

HEALTH AND WELLBEING BOARD

DATE	1 st October 2026
REPORT OF	Diane Lee, Director of Public Health
SUBJECT	Domestic Abuse Partnership Strategy 2026-2030
STATUS	For Information

CONTRIBUTION TO OUR AIMS

The Domestic Abuse Partnership Strategy 2026-2030 contributes to the Council Plan by supporting safer, healthier and more resilient communities, reducing health inequalities, strengthening safeguarding arrangements and improving outcomes for adults, children and families affected by domestic abuse.

The Domestic Abuse Partnership Strategy contributes to delivery of the North East Lincolnshire Joint Health and Wellbeing Strategy. The strategy adopts a whole-system and public health approach, recognising that domestic abuse affects individuals throughout the life course and is closely linked to wider determinants of health and inequality.

EXECUTIVE SUMMARY

The Domestic Abuse Act 2021 sets out the requirement for local authorities to prepare, publish and implement a Domestic Abuse Strategy. This report presents the new NEL Domestic Abuse Partnership Strategy 2026-2030 for information. The strategy has been informed by a comprehensive needs assessment, also required by the Domestic Abuse Act. A significant co-design programme undertaken between February and June 2026 has ensured the strategy is also informed by local evidence, professional expertise and the voices of people with lived experience.

RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

1. Note the contents of the Domestic Abuse Partnership Strategy 2026-2030, its strategic priorities and governance arrangements.
2. Support continued partnership action to deliver the strategic priorities and improve outcomes for adults, children and families.

REASONS FOR DECISION

The Domestic Abuse Partnership Strategy 2026-2030 is provided for information.

1. BACKGROUND AND ISSUES

- 1.1 Domestic abuse is one of the most significant public health, safeguarding and community safety challenges in North East Lincolnshire. Its impact is far-

reaching, affecting physical and mental health, contributing to health inequalities, impacting educational attainment, housing stability, employment and community safety, and creating lasting trauma for adults and children.

- 1.2 The strategy has been developed between February and June 2026 through a comprehensive needs assessment and co-design programme. The approach combined a Domestic Abuse Needs Assessment, system maturity assessment, national policy and best practice, local performance data and intelligence, professional expertise, co-design workshops, engagement with people with lived experience, public consultation and survey findings.
- 1.3 The strategy adopts a public health approach to domestic abuse as both a cause and consequence of wider social inequalities, trauma and adverse experiences. It is underpinned by four strategic priorities:
 - Prevention and culture change.
 - Support victims, survivors and children to recover and thrive.
 - Address harmful behaviour, improve accountability and improve confidence in the justice system.
 - Strengthen the whole-system response.
- 1.4 Delivery will be progressed through multi-agency steering groups, each responsible for driving delivery of agreed priorities and reporting progress to the Domestic Abuse Partnership Board. Each steering group will be led by a nominated system lead.
- 1.5 The strategy supports collaborative action across health and care, safeguarding, housing, community safety, education, criminal justice and the voluntary and community sector at all levels of prevention.
- 1.6 Long-term outcomes identified through the strategy include fewer people experiencing domestic abuse, improved safety and recovery for people affected by domestic abuse, earlier identification and management of those who cause harm, and a more seamless whole-system response informed by data, evidence and lived experience.

2. RISKS, OPPORTUNITIES AND EQUALITY ISSUES

- 2.1 The strategy provides an opportunity to strengthen partnership working, improve prevention and early intervention activity, enhance coordination across services and improve outcomes for individuals and families affected by domestic abuse.
- 2.2 Without a coordinated strategic approach there is a risk of fragmented pathways, inconsistent support, missed opportunities for prevention and reduced progress in addressing inequalities and improving outcomes for victims, survivors and children.

- 2.3 A full equality impact assessment has been completed and will be updated and continuously reviewed alongside implementation of the strategy and delivery plan, with specific consideration of victims, survivors and children, protected characteristics, multiple disadvantage, access to safe accommodation, and barriers faced by communities who may be less visible in domestic abuse services.

3. OTHER OPTIONS CONSIDERED

Item is for information.

4. REPUTATION AND COMMUNICATIONS CONSIDERATIONS

- 4.1 There are potential positive reputational opportunities associated with the strategy through demonstrating partnership leadership and commitment to addressing domestic abuse as a public health, safeguarding and community safety priority and its alignment with the Health and Wellbeing Strategy.
- 4.2 A communications plan will cover publication of the strategy, partner briefings, workforce communications, public awareness messages, consultation feedback where appropriate, and communication routes for people seeking support.
- 4.3 Communications will be trauma-informed and inclusive, avoiding language that could increase stigma or create barriers to help-seeking. Messages should clearly explain the strategy's purpose, priorities and partnership approach, and signpost to appropriate support services.

5. FINANCIAL CONSIDERATIONS

- 5.1 The strategy provides a framework for aligning commissioning, resources and investment to shared priorities and agreed outcomes. The strategy does not create additional financial commitments for partner organisations.
- 5.2 Any future proposals requiring additional expenditure or investment will be subject to separate governance and approval processes.
- 5.3 The strategy should support improved value for money through coordinated partnership delivery, reduced duplication, evidence-informed commissioning and continuous improvement.

6. CHILDREN AND YOUNG PEOPLE IMPLICATIONS

- 6.1 Domestic abuse has significant implications for children and young people. The Domestic Abuse Act 2021 recognises children as victims in their own right where they see, hear, experience or are affected by domestic abuse.
- 6.2 The strategy includes a specific priority focused on supporting victims, survivors and children to recover and thrive with commitments to improve access to timely, equitable and trauma-informed support, strengthen coordinated pathways,

improve access to safe accommodation and promote recovery, resilience and lived experience leadership.

7. CLIMATE CHANGE, NATURE RECOVERY AND ENVIRONMENTAL IMPLICATIONS

There are no direct climate change, nature recovery or environmental implications arising from this report or the strategy itself.

8. PUBLIC HEALTH, HEALTH INEQUALITIES AND MARMOT IMPLICATIONS

The strategy is strongly aligned to public health and Marmot principles. It recognises domestic abuse as both a cause and consequence of wider social inequalities and adverse experiences, and adopts a public health approach focused on prevention, early intervention, recovery and whole-system improvement.

9. MONITORING COMMENTS

In the opinion of the author, this report does not contain recommended changes to policy or resources (people, finance or physical assets). As a result, no monitoring comments have been sought from the Council's Monitoring Officer (Chief Legal Officer), Section 151 Officer (Director of Finance) or Strategic Workforce Lead.

10. WARD IMPLICATIONS

The strategy has borough-wide implications across North East Lincolnshire. Domestic abuse affects communities across all wards, although local evidence identifies higher concentrations within East Marsh, West Marsh and South wards. Delivery will therefore include both borough-wide and targeted approaches informed by local need.

11. BACKGROUND PAPERS

Domestic Abuse Partnership Strategy 2026-2030

12. CONTACT OFFICER(S)

Diane Halton, Associate Director of Public Health
diane.halton@nelincs.gov.uk

Diane Lee
Director of Public Health



North East Lincolnshire
Domestic Abuse Partnership

Domestic Abuse Partnership Strategy 2026 – 2030

Contents

Foreword	3
Introduction	4
National Legislative and Policy Framework	5
How this Strategy was Developed	6
Facts and Figures	7
Our Shared Vision	8
Our Shared Principles	9
Governance	10
Delivery Framework	11
Key Priorities and Commitments	12
Long-Term Outcomes and Impact	16

Domestic abuse causes significant harm to individuals, families and communities. It affects physical and mental health, contributes to health inequalities, impacts educational attainment, housing stability, employment and community safety, and creates lasting trauma for adults and children.

This strategy adopts a public health approach, recognising domestic abuse as both a cause and consequence of wider social inequalities and adverse experiences. It sets out our collective ambition to prevent abuse before it occurs, support victims and survivors to recover, hold perpetrators accountable for their behaviour, and strengthen our whole-system response.

The strategy has been co-developed through extensive engagement with partners, practitioners, community organisations and people with lived experience. It reflects a shared commitment to creating a North East Lincolnshire where everyone can live free from domestic abuse.

Finally, I would like to thank everyone who shared their lived experience, expertise and ideas throughout the co-development of this strategy. Your voices have helped shape our shared vision and ambitions, and this strategy would not have been possible without your commitment and engagement.

Diane Lee
Director of Public Health
Northern Lincolnshire

Foreword

Introduction

Domestic abuse (DA) is one of the most significant public health, safeguarding and community safety challenges in North East Lincolnshire (NEL). Its impact is far-reaching, affecting individuals, families and communities, contributing to trauma, health inequalities and intergenerational harm.

This strategy sets out our shared commitment to prevent DA, support victims, survivors and children to recover and thrive, hold perpetrators accountable, and strengthen our collective response.

Developed through a comprehensive needs assessment and co-design programme undertaken between February and June 2026, the strategy is informed by local evidence, professional expertise and the voices of people with lived experience.

Our Approach

Our public health approach focuses on preventing abuse as well as responding to harm by addressing the wider factors that increase risk, strengthening protective factors, promoting healthy relationships and delivering a coordinated whole-system response.

This strategy brings together partners across health and care, community safety, education, housing, the voluntary sector and people with lived experience around a shared vision and four strategic priorities.

Our Strategic Priorities

The strategy is underpinned by four strategic priorities:

- **Prevention and culture change**
- **Support victims, survivors and children to recover and thrive**
- **Address harmful behaviour, improve accountability and improve confidence in the justice system**
- **Strengthen the whole-system response**

Together, these priorities provide the framework for collective action over the next four years. Progress will be supported through a delivery plan, a performance framework and ongoing engagement with people with lived experience, ensuring meaningful improvements for victims, survivors, children and communities.

National Legislative and Policy Framework

The **Domestic Abuse Act 2021** transformed the national response to DA by introducing a statutory definition that recognises abuse as more than physical violence. It includes physical, sexual, emotional, psychological, economic and controlling or coercive behaviour between people aged 16 and over who are personally connected.

The Act also recognises children as victims in their own right where they see, hear, experience or are affected by domestic abuse.

The accompanying statutory guidance on the **Delivery of Support to Victims of Domestic Abuse in Safe Accommodation Services 2021** provides the national framework for local authorities to assess need, commission support and develop strategies that meet the needs of victims, survivors and their children.

The Act, supported by the statutory guidance for the delivery of support within safe accommodation, places responsibilities on local authorities to assess need, commission support within safe accommodation and publish a strategy for victims and their children.

Our approach recognises that DA can affect anyone, regardless of age, sex, gender or life circumstances. However, people's experiences of abuse and their ability to access support are often shaped by wider social, economic, and structural inequalities.

Applying an intersectional lens enables us to understand how multiple disadvantage can increase vulnerability, create barriers to support and contribute to negative outcomes.

This approach underpins how NEL will meet its statutory responsibilities under the Domestic Abuse Act 2021 and improve outcomes for those affected.

How this Strategy Was Developed

This strategy has been developed through a structured, evidence-led and co-development process between February and June 2026.

Rather than developing the strategy in isolation, partners worked together to understand local need, assess the strengths and maturity of the current system, listen to the experiences of victims and survivors, and use community insights to agree a shared direction for change.

The approach combined multiple sources of evidence, including:

- A comprehensive DA Needs Assessment
- System maturity assessment
- National policy and best practice
- Local performance data and intelligence
- Professional expertise from partner organisations
- Co-design workshops with partners
- Engagement with people with lived experience
- Public consultation and survey findings

Why This Approach?

Working closely with partners throughout an iterative process of gathering evidence, testing ideas, refining priorities and validating the final approach, has ensured this strategy reflects local evidence, professional expertise and the voices of people with lived experience.

This has resulted in a strategy that reflects shared ownership across the partnership and is grounded in both evidence and lived experience.

Our approach ensures the strategy is:

Evidence-led

Co-developed

System-owned

Outcome-focused

Deliverable



North East
Lincolnshire

Facts and Figures 2024/25

7,004

DA incidents
recorded by
the police

2,424

victims
referred into
DA services

52%

MARAC cases
are repeat
cases

9%

Of domestic abuse
crimes result in a
charge

50%

MARAC cases
involved
children in the
household

1,090

Children
victims of DA

43%

children exposed
to domestic abuse
were aged 0-5
years

2,720

children's social
care referrals
recorded DA as a
factor

39%

Of females who
died by suspected
suicide were
victims of
domestic abuse

91

households became
homeless in 25/26
due to domestic
abuse

50%

of homeless
households fleeing
domestic abuse had
dependent children

41%

Of all DA crimes
occur in just
three wards (East
Marsh, West Marsh
and South)

Our Shared Vision

North East Lincolnshire is a place where everyone can live free from domestic abuse, where healthy relationships are promoted, those who cause harm are held accountable, victims survivors and children receive the right support at the right time, and partners work together to deliver a coordinated, trauma-informed and continuously improving response.

Our Shared Principles

Success will depend on sustained partnership commitment, shared accountability and a consistent approach across the whole system.

Through the development of this strategy, partners have agreed a set of guiding principles that reflect our collective ambition and the values that will shape our work over the next four years.

These principles are not simply statements of intent; they represent a shared commitment, provide the foundation for our partnership action, and will guide decision-making, commissioning, service design and workforce development across sectors, ensuring a coordinated response to domestic abuse across NEL.

Trauma-informed practice

Child-centred and family focused

Partnership working with survivors

Equity, diversity and inclusion

Partnership Accountability

Evidence-based decision making



Governance

This Strategy is a **partnership strategy**, developed and delivered collectively by organisations across health and care, community safety, safeguarding, housing, education, criminal justice and the voluntary and community sector.

The **Domestic Abuse Partnership Board** provides strategic leadership, oversight and accountability for delivery, ensuring progress against the strategy's priorities and outcomes.

Recognising that DA is a cross-cutting issue, the Board will work closely with other strategic partnerships across NEL to ensure aligned priorities, shared ownership of outcomes and coordinated delivery.

Cross-partnership working will be enabled through:

- **Cross-Board membership**
- **Joint working arrangements**
- **Reciprocal updates between partnership boards**
- **Escalation of shared risks, issues and opportunities where appropriate.**

Delivery Framework

The Strategy will be delivered through **Multi-agency Steering Groups**, each responsible for driving delivery of agreed priorities and reporting progress to the Domestic Abuse Partnership Board.

The Steering Groups will bring together those with the expertise, influence and responsibilities needed to deliver change within its priority area.

Each Steering Group will be led by a nominated **System Lead**, providing strategic leadership, championing collaboration across the system, overseeing delivery of the action plan and ensuring accountability for outcomes.



The **Coordination and Support Team** will provide programme management and partnership support to enable effective delivery across all workstreams. The Team will:

- Coordinate meetings, work programmes and governance.
- Support System Leads to plan, deliver and monitor agreed actions.
- Monitor performance, risks and progress against outcomes.
- Provide data, intelligence and analytical support.
- Coordinate communications, engagement and partnership activity.
- Support joint and integrated commissioning, funding opportunities and drive continuous improvement.

Working across all Steering Groups, the Team will strengthen coordination, maximise resources, reduce duplication and support the delivery of agreed priorities and outcomes.

Prevention and Communities

Priority

1

Why this matters

Our engagement and needs assessment identified prevention as a key priority. This includes promoting healthy, respectful and safe relationships from early age, challenging harmful attitudes and behaviours, addressing misogyny and gender inequality, and intervening earlier to prevent abuse before it escalates.

Preventing DA requires informed, connected and resilient communities that recognise the signs of abuse, support healthy relationships, reduce stigma and enable people to access help at the earliest opportunity.

What success looks like

Healthy relationships are understood and valued. Individuals have the knowledge, skills and confidence to build healthy, respectful and safe relationships.

Communities recognise and respond to abuse. Communities are informed, empowered and confident in recognising DA, challenging harmful behaviours and supporting people to access help.

Abuse is identified and addressed earlier. DA is identified at the earliest opportunity, enabling timely intervention, support and prevention of escalation.

Harmful attitudes and social norms are challenged. Attitudes, beliefs and behaviours that enable DA, misogyny and gender inequality are actively challenged, contributing to lasting cultural change.

Our shared commitment

WE WILL invest in evidence-based prevention programmes that promote healthy relationships, consent, equality, respect and emotional wellbeing throughout the life course.

WE WILL work alongside communities to increase awareness, confidence and local leadership, creating environments where DA is recognised, challenged and prevented.

WE WILL strengthen workforce capability across all sectors to identify DA earlier, respond appropriately and connect people with timely support.

WE WILL deliver initiatives that address misogyny, gender inequality and other drivers of abuse, promoting positive behaviours, healthy masculinity and cultures of safety and respect.

Support Victims, Survivors and Children to Recover and Thrive

Priority

2

Why this matters

Our findings identified significant barriers in accessing support, navigating services, securing safe accommodation, addressing the impacts of trauma and achieving long-term recovery.

Evidence highlights the significant and lasting impact that DA can have on adults and children, affecting safety, wellbeing, recovery, development and life opportunities across the life course.

Victims, survivors and children need timely, coordinated and trauma-informed support that promotes safety, recovery, resilience and independence.

What success looks like

Victims, survivors and children access support when they need it. People affected by DA can easily access timely, appropriate and trauma-informed support before needs escalate into crisis.

Victims, survivors and children are safe and supported. Individuals feel safe, are supported to recover from the impacts of DA and experience improved wellbeing.

Victims, survivors and children have access to safe accommodation and sustainable housing pathways. Individuals can access safe, suitable accommodation and move-on options that support safety, recovery, independence and long-term stability.

Victims, survivors and children recover, thrive and shape services. Individuals are supported to achieve positive outcomes and influence the design, delivery and improvement of services through their lived experience.

Our shared commitment

WE WILL improve access to timely support and ensure victims, survivors and children can access equitable and trauma-informed support that promotes safety, recovery and wellbeing.

WE WILL strengthen coordinated pathways and integrated support, working with agencies to reduce barriers, improve navigation of services and ensure people receive the right support at the right time.

WE WILL improve access to safe accommodation and housing support, working collaboratively to ensure victims and survivors have access to safe accommodation and effective move-on pathways that support long-term safety and independence.

WE WILL promote recovery, resilience and lived-experience leadership, ensuring that they shape commissioning, services delivery, decision-making, and continuous improvement.

Reduce Harm, Improve Accountability and Confidence in the Justice System

Priority

3

Why this matters

The development of this strategy identified the need for a stronger focus on those who cause harm and the effective management of risk.

Engagement and evidence highlighted concerns about confidence in the criminal justice system, including inconsistent responses, delays in decision-making, poor communication with victims and survivors, and concerns about the effectiveness and enforcement of protective measures.

Strengthening perpetrator accountability, reducing repeat harm and improving confidence in the justice system are essential to improving safety and outcomes for victims, survivors and children.

What success looks like

Perpetrators are identified and held accountable. Those who cause harm are identified at the earliest opportunity, actively managed according to risk and held accountable for their actions.

Harm is reduced through effective enforcement and intervention. Protective measures are consistently enforced, breaches are acted upon promptly and perpetrators are subject to effective interventions that reduce repeat harm and reoffending.

Victims and survivors feel informed, protected and supported. Victims and survivors receive clear communication, timely information and effective protection, helping them feel safer and more confident through their journey through the justice system.

Confidence in the justice system is strengthened. Victims and survivors have confidence that reports of DA are taken seriously, protective measures are enforced, risks are managed effectively and justice processes deliver fair and timely outcomes.

Our shared commitment

WE WILL strengthen multi-agency approaches to identify, assess and manage those who pose the greatest risk, ensuring effective oversight and accountability.

WE WILL strengthen enforcement and harm reduction by improving the use of protective measures, responding robustly to breaches, and expanding access to behaviour change interventions that reduce repeat harm.

WE WILL improve victims' experience of the criminal justice system by strengthening communication, safety planning and support throughout the justice process.

WE WILL improve information sharing, partnership working and trauma-informed practice across agencies to improve decision-making, reduce delays and build confidence in the criminal justice response.

Improved Whole-System Response

Priority

4

Why this matters

The development of the strategy consistently identified opportunities to strengthen how organisations work together, in response to that services can feel fragmented, with inconsistent communication, barriers to information sharing and duplication.

Delivering meaningful change requires a coordinated whole system response, underpinned by strong partnership working, effective governance, shared accountability, high-quality data and intelligence and a commitment of continuous improvement.

Working in partnership will continue to shape decision-making, service improvement and the development of a more effective and responsive domestic abuse system.

What success looks like

Partners work together as one system.

Partners work collaboratively through effective governance, shared accountability, clear communication and coordinated service delivery.

Decisions are informed by evidence, data and lived experience.

Data, intelligence, performance information and lived experience are routinely used to understand need, monitor progress, identify inequalities and inform decision-making.

Joint and integrated commissioning and resources deliver better outcomes.

Commissioning, investment and service planning are aligned to shared priorities, evidence of need and agreed outcomes, ensuring resources are used effectively.

The system continuously learns and improves.

Quality assurance, workforce learning, evaluation and partnership performance drive continuous improvement, innovation and better outcomes for victims, survivors and children.

Our shared commitment

WE WILL work together to make sure organisations share responsibility, work well together and contribute to the coordinated delivery of the strategy.

WE WILL use data, evidence and the experience of victims and survivors to understand what works, improve services and make better decisions, and inform commissioning and service improvement.

WE WILL align commissioning, investment and shared priorities, working collaboratively to commission services that meet local needs, use resources wisely and achieve the best outcomes for people affected by domestic abuse.

WE WILL continue to improve the quality of services by listening, learning, evaluating what works and supporting staff to provide safe, effective and compassionate support.

Long-Term Outcomes and Impact

Long-Term Outcomes

1

Fewer people experience DA, harmful behaviours are challenged, and healthy, respectful relationships become the norm

2

People effected by DA experience improved safety, wellbeing, recovery, resilience and independence

3

Those who cause harm are identified earlier, managed effectively, held accountable and supported to change their behaviour, reducing repeat victimisation

4

Services work together seamlessly, decisions are informed by evidence and lived experience, with continuous learning and quality improvement embedded in delivery

Impact

DA is prevented, victims, survivors and children are safer and recover well, those who cause harm are held accountable, and people have confidence in a coordinated and effective whole-system response.



North East Lincolnshire
Health and Care
Partnership

2025/26 ANNUAL REPORT





Who are we?

At the North East Lincolnshire Health and Care Partnership we bring **local** health, social care, council, education, voluntary, and community organisations together to work as **one system**.

We aim to help people in North east Lincolnshire to live **healthier lives** and **reduce inequalities**.

The partnership focuses on providing support early, before problems become more serious. We prioritise **joined-up services** that work closely together rather than in isolation. Our approach is based on strong relationships, trauma-informed practice, and care that is shaped around **the needs of local people and communities**.



Our Population

159,911 people live in North East Lincolnshire
174, 692 people are registered with a GP in
North East Lincolnshire



Inclusion Health Groups



People with physical or learning disability
People with drug/alcohol problems
People with mental health problems
Care leavers



Ethnic minorities/ vulnerable migrants
People who have served in armed forces
Carers, including young carers
People who have experienced homelessness



Healthy Life Expectancy



54.7 years in males

54.3 years in females



There is a gap in healthy life expectancy between our most deprived wards and our most affluent wards of **15 years in males and over 16 years in females.**

Over the past decade, **health life expectancy has declined** in North East Lincolnshire.

Health Inequalities

North East Lincolnshire is the **29th most deprived (out of 317) local authority in England** as measured by the Index of Multiple Deprivation 2019. Two North East Lincolnshire wards (East Marsh and West Marsh) are in the most deprived 1% of wards in England, and five wards (East Marsh, West Marsh, South, Sidney Sussex, and Heneage) are in the most deprived 10% of wards in England.

**Patient
Empower-
ment**

Innovation

**Listening &
Person-
centred**

**Employee
Focused**

**Open &
Honest**

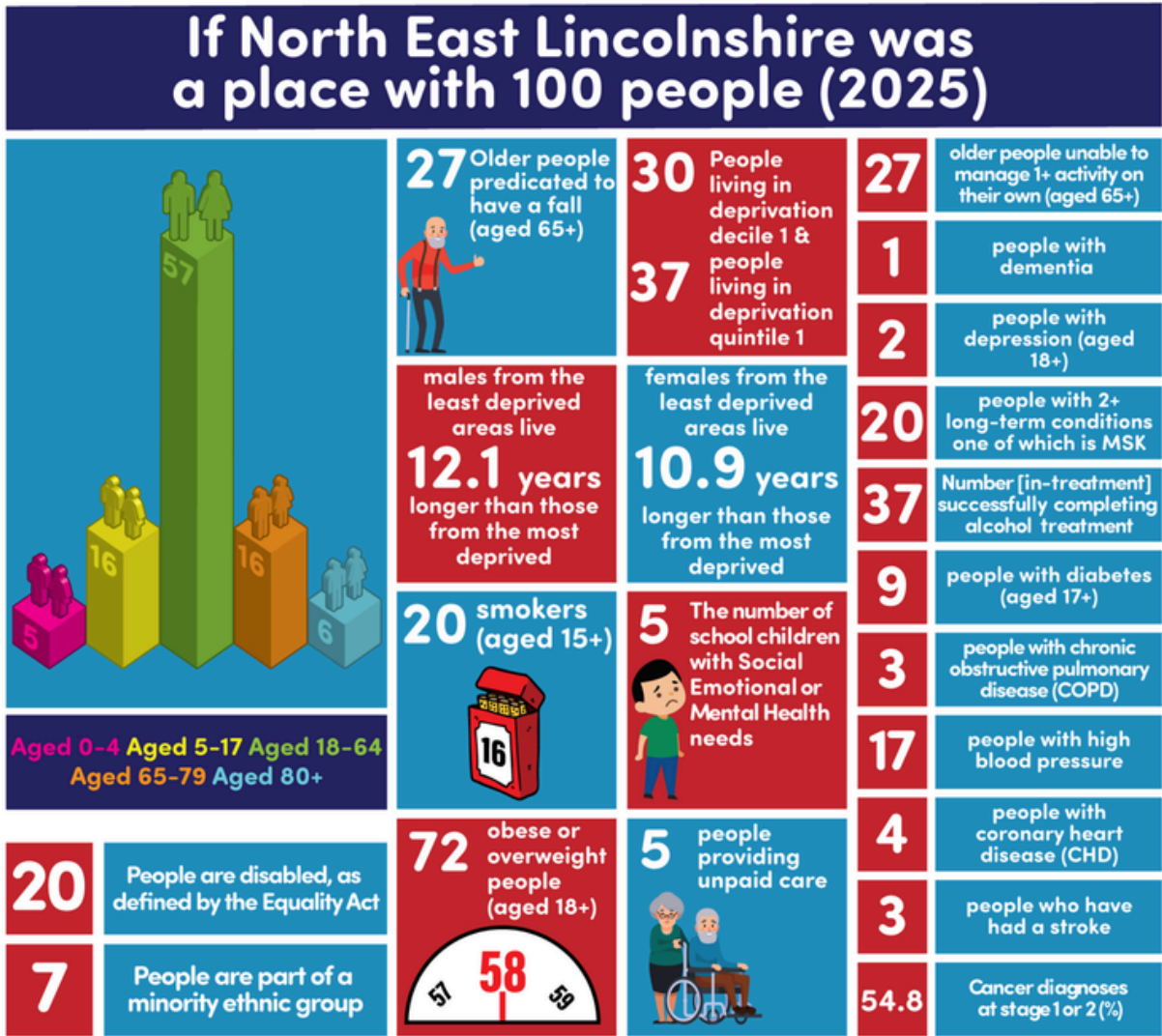
**High Quality
Care**

**Compassion
Respect &
Empathy**

**Partnership
Working**

**Our Collective
& Common
Values**

Our Population



Meet the Team



North East Lincolnshire
Health and Care
Partnership

OUR HCP TRANSFORMATION TEAM

ONE TEAM. ONE PLAN. ONE VISION.

Co-produced decisions, shared responsibility, lasting change.

Communities thrive
when people shape
the decisions that
affect them.

OUR VISION



Co-produced
decisions, shared
responsibility,
lasting change.

Communities in North East
Lincolnshire are empowered to
shape the decisions that
affect them, share
responsibility for local
priorities, and drive
lasting change.



We want a future
where health and
wellbeing are created
through a fully
integrated system
that looks beyond
traditional health
and care services and
focuses on the wider
determinants that
shape people's lives.



By joining up teams
and services around
population groups,
we aim to build a
system that is trusted,
efficient and rooted
in community
strength.

OUR AMBITION

- ✓ Strengthen community power through trust, participation and shared decision-making
- ✓ Embed co-production with local people and partners in all we do
- ✓ Build a culture of collective ownership and clear accountability across organisations
- ✓ Deliver holistic, person-centred support that responds to what matters to people
- ✓ Act on the wider determinants of health with partners beyond the traditional health and care sector
- ✓ Develop an integrated, place-based model where teams work around population groups rather than organisational boundaries
- ✓ Use population health data and insight to target resources, reduce inequalities and improve outcomes

HOW WE WORK



One team across organisations



Working around people
and neighbourhoods



Shared accountability
and collective focus



Using our workforce, estates
and data as one system resource



LOUISE FADINA

Children, Young People & families,
Workforce & OD, Mental Health,
Comms & Engagement



LAUREN KING
Children, Young
People & Families



AMY CHILVERS
CYP &
Mental Health



KAT GOODHAND
Mental
Health



AMY TWYMAN
Digital



LUCY MELLING
Workforce



SARAH EVEREST-FORD

NNHIP, Neighbourhood Health,
Frailty, Estates



ADAM JOHNSTON
NNHIP, Neighbourhood
Health & Frailty



AMY QUICKFALL
Community First
(Strategic Engagement
& Population Health)

OUR AIMS



Improve health
outcomes and
reduce inequalities



Support people to
live well, independently
and safely



Build fully
integrated
neighbourhood
teams



Strengthen and
support our local
health and care
workforce



**PARTNERSHIP
WORKING**
anchors the shift to
integrated
neighbourhood
teams.



**OPEN &
HONEST**
communication
enables shared
accountability and
transparent
decision making.



**LISTENING &
PERSON-CENTRED**
approaches
underpin
co-production.



INNOVATION
supports new
models of care
population-
health
approaches.



**COMPASSION,
RESPECT &
EMPATHY**
guide how we
support people
and each other.



**EMPLOYEE
FOCUSED**
values recognise
that a supported
workforce
delivers better
outcomes.



**PATIENT
EMPOWERMENT**
aligns with
community trust
and self-
determination.



**HIGH QUALITY
CARE**
remains the core
outcome regardless
of setting or
provider.

One team working with our communities to design joined-up care
that improves lives across North East Lincolnshire.

Purpose of the Annual Report



The North East Lincolnshire (NEL) Health and Care Partnership continues to **drive transformative change** across the local community and healthcare system, building on the momentum of previous years.

This report highlights **key achievements from 2025–26**, showcasing how collaborative projects and innovative programmes have delivered **real improvements in health outcomes, equity, and service integration**.

Through a strong commitment to tackling inequalities, supporting families, and investing in trauma-informed and integrated care, **NEL is setting new standards for community health, care and wellbeing**.



Jane Lewington
Chair, North East Lincolnshire Health and Care Partnership Board

It is a pleasure to introduce the North East Lincolnshire Health and Care Partnership Annual Report for 2025/26.

As I reflect on the past year, I am incredibly proud of what we have achieved together. At a time when our communities continue to face significant challenges, partners across health, care, local government, education, and the voluntary and community sector have come together with a shared determination to improve lives and reduce inequalities.

What stands out most is not just the range of work taking place, but the way it has been delivered. Whether supporting children and families through Growing Stronger Together, developing neighbourhood health initiatives, strengthening mental health and wellbeing support, investing in our workforce, or embracing innovation and digital technology, our approach has been built on collaboration, kindness, and a genuine commitment to putting people first.

This report contains many examples of the impact that can be achieved when organisations work as one system around the needs of local people. It also reflects the invaluable contributions of residents, communities, volunteers, people with lived experience and frontline staff, whose insight, dedication and passion continue to shape our work.

I am particularly excited about the opportunities ahead. Our selection as a national Neighbourhood Health Implementation Programme site positions North East Lincolnshire at the forefront of shaping a future where more care is delivered closer to home, prevention is prioritised, and people are supported to live healthier, more independent lives.

Thank you to everyone who has contributed to this journey. There is much more to do, but this report demonstrates the strength of our partnership and what we can achieve when we work together with a shared purpose.



Executive Summary

During 2025/26, the North East Lincolnshire Health and Care Partnership continued to build momentum in delivering more **joined-up, preventative and person-centred support for our local communities**.

Through **working together as one system with partners** across health, care, local authority and the voluntary sector we have focused on **improving outcomes, reducing inequalities and strengthening how services work together**.

Our progress this year has been driven through seven key enablers:

1

Neighbourhood Health

We have continued to strengthen our neighbourhood-based model, moving beyond pilots towards more embedded delivery. This has supported earlier identification of need, improved coordination across health and care services and enabled more care to be delivered closer to home. NEL are also 1 of 43 sites to be part of the National Neighbourhood Health Implementation programme.

2

Children & Young People

Through Growing Stronger Together and Growing Well Together, we have delivered earlier, more relational and trauma-informed support, improving experiences for families and helping to prevent escalation into crisis services.

3

Mental Health

Our focus on prevention, kindness, person centred care and early help has expanded community-based support, improved access to non-clinical services and strengthened how people are supported in the community before reaching crisis.

4

Community Engagement & Population Health

Investment in community-led approaches and VCSE partnerships has strengthened local support networks, increased engagement and enabled more people to access help in trusted, familiar settings.

5

Workforce

Through the People and Skills Pledge and shared development programmes, we have fostered a more connected workforce, strengthening confidence in system working, strengthening collaboration, and supporting sustainable workforce development pathways.

6

Digital

We have continued to develop our digital and data capability, introducing innovative tools and strengthening information sharing to improve access, coordination and the overall experience of care.

7

Estates

We focused on establishing governance, strengthening partnerships with estates team across the partnership, understanding estate needs, creating a long-term strategic estates approach and securing investment for delivering Neighbourhood Health Centres.

Together, these achievements reflect a system increasingly working as one partnership, with a shared commitment to improving the health and wellbeing of people in North East Lincolnshire.

Our Programmes of Work

Neighbourhood Health, Integrated Neighbourhood Teams & Frailty:

- **National Neighbourhood Health Implementation Programme (NNHIP)** – A national programme to shift care from hospitals into communities.
 1. Meridian MDT “Huddle” Model – Regular team reviews to coordinate care for high-risk patients.
- **Neighbourhood Health Centres (development)** – Plans to create local hubs offering joined-up health and care services.
- **Integrated Neighbourhood Teams (INTs)** – Local teams working together to provide coordinated, proactive care.
 1. Panacea Dementia Pathway – Joined-up support for identification and support for people living with early onset of dementia.
 2. Meridian Population Health Management Programme – developed and tested a holistic, neighbourhood-based model centred on a Cancer Care Coordinator role to improve coordination, patient experience and outcomes for people with a new cancer diagnosis, with plans to expand and embed this approach.
- **Whole System Users Programme** – Support for people who frequently use multiple services.
- **Frailty Programme** – Early support for older people to prevent deterioration and crisis.
- Voluntary, Community, and Social Enterprise involvement in Neighbourhood health agendas strengthened.



Children & Young People:

- **Growing Stronger Together** – a local partnership strategy to improve outcomes for children, young people and families.
- **Growing Well Together** – Supporting parent-infant relationships and early relational health through a preventative, whole-family trauma informed approach.
- **Children & Young People Asthma Transformation Programme** – Developing an Asthma Friendly NEL approach to improve prevention, education, self-management and improved outcomes
- **Let's Go Grimsby – Healthy Weight Pilot** – Supporting families to improve health and wellbeing.
- **Family Hubs & GP-in-Hub Model** – Bringing services together in local, accessible places.
- **Mental Health, Trauma & Emotional Wellbeing** – Leading partnership work on emotional wellbeing, trauma-informed practice and early intervention.
- **SEND, Neurodevelopment & Child Development** – Driving improvements across SEND, neurodevelopmental pathways, developmental support and parent/carer provision.
- **Complex Needs & Integrated Care** – Developing multidisciplinary approaches and coordinated support for children with complex health and care needs.



Mental Health & Prevention:

- Kind Places – Community spaces offering early mental health and wellbeing support.
- Health and Care Passport – A tool to help people communicate their needs across services.
- Hand in Hand Suicide Prevention Project – Support shaped by people with lived experience of suicide.
- Waiting Well Approach – Helping people stay supported while waiting for services.
- Blue & Green Social Prescribing – Connecting people to community and nature-based activities.

Community & Population Health:

Community Plans empower residents to shape local priorities, working alongside VCSE partners as stewards of their communities.

They provide the scaffolding and support needed to turn local insight into lasting change through:

- VCSE Grants Programme – Funding for community-led projects improving wellbeing.
- West Marsh Wraparound Neighbourhood Support – Local support for residents with practical and health needs.
- Know Your Numbers (CVD Prevention Programme) – Community health checks to identify risks early.
- Community Plans & Participatory Budgeting – Empowering residents to shape local priorities and funding.



Workforce:

- People and Skills Pledge – A coordinated approach to developing the local workforce.
- Health and Care Ambassadors Programme – Inspiring people into careers in health and care.
- Shared Leadership Development Programme – Building leadership skills across organisations.
- Oliver McGowan Training Collaborative – Joint training to improve awareness and inclusion.
- Digital Skills Workshops – Supporting staff to build confidence in using digital tools.



Digital & Innovation:

- AI Cancer Screening Navigation Assistant – A digital tool helping people access screening services.
- Minute (Digital Care Tool) – Technology to improve recording and communication in care.
- Hanc AI Legislation Assistant – A tool helping staff understand and apply complex rules.
- Wayfinder Patient Engagement Portal (PEP) – A digital platform connecting people to services.
- AI Practice Lab – Testing how AI can safely improve care and support.



Key Achievements

Children and Young People



300+ professionals trained in trauma-informed care



63% of families supported from the most deprived communities through the Growing Well Together Programme

40% reduction in parental anxiety for families supported through the Growing Well Together Programme

135 professionals trained to improve asthma care



Neighbourhood Health, Integrated Neighbourhood Teams & Frailty



235 people supported through the Panacea dementia pathway



33% reduction in GP appointments among targeted Whole System User cohorts

110+ professionals engage quarterly through the frailty sector network

392 cancer patients supported through Meridian PCN



North East Lincolnshire became **1 of the 43** pilot sites for the National Neighbourhood Health Implementation Plan (NNHIP) across England



NHSE have identified 7 priority enablers for the national delivery of neighbourhood working. The HCP is 1 of 8 pilot sites for a co-design initiative with a focus on the priority: 'Operational interoperability'.



Mental Health



175 referrals supported through buddying services in a single year



80 positive outcome case studies

Key Achievements

Workforce

£103,612

levy transfer through the People Skills Pledge

35

individuals gained employment in Health and Care through People Skills Pledge

£4.70

return for every £1 spent of public money through People Skills Pledge

179

"give an hour" to schools through ambassador programme



Community Engagement & Population Health

138

residents in West Marsh provided with benefit checks, hardship support, debt advice, housing issues and health referrals

38%

of those screened as part of the CVD Prevention project were identified at risk of hypertension & required follow-up

1550+

people engaged across VCSE funded projects

£7.66

average social value return on investment for every £1 invested for VCSE-funded grants



Digital

£380,000

of digital funding secured for North East Lincolnshire

35

new users of Minute (AI transcription and meeting summarisation tool)

30

users of Hanc AI Legislation Assistant which helped social care staff to quickly access and apply complex legislation in social care



Children & Young People

Our Children and Young People's workstream brings together early help, prevention and targeted support to **improve outcomes, reduce inequalities and strengthen wellbeing for children, young people and families** across North East Lincolnshire.



Why this work is important



Children and young people in North East Lincolnshire **face multiple and overlapping challenges**, including poverty, poor mental health, long-term conditions such as asthma, the impact of trauma, and unequal access to early support.

Families told us that health and care services often feel fragmented, hard to navigate and slow to respond, particularly for those with the greatest levels of need. These challenges made it harder for children to thrive, increased pressure on crisis and specialist services, and widened inequalities

What we set out to achieve

The overall Children and Young People programme set out to:

- **Provide earlier, more consistent and more relational support** for children and families
- **Reduce health and wellbeing inequalities**, particularly in the most deprived communities
- **Improve experiences of care** by making services easier to access and better joined-up
- **Embed trauma-informed, strengths-based practice** across the system
- **Ensure children, young people and families shape decisions** about the support they receive



This work is underpinned by the **Growing Stronger Together framework**, giving all partners a shared direction and way of working.



What we did

Throughout 2025/26 we worked across **six core, connected programmes of work**, to achieve the following shared outcomes:

1

System alignment: The launch of the **Growing Stronger Together Framework** has helped to inform how partners should work together to improve outcomes for children, young people and families. This resulted in clearer priorities, reduced duplication and more joined-up support for families.

2

Early years & family support: Through the **Growing Well Together** delivered trauma-informed early help from pregnancy to age two. This led to improved parental mental wellbeing, stronger parent–infant relationships and reduced escalation into statutory services.

3

Tackling inequalities: The **Let's Go Grimsby - Healthy Weight Pilot** helped to provide targeted healthy weight and wellbeing support in the most deprived neighbourhoods. This helped families make healthier choices and improved confidence and psychosocial wellbeing.

4

Long-term conditions: Asthma Friendly NEL has, improved asthma management through joined-up work with Primary Care, VCSe, families, schools and housing, contributing to safer inhaler use, better home environments and reduced avoidable harm.

5

Trauma-informed practice: The **Trauma-Informed Care (TIC) Framework, Pledge and Programme of Work** has helped to embed compassionate, relational approaches across organisations. In turn, this has improved engagement, trust and staff confidence in supporting children and families affected by trauma.

6

Mental health & wellbeing: A **whole-system approach to mental health transformation** for children and young people has resulted in the expansion of early mental health support, strengthened neurodevelopmental pathways and improved workforce development. This has enabled earlier access to help, smoother mental health and wellbeing pathways and improved experiences for children and young people.

7

Neighbourhood-based working: Began embedding **integrated neighbourhood approaches**, including a GP-in- Family Hub pilot and multi-disciplinary team working, to provide place-based, coordinated support closer to where children and families live, improving access, continuity and early identification of need. Informing the next steps of our Children's MDT pathways and neighbourhood working.



What changed for people

Across the programme, children, young people and families experienced:

- **Earlier access to support and fewer crisis points**
- **Improved mental wellbeing, confidence and relational strength**
- **More coordinated care, with fewer hand-offs between services**
- **Safer management of long-term conditions such as asthma**
- **Greater trust in services and feeling listened to rather than judged**

Professionals reported clearer shared priorities, improved collaboration and greater confidence in using trauma-informed approaches.

The Impact We Have Made

Trauma-Informed North East Lincolnshire

**Over 30
organisations**

engaged in the
trauma-informed pledge and
framework



Mental Health & Emotional Wellbeing

Over **300 professionals**
trained in trauma,
bereavement and
shame competence



Let's Go Grimsby - Healthy Weight

40+

families engaged in targeted
healthy weight and wellbeing
support in high-inequality wards

Asthma & Core20PLUS5

135 professionals
trained to improve
asthma care,
contributing to safer
inhaler use, improved
home environments
and reduced avoidable
harm.

Growing Well Together

**63% of early years
families** supported from
the most deprived
communities



40% reliable
improvement in
anxiety and **24%**
improvement in
depression for parents
accessing

A Story from A Parent in Our Community

One parent who accessed the **Growing Well Together service** described how early, trauma-informed support changed their experience of becoming a parent:



— “ —

I'm feeling so much better now I know the support is in place and I'm not being judged. It has taken such weight off my shoulders and I already feel in a better place for it.

— ” —

The parent had been experiencing high levels of anxiety and low confidence but did not meet the threshold for statutory services. Through relational, non-judgemental support delivered via Family Hubs and linked health services, they reported **reduced anxiety, improved confidence and a stronger bond with their baby.**

— “ —

Every person I have met through this service has changed my life for the better. Took me out of a very dark spot that I could not see changing.

— ” —

This reflects **the wider impact of the Children and Young People programme**, where early help, trauma-informed practice and joined-up working help prevent escalation, improve wellbeing and build trust in local services.



What we learnt

- ★ Early, relational and trauma-informed support **reduces distress and demand on specialist services**
- ★ Shared frameworks and language help systems **change how they work**, not just what they provide
- ★ Targeting inequality requires **going beyond health services** alone and working with schools, housing and communities
- ★ **Listening to children, young people and families** strengthens both design and delivery



What's next

Building on this programme, we pledge to:

- **Embed Growing Stronger Together** across all governance, commissioning and neighbourhood working
- **Strengthen prevention and early help offers**, particularly in deprived communities
- **Expand integrated neighbourhood approaches** and multi-disciplinary working
- **Improve how impact is measured** across the whole system
- **Continue to shape services with children, young people and families** at the centre

Delivering Neighbourhood Health through Integrated Neighbourhood Teams, Frailty and Whole System Users

Over the past year there has been significant progress in strengthening neighbourhood health delivery across the National neighbourhood Health Implementation Programme (NNHIP), Integrated Neighbourhood Teams (INTs), Frailty and whole system users. The focus aligned to national frameworks has been to move beyond projects to embedding sustainable, data-led neighbourhood models that improve outcomes while reducing avoidable demand on primary and acute care and supporting the reduction of health inequalities across the place working with Public health and wider system partners linking marmot Town and Pride Place.



Why this work is important

Aligned to Health and Care Partnership and Marmot priorities, the programme contributes to healthier communities, Bringing together partners across health, care and the voluntary sector, supports the continued development of integrated neighbourhood teams and place-based care. It enables a more **proactive approach to identifying and supporting people with complex needs, reducing inequalities and improving access to coordinated services.**

This work demonstrates our commitment to tackling health inequalities, strengthening neighbourhood health delivery and improving outcomes for local populations. The programme aligns with Health and Care Partnership and Marmot priorities to deliver integrated, person-centred care closer to home, creating a more resilient and sustainable health and care system for the future.

It supports **earlier intervention, improved coordination** and more consistent experiences for people with complex needs, while helping the system to work more **efficiently and sustainably.**

What we set out to achieve

- Improve **coordination, access and continuity of care** at neighbourhood level
- Reduce avoidable demand on general practice and emergency services
- Shift from reactive responses to **proactive, preventative support**, particularly for frailty
- Embed **data-led population health approaches** into day-to-day delivery
- Align neighbourhood delivery with system priorities and national direction



What we did

We delivered **three key programmes** using data-led neighbourhood models to improve coordination, reduce avoidable demand and support people with complex needs earlier and more effectively.

Integrated Neighbourhood Teams

- Supported Integrated Neighbourhood Teams to move from pilot activity into **business-as-usual delivery**
- Matured governance with **monthly delivery oversight**
- Embedded structured **case reviews**, integrated care clinics and improved visibility of complex patients within practices
- Developed evaluation papers and frameworks to evidence people, workforce and system impact



Frailty

- Re-scoped frailty work to focus on mild to moderate frailty inc. surveys in Apollo PCN to enhance early identification.
- Agreed clear cohort definitions using BI dashboards and neighbourhood intelligence
- Completed data-sharing agreements across PCNs and the wider system
- Introduced frailty service specification and SOP proactive to support identification and support prevention and patient independence.
- Developed a neighbourhood-based, multidisciplinary integrated frailty model that proactively identifies and supports people living with frailty through coordinated, person-centred care to improve outcomes and reduce avoidable hospital use.



Whole Systems Users

- Analysed 3+ years of GP attendance data, linked with wider service use
- Supported practices to identify long-term high-use patients through workshops and case reviews
- Redesigned neighbourhood responses around cohorts rather than episodes of care including integrated care Clinics.



What changed for people

People with complex needs experienced **better coordination, clearer support pathways and fewer repeated contacts** with services.

Earlier identification of need, (particularly for frailty), means people are supported before reaching crisis, helping them remain independent and better supported within their communities.

General practice and neighbourhood teams reported **greater confidence in identifying who needs coordinated support** and how best to provide it.

More support was received from **voluntary, community and social enterprise organisations** to support individuals in the community who were under the care of statutory services.

The Impact We Have Made



Whole Systems User Cohort

Fewer A&E attendees & GP Appointments

among people receiving co-ordinated support

Frailty Network

110+ professionals

40+ services

connected through the Frailty Network.

87 patients reviewed for frailty,

37.9% required follow-up

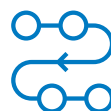
10.3% were escalated for assessment with

50% showing deterioration in frailty scores.

"This is an amazing opportunity to feel valued... nice to feel cared for in a holistic way."

Panacea Dementia Pathway

235



people supported through the dementia pathway with proactive outreach from Alzheimer's Society and CONNECT NEL

392 cancer patients supported through Meridian

296 proactively contacted

176 receiving regular 3-month reviews

259 aged 65+

Whole Systems User Cohort

~33%

reduction in GP appointments among targeted Whole System User cohorts



"We had no idea what to do next but **feel more confident now**"

"I would not have reached out on my own"



North East Lincolnshire
Health and Care
Partnership

Demonstrating the value of early intervention in **preventing crisis**

What we learnt

Behavioural data-led approaches are essential for targeting the **right support** to the **right people**



Neighbourhood delivery works best when **roles between practices and INTs are clear**



Voluntary, community and social enterprise organisations are valuable in supporting integrated and person-centred care



Prevention and early intervention require **time, trust and strong data foundations**



Evaluation frameworks are critical for demonstrating **value** and **sustainability**



What's next



- Strengthen and scale neighbourhood delivery models across INTs
- Continue embedding population health management into routine practice
- Expand proactive frailty approaches to support more people earlier
- Share learning across neighbourhoods and the wider system
- Align further with Neighbourhood Health Framework and Fit for the Future priorities
- Scaling the whole systems user approach and scaling the dementia pathway work to be delivered system-wide across North East Lincolnshire
- Implementing the Integrated Frailty Service

National Neighbourhood Implementation Plan (NNHIP)

North East Lincolnshire (NEL) was selected as one of 43 national Wave One sites in the National Neighbourhood Health Implementation Programme (NNHIP), a flagship NHS England and DHSC initiative designed to transform care from hospital-based, reactive models into integrated, community-based neighbourhood health systems.

Aims of NNHIP



- Work together across organisations and with communities so that more people live well, inequalities are reduced, and neighbourhoods become better places to live.
- Shift care from hospital to community.
- Move from reactive to preventative care.
- Improve outcomes for people with multiple long-term conditions
- Reduce health inequalities.

Locally, the programme is aligned with:

- Marmot Place
- Pride in Place
- Integrated care transformation priorities

Progress over 2025/26

During 2025/26, NEL has successfully moved from programme mobilisation to early delivery, establishing the foundations required to embed neighbourhood health as the future operating model.

A robust multi-agency governance structure has been established, bringing together:

- NHS, Local Authority, VCSE and community partners
- Joint leadership across Health and Care Partnership
- Alignment with wider system priorities

This has enabled shared ownership and accountability across partners.

Key Achievements

A robust multi-agency governance structure has been established, bringing together:

- NHS, Local Authority, VCSE and community partners
- Joint leadership through HCP and HWB
- Alignment with wider system priorities

This has enabled shared ownership and accountability across partners.

The Meridian Neighbourhood Team operates through a multidisciplinary "huddle" model, bringing services together to support high-risk patients.

- Scope & delivery: Around 80 individuals identified via PHM, with 35 reviewed within the first 8 weeks.
- Target cohort: People with 2+ long-term conditions, moderate-severe multimorbidity, frequent A&E attendance (5+), and rising risk of deterioration.
- Approach: Coordinated, team-based reviews focusing on early intervention and personalised care planning.
- Impact: Improved coordination and continuity of care, stronger involvement from VCSE partners, and positive feedback from both patients and staff.



Neighbourhood Health Centres are central to neighbourhood working, with **national targets of 120 by 2030 and 250 by 2035**.

- Locally, planning, funding discussions, and community co-design are underway.
- Residents want accessible, walk-in services in welcoming, non-clinical spaces.
- Emphasis on integrated care (health, social, VCSE) and prevention.
- Overall, NHCs should function as community hubs rather than traditional clinical sites.

Established 4 critical enablers of Neighbourhood Health:

- **Finance:** Early exploration of "left shift" funding and a developing business case to scale neighbourhood working.
- **Workforce:** Strong cross-system co-design, supported by surveys and cultural development work.
- **Estates:** HCP Estates Group established, with NHC strategy and estate alignment progressing.
- **Digital:** Selected as 1 of 8 national interoperability pilots; real-time data dashboard in development.

Extensive stakeholder engagement has been undertaken across:

- Patients and carers
- Primary care and providers
- VCSE sector
- Local authority and public health partners

Case Study

Betty

Female, White British 82yrs old. Lives at home with her dogs.



Betty identified through NNHIP cohort -30+ or 60+, 2+ LTCs, moderate-Severe MMI, 5+A&E, risk of admission or escalation.

Betty currently known to services:

- FOCUS,
- Awaiting corporate appointee,
- Amelius housing,
- Open door social
- Hales care
- OD/QS
- F@H
- Navigo
- Secondary Care
- Out of Hours

Betty's LTCs

Multiple LTC's and other conditions:

Kidney disease, osteoarthritis, ischaemic heart disease, hypothyroidism, anaemia, lumbar spondylosis, COPD, angina, awaiting 2week wait to gastro, respiratory with nodule on lung, hypertension, pre-diabetic, IBS, Anorexia

Care needs

Long-term MH condition or cognitive impairment:

Alzheimer's disease with late onset dementia



Home care:

HALES 4 visits per day

GP, A&E & OOHs

Multiple Visits in last year:



GP/Clinical input x 35



A&E x 5



OOH x 5

Initial Findings

- Social worker referred to friendship at home (FAH) July 2025.
- Betty becomes very confused with different agencies involved, currently adjusting to increase care package
- High footfall in and out of the house.
- Betty deemed not to have capacity for medication and finances.
- Best Interest meeting with professionals in Mar 26

Huddle Findings

FAH visit taken place & befriending offered. Social care to speak to Hale re carers. Update 04/03/2026 - FAH volunteer has made 2 phone calls - Spoke to Social worker who confirmed they are evidence gathering - they had visited last week
Focus seeking corporate appointee for financial affairs - this had not yet been to the Court of Protection, so Betty still vulnerable
Shared info about allegedly giving carers a key with Focus.
Betty is being monitored every couple of days and any concerns shared with Focus.
Carers reflect that Betty's behaviour is increasingly unpredictable and confused and she often refuses entry to carers P1 is offered a weekly shopping call of 2 hours but usually declines this.
Betty's home albeit tidy on the whole, does also have challenges with dogs, and urine and faeces smells and is difficult for those who enter and support.

Huddle Outcomes

- Betty is continued to be supported and discussed each time in the huddle
- Betty re-referral to Navigo - been seen by the team there and proactively had gone back into the Opendoor surgery and saw the GP and recently has a new social worker.
- Decision made to pull care calls due to this impacting mental health - social worker is reviewing this.
- FAH to speak with Social worker who knows Betty well to initiate further support conversations.
- Betty continues to want to be independent and cares for her dogs at home.

Challenges & Risks

Key risks to delivery include:

- Workforce capacity and competing priorities
- Data fragmentation and PHM tool disruption
- Lack of clarity in national contracts and guidance
- Limited additional investment
- Cultural barriers across organisations

Programme Maturity



- NEL has progressed from “Mobilising” to “Developing” maturity, with:
- Functional governance and delivery structures
- Implementation of a Population Health Management approach set-up using the ICB tool to identify a cohort and then track the impact.
- Early evidence of impact

However:

- Decision-making and funding remain largely centralised · Data is not yet fully driving proactive system-wide deliver

Next Steps

Priorities for 2026/27:

- Work with NAPC to develop a benefits realisation case to inform how we scale Integrated Neighbourhood working across NEL and inform a proposal for Social Finance investment
- Develop a Neighbourhood Health Plan with the Health and Wellbeing Board
- Develop our first Neighbourhood Health Centre
- Progress NHC development and capital investment pipeline
- Strengthen data, digital and workforce capacity
- Complete the Expression of Interest to be a Social Finance Trail Blazer

Mental Health

Why this work is important



Across North East Lincolnshire, **growing demand for mental health support** during 2025–2026 continued to be driven by **loneliness, social isolation, health inequalities and wider social pressures** rather than clinical need alone. People told us they often reached crisis services because they did not know where else to turn, felt unheard, or could not access help early enough.

Those most affected included:

- Adults experiencing health inequalities, long-term conditions or social crisis
- People with learning disabilities, autism and dementia experiencing communication barriers
- Carers, bereaved families and people waiting for services
- Communities experiencing isolation, poverty or reduced access to transport and services

What we set out to achieve



Focussing on prevention and creating a kindness culture across the system was deemed to be a priority. The focus for 2025–2026 was to strengthen early support, reduce escalation into crisis, and ensure that wherever people encountered services, they experienced compassion, respect and practical help easily.

This work aligned directly with the **Mental Health Strategy priorities of Prevention, Culture of Kindness, No Wrong Door and Person-Centred Care**, supported by the wider partnership commitment to reduce inequalities through community-based solutions.



What we did

Partners across statutory services, VCSE organisations, Public Health, Police, employers and communities worked collaboratively to deliver a **strong programme of prevention-focused activity around mental health.**

Warm Spaces were supported to become Kind Places, providing safe, welcoming environments with wrap around support for people experiencing loneliness or distress.

Public Kind Places and Employers of Kindness registers were launched.

Listening benches installed, linking people directly to local support.

Blue and Green Social Prescribing projects expanded access to non-clinical wellbeing support.

Waiting Well approaches embedded across VCSE and community services.

Kind Places and winter support calendars reduced inappropriate crisis presentation by increasing awareness of local help.

World Mental Health Day and Mental Health Awareness Week partnership events. Providing access to self-help activities and 30+ services in one venue.

Culture of Kindness media campaign developed by young people (1,600+ engagements)

Health and Care Excellence Awards Rewarding and recognising excellence in our workforce and community



200 passports distributed through nine VCSE organisations to people with learning disabilities, autism and dementia

People supported to complete the passport at their own pace, ensuring information reflected what mattered to them and enabled person centred care delivery

Suicide prevention training completed by all Mental Health Strategy Delivery Board members

Lived experience-led training on self-harm and suicide extended to VCSE workers

GDPR, co-production and shared learning delivered across partners

The Hand in Hand project was codesigned and renamed by people with lived experience of suicide.

Samaritans-led suicide call handling training delivered to **16 call handlers**
System learning identified around lone working risks and VCSE training gaps

Key Achievements



3 Strategies
fully Co-Produced



Johnson & Johnson using
co-production of the strategy
as best practice internationally



2 World Mental Health
Day events each attended
by 130 people



2 Mental Health
Awareness week launch
events and week of activities



2 GDPR Training events
for front line workers



2 AI Videos produced
(Mental Health Strategy
and Passport)



4 SEND Schools received
Co-Production training and
co-produced plans



11 organisations now
undertaken Culture of
Kindness Self-Assessment



1 Listening bench installed with more planned

We are proud to have a co-produced Mental Health Strategy in NEL



What changed for people

This work made a tangible difference to people's day-to-day experience of support.

People reported:

- **Greater access to early, non-clinical support in communities**
- **Reduced anxiety while waiting for services**
- **Improved confidence and dignity when accessing health and care**
- **Feeling listened to, respected and included**

Evidence of Impact

The Health and Care Passport supported people with learning disabilities, autism and dementia by helping with clearer conversations, not having to repeat themselves and reduced stress when accessing services.

Clinicians reported faster understanding without putting additional pressure on individuals.

The passport demonstrated strong value for money, costing approximately £1,060 to print 3,000 passports, and has since been adopted by the Humber Health Partnership.

My husband was treated with respect and given a bed in a quiet part of the ward because he hates loud noises

It gives us the information we need quickly, without putting pressure on the person.

People bereaved by suicide described **feeling listened to** and **valued** through involvement in **Hand in Hand project**.

Training improved **confidence, ability to manage the difficult conversations and mental health safety for front-line staff responding at points of crisis**.

VCSE partners such as Hull CVS, Kooth, Carers' Support Service and CPO embedded prevention, kindness and early intervention into everyday delivery:

175 

referrals supported through buddying services in a single year

80 

positive outcome case studies

24 

Places of Kindness trained to deliver wraparound support

Young people reported feeling safer to talk about mental health and seek help earlier

A Story from Our Community

A socially isolated woman with multiple long-term conditions living in North East Lincolnshire struggled with her finances, mobility, loneliness and accessing face-to-face support. Limited transport and long waiting lists increased her risk of deteriorating mental wellbeing.



What Changed

Through VCSE engagement, social prescribing, kind places and community support, multiple agencies coordinated practical help, debt advice, long-term befriending, community nursing input and occupational therapy assessment.

What's Different Now

She reports being more able to cope, feeling supported and less isolated, with adaptations in place and connections made that reduce future risks to her mental health. The case highlighted how isolation, connectivity and transport gaps increase vulnerability, shaping future prevention planning.

What we have learnt & Next steps



Delivery during 2025–2026 reinforced that **early, community-based and kindness-led mental health support** is effective in making mental health everyone's business, reducing escalation and improving experience, particularly when led by voluntary partners and shaped by lived experience. Simple, low-cost and non-digital approaches proved especially important for reducing inequalities. When people's voices are heard they drive innovation, partner activities and solutions focus.

In response, partners will **refresh the Mental Health Strategy through co-production**, scale the **Health and Care Passport**, expand **Kind Places and employer engagement**, and continue shared training and lived-experience influence. Throughout 2026/2027 we will maintain a clear focus on **earlier help, person centred care, kinder systems and reduced inequality**.

Workforce



Why this work is important

Across North East Lincolnshire, our workforce and partners were clear about their workforce challenges, including:

- Duplication across organisations, particularly in training and workforce processes
- Systems and ways of working that were not always aligned
- Variable understanding of the Health and Care Partnership

Staff described:

- Different systems, data-sharing barriers and duplication of work
- Unclear roles and responsibilities between teams
- Conflicting priorities and ways of working

Some staff described feeling that:

- Collaboration could feel inconsistent, with people sometimes “passed around” between services.
- Collaboration worked well in places, but was inconsistent across the system

As a result, there was a clear need to:

- Strengthen local workforce pipelines and “grow our own” approaches
- Create more joined-up routes into careers and progression

What we set out to achieve

We set out to focus on a defined number of shared workforce priorities:



Recruitment, retention and ‘grow our own’: Strengthening local pipelines, apprenticeships and outreach



Staff development and leadership: Building confidence in system working and supporting progression



Integration, alignment and shared purpose: Reducing duplication and working more consistently across organisations



Workforce culture and wellbeing: Creating a more inclusive, ‘people first’ approach

What we did



Evidence of Impact

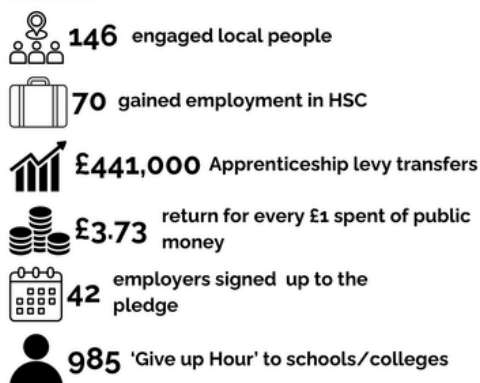


From Vision to Impact



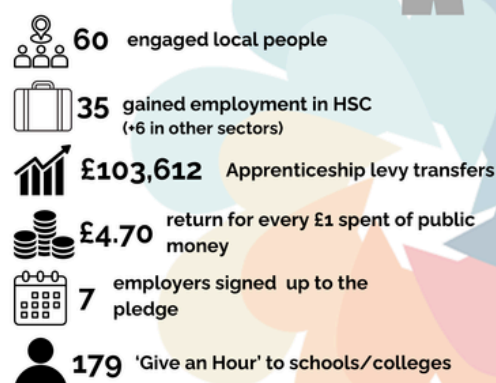
2-Year Pilot

Outcomes from April
2023 - July 2025



Widening Access Demonstrator Programme

Outcomes from July
2026 to March 2026



Health & Care Ambassadors Programme

By giving just an hour at a time, Naomi is helping to shape the workforce of the future, offering real-life insight, encouragement, and inspiration...

Shared Leadership and Staff Development Programme

By investing collaboratively in leadership development now, we are strengthening workforce sustainability, improving retention, building capability and confidence at all levels... and creating stronger relationships across the system.

Oliver McGowan Training - Collaborative Approach

This collaborative approach has worked very well, helping to quickly introduce training availability, ensure fair access across organisations, and make best use of capacity.

We can now meet our statutory requirements, whilst doing valuable work with organisations locally.



What Changed for People

For local people

- Better access to clear pathways into health and care careers
- More opportunities to gain skills, experience and employment locally

For staff

- Improved understanding of how organisations connect and work together
- Growing confidence in cross-system collaboration
- Increased access to development, leadership and digital skills support

For organisations

- Greater alignment and shared priorities
- More coordinated recruitment and workforce development

Stories from Our Community

Naomi, a Senior Palliative Nurse at St Andrew's Hospice, is helping to inspire the next generation of health and care professionals.

Through the Health and Care Ambassador programme, she gives her time to speak at schools, careers events and workshops by sharing her experience and helping young people understand what a career in care looks like.

By giving just an hour, she is:

- Building confidence in young people
- Raising awareness of health and care careers
- Showing that meaningful, local opportunities are within reach



Her contribution is part of a wider approach that connects education, employers and communities and helps to open doors and create pathways into the workforce of the future.

Our partnership with Friendship at Home shows how working together can create real opportunities for local people.

Through the People and Skills Pledge, we:

- Supported recruitment into key roles such as Community Engagement Workers
- Enabled voluntary placements, helping people build confidence and experience
- **Coordinated £22,000 in levy transfer funding**, supporting a team member to progress into a Social Worker role



What we learnt & Next steps

- Working collaboratively reduces duplication and creates better system solutions
- Staff need clarity, confidence and relationships to work across organisations
- Local, place-based approaches are more relevant and sustainable
- Progress relies on dedicated capacity, not goodwill alone

We also learned that culture and trust take time to build, but are critical for lasting change

We are now moving from early progress to system-wide delivery.



We will:

- Protect
 - The People and Skills Pledge as a core workforce model
 - Strong partnerships across the system
- Grow
 - Leadership development and shared induction
 - Digital capability and workforce confidence
- Strengthen
 - Workforce planning, data and coordination
 - Staff wellbeing and inclusive culture
- Rethink
 - How we sustain this work and reduce reliance on short-term capacity



Population Health and Community-First Programme



Why this work is important

Community engagement and population health is central to our work within the North East Lincolnshire Health and Care Partnership.

Across North East Lincolnshire, people's health and wellbeing continue to be shaped by wider challenges such as deprivation, isolation, access to support, and unequal opportunities.

Many residents, particularly those in more deprived neighbourhoods, were experiencing fragmented services, difficulty navigating support, and limited access to preventative care.

Community engagement demonstrated a **clear need to bring services closer to people, strengthen local support networks**, and focus more deliberately on **reducing health inequalities**. This work became a priority to ensure we were reaching those most at risk, improving outcomes earlier, and building a more connected, community-led approach to health and wellbeing.

What we set out to achieve

Throughout 2025 we continued to create a more joined-up, community-first approach that improves people's experiences, access to support, and long-term outcomes.

Our aims were to:

- understand local need more deeply through engagement and lived experience and act on this by working alongside communities and partners.
- shift from reactive services to earlier, preventative support through strengthening community capacity and reducing isolation.
- ensure resources and decision-making were better aligned to neighbourhood priorities and supporting people to live healthier, more independent lives.



What we did



Invested in Community-Led Projects through Health Inequalities Grant

1

We delivered a targeted voluntary, community, and social enterprise grants programme, funding 8 new and 2 continuation projects. This supported a range of initiatives including mental wellbeing, social connection and skills development. Examples include:



- Pawsitive Friendship supporting wellbeing through companionship
- The Black Gull dry bar, engaging 447 people in sober activities and skills development
- Doorstep's Igniting Sparks, supporting nearly 200 young people with trauma-informed therapy and practical support

2

Provided wraparound Neighbourhood Support in West Marsh

In West Marsh, we piloted embedded welfare support alongside food and baby bank provision:



- 138 residents supported with benefits, housing, debt and health needs
- £30,000+ financial gains identified
- Increased trust and engagement through visible, face-to-face access

This demonstrated the value of bringing practical, joined-up support directly into communities.

3

Delivered CVD Prevention - Know your Numbers and Beyond

Through partnership working, we took health checks into community settings:



- Nearly 700 people screened for blood pressure
- 38% identified with raised blood pressure
- 1.5% required urgent follow-up

Locations included football clubs, community venues and markets, helping reach people less likely to access traditional services.

4

Developed community plans and neighbourhood working

All four community plans progressed:



- West Marsh: Over 450 residents engaged, shaping priorities including transport and domestic abuse
- East Marsh: Launch of participatory budgeting (Community Roots) and creative engagement through a community quilt
- Sidney Sussex: Engagement with schools and families using new approaches to reach underrepresented groups
- South Ward: Strong resident-led governance and whole-ward representation

This work is now influencing Marmot work and wider system planning

Evidence of Impact

VCSE Funded Projects

1550+ people engaged across the various projects

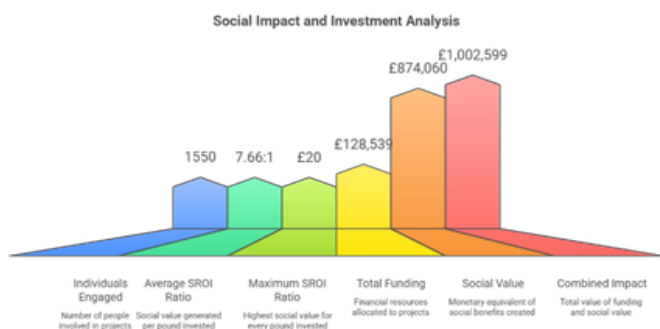
Measurable improvements in:

Mental wellbeing
Reduced isolation
Increased physical activity

Social Return on Investment (SROI):

Average £7.66 social value for every £1 invested

Some projects achieving up to £20 return per £1
 £128,539 investment +£874,060 social value=
 £1,002,599 combined impact



Wraparound Support In West Marsh

138 people provided with benefit checks, hardship support, debt advice, housing issues and health referrals.

£30,000 in financial gains already identified from the wraparound support in West Marsh

CVD Prevention Outcomes

38% of those screened identified at risk of hypertension

Targeting higher-risk populations beyond national averages

Early intervention helping prevent serious conditions such as stroke and heart attack



North East Lincolnshire
Health and Care
 Partnership



.....



What Changed for People



Through engagement, population health and community-first programmes of work across 2025/2026, tangible outcomes in what has changed for people in our community include:

- **Improved mental wellbeing, reduced isolation and increased physical activity**
- **Earlier identification of health risks** and access to preventative support
- Increased **confidence in accessing services** within trusted community spaces
- More **coordinated and personalised support** for people with multiple needs

Stories from Our Community



Case Study Pawsitive Friendship

Roy, an older man living alone, was experiencing profound isolation after the loss of his beloved dog. Struggling with grief and disengaged from mental health services, he continued setting out his dog's bowls daily.

Since being matched with volunteer Annemarie and her therapy dog Bruce, Roy has found renewed purpose. He now prepares treats and water for Bruce's visits, describing them as "fantastic" and something he looks forward to.

This simple, regular connection has lifted his mood, reduced his loneliness, and re-engaged him with life. This powerfully demonstrates the therapeutic impact of the Pawsitive Befriending model.

Case Study Igniting Sparks



XXX, an asylum seeker from Afghanistan, was supported by Doorstep to transition into independent living in the UK. He developed strong budgeting skills, secured benefits, and moved from shared to independent housing. With support, he gained employment, accessed health services, and maintained good physical and mental wellbeing.

XXX reunited with his wife, who is now in college, and they secured a home through social housing. He engaged with community groups, passed his driving theory test, and continues to build confidence and independence, managing his responsibilities and accessing support when needed. His journey highlights successful integration and improved quality of life.

What we learnt

- Community-based delivery increases **trust and engagement**
- **Preventative approaches** are more effective when taken into communities
- **VCSE organisations** deliver high impact and value
- **Co-production** leads to more relevant and sustainable solutions
- **Targeted outreach** can successfully reach higher-risk groups



Next Steps

Scale successful community-based and wraparound support models:

- Continue **investing in VCSE capacity** and community leadership
- **Expand preventative programmes** to reach more people earlier
- Strengthen the link between **community plans and system decision-making**
- Build on **Marmot principles** to address wider determinants of health
- Refresh the Population Health programme for 26/27 and determine how to invest the Health Inequalities grant.



Digital enablement and innovation



Why this work is important



People in North East Lincolnshire often need support from multiple services, but systems and information have not always supported joined up working. This has led to people repeating their stories, delays in finding the right help, and frustration for both individuals and staff.

These challenges are greatest for people with complex needs, including those requiring support across health, care and community services, and those navigating cancer screening and follow-up pathways.

Improving how digital tools support coordination, access and decision-making became a priority this year to reduce duplication, improve experience and make better use of workforce capacity across the partnership.

This work also supports the shift towards a Neighbourhood Health model, where care is organised around local populations and delivered through integrated, multidisciplinary teams. **Digital plays a key role in enabling this shift by supporting information sharing, coordination and improved access across services.**

What we set out to achieve



We set out to use **digital more deliberately to improve how people experience care and support.** This included strengthening coordination across services, supporting earlier access to the right help, and improving confidence for staff in using digital tools in practice.

Alongside this, we aimed to test **new and innovative approaches**, including AI-enabled tools, and to ensure the right governance and assurance processes were in place to support safe and ethical innovation.

This included supporting the **development of a Neighbourhood Health approach**, ensuring digital tools and data enable integrated, multidisciplinary working across health, care and community services.

This work supports wider partnership priorities around prevention, equity, workforce sustainability and improving outcomes for local people.

What we did



- 1 Delivered digital pilots to support people to access the right help, including development of an AI-enabled **Cancer Screening Navigation Assistant, funded by the HNY Cancer Alliance**
- 2 Worked with Focus Adult Social Care to test innovative digital and AI-enabled tools in practice, including, **Minute**, supporting more effective recording and communication in care settings and **Hanc AI Legislation Assistant**, helping staff quickly access and apply complex legislation in social care
- 3 Explored how ethical use of AI can support matching people's needs to services through **early partnership work on a local Social Care Institute of Excellent facilitated AI Practice Lab approach**
- 4 Developed **digital governance and assurance processes** to enable safe and ethical use of new technologies
- 5 Supported staff and VCSE partners to build **confidence in using digital tools** in day-to-day practice
- 6 Supported the **national digital requirements of the emerging Neighbourhood Health model**, including improving information sharing, enabling multidisciplinary working, and aligning tools to support proactive and coordinated care at neighbourhood level
- 7 Secured **external investment to support digital innovation**, including **Navigo and Care Plus Group Wayfinder Patient Engagement Portal (PEP) funding** and **Cancer Alliance funding for AI-enabled screening navigation**
- 8 Gained funding and regional agreement to host a **cyber security specialist role** within Navigo to lead the development of an ICS cyber strategy
- 9 Maintained the **monthly NEL Digital Place Board** to support ongoing collaboration across the digital agenda

Evidence of Impact

- Cancer Alliance funding supported the development of an AI-enabled Cancer Screening Navigation Assistant, demonstrating regional confidence in North East Lincolnshire's approach and enabling new ways to support engagement with screening and care.
- Navigo and Care Plus Group's Wayfinder PEP funding enabled these organisations to connect to the NHS App, widening the single front door to NHS services in North East Lincolnshire.
- Early use of Minute shows potential to reduce administrative burden and improve how information is captured and shared, enabling more time for direct support.
- The Hanc AI Legislation Assistant has improved the speed and confidence with which staff can access relevant legal frameworks, supporting more consistent practice.
- Feedback from staff and partners highlights improved confidence in navigating services and using digital tools to support people, particularly in complex situations.

Collectively, this work demonstrates growing system capability to attract investment, test innovation, and apply learning in practice to support Neighbourhood Health.



£380,000

of digital funding
secured for North
East Lincolnshire

30



users of Hanc AI Legislation
Assistant which helped social
care staff to quickly access and
apply complex legislation in
social care

35



new users of Minute (AI
transcription and meeting
summarisation tool)

What Changed for People



People are starting to experience more joined up and timely support, with improved navigation to the right services and less need to repeat information:

- The Cancer Screening Navigation Assistant is showing AIs potential to supporting clearer and earlier engagement with screening and follow-up care, helping people better understand their options and next steps.
- Staff are able to spend more time supporting people and less time searching for information, improving the overall experience of care. In social care and community settings, staff report increased confidence in applying legislation and guidance consistently, supporting safer and more equitable decision-making.

These improvements support a more neighbourhood-based approach, where people receive coordinated care closer to home from teams working together across organisational boundaries.

External funding has enabled additional innovation and support to be delivered locally, reaching more people and testing new approaches that would not have been possible within existing resources alone.

Story from Our Community



Before:

A practitioner supporting someone with complex needs needed to navigate multiple systems and sources of guidance, including legislation, to identify the right support. This often caused delays and uncertainty for the person.

What changed:

Through new digital tools and AI-enabled support, the practitioner could more quickly access relevant information, apply appropriate guidance, and identify suitable support options. These tools also supported better coordination with other services involved in the person's care.

What is different now:

The person received quicker, more coordinated support, and the practitioner felt more confident and less burdened by administrative and information barriers. Support was better aligned across services, reflecting a more neighbourhood-based, integrated approach.

What we learnt



- Digital tools are most effective when designed around real practice and people's lived experience rather than technology alone.
- AI and digital innovation can add real value in supporting navigation, decision-making and reducing administrative burden, particularly in complex systems.
- Building confidence and trust across partners is essential, and strong governance and ethical frameworks enable innovation to happen safely.
- Delivering Neighbourhood Health requires digital to be fully integrated into service design, enabling teams across organisations to work as one system rather than in isolation.
- Testing new approaches in real settings has been critical to understanding what works and what should be scaled.

Next Steps



- We will build on the approaches that have shown early impact, particularly around navigation, decision support and reducing administrative burden.
- We will continue to develop the digital and data capabilities needed to support Neighbourhood Health, including improving shared access to information, enabling multidisciplinary teams to work more effectively, and supporting proactive population health approaches at a local level.
- We will continue to work with partners to test and refine AI-enabled tools in practice, while strengthening governance and assurance to support wider adoption.
- We will ensure digital approaches are inclusive and meet the needs of all communities and continue to align investment and innovation with the delivery of integrated, neighbourhood-based care.

Estates



2025-26 focused on establishing the foundations for a strong and sustainable estates programme, enabling further development in 2026-27 and beyond:

- An HCP Estates Group was established, bringing together partners from across the North East Lincolnshire system.
- A comprehensive review of primary care lease data was undertaken, alongside early scoping of a collaborative approach to lease renewal.
- Relationships with our principal landlord have been strengthened, positioning them as a key delivery partner.
- Investment has been secured for the development of our first Neighbourhood Health Centre.
- Engagement has taken place with local communities and the workforce to shape the development of Neighbourhood Health Centres.



Through co-production with Franklin College, students identified that they felt an ideal community, neighbourhood health hub be a space where everyone feels included and supported, offering a wide range of services in one place.

They wanted easy access to healthcare like **GP services, mental health support, dental and physiotherapy, as well as support for families, young people, and sexual health.**

Alongside this, they wanted **social spaces, peer support, education, and community resources** to reduce isolation and build confidence. Accessibility, clear information, and inclusive design were important, with features like interpreters, accessible facilities, and flexible appointment options.

Overall, they were asking for a friendly, easy-to-navigate space that puts people at the centre, provides both practical help and wellbeing support, and helps individuals connect, grow, and belong within their community.

Next Steps



- Progress delivery of the first Neighbourhood Health Centre.
- Work with the ICB to identify additional sites for future Neighbourhood Health Centre investment.
- Develop a Strategic Estates Plan to support long-term system priorities.
- Continue engagement with communities and partners, including a planned Neighbourhood Health Centre workshop in summer 2026.

CONTACT US



Email Address:

navigo.hostingnelhcpteam@nhs.net



LinkedIn:

<https://www.linkedin.com/company/nel-hcp/posts/?feedView=all>



Location:

Navigo House, 3-7 Brighowgate,
Grimsby DN32 0QE



Youtube:

<https://www.youtube.com/@NELHCP>

THANK YOU

We would like to thank all our partners, colleagues, volunteers and communities across North East Lincolnshire for their continued commitment and collaboration. Together, we have made meaningful progress in improving outcomes and reducing inequalities, guided by the voices and experiences of the people in North East Lincolnshire.

