local area coordination

Fourteen month evaluation report

"The Local Area Coordinator came in at a very difficult time where I had hit rock bottom and was on anti depressants – The Local Area Coordinator was my lifeline."

The LAC is genuinely interested in me and does not have an agenda. I feel completely in control and that the LAC is on my side. There are things that I have done that I wouldn't have been able to do without the support of the LAC.

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Foreword

Comments from the steering group and partners

Les Billingham - Head of Adult Services (Thurrock Council) and Chair of the Steering Group

Implementing Local Area Coordination (LAC) was a big risk in an authority like Thurrock. We are small, not well resourced and subject to the same intense financial pressure faced by all of the public sector as a consequence of the Government's austerity programme; committing resources to a scheme focused on prevention that is outside of eligibility criteria was difficult.

The need for really impressive evidence concerning the impact of Local Area Coordination was therefore paramount. I hoped that the evidence would be incontrovertible and compelling and enable us, after a year of piloting the scheme, to build on our initial deployment of three LACS and achieve borough-wide coverage.

Being able to contribute to this report, which contains so much evidence of the positive impact of LAC after the scheme has been running for just over a year, feels very satisfying. Furthermore, being able to report that the evidence of success was so overwhelming so quickly, that we were able to convince partners to fund a further six posts within the pilot period, is testament to the significance of this approach in the context of preventing crisis and managing demand. I am really looking forward to receiving ever more heart-warming stories of the way that LAC is changing lives for the better as the new LACs join the team and begin to deploy into new communities.

Ralph Broad – Director of Inclusive Neighbourhoods

Thurrock Council is at the forefront of an emerging Local Area Coordination national movement to support individuals (especially those who may be isolated, excluded or vulnerable due to disability, age or mental health needs), their families and communities to stay strong, connected and supportive. Thurrock is also applying these same principles to build services that are more connected, local, personal, flexible and efficient as part of wider reform.

It has been exciting to hear stories of people and their families being supported to:

- find sustainable, local, low cost/no cost solutions to issues and aspirations
- build new, valued, supportive relationships - reducing isolation
- lead in the recruitment of their Local Area Coordinators – real co-production in practice
- having opportunities to be part of and contribute to their communities

Although it is very early days, this work now provides the opportunity to change the way that the Council and local citizens work together in the future.

The work in Thurrock, as lead members of the Local Area Coordination Network and national evaluation with University of Birmingham, is also informing, inspiring and supporting developments in other parts of England and Wales.

I welcome this new report and the possibilities in the future.

Michelle Stapleton – Integrated Care Director, Thurrock Locality (North East London NHS Foundation Trust)

The development of Local Area Co-ordination in Thurrock has been fully supported by NELFT community health provision. The LACs have worked closely with our integrated community teams and primary care MDT co-ordinator. This has developed into a collaborative approach to providing solutions for our patients in regard to enabling them to manage within the community setting.

The role of the LAC has embedded well into the community and has added a different but positive dimension to supporting our patients in the community.

Lesley Matthews – Thurrock Unsighted Peoples Society and recruitment panel member

The service has been absolutely brilliant. I have worked with several of the Local Area Coordinators and have found their professionalism, timekeeping and communication outstanding.

LAC is a personal service that really cares and there is always a follow up and an outcome. All avenues are explored and the LACs think out of the box to see if they can achieve outcomes in a number of different ways.

Sue Bradish – Public Health Manager (Thurrock Council)

The Public Health department has engaged positively with the development of the LAC service. We have been pleased to support their work on an individual and community level that has addressed some of the Public Health expected outcomes around increasing health improving behaviours and has informed some of our other work such as the JSNA and Public Health Annual Report.

We welcome the opportunity to work closely with the growing team to evolve this relationship further.

Sue Kane – Sheltered Housing Manager (Thurrock Council)

LAC compliments our work in housing. We have forged a good rapport with the LAC's and their support to us and the community has proved invaluable. By increasing the numbers to the ranks of LAC, it will provide a wider base for housing to work with in partnership, and support the community in all areas of Thurrock.

Kristina Jackson – Chief Executive (Thurrock CVS)
Being part of the LAC process since the beginning – it has be good to implement in partnership a change in the statutory recruitment process. The community are now involved in three stages of the LAC recruitment process, a role that they both enjoy, value and has given them a sense of ownership over their LAC.

Daniel Gatehouse – Strengthening Communities Manager (Fire Service)
Essex County Fire and Rescue Service are proud to have been able to take an active supporting role in the development of Local Area Coordination. We have given both financial and personnel support to the initiative because we see the true value in all it aims to achieve. The LAC's in Thurrock have been able to become the link between those vulnerable people most at risk of falling into the care system and the support services that are available to them. The LAC's have achieved astounding results in the relatively short time they have been in existence, changing the lives of people that had the potential to become dependent on public sector services or worse still become a fatal statistic.

We would like to confirm our continued support for Thurrock Council and Local Area Coordination, looking forward to all the initiative has the potential to achieve.

Executive Summary

I am very pleased and proud to present this report which details the impact and successes since the introduction of the first Local Area Coordinators in Thurrock fourteen months ago. The report will give some moving stories of the personal impact some people have had from working alongside Local Area Coordinators, and some quotes from stakeholders and others who have come into contact with the project and the Local Area Coordinators. Whilst this report covers 14 months of LAC activity, the most recent recruits have only been in post for 4 months. Most formative evaluations are undertaken 2 – 3 years after undertaking a new way of working, however, there is a challenge to share findings now. The full benefits will take longer to evidence and Thurrock will work with the LAC National Network and Birmingham University to ensure this takes place.

The change in thinking since working to the Local Area Coordination principles cannot be underestimated. For all involved there has been a mind shift and constant challenge to how we 'do business' and how we work with people and communities. This is particularly high on the agenda at the current time due to the need to review our offer in line with the Care Act and the budget challenges. This has impacted on other services and we will evidence this throughout the report. We are on a journey in Thurrock and this report will evidence how we have moved on. The report aims to give evidence on how working in a different way gives different outcomes and how having individuals based in the community with a different brief works. Also, it has helped us to develop our thinking about where Social Work fits in. Feedback from people who have worked with Local Area Coordinators is undeniably important, but the savings and impact on services and budgets are also key. There is evidence on numbers of people we have worked with, potential savings and how working in this way has avoided calls on formal services and prevented crisis. These areas are hard to evidence but the report has tried to show this where possible by talking to people and professionals and asking the question what would have happened if a LAC was not involved. We have also attempted to show how the LAC role works even when a number of services are involved and co ordination is required. Details of how Local Area Coordination has developed, how the project has been funded and expanded and the role of the steering group is explained.

Background to Local Area Coordination has been included in Appendix A of this report as many already know the principles and aims of working in this way. We have also been asked to include more stories for people to read if they want additional evidence of the impact for local people and want to see more examples of Local Area Coordination in practice (Appendix C). Whilst writing this report I also received a weekly update from an LAC which was very powerful and have included that as an appendix as an example of the week in the life of an LAC (Appendix D).

We hope you find this report interesting and helpful. Please do not hesitate to contact me or one of the team if you want to know more. This is still only the beginning of a new way of working and the potential is huge.

Tania Sitch, Project Lead for Local Area Coordination
November 2014

1. Introduction and Background

Over 2 years ago a representative Steering Group was established. The brief for the group was to provide active and visible leadership to the development and delivery of a Local Area Coordination Project in Thurrock. The Steering Group has remained strong and has led the expansion of Local Area Coordination and has been key to the success and impact that we will detail in this report. Their endorsements and comments are included in the front of the report.

Thurrock is also part of a growing national network developing Local Area Coordination across the UK.

The Steering Group and Project Team have continued to meet regularly and their focus and priorities remain as detailed below:

- To continue to assess the potential of Local Area Coordination and measure the impact of LAC in contributing to the Thurrock Vision, and the strengthening of communities and individuals.
- To embed Local Area Coordination and gain a clear understanding of how LAC can contribute to wider service reform.
- To build connections with other strength based approaches; we are a partner of the Stronger Together group which brings together all community initiatives including Asset Based Community Development, Community Hubs and community micro-enterprises etc.
- To have conversations across the council and with partner organisations in order to share learning.
- To work closely with the voluntary sector to ensure efficient joint working that supports citizens and avoids duplication.
- To hold conversations with local communities and make links with community leaders.
- To evidence that this is not only the right thing to do but is good use of public money.
- To support the principles that defines the unique role of the Local Area Coordinator within the community.
- To identify appropriate streams of funding to enable Local Area Coordination to continue whilst collecting evidence and measuring impact.

Membership of the Steering Group includes representatives from: South Essex Partnership Foundation Trust, North East London Foundation Trust, Community Voluntary Services, Housing, Adult Social Care, Healthwatch, Public Health, Children's Social Care, Thurrock Clinical Commissioning Group, The Essex Fire and Rescue Service and most recently Essex Police.

One of the successes of the Steering Group has been the opportunity for leaders to come together to share information, expertise and connections, start to build a shared vision for the future and challenge each other to work differently.

The Steering Group have all endorsed this report.

2. Recruitment and funding of Local Area Coordinators

It was initially agreed by the Steering Group to recruit Local Area Coordinators (LACs) in three areas and look at the impact Local Area Coordinators can have. Stanford–Le–Hope, Grays Riverside and Purfleet were identified by the group as the areas to start with. However, there was a lot of enthusiasm from stakeholders to trial the approach in South Ockendon working alongside the South Ockendon Centre.

Three LAC's were recruited and started in July 2013. Due to close partnership working as part of the steering group, the Fire Service were keen to second an officer to work as part of the LAC team. Martin Trevillion started in April 2014 as a jointly funded post in Purfleet.

After successful implementation of Local Area Coordination in these areas, it was agreed in April 2014 that two new LACs would be recruited and a decision was made to recruit a Team Manager. The two new areas identified were Stifford Clays and Tilbury Riverside/St Chads. Jon Biddle was appointed Manager of the team. All six LACs come from varying backgrounds, giving a broad range of skills, expertise and experience to the team. In total three LAC areas have had a LAC in post for 14 months, one for 7 months, two for just 4 months and one for 3 months.

We are in the process of recruiting for 3 LACs in East Tilbury, West Thurrock and Chadwell St Mary, which will give coverage across Thurrock. Please refer to Appendix E for full details.

The Local Area Coordinators have all been chosen by local communities in a highly inclusive recruitment process led by CVS and Thurrock Lifestyle Solutions. This approach is now also being used across other services for roles including Social workers, Support Planners and Occupational Therapists. This was achieved because we had already made good links with local community leaders. A summary of the recruitment process is attached at Appendix B.

A comprehensive induction process has been developed which includes meeting with Local Area Coordinators nationally and connecting with the local communities and the voluntary sector. This has been very successful and continues to be used for all new staff.

Funding of the LAC's

The Adult Social Care management team were sufficiently confident early on that the Local Area Coordination role would reduce demand on services that they funded three LAC posts from their core budget. This was achievable by deleting vacant social care fieldwork posts. It was a positive decision to move resources to a more preventative model and took a leap of faith on behalf of the management team.

The Fire and Rescue Service were of the view that this role could support them to further develop their community work and part funded a seconded Firefighter to the role of LAC. We are also currently in early discussions with the Police Service to consider a similar arrangement.

Three posts are funded from Public Health grants as it is the view that the LACs will improve the health and wellbeing of individuals by working alongside them. Robust outcome based measures are put in place to test this as the project develops.

The final three posts are currently funded through the Better Care fund. There were lots of competing requests for funding from this joint Health and Social care funding pot, and Adults Social care and health prioritised this bid for funding over other posts and initiatives, again demonstrating the focus on prevention and working differently with communities and individuals as a way forward.

The LAC posts are currently funded up to March 31st 2016.

3. Working alongside Individuals and Families

Since the Local Area Coordinators (LACs) started there have been over 300 introductions. Out of these introductions:

- 57 have been allocated to Stanford-Le-Hope
- 84 have been allocated to Grays Riverside
- 61 have been allocated to South Ockendon
- Since April 2014, 15 have been allocated to Purfleet
- Since June 2014, 18 have been allocated to Tilbury Riverside/St Chads
- Since June 2014, 21 have been allocated to Stifford Clays
- 52 are out of the allocated LAC areas and we have not allocated these to date.

There are two levels of support available through Local Area Coordination. These are:

- Level 1 support is the provision of information and/or limited support. There is no assessment or intake process. Anyone can contact the Local Area Coordinator for Level 1 support. Although information and advice is often given

and no further support is needed at that time, a connection has been made that may be of benefit in the future.

- Level 2 support is a longer term relationship supporting people (children and adults); 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, find practical solutions to problems etc.

Introductions are increasing, for the first 3 days of this week 11 introductions were received. This includes introductions for the new areas where a LAC isn't in post at present.

Who is receiving support?

- 136 are male and 120 are female.
- Ages 18 – 98 years
- 60 are receiving "Level 2" support
- Of the people currently receiving support:
    - 12% have learning disabilities,
    - 27% have mental health issues,
    - 31% are older people,
    - 15% have physical disabilities,
    - 4% have sensory impairments and
    - 11% "other"

How are we coming into contact with people?

To date introductions are from a wide variety of sources including:

- The Council's initial contact service - Community Solutions
- Social workers and support planners across all services including mental health teams
- Third Sector organisations
- Multi-disciplinary meetings (MDT's) based around GP surgeries
- The Mayor of Thurrock Council and ward Councillors
- Direct from the community and meeting people at Community Events
- Community Hubs
- Housing
- Police and Fire Services

We have also noticed an increase in introductions in recent months from colleagues in the Mental Health Services and Housing.

4. Analysis of achievements

In the first 14 months of operation, we have noted some key themes and outcomes emerging and so we have decided to report on the activities of the LACs and their achievements using these main areas of impact. You will find brief descriptions of activity and one story that we think best illustrates the outcomes that have resulted from the LAC's approach to working alongside an individual. What is so striking from these stories is the quality of life that the individual has achieved as a result of finding local solutions that equate to a 'good life' – the starting point for all conversations between the LAC and the individual.

But, as noted in our introduction, we have to evidence the financial savings to the whole system as a result of our investment in the LAC approach. To this end, we have also included costings data that relates to the potential savings that the LACs have achieved. So, for example, in the case of work with an individual to overcome hoarding and the risk of a house fire, we have provided the unit cost of a domestic fire.

A note on the data used in this report

The unit costs included in our report are largely derived from a database developed by The New Economy Manchester, for the DCLG's Transformation Challenge Award. The database contains costs across the following themes: crime; education and skills; employment; fire; health; housing; and social services. In particular, it builds on work by six localities (Birmingham, Hammersmith & Fulham, Oldham, Tameside and Westminster councils, and Essex County Council), alongside a range of other contributors. The data have been subject to a rigorous validation process, including assessing the robustness of the original source documentation, considering how data have been derived from constituent cost elements, comparing costs to related data, and exploring the availability of more recent/robust sources. Also, we have used data from ASH around smoking and associated costs and the British Heart Foundation on the cost to health on physical inactivity.

After each story we have attempted to evidence the potential savings and impact. Appendix E also includes a table of savings.

LAC activities and analysis of achievements

There is a very strong theme emerging around isolation in our local communities and the needs of people who do not meet current eligibility criteria for formal services:

Area of Impact

Supporting people to build new relationships, overcoming isolation

- Local Area Coordinators receive a large number of introductions from people regarding individuals who are isolated and would not meet the Council's criteria and therefore, not eligible for services. Isolation is a major health risk and so combating social isolation and loneliness is an important aspect of our prevention strategy.
- Local Area Coordinators have immersed themselves within their communities, getting to know local groups, organisations, businesses and individuals. Local Area Coordinators look for ways and work towards linking people into their communities matching up their strengths and passions with other individuals or groups in the local community. People have been linked with Community Hubs and forums, social groups, hobby groups, lunch clubs, faith groups, community cafes, support groups and volunteer opportunities. An example is one individual who now attends social gatherings each week which has had multiple benefits including reduced isolation and a **reduction in visits to the GP surgery**. The LAC was contacted by the social group when the individual had not attended due to illness, demonstrating the support network now actively working around this individual helping him remain strong.
- As the Local Area Coordinators have developed their knowledge of their communities and individuals within the community, it has also been possible to link people together, where there would be a mutual benefit to do so. This has meant people have been able to share what they have to offer with others including gardening, laptop tuition and providing transport.
- A high number of introductions have come from Adults who have experienced Mental Health and as a result become isolated and lost opportunities to work. Many of this group feedback that they need support when the crisis is over as this is when historically when services would have withdrawn.
- **Over 90 people** have been assisted to engage more with their community by linking with groups or to engage more with family and friends

Story 1 - Mr R

INTRODUCTION:
Mr R was introduced to the LAC by the Older People Mental Health Team Care Coordinator, as it was felt he would benefit from support by providing him with information and with overcoming isolation, being heard and planning for the future.

SITUATION:
Mr R is a 69 year old man, with a history of depression. He has made suicide attempts which required admission to hospital. There is limited family support and although physically healthy, Mr R was quite isolated and wanted to look at local facilities where he could make friends.

WHAT HAPPENED?
The LAC took time to get to know Mr R, to find out what was important to him and explore what a good life looked like to him. Mr R's key priority was to get out of the flat where he spent most of his time, as this contributed to his depression. He expressed a desire to help other people and to make more friends as well as wanting to feel safe, secure and confident. The LAC supported Mr R to explore family support from Ngage (a voluntary organisation supporting communities in Thurrock) and this resulted in Mr R becoming a volunteer driver three days a week with the Royal Volunteering Service and he is currently awaiting a DBS check to start volunteer driving for meals on wheels. The LAC also supported Mr R into a course, which he has now completed, in Computers for Absolute beginners at the Thurrock Adult College to improve his computer skills and enable access to social networks. With his new skills, he now uses Facebook and is registered with the local library to further enhance his computer training.

FOLLOW UP & NEXT STEPS:

Mr R is now settled in his volunteering role and continues to drive in the local community. Mr R has been connected to two individuals known to the LACs, and provides them with practical support.
An example of one of these connections has been with Mrs S, through volunteer driving. Through privileged conversation, they both mentioned and shared their experience of their own LAC involvement, how the LAC had supported them stay strong and connect with the community. Mr R now supports Mrs S, who suffers from agoraphobia, by sharing and using his experience with the local area coordinator. Mr R also supports another individual with his shopping who suffers from ulcerated legs, leaving him unable to walk to the shops or connect with his community.

QUOTES

'Before the LAC had been introduced to Mr R all he did was sit in doors 24 hours a day. The LAC has provided opportunities for Mr R to get out of the house a lot more involving helping others'.
'If it hadn't been for Francis I wouldn't be here now.'
Mr R's Psychologist also contacted the LAC to discuss how Mr R would benefit to a structured routine and volunteering. She commented that she had seen a drastic improvement in Mr R since working alongside the LAC (Francis) and she felt he had stayed well for longer than she had seen before, avoiding a crisis and potential admission.

Preventive Impact – Mr R - ***Based on the outcomes achieved and looking at what would likely have occurred if the LAC had not been involved, we can demonstrate potential savings to the system as follows:***

Mr R would have likely frequented the GP and other services including Mental Health Services and potentially inpatient. Mr R has contributed to the community by volunteering in a number of ways. Mr R has benefited from the volunteering but has also supported another individual who was isolated and in need of support.

Time and financial saving for reduction in GP visits: £125 per hour for General Medical Service (based on Curtis 2013 estimate).

Reduced demand on Mental Health Services:

£956 is the average annual fiscal cost of service provision per adult suffering from depression and anxiety disorders (based on 2008 research by the Kings Fund)

£445 average cost per bed day for adult mental health inpatients, specialist services, hospital attendance (NHS Reference Costs 2011-12, using the weighted average of data)

£162 average cost per contact for mental health community provision (NHS Reference Costs 2011-12, using the weighted average of data)

Fiscal contribution of Volunteering

£10.50 per hour is Thurrock's calculation of the fiscal value of volunteering. People assisted by LAC are now contributing 'social capital' to the wider benefit of the community.

From OPMH Team

"It has been great to have LAC provide to support to one of the individuals we introduced him to. The individual was receptive to the LAC where he hadn't been in the past. This was due to the LAC's persistence and also the fact that he wasn't a health professional.

The LAC had the time to get to know the individual and his passions and strengths, but also had the knowledge of the area that I wasn't aware of. Mr X had a history of being let down in the past and finds it difficult to trust people. The fact that LAC was there for him allowed him to build respect and trust.

I believe that if LAC was not involved there could potentially have been another admission."

From an Individual supported by LAC:

"The LAC has provided support where there didn't appear to be any support available – I have been linked into the community"

Area of Impact

Supporting people to find and develop non service, practical solutions to problems and assisting them to utilise personal and local networks where possible

- Local Area Coordinators have had much success with sharing their knowledge of the local area including groups and individuals to support people find non-service solutions to problems.

- There have been many examples of individuals being linked with voluntary organisations such as Besom, TLS and TRUPs to help equip their home to make it suitable for living. Also, referrals to CAB and other services have helped individuals access benefits and support.

- Local Area Coordination has made **18 introductions** where individuals have wanted to **share their passions or skills** with others to provide support. Examples include linking those with a passion for gardening to support those that are unable to tend to their own.

- Recently the LAC's have started to see success in connecting volunteers with local Day Care Centres and Residential Care Homes. By doing this the volunteers can share their passion and skills and the people attending those services also benefit.

- One individual has volunteered to support the Council's Workforce Planning Department to deliver training to Student Social Workers on his experience on living with depression. This connection was made possible by the LAC.

- Local Area Coordination is proving to be an alternative to social services and avoiding costly and time consuming assessments where they are not necessary. Feedback from the South Ockendon Centre that has made referrals to the LAC stated that if the LAC was not in place, they would have been referring more frequently to Adult Social Care.

- During the first 4 months of operation we reported that the Local Area Coordinators were helping people to find non service solutions to problems that would otherwise have required future funded services from Adult Social Care. This success has continued, including:
    - Supporting an individual to not need a personal budget **saving £7,500.00 per annum**.
    - Supporting individuals to not access social care funded day care by providing local alternatives – **over 19 individuals** have been supported to find local **alternatives to day care.** One day in local authority day care has a cost of £65 approx per day. There is also a waiting list for this service.
    - Supporting individuals which have led to a reduction in phone calls to and intervention from specialist services including safeguarding concerns being reduced.
    - Increasing number of stories of isolated older people being supported to think about the future and build connections and opportunities with

other local people – **more than 46 individuals over the age of 60 have been helped to engage more with other local people.**

- Also we have been able to work alongside families to find alternative ways to support them including linking a retired teacher to help with homework challenges and local mums to support with transport, and daily help with the Children.

- Individuals report that they feeling stronger and more supported thereby reducing dependency on Health Services including reduced calls and visits to A&E and GP surgeries. An example of this is one individual who required interventions from **Rapid Response Assessment Service, Out of Hours or NHS 111 service 41 times over a 7 month period,** which consequently **reduced after LAC intervention to 3 calls over a 4 month period**.

- LACs attend GP **Multi Disciplinary Team meetings** and offer alternative community and non service solutions to help people stay strong and also help people manage their own health more adequately. An example of this is supporting an individual to better manage his angina by introducing him to telehealth. The LACs are also looking to **support Children's Services MAGS (Multi Agency Group) panels** to help divert away from services by deploying alternative approaches.

Story 2 - Mr A

INTRODUCTION:

Mr A was introduced to the Local Area Coordinator (LAC) by his hospital Social Worker, for support with getting his bungalow ready to move into and connecting with the local community.

SITUATION:

Mr A is 58 years old and had two heart operations in September 2013 at Basildon Hospital. Following his surgery, he was transferred to Thurrock Community Hospital for further rehabilitation. Mr A was not able to return to his previous accommodation which was a rented room in a shared house in Grays as he was unable to climb the stairs. The hospital social worker assisted him to make an application to housing. Mr A accepted an offer of a bungalow in South Ockendon. The LAC was informed by his hospital social worker that an initial assessment was done: Mr A did not need support from carers, but may be eligible to apply for PIP (Personal Independence Payment) as well as Essential Living Fund. The bungalow had no appliances, furniture or carpet and Mr A had no support to help him move in.

WHAT HAPPENED?

The LAC took time to get to know Mr A: what was important to him and to explore some of his aspirations and key priorities. Mr A's key priority was support with getting his bungalow ready, help with navigating the service system, support with gaining healthy weight, managing medication and connecting with the local community. There were concerns that this was causing distress and might impact his health.
Mr A was supported in exploring friends and family support, plan the move, report the change of circumstance to different service systems (council, job centre, former landlord, care line, new suppliers of gas & electricity), apply for grants and benefits (Besoms, Essential Living Fund, Personal Independent Payment and Budgeted Loan).
Mr A moved into his allocated bungalow in South Ockendon in December 2013. He was supported to connect with his local community (shops, GP, neighbours, post office and the South Ockendon Centre), and introduced to Active Sports for life and supported to locate free outdoor gym equipment in the Park.

NEXT STEPS:

Mr A is now settled and accesses the local shops, post office, GP and pharmacy in Derwent Parade, the South Ockendon Centre and receives regular support from friends. He is now enrolled with the Active Sport for Life (swimming programme) and visits the free outdoor gym equipment in the park.

Mr A Says:

"Francis grabbed my ears and dragged me up from the grave."
"Everything good in my life started from the time the very clever hospital social worker made a plan and then introduced me to Francis."

Preventive Impact – Mr A - ***Based on the outcomes achieved and looking at what most likely would have occurred if the LAC was not involved, we can demonstrate potential savings to the system as follows:*** Mr A says he would have not managed his new home or resolved his previous tenancy and would have led him into debt. He feels his health would have suffered and he could have been readmitted to hospital as he was living on takeaways and not taking his medication properly. Mr A stated he is exercising more than he has done for years. Mr A would have potentially visited his GP more and could have been readmitted.

Time and financial saving for reduction in GP visits: £125 per hour for General Medical Service (based on Curtis 2013 estimate).

Reduced cost to housing

Homelessness advice and support - £682 is the average cost of a homelessness prevention or housing options scheme that leads to successful prevention of homelessness (Shelter 2012)

Hospital bed and reduction in number of nights spent in hospital

£1779 is the average cost per episode for hospital inpatients (elective and non-elective admissions; long and short stay) (National Schedule of Reference Costs 2011-12)

From an individual who has linked to another member of her community for support

"Between the Local Area Coordinator and Mr X (who was introduced to me by LAC) they have put me back together again. Mr X has been pivotal in breaking down this barrier. I know now I can get to the shops"

From Adult Safeguarding:

"Since Martin's involvement my visits have reduced to the point where the safeguarding concern has been closed. It is my opinion that without LAC involvement there was a high possibility that the individual's life was at risk due to self neglect, falls and injury."

Mr X – Supported by LAC

"Through volunteering in this way I know I am helping others and getting out of the house more, making me feel much better. The support provided by the Local Area Coordination filled the gaps where there didn't appear to be any support available."

Area of Impact

Helping people to speak up/be heard/be in control

- Local Area Coordinators have been able to support people speak up and be heard, providing support to help people advocate for themselves in challenging situations. Over the last year, we have successfully supported various individuals with ESA/DLA hearings and applications, some of which have been outstanding for a number of years.

- **20 individuals have been supported to access benefits** that they were entitled to, and 9 of these individuals received additional income, which helped them live more comfortably or pay off debt. Examples include applying for/accessing pensions that they may be entitled to or supporting individuals reclaim funds from TV licences that had been incorrectly paid.

- We have also supported many individuals organise meetings to coordinate the support they are receiving, to work towards solutions in the journey towards a more independent life.

- LACs have also advocated on behalf of people to help them move into housing more suitable for their health needs.

- LACs have also worked alongside individuals to overcome **housing and tenancy issues** and on two occasions **prevented possible evictions** by supporting them to deal with debts and to utilise housing related support.

Story 3 - Mrs H

INTRODUCTION:
Mrs H was first introduced to Local Area Coordination over a year ago by the Community Solutions Team. She made frequent calls to the Community Solutions team, however did not seem to fit any Adult Social Care or Community Mental Health Team criteria, although Mrs H had been offered Day Care in the past.

SITUATION:
Mrs H was a 53 year old woman who had felt let down by different services that she had experienced in the past. H had called Social Care and CMHT for help with her depression but she felt that the services offered were patronising to her capabilities and did not stimulate her. Mrs H also suffered from Fibromyalgia, bowel disease, diverticulitis and arthritis. She had unsuccessfully struggled to get through repeated benefit appeal attempts (ESA). This, plus the pain she was in, triggered the onset of depression. She was desperate to meet new people and use her passions for cooking, caring of animals and desire to learn something new.

WHAT HAPPENED?

The LAC listened to Mrs H and took the time to get to know what it was that could help Mrs H to achieve her vision of a good life. These priorities were to have more of a social life and feel connected to her local community. Mrs H also wanted to learn more about growing her own vegetables and herbs, but firstly her main priority was to conclude an ongoing ESA appeal.

Mrs H had never made it through an ESA appeal without crying and dismissing herself in front of the ATOS panel so the LAC and Mrs H worked together on what Mrs H wanted to say. The LAC and Mrs H wrote down prompt notes to keep her focussed and keep her composure to answer all of the panel's questions. The result of the ESA hearing was positive for the first time.

The LAC also looked at what community allotments were available in the local area. Mrs H rang the council to find out about the plots closest to her house and with the support of the LAC went along to view an appropriate plot. Mrs H quickly made friends with other allotment enthusiasts that were keen to show her the ropes and donated many tools and helpful items as well as their time, meaning Mrs H felt more empowered and more supported.

A few months later, Mrs H contacted the LAC again because she felt that she had got to grips with her allotment and was ready for something more to fill her week and thus get more involved with her community. H expressed that she would like to work with horses but she hadn't had any previous experience but felt confident about volunteering. The LAC linked Mrs H with a local volunteer organisation able to link Mrs H with 'SugarLoaf', a local horse riding school for children with learning difficulties. Through this volunteer work and the connection she made, Mrs H stated that she felt stronger and more supported and enjoyed helping others.

Mrs H has also since been linked with another individual who lived close by to Mrs H and was struggling to walk her dogs. Mrs H has now been able to befriend this lady by walking their dogs together building further support for both.

NEXT STEPS:

Mrs H has recently been introduced to an individual who would like to be connected with an allotment but doesn't know where to go or how to get started. Mrs H has expressed a desire to befriend this individual to show him how she learned through experience.

Preventive Impact – Mrs H - ***Based on the outcomes achieved and what would likely have occurred if a LAC was not involved, we can demonstrate potential savings to the system as follows:***

Mrs H was not getting the income that she was entitled to and this could have led to potential increased debts which could have impacted on her Housing. Mrs H has reported that her Mental Health has improved and if she had not been supported this could have deteriorated and led to a need to involve mental health services further. Mrs H has been volunteering to her benefit and others and has found alternatives to Day Care.

Reduced cost to housing

Homelessness advice and support - £682 is the average cost of a homelessness prevention or housing options scheme that leads to successful prevention of homelessness (Shelter 2012)

Preventing evictions: average cost of a complex eviction is **£7,095 -** Research briefing: Immediate costs to government of loss of home (Shelter, 2012), p.6.

Reduced demand on Mental Health Services:

£956 is the average annual fiscal cost of service provision per adult suffering from depression and anxiety disorders (based on 2008 research by the Kings Fund)

£445 average cost per bed day for adult mental health inpatients, specialist services, hospital attendance (NHS Reference Costs 2011-12, using the weighted average of data)

£162 average cost per contact for mental health community provision (NHS Reference Costs 2011-12, using the weighted average of data)

Time and financial saving for reduction in GP visits: £125 per hour for General Medical Service (based on Curtis 2013 estimate).

Reduced expense on Day Care

Day Care savings approximately £6,240 based on two days per week at £65 per day

Fiscal contribution of Volunteering

£10.50 per hour is Thurrock's calculation of the fiscal value of volunteering. People assisted by LAC are now contributing 'social capital' to the wider benefit of the community.

From an Individual supported by LAC:

The LAC is genuinely interested in me and does not have an agenda. I feel completely in control and that the LAC is on my side. There are things that I have done that I wouldn't have been able to do without the support of the LAC.

Area of Impact

Helping people to think about and plan for the future and stay strong, providing timely advice and information.

- Local Area Coordination has worked alongside many individuals to help them build towards their vision of a good life, planning for the future and helping people to stay strong. Examples of where we have helped individuals do this include:
    - Helping **13 individuals into volunteering roles** or paid employment
    - Supporting **15 people access training opportunities**
    - Helping people gain relevant experience to equip them better for the future

- The Local Area Coordinators have been able to help people break down barriers that have prevented them planning for the future – whether that be illness, hoarding, lifestyle/addiction. An example of this is by helping individuals make their home more suitable in new challenging circumstances. One individual who had recently lost his sight was linked into the local visually impaired support group and social club, where he was able to get support and advice with regard to independent living within the home.

- LAC contact and support has also played a part in **6 individuals reducing their smoking or alcohol intake**.

- 16 individuals have increased the amount of **physical exercise** they undertake through linking with gyms or groups or walking/cycling more.

- We have also worked alongside the fire service extensively to help people stay safe and strong within their own home.
    - Training has been provided to Adult Social Care staff on home fire safety so this can be shared with vulnerable individuals.
    - As well as providing information on fire safety to many individuals LACs have provided practical **support to 7 individuals to make their home safer** and reduce the risk of fires. This has included organising the installation of fire safety equipment.
    - LACs are working alongside the fire service to provide a framework around how the issue of hoarding can be dealt with using a multi disciplinary approach whilst keeping the individual in control.
    - Local people are now talking to LACs to find out what is in the area. They have provided people with information about all local services and resources - Citizens Advice, how to organise repairs, help to appeal and claim benefits, providing information about the impact of benefits of volunteering for example, an individual was directed to Ngage who provided legal information about hours able to work.
    - Many interventions have assisted individuals better navigate around what can be a very complex service system.
    - Homeless individuals – helping them to plan for the future
    - One of the LAC's has identified that a number of people he works alongside cannot be contacted as they cannot afford a mobile phone. It would greatly improve their ability to keep in touch and to prevent them feeling so isolated and we are currently looking at working with a voluntary organisation to recycle mobile phones and give them to people where they would be of benefit.

Story 4 - MR B

INTRODUCTION:

Mr B was introduced to the LAC on 06/05/2014 by the social work team as it was felt that he would benefit from LAC support as he had poor mobility and was struggling to do the basic things needed to get by.

SITUATION:

Mr B had just been released from hospital after breaking his hip, which had left him quite frail and vulnerable. The only means of support he had was his next door neighbour and a friend who supported him with basic tasks. B was already known to safeguarding due to historical issues and alcohol consumption as a result of family loss, leading to concerns for personal welfare as there had been a number of hospital admissions as a result of this. He was working alongside Family Mosaic. Bailiffs were called due to rent arrears and this was threatening his tenancy.

WHAT HAPPENED?

LAC met with B to establish what his vision of a good life was and to explain how Local Area Coordination could support him to build towards this. The main priority for Mr B at this time was to follow up with the hospital as they had his phone and money, which was stopping him from doing the essential things he needed to do. The LAC supported Mr B to do this and assisted him to hospital which resulted in it coming to light that an individual, who was known to B as a friend, was taking advantage of him leading to further Safeguarding concerns being raised. The LAC also supported Mr B to make his home more fire safe by having a home safety visit from the fire service, resulting in smoke alarms being fitted as well as fire safety information being provided.
The next step for the LAC was to organise a meeting for B, Safeguarding and Family Mosaic to keep everybody on the same page, avoid duplication and to ensure rent arrears were taken care of. Family Mosaic were able to get involved with the rent arrears situation. LAC kept all parties up to date with progress which resulted in all parties being at ease enough to close the safeguarding case.

B has a dog that was taken ill. B did not have the funds to take him to the vets for treatment so the LAC found a vet who would treat B's dog at no cost, which reduced the stress to B and provided treatment to his dog.
Through the relationship with B, it was also established that B used to work as a publican which made him eligible for a pension. B and LAC worked together to establish if he was eligible which resulted in B receiving a small lump sum that helped him pay off some of the rent arrears he owed.
A combination of all of the above resulted in a reduction in drinking, further exercise/mobility as he started accessing shops and local nature park independently after LAC and neighbour supported him first. Due to this and B finding the strength to cut ties with those who were taking advantage of him, the Safeguarding Team have been able to shut the open safeguarding case with B.

NEXT STEPS

Now B is looking into the possibility of volunteering as he feels he needs something to fill his days with. As well as this, B is looking to decorate his flat and the LAC is supporting him to access affordable decorating materials using a local reuse company.
B is also looking to take a more supportive role with his neighbour who is now unwell – so there is the opportunity to provide reciprocal support and potentially eat meals together which would both save on cost and reduce isolation.
Family Mosaic have a final meeting with B toward the end of this month as the progress B has made means all feel he is in a place where he can support himself with minimal intervention.
In the last week B has now agreed to get help to stop drinking and is looking into cessation programmes. B has also been to his GP to sort out medication with the support of his LAC. He is awaiting surgery that would greatly improve his health and has now paid all his rent and other financial arrears.

Preventive Impact – Mr B - ***Based on the outcomes achieved and looking at what would likely have occurred if the LAC was not involved, we can demonstrate potential savings to the system as follows:***

Mr B was in rent arrears and at risk of potential eviction. Mr B is exploring paid employment but is also volunteering currently. Mr B was at high risk of fire at home due to alcohol and other factors, Mr B's situation has also been closed to safeguarding team. Mr B was also at risk of his health deteriorating and admission to hospital which could have also been Mental Health services.

Reduced demand on Mental Health Services:

£956 is the average annual fiscal cost of service provision per adult suffering from depression and anxiety disorders (based on 2008 research by the Kings Fund)

£1,962 is the estimated annual cost to the NHS of alcohol dependency, per year per dependent drinker (NICE Clinical Practice Guidance)

Reduced cost to housing

Loss of home: £733 - Average fiscal cost of a simple repossession - Research briefing: Immediate costs to government of loss of home (Shelter, 2012), p.5

Helping people into paid employment

Fiscal benefit from workless claimant (Income Support) entering work: £7,744 Worklessness Co-Design - Interim Report, Annex A (DWP 2011)

Fiscal benefit from workless claimant (ESA) entering work: £8,831 (DWP Working Paper 86 unpublished)

Fire prevention:

£3568 is the average response cost per fire (DCLG 2011)

Reduction in assessment and Safeguarding intervention

£58 is the calculated average hourly cost for a qualified Social Worker (units of Health and Social Care Curtis 2013) It is estimated that 10 hours of Safeguarding as a minimum would have been avoided at a cost of **£580**

Fiscal contribution of Volunteering

£10.50 per hour is Thurrock's calculation of the fiscal value of volunteering. People assisted by LAC are now contributing 'social capital' to the wider benefit of the community.

From an individual supported to plan for the future

"Francis grabbed my ears and dragged me up from the grave."

"Francis has been the right man, in the right place at the right time".

"It is not possible to believe how much help I received and how much this man means in my life,"

From an Individual supported by LAC:

"Ben has been great, he has coordinated everything and got things moving where they weren't before. The LAC came in during a very difficult situation where I had hit rock bottom and was on anti depressants. He linked me in with people who could support me with shopping and cleaning as well as supporting me with my PIP application and potentially moving. I no longer feel as depressed. Ben was my lifeline"

Area of Impact

Identifying and building local community resources

- We have linked various local groups with small sparks funding to help them access funding to support them with community initiatives including a coffee morning group and a retired gentleman's group.
- Introductions have been made to organisations to help better equip them in supporting those who are vulnerable within the community. The LACs have worked alongside the Neighbourhood Watch team to link them into training opportunities around identifying vulnerable individuals and Dementia Friends training to enable them to support those with dementia.
- Local Area Coordinators have also had discussions with local banks that provide support and digital training to people, customers and groups within the community, better equipping them to navigate around the digital environment and open doors to further socialise. We are looking at the potential of linking these into small groups and individuals that would benefit.

Raising Awareness of and Supporting Local Community Resources

In his first 5 months, Martin has taken time to get to know his local community to

- find out what is available or already happening
- find out about people and places with gifts, skills and contributions to make
- looking to identify gaps in local opportunities

This has allowed Martin to find out about the natural resources and opportunities in his local area and support those he is working alongside to engage more with their community.

Through Martin working within the community it became apparent that there were very few bumping places for people to meet others and as a result of Martin building relationships with local businesses and organisations, he was able to facilitate and empower others to start filling these gaps and strengthen the community.

What Happened?

Through working within Purfleet Martin was aware of there being a lack of places or events where people who were elderly could spend time together. Martin met an owner of a local pub/restaurant who had elderly parents himself and had an understanding of the challenges of isolation and loneliness. The owner said he was more than happy to provide a space for others to come and eat together and would more than happily provide this at a discounted amount to make it affordable as well as providing a packed lunch for individuals to take home.

In doing this it was hoped that those of retirement age could come together and share a meal whilst also enjoying some entertainment that they may be interested in.

Through Martin's links with the fire service and understanding that the fire service are passionate and focussed on community development, he was able to facilitate a connection between the pub and the communication department of the Fire Service to produce leaflets advertising the new group. The weekly meal is now in its first few weeks and will hopefully lead to many building new relationships and eating a healthy meal together.

Preventive Impact

This initiative will lead to improved health for the people who attend and reduced isolation, it will also give an opportunity for people to volunteer in their local community.

From a local community trust

"Martin Trevillion is located in Purfleet, working to reach some of the most isolated and most vulnerable in our area. He has been a massive support, making a real difference to the community and the work we do. He helps network local people and uses his referral skills to get people better connected to local services."

"Thank you for supporting the Purfleet community - we have really noticed the change. Working with Martin has been an extremely positive outcome and we look forward to continuing work in the future."

From a Local Community Hub:

"Francis is an absolute asset to the Community in South Ockendon – he is a real conduit. We are always updated and there has been some great joint working between the LAC and the Hub"

Area of Impact

Taking time to build positive working relationships at individual, family, community and service levels (across service types)

- LAC's are continuing to grow their knowledge of the areas they work in by making connections. Introductions have been made to numerous clubs, groups, individuals, assets, schools across all age ranges. Surestart, Libraries, Community forums, Part of working group for development of Stanford Hub, Traveller communities, Fire Service, Police Service, Children and Family Services (Statutory and Community), GPs, Faith Groups, Local Schools and many Voluntary and Community Groups.
- Each Local Area Coordinator has also been able to work alongside individual, organisations and services to share knowledge of the local area to help better support individuals within their community.

- The LACs are continuing to support people to co ordinate services where more than one service is involved. **7 individuals** have been supported to organise meetings to help them to have a voice and feel in control in this way.

- Local Area Coordination has worked very closely with Essex Fire Service to better support individuals who are affected by hoarding. This has included working alongside one individual to make their living space safer. This has also involved producing a policy that will direct cross service working for future support, ensuring best practice is followed in extremely complex circumstances.

Story 6 - Mr P

INTRODUCTION:

Mr P was first introduced to Local Area Coordination through a Family Mosaic field worker. P was unable to access the community because of a physical disability due to an injury he suffered at work and he lived in a first floor flat.

SITUATION:

Mr P was a 65 year old man who lived an active life before sustaining an injury at work 3 years earlier, this injury meant that P could no longer walk without the aid of two crutches. P found himself stuck in a first floor flat with no lift facility to access his local community safely. P became depressed and was extremely isolated. His DLA had also been stopped for unknown reasons leaving P with no choice but to use his life savings in order to employ home help to get his food shopping on a weekly basis.

WHAT HAPPENED?

Upon being introduced to P, I listened to his story and was able to get to know him quite quickly. This was important to P as in the past he had been let down and felt left behind by everyone in his life including professionals. P's vision for a good life was to feel like he was in control of his finances and to move to a property that would allow him to feel like he was part of a community again.

Considering moving to more suitable accommodation was one of P's main priorities as he was struggling to have regular contact with the bidding team. Through my knowledge and relationships, I was able to provide P with a direct number that meant he would speak to the same worker every time about his property bidding.

P was also struggling with his feet due to having diabetes, and he wasn't sure where to turn to get regular medical care as he could not travel to the clinic every week. P was being admitted to A&E because of pressure sores and bleeding blisters. I supported P by linking him with an NHS community nail cutting programme, through my relationship with the MDT coordinator. This service is designed for people who are house-bound and avoided any further admissions to hospital.

As P had previously lost his DLA award, P and I worked together to fill out a form step by step that would attempt to reclaim the money owed to him. P was running out of money to pay for home help from Age UK which he relied on for basic food shopping. Through my relationships with the local community I contacted the local church and knew that there was an individual who lived very close to P and who may be willing to help with his shopping and tidying the flat he was living in. The volunteer was introduced to P and for the time leading up to P's claim for backdated DLA, she was able to simply call round to P when getting her own weekly shopping and pick up supplies for him as well.

Finally by encouraging and supporting P to speak to the DWP himself, he was able to identify a single point of contact at the DWP, instead of having to telephone via the call centre every time. This allowed him to chase this issue until it came to a suitable conclusion, resulting in backdated DLA being awarded to P, allowing him to move into more suitable accommodation.

NEXT STEPS:

P has now moved in to his new ground floor sheltered accommodation allowing him to access the community at his leisure. He would like to get back to his old passions of comic books, antiques and film memorabilia. He would also like to learn something new with the community college.

P now has his PIP level 1 award (DLA higher rate) and can afford to pay off his previous debts which P and I can work together to organise his repayments.

Now that P has free access to the community, the LAC can further support him achieve these goals and reintroducing him into a community full of possibility.

Preventive Impact – Mr P – Based on the outcomes achieved and looking at what would likely have occurred if a LAC was not involved, we can demonstrate potential to the system as follows:

Mr P was depressed and if he not had the support detailed above, it is likely that he would have needed Mental Health services and potential commission. Mr P would have had Housing issues which would have increased his isolation and potentially caused his health to deteriorate. Mr P's diabetes is under control and this has potentially avoided a hospital admission. He is now in a better financial situation, and is now in a position to pay off debts and reduce his risk of further financial problems.

Reduced cost to housing

Homelessness advice and support - £682 is the average cost of a homelessness prevention or housing options scheme that leads to successful prevention of homelessness (Shelter 2012)

Preventing evictions: average cost of a complex eviction is **£7,095 -** Research briefing: Immediate costs to government of loss of home (Shelter, 2012), p.6.

Reduced demand on Mental Health Services:

£956 is the average annual fiscal cost of service provision per adult suffering from depression and anxiety disorders (based on 2008 research by the Kings Fund)

£445 average cost per bed day for adult mental health inpatients, specialist services, hospital attendance (NHS Reference Costs 2011-12, using the weighted average of data)

£162 average cost per contact for mental health community provision (NHS Reference Costs 2011-12, using the weighted average of data)

From MDT coordinator (NEFLT)

"From a health perspective it links in well with the Primary Care MDT's as we identify patients who would benefit from LAC intervention and can do direct referrals. It is an effective way of supporting people to be independent but with the benefit of having local knowledge as the LACs are embedded in the Community, and are able to give them advice and information about the local area, making it more inclusive of health conditions. They are also supporting with navigating the complex systems and referral processes for more formal support due to LACs being part of Thurrock Council."

Mr P referring to LAC support in Grays

"The Local Area Coordinator came in at a very difficult time where I had hit rock bottom and was on anti depressants – The Local Area Coordinator was my lifeline."

From a GP surgery

Dr A's Surgery had some very positive feedback regarding the LAC and some work that has been carried out with one of their patients and introducing them to a local club

5. Wider Impact for Services and Communities

Local Area Coordination and Asset Based Community Development are driving conversations around strength based approaches/practice and reform to make services more local, personal, flexible and efficient. To sum up examples of the wider impact of the introduction of Local Area Coordination:

- Linking Neighbourhood Watch with training around identifying vulnerable individuals and focussed Dementia Friends training.
- Working with banks and other services to consider vulnerable people in their communities
- Emerging partnerships and joint working across service types including Fire and Police. This includes work around hoarding and creating a pathway to better support those in a multi disciplinary manner, and supporting Community Safety initiatives.
- There are emerging partnerships between LAC and Social Work and Housing teams including working more closely with Community Mental Health Team and Housing to reduce dependency on formal services and link people more into their community.
- Inclusive recruitment of LACs approach is now being used for recruiting to other roles
- Comprehensive induction of new LACs is now being developed by other services
- Supporting all services and organisations to move to a focus on strength and community based practice, prevention and capacity building including training staff e.g. Mental Health teams and Housing Teams.
- Utilising assets and having an increased presence within the community. An example of how this has been achieved is having meetings in the community rather than within the council offices. LACs also base themselves within the community, utilising community spaces.
- Discussions taking place around building a shared vision building across service types – a focus on prevention and keeping people strong as well as integrated service provision where this is needed.
- We have seen increased opportunities for “face to face” conversations across services and organisations including :
    - Greater awareness of roles
    - Conversations around future shared, efficient resourcing
- The gentleman who supported Workforce Planning to deliver training to Student Social Workers referred to earlier in the report gained excellent feedback. The Student Social Workers said they found his session “very informative”, “insightful”, “an eye opener” and “would help them recognise depression in others”.
- Services in the community for local people are being supported with volunteers connected by the LAC’s. This includes charity shops, Day Care, Residential Care and Community Centres.

6. What are the financial benefits and the potential savings of working this way?

The amount of time the LAC's have actually been working in the community collectively is 50 months, this equates to a cost of approximately £140k.

The table below identifies some of the savings that can be potentially attributed to the LAC's:

Cost	Unit of prevention cost	Savings & Commentary
£125	Per hour GP visit	It is unclear how many reduced visits to GP occurred but in one case referred to above the reduction in GP visits was from £730pa to £93pa (this is approx 10 min appointment time) however, a number of calls would have also been to out of hours which would have been more costly. A call to NHS 11 is £11.33 per call
£956	Annual cost of depression	Over 75 people introduced to LAC have identified depression as one of the main challenges they face. A very high percentage have reported an improvement in their depression and none have been readmitted since the LAC has been introduced. However, two people have needed the ongoing expertise of Mental Health services If 75 people have seen an improvement in their depression and avoided or delayed the need for mental health services this is a potential saving of: **£71,700**
£445	MH overnight stay in hospital	2 of the stories used in this report have clearly avoided a potential admission to hospital which has been backed up by Health professionals. We are confident there are many more stories like this If those two people had been admitted for 7 days this is a potential saving for the health

		economy of: **£6,230**
£162	MH community provision (per contact)	Individuals and professionals have fed back that the need for mental health professionals has reduced and this includes regular weekly support groups where community alternatives have been found. There are approximately 6 cases where people previously attended a support group. This will give a saving of: **£101k pa** (based on 6 people attending 2 hr session per week)
£1779	Episode of inpatient care	This is difficult to justify and we believe the numbers to be much higher but 2 people who have been part of this report would likely to have been admitted to hospital without support to manage their medication and their health.
£510	Adult Social Care assessment	32 individuals were referred from Community Solutions Team (CST) which is the front door for Adult Social Care. 50% of these would have led to an assessment and the others would have been signposted with no ongoing support. The South Ockendon Community Centre has also referred people to LAC rather than social care. This has given Adult Social Care a potential saving of: **£10, 720 which is 50% of CST referrals and 5 people introduced from the South Ockendon Centre**
£65	Day care provision	At least 19 individuals have avoided Day Care services because alternative solutions within the community have been found. On average people attend Day Care for 2 days a week at £65 approximately per day.

		This has given Adult Social Care an approximate saving of: **£120k** (based on 19 people, 2 days a week for 48 weeks)
£7,095 & £733	Complex eviction case & Simple housing repossession	The number is hard to justify but one of the individuals has fed back that they are sure they would have been evicted if not supported by the LAC. In Derby the number of evictions avoided by LAC's was a key feature in their evaluation report.
£1,962	Annual cost of alcohol abuse to NHS	At least 6 of the individuals that LAC's have been supporting have fed back that they have reduced or stopped their alcohol intake. They have all reported improvements in their health. This is a potential saving to the health economy of: **£11,772** (based on 6 people)
£7,744 & £8,831	Income support claimant entering work & ESA claimant entering work	At least 1 individual has been supported back into work and a number of others are working towards this goal
£3,568	Average response to a fire	At least 7 people have been supported to make their home safer. 3 of those individuals have been at a high risk of fire due to their environment and lifestyle. If those 7 people have avoided a fire response being required this is a potential saving to the fire service of: **£24,976** ***NB – cost of fires caused by smokers equates to £610m per year in England****
£10.50	Volunteering per hour contribution	13 people have been supported into volunteering with many more currently being pursued. If those 13 people provide an average of 3 hours of volunteering a week this is a potential

		benefit of **£21,294**

7. What are the Potential Benefits of Working in this Way?

- Shared resourcing and efficiencies across organisations
- Reduced dependence and demand on services and organisations being used more effectively
- For people with MH needs – early input/response where needed (before crisis). Following training with the Adult Mental Health Team, feedback was given on the LAC's input. This included:
    - Workers now have solutions to some conundrums when working with individuals
    - Practitioners see their role as now working alongside the client more
    - This gives power away, and gives it back to the individual but with shared responsibility
    - Workers can see clear areas for joint working, the LAC can provide support and create a lot of efficiencies and the LAC's will take away dependencies
- Reduced demand from people with "non health issues" and better management of Long Term conditions
- Finding non service, low cost/no cost solutions.
- Support to people who have refused traditional services
- Increased and better use of knowledge of community and individual resources
- A simpler, more integrated, effective and efficient service system
- A single point of contact and support in the local community
- Early prevention opportunities – environmental issues (housing adaptations etc)
- Wider opportunities of intentional co working of LAC, Asset Based Community Development and Community Hubs.

8. Next steps Building a Shared Vision – Our Challenge

Despite the significant achievements, we recognise the significant challenges ahead including:

- Continued funding in the longer term
- Establishing where the role fits in especially alongside other community-based initiatives

- Developing joint working with other partners – there are many opportunities for joint working but the essential principles of LAC need to be shared by partners – working from a strength based rather than deficit based model.
- Evaluation – nationally evidencing the impact of LAC
- Expansion to all citizens from cradle to grave. Do we want to work with children?
- Asset mapping and linking in with community building and development – LACs work best when they can connect people to supports that exist within communities
- Preventing Crisis – can the LACs further develop their role for instance, working with specialist dementia support workers and other health professionals
- The role of micro-enterprises – both as an opportunity for people working with the LACs, and for the wider community

We look forward to developing these themes in our next report.

Appendix A – Background to Local Area Coordination

Building Positive Futures

Building Positive Futures is Thurrock's programme to support older and vulnerable people to live well. Originating in Adult Social Care, Building Positive Futures recognises that to create neighbourhoods where older and vulnerable people can enjoy the best quality lives, requires a partnership between residents, the council, its health partners and community organisations as well as shops and businesses, schools and colleges. Building Positive Futures centres on three main themes:

- Better health and wellbeing: so people stay strong and independent
- Improved housing and neighbourhoods: to give people more – and better – choice over how and where they live as they grow older
- Stronger local networks: to create more hospitable, age-friendly communities

Local Area Coordination was selected as an approach because it builds partnerships with:

- People - who may be vulnerable, isolated or excluded due to age, frailty, disability or mental health needs to stay strong and connected and find non service solutions to issues wherever possible.
- Communities - to help make them more welcoming, inclusive and mutually supportive.
- Services - to promote a simpler, more connected system, better outcomes for local people and services that are more personal, flexible and local.

A key aim of Local Area Coordination remains to divert people from statutory or formal services through local, flexible, community solutions wherever possible. It supports individuals, families and communities to stay strong, connected and mutually supportive.

Why is this important?

The service system is very complicated and often disconnected, with either duplicating or conflicting services.
With current demands on existing services and the predicted increase in need across age and service types in coming years, we are faced with some big challenges and questions. Do we;

- *Increase the size of services to deal with increasing demand from people in crisis or vulnerable to needing service intervention?*
- *Manage demand by further tightening eligibility, but leaving higher unmet need and vulnerability?*
- *Reduce demand by intentionally working to support individuals, families and communities to stay strong, diverting people from formal services wherever possible through sustainable, local, flexible individual and community solutions.*

In reality, there needs to be a balance of all three, but now requires an intentional re balancing of the service system to support "demand reduction", with LAC and local

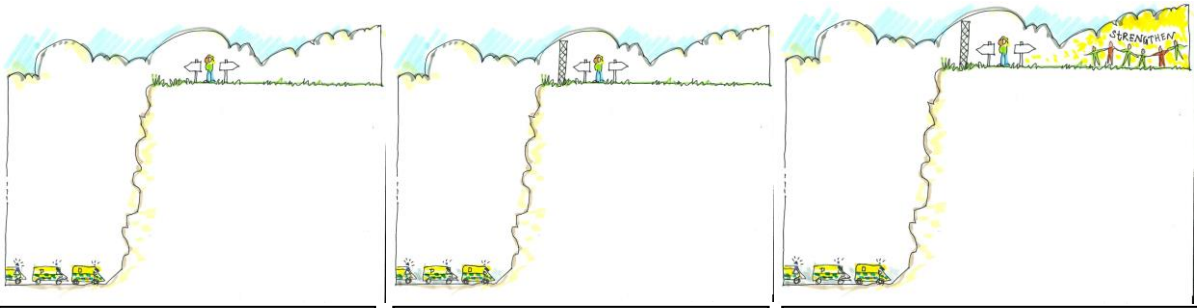
solutions at the front end, supported by strong, effective, integrated services as a "back up."

Our Challenge

The challenge now is, do we wait for people to fall into crisis and "fix" them with (increasingly scarce) services

or

help individuals, families and communities to stay strong and connected and to find practical, non service solutions wherever possible?



Do we just have services at the bottom of the cliff when people fall into crisis? (if available)	Do we build a fence at the top of the cliff (prevention)?	Do we strengthen and support citizens and communities further back from the cliff edge?

All organisations that work with communities including voluntary sector, local authorities and health are experiencing unprecedented financial challenges which are making the need to work differently with communities and individuals critical.

Building a shared vision is the building block for imagining and pursuing a better future for Thurrock citizens, local communities and services.

What do we already know about LAC?

Multiple evaluations over the past 25 years and our own evidence form the past year show that, where there is strong, connected leadership and effective design, there are a range of consistent outcomes and opportunities.

These include

- Reduced demand for formal services
- People diverted from crisis and more expensive services: for example: The recent Derby City evaluation showed estimated diverted costs of £800,000 within the first 12 months (formative stage), whilst operating at 40% capacity in 2 locations.

- Increased informal/unpaid supportive relationships/circles of support
- Preventing people from unnecessary out-of-home placements.
- Increasing the capacity of families to continuing care
- Improved access to information
- Contribution to reform of services and specialist roles – rebalancing funding and system
- Better resourced communities – LAC generates additional resources £3 for every £1 spent
- Cost per service user is 35% lower than the national average (when compared to non- LAC areas) – significantly increased coverage within existing resources and also 12% higher satisfaction rates with consumers (Government of Western Australia and Disability Services Commission report May 2003- LAC Review – Terms of Reference 3: Value for Money Final Report)

LAC's fit in with the requirements of the Care Act and will help all partners achieve some of the duties set out in the Act.

Appendix B - Citizen Led Recruitment

From Equal Opportunities to Real Citizens Recruiting (From LAC Network Newsletter Vol 6)

Thurrock Council has just started the journey of building Local Area Coordination alongside local citizens, services and communities as part of their vision for building more welcoming, inclusive and mutually supportive communities.
Local Area Coordination is about citizenship, inclusion, contribution and leadership, therefore finding your preferred LAC must be about real joint working, co-production….doing it together.

In Thurrock, they did just that. Local people, statutory services and community organisations came together to find their first Local Area Coordinators.
Here, Kristina Jackson (CEO Thurrock CVS), Neil Woodbridge (Chief Exec Thurrock Lifestyle Solutions) CIC and Tania Sitch (Thurrock Council Fieldwork Services Manager) tell the story of the community led open interview approach.

About Thurrock
Thurrock is a small unitary Authority just to the East of London and nestling between the A13, M25 and the Thames. Way back in 1996 its voluntary and community sector really pushed for the area to become Independent of the Essex Local Authority control, arguing Thurrock had a unique profile that deserved a highly tailored Local Authority. In 1998 this was granted and everyone stepped up to the plate for positive change.

Rolling forward, through many years of development and change this little Authority of 150,000 citizens still packs a major community punch (there are over 500 groups locally). Whoa betide anyone who thinks they can turn up on the doorstep and tell people what to do. The Local Authority concept of securing 4 Local Area Coordinators was thus set upon with some anxiety to get it right and a distinct desire to maximise involvement of everyone.

Real Engagement—Real Contribution—Real Leadership
The Local Authority Managers were keen to get this process right – when they looked at the original applications response to a standard advert they simply couldn't shortlist enough candidates. The steering group were asked to think again and together with CVS and a local Social Enterprise developed a citizen led model of recruitment:

The LA agreed that everyone who expressed an interest in the LAC posts from an advert would be allowed to go through the recruitment process.
This resulted in 105 people being invited to an all day experience! (The administration of which was quite an accomplishment;) but key were the Community Connectors / Citizens of Thurrock and local groups who were invited and supported to lead the decisions. These people were chosen via the local CVS and a local Social Enterprise as people who had most engaged with the sector.

As a result we had approximately 25 community advocates who were clearly involved in their communities as connectors and who spanned a wide variety of experience; from faith groups, disability, mental health, older people, and young people – all of whom came with a desire to bring positive change to Thurrock.

Local People in Control—Working Together

The Community groups were divided up and placed on 4 tables around the large hall in the local CVS building – the candidates were then briefed on mass and divided into small groups of 8. They all had numbers for name badges and the Citizens had cards that they could simply write the numbers on and then piece of paper with a scale of 1-5 written on which to score each Candidate instantly. Each group had a guide who stayed with them and scored also throughout the whole process. A triangle was rung to start and then every 25 minutes afterwards – just like speed dating!

There were a total of 6 tables that the applicants in their groups had to go around – one was to have a three-minute interview at and one was simply called 'Rest' where they could read articles about LAC.

The 4 tables of Citizens had specific tasks to ask the candidates supported by a facilitator. One was to lead a discussion about a proposed local large shopping development, two was to ask them to place post-sticks on a huge map of Thurrock showing what community connections they knew in the local area, Three was to translate a paragraph from a Local Authority document and Four was to discuss '"What I love about Thurrock is …". For each task the candidates took it in turns and only had three minutes to take the lead – all the time being observed by the Citizens and managers from Thurrock.

It's all about relationships

It was extremely interesting to observe how people did or did not engage with the Community. There were some clear winners and losers. At the end of this process the steering group looked at the collated score and at only this point did a formal panel agree to interview a shortlist of 16 people. From these, 6 candidates it totals across the four proposed LAC areas were chosen.

These people were then taken forward and given another final interview with a small group of community leaders from the specific area we wanted them to work in – so the final job offers were made to the Candidates from the Community Connectors in the area within which they would work. True Citizen empowerment.

Where the Community Connectors from the LAC area said no this was respected and the person not appointed.

What people told us?

Feedback from both the Candidates and the Citizens who took part has been extremely positive. The situation somehow felt very real to everyone; it wasn't what was written on any application paper it was the ability to engage, to show local knowledge, to deliver passion and to show a genuine interest in local people that allowed the candidates to succeed. People who can't get alongside Citizens, network and make community solution style links needed not to apply!!

It's helping us to do things differently

Footnote: - The Local Authority so engaged with the process that they asked the Community to help them again recently with a similar process in order to recruit their next batch of OT's and Social Workers …. **Power to the people!!**

Appendix C – Stories

Mr AP & Mr MC

INTRODUCTION:

AP was first introduced to Local Area Coordination via a Social Worker within the Adult Social Care department. AP was feeling lonely and unable to communicate with anyone due to a stroke. He became frustrated which led to volatile arguments with his wife. AP wanted to learn something new and to feel stimulated whilst engaging with more people around him.

SITUATION:

AP lived in sheltered accommodation with his wife. AP had suffered a stroke over 9 years ago and has had to cope with speech and communicative issues ever since. AP felt that no one listened to him and thought he was useless, especially to the people that lived in his complex. AP wanted to get out into his community again, he and his wife needed a break from each other as she was his main carer but felt that he didn't know where he could go, and did not want to go to a respite home.

WHAT HAPPENED?

After listening and really getting to know AP over the coming weeks the LAC was able to confirm what it was that made a good life for AP. He wanted to learn something new, find a new way of communicating with people, and to meet like-minded people that knew what it was like to experience the communicative consequences of a stroke, but most of all to feel independent as possible.

The LAC signposted AP to a local club that he could easily travel to on his scooter called SOCIAL EYES (SE), it is a club for people that have sensory deficits of any kind, all ages are welcome and weekly activities are voted upon. The LAC accompanied AP to SE for the first time, and ever since he has felt like he has made new friends and finds that a lot of people are more patient when AP is speaking. He has now attended this club for 7 months every other week. AP was also unfamiliar with the local Stroke Club that is located only 10 minutes walk from his house. AP now takes his wife to the Stroke Club as he feels he can relate to a lot of the stroke survivors that attend and his wife gets on with the carers that are attend as well.

AP had stated that he wanted to learn something new and find a new way of communicating with people, after some time AP decided that he would like to learn how to use a computer so that he could send emails to others, such as his sons and daughters who all live out of the country. Firstly, the LAC signed posted AP to The Adult Community College as they were running a free ICT course for 'absolute beginners' for anyone over 65 years old. AP enjoyed the 6 week course but thought

the teachers were teaching at a much faster pace than he was able keep up with. AP then expressed the desire to have someone to teach him 1-on-1 at home.

The LAC had been working with an individual (MC, 45 years old) very local to AP who was looking to gain more volunteer hours in the community who was very highly skilled in ICT but didn't have any official qualifications to use on his CV.

MC was also feeling disconnected from his local community and was feeling quite depressed due to a recent divorce with his wife. The LAC introduced MC to AP and now MC attends AP's house regularly to teach AP how to use the Laptop. Since MC has been visiting AP, AP has learned how to search the web, open a Facebook account and send and receive emails. This has allowed AP to connect with the 'Stroke Group Forum' on Facebook, which he interacts regularly, he is also able to speak to his sons and daughters through email, AP finds talking on the phone very difficult due to his speech problems. MC has also befriended AP whenever AP wants a break from sitting in doors.

NEXT STEPS:

AP is continuing to learn new things about the internet and his laptop, his daughter is currently very ill and is looking to use Skype so that he can see an speak to her again as she moved to Thailand some years ago.

AP also wants to look into British Sign Language as another alternative communication method. LAC is currently arranging a meeting with the local 'Sensory Impaired Specialist School' to see how AP could benefit from their expertise.

MC will continue to work with AP for as long as possible. MC also showed a great desire to tell his own story of depression and has now been linked up with the local Council's Social Care Training Team delivering lectures to Social Care students on a regular basis. MC said that he now feels a more active and participatory role within his local community.

Overcoming Isolation	Access to Health Info	Contribution Connection	Being Heard/ Advocacy	Community Building	Service Connection	Info and Advice
✓	✓	✓	✓	✓	✓	✓

ASC	Health	Public Health	CYP	Housing
		✓		

Mrs SS

INTRODUCTION:

Mrs SS was introduced to the Local Area Coordinator (LAC) by her GP through the deputy manager at the South Ockendon Centre (Community Hub). It was hoped that she would be able to gain support to help her go out more, access befriending and connecting her more with her community.

SITUATION:

Mrs SS was 62 years old, lives alone on a traveller site and stated she has no friends or family living with her. She suffers from agoraphobia as well as some other medical conditions which can make everyday living a little more challenging. She presently receives high disability payment and uses a walking stick to assist with mobility and was looking for support to be able to make friends and feel more connected and to get out more. The LAC also was able to identify some strengths and passions that Mrs SS has including a talent and enjoyment of cooking and her past employment giving her skills with formal writing and correspondence.

WHAT HAPPENED?

The LAC took time to get to know Mrs SS, what was important to her and to explore some of her key priorities. Mrs SS mentioned her key priorities were, to make friends, build confidence with going out, get support to improve her mental health and find practical ways to solve her problems. The LAC worked alongside Mrs SS to start addressing these priorities including introducing her to Therapy for you as a means of providing more support with improving her mental health.

LAC connected Mrs SS with another individual within the same area to help with building relationship and support network. Mr C was able to provide practical support to help Mrs SS address some of the challenges she was facing with accessing shops / supermarkets to do her own shopping; walking to the GP to attend appointments. This connection and the mutual support Mrs SS and Mr C provided each other helped her gain confidence to do the things she had previously not been able to do. Also the LAC provided an introduction to an over 60's club that further helped Mrs SS to build new relationships and get out into the community more.

NEXT STEPS:

The next priorities for Mrs SS are to work towards exploring better housing alternatives and follow up a suspended housing application. When Mrs SS is ready, the LAC is also looking to support her share her gifts / skills which could include supporting others with reading and responding to their letters, completing forms and sharing cooking skills with her immediate community / social clubs.

Mrs SS view of LAC:

Mrs SS said she was introduced to the LAC after the worst 4 years of her life and that she didn't feel there was anyone that could help her. The Local Area Coordinator was very good and explored different options that had not been explored before. The LAC helped with initial walks involving leaving the house and also introduced Mrs S to Mr X.

Overcoming Isolation	Access to Health Info	Contribution connection	Being Heard/ Advocacy	Community Building	Service Coordination	Info and Advice
✓	✓		✓	✓		✓

ASC	Health	Public Health	CYP	Housing
✓	✓	✓		✓

Mr X

INTRODUCTION
Mr X was originally introduced to LAC by an advocacy agency who felt that he required more practical support to engage more with his local community.

SITUATION
Mr X mother had recently passed away and was evicted from the property which they had shared, and was admitted to a mental health ward for support. Mr X was left to deal with a number of complex issues and the increasing impact of this on his mental health. At the time of introduction he was living within a room within a house share which was arranged by the Homeless team.

Upon visiting Mr X the LAC explained the role of LAC and wanted to find out what was important to him at this difficult time. Mr X advised that since he was discharged from the ward he had not been able to access his belongings. A removal company had cleared the flat from which he was evicted whilst he was in hospital, and had transported this to a storage unit. Mr X explained that he had one outfit that he had to wash every night, and had no television or reading material to keep him occupied which was increasingly impacting on his mental health, leading him to feel that he needed more formal support from Mental Health Services. He also expressed a desire to apply for some job opportunities, but did not feel confident doing this without a suit.

WHAT HAPPENED:
As one of X's main aims was to get his belongings back that were currently in storage, the LAC was able to assist him in visiting the storage locker to collect his belongings including his suit for job interviews. Mr X has now applied for 2 jobs and continues to search for employment.
The LAC also supported Mr X with getting updates from formal services as they were more aware of the pathways and contacts that would be able to find up to date information regarding potential of moving properties and he was also able to find out more about what had happened in regards to referrals and accessed health services through his GP. The LAC was also to provide information and signposting to local organisations that could help with addressing relational issues around his housing that were heightening his anxiety and stress, this included linking him in with HASS Open Door where he gained housing advice to help him move forward with this situation.

Mr X identified that his main priority was to move into a self-contained flat; he has recently identified a landlord and has changed his accommodation within the borough. The LAC was able to walk alongside him during this process, and he now reports that he is feeling more secure and optimistic. Another of Mr X's aims was to get back into re-employment, looking at careers and training. Mr X was especially interested in teaching adults and had researched teaching courses. Through

discussion with another LAC it became apparent that another individual in a different locality wanted to be supported to use a computer and would like to be introduced to others that would be happy to provide this support. The LAC spoke to Mr X who was keen to support C, and an introduction was arranged, facilitated by both LACs.

NEXT STEPS

Going forward Mr X has identified that his main priority is to look at regaining his belongings and control over their storage, and to look at career opportunities and training. He advised that he is now feeling more motivated and feels he is moving forward, including considering volunteering to re-build confidence and his self-esteem. Mr X is keen to continue supporting C, and reported that he enjoyed teaching her how to use the computer and looks forward to the next time that he visits her.

Overcoming Isolation	Access to Health Info	Contribution connection	Being Heard/ Advocacy	Community Building	Service Coordination	Info and Advice
	✓	✓	✓		✓	✓

ASC	Health	Public Health	CYP	Housing
	✓			✓

Mr C

INTRODUCTION
LAC was introduced to Mr C by a Family Mosaic floating support worker who was concerned that he was feeling socially isolated.

SITUATION
Mr C lives in an upstairs flat. Due to an accident a number of years ago, he now has reduced mobility and is now unable to use the stairs or access the community.

LAC visited Mr C for the first time and took time to get to know him, what life was like now and how he would like it to be in the future. He had just been discharged from Hospital, after having a fall whilst attempting to descend the communal stairs in his flats. He had an allocated support planner from the Hospital Social Work Team to arrange care and place him onto the housing waiting list for ground floor accommodation

Mr C has a passionate interest collecting memorabilia and jewellery. He used to love going to auctions and days out where he could browse 'old gems' and artefacts of interest.

Mr P talked about some issues including

- Had been trying, unsuccessfully, to sell his property for some time.
- He had little to no personal support networks around him. He had a weekly visit from a cleaner/shopper and a carer three times a week to attend to his personal care
- Felt let down in the past by various professionals – he had minimal feedback about his potential to move and agreed visits from community nurses and physios had not happened.
- He was not in receipt of any benefits and was finding it a struggle to cope financially. He found the DLA forms difficult and confusing and said that DLA had no record of the completed forms he had previously sent.

WHAT HAPPENED
Before LAC left Mr C's property for the first time, they agreed that

- The LAC would contact his support planner for an update on his housing situation and current availability of first floor sheltered accommodation.
- LAC would contact his worker from Family Mosaic for support help him fill in his DLA forms and post them to the DLA office.

The Family Mosaic worker then arranged for an ex-DWP worker to visit Mr C to help him fill in the DLA forms page by page and gave him the DLA contact number so that he would be able to track his application via telephone.

LAC contacted Mr C's support planner at the hospital and found his application had been transferred to the housing department and that he automatically qualifies for assisted bidding.
LAC gave Mr C the direct number of both his support planner and the assisted bidding department in the housing team so he could check on his progress for a move date at his leisure.

NEXT STEPS

After visiting Mr C again he advised LAC that he was still struggling to sell his flat and he thought he may be able to sell it quicker if his flat was a little more organised but was unable to do this himself.

LAC agreed to support Mr C

- Connect with Ngage, a local organisation that recruits volunteers in the community, and the local Salvation Army to seek help to organise his possessions into boxes and make the house look more appealing to buyers.

Once Mr C is successful in his bidding for a ground floor property Mr C has expressed a desire to become more of a part of his local community and would like support in achieving this goal

Overcoming Isolation	Access to Health Info	Contribution connection	Being Heard/ Advocacy	Community Building	Service Coordination	Info and Advice
✓		✓	✓		✓	✓

ASC	Health	Public Health	CYP	Housing	CCG
✓	✓	✓		✓	✓

Mrs D

INTRODUCTION
LAC introduced to 84 year old lady by the manager at South Ockendon Community Hub.

SITUATION
Concerns that Mrs D was losing mobility, had a number of falls and was waiting for sheltered housing. She was also having difficulty selling her flat, planning for the move, notifying utility providers etc.
Together, the LAC and Mrs D identified some things that were important.

- Arranging change of address with utilities and other services
- Arranging furniture removal

WHAT HAPPENED
LAC Supported Mrs D to plan for and contact all providers to notify change of address**.** Secured one off funding from Thurrock Housing to support furniture removal

Mrs D has now moved to a warden controlled flat.

WHAT NEXT
LAC and Mrs D are now exploring how she would like life to be in the future and some of the ways of making it happen

Supporting Mrs D to make a move meant much more than just contacting utility providers and calling in a removal firm. It was important to recognise, understand and walk alongside her through a big life change.

Overcoming Isolation	Access to Health Info	Contribution connection	Being Heard/ Advocacy	Community Building	Service Coordination	Info and Advice
✓		✓	✓		✓	✓

ASC	Health	Public Health	CYP	Housing
✓	✓			✓

Mr E

INTRODUCTION
LAC was introduced to Mr E via email by a local Councillor.

SITUATION
Mr E suffered a significant stroke earlier this year and has subsequently found living in his current property difficult. He has felt like he has been “passed from pillar to post” and received masses of conflicting information in relation to moving on medical grounds.

Mr E had been trying to move to a property that would better meet increasing health needs, but had been rejected based on “local connection.” There were concerns that the process was causing distress and increasing health needs.

LAC took time to get to know Mr E, what was important to him and to explore some of his aspirations and key priorities. His main aspiration was to move to more suitable housing and have help to navigate the service system and appeal process.

WHAT HAPPENED

- LAC and Mr E began to plan appealing decision by Thurrock Home Choices.
- He was supported to contact an advocate at the Beehive.
- The advocate supported him to complete housing appeal.
- Mr DP won the appeal for his name to be included on the housing register, but as a low priority.

WHAT NEXT
The Local Area Coordinator, Councillor and his advocate are now working together with Mr E for a band change based on his present medical condition, and to facilitate his move from the present accommodation.

Overcoming Isolation	Access to Health Info	Contribution connection	Being Heard/ Advocacy	Community Building	Service Coordination	Info and Advice
✓			✓		✓	✓

ASC	Health	Public Health	CYP	Housing
✓	✓			✓

Mr F

INTRODUCTION
Introduced to Mr F via email from the Mayor's Office

SITUATION
LAC met with Mr F and they talked about how life was like now and how he would like it to be in the future.

Mr F has recently moved into the area, and does not know anyone. He regularly attends hospital for treatment of medical conditions.

He identified some key issues that he would like help to resolve including

- Losing his rubbish bins
- People throwing things at his bungalow
- People breaking his fence at the side of his house, reducing access and making it difficult take his wheelie bin to the back of the house for easier access and protection from theft.

WHAT HAPPENED
With support from the LAC, Mr F:

- contacted the repair team for broken chestnut fence,
- contacted council waste department for missed blue wheelie bin replacement,
- purchase paint to label brown and green bins and
- Contact number for antisocial behaviour (left telephone number for him to contact Community Safety Team, whenever he needs support).

NEXT STEPS
At this stage, Mr F does not want continued LAC support. LAC gave him his contact details in case needed in the future.

- The Local Area Coordinator is also trying to connect Mr F with one of his neighbours, to help with moving the bins down the side entrance.
- The LAC will keep in contact with Mr F in the future to see how life is and to let him know he is still around in his community should he wish to think about the future, do new things or overcome some problems.

Overcoming Isolation	Access to Health Info	Contribution connection	Being Heard/ Advocacy	Community Building	Service Coordination	Info and Advice
✓			✓		✓	✓

ASC	Health	Public Health	CYP	Housing
✓	✓			✓

Appendix D - A Week in the life of a Local Area Coordinator

Monday

Supported a 64 year old male to attend a club for blind people in the morning and done my paperwork and made appointments for the week. In the Afternoon I took a 60 year old male that I have been supporting to the doctors. The doctor has looked at his medication and identified what he should take from now on. He also has agreed to support this man with a referral to a neurologist and to a Liver consultant. I have worked alongside this man for eight months and during that time he has had a HFSV and we have discussed on many times his lack of precaution when it came to fire safety. Over the past month he has left his cooker on all night on three occasions, when he has been under the influence of alcohol. He has finally agreed to seek help with his alcoholism and we have started the process. He has not had a drink now for nine days. We have also applied for him to be seen by Therapy for you and be counselled.

Tuesday

Supported a 77year old male form Aveley to attend an art class at the South Ockendon Hub. He is a new referral and has an interest in art, but would like to make friends as well. The session went well and he is now going to book Transvol to take him in the future as we have now together, arranged for this to take place. I then took a 38 year old male who suffers from anxiety and depression to Grays Hall to start his therapy sessions. This was a big step for him and was happy for the support.

Wednesday

in the morning I arranged for a social worker to support me with a meeting with a 75 year old male who I have been supporting since May, who refused to pay his rent. He was issued with a level one eviction notice. Together we talked to him and he has now agreed to pay his rent and the arrears. He has now secured his home and the eviction process has stopped. We have agreed to keep working together. I then supported a 58 year old female, who has cancer to contact her works occupational health team, to see if she could start a return to work program. They are going to support her with this. I then had a meeting with Lisa Henchen senior consultant with NEL commissioning support unit with regards to the Purfleet regeneration program. I then supported a 60 year old female to attend her doctor to get information that the bailiffs require to implement a payment program for her council tax arrears. I have contacted the bailiffs and they have now frozen the dept. We are working together to address her drinking problem and clear her depts.

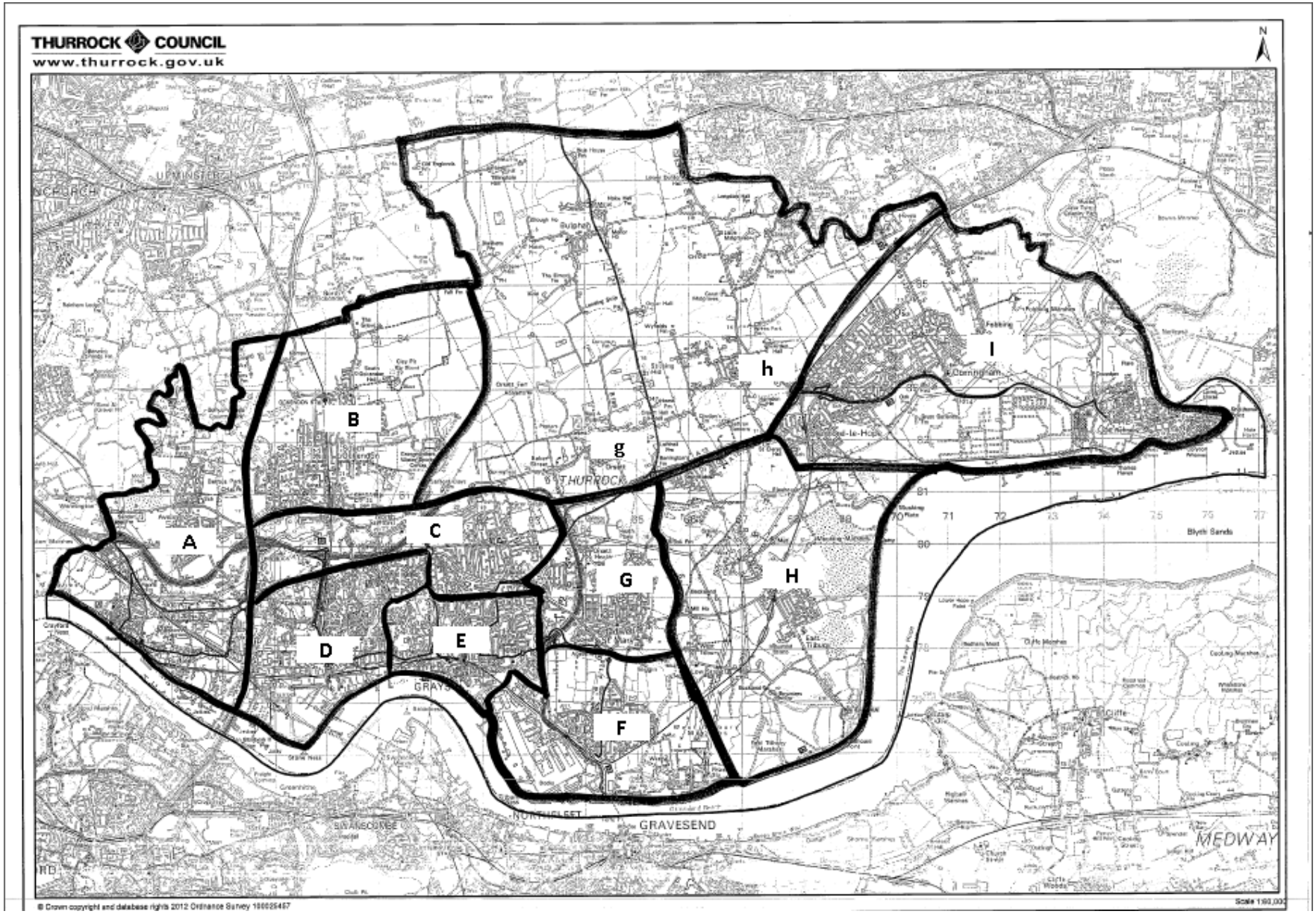
Thursday

Collected the new laptop from the Civic and then. Then supported a 60 year old male to fill in a questionnaire that was sent to him by Therapy for you. I then went to the Purfleet Care Centre and had a meeting with Age Concern who a based at that

location and we talked about providing referrals to each other. I then supported a 60 year old female from the Purfleet area.

Friday
I supported a 74 year old male to contact the adult mental health team to get support from his worker regarding a chair adaption that he needs. I then supported a 38 year old male to attend a meeting at the Job Centre in Grays. I then produced this report for the week.

Appendix E – Local Area Coordination Coverage



	Area	Local Area Coordinator
A	Purfleet/Aveley	Martin Trevillion
B	South Ockendon	Francis Allie
C	Stifford Clays	Rachel Cole
D	West Thurrock/Chafford Hundred	Pauline White
E	Grays Riverside	Ben Dubois
F	Tilbury Town/St Chads	Kate Williams
G	Chadwell St Mary	Helen Catterick
H	East Tilbury/Linford	Karen Dobson
I	Stanford Le Hope/Corringham	Susan Griggs