Annual Report 2024-2025

Community Led Support Services

Fife Health & Social Care Partnership

Contents

Executive Summary

The 2024/25 Annual Report outlines the strategic achievements and operational impact of the Community Led Support Service (CLSS), a key component of Fife's integrated health and social care system. Operating under Locality Planning within the Business Enabling portfolio, CLSS delivers vital, person-centred support across all seven localities in Fife.

Community Led Support (CLS) is a model that delivers early intervention and holistic, non-clinical support through the 'good conversation' approach. It is designed to reduce pressure on statutory services by addressing the social determinants of health, such as isolation, housing, and financial insecurity.

CLS is a strategic enabler for Fife's broader health and wellbeing ambitions. It aligns directly with:

- The HSCP Strategic Plan 2023–26
- The Plan for Fife
- NHS Fife Population Health and Wellbeing Strategy
- Health & Social Care Service Renewal Framework 2025-2035

Its open-access model ensures timely, equitable access to support, particularly for individuals who may not meet thresholds for formal services but still require meaningful intervention.

Impact and Reach

In 2024–25, CLSS supported over 4,000 individuals across Fife. These interventions aim to prevent escalation to formal health or social care services, demonstrating clear system efficiency benefits. Community Link Workers are embedded in every locality, ensuring that support is responsive to local needs and delivered in partnership with communities. CLS also plays a role in national policy development. As an active member of the Scottish Community Link Worker Network, CLS contributed to the Scottish Government's 2024 evidence review, reinforcing its role in integrated, person-centred care.

Highlights of progress made in 24/25:

- The Well achieved a 34% increase in referrals and 24% increase in "Good Conversations" from 23/24 to 24/25.
- Link Life Fife achieved a 42% increase in referrals and 17% increase in engagement from 23/24 to 24/25.
- ICJ seen a 6.4% reduction in referrals from 23/24 to 24/25, however sustained an engagement rate of 78%.
- Financial Wellbeing: Partnership with CARF generated over £434,553 in additional income for clients who engaged with CLS.
- Mental Health: Following joint work with Primary Care Mental Health Nursing Team and training in Distress Brief Intervention (DBI).
- Using the CollaboRATE tool, CLSS gathered 225 responses with an average score of 26 out of 27, reflecting strong shared decision-making and user satisfaction.
- CLSS successfully secured external funding of £119,589 from partner organisations. This investment has created an opportunity to expand the reach of both the Wells and Link Life Fife initiatives, enabling greater support for individuals and communities across the region.

Sustainability

The increasing demand for Community Led Support (CLS) reflects its proven value and impact. Recent funding has expanded access to key programmes like Link Life Fife and The Well, while the open-access model continues to enable inclusive, barrier free engagement. To sustain this growth, we will regularly review and refine the service using both qualitative and quantitative data, ensuring continued capacity, resilience, and excellence.

Looking Ahead: Priorities for 2025–26

CLSS will focus on the following improvements:

- Integrated Service Delivery: Introducing a unified HSCP Link Worker role and standardising assessments.
- Strengthened Partnerships: Deepening collaboration with statutory and third-sector partners and aligning with the No Wrong Door model.
- Data-Informed Innovation: Testing new approaches such as embedding Link Workers in the Queen Margaret Hospital Breast Clinic and raising

awareness of the Scottish Care Information (SCI) Gateway referral system.

Community Led Support is a critical asset in Fife's Health and Social Care Partnership. It delivers measurable impact, aligns with strategic priorities, and offers a scalable model for preventative, person-centred care.

Message from Roy Lawrence, Head of Culture, Engagement and Communities

"As the new lead for Locality Planning, I'm delighted to share with you the great work achieved over the past year, and the value Community Led Support brings to our communities.
"Community Led Support is a shining example of what happens when we truly listen, collaborate, and act with compassion. It's not just about services—it's about people, and the power of connection to transform lives."

I extend my heartfelt thanks to all those who make CLS possible: our dedicated Community Link Workers, our partners across sectors, and most importantly, the individuals and communities we serve. Together, we are building a healthier, more connected Fife."

Community Led Support Service (CLSS)- introduction

Community Led Support unites three services to provide seamless, person-centered support across the continuum of need. This integrated model enables early intervention and prevention, helping individuals in Fife with long term health conditions to maintain independence and live fulfilled lives. CLS is built on a foundation of cross-sector collaboration, working closely with:

- Primary and secondary care
- Social work and social care
- Third & Independent sector and community organisations

This integrated approach ensures that individuals receive the **right support, at the right time, from the right service**, reducing duplication and improving outcomes.

- **The Well**
  Offers accessible, light-touch support and information to individuals who may not require formal intervention. By helping people navigate local services and maintain independence, The Well plays a key role in preventing issues from escalating.
- **Link Life Fife**
  Community support service for anyone in Fife who is over 18. It provides support to manage issues including stress, anxiety, or feelings of being overwhelmed for anyone who finds their mental health or general wellbeing affected.
- **Macmillan Improving the Cancer Journey (ICJ)**
  Delivers holistic support to individuals affected by cancer through structured needs assessments and personalised care planning. The service ensures timely access to emotional, practical, and clinical support throughout the cancer journey.

What's been achieved

In 2024/25, CLSS addressed three main areas of need identified through service user engagement:

- Financial difficulties,
- Limited physical activity,
- Mental health.

CLSS introduced a range of targeted, locality-specific interventions to tackle key challenges and drive improved outcomes for individuals and communities across Fife.

Financial wellbeing

CLSS strengthened its partnership with Citizens Advice and Rights Fife (CARF) to ensure individuals receive expert support with complex financial matters.

- The Improving Cancer Journey (ICJ) service benefited from a dedicated CARF worker (funded by Macmillan Cancer Support) which generated over £453,352 in client income. The Health and Social Care Partnership (HSCP) funded two full-time CARF workers to support individuals accessing The Well which generated approx. £90,100.24 in client income (project started November 2024).

All Community Link Workers completed benefits training, enabling them to better support individuals in navigating the benefits system, demonstrating the value of embedding person-centered financial support within CLS services.

Physical Activity

To improve awareness of physical activity opportunities and strengthen referral pathways, Community Link Workers engaged in development sessions with:

- Fife Sport and Leisure Trust
- Active Fife Team
- Health Promotion
- Maggie's Fife

These sessions enhanced link workers' knowledge of local services and equipped them to confidently discuss the benefits of physical activity with

individuals. CLSS referred/signposted 388 people during 2024/25 to physical activity including for example, Active Options, Bums Off Seats and local community groups.

Mental Health Support

CLSS used referral data to identify underrepresented areas and launched targeted outreach, training and joint initiatives – resulting in a 42% referral increase from Primary Care in 2024/25 and demonstrating the impact of data-driven, collaborative approach.

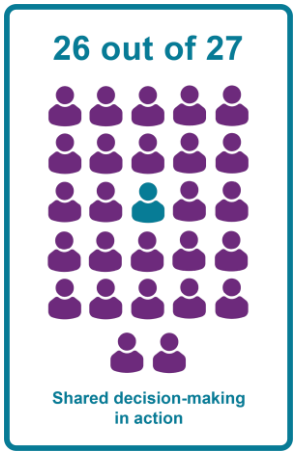
Key developments included:

- All link workers completed Distress Brief Intervention (DBI) training, with CLSS aiming to increase referrals to DBI.
- Ongoing collaboration with Scottish Association of Mental Health (SAMH) the DBI delivery partner, to ensure timely and effective referral pathways.
- Additional training completed by link workers on a rolling basis, including Scottish Mental Health First Aid, Suicide Assist, and Trauma-Informed Practice. By focusing on specific localities, link workers have built strong relationships with mental health providers, gained insight into referral criteria and waiting times, and developed a detailed understanding of local support groups and services. During 2024/25 CLS link workers referred/signposted **153** people to Better than Well and **57** people to DBI.

Listening to 'What Matters to People'

CLSS embedded the evidence based CollaboRATE tool in 2024/25 to measure shared decision-making from people using the service. This tool includes questions focused on understanding, listening, and inclusion, with a maximum score of 27.

In 2024/25, 225 responses were collected, with an impressive average score of 26 demonstrating strong user engagement and a clear sense that individuals felt heard, respected, and involved in decisions about their care.



Feedback from those who accessed CLS services:

> ***"I would rate the service 10 out of 10. The link worker was kind, understanding, and showed great patience as I discussed my concerns related to my early onset dementia. They clearly explained my options, and after choosing the Express Group, provided all necessary details, including bus times. I now attend weekly, which has significantly boosted my confidence and improved my routine."***

> ***"After taking the time to understand my concerns, the link worker referred me to Scottish Association of Mental Health (SAMH), a resource I wouldn't have known how to access on my own. They were exceptionally patient and attentive to what mattered to me. I also feel reassured knowing I can return to the service if I need further support."***

Priorities for 2025-26

In 2025/26, CLSS will focus on sustainability, extending integration, and equitable access, using service data analysis and service user feedback to ensure continued delivery of high-quality, person-centered care.

Key areas of improvement – 2025/26

1. Integrated Service Delivery

- Expand Community Led Support for individuals with long-term conditions by introducing a unified Health and Social Care Partnership (HSCP) Link Worker role to streamline access and promote equitable, cohesive service delivery.
- Standardise assessment processes across CLS to improve consistency, efficiency, and outcomes.

2. Strengthened Partnerships

- Enhance collaboration with Primary Care, Secondary Services, Statutory Agencies, and the Third Sector by issuing quarterly updates.
- Align with the No Wrong Door model by defining clear roles and referral pathways. Actively participating in daily triage meetings.
- Delivering presentations at team meetings and protected learning time.
- Promote a holistic, preventative approach by sharing summary reports or care plans with referrers when individuals exit the CLS service.

3. Data-Informed Tests of Change

- Implement targeted, data-driven initiatives in collaboration with key stakeholders, including Integrating the Link Worker pathway into the Urgent Care Out of Hours Service.
- Increasing referrals by embedding Link Workers in the Queen Margaret Hospital Breast Clinic to support patients at key transition points.
  Improving access for people with long-term conditions by continuing to work with GP practices to raise awareness and encourage use of the SCI Gateway referral system.

Conclusion

The Community Led Support Service (CLSS) continues to deliver measurable impact across Fife, reducing pressure on statutory services and supporting national policy through innovative, person-centred approaches.

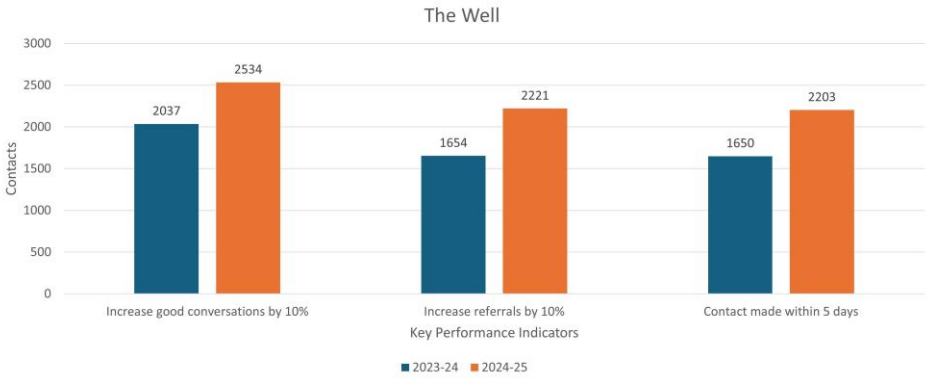
With strong foundations in collaboration and sustainability, CLSS is well-placed to expand its reach in support of Health & Social Care strategic priorities.

The 2025/26 focus on equity, responsiveness, and preventative approaches aligns with broader ambitions to improve health and wellbeing outcomes for people across Fife.

Appendix 1 – CLSS case studies

The Well – what has been achieved

A target was set to increase "good conversations" records carried out by The Well by 10% from the 2023/24 baseline into 2024/25. This target was exceeded, with an actual increase of 24.3%.



> *We rely heavily on the support of our Well colleagues to respond to adults and older people who fall into the substantial, moderate and low category. Given only a small number of adults and older people meet the critical criteria it is reassuring to know that the H&SCP SWCC Team can refer people to an accessible community-based resource who hold a wealth of knowledge about local resources and who can respond in a timely manner.*
> Senior Practitioner, Social Work Contact Centre

Alan's story

- Male, in his 40s
- Dunfermline Locality
- Struggling with mental health
- Referred by social work contact centre

Alan said: "It really helped, or it pointed me in the right direction and for than I'm grateful… not saying it's going to fix everything but it's good to know there is folk out there like you."

Alan's Good Conversation

- Alan was unsure about the support available.
- Alan felt lost and getting worse.
- Through the good conversation, Alan identified what he had not tried, why this had not worked and discussed suitable alternatives.

Actions agreed

- Well worker emailed Alan with more details on all the information discussed.
- Alan agreed to engage with counselling services, Andy's Man Club and online resources.
- Agreed Alan could reach out to those services on his own, and to contact The Well again he needed to.

Outcomes achieved

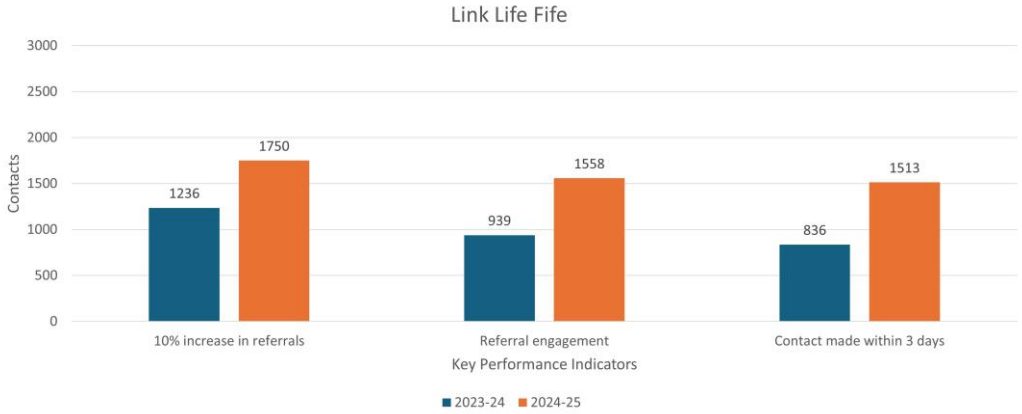
- Alan self-referred to a local counselling service and had received an initial call.
- Alan attended an Andy's Man Club drop-in.
- Alan has the Well contacts if needed in the future.

Key insight: approx. 60% of referrals to The Well come from the Social Work Contact Centre (SWCC), and that previously, those not meeting criteria received no alternative support, this has several important implications:

- Improved access to support
- Reduced pressure on statutory services
- Early intervention and prevention
- Enhanced person-centred approach

Link Life Fife – what has been achieved

A target was set to increase referrals to Link Life Fife by 10% from the 2023/24 baseline into 2024/25. This target was exceeded, with an actual increase of 42% in referrals



> *I feel reassured when I make the referral as I know the person will be contacted quickly and this prompt response means a great deal to people who feel no one cares and there is no help. LLF offers a comprehensive, holistic service. If it's out there, they know about it, and this is exactly what is needed. I feel safe handing over to the service as I am confident, they will do a good job. I also love the relationship between PCMHN and LLF.*
> Primary Care Mental Health Nurse

Tracy's story

- Female, 40s
- S & W Fife Locality
- Referred by Primary Care Mental Health Nurse
- Distressed after relationship breakdown
- Chronic pain condition
- Social isolation and loneliness

Tracy's hopes

- Struggling with current situation and I just want to be happy again.
- To learn how to manage the pain I am in, so I can keep on top of my home and the cleaning.
- To have hobbies and make new friends.

Actions agreed

- Link worker (LW) spoke with Tracy who was in distress and asked if Tracy would like to be referred to the Distress Brief Intervention (DBI) service. A referral was submitted.
- LW met wit Tracy in local café and discussed her struggles with chronic pain and keeping on top of cleaning at home. LW agreed to source information of cleaning companies for a one off clean and details of the nearest pain management clinic.
- Tracy mentioned her love of arts and craft. LW agreed to look into resources available in the local area and transport options to fit in with Tracy's commitments.

Tracy said:

"The support has been amazing, I am like a new person, nothing was too much, and you have helped me every step of the way."

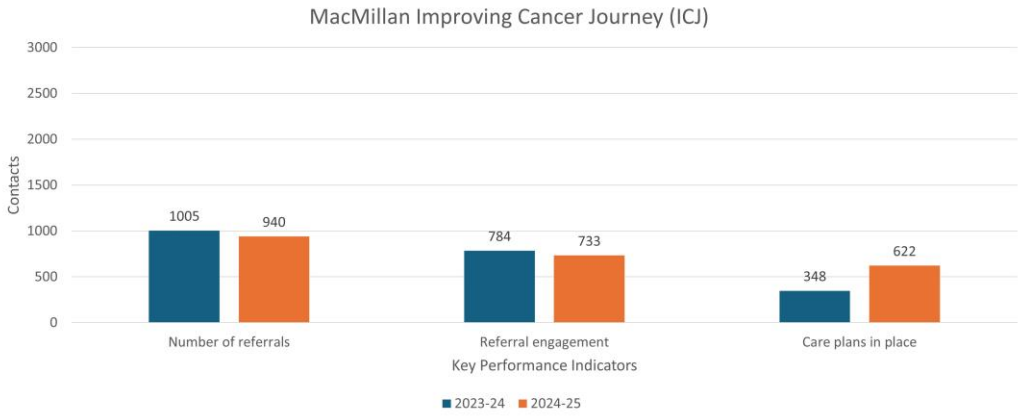
Outcomes achieved

- Tracy engaged with the DBI Service for 14 days of intervention. After this the LW contacted Tracy to resume support.
- LW provided information on cleaning services. Tracy booked a company and has had a deep clean. Tracy feels this has greatly improved her mood.
- LW contacted the pain management clinic on Tracy's behalf and found out dates and times. Tracy has attended her first session and is using new coping strategies to manage her pain.
- LW sourced information on groups and bus timetables to make an informed choice. LW supported Tracy on her first journey and group visit. Tracy then felt confident to travel and attend the art group by herself.

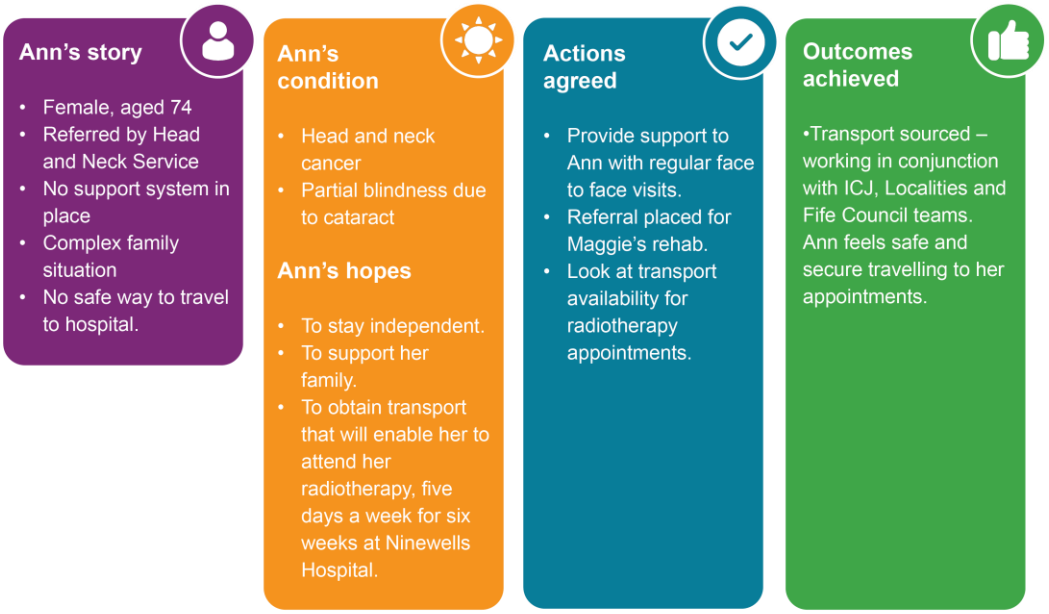
Key insight: 89% of people referred to Link Life Fife engage with the service. Contact is made within 3 working days, and appointments are offered within 10 working days, at the location of the person's choice. Delays beyond 10 days are typically due to personal reasons such as holidays or medical appointments.

Macmillan Improving Cancer Journey (ICJ) – what has been achieved

A target was set to increase referrals to Macmillan Improving the cancer Journey by 10 % from the 2023/24 baseline into 2024/25. This target has not been achieved; there has been a reduction of 6.4%.



"It's incredibly reassuring to have the Link Worker service as part of Improving the Cancer Journey. Their ability to refer on and connect people with the right support makes a real difference, not just for patients, but for us as professionals too. It strengthens the whole pathway of care."
Cancer Nurse Specialist

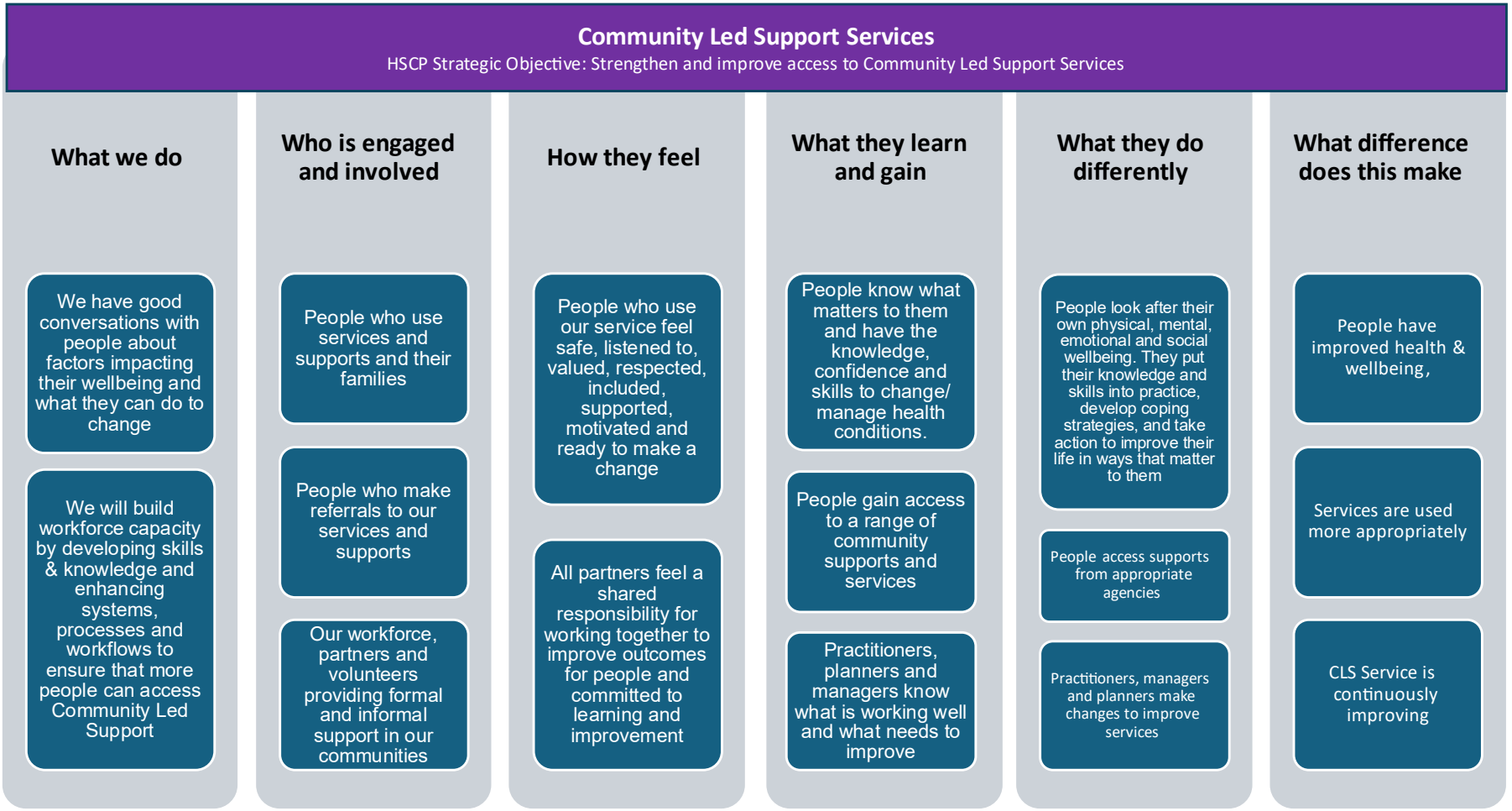


Key insight: Referral numbers to ICJ have declined, likely due to NHS Fife Cancer Team staff changes in 2024/25 and subsequent decrease in awareness of the service. Work is underway to improve referrals in 2025/26 by introducing an "opt-out" model.

Appendix 2

Fife Health & Social Care Partnership
Supporting the people of Fife together

COMMUNITY LED SUPPORT DELIVERY PLAN 2025-26


Community Led Support Services
HSCP Strategic Objective: Strengthen and improve access to Community Led Support Services
What we do
We have good conversations with people about factors impacting their wellbeing and what they can do to change
We will build workforce capacity by developing skills & knowledge and enhancing systems, processes and workflows to ensure that more people can access Community Led Support
Who is engaged and involved
People who use services and supports and their families
People who make referrals to our services and supports
Our workforce, partners and volunteers providing formal and informal support in our communities
How they feel
People who use our service feel safe, listened to, valued, respected, included, supported, motivated and ready to make a change
All partners feel a shared responsibility for working together to improve outcomes for people and committed to learning and improvement
What they learn and gain
People know what matters to them and have the knowledge, confidence and skills to change/ manage health conditions.
People gain access to a range of community supports and services
Practitioners, planners and managers know what is working well and what needs to improve
What they do differently
People look after their own physical, mental, emotional and social wellbeing. They put their knowledge and skills into practice, develop coping strategies, and take action to improve their life in ways that matter to them
People access supports from appropriate agencies
Practitioners, managers and planners make changes to improve services
What difference does this make
People have improved health & wellbeing,
Services are used more appropriately
CLS Service is continuously improving

2025-26 Delivery Plan on a page (note: The full delivery plan, detailing how the team will achieve the deliverables, is held at service level).

COMMUNITY LED SUPPORT DELIVERY PLAN 2025-26		
HSCP Strategic Objective: Strengthen and improve access to Community Led Support Services		
Our Strategic Deliverables	**Our Actions for 25-26**	**Our outcomes**
We will facilitate good conversations with people about factors impacting their wellbeing and what they can do to change	• We will increase referrals to CLSS via the SWCC and SCI gateway by delivering a targeted awareness raising and promotions campaign aimed at Primary Care and Social Work professionals. • We will build on our current monitoring and evaluation processes by developing an Outcomes Map and supporting evaluation plan for the service.	People have improved health and wellbeing and take action to improve their lives in ways meaningful to them.
We will build workforce capacity by developing skills & knowledge and enhancing systems, processes and workflows to ensure that more people can access Community Led Support	• We will review and refine the three existing Link Worker Job Profiles into a single, unified job profile, enabling Link Workers to support individuals with any long-term condition. • We will review and update the current CLSS service model to expand support to all individuals living with long term health conditions. • We will develop and test a standardised assessment process across CLSS to ensure consistency and improved outcomes • We will embed CLS within the 'no wrong door' framework by ensuring routine participation in triage meetings • We will embed CLS Macmillan Improving the Cancer Journey as an "opt out" service for people affected by cancer. •	Resources are used as effectively as possible towards the outcomes that matter most to people.

We provide accessible communication in a variety of formats including for people who are speakers of community languages, who need Easy Read versions, who speak BSL, read Braille or use Audio formats.

Our SMS text service number **07805800005** is available for people who have a hearing or speech impairment.

To find out more about accessible formats contact:
fife.EqualityandHumanRights@nhs.scot or phone **01592 729130**

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