Annex 4

York Local Area Coordination Update Report 24

York Local Area Coordination Update Report March – May 2022

Section 1 Local Area Coordination – learning to date

Local Area Coordination is an evidence-based approach to supporting people as valued citizens in their communities. It enables people to:

- Build and pursue their personal vision for a **good life**
- Stay strong, safe and connected as contributing citizens
- Find practical, non-service solutions to problems wherever possible
- Build more welcoming, inclusive and supportive communities

Therefore, it is about:

- Preventing or reducing demand for costly services wherever possible
- Building community capacity and resilience
- Supporting service reform and integration, having high quality services as a valued **back up** to local solutions

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Introduction

Since the last report the York LAC programme has transitioned along with major societal shifts such as the 'Living with Covid' strategy and the increasing 'Cost of Living Crisis'. This has seen LACs busy supporting community groups and local businesses to start welcoming some return to normality as well as supporting people in our communities in a complex range of situations to adjust to new ways of living, whilst trying to make sure no-one is left behind. LACs have been navigating these complex community landscapes where people experience mixed emotions around these shifts, especially those with long term health conditions and those facing extreme financial hardship. We continue to approach navigating these issues in a compassionate and person centred way, using our experience, networks and people skills to find ways to keep people connected and well, despite growing challenges and pressures.

As the energy crisis and wider cost of living impacts have affected many in our communities, LACs have been taking proactive early intervention approaches to lessen impacts as well as responsive, reactive approaches to help those who have been plunged in to poverty and make impossible choices between eating and heating. We continue to work alongside Customer and Communities, Financial Inclusion Group partners, the Welfare Benefits and Strategic Partnership Manager and the Advice York partnership Network to develop existing initiatives such as the fuel and food vouchers schemes, as well as developing new initiatives. As part of this we have taken on a piece of work to proactively reach those who have had their gas capped off or are at risk of this. We identified this is a key indicator of other challenges in life and the consequences of leaving people with no gas in their properties has catastrophic impacts on health and wellbeing. We continue to develop the Early Support Fund, using this to help people in contact with the LAC team; we have been developing processes and an online application system for this fund so this can be broadened out to wider partners to apply, widening the reach of these funds to citizens across York. We have worked with 2 Ridings Community Foundation to develop a wider Cost of Living Crisis Fund in to which households who don't need their Council Tax Rebate can donate this or to pay it forward to other people who may need it more, particularly this winter, which will be difficult for many.

We continue to see people facing complex challenges with their mental health in communities and work to improve these at an individual level as reflected in the stories in this report, which highlight the skills and kindness the LACs approach these situations with. We also remain committed to and heavily involved in the Community Mental Health Transformation work and Connecting our City. The LAC team

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continue to lead on the People on the Ground Network and contribute to various workstreams such as the development of the Pathway to Recovery project improving discharges from Foss Park and the development of new Mental Health Community Hubs which will be a valuable resource in the city in line with visions of Trieste. In this work our experience and input is repeatedly valued as helping to shape work that has the people of York at the heart of it. Linked to this and our commitment to 'bottom up' approaches to system change, we pulled together a summary report around the strategic partnership work with mental health services which has been driven by the LAC programme over the last 5 years *(accompanying document).* This has been shared with partners and is driving new conversations and appetite to try new ways of working. It has also fed in to conversation with colleagues in the CCG and TEWV who have committed some funding to help increase the capacity of the LAC team to allow more involvement in this work going forwards by enabling another member of the team to step in to an additional Senior LAC role.

Many of the stories in this report are related to housing, which remains a key area for us and the people we walk alongside. We remain committed to and involved with housing related projects such as the Resettlement Pathway Review, where several members of the team have been attending workshops to feed in valuable experience from our work across York.

Our commitment to research and development continues with the ongoing research projects with NIHR and Birmingham University. As part of this work we are collaborating around a deep dive in to some of the work in Huntington and New Earswick ward. We are also undertaking a thematic analysis of all of our stories and developing a repeatable methodology around this to provide some valuable insights in to patterns and themes which have arisen from our work over the course of the programme. We are also excited to learn about how we can improve the interaction and connection of strength based approaches in York, as well as celebrating what Birmingham University highlight we are doing well in their longitudinal research project which is coming to an end. Linked to these ongoing projects and our rich history of research and development we have been invited to speak at the Curiosity Partnership Event in York in June – this partnership will be highlighting the important role academic research and learning can have in public services.

Our strong partnerships with the LACN are developing in to richer international links as we liaise with Eddie Bartnik and Australian colleagues to develop learning matches and events which will happen later in the year. We enjoyed a national Leaders of LAC gathering

also, which was hosted in York in March and have contributed to an accompanying film, including some of the people we have been walking alongside.

May 2022 sees us reaching a five year anniversary of the development of LAC in York and this feels like a good time to reflect on where we started and where we are now. We started with three LACs and a Head of Service situated within the Adult Contracts and Commissioning Team and covering just 3 wards of the city. Today the programme has a team of thirteen sitting within a wider Communities and Prevention Team and covering over half of the city's wards. We are planning recruitment to welcome another team member soon and looking forward to the extra capacity having two Senior LACs will bring to benefit the team and wider partnership work. Along the way, over the last 5 years, we have achieved amazing things alongside partners and contributed to important shifts in cultural values and person centred ways of working. We have connected with thousands of people across York, grown an organic network of contributing citizens and had millions of good life conversations on the way to achieving countless positive outcomes and smiles on faces – which you can, as always, tangibly feel reflected in the stories in this report. I recently heard Cormac Russell, a leading thinker on Asset Based Community Development, describe these types of stories as 'warm data' - I am sure you will agree, as you read them, this is a very fitting description.

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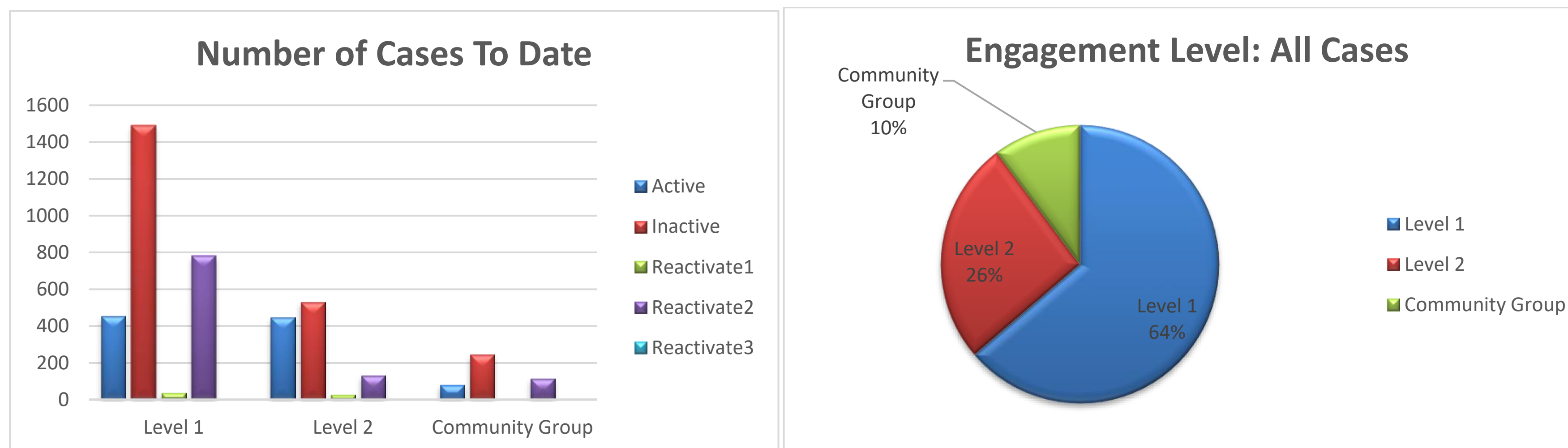
Section 2 - Engagement Level Analysis

Detailed below are the key outcomes Local Area Coordinators aim to achieve when working with individuals.

Level 1 support - provision of information, advice and connections and/or limited and short term support.
Level 2 support - providing a 1-2-1 relationship walking alongside people who are vulnerable due to physical, intellectual, cognitive and/or sensory disability, mental health needs, age or frailty, and require sustained assistance to build relationships, nurture control, choice and self-sufficiency, plan for the future and find practical solutions to problems.
Community Groups – provision of assistance related to an existing, new or start-up community group. This can be either a short-term or sustained level of support and would include activities including membership, funding, and location.

The bar graph below details a breakdown of the numbers of people which the Local Area Coordinators have worked with and what type of support was given, it also indicates where cases are still active or now inactive. The pie chart details the number of active introductions detailed as a percentage for the respective levels of support.



The total number of people the team have worked with to date is **4337** and currently **2071** are active (including reactivated cases). The pie chart shows the split for all people whether they are still active or inactive. This shows that over half of people introduced have been on a

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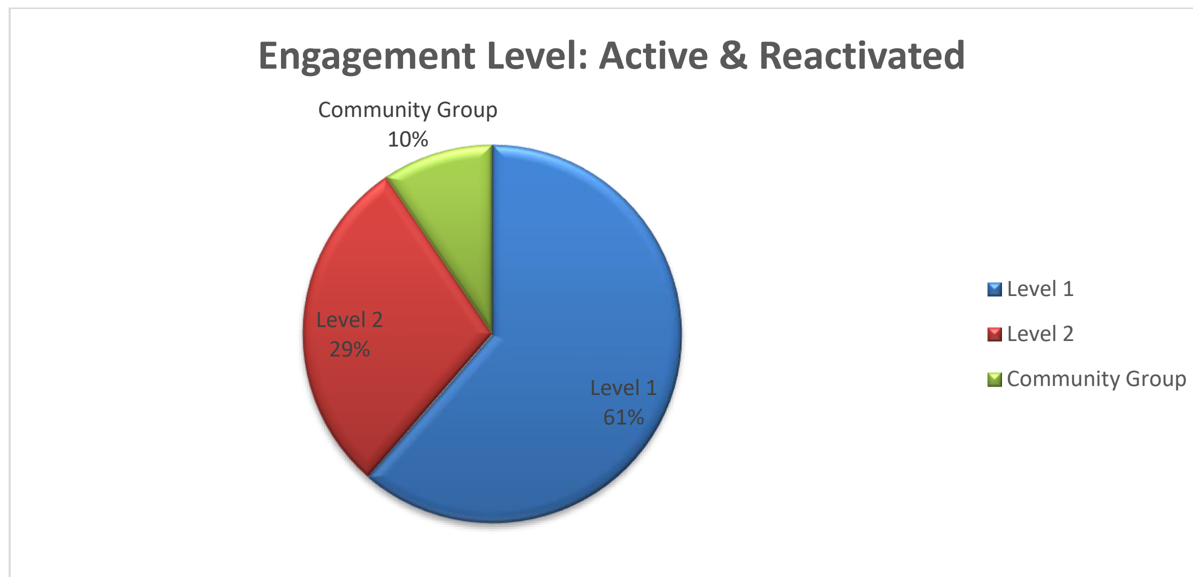
Level 1 basis (64%). Information recorded reveals that Level 2 introductions make up 26% and Community Groups make up 10% of total introductions to date.



The second pie chart shows the split between the three levels of support for all active cases (including reactivated cases). Currently there are 1272 active at Level 1 (61%), 603 at Level 2 (29%), and 196 are classed as Community Groups (10%).

In addition to these figures the Community Facilitator picks up cases in the areas of York that are not covered by LAC.

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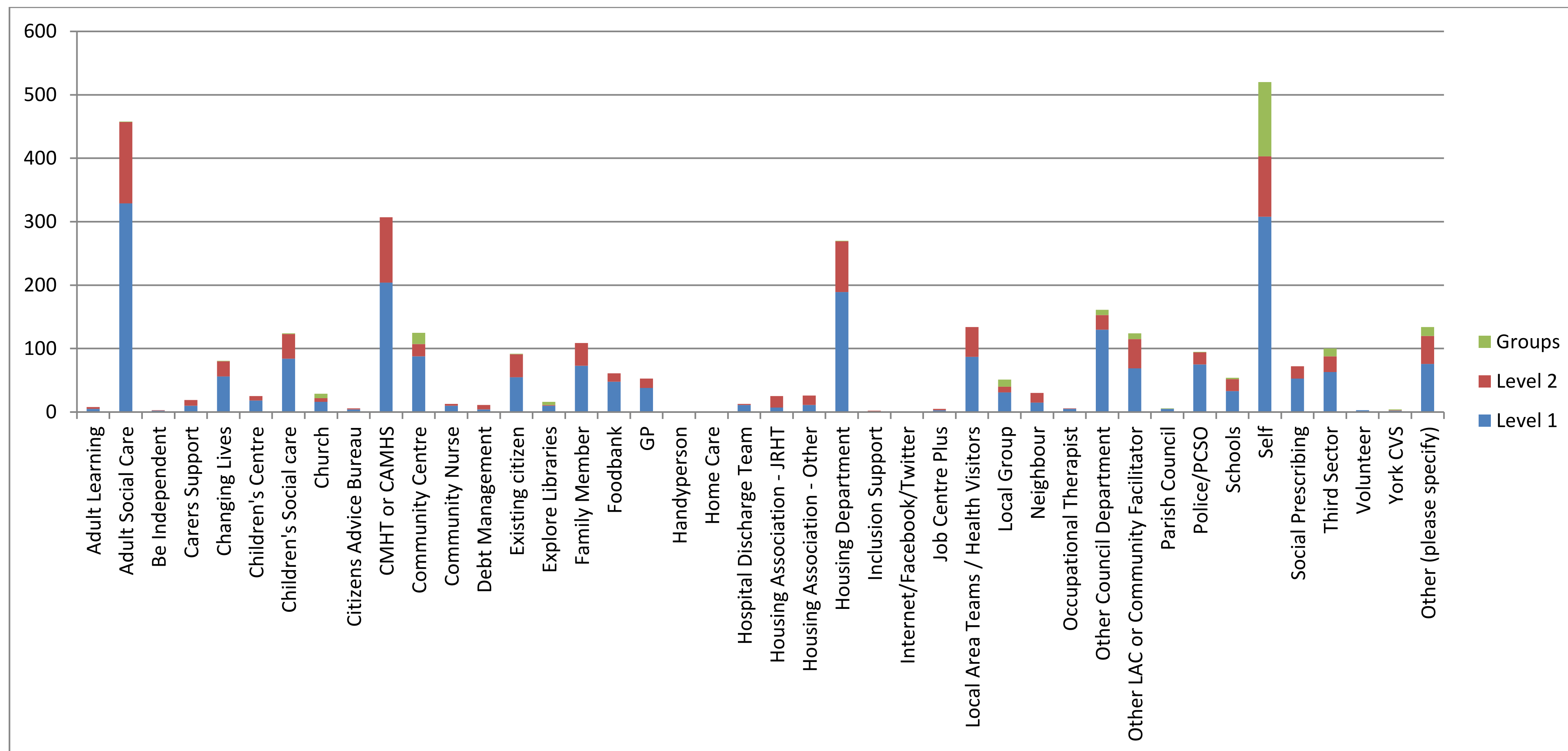
Section 3 - Source of Introduction

The graph below details the originating source of introductions made to the Local Area Coordination programme to date.

Introduction Source



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The bar graph shows that most referrals have come from Self referrals (15%), Adult Social Care (14%) and CMHT or CAMHS (9%).when you combine Level 1, Level 2 and Community Groups. These account for over a third (38%) of all total introductions to date.

When you just look at Level 1 and Level 2 introductions then most referrals have come through Adult Social Care (14%), Self (13%), and and Mental Health services (10%) which account for 37% of all introductions to date.

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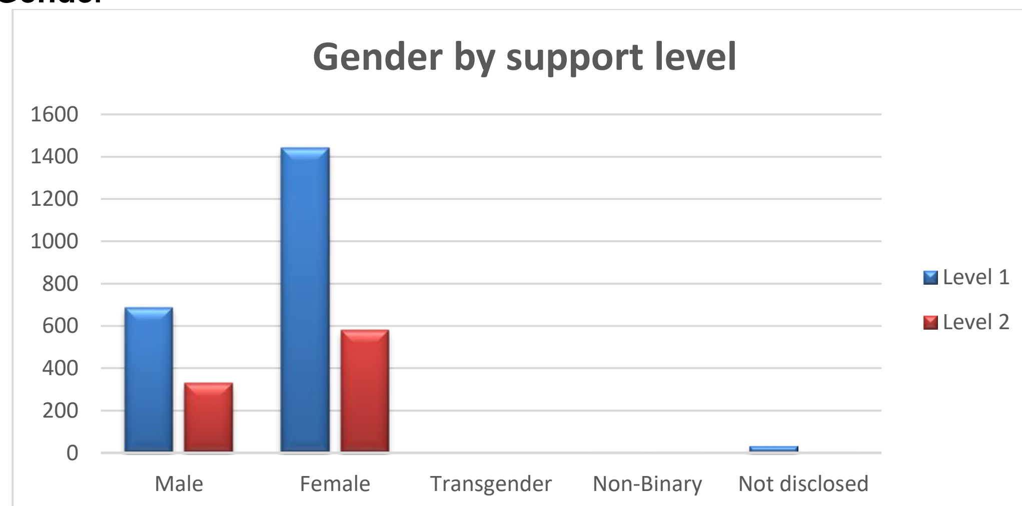
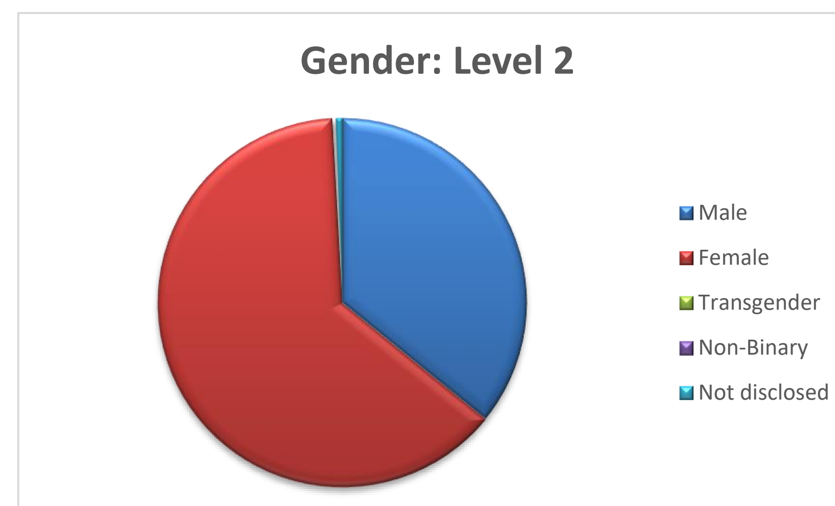
Section 4 – Demographic Information

As at the point of production (23rd May) of this report 3896 individuals and 441 groups have been introduced to the Local Area Coordinators. Detailed below are the gender breakdowns along with the reason why people have contacted the Local Area Coordinators. (*Note: Local Area Co-ordinators do not actively seek to obtain the ethnicity or date of birth of the individual but this information will be recorded if disclosed voluntarily by the person in question*)

Gender





It is widely accepted that gender is a socially constructed term for roles, behaviours, activities and attributes that society considers appropriate for men and women. We have limited our gender categories to 4 options; Male, Female, Transgender and Non-Binary. Other options can be added as and when they are captured.

Although we have not captured the gender of every participant it reflects a female bias in both Level 1 and Level 2 support levels. The bar graph by support level, where females represent 67% of Level 1 and 63% of Level 2 cases. The pie chart shows 66% of people across the board identify themselves as female; where 1% is undisclosed.

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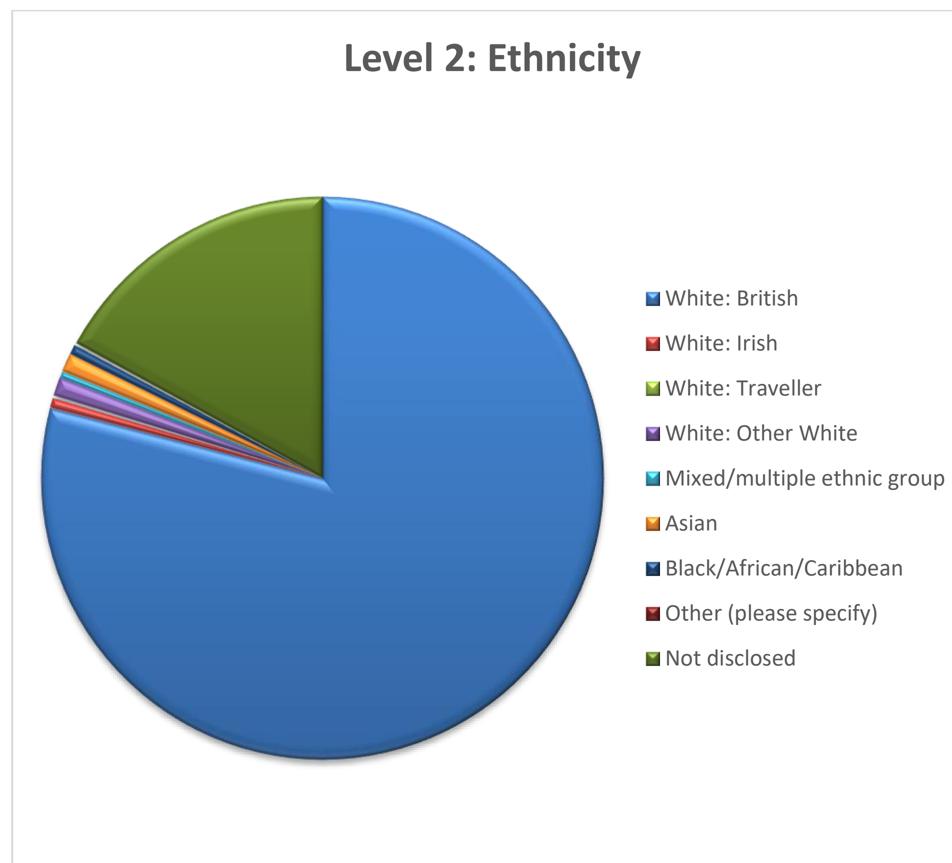
Ethnicity
We only collect this data for Level 2 cases.



The data we have collected so far shows as expected White: British are the largest proportion at 84%, with White: Other White at 1%, Asian at 1%, Black/African/Caribbean at 1% and where 13% of cases are not disclosed.

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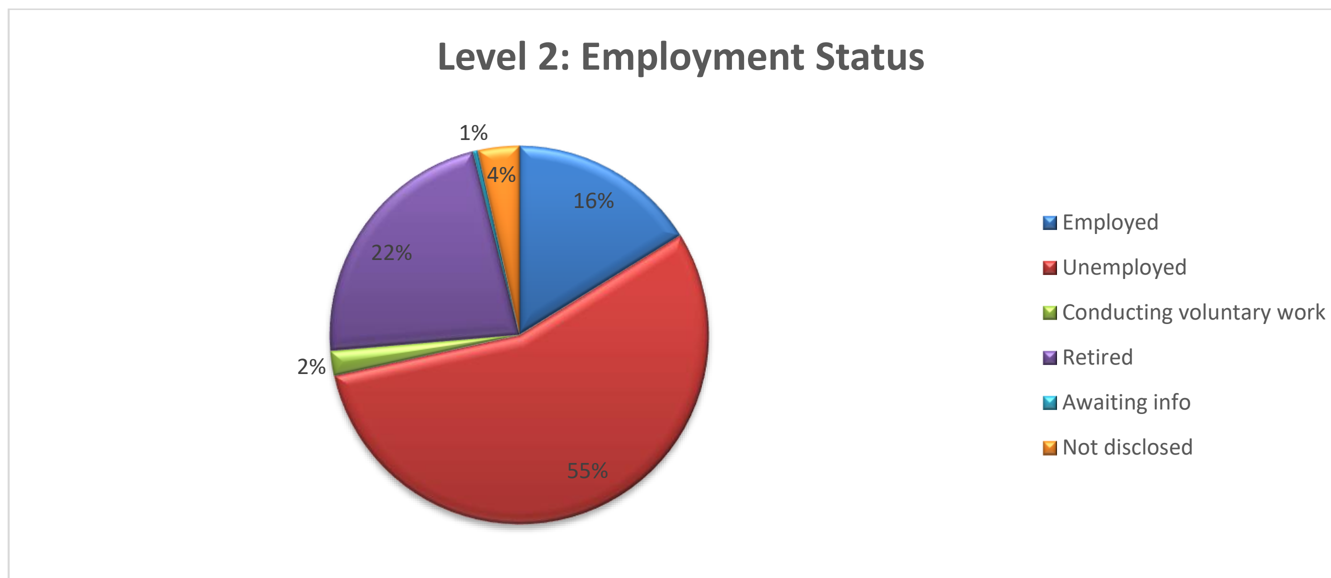
Employment Status
We only collect this data for Level 2 cases.



Over three quarters of cases are working with people who are Unemployed (55%) or Retired (22%), where 4% are not disclosed.

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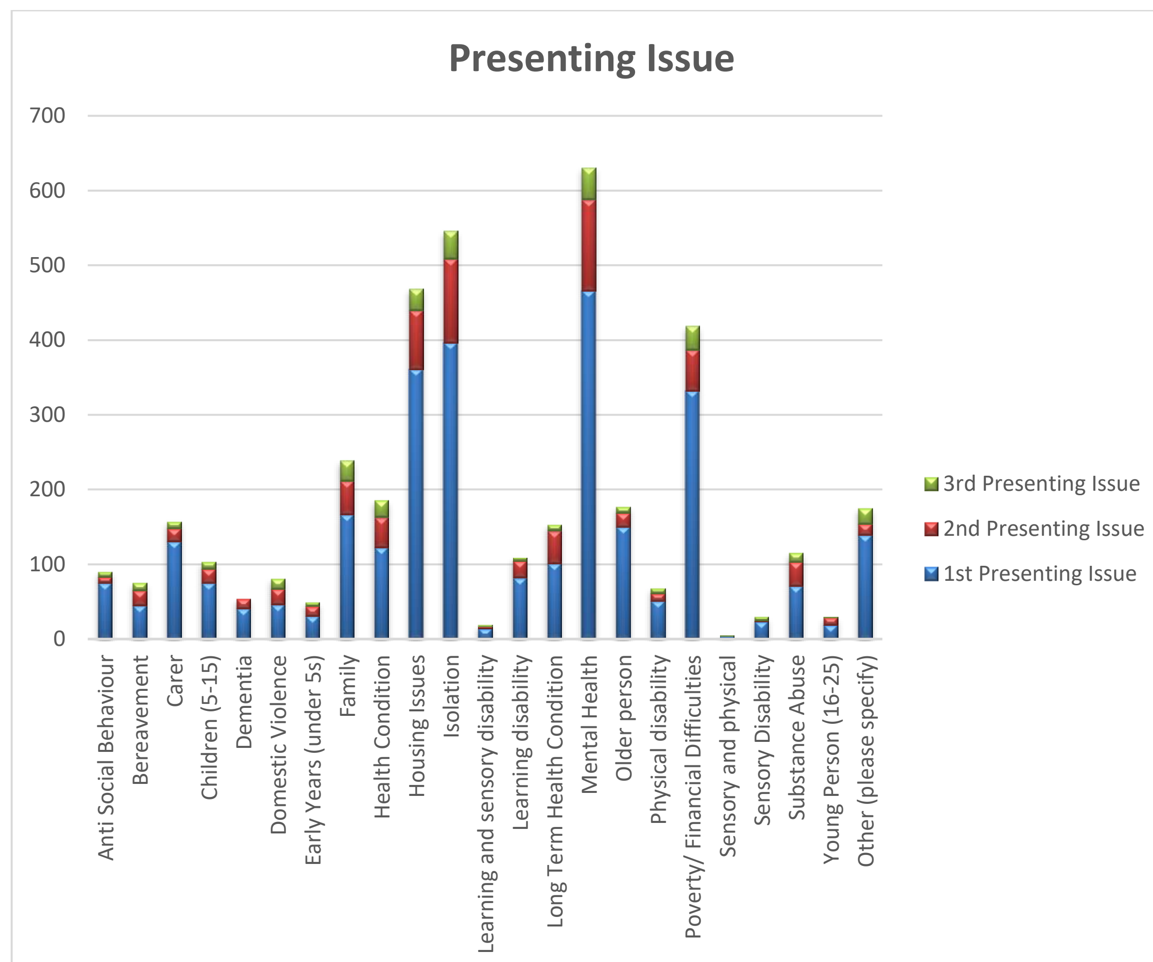
Reasons people are working with LAC
We are capturing the reasons why people make contact for Level 2 cases. For those seeking Level 2 support we are recording several presenting issues, up to three per individual.



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The main reasons for making contact across all cases are currently Mental Health (16%), Isolation (14%), Housing Issues (12%) and Poverty and Financial Difficulties (11%). These account for over half (53%) of concerns by the close of this period.

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Section 5 – Level 1 Actions
The table below shows the types of actions undertaken by the LACs in working with Level 1 recipients broken down by month.

This is where action types have been defined as follows:
Arranging joint visit – where a meeting or follow up is arranged with a third party source or service
Community Connection – where recipient is connected to a citizen
Group Connection – where recipient is connected to a Community Group
Information & Advice – where recipient requires low touch advice
Moved to Level2
Non-service solution – where a solution is reached which has no service costs
Self Advocacy – where recipient has referred themselves to LAC
Signpost to services – where recipient is passed over to a costed service

	Arranging joint visit	Community Connection	Group Connection	Information & Advice	Non-service solution	Self Advocacy	Signpost to services	Other	Grand Total
2017									
Jul	1		2	5			1		**9**
Aug	7	1	2	8	3		3		**24**
Sep	6			9			2	1	**18**
Oct	6	2	1	14			2		**25**
Nov	4	3		22	1	1	3	3	**37**
Dec	1			13				1	**15**
2018									
Jan	4	1	1	27				3	**36**
Feb	5	2		16			5		**28**
Mar	1			14				1	**16**

Apr	1	1	1	19					**22**
May	1	1	2	9			4		**17**
Jun	2	2		19			2	1	**26**
Jul				15			2	4	**21**
Aug				11			2	1	**14**
Sep	2			8			1	1	**12**
Oct	9	3		17			6		**35**
Nov	8	9	20	17	12		5	6	**77**
Dec	5	10	5	12	14		1	1	**48**
2019									
Jan	2	8	1	19	9		6	6	**51**
Feb	1	7	20	27			8	6	**69**
Mar	5	12	6	35	3		4	2	**67**
Apr	2	4	2	19	3		2	2	**34**
May	2	4	15	16	2	5	3	14	**61**
Jun	3	12	17	24	3		5	9	**73**
Jul	2	6	12	22	1		8	14	**65**
Aug	2	7	8	6	2		4	17	**46**
Sep	1	5	2	10	0		4		**22**
Oct	5	8	15	26	4		4		**62**
Nov	4	7	1	13	2		2		**29**
Dec	6	6	6	9	2		2		**31**
2020									
Jan		3	1	7	4		3	10	**28**
Feb		4	2	3	3			4	**16**
Mar	3	2	1	8	4			35	**53**
Apr	1	10	2	56	16		9	4	**98**

May		9	1	56	4		10	7	**87**
Jun		6	2	40	3		2	2	**55**
Jul		4		37	11	1	3		**56**
Aug	3	3		29	2		5	7	**49**
Sep	0	1		28	2	1	4	6	**42**
Oct	2	5	1	30	3		2	1	**44**
Nov	1	5	1	27	10	1	10	8	**63**
Dec	2	1	1	8	8	1	3	1	**25**
2021									
Jan		4		5	3	2	4	4	**22**
Feb	6	9		42	10		4	2	**73**
Mar	3	8	1	41	5		5	1	**64**
Apr	1	11	3	27		1	2	1	**46**
May	8		1	31	2		6	8	**56**
Jun	3	7	1	31	5	1	2	3	**53**
Jul	1	8	1	26	12		9	6	**63**
Aug		2	1	11	1		3	3	**21**
Sep		3		19	1	1	1	3	**28**
Oct		5		26	4		1	2	**38**
Nov		2	1	19	12		3	5	**42**
Dec		4		26	2		3	1	**36**
2022									
Jan		4		9	3		5	1	**22**
Feb				2					**2**
Mar		6	2	24		9	4		**45**
Apr		4	2	21	3	2	2	1	**35**
May		4	1	17	1	2	1		**26**

Grand Total	**132**	**255**	**165**	**1187**	**195**	**28**	**197**	**219**	**2378**

The data shows that since the service was introduced 50% required information & advice. Please note *Other* includes where individuals have declined the LAC service or moved to another service, e.g. Social Prescribing.

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Section 6 – Level 2 People's Stories Detailed below are a selection of stories relating to those introduced to the Local Area Coordination team. The names of the individuals have been changed to keep their identity undisclosed.

Story 1: Mike's Story, Acomb

Introduction

The Macmillan nurse rang and asked if I covered the area that her patient lived in. She explained that she was caring for a gentleman who was terminally ill. The nurse explained that Mike was currently responding to treatment but he occasionally needed to be admitted to hospital for chest infections. The nurse visited every other week to attend to his medical needs but there were outstanding needs that she did not know how to address. These things included his mobility scooter and payment of his bills. The nurse explained that it could be difficult to understand Mike when first speaking to him as his ability to speak had been damaged as a result of the cancer. We agreed a time and date for me to visit Mike and she was going to check this out with him on her next visit and she would get back to me if there was a problem with this.

Situation

Mike lives alone in a 2 bed bungalow that he used to share with his mum until she died a few years ago. Mike has a sister who lives away from York and she visits him once a month but phones him at least twice a week to see how he is doing. Mike is very independent and whilst he is aware that his cancer is terminal he is not prepared to acknowledge this so will not discuss any end of life care with anyone. He is a really sociable person who likes to go out daily and he has a good few friends in the local area where he is well known and his sister has people who keep an eye out for him. Until the Local Area Coordinator became involved his mobility scooter was broken and this was limiting his ability to get out and about as much as he liked to, his sister and the nurse were not certain that he would be strong enough to manage the scooter if it was fixed. He could not go to the park and feed the squirrels. His reduction in going out and about also meant that people did not see him as much so were unable to keep an eye out for him and let his sister know if they were worried about him.

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What happened?

The LAC met with Mike and explained what their role was, Mike communicated with a combination of written notes and speech. The LAC initially found this difficult but soon became able to pick up on words that Mike was using. Mike communicated that he wanted to have his mobility scooter fixed, he had bought it off ebay and did not have any paperwork for it, the LAC was able to ascertain how much he wanted to spend on fixing it and how he was going to pay for the repair. He also asked if the LAC was able to go to the post office and pay his fuel bills and phone bill.

The LAC was able to contact the local mobility centre and arrange a time for them to pick the mobility scooter up and make an assessment of what was needed and a price for it to be fixed. As far as the payment of the bills go, the LAC considered if this actually fit with the LAC model and considered if the act of doing for Mike would support his good life ambition or make him dependent on the support. The LAC decided that whilst in the long term this would not fit with the high fidelity model of LAC, it actually did enable Mike and the LAC to build a relationship and Mike to gain trust in the LAC. Over the next few weeks and months the relationship developed and the scooter was fixed and Mike was able to get back out and about and meet his friends, on one occasion Mike left the LAC a note on his door informing them that the he had gone into town to feed the squirrels so would not be in for the visit. He was also able to get back on top of his bills and pay them himself. On one visit Mike was distant and confused and was able to tell the LAC that he had fallen a couple of times, the LAC noticed that he had a bottle of morphine that had more out of it than should have been. The LAC was able to chat to him about this and he consented for the LAC to speak to the Mac Millan Nurse. The nurse confirmed that too much morphine had been taken so was able to act quickly to get Mike the medical support required. The LAC, alongside Mike, was able to set up a lifeline button for him to use in case of future falls. More recently mike was able to share with the LAC that he was in significant pain that was new, again the LAC was able to pass this on to the Mac Millan nurse and she was able to arrange for the appropriate ongoing treatment that was needed.

The relationship with Mike and the LAC continues to grow and they share many entertaining exchanges. One particular time Mike had bought a huge pair of reindeer slippers which he was most thrilled with as they were only £2 from a charity shop. He took great delight in telling the LAC that he had worn them out and a young child had told him they were silly. Great to see him able to converse and talk about other things than the difficulties in life.

The relationship with the Macmillan nurse also continues to develop and she is “blown away” with the difference in Mike’s life from the introduction of the LAC service and has stated that it has enabled her to concentrate on maintain Mike’s physical health and the co working

and relationship with Mike has meant that Mike is able to stay in his home longer. The Nurse has invited the LAC to attend their team meeting to discuss the role of LAC to the wider team.

Whilst Mike still will not discuss end of life care, the life he is living right now is as good as it can be with his diagnosis and he is happy with it. He has people around him that he trusts and uses in a way that enables him to continue doing the things he enjoys for as long as he can. The LAC is proud to be part of that.

Critical elements

- Mike was given time to build a relationship with the LAC.
- Mike was given the opportunity to make decisions that were important to him and not necessarily important for him.
- The co working of the LAC and MacMillan nurse
- The LAC knowledge and skill around medication protocol
- The LAC's wider network

Outcomes for individual:								
Assisted to access daily entitlements and/or benefits?	x	Connected with others in the community?		Supported to groups/clubs in the community?		Provided with advocacy?	x	How? Supported to give victim impact statement
Attending health appointments as appropriate?	x	Taking medication correctly?	x	Supported to formally volunteer?		Require formal service from Adult Social Care?		What service? ASC Up to 6 hours care a week given

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Supported with accommodation?		Does the individual feel safer in the community?	x	Supported to share skills in their community?		Referred to Public Health service?		What service?
Was the individual given fire safety advice?		Was the individual supported to access police advice?		Does the individual feel more confident?	x	Were family / carers / friends supported?	x	How? Supported her grandson to apply for carers allowance
<u>Any perceived/evidenced preventions or savings as a result of Local Area Coordination intervention:</u>								
i.e. Reduction in health support, reduction in services, community providers/groups involvement, what may of happened without Local Area Coordination, etc.								
Without LAC involvement Mike would still be without access to his mobility scooter and his social network. This had potential to lead to more chest infections and hospital stays due to chest infections. Also a reduction in his mental wellbeing due to social isolation. Potential re housing or admission to the hospice which would have had a cost implication for either health or social care.								

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Story 2: Cathy's Story, Clifton

Introduction

A social worker emailed the Clifton Local Area Coordinator to see if they could locate some funding to connect a washer and a cooker in Cathy's kitchen following a move to a more suitable council property.

Situation:

Cathy was a confident young woman but a recent stroke, where she lay on the floor for many hours afraid until she was found and an ambulance called, has had a major impact on her confidence and completely changed her life. After leaving hospital Cathy received support from adult social care and housing, who moved her into a smaller council property and helped her to access the benefits she was now entitled to.

What happened?

"Once Cathy had been moved to Clifton into her new home, her worker from adult social care emailed me to ask if they could help find funding for Cathy to get her washer and cooker connected. The social worker also wondered if I might be able to tell Cathy about what is going on in her local area for when she is ready and able to socialise again.

I contacted Cathy and had a chat on the phone. I discovered that Cathy was struggling with incontinence and really needed her washing machine, and that there were a few repairs that needed to happen in her home but that after her stroke she really struggles with her mobility, and was understandably afraid of falling again. Cathy was worried about money, and couldn't start to think about what a good life looked like until her basic amenities were met.

Cathy said she was previously really independent, so we made a plan together focusing on what Cathy felt was most important. A conversation with the LAC team indicated that we could use the Early Support Fund to pay for a plumber to connect Cathy's white goods.

Cathy felt that she would like to arrange for this, and would email me the invoice from the plumber so I could arrange this with our Early Help Fund, to avoid further delay. Cathy and I arranged to meet in person at her home the next week.

When I went to visit Cathy, her plumber had been and connected her white goods and she was really relieved. We completed the Early Support Fund paperwork together and I passed on the plumbers invoice. Cathy was really grateful and said it took a huge weight off her mind, as it was expensive. We discussed what other outstanding tasks there were in her home now that her panic had subsided about the white goods. Cathy said she felt her home was really cluttered, and she had lots of things in boxes, and small flatpack furniture she had had to order for the new flat that she was unable to build or sort out. She had taped a shower curtain over the window because she was physically unable to put her blinds up.

We made a list of what needed doing, but Cathy said she couldn't afford to do a lot of it, or do it physically. I showed her the York Council handyman webpage – which lists putting up blinds and building flatpack furniture as tasks covered for those on benefits – and Cathy was really excited. She said she felt comfortable arranging to get this sorted herself now that she knew about it. She had already negotiated with her occupational therapist for someone to come and fix the seal on her washroom, and install some accessibility grips and bars. The workmen actually arrived during my visit.

Cathy said it finally felt like she was getting all the help she needed. She said she felt sad, however, that because she needed this support physically, she felt people were treating her differently and kept telling her what she needed to do next. We had a 'good life' conversation about what Cathy might do next if it was up to her, and talked about setting boundaries with family, building her confidence, finding advocacy so she can either return to work or find other ways of feeling she has purpose. Cathy is really creative and motivated, but lacking in confidence in how to navigate her new world post stroke, so our goals together now are to continue to explore these new goals. In our recent phone calls, we have been discussing the Government Access to Work scheme, and the local York Mind Thriving at Work coaching service, neither of which Carla had heard about before Local Area Coordination.

Cathy is still a wonderful and really capable lady and is happy to be allowed to use the independence she still has. The connection to Local Area Coordination has given Cathy one off financial supports that have removed barriers to her staying as independent, calm and well as possible – and given her space to think about what is best for her. I have been able to introduce her to services and help her navigate asking for help on her own terms, and continue to support her to research where to go next."

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Critical elements

- The Local Area Coordinator had access to an Early Help Fund to pay for a connection of white goods that was preventing her getting out and about, staying clean and healthy. This also allowed us to build trust and give Cathy a confidence boost in being able to make tangible steps forward when she was particularly low and worried
- The Local Area Coordinator gave Cathy space to explore what was important to her, without an agenda or telling her what she needs to do
- The Local Area Coordinator was able to direct Cathy to services, groups and support she wasn't aware of otherwise
- Being able to visit Cathy in her own home at a flexible time and without needing to rush meant that Cathy could make a plan and show the Local Area Coordinator what she needed help with

Outcomes for individual:								
Assisted to access daily entitlements and/or benefits?	y	Connected with others in the community?	y	Supported to groups/clubs in the community?	y	Provided with advocacy?	n	
Attending health appointments as appropriate?	y	Taking medication correctly?	n	Supported to formally volunteer?	n	Require formal service from Adult Social Care?	n	
Supported with accommodation?	y	Does the individual feel safer in the community?	n	Supported to share skills in their community?	n	Referred to Public Health service?	n	
Was the individual given fire safety advice?	n	Was the individual supported to access police advice?	n	Does the individual feel more confident?	y	Were family / carers / friends supported?	n	

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Any perceived/evidenced preventions or savings as a result of Local Area Coordination intervention:
i.e. Reduction in health support, reduction in services, community providers/groups involvement, what may of happened without Local Area Coordination, etc.
Without local area coordination Cathy would have initially been plunged further into financial hardship and debt as she was already having to plan to pay for plumbers, handypeople and other services that she did not realise she would have access to through various schemes. Cathy's family relationships are also strained and she had been feeling pressured to do as they say and give up her work, goals and dreams and have low expectations of herself now, because she didn't know schemes like Access to Work existed for example. She may have continued to feel isolated and not have an outlet to explore other options for herself with neutral outsiders with no agenda.

Story 3: Shaun's Story – Fishergate, Fulford & Heslington

Introduction

Shaun was introduced to LAC by the Community Facilitator and GP primary link worker. The relationship between Shaun and other support services had broken down and Shaun had become more isolated, so it was hoped that an introduction to a LAC would give Shaun time to build trust and get the support he was needing.

Situation

Shaun is particularly susceptible to isolation and non-engagement due to high level social anxiety and panic attacks linked to unresolved childhood trauma; additionally, he made the decision not to own a mobile phone or computer device due to his potential risk of relapse to his previous life as a drug user. Relationships with services and support had previously broken down due to their inflexibility in nature

which resulted in Shaun cancelling all support when it became overwhelming. Shaun's only support network includes a friend and his adult son who is also experiencing his own difficulties. Shaun communicates with all support services and network via letter and has had several successes with advocating for himself in this manner. Shaun also has a number of long-term health conditions which impacted not only his ability to actively participate in the things he enjoyed doing but also contributed to his low feelings of self-worth and anxiety in public.

What happened?

The LAC met Shaun on a joint visit with the Primary Link worker with whom Shaun had a long-standing good relationship but initially stated he couldn't cope with having another professional in his life. After a month the LAC received a letter from Shaun stating he was ready to meet and asked that all appointments be arranged in advance so that he could prepare for the intrusion into his home. The LAC took the time to listen to Shaun, finding out that he enjoyed art, particularly painting, was excellent at fixing mechanical machines such as bikes, is an avid fisher and loved train watching. As Shaun had said that he did not like to be rushed in to making decisions the LAC suggested that they take some 'getting to know you' time and when Shaun was ready, they could start to explore what his good life would look like.

After several weeks Shaun divulged that he would like to clear his spare room of the excess junk so that he could start using his miniature railway set again and that as the weather got nicer, he would like to attempt short walks from the property so that he could build up to walking to Fulford Ings in September to fish for the first time in a few years. Since that date Shaun and the LAC have been looking into ways of improving his living circumstances including replacing his bed with one donated by a local church, purchasing a new fridge freezer, disconnecting a faulty electric oven and arranging the bulky items to be moved outside his flat for CYC bulk waste collection.

Critical elements

- Shaun was allowed the time to talk about his experiences and felt listened to.
- Shaun was reassured that his childhood abuse was not his fault and his subsequent experiences and reactions to the ongoing flashbacks were validated.

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- Shaun felt able to tackle things at his pace and if he couldn't face a particular action then he felt able to ask for it to be stopped.
- The LAC was able to extend her community connections to Shaun resulting in him being able to get assistance in sourcing a new bed, which in turn showed him that others can be kind without expecting anything in return.

Outcomes for individual:								
Assisted to access daily entitlements and/or benefits?	Y	Connected with others in the community?	N	Supported to groups/clubs in the community?	N	Provided with advocacy?	Y	How?
Attending health appointments as appropriate?	Y	Taking medication correctly?	N	Supported to formally volunteer?	N	Require formal service from Adult Social Care?	N	What service?
Supported with accommodation?	Y	Does the individual feel safer in the community?	N	Supported to share skills in their community?	N	Referred to Public Health service?	N	What service?
Was the individual given fire safety advice?	N	Was the individual supported to access police advice?	N	Does the individual feel more confident?	N	Were family / carers / friends supported?	Y	How?

Any perceived/evidenced preventions or savings as a result of Local Area Coordination intervention:
i.e. Reduction in health support, reduction in services, community providers/groups involvement, what may of happened without Local Area Coordination, etc.
Reduction in missed appointments with health care provision as Shaun now feels able to contact services to cancel in advance of appointments meaning these can be issued to someone else.

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Identifying with Shaun who he can contact for support in times of need means that he is not waiting until a deterioration in his health or property condition before asking for help.

By making an introduction to and receiving weekly support from Help at Hand Shaun is now eating a healthy balanced diet, by living a healthier lifestyle Shaun will likely reduce his use of Primary and Secondary Healthcare.

Story 4: Bobby's Story – Guildhall

Introduction

Bobby introduced himself to the LAC via Facebook and was invited to the local Community Drop in. He had heard from other members of the community that it was a good place to get help and support and so was happy to come along.

Situation

Bobby had left prison a few years earlier. He did not want to live in a hostel and so had been living in his van with his dog. Bobby had never had a tenancy. He had lived in Children's homes as a child and then in prison or approved premises.

Bobby's experiences of the system since he was a child had understandably left him distrustful of the council. He had approached homeless services in York over the years, but felt that he was being pushed towards hostel living.

Bobby was welcomed to the Drop in by the volunteers and LAC. Everyone took the time to get to know him. Trust was built up over the weeks and Bobby felt able to share more of his situation. It was clear that van life was taking its toll on Bobby's health. He was sleeping upright in a van seat and his only access to water was from a cemetery. He was using this water for both cooking and washing.

Bobby was not registered with a local GP and was not in receipt of the right benefits. It was a long time since his general health had been checked.

What happened?

Bobby became a regular attender at the Drop in and started to attend the second drop in at the other side of the patch. Bobby would often arrive 2 hours before he would be due to see the LAC, but volunteers and third sector employees would welcome him and ensure that he had everything he needed.

Bobby was born and raised in York, but as a child in the care system and an adult in the justice system, he had never felt part of York's community. The LAC has lived and worked in York for over 20 years and was able to establish common ground with Bobby quickly. Although they had never met before, the LAC had previously worked with some of the adults who had been important to Bobby in childhood.

As the LAC and Bobby built up trust with one another, Bobby agreed that he would be helped to register with a GP. The LAC used relationships with Social Prescribers at the local GP surgery, to ensure that Bobby once again felt welcomed and listened to.

Over the weeks they met each week and Bobby agreed to register and apply for Housing through Housing Registrations, but he did not want to go through the Homeless Resettlement route. This was listened to and respected, but did not affect any other support he was receiving from the LAC and community.

Bobby also agreed to apply for Limited Capability for Work. The LAC helped Bobby to complete the health questionnaire. Bobby felt comfortable enough to answer the more personal health questions honestly. This meant that he could be supported in getting the right help for some health concerns, that had never been treated or explored.

Bobby was quickly becoming a popular member of the community. His sense of humour and warmth shone through, as did his willingness to help others.

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Three months after meeting the LAC, Bobby agreed to be introduced to the Housing Navigators. The LAC advocated for Bobby to the Housing Navigators and was then able to reassure Bobby that they had listened to his wish not to be offered Hostel accommodation. Once Bobby agreed, the Navigators were able to meet him the same day.

It was agreed that Bobby should be offered “Housing First” and that in meantime he and his dog be offered a bed in a former hostel, that was in the process of being decommissioned and so empty apart from staff. This was a good stepping stone for Bobby, who was finding it difficult to sleep in a bed and without the noises from the street. This building was close to the LAC’s drop in and he was encouraged by the local community, the LAC and the Housing Navigators, to take his time to settle.

A few weeks later. Bobby was offered his first tenancy! Bobby has since moved in and is finding his feet. The new tenancy is in a different ward, but Bobby has been introduced to the LAC in that area.

The local Guildhall community had been gathering together a “bottom drawer” for when Bobby finally got his own home. Bobby came to the Drop in to collect it all, once he had his keys and was overwhelmed by everyone’s kindness.

Bobby is getting to know his new community, so we see him less and miss him madly; but he hasn’t forgotten his old friends in the Guildhall. Bobby still has his van and has offered to use it to transport a fridge freezer from a volunteer’s home to someone else in need of one in the community. He is always on hand to help out.

Bobby sums it up best, here is he describing a volunteer he has met through the LAC and the help he has received from everyone:

“She’s a angel and ile be comeing every Monday I can when I’m sorted. I want to bring her loads of stuff for outher people like me. You lot down there are the best in York that’s why I came all my friends that live in vans told me there’s no one else like it in York.

Thanks for all that you have done for me we cracked it and I am very appreciative.”

Critical elements

- The LAC took time to listen to Bobby and what he wanted, free from influence of what the system could provide.
- The LAC was able to spend time building trust and modelling trust to Bobby.

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- The LAC's established relationships within the community, meant that she could introduce Bobby to informal support, when he had lost faith and trust in the system.
- The trust that the community places in the LAC, meant that she was able to influence their response to Bobby.
- The LAC knew of safe spaces that Bobby could join, where he would not feel judged.
- The LAC's flexible approach, ensured that support was swift and tailored.
- Being embedded in community level systems as well as local authority systems, meant that the LAC could coordinate an effective response to Bobby, that wasn't just replicating the status quo.
- Support from volunteers rather than professionals, has provided Bobby with a life where he feels supported, rather than a careplan.
- The focus of support was on Bobby's strengths and what he could bring to his new community, in collaboration with any services he might need.
- The LAC nurtured Bobby's trust, so he is now able to replicate that in his new area.

Outcomes for individual:								
Assisted to access daily entitlements and/or benefits?	Y	Connected with others in the community?	Y	Supported to groups/clubs in the community?	Y	Provided with advocacy?	Y	How? With Housing Colleagues.
Attending health appointments as appropriate?	Y	Taking medication correctly?	N	Supported to formally volunteer?	N	Require formal service from Adult Social Care?	N	What service?
Supported with accommodation?	Y	Does the individual feel safer in the community?	Y	Supported to share skills in their community?	Y	Referred to Public Health service?	N	What service?
Was the individual given fire safety advice?	N	Was the individual supported to access police advice?	N	Does the individual feel more confident?	Y	Were family / carers / friends supported?	N	How?
Any perceived/evidenced preventions or savings as a result of Local Area Coordination intervention:								
i.e. Reduction in health support, reduction in services, community providers/groups involvement, what may of happened without Local Area Coordination, etc.								
Bobby's health and personal safety, remained at risk whilst he was living in the van. Costs to the NHS due to a hospital admission have been avoided, as have costs to local policing.								

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Bobby's mental health has been supported and protected, by feeling part of his local community and identified as a valued citizen. This has avoided the need for mental health services to become involved. Now that Bobby is in receipt of the right benefits and is a permanent resident of York, he is able to spend money within the local economy.

Story 5: Patricia's Story – Haxby & Wigginton

Introduction

Patricia was introduced to the LAC by TEWV. Patricia had been in touch with the crisis team due to the distress of the loss of her partner during a covid lockdown.

Situation

Patricia lives alone and is in her 80s. She has had a difficult past with abusive relationships, depression and the recent bereavement of her partner, made even more traumatic by not being able to see him in hospital before he passed away.

What happened?

As I got to know Patricia, it transpired there was a history of poor mental health, compounded by difficult family relationships, being estranged from her children, feeling targeted by neighbours, feelings of isolation, and regular distressed calls to the police, GP, and Yorkshire Housing, along with regular A&E attendance.

Patricia is very sociable and loves to chat, and told me she feels abandoned by her four children, and by services who “don’t have time for old people”. Patricia would reminisce about holidays and times with her partner, and said “now I have nobody”. She enjoys going out for meals, chatting and gardening.

The LAC took the time to get to know Patricia and we talked through options to help with her grief. The LAC connected Patricia with CRUSE and she received regular telephone calls from a counsellor, which she found comforting. The LAC also introduced Patricia to a local volunteer, who visits regularly for chats and helps her with odd jobs. The two have developed a friendship and the volunteer visits as regularly as ever two years later. Patricia says “I don’t know what I’d do without John, it feels like I’ve always known him” He’s helped her through a difficult time when her son passed away and still accompanies her to the cemetery to take flowers.

The LAC met with the local PCSOs and Yorkshire Housing officer to find a way forward regarding Patricia’s difficulties with her neighbour. CCTV was installed and the LAC helped Patricia to review it when needed. The LAC connected Patricia to Victim Support from whom she receives regular calls. Both the PCSOs and Yorkshire Housing visited Patricia, and she said she feels listened to and well supported by everyone involved.

Patricia was experiencing distressing visual and olfactory hallucinations and believed her neighbour was inflicting criminal damage on her property and entering when she was asleep, making her very afraid of any noise or movement. She would regularly call for an ambulance and went to A&E on occasions as she was so distressed. Because these issues continued, Patricia began to talk about moving away. The LAC accompanied Patricia to view some flats, and connected her to the local lunch group, where she has made many friends. She now sees these friends socially outside of the lunch groups and has decided not to move away. The social prescriber became involved due to frequent GP contact and the LAC worked with her to provide further local links and support for Patricia. We explored whether the GP could treat the mental health symptoms that were making Patricia so distressed, and the GP has now prescribed sertraline. Today Patricia has been to the garden centre with a friend from the lunch group and is planting flowers in her garden for the summer. She’s talking of joining the art groups at Kyra and taking up their counselling offer, so is feeling positive with plans for the future. She seems more settled in her home, and so far hasn’t experienced any episodes of distress/paranoia.

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Critical elements

- The LAC took the time to get to know Patricia and picked apart the many complex issues, which other services didn't have the resources to address.
- A collaborative approach was taken by getting the PCSOs, Yorkshire Housing, GP and social prescriber on board, utilising the LAC's contacts and good rapport with other services.
- The LAC's consistency over two years has been key to overcoming Patricia's fear of abandonment which has been perpetuated by most past personal and professional relationships.
- Having one consistent support and point of contact has been key Patricia being able to trust someone, build her own confidence and resilience.
- The LACs ability to connect citizens to the community has opened up Patricia's social circle, helping her feel connected and supported locally.

Outcomes for individual:								
Assisted to access daily entitlements and/or benefits?	N	Connected with others in the community?	Y	Supported to groups/clubs in the community?	Y	Provided with advocacy?	N	How? Advocacy with regard to dealing with utility company..
Attending health appointments as appropriate?	Y	Taking medication correctly?	Y	Supported to formally volunteer?	N	Require formal service from Adult Social Care?	N	What service?
Supported with accommodation?	Y	Does the individual feel safer in the community?	Y	Supported to share skills in their community?	N	Referred to Public Health service?	N	What service?
Was the individual given fire safety advice?	N	Was the individual supported to access police advice?	Y	Does the individual feel more confident?	Y	Were family / carers / friends supported?	N	How?
Any perceived/evidenced preventions or savings as a result of Local Area Coordination intervention:								
i.e. Reduction in health support, reduction in services, community providers/groups involvement, what may of happened without Local Area Coordination, etc.								

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Patricia's frequent contact with the GP, Police and Crisis Team was costly and the single interventions were not improving her quality of life. It is also hoped that local connections/support and non crisis mental health intervention will have a greater positive impact on Patricia at a lower cost.

Story 6: Diane's Story – Heworth

Introduction

Diane introduced herself to her LAC after getting their contact details from another resident.

Situation

Diane lived at home with her 3 young children, she had another older child who was in a hostel experiencing a decline in their mental health. Diane explained that she was main carer for her mother who she spent all her time with. Her mother was unwell and required support. Due to Diane's declining mental health she was unable to open any letters due to the debt mounting and the anxiety it created. She was aware that her benefits had changed but because she had not actioned a task she was not receiving her full allowance and this had gone on for some time.

What happened?

It took a number of arranged dates and times for LAC and Diane to meet. Diane was "spinning so many plates" that each arrangement would be cancelled or LAC would attend and no body was present. After approx. 6 weeks of this, sadly Dianes mum passed away unexpectedly. LAC was unaware but had been trying to encourage contact. Diane advised LAC that her mum had passed and they met shortly after this. The first visit that was completed was initially lots of talking to try and understand the finances, her needs, the children's

needs and what she felt the correct course of action would be. She was very upset, tearful and struggled to articulate the difficulties. We agreed that the number of different areas of things that needed doing would take time and we agreed to prioritise and get the support from as many supporting agencies as suitable. Diane was unable to open her mail but allowed LAC to so they could understand the situation and begin to unpick. Diane was very open and honest and didn't know where to turn. The relationship with CPN was sporadic so we discussed the support from them and LAC encouraged a closer relationship. CPN was then able to complete a home visit and monitor as suitable. We contacted DWP together to understand next steps and request suitable forms. Diane was happy to have a referral completed to the benefits team for appropriate benefits check and support completing paperwork. We then were able to get support from the peasholme charity to look into the debt issues and this also gave Diane the opportunity to discuss her complicated benefits claims and get support and reassurance.

Following the passing of Dianes mum, Diane very much took things day by day. She was lost, she didn't know how best to support her children with grief and nor did she know how she was going to cope, her “mum was everything” and they would spend most days together. We spoke about various support available for bereavement and online support for the children that help parents in this difficult situation. It was now more apparent the impact of her finances. LAC was required to drop food parcels weekly, source support for gas and electric, petrol money to get the kids to school and new uniforms for the kids as they started a new school year. Diane was so accepting of all support offered and engaged well with the agencies involved. Although some appointments were missed, in the main things were on track and the wheels were in motion to resolve the presenting issues. We were able to access YFAS and Household support fund. LAC was able to access Christmas presents for all the children to ensure they were happy on the day as Diane was so apprehensive about the first year with out her mum and the children's grandma.

Diane was so worried about her child in a hostel. They had frequent contact both face to face and over the phone by Diane found it hard to manage and advise her older child due to the complexities. LAC was able to introduce the child to another LAC in the area and they begun frequent contact and support.

Approximately eight months later and the LAC now only hears from Diane when she is trying to support her children. Diane has not asked for any help for herself for months now and is clearly in a more stable and comfortable position. The LAC and Diane would speak multiple times weekly for months as everything was being sorted out. The LAC bumped into Diane in the community and she was smiling and happy. She shared some really positive stories about recent weeks about things she had done and the children including one of the agencies contacting her months later to offer them a free photoshoot. Diane explained that they had not had a family photo together ever. She was visually beaming. This was even more special as her new grandchild her recently been born and would be included.

Diane now seems to have time to provide time, care and support to her older children as she always wanted. The void of her mum passing felt like it could never be filled but Diane has thrown herself into her family and seems like she is managing extremely well despite a very difficult period in her life. Diane was unable to open her letters and make phone calls due to her levels of anxiety. As we went through various introductions and discussed her situation LAC was over the moon when he learnt that Diane went through the PIP assessment independently without requesting his support. Diane was also then able to begin to collect her own food parcels and now supports her two eldest children with this.

Critical elements

- The LAC took time to explore Diane’s issues and connect the correct support.
- The LAC listened to what would make Diane’s life better, rather than offering what was available from a service.
- The LAC Team’s pre-existing relationships Peasholme Charity encouraged them to remain involved despite non engagement at points
- The LAC was responsive and this promoted a trusting and open connection. All interventions were therefore timely.
- The LAC worked in a creative way to ensure that the family’s needs were met i.e. any ad hoc financial support received was used appropriately to ensure the family were able to stay fed, watered, warm and safe.

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Outcomes for individual:								
Assisted to access daily entitlements and/or benefits?	Y	Connected with others in the community?	Y	Supported to groups/clubs in the community?	N	Provided with advocacy?	Y	How? PIP/UC applications.
Attending health appointments as appropriate?	N	Taking medication correctly?	Y	Supported to formally volunteer?	N	Require formal service from Adult Social Care?	N	What service?
Supported with accommodation?	N	Does the individual feel safer in the community?	N	Supported to share skills in their community?	Y	Referred to Public Health service?	N	What service?
Was the individual given fire safety advice?	N	Was the individual supported to access police advice?	NA	Does the individual feel more confident?	Y	Were family / carers / friends supported?	N	How?

Any perceived/evidenced preventions or savings as a result of Local Area Coordination intervention:
i.e. Reduction in health support, reduction in services, community providers/groups involvement, what may of happened without Local Area Coordination, etc.
Previously Diane has required increased support from mental health teams however, with encouragement and support at the right time this was minimised and now reduced significantly. Council tax and rent arrears were significant, however no action was taken by LA due to the support Diane received and management of her debts. The introduction of her child to another LAC was very timely due to the difficulty they were having and this has arguably reduced the impact on other formal services.

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Story 7: Tom's Story – Huntington

Introduction

Tom was introduced to LAC by his father who is his unpaid carer. His father had heard about LAC through the York Carers Centre as he is part of the Mental Health Support Group there. The LAC had been to do a talk to the group.

Situation

Tom's father was concerned about his son being isolated and was keen for me to meet Tom to tell him about what sort of activities were happening in the village and to have a good life conversation with Tom. Tom had lost confidence over the years and local connections due to his mental health and other factors such as lock down.

What happened?

LAC met Tom with his father in the Folk Hall initially, to find out more about Tom and what he liked doing. Tom was very keen on all animals and anything to do with nature especially bird watching. LAC suggested meeting again for a walk and suggested going to have a look at what Community Action for Nature do in the village. Tom and LAC met with one of the organisers and had a walk around the site. Tom felt very comfortable and was able to spot different flowers and birds. Tom said that he would like to volunteer once a week, with taking note of the different types of birds which is an important part of the group.

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We agreed to meet a few days after his first-time volunteering to see how he got on. Tom mentioned that he liked dogs and dog walking so LAC asked if he'd like her to bring her dog and go on a short dog walk. The following week LAC and Tom met with Roxy. Tom immediately relaxed and was a lot chattier. He loved petting Roxy and we had some rich good life conversations. Tom was settling well to the group, and they found him to be really helpful.

Tom continues to volunteer at Community Action for Nature and is looking to volunteer at other groups once he has built his confidence a little more. LAC and Tom meet to have a chat and continue to build the relationship. Which of course Roxy has been more than happy to help facilitate and get a treat afterwards.

(Roxy's payment in treats)

Critical elements

- Time to get to know Tom
- Build trust
- Look at community connections to reduce isolation and loneliness
- Thinking outside the box
- Volunteering to build confidence
- Roxy

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Outcomes for individual:								
Assisted to access daily entitlements and/or benefits?		Connected with others in the community?	Y	Supported to groups/clubs in the community?	Y	Provided with advocacy?		Support to liaise with solicitor & benefits team
Attending health appointments as appropriate?		Taking medication correctly?		Supported to formally volunteer?		Require formal service from Adult Social Care?		What service?
Supported with accommodation?		Does the individual feel safer in the community?	Y	Supported to share skills in their community?	y	Referred to Public Health service?		What service?
Was the individual given fire safety advice?		Was the individual supported to access police advice?		Does the individual feel more confident?	Y	Were family / carers / friends supported?		How?

Any perceived/evidenced preventions or savings as a result of Local Area Coordination intervention:
i.e. Reduction in health support, reduction in services, community providers/groups involvement, what may of happened without Local Area Coordination, etc.
Without LAC involvement Tom would continue to feel isolated in his community and to be reliant on his father to provide things to do or companionship. Tom has been able to start to grow in independence and contribute towards his community, which in turn prevents him from returning to statutory services.

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Story 8: Bev's Story – Micklegate

Introduction

Bev was introduced to LAC by a DWP Visiting Officer, who had popped to see Bev to offer support. During which time she had completed Bev's PIP application.

Situation

On visiting Bev, it was established Bev was anxious and wary of professionals. The Visiting Officer and LAC arranged a joint visit. During the visit Bev, said she would meet with the LAC again and said she wanted change in her life, expressing that she felt she lost thirty years and wanted to start getting out and changing her living environment.

During further visits Bev shared she hadn't had a working toilet in at least 2 years and that her boiler had not been working for a similar amount of time if not longer. Bev had no hot water or heating for several years. Bev, shared she was sleeping on the floor in a small space in the hall.

What happened?

LAC met with Bev once a week and an agreement was made with the LAC to support with removing three bags of unwanted items at each visit. Bev had a friend, who would do the same. The friend also supported with shopping. However, Bev's priority was to have a working toilet and hot water. Within three weeks of meeting Bev, the toilet was fixed, and boiler serviced and working.

Good life - Bev shared she wanted to start to leave her home and meet with people and develop contacts in the community and make friends. Bev has subsequently started to attend a local group at a Church and have a coffee on a Friday mornings. During this time Bev, played the piano and was an amazing pianist. Bev said she really enjoyed being able to do this. The following week she had ventured into town and bought some sheet music and played once again. Bev is now, with the support of a friend, going to Morrisons shopping, attending the Friday morning group and maintaining regular contact with the LAC.

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Bev, is wanting to address the hoarding and a plan has been made to do this. Bev is very self-aware and has a distrust of services especially the medical profession and together with the LAC progress is being made.

Critical elements

- Bev shared that she recognised her behaviour was as a result of childhood trauma following the death of her parents. Bev has read up on Adverse Childhood Experiences (ACES) and is able to relate the hoarding to her mental health and life experiences.
- Bev experienced both sexual and physical abuse from foster carers and one of their children
- Bev was bullied at school and by the children of her foster carers
- Bev felt the social work teams should have spoken to her at the time she was in care. No one did. Bev is considering at some point in the future, sharing her story with trainee Social Workers, to inform best practice.
- Bev experienced trauma from mental health services; the support triggered further trauma
- Bev has suicidal thoughts

Outcomes for individual:								
Assisted to access daily entitlements and/or benefits?		Connected with others in the community?	Y	Supported to groups/clubs in the community?	Y	Provided with advocacy?		How? Liaison with dwp and community projects.
Attending health appointments as appropriate?	N	Taking medication correctly?	N	Supported to formally volunteer?	N	Require formal service from Adult Social Care?	Y	What service? Supported with referral to adult social care.
Supported with accommodation?		Does the individual feel		Supported to share skills in		Referred to Public Health service?		What service?

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	N	safer in the community?	N	their community?	Y		N	Played the piano for those attending group.
Was the individual given fire safety advice?	Y	Was the individual supported to access police advice?	N	Does the individual feel more confident?	Y	Were family / carers / friends supported?		How? Fire safety has been discussed with LAC..

Any perceived/evidenced preventions or savings as a result of Local Area Coordination intervention:
i.e. Reduction in health support, reduction in services, community providers/groups involvement, what may of happened without Local Area Coordination, etc.
Boiler serviced and running safely as well as a working toilet, improving health and wellbeing long term Bev attending a weekly group so developing social contact and reducing isolation. Bev meeting with LAC weekly Bev leaving home, has attended groups, and had one trip to Rowntrees Park Café. Bev has ventured into town a couple of times so working towards the better quality of life she wants.

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Story 9: Issac's Story – Westfield

Introduction

Isaac was introduced to the Westfield LAC by a Housing Management Officer Sue, who had received an email from Isaac's Work coach at the Jobcentre.

Situation

Isaac was a 61 yr old man who had given up work 17 years previously, to care for his mother. When she died he was asked to leave the CYC house which he had shared with her. The trauma of losing his mother and being given notice to leave his home, resulted in "some kind of breakdown" as Isaac described it. He left the house, with a suitcase and used his savings to live in B&B's, finally sleeping on a park bench when his money ran out. Isaac then presented as homeless, and was re-housed in a CYC flat. He was unable to afford carpets and did not have the energy to paint the walls. He could not afford his energy costs, and ended up living for 3 years without gas or electricity, using a torch and candles after dark and doing his cooking on a gas camping stove. He did not have a phone or internet and so was not able to access GP appointments or a Covid jab. Isaac's health deteriorated, he lost weight and his walking became unsteady. He spent up to 16 hrs a day in bed trying to keep warm. He explained this to his job coach but was not offered any help. It was only after a change of job coach that Isaac's circumstances were brought to the attention of the Housing Department and the LAC.

What happened?

The LAC visited Isaac and listened to his story. He did not feel there was much prospect of life getting better for him as he felt "stuck" in a situation. Isaac agreed he was happy to work with the LAC to improve his circumstances, his life had become "a living hell" and he wanted to get out of the flat which held so many bad memories. On Universal Credit, he was having to choose between heating and eating. He owed some money to his energy supplier, CYC rents and Council Tax, which was being deducted from his benefits. The LAC contacted CAB Debt advice and they took on Isaac's case which led to a Debt Relief Order. The LAC supported with a PIP application on the grounds of his poor physical and mental health. She also emailed the GP practice to raise concerns, Isaac was visited by a team from

the NHS and also a GP who diagnosed him with malnutrition. The Specialist Housing advisor offered temporary accommodation in a flat within an independent Living Community, and Isaac was able to move in straight away and spent Christmas there. He was then offered the tenancy of a vacant flat and received support with carpets and furnishings. The LAC helped with establishing payments for his new rent and Council Tax. The LAC also referred Isaac to OCAY so that their specialist advocate could help him find the cheapest energy provider and set up an account with them. Isaac reported that his life was now 100% better, and his sleep patterns had improved. He donated 30 books to the lending library at the ILS, thereby making a contribution to the community. Isaac regularly spends time outside his flat in the communal areas and café, and has established at least one friendship with a fellow tenant. The LAC continues to keep in touch and supported Isaac to go for his 2nd Covid jab, she also introduced him to his local community foodbank. Five months after he moved home, he was awarded PIP which was backdated. Isaac also contributed to the Birmingham University research project into Strength Based Approaches.

Critical elements

- The LAC took an “expert generalist” approach and was able to deal with a lot of different departments on behalf of Isaac
- The LAC had good contacts and relationships within the housing department, which enabled effective team work and a speedy solution to the housing situation
- The LAC was flexible and maintained support for Isaac after he moved, to ensure continuity

Outcomes for individual:									
Assisted to access daily entitlements and/or benefits?	Y	Connected with others in the community?	Y	Supported to groups/clubs in the community?	Y	Provided with advocacy?		How?	
Attending health appointments as appropriate?	Y	Taking medication correctly?		Supported to formally volunteer?		Require formal service from Adult Social Care?	N	What service?	

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Supported with accommodation?	Y	Does the individual feel safer in the community?	Y	Supported to share skills in their community?	Y	Referred to Public Health service?		What service?
Was the individual given fire safety advice?		Was the individual supported to access police advice?		Does the individual feel more confident?	Y	Were family / carers / friends supported?		How?

Any perceived/evidenced preventions or savings as a result of Local Area Coordination intervention:

i.e. Reduction in health support, reduction in services, community providers/groups involvement, what may of happened without Local Area Coordination, etc.

In Isaac's own words:

"I would like to add without LAC intervention Isaac would not be alive today. Isaac had reached breaking point mentally and physically".

Reduction in health input: Isaac's health would have continued to deteriorate and he would have been at risk of death from malnutrition and the cold.

Without LAC, Isaac could not have booked a Covid jab, or travelled to receive it – given his poor health he could have died if he had caught Covid.

Isaac's mental health has improved as a result of being in secure, warm housing with plenty of opportunities to socialise.

Without LAC, Isaac would not have applied for a PIP and would not have had his debts written off.

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Story 10: Mel and Andy's Story – Tang Hall & Community Facilitator

Opening narrative from Alan in his words:

"My daughter Mel was born far too early. Ridiculously early, 17 whole weeks.
She weighed just 800grams.
Understandably the medical profession's priority at that point is keeping a baby alive. So no thought is given to the child's future. After six months Mel left hospital and a journey with an unknown end began.
Crucially, a baby leaving the womb as soon as Mel did is still developing. Mel didn't even have formed eyes - and a brain scan only showed the brain outer shell, but no innards.
What follows once outside of the womb is sporadic, accelerated and disproportionate development. And how that affects the baby's future is an unknown.
In Mel's case the impact of this development revealed itself gradually.
As she got older differences between her and her peers, which were at first slight, became more pronounced. At school she struggled with fatigue, physical activities, numbers, social interaction – everything really. What made things more difficult was the school's 'everybody's the same' attitude. We're not all the same. We're all different!
This approach wasn't embraced only by her schools.
As she bounced through innumerable medical appointments or groups of one kind or another, through more than two decades, all purportedly aimed at helping her, they each seemed to lack the same thing. Treating Mel as Mel. Understanding what made her the way she is. Why she might react in one way or another.
What made her, her! We're all the product of many different influences and factors - and that's if we're born 'normally'.
We experienced far too many such appointments, which unsurprisingly failed to have any positive or lasting outcomes.
Then, perhaps a couple of years ago it was suggested we contact our Local Area Co-ordinator Service. With hope, but little expectation, that's what we did.
The term 'person centred approach' was used.
Here's where things changed, not quickly, but change they did, gradually and carefully.
Phone calls took place prior to any contact where I was able to spout forth at length information, lots of information, years of background, explanations of character traits and behaviours, experiences undergone. Family background, relationships. Ways of thinking.

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“All of this was listened to kindly, carefully, and taken into account to form a considered approach. An approach with context. A compassionate approach. You’d be forgiven for thinking that’s how things should be done and you’d be right, they should, but too often in my experience they’re not.
It meant a trusted relationship was formed, slowly. And trust from Mel is very hard won. She’s been let down or not understood too many times. But that’s exactly what happened. It’s had the biggest impact. Nothing else which has gone before has come anywhere near achieving the amount of change or inspiring the amount of hope.

“My partner has worked for the NHS for about 30 years as an Occupational Therapist. In that time she has seen many people with similar issues to Mel and told me she can’t remember ever seeing or hearing of someone getting such excellent, comprehensive, personalised support.

“I think that says it all really.

“Apart from this one final thought:

“I refuse to think how things would be for Mel now had the compassion and care of ‘a person centred approach,’ the bothering to put together the jigsaw of pieces which make up a person, their life and their needs, had not been applied.”

Introduction

Alan contacted me as his LAC in August 2020, following an appointment at Huntington House with the Community Mental Health Team, who had made a decision to discharge Mel and suggested I might be able to offer ongoing support. I initially spoke to Alan on the phone, he explained that he and his 24 year old daughter, Mel, lived together and had a good relationship but a number of things were impacting on them both which meant life was far from good and they were both feeling like things needed to change. Alan was keen for Mel to get the right support and have the life she wanted. Alan explained how much Mel was struggling with a number of things at that time and the experiences they had which had got them to this point, which included a story of many different services being involved and he and Mel losing hope that anyone could help. Following the phone call he summarised some of Mel’s difficulties in an email listing the following things:

- *Extreme prematurity creating physical, mental and emotional challenges*
- *Mild Asperger's affecting face to face communication and confidence*
- *She finds social interaction challenging and often misperceives the meaning and intention of those she is attempting to communicate with.*
- *She has had life long issues with stamina and co-ordination and suffers from Dyscalculia and Dyspraxia.*
- *She is blind in one eye as a result of Retinopathy of Prematurity*
- *Mel experiences regular Migraines which are being monitored. She is being sent for a brain scan and is on daily preventative medication.*
- *As a teenager Mel was raped on the way home from school and aged 20 she entered into a relationship with an older man which quickly became coercive and controlling. These events have left her with severe PTSD, nightmares and sleep difficulty.*
- *Mel has suffered severely from depression and anxiety and two years ago, after a suicide attempt, spent several weeks in a psychiatric unit in Middlesbrough, followed by several more at Peppermill Court in York.*
- *In hospital she was described as showing signs of Borderline Personality Disorder and of having narcissistic traits.*
- *After years of worsening stamina issues, clicking joints and pain, her GP recently suggested she has Chronic Fatigue and Fibromyalgia and as a result has referred her to the Yorkshire Fatigue Clinic.*

Despite all of the above Mel is sharp, funny, intelligent and creative, a gifted writer of fiction - she's written a 45,000 word novel - and a talented actress, she was the lead in a regional touring production of Jane Eyre.

She has life goals she wishes to achieve and is keen to live independently.

Mel has a wonderful emotional support dog - the friendliest dog in the world!

Alan also said he felt more hope than he had felt in a long time following our discussion, my explanation of my role as a LAC and some ideas about what I might be able to discuss with Mel and suggest to help. He also felt reassured by my understanding of some of her mental health diagnoses and the stigma and labelling which can be attached to these, which could often lead to self fulfilling prophecies.

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Situation

I went to visit Mel at home as face to face visits in a space she felt comfortable were important at that time. We ensured this was safe in line with Covid guidance as Mel had a lot of anxiety around this due to her health conditions. Alan was also around initially to help support Mel, but he recognised the importance of building up to these conversations happening between the two of us - this happened quicker than he thought it might as we bonded over a shared love of Lou Reed's music and Dr Martens! Over a series of visits to her home, we explored her many creative interests and talents as well as make some practical plans around how she might achieve her goal of living independently. Most importantly we spent time building a relationship and trust.

Mel was keen to explore how she could publish the novel she had written, engage in some community groups linked to the Arts and also get back in to acting. We kept these long term plans and ambitions in sharp focus as important parts of Mel's identity and strengths whilst we also made shorter term plans around benefits and finances, developing independent living skills and daily routines through graded activity guided by the fatigue clinic. We also compiled a list of areas and property types Mel would feel safe and comfortable in as it became very apparent very quickly, through conversation with Mel and Alan, that it would be better to take time to think about what move would be right for her.

Mel's history of trauma, including violence perpetrated against her, meant she held a lot of anxiety about being in certain parts of the city or accessing things in these parts of the city. Her Aspergers diagnosis and issues related to her mental health and physical health meant it was important to have her own front door if possible and live in an area that was quiet and made her feel safe. Mel's neuro diversity made her sensitive to sensory input and past experiences created psychological difficulties with regulating emotions. She was often overwhelmed with exhaustion and could find some practical tasks difficult due to cognitive function and social anxiety. We also identified the need to think carefully about what support she would need in her own tenancy to set things up in a way she could manage, so a referral was made for floating support.

We established there wasn't an urgency to move in this case, but more a need to plan a move which would be right for her to succeed long term. This move done right, would vastly improve her quality of life as well as her father's. Mel, at the time, hardly left her home as she did not feel safe in Tang Hall and had therefore become very dependent on her father and isolated from a lot of opportunities.

Through time previously spent building positive partnership working with Housing colleagues we were able to take a collaborative approach with this family and put a case forward for a managed move and direct let to a bungalow in one of the outlying villages. We

agreed this would fit under the new ways of working agreed in our regular LAC/Housing Liaison meetings. This was in line with new person centred approaches and a trusted approach to LACs from Housing colleagues around complex cases, in order to reduce the burden of proof around what was previously asked for under the policy for these individuals. Instead of asking Mel to gather lots of letters from medical professionals, I, as her LAC, was able to summarise everything in to one supported statement as I'd had seen medical reports, discussed these conditions with Mel and her father and knew from spending a lot of time with them exactly how they impacted on day to day life.

The Housing Registrations manager and Head of Housing agreed a move outside of policy, through discretion, was the right way forward to enable Mel to live an independent life after attempts to move out of the family home had failed before. She recognised Mel had complex long term health conditions related to an underdeveloped automic nervous system linked to her premature birth, complex mental health issues and neuro diversity and that these conditions affected her profoundly on a daily basis making it challenging to live a good quality of life. It was also recognised that in other ways Mel was very independent, intelligent and creative and in the right environment with the right support, she would thrive. We agreed a general needs tenancy would lack the support and environment Mel needed to thrive independently and feel safe, we were unable to find supported accommodation in the right areas so considered bungalows in Independent Living Communities.

Some other considerations we took in to these decisions were around Mel wanting a new start away from difficult memories in order to move on, however, still being close enough to receive ongoing support from her father and a close friend who lives in York. Mel was also concerned about remaining in the catchment area for TEWV MH services and Mel's therapy dog was an important consideration too, of course.

What happened?

A direct let was agreed and Mel and I continued to plan and build confidence. We looked at publishing avenues, some of which were dead ends, until I introduced her to a local published author, who was also a Professor of literature at Nottingham University. She agreed to offer some advice and mentoring to Mel which was the start of a positive friendship. We explored links to Tang Hall SMART and acting opportunities through various projects, including a link to a local storytelling project in which Mel could write and perform her own monologue.

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We hit a bump in the road when I shared the news of my pregnancy with Mel, this brought up difficult memories which were very difficult for Mel to manage, so we agreed that a switch to meeting via video calls would be the best way forward so she didn't have to be faced with my growing bump. Mel was also anxious about what would happen when I went on maternity leave as she had built trust with me and we had so many ongoing plans – she was also worried about telling her story all over again. In response to this we quickly introduced our Community Facilitator, Sue, to these calls so she could meet Mel and I agreed to tell Mel's story to Sue and start a long handover. This worked well and provided the reassurance that was needed. Sue and Mel went on to form an equally trusting relationship and together they were able to facilitate Mel's move to independent living, in to a lovely bungalow in an idyllic area. Sue helped Mel to pursue all of her interests, using her many talents, including connecting her to creative writing group and funding her transport there through the Early Support Fund at CYC.

Mel went on to thrive in her own home. She has a new relationship with a committed, caring partner, she went on to take on more roles in theatre productions, she continues to write, is singing in a band with her father and is exploring other acting and volunteering opportunities in her local community. She has made some use of all the support which was put in place, but is, in many ways very independent and self sufficient. All of the worries around how she might cope have melted away and she presents as a resilient, bright young woman with a bright future. Both Mel and Alan are much happier these days – Sue and I hear from them occasionally and they know we are still around if they need us.

Critical elements

- Taking the time to build a relationship with Mel and keeping this, along with her good life vision and a comfortable pace at the heart of everything we did was key to achieving such positive outcomes together. Part of this was genuinely taking an interest and getting to know and understand Mel and Alan.
- Focusing on Mel's many strengths and talents, rather than just focusing on what she couldn't do and needed help with, has helped her to build her confidence and follow her dreams. Mel had become very stuck on dwelling on everything she couldn't do rather than valuing all the things she excelled at. The strengths based approach we use has shone in this situation.
- The relationships with and previous partnership work with Housing colleagues was key to taking a compassionate, person centred approach to stepping in to independent living in a home in which Mel could overcome multiple challenges to thrive in. We have

reflected that this should set a precedent for how we can work together in the future and what we can achieve through this approach.

- The relationships and flexible ways of working within the LAC team meant that two team members could work together to cover maternity leave, enable a smooth transition in a sensitive situation and minimise the impact on Mel. The personal skills and empathy of both LAC team members were also key to this.

Outcomes for individual:								
Assisted to access daily entitlements and/or benefits?	Y	Connected with others in the community?	Y	Supported to groups/clubs in the community?	Y	Provided with advocacy?	Y	How? Supported to claim benefits, access advice, access housing and articulate what she needed to live a good life.
Attending health appointments as appropriate?	Y	Taking medication correctly?	N	Supported to formally volunteer?	Y	Require formal service from Adult Social Care?	N	What service?
Supported with accommodation?	Y	Does the individual feel safer in the community?	Y	Supported to share skills in their community?	Y	Referred to Public Health service?	N	What service?
Was the individual given fire safety advice?	N	Was the individual supported to access police advice?	N	Does the individual feel more confident?	Y	Were family / carers / friends supported?	Y	How? The LAC worked with the whole family, including Mel's

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								Dad and his partner.

Any perceived/evidenced preventions or savings as a result of Local Area Coordination intervention:
i.e. Reduction in health support, reduction in services, community providers/groups involvement, what may of happened without Local Area Coordination, etc.
It seems very possible to look at this situation as a ‘sliding doors’ example, where if things had not happened this way with this very positive outcome, things could have gone in a very different catastrophic way for this family. In a worst case scenario, Mel would no longer be here today and may have completed suicide through further attempts. Alan may also have followed down this path, as his mental health has also been a key concern at times. It is difficult to say what might have happened, as with all preventative work, but we do know that further secondary care mental health services and crisis care services have been avoided and formal adult social care has been delayed and prevented. Further impact on Housing resources which would have occurred if another housing placement had broken down, have also been avoided. Mel has become an asset to her local community and the worlds of theatre and writing! Rather than a passive recipient of care and services. She is someone Sue and I have genuine admiration for as she has overcome so many challenges to become a strong and brilliantly talented young woman – we look forward to hearing about where her story will go next and will follow her career and performances with interest, feeling privileged to play a small part in her life.

Reflections from Mel:

“To say that, when I was first recommended to meet with Jennie, I was at a point in my life where I was feeling somewhat unmoored, would be an understatement. My partner and I had just purchased our forever home, when shortly after we realised that we weren’t as

suitable as first thought. A final argument over whether or not to have children, neither of us able to find a compromise that suited us, caused the relationship to come to a screeching halt. It was 2020, I was 24, and up until then life had been somewhat … challenging. When you're born at 23 weeks gestation like myself, it's unknown if you'll ever be able to make something of yourself, unknown if you'll have any quality of life at all, and so, with the mental, physical and developmental issues you face, it's a cause for celebration when you reach any milestone. A first house with someone I loved had been a tremendous achievement, and the trajectory of my experience growing up had reflected the possibility that such a thing may never happen. But it had! I was happy, and then everything plummeted to the ground. In the aftermath of this experience, I felt as though I were an open wound. I moved back in with my father, and life lost all it's previous glimmers of hope. In the relationship before this I'd been certain I would be jettisoned, the relationship had been abusive, so much so that upon finding an opportunity to leave it, my ex had a domestic violence charge put on his permanent record, and I simply turned into a shell of what I had once been. My new relationship several years later had felt like something I could cling to, and to have it ripped apart at the seams, with the only option to go back to my father's house, left me with poison festering within my already chronically ill body and mind.

"Enter Jennie.

"I can't recall how it happened, can't quite bring to mind how we got hold of them, I just remember several sheets of paper, one of which had the details of a York-based LAC on it. I know my father rang the number first, because even at 24 I'd not quite grown out of my 'phone-anxiety' stage and was in no mental state to talk to someone new. Their phone call went brilliantly. My father was effusive in his praise over the woman who would be my new handler (for at that point, that's what it felt like Jennie was to be, to my gloom-filled mind, at least.) However, I was … rather unconvinced at the thought of more mental health people coming in and poking around. They'd never done any good before, I'd been in therapy since I was very small, and had only recently been discharged from a psychiatric hospital after a suicide attempt that had occurred whilst I was under the guidance of mental health professionals. Still, I went along with it, clinging to any small possibility of help as if it were a lifeboat, telling myself that maybe this time it would be different, not even able to convince myself.

"The day arrived, and I somehow managed to put on some make up and get dressed. It would be the first time I'd had the energy or willpower to go downstairs in months, and I was anxious, a maelstrom of worry and expected disappointment clogging my veins. Jennie arrived, sat in the cream, leather armchair, and I noticed her Doc Martins, a faint feeling of intrigue tugging at my senses. I was pleased that she didn't speak to me quite like I was some poor little stray who was capable of biting and then breaking down at any given second. The meeting went well, we spoke of what I wanted, and I told her of my cabin-syndrome, highlighting my desperation for my own space. Having had my own 4 walls so suddenly taken away I was fearful that any freedom I had tasted would never be returned. Jennie understood this. We got on. I liked her, tentatively so, but still, the potential was there. After this I was able to go outside for the first time in

an age, and let me say that it may have only been to go and get some stuff from Currys, but, with my newfound adrenaline post-visit, going up to Clifton Moor had never been so exciting. I felt energised, falteringly hopeful, and I allowed myself to think about a future for the first time in far too long.

"The progress was slow, the cogs of bureaucracy ever in need of oil, and it wasn't Jennie's fault, for she had been in meetings with Housing colleagues for over a year, looking at ways they could work more flexibly together to develop person centred and strength-based solutions for people. I waited for an agonising period of time; it was so long I was beginning to think nothing would ever happen. There were many meetings with Jennie, many feelings of disappointment when it felt like things weren't going fast enough, and lots of times where I wanted to go to various council offices and tell people to stop being so difficult and 'Get on with it, for God's sake!' I was never irritated at Jennie though, her hard work and attitude made me believe that having my own place was still a possibility, and I knew lots of work was going on behind the scenes. I made a list of potential places to move to and my requirements, and I knew Jennie was attending numerous meetings with people about getting me moved up the urgent property ladder. Still, it dragged. Until finally I was informed that I'd been accepted as an occupant of a cottage in Dunnington. I was over the moon. The place sounded perfect, and it had a garden so my Service Dog would be able to roam around unhindered. Things felt like they were happening again, and happiness flooded me.

"But then it didn't work out.

"There were pitfalls, one of them being that the garden was shared, and I'd need to get permission to build a fence so that my dog would be able to go outside without being at risk. This was among many other things that gave me pause over whether or not the Dunnington place was the one for me, but I remained on the list, because I wanted something to happen so desperately. It was months and months of waiting. Months and months of hoping. And months and months of being told 'not yet.' At this point, I was climbing the walls, I was bedbound, housebound, the pandemic was still eating away at society. I just wanted it to end. The days I spent hoping that maybe today would be the day my sense of independence would be restored via being told my new place was ready, were almost a form of torture. During this period Jennie had to take leave for personal reasons, so my new LAC Sue was at the helm, and whilst she was doing a brilliant job and we very much respected and liked each other, by this point I was beyond fed up.

"As usual in my experience, a good thing ultimately followed from a terrible one.

"Towards the end of 2021 I had a fight with my father that can only be termed as being 'catastrophic.' I was at my wits end, both of us were, neither of us could hide how distressed we were by our situation, covid wasn't going away, Dad worked nonstop at a hectic, demanding job, I was terribly ill with no one to turn to, and so we exploded. It ended in me taking off in the midst of a BPD induced breakdown and spending the night in a hostel that the word 'sketchy' doesn't even cover. A few days later, after reconciliation had

occurred, I was sent to see someone who worked for the local Mental Health team, and it turned out that they should never of had any business dealing with anything close to the subject of mental health. Still, in an almost catatonic state of depression, myself and my father looked around York's surrounding villages, searching for a few other places I could put on my list in the hopes of speeding up my rehousing process. We found a few areas I'd be happy to consider, spoke to the council's housing department to update them, and then I went home, watched Pretty Woman, and tried not to get my hopes up.

"Later that week, as I sat in a hospital waiting room with an appointment to see an eye doctor, my father rang with news. I'd been offered a bungalow in Upper Poppleton. Too in shock to even cry, we decided to go see the property that afternoon, even though at that point I'd have gleefully accepted a shoebox, let alone a bungalow. After my appointment, we drove to Upper Poppleton, and I accepted the property with an alacrity never seen before. Now, in 2022, I sit writing this in my beautiful Poppleton-based home, and I cannot believe the journey it took to get me here. The input I've had from both LACs these past 2 years has been invaluable, and my life looks very different now, having had the support I've had from them, than I ever imagined it could all the way back in 2020, I'll forever be grateful for their help."