Notice of a public meeting of
Health and Adult Social Care Policy and Scrutiny Committee

To: Councillors Doughty (Chair), Hook (Vice-Chair), Barnes, Heaton, Vassie, Cullwick and Wells

Date: Wednesday, 28 September 2022

Time: 5.30pm

Venue: The George Hudson Board Room - 1st Floor, West Offices (F045)

AGENDA

1. Declarations of Interest
At this point in the meeting, Members are asked to declare any disclosable pecuniary interests or other registerable interests they might have in respect of business on this agenda, if they have not already done so in advance on the Register of Interests.

2. Minutes (Pages 1 - 6)
To approve and sign the minutes of the meeting held on 27 July 2022.

3. Public Participation
At this point in the meeting members of the public who have registered to speak can do so. Members of the public may speak on agenda items or on matters within the remit of the committee.

Please note that our registration deadlines are set as 2 working days before the meeting, in order to facilitate the management of public participation at our meetings. The deadline for registering at this meeting is **5:00pm** on **Monday 26 September 2022.**

To register to speak please visit www.york.gov.uk/AttendCouncilMeetings to fill in an online registration form. If you have any questions about the registration form or the meeting, please contact Democratic Services. Contact details can be found at the foot of this agenda.

Webcasting of Public Meetings

Please note that, subject to available resources, this meeting will be webcast including any registered public speakers who have given their permission. The meeting can be viewed live and on demand at http://www.york.gov.uk/webcasts.

During coronavirus, we made some changes to how we ran council meetings, including facilitating remote participation by public speakers. See our updates (http://www.york.gov.uk/COVIDDemocracy) for more information on meetings and decisions

4. Local Area Coordination and Social Prescribing update (Pages 7 - 218)

This report is being provided as a general update regarding the Local Area Coordination and Social Prescribing Programmes introduced in the city in 2016.

5. 2022-23 Finance and Performance Q1 Monitor Report – Health and Adult Social Care (Pages 219 - 236)

This report provides a detailed view of outturn position for Public Health (PH) and Adult Social Care for 2022/23.

6. York Health Trainer Service and NHS Healthchecks - update (Pages 237 - 242)

This report provides an update for Scrutiny discussion on the York Health Trainer Service and commissioned NHS Healthchecks service.

7. Work Plan (Pages 243 - 246)

Members are asked to consider the Committee's work plan for the 2022/23 municipal year.

8. Urgent Business

Any other business which the Chair considers urgent under the Local Government Act 1972.

Democracy Officer:

Name – Louise Cook
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For more information about any of the following please contact the Democracy Officer responsible for servicing this meeting:

- Registering to speak
- Business of the meeting
- Any special arrangements
- Copies of reports and
- For receiving reports in other formats

Contact details are set out above.

This information can be provided in your own language.

我們也用您們的語言提供這個信息 **(Cantonese)**

এই তথ্য আপনার নিজের ভাষায় দেয়া যেতে পারে। **(Bengali)**

Ta informacja może być dostarczona w twoim własnym języku. **(Polish)**

Bu bilgiyi kendi dilinizde almanız mümkündür. **(Turkish)**

یہ معلومات آپ کی اپنی زبان (بولی) میں بھی مہیا کی جاسکتی ہیں۔ **(Urdu)**

☎ **(01904) 551550**

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City of York Council	Committee Minutes
Meeting	Health and Adult Social Care Policy and Scrutiny Committee
Date	27 July 2022
Present	Councillors Doughty (Chair), Hook (Vice-Chair), S Barnes, Heaton, Wells and Pearson (Substitute for Cllr Cullwick)
Apologies	Councillor Cullwick
In Attendance	Councillor Runciman (Executive Member for Adult Social Care and Public Health)
Officers Present	Jamaila Hussain, Corporate Director of Adult Services and Integration Sharon Stoltz, Director of Public Health Steve Tait, Finance Manager: Adult Social Care

5. Declarations of Interest (5.31 pm)

Members were asked to declare, at this point in the meeting, any disclosable pecuniary interests or other registerable interests they might have in respect of business on the agenda, if they had not already done so in advance on the Register of Interests.

None were declared.

6. Minutes (5.31 pm)

The Chair requested that his comment at the last meeting with reference to the Dementia Strategy and the importance of reflection against the previous strategy, be noted

Resolved: That the minutes of the previous meeting held on 05 July 2022 be approved as a correct record and be signed by the Chair.

7. Public Participation (5.32 pm)

It was reported that there had been no registrations to speak at the meeting under the Council's Public Participation Scheme.

8. York Place Health and Care Partnership Board Update (5.33 pm)

The Corporate Director of Adult Services and Integration introduced the York Place Health and Care Partnership Board Update. She explained that the agreed key outcome of the Board was to make York the healthiest city in Northern England. She noted that the work of the York Board (YB) was closely aligned with the strategy of the Health and Wellbeing Board (HWBB). York was perceived as a healthy city but good health and access to medical services was not evenly distributed. The aim of the York Board was to reduce inequalities and improve service delivery.

[17:40 Cllr Pearson joined the meeting.]

The officer highlighted the work of the previous Health and Care Alliance, particularly in the area of learning disabilities and complex care.

It was emphasised that the new Board was introduced as a result of changes in the NHS. The implementation of Integrated Care Boards (ICB), had enabled Local Authorities to integrate its functions. The York Board was chaired by the Chief Operating Officer.

The ten year Health and Wellbeing Strategy was under development by the HWBB and was interlinked with the five year Integrated Care System (ICS) strategy. The York Place Board was working towards setting priorities which would be aligned with those of the HWBB. Suggested priorities including hospital admissions, delayed discharges, mental health delivery and Children's Services had been considered.

The next steps were to ensure the York Place Board membership was correct, work streams were in position and that learning from the previous Health Alliance had taken place.

The Corporate Director for Adult Services and Integration and the Director for Public Health responded to a number of questions regarding alcohol consumption, GP representation, governance arrangements for the Place Board, mental health provider services and the health and care workforce. It was confirmed that:

- York residents had a higher than ideal rate of alcohol consumption, predominantly drinking at home or in social situations. A social media campaign was due to start, encouraging people to be more alcohol aware. GP Practices and Health Trainers were focussed on alcohol support services to prevent more serious problems with alcohol from developing. GPs were well represented at strategic level and

clinically but had time constraints which would affect regular attendance at partnership meetings.

- The requirements for mental health services in York were different to North Yorkshire therefore arrangements would be redesigned to suit requirements in York.
- All 6 regional boards have a Local Authority Chair. However, York does not have an NHS Place Director which was an ongoing concern.
- Officers had looked at new ways of working and training, including working with schools and colleges, to attract and retain the health and care workforce.

During the discussion, Cllr Runciman, Executive Member for Adult Social Care and Public Health, mentioned the investment in assistive technology to support people with their independence.

The Chair raised the possibility of a cross scrutiny meeting with representatives from all six Place Boards and noted this could prove useful in securing influence for York. He asked that Democratic Services follow this up.

It was agreed that

i. The content of the report and the progress made be noted.
ii. The work of the previous York Alliance be noted.
iii. The possibility of a cross scrutiny meeting with representatives from each Place Board be investigated.

Reason: To keep the Committee updated.

9. 2021-22 Finance And Performance Outturn Report - Health And Adult Social Care (6.20 pm)

The Finance Manager for Adult Social Care and Public Health presented the 2021-22 Finance and Performance Outturn Report.

He reported that there had been a swing of £1.8m from Q3, which had reduced the overspend within the service. He explained that hard work and one off funding were responsible for the reduction and that the one off funding had probably masked underlying issues that would need to be addressed in the current financial year.

Savings from Public Health (PH) salaries, due to staff being redeployed and funded for Covid related work, had led to the transfer of reserves of £483,000. The plan for spending the sum had been agreed by Executive. Vacancies in the Healthy Child Service had also contributed to the savings.

In response to questions from Members, it was confirmed that:

- The Healthy Child Service had found it difficult to recruit Health Visitors and School Nurses due to the acute shortage of trained nurses with a PH nursing degree. There was also a growing pay differential between the Council and NHS salaries. Creative solutions to the recruitment problem included providing placements for student nurses, funding and training School Nurses and Health Visitors and offering flexible work contracts.
- There was a 14% vacancy rate across Health Visiting which had placed additional pressures on existing staff. The posts were funded through ring fenced PH monies, any financial incentives offered to staff needed to be weighed against the impact on PH services.
- Budgets were set against the figures in February / March and were assumed to remain steady throughout the year. Inflation increases had been included and for 2021/22 were set at 3%. Budgets for Learning Disabilities and Mental Health were difficult to set due to the complexities of the care.
- An increase in the number of safeguarding reports could be viewed as a positive. Levels of deterioration across the KPI's were considered to be low and it was important to ensure early intervention services were available in addition to information and advice with the aim to recover the deterioration quickly.
- Employers in York support employees with severe mental illness in paid employment, the recent dip in employees mental health may be due to Covid.
- NHS Health Checks was a statutory service aimed at residents within GP Practice boundaries, operationally it had been found that the most effective pathway to deliver the service was through GP practices.
- There had been an increase in the number of customers for P&SI Supported Living schemes, a new scheme at Wilberforce Trust was expected to take some of the customers who used the supported living schemes. The spend was also considered to be too high in comparison with other local authorities. It was a live issue and would be addressed this financial year.
- With reference to staff sickness levels, fewer members of staff were absent due to work related stress, reasons were variable but some absence was due to scheduled operations. Covid still impacted on the workforce although staff were able to return to work more quickly.

During the discussion, the Director of Public Health welcomed the opportunity to discuss further the implications of the staff shortages in the Healthy Child Service and the methods that could be used to improve the situation.

Officers agreed to seek clarification from the Business Intelligence Unit regarding the KPI – the percentage of adults in contact with secondary mental health services in paid employment.

They also agreed to seek clarification regarding the 2021-22 Survey of Adult Carers in England, paragraph 35 of the report, to establish the breakdown of responses.

Resolved:

i. The report be noted.
ii. The Healthy Child Service to be added to the Committee's Work Plan.
iii. A clearer description of the KPI 'percentage of adults in contact with secondary mental health services in paid employment' to be included in future reports.
iv. A breakdown of the responses regarding the satisfaction levels of Adult Carers in York be circulated to Members.

Reason: To keep the Committee updated on the financial and performance position for 2021/22.

10. Work Plan (6.50 pm)

Members considered the 2022/23 draft work plan for the Committee.

Officers advised that the Autism Strategy would be ready as a draft document for the meeting, 27 September 2022.

Members agreed that a Healthy Child item should be added to the agenda of the above joint committee meeting, subject to the approval of the Chair for Children, Education and Communities Policy and Scrutiny Committee (CEC).

Resolved:

i. That the work plan be noted.
ii. That a Healthy Child item be added to the agenda, subject to the approval of the CEC Chair.

Reason: To keep the work plan updated.

Cllr P Doughty, Chair
[The meeting started at 5.31 pm and finished at 6.59 pm].

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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.

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	Report Approved:	√	Date:	16/09/22
Wards Affected:			All	✓

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

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Annex 1

Coalition for Personalised Care

Understanding and aligning link worker and community capacity building activity: A place-based approach in York and Wakefield

Summary of Learning and Recommendations

Coalition for Personalised Care

Understanding and aligning link worker and community capacity building activity: a place-based approach in York and Wakefield

Summary of Learning and recommendations

Introduction

Universal Personalised Care[1] is a vision and strategy for making personalised care business as usual for health services in England. It was developed by NHS England and NHS Improvement's Personalised Care Group.

"Personalised care means people have choice and control over the way their care is planned and delivered, based on 'what matters' to them and their individual strengths, needs and preferences. This happens within a system that supports people to stay well for longer and makes the most of the expertise, capacity and potential of people, families and communities in delivering better health and wellbeing outcomes and experiences. This is one of the five major, practical changes to the NHS service model in the NHS Long Term Plan[2]. It recognises that personalised care is central to a new service model for the NHS, including working through primary care networks, in which people have more options, better support, and properly joined-up care at the right time in the optimal care setting.

This shift represents a new relationship between people, professionals and the health and care system. It provides a positive change in power and decision making that enables people to feel informed, have a voice, be heard and be connected to each other and their communities."

[1] Universal Personalised Care Implementing the Comprehensive Model

[2] NHS Long Term Plan

Universal Personalised Care (UPC) includes a focus on the role of social prescribing link-workers and their interrelationship with wider community capacity. As a key stakeholder body for the Personalised Care Group, the Coalition for Personalised Care (C4PC), was keen to support the delivery of the Universal Personalised Care Strategy. The C4PC partnership has a high level of diversity and reach and includes many people with lived experience. Partners were aware of the many different organisations employing link workers or involved in community capacity-building activity in areas where they were working. They felt that a piece of work that was place-based and explored ways to understand and align link worker and community capacity-building activity would be helpful to the delivery of social prescribing in line with UPC. C4PC was engaged to explore how social prescribing, the role of link workers and Voluntary and Community assets, worked together at place level.C4PC agreed a work programme, to be delivered in two places in the north of England.

This work began in January 2020 and prior to the Covid-19 Pandemic. There was an inevitable pause in the work as the focus of all areas turned to managing and mitigating the impact of the pandemic in their area. The vital role of communities, the value of the voluntary sector and the importance of the work of social prescribing and other link workers in supporting people at this time, became a dominant theme of this period of the pandemic and their experiences enriched the learning from the C4PC programme of work. Work began again on the work programme in September 2020 and was completed in early January 2021.

This report summarises the findings of this work programme and the practical recommendations to help Integrated Care Systems (ICS) better align social prescribing and other link worker activity and organisations involved in community strengthening activity. This alignment will help make best use of scarce resource, add value to the work of the different organisations involved and help health and other partners understand where investment may be best deployed. The overall aim is to strengthen the role of social prescribing link workers, the VCSE, and wider community support for improved health and wellbeing of populations.

Background

The Coalition for Personalised Care (C4PC) is a national strategic partnership working to further personalised care for all. It brings together health improvement bodies, royal colleges, think tanks, health organisations, VCSE organisations with a health focus and people living with long term health conditions to help ensure that people using health services receive personalised care.

C4PC has established subgroups to deliver a number of work streams, one of which focuses on communities and social prescribing and was the automatic choice to oversee the delivery of the work programme.[3] The sub-group used a transparent process to select four C4CP partner organisations with the right experience and skill sets to collaborate on the work programme and report. Community Catalysts, the National Association of Link Workers (NALW), the New NHS Alliance (now the Health Creation Alliance (THCA)) and Social Care Institute for Excellence (SCIE).

Approach

This work was coordinated by Community Catalysts and took place in two areas: York, and Wakefield. These places were selected because they supported a range of link worker activity including social prescribing link workers and had strategies to align their work as well as clear strategies for building the capacity and resilience of their communities. The lead for York was Joe Micheli, Head of Commissioning (Early Intervention, Prevention & Community Development) for York City Council. The lead for Wakefield was their Director of Public Health, Anna Hartley. The two councils welcomed this opportunity to share learning about what works really well in this space in their areas and to reflect on and explore ways to work even more effectively.

Community Catalysts worked with the two areas to identify and engage people who could help ensure that this work programme would be successful. It is a tribute to the two leaders that the kick-off meetings, which took place in early March and so at a time when Covid19 was beginning to be of major concern, were well attended with enthusiastic and engaged representatives from a very wide range of sectors.

All four partners and the York and Wakefield leads worked co-productively on the work programme to agree the following approach:

[3] See Appendix A for a list of members of the sub-group

1. Understanding the Landscape

a. Building on the knowledge in the kick-off meetings and working through community networks to understand and map the different link worker approaches and community strengthening activity already in place to support local people and communities. This included people who require more frequent use of acute health services.

b. Determining and understanding the connections, operating approaches and ways of working

c. Identifying duplications and gaps

d. Finding examples of great practice

e. Producing base line information for the other three delivery partners

Led by: Community Catalysts

2. Understanding and aligning link worker activity

a. Engage with community link workers identified through the scoping exercise in each area, including primary care network link workers, High Intensity User link-workers, Practice Health Champions, housing and police 'connectors' and Local Area Coordinators.

b. Bring link workers together to explore how they can and do collaborate and complement each other's' work, for the benefit of people needing the right kind of (non-clinical) help to live their lives.

c. Agree ways to reduce confusion and help ensure effective deployment of link-workers, including shared narratives.

Led by: National Association of Link Workers

3. Identifying 'what works' in effective strength-based support for people and communities (THCA)

a. Engage with organisations and groups involved in community capacity building identified by the scoping exercise in each area.

b. Build on the work of NALW to engage link workers in each area.

c. Bring together community capacity building organisations and groups with link-workers in each area to extract principles of effective strength-based support for people and communities.

d. Test principles against real life scenarios, drawing on experience of key leaders, local and national partners.

Led by: The Health Creation Alliance

4. Exploring alignment of community strengthening activity and investment by health (SCIE)

a. Engage with local leads and community capacity building organisations identified through the scoping exercise in each area to understand the factors that encourage alignment of current community-strengthening activity.

b. Bring local leads and community capacity building organisations in each area together to explore barriers and enablers to alignment further and to agree on sensible and practical measures that will enable communities to better support people in those areas, including people making frequent use of acute health services.

c. Use the findings and evidence to identify ways to encourage better alignment of current community-capacity building activity, to identify gaps and support investment decisions in sensible and practical measures that will enable communities to better support people.

Led by: The Social Care Institute for Excellence

5. Exploring how impact is captured and measured

a. With local leaders and community capacity building organisations, explore and identify existing validated measures, particularly local measures that measure the impact of community-capacity building activity on the strength and resilience of communities and the wellbeing of individuals, including people who make frequent use of acute services.

Led by: The Social Care Institute for Excellence

Key Findings and Learning

Understanding and aligning link worker activity

The scoping exercise identified a range of organisations across a number of sectors delivering link worker and connector activity in both York and Wakefield. York in particular was able to bring together link workers from a very wide range of sectors, including the police and housing as well as social care and health.

There were common findings from the engagement work with link workers and local leads in York and Wakefield, which were that:

a. The different models in operation were broadly complementary, supporting different groups in different ways and together supporting people with a very wide range of needs.

> *"The different models may capture people who are not visible to other services e.g., people who do not attend GPs are more likely to access support from a community-based link-worker and vice versa"*[4]

b. Working in partnership, allowed a more holistic and targeted approach that delivered better outcomes for people.

> *"People have complex live, complex problems and require multifaceted solutions and interventions. Sometimes it takes more than one individual or model to provide a full solution"*[5]

c. The strong values-driven leadership evident in both areas was vital in enabling collaborative working among link workers in different sectors.

The engagement work identified common barriers to collaborative working, such as:

d. Lack of clarity and information where a number of organisations offer support under the heading of social prescribing but offer different services to different client groups This leads to confusion for link workers and for people making referrals as well as clients.[6]

[4] Appendix C1 report on engagement work in Wakefield
[5] Appendix C2 Report on engagement work in York
[6] Appendix C1 Report on engagement work in Wakefield

e. The different tools and systems used by the different organisations employing link workers, for example different electronic systems and different assessment tools.[7]

In addition to strong leadership, there were other enablers identified that helped support collaborative working.

f. A Directory of Link Workers as practitioners were concerned that they were not aware of all the organisations supporting link worker activity locally.

g. A Practitioners Forum that meets regularly and brings together link workers across the sectors to share learning and explore opportunities for collaboration.

Finally, practitioners reflected on more general barriers and enablers to effective working. Their main area of concern was that:

h. Community groups and individuals often lack the resource to respond to the needs of the people being referred or introduced. Small, devolved budgets can be useful in enabling link workers to support community activity to fill gaps.[8]

Identifying 'what works' in effective strength-based support for people and communities[9]

The scoping exercise identified a range of organisations across a number of sectors delivering community capacity-building activity in both York and Wakefield. These organisations included community providers, VCSE anchor organisations, statutory bodies, grass-roots community groups, commissioners, activity leaders, link workers and other community representatives. The work took place during the Covid19 pandemic and so activity was virtual. After individual engagement, representatives were brought together into facilitated 'deep dive' workshops into community strengthening activity in each area. The workshops considered:

- 'What works' in community strengthening and
- Ways in which systems might need to change to support community strengthening.

[7] Appendix C1 Report in engagement work in Wakefield
[8] Appendix C2 Report on engagement work in York
[9] Appendix D Digging deeper, going further: creating health in communities

What works in community strengthening?

a. There was a common understanding in both areas that to become well and stay well, people and communities need four things:

- Opportunities to connect with each other and ourselves.

> *"This means being connected to other people in ways that feel natural and also being connected to the things that we love and, in fact, to ourselves ..... Connecting people and enabling communities to self-organise is the principal skill in community development and community strengthening."*

- Space – physical, emotional and systems space

> *"Physical spaces where people can meet and feel comfortable to share experiences and stories; emotional space to reflect and work things through, often on their own. Individuals and communities also need 'systems space' so that the system doesn't tell them what to do but enables them to find their own solution."*

- Opportunities to employ and enjoy their skills, talents and passions.

> *"This is how people connect with themselves and others. It is how they build confidence and develop purpose in their lives."*

- To take control over their lives and the places where they live.

> *"Taking control so that communities drive local agendas, influence services and create positive futures for residents and communities; the role of professionals is to share power and work with them as equal partners."*

b. Professionals have an important role in supporting communities and individuals to become and stay well. Those present at the workshops agreed a set of tangible actions, along with a focus on culture to support professionals to get this right. These include:

- Find out what matters to people locally. Listen to what the community wants (not what you think they want).

- Look for the connectors within communities – the people who get things done.

- Work with people on an equal basis

- Understand how the community functions. Identify and engage with key community networks. They are talented, resourceful, and embedded in the place.

- Develop community leaders. Spot talent in local people. Talent-spotting is a way to build people's confidence to act.

- Identify people that are ready to take on community leadership roles and help them to take the next step.

- Use meeting places where people are comfortable.

"A Community Dog Café started with an individual struggling with mental ill-health and alcohol issues. He connected to community through love for his dog and a shared interest with others and helped set up this new initiative in York: a shared common interest. They were in control so that meant it worked!"

"'Makey Wakey' - using empty retail outlets in a local shopping centre - Is led by The Art House. People came in because they saw something they connected with - words and paintings about Covid19. For many these were things they felt but couldn't express themselves."

How might systems need to change to enable individual and community wellbeing?

There was common agreement that systems needed to:

a. Invest in connection at both the community and the system level – to enable community strengthening and efficient, coherent, integrated systems. Community strengthening work needs to be resourced to be effective.

b. Support emerging informal groups and networks by enabling staff through training and support to work effectively with local people in their community.

c. Focus resources onto what works.

"Community strengthening work doesn't just happen. While it needs to be widely understood and elements of it practiced by everyone, there is also a need for dedicated resources to do it well."

d. Commission community-based models of healthcare. Workshops identified some key actions that supported effective commissioning.

   These included:

   - Ensuring NHS procurement processes encourage collaborative design with communities.
   - Encouraging collaborative commissioning between commissioners across health and social care.
   - Incentivising sharing and employment of ideas and skills by, for example funding coalitions where partners working together are bigger than the sum or their parts.
   - Offering match-funding to get behind community-led projects: NHS resources can 'make more' of community-secured funds from for example the National Lottery.
   - Building the confidence of commissioners to commission new things.
   - Trusting community groups with larger sums of money, once you are confident that they handle small sums well.

Tensions and gaps between community and health social care systems can get in the way of community development. York and Wakefield have worked differently but effectively to try to bridge those gaps. More detail of the ways in which York and Wakefield worked to bridge those gaps can be found in be found in Appendix D.

Exploring alignment of community strengthening activity and health investment

This strand of the work programme focused on developing and testing ways to encourage better alignment of community capacity-building activity across the health, social care and the voluntary sector in local places. The aim is to enable scarce funding for community capacity-building to be used effectively, to strengthen what is there and fill gaps. This work was conducted during the COVID-19 pandemic and so was done virtually. The progress of the pandemic meant that in Wakefield stakeholders felt that they did not have the capacity to take part in a workshop and so engagement was on an individual basis. In York it was possible to an online workshop which was attended by 25 strategic stakeholders.

There is a detailed report of this work, which will be put onto the C4PC website in due course.[10] There was common agreement on the following key lessons for local organisations working with communities that enable effective working and encourage better alignment.

a. Start where the energy is and build on existing partnerships – do not invent new structures when you already have these working well and in place.

> *"We went where the energy was strongest – we have been working on community development for years."*
>
> *City of York stakeholder*

b. Leaders need to take the time to visit other organisations and services to build a better understanding of their operating environment and cultures.

> *"Effective place-based leaders are moving their thinking beyond traditional health and social care to develop a shared understanding of their combined resources and assets."*

c. A key enabler is having a clear framework and set of guiding principles for the scope of work and decision making at each level of the wider health and social care system.

> *"A key enabler in York is having a clear framework and set of guiding principles – the community operating model – for the scope of work and decision making at each level of the wider system."*

d. Ensure that contracts and grants require investment in volunteering. Involve local citizens and communities in the governance and decision making on community-strengthening activities, especially people with lived experience.

> *"We live our lives in neighbourhoods – so it makes sense for them to be the starting point for how we think about services. Working at a neighbourhood level – with communities who understand both the challenges local people face and the strengths they have to overcome them – can help find creative solutions to seemingly insurmountable problems."*
>
> *Anna Hartley, Director of Public health, Wakefield Council*

[10] Appendix E Aligning Community-Strengthening Activity

Effective measures of community strength, resilience and individual wellbeing[11]

It is important to be able to measure the impact of various community capacity building activities on individual and community wellbeing, in order to decide which kinds of activities should receive investment.

Colleagues in York and Wakefield generously shared their learning about the measures of impact that were of most value in deciding where to invest. Key learning included:

a. Local systems leaders emphasised the need to develop and agree locally a common set of measures for measuring the impact of community-strengthening activity and social prescribing.

b. In Wakefield, a combination of quantitative validated measures to help leaders understand the impact of their community strengthening activities, such as a wellbeing measure based on the New Economics Foundation (NEF) Five Ways to Wellbeing and qualitative measures addressing issues like loneliness, volunteering which services worked well for people.

c. In York, a broad range of measures have been adopted to enable leaders to assess and track impact, ranging from harder statutory measures of impact such as the numbers of people accessing formal social care, delayed transfers of care and number of people attending GP appointments, through to bespoke validated measures of wellbeing and measures of wider capacity building, such as the number of new community enterprises set up and number of volunteers.

d. Increasingly, local areas are thinking about how they best capture how local community-strengthening work and social prescribing is reducing inequality, with Wakefield for instance developing measures on the number of people from disadvantaged communities using and benefiting from social prescribing.

e. Stakeholders in both York and Wakefield emphasised the importance of using measures which resonate with the NHS primary care clinicians and NHS commissioners, such as number of GP consultations and non-elective admissions to hospitals, social action and community development.

f. Explore opportunities to bring workers together to develop a shared culture and approach, including through joint training.

[11] Appendix E Aligning Impact of Community-Strengthening Activity

Recommendations

Scoping

1. It is important to take time to understand and engage with the range of organisations and individuals working across many sectors that have connector or community capacity-building roles, in order to ensure good alignment and effective use of investment.

Understanding and aligning link worker activity across sectors

While the detailed reports[12] make individual recommendations for York and Wakefield, there are many recommendations that would be applicable in any area keen to understand and align link worker activity. These recommendations are:

2. Provide strong leadership that supports person-centred working and collaboration across organisations and sectors.
3. Explore and address any leadership, management and culture-based barriers to person-centred working and collaboration.
4. Scope all the link worker and connector activity in the area, looking across sectors and organisations.
5. Review and address perceptions of lack of collaboration and confusion.
6. Reframe competition and duplication as being healthy and resulting in better care options.
7. Ensure regular community of practice meeting for link workers and similar connector models to share learning and reflect on their practice.
8. Review opportunities for integrated systems, tools, processes, and questionnaires which can be used by all link worker and connectors in an area.
9. Explore opportunities for link workers and connectors to further support one another and ensure funding is used well.
10. Consider allowing link workers a devolved budget to support community capacity building. This can be used to support people within an established community group or to help create coproduced new community groups or activities where there are gaps.

[12] Appendices C1 and C2

Identifying 'what works' in effective strength-based support for people and communities [13]

Colleagues in York and Wakefield generously shared learning about what they have found works in effective community capacity-building. This learning leads to a number of recommendations for professionals including health professional keen to support effective strengths-based support for people and communities in their area. Rather than repeating the learning points these are:

11. Senior leaders should enable staff with community-facing roles to understand and follow the principles of good community development. This is likely to involve both culture and system change as staff move from a professional to a peer-support role and the power-balance between statutory organisations and communities begins to shift.

12. Senior leaders should focus scarce resource on 'what works' by:

    - Making time for relationship-building and collaborative design with colleagues from other sectors, staff and communities.
    - Co-designing health and care solutions with people who have lived experience of using health or care services.
    - Creating 'safe spaces' where staff can challenge, question and make mistakes.
    - Listening carefully to all stakeholders including people and communities. before you invest. It's easy to make assumptions and spend money on solutions that do not work in practice.
    - Investing in connectors and relationship-building.
    - Investing in existing community hubs and infrastructures structures so that they continue as places of connection.
    - Resourcing the small stuff as a matter of course: Trust front-line workers (and communities) with resources to deliver whatever will make the difference.

13. Senior leaders should support commissioners to work collaboratively across sectors and have the confidence to commission new things. This

[13] Appendix D Digging deeper, going further: creating health in communities

may involve changes to systems and rules that can get in the way of creative commissioning.

Exploring alignment of community strengthening activity and investment by health

SCIE has drawn from the York and Wakefield case studies a number of very detailed recommendations for alignment of community strengthening activity. A summary of those of those recommendations is given below:

14. Develop a place-based and aligned strategy for social prescribing and community capacity building. Do this by:

    - Working co-productively with the voluntary, community and social enterprise sector (VCSE), and community-based organisations, people who use services and their families.

    - Engaging political and corporate leadership across all sectors from the outset to help secure support for a strategic, place-based approach to improving community wellbeing.

15. Commissioning

    - Practise collaborative commissioning - encourage partnership working and sharing of local priorities between commissioners.

    - Develop long term contracts for commissioning the VCSE.

16. Build the support of primary care for community-strengthening activity

    - Use evidence in building the case for support from primary care – particularly evidence that shows the impact on primary care, such as data on reductions in GP appointments or admissions to hospital.

    - Ensure that leaders from community capacity building organisations and the VCSE are represented on all health and social care partnership boards.

17. Workforce development

    - Trust your front-line workers with resources to deliver whatever will make the difference.
    - Train staff across workforce to promote a culture of ‘What matters to you?’ conversations, similar to those used in social prescribing.

- Use national initiatives such as the Asset-Based Area framework to scale up the approach systematically across the council.

18. Develop sustainable models

- Engage Primary Care Networks (PCNs) early, individually, and over a sustained period to grow their support and involvement in the shaping of social prescribing.

- Encourage other statutory and non-statutory organisations to fund and support link worker models, something which York is doing through the engagement of the police and housing in the further development of its local approach.

- Ensure that PCNs are strongly linked into community capacity building efforts.

Effective measures of community strength, resilience, and individual wellbeing

As part of any place based strategic for community strengthening, it is important to develop and agree a clear set of measures to evaluate the impact of social prescribing and community strengthening activity on communities, which are embedded in strategic performance management frameworks.

1. In developing a measurement framework, avoid reinventing the wheel, building on existing measurement frameworks.

2. Ensure that a wide range of local partners, including housing organisations, the police and the VCSE, and people with lived experience are involved in developing and agreeing a local measurement framework.

3. Ensure that in any measurement framework, there are clear measures about the impact of social prescribing and community-strengthening activity on the NHS, such as measures relating to reduced demand for hospital-based care and GPs.

4. As part of any measurement framework, where possible draw on existing standardised measures which are used nationally. Here it may be useful to refer to Evaluating Personalised Care, an NHS England and Improvement funded guide which includes several national validated measures.

Useful tools and further detailed information

Early engagement and scoping produced base line information about the organisations delivering link worker or community capacity building activity in each area. From this, Community Catalysts developed a tool[14] which can be used by health leads to effectively scope link worker and community capacity building activity in their area.

Each of the other partner organisations has produced detailed reports of their methodology and findings. These are referred to as footnotes throughout this report and will be accessible via the C4PC website at a future date.

[14] Appendix B

Coalition for Personalised Care

Work undertaken on behalf of the Coalition for Personalised Care by the following Partners:

National Association of Link Workers
CONNECT LINK

The Health Creation Alliance

scie social care institute for excellence

communitycatalysts®
unlocking potential effecting change

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Local Area Coordination in York: The story so far

Local Area Coordination is an approach emphasising the assets of people and communities. Local Area Coordinators 'walk alongside' individuals as they pursue their vision for a good life, and lessen the need for formal service interventions.

Local Area Coordinators support people to:

- Seek practical, non-service solutions;
- Access, navigate, coordinate and control services;
- Identify support and information;
- Build and maintain valued, mutually supportive relationships;
- Understand and nurture their gifts, skills, experiences and needs;
- Be part of community life;
- Be heard.

What is new about Local Area Coordination?

- The sole 'eligibility' condition is that the individual lives in the area;
- Local Area Coordinators do not directly provide services;
- A new language of 'introductions' and 'connections' rather than referral;
- Whole-person, whole-family approach to building family and social connections and relationships;
- Local Area Coordination support is not time limited;
- Local Area Coordination seeks to build resilience.

The City of York introduced three Local Area Coordinators during Summer 2017 within three wards. To support the early phases of development and to assess the difference made by the approach, a team at the University of York conducted a small-scale process and early outcomes evaluation.

We collected information to assess implementation (including recruitment and management), delivery and emerging outcomes at levels of individual, community and system.

We collected:

- Performance data
- Programme materials
- Information from meetings and events
- Interview data with:
  - Local Area Coordinators;
  - Programme Management;
  - Community organisations and professional stakeholders;
  - Those supported by Local Area Coordination.

What we learnt #1: Active ingredients for implementation and delivery

What we learnt #2: Local Area Coordination in action

Coordinators undertake a range of activities:

- Drop ins, lunches and coffee mornings
- Support for appointments/visits
- Companionship for isolated and vulnerable people
- Navigating financial systems
- Navigating housing, health and social care
- Advocacy
- Signposting to leisure activities

✓ Local Area Coordinators work true to the LAC aims and approach and it is operating as intended.

✓ Community residents and stakeholders welcome the long-term focus of Local Area Coordinator work.

✓ Real change has been achieved as a result of Local Area Coordinator support.

"My experience of the Coordinators is that they're able to catch the people as they're falling, before they've hit the bottom, whereas a lot of other support agencies the people have hit the bottom and been there for a while before support is available, because there isn't the support there." (Community Stakeholder)

"I would say, 'She's somebody who's in touch with lots of different services across our area, so that can be mental health. It can be childcare. It can be mobility. It can be work. She's just somebody who has access to this big network.' It's somebody who can help you through it and be a supportive person to help you navigate it." (Local Resident)

"There is a lot of lonely people. I was one of them. People don't realise that… Well, yes, I often think that if [LAC] hadn't materialised, I just don't know where I'd be. I think I'd be very, very poorly." (Local Resident)

Where next?

Further engagement: there are opportunities to improve engagement with isolated older people, sheltered accommodation, GP settings and some school inclusion teams.

Community impacts: Capturing community level evidence, including how activities build social capital, is a priority.

System impacts: There is a need to better understand wider system changes, including within statutory and community settings.

Prevention and deferral: Exploring caseloads and identifying measurable activities could allow preventative and deferred cost scenarios to be modelled.

But keeping people at the centre: Individuals and families must continue to provide stories and reflections on how Local Area Coordination has supported them in achieving their vision of a good life.

Supported by the University of York Economic and Social Research Council Impact Acceleration Account (Co-Production Call). The study was a collaboration of the University of York and City of York Council

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UNIVERSITY of York

E·S·R·C ECONOMIC & SOCIAL RESEARCH COUNCIL

Local Area Coordination Values and Principles:

Local Area Coordination is underpinned by a Vision, Charter and 10 core Principles.

They

- Inform the design and implementation of the programme
- guide our relationships, conversations and behaviours alongside people, families, communities and services.
- help us to reflect as we walk alongside people, their families and local communities.
- help us to think about how best to explain our values and role to people from a range of backgrounds and experience.

1. The Local Area Coordination Vision

'All people live in welcoming communities that provide friendship, mutual support, equity and opportunities for everyone'.

2. The Local Area Coordination Charter

'To develop partnerships with individuals and families/carers as they build and pursue their goals and dreams for a good life and with local communities to strengthen their capacity to welcome, include and support all people as valued, contributing citizens.'

The Vision, Charter and Principles are based on those originally developed by Disability Services Commission in Western Australia and subsequent developments internationally.

3. Local Area Coordination – The 10 Principles

The principle	What it means in practice
Citizenship	All people in our communities have the same rights, responsibilities and opportunities to participate in and contribute to the life of the community, respecting and supporting their identity, beliefs, values and practices.
Relationships	Families, friends and personal networks are the foundations of a rich and valued life in the community.
Natural Authority	People and their families are experts in their own lives, have knowledge about themselves and their communities and are best placed to make their own decisions.
Lifelong learning	All people have a life-long capacity for learning, development and contribution.
Information	Access to accurate, timely and relevant information supports informed decision-making, choice and control.
Choice and Control	Individuals, often with support of their families and personal networks, are best placed to lead in making their own decisions and plan, choose and control supports, services and resources.
Community	Communities are further enriched by the inclusion and participation of all people and these communities are the most important way of building friendship, support and a meaningful life.
Contribution	We value and encourage the strengths, knowledge, skills and contribution that all individuals, families and communities bring.
Working together	Effective partnerships with individuals/families, communities and services are vital in strengthening the rights and opportunities for people and their families to achieve their vision for a good life, inclusion and contribution.
Complementary Nature of Services	Services should support and complement the role of individuals, families and communities in supporting people to achieve their aspirations for a good life

York Local Area Coordination Update Report 24

York Local Area Coordination Update Report March – May 2022

Section 1 Local Area Coordination – learning to date

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

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

Therefore, it is about:

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

York Local Area Coordination Update Report 24

Introduction

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

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

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

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

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

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

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

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

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

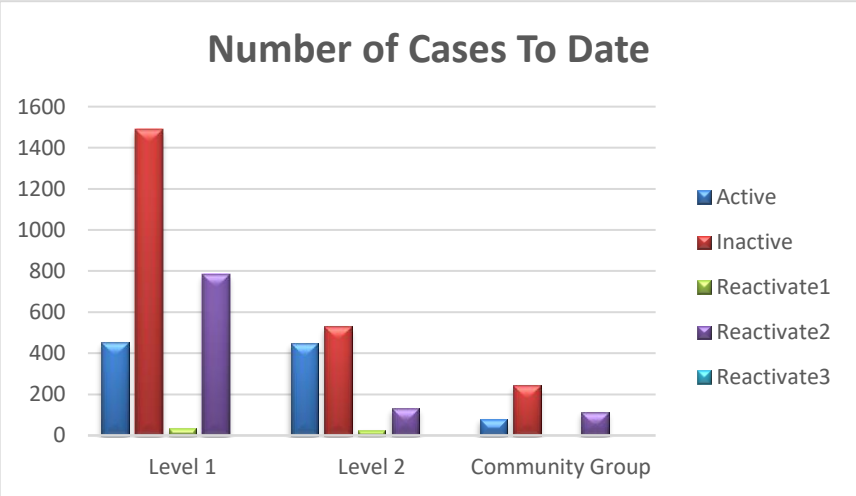
York Local Area Coordination Update Report 24

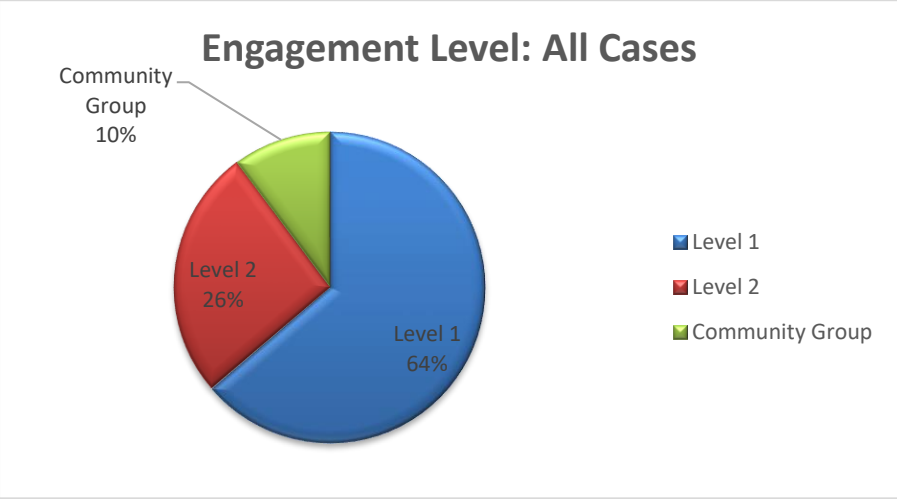
Section 2 - Engagement Level Analysis

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

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

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

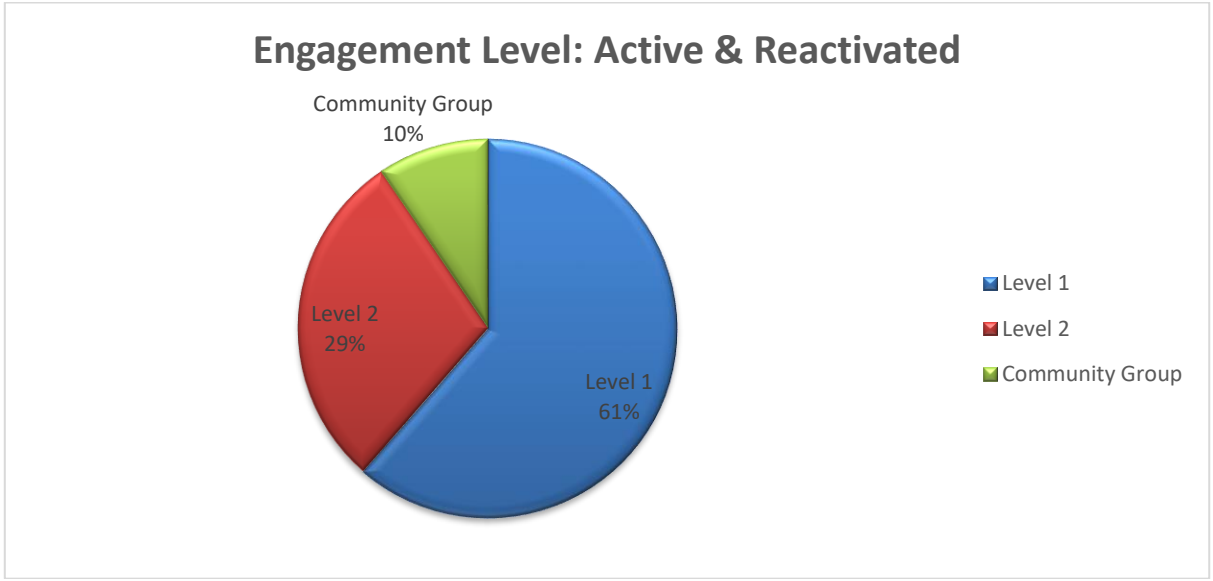




The total number of people the team have worked with to date is **4337** and currently **2071** are active (including reactivated cases). The pie chart shows the split for all people whether they are still active or inactive. This shows that over half of people introduced have been on a

York Local Area Coordination Update Report 24

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



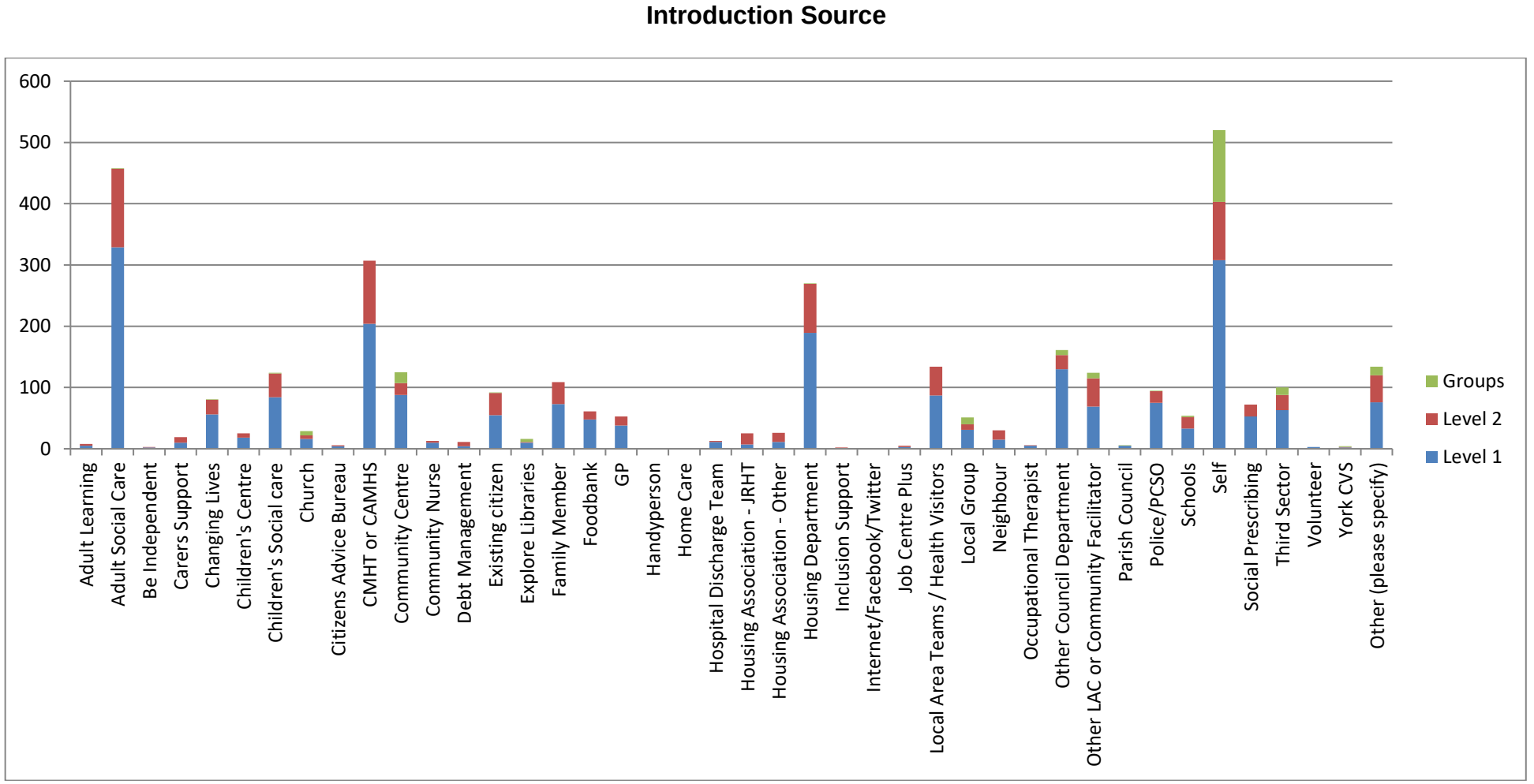
The second pie chart shows the split between the three levels of support for all active cases (including reactivated cases). Currently there are 1272 active at Level 1 (61%), 603 at Level 2 (29%), and 196 are classed as Community Groups (10%).

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

York Local Area Coordination Update Report 24

Section 3 - Source of Introduction

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



York Local Area Coordination Update Report 24

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

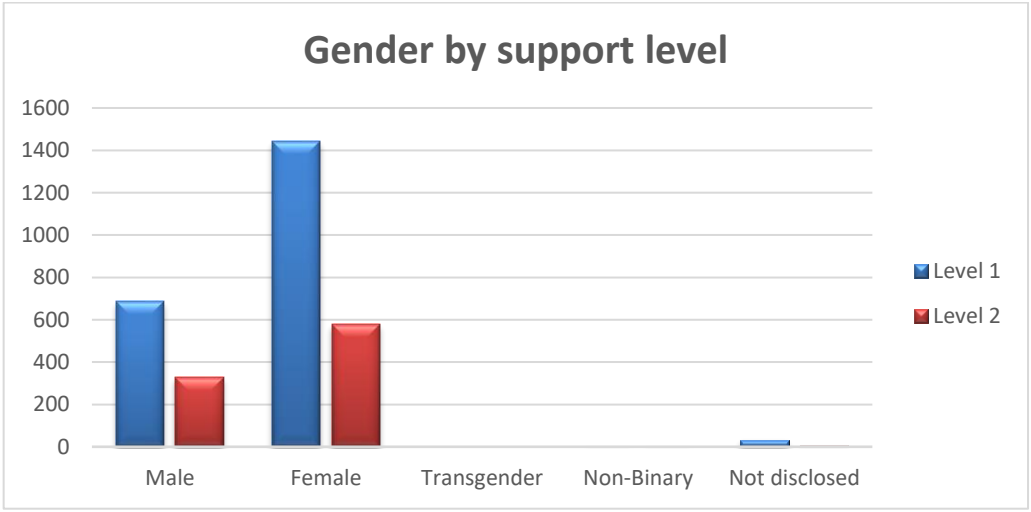
When you just look at Level 1 and Level 2 introductions then most referrals have come through Adult Social Care (14%), Self (13%), and and Mental Health services (10%) which account for 37% of all introductions to date.

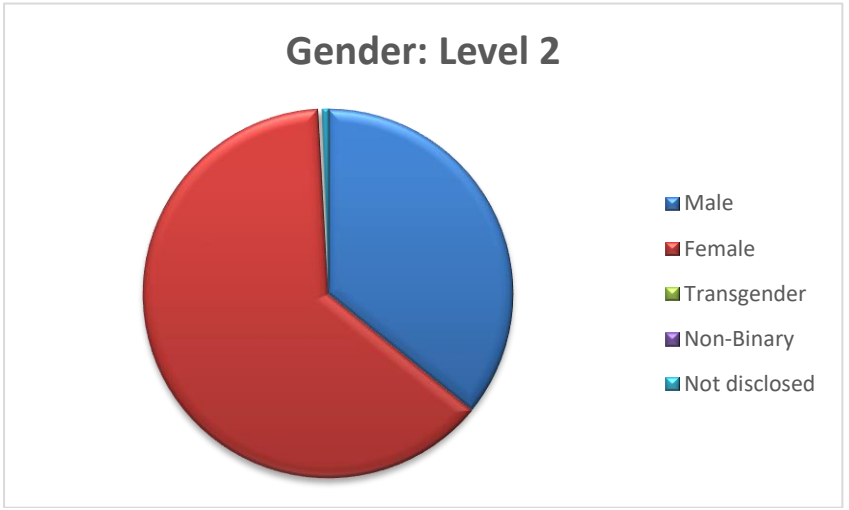
York Local Area Coordination Update Report 24

Section 4 – Demographic Information

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

Gender



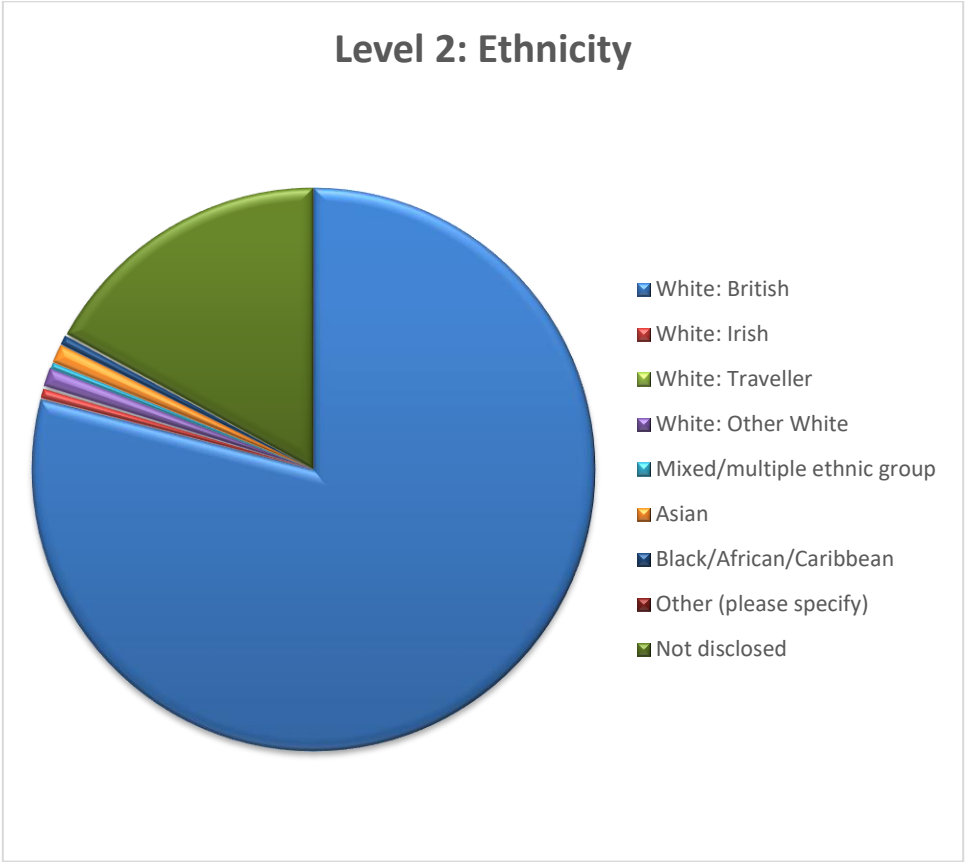


It is widely accepted that gender is a socially constructed term for roles, behaviours, activities and attributes that society considers appropriate for men and women. We have limited our gender categories to 4 options; Male, Female, Transgender and Non-Binary. Other options can be added as and when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

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

York Local Area Coordination Update Report 24

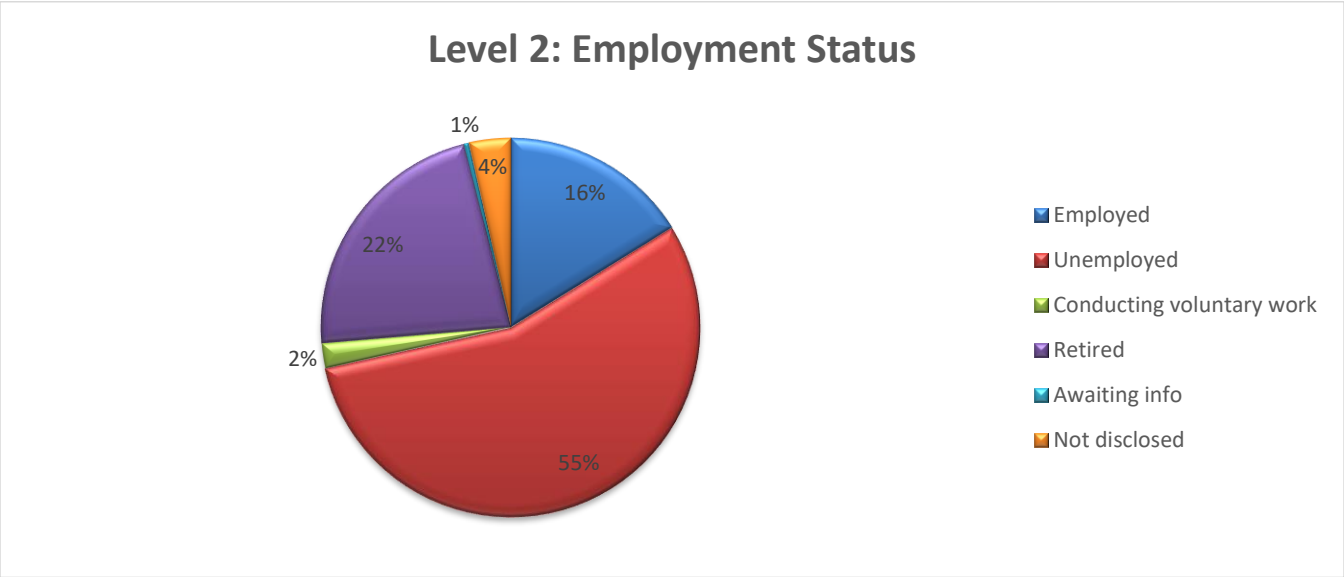
Ethnicity
We only collect this data for Level 2 cases.



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

York Local Area Coordination Update Report 24

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

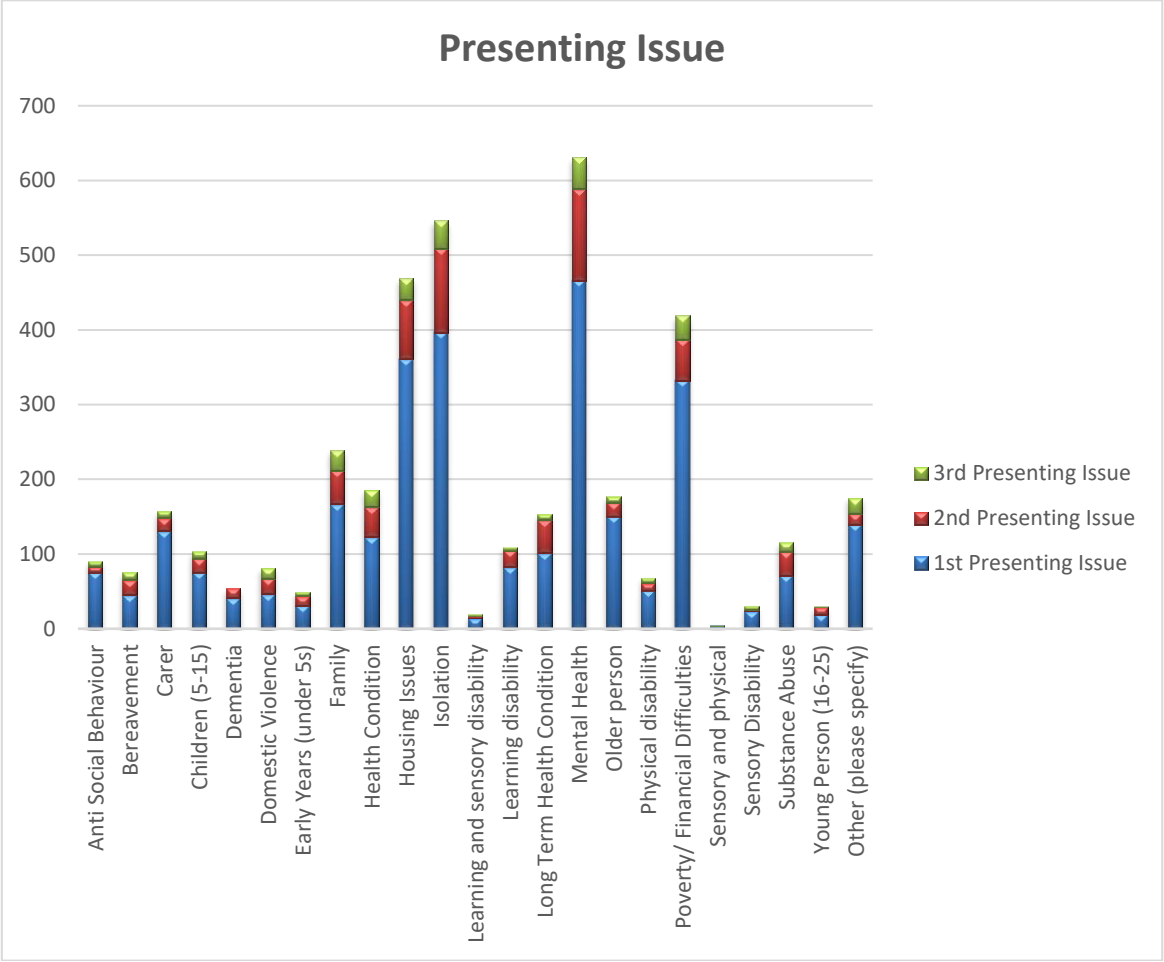


Over three quarters of cases are working with people who are Unemployed (55%) or Retired (22%), where 4% are not disclosed.

York Local Area Coordination Update Report 24

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.



York Local Area Coordination Update Report 24

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

York Local Area Coordination Update Report 24

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**

York Local Area Coordination Update Report 24

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**

York Local Area Coordination Update Report 24

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

York Local Area Coordination Update Report 24

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

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

York Local Area Coordination Update Report 24

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

Story 1: Mike's Story, Acomb

Introduction

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

Situation

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

York Local Area Coordination Update Report 24

What happened?

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

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

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

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

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

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

Critical elements

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

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

York Local Area Coordination Update Report 24

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

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

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

Without LAC involvement Mike would still be without access to his mobility scooter and his social network. This had potential to lead to more chest infections and hospital stays due to chest infections. Also a reduction in his mental wellbeing due to social isolation. Potential re housing or admission to the hospice which would have had a cost implication for either health or social care.

York Local Area Coordination Update Report 24

Story 2: Cathy's Story, Clifton

Introduction

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

Situation:

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

What happened?

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

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

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

York Local Area Coordination Update Report 24

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

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

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

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

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

York Local Area Coordination Update Report 24

Critical elements

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

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

York Local Area Coordination Update Report 24

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

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

Introduction

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

Situation

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

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

What happened?

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

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

Critical elements

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

York Local Area Coordination Update Report 24

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

<u>Outcomes for individual:</u>

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

<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.

Reduction in missed appointments with health care provision as Shaun now feels able to contact services to cancel in advance of appointments meaning these can be issued to someone else.

Identifying with Shaun who he can contact for support in times of need means that he is not waiting until a deterioration in his health or property condition before asking for help. By making an introduction to and receiving weekly support from Help at Hand Shaun is now eating a healthy balanced diet, by living a healthier lifestyle Shaun will likely reduce his use of Primary and Secondary Healthcare.

Story 4: Bobby's Story – Guildhall

Introduction

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

Situation

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

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

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

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

What happened?

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

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

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

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

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

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

York Local Area Coordination Update Report 24

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

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

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

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

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

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

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

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

Critical elements

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

York Local Area Coordination Update Report 24

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

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

York Local Area Coordination Update Report 24

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

Story 5: Patricia's Story – Haxby & Wigginton

Introduction

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

Situation

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

What happened?

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

York Local Area Coordination Update Report 24

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

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

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

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

York Local Area Coordination Update Report 24

Critical elements

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

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

York Local Area Coordination Update Report 24

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

Story 6: Diane's Story – Heworth

Introduction

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

Situation

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

What happened?

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

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

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

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

York Local Area Coordination Update Report 24

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

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

Critical elements

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

York Local Area Coordination Update Report 24

Outcomes for individual:

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

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

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

Previously Diane has required increased support from mental health teams however, with encouragement and support at the right time this was minimised and now reduced significantly. Council tax and rent arrears were significant, however no action was taken by LA due to the support Diane received and management of her debts. The introduction of her child to another LAC was very timely due to the difficulty they were having and this has arguably reduced the impact on other formal services.

York Local Area Coordination Update Report 24

Story 7: Tom's Story – Huntington

Introduction

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

Situation

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

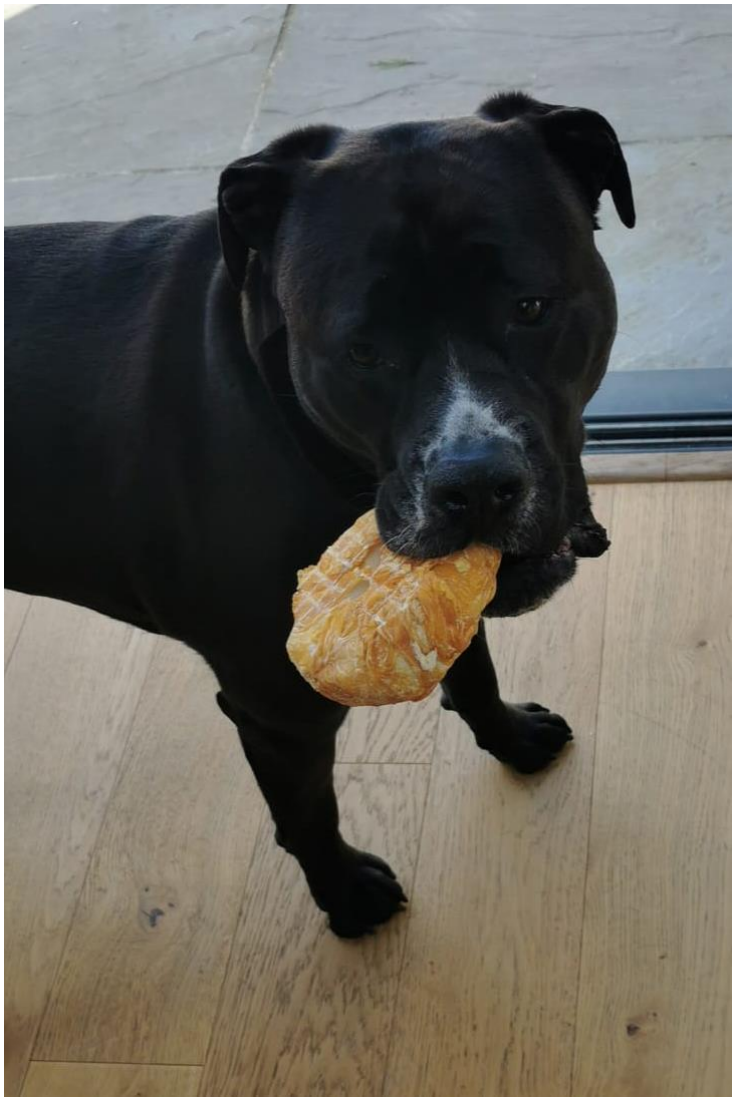
What happened?

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

York Local Area Coordination Update Report 24

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

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



(Roxy's payment in treats)

Critical elements

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

York Local Area Coordination Update Report 24

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

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

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

Without LAC involvement Tom would continue to feel isolated in his community and to be reliant on his father to provide things to do or companionship. Tom has been able to start to grow in independence and contribute towards his community, which in turn prevents him from returning to statutory services.

York Local Area Coordination Update Report 24

Story 8: Bev's Story – Micklegate

Introduction

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

Situation

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

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

What happened?

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

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

York Local Area Coordination Update Report 24

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

Critical elements

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

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

York Local Area Coordination Update Report 24

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

<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.

Boiler serviced and running safely as well as a working toilet, improving health and wellbeing long term

Bev attending a weekly group so developing social contact and reducing isolation.

Bev meeting with LAC weekly

Bev leaving home, has attended groups, and had one trip to Rowntrees Park Café. Bev has ventured into town a couple of times so working towards the better quality of life she wants.

York Local Area Coordination Update Report 24

Story 9: Issac's Story – Westfield

Introduction

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

Situation

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

What happened?

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

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

Critical elements

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

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

York Local Area Coordination Update Report 24

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

<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.

In Isaac's own words:

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

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

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

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

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

York Local Area Coordination Update Report 24

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

Opening narrative from Alan in his words:

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

York Local Area Coordination Update Report 24

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

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

"I think that says it all really.

"Apart from this one final thought:

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

Introduction

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

York Local Area Coordination Update Report 24

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

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

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

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

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

York Local Area Coordination Update Report 24

Situation

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

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

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

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

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

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

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

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

What happened?

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

York Local Area Coordination Update Report 24

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

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

Critical elements

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

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

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

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

York Local Area Coordination Update Report 24

								Dad and his partner.

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

Reflections from Mel:

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

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

"Enter Jennie.

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

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

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

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

"But then it didn't work out.

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

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

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

York Local Area Coordination Update Report 24

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

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

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.

York Local Area Coordination Update Report 25

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.

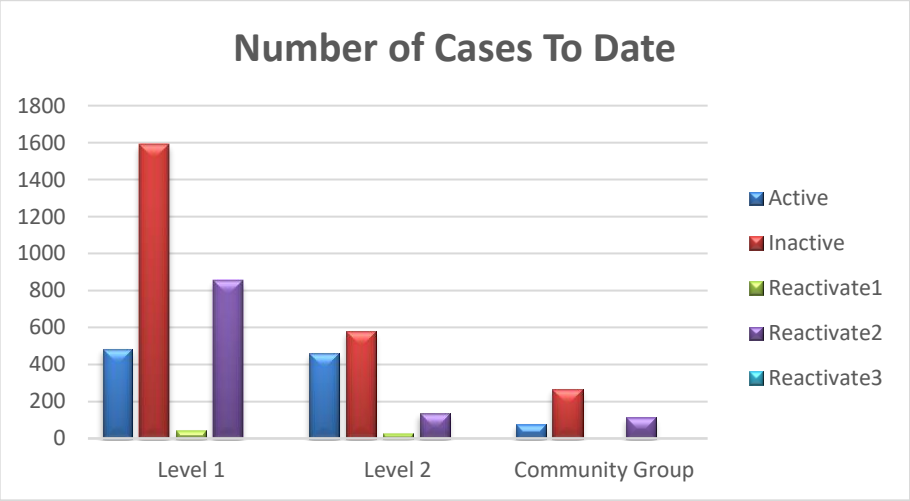
York Local Area Coordination Update Report 25

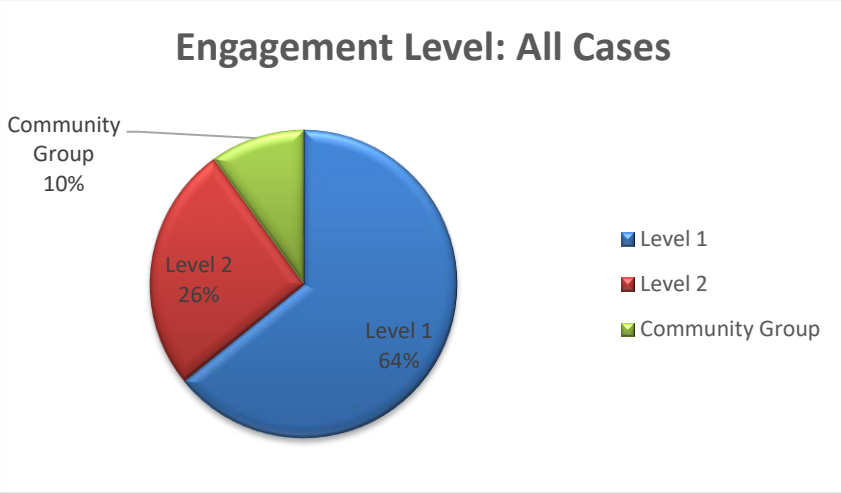
Section 2 - Engagement Level Analysis

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.

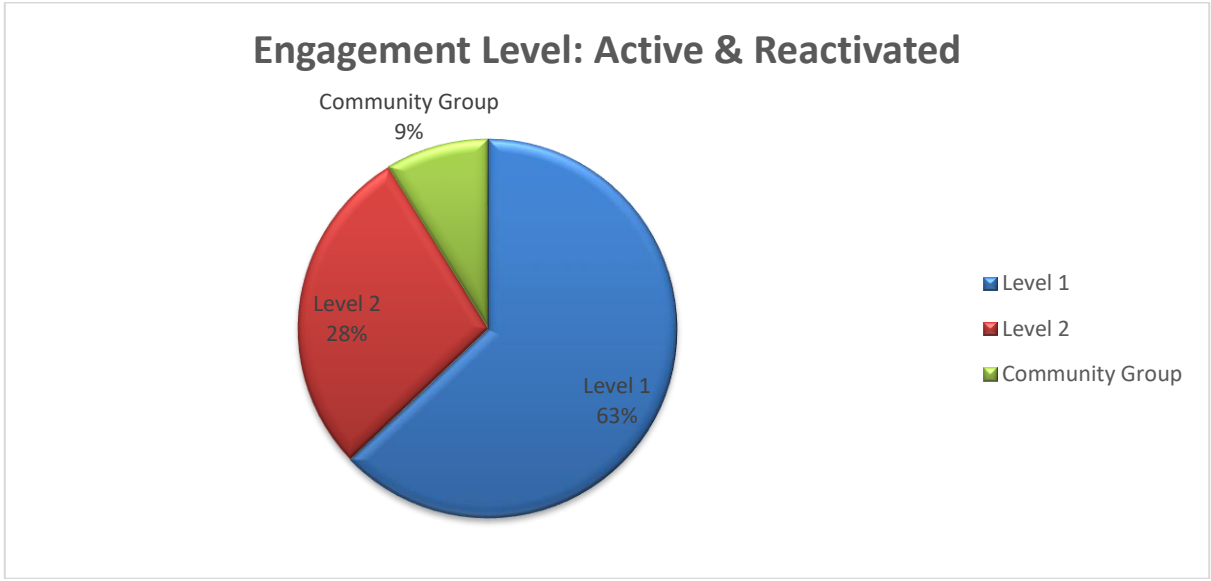




The total number of people the team have worked with to date is **4630** and currently **2193** are active (including reactivated cases). The pie chart shows the split for all people whether they are still active or inactive. This shows that over half of people introduced have been on a

York Local Area Coordination Update Report 25

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.



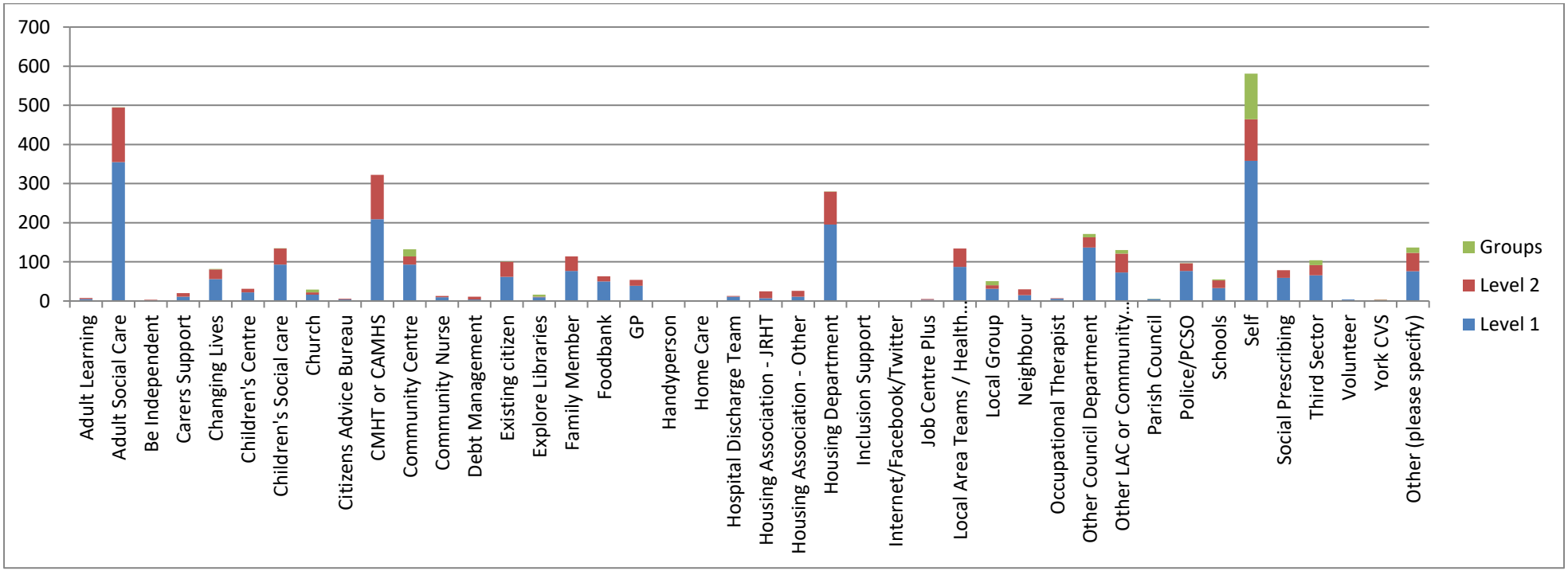
The second pie chart shows the split between the three levels of support for all active cases (including reactivated cases). Currently there are 1380 active at Level 1 (63%), 621 at Level 2 (28%), and 192 are classed as Community Groups (9%).

York Local Area Coordination Update Report 25

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.

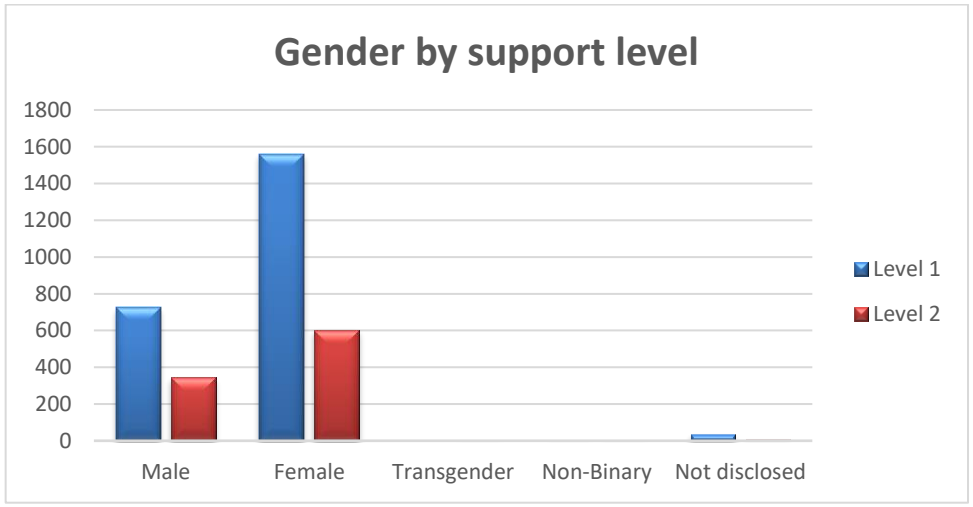
When you just look at Level 1 and Level 2 introductions then most referrals have come through Adult Social Care (15%), Self (14%), and and Mental Health services (10%) which account for 39% of all introductions to date.

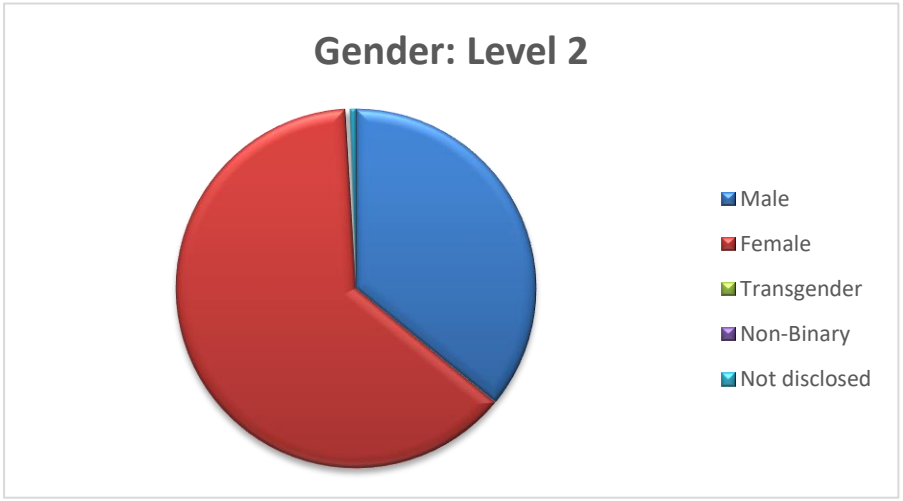
York Local Area Coordination Update Report 25

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



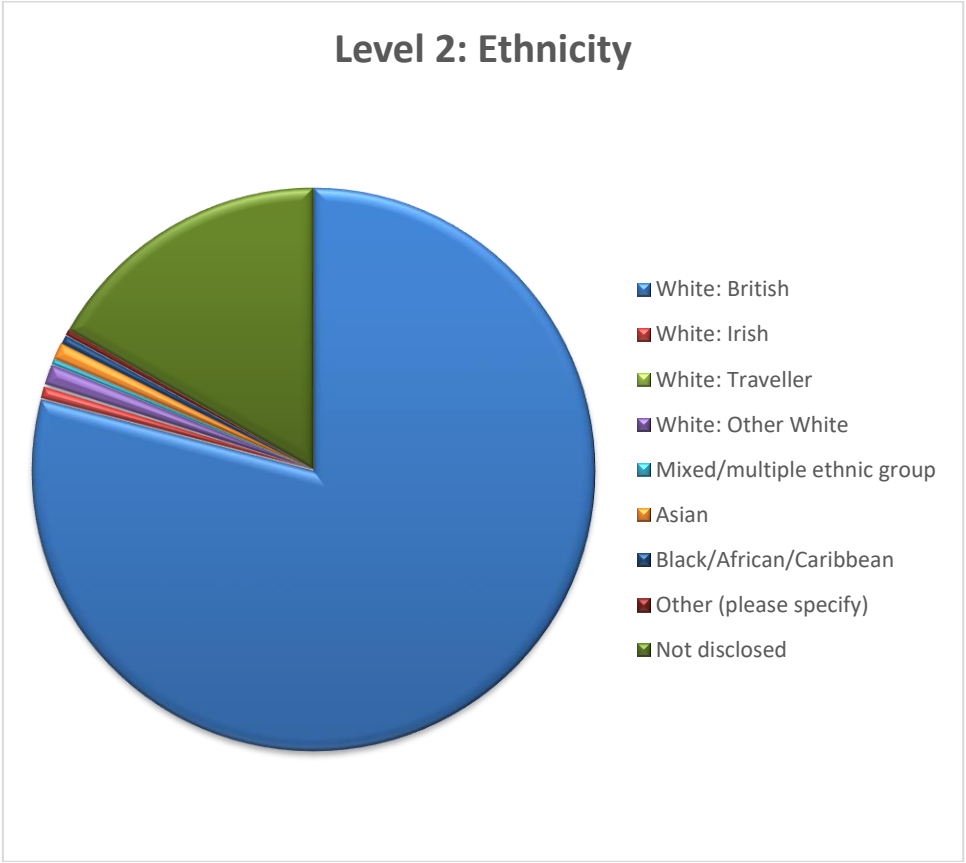


It is widely accepted that gender is a socially constructed term for roles, behaviours, activities and attributes that society considers appropriate for men and women. We have limited our gender categories to 4 options; Male, Female, Transgender and Non-Binary. Other options can be added as and when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

York Local Area Coordination Update Report 25

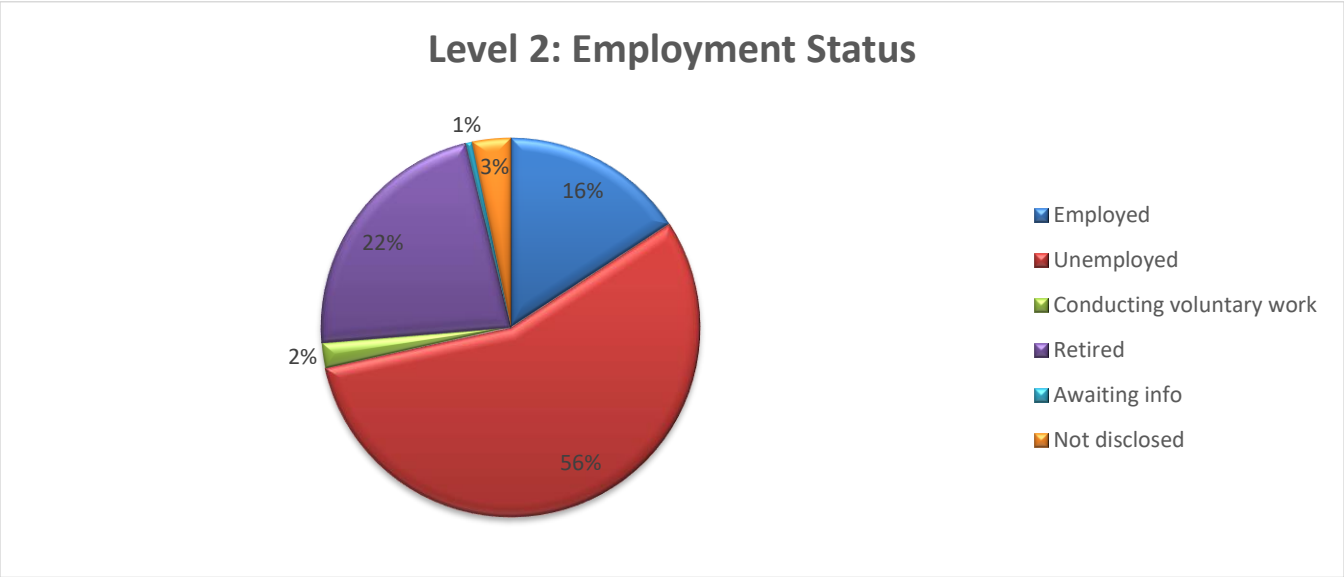
Ethnicity
We only collect this data for Level 2 cases.



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.

York Local Area Coordination Update Report 25

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

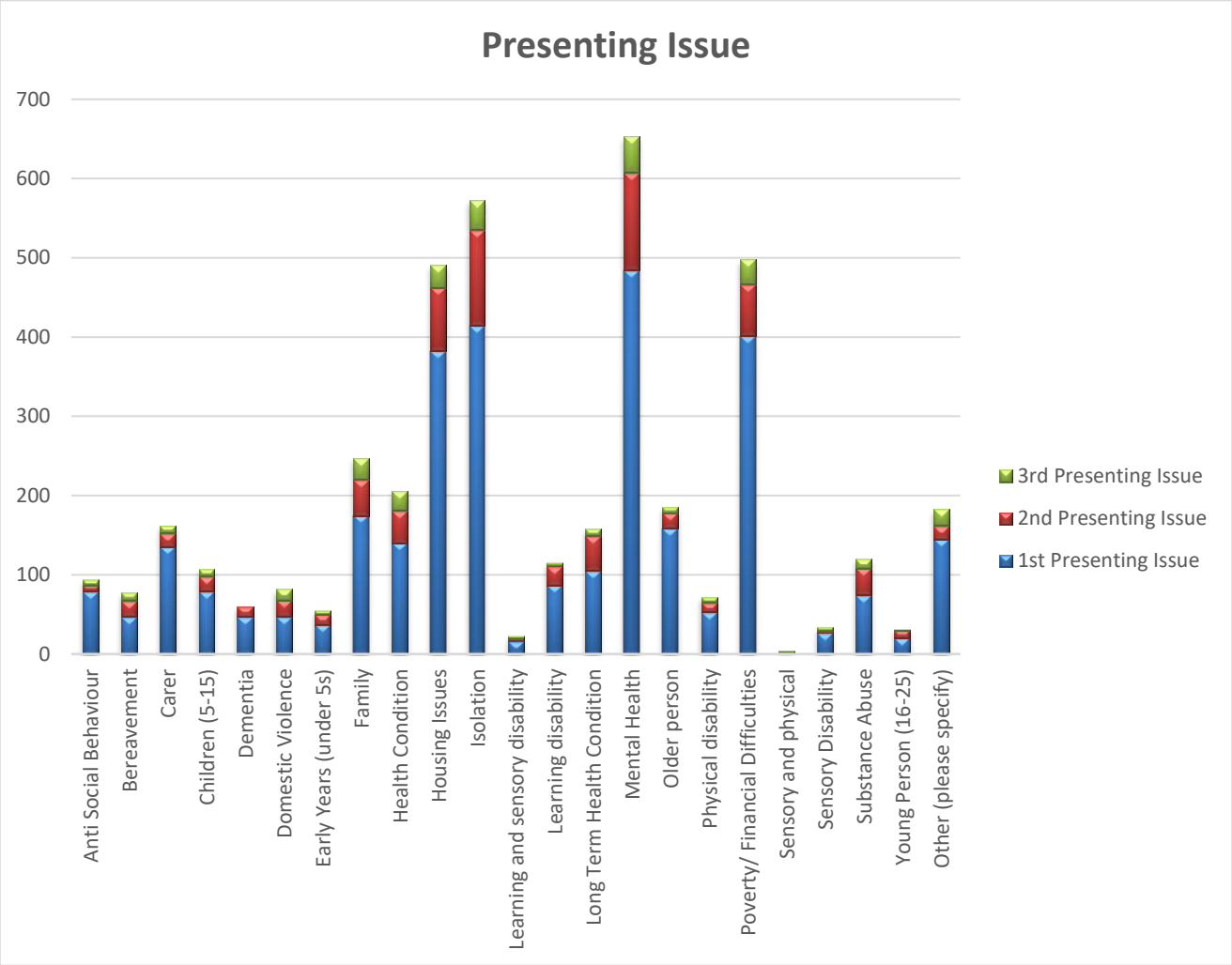


Over three quarters of cases are working with people who are Unemployed (56%) or Retired (22%), where 3% are not disclosed.

York Local Area Coordination Update Report 25

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.



York Local Area Coordination Update Report 25

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.

York Local Area Coordination Update Report 25

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**

York Local Area Coordination Update Report 25

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**

York Local Area Coordination Update Report 25

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**

York Local Area Coordination Update Report 25

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.

York Local Area Coordination Update Report 25

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.

York Local Area Coordination Update Report 25

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

York Local Area Coordination Update Report 25

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?

York Local Area Coordination Update Report 25

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.

York Local Area Coordination Update Report 25

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.

York Local Area Coordination Update Report 25

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

York Local Area Coordination Update Report 25

								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.

York Local Area Coordination Update Report 25

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.

York Local Area Coordination Update Report 25

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

York Local Area Coordination Update Report 25

								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.

York Local Area Coordination Update Report 25

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.

York Local Area Coordination Update Report 25

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.

York Local Area Coordination Update Report 25

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.

York Local Area Coordination Update Report 25

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.

York Local Area Coordination Update Report 25

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.

York Local Area Coordination Update Report 25

- 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.

York Local Area Coordination Update Report 25

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.

York Local Area Coordination Update Report 25

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?

York Local Area Coordination Update Report 25

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

York Local Area Coordination Update Report 25

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.

York Local Area Coordination Update Report 25

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.

York Local Area Coordination Update Report 25

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.

York Local Area Coordination Update Report 25

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?

York Local Area Coordination Update Report 25

			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.

York Local Area Coordination Update Report 25

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.

York Local Area Coordination Update Report 25

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:								

York Local Area Coordination Update Report 25

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.

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

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Annex 7 - 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.

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.

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, demonstrating reciprocal care and community mindedness.

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. Robert is aware of current affairs and enjoys debating current issues with the LAC.
- 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.
- Creative solutions were offered that remained person centred and strengths based, such as involving local community organisations.
- 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.

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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Annex 8 - LAC and Social Prescribing blogs

The power of the relationships between Social Prescribing and Local Area Coordination in York

Jasmine Howard is the manager of the Ways to Wellbeing Social Prescribing service in York. Jennie Cox is a Local Area Coordinator working in the same area of the city as Jasmine. Ways to Wellbeing has been operating in York for nearly two years, the Local Area Coordination was rolled out in York just over a year ago.

When Jasmine and Jennie heard about the lack of cohesion of these approaches in other areas, they were keen to share their reflections about how well they have worked together.

The wider context in York and cultural shifts

Jennie reflects - Local Area Coordination and Social Prescribing have evolved side by side over the last year in York at a time of shared vision and action. The groundwork had been set for a real culture shift within not just the Council and services but the wider community before I came into post. Mine and Jasmine's roles play an important part in that. The approaches encourage a bigger picture way of thinking and the flexibility to work with individuals and families in the way that suits them and values their strengths and the strengths of others in their community.

Jasmine reflects - Jennie works in a defined geographical area with introductions coming from a range of people and places. I am based within primary care in the East of the city so receive referrals from a smaller base within a bigger area. Our work is therefore targeted in different ways. Between us, I think our reach is wide.

I have introduced people to Jennie when having a longer-term relationship with someone has been important in building a positive vision for the future. But how we work together is bigger and more difficult to quantify than introductions and co-working, it is about culture. For me, the arrival of a new Head of Commissioning (Early Intervention, Prevention & Community Development) and Local Area Coordination bought with it a real culture shift from within the Council and across the city. This supportive context helped me feel more supported working in social prescribing. The environment has been such an important factor in how Jennie and I work together. We have never been pitted against each other but in contrast have been part of each other recruitment processes, have managers on each other's steering groups and have

had shared training opportunities. Time has been spent articulating to others where Local Area Coordination and Social Prescribing both sit in prevention. From the beginning the conversation has been around how we are better together.

Jennie reflects – The introduction of the Local Area Coordination programme has really benefited from the positive links already forged with the CVS. This gave us a strong ally in Jasmine, and the rest of her team as this expanded. We have widened these positive joint working practices to the development of a 'Practitioners Forum' which welcomes other services with social prescribing or community connection functions to meet regularly to share good practice and offer invaluable peer support. We are often asked if there is an overlap or duplication in our work, however we have forged such smart ways of working in coproduction that I couldn't now imagine one without the other.

Jasmine adds to this - Jennie and I meet on a regular basis with other colleagues for peer support. This works so well, I think largely because we share the same values – being collaborative, person centred and strengths based. These meetings are a chance to share knowledge, skills and experience, to come up with creative solutions but also to have a coffee and get to know each other as people. This friendliness helps with cohesion. We all share spirit and pride in what we are doing.

The power of relationships and the practicalities of co-production

Jasmine reflects - Local Area Coordination and Social Prescribing are both new ventures in York. There's been a lot to learn, and I feel we have done some of this together. Jennie and I have talked a lot about the volunteering pathway within Social Prescribing as well as some of the other resources we have access to. I have found Jennie a great person to think outside the box with. We've had honest conversations about things we've set up that haven't gone to plan so we can both learn from this.

Both Local Area Coordination and Social Prescribing approaches consciously spend time building community connections. Jennie and I have worked together to build and maintain relationships, inviting people to our peer support meetings, meeting people together and knowing each other's roles well enough to put each other in touch with others.

Jennie reflects - Jasmine has provided an important link to health services which has facilitated collaborative working to produce better

outcomes for the people I have been walking alongside. On a more personal note Jasmine is someone who is always at the other end of the phone and happy to talk through any situation with and will always ask ‘is there anything I can do to help?’ We offer each other regular informal peer support and I feel our strong working relationship provides a good example to others in health and social care. We have supported each other when faced with challenges in the system and strived to join up resources to fill gaps in provision we have identified in the local area.

An example of an individual in our area who we have both worked with - SB came in to contact with Jasmine through his GP as he was struggling with complex long term health conditions, physical and mental. He was homeless at the time but linked to appropriate housing services. Jasmine discussed his strengths and interests with him, discovering his love of music. She linked him to a ‘Musication’ programme at a local community group, Tang Hall Smart, where he flourished and formed a band with other group members.

Through this connection to the community he was introduced to his Local Area Coordinator, Jennie. SB had fallen out of the housing system after an intentional homeless decision had been made and was living in a tent with deteriorating health conditions. Jennie helped him explore options around his housing and finances. Jennie contacted Jasmine to gain context of the previous situation and health information which helped to better inform options.

SB now has a permanent bed in a hostel, a keyworker and a referral to a housing scheme which is his preference as it is linked to his local church. He is awaiting a decision from a PIP application.

SB is keen to participate in his community and contribute in any way he can, connecting others to available services and groups. At a recent event as part of the Festival of Ideas in York, Jasmine presented regarding Social Prescribing and invited SB’s band to play. Jennie came along to support the event. SB told Jasmine excitedly the week before ‘Jennie’s coming too’. At the end of the event SB said a few words and reflected on the ways Jasmine, Jennie and Tang Hall Smart all had a positive impact on his life.

The common thread through all of these reflections is positive relationships and how powerful these can be when they work well – working together really does work better - on *all* levels.

Social Prescribing and Local Area Coordination is about much more than 'just signposting…'

Jennie Cox is the Senior Local Area Coordinator in York and Christine Marmion is the Project Manager of Ways to Wellbeing, the Social Prescribing service in the city. They came together to address 'the signposting question' which they found their teams were frequently encountering….

Jennie: Several months ago I saw a question posed on Twitter by the leader of the Social Care Futures movement – "Social Prescribing, isn't that just social pointing at stuff?" I was quick to reply that this was definitely not my experience of the model operating in York, reflecting on a positive story of collaboration and relationships I had told with Jasmine Howard, the original Project Lead for Ways to Wellbeing social prescribing service, back in June 2018. I was challenged to write another blog articulating what else there was to Social Prescribing and Local Area Coordination in York which made it so much more than 'just signposting' and articulate how they were complimentary without duplicating. In the spirit of co-production, I invited the Project Manager of Ways to Wellbeing to write this with me.

Christine explains the model in York: Social Prescribing models differ across the country and can look very different depending on where you live in the UK. Our model supports individuals who are referred to us by Primary Care health professionals when an individual is accessing their GP's for non-clinical support. We link people to non-medical support from within the community to promote their mental and physical wellbeing in a holistic way. Ways to Wellbeing support people with a wide range of social, emotional and practical needs, including people with complex health needs, mild or long-term mental health problems or people who are quite simply lonely. We provide appointments in GP surgeries or out in the community. Patient feedback has told us that being embedded in the GP Groups allows patients to feel safe and provides the service with credibility. There is a natural synergy with Local Area Coordinators who are embedded in the wider system. Together we have a lot of agency and reach across the social sector.

Jennie reflects: Social Prescribing is a current buzz phrase which comes with a number of misconceptions. Many people imagine a prescription pad of social solutions, a fixed menu of options, but this is very far from the way that Ways to Wellbeing work. Local Area Coordination suffers from similar misconceptions and visions of LACs sitting with people drinking endless cups of tea and directing them to other places with leaflets and phone numbers. Of course, connecting people to activities, groups and services in the community and providing information and advice about these is a big part of what we all do, however, doing this without providing a supportive framework around this would be somewhat tokenistic. Which is why we offer flexible person centred support to those we work with. This involves being alongside them whilst they explore options to increase their wellbeing and live a good life. We are about relationships, listening, exploring options in a creative way, and helping to create options where very few exist which fit.

Christine adds to this: Collectively, we recognise that social issues can have a significant impact on a person's physical and mental wellbeing, where there is no health or social care solution. Ways to Wellbeing is a connecting service and we don't generally work with people long term but we support them to take the first steps to get to where they want to go. A lot of the people we work with need a little help to make what they feel are big changes. For those people struggling with their emotional health or significant life changes it can seem impossible to navigate or achieve the long term positive changes that are required to make a significant difference to their situation. This is where working alongside LACs can work really well as their time spent with a person can be longer term. Whether it is taking someone to a group before the activity starts so they can adjust to the environment or introducing individuals to group leaders, volunteers or other professionals so they feel confident they will know a friendly face. We are able to provide the additional support that is needed to take the first steps and connect. It is not just sign posting but supporting people to make simple changes to their lifestyle to improve independence and quality of life.

Jennie adds: Just signposting would add pressure to an already creaking voluntary and community sector and drain resources without putting anything back, which is definitely not our approach. Community capacity building is an important aspect of the roles of both of our teams. We work together to identify gaps in community provision or barriers to

engagement and find ways to overcome them. LACs do this through their connections in the local areas they cover and the wider system which enable them to link people together and encourage better use of resources, for example the sharing of buildings or equipment or encouraging flexibility and adapting of processes through their bottom up system change work. Ways to Wellbeing have developed a small grants fund helping to encourage sustainability of community provision and the development of new initiatives. Both programmes link in to volunteering pathways so people can share their skills and time with others, increasing social action and capital.

Jennie shares some thoughts on questions which arise about duplication: It's true there are a lot of commonalities between the York LAC and Ways to Wellbeing teams – we are person centred, strengths based, we are accessible by avoiding complicated referral processes and keep an open door rather than treating people like closed cases after a set amount of time or support has been offered. We are informal programmes of support which people enter in to voluntary relationships with which are alongside and are complimentary to formal service provision. We also share values and principles connected to sharing power, choice and control with people who are experts in their own lives.

Christine reflects: Across LAC and Ways to Wellbeing appointments are informal and individuals are allowed to set the agenda and set the pace. We provide time and space to explore what is important to a person, not rushing, acknowledging barriers and finding solutions. We use people's interests and values to create a person centred plan. We treat people as individuals and do not dictate to them what they should or should not do but provide information and guidance. We promote health responsibility, promote self care and encourage people to take control of their own health and wellbeing where possible.

Jennie adds: There are also some important differences – whereas Ways to Wellbeing are based in GP surgeries and take most of their referrals from GPs in primary care, LACs are more embedded in the wider system and take introductions from anywhere in the system, whilst covering discreet geographical areas as place based practitioners. The LAC is a broad approach which lends itself more to working with people and their families with more complex lives over a longer timeframe. Ways to Wellbeing have more focussed plans to connect individuals and increase wellbeing whilst reducing demand on GPs and health services. Most importantly, when addressing questions about duplication it is

helpful to point out there are more than enough people who want help from both programmes and both teams are in high demand. LACs continue to receive an average of five introductions (referrals) a week each and Ways to Wellbeing are operating a waiting list. We see this as indicative that both are needed and complement one another, offering choice, which is a good thing.

Christine adds: The cost of commissioning both programmes is low considering what we offer and the outcomes we have evidenced across our impact and evaluation reports. There have been a number of examples where joined up working between the Ways to Wellbeing Practitioner's and the LAC's have led to improved outcomes for the people we work with. Sharing knowledge and sharing information rather than guarding resources has helped with this. In the future we only plan to strengthen these relationships by exploring how we can use a whole system approach to evaluation and data collection.

Jennie summarises: We work together to manage demand and compare notes on where this is coming from, with our monitoring data often acting as a barometer of social need across the city. Our approach to working together is the opposite of silo working – we have sensible conversations about who would be best placed to offer support and no arguments about what is whose remit. Relationships, at all levels, is a common and important thread which we keep coming back to. We are positioned in very different parts of the system, with Ways to Wellbeing hosted by York CVS and LAC based in the Adult Contracts and Commissioning Team of the Local Authority. A large part of our funding comes from the same place, but we make it work and it works well.

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How Local Area Coordination can help us beyond this crisis towards a better future for all

communitycatalysts®
unlocking potential effecting change

local area coordination® network

Introduction

In this paper, we outline the Local Area Coordination approach before sharing our reflections on its impact during "Covid times". We then share how it can support multi-level recovery, renewal and rebuilding efforts by nurturing and sustaining the surge of community action we have recently seen. We conclude by encouraging more areas to join our growing movement, helping us take the Local Area Coordination approach to even more communities across England and Wales.

This is a co-produced report by the members of the Local Area Coordination Network which consists of the councils of Derby City, Leicestershire County, Kirklees, City of York, Thurrock, Wiltshire, Swansea, London Boroughs of Waltham Forest, Haringey and Havering.

Edited by Nick Sinclair and Cat Thomas.
July 2020

"Working with my Local Area Coordinator has not only made me want to live, it has for the first time in years, made me start to see there is a future. It has helped me come from feeling that I am completely useless, to realising that I do have qualities and I do deserve a life"

Recent feedback from citizen of Swansea.

CONTENTS

1 LOCAL AREA COORDINATION IN A NUTSHELL

Local Area Coordination is about:

- Supporting people and families achieve their vision of a good life, use their gifts and make their contribution.
- Helping communities to be self-supporting and to flourish.
- Transforming systems, building bridges and strengthening relationships between citizens, communities and services.

"This is about making services human, building trust, giving people the space to be themselves to make their contribution in their community. Local Area Coordination demonstrates that we do care about one another, that we want to be together and to pull through together."

Clenton Farquharson MBE.

Key Points:

- **It is an evidence-based approach[1] that emerged in Western Australia in the 1980's[2] & has been in England and Wales since the early 2010's.**
- **Local Area Coordinators are typically employed by their local authority but are rooted in communities of around 10,000 people.**
- **They can work with anyone in that community boundary.**
- **It is based on 10 core principles and key design features but is flexible to build on the strengths of local citizens, communities and service systems alike[3].**
- **It works!**

It's about citizenship and resilience not service dependency

The people and families who Coordinators are introduced to are often disconnected from others and facing complex physical health and wellbeing challenges. Coordinators invest time to understand a person's vision for a better life, focussing on their strengths and gifts to share and the natural support around them from family, friends and their community.

- **"Introductions" can come from anywhere and anyone.**
- **They have no pre-determined outcomes to work to, no time limits and no eligibility criteria for who they can support or as we would put it "walk alongside."**
- **They do not carry out formal assessments but remain highly accountable through something called "shared agreements".**

Where someone already has services in their life, Local Area Coordinators help people make sense of this, gradually reducing a need for external input by building relationships with those around them. Being so accessible and visible, they are often able to help prevent problems turning to crisis. This means that:

- **Local Area Coordination reduces costs to health and social care systems.**
- **Increases social value in communities as people move from being service users (or potential service users) to healthier, connected and contributing citizens.**

Evidence shows that working in this way addresses the wider determinants of poor health and addresses health and wellbeing inequalities[4].

"You couldn't capture much of this in an instruction manual. Local Area Coordination is compassionate, patient, thoughtful and relies on initiative, imagination and great relationship building."

David Robinson, Founder of the Relationships Project.

It's about building community assets and capacity

"Local Area Coordinators perform magic, we all knew that before this crisis, but where we had them in place, they proved pivotal in getting sustainable community-led support networks established. Their guidance, knowledge and example has created a learning network outside the council and all I ever hear is compliments for their work and 'what would we ever have done without them?!"

Councillor Mark Child, Lord Mayor of City and County of Swansea and former Cabinet Lead for Health and Wellbeing.

Local Area Coordinators are a resource to all in the place(s) they work. This includes helping local groups and organisations to develop and sustain their work whilst supporting people to establish new initiatives.

- **They are focussed on the assets that exist in communities, building knowledge of hyperlocal, neighbourly, non-service solutions and connections.**
- **They build collaborative relationships with organisations (charities, commissioned services, other statutory agencies etc.), to take and make introductions but also to support community capacity building.**

Evidence highlights that this helps communities to become self-supporting and welcoming places with natural supportive connections between neighbours, reducing a need for external service input[5].

"I find our Local Area Coordinator very approachable, knowledgeable and nothing is too much trouble to ask for advice. They can and do come to me for my knowledge of working within the community of York, as a volunteer"

John McGall, Community Leader in York.

"I have been consistently supported, advised and motivated by the Local Area Coordinators. My own wellbeing and capacity have been considered, as has my support requirements. As a volunteer and someone who values my community, the Local Area Coordinators have been invaluable."

Cindy Carter-Foster, Mutual Aid Group volunteer in Derby.

It's about improving and transforming local service systems

The leaders promoting Local Area Coordination often note that many of the systems surrounding local services are not fit for purpose and are in need of reform.

- **The Local Area Coordination approach can either support existing transformation plans or is a helpful starting point for influencing the change required to come up with new ones.**
- **Local Area Coordinators have a foot within communities and also within local health, social care, housing and third sectors. This helps them broker powerful, bridging connections and build trust.**

Leaders of local statutory systems, political leaders and community representatives come together to invest in and sustain Local Area Coordination as a Leadership Group. They do this by earmarking new funding, but also by recycling funding for roles that may be vacant or projects coming to an end. Beyond this, the group takes on a 'leaders of systems change' role, listening to stories of what works well and what doesn't, taking action as a result. It also enhances broader opportunities for collaboration, promoting integrated service working e.g. joint commissioning and co-production with communities. Local Area Coordination reduces costs to the system and supports stronger, more person-centred and more sustainable services[6].

Local Area Coordination is partly about clearing space 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[7]. 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 challenging times both individually and collectively. As a result of the Covid-19 Crisis it is likely that the next few years are going to be some of the toughest our country has ever had to face and just mitigating the impact of these pressures alone will be an enormous challenge. We explore this in the following section.

2 "WEATHERING THE STORM" LOCAL AREA COORDINATION DURING COVID TIMES

"Self-isolating has been a very emotional time for so many people but by listening we have truly made a difference helping individuals find the right connections for them. One of our team has managed to connect five individuals together all of which are shielding but speak on a regular basis over the telephone and will be meeting up once restrictions begin to lift."

Karen Dobson, Senior Local Area Coordinator Thurrock Council.

The current Covid-19 crisis highlights much of the theory and logic that underpins the Local Area Coordination approach.

- **It has been evident across our Network that it fosters hyper local neighbourliness and trusting relationships between communities and local service infrastructure[8].**
- **These relationships have enabled and supported community-led groups to use their natural capacity to respond quickly and effectively during the crisis.**

Coordinators have had to quickly adjust and adapt the way they work during this time[9] to support the new challenges faced by individuals, families, communities and local service organisations alike. They have used their creativity to continue helping people to recognise their value and strengths and to tap into the amazing support abundant from neighbours and community groups alike[10].

Although the way we work is different because we're not face-to-face with those residents, it's great to be able to focus on strengths and our person-centred way of being...We have also been able to reflect with other colleagues, helping to embed the strength-based way of working more broadly.

Andrea Wershof – Senior Local Area Coordinator Haringey Council.

LACderby @LACderby · May 16

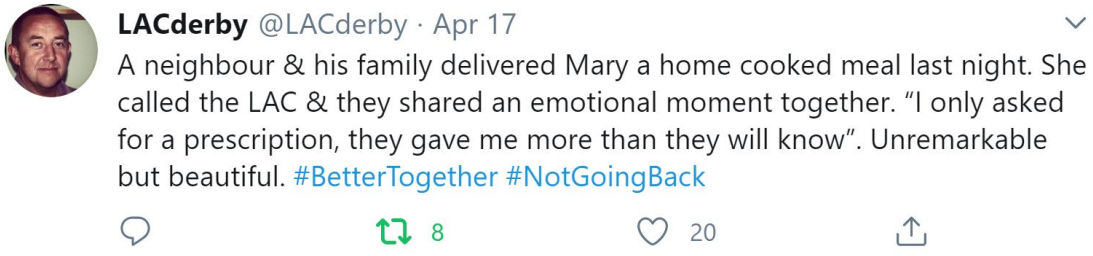
A person called our hub today. No food, struggling with their thoughts and worried about what they would do next. Immediate contact with a MH Firstaider & an LAC. 6 hours later they have food, connection to neighbours, support info and a plan to go forward with. #NoGoingBack

5 45 206

Stories of Community Power during Covid Times. Zoom on the Doorstep.

This story from Waltham Forest highlights the importance of Local Area Coordinators supporting flexible, practical action and holding strong knowledge of community assets.

A Local Area Coordinator was introduced by a Social Prescribing Link Worker to a resident who was due to start learning English (ESOL) through Zoom but who was anxious as she couldn't use it. As she was in the neighbourhood the Local Area Coordinator was able to go round and support a Zoom session on the doorstep to practice using technology. With this practical help she picked it up quickly. It turned out from further chatting that the woman had no access to food. The Coordinator helped arrange this with a community member who she knew spoke the same language as the woman. The community member offered to support the woman with further Zoom sessions so they could get to know each other and so she could connect her with other community activity.



Neighbourly Support Without Hesitation

This example of neighbours supporting one another in Wiltshire prevented unnecessary formal interventions.

An older woman had recently been discharged from hospital following radiotherapy. She was introduced to her Local Area Coordinator by someone who worked for the Housing Association she rented from. Due to the treatment and subsequent shielding, she wasn't able to go out and buy her own food, collect prescriptions etc. The side effects caused severe tiredness meaning she wasn't able to cook herself a hot meal.

The Local Area Coordinator made contact with a local community group and explained the situation. Without hesitation they began to organise neighbours and members of the group to support this woman for as long as needed.

The woman is now being supported by her neighbours, receiving a different hot meal from a different neighbour every night and has built some lasting connections.

"A show of solidarity exhibited through neighbourly action is heartening to watch and help facilitate...the benefits to the people offering to help are just as important for overall community health and wellbeing, as the benefits to those who need help."

Tara Hughes, Local Area Coordinator Swansea Council.

"Thank you very much for all your help and support. I got the parcel, pukka it was! Can you please thank everyone for me? I really appreciate the help - everyone has given me hope...I'm glad I got u in my corner looking out for me - ur a diamond"

from a Thurrock resident to their Local Area Coordinator.

A Supportive Welcome to the Community

This story from Leicestershire shows how, by harnessing the support of community, a family were able to move out of temporary accommodation preventing a nightmare lockdown experience for them.

A Local Area Coordinator was introduced to a family who had been living in a refuge for some time. Just before the lockdown, they were offered housing. Unfortunately, all usual channels of support (such as charity shops and community grants) were not operating as normal and until vital household items had been sourced, they were unable to move. The local community had started a neighbourhood WhatsApp group in response to Covid-19 and the Local Area Coordinator used this to ask for help. Within a few hours, they'd had 12 offers of help and were able to provide all the items the family needed as donations. As a result, the family moved into their new home before lockdown. The family felt welcomed in to their new community and had access to community support.

HOLDING UP A MIRROR TO TRADITIONAL APPROACHES - Sarah Edmundson, Senior Local Area Coordinator Derby City Council.

The current crisis has held a mirror up that highlights the limitations of the traditional "top down" approach and generated space for a more collaborative, community-driven response to a wide variety of issues. For example, early in the crisis a number of residents were unable to pay for food as they had no access to money. Working with our local community infrastructure organisation we were able to respond quickly in ways the traditional services could not:

> **"We have created innovative solutions to meet a range of needs – working together to support community members to support each other. This includes a simple cash and voucher system, operating with minimal input from us, which enables people to purchase essential items for their neighbours who cannot currently access their own money or who don't have the means to pay".**
>
> – Kim Harper – Chief Executive Officer, Community Action Derby

Circumstances have allowed us to have equal conversations with people at every level within the local authority and our contribution throughout the crisis has been highly valued. There is real opportunity in Derby for a significant culture shift across the whole local authority, across all directorates and beyond into the health, community and voluntary sector and there is a strong appetite for Local Area Coordination values to be at the core.

3 HOW LOCAL AREA COORDINATION WILL SUPPORT RECOVERY, RENEWAL AND REBUILDING

Local strategies are now being developed to confront post Covid challenges and reduce their impact. This is happening against a backdrop of the need to rebalance, reset and reimagine the relationships between local councils, health institutions, communities and citizens. Much of the leadership on how this might look has already been articulated preceding this crisis, for instance Social Care Institute for Excellence (SCIE), Social Care Future, Local Government Association (LGA), Coalition for Collaborative Care (C4CC), The Better Way Network, Think Local Act Personal (TLAP), Nesta, Hillary Cottam's Radical Help, The New Local Government Network (NLGN), Collaborate, Human-Learning-Systems and Asset-Based Community Development (ABCD). This radical thinking has led to leaders adopting Local Area Coordination as part of their efforts to do things differently.

We would like to outline here our collective perspective of the likely challenges on the horizon and the difference we think Local Area Coordination will make.

FOR INDIVIDUALS AND FAMILIES

LIKELY CHALLENGES ON THE HORIZON	THE DIFFERENCE LOCAL AREA COORDINATION WILL MAKE
• Those already facing poverty and exclusion are finding resources further stretched and meaningful support scarce • Many more people may lose employment, undermining the stability of households and families • People have had less contact with primary care and other community health services so much of the preventative/ early intervention work will not have taken place, impacting health • Stressors of isolation and lockdown may have exacerbated or introduced unhealthy habits into people's lifestyles • Poor physical health will have a negative impact on mental health and anxiety and depression will increase, limiting people's capacity to get back into their local communities, further entrenching social isolation and loneliness	**Local Area Coordinators will:** • Be present to help people and families tackle their challenges, rebuild their lives and make their contribution as we start to unlock • Prevent people who are isolated, as a result of lockdown and other reasons, from falling through the net and into crisis • Work alongside individuals and families, reducing future dependency on services by supporting natural connections between neighbours and community groups

THE VITAL LINK AND A CORE SOLUTION - Karen Starkey, Transformation Programme Manager, London Borough of Havering

During the Covid-19 crisis Havering Council and our partners have become increasingly connected with the incredible strengths and assets of Havering's communities. Community spirit has shone through and it has brought us much closer with our voluntary and community sector partners. There is a growing sense of optimism and anticipation around where we go next. It has been evident that Local Area Coordination is going to be a vital link between the council, other statutory partners, citizens and communities alike. We have been using the approach alongside our strengths-based practice model in adult social care to train the council's call centre operations for Covid-19, work with our community volunteers to build resilience and keep people out of services. Local Area Coordination is a flagship initiative for Havering and leadership and commitment for this has not waned, but is seen as a core solution going forward.

FOR COMMUNITIES

LIKELY CHALLENGES ON THE HORIZON	THE DIFFERENCE LOCAL AREA COORDINATION WILL MAKE
• The incredible energy that has been unleashed in communities may be lost or eroded especially if groups are overlooked in local service planning and design • Community resources needed to respond to new social challenges will be tighter than in pre-Covid times where they were often already scarce • Decreased resources could increase competition, making groups more insular and less collaborative, putting pressure on many aspects of community life • There may be a lasting and divisive sense of 'the vulnerable' and 'the valuable'[11] in communities, exacerbating dependency and inequity rather than redressing it	**Local Area Coordinators will:** • Support plans to ensure community organisations (including local Mutual Aid groups) are at the heart of council, health and housing recovery strategies • Support community groups to re-purpose their efforts to meet future challenges e.g. austerity, unemployment and mental health • Help build/rebuild trust between local institutions and communities • Support growth of the good things / assets in communities, preventing them from being lost and overlooked, sustaining the new energy and passion for neighbourly support

BRINGING OUR DIVIDED SOCIETY BACK TOGETHER - Councillor Carol Runciman, City of York Executive Member for Adult Social Care and Health and Chair of York Health and Wellbeing Board

Throughout the COVID-19 pandemic, our team of Local Area Coordinators have demonstrated just how valuable they are. In York, they were already well established in their communities with plenty of local connections, which were just what was needed to be able to respond to the many issues they met. 'Walking alongside' residents to support them to solve problems themselves, [they] saved precious time for specialist services, enabling efforts to be focussed on those in greatest need. In many cases, some low-level help was exactly what was needed to stop small problems getting bigger, and that's what Local Area Coordinators really do well. Hard working, flexible, adaptable and kind, Local Area Coordinators are just what are needed to help bring our divided society back together again.

FOR SERVICE SYSTEMS

LIKELY CHALLENGES ON THE HORIZON	THE DIFFERENCE LOCAL AREA COORDINATION WILL MAKE
• The significant loss of revenue during this time will have a detrimental effect, with many areas having to re-enact programmes of cuts to services • Demand for services will increase as needs go unmet during lockdown and pressures on individuals and communities emerge • Health systems will be under significant pressure to respond to poor health, placing higher demand on primary care • Primary Care Link Workers will likely be flooded with referrals from GPs to prescribe people to newly defunded social activities	**Local Area Coordinators will:** • Support service cultures that are risk aware but not risk averse • Give everyone a common lens to see the power and potential of communities through, building trust and confidence and encouraging people to work collaboratively with community members[12] • Enhance existing community facing roles whilst over time replacing funded work that is not having the greatest impact • Save the system money as people are introduced to Local Area Coordinators earlier on for connections and practical support, rather than being referred in crisis to health and social care services for assessment and funded support • Create social value as people start to make their contributions by supporting others in their communities

A CITIZEN LED MOVEMENT - Sharon Houlden City of York Corporate Director for Health, Housing & Adult Social Care

By using Local Area Coordination as a way to build relations with, and listen to citizens and communities, the council and our health partners have started to understand what is working well and what isn't across our city. We are using this learning to change and improve the systems that are getting in the way of our vision of an asset-based area that starts with people. We describe this as a citizen-led movement of community development, where we will empower people to find solutions that work for them, and where we strive and enable, rather than direct and prescribe.

OUR 'NEW NORMAL'
- Councillor Mark Child, Lord Mayor of City and County of Swansea and former Cabinet Lead for Health and Wellbeing.

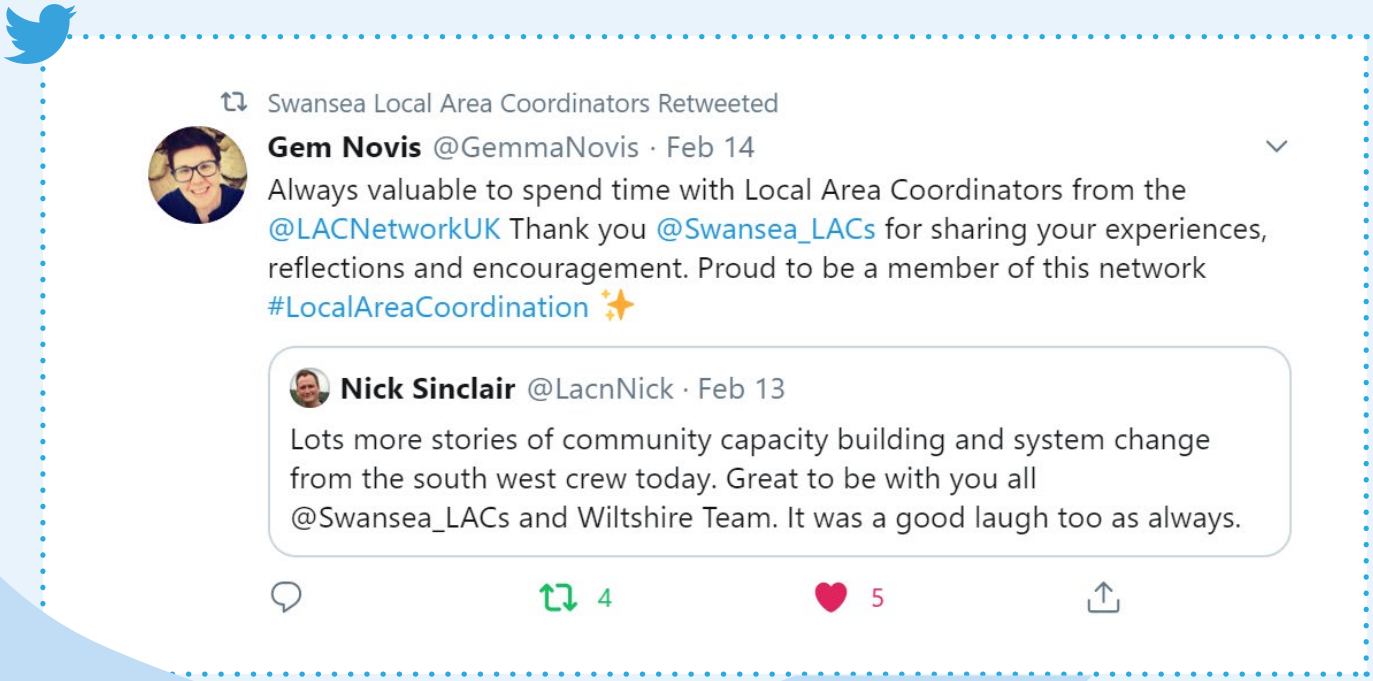
This crisis has made significant changes to the way Health and Social Care works, driven by two things; 1. the need for organisations to try and move non-Covid patients and clients out of the system whenever possible, and 2. by individual citizens deciding that they want a different type of support, often less, and in a different environment. Both of these issues play straight in to the work that Local Area Coordinators operate in, i.e. preventing, reducing and delaying service interventions in people's lives and building sustainable, supportive community networks. Both Health and Social Care have been working under severe stress before the Virus, and a new way of working was desperately needed that has now arrived. They see the benefits of this but we need to make it sustainable. This means citizens taking more responsibility for their own health and wellbeing, and who better than your friendly neighbourhood Local Area Coordinator to walk with them to achieve that. It has now become a major priority to secure long-term coverage and funding in our council and from our health partners as Local Area Coordination will be a key aspect of what our 'new normal' looks like.

It has been a rocky ride at times, particularly in relation to funding, however we have still maximised Local Area Coordinator availability across Swansea, increased political demand for more and embedded the principles in to how we operate. It has met with many of the demands of the Future Generations Act, prevented many calls on stretched services and made massive improvements to many people's quality of life. I hear many heart-warming stories of real positive differences Local Area Coordinators have made in people's lives. It shouldn't be amazing what a difference just sitting down with someone over a cup of tea and having a good chat can do for individual's wellbeing, and yet no service can do this. This is why they are so valued in the communities they work and the grassroots pressure to have them where they don't has grown since day one.

4 THE VALUE OF BEING PART OF A NATIONAL, NETWORKED LEARNING COMMUNITY

Our Network is the home of Local Area Coordination learning and development in England and Wales. It is supported by a number of research partners from different universities who support local and collective learning and evaluation. We have the dedicated resource to help us convene, reflect, share and learn. We also partner with new areas wishing to adopt Local Area Coordination, supporting them in all aspects of their design, development and implementation.

As members, we attend regular gatherings both in the community and online, opening up our learning, experience and resources. We support each other to tackle common challenges and build on our shared vision, principles and values. Since 2018 the Network has been part of social enterprise Community Catalysts.



Some perspectives on the Network

"The Network has knitted us into a family of people who all think and work to the same set of values and principles. A place where we can learn together and challenge each other's practice and thinking in a way only a family can do. During this time of Covid-19 it has never been so important. We have been able to share stories and learning together, to inspire and encourage each other. There's a saying, 'As iron sharpens iron, so one person sharpens another'. The Network helps us to keep sharp, to put our best foot forward, to work in the best way for our communities for today and the future."

From Claire McCarthy-Reed – Senior Local Area Coordinator, Swansea Council.

"The Local Area Coordination Network provides a much welcomed and unique opportunity for learning, and challenge, as well as strategic planning and growth. The knowledge and connections that exist within the members is impressively high and generously shared and there is genuine sense of it being a supportive and passionate movement of change. It has been a huge amount of support in our design, implementation and ongoing programme sustainment"

From Joe Micheli - Head of Commissioning for Early Intervention, Prevention and Community Development, City of York Council.

"Both before and during the Covid 19 pandemic our Network has regularly invited us to keep stepping back and reflecting on what we're doing and why we're doing it. When we went in to emergency response mode across our system in Kirklees, it was reassuring to know that the team and I had a regular space where we could meet colleagues across the country to connect virtually and share our learning. The Network has really helped us to recognise our achievements and highlight the elements of our work that are aligned with the principles of Local Area Coordination."

From Tamsin MacDonald, Local Area Coordination Manager, Kirklees Council.

5 WHICH WAY NEXT?

"There is nothing else quite like this and I don't know why it isn't everywhere. If you're interested in doing it though, do it right! There is so much more to this than just connecting and signposting. The people of the Local Area Coordination Network will help you."

Clenton Farquharson, MBE.

The challenges and opportunities we now face as a society are equally concerning and exciting. As we slowly start to emerge from crisis it feels like councils and other institutions are being presented with a tough question - "which way next?". One set of paths lead us to perhaps more familiar territory; enhanced gatekeeping of resource, reduction in services, pulling back from community and hoping for better times to come. Whilst another, sees us all intentionally building a powerful new deal based on the strengths and assets of our communities and the abundance of neighbourliness that is now so apparent.

Local Area Coordination is a key piece of this puzzle we now face. It will bring to life visions of more equitable, cooperative localities where people help people first and services remain in place as an essential and supportive backup to a functional society.

Over the next year our Network will be seeking a number of new partner areas to come and join our movement. We will support you from start to finish in the implementation of Local Area Coordination, getting you to a point where you are seeing the results that people, families, communities and service systems alike want.

Come and be part of this movement.

PLEASE GET IN TOUCH TO EXPLORE FURTHER

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www.lacnetwork.org

www.communitycatalysts.co.uk

Acknowledgements

We would like to extend our gratitude to Ralph Broad, the Founder of the Local Area Coordination Network and to Eddie Bartnik, one of the original key leaders of Local Area Coordination in Western Australia. Both Ralph and Eddie have remained a constant and generous source of support, encouragement and inspiration for our work in England and Wales. We look forward to further collaboration, supporting the international development of the approach.

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Ways to Wellbeing Annual Report 2021- 22

Service Review

Ways to Wellbeing is a full-time service, operating Mon to Fri, 9am to 5pm.

Q1 staff capacity
Q1 social prescriber hours: hrs pw = **1.8 FTE**
(3 social prescribers: 1 @ 20hrs pw, 1 @ 22.5hrs pw, 1 @ 25hrs pw, 1 on maternity leave)

Q2 staff capacity
Q2 social prescriber hours: 20hrs pw = **0.54 FTE**
(1 @ 20hrs pw, 1 on maternity leave)

Q3 staff capacity
Q3 social prescriber hours: 65hrs pw = **1.75 FTE**
(3 social prescribers: 1 @ 20hrs pw and 2 @ 22.5hrs pw)
1 social prescriber on maternity leave

Q4 staff capacity
Q4 social prescriber hours: 87.5hrs pw = **2.5 FTE**
(4 social prescribers: 1 @ 20hrs pw and 3 @ 22.5hrs pw)

Service data:

Referrals to W2W in the life of this SLA: 289

Gender:
201 females
88 males

Age:
(18-39)
(40-59)
(60-79)
(80-89)
(90+)

Primary reason for referral: Social interaction/leisure activities

Very closely followed by: Emotional health and wellbeing
Third most common reason: Exercise opportunities

Delivery outcomes (SLA 3.1)

Objective
1. People have more agency over their health and life choices
2. People experience increased self-confidence
3. People experience increased sense of wellbeing
4. Social benefits (inclusion, participation, access to new networks, feeling more connected to others)
5. Uptake of activities that promote physical and mental health (physical activity, arts and creativity, learning, volunteering)
6. Practical and material benefits (resolving problems with debt, benefit, housing)
7. Skills (linking people to opportunities for training, routes to employment)
8. Quality of life (reducing isolation, loneliness, lack of confidence and self-esteem)
9. Provide proactive case management, early intervention and preventative services, reducing the demand for primary and secondary care services.

Service user feedback data:

On discharge, all services users are asked four questions:

- Thinking back to when we first met, have you achieved the goals you identified with your Social Prescriber?

  93% achieved their goals

- Have you been to any new groups or services since working with your social prescriber?

  75% accessed new groups or services

- Do you feel more able to manage your health and wellbeing since working with your social prescriber?

  89% feel more are able to manage their health and wellbeing since working with their social prescriber

- If you hadn't worked with your social prescriber, would you have made these changes?

  86% said they would not have made their changes / accessed services / support without having worked with their social prescriber

SWEMWBS
(The Short Warwick-Edinburgh Mental Wellbeing Scale)

96 % of client scores indicated greater wellbeing
78% of client scores indicated an increase in self confidence
87% of client scores indicated a decrease in social isolation / loneliness

SWEMWBS is a seven-item self-report measure of mental wellbeing:

The 7 SWEMWBS statements (each with 5 ratable answers to choose from):
I've been feeling optimistic about the future
I've been feeling useful
I've been feeling relaxed
I've been dealing with problems well
I've been thinking clearly
I've been feeling close to other people
I've been able to make up my own mind about things
Additional question asked by W2W:
During the past 2 weeks, have you felt lonely?

Service user satisfaction

Social Prescribing feedback leaflets - feedback from people we have supported:

"I've had huge support from [my social prescriber] with building my confidence, I am more independent with an increased sense of wellbeing. I have got my life back on track"

"I am able to get out of the house again after a long time in. [My social prescriber] supported me to North Yorkshire Sport and it has increased my confidence, I'm now able to go to my local shop and working on getting back into community more"

"[My social prescriber] took time and gently encouraged me, I have attended some coffee mornings and go to knit and natter. I'm feeling better about mixing socially in the lounge area now. I have enjoyed having someone to talk to"

"Since working with [my Social Prescriber], A (who has dementia) now attends local coffee mornings at the church with their carer – we have seen an improvement in mood"

"I didn't know this service existed but now I have help managing my bills, post and admin tasks which were overwhelming before"

"Social Prescribing has made a huge difference to my life. Fantastic service – I will recommend to friends"

"I achieved all my goals and am more healthier, more sociable, more confident. I have been supported in connecting with the gym, Nordic Walking, Slimming World and City of York Health Trainers. I feel more confident. A lot calmer and able to handle crisis. My mental and physical health is much improved."

"Feel more confident in myself. Been good having someone by my side. Felt listened to. Made me feel important and that my needs should come first"

"Mental health and wellbeing is complex and individual. Social contact and belonging to any group is something I find really difficult. Without being listened to I wouldn't be going to any taster days (Archaeology on Prescription). The interest and support in going has far outweighed the anxiety"

"My goal was to meet people in the local community and build structure to my life after losing my husband and the pandemic. I feel much more motivated since working with [my social prescriber]. It has made a big difference to me, to be listened to and to start to look after me)"

Service user feedback from other sources:

"I really enjoyed the art group and can't wait to go again! I feel confident to get the bus next time too. I have barely left my home in recent months and after seeing a couple of ladies at the group in wheelchairs I feel less self-conscious of my own limited mobility."

(Participant feedback from our Cuppa and Craft sessions at York Art Gallery)

"With it being my first visit I didn't take part in any of the craft. But I was made to feel very welcome and had very good chats with others.
I am looking forward to the next time. I feel it will be a good avenue to help with my mental health.
Even after I return to work. I will still continue to go, and I am sure I will get approval from work.
I look forward to hearing from you. I continue to go to … [local café] ... and have started making friends there.
Thank you for your continued assistance"

(Participant feedback from our Cuppa and Craft sessions at York Art Gallery)

"The support you have given me has been the best I've had, very organised and you help organise things for me in a way I can manage.
I can tell early on people who care about their work. You look out for things that will help, and keep in contact with me. Then organise and offer help in useful ways that other services haven't."

(Message sent to their W2W social prescriber)

Stakeholder feedback

"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.

This collaborative approach for vulnerable patients who struggle to access mainstream out-patient clinics and social activities without support has been invaluable.

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"

Cath Speechley,
AHP York Community Therapy Team Lead
Care Group 1
York and Scarborough Teaching Hospitals NHS Foundation Trust

I can honestly say that the service is a tremendous support to our patients who require further therapy input or support with regards to minimising social isolation. I have found that the prescribers do their utmost in all ways to enhance quality of life and isolation for the older population. I have experience with referring one particular patient and the service made an incredible and positive difference to her life by the input from not only themselves by working with her to allow her to attend a social group independently, but the wider voluntary services included which all added to enhance independence and wellbeing.
Long may it continue.

Claire Stockton
Generic Therapy Assistant
York Community Therapy Team

Feedback from a patient who I referred to W2W. He said 'I don't know what I would have done without the support from the therapists and ways to wellbeing. Now I can go out and meet people again.'
This is from a patient who has mental health issues where we have observed a noticeable difference in his mental wellbeing following support from W2W with social prescribing and employment advice.

Rebecca Hall
York Community Rehab Team

Ways To Wellbeing has been a great option for finding support with issues that our clients with neurodevelopmental conditions might have. Many of our clients are socially isolated, and W2Wellbeing has been a way to have support with finding meaningful activities that are taking place in the community, and have support with exploring and accessing them. Many of our clients have interests and wish to meet other people, but taking steps to take action can be daunting, and so having a W2Wellbeing worker offer help with first steps is key.

Dr Katja Osswald, Consultant Clinical Psychologist
Adult Neurodevelopmental Service
The Retreat, York

System change outcomes (SLA 3.1)

10. More choice made available to people through supporting a widening range of non-clinical options delivered by VCSE sector organisations
11. More appropriate and effective contact with clinicians in primary and secondary care settings
12. Promote and support integrated health and social care, partnered with the voluntary, community and statutory sectors.
13. Build relationships across the VCSE sector, identify gaps in provision and work together across the system to address these gaps
14. Provision of a social prescribing model that continues to be fit for purpose across the city, and which can adapt to change

Expanding non-clinical VCSE options

Transitions CIC (equine therapy) - funded equine therapy sessions and a nature therapy group for people who have trouble engaging with conventional talking therapies. Agreed referral criteria and pathway for social prescribers. Signposted them to Local Area Coordination and useful local contacts and resources.

York Archaeological Trust (YAT) - We were approached by YAT for information about social prescribing in York, and advice re their Heritage Lottery 'Archaeology on Prescription' funding bid.

YAT (York Archaeological Trust) - consulted us about their proposed new Archaeology on Prescription project, and to explore social prescribing more widely.

We also signposted them to potential referrers including Local Area Coordination and useful local contacts and resources. Explained the coming changes to the health and care system (ie CCGs going, Humber Coast and Vale ICS, York Health and Care Collaborative)

York Learning - Agreed a bespoke process for social prescribers (W2W and Primary Care Link Workers) to refer people to York Learning courses (non-accredited, and accredited by arrangement), with course fees waived. This collaboration has wide-ranging potential benefits: learning opportunities for people who could not otherwise afford them; digital skills development (the online application process itself is a great IT learning opportunity, which social prescribers can support people with); increased access to learning for people in marginalised groups; helps York Learning reach more learners in their target groups.

York St John Active (YSJA) - Meetings with YSJA management exploring opportunities for

collaboration, including shared use of space; social prescribers being present at 'exercise on prescription' classes in order to support participants' social / emotional needs; promotion of YSJA-run community activities (eg Growing Active allotment gardening group)

This culminated in the March 2022 launch of YSJActive Together - a weekly health circuit course at the YSJA facilities on Haxby Road. The 12-week course is designed to introduce people who are not currently physically active to exercise and supported movement, in a gentle, adaptive, non-threatening group.

York Museums Trust - Discussions to explore partnership working. The focus has been on opportunities for social prescribers to use museum/gallery spaces for appointments, and the consequent opportunities for social prescribers to introduce the people they support to these cultural venues and their significant potential for positive wellbeing experience.

- **Cuppa and Craft**

  Launched in February, these monthly sessions in the Studio at York Art Gallery. Delivered by W2W for people being supported by social prescribing, as a gentle, supportive introduction to group activity for people who have not yet felt able to engage with other forms of community activity. Cuppa and Craft provides a stepping stone en route to engaging with local community activities and support, as well as being a therapeutic activity in itself, and an opportunity to introduce people to a wonderful local cultural resource that is on their doorstep but they never dared enter.

Supported fishing

Proposed and led the development of a joint pilot project with New Earswick Angling Club (NEAC) to gauge demand for supported fishing sessions, having heard from several York CVS social prescribers that there is a gap in York for people seeking this. They regularly have people who would like to try out or return to fishing, but who lack the confidence, knowledge, equipment and finances to do so.

Together we organised a series of Saturday morning sessions at New Earswick Nature Reserve in Autumn 2022. Volunteers from NEAC hosted 1-hour-long 1-to-1 sessions for participants who had been referred by social prescribers.

NEAC supply all the equipment, so all participants have to do is get there. However, for some this is the biggest barrier of all, so the W2W Opportunities Fund was made available to pay for transport costs (this was before we had secured the Transport Grant).

There is an £8 fee per session, though beyond the pilot we plan for sessions to accommodate a larger number of participants, thus bringing down the delivery costs.

The W2W Opportunities Fund is covering session fees for those who can't afford it, though a local business has offered to sponsor the sessions should the pilot be a success. This will mean that those who can't pay won't have to pay.

Living with chronic pain - having identified a common theme amongst people they support of living with chronic pain, our social prescribers took part in an intensive training package to learn

how best to support people to manage their pain.

The next step was to scope the creation of a peer support group for people with chronic pain, as this has been identified by both W2W social prescribers and their primary care social prescribing colleagues as something missing in York.

Having consulted such groups in other parts of the country, in March 2022 we held a focus group for social prescribing service users living with chronic pain, to inform creation of a chronic pain support pathway.

We also approached York Healthwise to explore collaboration on our chronic pain project, and next stage of the project is to pilot running the peer support group at Burnholme Leisure Centre, with Healthwise trainers on hand to gently and gradually introduce pain group members to appropriate physical movement groups & the Healthwise programme.

ASD / ADHD peer support – we are supporting development of a peer support group for people with ASD / ADHD. The project is being led by people who have been through The Retreat's Adult Neurodevelopmental Service, and they are keen to create more support opportunities for people like themselves who have ASD but don't have a learning difficulty.

Creating volunteering opportunities

Cuppa and Craft: created 2 volunteer roles to support the social prescribers running these sessions. Pleasingly, 4 applications were received within 48hrs of the role being advertised

Fishing: working with the angling club volunteers on design of phase 2 of our supported fishing joint project. This includes creating 2 to 3 new volunteering roles to increase project capacity, and to help the club with fundraising and thus strengthen the sustainability of the project.

NHS App engagement project

Supported York CVS's role in the Humber Coast and Vale ICS / NHSE project to increase awareness and use of the NHS App in under-represented communities.

Distribution of £28,000 to 14 local VCSE organisations recruited by W2W to deliver NHS App engagement activities with the people they support, funded by a grant from the ICS of £2000 per organisation. The grant process and project monitoring has been coordinated and administered by W2W.

Having access to the NHS App can be transformative for people as it gives them more control of their health, eg easier ordering/tracking prescriptions; easy access to correspondence between hospital and GP; easy access to test results; keeping track of appointments etc

Transport Grant

Received a grant of £10,000 to pilot funding transport for people being supported by York CVS social prescribing.

Lack of transport is a huge barrier to accessing services and support. Having access to this proof-of-concept funding is transformative for people, significantly expanding the options for how and where social prescribers support people.

For example, arranging funded taxis to and from a community group for the first few sessions, until the person has built enough confidence to use buses and done bus practice with the support of their social prescriber.

Other examples so far have included:

Limited finances

Currently in the process of claiming asylum meaning they are limited to money as can't work or access benefits

Poor mobility

Anxiety

Has LD and bus pass doesn't work until 9.30am

Patient is extremely frail. After walking to the group with just a walking stick, and it being cancelled, I wasn't comfortable with him walking back home.

Never been to the venue before - anxiety, limited finances

To minimise confusion and allow me to support

Unable to use public transport and cannot finance taxi herself.

Limited finances, poor mobility and anxiety

Very limited funds, poor mobility

Can’t use buss pass before 9.30am

Cannot finance herself due to visa issues

Limited finances, working on confidence building

W2W Small Grants Fund

This year’s SGF opened in July 2021with:

- A record number of applicants (55)
- £60,000 of funds awarded to 24 recipients
- **Total sum requested £245,713**

5 projects were solely funded by W2W

14 projects were joint-funded (W2W and CYC / Make It York)

Total sum awarded by W2W: £31,003

Ways to Wellbeing sole funded awards:

- **Haxby & Wigginton Youth & Community Association** – 'Pop Inn Club' – offering weekly coffee mornings to support isolated and/or vulnerable members of Haxby and Wigginton to return to social situations following the COVID19 pandemic.
- **Home-Start York** – 'New Parents Group' – face-to-face groups supporting new, first-time parents who are experiencing challenges, with particular emphasis around loneliness, isolation and the negative effects of the pandemic.
- **Smooth Moves Lab** – led by Feldenkrais Method practitioner Julie Wrigley – will run two programmes of 'Mindful Moves' Awareness Through Movement lessons. Feldenkrais is particularly helpful for people living with chronic pain, chronic fatigue, back pain, tension and stress as it re-educates the brain without tiring the muscles. 'Mindful Moves at Home' are online group sessions, and 'Mindful Moves: Moving On' are in-person group sessions.
- **The Conservation Volunteers** – 'Hull Road Park Coffee mornings' – providing opportunities for local people in the Hull and Heworth wards to come together and socialise while learning about local wildlife, and to gently introduce the idea of volunteering to people who may not have considered it before.
- **Central Methodist Church** – 'Place of Welcome' – part of a national network of local community groups that provide their neighbourhoods with places where all people feel safe to connect, belong and contribute. Weekly community drop-ins at Carecent.

Joint W2W and CYC / Make It York awards:

- **Accessible Arts & Media** – 'Movers & Shakers' – offering a weekly music, movement and social session for adults with complex needs from across the city. Activities include musical and theatrical games, dancing, singing and signing, playing different musical instruments, and writing songs, stories and music.
- **Explore York Libraries** – 'Creative Cafés at Acomb Explore and The Centre@Burnholme – giving people the opportunity to participate in and explore different creative activities in the company of two professional artists, helping them to discover hidden and new skills and develop confidence and self-esteem in a relaxed, friendly café environment.
- **Foss Fairy Trail** – Reviving a riverside walk along a section of the Foss. Offering a

creative approach to enhance the serene green refuge of the river the fairy trail and wildlife walk will provide much needed joy after a year of lockdown.

- **Kyra's Women's Project'** 'Culture for Confidence' – a programme of creative arts (crafts, reading, writing, etc) open to all women in York regardless of their experience, ability, or education.
- **Thunk-It Theatre** – 'Common Ground: Back in the Room' – engaging with participants aged 16-25 and 50+ in The Groves area who have been affected by isolation and loneliness through a series of workshops that explore creative communication, such as letter writing and postcard creation.
- **St Nicks** – 'Nature Connectedness for Wellbeing' – coordinating a group of green organisations to increase the number and diversity of people engaging with creative nature connectedness opportunities for mental wellbeing in York.
- **Converge** 'Converge Connected: Remote Access to Cultural Education for Adults with Mental Health Problems' – delivering six accessible courses (on writing, art, humanities, theatre and music) by post, through a specially designed website and virtual learning environment (LearnDash), and via Zoom sessions.
- **Next Door But One CIC** – 'Keeping Hold of Creativity: Maintaining Artistic Skills and Connections Post COVID' – delivering a series of youth theatre workshops for secondary school age young carers and for 14–25-year-olds who identify as LGBTQ+ and running 'Playback Theatre' training workshops for adults with mental health problems.
- **Club Wilber** (Part of the Wilberforce Trust) – 'Where's Wilber?' – offering a combination of online and Covid safe intergenerational activities designed to boost the mental wellbeing of families of children with severe sight loss.

Training

In Q1 we delivered our training to the CYC adult and children's social care teams, offering 4 different opportunities for attendance. In total we reached over 45 staff members, and have seen the impact of this with significantly improved relationships, further opportunities to discuss referral pathways and a deeper understanding of one another's services.

Alongside this we have had a number of one-to-one sessions with new and developing VCSE organisations to provide an overview of social prescribing and to ensure they have a clear understanding of our offer and the support available.

We delivered joint training to Changing Lives.

We delivered training on social prescribing to the district nursing team, and two CMHTeams

We have delivered training jointly with the Volunteer Centre to newly-recruited volunteer befrienders.

W2W social prescribers have also attended the following training:

Living Well with Pain

Green Social Prescribing

Gender, Sexuality Awareness

Excel Training

Fuel Poverty

Cancer Champions

York People First – Creating Easy Read materials

Adult Safeguarding

Talk Suicide

Frailty

Hoarding Awareness

Personalised - Care Core Skills

Personalised - Shared Decision Making

Museums, Wellbeing & Social Prescribing

Future improvements and developments

Trialling new referral sources, ie identifying secondary care services where social prescribing could have high impact because of the early intervention / prevention opportunities.

Heart failure

W2W will start accepting receiving referrals from local Heart Failure Specialist Nurses in Q1 of 2022-23.

The specialist heart failure team is involved with the care of patients with heart failure in both the hospital and community settings, from the time of diagnosis. In the community, the nurses visit patients in their home or at a clinic setting of their choice.

They focus on improving patient self-management to improve quality of care, quality of life and patient experience, reduce readmission rates and increase patient health and wellbeing.

By collaborating with W2W, the heart failure team can encourage a more holistic approach including consideration for psychological and social care needs.

The opportunity to work with social prescribers will significantly expand the help available to patients in learning to manage their condition, as well as learning to live with it in emotional terms.

A common experience of patients diagnosed with heart failure is feeling frozen in terror that their heart could stop at any second. This creates a huge barrier to being physical and socially active, creating a vicious circle in terms of managing their condition. Social prescribers are perfectly

placed to help rebuild confidence, and support them to engage in new or previously-enjoyed activities.

IDAS

Also, in Q1 of 2022-23, we will trial taking referrals from IDAS, as a step on for people who have (or are) experiencing domestic abuse and have received support from IDAS services.

Case studies

Karen

Karen was referred as she had not been out the house on her own for many months. Having previously been social and active, Karen's mental health and emotional wellbeing had declined following a period of illness and the pandemic.

Karen (a wheelchair user) had also developed anxiety when using the door ramp to leave her house, which left her in states of panic and rendered her housebound.

The limited availability of her physio team meant Karen felt she was not getting enough practice to be able to ever leave the house again.

How Karen and her social prescriber worked together:

Karen's goals –

- to regain confidence and reduce anxiety
- to practice using the ramp
- to be able to go back to her singing group independently

Referral to North Yorkshire Sport (indoor mobility practice for 4 weeks), and supported self-referral to IAPT.

Fortnightly, Karen practiced getting outdoors with her social prescriber, who also supported her to attend support to re-attend her singing group.

Karen has recently finished 4-weeks' intensive input form NYS. With this input, plus the additional support to practice outdoor mobility with SP, Karen's ability and confidence has improved markedly.

When Karen was first referred to W2W, even with her social prescriber's help it was taking an hour for her to get from front door to driveway, and required large amounts of verbal reassurance to reduce anxiety.

In 5 weeks, client is taking less than half an hour and shows independent ability to self-manage anxiety levels.

Karen herself feels that the input of others and the intensity of practice has increased her confidence and physical ability.

Input will now take the shape of her social prescriber reducing the frequency and intensity of support, to further promote Karen's independence as together they work towards discharge from W2W.

If further support is needed, they will discuss options around referrals to make adaptations to the home via the council, or support around finding carer support to assist with going to leisure activities and potential for Move Mates referral if at an appropriate level.

Peter

Peter was referred due to being isolated, increased alcohol consumption, poor diet and recent hospital admission. Suffering from reduced mobility on discharge. Previously socialised in pubs but had stopped this during pandemic.

On visit to client, they were feeling emotional and had a number of issues relating to their employment, lack of any social activity since covid pandemic, reduced mobility leading to difficulty accessing certain places. They also had goals to do a new course. Different kinds of services were discussed but client felt that having access to the right social places again would be how they could improve and maintain mental health.

How Peter and his social prescriber worked together:

1) providing list of very local community cafes to try and offering accompaniment on first visits if needed
2) Providing info of a free and confidential service to support returning to work
3) Providing details about other social activities on an accessible bus route from home address
4) Referral to York Learning for course starting in September

Peter began accessing his local community café independently. He went back more and more frequently as he found the food good and reasonably priced, and over a few weeks started making new friends there. Peter also made plans to start using it as a place to meet an old friend who lived close by.

The next step for Peter was attending the W2W Cuppa and Craft group at York Art Gallery. He managed the journey by bus, and thoroughly enjoyed the group.
In fact, he enjoyed it so much that he has decided to keep going even after returning to the workplace because of how it supports his mental health.

Peter is continuing to work with employers around returning to work currently and is awaiting information about starting the course which should be available over the summer. Following a review in 2 weeks in the hope that further progress will be made in the employment area, Peter will most likely be discharged from W2W with option to get back in touch if needed and for any support to connect to the course nearer the time.

What Peter said:

"With it being my first visit I don't take part in any of the craft sessions. But I was made to feel very welcome and had very good chats with others.
I am looking forward to the next time. I feel it will be a good avenue to help with my mental health.
Even after I return to work. I will still continue to go, and I am sure I will get approval from work.
I look forward to hearing from you. I continue to go to …[café]... and have started making friends there.
Thank you for your continued assistance"

Mr M

Due to his complex needs Mr M has been accessing support from the social prescribing team for over 6 months. He has long term health conditions due to a brain injury and lives with chronic pain. To date, we have offered almost 40 interventions in this time which far exceeds the input he has had from other services. This long-term constructive support is necessary to help improve Mr M's independence and mental wellbeing in the long term.

During this time, W2W has supported him to find voluntary work that fits his abilities and that will bring him a sense of purpose, by helping others. He has also been involved in bringing ideas to help shape and build our new Living with Pain group, which he is looking forward to attending independently, building a support network of people facing the same barriers as himself.

We are now coming towards the end of our work together, and Mr M provided this written feedback through direct message after a recent intervention:

What Mr M said:

"(The support) you have given me has been the best I've had, very organised and you help organise things for me in a way I can manage.
I can tell early on people who care about their work. You look out for things that will help, keep in contact with me. Then organise and offer help in useful ways that other services haven't."

Miss B

Miss B was a referral from the Adult Autism service at The Retreat. She experiences mental ill-health and faces barriers to accessing support and groups due to her needs.

Miss B required a high level of intervention and I have so far had input with her on 22 occasions in this quarter. It was important for me to take the time to understand Miss B's needs and build a strong working relationship with her before looking into avenues of support.

Finding suitable groups for Miss B to access has been challenging due to the huge gap in local provision for adults with autism who don't have a learning difficulty.

This has required me to work closely with the providers to ensure they were set up and able to meet the needs of Miss B. It was important that I also attended the initial few sessions with the client to ease anxieties, accompany her to familiarise her with the building prior to the group, and introduce her to the facilitators.

Betty

Betty is a 74-year-old lady who lives alone. She was referred for:

- exercise opportunities
- health and wellbeing opportunities
- social interaction/leisure activities

Since the pandemic Betty had been in hospital several times due to falls and poor balance due to her mild cerebral palsy.

Deconditioning and loss of confidence were her main barriers. She was keeping busy in her home, but felt isolated and lonely and with spring coming she wanted to get “out and about.”

Her community physiotherapist had issued her a new 3 wheeled walker but she wanted to have a purpose for exercising, not just walking round her block alone.

We spoke about all the options available and Betty was keen to try them all. Betty began with a Move the Masses local walk which she really enjoyed despite the rain. She said she enjoyed the company of others and getting some fresh air.

She then joined a health walk in town and now goes every week and has convinced a friend to go with her so they have a chat and a walk and she looks forward to it each week.

Betty is also attending York St John Active Together, an inclusive exercise circuit group where she feels confident using her walking aid and finds the instructor very support.

She was keen to try another class more local to her home so she has been referred to Healthwise (exercise on prescription) and is looking forward to starting with them.

Betty is grateful for all the different opportunities we have given her; she does not use the internet and says would never have known about any of the services she is now involved in.

Her confidence is increasing and her exercise tolerance is improved. Her mood is lifted and she has things to look forward to each week and is enjoying being out of the house and meeting new people in her community.

Joan

Joan is an 86-year-old widow; she has family but they all live down south.

Her health has recently deteriorated and she has to wear large bandages on her legs due to ulcers and she gets very short of breath on excursion.

Like many people her age Joan has been shielding at home since the pandemic and was only going out for food shopping. Joan was referred by the physiotherapist for support with health and wellbeing opportunities, and social interaction/leisure activities as she felt very isolated and alone.

Joan is a keen artist and her home was decorated with her beautiful painting by number pieces and her craft works. This was talking point on our visits over Christmas.

Joan got involved in our Christmas star craft project, making a decorative star at home with materials provided by W2W, to then give to another isolated person. She enjoyed making something for someone else.

Then this Spring Joan came to our new arts and craft group at York Art Gallery. She really enjoyed her time there and said being with other people with limited mobility or health conditions made her feel much more comfortable and confident in her own skin and made her realise that she could still go out and attend groups.

She used a W2W funded taxi for her first visit but says she feel confident to get the bus there now and will use the months group as a reason for her to pop into town which she hasn't done in years.

Joan was very appreciative of my input and is really keen to carry on attending the group each month. She said she would never have gone into town or the York Art Gallery if it wasn't for our input.

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Primary Care Link Workers
Social Prescribing in York

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Primary Care Links Update – July 2022

This provides an update on the work that has been delivered across the Social Prescribing services being delivered through York CVS. This update provides evidence of the benefits of Social Prescribing sitting with York CVS and partnerships across health and social care and the VCSE.

Living well with pain group

In collaboration with Ways to Well Being the 'Pain Sailing' Chronic pain peer support group was set up after our team had had some excellent Living Well with Pain Training funded by York CVS.

Our Social Prescribers identified a gap in support for people living with chronic pain. The group has 13 participants – 11 female, 2 male and 4 people on the waiting list (all female).

The group is doing very well. Regular attendance has been much better than we anticipated (people living with chronic pain finding it so hard to predict if / when they will be well enough to attend things). So far, the focus has been on building group cohesion through choosing a name, making a banner and developing a group agreement. The group have found commonalities in their experiences in living with pain – discussing being disbelieved, how they have adapted activities of daily living, worries regarding opioid addiction, managing family's expectations and incontinence issues. There was lots of laughter. The group have identified areas related to pain management that they wish to know more about. In July, a specialist Occupational Therapist from the Yorkshire Fatigue Clinic will visit to discuss pacing. Clarence St is working well as a venue. Having the café so group members can stay on for lunch is great in terms of the group's sustainability, developing friendships and an informal peer support structure that can exist beyond the monthly group sessions.

Cuppa and Craft group

This is a group set up by Ways to Wellbeing at York Art Gallery. It is a space for those patients we are working with who are extremely anxious about going to a group. Our Group helps to build confidence with the support of social prescribers, crafts and peer support for our patients to move onto groups within their community. This group is going from strength to strength – all 13 places are filled every session. We created 2 volunteer roles and filled both posts, with plans to recruit more. The next stage of this work is developing our 'move-on' group, i.e., the place people can continue to attend regularly, indefinitely. This means we can have a continual

throughput of people attending the core Cuppa and Craft group, moving on once they have built their confidence in coping in a group setting and feel ready for the next step. Because we don't want people to lose the friendships they make in the core group, the 'move-on' group also serves to provide a place for those social connections to continue and grow. We have also trialed holding a group at the Theatre Royal. Members of the Cuppa and Craft group spent a morning testing out the venue and were very positive about it. We have agreed to pilot a monthly group there at the midway point between our monthly Cuppa and Craft sessions at the Art Gallery. As well as providing a new social and confidence-building opportunity, it builds on the cultural access that Cuppa and Craft provides. Very few of the people who have attended it so far had ever been to York Art Gallery before joining the group. By also developing our relationship with the Theatre Royal and introducing people we support to it, we can continue the work of helping them feel comfortable in these cultural resources that they previously felt were not places they were entitled to go.

Social Prescribing Buddy Role

In collaboration with our colleagues at the York CVS Volunteer Centre, we have developed a Social Prescribing Buddy role – a type of short-term volunteering, where a buddy is introduced to someone being supported by a social prescriber, then accompanies them on a small number of occasions, to attend a new group or activity; do bus practice etc. We will start recruiting Buddies in August, with the first roles being called 'Geek Guardians' - Buddies who accompany keen gamers to a local inclusive café & community venue called Geek Retreat. This came about because we have a number of young adults we are supporting (referred by The Retreat) who have autism, are very keen gamers, would like to meet like-minded people, but need a little extra moral support the first couple of times they try out a new place and new people.

Befriending Calls

Our befriending calls run in collaboration with York CVS Volunteers Centre continue to be a success. This project was started after our Social Prescribers identified a gap in befriending calls for patients aged 18 and above. The project runs from March 2022 to December 2022.

Due to the success of the project, we are looking to recruit volunteer befrienders, if you or anyone you know would be interested in this and have an hour a week to spare then please email: volunteering@yorkcvs.org.uk

Primary Care Link Workers
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York Integrated Community Team (YICT) from Callum Neave

We now have a Social Prescriber, Callum Neave, who works as part of the York Integrated Community team (YICT). This is the first Social Prescriber to be in post within this team, and an exciting opportunity to connect people to their local community to help expedite safe discharge from hospital; preventing a deterioration in frailty and to live well for longer and support managing long term conditions by connecting patients with their local community.

Referrals can be made to Callum via the YICT Team

A quick hello and update from Callum...

"Hi, it is going well at YICT and I have settled into the team. Since July I have received 47 referrals for lots of different issues (carer strain/support, isolation, mental health support, financial aid, bereavement) and this does not include the times that I have given information to another member of the team to pass on to the patient as they have been reluctant to see me as they already have the relationship and trust built up with my colleague. This will be something we will work on.

In terms of positive outcomes, a couple of examples are as follows;

I have had a patient who was feeling very isolated after the loss of her husband 2 years ago and had then been unable to go out due to covid and lost all of her confidence. I visited with this patient a couple of times and we discussed the importance of socialising on both physical and mental wellbeing and then looked at what was available in her area, with some encouragement the patient agreed to attend a church-ran local coffee morning and I agreed to go with her as support. I am very pleased to say despite her reservations the patient told me she thoroughly enjoyed it and will be making the effort to attend each week going forward.

Another example would be a patient who was struggling with extreme carer strain from looking after her husband who has dementia amongst other comorbidities, when I met this patient, it was clear she was very worn out and she admitted to me she had lost 2 stone in the last couple of weeks due to being rushed off her feet and not having time to eat, she was admirably prioritising her husband's welfare over her own but it was now taking its toll. I spoke with the patient about York Carers centre and how they could support her and with her consent referred her to them, I also explained to the patient that I thought she should see a GP about her own health after losing so much weight and feeling as weak as she did, she agreed to let me contact her surgery and has since had a home visit from her GP who will be supporting her going forward. York Carers Centre are also in touch with the patient and working with her and her son to look at respite options for her husband.

I have had lots of support from all the members of YICT and my CVS colleagues which has been very helpful in settling in."

Primary Care Link Workers
Social Prescribing in York

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Green Social Prescribing Project

The Green Social Prescribing project that we are working in partnership with Hey Smile Foundation aims to embed Green Social Prescribing in existing community organisations to support people with their mental health by connecting with the outdoors.

The first cohort is coming to an end and the second cohort has just started. We will be reporting back on this when the project finishes.

Please follow the link below to look at the fantastic work already being done:

https://wetransfer.com/downloads/78ae5f58abf2793627baf272856abbaa20220508181555/b7ae4d382fe5fbc1bc2293526e4e4ed720220508181555/0c480c

Travel Grant

The grant, secured by York CVS, has enabled us to support people getting out to activities and appointments in the community. There is a huge gap in provision for patients who are housebound, and travel has proved to be one of the barriers.

So far, this grant has helped 67 patients get out into the community who otherwise would have been considered housebound in relation to connecting to their local community. Our team continues to work with these patients to re-build confidence going out, getting public transport, and managing finances.

Purey Cust Trust

We have applied and been successful for a small grant from the Purey Cust trust to help patients who find finances as an initial barrier to achieve an improvement in their health and wellbeing. For example, needing to pay administration fees from the surgery to get a bus pass when a patient cannot afford it.

Another example is a patient who has a diagnosis of Autism and Chronic Pain; she is a wheelchair user. The patient is in receipt of universal credit; she is on the waiting list for an assessment for Personal Independence Payment (PIP).

The patient lives in temporary accommodation and is delighted to soon be moving into her own place. However, she is moving into social housing with no furniture and no money to buy any. A priority for her is an orthopedic mattress, being in pain and

not being able to sleep has a huge impact on her health and wellbeing. Poor sleep exacerbates her chronic pain. Too little sleep can also heighten the challenges she experienced regarding her autism diagnosis, finding it harder to concentrate and communicate with others. A mattress that meets the patient's needs would give her the best chance of a good night's sleep and would in turn enable her to focus on her aspirations around starting a craft course and making new friends, resulting in an improvement in her sense of purpose, health and wellbeing.

Training

We have asked our Social Prescribing Link Workers to attend a Building Vaccine and Screening Confidence Training Programme This training is aimed at people who come into contact with low vaccine uptake populations and screening hesitancy including areas of higher deprivation, ethnic minority groups and parents of 2 and 3 year old's and those in at risk categories. Due to the nature of our role, we work alongside these groups on a regular basis so having this training will result in our team having the confidence to encourage and support the patients they work with to attend screening and immunisations addressing preventative health conditions and reducing health inequalities.

As always, please get in touch with me at lucy.kitson@yorkcvs.org.uk if you would like to discuss anything further.

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

Report of the Directors of Adult Social Care and Public Health

2022-23 Finance and Performance Q1 Monitor Report – Health and Adult Social Care

Summary

1. This report provides a detailed view of outturn position for Public Health (PH) and Adult Social Care for 2022/23. Discussions were held with budget managers to explain over and under spends against budget. Table 1 below provides a high-level summary.

Table 1: Q1 Monitor 2022/23

2021/22 Outturn		2022/23 Latest Approved Budget			2022/23 Q1 Variance	
		Gross Spend £000	Income £000	Net Spend £000	£000	%
	Corporate Director of Adult Services & Integration					
-1,026	ASC Centrally Held Budgets	5,163	2,893	2,270	+114	+5.0%
-520	ASC Commissioning and Early Intervention & Prevention	7,119	11,011	-3,892	-175	-4.5%
-233	ASC In-House Services	7,043	2,284	4,759	+633	+13.3%
	Director of Adults Safeguarding					
+1,959	ASC Older People and Physical & Sensory Impairment	39,081	20,946	18,135	+333	+1.8%
+1,102	ASC Learning Disabilities and Mental Health	37,238	8,966	28,272	+845	+3.0%
+1,282	**Adult Social Care Total**	**95,644**	**46,100**	**49,544**	**+1,750**	**+3.6%**
0	**Public Health**	**9,472**	**9,545**	**-73**	**0**	**0.0%**
+1,282	**Health and Adult Social Care Total**	**105,116**	**55,645**	**49,471**	**+1,750**	**+3.5%**

2. The projected outturn position for Adult Social Care is an overspend of £1,750k. This assumes that £1.2m of savings and £2.8m of mitigations will be made by the end of the year. The projection is based on customer numbers and costs in the first two months of the year.

3. Some of the main pressures on the ASC budget include:

    - Market prices for beds currently higher than CYC standard rates.
    - Accounting exercise has been developed for home care agencies asking for increases
    - Inability to recruit to vacancies leading to use of more expensive agency staff

4. Most of the above pressures are not reflected in the current projections as yet and will add to the current overspend. Given the level of savings and mitigations still to be made it is unlikely that further mitigations against these pressures will be achieved in year.
5. Referrals into social care are continuing to increase and remain above pre pandemic levels. It should be noted however, that this is not translating into more or higher packages of care in the community. In addition waiting lists are being reduced without this work converting into more care in the system
6. The following sections give more detail on the variations.

ASC Centrally Held Budgets (£114k / 5.0% of net budget)

7. No material variations – overspend is on legal fees (£51k) in line with 2021/22 and on a projected overspend on staffing.

ASC Commissioning and Early Intervention & Prevention (EIP) budgets (-£175k -4.5% of net budget)

8. There is a projected underspend on staffing in the Commissioning Team due to vacancies (£64k), and the Carers Commissioned Services budget is also expected to underspend.

ASC In house services Budgets (£633k / 13.3% of net budget)

9. The Community Care budget is projected to overspend by around £347k. This is due to the corporate decision to bring the service and staff of Riccall Carers in house following the company going into administration.

10. The Personal Support Service team budget is expected to overspend by £123k as difficulty in recruiting new care staff has meant an increased use of more expensive agency staff.
11. Yorkcraft is projected to overspend by £89k due to an underachievement of income (£120k) and failure to achieve a previous year's saving (£62k), offset by an underspend on staffing vacancies.
12. Small Day Services are projected to underspend by £133k. This is largely due to vacancies as the service has been running at reduced capacity due to Covid restrictions. In addition, the Service Manager post is currently vacant.
13. Be Independent is currently projected to overspend by £246k. There is still a budget gap of £130k which needs to be addressed, together with a historical budget overspend on recharges of £50k. There is also expected to be an underachievement on the sales income budget as no further sales are expected to be made.

ASC Older People (OP) and Physical & Sensory Impairment (P&SI) budgets (+£333k / +1.8% of net budget)

14. Permanent nursing care is projected to overspend by £317k. The average cost of an OP residential placement is around 1% higher than in the budget (£12 a week) (£154k), and there is currently one more customer than in the budget (£47k). In addition to this, there are three more customers in P&SI residential care placements than in the budget (£205k), offset by an increase in the average rate of S117 contributions being received per customer.
15. Based on activity to date there will be an underspend of £347k across the budgets for respite and short break residential and nursing placements for OP and P&SI customers.
16. P&SI Supported Living schemes are currently projected to overspend by £283k in 2022/23 due to having eight more customers than was assumed in the budget (£340k), offset by increased customer contributions.
17. The P&SI Direct Payment budget is projected to overspend by £380k largely due to the average cost per customer being £2.8k p.a. (£54 a week) more than in the budget (£321k) and in addition based on reclaims to date there is likely to be an underachievement of the reclaims budget.
18. There is projected to be an overspend on staffing in ASC Community Team of £201k due to the use of agency staff, being over establishment on Review Manager posts and failure to meet the vacancy factor.

19. The OP Community Support Budget is projected to underspend by £124k largely due to having four fewer customers on exception contracts than in the budget. The P&SI CSB budget is expected to underspend by £229k due to having four fewer exception customers (£143k) and also there is currently a lower number of homecare framework hours than was assumed in the budget.

ASC Learning Disabilities (LD) and Mental Health (MH) budgets (+£845k / +3.0% of net budget)

20. The LD residential working age budget is projected to overspend by £215k. This is largely due to the average cost per customer being £3.3k p.a. (£63 a week) more than in the budget.
21. The LD nursing working age budget is projected to overspend by £155k due to the average cost per customer being £29k p.a. more than in the budget.
22. LD direct payments are projected to overspend by £117k. This is due to the average cost per customer being around £4k p.a. (£77 per week) more than in the budget, offset by a projected overachievement of the reclaims budget.
23. There is a projected overspend of £163k on the LD Social Work team due to the use of agency staff to cover vacancies and sickness in the team. This is an improvement over the position at the start of the year (an initial projected overspend of £210k) and work is ongoing to bring this overspend down.
24. There is expected to be an overspend of £317k on the LD CSB budget due to having 3 more day support customers (£44k) and the average costs for both day support and home care placements are higher than budgeted for (£208k). In addition to this the average rate received per CHC customer is less than in the budget.
25. LD Supported Living schemes are projected to underspend by £392k due to currently having seven fewer customers than in the budget.
26. The (MH) residential care working age budget is projected to underspend by £100k largely due to having two fewer customers than was assumed in the budget.
27. The MH Nursing care budgets are expected to overspend by £82k due to having one more customer in the over 65 budget than was assumed when the budget was set.
28. There is projected to be an overspend of £73k on the DOLS budget due to having a SM post over establishment for 6 months and to the use of agency staff. There is also expected to be an overspend on the Safeguarding Team budget of around £77k due to the use of agency staff to cover vacancies.

Inflationary Pressures

29. Several providers have recently come forward to request an increase above the budgeted 3% already given and are currently going through the open book accounting exercise.

30. It is difficult at this stage to know how much the amount paid for care will increase as a result of these exercises. As examples:

- If the transport and utilities costs incurred by homecare providers were to double this would increase the hourly rate of homecare paid by 9.5%, which would add approx. £737k to the current projection
- If the hourly rate paid to care staff by homecare providers were to increase by 5%, this would increase the hourly rate paid for homecare by around 2.6%, which would add approx. £200k to the current projection.

31. Assuming a 5% increase in the hourly rates paid to care assistants and nurses in care homes the estimated impact would be an increase in the projected costs of residential care of around £476k, nursing care of around £256k and supported living of around £344k

32. Assuming that utility costs and care homes and supported living accommodation were to double the estimated impact would be £704k for residential care, £186k for nursing care and £531k for supported living placements.

33. The estimates are on the gross cost of care and do not take into account any corresponding increase in income.

Performance Analysis

ADULT SOCIAL CARE

34. Much of the information in the following paragraphs can also be found on CYC's "Open Data" website, which is available at

https://data.yorkopendata.org/dataset/executive-member-portfolio-scorecards-2021-2022

and by clicking on the "Explore" then "Go to" in the "Health and Adult Social Care" section of the web page.

35. Many of the comparisons made below look at the difference between the first quarter of 2021-22 and the first quarter of 2022-23, to compare periods at similar times of the financial year rather than to compare

differences which are likely to be due to seasonal variation. A summary of the information discussed in paragraphs 36 to 49 can be found in the table below.

KPI No	Measure	2019-20 Q1	2020-21 Q1	2021-22 Q1	2022-23 Q1	Change from 2021-22 Q1 to 2022-23 Q1
ASC01	Number of contacts to ASC Community Team	2,749	3,684	4,237	4,169	Improving
ASC01a	Percentage of initial contacts to ASC Community Team that are resolved with information/advice or guidance (IAG)	22	34	21	19	Stable
PVP14	Number of customers in receipt of a "paid-for" package of care (snapshot)	2,147	2,203	2,181	2,071	Improving
PVP18	Number of customers in long-term residential and nursing care (snapshot)	657	566	576	580	Stable
PVP02	Number of permanent admissions to residential and nursing care for older people (aged 65 and over)	68	27	57	61	Deteriorating
ASC03b	Number of customers receiving home care services (snapshot)	680	736	716	635	Improving
PVP31	Number of clients receiving paid services for first time	141	214	147	149	Stable
PVP32	Number of clients returning to ASC to receive a paid service	102	105	100	75	Improving
ASCOF1F	Percentage of adults in contact with secondary mental health services in paid employment	23	19	19	19	Stable
ASCOF1H	Percentage of adults in contact with secondary mental health services living independently, with or without support	83	77	65	63	Stable
ASCOF3A	Percentage of service users 'extremely or very satisfied' with care and support	68	72	N/A	N/A	Neutral
ASCOF3B	Percentage of carers 'extremely or very satisfied' with care and support	N/C	N/C	40	N/C	Deteriorating
ASCOF4A	Percentage of service users reporting that they feel "as safe as they want"	71	76	N/A	N/A	Neutral
SGAD02	Number of Adult Safeguarding pieces of work completed	365	304	360	571	Neutral
SGAD01	Number of Adult Safeguarding concerns reported	353	297	444	577	Deteriorating
PVP11	Percentage of completed safeguarding s42 enquiries where people reported that they felt safe	89	99	99	99	Stable
STF100 - People	Average sickness days per FTE - People directorate (rolling 12 month average)	N/A	15.1	12.1	16.1	Deteriorating

Demand for, and numbers receiving, adult social care services

36. There was a decreasing number of initial contacts to adult social care (ASC) during 2021-22, as demand for services caused by the initial stage of the COVID-19 pandemic has eased slightly – this has continued into 2022-23. Our Customer Contact Workers record the number of contacts received to ASC, whether made by email, telephone or other methods. During the first quarter of 2022-23, they received 4,169 contacts, which is 2% lower than the number received during 2021-22 Q1 (4,237). Around 19% of the contacts during 2022-23 Q1 were resolved using Information, Advice and Guidance (IAG), which is lower than the percentage

that were resolved using IAG during 2021-22 Q1 (21%); this reflects the increasing complexity of issues that are dealt with by them, and a change in recording practice which has meant that this percentage is lower than in previous years.

37. There has also been a decrease in the number of people that receive “paid-for” packages of care (i.e. CYC commissions it and pays an organisation to provide a service) over the last year. At 30 June 2022, this figure was 2,071, which represents a 5% decrease from the 30 June 2021 figure (2,181). This was achieved largely through the fall in the number of people receiving home care services (see paragraph 39). However, as the Finance section of the report outlines, the cost of care, particularly in residential/nursing care, continues to increase, reflecting the increasingly complex care issues our customers have.

38. The number of individuals in residential/nursing care placements fell rapidly at the start of the Covid-19 pandemic. There has been a slight increase in this number as noted in the table above (from 576 at the end of 2021-22 Q1 to 580 at the end of 2022-23 Q1). CYC have reduced the number of new admissions to residential/nursing care in recent years, partly because of the policy that people should no longer be placed in residential/nursing care directly following hospital discharge, but this number increased partly because of issues with the home care market, where some people had to be placed in residential/nursing care who might otherwise have received home care. Despite these challenges in the market, during 2022-23 Q1 the number of new admissions of older people to residential/nursing care only increased slightly, to 61, from the 2021-22 Q1 figure of 57.

39. There has been a rapid fall over the last year in the number of people placed with home care providers, partly because of issues with home care providers during 2021-22 (see paragraph 9). At the end of 2022-23 Q1 there were 635 people in receipt of a home care service; this is 11% lower than the corresponding figure at the end of 2021-22 Q1 (716).

40. In 2022-23 Q1, there were 149 clients that received a service, for the first time, which incurred ASC expenditure (“new starters”). This is broadly similar to the number of new starters in 2021-22 Q1 (147). There has also been a decrease (25%) in the number during 2022-23 Q1 (75) that have returned to ASC for a paid service compared with the number during 2021-22 Q1 (100). This suggests that we are continuing to keep the number of first-time entrants as low as we can, and that we are also doing well in preventing those returning to the ASC system after they have left, but making sure that as few people enter the system as possible remains an ongoing challenge.

Mental Health

41. The percentage of adults in contact with secondary mental health services living independently, with or without support, has fallen over the last year. At the end of 2022-23 Q1 63% of them were doing so, compared with 65% at the end of 2021-22 Q1. The 2020-21 ASCOF results showed that York is a “top quartile performer” in England as a whole, compared with 58% nationally and 65% in the Yorkshire and the Humber region, and it is likely that the 2021-22 ASCOF results will consolidate York’s performance. However, it should be noted that “in-year” performance is often lower than the final outturn for the financial year (the ASCOF outcome), as many assessments of whether people are living independently are conducted towards the end of the financial year.

42. At the end of 2022-23 Q1, 19% of all clients in contact with secondary mental health services were in employment – a figure that has consistently been above the regional and national averages, and the same percentage as a year earlier. Based on the 2020-21 ASCOF results, York is the 3rd best performing LA in England on this measure, with 20% of all those in contact with secondary mental health services in employment, compared with 9% in England and 11% in the Yorkshire and the Humber region. The 2021-22 ASCOF results are likely to show similar good performance. “In-year” performance on this measure can be lower than the final financial year (ASCOF) outcome due to people only being assessed to see whether they are in employment towards the end of the period.

Overall satisfaction of people who use services with their care and support

43. The 2021-22 Adult Social Care User Survey was a national survey of adult social care users that sought their opinions on aspects of their life and the care provided to them, whether from LAs, the voluntary sector or other providers. Of England’s 152 local authority (LA) areas, nearly all of them, including York, participated in 2021-22, compared with only 18 LA areas (which included York) that took part in it during 2020-21; participation in 2020-21 was voluntary due to the Covid-19 pandemic.

44. The provisional results for York during 2021-22, due to be published by NHS Digital in October, show that a smaller proportion of York’s ASC users were “extremely or very satisfied” with the care and support services they received – 72% of them in 2020-21 gave this response.

45. The 2021-22 Survey of Adult Carers in England (SACE) took place earlier in the year and the results have been published by NHS Digital. They

show that 40% of York's carers were "extremely or very satisfied" with the care and support services they received, which is in the upper quartile of performance amongst England's LAs, although it represents a slight deterioration from the last time the SACE was carried out in 2018-19 (43% gave this response); however, most LAs in England experienced similar deteriorations in satisfaction from their carers.

Safety of ASC service users and residents

46. The safety of residents, whether known or not to Adult Social Care, is a key priority for CYC. The ability of CYC to ensure that their service users remain safe is monitored in the annual Adult Social Care User Survey, and for all residents with care and support needs by the number of safeguarding concerns and enquiries that are reported to the Safeguarding Adults Board.

47. Results from the 2021-22 ASC Survey are due to be published in October 2022 by NHS Digital. In 2020-21, 76% of those that responded to the Survey said that they felt "as safe as I wanted".

48. During 2022-23 Q1 there were 571 completed safeguarding pieces of work, which is a 59% increase on the number completed during 2021-22 Q1 (360) – this is a partial reflection in the increase in the number of safeguarding concerns reported during the same period (577 in 2022-23 Q1 compared with 444 in 2021-22 Q1). The percentage of completed enquiries where people reported that they felt safe as a result of the enquiry continues to be high - 99% during both 2021-22 Q1 and 2022-23 Q1 and remains consistent with what has been reported historically in York.

Sickness rates of Adult Social Care staff

49. In the People directorate, which includes Adult Social Care, the number of sickness days taken per full-time employee rose from 12.1 in the year to the end of 2021-22 Q1 to 16.1 in the year to the end of 2022-23 Q1. This was partly caused by a large number of ASC staff being required to take sickness leave after contracting Covid-19.

PUBLIC HEALTH

Public Health (£0k / or 0% of gross expenditure budget)

50. Public Health is expected to underspend by £117k which will be transferred to the earmarked Public Health reserve to fund future commitments.

51. The table below provides a more detailed breakdown for the services within Public Health:

Service Area	Net Budget £'000's	Outturn Variance £'000's	Comments
Public Health General	1,565	+19	Funding for communication support
Substance Misuse	1,708	-1	
Sexual Health	1,824	0	
Health Protection	57	0	
Health Trainer Service	403	-10	Staffing vacancies
Healthy Child Service	2,525	-125	Staffing vacancies
Public Health grant	-8,143	0	
Total Public Health	**-289**	**-117**	
Transfer to Reserve		+117	Predicted reserve balance at year end is £824k
Reported Position		**0**	

52. The new staff structure is in operation and the posts filled. The small overspend relates to PH's contribution to a post in Communications.

53. Healthy Child Service has been restructured. There are a number of vacancies which if not filled by year end will result in a £125k underspend.

54. There was £1,259k in the Public Health Reserve at 31st March 2022. Based on current estimates the reserve will decrease by £435k to £824k. This reflects additional growth and restructuring in Public Health services which will prudently reduce the reserve balance over the next four years in a planned manner. Use of the reserve was/will be agreed/considered by the Executive Member, Cllr Runciman.

Directly Commissioned Public Health services

Health Trainer Service (NHS Health Checks and Smoking Cessation)

55. The Health Check programme aims to help prevent heart disease, stroke, diabetes and kidney disease. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions, will be invited (once every five years) to have a check to assess, raise awareness and support them to manage their risk of cardiovascular disease. A high take up of NHS Health Check is important to identify early signs of poor health, and lead to opportunities for early interventions.

56. The Health Check programme was halted for safety reasons during the COVID-19 pandemic period. Nimbuscare restarted the delivery of health checks towards the end of 2021. A total of 298 health checks were carried out of CYC residents during 2022-23 Q1. This represents 0.6% of the eligible population, which is a lower proportion compared with the national (1.3%) and regional (0.9%) averages.

57. Closer work with Primary Care Networks is being undertaken, with health checks being delivered in a number of community and primary care settings, leading to a more joined up service for the patient. Health Checks are delivered from various locations across the City. The service is targeted at those who have underlying risk factors and, in order to reduce health inequalities, at those in the city living in more deprived postcodes.

58. Our approach is more than just identifying risk, and through our Health Trainer Service, we provide individuals with treatment and support to tackle the things that increase their risk, such as excess weight, high blood pressure, lack of exercise and poor diet. The Health Trainers put the individual at the centre and work with them to help achieve the health goals that matter to them.

59. The Health Trainer service is also York's community Stop Smoking Service. This includes one-to-one behavioural interventions, as well as access to nicotine replacement medications such as NRt or e-cigarettes that make the journey to being smoke free easier. The Tobacco Alliance, chaired by a Consultant in Public Health,ensures that we tackle some of the wider issues that lead to people taking up smoking, such as ease of access to cheap illicit tobacco products.

60. The final data for 2021-22 shows that the Health Trainer Service's stop smoking team received 548 referrals from those wishing to quit smoking. Of these, 363 (66%) went on to engage with an advisor. Subsequently, 226 went on to set a quit date and 143 (63%) had quit smoking after four

weeks. There were 109 pregnant smokers who were in the group of 548 referrals. Of these, 52 (48%) went on to engage with an advisor. Subsequently, 33 went on to set a quit date and 24 of them (73%) had quit smoking after four weeks. To date in 2022-23 there have been 202 referrals from those wishing to quit smoking, of which 29 were pregnant smokers.

Substance Misuse

61. Individuals successfully completing drug / alcohol treatment programmes demonstrate a significant improvement in health and well-being in terms of increased longevity, reduced alcohol related illnesses and hospital admissions, reduced blood-borne virus transmission, improved parenting skills and improved physical and psychological health.

62. In the latest 18-month monitoring period, to the end of 2022-23 Q1, 318 alcohol users were in treatment in York and 70 (22%) left treatment successfully and did not represent within six months. The equivalent figures for opiate and non-opiate users were 4% (18 out of 471) and 25% (56 out of 226) respectively. The York rates are currently lower than the national averages (37% for alcohol users, 5% for opiate users and 34% for non-opiate users).

63. Through the Supplemental Substance Misuses treatment and recovery grant, we are investing £340k this year in drug and alcohol treatment services and prevention schemes, which will increase the number of treatment places available, expand the pathways into treatment, and reduce caseloads in order to improve quality and outcomes for York citizens.

Healthy Child Service

64. The full National Child Measurement Programme (NCMP) was completed in York for 2021-22 after a partial programme in the previous two measurement years due to the Covid-19 pandemic. 98% of reception aged children and 95% of Year 6 children were measured. The results are due to be published at LA level in November / December 2022.

65. In 2020-21 only five schools in York were measured as part of a limited programme to provide data at regional and national level. No local authority level obesity prevalence data was published for 2020-21.

66. The 2019-20 programme was discontinued in March 2020 due to the COVID-19 pandemic. The data submitted for children measured prior to lockdown was published with appropriate local data quality flags. The coverage rates for York for 2019-20 were 38% for year 6 pupils and 57% for reception (annual coverage rates are usually in excess of 95%). As a

result of this, the York values were flagged as ‘fit for publication but interpret with caution’. The 2019-20 NCMP found that 8% of reception children in York were obese, which is significantly lower than the England average (10%). The York figure has fallen from the 2018-19 level (10%). Of Year 6 children in York, 22% were found to be obese in 2019-20, which is not significantly different from the England average (21%). The York figure has increased from the 2018-19 level (15%). There is a wide variation in obesity rates at ward level, and there is a strong correlation between obesity and deprivation at ward level.

67. The key performance indicators for the Healthy Child Service in York for 2021-22 Q4 are presented below. 67% of new-born children in York received a new birth visit within 14 days (compared with the England average of 79%). 85% of new-born children in York received a 6-8 week review within 56 days (compared with the England average of 79%). 88% of children in York had a one-year review before 12 months (compared with the England average of 69%). 85% of children in York had a two-year review before 30 months (compared with the England average of 72%).

68. At the 2.5 year review, each child's level of development on five domains (communication, problem solving, personal and social development, gross motor and fine motor function) is measured using the ages and stages questionnaire. In 2021-22 Q4, 89% of children in York reached the expected level of development on all five domains, compared with the England average of 79%.

69. In 2021-22 Q4, 59% of children in York (with a feeding status recorded) were totally or partially breastfed at 6-8 weeks, compared with the England average of 55%.

70. Breastfeeding data was aggregated for a 4 year period (April 2018 to March 2022) to provide robust data at ward level. The percentage of children who were totally or partially breastfed at 6-8 weeks at ward level varied from 41.6% to 78.3% with York average of 59.0%. Higher rates of ward deprivation are associated with lower breastfeeding rates at the 6–8-week review.

Sexual and Reproductive health

71. Being sexually healthy enables people to avoid sexually transmitted infections and illnesses, and means that they are taking responsibility for ensuring that they protect themselves and others, emotionally and physically. It also ensures that unwanted pregnancies are less likely to occur.

72. In the period April 2020 to March 2021, the rate of conceptions per 1,000 females aged 15-17 in York (9.9) was lower than the regional (15.4) and national (12.2) averages. There has been a gradual fall in this rate in York over recent measuring periods (for example, the rate in York during April 2019 to March 2020 was 15.9).

Other Public Health Issues

Adult Obesity / Physical Activity

73. Obesity amongst the adult population is a major issue as it puts pressure on statutory health and social care services, and leads to increased risk of disease, with obese people being more likely to develop certain cancers, over twice as likely to develop high blood pressure and five times more likely to develop type 2 diabetes. It is estimated that obesity costs wider society £27 billion and is responsible for over 30,000 deaths each year in England.

74. The latest data from the Adult Active Lives Survey for the period from mid-November 2020 to mid-November 2021 was published in April 2022. The period covered by the survey includes five months of notable restrictions (two-and-a-half months of full national lockdowns and two-and-a-half months of significant restrictions) and seven months of limited restrictions (three months of easing restrictions and four months with no legal restrictions). In York, 523 people aged 16 and over took part in the survey, and they reported higher levels of physical activity, and lower levels of physical inactivity, compared with the national and regional averages.

75. The Survey showed that 67% of the people questioned in York did more than 150 minutes of physical activity per week compared with 61% nationally and 60% regionally. There has been no significant change in the York value from that of 12 months earlier. In addition, 24% of people questioned in York did fewer than 30 minutes per week compared with 27% nationally and 28% regionally. There has been no significant change in the York value from that of 12 months earlier.

Smoking: pregnant mothers

76. Smoking in pregnancy has well known detrimental effects for the growth and development of the baby and health of the mother. The Tobacco Control Plan contains a national ambition to reduce the rate of smoking throughout pregnancy to 6%, or less, by the end of 2022.

77. For the latest 12 month period for which figures are available (July 2021 to June 2022), 8.0% of mothers that gave birth in York were recorded as being smokers at the time of delivery. This represents an improvement on

the figure (9.9%) for the previous 12 month period (July 2020 to June 2021). However, there is considerable variation within the wards in York on this figure, ranging from 0% to 17% of mothers being recorded as smoking at the time of delivery in the latest 12 month period.

Smoking: general population

78. Smoking, amongst the general population, has a number of well-known detrimental effects, such as increased likelihood of certain cancers, increased likelihood of heart disease, diabetes and weaker muscles and bones. It is estimated that smoking-related illnesses contribute towards 79,000 premature deaths each year in England, and that the cost to the NHS is approximately £2.5bn each year, with almost 500,000 NHS hospital admissions attributable to smoking.

79. Information on smoking prevalence amongst the general population comes from the Annual Population Survey (APS). The data for 2020 shows that 9.6% of the 18+ population in York were reported as smokers, which is a lower percentage when compared with adults in the Yorkshire and Humber region (12.9%) and in England as a whole (12.1%). The survey methodology changed in 2020 and therefore comparisons with data published in previous years are not valid. Amongst those who work in “routine and manual occupations”, 17.6% of people aged 18-64 in York were reported as smokers, which is a lower percentage when compared with adults in the Yorkshire and Humber region (22.3%) and in England as a whole (21.4%), however people in ‘routine and manual occupations’ are 4.5 times as likely to smoke as the general population in York compared to 2.8 times nationally.

Alcohol-related issues

80. The effects of alcohol misuse are that it leads to poor physical and mental health, increased pressure on statutory health and social care services, lost productivity through unemployment and sickness, and can lead to public disorder and serious crime against others. It is estimated that harmful consumption of alcohol costs society £21 billion, with 10.8 million adults, in England, drinking at levels that pose some risk to their health.

81. In 2020, there were 69 deaths from alcohol-related conditions in York (53 males and 16 females); a rate of 35 per 100,000 population. This rate is lower than regional and national averages (41 and 38 per 100,000 population respectively).

82. Other relevant statistics demonstrate alcohol harms continues to be an issue for the city:

- In the off-trade (e.g. supermarkets), the amount of alcohol sold per adult per year in York is 6.4 litres, compared with 5.4 litres in England.

- The proportion of adults who abstain from drinking alcohol in York is 11.2%, compared with 16.2% in England.

- The proportion of adults drinking over 14 units per week is 21.4%, compared with 22.8% in England.

- In 19/20, the admission rate of York residents to hospital directly attributable to alcohol was 545 per 100,000 in York, compared with 519 per 100,000 in England; indirectly attributable to alcohol was 1,996 per 100,000 in York compared with 1,815 per 100,000 in England.

83. The newly commissioned Changing Habits service is for people who have started to develop unhealthy drinking habits or whose alcohol consumption may be causing health or relationship problems. The service offers help to change unhelpful drinking patterns and build new ways of coping with life's challenges. It is anticipated that later in 2022 the Public Health team in York will be able to resume delivery of the Alcohol IBA (Identification and Brief Advice) training to health professionals and frontline staff across the city. The training is aimed at staff who have regular contact with residents, to equip them with the skills to measure drinking levels and offer simple advice on how to reduce alcohol consumption.

Mental health

84. It is crucial to the overall well-being of a population that mental health is taken as seriously as (more visible) physical health. Common mental health problems include depression, panic attacks, anxiety and stress. In more serious cases, this can lead to thoughts of suicide and self-harm, particularly amongst older men and younger women. Dementia, particularly amongst the elderly population, is another major mental health issue.

85. The latest published data on deaths by suicide in York shows that in the three year period from 2018-20 there were 70 deaths by suicide for York residents, which represents an increase of nine deaths by suicide from the previous three year period (2017-2019). The rate per 100,000 of population in York (13) is above, but not significantly different from, the national average (10) and is in line with the regional average (13).

86. Published data for the three year period 2018-20 shows that there were 55 deaths by suicide for male York residents which represents an increase of nine deaths by suicide from the previous three year period (2017-2019). The rate per 100,000 of population in York (21) is significantly above the national average (16).

87. Published data for the three year period 2018-20 shows that there were 15 deaths by suicide for female York residents which represents no change compared with the previous three year period (2017-2019). The rate per 100,000 of population in York (6) is above, but not significantly different from, the national average (5).

88. A more up-to-date indication of the number of suicides in York is available from the Primary Care Mortality Database (PCMD). This dataset shows that in the most recent rolling three year period (April 2019 to March 2022) there were 70 deaths (55 male and 15 female) i.e. no change from the published total number of deaths in the previous three year period (2018-2020).

89. The proportion of people in York aged 65+ with a recorded diagnosis of dementia is 3.48% compared with a national average of 3.97% and a regional average of 3.96%. The estimated diagnosis rate (the number of people diagnosed with dementia as a proportion of the expected / modelled number of people with dementia) for people aged 65 and over in York is 55%, compared with a national average of 62% and a regional average of 63%.

Life Expectancy and Mortality

90. Average Life Expectancy and Healthy Life Expectancy for males in York (79.9 years and 65.3 years) is above the England average (79.4 years and 63.1 years). Average Life Expectancy and Healthy Life Expectancy for females in York (83.6 years and 64.6 years) is also above the England average (83.1 years and 63.9 years).

91. The inequality in life expectancy for men in York for the measurement period 2018-20 is 8.4 years. This means there is around an eight-year difference in life expectancy between men living in the most and least deprived areas of the City. This inequality has been fairly stable in recent periods (8.4 years in 2016-18 and 8.3 years in 2017-19).

92. The inequality in life expectancy for women in York for the measurement period 2018-20 is 5.7 years. This means there is around a six-year difference in life expectancy between women living in the most and least deprived areas of the City. This figure has fallen (improved) compared with the figure of 6.2 years in the period 2017-19. The inequality in York

is below the England average for men (9.7 years) and for women (7.9 years).

Recommendations

93. As this report is for information only there are no specific recommendations.

Reason: To update the committee on the final financial and performance position for 2022-23.

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Report Approved	X	**Date**	19 September 2022

Specialist Implications Officer(s) None

Wards Affected: List wards or tick box to indicate all **All** Y

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

Report of the Consultant in Public Health

York Health Trainer Service and NHS Healthchecks - update

Summary

1. This report provides an update for Scrutiny discussion on the York Health Trainer Service and commissioned NHS Healthchecks service.

Background

2. The council's public health priorities include supporting our citizens to achieve and maintain a healthy lifestyle.

3. At a population level, the determinants of healthy lifestyles are rooted in the circumstances and opportunities available to each individual, and they are especially determined by the building blocks of good health, including good housing, quality education, meaningful work and social connection.

4. However at an individual level, there are a number of identified behavioural risk factors for ill health, particularly the three main disease groupings which cause inequality in health outcomes (cardiovascular disease, respiratory disease and cancer). These risk factors – smoking, unhealthy diet, alcohol, lack of physical activity – are amenable to intervention and support, using evidence-based behaviour change methods

5. Two of the key programmes which we operate as part of this are the in-house Health Trainer Service, and the commissioned NHS 40-74 Healthchecks programme. This paper update scrutiny members on progress in both these areas.

Health Trainer Service – smoking cessation

6. The Health Trainer service functions as York's community Stop Smoking Service. This includes delivering around 6 sessions of one-to-

one behavioural interventions, as well as giving citizens easy access to free nicotine replacement medications such as NRT or e-cigarettes that make the journey to being smoke free easier.

7. Helping people stop smoking is the best intervention any health or care system can deliver to improve population health. Smoking is the single leading cause of preventable death in York, causing annually around 300 deaths and over 1,400 hospital admissions. Whilst smoking rates have reduced over the last decade, at least 1 in 10 residents still smoke. Smoking is responsible for half of the difference in life expectancy between the least and most deprived in our area. Nationally, there is an ambition is to create a smokefree generation, where fewer than 5% of people smoke across all demographic groupings within society by 2030.

8. Stop smoking interventions have a strong evidence base, and a combination of NRT and behavioural support lead to an individual being more than 3 times more likely to quit than quitting with no support. However, they are underused, and the most frequent quitting method is still going ‘cold turkey’ (the least effective).

9. The final data for 2021-22 shows that the Health Trainer Service’s stop smoking team received 548 referrals from those wishing to quit smoking. Of these, 363 (66%) went on to engage with an advisor. Subsequently, 226 went on to set a quit date and 143 (63%) had quit smoking after four weeks. There were 109 pregnant smokers who were in the group of 548 referrals. Of these, 52 (48%) went on to engage with an advisor. Subsequently, 33 went on to set a quit date and 24 of them (73%) had quit smoking after four weeks. To date in 2022-23 there have been 202 referrals from those wishing to quit smoking, of which 29 were pregnant smokers. Our quit rates are above the national average, and since closer working with primary care in the city and a communications campaign in 2021, the number of people referred to the service has risen steadily.

10. The Tobacco Alliance, chaired by a Consultant in Public Health, ensures that we tackle some of the wider issues that lead to people taking up smoking, such as ease of access to cheap illicit tobacco products, and published a Tobacco Control Plan for York in 2020.

11. To illustrate the real-life impact of the service, we include just one of many case studies on stop smoking we have collected:

    "I joined Health Trainers because the pandemic meant I was smoking more so I joined the service as I knew I couldn't stop smoking on my own. I also needed the extra support.

I've achieved something I've not been able to for the past 4 years! Quitting has paid for a holiday, which I booked with money saved. I've not had a single cigarette since quitting and I've been out around smokers without reaching for a cigarette. My friends can't believe I've quit and stuck to it!

"After evening meals was most challenging as I would always have a cigarette then, but using the lozenges and talking through with Beth (Health Trainer) how I could change my routine and distract myself helped with this.

"Not smoking has been a huge change to my lifestyle and means I'm able to focus on my diet and exercise easier now, as I could not focus on changing anything else until I had stopped smoking. It consumed me. I plan on staying quit forever!"

Health Trainer Service – alcohol, weight, diet, physical activity and social isolation

12. Our Health Trainer Team also provide individuals with treatment and support to tackle the things that increase the risk of ill health, such as excess weight, high blood pressure, lack of exercise and poor diet. The Health Trainers put the individual at the centre and work with them to help achieve the health goals that matter to them.

13. Over the last year, the service has run clinics in community venues across the city and has support around 300 people in up to 6 sessions of face-to-face and telephone support around five key areas:

    - reducing your alcohol intake
    - quitting smoking
    - healthy eating advice and weight management
    - finding new ways to be more active
    - helping you find groups and activities to get back out in the community

14. As an example, Health Trainers will give people advice and support on reducing alcohol intake, with information and guidance around safe levels of drinking, helping to understand the effects alcohol has on health, providing personalised support to stop or lower your levels of drinking, and link you with other services for specialist support, including the Changing Habits Service and the new 'Lower my Drinking' website and app which public health have recently commissioned.

15. To illustrate the real-life impact of the service, we include just one of many case studies on healthy weight we have collected:

"I joined Health Trainers because I'd gained a considerable amount of weight during lockdown and needed some help and support to stop the negative cycle.

My biggest achievement has been regaining control of my eating habits.

"The biggest challenge for me was that my relationship with food is always difficult but having the time set aside on a regular basis helped me have time and space to reflect on this.

"I've regained control of my diet and Beth (Health Trainer) really helped me put a stop to a negative cycle of weight gain... There was no judgement, every session was positive and gave practical, actionable next steps."

NHS Health Checks

16. The Health Check programme aims to help prevent heart disease, stroke, diabetes and kidney disease. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions, will be invited (once every five years) to have a check to assess, raise awareness and support them to manage their risk of cardiovascular disease (CVD). A high take up of NHS Health Check is important to identify early signs of poor health, and lead to opportunities for early interventions.

17. The Health Check programme was halted in line with national guidance during the COVID-19 pandemic period.

18. Since September 2021, we have re-launched Healthchecks in York, and have integrated into the service model the findings from the 2021 Deanfield Review. This has meant that the programme includes 'local' priorities as well as the national service specifications. These include:

    - Targeted invites to increase engagement from those living in the more deprived postcodes in York
    - Geographical spread to ensure good access
    - Specific work to invite and support those whose cardiovascular disease outcomes are often poorer (BMI, smoking, or a history of mental health issues)

19. Nimbuscare, the Primary Care Services collaboration in York with all 11 GP practices in the city as members, were appointed to restart the delivery of health checks towards the end of 2021, with a target of 2,000

checks a year. This target is lower than the number needed to see our eligible population every 5 years, due to constraints in the public health budget. However with the decisions made to target the checks to those in higher risk groups, this will be mitigated by a higher 'yield' of the population being identified as having CVD, maximising the gain the programme delivers for our population with the resources available.

20. So far 1,316 appointments have been offered and have been delivered in York over the three quarters in which the service has been delivered.

21. The checks also enable the public health team to work more closely with Primary Care Networks and the programme is being delivered in a number of community and primary care settings, often in conjunction with the Health Trainer service, leading to a more joined up service for the patient.

Recommendations

22. As this report is for information only there are no specific recommendations.

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Report Approved	X	**Date**	19 September 2022

Specialist Implications Officer(s) None

Wards Affected: *List wards or tick box to indicate all* **All** *Y*

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DRAFT - Health and Adult Social Care Policy and Scrutiny Committee

Work Plan 2022/23

27 June 2022, 5:30pm (Informal Forum)	1. Annual outline of aims and objectives for the coming Municipal year by Leader and/or relevant Portfolio Holders, including any significant issues likely to be in the Forward Plan.
5 July 2022, 5:30pm Commissioned Slot	1. Dementia Strategy
13 July 2022, 1:00pm Joint CSMC / HASC Commissioned Slot - Deferred, date TBC	1. 10 Year Strategy - Health & Wellbeing
27 July 2022, 5:30pm	1. An Integrated Care System (ICS) update (Jamaila Hussain) 2. Health and ASC Finance and Monitoring Report (Q4) (Steve Tait) 3. Work Plan

27 September 2022, 5:30pm Commissioned Joint Committee with Children, Education & Communities Policy & Scrutiny Committee Postponed – Date to be confirmed	1. Draft Autism Strategy (Jamaila Hussain/Abby Hands) 2. Healthy child update (Fiona Phillips/Jodie Farquharson)
28 September 2022, 5:30pm	1. Local Area Coordination/Social Prescribing – Update on the various provisions (Joe Micheli/Jennie Cox/Christine Marmion) 2. Health and ASC Finance and Monitoring Report (Q1) (Steve Tait/Terry Rudden) 3. York Health Trainer Update and NHS Healthchecks (Peter Roderick) 4. Work Plan
Informal Meeting, 01 November 2022, 5:30pm	1. Children's healthy weight update (Fiona Philips/Leigh Bell) 2. Health and Social Care, Reablement Pathway update (Jamaila Hussain) 3. Update on oral health in schools (Anita Dobson/Philippa Press) 4. Work Plan

22 November 2022, 5:30pm	1. Health and ASC Finance and Monitoring Report (Q2) (Steve Tait/Terry Rudden) 2. Update on the Care Quality Commission (CQC) inspection that took place at York hospital in March. (Chief Executive of York Teaching Hospital NHS Foundation Trust) 3. TEWV Foss Park update (Managing Director and Interim Care Group Director for North Yorkshire and York) 4. Access to GP services – (Humber & North Yorkshire Health and Care Partnership) 5. Work Plan
14 December 2022, 5:30pm	1. Integrated Care System 2. Elective Care post pandemic (TBC)
21 February 2023, 5:30pm	1. Health and ASC Finance and Monitoring Report (Q3) (Steve Tait/Terry Rudden) 2. Update on the Dementia Strategy (Jamaila Hussain) 3. Cost of Care Review – Cap of Care (Jamaila Hussain) 4. York Drug and Alcohol Strategy – (Peter Roderick/Ruth Hine) 5. Update on children's healthy weight - (Fiona Philips/Leigh Bell) - TBC 6. Work Plan

Proposed items for consideration:

- Children and Young People Plan / CAMHS Provision in York
- To receive the draft Market Position Statement