



RICHMOND SOCIAL PRESCRIBING SERVICE

Ruils Independent Living

Annual Report: April 2025 – March 2026

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Introduction

“I gained a lot of useful insights, and it was lovely to see how Social Prescribing can work together with the different aspects of people’s health. Particularly, I think holistic healthcare is more important than I thought before”

- Medical Student after shadowing a Link Worker

Social Prescribing is an important service that supports both healthcare professionals and the people they care for. It helps people with non-medical issues like loneliness, stress, or practical challenges, and looks at how wider factors in someone’s life affect their health and wellbeing. It is a key part of personalised care, focused on connecting people to the right support in their community, and helping build stronger links between individuals, local groups, and services.

This report provides an update on service delivery from 1 April 2025 to 31 March 2026.

The service continues to accept referrals from 25 GP practices across the five Primary Care Networks (PCNs) in Richmond. Over the past year, there have been some changes to how referrals are managed. Three PCNs have moved away from the Joy case management system, meaning Link Workers in those areas no longer use a shared digital platform. Instead, they have introduced a Microsoft Form for referrals, which has been shared with local practices to maintain a smooth and consistent process. Referrals have essentially reverted to the original paper-based process used when the service first launched in 2020.

Despite these changes, the team has remained flexible and committed to delivering a high-quality, person-centred service. They have adapted their ways of working to keep the service accessible and running effectively across all PCNs. As a result of these system changes, some activity and outcomes may not be fully reflected in the data.



The number of Social Prescribing Link Workers within Richmond General Practice Alliance (RGPA) has reduced slightly from 11 to 10. Each PCN occasionally assesses its requirements to ensure the appropriate level of support is maintained for their patient demographic.

Ruils continues to play a key role in supporting residents to navigate a changing health and social care system. By working closely with voluntary sector partners and developing personalised action plans with individuals, the team remains responsive and resilient, with a strong focus on addressing the wider factors that impact health and wellbeing.

Referral Overview

There have been 1,439 referrals received to Social Prescribing from 1st April 2025 to 31st March 2026.

This reflects an ongoing decline in referrals compared to previous years. As the team has become smaller, overall capacity has also decreased. Teddington and Richmond PCNs have maintained a cap of 18 referrals per month, as each has only one link worker. The current capacity within Social Prescribing in Richmond is 8.45 FTE Link Workers.

Figure 1: Social Prescribing Referrals by PCN 2025-2026

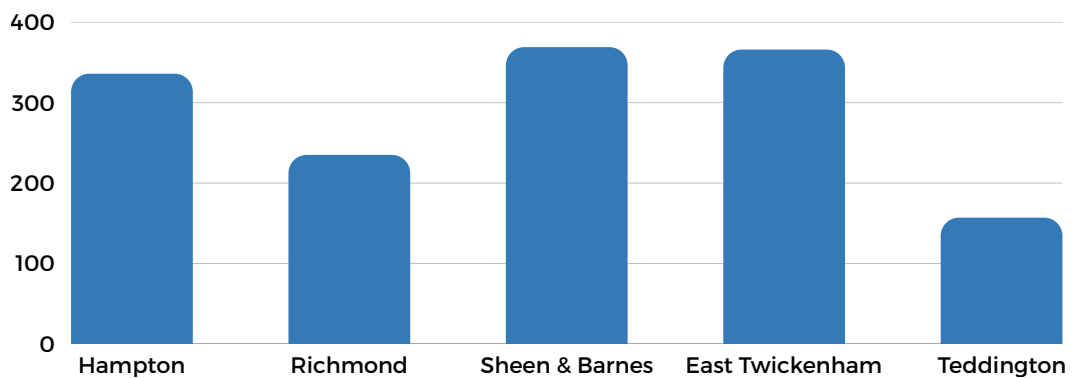
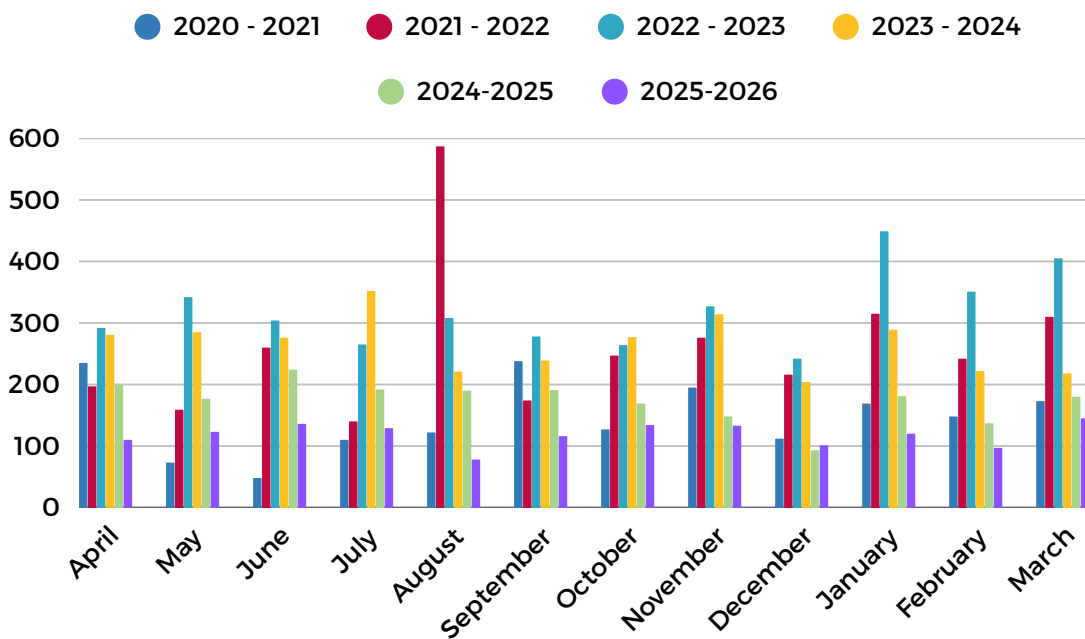


Figure 2: Social Prescribing Referrals 2020-2026



The figures below are taken from Joy data, as we are unable to report in the same level of detail from Charity Log. For example, the reason for cases being declined or discharged.

Charity Log is the case management system adopted by three of the five PCNs following the defunding of Joy. The transition was made to ensure continuity of service delivery, maintain effective record keeping, and support ongoing patient and referral management across those networks. Charity Log enables teams to securely record interactions, manage caseloads, and generate reports to support operational delivery and service coordination.

Of the referrals received via Joy, 12 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, on Joy we can see that 55 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 referrer 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 also work closely with PAC Care Coordinators, often referring clients with escalating risk if appropriate. Duplicate referrals are also declined if referred to Social Prescribing when already engaging with a PAC Care Coordinator.

202 clients could not be contacted despite multiple attempts to make meaningful contact through different methods of communication over a number of weeks. Of clients referred via Joy over the period, 936 were successfully discharged from the service. This means that outcomes were achieved and the client agreed with the Link Worker no further support was needed at the point of closing.

It isn't possible to track a breakdown of case closure reasons within the Charity Log case management system.

Reasons for Referral

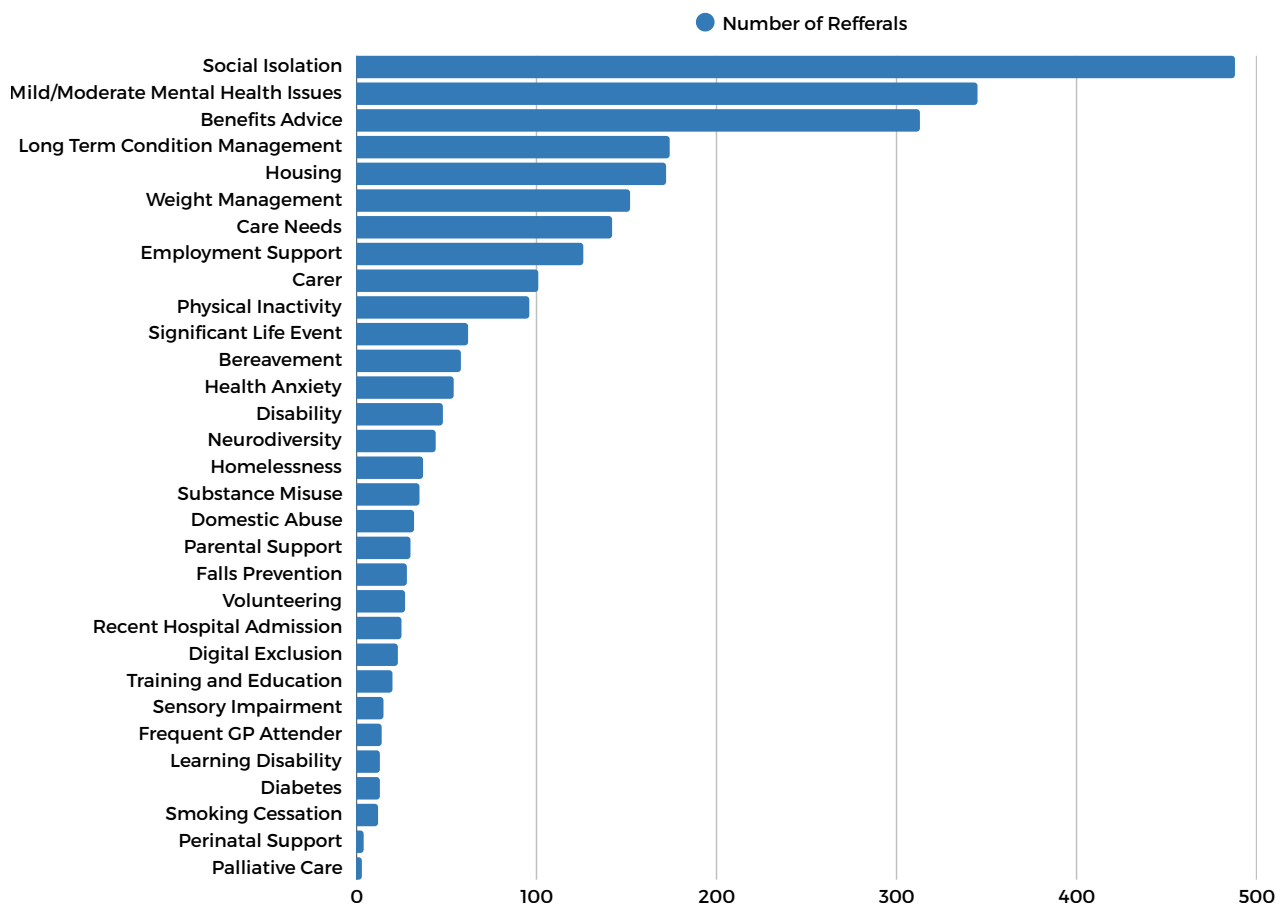
The main reasons for referral to Social Prescribing were:

- Social Isolation (488)
- Mild to Moderate Mental Health Issues (345)
- Benefits Advice (313)
- Long Term Condition Management (174)
- Housing (172)

The team continues to receive a high volume of referrals related to mental health and social isolation, consistent with previous years. Since the Cost of Living increases in August 2022, there has been a sustained rise in referrals for benefits advice. We have also seen ongoing growth in referrals to support neurodivergent clients, alongside increases in cases involving housing needs, long-term health conditions, and employment support.

This reflects increasing complexity in cases, often requiring more frequent contact with clients and longer periods of support, as their needs cannot be resolved within 12 sessions or a three-month timeframe. Link Workers continue to take a flexible approach, adapting to the varying complexity of each client's situation.

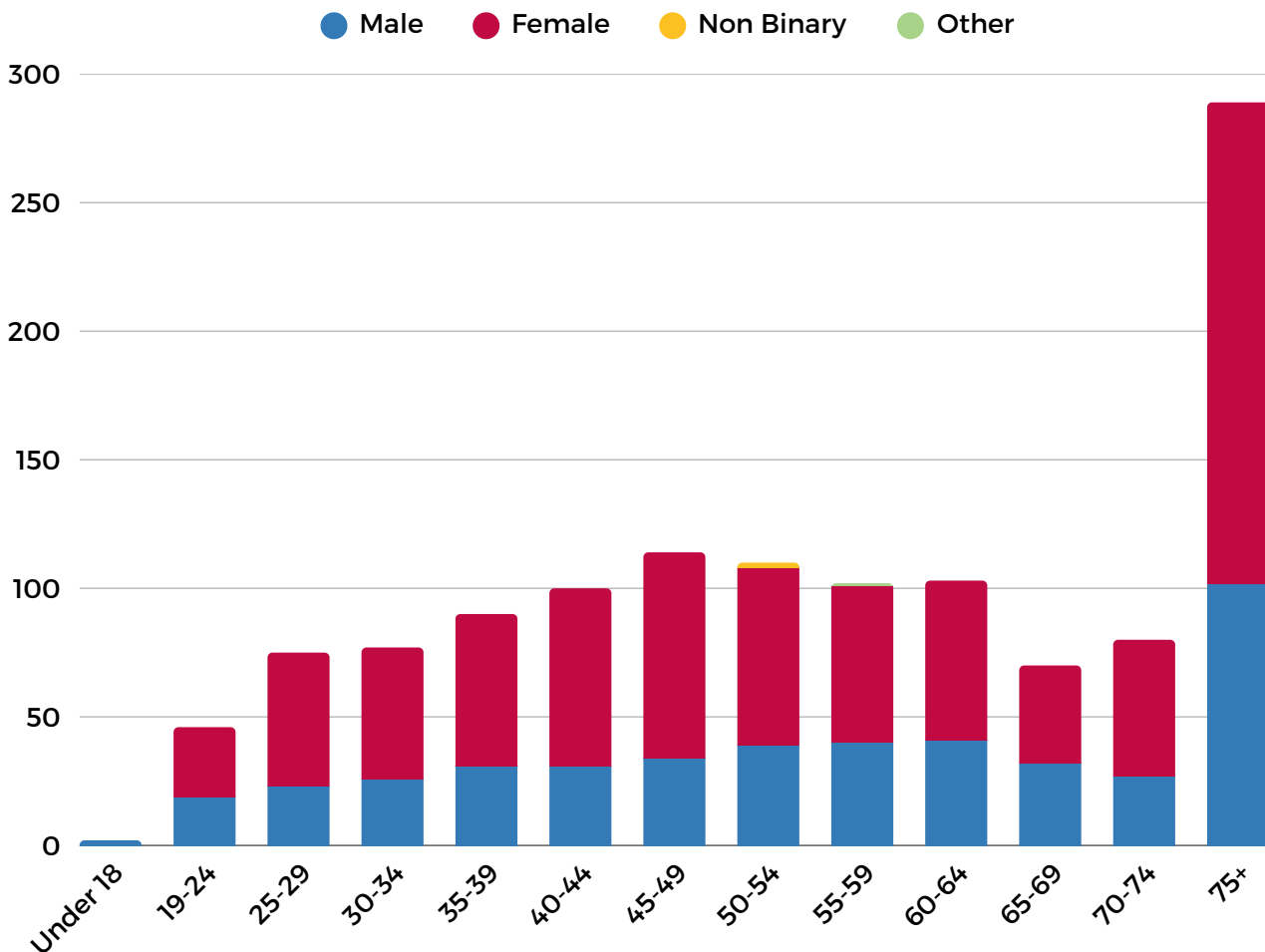
Figure 3: Reasons for Referral



Age and Gender of Clients

The majority of clients referred into the service identified as female (64%), 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



“Bring referred to my Social Prescriber has most definitely improved my wellbeing in every way. They always listened, but more than listened, they acted. At each session they remembered everything we spoke about last time. They gave me contacts that were particularly helpful to my situation, not just a list of every charity or organisation. I now attend Space to Grieve and I’m starting Thai Chi classes in April. My Social Prescriber is so emphatic that they have given me reasons to do things for myself and to view life with optimism. I now start the day without a heavy burden on my shoulders. I am 78 and have had many interactions with professionals but this is unique.” - Emma, Patient at Richmond Medical Group

Service Intervention

The number of contacts differs for each client and is influenced by the complexity of the referral, the range of issues involved, and the individual's willingness to engage with services.

A small proportion of clients need only one telephone appointment to explore their needs and can independently navigate available systems once provided with information about local services and support from the Link Worker. However, the majority of clients present with more complex or multiple needs and may receive up to 12 appointments over a 3 month period through a range of communication methods. For instance, Link Workers may meet clients in GP surgeries, at home, or in community settings to offer coaching, support goal setting, and collaboratively develop action plans.

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

734 in-person appointments

4281 telephone and video call appointments

7609 follow up contacts

Link workers use emails, texts and letters to communicate with clients and make additional contacts between appointments, of which 8,781 were outbound contacts and 1,517 were inbound contacts from clients. These contacts record information where research and options are discussed or further context is obtained.

Contact methods are recorded slightly differently on Charity Log:

31 home visits

33 MDTs attended

43 appointments in a group/community setting

133 in-person appointments

1595 unknown/other*

1976 email and letter contacts

2204 telephone appointments

*Link Workers in PCN's that transitioned away from Joy have been developing their proficiency with the new case management system, and efforts to standardise how information is recorded across the team are still in progress.

Overall, Link Workers have signposted and referred a total of 3,253 times to 879 different organisations, groups and local services and activities.

Richmond Aid (Benefits Advice) remained the most referred to service (137), followed by Citizens Advice Richmond (107), and Chronically Marvellous Free Counselling Service (105).

The other main services referred or signposted to include:

- Enable Tier 2 Adult Weight Management (101)
- Trailblazers Employment Support (57)
- Richmond Carers Centre (48)
- Dose of Nature (46)
- Richmond Adult Social Care (38)
- Richmond and Hillcroft Adult Community College (33)
- Choice Support (32) - no longer operating
- Richmond Work Match (32)
- Richmond Wellbeing Service (31)
- Space2Grieve Bereavement Support (31)
- Age UK Richmond (31)
- Richmond Borough Mind Counselling and Psychotherapy (30)
- Crossroads Care Richmond & Kingston (30)
- Vineyard Community Crisis Support (26)
- Free Council Swim Pass (25) - no longer operating
- Ruils Counselling Service (24)
- Ruils Befriending Service (23)

Trailblazer is a skills and employment support programme delivered by Richmond Work Match across Richmond, Wandsworth, Kingston, Merton, Croydon, and Sutton. It helps residents take the next steps into work by offering guidance, training, qualifications, confidence-building, and access to live job opportunities.

Link Workers also attend weekly service 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.

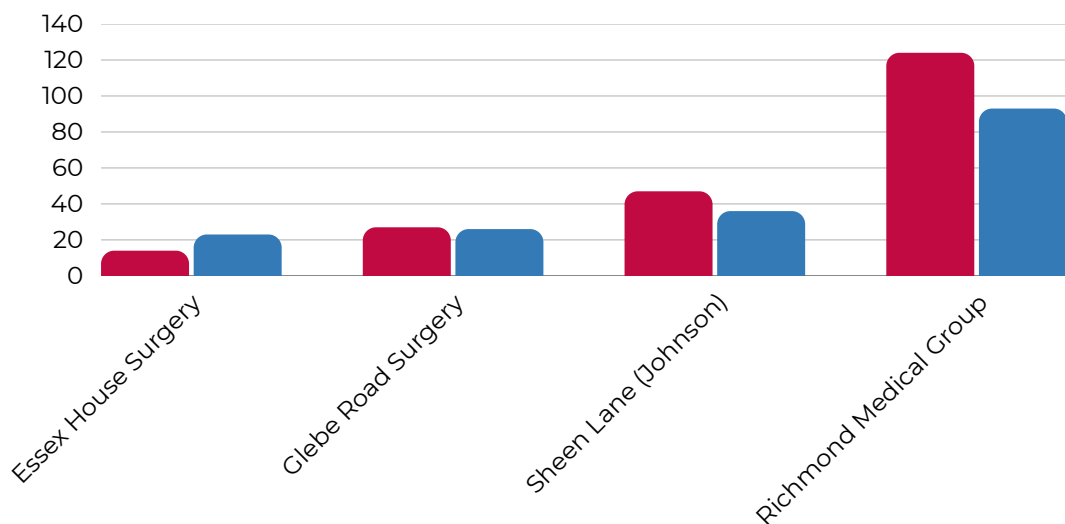
Primary Care Networks Impact Data

Sheen and Barnes PCN

“Having Support from my Link Worker helped me to not feel overwhelmed with what life was presenting me with at 84 years old and being registered disabled. I felt isolated having to care for my husband who has medical issues, and no family support to help me. My Link Worker arranged for someone to come and give me much needed emotional support, and contacted some care organisations, so I can find the care I need to support my 86 year old husband and myself.” - Jane, Patient at Richmond Medical Group

The service is delivered by 2.8 FTE Link Workers, who received 369 referrals. The current waiting time for an initial appointment from referral is 11 weeks. The PCN moved from using Joy referrals to Microsoft Forms on 21st August 2025. Email referrals from Essex House are not included in the data set below.

Figure 5 - Sheen and Barnes PCN Referrals 2025-2026



The main reasons for referral were:

- Social Isolation (110)
- Mild to Moderate Mental Health Issues (71)
- Benefits Advice (67)
- Care Needs (51)
- Housing (46)
- Long Term Condition Management (45)

We are not able to accurately break down age and gender, contacts, or onward referrals across the three different platforms of Joy, Microsoft Forms and Charitylog per PCN.

“Social Prescribing gave me my life back, before I was shattered all the time! The signposting was invaluable in identifying potential activities and the grant helped turn these into reality. I'm delighted to have achieved the lifestyle changes I wanted to make through social prescribing and now have the confidence to sustain them as well as to pursue other opportunities in the future” - Ian, patient at Glebe Road Surgery

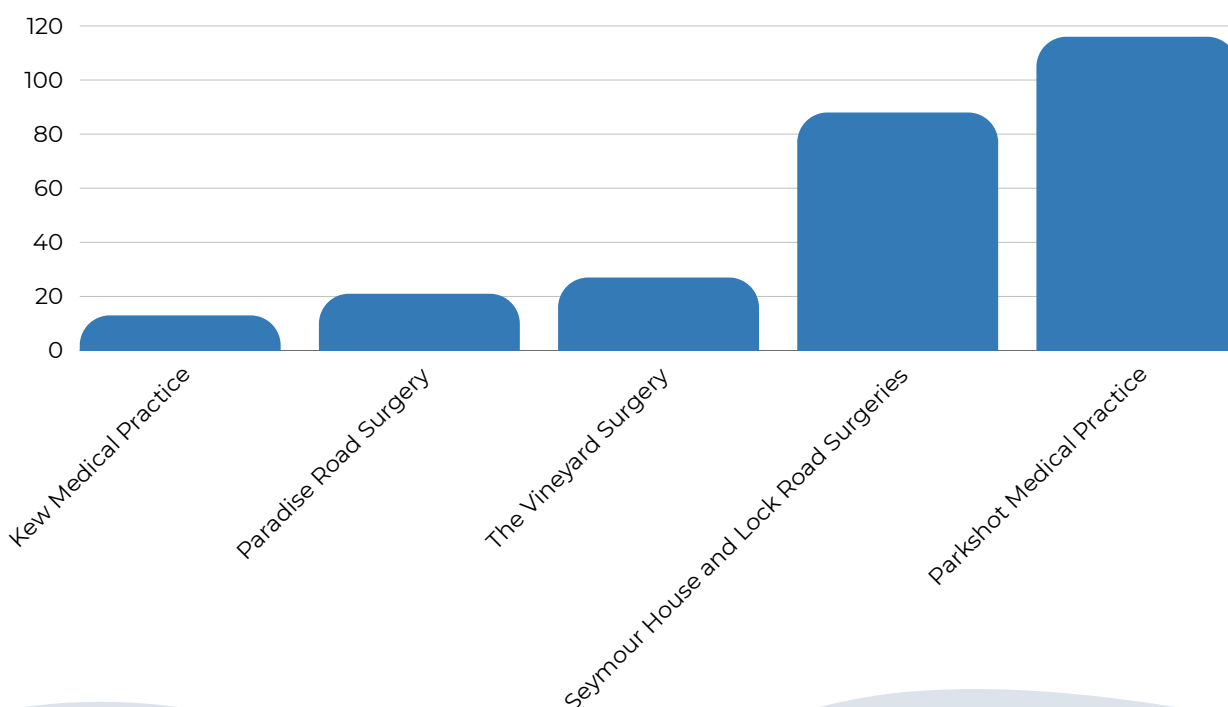
Richmond PCN

“I am starting to concentrate on the positive things I can get out of life rather than dwelling on the negative and letting it overtake my wellbeing and anxiety levels. I am about to start a nature prescription and feel open space, wildlife and nature growing around me is a calming influence” - Robert, patient at The Vineyard Surgery

The service is delivered by 1 FTE Link Worker. To ensure quality service delivery and manage waiting times effectively, referrals have been limited to 18 per month since November 2024.

They received 235 referrals. The current waiting time for an initial appointment from referral is 16 weeks.

Figure 6 - Richmond PCN Referrals 2025-2026



The main reasons for referral were:

- Mild to Moderate Mental Health Issues (89)
- Social Isolation (82)
- Long Term Condition Management (49)
- Housing (41)
- Employment Support (39)
- Benefits Advice (32)

Most clients identified as female (63%). In terms of age, the largest group was those aged over 75 (22%), followed by people aged 40–49 (11%). This represents a shift from last year, when the second largest group was aged 60–64, showing a change in the profile of people accessing the service.

Overall, Link Workers provided 131 appointments in person, with a further 646 contacts recorded over the phone or video call. Following these appointments, 796 contacts were recorded which includes additional contact between appointments.

Link Workers have signposted and referred a total of 464 times to organisations, groups and local services and activities. The main services referred or signposted to were:

- Trailblazers Employment Support
- Richmond Good Neighbours
- Richmond Council Housing and Information Advice
- Richmond Adult Social Care
- Richmond Aid Benefits Advice
- Citizens Advice Richmond
- Dose of Nature

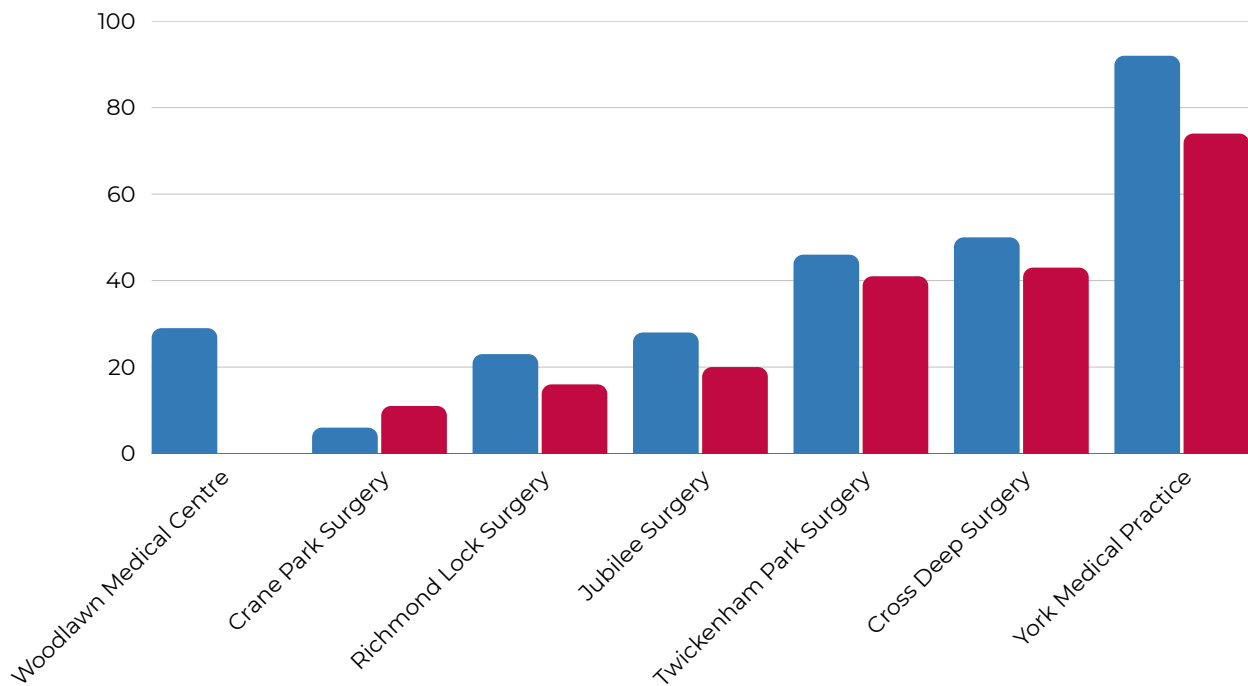
East Twickenham PCN

**“My approach to living has changed. I have felt more positive about getting out and joining classes, I have more social activity leading to a healthier state of mind. I am losing weight, swimming and generally a healthier person” -
Alice, patient at Cross Deep Surgery**

The service has reduced from 2.8 FTE Link Workers to 1.8 FTE Link Workers.

They have received 347 referrals. The current waiting time for an initial appointment from referral is 7 weeks. The PCN moved from Joy referrals to Microsoft Forms on 30th September 2025.

Figure 7 - East Twickenham PCN Referrals 2025-2026



The main reasons for referral were:

- Social Isolation (115)
- Mild to Moderate Mental Health Issues (108)
- Benefits Advice (90)
- Weight Management (87)
- Care Needs (59)

We are not able to accurately break down age and gender, contacts, or onward referrals across the three different platforms of Joy, Microsoft Forms and Charitylog per PCN.

“You helped me tremendously when I most needed it. My life is now much more stable, although I am still not working I am recovering better now and do hope to go back to work soon.”

- Carla, Patient at Twickenham Park Surgery

Teddington PCN

“My Link Worker’s help enabled me to start having a cleaner. They also helped me to get an NHS dentist and I am in process of getting comfortable dentures.

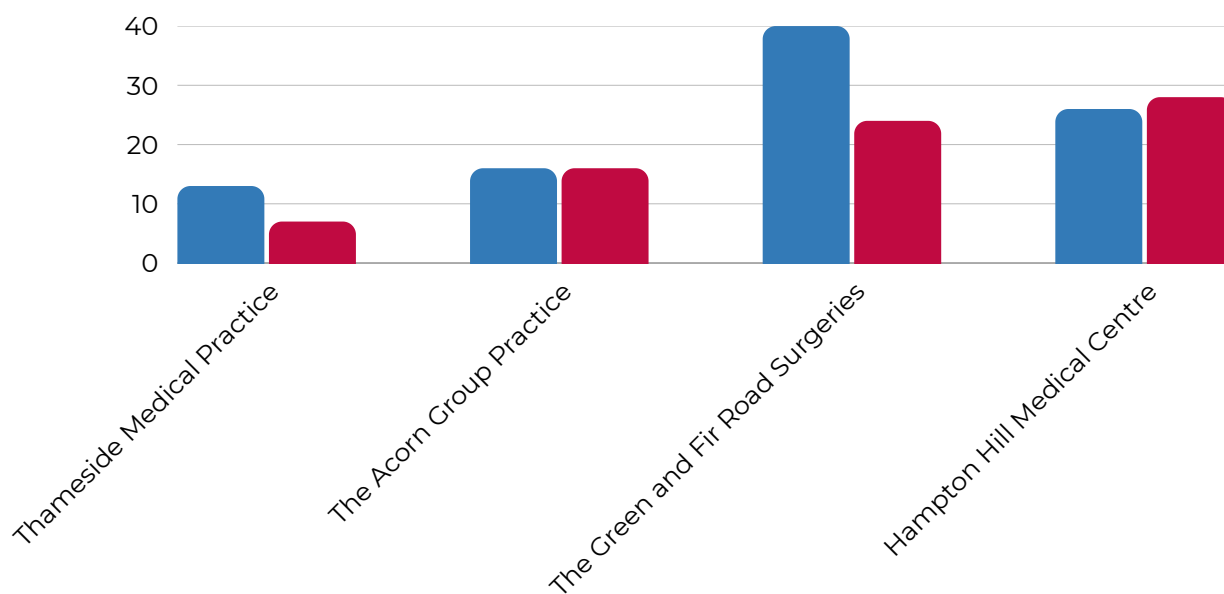
They are also helping me with a housing transfer and have found me a suitable physio rehabilitation course after my stroke”

- Rosemary, Patient at The Green & Fir Road Surgeries

The service is delivered by 1 FTE Link Worker. To ensure quality service delivery and manage waiting times effectively, referrals have been limited to 18 per month, though the cap limit has never been reached.

They received 152 referrals. The current waiting time for an initial appointment from referral is 9 weeks. The PCN moved from Joy referrals to Microsoft Forms on 30th September 2025.

Figure 8 - Teddington PCN Referrals 2025-2026



The main reasons for referral were:

- Social Isolation (55)
- Benefits Advice (39)
- Mild to Moderate Mental Health Issues (33)
- Housing (25)
- Care Needs (22)

We are not able to accurately break down age and gender, contacts, or onward referrals across the three different platforms of Joy, Microsoft Forms and Charitylog per PCN.

“Thank you for a lengthy and valuable session. I felt some headway was made, a shift of some kind has taken place for me. I’m still trying to put my finger on it; a glimmer of hope, perhaps?”
– Esther, Patient at Hampton Hill Medical Centre

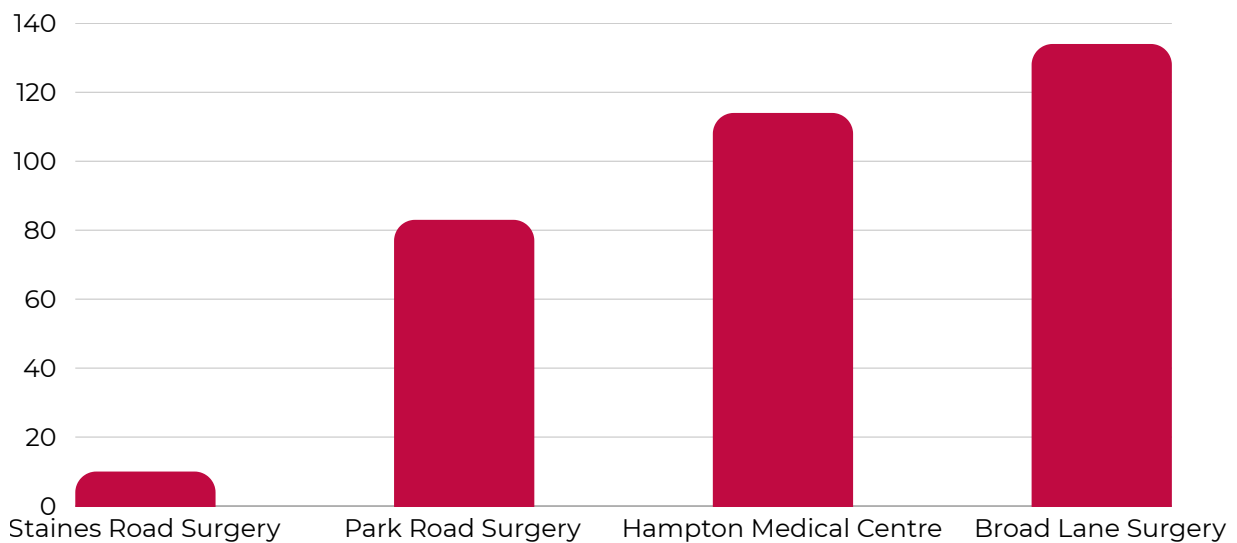
Hampton PCN

“Because of Social Prescribing I gave Zumba another chance (after 9 years) and I’ve applied for a volunteer position at Battersea. I’ve always wanted to do that but was postponing it. My Link Worker helped me to organise myself and get on with forging links instead of just thinking about it”
– Nancy, patient at Broad Lane Surgery

The service has reduced from 2.1 FTE Link Workers to 1.9 FTE Link Workers.

They received 336 referrals. The current waiting time for an initial appointment from referral is 15 weeks. A temporary pause on referrals was placed on Broad Lane Surgery to help regulate the service and reduce waiting times for clients after a delayed recruitment period.

Figure 9 - Hampton PCN Referrals 2025-2026



The main reasons for referral were:

- Mild to Moderate Mental Health Issues (144)
- Social Isolation (103)
- Benefits Advice (69)
- Long Term Condition Management (62)
- Weight Management (62)
- Housing (530)

This remains largely consistent with last year, though Weight Management referrals superseded Housing referrals.

The majority of clients identified as female (63%). The breakdown of age shows the majority of clients are over 75 (17%) followed by those aged between 70 - 74 (9%).

Overall, Link Workers provided 307 appointments in person, with a further 1,854 contacts recorded over the phone or video call. Following these appointments, 3,219 contacts were recorded via email, text or letter which includes additional contact between appointments.

Link Workers have signposted and referred a total of 425 times to organisations, groups and local services and activities. The main services referred or signposted to were:

- Richmond Aid Advice Service
- Ruils Welfare Grant
- Free Swim Pass
- Trailblazers Employment Support

Impact on Clients

Even though the service has become smaller, the positive feedback has grown. This shows that the quality of support hasn't reduced and has in fact, stayed strong. Clients still feel heard, supported, and helped in meaningful ways, which highlights that the impact of the service remains just as powerful, if not more so, despite the reduction in size.

With additional comments, a clear pattern emerges; Link Workers are consistently experienced as deeply empathetic, attentive, and effective professionals who listen carefully, understand complex situations, and offer practical, tailored support.

People feel genuinely seen, supported, and reassured by their Link Worker, often leaving interactions with greater clarity, confidence, and emotional relief. The holistic, non-judgemental approach, combined with the ability to motivate, empower, and create meaningful outcomes, has had a lasting positive impact on those who have been helped.

Following intervention with a Link Worker, 145 clients have completed the Ruils Outcomes (Feedback) Survey.



98%
felt their Link Worker listened to them

98%
felt their Link Worker understood what mattered to them

84%
felt they were managing their health and wellbeing better

90%
felt more confident to access services and activities



95%
felt they know where to go for help and support

95%
would recommend the service to friends and family

83%
felt their situation had improved

84%
felt they had made a positive change in their life

90%
felt more involved in decisions about their health and wellbeing

Comments included:

“

“Having Support from my Link Worker has helped me to find places that could work for me. Find the motivation to change things and start considering quitting smoking again.”

“

“The most important thing I received from Ruils, was the awareness that there were companies out there that could help me with my situation in a compassionate and non-judgmental manner. I'd tried many times in the past to search for such a service, but never quite hit the right keywords to discover them.”

“

“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 sooner.”

“

“The understanding and time the worker gave me was above and beyond, taking the time to email me rather than phone was a big help.”

“

“I received support with understanding of my needs and was given a variety and scope of avenues to look into to better my wellbeing for the future.”

“

“It allowed me to speak to someone as long as needed, understand some areas better and see more hope locally.”

Impact on Clients - Case Studies

Case Study 1

Craig was first supported in December 2024 following a referral to renew his swim pass. During initial conversations, he disclosed significant mental and physical health challenges. He had experienced a 13-14 year abusive marriage (ended 2017) and continued to receive threats from his ex-partner's family. He also reported a serious workplace electrocution, leaving him unable to continue working as an electrician and with ongoing mobility issues affecting daily living in his two-storey home.

Craig described a marked change in his social functioning, from being highly active in his community to becoming withdrawn and anxious. At the time, he was receiving 1:1 therapy via Richmond Wellbeing Service, maintaining regular GP contact, and using a local allotment as a key coping resource.

Initial support from the Link Worker included referrals to Dose of Nature, Richmond AID (housing support), an occupational therapist (OT), and a swim pass application.

In January 2025, Craig experienced further trauma following the death of his stepson in a hit-and-run incident, alongside ongoing legal stress involving his ex-wife. His mental health declined, and he was referred to bereavement support (Space 2 Grieve). The case was then closed as he was engaged with multiple services and felt supported.

Craig was re-referred later by his GP. Since case closure, he had experienced additional challenges including the death of his father, worsening physical health, continued legal stress, and notice from his landlord to vacate due to property sale. He expressed feeling overwhelmed, particularly by the risk of homelessness.

At this stage, his housing application lacked supporting medical evidence despite having substantial documentation. With consent, Craig's Link Worker scanned and uploaded 32 documents to strengthen his application, alongside support for a PIP appeal. Following receipt of a Section 21 notice, the Link Worker supported Craig to engage with Richmond Council's homelessness team, complete necessary forms, and access advice services (Shelter, CAB).

He was allocated a housing officer, though potential relocation outside the borough caused distress due to his reliance on local support networks, including his daughter and allotment. Additional supporting evidence was requested from his GP and psychologist, and a referral was made to the Pathways team.

Ongoing support focused on regular check-ins to provide continuity and reduce anxiety during the rehousing process. Craig was ultimately placed in temporary accommodation in Whitton.

At this point, support transitioned to the Ruils Pathways team to assist with securing long-term housing.

Case Study 2

Sarah, a 48-year-old single mother, was referred for support following separation from her partner. She has a 10-year-old son and was working two part-time jobs, including a seasonal role, which was due to end in October. She was also working as an estate agent assistant but felt unhappy due to changes in management. Financial pressure, including meeting Universal Credit requirements, was causing significant stress and impacting her mood.



Photos of Sarah's flower arrangements sent to her Link Worker.

Sarah's main priority was securing stable employment while exploring her long-term goal of becoming a florist and potentially running her own business. Support focused on job searching and identifying local opportunities. She was signposted by the Link Worker to an organisation for flexible hospitality shifts and potential work at Kew Gardens. She subsequently left her estate agent role, began helping a friend in a florist shop, and is awaiting confirmation of hospitality shifts.

Together, Sarah and her Link Worker explored training and development opportunities, including floristry courses at Capel Manor and RHACC, ranging from introductory to qualification level, alongside information on financial support. Sarah also expressed interest in creative hobbies such as woodwork and glassmaking and was signposted to relevant local courses and groups.

Although she did not feel counselling was suitable, Sarah was signposted to alternative wellbeing support, including health coaching, spiritual-based support, and the Riverbank Trust for financial and emotional guidance, though time constraints limited engagement.

Towards the end of support, Sarah was referred to the Trailblazer programme for continued employment assistance. She has engaged positively, attended her first appointment, and received practical support including a laptop.

Sarah has made positive steps towards improving her employment situation and progressing her longer-term career aspirations, and will continue to receive support through specialist services.

Case Study 3

Daisy sought support following a recent diagnosis of ADHD, alongside multiple long-term health conditions including OCD, depression, anxiety, and severe IBS, all of which significantly impacted her daily functioning. She had also experienced past trauma, including a period of street homelessness, which contributed to ongoing phobias. At the time of support, she had recently stopped working due to her health and was receiving Universal Credit, with upcoming assessments regarding her work capability and benefits.

Daisy expressed interest in accessing 1:1 therapy and ADHD coaching, as well as returning to employment within a disability-confident environment. She was signposted to West London Works and engaged well, attending multiple sessions focused on CV development and exploring suitable job opportunities.

She also required support with her Personal Independence Payment (PIP) application, finding the process overwhelming. A referral was made to Richmond AID's Hounslow Benefits Advice Service, and support was provided to attend her appointment. She was awaiting an outcome at the time of case closure.

In terms of mental health support, Daisy preferred not to re-engage with Richmond Wellbeing Service and was therefore referred to Hounslow Talking Therapies and Ruils counselling by the Link Worker. She commenced sessions with Hounslow Talking Therapies. Additionally, she attended Recovery College courses (including OCD, sleep, and grief), which she reported had positively supported both her wellbeing and her relationship with her mother.

Daisy independently identified a low-cost ADHD coach, and a welfare grant was successfully secured by the Link Worker to fund a block of sessions. Future therapeutic options, including Dose of Nature, were also discussed.

To support her physical and mental wellbeing, Daisy was also referred to the Healthy Hounslow exercise programme, aligning with her goal to re-engage in physical activity.

Daisy continued to actively engage with support services to improve her mental health and explore appropriate pathways back into employment.

Case Study 4

The client was referred to Social Prescribing by her GP due to anxiety, depression, and chronic physical health conditions, including migraines and sciatica. She was experiencing significant distress related to poor housing conditions and ongoing court proceedings.

Support focused on helping her manage anxiety around the court process by providing clear, step-by-step guidance and emotional reassurance. Safeguarding concerns were identified, leading to a referral to Adult Social Services. They are now involved and working to secure a suitable refuge placement.

The client was signposted to specialist services, though she chose not to engage with some, as Adult Social Care is arranging more appropriate support. She was also guided to obtain medical evidence from her GP to strengthen her housing application.

Ongoing support included regular check-ins, including during a hospital stay, and encouragement to continue counselling. While the case remains open, the client reports feeling more supported, less isolated, and better able to cope during a challenging period.

“It has helped me navigate a difficult life situation with confidence and less stress. My Link Worker’s guidance and encouragement made a real difference in managing the challenges I faced. They were really helpful, proactive and supporting, providing me with both practical and emotional support.” – Mary, patient at York Medical Practice

Conclusion

Social Prescribing continues to play an important role within Universal Personalised Care, helping connect people to community activities, groups and services that support the practical, social and emotional factors affecting their health and wellbeing.

Link Workers provide a flexible, person-centred service, offering tailored support that helps individuals take more control over their health. By building trusting relationships, they work alongside clients to identify meaningful opportunities for longer-term support and engagement.

Clients regularly highlight how valuable it is to have dedicated time to talk through their challenges and barriers. Together with Link Workers, they co-produce action plans that reflect their personal goals. Techniques such as health coaching and motivational interviewing are used to support positive outcomes and encourage sustainable changes.

Social Prescribing is also well integrated into wider programmes such as Proactive Anticipatory Care and Health in Your Hands, with teams working closely together to share knowledge and strengthen the overall support available.

At a time when demand on primary care is increasing, due to factors such as an ageing population and rising levels of long-term conditions, Social Prescribing continues to support a multidisciplinary approach. It helps ease pressure on traditional services while improving more holistic health and wellbeing outcomes.

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.

References

<https://www.england.nhs.uk/personalisedcare/social-prescribing/>

https://www.richmond.gov.uk/council/how_we_work/jobs/information_for_job_seekers

Contact

Lucy Bish
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ruils
independent living

