Fife Forum

Local Area Co-ordination

Fife Services

December 15 2021 – December 14 2022
(SLA Aligned)

January 2023

Fife Forum
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Informational Report – Index

Foreword

The purpose of this report is to present the data collected in relation to the work of the 'Local Area Co-ordination (LAC) Service' encapsulating three project areas (these being: GP Cluster Areas 16+; Adults 16-64; and, Older People 65+). The information presented relates to the period 15th December 2021–14th December 2022. It should be noted the timeline for reporting runs parallel with our Service Level Agreement (Fife Health & Social Care Partnership).

For the period, Adult and Older People LAC was funded through the Integrated Care Fund and GP LAC was funded through the Primary Care Transformation Fund, both administered by the Fife Health & Social Care Partnership. The projects are managed by the Fife Forum, an established Third Sector agency for adults and older people throughout Fife.

The number of 35-hour full-time equivalent posts intended and currently appointed by Fife Forum to deliver Local Area Co-ordination are:

- GP Cluster Areas – 3.0 posts intended (3.0 appointed)
- Adult – 3.0 posts intended (2.0 appointed)
- Older People – 4.0 posts intended (3.0 appointed)

The Adult and Older People projects operate in all seven localities within Fife, whilst the GP Cluster Areas are located within Glenrothes, Levenmouth, Kirkcaldy and Lochgelly (areas with a high Index of Multiple Deprivation).

During the year, within Older People, one vacant full-time post was appointed and one post is currently vacant. The Adult service continued to be impacted by a long-term absence and as we enter the new reporting period a vacant post has presented. This said, during the course of the year, service delivery was not significantly impacted as formal referrals were cross-referred internally to ensure continuity of provision.

For the forthcoming year, it is anticipated in the short-term staffing levels will be at 70%, with 2 posts to be recruited.

Post-Pandemic

As services gradually reopened following the wider impact of the coronavirus pandemic, new significant and commonly acknowledged national and global challenges arose compounding an already difficult socio-economic climate. In the short to medium term it is generally accepted the difficulties presented will continue to bear on individuals, groups, sectors and society in general.

As it was with the pandemic, the pressures presented by national and global events have and will continue to influence and impact upon the work of organisations and services, such as Local Area Co-ordination, which support community and social engagement as a core means to help improve overall well-being. As a consequence of events it is evident individual and wider

purchasing power will continue to reduce and, with this, individual needs and wants will likely focus increasingly on the fulfilment of basic living needs as people seek to ride the economic downturn. This will likely be reflected in an increased demand for services and supports which seek to maximise income and/or provide people with basic tools with which they might ease daily living. An early indicator of this is the rise of 'Warm Spaces' during the last quarter of 2022.

This said, during the year, general activity continued and the lessons learned from the pandemic allowed the service to continue with a safe and blended approach to delivering its activities responding to the needs of our client group. The service continued to deploy 'traditional' delivery (face-to-face and audio contact) alongside utilising virtual platforms. Perhaps, unsurprisingly, there was a marked increase in income-related enquiries.

Alongside supporting people to access information and activities, the service continued to facilitate in-person peer groups to help address the absence of some community-centred activities. This allowed the service to directly deliver free social activity for the benefit of a number of clients identified as socially and/or economically vulnerable or as reluctant to take their first step towards social engagement. The aim of these groups has increasingly shifted from encouraging post-Covid social engagement towards acting as a springboard for people to explore external activities in general (be this other community activities or the development of friendships out with the confines of the service arena).

Peer groups continue to incorporate a social café element and 'health and well-being' walking activity affording people the opportunity to socialise and improve well-being. It is envisaged these will continue during the forthcoming period as a means of supporting LAC engagement, broadening its delivery methods.

Formal Referrals & Supported People

Throughout the reporting period the service accepted new referrals. A total of **1,294 formal referrals** were received. This presents an increase in the number of formal referrals compared with the previous reporting year (27.1% increase) and remains above pre-pandemic levels (38.2% increase from 2019).

The total number of formal referrals received remains above the overarching target prescribed by our Service Level Agreement and it is worth noting our prescribed target was retrospectively increased from 705 to 1000 during the course of the reporting period (Targets: Fife-wide 1,000 – GP 300; Adult 300; Older People 400). Within the context of formal referrals received, 179 of these were cross-referred internally to help ensure demand was met. The majority of cross-referrals were made to our GP LACs (155 – 70 Adults; 85 Older People) with our Adult and Older People LACs accounting for the remaining 24 cross-referrals (respectively: 19 Older People & 2 GP Cluster; 2 Adult & 1 GP Cluster).

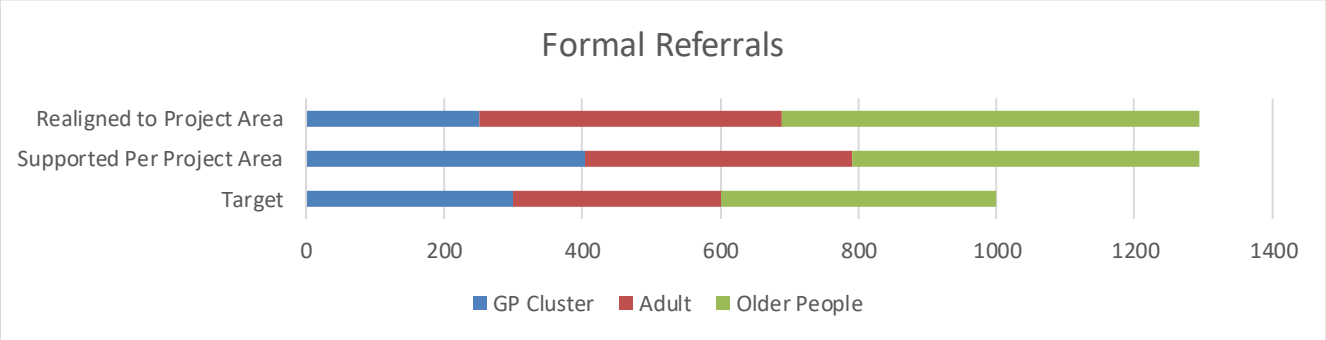
Whilst the overarching target was surpassed, when formal referrals are realigned to their intended project areas both Adult (+138) and Older People (+204) surpassed their prescribed

targets whilst the GP Cluster area did not (-48). This can largely be attributed to the prescribed target increasing, however, the development of the Link Life Fife Service (Fife Health & Social Care Partnership) which offers a shared-value service type within the same primary health setting throughout Fife might also, in part, be a contributing factor. This notion would appear to be supported by feedback received from a Mental Health Triage Nurse, a service where a reduction of formal referrals has been evident Fife-wide (from 226 to 170 or -24.8%):

> *"I have valued Fife Forum's input since commencing in post and find X to be very professional and efficient in her role. Really making a difference to those patients who engage. I have not referred many patients of late due to our team, MHTNs, being encouraged to use LLF due to Action 15 money, otherwise would be continuing to refer on a regular basis".*
> ***Mental Health Triage Nurse***

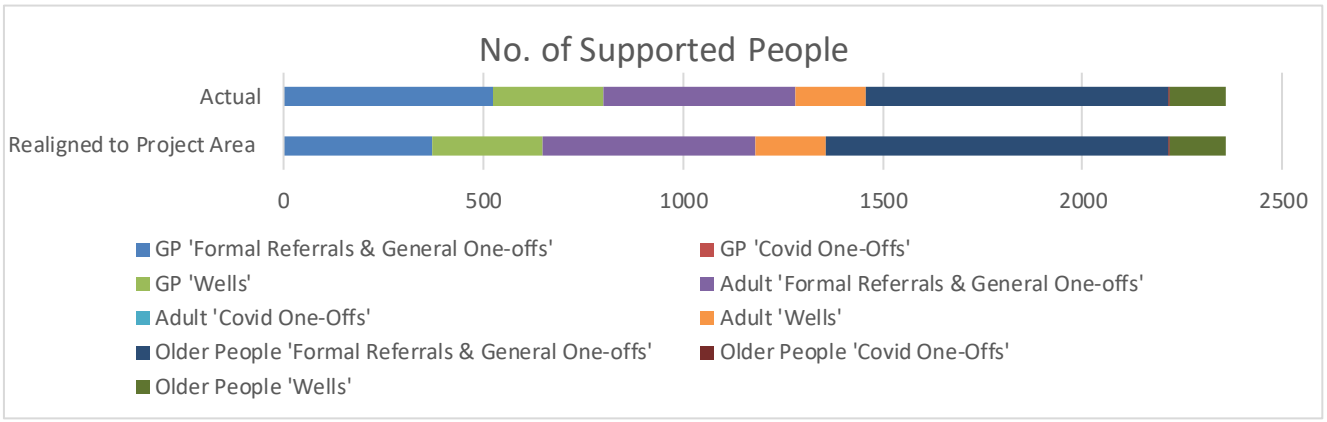
This said, conversely, formal referrals from other Medical Practice-centred professionals actually increased slightly from 195 to 204 (albeit these were not exclusively made to the GP Cluster project).

In itself, the expansion externally of our service type is welcomed. In isolation service trends or impacts which might result are often difficult to quantify and whilst our evidence suggests there has been a reduced volume of referrals from MHTNs this appears largely off-set in other areas (albeit this might be more evident within our GP Cluster project). Nevertheless, it is hoped each strand of LAC provision offered both internally and externally will in essence complement one another and it is anticipated this will be supported by external data which should, in all probability, indicate an increased demand for provisions utilising the LAC model and approach.

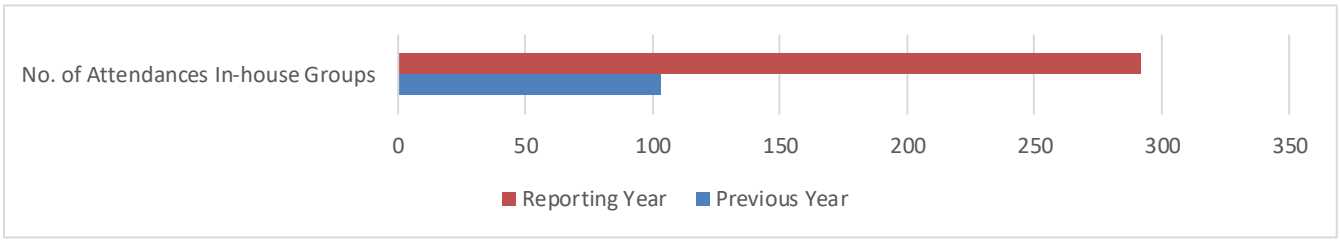


In addition to formal referrals, the service continued to offer guidance to people on a general and, to an almost negligible extent compared with the previous year, Covid-related one-off basis directly via Fife Forum itself or at locality venues (this includes locality-sited or virtual 'Wells Near Me' – community information points co-ordinated by the Fife Health & Social Care

Partnership). When these are included **the service supported 2,356 people** Fife-wide (an increase of 7.9%). Again, whilst the prescribed target was adjusted for the reporting year from 1,020 to 1,750, the total number of people supported by the service remains well above the over-arching target prescribed in our Service Level Agreement (34.6% higher).



Beyond core activity, **292 attendances** were supported within in-house developed groups (Health Walks & Café Forums). This is a near three-fold increase in comparison with the previous year. It is anticipated these supports will continue in to 2023 in some guise, with the potential of extending these in to other localities where there is need and capacity to do so (currently facilitated within Glenrothes, South West Fife and North East Fife localities).

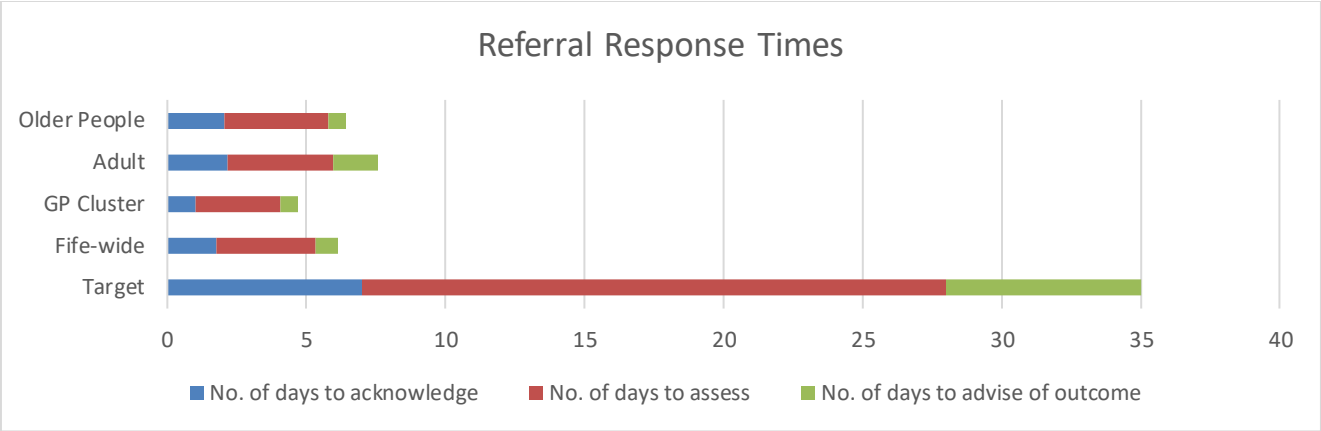


Formal Referral Response Times

In accordance with the Service Level Agreement (Fife Health & Social Care Partnership) the response times for formal referrals are as follows:

- Acknowledged within 7 days of receipt (**average:** GP 1.04; Adult 2.14; Older People 2.03)
- Assessed within 21 days of acknowledgement (**average:** GP 3.01; Adult 3.81; Older People 3.79)
- Advised of outcome within 7 days of assessment (**average:** GP 0.67; Adult 1.63; Older People 0.59)

In all three service areas the target timelines were met and the process from acknowledgment to assessment to reporting a first outcome averaged 6.16 days, well within the prescribed 35-day timescale and presents a marginal improvement upon the year previous (6.63 days).

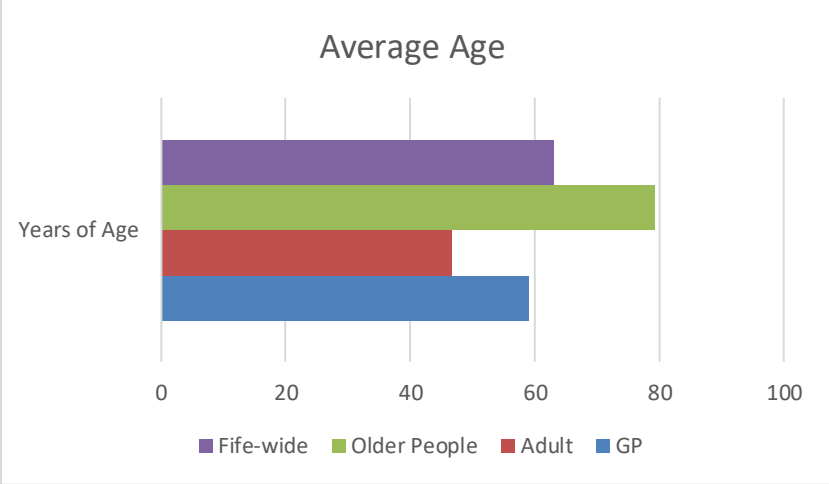


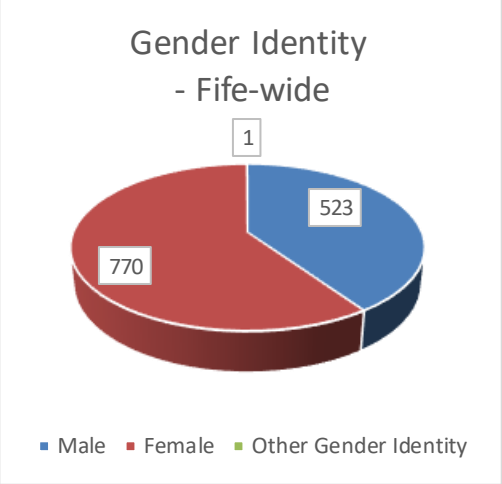
"I would firstly like to extend my thanks to you and the team at Fife Forum for all the support you have given the patients I have referred over the past year. It has been so helpful to know that patients referred will be contacted and how proactive the engagement is from your team. I know how valuable my patients have found the support and the difference it makes to patient's recovery and life to have the opportunity to increase their meaningful activities in the community".
Chief Registrar in Psychiatry, NHS

Gender & Age (Formal Referrals)

Fife-wide the ratio of male to female favour the latter (40:60) and this is replicated across the three project areas to varying degrees (GP 37:63; Adult 44:56; Older People 40:60). One person within the Adult project did not identify as male or female, which is the first recorded instance of this.

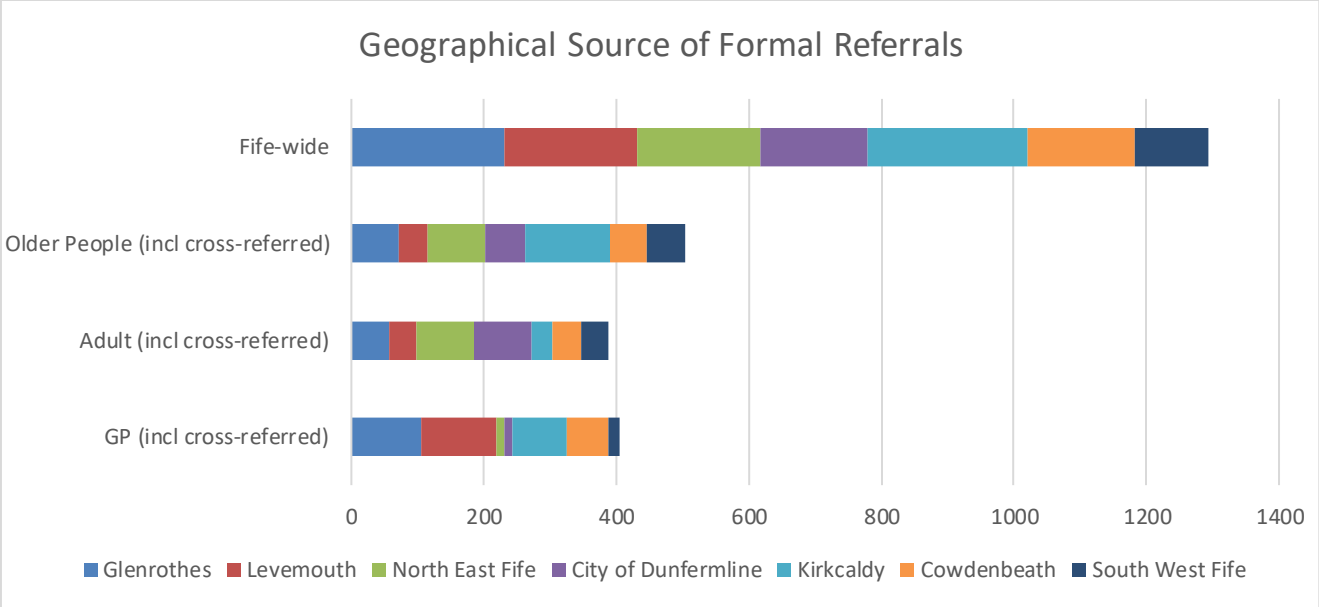
As should be expected given the age ranges served by each project area, average age varies (GP 59.0; Adult 46.7; Older People 79.2). Across all project areas the average age of all formal referrals increased from 57.0 to 63.1. This is the second year where average age has risen after a period of declining average age. Average age is on par with 2018 (62.7) having reached a low of 53.9 during 2020.

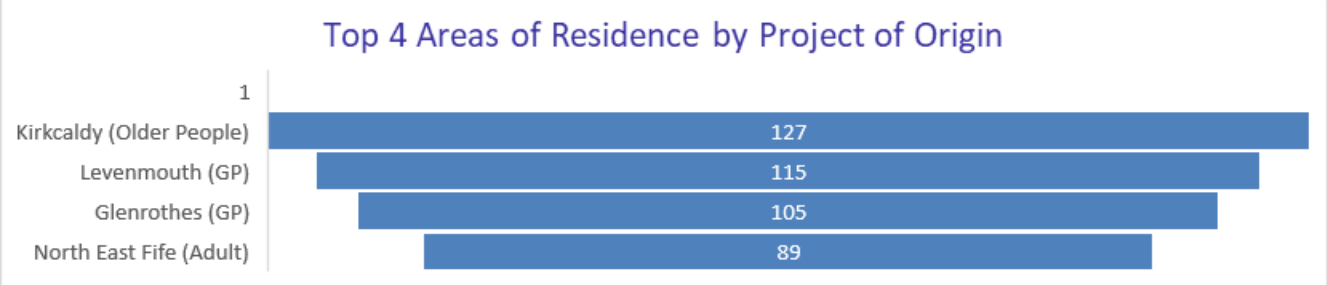




Geographical Areas (Formal Referrals)

For the period, the three localities where Fife's three largest towns (Dunfermline, Kirkcaldy and Glenrothes) are located accounted for 634 or 49.0% of all formal referrals (previously 47.2%). Kirkcaldy locality accounted for 242 formal referrals followed closely by Glenrothes with 232. It should be noted the GP Cluster areas are located in four of the seven localities (Kirkcaldy, Glenrothes, Levenmouth & Cowdenbeath).

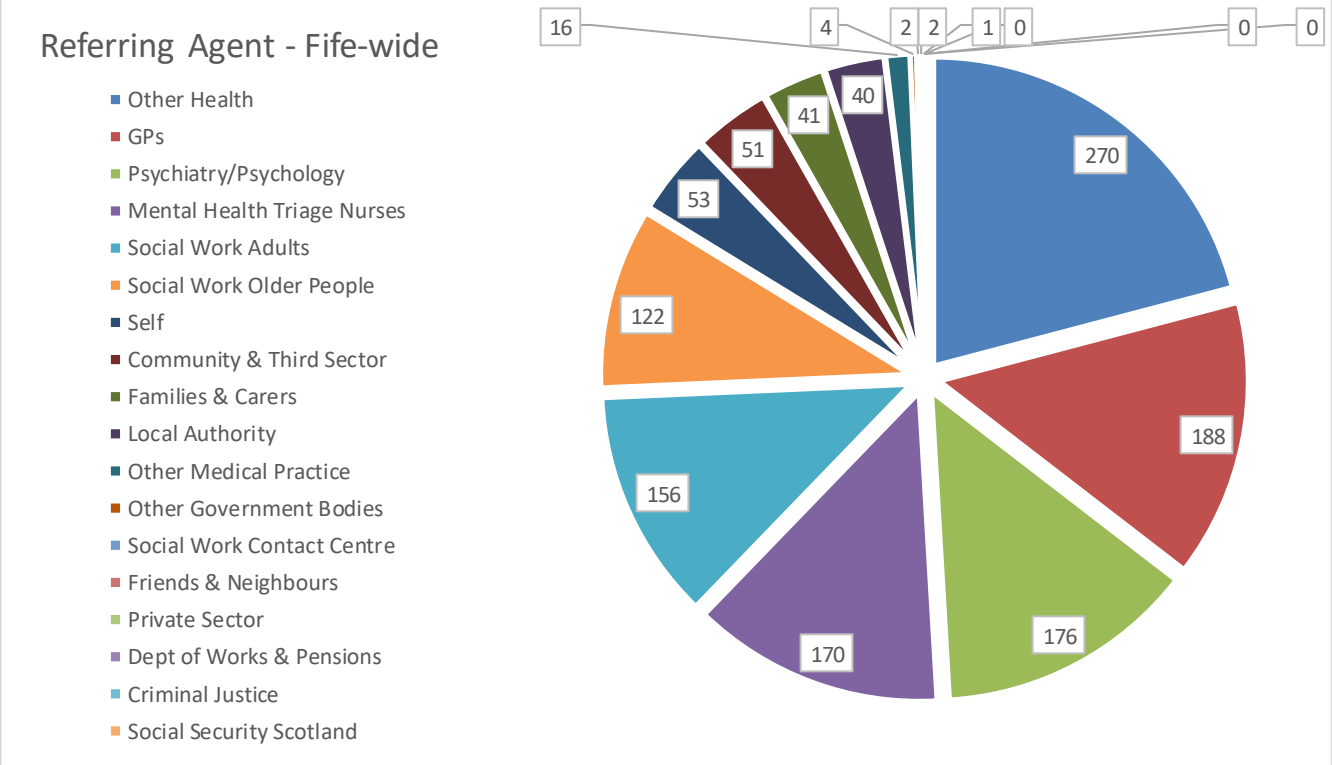




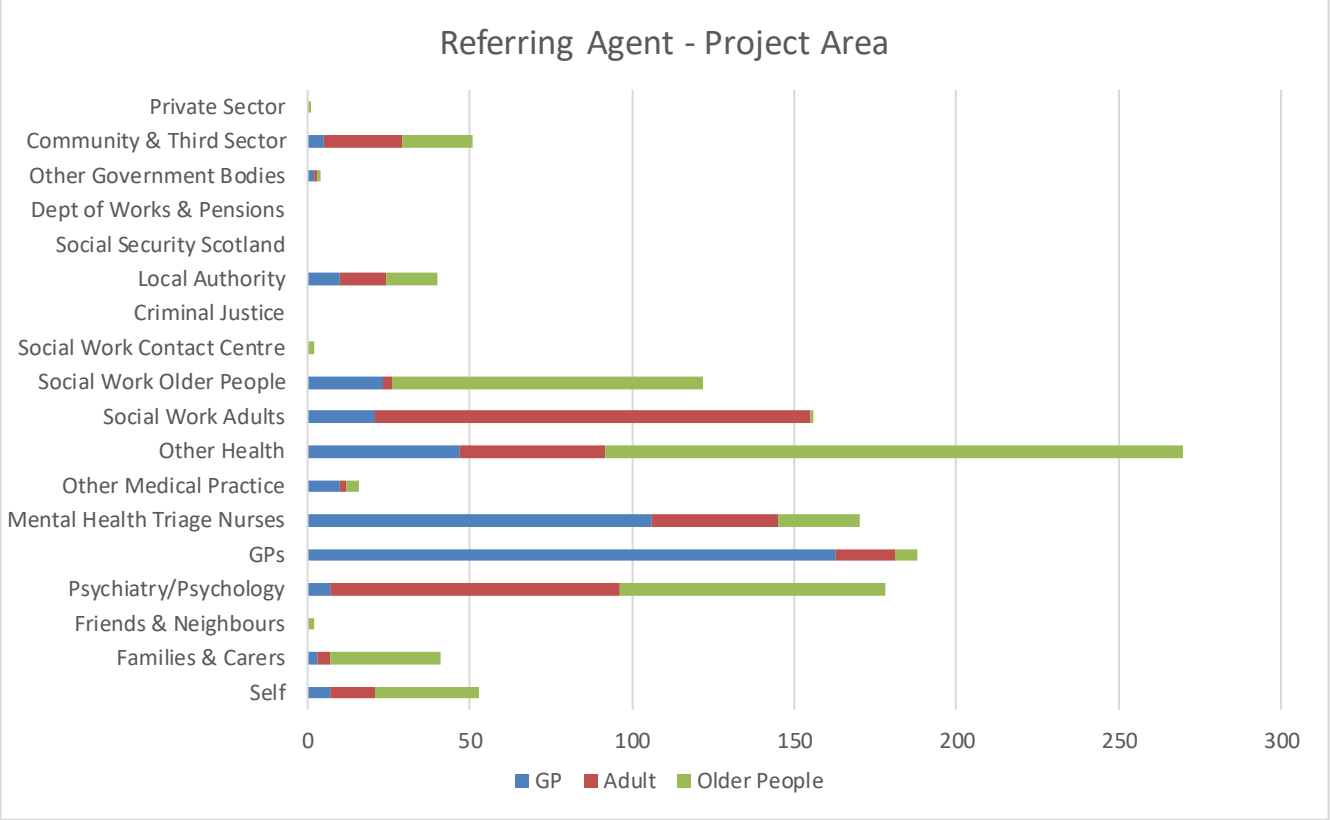
Formal Referral Source

For the period, the majority of referrals were sourced from both Health and Social Work & Care partners accounting for some 85.2% of referrals overall, slightly lower than the previous year (87.4%). As should be expected owing to the GP project area's remit within 'GP Cluster Areas' this ranged from 93.3% overall to Older People at the lower end of this with 78.5% (Adult 85.3%).

In relation to primary referral sources; within a GP project context GPs accounted for 40.3% (2021: 44.1%) of formal referrals made followed by Mental Health Triage Nurses with 26.2% (2021: 38.8%). Regarding Adults, Social Work Adult Teams accounted for 34.6% (2021: 29.9%) followed by Psychiatry/Psychology 23.0%. Mental Health Triage Nurses slipped to being the 4th main source with 10.1% (2021: 24.2%). Within Older People the highest proportion of referrals were sourced from 'Other Health' representing 35.4% of referrals made (2021: 21.3%) followed closely by Social Work Older People Teams (21.1%). The number of 'open' referrals from non-organisational sources remains highest within the Older People project at 13.5% (2021: 12.2%). Open referrals (this includes: self; families & carers; and, friends & neighbours) remains important as this helps to sustain an open referral process which allows access to provision for those who might not have any formal supports.



The primary referral source is 'Other Health' (this includes Intermediate Care Teams & hospital-based professionals) followed by GPs. Mental Health Triage Nurses which were the primary source during 2021 slipped to being the 4th most significant source.



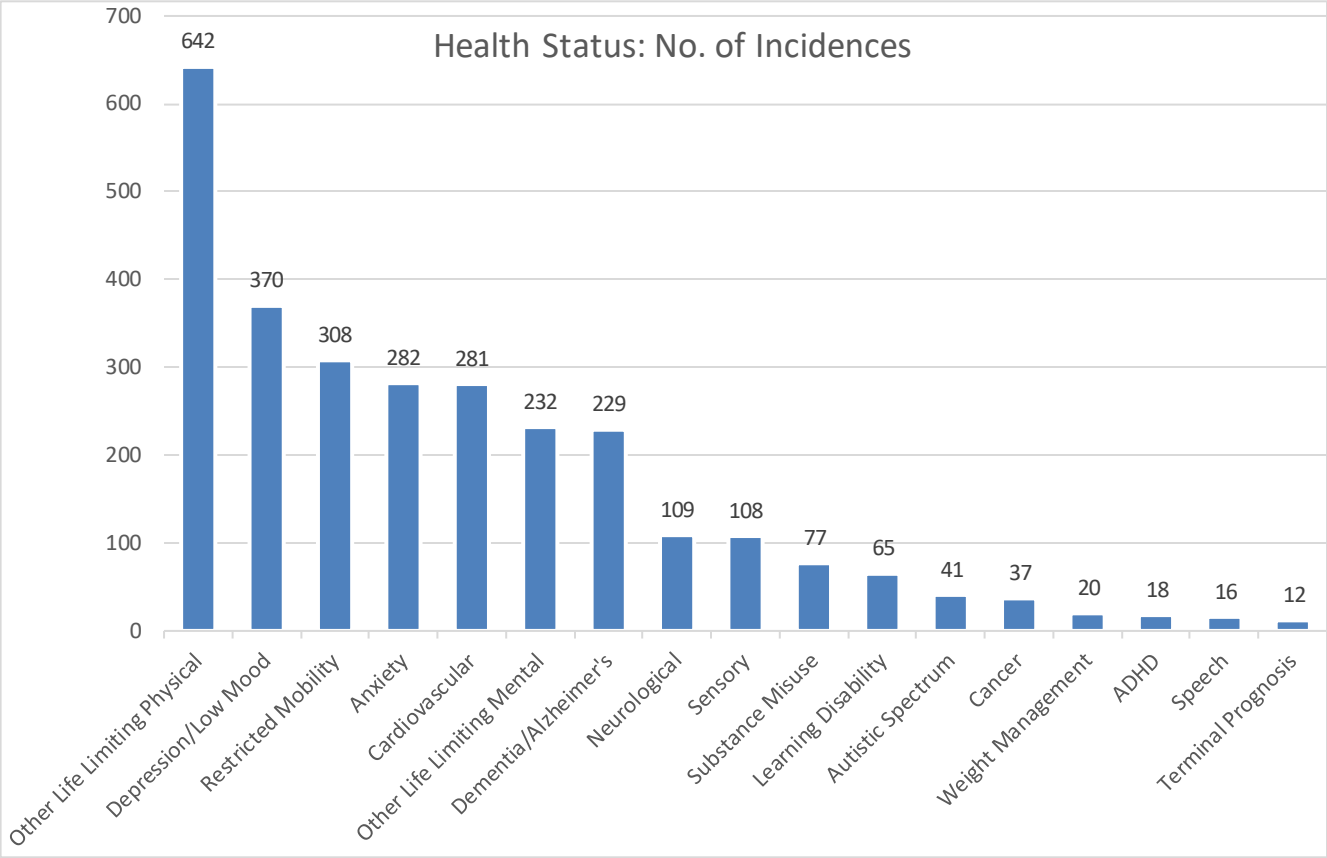
Incidence of Health Issues (Formal Referrals)

Among the 1,294 people formally referred, 1,266 reported a health and/or life affecting condition many with multiple issues (2,847 health incidences). Where a heath condition is reported there is on average 2.25 conditions per person (down from 2.29). This ranges from a high of 2.52 conditions per person (2021: 2.52) within an Older People context to a low of 1.90 (2021: 2.01) within a GP context (Adult: 2022 - 2.27; 2021 - 2.26).

The main health issue reported by people within each project area is: GP 146 incidences of Depression/Low Mood; Adult 349 incidences of 'Other Life Limiting Physical Health Conditions'; and, Older People 642 incidences of 'Other Life Limiting Physical Health Conditions'. In relation to specified physical-linked conditions the highest number reported within each service area is Cardiovascular Disease with 254 incidences (Older People 202; GP 52) and Neurological Disorders (Adult 58).

The incidence of mental health-related issues (excluding cognitive/memory issues) has both proportionally and in real terms decreased from 39.7% to 31.1% of incidences reported (from 915 to 884 incidences). Anxiety and depression/low mood account for 73.8% of reported mental health conditions (2021: 76.7%).

It would be prudent to note; the incidence of health issues is likely to be under-reported as focus is often given to a primary condition and in cases some people are unable or do not wish to disclose detail pertaining to this.

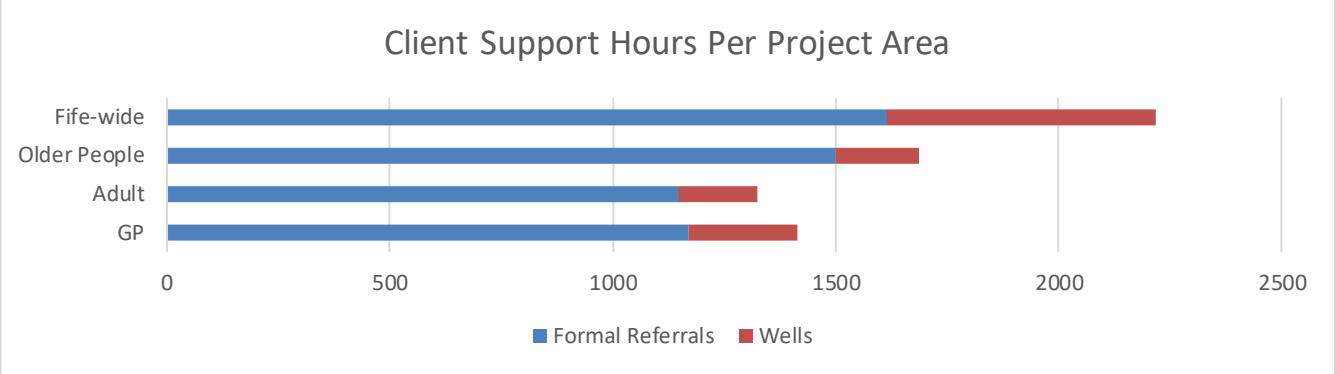


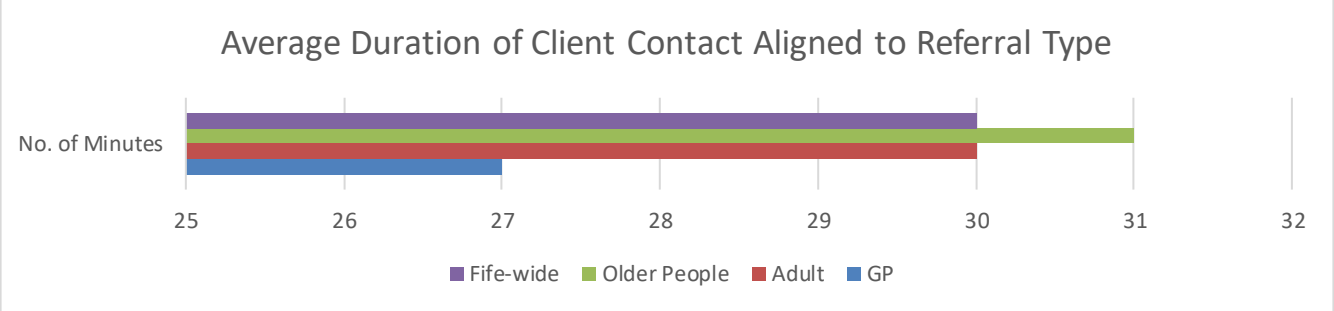
Support Hours (Formal Referrals & 'Wells Near Me')

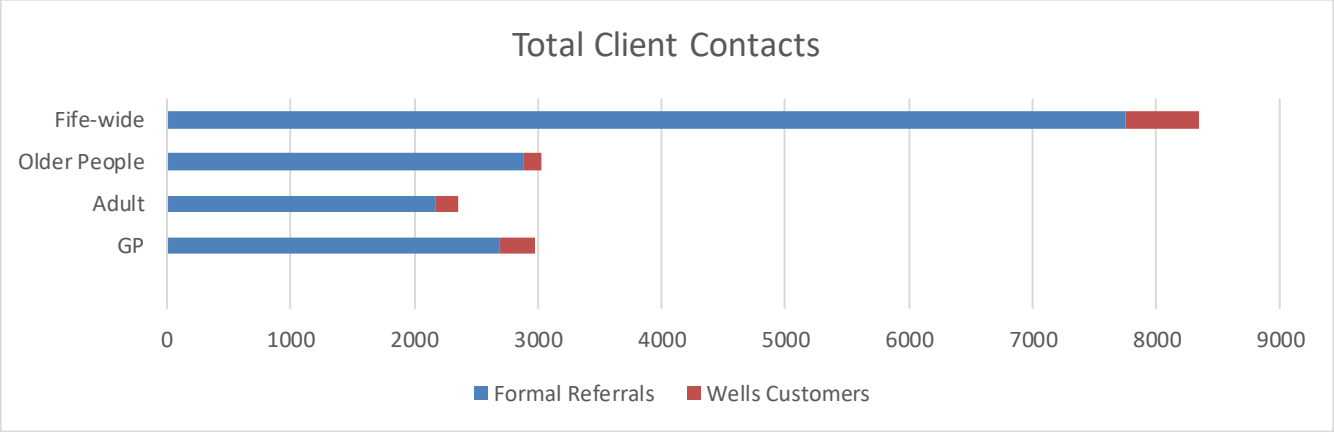
The number of support hours undertaken with formal referrals totalled **3,821 hours 40 minutes** decreasing from 3,908 hours (Source - Project Areas non-realigned to referral type: GP 1,170 hours 25 minutes increasing from 1,086 hours 25 minutes; Adult 1,150 hours increasing from 1,110 hours 5 minutes; Older People 1,501 hours 25 minutes decreasing from 1,711 hours 30 minutes). In addition to formal referrals a total of **603 hours 5 minutes** (increasing from 424 hours 35 minutes) was dedicated to supporting 267 'Wells Near Me' (2021: 197) and 592 related customer contacts (2021: 229 customer contacts).

On average the time spent per client contact relating to formal referrals was 30 minutes (Range - Project Areas aligned to referral type: GP 27 minutes; Adult 30 minutes; Older People 31 minutes). Following on from the pandemic, this continues to reflect the mixed contact method approach being deployed helping maximise LAC time, rather than utilising home visiting alone.

In relation to Formal Referrals and 'Wells Near Me', LACs delivered **4,424 hours 45 minutes** (2021: 4,332 hours 35 minutes) of direct support work culminating in **8,347 direct contacts with individuals** (2021: 8,198).

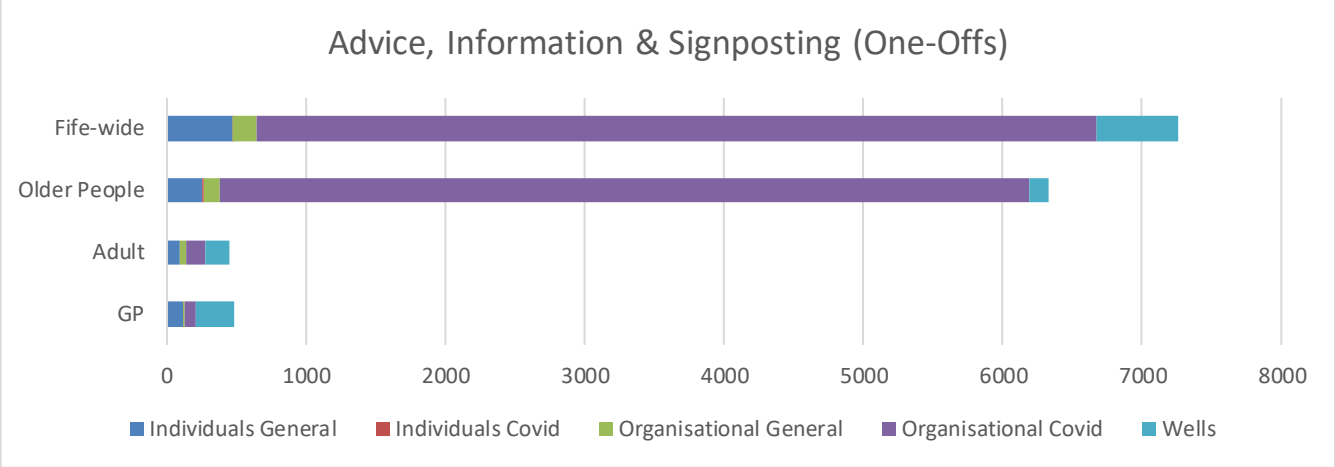




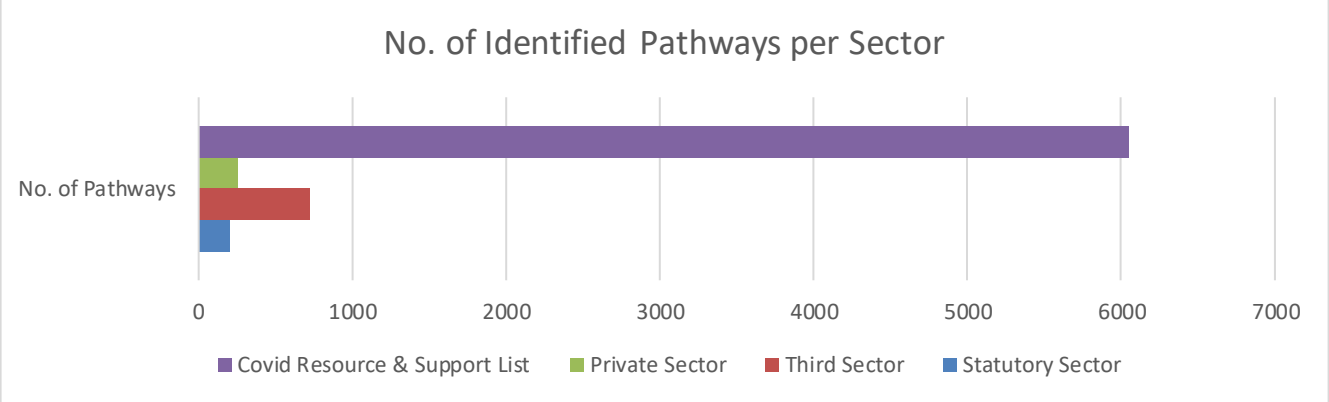


Guidance, Information & Signposting (One-Offs)

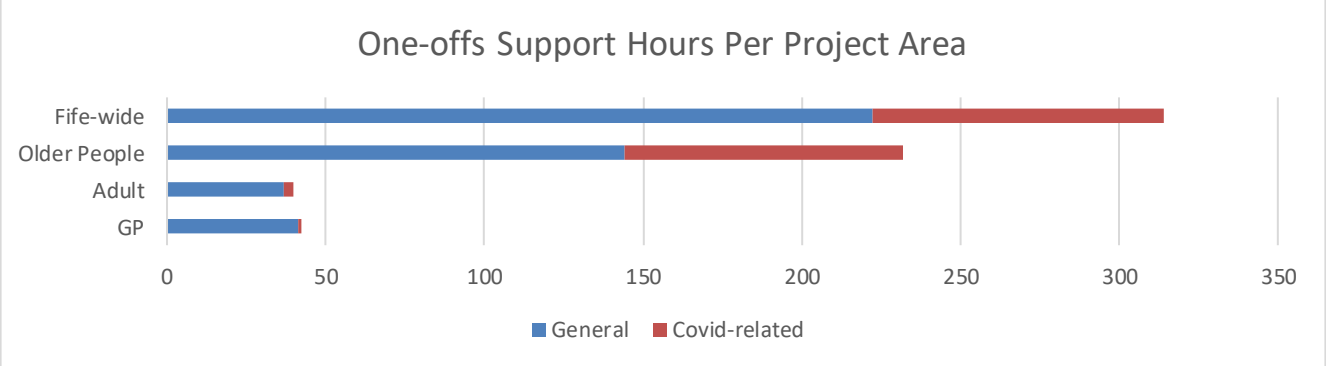
In addition to formal referrals the service offered guidance, information and signposting to both organisations and individuals. For general work, this was offered to **470 individuals** and on **168 occasions to organisations** (Source - Per Project Area: GP 119/8; Adult 94/38; Older People 257/122). Specific to Covid-related guidance, Fife-wide there were only **2 individuals** offered provision alongside this being offered on **6,033 occasions to organisations**. It should be noted the latter related to the regularly updated and distributed in-house 'Covid-19 Resource & Support List'. As previously indicated, **592** people were supported via the **'Wells Near Me'** suggesting a shift in balance to individuals being supported via the Wells Near Me rather than routing via Fife Forum directly.



In relation to one-off enquiries (excluding 'Wells Near Me') there were **1,170 pathways** identified ranging from local interest groups to statutory provision alongside **6,043 Covid Resource & Support Lists** having been distributed. Signposting to Third Sector services was the most prevalent route (61.4% of pathways identified). 'Advice and Information Services' (this includes in-house support) is, by far, the most prevalent individual pathway identified representing 28.3% of all pathways and 24.1% of pathways could reasonably be assumed to have primarily a social element/intent to them (this excludes Specialist Supports).



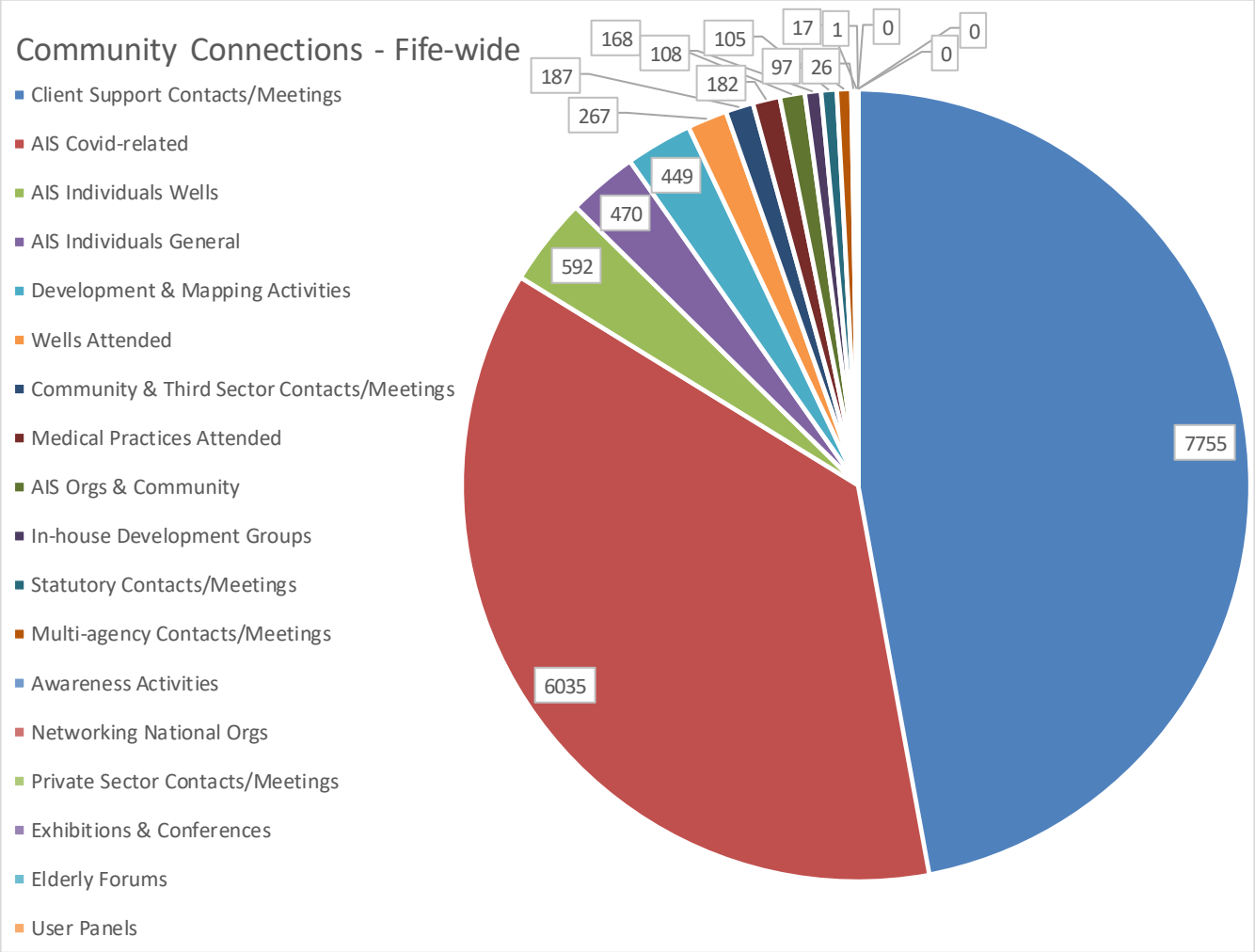
In total, **314 hours 5 minutes** of staff time was dedicated to one-off support which excludes Wells Near Me (Source – Per Project Area: GP 42 hours 25 minutes; Adult 39 hours 45 minutes; Older People 231 hours 55 minutes).



Community Connections

The service remains committed to establishing and developing connections with service providers and individuals throughout Fife. For the period the number of Community Connections undertaken with individuals, community groups and organisations **reached 16,459** (this includes: site visits; awareness raising events; instances of advice, information and signposting; development activity; and, Covid-19 related activity). This presents a decrease of 615 on the previous year largely reflecting a reduction in Covid-19 related activity.

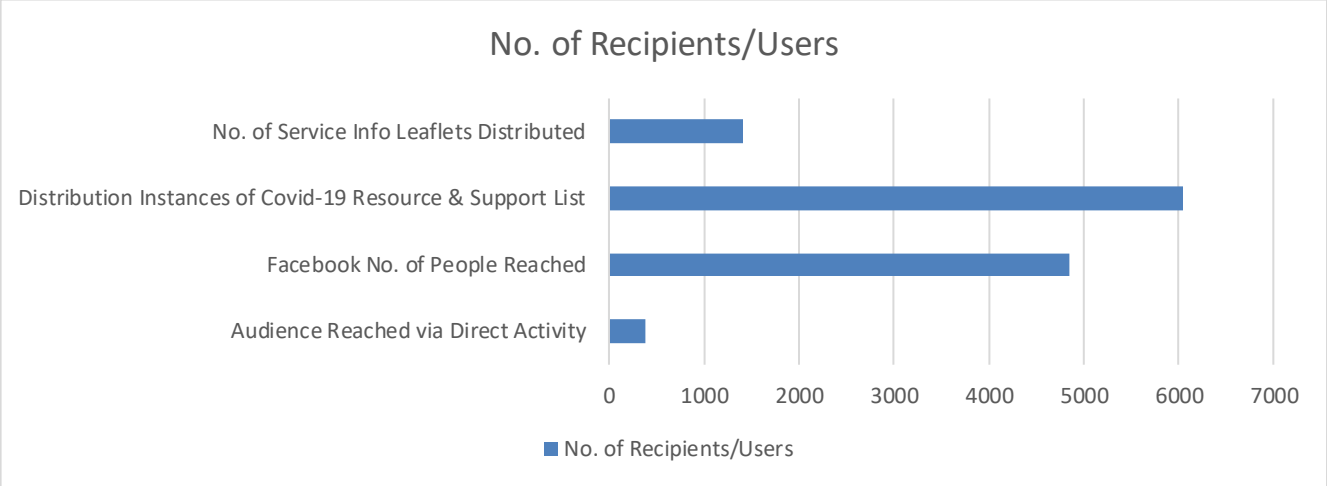
Direct client/individual-related connections account for 54.2% of the total (2021: 55.2%).



Awareness Raising

The service aims to raise awareness of Local Area Co-ordination to potential service recipients, stakeholders and the wider community. This type of activity was undertaken on 26 occasions (2021: 22) reaching an audience of 387 people (2021:159) which marks an increase overall, following lock-down periods endured during the pandemic.

The service and parent body (Fife Forum) continues to raise awareness of internal and external provisions via other methods such as Facebook (reach increased 168%) and via the direct distribution of the 'Covid-19 Resource & Support List' (6,043 instances). Additionally, the service distributed 1,408 articles of internal service literature.



Development Activity

Development activity continued during the reporting period and was largely an extension and/or development of the previous year's activity. This included:

- **In-house Development Groups –** The service developed and delivered in-person groups (Café Forum and Health Walks) which are locality-based almost tripling attendances to these; additionally, our GP LAC project developed and rolled out area specific 'Surgery Drop-ins' in partnership with the relevant stakeholders
- **Covid-19 Resource & Support List –** The service continued to develop, collate and update a comprehensive resource and support list for individuals and organisations which is regularly updated and widely distributed weekly; this was actively promoted on our Website and Facebook and is utilised by a wide number of stakeholders as a resource on their own sharing platforms
- **Fife Day Care Services Development Group –** Previously spearheaded by the Fife Health & Social Care Partnership, this multi-agency networking group continued to be co-ordinated by the service
- **Board Membership –** The service was represented on the Boards of two charitable organisations (Abbeyview Day Centre and Express Group Fife)
- **The Wells Near Me (Fife Health & Social Care Partnership) –** The service continued to engage with partners to help steer and deliver information points throughout Fife
- **The EAGLE Project -** A collaborative social prescribing initiative in which eligible primary care patients are offered free golf packages, known as 'Golf for Health', to help them to be more active (in partnership with The R&A, Fife Golf Trust, Scottish Golf, European Tour and Ladies European Tour researchers on the EAGLE programme at the University of St Andrews School of Medicine have developed connection pathways

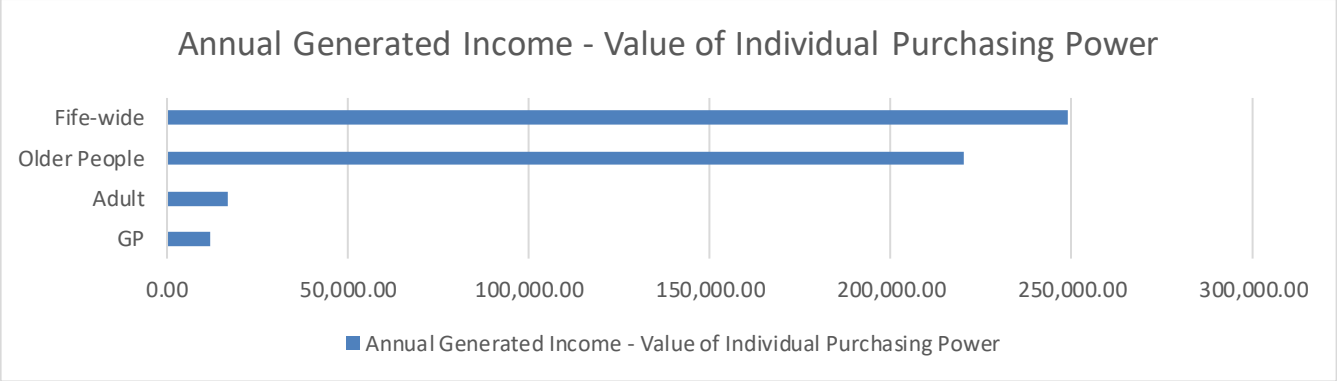
from GP practices to Golf for Health); Fife Forum LACs continue to work with the EAGLE team to identify and signpost patients who use their services to the Golf For Health packages

- **Holistic Needs Assessment (HNA) Approach Levenmouth Test of Change –** Continued collaboration utilising the Holistic Needs Assessment approach helping to assess the potential benefits this might bring - dedicated staff member appointed to this activity one day per week offering individuals support on 18 occasions dedicating 45 hours and 20 minutes of support time

Income Generation

The service remains committed, alongside partner agencies, to increasing the income of people in order that they are better supported to provide for their own needs. In conjunction with this, the service strives to directly support people to apply for disability-linked benefits wherever appropriate/practicable. When supported by the service to do this there is a high success rate for applicants.

As the pandemic eased and the opportunity to home visit increased our ability to directly support income maximisation resulted in a significant increase in income generation for our client group. In addition to one-off payments secured for service recipients, the service helped to generate income equating to **£248,955.80 per annum** (2021: £118,510.84 per annum) adding to individual purchasing power during a particularly difficult economic period. This is the highest level of generation since 2019 (£191,377.74 per annum). The most prevalent benefit application supported was for Attendance Allowance.



In addition to directly supporting income maximisation, the service routes people to external agents whom might assist with similar activity and/or offer a more specialised support.

During December 2022 the service also supported the **Fife Council/CARF Benefit Maximisation Taskforce** initiative with the view to assisting residents of a sheltered complex in Anstruther to navigate and apply for Pension Credits and other potential benefits which might arise from enquiries. Three LACs were deployed to deliver the initiative locally with follow-up carried forward by the LAC team.

"…I came across a very sheltered accommodation who were not in the position to support their residents themselves due to staffing issues. As their residents' demographics fitted those who maybe entitled, we decided it would be best for face-to-face support by staff who were trained to use the calculator. The timeline to identify people, train them and get the out to this sheltered complex was tight. My first thoughts were Fife Forum as they support the over 65's and are able to do home visits, I also hold the LACs in high regard as I know they do great work to tackle social isolation in NE Fife…They were able to see all the residents who wanted a check and also follow up phoning benefit phone lines and filling in forms. Both me and the staff at the sheltered accommodation are very thankful they were so adaptable, accommodating and supportive".

Benefit Maximisation Taskforce, Fife Council

Feedback

To help measure the impact of the service a client/carer consultation survey is deployed. During the reporting period the service reverted to surveying closed client cases during the course of the year rather than the final quarter seeking to capture a greater depth of qualitative findings, utilising a revised survey. Additionally, e surveys were developed and deployed. The latter included the revised survey with the addition of a 'Primary Care Feedback Form' to capture feedback relating specifically to the GP Cluster project. The feedback received remains overwhelmingly positive consistent with previous years.

"X was able to inform me of what I was able to apply for. She was the only person in 2 years who had been able to help me. I felt very supported & helped".

Service Recipient

"Just wanted to say thank you X. You gave me solutions when we did not know where to start. You were so supportive and we are forever grateful".

Service Recipient

"…the service your team provide is exceptional. Your help has given me a much better quality of life. I can't thank you enough especially X who is so kind and helpful…".

Service Recipient

"Thank you for your sensitive help & advice. It made all the difference to us in being able to stay in our own home. Despite our fragility we felt understood & respected. I am pleased to be able to say we can now ask for help".

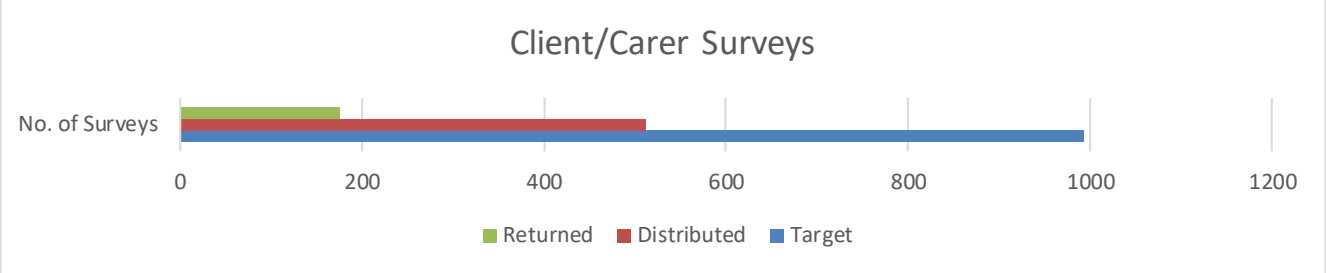
Service Recipient

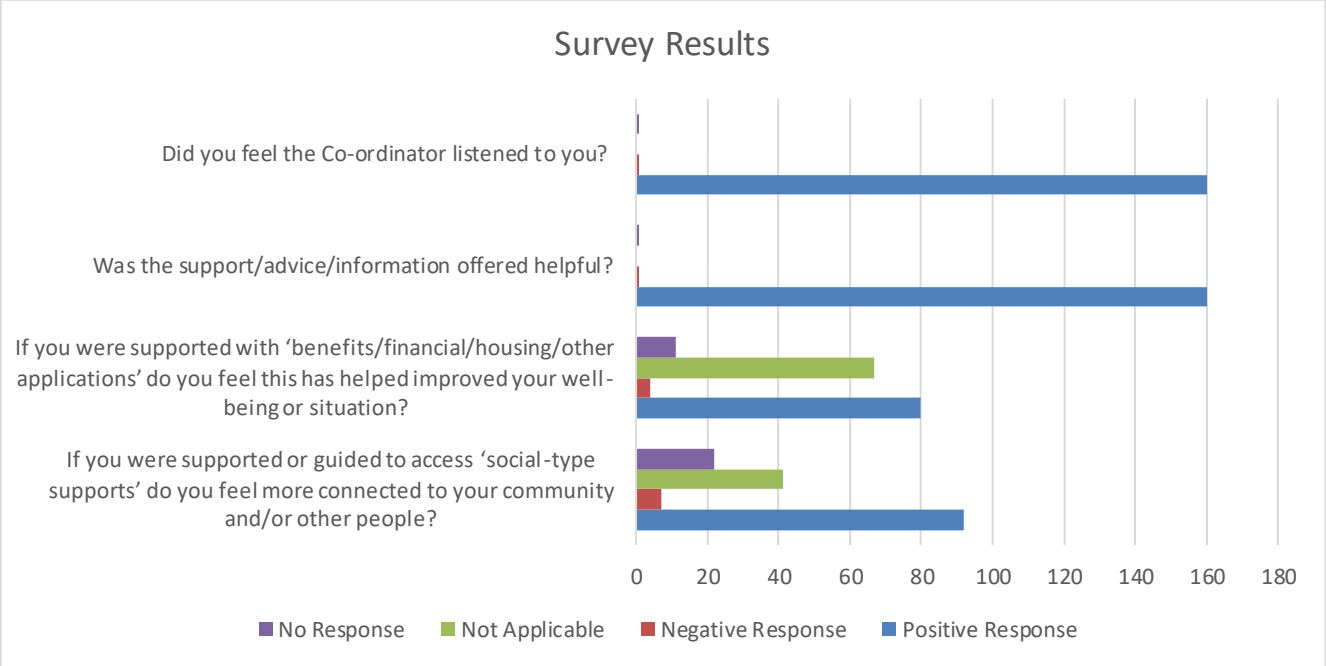
Within the context of open responses, it is worth noting service recipients continue to allude to the approach of each LAC; and, in particular, their swift response, their adoption of meaningful conversation, and their ability to build appropriate relationships. This, as with previous years, continues to reinforce the importance of the humanistic and Good Conversation approach taken by the service, being as it is a key driver for success.

Where repeat key words are extrapolated from open responses common themes appear to be suggested, these being the 'humanistic' approach deployed by the service; the 'motivational' aspect which helps facilitate engagement; and, the 'informational' role provided by a professional framework which aims to support and increase personal knowledge and engagement:

The target number of surveys for this reporting year was 994 reflecting the number of closed cases (it should be noted this target includes individuals who could not be reached at the point of closure – this would include those choosing not to engage with the service; deceased individuals; and, individuals who no longer had capacity). A survey return rate of 34.2% was recorded (Range: Adult 24.8%/GP 30.6%/Older People 45.4%). This is lower than the previous year (2021: 44.4%), however the number of surveys issued increased significantly from 169 to 512. **Please note:** 6 surveys were excluded from the data analysis as they were either indecipherable or in relation to e surveys could not be opened; and, 7 survey returns are presented separately relating as they are to the GP Cluster project.

The manner in which we monitor our work is reviewed annually as we seek to improve our methods of capturing qualitative feedback and it is hoped the introduction of e surveys will improve the survey return rate particularly among those aged 16-64.



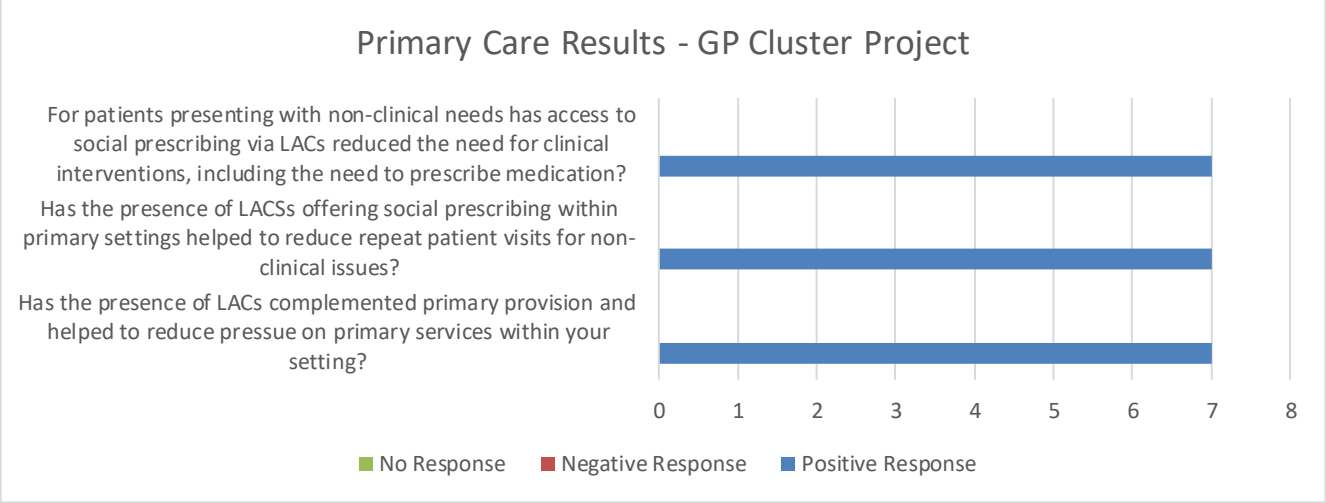


If what you were looking for was not available or you are having to wait for a service provision, please detail what gaps in pro vision are missing…

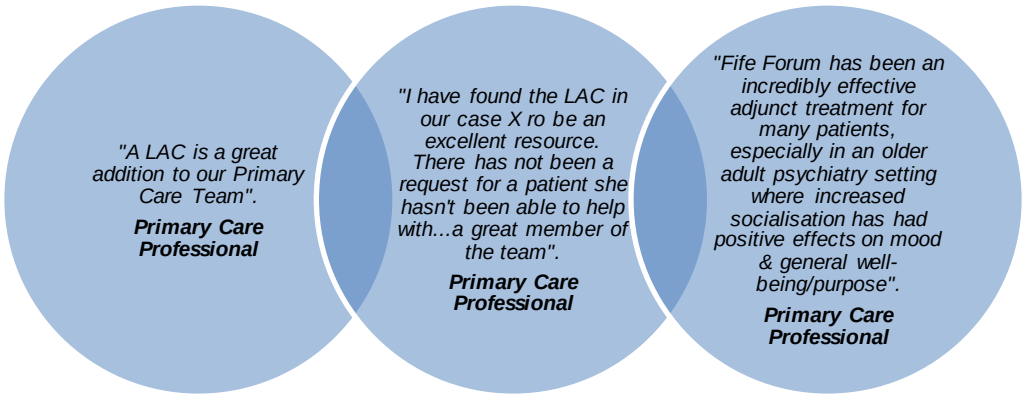
Specified Resources	Health	Housing	Social Work	Community-based
Deaf Services Glenrothes	Incontinence Services; Full-time GP Practice based LAC	Housing Stock; Housing Support	Respite; Day Care	New Groups (unspecified); Covid-19 (impact on existing groups)

Where gaps in service provision were alluded to almost all comments were generic in nature, however, several reflected the ongoing impact of the pandemic on community-centred resources.

In relation to **Primary Care Feedback (GP Cluster project)** please note the additional findings:



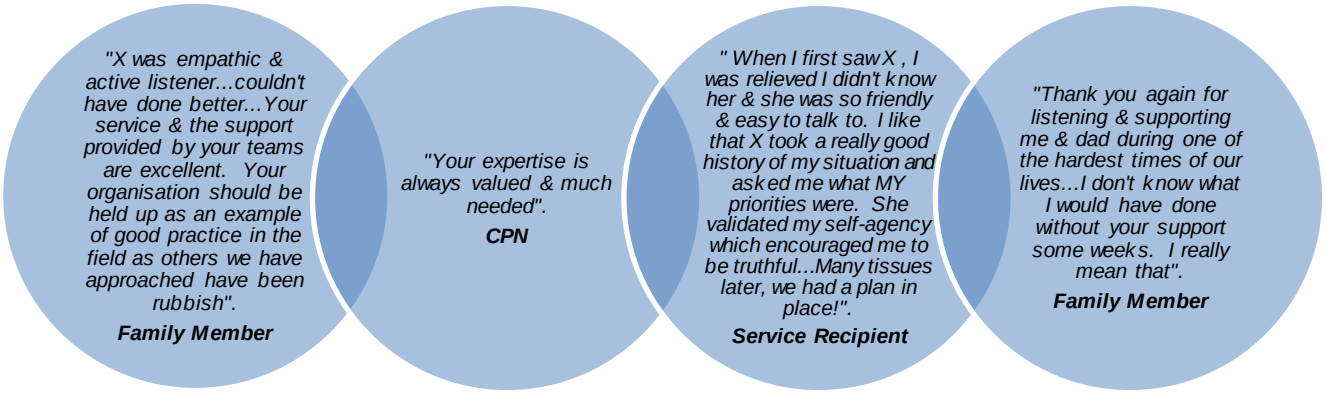
Feedback is limited as a further 7 professionals surveyed could not respond using the e survey platform owing to 'Firewall' issues, however, those who completed a survey appear to present a positive view of LAC within a Primary Care setting, suggesting the impact has resulted in helping to decrease pressure on health services, albeit in one instance an open response indicated it is, ***"Hard to know but I think so".***



One GP LAC service recipient included with their returned survey a short story in prose and an extract from this appears to offer a sense of positive change following their engagement with a LAC:

A new change of priorities, a new awareness.
Positive not negative, trying to maintain my sense of direction.
Happier, no shakes.
I don't forget the past.
I live in the here and now.
I look towards the future.
I now believe in myself.
There will still be doubts.
Now though, I am much better than who I was.
Service Recipient

In addition to this and throughout the reporting year, the Chief Executive Officer (CEO) of Fife Forum conducted random **telephone surveys** to capture feedback from those receiving a service from a Local Area Co-ordinator (LAC). All prospective clients are advised this may be conducted after a visit/contact from a LAC and in total 150 such surveys were carried out (50 per project area). The CEO reported telephone surveys elicited positive responses.



Pathways (Formal Referrals)

In relation to formal referrals the service strives to provide each client with options and information to support individual decision-making. It should be noted, in cases, the person concerned might not necessarily gain access to the routes explored. This is generally because:

- They might choose not to pursue a particular pathway as a matter of their own personal choice
- They might not meet the expressed criteria of the service they hope to access
- The service referred to might not be equipped to assist (skill, capacity or resource issues)
- The service closed their waiting lists
- Or, their personal circumstances might change (i.e. deterioration in health; death)

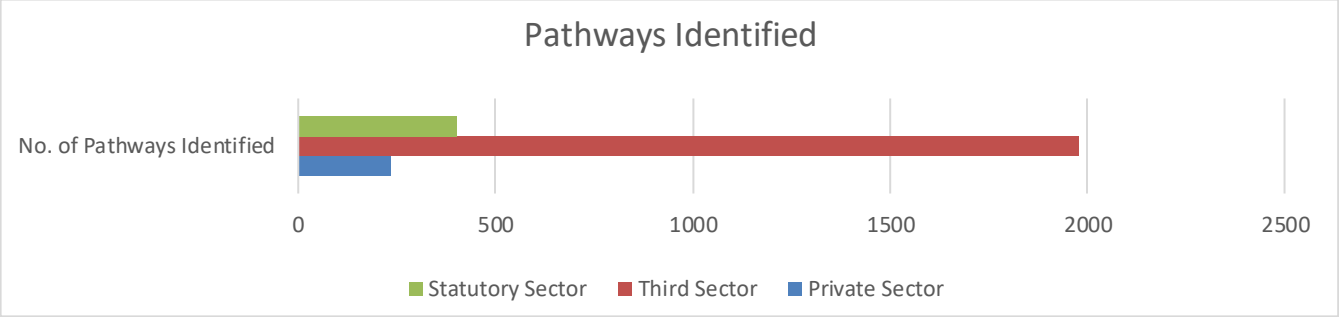
It is hoped by providing information relating to pathways for formal referrals it will help to reflect in part:

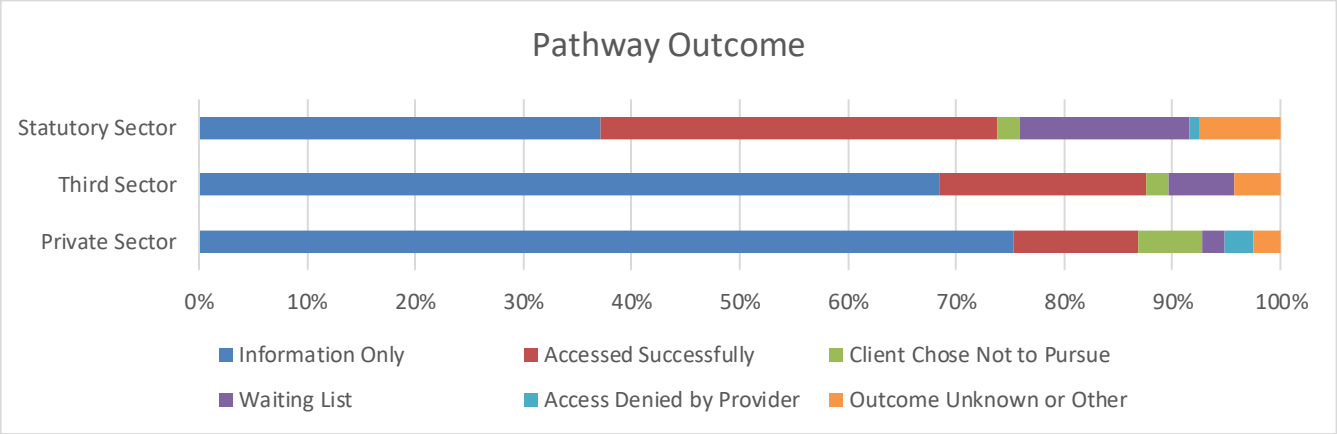
- Client outcomes
- Demand for service-type
- Gaps in provision

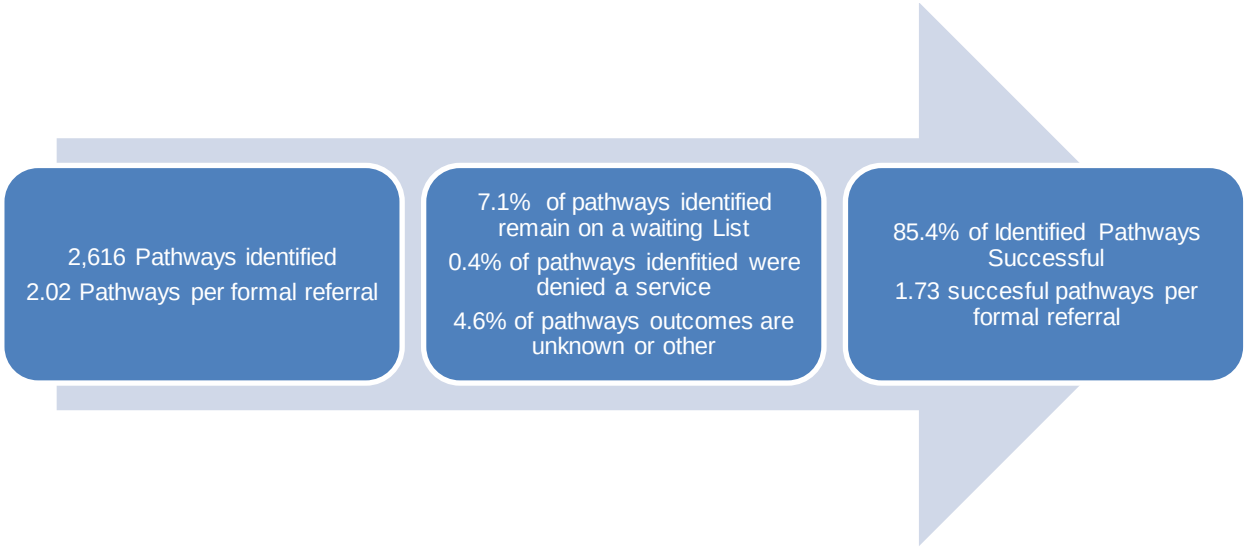
A total of 2,616 (2021: 2,442) pathways were identified and by the year end 21.1% or 553 incidences of all pathway outcomes were successful, in that access to routed provision was directly facilitated. This rises to 85.4% where the pathway route was intended/requested as 'Information Only' and is consistent with the previous year (2021: 85.6%). Of the pathways

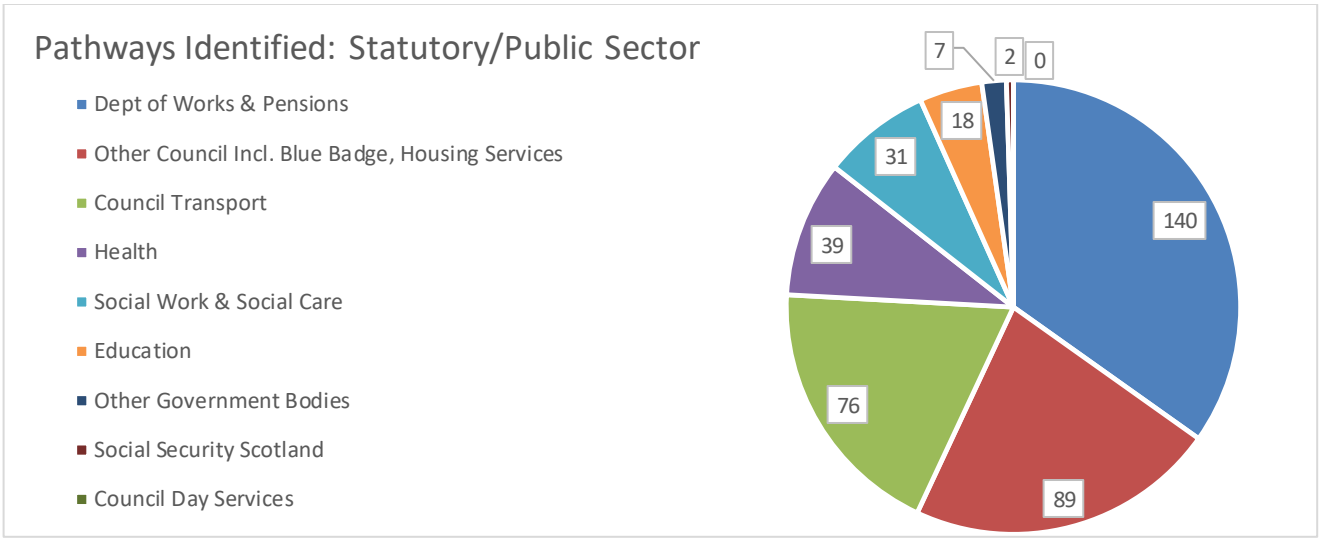
identified: 75.6% (2021: 81.3%) are attributed to the Third Sector; 15.4% (2021: 13.1%) Statutory Sector; and, 9.0% (2021: 5.6%) Private Sector.

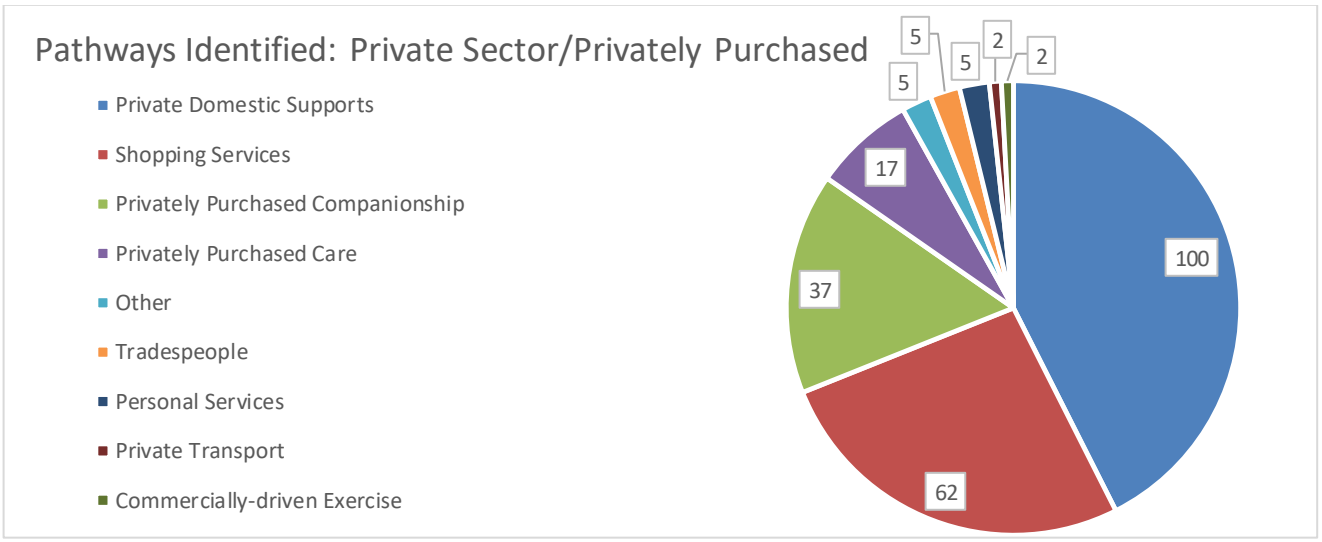
The data for the period is as follows:

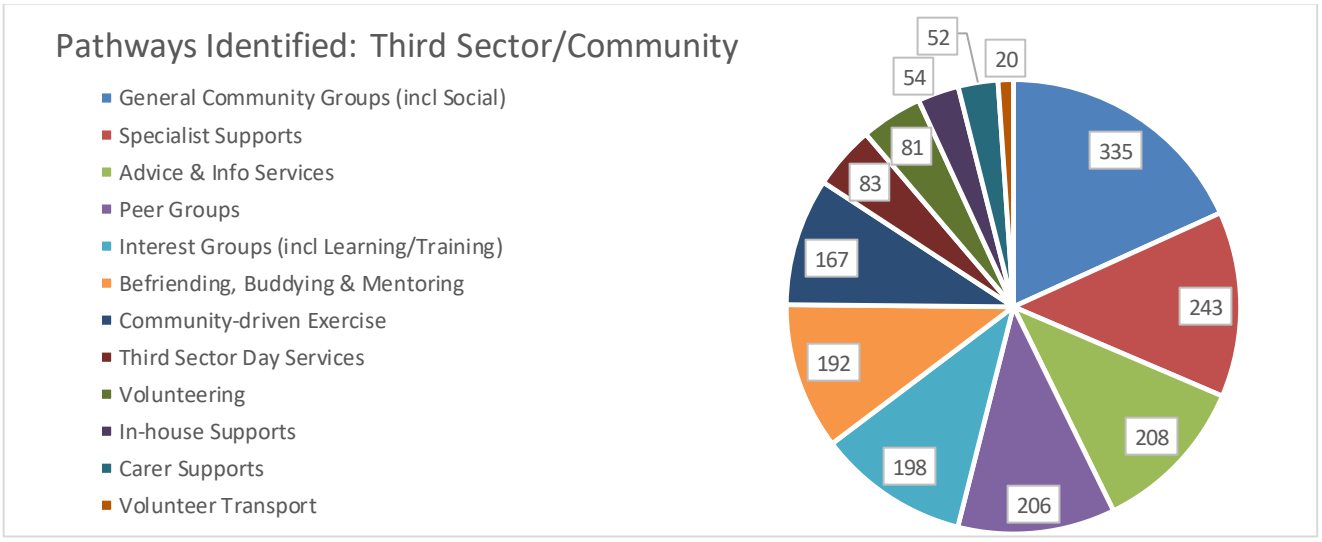












It is worth noting, as the pandemic eased and services remobilised, pathways provided in-house decreased significantly (from 634 pathways to 54). Correspondingly there was an

evident increase in pathways to external Third Sector provisions, particularly 'General Community Groups' (from 148 to 335) and social-linked supports. Within the context of Third Sector pathways it could reasonably be assumed that 45.3% had, primarily, a social reason for signposting to (this is likely far higher if secondary motivations are considered).

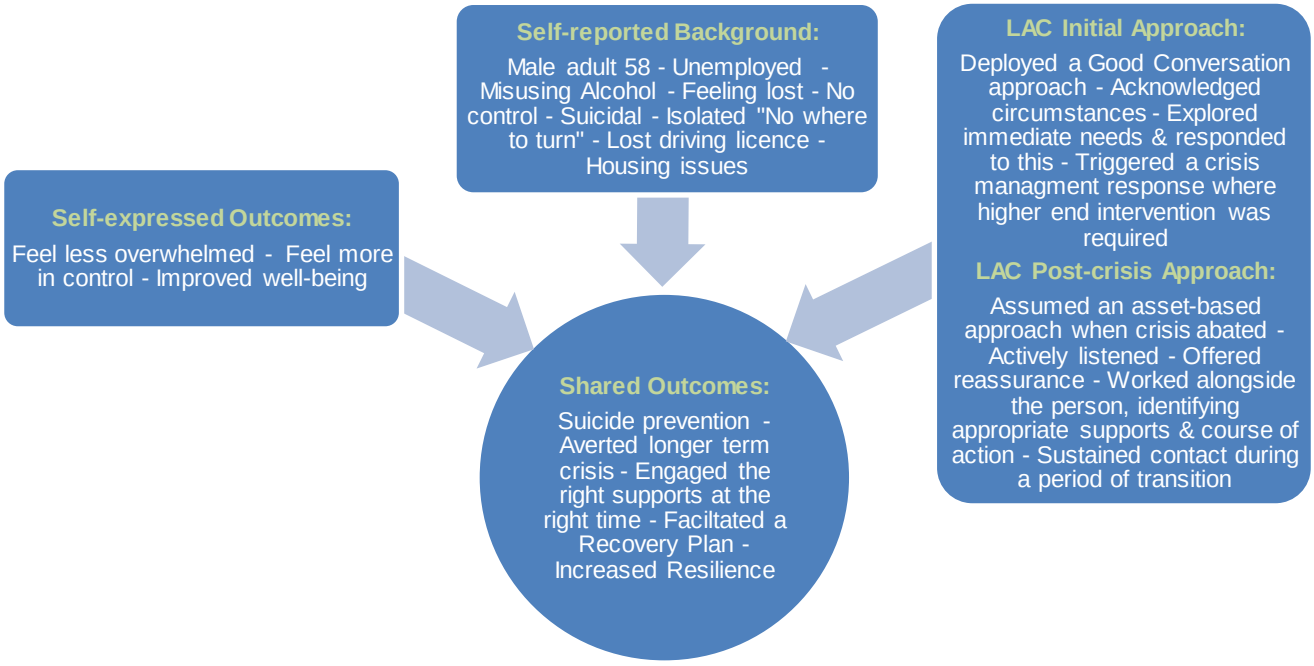
Within a Statutory context, there was a marked increase in supporting pathways to the Department of Works & Pensions (from 62 to 140), perhaps reflecting the wider economic downturn and its societal impact. Alongside this, pathways to 'Other Council Services' increased by 15.6% (from 77 to 89) largely as a result of directly assisting service recipients with Blue Badge applications which then required minimal input from the Local Authority itself other than assessing the application submitted.

Case Studies

Case studies are undertaken with the intent of exploring the benefits of Local Area Co-ordination for the person referred and how with the input of a Local Area Co-ordinator helps to meet both personally driven and organisational outcomes. Over the course of the reporting period three case studies were completed in relation to Formal Referrals and one in relation to In-house Group Work. For the purpose of reporting one Formal Referral case study has been presented alongside the In-house Group Work case study.

A questionnaire set is utilised to help capture feedback canvassing the referred person, referring agent (where applicable), and the Local Area Co-ordinator involved. For the purpose of this report, the information from these has been extrapolated forming a synopsis.

Formal Referral Case Study



Synopsis

Client X had a traumatic car accident and following this was deemed unfit to drive which impacted upon his employability. X has no family support having lost his parents whom previously lived with him. As a consequence, X was low in mood expressing suicidal ideation to a friend. Having concerns, the friend alerted his GP. The GP referred X to Fife Forum for the input of a LAC.

At the point of initial contact and by co-ordinating their approach with health professionals the LAC was able to ascertain X had reached crisis point and was at risk of self-harm. It was apparent higher end provision was required and the LAC liaised with a Mental Health Nurse resulting in X being identified as at risk. Circumstances escalated whereupon an admission to hospital was required to help stabilise and improve mental health.

Deploying a 'Good Conversation' approach helped the LAC to identify in the first instance X required specialised intervention to overcome a period of crisis. Whilst the initial conversation was able to introduce a notion of hope and pre-identify some issues presenting, particularly his unhappiness with his housing situation, it was evident immediate circumstances required external supports to help stabilise and manage X's health. Nevertheless, through ongoing contact during the period of hospitalisation consent was offered which enabled the LAC to assist with his housing needs (this being to downsize and relocate). The LAC was, therefore, able to liaise with housing to help support this and, in turn, offer X a degree of hope that positive change is possible.

Upon the point of hospital discharge, the LAC was able to re-engage more fully with the specific objective of working with X to help identify appropriate mechanisms which might help him to better self-manage his circumstances. Again, a Good Conversation approach was deployed to ascertain what was important to X and how he might formulate a sense of control over his circumstances. X wished to manage his alcohol misuse, improve his employability and assert more control over his life journey. To help support this X was afforded an opportunity to start afresh securing a new tenancy more suited to his needs and closer to community supports, including his friend whom identified as a willing asset for X. In tandem, practical issues were explored to support him during his period of unemployment. This focussed on maximising his income entitlement. Crucially X was supported to access a Self-help Coach which helped him to become alcohol free for the period since.

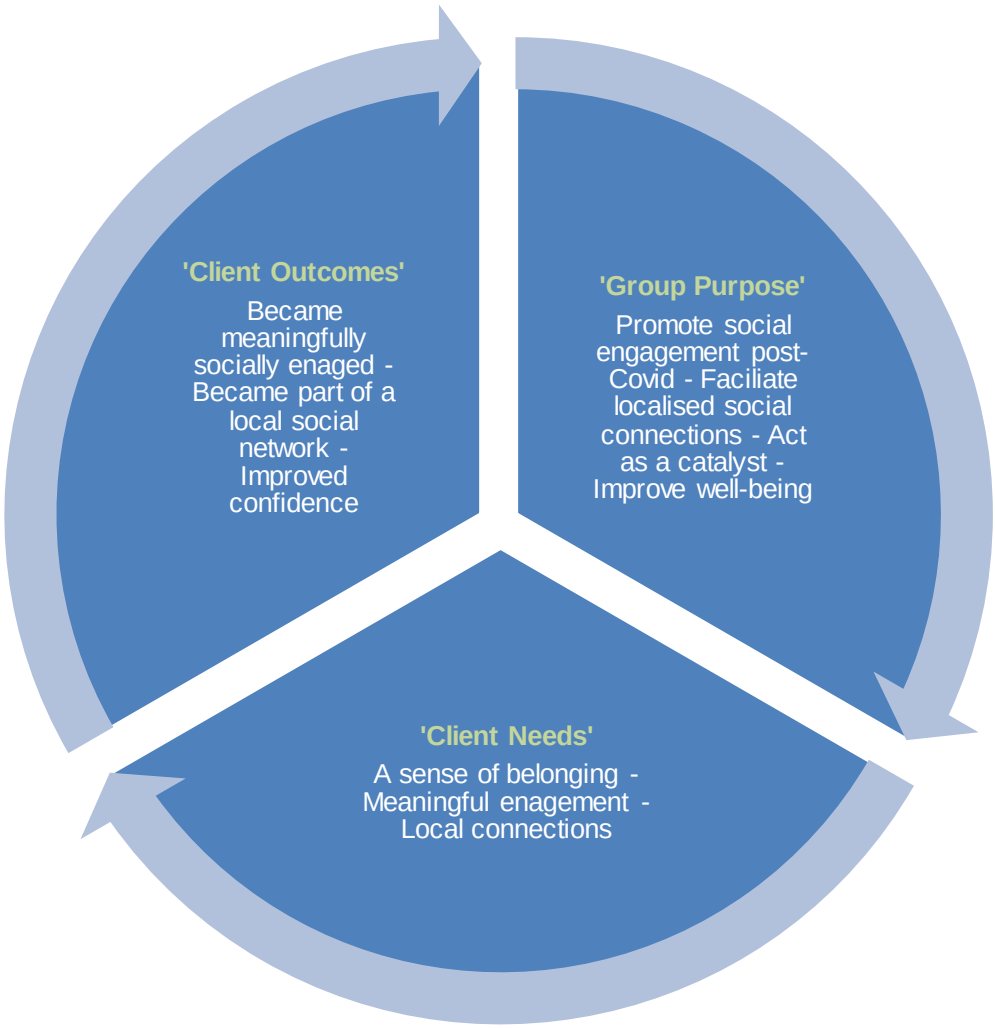
Longer term by seeking tools to self-manage his needs X has taken a step towards improving his employability. Although it may not be possible, important to X was regaining his ability to drive. This could not be guaranteed and X was made aware of this, however, the LAC was able to offer information and guidance as to how he might potentially be able to support this.

In summary, through his involvement with a LAC X was supported to overcome a period of crisis which initially appeared insurmountable. The LAC was able to identify appropriate pathways and inject a sense of hope during a difficult period, affording X tools to build a platform

upon which he could be helped to move forward and strengthen his resilience. X was supported to identify and access resources/supports which allow him to better self-manage affording him a greater sense of control over his life. His involvement with a LAC helped to avert a 'worst case scenario' giving him hope for the future. This synopsis is best reflected through the words of X himself:

"The LAC was patient with me & has helped me out greatly and managed to support me at my lowest when I was hospitalised. She gave me hope that things could change no matter how small. It's been a tough journey however having the support & knowledge of the LAC has helped me move into a smaller property which I am now comfortable in & I can start afresh & make memories. I have stopped drinking & managing my medication better. The LAC has advised me of potential support groups & employment agencies that will be good for me when I am ready to get back into work. She also supported me with my financial status & entitlement of benefits. I have got some form of life & every day is appreciated".

In-house Group Case Study



Synopsis

Client X started her journey as a Formal Referral having been referred to LAC by a CPN:

"X is struggling being on her own and is unaware of any supports in the area. She used to attend a group in St Andrews but has not been due to anxieties about going. The care home next door used to be open but now closed and they would always invite her in. Her needs are a befriender, as has no one around to talk to or help with some daily living activities. New groups locally." ***Extract from Referral***

Adopting the Good Conversation approach the LAC learned X experienced bullying at school and had been unable to share this with her parents as a child. She believed her mother provided for her materially but would say hurtful things. This affected her deeply and she believed this made it difficult for her to assert herself as an adult. She found it hard to know how to cope with people who were being rude or hurtful towards her, suffering from low confidence and self-esteem. She joined groups, when prompted, but found it hard to engage meaningfully. She expressed she found very little joy in life and described herself as pessimistic about the future. She did not want to attend the local church group, as she felt she had little in common with the members adding attending groups where she felt she did not belong made her feel lonelier than sitting at home.

Initially, X was referred to Better Than Well to help develop tools and techniques to manage her mental health**.** Other social supports were explored but these were not in her immediate locality. X displayed very little interest in this and felt it was the same activities over and over again. She expressed discomfort in large groups and avoided making plans with the LAC to visit groups. An inability to source an appropriate localised support for X presented as a gap in provision providing the service with a catalyst to explore developing a local Café Forum, building upon an existing virtual model deployed during the pandemic. This development was pursued working with this individual and other partners.

The in-person Café Forum resulted, utilising X's experience with an aim of facilitating a local low key supported social outlet which might in turn act as a catalyst for members to form and develop their own social networks within and out with the group itself. X fully engaged in this and her confidence and self-esteem increased. She became more connected to her local community and her mood improved dramatically. The group has been a stepping stone to other activities as she now feels more confident about trying new things. This is best expressed by X herself:

"You have no idea what a difference it has made to my life. It has given me a confidence I never knew I had. It's done so much good, I feel like a different person. It's improved my confidence, trying things I've never done before. I feel more able to talk to people. I've even started conversations with strangers in shops. There are so many nice people out there".

Learning

Not unlike the previous year, the Coronavirus Pandemic and more recently the Cost of Living Crisis has presented many challenges for individuals and organisations alike, and the LAC service including those employed within this have not been immune to its impact. During the year the service has sought to navigate this and continued to evolve and adapt how we approach, deliver and monitor our work. As was to be expected this was not without challenges, all of which have been ongoing issues since the worst of the pandemic:

- Working remotely from home with limited resources
- Recruiting (vacant posts) and absences (longer-term health issues)
- Adapting to change, its pace, and the ever-changing nature in which this unfolded
- The remobilisation of services and closure of some

These challenges are not atypical and remained for both individuals and organisation alike. This said, each team member and the management team continued to collectively address this to effectively deliver what remains an invaluable service during protracted and unprecedented times.

Whilst wider socio-economic issues are not welcomed, opportunities remain and are reflected in our commitment to:

- Accept, adapt and respond to change
- Remain flexible as to how we view and deliver provision, including the manner in which we do this and how we utilise the tools at our disposal
- Considering and enacting change
- Maintaining a reduced Carbon Footprint
- Developing and introducing more effective systems to record and monitor the work of the service, including refining and developing this in a responsive manner

It is hoped this will support forward momentum, affording the service a secure platform on which it continues to steer ahead, albeit the challenges ahead remain difficult to quantify.

The Year Ahead

Mirroring the previous year start, at the time of reporting, a new Service Level Agreement with the Fife Health & Social Care Partnership for the forthcoming year has not yet concluded; therefore, we are unable to present our prescribed targets for the forthcoming period. This said, during this reporting period itself an opportunity was afforded Fife Forum to revise and refine its Service Level Agreement with the Fife Health & Social Care Partnership as part of their Reimagining Third Sector Commissioning Strategy. This development was welcomed helping to redefine values, roles, functions and targets. As reported this resulted in targets being retrospectively revised upwards to mirror previously achieved performance levels. It is

anticipated that should the service continue to be supported prescribed outputs/outcomes will follow a broadly similar pattern.

As we enter our 12th year our aim remains to support social and economic inclusion and combat isolation and loneliness through engagement using an asset-based approach, helping people to remain and retain for as far as is practicable their independence and sense of connection.

Summary

The LAC Service, under the umbrella of the Fife Forum, continues to be a proactive provider achieving results which exceed prescribed targets.

The service continued to actively promote 'Local Area Co-ordination' with a view to working with and alongside stakeholders to support as many individuals as is practicable. The service will aim to support this by continuing to learn from experience (identifying and resolving any internal procedural issues) and adapt and develop to help ensure continuity and effectiveness throughout the service area. It will hopefully be supported to do this by those responsible for commissioning services.

As we enter 2023, the socio-economic landscape within Fife and beyond remains testing. This means, that whilst the service is well established and offers people a unique element within the service landscape, planning ahead remains an ever-present challenge. The service will continue to not lose sight of this as it moves forward, seeking to utilise/develop our evolving framework to work with all partners to adapt and support a shared recovery.

"WE FEEL VERY FORTUNATE & GRATEFUL FOR SUCH CARING & COMPASSION WHICH WE RECEIVED".
Family Member

"THIS ORGANISATION MAKES A REAL DIFFERENCE! X HAS MADE A REAL DIFFERENCE TO ME".
Service Recipient