# North Yorkshire Council: local authority assessment

How we assess local authorities

Assessment published: 30 October 2025

## About North Yorkshire Council

### Demographics

North Yorkshire is a unitary authority in Yorkshire and the Humber, England. It has a population of approximately 627,629 (Office of National Statistics 2023). The county has a higher-than-average older population, with 25.67% aged over 65, compared to 18.69% in England.

North Yorkshire ranks 129th out of 153 local authorities in the Index of Multiple Deprivation (IMD), making it one of the least deprived areas in England. However, pockets of deprivation exist, particularly in Scarborough, where 3 areas rank among the most deprived 1% nationally.

In 2021, 96.7% of North Yorkshire's population identified as White, which is higher than the England average of 81.05%. 3.3% identified as Asian, Black, Mixed, or Other ethnic groups.

North Yorkshire Council is part of the Humber and North Yorkshire Integrated Care System (ICS), alongside 5 other local authorities, which serves 1.7 million people. The ICS covers a geographical area taking in cities, market towns and many different rural and coastal communities. Parts of North Yorkshire are in NHS West Yorkshire ICS and Lancashire and South Cumbria ICS.

North Yorkshire Council was formed in 2023, consolidating 7 district councils and a county council into a single unitary authority. The local authority has been under no overall political control since June 2023, being led by Conservative administration with support from 3 independent councillors. The council leader is a Conservative councillor.

A combined authority was established in 2024 by North Yorkshire Council and York City Council, called the York and North Yorkshire Combined Authority. Their role is to use some of the money and powers that up to now have been held by central government, and work with local leaders and communities to deliver the devolved investment.

## Financial facts

- In the 2023/24, North Yorkshire Council total spend was **£895,107 million**.
- They spent **£253,909 million** on adult social care, which was **28.37%** of the total budget.
- Over the past year, the local authority has raised the full ASC precept by **2%**.
- Approximately **9955** people were supported by adult social care in this local authority.

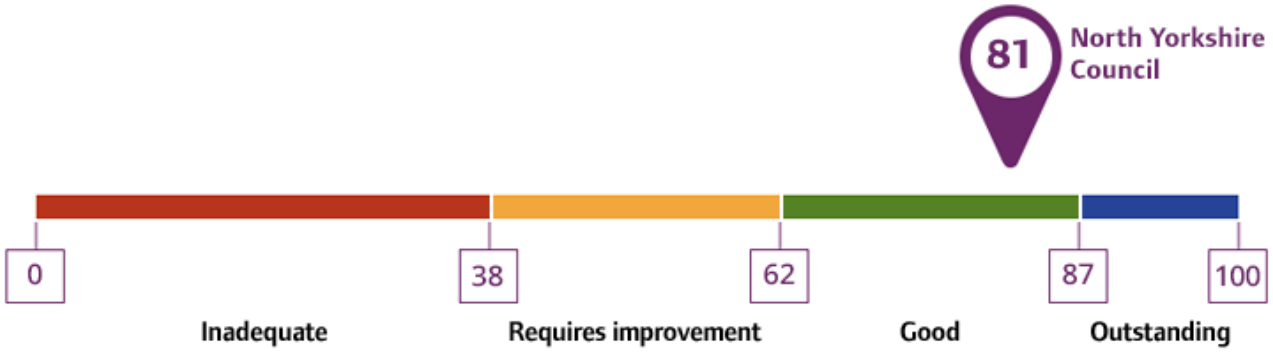
This data is reproduced at the request of the Department of Health and Social Care. It has not been factored into our assessment and is presented for information purposes only.

# Overall summary

## Local authority rating and score

### North Yorkshire Council

Good




## Quality statement scores

### Assessing needs

Score: 3

### Supporting people to lead healthier lives

Score: 3

### Equity in experience and outcomes

Score: 4

### Care provision, integration and continuity

Score: 3

### Partnerships and communities

Score: 3

### Safe pathways, systems and transitions

Score: 3

## Safeguarding
Score: 3

## Governance, management and sustainability
Score: 3

## Learning, improvement and innovation
Score: 4

## Summary of people's experiences

People generally felt happy with the care and support they received from North Yorkshire Council. They were able to find the advice and information they needed to make choices about their care. The support they received was well organised, and staff worked closely with them and each other to help people achieve their goals. Social workers kept in touch, and most people felt listened to and supported during the whole process.

People said they were treated with respect and their rights were protected. They were involved in making decisions during assessments and reviews, and their individual

characteristics such as age, disability, or background were recognised and considered in their care plans.

Many people were able to stay in their own homes for longer, through the care, support and equipment provided. They felt this helped them remain independent.

People said they felt safe using the services. They were helped to understand and manage any risks they faced. Data showed 73.69% of people receiving support felt safe, and 85.06% of carers felt the same. People had access to clear information about staying safe, what safeguarding meant, and what to do if they were worried about their own or someone else's safety.

Most people had a smooth experience when moving between services. Staff worked hard to make sure these changes were handled as smoothly and supportively as possible.

## Summary of strengths, areas for development and next steps

Senior leaders, managers, and staff in North Yorkshire were committed to strength-based approaches which helped people stay independent and delayed the need for formal services. Staff shared examples of supporting people's independence, such as providing equipment so people could live safely at home with a focus on achieving positive outcomes.

The move to a unitary authority had improved coordination between the Health and Adult Services directorate and Housing, leading to better engagement and smoother processes. Extra-care housing was embedded across the county and had a clear, positive impact on people.

Restructuring within Health and Adult Services was taking place to focus resources more effectively, with staff engaged and enthusiastic about the changes. Governance and risk management were strong, supported by good data which was used to track progress. Council members were well-informed and supportive of adult social care, with good scrutiny arrangements in place.

The local authority presented a confident, values-led approach to equity which was both practical and embedded. It included lived experience, intersectionality, and inclusive language, with clear commitment to co-production and continuous improvement. The strategy avoided tokenism by linking equity to governance, workforce development, and service design, whilst challenging structural barriers. The local authority's strength lay in making equity everyone's business, anchored in accountability, compassion, and measurable impact.

Plans for a North Yorkshire Health Collaborative, a formal section 75 Joint Committee between the largest Integrated Care Board and the local authority, with wider NHS, Voluntary and Community sector and care sector involvement, were being finalised to go live in July 2025, supported by leadership investment. Partnership working across services and with voluntary and community groups was strong, and co-production with people with lived experience helped shape services. The local authority used local data well to understand needs and address inequalities. It worked closely with partners to plan for current and future demand.

Safeguarding was a clear priority. Risks were well understood, incidents were dealt with quickly, and learning from reviews was used to improve practice. The Emergency Duty Team played a key role in managing urgent risks.

People had access to safe, high-quality care services, including those registered with the Care Quality Commission. Waiting lists were managed with oversight to ensure those most at risk were prioritised. Carers who had an assessment generally found it helpful and became more aware of available support. Some people used services outside of the county, but efforts were underway to expand local options. Out-of-county placements were monitored, and many had achieved good outcomes.

The local authority took a proactive role in developing services. There were many ongoing and planned projects, including extra-care housing, dementia care, and replacing outdated council-run care home buildings with up to 5 new Care and Support Hubs. However, issues remained around access to mental health beds and home care in rural areas, though pilot schemes were in place to address this.

Intermediate care and reablement services helped people regain independence quickly, supported by a strong referral process. The introduction of the new occupational therapy assistant roles had reduced waiting times. Leaders aimed to grow preventive services like Community Anchors and Care and Support Hubs and increase support for working-age adults with mental health needs, helping more people live independently.

Transitions, particularly of children to adulthood were handled with care. Improvements had been made to hospital discharges through joint working and models such as 'discharge to assess,' although some challenges persisted, such as shortages in specialist residential and nursing services for people with complex needs and due to pressures with waiting lists there are people waiting for assessments.

Staff were very positive and felt well supported, with a dynamic learning culture where learning, improvement and innovation was driven by curiosity, reflection, and collaboration. There was a strong visible and approachable leadership team who understood the challenges of frontline work.

# Theme 1: How North Yorkshire 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: 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.

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 could easily access the local authority's care and support services through multiple channels, including online and self-assessment options. People told us communication was good, and they knew how and where to access support.

National data from the Adult Social Care Survey for 2024 showed 83.01% of people who used services felt they had control over their daily life. This was better than the England average of 77.62%. 66.59% of people were satisfied with their care and support. This was better than the England average of 62.72%. And 49.35% of people reported they had as much social contact as they wanted with people they liked. This was similar to the England average of 45.56%.

The local authority's practice model was a person-centred, strength-based, community asset approach. It aligned practice quality and outcome ambitions with the "I" and "We" statements embedded in the 'Making It Real' initiative, which is a practical framework developed by Think Local Act Personal, a national partnership to drive forward personalisation in health and social care.

The model was underpinned by investment in prevention and early intervention, and a commitment to engage people with their care and support needs, ensuring their voice was heard throughout the assessment process, and identifying the outcomes they wished to achieve through their support plan. The focus was on achieving the ambition to see more people supported to live fulfilling lives in a home of their own, connected to family, friends and their community as described in the Health and Adult Services 2030 Plan. To support its delivery, practice was underpinned by the local authority's approach to embedding high- quality, values-led practice across its workforce, often referred to as the Confident and Consistent Practice model.

Overall people's experiences of care and support ensured their human rights were respected and protected, they were involved throughout in decisions and their protected characteristics under the Equality Act 2010 were understood and incorporated into care planning. For example, one person told us staff explained things clearly and acknowledged their need for time to process information before making decisions. Another person said their assessment was a positive experience. They felt the social worker was working with them, as they were asked what they wanted and their opinion on areas where they needed support. They added, they really felt listened to during the experience.

Staff ensured effective triage of referrals before proceeding with assessments, working closely with colleagues, including two assessors and two staff triaging referrals on duty daily to maintain adequate coverage of incoming referrals. Recent changes made to the Emergency Duty Team availability in the late afternoon helped manage the demand on staff resources more efficiently. Two AMHP hubs were created to ensure resilience and equity for AMHPs in terms of the amount of rota responsibilities, travel time and geographical spread. It also enabled them to respond to referrals in a timelier way. Decisions on which duty staff should respond to emergencies were based on specialisms, caseloads, knowledge of the area, and available services, with staff collaborating to overcome rural travel challenges.

Staff prioritised preventative measures, working alongside crisis services and exploring onward referral options early in the triage process. For example, in rural settings, they adapted to people's locations, utilising community taxi groups to provide affordable transport for appointments. Strong connections were maintained with GP surgeries, social prescribers, and voluntary and community sector groups, which responded well to identified resource gaps. While rural IT infrastructure remained a challenge for people, improvements in Wi-Fi and telephone signal enhanced service delivery.

Pathways and processes ensured people's support was planned and coordinated across different agencies and services. For example, the emergency duty team had robust systems for working out-of-hours to ensure handovers were effective and clearly communicated with recorded actions taken by the team. Staff could work autonomously to put support in place for people if services were required, and they were supported by an out-of-hours manager.

Partners told us assessments were often conducted jointly with social workers and supported by the voluntary and community sector (VCS) to ensure a person-centred approach. Overall, partners felt the local authority was responsive to people's needs, by knowing which VCS services to contact to meet people's needs.

The local authority had assessment teams who were competent to conduct assessments, including specialist assessments. Staff were qualified in their area of specialism such as Approved Mental Health Professionals, Sensory Impairment and Occupational Therapy. Staff told us they were given many opportunities for specialist training, practice development and career development opportunities.

People told us they had not always received copies of their completed assessments and they were not always notified by the professional carrying out the assessment that they were entitled to receive a copy. They shared that if they had known this information at the time of the assessment, then they would have liked a copy.

## Timeliness of assessments, care planning and reviews

At the time of our assessment, the local authority was actively working to improve timeliness in assessments, care planning and reviews, having identified this as a key area for development. While wait times varied across teams, the local authority had already taken steps to address the challenge, implementing clear strategies to reduce waiting lists and enhance responsiveness. Data provided by the local authority showed at the end of April 2025, 502 people were waiting for a Care Act assessment. The median waiting time was 41 days, against a target of 45 days. In 2024/25, 620 care needs assessments were completed on average each month.

A range of development work continued to target improved waiting list management. For example, a new online self-assessment tool had been launched in September 2024, informed by the national trailblazer project for charging reforms. Engagement with people with lived experience and their carers helped explore how assessment experiences could be improved and how online tools could be rolled out effectively for more people, providing greater choice, control and flexibility. North Yorkshire's Local Resilience Forum (LRF) resilience framework was being reviewed to ensure there was an effective response to emerging service pressures, making the best use of available resources to support areas seeing most pressure. The resilience framework is a plan that helps local organisations work together to prepare for, respond to, and recover from emergencies. It focuses on six key areas: risk, responsibility, partnerships, communities, investment, and skills. The local authority had started using an early contact model to help people access support more quickly and avoid long waits. This approach allowed teams to offer timely advice or low-level support without needing a full assessment in every case. Team managers had been upskilling their Advanced Practitioners to take on more of this work, such as making triage decisions, doing proportionate assessments and planning short-term support. These changes helped reduce waiting lists, freed time for more complex cases, and ensured people felt heard and supported from the start. A workshop took place in early 2025 with a group of people with lived experience to define what a good wait looked like. The feedback was used to inform practice.

Staff acknowledged the importance of timely assessments and were committed to supporting people as fully as possible, even under significant pressure to reduce waiting lists. While some reflected on the process-driven nature of the system, their dedication remained evident. In contrast, people shared positive experiences, noting their assessments had been delivered promptly and without delay.

The local authority had identified a shortfall in completion of assessments. North Yorkshire had faced some challenges recently which affected social care services. Rising care costs and limited availability of placements had made it harder to meet demand, especially in more rural areas. On top of this, more people were needing support after leaving hospital, putting extra strain on social care pathways and sometimes leading to delays in assessments. Leaders had identified waiting times as 1 of the 7 adult social care improvement priorities. To reduce risks, leaders had implemented a 'Waiting Well' initiative to ensure there was a proactive approach to risk management to support wellbeing while people waited for an assessment of their care and support needs. The task of undertaking welfare calls to people on a waiting list had been delegated to staff in the reablement team, to ensure people were waiting well, risks were mitigated whilst they waited and to check circumstances had not changed. Senior leaders were overseeing waiting lists using weekly performance reporting, tracking team-level performance in progressing new referrals to assessment and the timeliness of completing new assessments, which aimed to bring timescales back in line with the 45-day target.

Data provided by the local authority showed completed annual reviews of adults' support plans for 2024/25 totalled 4,286 compared with 3,784 for 2023/24, a 13.3% increase year on year. As at the end of April 2025 there were 2674 people waiting for a care review, with a median wait time of 119 days. These figures had significantly improved since the introduction of an insourced county-wide review team who had focused on completing residential care and nursing care reviews, with a completion rate of 72.4%. This action had expedited those reviews as workers were able to review multiple people in one care home and had significantly reduced the size of the waiting list.

The local authority did not have a target timescale for how long people should wait for their annual review. The improvement target for 2025/26 was for all service areas to progress to 70% of annual reviews being up to date. As part of an evaluation of the review team's work and impact, they were now prioritising work on the most overdue reviews for community- based care packages. The wider work of the improvement priority was exploring the potential use of trusted reviewers and developing new guidance for conducting reviews for people placed out-of-county.

## 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. We received lots of positive experience examples from unpaid carers. However, leaders recognised support for unpaid carers could be improved further. Although more carers assessments were being carried out than ever before, some feedback showed carers didn't always feel supported or valued. In response, leaders had expanded the carers assessment offer by including this responsibility within the Living Well team's remit, restarted an online assessment project, and established a Carers Round Table, which all aimed to make the carers offer more consistent and meaningful. All staff demonstrated the importance of identifying unpaid carers.

The 2021 Census data indicated that 53,723 people across North Yorkshire were involved in providing unpaid care for someone. Health and Adults Services, sharing an integrated budget with Children's Services, commissioned several services and specialist support for carers. The services were a Carers Support Service which was an all-age service to support young carers, parent carers and adult carers, and a Carers Break Service which arranged for volunteers to spend time with the cared for person either in their own home or in the community. It was delivered by 3 lead voluntary and community sector providers working in partnership with 11 community-based organisations.

Data provided by the local authority showed at the end of April 2025 there were 45 people waiting for a carers assessment with a median wait time of 27 days. The target timescale was 45 days. Referrals for carer support in 2024/25 totalled 2,101, compared with 1,593 for 2023/24, a 31.9% increase year on year (508 referrals).

Partners told us support for unpaid carers was a key priority for the local authority, including through the provision of ongoing support and development of the 2 commissioned carers organisations. They were aware the local authority had discussed future contracting to ensure timely renewals with carers organisations, supporting effective planning and sustainability.

Partners were also positive about how the Living Well team recently adapted to the increasing level of demand for carers assessments, and the team was now completing statutory carers assessments. They described how the local authority was reacting to carer needs and was currently trialling a digital offer of an on-line carers assessment platform. One partner described how the local authority had recognised there were many older people who were digitally excluded and had acknowledged their work to ensure the on-line assessment was accessible and people were totally supported to use this offer.

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

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. Staff were knowledgeable about the prevent, reduce, delay agenda, and had embedded this into their team culture, ethos, and way of working, to signpost and advise people.

The Living Well Service provided the initial help for people to meet their non-eligible care and support needs, including carers. The service received 2879 referrals in 2024/25, with 31.7% coming from NHS partners. Staff told us they also signposted people to the care directory on the local authority's website as well as other voluntary and universal services such as the Citizens Advice Bureau.

## Eligibility decisions for care and support

The local authority's framework for eligibility for care and support was transparent, clear and consistently applied. Decisions and outcomes were timely and transparent. Appeals were managed through the complaints process.

Staff told us they ensured there was consistency in their decision making, for example, by using a structured risk assessment process to prioritise. In relation to out-of-hours calls relating to homelessness, staff used risk assessment protocols and decision-making tools when assessing housing eligibility and securing temporary accommodation. For young people transitioning to adulthood, Care Act assessments were carried out at around 17 years of age to ensure continuity of support into adulthood. Key agencies, including health services and direct payment advisors, contributed to the process.

National data from the Adult Social Care Survey for 2024 showed 62.09% of people did not buy any additional care or support privately or pay more to 'top up' their care and support. This was similar to the England average of 64.39%.

## 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, transparent, and consistently applied. Decisions and outcomes were timely and transparent. The process for appeals against financial assessment decisions were handled via the complaints process.

Financial assessment processes were in place which detailed the customer journey from point of assessment, through to financial assessment, relevant payment arrangements and how to appeal. People could complete a care cost calculator online prior to a referral to Health and Adults Services.

Cost concerns were common, the online system helped simplify the process and reduce uncertainty. While financial assessments sometimes took time, they did not delay people from receiving services, as costs would be backdated from the assessment date. Staff told us the benefit of having financial assessments conducted online provided people with a quick estimate of their contributions.

One person told us their financial assessment was explained to them, and they had no concerns about finances and funding for the adaptations. They felt supported by the Occupational Therapist who conducted their financial assessment, after identifying the need for home adaptations. The outcome was a Disabled Facilities Grant being submitted for a stair lift and shower room.

Data provided by the local authority showed at the end of April 2025 no-one was awaiting allocation for a financial assessment. 127 assessments were awaiting completion with a median wait time of 2 days and maximum wait time of 4 days. The target timescale for the end-to-end financial assessment process was 10 days; performance at the end of April 2025 was an average of 10 days.

## Provision of independent advocacy

The local authority commissioned an external provider to deliver advocacy to help people fully participate in care assessments and care planning processes. The contract included provision of Relevant Persons Representatives (RPR), Independent Mental Health Advocacy (IMHAs), Care Act Advocacy, and Independent Mental Capacity Advocacy (IMCAs). The advocacy provider worked in a collaborative way with the local authority and key partners. Most recently, the advocacy provider had participated in the work carried out by a sub-group of the Safeguarding Adults Board to co-design the Safeguarding Policy.

Staff had good knowledge and understanding of advocacy services, what their role was, the benefits of advocacy and how to make a referral. Most staff were not experiencing any difficulties in accessing advocates. Staff said once an advocate was allocated to a person, the process was completed in a timely manner, and advocacy staff arranged joint visits with professionals but also met with people independently where appropriate. However, one team said they were experiencing delays in obtaining advocacy involvement for Mental Capacity Act (MCA) assessments during hospital stays, which they said prevented hospital discharges from taking place sooner. Leaders told us these situations were usually when people had complex needs or safeguarding issues, which were very rare. A refreshed practice guide had recently been shared with all staff in discharge hubs to support a shared understanding of MCA and Best Interest decisions and set out when the NHS should intervene to minimise any delays in hospital discharges.

Staff felt advocacy was particularly beneficial for people transitioning into care homes or unfamiliar settings. Advocates ensured autonomy, facilitated communication, and helped secure appropriate care arrangements. In cases where family disagreements over legal decision-making arose, advocates were appointed to protect people's best interests and challenge actions which did not align with safeguarding principles.

The commissioned advocacy provider told us they had not been able to provide non-statutory advocacy since December 2023, due to lack of capacity, lack of time to allocate an advocate and also due to the increase in demand of service. They had also raised concerns about their ability to provide safe RPR advocacy. They had made the local authority aware of this, and measures had been put in place, with the provider sending the local authority the waiting list each week detailing the names of the people for urgent allocation. The provider used their own triage tool to manage the waiting list.

The local authority had recognised they needed to address, as a priority, the issues which the advocacy provider had highlighted. Leaders told us a full-service review was being undertaken during 2025/26 in anticipation of a re-procurement of advocacy services in the county to meet increasing demand. The local authority had implemented short and long-term investment plans to ensure the contract remained sustainable pending re-procurement. This had enabled the commissioned provider to continue with their statutory advocacy role and make in-roads into the waiting list. Local authority staff were supporting people with non-statutory advocacy wherever possible.

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# Supporting people to live healthier lives

## Score: 3

3 - Evidence shows a good standard

## 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 community to promote independence and prevent, delay, or reduce the need for care and support. Prevention was a core focus, with early support offered to reduce reliance on ongoing social care.

A 2023/24 peer review recognised the local authority's investment in preventative services and its effective collaboration across social care, public health, and wider council functions. Following local government reorganisation, the Health and Adult Services directorate proactively strengthened cross-council working to improve outcomes and support healthier lives.

The local authority demonstrated its Care Act responsibilities through preventative strategies, including the work of the Prevention and Access Team. Based within the customer service centre, the team played a key role at the front door, resolving issues early through strength-based conversations, guidance, safeguarding enquiries, and signposting to preventative solutions such as simple equipment to promote independence.

The Living Well service formed a key part of the preventative offer, achieving high satisfaction and supporting both older adults and a broader, more complex client group. Operating for over 10 years, it provided social prescribing within a third of the county's Primary Care Networks. Social prescribing is a way of helping people improve their health and wellbeing by connecting them to local activities, groups or services that aren't medical. Staff worked with people on the verge of needing formal care, offering one-to-one support to help them achieve health and well-being goals and make positive life changes. The service was under review to assess its effectiveness, value for money, and future adaptability. The service was evolving as part of the Health and Adults Services 2030 Plan with a strong focus on prevention, independence, and community connection. Improvements had already begun by helping people across a wider range of issues. The service operated as a multi-disciplinary team, bringing together professionals from across health, housing and voluntary groups to offer joined-up support. Looking ahead, and subject to a full review, leaders planned to focus on unpaid carers, preventing falls, supporting more autistic people, and building strong partnerships to ensure people can build and maintain connections in their local communities to support their health and wellbeing.

The Localities Team worked closely with community groups, charities, and social enterprises to help them grow and support local people. They led programmes like Stronger Communities, managed small grant schemes, and supported Community Anchor Organisations to build resilience and deliver local services. Community Anchors are trusted local organisations, such as community centres which support people in their neighbourhood. They offer advice, activities, and help with everyday challenges. As they are rooted in the community, they understand local needs and work with others to make the area stronger, safer and more connected. The Localities Team also helped voluntary and community sector groups to access funding, training and advice. Their work is mainly funded by Public Health and focused on prevention, inclusion and reducing inequalities.

The Stronger Communities programme helped communities create local services which encouraged people to stay well, connected and independent, especially those at risk of needing long-term care. It focused on reducing loneliness, improving mental health, and helping people manage everyday challenges. While some services were open to everyone, others were targeted at people with specific needs, such as older adults living alone or carers needing extra support. The goal was to keep people living safely in their communities and reduce pressure on formal care services. It supported co-produced solutions by working with people, community groups, and partners across sectors, helping communities take greater control of their well-being.

Despite savings plans within the local authority budget, overall voluntary sector funding had been protected, with some redistribution based on need. The Localities Team worked with Health and Adult Services to shape proposals for enhancing prevention through more emerging Community Anchor organisations.

The local authority made significant investments in prevention and care, including expanding extra-care housing through 28 schemes accommodating 6,000 people over the past 20 years. It also protected and reshaped voluntary and community sector funding and increased care market investment. Council Members had recently approved plans to develop new Care and Support Hubs offering intermediate and specialist dementia care. A voluntary sector partner described North Yorkshire's prevention agenda as strong, highlighting its structured community support and effective links between commissioned services and the local authority.

The local authority prioritised unpaid carers and those most at risk of declining independence and wellbeing, offering a wide range of personalised preventative services. These included universal self-care initiatives, targeted interventions, reablement, rehabilitation, recovery, and supported employment. Commissioned investment supported community-based mental health services, carer support, dementia care, and services promoting independence. For example, a prevention project in Selby aimed to reduce falls by introducing exercise programmes. One person reported an improvement in supporting themselves to dress, whilst another person was hoping to return home from full-time care if their mobility improved.

Public Health were leading the local authority's contribution to an NHS/Ministry of Defence-led initiative to establish an integrated health hub in an area with a high military population, recognising the need to strengthen health protection in these communities. A partnership was developed with the military's Public Health Consultant to better understand local risks. Through this collaboration, sexual health screening and stop smoking services were identified as key needs and were incorporated into the hub's offer. The hub demonstrated a commitment to prevention, health promotion, and integrated delivery, ensuring services were tailored to the lived experience of military communities.

Commissioned carers services promoted social inclusion and helped prevent isolation. For example, staff worked with Nature Prescribing groups to reach rural communities through activities like farmers breakfasts and Dales walks, ensuring meaningful contact and collaborative planning to support carers effectively.

The Living Well service had been recently expanded to offer strength-based assessments for unpaid carers who were not in receipt of local authority support and showed no urgent needs. It used well-established preventative approaches and strong local knowledge to support carers. One carer described the emotional and physical demands of their role and said support from the commissioned carers organisation helped them adapt and feel less isolated. Another carer valued learning from peers, noting it empowered them to advise others. Data from the Survey for Adult Carers in England 2024 showed 14.94% of carers were able to spend time doing things they valued or enjoyed, which was similar to the England average of 15.97%.

Preventative services were having a positive impact on well-being outcomes for people. For example, one person said their care and support helped them live as they wanted by supporting their independence and involvement in structured activities. Community drop-in sessions, conservation work, and work placements boosted their confidence and personal growth and helped them develop new skills. They added that their Social Worker and Supported Employment Co-ordinator maintained a strong relationship with them, ensuring support remained aligned with their evolving needs.

The Support Time Recovery (STR) team supported people to build key life skills such as cooking, cleaning, and tenancy management to help them maintain independence. Staff highlighted the need for more resources to strengthen this preventative work. STR workers built trust and provided hands-on support, including teaching batch cooking and household management. Their work helped a previously isolated young man reconnect with his community and consider independent living.

Following a survey where 54% of farmers expressed a preference for services to reach them directly, staff from the Living Well service engaged farming communities by attending local auctions to offer support and taking services directly to them for example, blood pressure monitoring.

The local authority identified unmet care and support needs and successfully held a falls prevention forum to address unequal access to services. This led to an action plan focused on strength and balance programmes to promote independence. With funding from one of the Integrated Care Boards, a health inequalities programme launched falls prevention classes in extra-care housing and underserved community settings. Participants reported improved independence and social interaction, with some regaining the ability to carry out daily tasks. The initiative was also embedded into leisure services, securing sustainable, county-wide support. Data from the Adult Social Care Outcomes Framework 2024 showed 87.44% of people who had received short term support no longer required support, which was better than the England average of 79.39%.

## Provision and impact of intermediate care and reablement services

In 2024/25, the local authority renewed its focus on delivering reablement as a first option within an integrated intermediate care model to support people's return to optimal independence. This was driven by several pressures, including high hospital discharge activity, rising care costs, and workforce challenges. A service review made several recommendations to improve outcomes and reduce reliance on long-term care. The review called for better alignment with intermediate care services, more flexible delivery options, and increased support at weekends to help with hospital discharges. It also highlighted the need to invest in the workforce, especially in rural areas, and promote person-centred approaches focused on recovery and independence. These steps were designed to make the service more responsive and effective during times of increased demand. At the time of our assessment, progress had been made such as pilot projects, targeted rural recruitment and expansion of the out-of-hours service to cover peak demand times. While opportunities included developing new Care and Support Hubs and integrating rehabilitation services, staff and partners told us challenges persisted around care home occupancy, workforce pressures, and delayed discharges.

Reablement was 1 of 7 adult social care improvement priorities. The number of people accessing the service increased in 2023/24, with 1,876 services started, a 32% year-on-year increase. In June 2023, 74% of the service's capacity was being used to fill gaps in domiciliary care, a sign that workforce shortages and unmet demand were stretching the system. By quarter 3 (Q3) of 2024/25, only 24% of reablement capacity was being diverted, suggesting the council had strengthened its home care provision and restored reablement to its intended role of helping people recover and regain independence. Leaders told us the reablement service had the best capacity and outcomes since the COVID-19 pandemic, despite having to absorb some significant market failure during that period, such as providers going out of business, hospital discharge pressures and workforce shortages due to illness and staff leaving the care industry.

The local authority offered up to 6 weeks of reablement support, free of charge. Q3 2024/25 data provided by the local authority showed 71% of people required no further support after 90 days, up from 67.9% in Q2. Local areas such as Craven (91.3%) and Hambleton and Richmond (78.4%) exceeded the 75% target. However, data from the Adult Social Care Outcomes Framework 2024 showed only 1.03% of people aged over 65 received reablement/rehabilitation services after discharge from hospital, which was significantly worse than the England Average of 3.00%. 85.48% of people aged over 65 were still at home 91 days after discharge from hospital into reablement/rehabilitation which was similar to the England Average of 83.70%.

Leaders had developed 3 types of hubs to create a more joined-up intermediate care system in response to rising demand, hospital discharge pressures, and market fragility. They had secured capital investment to build new Care and Support Hubs, starting in Harrogate and Scarborough, to provide short-term bed-based rehabilitation and specialist dementia support, alongside existing Hospital Discharge Hubs to streamline transitions from hospital to community care. Around 25 Community Anchors were also supported to focus on prevention and low-level help.

The Bridging Service was jointly commissioned by the local authority and one of the Integrated Care Boards to offer a same day discharge when the reablement team did not have capacity. People were supported for 3 days to 14 days or until the reablement team could provide the support. Leaders told us, between January 2024 and February 2025, 314 people were either discharged with a bridging service alone prior to reablement or to a shared support package. The Reablement Service worked very closely with bridging providers, as did the discharge hubs and, due to this partnership working, they sometimes moved people between bridging and reablement services based on the person's needs and goals. There was no cost to the person and the movements were to ensure goals were being met. The service had been in place for 2 years and following a recent procurement exercise, 4 external providers had been commissioned from July 2025 to May 2026 to provide this service.

Staff told us that growing home care and intermediate care in Whitby was a priority. A 1-year pilot project was in progress which focused on enhancing home care through initiatives like trusted reviews and weekly assessed hours. Staff were confident the pilot would be successful in supporting people to remain at home and expressed interest in expanding the model to other areas of North Yorkshire. Plans were also underway to adapt reablement approaches for working-age adults.

## Access to equipment and home adaptations

People could access equipment and minor home adaptations to support independent living. Data provided by the local authority showed at the end of April 2025, the number of people waiting for an occupational therapy (OT) assessment was 209, the median waiting time was 44 days, against a 45 day target. The local authority had introduced Occupational Therapy Assistants (OTAs), which had produced sustained reductions in the waiting numbers and waiting times. Plans were underway to introduce an Advanced Practitioner role to strengthen consistency and manage complex cases.

Occupational therapy was integrated across the adult social care journey, from initial contact to long-term care. However, OT staff said they were delayed by pending social work reviews, leading them to raise concerns about workforce balance and timely support. A new single referral process and shared IT system had streamlined OT assessments and decision-making.

The provision of equipment was commissioned from an external provider. Data provided by the local authority showed at the end of April 2025 there were 19 people waiting for equipment, all of which were within the local authority's target timescales, and all had received initial contact. Over 90% of all referrals for equipment were processed within the target time frame. Activity levels were significant, with 60-70 referrals received in a 7-day period. There were delays for equipment in very rural areas, such as a 4–6 week wait for a grab rail installation in Ryedale which had raised concerns from staff about risks to people.

The Home Improvement Agency, launched in 2023, brought together services that used to be run separately by different district councils across North Yorkshire, creating a single, countywide service to support people with home repairs, adaptations and independent living. Leaders told us this had led to cost savings, better use of Disabled Facilities Grant (DFG) funding, and a consistent policy adopted in November 2024. A Disability Advisory Group was also created to review complex cases. The collaboration between Health and Adult Services and Housing was developing a stronger, more consistent service for people, highlighting the benefits of becoming a unitary authority and improving outcomes for everyone involved.

The Tech-Enabled Care (TEC) service supported around 1,700 people using technology to facilitate their care and support. Data provided by the local authority showed 87.6% of TEC users felt safer at home and 86% of carers experienced greater peace of mind with TEC in place.

Equipment for people with sensory loss was provided by the Sensory Support team offering practical tools, such as bump-ons and liquid level indicators. Staff had promoted accessible technologies such as phone apps that read surroundings or provided audio instructions. The support offered helped people maintain independence, dignity and control in daily life. By using simple equipment like bump-ons, liquid level indicators and Pen Friend technology, people were able to cook meals, choose clothing, organise personal items and engage in hobbies without relying on others. Staff told us about one person who regained pride in their appearance, matching outfits and jewellery independently, while another was able to select meals and enjoy music again thanks to labelling aids.

## Provision of accessible information and advice

People could access information and advice on their rights under the Care Act and ways to meet their care and support needs, including unpaid carers and people who funded or arranged their own care and support. Data from the Adult Social Care Survey 2024 showed 72.31% of people who used services found it easy to find information about support. This was better than the England average of 67.12%. Data from the Survey of Adult Carers 2024 showed 62.81% of carers found it easy to access information and advice. This was similar to the England average of 59.06%.

The local authority provided multiple access channels, such as postal, telephone, online, and face-to-face with interpreter services available, including language translation, British Sign Language, and Braille. Staff reported no difficulties in securing interpretation support.

In response to a 2023/24 Peer Review, the local authority commissioned a mystery shopping exercise with Healthwatch volunteers to support its approach to information and advice. Insights informed a website review, complementing accessibility work by the North Yorkshire Disability Forum. An Information, Advice, and Maturity Assessment (IAMA) also identified strengths and areas for improvement.

Co-production Network representatives told us they had previously raised concerns about information accessibility. In response, the local authority provided additional resources, such as video transcripts, to improve understanding and support form completion. We found the local authority's website featured a clear, well-structured directory of care services, advocacy, and safeguarding information, with links to universal organisations and council departments. A hard-copy version was also available to order.

## Direct payments

People had ongoing access to information, advice, and support to use direct payments. Direct payments were being used to improve people's control about how their care and support needs were met. However, uptake of direct payments was not very high in North Yorkshire. Data from Adult Social Care Outcomes Framework 2024 showed 19.73% of people received direct payments. This was worse than the England average of 25.48%. Boosting take-up was 1 of the local authority's 7 improvement priorities.

To increase the uptake, the local authority implemented performance reporting, co-produced resources, staff training, and were developing Independent Service Funds for those less confident in managing their own support. Improvements enabled greater flexibility, such as seasonal service choices.

At the end of 2023/24, the direct payment rate per 100,000 adults was 163.4 (above the target of 160), with a new target of 183 set for 2024/25. Countywide teams, including the sensory and review teams had the highest proportion of personal budgets with a direct payment (36.9%), while mental health teams had the lowest (10.5%). Younger people were more likely to use direct payments, often employing people they knew.

Staff highlighted challenges with personal assistant (PA) hourly rates, which were lower than neighbouring areas, affecting recruitment, particularly in border regions. In response, trials of higher PA rates were planned in Harrogate North and South Ryedale.

At the time of our assessment a pilot project was in progress which aimed to reshape the support planning process, whereby social workers completed assessments, but the direct payments team developed the support plans. Staff told us this approach had relieved pressure on social workers, improved personalisation, and gave people a consistent point of contact. Formal evaluation had not been undertaken as the pilot was in progress at the time of our assessment.

# Equity in experience and outcomes

## Score: 4

4 - Evidence shows an exceptional standard

## 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 placed equity at the heart of adult social care. Health and social inequalities were understood and used to identify and reduce disparities in care and support. There was evidence that actions taken made a difference for underserved populations and seldom heard groups.

The local authority fully understood its local population profile and demographics. It regularly collected and analysed equality data on people using adult social care services to identify differences in experience and outcomes. This data-driven insight informed its commissioning and strategic decisions, helping to reduce inequalities and improve access to care and support.

One example of this was a Social Justice workshop delivered by the Health and Adult Services Involvement and Governance Manager, whose role included responsibility for Equalities, and a senior Social Worker. The training explored local geography, population characteristics and the specific challenges faced by communities, such as the impact of rurality on access to services, particularly for ethnic minority groups. The session encouraged staff to examine the root causes of inequality and showcased steps the authority had taken in response. This included establishing an Equality and Diversity Group, signing an anti-racist practice pledge, facilitating peer support groups for women of colour, and running spotlight and awareness sessions on protected characteristics.

Senior leaders highlighted the significant variation in deprivation and inequality across the county. There were 11 neighbourhoods, mainly in the east of North Yorkshire, which ranked among the most deprived 10% of areas in England. The difference in life expectancy between neighbourhoods was substantial. High levels of rurality contributed to further inequalities, including difficulties accessing services, fuel poverty, limited affordable housing and digital exclusion. Office of National Statistics data confirmed North Yorkshire performed below average on indicators related to transport and broadband, and poor access to transport remained a significant barrier for many residents.

The local authority proactively engaged with people and communities where inequalities had been identified, to better understand and respond to the risks they faced. It recognised the impact of rural isolation, with remote communities needing to travel long distances or lacking digital access to essential services. To reduce this gap, social care teams were based in market towns, and the local authority was developing a network of 25 Community Anchor Organisations, each designed to reflect and meet the specific diverse needs of local populations.

Transport challenges remained a key issue in rural areas. However, a voluntary sector partner told us this was regularly discussed and ideas used to address these challenges. The local authority used creative outreach, such as engaging with the farming community at auction marts and country shows to ensure people could access support regardless of location.

Targeted work was carried out with communities facing significant inequalities. For example, a 2023 workshop helped the local authority, and its partners deepen their understanding of barriers faced by the Gypsy, Roma, Traveller and Show people (GRTS) communities. This work informed multiple equality objectives and created space for co-designed solutions and inclusive practice. Similarly, a health needs assessment for displaced populations identified risks such as limited cultural awareness, language barriers and inconsistent access to care. The local authority developed actions to improve outcomes for refugees and asylum seekers and monitored progress through a county-wide migrant health group.

The local authority's work was further enhanced by engaging people with lived experience. Staff listened directly to people's stories through collaborative projects such as the Healthwatch North Yorkshire study on LGBT+ experiences, disability awareness sessions co-led by the North Yorkshire Disability Forum, and spotlight events exploring racism, ableism, ageing and dementia in diverse communities. These experiences helped shape the local authority's approach and informed its corporate equality objectives.

In 2024, during a Joint Forum Question and Answer session, a community member raised the issue of social lives, sex and relationships for adults with lifelong physical disabilities. This led to a new working group involving local people, the voluntary sector and local authority staff, which focused on exploring solutions such as flexible care hours to support fuller lives.

The local authority had regard to its Public Sector Equality Duty (Equality Act 2010) in the way it delivered its Care Act 2014 functions. There were equality objectives and a co-produced approach, with an adequately resourced strategy to reduce inequalities and to improve the experiences and outcomes for people who are more likely to receive poor care. Recruitment was inclusive with diverse stakeholder panels and targeted outreach having increased ethnic diversity in the leadership pipelines.

The Involvement and Governance Manager led best practice, while a cross-directorate Equality, Diversity and Inclusion (EDI) Group supported action-planning and shared learning across services. The Health and Adult Services directorate also had an Involvement Team who promoted effective engagement techniques, helping staff to better include the voices of people with lived experience in all aspects of their work. This activity was coordinated through an EDI work plan, linked to the Equality Framework for Local Government and the local authority's wider equality objectives. Equality impact assessments were routinely completed for key policies and projects, with peer support available to staff. Partnership working supported this further, for example, with North Yorkshire Disability Forum to co-design and deliver training, through active participation in the regional ADASS Social Justice & EDI group, and as part of the North Yorkshire Equality and Inclusion Partnership.

EDI leads made good use of data to identify inequalities and remove barriers to access. They focused on understanding community needs rather than just numbers and engaged directly with people from diverse backgrounds to hear their stories. People with lived experience were involved in training delivery, helping staff understand the real-world impacts of exclusion. Insights from these engagements helped signpost people to the right support and informed efforts to improve access, for example, by building trust and better outcomes with GRTS communities.

Weekly data reports were shared with the senior leadership team to track equity in access to assessment and to monitor waiting times across the county. Where inequalities were identified, resources were reallocated to create a fairer and more responsive offer.

The local authority also took a deeper approach to understanding disparities. For example, when data indicated that people from ethnic minority communities were underrepresented in adult social care, Healthwatch was commissioned to lead research with these groups. The work aimed to understand the specific issues people faced and to co-develop actions that would address them.

A partner told us the local authority worked effectively with NHS partners to reduce health and care inequalities. They gave the example of a jointly funded post created to support delivery of the local health and wellbeing strategy, which focused on tackling inequality across organisational boundaries.

Staff carrying out Care Act duties demonstrated a solid understanding of cultural diversity and the needs of different communities across North Yorkshire. They positively engaged with people from a range of backgrounds, including those from seldom-heard groups. For example, they worked directly with Fijian veterans and their carers, providing tailored support such as hobby equipment to help maintain wellbeing in complex caring situations.

Data collection on protected characteristics was comprehensive and extended beyond the 9 legal categories to include areas such as rurality, armed forces status, and low income. A voluntary sector partner told us the local authority recognised data alone did not present a full picture of inequality, and strong locality-based working allowed richer narratives to inform the data. An example of this was their work on homelessness, where the numbers of rough sleepers were low, but local intelligence highlighted significant hidden homelessness, especially in rural and coastal areas. The local authority presented this issue at a rural summit to raise awareness. A partner told us the Safeguarding Adults Board was a champion in this area, with a strong understanding of local issues.

Staff also carried out outreach to promote safeguarding awareness, including through National Safeguarding Week, colleges, and local networks. In areas with large travelling communities, staff actively engaged with people in trusted community spaces, such as food banks. In Harrogate, Living Well Coordinators supported GRTS communities by building long-term trust. One coordinator supported a person to access a carer's assessment after previous professionals had denied them access, highlighting the value of sustained, respectful engagement.

Work to address health inequalities was strengthened through joint efforts between staff, involvement teams and data colleagues. This included mapping needs and developing creative solutions, for example, organising a tea party with veteran carers in rural areas, helping to tackle isolation and provide a platform for people to share their voices and experiences.

## Inclusion and accessibility arrangements

Inclusion and accessibility arrangements were in place so people could engage with services in ways that worked for them. Communication needs were proactively met during assessments, reviews, and in ongoing care and support. The local authority had taken positive action to improve accessibility by commissioning a range of interpretation and translation services, including for community languages, British Sign Language, audio and Braille. To make it easier and quicker for staff to access these services, a central directorate budget was established, and a translation library was developed to support wider use. The Health and Adult Services directorate also invested in improving communication by training staff in producing easy to read materials, using photo symbols, and set up a growing network of easy read champions. This work was strengthened by feedback and insights from co-production forums and networks, building on earlier easy read resources developed in partnership with the Learning Disability Partnership Board.

Leaders developed a communications plan to ensure all communication activity was accessible, diverse and inclusive, and promoted equality and equity. They also demonstrated their commitment to person-centred communication by joining the 8-month 'Gloriously Ordinary Language' programme, which began in December 2024. A cross-team group of staff from the directorate worked alongside other local authorities to rehumanise their language, reconnect practice with core principles, and reimagine approaches to care and support. In addition, a new 'active ageing' photobank, was created using images submitted by North Yorkshire residents, which offered a more positive and realistic portrayal of older people and supported the local authority's efforts to challenge age discrimination.

Staff recognised a key area of focus was identifying and meeting the communication needs of people from seldom-heard groups, to ensure no-one faced barriers to accessing care and support. Interpretation, advocacy or British Sign Language (BSL) support was routinely offered at the first point of contact, where needed. The Sensory Support Team made sure people received information in accessible formats. For example, assessments were sometimes delivered in person and staff used BSL to sign the contents for deaf people or provided them in large print or Braille for visually impaired people. Staff shared a range of local opportunities which supported inclusion, such as clubs for deaf and visually impaired people, where they had built strong friendships and enjoyed fulfilling hobbies like canoeing, archery and walking.

Staff told us they worked hard to remove barriers by increasing their visibility and reducing reliance solely on digital systems. For example, the Living Well team met people face-to-face at a farmers' market. Staff said they had strong access to translation services, including support from bilingual colleagues. One example involved a Ukrainian-speaking colleague supporting a social care assessment; another case involved a refugee whose wife had mental health needs, where assessment support was arranged through a telephone translator, with written materials provided in their language. Staff also used easy read resources, information in different languages, and clear signposting to connect people with further support.

Co-production Network representatives told us they had successfully trialled the use of photographs, to help people express their wishes where they struggled with language or being able to articulate their needs.

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# 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: 3

3 - Evidence shows a good standard

## 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 partners and used available data to understand the care and support needs of people and communities. This included people who were most likely to experience poor care and outcomes, people with protected characteristics, unpaid carers and people who funded or arranged their own care, now and in the future.

The Joint Strategic Needs Assessment (JSNA) for North Yorkshire provided a detailed overview of the current and emerging care and support needs across the county. The data highlighted a range of demographic, geographic, and socio-economic factors which influenced local planning and commissioning decisions. Ongoing updates to the JSNA ensured decision-making remained evidence-based and reflective of population needs.

The population of North Yorkshire was older than the England average, with 25.0% aged 65 years and above, compared with the England average of 18.4%. The JSNA data showed North Yorkshire faced significant demographic change, with a growing proportion of older adults. This trend was linked to rising demand for services related to dementia, frailty, and end-of-life care. The local authority had projected a 24% increase in demand for residential dementia beds and 14% increase in demand for nursing placements, and the provision for nursing beds was increasingly challenged for adults with dementia. In response to this, the local authority had heavily invested in plans to develop Care and Support Hubs which included the offer of intermediate care and specialist dementia residential care for over 250 people. It was also working with partners to co-design a new approach to commissioning residential and nursing care for people with advanced frailty and dementia.

The local authority's extra care framework incorporated rural needs and cultural diversity by ensuring extra-care housing was designed to keep people within their communities, allowing them to maintain local social connections. Tailored housing solutions accommodated ex-servicemen under the military covenant, coordinating social care, health, and housing services to provide holistic support. Community Anchor organisations played a vital role in capturing local voices, feeding insights into service planning, and ensuring inclusion for smaller rural populations. Digital inclusion initiatives helped people access services, particularly in farming communities, through outreach at auction markets and local libraries. A person-centred housing process enabled people in rural areas to remain near their families, ensuring care was tailored to their specific needs and lifestyle preferences.

The JSNAs highlighted under-served populations including people with learning disabilities, unpaid carers, Gypsy Roma Traveller and Show People communities, and individuals with mental health conditions, indicating the need for targeted, culturally competent support. A leader told us about the success of the Reducing Exclusion for Adults with Complex Housing Needs (REACH) model developed in Scarborough. This model, designed for people with high and complex needs, was being adapted for other areas, with adjustments to reflect local demographics, rurality, and specific needs such as support for veterans and mental health. Another leader told us the local authority was tackling inequalities by including several services within their prevention offer. For example, a sexual health primary offer, substance use, community pharmacy and primary care offer. They said they were targeting areas with the greatest inequalities, for example, those in rural areas and specific seldom-heard groups with the key focus of prevent, reduce and delay.

## Market shaping and commissioning to meet local needs

People had access to a diverse range of local support options that were safe, effective, and high-quality to meet their care and support needs. Data provided by the Adult Social Care Survey dated October 2024, showed 74.58% of people who used services felt they had choice over services. This was similar to the England Average of 70.28%.

The Health and Adult Services directorate worked closely with public health, housing, and the local Integrated Care Systems (ICS) to ensure their commissioning strategies were aligned with the strategic objectives of their partner agencies. The North Yorkshire Market Development Board oversaw the local authority's market shaping activities and oversight of the care market. It facilitated collaboration with partners to ensure provision of care and support was aligned with the diverse needs of local communities and contributed to meeting the Place Board objectives. The board's ambitions to transform the market over the next 3 years were set out in the Market Position Statement. This included workforce development, better commissioning, and greater provider stability. Progress included improved quality ratings, new dementia and intermediate care models, the co-design of specialist services, the growing homecare market and refreshed data tools to monitor supply and demand, all aimed at delivering responsive, inclusive services.

North Yorkshire Council had heavily invested in extra-care housing to provide older people and adults with disabilities the option to live independently while receiving tailored support. 28 schemes were developed, offering people self-contained flats with 24/7 care available. These housing options reduced isolation by encouraging community involvement and included accessible amenities like restaurants and hair salons. Support packages were flexible, allowing people to recover after hospital stays or adjust care as needed. Many schemes followed dementia-friendly design principles and welcomed pets and guests. Compared to traditional residential care, extra-care housing was more cost-effective and produced significant savings for the local authority. The extra-care housing options promoted person-centred care, choice and control, dignity, and safety which demonstrate high-quality adult social care.

Commissioning strategies included the provision of more suitable, local housing with support options for adults with care and support needs. The local authority already had around 1,500 extra-care housing units, which had supported approximately 6,000 people over the last 20 years. The commissioning strategy focused on diversifying provision through 3 main ways, core, complex needs, and rural extra-care models, such as the Bainbridge scheme, which supported both residents and the wider community by including a shop and a post office. As part of the 'Home First' priority, the local authority worked to reduce reliance on short- term residential care, expand extra-care housing, and test new models like Live-In Care and community-led pilots. Four new extra-care schemes were in development, with strong demand evidenced by 510 applicants. The local authority also aimed to improve supported housing for people with complex needs, including mental health, learning disability and diversity, through an investment plan and a new integrated intermediate care model co-designed with NHS and voluntary sector partners and investment in Care and Support Hubs for people with dementia. Market shaping efforts included standardising previously fragmented supported housing contracts and rebalancing provision geographically, such as in the Craven area, to ensure more consistent, needs-led services across the county. In addition to this, work to consolidate and localise the provision of home care was planned with a home care alliance model in Whitby, the development of Individual Service Funds alongside an improving picture on direct payment provision and work directly with the care market to develop a new commissioning approach for specialist care.

The North Yorkshire Substance Use Strategy 2024–2028 acknowledged a gap in drug and alcohol services, particularly in areas such as Scarborough where alcohol-specific death rates were high and treatment access was limited. Guided by JSNA data, the strategy responded by prioritising prevention, improving access to tailored support, and tackling drug supply chains. It committed to market shaping activity which targeted unmet demand and at-risk groups, including commissioning flexible, person-centred services and promoting co-production with people with lived experience. The strategy also drove integration across public health, housing, social care and criminal justice to build a more responsive and inclusive support system.

North Yorkshire Council recently became the lead commissioner for the community equipment service which was a large, complex system involving 17 prescribing organisations and 8 NHS trusts, including hospices, specialist hospitals, and children's services. Over 110 prescribing teams were involved. One key challenge was the financial pressure on care homes, especially around bariatric equipment, which was costly and rarely reused. In response, the local authority began co-producing guidance with community nurses, providers, and the Care Home Strategy Group to ensure fair access to equipment across all areas. Early plans were also being explored for an equipment library model to reduce waste and cost.

There was specific consideration for the provision of services to meet the needs of unpaid carers. The local authority had made several commitments to unpaid carers within its commissioning strategies, recognising their vital role in the care system. The local authority commissioned dedicated carers support services, including advice, emotional support, and carers' breaks designed to promote carers' wellbeing and help them sustain their caring role. These services were recommissioned in 2022 with a focus on outcomes, co-production, and long-term sustainability. Data from the Survey of Adult Carers in England showed 23.98% of carers accessed support or services which allowed them to take a break from caring for more than 24 hours. This was better than the England average of 16.14%.

The local authority also embedded carers' needs into its Market Position Statement and Strategic Market Development Plan, identifying carers as a priority group. This included commitments to improve identification, access to information, and support for carers to maintain employment and wellbeing. The strategy acknowledged the importance of respite, financial advice, and contingency planning, and promoted the use of Carers Emergency Cards and direct payments to offer flexibility.

In line with Care Act duties, the local authority ensured carers were involved in shaping services through consultation, forums, and co-production, and were committed to refreshing the Carers Strategy to reflect lived experience and changing needs. These actions supported the development of a more equitable, responsive care market which valued unpaid carers as partners in care.

A voluntary sector partner organisation told us they worked together with the local authority to improve and broaden the understanding of unpaid carers in the area, particularly to build awareness of young adult carers. The partner told us they had the opportunity to be involved in the tender process for this with the local authority and felt this was a good example of co-production work.

## Ensuring sufficient capacity in local services to meet demand

Partners, staff and leaders across North Yorkshire recognised that adult social care services were not always consistent in timing, location or delivery. This shared understanding led to targeted efforts to improve access and quality, particularly in areas where people's needs were not being met. The ongoing work focused on identifying service gaps, strengthening local provision, and ensuring that care and support were more responsive, equitable and person centred.

Data provided by the local authority in April 2025 showed there were 9 people waiting for a home care package with an average waiting time of 41 days. There were 3 people waiting for residential care, with an average waiting time of 91 days and 1 person waiting for nursing care with an average waiting time of 33 days. Leaders told us the 91-day average wait for residential care equated to 3 people with complex needs. By May 2025, these were all resolved. In May 2025, there were 4 people waiting for a care package. Three people had been waiting between 0-14 days, and 1 person had been waiting 2-3 months due to a complex situation.

Dementia care was a growing pressure. While there were many care homes across the county, there was a shift away from commissioning standard residential care toward services specialising in moderate to advanced dementia and frailty. The local authority had begun planning new specialist in-house and commissioned provision to address the growing pressures, starting with new Care and Support Hubs to be built in Harrogate and Scarborough.

Although the local authority had an ambitious plan to increase affordable housing stock to 40%, a partner felt the transition to a new unitary structure brought practical challenges, as delivering on these aims required coordination across services and careful planning to ensure housing supply met rising demand. To tackle these challenges, the local authority sought to bring services together through a single front door and assessment pathway for supported housing replacing the patchwork of legacy systems. This aimed to ensure more equitable access to services and better alignment of housing resources with local needs. One partner told us about a barrier for the people they supported was the limited availability of housing stock in the area. The shortage significantly disrupted people's housing journeys, often causing setbacks as they aimed to move from emergency accommodation to hostels, managed flats, and, ideally, into permanent housing.

We also heard examples of the positive impact of targeted support. A notable success involved a person overcoming drug misuse, securing stable housing, and being reunited with their children, demonstrating the transformative impact of structured support. Staff told us an increase in crisis housing would support them to coordinate timelier discharges from hospitals, preventing homelessness for vulnerable people. Another example of specialist provision helping to meet a vital need was a service commissioned to provide support for domestic abuse and sexual violence. The service received over 1,000 referrals each week, with about half coming from the police. A long-term commissioning arrangement, with the option to extend gave the service stability to plan and improve delivery.

While concerns were raised from a partner about fragility in the home care market, particularly around Harrogate, resulting in perceived delays to hospital discharge and pressure on bed availability, the data shows that such delays were limited and often linked to complex individual needs rather than systemic failure. Leaders in the local authority reported most discharges proceeded without requiring social care input, with only about 20% needing such support, and an escalation process was in place but had not been triggered. In June 2025, of the 13 patients delayed over 14 days, only two were affected by market-related issues, both of whom were self-funding and declined available options. Despite the geography of North Yorkshire presenting challenges, overall discharge rates remained steady, averaging 24 per day in May 2025, suggesting that system resilience was maintained in most cases.

Leaders also provided data which showed the Harrogate and Rural Alliance area had the most pathway 2 discharges across all 5 localities and were the highest achieving in terms of discharge times for pathways 2 and 3. In Harrogate, only 1 older person's residential care home had closed in the last 3 years and had since reopened under a new owner. Three care homes specialising in support for working-age adults had closed since 2023. Harrogate had the highest number of care homes across localities in North Yorkshire and there were 14 commissioned intermediate care beds. Data provided by the local authority showed in 2024/25, care home occupancy averaged 86%, with 57% of people returning home following an average stay of 24 days.

The local authority's Brokerage team worked to match care packages with vacancies and wherever possible respected people's preferences. For example, enabling a husband and wife to remain together in the same care home. However, limited availability in some areas, such as Whitby, reduced options and led to more people entering residential care, even when extra-care or supported living would have better met their needs. The lack of supported housing for people with disabilities, mental health conditions, and experiences of abuse was also identified by staff as a priority gap.

The local authority used services in places outside of North Yorkshire. However, there were plans in place to increase the capacity of specific services so people could move back if they wished to do so in the future, and some provision had recently been increased. Many placements were within a short radius of the North Yorkshire border, with neighbouring local authorities hosting placements. Leaders told us, these placements were often closer to family members and the community. Where services were commissioned jointly with other agencies, there were clear roles and accountabilities for monitoring the quality of the services being provided and the outcomes for the people using them.

Data provided by the local authority showed a total of 590 people living in placements out of the county, 93 of those had a service which started in the past 12 months, with the primary support reason being physical need (54%) and the placement type was residential care. Young people with higher support needs, requiring 24-hour care, often faced challenges in securing suitable placements beyond supported living. Out-of-county placements were sometimes necessary due to service gaps locally. Leaders and staff followed a strict protocol which fostered ethical decision-making for out-of-county arrangements. It promoted the Best Interest's framework in conjunction with the Mental Capacity Act, and the need to support contact with family members for accessible and personalised care.

## 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.

An integrated Quality Team working closely with health partners acted as a single point of contact for providers, supported by regular joint visits and a clear risk-based assurance process. Weekly multi-agency meetings were held to assess provider performance and determine levels of contact based on risk. Each approved provider was reviewed, given a risk rating, and assessed through structured tools which aligned with the Care Quality Commission (CQC) and national quality frameworks. When concerns were identified, for example in out-of-area placements, the team liaised with host authorities and recommended contract suspensions, supported by time-bound intervention plans involving clinical professionals where necessary. These plans were closely monitored, allowing phased reinstatement when improvements were embedded.

Quality officers were aligned to specific locality teams, helping to build trust with frontline staff and respond swiftly to concerns. The team maintained positive working relationships with their colleagues and used feedback tools like the 'PERSON Form' to gather intelligence from service visits. Their focus remained on helping services to improve rather than close. One example highlighted their quick action following a sudden drop in standards at a care home. The team responded immediately, engaged with the interim manager, and supported the home to make lasting changes, leading to a "Good" CQC rating and national recognition for their Principal Nurse. Feedback was actively sought from people using services and their families through on-site visits, care reviews, and visible engagement tools. The team's proactive, person-centred approach had earned them national recognition for supporting vulnerable people and enabling providers to improve and remain sustainable.

The local authority had a good provision of CQC registered adult social care services. This included home care, residential care, nursing care, and supported living services. Overall, 75.73% of those services were rated Good, and 4.75% rated Outstanding, meaning they were safe, effective, and provided a high-quality standard of care, which met people's needs. A key success for the Quality Team was that of the 40 providers they supported in their first year of inception, 11 providers (28%) achieved an improvement in their CQC ratings from Inadequate and Requiring Improvement to Good, promoting market sustainability.

The Market Development Team had a close partnership with the integrated Quality Team to address concerns such as workforce challenges, financial risks, and service hand-backs. By tracking trends and delivering targeted interventions, they helped reduce provider suspensions and service failures. The Market Development Team consisted of 12 members, each responsible for different parts of the county and/or market sectors but working collaboratively across the council area. They offered one-to-one provider surgeries to address issues ranging from contractual queries to financial stability, acting as a "critical friend" and key contact point. Insights on provider performance and market dynamics were captured in a Market Share Report to support strategic planning around sustainability and service gaps. In response to the sector's feedback, they had also begun rolling out dementia training through a train-the-trainer model and were developing a new bespoke contract to better support specialist care outside the current approved provider framework.

A partner highlighted the local authority's positive working relationship with the CQC, with monthly meetings in place. They told us risks were well managed, and the Quality Team acted quickly and appropriately to prevent issues from escalating, using the necessary resources. A monthly CQC Strategic meeting, chaired by the local authority's Assistant Director and attended by the Integrated Care Board, followed a set agenda. Topics included system pressures, updates on provider suspensions, and learning from incidents. There had recently been a focus on overseas recruitment, particularly where providers employed large numbers of international staff and risk assessments were planned in the event of changes to the rules about their employment.

Overall, partners felt there had been strong quality oversight, and the right support was in place for both people and providers. An NHS partner said the Integrated Quality Team had effectively supported struggling care providers. This helped prevent care home closures and kept beds available for their patients.

Data provided by the local authority dated February 2025 showed a total of 27 providers were in the stage of suspension or a phased uplift with key themes for suspensions including poor record keeping, late calls, and omitted medication calls.

## Ensuring local services are sustainable

The local authority provided wide-ranging support to help sustain and develop the local care market. It worked closely with the Independent Care Group (ICG), which represented providers and played a key role in shaping transformation and sustainability plans. The ICG also ran regular engagement events. To keep providers informed and connected, the local authority and the ICB hosted 'Care Connected', an online forum which enabled updates, questions, and sharing of good practice. High attendance and strong feedback showed it was well received.

The local authority collaborated with care providers to ensure the cost of care was transparent and fair, while striving to support the long-term sustainability of services. The Care Market Financial Sustainability Policy, March 2024 outlined how the local authority supported care providers facing financial challenges, including their approach to inflationary uplifts, risk-based assessments, and potential financial interventions. It also recognised sustainability extended beyond funding; it could also involve support with workforce pressures, training needs, or business model viability. When providers raised concerns, such as increased National Insurance Contributions or the impact of recruiting international staff, the local authority offered tailored support in response.

To strengthen service delivery and manage costs more effectively, the local authority had created a new contract management team. This team focused on building positive relationships with providers while improving contract governance and generated efficiencies through negotiations, issue resolution, and managing disputes. Governance arrangements were being strengthened to ensure a balanced approach between market sustainability and value for money.

In advance of its 2023–2024 Market Sustainability Plan, the local authority applied an 'actual cost of care' model to establish fair pricing for placements, ensuring fees reflected the real costs of delivering care. This approach was used alongside the Approved Provider List, which set quality and cost benchmarks for contracted providers. Despite these measures, around 75% of care homes charged fees above the calculated market rate, creating concerns about long-term financial sustainability and affordability. In response, the authority engaged in constructive dialogue with an independent care provider network, to explore collaborative, long-term solutions and support a stable, high-quality market.

Strategic efforts were also underway to develop the social care workforce, such as better use of data and case studies to shape future commissioning decisions. Challenges were identified in supporting young people who required personal assistants for independence and skill development. Some areas faced difficulties in providing tailored support, prompting trials in certain parts of North Yorkshire to increase pay rates for personal assistants and attract more staff to these roles.

The rising cost of building new extra-care schemes posed a significant challenge. Although Homes England had increased funding, a notable shortfall remained, requiring the local authority to contribute more. Additional barriers included limited access to suitable development sites and potential workforce shortages. Despite this, the local authority worked to make new schemes more community-facing, designing spaces with cafés and shared areas to encourage integration into community life and improve use of local authority-owned land.

Partners gave mixed feedback on the local authority's contracting approach and its impact on service stability and forward planning. One voluntary sector partner said they welcomed the rare award of a 10-year contract, which allowed them to invest in long-term development. In contrast, another partner highlighted sustainability as a key challenge, noting their short-term funding made it difficult to maintain and grow their relatively new service.

Feedback from staff and care providers confirmed the local authority worked with providers and partners 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.

The provider failure policy outlined the local authority's response to situations in which a care provider either failed or was at risk of failing. The policy aimed to protect people receiving care by ensuring continuity and safeguarding their well-being. It also promoted a coordinated, multi-agency approach involving health services, regulatory bodies, and other relevant partners. The local authority acted quickly and proportionately in response to failures which stemmed from financial instability, operational issues, or concerns over care quality. A key factor was the Risk Notification Return system, which enabled providers to report incidents that might indicate organisational instability, including missed visits, medication errors, or environmental concerns. These reports supported the Quality Team in monitoring risks and taking early, preventive action. In the event of a provider failure, the local authority assumed responsibility for ensuring continued care for all affected people, including those who privately funded their care. Clear communication with people and their families was prioritised, and lessons from each incident were used to strengthen future responses.

Data provided by the local authority showed throughout 2024 there were 4 care home failures affecting 23 people and 10 home care provider failures affecting 395 in their homes. Two day services had also been reported as a provider failure affecting 27 people. The reasons for failures were linked to consolidation of locations, financial viability, and the revocation of sponsorship licences. Leaders told us a notable development had been the creation of the integrated Quality Team to prevent market failure and promote quality of care and stability. To promote further sustainability, the local authority had introduced a Care Market Financial Sustainability Policy to provide financial support to providers.

The local authority understood its current and future social care workforce needs. It worked with care providers, including personal assistants and other agencies, to maintain and support capacity and capability. The Market Development Team worked in partnership with the workforce lead to support local recruitment initiatives and developed international workforce strategies where needed. For example, a pilot project in Whitby focused on building a place-based workforce model in partnership with home care providers and in-house teams, using packages shared between providers to improve flexibility and partnership working.

North Yorkshire Council have a vacancy rate ranged between 5% and 7% with a turnover rate of 5.3%. The local authority leaders recognised the significant impact of rural geography and competition from health partners. Lower pay rates in the independent sector (compared to local authority roles) further challenged recruitment in the independent sector. To address these issues, leaders focused on initiatives such as promoting social care careers in schools and colleges, maintaining a capacity tracker to monitor workforce capacity in individual services, and implementing targeted interventions.

The Yorkshire and Humber area secured funding in 2024 from the Department of Health and Social Care as part of a government initiative to provide support to displaced workers. North Yorkshire played a key role in regional efforts to strengthen workforce resilience through the Yorkshire and Humber regional international recruitment Hub which focused on helping displaced workers find suitable placements within the Adult Social Care sector. It aimed to ensure ethical and sustainable recruitment, connecting care providers with qualified people already in the United Kingdom who needed sponsorship. The hub provided support to care providers, including bursaries and training to enhance their capacity to recruit and support international workers. In cases where providers had their sponsorship licences suspended, local authority staff recognised affected overseas workers as potentially vulnerable people, working with the police to investigate well-being concerns such as modern slavery.

The local authority told us the ‘Make Care Matter’ campaign had supported around 400 providers through advertising, roadshows, and emergency responses, and had successfully placed 73 young people into care roles via a Prince’s Trust programme. It also contributed to international recruitment efforts by introducing a Graduate International Recruitment Officer and supporting care providers navigating sponsorship challenges. The local authority told us ‘Make Care Matter’ helped bridge workforce gaps, expand pathways into care roles, and strengthened the local authority’s capacity to respond to sector pressures. Additionally, the local authority's HR lead directed initiatives to support international recruitment, including free English language courses to address language barriers in home care. A partner representing providers praised the local authority’s efforts in training, recruitment, and business continuity, particularly the effectiveness of collaborative work between the ‘Make Care Matter’ team and the regional recruitment hub.

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# 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 partners to agree and align strategic priorities, plans and responsibilities for people in the area. A partner told us they had a really good working relationship with the local authority where they felt their input was valued and viewed it as a successful partnership where they met regularly to discuss alignment of strategic priorities and plans.

The local authority worked in a complex health and care system with non-contiguous boundaries, involving multiple NHS and community partners. These partners played a key role in delivering the local authority's programmes and were active members of local boards. Despite the scale and complexity, the local authority reported strong partnership working, often described as 'Team North Yorkshire'. The Health and Wellbeing Board, chaired by the Executive Member for Health and Adult Services, brought together all major partners in the local health and care system.

As part of the local authority's approach to prevention and voluntary and community sector partnerships, the Public Health-funded 'Stronger Communities' programme worked with local people, community groups, voluntary and community organisations and other partners from the public and private sectors across North Yorkshire. It empowered communities to develop local solutions and services to meet their needs, aiming to reduce inequalities, improve the wellbeing and social connectedness of people of all ages and helped to prevent, reduce or delay the need for social care interventions. The support offer included organisational development and grant funding, which had invested in 1,016 projects in 200 communities across North Yorkshire since 2017.

The Thriving Communities Partnership, co-chaired by a voluntary and community sector organisation and the local authority, brought together the council and their health and voluntary and community partners. The effectiveness of local partnership arrangements was recognised as an area of strength in a 2023/24 peer review, reflecting partners' confidence in the Health and Adult Services senior leadership team and their engagement in local forums. To build on this strength, as part of its 'Involvement Framework' action plan, the directorate was exploring options for creating a 'Making it Real Board' to enhance partnership working particularly around the co-production of services with people with lived experience.

The Health and Adult Services directorate was working with other local authority departments and community partners to improve mental health and wellbeing and enable adults in North Yorkshire to live well. A whole system approach was being taken to mental health across sectors such as health, education, housing, and employment to create an environment where mental well-being could be promoted, and mental illness could be prevented or effectively treated. Examples of work included, Trauma-informed care, the national initiative 'Making Every Adult Matter' (supporting people facing multiple disadvantages), supported housing provision, Substance Use transformation, and Community Mental Health transformation. An annual local authority and voluntary and community sector workshop had been established, sharing good practice and discussing opportunities for improvement.

The Harrogate and Rural Alliance (HARA) brought together community health and adult social care services into a joined-up system for adults over 18 in the Harrogate area, particularly focused on integrated intermediate care and reablement services. Health professionals and social care staff worked as one team, linked to GP practices, to make sure people received support that addressed both their medical and care needs. Services were accessed through a single point, which made things simpler and more coordinated for those seeking help. The partners shared goals and managed budgets together to support better outcomes. The alliance focused on helping people stay independent and avoid unnecessary hospital stays, with a strong emphasis on early support and care close to home.

The local authority had integrated aspects of its care and support functions with partner agencies where this was best practice and when it showed evidence of improved outcomes for people. Due to the complex health landscape across North Yorkshire, system leaders had agreed to establish a Section 75 Joint Committee, known as the 'North Yorkshire Health Collaborative', bringing together Chief Executives and/or senior Directors from the main local government and NHS organisations, as well as voluntary and community, and care sector leads. This was due to commence in July 2025. The local authority was co-leading this and co-creating a joint work programme so there was a full integration of health and care in the area. System leaders wanted a single operating model and established clear roles and expectations. Early priorities included commissioned work to support greater collaboration between and with community health providers, GPs and the local authority, and more focus on prevention services.

The local authority and local NHS Trusts had integrated their hospital discharge teams by using a shared assessment and "trusted assessor" model within the Discharge to Assess (D2A) framework. Health and social care professionals worked together as 1 team, placing people on tailored discharge pathways and ensuring quicker, more coordinated transitions out of hospital. Staff from both sectors accepted the same assessment, completed by trained assessors in hospital or the community, including voluntary partners. This reduced duplication, freed-up hospital beds, and gave people the right support at home or in short- term care settings while their longer-term needs were reviewed.

The Social Care Mental Health service continued to work in partnership with NHS Trusts (and, in some cases, teams were co-located), focusing on prevention, crisis response and recovery. An Approved Mental Health Professional (AMHP) Triage Hub model was pioneered at Scarborough Cross Lane Hospital, with learning applied county-wide. AMHPs were continuing to work at a circa 30% diversion rate for people being assessed under the Mental Health Act. And the council and voluntary sector were working with 2 specialist Trusts to support the NHS-led Community Mental Health Transformation Programme (CMHTP) to ensure it built on the work already undertaken by the local authority and voluntary and community organisations. The local authority organised a series of workshops during 2025 with the NHS and other partners to scope out a single Mental Health plan for North Yorkshire, drawing on feedback from people with lived experience and voluntary and community sector organisations, and on organisational transformation plans.

## Arrangements to support effective partnership working

When the local authority worked in partnerships with other agencies, there were clear arrangements for governance, accountability, monitoring, quality assurance and information sharing. Roles and responsibilities were clear.

The Governance Framework 2025 sat alongside the Health and Adult Services Engagement Framework. To create this framework, the Governance Team worked with people who used services and leaders across Health and Adult Services to bring all governance processes into one place. This was to be monitored annually both by those responsible for the processes, as well as those who received the services.

The local authority used opportunities to pool budgets and jointly fund services with partners to achieve better outcomes. The Better Care Fund (BCF) was a major programme of joint investment between North Yorkshire Council and the NHS via the 3 Integrated Care Boards (ICB) NHS Humber and North Yorkshire ICB, NHS Lancashire and South Cumbria ICB and NHS West Yorkshire ICB, all of whom contributed to plans, either through the Adults Joint Planning and Commissioning Group or an extraordinary meeting. Compliance with national conditions was confirmed through quarterly planning templates and narrative plans discussed and co-produced at the Joint Commissioning Group. This integrated delivery of the BCF had driven the commissioning and improvement of integrated services across North Yorkshire.

In 2023-24, the BCF Section 75 Agreement supported key health and care priorities such as implementing Discharge to Assess, easing pressure on hospitals, and strengthening system leadership. Pooled funding from the local authority, ICB, Integrated Better Care Fund (iBCF), the Disabled Facilities Grant (DFG) and NHS sources was used to deliver 74 schemes (including 7 new ones). These covered areas like reablement, equipment and assistive technology, carer support, short-term care, additional beds, community mental health and nursing, advocacy, and adult social care funding pressures.

The local authority's Mental Health teams had many joint policies and procedures with the local Mental Health trusts, and the police. The AMHP lead officer linked in with health and system partners. They shared policies to support each other to make sure they covered all partners responsibilities in joint policies. For example, a joint S117 policy was formed from working groups with a local NHS Foundation Trust. Leaders were currently doing similar work with ICB colleagues on how they could implement the national Continuing Health Care framework on a local level.

Most voluntary sector partners spoke positively of effective partnership working. One partner told us communication channels with the local authority were strong, and partners felt able to escalate concerns directly to senior leaders. Another partner told us they had contract monitoring meetings with the local authority where they discussed strategic priorities and plans by formulating their key objectives for the next 6 months. Contract monitoring staff then returned and measured them on those and discussed what had been working well, what had not been working well and action plans on how to fix those issues for the following 6 months. A third partner told us they also had formal quarterly contract meeting arrangements with the local authority and felt there was an open door approach to communication, in that they could reach out to them for support or with concerns or queries as and when needed. They felt the local authority was responsive and accessible.

## Impact of partnership working

The local authority evaluated how its partnership working influenced the cost of social care and outcomes for people, using insight to drive continuous improvement. Leaders shared examples which highlighted how collaborative, responsive working delivered real benefits, improving people's lives while containing pressures on social care budgets. Through the 2024–25 Better Care Fund Plan, the local authority introduced a multi-agency approach to falls commissioned admission avoidance and step-up/step-down beds in Hambleton and Richmondshire helping people stay independent and easing hospital pressures. Monitoring showed measurable impact, with a reduction in residential placements (376 in 2024–25 vs 665 in 2022–23) and a decrease in recorded falls (2,441 vs 2,754). Discharge to usual residence remained high at 93%.

The Living Well programme bridged gaps by linking people to the right support and grants. Coordinators were proactive and responsive, ensuring help reached people who might not have otherwise accessed it. The 'Moving North Yorkshire' initiative promoted physical activity and resilience among older people through guided walks, home exercise programmes, and increased community involvement in shaping services. This local authority funded initiative empowered communities to take a greater role in service delivery, fostering local solutions and collective control over well-being.

During the COVID-19 pandemic a community hub was formed in the town of Leyburn to help people with transport, medical and hospital appointments, and isolation within the community. The community hub had since evolved into a long-term Community Anchor, with the help and support of the local authority. It hosted services such as Carers Plus and Citizens Advice, and a variety of other local support groups. With support from the local authority, they had formed a Community Partnership, which looked at how they could address concerns within the town and the surrounding parishes and villages. The partnership had identified future priorities such as transport, banking access, and end-of-life care. Due to the success in Leyburn and other areas the model has been extended to other parts of the county.

In response to a rise in neurodivergent referrals, the Mental Health team had adapted their practices, introducing personalised communication methods and drawing on specialist advice from a local NHS Trust's Neurodiverse officer. Staff received training on neurodiversity, and multidisciplinary teams provided holistic care tailored to individual needs. A multi-disciplinary approach provided comprehensive care, as seen in an example of a person with a late autism diagnosis and OCD, where Support Time Recovery staff built trust over months, ultimately supporting their personal care routine. The multi-disciplinary panel played a key role in coordinating interventions and ensuring effective collaboration across services.

## Working with voluntary and charity sector groups

Overall, the local authority worked collaboratively with voluntary sector and charity organisations to understand and meet local social care needs. The local authority provided funding and other support opportunities to encourage growth and innovation.

Local authority staff told us voluntary, community and social enterprise (VCSE) groups had sought local authority funding to pilot new services. Some initiatives faced difficulties due to uncertain demand, but commissioners provided short-term funding trials to assess viability. Collaboration between teams ensured services were tailored to community needs.

In North Yorkshire the Community Anchor organisations were well established, locally rooted VCSE groups which played a vital role in connecting people, local groups and other organisations to improve community well-being and resilience. There were 25 Community Anchor organisations which were deeply embedded in their communities, acting as a voice for local people, fostering collaboration and encouraging community-led initiatives.

A local infrastructure organisation worked closely with the VCSE sector, health, and adult social care partners, delivering support under commission from the local authority. Funded by the Department for Environment, Food and Rural Affairs (DEFRA), they provided rural advocacy to ensure the VCSE sector had a voice and could support itself. They established over 20 community networks and delivered more than 50 training programmes across Yorkshire. In North Yorkshire, VCSE representatives were active partners on all Health and Adult Services boards, including participating in recruiting the new Safeguarding Board chairperson. The organisation also sat on the North Yorkshire Health Collaborative, which aimed to align budgets under Section 75 agreements, and although the VCSE sector sat outside those arrangements, they said the local authority valued their input. They reported strong, responsive relationships with local authority senior leaders, enabling greater place-based collaboration and board-level representation.

A local charity working with voluntary and community groups was actively engaged in several strategic boards at the local authority, including the Safeguarding Adults Board, where they felt their voice was well represented. The charity's Chief Executive regularly met with senior leaders and reported feeling recognised and valued for their significant role in providing emergency and short-term accommodation. Although not commissioned by the local authority, the organisation collaborated closely with local authority services to support people experiencing homelessness within the Harrogate area, through weekly joint patrols, safeguarding work, and contributing to strategic discussions at board level. They noted the VCSE sector in North Yorkshire was given a strong voice and included early in planning processes.

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# Theme 3: How North Yorkshire 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: 3

3 - Evidence shows a good standard

## What people expect

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

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

## The local authority commitment

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

## Key findings for this quality statement

## Safety management

Safety was a priority for everyone. The local authority understood the risks to people across their care journeys; risks were identified and managed proactively; the effectiveness of these processes in keeping people safe was routinely monitored. Policies and safety processes were aligned with other partners involved in people's care journeys.

The local authority adopted a well-organised and joined-up approach to managing safety. Strong partnerships, early intervention, and active leadership helped reduce risks across care services. Clear governance supported these systems. By involving partners in key decision-making groups, the local authority gained a better understanding of how to prevent risks early. This helped make sure voluntary and community sector views were included in designing safe care pathways.

Cross-agency Boards helped oversee key areas such as mental health, continuing healthcare, and crisis support. The local authority also designed services which focused on reducing risk, such as intermediate care, urgent response, and reablement to help people stay safe at home and avoid hospital admission. Data was used actively to improve safety. For example, mortality reviews and live dashboards helped leaders and partners learn and adapt services when under pressure. Staff were supported with ongoing training, policy updates, and workshops to improve confidence and skills, especially around trauma-informed care and complex transitions.

Waiting lists were monitored and triaged across teams with management oversight to ensure people with the highest need or at most risk were prioritised. Referrals were initially screened, and immediate action was taken as necessary to mitigate or reduce risks until longer-term support was put in place. There was a comprehensive process used out-of- hours to ensure people received the same level of service and protection from harm outside of normal working hours.

The Emergency Duty Team (EDT) played a key role in managing safety by delivering out-of-hours social care across North Yorkshire and York. It operated during evenings, nights, and weekends to support both adults and children in urgent situations. Calls were filtered through a central number, with urgent issues passed directly to the EDT. The team supported mental health assessments, responded to environmental emergencies, and helped ensure vulnerable people remained safe when regular services were closed. The EDT had worked to educate daytime teams about its role as an emergency response service, rather than a continuation of daytime care. Presentations and team meetings helped set clear expectations, improving collaboration between departments. Staff in hybrid roles strengthened links between daytime and out-of-hours services. To strengthen workforce capacity, the EDT used relief and auxiliary staff, often with previous experience in out-of-hours or daytime services. Many staff had worked across North Yorkshire and York, improving cross-border collaboration. The EDT's focus was on quick, coordinated action to protect those at immediate risk.

In response to peer review feedback highlighting gaps in recorded risk assessments and overall risk management, existing work was accelerated to develop 'Team Around the Person' Practice Support meetings. These meetings brought together a multi-disciplinary team to assess and manage risk using psychological formulation tools, aimed at better supporting people facing multiple disadvantages. Both internal staff and external partners, including the police, housing services, domestic violence agencies, NHS staff, and children's services took part. Specialist psychologists from a local NHS Trust helped guide discussions, assess risk, and create support plans for complex situations. These meetings offered an alternative approach to managing risk and practice where safeguarding thresholds were not met, but concerns remained.

Staff told us they were well-rehearsed in responding to unplanned critical events in North Yorkshire such as extreme weather events or large-scale power cuts. Learning from each incident informed practice at the next incident. There was a current focus on people who used care and support services having planned contingencies to keep them safe in the event of service disruption or carer breakdown. Leaders used clear processes to monitor risks. These included daily performance reviews, regular strategic board meetings, and an escalation system (Bronze-Silver-Gold) to quickly respond to discharge delays, staffing issues, seasonal pressures, and safeguarding concerns.

Staff highlighted ongoing workforce shortages which compromised service safety and consistency. Recruitment and retention remained particularly difficult in specialist areas such as within the Approved Mental Health Professionals (AMHP) service and with Mental Health social workers. In response, leaders had begun planning new specialist teams through the ongoing restructuring of the Health and Adult Services directorate. The local authority worked closely with NHS partners to deal with recruitment and staff shortages. For example, it used Adult Social Care Discharge Fund money to fund posts which helped coordinate safer hospital discharges.

Staff and partners told us a lack of local specialist provision had led to increased use of out-of-county placements, affecting continuity of care. Access to crisis support from partner services especially for people with substance use or trauma needs faced sustained pressure. Although training and support networks were introduced, these initiatives had not yet become fully established.

Information sharing protocols supported safe, secure, and timely sharing of personal information in ways which protected people's rights and privacy. Local authority and hospital staff had access to shared systems which allowed them to view records for a more holistic view of the person they were supporting and reducing the number of times a person must retell their story. This allowed better communication between services and improved the safety and timeliness of people receiving care and support.

## Safety during transitions

Care and support were planned and organised with people, together with partners and communities in ways that improved their safety across their care journeys and ensured continuity in care. This included referrals, admissions and discharge, and where people were moving between services.

The local authority developed a clear and joined-up approach to help people move safely through different stages of care. This covered transitions from childhood to adulthood, hospital discharge, moving between areas, and starting long-term support. The approach involved close working with the NHS, education, the voluntary and community sector, and other key partners. It was supported by formal processes such as Preparing for Adulthood (PfA), hospital discharge procedures, the Acute response & Rehabilitation in the Community and Hospital (ARCH) service, and local discharge hubs.

Using the PfA framework, staff started early with young people making referrals to adult services by age 14 and completing Care Act assessments by age 17 years and 3 months. Specialist workers supported transitions, and occupational therapists worked with children's services. Tools such as PfA passports and workshops helped young people get ready for adult life.

Some parent carers said communication before transition had been inconsistent, especially when there were staff changes or unclear roles. In response, the local authority had increased capacity, improved staff training, and updated how information was shared. One parent carer said their adult social care experience was far superior to children's services, and everything was provided at the right time. They added, adult social care went above and beyond to support. The Special Educational Needs and Disabilities (SEND) Strategy 2023–2026 set goals to reduce reliance on Education, Health and Care Plans and improve support outcomes. But a joint Ofsted and CQC SEND inspection in 2024 found delivery varied and asked the local authority to improve oversight.

The local authority and NHS worked together to provide transitional care using an Intermediate Care model focused on helping people return home safely and avoid unnecessary hospital stays. In 2023/24, 815 reablement packages were delivered, usually starting within 6 days of discharge. The local authority had extended the service to operate 7 days a week and commissioned 73 extra intermediate care beds. Voluntary and community sector partners supported over 2,000 people annually through the 'Home from Hospital' service, exceeding targets. As a commissioned service it was not included in national Adult Social Care Outcomes Framework data, however leaders said it played an important role in supporting safe discharges.

Teams based at discharge hubs met daily and used checklists and escalation frameworks to manage safe transfers. The Harrogate team had achieved good results through its Discharge-to-Assess pathway: the ARCH programme combined urgent response, therapy, and nursing to support people leaving hospital.

Despite good progress, staff highlighted ongoing difficulties. These included shortages of bridging services, variable reablement availability, and staff shortages in areas such as Scarborough and Whitby. Incompatible digital systems and rural access issues also made transitions harder in some areas. In response to this, leaders told us they had not had any issues raised by people, reablement or bridging services and the approach consistently delivered good outcomes.

Mental health teams focused on people with severe and enduring mental health needs. However, services still faced delays in NHS dementia diagnoses, a shortage of nursing care beds, and discharge delays due to gaps in community services. In March 2024, the NHS launched a new mental health crisis phone line to help people get urgent support faster. At the same time, senior leaders across the system began joint reviews to improve how transitions were managed. Staff also reported long waits for Deprivation of Liberty Safeguards (DoLS) decisions, due to a shortage of advocates and limited specialist services. These challenges were being considered in future planning.

Specific consideration was given to protecting the safety and well-being of people who were using services which were located away from their local area, and when people moved from one local authority area to another. The Quality Team monitored these providers and raised concerns when needed. The updated Health and Adult Services policy (July 2024) gave staff clearer instructions for how to manage cases when people move between local areas.

Overall, the local authority showed real progress in helping people move safely between services. Staff and partners shared positive examples of how planning, recovery services, and integrated working supported people through major life changes. While some challenges remained such as digital issues, workforce shortages, and rural service gaps, leaders took steps to learn, adapt, and improve transitions across the system.

## Contingency planning

The local authority undertook contingency planning to ensure preparedness for possible interruptions in the provision of care and support. The local authority knew how it would respond to different scenarios; plans and information sharing arrangements were set up in advance with partner agencies and neighbouring authorities to minimise the risks to people's safety and wellbeing.

Leaders told us Business Continuity Plans, Business Impact Assessments and Incident Management Plans were stored in a cloud-based space which could be accessed in the event of a cyber-attack or complete IT system failure. They said any response to incidents was coordinated by the Quality and Service Continuity staff within the Quality Team.

The local authority showed a strong, system-wide focus on contingency planning through joint working between the Emergency Duty Team, senior leaders, and health and care partners. Their response to flooding, carer emergencies, and hospital discharge pressures showed practical and coordinated action. We reviewed robust documentation describing its emergency plans, including the Major Incident Plan, Recovery Plan, Flood Plan, and Adverse Weather Events Plan. We heard from staff and leaders how these plans had been tested in real-life scenarios. For example, during heavy flooding in Malton, they described how public health and adult social care teams, alongside senior leaders, telephoned people to check whether they had electricity, medication, and food. They demonstrated how they responded quickly with practical help.

The Emergency Duty Team (EDT) told us managers were on-call 24/7 to support them in emergencies. During major incidents like floods or power cuts, senior leaders took charge of keeping services running. Team leaders said they used weekly Hazard Advisory meetings to prepare for risks like severe weather or public events. For example, before protests at a local power station, the EDT held a separate meeting to plan for people who might be at risk.

The EDT also explained how they responded when carers were suddenly unavailable to look after the people they cared for. They first contacted in-house providers for emergency care. If none were available, they reached out to external providers. If no services were found, EDT staff transported people to temporary accommodation. They only used hospital admission as a last resort. Carers gave positive feedback about tools like the Carers Emergency Card. A carer told us they had a 'Carers Emergency Card' so if anything happened to them, people could see they were registered as a carer. This helped emergency responders act quickly to keep those they cared for safe and provided reassurance for carers.

Staff who supported people with learning disabilities and autism encouraged families to plan five years ahead. They worked with parents early to explore options like independent living, helping reduce the risk of emergency situations later. Mental health leaders built contingency planning into their service model and planned to expand drug and alcohol hubs to include mental health support. They recognised many people needed joined-up care in one place.

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# 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

There were effective systems, processes, and practices to make sure people were protected from abuse and neglect. National data from the Adult Social Care Survey 2024 showed 73.69% of people who used services felt safe. This was similar to the England average of 71.06%. The data also showed 91.67% of people who used services said those services had made them feel safe and secure. This was also similar to the England Average of 87.82%. National data from the Survey of Adult Carers in England 2024 showed 85.06% of carers felt safe. This was better than the England average of 80.93%.

The Joint Multi-Agency Safeguarding Policy and Procedures provided a comprehensive and detailed framework for safeguarding adults across partner agencies. It reinforced collaborative work, including transitional safeguarding to prevent young people from losing support at age 18, and responded directly to learning from safeguarding reviews. The document promoted professional curiosity through guidance on repeated concerns and included significant case studies and risk assessment tools to support practice. It covered safeguarding topics such as cuckooing, modern slavery, scams, radicalisation, and extreme violence, with clear procedures for responding locally. The policy sets out expectations for information sharing with reference to the 'Seven Golden Rules', emphasising GDPR was not a barrier to safeguarding. It also embedded guidance on the Section 42 Care Act duty, along with referral pathways, urgent risk tools, and a four-stage referral process. The procedures promoted personalised safeguarding, ensuring people were central to decisions, and supported staff with clear, evidence-informed guidance.

Each locality team managed their own safeguarding enquiries, however, there was a safeguarding advisory function which supported staff with enquiries, investigations and decision-making if additional support was required. All safeguarding referrals were initially handled by the county-wide Prevention and Access Team. If the person was already known, the case was passed directly to the named worker in the locality team. If not, the Prevention and Access Team took the lead, gathering information from the referrer and the person involved, where possible. They did not carry out visits but focused on initial risk assessment and immediate safety actions, such as referrals to services like Living Well. Managers decided whether the concern should progress to a Section 42 enquiry and, if so, allocated it to an enquiry officer. Cases deemed high risk or requiring in-person visits were transferred to locality teams. Staff aimed to contact people within 1 day to ensure safety, followed by a 5-day period for gathering further information and determining the next steps. Where appropriate, a multi-agency approach was recommended to ensure effective safeguarding interventions.

The local authority worked closely with the North Yorkshire Safeguarding Adults Board (NYSAB) and its partners to ensure a coordinated and effective approach to adult safeguarding. There was a strong multi-agency safeguarding partnership in place, with clearly defined roles and responsibilities for identifying and responding to concerns. Information sharing arrangements enabled concerns to be raised and acted upon promptly.

Together, all partners focused on evidence-based policy, strong multi-agency collaboration, and supporting practitioners to deliver best practice. The Board's leadership, including active NHS involvement, helped maintain robust governance and accountability across the system. Partner agencies participated in safeguarding campaigns and webinars, and their performance was monitored through multi and single-agency audits and case reviews using a structured, 4-tier approach. Sub-groups met regularly and were empowered to report directly to the Board, improving transparency and strengthening inter-agency relationships. The Board launched a 3-year strategic plan centred on connection, prevention, and confident practice, targeting key issues such as self-neglect, youth transitions, and rough sleeping. Sub-groups brought additional perspectives into decision- making, ensuring the voices of those not directly represented at Board level were included in shaping safeguarding priorities.

NYSAB promoted co-production by involving people with lived experience in shaping practice, supported by a Keeping Safe Champion and expert guidance from the local authority's Participation & Involvement Team. This approach was nationally recognised and shared regionally.

The annual Safeguarding Week campaign, delivered in partnership across North Yorkshire, York, and East Riding, raised awareness of key safeguarding issues through online workshops and community events, engaging over 10,000 people in five years. The 2024 campaign led directly to further practitioner training in suicide prevention. Regular Community Safety Hub meetings brought together a wide range of agencies, operating under formal information sharing agreements. The local authority played an active role in prevention work, taking a holistic and proactive approach to safeguarding people at risk of harm, including those facing homelessness.

All local authority staff involved in safeguarding work were suitably skilled and supported to undertake safeguarding duties effectively. Partners had access to the local authority's safeguarding training platform, and they also had their own arrangements in place. In 2024/25, a total of 960 wider sector staff attended Safeguarding level 1 training and a further 112 managers attended level 2. They told us they learned from Safeguarding Adult Reviews and found the local authority to be a good partner. One partner said their Safeguarding Lead had a good working relationship with the local authority safeguarding team, and they felt well connected.

## Responding to local safeguarding risks and issues

People in North Yorkshire faced a range of safeguarding risks shaped by rural isolation, mental health needs, housing instability, and complex transitions between services. Issues such as self-neglect, substance misuse, domestic abuse, and exploitation, including scams and modern slavery were of particular concern. Young people moving from children to adult services and those living in supported housing were especially vulnerable, as identified in Safeguarding Adult Reviews. In response, the local authority and its partners took targeted action through improved policies, training, and early intervention. Initiatives such as the REACH model, weekly Community Safety Hub meetings, and locally designed services in rural areas strengthened person-centred support. Campaigns such as 'Safeguarding Week' helped raise awareness and encouraged further learning, while efforts to improve digital access and feedback mechanisms aimed to include seldom-heard voices. These approaches demonstrated a system-wide commitment to prevention, collaboration, and continuous improvement.

The Principal Occupational Therapist told us the Occupational Therapists in the Prevention and Access team were actively involved in gathering information for safeguarding enquiries, working closely with care homes and professionals. Their involvement had helped support a quicker approach to over half of these enquiries.

The Quality Team worked with health colleagues to improve care pathways and participated in safeguarding meetings where systemic issues were identified. This allowed them to respond to emerging quality themes both at the individual service level and across the wider system.

Lessons were learned when people had experienced serious abuse or neglect, and action was taken to reduce future risks and drive best practice. For example, learning from two SARs reflected the critical importance of robust, joined-up safeguarding systems for people at risk of harm. In both cases, gaps in multi-agency coordination, professional curiosity, and risk management had significant consequences, highlighting the need for more proactive, person-centred approaches.

One case revealed how unclear responsibilities and procedural limitations in supported housing settings could delay vital safeguarding action. Their death due to substance-related toxicity led to recommendations for improved oversight of non-CQC registered providers, clarity on lone working policies, and greater preparedness among staff to identify and act on safeguarding risks. The themes across both SARs emphasised the need for earlier intervention, clearer escalation routes, and a shared culture of accountability across services. Action plans have since focused on strengthening collaboration, embedding learning into practice, and ensuring safeguarding systems were responsive to both complexity and individual need.

Over the past 5 years the Safeguarding Adults Board had seen a steady increase in the number of SAR referrals regarding people with complex life circumstances and multiple disadvantages, such as self-neglect, homelessness, substance use and mental health, including suicidal ideation. Leaders told us they felt learning from published SARs and those identified for discretionary learning was seen as crucial for practice development and identifying key improvement areas. The Board recognised it needed to be more rigorous in monitoring and seeking assurance that learning from SARs had been embedded and positively impacted practice and service delivery. This was planned to be achieved through regular audits, thematic analysis, and deep dive exercises.

## Responding to concerns and undertaking Section 42 enquiries

Staff followed clear and robust policies and procedures when carrying out Section 42 (s42) safeguarding enquiries. They consistently demonstrated an understanding of when concerns met the s42 threshold and recorded clear rationale for decisions, even when cases did not progress. In 2023, the local authority received 4,435 safeguarding concerns, with 2,200 (50%) progressing to a s42 enquiry under the Care Act 2014.

There was a defined process in place, beginning with fact-finding and moving to investigation or alternative actions such as assessments, complaints, or referrals to other services. When enquiries were carried out by partner agencies, the local authority retained oversight and responsibility. Criminal safeguarding matters were referred to public protection and police, who communicated directly with social work teams on urgent cases.

To improve practice, leaders conducted regular audits and safeguarding activity reports, monitored enquiry officer capacity, and reviewed why some people withdrew from the enquiry process. Digital recording systems supported quality assurance, and staff received supervision, reflective practice, and used forums for advice. Managers, including the Principal Social Worker, monitored the process and recorded quality.

As of April 2025, there were no outstanding safeguarding referrals awaiting initial review but 41 s42 enquiries awaited allocation. At the same time, 987 Deprivation of Liberty Safeguards (DoLS) applications were awaiting allocation, though all had been risk assessed. Additional Best Interest Assessors (BIAs) and s12 doctors had been recruited, and training was underway to address capacity challenges. Despite a target timescale of 21 days for standard DoLS applications, the median wait time was 83 days, with some delays longer.

Staff kept people and referrers involved throughout the safeguarding process and acted to reduce future risks. Some partners confirmed they were informed of outcomes when required for safety, however others reported delays and said they had to chase responses, which sometimes delayed their ability to close cases. Leaders told us sometimes due to confidentiality it was not always appropriate to feed back to a referrer.

Some partners and providers were frustrated with some aspects of safeguarding processes. They reported difficulties with communication, including not always receiving outcomes to referrals they had made.

## Making safeguarding personal

The local authority's safeguarding strategy followed the Making Safeguarding Personal approach, aiming to create a culture focused on personalised outcomes. Safeguarding practices were person-centred, with policies and procedures reflecting this commitment.

Safeguarding enquiries were handled sensitively and without delay, ensuring the wishes and best interests of the person remained the priority. People received clear information to help them understand safeguarding and what being safe meant for them. Leaflets were available in easy-read formats to support understanding. Staff guidance outlined clear, step-by-step processes, beginning with a conversation with the person at risk. This approach ensured safeguarding remained focused on outcomes and individual needs.

People were encouraged to be involved in safeguarding decisions as much as they wished, with advocacy support available if needed. Safeguarding support aimed to balance risk with positive choice and control. Staff supported carers and families in understanding a person's right to make unwise or risky decisions if they had full capacity.

People were helped to understand their rights, including protections under the Mental Capacity Act 2005 and Equality Act 2010, as well as their Human Rights. Data from the Safeguarding Adults Collection in England 2024 showed that 93.83% of people in North Yorkshire who lacked capacity received support from an advocate, family, or friend, which was significantly better the national average of 83.38%.

Staff emphasised safeguarding interventions placed people's wishes and preferred outcomes at the centre. They ensured people were involved throughout the process, working alongside family or advocates when appropriate, and incorporating their views into strategies and decisions. Staff recorded and monitored data on preferred outcomes, focusing on enabling positive risk-taking while respecting capacity.

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# 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: 3

3 - Evidence shows a good standard

## 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

There were clear and effective governance, management and accountability arrangements at all levels within the local authority; these provided visibility and assurance on the delivery of Care Act duties. There were also clear risk management and escalation arrangements. These included escalation internally and externally as required.

The Governance Framework 2025 was developed collaboratively with people and Health and Adult Services leaders to consolidate all governance processes into a single, transparent system which was reviewed annually by both providers and people who used services. It aimed to ensure high-quality, person-centred care by fostering continuous improvement, learning, and accountability, and was supported by weekly Adult Social Care Leadership Team meetings focused on governance, transformation, and confident, consistent practice.

In response to shifting population needs and feedback from staff and managers, the Health and Adult Services (HAS) directorate undertook a major structural review, moving from a generalist, locality-based model to a county-wide specialist model delivered through local teams. Phase 1, launched in April 2025, restructured the Heads of Service roles following extensive engagement, with aims to close practice gaps and build on strengths such as prevention and housing with care. Leadership expectations and development plans were introduced, supported by a Corporate Masterclass and Directorate Leadership Academy which began in April 2025. Phase 2, led by the HAS Leadership Team, was being co-produced with staff and aimed for implementation in October 2025, focusing on creating specialist teams, improving practice leadership, and enhancing career progression. Since our visit, there has been a revised date of January 2026 in response to issues raised during the consultation.

The Corporate Director for Health and Adult Services (DASS) explained the restructuring was prompted by growing demand, rising complexity of need, and financial pressures. It aimed to ensure the right leadership was in place through new Heads of Service roles, supported by strong staff engagement to co-produce the structure proposals. While moving towards a county-wide specialist model, leaders were mindful of preserving the benefits of local team working. Staff reported feeling heard during the process and welcomed the direction of travel, despite ongoing concerns about high and complex caseloads. Efforts were underway to boost capacity in key areas such as mental health, substance misuse, and working-age adult support. By early 2025, around 95% of frontline posts had been filled, and additional resources were introduced to better monitor workloads. The restructuring also aimed to harness existing strengths and invest in future leadership through development and specialisation.

The HAS Directorate improvement priorities were shaped by performance data, such as waiting lists, review completion rates, Direct Payment uptake, and complaints. These were regularly reviewed through in-depth analysis to inform action. The HAS Leadership Team took a proactive approach to risk, supported by a live risk register (updated biannually and reported annually to the Audit Committee), which in recent years had identified finance as the directorate's most significant risk. Independent evaluations were also provided through internal audit reports, while the HAS Risk Management Group, chaired by the Assistant Director (Resources), met monthly to bring together key officers and corporate colleagues to oversee risk management across services.

The Involvement Framework and Charter, co-produced in 2023 and 2024 with people with lived experience, outlined how HAS worked in partnership with communities to shape and deliver services. Launched in September 2024, the Framework marked a step toward meaningful co-production and was being embedded across the directorate. Actions included developing resources to support transitions into adulthood, strengthening local voice groups, exploring a 'Making it Real' Board, introducing a payment policy to pay people with lived experience for contributing, and providing staff training and guidance. Feedback gathered during case file reviews reflected largely positive experiences, highlighting the value of services such as Living Well, the flexibility of Direct Payments, and the effectiveness of occupational therapy. People also praised how HAS leaders listened and responded during strategic engagement, reinforcing the importance and impact of authentic collaboration.

Relationships at a corporate level were described as strong and cohesive, with a delivery-oriented culture among directors. Despite the local authority being relatively new (established 2 years ago), HAS experienced minimal disruption due to its existing position within the previous upper-tier structure. The transition to a unitary authority enabled more integrated working across previously separate district councils. This shift facilitated joined- up approaches in areas such as housing, leisure, and the Disabled Facilities Grant, leading to more consistent and person-centred services across North Yorkshire.

There was a stable adult social care leadership team with clear roles, responsibilities and accountabilities. Leaders were visible, capable and compassionate. We heard lots of positive feedback about staff engagement, and work on the culture and values of the local authority. Staff told us the senior leadership team were visible in the offices and were open and approachable. They attended team meetings to meet staff, listened and gained feedback. We heard lots of feedback about career progression opportunities, supervision, mentors, and positive apprenticeship outcomes in multiple teams. Staff told us they were well supported and had good access to training and development to help their progression. They received regular supervision sessions and were encouraged to develop their careers such as completing the Approved Mental Health Professional (AMHP) training.

Leaders told us visible leadership was championed within the HAS directorate and robust and regular staff engagement opportunities were in place. In addition to the corporate key weekly messages, blogs, Chief Executive webinars and Senior Manager Seminars, leaders provided regular updates and engagement opportunities across frontline teams and managers, including a weekly 30-minute directorate Weekly Team Brief, open to all colleagues and chaired by members of the HAS Leadership Team, providing two-way communication. There were also regular meetings for the HAS Leadership Team, Adult Social Care Managers' and the Provider Forums to consider practice and performance.

Quarterly Locality HAS Connected online sessions, focused on local issues/good practice and the 'Care Connected' online forum shared information with providers in the wider sector.

The Principal Social Worker (PSW), who was also an Assistant Director, was supported by 4 Heads of Service, who managed their services independently. This allowed the PSW to focus on their core role, spending time with teams and supporting practice, while maintaining oversight. Their visibility and close connection to staff provided valuable insight into day-to-day operations, strengthening their effectiveness. Knowledge of assessment teams further enhanced the PSW's role, enabling them to escalate high-risk issues to the DASS and, when necessary, chair multidisciplinary team meetings. The PSW also regularly engaged in ethical case discussions, helping them stay connected to frontline challenges.

Equality, Diversity and Inclusion (EDI) leads reported strong governance and leadership across HAS supported by visible corporate commitment and investment in the EDI lead role. This role effectively linked operations, leadership, and external partners, and was embedded in both corporate and public health workstreams. Leaders had a clear EDI work plan aligned with the corporate strategy and were able to take forward improvement proposals. Initiatives such as the RESPECT agenda addressed workplace racism, and learning from EDI activities was shared through regular reporting to the Confident and Consistent Practice Board, influencing staff training, service design, and market development.

The local authority's political and executive leaders were well informed about the potential risks facing adult social care. These were reflected in the corporate risk register and considered in decisions across the wider Council.

The Lead Member for Adult Social Care (ASC) explained the Health and Wellbeing Board had played a key role in shaping strategies such as the Autism Strategy, which was developed over time through co-production with partners and people with lived experience. Leadership was shared across sectors, with involvement from public health and the NHS and other partner agencies to ensure a collaborative and balanced approach.

Progress was tracked against the 7 improvement priorities using online dashboards which enabled both local and county-level data analysis. These tools helped leaders monitor trends and respond to issues, particularly during the COVID-19 pandemic, when services such as reablement and hospital discharges were under pressure. In addition to formal structures, regular fortnightly meetings allowed informal updates and discussion of incidents, and all communications were recorded. The Lead Member said the integration of public health into the unitary authority had been a steep learning curve but ultimately enhanced work around prevention and health improvement. A strong communication framework supported decision-making across ASC, with regular briefings, leadership meetings, and sessions with the DASS. The Lead Member stayed actively involved despite operational decision- making being delegated, valuing open discussion and scrutiny to ensure the system functioned effectively.

The Overview and Scrutiny (OS) committee consisted of 16 councillors from a broad range of political backgrounds, communities, and work experiences, providing diverse insight during discussions. The Scrutiny Board included the chairs of all 7 OS committees, as well as the Older People's, Young Person's, and Climate Change Champions. They all had a realistic and impactful work programme, with recent focus areas including support for unpaid carers, ensuring access to assessments and services based on eligible needs. They managed referrals from the whole council and worked collaboratively to support and challenge effectively. Performance monitoring was underpinned by a range of data, such as KPIs, surveys, and charts compiled quarterly by the local authority's data and performance team. These insights informed the questions raised to the Executive Members, either answered immediately or followed up. The local authority was also introducing biannual performance updates to strengthen collaboration with Area Committees. A political leader expressed strong confidence in the committee's ability to scrutinise senior officers, using the example of Direct Payments, which were added to the work programme after initial questioning. They said the committee paid close attention to hospital discharges, associated pressures, and plans for new intermediate care services. They also focused on improving assessment timescales. Members brought concerns from their local divisions to the committee, which were discussed and often acted upon, such as revising the data format after a specific request. They added, the committee valued openness and mutual support.

The DASS recognised the importance of using robust data and evidence of impact to strengthen business cases and secure support from political leaders, particularly for preventative services. One example was the development of the Living Well model, which was backed by financial modelling and successfully piloted to demonstrate cost savings. Similar impact work was underway with extra-care housing in partnership with the Housing Learning Improvement Network, and mental health and learning disability supported housing investment was also being explored. Acknowledging some communities were reluctant to engage with formal council services, the DASS described alternative approaches such as providing grants to grassroots initiatives like lunch clubs. Across the local authority, data was used to support individual practice, guide strategic planning, and inform the improvement priorities.

Performance systems featured built-in feedback loops to monitor data quality and timeliness, feeding into ongoing development and improvements.

## Strategic planning

The local authority used information about risks, performance, inequalities and outcomes to inform its adult social care strategy, allocate resources and deliver the actions needed to improve care and support for people and local communities.

In terms of challenges in Health and Adult Services the DASS told us the local mission was to secure the future of adult social care for people living in North Yorkshire. They were confident the strategies in place will secure the resources needed to deliver services and secure the workforce for the future by developing and nurturing the next generation of leaders and practitioners. The DASS said he had good support from the Chief Executive Officer and S151 Officer, and they were looking at extending the prevention offer through Community Anchors and Care and Support Hubs. The DASS also planned to do more in terms of mental health support for working age adults by supporting better outcomes, supporting employment and increasing the number of people living in their own homes.

North Yorkshire's Adult Social Care Strategy, set out in the Health and Adult Services Plan 2022–2025 and revised to 2030, aimed to help people live longer, healthier, and more independent lives. It focused on promoting early intervention and prevention, supporting people to have choice and control over their care, and delivering personalised, high-quality services. The strategy emphasised strengthening local, community-based support to reduce reliance on institutional care and was shaped through collaboration with people with lived experience, carers, and providers. It also aimed to build a sustainable, diverse care market and was grounded in co-production, continuous improvement, and a firm commitment to dignity, inclusion, and fairness.

To meet the aims of its Adult Social Care Strategy, leaders had undertaken a range of actions focused on improving independence, wellbeing, and person-centred support. The local authority restructured its service model to enhance leadership and specialisation, invested in multiple workforce development initiatives, and embedded co-production via the Involvement Framework and Charter. Leaders used performance data and risk management tools to track progress against 7 improvement priorities, while expanding preventative services such as the Living Well model and local community grants. Support for carers was strengthened in line with the Carers Roundtable and the emerging new Carers Strategy, and governance structures were enhanced through regular leadership meetings and strong links with Public Health and corporate EDI work. Efforts to develop a sustainable and diverse care market were supported by the Strategic Market Development Plan, with a continued emphasis on collaboration, accountability, and continuous improvement.

North Yorkshire's All-Ages Carers Strategy (2025–2030) was in draft form but set out refreshed priorities shaped through engagement with carers and the Carers Roundtable. The 3 priorities, (ABC's - Advice/Access/Assessment, Breaks, and Community / Contribution) aimed to support unpaid carers in continuing their caring roles while also maintaining a fulfilled life of their own. The strategy focused on: Promoting carers' health and wellbeing, Improving the identification of carers, Enhancing access to information, advice, and support, Enabling carers to take meaningful breaks, Recognising carers as experts in shaping services. It also acknowledged the financial and emotional pressures carers face and committed to improving their financial wellbeing and access to support. The strategy aligned with other local plans, including those for mental health, dementia, and learning disabilities, to ensure a joined-up approach to care and support. Alongside the strategy, a Carers Improvement Priority Area was driving progress in key areas such as strengthening carers practice, expanding online assessments and enhancing support for carers entering or returning to employment.

North Yorkshire's Dementia Strategy was designed to help people live well with dementia by promoting dignity, inclusion, and independence. Developed through engagement with over 1,300 residents, the strategy aimed to raise awareness and understanding of dementia, improve early diagnosis and timely access to support, and ensured person-centred care tailored to individual needs. It also focused on supporting carers through practical and emotional help, creating dementia-friendly environments, and strengthening workforce training to deliver compassionate care. Future planning, including end-of-life care, was encouraged to give people greater control and reassurance. The strategy was shaped by the voices of those living with dementia and their carers and aligned with broader health and wellbeing priorities across the county. The strategy led to a wide range of actions and services aimed at helping people live well with dementia. The local authority commissioned a local dementia support provider to deliver county-wide services including a helpline, home visits, wellbeing groups, and tailored advice for individuals and carers. Libraries across the county were made dementia-friendly, offering trained staff, accessible spaces, and health-related events. A voluntary sector partner told us the local authority had a positive long-term dementia strategy that was ambitious and forward-looking.

North Yorkshire's Housing Strategy 2024–2029 aimed to provide affordable, high-quality, and sustainable homes that met the needs of all communities. It prioritised preventing homelessness, reducing rough-sleeping, and addressed the housing needs of older adults and those requiring additional support. To support people with adult social care needs, the local authority offered a range of tailored housing options, including supported living for people with complex needs, such as learning disabilities or autism, where people lived independently with access to appropriate support. The expansion of extra-care housing provided self-contained homes with 24-hour care, for older adults. Short-term supported accommodation helped people regain independence after issues like homelessness, substance misuse, or mental health challenges. The Shared Lives scheme placed people with long-term care needs with host families, offering support in a home environment. These models promoted independence, community inclusion, and personalised support, with social care assessments used to ensure suitable placements and funding.

## Information security

The local authority had arrangements to comply with information governance requirements in line with legislation, mitigate risks and maintain GDPR 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. In some cases, disciplinary action was taken in instances where preventable breaches had occurred. The directorate Information Governance Group was chaired by the Director of Public Health who was also the Caldicott Guardian. The group met regularly to discuss issues across the directorate relating to information governance policy and practices. Membership included operational representatives alongside data governance leads and an independent auditor for the local authority. Learning from breaches was shared across the directorate to ensure learning was embedded and to prevent future breaches. 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.

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# Learning, improvement and innovation

## Score: 4

4 - Evidence shows an exceptional 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

There was a strong, inclusive learning culture focused on continuous improvement. Staff had ongoing access to training and support to safely and effectively carry out Care Act duties.

The induction process for new staff was detailed and supportive, involving shadowing, learning processes, and gradually taking on responsibilities. Peer support was central, with colleagues offering guidance and a buddy system to assist new team members. Staff felt very well supported by senior leadership, who engaged directly through shadowing visits and meetings. They were confident raising concerns, knowing their voices would be heard. For instance, feedback on proposed personal assistant rates led to collaboration with managers and leaders, resulting in an increased rate and a pilot project aimed at boosting the personal assistant market. Internal staff networks, such as for race equality, LGBTQ+, and carers provided further support. Members of these groups championed equality, diversity, and inclusion (EDI), using their insights to shape improvements in data collection.

The Learning Zone provided easy-to-access training for annual updates and skill development. The Practice Framework outlined tools and guidance to help staff work with confidence, consistency, compassion, and ethics. Career development was actively encouraged through internal and external training, job movement, and the opportunity to gain qualifications. Leaders supported staff in taking on new responsibilities, and shadowing helped with transitions between roles. The Assessed and Supported Year in Employment (ASYE) programme offered a solid foundation of learning, reflective practice, and support. Staff felt this promoted a positive learning environment and strengthened ongoing professional development. Opportunities like becoming ASYE assessors, training in Best Interests Assessment (BIA), and stepping into leadership roles highlighted a strong commitment to developing staff across the organisation.

There had been a strong focus on dementia training and development of a 'train the trainer' programme. Staff responsible for delivering the programme were recognised with a Contribution to Service Improvement Award due to its success. A blended approach was used; external trainers delivered sessions, followed by a 'train the trainer' model. Training was enhanced through partnerships with voluntary sector organisations and aligned with standards set by the Alzheimer's Society and Dementia UK. Sessional speakers shared powerful insights based on lived experiences of dementia. Additional tailored training supported staff understanding of conditions such as autism. Staff also requested further training in areas such as Motor Neurone Disease (MND) and Multiple Sclerosis (MS), highlighting the desire to deepen knowledge of specific conditions.

The local authority demonstrated a strong commitment to inclusion by encouraging staff to use positive, non-stigmatising language. Specialist training in the power of language and stigma helped staff reflect on how language affects people and their experiences of equality and inclusion. Hate crime awareness training and a 'Respect Spotlight' clarified the differences between hate crimes and hate incidents, including issues like misogyny and discrimination against sex workers. This helped staff understand how such incidents impact people and the barriers to reporting them. Building on this, the authority introduced a 'RESPECT' initiative. It explored the reasons behind people requesting different workers and reviewed how other local authorities approached zero tolerance. These steps showed a proactive effort to address misunderstandings through respectful language and behaviour.

An improved Practice Quality Assurance Audit Tool had been introduced, using monthly dip sampling of cases to review key areas such as the support provided by staff, the quality of assessments, and any missing critical information. This helped identify issues early and led to clear improvements in practice. To support the audit process, a new supervision policy was put in place. It emphasised meaningful supervision by encouraging staff to complete their notes in advance and reflect on their work. Staff were also prompted to consider their personal resilience when handling complex cases. The supervision template was adapted to fit the needs of different teams, making discussions more relevant to current work. Case file reviews were carried out collaboratively, with staff present, allowing for immediate feedback and shared learning.

Data dashboards were created to help track the volume of support requests and monitor progress at each stage. Managers could view data at team level to have reflective discussions with staff and promote peer support. Staff also accessed the dashboards and gave feedback, which led to improvements such as linking start dates with assessments and adding clear review dates to track case progression.

Managers and staff viewed the values-based restructuring of the Health and Adults Services directorate positively, noting it followed a thorough period of genuine staff engagement. The new Heads of Service structure had been put in place, with ongoing stages shaped by continued consultation and involvement. Although the restructuring was a major change requiring careful management, leaders expressed confidence in the team's ability to manage it effectively. Their experience with transformation, commitment to maintain a strong local presence, and a high recruitment rate of 95% helped ensure a stable and capable workforce.

The local authority actively took part in peer reviews and sector-led improvement initiatives, drawing on external support when needed. Staff and leaders were involved in research, pilot projects, and applying evidence-based practices. For example, they collaborated with academic partners such as a university and external specialists to focus on trauma-informed care. This included workforce training to support people affected by trauma while avoiding retraumatisation. This work strengthened their focus on mental health, with specialist roles supporting people with complex needs, including dual diagnoses. These efforts were backed by close partnerships with housing services, NHS trusts, psychologists, and voluntary sector organisations. The local authority showed a strong commitment to working collaboratively with people and partners. It had developed an Involvement Framework to embed this approach throughout its work. Voluntary sector partners highlighted a shift towards genuine co-production, noting they were involved early in the process and able to influence decisions. Several examples demonstrated how innovation and forward-thinking were encouraged. In Nidderdale and the Washburn Valley, the local community identified a rural service gap and co-designed a tailored solution with commissioners, led entirely by the community.

Public Health also worked with local people to co-produce a substance use Involvement Framework, which led to the creation of recovery groups supported by the voluntary sector. Members of the Co-Production Network spoke very positively about their involvement with the local authority. They felt their input was valued, particularly when using creative approaches like photographs to share their views. The local authority welcomed this and planned to use it more widely. Members also appreciated direct access to the Director of Adult Social Services, who attended local forums, listened to their ideas, and acted on their feedback.

The Adult Social Care Carers Lead described how carers were actively involved in producing an evidence and engagement report, developed with support from Carers Trust and Carers UK. The report highlighted the difficulties carers faced by balancing work and caring responsibilities. In response, the local authority's strategy promoted reasonable workplace adjustments and led to the creation of an employer training platform shaped by carers. This helped more carers access job opportunities while continuing in their caring roles. Carers also helped design an online self-assessment tool to ensure the assessment process reflected their needs and identified the support they might require.

The local authority focused on addressing local needs through innovative developments. After the closure of a traditional supported housing setting in Scarborough, the REACH model was introduced. This approach brought together social workers, housing staff, housing associations, and clinical psychologists to provide holistic support. A key feature of the model allowed people to remain in their homes while services were delivered around them, leading to greater stability. The REACH project was evaluated positively, and plans were in place to expand it across North Yorkshire, with adaptations to reflect the specific needs of each area.

## Learning from feedback

The local authority learned from people's feedback about their experiences of care and support, and feedback from staff and partners. Leaders used this feedback to inform strategy, improvement activity, and decision making at all levels.

A Continuous Learning and Improvement Officer oversaw incidents such as Safeguarding Adult Reviews (SARs) and embedded learning into practice. For instance, self-neglect was identified as a key issue, leading to dedicated sessions on applying Care Act eligibility criteria in such cases. Staff were also encouraged to bring complex situations to group discussions to explore solutions, often involving partners such as the police. Learning from SARs was widely shared. One case highlighted delays in converting documents into accessible formats such as audio and Braille. In response, the authority planned to outsource this work to improve future responses. Additional learning from complaints and incidents was picked up by the Principal Social Worker and incorporated into training and events, including World Social Work Day.

The local authority responded robustly to complaints. The 2023/24 Health and Adult Services Customer Response and Governance Team Annual Report provided details on the number and nature of complaints and how they were addressed. It showed a rise in complaints over the year: 82 in Quarter 1, 91 in Quarter 2, 71 in Quarter 3, and 104 in Quarter 4. To strengthen learning, the local authority introduced quarterly "deep dives" into complaint themes. Over the past year, these focused on areas such as communication, mental health complaints, benefits and charging, and issues in the Harrogate and Rural Alliance area. The aim was to identify patterns and improve practice to help prevent repeat issues. Findings were shared with relevant service areas and wider forums, including the Mental Health Development Board, Adult Social Care Forum, and via the Practice Bulletin to support wider learning and improvement.

In 2024, the Local Government Social Care Ombudsman (LGSCO) received 8 complaints about North Yorkshire Council, 7 fewer than the previous year. Past LGSCO complaints had led to service improvements, including policy and procedural changes, and targeted staff training on mental capacity. At the time of our assessment, there were no open investigations with the LGSCO.

During 2023/2024, 599 compliments were recorded for Health and Adult Services, 385 fewer than the previous year. The decline was linked to a shift towards online assessments, which meant feedback cards were no longer handed out during social care or financial assessments. The local authority had begun exploring new ways to collect feedback. At World Social Work Day in March 2024, the local authority celebrated positive impact through a showcase titled 'The Difference We Make', highlighting compliments and examples of good practice.

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