LAC, Social prescriber and Bruce working in collaboration – Clifton

Introduction

When the SP link worker for York Medical Group which covers surgeries in Clifton, Clifton Without and Rawcliffe started in post early this year, she got in touch with the LAC for Clifton to introduce herself, since then they have been sharing information about community groups/resources through the phone regularly.

One morning, the SP Link worker gets in touch with the LAC for Clifton to discuss a resident she is working with. The person is question is Bruce, he is in his middle 50's, lives alone in a property in Clifton Moor that he parents bought before they passed away. He has learning disabilities and other physical issues, such as asthma, gout, iron deficiency and he has ended up in hospital a couple of times due to members of the public being worried about him when he was wandering the streets, in one of these admissions Bruce had self-harmed which worried staff at the hospital

The Link worker asks the LAC if it would be possible to work together on this case due to it's complexity, Bruce seems to need a lot of support and connection to services and community resources.

Situation

Bruce lives alone, however he doesn't seem to have the skills to cope independently. His skills to perform instrumental activities of daily living are really poor. Bruce struggles to initiate tasks such as do laundry, cook, clean the house, pay bills, remember to take meds and attend appointments, etc.

Bruce tends to have jobs as a cleaner however he struggles to maintain these jobs due to his disorganized routine.

In Bruce's property there is no gas – this means that Bruce can't take warm showers, do dishes or use hot water to disinfect/clean the property. The reason why Bruce doesn't have gas is because of his money management skills – Bruce has inherited around £40k from his parents however, he has no idea how much money this is or how to administrate it. After conversations with the SP and LAC, Bruce expressed that he feels he would lose all his money if he starts paying for gas and other services like mobile phone credit, TV license, etc., that's why he goes without. Bruce tends to go the local chippy to get food for free as he avoids spending money on groceries.

Support from ASC has been offered to Bruce in the past, however he declined. The police attended his property a couple for times due to neighbours being concerned about him. Bruce doesn't seem to get on well with "figures of authority"

What happened?

The SP and LAC organized with Bruce a joint visit at his property to get a better picture of how he was living. The house was unkempt, the kitchen was full of clutter making it not fit for purpose, Bruce was wearing dirty clothes and he couldn't remember when was the last time he had something to eat. As Bruce never gets rid of old post he was reading old letters and getting confused. The LAC and SP gave him advice on cheap places where to get his food from such as Aldi,

(that is a 5 minute walk from his home), St Luke's Larders, etc. They also explained the importance of having hot water and electric.

There was a lot on Bruce's plate, he was getting overwhelmed. The SP and the LAC decided to co-produce with him a plan of action (shared agreement) to start working on specific objectives. Bruce decided to start by applying for PIP and after this was done he said he would think of maybe putting the gas back on with support from SP and LAC.

The LAC and SP allocated specifics task to themselves depending on their knowledge and contacts (CYC, NHS). Bruce said his job would be to find the cheapest plan for gas.

The LAC supported Bruce to complete the PIP form face to face, the SP posted medical reports as evidence that she could easily access due to working for the surgery. This made process a lot easier, as surgeries can take a long time to get the reports needed for PIP.

Once the PIP form was sent, the SP and the LAC had another conversation with Bruce regarding support from the LD team at CYC – It is believed that Bruce will need intense support and he would benefit from a support worker to teach him some independent living skills – Bruce agreed to the referral this time. Bruce was assessed over the phone with support from the LAC, the LD team will get in touch with the SP and the LAC to gather more info

The SP keeps in touch with the hospital regarding Bruce's appointments and she is making sure Bruce doesn't miss these appointments as he is undergoing investigation in his stomach.

This is only the beginning of Bruce's story, Bruce has been on his own for a long time and there is a lot of things that need untangling. With the ongoing support from SP and LAC we are confident Bruce will achieve his vision of a good life. The SP and LAC hold regular catch ups over the phone to update each other and ensure there is no duplication

Critical elements

- Team work – SP and LAC working together on a complex case. SP brings knowledge and contacts of services available on the NHS/GP and the LAC brings the same from CYC and the local community.
- Flexibility of the LAC to take on introductions out of area due to need/complexity
- Bruce felt a lot more comfortable having the appointments at home without any formal processes. Bruce didn't seem to respond well to figures of authority in the past (ASC, police)
- No time limit – this allows Bruce to choose what he wants to work on and take the lead at his own time
- LAC and SP knowledge of the area and its assets

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?		How?

Attending health appointments as appropriate?	x	Taking medication correctly?		Supported to formally volunteer?		Require formal service from Adult Social Care?	x	What service?
Supported with accommodation?		Does the individual feel safer in the community?	x	Supported to share skills in their community?		Referred to Public Health service?		What service?
Was the individual given fire safety advice?		Was the individual supported to access police advice?		Does the individual feel more confident?	x	Were family / carers / friends supported?		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.

Bruce is less likely to need support from emergency services as he knows where to get affordable food and he will have a warm house to go to in winter therefore he won't be wandering the streets.
Bruce is less likely to need support from MH services and police in the future – reducing the pressure on this services.
Bruce has been referred to the Learning disabilities team – which might be able to offer long term support until Bruce learns some skills for independent living this will reduce referrals to GP, ASC, etc and will allow him to remain in the community rather than go into care facilities.
Bruce will learn how to administrate his money which means it will help the local economy.
Bruce to join the ATI programme which will allow him to get paid work