York Local Area Coordination Update Report 25

York Local Area Coordination Update Report May – August 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

Introduction

The deepening Cost of Living Crisis remains a clear and present focus of the LAC Team as we continue to support citizens and communities facing complex emotions regarding their financial situations and quality of life. There is a feeling of palpable desperation in some of our local communities, where people are concerned about a bleak winter ahead and an approaching recession. The anxiety this is creating is immeasurable and the impacts on health and wellbeing are obvious. The demand on support and advice services is at levels we have never seen before. This continues to add pressure to busy teams, including our own, with particular areas of demand such as support to access a programme of government financial assistance schemes or welfare benefits for those who are unfamiliar to form filling or those who are digitally excluded. At a system level we continue to raise these themes and issues as we see them emerging in our communities and identify where gaps are within these. We continue to feed in to plans to address these gaps across the Advice York Partnership so that we can help to develop longer term, sustainable plans to keep our citizens and communities well and resilient in challenging times. As part of this work, we have continued to use the Early Support Fund to help people overcome destitution and then, with our support, realise that good life which we all have a fundamental right to. This is illustrated well in a number of the stories included

in this report. We have completed the development of a wider online application process to support this fund and will roll out to additional internal City of York Council partners in Housing and Communities in September, with a view to rolling out wider to further external partners such as TEWV Mental Health teams and Changing Lives later in the year.

We continue to grow our support for the Community Mental Health Transformation programme and Connecting our City through our commitment to support the ongoing plans to develop a Community Mental Health Hub, with representation from the LAC team on the prototyping team for developing a new values based and community focused approach to mental health service delivery longer term through the alliance group. This is exciting work, bringing together years of commitment to Connecting our City, alongside partners, and the vision that goes with this. We have also been piloting new ways of working alongside the West Community Mental Health Team (CMHT), which is leading to the development of a replicable model we can take to other CMHTs to try out – this will see us moving towards more fluid, joined up approaches to keeping people well and moving away from the negative language of discharge and referral.

We have been contributing to a project run by York Disability Forum to raise awareness of and challenge disability hate, with some focus on how the Covid pandemic has increased health inequalities. Two members of the team have been interviewed for a podcast series linked to this which will be shared later this year, where they share their experiences as LACs walking alongside people with disabilities, the dangers of the increased invisibility isolation/exclusion leads to and experiences of the impact of hate. We have also contributed to Healthwatch research into Mental Health Crisis Care, where we received positive feedback around how LACs are viewed in a positive light by many different people across different sectors in York and how LAC has become intrinsically “part of the language of York”.

Following the last report, where the Leaders of LAC gathering in York was mentioned along with the development of new LACN films, I am delighted to share a series of short films which were developed and can be found on the LACN website. These films share stories from York and reflections of the LAC model which will be important aids in our toolkit for partnership working and the ongoing challenging of articulating our multi-faceted model, why it works and why it means so much to all of us who become LACs. The films can be found here: Reflections from the Network (lacnetwork.org)

After a recent phase of recruitment we welcome three new members to the team and look forward to a LAC Network Development day in September as part of their induction to the team and the LAC model. This will focus on identifying examples and stories of the subtle shifts in culture and changes to systems and process we see occurring as a result of our day to day practice as LACs. An example of this is the ‘infectious flexibility’ which was articulated in one of our featured LACN stories ‘The A Team’ some time ago. We aim to collate these examples into a resource which we can use to evidence and learn more about our approaches to system change as well as aid us in the development of further change projects alongside partners – building on these examples and great work we have already done, driven by those we walk alongside and what matters to them.

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One of the things that is striking reading through the set of stories for this report, and indeed about LAC in general, is the complexity of the situations we often find people in and the way we work alongside to help people navigate their way forwards towards a good life. The skills used are often described as ‘soft’ but are very sophisticated in terms of the way we relate to people, listen, understand and allow them room to develop their own solutions, ideas and subsequently build their own resilience. This work is hard and the descriptor ‘soft skills’ just does not do it justice. These complex situations also often require the skill of an expert generalist to look at in the whole and help to unpick, to identify where to start and where to go in order to move things forward - when things feel too overwhelming to move. LACs use skills which are demonstrated in common threads in some of these stories – we use judgment to know when critical windows of opportunities arise, as described in the Acomb/Holgate story and build trust where people have every reason to have lost trust in others, as illustrated in the Tang Hall story and the Fishergate/Fulford story of a Refugee family. The areas of knowledge we have to tap in to and develop as LACs is limitless in its breadth and depth, as highlighted in the story from Huntington and New Earswick. Some of the other stories in this report really highlight how sometimes it is the little things which can make a big difference, and the variety of support, contact and connection we offer people through our approach across the whole spectrum feels unique and makes every day so different as a LAC, with the approach tailored to each person in each community. All of these stories have read across to stories from our previous reports where we see LACs working in similar ways, with similar skills and values. It will be fascinating to see what the NIHR Research Team’s thematic analysis of all of our stories to date will show us.

As the cost of living crisis and other societal challenges deepen I can only imagine we will need more generalist roles, working in the person centred way described in our stories, to help people keep moving forwards in creative ways to ensure people continue to live good lives, or even adequate lives which meet their basic needs. As described in Robert’s story from the Guildhall ward, we continue ‘to hold hope’ for people, even when things feel at their worse. We also hold hope for our communities and hold hope in the ways we continue to be the change we want to see in the wider system.

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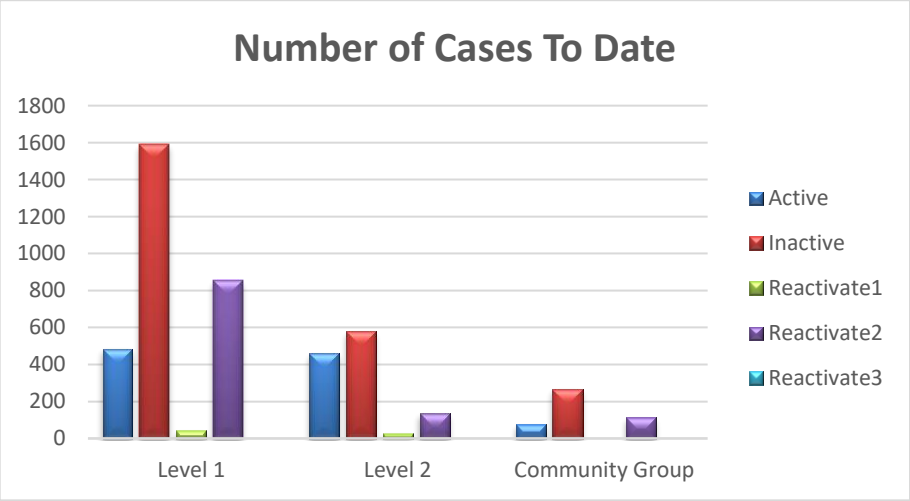
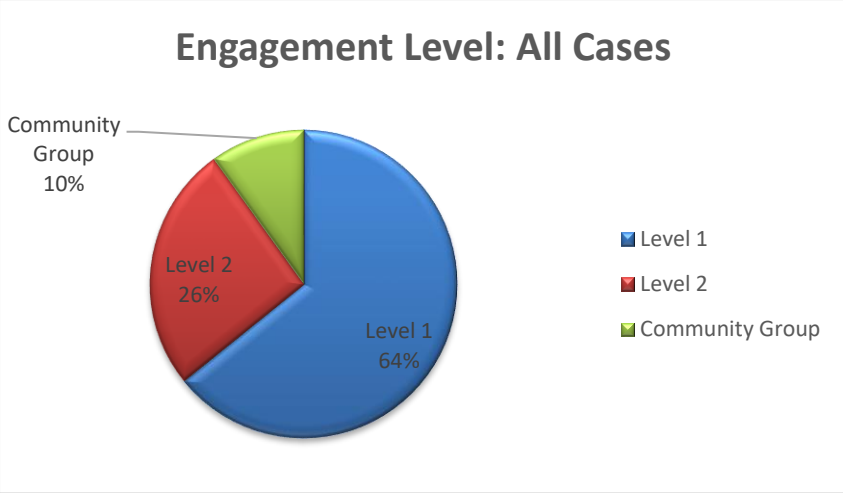
Section 2 - Engagement Level Analysis

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 **4630** and currently **2193** 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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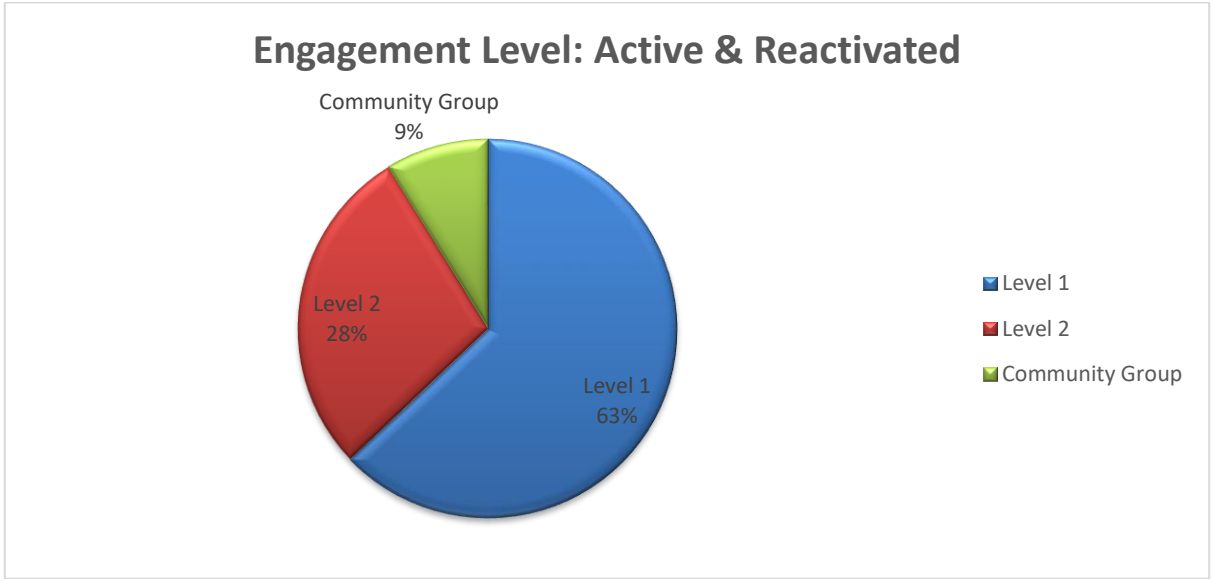
Level 1 basis (64%). Information recorded reveals that Level 2 introductions make up 26% and Community Groups make up 10% of total introductions to date.



The second pie chart shows the split between the three levels of support for all active cases (including reactivated cases). Currently there are 1380 active at Level 1 (63%), 621 at Level 2 (28%), and 192 are classed as Community Groups (9%).

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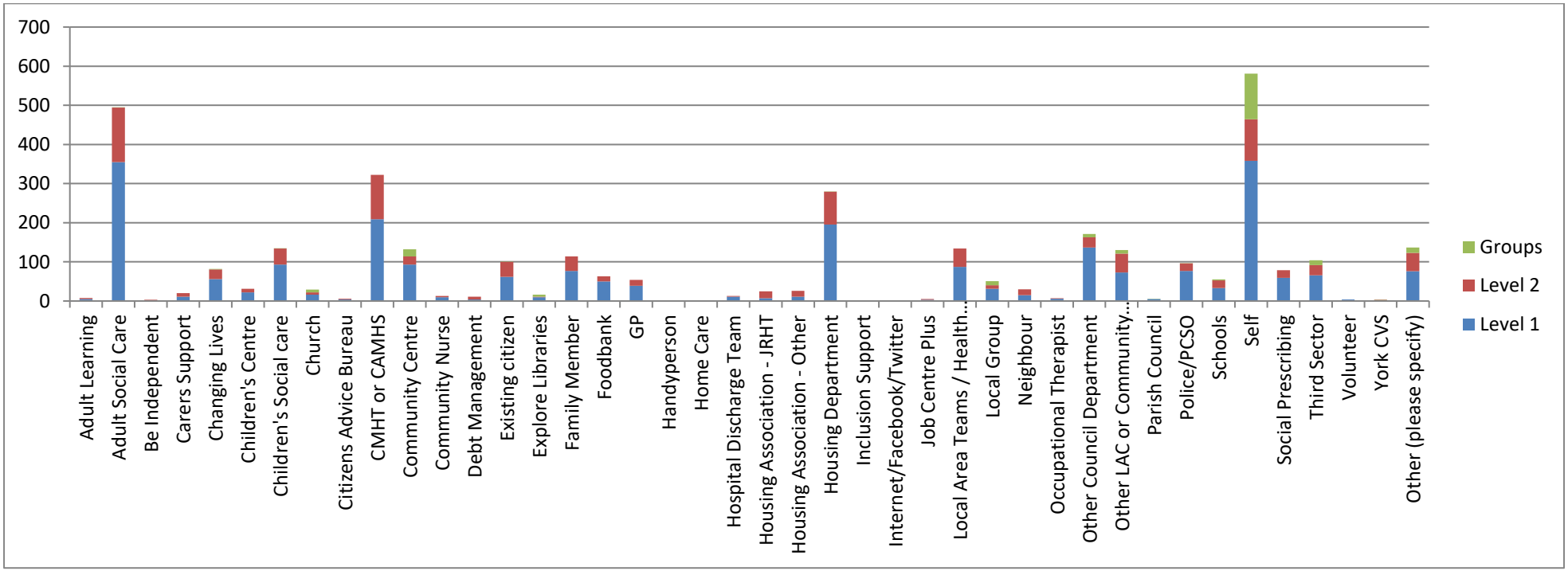
Section 3 - Source of Introduction

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

Introduction Source



The bar graph shows that most referrals have come from Self referrals (16%), 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 (39%) 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 (15%), Self (14%), and and Mental Health services (10%) which account for 39% of all introductions to date.

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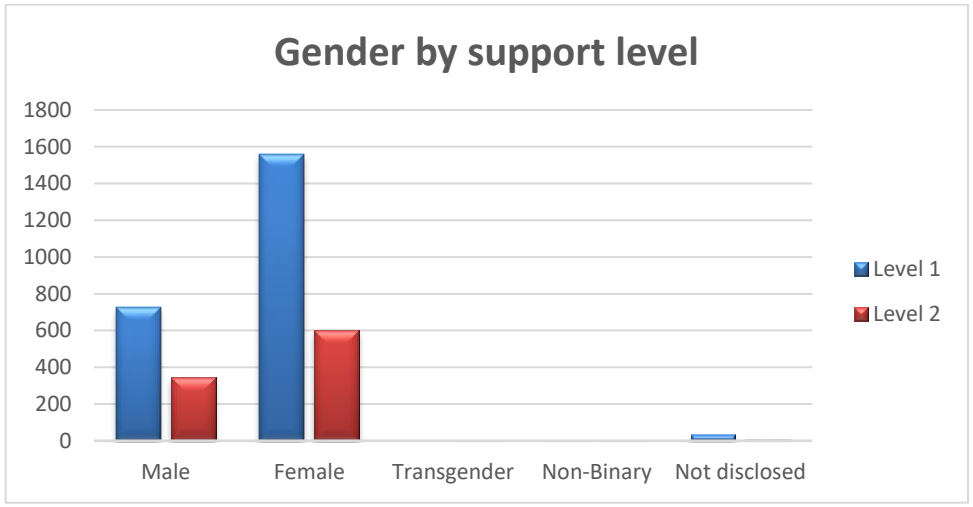
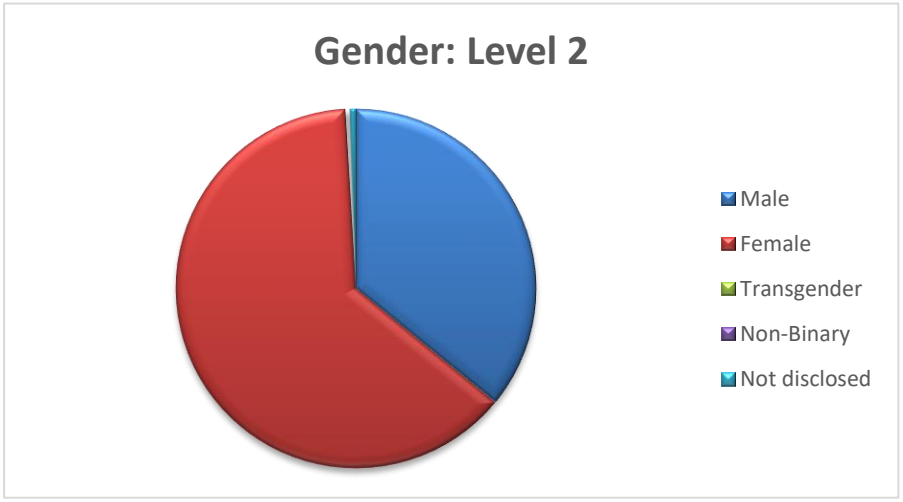
Section 4 – Demographic Information

As at the point of production (17th August) of this report 4170 individuals and 460 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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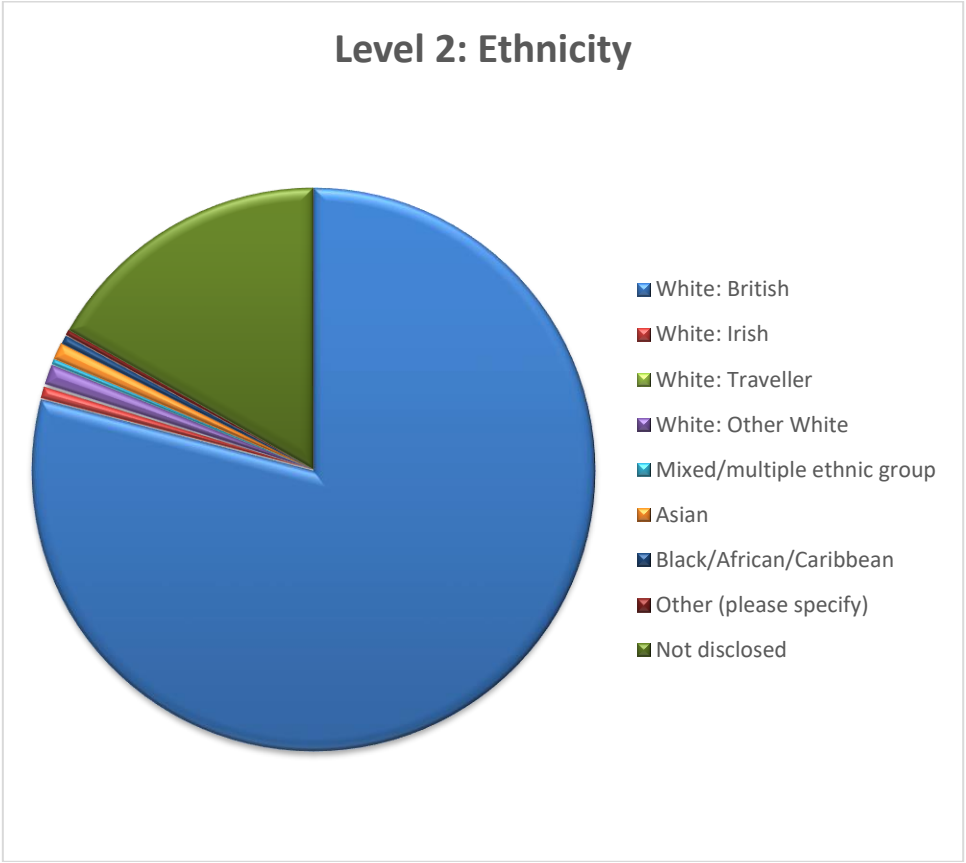
Ethnicity
We only collect this data for Level 2 cases.



The data we have collected so far shows as expected White: British are the largest proportion at 83%, 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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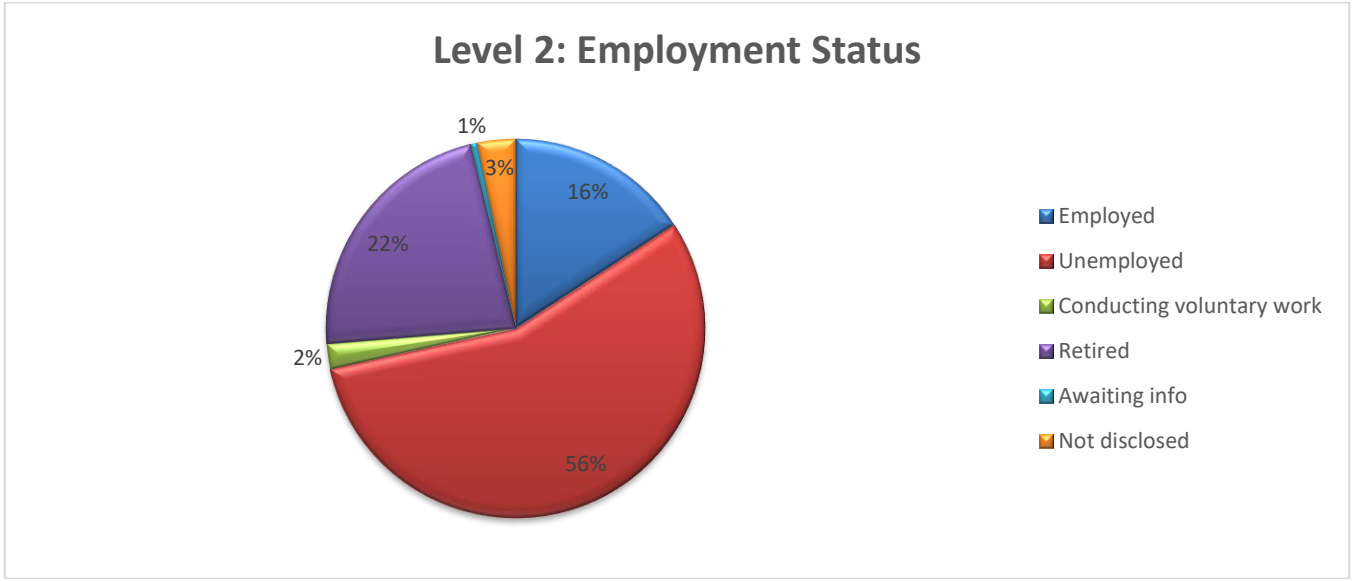
Employment Status
We only collect this data for Level 2 cases.



Over three quarters of cases are working with people who are Unemployed (56%) or Retired (22%), where 3% are not disclosed.

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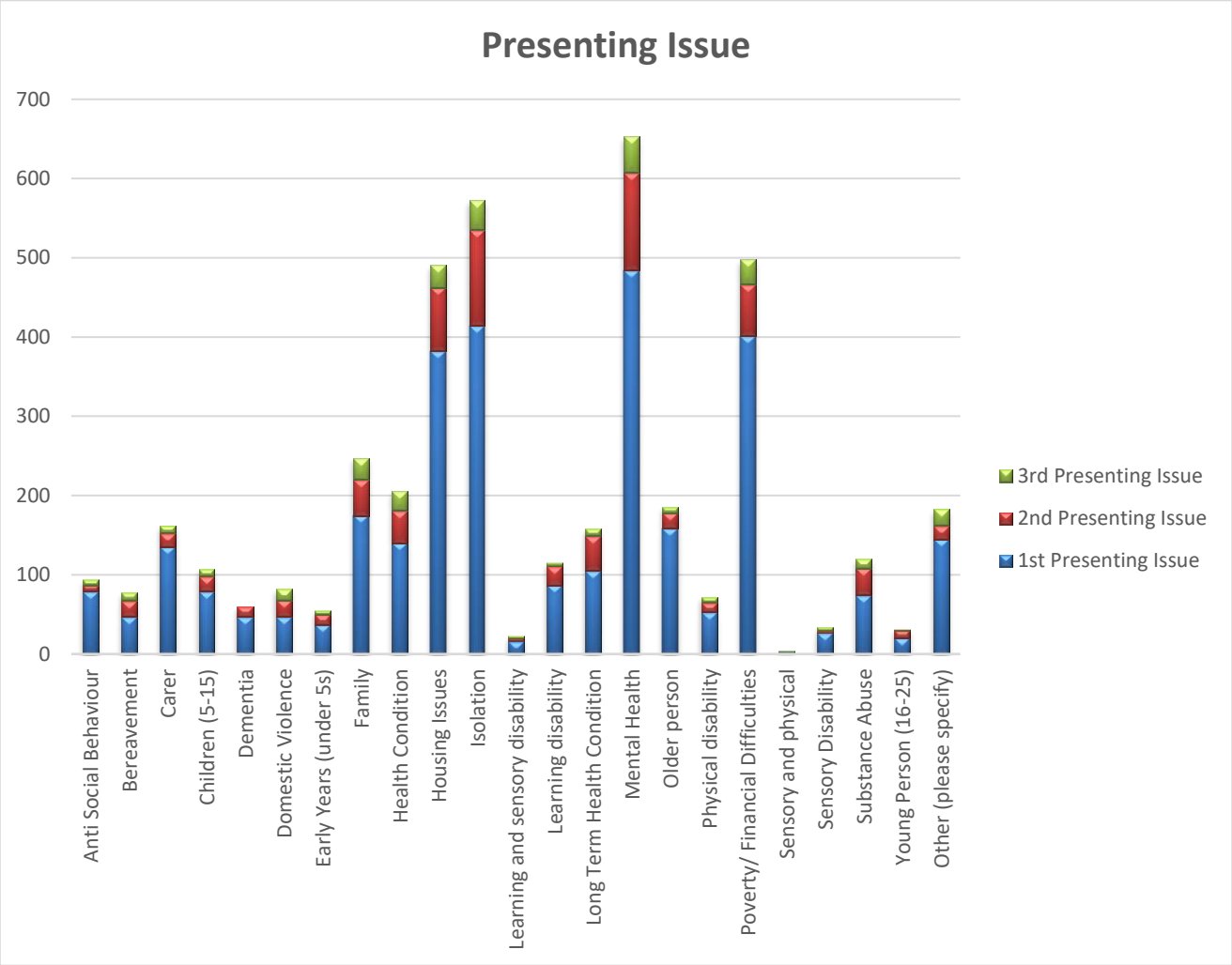
Reasons people are working with LAC

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 (15%), Isolation (14%), Housing Issues (12%) and Poverty and Financial Difficulties (12%). 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**

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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**

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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	3	8	1	35	2	5	6	3	**63**

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Jun				42		6	5		**53**
Jul		3	1	39		3	6		**52**
Aug		2	2	13			2		**19**
Grand Total	**135**	**264**	**168**	**1299**	**196**	**40**	**215**	**222**	**2539**

The data shows that since the service was introduced 51% 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: Michael's Story, Holgate

Introduction

Adult Social Care introduced Michael to the LAC in July of 2021. There was an ongoing assessment and it was felt that Michael would benefit from an introduction with the LAC. Michael had recently moved into the area as part of a planned moved as he was a victim of cuckooing at his previous address and there was a worry that he may be vulnerable in his new property. Previously Michael has not wanted to accept formal support as it did not fit with his lifestyle.

Michael was contacted via phone and a date and time was arranged that would be suitable for him to meet.

Situation

Michael moved into the area into a one bedroom ground floor flat. On the first visit to Michael, he introduced me to his friend who was homeless so was staying with him. At the time Michael was drinking heavily and this was having an impact on his physical health as he was already diagnosed with alcohol related sclerosis. Along with his friend who was staying, there were several other adults visiting the property and using it as a place to sell and take drugs. Michael was clearly vulnerable and described these people as friends, he informed the LAC that he did not like them taking drugs at his property and said he would like to sort his life out but was not really sure how to go about this as this was his life. The LAC asked Michael how they could be of best use to him and what would make it easier for him to keep to meetings or agreements. Michael asked that rather than appointments that he would forget he would prefer that the LAC just "knocked on" if she was in and around the area but suggested that afternoons would be better. Over the next few months the LAC visited regularly and began to build up a relationship with Michael and was able to support him with dealing with some debts and develop a system for dealing with his mail.

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What happened?

The LAC took a phone call from a worker from the homeless charity that offers outreach work to Michael. He had visited Michael and told me he thought he did not look well so had called the GP who had agreed to make an appointment to see Michael. It was agreed that the LAC was to drop in on Michael the next day to see how he was feeling.

When the LAC arrived at Michael's house he presented as very yellow, he was heavily under the influence of alcohol and told the LAC that he had drunk 2.5L of vodka in the last 48hrs. The LAC assessed the situation and made a judgement based on the situation and rang for an ambulance. Michael went to hospital where he spent 3 weeks. During his time in hospital the LAC visited Michael and they discussed how he wanted to live his life when discharged and what would make a Good Life for him. On discharge Michael was positive about remaining alcohol free and changing his life. Michael asked his friend to leave, which he did. The LAC spoke to the landlord and requested the locks to be changed. A request for housing support was made and Michael was allocated a worker. Michael remained alcohol free for 4 months with continuing support from the LAC, Michael discussed wanting to take up his hobby of calligraphy again; the search for some sessions for this are ongoing and Michael is slowly getting together the equipment he needs for this. On one phone call from the LAC Michael sounded as though he had been drinking and he confirmed that, that was the case. The LAC contacted the support worker and agreed a joint visit the next day.

Michael's bedroom was still out of use due to the used needles and clothing and rubbish left by his friend and the other people that was using his flat. Prior to the visit the LAC acquired a litter picker and collected a sharps disposal tub from his GP surgery. During the visit Michael was apologetic and believed he had let himself and everyone else down, within an hour he had helped the LAC and support worker to tidy his flat, the end result was much improved and clear of any alcohol and drug paraphernalia. The LAC supported Michael with his repeat prescription online form. The support worker also informed Michael that his friend was also to be released from prison and he may visit Michael asking for somewhere to stay. Michael was adamant that he would not allow the friend anywhere near his flat and he could not return to that way of life. The LAC also spoke to the local PCSO and made her aware of the situation and they agreed that they would do extra walk rounds in the area where Michael lived.

Michaels lapse in his strive for a Good Life was 3 weeks ago from writing this story and he remains alcohol free. He puts that down to the support he had at a crucial time and that the hour spent tidying and sorting with him made him again recognise that he did not want to return to his previous habits. Everyone who supports Michael is fully aware of the strength it takes to beat addiction and are committed to supporting

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Michael with this and can continue with low level support to keep him safe and well and not requiring further resources. The LAC role allows her to continue to walk alongside Michael on his journey.

Critical elements

- Michael was given time to build a relationship with the LAC.
- Joint working with other agencies in the community
- Michael's commitment to a good life for himself
- Michael's open and honest relationship with the LAC

Outcomes for individual:								
Assisted to access daily entitlements and/or benefits?		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?		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
Supported with accommodation?	x	Does the individual feel safer in the community?	x	Supported to share skills in their community?		Referred to Public Health service?		What service?

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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?		How?

<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 the LAC intervention Michael would require more support from health professionals, mental health services, police and drug and alcohol services – all of these interventions with formal services would be costly so cost savings have undoubtedly been made.

Story 2: Sheila & Ken's Story, Dringhouses & Woodthorpe

Introduction

Ken attended the LACs drop in at the local church following the mention of Local Area Coordination and the new drop in, in the Focus Newsletter. Ken attended on a mobility scooter due to impaired mobility and was seeking some advice regarding the over-grown brambles at the end of his garden which were starting to impede upon his view and his ability to trim his hedges. The brambles intruding upon his garden were growing in what appeared to be a thin section of land between his garden and the local school playing fields.

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Situation

Ken is a gentleman in his late 80s in need of full-time care; his wife, Shelia, also in her late 80s, is his carer. He attended the drop in on a mobility scooter as he had been trying to resolve the issue of the overgrown brambles. He had written to the council but was informed that the land was not council land and therefore not the council's responsibility.

Although this was Ken's primary concern, he also requested that his benefit entitlement be checked.

What happened?

With the help of a colleague, the LAC checked local land boundaries and identified the land in question belonged to the local school. The LAC emailed the school to enquire if this was so, and would it be possible to cut back the brambles. The school responded promptly confirming that they were responsible for the land and within two days had sent the school maintenance worker to cut back the brambles.

The LAC arranged to do a home visit to check Ken and Shelia's benefit entitlement, and to assist with claiming benefits.

During this visit Shelia expressed delight at the *"lovely man"* who came within days to cut the brambles. Shelia spoke at length about her children, her past careers and her role as Ken's carer. It transpired that they couldn't get out together as both have impaired mobility, and only one mobility scooter. Shelia stated that she only went out for about two hours a week to do the food shopping; she couldn't leave Ken unattended for long periods. The LAC suggested that the purchase of another scooter would allow them both to get out to attend some coffee mornings and local events. Shelia stated that she would think about this, but what she really wanted was for someone to come and take both of them out in their automatic car for days out. Together they explored the option of a 'micro-provider' and after emails and telephone conversations with a number of providers, they arranged a joint meeting with a provider who was familiar with driving an automatic car, and had availability to take Ken and Shelia out. They all got on well and arranged a date for their first trip. Again, Shelia expressed delight as she had had no idea *"that this was even possible"*.

The LAC provided some information about Age UK in Safe Hands service, which may allow Shelia some free time to engage in social activities and give her some respite from caring for Ken. They discussed the number of groups and activities that are available in the area which Shelia and Ken may benefit from engaging in.

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Critical elements

- Assisting in resolving an issue that was impeding upon the enjoyment of the garden. The couple had tried to resolve the issue themselves. The LAC recognised the importance that their garden had for the couple in terms of enjoyment.
- Through the Good Life conversation, the couple were able to identify an activity that would give them a great deal of satisfaction and connect them to a specific person to enable them to enjoy some freedom.
- The initial issue that Ken presented with gave an opportunity for connection with LAC and taking the time for further discussion and home visits revealed the desire to expand their social contact.

Outcomes for individual:								
Assisted to access daily entitlements and/or benefits?	x	Connected with others in the community?	x	Supported to groups/clubs in the community?		Provided with advocacy?		How? Benefits check introduced to a micro provider.
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?		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?		Were family / carers / friends supported?	x	How? Shelia is Ken's carer and her life is restricted by his care

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								needs. Allowing her some time to explore her own needs increased wellbeing for both.
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.								
Walking alongside Shelia and Ken will be an on-going journey. Shelia has to some extent, had her social life and life outside the home limited by Ken's care needs. Allowing her some time to socialise and leave the home knowing Ken has some care, could help with her capacity to manage her role as Ken's carer.								

Story 3: A Refugee Family's Story – Fishergate, Fulford & Heslington

Introduction

Max and Sara, along with their 2 children Alee and Kes, were introduced to their LAC by John Williamson at Refugee Action York (RAY). The family have been living in York since September 2020 when they emigrated from Africa for Max to study at Leicester University. Whilst here Max developed Osteo Myelitis, an infection of the leg and hip bone. As a result he was not able to undertake his studies and the family's visa was revoked in September 2021. Additionally, Sara was not able to continue working at York Hospital to financially sustain the family and the arrears including paying their private rent and utility bills began to accrue.

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Situation

Due to their No Recourse to Public Funds (NRPF) status the family were reliant on financial donations from RAY and food from foodbanks. RAY were struggling to get meaningful financial assistance for the family; particularly concerning was the family's expensive private rent which they were 2 months in arrears for. Relationships with services and support was non-existent due to the family being concerned that they would get into trouble, or their children would be removed. The only support network they had was RAY and York's Mosque, who were giving everything they could in terms of practical, financial and emotional assistance. The family's emotional wellbeing was particularly low, all were anxious and they had all but stopped accessing healthcare services due to receiving threatening letters from the NHS finance team for unpaid bills.

What happened?

The LAC met the family on a joint visit with RAY's senior case worker to discuss what support they needed/what the LAC could offer. It was agreed that the LAC would assist with identifying how the family could claim section 17 support. The LAC took the time to listen to the whole family, finding out that they all played an active part in their community supporting African students through the Yorkshire African Association, that Alee loved football and Kes desperately wanted to get involved in school swimming lessons. RAY's senior caseworker also shared that Sara, as well as receiving support from RAY's services also volunteered her time to keep them running. They said that initially their vision for a good life was remaining in the house through financial assistance to pay the rent but in the long term both Max and Sara want to be more active in their community finding employment and activities which helped others.

After being advised by Project 17 and York's MASH team about how to apply for Section 17 support the LAC walked alongside the family to build their trust to complete a MASH referral, engage the children's schools and identify other formal support for the family. This took time due to the family's reluctance for social services involvement. After speaking with both schools the LAC was able to secure support for the family through supermarket vouchers, free school meals, access to school trips, new school uniform and a swimming costume for Kes. The schools have also provided ongoing emotional support to the children and their parents, making sure to share the children's achievements and successes as well as providing practical support.

After the family were allocated a social worker the LAC continued to advocate for and challenge the speed at which decisions were being made regarding the section 17 financial assistance to make sure that the rent was paid. This was agreed in July, with back payments for the 2 months of arrears plus 4 additional months rent paid directly to the landlord, should cover the time period for the Home Office to make their decision on the family's visa application.

After removing the biggest stress element in the family's life they have been able to concentrate on other areas of their lives being assisted by the LAC to seek appropriate support. This includes a referral to Citizen's Advice York for support through their debt project to speak with all of their utilities and services regarding arrears; finding a volunteer to repair Kes's bike when it was damaged by a car; and finding funding through the Early Support Fund to pay for Max to attend an important follow up medical appointment with the specialist consultant at Oxford's Bone Infection Unit.

Critical elements

- The family were allowed the time to talk about their experiences and felt listened to.
- The LAC took the time to explain how different services work and made sure that the family knew where they could ask for advice and support from on different issues.
- The LAC brought all the different support services together to make sure that the family received a united support package and joined up approach.
- The LAC was able to extend her community connections to the family resulting in Kes's bike being repaired so that she could continue to get to school without her parents worrying that she was walking alone; which in turn showed the family 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?	Y	Supported to groups/clubs in the community?	Y	Provided with advocacy?	Y	How? Advocated for the family to ensure statutory decisions were made quickly to

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								avoid homelessness
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? Funding obtained to access a medical appointment in Oxford
Supported with accommodation?	Y	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? Support to avoid homelessness
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? A whole family approach was taken to ensure all felt well and connected to the community/city

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.

Services are working together to identify with the family what support is required at an early stage which means less repetition and less costly prevention rather than emergency assistance when the situation becomes unmanageable.

Access to good quality food through both supermarket vouchers and foodbanks means that the family are eating nutritionally balanced diet, are not worrying about how they will eat and particularly in the case of the children are able to focus their energy on studying.

Identifying with the family who they can contact for support in times of need means that they are not waiting until a deterioration in their health or financial/social situation before asking for help – also promoting resilience and independence.

By encouraging the family to seek support from the children's schools they have access to support which only schools can offer such as access to school uniforms, paid for trips and free school meals

the children do not feel isolated and different from their peers so they are concentrating on school work and achieving high grades.

Story 4: Robert's Story – Guildhall

Introduction

Robert introduced himself to the LAC, after an assessment with the Mental Access Team where he was given the details and advised to contact.

Situation

Robert had recently been discharged from hospital. He had been quite unwell and needed urgent treatment at the beginning of the pandemic. Being in a hospital environment during that time, had been a traumatic experience for Robert and the anxiety he felt had continued and become more generalised once he had returned home.

Household chores began to build up and Robert had begun to use alcohol and cannabis to cope. Robert felt unable to open his post and so follow up appointments with his health and wellbeing were missed, along with bills and other important correspondence. Robert felt bewildered by the world and that he was living in destitution.

What happened?

At the first meeting, the LAC gave Robert the choice over how and where they would meet. Robert said that he would prefer to meet face to face but did not want to meet in his flat, he was really pleased to hear that he had choices over how to meet, even in the pandemic. The LAC and Robert agreed to meet in a local park.

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The LAC listened to Robert's experiences of being in a hospital setting alone, at the height of the pandemic and how that had affected him. The LAC gave Robert time to talk about his worries and anxieties, but also the things that give him joy. Robert loves Lego and Karate Kid! He has a great eye for colour patterns.

During the conversation, Robert mentioned that his vision had been deteriorating and that he knew he had cataracts, but was too anxious to return to a medical setting for more treatment. He also mentioned worrying debts that had mounted with rent arrears, during his stay in hospital and recouperation at home.

Robert had also made repeated calls to his GP Practice, concerned about the after effects from surgery, but did not feel listened to. This had compounded his traumatic experience of health care.

The LAC offered to introduce Robert to some trusted colleagues in health and also financial advice, who could help. Robert tentatively agreed and the LAC set about introducing Robert to his GP Practice Link Worker and an advisor from Citizen's Advice. Together, post was opened and plans to address finances were made.

The LAC applied for Discretionary Housing Payments, to cover the period of rent while he was in hospital and then recovering. The LAC and the Link Worker, worked together to support Robert to access the treatment he needed to recover his eyesight. Both operations were successful.

Robert began to feel more supported and agreed to allow the LAC to visit him in his flat.

A small bedsit within a housing association block, Robert was no longer able to access the kitchen due to the accumulation of food packaging. The LAC sympathised with Robert's living environment and used the established relationship to enquire sensitively about how he was managing with personal care tasks. This conversation then led Robert to agree to allow the Falls Prevention Team to visit. Robert was happy with the way the team spoke to him, showing care and concern. From this Robert agreed to a referral to Move Mates and started Monday walks with a volunteer.

As time went on and Robert shared more about his situation, it was agreed that he should apply for Personal Independence Payments. The application process was started and Robert was supported by the LAC through the process. When Robert's application was declined, the LAC supported Robert through the Mandatory Reconsideration Process and finally a Tribunal Hearing. At this hearing, Robert was awarded the higher rate for both elements and received backpay.

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The PIP application process took 19 months from start to finish. During these times Robert lost hope that his financial situation would improve and became despondent with the process. The LAC carried the hope for Robert and in the interim, arranged for short term funding so that Community Bees could help improve the environment that he was living in.

Robert is currently waiting for the PIP backpay to arrive and has plans to use the money to buy some lego and pay for Community Bees to visit regularly. Robert still walks with his Move Mate every week and his confidence is starting to grow a little.

Having tried Changing Lives to address his alcohol dependency, Robert shared that he feels that the route to recovery and maintenance for him, is to feel that he has a purpose. The LAC introduced Robert to a colleague who is putting together a programme of change around poverty, that Robert is keen to be part of. Robert enjoyed the meeting and has attended more since, he speaks enthusiastically about the group.

Life still throws challenges at Robert (the LAC is currently advocating with his social Landlord who has made errors with his rent account), but Robert is more able to cope and speaks to his supporters when he can feel himself starting to become overwhelmed.

Having recently spotted that a neighbour was struggling, he has introduced them to the LAC.

Critical elements

- Robert was allowed the opportunity to develop trust with the LAC at his own pace.
- Issues other than housing, were listened to and spoken about.
- Creative solutions were offered that remained person centred and strengths based, such as involving local community organisations.
- The joint working with the LAC and Social Prescribing Link Worker allowed Robert to rebuild his confidence in health services and access treatment he needed.
- The LAC’s knowledge of the system and competency, were able to help address financial hardship and the imminent risks to Robert’s housing and wellbeing.

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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?	Y	Provided with advocacy?	Y	How? Advocacy in applying for PIP and with Housing..
Attending health appointments as appropriate?	Y	Taking medication correctly?	Y	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?	Y	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.

Robert's tenancy is now stable as rent arrears and environment have been addressed.

Robert is more aware of what is available in his local community and is more likely to become part of it. This will hopefully prevent Robert from entering a mental health crisis and reduce Robert's loneliness and isolation.

Robert is now in receipt of the correct benefits. This puts him more in control of his own wellbeing and helps bring money into the local economy. He has help, rather than a care package.

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Story 5: Mr & Mrs Lesley's Story – Haxby & Wigginton

Introduction

I received an introduction from another resident who wanted to support her friends by finding advice when, due to ill health, life was becoming overwhelming. The LAC contacted the couple by phone and realised after a chat that a visit would be helpful.

Situation

Mr & Mrs Lesley live in a bungalow in Haxby and both find things difficult due to ill health. Mr Lesley is severely sight impaired and has glaucoma, cataracts and diabetes, so his wife helps him with most tasks. Mrs Lesley has poor mobility due to arthritis, so the household tasks take up all of her energy, and due to being on a low budget a number of their household appliances had been broken for some time. Mrs Lesley said that everything felt chaotic and she needed a bit of help to sort things out.

What happened?

The LAC visited the couple and chatted with them about what was important to them, and they both agreed that varied meals and to get on top of things around the house would improve their lives. They eat the same meal (cod, waffles and peas) every day as Mr Lesley then knows the correct dose of insulin to give himself. I contacted the Health Trainers who will support Mrs Lesley to plan more varied meals and calculate the correct amount of insulin for Mr Lesley. The LAC put them in touch with the Falls Prevention Team who installed half steps painted white with a grab rail to make the front entrance safer for both. The LAC facilitated attendance allowance applications via Age UK for them to make things financially easier, which allowed them to pay for a regular cleaner, and a handyman to fix their broken oven and washing machine. Mrs Lesley said the changes were *"wonderful"* and had made a big difference to their lives.

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Critical elements

- The LAC listened to the couple and helped them identify small things that would make a big improvement to their lives.
- The LAC identified elements that would potentially prevent a crisis in future

Outcomes for individual:								
Assisted to access daily entitlements and/or benefits?	Y	Connected with others in the community?		Supported to groups/clubs in the community?		Provided with advocacy?		How?
Attending health appointments as appropriate?		Taking medication correctly?	Y	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?		Referred to Public Health service?	Y	What service? Health trainers
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 have happened without Local Area Coordination, etc.								

Both were at risk of falling due to poor mobility and poor vision and their home was made safer to prevent potential falls, hospital stays and rehab. Access to advice on healthy eating to prevent deterioration in diabetes/health which could also lead to a crisis.

Story 6: Fred's Story – Heworth/Tang Hall

Introduction

Fred got in touch after finding his LACs number on the CYC website. He and his wife were in their 60s and had lived in their Council property for over 30 years. Through that time had not had to ask for much help and support with anything as a working, independent couple. He had been searching online for someone to contact to help him as he was feeling exasperated and frustrated about a difficult situation which was causing a lot of upheaval for him and his wife which he was struggling to get hold of the right person to resolve.

Situation

Fred found details of his Local Area Coordinator for Tang Hall and thought he would give her a call, not knowing much about the role but hoping she might be able to offer some friendly advice and help. He left a voicemail on a Friday lunchtime sounding quite angry and explaining how desperate he was to speak to someone before the weekend. He was grateful when she called him back within the hour. He explained to her he was feeling really worried and upset as they had some major repair work done to replace and make safe the flooring in his house. In order to do this work all of their furniture had to be moved out and placed in storage and Fred had to take two days off work to allow the contractors access. The work was completed and he had been trying to get in touch with someone from repairs for the last few days to arrange his furniture to be returned to the house. He was also not very happy with the job the contractors have done

and the damage they had caused, he wanted to know what he would be offered in terms of disturbance allowance to put the décor right in their home.

What happened?

The LAC listened and discussed this calmly with Fred, who was keen she sort this out as soon as possible as she was the only person in the Council he had been able to speak with in days. She sympathised with the stressful situation, explained her role, her limitations as not being directly part of building services, but more importantly what she could do. When Fred was describing the work that had been done the LAC worked out which team and manager this fell within so she took the relevant details and offered to contact the manager direct via email. She used her knowledge and network of positive existing relationships to get a message to the right person quickly to ask them to resolve this. The manager rang Fred and emailed the LAC within the hour to let her know the furniture was being transported to Fred's house that afternoon, so they would have something to sit on and sleep on that evening and would be able to enjoy their weekend.

Critical elements

- This is a good example of the value of LAC as a single point of contact, accessible in their roles in the community and always ready to help with any query which comes to them.
- This story is a good example of the increased awareness of LACs within communities which has resulted from work with the web team to develop the website and online information about LACs – making it easier for people to find their LACs details, increasing self introductions to the team.
- The good communication and people skills of the LAC helped in this situation, where an angry, frustrated tenant was considering raising a formal complaint.
- The value of strong partnership working and the relationships at the heart of LAC shine through in this example of resolving an issue quickly for a local resident, keeping compassion for their situation at the forefront.

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- This story is a good example of simple level 1 interactions LACs have with people everyday, outside of their caseloads and planned work, demonstrating the value of flexible and responsive practitioners on the ground. This was a simple and short interaction which had a big impact on the person and their perceptions of the Council as a whole.

Outcomes for individual:								
Assisted to access daily entitlements and/or benefits?		Connected with others in the community?		Supported to groups/clubs in the community?		Provided with advocacy?	x	How? The LAC relayed the importance of resolving the situation for this couple in a timely manner
Attending health appointments as appropriate?		Taking medication correctly?		Supported to formally volunteer?		Require formal service from Adult Social Care?		What service?
Supported with accommodation?	x	Does the individual feel safer in the community?		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?		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.
This short piece of work arguably saved a lengthy complaints process and time resource. It may also have gone a little way to restoring the reputation of the Council with two longstanding members of the local community in the Tang Hall/Heworth area.

Story 7: Ted's Story – Huntington

Introduction

Ted was introduced to the Local Area Coordinator by the social worker for Ted. He had just moved into his new apartment in New Lodge and was happy with his new home.

Situation

Ted showed me the house that he had come from, and it was in a very poor state. The house had no central heating, and the windows were single glazed. Ted carried on living in the house after his parents died in the early 90's and was unknown to any services. It was only when he had a stroke next to the river and was found with his legs in the water that life began to change for him. Ted had no living relatives, vaguely thought that there might be some cousins somewhere but had lost touch.

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What happened?

Having had the good life conversation with Ted there were still things that needed sorting out with his new home. Ted still had his old home in Huntington which had a lot of his belongings and he wanted to sell it.

The LAC was able to support Ted to call a local van company to retrieve goods from his home in Huntington. This made his apartment feel more like his and he could have sentimental belongings around him. Ted also loves music, so with the LAC's help was able to retrieve his record player and all of his LP's. With guidance and understanding Ted was able to find a local estate agent who was happy to sell the house for him as it was.

When the estate agents put the house on the market, a living relative was visiting someone in York and noticed that Ted's house was up for sale. They contacted the estate agents wondering what had happened. The estate agents passed on the LACs details. LAC and the cousin of Ted had a conversation and she explained how her father had died and had lost touch with his nephew Ted. The LAC was able to tell Ted about this relative coming forward and the LAC was able to facilitate a video call between Ted and his cousin. Ted was pleased that she had got in touch and was delighted that he had some living relatives still.

The LAC has been able to support Ted to navigate the different stages of selling a house explaining information and supporting him to have a voice in the process.

With Ted being new to New Earswick' the LAC has been able to introduce Ted to NELLI which he enjoys attending each week and his confidence around people has grown. He still enjoys going back to Bairstow House where he lived for a short time whilst recovering as he has made good relationships there.

Ted has his own routines now and once the selling of his house is complete; he can continue to enjoy living in his beautiful apartment surrounded by a people who have made him feel part of the community. The need for formal services is not needed and he is able to remain independent.

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Critical elements

- Building a trusting relationship
- Being able to support someone to have a voice and make decisions
- Navigate complex situations
- Coordinated response.
- Look at community connections to reduce isolation and loneliness
- Time for Ted to share his interests
- LAC able to use local networks and connections to help Ted
- Keeping him safe

Outcomes for individual:								
Assisted to access daily entitlements and/or benefits?		Connected with others in the community?	yes	Supported to groups/clubs in the community?	yes	Provided with advocacy?	yes	How? Through selling his house
Attending health appointments as appropriate?		Taking medication correctly?		Supported to formally volunteer?		Require formal service from Adult Social Care?	yes	What service? From Adult social care but they were able to step back.
Supported with accommodation?	yes	Does the individual feel safer in the community?	yes	Supported to share skills in their community?		Referred to Public Health service?	no	What service?

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Was the individual given fire safety advice?		Was the individual supported to access police advice?		Does the individual feel more confident?	yes	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.								
Reduction in the time Ted needed to have intervention from Adult Social Care. Connected into the community to reduce isolation and loneliness.								

Story 8: Mary's Story – Micklegate

Introduction

Mary and the LAC met at Planet Food (surplus food distribution/meal session) A volunteer there had suggested Mary speak with the LAC.

Situation

Mary and LAC had a conversation. Mary explained she had recently moved to the area and was looking for things to do in the area. Mary is retired and lives on her own, having moved to York she had no immediate family in the area, however has a brother living approx. 20

miles away. They had a conversation about 'Community Connect' (tea/coffee and chat along side internet support with LAC available on site) Fridays 10-12.

What happened?

Mary started attending both Planet Food and Community Connect on a regular basis. Other community assets were discussed with Mary. On Friday's, Mary will now help out making coffee and tea, and shows and interest in those around her, promoting conversation and being inclusive.

On Thursday 4th August 2022 Mary said, having met with the LAC, she had gone on to Community Connect and had support with both her mobile and tablet and met new people. Mary now attends regularly; from here Mary attended the Refil Café and Community Fridge on Fairfax Street, where she met Dom who does local history/health walks. Mary completed a walk with Dom and others. Mary shared her progress with the LAC and said she is a good example of how Local Area Coordination works organically to assist someone in growing connections and knowledge of what is happening in the community.

Critical elements

- Mary understood the model of Local Area Coordination and pointed this out to the LAC
- Mary can often be seen helping others at Community Connect, and supports all round making teas and coffees and initiating conversation with others.
- Mary was able to and felt comfortable to access support with her tablet and mobile phone at Community Connect. She is now able to use devices more confidently.
- Mary now has started to build a network of contacts in the area
- Mary can talk to others about Local Area Coordination and can direct people to LAC

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Outcomes for individual:

Assisted to access daily entitlements and/or benefits?		Connected with others in the community?	x	Supported to groups/clubs in the community?	x	Provided with advocacy?		How?
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?		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?		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.

Mary has developed a good understanding of the LAC model, she is a good advocate and encourages other to make contact where appropriate.

Accessing support at Community Connect she has become more confident using the internet and her electronic devices, which has resulted in her becoming more digitally included, arguably reducing isolation and building resilience and independence – she is now able to pay bills and set up direct debits etc online.

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Story 9: Susan's Story – Tang Hall

Introduction

Susan was first introduced to her LAC, Jennie, by a Customer Contact Worker (CCW) in Adult Social Care in 2019. Concerns had been raised about Susan's self care as she didn't have access to a functioning bathroom, particularly a toilet, after something had gone wrong with the plumbing in her house several months prior. Susan had felt unable to afford to get it fixed – imagining this could cost thousands. Susan came along to see the LAC at her drop in at the local foodbank after getting the details about this from the CCW. At the drop in she was also able to access a food parcel and got some debt advice from CAP. Susan had been left in a difficult position after the breakdown of relationship with her ex partner a few years previously. He had moved out of their house, which they had joint ownership of and an outstanding mortgage, which he continued to pay. Her ex partner had moved all the other bills in to her name when he left, without telling her, which resulted in significant debts mounting. Susan's mental health had been a challenge for her to manage for some time before and after the break up. She was finding it hard to cope and impossible to unpick all the debt and house maintenance issues, including the plumbing. Susan had found it hard to ask for help – she had previously been financially dependent on her ex partner and didn't know where to start with her personal administration or claiming welfare benefits.

Situation

Susan and Jennie spent a lot of time discussing the various problems which needed to be addressed and made a plan, or a shared agreement, together – they quickly decided the plumbing was a clear priority so Jennie helped Susan to contact some plumbers, get some quotes and put in an application for YFAS via the local library computers. Susan wasn't confident with doing anything online, or making phone calls so she needed a lot of support with this.

Jennie then lost contact with Susan soon after this and did not see her at the drop in to follow up as arranged – she hoped that this was because the plumbing issue had been resolved and the debts were being managed via CAP. Jennie tried to call and sent some messages saying Susan could contact her again at any time if she needed help with anything else in the future – leaving things open, as LACs never 'close' cases and Jennie suspected there might be more going on for Susan, who was finding it hard to know who to trust after living with a complicated relationship with her ex partner for some time.

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In April 2022 the LAC received an email from a GP asking her to give Susan a call. The GP was concerned about the impact on Susan's physical and mental health from not having a working bathroom, which meant she could not wash properly or use the toilet. Susan had mentioned to the GP during the consultation that she had previously spoken with a LAC who was supportive and understanding and said she could get in touch again if she needed to – she had lost her number but the GP knew how to get in touch.

Jennie rang Susan, who explained she had never received a YFAS award, though this may have been because they had tried to contact her and she hadn't opened her emails or answered her phone. Susan also disclosed she had cancelled the appointments with contractors who were due to come out and quote for the work, as she was worried they might be known to her ex partner, who she didn't want any contact with as there was a difficult history there. She told Jennie that she had managed to achieve a short term fix on her plumbing herself, but this soon broke again and she was back to square one – leaving her without a functioning bathroom or boiler for over 18 months now.

The debts, in the meantime, had continued to mount. Susan had managed to maintain a UC claim, but had been sanctioned several times and she didn't really understand why as she found it hard to access her online journal. Susan's mental health and isolation were key factors as this affected her motivation and meant she often felt overwhelmed and anxious which had prevented her from knowing where to start or processing what she needed to do to get things in order. One of her adult sons had recently moved home, which was a motivating factor to get things in order, not just for her but for him also.

What happened?

Again, Jennie and Susan sat down together and came up with a plan, breaking things down to one step at a time, starting with the plumbing. Learning from the last contact with Susan and hearing more of her story, Jennie took a different approach this time, being much more alongside Susan initially to encourage her whilst avoiding things becoming too overwhelming again. They looked at creative approaches to contact a tradesman who wouldn't know her ex partner, who was a local builder with a lot of contacts in York. They explored access to grants which Susan could use for home improvements without involving her ex partner, whose names were on the deeds – this excluded some of the options offered by the Housing Standards team in CYC.

In the end, they settled on a quote from a small handyman service under the Age UK Trusted Traders list and Susan was delighted to hear the problem could be fixed for less than £200, rather than a bill for thousands of pounds, which she had been worrying about for some time. This was covered by the Early Help Fund and her plumbing was quickly back in working order. Motivated by this progress, Susan started exploring ways to put the damage from leaks in the plumbing back in good repair and got her boiler looked at by the same handyman, who told her that the problem was due to a small part which needed replacing. Susan started to pursue getting this fixed through an energy provider insurance claim. She went on to share she had been without a working fridge for over a year and her son was sleeping on a child's cabin bed as they couldn't afford to get him an adult bed – this was starting to cause him back problems. She was embarrassed about how she had been living and reluctant to ask for more help, but Jennie encouraged her to open up with a non judgmental and compassionate approach. Together they put in a claim for a YFAS, but this time a supported application was made by Jennie, who was able to give her contact details as the main point of contact and help with the administration of this much more. A fridge freezer, bed and a supermarket voucher was awarded to Susan and her son. This meant that they could stock up their new fridge with healthy foods they could cook from scratch rather than living on a limited diet of ambient temperature foods and takeaways.

Susan has been referred to the Community Mental Health Team for some support with her mental health and is viewing these sessions as important steps forward to deal with symptoms which have been holding her back for too long. Together, she and Jennie continue to plan additional steps forward with her home and her life, focusing on her wellbeing and some complicated family relationships. They are looking at building her confidence to access things online, addressing the digital exclusion Susan has been facing throughout the pandemic which has exacerbated her feelings of isolation. They are also looking at small steps to get involved with more things in the local community to build social networks. Susan and her son have been connected to Citizens Advice York to get specialist debt advice and to help challenge the benefits sanctions which have been imposed in the past.

It is likely to be long term work, but there is a clearly strong and trusted relationship at the heart of this between Jennie and Susan, which Susan can keep going back to, along with encouragement that there is help out there and she doesn't need to feel guilty for asking for it.

Critical elements

- The LAC approach to no 'closed cases' was really important in this situation, where Susan was able to pick the conversation up where they left it, even though this was over two years later. There was no questioning and a lack of judgement which meant Susan

was able to overcome the guilt and embarrassment she felt about the way she had been living, which was far from meeting her basic needs.

- The LACs expert generalist knowledge of what was available in terms of financial support, who to enquire with and the Trusted Traders list meant they could look at options creatively and sensitively in a way Susan was comfortable with.
- The Early Support Fund, which was developed from the LAC Programme's pilot Opportunity Fund was key to helping Susan overcome a barrier to living a good life. Once this initial problem was overcome it gave her the confidence to start exploring other areas of her life and home environment which she wanted to change after several years of living in quite poor conditions, which had severely impacted on her quality of life and confidence.
- The LACs ability to build trust and work at Susan's pace, alongside her, was key to helping her take steps towards a more positive future – which is the essence of the LAC approach.

Outcomes for individual:								
Assisted to access daily entitlements and/or benefits?	x	Connected with others in the community?	x	Supported to groups/clubs in the community?		Provided with advocacy?	x	How? Helped to Access YFAS through a supported application and also support to access the ESF
Attending health appointments as appropriate?		Taking medication correctly?		Supported to formally volunteer?		Require formal service from Adult Social Care?		What service?
Supported with accommodation?	x	Does the individual feel safer in the community?		Supported to share skills in their community?		Referred to Public Health service?		What service?

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			x					
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? Susan feels much more confident and that she is taking control of important issues in her life. This is also helping her son, who lives with her and she has introduced to the 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.

Susan's health would undoubtedly have continued to decline without the support to explore options to ensure her very basic needs were being met. Without exploration of these options she may not have been able to determine there were low cost solutions to big problems in her home. The steps forward which have been taken with the LAC support have reduced health inequalities and arguably increased Susan's life expectancy. The way these steps have been taken have been alongside, ensuring Susan has been involved and doing with the LAC rather than having things done for her – this has helped to nurture her confidence and belief in herself to address the other problems in her life, therefore building resilience to address any future problems as they arise.

Susan was becoming increasingly isolated and depressed, this decline may have seen the need for costly crisis intervention services from both mental and physical health services had support not been offered to improve the quality of life she was living.

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Story 10: Dennis' Story – Westfield

Introduction

Dennis was introduced to his LAC by a Council Benefits Advisor.

Situation

Dennis is a 67 year old man with mobility problems, living alone in a CYC flat. The Advisor noted that he was short of food and also seemed quite isolated. The LAC phoned Dennis and they had a chat about his situation. She issued a voucher for the local food bank (which included a voucher for fresh food at the Co-op).

Dennis said he would like to get out and about more and the LAC invited him to a local community café run by Age UK, and to the local Community Centre for some lunch.

What happened?

Dennis went to the food bank, and later told his LAC *"I had fruit on the sideboard for the first time in years!"*

Dennis really enjoyed the Age UK café and the Community Hub and has become a regular attender at both. He told the LAC it had made him realise how important it is just to be around people, and it has built his confidence around trying some more social opportunities. He said the Community Hub has given him something to look forward to, the whole week.

Dennis also approached the LAC for info about getting his hedge cut; the LAC put him in touch with his new Housing Management Officer so that he could request this for himself, and the next morning he awoke to the sound of the hedge being cut.

The Benefits Advisor has helped Dennis apply for Attendance Allowance which, if awarded, will provide him with a better quality of life.

Denis, who was born overseas, has now decided to apply for his passport so he can travel to see his birthplace.

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Critical elements

- The LAC has a good working relationship with the Benefits Advisor
- The LAC made time to have a chat on the phone with Denis to start to get to know him
- The Foodbank's links to the Coop meant Denis was able to enjoy some fresh food
- The LAC put Denis in touch with social activities within walking distance
- The LAC linked Denis to his new HMO, another "local connection"

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?		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?		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?	Y	Were family / carers / friends supported?		How?
Any perceived/evidenced preventions or savings as a result of Local Area Coordination intervention:								

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i.e. Reduction in health support, reduction in services, community providers/groups involvement, what may of happened without Local Area Coordination, etc.
Without LAC, Denis would have continued to be isolated in his own home, only leaving the house for essential shopping. Without LAC, Denis would have continued to be in low mood, with possible implications for demands on the NHS in future, both for his physical and mental health. With LAC Denis has opened up his horizons, is enjoying a fuller life with new confidence and is exploring possibilities for overseas travel.