Fife Forum

Local Area Co-ordination –
Making Community Connections

Fife Services

December 15 2023 – December 14 2024
(SLA Aligned)

February 2024

Fife Forum
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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 2022–14th December 2023. 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 as of February 2024:

- GP Cluster Areas – 3.0 posts intended (2.0 appointed)
- Adult – 3.0 posts intended (3.0 appointed)
- Older People – 4.0 posts intended (2.0 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, two vacancies were filled; however, this has been off-set with two posts left currently vacant. Within the GP project, one vacancy has arisen as the LAC transferred to Older People, however, it should be noted service delivery in this area continued including the provision of weekly drop-ins throughout the area affected. The Adult service is currently running with a full complement of staff with one new appointment made during the course of the year. Whilst staffing levels were and remain a challenge and are broadly similar to circumstances at the beginning of the previous reporting period, 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 be further impacted and might reduce to 60% capacity. A current recruitment drive during the first quarter is hoped to minimise the impact of this, however, new staff will require an induction period.

Post-Pandemic & Recovery

During the course of the year services across the board have largely resumed, albeit many providers have reframed what and how they deliver these. This said, the journey of recovery continues as national and global challenges have not readily dissipated leading to an extended period of difficult socio-economic circumstances.

As it was with the pandemic, the ongoing pressures presented by societal events had and 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 issues presented by the cost of living crisis continued to influence individual needs and wants which centred 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 increased 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 significant increase in the value of monies directly raised by our service in relation to helping people achieve this.

Like many organisations, Fife Forum has post-pandemic 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.

Alongside supporting people to access information and activities, the service facilitated 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 shifted from encouraging post-Covid social engagement towards acting as a springboard for people to explore external activities in general (be this via other community activities or the development of friendships out with the confines of the service arena). To allow the service to consider developing new groups the service has formally disengaged from already developed walking and social group provisions having encouraged them to be self-sustaining informal entities.

The service hopes to develop new peer groups which incorporates social café and 'health and well-being' elements where gaps are identified and capacity allows this. Our aim would continue to centre on affording people the opportunity to socialise and improve well-being. In addition to this, the service developed and facilitated community-based and hospital-centred drop-ins to support information sharing, signposting and community connections.

Formal Referrals & Supported People

Throughout the reporting period the service accepted new referrals. A total of **1,306 formal referrals** were received. This presented a marginal increase in the number of formal referrals received compared with the previous reporting year (0.9% increase) remaining well above pre-pandemic levels (almost 40% higher compared to 2019).

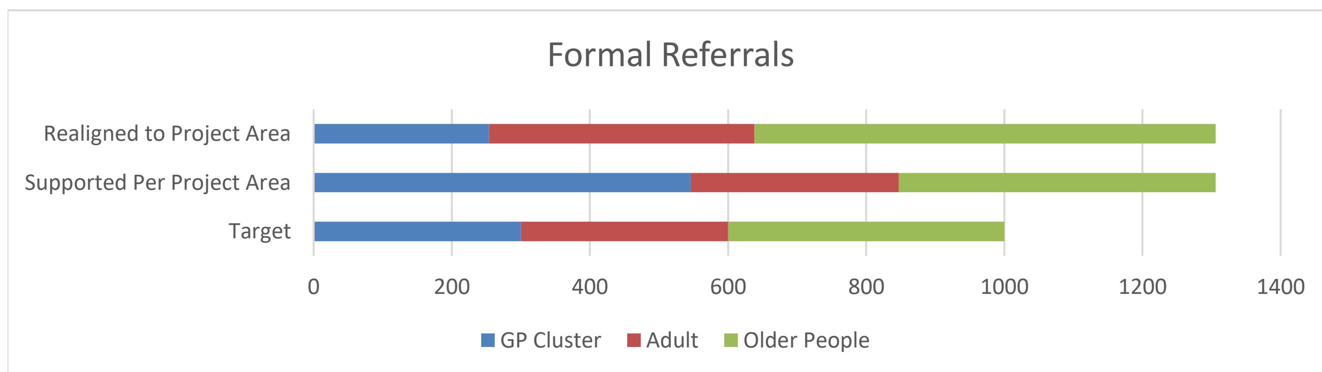
The total number of formal referrals received remains above the overarching target prescribed by our Service Level Agreement (Targets: Fife-wide 1,000 – GP 300; Adult 300; Older People 400). Within the context of formal referrals received, 377 of these were cross-referred internally to help ensure demand was met. This number was significantly higher than the previous year (179). The majority of cross-referrals were made to our GP LACs (303 – 121 Adults; 182 Older

People) with our Adult and Older People LACs accounting for the remaining 74 cross-referrals (respectively: 49 Older People & 3 GP Cluster; 14 Adult & 8 GP Cluster).

Whilst the overarching target was surpassed (+306), when formal referrals are realigned to their intended project areas both Adult (+84) and Older People (+268) reflected this whilst the GP Cluster area did not (-46). This pattern largely mirrored the previous reporting period. However, within the GP Cluster context, the shortfall was nevertheless a slight improvement (2022: -48). It is also important to note, the number of formal referrals supported by the GP Cluster project totaled 546 and it would be fair to assume each person cross-referred from its sister projects would likely have had a direct link to a health service and/or Medical Practice. Thus, the benefits of Local Area Co-ordination for the patients of the Medical Practices supported by our GP Cluster Project would be similarly felt by those elsewhere in Fife.

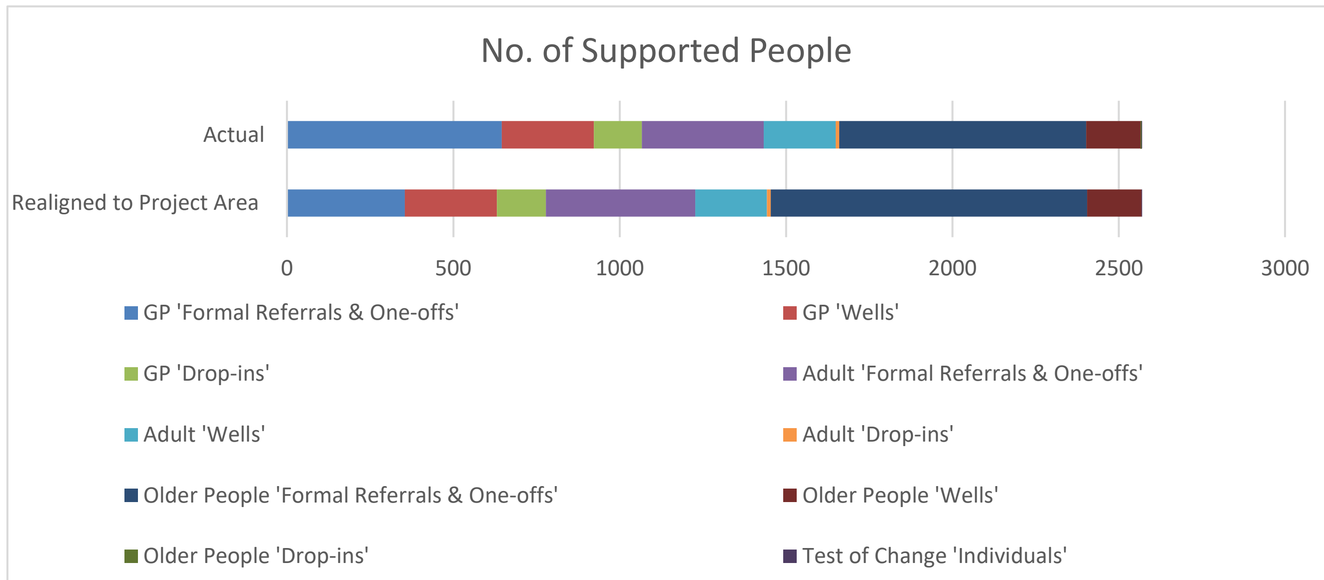
The continued and welcomed development of community-led support provided by Link Life Fife (Fife Health & Social Care Partnership) which offers a shared-value service type focusing on mental health within the same primary health setting Fife-wide might also, in part, be a contributing factor to referrals remaining relatively static within our GP Cluster project. This would appear to be supported by the continued reduction in referrals received from the Mental Health Triage Service which over the course of the last 3 years has reduced the number of formal referrals to all our LAC projects from 226 to 170 to 36. This is now an expected transference of this referral source which we would anticipate would shift towards Link Life Fife which would offer a natural fit, given their mental health improvement remit Fife-wide. This said, it has not resulted in a downward direction of travel for the GP Cluster project as the source of referrals has been off-set by GPs and other Medical Practice-centred professionals.

As stated in our previous report, we continue to believe that the expansion of LAC 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.

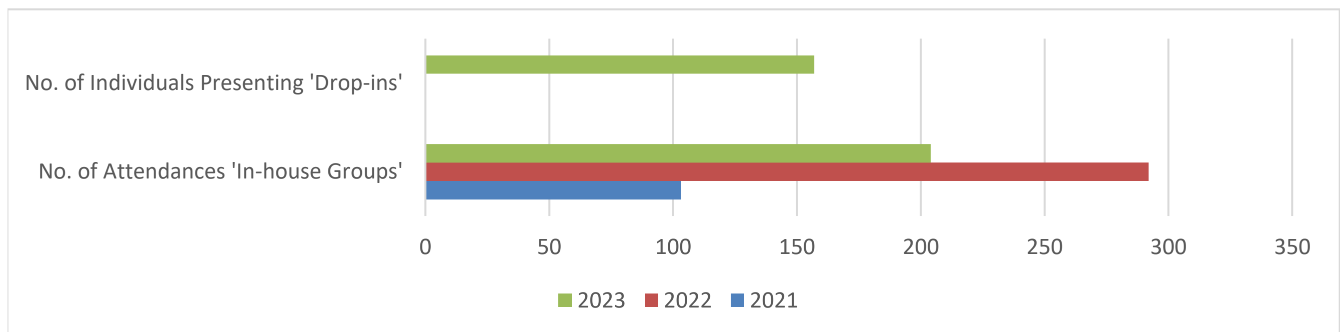


In addition to formal referrals, the service continued to offer guidance and signposting to people on a one-off basis directly via Fife Forum itself or at locality venues (this includes locality-sited or virtual 'Wells Near Me' – community information points co-ordinated by the Fife Health & Social

Care Partnership). During this reporting period there was one Covid-related enquiry made by an individual, again almost negligible as it was during the previous reporting period. When one-off enquiries are included **the service supported 2,571 people** Fife-wide (an increase of 9.1% from 2,356). The total number of people supported by the service remains well above the over-arching target prescribed in our Service Level Agreement (Target: 1,750 – 46.9% higher).



Beyond core activity, **204 attendances** were supported within **in-house developed groups** (Health Walks & Café Forums). This presents a 30% decrease on the previous year; however, it is in line with the expectations that in-house groups would become self-sustaining as the year progressed. The 3 groups operating under the guises of a social café and health walks all became self-sustaining during 2023. It is anticipated further supports will be developed during 2024 in some guise, however, there was a shift towards a focus on **drop-ins** offering guidance either on a one-off basis and/or with follow-up input where appropriate. This perhaps reflects a trend towards people seeking more immediate interventions via a more visible platform within their immediate communities. Those presenting at our drop-ins totaled **157 individuals**. These were facilitated within GP surgeries (Glenrothes, Levenmouth, Kirkcaldy & Lochgelly) and co-facilitated within Community Centres located in areas of multiple deprivation (Kirkcaldy & Dunfermline).



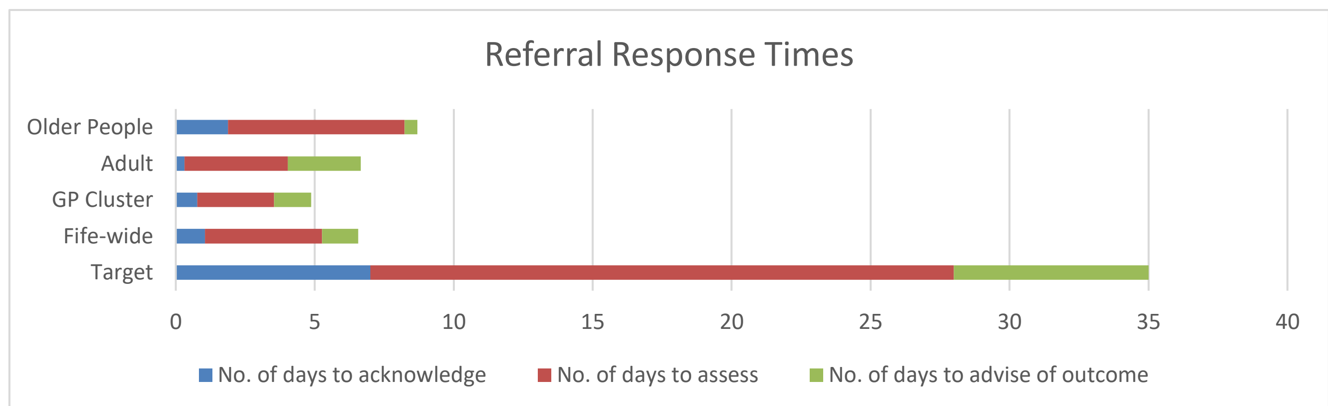
"I would like to say that you have been very approachable & friendly towards myself and the other staff within the surgery. You have taken a huge burden off of my work as I now feel able to share some of the workload & trust that someone will actually follow up patients in terms of benefit stuff and general DWP issues which are very time consuming. I like that you have drop in days as that often suits people with mental health issues".
Mental Health Triage Nurse

Formal Referral Response Times & Engagement Rates

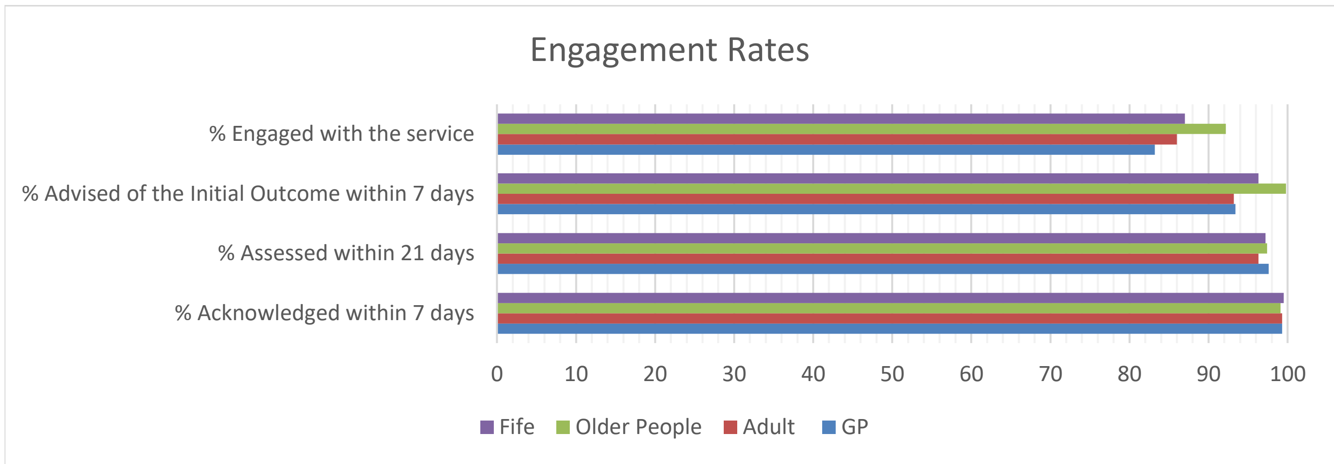
In accordance with the Service Level Agreement (Fife Health & Social Care Partnership) the average response times for formal referrals are as follows:

- Acknowledged within 7 days of receipt (**average:** GP 0.77; Adult 0.31; Older People 1.88)
- Assessed within 21 days of acknowledgement (**average:** GP 2.77; Adult 3.72; Older People 6.35)
- Advised of outcome within 7 days of assessment (**average:** GP 1.33; Adult 2.62; Older People 0.46)

In all three service areas the average target timelines were met and the process from acknowledgment to assessment to reporting an initial outcome averaged 6.56 days, well within the prescribed 35-day timescale and is broadly similar to previous reporting periods (2021: 6.63 days; 2022: 6.16 days).



Fife-wide the percentage of formal referrals acknowledged within 7 days reached 99.5%; assessed within 21 days 97.2%; and, advised of the initial outcome within 7 days 96.3%. The percentage of formal referrals that chose to fully engage with the service equaled 87.0%. Older People served by the Older People Project were most likely to engage with the service (92.2%).



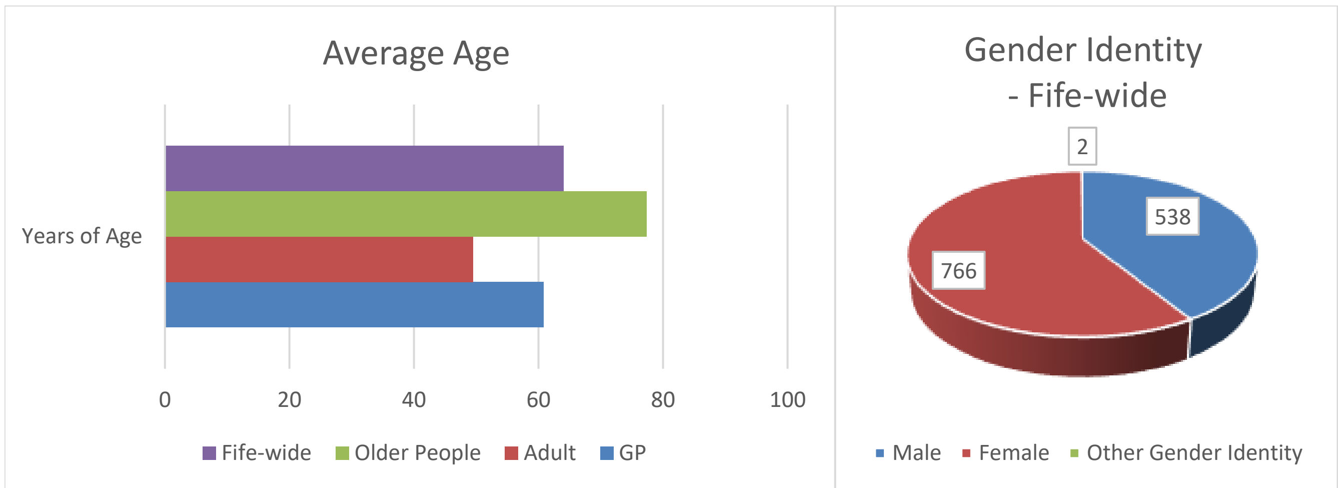
"The Local Area Co-ordinator continues to be an invaluable resource for our community. Over the past year I have referred patients with varying problems regularly. The service is timely, person centred, responsive & holistic with excellent communication. Patients have benefited greatly from the input and advice offered & feedback from them has been very positive & I look forward to ongoing strong partnership working in the next year".

Mental Health Nurse Practitioner

Gender & Age (Formal Referrals)

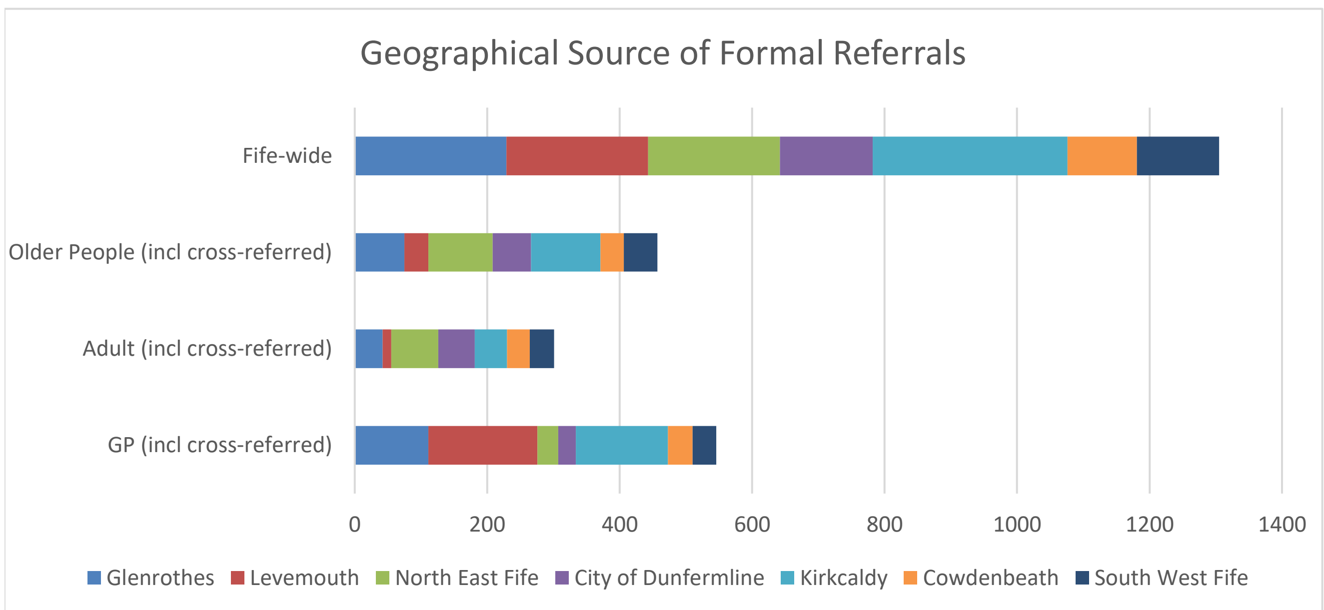
Fife-wide the ratio of male to female favour the latter (41:59) and this is replicated across the three project areas to varying degrees (GP 39:61; Adult 46:53; Older People 40:60). Two people within the Adult project did not self-identify as male or female, which is the second recorded instance of this.

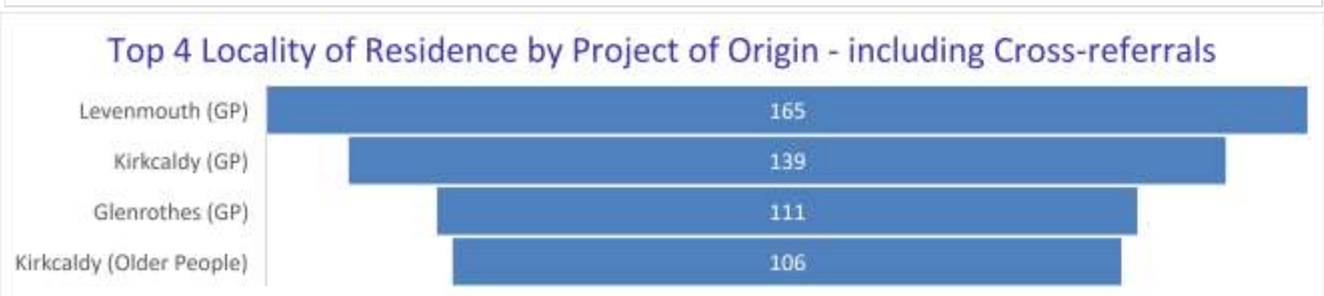
As should be expected given the age ranges served by each project area, average age varies (GP 60.8; Adult 49.5; Older People 77.3). Fife-wide the average age of all formal referrals increased from 63.1 to 64.0 continuing a trend albeit at a much slower rate. This is the third year where average age 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 643 or 49.2% of all formal referrals (previously 49.0%). Kirkcaldy locality accounted for 294 formal referrals followed by Glenrothes with 229. It should be noted the GP Cluster areas are located in four of the seven localities (Kirkcaldy, Glenrothes, Levenmouth & Cowdenbeath). Mid-table, Levenmouth and North East Fife were not significantly behind the main centres of population with 214 and 199 formal referrals respectively.

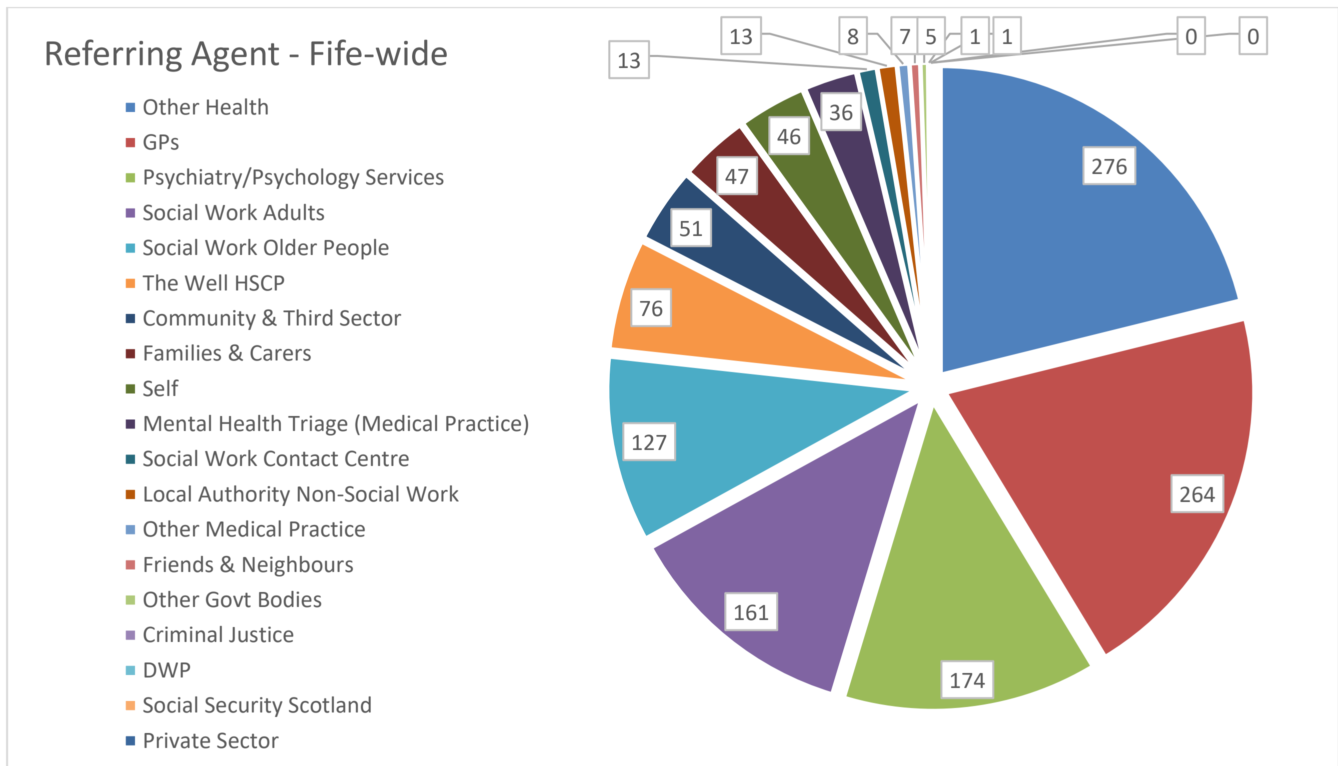




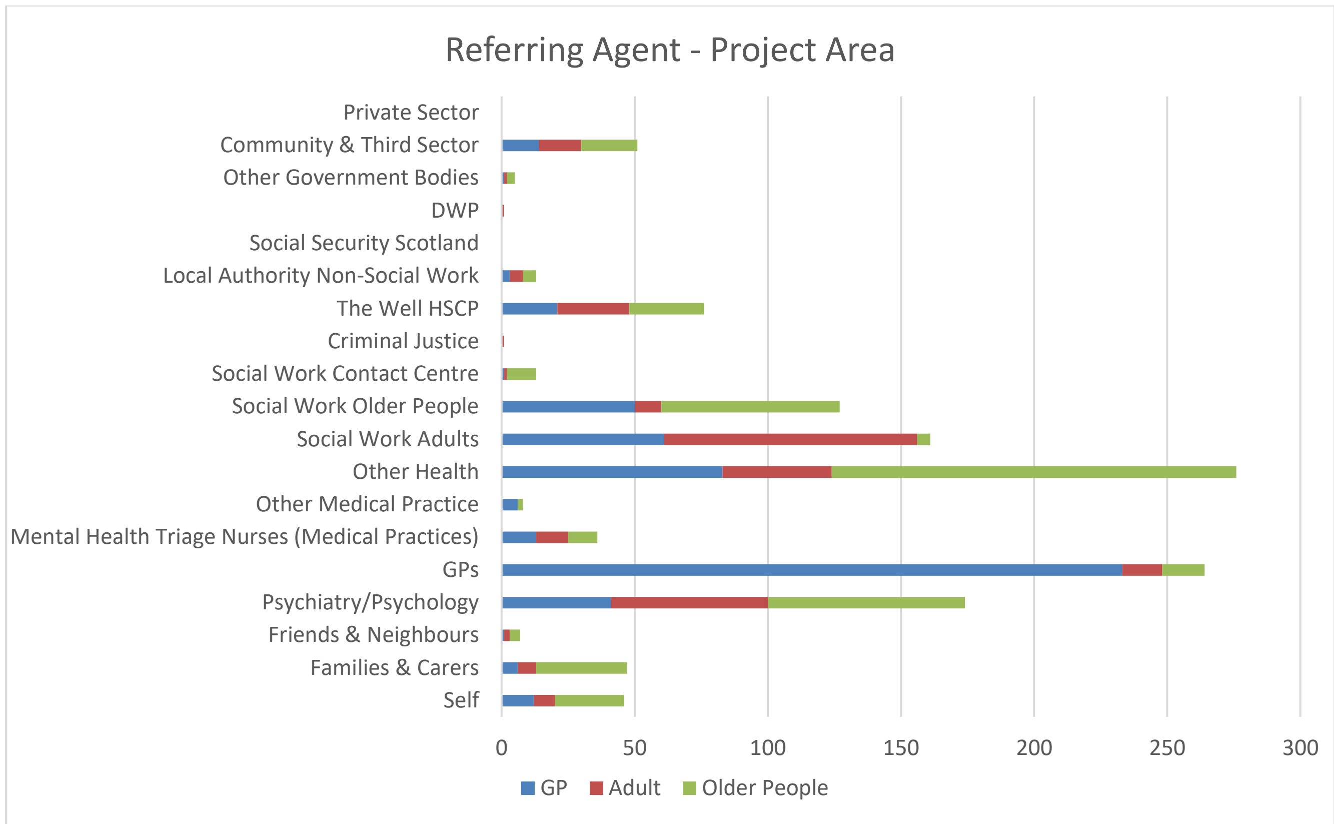
Formal Referral Source

For the period, the majority of referrals were sourced from both Health and Social Work & Care partners accounting for 81.1% of referrals made, lower than the previous year (85.2%). As should be expected owing to the GP project's remit within 'GP Cluster Areas' this ranged from 81.1% overall to Older People at the lower end with 73.6% (Adult 77.7%).

In relation to primary referral sources; within a GP project context GPs accounted for 42.7% (2022: 40.3%) of formal referrals made followed by Other Health (Non-Medical Practice) with 15.2%. Mental Health Triage Nurses decreased to 2.4% (2022: 26.2%). Regarding Adults, Social Work Adult Teams accounted for 31.6% (2022: 34.6%) followed by Psychiatry/Psychology (19.6%). Mental Health Triage Nurses decreased to 4.0% (2022: 10.1%). Within Older People, the highest proportion of referrals were sourced from Other Health (Non-Medical Practice) accounting for 33.1% of referrals made (2022: 35.4%) followed by Psychiatry/Psychology (16.1%). The number of 'open' referrals from non-organisational sources remains highest within the Older People project representing 13.9% (2022: 13.5%). Fife-wide open referrals account for 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 referral source Fife-wide is 'Other Health' (this includes Intermediate Care Teams & hospital-based professionals) followed by GPs. Mental Health Triage Nurses which were the primary source of referrals during 2021, and 4th during 2022, fell to being the 10th.



Incidence of Health Issues (Formal Referrals)

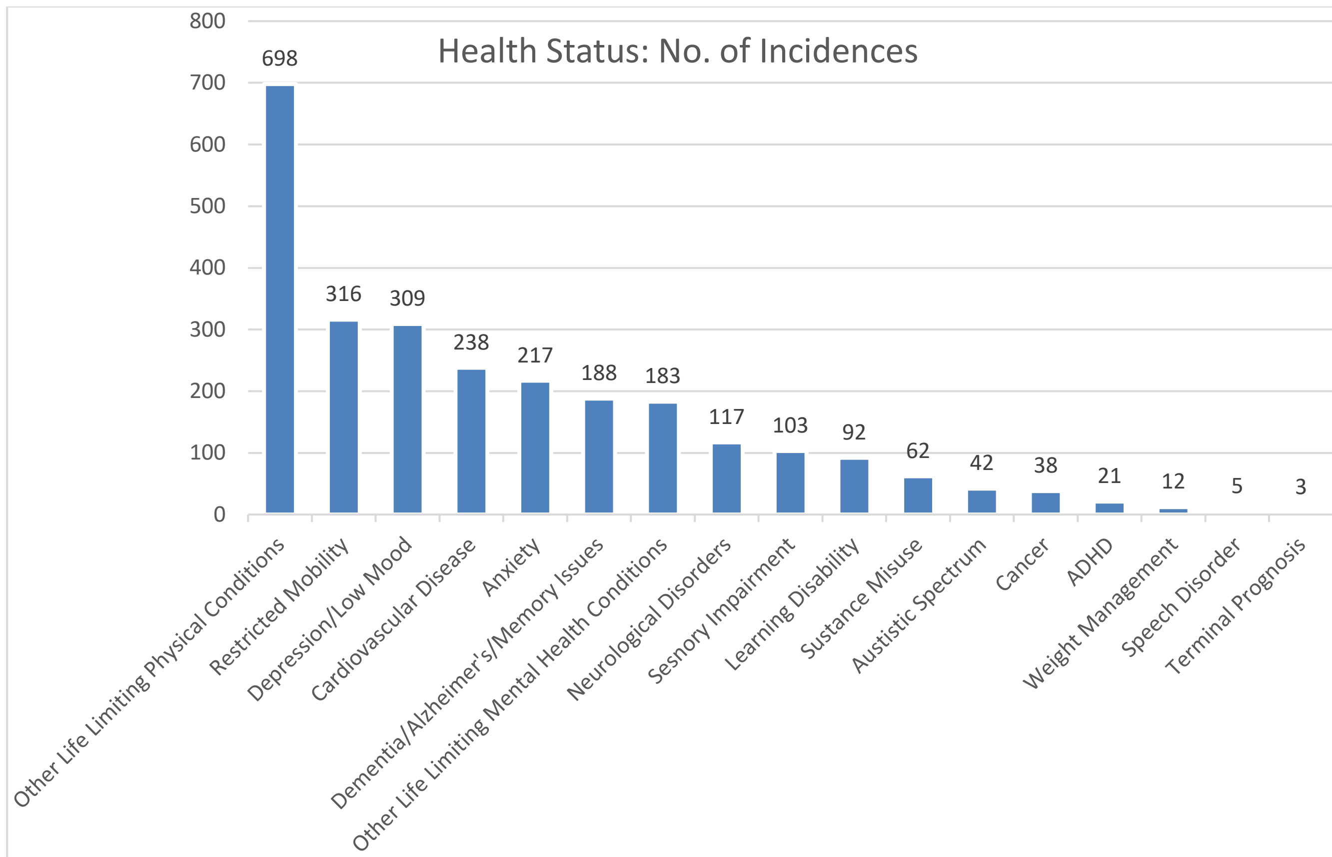
Among the 1,306 people formally referred, 1,255 reported a health and/or life affecting condition many with multiple issues (2,644 health incidences). Where a heath condition is reported there is on average 2.11 conditions per person (down from 2.25). This ranges from a high of 2.31 conditions per person (2022: 2.52) within an Older People context to a low of 1.96 (2021: 1.90) within a GP context (Adult: 2022 - 2.26; 2023 – 2.08).

The main health issue reported by people within each project area is: GP 274 'Other Life Limiting Conditions' followed by 170 incidences of 'Depression/Low Mood'; Adult 80 incidences of 'Other Life Limiting Physical Health Conditions' followed by 'Depression/Low Mood' and 'Other Life Limiting Mental Health Conditions' each recording 80 incidences; and, Older People 347 incidences of 'Other Life Limiting Physical Health Conditions' followed by 'Restricted Mobility' with 163 incidences. In relation to specified physical-linked conditions the highest number reported within each service area is Cardiovascular Disease with 200 incidences (Older People 202; GP 52) and Neurological Disorders (Adult 47).

The incidence 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) of incidences reported (from 915 to 884 to 709 incidences). Anxiety and depression/low mood account for 69.4% of reported mental health conditions (2022: 73.8%).

Reported incidences of cognitive decline (Alzheimer's/Dementia/Memory Loss) accounted for 7.1% of all incidences reported (188 incidences) decreasing from 8.0% during 2022 (229 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)

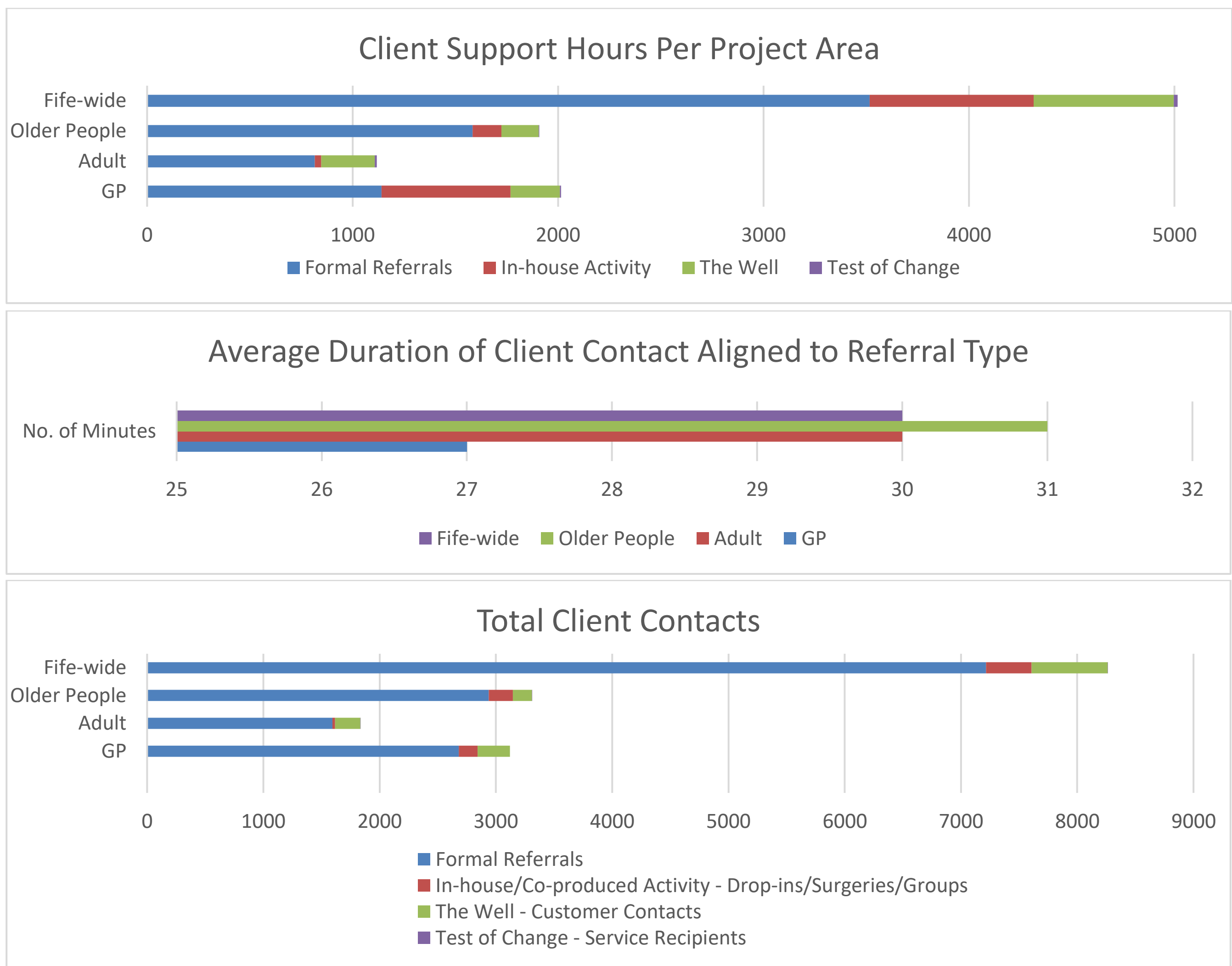
The number of support hours undertaken with **formal referrals** totaled **3,516 hours 20 minutes** decreasing from 3,821hours (Source - Project Areas non-realigned to referral type: GP 1,141 hours 25 minutes decreasing from 1,170 hours 25 minutes; Adult 816 hours 30 minutes decreasing from 1,150 hours 25 minutes; Older People 1,558 hours 25 minutes increasing from 1,501 hours 25 minutes).

On average the time spent per client contact relating to all formal referrals was 29 minutes (Range - Project Areas aligned to referral type: GP 30 minutes; Adult 27 minutes; Older People 30 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.

In-house client facing activity (including co-produced activity) in the form of groupwork, drop-ins and surgeries offered an additional **798 hours 10 minutes** of support work.

In relation to external activities involving client facing work **682 hours 10 minutes** (2022: 603 hours 5 minutes) was dedicated to supporting **307 'Wells'** in-person and remotely (2022: 267) providing 657 related customer contacts (2022: 592 customer contacts). Additionally, **18 hours 30 minutes** of support time was committed to **Test of Change** initiatives (these being the NEF Single Point of Access and Collective Force Link Worker Pathfinder).

Overall this delivered **5,015 hours 10 minutes** (2022: 4,424 hours 45 minutes) of direct support work culminating in **8,265 direct contacts with individuals**.

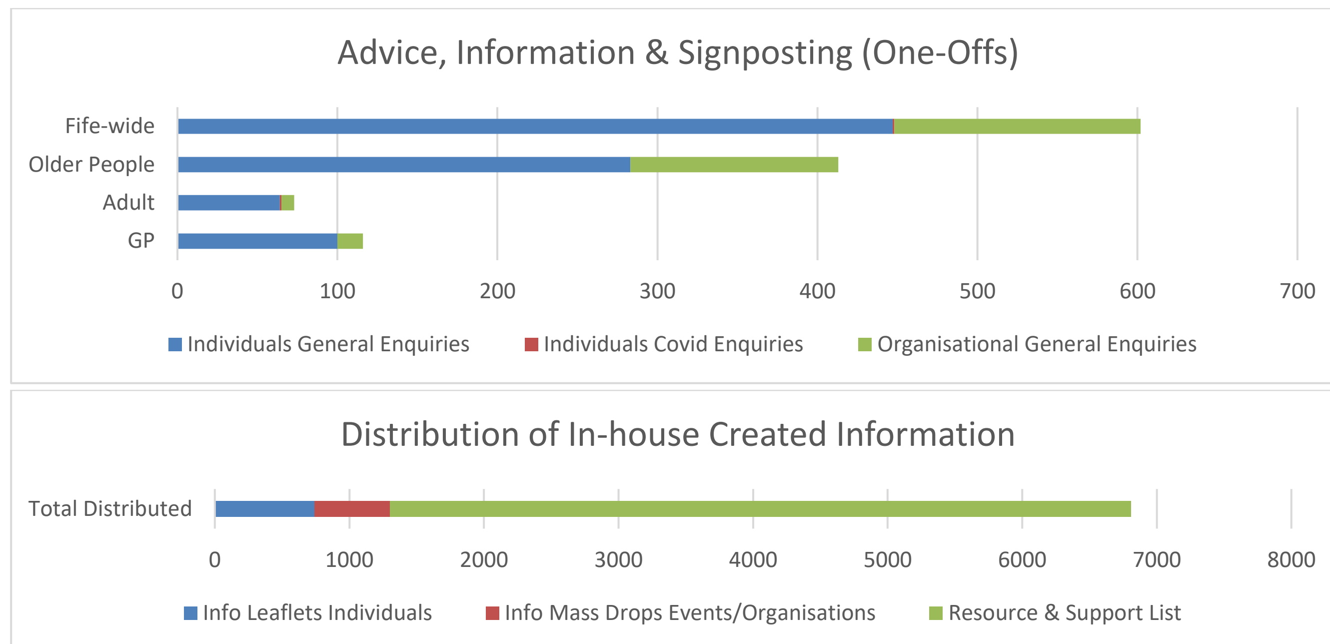


Guidance, Information & Signposting (One-Offs)

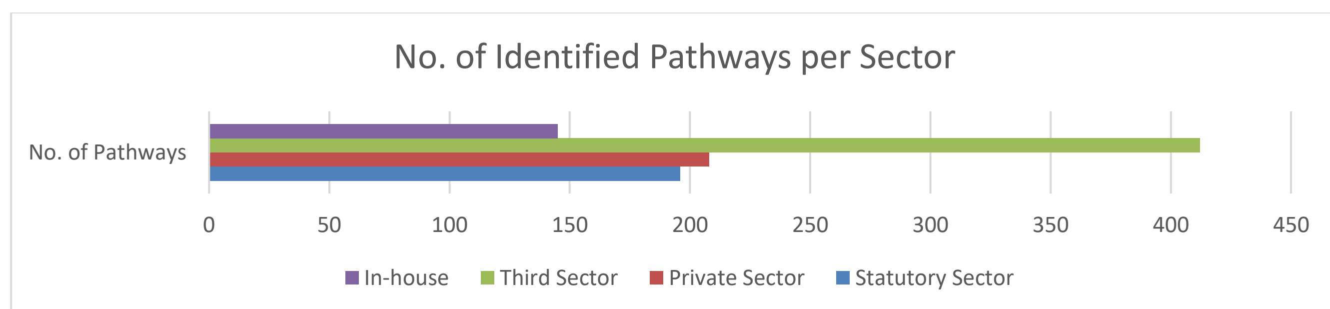
In addition to formal referrals and other client facing activities; the service offered guidance, information and signposting to both organisations and individuals. For **general activity**, this was offered to **447 individuals** and on **154 occasions to organisations** (Source - Per Project Area: GP 100/16; Adult 64/8; Older People 283/130). Specific to **Covid-related** activity, Fife-

wide there was only **1 individual** offered guidance specific to Covid. The distribution of the in-house published Covid Resource & Support List continued during 2023 and was rebranded and edited as a more general **'Resource & Support List'** to reflect a marked movement away from Covid-related enquiries with a **distribution total of 5,507**.

Overall, the number of one-off enquires remained on par with the previous year.

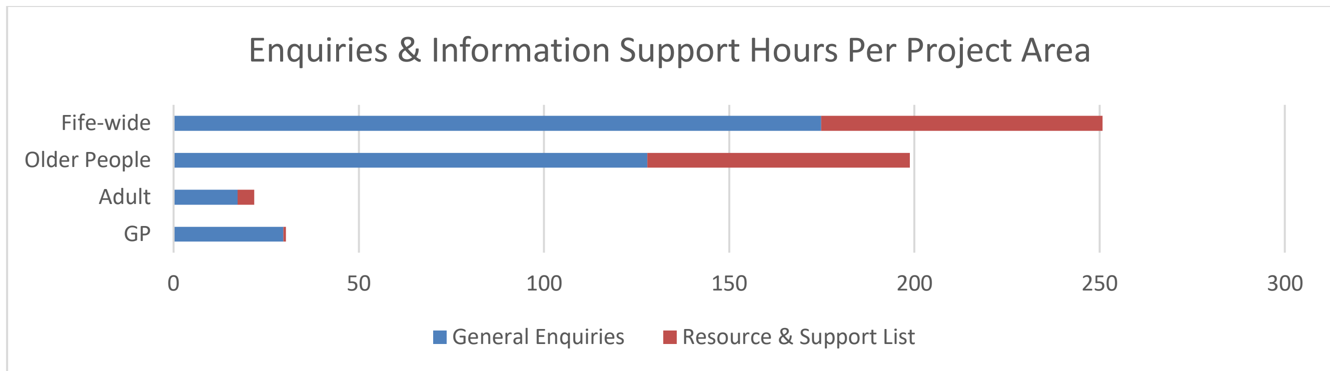


In relation to one-off enquiries there were **961 pathways** identified ranging from local interest groups to statutory and privately purchased provisions. Signposting to Third Sector/Community services was the most prevalent route equating to 42.9% of pathways identified and increasing to 58.% when in-house pathways are included. 'Advice and Information Services – for example: Helplines' (including signposting to LAC) is, by far, the most prevalent individual pathway identified representing 22.8% of all pathways recorded. In addition to this, 29.4% of pathways could reasonably be assumed to have a social element/intent to them.



In total, **174 hours 50 minutes** of project time was dedicated to one-off support and signposting (Source – Per Project Area: GP 29 hours 40 minutes; Adult 17 hours 15 minutes; Older People

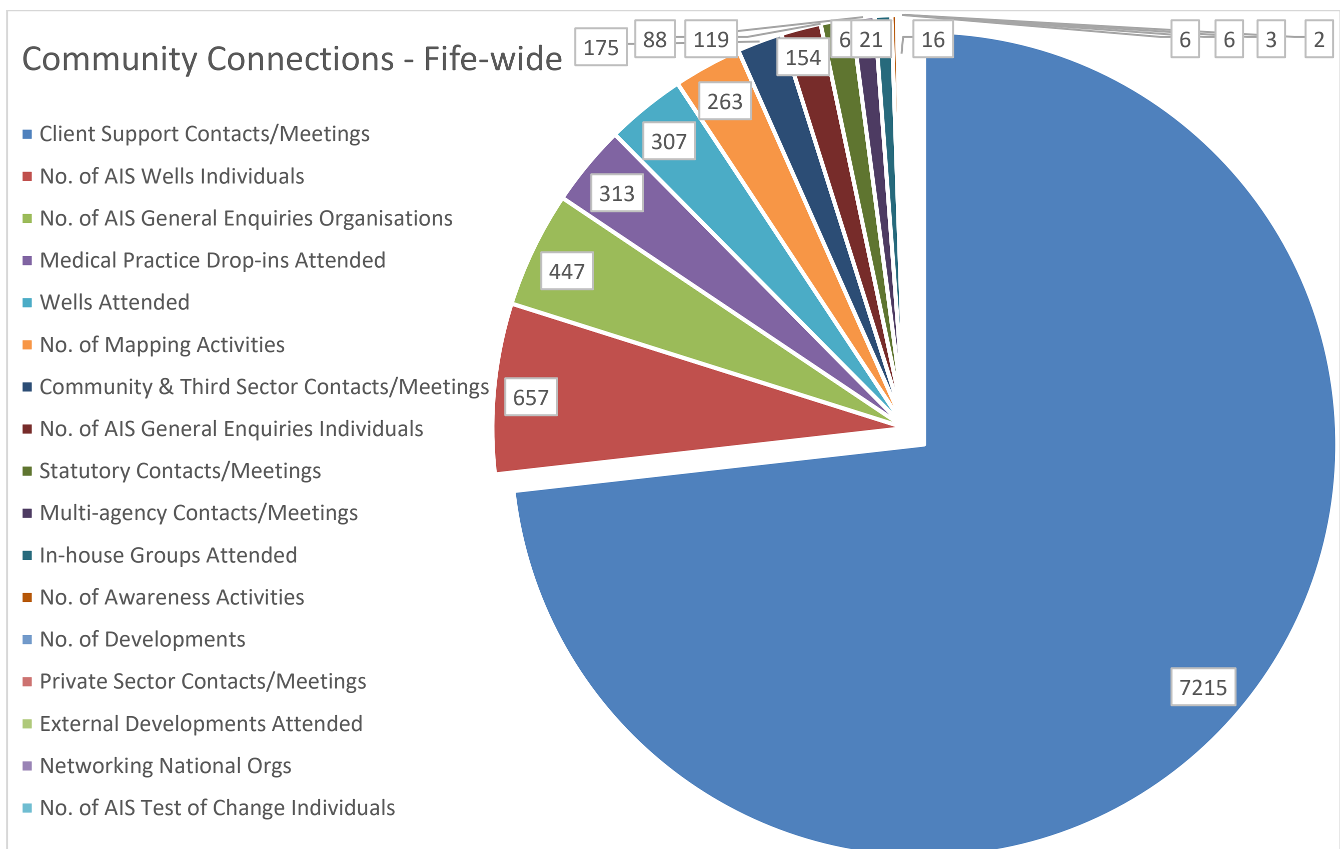
127 hours 55 minutes); alongside **76 hours** of project time directed towards supporting the development and distribution of the Resource & Support List.



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 **9,856** (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 73.2% of the overall total reflecting the concentration on client-related activity.

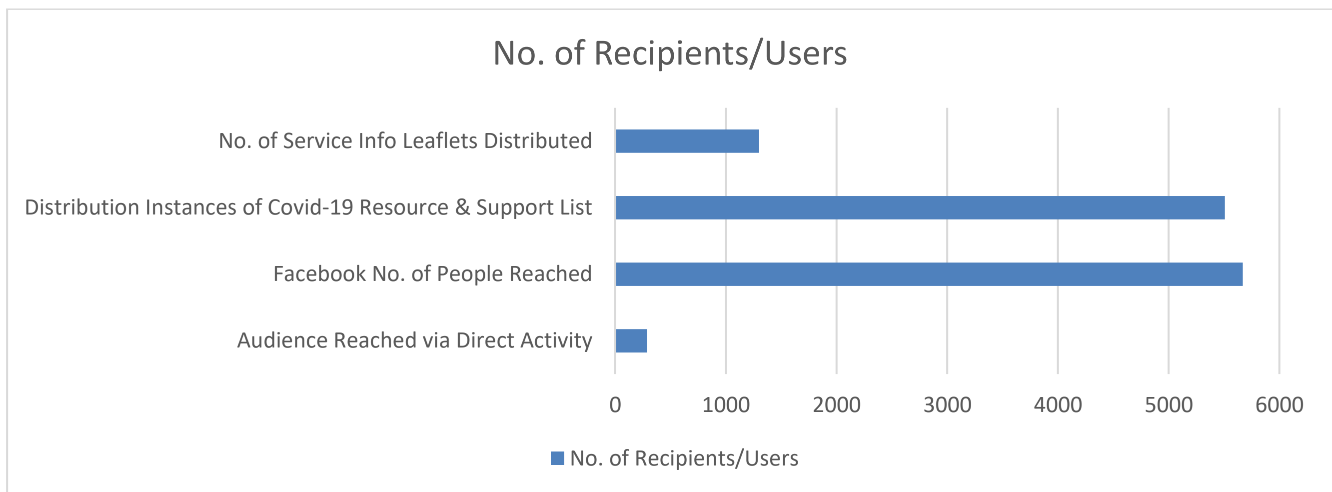


Awareness Raising

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 21 occasions (2022: 26) reaching an audience of 289 people (2022: 387).

"Another round of really useful information, I will share it with the team and our carers networks".
Manager, Third Sector

The service and parent body (Fife Forum) continues to raise awareness of internal and external provisions via other methods such as Facebook (reach increased 34.1%) and via the direct distribution of the 'Covid-19 Resource & Support List' (5,507 instances). Additionally, the service distributed 1,301 articles of internal service literature.



Development & Co-production

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

"It is great to see that you are keen to get to know the patients and hear their story that will assist your service in how they will access the community when they return".
Lead Nurse, Specialist Mental Health Services

- **In-house Groups –** The service supported the Café Forum and Health Walks to become self-sustaining friendship circles with the former continuing to recruit new members
- **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 facilitate community-centred drop-ins and a Recovery Café within Stratheden Hospital (pilot commencing 2024)
- **Collective Force Link Worker Pathfinder –** The service worked alongside the Fife Cultural Trust and partners to help promote services

provided and the role of Link Workers culminating in a piloted drop-in and bitesize information bulletins for library staff; the Lochgelly drop-in pilot was not extended

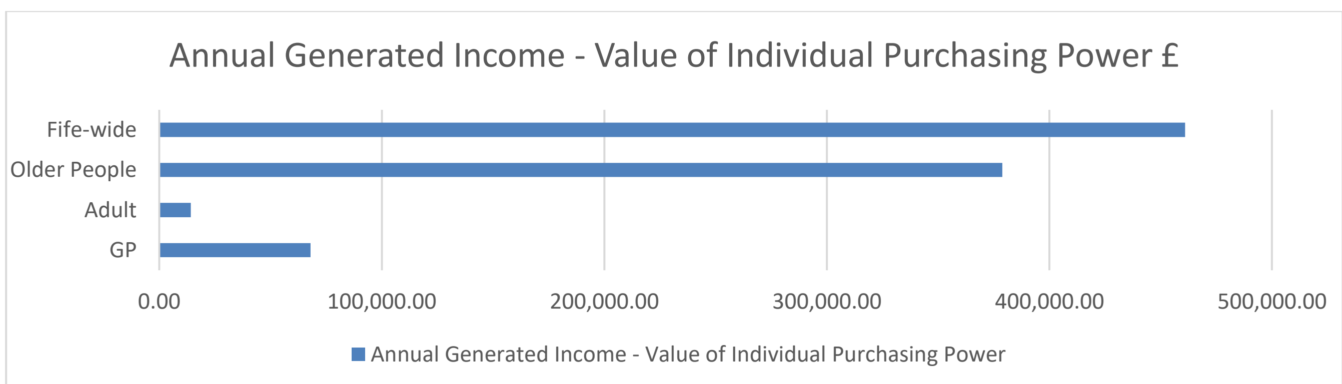
- **Fife Day Care Services Development Group –** Previously spearheaded by the Fife Health & Social Care Partnership, this multi-agency networking group continued to be co-ordinated by the Older People project
- **Board Membership –** The service was represented on the Boards of two charitable organisations (Abbeyview Day Centre and 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
- **NEF Single Point of Access Test of Change, NEF Locality Planning –** The service engaged in this Test of Change via its engagement with the NEF Locality Planning Group and The Wells; 2 referrals were received via this route during the test period and the test was not extended

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.

"I have peace of mind from rising winter heating bills & dreadful increasing food bills".
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 equating to **£461,028.25 per annum** (2021: £118,510.84 per annum; 2022: £248,955.80) adding to individual purchasing power during what has been an extended period of economic insecurity. This is the highest level of generation since the service's inception following the previous year high. 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.

Feedback

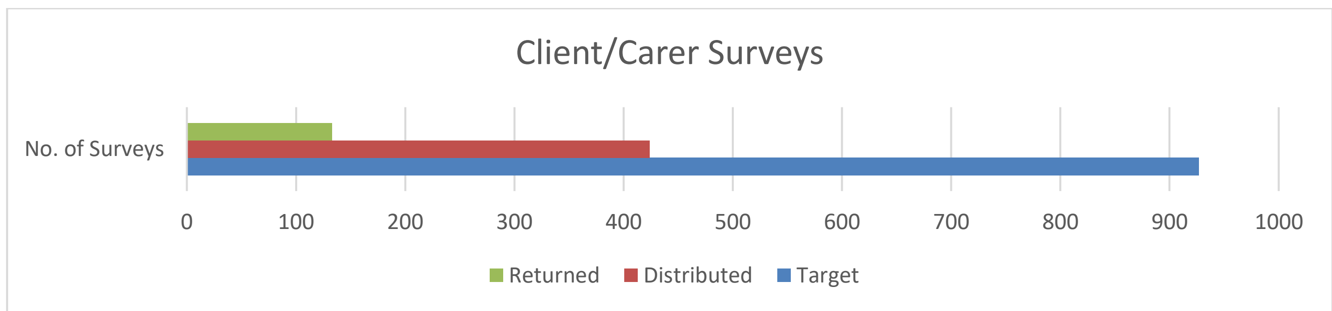
To help measure the impact of the service a client/carer consultation survey is deployed. During the reporting period the service continued to survey closed client cases during the course of the year attempting to capture a depth of qualitative finding. Additionally, e surveys were deployed. The latter 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.

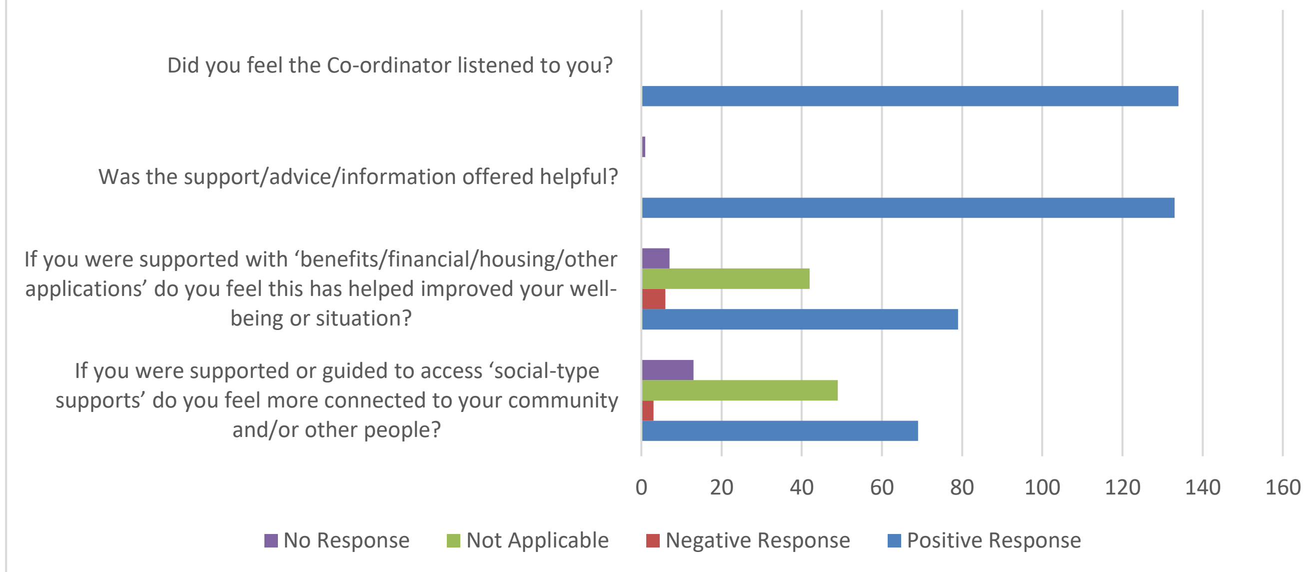
Within the context of open responses, it continues to be worth noting service recipients allude to the approach of each LAC; and, in particular, their swift response, their adoption of meaningful conversation, and their ability to build appropriate relationships. This, as with previous years, continues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

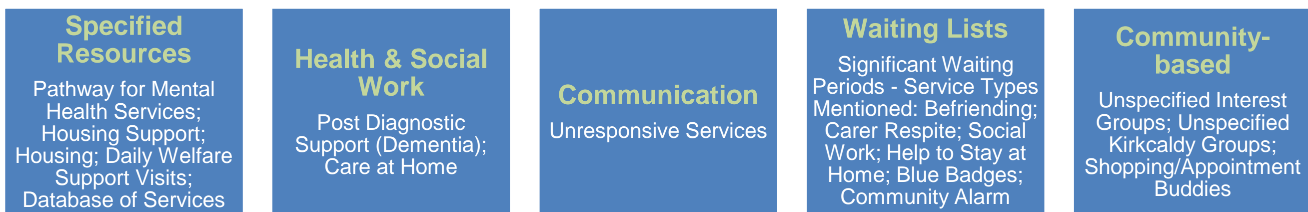
The unqualified target distribution of surveys for this reporting year was 927 this being the number of closed cases, excluding those where there was non-engagement (it should be noted the target is not fully qualified as it includes individuals who could not be reached at the point of closure – this would include deceased individuals; and, individuals who no longer had capacity). A survey return rate of 31.4% was recorded (Range: Adult 11.6%/GP 28.0%/Older People 47.4%). This is lower than the previous year, however, improved within an Older People context (2022: Fife-wide 34.2%/Older People 45.4%).

The manner in which we monitor our work is reviewed annually as we seek to improve our methods of capturing qualitative feedback and systematic surveying will be monitored to better 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…



Where gaps in service provision were alluded to almost all likely relate to the capacity and resource issues of existing provisions and, perhaps, in cases unrealistic expectations (for example: daily welfare support visits which would be impossible to universally provide as a standalone service albiet elements of this can be found in exisitng provisions which already regularly support people). This said, the suggestion of a defined and clear mental health pathway for mental health services being needed is something that already has form; however, perhaps this could be clearer (it might also relate to the absence of provision as the pathway is followed).

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:

"Fife Forum LAC services are a very essential partnership service to not only the NE Fife Practices and Communities, they are an essential resource for the Primary Care Mental Health Nurse. We are always grateful for the partnership & support from Fife Forum LAC team, fantastic staff always responsive at perfect times".

Primary Mental Health Nurse

"From my experience with patients, Fife Forum is an extremely positive addition to the practice. Being able to directly make appointments & being based in the practice, is invaluable. Often faced with issues that are non-medical it is excellent to have an appropriate service to liaise with, not only for the initial referral but also when appropriate for follow up & being able to tie that into the patients' medical care. Feedback from the patients has been very positive, in particular they gain insight to additional avenues of support that they were unaware of. In addition, patients speak extremely highly of X often saying she is easy to speak with & are grateful of the support that she has given, & having directly observed patient encounters with X, she has a wonderful approachable manner with patients & gives succinct practical guidance. Overall, Fife Forum enables the practice to promote holistic care for our patients".

GP

"I have always received a timely, supportive & effective service through Fife Forum and the Local Area Co-ordinator & appreciated the opportunities to work collaboratively to identify the most suitable opportunities & support in the community. A service that is highly valued".

Occupational Therapist, CMHT

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 would like to say how excellent your service is & how very much I appreciate it as it has relieved me of so much worry & helped me both physically & mentally. I would also like to add how kind, caring and understanding my Co-ordinator X has been & I appreciate so much the help he has given me".

Service Recipient, referred by GP North East Fife

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.

"I am most impressed with the high standard of professionalism & service given which has achieved a successful conclusion. Many thanks for all you've done".

Service Recipient

"Such lovely caring staff. A big thanks to you all".

Service Recipient

" I was surprsied & pleased to find out your service invovled a home visit which is most unusual these days. I have recommended your service to several other people. A huge thank you to X & your organisation who I know I can call on in the future if need be".

Service Recipient

"My personal experience was very much a positive one as I received all the information I needed...I think if Fife Forum couldn't help me I'm sure they would be more than willing to get you the correct info required...I had a great experience & have told a friend about it".

Service Recipient

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:

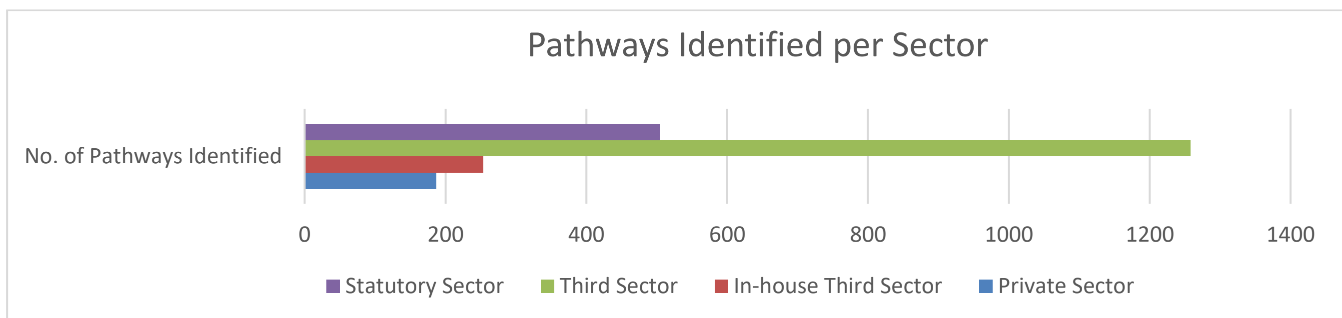
- They might choose not to pursue a particular pathway as a matter of their own personal choice
- They might not meet the expressed criteria of the service they hope to access
- The service referred to might not be equipped to assist (skill, capacity or resource issues)
- The service closed their waiting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

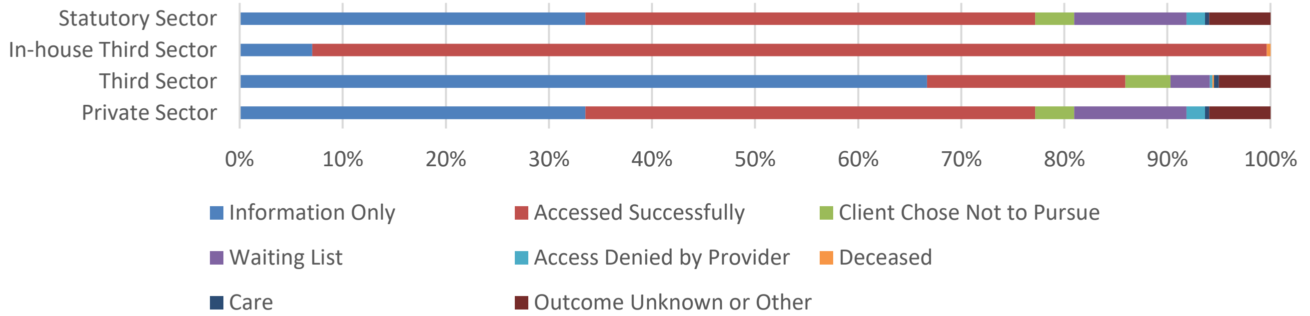
It is hoped by providing information relating to pathways for formal referrals it will help to reflect in part:

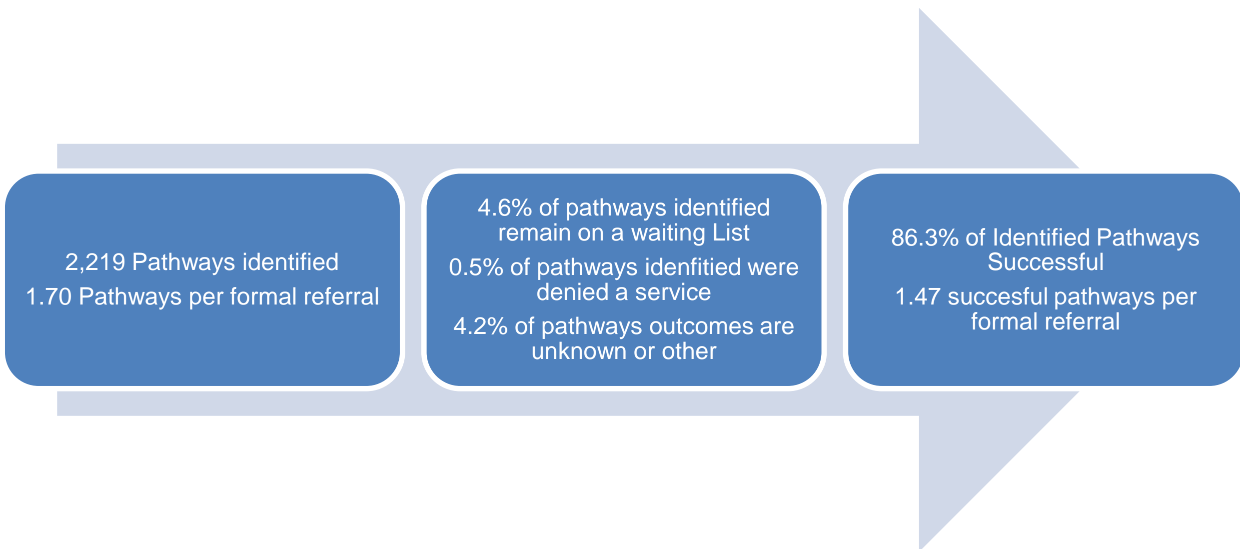
- Client outcomes
- Demand for service-type
- Gaps in provision

A total of 2,219 (2022: 2,616) pathways were identified and by the year end 33.3% or 740 incidences of all pathway outcomes were successful in that access to routed provision was directly facilitated. This is a considerable improvement compared to 2022 (21.1% or 553 incidences). This rises to 86.3% where the pathway route was intended/requested as 'Information Only' and is consistent with the previous year (2022: 85.4%). Of the pathways identified: 68.9% (2022: 75.6%) are attributed to the Third Sector; 22.7% (2022: 15.4%) Statutory Sector; and, 8.4% (2022: 9.0%) Private Sector.

The data for the period is as follows:

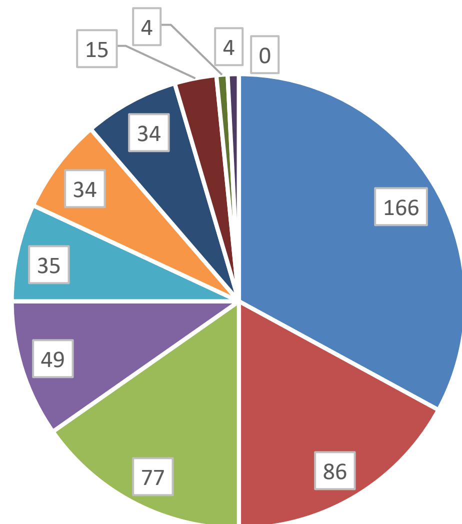


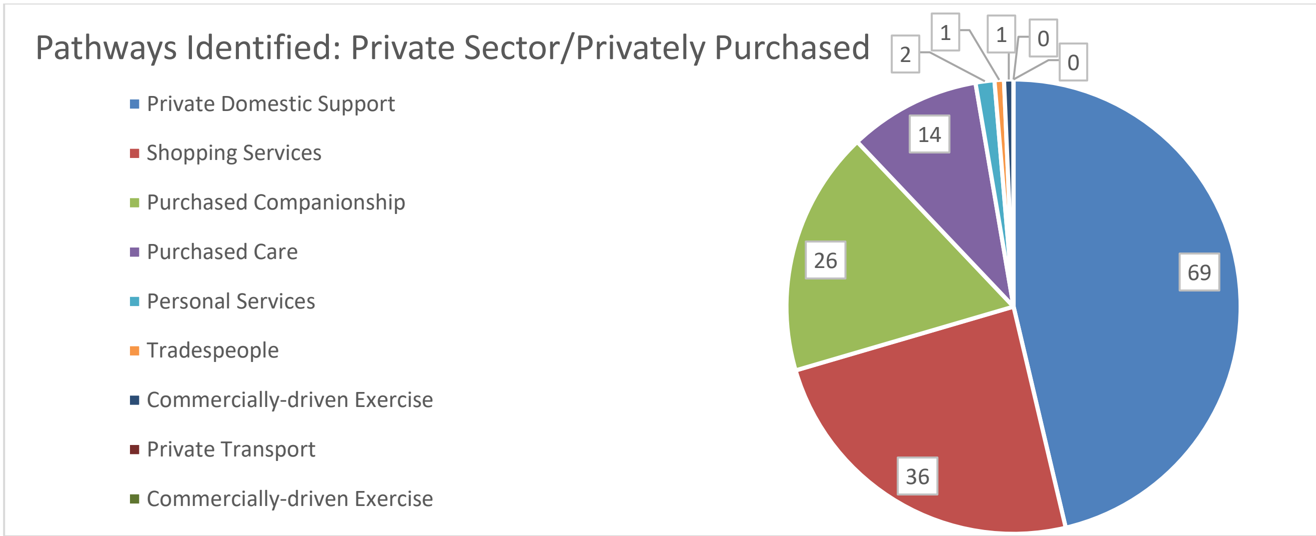


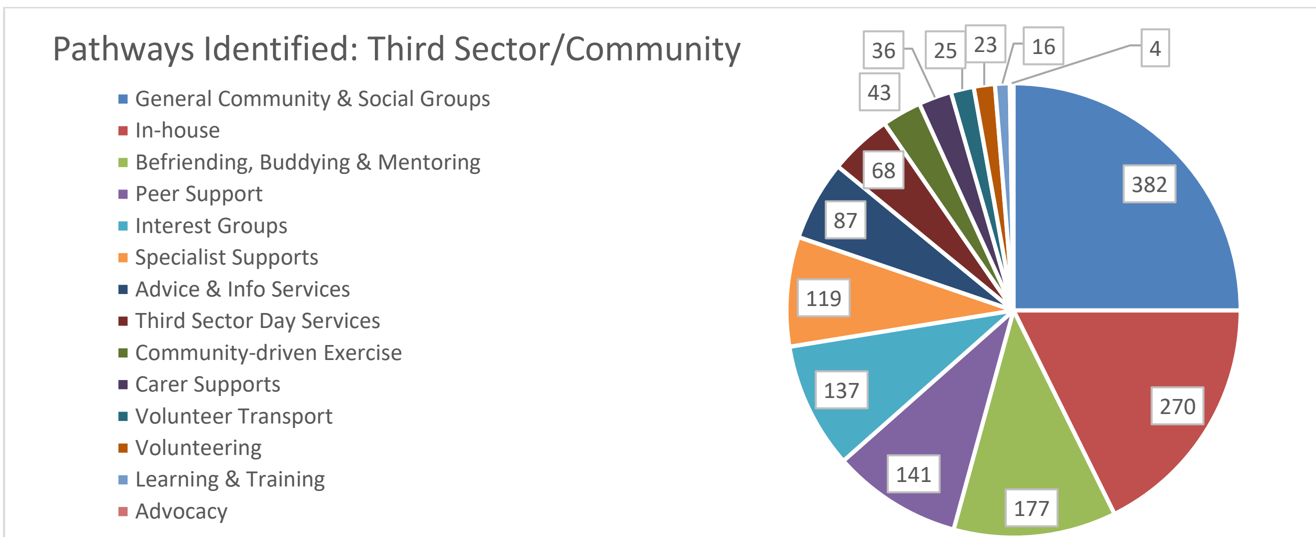


Pathways Identified: Statutory/Public Sector

- DWP
- Council Transport
- Other Council Services
- Blue Badge/Disability Parking Bay
- Social Security Scotland
- Social Work & Social Care
- Housing
- Health
- Other Government Bodies
- Education
- Council Day Services







Within the context of all sector pathways it could reasonably be assumed that 53.2% had a social motivation for signposting to this (this is likely far 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 140 to 201), perhaps 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, almost 50% of all pathways to statutory supports required minimal input from the statutory partners other than assessing the applications submitted.

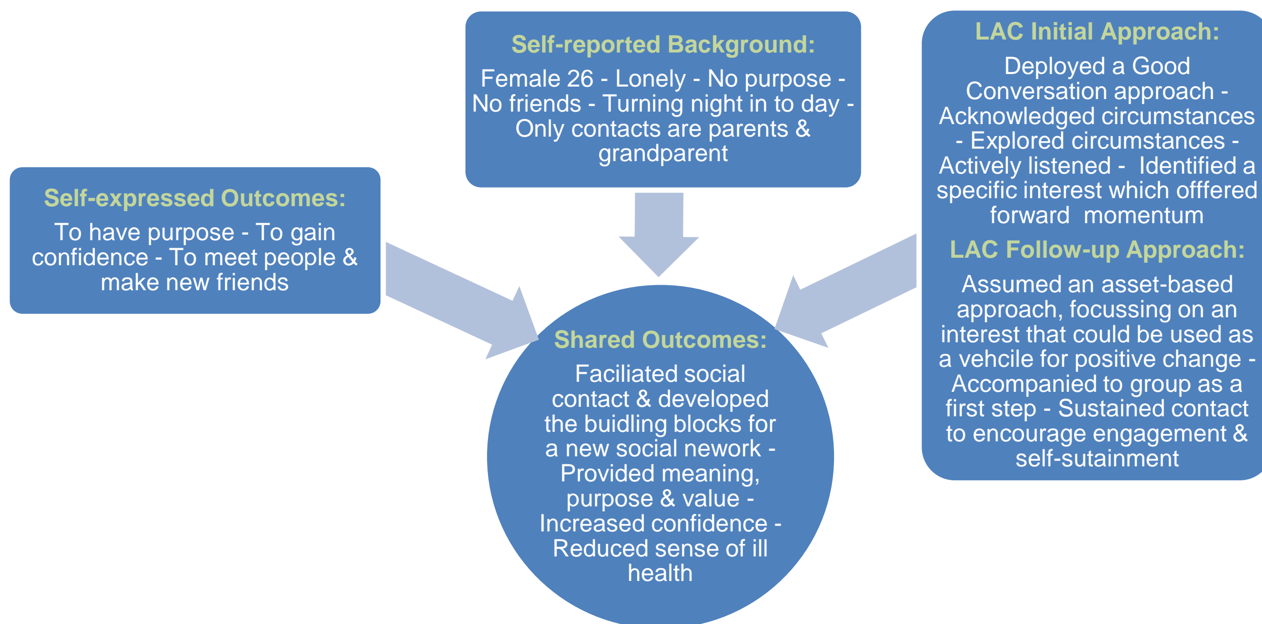
Case Studies

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 this helps to meet both personally driven and organisational outcomes. Over the course of the reporting period five 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 is a young woman whom after leaving school felt she had lost her way. She has endured anxiety and depression leading to the loss of her social network and reported no purpose in life. She believed she had no life beyond the home she shares with her parents and with no routine has turned night-in-to-day. Her low mental health appeared to be impacting her physical state and she would contact her surgery repeatedly and her GP believed the reason for presenting was for non-clinical issues. As a result, X was referred to LAC to be assisted with social prescribing.

By adopting a Good Conversation approach and offering X time to explore her situation without prejudging her circumstances, it became apparent through this that she has a particular interest in a form of craft which was an identifiable asset on which could potentially be built upon. This was pursued and a local craft group supporting her specific interest was identified. Given the length of her disengagement from social activity, the LAC supported her introduction to the group; however, post-introduction to avoid dependency and encourage self-sustainment the LAC restricted contact to check-ins and ongoing encouragement. This approach worked as X self-sustained the activity and through her interest was able to utilise the group to broaden her social contacts attending a Panto with the other members during the festive period. In addition to this, growing confidence has supported X to consider other social activities in the New Year;

hopefully, helping her to sustain purpose and structure with the benefit of improving health and well-being. Although early days, this would seem to be reflected by X having not reattended to-date her medical practice since her engagement with a LAC.

In summary, by engaging with LAC and by being open to and accepting social prescribing X has been supported to re-engage, find meaning and purpose within her daily life. This appears to have resulted in improved health and well-being and a reduced need for primary care health services. It is hoped as X builds upon her own asset base she can become more resilient and enjoy a more meaningful quality of life as she seeks to grow her social network.

This synopsis is perhaps best reflected by the reasoning motivating X's referral and in the straightforward statement made by X herself post-involvement:

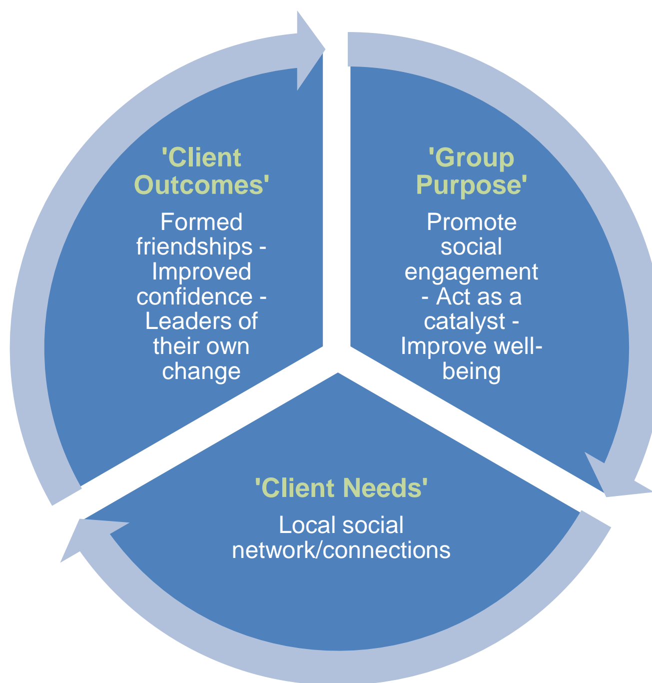
"Long history of anxiety & depression. At the time of her referral felt her medication (fluoxetine) was no longer working. Mood up and down, anxiety when out and about. Has tried multiple antidepressants over the years which didn't help. I felt LAC could offer help to integrate in to the community…Patient was very positive about the referral to LAC and felt this would be more beneficial than medication".

GP describing reason for referral to LAC

"Prior to being involved with the LAC, I was very lonely had no purpose, no friends and was turning night into day. I am now attending a weekly craft group, which I enjoy. I do my diamond art there. I am planning on visiting other groups in the new year".

Client X post-involvement of LAC

In-house Group Case Study



Synopsis

As an extension of the case study reported in the previous year which focussed on one individual whom engaged in our social café and the benefits gleaned, the wider context of the provision is explored as the group achieved its final aim of becoming self-sustaining and client-led.

An important tenet of the service is to develop a comprehensive knowledge base of supports and provisions within local communities. This then lends itself to our ability to then identify gaps in provision. As previously reported, following the easing of Covid restrictions, the LACs operating in North East Fife observed a loss of low level social-type provisions and in particular this was evident in the communities of Leuchars and Guardbridge. This was highlighted where formal referrals were received for these areas whereupon the LACs would find themselves having to suggest travelling to other towns such as St Andrews or Cupar to engage in community activities. Travel can already be difficult for some; however, this was made more difficult for people following their experience of Covid and the lockdowns that ensued. Some felt too anxious to step out with their immediate environ and running parallel to this, the LACs felt promoting activity out with their area did not lend to people feeling supported to develop connections within their own immediate community.

Fife Forum proposed a fortnightly social café, open to all in the local community. Funding was secured from the Fife Communities Mental Health and Wellbeing Fund, administered by Fife Voluntary Action. The group started in April of 2022 and was named the Café Forum, to align with Fife Forum's online groups. Fundamentally, from the outset, the main objective of the group would to become an inclusive self-sustaining social support. With this in mind the LACs who steered the group encouraged the participants to develop, grow in confidence and take on a active roles in the planning and delivery of the group itself.

The group participants enjoyed the welcoming atmosphere and the funding allowed them to engage in arts and crafts that many had never tried before. All of the group participants reported an increase in confidence and, significantly, those who had been struggling with low mood or anxiety believed their symptoms had decreased. They formed friendships and planned trips together beyond the confines of the Café Forum to visit social groups in Tayport, St Andrews and Balmullo. In essence, the Café Forum served as that hoped for stepping stone to wider engagement alongside affording individuals the opportunity to form local friendships which allowed them to feel more confident in exploring other opportunities out with their own immediate surroundings.

During 2023 an operational change at the host venue prompted a discussion amongst the group members about the future of the Café Forum and its long-term sustainability. Importantly, the members all expressed how important the group was to them and equally felt sufficiently equipped to commit to ensuring its continuation. The members collectively led a new direction of travel which started with negotiating an alternative day to meet with the host venue, agreeing how to self-fund this. The group relaunched during January 2024 as a peer-

led, self-sustaining group, and will remain open to all in the local community. To finalise ownership of the groups and its transition the group decided to change its name to better reflect its purpose, the 'Leuchars Friendship Club'.

What started as a small service-led support has now fledged and is self-sustaining. The key aim of both the service and the participants of providing a local socially-driven network was achieved and is echoed by the members themselves:

"We have established a group of friends, we wish to stay together".

"We have bonded".

"The people are fantastic, everybody chips in. If you can't do something someone will help you".

"I call it stressless…it's very relaxing. We do things everyone is capable of, no matter their ability".

Group Members, The Leuchars Friendship Club (previously the Café Forum)

Learning

Not unlike the previous 2 years, the Coronavirus pandemic and the ongoing cost of living crisis has left a legacy and 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 previously reported this is not without persisting challenges such as:

- Remaining competitive; 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 management team continued to collectively address this to effectively deliver what remains an invaluable service with every LAC engaged by the service stepping 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 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, 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 2022 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 previously 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 13th 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, 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 2024, 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 recovery programme.

"TO ALL AT FIFE FORUM WHO HELP SO MANY IN THIS HARD TIMES WE ARE LIVING IN JUST NOW, THANK YOU THANK YOU".
Service Recipient

"EVERYBODY NEEDS SOMEBODY SOMETIME! THE FRIENDLY PROFESSIONAL SERVICE PROVIDED AT SUCH A TIME IS IMPORTANT".
Service Recipient

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