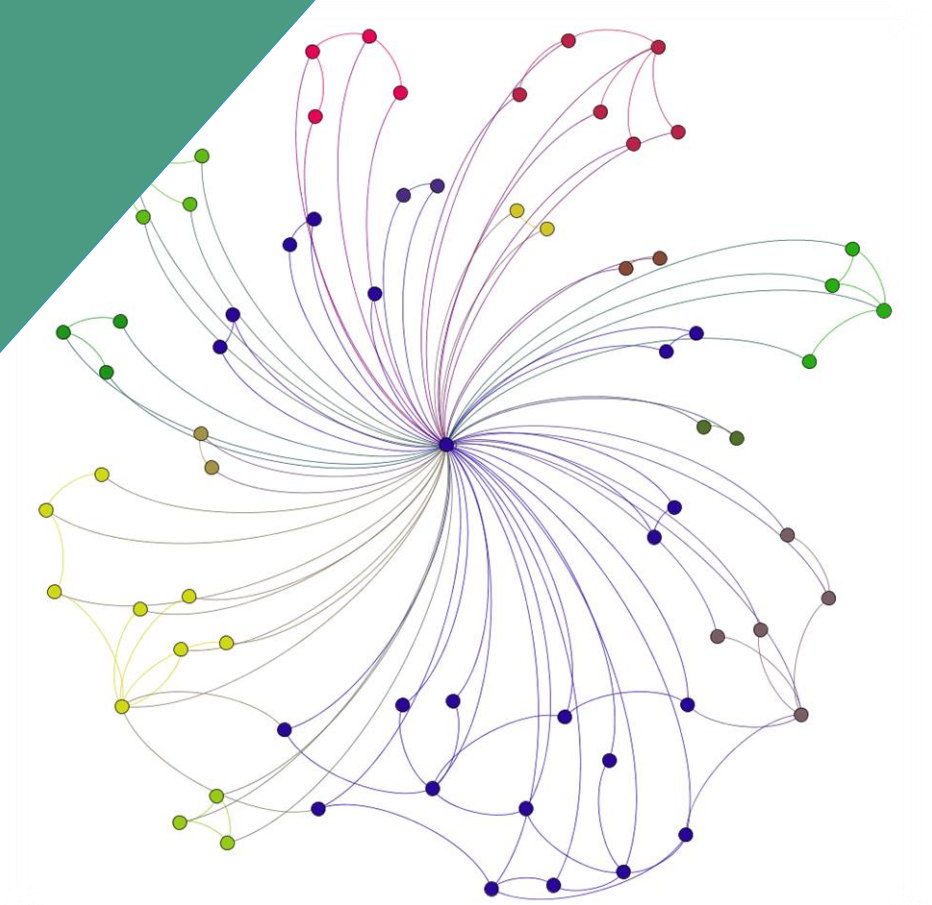
Formative Evaluation Summary Report

Local Community Initiatives in Western Bay



Caring Together Western Bay
Health and Social Care Programme
Gofalu Gyda'n Gilydd Bae'r Gorllewin
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Foreword

The Western Bay Programme has recently overseen the implementation of Local Area Co-ordination (LAC) across sites in Swansea and Neath Port Talbot and Local Community Coordination (LCC) across sites in Bridgend. These novel approaches aim to support communities with a focus upon local relationships and assistance rather than use of statutory services. To support this work, and inform key stakeholders of progress and early outcomes a formative evaluation has been undertaken. This report provides the first formal feedback from this evaluation process, with focus upon the setup activities and initial activities of Local Area Co-ordination and Local Community Coordination across the Western Bay Region.

This early phase evaluation gives particular focus to the emerging outcomes for individuals, Coordinators and communities, early indications of financial cost/benefit and the establishment of networks within communities.

It is hoped that the evaluation process continues beyond this formative stage and that ongoing monitoring and longer-term summative evaluations give further insight into the impact of both Local Area Coordination and Local Community Coordination. This work is intended to support both practitioners in optimising delivery, and policy makers in potential future use of Local Area Coordination and Local Community Coordination in the Western Bay region and beyond.

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Executive Summary

Context

Traditional approaches to health and social care across the UK and Wales are struggling to address growing demand, exacerbated by the challenges of an ageing population, chronic disease and economic hardship, all set within a context of public sector austerity. The Western Bay region faces some acute manifestations of this challenge, particularly in its Communities First Clusters where socio-economic deprivation is greatest. The continued pressure upon public services makes it a challenge to embrace opportunities to adopt new practice, especially whilst maintaining quality and safeguarding obligations for services upon which users are highly dependent. This apparent paradox makes innovation most intriguing, particularly where further resource is unavailable, demand is growing, and change difficult. These challenges, and efforts to address them are not unique to Wales or the Western Bay region, and Welsh Government through the Social Services and Wellbeing (Wales) Act 2014 (1) sets new obligations on organisations to work collaboratively in supporting individuals. The identification, appraisal, tailoring and adoption of relevant effective approaches to collaboration is itself a challenge for organisations balancing concurrent priorities. It is with this in mind that Western Bay has coordinated the implementation of two initiatives designed to address some of these challenges – Local Area Coordination (Swansea and Neath Port Talbot) and Local Community Coordination (Bridgend). Previous implementations and subsequent evaluations of Local Area Coordination (LAC), including within the UK, have validated the effectiveness of the approach for individuals and communities, together with potential short and longer-term financial benefits for stakeholders. However, Local Community Coordination (LCC) has been developed by Bridgend County Borough Council (BCBC) based on key components of the Local Areas Coordination model.

A formative evaluation undertaken by researchers at Swansea University commenced in June 2015 and began with Local Area Coordination in Swansea, this was followed by Local Community Coordination in Bridgend (October 2015) and finally Local Area Coordination in Neath Port Talbot (February 2016). Data collection was completed in April 2016.

This formative evaluation, aims to assist Western Bay support implementation delivery and inform stakeholders of progress and implementation across all three Local Authority areas. These are the formative findings and recommendations from both LAC and LCC initiatives.

Overview

Local Area Coordination (LAC) and Local Community Coordination (LCC) are a person-centered approach aligned with the prevention agenda of Western Bay and the ethos of co-production to help individuals lead lives with greater control and independence (Social Services and Wellbeing (Wales) Act (2014).

Coordinators are embedded in the community and come alongside people of all ages, disabilities and backgrounds. Both LAC and LCC Coordinators are a local single point of contact working to reduce dependence on services and creating conditions for long-term resilience. Interventions are not time-bound. There is an emphasis on nurturing trusting and supportive relationships with individuals and families which can take time to develop, building reliance and supportive connections to reduce the risk of future crisis and service dependency.

This initiation report provides the first formal insight from the recruitment and initial delivery activities of Local Area Coordination across areas of Swansea and Neath Port Talbot and Local Community Coordination across areas of Bridgend.

Initial activity undertaken over the past 3-11 months (depending on area) has been progressing well in both LAC and LCC areas, including community engagement, identifying community assets and individuals for support.

LAC and LCC complement and seek to add value to existing support services and must be understood as a medium-long term community resilience effort and not a rebranding of Social Services or Community Development.

Both LAC and LCC fulfils the prevention and wellbeing part of the Social Services and Wellbeing (Wales) Act (2014) with co-production at its core. Furthermore, both models align with the ambition of the Future Generation Act (Wales).

In line with LAC benchmarking, the Swansea and Neath Port Talbot learning sites have implemented Local Area Coordination effectively and all Coordinators are making good progress. The complexity and size of caseload as well as the expansion of Coordinator networks supports this finding.

Implementation of Local Community Coordination (LCC) has been difficult to benchmark at this early stage due to it being a new approach. It has no established evidence base. However, LCC has recruited effectively both in terms of the Local Community Coordinator, Arts Connector and Project Manager which has enabled rapid deployment of LCC. Coordinators are making good progress across a broad range of complex cases and networks.

All teams are extremely committed, passionate and driven in their approaches to their respective initiatives. Success of the formative stage has been driven by highly agile and dedicated Management teams and Coordinators. Furthermore, all sites report that the level of autonomy awarded to them by their respective Local Authorities has played a significant role in the successful pace and scope of set-up.

Successful co-produced recruitment of high caliber Coordinators has ensured early impact in all sites and these teams are supported at senior level and throughout the Local Authorities.

Both LAC and LCC fulfil the needs of the different contexts. Researchers deem the adoption of two models as a feature and not a fault as there is a unique opportunity for both 'models' to inform one another.

Whilst LCC continues to develop for Bridgend's context and purposes, the LAC model should maintain design integrity in order to build on outcomes and evidence-base. As LCC develops, it should establish and grow it's own evidence-base in order to inform effective strategic and operational direction.

Whilst population figures for Co-ordinators were originally recommended to cover 10,000-15,000. The complexity of cases reflected in this report and supported by UK LAC Managers feedback, would support a revised recommendation of 9,000-12,000 people. This would provide the basis to maximize outcomes and maintain core aspects of each approach.

Coordinators have established extensive networks of resources and supported individuals across sites with links between sites already starting to emerge involving over 305 individuals and over 1,200 connections. Furthermore, evidence of community resilience is also emerging at this early stage.

LAC implementation in Swansea demonstrated benefits in the range of £800k-£1.2m during this brief period (July 2015 – April 2016). This represents a benefit/cost ratio of between 2:1 and 3:1 using the core range assumptions and under the most conservative parameters. Sustained LAC/LCC activity would see the benefit/cost ratio improve further rising to between 3:1 and 4:1 with a net return of £1.2m-£1.8m.

Therefore, both LAC and LCC require longer-term evaluation and a commitment to the approach in order to continue with the building of trusting relationships and forge meaningful engagement which ultimately underpin resilience and optimise the longer-term impact. Further support for LAC evaluation and learning can be accessed via the growing Local Area Coordination Network Research Group. The group consists of a number of researchers and managers from across the UK seeking to progress the knowledge-base of LAC and share learning for better outcomes. LCC is an interesting research proposition to universities involved in social and health sciences and could gain additional evidence through project work with these institutions.

Local Community Coordination overview

LCC is supported and driven by a small but passionate and committed team with 'buy in' reported at all levels within the organisation. Early communication challenges between partners was evident during this formative stage and interviews gave the sense that more frequent and open communication, inclusion and an acknowledgement of existing experience and skills may build trust and encourage and grow the relationship.

The LCC's case load grew rapidly with much of it classed as Tier 2 level [1]. Emerging cases via self-referrals

[1] [1] Those who need a light touch approach are 'Tier 1' cases, through to more complex and longer-term cases 'Tier 2'

suggest LCC is already being effectively communicated to the Llynfi population. There is a risk of the Coordinator reaching not only caseload capacity shortly but being impacted by the additional task of working on the development the LCC model and being involved in the establishment of groups.

LCC is still being developed and shaped, it is therefore very fluid in nature and has emerging boundaries. It will take time to develop relationships, trust with external organisations and develop an effective evidence base.

1. Local Area Coordination

Development and Context

Developed in 1988 in Australia, Local Area Coordination (LAC) was formed in response to the urgent need to find new and innovative approaches for supporting people with learning disabilities and their families. Given the large rural expanse of Australia, supporting people to remain with their families and in their communities was for many integral to their vision of 'good life'. Since then Local Area Coordination form a key pillar of national service and funding reform across Australia (as part of the National Disability Insurance Scheme) and has been adopted by areas of New Zealand, Ireland and the UK. To date, operating sites are Derby City, Thurrock, Suffolk, Isle of Wight, Leicestershire, Derbyshire, Swansea and Neath Port Talbot.

These sites have implemented Local Area Coordination to address not only the needs of people with learning disabilities and their families, but people facing challenges in a multitude of ways. The approach involves a strong person-centred value base and operates as a single point of contact for those individuals and their families in the community. It has a 'slow-build' approach, investing in forging strong relationships with individuals, families, community and networks of stakeholders. It works to develop and enhance the capacity of communities for inclusion and resilience. It draws support from the community with the aim of enabling people to live a good life with increased choice and control. Furthermore, Local Area Coordination is attempting to drive system reform using *'small scale levers to create large scale change*' (Richie, 1999 as cited in Hunter and Ritchie, 2007, p.20).

Perhaps the mission is best summarized by the founder of Local Area Coordination – Eddie Bartnik - "The essence of the reform was to make disability services and supports more personal, local and accountable, and thereby to build and strengthen informal support and community self-sufficiency. Consistent with the values of co-production, the reform was built on an assumption that people with disabilities are not just passive recipents of services. Along with their families, friends and local communities, they have expertise, natural authority and assets that can maximize the impact of resources and improve outcomes. The reform also emphasizes the transformative effects of shifting power. Resources and accountability for outcomes to a partnership between government and people, where together problems are defined and solutions designed and implemented" (Eddie Bartnik, 2008 as cited in Gregg and Cooks, 2008).

Having been subject to numerous evaluations and reviews, the evidence base stemming from these implementations indicates that LAC can achieve significant impact for the individuals, families, communities and at wider service and reform level.

2. Local Community Coordination (Bridgend)

Development

Based on components of Local Area Coordination, Local Community Coordination has been formed by a small team working within the Directorate of Social Services & Wellbeing (Adult Social Care) at Bridgend County Borough Council (BCBC). It is an emerging framework being shaped as it becomes embedded within the Local Authority. LCC shares its principles with LAC but does not fully implement all core design features. There are differences in the way LCC recruits, implements and supports the role of the Coordinator. This has resulted in the rapid acquisition of cases and caseload.

LCC is a framework being built from the ground up and is driven heavily by the context within which it is operating at present. It does not rely on the presence of a dedicated 'leadership group' per se but instead places high autonomy on the Coordinator to shape and develop the working model and feed into the supporting team. It is fortunate enough to have multilevel 'buy in' of members throughout the Local Authority.

Reflecting LAC, LCC has no specific 'client' categories. As with Local Area Coordination, it offers to come alongside those who need a light touch approach (Tier 1 cases) through to more complex and longer-term cases (Tier 2). It is not time bound or exclusive to the individual but also helps to support families and communities find self-sustaining solutions to the challenges they face. Furthermore, it also involves a strong person-centred value base, operates as a single point of contact for individuals and families. It also has a 'slow-build' approach, forging strong relationships with individuals, families, community and networks of stakeholders. It works to develop and enhance the capacity of communities for inclusion and resilience. It draws support from the community with the aim of enabling people to regain control of their lives.

3. The Inception of Co-ordination Initiatives for Western Bay

Western Bay's mission is to progress social care and health integration and encourages collaboration where there is value to be added. It aims to identify programmes of change, priorities for the sector and opportunities for joint working. It currently has three key areas it oversees:-

- Services for older people
- Prevention and wellbeing
- Contracting and procurement

Western Bay identifies service improvements, better outcomes as a result of collaborations across Social care and health agendas.

The prevention and wellbeing agenda was already identified as a priority for Western Bay as well as services for older people with complex needs. It was evident there needed to be early intervention

across these areas before individuals reached crisis point. This was further reinforced by the emergence of the new Social Services and Wellbeing (Wales) Act 2014 which placed a lens on prevention and highlighted co-production and community resilience as a solution. Local Area Co-ordination (LAC) was an approach which fitted with the prevention and wellbeing agenda and had come to the attention of the Local Authority after staff members attended a conference which discussed the LAC model and its impact. Swansea Council and Neath Port Talbot proposed the adoption of the model to the Western Bay Programme and subsequently secured funding for the approach to be implementated across the three Western Bay areas. Bridgend considered the LAC model but decided to adopt key elements of the LAC model and create Local Community Coordination (LCC) to serve their context and mission.

Swansea implementation areas

Three areas were agreed upon:

- Gorseinon (Swansea North) and also covers the communities of Loughor, Kingsbridge and Garden Village – *Population 15,420*
- St. Thomas and Bonymaen (Swansea East and a 'Communities First' area) this area also covers the communities of Port Tennant, Danygraig, Pentrechwyth, and SA1 Waterfront - *Population of 14,410*
- Sketty (Swansea West) and includes the communities of Sketty Park, Derwen Fawr and Tycoch - *Population of 15,420*

Neath Port Talbot Implementation Areas

Three areas were agreed upon:

- Ystalyfera, including the communities of Godre'r Graig, Cwmllynfell, Lower Brynamman, and Gwaun Cae Gurwen - *Population 10,014*
- Skewen, including the communities of Longford/Neath Abbey – *Population 11,559*
- Glyncorrwg, including the communities of Cymmer, and Gwinfi – *Population 15,214*

The Bridgend Implementation Area

The Llynfi Valley was identified for Local Community Coordination (LCC) implementation.
The criteria for selecting the first areas were as follows:

- High levels of socio-economic deprivation
- High levels of unemployment
- Poor levels of health and wellbeing
- A population of between 10—15,000

A Group Manager based in the Social Services and Wellbeing Directorate discussed the initial location with colleagues and said "*we looked at the whole area of Bridgend and saw that the Llynfi Valley had*

the right ingredients. We had to give LCC the best start to secure its future, we cannot afford for it not to work and Llynfi jumped off the page".

4. The Formative Evaluation Framework

Previous evaluations of LAC have followed the transfer of the approach to a UK context both at national/regional level in evaluation of its implementation in Scotland together with more recent reviews of implementation in the English local authorities of Thurrock and Middleborough. The Western Bay LAC and LCC Implementation Evaluation has been developed as a partnership between Western Bay, researchers from Swansea University, and the local authority partners delivering the activity. The formative evaluation key components and aims are assessment of:

- Project design and implementation
- Outcomes at the level of individuals, families, community and system
- Benchmarking processes and achievements (LAC) (see figure 4a)
- Recommendations for future development and expansion

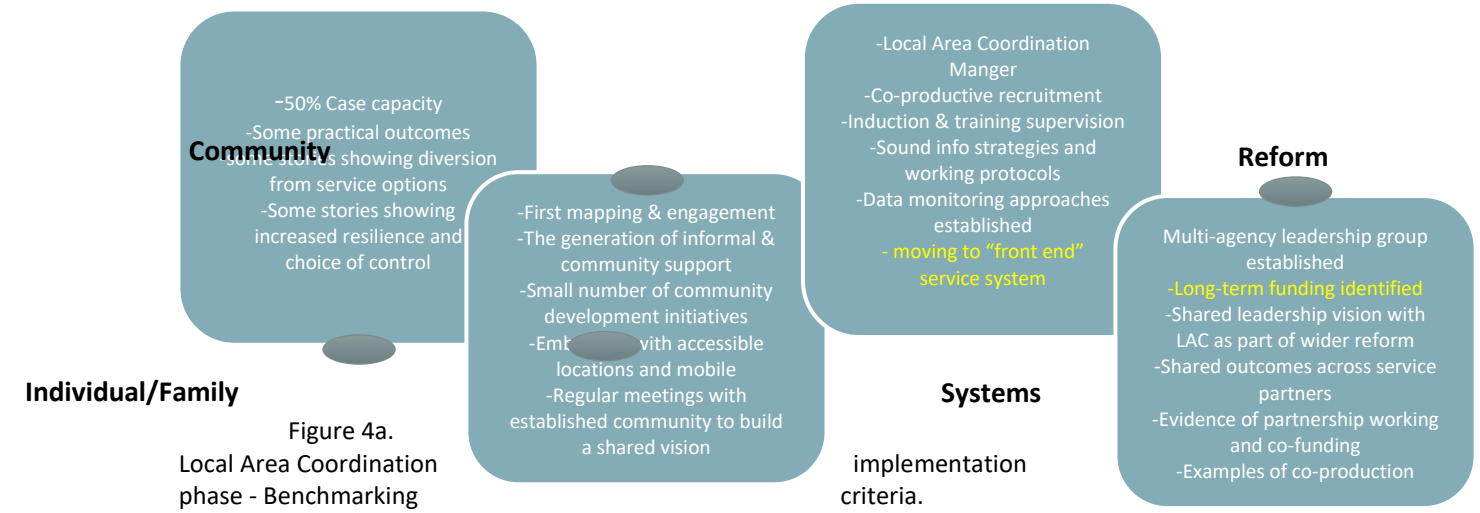


Figure 4a. Local Area Coordination implementation phase - Benchmarking criteria.

When benchmarking processes and achievements for Local Area Coordination against the original implementation framework, all of the criteria have been successfully met and many exceeded by Swansea and Neath Port Talbot with the exception of those aims highlighted in yellow. At the time of writing, it was too early to determine whether Neath Port Talbot had yet to achieve or exceeded these markers. Swansea is working towards becoming a front end service system but acknowledge this is an ongoing process. Swansea has also identified potential funding streams to support the ongoing development of Local Area Coordination. Local Community Coordination is new and therefore does not have established benchmarking measures at the time of writing, this initiative continues to be shaped and build from a 'bottom up' approach.

The LAC formative evaluation study commenced on 1st April 2015 and data capture began at the end of June 2015 and continued through to April, 2016. This report presents findings in each of the three Western Bay Local Authority areas (see figure 5).

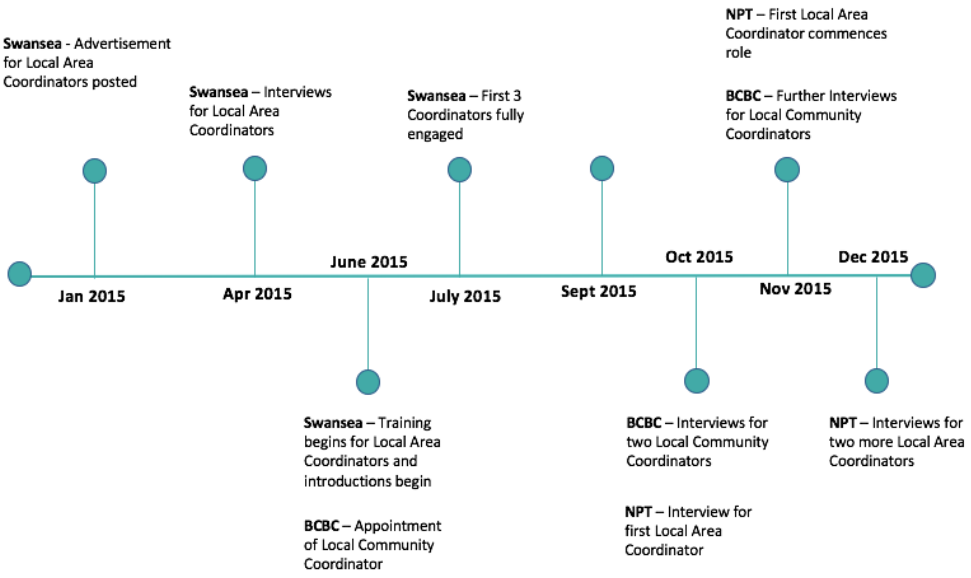


Figure 5. The timeline of implementation of Local Area Coordination and Local Community Coordination over a 12 month period.

5. Emerging stories

A small sample of stories starting to emerge across each of the three regions. Names have been changed and some details edited to protect the identity of the individual.

Dennis' Story

"I feel alone, I have nobody to turn to"

Introduction: Dennis is a 76 year old father with one child (who lives in England). He is isolated ad lonely and lives in a three bedroom house by himself. Dennis' health is deteriorating and has realised he needs to make changes for a better life but is unsure where to start.

Dennis's Situation: The Local Area coordinator was introduced to Dennis by the supervisor of the local community centre who was concerned about his well-being. Dennis visits the community centre a few times per week where he rents a room upstairs to paint and draw which is his passion. Dennis suffers from depression and doesn't have any support from neighbours or family. When he feels sad and lonely he stops doing the things he loves and stays at home. Dennis showed concern about his health and confessed that he can struggle breathing because he is overweight and it is something he needs to change. There are a few issues with Dennis' house which he highlighted he would like to change but either can't because it is too physical, or because it gets him angry which then hurts his chest. Dennis loves talking to people however has lost contact with friends and since becoming a divorcee has become lonely. He struggles with his hearing and wears an aid so sometimes can't fully understand a conversation from someone he doesn't know. Dennis uses a stick to get around and cannot walk far, which can stop him doing the things he wants. Dennis has a mobile phone but was unsure how to use it and was concerned as this was a way of contacting his daughter who lives in England.

What happened?

The coordinator spent time getting to know Dennis and building a relationship with him. Dennis has booked an appointment with the GP to ask for his options regarding exercise referral and his eligibility. Alongside Dennis the local area coordinator contacted a builder who did not fulfill their guarantee on the work completed on the house. The Local Area Coordinator and a local councillor met with the builder to advocate on Dennis's behalf and the situation is currently being reviewed. Dennis has started painting again and is considering attending a local art group with the aim of teaching painting. Supported by the Local Area Coordinator Dennis is able to use his mobile phone to contact his daughter on a regular basis which has eased his feelings of isolation.

Follow up and next steps: The local area coordinator is going to support Dennis to address his health issues as this was a key priority for Dennis. When Dennis' health begins to improve he would like to visit and connect more with this family. At present Dennis does not want to bother his family when he is unwell however confides in the local area coordinator for advice.

Andrea's Story

"I want to have the confidence to leave my home"

Introduction: Andrea is in her 80s and lives alone. She has family but they do not live close to her. Andrea has had two strokes and suffers with Osteoporosis. These illnesses have contributed to Andrea's fear of leaving the house and the anxiety of being alone. For 12 years Andrea has lived with this fear and has stayed in her home and relied on neighbours to do her shopping.

Source of referral: Introduced by the Gateway Team as Andrea did not meet their criteria

Andrea's Situation: Andrea spent her life travelling around the UK as a solo singer from the 1940s for twenty years, being invited to grand openings and then asked to travel to different parts of the world with a band and never let her osteoporosis get in her way. She later settled to have a family, but the marriage broke down and she moved to set up her own home and live independently. Andrea was very active and still enjoyed travelling, meeting up with friends and gardening.

Later in Life Andrea suffered a mild stroke and she was determined to live life and travel further afield and set up her own business. A few years later Andrea suffered a severe stroke and had a long recovery time in hospital where she picked up further illnesses, suffered with depression and panic attacks in fear of not being able to do anything and didn't want to chance anything else happening to her. After hospital discharge Andrea left her house on a few occasions but became anxious and had a few falls, which led to Andrea being too afraid leave her home again.

What happened? The Local Area Coordinator too time to get to know Andrea and to find out what was important to her, exploring what a good life would look like for her. Andrea's key priority was to leave her home and start gardening again. She also expressed her desire to learn how to use her laptop, in order that she could Skype her family who lived away and to be able to shop online. The Local Area Coordinator supported Andrea to become familiar with the internet, which enabled her to see her family for the first time in years via Skype. Andrea was so overwhelmed by this experience that she was motivated to leave her house and visit them.

The Local Area Coordinator supported Andrea to set small but realistic goals to work towards leaving the house. Initially Andrea went into the garden, then out for a short drive supported by the Local Area Coordinator and finally on her own, she walked to the coffee shop. The sense of accomplishment was huge for Andrea, and she has gone on longer bus journeys and no longer feels isolated, anxious/worried about leaving her house.

Follow up and next steps: Andrea continues to go out and about and in June 2016 she will be travelling to London to visit her family for the first time in 12 years. Andrea has also been connected via the Local Area Coordinator to another lady who was in a similar situation to Andrea, and they now support each other. Andrea has recently joined a computer course at the local training centre, which begins in September 2016 and is looking forward to a more positive future.

Ruth's Story

Introduction: I was originally introduced to Ruth's daughter. Ruth is a carer for both her adult children. Ruth doesn't have much time for herself and her mental health suffers because of this.

Ruth's Situation: I have known Ruth for about 6 months now. We have spent a lot of time together, along with her daughter. At the start, the focus was on supporting her daughter to get involved in the community and finding out what her strengths and talents were. However, as time developed, the focus would move between her daughter and herself. One of the overarching issues for the family was the loss of Ruth's second son 3 years previously. He died suddenly and the family have found it hard to come to terms with, having never received counselling. Ruth also calls with her elderly parents: her step dad has dementia and her mum has had periods of being unwell also.

What happened? One of the first things I did was to connect Ruth up with the Carer's Centre. She now gets their newsletter through the post and is quite interested by a number of things they put on, although hasn't been able to attend anything yet.

I was concerned about the amount of clutter in the home and whether they had all the fire safety equipment that they needed, so I asked Ruth if she would like a fire safety check which she agreed to. The fire safety officer checked the home, gave the family some advice and installed a smoke alarm, heat alarm and co2 alarm. Ruth asked him if he would call to her parent's house also, which they did.

I supported Ruth and her daughter to attend a local coffee morning which they enjoyed. Ruth met one of her old friends who she hadn't seen in years while she was there.
I made a referral to CRUSE bereavement support for the family. There was a 6 month waiting list.

Ruth regularly takes her daughter to a disco for adults with learning disabilities that I told them about. Her daughter met her boyfriend at this.

Recently I have met another lady, Angie, who doesn't live far from Ruth. Angie is an artist and also a full time Carer for her son who is on the autistic spectrum. Her daughter died suddenly 7 years previously when she was in her teens. Angie has been learning how to cope and get herself involved in the community ever since. She has been through a very difficult time but feels she has a lot to offer other people now. I mentioned there was a lady I knew who was going through a lot of similar experiences but wasn't as far on the journey and it was still having a major impact on her life, Angie offered to meet up with her and talk with her about it. I went back to Ruth with this offer and she said she would like that. Ruth's daughter also thought this would be a great idea and might provide her mum with a friend as well as having someone she can talk to about shared experiences such as being a parent carer and suffering through the loss of a child

Follow up and next steps: The next step will be to arrange Ruth meeting with Angie. We might tie it in with one of my visits so that I can stay home with Ruth's daughter for an hour while Ruth and Angie visit a café. I will continue supporting and meeting with the family. Ruth's daughter will hopefully be starting on a direct payment shortly and I will work with them through the interview process for a PA and then work together to look at community activities and groups they can access.

Barbara's Story

"I appreciate all your help"

Introduction: I first met Barbara in October, having received the introduction from her GP. She is a carer for her adult son who recently was hospitalised. Her husband passed away ten months previously. She was finding it difficult to cope.

Barbara's Situation: I spent a long time with Barbara the first time I visited here. She had a lot on her plate that she needed some help with. Since losing her husband she had become extremely isolated. Her son, who is in his 50s, has a learning difficulty and alcohol problems. He had recently been admitted to hospital with a bleed on his brain. She was extremely concerned about him and was in the process of dealing with his empty flat and a lot of his correspondence. Her daughter lives in England and calls down when she can.

What Happened? The first thing we did together was go through the pile of mail for her son and I helped her read and understand it. She was having some difficulty reading the mail, even with the aids she had. I discussed this with her and she said her eyesight had gotten worse recently. She also said that she had burned herself while filling a hot water bottle. We decided to make a referral to the Sensory Team who would be able to do an assessment for her and provide her with advice and additional aids to make sure she can see things better and stay safe. She also said that she would contact Spec Savers and ask them for a new eye test with the view to getting a stronger magnifier for reading.

During the course of these tasks, Barbara was talking about herself and her history. She had been a very popular singer and had won the Eisteddfod three times when she was a young girl. She always enjoyed working and was a very keen Welsh speaker. She really enjoyed attending her local Church but hadn't been in a long time as she had so much on her mind. She missed her husband a lot since he passed away.

I made a referral for Barbara to the counselling service at the Carer's Centre after she told me what a relief it was to have someone to talk to about her problems with her son and how much it was benefiting her. I thought that someone with counselling expertise would be able to provide a great service for her, which would have an immediate benefit. She reported that the counsellor had helped her a lot.

In January, it was time for Barbara's son to move into supported living from the hospital. I spoke with Barbara's daughter when there were concerns around this. His mood was fluctuating and it was hard to tell if it was what he wanted or not and whether it suited him. They didn't fell they had good lines of communication with his social worker, and Barbara in particular felt that she wasn't always kept up to date with what was happening. I contacted the social worker and talked with him about how Barbara was feeling and he said he hadn't realised. He contacted her straight away and talked through some things with her. I also visited her son in hospital which he was extremely pleased about as he wasn't getting any visitors. The move happened and so far has been ok, with a few minor concerns coming to light. Knowing that her son is living somewhere safe and where he is happy will be a big weight off for Barbara.

Anita's Story

Introduction: Anita was suffering with acute anxiety and depression for more than 17 years. Her husband had to stop working to support and care for her, as she struggled to be in the house alone. Anita struggled to be around people and could not go out and had become isolated, she worried that she would never be able to do the ordinary things in life.

Referral source: Working Links Job Club

Anita's Situation: Anita has been known to the **Local Community Coordinator** for over a year. She had been signposted to the LCC from Working Links job club. Anita was suffering with acute anxiety and depression for more than 17 years. Her husband had to stop working to support and care for her, as she struggled to be in the house alone. She explained that she could not concentrate on any given task for more than a few seconds, struggled to be around others and could not go out as she felt paranoid about people. She had become isolated and her anxiety dominated her every waking second. Anita had been prescribed medication and specialist help from a local mental health team, but she felt no further forward. Her mother had passed away two years previously and she describes this as, 'losing her rock'. She became further distressed and depressed and worried she would never do ordinary things with her husband such as go for a meal, go for a walk, have a holiday. She cried daily, shook all the time and felt unable to slow her racing thoughts to concentrate.

What happened? I've met with Anita over the year on a regular basis. Anita initially discussed her desire to go for a walk with a friend and small goals were identified and set that were important to her. Both Anita and I discussed anxiety management; using the Local Health Board's self-help guides and tips, and mindfulness. I built a relationship with Anita and slowly gained her trust. On the back of meeting her and several others in a similar situation, I organised a free 10 week local Mindfulness course. It was a massive step for Anita to attend, but she made it, and this spurred her on. At the group, she met others who understood her anxiety. For the first time, she felt able to declare that she suffered with anxiety. Following the 10 week mindfulness course, other goals were set, such as walking to her son's house, going shopping, going to the local pharmacy, food shopping without panic – using visualisation etc.

Over a year ago, Anita could not leave her front door and had become a prisoner in her own home, lonely and depressed. She currently attends a weekly 'wellbeing through creativity group', a social prescribing course run in conjunction with the Health Board, Valley and the Vale Arts and LCC. She has become good friends with the other ladies who attend, meeting up outside of the group. Anita is a massive part of running the Wellbeing Group, often escorting the older ladies on the community bus, organising the tea/coffee and helping the group to decide on what they would like to learn next. Using the community bus has been a recent achievement. Anita is helping to set up a walking group each Friday and enrolled herself on a sewing course which she attends each Thursday, independently. She regularly goes out for meals with her husband and they are planning a trip away next year. Anita's husband has also been able to return to work and now they are financially in a much better position.

Follow up and next steps: Anita is helping to run a Christmas stall this December to raise money for charity and despite overwhelming feelings at times of anxiety, she says she now feels she has the 'tools' to manage it and have the life she wants. Anita says she would like to help others, which she is already doing in the Wellbeing Group. She can be heard talking in her own words on the LCC website testimonials page. This was recorded some months ago, but she wanted to record her thanks and support for Local Community Coordination as she feels without this, she would not have been able to get her life back on track.

Paul's Story

Introduction: Paul is a 57 year old male who lives alone and has been a wheelchair user for several years due to a knee injury. Paul lost his wife six years ago and in the last two years as suffered two strokes, he has limited movement down the right side of his body. Paul is also diabetic and has a care package to provide his meals and movement in and out of bed. Paul is extremely isolated and craves social interaction.

Referral source: Social Services

Paul's Situation: Paul is a 57 year old male. He lives alone and has been a wheelchair user for several years after breaking his knee. His knee was not aligned correctly after the fracture and after several falls using crutches he was recommended by his GP to use a wheelchair. Paul lost his wife six years ago and in the last two years as suffered two strokes. The strokes have made him dependant on the wheelchair and he has limited movement down the right side of his body. He is also diabetic and has a care package to provide his meals and movement in and out of bed.
Paul has two grown up children, his only contact with his daughter is when she telephones to arrange his groceries to be delivered. His son was living at home until he was sectioned for drug induced psychotic behaviour and several weapons were removed from the property.

What happened? I received Paul's referral to **Local Community Coordination** was through social services and have been working with him since June 2016. Paul was extremely isolated and craved social contact as he enjoyed talking about all manner of subjects, particularly family history. He had not left the house for months other than a trip to the hospital, which he found very stressful after being left in a corridor for several hours after his appointment waiting for his return transport. When I first met Paul his speech was poor but we were able to converse even though he was frustrated about his speech. His speed of thought was clear to see but his speech was lagging behind which annoyed him. I have visited Paul weekly since and have seen him develop more confidence and strength on his right side. His speech has also improved through practising when I visit. I have encouraged Paul to practice his writing with both hands and he has begun writing short stories. He has some sight loss through the strokes and had difficulty recognising letters and words. I provided large print copies of the historical stories he enjoys. He is now able to read short words and we are working on words longer than three letters. I arranged for the library to deliver talking books which he has enjoyed and has been a great source of comfort. I have built a good working relationship with Paul and have built up trust. I read his mail for him and been able to pass on important forms to his son, which was of great concern for Paul as he thought he may lose his benefits if the forms were not completed. After a few months I gained enough trust for him to allow me to take him outside in his chair across the road to local shop. Paul was extremely pleased that he could remember his PIN and was able to buy the goods he wanted. He has a passion for family history and had previously traced his family back centuries and had stories published in heritage society newsletters.

Follow up and next steps: Through supporting Paul he has gained confidence and has written another article to be published in the next newsletter. To create a sustainable vehicle for Paul's love of family history and to enable social interaction, we have discussed forming a local history society in which he will support others to trace their family trees. To enable this, I have facilitated adverts requesting expressions of interest for the society. There has been a positive response and we shall look to set up an initial group in the new-year. He now has a sense of purpose and is looking forward to being part of the 'art on prescription' course in January. Paul was so excited about the history society he asked me to find his cousin from Cardiff's phone number so he could let her know. I wrote the number down in large print and when I returned the following week he had called and had had a long chat with his cousin. He has since received a letter from her which I read to him and they are now in regular contact.

6. The findings to date: Networks and Relationships

LAC aims to support people in staying strong and safe while contributing within inclusive and supportive communities, with the approach working to foster social networks beyond the formal relationships between public bodies and individuals. In this respect, the effectiveness of the Co-ordinator is only as effective as their work acting as a 'social network engineer'. The scale, nature and strength of the relationships established by the Co-ordinator across the community is critical for successful application of the approach. This is a challenging and complex task as meaningful relationships take time to develop, require ongoing care, and in a social context give significant importance to trust. Furthermore, network structure and local context are critical factors. For example, numerous strong relationships with individuals requiring support are compromised if there are insufficient strong links with appropriate resources. As individuals' situations, communities, and resource availabilities are themselves dynamic, then so too are the network requirements.

This is the first formative evaluation to map the creation and examine the importance of the network, beginning with Local Area Coordination in Swansea. The analysis examines the Network; the interconnected entities, and the Relationships; the individual and collective bonds between the entities. Visualisations (or mappings) of these networks using coloured or weighted lines to denote the nature of relationships, together with metrics provides useful insight to observe and analyse network development and activity. Analysis of data has shown that all three aspects have been effectively developed during the Implementation, with development of strong, dense and effective networks (see figures 6,7,8,9 and 10).

Western Bay LAC Implementation Network & Relationship Approach

Each Co-ordinator maintained a log of individuals and resources they identified within their site, together with recording of any interactions. An anonymised version of this was shared with the research team. As the Swansea sites provided the longest duration of data collection, these have been used to test the three areas defined in the opening section.

Network and relationship mapping in the case of LAC, and potentially LCC, allows identification of gaps, bottlenecks and resilience challenges. For example, multiple linkages to a unique critical resource in a community may highlight a risk if its capacity becomes pressured or its existence threatened. The approach identifies assets and individuals, charting the relationships established between them. This is recorded by the Coordinators in field notes and case studies. A simple characterisation and hierarchy of relationships was used to chart their development.
While it is technically possible to collect and overlay specific location data this has been excluded from this analysis in order to preserve anonymity of those receiving support.

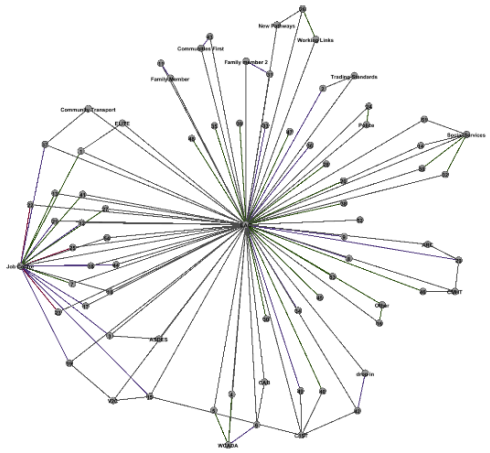
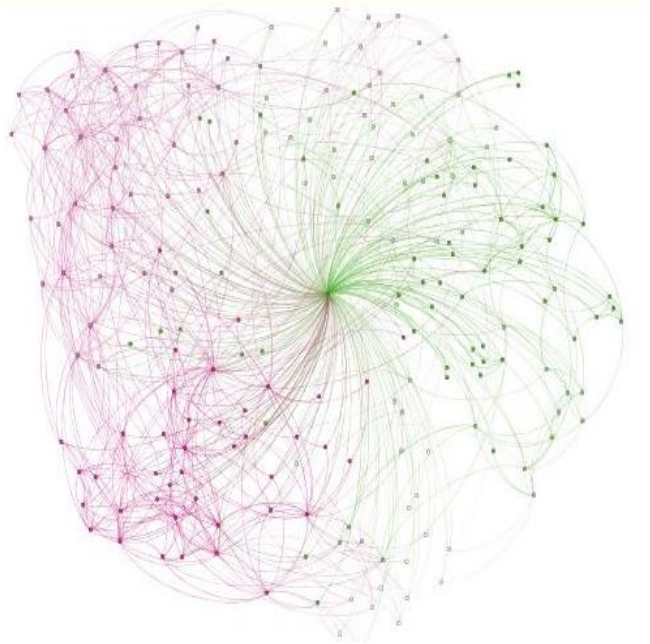


Figure 6 (above). An example of early networks and relationships established from June-August 2015 at one Swansea site.

The progression of relationships shown in Fig.6 to the left (denoted by the range of colours, moving from black with initial engagement through to green for positive outcomes) showed that Co-ordinators had already moved from initial engagement through into active support even at this early stage. While there was a high level of Co-ordinator centrality, the emerging complexities (indirect linkages) demonstrated that denser networks were starting to form. This also allowed logical groupings of individuals for support and key resources within the area to be identified.

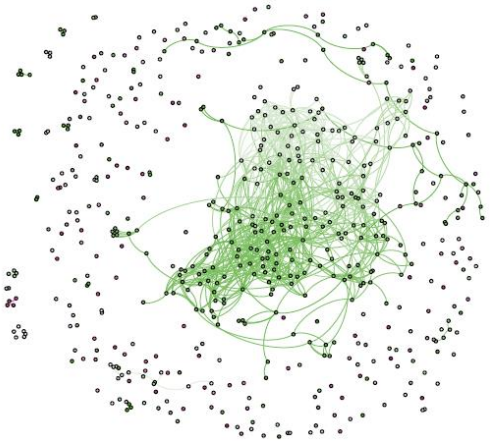
The continued work and data collection by the Co-ordinators allowed the three aspects of the Network and Relationships to be tested, building upon the early insight as follows;



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.

Figure 7: Swansea Co-ordinators' Network

Furthermore, evidence of resilience forming is shown in the network map featured in figure 8.



Helping create a resilient community network functioning beyond the involvement of the Co-ordinator is critical for scalability and maintaining sustainability of the intervention. As shown in Fig.8, percentage of linkages formed through LAC activity are directly between individuals and resources. However, the significant number of unconnected nodes, represent individuals and resources which are only connected through a Co-ordinator. This observation highlights the clear additionality of the LAC activity, while also showing the deeper contribution to community resilience.

Fig. 8 Network without Co-ordinator Links

The reach of the networks across and between Co-ordinators is shown in figure 9, resulting in a network of networks. This is to be expected with for example common resources, though demonstrates both the importance and opportunity of knowledge exchange between Co-ordinators and sites to maximise impact and efficiency.

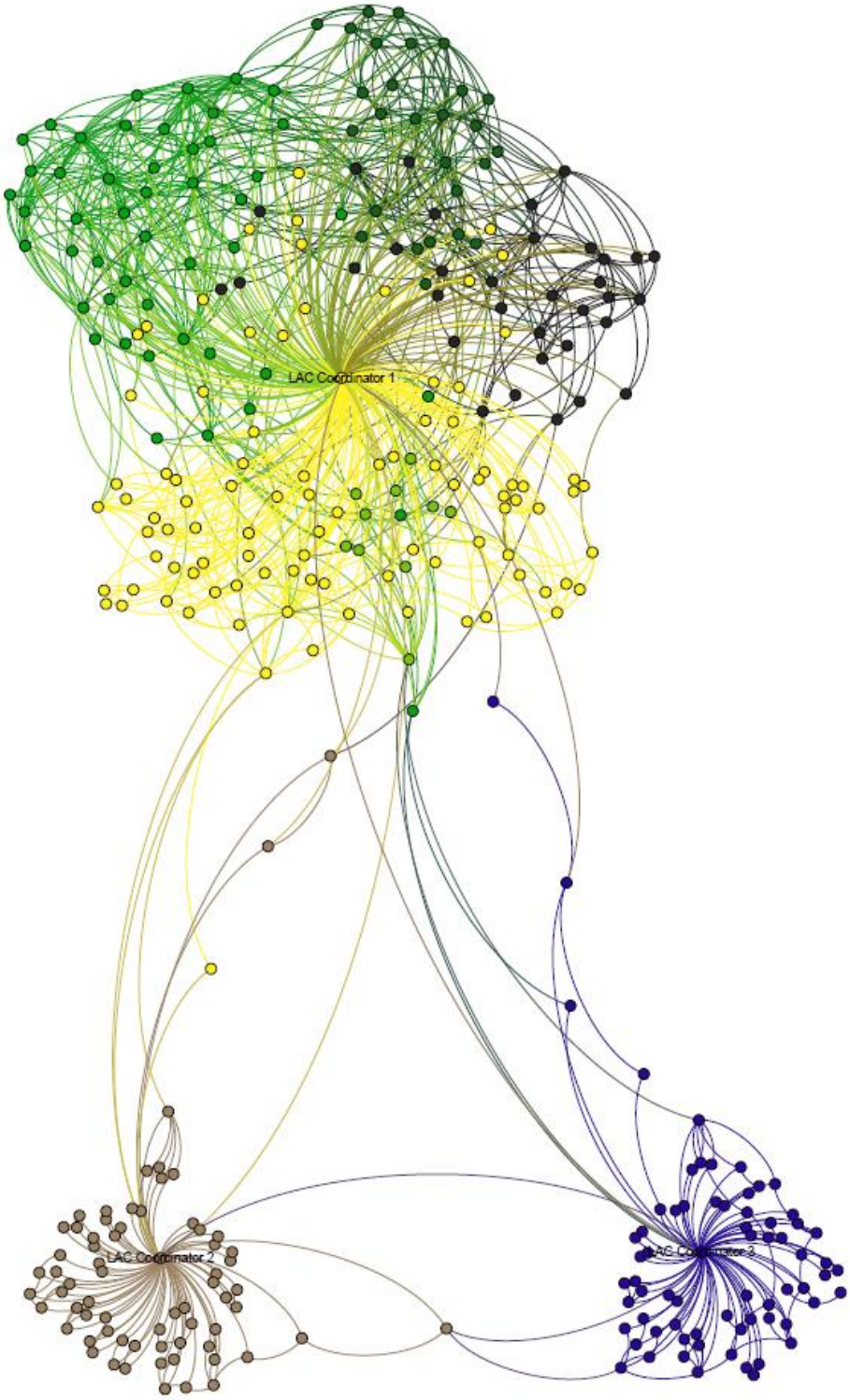
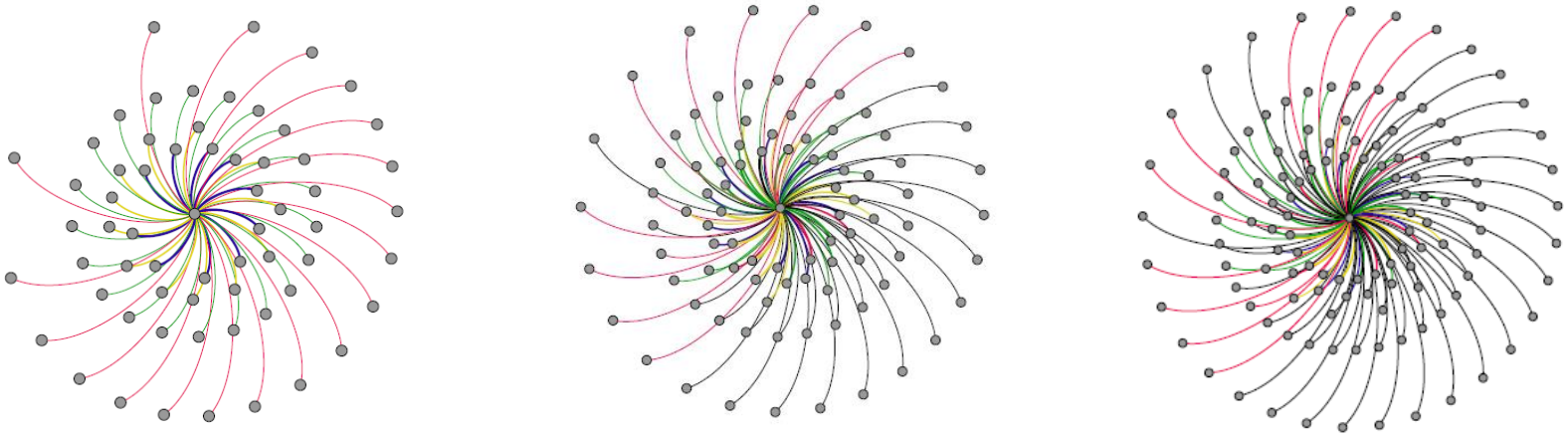


Figure 9. Inter-Co-ordinator Links

Figure 9. Progression of network activity beyond connection into resilient and sustained activity

Examining whether engagements progress to meaningful activity and outcomes, and at scale, is key in determining the success of the LAC Implementation. The following mapping for a representative Swansea site Co-ordinator presents the progression of engagements over a number of months. The outermost layer presents the level of Initial Engagement (1) while increasingly central layer points show linkages at higher levels of engagement through to Resolution (4) and continued activity (5).

Fig.10 Example Swansea Co-ordinator engagement progression



November January March

During the Implementation period, the portfolio had developed such that 38% of interactions had progressed to resolution or further activity, supporting that Co-ordinators are providing valued support as well as creating durable networks. The early stage of the activity makes it difficult to examine from network data whether individuals are turning into resources, however the more in-depth perspective of case studies suggest this is indeed occurring.

The increasing volume of cases progressing to resolution, together with the dense networks of individuals and resources both across communities and Co-ordinators demonstrate effective delivery across all three aspects of Networks & Relationships. Furthermore, the above visualisations have demonstrated how individual impacts described in case studies combine and reach across communities. This underscores the contribution of each LAC interaction, not only to individuals but communities as a whole.

In summary, a novel network and relationship mapping approach was applied to this formative stage with data collected across all three Swansea sites. This was because Swansea were the first to be initiated into the implementation phase of LAC and therefore held the most comprehensive database at the time of writing. This captured interactions during the implementation phase with the aim of identifying how LAC was engaging across the community; creating change beyond the direct Coordinator involvement; and how activity was progressing and being sustained.

Network analysis revealed the following:

- The formative nature and start-up phase observed development of new networks and relationships, drawing upon existing and new actors and clusters of activity.
- Coordinators have established extensive networks of resources and supported individuals across sites, with links between sites already starting to emerge involving over 305 individuals and over 1,200 connections.
- Linkages created between resources and supported individuals which are sustained without Coordinator involvement demonstrate capacity building and contribute to community resilience.
- A positive progression of relationships, from initial engagement through to active collaboration, to positive resolutions – demonstrates that Coordinators are having a positive sustainable effect within broadening portfolios.
- Continued data collection, with appropriate privacy safeguards, would support ongoing planning and management of LAC/LCC including identification of resource requirements and performance.

7. Financial Perspective

The Approach to Financial Evaluation

Each individual situation of a LAC or LCC supported person will have an outcome irrespective of LAC/LCC involvement with possible (or in many cases probable) use of public resources. Therefore, this study considers purely the marginal improvements delivered by the approach and the combined value this represents across the case portfolio. This approach protects against the variation in benefit across the portfolio and recognises LAC and LCC are not sole panaceas for all individual and societal challenges.

Profiling of Co-ordinator portfolios

Anonymised case portfolios for each of the seven Co-ordinators (3 from Swansea, 3 from Neath Port Talbot and 1 from Bridgend) with available data were mapped against the standard LAC case categories. While many cases were in early stages of engagement, the comprehensive understanding and record-keeping of the Co-ordinators provided sufficient information for all interactions to be profiled. The profiling involved review of each case (267 in total) between the Co-ordinator and research team, ensuring consistency in categorisation across sites. This resulted in the portfolio profile shown in figure 11 below;

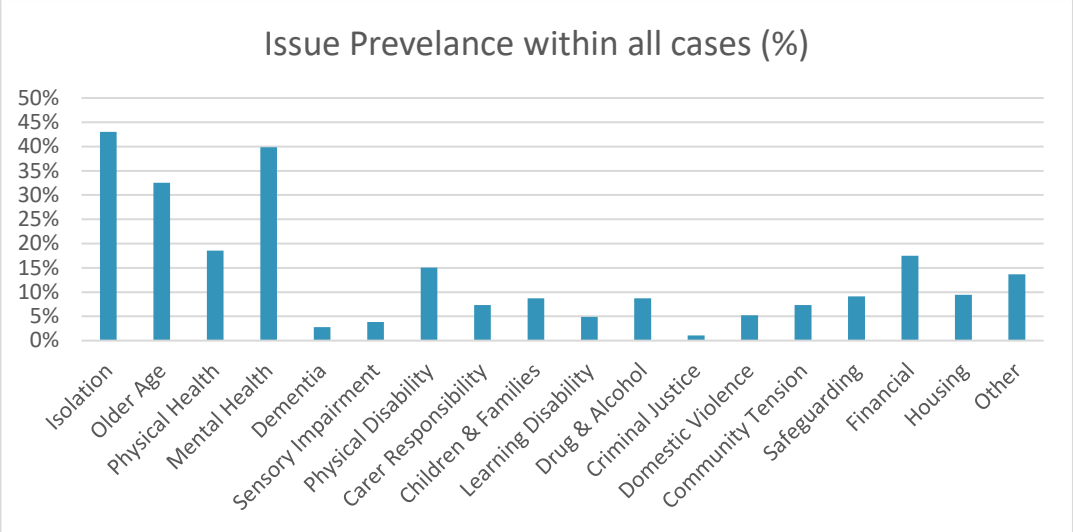


Figure 11. Issue of prevalence within the caseload (*n*=267) of Swansea, Neath Port Talbot and Bridgend's Coordinators (*n*=7). Figures show isolation, mental health and older age are the most common features within cases.

The portfolio indicates a significant prevalence of Isolation, Mental Health and Older Age issues across Western Bay. Loneliness and isolation have been shown to have adverse effects on physical and mental health and ultimately mortality (Public Health Wales, 2015). However, one of the most striking findings is the complexity of cases with the vast majority of cases involving multiple issues. Both LAC and LCC cases often involve a multiplicity issues (figure 12, below), with numerous public services either already or potentially involved in the future where situations deteriorate.

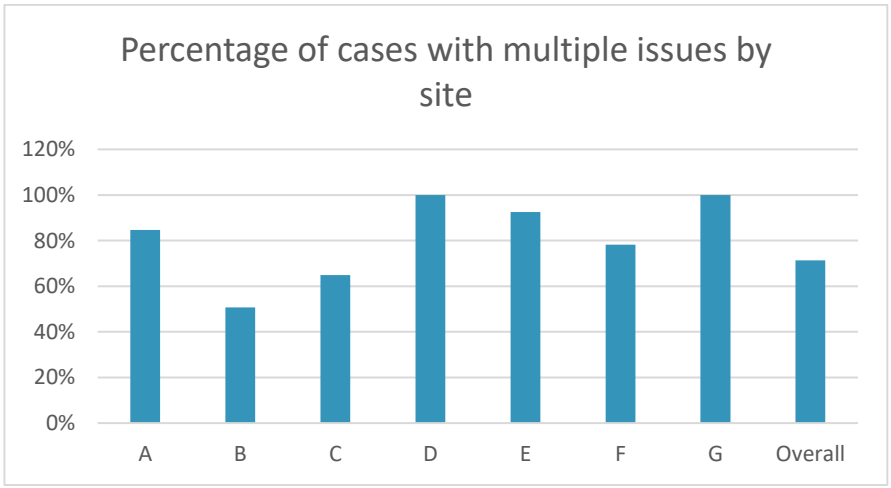


Figure 12. Shows the percentage of cases with multiple issues. All sites show a general high level of complexity but with variation. In particular, area 'D' and area 'G' already face caseloads where 100% of their work involves individuals or families reporting multiple issues.

Development and mapping of generic cases

The second phase of the process involved development of generic scenarios to group interactions by nature and intensity of services involved and potential outcomes (Table 1, below). These scenarios were based upon a review of issues that were presented within the Coordinators caseload, along with assessment of case Level (Tier 1 or Tier 2).

Generic Case	Number
1: Individual with family caring responsibilities	15
2: Younger/Middle-aged individual with health and financial challenges	38
3: Single parent with former spouse and wider issues	16
4: Isolated single parent with financial challenges	67
5: Younger/Middle-aged individual with social issues	19
6: Older isolated individual with health challenges	112
Total	**267**

Table 1. Through review of each interaction by the Co-ordinators, the following Generic Cases were produced and a breakdown identified by the researchers.

The frequencies in the above clearly reflect the issues noted in earlier sections, with notable scale of isolation and health issues, particularly amongst older individuals. However, the mapping also echoes the observation of many younger and middle-aged individuals receiving LAC and LCC support.

Generic cases by optimistic, base and pessimistic outcome scenarios

Each generic case was reviewed against a set of 'impact groupings' to identify the nature and intensity of costs and benefits. This exercise mapped against outcomes drawn from the Western Bay case studies, wider portfolio and benefits from extensive prior research noted in the People, Places, Possibilities report[1] (table 2). For the analysis these were grouped by:

Impact Groupings	Example Costs and Benefits considered
Economic Activity	Unemployment benefits[2], volunteering/employment contributions
Housing	Temporary Accommodation, repossession /relocation, housing costs
Older Persons Care	Nursing/Residential Care, Home/Day Care Packages
Health Professionals/Services Interventions	GP Visits, A&E Visits, Mental Health services
Social Services Interventions	Social worker involvement, fostering support
Skills and Education	Qualifications gained, truancy/exclusion costs
Safety and Security	Anti-social behaviour costs, police involvement

Table 2. Generic Cases were reviewed against a set of Impact Groupings to identify the nature and intensity of costs and benefits.

[1&2] It is noted that some benefits will relate to local/devolved WG services/responsibilities, while others such as unemployment benefit relate to UK Government expenditure.

Available service unit costs from Government[i] and academic[ii] research, or other appropriate benchmarks for avoided service requirements, together with further quantifiable benefits allow a level of assessment of each Case. These have been related to the relevant benefits grouping as noted above.

The following table presents anticipated costs for each Generic Case based on the optimistic, base and pessimistic scenarios. These were based upon services which would be involved in supporting an individual for each scenario. Also presented in the' differential benefit' of an improved scenario i.e. progressing from a pessimistic outcome to base scenario etc. and therefore recognises that not all service support use and associated costs will be avoided.

	Anticipated Costs			Value of Improvement	
Generic Case	Optimistic	Base	Pessimistic	Base-Optimistic	Pessimistic-Base
1: Individual with family caring responsibilities	2,441	9,095	22,845	6,654	13,750
2: Younger/Middle-aged individual with health and financial challenges	1,123	3,014	4,030	1,891	1,016
3: Single parent with former spouse and wider issues	12,704	17,481	78,719	4,777	61,238
4: Isolated single parent with financial challenges	1,498	5,129	16,996	3,631	11,867
5: Younger/Middle-aged individual with social issues	2,659	5,787	12,224	3,128	6,437
6: Older isolated individual with health challenges	9,252	27,782	63,622	18,530	35,840

Table 3. Presents anticipated costs for each generic case based on the optimistic, base and pessimistic scenarios. These were based upon services which would be involved in supporting an individual for each scenario. Also presented is the 'differential benefit' or value of improvement i.e. where a case progresses from a pessimistic outcome to base scenario, and moving from a base to optimistic scenario etc.

Review of Results

The number of Co-ordinator interactions; the multitude of issues confronted and resolved; and the individual cases presented in earlier sections show the direct human value of the activity. Data from the seven Co-ordinators involved in this part of the study (including notably a number still at early stages) have shown activities relating to a broad range of public services and other beneficiaries. The table below (table 4) maps the LAC/LCC portfolio against the generic cases, presenting the respective volumes of cases across the sites. To provide overall portfolio support costs, this is combined with the optimistic, base and pessimistic scenario costings using the individual costs described in the previous section. The complexity of cases further underlines the challenge in making positive individual, societal and financial benefits without the earliest possible interventions.

Generic Case	Number	Combined Costs		
		Optimistic	Base	Pessimistic
1: Individual with family caring responsibilities	15	36,615	136,425	342,675
2: Younger/Middle-aged individual with health and financial challenges	38	42,674	114,532	153,140
3: Single parent with former spouse and wider issues	16	203,264	279,696	1,259,504
4: Isolated single parent with financial challenges	67	100,366	343,643	1,138,732
5: Younger/Middle-aged individual with social issues	19	50,521	109,953	232,256
6: Older isolated individual with health challenges	112	1,036,224	3,111,584	7,125,664
Total	**267**	**1,469,664**	**4,095,833**	**10,251,971**

Table 4. LAC/LCC portfolio of generic cases, presenting the respective volumes of cases across sites and using the individual costs described in the previous section.

In terms of costs, the Swansea LAC implementation is budgeted as a ~£200k initial investment for twelve months, inclusive of Co-ordinator and other management costs. The collective scale and costs of the Bridgend and Neath Port Talbot implications are taken as being broadly similar, representing combined investment of no more than £400k across the Western Bay region. At this stage comprehensive tracking data are only available for Swansea and Neath Port Talbot sites, which, combined with a staggered start-up, makes comparison across sites both meaningless and inappropriate.

Where complete data sets are available interaction costs per supported individual average at ~£980, though it should be noted that costs during this phase include start-up costs, and cost per interaction should therefore decline as the activity matures, networks are formed, and start-up costs are diluted. For example, with each Co-ordinator establishing a portfolio similar in scale to the most mature, this would see average cost per individual reduce to ~£600. As noted in previous sections, this analysis focuses upon the incremental improvement across the portfolio, acknowledging that LAC/LCC will not fully resolve issues, but forms part of a more integrated approach with individuals, families, communities, and services. Therefore, the financial benefit in improvement between scenarios is only related to 20-30% of interventions, with a range providing consideration to sensitivity in the underpinning assumptions. This is in keeping with levels of additionality noted from previous LAC evaluations.

Based upon this model, this initial implementation data presents a strong performance with financial benefit of between £787k-£1,231k across the mid-range (high-lighted), further reflected in the accompanying benefit/cost figures (Table 5).

LAC Pilot Portflio - Impact Value	Total Value	20% Outcomes	30% Outcomes
Improvement: Base - Optimistic	2,626,169	525,234	787,851
Improvement: Pessimistic - Base	6,156,138	1,231,228	1,846,841

LAC Pilot Portflio - Benefit/Cost	Costs	20% Outcomes	30% Outcomes
Improvement: Base - Optimistic B/C	400,000	1.31	1.97
Improvement: Pessimistic - Base B/C	400,000	3.08	4.62

Table 5. Implementation data present a strong performance with financial benefit of between £787k-£1,231k across the mid-range (high-lighted).

While the above provides a relatively broad range it presents, even under the most conservative conditions a positive and meaningful return. However, the formative nature of the implementation where relationships are developing and knowledge/understanding of the role is building, should be noted and therefore progression to steady state should be considered. The increasing rate of introductions observed in the Network section suggests that saturation has not been achieved and there is continued demand for Co-ordinator support. Indeed, this is likely to be compounded by developments such as the growing economic and social tensions caused by the recent Brexit referendum result. Based upon continued momentum to a steady state across Co-ordinators that reflects the most mature site (with case load of ~70 individuals p.a.), together with maintained investment, this would result in ongoing impacts and benefit/costs as indicated in table 6 below;

LAC Ongoing - Impact Value	Total Value	20% Outcomes	30% Outcomes
Improvement: Base - Optimistic	4,037,008	807,402	1,211,102
Improvement: Pessimistic - Base	9,463,359	1,892,672	2,839,008

LAC Pilot Portflio - Benefit/Cost	Costs	20% Outcomes	30% Outcomes
Improvement: Base - Optimistic B/C	400,000	2.02	3.03
Improvement: Pessimistic - Base B/C	400,000	4.73	7.10

Table 6. Steady state across Co-ordinators that reflects the most mature site (with case load of ~70 individuals p.a.), together with maintained investment, this would result in ongoing impacts and benefit/costs as indicated above.

The steady state across the existing sites would show continued and increased benefit across the range of assumptions, with potential for further improvement via efficiencies of scale and shared learning/resources. The replicability of LAC/LCC and its benefits across the Western Bay region supports its continued rollout, representing a proven, impactful and cost-effective approach to supporting communities within Western Bay. The integrity of both LAC and LCC 'models' should be maintained and by nature embedded in communities and remain out of service settings.

Emerging Benefits

- Avoided calls upon Social Worker support (Adult Services)
- Avoided General Practitioner visits
- Avoided calls upon mental health services

Anticipated Potential Benefits

- Potential employment (with associated benefits to UK central government)
- Avoided Community Nurse visits
- Avoided/Delayed transition into residential care or nursing home
- Avoided Home Care Visits

In terms of cost, the Neath Port Talbot LAC implementation is approximately £200k for twelve months, inclusive of Co-ordinator and other management costs. This is comparable with other

benchmarks for delivery and will be tracked against the scale up of delivery and benefits achieved during the further stages of this evaluation.

In Summary, and based solely on Swansea LAC Coordinator activities at three sites (as they were initiated first and therefore have a more developed portfolio), the data revealed the following:

- In line with the findings from previous studies and building upon their approaches, this review found LAC/LCC to be tackling a broad range of social and personal issues.
- The data demonstrates a positive return on investment across the portfolio of 267 individuals supported and reviewed for financial benefit.
- The cost per supported individual were on average £980, though trending to circa £600 per individual as set-up costs were absorbed into portfolios reaching steady state.
- High levels of complexity within the portfolio, with positive outcomes noted in other sections, suggest that Coordinators are adding value across a range of public service pressures.
- Mapping of the portfolio across representative generic cases allowed incremental improvements to be considered, with sensitivity analysis using defined parameters.
- LAC/LCC implementation, as reviewed, involved costs of circa £400k with benefits in the range of £800k-£1.2m. This represents a benefit/cost ratio of between 2:1 and 3:1 using the core range assumptions, whilst continuing to provide returns even under the most conservative parameters.
- Sustained LAC/LCC activity for the implementation sites alone would see the benefit/cost ratio improve further, rising to between 3:1 and 4:1 with a net return of £1.2m-£1.8m. This would also benefit from economies of scale and operational synergies with wider rollout of the approach.
- To develop upon insight drawn from previous LAC evaluations, the study uses an original approach which aggregates cases into a combined effect with a sensitivity analysis to provide an outline of the financial benefits. However, continued evaluation and recording of data is required to monitor progress on multiple levels.

Clearly the complexity and diversity of the LAC case portfolio creates uncertainty as to the extent to which LAC is contributing to improvements and not all interactions will be effective. Indeed, some cases may improve on their own and others may be beyond unreceptive or unaffected by the LAC support. The relatively early stage of interactions makes it challenging to quantify benefits as limited data are available. However, interim case studies developing around individual interactions allowed identification of the nature of service use already avoided through LAC/LCC interventions (along with anticipated outcomes). Encouragingly, even at early stages these already demonstrated both emerging and planned benefits for individuals, together with interventions targeting wider groups within communities.

8. Findings & Recommendations

Findings and Recommendations by Theme

Strategy

Finding: The implementation phase of LAC/LCC was characterised by a lack of understanding of certain aspects, such as an awareness of the strategic positioning, boundaries, and the role of the Coordinator amongst certain key stakeholder groups.

Recommendation 1: Development of a strategic plan for the regions giving an overview of how LAC/LCC dovetail with the Local Authorities' vision and mission, funding plans and strategic direction. This would also help to clarify the role and scope of Coordinators and reduce 'cross-boundary exploitation' and potential duplication.

Recommendation 2: Knowledge exchange between strategic partners could be encouraged by hosting LAC and LCC 'Summits' to inform potential funding opportunities and mutually beneficial collaboration.

Funding

Finding: Increasing pressure on resources and availability of funding has put constraints on other community and social initiatives supported by the local authority. This has contributed to some of the negative perceptions of LAC and LCC at the beginning in that it has been viewed as a repetition of existing initiatives.

Finding: Co-funding of Coordinators has already taken place in other UK sites where partners see mutual preventative benefits.

Recommendation 3: Development of a co-funding plan which should include contributions from local authorities and partner organisations, including universities, housing providers, health (including public health), fire and police as well as consideration of the private sector.

Shared Learning

Finding: Swansea and Neath Port Talbot are part of an emerging Local Area Coordination 'South West Region' to build wider regional connections, mutual support, shared learning and richer, more cost effective induction and training. Swansea was the first to launch LAC and both Swansea and Neath Port Talbot Implementation Managers have formed a supportive relationship. Shared learning around safe guarding and best practice has already taken place between Swansea, Neath Port Talbot and Bridgend.

Recommendation 4: Shared learning and best practice between localities and regions should continue and be encouraged with regular meetings between management and Coordinators, this includes LAC and LCC. Shared learning should also be communicated to/between LAC leadership groups. Strong leadership has the capacity to link equivalents in other areas.

Finding: The UK LAC network is a collective of managers overseeing Local Area Coordination. They meet on a regular basis to share learning and discuss progression. This is an extremely valuable resource, especially for those at implementation stage.
Recommendation 5: Learning from other partners across the UK LAC Network should be encouraged where appropriate. This should be driven through open and transparent inclusion and by working and achieving together.

Finding: Language and terminology are an issue when communicating with partners. LAC has its own terminology which for some, sets it apart from the mainstream.
Recommendation 6: Consideration of terminology should be reviewed over the long-term.

Leadership

Finding: Sustainability and adoption of LAC has traditionally been linked with the presence of strong leadership. However, both NPT and BCBC have taken a 'bottom up' approach and have only recently convened leadership groups. Leadership groups provide valuable support and connections at strategic level. Furthermore, membership to the group is integral to developing and driving partnership working and organisational change.
Recommendation 7: Nurturing the development of an effective Leadership Group in each region (Swansea, Neath Port Talbot and Bridgend) with regular review of membership. Leadership Groups should also share key information and link with equivalents where possible.
Recommendation 8: Membership of the Leadership Group should also include contributions from Coordinators, people with a lived experience of disability/mental health difficulties/ageing or as family/carer, 'community champions' and centres of community activity. These might include individuals from libraries, foodbanks, faith groups etc.

Finding: Buy-in at senior level is integral to the success and sustainability of the teams supporting LAC and LCC. Senior buy-in is also related to systems change, service reform and greater propensity towards joint working. The UK LAC network reports that senior colleagues have the ability to unlock barriers and expand meaningful networks.
Recommendation 9: Understanding and communication of the LAC and LCC models are essential for realising the aim of becoming a front-end service. Social media has an important role to play in this as well as senior management and leadership communicating LAC and LCC concepts and ethos to their individual fora.

Area Selection

Finding: Swansea in particular has evidence of several requests for LAC just outside the boundaries of all three areas. This will only increase as LAC is communicated to a wider audience over time. The same will apply to LCC.
Recommendation 10: Allocation of future Coordinators should be adjacent to existing LAC and LCC areas and where there is evidence of demand. Growing from the centre has the

potential to strengthen the delivery of Local Area Coordination and Local Community Coordination as Coordinators share local knowledge and connections in closer proximity. This, in turn, may build conditions for enabling quicker development of introductions, expansion of bordering networks and sustainable local, non-service solutions. In addition, this will allow for rapid acquisition of caseload.

Finding: The LAC areas were originally scoped on the basis of population and convenience rather than evidence of need. Consequently, not all communities within some Coordinators' areas have engaged with LAC to the extent of other communities within the same areas.
Recommendation 11: Regularly review the prescribed area and shape it to fit the communities they serve, moving beyond a basic geographic/population/convenience approach. We suggest this should also be applied to LCC areas.

Recording Information

Finding: There is no standardised method for recording and storing data at present across the UK LAC Network. Each region has its own processes, requirements and measures. However, there are shared data capture fields being used across all National LAC sites with some local variations. This notwithstanding, these need to be reviewed and aligned.
Recommendation 12: Data capture and storage needs to be reviewed and aligned. This could be potentially co-funded and provide mutual benefit to partners.
Recommendation 13: The development of a bespoke database - fit for purpose and with App potential, which would link across regional sites should be considered. Discussions regarding the WCCIS (Wales Community Care Information System) and how it might fit with LAC and LCC should be raised with the Western Bay WCCIS Project Board.
A dedicated App has the potential to:

- *Enable rapid input of information without impinging on the Coordinators' time.*
- *Contribute data to ongoing research initiatives and help to inform Local Area Coordination in the UK.*
- *GPS function could support the safety aspects of lone working*
- *Update CRM database in real time*
- *Inform asset mapping*
- *Monitor caseloads and flag capacity issues*
- *Enable informed case transition for people covering holiday cover/sickness/Coordinators leaving etc.*
- *Contribute data to reports, leadership meetings*
- *Provide evidence to potential partners when attempting to build new relationships with key partners.*
- *Provide clear evidence of shared outcomes and joint working*
- *Build a profile of the community ecosystem*

However, partners would have to agree on the type of data/categories to be recorded using the App and Database.

Recommendation 14: Continuation of data collection in order to inform a business case for co-funding opportunities to key partners.

Recruitment and Roles

Finding: Recruitment to date by LAC and LCC has included the use of a community panel, this has enables direct, shared contribution and decision making by community and services co-production. This enables Coordinators to access community assets more easily and rapidly build networks. Community members from these interview panels are extremely valuable in helping a new Coordinator embed themselves within their prospective community.

Recommendation 15: Local Area Coordinators should also be included in the recruitment process, whether it be through introductory presentations e.g. "a day in the life of a Coordinator", having a view as to how a candidate might fit within the LAC or LCC team, or assisting with final decisions if there is disagreement or 'deadlock' in the selection process.

Finding: Implementation of both LAC and LCC was overseen by key individuals who simultaneously held other roles on other projects. In the medium/long-term this is unsustainable.

Recommendation 16: The LAC and LCC Manager roles need to be clearly defined and protected to give both initiatives the necessary and appropriate full-time investment in order to maximise potential impact and sustainability.

Finding: Both LAC and LCC are new to Western Bay and reporting structures vary. Governance structures, accountability and monitoring remain vague to colleagues and external partners.

Recommendation 17: Clear reporting structures should be agreed, defined and communicated to the wider network at a local level to help protect and support LAC and LCC managers and Coordinators.

Finding: Concerns around duplication of services by LAC and LCC were reported by third sector partners and colleagues within the Local Authorities.

Recommendation 18: Clear methods and processes of communication should be designed and maintained in order to avoid duplication, promote joint working, share news, celebrate success, and community cohesion.

Health

Finding: There are a significant number of initiatives within the health sector aligning to the preventative agenda. Health is a key partner that NPT LAC has successfully linked with. However, the individual overseeing the implementation of LAC in NPT is employed by the Health Board and has been able to link in with many of these initiatives, avoid duplication and forge complimentary relationships.

Recommendation 19: The value of engaging health sector partners should not be underestimated. Health Partners should remain a key focus for engagement and feature at a senior level in the Leadership Groups for both LAC and LCC.

Profile of Coordinator Portfolios

Finding: Whilst many of the cases were in the early stages of engagement, a profile review revealed a striking percentage of complex cases, involving a myriad of issues with numerous stakeholders either already or potentially involved.

Finding: Previous LAC evaluations, including Social Return on Investment (SROI) evaluations have highlighted the risk of over-dependency on the Coordinator. Whilst this formative evaluation has not yet presented this issue due to the nature of this early stage, given previous findings this development cannot be ruled out.

Recommendation 20: Appropriate sensitivity should be extended to the portfolio management of each Coordinator in order to mitigate against developing dependency and/or the coordination of a disproportionate amount of multiple-issue cases.

Third Sector

Finding: Third Sector partners are extremely committed, passionate and experienced in community work. There is a wealth of highly experienced staff and volunteers as well as proven processes and measures in place.

Recommendation 21: Enhance engagement with the CVCs at senior level in order to support and complement existing links created by Coordinators at operational level. CVCs operate as an umbrella organisation for third sector partners. Third Sector and CVC representation should be present and contribute to Leadership Groups and steering committees on a regular basis.

Finding: There is exceptional expertise and experience within the Third Sector and the dedicated teams of the Local Authority and whilst there are cultural differences in working, both LCC and BAVO and LAC and CVS all share key values of providing guidance, community cohesion and community development.

Recommendation 22: Clear and open channels of communication between BAVO, CVS and the Local Authority may help to clarify the mission, share expertise, agree potential areas for joint working and create a stronger working partnership.

Recommendation 23: Strategic and operational relationships should be nurtured with Third Sector, including CVC partners. It is clear there is great potential to work together to identify gaps, seek collaborative opportunities and avoid duplication. Again, this needs regular, clear and open channels of communication.

Networks

An innovative network and relationship mapping approach was applied to this formative stage with data collected across all three Swansea sites. This captured interactions during the implementation phase with the aim of identifying how LAC was engaging across the

community; creating change beyond the direct Coordinator involvement; and how activity was progressing and being sustained.

Findings: Network analysis revealed the following:

- The formative nature of the mapping observed development of new networks and relationships, drawing upon existing and new factors, and clusters of activity.
- Coordinators have established extensive networks of resources and supported individuals across sites, with links between sites already starting to emerge involving over 305 individuals and over 1,200 connections
- Linkages created between resources and supported individuals which are sustained without Coordinator involvement demonstrate capacity building and contribute to community resilience.
- A positive progression of relationships, from initial engagement through to active collaboration, to positive resolutions – demonstrates that Coordinators are having a positive sustainable effect within broadening portfolios.

Recommendation 24: Continued data collection, with appropriate privacy safeguards, would support ongoing planning and management of LAC/LCC including identification of resource requirements and performance.

Cost/Benefit

Findings: Based on activities at three Western Bay Local Authority areas (3 Swansea sites, 3 NPT sites and 1 Bridgend site), the data revealed the following:

- In line with the finding from previous studies and building upon their approaches, this review found LAC/LCC to be tackling a broad range of social and personal issues.
- The data demonstrates a positive return on investment across the portfolio of 267 individuals supported and reviewed for financial benefit.
- The cost per supported individual were on average £980, though trending to circa £600 per individual as set-up costs were absorbed into portfolios reaching steady state.
- High levels of complexity within the portfolio, with positive outcomes noted in other sections, suggest that Coordinators are adding value across a range of public service pressures.
- Mapping of the portfolio across representative generic cases allowed incremental improvements to be considered, with sensitivity analysis using defined parameters.
- LAC/LCC implementation, as reviewed, involved costs of circa £400k with benefits in the range of £800k-£1.2m. This represents a benefit/cost ratio of between 2:1 and 3:1 using the core range assumptions, whilst continuing to provide return even under the most conservative parameters.

Recommendation 25: Sustained LAC/LCC activity for the implementation sites alone would see the benefit/cost ratio improve further rising to between 3:1 and 4:1 with a net return

of £1.2m-£1.8m. This would also benefit from economies of scale and operational synergies with wider rollout of the approach.

Next Steps

Local Area Coordination and Local Community Coordination aims to support communities and build resilience with focus upon local relationships and assistance rather than use of statutory services. To support this work, and inform key stakeholders of progress and early outcomes a formative evaluation has been undertaken. This report contains the first formal feedback from this evaluation process, with focus upon the setup activities and initial activities (Initiation) of Local Area Co-ordination and Local Community Coordination across the Western Bay Region.

Recommendation 26: The evaluation process should continue beyond this formative stage and that ongoing monitoring and longer-term evaluations will provide further insight into the impact of both Local Area Coordination and Local Community Coordination. It is hoped this activity will inform both practitioners in optimising delivery, and policy makers in potential future use of Local Area Coordination and Local Community Coordination in the Western Bay region and beyond.

Recommendation 27: In addition to a summative evaluation, it is the recommendation of the researchers that a 'Social Return on Investment' (SROI) evaluation be commissioned in order to confirm existing and inform future social value.

Recommendation 28: Swansea and Neath Port Talbot regions should continue to work with the UK LAC Research Network to inform future research directions and initiatives. Swansea, Neath Port Talbot and Bridgend all have access to specialist research centres such as the Wales School for Social Care Research (Welsh Government, based at the College of Human & Health Sciences, Swansea University) and these potentially offer a valuable source of research support.

Recommendation 29: Western Bay is in a unique position in that it has implemented both LAC and LCC and would benefit from longitudinal study to inform future recruitment, roll-out and policy.

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References

Annual Report 2014, Director of Social Services, City & County of Swansea

Bartnik E (2008) in Gregg P and Cooks G (Eds) (2010) *'Putting people in control: reforming the system of support for disabled people', in Liberation Welfare'*, London, Demos.

Communities First Clusters and Communities, City and County of Swansea, www.swansea.gov.uk/communitiesfirst

Evaluation of the Implementation of Local Area Co-ordination in Scotland, Scottish Executive, 2007.

Evaluation of Local Area Coordination in Middleborough: Final report. Peter Fletcher Associates, 2011.

Life expectancy by local authority and gender, StatsWales, Welsh Government, 2015.

Local Area Coordination, Fourteen month evaluation report. Thurrock Council, Inclusive neighbourhoods, 2014.

Local Area Coordination: From Service Users to Citizens. R.Broad, Centre for Welfare Reform, 2012.

Measuring Inequality, Trends in mortality and life expectancy in Swansea, Public Health Wales Observatory, 2015.

Mid-Year Estimate 2014, www.swansea.gov.uk

National Assembly for Wales Welsh *(2014) Social Services and Well-being (Wales) Bill, Approach to Implementation*, 2014.

National Guidance on the Implementation of Local Area Coordination, Scottish Government, 2008.

People, Places, Possibilities; Progress on Local Area Coordination in England and Wales. The Centre for

Personal Social Services: Expenditure and Unit Costs, England, 2013-14, Health & Social Care Information Centre, 2014

Population and Household Projections, Briefing Note, Welsh Government, 2011.

PSSRU 2010 research cited, Care in Crisis 2014, Age UK, 2014

Ritchie P (1999) in Hunter, S. and Richie, P. *Co-Production and Personalisation in Social Care: Changing Relationships in the Provision of Social Car*e. Jessica Kingsley Publishers, London, 2007

Social Services and Well-being (Wales) Bill, Approach to Implementation. Welsh Government, 2014.

The Social Care and Well-being (Wales) Act 2014, legislation.gov.uk/anaw/2014/4/contents, 2014
Unit Costs of Health & Social Care 2013, Personal Social Services Research Unit, The University of Kent, 2013

Welfare Reform, 2015.

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