Fife Forum

Local Area Co-ordination – Making Community Connections

Fife Services

December 15 2024 – December 14 2025 (SLA Aligned)

December 2024

Fife Forum

Authored by: Wayne Mathieson

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 service areas (these being: GP Cluster Areas 16+; Adults 16-64; and, Older People 65+). The information presented relates to the period 15th December 2023–14th December 2024. 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 services were funded through the Integrated Care Fund and GP Cluster service 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 as of December 2024:

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

The Adult and Older People services 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, two vacancies were filled and one postholder transferred from the Adult Team. Within the GP Cluster and Adult services, three vacancies were filled affording the service a full complement of staff for the first time following the Covid pandemic. Recruitment during the year was a challenge, however, service delivery was not significantly impacted as formal referrals were cross-referred internally to ensure continuity of provision and this assisted a period of transition and supported the induction of new staff.

For the forthcoming year, it is hoped staffing levels will remain at 100% or near to, however, it should be noted there are several staff members nearing retirement.

Post-Pandemic & Recovery

During the course of the year Local Area Co-ordination has continued to deliver upon its objectives. In a wider context, there remains a sense that the path ahead is one of continued recovery as provisions are reviewed albeit this is evidently framed by financial challenges which have not yet dissipated.

As it was with the pandemic and the previous reporting year, the ongoing pressures presented by societal events continue to influence the work of organisations and services, such as Local Area Co-ordination, which aim to support community and social engagement as a core means to help improve overall well-being. The sustained issues presented by the cost of living crisis

continued to influence individual needs and wants which continued to centre significantly on the fulfilment of basic living needs as people sought to combat the impact of the economic crisis. This appeared to be reflected in an ever-increasing demand for services and supports which help to maximise income and/or provide people with basic tools which aid daily living. Our data shows a quite considerable increase in the value of monies directly raised by our service in relation to helping people achieve this and should national and devolved governments seek to reduce the extent and/or cost of welfare benefits this will not likely abate.

During the year, Fife Forum continued to utilise a blended approach to delivery whilst responding to the needs of our client group. The service continued to deploy 'traditional' delivery methods (face-to-face and audio contact) alongside virtual platforms. As intimated, unsurprisingly, there was a marked increase in income/benefit-related enquiries, however, equally there was an evident increase in successfully helping people to maximise their benefit entitlement, particularly for those experiencing ill health and disability.

Alongside supporting people to access information and activities, the service supported the remaining in-house and in-person peer group to become fully independent. The development of this group sought to help address the absence of community-centred social activity in Leuchars (North East Fife) with a view to this becoming self-sustaining and to this end succeeded. The service remains committed to the potential development of new peer groups which incorporate a social café and 'health and well-being' theme where gaps are identified and capacity allows for this. Our aim would continue to centre on affording people the opportunity to socialise and improve well-being in a localised and self-sustaining capacity, however, during this year this has not been possible. Instead, the service has continued to support, develop and co-deliver community-based and hospital-centred drop-ins to support information sharing, signposting and community connections. Aside, from supporting the delivery of the Wells (Fife HSCP) Fife-wide, drop-ins have been centred on Dunfermline, Kirkcaldy and North East Fife localities where we have either identified a gap in provision or have been able to co-deliver with partners.

Formal Referrals & Supported People

Throughout the reporting period the service accepted new referrals. A total of **1,272 formal referrals** were received. This presented a marginal decrease in the number of formal referrals received compared with the previous reporting year (2.6% decrease), however, this remains well above pre-pandemic levels (almost 38% higher compared to 2020) and is on par with the second highest reporting period since its conception during late 2011.

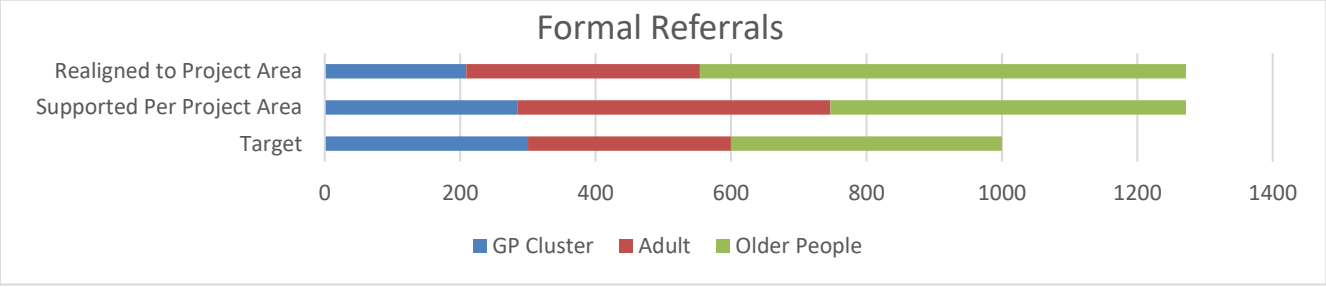
The total number of formal referrals received remains above the overarching target prescribed by our Service Level Agreement (Targets: Fife-wide 1,000 – GP Cluster 300; Adult 300; Older People 400). Within the context of formal referrals received, 310 of these were cross-referred internally to help ensure demand was met throughout the three service areas. This number was lower than the previous year (377). The majority of cross-referrals were made to our Adult LAC team (174 – 5 GP Cluster; 169 Older People) with our GP Cluster and Older People LAC teams accounting

for the remaining 136 cross-referrals (respectively: 46 Adult & 57 Older People; 11 Adult & 22 GP Cluster).

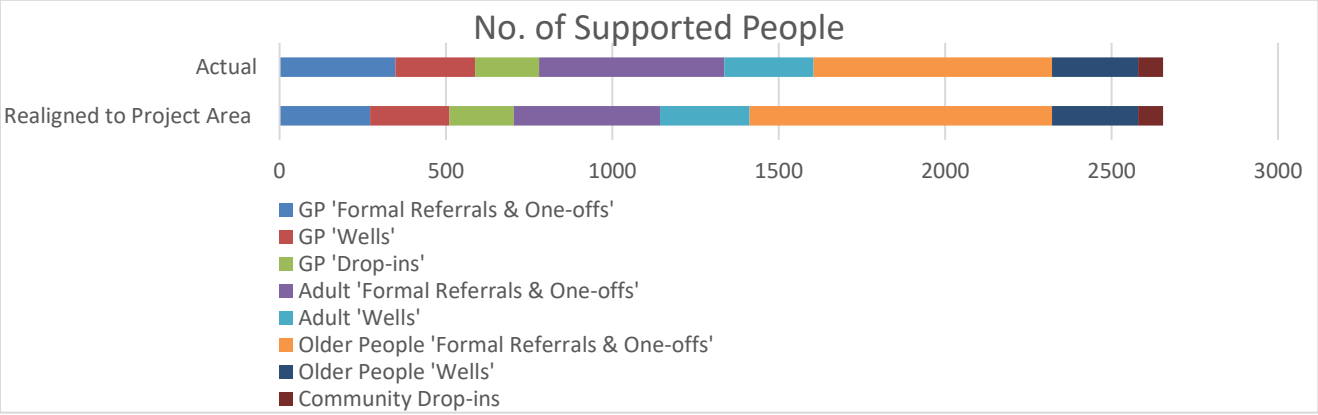
Whilst the overarching target was surpassed (+272), when formal referrals are realigned to their intended services areas both Adult (+45) and Older People (+318) reflected this whilst the GP Cluster area did not (-91). This pattern in part mirrors the previous reporting period, however, the volume of referrals for Older People has significantly increased. Within the GP Cluster context, the shortfall might in part be attributed to a physical absence/reduction of staffing within Kirkcaldy, Lochgelly and Glenrothes albeit the wider service continued to support delivery. It is also important to note, the number of formal referrals supported by the GP Cluster service totaled 285 and it would be fair to assume each person cross-referred from its sibling service areas would likely have had a direct link to a health service and/or Medical Practice, meaning the overall shortfall in relation to the target is 15. Similarly, the benefits of Local Area Co-ordination for the patients of the Medical Practices supported by our GP Cluster Project and the wider service should not be underestimated as overall 583 formal referrals were routed from Health, with 280 of these attributed directly to Medical Practice-linked sources (GPs, Mental Health Triage and Other Medical Practice staff). Health sourced referrals account for 45.8% of formal referrals overall.

The continued and welcomed development of community-led support provided by Link Life Fife (Fife Health & Social Care Partnership - HSCP) which offers a shared-value service type focusing on mental health within the same primary health setting Fife-wide alongside the practice of encouraging use of the Wells might also, in part, be a contributing factor impacting formal referrals within our GP Cluster project. Whilst this is difficult to quantify, the service has noted the number of formal referrals sourced from Mental Health Triage Nurses has fallen considerably since 2020 from 226 to 39 albeit this number appears to have stabilised being as it is slightly higher than the previous year (36). The exception this period is that the reduction in Mental Health Triage referrals has not been off-set by the number of formal referrals made by GPs and Other Medical-Practice Staff which reduced from 272 to 221 formal referrals. This said, the Wells (HSCP) is now the 6th most significant source of formal referrals Fife-wide (6 of 19).

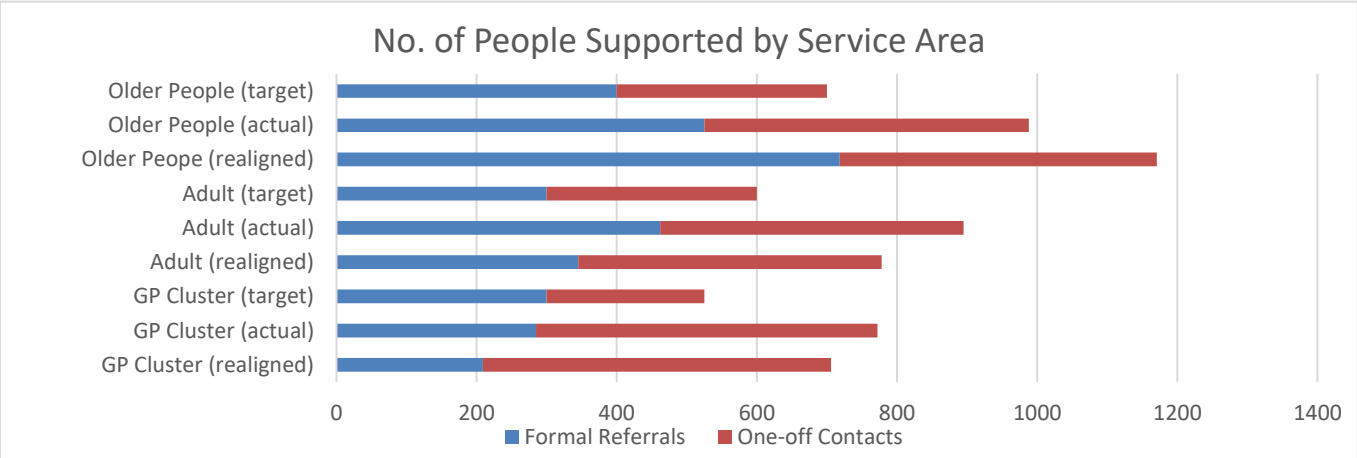
As stated in our previous report, we continue to believe that the expansion of Local Area Co-ordination and community-led provision both internally and externally should in essence complement and not purposely overlap one another and we believe this will be supported by our own and external evidence which should, in all probability, indicate an increased demand for provisions utilising the LAC/community-led model and approach.



In addition to formal referrals, the service continued to offer guidance and signposting to people on a 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). During this reporting period Covid-related enquiries were no longer recorded. When one-off enquiries/contacts are included **the service supported 2,655 people** Fife-wide (an increase of 3.3% from 2,571). This is the highest level of support offered by the service since 2011 and the total number of people supported remains well above the over-arching target prescribed in our Service Level Agreement (Target: 1,750 – 51.7% higher).



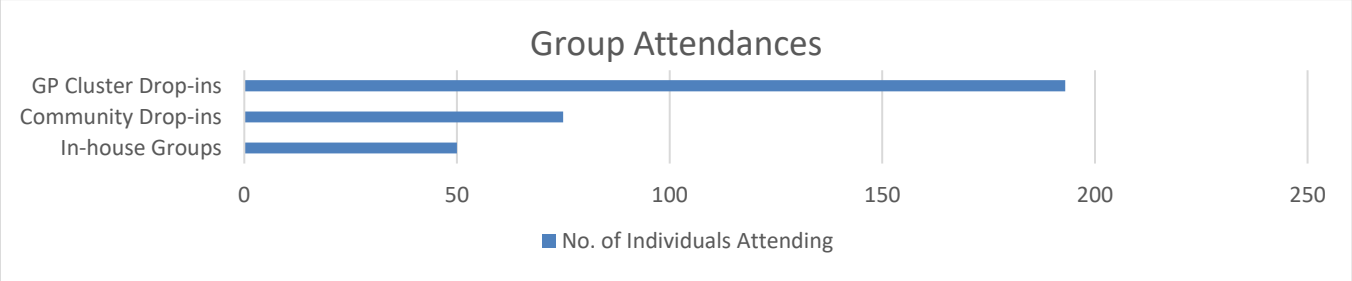
In relation to the targets prescribed within our Service Level Agreement each project area surpassed their targets. **The GP Cluster team supported 706 people (realigned to the service area) working with 772 people within a wider context**. This is 35.2% (realigned) or 47.0% (actual) more than prescribed (target 525 – 300 Formal Referrals/225 One-off Contacts). **The Adult team supported 778 people (realigned to the project area) working with 895 people within a wider context**. This is 48.2% (realigned) or 70.5% (actual) more than prescribed (target 525 – 300 Formal Referrals/225 One-off Contacts). Finally, **the Older People team supported 1,171 (realigned to the service area) working with 988 people within a wider context**. This is 67.3% (realigned) or 41.1% (actual) more than prescribed (target 700 – 400 Formal Referrals/300 One-off Contacts).



Beyond core activity, **50 attendances** were supported within **in-house groups** (Café Forums & Older People Forums). This presents a decrease on the previous year; however, it is in line with the expectation that the remaining in-house Café Forum progressed as self-sustaining. In

addition to this, the Older People team linked with the Older People Forums in 4 localities towards the end of the reporting period to support the transition of Fife Forum Action Groups.

The service continued to facilitate community and Medical Practice-centred drop-ins offering guidance either on a one-off basis and/or with follow-up input where appropriate. This reflects a trend towards people seeking more immediate interventions via a more visible platform within their immediate communities. In total there were 287 Medical Practice drop-ins and 52 community-centred drop-ins held in 6 of the 7 Fife localities. **Those presenting at our drop-ins totaled 268 individuals, 193 of which were within Medical Practices within our prescribed GP Cluster Areas**.



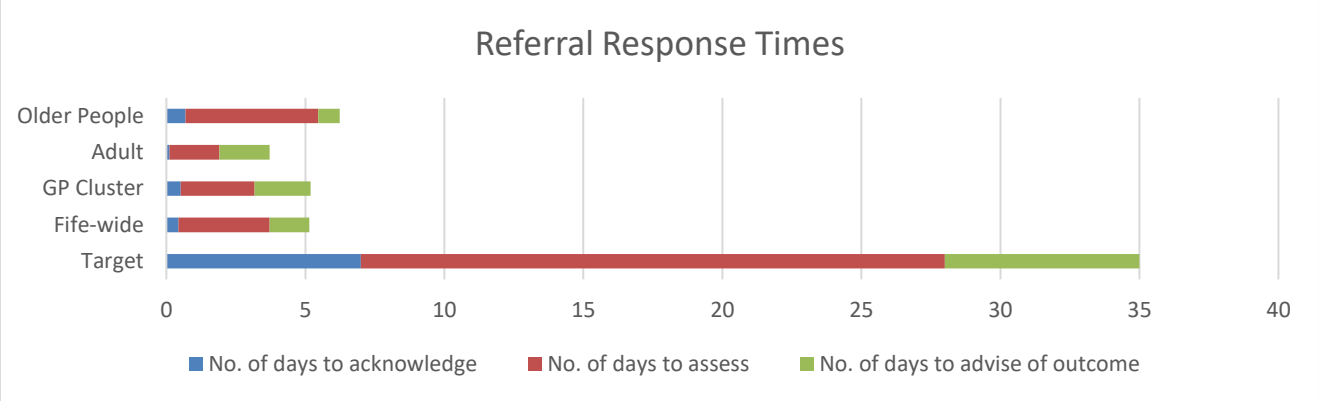
"Your service was great, I would recommend your service to anyone who is in need and I am very grateful to my GP who put me in touch with my co-ordinator as she was great and extremely supportive".
Service Recipient

Formal Referral Response Times & Engagement Rates

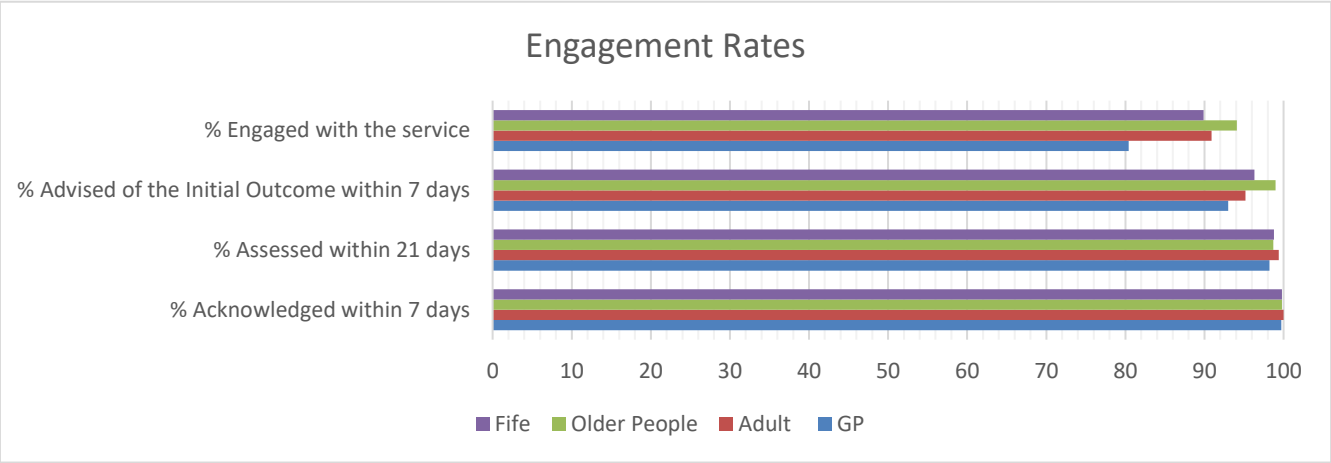
In accordance with the Service Level Agreement (Fife Health & Social Care Partnership) the average response times for formal referrals are as follows:

- Acknowledged within 7 days of receipt (**average:** GP 0.51; Adult 0.11; Older People 0.69)
- Assessed within 21 days of acknowledgement (**average:** GP 2.66; Adult 1.80; Older People 4.78)
- Advised of outcome within 7 days of assessment (**average:** GP 1.02; Adult 1.80; Older People 0.)

In all three service areas the average target timelines were met and the process from acknowledgment to assessment to reporting an initial outcome averaged 5.14 days, well within the prescribed 35-day timescale and is broadly similar to previous reporting periods (2022: 6.16 days; 2023: 6.56 days).



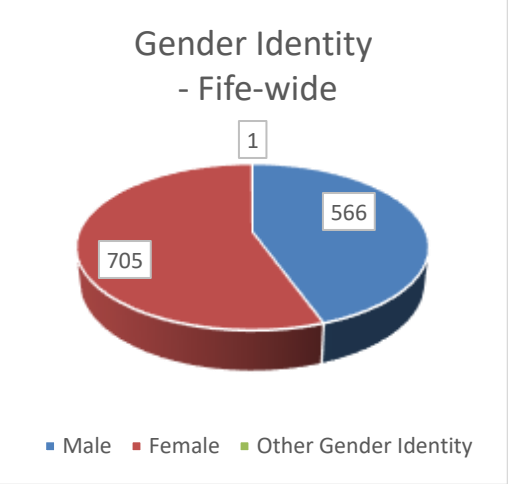
Fife-wide the percentage of formal referrals acknowledged within 7 days reached 99.8% (2023: 99.5%); assessed within 21 days 98.7% (2023: 97.2%); and, advised of the initial outcome within 7 days 99.0% (2023: 96.3%). The percentage of formal referrals that chose to fully engage with the service equaled 94.1% (2023: 87.0%). Individuals served by the Older People team were most likely to engage with the service with a rate of 94.0% (2023: 92.2%).



"The service you offer remains invaluable from my point of view. Your knowledge of benefits and who might be entitled to what and local services and their specific remits as well as any local initiatives and housing, is an extremely helpful resource which is available to us. Your presence here provides an opportunity for patients to discuss these issues separate from any clinical issues and I have had very good positive feedback from some after their encounters with you. Hope this help in us being able to continue to access your assistance for patients here".

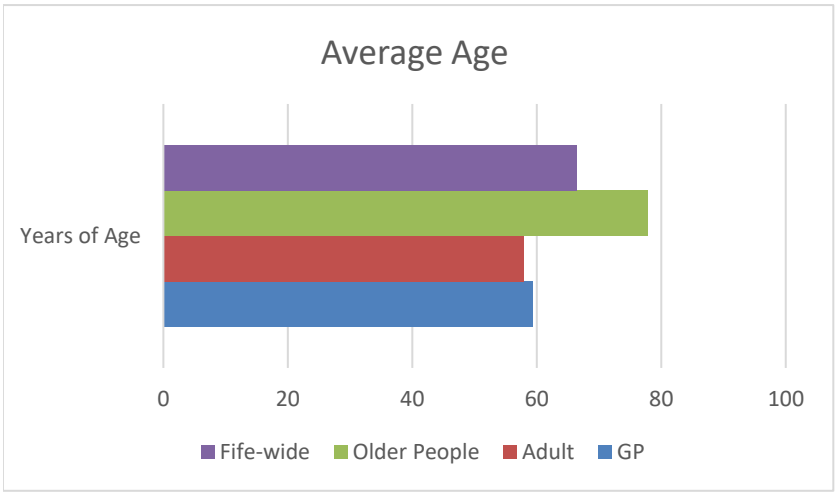
Medical Practice Mental Health Nurse

Gender & Age (Formal Referrals)



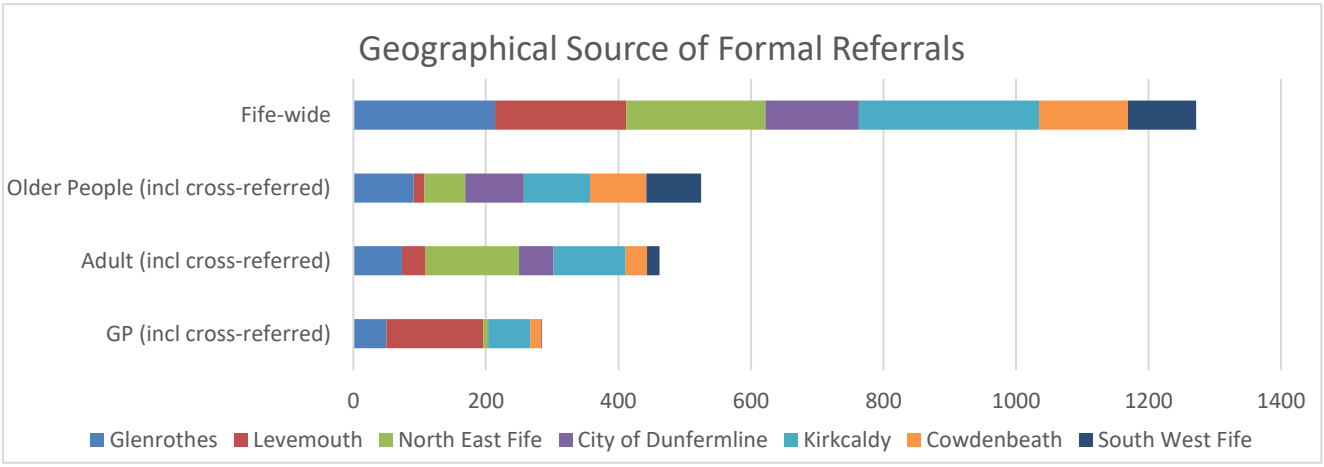
Fife-wide the ratio of male to female favour the latter (45:55) with 1 individual under 65 not identifying as male or female (2023: 2). The gender ratio is replicated across two service areas (Adult 46:54; Older People 40:60), however, within a GP Cluster context the ratio is almost evenly split (49:51).

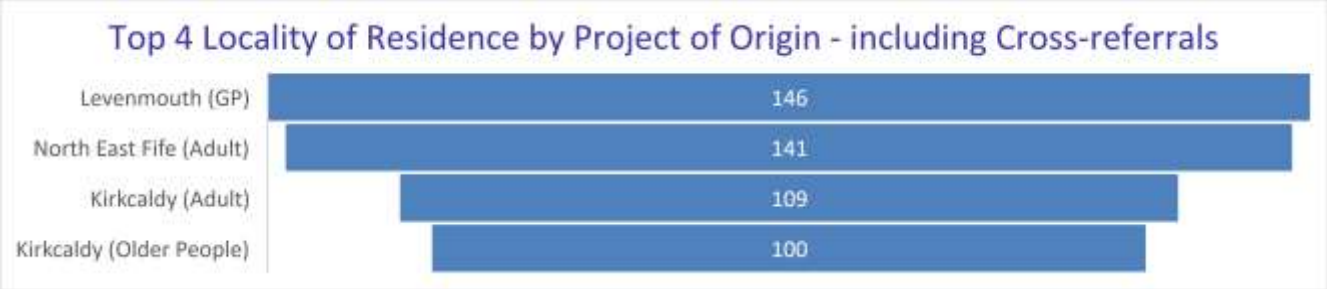
As should be expected given the age ranges served by each project area, average age varies with an age spectrum ranging from 16-100+ (GP 59.4; Adult 58.0; Older People 77.8). Fife-wide the average age of all formal referrals increased from 64.0 to 66.5 continuing a trend upwards. This is the fourth year where average age has risen after a period of declining average age having reached a low of 53.9 in 2020 during the Covid pandemic.



Geographical Areas (Formal Referrals)

For the period, the three localities where Fife's three largest settlements (Dunfermline, Kirkcaldy & Glenrothes) are located accounted for 627 or 49.3% of all formal referrals (previously 49.2%). Kirkcaldy locality accounted for 272 formal referrals followed by Glenrothes with 214. It should be noted the GP Cluster areas are located in four of the seven localities (Kirkcaldy, Glenrothes, Levenmouth & Cowdenbeath). Mid-table, North East Fife and Levenmouth were not significantly behind the main centres of population with 210 and 198 formal referrals respectively.

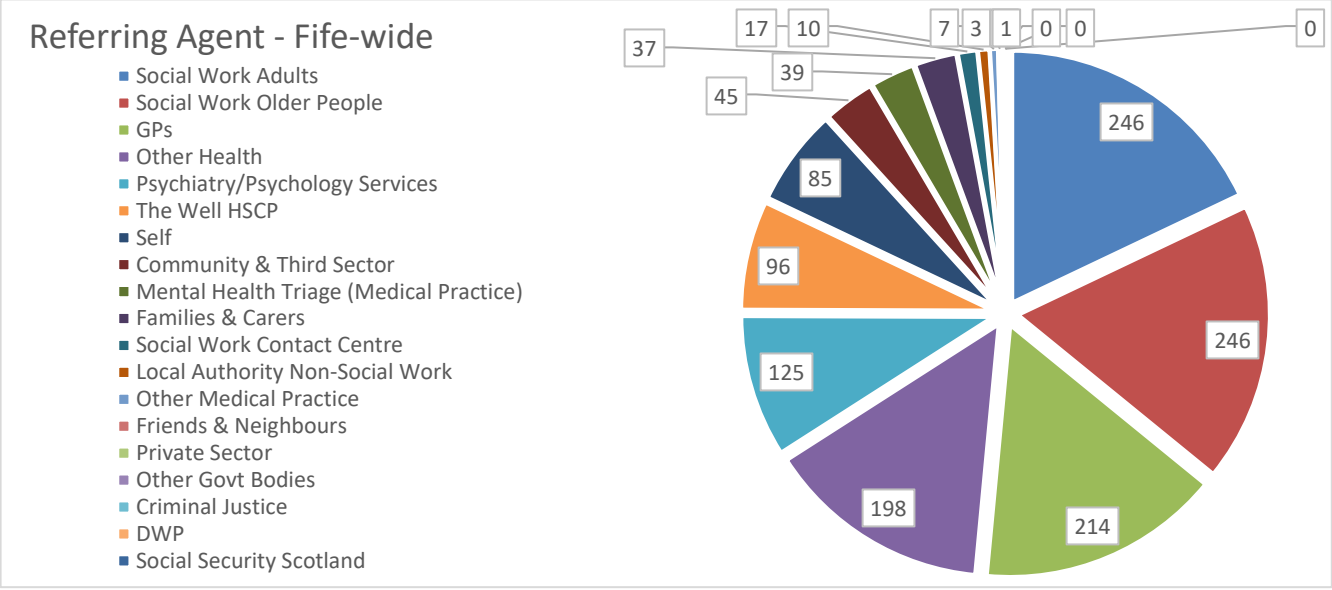




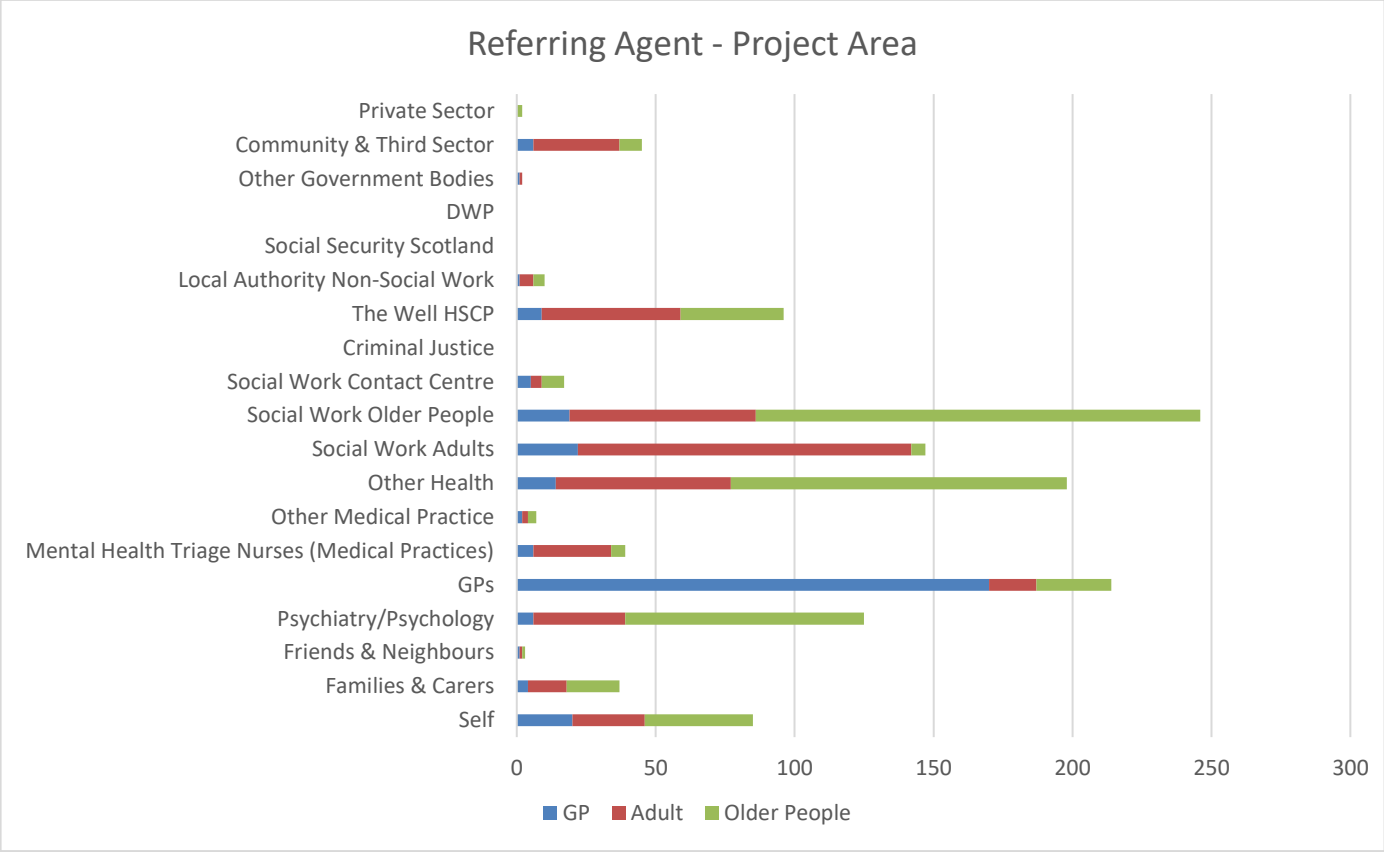
Formal Referral Source

For the period, the majority of referrals were sourced from both Health and Social Work & Care partners accounting for 78.1% of referrals made, lower than the previous year (81.1%). As should be expected owing to the GP Cluster service remit within 'GP Cluster Areas' this ranged from 85.6% overall to Older People at the lower end with 72.3% (Adult 79.0%).

In relation to primary referral sources; within a GP Cluster service context GPs accounted for 59.6% (2023: 42.7%) of formal referrals made followed by Social Work Adults Teams with 7.7%. Mental Health Triage Nurses decreased to 2.1% (2022: 26.2% & 2023: 2.4%). Regarding the Adult service area, Social Work Adult Teams accounted for 26.0% followed by Social Work Older People Teams (14.5%). Mental Health Triage Nurses increased to 6.1% (2022: 10.1% & 2023: 4.0%). Within the context of the Older People service area, the highest proportion of referrals were sourced from Social Work Older People Teams accounting for 33.1% of referrals made followed by Other Health (this includes Intermediate Care Teams & hospital-based professionals) at 23.0%. The number of 'open' referrals from non-organisational sources remains highest within the Older People project representing 11.2% (2023: 13.9%). Fife-wide open referrals account for 9.8% (2023: 7.7%) of all formal referrals received. 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 three referral sources Fife-wide are: Social Work Older People Teams 19.3%; GPs 16.8%; and, 'Other Health' (this includes Intermediate Care Teams & hospital-based professionals) 15.6%. Mental Health Triage Nurses which were the primary source of referrals during 2021, 4th during 2022, 10th 2023; rose slightly during 2024 to 9th of 19 sources (3.1%).



Incidence of Health Issues (Formal Referrals)

Among the 1,272 people formally referred, 1,255 reported a health and/or life affecting condition many with multiple issues (2,518 health incidences). Where a heath condition is reported there is on average 1.98 conditions per person (down from 2.11). This ranges from a high of 2.46 conditions per person (2023: 2.31) within an Older People context to a low of 1.91 (2023: 2.08) within an Adult context (GP Cluster 2024 – 2.03; 2023 – 1.96).

The two main health issues reported by people within each service area are:

GP Cluster

1. 184 'Other Physical/Neurological/Cardiovascular Conditions'
2. 121 'Other Mental Health Conditions' (this excludes depression)

Adult

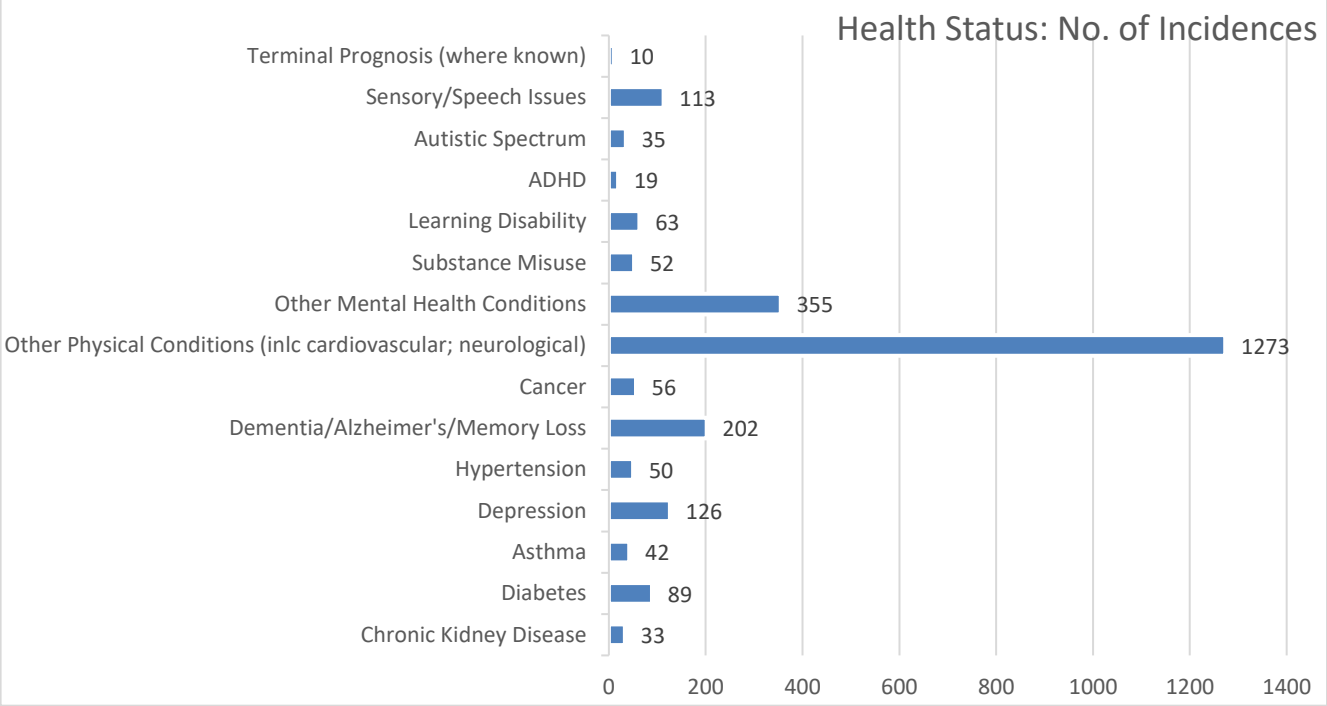
1. 364 'Other Physical/Neurological/Cardiovascular Conditions'
2. 144 'Other Mental Health Conditions' (this excludes depression)

Older People

1. 725 'Other Physical/Neurological/Cardiovascular Conditions'
2. 135 'Dementia/Alzheimer's/Memory Issues

Physical-linked conditions account for 61.7% conditions reported health incidences and the rate of mental health-related issues (excluding cognitive/memory issues) has both proportionally and in real terms continued to decrease from 39.7% (2021) to 31.1% (2022) to 26.8% (2023) to 19.1% (2024) of incidences reported (from 915 to 884 to 709 to 481 incidences). Depression accounts for 26.2% of reported mental health conditions. Reported incidences of cognitive decline (Alzheimer's/Dementia/Memory Loss) accounted for 8.0% (2024: 202) of all health incidences reported increasing from 7.1% (2023: 188 incidences).

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 & Internal/External Client Facing Activities)

The number of support hours undertaken with **formal referrals** totaled **3,356 hours 30 minutes** (Source - Project Areas non-realigned to referral type: GP 590 hours 35 minutes; Adult 1,497 hours 35 minutes; Older People 1,269 hours 20 minutes).

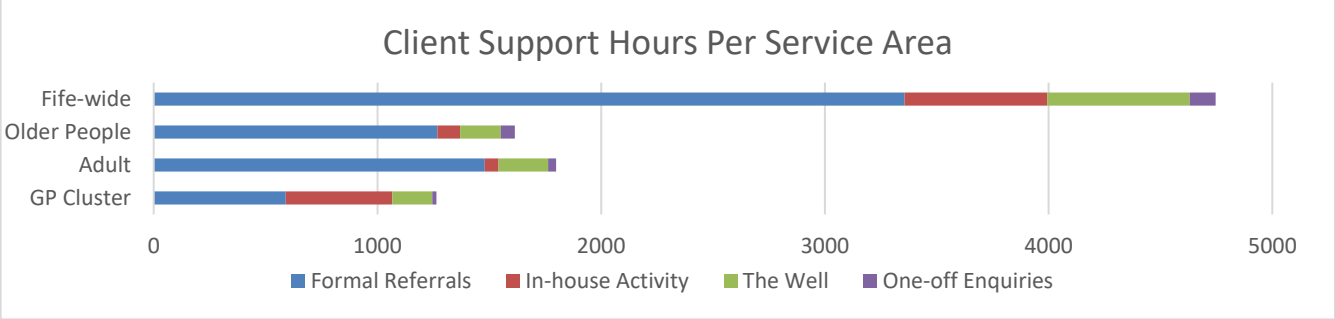
On average, in relation to all formal referrals, the **time spent per client contact was 36 minutes**; increasing from 29 minutes during the previous reporting period (Range - Project Areas aligned to referral type: GP 29 minutes; Adult 35 minutes; Older People 40 minutes). Following on from the pandemic and the previous year, this continues to reflect the mixed

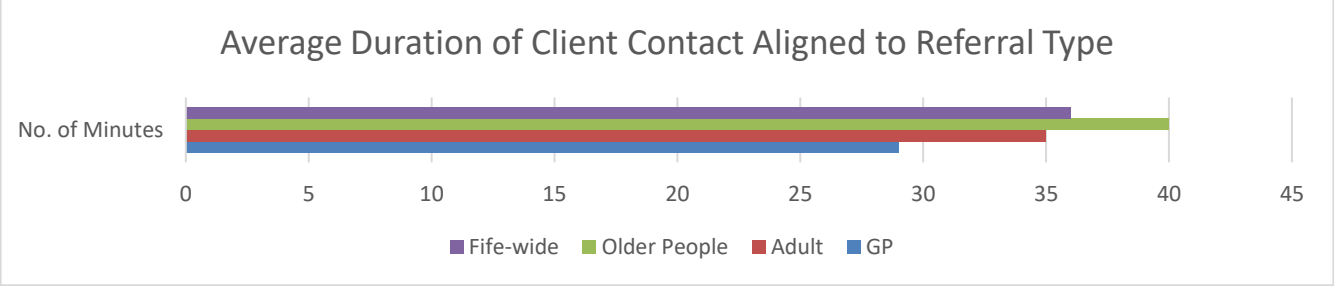
contact method approach being deployed helping maximise LAC time, rather than utilising home visiting alone; however, the increase might reflect the time required to assist with disability-linked benefits.

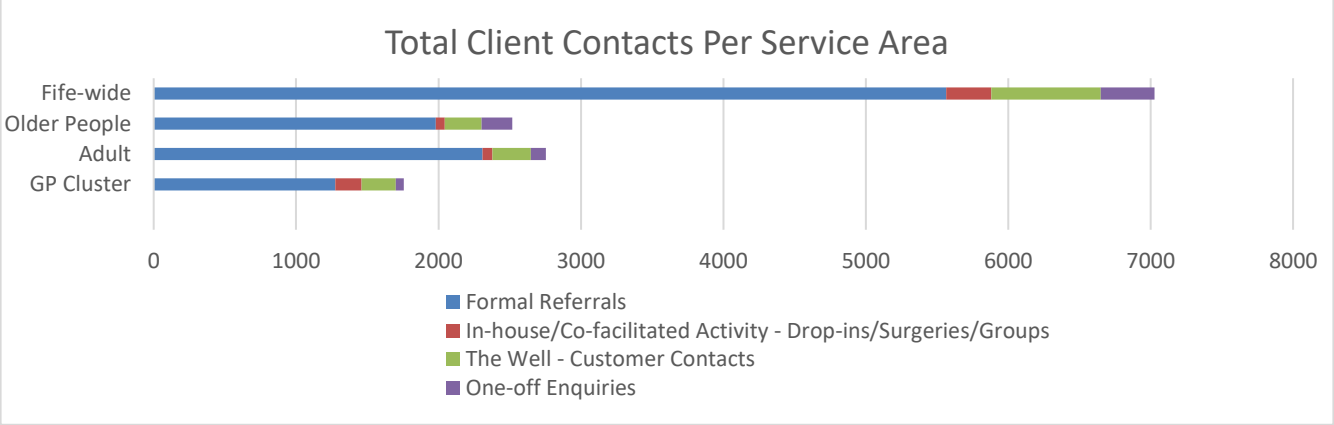
In-house client facing activity (including co-facilitated activity) in the form of groupwork, drop-ins and surgeries accounted for an additional **638 hours 30 minutes** of support work supporting 268 individual contacts. Additionally, one-off enquiries from both individuals and organisations (696 contacts) totaled **116 hours 35 minutes** of support work.

External client facing activity accounted for **635 hours 20 minutes** (2023: 682 hours 10 minutes) of staff time supporting **298 'Wells'** (2023: 307) providing 767 related customer contacts (2023: 657 customer contacts).

Overall the service delivered **4,746 hours 55 minutes** of direct support work deriving from **7,027 direct contacts with individuals**.



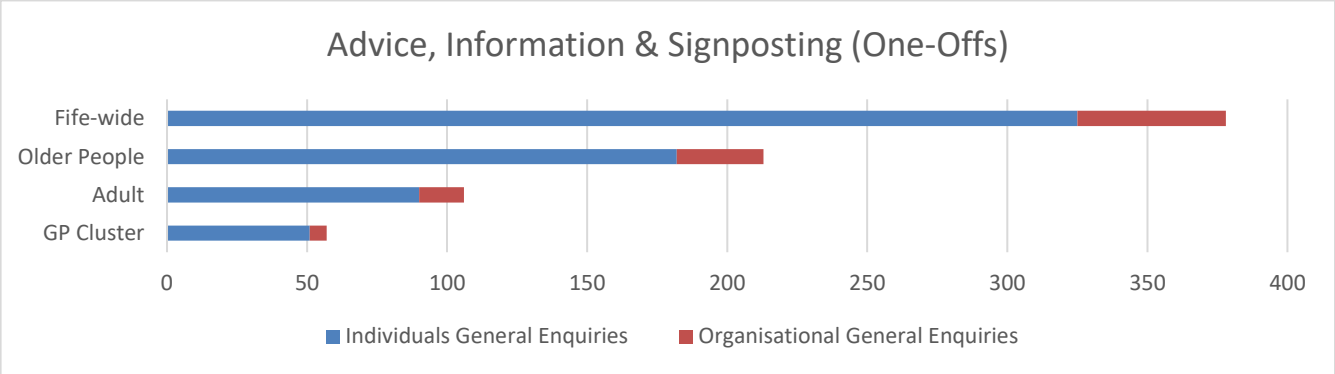


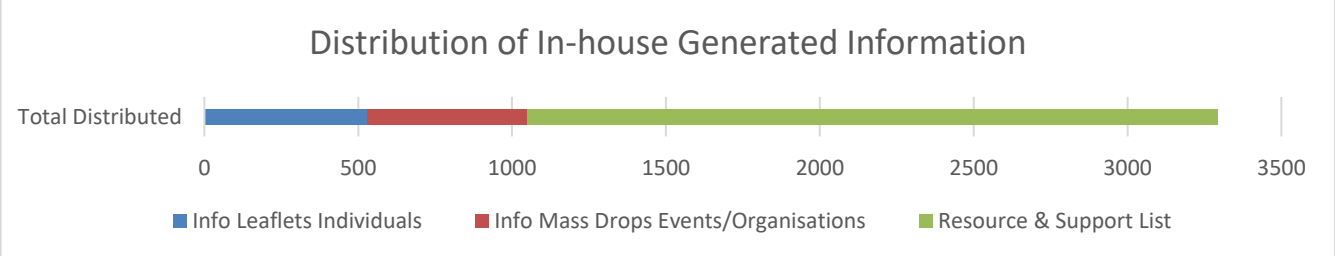


Guidance, Information & Signposting (One-Offs)

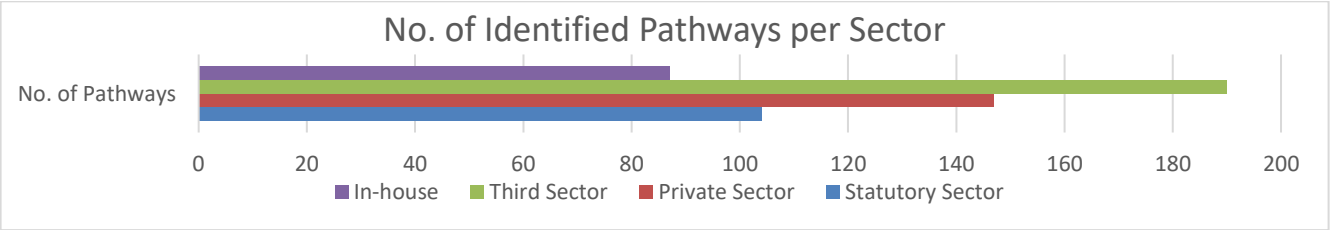
In addition to formal referrals and other client facing activities; the service offered guidance, information and signposting to both organisations and individuals. For **general activity**, this was offered to **325 individuals** and on **53 occasions to organisations** (Source - Per Project Area: GP 51/6; Adult 90/16; Older People 184/31).

The distribution of the in-house published Resource & Support List continued during 2024, however the regular distribution of this was hampered mid-year owing to IT-related issues. Nevertheless, this presented a **distribution total of 2,245 (**2,222 organisational & 23 individual members of the public**)**. The resource is also utilised within the context of formal referrals and was deployed for use on **137 occasions**. The resource continues to be updated and remains downloadable on the Fife Forum website.

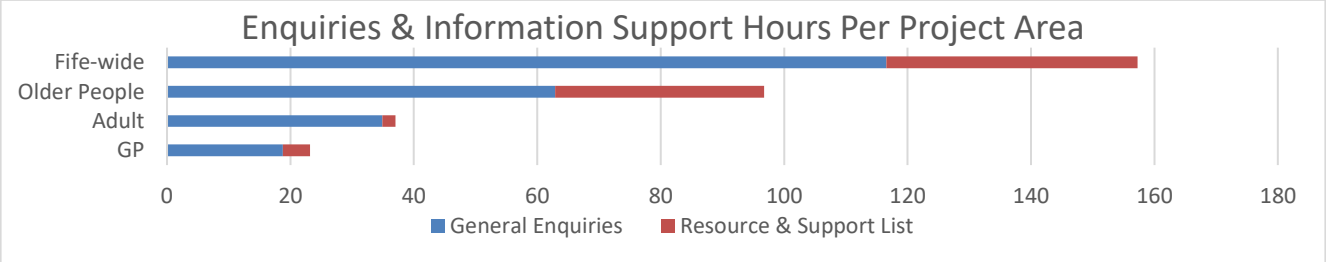




In relation to one-off enquiries there were **528 pathways** identified ranging from local interest groups to statutory and privately purchased provisions. Signposting to Third Sector/Community services was the most prevalent route equating to 43.1% of pathways identified and increasing to 52.5% when in-house pathways are included. This said, the most prevalent pathway signposted to is 'Privately Purchased Domestic Supports' (15.2% of sector related pathways). In addition to this, 33.3% of pathways could reasonably be assumed to have a social element/intent to them.



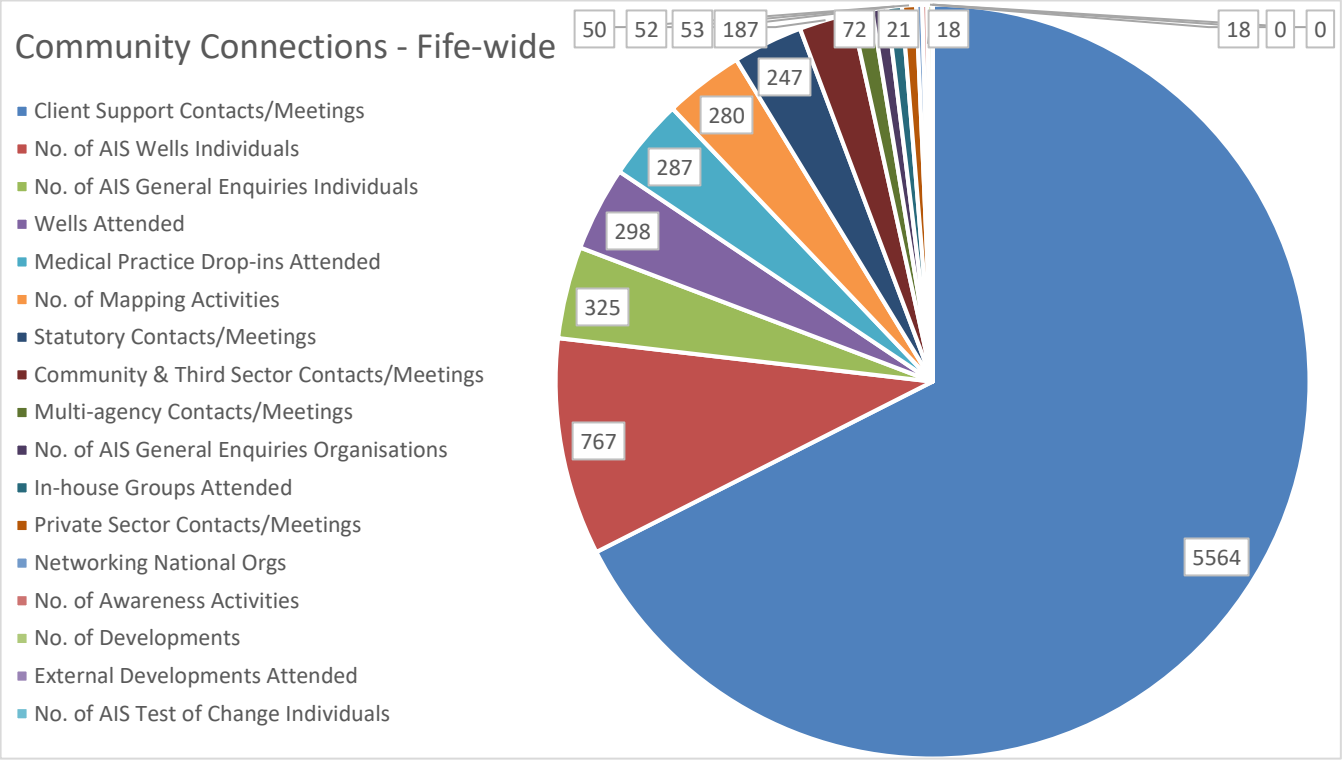
In total, **116 hours 35 minutes** of staff time was dedicated to one-off support and signposting (Source – Per Project Area: GP 18 hours 45 minutes; Adult 34 hours 55 minutes; Older People 62 hours 55 minutes); alongside **40 hours 40 minutes** of staff time directed towards supporting the development and distribution of the Resource & Support List.



Community Connections

The service remains committed to establishing, developing and maintaining connections with service providers and individuals throughout Fife. For the period the number of Community Connections undertaken with individuals, community groups and organisations reached **8,239** (this includes: site visits; awareness raising events; instances of advice, information and signposting; development activity; and, client related contacts).

Direct client/individual-related connections account for 81.4% of the overall total reflecting the concentration on client-centred activity. Direct contact with formal referrals alone accounted for 67.5% of the total with **5,564 client contacts** made.



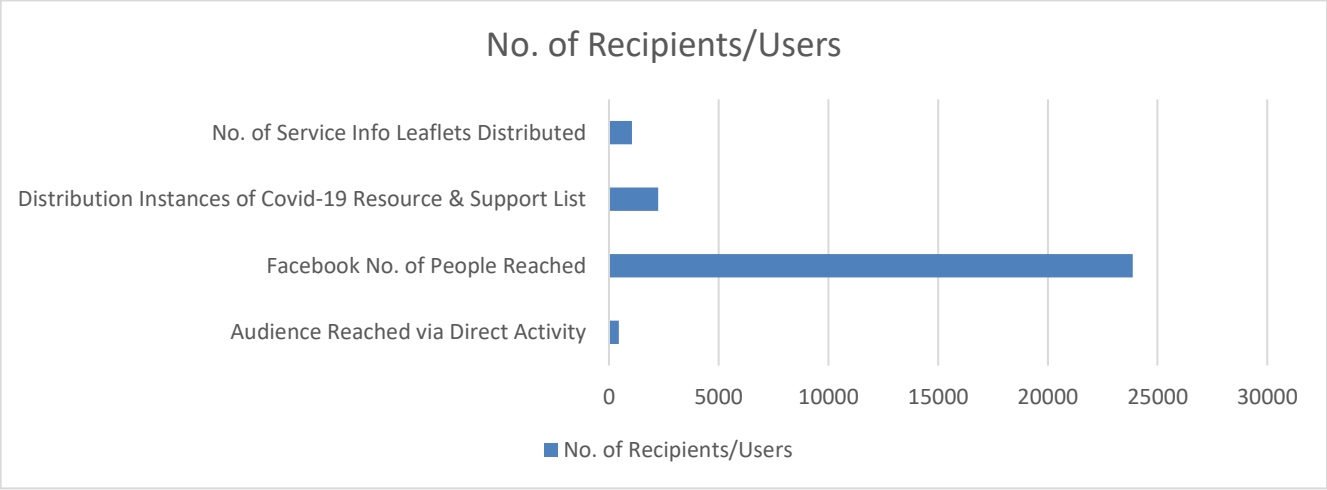
Awareness Raising

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 18 occasions (2023: 21) reaching an audience of 452 people (2023: 289).

"Thank you so much for sending me the updated Resource & Support List… I can't thank you enough as I found it very helpful".
DWP Home Visiting Service

The service and parent body (Fife Forum) continued to raise awareness of internal and external provisions via other methods such as Facebook (reach increased 350.0%) and via the direct distribution of the 'Resource & Support List' (2,245 instances). Additionally, the service distributed 1,048 articles of internal service literature.

"I just wanted to say a massive thank you to you & the team for coming along to our Autumn Gathering on Friday & hosting a stall. It was great to have Fife Forum there. The feedback from customers was really positive & we are so grateful for everything you contributed to the day. Hopefully we can work together again in the future at other events!".
Customer Engagement Officer, Kingdom HA



Development & Co-facilitation

Development activity continued during the reporting period, including extending the development of the previous year's activity. This included:

"I also received my post today & the bus pass is in it 🎉🎉🎉 just in time lol means I can go to pride this weekend too Yay. Thank you again for sorting that out".
Service Recipient, GP Cluster Glenrothes

- **In-house Groups –** The service withdrew from active engagement as the groups became self-sustaining.
- **Drop-ins, Surgeries & Recovery Café –** The GP LAC project continued to roll out area specific 'Surgery Drop-ins' in partnership with the relevant health stakeholders; in addition to this, the Adult LAC project worked alongside existing partners to further develop and facilitate community-centred drop-ins and a Recovery Café within Stratheden Hospital
- **National Entitlement Card NCT002 Mental Health –** Linked to our Local Area Co-ordinator (GP Cluster Glenrothes) this service area can provide a signatory for the scheme. For those impacted by Mental Health issues and whom require the travel card to attend appointments and/or their mental health treatment plan this can contribute positively to mental health. It offers a sense of autonomy and control crucial for self-esteem and confidence. The freedom to travel facilitates social connections, allowing individuals to engage with their community, access support networks and participate in activities that bring joy and fulfilment. Moreover, independent mobility can reduce feelings of isolation and dependency which are often linked to depression and anxiety. Our ability to support access to transportation helps empower individuals to lead more engaged and fulfilling lives, contributing to overall mental well-being.
- **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 Older People service area.
- **Board Membership –** The service was represented on the Boards of one charitable organisation (Express Group Fife).
- **The Wells (Fife Health & Social Care Partnership) –** The service continued to engage with partners to help steer and deliver information points throughout Fife.

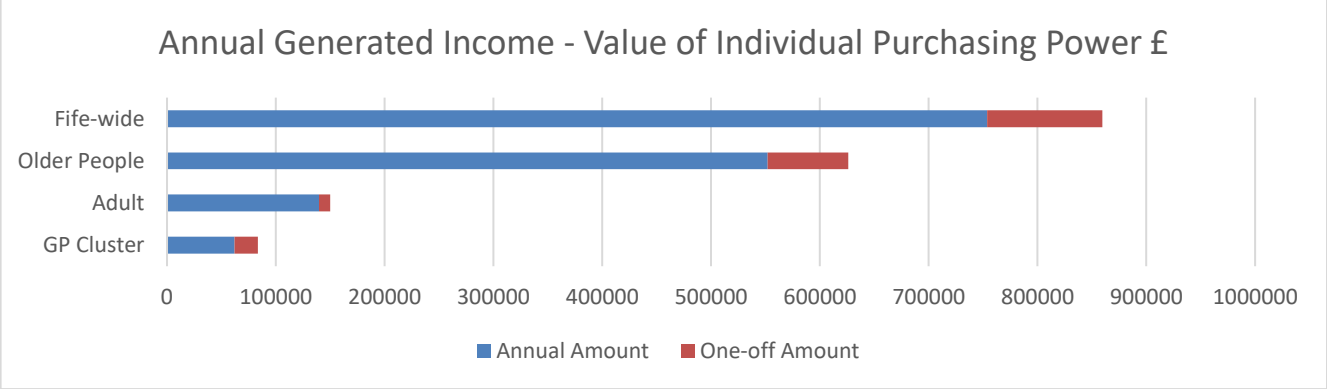
Income Generation

The service remains committed, alongside partner agencies, to help maximise 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 and/or practicable. When supported by the service to do this there is a high success rate for applicants.

"I initially applied for PIP but was refused & I never appealed. Your agent (XXXX) was very helpful & was able to get me the support I needed. Thanks".
Service Recipient

"I was overwhelmed with the support on offer. We were put in touch with your service by XXXX one of the hospital (QM) mental health nurses. Such an amazing service which I am sure helped us to receive Attendance Allowance".
Service Recipient

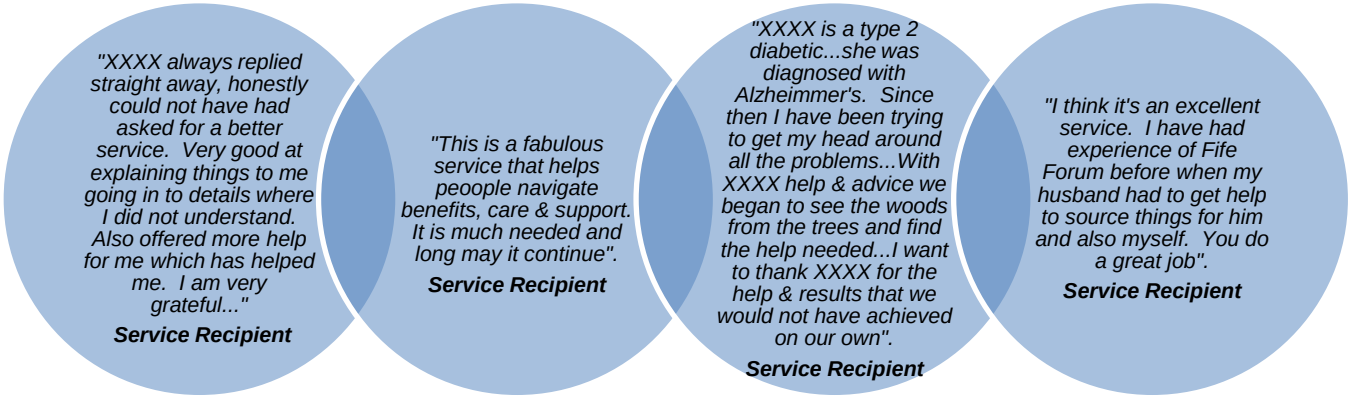
During the year income maximisation continued to remain apparent as an identified need resulting in a significant increase in income generated for our client group by the service. In addition to one-off payments secured for service recipients, the service helped to generate income of **£859,632.69** equating to an ongoing amount of **£753,739.99 per annum**. This surpasses the previous year by a significant margin (2023: £461,028.25 per annum) and over the course of the last three years has increased by **an incredible 536%** (2021: £118,510.84 per annum). This adds both individual and wider socio-economic value adding as it does to individual purchasing power and the wider Fife economy. In a similar vein, this more than matches pound for pound the funding Fife Forum received from the Fife Health & Social Care Partnership. The most prevalent benefit application supported was for Attendance Allowance (Older People).



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.

Feedback

To help measure the impact of the service a client/carer consultation survey is deployed. During the reporting period the service continued to survey closed client cases during the course of the year attempting to capture a depth of qualitative finding. Additionally, e surveys were deployed, however, when deployed the return rate for this has been extremely low. The feedback received remains overwhelmingly positive and is consistent with previous years.

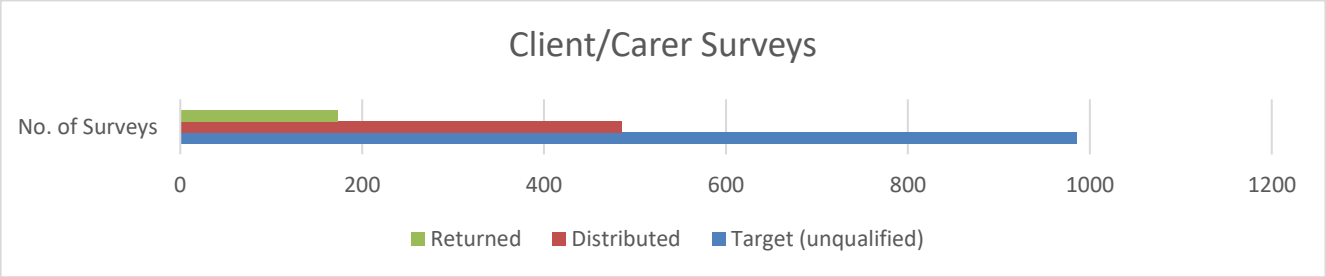


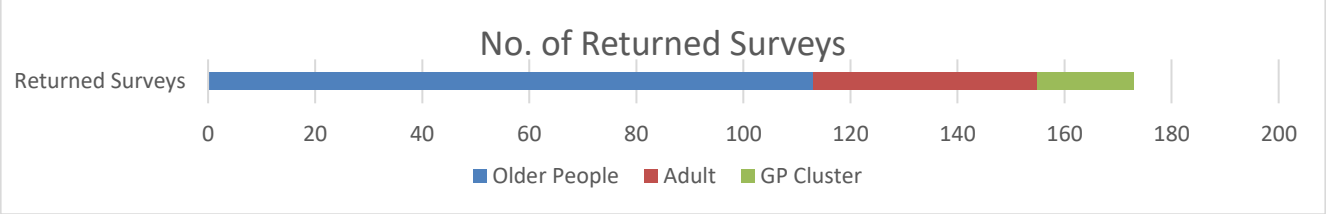
Within the context of open responses, it continues to be worth noting service recipients allude to the approach of each Local Area Co-ordinator; and, in particular, their swift response, their adoption of meaningful conversation, and their ability to build appropriate relationships. This, as with previous 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.

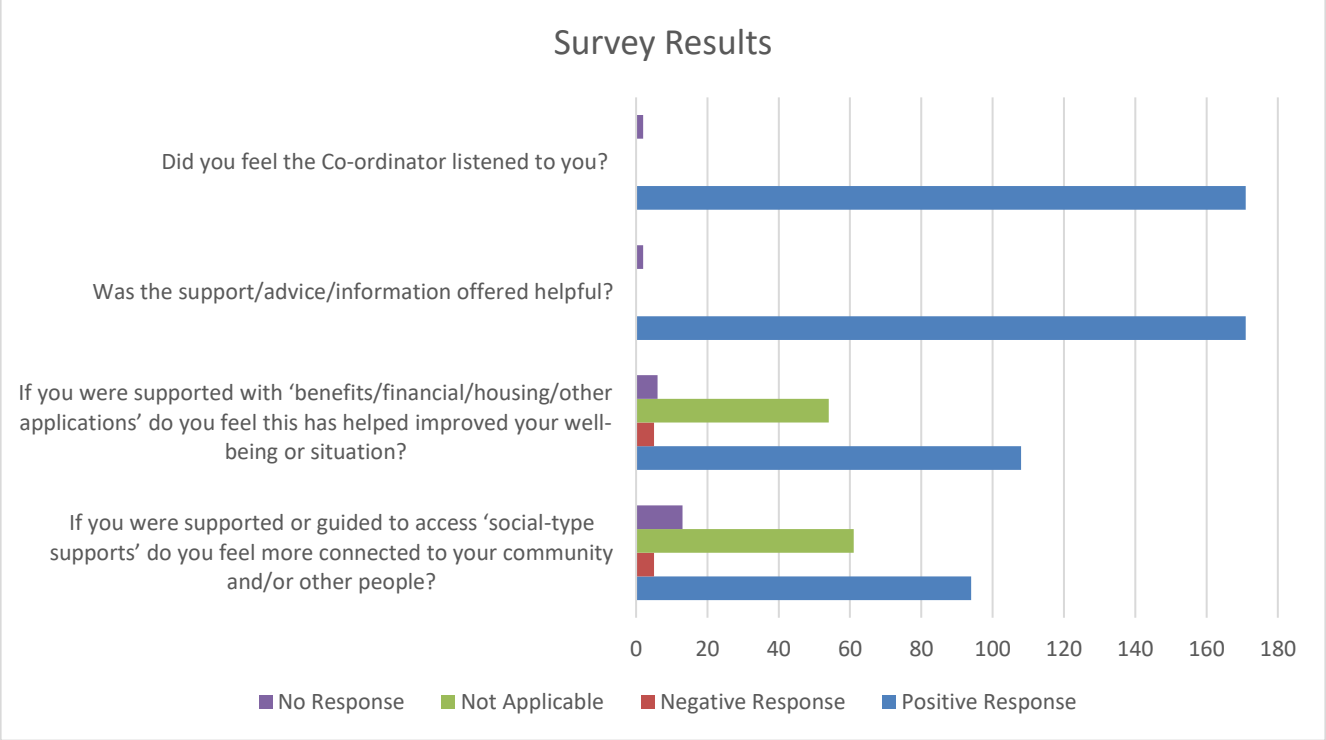
Where repeat key words are extrapolated from open responses common themes appear to be suggested and the language presented mirrors previously recorded feedback, this being the 'humanistic' approach deployed by the service; the 'motivational' aspect which helps facilitate engagement; and, the 'informational' role provided by a professional framework which aims to support and increase personal knowledge and engagement. In total 133 open responses were received in relation to the request 'Please share any further thoughts you may have regarding our service' which informed this. It is also worth noting the same words/themes emerged throughout all survey questions where each provided scope for additional comments.

The unqualified target distribution of surveys for this reporting year was 986 this being the number of closed cases excluding those where there was non-engagement and the number of surveys issued during the final two weeks of reporting (it should be noted the target is not fully qualified as it includes individuals who could not be reached at the point of closure – this would include deceased individuals; and, individuals who no longer had capacity). A **survey return rate of 37.4%** was recorded (2023: 31.4%) - Range: GP Cluster 2024 21.7% v 2023 28.0%; Adult 2024 26.4% v 2023 11.6%; Older People 2024 53.3% v 2023 47.4%. This is an overall improvement compared to the previous year aside from the GP Cluster service area.

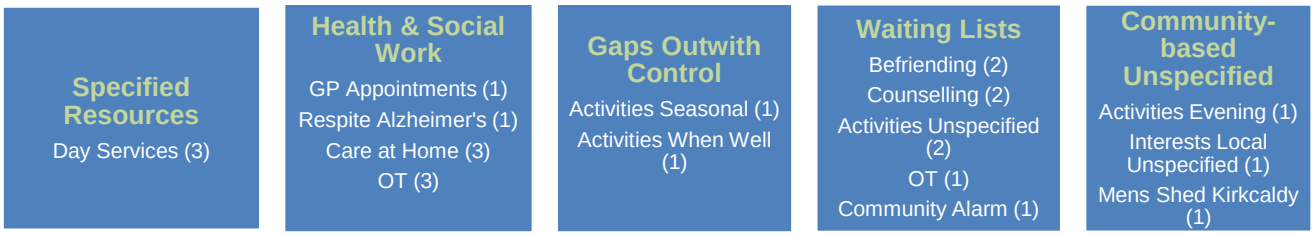
The manner in which we monitor our work is reviewed annually as we seek to improve our methods of capturing qualitative feedback and, as a result, the method deployed to systematically survey closed cases will be centralised to better monitor and support this.





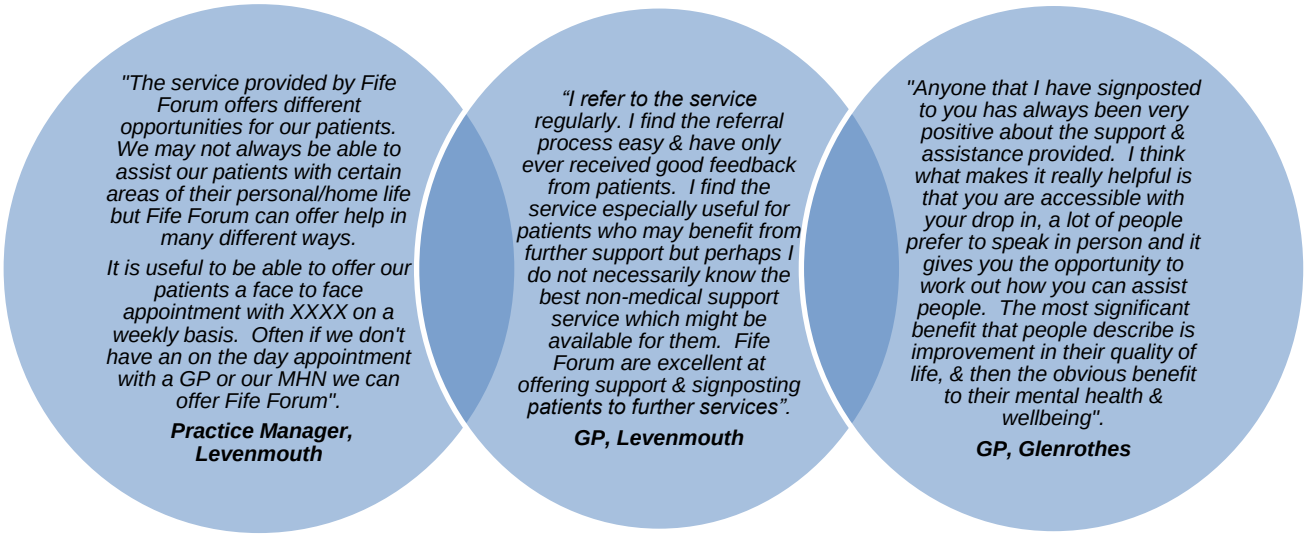


If what you were looking for was not available or you are having to wait for a service provision, please detail what gaps in provision are missing (**24 from 173 Responses Received**)



Where gaps in service provision were alluded to it would be fair to surmise most related to waiting periods for provision or issues regarding access. Anecdotally, this is supported by verbal feedback received by Local Area Co-ordinators during the course of their client contacts. This said, in isolation, there is insuffient evidence to suggest any trend based on the limited data presented.

In relation to **Primary Care Feedback** please note the additional practitioner comments supporting the benefits of Local Area Co-ordination as a resource which supports a holistic approach to health care helping to address non-clinical issues and in turn reduce the need for clinical intervention:



The feedback received from health professionals is reflected in the comments of service recipients whom were formally referred by a Primary Health source. The following is one comment received:

> *"I do not think I would have found the help I needed without XXXX support. We discussed in depth previous counselling and courses I had attended, she helped me make my own decisions on what I needed help with. She checked on me regularly and I was confident I could reach out to her at any time for support or guidance".*
>
> ***Service Recipient, GP Cluster Area Kirkcaldy***

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 75 such surveys were carried out (25 per project area). The 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:

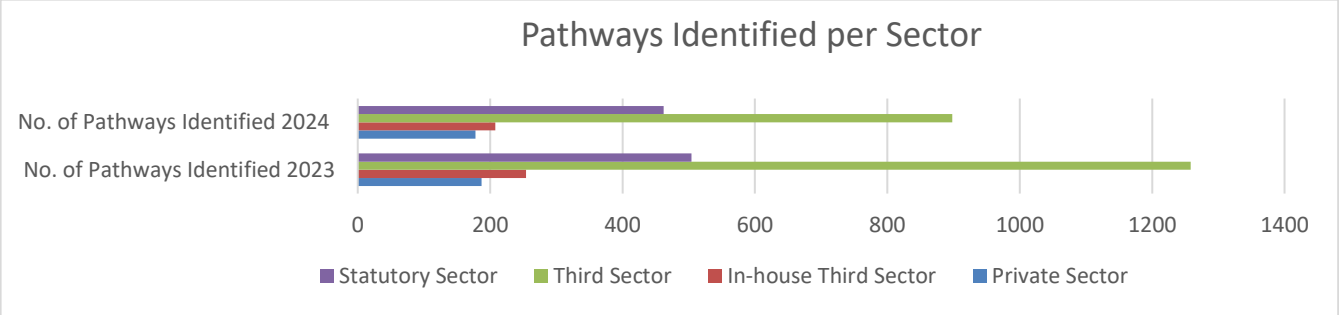
- They might choose not to pursue a particular pathway as a matter of their own personal choice
- They might not meet the expressed criteria of the service they hope to access
- The service referred to might not be equipped to assist (skill, capacity or resource issues)
- The service closed their waiting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

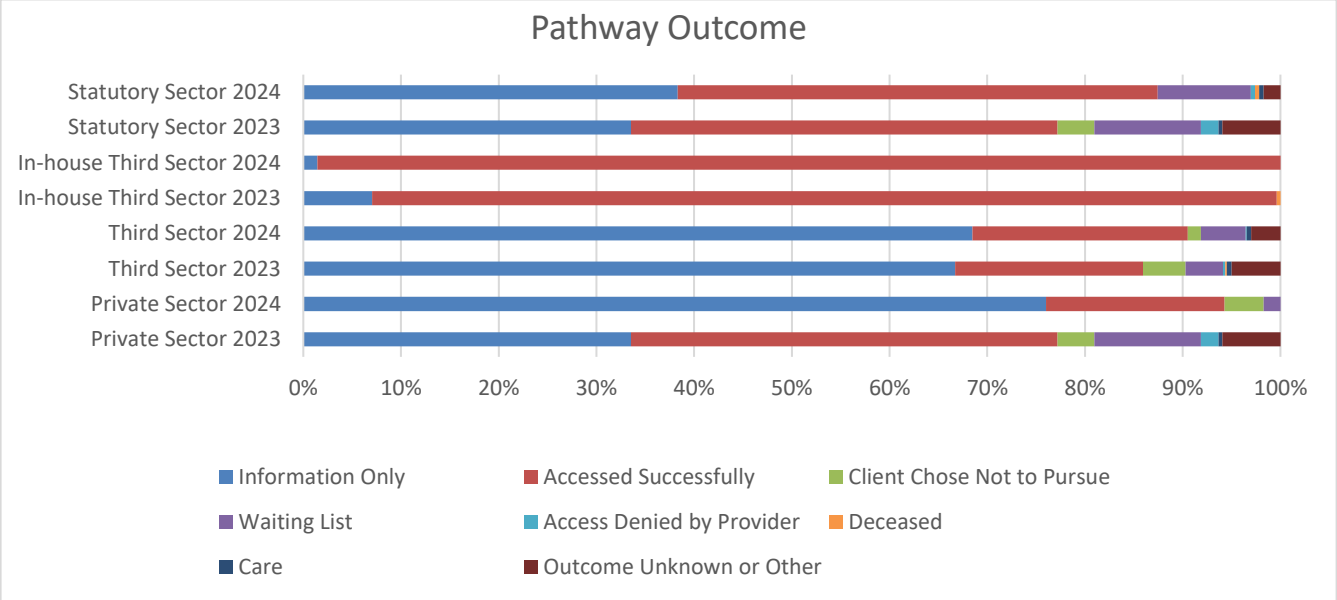
It is hoped by providing information relating to pathways for formal referrals it will help to reflect in part:

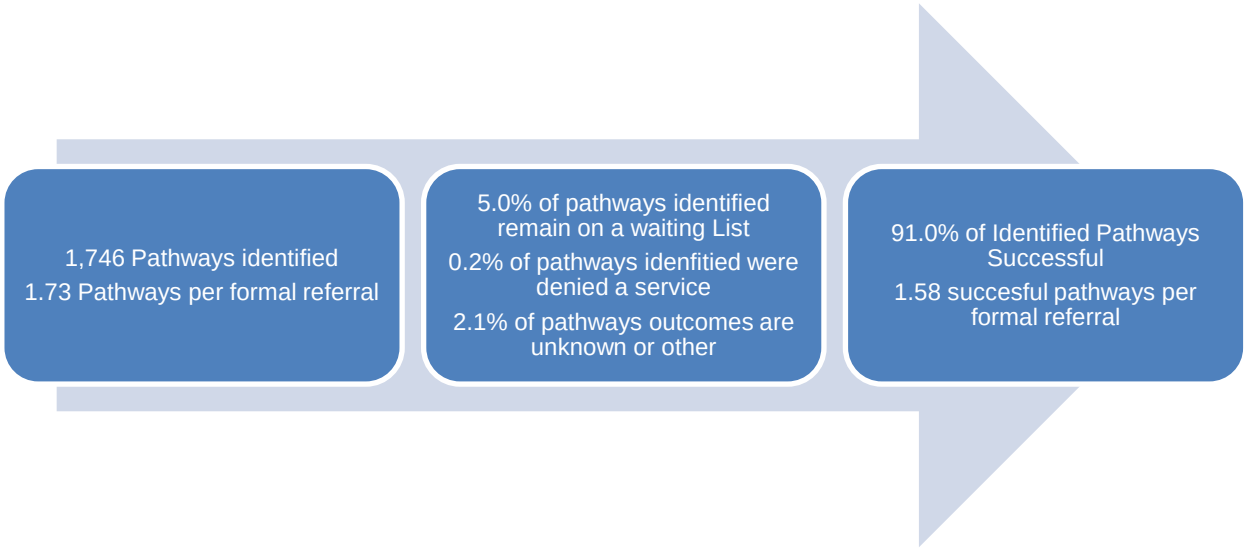
- Client outcomes
- Demand for service-type
- Gaps in provision

A total of 1,746 (2023: 2,219) pathways were identified and by the year end 37.9% (2023: 33.3%) or 662 incidences of all pathway outcomes were successful in that access to routed provision was directly facilitated. This rises to 91.1% (2023: 86.3%) where the pathway route was intended/requested as 'Information Only'. Of the pathways identified: 63.3% (2023: 68.9%) are attributed to the Third Sector; 26.5% (2023: 22.7%) Statutory Sector; and, 10.2% (2023: 8.4%) Private Sector.

The data for the period is as follows:

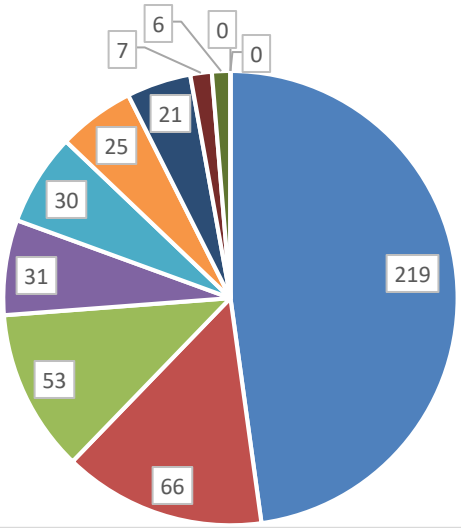






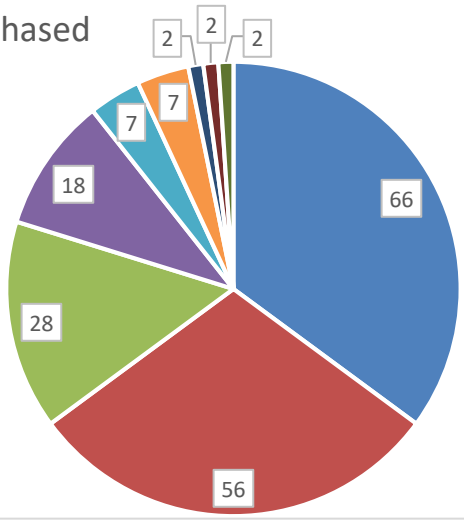
Pathways Identified: Statutory/Public Sector

- Dept of Works & Pensions
- Other Council Services
- Social Security Scotland
- Council Transport
- Blue Badge/Disability Parking Bay
- Social Work & Social Care
- Housing
- Health
- Other Government Bodies (ie DVLA; elected Reps)
- HSCP Well
- Education



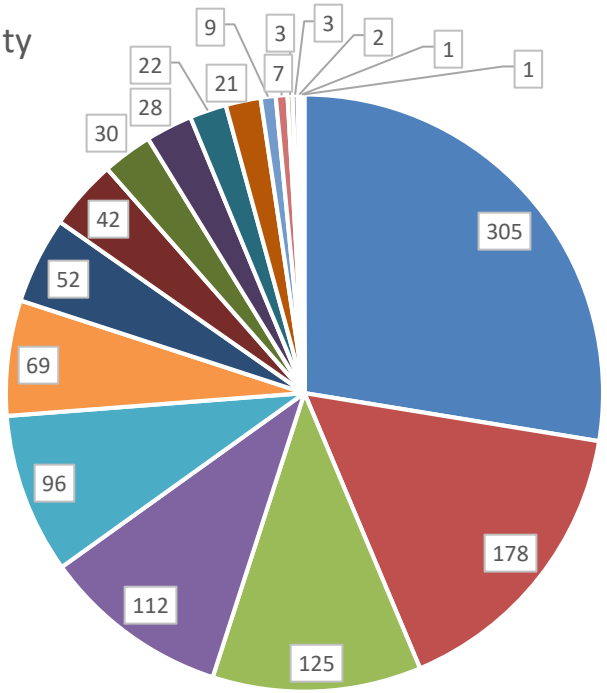
Pathways Identified: Private Sector/Privately Purchased

- Private Domestic Support
- Shopping Services
- Purchased Companionship
- Privately Purchased Care
- Personal Services (ie Hairdresser)
- Private Transport (ie Taxi; Public Transport)
- Tradespeople
- Commercially-driven Exercise (ie Private Gyms)



Pathways Identified: Third Sector/Community

- General Community & Social Groups
- In-house Representation (Paperwork &/or Rep Role)
- Befriending/Buddying/Mentoring
- Peer Support Groups
- Specialist Supports (ie Dementia)
- Interest Groups
- Advice & Info Services (inlc Helplines)
- Community-driven Exercise (ie Fife Sports & Leisure)
- Day Services
- Volunteering
- In-house Listening Ear (Primary Need)
- Carer Supports
- Learning & Training
- Advocacy
- In-house Advocacy
- In-house Group
- Volunteeer Transport
- In-house Welfare Check
- In-house LAC



Within the context of all sector pathways it could reasonably be assumed that 50.9% had a social motivation for signposting to this (this is likely to be higher if secondary motivations are considered).

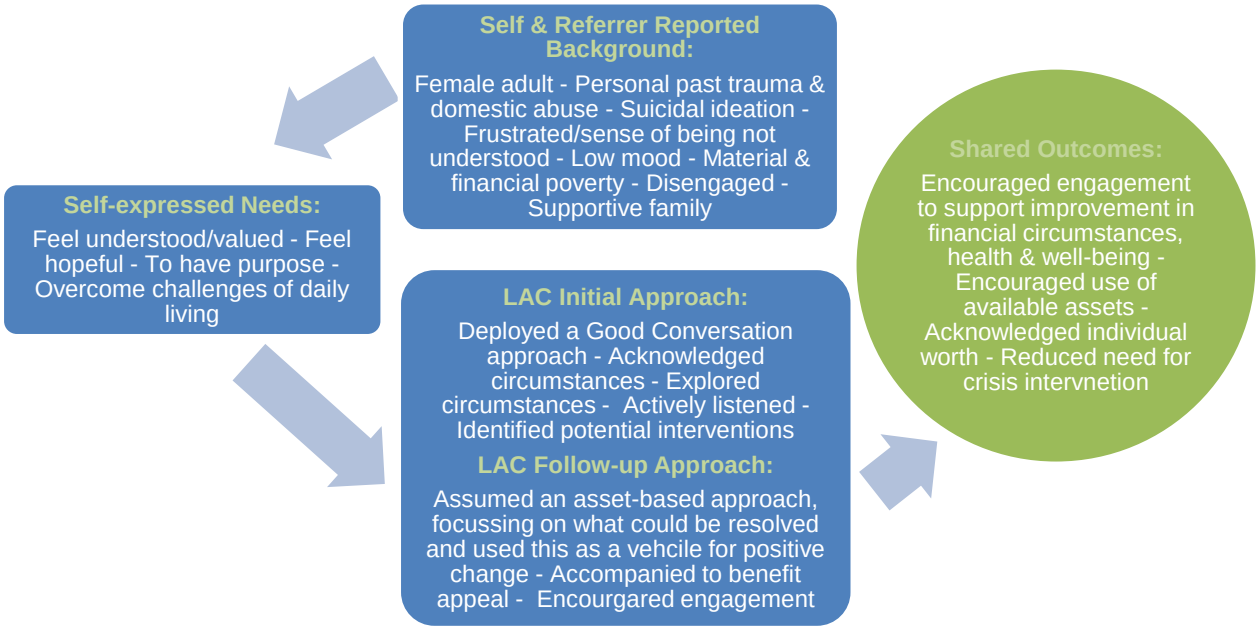
Within a Statutory context, there continued to be an increase in pathways connected to income maximisation/benefit uptake (from 201 to 272) indicative of the wider economic crisis and its impact. When assistance given to those seeking support with a Blue Badge and/or Parking Bay application is included, 65.4% of all pathways to statutory supports required minimal input from the statutory partners other than assessing the applications 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 5 case studies were completed in relation to Formal Referrals. For the purpose of reporting 2 case studies are presented.

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 1



Synopsis

Client X found herself to be in a challenging period following the end of a previously traumatic relationship. Still recovering from this, X reported to be struggling with life believing no one

could understand her, her behaviour or her low mood. Whilst she reported to have a supportive extended family she believed there was little value left in her life to the point where she believed life was no longer worth living. She believed she could not move on from her past circumstances. X presented to her GP and as an extension to the clinical role was encouraged to meet with a Local Area Co-ordinator on site at the Medical Practice. Although apprehensive, X agreed to this and an appointment was booked to meet with a Local Area Co-ordinator. X took the initial step by turning up for the appointment.

By adopting a Good Conversation approach and offering X time to explore her situation without prejudging her circumstances, X was afforded space and time to convey the depth of her past trauma and how she felt she was the only person to understand this and the impact this has had on her overall mental health, feeling alone and isolated in this. During the course of the initial conversation X shared her past history and went on to convey other trigger factors which were contributing to her deteriorating mental health. By encouraging a shared approach with X to identify what could be supported more immediately an initial pathway was agreed with a view to promoting a degree of optimism which hoped to promote a sense of moving forward.

In relation to her trauma and low mood X was supported to access both community-led specialised supports and was encouraged to reconnect with and make use of her existing assets, encouraging her not to lose sight of these (the support of her family network and professional mental health support). This, part reminder, was to reflect the notion she had assets upon which she could utilise helping to dissipate her sense of hopelessness in the moment. Beyond this, a pathway forward was agreed in relation to other life factors which were adversely impacting her circumstances but which could be actioned with support. Financial and material poverty were significant factors which added to her sense of hopelessness and by helping to identify this the Local Area Co-ordinator was enabled to in turn identify potential pathways which offered hope and, with progression, resolve. This included support to access and obtain essential white goods and a benefits check, alongside more practical support to appeal a recently refused claim for Adult Disability Payment. In relation to the latter, it was evident without support X would not appeal the decision disallowing benefit claim and, thus, the local Area Co-ordinator was able to offer both encouragement and a practical presence which would facilitate this via the appeal process. Although some of these issues could not be resolved immediately, what it achieved was the beginnings of an agreed pathway which might support change, encouraging personal resilience by promoting forward momentum.

By focussing on more immediately resolvable issues and by facilitating follow-up contact the Local Area Co-ordinator was able to support X to overcome some perceived challenges (financial and material poverty) which improved daily living and offered X hope. This coupled with X making use of her existing available assets afforded her a sense that she was managing daily life better, allowing her to better address her own thoughts, feelings and self-worth.

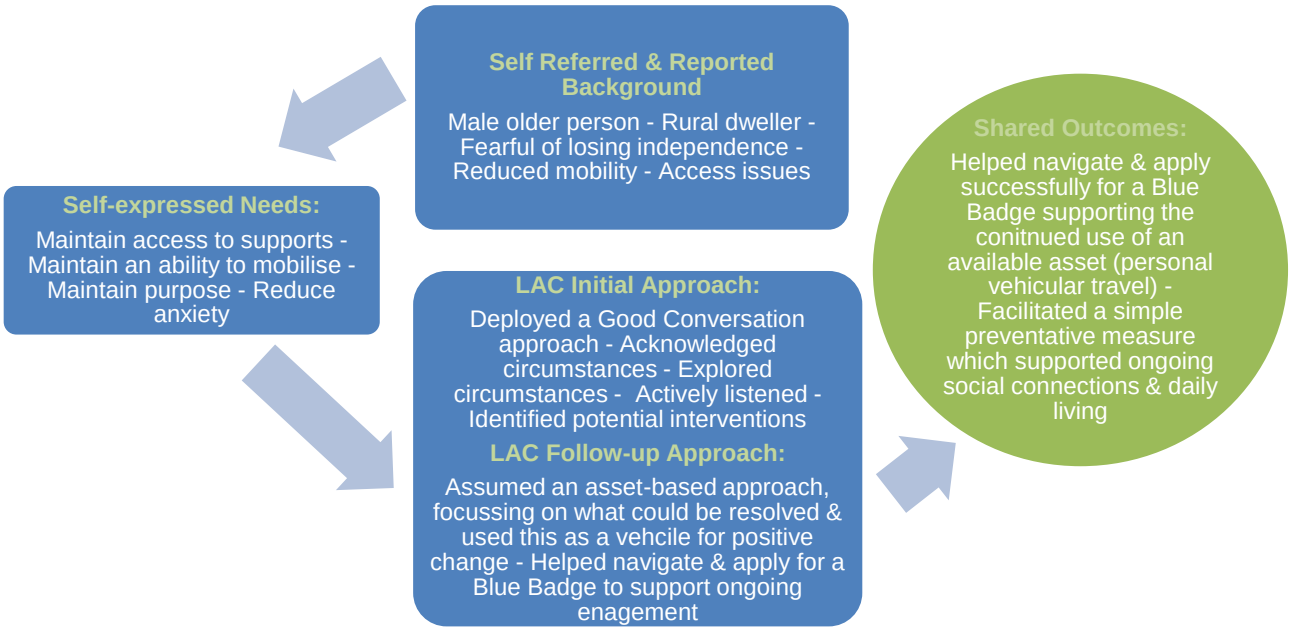
In summary, through a Good Conversation approach, empathy, time and encouragement an immediate crisis was averted and key outcomes were achieved for all parties concerned. Building trust was cornerstone to this and ultimately allowed X to reassert a level of self-control

over her circumstances, accepting and asking for support when required including doing so via less clinical methods.

This synopsis is best reflected in the statement made by X herself:

"I feel more in control of my life and I feel with continued support I will get to a level that I am comfortable with. The support has been invaluable and I hope more people can get the support & understanding I did".

Formal Referral Case Study 2



Synopsis

X self-referred to the service. He is is an older gentleman living alone in a rural community with a limited support network. X has reduced mobility following multiple knee and hip operations and replacements resulting in ongoing pain. X believed his ability to remain independent out with the home was much reduced and although able to drive he believed this was becoming impossible as he could no longer adequately reach his intended destinations when travelling as he struggled to park near to venues. X did not feel able to apply for a Blue Badge as he could not cope completing the application process and as a result felt destined to give up driving, however, a neighbour recommended he contact Fife Forum.

Adopting a Good Conversation approach, initially by telephone and then with a follow-up home visit, it became apparent to the Local Area Co-ordinator that X remained able to drive and had access to others whom could assist him with travel and that the barrier presenting was the simple inability to reach any intended destination within a reasonable distance from parking. The anxiety this caused X was becoming prohibitive to the point he believed he could no longer drive which would greatly reduce his already limited network. Identifying that the asset of

remaining able and medically fit to drive could be supported with a Blue Badge application was presented as a simple measure which could be supported by the service.

In addition to assisting with a Blue Badge application, adopting a holistic approach, the Local Area Co-ordinator sought to ascertain if there were any other social or practical supports required. X indicated he already accessed other preventative and practical supports such as domestic assistance and meal-on-wheels. It was also apparent that if X was supported to remain mobile this would help to stem social isolation and reduce the need for provisions which already struggle to meet demand such as befriending for those whom are unable to access community-centred supported. Private vehicular travel allowed X to remain connected to the wider community and his already limited rural social network. It would also allow him to utilise the vehicles of those with whom he has contact, which again supported the retention of his social network.

Post the initial home visit, the Local Area Co-ordinator maintained contact with X via telephone until the Blue Badge application was successfully awarded within a 9-week time frame. X was then made aware the service could support the possibility of applying for a Disabled Parking Bay as he often struggled to find parking close to his home. X advised he would re-establish contact in the new year to consider this.

In summary, key shared outcomes were achieved. Through a simple measure X was supported to retain his independence and social network, delaying and potentially preventing the need for ongoing service-orientated interventions. X has reduced anxiety and reports an improvement in his well-being as a result of the service supporting him.

This synopsis is best reflected in the statement made by X himself:

"Having been awarded with a Blue Badge I have managed to maintain a good level of independence. I no longer worry about not getting parked close to shops or for health appointments. I now go to places of enjoyment. Even if I am going out with a friend in their car, I take my Blue Badge so I can park closer to entrances. This has filled me with a large sense of relief as walking for even short distances causes a lot of pain and discomfort. I feel relieved and my anxiety when trying to find a parking space has decreased. Having someone to help me with my application was excellent. I have managed to go to appointments and shops on my own which was a main goal for me, without my Blue Badge I don't think I could have done this for much longer".

Learning

Not unlike recent years, the ongoing cost of living crisis has left a legacy and presented many challenges for individuals and organisations alike; and, Fife Forum, 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 previously reported this is not without persisting challenges such as:

- Remaining competitive in relation to retaining and recruiting staff
- Adapting to change and the enduring economic and societal pressures
- Providing more with less

These challenges are not atypical and remained for both individuals and organisation alike. This said, each team member and the newly formed management team have collectively sought to address this and effectively deliver what remains an invaluable service with every staff member engaged by the service continuing to step up to ensure continuity of service.

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 in line with our service requirements

It is hoped this will support the ongoing endurance, effectiveness and high value of the service albeit the challenges ahead, as ever, remain difficult to quantify.

The Year Ahead

Mirroring the previous year start, at the time of reporting, the anticipated 3-year Service Level Agreement with the Fife Health & Social Care Partnership for the forthcoming year, whilst in situ, has not yet been fully concluded as late revisions are to be considered retrospectively; however, in line with the review of the Service Level Agreement during 2024 it is believed that the existing prescribed targets will remain relevant for the forthcoming period.

As we enter our 14th 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

Local Area Co-ordination, under the umbrella of the Fife Forum, continues to be a proactive service provider, achieving positive results which exceed prescribed targets, both quantitative and qualitative.

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 2025, there are challenges ahead both from an internal and external perspective. The service will continue to not lose sight of this and, where appropriate, enact reasonable and meaningful change as it evolves. The service remains committed to supporting a shared programme or recovery and resilience.

"THE SUPPORT/GUIDANCE I RECEIVED WAS VERY HELPFUL, I WAS INTRODUCED TO A NEW GROUP. I FEEL MORE CONNECTED TO BOTH MY COMMUNITY & OTHER PEOPLE. THE CO-ORDINATOR WENT BEYOND & ABOVE TO HELP ME ACCESS NEW GROUPS. I AM VERY GRATEFUL TO HER".
Service Recipient

"WE REALLY APPRECIATE EVERYTHING YOU DID YESTERDAY & ALL THE ADVICE & SUPPORT. IT WAS A REAL POSITIVE STEP FORWARD IN GETTING THE CARE BOTH MY MUM & DAD NEED ".
Service Recipient, Carer

Annual Report, Published 23/12/2024

Fife Forum
Fraser Buildings
Millie Street
Kirkcaldy
Fife KY1 2NL
Tel 01592 643743
Email info@fifeforum.org.uk
Website www.fifeforum.org.uk
Like & Follow us on Facebook

Funded with the support of
Fife Health & Social Care
Partnership
Scottish Charity No.
SC022596