Fife Forum

Local Area Co-ordination – Making Community Connections

Fife Services

December 15 2024 – November 30 2025 (SLA Aligned)

December 2025

Fife Forum
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"Her empathy, knowledge & encouragement were invaluable. She lifted me up when I was low, listened & made sure X and I had the right supports in place. We're truly grateful – thank you so much from all of us".
Service Recipient

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 2024–30th November 2025. 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. It should be noted, funding via the Primary Care Transformation Fund ceased June 2025 with a period of winddown prior to this. Staffing was also reduced by 3 full-time posts. Following this, the remaining service area was reconfigured in consultation with the Fife Health & Social Care Partnership and moving forward was funded via a Core Social Work Grant for service recipients 18+.

The number of 35-hour full-time equivalent posts appointed by Fife Forum to deliver Local Area Co-ordination are as of December 2025:

- Adult – 2.0 posts intended (2.0 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 worked within prescribed localities (Glenrothes, Levenmouth, Kirkcaldy and Lochgelly - areas with a high Index of Multiple Deprivation).

During the year, within Older People, one postholder was and remains on long-term sick leave.

Despite a level of uncertainty in relation to funding, Local Area Co-ordination has continued to deliver successfully upon its objectives. As it was during previous reporting periods, the ongoing pressures presented by societal events continue to influence the work of organisations, 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 concentrate on the fulfilment of basic living needs as people sought to combat the impact of the economic crisis. This is reflected in an ever-increasing demand for support to help maximise income and/or provide people with basic tools which aid daily living. Our data shows a continuing and 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 fail to tackle rising costs and seek to reduce the extent and/or devalue 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, however this has decreased since the Covid pandemic. 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 with protected characteristics experiencing ill health and disability.

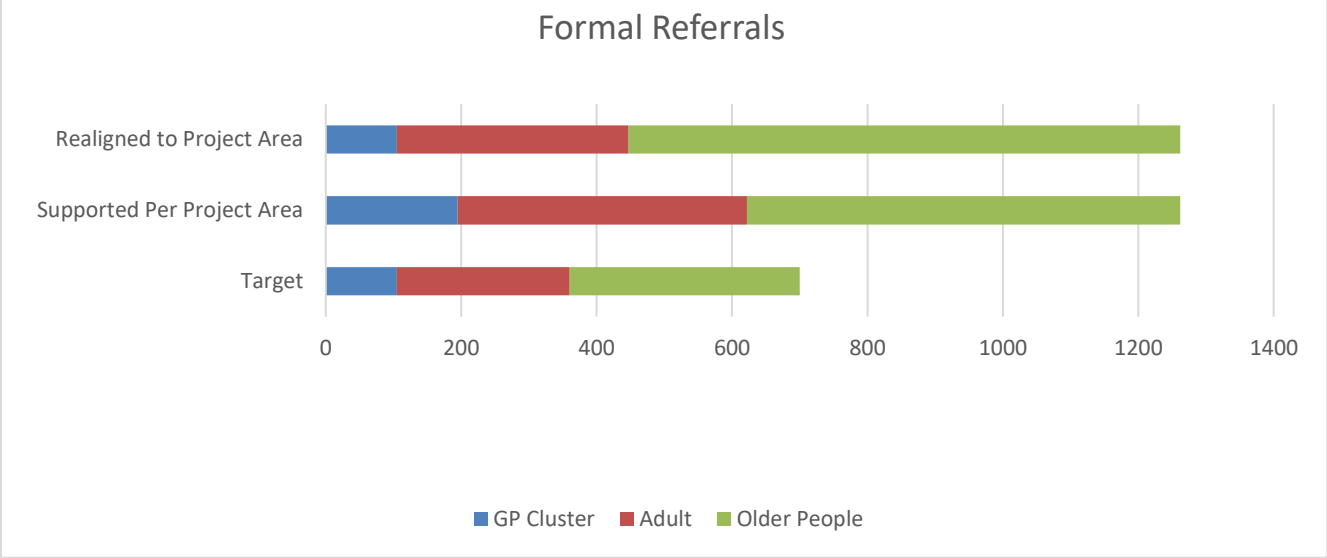
The service continued to support, develop and co-deliver community-based and hospital-centred information points/drop-ins to support information sharing, signposting and community connections. In addition to supporting the delivery of the Wells (Fife HSCP) Fife-wide, information points have been delivered in areas where there has been an identified gap in provision, mutual benefit and within other Fife Forum supported Older People focused group settings.

Formal Referrals & Supported People

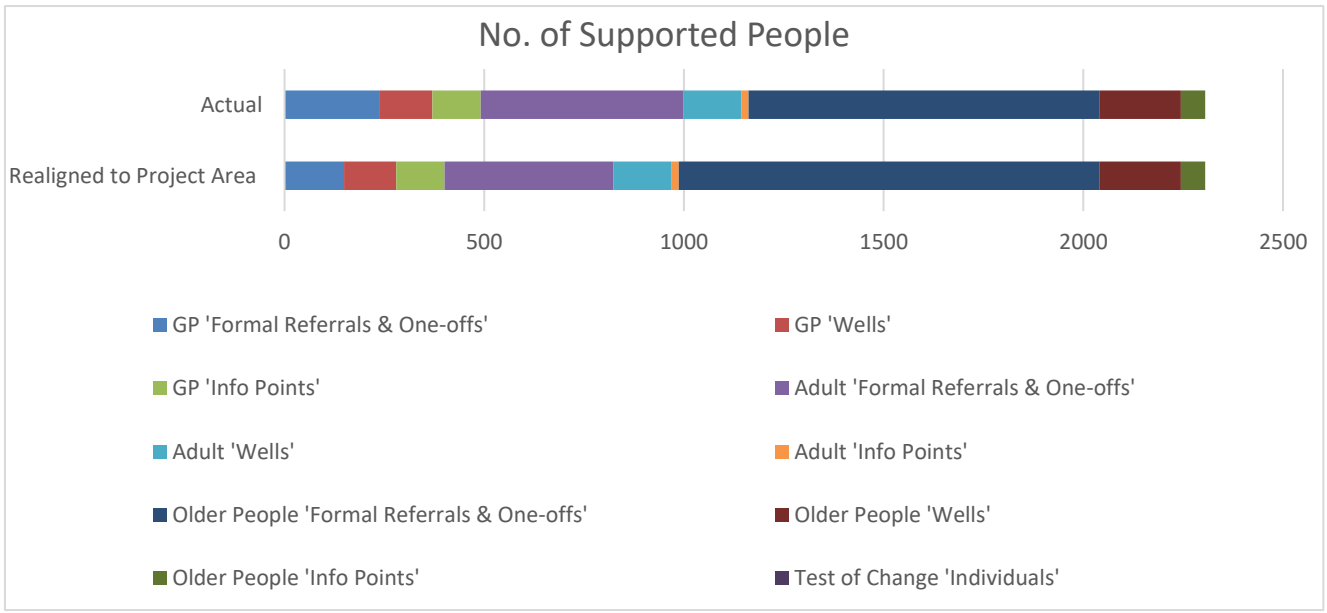
Throughout the reporting period the service accepted new formal referrals. A total of **1,262 formal referrals** were received. This presented a marginal decrease in the number of formal referrals received compared with the previous reporting year (0.8% decrease), however, this remains well above pre-pandemic levels (almost 38% higher compared to 2020) and remains on par with the second highest reporting period since its conception during late 2011. The achievement of reaching this referral rate should also be considered within the context of capacity being reduced by 30% following the withdrawal of GP Cluster funding mid-year.

The total number of formal referrals received remains above the overarching target prescribed by our Service Level Agreement (Targets: Fife-wide 700 realigned by the Fife Health & Social Care Partnership following a reduction in funding – GP Cluster 105; Adult 255; Older People 340). Within the context of formal referrals received, 306 of these were cross-referred internally to help ensure demand was met throughout the three service areas. This number was marginally lower than the previous year (310). The majority of cross-referrals were made to our Adult LAC team (166 – 1 GP Cluster; 165 Older People) with our GP Cluster and Older People LAC teams accounting for the remaining 140 cross-referrals (respectively: 32 Adult & 59 Older People; 49 Adult & 0 GP Cluster).

The **overarching target was surpassed (+562)** and when formal referrals are realigned to their intended services areas each of the service areas also met or surpassed their targets (GP Cluster +0; Adult +87; Older People +475). This pattern mirrors the previous reporting period, with the volume of referrals for Older People continuing to be the area seeing most growth. Despite the withdrawal of GP Cluster Funding the number of formal referrals routed from Medical Practice settings accounted for 12.5% of formal referrals received and overall Primary Health services accounted for 39.7% of the total (decreasing from 45.8% during the previous reporting period).



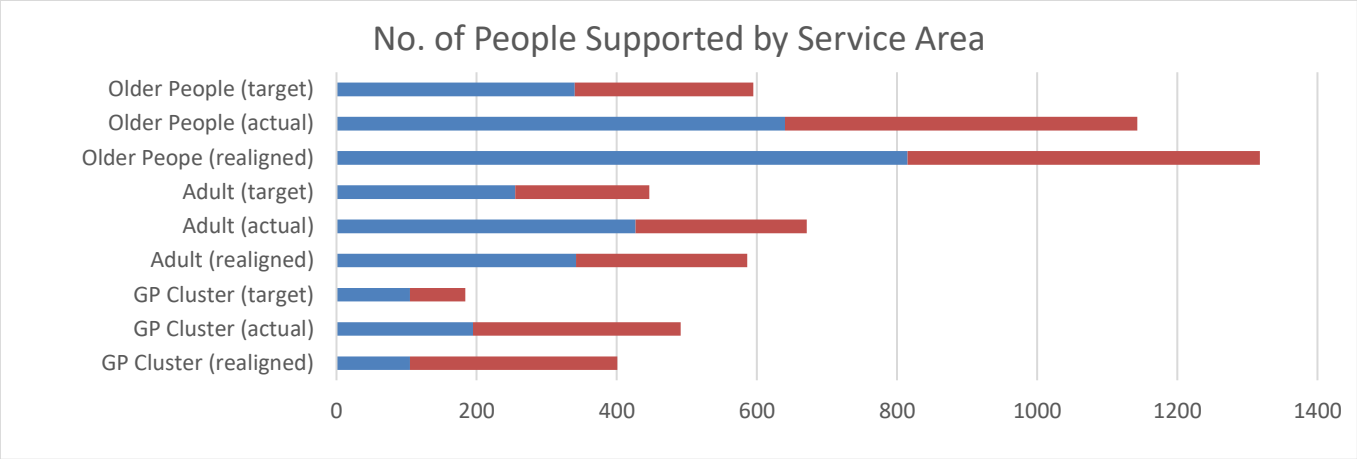
In addition to formal referrals, the service continued to offer guidance, information and signposting to people on a one-off basis directly via Fife Forum itself or at locality venues (this includes locality-sited or virtual Wells – community information points co-ordinated by the Fife Health & Social Care Partnership). When one-off enquiries/contacts are included **the service supported 2,305 people** Fife-wide and is well above the over-arching target prescribed in our Service Level Agreement (Target: 1,225 – 88.2% higher).



"Co-ordinator was extremely supportive & informative. I will have no problem recommending your service as it was excellent and I would have struggled without the support…"
Service Recipient

In relation to the targets prescribed within our Service Level Agreement each project area exceeded prescribed targets:

- **GP Cluster team supported 401 people (realigned to the service area)/491 people within a wider service context** (target: 183.75 – 105 Formal Referrals/78.75 One-off Contacts)
- **Adult team supported 586 people (realigned to the project area)/671 people within a wider service context** (target: 446.25 – 255 Formal Referrals/191.25 One-off Contacts).
- **Older People team supported 1,318 (realigned to the service area)/1,143 people within a wider service context** (target: 595 - 340 Formal Referrals/255 One-off Contacts)



Beyond, core one-off support giving the service facilitated client-facing information point activity in:

- **43** community-based settings
- **107** Medical Practice settings
- **227** Well settings (Fife Health & Social Care Partnership)

During the duration of our GP Cluster funding period the number of people (patients) presenting via our information points within a Medical Practice setting totaled 109 over 107 occasions.

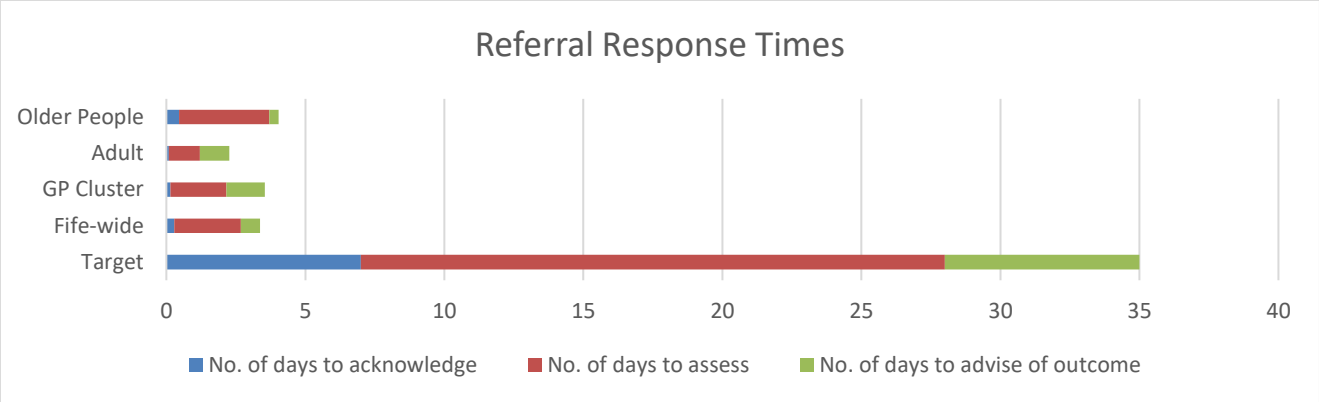
Formal Referral Response Times & Engagement Rates

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

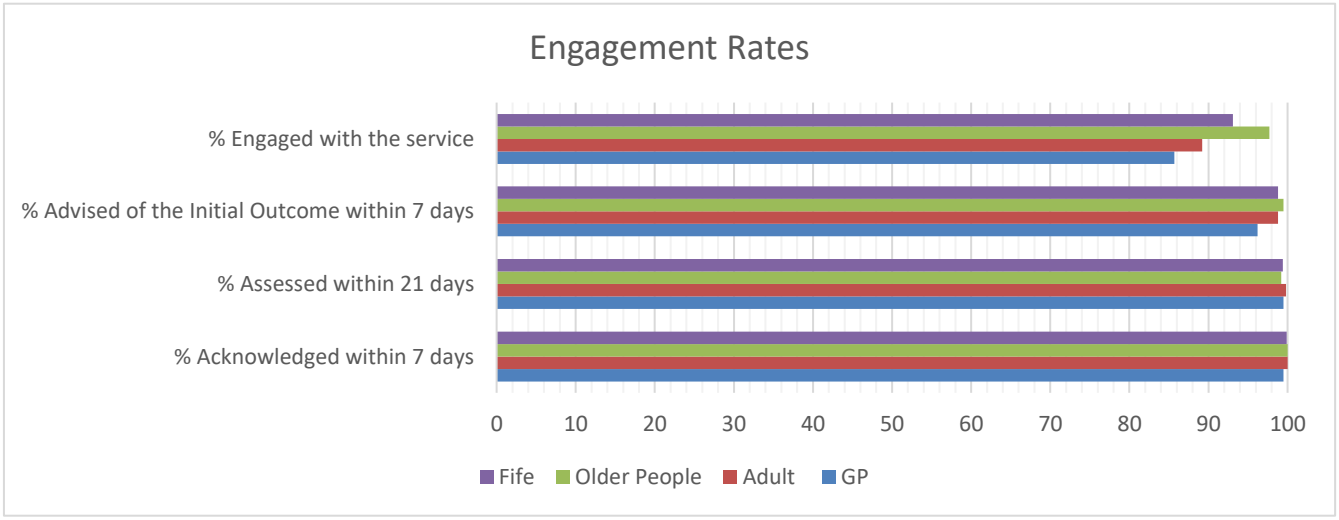
- Acknowledged within 7 days of receipt (**average:** GP 0.15; Adult 0.09; Older People 0.46)
- Assessed within 21 days of acknowledgement (**average:** GP 2.01; Adult 1.11; Older People 3.24)
- Advised of outcome within 7 days of assessment (**average:** GP 1.38; Adult 1.07; Older People 0.34)

In all three service areas the average target timelines were met and the process from acknowledgment to assessment to reporting an initial outcome averaged 3.37 days, well within

the prescribed 35-day timescale and is below previous reporting periods (2023: 6.56 days; 2024: 5.14 days).



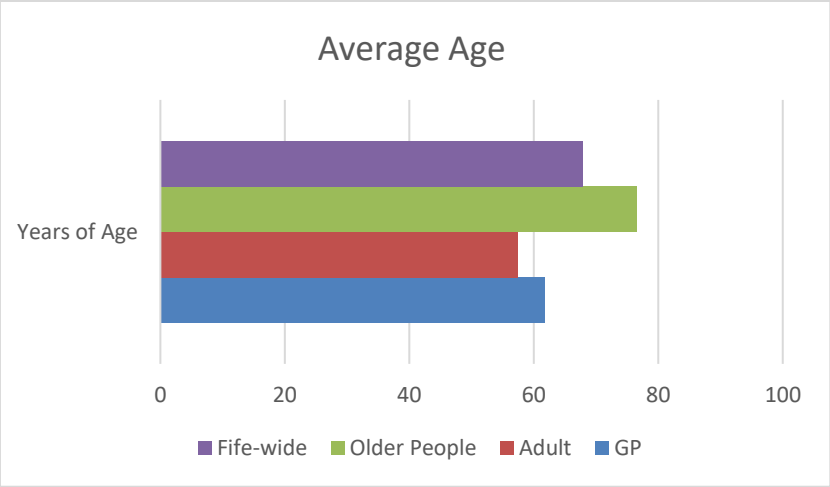
Fife-wide the percentage of formal referrals acknowledged within 7 days stood at 99.9% (2023: 99.5%; 2024: 99.8%); assessed within 21 days 99.4% (2023: 97.2%; 2024: 98.7%); and, advised of the initial outcome within 7 days 98.8% (2023: 96.3%; 2024: 99.0%). The engagement rate for formal referrals was 93.1% (2023: 87.0%; 2024: 94.1%). Individuals served by the Older People team were most likely to engage with the service with a rate of 97.7% (2023: 92.2%; 2024: 94.0%).

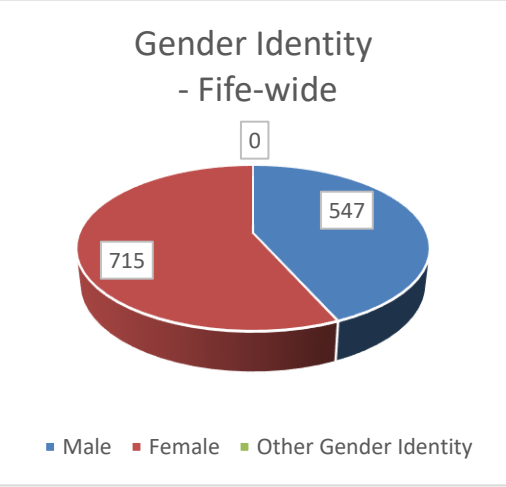


Gender & Age (Formal Referrals)

Fife-wide the ratio of male to female favour the latter (43:57). The gender ratio is replicated across the service areas (GP 42:58; Adult 46:54; Older People 42:58).

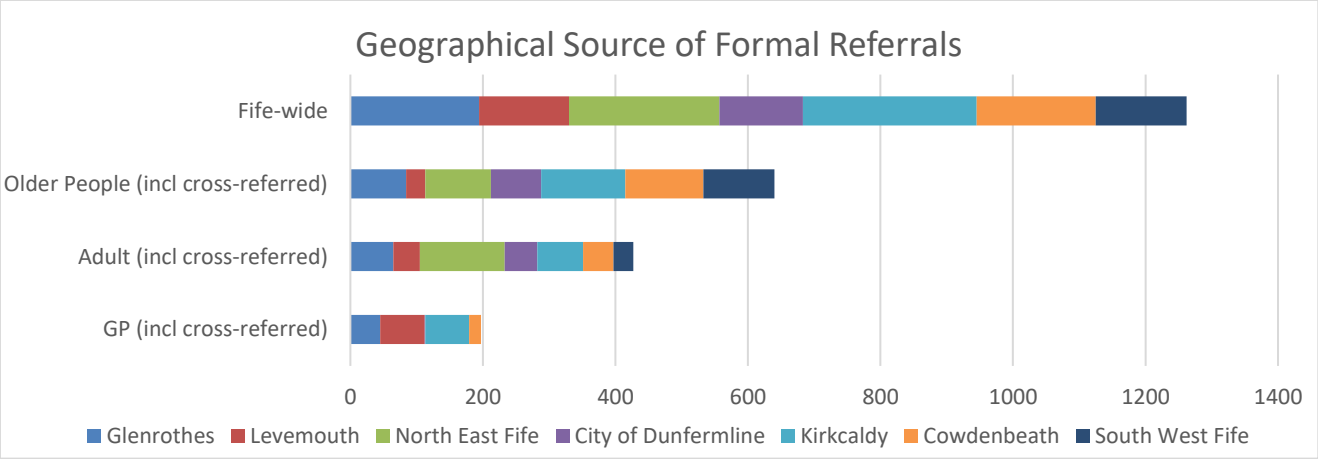
As should be expected given the age ranges served by each project area, average age varies with an age spectrum ranging from 16-102 (GP 61.8; Adult 57.4; Older People 76.6). Fife-wide the average age of all formal referrals has increased steadily from 64.0 (2023) to 66.5 (2024) to 67.9 (2025) continuing a trend upwards. This is the fifth 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.

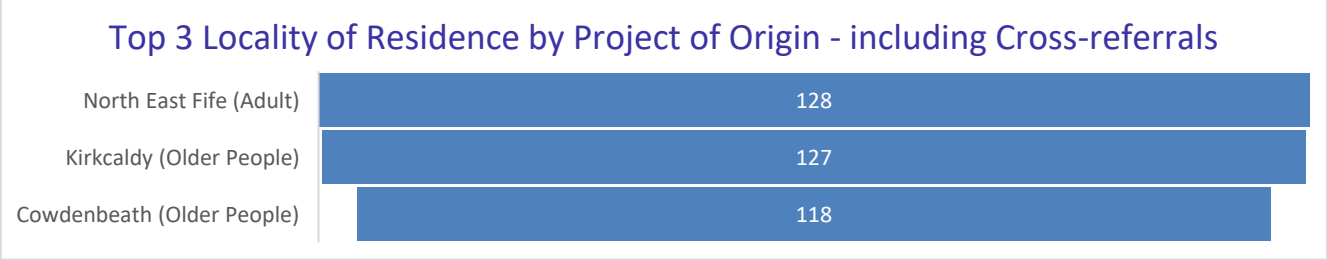




Geographical Areas (Formal Referrals)

For the period, the three localities where Fife's three largest settlements (Dunfermline, Kirkcaldy & Glenrothes) are located accounted for 582 or 46.1% of all formal referrals (previously 49.3%). Kirkcaldy locality accounted for 262 formal referrals followed by largely rural North East Fife with 227. It should be noted the GP Cluster areas were located in four of the seven localities (Kirkcaldy, Glenrothes, Levenmouth & Cowdenbeath). Localities with proportionately higher rates of multiple deprivation account for 61.1% of formal referrals (this would exclude North East Fife, South West Fife and the City of Dunfermline albeit each of these localities have areas of deprivation contained within).



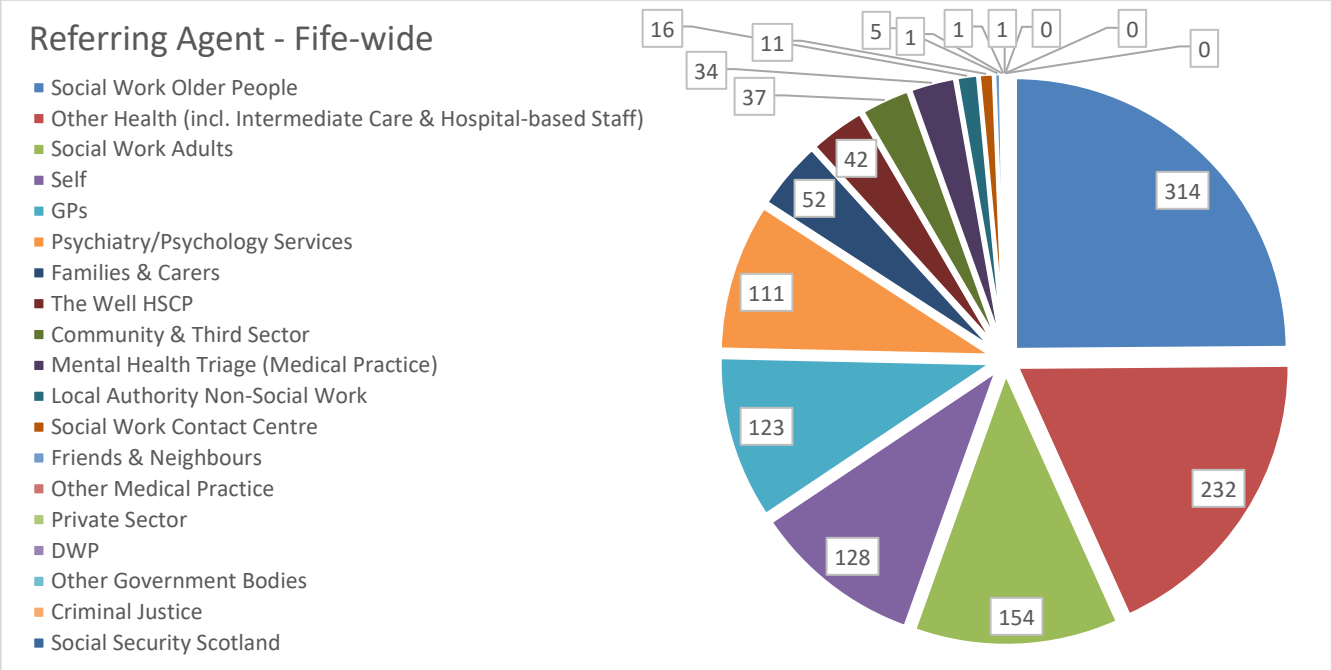


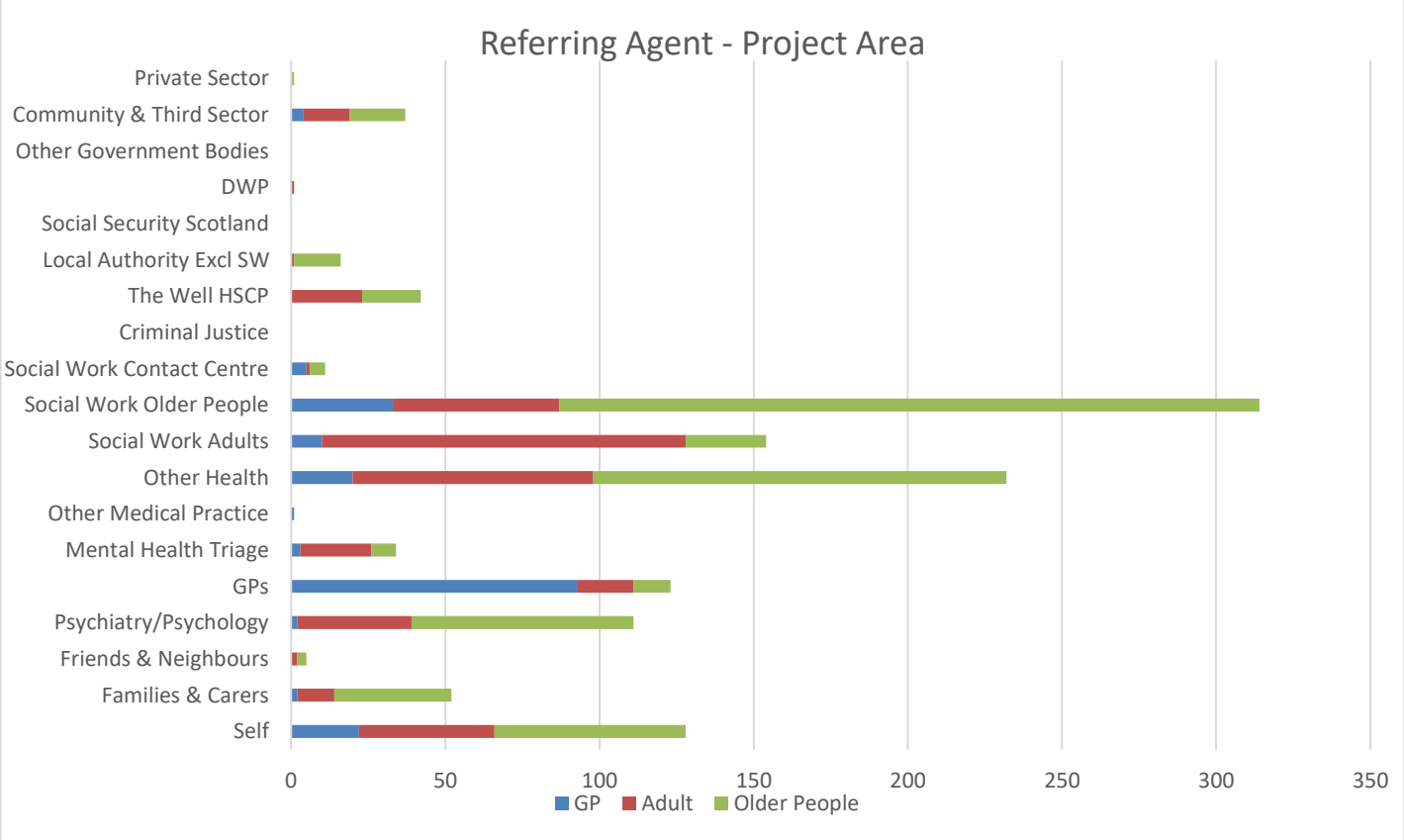
Formal Referral Source

Most formal referrals were sourced from Health and Social Work & Care partners accounting for 77.7% of referrals made, however, this is marginally lower than the previous two years (2023: 81.1%; 2024: 78.1%). As is to be expected owing to the GP funded remit within 'GP Cluster Areas' this was 85.6% overall ranging to Older People at the lower end with 75.6% (Adult 77.0%).

In a GP Cluster context, GPs accounted for 47.7% (2023: 42.7%; 2024: 59.6%) of formal referrals made followed by Social Work Older People (16.9%). Mental Health Triage Nurses decreased to 1.5% continuing a downward trajectory following the introduction of the Fife Health & Social Care Partnership community-led support pathway focusing on Mental Health (2022: 26.2%; 2023: 2.4%; 2024: 1.5%). Relating to the Adult service area, Social Work Adult Teams accounted for 27.6% followed by Other Health at 18.3% (this includes Intermediate Care Teams & hospital-based professionals). Similarly, Mental Health Triage Nurses decreased albeit the proportion is higher than 2023 (2022: 10.1%; 2023: 4.0%; 2024: 6.1%). Within the context of the Older People service area, the highest proportion of referrals were sourced from Social Work Older People Teams (35.5%), followed by Other Health (20.9)%.

The number of 'open' referrals from non-organisational sources remains highest within the Older People project (16.1%). Fife-wide open referrals accounted for 14.7% of all formal referrals nearly doubling since 2023 (2023: 7.7%; 2024: 9.8%). An open referral pathway (this includes: self; families & carers; friends & neighbours) ensures equitable access particularly for those who might not otherwise be engaged by services. This presents opportunity for preventative engagement helping to reduce, stem or, in cases, negate the need for more costly interventions. Self-referrals are now the fourth largest referral source behind Social Work Older People, Other Health and Social Work Adults.





Incidence of Health Issues (Formal Referrals)

Among the 1,262 people formally referred, 1,097 reported a health and/or life affecting condition many with multiple issues (2,591 health incidences). Where a heath condition is reported there is on average 2.36 conditions per person up from 2023 (1.98) and 2024 (2.11). This ranges from a high of 2.56 conditions per person within a GP Cluster context (2024: 2.03) to a low of 2.06 within an Adult context (2024: 1.91). The Older Person figure was 2.50 (2024: 2.46).

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

GP Cluster

1. 180 'Other Physical/Neurological/Cardiovascular Conditions'
2. 102 'Other Mental Health Conditions' (this excludes depression)

Adult

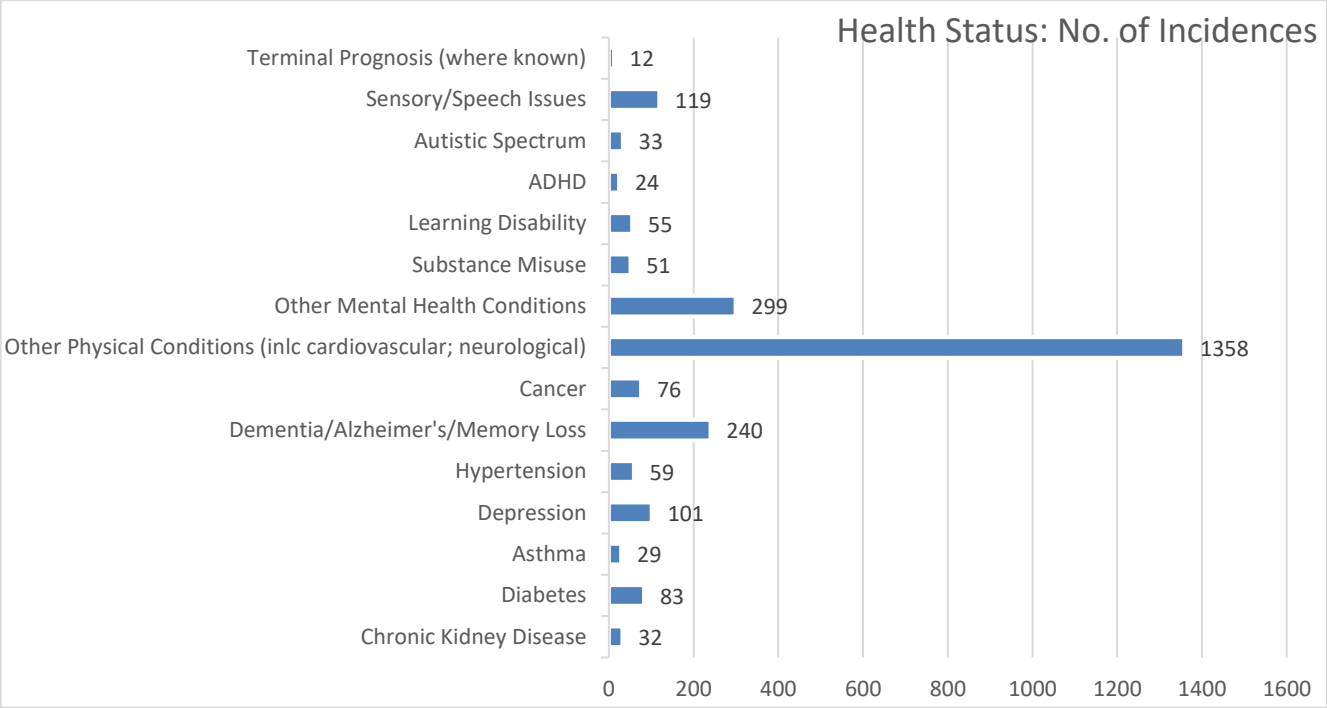
1. 295 'Other Physical/Neurological/Cardiovascular Conditions'
2. 113 'Other Mental Health Conditions' (this excludes depression)

Older People

1. 883 'Other Physical/Neurological/Cardiovascular Conditions'
2. 165 'Dementia/Alzheimer's/Memory Issues'

Physical-linked conditions account for 67.1% (2024: 61.7%) of all conditions reported and the rate of mental health-related issues (excluding 'Dementia/Alzheimer's/memory issues') has both proportionally and in real terms continued to decrease from 39.7% in 2021 to 15.4% during 2025 with incidences decreasing from a high of 915 during the covid pandemic in 2021 to 400 for this reporting period (2024: 481). Depression accounts for 25.3% of reported mental health conditions (101 incidences). Reported incidences of cognitive decline (Dementia/Alzheimer's/Memory Loss) accounted for 9.3% with 240 incidences rising steadily from 2023 (7.1%/188) and 2024 (8.0%/202).

It remains 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)

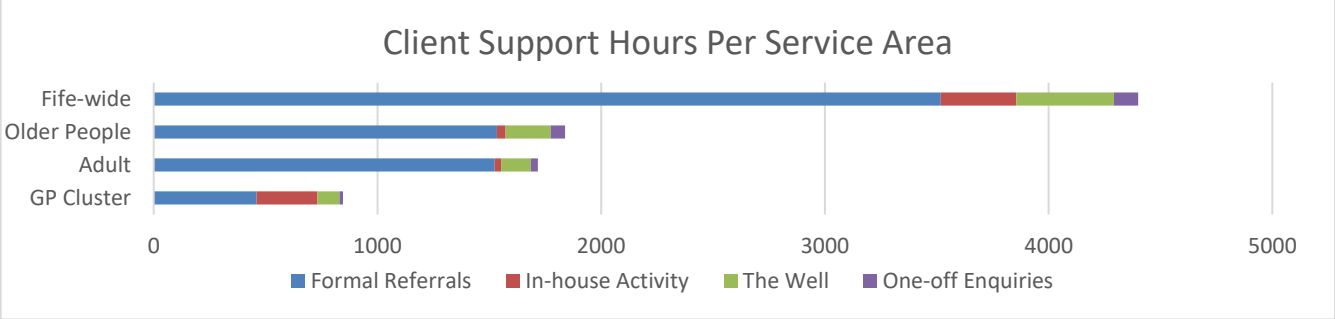
The number of support hours undertaken with **formal referrals** totaled **3,518 hours 10 minutes** increasing from 3,356 hours 30 minutes in 2024 (Source - Project Areas non-realigned to referral type: GP 459 hours 35 minutes; Adult 1,524 hours 30 minutes; Older People 1,534 hours 5 minutes).

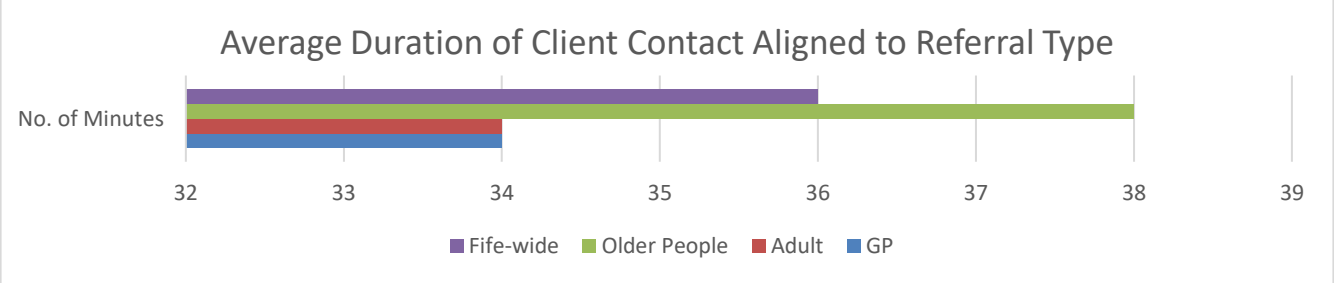
On average, in relation to all formal referrals, the **time spent per client contact was 36 minutes**; mirroring the previous period (Range - Project Areas aligned to referral type: GP 34 minutes; Adult 34 minutes; Older People 38 minutes). Following on from previous years, this continues to reflect the mixed contact method approach being deployed helping maximise LAC time, rather than utilising home visiting alone.

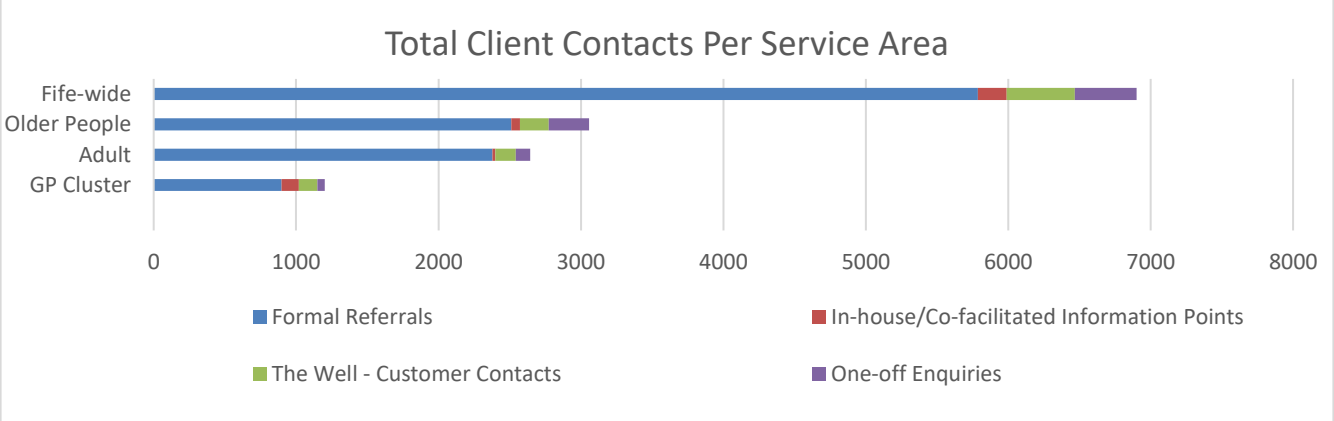
Other in-house client-facing activity (including co-facilitated activity) in the form of information points/drop-ins accounted for an additional **337 hours 25 minutes** of support work supporting 201 individual contacts. Additionally, **one-off enquiries** from both individuals and organisations (434 contacts) totaled **109 hours 10 minutes** of support work.

External client-facing activity accounted for **436 hours 5 minutes** of staff time supporting **480 customer contacts** over the course of **227 Wells** (2024: 635 hours 20 minutes/767 individuals/298 Wells). This reflects the reduction in capacity to support this as staffing numbers reduced.

Overall, the service delivered **4,400 hours 50 minutes support** hours deriving from **6,902 direct contacts** with individuals.



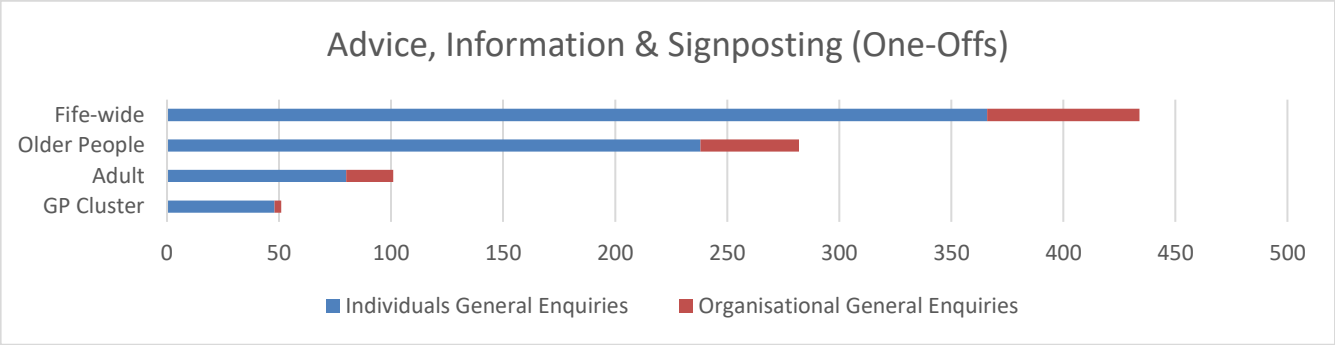


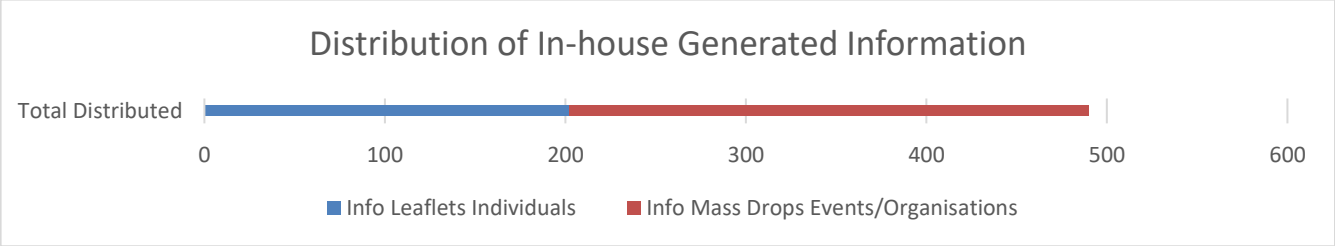


Guidance, Information & Signposting (One-Offs)

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 **362 individuals** and on **68 occasions to organisations** (Source - Per Project Area: GP 48/3; Adult 80/21; Older People 238/44). This increased from 325 individuals and 53 organisations during 2024.

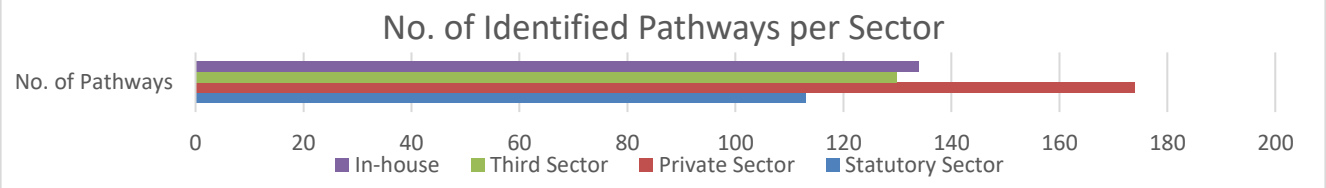
The promotion of the in-house published materials including the 'Resource & Support List' continued during 2025 with a total **distribution total of 490 in-house materials.** This is a decrease on previous years as the organisation reduced reliance upon paper versions of materials as information could be sourced on the website and social media page**.** The two in-house information resources (Privately Purchased Supports and Resource & Support List) continue to be reviewed/updated and remain downloadable on the Fife Forum website.



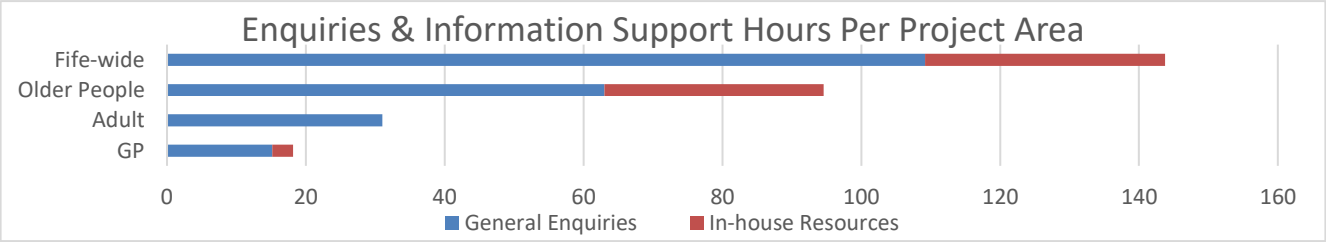


In relation to one-off enquiries there were **551 pathways** identified ranging from local interest groups to statutory and privately purchased provisions. Signposting to the Private Sector/Privately Purchased was the most prevalent route identified, equating to 31.6% of pathways. Third Sector/Community services, traditionally the most prevalent pathway route, decreased to 23.6% of pathways from 43.1% the previous year. This said, when in-house pathways are included this increased to 47.9% of pathways (2024: 52.5%).

It might be reasonable to assume 48.6% of pathways identified have a social element/intent to them.



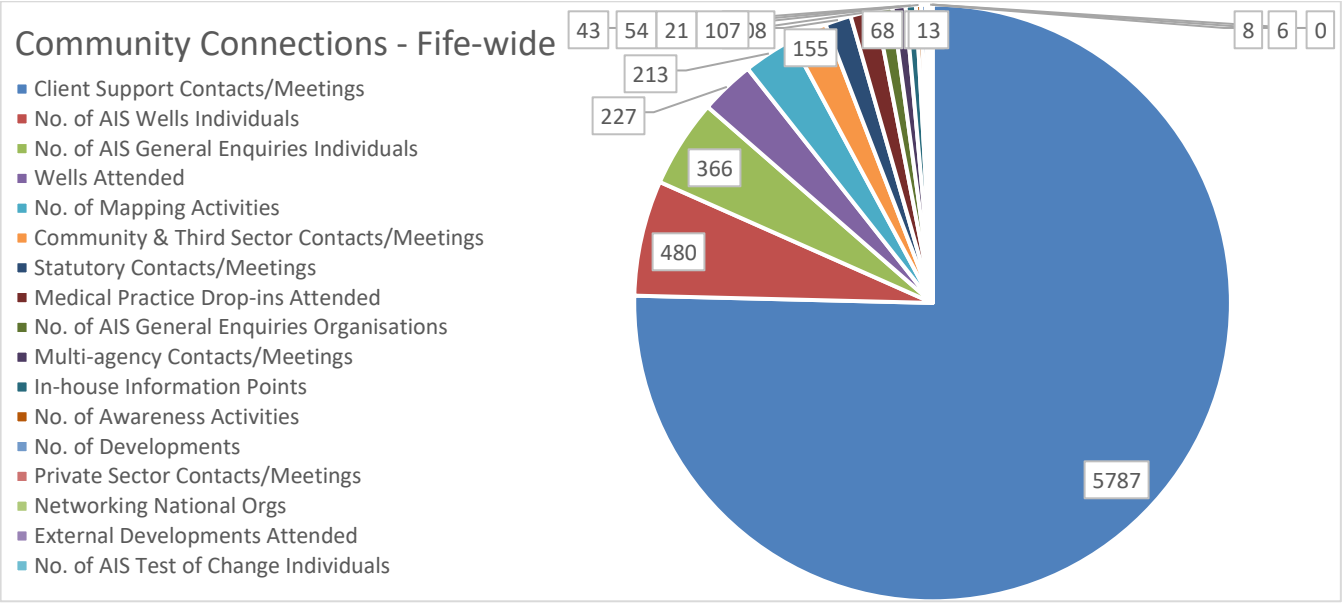
In total, service-wide **109 hours 10 minutes** of staff time was dedicated to one-off support and signposting alongside **34 hours 35 minutes** of staff time directed towards updating/reviewing in-house resources.



Community Connections

The service remains committed to establishing, developing and maintaining connections with service providers and individuals throughout Fife. The number of Community Connections undertaken with individuals, community groups and organisations reached **7,672** (this includes: site visits; awareness raising events; advice, information and signposting; development activity; and client-related contacts). This decreased from 8,239 (2025) reflecting a mid-year reduction in resources available.

Direct client/individual-related connections account for 92.2% of the overall total reflecting the concentration on client-focused activity (2024: 81.4%). Direct contact with formal referrals accounted for 75.4% of the total with **5,787 client contacts** made. This is an increase from 2024 in real terms and is of note given the reduction in staffing mid-year (2024: 67.5%/5,564).



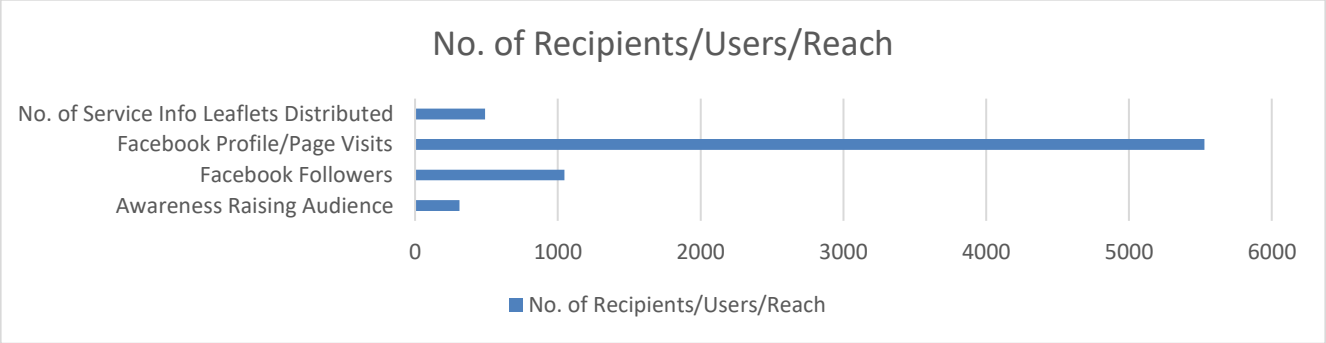
Awareness Raising

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 (2023: 21; 2024: 18) reaching an audience of 311 people (2023: 289; 2024: 452).

> *"…a great big thank you for your excellent and very helpful presentation about Fife Forum. The information you shared, will be so helpful to our volunteers, when it comes to trying to address the wider needs of some of our clients.".*
> ***Continuing Care North East Fife, Trustee***

The service and parent body (Fife Forum) continued to raise awareness of internal and external provisions utilising in-house promotional materials and social media platforms such as Facebook. During the year the Fife Forum Facebook received 121,412 organic views, 5,528 visits and reached 1,046 followers.

> *"Prior to LACs visiting our Forum meetings there was very little information regarding assistance. The service has improved greatly in our area under recent activity".*
> ***Older People Community Forum, Chairperson***



Development & Co-facilitation

Focus during the period centred primarily on the development of Information Points/drop-ins within community settings. This included working more closely with the Fife Forum older people Action Groups where Older People Local Area Co-ordinators directly worked alongside the Support & Development Worker by facilitating on-site information portals for members. For the first half of 2025 Information Points/drop-ins were supported at Medical Practices within the GP Cluster areas prior to the cessation of funding.

"Thank you, as always, for your continued support and for the collaborative approach in delivering The Well.".
Fife HSCP

Access to the National Entitlement Card NCT002 Mental Health was expanded to include a second signatory allowing Fife Forum to support applications for those impacted by Mental Health issues and who require the travel card to attend appointments and/or their mental health treatment plan. This can contribute positively to mental health offering 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 positively to overall mental well-being.

The service continued to support The Wells (Fife Health & Social Care Partnership) assisting the delivery of 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 with protected characteristics to apply for disability-linked benefits wherever appropriate and/or practicable. This directly assists those where there are barriers presenting which would prohibit them from accessing existing external supports to achieve this. When supported by the service to do this there is a high success rate for applicants.

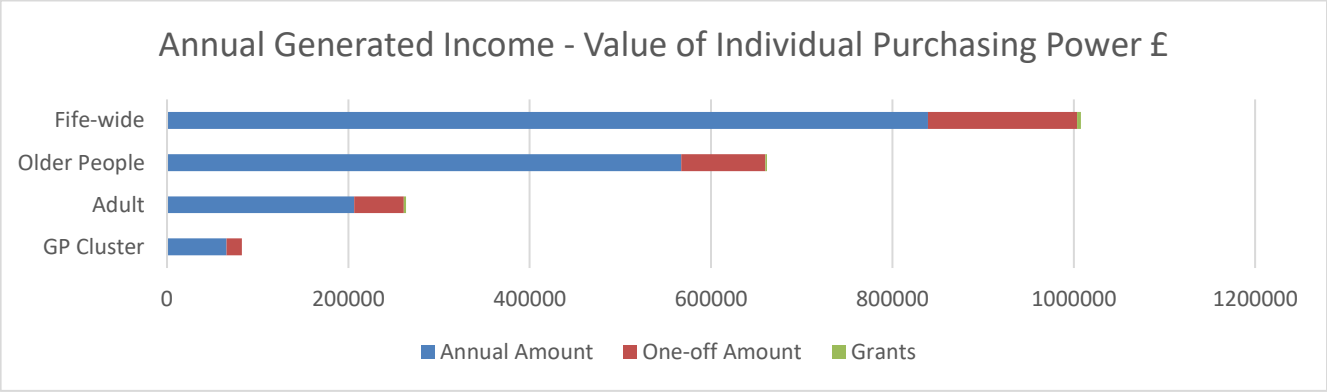
"We feel this service has been invaluable and we certainly would not have been able to complete this monstrous and forbidding form without X's full support, guidance and understanding. Thank you so much, we hope this service continues into the future".
Service Recipient

"I could not have done it without him. He was kind and was so helpful filling all the forms in…I am sorry I cannot write all about how caring X was. If people in the world were like him it would be a better place. Can't thank him enough".
Service Recipient

During the reporting year, 13.7% of individuals who were engaged as formal referrals were supported directly with income maximisation. For beneficiaries, the service **generated income and one-off payments worth £1,007,837.60** translating to an ongoing amount of **£839,247.92 per annum**. This surpasses the previous two years (2023: £461,028.25 per annum; 2024: £753,739.99) and over the course of the last four years has increased by **an incredible 608%** (2021: £118,510.84 per annum).

This adds both individual and wider socio-economic value, adding as it does to individual purchasing power and by contributing to the wider Fife economy. In a similar vein, this more than matches pound-for-pound funding received by Fife Forum from the Fife Health & Social Care Partnership.

The most prevalent benefit application supported was Attendance Allowance and the Pension Age Disability Payment (Older People). It is also worth noting, total income generation will likely be under presented as other associated benefits paid alongside disability-linked benefits are not commonly reported back to the service as the recipient's focus tends to be on the primary benefit itself.

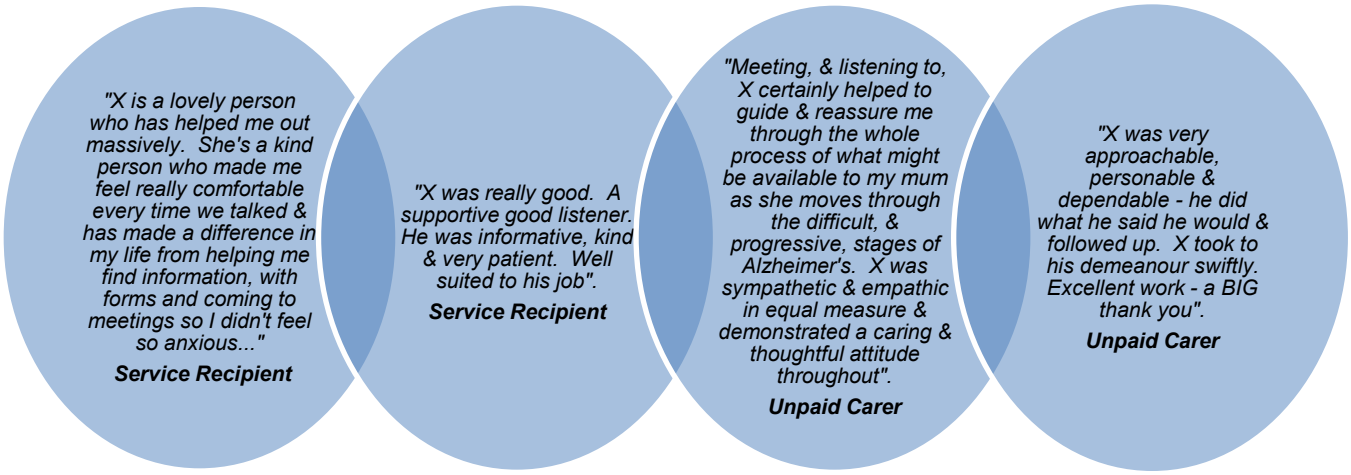


On average beneficiaries were awarded a **one-off backdated payment of £1,047.83 per person** and the service area successfully supported **grant applications worth £4,080.75**.

In addition to directly supporting beneficiaries accessing their entitlement, the service also routes people to external agents who are tasked to assist in a similar, direct or more specialised capacity (for example: CARF; DWP Home Visiting Service; Voiceability; and Social Security Scotland).

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 year attempting to capture a breadth of qualitative findings. Additionally, e surveys were deployed, however, when deployed the return rate for this remains extremely low. The feedback received remains overwhelmingly positive and is consistent with previous years.

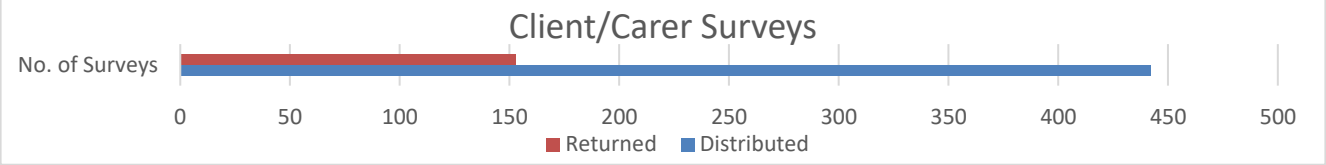


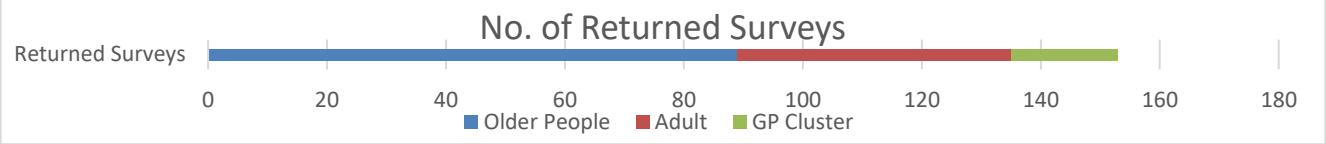
Within the context of open responses, it continues to be worth noting service recipients allude to the approach of each Local Area Co-ordinator; particularly their swift response, their adoption of meaningful conversation, and their ability to build appropriate relationships. This, as with previous years,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

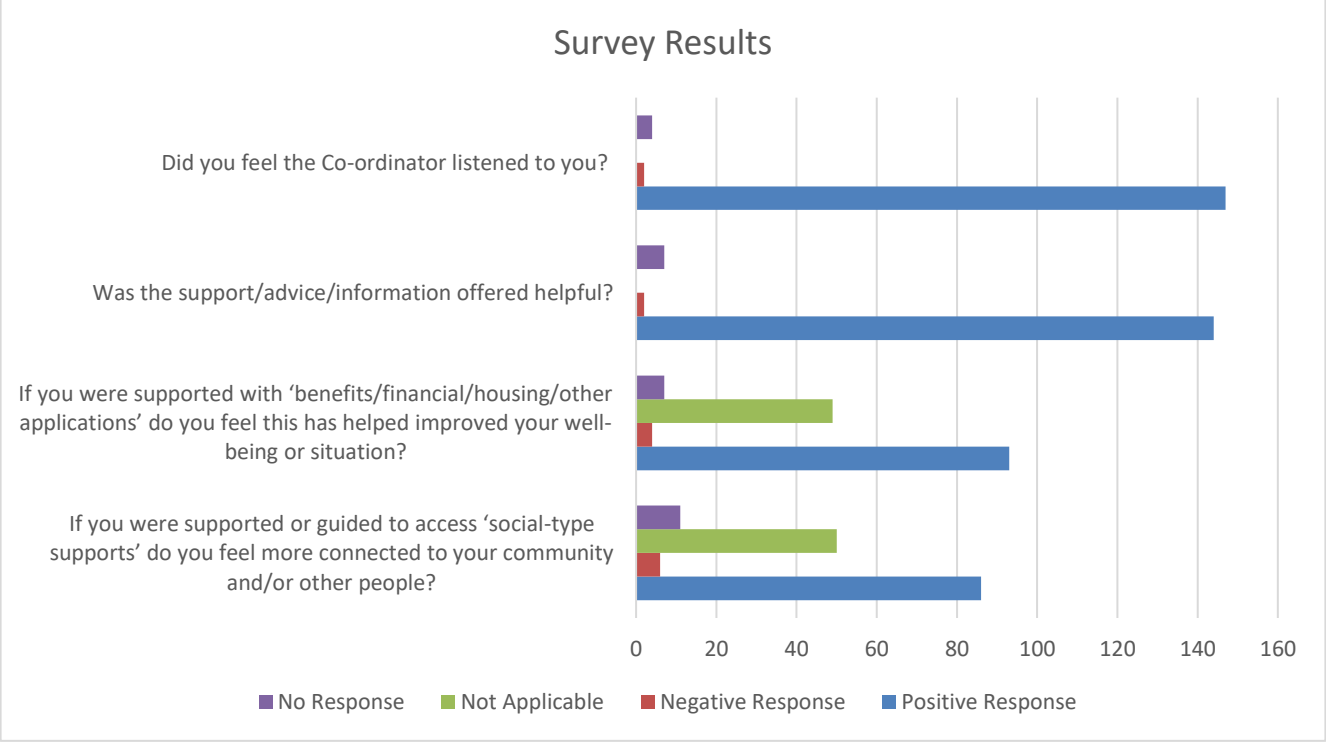
Where repeat key words are extrapolated from open responses common themes appear to emerge and the language mirrors previously recorded themes, this being the 'humanistic' approach deployed by the service; the 'motivational' aspect which helps facilitate engagement; and the 'informational' role provided by a professional framework which aims to support and increase personal knowledge and engagement. In total 140 open responses were received in relation to the request 'Please share any further thoughts you may have regarding our service'. It is also worth noting the similar 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 909 this being the number of closed cases excluding those where there was non-engagement, the number of surveys issued during the final two weeks of reporting and the number of active clients at the year-end (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 34.6%** was recorded (2023: 31.4%; 2024: 37.4%) - Range: GP Cluster 2025 52.9% v 2024 21.7%; Adult 2025 36.8% v 2023 26.4%; Older People 2025 31.4% v 2024 53.3%). Whilst higher than a typical return rate of between 5-30% this is a decrease compared to the previous year, largely owing to a lower percentage return rate within Older People albeit the actual number of returns is higher.

How we monitor our work is reviewed annually as we seek to improve our methods of capturing qualitative feedback and, this year the method of deploying surveys was centralised to help ensure issuing was systematic. This will be strengthened moving forward to ensure service leads are notified of all case closures regardless of status.







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 (**23 from 153 returns received**):

Specified Resource type	Health & Social Work	Community-based	Waiting & Response Times	Hard to identify Gaps
Respite (3)	GP Appointments (2)	Carer Support (1)	Befriending (4)	Area not specified (10)
Housing (2)	Respite (2)	Brain Injury Support (1)	Housing (3)	
Transport: Hospital (1) & Evening (1)	OT Adaptations (1)	Time to Care Grant (1) * May be alluding to Time to Live Fund	Day Care (3)	
Council Locality Office (1)	Accessible Hospital (1)		OT (2)	
Adaptations Wetroom (1)			Blue Badge (1)	
Brain Injury Support (1)				
Cleaner (1)				
Befriending: Kennoway (1) & Tele (1)				

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.

- **98.7% of respondents felt listened to**
- **98.6% of respondents felt the support was helpful**
- **95.9% of respondents felt their wellbeing or situation had improved**
- **93.5% of respondents felt more connected**

In relation to **Referrer Feedback** please note the additional comments supporting the benefits of Local Area Co-ordination as a resource:

"Thank you for the update, that's amazing, thank you so much for the support you are giving this gentleman & his wife. It must give them an enormous sense of relief having this support".

Specialist Practice District Nurse

"I really wanted to take a moment to express just how much X meant...This woman is an absolute force of nature, in the best way. Her no-nonsense approach, wealth of knowledge & calm reassurance made an instant difference. She stepped in when I felt completely broken, overwhelmed & didn't know where to turn. X picked me up, got things moving without fuss, & made sure we weren't left to struggle alone...We will never forget her patience, support & kindness".

Family Member (referrer)

"...I also had some feedback from a family that you helped support earlier this year with the PADP. They praised your support, found you very helpful and lovely & so supportive, they would not have managed without you! I thought it would be nice to share some positive feedback ".

Dementia Link Worker

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 Local Area Co-ordinator and in total 75 surveys were carried out (40 Older People/20 Adults/15 GP Cluster). The surveys elicited positive responses bar one respondent (Adult) who indicated they had not given permission for a referral to have been made and one respondent (Adult) who was critical of the Social Work system stating it was not fit for purpose, however, added they found Fife Forum to be helpful and understanding of their position.

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)

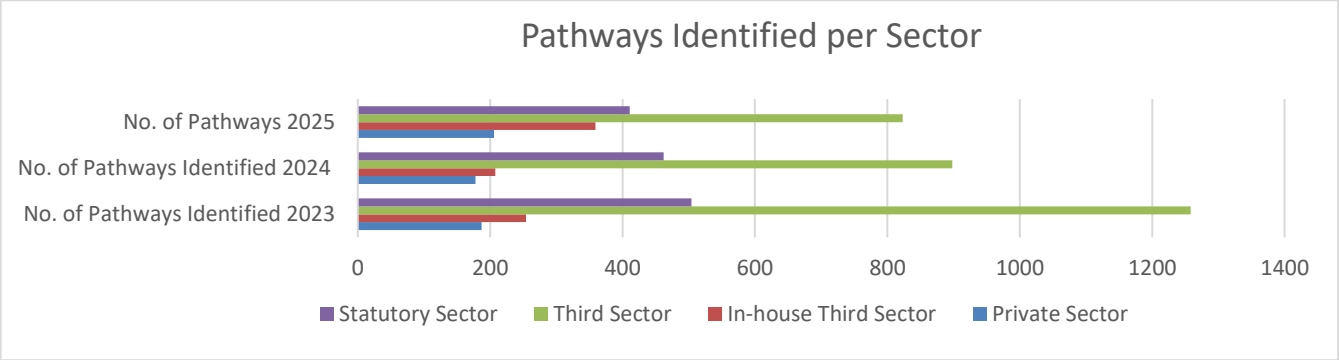
It is hoped by providing information relating to pathways for formal referrals it will help to reflect in part:

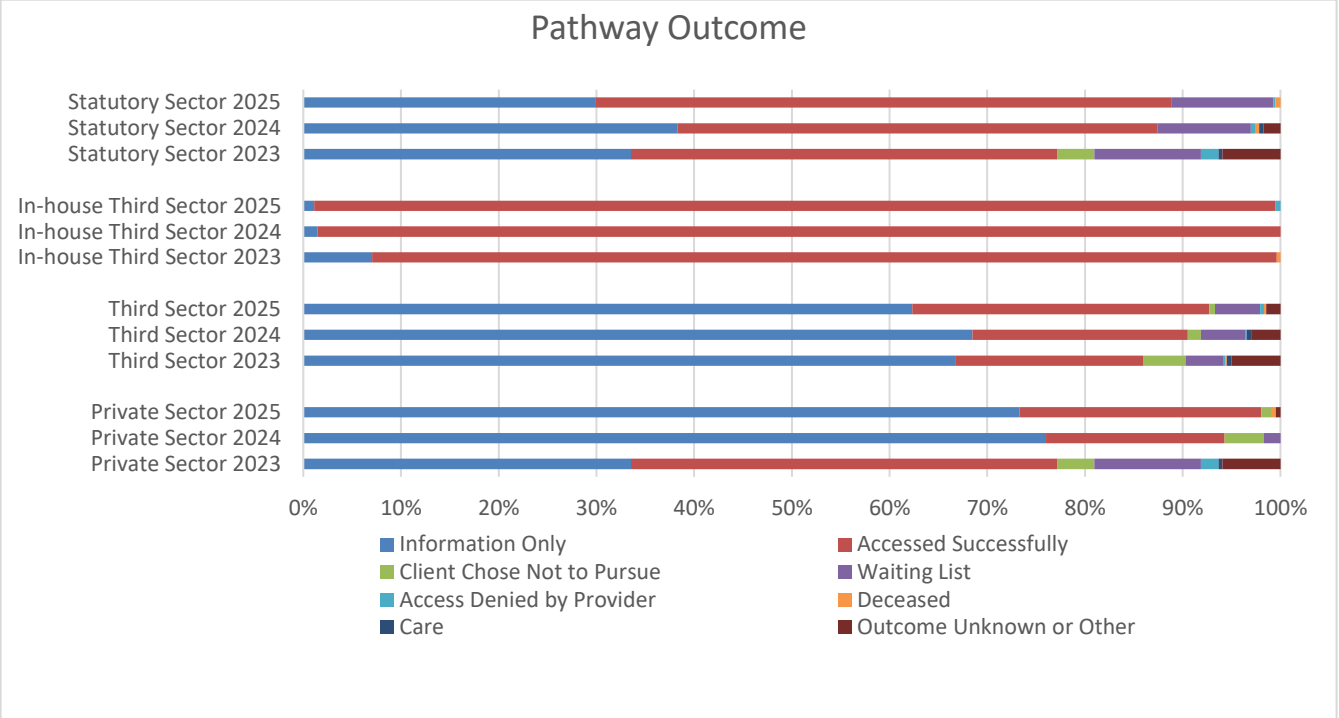
- Client outcomes
- Demand for service-type
- Gaps in provision

A total of 1,799 (2024: 1,746) pathways were identified and by the year end 49.6% (2024: 37.9%) or 893 incidences of all pathway outcomes were successful in that access to routed

provision was directly facilitated. This rises to 93.5% (2024: 91.1%) where the pathway route was intended/requested as 'Information Only'. Of the pathways identified: 65.7% (2024: 63.3%) are attributed to the Third Sector; 22.8% (2024: 26.5%) Statutory Sector; and 11.5% (2024: 10.2%) Private Sector.

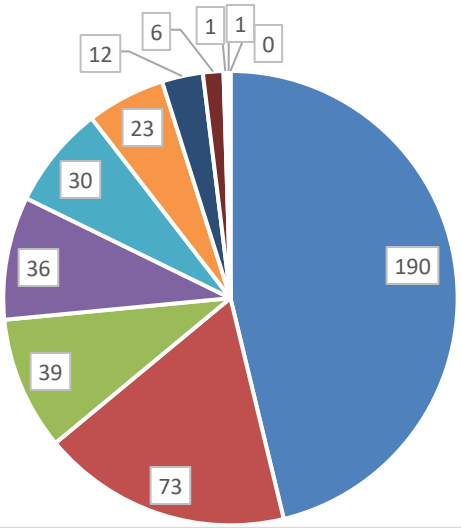
The data for the period is as follows:





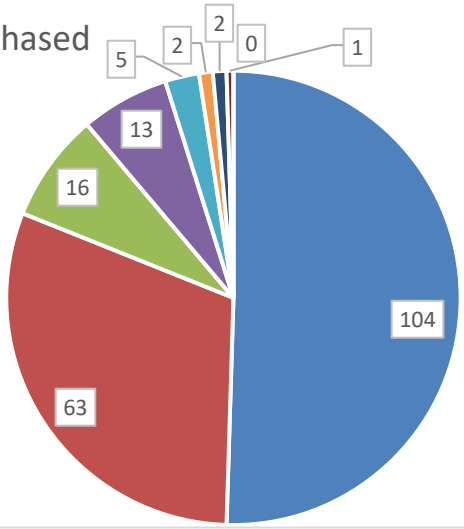
Pathways Identified: Statutory/Public Sector

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



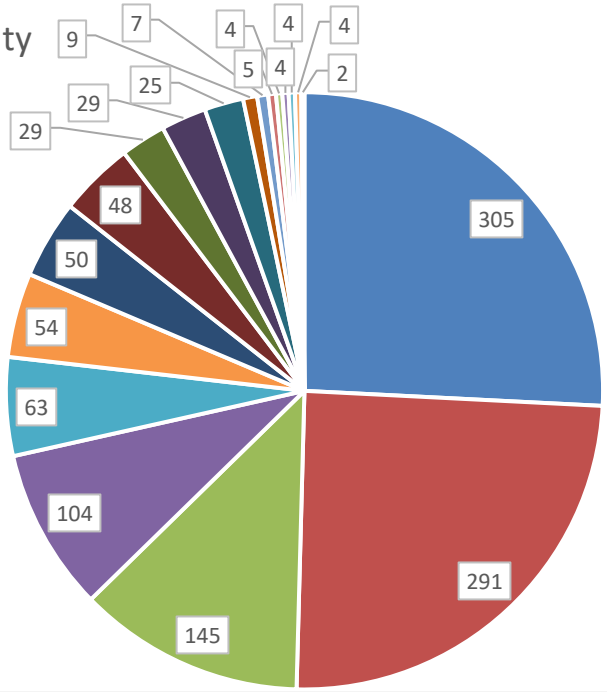
Pathways Identified: Private Sector/Privately Purchased

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



Pathways Identified: Third Sector/Community

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



Within the context of all sector pathways, it could reasonably be assumed that 43.1% were socially motivated. This is likely to be higher if secondary motivations are considered.

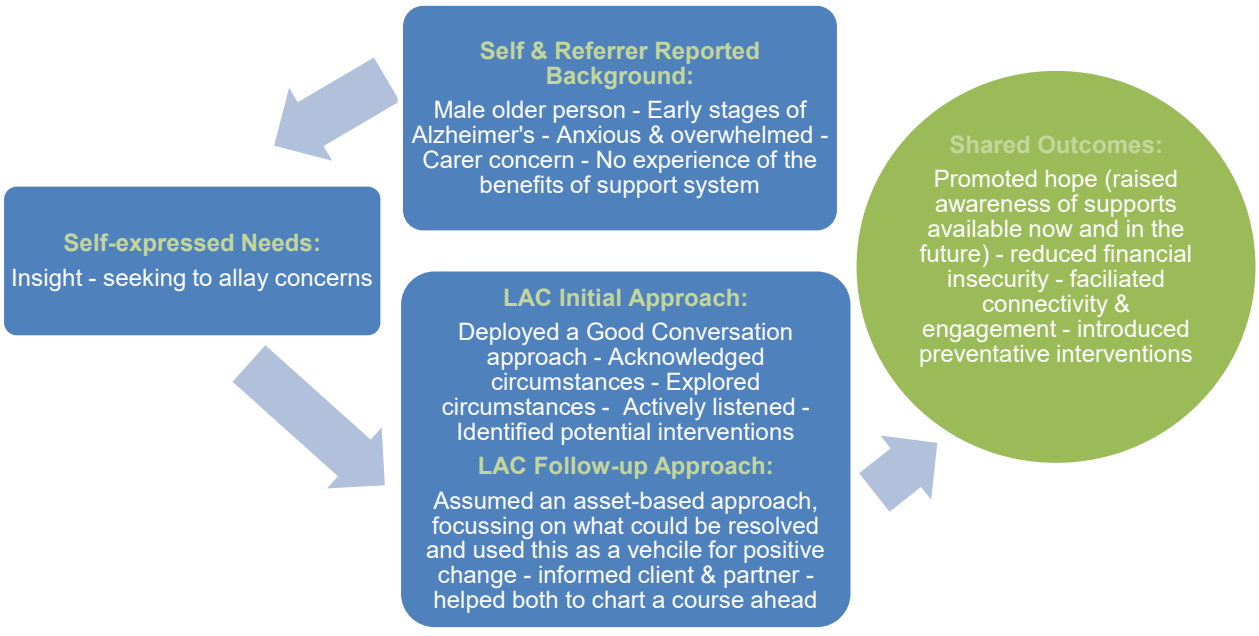
Within a Statutory context, there continued to be a high level of pathways identified in relation to the Department of Works & Pensions and Social Security Scotland (226) indicative of ongoing concerns in relation to personal finances and the wider economic crisis and its impact. When assistance given to those seeking support with a Blue Badge and/or Parking Bay application is included, it would be reasonable to assume 62.3% 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 purposes 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. The information from these has been extrapolated forming a synopsis.

Formal Referral Case Study 1



Synopsis

Client X found himself at a loss following a diagnosis of Alzheimer's and was referred to the service by the Community Mental Health Team, indicating support was required with navigating the benefit system. X lives with his partner and both indicated they felt overwhelmed, low in mood and were worried for their future. Prior to diagnosis, they had not previously engaged with services and had no knowledge of what supports are or could be available to them in the future.

By adopting a Good Conversation approach and offering X time to explore his situation without prejudging his circumstances, X was afforded an opportunity to express his concerns and to have these heard. This was supported by his partner. In the immediate sense, this allowed X and his partner to reflect on their current circumstances, identify the issues which were of more immediate concern and how this might be addressed with the support of a Local Area Co-ordinator. This primarily related to financial insecurity and a fear of not knowing how they might cope.

By working with the couple to resolve more immediate concerns this aimed to help allay their feeling of being overwhelmed, helping to establish a starting block on which they could begin to move forward. To support a sense of financial control, and as it was apparent neither had knowledge or insight of the benefits system, it was agreed an application for Pension Age Disability Payment could be supported. Once this was completed attention, could then be given to applying for a Council tax reduction. By supporting a pathway which would facilitate greater financial security this allowed conversation to open in relation to what community-based supports are and could be available, including how these might be purchased where required with the support of a successful benefit application.

An immediate asset available to both was carer and peer support. This was encouraged as this presented each with a community-based asset which could support their wellbeing, social and learning needs. The aim of this would be to support longer-term connectivity in community and peer environments. Additionally, LAC offered a reassurance that if they require further information, guidance or support on their journey they can independently return to the service.

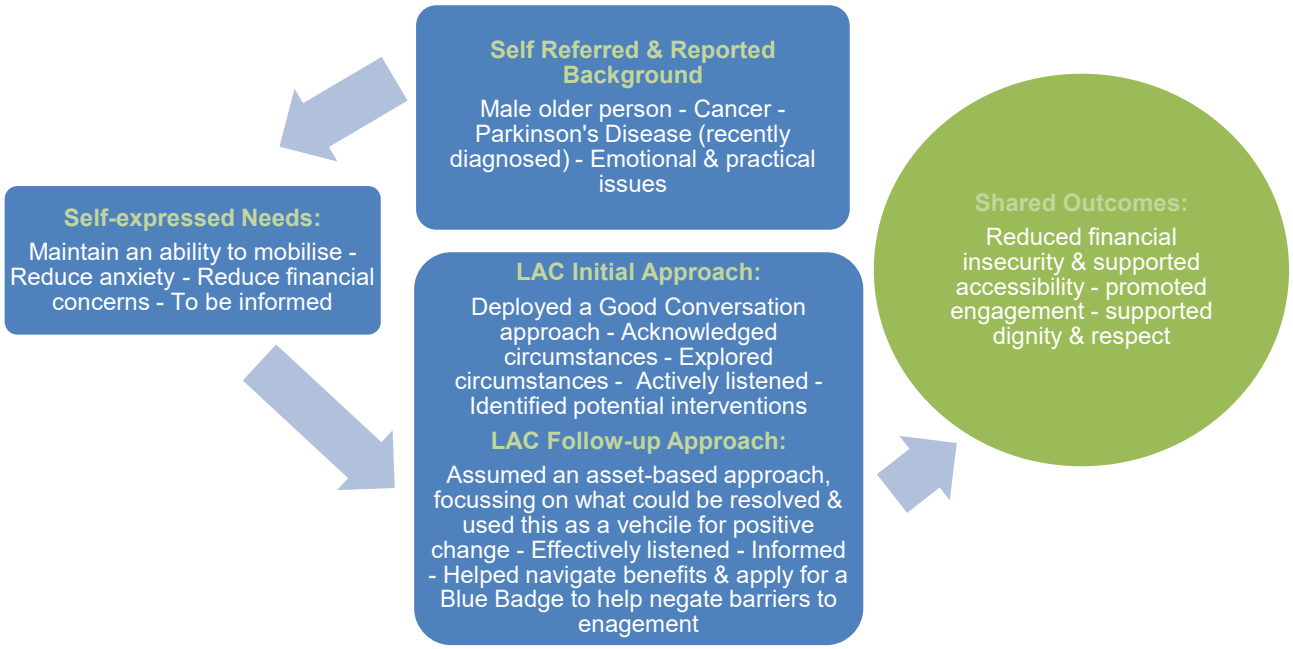
In summary, through a Good Conversation approach, empathy and encouragement both X and his carer's immediate sense of hopelessness was allayed; with key personal and organisational outcomes achieved over a relatively brief period. Securing income, building trust and offering reassurance was cornerstone to this and ultimately allowed X to assert a level of self-control over his circumstances. Crucially, X was made aware support can be re-established at any point of his journey.

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

"Having someone who is well informed & able to access all necessary supports & financial assistance for me has been a terrific help. I have been extremely anxious

over the increasing caring role my partner is having to undertake so the support of the Co-ordinator has enabled both of us to feel more informed, supported and secure in our future. Given that my Alzheimer's diagnosis is still in its early stages I am relieved that I have been able to rely on the Fife Forum Co-ordinator as a direct point of contact & assistance for many of the services that I have needed to employ".

Formal Referral Case Study 2



Synopsis

X and his spouse self-presented to a Fife Health & Social Care Partnership Well. X was motivated to attend a Well following being diagnosed with serious progressive health issues and was unsure of what supports might be available to support them. It was recognised that the couple were enduring a challenging period, and it was agreed with them that they might benefit from a formal referral to Fife Forum whereupon a Local Area Co-ordinator could visit and explore their needs more holistically.

A Local Area Co-ordinator was introduced via the Well and visited the couple. It was evident both were experiencing anxiety and stress, weighed down by X's prognosis. Through Good Conversations, active listening and by establishing a relationship with X and his spouse it was evident that whilst the health outcome could not be changed, the route ahead could be made more comfortable and manageable for X and his spouse.

It is recognised that when people experience significant life limiting health issues, financial insecurity can be detrimental to better outcomes in relation to care and wellbeing. As such, it is crucial any barriers to this are removed. The Local Area Co-ordinator was able to facilitate this through direct and sustained contact helping to allay concerns, provide information to support connectivity, raise awareness of entitlement to and support application processes for

financial and practical assistance. This does not change the health prognosis but does support more sustainable engagement and improved wellbeing. In this case, in a very practical sense, X and his spouse were supported to apply for the Pension Age Disability Payment and Blue Badge successfully which reduced financial insecurity and supported accessibility.

Adopting a Good Conversation approach, initially via the Well and then with follow-up home visits by a Fife Forum Local Area Co-ordinator, averted a deterioration in circumstances, reduced a sense of hopelessness and provided practical tools and supports which will support better wellbeing outcomes for the individuals concerned.

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

"Before I met X, I wasn't really sure what kind of support was available after being diagnosed with …My wife and I met X at the Well drop-in in Cupar, & from that moment things started to feel a bit easier. He referred us to Fife Forum and arranged the first of several home visits to see how we were getting on. Even just talking with X when he came to visit - & having him take the time to really listen – made me feel that I wasn't alone. He helped me with my Pension Age Disability form and Blue Badge application, but more than that, he offered genuine kindness & understanding. We also had some good chats about life, & he shared a few helpful ideas that really made a difference…The financial assistance has enabled me to pay for help with tasks I am no longer able to do on my own…The Blue Badge has made a significant difference…travelling to shops & other places has become so much easier & more manageable. It was really reassuring to have someone there to offer support & to genuinely listen. The discussions provided me with helpful ideas & practical suggestions on how to better cope with the illness I'm managing".

Learning

Not unlike previous 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 continued to navigate this and evolve; adapting how we approach, deliver and monitor our work. The precarious climate in which we find ourselves was, however, compounded by the sudden ending of funding within our GP project area exacerbating 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 management team continue to collectively address this and effectively deliver what remains an invaluable 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

At the time of reporting, our 3-year Service Level Agreement funding cycle with the Fife Health & Social Care Partnership is soon to end and as a service we cannot guarantee this will be carried forward to a new cycle. It is our believe, despite challenges, Local Area Co-ordination remains an invaluable asset and has and is delivered effectively by Fife Forum with far reaching benefits for both individuals and the partnership alike.

As we enter our 15th 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, continued to be a proactive service provider, achieving positive results far exceeding prescribed targets, both quantitative and qualitative.

The service continued to actively promote ‘Local Area Co-ordination’ with a view to working collaboratively to support as many individuals as is practicable. The service supports this by continuing to learn from experience (identifying and resolving any internal procedural issues) and by adapting and developing to help ensure continuity and effectiveness throughout the service area.

As we enter 2026, there are challenges ahead both from an internal and external perspective, not least ongoing sustainable funding. The service will continue to not lose sight of this and, where appropriate, will enact reasonable and meaningful change to evolve. The service remains committed to supporting a shared programme or recovery and resilience helping to support the people of Fife.

"GOOD FRIENDLY PEOPLE WHO TAKE THE PAIN OUT OF BUREAUCRACY".
Service Recipient

"YOUR SERVICE IS TOTALLY INVALUABLE TO EVERYONE OF ALL AGES REGARDLESS OF STATUS. I WILL NOT HESITATE SHOULD I REQUIRE YOUR SERVICE & X IN PARTICULAR. I AM GOING TO PUT X'S WORK NUMBER ON SPEED DIAL FOR FUTURE REFERENCE. THANK YOU ALL SO MUCH".
Service Recipient

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