West Northamptonshire Council: local authority assessment

How we assess local authorities

Assessment published: 28 January 2026

About West Northamptonshire Council

Demographics

West Northamptonshire is a unitary authority in the East Midlands, England. The area has a population of approximately 439,811 (Office National Statistics, 2024). Around 67% of residents live in urban areas, with Northampton as the largest settlement, while 33% reside in rural communities including market towns and villages. West Northamptonshire ranks 115th out of 151 upper-tier local authorities in the Index of Multiple Deprivation (IMD), indicating relatively low overall deprivation. However, significant inequalities exist, particularly in parts of Northampton, where some neighbourhoods fall within the most deprived 10% nationally.

The population of West Northamptonshire grew by 13.5% between 2011 and 2021, making it one of the fastest-growing areas in the East Midlands. The median age is 41 years, slightly above the national average. People aged 65 and over make up 17.5% of the population, while 21.89% are aged 17 and under. People aged 18-64 account for 60.6%. Ethnically, the area is predominantly White (85.91%), with Asian (5.3%) and Black (4.9%) communities forming the largest minority groups. The proportion of residents born outside the UK has increased, with notable growth in communities from Romania and other non-EU European countries.

West Northamptonshire Council is part of the Northamptonshire Integrated Care System (ICS), which covers both West and North Northamptonshire. Delivery is structured around 9 Local Area Partnerships, with founding models in Northampton, Daventry, and South Northamptonshire.

Following the May 2025 local elections, West Northamptonshire Council is under the political control of Reform UK, which secured 42 of the 76 seats. The council leader is a Reform UK councillor. The remaining seats are held by Conservative (17), Labour (9), Liberal Democrat (6), and Independent (2) councillors. This marked a significant shift from previous Conservative dominance. The council operates under newly established electoral boundaries, and the political change has prompted adjustments to governance structures and committee memberships.

In 2021, Northamptonshire's local government was restructured following the financial collapse of the county council in 2018. To improve efficiency and accountability, the UK government replaced the county council and 7 district councils with 2 new unitary authorities: West Northamptonshire Council (covering Northampton, Daventry, and South Northamptonshire) and North Northamptonshire Council (covering Corby, Kettering, Wellingborough, and East Northamptonshire).

Financial facts

- In 2023/24, the local authority estimated its total budget would be **£589.122 million**. Its actual spend for that year was **£621.371 million**, which was **£32.249 million** more than planned.
- The local authority estimated that it would spend **£139.352 million** of its total budget on adult social care in 2023/24. Its actual spend was **£159.605 million**, which is **£20.253 million** more than planned.
- In 2023/24, **25.69%** of the budget was spent on adult social care.
- The local authority has raised the full adult social care precept for 2023/24, with a value of **2%**. Please note that the amount raised through ASC precept varies from local authority to local authority.
- Approximately **4905** people were accessing long-term adult social care support, and approximately **1385** people were accessing short-term adult social care support in 2023/24. Local authorities spend money on a range of adult social care services, including supporting individuals. No two care packages are the same and vary significantly in their intensity, duration, and cost.

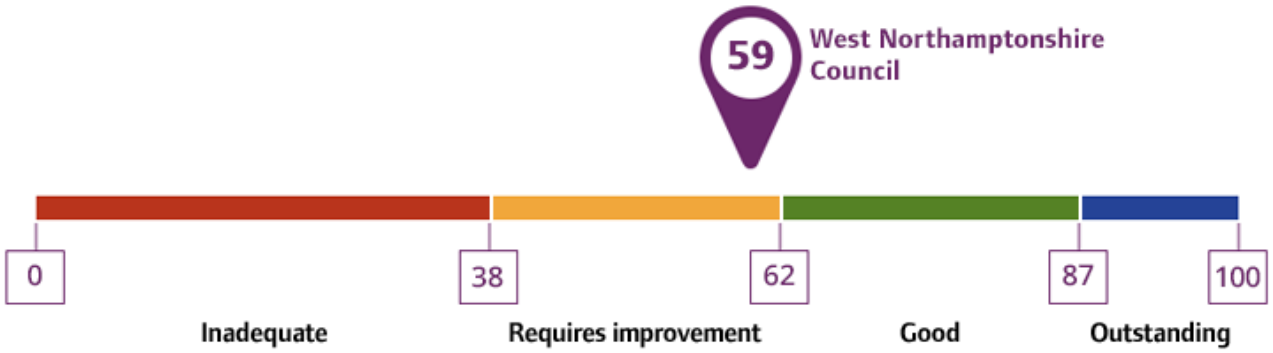
This data is reproduced at the request of the Department of Health and Social Care. It has not been factored into our assessment and is presented for information purposes only.

Overall summary

Local authority rating and score

West Northamptonshire Council

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: 2

Safeguarding
Score: 3

Governance, management and sustainability
Score: 2

Learning, improvement and innovation

Score: 3

Summary of people's experiences

People had mixed experiences with accessing care, some got assessments quickly, while others faced long waits and struggled to get through to the local authority by telephone. Most people felt listened to during assessments and said staff were respectful, person-centred, and included their family and unpaid carers. Some carers said they weren't offered assessments or didn't know if they'd had one, and many found the carers service hard to reach during a crisis.

People appreciated support which helped them stay independent, like reablement, assistive technology, and community services, but waiting times for equipment and occupational therapy were often long. People with complex needs sometimes faced delays before receiving care and support, especially in rural areas. Some people felt unclear about their rights or found information hard to access, especially if English wasn't their first language. Unpaid carers valued respite and direct payments when they got them, but many said the process was slow and confusing.

People said transitions between services were sometimes well-coordinated, but others experienced delays, poor communication, or felt unsupported. Overall, many people felt safe and respected, but there were gaps in consistency, responsiveness, and equity especially for those with less visible needs or living in rural areas.

Summary of strengths, areas for development and next steps

Staff took a strengths-based approach, and most assessments showed good practice. People said they felt listened to, involved in decisions, and treated with respect. However, annual reviews didn't always happen on time, and changes to the data system led to gaps in reporting. To address this, leaders had started fixing problems in the data and set up focused checks to look more closely at how care homes were doing. Carers' assessments had started to improve, but some carers still hadn't been offered one or weren't sure if they'd had one. Carers' assessments were carried out alongside the person's own assessment, with prompts built into the new case management system to support this.

The local authority had worked with partners and communities to develop a Prevention Strategy and invested in services which helped people stay independent such as reablement, assistive technology and social prescribing. People responded well to initiatives such as the Falls Management Toolkit and the Wellbeing service. Staff received more training, and leaders improved how they captured data and linked early contact with longer-term planning. They also updated performance measures to focus more on prevention and introduced targeted support for carers.

The local authority used Joint Strategic Needs Assessment data and co-produced strategies with local communities to tackle inequalities. West Northamptonshire has 9 Local Area Partnerships, to coordinate place-based health and care services and address local inequalities through multi-agency collaboration. The local authority developed tailored services and worked with diverse groups, but some gaps remained, especially in rural areas support for autistic people and culturally appropriate care. Transport and digital barriers also made it harder for some people to access services. Leaders had plans to expand outreach, improve cultural competence, and embed inclusive design principles. They were committed to improving representation, and access to underserved areas.

Mental health and autism support in West Northamptonshire faced significant challenges, including limited rural access, long waits for diagnosis, and gaps in culturally responsive care. Staff and leaders highlighted workforce pressures, inconsistent crisis response, and difficulties in managing complex risk, particularly in transitions and prison release planning. Systemic issues such as funding disputes, lack of dedicated autism frameworks, and unequal outreach contributed to variable experiences and outcomes, with seldom heard groups and rural communities disproportionately affected.

Partnership working with the 4 prisons serving West Northamptonshire was inconsistent, with gaps in coordination, planning, and joint working reported by staff. Steps had been taken to strengthen relationships with probation services and improve inter-agency understanding, but further development is needed to ensure consistent support for prison leavers.

Partnerships with health and voluntary organisations were strong and joined-up discharge models helped people return home safely from hospital. Reablement services were appreciated by people, but delays in therapy and equipment affected outcomes. People with complex needs, especially in rural areas, often waited longer for care. Leaders responded by introducing trusted assessors, weekend work, and agency staff to speed things up. It also mapped supported living options and trialled referral review meetings to improve the matching process and reduce gaps.

Joint strategies and co-production were built into services. Experts by Experience helped shape commissioning decisions, and voluntary and community sector partners played a key role in prevention and inclusion. However, smaller organisations sometimes struggled with limited involvement. Leaders strengthened governance processes, widened co-production and made commissioning more visible. Regular roadshows were planned to support frontline staff and respond to emerging issues.

Hospital discharge was generally well managed, and staff used risk tools to prioritise urgent cases. Teams worked together to support smooth transitions, but delays in NHS Continuing Health Care (CHC) funding and equipment sometimes disrupted care. Transitions for autistic people and prison leavers were inconsistent. Leaders had trialled trusted assessor models, improved coordination around CHC, and delivered joint training with probation services. They were committed to improving post-release support and discharge planning for people with complex needs.

Safeguarding systems were strong, with clear triage processes, assurance teams, and good partnership working. Most people said they felt safe, and staff responded quickly to their concerns. However, delays in Deprivation of Liberty Safeguard authorisations remained a problem, with some people waiting nearly a year. Staff used risk-based prioritisation and looked at technical solutions to speed up the process. Leaders increased staff training and promoted advocacy with staff to support them to help people understand their rights and stay involved.

Governance had improved since the local authority was formed, with clearer structures and more inclusive leadership. Staff felt supported, and strategic plans were shaped by both data and peoples lived experience. Despite interim leadership and legacy issues from before the restructuring, the local authority had embedded prevention across its strategies, aligned planning with health partners, and strengthened scrutiny. Leaders were committed to driving continued improvement and ensuring stability in the leadership team.

Staff embraced reflective practice and ongoing learning. Co-production was part of everyday work, and innovation was encouraged such as using AI tools and digital falls detection. Feedback from people using services helped shape improvements, although some people wanted better feedback on changes made. Leaders had expanded training, improved how they responded to feedback, and strengthened co-production with groups who were less often heard. They used complaints and compliments to drive service changes and shared learning across teams.

Theme 1: How West Northamptonshire Council 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

People were able to access the local authority's support through multiple channels, including online, over the telephone and in-person. People had mixed experiences when contacting the local authority's care and support services. People and partners told us it could sometimes be difficult to contact staff, and trying to get in touch by using the telephone could take a long time. However, some people told us they received an assessment the same day as they first contacted the local authority. People were able to refer themselves to the local authority for an assessment by using the website.

The local authority website provided written information, however this was not yet available in alternative formats, such as easy read. The Community and Voluntary Organisations Directory website provided information for people to find services independently.

The main point of contact with the local authority was with the Customer Services team who received and triaged referrals through to the community teams. The local area partnership teams included qualified social workers, social work assistants and qualified social work managers. Staff told us they used the local authority's strengths-based assessment framework. The practice framework was based on the '3 conversations' approach to carrying out a strengths-based assessment. We saw the assessment framework was embedded into practice, for example, staff told us 75% of assessments audited against the local authority's own criteria demonstrated good evidence of strengths-based approaches to peoples care and support. Staff told us people were connected to local resources to delay their needs and prevent further deterioration prior to formal support being arranged.

People's experiences of receiving a Care Act assessment were positive and the local authority worked with them in a person-centred and strengths-based way which included unpaid carers and relatives involved in their care and support. People's experiences of care and support ensured their human rights were respected and protected, that they were involved throughout in decisions and their protected characteristics under the Equality Act 2010 were understood and were incorporated into care planning. People felt they were taken seriously by staff during their assessments, who were sensitive and understanding of their needs. We were told staff made sure everyone important to the person were involved in their care and support, and the person was able to take the lead. People told us staff listened and acted upon any preferences and needs they told them about to ensure the assessment process was tailored and able to capture their desired outcomes. For example, assessments acknowledged fluctuating needs, i.e. related to alcohol dependency, including personal care, nutrition, home safety, and mental health. One person told us local authority care planning reflected their strengths and risks, and assessments were personal rather than procedural.

Care Act assessments reflected people's desired outcomes in a way which was personal to them. The Adult Social Care Survey 2024 data showed 66.15% of people were satisfied with their care and support which was similar to the England average of 62.72% and, 78.03% of people felt they had control over their daily life; also similar to the England average of 77.21%.

There were pathways to ensure people's support was planned and co-ordinated across different agencies and services. All referrals which came through to Community Social Work Teams were screened and risk rated by qualified social work managers to ensure risk-based decisions were consistent with the most urgent cases being prioritised. The risk rating framework was applied in the same way across all frontline teams.

The local authority had competent staff who were able to carry out assessments. Staff told us they had mixed experiences of training to support their roles. Some staff told us they had access to a wide range of training and support which included specialist visual impairment training. Other staff told us the local authority's training offer had reduced over the past year, and the online learning platform would benefit from being updated. A leader told us, the local authority has strengthened its training offer by expanding access to specialist, bite-size, and evidence-informed learning, supporting staff development through new partnerships, national resources, and targeted guidance. They added, only 1 training programme had been discontinued.

Timeliness of assessments, care planning and reviews

Local authority data showed Care Act assessments and care planning were meeting their target timescale which was 21 days. Figures provided by the local authority in July 2025 showed the number of people waiting had remained consistent between April and July 2025 at around 200 people, compared to an average of 59 per month between May 2024 and February 2025. The local authority said the reasons for this were delays caused by high demand on community teams, though they told us work had been done to cleanse data and reduce the backlog. A prioritisation tool was in place to risk-assess all individuals waiting and ensure no one at high risk was left without support. Additionally, customer services provided signposting, and 'Waiting Well' guidance had been published to support people while waiting. This supported more timely and targeted assessments and helped ensure people's needs were identified and addressed sooner, in line with statutory duties. Despite this, some partners told us waiting times for were long and sometimes people didn't receive a receipt of a referral, so they were unsure of how long they would have to wait.

The Adult Social Care Outcomes Framework data showed 48.59% of long-term support clients received a planned or unplanned review which was worse than the England average of 58.77%. Annual Care Act reviews were not being undertaken in a timely manner. Data provided by the local authority was not accurate, they told us this was due to the data not accurately migrating over to the new case management system. Leaders had carried out 'dip tests' of records to understand more about the progress they had made in completing reviews, confirming the data was inaccurate and incorrectly indicating a higher number of incomplete reviews was being shown. However, due to the data issues the actual number of outstanding reviews could not be determined, during our assessment. Leaders told us resources had been brought in to complete a data correction exercise which was currently taking place and was due to be completed by the end of September 2025. Following the receipt of further information in November 2025, the local authority data showed 67% of people receiving long-term support had received a review in the past 12 months.

Providers told us annual reviews were not timely, with some people not receiving a review in several years. Providers told us the local authority's response if a person had a change in need and required a review was also not timely, even if the situation was urgent. For example, providers told us they had sometimes been left to deal with crises and to manage risk alone.

Leaders told us they had prioritised timely reviews and introduced a strengths-based approach to improve how people's needs were reassessed. Staff confirmed this was happening in practice, with recent improvements made to ensure people could receive a review of their care and support needs in a timely way. We heard this included the introduction of the strengths-based model of assessment and a duty function within the review teams. Additional staff had been recruited to the review teams to help complete reviews, including over the telephone or face-to-face. This has helped to reduce the amount of people waiting and they time they waited. Staff told us with the new commissioning framework, the local authority can complete people's care reviews by care home, and this was supported by the new case management system which could group people needing a review by the service they were currently residing in. This allowed a more targeted approach to improve waiting times. Staff told us workers would be allocated to a care home to complete people's reviews alongside families and carers, before engaging in a multi-disciplinary meeting with the care home, adult social care staff, carers, quality teams and commissioning teams. These changes reflected the aims set out in the local authority's improvement plans and showed that leadership decisions were starting to make a difference on the ground.

For more complex assessments, staff and partners described some blockages in partnership working, which had led to peoples support not being joined up across agencies and services. For example, staff and providers told us there had been issues with people receiving NHS Continuing Health Care (CHC) assessments, reviews and funding, and they were addressing this with partners. This had led to people experiencing worry about what was going to happen next with their care and support. CHC is ongoing health care outside hospital in a person's home or in a care home for someone who is ill or disabled with long-term complex health needs. It is provided when people's requirements for day-to-day support are mostly due to a need for health care, rather than social care. A leader told us robust arrangements were in place to ensure people continued to receive the necessary care and support without interruption, while the appropriate funding mechanisms were being determined and implemented between local partners.

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

The needs of unpaid carers were recognised as distinct from the person with care needs; assessments, support plans, and reviews for unpaid carers were undertaken separately. The Survey of Adult Carers in England 2024 data showed 30.95% of carers were satisfied with social services which was worse than the England average of 36.83%. The local authority commissioned an all-age unpaid carers support organisation to deliver Care Act responsibilities for unpaid carers, including most assessments, support planning, and reviews. Social workers supporting the cared-for person also completed carer's assessments where appropriate. The commissioned provider also offered information, advice, contingency planning, and age-appropriate support for young carers under 18.

Data provided by the local authority for July 2025 showed there were 55 people waiting for a carers assessment. The local authority target timescale was 20 days; the average waiting time was at 7 days with a maximum waiting time of 18 days. This had significantly improved from previous data provided in May 2025 which showed 88 people were waiting for a carers assessment with an average waiting time of 91 days and a maximum waiting time of 206 days. The local authority said the improvements had been made due to them working with the provider to reinforce the importance of statutory duties like assessments and reviews, and the provider also moving onto the local authority case management system to improve communication and reporting.

The local authority had an unpaid carers assessment process map which detailed how referrals were managed from initial contact to outcome, but the experience of unpaid carers was mixed. Some unpaid carers told us they were not offered carers assessments and others were unclear about whether they had received reviews. Not all unpaid carers thought their needs had been met. The Survey of Adult Carers in England 2024 data showed 56.52% of carers felt involved or consulted as much as they wanted to be in discussions, which was similar to the England average of 56.56%.

Some unpaid carers also told us they found interactions with the unpaid carer provider frustrating, particularly due to their limited operational hours and lack of responsiveness during times of crisis. In contrast, a leader explained that outside working hours, carers were directed to a 24-hour crisis and respite service run by a regulated part of the provider's organisation, which they said was well used by carers. Other unpaid carers told us they had been supported with respite following an assessment and gave examples such as being provided with vouchers to pursue hobbies and gym memberships. Respite is a service giving carers a break, by providing short-term care for the person with care needs in their own home or in a residential setting. The local authority also supported unpaid carers to use direct payments.

Leaders told us they had identified unpaid carer's support as a priority area for development, and this was reflected within the unpaid carer's strategy which was co-produced with unpaid carers and the unpaid carer's implementation plan. Staff said, historically, carers had not always been well identified and were signposted to the commissioned carer's organisation for support or statutory assessment. Staff told us there had been a recent shift in that local authority staff could now complete carer's assessments alongside the person's assessment if appropriate. This had been facilitated by the assessment tool and prompts within the new case management system. Staff told us they sought to identify any unpaid carers, including young carers, involved in people's care when carrying out assessments. They said they offered unpaid carers a carer's assessment and appropriate signposting. For example, staff told us they were able to identify people who may be unpaid carers during their first conversation at the initial contact stage.

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

People and partners told us it could be difficult to access support for non-eligible care needs, particularly following a Care Act assessment. We heard this was a particular issue for people whose voices are seldom heard such as autistic people and people who use substances. The West Northamptonshire Adult Prevention Strategy 2025 acknowledged people with non-eligible care needs, particularly autistic people and those who use substances faced challenges accessing support following a Care Act assessment. It set out commitments to improve early help pathways, strengthen community-based support, and embed co-produced, inclusive approaches to better meet the needs of seldom-heard groups.

Staff told us people were given help, advice and information about how to access services, facilities and other agencies for help with non-eligible care and support needs. For example, staff were able to refer people to befriending services in the community, and a 12-week wellbeing service which people could access. Leaders told us work remained underway to embed the prevention offer.

The local authority had an online directory which provided a place for people to access advice and information about support services. Staff told us they used this to support them in their work to prevent, reduce, or delay the risk of people requiring further specialised support. This was followed up by staff within 6 weeks after their initial contact which they told us was enabling people's independence to be maintained. The local authority could not provide us with data evaluating this and monitoring people's outcomes, but they had recently begun to capture this data within their new case management system.

Partners and staff told us people who did not meet the financial threshold for commissioned services received support from the local authority. For example, when the local authority decided to end a contract with a care home, as well as supporting those in receipt of adult social care funding, they gave advice and support to self-funders to explore alternative options, make a choice about where to move on to and make the arrangements. The local authority had also updated relevant public information on the website to inform people about how to manage their own care and support. Staff told us they were clear about the need to ensure people funding their own care received advice and support to mitigate large fee top-ups.

Eligibility decisions for care and support

The local authority used national eligibility criteria to decide whether people and unpaid carers were eligible for support. The framework for these eligibility criteria was clear. The local authority had systems to provide outcomes of assessments, including written decisions on eligibility, and ensured people received a copy of their Care Act assessment and eligibility decision. The Adult Social Care Survey 2024 data showed 69.58% of people did not buy any additional care or support privately or pay more to 'top up' their care and support which was better than the England average of 64.39%.

The local authority had a separate appeals process for eligibility decisions which was introduced in March 2025. Leaders told us over the last 12 months they had received 5 appeals regarding eligibility for services. 2 were upheld or partially upheld and 3 were not upheld. Between May 2025 and July 2025, 2 eligibility appeals were made. One was in relation to a person being refused a Care Act assessment after becoming a self-funder which was not upheld. The second appeal was about the refusal of a deferred payment request, which was upheld.

Financial assessment and charging policy for care and support

The local authority's framework for assessing and charging adults for care and support was clear and transparent. The charging policy was available on the local authority's website. People were able to access support via telephone and by completing a financial assessment online. In addition, 5% of all financial assessments were completed in person.

Initial financial assessments were carried out in a timely way. Leaders told us there were 317 outstanding financial assessment requests, but only 38 were waiting to be processed, with the rest pending financial information from clients or families (July 2025). The local authority target timescale was 28 days; the median waiting time was 14 days. Leaders told us delays were a result of staff shortages and the annual uplift process increasing customer contact. Leaders told us they had appointed new managers within the finance team, improved system integration, and introduced weekly performance reporting to monitor backlogs which had further improved waiting times. Despite the challenges, over 90% of financial assessments were completed with 28 days of the referral being received.

There had been no appeals related to financial assessment over the past 12 months. The local authority provided public information leaflets which clearly described how people could access the complaints and appeals process, and staff told us they ensured these were given to people as early as possible in the assessment process. Unpaid carers told us they were increasingly being involved in financial assessments and the information provided was useful and easy to access.

The local authority also took steps to ensure self-funders were identified at an early stage to ensure timely financial assessments and minimise negative financial and emotional impacts. Staff were able to record a person's funding status on the case recording system at the time of a referral, if they were in residential or nursing care this would progress to a Care Act assessment by local authority staff. This ensured timely decision making and a smooth transition before a person's funding depleted. The financial assessment team would prioritise the assessment for completion to ensure delays were minimal.

Provision of independent advocacy

The local authority had commissioned an independent advocacy provider who supported people to access statutory advocacy. An advocate can help a person express their needs and wishes, weigh up and make decisions about the options available to them. They can help them find services, make sure correct procedures are followed and challenge decisions made by local authorities or other organisations.

We received mixed feedback regarding the use of advocacy within the local authority. People told us advocacy support for young people who were transitioning to adult services and unpaid carers was lacking. Some staff told us they refer for advocates, however, people could wait for some types of statutory advocacy support due to limited availability from the provider who would prioritise safeguarding advocacy. A leader told us there was currently no-one on a waiting list for any type of statutory advocacy, as all referrals were allocated as soon as they were received. Other staff told us they were able to refer easily to the provider, and the advocates were put in place in a timely manner, for example, when people were planning to leave hospital and when they were accessing safeguarding support.

The advocacy provider told us there were issues with delays in support. This was due to expectations of advocates being available within short timeframes and late referrals. To improve these issues, the provider told us they gave presentations to all staff and have attended team meetings Leaders told us following this training, they had found through case audits that advocacy referrals had increased, however, both the local authority and the provider acknowledged more work was needed to improve uptake further. The provider told us they had good relationships with staff in the local authority and the importance of advocacy was recognised.

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 local authority worked with people, partners and the local community to make available a range of services, facilities, resources and other measures to promote independence, and to prevent, delay or reduce the need for care and support. While this reflected positive intent, feedback and performance data suggested further development to ensure consistency and reach across all communities.

West Northamptonshire Council put in place a system-wide Prevention Strategy to meet its Care Act duties by working with communities, partners, and over 400 stakeholders to co-produce a 5-year plan focused on promoting independence and reducing demand for care. The strategy prioritised population health, early help, and support for unpaid carers, and was underpinned by their Joint Strategic Needs Assessment evidence and outcome-based commissioning. Key services included reablement, social prescribing, community hubs, assistive technology, mental health support, and carer interventions. The local authority also launched a wellbeing service aligned with its 'Live Your Best Life' strategy, integrating public health and social care at the local area partnership level to deliver coordinated, community-based support that delayed the need for intensive services.

The local authority had a range of dedicated teams and services in place to prevent, reduce, and delay the need for care and support, with prevention embedded as a core mindset across practice. For example, the Prevention Oversight team worked closely with the Departmental Management team to champion strengths-based approaches, including the development and expansion of a community reablement service supporting people post-discharge and in the community. The Hospital Avoidance team operated within acute settings to identify people early and put in place measures, such as home adaptations and reablement to avoid admission or plan safe discharge within 72 hours. A coordinated Prevention and Therapy service brought together occupational therapy, reablement, assistive technology, and specialist teams to promote independence. Customer Services played a key role in triaging referrals to the wellbeing service, while Public Health initiatives delivered through community hubs focused on reducing frailty, improving mental health, encouraging active lifestyles, and tackling isolation through accessible, preventative activities.

Leaders reported that prevention had become a stronger focus over time, with corporate Key Performance Indicators (KPIs) shifting from measuring delayed discharges to tracking avoided admissions and successful reablement outcomes. Audits were used to assess whether cases were entering through the prevention pathway, and while progress had been made, further development was needed. Staff were often keen to offer support to people, but leaders emphasised the importance of balancing this with enabling people to maintain independence. Confidence in applying preventative approaches without creating dependency was seen as essential. Audit findings also highlighted the need to strengthen links between initial contact and longer-term support planning, and leaders acknowledged that the system remained a work in progress.

Health partners reported that the local authority had shown a strong commitment to prevention, supported by a clear strategy and investment in community infrastructure. They highlighted initiatives such as warm spaces and outreach as examples of proactive work. However, they also felt that the customer service response to new enquiries needed improvement, as opportunities to prevent, reduce, or delay care needs were not consistently maximised during initial contact.

The local authority considered unpaid carers and those most at risk of declining independence and wellbeing, revising its KPIs to embed prevention, information, and advice at the heart of a new carer service model from April 2025. This supported early intervention and helped carers maintain their own wellbeing while continuing their caring roles. A wide-ranging support offer was available through an externally commissioned carers service, including group sessions, one-to-one support, and signposting for financial, employment, and training help. Carer training included core topics such as first aid and manual handling, alongside new condition-specific modules on diabetes, sickle cell, and neurodiversity. The Better Care Fund provided targeted support for carers of people with complex needs, and early engagement through advisory boards helped prevent crisis escalation. In response to rising demand, particularly from hidden carers, a co-produced carers strategy was developed with Experts by Experience, prioritising access to information and support. This led to the creation of one-stop shops tailored to identified needs. The 2024 Survey of Adult Carers in England showed 90% of carers found information and advice helpful, this was better than the England average of 85.22%.

Preventative services had a positive impact on people's wellbeing, with staff providing tailored support to promote independence and reduce future care needs. For example, the Visual Impairment team helped people with daily living tasks, mobility training and installed minor adaptations to avoid delays. Staff supported younger people with learning disabilities and autistic people to access employment, volunteering, and travel training, helping them build confidence and achieve personal goals. Innovative use of artificial intelligence was trialled to identify people at risk of homelessness, enabling housing and adult social care teams to intervene early. Staff also worked with health partners, including the Integrated Care Board, to use shared care records and data to identify people before their needs escalated. Despite these positive examples, national data from the 2024 Adult Social Care Outcomes Framework showed that only 50.57% of people receiving short-term support no longer required ongoing care. This was significantly worse than the England average of 79.39%.

The local authority took active steps to identify and support people whose care and support needs were not being met, particularly in response to high rates of emergency hospital admissions and hip fractures among those aged 65 and over. The data showed the rates were significantly above the national average in 2021/22. To address this, the Wellbeing service and Falls Management service referred people to the 'Get up and Go' strength and balance programme, funded by Public Health, which ran 35 sessions with over 400 regular participants. The Falls Management service received around 110 referrals per month and provided assessments and advice to people at risk of falling. It worked closely with the Wellbeing service and developed a Falls Management Toolkit for use in residential and nursing care settings, helping to reduce risks and support early intervention.

Provision and impact of intermediate care and reablement services

The local authority worked in partnership with health and community organisations to deliver intermediate care and reablement services which supported people to regain independence and return home safely. A carer described how their recovery was supported through coordinated hospital, rehabilitation, and social care services, enabling a smooth transition back into the community.

Staff and leaders reported intermediate care pathways, including discharge-to-assess models, facilitated safe transitions and continuity of support. The hospital discharge model used 4 main pathways to help people leave hospital safely. Some go straight home with no extra help (Pathway 0), while others get short-term support at home to recover (Pathway 1). If someone isn't ready to return home, they may go to a temporary care setting like a rehab bed (Pathway 2). For those with more complex needs, long-term care in a care home or supported housing may be needed (Pathway 3). Reablement services played a key role in promoting recovery and reducing hospital readmissions, although leaders acknowledged outcomes required ongoing monitoring to ensure effectiveness. Partners praised the quality of reablement workers and their collaborative approach.

The Reablement West team received referrals from both hospitals and community teams. For hospital discharges, there was strong coordination with the Flow and Capacity Team, with reablement staff visiting people's homes to assess the environment and agree realistic goals. Support was typically provided for 12 days but could extend up to six weeks. Once ongoing care needs were identified, the team completed a 'Transfer of Care' process to ensure further assessment and arrangements were made. While capacity in the reablement service was generally good and supplemented by independent providers, occasional delays were reported due to hospital-related issues such as transport or medication, typically causing only a 1-day delay. National data from the Adult Social Care Outcomes Framework showed 3% of people aged 65+ received reablement after hospital discharge, and 81.82% remained at home 91 days later. Both figures were similar to the England averages.

A separate Reablement Therapy team worked in the community and with the Recovery and Independence Unit (RIBU) to support discharges from Pathway 2. The team helped people reconnect with their communities, for example, by supporting people to resume swimming or cycling. However, wait times for therapy allocation were longer than the 14-day target, with current waits at 23 days for occupational therapy and 29 for physiotherapy. A 'Waiting Well' policy was in place, alongside prioritisation systems and a planned capacity and demand review.

RIBU operated as a multidisciplinary bedded intermediate care unit with 51 beds and an average stay of 35 days. Health-led therapeutic interventions supported recovery and independence, with regular multidisciplinary meetings to track progress. Where ongoing support was not needed, staff ensured the home environment was safe and made referrals for community therapy. If further care was required, the Transfer of Care process was completed. Staff prioritised reablement over long-term care to promote independence. However, capacity issues were noted, occasionally due to delays in moving people on from RIBU or waiting for equipment and transport. In some cases, staff used their own vehicles to deliver equipment to avoid delays. This was recognised as not best practice but necessary to maintain momentum.

Equity of access was supported through arrangements with specialist teams. For example, people known to the Learning Disability team had their discharge managed by those staff but could still access reablement and RIBU services where appropriate. Staff liaised directly to ensure suitable support was in place.

The local authority reported its partnership approach to discharge-to-assess had improved capacity in Pathway 1, allowing the reablement service to support people with higher acuteness and more complex needs. The commissioned reablement provider, alongside in-house home care, reduced discharge times from 7 days to 3 days. Intermediate care was also provided through RIBU. Health led on nursing and therapy, while the local authority managed care support. RIBU worked closely with Reablement West to promote a home-first approach. Outcomes were tracked using functional independence measures, with 36% of people returning to their usual residence. However, admission delays were identified, with average times exceeding the 3-day target and reaching 9 days or more between March and August 2024. A Coordinator post was created to address this issue. Data from the local General Hospital showed patients waited an average of 10.1 days for a Pathway 2 bed, prompting a review of assessment criteria and response times. Between April and October 2024, the home-based intermediate care scheme supported 1,072 people to return home, which exceeded the target of 877. Of those discharged, 77% remained at home. Referral-to-discharge times averaged 4 days earlier in the year, rising to 8 days by November 2024, which was attributed to changes in the delivery model. Hospital discharge pathways are the different routes people can take when they leave hospital, depending on the type of support they need.

Access to equipment and home adaptations

People were able to access equipment and minor home adaptations to help them stay independent and continue living in their own homes. These included practical aids, assistive technology, and changes to the home environment which supported daily living and reduced reliance on formal care. The local authority continued to invest in these services, with the Therapy and Assistive Technology team supporting over 3,000 people in 2023-24. Of these, 33% received community equipment, 16% received minor adaptations, and 28% were supported with major adaptations. The local authority also completed 417 assessments for Disabled Facilities Grants (DFG), reducing wait times from 20 weeks to 6.5 weeks through joint working with its local housing partner.

People shared positive experiences of how equipment had helped them manage health conditions and maintain independence. One person described receiving a sensor that alerted them when a cup was full, which supported their sight loss and helped them feel more confident at home. A carer reported equipment provided by the local authority's commissioned provider improved comfort for the person they cared for, although delays in receiving a ceiling hoist led to a deterioration in the person's condition. Another carer explained that while a referral for a walk-in shower had been made, long waiting times for assessment and installation had negatively affected the person's physical wellbeing and independence.

Despite improvements in some areas, wait times for occupational therapy (OT) assessments remained a challenge. Data provided by the local authority showed from April to July 2025 a rising waiting list for the Community OT team, increasing from 316 to 417 people. Median wait times ranged from 28 to 34 days, with maximum waits reaching up to 110 days. Staff and leaders had identified wait times as a key pressure point, particularly following the withdrawal of in-house OT support by most local housing associations. A recovery plan was in place to improve access for people with less complex needs, including the use of trusted assessors and training for health colleagues to make direct referrals for major adaptations. Staff across the Prevention and Therapy service and in partner agencies were upskilled to carry out tasks usually assigned to other teams. For example, the Ageing Well service, Assistive Technology team, and Visual Impairment team were trained to assess and install minor adaptations, and the Specialist Moving and Handling team could prepare DFG paperwork. This approach improved responsiveness and helped people access support more quickly. To manage risk and people's expectations, a 'Waiting Well' policy was used across the Prevention and Therapy service. People received written communication after referral, with information about expected wait times and what to do if their circumstances changed. Follow-up letters were sent if delays exceeded the original timeframe. However, staff did not have capacity to make proactive telephone contact and relied on people getting in touch if their needs changed. The Visual Impairment service was an exception, offering follow-up calls to ensure accessibility.

At the end of March 2025, 514 people were waiting for equipment delivery. However, the median wait time had improved from the preceding months, falling from 14 days to 7.2 days. The data included equipment ordered by all health and care teams, suggesting system-wide pressures rather than local authority delays alone. A performance review in February 2025 showed that of 3,038 orders, 8% were delivered late due to staffing shortages, which were partially mitigated by the introduction of weekend shifts and agency staff. Specialist items took an average of 17 days to deliver. Recycling rates were below target, with 87.9% of items processed against a 92% goal. The local authority responded with recruitment plans, further performance reviews, and closer monitoring to improve safety and service delivery.

The local authority maintained a commissioned contract for equipment delivery, collection, and maintenance, with clear provider contact and escalation routes. This supported operational continuity and accountability. Staff reported their professional judgement was respected when recommending specialist equipment, with minimal resistance from decision-makers. The Specialist Moving and Handling team was well-established and had access to a wide range of equipment, including ceiling track hoists, gantries, bed systems, and specialist seating. Equipment could be provided quickly in urgent cases, for example, ceiling hoists could be installed within 10 days without needing a DFG, and specialist seating could be requested outside of the usual panel process.

Assistive technology was used to promote independence and prevent, reduce, or delay care needs. Examples included artificial intelligence (AI) powered tools like robotic pets, AI glasses, smartphone apps, and remote health-monitoring systems. Staff described how a robotic pet helped someone re-engage with support after losing their cat, and how a smartphone app supported someone to manage anxiety and access community activities. Other tools included smart plugs which alerted carers if appliances were used unusually, helping monitor wellbeing remotely. Despite training efforts, staff felt there was more to do to improve social workers' confidence in using technology during assessments. Leaders acknowledged the rapid evolution of technology and the need to ensure people benefited, though concerns were raised about high equipment hire costs affecting affordability and access.

The Prevention and Therapy service provided training and equipment setup to ensure consistent standards across agencies and families. This included safer moving and handling practices, which contributed to reduced double-handed care and better health outcomes.

OT teams worked closely with housing and DFG teams to improve accommodation earlier and reduce waiting lists. Plans included more significant property conversions to support people with complex care needs. The local authority's continued investment in a strong therapy framework was recognised in the Local Government Association Survey 2024, with a score of 80 reflecting structured, evidence-based support to help people manage their health and reduce future care needs.

Partners reported good collaboration with the Visual Impairment team and said they had received positive feedback from people. They added that although the local authority only had the budget to provide low level equipment, it was provided quickly. Health partners felt the use of assistive technology for prevention could be strengthened further.

Provision of accessible information and advice

People were able to access information and advice about their rights under the Care Act and the different ways to meet their care and support needs, including unpaid carers and those who fund or arrange their own care. The Adult Social Care Survey 2024 showed 64.18% of people using services found it easy to access support information, and 62.75% of carers found it easy to access advice, which were both similar to the England averages.

Carers described receiving tailored support and accessible digital resources, with some able to engage independently. However, feedback also highlighted inconsistencies. While some carers felt well supported, others found the system difficult to navigate, particularly when using multiple websites or seeking information about respite services. A young adult carer shared they felt overwhelmed by their role and unsupported in pursuing their own life goals. Tailored information was also provided for people with specific conditions such as dementia, neurological disorders, and brain injury, alongside links to national and local wellbeing services. A leader told us the Northamptonshire Unpaid Carer Guide had been recently published; it was available in 2 printed sizes and online. The online version was available in 7 other languages.

The local authority made efforts to improve access, including outreach sessions in community venues and coffee mornings to support transition into adulthood. Parent carers reported receiving helpful signposting to local services, and staff used carer groups to share information and build engagement. Experts by Experience had participated in a trial of a social media messaging service bot, which was an automated tool designed to simulate a customer service assistant by providing instant replies to user questions. The bot drew information from the local authority's website to help users navigate adult social care, assessments, and available support. While the tool showed potential for improving access outside of office hours, the testing phase highlighted issues such as outdated website content and technical limitations. These findings informed plans to update the system and improve reliability ahead of any wider public rollout.

The local authority provided information about eligibility and adult social care through its website, printed leaflets, and 'Welcoming Spaces', with the 'Waiting Well Pack for Citizens' offering clear, visual guidance on assessment stages, rights, and advocacy. Letters sent during the waiting period included service links, and easy read formats were being developed to improve accessibility. However, partners raised concerns that advice was often generic and lacked practical support, particularly for people whose first language was not English or those navigating services independently. While digital access was improving, especially through AI tools available outside working hours, feedback highlighted the need for more personalised, proactive communication to help people understand and act on their rights.

Accessibility remained a key focus, with the local authority using clear language to explain legal responsibilities and providing an accessibility statement on its website. This included links to translation tools, visual impairment resources, and customer contact details. A dedicated team supported content design for people with sensory loss, and simplified guidance was available to help staff meet accessibility standards. However, some documents lacked confirmation of alternative formats such as translations or easy read versions, which may have limited their reach. While the local authority demonstrated a systems-led approach to accessible information, further co-production and inclusive design were needed to ensure all communities could benefit.

Direct payments

West Northamptonshire Council used direct payments to give people greater control over how their care and support needs were met. People and carers who accessed them valued flexibility, using funds for respite, wellbeing activities, and personal assistance. The Adult Social Care Outcomes Framework 2024 showed 33.04% of people received direct payments, which was better than the England average of 25.48%. However, only 29.46% of carers received direct payments, which was significantly below the England average. This gap prompted strategic reform, including strengthened partnerships with the commissioned carers service and successful lottery funding to expand support for young carers.

Despite positive feedback from those using direct payments, their awareness and understanding remained inconsistent. Staff described the process as lengthy and complex, with several stages of approval. Although financial assessments were completed on time, Direct Payments could not progress until these were finalised, which contributed to delays. Issues with contract returns also added to the complexity. Data provided by the local authority showed between February and July 2025, the number of people receiving direct payments fell from 925 to 850, despite 201 new packages being initiated since April. As of August 2025, 223 cases were active, with 71 awaiting new contracts, many delayed due to missing referral details or outstanding financial contributions. Carer uptake remained low, with only 110 receiving direct payments over the past year and just 4 in the last 3 months.

To address these challenges, the local authority introduced a revised Direct Payments Policy in March 2025, expanding eligibility and offering fast-track options for urgent cases. Improvements included digital contract signing, updated guidance materials, and plans to promote prepaid card use. People could choose between prepaid cards or accounts, with support available to manage payments and recruit personal assistants (PA), though staff told us sourcing PAs locally remained difficult. The local authority also introduced direct transport payments and produced clear leaflets outlining how direct payments work, including employer responsibilities and support for those lacking mental capacity. Consultation with people and providers informed the revised policy, though response rates were low. While provider feedback helped shape improvements to contracts and training, the lack of follow-up with non-respondents limited understanding of why the uptake was falling. Further work was needed to improve promotion, streamline processes, and ensure the system was inclusive, accessible, and responsive to the needs of all.

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 engaged with the people and groups where inequalities had been identified, to understand and address the specific risks and issues experienced by them. However, some inequalities persisted, and further action was needed to ensure that engagement translated into meaningful change.

The local authority understood its local population profile and demographics. It analysed equality data on social care users and used it to identify and reduce inequalities in people's care and support experiences and outcomes. This included the use of the Joint Strategic Needs Assessment (JSNA) to identify health inequalities across the local authority and support local area partnerships (LAP) to understand the needs of their communities. In 2024/25, the local authority completed needs assessments for a wide range of groups including people experiencing homelessness, substance abuse, autism, children and young people, Gypsy, Roma and Traveller communities, the Eastern European community, sex workers, and those affected by air quality. Plans were in place to expand this work in 2025/26 to include people with special educational needs, mental health needs, learning disabilities, and older people experiencing isolation and loneliness.

Targeted initiatives under the Better Care Fund (BCF) included frailty classes, support groups for older Asian communities, dementia asset groups, mental health cafés and houses, and a memory hub, which was co-produced with people and designed for rollout across localities. A Health Equity Assessment Tool was used to review the BCF plan and its schemes, and a data project group was established to improve the quality and relevance of inequalities data. Where inequities were identified, further insights were gathered and solutions co-produced with communities and stakeholders.

The local authority had regard to its Public Sector Equality Duty (Equality Act 2010) in the way it delivered its Care Act functions; there were equality objectives and a coproduced and adequately resourced strategy to reduce inequalities and to improve the experiences and outcomes for people who are more likely to have poor care. The Equality, Diversity and Inclusion (EDI) Policy and Action Plan set out the local authority's commitment to inclusive communities, with services expected to be responsive to different needs and delivered with dignity and respect. Staff were trained in strengths-based practice from an EDI perspective, and equality impact assessments were routinely completed to identify and address unmet needs.

Local authority staff involved in carrying out Care Act duties understood cultural diversity within the area and how to engage appropriately. The local authority acknowledged that its workforce did not yet reflect the demographic of the community, particularly in leadership roles, and committed to implementing the Local Government Association's Diverse by Design principles. Training on cultural curiosity and rights-based practice was commissioned for newly qualified social workers, and the Adult Social Care EDI delivery plan aimed to build cultural competence across the workforce. The East Midlands Practice Framework and the Learning and Development Policy both promoted inclusive, person-led engagement, with practitioners expected to use inclusive language and behaviours that built trust and supported fair access to support.

Senior leaders described a growing commitment to equity and inclusion, with Adult Social Care using tools like Diverse by Design and the Health Equality Assessment Tool to identify gaps and improve practice. EDI was embedded in governance and strategy, with oversight from senior leadership and visible impact in frontline delivery. Leaders acknowledged challenges in reaching seldom-heard groups and recognised the need for deeper engagement, better data use, and more consistent recording of identity-related information. Locally tailored approaches were developed through LAPs and JSNAs, with targeted work around isolation and falls in Brackley and support for homelessness, substance use and migration in Northampton. Community-based services, drop-ins, and partnerships with voluntary groups were used to reduce barriers, though leaders noted that availability didn't always translate to access. The LAP model evolved to distinguish between people with multiple and complex needs and those requiring routine support. This allowed for more targeted service delivery and stronger links with housing, drug and alcohol services, churches, and faith groups. Drop-in services were provided locally, and staff received direct feedback from the community. The LAP model helped staff stay connected to the communities they served on a daily basis. Plans were in place to strengthen cultural competency, improve reasonable adjustments, and expand provision in rural areas. Equality Impact Assessments were routinely used in commissioning, and actions from needs assessments were being embedded into delivery plans.

Some staff and leaders highlighted a range of inequalities in experience and outcomes. They told us, cultural and religious needs were not consistently met in rural care placements due to limited service availability, despite the presence of ethnic minority communities. Mental health services were concentrated in central Northampton, with limited access in towns like Brackley, Daventry and Towcester, meaning some people had to travel long distances or relocate for support. While urban areas benefited from regular drop-ins and proactive outreach, access in rural communities was more limited and may not have been proportionate to local need. Cuts to bus routes and high transport costs made it harder, especially for younger people to access services, volunteering, and social opportunities. Although transport is not the council's responsibility under the Care Act, these issues still shaped people's experience of access. It is important the local authority takes such barriers into account when planning and delivering services, particularly where they affect equitable access. Rural care homes showed inconsistent activity levels and limited cultural responsiveness. Rural deprivation and suicide rates among farmers highlighted the need for targeted mental health interventions.

People with lived experience highlighted a range of barriers that contributed to unequal access and outcomes. Transport was a major issue, particularly for those in rural areas without a driving licence, limiting access to therapy and services during key recovery phases. Some people felt unclear about how the local authority was involving different communities, especially those who were seldom heard or harder to reach. In West Northamptonshire, outreach to the Bangladeshi community was seen as limited, with concerns that engagement relied too heavily on individual councillors rather than broader representation. People suggested faith groups could play a stronger role in engagement but were unsure if this was happening. Fear and distrust of local authority services were also raised, with calls for greater understanding and representation to reduce barriers. There was also a view that the workforce needed to better reflect the area's growing ethnic diversity. Unpaid carers described geographic disparities and unrealistic expectations to travel for support, calling for more localised approaches. New carers faced complex systems and a lack of guidance, with those without strong advocates at risk of being excluded. A leader told us that following the Carers Strategy launch in July 2025, one-stop shops for carers were in place across all Local Area Partnerships by September 2025, ensuring inclusion of rural communities.

Partners felt the local authority had made efforts to improve equity by engaging more directly with communities, using data to identify unmet needs, and supporting diverse representation in commissioning. Positive steps included targeted work with hidden carers and Gypsy, Roma Traveller communities, and rural initiatives like 'Warm Spaces' and home care frameworks. However, concerns remained about inconsistent support across areas, where poor transport, housing barriers, and limited contact with the local authority affected access. Some groups, including autistic people and those with sight loss, were seen as underserved, with gaps in communication, eligibility, and service coordination.

Inclusion and accessibility arrangements

West Northamptonshire Council put in place a range of inclusion and accessibility arrangements to help people engage with adult social care in ways that suited their needs. Interpreter services, including British Sign Language (BSL), translation support, and advocacy were available to ensure people could participate fully in assessments and care planning. However, some gaps persisted.

Staff recorded communication preferences in case management systems and used visual aids, easy read formats, and video resources to support understanding. For people with sensory impairments, tailored approaches were used, such as follow-up phone calls after written communication and joint assessments with specialist staff. The local authority was able to meet the Care Act's specific assessment duties for DeafBlind people by using an in-house specialist assessor. The local authority also offered flexible options for financial assessments, including home visits and online forms, and created digital flags to ensure reasonable adjustments were consistently applied. Outreach efforts included library sessions, QR codes to scan at roadshows, and community engagement through voluntary sector partners, although access varied across rural and urban areas.

Despite these efforts, feedback from people and partners highlighted gaps. Some carers felt their hearing needs were overlooked, and others described limited outreach for housebound people. Autistic people and their families reported that staff understanding, and communication approaches were inconsistent. While some found digital tools and remote support helpful, others experienced barriers due to language, literacy, or digital exclusion.

Staff acknowledged that translation services were harder to access in rural areas and that Easy Read materials were not consistently embedded in processes like the 'Waiting Well' pathway. Partners also raised concerns about the lack of information in different languages and the need for more proactive support for those unable to access online services. The local authority had taken steps to improve accessibility, including workplace training and inclusive service specifications, but recognised further work was needed to ensure equitable access for all.

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 and used available data to understand the care and support needs of people and communities.

The Joint Strategic Needs Assessment (JSNA) for West Northamptonshire provided a detailed overview of the current and emerging care and support needs across the area. The data highlighted a range of demographic, geographic, and socio-economic factors which influenced local planning and commissioning decisions. Leaders used the JSNA findings to inform the Health and Wellbeing Strategy and Better Care Fund planning, with a focus on prevention, early intervention, and reducing inequalities across the system. Ongoing updates to the JSNA ensured decision-making remained evidence-based and reflective of population needs.

The most recent JSNA for West Northamptonshire provided a clear picture of local care and support needs, with a focus on people most at risk of poor outcomes. It highlighted rising demand and service gaps for children and young people with special educational needs and flagged the need for improved support for people with autism, learning disabilities, and mental health conditions. The assessment recognised the importance of inclusive engagement for people with protected characteristics, unpaid carers, and those who fund or arrange their own care. It drew on local data and lived experience to inform joint commissioning and future planning, with a strong emphasis on reducing inequalities and improving outcomes across health and social care.

Specific examples drawn from the wider JSNA programme for West Northamptonshire included, autism, COVID-19, sex workers, and the Eastern European community. They were addressed through dedicated thematic assessments commissioned or published as part of the JSNA suite. The Autism Health Needs Assessment showed a rising population of autistic children and adults, with projected increases of 3% and 14% respectively by 2040, but it remained unclear how service capacity would meet future demand. The COVID Health Impact Assessment revealed that 14% of respondents continued to experience long COVID symptoms, with gaps in diagnosis and treatment contributing to worsening mental health and pressure on services. The Sex Workers Community Profile recommended a preventative, person-centred approach, including detox and mental health support, and highlighted good practice through outreach, drop-in and safe centre initiatives. The Eastern European Health Needs Assessment identified high levels of chronic illness and mental health concerns linked to poverty and poor nutrition and called for culturally sensitive service design.

While some care providers reported being engaged through forums and newsletters, others said they were not consulted and felt opportunities to shape local services were missed. This made it harder for the local authority to fully understand what was needed in the area, and meant important insights from providers weren't always used in planning. However, a leader told us all providers were asked to co-design services with the Council. They believed the approach taken had enabled important insights to be captured appropriately.

Staff and leaders reported they used performance data to inform commissioning, supporting Better Care Fund reporting and the Market Position Statement and had plans to commission a specialist team to build more robust datasets for decision making. They said they convened parent and carer forums, and lived-experience enabler groups, and recruited unpaid carers and autistic people to co-production boards to shape service design, including the autism strategy. They noted population profiles guided team objectives and training, and an influx of about 36 new carers each month had prompted a carers' strategy to improve self-identification access to support. They described efforts to balance supported living with community-based day services according to individual preferences, while acknowledging limited data on employment and community engagement outcomes for people with learning disabilities. They added a rural loneliness survey had informed initiatives such as community lounges, and the final-stage Mental Health JSNA would further refine preventive service planning.

Market shaping and commissioning to meet local needs

The local authority developed commissioning strategies that aligned with the strategic objectives of partner agencies, including health, housing and public health. A Market Position Statement was published, with a dedicated version for mental health services, alongside a Market Sustainability Plan for older people, care homes and home care. The commissioning approach was based on transparency, co-production and strengths-based principles, with a focus on lean processes and continuous improvement to support financial sustainability.

Local priorities were shaped through 9 Local Area Partnerships, and some joint commissioning arrangements were in place, such as for home care and care home placements, supported by integrated brokerage and recovery beds to aid hospital discharge. Support was tailored to individual needs through ongoing engagement with user forums and co-production groups. The local authority's review of commissioning models found people with acquired brain injury and autism didn't always have the right support. In response, the 2025 Supported Living framework included dedicated options for both, helping to make services more inclusive. The previous tiered commissioning system was found to lack transparency and outcome focus, prompting a cost-benefit appraisal of 5 new options to ensure future sustainability.

Leaders told us market shaping activity was focused on sustainability, inclusion and meeting local needs. The care market faced financial pressures from rising costs and falling self-funder thresholds, prompting early engagement with providers and the use of Market Sustainability Plans and Position Statements to manage risks. There was a strategic ambition to reduce reliance on residential care through specialist housing, supported living and extra care schemes, with new developments designed to meet future needs and shared with providers in advance.

In rural areas, dementia cafés and community activities helped reduce loneliness, especially for older adults in supported housing. The local authority had begun work on a new advocacy contract in response to changes in the Mental Health Act and rising demand. Frameworks were revised to address inequalities, including access for autistic people and those with acquired brain injuries, with tailored specifications and engagement from people with lived experience.

The local authority developed commissioning strategies to improve access to suitable, local housing with support for adults with care and support needs. A revised extra care model was introduced, removing the 55+ age threshold to include younger adults with complex needs. This included contract extensions and dedicated monitoring officers to support quality and sustainability. Extra care provision was expanded with 3 services commissioned and a fourth in development, offering a less restrictive alternative for adults aged 18 and over. Providers contributed to the development of these schemes, although feedback suggested that market shaping exercises were too generic and did not fully engage those outside the framework. Contract monitoring was streamlined to support this work, but broader inclusion remained limited.

In supported living, the local authority replaced previous arrangements with a 5-year commissioning strategy aligned to the emerging Housing Strategy. A detailed review identified some support packages were overprescribed, and nearly 100 providers were operating within the framework. This prompted a shift away from a tiered model towards an itemised approach, focusing on shared hours, individualised support, and night care. Recommendations included rebalancing housing stock, reviewing single-person placements, separating housing and care roles, and introducing standard and enhanced hourly rates to improve transparency. Financial pressures led to market exits by 3 providers, and the new model was applied only to future placements following a financial impact assessment. The number of providers was reduced from 112 to 29, enabling stronger relationships and better oversight. The framework was co-produced with people and providers, and legacy providers were supported through the transition. The Commissioning team reviewed future needs, held welcome meetings with landlords, and addressed gaps in provision, particularly for people with learning disabilities through targeted development and provider insight.

Commissioning staff supported innovative approaches such as the integration of discharge-to-assess beds within supported living schemes, and the development of specialist housing with assistive technology to reduce managed moves. The local authority also trialled a two-tiered pricing model for supported living to improve financial sustainability and reduce costs for people with multiple care and support needs. Co-production frameworks, user-led governance boards, and the use of Experts by Experience further demonstrated a commitment to inclusive, outcome-focused commissioning.

The local authority operated a small care home market, with lower occupancy in its own homes compared to the independent sector, which raised concerns about care quality and financial viability. Since 2014, over 20% of older persons care homes had closed, and while 17.5% of bed capacity had been replaced by new homes, this left a small shortfall. In addition, 29 care homes had been rated as inadequate or requiring improvement, representing a significant proportion of the local market. Workforce challenges, recruitment difficulties, and post-pandemic staff burnout had contributed to poor practices, requiring increased support from the council to mitigate risks to people. These quality concerns, combined with contract suspensions and terminations, made placements more difficult. The local authority had increasingly relied on spot purchasing for complex cases outside standard contracts, particularly as the contractual framework had not kept pace with rising complexity and need. There had also been a rise in self-funders seeking support, which further added to market pressure.

There was consideration for the provision of services to meet the needs of unpaid carers. The local authority commissioned an external carer's organisation to deliver a wide range of support services, including carers assessments, breaks, support groups, cafés, sit-in services and emergency overnight care.

The Carer Strategy 2024–2029 was co-produced with Experts by Experience and set out strategic priorities, including, reducing waiting times for assessments, helping carers identify themselves, increasing access to support, and improving joined-up assessments for carers and the people they support. The implementation plan operationalised these priorities in the first year, with actions including advanced care planning, preventative approaches, and recruitment of lived-experience representatives. The strategy acknowledged barriers such as transport and committed to exploring volunteer driver schemes and more localised services. Support for end-of-life care was also planned through training and partnership working, with feedback from carers used to measure impact.

Carers told us co-production had been embedded in service planning since 1998 and had evolved into a formal framework, with lived experience shaping commissioning and market development. The register of Experts by Experience, managed by a carer's charity, supported this work. Staff highlighted challenges in rural areas, such as reduced service availability and limited travel capacity. Poor transport links further restricted access for carers outside central Northampton. However, carers welcomed initiatives like the carer-friendly 'community passport' and 'one-stop shops', which improved access and streamlined support. Governance was inclusive, with a user-led board and annual chair selection by people who used services.

Ensuring sufficient capacity in local services to meet demand

There was not always sufficient care and support available to meet demand, and people could not always access it when, where and how they needed it.

Staff across multiple teams told us there were persistent gaps in care provision, particularly in rural parts of West Northamptonshire. There were no extra care schemes in rural areas, and staff reported limited availability of homecare, day services, and respite options, especially for people with complex needs, autism, or behaviours of concern. Staff described difficulties sourcing providers with the right expertise and said they often had to justify out of area placements due to lack of local options. Mental health services were concentrated in central Northampton, with few alternatives in towns like Daventry and Towcester. However, West Northamptonshire Council were leading on the recommissioning of mental health services on behalf of their health partners. A leader told us plans were in place to address the identified gaps. Staff also highlighted the absence of a formal framework for day services for older people, requiring spot contracts to be arranged individually. Brokerage teams reported escalating concerns when placements couldn't be found, and said they were unclear on what was being done to address geographical disparities. While some work was underway to develop smaller-scale options, staff said progress was slow and demand continued to outpace capacity.

In response to concerns raised by staff about service gaps and insufficient provision in rural areas, the Director of Adult Social Services (DASS) said follow-up enquiries had taken place with the Commissioning team. While some issues such as the lack of extra care provision had only recently been flagged through commissioning roadshows and were not previously identified in the Market Position Statement, other concerns were described as isolated and resolved through existing processes. The DASS outlined current provision, including 13 dementia care homes in rural South Northamptonshire with 31 vacancies, and 2 new care homes in development expected to add around 140 beds. Community dementia support was also available across multiple rural locations. For learning disabilities, although a day service in Brackley had closed, all current referrals were being met, and only 1 complex home care package remained unresolved following a provider withdrawal. The DASS also noted no formal escalations had been received regarding extra care or home care in rural areas, and the escalation process was being reinforced through commissioning roadshows. These sessions were designed to support frontline staff, improve communication, and strengthen oversight of emerging issues, with quarterly sessions planned from next year to ensure ongoing engagement and support.

Partners highlighted several ongoing challenges across the adult social care system, particularly around delays in accessing personal care at home. They told us long waits for care and financial assessment outcomes, followed by delays in brokerage, often led to deterioration in people's health and avoidable hospital admissions. Once admitted, people were moved into a different system and had to restart the process, which was described as frustrating and inefficient. Voluntary sector partners also reported significant gaps in end of life and palliative care provision across West Northamptonshire. Health partners raised concerns about gaps in the home care framework, especially in relation to neurodiversity. In terms of day care, a provider told us local authority funding for places had reduced in recent years, resulting in more people having to self-fund. A carer told us that although the assessment was completed promptly, the care did not begin until 3 months later. During this time, the person remained in hospital as an interim measure. One person told us a local substance misuse support service was overstretched and focused primarily on crisis response. They felt there was limited capacity to offer ongoing, sustained support, which reflected wider pressures across the system.

There was not always sufficient capacity for unpaid carers to have access to replacement care for the person they cared for, in both planned and unplanned situations. Feedback from carers highlighted difficulties in accessing both planned and emergency respite. One unpaid carer felt the support organisation was overwhelmed and unable to meet demand. Another reported having to cancel a planned holiday due to care worker cancellations and noted a lack of emergency respite options when needed. Carers organisations reported demand for support consistently outweighed capacity, particularly when trying to arrange regular breaks. The Survey of Adult Carers in England 2024 data showed only 8.06% of carers were accessing support or services which allowed them to take a break from caring at short notice or in an emergency. This was lower than the England average of 12.08%. However, staff said the support provision for unpaid carers was good. Examples shared included welfare checks and sitting services, including overnight sitting services. Staff supporting people and their carers when leaving hospital said they had not experienced any capacity issues with these services and felt they were straight forward to access.

Between February and August 2025, the local authority reported rising average waiting times across all adult social care service types. In February, the average wait for home care was 2 days; by August, this had increased to 3.72 days. Nursing care saw the most significant change, with average waits rising from 5 days to 17.35 days. Residential care also increased from 6 days to 10.4 days, while supported living rose from 3 days to 13.45 days. These changes reflected a combination of planned system adjustments and external factors. Commissioners had worked with a provider to develop a new 81-bedded nursing home, as part of the system response. The overall increase in wait times also coincided with a planned restructuring of the brokerage function, which temporarily affected resourcing and introduced new processes. For supported living, the rise in wait times followed the introduction of a new framework. The framework now offers greater choice and flexibility for people, and a longer sourcing period to ensure better service matching is accepted. To support people with complex needs and improve access to adapted accommodation, the local authority mapped 180 supported living properties and introduced pilot referral review meetings to improve matching and support commissioning solutions where provider interest was limited.

Between October and December 2024, the local authority arranged a range of services to support hospital discharge. During this period, one reablement service delivered 374 packages with an average wait time of 2 days, while another team arranged 59 packages with an average wait of 4 days. Home care services had a longer average wait of 10 days across 407 packages. For residential discharge-to-assess (D2A) placements, 14 were arranged with an average wait of 9 days, and respite services saw similar delays, with 8 packages arranged and an average wait of 9 days.

More recent data from the last 3 calendar months showed the average delay from referral to discharge was 4 days, with 74.6% of discharges completed within that timeframe. These delays were not consistently linked to service availability or capacity. Instead, they were often caused by batching of referrals from the Acute hospital on specific days, which placed pressure on the validation process ahead of discharge planning. The local authority continued to use a blended approach to hospital discharge, drawing on both in-house provision and commissioned providers. This comparison highlights that while average discharge delays have remained relatively low overall, specific service types, particularly home care and residential placements have historically experienced longer waits. The recent data suggests operational processes, rather than service gaps alone, may be contributing to delays.

As of August 2025, the local authority reported 275 placements outside of West Northamptonshire. All were located in neighbouring or nearby areas, with the majority (224) in North Northamptonshire. These placements were not classified as out of area due to the county-wide commissioning footprint. The primary support reasons were learning disability and physical support, and leaders stated these placements had been made entirely based on individual choice, rather than due to any gaps in local service provision.

Some services were commissioned jointly with other agencies. In these instances, there were clear roles and accountabilities for monitoring the quality of the services being provided and the outcomes for the people using them.

Ensuring quality of local services

The local authority had clear arrangements to monitor the quality and impact of the care and support services being commissioned for people and it supported improvements where needed.

The local authority put in place a range of processes to monitor and improve the quality and safety of care services. The Quality Improvement team regularly engaged with providers through site visits, feedback forms, and relationship-building to support ongoing improvement. A Joint Quality Board brought together representatives from the local authority, health partners, and the regulator to oversee standards and inspect new services. Monitoring arrangements with health colleagues included joint visits, data sharing, and escalation protocols, with a focus on learning and involving people and families. Data tools were used to analyse service performance and audits led to targeted training, such as improving staff understanding of Deprivation of Liberty Safeguards (DoLS).

Quality concerns were managed through a structured escalation and suspension process, supported by a risk register and a traffic light system to identify and respond to high-risk providers. A notification of concern protocol enabled monthly analysis of emerging themes, which informed training and learning offers for providers. The local authority tracked Care Quality Commission (CQC) ratings and used a quality monitoring cycle that drew on feedback from families, forums, and provider self-assessments. Local authority data showed 96% of commissioned providers were compliant with quality standards.

Staff confirmed the local authority's approach to quality monitoring and improvement, describing it as structured and proactive. They reported quality assurance included annual visits, pre-monitoring checks, and scoring systems which helped providers focus on specific areas for improvement. Staff highlighted the importance of building relationships with providers, using feedback from people and carers, and working in partnership with health colleagues through joint visits and intelligence sharing. They gave examples of targeted actions taken following concerns, such as improving menu options for people with modified diets and checking staff competency in administering specialist medication. Strategic commissioning staff referred to the use of data workbooks, equality monitoring, and regular reviews to track performance. Brokerage teams described efforts to upskill the workforce through specialist training, and senior leaders noted that concerns, such as pest issues were addressed promptly. Overall, staff demonstrated a shared commitment to improving care quality through collaboration, responsiveness, and continuous learning.

Data provided by the local authority showed between May and August 2025, 3 care providers were suspended due to serious concerns. The reasons included poor risk management, safeguarding failures, inadequate staff training, and issues with medication and care planning. One provider was suspended following the revocation of its sponsorship licence due to non-payment of staff and financial instability. Another faced suspension due to concerns around diagnosis-specific support and the overall quality of care.

Ensuring local services are sustainable

The local authority collaborated with care providers to ensure the cost of care was transparent and fair. West Northamptonshire Council set out its approach to the cost of care in its Market Sustainability Plan published in March 2023 by engaging with local care home and home care providers to understand the actual costs of delivering services. This work formed part of the national Fair Cost of Care exercise, which used the median cost of care as a benchmark. The local authority used this data to inform commissioning decisions and took steps to improve service models, including recommissioning its care home framework and introducing a new local area partnership model for home care. These changes aimed to support more responsive, person-centred care and expand options for people with complex needs. The plan also recognised extra care housing was a cost-effective alternative to residential care and committed to developing this model further. A new supported living framework was launched to improve consistency and stability across services. Overall, the local authority aimed to balance financial sustainability with improving outcomes for people who draw on care and support.

Staff told us the local authority had made efforts to collaborate with providers through regular forums, open dialogue, and dedicated support. Forums were described as inclusive and provider-led, with opportunities to raise issues and hear from internal teams and external agencies. A clear process was in place for providers to escalate concerns, and a named commissioning officer worked directly with them. While cost-cutting measures had previously strained relationships, staff said regular meetings and transparent communication had helped rebuild trust and improve understanding of commissioning decisions.

The local authority had several contracting arrangements in place which aimed to support provider stability and long-term planning, including a 10-year care home commissioning framework and a structured home care framework with increased hourly rates. These frameworks were designed to improve occupancy, consistency, and financial sustainability, and were supported by robust onboarding processes for providers. Leaders described collaborative commissioning relationships and regular engagement with providers, including face-to-face meetings and shared training initiatives.

However, feedback from voluntary and community sector partners highlighted concerns about inflexible arrangements, and limited financial support, which constrained innovation and continuity. While some smaller organisations were awarded longer contracts following feedback, others reported outdated frameworks, inconsistent monitoring, and delayed payments, sometimes up to 10 weeks, which created operational strain. The local authority had a payments team in place to resolve issues and was developing new policies to address challenges such as top-up fees and provider closures. Despite efforts to improve financial modelling and adapt business models, sustainability remained a concern, particularly for small care homes and under-resourced community services. Overall, while the contracting infrastructure offered some stability, gaps in oversight, flexibility, and financial resilience continued to impact provider confidence and system continuity.

The local authority worked with providers and stakeholders to understand current trading conditions and how providers were coping with them. Engagement and monitoring arrangements enabled the local authority to get early warnings of potential service disruption or provider failure; contingency plans were in place to ensure people had continuity of care provision in this event.

West Northamptonshire Council had protocols and contingency plans in place to manage risks linked to service disruption or provider closure. These included a Service Closure Protocol and a Provider Market Business Continuity Plan, which set out clear roles, actions, and communication procedures to ensure continuity of care. In the event of a potential closure, a multi-agency strategy meeting was convened to agree a response and form an incident group. The local authority had a range of options such as spot purchasing, temporary staffing, and working with alternative providers to maintain support for people. During 2023/24, although no provider failures occurred, staff responded to 5 contract hand backs, resulting in 4 managed service closures. These were handled in line with established procedures, with a focus on minimising disruption and safeguarding people's wellbeing. The local authority shared detailed documentation outlining its response to a provider closure, demonstrating a clear and robust process that followed established guidelines. The closure was linked to concerns about the building's layout, accessibility, referral challenges, and limitations in delivering quality care. The site, which offered supported living accommodation, was decommissioned due to persistent unoccupied properties and suitability issues. People receiving care were supported to move to more appropriate settings with their agreement. More recent data shared by the local authority showed between May and July 2025, 4 providers exited the market, 1 due to quality concerns and 3 due to financial failure.

The local authority demonstrated a clear understanding of its current and future social care workforce needs, with a range of processes in place to support capacity and capability. It recognised high vacancy rates and skills gaps, particularly in complex care and responded through targeted training, international recruitment, and structured development plans. Over 700 international recruits had joined the commissioned market, supported by monitoring systems and a newly appointed recruitment lead. While concerns remained about some providers acting as recruitment agencies, leaders described the overall impact on workforce stability as minimal.

Leaders acknowledged challenges with pay, recruitment, and attracting experienced care home managers and qualified social workers. Internal efforts were underway to reduce reliance on agency staff and support non-qualified staff into qualification. Some services, such as Occupational Therapy and Visual Impairment, reported good retention and no current vacancies, while others, such as Approved Mental Health Professionals and the Deprivation of Liberty Safeguards team faced capacity pressures due to limited availability and lack of formal rotas. Work was ongoing to develop a system-wide training plan, although learning activity was described by staff as fragmented. The local authority had begun mapping training offers and costs and was engaging with providers to identify priority areas. Apprenticeships, student placements, and outreach to schools were used to promote careers in care. Senior practitioner roles were being explored to support mentoring and professional development. Leaders recognised the need to build a more skilled and sustainable workforce but acknowledged progress was uneven and further investment would be required.

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 collaboratively with health, community, and voluntary sector partners to agree and deliver shared local and national objectives. Strategic priorities and responsibilities were aligned through system leadership conversations, joint commissioning, and co-produced plans. A 10-year integrated care strategy and a 3-year prevention plan were developed and delivered through local area partnerships, which enabled place-based planning, resident engagement, and service redesign to address inequalities.

Senior leaders described long-standing relationships across health and care that supported continuity through national system changes. The local authority maintained strong links with shared service providers and acute hospitals, helping to protect the place voice and clarify decision-making between system and place levels. Despite national reductions, local cuts were lower, and integrated delivery continued where it added value, including joint quality teams, infection control, and brokerage.

Housing's transition into the Strategic Commissioning team marked a change in integration with adult social care, addressing historic gaps. Leaders emphasised the need to reduce silo working, particularly with GPs and in mental health, to improve outcomes and prevent crises. Public Health leaders described adult social care as a key partner in embedding Integrated Neighbourhood teams to strengthen coordination and strengths-based practice.

Health partners described their relationship with the local authority as strategically collaborative, with collective ownership of the Better Care Fund and a shared commitment to integration with collective responsibility for problem solving. While structural challenges such as misaligned primary care boundaries remained, integration conversations were seen as constructive. Partners saw the local authority as a driver of practical coordination, including shared training and low-level integration activity. However, they noted the need to embed strategic collaboration more consistently at operational level. Voluntary sector partners highlighted the Carer's Strategy as a strong example of joint working, with the overnight care service cited as a practical intervention which helped prevent hospital admissions and maintain independence.

Operational integration was described as strong, with joint delivery in areas such as Age Well, telecare, equipment stores, and crisis response. Multi-agency teams and monitoring hubs supported prevention and wellbeing, reducing hospital admissions and increasing referrals to community support. Joint commissioning strategies were developed for mental health supported accommodation, and workforce planning was coordinated to strengthen recruitment and training.

Hospital discharge processes were improved through integrated models and joint initiatives. A Flow and Capacity team was established with the Integrated Discharge Hub to streamline transitions and coordinate ongoing care. The discharge-to-assess model was reviewed and enhanced, including trialling new assessment processes for people with complex needs and establishing an integrated health and social care centre. Discharge planning began on Day 1 of admission, supported by joint staffing models to reduce handovers and improve continuity.

Partners said they worked towards joint commissioning of bed brokerage and had developed shared dashboards to track discharge pathways and identify delays. A single set of processes was introduced to avoid duplication and competition for beds. Areas for improvement included weekend discharge rates, and the need for a shared care record to support live information sharing.

Staff described relationships with health colleagues on hospital wards as generally positive, though challenges remained. This included pressure to discharge quickly, gaps in mental capacity assessments, and unrealistic expectations set with families. Despite the removal of a dedicated link worker at 1 mental health hospital, staff valued opportunities to attend ward rounds and strengthen relationships. Managers also highlighted close working with Integrated Care Board colleagues through the transforming care programme. Co-located workers supported people with learning disabilities and/or autism, helping to prevent admissions and respond to complex needs. They told us their teams had received positive feedback for their ability to provide tailored support.

However, feedback from a voluntary organisation raised concerns about unsafe discharge practices and gaps in adult social care involvement. In one case, appropriate services were only arranged after an advocacy partner directly intervened to help facilitate the right care for a person. The organisation described adult social care as inaccessible and impersonal, with difficulties in building relationships with staff and leadership.

West Northamptonshire is served by several prisons, including, HMP Five Wells (within the area), HMP Woodhill, HMP Onley, HMP Ryehill and HMP Peterborough, each with different security categories and operational arrangements. Partnership working with the prison service was described as inconsistent. Not all local area partnership teams had link workers for the 4 local prisons, which staff said led to gaps in coordination and support for prison leavers. Staff reported that bail conditions and release dates were sometimes only known on the day, leaving no time for planning. Multiple probation workers involved in cases also caused inconsistency, and effective joint working with mental health and housing teams was described by staff as variable.

In response, the Director of Adult Social Services told us, the local authority had taken steps to strengthen its relationship with the Probation service. A joint session was delivered to improve probation officers' understanding of adult social care, covering the Care Act, safeguarding, and risk management. A reciprocal session for adult social care staff was scheduled to promote future collaboration. These sessions formed part of a wider commitment to improving inter-agency coordination and outcomes for people transitioning between services.

Arrangements to support effective partnership working

When the local authority worked in partnership with other agencies, governance, accountability, and information-sharing arrangements were clearly defined. Shared frameworks, integrated boards, and executive meetings supported joint decision-making, with roles and responsibilities agreed across partners. The Better Care Fund, underpinned by Section 75 agreements, was overseen by a dedicated Executive Board chaired by the Director of Adult Social Services, with monthly reporting into the Health and Wellbeing Board. Scheme reviews, risk registers, and performance dashboards informed planning and quality assurance.

Staff and leaders described how governance had matured over time, from fragmented relationships to coordinated, outcome-focused collaboration. Strategic partnerships were strengthened through regular meetings between health leaders, shared financial oversight, and flexible leadership models, including rotating Senior Responsible Officers. The Health and Wellbeing Board had become a well-attended forum with active representation around wellbeing, prevention, and integrated neighbourhood strategies from health, voluntary, and community sectors, including carers and Healthwatch. A leader told us monitoring had moved beyond activity counts to outcome-based measures, helping them to understand how well people were supported to regain independence and avoid crisis. Additional governance structures such as the Prevention Board, Joint Strategic Needs Assessment Board, and Transforming Care meetings supported oversight of complex areas like mental health and learning disabilities.

Joint commissioning had improved through initiatives such as the merged care home contract, trusted assessor pilot, and jointly funded community equipment service. Monthly stakeholder meetings and integrated IT systems, such as shared access to local authority's care management platform and health records enhanced communication, reduced delays, and supported holistic planning. Co-production was embedded in governance, with lived experience groups contributing to service design and review.

Operational support around NHS Continuing Healthcare (CHC) and Section 117 arrangements was strengthened through specialist teams, though staff reported ongoing challenges. These included rigid review processes, limited multi-disciplinary input, and funding decisions driven by financial constraints rather than person-centred planning. Staff often had to advocate for people alone, particularly during transitions into adulthood or hospital discharge, where securing NHS Funded Nursing Care was difficult and health decision-makers were not always visible.

Health partners acknowledged CHC and Section 117 funding disputes but viewed them as national issues. Plans were underway to introduce interim funding to support timely discharge, with final decisions made post-discharge. Voluntary sector partners also reported disagreements over accountability and care coordination, highlighting the need for clearer processes and shared responsibility to ensure people received appropriate support without delay.

Despite these challenges, staff consistently described a culture of constructive engagement, shared responsibility, and continuous improvement across the system.

Impact of partnership working

The local authority monitored and evaluated the impact of its partnership working on the costs of social care and the outcomes for people. This informed ongoing development and continuous improvement.

Partnership working across West Northamptonshire had a measurable impact on both cost-effectiveness and improved outcomes. Collaboration with health partners, including the Integrated Care Board, enabled better use of shared care records and data to identify individuals at risk earlier, helping to prevent escalation and reduce demand on statutory services. Integration with the carers organisation improved coordination and reduced delays in hospital discharge, while joint working between therapy services, social workers, and the voluntary sector helped people access support before reaching crisis point.

Preventative approaches were strengthened through drop-in sessions and shared decision-making, which raised awareness of available services and promoted independence, particularly for those with complex needs. The Better Care Fund supported a range of initiatives that demonstrated positive impact, including admission avoidance through expanded urgent community response capacity and targeted interventions for falls and minor injuries.

Performance reports showed the local authority was on track to meet key metrics, such as discharge to usual place of residence and reduced residential admissions. Some creative use of direct payments enabled more people to remain at home. Although there were temporary challenges with falls response due to a technology issue, this was resolved through the introduction of a new app.

An example from the Living Well service illustrated how multi-disciplinary support for a carer with mental health needs improved wellbeing and housing stability, while also reducing pressure on primary care. These examples reflected the value of strong communication, shared planning, and flexible approaches in delivering better outcomes and more efficient use of resources.

Working with voluntary and charity sector groups

Voluntary and Community Sector (VCS) partners described themselves as vital contributors to prevention, inclusion, and strategic planning in adult social care. A key VCS organisation held formal seats on both the Health and Wellbeing Board and the Integrated Care Board, sharing insight from thousands of local groups. Partners highlighted successful collaboration on initiatives such as support for autistic individuals, crisis cafes, and hospital-at-home pilots. Integrated models like Age Well and the Collaborative Care team were praised for bringing together health, social care, and VCS staff to deliver preventative, person-centred support, though these were largely funded through health and ICB budgets, with limited contributions from the local authority.

Despite positive relationships and opportunities for informal collaboration, VCS organisations raised concerns about unfunded representation, duplication of services, and centralised decision-making, which risked undermining trust and accountability. Some groups, including those providing community advocacy and sensory support, highlighted disparities in engagement between North and West Northamptonshire. While North was described as collaborative and responsive, West was seen as less accessible, with limited commissioning, unclear contact routes, and inconsistent feedback. Smaller organisations reported difficulty navigating council structures and a lack of direct relationships with adult social care. Several partners expressed a willingness to engage more actively in strategic planning and co-production but noted that capacity constraints and lack of formal invitations limited their involvement.

The local authority worked proactively with VCS organisations to understand and respond to local social care needs. This included commissioning services, supporting innovation, and enabling access to community-based support that did not require formal assessment. Initiatives such as the 'Waiting Well' pack and 'Waiting List Prioritisation Framework' enabled preventative support and interim care through trusted VCS partners, helping to reduce reliance on statutory services and maintain wellbeing.

Collaboration with carers organisations was a particular strength. Services were commissioned in partnership with neighbouring councils, and carer voice was embedded through Experts by Experience. Voluntary sector partners worked alongside health and social care providers to deliver coordinated, inclusive support, with case studies highlighting carer-led approaches and community-building efforts.

Staff and leaders described the VCS as central to delivering the prevention strategy and building resilient communities. The Community Development team led on VCS contracts, supported by Strategic Commissioning and Community Assets teams. Reform funding was used to expand co-production and offer grants, including those distributed via carer organisations to identify hidden carers. VCS organisations were actively involved in system-level decision-making, with representation on the Place Board and Local Area Partnerships, contributing insight, shaping priorities, and helping evaluate impact.

Examples of partnership working included events with churches and seniors' groups to reduce isolation, and public health-funded initiatives with charities to address substance misuse and mental health. Community engagement trials invited VCS organisations to propose projects based on local priorities, with funding allocated through community voting. Funded activities included arts, gardening, and parent groups, with staff emphasising the need for inclusive processes.

Operational teams valued the VCS for its flexibility and responsiveness. The Prevention and Therapy service worked with specialist organisations to provide equipment and bespoke adaptations, enabling greater independence. Informal pathways such as introductions via councillors and carers groups were effective in engaging communities, and the local voluntary sector infrastructure organisation played a key role in facilitating co-production through the Expert by Experience register.

While partnerships were generally strong, staff identified areas for improvement, particularly in services for people with learning disabilities and autism. Plans were in place to expand engagement, supported by new communications roles and experienced staff.

Theme 3: How West Northamptonshire Council 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: 2

2 - Evidence shows some shortfalls

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

The local authority understood the risks to people across their care journeys and had systems in place to identify risk and manage them proactively. Staff demonstrated a culture where safety was a priority and feedback from people and unpaid carers reflected positively on how the local authority managed and monitored risk. For example, an unpaid carer described how effective coordination between hospital staff, social care, and family ensured everything was in place for a smooth transition home following discharge from hospital.

To support timely responses to risk, a waiting list prioritisation tool had been introduced to screen all incoming referrals and requests for support. The tool categorised risk into priority levels, each with a target timeframe for assessment. A senior leader explained how the tool was supporting staff to better understand the urgency of different risks, particularly in complex situations such as carer breakdowns. Urgent duty action could be provided when an immediate response was needed, such as a home visit or referral to an emergency service. We also heard an example of duty staff working with the brokerage service to arrange urgent support when an unpaid carer was suddenly admitted to hospital.

To support those waiting for assessment or review, the local authority implemented a 'Waiting Well' approach. This included sending letters and an information pack advising people what to do should their circumstances change. The waiting well policy required staff to contact anyone waiting beyond the priority target timescale to review risk and any need to reprioritise. Staff described how these contacts were also used as opportunities to arrange interim or preventative support, or to signpost to community services.

The specialist moving and handling team played a key role in managing complex risks while promoting independence. Providing assessment, training and advice, the team was embedded into several key safety systems, including hospital discharge, intermediate care, and commissioned provider frameworks. They also supported personal assistants and unpaid carers. A leader described how moving and handling risks could be addressed swiftly via expedited access to equipment, such as specialist seating or a ceiling track hoist.

The local authority collaborated and worked with strategic partners to identify and manage risks across care journeys, and to monitor the effectiveness of processes and arrangements in keeping people safe. For example, through the Place Board and the Better Care Fund Executive Board. In particular, the local authority worked in partnership with the Integrated Care Board to implement a range of systems and processes to coordinate safe hospital discharges. For example, multi-disciplinary transfer of care hub meetings and integrated intermediate care provision. Staff described historical operational challenges as improving, and a coordinated approach to hospital discharge was well evidenced. This included effective communication between the different teams across the discharge-to-assess pathways, including hospital avoidance and reablement. This reduced delays in discharge, facilitated smooth transitions between services and reduced risk.

Providers told us how staff worked with them to ensure safety. For example, by sharing information about people's needs, involving them in planning processes and keeping them informed. However, some providers reported a more mixed experience. For example, the quality and accuracy of information could make it harder to plan the right care and support, and, when people's needs changes, some providers felt unsupported and left to manage risk alone.

The local authority's 'out of hours' service operated countywide and was managed by Northamptonshire Children's Trust. In the 12 months to August 2025, data showed the service received 4,936 contacts relating to adult social care. West Northamptonshire staff reported no concerns or challenges with this service. They described good communication, supported by systems which facilitated effective information exchange. While no specific issues were raised, there were opportunities to strengthen local authority governance to ensure robust oversight of safe systems in line with Care Act responsibilities. From 1 September 2025, a new consolidated out-of-hours model was introduced, offering greater clarity, consistency, and assurance for adults accessing services across the county.

Safety management systems for people experiencing a mental health crisis included access to the Approved Mental Health Professional (AMHP) service and health-led crisis houses. Staff noted they could not directly access crisis house placements, which occasionally presented challenges. However, once arrangements were in place, risks were managed effectively in partnership with health colleagues, and people could access the urgent support they needed. Staff did raise some concerns about the local authority's use of hotels as temporary accommodation for people experiencing homelessness alongside mental health needs. They explained the challenge this can pose for risk management and relevant information sharing.

Statutory Mental Health Act assessments were carried out by the AMHP service. This operated a countywide service, under an interagency agreement led by North Northamptonshire. A senior leader described the single countywide model as a practical approach to maintaining oversight and managing demand. Staff spoke positively about collaborative and well-established operational relationships across the 2 local authority areas. However, they told us about challenges in West Northamptonshire which impacted on the services' ability to consistently respond to mental health risks. These included workforce capacity challenges, with several AMHP's holding multiple other roles, resulting in conflicting pressures and increased workloads. A senior leader outlined plans to increase specialist training to strengthen capacity. Staff also highlighted wider system challenges, such as delays in response times from Section 12 doctors and the police, as well as limited availability in hospitals and designated places of safety. These workforce pressures and system delays limited the AMHP service's ability to consistently respond to mental health risks, impacting the local authority's ability to meet Care Act duties around safeguarding and timely intervention. While collaborative relationships were strong, further development was needed to strengthen capacity and ensure equitable delivery across the countywide model.

In situations involving complex mental health risks, staff would sometimes seek guidance from the AMHP service. While AMHP staff were happy to support colleagues, there was some concern that the regular reliance on this advice could indicate a lack of structure or confidence in managing complex risk within community teams. A leader told us West Northamptonshire used an Adult Risk Management approach in situations involving complex risk and progressed to a complex case panel where required.

Information sharing protocols supported the safe, secure and timely sharing of personal information in ways that protected people's rights and privacy. For example, some staff had access to the shared care record. The introduction of the new case management system had improved the timeliness and quality of information sharing internally, helping to reduce service delays and mitigate risk.

Safety during transitions

Care and support were planned and organised with people, unpaid carers and partners in ways which improved safety across care journeys and ensured continuity in care. One unpaid carer described how care at home was arranged following a hospital stay outside the area. West Northamptonshire staff had worked with health colleagues from the out of area hospital to coordinate the transition and ensure appropriate care was in place. Another unpaid carer shared how they had been involved from the outset in a transition process for a young person, which had given them confidence and reassurance.

Experience among partners varied. Some said the local authority consistently coordinated moves between services well, citing clear communication and care planning with the person and providers as particular strengths. However, others described challenges, including care plans not reflecting needs, a lack of response to emails and insufficient time being given for transitions between services.

The local authority had specific guidance for when people moved between teams. For instance, a transfer to the review team when their service was in place and working well. The guidance included clear responsibilities for each team, with the aim of facilitating a timely, smooth handover.

The Flow and Capacity team supported discharges from the local General Hospital but also received referrals from out of area hospitals for West Northamptonshire residents. Leaders, staff and partners all told us referral processes into that team worked well, with the multidisciplinary transfer of care hub helping to ensure people accessed the right service through the most appropriate discharge pathway for them. Staff described how the introduction of Pathway 1 verbal referrals had led to swifter discharge planning and a significant reduction in the average time to discharge.

While Pathway 1 worked well, partners reported challenges with delays in Pathways 2 and 3, particularly for people with complex needs or where discharge planning was being coordinated by a community team. Some of the issues included delays in equipment, availability of care provision (a particular issue in some rural areas) and delays when adjusting existing care packages. Staff also said delays could be caused by challenges securing NHS Continuing Healthcare (CHC) or NHS Funded Nursing Care, especially when people were being discharged into a nursing home on Pathway 2. The local authority demonstrated a continued focus on addressing challenges and reducing delays. For example, we heard how a dedicated CHC team had strengthened operational support to complex cases, and a trusted assessor pilot with care home providers to reduce delays in Pathway 3.

Acute hospital discharges were well-coordinated and fluid across local authority led services, with effective systems of communication and joint working evident. This included hospital avoidance, reablement and the integrated intermediate care provision. These services were all used to maximise opportunities to promote independence and prevent, reduce or delay the need for ongoing services. Staff supporting hospital discharges demonstrated a clear culture of prevention. We heard several examples of working to support people back home. For example, with housing providers, using assistive technology, input from the specialist manual handling team, and referrals to community services such as social prescribing and the wellbeing service.

Transitions from mental health hospital were coordinated with Northamptonshire Healthcare NHS Foundation Trust and managed by specialist staff within the local authority's community teams. Staff told us relationships with hospital-based health colleagues were effective, with timely referrals and inclusion in ward rounds supporting proactive and person-centred discharge planning. However, there could be disputes with Section 117 funding decisions, and staff told us these processes did not always work well. A senior leader and partners acknowledged there were issues but shared a commitment to ensuring transitions were not negatively impacted by delays caused by inter-agency funding disputes. For example, we heard about plans to establish an interim funding process which would allow discharges to proceed while final decisions were made. Post discharge, there were some onward transition challenges in terms of partnership working with health colleagues in the Community Mental Health team, particularly in terms of ease of contact and timely responses to requests for joint work or interventions to prevent or reduce the risk of a deterioration in mental health.

Staff demonstrated an understanding of the specific needs and challenges faced by people with a learning disability or autism during hospital stays, and there were several approaches to support their transition and help ensure equity of experience. For example, the Transforming Care Programme enabled the ability to identify and track people when they were admitted to hospital, helping to ensure a timely approach to support. Where a person with a learning disability or autism was already known to a worker, that worker would typically take the lead in discharge planning, ensuring continuity and familiarity. In cases involving mental health hospital discharge, staff reported being able to access the expertise of a jointly commissioned specialist autism Doctor, which helped ensure discharge decisions were safe and proportionate. However, staff told us there could be challenges in finding suitable provision for people leaving hospital with the most complex or forensic needs.

Adult Social Care staff worked closely with children's services to support young people, parent carers and young carers as they moved into adulthood. Transitions were typically planned from age 14, with adult social workers becoming actively involved from age 16. This coordinated approach was led by designated staff in community teams and aimed at ensuring a smooth, person-centred process. The Transitions Outcome Group played a key role in identifying and planning support, with referrals coming from children's services. Two Moving into Adulthood (MIA) workers acted as links with education settings to spot young people not already known to children's services, particularly those without an Education, Health and Care Plan (EHCP) or with less complex needs. This helped prevent gaps in access and ensured clearer referral, allocation and assessment pathways.

Staff gave examples of working with care leavers and young people with complex needs, including attending EHCP reviews and building relationships with schools and personal advisors. Parent carers described the support as proactive and well-coordinated across social care, health and education, and felt confident in the plans in place. However, some partners raised concerns about inconsistencies in transition support, particularly for young people with autism or sensory impairments who were not always identified through existing MIA processes. Leaders also highlighted a gap between children's and adult mental health services, which risked leaving young people without support.

Views on MIA commissioning were mixed. Some staff felt commissioners understood service gaps and planned ahead for young people with complex needs. Others reported delays in action, which sometimes caused disruption when a young person turned 18. A particular challenge was the transition from Ofsted-registered services to those regulated by the Care Quality Commission (CQC), where staff described a lack of suitable adult services to support young people transitioning from regulated children's care.

Transition arrangements for people with care and support needs leaving prison were found to be largely reactive. A senior leader explained that the local authority used Multi-Agency Public Protection Arrangements (MAPPA) meetings to support early notification, and some community teams also had link workers in place. However, staff told us communication and partnership working with prisons and the probation service could be ineffective and late notifications of release were not uncommon. These delays presented a challenge for care planning and the sourcing of timely, appropriate support. Staff also told us people were released with other unmet needs, such as housing or mental health needs, indicating a lack of consistent, multi-agency wraparound support. The local authority recognised these issues, and a senior leader demonstrated a proactive commitment to strengthening relationships and improving operational coordination. For example, reciprocal training with the probation service had recently taken place to raise awareness of roles and responsibilities, and work was underway with housing colleagues to strengthen post-release housing support.

Staff told us they worked in collaboration with partners to monitor people's safety when care and support was received outside the local authority area. We heard CQC ratings were used to provide assurance before arranging services, and intelligence received from other local authorities helped to inform quality monitoring activity. The joint quality board was an effective mechanism for sharing provider safety information with partners across Northamptonshire. However, a robust, proactive system specifically focussed on protecting the safety and wellbeing of people placed outside of the county was lacking, indicating a gap in assurance.

Contingency planning

People described a lack of contingency planning. One person said there had been no conversations about what would happen if their family could not provide care. Another person felt their support was not flexible enough to adapt to changes in their needs or circumstances.

Leaders told us contingency plans were completed for unpaid carers within 10 days of assessment and support included things like crisis respite and sitting services. This was not the experience of unpaid carers, who told us contingency planning was often reactive, with a lack of responsiveness during moments of urgent need. Where contingency plans were completed, unpaid carers said there was often a reliance on other family members being able to step in, rather than accessing crisis support from the local authority.

The local authority had plans and protocols in place which enabled staff to respond to unplanned events and emergencies. This ensured potential risks to safety and wellbeing from service disruptions were minimised. These plans included the provider market business continuity plan and the service closure protocol. Staff provided several examples of working together, and with partners to ensure continuity and manage risks during periods of service disruption.

Staff told us providers had named contacts and were encouraged to raise sustainability issues early. However, providers told us clear support with business continuity and risk management was lacking.

Safeguarding

Score: 3

3 - Evidence shows a good standard

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 for 2024 showed 73.80% of people who used services felt safe, aligning with the England average of 71.06%. Additionally, the percentage of people using services who said those services made them feel safe and secure was 89.30%, again consistent with the England average of 87.82%. Similarly, data from the Survey of Adult Carers in England for 2024 showed 80.95% of carers felt safe, in line with the England average of 80.93%.

There were effective systems, processes and practices in place to ensure people were protected from abuse and neglect. Since July 2024, safeguarding concerns had been triaged by the Safeguarding Assurance team. There was a clear framework to support consistent decision-making and well-defined roles and responsibilities in relation to carrying out Section 42 enquiries, with the Safeguarding Assurance team maintaining good oversight of those delegated to external partners. Within community teams, safeguarding was prioritised and staff adjusted workloads to respond swiftly. However, staff felt this could sometimes detract from other work, such as lower priority Care Act assessments. Dashboards, thematic reports and practice audits tracked outcomes and timeframes, and helped identify themes and trends. For instance, audits had identified the need for clearer recording of outcomes and greater involvement of referrers in enquiries, which directly informed updates to training and guidance.

The local authority worked with the Safeguarding Adults Board (SAB) and partners to deliver a co-ordinated and unified approach to safeguarding adults across the whole county of Northamptonshire. All partners contributed to the Board's strategic plan and participated in a range of subgroups focused on areas such as learning and development, and quality and performance. Granular data was used to identify local needs and priorities, ensuring equity across the different local authority areas.

Safeguarding staff were linked to different care providers and settings, including hospitals. These link workers provided safeguarding information, support and oversight, helping monitor sustainability of protection plan measures to reduce the risk of recurring concerns.

Partnership working was effective at responding to concerns and quality issues in care settings. Staff described joint quality visits involving social workers, occupational therapists and other partners to address specific risks such as manual handling or medication safety. A monthly Joint Quality Board provided a formal mechanism for sharing intelligence and managing provider risk with key partners, including the Integrated Care Board. The Adult Risk Management (ARM) process was a partnership approach to managing serious risk of harm associated with self-neglect, risk-taking behaviour or disengagement with services. While ARM was used within safeguarding, it could also support broader case management interventions. A leader reported efforts to build partner confidence in leading ARM processes, and staff noted increased engagement from partners as a positive development.

Additional systems and processes included property protection under Section 47 of the Care Act, financial safeguarding through deputyships, and Community Deprivation of Liberty (CDoL) authorisations. Practice guidance for CDoL was introduced in August 2024. A senior leader confirmed the local authority did not currently maintain a CDoL waiting list, although one was expected to develop as referral volumes increased and the process became more embedded. Systems were in place to monitor referrals, enabling a clearer understanding of demand and resource implications over time. Staff reported limited experience with CDoL cases, with many identifying this as a new area of practice. Some expressed concerns about confidence levels, indicating a potential need for further support and training.

Staff involved in safeguarding work were suitably skilled and supported to undertake safeguarding duties effectively. Procedures and guidance were described as comprehensive and regularly used to inform practice and decision-making. Support structures such as bi-weekly case discussions, weekly 'on-track' chats, and topic-based huddles helped distribute risk and alleviate pressure. Line managers were described as knowledgeable and supportive.

Safeguarding training was delivered across 4 levels, tailored to role-specific requirements. There was also specialist training available, covering areas such as skin integrity training, domestic abuse, multi-exclusion and homelessness, and Think Family.

Learning from Safeguarding Adult Reviews (SARs) was disseminated through monthly briefings, bitesize sessions, and guidance documents. Shared learning was facilitated through the SAB subgroups, and we heard about a collaborative approach with North Northamptonshire to deliver a 'Week of Learning' involving all partner agencies. A partner noted that whilst joint learning with children's services had begun, further opportunities could be explored.

Responding to local safeguarding risks and issues

The Safeguarding Adults Board (SAB) annual report 2023/2024 highlighted an increase in rough sleepers, identifying this as a safeguarding risk. A partner told us emerging safeguarding risks and issues in West Northamptonshire also included risks to asylum seekers and refugees in temporary accommodation, and the potential exploitation of people upon release from prison. While the SAB had worked with the prison service to strengthen coordination and data sharing, staff reported that communication with prisons remained inconsistent and, at times, untimely. This posed challenges in managing risks both to and from prisoners. A leader told us this was being addressed by joint awareness sessions to increase engagement.

The SAB annual report further identified safeguarding issues such as low rates of conversion from concern to Section 42 enquiries, a high volume of inappropriate concerns, and the need for improved recording of people's outcomes. The local authority and partners had worked to address these issues, including the establishment of the Safeguarding Assurance team and working to educate referrers. A SAB thematic safeguarding report from November 2024 showed positive developments, with improved conversion rates and a reduction in repeat referrals. Progress continued to be monitored by the SAB strategic delivery board.

The local authority demonstrated an ability to respond swiftly to specific safeguarding risks, particularly within care setting. The Safeguarding Assurance team monitored concerns and worked with the quality team to seek assurances or escalate actions to suspend services. Effective communication with social workers and brokerage teams ensured people were not placed into services where there was a known risk of harm. Lessons were learned when people had experienced serious abuse or neglect, and action was taken to reduce future risks and drive best practice.

Between January 2023 and March 2025, the SAB received a high number of Safeguarding Adult Review (SAR) referrals concerning people living in West Northamptonshire, reflecting both the complexity of local need and a proactive approach to identifying serious risks. This suggested increased awareness and reporting but also highlighted system pressures that may require further scrutiny and improvement. These SARs revealed a wide range of themes, including self-neglect including substance misuse, mental health including self-harm, domestic abuse, hoarding, neglect, rough sleeping, medical neglect and exploitation. With oversight from the Principal Social Worker, the practice development team reviewed all SAR findings, identifying themes and disseminating learning to staff. The team also had a strategic role, contributing to the SAB strategic delivery board and co-chairing the learning and development subgroup, thereby influencing regional improvement initiatives.

A partner described how SAR related action plans had driven targeted improvements in areas such as human trafficking, mental capacity, and multiple exclusion. Staff told us the Adult Risk Management (ARM) process, multi-exclusion and homelessness training, and Think Family training, all came out of learning from SARs.

Through its Learning from the Lives and Deaths of People with a Learning Disability and Autistic People (LeDeR) improvement action plan, the local authority and partners had made tangible improvements. This included broader delivery of nationally recognised training, as well as the introduction of a reasonable adjustment flag within the case management system to better support people with additional needs.

Responding to concerns and undertaking Section 42 enquiries

The local authority demonstrated effective triage processes, using a structured decision-making framework to determine Section 42 (S42) thresholds. Where immediate risk of harm was identified, measures to reduce harm were implemented promptly. While the Safeguarding Adults Board (SAB) set a timeframe of 5 days for triaging new concerns, the local authority had committed to a more ambitious target of 24 hours. Between March 2024 and February 2025, the average triage time was 2.5 days. However, this increased to 4 days between March and July 2025, indicating that while SAB parameters were met, local targets were not consistently achieved.

Partners found the online process for raising safeguarding concerns straightforward, and initial responses timely. They had confidence in the knowledge and skills of staff in the Safeguarding Assurance team, describing telephone advice as supportive and non-judgmental.

There was clarity on what constitutes a S42 safeguarding concern and when S42 safeguarding enquiries were required, and this was applied consistently. S42 enquiries are the actions taken by a local authority in response to a concern that a person with care and support needs may be at risk of or experiencing abuse or neglect.

In 2023, the local authority received 6,585 concerns, of which only 19% were converted into S42 enquiries. Between April 2025 and July 2025, the conversion rate ranged between 18.73% and 25.76%. In its own analysis of safeguarding themes and trends, the local authority had identified an issue with partners incorrectly identifying and referring safeguarding concerns, and there were ongoing educational efforts to improve this. Staff also told us safeguarding referrals were being used inappropriately as a ‘fast-track’ into adult social care, which they felt was being fuelled by long wait times in other teams.

The introduction of the Safeguarding Assurance team in July 2024 initially led to significant improvements in waiting times for S42 enquiry allocation. For instance, in May 2024 there were 23 unallocated enquiries and in January 2025 there were only 5. However, more recent data from March 2025 – July 2025 showed a rise in the number of unallocated enquiries, ranging from 18 to 54. A leader told us the increase to unallocated enquiries was due to the case management system change.

When safeguarding enquiries were conducted by another agency, such as a care or health provider, the local authority retained responsibility for the enquiries and the outcome for the person concerned. The Safeguarding Assurance team provided clear scope for enquiries, monitored progress, and carried out quality assurance of the findings.

Protection plans were used effectively to monitor ongoing actions to reduce risk, and there was evidence of good partnership working, for example with the quality team and a local pharmacy to ensure proportionate responses to provider concerns and medication errors.

Feedback from partners about communication during enquiries was mixed. While some felt well-informed, others reported needing to chase the local authority for updates. Similarly, views on how effectively the local authority shared outcomes and learning varied. Some providers saw this as a strength which helped to inform their own service improvements, while others said such feedback was rarely, if ever, provided.

Regarding Deprivation of Liberty Safeguards (DoLS) authorisations, the local authority reported a significant backlog of applications awaiting authorisation. Between May 2024 and February 2025, the number of people awaiting a DoLS authorisation ranged from 1,213 to 1,406. In July 2025, there were 1,117 people waiting, indicating a slight recent reduction. However, the median wait time was at its greatest (308 days), as was the maximum wait time (1,492 days). Staff told us around 90% of those waiting required new DoLS authorisations, with the remainder being renewals.

The local authority took a risk-based approach to managing demand, using a specific tool to prioritise cases by risk. This provided consistency in decision-making and ensured that those with the highest risk attached received the fastest response.

A senior leader told us the approach to reducing DoLS wait times was driven by continuous improvement and informed by annual service reviews. A range of measures were currently being explored. These included the use of equivalent assessments, technical solutions to streamline administrative functions and ongoing conversations with referring partners to identify collaborative solutions. Staff said independent Best Interest Assessors had also been engaged, although budget constraints had limited this option.

Making safeguarding personal

A person shared their experience of a personalised safeguarding approach which had considered their specific needs, involved them in conversations and kept their wishes at the centre of decision-making about risk.

Making Safeguarding Personal (MSP) was one of three strategic priorities for the Safeguarding Adults Board (SAB), and a senior leader told us it was well established. The SAB set measurable objectives around MSP, and progress was monitored through data analysis, supervision and practice audits. The Principal Social Worker analysed audit findings to identify themes and trends, supporting continuous improvement in MSP.

Safeguarding policy, procedure and practice guidelines clearly outlined an operational expectation that staff should, wherever possible, support people to achieve their desired outcomes throughout the whole safeguarding process, from initial concerns to enquiry and closure. MSP training was delivered through bite-sized sessions and multi-agency events, helping staff embed personalised approaches.

The local authority had developed a leaflet for people and unpaid carers, with the information they needed to understand safeguarding, and how to raise concerns when they didn't feel safe or had concerns about the safety of others.

Staff expressed positive attitudes towards risk-taking in safeguarding. They demonstrated an understanding of people rights, including human rights, rights under the Mental Capacity Act 2005 and rights under the Equality Act 2010. For example, we heard how the Mental Capacity Act 2005 had been used to support people to have choice and control over decisions about risk.

A SAB thematic safeguarding report from November 2024 found that 98% of people who expressed an outcome had it achieved or partially achieved. However, the report highlighted the percentage of people not being asked to define their desired outcome from a safeguarding enquiry had increased, rising from 14% in 2023/24 to 18% in 2024/25, suggesting people were not always given opportunities to make their views known. Staff told us outcomes were not being consistently sought in the initial stages of safeguarding, leading to professionals making decisions without meaningful involvement of the person. The Principal Social Worker's 2024/25 annual report identified data integrity issues in relation to inconsistencies in recording outcomes. Work was ongoing with staff to improve this.

A partner told us statutory advocacy provision in safeguarding was actively monitored, and with the local authority demonstrating strong performance. National data from the Safeguarding Adults Collection for 2024 showed 85% of people lacking capacity were supported by an advocate, family, or friend, aligning with the England average of 83.38%.

Where people needed support to engage with safeguarding processes, staff told us they consulted with a Lasting Power of Attorney or family member. While statutory advocacy was mentioned, there was limited evidence of referrals being made specifically to support engagement in safeguarding processes. Instead, staff tended to work with advocates already involved at the time of concern. A partner described system-wide efforts to improve staff understanding of statutory advocacy and promote its use in safeguarding. Staff confirmed this, citing recent guidance and encouragement to use advocacy more proactively.

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

Governance within the local authority had strengthened following the council's formation in 2021, but many strategies and systems remained in their early stages and were not yet fully embedded. The local authority inherited a complex legacy including the collapse of the former county council, a Section 114 notice, and years of underinvestment in adult social care, and had begun from a position widely recognised as critically low. Despite visible progress, strategic maturity and continuity were still developing, particularly given interim leadership in key roles, such as the Director of Adult Social Services (DASS) and Director of Public Health (DPH), and the Chief Executive Officer's (CEO) plans to leave the local authority later in the year. A leader told us permanent appointments had been made to both the DASS and DPH roles and a deputy CEO had been announced to cover until a permanent arrangement was made for that role.

While governance arrangements were structured and effective, findings throughout this report have highlighted areas where further development was needed to ensure oversight translated into sustained improvement and equitable outcomes. A tiered framework supported decision-making, serious incident response and performance oversight. The Executive Leadership team oversaw the People Directorate, with dedicated management teams for Adult Social Care, Children's Services and Public Health. Weekly adult social care meetings focused on performance, finance and transformation, enabling timely risk management and alignment with service plans. The Assurance Board monitored operational delivery using the Local Assurance Framework, informed by audit findings and staff feedback.

Staff and leaders consistently described governance as inclusive, responsive and well-integrated. The Principal Social Worker had regular access to senior leaders and worked alongside the Principal Occupational Therapist in strategic forums. Adult Social Care was well-supported at cabinet and council level, with cross-directorate working structured to avoid siloed thinking. Senior Leadership team meetings rotated between strategic, operational and financial themes, and performance was monitored through a layered approach, combining quarterly corporate reports, operational tracking, and deep dives when issues emerged. Staff confirmed concerns could be escalated and that additional capacity was deployed when needed, such as during the rollout of the new case management system.

Strategic oversight extended to workforce, carers and autism strategies, each governed through outcome frameworks and annual reviews. The People Directorate Board ensured alignment across public health, carers and wider service needs. The DASS described 4 key governance strands; Quality Assurance, Programme Strategies, Finance and Performance which embedded strategic impact and financial sustainability. Staff and political leaders confirmed that Adult Social Care had gained prominence in the new administration, with efforts to maintain momentum despite leadership transitions.

Leadership was generally visible, approachable and engaged with staff through regular briefings, blogs and celebratory communications. Strategic leads were described as passionate and unifying, with some teams benefiting from improvement panels and drop-in sessions. While staff felt supported and informed, some noted a decline in informal engagement, such as coffee chats and time spent alongside teams.

Risk management was embedded at corporate and directorate levels, supported by monthly reviewed registers and clear escalation routes. Key risks including workforce, finance, safeguarding and market fragility were consistently flagged and addressed through advocacy, restructuring and leadership changes. Prevention was prioritised, especially for frail older people, though its financial impact remained uncertain. A cabinet decision to bring social housing provision back in-house aimed to improve governance and reduce budget pressures.

Political and executive leaders were well-informed, with risks clearly reflected in the corporate register and considered in wider council decisions. The CEO and DASS strengthened oversight through regular briefings, improved data sharing and proactive engagement with scrutiny. Scrutiny processes had become more forward-looking, with cross-departmental agenda-setting and tailored support for councillors. While gaps remained such as involvement from people with lived experience and clarity around financial data, leaders demonstrated a commitment to transparency and continuous improvement.

Strategic planning

The local authority shaped its Adult Social Care Strategic Plan for 2025/26 using a broad evidence base which included performance data, risk assessments, and feedback from people and communities. This intelligence helped leaders identify strengths, pinpoint areas for improvement, and target resources where they would have the greatest impact such as investing in preventative services, addressing workforce challenges, and stabilising the care market. Insights into inequalities and outcomes informed commissioning decisions, while dashboards and monitoring tools supported ongoing evaluation and adjustment. Community engagement and lived experience were central to shaping priorities, with co-production embedded throughout planning and delivery.

To improve care and support outcomes, the local authority took a targeted, evidence-led approach. It developed new frameworks for care homes, supported living, and home care to promote independence and respond to complex needs. Preventative models were expanded, including extra care housing and integrated locality-based services delivered through developing the local area partnership model. Collaborative initiatives with health partners such as hospital-at-home pilots and crisis cafes were co-developed to support people earlier and more effectively. Targeted investment to support service transformation and improvement was used to strengthen co-production and community engagement, ensuring services reflected what mattered most to residents. These actions were aligned with the Integrated Care Northamptonshire system and driven by a commitment to reduce inequalities, improve access, and help people live well at home for longer. Leaders acknowledged gaps in access for seldom heard groups and had committed to embedding equality, diversity, and inclusion more fully across adult social care.

The Chief Executive Officer said, the local authority's vision for adult social care had evolved from its early focus on hospital discharge and supporting independent living, shaped by the legacy of the previous local authority. In its formative years, the new council prioritised laying strong foundations and aligning with health partners, while developing a wellbeing strategy that spanned both authorities. The refreshed 'One West Northants' plan, adopted in February, reaffirmed prevention as a central priority responding to historic gaps where services had become reactive. The 'Live Your Best Life' strategy was introduced to promote independence, offer people real choices, and embed prevention across all pillars of care. Council members recognised the pressures from rising demand, especially around working-age adults, learning disabilities, and emergency healthcare pathways, and were committed to tackling these challenges through proactive, person-centred approaches.

The local authority developed its Carers Strategy by working closely with local carers and placing their experiences at the heart of decision-making. It recognised that many carers were not known to services and committed to improving identification and outreach, using tools such as training, reform funding, and support to help carers recognise their role. The strategy focused on enabling carers to stay well, access community-based support, and balance caring responsibilities with their own wellbeing. Support was designed to be inclusive, locally delivered, and underpinned by strong partnerships across health, social care, and the voluntary and community sector. Leaders acknowledged previous gaps and worked to rebuild trust strengthening relationships with a commissioned carers support provider and improved access to systems. Progress was tracked through clear measures and aligned with wider system plans, with carers' voices embedded in planning and delivery. The local authority's self-assessment process helped refine the approach, and carers remained central to ongoing dialogue. The Director of Adult Social Services (DASS) described the strategy as a genuine reset, shifting from reactive support to proactive partnership, and ensuring future delivery reflected what mattered most to carers. While early progress was positive, the work was recognised as ongoing.

The Adult Prevention Strategy for 2025 took a whole-life approach to improving health and wellbeing by preventing, reducing, and delaying poor outcomes. It aimed to help people live independently, stay well, and avoid crisis situations. The strategy was informed by local data on inequalities, population needs, and service pressures, and was aligned with national policy and the Integrated Care Northamptonshire system. Key priorities included making preventative support easier to access through digital tools and community services, strengthening local networks to reduce reliance on formal care, identifying risks earlier through better data sharing and outreach, targeting resources to those most in need, and using technology to support coordination and self-management. Delivery was supported by cross-sector collaboration, with oversight from the Health and Wellbeing Board and Executive Place Board, and the overall goal was to shift the system from reactive care to proactive support so people could live longer, healthier lives in their communities. The DASS told us, the prevention strategy had originally been delivered in a piecemeal way, with different elements developed across teams. Over the past year, senior oversight had helped bring those strands together, and delivery was becoming more coordinated. Success was defined by having clear themes at a strategic level, while tailoring specific actions to each local area partnership. This approach aligned with work across Integrated Neighbourhood teams and health partners. The DASS added, prevention was measured from the point of initial contact, with wellbeing teams using a strengths-based outcomes tool, though integration with the social care system was still in progress. The long-term aim was to create a familiar, user-friendly model where accessing one service could generate personalised recommendations for others, based on shared needs.

With both the DASS and the Director of Public Health currently in interim roles, and a new Chief Executive to be appointed, there could be a potential risk of disruption in strategic direction and continuity, with a need for careful mitigation. This could also affect the momentum of data-driven initiatives and the consistency of support for long-term planning.

Information security

The local authority had arrangements to comply with information governance requirements in line with legislation, mitigate risks and maintain the General Data Protection Regulation compliance. Leaders told us Integrity and confidentiality of records and data was an essential part of everyday practice across the directorate. This included mandatory training for colleagues and regular reminders of the importance of information governance. Staff demonstrated a clear understanding of information security within the local authority's systems. They were familiar with established protocols, including security password procedures. They told us access to the systems was restricted to trained personnel, with defined access levels ensuring only authorised staff could reach specific sections.

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

West Northamptonshire Council fostered an inclusive and positive culture of continuous learning and improvement. Staff described feeling supported by managers and senior leaders, with access to regular supervision, reflective sessions and tailored development opportunities. Practice audits were embedded across teams to identify strengths and areas for improvement, with findings shared through monthly briefings and thematic learning sessions. The Principal Social Worker and the Principal Occupational Therapist played a key role in coordinating audit activity and aligning it with staff development priorities, helping ensure Care Act duties were delivered safely and effectively. However, some staff noted audit findings were not always embedded into supervision, and action plans were occasionally lacking.

There was a strong commitment to continuous professional development. Staff were encouraged to take ownership of their learning, supported by structured training pathways, protected development time and access to resources. Apprenticeship programmes, practice educator roles and leadership development schemes enabled career progression and helped build a skilled, resilient workforce. The Learning and Development Policy introduced a training matrix aligned to statutory duties, and the People Strategy promoted a blended learning model through experience, exposure and education. However, some staff felt progression routes into leadership were unclear, particularly in specialist services, such as Approved Mental Health Professionals.

The local authority worked collaboratively with people and partners to promote innovation and improve outcomes. Co-production was embedded across adult social care, with people with lived experience involved in strategy development, service design and operational delivery. Examples included the co-produced Carers Passport, Waiting Well packs and the redesign of the carers service model. Experts by Experience sat on multiple boards and were compensated for their time, reinforcing the value placed on their contributions. However, some contributors reported delays, unclear workplans and limited feedback on how their input was used. External partners also highlighted underrepresentation of seldom-heard groups and rural communities, and some felt co-production was occasionally confused with consultation.

Innovation was actively supported and shared across the system. Staff piloted artificial intelligence (AI) powered tools to reduce documentation time and improve case recording, and developed apps such as a digital falls detection tool to support safer handling after falls in care homes. Staff trialled AI tools to identify housing risks and improve access to advice, and learning was shared with regional and national partners through collaborative demonstrator initiatives supported by national improvement programmes, as well as contributions to the Department of Health and Social Care policy development. The local authority participated in peer reviews, including the Association of Directors of Adult Social Services led Deprivation of Liberty Safeguards review, and used findings to strengthen oversight and embed improvements.

Evidence-based practice was central to the local authority's approach. Staff engaged with academic partners, including the University of Northampton, to evaluate technology and inform service design. Research-informed initiatives such as the Autism Strategy and the Learning from Lives and Deaths – People with a Learning Disability and Autistic People. Programme (LeDeR) were used to improve outcomes and embed inclusive, preventative approaches. The local authority's involvement in the East Midlands Practice Framework and regional communities of practice supported shared learning and consistency across the sector. Despite some system challenges, including navigating new processes and information systems, senior leaders remained committed to improvement, drawing on peer review, sector-led support and research to strengthen practice and outcomes.

Learning from feedback

West Northamptonshire Council actively sought feedback from people drawing on care and support services, as well as from staff and partners. This informed strategy, service improvement and decision-making at all levels. In response to low survey engagement and concerns about satisfaction, the local authority introduced QR codes on correspondence and updated its Adult Social Care webpage to make feedback easier to give. Between October and December 2024, 160 responses were received across teams, highlighting themes which shaped service adjustments. Specialist services such as reablement and assistive technology also used tailored surveys to assess satisfaction and improve delivery.

People shared a range of experiences. One carer explained their concerns about care reduction were addressed through discussion and review, resulting in adjustments to the care package. Another carer described the emotional strain and low energy levels that made it difficult to consistently report issues, highlighting the toll on informal carers. Unpaid carers told us they had proposed service improvements such as proactive check-in calls, on-demand support, and designing services which enhanced the lives of cared-for people recognising this would indirectly improve carers' wellbeing.

Staff and leaders also contributed valuable insights. Managers involved in practice development identified the need for frontline staff to routinely seek feedback during assessment and care planning, aiming to embed this as standard practice. Staff encouraged resident engagement through one-stop shops and care home visits, and the newly established adult scrutiny board used lived experience to inform oversight and challenge. Staff noted that while feedback helped identify service gaps, it had not always led to visible changes highlighting a need to strengthen how learning is applied.

The Quality Improvement team used feedback from people and their families to shape provider priorities and quality assurance processes, though they noted that complaints data was not routinely captured and could enhance their work. Occupational Therapy staff used lived experience to develop initiatives like 'Waiting Well' letters, and celebrated compliments to reinforce a culture of pride. The Moving into Adulthood Service prioritised the voices of young people and parent carers in shaping service improvements. In the Direct Payments team, feedback led to broader recruitment efforts for personal assistants, including outreach to university students with relevant skills.

Staff feedback was gathered through employee surveys, focus groups, pulse checks and anonymous reporting. These informed the local authority's People Strategy and broader workforce development plans. Staff networks provided peer support and a collective voice, helping shape system-wide improvements. The ARISE project and Directorate-wide surveys revealed generally positive staff engagement, with many reporting strong team support and a collaborative culture. However, earlier surveys in Commissioning and Performance highlighted concerns around leadership, communication and morale, prompting targeted actions to rebuild trust and improve management practices. Survey results from 2024 showed marked improvement, with increased response rates and high levels of staff feeling supported, informed and aware of their Care Act responsibilities. Areas for development included access to training and confidence in senior leadership. In response, the senior leaders introduced mentoring programmes, training needs analysis, and office tours to strengthen visibility and engagement. The Adult Services Workforce Board used this feedback to adapt learning offers and align training with frontline experience.

The local authority had clear processes to learn when things went wrong and from examples of good practice. Leaders promoted reflection and collective problem-solving through thematic sessions and practice development meetings. For example, complaints about financial assessments led to improved communication, with the Financial Assessment team now making direct contact to explain processes and manage expectations. Within the Direct Payments team, complaints were used to foster empathy and a person-centred approach, and practical changes were made such as securing blank prepaid cards to reduce delays.

Complaints were managed through a structured policy, with 170 received in 2023–2024. Of these, 49% were responded to within the agreed 28-day timeframe. Most complaints related to financial issues, care planning, safeguarding, and delays in service. Key themes included unclear charging information, slow assessments, and placement delays. The local authority responded by reviewing policies, improving public information, and providing staff training. Thirteen complaints were escalated to the Local Government and Social Care Ombudsman, with 5 upheld. Four related to assessment and care planning, and one to safeguarding. The local authority published Ombudsman decisions and implemented recommended actions. Of 4 published reviews, 3 were upheld and 1 was not. These findings were used to strengthen practice and accountability.
