Health and Adult Social Care Policy and Scrutiny Committee **28 September 2022**

Report of the Director of Customer and Communities

Local Area Coordination and Social Prescribing update

Summary

1. This report is being provided as a general update regarding the Local Area Coordination and Social Prescribing Programmes introduced in the city in 2016. We will outline a summary of the current status and work of both strength based programmes, including what we are achieving both separately and in collaboration. This report aims to outline how these programmes have evolved together, how they currently work together and their aims for the future.

Background

2. Local Area Coordination and Social Prescribing are recognised as strengths based programmes that apply person centred approaches, supporting people to achieve more healthy, happy and connected lives. Introduced alongside one another in 2016/17 as integral parts of the Health and Adult Social Care community operating model, and recognising the need to invest more in early intervention, prevention and asset based community development, the teams have always actively collaborated to enable added value, whilst respecting their unique offers.

3. As referenced in the draft Health and Wellbeing Strategy, these strength based approaches have enabled a focus on prevention and asset based community development, often referred to as seeing ‘what’s strong not what’s wrong’. York has taken a strategic and deliberate strength-based approach which sees people as valuable, not vulnerable, and recognises that everyone has gifts, talents and skills, which empower people as active citizens and gives them hope, rather than being a passive recipient of services. This work over the last six years, pioneered through local area coordination and social prescribing has helped us to change the relationship between statutory services, citizens and communities and has enabled people to navigate an often complex system of care, helping to address health inequalities and social exclusion.

4. Both teams have built up trusted relationships with the people they walk alongside and a deep appreciation of community networks, focusing on peoples' goals and resources rather than their problems. The teams actively collaborate within each other and often work on cases together, providing additionality, whilst reflecting the value of their respective unique offers. There are examples of stories that reflect the collaboration across the social prescribing and Local Area Coordination teams in the appendices, alongside some joint blogs that have been written by the teams.

5. The teams are primarily funded through the Better Care Fund (BCF) and following a review of the BCF and move to a multi-year funding agreement set out in the NHS White Paper, the Local Area Coordination team were moved to permanent contracts in 2022, enabling stability of the team and reflecting their highly valued and trusted relationships built with communities. Both programmes directly contribute to the BCF policy framework, enabling local integration of health and social care. In particular, through applying a place based and person centred approach to joining up services to help improve the health and wellbeing of local populations, by making more effective use of available resources, including natural support networks and communities.

6. In 2020 York was also featured in a national report by the Coalition for Personalised Care "Understanding and aligning link worker and community capacity building activity; a place based approach in York and Wakefield". The report recognised the collaboration between both teams as best practice and reflected how it should inform the roll out of social prescribing primary care link workers nationally. The report is attached at Annex 1.

   An update on both programmes and teams is provided below:

Local Area Coordination (LAC)

7. LAC is an internationally recognised approach to creating networks of support around people to increase independence and reduce dependence on statutory services. It is an evidence based approach to supporting people as valued citizens in their communities. It enables people to pursue their vision for a good life and to stay safe, strong, healthy, connected and in control. As well as building the skills, knowledge and confidence of people and the community, Local Area Coordination is an integral part of system transformation. It simplifies the system and provides a single accessible point of contact for people in their local community.

8. It has been successfully used in Western Australia for over 30 years and is being used in 12 cities across England and Wales. Where it is developed with strong leadership and together with communities, reflecting coproduction, it shows predictable and positive results across health, social care and community outcome areas. This has been the case in York, as evidenced by the University of York evaluation of the programme published in 2019 (see Annex 2). Local Area Coordinators are driven by a set of values and principles reflecting that national LAC Network model. They can offer advice or share information about local connections that might be of interest to people who are introduced, as well as walking alongside to help people achieve aspirations. Local Area Coordination is an informal programme which is accessible with no formal referral process.

9. The Local Area Coordination model works over three levels – individual, community and systemic. This reflects the trusted relationships we build with people we walk alongside, strengthened and more inclusive communities and a system that is then more informed by peoples lived experience and stories. Local Area Coordinators seek to gather intelligence from the communities they are embedded in to inform change, alongside citizens and partners. In this way we view system change through an asset based community development lens. Local Area Coordination also encourages organic system and culture change through person centred and strength based practice, underpinned by the 10 values and principles which form the Local Area Coordination model framework (Annex 3).

10. The programme is strategically overseen by the York LAC Leadership Group of cross system partners and chaired by the Executive member of Health and Adult Social Care reflective her Executive role and Health & Wellbeing Board leadership role.

11. Building on the initial recruitment of three Local Area Coordinators in May 2017, the programme was expanded by a further four coordinators in Oct 2018 with BCF funding. The team again expanded in August 2019 with the introduction of a Senior LAC to provide additional management and system change capacity and four further LAC's were recruited in 2021 and 2022. The team currently includes 13 staff and 2 Seniors covering 12 of the wards in the city.

12. The overall outcomes of the Local Area Coordination programme in York are to:

- Change the way that people think about support around them and create a new accessible, single, local point of contact to help them identify it.
- Simplify the routes to support, providing independent connections to the most appropriate support, rather than drawing people towards particular services.
- Reduce the dependency on service-based support
- Identify areas of high quality or duplication across service types to inform future commissioning, helping the realignment of resource away from intensive support towards preventative community-based activities.

13. The above outcome areas naturally complement the ambitions for the community hubs and reflect the close partnership working between the LAC and Communities teams, building social capital in communities and enhancing our community recovery planning process. Following the council's restructure in 2021, this collaborative approach was further enhanced through the introduction of the Communities and Prevention Service within the Customer and Communities Directorate, aligning the council's community development teams and resources.

Impact measures and the power of stories:

14. The previous two Local Area Coordination quarterly performance reports are included in as Annex 4 and 5. These provide a detailed overview of our current reporting data and an up-to-date overview of our work programme. Quarterly reports are provided for the Better Care Fund performance management framework, LAC Leadership Group and Executive Communities Recovery Group. Stories that reflect collaboration between the Social Prescribing and LAC teams are also included as Annex 6 and 7 alongside some joint blogs at Annex 8

Key metrics include:

- The LAC team has supported 4630 people since the inception of the programme. The number of people we are walking alongside is currently 2193. This reflects Level 1 work where information, advice and guidance is provided and more intensive work at Level 2 where a 'shared agreement' action plan is codesigned with the citizen. The full caseload capacity for the team looking at long term 'level 2' support is 660, reflecting an individual caseload for a LAC being 60 people.

- The main reasons people get in touch with a LAC or are introduced to a LAC are related to Mental Health, Isolation, Housing and most recently

Poverty and Financial concerns – linked to the deepening cost of living crisis.

- Introductions can be received from any part of the system and our main sources of introductions are direct contacts or self-introductions from citizens, their friends and families, followed by some of our main statutory services, including Adult and Childrens Social Care, Mental Health Services and CYC Housing Departments.

- An internal study in 2020, analysing current caseloads, estimated between 76% and 96% of LAC work is diverting a need for services in people's lives, through supporting non-service solutions instead.

15. The York team have also recently collaborated with the national Local Area Coordination Network to capture the digital stories of two citizens, Glynn and Steve, who the Westfield and Tang Hall Local Area Coordinators has walked alongside. You can watch their stories here alongside some further reflections from a national LAC Network event in York earlier this year.
View Reflections from the Network here

16. The Network has also produced an animation of the story of Dee, a disabled citizen who the Huntington and New Earswick Coordinator has supported. Dee provided a speech at the Network's online conference in November 2021, which also featured in the Social Care Futures annual conference. This has recently been captured as an interactive story that highlights, in Dee's own words, how the principles of Local Area Coordination can be applied. This is another really powerful real life example of what can be achieved when someone has a Local Area Coordinator alongside them.
Read Dee's Story here

17. A further film produced with Nesta, describing LAC as an example of ABCD and also featuring Dee is captured here. People helping people This was launched as part of the 2020 new operating models for local government report, reflecting York's participation in the Upstream Collaborative programme of 20 local authorities actively working upstream of complex social problems. Further details are here Upstream Collaborative (nesta.org.uk)

18. The LAC programme is currently involved in two independent research studies, funded by the National Institute for Health Research. Birmingham University will be concluding a two year research project in 2022, looking at the impact of asset based approaches on social care and how they collaborate to achieve outcomes. This project has focussed on Local

Area Coordination and Social Prescribing in York alongside our Adult Social Care colleagues. The second project is a multi-site evaluation of LAC in York, Derby, Swansea and Leicestershire and its impact on adult social care. This will include an economic impact study of cases, providing invaluable cost divergence information, reflecting projected savings to adult social care and a thematic analysis of stories with a repeatable methodology. This two study will conclude in 2023.

Social Prescribing update

19. Our model of Social Prescribing reflects a holistic person centred approach to working with people, we have the time and opportunity to explore not what is the matter with people but what matters to them. The aim of Social Prescribing is to empower individuals to take more responsibility for their own health and wellbeing and to identify support networks within their community. In turn this reduces the number of patients attending health services with non-medical conditions that may well have a social solution.

20. Social Prescribing is delivered as a national programme within Primary Care with funding through NHS England. Ways to Wellbeing funded through the Better Care Fund and goes one step further and delivers the same model in Secondary Care health settings. By being adaptable and flexible in this way we have brought more funding into the city from different partners to deliver social Prescribing across the four city Primary Care Network's (PCN's) and within Foss Park Hospital and York District Teaching Hospital.

21. Ways to Wellbeing is commissioned to:
    - Deliver Social Prescribing to patients referred through secondary Care Health professionals
    - Deliver a small grants programme each year to the VCSE
    - Build and maintain good relationships across the VCSE sector, identify gaps in provision and work together across the system to address these gap

22. The team take referrals from Foss Park Hospital, York and Scarborough Teaching Hospital and The Retreat York. In total the team have received 389 referrals across the last year. The team are constantly building new relationships and working to identify appropriate referral partners in health.

23. However, the team do not just take referrals but build strong relationships and links with the health partners they work with:

"The links made between the York Community Therapy team and the Ways to Wellbeing team have made a significant difference to the confidence with which patients have been discharged from a health setting to continue to manage their conditions on a longer-term basis.

Patient journeys have been completed in a meaningful and sustainable way as the blurred boundaries between health and social care are addressed and navigated in a supportive manner with an individual approach.

Regular discussion and handovers between the teams have nurtured a confidence in each other's ability to source the right referrals and hand over from health to social support with confidence.

This has proved an excellent example of co-operative working between social services and health. It puts the needs of the patient at the very centre of the service"

Quote from AHP York Community Therapy Team Lead

24. Part of the role of Social Prescribing is to enhance connectivity between services, in order to improve people's longer-term recovery, reablement and independence, which requires a significant level of multi-agency working. Social Prescribing can improve the transition away from health care services when one form of care comes to an end, stopping the 'cliff-edge' feeling some people experience upon discharge. This has been seen in our work at both hospitals.

25. York CVS has grown Social Prescribing in York, we actively identifies gaps in the system where patients need more holistic support either after discharge, in response to multiple complex needs or as a preventative measure. Ways to Wellbeing has always been responsive in this way and we are already making plans for new referral pathways within health and social care.

26. Under the umbrella Ways to Wellbeing we have a 24 month pilot running; Pathway to Recovery (P2R) is the pilot with a Social Prescriber working as part of a multi-disciplinary Team in Foss Park, taking referrals directly from clinicians and supporting individuals during their time at Foss Park and when they return home. One hundred patients were supported through this pilot last year. A number of the people referred to the services have consistently gone in and out of hospital, at the time of

writing this report over 95% of people supported have not been readmitted to Foss Park.

27. We have recently received additional funding through the Community Mental Health Transformation funding to support the prototyping of the hub and to ensure extra capacity within the Social Prescribing service. This will complement the existing P2R role and will again be part of a multidisciplinary team.

28. York CVS also delivers the Primary Care Link Workers (PCLW) service in the four city centre PCN's. The model of Social Prescribing within the service is the same as that delivered through Ways to Wellbeing but is based within Primary Care. The Link Workers support patients who are accessing Primary Care with what is primarily a social problem. The team deliver appointments in practice in the community or where people live and offer a flexible and bespoke service. There are no maximum numbers of appointments and we work to minimal thresholds. By working within general practice those accessing the service have access to support for their physical, social and emotional needs. Referrals come from anyone within Primary Care, Adult Social Care and self-referrals.

29. Whilst an individual's clinical needs are met within Primary Care they now also have access to person centred bespoke support to address social determinants of health, alongside raising awareness of health and wellbeing support available outside of Primary Care. This enables people to take control of their own health and wellbeing. People are supported to access further preventative programmes and are empowered to make informed choices about their own health and care.

30. The Primary Care Links team have received 2405 referrals in total across the past year. The team have worked with the individual PCN's to understand their priorities and have delivered a number of projects.

31. The team have supported patients Cancer Care reviews, supported patients to access SMI health checks and follow up, delivered a diabetes offer across the four PCN's and worked with 'green' providers in the VCSE to deliver a model of Green Social Prescribing (increased access to green spaces for people with mild to moderate mental ill health) as part of a national programme. York CVS has brought in additional funding to cover the cost of delivering these programmes outside of the day to day case load delivery.

32. Recent feedback from health leaders in York has been that *"Social Prescribing should be seen as a fundamental part of service delivery in*

York, it is an interdependent model that we need to ensure is here permanently" CEO, York Medical Group.

33. Across both Social Prescribing services, patient feedback showed:

    - 93% of people who worked with the service felt they had achieved the goals they identified with their social prescriber
    - 89% of people felt more are able to manage their own health and wellbeing
    - 86% of people said that they would not have made the changes they have without the input of their social prescriber

34. It is important to note that the role of Social Prescribing is not to deter people from Primary and Secondary Care or any health service but to look at how we can work better together and better utilise the existing resource within the voluntary sector and the community. The Social Prescribing teams have worked hard to build and maintain relationships across the voluntary sector, identify gaps in provision and working together across the system to address these gaps. The teams have supported the development of new groups and supported 'stepping stone' groups into other voluntary sector organisations.

35. There is no space for these approaches that utilise the voluntary sector and community support if we do not have a robust voluntary sector. By hosting Social Prescribing through York CVS we have the unique opportunity to build strong relationships with the sector and respond to what the sector is telling us. Through the Social Prescribing schemes and as part of York CVS we have brought in a significant number of grants that will be distributed to the sector across the year.

36. We have delivered the Ways to Wellbeing grant programme over a number of years, this is informed by intelligence from the Social Prescribers, the voluntary sector and those we support. This 'gapping exercise' enables us to ensure the grants are distributed in a sustainable way to organisations that can address the gaps and are provided with ongoing support as and when needed. We will continue to deliver grants through this model, expanding the number of groups and individuals that can feed into the gapping exercise.

37. Social Prescribing at York CVS will continue to be delivered as a collaborative approach across health and social care and the voluntary sector and with the people accessing the services. This will ensure the

service remains fit for purpose and meets the needs of the system and those that need the service.

38. The Ways to Wellbeing annual report 2021/22 is attached as Annex 10 and Primary Care Links Update July 2022 as Annex 11.

Staffing:

39. Ways to Wellbeing - started as a team of one and has now grown to a team four part-time practitioners and one team leader. This remains a small team that achieves a lot with 2 x Full Time Equivalent (FTE) plus an additional 13.5 hours of practitioner time. We still deliver a full service Monday to Friday. Offering evening appointments when needed. Primary Care Links Workers – There now ranges between a minimum of two FTE Link Workers – 4 Link workers in each Primary Care Network. A Link Worker is also based as part of the York Integrated Community Team (YICT)

40. £161,000 is received in funding through the BCF plus £10,000 transport budget to deliver the Ways to Wellbeing Scheme. This continues to be reviewed and commissioned on a 12 month contract.

Primary Care Link Workers are funded through a salary reimbursement scheme (ARSS) scheme – reimbursed through National Health Service England (NHSE)

Reflections of Local Area Coordination and Social Prescribing teams during Covid-19

41. The York LAC team moved seamlessly to homeworking whilst maintaining a community presence supporting vulnerable people during lockdown. The Covid-19 crisis highlighted much of the theory and logic that underpins the Local Area Coordination approach. It has been so evident across our city and national network that it fosters hyper local neighbourliness and trusting relationships between communities and local service infrastructure. This has supported community-led groups to use their natural capacity to respond quickly and effectively in these crisis times, just as it does in normal times. For example, we have seen many food banks evolve from community groups, with people helping people in their respective neighbourhoods and beyond, supported and validated by the LAC team.

42. In addition, the team's simple to use 'Opportunities Fund' has enabled people facing immediate digital and financial exclusion challenges to be

overcome quickly and with relative ease, and personal dignity regained. This financial support has subsequently been expanded, through the additional York Financial Assistance Scheme (YFAS) emergency funding to support an enhanced Early Support Fund supporting people to overcome destitution and, with the support of LACs, realise their vision for a good life. Small grants are now regularly being distributed by the LAC team to residents facing deepening destitution, reflecting a downward spiral of poverty and social exclusion. The scheme has recently been expanded to colleagues within our Communities and Housing Services teams.

43. These grants are vital in supporting people to regain their respect, dignity and confidence and thereby contribute to their areas, through sharing their own gifts and skills. They reflect financial support to purchase a broad variety of items such as ID, clothing, disability aids, devices and equipment or payments to resolve housing issues or make homes energy efficient, provide transport to courses – anything which would address barriers to a good life.

44. This has been a game changer for the team and the people they support, enabling immediate financial hardship to be overcome and person centred solutions realised with choice and control as a driving principle. The LAC team have also been able to mobilise rapidly alongside shifting social contexts, utilising their high profile within communities and social media presence to engage with the mutual aid and advice groups that evolved in response to the coronavirus and subsequent cost of living crisis. Sometimes overnight, validating them and assisting in making connections with established community and neighbourhood associations, aiding community cohesion and ensuring important information reaches everyone, even those who are marginalised.

45. In terms of LACs work with individuals and families, they had to quickly adjust and adapt during Covid to the new challenges faced by communities and the council alike. Maintaining a trusted and visible presence in communities, the LAC team worked alongside the Communities and Equalities Team to help develop the Community Hubs model, ensuring people with complex health conditions and challenges with their mental health received support throughout ‘lockdowns’ and beyond. This has been further enhanced by our work with the volunteers who responded to the city’s ‘call for action’, with over 40 volunteers working with the LACs to provide additional capacity on wellbeing calls. Importantly, LACs have used their creativity in a way that still helps

people to recognise their value and strengths and to tap into the amazing support abundant from neighbours and community groups alike, reflecting the value of relationships, connectedness and belonging.

46. The LAC team supported 1708 people during the pandemic and worked with 112 community groups to help other residents who were struggling. Much of this work and the reflections at the time were captured in a blog by the Senior Local Area Coordinator - Jennie Cox, during the first few weeks of the crisis here . Reflections from the pandemic are also captured in the national LAC Network report 'Which Way Next' and how LAC should be built into future recovery plans, a copy is provided at **Annex 9.**

Social Prescribing covid response

47. When we went into lockdown York CVS provided a social prescribing number to all the PCN's which was placed into their call menu. This number was staffed by the social prescribing team at York CVS and provided social, emotional and wellbeing support. We quickly established a programme of weekly welfare calls for those experiencing significant isolation and loneliness delivered by social prescribers alongside a team of volunteers.

48. Key metrics include:
• 1,759 individuals came through the social prescribing number, 1005 required social support
• Only 8% of people who contacted us through this required medical support from a GP or practice nurse
• 223 patients were referred to weekly welfare calls
• Supported a number of vulnerable individuals identified by their GP to successfully amend prescriptions and arrange delivery or collection of medicines.
• Provided support for people with learning difficulties to understand the importance of staying home and how to access support
• Put plans in place for individuals living with Dementia to receive a daily welfare call
• Arranged patient transport for individuals who otherwise would not have been able to attend their appointments or vaccinations
• Arranged for emergency food parcels to be delivered to those most in need

Local recovery, resilience building and future plans.

49. York continues to be regarded nationally as a city at the forefront of ABCD, utilising person and community centred approaches to build

health and wellbeing and the resilience of communities. This is demonstrated through regular requests to speak at national conferences. These have included, the Kings Fund 'Community is the Best Medicine' conference and NESTA Government Innovation Summit in 2019, writing a chapter for the 2020 Improvement and Development Agency / LGA 10th anniversary edition of 'A Glass Half Full' and being chosen by NESTA to join the Upstream Collaborative. The Ways to Wellbeing Team are also acting as advisors to the national Social Prescribing Academy, informing the roll out of social prescribing nationally and are regularly asked to support social prescribing evolution amongst NHS England.

50. Reflecting York's own 'recovery plan', strategies are now being discussed across the country around how localities might confront the challenges we face and reduce the impact they may have. This is likely to be happening against a backdrop of important discussions around emerging opportunities to re-balance, reset and reform the relationships between local councils, health institutions, communities and citizens alike. Local Area Coordination and Social Prescribing continue to enable people to have choice and control over their health and wellbeing and our work on prevention is captured in the new draft Health and Wellbeing Strategy, reflecting our ambition to become a health generating city.

51. Local Area Coordination and Social Prescribing are very much about clearing space in the system in order to listen and learn from communities and citizens as to what works well and what doesn't. This learning provides a platform for people to collaborate together to achieve lasting change. Both teams are proving integral to York's 'Connecting Our City' community mental health transformation programme.

52. However, Local Area Coordination is also a highly pragmatic and realistic approach that recognises the importance of being 'alongside' people and communities as they go through some dark times both individually and collectively. It is likely that the next few years are going to be some of toughest our citizens and communities has ever had to face in many different ways. The circumstances we are facing mean that just mitigating the impact of these post covid and 'cost of living' pressures alone will be an enormous challenge.

53. The practice of both teams will enable outcomes to continue to be codesigned with people, realising the 'good life' we all seek. Scaling and growing the teams within York's local system at this time will support strong outcomes at all levels to continue to be achieved reflecting a human learning systems approach of continuous learning and innovation.

54. Recent investment from the NHSE Community Mental Health Transformation programme is also enabling the teams to focus more deliberately on the development of a Community Mental Health Hub in the city, lead a People on the Ground Network and develop a new Mental Health Roadmap to help people to navigate what is available where and when to stay well.

55. Continuing to adopt an asset-based area approach, with LAC and Social Prescribing at its heart, will enable us to work with partner organisations and communities to help citizens of all ages to support themselves, providing services to those who need our help the most and signposting others to more appropriate help. This will ensure that we are able to manage demand moving forward and realise our ambition to become a 'health generating city'.

Implications

Financial

56. There are no direct financial implications associated with this report as the funding associated with the programmes has been previously agreed through the Better Care Fund or Adult Social Care base budget. Naturally, any future strategic expansion of Local Area Coordination will require further reports to be travelled through the Executive. York CVS host the Social Prescribing Ways to Wellbeing Team and Primary Care Link Workers. The funding for the link workers is provided through the national Primary Care GP contract. Further funding has been supplied through the Community Mental Health Transformation Programme for additional social prescribers linked to the Connecting Our City programme.

Human Resources (HR)

57. There are no HR implications associated with this report

Equalities

58. The Local Area Coordination and Social Prescribing teams referred to in the report have at their heart principles of equality, diversity, and inclusion, reflecting their strong value base and focus on social justice. Local Area Coordination in particular is recognised as a programme that supports human rights, social inclusion and the right to a 'good life'.

Legal

59. There are no legal implications associated with this report

Crime and Disorder

60. Both programmes are linked in with deliberate strategic partnership work with North Yorkshire Police to help alleviate the impacts of Crime and Disorder in the city. Local Area Coordination has been instrumental in addressing issues related to anti social behaviour and County lines in some of the ward areas

Information Technology

61. Digital inclusion issues are considered within the practice of both LAC and social prescribing teams and link to the Information and Advice strategy and comprehensive research into digital exclusion in society. The cost-of-living crisis has continued to highlight the importance of digital inclusion and the inequalities faced by those without access. For those residents without IT equipment and/or internet access the teams provide vital support connecting people to community solutions such as the IT reuse scheme.

Property

62. There are no property implications associated with this report

Other

63. There are no 'other' known implications associated with this report

Council Plan

64. The Local Area Coordination and Social Prescribing programmes will support the following aims of the Council Plan:
    - Good Health and Wellbeing
    - A Better Start for Children and Young People
    - Safe Communities and Culture for All

Risk Management

65. The key risks relate to the sustainability of the Local Area Coordination and Social Prescribing Teams, given the funding through the Better Care Fund. Their value to building the resilience of citizens, social and financial inclusion, alongside health and wellbeing is key to the delivery of the council plan and health and wellbeing strategy. Furthermore, to support residents through what seems likely to be a protracted cost of living crisis, will need to recognise the following issues:

- The pandemic and now the cost of living crisis has impacted on the funding of the council and of our partners in the voluntary and community sectors, so service resilience across all partners needs to be a key consideration for decision makers in the short and medium term to protect ongoing service delivery.
- Any failure to provide an appropriate service will have a negative impact on the wellbeing of vulnerable people.

Recommendations

66. Members are asked to:
- Comment on the updates provided by the Local Area Coordination and Social Prescribing teams.
- Note the latest performance reports.

<table>
<tr><td>Author:</td><td colspan="4">Chief Officer responsible for the report:</td></tr>
<tr><td>Joe Micheli,
Head of Communities
joe.micheli@york.gov.uk

Jennie Cox, Senior LAC

Christine Marmion, York CVS Deputy CEO</td><td colspan="4">Pauline Stuchfield
Director of Customer and Communities</td></tr>
<tr><td></td><td>Report Approved:</td><td>√</td><td>Date:</td><td>16/09/22</td></tr>
<tr><td colspan="3">Wards Affected:</td><td>All</td><td>✓</td></tr>
</table>

Annexes

Annex 1 - Coalition for Personalised Care report LAC Performance report 25

Annex 2 - University of York LAC evaluation report summary LAC Performance report 24

Annex 3 - LAC Values and Principles

Annex 4 - LAC Performance report 24

Annex 5 - LAC Performance report 25

Annex 6 - Bruce’s Story

Annex 7 - Robert’s story

Annex 8 - LAC and Social Prescribing blogs

Annex 9 - LAC Network – Which Way Next report

Annex 10 – Ways to Wellbeing Annual Report 2021- 22

Annex 11 - Primary Care Links Update July 2022

Abbreviations

ABCD – Asset Based Community Development

FTE – Full Time Equivalent

LAC - Local Area Coordination (LAC)

LGA – Local Government Association

LWY – Live Well York

NIHR – National Institute for Health Research

PCNs – Primary Care Networks

P2R – Pathway to Recovery

PCLW – Primary Care Link Workers

YFAS – York Financial Assistance Scheme

York CVS – York Council for Voluntary Service