

RICHMOND SOCIAL PRESCRIBING SERVICE

Ruils Independent Living

6 Month Report: April – September 2025

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Introduction

“Social Prescribing helped me get my life back. I no longer fear a knock at the door, phone call or email. The Link Worker helped me find practical solutions to the problems I was facing.”

Steven – 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. This 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 to 30th September 2025.

The service continues to work in partnership with 25 GP Practices that make up the 5 Primary Care Networks (PCNs) within Richmond. There have been significant changes in how referrals are processed and managed. Three of the five PCNs have discontinued their subscription to the Joy case management system, and as a result, these Link Workers no longer have access to a centralised digital platform for case management.

In response, the team have transitioned away from Joy and introduced a Microsoft Form to facilitate referrals. This new referral method has been shared with relevant practices to ensure continuity of service. Despite these changes, the team remains resilient and committed to delivering a high quality, person centred service and continues to adapt to ensure accessibility and efficiency across all PCNs. As a result, the dataset may not fully reflect recent activity or outcomes.

The number of Social Prescribing Link Workers across Richmond General Practice Alliance (RGPA) remains at 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 are committed to addressing the broader social factors that impact health and wellbeing.



Referrals to Social Prescribing

There have been 720 referrals received to Social Prescribing. During the transition period, some referrals were received directly via email and as a result were not captured within the reporting dataset.

Teddington and Richmond PCN have continued to limit their referrals due to a previous reduction in staff. Link Workers typically hold an annual caseload between 200 - 250 clients, depending on complexity.

Figure 1: Social Prescribing Referrals

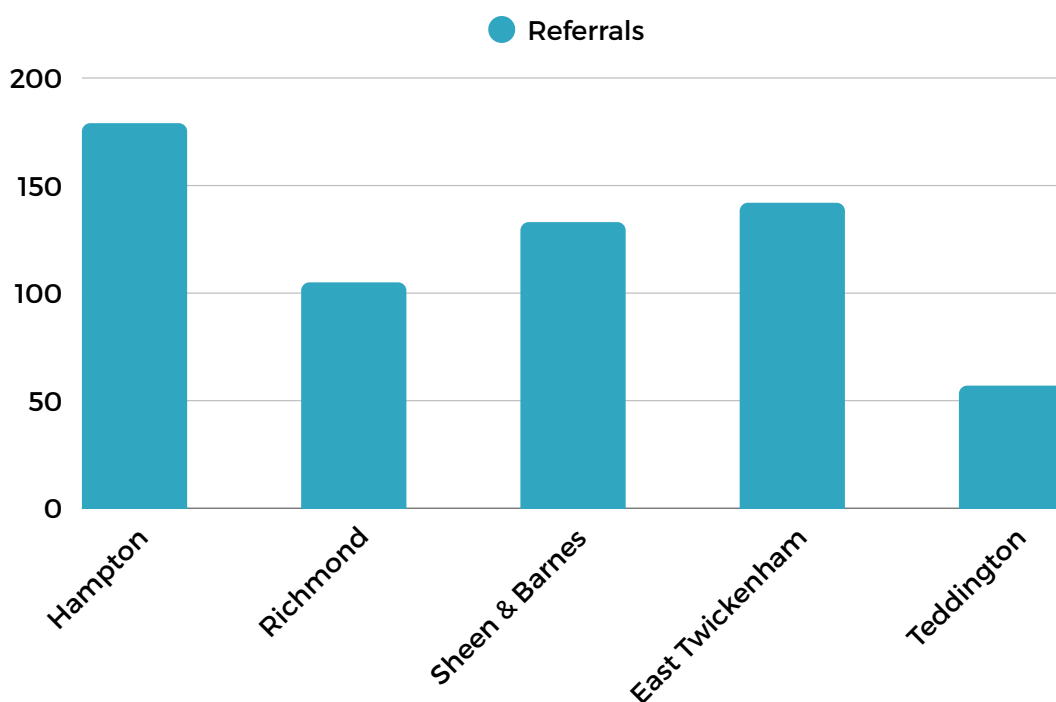
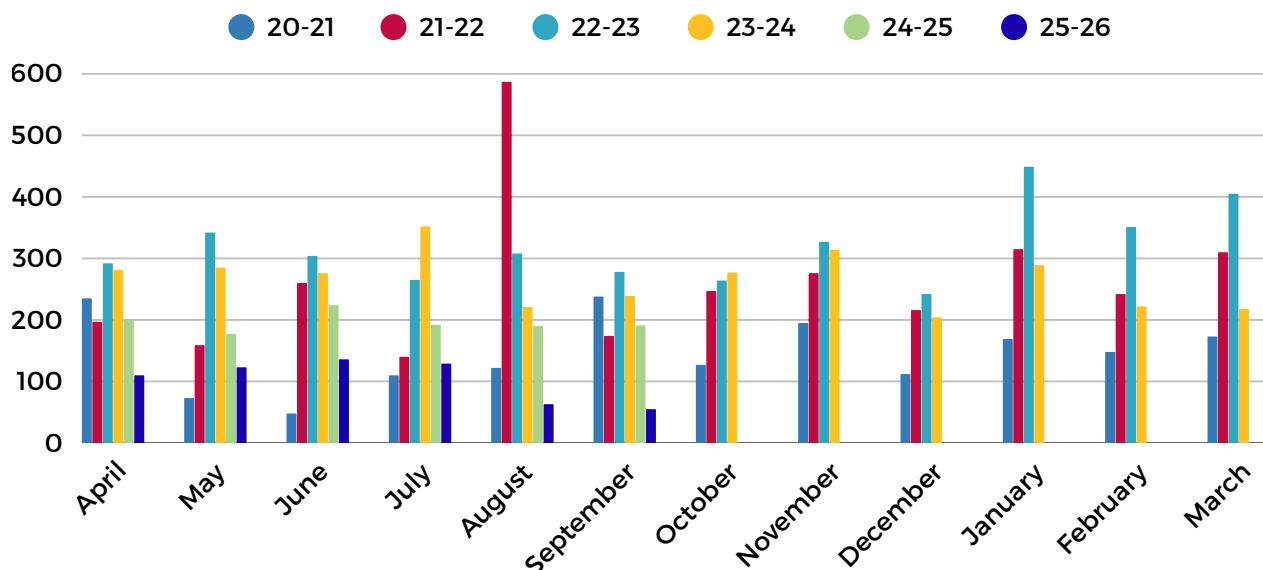


Figure 2: Social Prescribing Referrals 2020-2024



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 the patient is under the age of 18 or the patient has uncontrolled addiction and/or acute mental health or social crisis.

During the initial contact and engagement process, 2% of clients declined support from a Link Worker. Reasons for clients declining support included wanting information for services in advance of an operation, which had not yet been scheduled. Sometimes, clients had taken steps independently to support their health and wellbeing such as managing a housing transfer and moving. A small number of 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.

Link Workers work closely with PAC Care Coordinators, often referring clients with escalating risk if appropriate. 1% of clients referred to Social Prescribing were already engaging with a PAC Care Coordinator who continued with personalised action plans. 4% of clients could not be contacted despite multiple attempts to make meaningful contact through different methods of communication over a number of weeks.

At the time of reporting, 35% of referrals have been successfully discharged from the service. 41% of clients are either actively engaged with a Link Worker, with a further 16% awaiting their initial appointment.

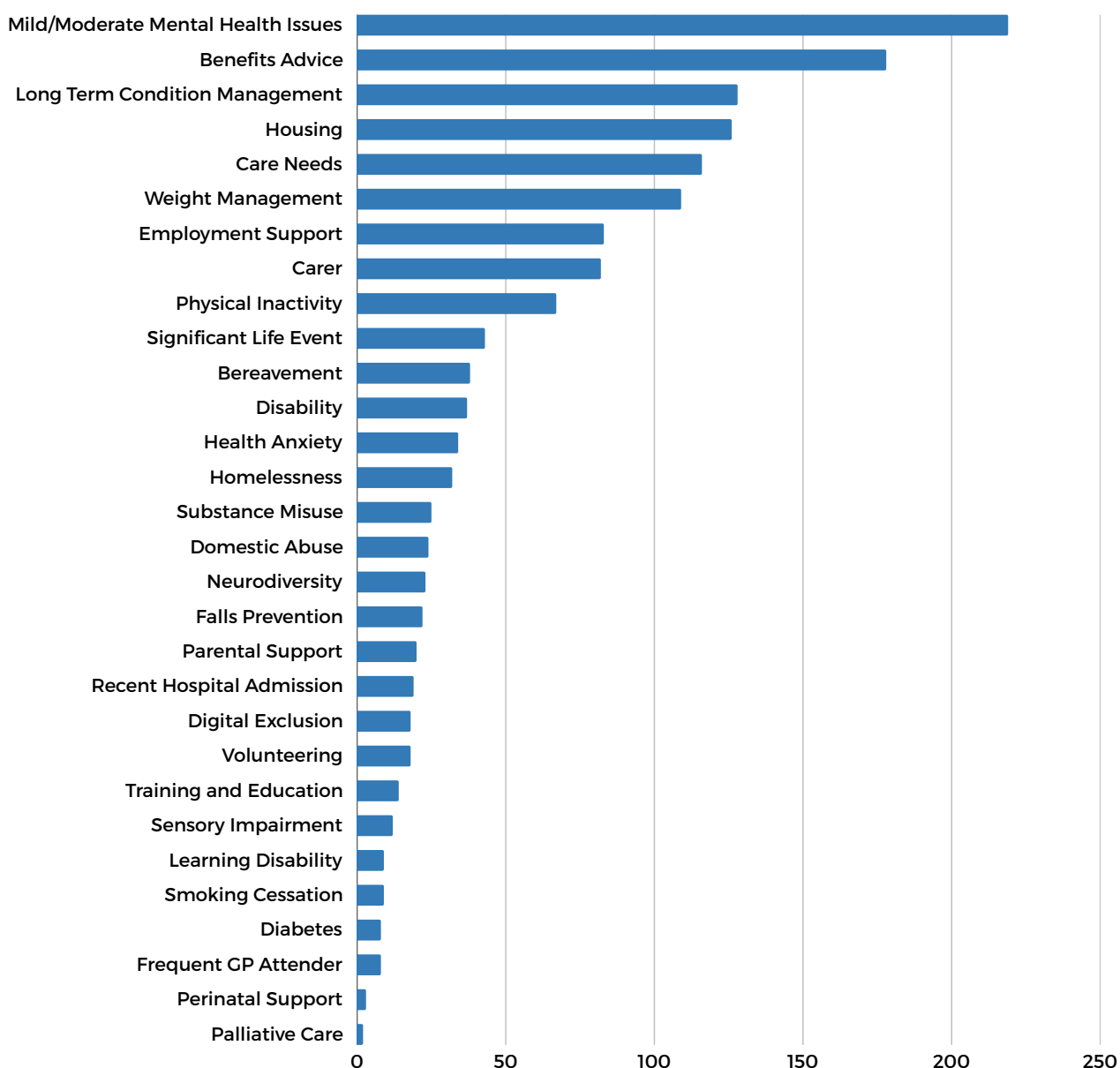
Reasons for Referral

The main reasons for referring to Social Prescribing were:

- Social Isolation (281)
- Mild to Moderate Mental Health Issues (219)
- Benefits Advice (178)
- Long Term Condition Management (128)
- Housing (126)
- Care Needs (116)

The team continues to receive high numbers of referrals for mental health and social isolation, which remains consistent with previous years. We have continued to see increased referrals for benefits advice since the Cost of Living increases in August 2022.

Figure 3: Reasons for Referral



Age and Gender of Clients

The majority of clients referred into the service identified as female (63%) and a breakdown of age shows the majority of clients are aged over 75. This remains consistent with previous years.

Figure 4: Age of clients

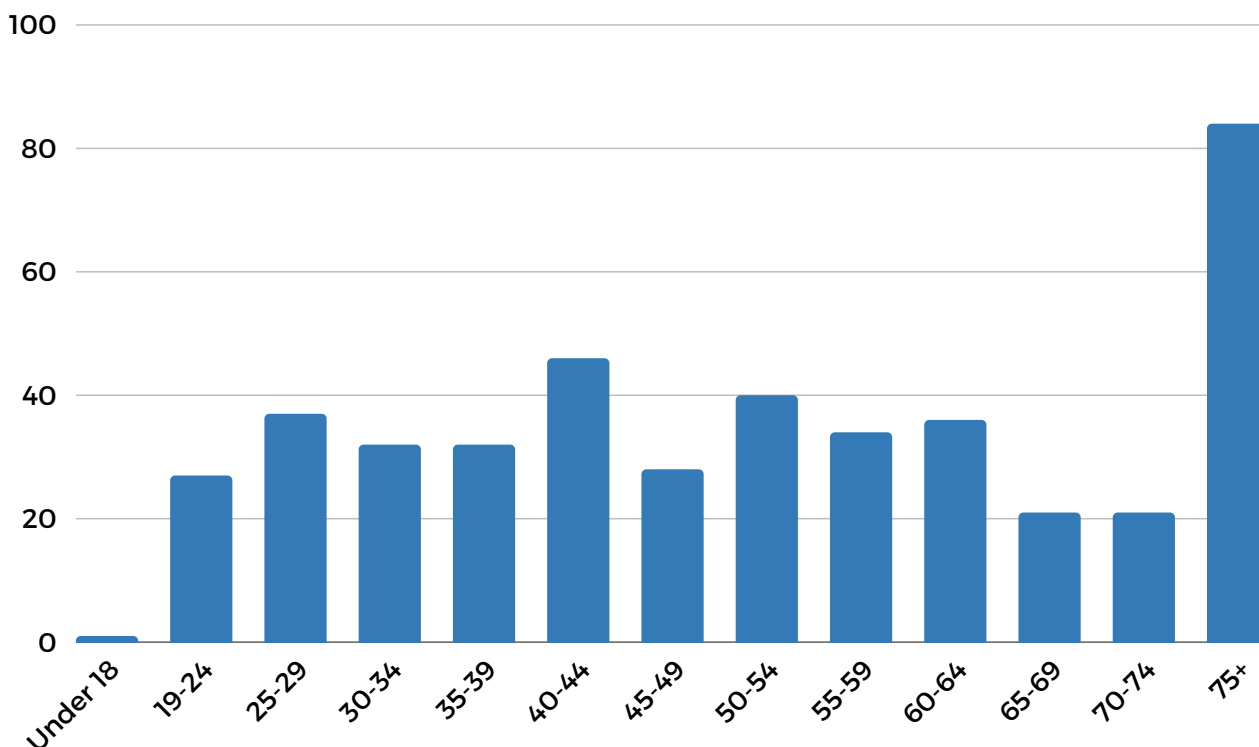
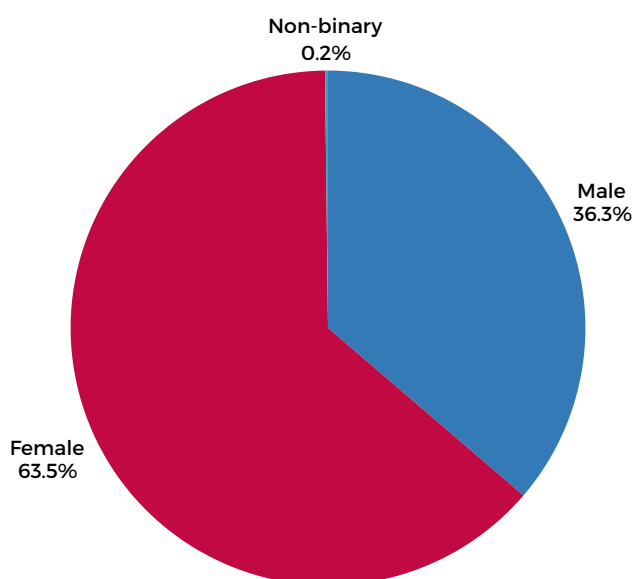


Figure 5: Gender of clients



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 the 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, through the Joy case management system, Link Workers completed:

391 face to face appointments

3157 telephone and video calls

5838 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 1,626 times to 464 different organisations, groups and local services and activities.

Richmond Aid (Benefits Advice) was the most referred to service (68), followed by Citizens Advice Richmond (57) who also offer benefits and financial advice. The other main services referred or signposted to include:

- Enable Adult Weight Management (45)
- Chronically Marvellous Counselling (41)
- Choice Support (34)
- Dose of Nature (30)
- Richmond Work Match (25)
- Richmond Carers Centre Adult Support (25)
- Richmond Council Swimming Pass (23)
- Vineyard Community Centre Crisis Support (22)
- Crossroads Care Richmond and Kingston (20)
- Ruils Counselling Service (20)
- Richmond Adult Social Care (19)
- Cambrian Community Gym (18)
- Richmond and Hillcroft Adult Community College (17)
- Space2Grieve Bereavement Support (16)
- Richmond CVS Volunteering Support (16)
- Richmond Counselling and Psychotherapy Service (14)
- Homelink Day Respite Centre (11)
- Care Home Selection (10)
- Connect to Tech Service (10)
- Kaylo (10)

Impact on Clients - Feedback

Following intervention with a Link Worker, 107 clients have completed Ruils Outcomes (Feedback) Survey.



96%

felt their Link Worker listened to them

97%

felt their Link Worker understood what mattered to them

79%

felt they were managing their health and wellbeing better

86%

felt more confident to access services and activities



93%

felt they know where to go for help and support

91%

would recommend the service to friends and family

80%

felt their situation had improved

81%

felt they had made a positive change in their life



Within additional comments, many clients described feeling heard, understood and supported during times of stress, poor mental health or practical difficulties. They felt the service enabled them to connect with a wide range of community resources and services, often for the first time.

Many clients referred to Social Prescribing are dealing with long-term and multilayered issues where short term support is not enough for them to feel like meaningful change has occurred. This is also apparent where external barriers, such as waiting lists, impact on tangible outcomes.

Clients reported increased confidence, motivation and emotional resilience, with many expressing a renewed sense of hope and control of their lives. The relationships built through the service were consistently described as compassionate, respectful and empowering. Clients felt the Link Worker played a central role in helping them take meaningful steps towards better health and wellbeing. Comments included:

“

“The Link Worker helped me see life in a positive light and recognise my skills and abilities. I found our conversations enlightening, encouraging and helpful.”

“

“The Link Worker was a breath of fresh air. They made me feel validated, heard and supported. I felt a bit strong armed into the referral and nearly cancelled my initial appointment several times. They put me completely at ease and given what life had been throwing at me became a wonderful anchor point.”

“

“I felt very vulnerable coming from working in the voluntary sector myself and now being in a similar position to some of my previous clients. It was very difficult for me to be on the receiving end of such help. The Link Worker was the perfect example of what I needed as the first person to support me. They showed me sincere kindness, care and really listened.”

“

“The Link Worker was incredibly empathetic and created a safe, non-judgemental space where I have felt supported. They were proactive in connecting me with services and resources that can support my mental health and overall wellbeing. They encouraged me to explore therapy and guided me towards the right options. I am in a much better place than I was 6 months ago and they made this all possible for me, especially when there were times I did not see the light at the end of the tunnel.”

“

“The Link Worker helped me gain confidence in asking for help and try new things. I have been able to seek legal advice which will help me resolve a situation that has been causing much anxiety and stress. I feel more capable of being in control as I was heard.”

“

“Having support from a Link Worker has helped me not feel overwhelmed with what life was presenting me with at 84 years old. I felt isolated having to care for my husband who has medical issues and no family support to help me. The Link Worker visited me at home to give me much needed emotional support and contact some organisations to find support for my husband and myself.”

Impact on Clients - Case Studies

Case Study 1

Mavis was referred to the service for support with social isolation. During the initial appointment she informed the Link Worker that she was unable to leave her flat and was waiting for an assessment following a referral to the wheelchair service.

She was unable to use the stairlift as this was broken and explained that as her neighbour often smoked cannabis was unable to open the window. She commented that she felt low and did not see the point of living. Mavis explained she just wanted to go outside.

The Link Worker contacted the Council Home Improvement Agency who were able to assess the stairlift. They were unable to repair this, although Mavis was then able to organise the repairs needed. The Link Worker also contacted services offering wheelchairs and explored a number of options, including a grant. Mavis was able to research mobility scooters that would suit her needs.

After a successful application, Mavis was awarded funding for a foldable power wheelchair and this was delivered to her home. The Link Worker met Mavis at home and accompanied her to leave her home. Mavis explained that this had given her independence and ability to connect with the community.

Case Study 2

Linda was referred to the service for support as a carer for her daughter, who has complex mental health difficulties. During the initial appointment, Linda was concerned as she did not feel that she could keep her daughter safe at home following an admission to a crisis centre. The GP was able to liaise with the crisis centre and extend her daughters' stay over the weekend. The Link Worker initially provided details and contact information for out of hours services and local resources.

Afterwards, Linda asked for support with navigating mental health services and support for both herself and her daughter. Linda explained she had fibromyalgia and her own mental health conditions, which she felt were exacerbated from the current stress of her caring role. She commented she was not sleeping as she worried about her daughter's safety and was reflecting on her daughter's experiences of self harm.

The Link Worker supported the daughter to engage with peer support sessions, alongside carer groups for Linda. Linda signed up to attend a garden outing and coffee morning.

During the next appointment and reviewing these outcomes, Linda spoke about her experience of domestic abuse and that she had not accessed any support for this. The Link Worker shared outcomes from other services and Linda requested a referral into a service offering a course to learn about patterns of abuse and protecting herself in the future. Linda also explored further courses and programmes to help her understand more about mental health conditions, including psychosis and medication.

Linda was also concerned her daughter had not finished education. The Link Worker signposted them to the local community college to explore potential support. Linda was also provided with contact information to discuss additional support.

Due to Linda's caring responsibilities and her own health she was spending most of her disposable income on transport to and from appointments. The landlord was planning on increasing her rent. The Link Worker applied internally (Ruils) for a welfare grant whilst they engaged with benefits advice services. This included a food voucher to access additional provision.

Case Study 3

Sandra self-referred to the service after seeing the flyer at her GP Practice. During her first appointment she presented with symptoms of low mood and anxiety. She shared with her Link Worker that her mental health had deteriorated since the pandemic and she was now a single parent to two sons. She described feeling overwhelmed and directionless, especially around her finances.

The initial appointment focused on building trust and understanding Sandra's priorities. She identified yoga was something she used to enjoy, although had been unable to access this due to the cost and motivation. The Link Worker encouraged her to research local classes and committed to applying for a Ruils welfare grant to cover the cost, including equipment needed.

Sandra was referred to an employment support service, and to another organisation that provided outfits for interviews. Sandra was also referred to a service that provides long term emotional and practical support for single parents through community groups. The Link Worker secured a food parcel and hamper of other items. Following this engagement, Sandra started attending yoga classes and enrolled in a five week computer course. She reported that her mood had improved, she felt more confident and had a renewed sense of purpose.

Initially hesitant to accessing counselling or therapy, Sandra asked her Link Worker for a referral to a local service.

“My Link Worker was very supportive and helpful throughout my sessions. They made connections which helped me meet the right people. All these things made me more positive and more confident. The sessions were productive and helped me find new opportunities and hope for the future.”

Conclusion

“It has been a wonderful experience. My only regret is as a long-term mental health patient, I was not put in touch with this service much earlier. I know it could have had significant benefits in my health and wellbeing.”

David – Broad Lane Surgery

Social Prescribing continues to play a vital role in supporting individuals with non-medical needs to offer practical interventions that improve health and wellbeing. Despite recent operational changes, including the transition away from the Joy system, the service has remained resilient and adaptive.

Link Workers continue to respond to increasing levels of complexity and demand, helping clients navigate challenges. Through working in partnership with voluntary sector organisations and statutory services they have enabled onward referrals to a variety of services and sources of support. This highlights the strength and breadth of community collaboration.

The service remains an integral part of wider health initiatives and ensuring a joined-up approach to supporting people beyond the consultation room. Looking ahead, Social Prescribing remains a key mechanism for embedding personalised and preventative care within the local system, responding to growing pressures in primary care and supporting individuals to lead healthier, more connected lives.

Acknowledgements

Ruils would like to thank Richmond General Practice Alliance (RGPA) and the Primary Care Networks for their on-going support of this much needed service, alongside additional projects supporting their patient population.

Ruils would also like to recognise the partnership with Public Health in delivering Social Prescribing within Richmond.

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