Improving Lives Initiative

Quarter Report Oct-Dec 2025

COMMUNITY SOLUTIONS
Building Community Capacity and Carer Support

VOLUNTARY ACTION North Lanarkshire

University Health&Social Care North Lanarkshire

north lanarkshire disability forum

MACMILLAN CANCER SUPPORT

Community Solutions

Improving Lives Initiative
Quarter Report Oct-Dec 2025

The Programme

The ICJ Lanarkshire service is delivered in both North and South Lanarkshire. The ILI is delivered in North Lanarkshire only. This report covers North Lanarkshire.

Within North Lanarkshire, the ILI and ICJ have joined together to fund a team of 10 Community Connectors who support **people who are living with a long-term condition/disability and those affected by cancer,** including their carers, with accessing non-clinical support.

ICJ Lanarkshire

- ICJ North Lanarkshire
- ICJ South Lanarkshire

- ILI North Lanarkshire

Improving the Cancer Journey (ICJ)

MacMillan ICJ aims to improve the non-clinical support provided to **people affected by cancer** from the point of diagnosis. The ICJ provides holistic care solutions to ensure everyone diagnosed with cancer can easily access the support they need as soon as they need it to enable them to live as well and as independently as possible.

Improving Lives Initiative (ILI)

The ILI aims to help **improve people's physical, mental, and social wellbeing** in North Lanarkshire through a locally coordinated approach to providing community-based support for vulnerable and equality groups, as set out in the Community Solutions Strategy and investment Plan.

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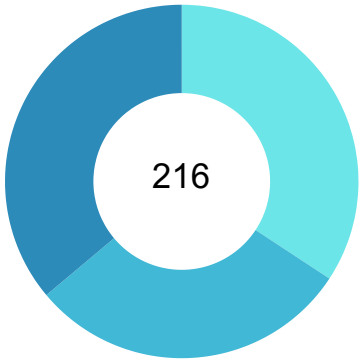
Improving Lives Initiative

In the period Oct-Dec 2025, 216 new clients were referred to the ILI service. This is an increase of 21 referrals from last period.

New clients are broken down by the following categories:

Month

- Oct 2025 - 74
- Nov 2025 - 64
- Dec 2025 - 78



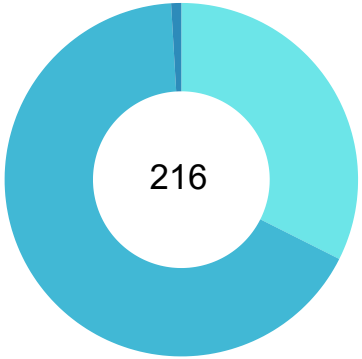
The most common referrer organisations during this period were:

- Department for Work and Pensions (DWP)
- NHS
- North Lanarkshire Council

This remains the same as last period.

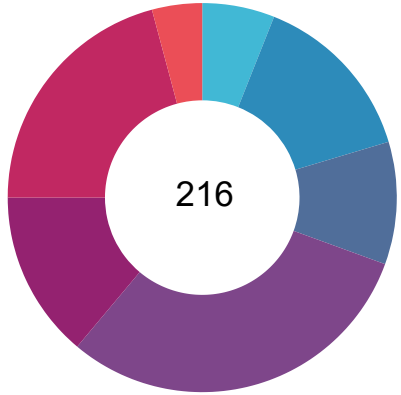
Referral Type

- Self - 70
- Organisation - 144
- Other - 2



Locality

- Airdrie - 13
- Bellshill - 31
- Coatbridge - 22
- Motherwell - 66
- The North - 30
- Wishaw and Shotts - 45
- Other - 9



The highest number of referrals was received in December (36%). The locality with the most referrals was Motherwell (30.5%). This remains the same as last quarter.

The most common referral pathway to the service was through an organisation (67%). This is a decrease of 17 clients from last period.

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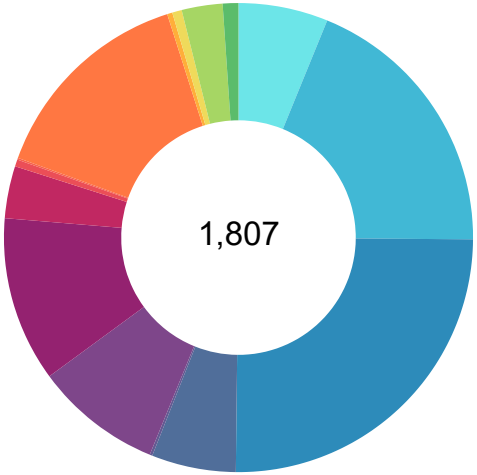
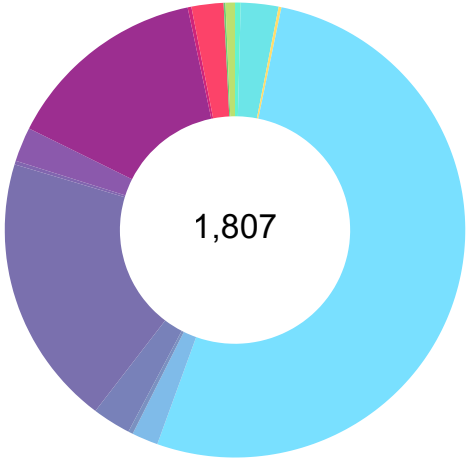
Number of support tasks by task type

- Action Plan - 118
- Administration - 316
- Advice/Support - 418
- Appointment - 97
- Care Plan - 3
- Community Support - 146
- Follow Up - 190
- Form Filling - 60
- Funding - 8
- GP Referral - 2
- Initial Contact - 243
- NHS Referral - 6
- Post Information - 11
- Research - 47
- Review - 18



Number of support tasks by support type



- Active Health Referral - 6
- Adaptations - 40
- Addiction - 3
- Advice/Information - 791
- Advocacy - 28
- Appointment Cancelled - 5
- Appointment Support - 41
- Benefits - 292
- Benefits Reconsideration - 4
- Carer Support - 37
- Community Links - 217
- Education - 4
- Emotional Support - 34
- Employment - 2
- Employment Support - 10

1,807* tasks were logged by the Community Connectors during this period, which is a decrease of 11 from last quarter. The most common task type was Advice/Support (418), Administration (316), and Initial Contact (243). This is a change from last quarter, as Initial Contact has replaced Community Support.

The most common type of support was Advice/Information (791), Benefits (292), and Community Links (217). This is the same as last quarter.

*Please note, this does not capture everything the Connectors do.

*Please see next page for a glossary of terms. Please note, Advocacy and Carer Support refers to signposting

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ILI Tasks Glossary

- Action Plan - Helping people to decide what is important and helping them take the first steps such as who to call and when
- Adaptations - Referrals made for physical adaptations to services such as the falls service or Making Life Easier
- Advising of eligibility
- Benefits
- Care plan - Finding out someone's priorities in order to help with their most pressing needs
- Education - For example, supporting parents to navigate their children's schooling needs
- eHNA (electronic Holistic Needs Assessment) - An online conversation tool to support a person-centred conversation with the client, which determines the individual's non-clinical needs such as finance, family, work, emotions (offering practical assistance and community support) and health needs. The Connectors offer reassurance and signposting back to clinical nurse
- Energy - Home fuel services
- Form filling support by NLDF
- Funds - Referral to an independent funder such as Hospital Saturday Fund for health needs equipment
- Legal - Referrals for power of attorney (McKellar Associates)
- Initial contact – The Connector makes initial contact with the person referred to the ILI service
- NHS referral - OT/Physio/falls team
- Referral to CAB or Social Security Scotland for form filling support
- Referral to DWP or Job Centre Plus
- Referral to the Tackling Poverty team for income related benefits or appeal
- Research - Searching for groups/activities in an area for someone

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Improving Lives Service

Case Study - Improving Mobility, Reducing Isolation, and Preventing Crisis Through Early Support

Overview

This case study outlines how NLDF's Community Connector service supported a gentleman experiencing chronic hip pain, social isolation, and declining independence. Through targeted advice, form-filling support, and holistic guidance, he secured essential entitlements that significantly improved his wellbeing and reduced future demand on health and social care services.

Background and Initial Challenges

The gentleman was living with chronic hip pain that severely restricted his mobility. His circumstances included:

- Limited ability to walk from parking spaces to shops or essential services
- An unreliable car, preventing regular visits to family
- Inability to use public transport due to steep hills and steps at the nearest station
- Increasing social isolation, which was beginning to affect his mental health
- Loss of previous roles, including volunteering and community participation
- Difficulty completing forms, preventing him from accessing support independently

He described himself as "stagnating at home" and felt disconnected from his community.

NLDF Intervention

The gentleman contacted NLDF seeking help to apply for a Blue Badge. During his appointment:

- He was supported to complete the Blue Badge application
- The Community Connector identified that he was also eligible for Attendance Allowance
- He was supported to complete this application
- He was additionally assisted to apply for a bus pass and companion card
- He received holistic, person-centred guidance and emotional reassurance throughout #

All applications were successful.

Outcomes for the Individual

Following the approvals, the gentleman reported significant improvements:

- "I am no longer stagnating — **I feel included**."
- He can now **park close enough** to shop independently and visit the post office
- He can **treat his brother to lunch** as a gesture of gratitude
- He purchased a **more reliable car**, giving him confidence to travel and stay connected
- He now joins **bus trips with friends and family**, including the North Coast 500
- He feels **reassured and independent**, able to purchase aids such as a higher toilet seat
- He has recommended NLDF to others

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Improving Lives Service

Case Study cont'd - Improving Mobility, Reducing Isolation, and Preventing Crisis Through Early Support

Projected Financial Savings

While individual outcomes are the priority, this case also demonstrates clear preventative savings across health and social care systems. Below is a conservative projection based on national evidence around mobility support, reduced isolation, and delayed need for formal care.

Area of Impact	Description	Projected Annual Savings
Reduced GP Appointments	Improved mobility, reduced pain-related stress, improved mental wellbeing	£200-400
Delayed need for home care	Blue Badge + Attendance Allowance + mobility aids help him remain independent at home	£1,200-£3,000
Reduced risk of falls	Ability to purchase appropriate equipment (e.g., higher toilet seat)	£1,000-£2,500
Reduced social isolation	Increased community participation reduces risk of depression and crisis intervention	£300-£800
Reduced transport-related support needs	Reliable car + bus pass reduces reliance on statutory transport services	£500-£1,000

Estimated Total Annual Savings: £3,200 – £7,700 per year

These figures reflect preventative value, not just cost avoidance. They demonstrate how early, low-cost community support can significantly reduce long-term demand on statutory services.

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Case Study - cont'd

Wider System Benefits

- Improved mental health, reducing risk of crisis intervention
- Strengthened community connections, reducing loneliness
- Increased self-management, reducing reliance on formal services
- Enhanced quality of life, enabling continued participation in family and community activities
- Empowerment, as he now supports others by signposting them to NLDF

Summary

This case demonstrates the transformative impact of NLDF's approach:

- A single conversation led to **multiple successful applications**
- The gentleman regained **independence, mobility, and confidence**
- His wellbeing improved across physical, emotional, and social domains
- The intervention generated **significant preventative savings** for public services
- The ripple effect extended to his family, friends, and wider community

This is a clear example of how NLDF's work **keeps people connected, safe, independent, and included**, while delivering measurable value to the wider system.

Care Opinion

The following feedback was left by a service user via Care Opinion.

'Support After Bereavement'

"I lost my mother in early July and my husband become pension age at the end of June. I had a lot of issues coping with changing over benefits whilst coping with the death of my mother. My Doctor promptly altered my medication and referred me to Catherine the surgery's therapist, who's care I am now under.

To see more stories about the Improving Lives Service, click here.

I've had two sessions and already feel we are getting somewhere with the deeper causes of my anxiety. He also referred me to Gillian to help me with money issues. She kept in regular tough to check up on how things were progressing. Gillian also led me to North Lanarkshire Disability Forum where one of their Community Connecters, Tom who's help and advice was invaluable.

After an initial chat over the phone, he came to the house to help me fill in forms and lead me to various bereavement groups. He even spent 3 hours supporting me for a UC50 WCA appointment at my home even though the person assessing me never turned up. He has kept in constant touch to see if I need any more help with anything.

He also referred me to Lanarkshire Carers who have been fantastic too. I was initially contacted by Paul who listened to me for nearly an hour and suggested I attend a Time for me Day. I never thought I would feel mentally fragile and burned out. I also would never have thought there was so much help available out there for someone going though a hard time.I realise I have a long way to go but I cannot fault the help I've been given along the way. I truly am grateful to everyone involved in my care."

Community Solutions

Improving the Cancer Journey North Lanarkshire

Improving Cancer Journey

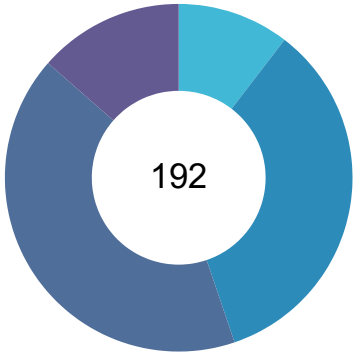
In the period July-Sept 2025, **192** new clients were referred to the ICJ service in North Lanarkshire. This is a decrease of **58** referrals from last period.

Most referrals during this period were between 66 to 80 years old (**47**%). This remains the same as last period. More referrals were female (**52**%) than male (**45**%). This is the same as the previous quarter.

New clients are broken down by the following categories:

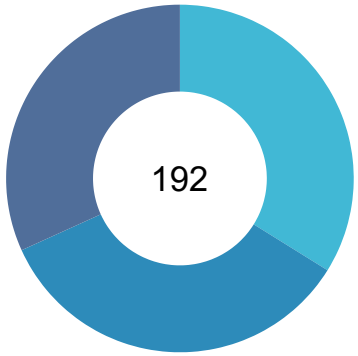
Age

- 25 to 49 - 20
- 50 to 65 - 66
- 66 to 80 - 80
- Over 80 - 26



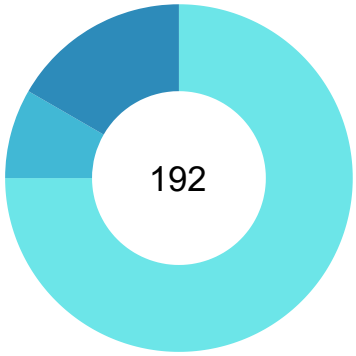
Month

- Oct 2025 - 65
- Nov 2025 - 66
- Dec 2025 - 61



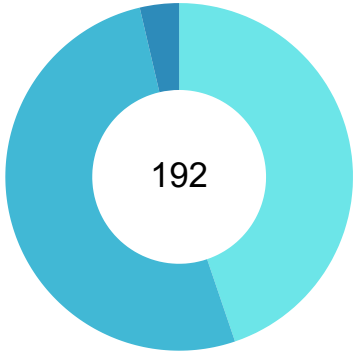
Referral Type

- Clinical - 144
- Self - 16
- Other - 32



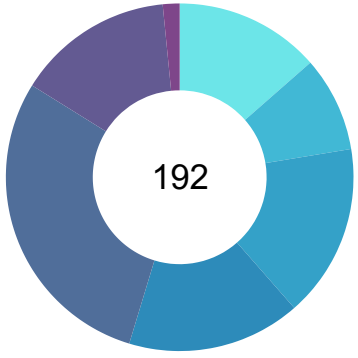
Gender

- Male - 86
- Female - 99
- Other - 7



Locality

- Airdrie - 26
- Bellshill - 17
- Coatbridge - 31
- Motherwell - 31
- The North - 56
- Wishaw - 28
- Shotts Prison - 3



The most common referral type in this period was through a clinical pathway (**75**%).
The most common referrer to the service in the last quarter was Clinical Nurses, and Cancer Navigators. This remains the same as last quarter.

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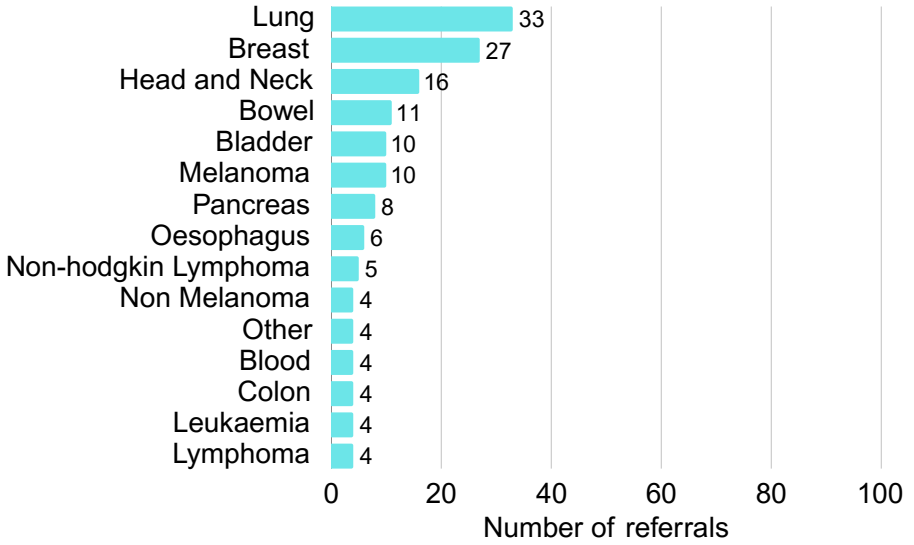
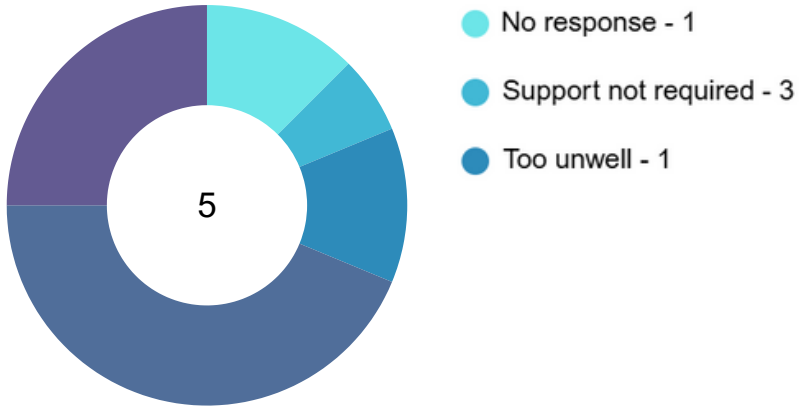
Improving the Cancer Journey North Lanarkshire

Referrals by type of cancer



Declined referrals

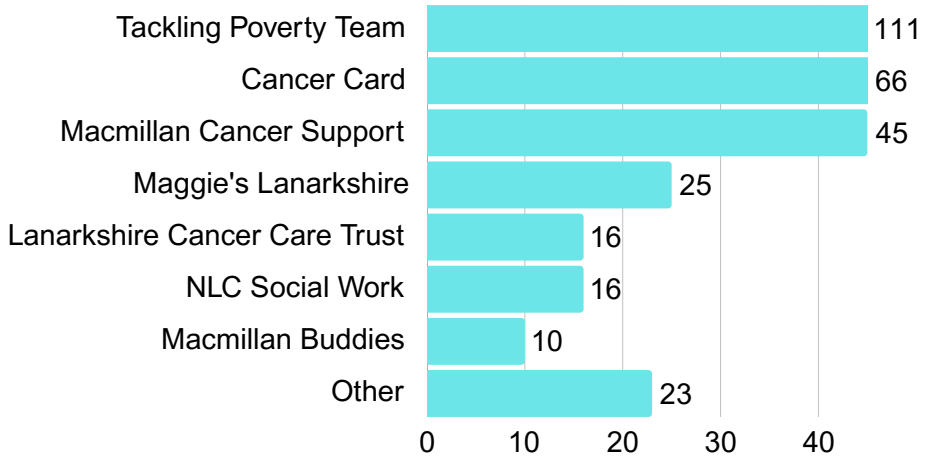


The most common cancer type was Lung. This has changed from last quarter, which was Breast. The second most common was Breast. Across the past year, it is common for Breast and Lung to be within the top 3, as these are the most common cancer types in North Lanarkshire.

The service continues to have a low decline rate (less than 3%). This has dropped by 11 referrals. Of the 5 who declined the service, 3 felt the support was not required. The most common reason given by people who declined the service was that the had a good support system already.

380 onward referrals were made to other community services. This is a decrease of 197. Tackling Poverty remains the most common onward referral.

Top organisations for onward referrals



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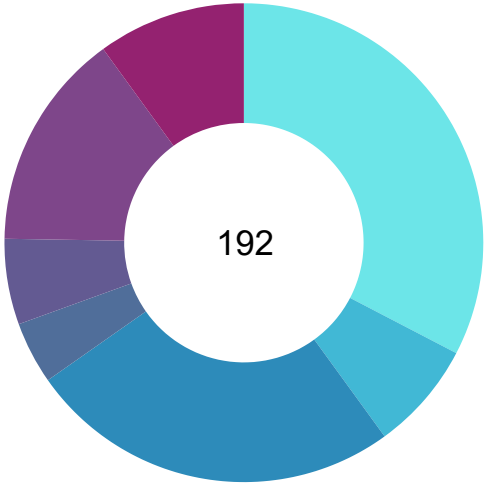
Improving the Cancer Journey
North Lanarkshire

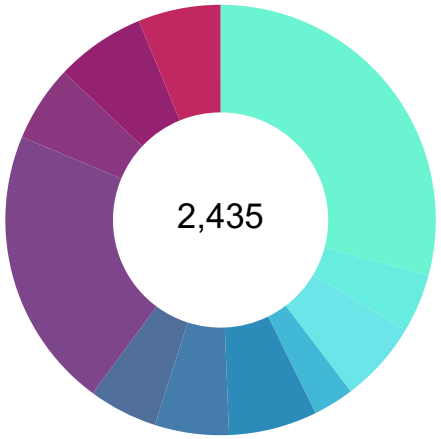
Referrals by pathway stage

- Initial Diagnosis - 62
- Start of Treatment - 14
- During Treatment - 48
- Follow Up - 8
- Transition to Palliative Care - 11
- In Palliative Care - 28
- Other - 19

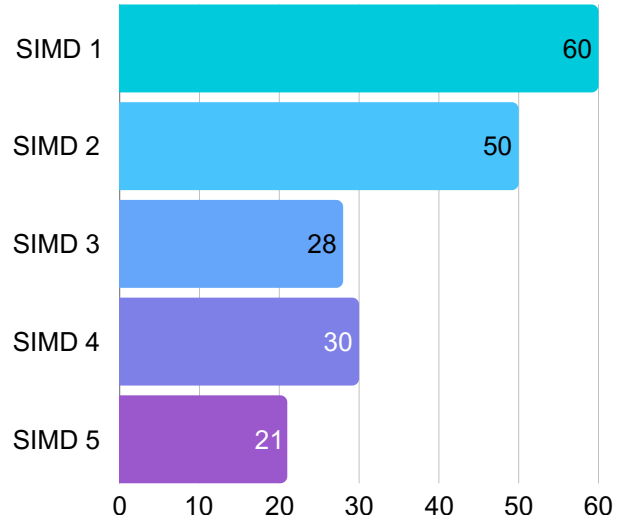


Tasks by task type

- Admin - 696
- Appointment - 106
- Care Plan - 146
- Community Support - 73
- EHNA - 159
- Financial Support - 133
- ICJ Wait Well Letter - 124
- Initial Contact - 506
- Wellbeing Check - 137
- Review - 162
- Other - 148



SIMD Quintile



The most common pathway stage for referrals to the service was at initial diagnosis (**32**%). This remains the same as last quarter.

2,435 tasks were logged by Connectors. Please note, this does not cover everything that the Connectors do. The most common tasks logged by Connectors, were making initial contact (**506**) and admin (**696**).

Most referrals were within SIMD 1 (**31**%) or SIMD 2 (**26**%).

Community Solutions

Improving the Cancer Journey North Lanarkshire

Case Study

Abstract

This case study demonstrates the impact of ICJ for P, a gentleman diagnosed with metastatic melanoma. P was struggling to cope with his diagnosis, retain complex information, and manage day-to-day responsibilities, including caring for his father with dementia. ICJ involvement provided a single point of contact, coordinating practical, emotional, and financial support. This included home visits, referrals to spiritual care, dietetic guidance, financial support, peer support groups, and carers services for his wife. As a result, P engaged positively with face-to-face emotional support, submitted applications for financial support and a Blue Badge, and plans to attend ICJ drop-in sessions and peer support groups. This case highlights ICJ's role in reducing isolation, improving access, and supporting both client and family.

Context and Referral to ICJ

P was referred to ICJ by their CNS due to metastatic melanoma and complex care needs that would not be fully addressed through existing clinical pathways. P was experiencing fatigue, weight loss, emotional distress, and difficulty retaining information about his diagnosis and treatment. He and his wife were also responsible for caring for his father, who has dementia, and P was not receiving any financial support, further compounding stress. ICJ involvement aimed to provide a coordinated, person-centred response that addressed both practical and emotional needs, ensured access to relevant services, and reduced the risk of unmet support.

Client Needs and Barriers

At the time of referral, P was struggling to cope emotionally with his diagnosis and found it difficult to retain important information. He expressed concerns about his weight loss, fatigue, and general wellbeing, as well as the impact of his responsibilities in caring for his father. P and his wife had limited knowledge of available support services, including financial assistance, community groups, or dietary guidance. The complexity of navigating multiple services, coupled with mobility challenges and the burden of caregiving, created barriers to accessing timely support. These needs highlighted a gap in care that extended beyond the clinical focus of the CNS and required a holistic, coordinated approach.

ICJ Intervention and My Role

ICJ became involved to provide a single point of contact for P and his family, ensuring that his practical, emotional, and health-related needs were addressed. Referrals were coordinated to the Lanarkshire Listening Service for emotional support, to Money Matters for financial guidance, and to the dietician for advice on building up nutrition to counteract weight loss. The Wellbeing Practitioner conducted home visits to discuss support face-to-face, assist with applications for a Blue Badge, and help with financial support submissions. ICJ also introduced P to the local ICJ peer support group and weekly drop-in sessions, and offered his wife referrals to Lanarkshire Carers Services and complementary therapy at the Macmillan EK Library Hub. By facilitating these connections and maintaining consistent communication, ICJ ensured that both P and his wife were aware of and able to access the support they needed.

Impact on the Client

Through ICJ involvement, P engaged actively with face-to-face emotional support, which he found valuable for discussing his feelings and concerns. He submitted applications for financial support through Maggie's and for a Blue Badge, easing the burden of accessing appointments and reducing practical stress. P and his wife intend to attend the ICJ peer support group and library drop-in sessions, providing ongoing social and emotional support. P reported feeling relieved and reassured to have a consistent point of contact for guidance and support, which enhanced his confidence in managing both his health and caregiving responsibilities.

Community Solutions

Improving the Cancer Journey North Lanarkshire

Care Opinion

The following feedback was left by a service user via Care Opinion.

To see more stories about the Improving the Cancer Journey, click here.

"Exceptional Support From MacMillan Improving Cancer Journey"

Posted by Scatcho24 (as a service user)

I was referred to MacMillan Improving Your Cancer Journey a few months back afterbeing diagnosed with AML and needing a stem cell transplant to save my life. The service has made a huge difference to me in terms of being able to speak about my journey for me to realise just how far I've come. The service also provided me with support and advice with financial services and benefits which takes a huge weight off you at a very uncertain time in your life. Pauline's manner, time and support had been invaluable to me. She really is a credit to your team. She really has went above and beyond to ensure I feel supported in the best way. You can truly hear the passion She has for caring and supporting people in a very difficult situation. For this I would like to express my appreciation for Pauline's time it really has ment so much to me. Going through a journey with cancer makes you realise how much you rely on charities and support networks as they really do make such a difference to your whole journey. I belief Pauline is very special and absolute in the right job. I will forever be grateful for her everything she has done for me. I have a few people that stand out in my journey for their care, support and time nd Pauline certainly is one of them. MacMillan Improving Your Cancer Journey really has been amazing. You all do such a special job. Thank you so much once again Pauline.

"My Cancer Journey"

Posted by MartinO2 (as the patient)

I was struggling with a sore chest for a few months then went to the hospital. They gave me antibiotics thinking I had an infection. I then had to return due to breathing they gave me sinus relievers. I then went to my doctor and they referred me for an X-ray which had shown some shadowing. I was referred to the respiratory clinic, which showed cancer. I went through all tests that day and waited 9 days for my results, to be admitted straight away. I went through chemo immuno therapy, which was called R-CHOP. This has been the hardest thing I have ever been through in my life and I struggled, physically, mentally and emotionally. I spoke with Mcmillan and Jennifer had spoken to me and helped me so much with paperwork, befrienders and therapies. Which helps me so much. Jennifer was very professional and fabulous with me and my partner and checked in regularly. I have now been told I'm in remission and the next 2 years are crucial for me.

I am hoping to get back to work in January, this will help me massively financially and mentally.