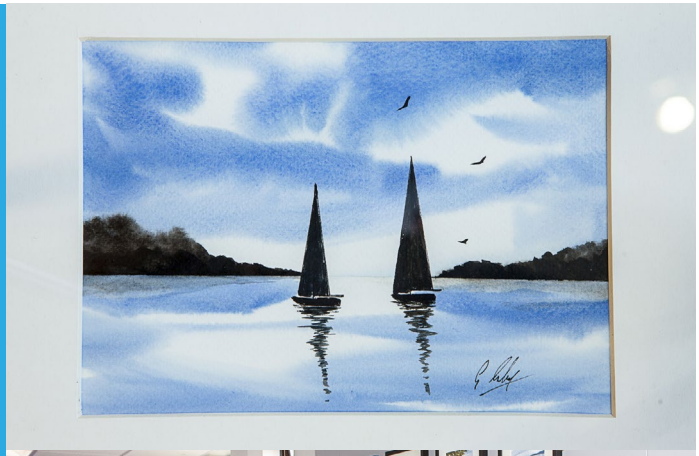
Alongside

Stories of local area coordination®

ALONGSIDE

Cover image:

The picture of the two ships on the front is by Gary Crosby from Swansea. We love this picture as it is such a great metaphor for Local Area Coordinators being alongside people during their journey. With Local Area Coordinator Dan alongside Gary they found a way to share his incredible gifts by exhibiting his art work with a local veteran's group. Gary decided to donate his art portfolio to the group with proceeds from a sale going to support their work. Gary is now continuing to support his community by helping people with art therapy sessions. He is feeling happier and more hopeful for the future as a result.

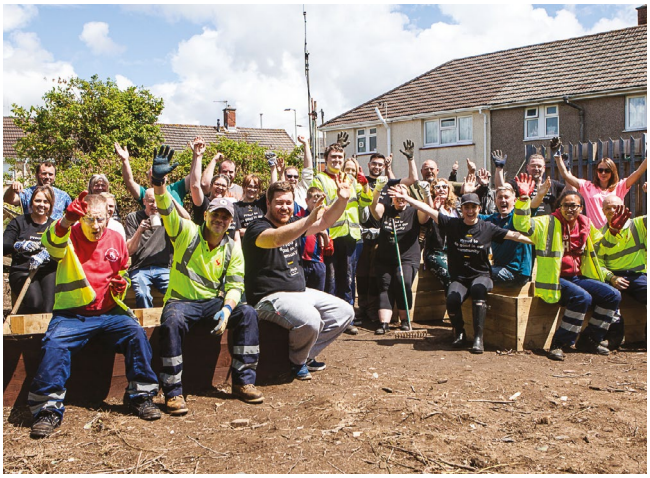


STORIES OF LOCAL AREA COORDINATION

Local Area Coordinators are typically employed by local authorities but recruited by and rooted within the communities they serve. Their mission is to help anyone who needs support in that community to achieve their vision of a good life, whatever that may be. Through their detailed knowledge of the local area, Coordinators help people develop natural supportive relationships and tap in to opportunities local to them. They also help people establish new solutions where there are gaps and support existing groups and organisations to grow and sustain their work. By always building on what is strong and by taking prompt, practical, person-centred action, Coordinators are able to support people to prevent or reduce the things that are going wrong in their lives. This gives people the space and capacity to become a contributing member of their community sharing their gifts with those around them.

The evidence from 14 academic evaluations highlights three main impacts of Local Area Coordination:

1. **Individuals and families become healthier, happier, stronger, better connected and with greater opportunity to make a contribution to their community.**
2. **Communities become more inclusive and self-supporting places.**
3. **Stretched and underfunded service systems are relied upon less as people are able to find local, natural solutions instead.**



There is a bigger picture to this though. Coordinators are also tasked with sharing the rich and detailed picture they see with their local strategic leadership groups. This group is typically made up of representatives from the local authority, health, voluntary sector and local community members. The purpose of the group is to grow and drive the Local Area Coordination model approach forward but also to make the most of the learning coming back from communities. This learning helps to promote wider cross-system collaboration, ways to reform local processes and opportunity to apply similar place and strengths-based practice across other parts of the system.

There are currently 11 local authorities across England and Wales who have adopted this model as part of their vision for stronger, more inclusive and self-supporting communities. The unique Local Area Coordination Network (part of Community Catalysts) has been established to help create space for the Coordinators and Managers from those areas to connect, share and learn from each other. Peers regularly meet for support and advice across the Network and meet in facilitated regional gatherings. This network community approach helps people stay true to the principles of the Local Area Coordination model and to find ways to grow and sustain it.

THE STORIES...

Local Area Coordination begins with an introduction and an initial connection between a Local Area Coordinator and someone in their community. These twenty stories are about what happened next. You will see that they follow a similar pattern:

- **The initial introduction to the Local Area Coordinator was one that happened naturally through the community or via a service partner. It was open, timely and not limited by deficit-focussed assessment criteria.**
- **The person and the Coordinator formed a relationship that was built on their vision for a good life. The Coordinator's role was to help them identify their strengths, hopes and dreams and to connect with the natural, local resources around them. The relationship was not focussed on what was wrong and what was missing for them, although finding solutions to immediate and pressing issues was often the starting point.**
- **Practical action was taken so that people weren't passed from pillar to post and didn't fall through the services net. The approach promoted collaborative working with service partners.**
- **Whilst the relationship was open ended, no unnecessary dependencies were formed.**
- **As a result, people built on their natural authority, took control and made supportive, natural relationships with those around them. They became happier and healthier. They became contributing citizens in their communities and beyond. They needed services less.**

The Local Area Coordinators didn't achieve these outcomes, the people who the stories are about did. What the Coordinators did do was to use a very particular, principled and evidence-based approach that works. They knew what the right amount of support looked like, not too much, not too little. They knew the community inside out and they shared that knowledge with those they were alongside.

For more information please see our latest report It's Time for Local Area Coordination or contact:

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IMPACT THEMES INDEX

1 CHANGING PATHS
COLIN'S STORY

In this extract from Colin's story we hear about the powerful contribution people can make to the physical safety of their communities when they work together.

Colin was spending as much time as he could with his wife after she had to move in to a care home. They would regularly go out and about together in the local area. One day they were involved in an accident where her wheelchair struck an uneven path resulting in a serious injury to her face. Colin's wife needed surgery and was unconscious for several weeks as a result. Naturally this accident hit Colin hard. He quickly found himself on a path to illness as his mental health deteriorated as a result of the stress and trauma incurred. It was at this point that Debbie, a Local Area Coordinator, was introduced to Colin via his granddaughter who heard about Local Area Coordination from the community pharmacist. Colin told his story to Debbie who listened before explaining what Local Area Coordination was all about. Debbie then asked Colin what would help him make his life better? Colin said that in the short term he would be reassured to know that a similar accident never happened again by safety changes being made to the path.

Debbie and Colin agreed to work together in bringing his vision to life.

They explored together how this might happen in practice which included Debbie being alongside Colin to phone the land owners and discussing the introduction of a hand rail and markings. Colin was very clear from the outset that this wasn't about blaming others, it was purely about making sure it didn't happen again.

The land owners acted immediately by installing a handrail and painting luminous markings along the steps. Everything was in place within four weeks. On completion, Colin asked Debbie to walk alongside him when he visited the accident spot for the first time to see the improvements. Colin also wanted to thank the staff from a local shop, who helped him at the time of the accident. After the visit Colin felt more confident to drive past the spot meaning he could use a much quicker route to see his wife whilst she remained in hospital for several more weeks.

2 OVERCOMING ADVERSITY AND MOVING ON
DAVE'S STORY

Dave was going through a tough time when he first met his Local Area Coordinator. In his story we hear how the powerful principles of information, choice and control allowed him to grasp his natural authority and move towards his vision of a better life.

Hazel, a Local Area Coordinator, met Dave at a food bank after someone who worked there suggested she introduce herself to him. He appeared very withdrawn, he was shaking and seemed unwell. It transpired that he was struggling with serious headaches and deteriorating mental health. He was also grieving the loss of his brother. He was divorced, with two grown up children and his relationship with them had broken down. He only had a couple of acquaintances. All of this pressure was impacting on his work and income. He had little money and was on the brink of destitution.

Hazel and Dave got to know each other over a series of meetings and began to build a trusting relationship together. She walked alongside Dave as he sought what he needed from both the mental health team and his GP. He was struggling to get what he was looking for and felt that this was making his health worse and he was having suicidal thoughts. Hazel helped Dave access the information he needed to explore his rights around changing his GP practice so he could get the support he was looking for and identify positive ways to get the most out of his meetings with the mental health team. They also explored welfare rights and found some discretionary funding to support Dave during his hardship.

Through finding a new GP, Dave was able to be seen by a consultant who told him he needed oxygen in order to reduce his headaches. As a result of his employer not agreeing to make reasonable adjustments for his health, Dave was dismissed from work. Through an introduction and advice given by ACAS he was able to challenge the decision though and settle out of court.

Hazel supported Dave to connect with a community employment organisation. Dave was eventually able to gain self-employment as a delivery driver, something he had identified as a perfect job for him. He has paid off his rent arrears and nearly cleared his council tax arrears.

In terms of his health, Dave managed to stop taking pain relief medication. He is managing his cluster headaches with the oxygen and is feeling much better and stronger.

As Dave's mental health has improved, he has been able to reconnect with his two children and is now a very busy man.

Some months on Dave has sustained his driving job and is loving it. He is socialising with his work mates, has remained debt free and is now saving money. He has maintained his connection with family and sees them more often. His cluster headaches have reduced to the point where they no longer concern him. He currently does not need to see Hazel regularly but knows she is there should his mental health dip again or he just needs a cuppa and chat.

3 THE A TEAM
GILLIAN AND MICHAEL'S STORY

In Gillian and Michael's story we hear how the services in their lives became complementary when everyone started working together as a team with them at the centre. We also here how processes were changed in order to better support them.

Gillian and Michael, a mother and adult son living together, both have Autism. Their lives had become very complex with a number of things impacting in a tangled way which was difficult to unpick.

Gillian and Michael's Housing Management Officer was the first member of what Gillian later referred to as her 'A Team'. The Housing Management Officer had concerns that something was not quite right for them - the rent account had gone into debt and there were complaints about the rubbish piling up in the garden. She was keen to try and get the family the help and support they needed before going down an enforcement route so she introduced them to Jennie, their Local Area Coordinator and the next member of the A Team.

Gillian explained that she had started drinking heavily after the death of her father eight months previously and had lost her job after turning up to work intoxicated. Gillian had cared for her father whilst he was terminally ill – alcohol and prescription medication became a coping strategy which quickly became an addiction, then a dependency.

Michael, Gillian's son, had been trying to care for his mum and continue working in his part time job but was feeling under a lot of pressure – they had been struggling to keep on top of the bills and maintain the house, he was anxious about his mum's health and didn't want to lose her.

Gillian started to work with drug and alcohol services - her keyworker and nurse becoming the next members of the A Team. Jennie connected them all with a Citizen's Advice caseworker to support them with their financial issues and he joined the team too.

It quickly became apparent that a community detox wouldn't work for a number of reasons. Gillian's poor health meant rehabilitation became a pressing need. Drug and alcohol services and Jennie worked with each other to put together a compelling case for out of area rehabilitation and a place was eventually allocated. This was a significant turning point.

The A Team is a model example of services working together to complement the role of individuals and families in achieving their aspirations for a better life. Gillian and Michael's A Team worked well together in a complex situation when 'silo working' often becomes the tendency, making things even more complex. There were a number of factors which brought this A Team together with the most important being that Gillian and Michael were lead members of it. The A Team maintained good communication throughout, when the combination of factors impacting on this family were often overwhelming. Having Jennie, a Local Area Coordinator who was able to coordinate that communication was helpful but this relied on all of those involved listening to each other with understanding and their focus being on Gillian and Michael. There was a collaborative agreement amongst those involved to work together to meet the family in surroundings where they felt comfortable. This included flexing processes to meet them at home in services where appointments would usually be in an office. Gillian and Michael came as a package and preferred to be seen together, members of the A Team recognised this and didn't try to separate their support and care. The relationships and the very human conversations held made all the difference.

The flexibility of the Local Area Coordination model in this case played a big part in inspiring the service partners to take a more flexible approach in the future. This was one factor of many which created this dream example of joint working at all levels. Gillian recognised a common thread with members of the A Team that

> **"they weren't rigid professionals but people who came in as human beings."**

4 IT'S NEVER TOO LATE TO LIVE YOUR BEST LIFE
JOAN'S STORY

In Joan's story we hear how she was able to get the care she needed with progressive vascular dementia whilst simultaneously building strong relationships with others and getting more involved in her community. We also hear how her Local Area Coordinator supported her and her family to ensure services were complementary with Joan at the centre.

Joan was 84 when she was introduced to Local Area Coordinator, Lisa. Joan was concerned that she had become isolated and wanted to build on her social connections in her community.

When Lisa met Joan and her daughter Amy she found her to be a chatty, energetic and affable lady. Joan explained to Lisa that she had always been an active person and enjoyed socialising and learning new skills.

Amy explained that Joan would often forget things and so she had devised a large board with dates and appointments that Joan could look at every day. It was evident throughout the visit that Joan was struggling with her memory. They discussed various activities available in the community and Joan was keen to get involved in everything suggested.

Lisa and Joan attended the local Mothers' Union meeting at her local church and she was warmly welcomed by the members. They also attended a dance party where Joan chatted to other attendees and assisted by making sure everyone was supplied with tea and cakes. They went along to the monthly coffee morning at the Church and Joan socialised with old neighbours and friends she knew from past keep fit classes.

During this time, Amy let Lisa know that Joan had officially been diagnosed with Vascular Dementia. Having had experience of supporting people receiving this news and knowing how daunting and upsetting it could be, Lisa arranged to visit Amy at her home to offer advice and support in how to assist Joan in the future.

She suggested that Amy request a Carer's Assessment via Social Services and provided information about a small community day centre run by the Carers' Centre. They contacted the centre together and arrangements were made for Amy to take Joan for an assessment the following week. They also discussed financial and legal matters such as Carer's Allowance, Power of Attorney and Joan's financial situation.

Lisa continued to meet with Joan on a weekly basis to help her attend social events in the area, and kept in touch with Amy via email and telephone.

Joan's health continued to deteriorate and she was hospitalised over Christmas and New Year. Lisa visited her in hospital finding her content and chatty, but struggling to follow a long conversation and repeating herself. Joan's dementia was progressing rapidly throughout her stay in hospital resulting in a psychiatric assessment concluding she would be unable to remain at home without 24 hour supervision. The painful decision was made by Amy to source a residential home for her mother.

Joan has now settled well into a home nearby and receives regular visits from friends and family. Although upset by having to make this decision, Amy is content that her mother has the level of support needed to ensure she remains safe and happy in her new home.

Amy remains in contact with Lisa via email and is grateful for the assistance provided to both her and Joan. Amy recently contacted Lisa saying

> **"Thank you for all your help and assistance. It's been a traumatic few months, made easier by knowing you were on hand to guide, advise and support us."**

5 BRAVE STEPS TOWARDS A BETTER LIFE
CASSIE'S STORY

In this story we hear about Cassie, a woman in her 20s struggling with an abusive relationship and deteriorating mental health. We see that through building a relationship with her Local Area Coordinator, Cassie was able to harness her natural authority, take control of her situation and make choices that took her closer to her vision of a better life.

Cassie contacted her Local Area Coordinator Sarah after seeing one of her postcards in the area. They met the following week and started to talk about what was important to Cassie and what she wanted to achieve out of her life. Cassie explained that her mum had passed away when she was a young child and her father struggles with addiction. She grew up in a different city, and had to move due to being abused by a family member. She was homeless when she moved to her new community a few years ago and had worked hard to maintain her tenancy once she secured it. Cassie had been volunteering locally and also in the city centre, but she felt that she had not been managing her mental health particularly well.

Sarah and Cassie worked together to think about her options to address what she felt the pressing issues were. She decided that she would like to try counselling therapy and, with a little bit of guidance from Sarah, quickly started with therapy. She found that the therapy really helped her to manage her day to day feelings and to keep her on track with moving forward.

As they got to know each other, Cassie confided in Sarah about her relationship with her partner which was both violent and abusive. She felt she could not get out. Sarah listened and together they agreed to complete a safeguarding referral which led to providing the Police with a statement. Doing this enabled Cassie to access support from the Domestic Violence team. She was eventually able to leave her partner, which she told Sarah was as a result of the support she was receiving. After doing this Cassie felt she would like to move back home to where her support network was in order to remain safe, be supported and to move forward with her life.

Sarah helped Cassie to apply to be rehoused to an area where she had a network of family and friends. By supporting Cassie to gather evidence of the recent circumstances of her relationship and the risk she faced, she was accepted by another Local Authority and started bidding on suitable properties. Recently, Cassie went to view a property which she really had her heart set on, and was accepted.

She will be moving to her new home soon and is absolutely over the moon as it is down the road from her grandmother who she is close with and visits often. Cassie told Sarah she wants to settle down there and make it her forever home.

Cassie also met a lady from a nearby street whilst she was at an event organised by Sarah. Sarah suggested they share a taxi home due to the lady being visually impaired. Cassie helped her home and has continued to check in on her since, she's also been to the shop for her a couple of times. Cassie explains that although she didn't feel like she could continue to formally volunteer in a support role, she really enjoys helping this neighbour out and her help has been gratefully received.

Cassie is now focussed on moving and looking at her options for going to University as she thinks she would like to pursue a career in social care. She has the self-belief that this is achievable as she has accomplished so much in recent months. Cassie told Sarah she now realises how strong she is.

6 COMMUNITY IS THE BEST MEDICINE
ALISON'S STORY

In this story we hear about Alison who, with a bit of information and encouragement from Local Area Coordinator Tammy, was able to tap in to powerful community resources that helped her with her inclusion and health goals.

Alison was introduced to Tammy by a Care Management Officer in Social Services. Alison told Tammy that she had a learning disabilitiy and lives independently although she finds it difficult to socialise in groups as she gets very anxious. She had become very isolated since stopping work and being unable to volunteer. Alison also had health concerns around her diet and lifestyle. Alison's family were very supportive but keen that Alison formed new friendships in her community as she could become quite low due to her being isolated.

Tammy and Alison spent time getting to know each other and built a trusting relationship together. As their relationship strengthened Alison started to feel comfortable to visit some local community cafés with Tammy.

After meeting people at the cafés Alison now visits these independently every week and is looking forward to exploring other new activities and groups.

Tammy also supported Alison to connect with a healthy eating programme where she is able to get healthy eating and healthy meal preparation advice which she practices at her flat.

Tammy continues to walk alongside Alison when Alison wants and they plan to explore other groups or activities she may like to join too, specifically those which will help her achieve her goals of becoming healthy and active. Tammy and Alison are also exploring new volunteering opportunities as this was something which brought Alison great joy.

7 MAKING SENSE OF CONFUSING COMPLEXITY
JIM'S STORY

Jim's story highlights the role that Local Area Coordinators can play in helping people make sense of things at a time of rapidly declining capacity, ensuring services are complementary and are there when needed. It also highlights the importance of knowledge and information in helping people make the right decisions at the right time.

Jim was introduced to Local Area Coordinator Lisa via staff from the housing association he lived with. He was living alone and had suffered a stroke 2 years ago. He was experiencing memory problems and had recently attended a memory clinic and was awaiting results.

At their first meeting Jim struggled to recall how he was spending his money, why he was taking out doorstep loans and how he accrued credit card debt. His flat was dirty and unkempt and he smoked a lot. He confirmed he had difficulty getting to the toilet on time as he was often incontinent.

Lisa and Jim discussed his interests past and present and how he usually spent his days. He said he did not have any hobbies, although he enjoyed visiting the town centre on a daily basis and having breakfast at a local café. He said he did not have close friends and explained he had always preferred his own company. When Jim's wife was alive they used to enjoy going out for a drink, however, he no longer went to the pub due to his diabetes.

Lisa and Jim discussed what he wanted and whether he was keen to meet people or attend any social activities, however he explained he did not enjoy that sort of thing. Later that day Jim showed Lisa his bank book which had a balance of £4000+ credit. He was unable to explain why he was taking out door step loans when he had so much money in the bank.

As Jim explained more to Lisa it transpired that he had been receiving a lot of scam mail and sending money to various places in response. With his consent, Lisa contacted Trading Standards who arranged for an officer to visit him to discuss options available to prevent more scam mail from being delivered. Jim was happy for the officer to prevent further contact. With Jim's consent the officer also called the loan company and requested they no longer visit him.

In time Lisa and Jim discussed his care together and agreed for Lisa to help arrange a social work assessment for him. She also supported him to refer to the Community Dementia Team for assessment and the result of his recent tests. A nurse from the team visited Jim and was able to confirm he had been diagnosed with Vascular Dementia. They gently explained to the nurse the difficulty Jim was experiencing getting to the toilet. The nurse made an appointment for him to visit an incontinence nurse at a local clinic.

As Jim was smoking a lot, the fire service also provided Jim with fire safety ashtrays, fire retardant throws for his furniture, fire retardant bedding and nightwear.

Sadly, Jims mental health was deteriorating rapidly. During his care assessment, the door step loan collector turned up saying he had taken another £500 loan out. Jim was unable to say where the money was or what he had spent it on. During this time, Sally, Jim's daughter telephoned and informed the Social Worker that Jim's memory was deteriorating rapidly and he often didn't know her name and certainly could not remember her address.

Jim was offered a care package which he initially declined. The Social Worker arranged to meet Sally at Jim's flat and carried out a Mental Capacity test resulting in her considering power of attorney for Jim. The Social Worker also arranged funding of a care package for medication calls and assistance with meals. In addition, she wrote to the door step loan company informing them Jim was unable to manage his day to day finances and they were not to provide him with further loans.

Jim remained living independently for 1 month before falling and being hospitalised. From hospital, he was discharged to a care home.

8 LIFE WON'T GET IN THE WAY OF LIFELONG LEARNING ELLA'S STORY

In this story we hear about Ella who was doing her best to stay in college whilst facing destitution and homelessness. With Local Area Coordinator Tammy walking alongside her, Ella managed to continue with her lifelong learning ambitions by taking control of the services in her life, ensuring they were complementary to her goals and thus preventing homelessness from occurring.

Ella was attending college when an employment advisor introduced her to Tammy her Local Area Coordinator. The advisor was concerned that Ella had no income. They had reached out to Tammy to see if she could advise on free meals in the area

Ella and Tammy met and Ella shared her story. She had been denied Universal Credit over 8 months previously and she had no income and no family or friends supporting her. She was about to be evicted from her flat, had no access to food other than soup kitchens in the city centre and struggled accessing those due to transport. Ella's health and mental health were deteriorating and she told Tammy she felt very isolated.

Ella told Tammy she was receiving intermittent support from the tenancy support service through her social housing landlord, an employment and advice service and a homeless charity. Tammy was able to help Ella join these services together to get the full picture of support she needed. This included initially offering quite a lot of support, for example agreeing to pick up food parcels for Ella, attending meetings with her landlord and the welfare rights team and advocating on her behalf. Ella managed to secure her tenancy until a pending tribunal where she won her appeal and all her benefits were back dated. Ella paid off all of her arrears and was then able to focus on her health.

Throughout this process Tammy introduced Ella to community places in her local area. She has since met people in her community who now also support her.

Ella feels connected and has made real friendships.

She gives back to others with her time and gifts through volunteering whilst she continues with college and searching for work.

Ella says she now feels more in control, safe and secure in her tenancy and is exploring future housing options. She is able to concentrate on recovering both her health and mental health and has the income to do so. Tammy continues to be a presence, walking alongside Ella as she strives reach her vision of a good life.

9 STAYING STRONG BY STANDING UP FOR RIGHTS CLARE'S STORY

In Clare's story we hear about the complex challenges and potentially detrimental impact associated with changes to welfare benefits. We will hear that, by accessing the information she needed to challenge the system, Clare was able to stand up for her rights, find ongoing support from within her community and move closer towards her vision of a better life.

Local Area Coordinator Jill first met Clare via her mental health support worker following a particularly difficult period in Clare's life. Clare had been managing depression and anxiety along with her learning disability for as long as she could remember. She had found helpful ways of coping in order to live her life as much as possible without limitations. Sometimes this meant she could live life with little support from professionals, however at times she had also become extremely un-well and required intensive support with her mental health.

Jill and Clare explored positive changes that she wished to make in her life including connecting with people and managing her finances as well as accessing counselling therapy. Sometimes they met regularly and sometimes months went by where Clare didn't make any contact with Jill. This was usually when things had been going really well for her.

Due to the difficulties Clare faced she was unable to work, and had been receiving benefits for these reasons. Clare's benefits were stopped after an assessment was completed which did not accurately reflect her difficulties. Jill and Clare worked together to find where she could get appropriate support to challenge the decision. As a result, the decision was overturned meaning Clare is now receiving her payments again. During this process she made helpful links with other professionals who will continue to help in the future if any similar problems arise with her benefits.

Due to Clare's benefits being stopped she had received a notice informing her of a court date to be evicted from her property. Jill supported Clare to contact the housing provider and she has since been allocated with a worker from the provider to support with housing related issues if needed. By working closely with this worker, Clare was able to stop the eviction process and apply for Discretionary Housing Payments which were awarded. This means that Clare was no longer being evicted plus she was no longer required to pay the "bedroom tax" amount towards her future rent. This afforded her more opportunity to get out and about.

Clare told Jill afterwards that an instance like this eviction notice would in the past have triggered a severe decline in her mental health but with Jill alongside her she was able to deal with the complexities of the situation and get through it. Since then, Clare has ended her mental health support and her support package provided by Adult Social Care which included carers visiting once every day to prepare her a meal. Clare is now in a more independent place where she is doing weekly shops and other local trips with her friend. Last year she enjoyed a camping trip with another friend for the first time in a few years. She is managing her mental health well and contacts Jill if and when she needs to. Clare knows the door is always open and she has previously explained to Jill that just knowing that she is not alone is in itself a huge help.

10 A STRENGTH WITHIN
JAKE'S STORY

Jake's story highlights the awesome strength that can be found within to overcome health barriers and achieve a better life. Through his desire to build relationships with those in the community around him Jake became stronger, happier and inspired to contribute to the community himself.

Jake was introduced to Local Area Coordinator Kate through a housing support worker. He was living with his brother who was classed as his carer. Jake was born with degenerative kidney disease and has had multiple unsuccessful kidney transplants. He attends hospital three days every week for dialysis and also suffers with severe psoriasis and depression.

When they first met, Jake expressed how unhappy he felt with his life. He told Kate what he wanted things to be like but felt he couldn't get there due to his health conditions. They started to get to know each other and built a trusting relationship exploring the changes he wants to make in his life.

Jake wanted to move out from living with his brother but to stay in the local area close to his family. He explained that he felt as though living on his own would be better for him. He wished to be in a flat, explaining how much this would help his ability to complete tasks at home.

Kate and Jake discussed how to make a housing application and what medical evidence he needed to show his medical need for rehousing. Jake successfully did this and moved in to his new home where he says he is happy and has really made it his own. His relationship with his brother has also improved as a result of them no longer living together.

Jake and Kate discussed the potential for personal health budgets and occupational therapy assessments in order to maximise and make the most of Jake's independence at home. However, Jake feels that he is managing well and is able to care for himself especially now that his accommodation is all on one level.

Jake also wanted support with trying to build his networks and develop new relationships. He had little contact with his family and told Kate he had very few friends other than those he sees during dialysis.

Slowly Kate helped Jake to build his self-confidence and encouraged him to visit a new place to meet people. Eventually they attended a local community group together where Jake bumped in to an old school friend. They were both pleased to see each other and swapped numbers to meet up. By chance the friend had recently been given Kate's details by his Crisis Team worker. He told Kate that he had been meaning to get in touch so they arranged to meet too.

In the weeks that followed Jake's old school friend introduced him to some of his friends. Jake has been back to the group and it is clear that he enjoys it and is starting to make some great connections with other people too.

Jake told Kate that his mental health is really improving and he is spending less days feeling depressed. He has overcome many issues in recent months and demonstrated his great strength and skills.

He told Kate that he is starting to believe there are things to look forward to in his life and is eager to give back by connecting more people in the community together, helping to reduce isolation for others.

Jake and Kate are now exploring existing local opportunities that Jake can support. He is also considering surveying local residents to help him to find out what kind of groups people may be interested in.

11 NEW COMMUNITY, NEW OPPORTUNITY
FRANKIE'S STORY

In Frankie's story we hear about how he overcame homelessness and addiction in part by building relationships in a community that he wanted to be part of. Eventually Frankie became a contributing citizen in that community and has achieved significant positive changes in his life since.

Local Area Coordinator John met Frankie and his mum at a pop-up café. Frankie was homeless and couch surfing. He was also seeking support for his mental health problems and addictions. He had ongoing issues with debt and managing his health needs. He told John that he had been anxious about coming to the pop-up café but after the chat was glad to have made the effort.

Frankie wanted to build links in a supportive community outside of the city centre where all his previous negative relationships were formed.

Initially John introduced Frankie to Rachel, the Local Area Coordinator in the City Centre as that was where he was staying at the time they met. Rachel assisted him with accessing the Housing Options team and homelessness support from a local homelessness support charity. Over time it became clear Frankie was spending more time at his mum's where John was based so Frankie began meeting him instead of Rachel. This was usually at the pop-up café which Frankie was regularly attending and building natural relationships in that community.

Alongside support from the homelessness support charity, Frankie and John worked on his housing situation. The charity provided expertise with this issue while John provided encouragement and explanation with some of the processes helping Frankie make sense of things.

Frankie had previously applied for Personal Independence Payments and John provided support at the assessment. This was a process he had previously struggled with having not been awarded the payments on two occasions before. This time he was successful and was awarded the benefit.

At the pop-up café Frankie noticed that the man delivering the surplus food for use there was always busy. He asked John if he thought the man might need some help. John talked to the organiser who said he would love to take Frankie on as a new volunteer. John connected them both and Frankie began volunteering a few days a week at the food bank, helping to redistribute surplus food to those who needed it.

Frankie submitted an application for a property near to his mum's house in the community where he was starting to find his feet. John attended the interview with Frankie for support and to emphasise the connections that Frankie was building in the community. His application was successful and he moved into his brand new flat a few weeks later.

John also helped Frankie access free furniture via the Council.

Frankie said the flat was somewhere he was proud of, somewhere in a community that has been supportive of him and that he is part of and it's somewhere he feels at home.

Frankie intends to continue attending the pop-up café and volunteering at the food bank.

He is not using drugs.

He knows that he will see John out and about in the in the community and is reassured by this.

12 A FRESH START FOR A FAMILY
GEMMA'S STORY

In this inspiring story about Gemma we hear how she overcame multiple crises to connect with her community and achieve a better life for her and her children. We see how the consistent support offered at the right time and in the right way by the Local Area Coordinator helped her build on her strengths, find natural support from within her community and overcome the challenges she faced.

Local Area Coordinator John, was introduced to Gemma by the Headteacher of her children's primary school. As they got to know each other Gemma explained she was facing a number of crises including a recent split from the father of her children. She was also dealing with a difficult past, benefit issues and supporting her children on her own whilst she coped with bi-polar disorder. She had moved to the area from London to escape a past of drugs and violence. As a result she didn't know or see many people, choosing instead to devote all her time to her children. Gemma also had anxieties about what her neighbours thought. All of this kept her indoors, rather than seeking ways to socialise with people.

She wanted to feel well, safe and confident in her and her children's futures keeping them safe from drugs and violence.

John and Gemma agreed to try and tackle her lack of income first. They soon got that sorted and explored what other welfare provision she was entitled too. Between Gemma, the school and John they explored what support was available from family and the children's social workers but there wasn't any.

The school made a referral for Gemma to access the Family Partnership. She was anxious about attending on her own so John accompanied her to the initial meeting. She attended subsequent meetings on her own. John also helped Gemma acquire some new furniture.

Concerns about Gemma's ex-partner got to the point that the school rang the police. The police, a housing officer and a family and children's social worker visited Gemma. The social worker was able to apply for some funding for carpets and beds for the children. The housing officer was able to organise a clearance of the rubbish in the garden. And the police reassured Gemma that she was taking the right direction with ensuring her children's safety. John helped Gemma make sense of everything that was going on and provided reassurances when it all felt like it was getting too much.

Over the course of the relationship, John and Gemma found time to discuss her idea of a good life. It had been difficult for her to think about this as much of her life was impacted by ongoing crises. She told John that she would like to have a wider social network of people who would accept her as she is. They looked at lots of possibilities.

Gemma didn't take up the offers to go anywhere or meet anyone until a local church, two minutes' walk from her house started a coffee morning.

John knew the people involved in the coffee morning and encouraged Gemma to meet him there to do some practical form filling for discretionary housing assistance. Gemma came along and it turned out that she knew the pastor and one of the other people there. When John spoke to Gemma again, she told him that she had been along to the Sunday church service and her children were going to the kids' club. She had really taken to the group and she said she had even surprised herself.

Gemma sees John quite regularly usually at the church coffee morning, where she has taken up crotchet.

She has had other periods of crisis since including a theft of money from her handbag and one of her sons getting involved in drugs and being in trouble with the police. John has been able to guide her to the specialist service whilst also helping her reflect on the qualities and strengths she has to get through these difficult periods.

Gemma is now a lot more connected to her community; a group of people who accept her for who she is. She is more confident in the future and more confident in making decisions for her and her children. She knows where to turn for support and is comfortable enough to ask.

13 A KNOCK AT THE DOOR
MAUREEN'S STORY

In Maureen's story we hear how her Local Area Coordinator Lisa became aware she may need some help via a local shop keeper who was worried for her wellbeing. With a bit of encouragement Maureen was then able to get back out in to her community and contribute again.

Local Area Coordinator Lisa was asked to visit Maureen by a local shop keeper. Maureen had received threats from an unknown male and had also been the victim of criminal damage. Her front window had been smashed on four occasions over the course of 3 weeks.

When Lisa knocked on the door to see her, Maureen was tearful and upset. She explained to Lisa that she felt overwhelmed by sadness and fear and said she did not know who was carrying out the criminal damage to her home or who the male was that had threatened to kill her. Since these events she hadn't ventured out much and was reliant on her grandsons to complete her shopping. She went onto say her daughter had died 2 years previously, and explained that her daughter and both adult grandsons had always lived with her.

She missed her daughter tremendously and believed the youngest grandson had great difficulty coming to terms with his mother's death.

Lisa arranged to visit again in a few days and suggested they could walk together to visit a local coffee shop. Maureen agreed she would consider this.

Lisa continued to visit Maureen and met with her grandsons too. Maureen had previously mentioned she enjoyed attending Mothers' Union, however, had missed many months due to family worries and the recent incidents.

Lisa suggested they go to the next meeting together. Maureen agreed to attend, and as expected, members welcomed her return with warmth. Lisa continued to visit with Maureen and also introduced her to some new members she had taken to the group. Maureen took on the role of 'mother hen' welcoming the new members and ensuring they were comfortable and included.

Within a month, the police had charged a male from outside of the area with the offences of threats to kill and criminal damage. His defence being he had targeted the wrong house.

The news had a positive effect on Maureen and the whole family. Maureen continues to attend Mother's Union and has returned to worship in Church every Sunday.

She feels happy and safe in her home.

14 GETTING STRONGER AFTER TOUGH TIMES
TONY'S STORY

In Tony's story we hear examples of how Local Area Coordination can help people to take control, prevent personal crisis, support recovery and connect with the community.

In Tony's story we hear examples of how Local Area Coordination can help people to take control, prevent personal crisis, support recovery and connect with the community.

Tony was introduced to Local Area Coordinator Davina by an independent living officer. He was living in sheltered housing and experiencing difficulty managing on benefits with little disposable income left after paying bills. Tony told Davina that he had been extremely worried about his situation and had been trying to manage on his own but felt he could no longer cope.

Tony used to work as a taxi driver and later a security guard. He lost his job after his health declined, resulting in him losing his home and becoming street homeless for several months. Becoming homeless turned his world upside down and continues to have a massive impact on his self-worth and confidence. He told Davina that he worries constantly about all of this and will go without food to ensure his rent and service charge are paid.

Tony told Davina that he likes to get on with things himself. His vision is to get back in control of his life and to start living again, ideally returning to work in the future but he said that this was an unlikely prospect at present due to certain health issues. He had been surviving on free food handouts and food bank referrals. He told Davina it is not uncommon for him to miss meals, typically eating once a day which is having serious impacts to his health as he has type 2 diabetes and has painful reoccurring leg ulcers which affect his mobility. He wasn't keeping up with health appointments.

Tony had also been sleeping on his sofa and sometimes on cushions on the floor, as he did not have the money for a bed or carpet. This was also having a negative impact on his sleep and contributing to the decline in his health.

He told Davina about a traumatic experience many years ago when he had been outside a department store in central London when a bomb exploded nearby. Tony had been collecting money for charity when the explosion took place and was lucky to have survived. He is still in contact with survivors and continues to be affected by the events he experienced on that day. Through the years he has never sought professional help regarding this.

Tony was spending little time in his local area. He told Davina that he does not have many friends and connections and is unhappy living there.

Davina and Tony worked together to achieve funds from a charity for a bed and carpets. They also looked into assistance that could be provided with Age UK and explored support to move on to different benefits. Tony also started the process to apply for Personal Independence Payments due to the decline in his health. Tony was proactive in seeking assistance to address his debt and attended a Citizens Advice appointment on his own, following a coaching session with Davina.

Tony has started giving back. He has got involved with updating the council's free food resources and foodbank information of current services and has kindly shared his first-hand experience of services available in the borough. He has expressed an interest in exploring becoming a volunteer driver for community transport. He is currently focussed on widening and establishing local connections and friendship groups by exploring his hobbies, interests and talents.

Davina and Tony are also exploring what more he can do around his diabetes by further understanding the impact of the condition and what can be done to manage it.

15 A NEW HOPE AFTER BEING FAILED BY THE SYSTEM KATE'S STORY

Through Kate's story we hear about the supportive role that Local Area Coordinator Jennie played in ensuring services around her were complementary to her goals. This led to Kate's natural authority being recognised giving her choice and control over her care. In turn, this supported her on a journey towards recovery and her vision of a better life. Kate's story also shows the Local Area Coordination introduction process as one that is quick, natural and person centred. This helped Kate to develop a trusting relationship with Jennie from the start.

When Kate met her Local Area Coordinator Jennie, she explained she had some very bad experiences with services and had been "dismissed and neglected for years". Kate's initial priority was appealing a recently declined Personal Independence Payment decision which had a big impact on her. Jennie quickly supported Kate to access help from Citizens Advice with this. The appeal was successful. With the benefit reinstated they were able to start looking at getting some of her other bills and debts paid.

As their relationship developed, Kate explained how she had endured years of domestic abuse when she was bringing up her daughters, all of whom were now grown up and she lived alone. She described the impact of her past on her mental health which included developing an eating disorder. She also had ADHD. Kate needed specialist support to understand all of this and get better.

Although Kate was on the Community Mental Health Team's (CMHT) caseload she didn't feel she was getting the support she needed. Her diagnosis report had recommended a referral for an Adult Social Care Assessment but this had not been followed up. Jennie picked this up immediately and contacted the Mental Health Social Work Team to ask if they could move forward with this assessment.

Kate hardly ever saw her Care Coordinator and had been told she was on the waiting list for an eating disorder specialist for over five months. She had been allocated a support worker for a short amount of time but he had stopped getting in touch. Kate didn't understand why but presumed that the support had ended. Kate's daughter Anne had seen her mother's health deteriorate in this time and had very real fears she would die if she kept losing weight.

Kate admitted some difficult interactions with her Care Coordinator, due to her frustration and communication style, which could be interpreted as aggressive. She felt that because of this she had been labelled 'difficult' and this was why she was being ignored. This was somewhat confirmed in the wording of her care plan which she had not been involved in but it described her as 'confrontational and aggressive' and having 'sacked a lot of professionals'. Kate and Jennie discussed openly how her communication could often be misunderstood. Kate said she felt calmer and more comfortable talking to Jennie as conversation seemed more natural. She acknowledged the relationship with her Care Coordinator had broken down so she requested a new one.

Jennie helped Kate to communicate what help she needed to get better, get life back on track and navigate complex service systems. This took some time and persistence due to staff shortages in CMHT and changes of Care Coordinator. Miscommunication had meant a referral had never been made to the eating disorder specialist. The long wait for an Adult Social Care Assessment had been complicated by a stalemate between Adult Social Care and CMHT regarding who would offer what support. Understandably Kate felt caught in the middle of all of this.

Seven months later and Kate felt that things were much more positive. She felt that she went from having no support to a robust network of specialist support with a new CPN and care overseen by the manager of the CMHT, a mental health social worker, an eating disorder specialist and nutritionist and a support worker. All of whom met, along with Kate and Jennie, to write a new care plan which much better reflected her and her family's needs and wishes.

Kate is on the road to recovery, but still has a long way to go in her journey. She is motivated to help others to have their voice heard in the future, when she is better. She is pursuing a complaint with an independent advocate, who Jennie connected her with as it is important to Kate that others don't have the same poor experience.

Kate has other plans too - she would like to write a book about her experiences and set up a support group for adults with ADHD. She spent most of her life working in care and would love to work again.

Jennie will continue to walk alongside Kate and her family and will be there to explore options regarding all of these things as and when Kate is ready.

16 INFORMATION CAN BE THE KEY TO A BETTER LIFE THE SMITH FAMILY STORY

In this family story we hear about the powerful combination of the right information with the right amount of support. Through working with Local Area Coordinator Lana, Mrs Smith and her family were able to get what they were looking for and move closer towards their whole family vision for a better life.

Mrs Smith was introduced to Local Area Coordinator Lana through her children's school. At the time Mrs Smith and her family were facing some challenges and had a lot going on.

She explained to Lana that her youngest child was going through a diagnosis process for Autism and was finding school life challenging. The eldest child had just been diagnosed with epilepsy and had recently had a year out from school which had impacted on their mental health. She also had two other children in the family too. Mrs Smith's partner works away during the week and she also has her own business to run. She told Lana how the stressors of family life were impacting on her own mental health. She expressed a wish to speak to other parents who may have had similar experiences for some support.

Lana provided Mrs Smith with some information about a support group for families experiencing autism and supported her to make contact with the group. She also provided her with some information about the service offered by a carers support organisation.

The family have now become members of the support group and intend to attend some of the family days and activities which take place throughout the year.

Mrs Smith met up with one of the Trustees of the group who shared some of her own experiences of parenting a child with Autism. The Trustee put Mrs Smith in touch with other parents in the local area too.

Since then Mrs Smith has received some advice and support from other parents about the diagnosis process for her youngest child, and she has also made contact with Autism outreach.

Through a good life conversation with Lana, Mrs Smith has identified that she doesn't have any time for herself. She has set herself a goal to do something for herself once a week with a view of this improving her mental wellbeing. This could be walking the dog, going to the gym, or being outdoors as this is one of her interests. The family were provided with some information on the closest gym, and about Yoga and Pilates Class at the Village Hall.

Lana has also been introduced to Mrs Smith's eldest child who would like to discuss planning for their future, researching different universities and building on confidence to reconnect with school friends. The meeting has been arranged to take place with her in a local café.

17 HEALTHY BODY, HEALTHY MIND
SHAUN'S STORY

In Shaun's story we hear how he was able to get the resources he needed in order to continue accessing a gym which prevented further mental health decline.

Local Area Coordinator Kay received a call from Shaun who had been to speak with a mental health charity who had suggested he give her a call.

When Kay and Shaun first met they quickly realised they knew each other from volunteering together at the local Parkrun. Shaun was relieved to see someone he knew and went about explaining his situation. Shaun is a wheelchair user following a spinal injury 10 years ago but remains very active and has completed many marathons and half marathons all over the world. Shaun has also recently qualified as a counsellor and life coach as he feels he has a great understanding and life skills to share. He also volunteers for a mental health charity and is building his private work to fit around that.

He explained to Kay that he was going through a brief spell of financial difficulties due to trying to build his business. This has led to difficulty paying for his gym membership which had to be cancelled. He described how his mental health was really declining; he was experiencing low moods, and started avoiding going out.

Kay and Shaun set about exploring his options. This included the different memberships on offer and gyms available. They discussed the costs of different concessionary offers and their suitability in order to allow Shaun to access peak times due to his work and volunteering. They also applied for some funding from a charity to cover the gym membership costs.

Shaun was awarded funding to cover 6 months full gym access. He is now exploring different avenues for future funding so he can continue, including looking at possible sponsorships for his marathons which would cover his physical activity.

He is back to volunteering and regularly going out and intends to fundraise for the charity that supported him financially as a way of saying thank you.

18 FINDING NATURAL AUTHORITY
EDDIE'S STORY

In Eddie's story we hear about how Local Area Coordinators are able to help people achieve the life they want by supporting them to find a voice and natural authority from within.

Local Area Coordinator Philippa met with Eddie at a local drop in centre. As they got to know each other, Eddie went about telling Philippa his story. Eddie is 62 years old and has a suspected, undiagnosed learning disability. He lived with his mum and dad, who looked after him until they passed away about 12 years ago. He had to leave his family home and was temporarily rehomed in a nearby flat. He's never liked living there. He told Philippa he was being financially abused by his landlord who refused to make repairs. Lots of things were broken such as the windows, the shower, fridge, washing machine and bed. For the past few years Eddie slept on a wooden chair (the only piece of furniture that wasn't broken) and has been unable to wash his clothes or himself.

Eddie told Philippa that he is frightened of the landlord, who he says is a bully. He finds it very hard to speak up for himself and when he had been able to pluck up the courage to go to the council housing department, he felt he was fobbed off and nobody listened or helped him. He explained he has no next-of-kin and very few friends. He was finding it very difficult to look after himself or his home, which was in a very bad state. He wanted things to be better and had tried to get some voluntary work but was rejected. He explained he had twice attempted to take his own life because he felt so lonely.

Philippa and Eddie went about exploring what a good life meant to him. Eddie said it was to have a comfortable bed, a fridge that works, and hot running water. To feel safe at home. To be able to help other people.

Philippa suggested that they go see a sheltered housing scheme to look at what good housing could be like. She supported him to arrange a housing assessment and also attended a learning disability assessment with him as well as GP meetings and other meetings. Philippa supporting Eddie to find his natural authority and when absolutely necessary spoke out on his behalf. Eddie required a significant amount of practical and emotional support going through all of this. Philippa was on hand to help him explore options and make sense of things whilst also ensuring that the new services in his life were complementary with him at the centre.

Eddie was approved with priority for sheltered housing and after 4 months was offered and accepted suitable accommodation in a nearby sheltered housing scheme. Philippa and Eddie sourced a number of donations for his new place. He received everything he needed for his new home and was even able to donate some unwanted furniture to other residents. He was also awarded a local charity grant of £350 to pay for new floor covering.

With support from the housing scheme manager, Eddie now uses a visual timetable that he and Philippa came up with. He is taking greater care over his appearance and he is able to maintain a clean and tidy home. He is beginning to make friends with other residents; he is attending activities in the communal spaces, such as the community lunch and gardening club.

Eddie is building a good relationship with the housing scheme manager to the extent that he feels he no longer needs input from Philippa. He has more self-confidence and more optimism for his future; he has embarked on a new romantic relationship and says he is happier now than he has ever been.

19 GREATER WELLBEING AFTER CONTRIBUTING IN THE COMMUNITY
CHELSEA'S STORY

In Chelsea's story we hear about how by getting involved in local volunteering she gained a greater sense wellbeing and felt part of community around her.

Local Area Coordinator Kerry met with Chelsea after she moved into a local supported living complex. Chelsea told Kerry that whilst she loved living there she was feeling depressed as she was on her own most of the time as the other residents were out.

Kerry and Chelsea got to know each other. Chelsea told Kerry what her picture of a good life was. She said she would love to volunteer supporting young children as she had done this once before and wanted to do it again.

Together they set about contacting a local community trust based at a local church. They asked if Chelsea could join the team that supported the mother and toddler group that met at the church on a Thursday morning. The people at the trust were very happy to say yes. Chelsea quickly took up a role helping to make the breakfast for the children in the morning.

She told Kerry that her new volunteering helps her gets her out and has increased her confidence. This has inspired her to volunteer at a local hub after she finishes work at the church on Thursday.

Chelsea says that even though it's one day a week, she now has something to look forward to and this has made her so happy.

She is more motivated and feels part of a team, feels less isolated and has made new friends. She is not using formal services and says she no longer feels depressed as she is contributing to her community.

20 PRACTICAL ACTION LEADS TO GREATER WELLBEING KYLE'S STORY

In Kyle's story we hear about the practical action he and his Local Area Coordinator took together and the stabilising impact this had for him. This led to him feeling confident to contribute to his community and look to the future.

Kyle was introduced to his Local Area Coordinator Gina following a discussion with his GP. Kyle was a regular visitor to the surgery due to his ongoing and serious health issues. The GP was concerned that he was becoming very isolated, depressed and withdrawn.

Gina and Kyle arranged to meet at his home. When they met, Kyle was in a low mood and didn't seem very interested in Gina's role at first. So, they just sat and chatted for a while instead and slowly he began to explain his situation and his anxieties. He was worried about his benefits and lack of income; he had not been receiving any benefits and his savings were now all gone. Kyle was being supported by his parents and felt guilty. He spoke about not having a purpose to get up in the morning and no reason to leave the house.

Gina listened before explaining some of the practical ways she thought she may be able to help starting with his benefits and income. She told Kyle they could work together to make a referral for him to get support to talk through his entitlements and how to apply. Kyle wasn't confident there was a point to this, but Gina reassured him that with the right help he would get the appropriate information to be more successful.

As they got to know each other they started to discuss Kyle's vision for a good life and how he could set about achieving this. Kyle explained just how much he loved working before he became ill. He had trained to be a chef but his illness had impacted on him resulting in him struggling to fully function for more than a few hours at a time.

Gina and Kyle continued to meet regularly and would often chat about his interests and aspirations. Following the referral and the additional support they arranged together, Kyle's benefits were eventually sorted out so he was able to receive a regular income. Gradually, as he became more confident about his situation, Kyle started to express aspirations to volunteer again.

Gina and Kyle went along together to the local Charity shops and found an opportunity to volunteer on Saturday mornings.

Gina also supported Kyle to contact and access local support groups for people with the same health problems as him. This gave him a safe space to talk about his problems and feelings. She also gave him information on other projects that may be of interest for him in the future.

As a result of Gina being alongside Kyle, he now feels less of a burden to his parents and is happy with receiving an income. His volunteering has massively increased his confidence and he enjoys the interaction with colleagues and members of the community.

Kyle feels he is contributing to his community and has a purpose to get up in the mornings.

When he feels low he is able to contact his local support group who are a great help. Kyle is now looking at future courses and employment with a view to return to work as a chef.

Alongside

Stories of local area coordination®