Derby City Council

Local Area Co-ordination in Derby

Evaluation report 2018 – 2021

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Foreword

Derby City Council initiated the Local Area Coordination (LAC) programme over 9 years ago because of our belief that many of the solutions to helping people lead a better, more independent life, lay in communities rather than services. By unlocking the strengths and assets within individuals, their families and neighbourhoods, we could support better outcomes for everyone. Nine years on Derby's Local Area Coordination programme has grown to establish itself as an integral and vital element of the city's prevention and resilience approach. This sustained commitment and growth has been both remarkable and far-sighted when considered against a national backdrop of reductions to Local Authority funding. This is a testament to the cross-sector leadership in Derby that has belief and confidence in this humane and person-centred approach. The national government have recognised this and provided temporary funding for part of the expansion of this service covering looked after children in transition to adulthood. It is a great source of satisfaction to me as a champion of LAC that this approach has been able to achieve the hoped-for outcomes for citizens, communities, partners and the Council. I am particularly pleased that I have been able to support LAC to expand to all wards of the city.

Over the last 12 months LAC has responded rapidly to the changing local and national context, as we experienced the devastating impact of the spread of the Coronavirus pandemic. This has had a considerable effect on the focus of the team and on their ways of working. Local Area Coordinators provided a care and support offer capable of making the connections between people in need of help, their neighbours and community resources able to offer that helping hand. As we look to move beyond COVID, the relationships, connections and networks forged in the crisis of the pandemic will undoubtedly have a positive and enduring impact on the work of the team and the resilience of our City.

Beyond the evidence of benefits during this pandemic, Derby's Local Area Coordination work has, since 2012, been subject to three external evaluations, each designed with a focus on clarifying the extent and nature of the benefits of the LAC work in Derby – to citizens, to services and to finances. These benefits have been consistently evidenced. As Cabinet Member I am confident that LAC works. This latest internal evaluation marks an important change in focus. We are now moving to a more strategic focus, seeking to understand:

i. the conditions that enable it to work best
ii. where it can have most impact on reforming and supporting our local health and social care systems and
iii. how it can best support the growth of truly resilient individuals, families and communities.

In addition, we are hoping to make this an open evaluation, such that the National LAC Network and other Local Authorities can benefit from Derby's work.

This evaluation is the first in what I hope will be an ongoing piece of work, where Derby's LAC programme moves to embed a process of continuous learning and improvement, based on a desire to understand the optimum contribution of LAC to all communities, regardless of their demographic. I thoroughly recommend this evaluation to you.

R. M. Webb

Councillor Roy Webb.
Cabinet Member for Adults, Health and Housing. 02/2021.

Acknowledgements

The author would like to express his sincere gratitude to everybody involved with this evaluation of Local Area Co-ordination in Derby. There are too many people to name here but, without all of their support, it would not have been possible to undertake such a comprehensive evaluation, examining the impact of Local Area Co-ordination not only on the people supported but also on different parts of the local system.

Special thanks must go to the Local Area Co-ordination team at Derby City Council, but particularly to Neil Woodhead (Social Capital Development Manager) and Sarah Edmundson (Senior Local Area Co-ordinator). Their support for this evaluation was driven by a desire to genuinely understand the impact of LAC in order to drive continuous improvement for local residents and their communities.

Likewise, the author would like to thank Anthony Mains (Team Manager) and the Leaving Care Team at Derby City Council.

Particular thanks must also go to Ralph Broad (Director, Inclusive Neighbourhoods Ltd.) for his support and for all of the information that he kindly shared. His generous provision of information, and permission to include it in the evaluation report, will greatly assist the readers' understanding about Local Area Co-ordination.

The author would also like to express his appreciation for the support of, and analysis undertaken by, the Business Intelligence Teams at Derby City Council, the University Hospitals of Derby and Burton NHS Foundation Trust, Derbyshire Healthcare NHS Foundation Trust and Derbyshire Community Health Services NHS Foundation Trust. Their support is genuinely appreciated and we look forward to working together in the future as we continue to develop our knowledge about the impact of LAC in conjunction with other services.

Thanks must also go to the Information Governance Team at Derby City Council, without whom the data sharing with partners could not have happened.

The LAC network is an important forum for the exchange of ideas and best practice - accordingly, the author would also like to recognise the support of the network and in particular that of Nick Sinclair, Director of the LAC Network.

Thanks must also go to the evaluation team at Ipsos MORI, but especially to Dr Claudia Mollidor and Raynette Bierman, for their support and permission to reproduce selected infographics from the formal evaluation.

Finally, the author would like to express his thanks to Andy Muirhead (Senior Public Health Manager (Epidemiology), Derby City Council) for his support and guidance.

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Aims

Key design factors within Local Area Co-ordination aim to drive changes at multiple levels; outcomes would be expected for people and their families, communities and local services.

This evaluation aims to build on previous local and national evaluations to look at changes at the system level, assessing the impact of Local Area Co-ordination against the outcomes expected within the local Theory of Change.

The approach taken forms a baseline against which Local Area Co-ordination in Derby can be assessed in the future. It also forms the basis for ongoing learning and continuous improvement, identifying areas for further research and investigation.

Challenges

The requirement for this evaluation was to assess the impact of Local Area Co-ordination within Derby; the principal challenge within this is that LAC does not operate in isolation of other services. The people introduced to LAC often have multiple and complex needs; accordingly, they are likely to be receiving support from a range of services across the public sector, but especially health and social care services.

Further, support for a resident provided by one service may lead to efficiency savings being realised in another part of the same organisation or within another part of the public sector. For example, LAC support for the introduction of disability adaptations within somebody's home may lead to a reduction in falls; this may lead to a reduction in calls for ambulances, Emergency Department attendance, inpatient hospital admissions, Delayed Transfers of Care, physiotherapy, social care reablement packages, GP attendance and District Nurse appointments. It is, therefore, extremely difficult to identify the impact of a single service within the matrix of inter-related services being provided.

Accordingly, this evaluation does not attempt to isolate the benefits which can be attributed only to Local Area Co-ordination. Instead, assessment against the Theory of Change outcomes assumes that Local Area Co-ordination is working alongside all other services that residents may be receiving. In terms of LAC, this also introduces the additional challenge that the benefits arising may be different to the objectives being recorded in Shared Agreements.

The longer time taken to achieve some outcomes, as identified in previous evaluations, is also a challenge – this may result in benefits being realised outside the timeframe of a specific evaluation.

As a result, the approach taken within this evaluation was to develop Information Governance documents for LAC that would enable the sharing of personally identifiable information for research and evaluation purposes, including for a period after active LAC support has ceased; all residents supported by LAC are given the opportunity to object to this data sharing. Information Sharing Agreements could then be developed, with partner organisations, enabling the analysis of service usage before and after introduction to LAC, together with an assessment of resilience once active LAC support ceases.

This reduced the available sample because it was not considered ethical to share the data of people who had not been given opportunity to object; however, this was considered compatible with the project aim of establishing a baseline for the future monitoring of LAC within Derby.

It has not been possible to finalise and agree Information Sharing Agreements with all partners but efforts will continue in order to broaden the scope of future evaluations.

Finally, this evaluation has been run in parallel with Ipsos MORI's formal evaluation of the Local Area Co-ordination approach to supporting care leavers. The methodology developed, for this evaluation, also had to avoid duplication of effort and survey fatigue amongst the care leavers being supported by Local Area Co-ordinators.

Executive Summary

What is Local Area Co-ordination?[1]

Local Area Co-ordination has proven to be accessible and effective for people of all ages including some labelled as having complex needs, who can be helped to reduce the frequency of crises[2].

Local Area Co-ordination (LAC) is a practical assets based approach which:

- helps communities to become inclusive, welcoming and self-supporting places
- supports people to stay strong and prevents a need for service intervention by building on personal strengths and by finding natural support through local relationships
- supports people facing crisis to get a person-centred service within the context of a supported community network around them
- helps public services to transform so that they are integrated, person-centred and co-produced with communities
- reduces costs to the system as a result of people requiring less assessment, intervention and ongoing care[3].

Local Area Co-ordination intentionally develops strong partnerships with specialist, statutory and funded services, as well as local people, families and communities.

It is specifically designed to respond to issues associated with increasing service demand as part of an evolving and more personal, local, flexible and sustainable system. Long-term evidence shows that, where there is strong leadership and strong design (building on values, practice and evidence), there are highly positive and consistent outcomes at the individual, family, community and systems levels.

Local Area Co-ordination does not start with the perspective of identifying the problems that a person has and the services/resources that they need. Instead, it explores the person's vision of their 'good life' and how they (the person) can make it happen.

Understanding and celebrating people and how their family, friends, neighbours and community can help is a powerful starting point. Services then complement and support the role of people and community.

LAC has proven to be accessible and effective for people of all ages including some labelled as having complex needs, who can be helped to reduce the frequency of crises[2]. It has proven to be equally successful for people across all service labels, including people with mental health problems, physical disabilities and carers[4].

By 'thinking natural first,' and developing social capital within neighbourhoods, Local Area Co-ordination helps to reduce demand on services. People who do not need services, but who have limited other support, are prevented from entering the service system; similarly, with effective support within their community, people's service needs may be delayed or reduced.

Outcomes are stronger through intentional partnership working.

The order in which Local Area Co-ordinators approach helping somebody to solve their problems[5]

What can you do using your own skills and experience?

How can family, friends and community help?

What is the role of services and funding?

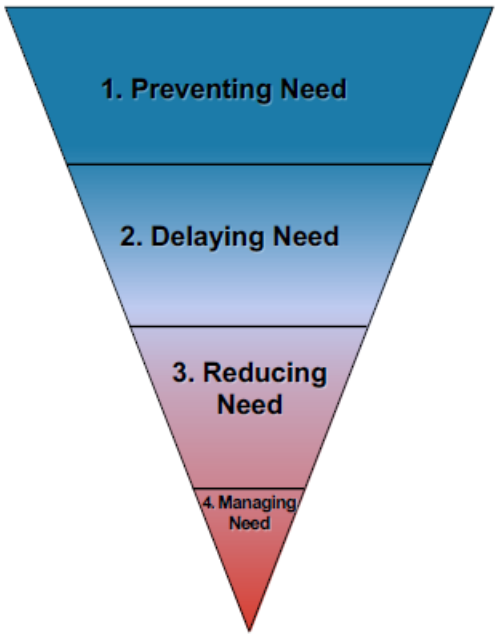
Reducing demand upon the system[6]

Whole person, community, system

The LAC role supports:

- **People not yet known to services** to help build resilience and remain part of their community* (avoiding need for services).
- **People at risk of becoming dependent on services** to remain strong in their own community - diverting the need for more expensive formal service responses (delay/divert need)
- **People already using services** to become less so and more connected and resilient in their own community (reduce need)

*including family, kin, culture



Local Area Co-ordination in Derby

It is estimated that more than 2,000 Derby residents and their families have been actively supported by Local Area Co-ordination.

In Derby, Local Area Co-ordination began in 2012 as part of the Adult Social Care personalisation programme. Local leaders identified that the values underpinning LAC were the same as those which underpinned an authentic approach to personalisation.

Local Area Co-ordination began in two wards but has since undergone several phases of expansion to cover 11 wards in 2019. Within these neighbourhoods, Derby's Local Area Co-ordinators have always offered support to adults aged 18+, however, since 2018, support has also been offered to young people (aged 16+) leaving care[7].

To date, it is estimated that more than 2,000 Derby residents and their families have been supported actively by Local Area Co-ordination.

During 2020/21, LAC is being further expanded to offer support to people across all of Derby, with each ward having a Local Area Co-ordinator. With a LAC in each of the city's seventeen wards, it is expected that 765 people will be supported actively each year. In addition, LACs would be expected to be 'keeping an eye on' approximately 200 more people, checking that they do not need extra support or services.

Notably, all wards within the city have a population larger than the upper limit of recommended population sizes for Local Area Co-ordination – close monitoring will be required to ensure that elements of the LAC role are not being diluted by working within larger communities.

The people supported by LAC, to date, have also tended to reside in areas of comparatively greater deprivation. Approximately 81.5% of the people supported reside in parts of the city which fall into the 30% most deprived areas of England. This will represent a challenge to the LAC service as it expands into new areas of Derby, many of which fall into the 30% least deprived areas nationally.

52.5% of people were introduced to support their reablement

Introductions to Local Area Co-ordination come from a wide range of sources, including statutory bodies, schools, the voluntary sector, people themselves and concerned members of the public. However, the majority of introductions come from within the health and social care arenas[8] with the reasons for introduction being closely aligned with these sources[9]:

- 52.5% of people were introduced to LAC to support their reablement; helping them to regain needed skills, confidence and independence (often following a life-changing event)
- 12.7% of people were introduced to prevent them being admitted to hospital
- 7.7% of people were supported to prevent/ delay the need for them to enter residential care.

12.7% of people were introduced to prevent hospital admission

The people introduced to Local Area Co-ordination have a wide variety of needs and problems with which they need support, with many of the people introduced to the service having multiple and complex needs. At introduction, approximately:

- 75% of people need to overcome isolation (with approximately two thirds wanting to make connections in the community)
- 45% of people require support to be 'heard' and have their circumstances/needs understood by formal services
- 35% of people have financial problems and need to access financial advice
- 25% of people have health/medical problems and need to access healthcare[10].

At the beginning of the Covid-19 pandemic, Local Area Co-ordination played a key role in developing the Derby Community Hub to co-ordinate help and support for people needing it during the national crisis. Through the hub, anybody within the community who is vulnerable, self-isolating or shielding can seek assistance – by September 2020, the hub had received more than 3,000 calls for support and more than 1,000 calls from volunteers.

New introductions to LAC are coming from people who have contacted the Derby Community Hub; others are being identified who may benefit, in the future, from LAC support. Consideration needs to be given about how best to support the vulnerable people who have registered with the hub and how it can be developed and maintained to increase social capital and community capacity within the city.

A bespoke Theory of Change has been produced for LAC in the city (see Figure 1.2.6). It articulates the development from fragmented, isolated communities with increasing demand for services towards more resilient individuals and communities, rich in social capital, with reduced demand for services. As a result of LAC support for residents, there should be a number of visible changes to services/service demand, including:

- reductions in social care packages and interventions
- a reduction in nursing and residential care placements
- reduced demand on secondary Mental Health services
- reductions in unnecessary crisis health interventions
- a reduction in Delayed Transfers of Care
- reductions in unnecessary Primary Care appointments
- sustainment of tenancies – reduction in eviction and associated costs.

Care leavers

Nationally, young people report that leaving care feels like a 'cliff edge,' feeling unprepared for the challenges of adulthood. Upon leaving care, young people struggle most with:

- housing and accommodation
- finances, benefits and budgeting
- transitions to adult services, especially mental health services
- education, employment and training[11].

Overwhelmingly, however, the largest issues raised by care leavers are isolation and loneliness; it is recognised that care leavers have difficulty navigating their way through their late teens and early twenties without a strong and stable support network around them[13].

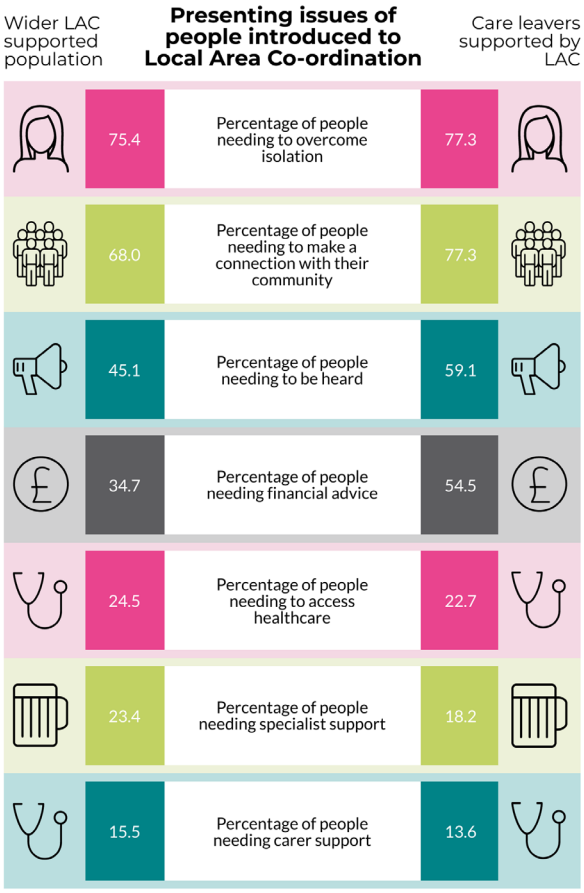
"Young people leaving care constitute one of the most vulnerable groups in our society, and both government and wider society have a moral obligation to give them the support they need as they make the transition to adulthood and independent living[12]."

As would be expected, the presenting issues of care leavers in Derby echo the issues identified nationally, with priorities in all of these areas being reflected in the young people's shared agreements. Notably, with the exception of some issues, which are likely a result of people's life stages, there is a clear similarity between the presenting issues identified by care leavers and other people receiving support from Local Area Co-ordination.

Ipsos MORI were appointed by the Department for Education to undertake an independent evaluation of Local Area Co-ordination support for care leavers. The formal evaluation[14] identified that LACs developed strong and trusting relationships with the young people to whom they were introduced. Further, they supported them to make progress in these areas of their life and helped them to be more resilient when facing adverse circumstances.

Young people felt that they could rely upon their LAC and felt valued as a result of their LAC not having an agenda, just a genuine desire to help. Furthermore, they enjoyed the ability to contact their LAC as often as they wanted or needed to. They also appreciated the 'open ended' nature of the relationship with Local Area Co-ordination, being able to maintain a relationship for as long as they feel that they need to do so. The presence and reliability of their LAC, together with the stability of the relationship, were particularly valued by young people with mental health issues or difficult life situations.

It was also clear from the formal evaluation that Local Area Co-ordination helped to produce sustainable results for young people – when prompted about their need for Local Area Co-ordination support in the future, some care leavers thought it would be minimal, as they had acquired the confidence to live their life.



Positioning this evaluation

Since 2012, there have been 14 independent academic evaluations of Local Area Co-ordination conducted across programmes in England and Wales[15], identifying a range of benefits to people, society and the public sector.

Many of these evaluations have focussed upon the benefits to individuals, with Social Return on Investment (SROI) calculations consistently identifying benefits in the region of £4 for every £1 invested. Whilst SROI measures social value, cost benefit analysis has identified a benefit cost ratio of between 2:1 and 3:1, potentially

rising as high as 4:1 with sustained LAC activity[16].

Building upon these evaluations, it was concluded that this evaluation should focus upon:

1. **Qualitative evaluation:**
- analysis of the contact logs kept by Local Area Co-ordinators to help to identify the range of issues with which people needed support together with the organisations which were involved with the residents supported
- capturing the change in people's personal networks to identify how their situation has changed, their increased resilience and contribution to their local community

Previous evaluations identified a benefit : cost ratio of between 2:1 and 3:1

2. **Quantitative evaluation:**
- analysis of the impact of LAC, at the system level, in the areas identified within the local Theory of Change; where possible, identifying efficiency savings that may be associated with LAC support in these areas.

Problems faced by residents and support provided by LACs

The contact logs kept by Local Area Co-ordinators essentially tell the story of the journey that the person supported and their LAC undertake together. A sample of these logs was reviewed and content analysis undertaken to quantify the problems faced by residents and the support offered by LACs - in total, approximately 2,800 – 3,000 pages of text were included in the analysis.

Below are the most prevalent issues identified within the logs - the results are presented thematically. To prevent disclosure, values below 5% have been suppressed.

Health

Issue experienced / support provided	Percentage of people	
	LAC - General population	LAC - Care leavers
Mental health problems (inc. anxiety)	47.5	59.1
Mobility problems	33.9	-
Self-harm	#	27.3
Recent history of falls	10.2	-
Suicidal / possible suicidal ideation (inc. history of attempted suicide)	10.2	22.7
Drug problems / addiction	5.1	18.2
Support accessing healthcare	~	13.6

- classified elsewhere ~ - not coded but routine for some people and at points of relationships

Social work and Social Care

Issue experienced / support provided	Percentage of people	
	LAC - General population	LAC - Care leavers
Safeguarding	~	31.8
Overcome isolation	29.7	77.3
Home maintenance / tidiness / cleanliness / cleaner	13.6	-
Struggles getting food / food parcels / food banks	8.5	27.3
Person not looking after themselves / neglecting themselves	5.1	9.1

- classified elsewhere ~ - not coded but routine for some people and at points of relationships

Housing

Issue experienced / support provided	Percentage of people	
	LAC - General population	LAC - Care leavers
Support with property search / re-housing / finding a home	~	13.6
Home in poor condition / support to resolve	7.6	9.1
Problems with neighbours	7.6	9.1
Tenancy problems / preventing homelessness	^	22.7
No furniture / support furnishing or equipping home / changing furniture / repairing furniture	^	22.7

- classified elsewhere ~ - not coded but routine for some people and at points of relationship
^ - <5% of cases

Crime and Anti-social behaviour

Issue experienced / support provided	Percentage of people	
	LAC - General population	LAC - Care leavers
Person being exploited / at risk of being exploited (inc. financial)	8.5	9.1
Court proceedings	~	9.1
ASB	6.8	^
Home security	5.9	-
Domestic violence / domestic abuse	^	9.1

- classified elsewhere ~ - not coded but routine for some people and at points of relationship
^ - <5% of cases

Administration

Issue experienced / support provided	Percentage of people	
	LAC - General population	LAC - Care leavers
Financial difficulties / advice (inc. parents)	32.2	36.4
Getting people onto the correct benefits / amounts (inc. appeals / support with assessments)	22.9	-
Support required with official correspondence / forms / paperwork / finance administration	16.9	9.1

- classified elsewhere ~ - not coded but routine for some people and at points of relationships

Other

Issue experienced / support provided	Percentage of people	
	LAC - General population	LAC - Care leavers
Connecting with activities	30.5	36.4
Community connection	24.6	77.3
Serious lack of money	#	18.2
Personal loss / grief / bereavement	16.1	13.6
Volunteering	13.6	18.2
Advocacy / being heard	11.0	59.1
Support with essentials for child	#	13.6

- classified elsewhere ~ - not coded but routine for some people and at points of relationships

The effectiveness of Local Area Co-ordination for people of all ages and with different needs has been well established internationally. Whilst the percentage of people experiencing specific issues may vary, the analysis above indicates that many of the issues faced by care leavers are also commonly experienced within the wider population who have been supported by LAC. There were, however, some issues encountered by LACs that are more prevalent amongst care leavers because of their life stage, including: education, employment and life skills.

Employment and education

Issue experienced / support provided	Percentage of people	
	LAC - General population	LAC - Care leavers
Support looking for work or placement (care leaver or partner) / help to get back into work	^	27.3
Volunteering	13.6	18.2
College courses	-	9.1
Advice / support with applications / CV / getting to interview	#	9.1
Advice / support with interview preparation	#	9.1

- classified elsewhere ~ - not coded but routine for some people and at points of relationship
^ - <5% of cases

Life skills

Issue experienced / support provided	Percentage of people	
	LAC - General population	LAC - Care leavers
Support with food shopping	-	27.3
Mentorship (of care leaver)	~	13.6
Learning to cook / support with cooking and healthy eating	^	9.1
Support with budgeting	^	^
Support with cleaning the home	9.3	^

- classified elsewhere ~ - not coded but routine for some people and at points of relationship
^ - <5% of cases

Evaluation against the Derby Theory of Change

Local Area Co-ordination does not operate in isolation of other services. The people introduced to LAC often have multiple and complex needs; accordingly, they are likely to be receiving support from a range of services across the public sector, but especially health and social care services.

Further, support for a resident provided by one service may lead to efficiency savings being realised in another part of the same organisation or within another part of the public sector. It is, therefore, extremely difficult to identify the impact of a single service within the matrix of inter-related services being provided.

Accordingly, this evaluation does not attempt to isolate the benefits which can be attributed only to Local Area Co-ordination. Instead, the analysis of outcomes assumes that Local Area Co-ordination is working alongside all other services that residents may be receiving or that are introduced post introduction to LAC.

Reduction in nursing and residential care placements

There is clear evidence of Local Area Co-ordination contributing to a reduction in the number of residential and nursing care placements by preventing/delaying people's entry into residential care. Further, modelling suggests that there are appreciable cost savings being delivered through LAC helping to prevent / delay people's entry into council funded residential care.

At least 7.7% of people supported by LAC were either introduced to prevent admission to residential care or had this as an emerging aim during the period of the relationship. 36.4% of these people have/had homecare packages and would therefore be likely to qualify for council funded residential care. It is estimated that the average cost saving associated with delaying their entry to residential care is approximately £19,400 per person per year.

To date, these people have had entry to residential care delayed for an average of approximately 20 months. However, where the LAC relationship has lasted for 4 years, or more, the average delay is approximately 45 months.

For these people, it is estimated that LAC has already contributed to savings of more than £535,000 (less any costs for LAC and other services commencing post introduction to LAC).

With the expansion of LAC to cover the whole city, it is estimated that LAC will be supporting 765 people each year – of these, potentially 59 people per year could either be prevented from entering residential care or have their entry delayed. 22 of these people are likely to qualify for the cost of their care to be covered by the council. Modelling delayed entry of 1-3 years, potential savings are between £376,376 and £1,129,128 per year before any costs associated with LAC and other services introduced[17].

With an ageing population, it is reasonable to assume that demand for residential care will increase; there is a clear need to support more people to find solutions that will enable them to take an active role in their community and have their care needs met within their own home.

If, through a combination of LAC and other services, more people could have their entry to residential care delayed, or prevented, the cost savings could be increased further. If the number of people having delayed entry to council funded residential care could be increased to 35, potential savings could be increased to £598,780 - £1,796,340 p.a. before any costs associated with LAC and other services introduced.

It is estimated that LAC has already contributed to savings of more than £535,000.

Cost savings associated with 22 people per year being prevented from entering the residential care system, based upon an average saving of £329 per person per week[18]

Number of years entry into residential care is prevented / delayed	Cumulative cost savings (£s)				
	Year 1	Year 2	Year 3	Year 4	Year 5
1 year	376,376	376,376	376,376	376,376	376,376
2 years	376,376	752,752	752,752	752,752	752,752
3 years	376,376	752,752	1,129,128	1,129,128	1,129,128

Less any costs associated with Local Area Co-ordination support (2.88% of total LAC costs) and any other services introduced

"I've been able to stay at home with help from my neighbours instead of going into a Care Home." (A Derby resident)

Reduction in social care packages and interventions

More than half of the people introduced to Local Area Co-ordination have been introduced to help them to reable; the Theory of Change identified that LAC would contribute to a reduction in the value (cost) of social care packages and interventions.

For some people, LAC has been successful in achieving this outcome. However, with the deteriorating health of many people in receipt of social care packages, there is a nuanced pattern. For people introduced to LAC:

- 12.6% had a reduction in the value of their care package
- 39.7% had no overall change in the value of their care package
- 47.7% had the value of their care package increased.

Where the cost of care has been reduced, the average weekly reduction was £109 – this suggests potential savings of up to £5,668 per person per year before any costs associated with LAC and other support introduced.

Expanding LAC coverage across the city, it is estimated that 234 people with an adult social care package will be supported each year. Of these, 30 people would be expected to see a reduction in the cost of their care package. If the cost of care packages for these people could be reduced for a period of 1-3 years, potential savings could be between £170,040 and £510,120 per year.

It is likely that not all of these costs savings would be realised due to the need to introduce additional services to help people. Further, in some cases, reductions in the value of care packages may occur without any intervention or support from LAC.

There may be additional savings associated with the 39.7% of people who saw no change in the value of their care package but further research would be required to investigate this.

Notably, 47.7% of people saw the cost of their weekly care increase, with a third of the people supported starting a homecare package. The increased cost of care for these people was five times more than the savings resulting from reductions in care packages; however, the cost of supporting these people to remain independent in their own homes and communities is likely to be cheaper than their entry into residential care.

Potential savings could be between £170,040 and £510,120 per year.

Cost savings associated with 30 people per year having the costs of their care reduced, based upon an average saving of £109 per person per week[19]

Number of years for which the cost of care is reduced	Cumulative cost savings (£s)				
	Year 1	Year 2	Year 3	Year 4	Year 5
1 year	170,040	170,040	170,040	170,040	170,040
2 years	170,040	340,080	340,080	340,080	340,080
3 years	170,040	340,080	510,120	510,120	510,120

Less any costs associated with Local Area Co-ordination support (3.79% of total LAC costs) and any other services introduced

Sustainment of tenancies – reduction in eviction and associated costs

The local Theory of Change identifies that Local Area Co-ordination should contribute to efficiency savings by helping to reduce evictions and associated costs. This evaluation has confirmed that this has been the case for some of the people introduced to LAC.

During 2018/19 and 2019/2020, it is estimated that 39.3% of people supported by Local Area Co-ordinators live in homes managed by Derby Homes. For these tenants, it is estimated that LAC has helped:

- 10% to resolve or reduce rent arrears
- 11% to resolve problems with their neighbours
- 21% to resolve problems with the 'state' of their home and/or garden.

Overall, it is estimated that Local Area Co-ordinators have helped to prevent the loss of a tenancy in 9% of cases. Notably, in at least a third of these cases, the person supported suffered from mental health problems which were affecting their ability to manage their tenancy or to understand the information relating to their possible eviction.

Derby Homes take every possible avoiding action before eviction; it is therefore reasonable to assume a more conservative estimate of 6% for modelling purposes. Assuming that LAC continues to support the same number of Derby Homes tenants, and assuming a £5,000 average cost for terminating a tenancy, it is projected that annual cost savings could equate to £50,000. However, the actual saving is likely to be lower due to not all of the estimated £5,000 eviction costs being saved with each termination.

"The Local Area Co-ordinators have been a vital resource to the Frequent Attenders Team working in the Emergency Department (ED) at Royal Derby Hospital. Quite often the process of identifying frequent attenders is straightforward but what becomes challenging is how to manage them. The LACs form a vital link between our department and Primary Care services. Over the last year they have helped a number of our highest attending patients and we have seen significant reductions in ED attendances and use of the ambulance service. This combined with increasing engagement with appropriate services has seen their lifestyles become significantly less chaotic.

...for me, they have quickly become a vital part of the multi-disciplinary team, especially when it comes to communication and continuity of care."

(ED Clinical Lead - High Volume Service Users)

Reductions in unnecessary crisis health interventions and appointments

A sample of 200 people who have been / are being supported by LAC was drawn and their NHS numbers shared with the University Hospitals of Derby and Burton. There is a nuanced picture of success in LAC contributing to a reduction in unnecessary crisis health interventions and appointments. Across Emergency Department (ED) attendance, Outpatient appointments and Inpatient admissions, overall hospital attendance increased within the sample.

Whilst this is contrary to the aims of LAC and counter to the expected results, more detailed analysis of the results identified that hospital attendances, for this sample of people, fell into three groups; those with:

- Increased attendance
- Steady state - little change in their attendance with very few attendances before or after their first meeting
- Decreased attendance.

Notably, care leavers also fell into all of the three groups.

Further investigation identified that the increased attendance can largely be explained by people either developing new medical conditions or having deteriorating health – for each area, the increase is due to a small number of people greatly increasing their attendances.

Increased attendance is not necessarily undesirable; early intervention to treat health problems can lead to improved outcomes for people and, ultimately, be cheaper than treating people at the point of crisis. Notably, at least 7% of people within the sample had underlying health problems that were not being treated before they were introduced to Local Area Co-ordination.

For other people within the sample, it is reasonable to conclude that LAC support, in addition to other services to which people had access, has helped to reduce or prevent unnecessary hospital attendance. For example, the 13 people who have decreased ED attendance (by 3+ attendances) have collectively reduced attendance by 80 attendances, or 80.2%. Additionally, many other people within the steady state groups had either medical or non-medical problems which may have increased attendance without the support of their Local Area Co-ordinator.

13 people reduced their attendance at the Emergency Dept. by 80.2%.

However, it is not possible, at this time to quantify any possible changes - more detailed research will be required to understand how LAC support is able to contribute to a reduction in unnecessary hospital attendance.

Change in the number of attendances to the Emergency Department for an equal period prior to and post the first meeting with Local Area Co-ordination

Attendance group	Number of people	Number of attendances:		
		Before the first meeting with LAC	After the first meeting with LAC	Difference
Increase	13	22	135	+113
Steady State	81	87	92	+5
Decrease	13	99	19	-80

Note – 10 people showed small changes with more than 4 attendances prior to and post introduction to LAC

Change in the number of inpatient admissions for an equal period prior to and post the first meeting with Local Area Co-ordination

Attendance group	Number of people	Number of attendances:		
		Before the first meeting with LAC	After the first meeting with LAC	Difference
Increase	25	29	144	+115
Steady State	49	55	57	+2
Decrease	17	70	22	-48

Note – 5 people showed small changes with more than 4 admissions prior to and post introduction to LAC

Change in the number of outpatient appointments for an equal period prior to and post the first meeting with Local Area Co-ordination

Attendance group	Number of people	Number of attendances:		
		Before the first meeting with LAC	After the first meeting with LAC	Difference
Increase	61	306	828	+522
Steady State	34	31	41	+10
Decrease	38	591	295	-296

Note – 11 people showed small changes with more than 3 appointments prior to and post introduction to LAC

"The LAC never badgered me. If they'd have pushed me, I would never have got involved with the group of friends I have now and I have no doubt that I would still be drinking." (A Derby resident)

"Strong links and relationships between hospital discharge and Local Area Co-ordination help to unlock barriers that prevent customers returning home. Social isolation can be a huge factor in customers being reticent in returning home from hospital. The role of the LAC in reconnecting customers to their community is instrumental in helping customers maintain their independence."

(Team Manager, Hospital to Home Team)

Reduction in Delayed Transfer of Care (DTOCs)

Local Area Co-ordination aims to reduce the number of delayed discharges caused by social care or jointly by health and social care reasons – during 2019, there were 506 delayed days for these reasons at Derby hospitals[20].

This evaluation has found evidence to support this; it is estimated that at least 22 people (3.9%) were either introduced to LAC to prevent DTOCs or had this develop during the period of the relationship. Every person supported by LAC has their own individual needs and aspirations; it is notable, however, that the people who have been supported to avoid delayed transfer typically have greater needs.

It is difficult to identify the exact number of DTOCs that LAC has helped to avoid due to a lack of data recording. However, for those people for whom it has been possible to estimate the number of DTOCs avoided, the average length of LAC support, to date, is 24 months with an average of 1 DTOC avoided per person per year. If we assume an average of 3 delayed days per DTOC, and an average of 1 DTOC per person per year, the 22 people for whom DTOCs have been prevented may have totalled as many as 66 days in 2019.

This would equate to a possible 11.5% reduction in delayed days caused by social care and jointly by social care and health reasons.

With LAC support being extended to an estimated 765 people per year, it is likely that LAC may contribute to at least 30 people per year avoiding DTOCs. Assuming an average delay of 3 days, at approximately £350[21] per day, and a DTOC avoided each year during an average 2 year period of LAC support, the potential cost savings in year 1 could be £31,500; from year 2 onwards potential savings could be £63,000 per year.

It should be noted, however, that where the person's support network and condition of their home have developed to a standard where they can be safely released from hospital, further DTOCs could be avoided whenever they are admitted. Accordingly, the potential cumulative reduction in delayed days and cost savings would be expected to be greater than those identified above.

"My Local Area Co-ordinator gave me hope during my most challenging times. I felt suicidal before [they] came into my life and helped me navigate many challenges. Thanks to [them] I am now independent, confident and have connections to my local community. [They are] 'my angel'."

(A Derby resident)

Reduced demand on secondary Mental Health services

Due to minor limitations within the data shared with Derbyshire Healthcare NHS Foundation Trust, and also within the analysis undertaken, it has not been possible to identify the full impact of LAC on Secondary Mental Health services.

Whilst it is the experience of Local Area Co-ordinators that LAC has helped to reduce demand on Secondary Mental Health services, further research is required to more fully understand the scale and extent of any potential impact.

Conclusions

Local Area Co-ordinators generally 'walk alongside' approximately 40-50 people and families, living in their area, who may be facing complex, enduring life situations. This includes a balance of people receiving ongoing light touch support (building and maintaining connections, contribution, capacity), and people who may benefit from ongoing or more intensive support.

With expansion to cover the whole city, it is estimated that 765 people per year will receive active support through Local Area Co-ordination.

Local Area Co-ordination does not operate in isolation of other services; accordingly, this evaluation did not attempt to isolate the benefits attributable solely to LAC. Instead, the analysis of outcomes assumed that LAC was working alongside all of the other services that residents were/are receiving or which may have been introduced following their introduction to Local Area Co-ordination.

It is evident from the qualitative analysis (see also the case study attached) that Local Area Co-ordination is contributing positively to people's lives, supporting them to achieve their version of a good life by helping them to resolve a wide range of problems, increase their confidence and capacity, maintain their independence and increase their resilience to possible crises.

Through intentional partnership working and connecting people to their communities, local groups and specialist services, there is also evidence that LAC in Derby is helping to prevent, delay and reduce the need for people's use of formal services across the system.

Within the context of LAC operating alongside other services, there is evidence that LAC is helping to reduce unnecessary demand on NHS services. Many of the people who decreased attendance or saw little change in attendance (the steady state group) had

conditions which may have caused them to 'go into crisis' without LAC support. Others had non-medical problems which may have caused hospital attendance without support from their Local Area Co-ordinator.

Where people have been admitted as an inpatient, there is evidence that LAC, together with other services, has helped to reduce the number of delayed days, freeing-up bed spaces to enable the NHS to treat additional patients.

Within the social care system, there is evidence that LAC has helped to reduce the value of homecare packages for some people. For others, there is evidence that LAC has helped them to maintain their independence in their own home and community, thereby, preventing, or delaying, their entry to residential care.

There is also evidence that Local Area Co-ordinators have helped to prevent the loss of tenancies – in at least a third of these cases, the tenants had mental health problems that were affecting their ability to manage their tenancies. In these cases, eviction may have caused worsening mental health.

It should be noted that services which are already seeing high, and increasing, demand may not notice a reduction in demand as more people are in need of the service – they may, however, be able to respond better to people who are in greater need[22].

The expansion of Local Area Co-ordination to cover the whole city means that these efficiency savings should increase. Further, subject to capacity, it would be expected that the efficiency savings being observed could be increased with the introduction of more people to Local Area Co-ordination at the correct point of their journey with services.

However, in order to contribute most efficiently to cost savings, and to deliver the maximum benefit to people and local communities, Local Area Co-ordinators must have the capacity to deliver all aspects of their role.

Global experience has identified that, ideally, a Local Area Co-ordinator should work with a population of approximately 8-10,000 people.

This size of population enables a LAC to develop a deep knowledge about/connection with local people, places, resources, supports and opportunities - it creates the conditions for building and utilising natural supports and local solutions, developing capacity and social capital.

All wards within the city have a population in excess of 10,000 people. It will be necessary to maintain constant review of the activities that LACs are undertaking to prevent critical parts of the LAC role, notably support for community activities, from reducing. The evidence suggests that decreased community capacity building will lead to increasing demand for services.

Finally, Local Area Co-ordinators are embedded within a community and work in partnership with local people, services, organisations and statutory partners. They do not carry out assessments or solve people's problems for them - their key aim is to build individual, family and community capacity[24]. This is reflected in the Derby Care and Support wedge (see Figure 4.1.1); Local Area Co-ordination operates at the left side of the wedge:

- developing people's and families' capacity to help themselves
- increasing social capital to enable people to remain independent in their own homes and communities.

If LACs are drawn too far towards the right side of the wedge, service dependence will switch to Local Area Co-ordination and there will be less time to develop community capacity; both are likely to result in increasing service demand.

Selected recommendations

1. Local Area Co-ordination practices are locality-centred and user-orientated, focused on holistic outcomes for people rather than targets for service silos. Derby City Council plans to develop locality-based services during its post-Covid recovery phase and so, whilst secure and sustainable funding for LAC has been a challenge previously, now would be the time to address this issue as LAC becomes a key part of a wider, place based landscape.

2. To consider how best to position LAC in business-as-usual processes so that people are offered an introduction at the timeliest opportunity.

3. To undertake research into the outcomes for families introduced to LAC and to develop indicators which can be used for monitoring progress for both adults and children within these introductions.

4. To further develop a population outcomes framework that can be used to regularly monitor the impact of LAC. This could include a range of metrics that are shared with partner organisations and integrated within system-wide outcomes frameworks.

5. To embed a continuous learning approach to performance reporting that moves away from looking to prove that LAC works, to better understanding how it works, what could be done to improve performance and how what we learn informs and supports wider system reform.

6. Given the emerging evidence around the impact that LAC can have in reducing demand through to ASC and resultant care packages and placements, more work should be done to understand and explore:
    a. what conditions best support a successful introduction to LAC;
    b. how the Community Hub impacts upon demand for ASC support;
    c. when and from what areas is the optimal time for an introduction to LAC from ASC services?

7. To undertake further (joint) research with the University Hospitals of Derby & Burton, and Royal Derby Hospital specifically, to more fully understand any potential impacts that LAC has on Delayed Transfers of Care.

8. To undertake further (joint) research with Derbyshire Healthcare NHS Foundation Trust to more fully understand any potential impacts that Local Area Co-ordination has on secondary Mental Health Services and potential benefits to the patients. For example, where LAC support is available:
    a. are mental health outcomes better;
    b. do patients reach outcomes more quickly, leading to earlier discharge;
    c. post discharge, are patients more resilient?

Chapter 1 - Introduction

1.1) What is Local Area Co-ordination?[25]

Local Area Co-ordination has proven to be accessible and effective for people of all ages including some labelled as having complex needs, who can be helped to reduce the frequency of crises[26].

Local Area Co-ordination (LAC) can be traced back to its origins in Albany, Western Australia, in 1988, in response to a need to find new ways of supporting disabled people. Since that time, it has expanded state-wide within Australia and has been introduced into locations across New Zealand and the United Kingdom. In addition to geographical expansion, LAC has expanded to cover a more diverse range of needs within the population, including people with mental health needs and older people[27].

Local Area Co-ordination is a practical assets based approach which:

- helps communities to become inclusive, welcoming and self-supporting places
- supports people to stay strong and prevents a need for service intervention by building on personal strengths and by finding natural support through local relationships
- supports people facing crisis to get a person-centred service within the context of a supported community network around them
- helps public services to transform so that they are integrated, person-centred and co-produced with communities
- reduces costs to the system as a result of people requiring less assessment, intervention and ongoing care[28].

Who can benefit from Local Area Co-ordination?

The Local Area Co-ordination Network identify that *"Local Area Coordination can be accessed and is effective for people of all ages including some labelled as having complex needs, who can be helped to reduce the frequency of crises. It avoids set eligibility criteria and formal assessment processes, in order to get straight to planning and practical action[29]".*

It has proven to be equally successful for people across all service labels, including people with mental health problems, physical disabilities and carers[30].

Why Local Area Co-ordination?

Bartnik, Broad and Sinclair (2020)[31] identify that services can be complicated to access and navigate; with feedback consistently indicating that their processes can be frustrating and detrimental to people's wellbeing. The result is a cycle of waiting, negativity, harm, dependency and cost.

"I have been consistently supported, advised and motivated by the Co-ordinators. I am more informed, safer and connected because of the work they are doing." (A Derby local group organiser)

Recurring themes	Unintended consequences
Services can be very complicated and difficult to access, navigate and control. There can be many people in those services focusing on different parts of someone's life.	Many don't access any support, causing further harm and leading to escalation of unmet needs. Multiple workers involved from a variety of services. People have to re build trust, re tell story.
It can be difficult to build a trusting relationship and people often have to re-tell their story over and over again.	People get frustrated and disengage with support.
Service systems often wait for people to fall into crisis before responding, assess people in terms of their deficits (defining people by what they can't do), test their eligibility or worthiness for support and then apply services or resources to "fix" those deficits or problems (if eligible).	Further labelling and exclusion of people based on their perceived deficits or "reputation". Low expectations of individual and family expertise, capability and resilience.
If not eligible, people have to wait until their situation worsens before help is available.	People waiting in negativity, causing further harm, disconnection and dependency.
As available resources reduce and demand increases, this process is "tightened" making it even more difficult to access timely support.	Greater rationing of services, repeated time limited "interventions", embedded dependency, higher unmet need and system costs.
For those who are eligible for supports and services, there are often limited options, predominantly focussed on crisis, rather than sustainable, community alternatives and resilience.	Due to pressure on services, support is likely to be time limited and focused on one particular area of their life, with little time to think about / offer support with the issues or experiences that have brought them where they are.

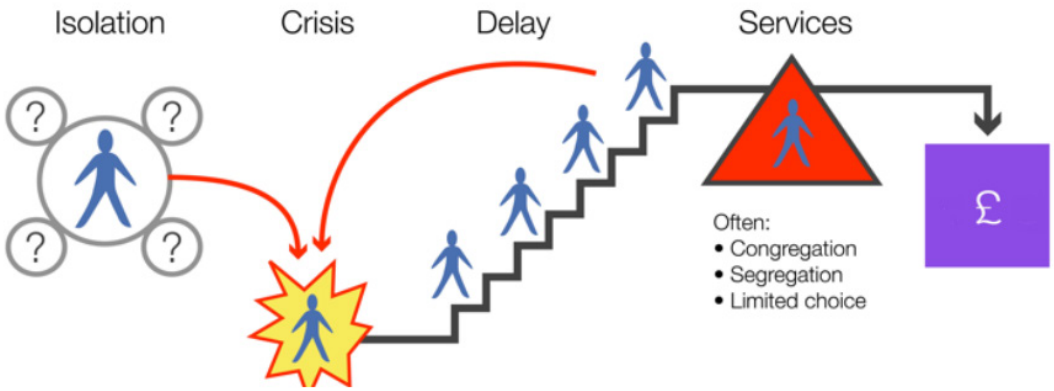
"I didn't feel like any of the other professionals in my life were actually listening to me. The LAC has given me the confidence to say what I want and need." (A Derby resident)

With increasing demand upon local services and reduced resources, this is neither sustainable or an effective use of resources. As a result, services may:

- be available too late, or may not be available
- offer limited choice
- not offer the best solution for everybody.

Local Area Co-ordination is specifically designed to respond to these issues as part of an evolving and more personal, local, flexible and sustainable system.

Figure 1.1.1 – Impacts of the current care system[32]



What is Local Area Co-ordination designed to do and how?

Understanding that services are an important part of life for some people, it is then important to make sure that any service design and delivery starts to address these problems.

Local Area Coordination builds on the universal themes and feedback from people around "what good would look like" in terms of support in their local community, including having someone who:

- is local and easy to find or contact
- will listen
- will take time to get to know and understand what's important to me - my strengths, aspirations, people who are important to me, as well as my needs or challenges
- does not take over, have their own agenda or 'the answers'
- helps me to do more for myself - my confidence, connections and resilience
- is embedded in and connected with our community - relationships and connections, resources, mutual support, opportunities.

Key design features of Local Area Co-ordination that drive outcomes and sustainability

Local Area Co-ordination strives to build and maintain positive relationships, connections and outcomes alongside individuals, families, communities and across the service system.

It is designed to address the complexities and obstacles inherent within service systems. Long-term evidence shows that, where there is strong leadership and strong design (building on values, practice and evidence), there are highly positive and consistent outcomes at the individual, family, community and systems levels.

The Local Area Co-ordination Charter

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

(Source: Local Area Co-ordination Network)

10 Principles of Local Area Co-ordination

1. Citizenship for all
2. Relationships matter
3. People have natural authority
4. Lifelong learning for all
5. Information is power
6. People need choice and control
7. Community creates opportunity
8. Everyone can contribute
9. Working together is powerful
10. Services should complement people's goals.

(Source: Local Area Co-ordination Network)
(Shown in full in Appendix 1)

Key design features include…

a. The Local Area Co-ordination Framework

The Framework clearly outlines
- programme values, expectations, outcomes and cohesion around strength and place-based practice,
- key design factors that drive person, family and community led outcomes and service resilience, flexibility and relevance
- what a Local Area Co-ordinator does / doesn't do (Appendix 2).

b. Access – from assessment and waiting to conversation, exploring and doing …

Local Area Co-ordination works to overcome common system issues that stop people being able to access timely, relevant support in the community.

1. Anyone can connect with a Local Area Co-ordinator.
2. Anyone can introduce someone to a Local Area Co-ordinator.
3. There is no assessment and no eligibility criteria for longer term support, apart from being a resident within the local community.

c. Short term information, connections and support.

Anyone can access Local Area Co-ordination for short term information, connections or support, with the aim of ***building individual, family, and community capacity.***

d. Longer term support

Local Area Co-ordinators generally 'walk alongside' approximately 40-50 people and families, living in the area, who may be facing complex, enduring life situations. This includes a balance of people receiving ongoing light touch support (building and maintaining connections, contribution, capacity) and people

The Local Area Co-ordination Charter

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

(Source: Local Area Co-ordination Network)

who may benefit from ongoing or more intensive support.

Where numbers are higher, it disrupts the connected role, reduces time with the person and connection with the community. This reduces opportunities for building each person's capacity, confidence, connections, contribution and resilience.

Where numbers are lower, there are increasing risks around being "too involved" and creating a dependence upon the Local Area Co-ordinator.

e. The multi-element role - Simplifying the system for people, families and communities

As part of building more trusting and purposeful relationships, and simplifying the system for local people, communities and services, Local Area Co-ordination combines a range of roles that have often been kept separate and delivers these alongside local people in their local community.

Figure 1.1.2 – The Local Area Co-ordination approach[33]

A personal, local, human approach

Defined geographical area – **Place based**/located in/connect with community.

Conversation focused on a **good life.**

Build on the strengths and contribution of people and communities. **Think natural first.**

Whole person, family, community, system.

Voluntary relationship – introductions not referrals.

Not time limited, but avoids dependency.

Intentional partnership working with local people, communities, organisations and services

Local Area Co-ordinators start at the beginning - they will take time to get to know individuals, families, carers and communities over time. A positive, trusting relationship is central.

Local Area Co-ordinators:

- are available to people of ***all ages and all backgrounds*** and their families
- take time to ***listen***, get to know and find out what's important – good, purposeful conversations, at the "speed of trust"
- explore and ***discover dreams and aspirations*** of the people that they support, now and in the future,
- understand, respect and acknowledge people's journey, ***strengths***, skills, experiences and needs
- are available to ***anyone in the community for information, connections or short-term support***
- are available for ***longer-term support*** alongside people in that community facing more ***complex and enduring life issues***,
- access accurate, relevant and timely ***information***
- build and maintain valued, mutually ***supportive relationships***
- help people to be heard and ***have a voice***
- assist people to ***take actions*** to do what they want or need to do in life
- nurture more ***welcoming, inclusive, supportive and better resourced communities***
- are part of, and actively ***contribute*** to, community life
- access, navigate, choose and control services and resources they may need.

This provides the opportunity to build relationships of trust, explore together people's vision for a good life, not just their service needs or eligibility, and support the person to make it a reality.

When also combined with being locally based in communities (in accessible, trusted, non-service locations), avoiding deficit/needs assessments or exclusion/eligibility criteria, intentional partnerships with community and funded services, Local Area Co-ordination offers the foundations of a highly personal, local approach to building individual, family and community resilience.

f. Place

Communities are a rich source of relationships, opportunities, valued contributions, information and support. Therefore, the knowledge of and connection with those communities is vital for building individual and family resilience. Without this, service demand and dependency will increase.

Global experience has identified that, ideally, a Local Area Co-ordinator should work with a population of approximately 8-10,000 people. This size of population enables a Local Area Co-ordinator to develop a deep knowledge about/connection with local people, places, resources, connections, supports and opportunities. It creates the conditions for building and utilising natural supports and local solutions, developing capacity and social capital.

Local Area Co-ordinators are visible within their local community. They are mobile but also have bases within their community that are easy to find and access irrespective of their age, background or service label.

g. Think natural first

Local Area Co-ordination does not start with the perspective of identifying the problems that a person has and the services/resources that they need. Instead, it explores the person's vision of their 'good life' and how they (the person) can make it happen.

Understanding and celebrating people and how their family, friends, neighbours and community can help is a powerful starting point. Services then complement and support the role of people and community.

"The LAC never badgered me. If they'd have pushed me, I would never have got involved with the group of friends I have now and I have no doubt that I would still be drinking." (A Derby resident)

Figure 1.1.3 – The order in which Local Area Co-ordinators approach helping somebody to solve their problems[34]

What can you do using your own skills and experience?

How can family, friends and community help?

What is the role of services and funding?

h. Inclusion, Leadership and Contribution

Local Area Co-ordination is built on the genuine contribution of local people, from the original co-design, through to the ongoing active contribution to recruitment of their Local Area Co-ordinators and development and delivery of LAC in their community.

Long-term learning has shown that where there is genuine contribution and joint decision-making alongside local people, there are a range of positive outcomes, including:

- natural, enduring relationships and partnerships with and between local people
- people reporting feeling valued and respected for their knowledge, skills and decision-making
- local people having an investment in Local Area Co-ordination and their Local Area Co-ordinator
- better knowledge of, and connections with, local people, resources and opportunities in our communities
- people building a shared, positive community vision for the future
- increased awareness of what Local Area Co-ordination is/is not
- quicker, better and more sustainable outcomes
- local people choosing good Local Area Co-ordinators!

i. Partnerships

Local Area Co-ordination intentionally develops strong partnerships with specialist, statutory and funded services, as well as local people, families and communities.

It starts with building a shared understanding of what we all do individually, the limits of what we do and exploring how we can work together to support better outcomes alongside local people.

Outcomes are stronger through intentional partnership working.

Outcomes are stronger through intentional partnership working.

j. Whole system. People – Prevent, Delay, Reduce

By 'thinking natural first,' and developing social capital within neighbourhoods, Local Area Co-ordination helps to reduce demand on services. People who do not need services, but

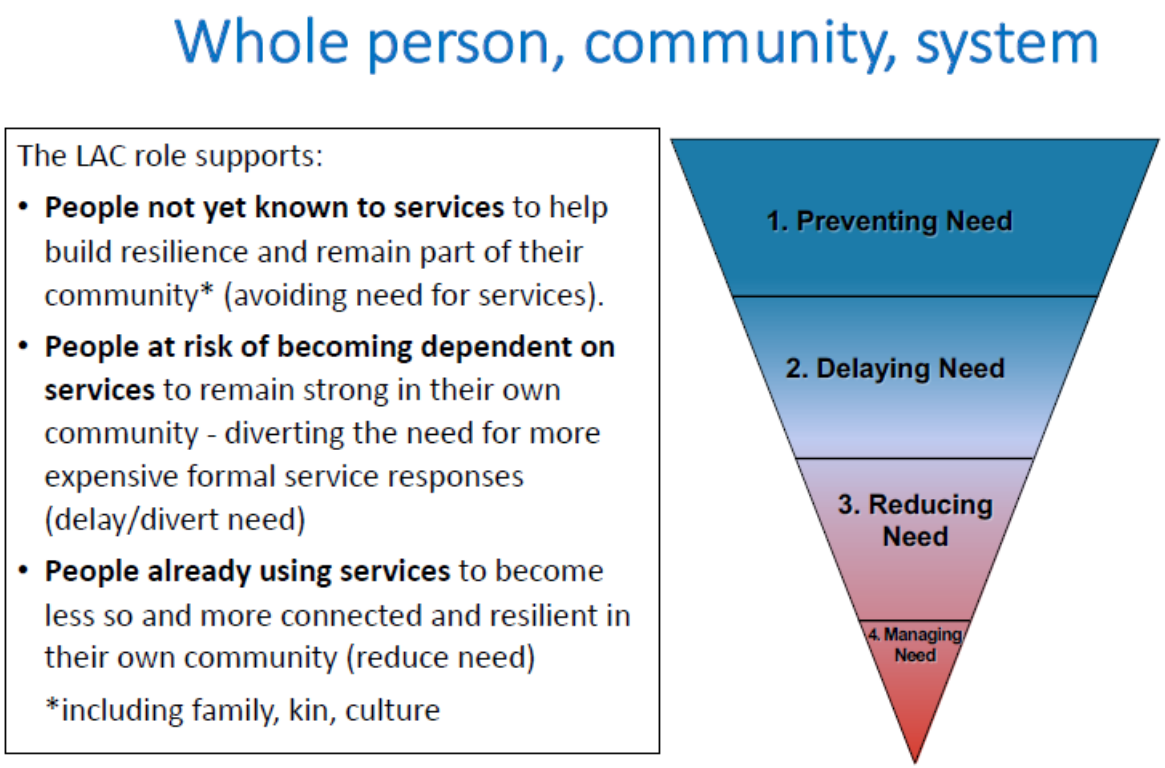
who have limited other support, are prevented from entering the service system; similarly, with effective support within their community, people's service needs may be delayed or reduced.

Local Area Co-ordinators do help people to access local services, where they are required, but they see services as the last thing to consider, not the first[35]. This can only be accomplished by walking alongside people, in partnership with services and integrated with service pathways throughout the whole system.

Equally, it requires a consistent, trusted, accessible, local person available in the local community who understands and can bridge natural/community support, service pathways and the transition process.

Local Area Co-ordination works at the person, community and system levels; a specific Theory of Change has been developed for Local Area Co-ordination in Derby – this is included within the next section.

Figure 1.1.4 – Reducing demand upon the system[36]



"Part of my role is to help people identify community-based solutions, with a view to preventing, reducing or delaying the need to access a more formal service, and finding creative ways to improve health and well-being." (A Derby Local Area Co-ordinator)

1.2) Local Area Co-ordination in Derby

"My Local Area Co-ordinator is my angel – [they] literally saved my life." (A Derby resident)

In Derby, Local Area Co-ordination began its journey in 2012 as part of the Adult Social Care personalisation programme. Local leaders identified that the values underpinning LAC were the same as those which underpinned an authentic approach to personalisation, including:

- starting with the person as an individual with gifts, strengths and aspirations
- listening and helping people to lead a more independent life
- finding new ways to give people more choices
- supporting people to build upon or develop connections and relationships with others within inclusive and mutually supportive communities
- helping people to take more control over their lives
- where a service is required, supporting people to access, navigate, choose, self-manage and, where appropriate, exit services[37].

Local Area Co-ordination began in two wards (Alvaston and Arboretum). Since this time, the service has undergone several phases of expansion, including:

- an additional 5 wards in 2014 (Sinfin, Abbey, Derwent, Normanton and Darley)
- a further 3 in 2015 (Mackworth, Chaddesden and Boulton)
- another in 2019 (Spondon).

Within these neighbourhoods, Derby's Local Area Co-ordinators have always offered support to adults aged 18+ however, since 2018, support has also been offered to young people (aged 16+) leaving care[38].

Local Area Co-ordination also attends the Council's Vulnerable Children's Meetings and, since 2018, has been receiving introductions to support families with vulnerable children. To date, approximately 60 families have been introduced to LAC through this route. The outcome of LAC support to these families should be a priority for future evaluation.

Since 2018, LAC support has also been offered to young people leaving care.

Since October 2019, Local Area Co-ordination support has also been available to people with 'chaotic lives' who are using primary care services intensively and where it is believed that there is a non-medical reason underlying attendance. Introductions come via primary care services, where people have consented to have their information shared with Local Area Co-ordination. Whilst interrupted by the pandemic, between October 2019 and February 2020, 26 people for whom LAC support was suitable, were introduced as a part of this pilot project – introductions and support are ongoing.

At the beginning of the Covid-19 pandemic, alongside Community Action Derby, Derby Homes and other council teams, Local Area Co-ordination played a key role in developing

Since 2018, approx. 60 families have been introduced to LAC through Vulnerable Children's Meetings.

the Derby Community Hub to co-ordinate help and support for people needing it during the national crisis. Through the hub, anybody within the community who is vulnerable, self-isolating or shielding can seek assistance – help is being prioritised for people with no family, friends or neighbours who can help them.

Since the start of the pandemic, within Derby, at any time there are 8,000-9,000 people on the clinically vulnerable (shielding) list, however, not all of these people need support from the hub. By September 2020, the hub had received more than 3,000 calls for support and more than 1,000 calls from volunteers.

Local Area Co-ordinators, are managing the response within multiple wards, listening to people's needs and the problems that they may be having and then either providing information or connecting them with community resources, other people in the community, volunteers and other services.

As would be expected, the hub is developing into another source of introductions to Local Area Co-ordination. LACs are taking/making calls from people contacting the hub and listening to people's requests for support; explanations about Local Area Co-ordination are often being met with a request for future LAC support. In one ward, at least 7 new introductions came from this channel between the national lockdown and October 2020.

During 2020/21, LAC is being further expanded to offer support to people across all of Derby, with each ward having a Local Area Co-ordinator. Notably, all wards within the city have a population larger than the upper limit of recommended population sizes for Local Area Co-ordination – close monitoring will be required to ensure that elements of the LAC role are not being diluted by working within larger communities.

"Volunteers are saying they want to stay in touch with people – as LACs we work hard to try and encourage those natural relationships amongst people in the community. It has the potential to be more sustainable. Relationships are everything. I'm just one link in the chain, connecting people and then the future is up to them."

(A Derby Local Area Co-ordinator)

Table 1.2.1 – Derby ward populations, 2019

Ward	Population
Abbey	15,600
Allestree	13,400
Alvaston	17,100
Arboretum	22,100
Blagreaves	12,900
Boulton	13,700
Chaddesden	13,000
Chellaston	15,500
Darley	15,500
Derwent	14,100
Littleover	15,000
Mackworth	15,100
Mickleover	13,800
Normanton	19,700
Oakwood	12,500
Sinfin	16,200
Spondon	12,200
Derby	**257,300**

Note: figures have been rounded to the nearest 100 people. Figures may not sum due to rounding

Source: ONS, Mid-year estimates of population, 2019

Introductions to Local Area Co-ordination come from a wide range of sources, including statutory bodies, schools, the voluntary sector, people themselves and concerned members of the public. However, the majority of introductions come from within the health and social care arenas[39].

This illustrates the integration of Local Area Co-ordination across the public sector; however, the number of self-introductions together with the number of introductions from people's family, friends and neighbours also indicates the reach of LACs within their local communities.

Table 1.2.2 – Sources of introduction to Local Area Co-ordination

Source of Introduction	Percentage
Council departments	36.4
Primary and secondary health services (inc. GPs, hospitals and mental health services)	29.7
Self-introduction	13.9
Family, friends and neighbours	5.4
Housing services	5.0
Other	9.6

Source: Derby City Council, Local Area Co-ordination

Funding Local Area Co-ordination in Derby

In addition to funding through Derby City Council, Local Area Co-ordination has been / is being funded through:

- **The Better Care Fund (BCF)** – the BCF is a programme spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and well-being, and live independently in their communities for as long as possible. (The BCF has been created to improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support, and providing them integrated health and social care services, resulting in an improved experience and better quality of life (NHS England)).

- **The Department for Education (DfE), Children's Social Care Innovation Programme** – funding was received through this programme to provide Local Area Co-ordination Support to care leavers within neighbourhoods of Derby that are covered by LAC. Following the completion of the two-year project providing support to care leavers, the DfE have funded LAC in Derby for an additional year, through 2020/21, to support and promote it's sustainability due to their recognition of the potential impact that it could have if scaled nationally.

- **Derby Homes** – to provide Local Area Co-ordination support to people who live in tenancies managed by Derby Homes

- **NHS Derby and Derbyshire Clinical Commissioning Group** – a pilot project to provide Local Area Co-ordination support to high intensity users of primary care services 'with chaotic lives,' where there may be underlying non-medical causes resulting in high usage of primary care services.

Evidence, nationally, identifies that people receiving support include those who (a) are new to local services, (b) have existing, and sometimes long-standing, service histories and (c) have become disconnected from services[40]. To these we can add growing evidence in Derby of people who have been discharged from services.

Nationally and internationally, the number of people being supported by a Local Area Co-ordinator varies; however, Bartnik et al (2020)[41] identify that each LAC ordinarily supports 40-50 residents and their families. Within Derby, support is more intensive, with each LAC actively supporting approximately 30 residents at any time - sign-posting help is also provided to a larger number of people on an ad hoc basis. In addition, each LAC is 'keeping an eye on' approximately 15 people to ensure that they are still resilient and do not need any additional support or services.

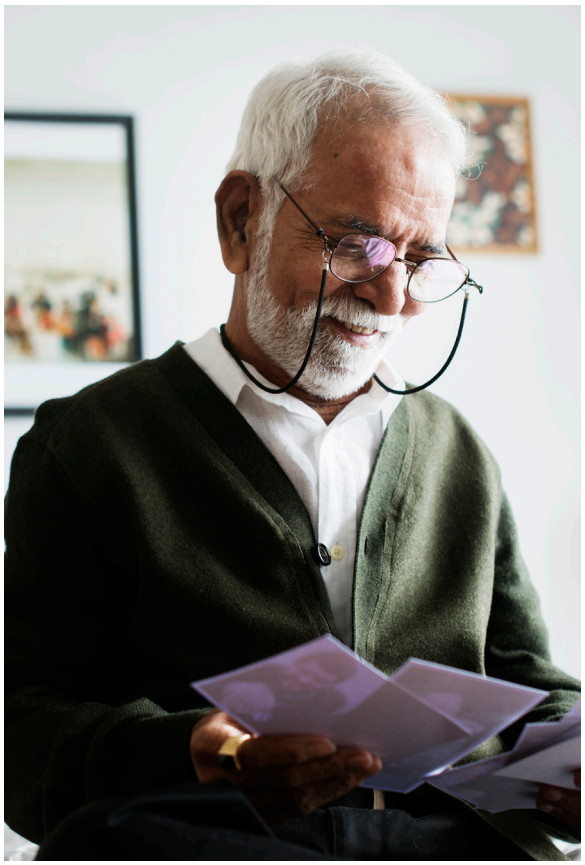
With 14 Local Area Co-ordinators, this means that, at any time, Local Area Co-ordinators are providing active support to approximately 400-450 residents, and their families, within the city. Relationships never end; once a resident has achieved all of their goals and does not wish to set more, active support ceases but the resident is free to contact their LAC at any time in the future if they feel that they need more support.

Upon introduction, Local Area Co-ordinators generally meet with people weekly; over time, the frequency of contact reduces to fortnightly and then monthly. Finally, contact is just by phone calls to 'check-up' on people. However, people can contact their LAC, at any time, if they have a problem.

Whilst it is difficult to identify exactly, due to changes in recording methods, it is estimated that more than 2,000 Derby residents and their families have been actively supported by Local Area Co-ordination since its introduction. This equates to approximately 1.8% of all Derby households.

It is estimated that more than 2,000 people and their families have been actively supported by LAC.

New introductions to the LAC team, where support has been accepted by the resident and a first meeting takes place, are currently running at approximately 26 per month (based on first meetings during calendar year 2019).



"I don't speak to my LAC very often anymore. I don't have to. But I know they're there if I need some advice." (A Derby resident)

"Because of that first initial coffee morning meeting, I'm not that self-isolated hateful woman - I have changed so much. I'm not scared at all. I instigate new activities and welcome strangers. I know that I'm just helping out but I feel a part of something again. I feel I have a value again."

(A Derby resident)

Bartnik, Broad and Sinclair (2020)[42] identify that Local Area Co-ordination relationships develop 'at the speed of trust.' Accordingly, in Derby, there is no a set length of relationship between people and Local Area Co-ordinators. The length of the relationship is dictated by the time taken to develop a trusting relationship, the complexity of the resident's situation, their needs and what they wish to achieve together with the pace at which they are able to/wish to move. It is also notable, that as relationships progress and trust develops, additional issues can be identified, extending the length of active support.

Further, Local Area Co-ordination is not something that 'is done for you.' Despite commitment from the Local Area Co-ordinators, the partnership nature of the relationship results in people 'getting out what they put in.' It is evident that, where residents are less/not committed to the relationship, the length of the relationship is shorter than where people commit fully.

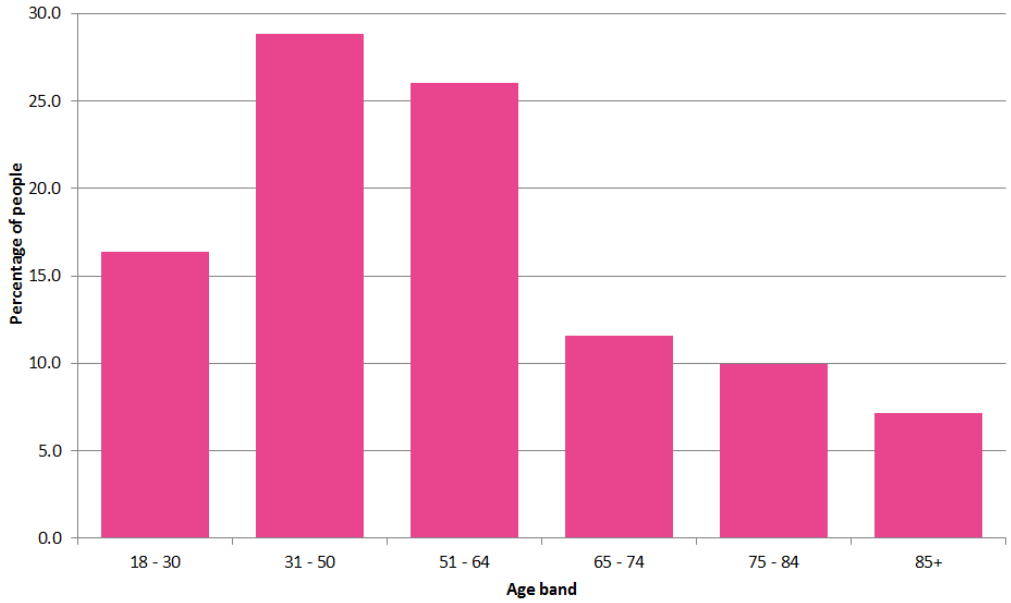
Within Derby, the average length of a relationship is approximately 8 months, meaning that each LAC can support, on average, 45 people (and their families) per year.

Accordingly, with expansion to cover the whole city, with a Local Area Co-ordinator based in each of the city's seventeen wards, it would be expected that 765 people will be supported actively each year. In addition, Local Area Co-ordinators would be expected to be 'keeping an eye on' approximately 200 more people, checking that they do not need extra support or services.

People in Derby supported by Local Area Co-ordination

In 2019, the LAC Network identified that Local Area Co-ordination could be effective for people of all ages – the age profile of people accessing LAC support in Derby reinforces this, with approximately 55% of residents being aged between 31 and 64[43] compared to approximately 29% aged 65+.

Figure 1.2.1 – Ages of people receiving support from Local Area Co-ordination



Source: Derby City Council, Local Area Co-ordination

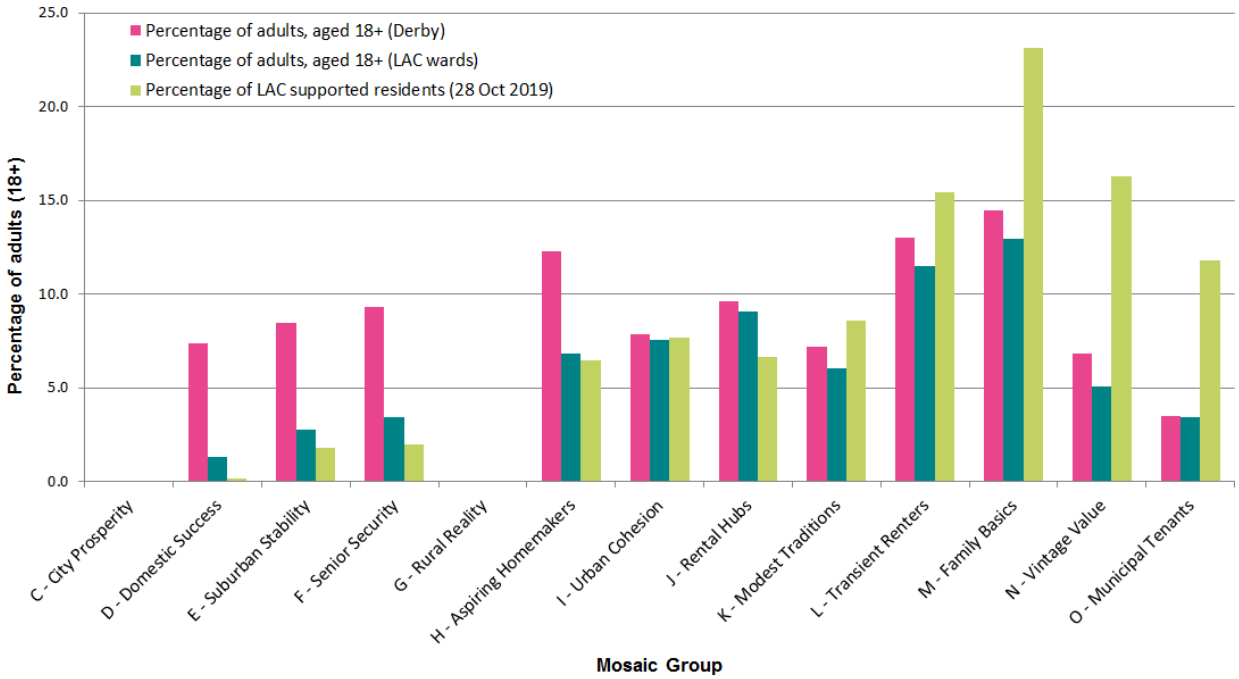
Whilst Local Area Co-ordination is effective for people of all ages and backgrounds, to date, due to the communities in which LAC has been operating and the circumstances of the people assisted, the service has supported a greater number of people with more modest means. This is reflected in the Mosaic PS6 Groups of the people supported, with a greater percentage of people falling into the Modest Traditions, Transient Renters, Family Basics, Vintage Value and Municipal Tenants groups compared to both the Derby adult population and that of the wards in which LACs are based – this is illustrated in Figure 1.2.2.

More than 80% of the people supported by LAC, to date, live within the 30% most deprived areas in England.

The people supported by LAC, to date, have also tended to reside in areas of comparatively greater deprivation. Approximately 81.5% of the people supported reside in parts of the city which fall into the 30% most deprived areas in England. In contrast, only 2% of the people supported live in areas of Derby which fall into the 30% least deprived areas nationally.

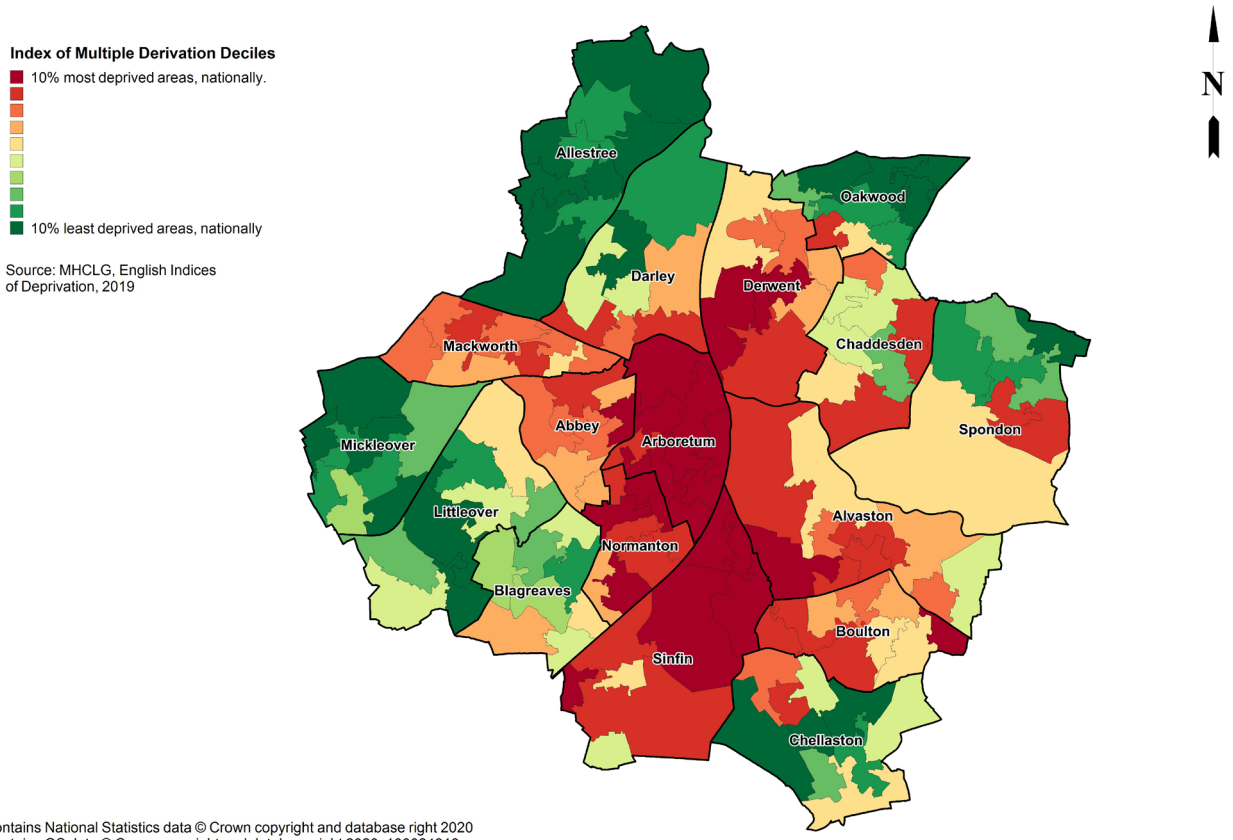
This will represent a challenge to the LAC service as it expands into new areas of Derby, many of which, as identified in Figure 1.2.3, fall into the 30% least deprived areas nationally.

Figure 1.2.2 - LAC Supported Residents Compared to the Derby and LAC Ward Adult (18+) Populations, 2018 - by Mosaic group



Sources: Derby City Council, Local Area Co-ordination; Experian Ltd, Mosaic PS6, 2019

Figure 1.2.3 – Indices of Multiple Deprivation, 2019, showing the areas of Derby within each deprivation decile



A possible challenge within some of the more affluent areas of the city will be to identify hidden need amongst the population. This may include a requirement to identify hidden need amongst older people, in some neighbourhoods, where their families may live some distance from Derby. Whilst each person supported by Local Area Co-ordination is unique, some value may be gained from looking at the approach taken with, and the experiences/needs of the people supported by LACs in the more affluent Mosaic Groups.

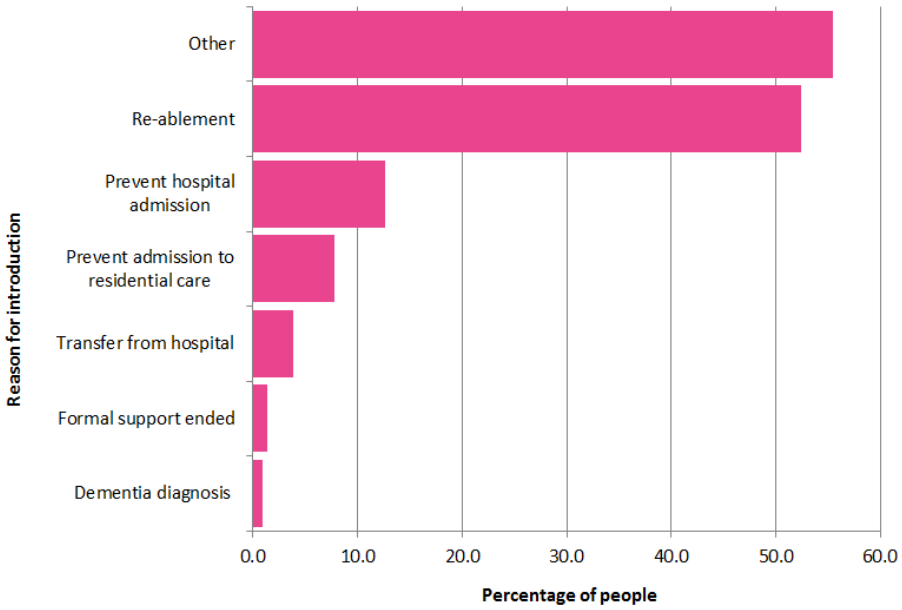
The reasons for which people were introduced to LAC are closely aligned with the sources of the introductions. Within Derby:

- 52.5% of people were introduced to LAC to support their reablement; helping them to regain needed skills, confidence and independence (often following a life-changing event)
- 12.7% of people were introduced to prevent them being admitted to hospital
- 7.7% of people were supported to prevent/ delay the need for them to enter residential care[44].

52.5% of people were introduced to support their reablement

"I was building a relationship with [my Local Area Co-ordinator] without even knowing it. I didn't realise how much I relied on [their] feedback and reassurance – it just crept up." (A Derby resident)

Figure 1.2.4 – Reasons for people being introduced to Local Area Co-ordination



Source: Derby City Council, Local Area Co-ordination

The people introduced to Local Area Co-ordination have a wide variety of needs and problems with which they need support, with many of the people introduced to the service having multiple and complex needs. These will be explored further in Chapter 3, however, some notable reasons include approximately:

- 75% of people introduced needing to overcome isolation (with approximately two thirds wanting to make connections in the community)
- 45% of people requiring support to be 'heard' and have their circumstances/needs understood by formal services
- 35% of people having financial problems and needing to access financial advice
- 25% of people having health/medical problems and needing to access healthcare[45].

There is also emerging evidence, within the city, that people are being introduced to Local Area Co-ordination at the point of being discharged from services. Introduction at the point of discharge from some services may be beneficial to patients/people to ensure that they have the necessary support and, if lacking, can start to build resilience with support from their family, friends and local community. Indeed, within Thurrock, it was noted that *"a high number of introductions have come from adults who have experienced Mental Health [problems] 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 services would have withdrawn[46]."*

75% of the people introduced needed to overcome isolation.

The knowledge gained and lessons learned from the years of developing and running Local Area Co-ordination in Derby have been combined to produce a bespoke Theory of Change for LAC in the city. This Theory of Change articulates the development from fragmented, isolated communities, with increasing demand for services, towards more resilient individuals and communities, rich in social capital, with reduced demand for services.

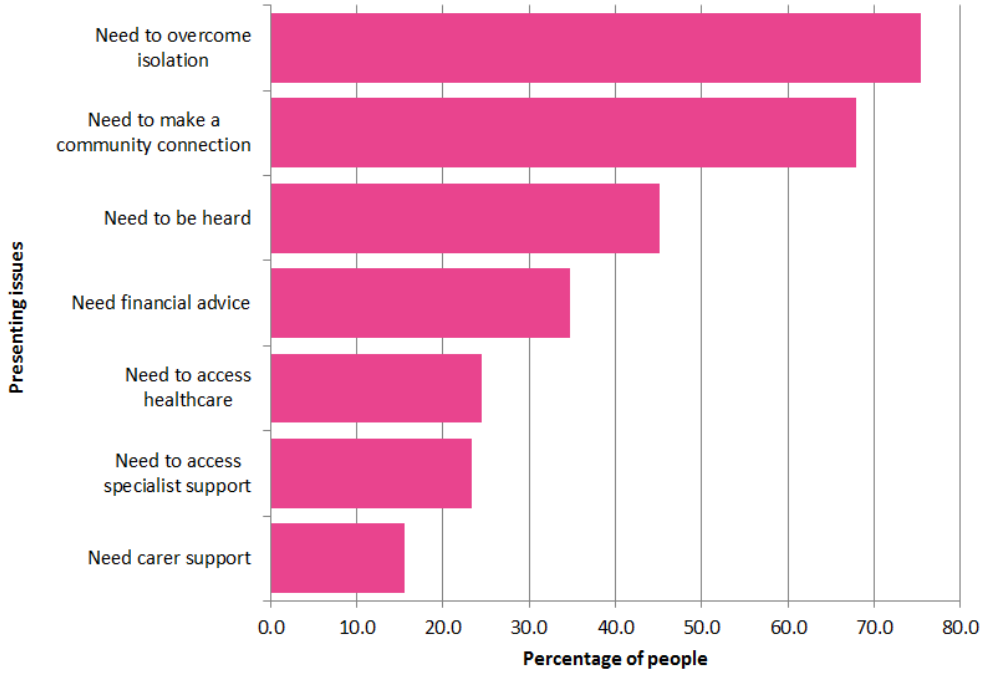
It also identifies a number of changes to services/service demand which would be expected as a result of Local Area Co-ordination support for residents. These include:

- reductions in social care packages and

interventions
- reduction in nursing and residential care placements
- reduced demand on secondary Mental Health services
- reductions in unnecessary crisis health interventions
- reduction in Delayed Transfers of Care
- reductions in unnecessary Primary Care appointments
- sustainment of tenancies – reduction in eviction and associated costs
- reductions in number of young people identified as at risk.

Analysis of these anticipated changes forms the basis of this quantitative evaluation for Local Area Co-ordination in Derby, with Information Governance being developed accordingly.

Figure 1.2.5 - Presenting issues of people introduced to Local Area Co-ordination



Source: Derby City Council, Local Area Co-ordination

Figure 1.2.6 – Derby Local Area Co-ordination Theory of Change

Recommendations and Challenges for 2020/21 - 2021/22

LAC leadership:

1. The Local Area Co-ordination Leadership Group should:
    a. Consider how best to position LAC in business-as-usual processes so that people are offered an introduction at the timeliest opportunity.
    b. Ensure that LAC is promoted effectively so that decision-makers at all levels, both inside and out of the council, can consider the best approach to make LAC support available to people within the city who may benefit from it most.
    c. Explore the most effective way to promote LAC to Derby's residents and communities.
    d. In relation to points a. - c., and given current demand, maintain a constant review of LAC's capacity to support new introductions with a view to increasing capacity if evidence supports this.
    e. Local Area Coordination practices are locality-centred and user-orientated, focused on holistic outcomes for people rather than targets for service silos. It would appear that this is the direction that Derby wishes to continue to travel during its post-Covid recovery phase and so, whilst secure and sustainable funding for LAC has been a challenge previously, now would be the time to address this issue as LAC becomes a key part of a wider, place based landscape.

LAC in Derby:

1. Global experience suggests that an individual LAC works most effectively within a population of approximately 8,000 to 10,000 people. All 17 wards within the city have a population in excess of 10,000 people. Accordingly, it is necessary at this point to review:
    - The volume of need in each neighbourhood. Specifically, the population segments most amenable to the LAC approach.
    - The current levels of demand and emerging requests for introductions within each neighbourhood.
    - The time LACs are investing in community capacity building activities. The evidence suggests that reduced focus on building community capacity will lead to increased demand on formal services.

2. Consideration should be given to increasing the number of LACs. With an estimated population of 257,300 people in 2019, international experience suggests that the optimum number of LACs to effectively support and maximise outcomes for Derby residents, should be between 26 and 32. It is recommended that any new investment should be made incrementally through an invest-to-save business case.

3. To further develop a population outcomes framework that can be used to regularly monitor the impact of LAC. This could include a range of metrics that are shared with partner organisations and integrated within systemwide outcomes frameworks.

4. To embed a continuous learning approach to performance reporting that moves away from looking to prove if LAC works, to better understanding how it works, what could be done to improve performance and how what we learn informs and supports wider system reform.

5. The response to the Covid-19 crisis has highlighted much of the theory and logic that underpins the LAC approach. New introductions to LAC are coming from people who have contacted the Derby Community Hub; others are being identified through discussion, who may benefit, in the future, from LAC support. Following the immediate requirements for support during the pandemic and within the Information Governance framework, consideration needs to be given about the impact of this new introduction route for the LAC team and wider system.

Recommendations and Challenges for 2020/21 - 2021/22 (cont.)

Consideration also needs to be given to how the hub can be developed, and maintained, to increase social capital and community capacity within the city.

6. Social Prescribing Link Workers (SPLWs) have been employed across the city's 5 Primary Care Networks (PCNs) since 2019. Some are managed directly by the PCNs while others are hosted by Community Action Derby. Priorities for the SPLWs differ according to the priorities established by the PCNs; some are working with frequent visitors to surgeries whereas others are working with people who have more complex needs.

   Depending on the level of need and route of referral, people requiring support may potentially be introduced to either LAC or Social Prescribing. The Derby City Place Alliance of Derby City Council, NHS Derby and Derbyshire CCG, and the city's 5 PCNs and wider system partners, should work together to better understand the offer in the city to ensure that there is seamless and complimentary provision, avoiding duplication of effort.

Case study - Gemma's story

In early 2018, Gemma was finding life really difficult - her young son had recently been taken into foster care. Gemma only had a small support network; she was spending most of her time with her "friend" Karen and was taking on a lot of Karen's responsibilities, such as helping with her children and paying for her family's food. Gemma was in very low mood and had very little trust in professionals due to the way in which the removal of her son had been handled. She had her own flat but was not spending much time there and, most difficult for her, was allowed only very few hours contact with her son each week.

Shortly afterwards, Gemma met her neighbourhood's Local Area Co-ordinator. Her LAC spent time building a relationship with Gemma and her new partner. Gemma recalls that she wasn't expecting much from her LAC, having had numerous workers throughout her own childhood, part of which was spent in care; the workers changed regularly and she wasn't able to establish a connection with them. Then, when her own son was taken into care, she didn't feel supported at all. The biggest difference Gemma noticed in her Local Area Co-ordinator was how smiley and friendly they were. She immediately felt at ease.

Gemma and her LAC got to know each other and built a really strong relationship. Gemma was very clear about what she wanted to achieve; first and foremost, she wanted to regain full-time care of her son without the need for involvement from Children's Services. She wanted to move to a better home and also help to sort-out her benefits.

Working towards these goals, and with support from her LAC, Gemma made significant changes in her life which resulted in her son being returned back to her full-time care. She felt that her Local Area Co-ordinator really earned her trust and knew that she could ask her LAC's advice without it being held against her.

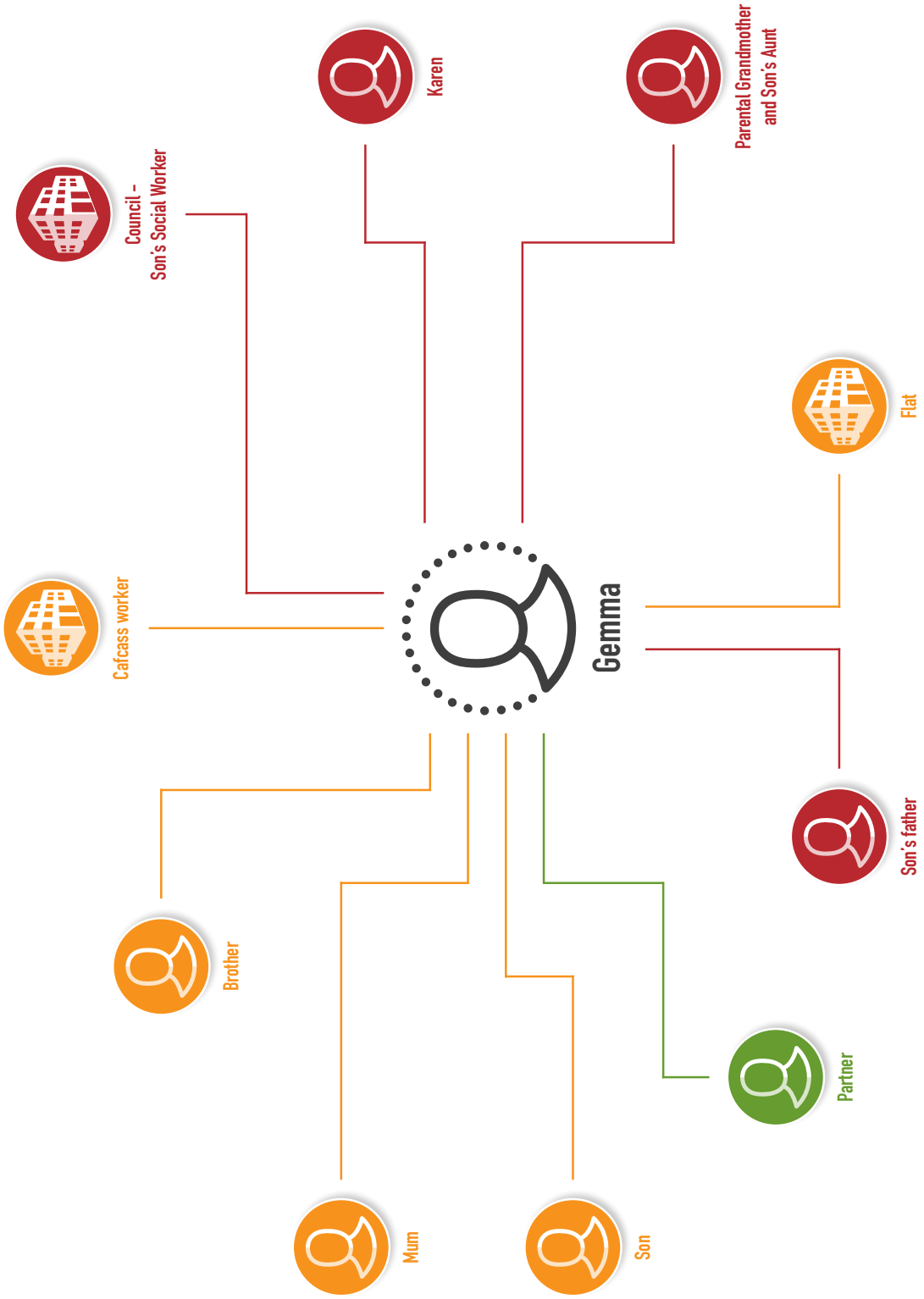
Gemma's confidence has grown considerably, which she attributes to having her Local Area Co-ordinator there for guidance and support. She commented, *"[My LAC] thinks that [they're] just doing [their] job, but it's so much more".* Things feel a lot more positive for Gemma and her family now. Her son is due to come off the Child in Need Plan, which will finish their involvement with Children's Services. When Gemma was expecting another baby, her midwife saw no need for involvement from Children's Services as she was considered to be very low risk.

Gemma has stopped having contact with people who she feels are not good for her; she now surrounds herself with people who are good for her and her children. She has good support from her son's nursery and they recognise the difference in Gemma. Once her new baby is old enough, she plans to return to work.

Gemma has moved with her children to a better home in a different part of the city. Even though she is now in a different neighbourhood, she keeps in touch with her old Local Area Co-ordinator, sharing good news (and baby pictures), not just problems.

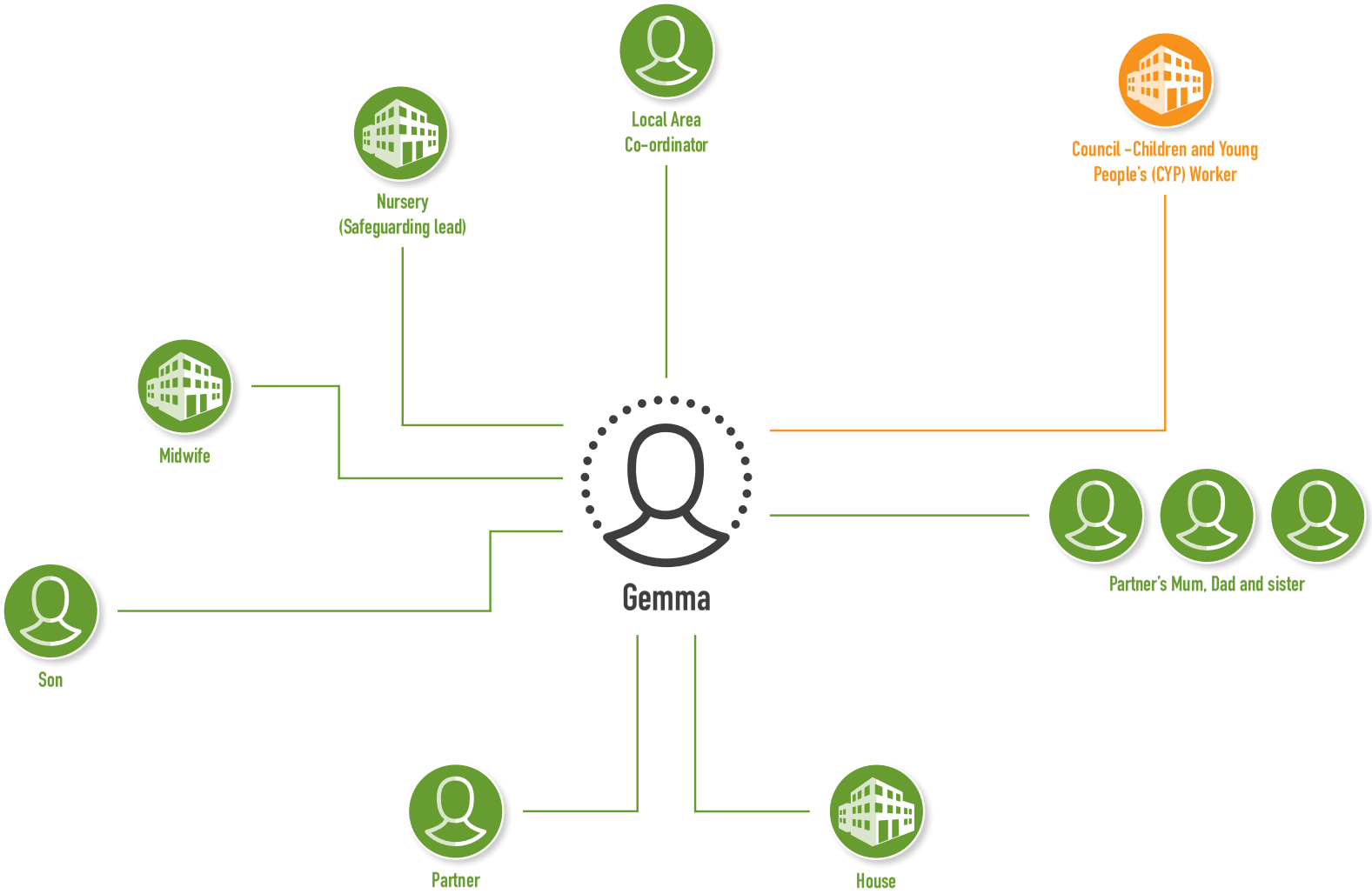
Gemma no longer needs support from Local Area Co-ordination but knows that she can get in touch again should there be more things that she would like help to achieve.

Gemma's World
(Before Introduction to Local Area Co-ordination)

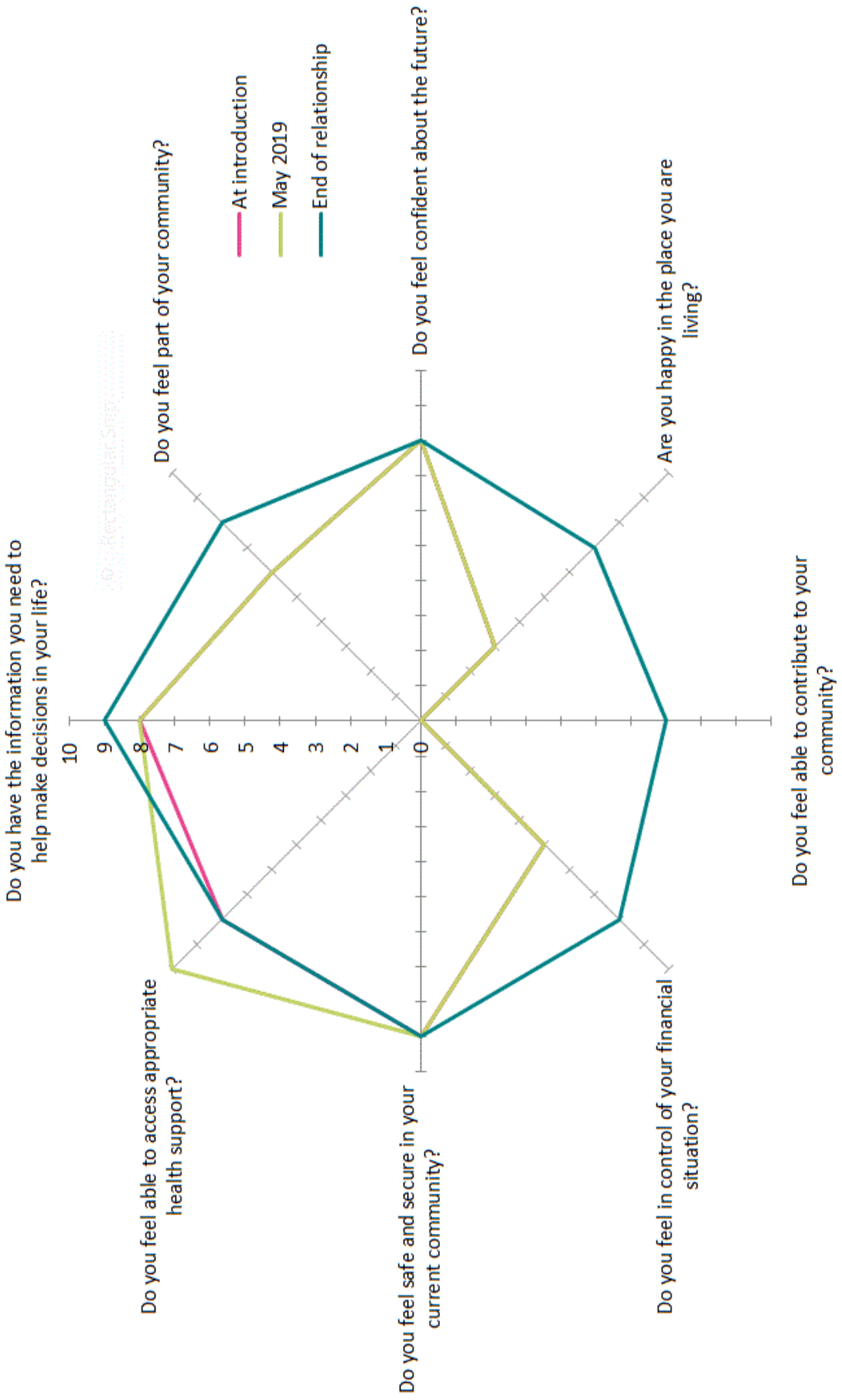


Gemma's World

(After Introduction to
Local Area Co-ordination)



Gemma's Outcome Star scores



1.3) Local Area Co-ordination and Care Leavers

"Young people leaving care constitute one of the most vulnerable groups in our society, and both government and wider society have a moral obligation to give them the support they need as they make the transition to adulthood and independent living[47]."

Young people who have spent time in care are more likely than their peers to have poor social outcomes later in life:

- in 2010, 25% of homeless people had been in care at some point in their lives
- in 2008, 49% of young men under the age of 21 who had contact with the criminal justice system had experience of being in care
- in 2014, 22% of female care leavers became teenage parents
- in 2012, it was identified that looked-after children and care leavers were between four and five times more likely to self-harm in adulthood[48].

Mental health is a particular concern. Research undertaken by Barnardo's on young people in their care services estimates that 46% of care leavers have mental health needs, with a quarter of care leavers having faced a mental health crisis since leaving care[49].

Nationally, young people report that leaving care feels like a 'cliff edge,' feeling unprepared for the challenges of adulthood. Upon leaving care, young people struggle most with:

- housing and accommodation
- finances, benefits and budgeting
- transitions to adult services, especially mental health services
- education, employment and training[50].

Young people leaving care often lack basic life skills and need support learning how to run a home (including cooking, cleaning and DIY/ maintenance etc.), access services and build healthy relationships. Some care leavers also

report concerns about their personal safety and their vulnerability to gangs and sexual exploitation.

Overwhelmingly, however, the largest issues raised by care leavers are isolation and loneliness; it is recognised that care leavers have difficulty navigating their way through their late teens and early twenties without a strong and stable support network around them[51].

As part of the Government's strategy[52] to improve support and outcomes for care leavers, there was a commitment to use the Department for Education's Children's Social Care Innovation Fund to rethink transitions to adulthood for young people in the children's social care system. Following on from this commitment, Derby City Council was successful in securing funding from this innovation fund to provide Local Area Co-ordination support for care leavers.

39 young people were introduced to Local Area Co-ordination as part of this pilot programme. Of these, 9 young people declined the offer of support. Local Area Co-ordinators met with the remaining 30 young people but 5 relationships did not progress due to the young people failing to engage.

Table 1.3.1 – Ages of care leavers introduced to Local Area Co-ordination

Age at introduction	Number of people
16 (or under)	4
17	7
18	5
19	4
20	3
21	3
22	2
23	3
24	2

Source: Derby City Council, Local Area Co-ordination

As would be expected, the presenting issues of care leavers echo the issues identified nationally; they also give an initial insight into the multiple and complex needs of this group of people. The needs of care leavers will be explored further in Chapter 3, however, of the care leavers introduced to Local Area Co-ordination, more than 75% needed to overcome problems with isolation and to establish connections with their local community[53] – this is possibly indicative of the need to build healthy relationships and to develop a strong and stable social network for support[54].

More than 75% of the care leavers introduced to LAC needed to overcome isolation.

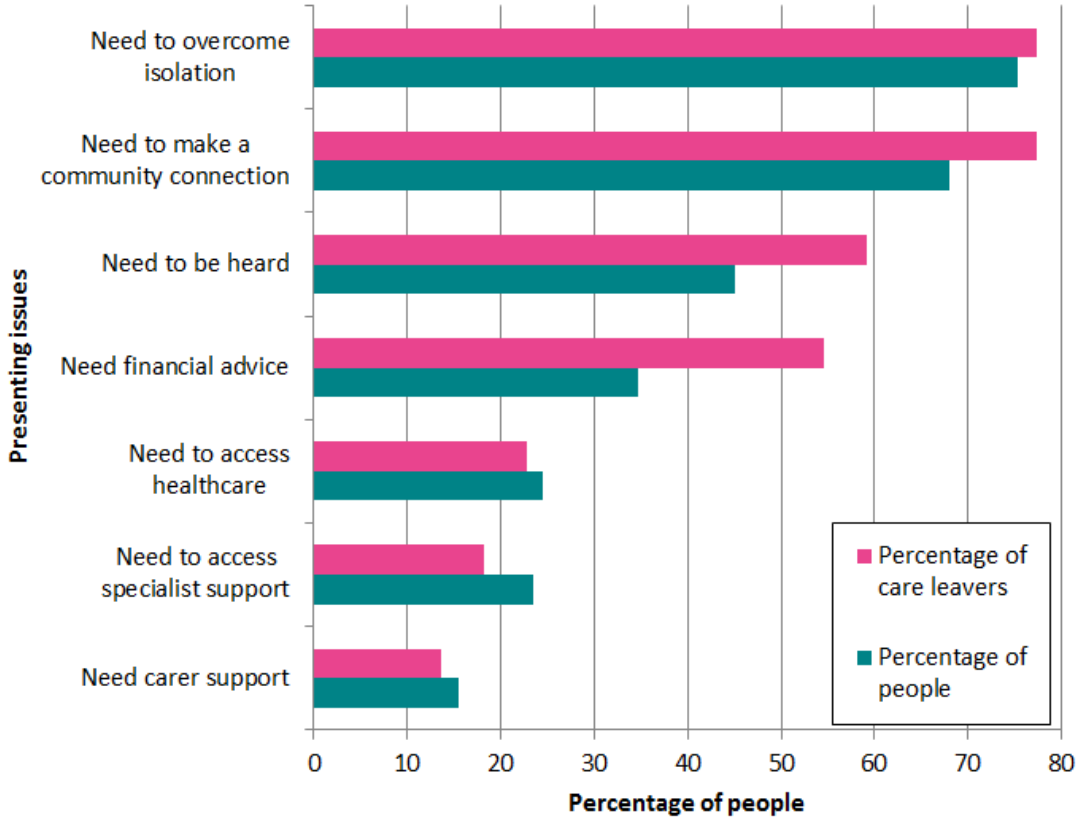
Similarly, the need to 'be heard' (and to have their circumstances understood by formal services), for financial advice (54.5%) and to access healthcare (22.7%) were major issues for the care leavers introduced to LAC.

With the exception of some issues, which are likely a result of people's life stages, there is a notable similarity between the presenting issues identified by care leavers and other people receiving support from Local Area Co-ordination – this is illustrated in Figure 1.3.1.

Analysis of the shared agreements completed with the young people identified that the young people's priorities closely match the issues identified nationally; housing, employment, education and training, finances and life skills all feature prominently. Of these, the greatest number of actions were centred around employment, education and training:

- more than 27% of young people wanted to find paid work
- volunteering, or finding voluntary work, was a priority for more than 27%
- approximately 9% wanted to find training (paid or unpaid)
- approximately 9% wanted to explore opportunities for work
- a further 9% wanted to explore opportunities for education or qualifications.

Figure 1.3.1 – Presenting issues of people introduced to Local Area Co-ordination



Source: Derby City Council, Local Area Co-ordination

Maintaining attendance at educational establishments was also a goal for some young people.

Securing the correct home was the next highest priority for care leavers:

- nearly 23% expressed the desire to either move home or move to a better home
- approximately 14% wanted to have a home of their own.

Other actions included young people wanting safe and secure accommodation and a desire to live in particular types of accommodation. Notably, one young person was homeless and finding a home was a priority.

Mental health was the most important health related priority for young people, with approximately 18% wanting to improve or better manage their mental health - linked to this were the need for counselling and the need to have somebody to talk to about issues that worried them. Other actions included keep-fit and sporting activities, registering with health services and support to reduce drug usage.

Managing finances and other life skills also feature prominently in shared agreement actions, with approximately 14% of young people wanting to learn budgeting skills. Becoming more financially independent (14%), organising benefits (9%) and learning to drive (9%) were also important to young people. Other actions included learning to shop for and prepare food together and gaining other skills necessary for independent living.

Finally, care leavers had notable actions about developing friendships /healthy relationships and getting involved in their local community, keeping busy, establishing a routine, being in control and planning for the future.

Other specific actions were identified but are not recorded here due to the potential for disclosure.

Formal evaluation[55]

Ipsos MORI were appointed by the Department for Education to undertake an independent evaluation of Local Area Co-ordination support for care leavers. Their methodology

utilised a range of quantitative and qualitative techniques including:

- interviews with senior staff in Derby City Council
- focus groups with the Local Area Co-ordination team
- case studies with care leavers supported by LACs
- interviews with LACs supporting case study care leavers
- outcome measurement surveys among care leavers
- analysis of information collected by LACs (Shared Agreements and logs)
- analysis of child-level statutory data of Derby's care leavers (OC3 data returns).

The evaluation aimed to identify how circumstances and outcomes changed over time for young people supported by Local Area Co-ordination compared to a representative group of care leavers who did not receive support from LAC. However, direct comparison was not possible due to the young people introduced to LAC seeming to have higher levels of need for support than the young people in the comparator group; young people introduced to LAC were also less likely to be in employment, education or training.

Ipsos MORI make important operational recommendations about developing and/or

continuing Local Area Co-ordination support for care leavers and note the learning curve experienced by LACs within Derby. However, despite this learning curve, it was identified that Local Area Co-ordinators developed strong and trusting relationships with the young people to whom they were introduced. Further, they supported them to make progress in various areas of their life and helped them to be more resilient when facing adverse circumstances.

Young people felt that they could rely upon their LAC and felt valued as a result of their LAC not having an agenda, just a genuine desire to help. Furthermore, they enjoyed the ability to contact their LAC as often as they wanted or needed to. They also appreciated the 'open ended' nature of the relationship with Local Area Co-ordination, being able to maintain a relationship for as long as they feel that they need to do so.

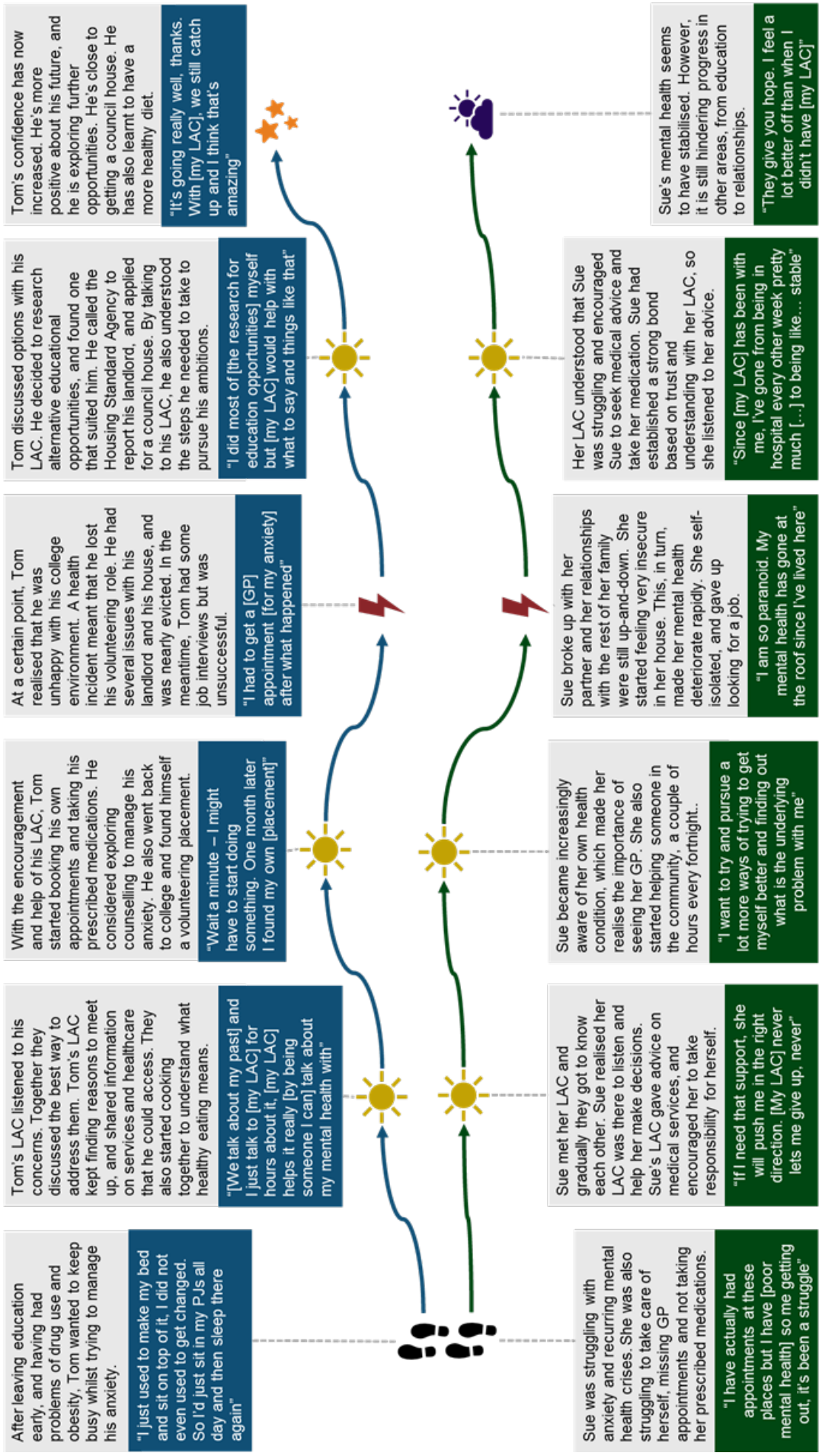
The presence and reliability of their LAC, together with the stability of the relationship, were particularly valued by young people with mental health issues or difficult life situations.

It was also noted that some of the young people who were introduced to Local Area Co-ordination did not have any other sources of support. This includes young people who had spent time in care as a child but who did not meet the requirements to be defined as a care leaver and therefore qualify for statutory Leaving Care support.

It was identified that, in relation to the comparator group, a greater proportion of the young people introduced to Local Area Co-ordination had mental health problems or disabilities that affected their daily life. Further, it was recognised that some of these young people's ability to reach their 'good life,' and achieve their goals, was reliant upon the stability of their mental health – inconsistent or deteriorating mental health could affect their progress.

Through qualitative research, it was identified that Local Area Co-ordinators were able to support successfully some young people to manage their mental health. However, progress was nuanced. Some young people showed improvements in confidence, relationships and health over a comparatively

Figure 1.3.3 - Evidence summary on housing and living arrangements



Source: Ipsos MORI, based on case study interviews with young people and Co-ordinators

short period, whereas other young people showed little improvement or even a slight worsening due to life events. Despite the new problems arising in their lives, young people stated that they would have been in a worse position without support from their LAC, suggesting that they felt more resilient with their support. This highlighted the impact of Local Area Co-ordinators in mitigating additional negative consequences and increasing young people's resilience – this is illustrated in Figure 1.3.2 which depicts two composite case studies based on interviews with young people.

Isolation was the most significant presenting issue of care leavers introduced to Local Area Co-ordination, with more than three quarters of young people feeling isolated at the time of introduction – young people typically described feeling close to only a small group of people. The independent evaluation identified that LACs were able to support young people with their existing relationships and, in some cases, to re-establish relationships with their families. LACs were also able to support some young people to expand their social networks through connecting them to activities in which they were interested.

Importantly, the evaluation also noted the importance of the relationship that the young people had with their Local Area Co-ordinator.

It was identified that LACs helped young people to build their confidence, working together to develop the young people's social skills and confidence to navigate conversations and processes independently. Notably, this was especially apparent in the areas which were most important to the young people and where they felt that they did not have the knowledge or confidence to make the changes that they wanted: accommodation, health and financial services.

Care leavers reported multiple problems with their accommodation, including their home:
- having structural problems
- being unsuitable for their current family
- being unsuitable as a result of changing circumstances.

The wider problem of being able to access suitable accommodation due to excess demand was also noted – see Figure 1.3.3.

Local Area Co-ordinators supported young people to understand what they could do to rectify these problems. Where there were structural problems with their home, they were supported to contact the Council's Housing Standards Team. Others were supported to complete housing applications to help them obtain a more suitable home, with multiple young people moving home during their period of LAC support. The formal evaluation also identifies that young people have also started to discuss, with their LACs, longer-term solutions to their housing problems.

More than half of the care leavers introduced to Local Area Co-ordination needed financial advice. Ipsos MORI identified that, whilst managing money was not the most important issue for all of the young people, they reported struggling with debt and had difficulties understanding the benefits system. Some young people were struggling with rent arrears whilst others reported having insufficient credit on their phone to make medical appointments.

Young people and Coordinators worked together on budgeting and using money sensibly; this included advice about:
- how to do the shopping
- how to navigate the benefits system
- assessing the impact that work could have on benefit eligibility.

Some young people had increasing amounts of debt. Where this was the case, Local Area Co-ordinators helped them to make a repayment plan and supported them to access relevant helplines or statutory services.

It was also clear from the formal evaluation that Local Area Co-ordination produced sustainable results for young people – see Figure 1.3.4. When prompted about their need for Local Area Co-ordination support in the future, some care leavers thought it would be minimal, as they had acquired the confidence to live their life independently.

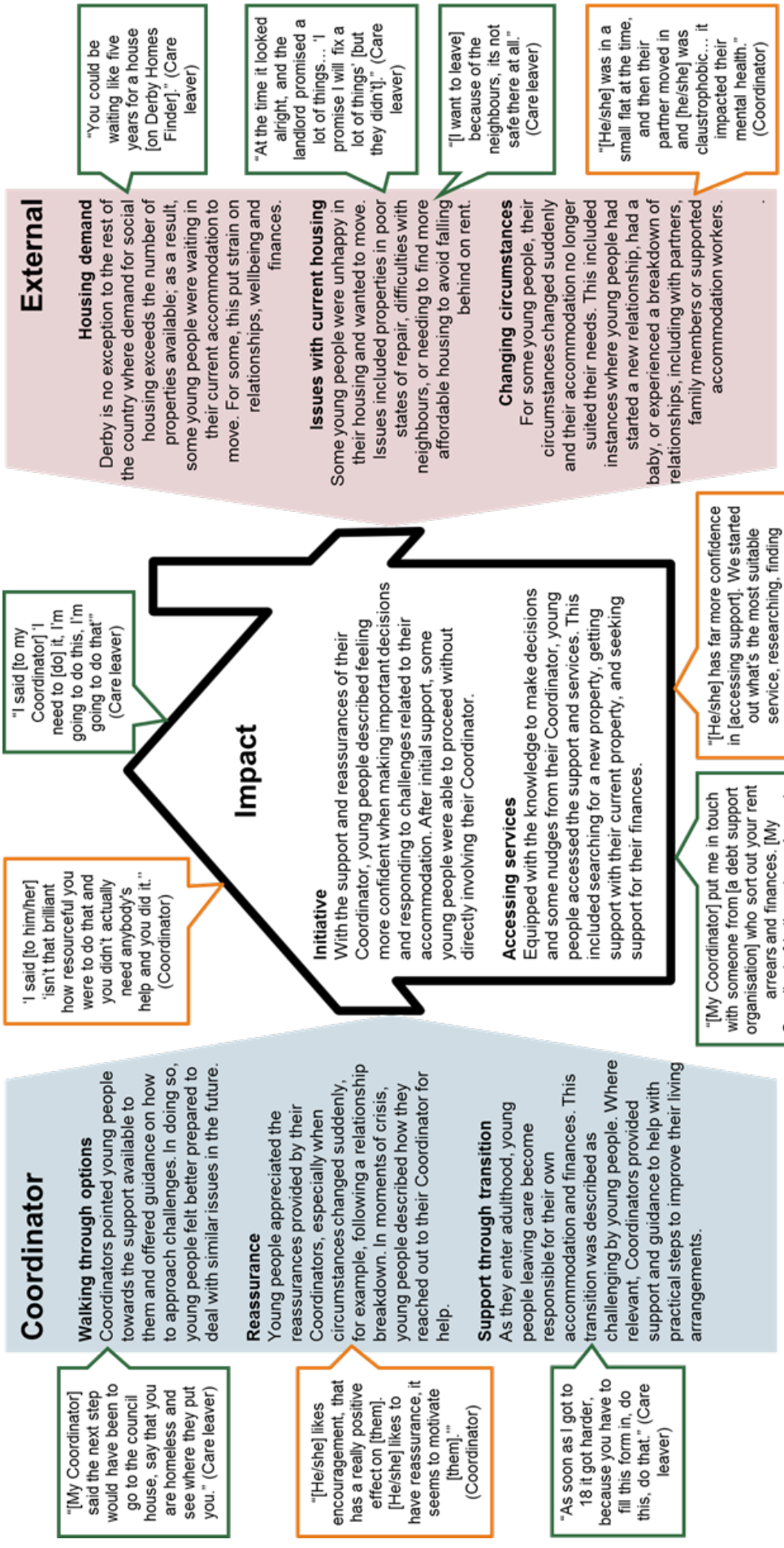


Figure 1.3.2 - Evidence summary on mental health and resilience

Source: Ipsos MORI, based on case study interviews with young people and Co-ordinators

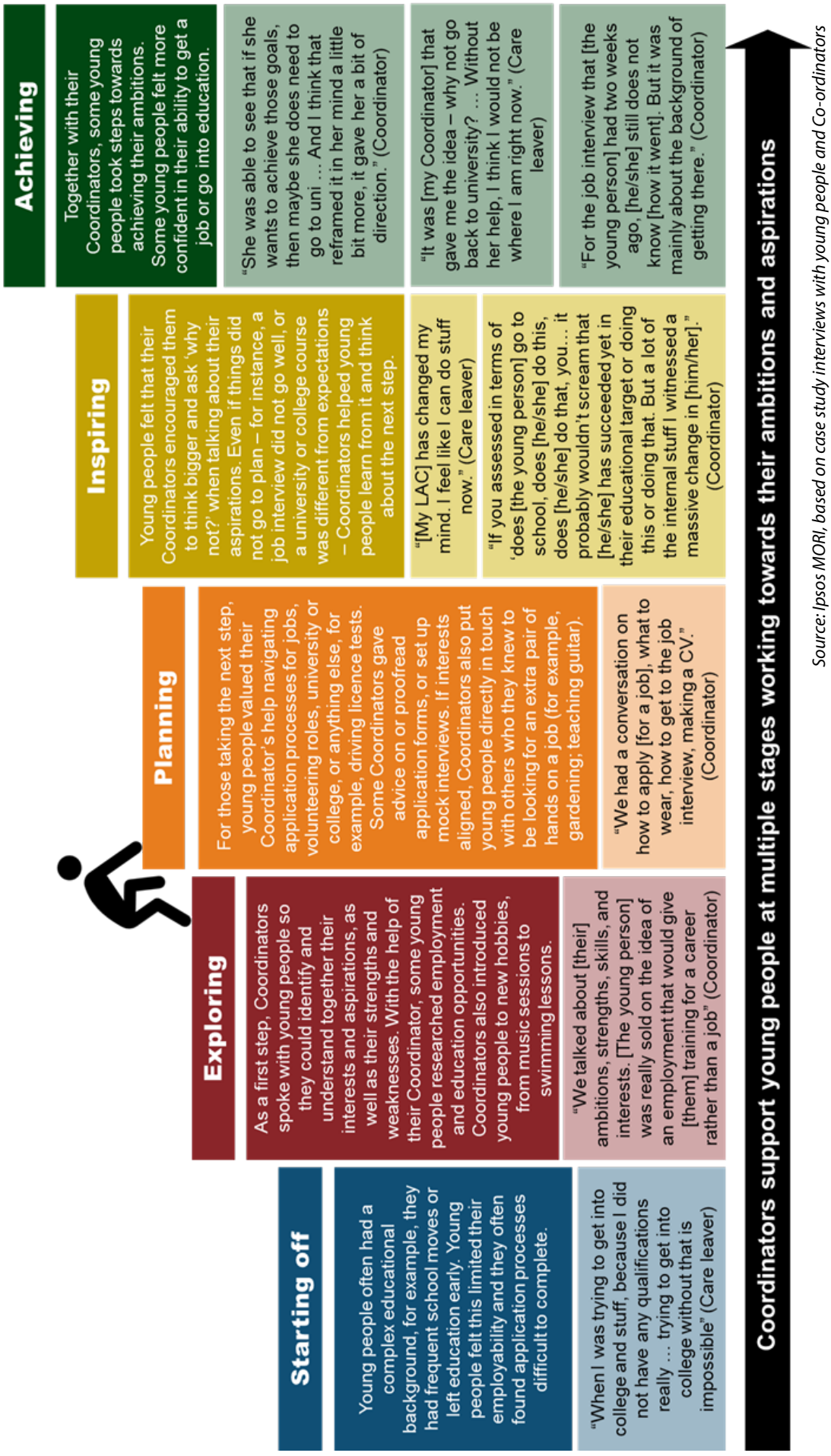


Figure 1.3.4 – Supporting young people to work towards achieving their goals and aspirations

Source: Ipsos MORI, based on case study interviews with young people and Co-ordinators

Recommendations

1. To continue research into the impact of Local Area Co-ordination for care leavers, using a carefully selected set of outcome measures and, ideally, continuing post LAC support to identify the sustainability of any changes and the resilience of the young people over time.

2. To undertake research into the outcomes for families introduced to LAC and to develop indicators which can be used for monitoring progress for both adults and children within these introductions.

Case study - Emma's story

Emma was introduced to Local Area Co-ordination in 2019 by the staff at the Children's home where she had lived for a number of years. She was due to turn 18 in the summer and would need to move from the home.

When she was introduced to Local Area Co-ordination, Emma she said that she felt lonely at times. She said she was preparing to live independently and would be leaving the Children's Home shortly. She explained that she did not want to live in shared accommodation but said that the staff at her home said this was the only option available to her.

Emma explained that she wanted to learn the skills needed to live independently in preparation for the time she would be asked to leave the children's home. She also explained it was important for her to be able to manage her money. She volunteered that she had never planned or prepared a meal and was tired of ready meals that were unaffordable.

Emma did not have a good relationship with her parents who were separated; she has siblings but had not seen them for some time. Other than her boyfriend, who was not always a positive influence, she explained that she only had one friend because she finds it difficult to trust people.

Having established a trusting relationship, Emma felt that she could discuss things openly with her Local Area Co-ordinator. She expressed a desire to work full-time but was concerned about her future job prospects because she had been prosecuted for knife crime. She was unemployed and having very little success in getting to interview or finding work.

To help Emma to achieve her goals, she worked with her Local Area Co-ordinator on:

- learning how to cook – Emma could not register on an adult education course until she was 18 years old. Until this time, she and her LAC would spend time preparing meals together – they would prepare a shopping list, Emma would shop for the ingredients and then they would cook the meal together
- enrolling on a cookery course at Emma's local college
- learning about healthy eating
- identifying opportunities for keep-fit activities at local sports venues
- learning how to maintain a home
- preparing a CV
- exploring opportunities for paid and voluntary work.

Emma was keen to learn to drive and was supported to apply for a provisional driving licence.

With the support of her LAC, Emma enrolled at her local library so that she could do job searches. In spring 2019, Emma succeeded in gaining paid employment, working in retail.

When she turned 18, Emma was asked to leave the Children's Home.

The following month, Emma's father contacted her LAC to share his concerns. Everything had gone wrong for Emma; he explained that Emma's move into shared accommodation

had broken down – Emma was now homeless and sleeping on her friend's sofa. She had lost her job, had no money and had been arrested. He was concerned that her boyfriend was a negative influence.

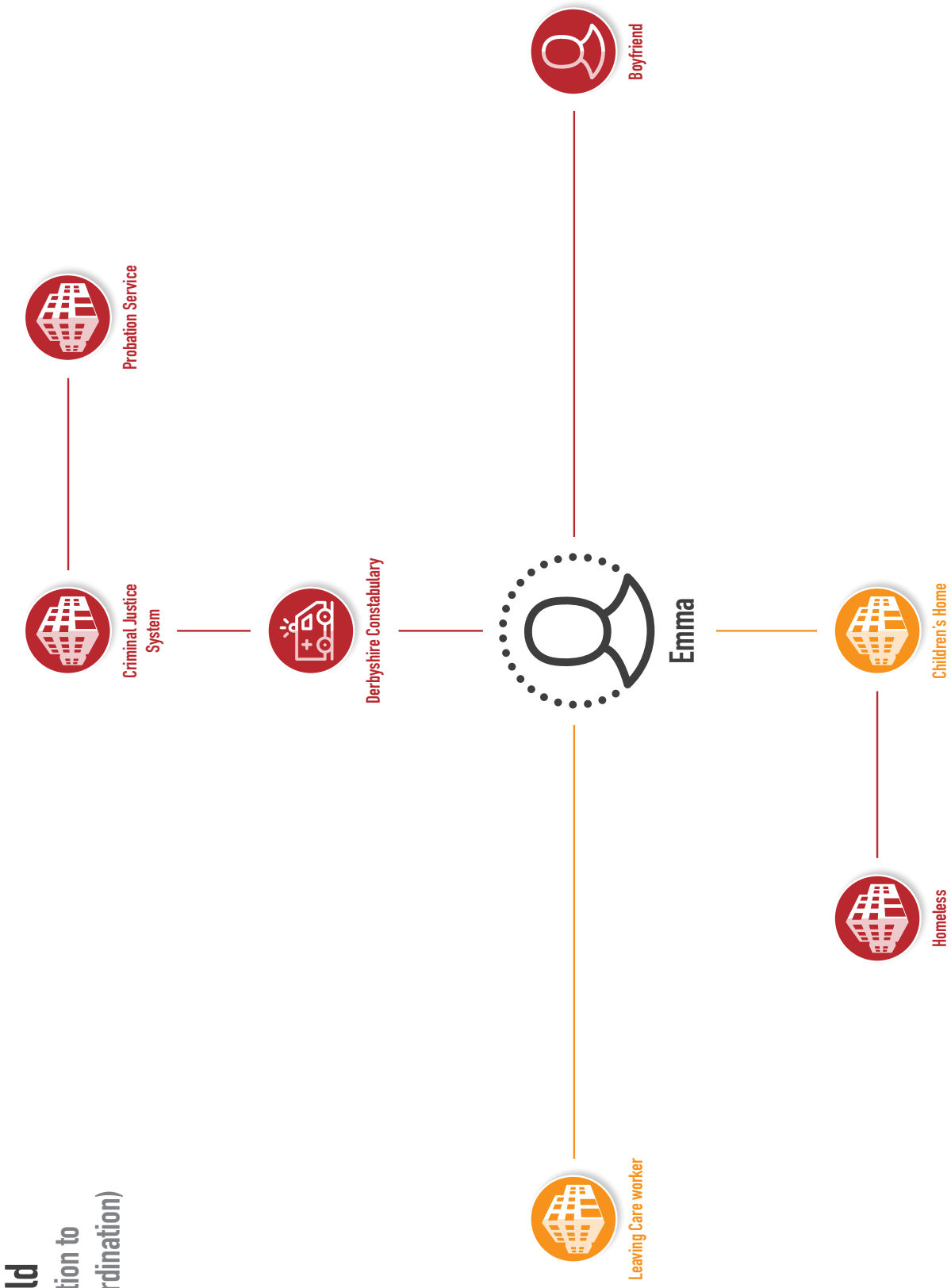
As she was now homeless, Emma and her LAC spent time urgently finding new accommodation. As a result, Emma moved into hostel accommodation. They also spent time that month reconnecting Emma with her sister and father, a positive influence. Emma was also supported to apply for Universal Credit to ensure that she had money to live on.

Once things were more settled, Emma was introduced to a local lady named Katie. They have become good friends, providing support and guidance to each other; they go on outings together and support each other on connecting with their local community.

As a result of being introduced to LAC, Emma has developed her confidence, developed aspirations, embraced responsibility and set herself new goals for the future.

Emma now takes pride in living healthily. She is actively looking for work and attending interviews. She is still involved with the probation service but has not re-offended.

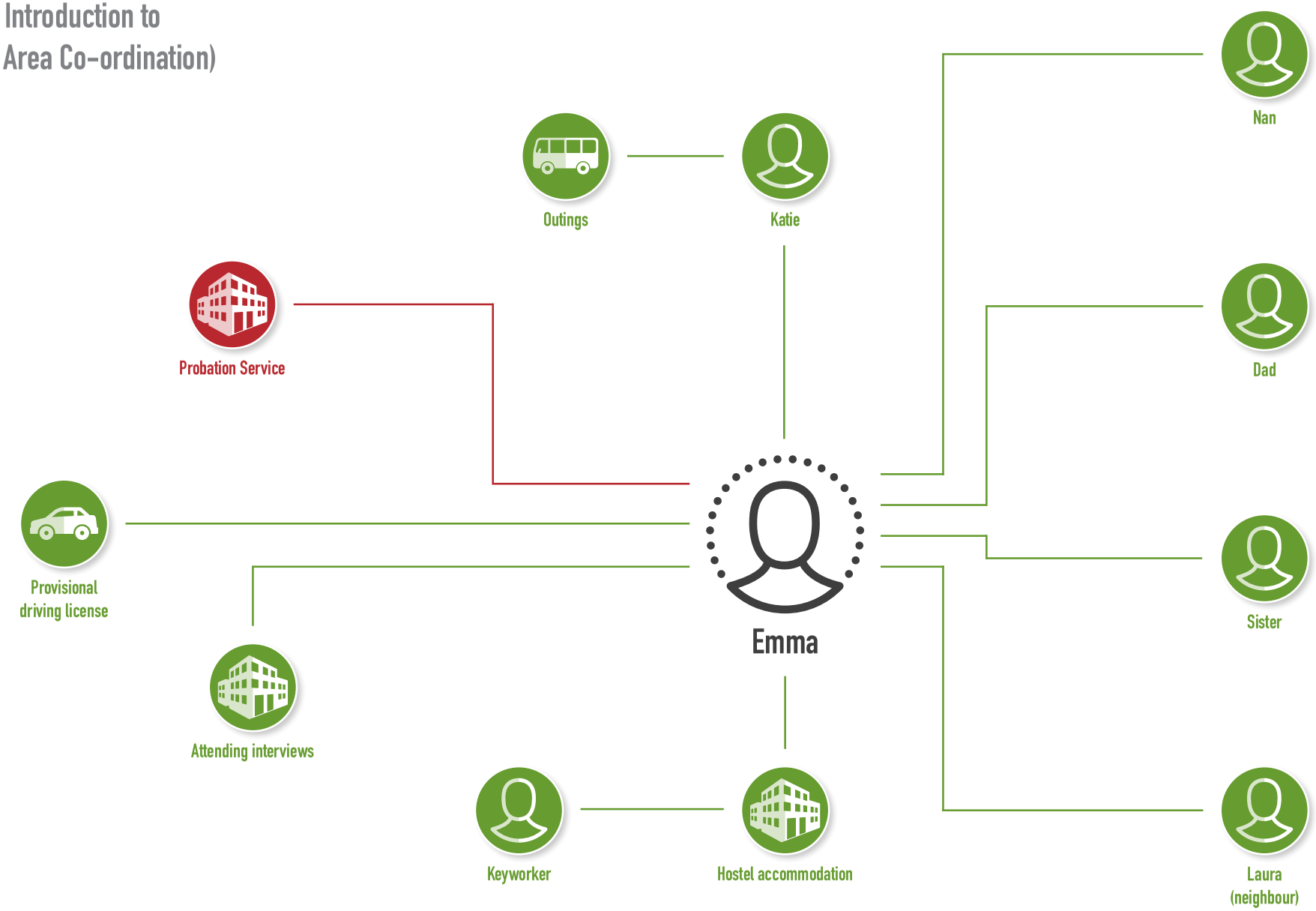
Emma continues to work with Local Area Co-ordination to help her to achieve her goals.



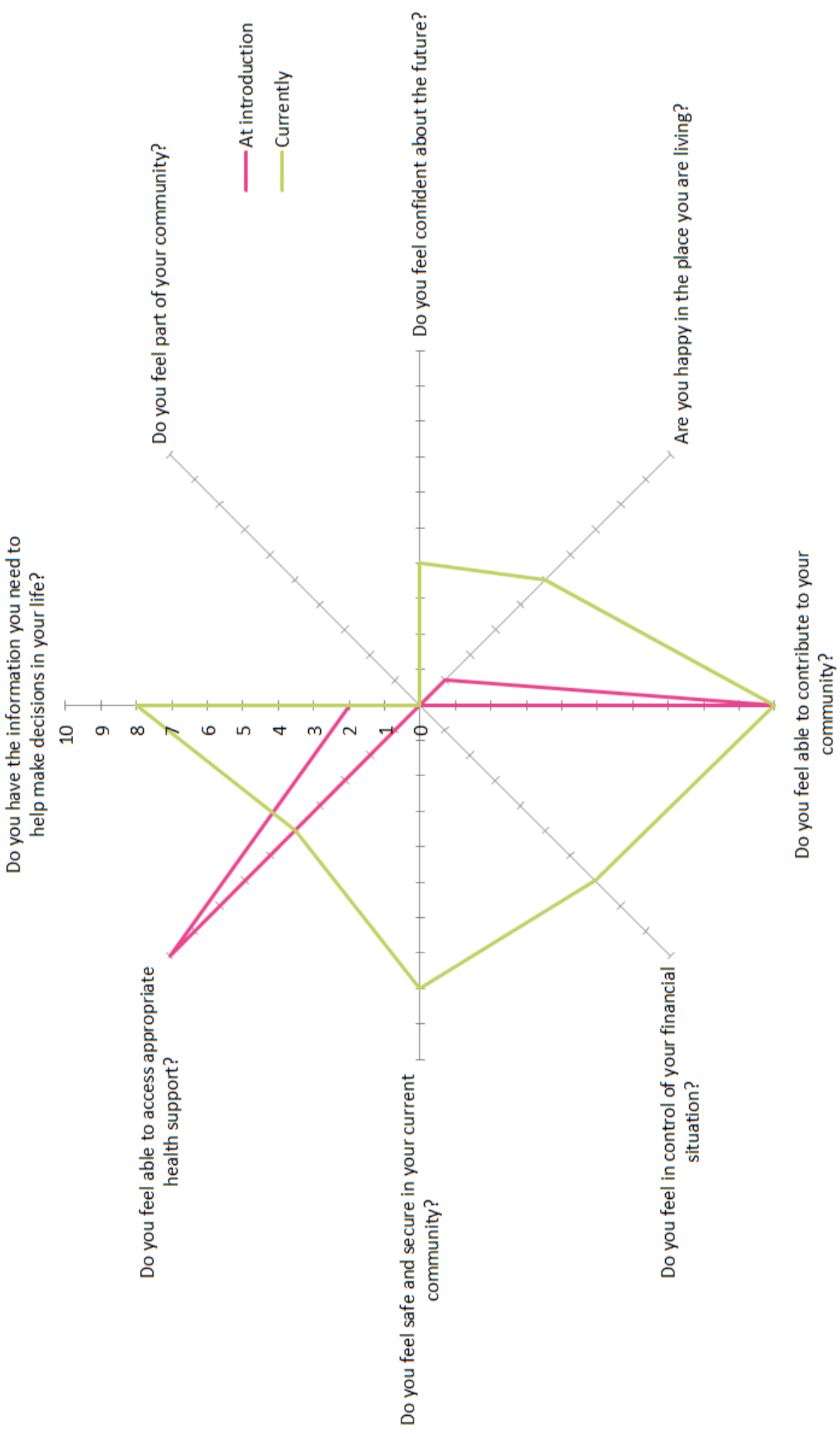
Emma's World
(Before Introduction to Local Area Co-ordination)

Emma's World

(After Introduction to Local Area Co-ordination)



Emma's Outcome Star scores



Chapter 2 - A history of LAC Evaluations

Positioning this evaluation

Since 2012, there have been 14 independent academic evaluations of Local Area Co-ordination conducted across programmes in England and Wales[56], examining a range of potential benefits to people, society and the public sector.

Fitting with the person-centred nature of Local Area Co-ordination, many of these evaluations have focussed upon qualitative research and outcomes for people who have been supported by LAC. The evaluations have utilised a variety of different techniques to assess the impact of LAC, however, common within these are the use of case studies, interviews, focus groups and workshops. These studies have demonstrated the positive impact that LAC has upon the people supported together with qualitative evidence about reduced demand upon services; for example, closure of adult safeguarding cases.

Some evaluations recognise the role of personal support networks, identifying that *"[p]ersonal support networks are an untapped source of resilience and force for good for individuals in times of crisis. The LAC programme with its informal network and relationship building could support individuals further, by building capacity and raising awareness in that area[57]."*

Notably, the evaluation undertaken in Western Bay (Neath, Port Talbot, Swansea and Bridgend) used social network analysis to identify the progress of relationships within the community and connections between supported individuals[58]. This technique effectively identified the penetration of LAC services into the community and illustrated the development of new relationships. Further, it was concluded that both the capacity of individuals and community resilience were increased due to relationships being sustained without LAC involvement.

Accepting the development of community connections, and the fact that Local Area Co-ordination was established in Derby before Western Bay, it was considered that capturing

Figure 2.1 – Development of the Local Area Co-ordination network in Swansea

The mapping of the LAC network across just the three initial Swansea Co-ordinators (Figure.7) demonstrates the scale and complexity of work being undertaken. Involving 350 individuals and resources with 1,217 connections, the scope and scale of relationships, each one unique, gives insight to the complex nature of the Co-ordinator role. While a steady case load may be maintained, this complex context is both the challenge and opportunity to support individuals. The rapid progress in engaging and supporting is testament to the implementation, in particular the dedication and efforts of the Co-ordinators and the support of their leadership.

Social network analysis (SNA) is the process of investigating social structures through the use of networks and graph theory. It characterizes networked structures in terms of nodes (individual actors, people, or things within the network) and the ties, edges, or links (relationships or interactions) that connect them.

(https://en.wikipedia.org/wiki/Social_network_analysis)

(co-producing) the development of personal networks, from the point of the person supported, could be a useful mechanism to illustrate the changes in a person's life.

There was no evidence of significant qualitative evaluation of the contact logs kept by Local Area Co-ordinators. These logs essentially tell the story of the journey that the person supported and the co-ordinator undertake together. They contain a detailed account of the interactions between LACs and residents, the problems/issues that residents experienced and the changes in residents' lives. As such, it was determined that qualitative analysis of a sample of logs would illustrate the range of issues with which LACs provide support. This analysis would also identify how Local Area Co-ordination is affecting public sector services within the city and form the basis for any quantitative analysis to investigate this.

Across previous evaluations, quantitative analysis has focussed predominantly upon analysis of information collected by the LAC service:

- operational data
- demographic data
- the outcomes stars/models which form part of Shared Agreements
- performance indicators.

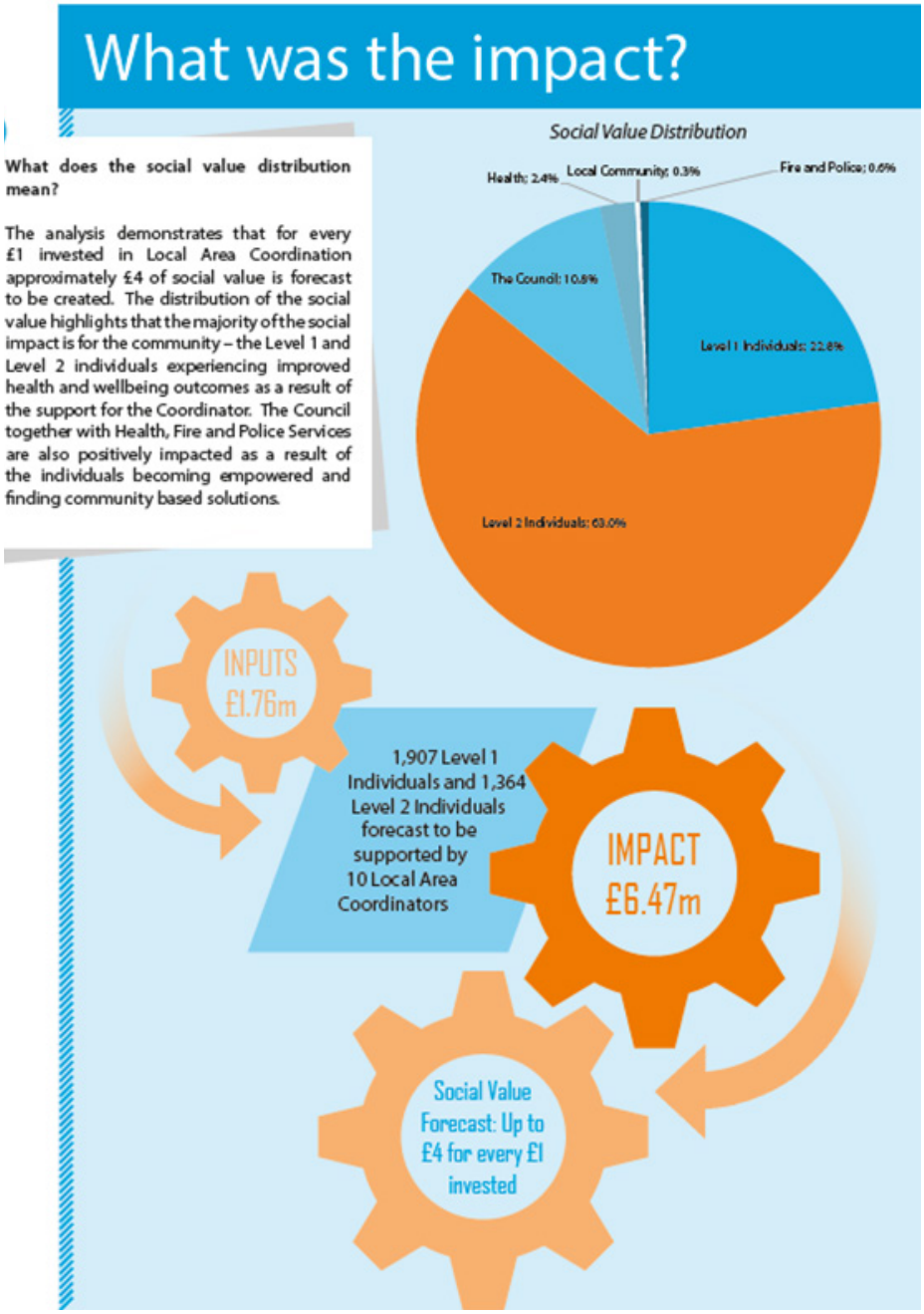
There is also extensive evidence of questionnaire surveys being undertaken with residents, Local Area Co-ordinators and partners organisations. Some of these evaluations, notably the Isle of Wight and Suffolk, applied health and wellbeing questionnaires to identify any improved outcomes for the people supported by Local Area Co-ordination. Significantly, both of these evaluations reported improvements in the outcomes of the people supported:

- using R Outcomes, a short patient reported outcome measures questionnaire, the Isle of Wight evaluation identified statistically significant improvements in the mean scores for health status, health confidence, and personal well-being
- using a 5 Ways to Well-being questionnaire, based upon the Warwick-Edinburgh Mental Well-being Scale (WEMWBS), the Suffolk evaluation identified an overall improvement in users' perceptions of well-being from an average score of 3 to an average score of 6 (in a scale of 1-10, where a score of 10 indicates improved well-being).

Attempts have also been made, using various methodologies, to understand the financial impact of Local Area Co-ordination. Several evaluations have used a Social Return on Investment (SROI) methodology to estimate the value arising from Local Area Co-ordination; these include Thurrock, Leicestershire and notably, in 2016, Derby. There is strong and consistent evidence, across all of these evaluations, that the SROI associated with LAC is approximately 4:1; i.e. a £4 social return for every £1 invested.

The Social Return on Investment for LAC is approximately 4:1.

Figure 2.2– An SROI calculation of the impact of LAC in Derby



It should also be noted that SROI is about value, with money simply used as the unit by which value is expressed[59] and that a strong SROI does not automatically translate into efficiency savings[60]. Various reasons are identified for this, including that comparatively small schemes, such as LAC, may not impact upon demand for statutory services sufficiently for several years. Similarly, services which are already seeing high, and increasing, demand may not notice a reduction in demand as more people are in need of the service – they may, however, be able to respond better to people who are in greater need[61].

Recognising the difficulty in identifying cashable savings within the system with SROI, and from the qualitative evidence available in Derby, it was felt probable that the return on investment to the public sector, and in particular health and social care services, was under-represented in the Derby SROI calculations. Accordingly, further research needed to be undertaken to identify the financial benefit of Local Area Co-ordination.

Attempts have also been made in several evaluations to undertake cost benefit analysis.

Notable amongst these is the Western Bay evaluation, with other evaluations attempting to reproduce this methodology.

Analysis from Western Bay identified a benefit/cost ratio of between 2:1 and 3:1 using the core range assumptions. It was estimated that sustained LAC activity, at the initial sites, would see the benefit/cost ratio improve to between 3:1 and 4:1. Critically, however, even the most conservative estimates produced positive returns.

Gamsu and Rippon (2018) summarise some of the difficulties associated with return on investment calculations, maintaining that *"it is not possible to comprehensively and definitively describe future patterns of service utilisation – only possible to estimate it."* It is recognised that:

- *"the impact of a particular relationship may not be apparent for some time… and it may be that patterns of service utilisation could change negatively over time (for example because support drops away or someone becomes more dependent because their vulnerability increases through natural circumstances such as ageing or the progression of a particular condition*
- *in some cases, more so where pre-existing health conditions are present, service utilisation may actually increase in the medium term – as people are re-connected with services and support which they were not accessing before[62]."*

Notably, within the existing evaluations of Local Area Co-ordination, there have been no significant attempts to identify directly impacts upon services, following LAC support to people who have been using them, or the efficiency savings which can be identified as a result. Instead the evaluations attempt to model potential changes and savings associated with particular LAC categories (isolation, physical health, mental health, carer responsibility etc.).

Accordingly, reduction in service dependence and usage, and any inherent avoided costs, was an area identified for further exploration in this evaluation; if possible, investigating actual change in service usage for a sample of residents who are being supported by Local Area Co-ordinators.

Previous evaluations also note the difficulties of measuring the long-term impact of Local Area Co-ordination. LAC staff within the Isle of Wight recognised that some, if not much, of the impact of LAC support may not realise benefits for many months or years. Difficulties were recognised in being able to collect the information to undertake the required quantitative evaluation, with concern also raised about selecting the correct measures to assess LAC – concerns were raised about the use of hospital admissions, possibly because of the potential for people's use of health services to increase in the short-term[63] .

"Social Return on Investment (SROI) is a framework for measuring and accounting for this much broader concept of value; it seeks to reduce inequality and environmental degradation and improve well-being by incorporating social, environmental and economic costs and benefits.

SROI measures change in ways that are relevant to the people or organisations that experience or contribute to it. It tells the story of how change is being created by measuring social, environmental and economic outcomes and uses monetary values to represent them. This enables a ratio of benefits to costs to be calculated. For example, a ratio of 3:1 indicates that an investment of £1 delivers £3 of social value."

(A Guide to Social Return on Investment. January 2012 – The SROI Network)

From the existing evaluations, it is evident that no single approach can identify the changes to people's lives, community capacity and the impact upon the public sector. Clearly, therefore, a mixed methods approach, utilising both qualitative and quantitative techniques, is required to identify how Local Area Co-ordination impacts upon all of these areas.

Following the previous national evaluations, and considering the methodology being adopted by Ipsos MORI, it was concluded that this evaluation should focus upon:

1. **Qualitative evaluation:**

- undertaking a detailed qualitative evaluation of a sample of the contact logs kept by Local Area Co-ordinators. This would help to identify the range of issues with which people needed support together with the number of organisations which were involved with the residents supported (to inform the development of Information Sharing Agreements with partner organisations).
- capturing the change in people's personal networks to identify how their situation has changed, their increased resilience and contribution to their local community. The personal network diagrams being incorporated into case studies to show, at a personal level, the impact of LAC on people's lives. *(Please note that people's situations and relationships change over time - all case studies were correct at the time they were captured).*

2. **Quantitative evaluation:**

- analysis of the impact of Local Area Co-ordination, at the system level, in the areas identified within the local Theory of Change, where possible, identifying efficiency savings that may be associated with LAC support in these areas
- development of a baseline from which the long-term impact of Local Area Co-ordination can be measured and which will enable continuous monitoring, and learning, to drive ongoing improvements to LAC within the city.

Chapter 3 - Problems faced by residents and support provided by LACs

Methodology

For older residents, a stratified probability sample of Local Area Co-ordinator's contact logs was drawn, for people requiring active support, selecting either 10% or a minimum of ten logs per ward. In addition, all of the logs relating to support for care leavers were included.

The logs were reviewed and content analysis undertaken to quantify the problems faced by residents and the support offered by Local Area Co-ordinators. Content analysis was also undertaken to identify the organisations with which residents were engaging. In total, approximately 2,800 – 3,000 pages of text were included in the analysis.

Due to the need to establish relationships with the care leavers, and to work through the issues with which they wanted support, it was necessary to undertake the analysis at different times. Accordingly, there are subtle differences in the classification used for each group.

Local Area Co-ordinators support people with a wide range of backgrounds, interests and abilities, who have been introduced to the service by organisations across the public sector, voluntary organisations and members of the public. As a result, they support people to deal with problems across many areas of their lives.

They form trusting relationships with the people to whom they are introduced, learning about new interests, experiences and problems throughout their journey with each person. Accordingly, this analysis reflects all of the problems revealed to, and observed by, LACs, not solely the problems identified at the point of introduction.

For ease of understanding, the results are presented thematically, however, due to the cross-cutting nature of problems and support, some are reflected under multiple themes.

To prevent disclosure, values below 5% have been suppressed.

Health

Issue experienced / support provided	Percentage of people	
	LAC - General population	LAC - Care leavers
Mental health problems (inc. anxiety)	47.5	59.1
Mobility problems	33.9	-
Self-harm	#	27.3
Recent history of falls	10.2	-
Suicidal / possible suicidal ideation (inc. history of attempted suicide)	10.2	22.7
Disability adaptations, (not housing) inc. Care Link	10.2	-
Improvements to home (inc. safety)	8.5	-
Excessive alcohol consumption	7.6	-
Sensory impairment	7.6	-
Drug problems / addiction	5.1	18.2
Missed GP appointments / attendance of medical appointments / accessing medical appointments	5.1	22.7
Put in touch with support group(s) / societies (inc. attempt to find local)	5.1	-
Learning disability	#	^
Support organising medication to ensure taking medication / correct doses / avoid overdoses / access medication	^	^
End of life support / terminally ill	^	-
Support with cooking and healthy eating	^	^
Support organising medical appointments	^	-
Support accessing healthcare	~	13.6
Reducing drug / alcohol consumption (inc. LAC support to do so)	#	9.1
Behavioural / anger issues / ideation to harm others	#	9.1
Relative terminally ill	^	-
Support with exercise / exercise classes	^	-
Keeping fit / losing weight	^	^

- classified elsewhere ~ - not coded but routine for some people and at points of relationship
^ - <5% of cases

People introduced to Local Area Co-ordination also had problems with their memories, malnourishment and food hygiene.

Social work and social care

Issue experienced / support provided	Percentage of people	
	LAC - General population	LAC - Care leavers
Mental health problems (inc. anxiety)	47.5	59.1
Mobility problems	33.9	-
Safeguarding	~	31.8
Overcome isolation	29.7	77.3
Home maintenance / tidiness / cleanliness / cleaner	13.6	-
Person struggling to look after themselves (personal hygiene, dressing, food preparation etc.)	11.9	-
Suicidal / possible suicidal ideation (inc. history of attempted suicide)	10.2	22.7
Recent history of falls	10.2	-
Disability adaptations (not housing) inc. Care Link	10.2	-
Support with garden maintenance / clearance	9.3	-
Person being exploited / at risk of being exploited (inc. financial)	8.5	-
Improvements to home (inc. safety)	8.5	-
Struggles getting food / food parcels / food banks	8.5	27.3
Carer support / respite for carers	7.6	-
Sensory impairment	7.6	-
Learning difficulties / disability	6.8	^
Support for assisted / supported living / Extra care	6.8	-
Difficulties cleaning, gardening etc.	6.8	-
Person not looking after themselves / neglecting themselves	5.1	9.1
Put in touch with support group(s) / societies (inc. attempt to find local)	5.1	-
Missed GP appointments / attendance of medical appointments / accessing medical appointments	5.1	-
Support with emergency accommodation	-	^
Providing care for relatives	~	^
Support facilitating / mediating access to child(ren)	-	^

Social work and social care (cont.)

Issue experienced / support provided	Percentage of people	
	LAC - General population	LAC - Care leavers
Support to raise concerns to social care to protect siblings / about siblings welfare	-	^
Cluttered home / de-cluttering	^	^
Support to remain in own home (i.e. not go into care)	^	-
Person struggles to get out and about (health / disability related)	^	-
Support organising medication to ensure taking medication / correct doses / avoid overdoses	^	-
Personal security / safety concerns (housing related)	^	-
End of life support / terminally ill	^	-
Support moving to more appropriate accommodation (not assisted or supported living / Extra care)	^	-
Support organising medical appointments	^	-
Support with cooking and healthy eating	^	-
Memory problems	^	-
Relative terminally ill	^	-
Blue badge	^	-
Support with food shopping (not internet)	^	-
Abusive relationship / friend	^	-
Support with exercise / exercise classes	^	-

- classified elsewhere ~ - not coded but routine for some people and at points of relationship
^ - <5% of cases

Local Area Co-ordinators also supported people to access specialist support and counselling, connect with private care agencies, research respite care and look into befriending services.

Housing

Issue experienced / support provided	Percentage of people	
	LAC - General population	LAC - Care leavers
Home maintenance / tidiness / cleanliness / cleaner	13.6	^
Support with property search / re-housing / finding a home	~	13.6
Recent history of falls	10.2	-
Support with domestic energy / energy top-ups	-	9.1
Re-housing request / need to find new home	8.5	-
Improvements to home (inc. safety)	8.5	-
Home in poor condition / support to resolve	7.6	9.1
Problems with neighbours	7.6	9.1
Support for assisted / supported living / Extra care	6.8	-
Home security	5.9	-
Support moving house	#	^
Support with emergency accommodation	-	^
Cluttered home / de-cluttering	^	^
Eviction / loss of tenancy / homelessness (parents)	-	^
Fire safety / fire safety measures	^	-
Tenancy problems / preventing homelessness	^	22.7
No furniture / support furnishing or equipping home / changing furniture / repairing furniture	^	22.7
Support to remain in own home (i.e. not go into care)	^	-
Personal security / safety concerns (housing related)	^	-
Small works to home (not safety) (bigger than day-to-day maintenance)	^	-
Support moving to more appropriate accommodation (not assisted or supported living / Extra care)	^	-
Energy efficiency improvements	^	
Home in need of decoration	^	-
Problems with heating system(s)	^	-

- classified elsewhere ~ - not coded but routine for some people and at points of relationship
^ - <5% of cases

Local Area Co-ordinators also noted problems and supported people with replacing a boiler, getting access to domestic fuel and obtaining disability adaptations.

Crime and anti-social behaviour

Issue experienced / support provided	Percentage of people	
	LAC - General population	LAC - Care leavers
Person being exploited / at risk of being exploited (inc. financial)	8.5	9.1
Court proceedings	~	9.1
ASB	6.8	^
Home security	5.9	-
Personal security / safety concerns (housing related)	^	-
Domestic violence / domestic abuse	^	9.1

- classified elsewhere ~ - not coded but routine for some people and at points of relationship
^ - <5% of cases

Administration

Issue experienced / support provided	Percentage of people	
	LAC - General population	LAC - Care leavers
Financial difficulties / advice (inc. parents)	32.2	36.4
Getting people onto the correct benefits / amounts (inc. appeals / support with assessments)	22.9	-
Support required with official correspondence / forms / paperwork / finance administration	16.9	9.1
Sensory impairment	7.6	-
Illiteracy	^	-
Memory problems	^	-
Support dealing with outside agencies	^	-
Support making a complaint to an organisation about treatment / staff	^	-
Clarification about information held in official records	^	-
Administrative support with bereavement	^	-
Difficulty budgeting / support budgeting	^	^

- classified elsewhere ~ - not coded but routine for some people and at points of relationship
^ - <5% of cases

Other LAC support included helping people to manage their dealings with multiple organisations, paying bills and reducing their dependency upon individuals at specific organisations.

Other presenting and emerging issues

Issue experienced / support provided	Percentage of people	
	LAC - General population	LAC - Care leavers
Connecting with activities	30.5	36.4
Overcome isolation	29.7	77.3
Community connection	24.6	77.3
Serious lack of money	#	18.2
Personal loss / grief / bereavement	16.1	13.6
Volunteering	13.6	18.2
Advocacy / being heard	11.0	59.1
Strained / difficult relationships	7.6	^
Specialist support	^	-
Support helping someone to organise committee / group activities	^	-
Bulky waste collection	^	-
Being bullied	-	^
Information / advice about parenting and children	#	^
Support with essentials for child	#	13.6
Relationship advice / discussion	#	^

- classified elsewhere ~ - not coded but routine for some people and at points of relationship
^ - <5% of cases

The effectiveness of Local Area Co-ordination for people of all ages is well established, as has been the transition from providing support for people with disabilities to other groups, including people with mental health needs and older people[64]. Whilst the percentage of people experiencing specific issues may vary, the analysis above indicates that many of the issues faced by care leavers are also commonly experienced within the wider population who have been supported by LAC. There were, however, some issues encountered by LACs that are more prevalent amongst care leavers because of their life stage, including: education, employment and life skills.

Employment and education

Issue experienced / support provided	Percentage of people	
	LAC - General population	LAC - Care leavers
Support looking for work or placement (care leaver or partner) / help to get back into work	^	27.3
Volunteering	13.6	18.2
College courses	-	9.1
Advice / support with applications / CV / getting to interview	#	9.1
Advice / support with interview preparation	#	9.1
Support identifying courses / information about courses	^	^
Improved attendance at school	-	^

- classified elsewhere ~ - not coded but routine for some people and at points of relationship
^ - <5% of cases

Life skills

Issue experienced / support provided	Percentage of people	
	LAC - General population	LAC - Care leavers
Support with food shopping	-	27.3
Mentorship (of care leaver)	~	13.6
Learning to cook / support with cooking and healthy eating	^	9.1
Support with budgeting	^	^
Support with cleaning the home	9.3	^

- classified elsewhere ~ - not coded but routine for some people and at points of relationship
^ - <5% of cases

Chapter 4 - Evaluation of LAC against the Derby Theory of Change

Local Area Co-ordination does not operate in isolation of other services. The people introduced to LAC often have multiple and complex needs; accordingly, they are likely to be receiving support from a range of services across the public sector, but especially health and social care services.

Further, support for a resident provided by one service may lead to efficiency savings being realised in another part of the same organisation or within another part of the public sector. It is, therefore, extremely difficult to identify the impact of a single service within the matrix of inter-related services being provided.

Accordingly, this evaluation does not attempt to isolate the benefits which can be attributed only to Local Area Co-ordination. Instead, the analysis of outcomes, within this chapter, assumes that Local Area Co-ordination is working alongside all other services that residents may be receiving and which may be introduced following introduction to LAC.

The Theory of Change identifies that Derby should start to see reductions in:

- nursing and residential care placements
- social care packages and interventions
- evictions and associated costs - sustainment of tenancies
- unnecessary crisis health interventions
- unnecessary Primary Care appointments
- Delayed Transfers of Care
- the demand on secondary Mental Health services
- the number of young people identified as being at risk.

Evidence has been collected to evaluate the impact of Local Area Co-ordination, in combination with other services, on the majority of these measures.

However, the number of young people identified as being at risk has been excluded from this evaluation because of the comparatively small number of families being supported by LAC - family introductions began to increase during the second half of the evaluation period. Accordingly, evaluation of LAC's impact in this area should be prioritised for the next phase of research/evaluation.

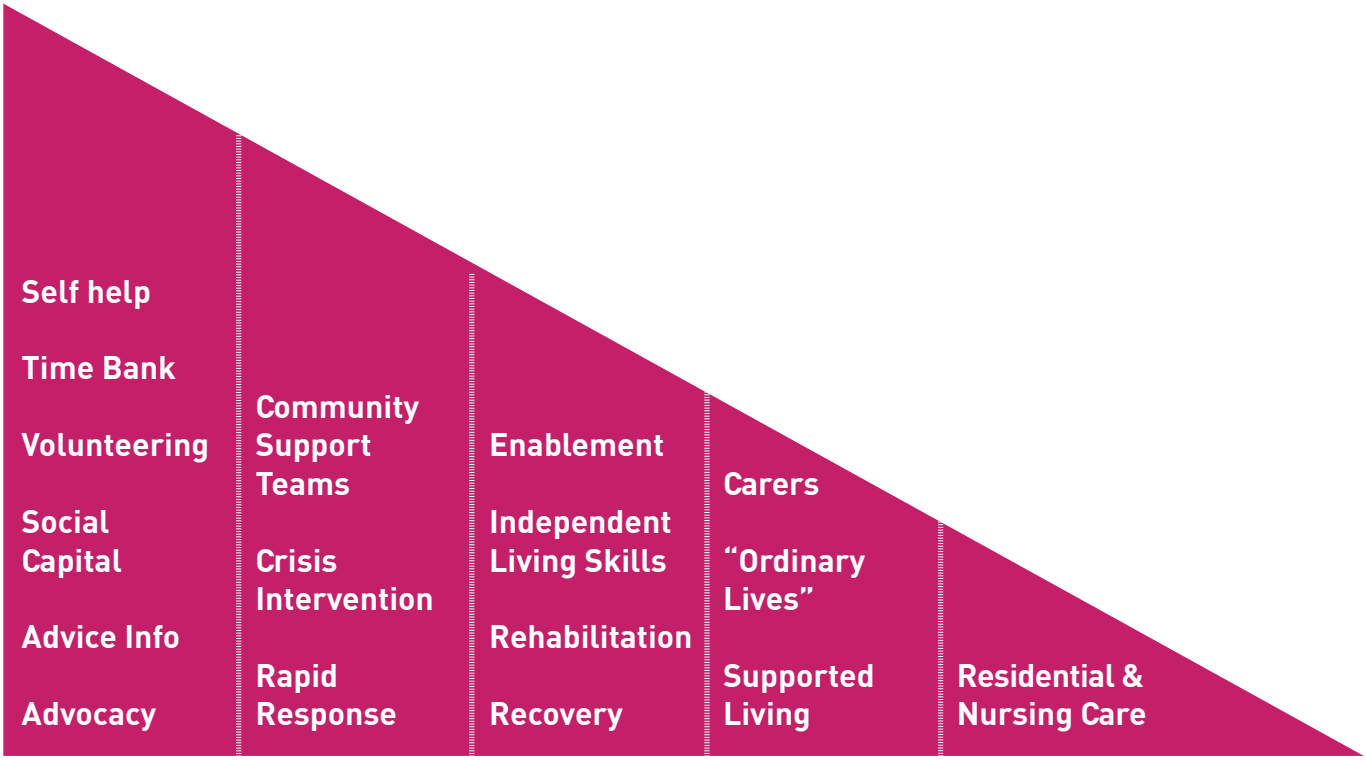
4.1) Reduction in nursing and residential care placements

This Council's Adult Social Care Strategy, 'Your Life, Your Choice[65]' identifies the need to do things differently in order to be able to provide the support that people need within the available budget. The strategy details an approach operating at four levels:

1. At the community level: building resilient individuals, families and communities.
2. At individual practice level: working in a different way to help individuals, their families and/or other support networks to find solutions that build on their strengths, skills and assets.
3. At the service level: building flexible, empowering and responsive services that are delivered in new and innovative ways.
4. At whole systems level: recognising that part of the solution to our challenge rests in working in partnership with our colleagues in the wider public and private sectors. We need to all work together to create local solutions across health and social care to manage demand pressures and to keep people safe and well.

The process is illustrated diagrammatically in Figure 4.1.1.

Figure 4.1.1 – Derby's Care and Support wedge



"[The] ambition is that, as much as possible, people find the support they need on the left hand side of the "wedge" and the balances of resources and support shift from the right to the left side of the system to make this happen[66]."

"I've been able to stay at home with help from my neighbours instead of going into a Care Home." (A Derby resident)

Local Area Co-ordination operates primarily within the first level of the Council's approach to delivering quality adult social care services. Accordingly, the LAC Theory of Change identifies that one of the anticipated outcomes, fitting with the LAC principle of helping people to achieve their good life within their community, is to prevent / delay the need for people to enter residential and nursing care. Further, the LAC principles of increasing social capacity and connection should increase the level of support for vulnerable people within their communities.

Of the 568 people with dated forms on the council's adult social care system (LAS), at June 2020, at least 44 people were either introduced to LAC to prevent admission to residential care or had this as an emerging aim during the period of the relationship. Delayed entry to residential care was a possible aim for a further 18 people. This represents between 7.7% and 10.9% of the people supported by Local Area Co-ordination in the city[67].

Considering the 44 people, where delaying entry to residential care was a known aim, 16 (36.4%) have/had homecare packages and would therefore be likely to qualify for council funded residential care. To date, these people have had entry to residential care delayed for an average of approximately 20 months. However, it should be noted that, where the LAC relationship has lasted for 4 years, or more, the average delay is approximately 45 months.

The average weekly value of these homecare packages is/was approximately £156. Based upon the standard weekly residential contract cost of £529, this represents an average cost saving of £373 per person per week (or £19,396 per person per year). It is estimated that preventing these 16 people from entering the residential care system has, to date, saved more than £535,000 (less any costs for LAC and other services commencing post introduction to LAC).

Delayed entry to residential care was a priority for at least 7.7% of people introduced to LAC.

At the same rate (7.7%), of the estimated 765 people to be supported by LAC each year, potentially 59 people per year could either be prevented from entering residential care or have their entry delayed. If 36.4% (22) of these people would qualify for their costs to be covered by the council, and assuming a weekly homecare cost of £200, cost savings would be appreciable.

Table 4.1.1 - Cost savings associated with 22 people per year being prevented from entering the residential care system, based upon an average saving of £329 per person per week[68]

Number of years entry into residential care is prevented / delayed	Cumulative cost savings (£s)				
	Year 1	Year 2	Year 3	Year 4	Year 5
1 year	376,376	376,376	376,376	376,376	376,376
2 years	376,376	752,752	752,752	752,752	752,752
3 years	376,376	752,752	1,129,128	1,129,128	1,129,128

Less any costs associated with Local Area Co-ordination support (2.88% of total LAC costs) and any other services introduced

Table 4.1.2 - An ageing population: projected population change in Derby, 2019 to 2030

Population Aged	2019	2025	Population increase 2019 - 2025	2030	Population increase 2019 - 2030
75+	20,499	23,331	2,832	24,788	4,289
85+	6,371	6,856	485	7,565	1,194

Sources: ONS, Mid-year estimate of population, 2019; ONS, Sub-national population projections, 2018

This is clearly an area of significant cost to the council and potentially an area of significant cost savings should it be possible to prevent / delay the admission of more people into residential care.

Currently, approximately 160-170[69] people in Derby enter residential care, each year, with the cost of their care being met by the council – a further 80-90 people enter nursing care each year[70]. With the projected increase in the number of people aged 75 years and over, it is reasonable to assume that demand will increase.

Approximately 160-170 people enter residential care each year with the cost of their care being met by the Council.

With an ageing population, there is a clear need to support more people to find solutions that will enable them to take an active role in their community and have their care needs met within their own home. If, through a combination of Local Area Co-ordination and other services, more people could have their entry to residential care delayed, or prevented, the cost savings could be increased further.

It is likely that not all of these cost savings would be realised due to the need to introduce additional services to help people. As more people are supported by Local Area Co-ordination to delay/prevent their entry into residential care, further work needs to be undertaken to refine the average length of this delay and to identify the costs of other services introduced – this will enable the potential cost savings to be fine-tuned.

However, this is an obvious area in which LAC can contribute to cost savings, whilst also helping residents to remain independent in their own home and active within their community. In line with council policy, this activity would also be expected to increase social capital.

Table 4.1.3 - Cost savings associated with 35 people per year being prevented from entering the residential care system, based upon an average saving of £329 per person per week[71]

Number of years entry into residential care is prevented / delayed	Cumulative cost savings (£s)				
	Year 1	Year 2	Year 3	Year 4	Year 5
1 year	598,780	598,780	598,780	598,780	598,780
2 years	598,780	1,197,560	1,197,560	1,197,560	1,197,560
3 years	598,780	1,197,560	1,796,340	1,796,340	1,796,340

Less any costs associated with Local Area Co-ordination support (4.58% of total LAC costs) and any other services introduced

Table – 4.1.4 - Cost savings associated with 50 people per year being prevented from entering the residential care system, based upon an average saving of £329 per person per week[72]

Number of years entry into residential care is prevented / delayed	Cumulative cost savings (£s)				
	Year 1	Year 2	Year 3	Year 4	Year 5
1 year	855,400	855,400	855,400	855,400	855,400
2 years	855,400	1,710,800	1,710,800	1,710,800	1,710,800
3 years	855,400	1,710,800	2,566,200	2,566,200	2,566,200

Less any costs associated with Local Area Co-ordination support (6.54% of total LAC costs) and any other services introduced

Table 4.1.5 - Cost savings associated with 60 people per year being prevented from entering the residential care system, based upon an average saving of £329 per person per week[73]

Number of years entry into residential care is prevented / delayed	Cumulative cost savings (£s)				
	Year 1	Year 2	Year 3	Year 4	Year 5
1 year	1,026,480	1,026,480	1,026,480	1,026,480	1,026,480
2 years	1,026,480	2,052,960	2,052,960	2,052,960	2,052,960
3 years	1,026,480	2,052,960	3,079,440	3,079,440	3,079,440

Less any costs associated with Local Area Co-ordination support (7.84% of total LAC costs) and any other services introduced

Case study - George's story

George was in his late 80s and had not left his home for many years. He was socially isolated - he had a good relationship with his daughter and grandchildren; his daughter did his shopping for him online but was unable to visit frequently. His only regular companion was his dog.

George was neglecting himself, his home was dirty and, importantly, he was not attending his medical appointments, including for his specialist health checks. There were concerns for George's welfare but he refused to engage with social workers or other services. There were also concerns for the welfare of his dog.

Due to his isolation, George was drinking more heavily through the week – often late in a week, he would start to have chest pains and call for an ambulance. His mobility was also poor, causing him to fall frequently; on one occasion, he was unable to get up and was stuck on the floor for a long period until a neighbour heard his calls for help. His falls also resulted in calls for an ambulance and, for both problems, he was often taken to the hospital.

Through his GP Surgery, George was then introduced to Local Area Co-ordination. His LAC took time to get to know George and slowly a trusting relationship developed.

George described himself as a proud and independent man; his priorities were to:

- maintain his independence
- make some new friends to help with his loneliness
- get some advice to help him to manage his health and well-being
- get help to attend his appointments.

George and his LAC got to work on his priorities. The first thing that they did was to tackle his problem with falls – they arranged to get some help with de-cluttering and cleaning to help to reduce the risk of tripping. They also contacted Carelink, to get George a telecare system, so that he had someone to contact in an emergency – this reduced the need to call for an ambulance and also gave his daughter re-assurance that her father was getting the help that he needed.

His LAC also connected him with the Fire Service who made some changes to his home to reduce the risk of fire.

His LAC then introduced George to groups at his local community centre and his local community café. He was delighted to get out of the house and to start to make some new friends – he was becoming connected with his local community.

Through these connections, he met a good friend named Jim. Jim had a car and was happy to help George get to his medical appointments.

George also met some people who shared his interest in hobbies; they took him to meetings of local hobby groups where he got to know more people. Another friend, Albert, was happy to go to the local shops for him.

He met another man named Geoff - Geoff was very interested in gardening and agreed to help George to maintain his garden and home; in return, George helped Geoff with something that he struggled with.

One day, at the local community centre, he met a lady named Sarah. Sarah had a genuine love of animals and was happy to take George's dog for a regular walk – this helped to remove the welfare concerns about his daily companion.

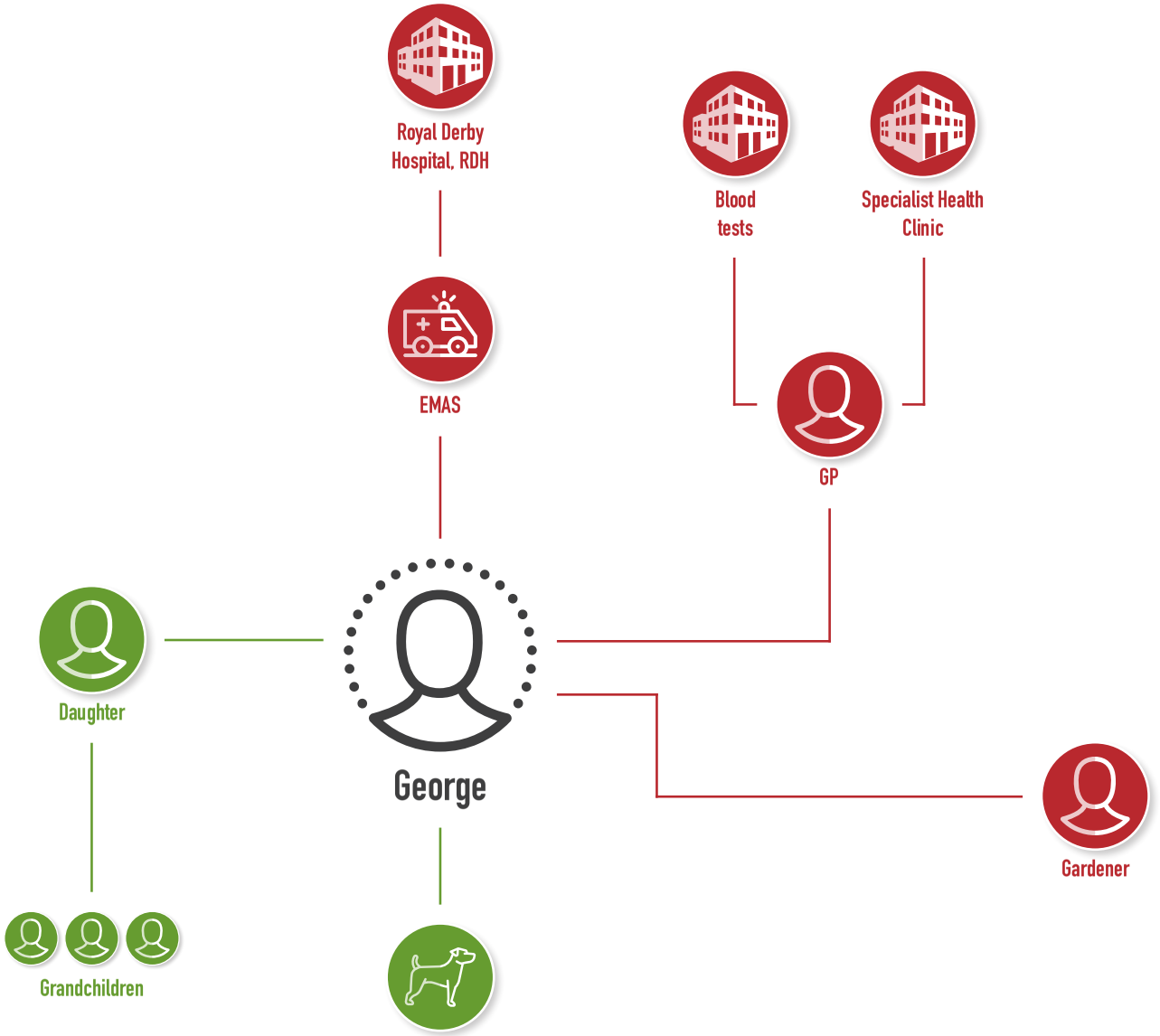
George was very grateful for his new friends and the support that he was receiving; he wanted to give something back to his local community. With support from his LAC, he set up a regular social activity to help local people to meet-up and to raise funds for charity. He also wanted to pass on his knowledge and was happy to teach other people traditional handicrafts.

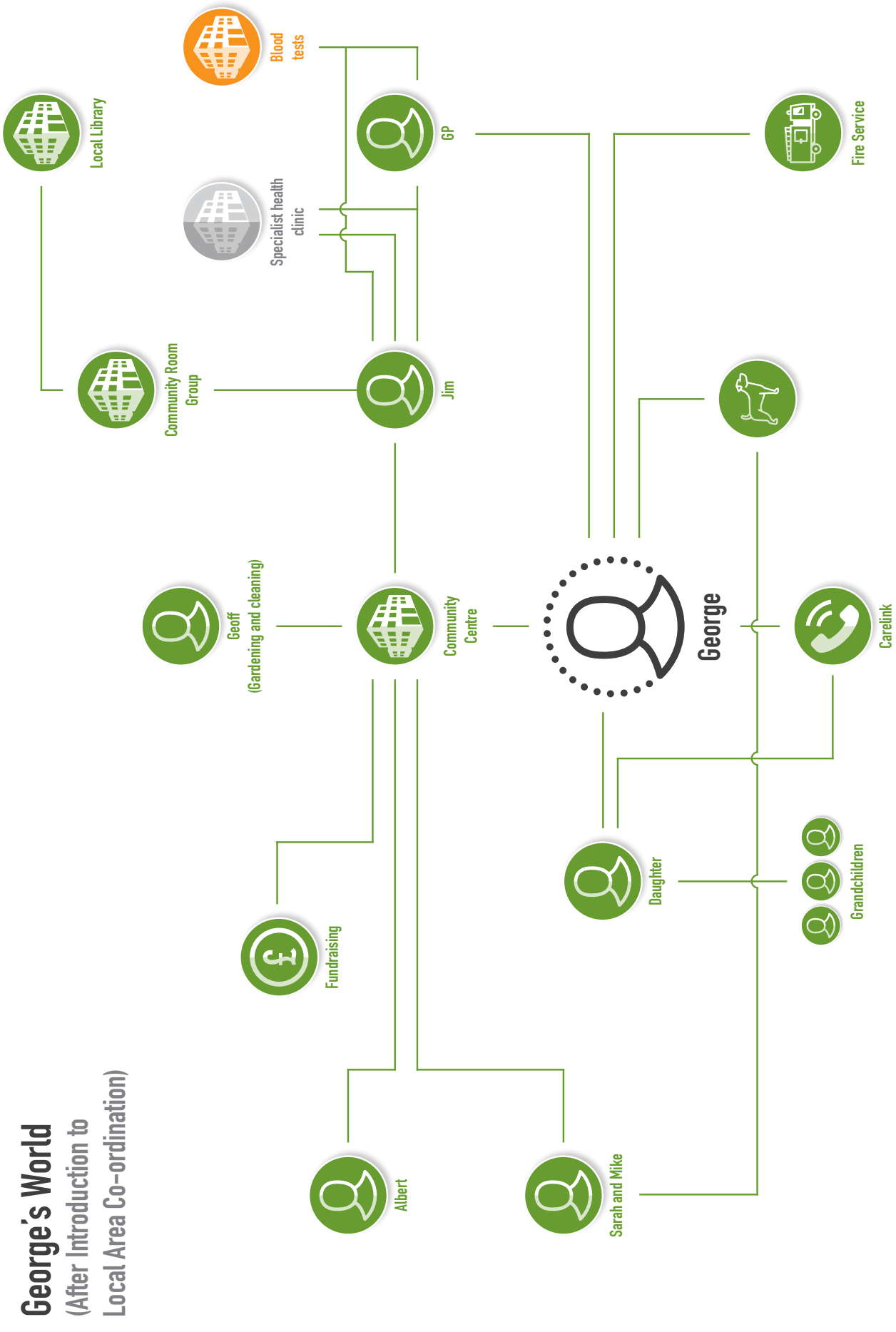
Following his introduction to Local Area Co-ordination, George is connected to his local community and is no longer lonely. He is no longer drinking heavily and his home has been de-cluttered; as a result of this and the introduction of Carelink, his calls for ambulances and hospital attendance have decreased. He has community support to help him manage and maintain an independent life in his home, he is able to attend his medical appointments and there are no longer concerns for the welfare of George (or his dog).

George no longer needs support from his Local Area Co-ordinator but they still 'keep an eye' on him to make sure that he is still coping and does not need more support.

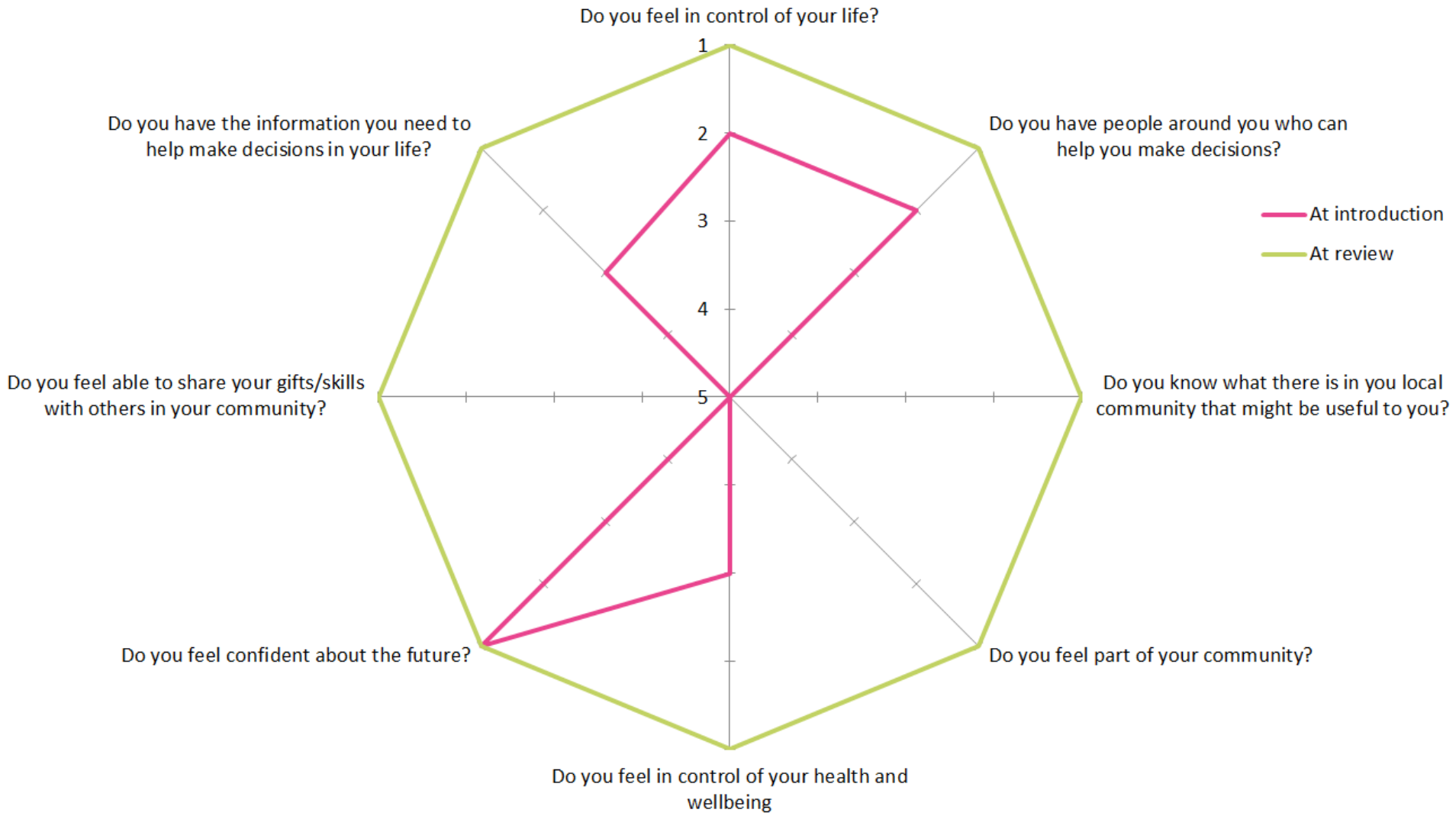
George's World

(Before Introduction to
Local Area Co-ordination)




George's World
(After Introduction to Local Area Co-ordination)
Blood tests
Local Library
GP
Fire Service
Specialist health clinic
Community Room Group
Jim
George
Geoff (Gardening and cleaning)
Community Centre
Carelink
Fundraising
Daughter
Grandchildren
Albert
Sarah and Mike

George's Outcome Star (Derby flower) scores



4.2) Reductions in social care packages and interventions

More than half of the people introduced to Local Area Co-ordination have been introduced to help them to reable, supporting them to accommodate their illness by learning or re-learning the skills necessary for daily living[74]. Accordingly, reducing the number of people in receipt of adult social care packages and reducing the cost of packages are important aims for the service.

Between April 2018 and March 2020, Local Area Co-ordinators supported 198 people who have received adult social care in their own home[75] - 174 have been included in the analysis below[76]. Of these people, during the period of LAC support:

- 69 (39.7%) had no overall change in the value of their care package
  - of which, 22 (12.6%) had a care package start and stop – this includes temporary reablement packages
- 22 (12.6%) had a reduction in the value of their care package
  - of which, 12 (6.9%) saw all long-term support ended
- 83 (47.7%) had the value of their care package increased
  - of which, 58 (33.3%) started a care package.

12.6% of people had a reduction in the value of their care package following introduction to LAC.

These 174 people represent 30.6% of the people supported by Local Area Co-ordination during 2018/19 – 2019/20. At the same rate, of the 765 people that LACs may be expected to support each year, 234 people would be expected to have an adult social care package. During the period of LAC support:

- 12.6% of these, or 30 people would be expected to reduce the cost of their package, and
- a further 12.6%, or 30 people, would be expected to begin and end a care package.

The average weekly reduction in the cost of a care package is £109 per person per week. Projecting possible savings using these costs, suggests that LAC support will contribute to potential savings of £5,668 per person per year – projected cost savings are identified in Table 4.2.1.

It is likely that not all of these costs savings would be realised due to the need to introduce additional services to help people. Further, in some cases, reductions in the value of care packages may occur without any intervention or support from LAC.

It would be estimated that a further 29 people, each year, would have a care package begin and end during the period of their LAC support. For these people, the average weekly cost of care, at the point the care package stopped, was £72.30 (or £3,756 per person per year). If all of these people were to be prevented from re-entering the social care system, potential savings could reach a further £109,028 per year. However, these people have been excluded from the calculation of future savings in order to avoid over-estimating the potential savings resulting from reductions in social care packages.

Notably, for the 83 people where the cost of care increased, the total weekly increase was £12,010 – this was five times more than the weekly savings from the 22 people where the cost of care decreased. However, this would be expected with the deteriorating health of many people in need of social care.

Table 4.2.1 - Cost savings associated with 30 people per year having the costs of their care reduced, based upon an average saving of £109 per person per week

Number of years for which the cost of care is reduced	Cumulative cost savings (£s)				
	Year 1	Year 2	Year 3	Year 4	Year 5
1 year	170,040	170,040	170,040	170,040	170,040
2 years	170,040	340,080	340,080	340,080	340,080
3 years	170,040	340,080	510,120	510,120	510,120

Less any costs associated with Local Area Co-ordination support (3.79% of total LAC costs) and any other services introduced

Reablement

Of the 174 people included in the analysis, 61 were introduced to Local Area Co-ordination to support their reablement. Notably:

- of the 22 people who saw the values of their care package reduced, half were introduced to support their reablement
- of the 12 people who saw their long-term care support end, two thirds were introduced to support their reablement
- Of the 69 people who saw no change in the value of their care package, a third (23) were introduced to support their reablement.

For more than 55% of the people introduced to Local Area Co-ordination, to support their reablement, the cost of their care package either decreased or remained constant. More research is required to assess these changes in relation to people who have not received LAC support; however, this analysis suggests that LAC has contributed to either reducing the value of the care package or preventing/ delaying an increase.

Safeguarding adults

To early June 2020, 176 (or 31%) of the residents who had received LAC support (since LAC started to record data on the council's adult social care system) had had a safeguarding referral; in total, these 176 residents had had 315 safeguarding referrals to that time.

71 people were introduced to LAC with either an open safeguarding referral or had a safeguarding referral opened on the same date as their introduction to Local Area Co-ordination. Of those, safeguarding referrals were closed for 69 people following their introduction; safeguarding referrals remained open for two people.

For 38 (53.5%) of these people, there were no further safeguarding referrals following their introduction to LAC.

A further 211 safeguarding referrals were opened (and closed) for people being supported by LACs, with many of the referrals being made by Local Area Co-ordinators.

Recommendations (Adult Social Care)

Given the emerging evidence around the impact that LAC can have in reducing demand through to ASC and resultant care packages and placements, more work should be done to understand and explore:

1. What conditions best support a successful introduction to LAC.

2. How the Community Hub impacts upon demand for ASC support.

3. When and from what areas is the optimal time for an introduction to LAC from ASC services.

4. To undertake further research to refine potential savings associated with delayed entry to residential care by:
    a. refining the average length of this delay
    b. identifying the costs of other services introduced.

5. Where people have an assessment for a social care package but do not qualify, consideration of an introduction to LAC on a case-by-case basis should be made with an assessment of how it could help them to meet their needs within their community and to prevent, or delay, their entry into the social care system.

6. For cases where people are entering the care system following an illness, or experience an illness and require reablement support, an introduction to LAC should be considered. This may help to reduce the value of their care package, through time, if some support can be provided by family members or the local community.

Case study - James' story

James was introduced to Local Area Co-ordination by his Local Housing Officer. He was struggling to maintain his tenancy, manage his property and budget his money. He had also fallen out with most of his neighbours over the state of his garden. At the time of introduction, he was in the process of being evicted and was refusing to engage with services and other people.

James has no family. Prior to introduction, he was addicted to alcohol. His drinking and loneliness often caused him to neglect himself; he would go days without food. On one occasion, James was found collapsed in the street. A passer-by called an ambulance and James was admitted to hospital.

James was not managing his long-term health conditions; as a result of his drinking and his self-neglect, he was making frequent calls for an ambulance which often led to hospital admissions.

There were safeguarding concerns for James because of these problems. His vulnerability also caused to him to be at risk of abuse. As a result of these problems, the police were sometimes called-out to see James.

Over a period of months, James and his Local Area Co-ordinator developed a good, trusting relationship. He allowed his LAC into his home and they spent time talking together. James still often said that he was 'OK' when others may have disagreed with that.

During one visit to James' home, his LAC discovered that he had no money until the following weekend (5 days away) – he only had one Pot Noodle to last him for the whole week. His LAC quickly liaised with the volunteer at the local church's food bank to see whether they could provide a James with a bag of food. James was invited to the church and they reassured him that, if he was struggling to eat, he would be welcomed to collect a food parcel. James is now connected to his church and has met new friends.

Through that connection and also connection with his local community café, a local volunteer offered to help by tidying James' garden, which he gratefully accepted. This helped him to maintain his tenancy and improved his relationship with his neighbours.

As the trust with his LAC developed, during one particular visit, James confessed that he was in pain and showed his leg to his LAC. His leg appeared to be heavily infected, inflamed and oozing. James said he had been to the GP a few weeks before, who had prescribed medication, but he had now completed the course. James explained that he was struggling to walk, had no means of transport and sometimes, due to drinking alcohol, could be forgetful. As a result, he had not been back to see his GP.

After some persuasion, James agreed that his Local Area Co-ordinator could help him to contact his doctor to ask if more medication could be prescribed. Together, they telephoned the surgery and spoke with the doctor who agreed to prescribe a stronger antibiotic and stressed the need for James' leg to be dressed. His LAC explained to the doctor that James was now unable to walk and asked if the district nurse could call to his home to apply a dressing. This was agreed and the district nurse visited James at home to apply clean dressings. James's LAC collected his prescription for him. James was very grateful and said "Thanks for caring."

Without the support of Local Area Co-ordination, it was inevitable that James would have been admitted to hospital if his leg had been left untreated.

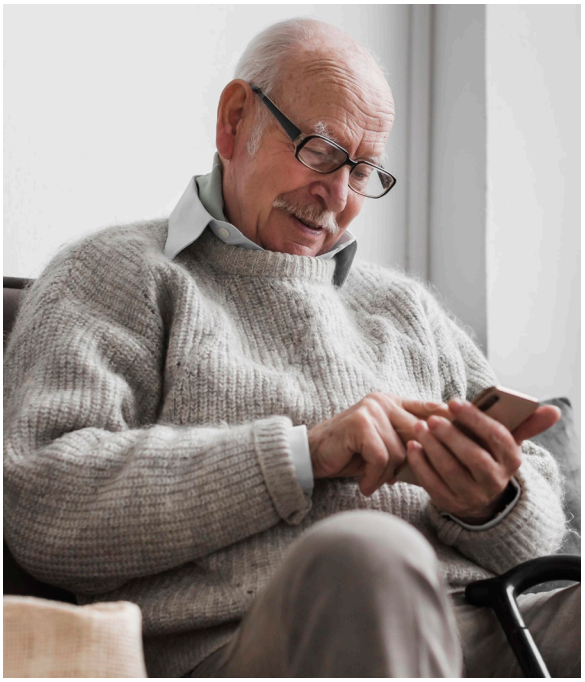
His LAC continued to walk alongside James for some time. Together they registered James with a GP surgery within a few minutes walking distance from his home. It would now be more accessible for James and easier for him to attend his health appointments.

Through getting to know the neighbourhood and local residents, his LAC was able to support James to connect with his neighbours. One neighbour, Catherine, started to remind James to take his medication and keep an eye on him. She would remind James to attend his medical appointments to have his ulcers re-dressed. She also supported James to sort

out his DWP pension as his payment plan had been changed. Another neighbour ran a local food bank and would check to see if James had enough food.

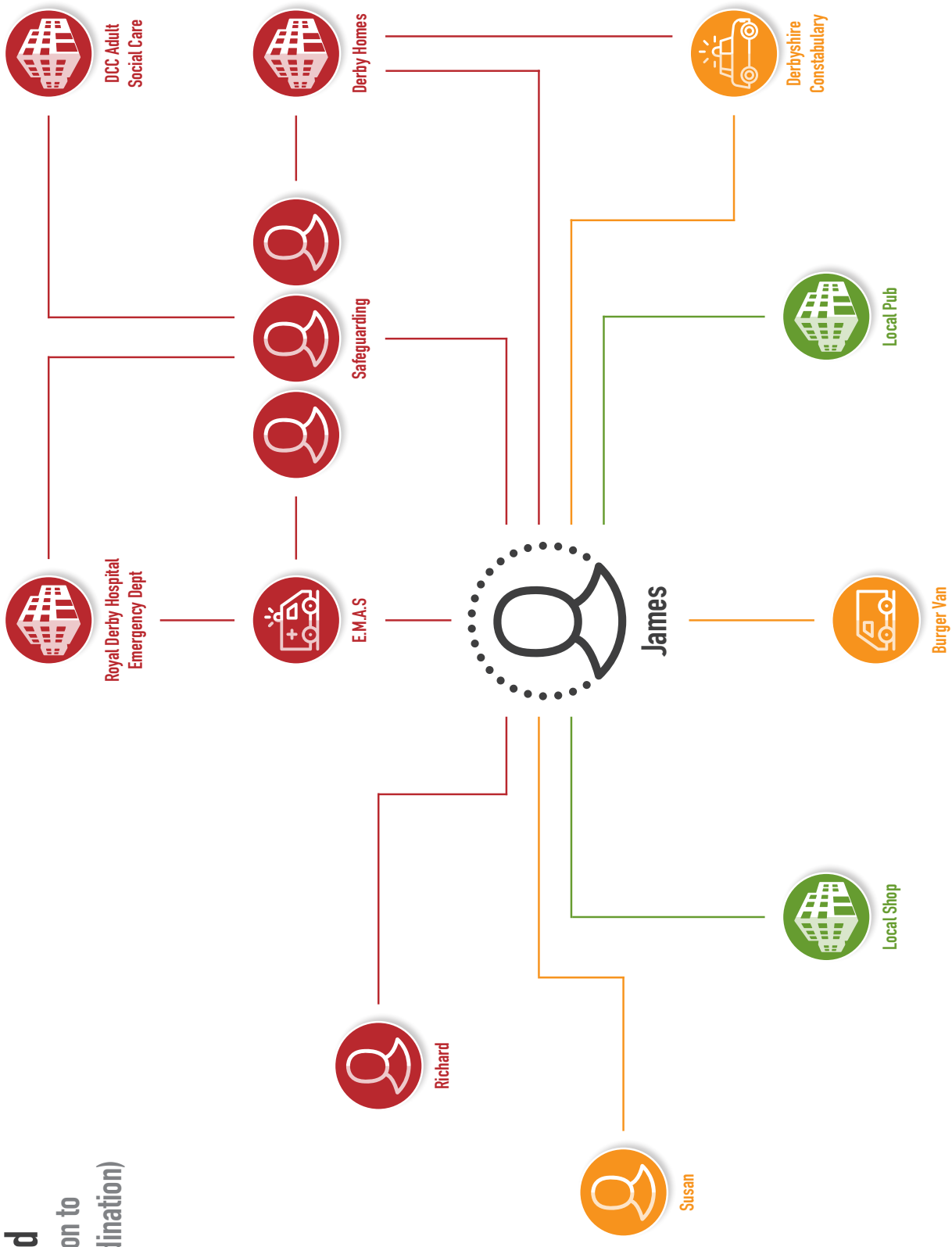
James was no longer isolated and was abstaining from drinking alcohol. Following his introduction to Local Area Co-ordination, he has not called for an ambulance or been admitted to hospital. There were no longer concerns for his wellbeing; what had previously been regular safeguarding referrals and calls to the police had reduced to none.

James said that he had started to take some pride in his appearance and for the first time in a number of years had managed to save money and buy new clothes. He said he felt proud going into his local pub to have a meal.

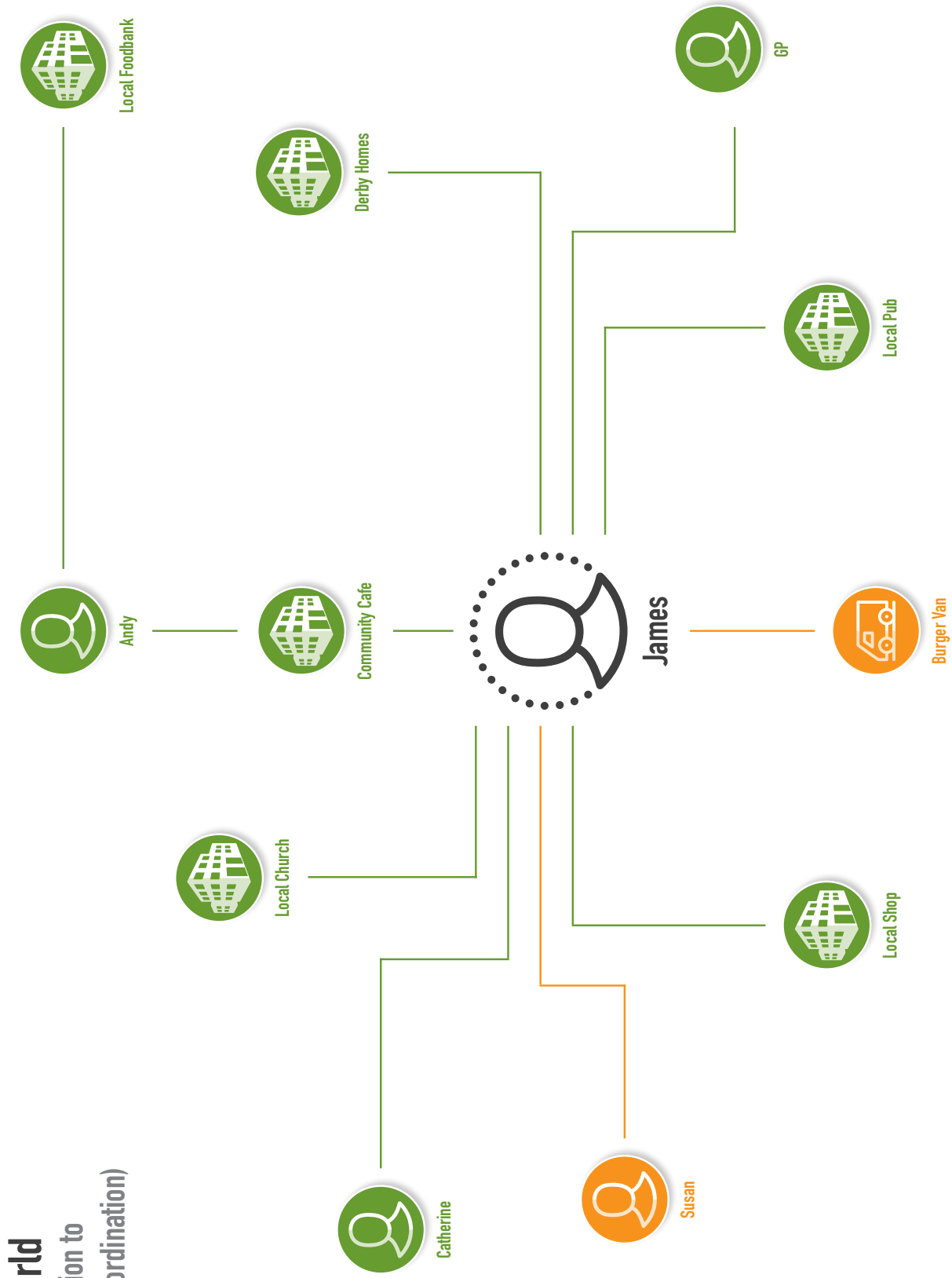


James has recently moved to a different neighbourhood; he has made new friends in his new community but stays in touch with his old neighbours, who still 'keep an eye on him.' He remains abstinent from alcohol.

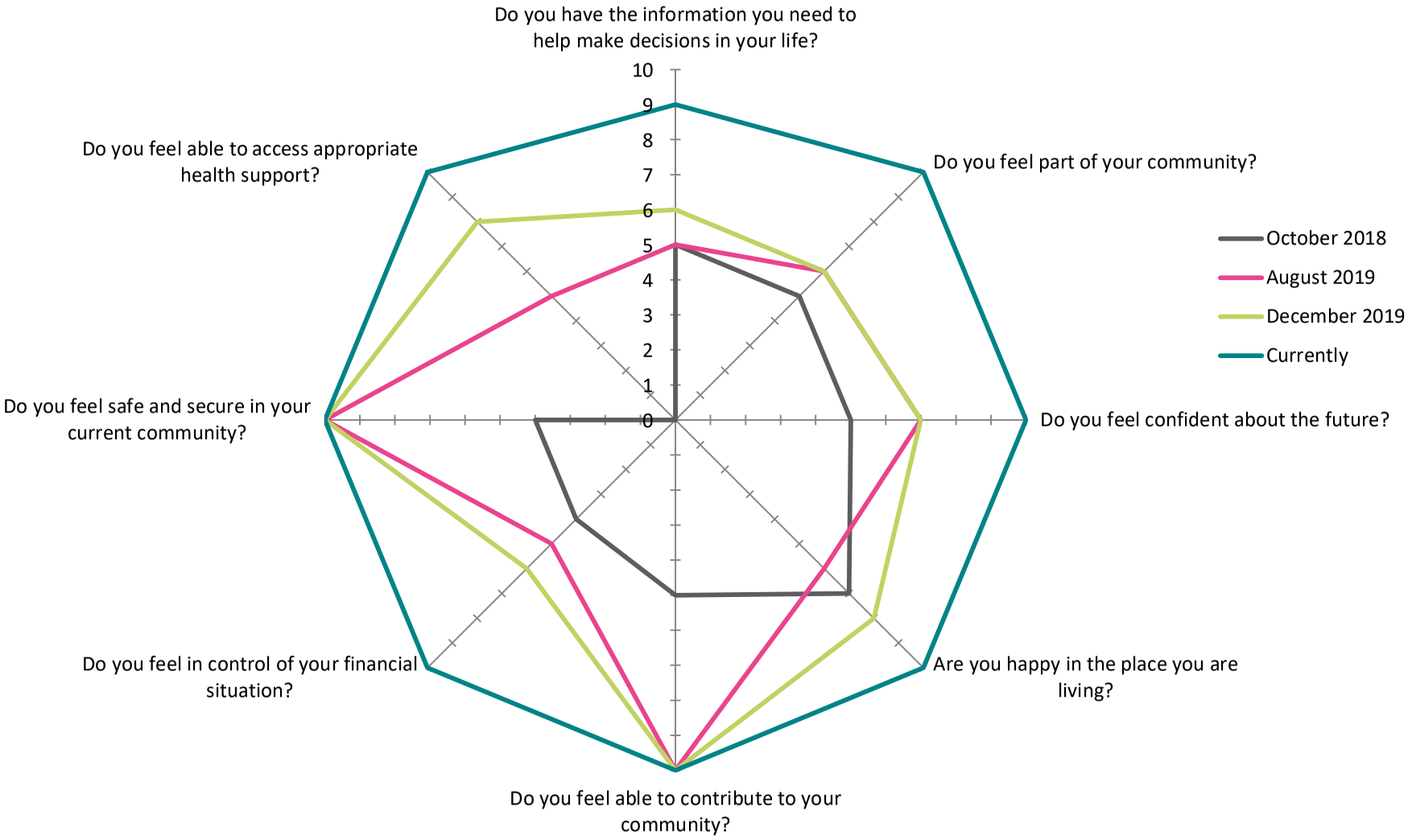
James continues to work with Local Area Co-ordination, helping him to maintain his independence and delaying the time at which he may need to enter residential care.



James's World
(Before Introduction to Local Area Co-ordination)


James's World
(After Introduction to
Local Area Co-ordination)
Local Foodbank
Derby Homes
GP
Local Pub
Andy
Community Cafe
James
Burger Van
Local Church
Local Shop
Catherine
Susan

James' Outcome Star scores



4.3) Sustainment of tenancies – reduction in eviction and associated costs

Local Area Co-ordinators support people living in all tenures. It is difficult to identify the exact number of people, who are supported by LACs and live in social housing, because of incomplete data recording; however, during 2018/19 and 2019/2020, it is estimated that 39.3% of people supported by LACs live in homes managed by Derby Homes[77].

People living in social rented accommodation are introduced to Local Area Co-ordination by a wide range of sources to help them to resolve an equally wide range of problems. In addition to all of the non-housing related problems with which LACs support tenants, they also support them to resolve a number of housing related issues which might affect their tenancy. For people living in homes managed by Derby Homes, this includes helping tenants to:

- resolve or reduce rent arrears – 10%
- resolve problems with their neighbours – 11%
- resolve problems with the 'state' of their home and/or garden – 21%.

In all, for people who live in homes managed by Derby Homes, Local Area Co-ordinators estimate that they help to prevent the loss of a tenancy in 9% of cases. Notably, in at least a third of these cases, the person supported suffered from mental health problems which were affecting their ability to manage their tenancy or to understand the information relating to their possible eviction.

Derby Homes estimate that the average cost of terminating a tenancy is approximately £5,000; this includes legal and administrative costs, the cost of preparing the property for the next tenant and rent arrears - potentially, there may be additional costs associated with having to re-house people. However, not all of these costs would be avoided if the tenancy was not terminated.

Every case which could result in the loss of a tenancy is unique. Accordingly, Derby Homes take every possible avoiding action before eviction and, in a number of cases, this has included introducing people to Local Area Co-ordination.

LACs estimate that they help to prevent the loss of a tenancy in 9% of cases.

Of the 420 people being supported at any time by 14 Local Area Co-ordinators, 165 are likely to be living in homes managed by Derby Homes. It is difficult to estimate how this number may change, with the expansion of LAC to cover the whole city, because of the significantly lower rates of social-renting in the 6 new wards and the re-allocation of three LACs out of existing wards. However, it may be reasonable to assume that LAC will continue to support approximately 165 people per year from homes managed by Derby Homes.

Methodology

A probability sample of 100 people living in homes managed by Derby Homes was drawn. The sample was circulated to the Local Area Co-ordinators to answer a number of questions about issues which may have affected / be affecting each person's tenancy – these answers were analysed, referring to the Local Area Co-ordinator's contact logs for additional information.

As Derby Homes take every possible avoiding action before eviction, we may assume a more conservative estimate for LACs helping to prevent loss of tenancy. If we assume LAC support to avoid eviction in 6% of cases, this would equate to approximately 10 tenancies per year being saved. The maximum saving, therefore, could be up to £50,000 per year but is likely to be lower due to not all of the estimated £5,000 eviction costs being saved.

Recommendations

1. Where tenancies are at risk, and housing managers believe that there is an underlying cause which may be affecting the tenant's ability to manage their tenancy, consideration should be given to introducing the tenant to LAC.

2. Work should be done to build a clearer picture around the impact of LAC on the private as well as the social housing sectors.

4.4) Reductions in unnecessary crisis health interventions / unnecessary Primary Care appointments

Methodology

In October 2019, 200 NHS numbers were identified from all of the people that Local Area Co-ordination supported during 2018/19 and 2019/20 – none of the people identified objected to the sharing of identifiable data. Along with the NHS numbers, the dates at which LAC support began and stopped were also provided. The data also contained a grouping variable to identify care leavers.

The NHS numbers were shared with the:
- University Hospitals of Derby and Burton
- Derbyshire Community Health Services NHS Foundation Trust
- Derbyshire Healthcare NHS Foundation Trust.

These partner organisations returned aggregated data relating to the number of attendances for an equal period before and after introduction to LAC.

The sample was also circulated to the Local Area Co-ordinators to answer a number of questions about issues which may have affected / be affecting each person's hospital attendance – these answers were analysed, referring to the LAC's contact logs for additional information.

Local Area Co-ordinators support people of all ages and backgrounds; however, many of the people introduced to LAC have complex health and care needs. Accordingly, they have many interactions with primary care services.

Darnton et al (2018) note concern from Local Area Co-ordination staff, in the Isle of Wight, about the appropriateness of using hospital based metrics about admissions in assessing LAC[78]. However, as the potential benefits from LAC are felt across the public sector, they are included within this evaluation.

Attendance at Emergency Departments

Between April 2014 and February 2020, 163 of the 200 people supported by Local Area Co-ordination attended the Emergency Department (ED), attending a total of 1,190 times.

Of these 163 people, 45 did not attend ED during the equal period prior to and following the first meeting with their Local Area Co-ordinator; 1 person could not be included in the analysis because they were introduced to LAC before April 2014. Accordingly, 117 people were included in the analysis.

The people included in the analysis attended ED a total of 559 times during the qualifying period; 259 times prior to the first meeting with their LAC and 300 times following this first meeting. This represents a total increase of 41 attendances or 15.8%. However, it should be noted that 6 people increased their ED attendance by 6 or more attendances, totalling 76 additional attendances.

Whilst this is contrary to the aims of LAC and counter to the expected results, more detailed analysis of the results identified that the ED attendances, for this sample of people, fell into three groups; those with:
- Increased attendance (an increase of 3 or more attendances)
- Steady state - little change in their

Table 4.4.1 - Change in the number of attendances to the Emergency Department for an equal prior to and post the first meeting with Local Area Co-ordination

Attendance group	Number of people	Number of attendances:		
		Before the first meeting with LAC	After the first meeting with LAC	Difference
Increase	13	22	135	+113
Steady State	81	87	92	+5
Decrease	13	99	19	-80

Note – 10 people showed small changes with more than 4 attendances prior to and post introduction to LAC

attendance (an overall change of +/-2 with only 4 attendances before or after their first meeting)

- Decreased attendance (a decrease of 3 or more attendances).

Notably, care leavers also fell into all of the three groups.

More detailed analysis, of the issues affecting the people in each group, identified the potential contribution that Local Area Co-ordination, in association with other services, played in the changing ED attendance.

The overall increase in ED attendance can be explained principally by many of the people being supported by LAC either developing new health conditions or having worsening conditions that would be expected to increase hospital attendance – these include dementia and terminal conditions. Of the 13 people who increased attendance (by 3+ attendances), half had either developed a new medical condition or had a worsening condition which may explain this, including the majority of the people with the largest increases.

LAC support has probably contributed to a reduction in attendance for people who have decreased attendance and also people who have shown little variation in attendance (within the Steady State group). Of the 13 people who had decreased attendance (by 3+ attendances), at least 8 people had conditions which may have caused them to 'go into crisis' without LAC support or had non-medical problems which may have caused hospital attendance without LAC support.

The 13 people who have decreased ED attendance (by 3+ attendances) have collectively reduced attendance by 80 attendances, or 80.2%. Whilst it is difficult to project how this may equate to a future reduction in attendance, the NHS identify that the cost of an ED attendance in 2019/20 was between £73 and £338 depending upon the type of department and the nature and category of treatment[79].

13 people reduced their ED attendance by approximately 80%.

Equally, of the 38 people in the Steady State group that had increased ED attendance, at least 14 people had either medical or non-medical problems which may have increased attendance without the support of their Local Area Co-ordinator.

Inpatient admissions

A similar pattern is observed both for people who have had inpatient admissions and outpatient appointments.

145 people had an inpatient admission between April 2014 and February 2020, totalling 800 admissions.

Of these 145 people, 48 had no admissions during the equal period prior to and following the first meeting with their Local Area Co-ordinator; 1 person could not be included in the analysis because they were introduced to LAC before April 2014. Accordingly, 96 people were included in the analysis.

These people had 154 admissions prior to the first meeting with their Co-ordinator and 233 afterwards – an increase of 79 admissions or 51.3%. However, it should be noted that 6 people accounted for 66 of the additional admissions.

All of the care leavers within the sample either had no admissions between April 2014 and February 2020 or only had few admissions, falling into the Steady State group.

As with ED attendance, the overall increase in inpatient admissions can be explained by people having deteriorating health or developing new conditions – these include cancer, heart attacks and organ failures. Of the 25 people who had increased admissions (by 2+ admissions), at least 16 people suffered from deteriorating health or had developed a new condition, including the majority of the people with the largest increase in admissions.

More than half of the people, who have had decreased admissions, either had health problems which may have gone 'into crisis' or had non-medical problems which may have led to hospital admission without support from their Local Area Co-ordinator. These include people that LAC has provided with and/or connected with additional support which has avoided suicide attempts.

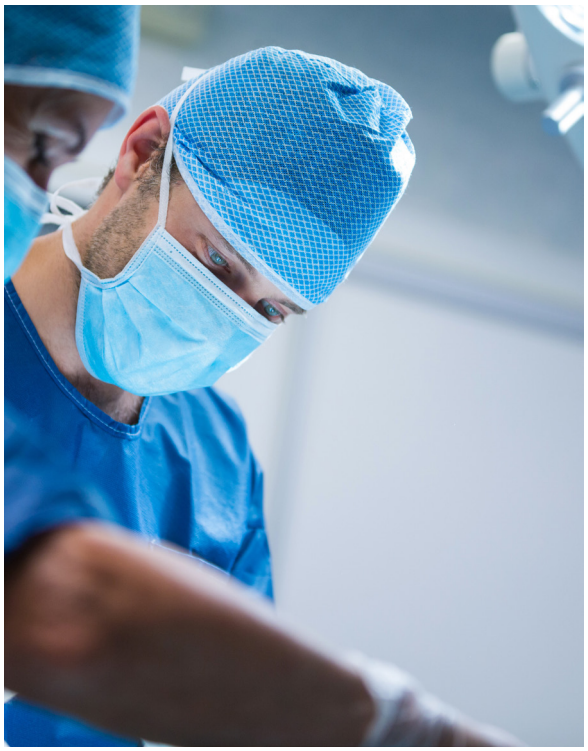


Table 4.4.2 - Change in the number of inpatient admissions for an equal prior to and post the first meeting with Local Area Co-ordination

Attendance group	Number of people	Number of admissions:		
		Before the first meeting with LAC	After the first meeting with LAC	Difference
Increase	25	29	144	+115
Steady State	49	55	57	+2
Decrease	17	70	22	-48

Note – 5 people showed small changes with more than 4 admissions prior to and post introduction to LAC

A similar pattern is observed for people within the Steady State group, at least 22 of whom had health problems which may have gone 'into crisis' or had non-medical problems which may have led to hospital admission without support from LAC.

It is not possible to estimate the number of inpatient admissions which may have been prevented, especially for people within the Steady State group. Further, the cost of inpatient admissions vary greatly depending upon the investigations and treatment performed together with the length of stay. Accordingly, it is not possible to estimate the potential savings that have resulted where LAC, in addition to other services, has supported people within this sample.

Outpatient appointments

Between April 2014 and February 2020, 169 of the 200 people supported by Local Area Co-ordination had an inpatient appointment, totalling 4,715 appointments.

Of these 169 people, 23 had no impatient appointments during the equal period prior to and following the first meeting with their Local Area Co-ordinator; 1 person could not be included in the analysis because they were introduced to LAC before April 2014. Accordingly, 144 people were included in the analysis.

The people included in the analysis attended 2,290 inpatient appointments during the qualifying period; 1,028 times prior to the first meeting with their LAC and 1,262 times following this first meeting. This represents a total increase of 234 appointments or 22.8%. However, it should be noted that 10 people account for 214 of the additional appointments.

Care leavers, who had appointments during the qualifying period, either fell into the Steady State group or had a slight increase in the number of outpatient appointments following introduction to Local Area Co-ordination.

At least 59% of the people who had more inpatient appointments (3+ more appointments) following the first meeting with their Local Area Co-ordinator had either developed a new medical condition or had a worsening condition. This includes all of the ten people with the largest increases in appointments.

Table 4.4.3 - Change in the number of outpatient appointments for an equal prior to and post the first meeting with Local Area Co-ordination

Attendance group	Number of people	Number of appointments:		
		Before the first meeting with LAC	After the first meeting with LAC	Difference
Increase	61	306	828	+522
Steady State	34	31	41	+10
Decrease	38	591	295	-296

Note – 12 people showed small changes with more than 3 appointments prior to and post introduction to LAC

More than a third of people who had 3+ fewer inpatient appointments, and more than half of the people in the Steady State group, either had health problems which may have gone 'into crisis' or had non-medical problems which may have led to hospital admission without support from their LAC.

As with the number of inpatient admissions, it is difficult to estimate the number of appointments or the possible cost savings to which LAC support has contributed.

Overall change in attendance / appointments at University Hospitals of Derby and Burton

Across all three areas, hospital attendance increased within the sample. However, this can largely be explained by people developing new medical conditions or having deteriorating health. Increased attendance is not necessarily undesirable; early intervention to treat health problems can lead to improved outcomes for people and, ultimately, be cheaper than treating people at the point of crisis. Notably, at least 14 people within the sample had underlying health problems that were not being treated before they were introduced to Local Area Co-ordination.

7% of people had underlying health problems that were not being treated before introduction to LAC.

For other people within the sample, it is reasonable to conclude that LAC support, in addition to other services to which people had access, has helped to reduce or prevent unnecessary hospital attendance. However, it is not possible, at this time to quantify any possible changes - more detailed research will be required to understand how LAC support is able to contribute to a reduction in unnecessary hospital attendance.

Further research has been commissioned by Derby and Derbyshire Clinical Commissioning Group into the effect of providing LAC support to people with complex lives who are also high intensity users (HIU) of NHS services. This research will quantify any changes in service usage, and associated costs, for the group of people who have consented to participate.

Derbyshire Community Health Services

The same sample was shared with Derbyshire Community Health Services (DCHS) and similar analysis undertaken for a period of four months either side of people's introduction to LAC - during that period more than a third of the people had contact with DCHS.

As may be expected, patients that have also been introduced to LAC have, on average, more contact with DCHS than other patients. All DCHS patients averaged 8 total contacts during September to December 2019 – for people introduced to LAC, this compares to a four-monthly average of 17.9 contacts.

Analysis was complicated by the cessation of Support Worker services by DCHS, during this period, with those services being absorbed by Community Nursing services; accordingly, patients who were in contact with Support workers have been excluded from the analysis of change.

There is a nuanced pattern of change in the contacts with DCHS for people who have been supported by LAC; 26 patients increased contact and 27 patients decreased contact. Excluding patients in contact with Support Workers, there were 867 contacts in the four months before introduction to LAC and 715 in the four months post introduction – a reduction of 152 contacts. However, at least 165 fewer contacts cannot be attributed to LAC support due to people not engaging with their Local Area Co-ordinator.

Notably, some patients who reduced contact with DCHS were receiving LAC support to deal with non-medical problems that may have been causing needless primary care attendance; others had health problems that

could have worsened, or the person 'gone into crisis' and increased primary care attendance, without LAC support.

It is also evident that the majority patients with the largest increase in their contacts with DCHS had either developed new medical conditions or experienced deteriorating health during the period of their LAC support. However, some people who increased attendance had also started to pay more attention to their health as they had started to socialise more frequently.

As with hospital attendance, increased use of DCHS services is not necessarily undesirable if people are taking more care of themselves and paying greater attention to their health problems. Equally, increased care from some DCHS services, such as Community Nursing, may help to prevent unnecessary use of emergency services.

Further research would be required to fully understand any potential impact of LAC upon DCHS patients.

Recommendations

1. LAC is seen as an integral partner in the development of Derby's Community Urgent Response (CUR) – the council's integrated and rapid community response team, in partnership with the NHS, and led by the Home First and emerging RIIGHT service (Rapid Integrated Independence at Home Team), to help support older people to remain well at home and avoid admission to hospital.

   The CUR project should take note of the key findings of this report and learn from the current application of LAC in the community in avoiding crisis, issues of capacity within the LAC team, as well as ensure the integration of LAC at the council's 'front door'.

2. For people who may have non-medical problems which may be causing unnecessary hospital attendance or ambulance call-out, for example, to explore further the contribution that LAC can make to a change in use of acute services, and the outcomes for these people.

3. To consider the findings from the High Impact User (HIU) project. If this research identifies a reduction in the cost of providing NHS services for this group, options should be discussed with the CCG about how LAC support can contribute to a reduction in unnecessary medical appointments and hospital attendance.

4. At the time of analysis, the LAS adult social care system was missing the NHS numbers of many people supported by Local Area Co-ordination - this reduced the sample size that could be shared with NHS partners for purpose of service evaluation. Consideration should be given about how best to increase the percentage of people supported by LAC who have their NHS number across all of our electronic care systems.

Henry's story

Henry was introduced to Local Area Co-ordination by a local Councillor following a call from Henry's son, who lived away.

The son was concerned about his Dad's deteriorating health and the number of times he was being admitted to hospital following falls in his home. At the point of introduction to LAC, Henry had been in hospital on three separate occasions over the course of two months.

A LAC visited Henry to find out how he was doing. Over the course of the next few visits his LAC recognised that actually Henry was pretty fed up with people interfering in his life, telling him what to do and how to do it. Henry was a proud man and, in his 80s, felt that nobody had the right to tell him how to live.

However, he was confused about some of the things that were going on. During one of his early admissions to hospital he had been prescribed Tramadol; Henry didn't really understand what this was for or how to take it and it transpired that he had been taking it when having a drink of whiskey. This had, unsurprisingly, resulted in an increased number of falls.

His LAC supported Henry to tackle this issue quickly and together they arranged for a medication review with Henry's GP. As the relationship and trust grew, Henry's LAC also started to talk to him about how lonely he felt and the things he was doing to combat this. At that point, Henry was going to his local pub most days - whilst he was going to socialise and see people, he also found it difficult to not drink like he once did as a young man. Whilst he would often get a taxi home, he was finding that he couldn't drink like he used to and would often trip-up over his walking stick, again causing him to have to go into hospital. Together they agreed to make a plan around this. Henry decided that whilst he didn't want to stop going to the pub, he needed to drink socially rather than drinking to get drunk. They had a really frank conversation about Henry's hatred of going to hospital, medical procedures and the need for him to take control of this situation. Soon afterwards, they started to seek support to make adaptations to his home, working with the Healthy Housing Hub to have a new, more secure banister fitted to Henry's stairwell.

Over a period of time and as a result of building a trusting, equal relationship with Henry, his LAC was able to support him to get back on top of life, manage his drinking and his home as a result. Henry has not been admitted back to hospital.

4.5) Reduction in Delayed Transfers of Care

Delayed Transfers of Care (DTOCs), which impact upon the number of available hospital beds are a key priority for the NHS. In Derby, from January to December 2019 there were more than 3,600 delayed days due to the NHS, social care or both.

Health delays account for the majority of delayed days. Whilst Local Area Co-ordination does not impact upon the delayed days due to health, it may reasonably be assumed that it could impact the delays caused by social care or jointly by social care and health reasons.

Of the 568 people with dated forms on LAS, at 5 March 2020, at least 22 people, and possibly as many as 36 people, were either introduced to LAC to prevent DTOCs or had this develop during the period of the relationship. This represents between 3.9% and 6.3% of the people supported by Local Area Co-ordination in the city.

It is difficult to identify the exact number of DTOCs that LAC has helped to avoid due to DTOCs not being recorded on LAS; however, it is estimated that LAC support has helped to avoid at least 25 delayed transfers for these 22 people.

Every person supported by LAC has their own individual needs and aspirations. It is notable, however, that the people who have been supported to avoid delayed transfer typically have greater needs. For those people for whom it has been possible to estimate the number of DTOCs avoided, the average length of LAC support, to date, is 24 months with an average of 1 DTOC avoided per person per year.

LAC support, in addition to other services helping to avoid delayed release from hospital, could potentially contribute to reducing the annual 500+ delayed days due to either social care or both the NHS and social care.

Table 4.5.1 - Number of delayed days in Derby, per month, 2019

Month	Number of delayed days			
	NHS	Social care	Both	Total
January	221	6	0	227
February	314	34	0	348
March	291	42	0	333
April	306	44	30	380
May	291	5	31	327
June	235	31	0	266
July	242	24	24	290
August	236	25	13	274
September	217	36	0	253
October	230	23	0	253
November	239	54	0	293
December	273	84	0	357
Total	**3,095**	**408**	**98**	**3,601**

Source: NHS England[80]

If we assume an average of 3 delayed days per DTOC, and an average of 1 DTOC per person per year, the 22 people for whom DTOCs have been prevented may have totalled as many as 66 days in 2019. This would equate to a possible 11.5% reduction in delayed days caused by social care or jointly by social care and health reasons.

In 2019, LAC contributed to a possible 11.5% reduction in DTOCs for social care / joint social care and NHS reasons.

With the anticipated increase to 765 people being supported each year, LAC may contribute to at least 30 people per year avoiding DTOCs. If we assume 3 delayed days per DTOC at a cost of approximately £350[81] per day, and a DTOC avoided each year during an average 2 year period of LAC support, the cumulative cost savings are sizeable. In year 1, there would be an expected reduction of 90 days (£31,500); from year 2 onwards, the expected reduction would be 180 days (£63,000) per year.

It should be noted, however, that where the person's support network and condition of their home have developed to a standard where they can be safely released from hospital, further DTOCs could be avoided whenever they are admitted. Accordingly, the potential cumulative reduction in delayed days and cost savings would be expected to be greater than those identified above.

Recommendations

1. To undertake further, possibly joint, research with the University Hospitals of Derby & Burton, and Royal Derby Hospital specifically, to more fully understand any potential impacts that LAC has on DTOC.

2. For LAC to explore ways to increase their operational links with the discharge teams at the Royal Derby Hospital.

3. Undertake further research to quantify the number of potential DTOCs that can be avoided, both during the period of their relationship with LAC and after active support has ceased. The data required to analyse Theory of Change outcomes should be reviewed continually and the LAS system updated to ensure that all necessary data for monitoring purposes is being captured.

4.6) Reduced demand on secondary Mental Health services

Methodology

Derbyshire Healthcare NHS Foundation Trust undertook analysis on the sample of 200 NHS numbers on two occasions, matching the list to people who were known to secondary mental health services:

- in January 2020, they matched 115 people
- in March 2020, they matched 127 people.

Aggregated results were provided to Derby City Council.

This sample represents 0.21% of the approximately 55,000 patients open to Secondary Mental Health Services between 1 April 2018 and 10 January 2020.

The people known to both Secondary Mental Health Services and Local Area Co-ordination, appear to place a greater demand on Secondary Mental Health Services than other patients open to the service.

Whilst this is a small sample, the analysis undertaken in January 2020 identified that, compared to other patients open to Secondary Mental Health Services, patients who are also receiving support from LAC have had, on average, a higher number of:

- total contacts (approx. 180 compared to approx. 70)
- crisis contacts (approx. 6.25 compared to approx. 3.25)
- inpatient stays (approx. 0.7 compared to approx. 0.3)
- missed (Did not attend) appointments (approx. 8 compared to approx. 4)
- days open to Secondary Mental Health Services (approx. 360 compared to approx. 260).

This suggests that the people being supported by Local Area Co-ordination have more complex needs than other patients open to Secondary Mental Health Services.

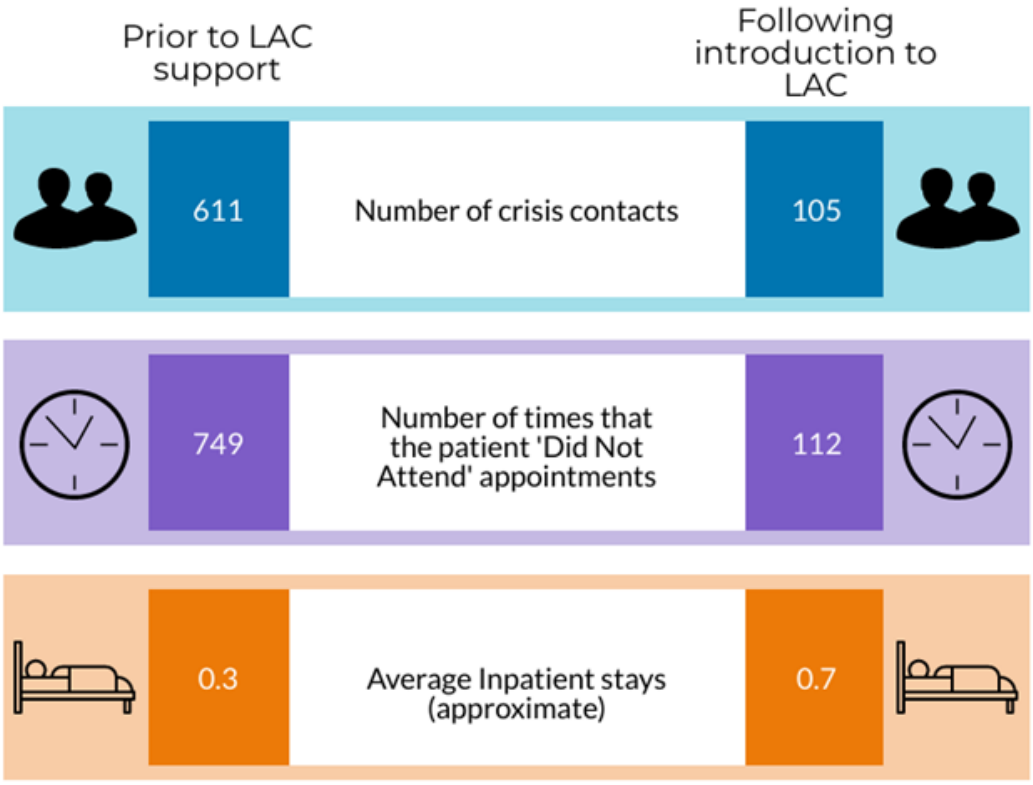
Following introduction to Local Area Co-ordination, there appeared to be a notable reduction in demand for Secondary Mental Health Services and the number of missed (Did not attend) appointments. This suggests that LAC is contributing to a reduction in demand for Secondary Mental Health Services.

However, the analysis is based upon data which does not consider an equal time period prior to and following introduction to LAC. It is therefore difficult to quantify the scale of the impact.

"My Local Area Co-ordinator listened to me when no one else did. [They were] the one I shared my troubles with and helped me navigate through these at a pace I felt comfortable with. [They] helped me explore various mental ill health groups until we found one that I felt comfortable with."

(A Derby resident)

Figure 4.6.1 - Analysis of people known to both Local Area Co-ordination and Secondary Mental Health Services, based on an unequal time period prior to and post introduction to LAC



To address this, further analysis was undertaken in March 2020, for each patient, based on the number of days from their first meeting with a Local Area Co-ordinator to the date that the report was executed. This was compared to an equal number of days of historic activity before involvement with LAC.

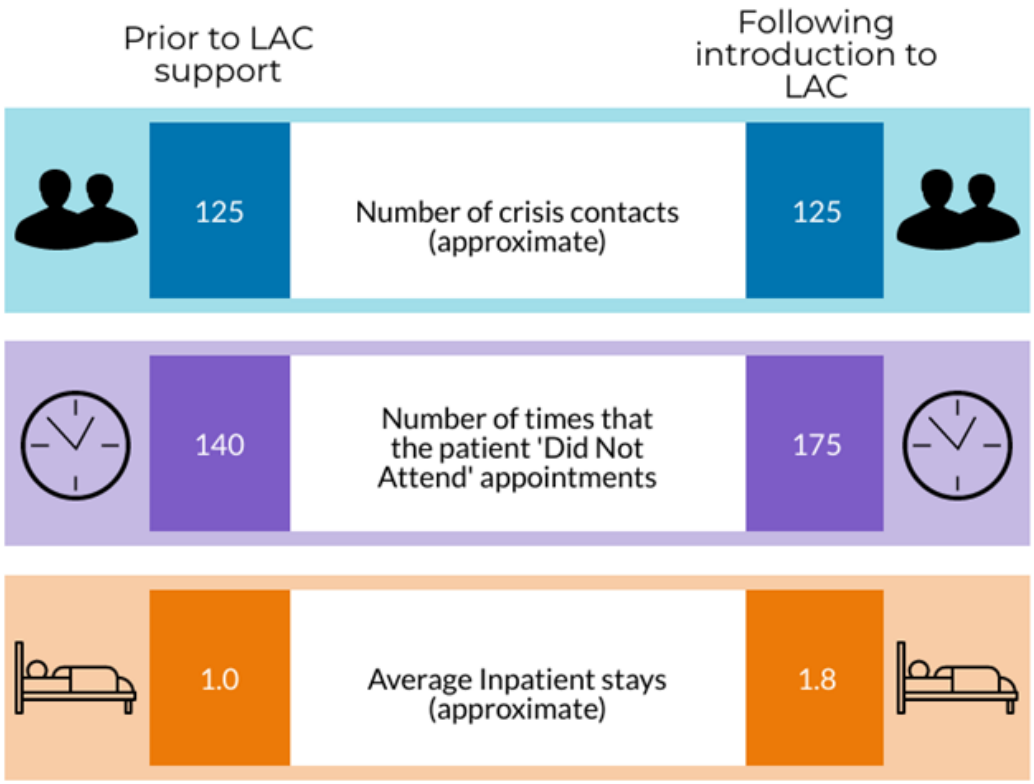
The results suggest that introduction to LAC has not reduced the number of crisis contacts, number of DNAs or average number of inpatient stays. In fact, to the contrary, the number of DNAs and average number of inpatient stays seemingly increase following the first meeting with a Co-ordinator.

However, Derbyshire Healthcare NHS Foundation Trust identify some limitations with the analysis which may negatively skew the results. Patients that started their treatment with mental health services after introduction to LAC were not excluded from the analysis - this will skew the results because there is no pre-LAC involvement data. Similarly, patients that haven't been open to mental health services for a long period of time will not necessarily include their whole history; i.e. they have not had time to undertake their full journey with the services. Accordingly, for example, the rates of people failing to attend appointments (DNAs) won't necessarily show the potential impact a Co-ordinator has had on the service user.

It has not, therefore, been possible to identify the potential impact of LAC upon Secondary Mental Health Services.

Whilst it is the experience of Local Area Co-ordinators that LAC has helped to reduce demand on Secondary Mental Health Services, further research is required to more fully understand the scale and extent of any potential impact.

Figure 4.6.2 - Analysis of people known to both Local Area Co-ordination and Secondary Mental Health Services, based on an equal time period prior to and post introduction to LAC



Recommendation

1. Data demonstrates that approximately 50% of people supported by the LAC team are living with mental health issues that they are managing either through the support of their GP, or secondary mental health services.

   A representative senior leader from within Derbyshire Healthcare NHS Foundation Trust should be invited to join the LAC Custodian Group to support the development of the approach in the city.

2. To undertake further (joint) research with Derbyshire Healthcare NHS Foundation Trust to more fully understand any potential impacts that Local Area Co-ordination has on secondary Mental Health Services and potential benefits to the patients. For example, where LAC support is available:
   a. are mental health outcomes better;
   b. do patients reach outcomes more quickly, leading to earlier discharge;
   c. post discharge, are patients more resilient?

"My Local Area Co-ordinator gave me hope during my most challenging times. I felt suicidal before [they] came into my life and helped me navigate many challenges. Thanks to [them] I am now independent, confident and have connections to my local community. [They are] 'my angel'."

(A Derby resident)

Case study - Sally's story

When Sally was introduced to Local Area Co-ordination, she had a chaotic lifestyle. She had very few friends, had substance misuse problems and was in contact with the police. She had mental health problems which were causing frequent visits to her local GP and the Emergency Department at the local hospital. She was homeless and about to be accommodated into a homeless hostel.

For a while, Sally and her Local Area Co-ordinator only spoke on the phone – things went quiet for a while as she didn't really seem to engage. A little while later, Sally came back to the attention of LAC, having been asked to leave the hostel because of her behaviour.

After she left the hostel, Sally stayed with her sister. However, this wasn't an ideal situation as it was causing distress for both of them; her sister felt very torn as she didn't want to see Sally out on the streets but was worried that having her sister stay with her would have a negative impact on her own circumstances.

Sally and her Local Area Co-ordinator met for the first time in the city centre; at that time Sally shared a lot of personal things about her life and her ongoing struggles relating to her mental health. The fact that she was homeless again just compounded everything for her. Sally struggled to see a way forward and appeared to be at breaking point.

Sally's LAC spent a lot of time with her that first afternoon, listening as she explained her situation. They sat and worked through Sally's main priorities, housing being at the top of the list. They got straight onto it! They were just around the corner from the main Council building, so they used the opportunity to go in and complete a 'homefinder' application; Sally's LAC sat beside her whilst she completed the online form. The next step was to meet with the homelessness team to see what help they could offer her.

Over the course of the following weeks, Sally's mental health seemed to get a lot worse. Nothing was moving quickly enough for her and, even though everyone who was able to help was doing everything possible, she was ready to give up.

Her LAC supported her to visit her GP; Sally was grateful that she didn't have to go on her own and try to explain everything that was going on.

Sally was prescribed a low dose of medication to try and help relieve some of her anxiety; she was to return a week later for this to be reviewed. Meanwhile she had been offered some temporary accommodation at another homeless hostel – this was far from ideal, but it was all she could get.

During one of their meetings, Sally shared some of her artwork with her Local Area Co-ordinator. Sally explained that she uses her artwork to express herself, particularly when she is feeling low. It was immediately clear that Sally had a real talent.

Over the coming months, a trusting relationship developed and her LAC learned a lot more about Sally. Sally talked about wanting to be able to express herself through dance and stage performance, she wanted to find ways to build her confidence and improve her mental well-being.

Through her LAC's knowledge of the local community, Sally was introduced to Jill who was very 'active' and who was a talented artist and dancer. They got on extremely well; Jill took Sally under her wing and accepted her for who she was. By Christmas Sally was fully engaged with a local dance group and had shown significant signs of improvement in terms of her mental health.

Sally started to give back to her local community. She and Jill worked together to plan and deliver a community event for local residents. The event was a huge success and gave Sally a real confidence boost.

It was also through the connection with Jill that Sally made new friends in the community. Sally reconnected with her long-time friend, Amy, and introduced her to Jill, as she too is a talented artist and was able to get involved with the community event.

Sally was eventually offered shared/supported accommodation and has since been a lot more settled. She has stabilised her mental health with the right medication but, equally, she has found new and creative ways to better manage her mental health through making new connections and focussing on what matters to her.

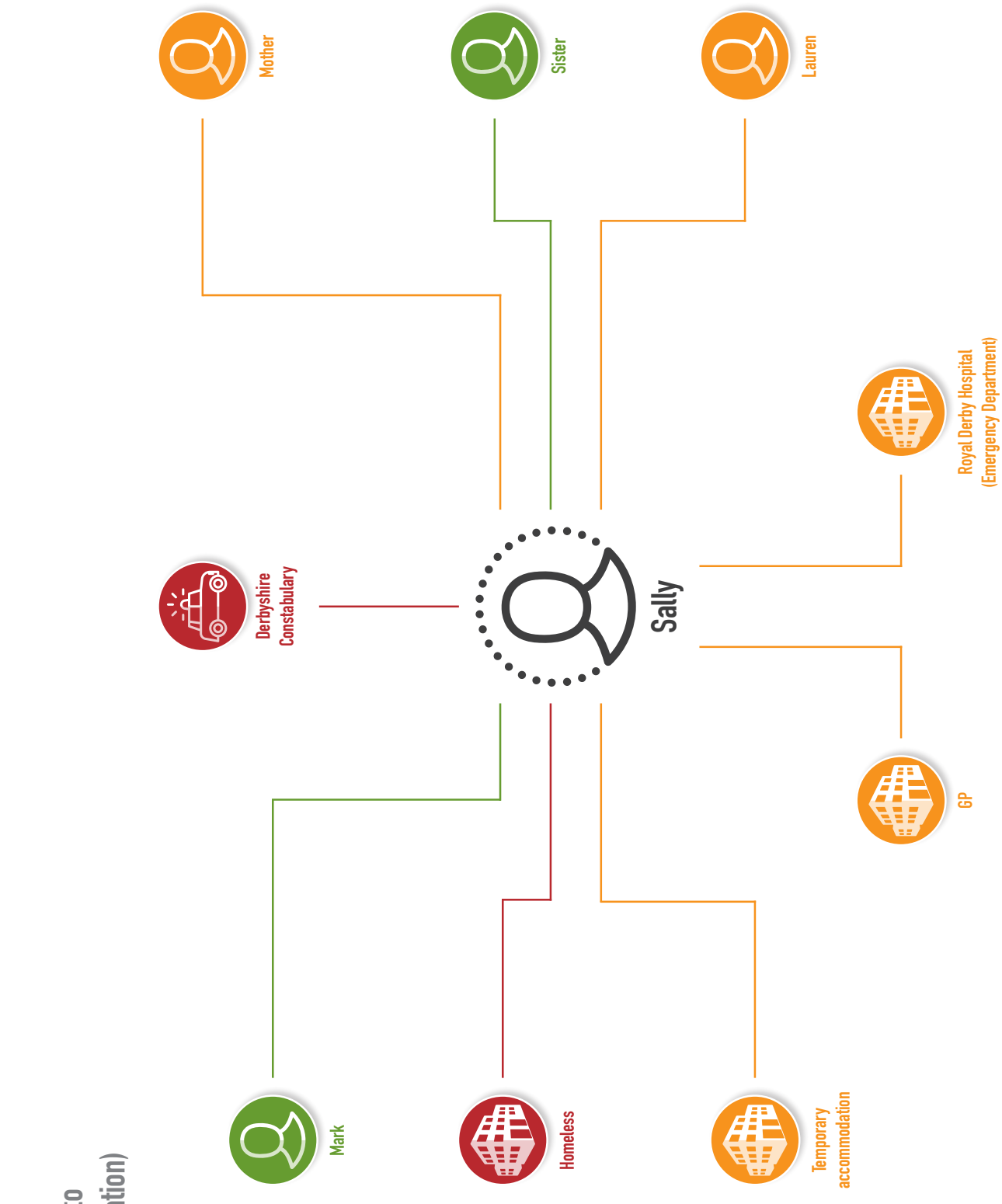
Sally thinks more about the future now, and where she wants to be in life. To help her to work this out, her Local Area Co-ordinator suggested The Prince's Trust programme. Sally thought this was a great idea and would help her to further develop her confidence – she has since enrolled on the programme and has been enjoying it greatly. She is now looking at options for work and university.

More recently, her new-found connection with her local community has come to the fore. During the pandemic, she has played a role in supporting her wider community by supporting a local food bank and assisting with the delivery of food parcels to vulnerable people. She would not have had the confidence to be able to do these things before her introduction to Local Area Co-ordination.

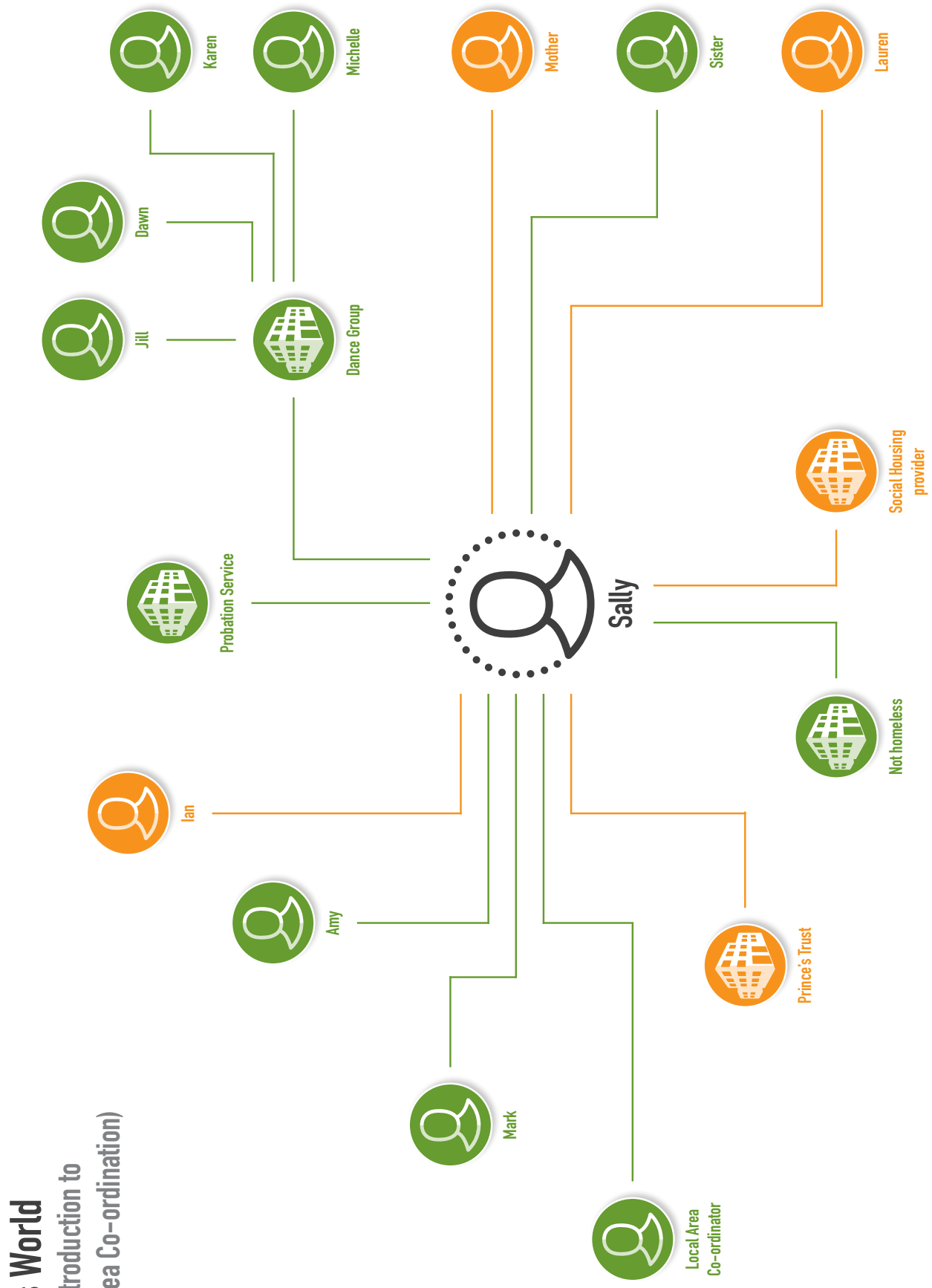
Sally is no longer supported by her Local Area Co-ordinator but they still have a good relationship; Sally knows that she can contact LAC again, at any time, should she need further support.

Addendum

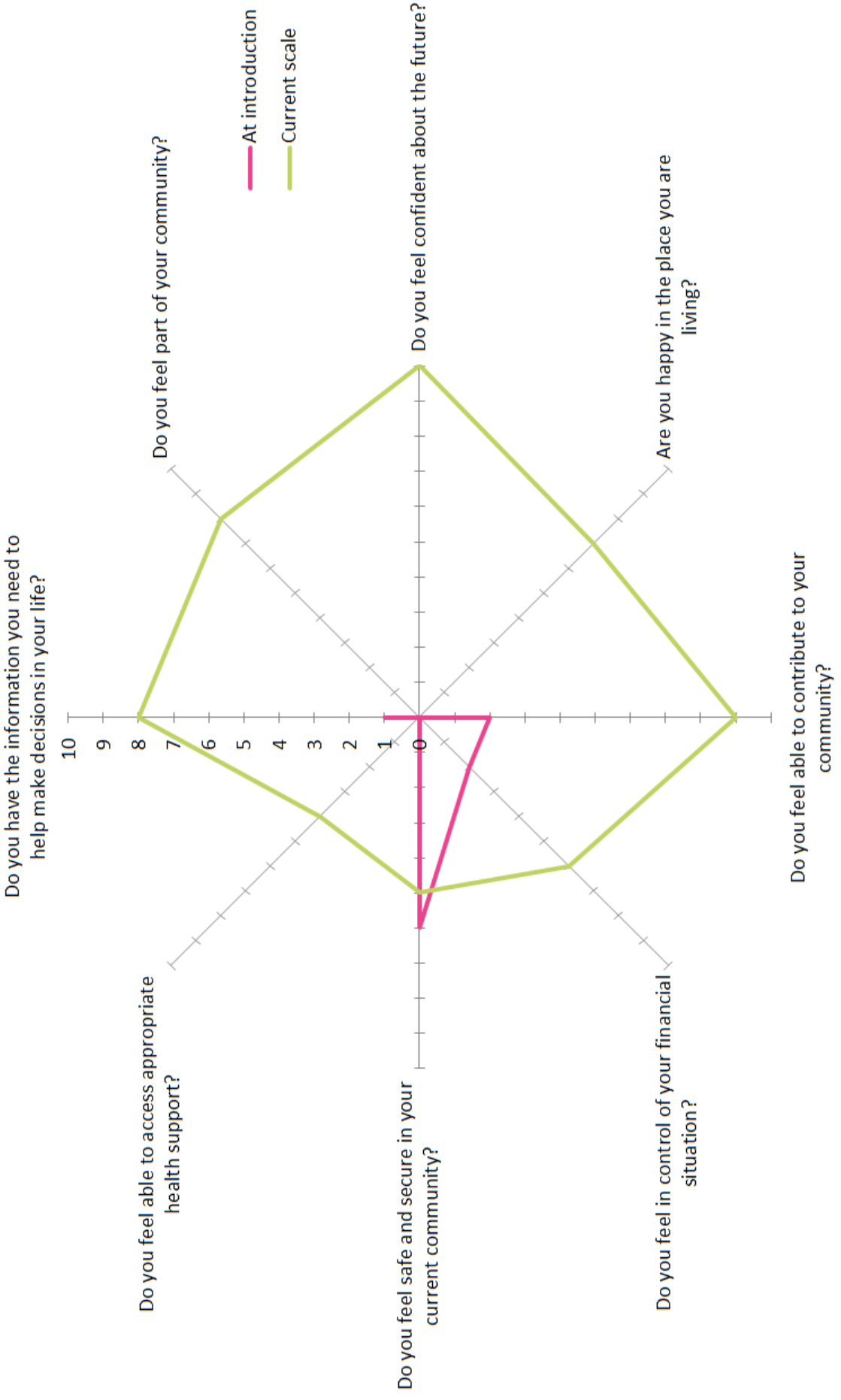
At the time of writing, Sally has been in touch with her old LAC to let them know that she has been offered, and has accepted, a place to study art at university.



Sally's World
(Before Introduction to Local Area Co-ordination)


Sally's World
(After Introduction to Local Area Co-ordination)
Karen
Michelle
Mother
Sister
Lauren
Dawn
Jill
Dance Group
Social Housing provider
Probation Service
Sally
Not homeless
Ian
Amy
Prince's Trust
Mark
Local Area Co-ordinator

Sally's Outcome Star scores



Conclusions

Local Area Co-ordinators generally 'walk alongside' approximately 40-50 people and families, living in their area, who may be facing complex, enduring life situations. This includes a balance of people receiving ongoing light touch support (building and maintaining connections, contribution, capacity), and people who may benefit from ongoing or more intensive support.

With expansion to cover the whole city, it is estimated that 765 people per year will receive active support through Local Area Co-ordination.

Local Area Co-ordination does not operate in isolation of other services. The people introduced to LAC often have multiple and complex needs; accordingly, they are likely to be receiving support from a range of services across the public sector, but especially health and social care services.

Further, support for a resident provided by one service may lead to efficiency savings being realised in another part of the same organisation or within another part of the public sector. It is, therefore, extremely difficult to identify the impact of a single service within the matrix of inter-related services being provided.

Accordingly, this evaluation does not attempt to isolate the benefits which can be attributed only to Local Area Co-ordination. Instead, the analysis of outcomes assumes that Local Area Co-ordination is working alongside all other services that residents may be receiving.

It is evident from the qualitative analysis (see also the case studies included) that Local Area Co-ordination is contributing positively to people's lives, supporting them to achieve their version of a good life by helping them to resolve a wide range of problems, increase their confidence and capacity, maintain their independence and increase their resilience to possible crises.

Through intentional partnership working and connecting people to their communities, local groups and specialist services, there is also evidence that LAC in Derby is helping to prevent, delay and reduce the need for people's use of formal services across the system.

Within the context of LAC operating alongside other services, there is evidence that LAC is contributing positively to the outcomes anticipated in the local Theory of Change.

Residential care

There is clear evidence to support LAC helping to reduce the number of residential and nursing care placements by preventing/ delaying people's entry into residential care. Further, modelling suggests that there are appreciable cost savings being delivered through this prevention / delay.

At least 7.7% of people were either introduced to LAC to prevent admission to residential care or had this as an emerging aim during the period of the relationship. 36.4% of these people have/had homecare packages and would therefore be likely to qualify for council funded residential care. It is estimated that the average cost saving associated with delaying their entry to residential care is approximately £19,396 per person per year

To date, these people have had entry to residential care delayed for an average of approximately 20 months. However, where the LAC relationship has lasted for 4 years, or more, the average delay is approximately 45 months.

With the expansion of LAC to cover the whole city, it is estimated that LAC will potentially be supporting 59 people per year to remain independent in their own homes - 22 of these people are likely to qualify for the cost of their care to be covered by the council. Modelling delayed entry of 1-3 years, potential savings are between £376,376 and £1,129,128 per year before any costs associated with LAC and other services introduced[82].

With an ageing population, it is reasonable to

assume that demand for residential care will increase; there is a clear need to support more people to find solutions that will enable them to take an active role in their community and have their care needs met within their own home.

If, through a combination of Local Area Co-ordination and other services, more people could have their entry to residential care delayed, or prevented, the cost savings could be increased further. If the number of people having their entry to council funded residential care could be increased to 35, potential savings could be increased to £598,780 - £1,796,340 p.a. before any costs associated with LAC and other services introduced.

Social work and social care

More than half of the people introduced to Local Area Co-ordination have been introduced to help them to reable; the Theory of Change identified that LAC would contribute to a reduction in the value (cost) of social care packages and interventions.

For some people, LAC has been successful in achieving this outcome. However, with the deteriorating health of many people in receipt of social care packages, there is a nuanced pattern:

- 12.6% had a reduction in the value of their care package
- 39.7% had no overall change in the value of their care package
- 47.7% had the value of their care package increased.

Where the cost of care has been reduced, the average weekly reduction was £109 – this suggests potential savings of up to £5,668 per person per year before any costs associated with LAC and other support introduced.

Expanding LAC coverage across the city, it is estimated that 234 people with an adult social care package will be supported each year. Of these, 30 people would be expected to see a reduction in the cost of their care package. If the cost of care packages for these people for could be reduced for a period of 1-3 years, potential savings could be between £170,040 and £510,120 per year.

However, it is likely that not all of these costs savings would be realised due to the need to introduce additional services to help people. Further, in some cases, reductions in the value of care packages may occur without any intervention or support from LAC.

There may be other savings associated with the 39.7% of people who saw no change in the value of their care package but further research would be required to investigate this.

Notably, however, 47.7% of people saw the cost of their weekly care increase, with a third of the people supported starting a homecare package - this may be expected with people's deteriorating health. The increased cost of these people was five times more than the savings resulting from reductions in care packages.

Sustaining tenancies

This evaluation has confirmed that Local Area Co-ordination contributes to efficiency savings by helping to reduce evictions and associated costs.

During 2018/19 and 2019/2020, it is estimated that 39.3% of people supported by Local Area Co-ordinators live in homes managed by Derby Homes. For these tenants, it is estimated that LAC has helped:

- 10% to resolve or reduce rent arrears
- 11% to resolve problems with their neighbours
- 21 % to resolve problems with the 'state' of their home and/or garden.

Overall, it is estimated that Local Area Co-ordinators have helped to prevent the loss of a tenancy in 9% of cases. Notably, in at least a third of these cases, the person supported suffered from mental health problems which were affecting their ability to manage their tenancy or to understand the information relating to their possible eviction.

Derby Homes take every possible avoiding action before eviction; it is therefore reasonable to assume a more conservative estimate of 6% for modelling purposes. Assuming that LAC continues to support the same number of Derby Homes tenants, and

assuming a £5,000 average cost for terminating a tenancy, it is projected that annual cost savings could equate to £50,000. However, the actual saving is likely to be lower due to not all of the estimated £5,000 eviction costs being saved with each termination.

Crisis health interventions and appointments

The local Theory of Change identifies that Local Area Co-ordination should contribute to a reduction in the number of crisis healthcare interventions and appointments.

For the sample of people shared with the University Hospitals of Derby and Burton, there is a very nuanced picture of success in this area. Across Emergency Department attendance, Outpatient appointments and Inpatient admissions, hospital attendance increased within the sample. However, this can largely be explained by people developing new medical conditions or having deteriorating health – for each area, the increase is due to a small number of people greatly increasing their attendances.

Increased attendance is not necessarily undesirable; early intervention to treat health problems can lead to improved outcomes for people and, ultimately, be cheaper than treating people at the point of crisis. Notably, at least 7% of people within the sample had underlying health problems that were not being treated before they were introduced to Local Area Co-ordination.

For other people within the sample, it is reasonable to conclude that LAC support, in addition to other services to which people had access, has helped to reduce or prevent unnecessary hospital attendance. However, it is not possible, at this time to quantify any possible changes - more detailed research will be required to understand how LAC support is able to contribute to a reduction in unnecessary hospital attendance.

Delayed Transfer of Care (DTOCs)

Local Area Co-ordination aims to reduce the number of delayed discharges caused by social care or jointly by health and social care reasons. This evaluation has found evidence to support this; it is estimated that at least 3.9% of people were either introduced to LAC to prevent DTOCs or had this develop during the period of the relationship.

It is difficult to identify the exact number of DTOCs that LAC has helped to avoid due to a lack of data recording; however, it is estimated that LAC support, in addition to other services, has helped to avoid at least 25 delayed transfers for this 3.9%.

It is also notable that the people who have been supported to avoid delayed transfer typically have greater needs. For those people for whom it has been possible to estimate the number of DTOCs avoided, the average length of LAC support, to date, is 24 months with an average of 1 DTOC avoided per person per year.

With the expansion citywide, it is likely that LAC may contribute to at least 30 people per year avoiding DTOCs. Assuming an average delay of 3 days, at approximately £350[83] per day, and a DTOC avoided each year during an average 2 year period of LAC support, the potential cost savings in year 1 could be £31,500; from year 2 onwards potential savings could be £63,000 per year.

It should be noted, however, that where the person's support network and condition of their home have developed to a standard where they can be safely released from hospital, further DTOCs could be avoided whenever they are admitted. Accordingly, the potential cumulative reduction in delayed days and cost savings would be expected to be greater than those identified above.

Secondary Mental Health Services

Due to minor limitations within the data shared with Derbyshire Healthcare NHS Foundation Trust, and also within the analysis undertaken, it has not been possible to identify the impact of LAC on Secondary Mental Health services.

Whilst it is the experience of Local Area Co-ordinators that LAC has helped to reduce demand on Secondary Mental Health Services, further research is required to more fully understand the scale and extent of any

potential impact.

Overall

As outlined above, the expansion of Local Area Co-ordination to cover the whole city suggests that potential efficiency savings should increase. Further, subject to capacity, it would be expected that the efficiency savings being observed could be increased with the introduction of more people to Local Area Co-ordination at the correct point of their journey with services.

It should be noted that services which are already seeing high, and increasing, demand may not notice a reduction in demand as more people are in need of the service – they may, however, be able to respond better to people who are in greater need[84].

However, in order to contribute most efficiently to cost savings, and to deliver the maximum benefit to people and local communities, Local Area Co-ordinators must have the capacity to deliver all aspects of their role.

Global experience has identified that, ideally, a Local Area Co-ordinator should work with a population of approximately 8-10,000 people. This size of population enables a LAC to develop a deep knowledge about/connection with local people, places, resources, supports and opportunities - it creates the conditions for building and utilising natural supports and local solutions, developing capacity and social capital.

All wards within the city have a population in excess of 10,000 people. It will be necessary to maintain constant review of the activities that LACs are undertaking to prevent critical parts of the LAC role, notably support for community activities, from reducing. The evidence suggests that decreased community capacity building will lead to increasing demand for services.

Finally, Local Area Co-ordinators are embedded within a community and work in partnership with local people, services, organisations and statutory partners. They do not carry out assessments or solve people's problems for them - their key aim is to build individual, family and community capacity[85]. This is reflected in the Derby Care and Support wedge; Local Area Co-ordination operates at the left side of the wedge:

- developing people's and families' capacity to help themselves
- increasing social capital to enable people to remain independent in their own homes and communities.

If LACs are drawn too far towards the right side of the wedge, service dependence will switch to Local Area Co-ordination and there will be less time to develop community capacity; both are likely to result in increasing service demand.

Notes and references

1. Unless otherwise stated, based on information provided by Ralph Broad and Sarah Edmundson
2. **Broad, R. (2015)** *People, Places, Possibilities* The Centre for Welfare Reform
3. **Local Area Coordination Network (2019)** *It's time for local area coordination* Community Catalysts
4. **Wessex Academic Health Science Network (2018)** I*ndependent Evaluation of Local Area Coordination on the Isle of Wight*
5. Broad and Duffy 2012, updated with Bartnik 2019
6. Developed by Woodhead, N. and Broad, R.
7. As part of the Department for Education (DfE) Children's Social Care Innovation Programme
8. LAC data extract, October 2019
9. Adapted from Local Area Co-ordination cases, June 2020
10. Local Area Co-ordination cases, June 2020
11. **Slater, N. (2014)** *The way forward: a report for care leavers* Barnardo's
12. **HM Government (2016)** *Keep on Caring – Supporting Young People from Care to Independence* HM Government (p.6)
13. **HM Government (2016)** *Keep on Caring – Supporting Young People from Care to Independence* HM Government
14. **Mollidor, C., Bierman, R., Goujon, C. and Zanobetti, L. (Ipsos MORI) (2020)** *Evaluation of the Derby Local Area Coordination Approach* Department for Education
15. Local Area Coordination Network website, May 2020 (https://lacnetwork.org/)
16. **Swansea University (2016)** *Local Community Initiatives in Western Bay. Formative Evaluation Summary Report* Swansea University
17. These savings are in addition to the people currently being supported These potential cost savings are in addition to the savings from residents who are currently having their entry to residential care delayed as a result of LAC support These savings are in addition to the people currently being supported
18. These potential cost savings are in addition to the savings from residents who are currently having their entry to residential care delayed as a result of LAC support These savings are in addition to the people currently being supported
19. These potential cost savings are in addition to the savings from residents who are currently having the cost of their care reduced as a result of LAC support
20. https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/
21. Derived from an estimated cost of £2,500 per week in 2018
22. **The SROI Network (2012)** *A Guide to Social Return on Investment*
23. Your Life, Your Choice – Building the care and support you need in Derby (2020)
24. Local Area Co-ordination Network
25. Unless otherwise stated, based on information provided by Ralph Broad and Sarah Edmundson
26. **Broad, R. (2015)** *People, Places, Possibilities* The Centre for Welfare Reform
27. **Broad, R. (2015)** *People, Places, Possibilities* The Centre for Welfare Reform
28. **Local Area Coordination Network (2019)** *It's time for local area coordination* Community Catalysts
29. **Broad, R. (2015)** *People, Places, Possibilities* The Centre for Welfare Reform
30. **Wessex Academic Health Science Network (2018)** *Independent Evaluation of Local Area Coordination on the Isle of Wight*
31. Bartnik, Broad and Sinclair (2020) – publication pending
32. Broad and Duffy 2012, updated with Bartnik 2019
33. Broad and Duffy 2012, updated with Bartnik 2019
34. Broad and Duffy 2012, updated with Bartnik 2019
35. **Broad, R. (2012)** *Local Area Coordination: From Service Users to Citizens* The Centre for Welfare Reform
36. Developed by Woodhead, N. and Broad, R.
37. Adapted from **Social Care Institute for Excellence (2012)** *Personalisation: an Easy Read Guide* SCIE
38. As part of the Department for Education (DfE) Children's Social Care Innovation Programme
39. LAC data extract, October 2019

40. **Lunt, N., Bainbridge, L. and Rippon, S. (2020)** *Strengths, assets and place – The emergence of Local Area Coordination initiatives in England and Wales* Journal of Social Work 0(0) pp1-24, 11 April 2020
41. Bartnik, Broad and Sinclair (2020) – publication pending
42. Bartnik, Broad and Sinclair (2020) – publication pending
43. LAC summary report, 5 March 2019
44. Adapted from Local Area Co-ordination cases, June 2020
45. Local Area Co-ordination cases, June 2020
46. local area coordination – Fourteen month evaluation report (2014)
47. **HM Government (2016)** *Keep on Caring – Supporting Young People from Care to Independence* HM Government (p.6)
48. **Comptroller and Auditor General (2015)** *Care leaver's transition to adulthood* National Audit Office
49. **Smith, N. (2017)** *Neglected Minds – A report on mental health support for young people leaving care* Barnardo's
50. **Slater, N. (2014)** *The way forward: a report for care leavers* Barnardo's
51. **HM Government (2016)** *Keep on Caring – Supporting Young People from Care to Independence* HM Government
52. **HM Government (2016)** *Keep on Caring – Supporting Young People from Care to Independence* HM Government
53. Derby City Council, Local Area Co-ordination introductions
54. **HM Government (2016**) *Keep on Caring – Supporting Young People from Care to Independence* HM Government
55. **Mollidor, C., Bierman, R., Goujon, C. and Zanobetti, L. (Ipsos MORI) (2020)** *Evaluation of the Derby Local Area Coordination Approach* Department for Education
56. Local Area Coordination Network website, May 2020 (https://lacnetwork.org/)
57. **Reinhardt, G. and Chatsiou, K. (2018)** *Evaluation – Local Area Co-ordination in Suffolk Programme* University of Essex
58. **Swansea University (2016)** *Local Community Initiatives in Western Bay. Formative Evaluation Summary Report* Swansea University
59. **The SROI Network (2012)** *A Guide to Social Return on Investment*
60. **Gamsu, M. and Rippon, S. (2018)** *Local Area Co-ordination in Waltham Forest – A Formative Evaluation* Leeds Beckett University
61. **The SROI Network (2012)** *A Guide to Social Return on Investment*
62. **Gamsu, M. and Rippon, S. (2018)** *Local Area Co-ordination in Waltham Forest – A Formative Evaluation* Leeds Beckett University
63. **Wessex Academic Health Science Network (2018)** *Independent Evaluation of Local Area Coordination on the Isle of Wight*
64. **Broad, R. (2015)** *People, Places, Possibilities* The Centre for Welfare Reform
65. Your Life, Your Choice – Building the care and support you need in Derby (2020)
66. Your Life, Your Choice – Building the care and support you need in Derby (2020)
67. Following a review of aims, with Local Area Co-ordinators, to compensate for believed under-recording of activity against theory of change indicators
68. These potential cost savings are in addition to the savings from residents who are currently having their entry to residential care delayed as a result of LAC support
69. Personal communication – Derby City Council, Business Intelligence Team, July 2020
70. Personal communication – Derby City Council, Business Intelligence Team, October 2020
71. These potential cost savings are in addition to the savings from residents who are currently having their entry to residential care delayed as a result of LAC support
72. These potential cost savings are in addition to the savings from residents who are currently having their entry to residential care delayed as a result of LAC support
73. These potential cost savings are in addition to the savings from residents who are currently having their entry to residential care delayed as a result of LAC support
74. Definition from the Social Care Institute for Excellence - https://www.scie.org.uk/reablement/research/emerging-practice-messages

75. This excludes people who have only received a one-off payment and people who have only used Home First upon discharge from hospital
76. 24 people were excluded because they entered residential care, it was considered inappropriate to include them (for example, as their care package started on the same day as their first meeting with their Co-ordinator) or it was difficult to assess the value of their care package through time
77. Derby Homes Limited is an Arm's Length Management Organisation (ALMO) created by Derby City Council to manage, maintain and improve its council houses and estates. It is non-profit making and is 100% owned and controlled by Derby City Council
78. **Darnton, P. et al (2018)** *Independent Evaluation of Local Area Coordination on the Isle of Wight* Wessex Academic Health Science Network
79. NHS 2019/20 National Tariff Payment System: national prices and prices for emergency care services
80. https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/
81. Derived from an estimated cost of £2,500 per week in 2018.
82. These savings are in addition to the people currently being supported
83. Derived from an estimated cost of £2,500 per week in 2018
84. **The SROI Network (2012)** *A Guide to Social Return on Investment*
85. Local Area Co-ordination Network
86. Local Area Co-ordination Network
87. Local Area Co-ordination Network

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Appendix 1 - The 10 principles of Local Area Co-ordination[86]

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

Appendix 2 - What Local Area Co-ordinators Do / Don't Do[87]

What Local Area Co-ordinators do

Alongside Individuals, Families and Carers, Local Area Co-ordinators will:

- **take time to get to know** local people, families and the local community well and develop effective, trusting relationships and partnerships that are sustainable;
- understand the need to ask the **right question** – 'what is a good life?' instead of 'what services do people need?'
- assist individuals and families to imagine better, have a **vision for a positive future**
- support individuals and families to identify their **strengths, goals and needs**;
- support people to **plan for the future**, promoting self-sufficiency and not dependency;
- help people to develop **practical ways** of doing the things they need or want to do and to overcome issues or problems that may prevent them from achieving personal goals;
- think **"local and natural" first** – "How does anyone else pursue their aspirations, solve problems or get their needs met?
- help to **build capacity in individuals and families** with the key aims of self-determination and self-sufficiency, rather than just providing a service to help 'fix' a problem.
- hold **positive values and assumptions about individuals**, their families and carers and the local community;
- support people to make **choices**;
- support people to be **part of and contribute to** their local communities and share their gifts, skills and experience;
- help people to develop supportive, **natural personal relationships** and connect with local people, community groups, organisations and mainstream services and formal services (if required)
- provide **timely, accessible and relevant information** in an variety of ways to enable individuals and families to **make their own decisions**;
- promote **self-advocacy**, advocate with people, access independent advocacy
- help people to **access, navigate, choose and control supports and services** if required;
- assist individuals and families to consider safeguards.

Working with local communities, Local Area Coordinators will:

- be based in a range of predictable **accessible, local places** within the local community;
- focus on **natural networks** and community supports;
- build **partnerships** in community and assist people to come together.
- contribute to building **inclusive and welcoming local communities**;
- help to **build community capacity** and resources to underpin the natural support available to individuals and families;
- raise **community awareness** of and support for people with disabilities, mental health needs and older people and/or their families/carers;
- help to develop **community leadership** skills of people with disabilities, mental health needs, older people their families and carers in the local community;
- promote **inclusion and contribution** of people with disabilities, mental health needs, older people, their families and carers in all aspects of community life i.e. social, economic, cultural and environmental;
- **challenge negative attitudes** that deny equal access to the same opportunities and services as other people in the community;
- establish an ***identity as a community resource that is connected to and part of the community*** in which they are based.

- assist communities, groups, organisations and services to intentionally and strategically include people with disabilities, mental health issues older people and families as valued contributors.

Decisions made that affect people's lives are made by the individual and/or their families and carers and any authority for a Local Communities Coordinator to act on these decisions is given by those individuals and/or their carers and families.

What Local Area Co-ordinators do

A Local Area Co-ordinator is embedded within a community and works in partnership with local people, services, organisations and statutory partners.

The key aim of Local Area Co-ordinators is to build individual, family and community capacity; i.e. the goal of the Local Area Co-ordinator is to not be needed or to be needed less over time.

They offer ideas, not solutions – they are not in the role of, nor must put themselves in the situation of decision maker.

Local Area Co-ordinators do not:

- assume responsibility for people's actions or inaction
- stay within formal "office" settings and expect people to come to them
- assume responsibility, even in the 'perceived' absence of others in the individual or family's life
- "own" peoples issues
- judge or "monitor' individual/family circumstances
- 'rescue' individuals or families
- "take over" or do "to" or "for" people
- solve individual's/family's problems for them
- carry out statutory assessments
- manage care packages or budgets on behalf of people.
- act as a support planner or control access to funding (e.g. care planning, budget allocation/personal budget assessments etc.)
- "fit" people into existing services
- replace appropriate specialist support
- replace natural supports or solutions e.g. Local Area Co-ordinators do not become a "taxi service", but help people find natural, sustainable ways of accessing their preferred opportunities.
- deliver a time limited intervention
- receive or give referrals
- "specialise" support to people with particular labels e.g. 'Autism Local Area Co-ordinator' or 'Older Persons Local Area Co-ordinator'
- allow their relationships with individuals/families to become those of personal friend. Local Area Co-ordinators recognise that they are paid workers and a paid context establishes a very different relationship to that which is "freely given"
- have split roles, e.g. 'Local Area Co-ordinator/Case Manager', 'Local Area Co-ordinator/Prescriber', 'Local Area Co-ordinator/Support Planner'.

Derby City Council

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