

North East Lincolnshire Council: local authority assessment

[How we assess local authorities](#)

Assessment published: 19 December 2025

About North East Lincolnshire Council

Demographics

North East Lincolnshire is a unitary authority located on England's eastern coast, south of the Humber estuary. It includes the port towns of Grimsby and Immingham, as well as the coastal resort of Cleethorpes, covering approximately 192 square kilometres.

The borough has an estimated population of 158,335. The majority of people identify as White British (96.2%), with smaller proportions identifying as Asian or Asian British (1.6%), Black or Black British (0.5%), Mixed or Multiple ethnic groups (1%), and Other ethnic groups (0.7%).

Approximately 21% of the population are aged 0–17 years, 57.56% are of working age (18–64 years), and 21.43% are aged 65 and over.

North East Lincolnshire has an Index of Multiple Deprivation decile score of 7 and is ranked 51 out of 153 local authorities in England (with 1 being the most deprived). Deprivation was concentrated in specific areas, particularly East Marsh and West Marsh, which fall within the most deprived 1% nationally.

Life expectancy in the borough was below the national average. Healthy life expectancy at birth was 55 years for males and 58 years for females. There was a significant disparity in life expectancy between the most and least deprived areas. Women in the most deprived areas live 10 years less, and men 12 years less, than those in the least deprived areas.

North East Lincolnshire is part of the Humber and North Yorkshire Integrated Care System (ICS), which also includes East Riding, Hull, North Yorkshire, and York. The main hospital serving the area is the Diana, Princess of Wales Hospital in Grimsby, operated by Northern Lincolnshire and Goole NHS Foundation Trust.

The council is Conservative led with no overall control, with 42 elected members representing 15 wards across the borough.

Since 2004, the local authority and NHS have operated under a Section 75 agreement, enabling formal delegation of functions and responsibilities to meet Care Act duties. This arrangement supports joint commissioning, pooled funding, and integrated health and social care services between North East Lincolnshire Council and the Humber and North Yorkshire Integrated Care Board (ICB).

Services are commissioned through three Community Interest Companies (CiCs): Navigo (mental health), Care Plus Group (community services), and Focus Independent Adult Social Work (Care Act duties). All three CiCs contribute to the Single Point of Access (SPA). Focus delivered 100% of its services under Care Act duties, while Navigo and Care Plus Group deliver approximately 10% of their services under this function. Throughout this report, references to frontline teams and staff working across these CiCs will be described as the local authority under delegated responsibility.

Financial facts

- The local authority estimated that in 2024/25, its total budget would be **£254,517,000**. Its actual spend for that year was **£269,566,000**, which was **£15,049,000** more than estimated.
- The local authority estimated that it would spend **£62,052,000** of its total budget on adult social care in 2024/25. Its actual spend was **£63,147,000**, which was **£1,095,000** more than estimated.
- In 2024/25, **23.43%** of the budget was spent on adult social care.
- The local authority had raised the full adult social care precept for 2024/25, with a value of **2%**. Please note that the amount raised through ASC precept varies from local authority to local authority.
- Approximately **2750** people were accessing long-term adult social care support, and approximately **455** people were accessing short-term adult social care support in 2023/24. Local authorities had spent money on a range of adult social care services, including supporting people. No two care packages were the same and varied significantly in their intensity, duration, and cost.

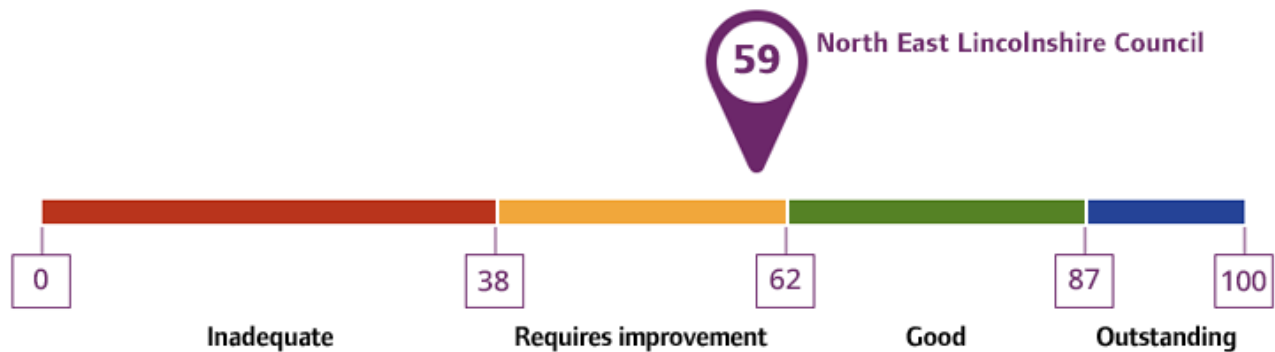
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Overall Summary

Local authority rating and score

North East Lincolnshire

Requires improvement



Quality statement scores

Assessing needs

Score: 2

Supporting people to lead healthier lives

Score: 2

Equity in experience and outcomes

Score: 2

Care provision, integration and continuity

Score: 2

Partnerships and communities

Score: 3

Safe pathways, systems and transitions

Score: 3

Safeguarding

Score: 2

Governance, management and sustainability

Score: 2

Learning, improvement and innovation

Score: 3

Summary of people's experiences

People in North East Lincolnshire shared a wide range of experiences when accessing adult social care services. Many of the people we spoke with described the Single Point of Access (SPA) as a helpful and efficient gateway, with staff providing clear advice and timely responses. Shared recording systems and daily team briefings supported smoother transitions and reduced duplication by enabling real-time information sharing, improving team coordination, and ensuring access to up-to-date records. Some people appreciated the flexibility of frontline teams, who made small adjustments to care packages without delay, helping them feel heard and supported.

While many experiences were positive, some people reported difficulties accessing support, highlighting areas for improvement. Unpaid carers frequently described delays in assessments and reviews, limited respite options, and confusion around eligibility and financial processes. Although the carers centre was widely recognised as a valuable source of support, many carers felt formal assessments did not lead to meaningful change. Some described feeling excluded from decision-making, particularly around safeguarding and hospital discharge.

People with complex needs, including those with learning disabilities, mental health needs, and sensory impairments, shared examples of tailored support that promoted independence. Access to specialist equipment and services was generally timely for urgent needs, though some staff reported variation in access to higher-cost or complex equipment, particularly where panel approval was required. In addition, advocacy provision was underused and not consistently embedded across all stages of support. People from diverse communities, including people seeking asylum and LGBTQ+ individuals, valued inclusive outreach and translation services, though gaps in accessible resources and staff awareness remained.

Transitions between services were generally well-managed. Young people and families that we spoke to reported positive experiences when preparing for adulthood. Hospital discharge pathways were described as timely and well-coordinated, supported by voluntary and community sector partners and community teams.

Overall, people's experiences reflected a system committed to person-centred care and partnership working. However, improvements are needed in consistency, timeliness, and communication to ensure equitable and high-quality support for everyone accessing adult social care.

Summary of strengths, areas for development and next steps

North East Lincolnshire demonstrated several strengths across its adult social care system. The SPA provided a single point of contact for accessing services, improving coordination and reducing barriers. Strong partnership working with the Humber and North Yorkshire Integrated Care System, voluntary and community sector organisations, and community interest companies supported joined-up service delivery and strategic planning. Preventative approaches were embedded across strategies, with investment in social prescribing, early intervention, and community-led initiatives helping people maintain independence.

The carers centre was widely praised, and co-produced strategies reflected meaningful engagement. Transitions between services particularly hospital discharge and preparing for adulthood, were well-managed and supported by clear protocols. Staff were encouraged to deliver better outcomes for people, with examples including virtual reality technology, supported employment programmes, and bespoke training. A shared quality assurance framework promoted continuous improvement across services. In addition, shared IT systems and effective information-sharing enabled real-time access to records, supporting smoother transitions and more coordinated care.

Despite these strengths, several areas require development. Delays in assessments, reviews, affected people's experiences, with review completion rates and waiting lists remaining high. Some delays were reported in accessing higher-cost or specialist equipment, though routine and urgent equipment provision was consistently timely. Advocacy was underused, especially at the triage stage, and staff understanding of the Mental Capacity Act and safeguarding processes varied. While inclusive practices were evident, equitable access to services was not always achieved.

Furthermore, gaps in accessible resources, data collection, and staff confidence in applying equality, diversity and inclusion principles were identified. Uptake of direct payments was significantly below national averages, particularly among older adults, and both staff and unpaid carers found the process confusing and time-consuming. Quality assurance of commissioned services was managed on a risk basis and was largely reactive rather than proactive, with some providers reporting limited engagement and missed opportunities for triangulation. Long waits for non-urgent Deprivation of Liberty Safeguards and inconsistent referral logging raised concerns about safeguarding oversight and responsiveness.

To address these shortfalls, the local authority has committed to a number of next steps. A co-produced strength-based practice framework and provider-led training will launch in September 2025, with clear governance and oversight from senior leaders to ensure effective implementation. Alongside this, a review risk matrix and trusted reviewer model are being developed to improve the timeliness of reviews and empower providers to support reassessments, with progress monitored through regular performance dashboards and risk registers.

In addition, an upcoming advocacy contract tender will address referral gaps and staff training needs, supported by robust contract monitoring and thematic audits to ensure quality and safety standards are met. The Equality, Diversity and Inclusion Strategy will strengthen data collection, inclusive service planning, and workforce development, overseen by dedicated governance forums.

To further support equitable access and staff confidence, a clearer information guide, payment card system, and direct payment champions have been introduced, with uptake and impact tracked through regular reporting. Enhanced contract monitoring, provider engagement, and thematic audits will further strengthen quality assurance and ensure services remain on track.

Finally, safeguarding improvements include updated Mental Capacity Act guidance, peer review panels, and improved triage processes, all subject to ongoing oversight and regular review to ensure timely and person-centred safeguarding responses.

Theme 1: How North East Lincolnshire works with people

This theme includes these quality statements:

- Assessing needs
- Supporting people to live healthier lives
- Equity in experience and outcomes

We may not always review all quality statements during every assessment.

Assessing needs

Score: 2

2 - Evidence shows some shortfalls

What people expect

I have care and support that is coordinated, and everyone works well together and with me.

I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and goals.

The local authority commitment

We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Key findings for this quality statement

Assessment, care planning and review arrangements

National data from the Adult Social Care Survey 2023/24 showed 60.5% of people in North East Lincolnshire were satisfied with their care and support, lower than the England average of 65.39%. However, 78% of people felt they had control over their daily life, which was similar to the national average of 77.62%. These findings were reflected in the mixed experiences shared by people and unpaid carers during the assessment.

Since its establishment in 2011, the Single Point of Access (SPA) had operated as the borough's integrated front door to care and support services. Through a single telephone number, people accessed information and advice aimed at preventing, reducing, and delaying care needs. The SPA provided pathways into clinical assessment services, adult social care, safeguarding, mental health services, and hospital discharge teams. It also included access to the voluntary and community sector enterprises (VCSE) via a commissioned wellbeing hub.

The VCSE-led service worked alongside statutory teams, offering free signposting and support via telephone, email, and an online directory. It enabled access to a broad range of services, including adult social care, benefits and debt advice, welfare, and housing. Together, SPA and the VCSE hub delivered effective lower-level support, helping people maintain independence and navigate available resources. This demonstrated how partnership working enabled early intervention, which helped people maintain independence and avoid crisis.

Out-of-hours adult social care was also delivered via SPA, offering 24-hour access to health and social care through the community urgent care team. This included delegated authority to commission emergency care and support when required. This ensured that people in crisis could receive timely support, reducing the risk of escalation and hospital admission.

In response to rising call volumes in 2025, a working group was organised to review SPA functions. This involved collaboration with partners and included face-to-face co-production with unpaid carers and SPA staff. The review was ongoing, with no confirmed completion date. While the review was underway, the group was collaborating with partners and unpaid carers to assess current effectiveness and explore opportunities for development, including the use of emerging technologies.

Unpaid carers highlighted limited support with respite and future planning, alongside delays and repeated conversations, often caused by inconsistent approaches across frontline teams. One unpaid carer described a lengthy assessment process which involved five best interest meetings over six months. This was due to an inconsistent understanding of consent and best interest. During this period family had to provide additional support, with no consideration of how other support could be offered.

While some found the process challenging, others reported positive experiences. One unpaid carer praised a staff member's understanding, empathy, and clear communication, although they had to chase for updates. Another person appreciated being directed to the carers service without needing to go through initial assessments.

Feedback from partners was varied. Some reported timely assessments. Others raised concerns about staff turnover and care packages that focused more on physical needs than overall wellbeing. Care providers told us information about people was sometimes lacking when support was requested. In some examples, the level of care required exceeded initial expectations, creating a mismatch between needs and deliverable support.

Daily huddles were used to allocate referrals from SPA, and a shared recording system with health partners supported effective information sharing. Staff also highlighted the autonomy of the front door team to make small adjustments to care packages, providing a quicker response to people's changing needs. This demonstrated how streamlined processes and empowered teams contributed to more responsive and person-centred care, which improved outcomes for people.

Staff shared examples of person-centred care planning, which included supporting a person with a learning disability to return to the borough and achieve greater independence through a multidisciplinary approach.

The Principal Social Worker (PSW) took action to support social workers and raise the profile of their role with partners. This included engaging directly with staff, sharing key messages through newsletters, and addressing the issue at a social work conference. Staff reported feeling more embedded and influential in their roles as a result.

Staff also described managing complex risks effectively, including supporting a person with mental health needs through a risk management meeting. The panel process for care packages was praised for its flexibility, with virtual meetings enabling urgent decisions.

Staff reported using a strength-based model to support people with complex needs, including hoarding and addiction. However, care plan reviews showed that while people were asked strength-based questions, their responses were not consistently captured in that way. Senior leaders acknowledged challenges in delivering a consistent strength-based approach. In response, a co-produced practice framework was developed, and a provider-led programme to embed strength-based approaches was scheduled to begin in September 2025.

Timeliness of assessments, care planning and reviews

National data from the Short and Long Term Support dataset for 2023/24 showed 65.71% of people receiving long-term support had their reviews completed (planned or unplanned), which was similar to the England average of 58.77%.

A senior leader told us that people had timely access to assessments and reviews, with teams completing full assessments within approximately 13 days of first contact. Where delays occurred, there was a clear process for keeping people informed. Front door services supported people while they waited, including access to prevention and befriending services. However, as of July 2025, 83 people were waiting for an assessment, with a median wait of 13 days and a maximum wait of 33 days.

There were 856 people waiting for a review (median 172 days), and 307 unpaid carers waiting for reviews (median 157 days). Senior leaders recognised there was a low review completion rate, sharing of the 85% of reviews that had been planned, only 60% were completed since July 2024. To address delays, the local authority introduced a review risk matrix process and had planned to recruit two full-time posts to support review activity. This demonstrated a proactive response to improving timeliness.

The Waiting Well approach was identified as needing strengthening within the review process, particularly for people in care homes who appeared settled but still required reassessment. Teams were actively involved in developing these practices to ensure care remained person-centred and responsive to changing needs. A senior leader also shared that the Assistant Director was drafting a proposal for a trusted reviewer model, which would involve training providers to review non-complex home care packages. Staff spoke positively about the support received from the Individual Commissioning and Advice Panel, which was used for higher-cost or complex care decisions.

Despite this positive feedback from staff, some partners told us it was taking a long time for people to access services through the SPA. Staff also acknowledged the number of people waiting for support had been increasing and felt that additional capacity was needed to manage the growing volume of complex referrals.

Assessment and care planning for unpaid carers, child's carers and child carers

National data from the Survey of Adult Carers in England (2024) showed 41.38% of unpaid carers were satisfied with social services, which was similar to the England average of 36.83%. Additionally, 23.81% of carers felt they had control over their daily life, which was also similar to the England average of 21.53%.

The local authority had prioritised support for unpaid carers since 2007, underpinned by integrated commissioning and pooled budgets. A commissioned carers support service acted as the main access point, accepting both self-referrals and professional referrals. The service aimed to identify hidden carers, inform them of their rights, and connect them to appropriate support or assessments. Evidence indicated that this approach was effective in identifying more carers and demonstrated a proactive model of early intervention. The carers hospital liaison service, delivered by the Carers' Support Service, resulted in a 400% increase in the number of carers identified at Diana Princess of Wales Hospital, Grimsby. Between Q1 and Q3 2024/25, 480 carers received specialist financial advice, which led to over £2 million in previously unclaimed benefits, alongside access to therapy, befriending, and social activities. In addition, extensive consultation during 2023 informed the development of a co-produced Carers Strategy, further strengthening the local authority's commitment to supporting carers.

Despite these efforts, some unpaid carers reported mixed and often negative experiences. Some carers had to request assessments, which were poorly completed and resulted in no support, alongside gaps in respite provision. Many carers found the system difficult to navigate and felt excluded by complex language and terminology. Formal assessments did not always lead to meaningful support. Some carers told us they received 3 hours of support via a direct payment and felt this was insufficient to support their role or enable time for themselves, with this time often used for domestic tasks. The local authority told us that as of October 2025, the average carer break was 6 hours per week, with some carers receiving up to 32 hours. Barriers also included misinformation, being told they were not eligible, and difficulty accessing support through SPA or frontline teams. In some examples, carers escalated concerns to Carers Voice forums before receiving assessments.

Carers supporting people in 24-hour care told us they were often not offered assessments. Some were offered wellbeing activities but said they could not attend due to insufficient respite. Other carers reported not receiving information about benefits or services, inadequate assessments, lack of consultation, and incorrect identification of needs. These issues, in some instances, led to poor placements and deteriorating health.

Despite ongoing challenges, both carers and staff highlighted examples of good practice and improvement. The carers centre was widely praised for its role in referrals, signposting, and helping carers navigate the system. Some carers described contacting the local authority as straightforward, with accessible options such as texting. Several also reported positive experiences with SPA, including timely annual reviews and thorough assessments that identified their needs and led to appropriate support.

Frontline teams told us that support for unpaid carers had been a focus within their transformation project, including clearer language and better promotion of carers direct payments. Staff shared an example where an unpaid carer's respite service was increased ahead of their review due to a change in circumstances, even though the cared-for person was self-funded. This demonstrated a flexible and responsive approach to unpaid carers' support, where frontline staff adapted provision efficiently to meet changing needs outside of the formal review process.

Staff reported providing peer support and helping colleagues identify and support young carers, with attention to age-appropriate care. Concerns around unsuitable language in assessments were acknowledged, and improvements were underway. A social care handbook for unpaid carers and cared-for people was introduced, and dedicated unpaid carers wellbeing workers were embedded across teams.

A senior leader reported that a deep dive audit in November 2024 led to monthly meetings between three community interest companies (CICs), supported by an action plan and training programme. Leaders described a clear focus on unpaid carers, including a carers voice group, shared lives development, digital tools, and the use of artificial intelligence.

Partners gave positive feedback on joint work with commissioners, which focused on prevention, intensive support for families in complex situations, and a wide range of services including counselling, befriending, and holistic therapies.

Help for people to meet their non-eligible care and support needs

When contacting the local authority, people were given advice, information, and signposting to other services and facilities in the area for help with care and support needs that fell outside Care Act eligibility. Referrals were made to other teams and agencies as needed.

The local authority monitored this activity to understand emerging trends. For example, a frontline team reported people not meeting eligibility criteria often re-presented in crisis within 8 weeks. In response, teams created an internal service called one front door, which operated separately from the single point of access. This service allowed people, such as those visiting their GP but not meeting mental health service criteria, to be referred to a key worker. The key worker supported people with practical needs such as benefits, temporary debt pausing, or referrals to voluntary, community and social enterprise (VCSE) organisations.

Staff also shared examples of how local services collaborated to support people with non-eligible needs. This included referrals to partners and VCSE organisations to help with emergency housing and employment opportunities. This demonstrated the local authority's commitment to promoting wellbeing and preventing escalation beyond statutory duties.

Eligibility decisions for care and support

National data from the Adult Social Care Survey for 2023/24 showed 58.50% of people in North East Lincolnshire did not purchase additional care or support privately or pay more to top up their care. This was lower than the England average of 64.39%. This showed a lower proportion of people contributed privately to meet their care needs, which reflects the local authority's approach to consistent market management of care costs.

Eligibility and charging information was available to adults and their families through the social care handbook and direct communication with staff. This included guidance on assessment, eligibility, support planning, budget approval, financial contributions, and appeals. People who were ineligible for support under the Care Act were signposted to other services. This practice was evidenced in a person's care record, which showed a person had been informed they could access support to arrange care at a cost. They were also informed they could choose to arrange care independently. An unpaid carer explained the person was over the financial threshold and therefore did not meet the criteria for funded care.

The Individual Commissioning Approval and Advice Panel acted as an internal assurance forum. It involved the local authority, Humber and North Yorkshire Integrated Care Board, continuing healthcare, and community interest companies. The panel reviewed strengths-based, least restrictive, and cost-effective care packages commissioned within North East Lincolnshire. This collaborative approach ensured care was person-centred and financially accountable.

Financial assessment and charging policy for care and support

As of July 2025, 19 people had been waiting for a financial assessment, with a median wait time of 16 days. This indicated relatively timely access to financial assessments. Staff told us the financial assessment system was flexible and person-centred, with requests submitted by frontline teams. A shared recording system enabled collaboration across teams, and where support was needed before the financial assessment was completed, care was provided to ensure people's wellbeing needs were met.

Staff told us conversations around the financial process started at the hospital and were passed to the relevant frontline teams. The financial team supported people with monitoring income, paying invoices, and managing financial responsibilities. The corporate appointee team managed finances for people who needed additional support, helping people achieve financial goals and manage bills.

A senior leader told us about monthly meetings to review processes and address issues. Only a small number of complaints were reported, and the Assistant Director chaired the charging appeals panel. While the system was effective, discussions were ongoing to improve simplicity and clarity of communication. A frontline team told us complaints were acknowledged, and a feedback system was used to capture lessons learned, with a quality assurance process informed by appeals.

In 2024, the local authority received 34 appeals related to financial assessments and charging. Of these, 38% were upheld and 24% were partially upheld. Common issues included changes in circumstances, unclear communication, and delays. These concerns were also reflected in feedback from unpaid carers. One family received a large invoice after care had been provided, as charging had not been discussed in advance. These insights informed staff training, system reviews, and professional development activities.

Provision of independent advocacy

The local authority had commissioned an external provider to deliver advocacy services, supporting people to participate in care assessments and planning. The contract included support for Relevant Persons Representatives (RPRs), Independent Mental Health Advocates (IMHAs), Care Act Advocates, and Independent Mental Capacity Advocates (IMCAs).

When referrals were made, staff felt the provider responded well and delivered a high-quality service. In one example, an advocate supported a person throughout their transition from child to adult services, ensuring consistency and continuity of care. An additional independent advocacy service was available for complex referrals.

Partners raised concerns about staff awareness of advocacy referrals and their understanding of the different types of advocacy available. For example, staff sometimes struggled to distinguish between IMCA and Care Act advocacy. This created risks of missed opportunities for appropriate advocacy support. To address this, a provider delivered training sessions focused on IMCA, which had led to improved understanding and increased referrals within this one area.

The local authority recognised the need to improve advocacy provision. Although the upcoming contract tender aimed to address these issues, predicting future demand remained challenging due to low referral rates. Senior leaders acknowledged advocacy was being used less than expected across all areas. They recognised the need for further staff training and awareness to ensure advocacy was used not only for statutory requirements but also in other situations where it could benefit the person.

The advocacy provider worked collaboratively with the local authority and key partners. Most recently, they carried out engagement work with the Learning Disability Partnership Board.

Supporting people to live healthier lives

Score: 2

2 - Evidence shows some shortfalls

What people expect

I can get information and advice about my health, care and support and how I can be as well as possible – physically, mentally and emotionally.

I am supported to plan ahead for important changes in my life that I can anticipate.

The local authority commitment

We support people to manage their health and wellbeing so they can maximise their independence, choice and control, live healthier lives and where possible, reduce future needs for care and support.

Key findings for this quality statement

Arrangements to prevent, delay or reduce needs for care and support

The Adult Social Care Survey 2023/24 showed that 68.50% of people had spent time doing things they valued or enjoyed, which was similar to the England average of 69.09%. However, data from the Adult Social Care Outcomes Framework 2023/24 showed that only 48.18% of people who received short-term support no longer required ongoing care, which was significantly lower than the England average of 79.39%.

A senior leader told us that people were often not identified early enough for preventative services to be effective. In response, the local authority worked with partners, neighbourhood colleagues, and community groups to identify people who could benefit from preventative support, reflecting a focus on proactive outreach.

The local authority implemented an “initial conversation” model as part of its approach to prevention. Since its introduction, the local authority told us the number of Care Act assessments resulting in a paid service reduced by one-third, while the number of people receiving information and advice increased significantly. This demonstrated how early engagement helped people maintain independence, which reduced reliance on formal care and improved wellbeing.

The local authority's approach to preventing, reducing, or delaying the need for care and support was embedded in its strategies. Examples included the Health and Wellbeing Strategy, which recognised people's preference to remain at home, and the Carers Strategy, which supported unpaid carers in continuing their roles.

According to the North East Lincolnshire Social Care Market Position Statement (2022–2025), the local authority aimed to move away from traditional service models, focusing on prevention and community-centred redesign. While the strategy outlined a clear vision for aligning health and social care, there is limited publicly available evidence to confirm whether these plans have been fully realised as the strategy nears its end.

Through investment in the voluntary and community sector enterprise (VCSE), the local authority offered a wide range of preventative and support services, including hospital discharge support, housing-related services, frailty and befriending initiatives, and information and advice provision. A health partner confirmed the local authority's proactive involvement of the VCSE in hospital discharge planning, especially when care was refused, by connecting people to VCSE partners. This helped prevent readmission and ensured people were not left without support, which promoted recovery and reduced crisis.

Staff told us they used a person-centred approach, offering alternative support options, such as family, community, and the VCSE to prevent or reduce the need for formal assessment. A health partner described collaborative prevention work with East Midlands Ambulance Service, where low-level call-outs were routed through the single point of access (SPA) team to prevent hospital admissions.

Staff highlighted positive working relationships with other professionals, such as the police, which supported safe service delivery. A senior leader told us they were assured prevention was well covered within the services provided to people, through a wide range of resources available online and investment with the VCSE, which offered accessible support.

The community advice and support team gathered information from each contact and made daily decisions about team referrals, aiming to reduce handovers and avoid repeated storytelling. This improved people's experience of accessing support and reduced impact on their wellbeing during initial contact.

The Survey of Adult Carers in England 2023/24 showed that 88.64% of carers found information and advice helpful, which was higher than the national average of 85.22%. However, only 11.11% said they had time to do things they valued or enjoyed, which was below the national average of 15.97%. In response to growing demand and the increasing role of carers in an ageing population, the local authority expanded its provider base and commissioned a dedicated support service for unpaid carers.

The local authority also advanced its use of data to improve health and support outcomes, exploring new ways to share data and enhance prevention, such as signposting at the front door. Partnerships with the VCSE also supported the social prescribing programme, coordinated by a community organisation and linked with primary care networks. Social prescribing link workers helped people manage long-term conditions by connecting them to community-based support, including debt advice to address barriers to wellness. This integrated approach helped people address underlying issues that affected their health and independence.

Staff told us a wide range of tailored support options were designed to enhance independence for people with both eligible and non-eligible needs. Innovative work included developing capacity for specialist conditions such as Huntington's disease and eating disorders, alongside creating opportunities in education, volunteering, and supported employment. This included ownership of a local garden centre and café, enhancing support for young people. However, the success of the supported employment service led to a long waitlist, prompting the development of foundational skills placements, internships, and a care coordinator role to manage waiting lists and improve service, which had a positive impact.

Partners had identified transport as a key issue for older people, particularly those with a diagnosis of dementia, although improvements had been made over the past three years. Limited transport had contributed to isolation and loneliness, reducing people's ability to access community support.

Provision and impact of intermediate care and reablement services

National data from the Adult Social Care Outcomes Framework for 2023/24 showed 1.67% of people aged 65 and over received reablement or rehabilitation services following hospital discharge. This was lower than the England average of 3.00%. In contrast, data from the Short and Long Term Support dataset showed 86.36% of people aged 65 and over were still at home 91 days after discharge into reablement or rehabilitation services, which was similar to the England average of 83.70%. This suggested while outcomes for those receiving reablement were positive, access to these services had been limited.

In early 2024, the local authority acknowledged its performance on national reablement indicators, particularly those related to improving independence was below benchmark. Data showed that a higher proportion of people were discharged to long-term care and bed-based settings, rather than being considered for step down and reablement services. In response, the local authority launched a three-phase reablement review.

A senior leader told us the local authority had entered Phase 2 of its reablement review, building on the success of Phase 1, which focused on reablement at home and was conducted from April 2024 to January 2025. Phase 2 focused on bed-based reablement, with baseline assessments and reviews underway. Phase 3, planned as the final stage, will examine the broader system-wide reablement offer, with the overall review expected to conclude by February 2026. This reflects a commitment to evidence-based improvement and a strategic approach to supporting people to regain independence.

Performance dashboards were introduced to strengthen monitoring and accountability. The overarching goal was to embed a reablement culture across health and care services, guided by the philosophy of “get up, get dressed, get moving.” This approach was supported by modern technology, equipment, and techniques, designed to help people maintain or regain independence.

A health partner reported the local authority had commissioned over 40 inpatient rehabilitation beds, some of which had been specific for people who had experienced a stroke. This had positively impacted discharge delays, as the hospital discharge team used appropriate pathways to facilitate timely discharges. This helped reduce hospital stays, improved flow across the system, and led to better outcomes for people.

A senior leader told us, in partnership with health services, the local authority invested in a community therapy occupational lead, responsible for managing reablement and urgent care provision. Community therapists played a key role in delivering these services, with no waiting times reported for urgent referrals. Therapists, working closely with housing teams and social workers, supported people in care homes by keeping them active and engaged while awaiting occupational therapy assessments.

Weekly meetings were held to prioritise people based on urgency, and by working collaboratively with social workers, therapists facilitated timely hospital discharges, for example, by arranging essential equipment such as commodes, enabling safe and efficient returns home. A senior leader told us waiting times had significantly reduced from 4–5 weeks to just 1–2 weeks. Palliative care services were also highlighted for their responsiveness, with support provided within one week. These improvements had reduced delays and helped people return home with the right support in place.

A senior leader told us reablement was recognised as a key component of the preventative approach, which was led by Public Health which included early intervention from childhood onwards. There was ongoing exploration of how digital technology could be used to support people more effectively. To address digital exclusion, a partner told us the local authority had supported the distribution of 200 tablet devices in the community. These tablets enabled people to access exercise classes from home and join online clubs following hospital discharge, helping them rebuild their independence and improve overall wellbeing.

The local authority shared a story of success, where a person who had experienced a fall, sustained a fracture, undergone surgery, and received treatment, rehabilitation, and therapy care. The person returned to their former ability and regained independence. A care record also evidenced the positive impact of reablement services on a person's mobility and independence.

Access to equipment and home adaptations

There were several routes to access equipment. The community-based Assisted Living Centre (ALC) offered a self-referral route, supported by specialist therapy advice and telecare via a commissioned partner. In June 2025, the therapy support team had 68 people waiting for occupational therapy (OT) assessment, with a median wait of 2 weeks and 5 days. Drop-in or clinic appointments had 13 people waiting, while 53 people were awaiting home visits, with a median wait of 9 weeks. In contrast, equipment requested during acute stay assessments for discharge facilitation had no wait times. Similarly, urgent community responses from the Single Point of Access (SPA) provided same-day equipment as part of integrated assessments. This ensured people leaving hospital or in urgent need were not delayed by equipment access, reducing risk and supporting recovery.

Frontline teams told us shared recording systems improved communication, allowing staff to allocate low-level equipment more quickly. These allocations were supported by OTs in weekly meetings. Staff also told us there were positive working relationships between hospital discharge teams and community OTs, with joint visits and trusted assessor training. This collaborative approach helped ensure timely and appropriate equipment provision across settings.

Once assessed, equipment delivery was timely. In June 2025, 97% of people received urgent equipment within the required timeframe, 93.82% received routine equipment within 5 days. Staff told us they could assess, order, and supply low-level equipment or adaptations without formal OT referral and had access to their own equipment stores, which helped prevent delays in delivery and installation.

The Disabled Facilities Grant (DFG) panel was introduced to community teams to ensure consistency in eligibility decisions. Despite this, staff highlighted problems with the DFG process, where people were experiencing long delays. Some staff told us timeframes for delivery and tracking progress were unclear, and there was no data oversight or system to manage waiting lists. However, the local authority told us significant improvements had been made to the DFG waiting list, reducing from 172 in April 2024 to 7 in August 2025. This progress was overseen by the DFG Steering Group chaired by the Director of Adult Social Service.

Partners reported long waiting times for home adaptations. Although assessments were completed in a timely manner, major adaptations were often delayed, increasing anxiety and dependency for both people and unpaid carers. This highlighted the need for improved coordination and system oversight.

Higher-cost equipment required a request with 2 quotes and panel approval before ordering. Some staff expressed frustration with this process. The local authority told us the equipment panels were held weekly with occupational therapy representation, and urgent requests were addressed virtually. Sometimes there were delays due to people's complex situation which required further exploration to ensure the right support. One example involved delays in ordering a cot bed for an adult in supported living. Although provisionally approved, the item required further quotes and details before it could be ordered. During the delay, night care staff were provided, increasing costs and creating dependency for the person.

After concerns were raised about the panel process, some items were moved from the specialist list to standard provision, improving access. For example, specialised slings for use with hoists were reclassified, allowing for quicker and more consistent provision.

Staff told us virtual reality (VR) had been used successfully in group settings to support people with respiratory needs. This two-year project led some people to purchase their own VR sets, enabling continued engagement and self-management at home.

One partner told us the equipment offer met people's needs, including items such as digital magnifying glasses, which had positively impacted people's independence. However, another partner had raised concerns about the telecare service requiring Care Act eligibility. The local authority told us that eligibility criteria had been introduced in April 2025 as part of a new contract to ensure telecare equipment was deployed effectively and supported those most likely to benefit. Telecare continued to be used preventatively, including for hospital discharge and reablement services.

Provision of accessible information and advice

National data from the Adult Social Care Survey for 2023/24 showed 75.70% of people who used services found it easy to find information, which was higher than the England average of 67.12%. Similarly, the Survey of Adult Carers in England found 68.18% of carers found it easy to access information and advice, also higher than the England average of 59.06%.

LiveWell was an integrated health and social care website designed for both the public and professionals. It provided guidance on needs assessments, care options, financial assessments, direct payments, life planning, and Mental Capacity Act processes. It also had links to specialist portals for people living with dementia and unpaid carers. Much of the content was co-produced with the local community, enhancing relevance and accessibility. The platform included a digital self-assessment tool that provided tailored advice and referral options to the single point of access (SPA), along with contact details for further support. Another partnership project complemented this by linking people to community services such as therapy, support groups and financial advice. These tools helped people navigate complex systems and access timely support without needing formal intervention.

Although the digital offer was comprehensive, at the time of the assessment the local authority had initiated a review to improve consistency and accessibility, led by a dedicated working group. A senior leader also told us the LiveWell website was being improved to better support unpaid carers, complementing information provided by carers' organisations.

A senior leader told us about a community service operating as a one-stop-shop organisation, which was widely regarded as valued community asset. It offered a range of services, including a café and an animal farm. This created a welcoming, multifunctional space that encouraged engagement and reduced isolation.

Frontline staff told us people and unpaid carers were provided with tailored information, especially during hospital discharge, including details on reablement, community services, and financial assessments. These resources were available in multiple formats, supporting accessibility for people with diverse needs.

Partners told us they were working with commissioners to explore the use of artificial intelligence (AI) in preventative care, although implementation was at an early stage. One partner told us about a commissioned online service that used an extensive database to connect people to local and national services. Support was available face-to-face and by telephone, and included help with employment, household support fund applications, and referrals to food banks and community shops. An advice team also supported welfare checks, benefits applications, and debt management referrals, helping to reduce financial stress and improve people's overall wellbeing.

Another partner described how people could access services in multiple ways by telephone, email, online form, or in person. Most contacts were made via a direct telephone line, though the SPA number was also available. People were also connected to the carers support service and provided with welfare benefits advice. Staff were co-located, which improved communication and support for unpaid carers. This multi-channel approach ensured people could access help in ways that suited their preferences and circumstances.

Direct payments

Further development of direct payments (DP) was needed, following mixed feedback from some people and staff regarding uptake.

People and unpaid carers told us they found the system confusing and time-consuming, with delays in processing their DPs. Some examples shared with us from unpaid carers reflected a wait of up to 18 months. Other unpaid carers told us they received one-off direct payment to support their wellbeing, and this was granted yearly on request. The carers service reported that they had recently worked with the main local authority provider to improve access to Direct Payments (DPs). As part of this work, they produced a clearer information guide aimed at raising awareness and understanding of how DPs could be better utilised to support unpaid carers.

National data from the Adult Social Care Outcomes Framework for 2023/24 showed only 31.36% of carers received DPs. This was lower than expected. The local authority provided early intervention through their commissioned carers service, including one off DPs, financial grants, and emotional support to help unpaid carers continue in their caring roles.

The mixed feedback from people was supported by national data, as the percentage of people receiving DPs was much lower than the national average for all ages. The Adult Social Care Outcomes Framework for 2023/24 showed 19.43% of people received direct payments. This was lower than the England average of 25.48%. Similarly, among people aged 18–64, 34.17% received direct payments compared to the England average of 37.12%. For people aged 65 and over, the figure was 5.04%. This was significantly lower than the England average of 14.32%. This highlighted a significant gap in uptake, particularly among older adults. More work was needed on the continuing development of the DP offer to achieve an equitable uptake of direct payments across the population and to understand any barriers for people using DPs.

Although the social care handbook explained direct payments, staff reported the process was confusing and many lacked confidence in discussing direct payments with people. A senior leader told us the local authority was linked to national networks around DPs, sharing learning and best practice. This connection had supported the introduction of the new financial system and use of payment cards, aiming to improve the process. The local authority had also established DP champions within teams, though their initial focus was on supporting unpaid carers and working with the carers organisations.

A senior leader told us DP uptake was a concern. A plan had been developed, but progress had been delayed due to difficulties in recruiting and retaining personal assistants. The slow progress had also been linked to a lack of staff confidence, and leaders had acknowledged further training was required, to be included in the upcoming strength-based training model, which was scheduled to begin in September 2025.

Equity in experience and outcomes

Score: 2

2 - Evidence shows some shortfalls

What people expect

I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and goals.

The local authority commitment

We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this.

Key findings for this quality statement

Understanding and reducing barriers to care and support and reducing inequalities

The local authority was committed to improving Equality, Diversity and Inclusion (EDI) for people in the borough. This work had been guided by the Council Plan (2025–2028) and Health and Care Partnership Plan, introduced in April 2022. The adult social care framework adopted a life-stage approach to support people from youth to end-of-life care. This demonstrated a whole-life approach to inclusive care planning.

The Director of Adult Social Services (DASS) held overall responsibility for EDI within adult social care, with support from leaders in Children's Services and Public Health. A peer review in 2023 shaped EDI priorities, and EDI champions were appointed. A single data system enabled analysis of inequalities and supported outreach to seldom-heard groups. An EDI Strategy was in final draft and had identified gaps in data collection, unclear service impact, and low confidence in staff applying EDI principles. The strategy proposed improving data, planning inclusive services, and building staff confidence through training. A community engagement programme and action plan supported its implementation.

In response to the Local Government Ombudsman's Equal Access report published in May 2022, teams had audited services and developed action plans to address gaps, reporting progress through shared meetings with the Integrated Care Board (ICB).

Deprivation in North East Lincolnshire was concentrated in specific areas, with five wards, East Marsh, West Marsh, South, Sidney Sussex, and Heneage, among the most deprived in England. East and West Marsh ranked in the bottom 1% nationally, contributing to significant health inequalities, with homelessness and unemployment rates above national averages.

The local authority adopted a population health approach, supported by the public health team, which had produced a paper examining the impact of health inequalities on adult social care outcomes and workforce. Integrated neighbourhood teams were developed to improve health and social outcomes, reduce inequalities, and promote fairness through personalised, strengths-based care planning. Frontline teams collaborated with public health, primary care networks, and other partners to improve coordination and person-centred care.

A health partner told us about a specialist GP service in high-deprivation areas, offering walk-in support for health and social care needs, including housing, benefits, and referrals to voluntary community sector enterprise (VCSE) services for unpaid carers. A senior leader told us frontline teams worked with people from diverse ethnic backgrounds, including the growing 'white other' population, and collaborated with VCSE organisations to improve outreach. This helped ensure people from underrepresented groups were not excluded from accessing support.

The East Marsh Community Plan demonstrated proactive engagement, with 40 community conversations and six events involving 150 residents, leading to the co-production of 30 projects. A senior leader told us support was extended to Lesbian, Gay, Bisexual, Transgender, Queer or Questioning+ (LGBTQ+) carers through the carers contract, and specialist support groups were commissioned for the transgender community. These initiatives had helped build trust and visibility for marginalised groups.

Frontline teams told us they engaged appropriately with diverse communities. Examples included supporting a person with an amputation and history of homelessness into accommodation and assisting a German-speaking person through translation services and embassy connections. Staff told us they used shared records and screening tools to identify protected characteristics, enabling them to adapt engagement and connect people to culturally appropriate services, including translation support. These examples showed staff were responsive to diverse needs, even when people did not meet eligibility criteria, which promoted inclusion and reduced barriers to care.

Staff reported improvements in data collection on protected characteristics, including sexual orientation, and were developing processes to address gaps. A senior leader confirmed that plans were in place to tackle data collection issues across the health and care system.

Partners told us there were inconsistencies in involvement with the EDI and Carers Strategy. Some had oversight of adult social care and partnership working, while others had not been engaged. Some told us protected characteristics were not part of contract monitoring, and more funding was needed to regenerate deprived areas and address health inequalities. This suggested a need for stronger alignment between the local authority's strategy and partner agency practices, to ensure equitable service delivery and inclusive commissioning.

Inclusion and accessibility arrangements

The local authority told us they had prioritised making information accessible and tailored to local needs, including adding website features that allowed content to be translated into multiple languages for people whose first language was not English. The Talking, Listening and Working Together Engagement Strategy (2023–2025) emphasised accessible communication, recommending formats such as paper copies, audio, other languages, and Easy Read. A digital engagement toolkit supported this approach. These measures helped ensure people with different communication needs could access essential information and participate in decision-making.

A health leader told us literacy and digital literacy were barriers to accessing services. In response, the local authority worked to provide free Wi-Fi and computer access across the borough, with staff available to help people use technology. This initiative aimed to reduce digital exclusion and improve access to online services, particularly for people who may otherwise be isolated or unable to engage with digital platforms. This was a targeted approach, designed to address specific barriers faced by digitally excluded groups, and demonstrated a commitment to inclusive service delivery and equitable access.

Staff told us the borough's demographics had been changing, with increasing multicultural populations, including people seeking asylum and refugees. Senior leaders shared there was a rise in translation service use and the development of staff-led support networks for these communities. Some staff also told us the engagement team attended events to raise awareness of services and had developed resources such as the social care handbook, some of which were available in easy read. These efforts supported inclusion and helped build trust with communities who may face barriers to accessing care.

Frontline teams had access to translation services, with next-day interpreter responses by telephone, and same-day support in emergencies. These services were used effectively during Education, Health and Care Plan (EHCP) reviews and transitions into supported living for people with sensory needs. However, some teams reported not having access to easy read resources, while others did, due to a dedicated accessible information officer. This inconsistency highlighted the need for equitable access.

Staff shared examples of using Polish-speaking interpreters to support a person's communication requirements during hospital discharge planning. Another staff member provided direct interpreting support, enhancing understanding and person-centred care. A partner told us the local authority facilitated weekly drop-in sessions for people seeking asylum and refugees, offering opportunities to learn about available services. These initiatives supported inclusion and helped reduce barriers to accessing care and support, particularly for people unfamiliar with local systems or facing language barriers.

Theme 2: Providing support

This theme includes these quality statements:

- Care provision, integration and continuity
- Partnerships and communities

We may not always review all quality statements during every assessment.

Care provision, integration and continuity

Score: 2

2 - Evidence shows some shortfalls

What people expect

I have care and support that is co-ordinated, and everyone works well together and with me.

The local authority commitment

We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.

Key findings for this quality statement

Understanding local needs for care and support

The local authority worked with local people and stakeholders to understand the care and support needs of individuals and communities. The Joint Strategic Needs Assessment (JSNA) for North East Lincolnshire provided a detailed overview of current and emerging care and support needs across the borough. The data highlighted high levels of deprivation in certain areas, alongside a growing older population and rising demand for care. It noted life expectancy in the borough had fallen below the national average. Male healthy life expectancy at birth was 55 years, while for females it was 58. Women living in the most deprived areas lived on average, 10 years less than those in the least deprived areas. This gap had widened to 12 years for men.

The borough's demographic showed most of the population were White British. However, senior leaders and data identified emerging communities who did not currently have the right support, such as people seeking asylum and people from the Gypsy, Roma, and Traveller communities. This highlighted the need for inclusive service design and culturally appropriate outreach.

North East Lincolnshire Council's Dementia Strategy 2025–2030 recognised an increase in people living with dementia and in early diagnoses. Although diagnostic support was provided quickly, services and support systems had not yet been fully aligned, and the strategy was not yet fully implemented. Other strategies, such as the carers and autism strategies, identified rising numbers in these groups and gaps in service provision. These strategies were coproduced and included action plans to improve and develop services tailored to these needs.

The local authority identified alcohol abuse, domestic abuse, and mental health as areas of concern. In response, they worked with the North East Lincolnshire Community Safety Partnership, which focused on increasing safety, reducing alcohol and drug misuse, and preventing violent extremism and modern slavery. Voluntary community sector enterprise (VCSE) partners also supported this work, contributing to a multi-agency approach to safeguarding and prevention.

The VCSE and commissioned providers shared information with the local authority when they identified a need or gap in provision. For example, in Immingham, where deprivation was high, a local provider offered a community kitchen to increase engagement. Another example from last year related to increased requests for household fuel support. The provider, in discussion with the local authority, helped resolve this by providing more fuel vouchers through a revised approach. These examples showed how community-led initiatives had helped meet urgent needs and reduce hardship.

A senior leader told us the ageing workforce was under review, with the Healthcare Partnership (HCP) establishing a workforce development group. While the HCP had a workforce development plan, the local authority's plan had not included adult social care, as adult social care was externally commissioned. This revealed a structural challenge in aligning workforce strategies across systems, particularly where adult social care was externally commissioned.

The local authority recognised accommodation as the biggest barrier to meeting people's needs effectively and developed an All-Age Housing with Care Strategy 2025. Through this approach, they aimed to increase capacity and create adaptable housing options. The local authority used its asset disposal list to support extra care schemes and reviewed housing allocations to align with adult social care and mental health priorities. For supported living, the focus was on working with the housing register provider and reviewing the allocation list to reflect changing priorities. This demonstrated how strategic use of local authority assets and housing policy supported care-focused accommodation, which improved access to suitable housing and reduced out-of-area placements.

Day opportunities were provided for people with learning disabilities, physical disabilities, and older adults across two centres. A transformation programme, including reviews with people, was underway to understand their priorities and explore ways to reimagine the service. Early feedback showed older people preferred more individualised services. The local authority began working with VCSE partners to develop flexible, community-based options. This reflected growing recognition that traditional, centre-based models may no longer meet the diverse and evolving needs of the community, and co-produced, personalised approaches were increasingly valued.

Market shaping and commissioning to meet local needs

The local authority worked to ensure all groups of people had access to a diverse range of local support options that were safe, effective, and high-quality to meet their care and support needs. However, National Data from the Adult Social Care Survey for 2023/24 showed 64.89% of people who used services felt they had choice over services, which was lower than the England average of 70.28%.

The local authority and Integrated Care Boards (ICBs) adopted a joint commissioning approach, as outlined in their Market Position Statement and Market Sustainability Plan. With 92% of care commissioned through an agreed framework and each provider assigned an integrated contract lead, this approach aimed to ensure collaboration and consistency.

People and unpaid carers told us there were more opportunities to influence the market. National Data from the Survey of Adult Carers in England for 2023/24 showed 28.57% of carers accessed support or services allowing them to take a break from caring for more than 24 hours. This was higher than the England average of 16.14%. The same data showed 50.00% of carers accessed support or services allowing them to take a break from caring for 1–24 hours, this also was significantly higher than the England average of 21.73%.

The carers voice forum shared their work with the local authority on the new homecare contract. They ensured a specific element for carers was included, enabling more consistency and focus when carer-specific services were commissioned. The support at home service was co-produced with the NHS and people using services, to develop an enhanced specification for those with continuing health needs. This replaced previously fragmented contracts and demonstrated a strategic shift towards an integrated, person-centred model with future planning as a priority.

Further work was developed with unpaid carers on the new carer service tender. Unpaid carers were supported to help scope the specification, created scenarios for procurement evaluation, and were included in the tender interview panels. Following the award of the contract, it was anticipated unpaid carers would be involved in ongoing monitoring to ensure the contract continued to be developed in line with unpaid carers' needs. This approach promoted transparency and ensured services remained responsive to people's experienced needs.

Data systems were used to inform local authority commissioning needs. For example, they identified a need for more supported living. A senior leader told us a new Community Living and Supported Living Framework had been introduced, which projected the future demand over the next 5 years and worked with new providers to shape property development. The Autism Strategy shared the development of the Supported Employment Programme and the local authority's commissioning plans for supported living accommodation for 50 additional people aged 18–65 with a learning disability and/or autism, who would need accommodation in the next 3 years. This demonstrated the local authority understood diverse local health and care needs and used data to develop more choice and better continuity of care.

Shared Lives was identified as an opportunity to support alternative respite and accommodation options. The local authority joined neighbouring authorities to commission Shared Lives, acting as a third equal partner. Other joint commissioning arrangements supported consistent rates for homecare to maintain market stability. Having main providers for each service in each area reduced the need for spot purchasing and provided budget certainty to providers, allowing them to forward plan and develop their services.

The local authority maintained an open-ended framework for care homes and nursing care, jointly managed with the ICB. A review with providers and people was planned for the end of 2025 to address oversupply and ensure alignment with current needs. These actions demonstrated a collaborative and adaptive approach to commissioning, with a focus on sustainability and responsiveness to local demand.

Providers told us they were able to work with the local authority to develop established services. For example, some people accessing the Lifeline service, which is a personal alarm and telecare system that enables people to call for help at any time by pressing a pendant or button, were not always responding during a call, meaning staff were unable to gain access, which placed people at risk. The solution was to work with commissioners to ensure all new Lifeline users had a key safe installed. This introduced safety measures and reduced potential risks, improving outcomes for people living alone or with complex needs.

Ensuring sufficient capacity in local services to meet demand

People and unpaid carers told us there was a waiting list for supported living, especially for young people with learning disabilities or those with specific health conditions like Huntington's Chorea. Around 80 people with complex learning disability needs were placed outside the area, with over 50 unable to be supported locally. This highlighted the need to establish specialised local provision to reduce out-of-area placements. Senior leaders were aware of this and, alongside the Support at Home framework, were looking at enhanced provision for complex needs.

The local authority planned to invest in extra-care housing to give older people and adults with disabilities the option to live independently while receiving tailored support. Two schemes were already in operation, providing 120 units, all located in urban areas. A procurement process was underway for two more schemes, offering between 74 and 90 units, to support further development. This investment aimed to increase housing choice and reduce reliance on residential care. A Cabinet report from August 2025 confirmed approval for a new extra-care housing scheme, with development expected to begin later in 2025. The strategic ambition was to double provision by 2029, though exact delivery timescales for the new schemes were not detailed.

The Market Sustainability Plan (March 2023) recognised there were no dedicated dementia care homes in North East Lincolnshire. Although some homes provided support for people with a range of complex conditions including dementia and behaviours that challenge, there remained a gap in dedicated dementia provision. It was noted within the plan there was a gap in specialist provision, such as for people with a diagnosis of early onset dementia and homes with this specific expertise.

The local authority's current capacity for residential and nursing care included 34 residential homes and 4 residential homes with nursing. The residential occupancy rate was 86.56%, and the nursing occupancy rate was 88.29%. This reflected an oversupply of beds, with some buildings being unsuitable for complex care needs. A market shaping activity with providers was planned later in 2025.

Homecare support was provided by three providers, each covering a geographical area. A new homecare contract was procured and awarded, due to start in October 2025. The tender had been co-produced, building on the “teams not times” model. The approach of three locality providers continued, but with in-hours care delivered separately from out-of-hours services, including step-down reablement support, carer support, and enhanced provision for complex needs. This model aimed to improve flexibility and responsiveness in home-based care.

Following the planned change in the homecare provider due to commence in October 2025, the local authority had taken measures to keep people using the current service remain informed and given choices about their care provider. Communication was also shared with staff to ensure consistent messaging in preparation for the change in contract provider, helping to reduce anxiety and maintain trust during the transition.

The local authority’s newly developed brokerage team worked to match care packages with vacancies, and wherever possible, respected people’s preferences. The introduction of the brokerage function significantly improved the commissioning of care packages by streamlining processes, reducing delays, and freeing up practice staff to focus on direct support. Feedback from partners and people highlighted its speed, responsiveness, and positive impact on outcomes. There was strong collaboration with partners and providers, and data was used to review care arrangements and build on specialist expertise that operations staff relied on.

Ensuring quality of local services

The local authority had arrangements in place to monitor the quality and impact of care and support services being commissioned for people, and it supported improvements where needed. However, quality assurance was managed on a risk basis rather than through a comprehensive oversight framework.

There were examples where emerging and immediate risks were dealt with effectively. For example, when a care home closed at short notice, people using the service and their families were provided with clear information and communication, including the necessary assessments and suitable options. This responsive approach helped minimise disruption and ensure continuity of care.

Other commissioned services were monitored when a risk was highlighted. The local authority took action to remove the contract with a care home due to non-compliance, and other residential and nursing homes were placed under enhanced oversight, with improvement plans put in place due to concerns about quality and safety. However, ongoing consistent monitoring of commissioned services was often managed through the use of regular data and quarterly reports rather than proactive assessment.

Providers reported positive relationships with the local authority, including responsive support during service suspensions and improvement notices. Providers were required to submit monthly and quarterly contract monitoring reports, alongside quarterly contract monitoring meetings.

Some providers told us contract monitoring meetings had not consistently taken place or been planned following newly commissioned services. When meetings did occur, they were not always attended by a representative from frontline services and were based on provider data and agreed Key Performance Indicators (KPIs). This meant the local authority could not be assured of a robust approach to all commissioned contracts and missed opportunities to triangulate provider data with frontline experience.

A residential quality standards document dated November 2022 outlined quality expectations for residential and nursing homes. The local authority told us the document had not been reviewed, as the framework it supported remained unchanged and continued to be fit for purpose. A full review of the residential care contract and quality standards was scheduled to commence in summer 2026.

The local authority told us they had built positive relationships, supported by monthly webinars involving care providers, residential services, and supported living provision. They had recently improved contract management arrangements, introducing more detailed quarterly reporting requirements, including the number of complaints, missed visits, incident logs, staffing levels, and a capacity tracker. An annual self-assessment for providers was introduced and was reviewed by the contract team. The information was triangulated with other intelligence to inform prioritisation for contract monitoring as part of monthly reviews.

A senior leader told us about developments with care providers, including the introduction of the trusted assessor model. They also recognised the importance of the quality assurance function and had invested in recruiting further staff to the team. This demonstrated a commitment to workforce investment and the importance of contract monitoring in ensuring good quality care and developing the market.

A monthly market intelligence meeting, involving a range of partner agencies, enabled discussions on concerns to support monitoring. This provided shared knowledge across teams about market intelligence and services of concern, creating a two-way process for information sharing and decisions on suspensions or support a service might require. For example, a care home had its placements suspended by the local authority, but the service continued to receive support to make improvements, and it remained on the agenda for monitoring while working through a gradual lifting of the suspension. This demonstrated a balanced approach to enforcement and support.

Supported living services followed a Supported Living Outcomes Framework (September 2024). This was informed by previous quality frameworks and provider feedback, and it embedded the REACH standards. These are a set of 11 outcome-based principles that promote person-centred support for people with learning disabilities and/or autism, focusing on choice, rights, control, and inclusion in all aspects of life, such as who they live with, where they live, how they are supported, and how they participate in their community.

Ensuring local services are sustainable

The local authority worked with providers and stakeholders to understand current trading conditions and to ensure services were sustainable, affordable, and provided continuity for people. The local authority told us they had three support at home providers on its framework. One was under enhanced monitoring. All three providers were rated Good by the CQC. No support at home contracts had been returned in the past 12 months.

There were mechanisms in place to anticipate and receive early warnings of business failure, through regular contact with providers and partners. Contingency plans were prepared to ensure people continued to receive the care they needed, even if a change of provider was required. This helped prevent disruption and maintained continuity of care during provider transitions.

A Care Provider News Bulletin was issued by the Director of Adult Social Care, including general updates on adult social care, service-specific news, and reminders about priorities and targets. Support was also provided through the newly established North East Lincolnshire Care Association (NELCA), which aimed at providing support to providers in the region. NELCA focused on recruitment and retention through the People and Skills Pledge, and supported with uplifts in costs, and held its first annual conference in March 2025. This created a forum for collaboration and shared learning across the provider network.

In 2023, the local authority developed a new Adult Social Care Workforce Development Plan to support and promote the value of social care. This initiative aimed to address workforce challenges by investing in skills, improving job satisfaction, and creating clearer pathways for professional growth. The plan focused particularly on the provider workforce and direct care roles, recognising their central role in delivering high-quality, person-centred support.

In early 2024, the People and Skills Pledge was designed to maximise employment opportunities across the borough, with a key focus on engaging the local community to inspire careers in health and social care. This work was supported by the Health and Care Partnership (HCP) Workforce Strategy 2024-2029, reinforcing a system-wide commitment to workforce development.

The wider care market was supported through coordinated recruitment events in partnership with the Department for Work and Pensions (DWP). These included job fairs, advertising vacancies, and shortlisting candidates on behalf of local care providers across residential, supported living, and care-at-home settings. The local authority also developed a borough-wide recruitment campaign called Life in North East Lincolnshire, which was adopted by several employers, including HCP members.

The local authority provided free training opportunities for the workforce. For example, 17 free training courses were offered across all service areas, including the Mental Capacity Act pathway and safeguarding. Training was delivered via a self-service database, accessible to service managers. Feedback on the training was positive and reflected wide usage across a range of services areas. This supported workforce development and helped ensure staff were equipped to deliver safe, person-centred care.

The local authority had worked closely with the care association to understand cost pressures and awarded providers financial uplifts in 2025/26. However, some providers felt that rising costs continued to place pressure on service delivery.

The Strategic Register, completed by the local authority, identified financial constraints as a key risk linked to the cost of living, increases in the National Minimum Wage, and recruitment and retention challenges. In response, the local authority proposed progressing the implementation of the Market Sustainability Plan and working with providers to address cost pressures. The plan also considered potential market changes, such as the introduction of the Fair Cost of Care Fund.

The Fair Cost of Care process aimed to ensure care providers were compensated at rates that covered actual costs, including staffing, utilities, and other expenses, often achieved by increasing the fee rates paid by the local authority. This demonstrated an approach was in place to address concerns, although it had not yet had the required impact on commissioned or partner services, which were still experiencing cost pressures. This suggested further action was needed to ensure financial viability and continuity of care across the market.

Partnerships and communities

Score: 3

3 - Evidence shows a good standard

What people expect

I have care and support that is coordinated, and everyone works well together and with me.

The local authority commitment

We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

Key findings for this quality statement

Partnership working to deliver shared local and national objectives

The local authority worked in formal partnership with the Humber and North Yorkshire Integrated Care Board (ICB) under a Section 75 agreement which had been in place since 2007. This enabled joint commissioning, pooled funding, and integrated health and social care services. Services were delivered through three community interest companies (CICs): Navigo (mental health), Care Plus Group (intermediate and transport services), and Focus Independent Adult Social Work (Care Act duties). All CICs operated through a single point of access (SPA). People benefited from coordinated services that reduced duplication and improved access to care.

A senior leader highlighted assurance gaps identified in one CIC which had led to the development of a dashboard aligned with local authority standards, demonstrating the local authority's ability to influence external partners. Despite progress, leaders acknowledged more work was needed due to the persistent health inequalities, with some wards showing life expectancy gaps of up to 15 years. The dashboard improved oversight and accountability, helping to address service quality concerns.

Strategic oversight was provided by the Health and Care Partnership Board (HCP), which included senior representation from health and social care organisations and a person with lived experience. The board shaped the vision and strategic direction for integrated services, aiming to improve health outcomes, reduce inequalities, and ensure sustainable use of resources. Governance arrangements included lived experience in decision-making and regular engagement with communities, helping ensure the partnership remained accountable and responsive to people's needs.

A political leader told us they were actively involved in integrated governance through partnership boards and joint committees, supported by the Section 75 agreement. Co-located offices and weekly leadership meetings facilitated joint working and quick decision-making. The Director of Public Health reported directly to the Chief Executive Officer (CEO), with reducing health inequalities as a key priority.

Partnership working was embedded across strategies, including the Health and Wellbeing Strategic Framework and the Carers Strategy. These highlighted a life-course approach and recognised the importance of enabling people to remain at home and supporting unpaid carers to continue in their roles.

Public Health and the local authority collaborated on the Mental Health Strategy and were jointly commissioning work under the Marmot Framework, which focuses on reducing health inequalities through action on the social determinants of health. This work had political and corporate backing. A senior leader told us the partnership was strategic rather than contractual, with shared priorities and regular engagement through the HCP Board.

A senior leader told us the local authority had faced challenges around homelessness and housing supply. In response, adult social care, public health, and children's services jointly developed a Housing with Care Strategy, promoting coordinated planning and person-centred support. The integration of a social worker into the housing team enabled individualised support for people experiencing homelessness, helping to reduce repeat homelessness and improve access to support.

A senior leader told us a lead officer had been appointed to ensure new housing developments considered care needs, including social housing and supported accommodation. Also, the local authority planned to invest in voluntary sector programmes to support older people during winter, improve hospital discharge, and promote healthy ageing. However, no specific timeframe or launch date for this investment was provided.

Partners told us the voluntary community sector enterprise (VCSE) was a key system partner, contributing to both service delivery and governance. Its involvement enhanced community engagement and ensured services were responsive to the needs of people with care and support needs, particularly those experiencing barriers to care. This demonstrated the value of inclusive commissioning and the importance of community innovation in meeting local needs.

A partner told us the local authority commissioned an organisation to strategically support VCSE involvement, including recruitment, governance, and event facilitation. This strengthened the role of VCSE in health and care planning, enabling community-led services to contribute fully to service improvement.

VCSE partners played an important role in hospital discharge, prevention, and support for vulnerable groups. Their flexible, community-led services complemented statutory provision and were recognised as key contributors to the Healthcare Partnership. Funding was used creatively, resulting in positive outcomes for people and demonstrating the value of commissioning community innovation.

Health partners told us the local authority was visible in the community and proactive in building relationships. The unpaid carers board, chaired by a person with lived experience, met monthly to review strategies and actions. Unpaid carers told us support groups such as carers voice and the mental health support group were helpful and inclusive.

Following the pandemic, the local authority re-established the Learning Disability Partnership Board, ensuring representation from people with lived experience. A tailored group, Stand Together, supported people with communication needs, and easy-read materials helped ensure accessibility. These initiatives promoted inclusion and ensured people with diverse needs could participate in shaping services.

Partners told us the local authority responded promptly to concerns and worked collaboratively to find solutions. One health partner described the development of the discharge to assess model as a positive outcome of joint working, with hospital discharge teams relocated to the community. VCSE partners supported this with befriending and advocacy services, helping to reduce delays and improve transitions from hospital to home.

The local authority hosted monthly webinars for adult social care providers, sharing updates, training opportunities, and inspection notices. Practice development was supported through forums, training weeks, and a quality assurance panel. Staff told us they planned to invite more frontline teams to hub meetings to share learning and improve collaboration.

An established partner commissioned to run a day centre described their relationship with the local authority as both equal and constructive. They were involved in engagement activities and peer reviews, contributing to service improvements for people with learning disabilities.

Arrangements to support effective partnership working

Frontline staff told us the hospital discharge model was streamlined through a Single Point of Access (SPA), which focused on describing people's needs rather than prescribing support packages. Staff said this approach, supported by collaboration with local authorities, community health services, and VCSE partners, enabled more responsive and person-centred care.

A senior leader told us people did not experience delays in receiving services. Services were put in place promptly using pooled budgets, with funding responsibilities clarified later. This meant people received timely support, regardless of funding arrangements, improving outcomes for people and unpaid carers.

The Better Care Fund (BCF) was used to expand and improve community-based services. Staff told us these included initiatives such as single-handed care, enhanced reablement provision, and increased intermediate care beds. These developments helped people remain independent at home and reduced reliance on hospital care.

Partners told us the BCF plan reflected strong joint commissioning arrangements. Examples included the SPA offering integrated access to health, mental health, social care, and therapy services, and the Assisted Living Centre, which ensured timely delivery of equipment. This demonstrated joined-up planning and delivery, improving access and coordination across services.

The local authority told us the principles of the BCF had long been embedded in the integrated health and care model. The 2023–2025 BCF plan outlined shared priorities such as implementing reablement review findings, developing extra care housing, expanding community-based support, and investing in workforce development. These priorities supported a more preventative and strengths-based approach to care, helping people maintain independence and reduce crisis.

Partners told us the governance structure of the Health and Care Partnership (HCP) was inclusive and enabled effective collaboration across health, social care, VCSE, and community organisations. The structure included a Board, leadership group, and forums for engagement, professionals, and staff. This ensured all partners were involved in shaping and delivering strategic plans.

The local authority told us partnership working was their default approach. They said the HCP formed the foundation of their integrated model, which extended beyond adult social care to all aspects of health and care. Terms of reference showed clear responsibilities for workforce development, performance scrutiny, and operational planning, supporting accountability and shared leadership.

Partners told us the VCSE sector was a key system partner, contributing to both service delivery and governance. Its involvement enhanced community engagement and ensured services were responsive to the needs of people with care and support needs, particularly those experiencing barriers to care. This demonstrated the value of inclusive commissioning and the importance of community innovation in meeting local needs.

A partner told us the local authority commissioned an organisation to strategically support VCSE involvement, including recruitment, governance, and event facilitation. This strengthened the role of VCSE in health and care planning, enabling community-led services to contribute fully to service improvement.

Furthermore, a health leader highlighted the local authority and ICB were proactively planning for upcoming national changes to ICB structures. They were working together to maintain stability, governance, and effective partnership working, ensuring continuity during system reform. This meant people continued to receive consistent care during system changes, with minimal disruption.

Impact of partnership working

A senior leader told us the North East Lincolnshire Community Engagement Strategy (2023–2025) promoted collaboration across health, care, and community organisations. It prioritised listening to local people and aligning with national health goals. VCSE partners were treated as equal partners, not just consulted, helping to build trust and shared ownership of service development.

A partner described a strong relationship with the local authority, supported by open dialogue and the ability to challenge and negotiate contract terms based on carers' needs. The VCSE sector was described as having an “open door” relationship with the local authority, which had enabled flexible and responsive commissioning.

Another partner told us the local authority allocated part of the household support fund to their organisation, enabling rapid financial support for people. Some of this funding was used to commission 30 hours per week of benefits advice, increasing access to essential services and reducing financial stress.

The Place Chair and Director of Adult Social Services (DASS) met regularly with Chief Executive Officers (CEOs) of community interest companies (CICs) for performance and contractual reviews. CICs were commissioned under a single contract with integrated health and adult social care specifications. A senior leader told us the CICs were performing well against their agreements, supporting stable delivery of integrated services.

The ICB Place budget and local authority budget were pooled under a Section 75 agreement, enabling joint decision-making at the local level. This reduced duplication and service gaps, supporting better outcomes for people.

Frontline teams attended “Pit Stop” meetings led by the police to share information about local risks. Staff shared an example where police raised concerns about an unpaid carer accused of financial abuse. Although no crime was committed, the safeguarding team became involved, resulting in positive outcomes for both the unpaid carer and the person receiving care. This demonstrated effective multi-agency safeguarding and early intervention.

The integrated model allowed services to move beyond a “diagnose, medicate, discharge” approach, embedding social care into holistic practices. A senior leader highlighted, although less than 10% of funding came from adult social care, it shaped the service’s thinking. This integration led to improved experiences and outcomes for people.

Partners also told us health and social care teams collaborated on data collection and analysis to improve outcomes. For example, a lack of data on the transgender people prompted targeted work to address gaps and drive improvements, supporting inclusive service planning.

Staff told us about how effective multi-disciplinary working supported people to achieve their care and support outcomes. A senior leader reported VCSE partners received funding and consistently used it creatively. One VCSE partner, jointly funded by the local authority ICB, worked closely with hospitals to provide a step-down service for people leaving hospital. Feedback from people was positive, and the initiative helped fill critical gaps in transitional care, improving outcomes and reducing pressure on statutory services.

Another senior leader described the impact of partnership working with VCSE organisations, including one that hosted an apprentice social worker with tailored support. Other VCSE partners were exploring similar models, indicating a growing commitment to workforce development.

Healthwatch was a key member of the Health and Care Partnership and supported them through collaboration to improve services and outcomes for people. Healthwatch contributed to the development and oversight of care delivered in people's homes, referred to as the at home framework. This included monitoring care home standards, reviewing extra care housing, and evaluating end of life care services. The framework aimed to promote independence, reduce reliance on institutional care, and ensure people received high-quality support in their own homes.

A partner reported high indicators of substance use and mental health in the borough. In response, they received funding for a dedicated support worker. This intervention aligned with the strategic drug and alcohol partnership and was described as impactful, helping to support people and unpaid carers to reduce harm.

Strategic partnerships in North East Lincolnshire were well-established and collaborative, with clear evidence of positive outcomes for people. The local authority's integrated governance arrangements, pooled budgets, and co-produced strategies supported joined-up planning and delivery across health, social care, and the voluntary and community sector (VCSE). Services delivered through the three CICs contributed to timely hospital discharges, improved transitions, and person-centred support.

People benefited from coordinated services that reduced duplication and improved access to care. For example, the Single Point of Access (SPA) enabled integrated triage and rapid response, while VCSE partners played a key role in prevention and step-down support. Strategic oversight through the Health and Care Partnership Board and Social Work Performance Board ensured accountability and alignment with local priorities.

While some variation in operational delivery was noted, such as delays in reviews and underuse of advocacy these were being addressed through strengthened quality assurance and targeted improvement plans. This demonstrated a proactive and transparent approach to continuous improvement, with a clear focus on monitoring outcomes and ensuring consistency in frontline delivery.

Working with voluntary and charity sector groups

The local authority had actively collaborated with the North East Lincolnshire Health and Care Partnership to develop the Adult Services Market Sustainability Plan (March 2023), fostering integrated working across health, social care, and the VCSE. This was formalised through the Health Care Partnership Agreement (May 2023), which set out shared objectives and a shared vision for service delivery.

Partners told us the local authority recognised VCSE's contribution by maintaining commissioning arrangements and open communication channels, such as the voluntary sector forum. This forum was well-established and proportionately represented, including organisations supporting people seeking asylum, refugees, and faith-based communities. This ensured diverse voices were included in service planning and delivery.

Partners told us the local authority played an important role in the VCSE forum and the Later Life Partnership, working alongside VCSE partners to meet the needs of older people. These partnerships hosted large advice days and forums, attended by local authority representatives including the Director of Adult Social Services (DASS), helping older people access support and information.

A senior leader highlighted the VCSE had delivered preventative services that helped older people stay well and avoid formal care, including falls prevention and participation in partnership boards. They also highlighted the VCSE's effectiveness in delivering transformational change and maintaining independence.

Another partner highlighted the commissioners had played a key role in bringing VCSE organisations together to deliver early intervention services, such as those provided by the Later Life Partnership. These efforts helped reduce demand on formal care services, supporting sustainability and prevention.

People told us the local authority had worked with local groups and charities to support autistic people and people with learning disabilities. In collaboration with the ICB and VCSE partners, they helped establish a peer support company led by autistic people, promoting empowerment and community-led solutions. This initiative supported inclusion and gave people greater control over their support networks.

Healthwatch also met regularly with VCSE partners, gaining insight into services and identifying opportunities for joint working with the local authority, to better meet people's needs.

A frontline team told us about collaborative work with partners to deliver services for both eligible and non-eligible needs. This included bespoke support for people with Huntington's disease, improved understanding of neurodiversity and autism among social workers, and new supported living arrangements where the local authority managed tenancies.

Staff also shared aspirations to expand mental health housing and create a community gym to support young people transitioning between services. These developments reflected a proactive approach to meeting complex and changing needs.

Staff told us they had a strong working relationship with the VCSE. Local VCSE members had delivered informative sessions to frontline teams, increasing awareness of available services. One example involved a referral for a person with non-eligible needs, where the VCSE helped secure grants for essential items like white goods. This demonstrated the value of flexible, community-led support in addressing practical needs and improving wellbeing.

Theme 3: How North East Lincolnshire ensures safety within the system

This theme includes these quality statements:

- Safe pathways, systems and transitions
- Safeguarding

We may not always review all quality statements during every assessment.

Safe pathways, systems and transitions

Score: 3

3 - Evidence shows a good standard

What people expect

When I move between services, settings or areas, there is a plan for what happens next and who will do what, and all the practical arrangements are in place. I feel safe and am supported to understand and manage any risks.

I feel safe and am supported to understand and manage any risks.

The local authority commitment

We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.

Key findings for this quality statement

Safety management

Safety was a priority for everyone involved. The local authority took time to reflect on and understand the risks people faced throughout their care journeys. Policies and procedures were aligned with partner organisations. A community integration approach helped remove organisational barriers and ensured people received support that matched their needs.

The local authority used a shared recording system with health colleagues, to store records and track support. Staff said it helped them see a person's full journey and reflect on what had worked before. This supported consistent service delivery and allowed staff to explore other support options. The integrated commissioning system also helped avoid funding disagreements, meaning services could be delivered without delay or impact on the person.

Processes were in place to ensure continuity of care for people receiving services outside the local authority area. These placements were only used when local options were unavailable, mainly for people with complex learning needs. In the past 12 months, only 10 out-of-area placements were made, showing reduced reliance on external services. When used, these placements were carefully assessed and regularly reviewed to ensure they continued to meet the person's needs.

The Community Safety Partnership (CSP) brought together statutory and VCSE partners to address crime, anti-social behaviour and substance misuse. Its work supported adults at risk, with targeted interventions and accredited victim support processes helping prevent repeat abuse.

Where unpaid carers were identified, they were offered advice, information, and a carers guide. In response to feedback, a carers liaison worker was introduced to support unpaid carers and help with discharge planning. Between April and November 2024, hospital staff referred 375 unpaid carers to the support service. This led to better identification of unpaid carers and improved outcomes for both unpaid carers and the people they supported.

There was good oversight of children transitioning into adulthood, which helped with planning. A senior leader said the Preparing for Adulthood (PFA) Strategy had been improved through close work with children's services. More effort was made to engage young people and their families early, with clear conversations about the differences between children's and adult social care. The team made meaningful progress in planning transitions, ensuring continuity of care and strong family involvement. This meant young people and families felt more prepared and supported during transitions, reducing anxiety and improving engagement.

The Preparing for Adulthood Protocol provided a detailed multi-agency approach to ensure consistency across education, health, and social care. It focused on early identification, collaborative planning, and individual needs. Key practices included Care Act assessments, team allocations, and involvement of young people and their families. The process was monitored and adjusted as needed.

Safety during transitions

The local authority responded to feedback from unpaid carers via the carers forum, particularly around accessing information during the hospital discharge process. In collaboration with the hospital, they created a quick-start guide with the most relevant information. This led to the employment of a dedicated carers worker at the carers centre who regularly attended the hospital.

In addition to the guide, posters were placed on wards and a carers lanyard was introduced. This lanyard helped unpaid carers be recognised and allowed them to visit outside normal hours. Unpaid carers who wanted to be actively involved were included in support planning, which was available at the bedside. This approach helped unpaid carers stay informed and involved in the discharge plan.

The local authority also produced a social care handbook covering a wide range of topics, including assessments, finances, hospital discharge, and how to report neglect or abuse. The handbook helped people understand their journey through the social care system, from initial contact to ongoing support.

Out-of-hours teams were linked to the Single Point of Access (SPA), which provided one contact number for all services. The SPA triage service covered all disciplines and used staff knowledge to refer people to the right team after gathering all necessary information. Staff said this system was effective and prevented people from having to repeat their stories. Staff rotations across the 24-hour period allowed for detailed handovers, ensuring continuity in emerging or ongoing circumstances.

People's safety and needs were central to the service. One example involved a member of the public contacting SPA with concerns about a neighbour possibly trapped inside a boarded-up property. The person had a history of alcohol misuse. The duty worker assessed the risk and coordinated with the fire service and medical professionals. The person was contacted, their immediate needs were met, and they were later transferred to the long-term social work team. This showed a risk-based approach focused on both short- and long-term needs.

The mental health team had its own 24-hour support service with Approved Mental Health Professionals (AMHPs). When someone needed this level of support, the out-of-hours team referred them through SPA for triage and allocation.

People in crisis were initially referred to the urgent care team, reducing hospital admissions. The local authority also provided 24/7 open-access mental health walk-in facilities, used by police and ambulance services as alternatives to custody or hospital, demonstrating a preventative approach. The SPA model had included therapy services, enabling streamlined referrals and improved coordination across health and social care teams.

The hospital discharge model used a whole-system approach to help people live independently and stay healthy after leaving hospital. Discharge pathways offered a range of options, including signposting, further assessment in other settings, reablement at home, or support in a care facility.

Health leaders described discharge performance in North East Lincolnshire as "gold standard," based on the evidence that people were discharged without delays. Neighbouring local authorities often referred to the approach as best practice. This demonstrated people experienced timely transitions from hospital, reducing stress and improving recovery outcomes.

The discharge process focused on people's strengths, using the phrase "why not home, why not today." As a result, 94.8% of people were discharged back to their usual place of residence. Every discharge was followed up with a call within 24 hours to check for any unmet needs. If further support was needed, referrals were made to the Home from Hospital service, delivered by the voluntary community sector enterprise (VCSE).

The Reablement at Home (R@Home) service was a key part of the discharge process. A representative attended daily community hub meetings to help coordinate care. The service accepted same-day referrals, and when it was at capacity, people were temporarily supported by domiciliary care services. R@Home helped people regain independence and stay in their own homes. When the service ended, the team made sure any voluntary or community support or equipment was in place. If ongoing care was needed, people were referred to the Focus duty triage team, which reviewed their needs within 72 hours. This evidenced people experienced seamless transitions between services, reducing gaps in care and improving recovery.

VCSE played an important role in helping people return home safely and stay independent. Services included meals, medication support, lifeline pendants, and welfare calls. Between 1 April and 31 December 2024, 880 people were supported, with 69 key safes fitted and 141 care link units installed for up to 6 weeks. These services were originally part of the winter pressures response but were made permanent due to their success, with commissioners working alongside the VCSE and hospital teams. The Health and Wellbeing Strategic Framework also highlighted the positive impact of the stronger communities approach.

The Discharge System Improvement Group (DSIG) acted as the strategic governance body for discharge performance. It drove cultural, practical, and system-wide changes to meet the requirements of the hospital discharge services policy. DSIG reported to the A&E Delivery Board, ensuring alignment with wider urgent care strategies. A range of operational meetings across Northern Lincolnshire supported safe and timely discharges and ensured people were placed on the correct pathway. Staff spoke positively about working with the Continuing Health Care (CHC) team, where CHC nurses completed assessments and passed them to the local authority for follow-up.

Several examples highlighted the importance of meeting people's needs to help them return home. Complex case workers identified people with high needs upon admission and worked closely with them and their families to gather information for a smooth discharge. One example involved a person with limited mobility who needed a voice-activated device and a tailored care package to return home safely.

Occasionally, care packages were delayed for up to 2 weeks, usually for complex referrals requiring specialist knowledge. For example, one person living with Parkinson's disease needed a neck brace, which required a provider with specific expertise.

Processes were in place to access equipment for both simple and complex needs. One person on end-of-life care needed oxygen for discharge; after a risk assessment, the equipment was delivered the same day. Others received small aids through the Trusted Assessor approach, which included advice and equipment to help them stay independent.

Discharge pathways offered various options. People needing bed-based intermediate care or a Discharge to Assess placement were supported by the Community Inpatient Unit (CIU), where they received personalised recovery, rehabilitation, or reablement support.

The local authority developed a joined-up approach to help people move safely through different stages of care, including the transition from childhood to adulthood. Tracking tools were used to make early contact with young people from Year 8, giving a five-year lead-in to adult social care. The tracker showed 792 young people aged 14 to 25, each supported by a lead practitioner. Staff said this gave them time to build relationships and understand individual needs.

For young people who did not meet eligibility for statutory support, the team worked with the VCSE to explore other options, such as volunteering and life skills support. A video was created to show alternative pathways for those without SEND support. The Preparing for Adulthood (PFA) structure included internships, with 14 young people participating. One notable success was a young person securing a job with the police.

Contingency planning

The local authority had contingency plans in place to prepare for any interruptions in care and support services. A shared recording system between health and social care helped ensure a smoother and more consistent approach. Around 80% of GP practices used the same system, along with community therapists and hospital discharge teams. This made it easier to access a person's journey and needs, allowing for a more holistic and joined-up approach to care. During emergencies or when contingency plans were needed, teams could communicate quickly and work together to provide responsive support.

Clear pathways were in place for people experiencing emergencies or crises. Initial support was available by telephone, including advice, guidance, and signposting. If an emergency assessment was needed, it could be arranged along with any necessary medical input from clinical professionals. One example involved a person with a learning disability who experienced a crisis after the death of their main caregiver. A multi-disciplinary team came together to assess the situation and provide the support needed to help the person remain in their preferred care setting.

The local authority's commissioning teams had policies and procedures ready in case a care provider stopped operating. The Quality Assurance and Improvement Framework 2023–2026, developed jointly with the Integrated Care Board (ICB) and Humber and North Yorkshire Health and Care Partnership, provided clear guidance on actions to reduce risks and support people in transferring to another service safely.

The local authority also had plans for responding to urgent or unexpected events, such as extreme weather or service failures. These plans had been recently reviewed. The Emergency Preparedness, Resilience and Response Policy included ongoing risk assessments and strategies to identify hazards and respond appropriately.

Business continuity plans focused on keeping services running during disruptions. They ensured resources were available and communication channels were clear. Key elements included a risk matrix to identify essential skills, redeployment of staff, and collaboration with third-party organisations. Plans were regularly reviewed, and emergency services and other agencies carried out simulations and training exercises to test readiness.

Safeguarding

Score: 2

2 - Evidence shows some shortfalls

What people expect

I feel safe and am supported to understand and manage any risks.

The local authority commitment

We work with people to understand what being safe means to them and work with our partners to develop the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.

Key findings for this quality statement

Safeguarding systems, processes and practices

National data from the Adult Social Care Survey 2023/24 showed 88.00% of people who used services felt these made them feel safe and secure, similar to the England average of 87.82%. Additionally, 68.00% of people who used services felt safe, also close to the national average of 71.06%. Data from the Survey of Adult Carers in England 2023/24 showed 81.25% of carers felt safe, which was also similar to the England average of 80.93%. This demonstrated the local authority supported people and unpaid carers with consistent safeguarding practices, which helped them feel safe and secure in line with national trends.

There were effective systems and practices in place to protect people from abuse and neglect. The safeguarding adults and Deprivation of Liberty Safeguards (DoLS) teams operated a duty triage function, with safeguarding practitioners completing Section 42 enquiries. Recruitment was underway for two additional social workers to meet rising referral volumes.

Safeguarding remained inclusive. A senior leader told us vulnerable adults were prioritised even when they did not meet Care Act eligibility. Staff also reported system improvements had enabled out-of-hours teams to access safeguarding records, supporting better-informed decisions and continuity of care.

There was a clear process for communicating safeguarding concerns, supported by training for providers and partners on issues such as self-neglect, a theme identified through the safeguarding referrals quality assurance process. An intelligence portal was available for anyone to submit concerns about services or safeguarding. This could be used by other partners such as the Care Quality Commission (CQC).

However, some frontline staff shared with us they were not always sure how to raise concerns, which meant we could not be assured all concerns had been recorded in a timely and consistent way. All recorded concerns were brought together at weekly triage meetings, but staff uncertainty may have delayed appropriate action in some situations.

The Safeguarding Adults Board (SAB) adopted a rotating chair model, alternating between the Police Divisional Commander and the Director of Adult Social Services (DASS). The chair shared horizon scanning work, including a deep dive into homelessness and hoarding. Learning from a care home death was shared across North Lincolnshire and North East Lincolnshire boards, with links to public health and the Integrated Care Board (ICB). This showed the SAB promoted cross-boundary learning and strategic oversight of safeguarding themes.

Staff told us the multi-agency approach was effective but felt it could be strengthened by involving a wider range of services to ensure a consistent approach to all safeguarding concerns, and by introducing an additional multidisciplinary panel beyond the existing Organisational Risk Management (ORM) meetings to review complex referrals and streamline processes. The local authority told us that ORM meetings already operated as a multidisciplinary panel for complex referrals, involving staff from all relevant areas. The designated safeguarding manager attended these meetings, which used a collaborative, mandatory attendance model to manage high-risk referrals.

A health partner told us safeguarding practices were strong, with documentation and information-sharing supporting hospital discharge. Focus was the main Community Interest Company who led statutory safeguarding duties on behalf of the local authority, with oversight provided through contractual arrangements and direct assurance to the DASS.

Safeguarding performance was reviewed monthly at the Performance Board, enabling continuous improvement. All safeguarding notifications were received via the Single Point of Access (SPA), where senior practitioners triaged referrals against Section 42 criteria. Through these meetings the threshold was identified and referrals allocated within one working day. Others were redirected to appropriate teams or to voluntary community sector enterprise (VCSE) partners.

The safeguarding team maintained positive working relationships with care providers and partners, coordinating notifications and enquiries. Collaboration with the contracts team and ICB quality team supported early identification of systemic issues and promoted sector-wide improvement.

The local authority published a Safeguarding Strategic Plan (2024–2027) and relaunched the Multiagency Learning and Workforce Development Strategy (2023–2026), aligning training with legislation and local policy. This supported a shared understanding of safeguarding responsibilities and built workforce capability.

The SAB maintained four active sub-groups: Safeguarding Adults Review, Adults at Risk of Harm, Mental Capacity Act, and Scrutiny and Assurance. These focused on priority themes and ensured accountability.

Practice development was tailored to individual staff needs, supported by core training modules. However, national data from the Adult Social Care Workforce Estimates for 2023/24 showed 22.80% of independent or local authority staff completed Mental Capacity Act (MCA) or Deprivation of Liberty Safeguards (DoLS) training. This was significantly lower than the England average of 37.58%. Additionally, 44.00% completed safeguarding training, also lower than the national average of 48.70%. This demonstrated a need for strengthened workforce training to ensure consistent safeguarding practice across all settings.

Responding to local safeguarding risks and issues

There was a clear understanding of safeguarding risks across the system, with coordinated efforts to address concerns and improve outcomes. A safeguarding concern involving a sexual allegation prompted a review of capacity and vulnerability assessments for people returning home. Staff told us this led to greater frontline involvement and reflection on practice, which helped ensure people's needs were more thoroughly considered before discharge, reducing the risk of harm.

Since 2024, hoarding was identified as an emerging concern, prompting increased partnership focus. Leaders further highlighted the importance of consistency in safeguarding investigations, reflecting a commitment to learning and continuous quality improvement.

Domestic abuse was identified as a growing risk and was addressed through a joint strategic plan between the Safeguarding Adults Board (SAB), Community Safety Partnership, and Children's Safeguarding Board, promoting a whole-system approach. Public health led domestic abuse work, with increased senior representation, including the Director of Adult Social Services (DASS).

A new Quality Assurance Framework was introduced in April 2025. Monthly audits, led by supervisors and reviewed in 1:1s, informed team manager reports submitted to a multi-agency Quality Assurance Panel, strengthening oversight and accountability. Staff told us this took time to embed but had begun to show progress. This helped ensure people received more consistent and timely safeguarding responses, with clearer escalation pathways.

Learning from Safeguarding Adults Reviews (SARs) was a standing item at the Quality Assurance Panel. Previously, learning had been shared through 7-minute briefings and newsletters. A local SAR on the Mental Capacity Act was anonymised to support wider learning. However, some staff were unclear about recent SAR learning or how it had been shared. This indicated that while mechanisms for sharing learning were in place, further work was needed to embed learning consistently across teams and ensure accessibility.

The SAB supported workforce development through a formal agreement, and staff told us there was positive local investment in safeguarding knowledge and skills. A thematic review by the practice development, assurance and education team identified a high volume of self-neglect referrals, prompting the SAB's Mental Capacity Act subgroup to develop updated capacity assessment guidance with practical prompts for practitioners. This supported more consistent, person-centred, and legally compliant assessments across the system.

Staff reported feeling supported and well-trained to deliver the required information and guidance for their roles, contributing to a confident and capable workforce. Safeguarding feedback was shared through team discussions, quarterly bulletins, and safeguarding guardians within care provider groups, which helped staff stay informed and responsive to emerging risks.

Frontline teams held weekly hub meetings to share learning and manage high volumes of enquiries, which staff said improved coordination. Initially, triage staff handled enquiries, but this led to misclassification. The SAB supported improvements to ensure more accurate logging and triage processes. Staff demonstrated flexibility in managing risk and demand, which helped reduce delays and ensure timely and proportionate safeguarding responses.

Safeguarding concerns were triaged through the Single Point of Access (SPA) team. Staff told us that patterns in referrals were analysed and shared with the safeguarding team, and plans were underway to align SPA and safeguarding meetings to streamline decision-making and improve oversight. Staff also said that clear out-of-hours pathways ensured continuity of safeguarding responses, helping to protect people at risk during evenings and weekends when services were limited.

External peer reviews were being developed across the three community interest companies (CICs), supporting shared learning and benchmarking. A joint pilot team embedded mental health practitioners within homelessness services, improving access to specialist support. Staff attended multi-agency safeguarding meetings, which they said strengthened inter-agency relationships and improved coordination. This had improved access to mental health support for people experiencing homelessness, reducing the risk of unmet need and crisis escalation.

The Adults at Risk Group, focusing on homelessness, introduced structured partnership engagement through regular data presentations at SAB meetings, enabling targeted responses.

Partners told us the SPA worked well for reporting concerns and praised the local authority's open and transparent safeguarding culture. They highlighted positive relationships with frontline teams and named safeguarding leads, which helped build trust, improve coordination, and support timely interventions.

The safeguarding team was described as responsive, knowledgeable, and well-informed. Partners told us the team communicated promptly with the Care Quality Commission, shared updates, and provided support during complex situations. The SAB website was seen as informative, and providers appreciated the low-level safeguarding log system, which included clear criteria for escalation and resolution, supporting early identification and management of lower-level risks.

A partner told us that referrals to the safeguarding team received prompt responses, with updates and advice provided. This showed the local authority maintained a responsive, well-led safeguarding service that supported both staff and partners and promoted continuous improvement.

Responding to concerns and undertaking Section 42 enquiries

Frontline staff described a multidisciplinary and person-centred response to a modern slavery referral received via hospital and ambulance services. Duty workers conducted a capacity assessment using translation services. Although the person had non-eligible needs, the triage worker collaborated with voluntary and community sector enterprise (VCSE) partners and safeguarding teams across local authorities. This ensured a person-centred response despite the absence of statutory thresholds, demonstrating flexible safeguarding systems that prioritised individual needs and human rights.

Staff also described how they supported people in a safeguarding capacity, even when they did not meet Care Act eligibility or adult-at-risk criteria. For example, one person was referred from hospital via the national modern slavery framework. Although the person did not qualify for ongoing support under the Care Act, the safeguarding practitioner followed up with relevant partners and teams. This demonstrated a commitment to safeguarding people regardless of eligibility.

The Safeguarding Adults Board Annual Report (2023–2024) showed that out of 886 safeguarding concerns reported, 351 progressed to a Section 42 enquiry. In February 2024, 42 safeguarding concerns progressed to enquiry, while the lowest monthly figure was recorded in June 2024, with 16 referrals progressing to enquiry. There was no waiting list for Section 42 enquiries, and referrals were allocated to a safeguarding practitioner on the same day a decision was made via the triage process. The latest figures from July 2025 reflected similar patterns.

By May 2025, only 3 people were waiting, with a median wait of 2 days. Delays were linked to hospital or police processes. Staff confirmed there was no waiting list for allocation.

Daily triage ensured prompt allocation of Section 42 enquiries. However, some enquiries were not logged correctly, leading to underreporting. The Safeguarding Adults Board intervened to resolve this issue, but initial misreporting may have affected oversight, resource planning, and timely responses. Additionally, safeguarding data trends in North East Lincolnshire did not align with national patterns, prompting further analysis by the Safeguarding Adults Board and the Director of Adult Social Services. While initial assurance confirmed that triage processes were robust and appropriate actions were taken, the discrepancy raised concerns about whether safeguarding activity was being fully captured, potentially impacting strategic oversight and the timely protection of people at risk.

Referrals were mostly received via the single point of access (SPA). If the person was already known to other frontline teams, enquiries were delegated with safeguarding team oversight, ensuring continuity of care.

Partners confirmed they received safeguarding training and could contact the local authority for advice. However, one partner told us the information and advice they received on safeguarding issues was inconsistent, which caused confusion about the appropriate course of action. Another partner told us they did not receive the outcome of concerns they had reported. These issues may have led to delays or missed safeguarding opportunities, affecting the safety and confidence of professionals and the people they support.

The local authority managed Deprivation of Liberty Safeguards (DoLS) through shared systems that supported waiting list oversight and risk-based prioritisation. Staff used tools developed by the Association of Directors of Adult Social Services (ADASS) to triage referrals and ensure urgent cases were addressed promptly. While delays remained, particularly for non-urgent applications, strategic oversight and regular reviews helped maintain a proportionate and person-centred approach. Long waits for non-standard DoLS were recognised as a key concern and added to the local authority's risk register.

Making safeguarding personal

National data from the Safeguarding Adults Collection for 2023/24 showed that only 11.76% of people lacking capacity were supported by an advocate, family, or friend, compared to the England average of 83.38%.

Staff told us advocacy was used for out-of-borough referrals and praised the commissioned advocacy service for being helpful and responsive, particularly in Deprivation of Liberty Safeguards (DoLS) referrals. Staff confirmed closure forms included justification for the use or non-use of advocacy in Section 42 enquiries. However, triage staff told us they did not make advocacy referrals at the triage stage. This demonstrated a gap in early-stage advocacy that may have impacted person-centred safeguarding responses.

A senior leader told us the application of the MCA had been a recurring theme in safeguarding work and Safeguarding Adults Reviews (SARs). In response, the local authority invested in free MCA training and webinars for all partners, aiming to reduce variation and improve decision-making. This showed a commitment to improving practice and achieving better outcomes for people through shared learning and system-wide development.

Some staff told us people were always asked for consent during the safeguarding process unless it was inappropriate due to risk or lack of capacity. During Section 42 enquiries, people were asked about their desired outcomes, which were reviewed throughout, and at the conclusion of, the enquiry. This helped ensure safeguarding actions supported the person's wishes.

Staff shared an example of a person who had experienced multiple safeguarding referrals over two years. They wanted to move out of the family home, but family initially raised concerns about their ability to live independently. The person's wishes were upheld, and staff told us they had "thrived" in the community. This demonstrated how safeguarding systems supported choice, independence, and wellbeing when the person's voice was prioritised.

Staff told us safeguarding was made personal through the shared recording system, which allowed practitioners to view all relevant information and build enquiries based on previous involvement. Triage teams used this information to contact people, where appropriate, to discuss concerns and understand their perspective.

As part of the new Quality Assurance Framework, staff told us audit templates had been developed to support Making Safeguarding Personal (MSP). The local authority reviewed MSP outcomes through Section 42 enquiry reports and monthly file audits, with findings discussed in weekly hub meetings. Completed reports were saved to the shared records database, and audits were returned to teams for evaluation.

Coproduction was used to support learning and development. Families were invited to share feedback following safeguarding investigations, which staff described as powerful. Families said they valued earlier involvement, which led to changes in practice. This demonstrated the local authority used coproduction to strengthen safeguarding practice and staff reflection, and family engagement.

Theme 4: Leadership

This theme includes these quality statements:

- Governance, management and sustainability
- Learning, improvement and innovation

We may not always review all quality statements during every assessment.

Governance, management and sustainability

Score: 2

2 - Evidence shows some shortfalls

The local authority commitment

We have clear responsibilities, roles, systems of accountability and good governance to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.

Key findings for this quality statement

Governance, accountability and risk management

Senior leadership at the local authority were described as collaborative, community-led, and focused on prevention and early intervention. The Director of Adult Social Services (DASS), in post since January 2023, and the Assistant Director (AD), appointed in March 2023, provided continuity and strategic oversight across integrated health and social care arrangements. Their leadership helped maintain visibility and influence of adult social care within health structures, ensuring decisions reflected the needs of people receiving care.

Unpaid carers consistently reported feeling supported by senior leadership. They were embedded in strategic forums such as the Better Care Fund (BCF) and the Health and Care Partnership Leadership Forum. Carers' feedback was reported directly to the DASS, and the Chief Executive Officer (CEO) maintained a clear focus on unpaid carer support. A memorandum of agreement between children's services, adult social care, and the carers centre further strengthened this commitment.

However, unpaid carers told us changes led by senior leadership were not always reflected in frontline practice. Carers said senior leadership at the local authority listened to them and valued their opinions, but they felt changes made at a strategic level did not always translate into operational delivery. Carers provided examples of how frontline staff continued to use inappropriate language, such as referring to a cared-for person as a "burden," despite knowing that the senior leadership had implemented changes to practice and involved carers in shaping those changes. This highlighted the need for targeted best practice training on respectful and inclusive language, to ensure strategic values were consistently embedded in day-to-day interactions.

The local authority operated under a well-established Section 75 agreement, pooling adult social care and health budgets to support integrated working. The DASS and the ICB Place Director jointly chaired governance forums, including the Health and Care Contracting Group and the Place Quality Group. These arrangements ensured decisions were made collaboratively and adult social care retained equal importance within the wider system. The Adults Delivery Programme Board monitored performance and led transformation programmes, while the Health and Care Partnership Board (HCP) provided assurance on strategic priorities. These structures supported alignment of financial and operational oversight, helping services remain responsive to local needs.

Targeted programmes had started to improve health inclusion, using data to identify people with specific risks and provide tailored support. Integrated neighbourhood teams reviewed service usage data to develop new approaches for people frequently accessing services. There was also a clear focus on improving outcomes for people living with dementia, cancer, and frailty. Work began in 2022 on co-producing interventions with communities experiencing high levels of inequality, starting in East Marsh and West Marsh.

Political engagement in North East Lincolnshire was inclusive and well-established, with strong cross-party relationships. Elected members were actively involved in scrutiny and commissioning decisions, supported by regular briefings on key topics such as the local authority's 10-year plan. This approach enabled oversight and assurance before decisions reached Cabinet, helping to build trust and support informed, joined-up governance.

The Portfolio Holder for Adult Social Care met formally with the DASS fortnightly, with additional informal contact as needed. Political leaders were described as knowledgeable and constructively challenging, contributing to strategic vision. All parties had signed up to the integrated model, providing a stable foundation for collaborative decision-making.

The DASS chaired key governance forums, including the Place Quality Group and provider performance boards, and held equal responsibility for health and social care funding decisions under the Section 75 agreement. The shared governance model helped safeguard the delivery of adult social care while enabling integrated service delivery. Senior leaders described positive and effective partnerships with health and care providers, supported by pooled budgets and shared governance. These arrangements helped avoid common disputes, such as those related to continuing healthcare funding, and ensured adult social care priorities were represented in broader health structures. For example, the Assistant Director (AD) sat on the Navigo Mental Health Act Board, reinforcing adult social care's strategic presence.

The Principal Social Worker (PSW) played a key role in bridging systems, working closely with senior leadership and spending time with frontline teams to build relationships. This relational approach was viewed positively by staff and helped foster a culture of openness and shared learning.

The Social Work Performance Board was established to strengthen oversight, clarify statutory responsibilities across providers, and ensure that practice remained person-centred and compliant with legal duties.

Quality assurance (QA) became a developmental priority following a workshop with one of the CICs. A QA strategy and board were created, with the PSW providing six-weekly thematic reports on trends and emerging issues. These structures strengthened the connection between frontline practice and strategic oversight, supporting continuous improvement. Multiple QA boards were in place, including three monthly formal meetings to monitor contract delivery, data performance, and quality. The AD and PSW chaired a cross-organisational social work assurance board, which focused on quality audits and involved direct engagement with staff. This structure helped maintain consistent standards and shared responsibility for service quality.

Senior leaders maintained visibility across the system, with the PSW and AD regularly engaging with frontline teams. Staff described this visibility as supportive and confidence-building, helping to support practice with strategic priorities. Despite this, workforce pressures were evident. One CiC experienced staffing challenges during mid-2024, leading to delays in reviews. While waiting times for care packages remained short, support with staffing was provided to help teams catch up with reviews. Deprivation of Liberty Safeguards (DoLS) backlog was placed on the risk register, and the DASS oversaw a matrix approach to prioritisation. Urgent and high-risk referrals were addressed first, helping to maintain safety and uphold people's rights.

Demographic change was identified as a key risk. A decline in the working-age population, alongside a rise in people aged 80–85 and earlier onset of care needs, placed increasing pressure on services. Public Health worked with adult social care to analyse these trends and plan for future demand. The local authority responded by investing in prevention and developing a frailty network involving GPs and voluntary sector partners.

The transfer of housing functions into adult social care was described as a positive move, supporting stronger joint working. Strategies were developed to address homelessness, which accounted for 40% of referrals into high-risk panels. Leaders identified a shortage of one-bedroom properties and sheltered housing, prompting a review of stock and remodelling plans. The Housing Strategy aimed to reflect diverse needs across age groups and demographics, involving both children's and adults' services.

Under the DASS's leadership, the Disabled Facilities Grant (DFG) programme was refreshed. Social housing landlords with their own occupational therapists were allowed direct access to funding, removing them from the local authority's waiting list. Work with private sector landlords also produced positive outcomes for care leavers. A trusted assessor model and full dataset supported decision-making, improving efficiency and access to adaptations.

Frontline teams used data sharing agreements and live tracking systems to manage referrals and monitor risk. For example, the GP Learning Disability Register supported better coordination for people with complex needs, enabling timely and informed responses. Staff acknowledged the fast-paced nature of work sometimes led to errors, such as misdirected referrals due to similar names or dates of birth. These incidents were identified and addressed through targeted training and system improvements, helping to reduce future risk.

Although strategic governance arrangements appeared well-developed, the variation in operational delivery and its impact on people's experiences showed further development was needed to ensure governance was consistently effective across the system.

Strategic planning

The local authority used pooled budgets to strengthen integration between health and social care, supporting shared priorities and efficient resource use. A senior leader told us this approach promoted positive working relationships and a shared commitment to delivering the best outcomes for people. Despite services being delivered by three community interest companies (CiCs), a senior leader told us the system was well-integrated, with shared records enabling rapid provision of equipment and support, particularly for people with complex needs. This helped avoid delays and ensured continuity of care.

In response to national policy, the local authority advanced its integration agenda through a "team of teams" model coordinated by a single system leader. Priority areas included the first 1,000 days of life, youth resilience, adult health inequalities, and support for the frail elderly. This approach reflected a commitment to coordinated, lifespan-focused care planning across health and care services.

The Health Care Partnership (HCP), introduced in 2018, supported joint planning to address health inequalities. Membership included the local authority, Integrated Care Board, three community interest companies, and voluntary community sector enterprise (VCSE) partners. The Joint Committee, chaired by the Executive Place Lead, held delegated authority under Section 75 and included elected representatives and people with lived experience. It oversaw integrated service delivery and budget decisions at place level, supporting joined-up planning and accountability.

A senior leader told us weekly partnership meetings involving all key leads and partners enabled timely issue resolution and maintained strong working relationships. Informal conversations outside of meetings supported open communication. Strategic leaders, including the DASS, AD, and PSW, attended board meetings and engaged directly with staff through drop-in sessions and forums, delivering a culture of collaboration, visibility, and accessibility.

The PSW had regular supervision and a visible role in strategic decision-making. Monthly meetings with the DASS and active participation in strategic meetings enabled them to influence practice and promote best outcomes across the system.

North East Lincolnshire identified three future priorities for adult social care: supporting young people transitioning into adulthood, addressing health inequalities among adults, and meeting the needs of a growing population of frail older people. These priorities reflected a strategic change toward proactive, lifespan-focused care planning, aiming to improve outcomes across all stages of adulthood and ensure services were responsive to demographic changes.

The local authority had developed a range of co-produced strategies to ensure services met people's diverse needs. These included the Carers Strategy, which set out six priorities shaped by unpaid carers; the Autism Strategy, which responded to feedback and focused on person-centred adjustments; and the Dementia Strategy, which aimed to support a dignified care journey. The Engagement Strategy committed to early, honest communication and using feedback to drive change, while the Mental Health Strategy outlined a vision for person-centred support across all age groups.

A political leader told us they had contributed to strategic work both directly through involvement in mental health initiatives and indirectly, by supporting the local authority's ambition to become a Marmot place. This work focused on reducing health inequalities and improving life expectancy, through collaboration with the Director of Public Health and a cross-party working group.

The local authority collaborated with the "Our Future - Grimsby Together" project to develop a long-term vision for the town. While not specific to adult social care, the initiative explored housing, employment, and community life, contributing to place-based planning and investment. A senior leader told us the model, designed for national replication, continued to influence local and national approaches to integrated planning.

Information security

The local authority had a well-developed quarterly data and performance monitoring report, which supported transparency and oversight. A political member told us they regularly requested and received updates on current issues, including delays in administering the Disabled Facilities Grant. They said their involvement helped streamline aspects of the process, resulting in reduced waiting times for people needing adaptations.

Staff told us they had read-only access to hospital and GP records, which enabled them to identify additional concerns or support needs during assessments. The use of a single recording system across health and adult social care was described as particularly beneficial. It allowed staff to view the timeline of each person's journey, read each other's notes, and work in a coordinated, workflow-style approach. This supported more person-centred care by reducing duplication and minimising the number of times people had to repeat their stories. Frontline teams praised the system for its efficiency and integration. This demonstrated the local authority used digital tools to enhance coordination and improve people's experience of care.

The Focus Social Care Handbook (February 2025) outlined policies for retaining information and confirmed that data management practices met legislative requirements. It described how information was shared and accessed, including guidance for people who wished to view their own records. This provided clarity and transparency around data rights and responsibilities.

Breach data was shared across teams and discussed in governance meetings, supporting a culture of transparency and accountability and continuous improvement. One breach involving a staff member led to specific changes in safety measures, including revised voicemail protocols that now include only a contact name and number. This demonstrated the local authority's commitment to improving data handling and safeguarding personal information, ensuring that digital systems supported safe and respectful care.

Learning, improvement and innovation

Score: 3

3 - Evidence shows a good standard

The local authority commitment

We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.

Key findings for this quality statement

Continuous learning, improvement and professional development

Staff told us they had access to a wide range of learning opportunities. These included monthly practice sessions, mandatory training, and specialist sessions such as Deprivation of Liberty Safeguards (DoLS) training. The carers support centre also participated in these sessions, helping to strengthen carer engagement and build shared understanding across services.

Additional training was offered through the social work conference and shadowing opportunities across sectors, including voluntary community sector enterprise (VCSE) partners and hospital discharge teams. Staff said this helped them gain broader perspectives and apply learning in practice. Targeted training on substance misuse was also provided, supporting staff to better understand and respond to complex needs.

Staff could access bespoke training from across the Community Interest Companies (CICs) when requested, including sessions on Section 117, Speech and Language Therapy, and Makaton communication, which is a language programme that uses signs, symbols, and speech to support people with communication needs. Personal Assistants were also able to access training, funded through direct payments where needed.

Supervisions provided space to focus on continuous professional development, with staff encouraged to identify and request training tailored to their roles. Staff described a positive working culture, supported by approachable teams and a supportive structure. Continuous professional development was encouraged, with staff able to highlight gaps in training, such as bespoke conflict resolution training, which was then addressed. Training was delivered internally and through commissioned providers, with regular supervisions and team-based approaches trialled to strengthen support and peer learning.

Staff told us the onboarding process for new staff was well-structured and consistent, with mandatory training completed by all new employees regardless of team. Assessed Supported Year in Employment (ASYE) staff had protected workloads and received dedicated supervision. This approach helped ensure a smooth transition into roles and supported early professional development.

Staff were encouraged and supported to attend a national conference and share learning with the wider team. They also described training to become a trusted assessor for equipment, an identified need within the duty team, where delays in accessing simple items like commodes or zimmer frames were impacting ongoing care due to occupational therapy waiting times.

Staff told us, as part of the new Quality Assurance Framework and case audits, thematic reviews had been conducted to inform training needs. For example, hoarding training was delivered in collaboration with a psychotherapist, with links to Safeguarding Adults Board priorities.

While the three CICs delivering Care Act duties in North East Lincolnshire each had distinct internal cultures, a shared Quality Assurance framework was used across all services. The Principal Social Worker (PSW) maintained oversight of social work teams across the organisations, supporting consistency, collaboration and shared standards. Staff gave examples of joint working to ensure quality, such as complex care meetings involving multiple local partners.

In CICs, dashboards guided staff through processes, with alerts for incomplete forms. Quality performance systems operated at multiple levels, from manager one-to-ones to external audits by other local authorities. Compliments and complaints were standing agenda items, and Quality and Performance teams led audit programmes in each directorate. An independently chaired performance subgroup conducted quarterly audits, with action points fed back to teams to drive improvement.

Staff told us they used a shared recording database to view a person's journey across health and social care. This supported more joined-up working and strengthened partnerships by improving visibility and continuity of care.

Staff described how innovation was driven through small task-and-finish groups involving occupational therapists and physiotherapists. These groups focused on service improvements and new approaches. A performance and digital lead supported staff across health and social care and was exploring the recruitment of a research lead to further advance technology integration and promote evidence-based practice.

A senior leader told us virtual reality technology had been successfully piloted to support people with respiratory conditions, falls prevention, anxiety, and breathlessness. Feedback from people using the service was overwhelmingly positive, and staff were enthusiastic about the innovation. Following successful funding bids, a two-year implementation plan was developed. However, sustainability remained a challenge, as the initiative was dependent on grant funding. This highlighted the need for longer-term investment to ensure continued access to innovative, person-centred support.

Staff shared multiple examples of being encouraged to innovate and develop new services in response to local need, demand, and feedback. One staff member was supported to attend a neurology course to establish a neuropsychiatry service within a CIC. Staff collaborated to submit a funding bid, establish a Huntington's disease support reference group, and partner with a garden centre to create employment and support opportunities. These initiatives helped reduce out-of-area placements and promote community inclusion.

At the time of the site visit, staff told us the local authority supported 10 social work apprentices across all CICs and a VCSE provider. They said feedback was actively sought to improve learning and development. Apprenticeship programmes contributed to successful recruitment of occupational therapists and physiotherapists, helping to strengthen service capacity. However, securing placements for occupational therapy students was sometimes challenging due to a national shortage of trained supervisors.

A senior leader told us there was an ongoing focus on recruiting senior occupational therapists to build resilience and meet growing demand. Despite recruitment challenges, services continued to meet increasing demand through competency-based training and targeted staff support.

A senior leader told us, given the distinct context of North East Lincolnshire, a standard training package was not suitable. In response, the local authority commissioned an external consultancy to develop a bespoke co-designed training programme to embed a strengths based approach. The programme included a discovery phase to commence in September 2025, to assess current strengths in practice, followed by a structured implementation plan. Early engagement with people highlighted the need for stronger frontline involvement and more reflective practice. This phased, locally grounded approach aimed to embed new ways of working and support sustainable change across the system.

Staff also described visible leadership, including regular meetings with the Director for Adult Services (DASS) and the PSW to discuss developments like the new direct payments process. They felt well-supported and described the local authority as a great place to work, committed to flexible innovation in delivering care and support to people and unpaid carers.

Learning from feedback

People told us the local authority actively sought feedback from those receiving care and support, unpaid carers, and staff, using it to shape strategic priorities and improve service delivery. For example, autistic people with lived experience delivered training that informed local practice across sectors, including providers, police, and ambulance services. This work was commissioned by the local authority and supported by the Integrated Care Board (ICB), demonstrating a commitment to inclusive, experience-led improvement.

Unpaid carers told us they were involved in consultation for the Carers Strategy, reflecting the local authority's approach to engage carers as partners in shaping strategic priorities. A senior leader told us the strategy was being continuously updated in co-production with unpaid carers, and carers were also consulted on the draft Equality, Diversity and Inclusion (EDI) Strategy.

Health leaders confirmed unpaid carers were involved not only in the design but also in the implementation of the strategy, and carers described feeling heard through the carers forum and valued for their contributions. Carers also worked closely with the local authority to co-develop the new carers service, actively participating throughout the process.

Partners told us feedback from people with lived experience directly influenced changes to the information and advice service. Community involvement was central to shaping improvements and ensuring relevance to local needs.

People told us they were engaged in a project to understand their experiences of services and how they wanted them to improve. This helped the local authority identify gaps in care provision and support more person-centred planning.

A partner told us they had participated in consultation for the Mental Health Strategy. They reported feeling valued and listened to as a member of the VCSE sector, suggesting the local authority had created a space for meaningful engagement and shared ownership.

Feedback from political leaders was used to enhance care provision and resolve issues between people receiving care, their families, and providers. Political leaders described this as an example of good local practice, with voices of people included on the Health and Wellbeing Board and scrutiny panels, supporting transparency and accountability.

Staff described a culture of responsiveness, where senior managers listened and acted when concerns were raised. Managers were present in the office, which helped maintain visibility and approachability. Staff said concerns were escalated appropriately, contributing to trust and openness.

Staff told us they felt confident challenging the senior leaders when needed. Following local unrest, staff raised concerns about the risk of harassment faced by new starters from minority ethnic groups. They advocated for appropriate support to be put in place, which was subsequently addressed and offered. This demonstrated a culture where staff felt safe to speak up and influence action to protect colleagues and promote inclusion.

Staff described how communication teams contacted people to gather feedback, which was shared during daily huddles. Managers used Power BI dashboards to reflect outcomes and support staff understanding of their work, waiting lists, and learning needs. A 'lessons learned' blog helped staff identify areas for improvement and shape future priorities.

Frontline teams told us their calls were routinely monitored and audited. Staff completed individual journey assessments detailing the support provided through the Single Point of Access, including where people had been signposted. Data from these assessments was used to identify areas for improvement and strengthen service delivery.

A senior leader told us the Assistant Director had taken on a key role in reviewing complaints prior to sign-off, tracking emerging themes and worked with CICs and the ICB to deliver training on complaint handling and appropriate language use. This improved oversight and ensured learning was embedded across organisations.

Staff told us all organisations adopted a learning-from-complaints approach. However, a 2024 analysis within one CIC identified gaps in how learning was captured and shared. In response, the CIC implemented a new complaints policy in September 2024, requiring managers to identify learning, develop action plans, and communicate outcomes through internal systems, meetings, supervision, and training. Trends were monitored and reviewed by the complaints lead to support continuous improvement and accountability.

The Assistant Director for Adult Social Services maintained oversight of complaints, offering additional assurance to the wider council. This demonstrated a system-wide commitment to learning from feedback and improving service quality.

A Local Government Association Corporate Peer Challenge conducted in March 2023 praised the local authority's partnership working arrangements across health and social care. The report highlighted positive outcomes for people and recognised the local authority's long-standing commitment to collaborative practice and integrated governance.
