

# Milton Keynes City Council: local authority assessment

[How we assess local authorities](#)

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## About Milton Keynes City Council

### Demographics

Milton Keynes is a unitary local authority located in the South East of England. It was officially designated as a new town in 1967 and was developed to relieve housing congestion in London. It was officially granted city status in August 2022 as part of Queen Elizabeths II's Platinum Jubilee celebrations. The city has a population of approximately 305,884. The age distribution reflects a strong working-age population, with 61.40% aged 18-64 years, 24.38% aged 0-17 years and 14.22% aged 65 years and over. The city's ageing population is increasing, with the number of residents aged 65 and over rising by 24% over the past decade.

Milton Keynes ranks 108th out of 153 local authorities in England for deprivation (with 153 being the least deprived), with an Index of Multiple Deprivation (IMD) score of 3 (with 10 being the least deprived). This ranking considers various factors such as income, employment, health, education, and crime and the scores for Milton Keynes indicate moderate socio-economic challenges overall, though some areas such as Bletchley East and Woughton & Fishermead fall within the most deprived 3% nationally. Milton Keynes has a health index score of 97.1 which shows the population's health was slightly below England's average health status in 2015. The health index score is a composite measure that reflects various health-related aspects of the population, including physical wellbeing, lifestyle choices, and access to healthcare services. The Office for National Statistics (ONS) describes scores above 100 indicating better health, and below, worse health compared to England overall in 2015.

Milton Keynes is a diverse city. Around 71.80% of residents identify as White, 12.42% identify as Asian or Asian British, 9.7% identify as Black, Black British, Caribbean or African, 4.1% identify as Mixed or Multiple ethnicity and 2% identify as Other.

Milton Keynes is part of the Bedfordshire, Luton and Milton Keynes Integrated Care System (BLMK ICS), which aims to improve health outcomes and service coordination across the region. The local authority works with partners such as Milton Keynes University Hospital NHS Foundation Trust and Central and North West London NHS Foundation Trust to meet the healthcare needs of its residents.

Politically, Milton Keynes operates under a council structure without a directly elected mayor. The local authority is currently Labour-led, with representation from the Labour Party, Conservative Party, Liberal Democrat Party, and Independent councillors across its 57 seats.

## Financial facts

- The local authority estimated that in 2023/24, its total budget would be **£431,220,000.00**. Its actual spend for the year was **£459,594,000.00**, which was **£28,374,000.00** more than estimated.

- The local authority estimated that it would spend **£98,507,000.00** of its total budget on Adult Social Care in 2023/24. Its actual spend for that year was **£100,092,000.00**, which was **£1,585,000.00** more than estimated.
- In 2023/2024, **21.78%** of the budget was spent on adult social care.
- The local authority has raised the full adult social care precept for 2023/24, with a value of **2%**. Please note that the amount raised through adult social care precept varies from local authority to local authority.
- Approximately **3360** people were accessing long-term Adult Social Care support, and approximately **840** people were accessing short-term Adult Social Care support in the 2023/24 period. Local authorities spend money on a range of adult social care services, including supporting individuals. No two care packages are the same and vary significantly in their intensity, duration, and cost.

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

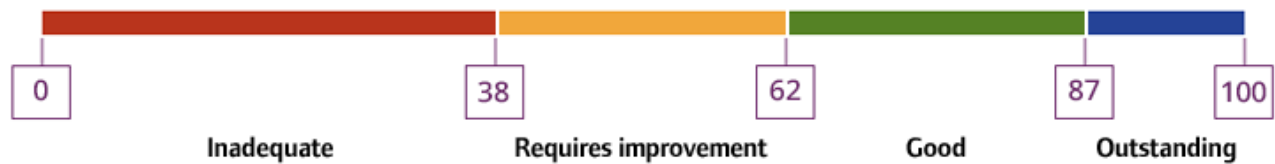
# Overall summary

## Local authority rating and score

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Milton Keynes City Council

Good



## Quality statement scores

### Assessing needs

Score: 2

### Supporting people to lead healthier lives

Score: 3

### Equity in experience and outcomes

Score: 3

### Care provision, integration and continuity

Score: 3

### Partnerships and communities

Score: 4

### Safe pathways, systems and transitions

Score: 3

### Safeguarding

Score: 3

### Governance, management and sustainability

Score: 3

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## Learning, improvement and innovation

Score: 4

### Summary of people's experiences

People shared many encouraging experiences of adult social care provided by the local authority. Many described compassionate, person-centred assessments and flexible support that promoted independence, wellbeing, and choice. Carers spoke highly of the support they received, including carers assessments and direct payments, which helped them feel valued and sustained in their caring roles. People praised staff for going the extra mile, offering practical help and emotional reassurance to people.

People appreciated timely interventions that helped prevent or delay the need for formal care, such as support to attend health appointments, access supported living, and staying connected to their communities. Direct payments were described as empowering, enabling individuals and carers to tailor support to their personal needs. The newly commissioned carers service and dedicated smartphone app were well received, offering accessible advice and 24/7 information in one place.

Communication was often described as clear and responsive, and people felt safe, respected, and listened to. Co-production was a strong feature of the local authority's approach, with the Stronger Together Board providing an inclusive space where lived experience shaped services. Members felt empowered and proud that their contributions led to tangible improvements, including increased uptake of direct payments and more person-centred assessments.

Carers and people using services valued the variety of community-based options available, such as day centres, respite care, and short breaks. They also highlighted the benefits of coordinated partnership working, which supported smooth transitions from hospital and helped people remain safely at home. Some people shared how the local authority provided emergency support during times of crisis and helped plan for future care, offering reassurance and continuity.

While some people suggested improvements to written materials and greater inclusion of underrepresented groups, they were confident that the local authority was actively working to address these areas. Overall, people described adult social care in Milton Keynes as supportive, empowering, and responsive to their needs.

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

The local authority provided a broad range of accessible care and support services, with assessments designed to be person-centred and focused on individual strengths. National data measures indicated that satisfaction with care, feelings of autonomy, and opportunities for social contact in Milton Keynes were broadly consistent with national averages, reflecting a stable and responsive service offer. Assessment processes were supported by clear eligibility frameworks and efficient financial assessments, typically completed within the five-day target. While some variation in waiting times was noted, the local authority maintained robust risk management practices, prioritising urgent and high-risk cases and applying “waiting well” protocols.

There was a notable increase in carers’ assessments, reflecting the local authority’s commitment to identifying and supporting carers. Referrals to the newly commissioned carers offer helped ensure carers received tailored support, enhancing their wellbeing and ability to continue in their roles.

The local authority demonstrated strong and effective partnership working that had a clear and positive impact on people's lives. Collaborative initiatives such as the Linford Wood Place project and the MK Deal showcased how joint working across sectors could improve outcomes, particularly in supporting timely hospital discharge and enhancing neighbourhood health. By utilising the Better Care Fund to establish an integrated neighbourhood model, the local authority strengthened its focus on prevention and community wellbeing. Partners consistently described their relationships with the local authority as productive and responsive, contributing to improved coordination, better patient flow, and more holistic support for individuals. These partnerships were underpinned by robust governance structures and a shared commitment to delivering person-centred care.

Intermediate care and reablement services were delivered in collaboration with health partners, with a clear emphasis on recovery at home through "home first" and recuperation initiatives. Transitions from hospital and into adulthood were well coordinated, supported by integrated team working and timely planning. The local authority demonstrated a good understanding of risks across care journeys and took appropriate steps to manage these. Out-of-hours arrangements and contingency plans were well established, including procedures for managing potential service disruptions.

Safeguarding systems were well embedded, with consistent oversight from managers to support decision-making around Section 42 enquiries. Over 1,000 inter-agency risk management meetings were held in the past year, reflecting strong collaborative efforts to keep people safe. The local authority worked closely with the MK Together Safeguarding Partnership to identify priorities, and its Safeguarding Adults Annual Report outlined responsive actions taken. While feedback from safeguarding enquiries was not always consistently shared with partners, the local authority responded to learning from Safeguarding Adults Reviews through action plans and staff training.

Governance, management, and accountability arrangements were well established across adult social care. The leadership team was stable, and services were structured with clear oversight of Care Act responsibilities. Regular meetings at all levels supported strategic alignment, with system leadership linked to steering groups and safeguarding priorities. The local authority made notable improvements in how data and information were used, enhancing oversight and accountability. Data informed performance monitoring, strategic planning, and commissioning decisions. A range of adult social care strategies were in place, covering carers, dementia, prevention, preparing for adulthood, supported housing, and equity, diversity and inclusion.

A strong culture of continuous learning and improvement was evident, underpinned by inclusivity and support. Staff had access to a wide range of learning opportunities and were encouraged to pursue professional development. They were empowered to work creatively and supported with professional guidance and resources, including budgetary support. Co-production was clearly embedded across adult social care, with the “Stronger Together” board serving as a central forum for collaboration. The local authority demonstrated a commitment to listening and learning, incorporating feedback into strategic planning and decision-making.

# Theme 1: How Milton Keynes City Council works with people

This theme includes these quality statements:

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

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

# Assessing needs

Score: 2

2 - Evidence shows some shortfalls

## What people expect

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

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

## The local authority commitment

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

## Key findings for this quality statement

## Assessment, care planning and review arrangements

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People could access the local authority's care and support services through multiple channels, including online and by telephone. The local authority Access Team acted as the first point of contact for Adult Social Care, delivering support through Community Access Advisors (CAAs). The team provided information, advice, and guidance, aimed at helping people achieve their desired outcomes while promoting independence and wellbeing. There was a preventative focus, in 2023/24, 40% of contacts were resolved through direct advice, and a further 15% were referred to services such as community alarms, voluntary organisations like Age UK, and the Home First Reablement service.

The approach used by the local authority during assessment and care planning was person-centred and strengths based. Staff were supported with detailed guidance, structured processes, and training, including trauma-informed practice and strengths-based conversation models. Policies and procedures promoted best practice under the Care Act, with a focus on whole-family systems and safeguarding. Tools such as their Carers Conversation, Planning Live for young people, the Well 12 framework and weekly 'drop in' offer in mental health services, and the Home First model for hospital discharge demonstrated their commitment to tailored, effective support.

There was a coordinated approach to planning and delivering support across multiple agencies and services. Clear pathways such as the Integrated Community Support Team referral process and the Adult Social Care-Care Planning Pathway supported access and reduced duplication for people. The local authority's commitment to consistency and best practice was evident through its standardised procedures.

The local authority organised its social work services into specialised teams to ensure tailored support for individuals based on their needs. These included teams for working-age adults, older people, learning disabilities, mental health, and those preparing for adulthood. In addition, there were dedicated teams for access and triage, occupational therapy, and hospital discharge and admission avoidance. To ensure people received the most appropriate support, the local authority adopted a 'best fit model'. This approach focused on identifying which team and professional were best placed to meet an individual's specific circumstances, promoting personalised care.

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People's views of their assessment journey in Milton Keynes were mixed. Many described positive experiences, including person-centred assessments, compassionate social workers, and flexible support that promoted independence and wellbeing. However, some people and partners reported concerns around communication, especially during staff changes or absences and some people said the support that they received felt task-focused and their needs were not fully met. Data from the Adult Social Care Survey 2023/24 indicated that 75.77% of people felt they had control over their life, 59.41% were satisfied with their care and support and 43.31% reported they had as much social contact as required. These were all similar to the England averages which were 77.62%, 62.72% and 45.56% respectively.

Staff across adult social care services consistently described using person-centred and strengths-based approaches in assessment, care planning, and review. Staff emphasised personalised conversations at first contact, listening closely to understand people's needs and wishes. Staff also reflected on the importance of avoiding assumptions, adapting communication, and building trust, particularly when working with autistic people or people with sensory impairments. Staff were committed to delivering person-centred and meaningful support to people.

## Timeliness of assessments, care planning and reviews

Assessment and care planning arrangements were mostly timely and up to date with the exception of the working age adult team. The local authority's target timescale for assessments was 28 days. According to local authority data as of the end of September 2025, there was nobody waiting for assessments from the reablement and hospital assessment team or the mental health team. There were 17 people awaiting assessment in the working age adult team and 2 people awaiting assessment in the older people team. The median wait time, as of September 2025, in the working age adult team was 63 days and the maximum was 85 days. The median wait in the older people team was 31 days and the maximum was 33 days, with no wait times for reablement and hospital discharge or mental health.

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Performance data from the local authority shows a clear improvement in assessment waiting times across Working Age Adults and Older People's services. Between September 2024 and September 2025, the Working Age Adults waitlist reduced from 46 to 17 people, with median waits falling from 89 to 63 days and maximum waits from 172 to 85 days. Older People's services saw similar progress, with the waitlist decreasing from 12 to 2 people and median and maximum waits reducing from 45 and 77 days to 31 and 33 days. These improvements indicate that recent process changes are delivering sustained, positive impacts on timeliness.

The local authority reported that a 44% increase in safeguarding referrals had put additional pressure on social work teams, and this affected their ability to complete all assessments within timescales. To mitigate risk, a rating matrix was used to prioritise and allocate high-risk cases immediately, helping ensure urgent needs were addressed without delay.

As of September 2025, annual review activity across adult social care teams showed a generally positive trajectory, with an 11% increase in completed reviews compared to the previous year. While no reviews were pending in the reablement and hospital discharge team, there were 170 people awaiting review in the working age adult team, 113 in the older people team, and 23 in the mental health team. Median wait times (post 365 days) ranged from 42 to 78 days, with some cases waiting up to 154 days. Data from the Short and Long-Term Support (SALT) 2023/24 report indicated that 58.33% of long-term support clients had been reviewed which was similar to the England average of 59.13%.

The local authority was acting to manage and reduce waiting times for assessment, care planning and reviews. This included actions to reduce risks to people's wellbeing, while they were waiting for an assessment. Staff across teams consistently referenced the use of the "Waiting Well" policy, including regular welfare calls, risk-based prioritisation, and escalation routes to ensure urgent needs are addressed promptly. Staff also shared that managers monitor waiting lists closely, immediate needs are met during initial contact, and support workers help bridge gaps in care. New strategies, such as sub-grouping and process reviews, were being trialled to improve service flow.

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## 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. All carers' conversations (which were the local authority's statutory assessments for unpaid carers), were undertaken by workers across all social work teams, and were conducted independently from the assessments of the people they support, unless a joint assessment was specifically requested.

The local authority demonstrated a clear and transparent commitment to supporting unpaid carers through accessible information, flexible care planning, and tailored services. Carers could request assessments without financial implications, regardless of their circumstances. The local authority conducted a comprehensive review of carers support services, shaped by co-production, that identified service gaps and led to the development of a new model launched in June 2025, featuring carers hubs, provided by Voluntary, Community and Social Enterprise partners, which would be matched to the specific support needs of the carer. The local authority's offer to carers included a broad range of tailored support services, reflecting its commitment to meeting diverse needs. The support offer included (but was not limited to) a one-off direct payment (subject to eligibility), respite care, annual short breaks, and access to support services such as advice and Admiral Nurses. The new carers hub included dedicated support for young carers, people living with dementia, older people, people with learning disabilities and neurodiverse needs, and people needing support with mental health. The local authority's procedures and support offers reflected its obligations under the Care Act and promoted strength-based approaches, ensuring carers' voices were central to planning and decision-making.

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There were no waiting lists for carers assessments from the working age adults' team, the reablement and hospital discharge team or the mental health team. As of the end of September 2025, there were 38 people awaiting a carers assessment from the older people team with median wait time of 63 days and a maximum wait time of 112 days. According to local authority data, in 2024/2025, the local authority completed 853 Carers Conversations and provided 906 direct payments to carers, reflecting a 10% increase in conversations and an 8.5% rise in direct payments compared to the previous year. This demonstrated positive impact in the local authority's ongoing efforts to identify and support carers.

Most carers told us they had been offered and completed carers assessments, often receiving direct payments as part of the process. Many described the support as helpful and necessary, with some telling us that the local authority was responsive and considerate of their needs. Carers who previously felt overwhelmed or isolated said the support provided helped alleviate pressure. Carers also praised staff for their responsiveness and dedication, describing social workers going the 'extra mile', such as providing financial support and attending key meetings to advocate for carers.

Staff demonstrated a person-centred and coordinated approach to supporting unpaid carers across adult social care teams with good knowledge of carers support offers. They described a range of practices aimed at recognising carers' needs and preferences and emphasised the positive impact of Admiral Nurses (employed by the local authority), whose specialist dementia support and regular drop-in sessions were seen as particularly beneficial. Leaders emphasised the importance of recognising carers early, offering separate face-to-face assessments, and providing direct payments. Additional staff were recruited to meet rising demand for carers support, and collaboration with health partners led to a 30% increase in identifying carers at hospital discharge. Young carers were identified through a linked children's and adult services framework, ensuring they were recognised early to enable support for them during transitions. There was a specialist offer of support for young carers within the newly commissioned carers hub.

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National data from the Survey of Adult Carers in England 2023/24 highlighted areas of both strength and challenge for carers locally. 71.23% of carers felt involved or consulted in discussions, which was somewhat better than the England average of 66.56%. Most indicators showed no statistical variation from national averages, including satisfaction with social services which was 36.14% compared with the England average of 36.83%. However, 2.17% of carers accessed training which was somewhat worse than the England average of 4.30% and 1.09% were accessing employment-related support again somewhat worse than the England average of 2.79%, suggesting potential areas for future focus.

Since the implementation of the new carers support offer in June 2025, the local authority told us there had been a significant increase in the numbers of carers accessing their digital offer. Their data indicated 12,000 people accessed the digital website and app, and of these 2,152 carers were actively engaging. Between June and September 2025, local authority data showed that 4.83% of carers engaging with the platform completed the email course which covered topics such as coping with trauma, carers rights and the law and building resilience and managing guilt. Additionally, 22% completed the financial toolkit which included information and guidance on benefits and financial wellbeing, and 24% accessed the E-Hub Learning digital platform. This demonstrated a positive response to findings from the national data.

## 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. The local authority demonstrated effective signposting for people who did not meet Care Act eligibility criteria, with staff able to offer guidance and referrals at the initial point of contact through the Access Team and through triage arrangements within all teams. The local authority told us this proactive approach enabled the resolution of 40% of service contacts through appropriate advice, information, and connection to alternative support services, ensuring people still received help tailored to their needs.

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Staff across teams described a wide range of support available for people who did not meet Care Act eligibility, demonstrating local knowledge and effective signposting. People were connected to services such as housing teams, Citizens Advice Bureau, Connection Support, and assistive technology, as well as Parish Councils offering access to local courses and food banks. Staff used a resource folder to guide referrals and provided practical items like kettle packs and sleeping bags to support newly housed individuals. Creative and personalised solutions were used, such as linking people to access therapy dogs or NHS talking therapies, which demonstrated a commitment to wellbeing beyond statutory thresholds.

## Eligibility decisions for care and support

The local authority had a clear and structured approach to determining eligibility and supporting people in accessing care. It provided transparent guidance on arranging and paying for care, including access to third-party services and NHS funding where applicable. Tools such as the “A Person’s Journey” and “Working Age Customer Journey” frameworks outlined pathways for assessing both urgent and non-urgent needs.

The local authority assessed eligibility for care and support through a structured set of procedures, practice guidance, and tools. These covered key areas such as commissioning and brokerage, direct payments, urgent or interim support, professional input, and alternative service arrangements. The framework also included guidance for people who self-fund and those accessing services out of area, supporting a comprehensive and inclusive approach to meeting diverse needs.

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Procedures were underpinned by the local authority's Care and Support Operational Policy which outlined the framework for assessing eligibility and delivering support to adults under the Care Act 2014. The policy set out a strengths-based, person-centred approach to assessment, care planning, and service provision, underpinned by a statutory duty to promote wellbeing. The policy supported consistency with legislation and guidance, supported integrated working with health, housing, and voluntary sectors, and provided staff with clear procedures and definitions to guide practice. It also emphasised the importance of dignity, autonomy, and holistic support across all areas of adult social care.

Additionally, Case Assurance meetings were held as a weekly forum within Adult Social Care where decisions regarding new or increased care and support packages were discussed and authorised. This promoted consistency in decision-making regarding eligibility through collaborative discussion, aiming for strength-based, creative, and consistent approaches across teams.

## Financial assessment and charging policy for care and support

The local authority provided clear and supportive guidance around financial assessments and care funding. It offered public-facing resources on their website, that explained access to commissioned and non-commissioned services, independent financial advice, and wellbeing tools. Internally, practitioners were equipped with structured procedures that promoted consistency when discussing and managing financial contributions with people who use services. The local authority stated its assessment process was designed to be fair and transparent, with step-by-step instructions and timescales that aimed to help reduce uncertainty. Charging policies were openly shared and aligned with statutory guidance, aiming for people to be well informed and supported throughout the financial assessment process.

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As of August 2025, the local authority demonstrated strong performance in completing financial assessments, with 99% completed within its five-day target. At that time, 35 people were awaiting financial assessment, with a median wait of 1 day and a maximum wait of 20 days, indicating timely and efficient service delivery around financial assessments and decisions.

## Provision of independent advocacy

The local authority offered independent advocacy services through a charity that provided free and confidential support tailored to individual needs. Their advocacy offers included assistance with NHS complaints, care and support decisions, and mental health matters, particularly for people detained under the Mental Health Act. They also supported people who may lack capacity, in line with the Mental Capacity Act. Referrals could be made online, by phone, or by email, and were typically responded to within 48 hours for non-urgent cases. This service aimed to ensure people had a voice in decisions affecting their lives and receive appropriate representation when needed.

There was a clear commitment within the local authority to supporting people through advocacy, but practice varied across adult social care services. In some areas, staff made timely referrals, particularly for people lacking capacity or undergoing Deprivation of Liberty Safeguard (DoLS) assessments, with advocates providing detailed input to support decision-making. Staff told us they had worked to improve their understanding of advocacy processes, especially in hospital settings. However, in other parts of the service, advocacy did not appear to be consistently embedded, and according to staff feedback, referrals could depend on the absence of family support.

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Partners raised concerns about delayed referrals and limited staff awareness of statutory advocacy duties. Some partners said staff misunderstood the safeguarding role of advocacy, sometimes confusing safety protection with the right to have one's voice heard. This was also apparent from staff feedback with some staff reporting they acted as advocates themselves, with gaps in their understanding of when formal, independent advocacy was legally required. This suggested that while advocacy was available, it may not be systematically offered to all who are entitled to it under the Care Act.

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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 works with people, partners and the local community to make available a range of services, facilities, resources and other measures to promote independence, and to prevent, delay or reduce the need for care and support. Through its Prevention Strategy, the local authority committed to helping people live healthier, fuller lives by improving access to advice, information, and early help services.

Partnerships with NHS trusts, the Integrated Care Board, and police services enabled targeted prevention support for people with complex needs, helping to prevent crises and maintain stability.

The local authority had a dedicated Rough Sleeper Team which provided targeted support to people experiencing or at risk of homelessness through assertive outreach, temporary accommodation, and multi-agency collaboration. Facilities like the Fishermead Hub offered 24/7 staffed rooms with access to mental health, substance misuse, and independent living support. The service aimed to reduce rough sleeping, promote recovery, and prevent escalation by connecting people to housing, health, and social care pathways. Local authority data showed the number of rough sleepers in the city had reduced since this team was introduced.

The local authority worked with system partners to implement a falls prevention strategy focused on promoting independence and reducing fall-related risks. To address service challenges, it established 'B Well Therapy', a single point of access that functioned as a triage and assessment hub. 'B Well Therapy' coordinates health and social care responses based on individual complexity and risk, while also linking people to community activities that support wellbeing. In 2024/25 the service handled over 2,000 referrals, helping individuals maintain independence and prevent falls.

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The Recovery College, developed in partnership with a community organisation, supported people with mental health needs to improve wellbeing and engage in voluntary or paid employment. The local authority reported improved outcomes, including reduced symptoms and increased participation in work. They stated by offering early access to support, the service also helped alleviate pressure on statutory health and social care services.

Specific consideration was given to unpaid carers and people at the most risk of a decline in their independence and wellbeing. Data from the Survey of Adult Carers in England 2023/24 showed 11.70% of carers were able to spend time doing things they enjoyed. This was worse than the England average of 15.97%. To address this, the newly commissioned carers hub offered tailored support, including (but not limited to) dementia-specific services, access to Admiral Nurses and support for young carers. This supported unpaid carers to receive the help they needed to continue in their roles and aimed to delay reliance on formal services.

Projects like the Bletchley Pathfinder and Tinkers Bridge were created to prevent, reduce and delay needs for people living in deprived communities. These projects demonstrated how bespoke, community-led approaches, such as bereavement groups, wellbeing drop-ins, and holistic mental health support could reduce isolation and support people to remain independent, particularly in deprived areas. The local authority told us these initiatives contributed to reduced hospital admissions and improved discharge outcomes.

People described positive outcomes where timely interventions helped prevent, reduce, or delay the need for formal care. Examples included support to attend health appointments, access supported living, and receive multi-agency input for daily living, emotional wellbeing, and independence. People told us they valued practical help with tasks like shopping and laundry, and support to stay connected with their communities.

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Data from the Adult Social Care Survey for 2023/24 showed 62.31% of people said help and support helped them to think and feel better about themselves and 80.30% of people no longer needing support after receiving short-term support, both similar to the England averages of 62.48% and 79.39% respectively. Carers spoke positively about the support available from the newly commissioned carers service and valued being able to access tailored support specific to the person they were caring for. According to the Survey of Adult Carers in England 2023/24 84.29% of carers found information and advice helpful which was similar to the England average of 85.22%.

Staff were passionate about ensuring people could lead fulfilling, independent lives and gave many meaningful examples of support leading to positive impact for people. For example, staff working with young people transitioning into adulthood told us about supporting a person to find suitable employment, and liaising with the employer to ensure their personal assistant could attend and support them. This enabled a better outcome for the person who was able to work independently and retain their employment. A leader told us how new temporary housing provision was set up with the use of housing officers to prevent, reduce and delay people's needs. Within the new service, people could be supported by specialist drug and alcohol support workers, as well as accessing support with employment and daily living skills to support their transition into independent accommodation.

Partners highlighted the local authority's strong commitment to collaborative working across the system to prevent people's needs from escalating. They praised its prevention strategies, noting effective support for people in complex situations and proactive community engagement. Positive feedback was given particularly for the local authority's work with rough sleepers and targeted initiatives in deprived areas, which partners reported were making a meaningful difference in reducing risk and promoting wellbeing.

## Provision and impact of intermediate care and reablement services

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The local authority worked with partners to deliver intermediate care and reablement services that enabled people to return to their optimal independence. Services were delivered collaboratively, and joint working with health partners had improved system flow.

The Integrated Discharge Hub (IDH) was being used to support people with their reablement goals following their hospital discharge. Housing officers worked alongside the IDH to support safe and effective intermediate care options for people whilst accommodation was being made suitable for them, helping to prevent a deterioration of their needs. Reablement staff worked alongside therapists, nurses and health care assistants on the hospital wards to ensure early care planning and intervention. This enabled a multi-disciplinary approach to providing reablement services for people and helped to ensure people received coordinated, person-centred care.

There was a clear emphasis on supporting people to recover at home through 'home first' initiatives. The local authority told us how the home first approach had replaced previous strategies for reablement and intermediate care, with a focus on supporting people to recover and gain independence within their own home. This included supporting people on discharge from hospital (pathway 1) and providing support to people to prevent them needing further hospital admission. The functions of support included an in-reach function to provide early intervention, a home to assess function (Bridging Care), a rehabilitation pathway, a recovery pathway and a collaborative approach to discharge from services. The local authority told us the aim was to shift the focus of intermediate care toward supporting people in their own homes whenever possible.

The local authority worked with health partners to provide intermediate and reablement care options for people. This included a range of bed placements for people, some commissioned by the Integrated Care Board (ICB), and others commissioned by the local authority. There were 3 residential and nursing care homes within Milton Keynes offering intermediate care, including a specialist service for people living with dementia.

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National data from the Adult Social Care Outcomes Framework for 2023/24 showed 2.44% of people aged 65 and over received reablement services after their discharge from hospital, which was similar to the England average of 3%. Data also showed 87.50% of people aged 65 and over were still at home 91 days after their hospital discharge after receiving reablement, which was also similar the England average of 83.70%.

The local authority commissioned a 'Bridging Care' service which used domiciliary care services to help people who are medically ready for discharge to return to their home at short notice. The service could work alongside reablement where appropriate. Staff spoke positively about this being an effective support option for people to return home and make progress on regaining independence.

## Access to equipment and home adaptations

People could access equipment and minor home adaptations to maintain their independence and continue living in their own homes. This included practical aids, assistive technology and changes to people's home environment.

The Community Occupational Therapy (COT) service was led by a Principal Occupational Therapist and co-located with social care teams to ensure integrated support. The service included a triage team of Occupational Therapy Support Assistants (OTSA) who screened referrals for early intervention, while clinical teams handled complex assessments. The local authority also used a trusted installer service and a self-care signposting tool as part of its commissioned equipment loan offer.

The local authority offered an online self-assessment tool, enabling residents to explore suitable equipment options before requesting or purchasing items. In addition, assistive technology was available to support people with sensory impairments, memory loss, or physical disabilities, helping people manage safely at home. Equipment provision was overseen by trained prescribers and occupational therapists (OT) who assessed, advised, and prescribed based on individual needs.

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The local authority reported that its COT service continued to manage a high volume of referrals through an efficient triage process. As of the end of September 2025, the service had received 2,898 referrals over the past 12 months, resulting in 2,690 episodes, 1,710 assessments, and 2,617 interventions. Cases were prioritised as high, normal, or low, with assessment targets based on urgency and complexity. Qualified OTs handled complex cases, while OTSAs supported lower-risk assessments.

Waiting times varied across priority levels. Target timescales were 7 days for high priority, 14 days for normal priority and 28 days for low priority. For cases rated at high the maximum wait time was 37 days, and the median was 20 days, there were 4 people waiting rated as high priority. For cases rated a low priority the maximum wait time was 131 days with a median of 48 days, there were 53 people waiting rated as low priority. The local authority consistently applied a waiting well protocol for people waiting for occupational therapy assessments or interventions which mitigated risk and enabled people to be reprioritised in terms of priority where needed. People requiring urgent or immediate support received this without delay.

In April 2024, the local authority joined a new collaborative framework with the Integrated Care Board (ICB) and neighbouring local authorities, commissioning an equipment provider to deliver a consistent and standardised approach to equipment provision. The local authority said the framework had improved referral management and guidance for care homes, ensuring a more consistent experience for residents across the system. The Improving System Flow programme enabled streamlined therapy provision and the creation of a dedicated social care therapy team, improving transitions between intermediate and long-term care services.

The local authority stated the target for completing equipment orders was five days, though this can range from one to 30 days depending on the complexity and type of equipment. The majority of equipment provision met the target. Delays typically related to specialist items or minor works, which could exceed the 30-day threshold.

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The local authority told us about several core functions, including the provision of equipment, production of adaptation requests, reviews of moving and positioning, face-to-face equipment follow-ups, and support package reviews in collaboration with social work teams.

Staff demonstrated a creative and holistic approach to using equipment and adaptations to improve outcomes for people. This included working closely with housing teams to ensure new-build homes were suitable for people with physical disabilities and collaborating with health partners and specialist services to deliver bespoke solutions that restore mobility and independence. Staff gave examples of utilising technology-enabled care to enhance safety and wellbeing, particularly for people living with dementia. Staff also shared examples of supporting people to achieve personal goals, such as attending family events, through tailored equipment provision.

At the time of the assessment, there was no waiting list for people to have a financial assessment to access the Disabled Facilities Grant (DFG). The local authority told us delays for adaptations were mainly due to gaining landlord consent.

## Provision of accessible information and advice

People could easily access information and advice on their rights under the Care Act and ways to meet their care and support needs, including for unpaid carers and people who fund or arrange their own care and support.

The local authority demonstrated a commitment to providing clear, accessible information and advice to promote independence, choice, and wellbeing, and to help prevent or delay reliance on care. A wide range of resources were made available through flyers, online tools, and a front-facing website, covering topics such as adult social care assessments, financial contributions, direct payments, equipment and adaptations, and short-term support following hospital discharge. The local authority offered self-assessment tools, directories of community services, and guidance on transitions to adult care, with contact details and QR codes to aid navigation.

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People and carers told us they had received advice and information from the local authority. We heard positive feedback about the information and advice available from the new carers service, with carers telling us they had received information on finance and benefits which helped them continue in their caring role. The local authority worked with a partner organisation to provide a smartphone app for carers which provided advice and information. The carers we spoke to were positive about this, telling us it was beneficial to have 24/7 access to a range of information in one app, instead of across multiple areas. People told us they had been supported to access information and advice they needed as well as help to understand the options available.

National data from the Adult Social Care Survey and Adult Survey for Carers in England 2023/24 showed 67.66% of people who used services found it easy to access information about support and 61.97% of carers found it easy to access information and advice. Both were similar to the England averages 67.12% and 59.06% respectively.

Staff described how they provided information in accessible formats. Some staff told us they supported people with easy-read documents and other adapted information such as translated leaflets. Staff also told us they utilised support from Speech and Language Therapists for advice and guidance in communication.

Some partners raised concerns that not all people were aware of available resources and support within their community, especially people who may be unable to use the internet. To help this, the local authority held regular events throughout Milton Keynes to engage with people in communities and to share information about support. Staff told us about drop-in sessions they held in different community settings, such as local community halls and dementia cafés, in order to improve accessibility for people who may be unable to use online or telephone options.

## Direct payments

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Direct payments were being used to improve people's control about how their care and support needs are met. People had ongoing access to information, advice and support to use direct payments. However, uptake of direct payments in Milton Keynes was lower when compared to national averages.

National data from the Adult Social Care Outcomes Framework for 2023/24 showed the uptake of direct payments in Milton Keynes was worse than the England average. Overall, 19.75% of people using services in Milton Keynes received a direct payment, compared to 25.48% nationally. Among adults aged 18–64, 28.15% received a direct payment, which was worse than the England average of 37.12%. For those aged 65 and over, uptake was 10.14%, also somewhat worse than the national figure of 14.32%.

The local authority acknowledged direct payments were an area for improvement and established a co-production sub-group to lead this work. People involved in the group contributed to developing new information packs and staff workshops to raise awareness and understanding. Targets were introduced within frontline teams to encourage uptake, and the group actively monitored progress. Members of the co-production group reported seeing an increase in direct payments, supported by data shared with them, which they said demonstrated the effectiveness of their efforts in making positive changes.

To help people access and use direct payments, the local authority worked with an external organisation that provided advice and guidance. This organisation maintained a register of personal assistants (PAs) in the area and offered support with recruitment to help individuals find someone suitable for their needs.

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People told us that direct payments were helping them make informed choices about their care and support. Unpaid carers and people using services said they were aware of direct payments and shared examples of how they were used flexibly to meet personal needs. Carers described how direct payments enabled them to take breaks from their caring role, which they said improved their wellbeing and helped sustain their ability to continue providing care. People also said they had received clear information and advice and felt supported throughout the process of setting up and managing their direct payment.

Staff told us they actively promoted direct payments as a way for people to make personalised choices about their care and support. They shared examples of using direct payments creatively to achieve bespoke, person-centred outcomes, such as helping someone find a PA to support their participation in sports, which improved their physical health and independence. Staff also used direct payments to meet peoples' cultural, social, and religious needs, including arranging support with familiar food preparation. Staff expressed pride in being able to deliver meaningful and tailored support through this approach.

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# Equity in experience and outcomes

Score: 3

3 - Evidence shows a good 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 demonstrated a good understanding of its demographic profile, using data effectively to identify inequalities and direct resources to areas where they were most needed. It was aware of under-represented groups and communities in Milton Keynes and actively engaged with them on a regular basis.

The Health and Wellbeing Strategy highlighted several examples of inequalities across the area, drawing on evidence from the Joint Strategic Needs Assessment (JSNA). There were notable inequalities linked to deprivation, health access, and representation. Areas such as Bletchley East and Woughton & Fishermead ranked among the most deprived in England, with higher rates of domestic abuse and poorer health outcomes. Drug misuse was underreported in Black communities, who were also underrepresented in treatment services, possibly due to cultural barriers or reliance on self-referral systems. People in deprived areas face limited access to education, employment, and healthcare, reducing their chances of recovery and increasing reliance on local services. These disparities highlighted the need for targeted, inclusive approaches to reduce inequality across the City.

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The local authority's Equity, Diversity and Inclusion (EDI) Strategy 2025–2027 outlined a proactive response to local inequalities by identifying barriers such as language, inaccessible information formats, and limited cultural awareness in service delivery. The strategy committed to improving engagement with underrepresented communities through co-production, consultation, and inclusive recruitment practices. It also emphasised the need for culturally sensitive care, regular monitoring of service providers, and the use of population data to inform planning and training. These actions reflected the local authority's intention to reduce systemic barriers and ensure services were fair, inclusive, and responsive to the needs of all residents.

The local authority demonstrated a proactive approach to engaging with communities where inequalities were identified, aiming to understand and address specific risks and barriers. The EDI Strategy was co-produced and aligned with the Public Sector Equality Duty under the Equality Act 2010. It set clear objectives to improve outcomes for groups more likely to experience poor care, such as ethnic minorities, LGBTQ+ communities, carers, and people with disabilities.

Staff involved in delivering Care Act duties showed strong cultural awareness and personalised care planning. For example, staff identified gaps in documenting religious dietary needs, such as Halal food requirements, and worked to ensure these were reflected in care plans and hospital passports. The local authority used referral data to match people with culturally appropriate providers, including arranging care with Gujarati-speaking staff and ensuring access to gender specific care and support.

Community engagement efforts extended to faith groups, with officers visiting Gurdwaras, Bahai groups and mosques to explain adult social care services and gather feedback. Engagement sessions were held with members of the armed forces, people who are hard of hearing, autistic people and people with other neurodivergent needs, and groups representing the visually impaired community. The local authority also engaged with the LGBTQ+ community through coffee evenings and a dedicated community day, and commissioned staff training to support inclusive conversations during assessments.

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Data collection practices were strengthened, with mandatory fields introduced to capture information on ethnicity, sexual orientation, and other protected characteristics. This enabled the local authority to identify underserved groups, such as older South Asian people with dementia, and target interventions accordingly. Staff told us about forums like “Every One of Us” which encouraged open dialogue on EDI issues, feeding into strategic planning and supporting anti-oppressive and anti-racist values across teams. Staff said anti-racist values were being embedded across all teams.

Targeted initiatives supported by the local authority, such as the regeneration of Tinkers Bridge, a ward with high deprivation and health inequalities, demonstrated integrated place-based engagement, with investment in housing, green spaces, and grassroots clubs like sewing groups for Asian women supporting wellbeing and social inclusion for under-represented groups. The recommissioning of carers’ support under Citizens Advice introduced tailored strands targeted for dementia, neurodiversity, mental health, and ethnic minority outreach. Staff also supported inclusive social opportunities, such as the “Hearts Without Limits” a group for people with learning disabilities and autistic people, promoting access to relationships and community life.

The local authority supported Gypsy, Roma, and Traveller communities through two dedicated sites at Calverton and Willen, accommodating a combined total of 75 residents. A neighbourhood officer regularly visited both sites and provided ongoing support with site management, rent, mobile home agreements, and access to services. The officer worked collaboratively with partners across public health, education, welfare, housing, policing, and social care to address health inequalities, support income maximisation, facilitate school applications, and provide safeguarding and domestic abuse support, ensuring residents’ voices are heard and their needs met.

Overall, the local authority’s approach reflected a strong commitment to equity, combining strategic planning, community partnerships, data-driven insight, and culturally responsive practice to reduce barriers and improve experiences for diverse populations.

## Inclusion and accessibility arrangements

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The local authority had taken meaningful steps to meet its Care Act duties around inclusion and accessibility, offering a range of tools and formats to support diverse communication needs. These included British Sign Language interpretation via an organisation who provided a live stream interpretation service for British Sign Language (BSL) to support people who were deaf and hard of hearing, multilingual support through a staff language directory, and flexible care planning formats such as easy-read, braille, and visual aids. Staff told us they used professional translation services and assistive technologies and communication cards, ensuring peoples' voices were heard and their needs understood. The local authority invested in digital accessibility, with translation tools on its website and translated outreach materials. The tool which was included on the website offered features such as text-to-speech, translation into over 100 languages, customisable text styling, and reading aids like screen masks and magnifiers. It enabled users with disabilities, language barriers, or learning differences to tailor their online experience, supporting better access to digital content.

Many people reported clear and concise communication and ease of access, however, some autistic people and their carers reported some confusion around written materials and said that information could be presented more clearly. The local authority had already made a range of accessible resources available, including an accessibility/easy read visual tool on their website, developed through the Accessible Information Standard (AIS) to support informed choices, reasonable adjustments, and effective communication. The Care and Support Planning procedure also offered flexible formats, such as pictures, videos, and drawings to accommodate individual preferences. However, based on feedback, there was an opportunity to further promote and embed these tools to ensure they were consistently used and understood by people.

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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

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The local authority worked with local people and stakeholders and used available data (for example the Joint Strategic Needs Assessment) 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 fund or arrange their own care, now and in the future.

The local authority demonstrated a commitment to understanding the care and support needs of its population by actively using the Joint Strategic Needs Assessment (JSNA) as a foundation for planning and decision-making. The JSNA was structured around a life course approach and included detailed data on population demographics, health inequalities, long-term conditions, and specific vulnerabilities such as homelessness. It highlighted the needs of people most at risk of poor outcomes, including those with protected characteristics, unpaid carers, and self-funders.

Additionally, the local authority's People Commissioning Strategy 2023–26 highlighted a strength-based approach to working with local businesses, ensuring services were tailored to community needs such as the newly commissioned carers hub. This approach ensured that services were informed by evidence and reflected the lived experiences of local people.

The local authority engaged with people through active engagement and their Stronger Together co-production forum in shaping responsive, inclusive care strategies. In June 2023, the local authority hosted a dementia-focused event attended by over 100 people living with dementia, their families, and service providers, creating space for shared experiences and suggestions to inform meaningful support. Similarly, in September 2023, 25 people involved in Mental Health Supported Accommodation participated in a two-day workshop to discuss their priorities, which directly influenced service commissioning. A dedicated Mental Health co-production group was also formed to contribute to tender specifications and evaluations.

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Partners reported active involvement in market engagement and said the local authority was committed to incorporating the voices of people and partners in understanding the needs of the local community.

## Market shaping and commissioning to meet local needs

People had access to a diverse range of local support options that were safe, effective, affordable and high-quality to meet their care and support needs. The local authority developed a comprehensive Adult Social Care Strategy, underpinned by inclusive commissioning, co-production, and a commitment to meeting diverse needs.

The local authority had well-defined commissioning priorities, shaped by insights from Joint Strategic Needs Assessments (JSNAs), census data, and other analytical sources. It demonstrated a clear understanding of future demographic trends and was proactively focusing on areas of greatest need, such as housing development, care home capacity, and specialist dementia support to meet the anticipated requirements of an ageing population.

The local authority was investing in tailored day opportunities for people with learning disabilities and autistic people, including extended hours and weekend access, alongside plans for self-contained supported housing units by 2026. Its Supported Housing Strategy promoted independence through adaptations and Care Ready Housing that is suitable for personalised adaptations, designed for future flexibility.

Mental health services were being transformed through outcome-based commissioning and a new recovery pathway, including supported accommodation for varying levels of need and community-based floating support. Support included face-to-face training, self-help workshops and a 'lifeline' for people needing support with their mental health and substance use. Staff shared an example of how the service supported a person in their recovery from a mental health condition, enabling them to enrol in a local college course. They described how the person's self-esteem had significantly improved and how the support provided helped them maintain their independence and pursue personal goals.

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For older adults and those living with dementia, the local authority offered specialist services such as memory clinics, Admiral Nurses, and dementia cafés. A re-commissioned Dementia Support Service provided post-diagnostic guidance, emotional support, and activities like singing groups and empowerment sessions, supporting over 480 people in 2022/23. The local authority also partnered with a charity to fund a Dementia Friendly project officer who offered ongoing information, support, and guidance, to both carers and people living with dementia, for the whole of their dementia journey.

There was mixed feedback from people about care services in the local authority. Some people reported having limited choice over the services they received, while others were happy with the care and support they received and said it met their needs and helped them to feel more positive. Data from the Adult Social Care Survey 2023/24 reported 67.36% of people who use services felt they had a choice over services which was similar to the England average of 70.28%. Additionally, 62.31% of people said help and support helped them to think and feel better about themselves, also similar to the England average of 62.48%.

There was specific consideration for the provision of services to meet the needs of unpaid carers. The local authority commissioned services to offer a wide range of support for unpaid carers by offering targeted support for young carers, carers of people living with dementia, mental health support and support with neurodiversity conditions. Additionally, there were offers of respite and peer groups to offer advice for finances and direct payments, with plans to increase this further.

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Feedback from unpaid carers reported a generally positive experience with local care and support services shaped through commissioning. Carers reported that they, and those they cared for benefitted from a variety of community-based options, including regular day centre attendance, weekend respite care, and short breaks that supported wellbeing. Many carers also accessed respite services during the week to help manage their responsibilities. Carers said community transport made it easier for people to get to the services they needed. However, some carers raised concerns about the consolidation of 3 day centres into a single central location, with some fearing this may reduce overall provision.

Data from the Survey of Adult Carers in England 2023/24 showed 10.87% of carers were accessing support or services allowing them to take a break from caring at short notice or in an emergency, this was similar to the England average of 12.08%. Percentages for carers accessing support or services for 1-24 hours or for more than 24 hours were also similar to England averages with no statistical variation.

The local authority commissioned models of care and support that were in line with recognised best practice. Commissioning strategies were increasingly outcome-focused and informed by data from the JSNA, census, and performance indicators. The local authority supported new and innovative approaches to care provision, where this led to better outcomes for people. For example, in housing and homelessness, the local authority introduced specialist temporary accommodation with wrap-around services, including food banks, employment support, and children's services. Kernow House was launched in May 2025 and had successfully supported 50 rough sleepers, with 30 transitioning to stable community living. Bridging Care, a new service supporting hospital discharge, used a quality-driven dynamic purchasing system and allowed continuity of care by allowing the service to continue through to long-term packages where appropriate. These initiatives reflected a strategic, person-centred commissioning model that valued co-production, quality, and inclusivity.

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Partners were positive about the local authority's enthusiasm and collaborative approach, especially in facilitating information-sharing meetings such as provider concerns meetings and inter-agency risk management meetings. They also reported a positive shift from traditional day centres to a strengths-based, goal-oriented model, supported by commissioners who enabled more personalised care and collaborative innovation.

## Ensuring sufficient capacity in local services to meet demand

There was sufficient care and support available to meet demand, and people could access it when, where and how they needed it. The local authority had taken proactive steps to ensure sufficient capacity in adult social care services, with readily available capacity across homecare, supported living, and respite provision. Staff consistently reported that homecare was easy to source, with no waiting times and a competitive market of 21 providers under a new framework. Supported living placements could often be arranged within hours, and residential and nursing homes, some with dual registration and specialist dementia care were reported to be readily available, supporting continuity of care. The local authority supported the opening of 2 new care homes in the last 12 months, with a further 2 planned to open in the next 2 years in response to their forecasted rise in demand for these services.

The local authority's in-house services were well equipped and designed to meet complex needs, and a substantial investment has been made to develop a new building for day and respite services for people with learning disabilities. Other provision included community alarm services, supported housing for older people, housing for rough sleepers and accommodation for people with complex mental health needs. Staff also highlighted culturally appropriate care options, including personalised support through direct payments, enabling people to choose carers who understood their cultural and linguistic needs.

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While accommodation remained a challenge, particularly in supported and temporary housing, the local authority was addressing this through initiatives like “housing with care,” which integrated accommodation and support. For people with learning disabilities and autistic people, there was a strong focus on supported living, with services like Camphill offering a village-style environment with work experience opportunities.

To address market gaps, the local authority collaborated across commissioning and community resource teams (brokerage), offering training to providers to support a wider diverse range of care, improve care quality, and reduce out-of-area placements. In 2024/25 64 searches were undertaken for out-of-area care provision, 39 of these were due to ‘no local capacity’, 21 were at the request of the person needing care, 1 was a family request and 3 people were declined by homes in Milton Keynes. However, since this time, staff told us most out-of-area placements now reflected personal choice rather than lack of capacity.

The care market was described by staff and leaders as buoyant, with ongoing efforts to shape future provision and ensure services remained responsive and inclusive, particularly for older people and those living with dementia which are forecasted to increase in demand with Milton Keynes ageing population.

## 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.

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The local authority had a comprehensive approach to monitoring the quality and impact of its commissioned care and support services. The Quality and Compliance Team (QCT) carried out a wide range of activities, including quality assurance visits, follow-ups, and out-of-area assessments, to ensure services were meeting expectations and supporting positive outcomes. They used a nationally recognised quality monitoring system which provided ratings and a clear overview of provider performance, with most services rated as good or excellent. Where improvements were needed, the QCT worked constructively with providers through action plans, regular visits, and guidance, helping to strengthen service delivery.

Feedback from internal and external partners was actively incorporated into monitoring processes. The local authority also commissioned an independent organisation to undertake 'enter and view' visits. In 2024/25 the organisation conducted 20 enter and view visits, several of which were jointly conducted with QCT. They provided written reports which included recommendations for changes and improvements made directly to the provider, feedback from people who used the services, and an update on action taken by providers on the recommendations made during the 'enter and view' visits. The local authority's commitment to continuous improvement and quality was further reflected in its collaborative work with stakeholders and its plans to expand this service into supported living and home care.

Staff told us they worked collaboratively with partners including the Care Quality Commission (CQC), health professionals, safeguarding teams, and fire safety experts to share information and conduct joint quality assurance visits. They described responding to concerns by developing joint action plans and actively seeking feedback from people who used services, including through experts by experience. Feedback was gathered through interviews and observation, and providers are supported to implement improvements. Staff also offered direct advice and guidance to raise standards, with one example involving the introduction of a visual daily rota for people in supported living to reduce anxiety, which was later adopted more widely following positive feedback.

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Staff told us they held regular contract meetings with providers and use key performance indicators to monitor service outcomes. They also facilitated provider forums, which were valued by the local authority and partners as collaborative spaces to share ideas and discuss developments. Providers reported that the local authority had effective systems in place to monitor the quality and impact of commissioned care services, including checks on working conditions to help maintain standards. The local authority was described as receptive to constructive feedback, with one example being the jointly developed 'declines form' used to explain decisions around being unable to offer support or accommodation.

## Ensuring local services are sustainable

The local authority collaborated with care providers to ensure that the cost of care was transparent and fair. To ensure local services remained sustainable amid significant market pressures, including rising demand, workforce challenges, and the cost-of-living pressures, the local authority had taken a proactive and supportive approach. They delivered substantial fee increases to care providers, with uplifts averaging 5.23% in 2022/23, 9.5% in 2023/24 and 8.91% in 2024/25. Additional financial support could also be offered to providers experiencing hardship, following individual assessments. The local authority allocated funding from the Market Sustainability and Improvement Fund, prioritising inflationary uplifts to promote long-term stability. Alongside this, they updated their Market Position Statement and continue to monitor capacity and demand to inform future planning and support a resilient care market.

The Milton Keynes Adult Services Workforce Strategy 2024–2027 demonstrated the local authority had a clear understanding of both current and future workforce needs in social care. The strategy outlined key challenges such as recruitment and retention pressures, an ageing workforce, and increasing demand for complex care. In response, the local authority prioritised actions to strengthen workforce capacity and capability, including targeted support for personal assistants and collaboration with care providers and agencies.

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The local authority told us their contracting arrangements were designed to offer long-term security, enabling providers to plan ahead and deliver consistent care. Engagement with providers and stakeholders helped the local authority understand current trading conditions and identify early signs of service disruption or provider failure. In such cases, contingency protocols are in place to safeguard continuity of care, including guidance for staff and frameworks for managing interruptions.

The local authority had procedures for suspending placements with providers where quality concerns arose, while offering support to improve standards and resolve issues collaboratively. The local authority told us 7 contracts had been handed back or terminated for homecare and supported living in the last 12 months due to financial viability. This highlighted there was an opportunity to strengthen market oversight and explore ways to identify and respond to financial challenges earlier, helping to support long-term sustainability.

Staff told us that the local authority had effective arrangements in place to support service sustainability, including during unexpected changes. They shared an example of a care home closure where teams worked swiftly and collaboratively to find suitable placements for 12 residents, ensuring friends could remain together and supporting others to relocate closer to family. Staff told us they felt proud of the outcome and noted positive feedback from people following their move. They also told us that provider exits from the market were infrequent, and when they did occur, there was sufficient capacity within the local care market to respond promptly and maintain continuity of care.

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## Partnerships and communities

Score: 4

4 - Evidence shows an exceptional 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. The local authority demonstrated a strong commitment to partnership working, embedding collaborative approaches across health, social care, housing, education, and the voluntary sector.

The 'MK Deal', developed with the Integrated Care Board (ICB), provided a foundation for place-based planning and delivery. Through this agreement, the local authority and its partners progressed four key priorities: improving system flow, tackling obesity, supporting children's mental health, and strengthening locality working. Achievements included the launch of the Integrated Discharge Hub, which operated seven days a week and involved housing teams, voluntary organisations, and a medication delivery service. A joint care academy was also introduced to enhance reablement skills across health and social care roles. These initiatives supported improved system flow and promoted independence through improved offers of reablement.

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The local authority supported innovative locality-based working through the Bletchley Pathfinder, which piloted multi-professional collaboration and developed a problem-solving model to support people at risk of exclusion. Community engagement was strengthened through the creation of over thirty new clubs and activities. The Tinkers Bridge Project, coordinated by the local authority's mental health and complex needs team, brought together police, NHS, housing, and social care professionals to address anti-social behaviour and support individuals with complex needs. The local authority also prioritised investment in modern facilities through the development of Linford Wood Place, a new integrated care hub for adult day services and short breaks. This initiative aimed to improve care quality and increase future capacity, reflecting the local authority's ongoing commitment to inclusive, person-centred services.

In adult services, the Dementia Information Support Service (DISS) played a key role in improving access to diagnosis and support. Delivered in partnership with Adult Social Care, the NHS, GPs, and voluntary organisations, DISS aligned with the Care Act 2014 by focusing on prevention and wellbeing. Regional collaboration helped raise awareness and supported to improve outcomes for people living with dementia. The local authority gathered feedback from people using the service which included people saying they received quality support services which helped them understand their condition, achieve their desired outcomes and maintain their wellbeing and quality of life.

The local authority co-produced the 'Hearts Without Limits' programme with adults with learning disabilities. This programme was aimed at supporting social connection, friendships, and relationships for adults with learning disabilities and offered inclusive social events tailored to individual preferences, including quieter environments and sensory-friendly spaces. Feedback from a targeted survey informed the design, ensuring accessibility and support needs were addressed. People reported they enjoyed the programme and wanted it to continue but it needed to include a quiet sensory room and some transport options which was being addressed by the local authority. The local authority was also planning to expand the programme to autistic people.

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Partnership working extended to equipment provision through the Integrated Community Equipment Service (ICES), a regional consortium involving multiple local authorities and the ICB. This service supported timely access to aids and equipment, supporting hospital discharge, independence, and quality of life.

The local authority's Supported Housing Strategy, developed with housing associations, increased the availability of accessible and adapted housing for older people and those with physical disabilities. This offered alternatives to traditional care homes and supported people to live independently in the community.

Access to welfare benefits was improved through the local authority's partnership with third-party agencies, which supported residents in securing income-related advice and financial support. This also reflected the local authority's commitment to improving financial wellbeing and reducing inequalities.

The local authority also contributed to regional planning through participation in the Association of Directors of Adult Social Services (ADASS) Spring Seminar, which developed guiding principles and metrics for intermediate care. In response to rising demand and complexity, the local authority and its partners held workshops to explore challenges in Pathway 1 discharge services, particularly for people with age-related conditions such as dementia. The local authority told us the creation of the Integrated Discharge Hub (IDH) had resulted in more patients being discharged home (pathway 1) from hospital in line with their 'home first' approach.

People described how partnership working had supported them and the people they care for, particularly through coordinated input from physiotherapists, mental health teams, and hospital discharge services. They shared examples of how joint assessments had helped ensure appropriate support was in place, particularly following hospital discharge, enabling people to remain safely at home and how they were able to connect with others through local groups, which they found beneficial.

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Staff and leaders consistently described partnership working as a central and well embedded feature of service delivery in Milton Keynes. They highlighted strong relationships across health, housing, education, and voluntary sectors, supported by co-location of teams, joint planning, and shared governance structures. Staff spoke positively about multi-disciplinary working, particularly in areas like hospital discharge, falls prevention, and safeguarding, where joint decision-making and integrated hubs had led to improved outcomes.

Collaborative approaches were also evident in support for people with learning disabilities, dementia, and those transitioning to adulthood, with joint assessments, triage meetings, and education initiatives helping to ensure continuity of care. While some challenges were noted, such as referral pathways between housing and adult social care, staff emphasised a shared commitment to problem-solving and mutual accountability. Overall, partnership working was described as mature, inclusive, and impactful, with a clear focus on improving people's experiences and outcomes.

Partners described a constructive and evolving relationship with the local authority, highlighting strong leadership, inclusive engagement, and a shared commitment to improving outcomes. They valued opportunities to contribute to strategic boards, co-produced initiatives, and integrated service planning, particularly around hospital discharge, mental health, and support for older people. Several partners noted that the local authority had worked effectively to convene stakeholders, support innovation, and respond to the lived experience of people who use services. While some partners identified areas for improvement in frontline operational working, there was a clear sense of collaboration, mutual respect, and a willingness to problem-solve together.

## Arrangements to support effective partnership working

The local authority had well established arrangements to support partnership working, governance, and accountability, with a clear focus on improving outcomes through collaborative leadership and integrated structures. The Care and Support Operational Policy outlined the partnership mechanisms used to meet care and wellbeing obligations, while the Health and Wellbeing Strategy confirmed that all invested partners were represented at board level.

The 'MK Deal' introduced a Joint Leadership Team that met regularly to oversee four priority areas: improving system flow, obesity, children's mental health, and locality working, each aimed at strengthening relationships between health and care partners. Governance was further supported by the MK Together Safeguarding Partnership, affiliated Assurance Group, which brought together public health, probation, fire and police services, and the local authority to oversee shared priorities. Monthly Inter-Agency Risk Management Meetings (IARMMs) facilitated shared decision-making and improved coordination of care for vulnerable individuals.

The Carers Operational Management Group (COMG) ensured carers' voices were central to service planning, bringing together carers, health, education, and social care professionals to oversee the Carers Strategy. The COMG included the Carers Project Group, the local authority Commissioning Board, and the local authority Adult Social Care leadership team, the Children's leadership team, and the Integrated Care Board.

The local authority and its health and care partners had embedded governance and partnership arrangements in place to deliver and monitor the impact of the Better Care Fund (BCF). The BCF was governed through the Health and Care Partnership and aligned with the MK Deal, which provided a strategic framework for collaboration across the local authority, ICB, NHS Trusts, primary care networks, and the Voluntary, Community and Social Enterprises (VCSE) sector. The Joint Leadership Team met regularly to oversee priority areas, including improving system flow, neighbourhood health, and carers support, while the Improving System Flow Steering Group reviewed BCF progress and delivery.

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The local authority used pooled budgets through the Better Care Fund (BCF) to jointly commission and deliver a wide range of integrated services with health and care partners, aimed at improving outcomes for local residents. These arrangements were underpinned by formal governance structures and oversight from the Health and Care Partnership and the Improving System Flow Steering Group, ensuring accountability and strategic alignment. Where services were found to be underperforming, the local authority and partners demonstrated effective oversight by reviewing contracts and reallocating funding to better meet local needs.

The BCF supported the redesign of falls prevention services following a system-wide review that identified fragmentation and limited preventative impact. A new clinically led model was introduced through the NHS Trust's Staying Steady service, with plans to expand preventative work via voluntary sector partners and public health. Similarly, dementia support was strengthened through pooled funding, enabling the introduction of care home liaison roles, the Dementia Information and Support Service (DISS), Admiral Nurse provision, and dedicated step-down beds to support timely discharge and post-diagnostic care.

Staff and leaders described partnership working in Milton Keynes as well established and strategically driven, supported by clear governance structures and pooled funding arrangements. Partners said the co-location and newly integrated arrangements had resulted in positive outcomes for people, examples given were more people returning home from hospital and improved support for people with more complex needs.

## Impact of partnership working

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

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Through the MK Deal and aligned governance structures such as the Joint Leadership Team and Health and Care Partnership (Health and Wellbeing Board), the local authority worked collaboratively with health, housing, education, and voluntary sector partners to set shared priorities and monitor progress. Initiatives like the Integrated Discharge Hub, the Staying Steady falls prevention service, and the Dementia Information and Support Service (DISS) were jointly commissioned using pooled budgets through the Better Care Fund (BCF), enabling more efficient use of resources and improved service delivery.

Locality-based initiatives such as the Bletchley Pathfinder and Tinkers Bridge Project demonstrated how multi-professional collaboration could address exclusion and complex needs, while investment in Linford Wood Place reflected a commitment to inclusive, person-centred care. Dementia support was strengthened through services like DISS and Admiral Nurses, and the co-produced 'Hearts Without Limits' programme offered tailored social opportunities for adults with learning disabilities.

The local authority evaluated the effectiveness of these partnerships through regular steering group reviews and strategic oversight mechanisms. For example, the redesign of falls services followed a system-wide review that identified fragmentation and duplication, leading to a more streamlined, preventative model with measurable outcomes. Similarly, underperforming services such as live-in care and end-of-life support were reviewed, and funding reallocated to more impactful areas.

Partners reported that integrated working in Milton Keynes had led to measurable improvements in hospital discharge and care coordination. Partners said the Integrated Discharge Hub (IDH), developed collaboratively by the local authority, NHS, and voluntary sector, reduced hospital stays of 15 days or less by 15% and improved discharge pathways, with more patients supported to return home under Pathway 1. The addition of housing and pharmacy roles within the IDH enhanced support for people with higher needs, while a 72-hour post-discharge follow-up helped prevent readmissions. Co-location of mental health practitioners and shared roles like the Housing Sustainment Officer enabled faster responses and smoother transitions, demonstrating the positive impact of partnership working on outcomes for people.

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## Working with voluntary and charity sector groups

The local authority worked collaboratively with voluntary 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.

The local authority established a Covenant for Partnership Working to formalise collaboration with the voluntary and community sector, which included charities, trusts, faith groups, social enterprises, and community organisations. This covenant set out a shared commitment to empowering local communities through a preventative and early intervention model of support. It was underpinned by four guiding principles: recognition of the sector's value, shared learning of best practices, enabling communities to influence change, and maintaining transparency. This approach aimed to strengthen relationships and aimed to align community-led initiatives with broader public sector goals.

Through the Voluntary Sector Alliance, the local authority collaborated with community organisations, charities, trusts, faith groups, and social enterprises to review activities, share best practices, and identify service gaps. Commissioners regularly engaged with the sector, including presenting commissioning plans and co-developing the new Covenant that set out shared principles for collaboration.

The local authority commissioned a wide range of services from voluntary organisations, including domestic abuse support, dementia support, and floating support services. Advocacy for people was provided and another commissioned service offered independent assessments for care home placements. Grants were also awarded to partnered groups and organisations, who act as 'critical friends' in shaping strategies and service changes. The newly commissioned carers hub also aligned with several voluntary sector organisations to support carers.

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Partners described positive and collaborative relationships with the local authority, highlighting commissioners as approachable, responsive, and committed to listening. They said they were supported in their roles, particularly around autism, learning disability, and community inclusion. Partners valued involvement in strategic planning and co-production, though some noted their input wasn't always reflected in changes. Overall, partners felt recognised and empowered, with the local authority fostering trust, innovation, and shared accountability.

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## Theme 3: How Milton Keynes City 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

The local authority demonstrated a clear understanding of the risks people may face throughout their care journeys and took proactive steps to manage these effectively. Safety was supported through structured processes and multi-agency coordination, with workflow protocols ensuring that people's needs were considered and decisions made through consistent oversight. Risk assessments were guided by tools such as RAG-rated triage systems and waiting lists, helping teams respond appropriately based on urgency and complexity. Additionally, the local authority held over 1000 Inter-Agency Risk Management discussions between April 2024 and April 2025, supporting coordinated responses to people with high risk needs.

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'Waiting well' protocols were in place to maintain regular contact with people awaiting assessments or interventions, and this approach was generally applied across services. However, staff told us the working age adult team experienced challenges in maintaining its application due to competing demands. Despite this, robust risk management practices ensured that urgent and high-risk cases were prioritised, which contributed to a safe and responsive care environment.

Out-of-hours arrangements were well established, with clear contingency plans in place. The Approved Mental Health Professional (AMHP) team provided 24-hour cover, supported out-of-hours by a rota of qualified social workers. The AMHP service managed both emergency and planned work, with safeguards in place, such as escalation procedures and management cover, to address unpredictable demand and support continuity of care. Handover processes between out-of-hours and daytime teams were tailored to the level of risk, with routine cases assigned through standard alerts and safeguarding concerns addressed through detailed communication and direct coordination. This flexible and thorough approach supported continuity of care and timely support for those at risk.

Staff described a responsive out-of-hours system that prioritised urgent needs, even when private providers were unavailable. In-house services like Home First and rapid response teams were praised by staff and partners for their flexibility, and creative use of resources such as kettle packs and community alarms which helped prevent crises.

The local authority managed large scale enquiries and organisational abuse enquiries across the system. The Quality and Compliance Team worked closely with the Safeguarding Adults Team to monitor providers of concern, share information, and coordinate responses to issues affecting care quality and safety. Internal policies supported the management of these enquiries and care provider failures, including reassessments and identifying suitable alternative services, helping to maintain a consistent and responsive approach to identified concerns.

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Staff told us they were committed to tracking concerns, which were primarily managed through spreadsheets. While filters on the spreadsheets were used to explore patterns, there was no formalised process in place for identifying overarching themes or linking safeguarding issues to provider concerns. Information was shared through various channels, such as team inboxes and direct communication, but lacked a single point of contact or standardised approach. Despite this, staff described strong cross-team collaboration, with regular multi-agency meetings supporting coordinated and timely responses to provider-related issues.

## Safety during transitions

Care and support was 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.

People shared positive experiences of transitions, including support to attend college and help setting up direct payments to maintain continuity with care providers, which they said was important to them.

The local authority described a well developed, multi-agency approach to supporting transitions from children's to adult services, beginning at age 14. Joint reviews between children's and adult teams helped identify support needs early, with dedicated workers allocated from age 17 to complete Care Act assessments and coordinate referrals. At age 18, action plans were implemented and reviewed after eight weeks, followed by annual reviews. The Preparing for Adulthood Strategy and Protocol outlined best practice, legal duties, and personalised pathways for young people with special educational needs, disabilities, mental health needs, or care experience.

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Staff highlighted the role of a dedicated transitions colleague in children's services, which helped bridge gaps between services and ensured timely information sharing. They told us that improvements to the team had prevented late identification of young people needing support. The Preparing for Adulthood Team supported individuals aged 18 to 25, with early engagement from age 14 or 16 helping to reduce anxiety for young people and their families. A monthly forum for those with complex needs promoted coordinated planning, with some young people directly involved to better understand their transition journey.

The local authority had a range of measures designed to support safe and timely hospital discharge, reducing risks linked to prolonged hospital stays. The Hospital Triage and Allocation Process was used to accelerate discharge planning, while the Integrated Discharge Hub provided a collaborative foundation for managing transitions in and out of hospital settings. A structured referral pathway covering Hospital Discharge, Home First, Reablement, and Inpatient Rehabilitation was in place to promote patient flow and remove barriers to discharge. The local authority's bridging care service enabled short notice discharges by commissioning providers at an enhanced rate for up to seven days, with the option to continue longer-term support if needed. This approach helped to support continuity of care and smooth transitions between services.

People told us they received holistic support when transitioning from hospital with joint care and support from health and social care enabling them to return home safely and maintain independence.

## Contingency planning

The local authority undertook contingency planning to ensure it was prepared for any potential interruptions in the provision of care and support. It developed clear response strategies for various scenarios and established information-sharing arrangements with partner agencies and neighbouring authorities. These proactive measures were designed to minimise risks to people's safety and wellbeing.

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The local authority developed detailed plans to manage potential disruptions in care services. These included scenario-based responses and pre-established information-sharing protocols with partner agencies. There were system processes in place to respond to provider concerns and failures. It applied this protocol to safeguard people when such issues arose. The local authority also collaborated with internal teams and external organisations to deliver graduated notifications and responses. It took appropriate actions and imposed sanctions when breaches occurred, in line with Quality Assurance and Safeguarding protocols.

People reported receiving help during times of carer fatigue, with the local authority stepping in to arrange emergency care and support services. Examples included support which enabled carers to take necessary breaks whilst ensuring continuity of care for those they supported. Additionally, carers shared that the local authority had been helpful in planning for future care arrangements, which provided reassurance and reduced the risk of situations requiring contingency measures.

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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, practices to make sure people were protected from abuse and neglect. The local authority provided clear guidance for reporting safeguarding concerns. Policies and procedures detailed who to contact, including external agencies such as the Care Quality Commission and Thames Valley Police's Protecting Vulnerable People Unit. Public contact numbers were available for both in-hours and out-of-hours reporting, and professionals could submit referrals online directly to the local authority.

The local authority had a dedicated Safeguarding Adults Team, although all social work teams were involved in managing safeguarding concerns. They explained that a 'best fit' model was used to allocate Section 42 enquiries, meaning the team most suited to support the individual, based on their care and support needs would lead the enquiry when required, with input from the Safeguarding Adults Team as needed. For large-scale investigations or concerns involving organisational abuse, the Safeguarding Adults Team took the lead, as they were responsible for overseeing these complex cases.

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Risk management was a key component of safeguarding practice. The local authority implemented a structured process to guide staff in managing risk appropriately and making referrals to relevant partners such as the Multi Agency Risk Assessment Conference (MARAC) team. For people placed in Milton Keynes by other local authorities, the local authority followed the Association of Directors of Adult Social Services (ADASS) Safeguarding Adults Out-of-Area Guidance to ensure consistent and appropriate responses.

Staff were supported with practical tools and resources. These included checklists for managing safeguarding concerns and a multi-agency decision-making tool developed in collaboration with MK Together Safeguarding Partnership. The tool helped staff identify abuse types, assess risk levels, and determine appropriate interventions. It also included contact details for specialist support services and guidance on reporting specific abuse types.

The local authority told us all incoming safeguarding referrals were reviewed by a manager on the same day they were received and were risk assessed using a RAG (Red, Amber, Green) rating system that considered both risk and protective factors. Urgent cases involving significant harm were immediately allocated to senior social workers for prompt assessment. Enquiries awaiting allocation were prioritised based on factors such as the level of harm, involvement of other agencies, and urgency of risk, with safety plans put in place where necessary.

Partners described generally positive relationships with the local authority's safeguarding team, highlighting accessible referral systems and helpful support. However, several partners noted delays or inconsistencies in receiving feedback and outcomes following referrals, which sometimes impacted their ability to follow up with people receiving services. Despite these challenges, partners told us they valued the opportunity to engage in safeguarding processes and appreciated the local authority's responsiveness and willingness to work together to improve safeguarding outcomes.

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The local authority ensured that safeguarding policies remained current, and person-centred. For example, their Concern for Welfare guidance recently replaced the previous 'no response' policy and included updated escalation procedures and information-sharing protocols.

The local authority worked with partners as part of the MK Together Safeguarding Partnership, the multi-agency safeguarding partnership for Milton Keynes, to deliver a coordinated approach to safeguarding adults in the area. The MK Together Partnership fulfilled the responsibilities of the Safeguarding Adults Board. It brought together senior leaders from key organisations including the local authority, health services, police, and other statutory and voluntary agencies to coordinate and oversee safeguarding for both children and adults in the area.

There was a strong multi-agency safeguarding partnership, and the roles and responsibilities for identifying and responding to concerns were clear. As active partners in the MK Together Safeguarding Partnership, the local authority contributed to a governance structure that included annual meetings with chief executives and quarterly meetings between leaders from health, police, and local authority services. The partnership operated through four working groups, assurance, review, delivery, and child death, each led by different partner organisations, and supported by independent scrutiny to ensure transparency and accountability.

Independent scrutiny had been part of the Safeguarding Partnership arrangements since 2019. There was an independent safeguarding scrutineer who acted as a 'critical friend' for the partnership identifying and addressing potential gaps. At the time of our assessment, they were new in post, therefore their impact was yet to be established.

The local authority reported a strong collaborative relationship with Thames Valley Police (TVP), meeting weekly to review safeguarding cases, themes, and systems. Joint working with TVP also included the implementation of the 'Right Care, Right Person' policy, which supported timely and safe responses to people.

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Information sharing arrangements were in place so that concerns were raised quickly and investigated without delay. The Integrated Care Board (ICB) Designated Safeguarding Lead Nurse was co-located with the adult safeguarding team, facilitating swift information sharing between services.

A representative from the Safeguarding Adults Team regularly attended multi-agency risk management forums, including meetings focused on high-risk domestic abuse cases, public protection arrangements for people who posed a risk to others, tasking and coordination meetings aimed at reducing repeat offending, panels addressing concerns related to radicalisation, and the newly established panel for managing domestic abuse perpetrators. They offered safeguarding advice and served as a link between these forums and the Adult Social Care teams working directly with individuals.

Staff described effective collaboration through the MK Together Safeguarding Partnership and the Multi-Agency Safeguarding Hub, enabling coordinated responses to complex safeguarding issues. Staff offered meaningful examples, they told us they supported a person facing financial abuse by liaising with the police and making referrals. In another, they worked with housing, probation, and support services to help a person recently released from prison resolve rent arrears and secure safe accommodation after their property had been cuckooed. Cuckooing is when the control of a person's home is taken over by people who are committing criminal offences. These examples highlighted the strength of partnership working in delivering positive safeguarding outcomes.

According to data from the Adult Social Care Survey 2023/24 69.82% of people who used services felt safe and 85% of people who used services said those services made them feel safe and secure. This was similar to the England averages of 71.06% and 87.82% respectively. Similarly, according to data from the Survey of Adult Carers in England 2023/24, 80.85% of carers said they felt safe which was similar to the England average of 80.93%. This suggested the local authority's adult social care services were broadly in line with national standards with regards to safety and security for carers and people who used services.

## Responding to local safeguarding risks and issues

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There was a clear understanding of the safeguarding risks and issues in the area. The local authority worked with safeguarding partners to reduce risks and to prevent abuse and neglect from occurring. The MK Together Partnership Safeguarding Annual Report 2023–24 identified key adult safeguarding priorities including mental capacity assessments, exploitation, persons in positions of trust, self-neglect and hoarding, transitional safeguarding, and the 'Think Family' approach.

The local authority demonstrated a proactive and responsive approach to addressing local safeguarding risks. In response to concerns around mental capacity assessments, the local authority led the development of Mental Capacity Act Standards to address inconsistencies across agencies and introduced targeted training, which they reported resulted in improved assessment quality and consistency. Exploitation was tackled through increased use of the Inter-Agency Risk Management (IARM) protocol, particularly for people vulnerable due to rough sleeping, and the implementation of a data dashboard to monitor abuse types and inform decision-making. In cases of self-neglect and hoarding, the local authority used a multi-agency decision-making tool with indicators for self-harm and a Clutter Image Rating Scale to assess environmental risks. These tools enabled staff to take appropriate steps to support individuals while reducing harm.

Staff also spoke positively about the role of IARM meetings in safeguarding practice across Milton Keynes. They told us meetings supported approximately 150 people each month and involved a wide range of partners, including mental health professionals, community psychiatric nurses, housing teams, emergency services, and representatives from the voluntary and community sectors. One example shared involved supporting a person experiencing domestic abuse. Through the IARM process, staff helped the person recover from substance misuse and to engage in a programme that enabled them to support other young people.

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The Think Family approach was embedded through collaboration with people with lived experience and the development of follow-up systems for young people transitioning from services, ensuring their support networks were involved in care planning. Their commitment to tackling abuse against women and girls was demonstrated through White Ribbon accreditation and a three-year strategic plan. This included specialist training for staff and support services led by White Ribbon Ambassadors. Self-neglect was addressed through enhanced staff training and the launch of a “Safeguarding Unlocked” series, alongside the creation of a hoarding peer support group and a forum for oversight of complex cases.

Lessons were learned when people had experienced serious abuse or neglect, and action was taken to reduce future risks and drive best practice. The Principal Social Worker (PSW) led a review of Safeguarding Adults Review (SAR) referrals across the partnership in 2024. Following the SAR Review Report, each agency participated in workshops focused on identifying and escalating cases to the SAR process.

Staff told us learning bulletins summarising key insights from SARs were distributed to all staff, supported by training workshops and reflective sessions to embed learning into practice. While staff reported that learning from Safeguarding Adults Reviews (SARs) was shared with providers through regular forums, some partners noted that this information was not consistently communicated to all sectors, particularly the voluntary and contracted providers. As a result, key lessons and training opportunities linked to SARs were not always accessible to those outside the core statutory services, limiting broader system-wide learning.

## Responding to concerns and undertaking Section 42 enquiries

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There was clarity on what constituted a Section 42 (s42) safeguarding concern and when s42 safeguarding enquiries were required, and this was applied consistently. The local authority had structured processes to manage safeguarding concerns effectively and promptly. Policies and procedures outlined the s42 enquiry process, promoting joint working and adherence to the principles of making safeguarding personal.

Staff used a Decision-Making Tool (DMT), developed by multi-agency partners of the MK Together Safeguarding Partnership which aimed to establish a shared understanding of when adult safeguarding applies, based on the three-stage criteria within Care Act guidance. It guided practitioners in identifying abuse types, assessing risk levels, and determining appropriate initial actions. Practitioners were encouraged to use their professional judgement and record all decisions. Enquiries open beyond 28 days were reviewed at safeguarding panels and escalated if high risk persists.

There had been a 44% increase in safeguarding referrals in the last 12 months. To manage the rising volume of safeguarding referrals, the local authority recruited 5 additional staff into the Safeguarding Adults Team. Despite this significant increase in referrals, as of the end of September 2025 there were no waits at the point of referral to triage safeguarding concerns. They were all triaged on the day of receipt. As of the end of September 2025 there were 6 people waiting to be allocated for a s42 enquiry with a median wait time of 15 days and a maximum wait time of 28 days. The increase in referrals over the past year had led to longer wait times for s42 enquiries. Despite this, the Safeguarding Adults Team maintained oversight of all pending cases, ensuring regular reviews, inclusion of the person's views, home visits, and the implementation of safety plans for those waiting. Safeguarding conversion rates remained stable between 22-29% between 2021-2023.

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When safeguarding enquiries were delegated to another agency, the local authority maintained overall responsibility to ensure they were effective and compliant with Section 42 of the Care Act 2014. Enquiries were assigned to the most appropriate professionals, often those with prior knowledge of the individual or relevant expertise. To support a consistent approach, the local authority provided clear documentation such as terms of reference, and report templates, and agreed the scope and timescales in advance. Completed enquiries were reviewed by the local authority to ensure safeguarding concerns were fully addressed and to determine any necessary follow-up.

The local authority had clear standards and robust quality assurance arrangements in place for conducting s42 enquiries. Managers provided oversight and authorisation at both triage and closure stages, ensuring consistency and accountability. Regular safeguarding audits were carried out by senior staff, using reflective conversations to promote learning and improve practice. These audits, supported by practice leads, reinforced professional development and encouraged open communication. Staff also participated in peer supervision and reflective practice across various forums, including senior social work, social work, and assistant forums, helping to embed a strong culture of shared learning and continuous improvement in safeguarding management.

The local authority's Deprivation of Liberty Safeguards (DoLS) service demonstrated strong performance and effective management. Between September 2024 and September 2025, 1,738 applications were received (a 4.2% increase from the previous year), with 93.2% signed off within the 7-day target. As of 24th September 2025, 7 people were awaiting assessment, with a median wait of nine days and a maximum of twelve, and no backlog was reported. This demonstrated effective management of referrals and reliable access to Independent Best Interests Assessors. As the supervisory body, the DoLS team supported to ensure lawful and proportionate deprivation of liberty, supported professionals via an advice line, and upheld its statutory responsibilities under the Care Act.

## Making safeguarding personal

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The local authority had taken active steps to embed Making Safeguarding Personal (MSP) across its safeguarding practice. By integrating the Local Government Association's MSP framework into Section 42 enquiry forms and using a data dashboard to monitor outcomes, it was able to track the effectiveness of MSP. In 2023/24, the safeguarding annual report showed 88.3% of enquiries where risk was identified resulted in that risk being reduced or removed, and 96.9% of people who were asked about their desired outcomes saw those outcomes fully or partially achieved. Prompts within delegated enquiry guidance further reinforced MSP principles, helping staff maintain a person-centred approach throughout safeguarding processes.

Staff described working collaboratively across agencies to ensure safeguarding responses were tailored to individual needs, taking time to understand each person's history, preferences, and support networks. Staff told us making safeguarding personal began at screening, with key information captured early and outcomes shaped through direct engagement during visits. For people living with dementia, staff told us they considered life experiences and advocacy needs to inform decisions. This empathetic approach was evident in how staff recognised meaningful behaviours. They gave examples such as a man taking shoes who had been a cobbler, and a woman shouting in a dining room who had once worked as a dinner lady, ensuring responses were respectful, informed, and person-centred.

Some people shared they felt safe, respected, listened to, and knew how to raise concerns. However, feedback from some partners highlighted people told them there had been a lack of communication, particularly around safeguarding outcomes. Data from the Safeguarding Adults Collection 2023/24 showed 100% of individuals lacking capacity were supported by an advocate, family member, or friend which was better than the England average of 83.38%.

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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 well established governance, management, and accountability arrangements across adult social care. The leadership team was stable, and services were organised into structured areas with clear oversight for fulfilling Care Act responsibilities.

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The Adult Leadership Team (ALT) was led by the Director of Adult Social Services (DASS). The DASS was supported by four Assistant Directors and eight Heads of Service. The Adult Services division had four key areas: Adult Social Care, Commissioning (for both adults and young people), Provider Services, and Housing. These areas were further supported by a dedicated Quality and Performance team.

The ALT had fortnightly meetings to provide oversight across several strategic functions. These included reviewing and monitoring service-wide planning, making collaborative decisions to address challenges and risks, and resolving issues that could impact service delivery. The team also tracked the development of key projects and programmes through the Project Review Board, assessed performance across all service areas, and explored opportunities for innovation and growth.

The Adult Social Care Assurance Board, chaired by the DASS, met monthly to oversee service performance, improvement, and strategic development. It managed quality assurance frameworks, monitored compliance with key reviews, and incorporated recommendations from co-production groups. The Board also tracked national and regional service improvement initiatives through the Association of Directors of Adult Social Services (ADASS) networks.

The Adult Social Care Operational Management Meeting (OMM), chaired by the Assistant Director of Adult Social Care, took place monthly to oversee service-related business, improvement initiatives, and the performance and quality of adult social care services. The meeting was attended by a broad range of colleagues, including those from Provider Services, Heads of Service, service and team managers, the Principal Social Worker (PSW), and the Principal Occupational Therapist (POT), and the Practice Development Team.

During these meetings, participants reviewed performance across social care teams, identified examples of good practice, discussed service developments, and considered risks and audit outcomes. Waiting list data was regularly examined, and assurance was sought on the actions being taken to manage demand. Where necessary, issues and risks were escalated to the Adult Leadership Team (ALT) or the Assurance Board.

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The local authority had a corporate risk register that outlined key strategic risks, including financial sustainability, safeguarding vulnerable adults, workforce planning and development, procurement and contract management, and business continuity. Each risk was accompanied by identified triggers, controls, critical success factors, and high-level action plans with designated leads and target dates.

Leaders described adult social care as central to the local authority's mission, supported by engaged councillors and stable political leadership. They emphasised the integrated approach taken by the local authority, which aimed to break down departmental silos and foster a culture of openness, shared risk, and collective responsibility.

The local authority highlighted the scrutiny function as an area with potential for further development. While a planning group was established to support the committee's agenda, some leaders noted that meetings could be more frequent and benefit from additional preparation. There were reflections on the committee's wide remit covering health, housing, and adult social care and whether this breadth allowed for sufficiently focused scrutiny. Some leaders shared uncertainty about how effectively the committee was able to challenge strategies or monitor progress.

Leaders reflected that scrutiny had previously been identified as an area for development during a Local Government Association (LGA) peer review of adult social care in 2023. In response, the Director of Adult Social Services (DASS) supported council members by offering training to help strengthen their understanding of the scrutiny role. However, partners told us some challenges remained, such as frequent changes in committee membership and the wide scope of the committee's responsibilities, which could make it difficult for members to gain detailed insight across all areas. It was noted the committee received data on adult social care performance and had welcomed people who use services to share their experiences. There were plans to build on this approach, with the aim of enhancing engagement and supporting more informed scrutiny in the future.

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Leaders were described as visible, capable, and compassionate, with staff consistently highlighting their accessibility and supportive approach. Staff spoke positively about the inclusive culture fostered by leadership, where innovation was encouraged and autonomy was promoted, allowing individuals to take initiative and ownership within their service areas. The co-location of teams was seen by staff and leaders as a key part of open communication and collaborative working, with colleagues able to engage easily and stay informed through shared systems. Blended working arrangements, including flexible schedules and regular leadership updates, were also valued by staff who said this contributed to a positive and responsive working environment.

Partners praised the local authority's leadership, noting strong commitment to partnership working and a clear focus on the needs of people using services. They observed that this commitment was evident across both political and corporate levels of the local authority. There was also positive feedback for effective joint governance systems often led by the local authority and commitment to collaborative decision-making.

## Strategic planning

The local authority used a broad evidence base which included data on risks, performance, inequalities, and outcomes to shape its adult social care strategies and plans. For example, the Dementia Strategy 2023–2028 was informed by projected demographic changes, including a significant rise in people diagnosed with dementia by 2040, and used feedback from people and communities to guide service development. The Carers Strategy 2023–2026 drew on census data and service usage statistics to identify priorities such as early identification of carers and culturally appropriate support. Similarly, the Health and Wellbeing Strategy 2018–2028 was underpinned by insights from the Joint Strategic Needs Assessment, highlighting trends such as increasing mental health needs and child poverty. These strategies demonstrated how the local authority used diverse sources of information to align services with the evolving needs of its population.

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Leaders highlighted the importance of population data in shaping adult social care strategies, noting the anticipated rise in people living with dementia and the need for appropriate service development. Leaders told us a partnership approach was being taken to become a dementia-friendly city and personal engagement with communities further supported strategic oversight, helping to ensure priorities reflected local needs.

Staff and leaders told us data was used to inform commissioning decisions, such as renewing contracts based on safeguarding and quality concerns. Equality, diversity, and inclusion data was used to inform and support targeted engagement, and rising numbers of people diagnosed with autism informed the development of an autism strategy and pathway.

Partners described encouraging progress in collaboration and engagement around strategic planning. Some partners told us about increased opportunities to participate in strategic meetings, which helped broaden their involvement in shaping local priorities. Others highlighted their active role in commissioning discussions, praising the local authority's transparent approach and emphasis on meaningful outcomes. While partners reported feedback was generally welcomed, some said it did not always lead to tangible change.

## Information security

The local authority had arrangements to maintain the security, availability, integrity and confidentiality of data, records and data management systems.

According to the local authority website, the local authority ensured information security through a structured and legally compliant approach, as outlined in its Corporate Privacy Notice and supporting documentation. The Corporate Information Management Team handles personal data only when necessary to deliver statutory services such as Data Protection, Freedom of Information, and Environmental Information.

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To safeguard this information, the local authority limited data usage strictly to what was required and ensured it was handled securely. Staff received dedicated training on data protection and information security, and any third parties or internal teams with access to data were also required to uphold these standards. Information was shared only when necessary, such as with other local authority departments, partner local authorities, or regulatory bodies, and always in line with statutory requirements.

Retention periods for personal data were clearly defined, ranging from two to six years depending on legal mandates or guidance from the Local Government Association. This structured approach reflected the local authority's commitment to the responsible management of personal information.

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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 an inclusive and positive culture of continuous learning and improvement. Local authority staff had ongoing access to learning and support and continuous professional development, so that Care Act duties could be delivered safely and effectively.

The local authority demonstrated a strong commitment to building a skilled, confident, and supported workforce through its Adult Services Workforce Strategy 2024–2027 and Learning Strategy 2025–2026. These strategies prioritised recruitment, retention, career progression, and continuous professional development. Staff feedback and performance analysis shaped a revised learning offer aimed at making training accessible, engaging, and impactful for frontline staff.

The local authority developed a bespoke 12-month Assessed and Supported Year in Employment (ASYE) programme led by a Practice Educator. The programme included peer support, workshops on equality, strengths-based practice, and professional curiosity, alongside guest speaker seminars, bite-sized training, and a new learning directory. The ASYE handbook provided a structured framework for learning and development, with formal assessments, regular supervision, reflective practice sessions, and direct observation to support newly qualified social workers (NQSWs) in becoming competent professionals. Staff spoke positively about having access to this pathway and the support they received from practice educators.

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Over the last 12 months, the local authority had improved mandatory training compliance through streamlined learning offers, role-specific training groups, and enhanced communication with managers. Real-time tracking via data dashboards enabled better visibility and responsiveness to training needs. This led to notable improvements, for example, compliance with Multi-Agency Safeguarding training rose from 56% to 94%, and Mental Capacity Act (In Practice) training increased from 48% to 78%. DoLS Awareness, previously untracked, reached 93% compliance. These improvements demonstrated the impact of the local authority's focused efforts to drive change.

Training and development opportunities were widely valued by staff. Staff highlighted access to bespoke training packages, mandatory safeguarding and mental capacity training, and learning weeks featuring guest speakers and workshops. Staff spoke positively about anti-discriminatory and values-based recruitment training, cultural awareness programmes, and initiatives like the 'Moving Up' career progression scheme and the 'MKCC REACH' (Race, Ethnicity and Cultural Heritage) Network for staff from non-white backgrounds. Staff described being encouraged to pursue professional qualifications, including through apprenticeship schemes, and contribute to shaping service delivery.

The local authority worked collaboratively with people and partners to actively promote and support innovative and new ways of working that improve people's social care experiences and outcomes. Co-production was deeply embedded throughout the local authority's work.

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The local authority championed co-production as a central principle in shaping adult social care services, ensuring people with lived experience, carers, and communities had meaningful influence over service design and delivery. Through initiatives like the Stronger Together Board, co-chaired by the Director of Adult Social Services (DASS) and a person with lived experience, monthly meetings brought together service users and staff to discuss improvements across key areas such as direct payments, carers, supported living, and mental health. Each area was supported by subgroups led jointly by professionals and people with lived experience, with recommendations feeding directly into service planning and strategies.

The local authority adopted the Working Together for Change methodology across multiple programmes, including the Preparing for Adulthood Strategy, where workshops in April 2024 gathered insights from young people, carers, and professionals to identify what worked, what didn't, and what needed to change. Similar workshops were held for mental health supported accommodation and direct payments, resulting in clear action plans themed around "I statements" and practical improvements like inclusive communication tools and better access to community resources.

Strategies were fully co-produced. The Carers Strategy 2023–2026 was co-produced with input from over 180 unpaid carers via surveys and workshops, leading to the identification of key themes and priorities. Co-production also shaped the Approved Mental Health Professional (AMHP) feedback workshop, where people with lived experience helped design feedback questions to ensure respectful and informed engagement. The newly developed Autism Strategy (not yet published) was shaped through a robust co-production process involving autistic adults, parent carers, young people, and professionals from health, social care, and education. Engagement activities included large-scale events, focus groups, interviews, and input from representative organisations, ensuring a wide range of lived experiences informed the strategy.

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People involved in co-production through the Stronger Together Board told us they felt empowered, valued, and listened to. They described the board as a safe and inclusive space where lived experience was central to shaping adult social care services. Members appreciated the leadership of the Director of Adult Services (DASS) as co-chair, which reinforced their sense of equality and influence. Many said their contributions directly led to improvements, such as a 10% increase in direct payment uptake and enhancements to assessment processes based on feedback about the need for more person-centred conversations.

People told us the local authority ensured psychological safety within the board, allowing open and honest dialogue and for people to communicate in ways that best suited them. They told us co-production was deeply embedded in local authority processes. While people told us most communities were felt to be represented, they also reported the need for greater inclusion of groups such as the Gypsy, Roma and Traveller community and autistic women, but were confident that outreach efforts were ongoing to address this.

Staff told us co-production had become a central and valued part of adult social care, with clear improvements in how the local authority listened to and worked alongside people who use services. Leaders stated co-production was embedded at both strategic and operational levels. This included its integration into commissioning, policies, and procedures, and the development of a Co-production Charter to guide and measure progress.

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Staff also spoke about co-produced initiatives like the hoarding support group, which was co-chaired by someone with lived experience and supported by specialist training. Leaders expressed pride in facilitating co-production for new services, such as the Linford Wood Place accommodation for people with learning disabilities. Leaders also described how feedback from people who use services was captured through reflective forums, audits, and thematic reviews, feeding into a quality assurance framework that informed service improvements, such as the creation of a safeguarding consultation line. Partners spoke positively about this offer of support and said it was helpful “being able to talk things through with the safeguarding team”.

The local authority demonstrated a commitment to sector-led improvement through active participation in peer reviews and by drawing on external support when needed. The Corporate Peer Challenge in March 2025, the Adult Social Care Preparation for Assurance Peer Challenge in March 2023 and the Commissioning Peer Review in 2024 all resulted in recommendations to strengthen service delivery. In response, the local authority took clear actions, including embedding co-production strategically across services and driving innovation in service design. Notable examples included the recommissioning of the sensory service, contributing to an increase in the number of people with sensory needs supported over the past year.

## Learning from feedback

The local authority learned from people’s feedback about their experiences of care and support, and feedback from staff and partners, which informed strategy and improvement activity. The local authority’s commitment to continuous learning and improvement was reflected in its investment in a dedicated Quality and Performance Team, which included senior practitioners and coordinators across social work and occupational therapy. This team managed the implementation of the Adult Social Care (ASC) Quality Assurance Framework, which set standards for excellence and outlined governance arrangements for oversight and feedback from people using services.

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A quarterly audit cycle, developed by the Social Work Practice Lead and overseen by the Principal Social Worker, aimed to provide a consistent evaluation of frontline practice. The 2024 audit of assessment and review processes focused on nine key areas, including advocacy, person-centred practice, cultural identity, carer support, risk, legal frameworks, and decision-making. The findings led to the creation of a practice matrix to define 'good' standards and highlighted the need for clearer eligibility statements under the Care Act. In response, the assessment form was revised, and workshops were delivered to frontline staff to consolidate strengths-based practice. According to local authority data, the improvements had a measurable impact with feedback from people using services following the interventions showing 100% satisfaction. Additionally, in response to areas identified in the 2023 Local Government Association (LGA) adult social care peer review and the LGA Partners in Care and Health bespoke safeguarding review, the local authority enhanced its approach to capturing the 'voice of the person' by having managers directly engage with individuals through calls and home visits. This feedback was used to identify themes, celebrate good practice, and inform further service enhancements.

The local authority had a dedicated dashboard to track complaints throughout their lifecycle, with monthly updates on volume and type presented to the Assurance Board for oversight. Feedback was triangulated from multiple sources, including the Quality Assurance Framework, direct interview calls, and insights gathered by the engagement officer to identify recurring themes and inform service improvements. This analysis supported a responsive learning culture, with an action plan in place to address findings, monitored and reviewed by the Assurance Board to ensure progress and accountability.

There was an annual adult social care complaints report that summarised data for each year and detailed local authority learning from the year. In 2023/24 the local authority annual report detailed that 109 complaints were raised, an increase from the previous year. There were 8 complaints upheld, or partially upheld and key themes included staff conduct, service failure, and contractor issues.

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Data from the Local Government Social Care Ombudsman (LGSCO) showed from July 2024 to June 2025 there were 4 detailed investigations which was in line with the England average for similar local authorities. The compliance rate was 100% with no late incidents and the uphold rate was 75% which again was similar to the England average.

Complaints highlighted the need for clearer communication, empathy, and timely responses. Delays in assessments, isolated case errors, and unclear complaint outcomes were key themes. In response, the local authority improved Stage 2 complaint handling by allocating more resources, revised assessment forms, and introduced training to strengthen case recording and response quality. These actions aimed to build trust and ensure concerns were addressed effectively. Leaders told us learning from these outcomes led to improvement actions focused on reducing delays, enhancing response quality, and strengthening case handling processes.