with Marmalade Care, initiating a home decluttering process.
- Encouraging and empowering a client to independently learn reading and writing skills, enabling them to communicate directly with their housing provider and complete a Personal Independence Payment application.
- Facilitating a referral into a younger person's befriending service, providing a structured and safe environment that has directly contributed to a reduction in substance misuse.
- Helping a client apply for and secure a grant from the Victoria Foundation, resulting in the provision of an electric wheelchair and improved access to the community.
- Empowering a client with Multiple Sclerosis to attend Pilates class and providing encouragement to successfully attend by involving a supportive friend.
- Utilising easy-read weight management resources to support a client with a learning disability in making healthier food choices.
- Locating an art therapy programme tailored to the specific format requested by a client recovering from substance misuse.
- Supporting a visually impaired client to reduce falls risk by coordinating garden clearance and assistance with home lighting.
- Negotiating and re-establishing access to a local shopping bus for a client, addressing previous behavioural concerns and promoting independence.

"The Link Worker helped me set up activities throughout the week. I now have a timetable on my fridge with my new routine including attending a day centre twice a week, a care agency one day to support me with lunch and having a cleaner. On the weekend I am now going to the pub for lunch. My niece is also happy I can go to the hospital and make it there on my own"

Judy – The Green & Fir Road Surgery

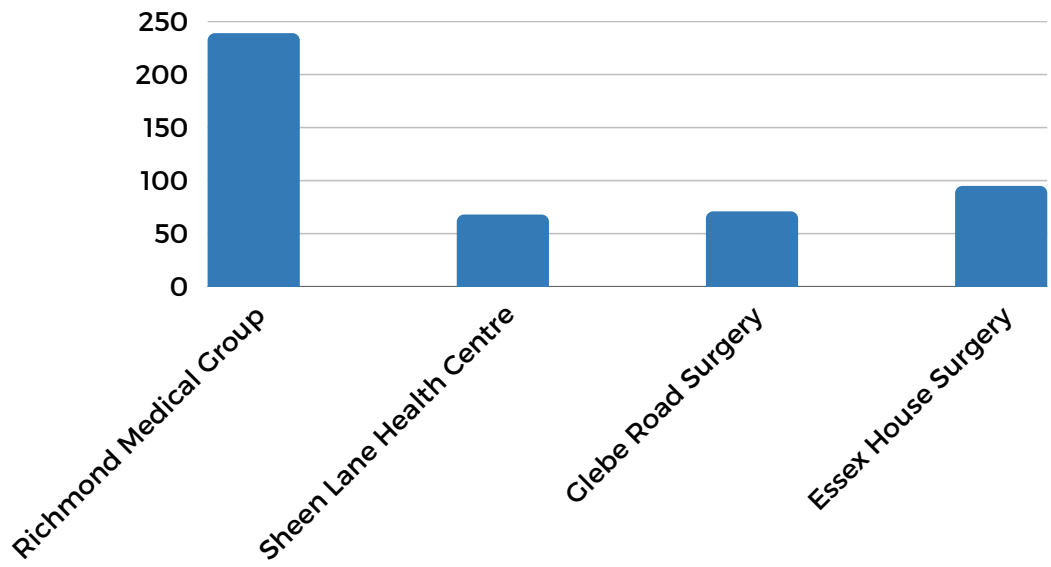
Primary Care Networks Impact Data

Sheen and Barnes PCN

"The Link Worker has been kind and supportive during my recent bipolar relapse. It meant a lot to know someone cared and they have been pivotal in my recovery. They have provided practical suggestions regarding my employment and signposted me to services, which I am grateful more. They helped me re-evaluate my priorities"
Joanna, Sheen Lane Health Centre

The service is delivered by 2.8 FTE Link Workers, who received 473 referrals. The current waiting time for an initial appointment from referral is 4 weeks.

Figure 5 - Sheen and Barnes PCN Referrals 2024-2025



The main reasons for referral were:

- Social Isolation (172)
- Mild to Moderate Mental Health Issues (116)
- Benefits Advice (96)
- Housing (95)
- Long Term Condition Management (85)

The majority of clients identified as female (68%). The breakdown of age shows the majority of clients are over 75 (27%) followed by those aged between 50 – 54 (11%).

Overall, Link Workers provided 312 appointments in person, with a further 1,521 contacts recorded over the phone or video call. Following these appointments, 3,403 contacts were recorded which includes additional contact between appointments.

Link Workers have signposted and referred a total of 942 times to organisations, groups and local services and activities. The main services referred or signposted to were:

- Citizens Advice Richmond (64)
- Chronically Marvellous (31)
- Richmond Aid Benefits Advice (27)
- FiSH Neighbourhood Care (19)
- Richmond Carers Centre (19)
- Age UK Richmond Advice Service (17)
- Love Me Wellbeing Programme (16)
- Richmond Wellbeing Service (16)
- Age UK Richmond Barnes Green Centre (15)

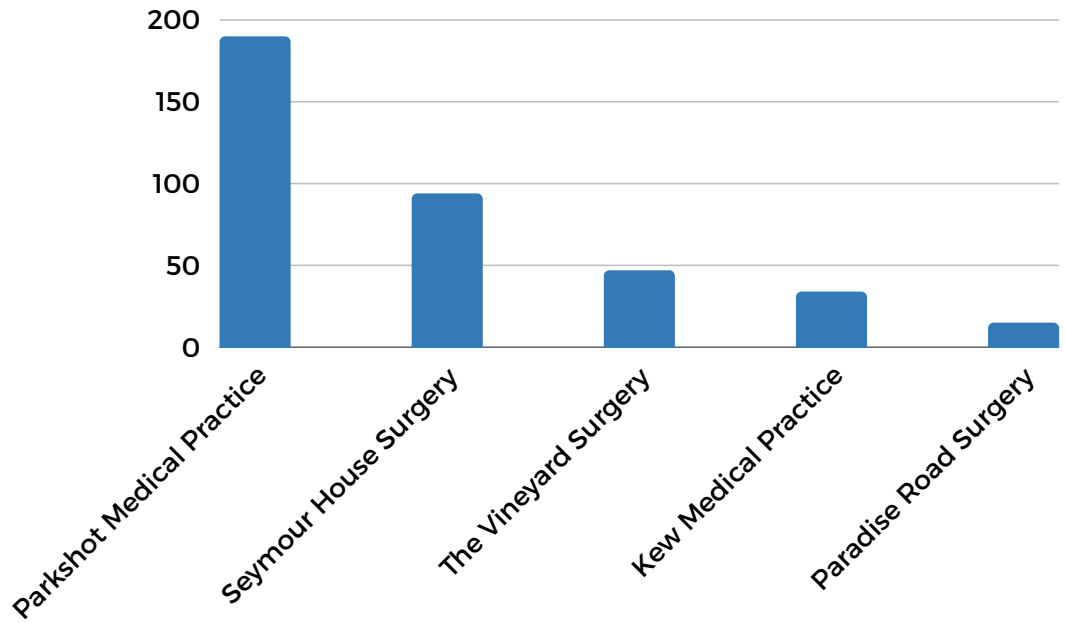
Richmond PCN

"I have been able to establish a gym membership to improve my core, muscle and bone strength which will enable me to better deal with heart disease. The Link Worker has helped me understand the pathway to improve my quality of my life"
Lorraine – Parkshot Medical Practice

The Link Workers within the PCN have reduced from 4.6 FTE to 1 FTE. To ensure quality service delivery and manage waiting times effectively, referrals have been limited to 18 per month since November 2024.

They received 380 referrals. The current waiting time for an initial appointment from referral is 15 weeks.

Figure 6 - Richmond PCN Referrals 2024-2025



The main reasons for referral were:

- Social Isolation (137)
- Mild to Moderate Mental Health Issues (105)
- Benefits Advice (82)
- Care Needs (70)
- Housing (68)

The majority of clients identified as female (60%). The breakdown of age shows the majority of clients are over 75 (25%) followed by those aged between 60 – 64 (10%).

Overall, Link Workers provided 157 appointments in person, with a further 1,125 contacts recorded over the phone or video call. Following these appointments, 1,740 contacts were recorded which includes additional contact between appointments.

Link Workers have signposted and referred a total of 662 times to organisations, groups and local services and activities. The main services referred or signposted to were:

- Richmond Aid Benefits Advice (42)
- Richmond Wellbeing Service (26)
- Citizens Advice Richmond (19)
- Richmond Carers Centre (16)
- Dose of Nature (15)
- Richmond Work Match (15)
- Richmond Adult Social Care (14)
- Richmond and Hillcroft Adult Community College (13)
- Choice Support (12)
- Richmond Borough Mind (12)

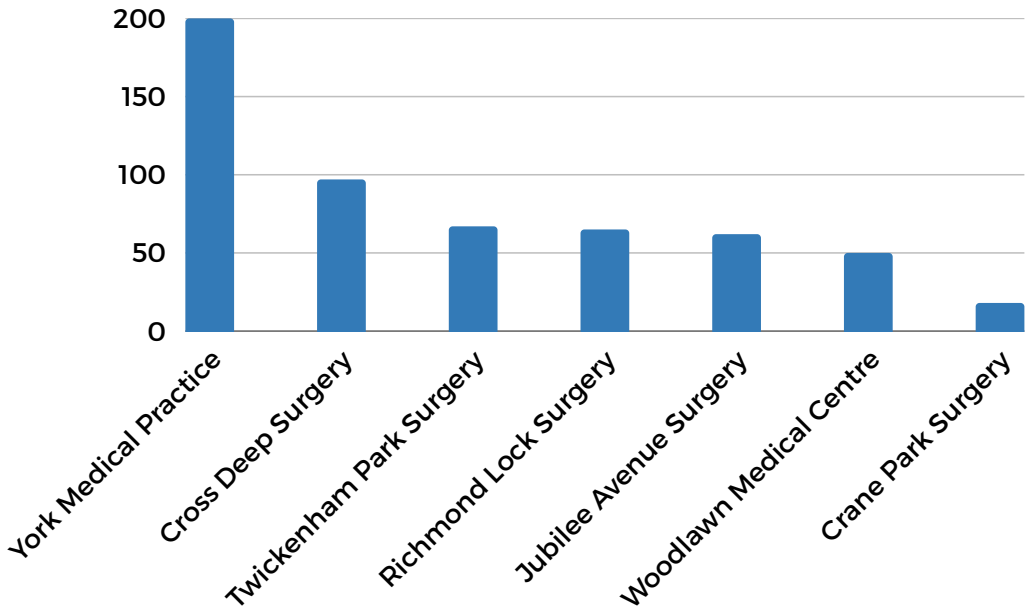
East Twickenham PCN

"I felt listened to and the service has helped me regain a little more confidence to start something new to improve my health. I have improved my dietary intake, increased exercise and register for swimming lessons. I am now trying to get back into employment" Luna – Woodlawn Medical Centre

The service is delivered by 2.8 FTE Link Workers. The current waiting time for an initial appointment from referral is 1 week. They have received 559 referrals.

From 1st October 2024, Jubilee Avenue Surgery, Richmond Lock Surgery and Twickenham Park Surgery have been included within the PCN.

Figure 7 - East Twickenham PCN Referrals 2024-2025



The main reasons for referral were:
Social Isolation (142)
Mild to Moderate Mental Health Issues (128)
Weight Management (104)
Benefits Advice (102)
Care Needs (95)

380 additional referrals were received during 2024 as part of their tackling health inequalities project to support unpaid carers. 21% of clients were contacted for an initial assessment and to identify unmet needs. Clients were provided with personalised information based on their caring role. 16% of clients declined and reasons for this included; the person being card for or had passed away, the client had misunderstood the initial message and was not providing care for anyone. The remaining clients were uncontactable.

The majority of clients identified as female (63%). The breakdown of age shows the majority of clients are over 75 (22%) followed by those aged between 55 - 59 (9%).

Overall, Link Workers provided 413 appointments in person, with a further 2,629 contacts recorded over the phone or video call. Following these appointments, 5,286 contacts were recorded which includes additional contact between appointments.

Link Workers have signposted and referred a total of 1,990 times to organisations, groups and local services and activities. The main services referred or signposted to were:

- Citizens Advice Richmond (58)
- Richmond Carers Centre (50)
- Dose of Nature (36)
- Age UK Twickenham Wellbeing Centre (34)
- Crossroads Care Richmond and Kingston (33)
- Richmond Counselling and Psychotherapy Service (30)
- Richmond Work Match (30)
- Ruils Counselling Service (28)
- Richmond Aid Benefits Advice (25)
- Space2Grieve Bereavement Support (25)
- Choice Support (25)

Teddington PCN

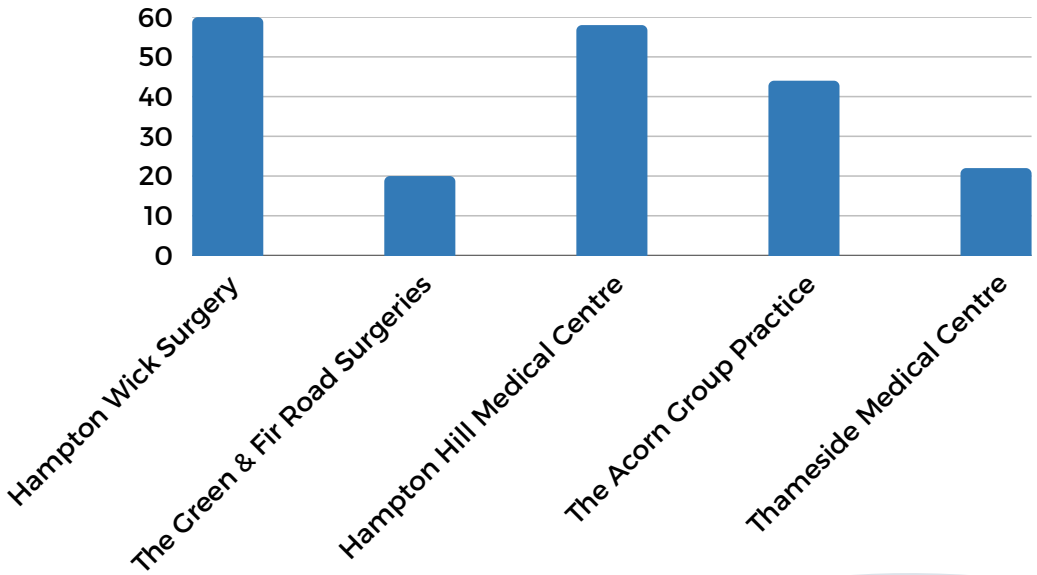
"I have learnt how to express myself, set my goals, identify my problems and calm myself down. Through the activities provided to me, I have been able to reconnect with people after being disconnected from others for more than eighteen months."
Elaine – Hampton Hill Medical Centre

Since June 2024, the Link Workers within the PCN has reduced from 2 FTE to 1 FTE. To ensure quality service delivery and manage waiting times effectively, referrals have been limited to 18 per month.

They received 204 referrals. The current waiting time for an initial appointment from referral is 7 weeks.

From 1st October 2024, Acorn Group Practice have been included within the PCN.

Figure 8 - Teddington PCN Referrals 2024-2025



The main reasons for referral were:

- Social Isolation (92)
- Benefits Advice (62)
- Mild to Moderate Mental Health Issues (59)
- Housing (44)
- Long Term Condition Management (25)

The majority of clients identified as female (56%). The breakdown of age shows the majority of clients are over 75 (25%) followed by those aged between 45 – 49 (11%) and 60 - 64 (11%).

Overall, Link Workers provided 97 appointments in person, with a further 1,159 contacts recorded over the phone or video call. Following these appointments, 1,085 contacts were recorded which includes additional contact between appointments.

Link Workers have signposted and referred a total of 225 times to organisations, groups and local services and activities. The main services referred or signposted to were:

- Richmond Aid Benefits Advice (16)
- Citizens Advice Richmond (13)
- Choice Support (6)
- Greenwood Community Centre (6)
- Richmond Carers Centre (6)
- Space2Grieve Bereavement Support (5)
- Elleray Hall Social Centre (5)
- Chronically Marvellous (5)

Hampton PCN

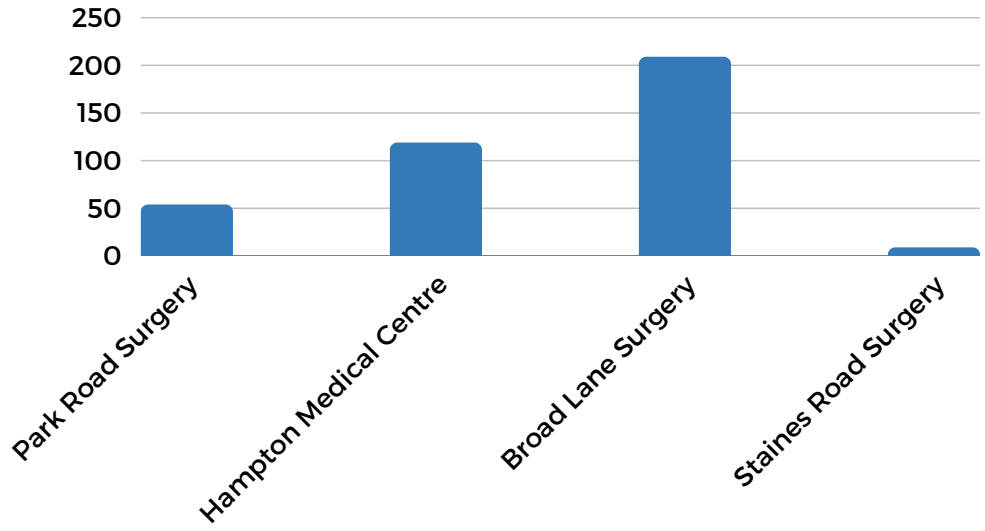
"My sleeping pattern has dramatically changed and my overall health and wellbeing. Before the Link Worker stepped in, my life was completely chaotic. They gave me a platform to speak my mind, listened to my problems and offered support. They went above and beyond to make sure I got the maximum amount of help"

Imogen – Broad Lane Surgery

The service is delivered by 2.1 FTE Link Workers. They received 391 referrals. The current waiting time for an initial appointment from referral is 7 weeks.

From 1st October 2024, Staines Road Surgery have been included within the PCN.

Figure 9 - Hampton PCN Referrals 2024-2025



The main reasons for referral were:

- Mild to Moderate Mental Health Issues (136)
- Social Isolation (116)
- Benefits Advice (72)
- Housing (530)
- Long Term Condition Management (46)

The majority of clients identified as female (53%). The breakdown of age shows the majority of clients are over 75 (26%) followed by those aged between 50 - 54 (10%).

Overall, Link Workers provided 225 appointments in person, with a further 1,825 contacts recorded over the phone or video call. Following these appointments, 3,717 contacts were recorded which includes additional contact between appointments.

Link Workers have signposted and referred a total of 496 times to organisations, groups and local services and activities. The main services referred or signposted to were:

- Richmond Aid Advice Service (22)
- Chronically Marvellous (18)
- Greenwood Community Centre (17)
- Enable Adult Weight Management Service (14)
- Ruils Counselling Service (11)
- Ruils Welfare Grant (11)
- Dose of Nature (10)
- Age UK Richmond Advice Service (9)
- Citizens Advice Richmond (9)
- Richmond Wellbeing Service (9)
- Richmond Council Swim Pass (9)

Additional Projects

Health in Your Hands)

Working in partnership with the NHS Integrated Care Board, this project aims to tackle health inequalities in Richmond. Social Prescribing Wellbeing Coordinators attended 88 groups within the community to offer basic health checks to residents.

450 community health checks were provided through outreach and community events organised and delivered by the Wellbeing Coordinators. These checks included assessing individuals BMI, diabetes risk score and atrial fibrillation. Wellbeing Coordinators were trained and followed clinical guidelines. Of the residents checked:

- 31% required further investigation through blood pressure reading.
- 19% required further investigation through diabetes risk score.
- 3% required further investigation through electrocardiogram score.

The Wellbeing Coordinators have worked across all 5 PCNs, contacting patients with long term health conditions (diabetes, asthma, hypertension and depression) and providing one-to-one support. They have used the Signal Tool to help them to identify areas of risk and to aid better self-management of patients' health and wellbeing.

Events were organised in Hampton, Whitton, Ham, Mortlake and South Richmond to bring a range of services to the community. Link Workers have continued to support these events, encouraging clients to attend, including those waiting to be contacted for an initial appointment.

Proactive Anticipatory Care

Working in partnership with the NHS Integrated Care Board, PAC Care Coordinators have supported each PCN. They provide support to the person and their family to improve self-resilience, connecting them with activities and services in their community and ensuring that care and support needs are met. Through this project we identify people, early on, who have rising complexity and risks.

294 patients were accepted onto the programme between 1st April 2024 – 31st March 2025. A review in August 2024 found that patients who have been on the on the PAC programme for 4 months or longer experienced a 49% reduction in unplanned care, and length of stay for unplanned non-elective reasons reduced by 55% overall.

Community Health and Wellbeing Programme

Working in partnership with the NHS Integrated Care Board, this project aims to tackle health inequalities in Richmond. Community Health and Wellbeing Workers have focused on building relationships and embedding themselves in Fulmer Close (Hampton North).

They have engaged with 98 residents since July 2024, providing monthly home visits, offering proactive support to meet unmet social needs and improve engagement with primary care. Clinical supervision has been provided by Dr Sapna Gulati to support residents with accessing medical information and guidance on complex health conditions.

Get Me Active Fund

Since September 2023, following a successful application to Active Richmond Fund, Ruils has been able to provide grants up to the value of £100 for 51 clients to purchase items they needed to become more active and engage in physical activities.

The majority of applications were for gym memberships, Pilates classes and swimming lessons. Link Workers continue to report that due to Cost of Living increases, the cost of items or classes can deter their clients from engaging with existing provision in Richmond. We have been successful with another application for £5000.

Homes for Ukraine

Working in partnership with Richmond Council, Link Workers have continued to complete home visits to guests sponsored through the Homes for Ukraine Scheme. Link Workers have completed 47 welcome visits, and 40 follow up visits at 6 months to guests over the past 12 months. The team have been able to connect guests to services, such as Refugees Welcome in Richmond who provide befriending and support in learning English as a second language.

Impact to Clients - ONS and GP Appointments

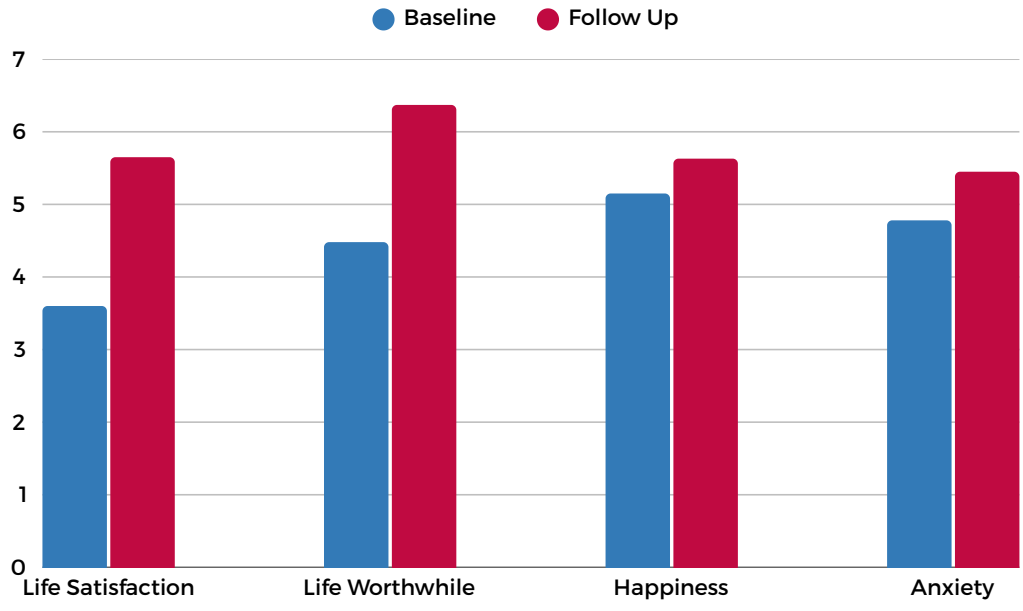
The service uses ONS4, a validated tool to assess personal wellbeing. These measures ask people to evaluate how satisfied with their life overall, asking whether they feel they have meaning and purpose in their life, and asks about their emotions during a particular period.

Baseline data is collected usually during the first appointment, where a client is asked to score themselves on a scale of 0 – 10. Within ONS 1, 2 and 3, 0 is 'not at all' and 10 is 'completely'. Within ONS 4, 0 is 'not at all anxious' and 10 is 'completely anxious'. Follow up data is collected during the last one-to-one appointment.

182 clients have completed ONS4 baseline and follow up questions. 68% of clients felt more satisfied with their life, that the things they do are worthwhile and were happier when discharged from the service.

Compared to previous years, clients are reporting higher levels of anxiety when being discharged from the service. We understand that clients are starting new activities, or are waiting for contact from information and advice services. There is an increased demand on voluntary advice services, which affects waiting times for clients' to access support and work towards their longer term goals.

Figure 10: ONS4 Data



During the last year, our database Joy has introduced a new outcomes measurement tool. This has measured the number of GP appointments 3 months prior to a referral to Social Prescribing, and again 3 months after successfully being discharged from the service.

Based on a sample of 500, it showed the average number of appointments reduced from 31 to 17 per client. We understand that this is still a blunt tool and these figures could also be influenced by a number of factors, such as changes within primary care triage systems, but it is encouraging to see an impact on the number of appointments booked. We look forward to seeing further results as this tool is developed further.

In addition to this, the NASP Evaluations that were carried out in nine local health systems across England in November 2024 found that Social Prescribing can substantially reduce pressure on the NHS, including reduced GP appointments, hospital admissions and A&E visits.

Impact on Clients - Feedback

Following intervention with a Link Worker, 226 clients have completed Ruils Outcomes (Feedback) Survey.

95% felt their Link Worker listened to them

97% felt their Link Worker understood what mattered to them

84% felt they were managing their health and wellbeing better

91% felt more confident to access services and activities

93% felt they know where to go for help and support

92% would recommend the service to friends and family

76% felt their situation had improved

84% felt more involved in decisions about their health and wellbeing

Within additional comments, clients often described their Link Worker as empathetic, kind and non-judgmental. A large number mentioned that their Link Worker has helped them navigate complex systems and access services they did not know about.

Clients commented that they felt a boost in self-belief and confidence to ask for help in the future. Many reported reduced anxiety, improved mood and greater hope. Clients described feeling less alone and more connected to their communities. **Comments included:**

> "The Link Worker has been incredibly helpful during a difficult time when I felt lost and alone due to anxiety after being made redundant. I am truly grateful for their support, as it made a significant difference. Their guidance was invaluable in helping me determine where to begin my job search."

> "As a direct result of the information provided by the Link Worker, I was able to contact a learning group and become a member, alongside being contacted by a volunteer transport service. I also now have twice weekly visits from a cleaner. Having support from a Link Worker has helped me to be more positive in my outlook and do things, instead of thinking of doing things."

> "Having support from a Link Worker helped me to realise there is support out there. I have had to deal with being a carer and bereavement of my Mother. The Link Worker helped me through these tough stages through providing useful resources. I have joined an art group and awaiting an appointment with a bereavement service."

> "We are actively pursuing positive lines of enquiry for our son's medium and long term future. This is a key issue for us both, in terms of our own peace of mind. The Link Worker helped articulate and externalise our concerns and worries, leading to a lowering of our stress and more positive feelings."

> "Having support from a Link Worker helped address my problem of over-eating and understand what is available to me locally, alongside overcome some of the shame associated with the problem. I have signed up to attend online peer support groups people who have an eating disorder."

Impact on Clients - Case Studies

Case Study 1

Alice made contact directly with the Link Worker, following an appointment with their GP who had suggested exploring Social Prescribing. Alice explained she had been diagnosed with Multiple Sclerosis in her late 40's and wanted to find social groups and activities to support her wellbeing.

During the initial appointment, the Link Worker opened the discussion on the Alice's interests, which focused on being outside and wishing to access an allotment group. The Link Worker spoke to several providers on behalf of the Alice, with only one confirming the allotment and garden was accessible via a rollator frame and had toilet facilities, which was important to the Alice.

Alice had also expressed an interest in exercise groups to support with muscle strength. With support from the Link Worker, they reviewed the schedules of two local community centres to consider chair based classes. Through attending several sessions of Pilates, Alice met another attendee who also had a diagnosis of Multiple Sclerosis.

Although Alice was able to use technology and had a smart phone, she was unsure how to use the calendar application to manage her appointments. The Link Worker was able to signpost her to informal groups that could support with this and Alice attended a number of sessions.

Alice was already attending a peer support session for those living with Multiple Sclerosis, and had been informed of an emotional resilience course by another member. The Link Worker was able to locate courses through the local community college, alongside other mindfulness groups locally.

During their appointments, Alice had explained how her diagnosis of Multiple Sclerosis had a significant impact on her mental health. She was supported by their partner, although commented how she often felt alone. The Link Worker spent time exploring the Alice's symptoms and how this impacted her as an individual. Initially, Alice engaged with counselling sessions although after a few felt this was not the right avenue of support for them.

Although supported by their partner, and family. Alice felt that others did not fully understand her health condition. The Link Worker found various resources for her that they could pass on to others.

She felt that talking was helpful and the Link Worker supported a referral for befriending. Alice was matched with a volunteer locally that could meet them at home, without Alice needing to ask their partner to drive them anywhere. With a shared interest in psychology, this has supported them to build a relationship with a volunteer befriender.

Before closing the case, Alice wished to explore further volunteering opportunities in the community. Following an initial discussion on horses, she was signposted to a local stables and has met them for an informal conversation, which she plans to take forward independently.

Case Study 2

Rachel had already been referred to Talking Therapies, although felt they unable to offer the support she would like. The GP wanted to see if there were any other services she could access to support her mental health and wellbeing.

When the Link Worker made initial contact, Rachel described how she spent most of her days in bed and felt like she was 'dying inside'. Rachel explained how she used to engage with boxing and football, although lacked motivation to participate due to her mental health. Her sister lived locally, although was caring for four children, one of which has additional needs. Rachel did not want to burden their sister with her emotions and how she was feeling.

During this initial contact, Rachel started to open up on the loss of her parents and other family members at a young age. She revisited the support that was offered at the time, which was a group of fifty people with advice from a Psychiatrist. She had been offered to attend a CBT group although felt she needed to talk through her feelings. Rachel spoke about a number of health conditions which affected her, including epilepsy. She spoke several languages and was currently enrolled on a University course and remained interested in learning.

The Link Worker supported an initial referral to a counselling service, alongside exploring programmes that could support Rachel's mental health and physical activity. Once emailed, Rachel was proactive in reviewing each option and was keen to speak with the Link Worker during the next appointment in more depth about each of these.

Within the second appointment, Rachel was able to discuss her thoughts on what was available locally. She then focused on a one-to-one exercise programme, specifically for those diagnosed severe and enduring mental health illness. The Link Worker also provided information on a disabled person's Freedom Pass to support Rachel with travel costs and made a referral to the provider.

The Link Worker maintained contact once the referrals had been accepted by both providers. Rachel was offered an initial appointment on the exercise programme and following an initial assessment with the counselling service, was provided with a timeframe of when she could expect sessions to start.

Rachel was hesitant for the case to be closed. The Link Worker reflected with her on the support provided. Rachel explained she felt noticeably more energetic and motivated. Rachel explained how when initially contacted she felt her life was chaotic, although felt the service offered a platform for her to speak her mind, provided someone to listen to her problems and offer support.

Case Study 3

Natasha was referred for support with symptoms of depression and isolation. During the initial appointment, she explained to the Link Worker she had spent days at home, solely watching television to numb her emotions. This left her feeling isolated, disconnected and overwhelmed by negative thoughts and feelings.

The Link Worker encouraged Natasha to reflect on her past and joyous moments, which included caring for her children and providing a fulfilling routine. Natasha explained her children had become older and were spending time with her own friends. She also described how her daughter had an undiagnosed mental health condition, which caring for them intensified her feeling of anxiety and depression.

Together, they explored counselling as an avenue for emotional support, which Natasha found appealing to support her in developing strategies to manage feelings of depression and anxiety. She discussed the possibility of attending a carers support group, specifically designed for those caring for someone with mental health issues. Natasha expressed a strong desire to engage with the community and help others, based on the joy and fulfillment she found caring for others. This evolved into Natasha wanting to volunteer as a befriender to offer others companionship.

Since engaging with these services, Natasha has continued to attend coffee mornings and also attended a theatre trip with the carers support group. Through weekly counselling sessions, she has learnt to understand and manage her own mental health. Natasha explained to the Link Worker she feel more in control of her emotions.

Following this, Natasha explained it has encouraged her to take more proactive steps towards improving her physical health. She were keen to become more active and make changes to her diet and had self-referred to the local weight management service.

Case Study 4

Elliott was referred for support with care at home, alongside being a carer for his partner. When contacted, Elliott explained to the Link Worker he is partially sighted due to age-related macular degeneration. This affected Elliott's ability to travel to the surgery for appointments. The Link Worker offered to visit him at home.

Elliott discussed his role caring for his partner, although the main priority was his sight loss and navigating this. He was in receipt of additional benefits and was awaiting a further benefits check. He explained that some of the challenges he faced were reading bus numbers, withdrawing money from cash machines and accessing online banking. It also affected him with activities of daily living, such as changes light bulbs or cleaning. Due to resources solely being available online, Elliott felt unable to complete application forms or find information.

They spoke about accessibility features for his computer, although he wanted to learn how to use these. The Link Worker supported a referral to a service connecting him to technology, who were able to visit and offer practical solutions. This included increasing font sizes, zoom functions and adding WhatsApp onto the computer so he could communicate with family members.

The Link Worker was able to provide information on a taxi card scheme to support travel and provide more independence. Elliott was referred to a service to offer support with completing forms, alongside applying for a Blue Badge. Although he was no longer driving, Elliott felt this would support others providing him with transport.

Through connecting Elliott to a handyperson service, they were able to organise someone to put up curtains over windows in the office to reduce glare on the screen when using the computer.

The benefits assessment provided information he was eligible for a council tax reduction, which he has been able to apply for. Elliott also wished to explore carers allowance. The Link Worker referred him to a local service offering information, advice and guidance for carers. Following the initial discussion, Elliott's partner has been registered as a carer to receive information. They have made an informed decision to not apply for carers allowance due to the impact it would have on other benefits being claimed for.

Elliott explained he found navigating interactions between healthcare professionals and the voluntary sector confusing. The Link Worker created a supporting document of the services they had accessed throughout the service, including those with outstanding referrals or where to access information in the future. Elliott explained he could maintain this moving forward and update this independently.

Conclusion

"The connection through our GP practice was vital in encouraging us both to engage with the service, the link to clinical and pastoral care being vitally important from our point of view. The Link Worker helped me explore opportunities I wasn't aware of or even considered"
Malcolm – York Medical Practice

Social Prescribing remains a vital component of Universal Personalised Care, connecting individuals to community-based activities, groups and services that address the practical, social and emotional factors that affect clients' health and wellbeing.

Link Workers continue to provide a flexible and person-centred service, offering tailored support to help individuals take greater control of their health and wellbeing. Through building trusting relationships, they work collaboratively with clients to explore meaningful opportunities for long term engagement and support.

Clients consistently report the value of having dedicated time to identify and address person barriers and challenges, co-producing action plans that reflect their individual goals. Link Workers utilise health coaching and motivational interviewing techniques to facilitate positive outcomes and empower clients to make sustainable lifestyle changes.

The principles of Social Prescribing are deeply embedded across wider initiatives, such as Proactive Anticipatory Care, Health in Your Hands and Community Health and Wellbeing Programme. These programmes work cohesively, sharing expertise, knowledge and experience to enhance the support offered to clients.

Where there are increasing demand on primary care, driven by an ageing population, a rise in long-term health conditions and limitations to secondary care, Social Prescribing continues to support a multidisciplinary approach to managing health and wellbeing, easing pressure on traditional services whilst improving holistic care outcomes.

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