London Borough of Richmond upon Thames: local authority assessment

How we assess local authorities

Assessment published: 13 March 2026

About London Borough of Richmond upon Thames

Demographics

The London Borough of Richmond upon Thames is a unique outer London borough, notable for being the only one that spans both sides of the River Thames. It covers approximately 57 square kilometres and includes a mix of urban centres and suburban villages such as Richmond, Twickenham, Barnes, and Hampton. The borough is characterised by its extensive green spaces, including Richmond Park and Bushy Park, and has a strong conservation ethos. Richmond has an Index of Multiple Deprivation decile of 10. A local authority with a decile of 1 means it is in the most deprived group (most deprived 10%), while a local authority with a decile of 10 means it is in the least deprived group (least deprived 10%).

Richmond has a population of 196,678, comprising 44,038 children aged 0–17 (22.39%), 119,254 adults aged 18–64 (60.63%), and 33,386 people aged 65 and over (16.97%). In Richmond most people identify as White and White British (81.05%), with Asian and Asian British residents making up 9.61%, followed by Black and Black British 4.22%, Mixed or Multiple ethnic groups 2.96% and other ethnicities (2.18%).

Richmond is part of the South West London Integrated Care System (ICS), which includes six boroughs: Richmond, Kingston, Wandsworth, Merton, Croydon, and Sutton. Within this ICS, Richmond operates a Place-Based Partnership Committee, which brings together local NHS organisations, the council, and voluntary sector partners to improve health outcomes.

The London Borough of Richmond upon Thames Council is currently under Liberal Democrat majority control, holding 49 of the 54 seats, with the remaining 5 held by the Green Party. The council operates under a committee system of governance, with decisions made across five main service committees and a full council responsible for budget and policy. The borough is known for its emphasis on transparency and community-led decision-making.

Financial facts

- The local authority estimated that in 2023/24, its total budget would be **£328,768,000.00**. Its actual spend for that year was **£355,135,000.00** which was **£26,367,000.00** more than estimated.
- The local authority estimated that it would spend **£80,324,000.00** of its total budget on adult social care in 2023/24. Its actual spend for that year was **£81,881,000.00**, which was **£1,557,000.00** more than estimated.
- In 2023/24, **23.06%** of the budget was spent on adult social care.

- The local authority has raised the full adult social care precept for 2023/24, with a value of **2%**.
- Approximately 2045 people were accessing long-term ASC support, and approximately **1130** people were accessing short-term adult social care support in 2023/24.

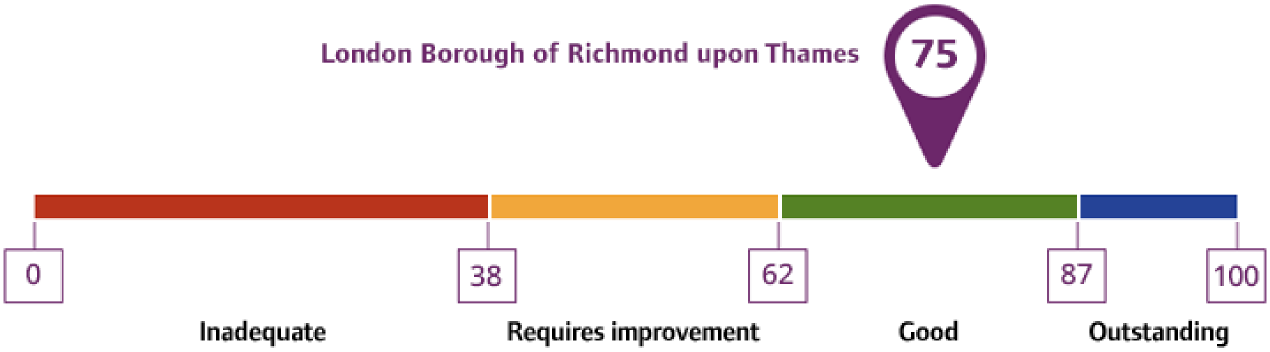
This data is reproduced at the request of the Department of Health and Social Care. It has not been factored into our assessment and is presented for information purposes only.

Overall summary

Local authority rating and score

London Borough of Richmond upon Thames

Good



Quality statement scores

Assessing needs

Score: 3

Supporting people to lead healthier lives

Score: 3

Equity in experience and outcomes

Score: 3

Care provision, integration and continuity

Score: 3

Partnerships and communities

Score: 3

Safe pathways, systems and transitions

Score: 3

Safeguarding

Score: 3

Governance, management and sustainability

Score: 3

Learning, improvement and innovation

Score: 3

Summary of people’s experiences

Care and support was planned and organised with people and people and unpaid carers described feeling listened to during assessments and were involved in decisions.

Feedback from unpaid carers showed that they valued being able to return for help when circumstances changed, which gave them reassurance and reduced stress.

Some people and unpaid carers said it could be confusing to access information across so many different systems and organisations. They also told us the local authority had taken steps to support people's access to information about the local authority and partner organisations.

Some people, who self-funded their care and support, told us that finding the information they needed was a challenge. The local authority was committed to improving self-funders access information and staff across the local authority described sharing information on how to commission services and financial advice on how to pay for care.

People told us direct payments had improved outcomes and wellbeing. Unpaid carers told us direct payments supported them with their physical and mental health. However, feedback in relation to support with direct payments was mixed. One unpaid carer told us they had found the support helpful, however other unpaid carers said they did not have enough support with the system, and remained confused, in particular around the flexibility and restrictions when using a direct payment.

Some people told us transitions from children to adults' services were not consistently planned or supported. Some unpaid carers highlighted gaps in support during transitions from children to adult services. An example of this was that unpaid carers told us clubs and breaks disappeared when young people turned 18, and although direct payments helped maintain some support there was a loss of structure and a risk of isolation.

People told us respite care was limited, although social workers acted when needed. A voluntary sector partner said there needed to be more choice in respite for unpaid carers.

People's experiences reflected both positive and negative aspects of eligibility and decision-making in relation to adaptations. For example, some people described delays and unclear communication about eligibility for adaptations.

Summary of strengths, areas for development and next steps

Performance across key adult social care indicators demonstrated strong outcomes compared to national averages. All people lacking capacity were supported by an advocate, family member, or friend. A higher proportion of people received direct payments than the England average.

People's feedback was also positive, in relation to accessing information and the provision of support helps them feel better about themselves.

According to the Adult Social Care Activity Report (ASCAR) 2024/25, 76.54% of long-term support clients received a review, significantly better than the England average of 59.13%. There were also significant levels of people receiving short-term support that no longer required further assistance. This included people aged 65+ remaining at home 91 days after discharge from hospital into reablement or rehabilitation services.

The local authority offered accessible care and support through various channels, including online, phone, email, and walk-ins. A well-structured front door process ensured effective triage and smooth transitions, minimising the need for people to repeat their stories. The local authority had commissioned advocacy services to support people and unpaid carers through assessment, review and safeguarding processes.

Assessments were person-centred and strengths-based, promoting independence and choice. Trauma-informed practices were embedded, with staff trained to support people respectfully and sensitively. Staff surveys showed high confidence and training levels, supporting the quality of care planning.

Care was coordinated across teams and partners agencies. Specialist teams managed complex referrals, and policies emphasised prevention and person-centred approaches, ensuring compliance with the Care Act and consistent, high-quality assessments.

There were no concerns about the timeliness of assessments for people and unpaid carers, and changes in need were addressed promptly. Efforts to manage and reduce waiting times were proactive and targeted.

People on waiting lists were contacted to monitor changes in their circumstances and connect them to community resources. Similarly, processes to ensure prioritisation of transition cases ensured people were assessed in advance of reaching the age of 18.

The local authority had adopted additional measures, including increasing staff capacity and encouraging front door teams to explore interim support options while full assessments were pending. These actions improved responsiveness and helped prevent crises.

Unpaid carers’ needs were treated as distinct from those they cared for, with separate assessments and support plans often included contingency planning. Carers appreciated measures like Carers Emergency Cards. Practical support such as direct payments and respite care enhanced carers’ wellbeing.

The local authority maintained a clear, transparent, and consistently applied framework for assessing and charging adults for care and support. Guidance documents were well-structured and accessible, with regularly reviewed procedures and policies that ensured transparency and accountability.

The local authority adopted a proactive, prevention-focused approach to care and support, working collaboratively with people, partners, and the community to promote independence and reduce reliance on formal services. This strategy was underpinned by access to reablement, community health initiatives, and digital tools.

Staff demonstrated creativity and commitment in using care technology and practical interventions to prevent escalation of needs, while initiatives like Making Every Contact Count (MECC) helped streamline support and reduce duplication. Housing and homelessness were key challenges, addressed through cross-sector collaboration and inclusive design, including a new homeless hub and specialist occupational therapy input. Prevention was embedded across the organisation, supported by a shared vision between Public Health and Adult Social Care.

Mental health support was enhanced through strategic partnerships, and the impact of the prevention strategy was monitored using outcome data.

The local authority prioritised access to equipment and home adaptations to support independence and reduce reliance on care packages. The Occupational Therapy team collaborated with frontline services and the Home Improvement Agency to ensure needs were met and to manage the Disabled Facilities Grant effectively. Trusted assessors in voluntary organisations provided minor aids, reducing duplication and unnecessary referrals.

Investment in smart care technology enabled personalised support and improved outcomes, benefiting both people and unpaid carers. The local authority also had an established responder service, however acknowledged that a small number of people were unable to access this service due to living alone and not having the minimum requirement for two named contacts. Staff told us that people who don't have two local named contacts cannot access the responder service, and this lack of informal support could potentially lead to unnecessary hospital admission.

The local authority were exploring this issue and actively looking at ways to resolve the situation. Staff told us people can use smart digital alternatives, but this required people to have at least one family or friend as their named representative, but they may not need to live in the local area.

Following the collapse of the externally commissioned community equipment provider, the local authority responded swiftly by securing a new local supplier, prioritising those most at risk and maintaining communication with staff. While it was too early to assess the long-term impact, safe and effective interim arrangements were in place.

The local authority demonstrated a strong commitment to equality and inclusion by using detailed demographic and equality data to inform service design and reduce inequalities in care experiences and outcomes. It identified gaps in culturally responsive care and addressed underrepresentation of ethnic minorities in services through collaboration with community organisations and audits of support plans.

Barriers included digitally excluded groups, and initiatives like 'Connect to Tech' and dedicated refugee support teams helped to bridge access gaps. A Culturally Responsive Services Action Plan guided improvements in service specifications, workforce capability, and data monitoring. Equality Impact Assessments were used to mitigate risks and ensure inclusive service changes. The local authority embedded equality objectives into corporate plans.

There was a culture of continuous improvement and proactive learning from feedback from people which was systematically gathered and used to shape priorities and improve services. Co-production with people with lived experience and unpaid carers shaped services.

Staff training in cultural competence and gender identity supported inclusive care delivery. Continuous learning was promoted through staff forums and bite-size training, enhancing professional curiosity and confidence in addressing equality issues.

The local authority demonstrated strong and effective partnership working with health, social care, and community organisations, underpinned by clear governance, accountability, and information-sharing arrangements.

There were collaborative working arrangements in place, and innovative actions to support system wide improvements that would positively impact on people in Richmond. Strategic relationships with health partners and the voluntary sector enabled integrated care and innovation, while forums like the Urgent and Emergency Care Board facilitated collaborative responses to challenges such as hospital discharge.

Joint planning and commissioning improved service design and outcomes, and pooled budgets supported tailored services and innovation, including micro-grants for community-led initiatives.

We found evidence of strong governance and accountability, with clear structures at all levels ensure visibility, assurance, and compliance with Care Act duties. Robust risk management included embedded processes and proactive escalation routes were in operation.

Quality assurance processes and structured feedback mechanisms ensured continuous improvement and reinforced shared responsibility for care standards. These led to more coordinated care, quicker access to support, and reduced delays, with examples showing how joint working addressed urgent health needs and improved transitions.

Areas requiring further attention included communication arrangements between the emergency duty team and daytime teams, as there was a reliance on system notes rather than direct dialogue which limited opportunities to clarify urgent issues and could affect continuity of care.

We found transition arrangements and processes were well-established with structured tracking processes, regular multi-agency discussions and strong collaboration between adults' and children's services. However, evidence showed when young people turned 18, many of the clubs and short breaks they previously attended stopped. While some families received direct payments to arrange additional care, some unpaid carers felt this often placed responsibility on them to fill gaps resulting in additional pressure for families, reducing continuity of care and limiting opportunities for young people to maintain social networks.

Theme 1: How London Borough of Richmond upon Thames works with people

This theme includes these quality statements:

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

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

Assessing needs

Score: 3

3 - Evidence shows a good standard

What people expect

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

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

The local authority commitment

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

Key findings for this quality statement

Assessment, care planning and review arrangements

People could easily access the local authority’s care and support services through multiple channels, including online and self-assessment options. People accessed support through a clear front door process that included phone, email and walk-in options. Staff described how the front door team triaged referrals to ensure people met Care Act criteria or safeguarding thresholds and passed information to locality teams to avoid people repeating their story. For example, staff said the front door communicated well with locality teams and handed over information effectively. This meant people experienced smoother transitions and less frustration when seeking help.

First Contact staff managed a high volumes of calls, including safeguarding and police reports, and signposted people to appropriate services. We heard that one staff member handled 35 calls in a single morning, showing the demand and pressure on the system. Despite this, people were listened to and their needs recorded, which helped ensure timely responses.

The approach to assessment and care planning was person-centred and strengths-based. The approach reflected people's right to choice, built on their strengths and assets and reflected what they want to achieve and how they wish to live their lives. Assessments were described as person-centred and strengths-based, focusing on what mattered most to people. For example, care records showed assessments included prompts such as “What strengths does the person have and what support do they need?” This helped ensure plans promoted independence and choice.

We saw evidence of trauma-informed practice, where social workers gave time and breaks during assessments and considered triggers. This approach enabled people to feel supported and respected. Similarly, we observed reviews showed how tasks were broken down to highlight what the person could do, such as placing clothes in the washing machine, which promoted independence.

Staff confirmed this approach was embedded in practice. Leaders said they were proud of work on personalisation and direct payments, and staff surveys showed 86% of practitioners had sufficient training in strengths-based practice. This meant people's assessments were more empowering and aligned with their preferences.

Performance in key adult social care indicators highlighted good outcomes compared to national averages with the Adult Social Care Survey (ASCS) showing 65.43% of people were satisfied with care and support, similar to the England average of 65.39% and 79.01% of people felt they had control over their daily life, similar to the England average of 77.62%. In addition, 42.59% of people reported they had as much social contact as desired, similar to the England average of 45.56%. These figures suggested most people experienced positive outcomes, especially around satisfaction and control although social contact remained a challenge.

People's experiences of care and support ensured their human rights were respected and protected; they were involved throughout in decisions and their protected characteristics under the Equality Act 2010 were understood and were incorporated into care planning. People described feeling listened to and involved in decisions. Unpaid carers said they felt heard during assessments, even though they noted paperwork was extensive. Care records showed assessments considered communication needs and wellbeing, and examples from records demonstrated sensitivity to autism and mental health challenges. The social worker apologised for terminology that could have caused distress, which set a positive tone for engagement.

Staff also worked to ensure equality and inclusion. For example, assessments for people with complex needs included input from families and professionals, and reviews considered cultural and communication requirements such as Makaton and British Sign Language (BSL). This helped ensure plans respected rights and supported participation.

Pathways and processes ensured people's support was planned and co-ordinated across different agencies and services. Processes supported joined-up working. For example, quarterly reports showed teams collaborated when family members were open to multiple services, ensuring documentation, for example Lasting Power of Attorney (LPA) documentation and advanced decisions were recorded. This improved continuity and reduced duplication.

Staff described strong relationships with health partners and voluntary sector agencies, though some partners raised concerns about inappropriate referrals and gaps in understanding complex neurological needs. These issues were being addressed through open dialogue and training, which aimed to improve co-ordination and safety.

Digital solutions also supported co-ordination. For instance, care technology was used to tailor packages, such as installing devices to maintain contact and reduce additional care calls. This promoted choice and improved outcomes for people while supporting efficiency.

The local authority had assessment teams who were competent to carry out assessments, including specialist assessments. Staff surveys indicated high engagement and confidence, with 91% of staff feeling part of a supportive team and 80% able to access learning when needed. This prepared practitioners to deliver accurate and timely assessments.

Specialist teams managed complex cases, including mental health, substance use and neurodiversity. For example, the mental health team undertook safeguarding, transitions and section 117 reviews with health partners. The local authority also commissioned deep dives to understand rising safeguarding concerns in substance misuse, showing proactive risk management.

Policies and procedures were up to date and comprehensive, covering assessment, care planning and review. They emphasised prevention, proportionality and person-centred practice, ensuring compliance with Care Act duties. This framework supported staff competence and consistency in delivering high-quality assessments.

Timeliness of assessments, care planning and reviews

Assessment and care planning arrangements were timely and up to date. The local authority had acted to ensure assessments and care planning were timely and up to date.

Performance data showed that from March to July 2025, waiting times and completion rates for care assessments, financial assessments, and reviews improved. For example, the local authority reported 75.7% of Care Act assessments were completed within 30 days, and 83.9% of people were reviewed in 2024/25. This exceeded their target of 70% for annual reviews, with 78% achieved in 2023/24. These improvements meant people accessed support earlier and experienced fewer delays in having their needs met.

Partners told us they had no concerns about timeliness of Care Act assessments for people and unpaid carers. Providers said changes in need were addressed promptly, and the process for self-funders worked well, with reviews set up seamlessly. This responsiveness ensured people remained in stable care arrangements and avoided unnecessary disruption.

Performance data from the local authority showed that in July 2025 there were 8 people waiting for an assessment, with a median wait time of 1 day and a maximum wait time of 246 days. The local authority had set a target timescale for assessment completion of 30 days.

The local authority also confirmed that in July 2025 there were 187 people were waiting for a review, with a median wait time of 22 days and a maximum wait time of 600 days. The local authority had set a target of achieving 75% completion of reviews annually.

According to the Adult Social Care Activity Report (ASCAR) 2024/25, 76.54% of long-term support clients received a review, significantly better than the England average of 59.13%. The local authority was acting to manage and reduce waiting times for assessment, care planning and reviews. This included actions to reduce any risks to people's wellbeing, while they are waiting for an assessment. For example, in March 2025, 49 people were waiting for occupational therapy assessment, which reduced to 34 by July 2025. The occupational therapy team worked hard to lower the waiting list, using a risk rating system and prioritising high-risk referrals within 2 weeks. They contacted people on the waiting list to check their needs and asked them to update the team if circumstances changed. This approach meant people waiting for support were monitored and connected to community resources, reducing risks to wellbeing.

For instance, the preparing for adulthood team held weekly meetings to review referrals and used a red, amber, green rating system. People waiting six months were rated amber, and those approaching transition at 17 were rated red. This prioritisation ensured urgent referrals were addressed promptly, reducing anxiety and safeguarding continuity of care.

The local authority also reminded front door teams to explore immediate support options while full Care Act assessments were pending and increased staff capacity to enable timely allocation. These actions improved responsiveness and reduced delays, meaning people accessed interim support earlier and avoided crises.

Partners confirmed these efforts were effective. For example, voluntary sector organisations said they had no concerns about timeliness, and providers reported that urgent changes were picked up responsively. This meant people experienced continuity of care and avoided gaps in support.

Data showed consistent improvement. In March 2025, there were 11 people waiting for assessment, and by July 2025, only 8 people were waiting. Median waiting time for assessments was 1 day, and the maximum waiting time reduced from 236 days to 75 days. These reductions meant people accessed assessments faster, improving their experience and reducing risks of harm.

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

The needs of unpaid carers were recognised as distinct from the person with care needs; assessments, support plans and reviews for unpaid carers were undertaken separately. For example, unpaid carers described having a dedicated assessment alongside the Care Act assessment, which captured their own needs and included contingency planning. Staff confirmed unpaid carers' assessments were scheduled independently and could be completed in person or by phone. These assessments often led to signposting or one-off support rather than a package of care, but they were recognised as an important step in acknowledging unpaid carers' roles.

Evidence from multiple sources indicated contingency planning was a priority. Unpaid carers spoke positively about receiving Carers Emergency Cards, which reassured them that plans were in place should an emergency occur. Staff explained these cards were incorporated into assessments and reviews, and the local authority had updated its processes to include a contingency section in assessments following feedback. This change aimed to ensure unpaid carers' relationships were flagged promptly in emergencies.

National data supported the view that unpaid carers were generally satisfied with the support they received, though there were areas for improvement. Survey of Adult Carers in England (SACE) 2023/24 metrics showed 41.07% of carers were satisfied with social services, better than the England average of 36.83%. Unpaid carers reported feeling encouraged and supported was 36.36%, compared to the England average of 32.44%. However, only 21.21% felt they had control over their daily life, similar to the England average of 21.53%.and 48.48% of unpaid carers experienced financial difficulties because of caring responsibilities, similar to the England average of 46.55%. These figures highlighted that while satisfaction was relatively strong, challenges around autonomy and financial strain were present.

Local authority data demonstrated progress in reducing delays for carers' assessments. In July 2025, 7 unpaid carers were waiting for an assessment, with a median wait time of 28.4 days and a maximum of 159 days. This was a significant improvement from February 2025, when the maximum wait time was 236 days. Staff attributed this reduction to increased flexibility in scheduling and the introduction of online assessments, which allowed unpaid carers to request reviews when their circumstances changed.

Examples such as unpaid carers receiving direct payments for gym memberships, theatre tickets, or equipment repairs illustrated how assessments translated into practical support. These measures helped unpaid carers maintain their wellbeing and continue their caring role effectively. For instance, one carer struggling to afford travel costs received a direct payment for petrol, enabling them to visit the person they cared for. Staff also described funding short-term respite through voluntary sector partners, which provided unpaid carers with essential breaks.

Feedback from unpaid carers reinforced the impact of these changes. Unpaid carers said they felt listened to during assessments, even though paperwork was burdensome. They valued support from local organisations, which offered counselling, training, and social activities. For example, unpaid carers reported counselling sessions and training days helped them cope better and feel less isolated.

These experiences aligned with findings from the Survey of Adult Carers in England (SACE) 2023/24, which showed that 38.46% of carers accessed a support group or someone to talk to in confidence, somewhat better than the England average of 32.98%.

Overall, the recognition of unpaid carers’ distinct needs and the improvements in assessment processes had a positive impact on people’s experiences. Unpaid carers felt more informed, supported, and able to plan ahead, which reduced stress and improved their ability to care. However, ongoing challenges around financial hardship, social isolation, and control over daily life indicated further work was needed to strengthen outcomes for unpaid carers.

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

People were given help, advice and information about how to access services, facilities and other agencies for help with non-eligible care and support needs. People had access to advice and information through various channels, and this often helped them understand what support was available and how to plan ahead. People were given help, advice and information through various channels about how to access services, facilities and other agencies for non-eligible care and support needs, which often helped them understand available support and plan.

For example, unpaid carers said they had received guidance and signposting from local organisations, which included information about coffee mornings, training sessions, and counselling opportunities. This support helped unpaid carers feel less isolated and more confident in their caring role. Feedback from unpaid carers showed they valued being able to return for help when circumstances changed, which gave them reassurance and reduced stress.

Staff described how they worked to ensure unpaid carers were informed about options for support. Staff explained they provided contingency planning advice and issued carers' emergency cards to help people prepare for unexpected situations. These cards were incorporated into assessments and gave unpaid carers peace of mind, knowing that emergency contacts were clear. The local authority also introduced flexibility in reviews, allowing unpaid carers to request earlier reviews when their circumstances changed. This meant unpaid carers could access timely advice and avoid crises.

Partners confirmed that the local authority expected voluntary sector organisations to identify unpaid carers and make sure they were told about available support, including assessments. Examples such as the Carers Hub and Carers Centre showed how unpaid carers were supported with information and advice, including help to prepare for assessments. This collaborative approach ensured unpaid carers were not left without guidance and could access services that maintained their wellbeing.

National data from the Survey of Adult Carers in England (SACE) 2023/24 supported these findings, showing that 74% of carers felt involved or consulted as much as they wanted in discussions, and 36.36% felt they had encouragement and support. These figures were above the England averages, indicating people generally felt informed and supported. The impact of this was significant and unpaid carers reported feeling less alone, more able to cope with caring demands, and better able to maintain their own health and wellbeing. For example, feedback from the Carers Centre Impact Report highlighted that 85% of unpaid carers felt their caring needs had been understood and 73% felt more confident in their role. This improved people's experience by reducing isolation and helping them manage responsibilities effectively.

Eligibility decisions for care and support

The local authority's framework for eligibility for care and support was transparent, clear and consistently applied. Decisions and outcomes were timely and transparent. The local authority had a clear framework for determining eligibility for care and support. It provided staff with structured guidance documents were comprehensive, easy to read, and included clear ownership and review dates. These documents were on standard templates, included contents lists, and outlined processes in a logical way. This ensured staff had access to consistent information when making decisions.

The local authority also introduced an appeals process that allowed people to challenge decisions. The process had two stages and gave people the option to escalate to a formal complaint if they disagreed with the outcome. For example, the guidance stated appeals must be reviewed by a Head of Service within 15 days, and outcomes communicated in writing. If people remained dissatisfied, they could approach the Ombudsman. This provided a clear route for people to raise concerns and seek resolution.

However, despite these processes, the local authority reported that it had not received any formal appeals in the previous 12 months. It acknowledged that some people had challenged assessment outcomes through the complaint's procedure, but it did not provide data on the number or themes of these challenges. It was unclear why the appeals process was not used in these cases but the existence of a two-stage appeals process with an option to escalate to a formal complaint gave people a clear route to challenge decisions. This helped ensure fairness and accountability.

Quarterly reports showed social workers were reminded to explain the rationale behind decisions and outline team roles during assessments. This improved transparency and supported person-centred practice. For example, guidance encouraged staff to provide clear explanations, which helped people understand why decisions were made and what options were available.

People’s experiences reflected both positive and negative aspects of decision-making. For example, some people described delays and unclear communication about eligibility for adaptations. Occupational therapists visited properties and discussed adaptations, but some people told us that months later they were told they did not meet criteria for adaptations without a clear explanation as to why. Some people said they would have paid for work earlier if they had known, which caused frustration and limited independence, such as being unable to leave their homes without a carer. We heard one example regarding the rejection was for an automated door, which would have allowed the person to leave their home independently rather than waiting for a carer. This showed inconsistent communication about eligibility decisions could negatively affect people’s independence and wellbeing.

In contrast, partners gave positive feedback about how staff applied eligibility decisions in practice. For example, an occupational therapist managed a dispute about ineligibility for equipment provision in a professional and sensitive way. They explained the rationale for the decision clearly, which helped the person understand the outcome. This demonstrated that staff communicated decisions in a respectful and transparent manner.

The local authority had reminded social workers to explain the rationale behind decisions and outline the roles of different teams during assessments. This aimed to improve transparency and make assessments more person-centred. For example, quarterly reports highlighted this as an area of focus, which indicated that the local authority was taking steps to address gaps in communication.

National data from the Adult Social Care Survey (ASCS) 2024/25 showed 71.60% of people did not buy additional care or support privately or pay more to ‘top up’ their care and support, this was better than the England average of 63.73%.

Financial assessment and charging policy for care and support

The local authority's framework for assessing and charging adults for care and support was clear, transparent and consistently applied. Decisions and outcomes were timely and transparent. The local authority had a structured framework for assessing and charging adults for care and support. Guidance documents for determining eligibility and appeals were comprehensive, well-structured, and easy to read. For example, the Guide to Delegated Financial Decision-making outlines how managers will make delegated financial decisions in an effective and proportionate way, which is compliant with the duties under the Care Act 2014 and was last updated in May 2024 and scheduled for review in April 2025. The appeals policy launched in November 2024 had clear timelines and escalation routes. These processes showed a commitment to transparency and consistency.

Data from the local authority indicated that in July 2025, 5 people were waiting for a financial assessment. The median wait time was 2 days, and the maximum wait time was 43 days. The local authority had a target to complete 90% of assessments within five days, which demonstrated an ambition to provide timely decisions. This was important because delays in financial assessments could affect when people accessed care and support.

Provision of independent advocacy

Timely, independent advocacy support was available to help people participate fully in care assessments and care planning processes.

The local authority had commissioned advocacy services to support people and unpaid carers. The advocacy provider had established their own local operating procedures which sets a 5-day allocation of referrals including a prioritisation system meaning referrals to safeguarding or support for those people deemed to lack capacity to make decisions were assigned as high priority.

The local authority closely monitored data relating to referrals and allocation times. For example, in quarter 4 of the Advocacy Update dated November 2024, out of 77 referrals only 30 fell outside of the 5-day allocation target. The local authority explained that during this period a system change may have impacted on the recording of allocations.

Data collated by the provider was regularly analysed and where issues were identified the provider would implement remedial actions. For example, the 2023/24 data demonstrated block hours commissioned had not been utilised, and this led to the provider attending adult social care team meetings to raise awareness of the service and referral routes.

A partner told us the local authority's understanding of advocacy has improved. They expressed that there previously had been a misunderstanding of advocacy's remit. However, the local authority acted prompting in facilitating advocacy visits to team meetings to raise a better understanding of advocacy as the support it could provide to people. Partners told us commissioners arranged bi-monthly drop-in sessions for staff to attend to improve their understand of advocacy and to clarify any queries they had with the commissioned advocacy service.

Staff told us they routinely considered advocacy support for people who required it. They said the commissioned advocacy service for Care Act advocacy, safeguarding, and Independent Mental Capacity Advocates (IMCAs) was available. For out-of-area placements, staff explained it sometimes took longer to secure an advocate because they had to use a different provider, but they always managed to achieve this.

Staff provided examples of the positive impact of advocacy. One example involved a person with fluctuating capacity who wanted to return home from hospital, while professionals preferred a care home placement. Advocacy involvement had supported the person to return home, and additional measures were put in place to facilitate discharge, such as arranging extra introductions with the care agency to help the person accept care.

We heard from one partner that the local authority had a good person-centred approach to advocacy. For example, when advocates felt they needed more time to build rapport with people this was appropriately provided to ensure best outcomes were reached for people when assessing their needs. Feedback they received from some people using services was that they did not always feel heard but they expressed that when advocacy was involved, they had felt listened to.

Another partner told us a review was planned to look at the high numbers of families advocating for their family member, especially during safeguarding matters, to ensure this was appropriate and that everyone had access to independent advocacy.

The Commissioning Team told us they had worked with other London boroughs in respect of Independent Mental Capacity Act advocates (IMCAs) in hospitals. They now had a single provider to cover all acute mental health hospitals, with a single point of access.

Supporting people to live healthier lives

Score: 3

3 - Evidence shows a good standard

What people expect

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

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

The local authority commitment

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

Key findings for this quality statement

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

The local authority worked with people, partners and the local community to promote independence, and to prevent, delay or reduce the need for care and support. Leaders told us they promoted prevention across the whole local authority with a focus on access to reablement, community health support, and digital tools. National data reflected this approach. Data from the Adult Social Care Outcomes Framework for 2023/24 showed 94.49% of people who received short-term support no longer required ongoing support, significantly above the England average of 79.39%.

Staff spoke passionately about the importance of prevention, such as using care technology to minimise the risk of falls. Staff worked creatively with people to provide practical support to prevent needs from escalating, for example, supporting a person with their communication needs during a housing appointment. An unpaid carer for an autistic person described how funding for a personal assistant aimed to promote their family member's skills and independence, reducing reliance on care services in the future.

The Making Every Contact Count (MECC) initiative aimed to ensure people did not have to keep repeating their story or being referred on multiple times. Staff were required to attend MECC training to aid their conversations with people. This initiative was central to the prevention agenda, and the staff gave us examples of the practical advice provided, for example a person receiving advice on benefits could be given additional support around keeping warm in winter.

Access to appropriate and affordable housing and homelessness were central challenges in Richmond which impacted on peoples' wellbeing and led to the escalation of care and support needs. The local authority worked well across the organisation and with partners, such as housing providers, to address these challenges and reduce the need for care homes. A specialist housing Occupational Therapist championed inclusive and flexible design for disabled and older people, advising on the build and design of supported and general housing. For example, recommending contrasting colours in flooring and kitchens to support people with visual impairments. They had published a design guide developed to inform the design of new builds. Staff highlighted an innovative homeless hub, due to open imminently, which would bring together services under one roof and support those people who potentially had care and support needs. This service aimed to target people who did not actively approach the local authority, and preventing their needs from escalating.

Care technology supported prevention, promoting people's independence to enable them to continue living at home. Staff provided examples, including one in which they had arranged for automated blind tilts to be fitted, increasing a person's autonomy and wellbeing and reducing the need for paid carers.

The local authority had developed a framework which was central to embedding prevention across the organisation and wider community. Public Health sat within the same directorate as Adult Social Care, which helped promote a shared vision and commitment to implementing preventative public health initiatives. For instance, care homes received targeted guidance around risk management in hot and cold weather.

The local authority told us their prevention agenda focused on people at greatest risk of a decline in their independence and wellbeing. Specific consideration was given to supporting unpaid carers preventatively. The local authority worked with unpaid carers around contingency planning, aimed at preventing people's needs from escalating in an emergency. Staff told us contingency planning was written into carer's assessments, such as respite options in an emergency.

However, a carer told us they had not received support when their family member was diagnosed with dementia. A gradual escalation of needs led to a crisis and emergency care interventions. A partner confirmed current provision tended to cater to those with more advanced needs. The local authority had recognised there was a gap in this area and were collaborating with key partners to develop a dementia awareness and prevention programme. This included the remodelling of dementia day services to target people in a more preventative manner.

The local authority collaborated with partners to target support to people who did not have identified care needs but were at risk of a decline in their independence and wellbeing, such as door sensors for a person experiencing domestic violence. There was a focus on reducing pressure on acute health services, including monitoring the health of people with learning disabilities who were more likely to be admitted to hospital and enabling the voluntary sector to identify and target support to frequent attendees at Accident & Emergency.

People with mental health needs faced challenges, such as waiting times for support which increased the likelihood of their needs escalating. The Local Authority was actively addressing this with partners through several initiatives, such as the South West London Integrated Care System strategy, which included a preventative service to support people who presented in a mental health crisis.

The local authority had taken steps to identify people with needs for care and support that were not being met. They had worked with Kingston Hospital to reach unpaid carers who did not recognise themselves as carers. Joint work with partners in mental health also aimed to increase representation of ethnic minority communities in early intervention services, targeting people whose needs were not currently being met.

The local authority had arrangements to monitor and evaluate the impact of its prevention strategy and the outcomes for people and the community. Data had been used to measure the outcomes for people who had been supported to remain at home through a ‘Home First’ approach.

Provision and impact of intermediate care and reablement services

The local authority worked with partners to deliver intermediate care and reablement services to enable people to return to their optimal independence. In 2024–25, discharge timeliness improved significantly, with average discharge times reduced by 3.08 days compared to the previous year. National data also reflected this positive picture, with the Adult Social Care Outcomes Framework showing 96.88% of people aged 65 and over remained at home 91 days after discharge into reablement/rehab, well above the England average of 83.70%.

Staff told us intermediate care beds were available, which people might use if they were ready for hospital discharge but needed more support to enable them to return home. Staff said the success of reablement within people's homes meant intermediate beds were used less frequently. They were still used to support a return to optimal independence and prevent long-term admission to residential care, such as an older person who stayed in an intermediate care while their home was being adapted. A partner confirmed there were good quality intermediate care services in Richmond.

Reablement in Richmond was provided through the Richmond Response and Rehabilitation team (RRRT) and a separate Mental Health Reablement team. Reablement provided integrated personalised support to people to prevent deterioration in their well-being. It helped avoid unnecessary admission to hospital and supported people being discharged from hospital to regain their independence. The reablement teams included professionals from different disciplines who worked together effectively, with clearly defined responsibilities focused on supporting people to meet achievable objectives and improved outcomes. A person described how reablement had supported them on discharge from hospital, enabling care visits to reduce as they regained their independence.

There were three contracted providers who delivered reablement support funded by the local authority. Local authority staff worked in partnership with providers, meeting weekly to provide guidance, help set achievable aims and monitor people's outcomes. Voluntary services also had a key role in supporting people's reablement. Local organisations worked in partnership with RRRT, for example supporting people with decluttering or shopping to enable them to be discharged from hospital.

Access to equipment and home adaptations

The local authority told us access to equipment and home adaptations was central to supporting independence and delaying or preventing the need for an increase in care packages or development of care needs. Staff said they encouraged people to consider installing equipment before opting to set up care packages. An unpaid carer described how their relative had benefited from equipment to minimise the risk of falls, which provided reassurance and enabled them to continue living at home. Staff had provided equipment to another person to enable them to be discharged home promptly from hospital.

The local authority had a specialist occupational therapy team who worked closely with other frontline teams, including carrying out joint visits, to ensure people's needs for aids and equipment were met. Staff in other teams and organisations, including in voluntary services, had been trained to become trusted assessors, providing minor aids and equipment to people they were already in contact with. This helped avoid unnecessary referrals and supported the principle of Make Every Contact Count where people only had to tell their story once.

The occupational therapy team also worked in partnership with the Home Improvement Agency in the assessment and delivery of the Disabled Facility's Grant. Through engagement with housing providers, a specialist occupational therapist promoted more accessible housing design, which helped protect the Disabled Facility's Grant for people at greatest need, by delaying people's needs from escalating.

As part of their transformation programme, the local authority had invested significantly in developing smart care technology to help people remain healthy, independent and to reduce the need for care services. Staff were passionate when describing the way technology could promote people's wellbeing and improve outcomes. Support was tailored and personalised. Technology assisted unpaid carers in their role, as well as the person being cared for, such as installing a smart bulb which a person could turn on remotely from their bed, reducing dependence on their unpaid carer.

The local authority acknowledged that there was a lack of responder service in the borough which may impact on the support available to some people living alone without family or friends to support them and could potentially lead to increased admissions to hospital.

The local authority had joined other councils to commission an external agency to provide equipment. The agency went into receivership immediately prior to our assessment. The local authority had responded effectively to source equipment from a new local provider and managed the transition safely. They had applied learning from the previous contract, setting up arrangements to enable people to receive equipment promptly. Staff told us leaders had communicated effectively with them during the changes. Interim arrangements ensured those most at risk had been prioritised during the transition and to ensure information and support was provided to people while they waited for equipment. It was too early for data to evidence the new arrangements had been embedded fully but the local authority had demonstrated it had put safe and effective arrangements in place to manage the provision of aid and adaptations.

Provision of accessible information and advice

People could access information and advice on their rights under the Care Act and ways to meet their care and support needs. Most people contacting the local authority for the first time spoke with the First Contact team, which had a key role in ensuring people accessed good quality information and advice. Detailed information was also available on the local authority's website. National data indicated the local authority was slightly better than the national average in this area. Data from the Adult Social Care Outcomes Framework showed 70.00% of people who used services found it easy to find information about support in 2023/24, compared to England the average 67.12%. Similarly, national data from Survey of Adult Carers in England (SACE) 2023/24 showed 69.39% of carers who find it easy to access information and advice, significantly better than the England average of 59.06%.

Some people and partners told us access to information was challenging for people who did not have a named contact in the local authority or did not use the internet. The local authority had recognised this and had a programme to support people who were digitally excluded, for example by providing tablets to people to help them access the internet. They also funded a wide range of community and voluntary organisations to reach into the community and provide information to people, such as in local coffee mornings. This included charities who could provide specialist advice on medical conditions. As part of this funding, an information navigation service had been set up by the Community Independent Living Service (CILS). Staff described working well with the information service and individual organisations, signposting people who needed more support to access information.

Some people and unpaid carers said it could be confusing to access information across so many different systems and organisations. They told us the local authority had taken steps to support people's access to information about the local authority and partner organisations. The local authority published a weekly online newsletter and held a popular annual 'Full of Life' fair, attended by older people, which gave access to multiple partners, such as the police and trading standards. People told us the fair was a great way to find information on a wide range of topics.

Due to the number of self-funders in Richmond, some people who required advice did not have services arranged for them by the local authority. People and unpaid carers told us this could make finding information more of a challenge. The local authority was committed to improving self-funders access information and staff across the local authority reflected this commitment. For example, staff described sharing information on how to commission services and financial advice on how to pay for care.

Direct payments

The local authority was committed to increasing the use of direct payments to improve people's choice and control about how their care and support needs were met. Direct payments were promoted through a named commissioner, specialist team and a champions network. National data from the Adult Social Care Outcomes Framework for 2023/24 demonstrated the local authority was performing well in relation to direct payments, with 35.30% of total service users receiving direct payments, somewhat better than the England average of 25.48%. Data provided by the local authority also showed support for unpaid carers through direct payments had increased significantly over recent years. In 2022/23, 109 unpaid carers received a direct payment, and by 2024/25 this had increased to 267. Data from the Adult Social Care Outcomes Framework highlighted that 100% of carers receive a direct payment in Richmond.

People and their unpaid carers gave us examples where direct payments had improved outcomes and wellbeing. A young person with autism who was at risk of refusing care had used direct payments to employ a younger personal assistant who they felt comfortable with in the local community. Unpaid carers told us direct payments supported them with their physical and mental health, such as purchasing a massage session.

Staff ensured direct payments were linked to clear outcomes, such as increase in confidence or skills. Staff spoke positively about how direct payments supported choice and personalised care, such as funding training for a person with mental health needs so they could move into paid employment. Staff supporting people being discharged from hospital described practical arrangements to ensure equal access to direct payments, which did not delay discharge.

There was wide-ranging support for people around direct payments. Social work staff described how finance staff could join them on visits to people to provide advice around completing forms. The local authority funded a local organisation to ensure people had ongoing access to information about direct payments. Feedback from people and unpaid carers was mixed in relation to this support. One unpaid carer told us they had found the support helpful, however other unpaid carers said they did not have enough support with the system, and remained confused, around the flexibility and restrictions when using a direct payment.

Partners told us there was scope for using direct payments to facilitate more creative support options for people with dementia. The local authority reviewed the uptake of direct payments on an ongoing basis, looking at data and trying to understand why people might chose or refuse direct payments. They demonstrated a recognition of the challenges people might face and were taking action, for example improving systems and developing support for people who might not be able to manage direct payments themselves.

Equity in experience and outcomes

Score: 3

3 - Evidence shows a good standard

What people expect

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

The local authority commitment

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

Key findings for this quality statement

Understanding and reducing barriers to care and support and reducing inequalities

The local authority understood its local population profile, using demographic and equality data, such as languages spoken, gender identity, sexual orientation, religion and ethnicity, to identify inequalities and shape services. For example, data showing diverse language needs and small but significant LGBTQ+ communities helped the authority recognise gaps in culturally responsive care. This insight informed a Culturally Responsive Services Action Plan, which prioritised improving experiences for ethnic minority groups, strengthening service specifications and building workforce capability.

Engagement with communities and partners played a central role in identifying barriers. Feedback from partners highlighted the value of targeted engagement with homeless people, refugees and ethnic minority groups, although they also reported gaps in outreach to LGBTQ+ communities and some long-established minority groups. Insights gained through the Public Health Engagement Fund supported decisions about where resources were most needed, and joint work on maximising benefits uptake addressed inequalities linked to poverty.

The local authority also had regard to its Public Sector Equality Duty (Equality Act 2010) in the way it delivered its Care Act functions; there were equality objectives and a coproduced and adequately resourced strategy to reduce inequalities and to improve the experiences and outcomes for people who are more likely to have poor care. The local authority demonstrated compliance with the Public Sector Equality Duty by embedding equality considerations into policy design, commissioning, and service delivery. It used Equality Impact Assessments to identify risks and mitigate negative impacts, ensuring changes promoted fairness and inclusion. Strategies such as the Joint Health and Wellbeing Strategy and the South West London Mental Health Strategy aimed to tackle health inequalities and improve equity of access.

Richmond’s Corporate Plan 2022–2026 prioritised protecting vulnerable residents amidst rising living costs, guiding how adult social care is delivered. Strategies including the Adult Social Care Annual Report, Carers Strategy, Market Position Statement, Learning Disability Big Plan, and Dementia Strategy set out clear priorities and commissioning intentions to improve outcomes. The Big Plan 2023–2028 strengthened independence, accessibility, and community inclusion for adults with learning disabilities and autism, supported by ongoing monitoring and resident feedback. The Dementia Strategy demonstrated measurable progress through enhanced prevention programmes, improved diagnostic pathways, and expanded post-diagnosis support, leading to better resident wellbeing and service access. The Carers Strategy 2020–2025 also shows sustained delivery, with quarterly oversight, a co-produced Carers Charter, and initiatives that improve recognition and support for unpaid, adult, and young carers. This includes counselling, advice, emotional support, and targeted programmes contributing to improved resilience and reduced inequalities for carers.

Equality objectives were embedded in corporate plans, and socio-economic duty was considered alongside protected characteristics. Directorate Equality Groups monitored delivery through annual action plans. Equality Impact Needs Assessments (EINAs) were used to identify and mitigate risks. For example, an EINA revealed under-representation of ethnic minorities in day services, prompting collaboration with community organisations to redesign these services. Audits of support plans and staff feedback showed the need for better consideration and recording of cultural needs, resulting in targeted improvements to monitoring tools and contract requirements. Data gaps highlighted during care home re-procurement led to further work with providers to improve the recording of protected characteristics.

The local authority also recognised persisting health inequalities, including challenges experienced by people who were homeless or from Traveller communities. Digital exclusion remained a significant barrier, particularly for people facing cost-of-living pressures. Initiatives like Connect to Tech offered training and home visits to improve access to online services and reduce isolation. Support for refugees and asylum seekers was strengthened through a dedicated team and investment in grassroots organisations.

The local authority demonstrated strong compliance with the Public Sector Equality Duty by embedding equality considerations into policy design and implementation. Co-production with residents, carers and community groups ensured lived experience shaped priorities. For example, feedback from people highlighted digital barriers and cultural needs, which informed service redesign and training.

Staff demonstrated enhanced skills and confidence in responding to equality-related needs. Mandatory training was complemented by additional cultural competence and sessions on gender identity. Staff feedback and audit findings identified a need for greater professional curiosity around protected characteristics, leading to bite-size training that improved confidence. Staff from brokerage teams used provider information to arrange culturally appropriate support, including matching people with language-specific carers.

Inclusion and accessibility arrangements

There were appropriate inclusion and accessibility arrangements in place so that people could engage with the local authority in ways that worked for them, for example British Sign Language or interpreter services. The local authority had acted to ensure people could access services in ways that suited their needs. It understood the diverse demographics of its population and used this knowledge to shape culturally responsive services. For example, data showed 88.69% of residents spoke English as their main language, while smaller proportions spoke Spanish, Polish, Turkish, and other languages. This informed an action plan that aimed to improve the availability of culturally appropriate care and strengthen specifications, so commissioned services reflected the cultural needs of people. In terms of impact, this meant that people were more likely to receive care that respected their identity and preferences, reducing barriers to engagement.

The local authority had also worked to address language needs in practical ways. For instance, brokerage teams maintained a database of providers' ability to meet cultural and language requirements. This enabled them to respond quickly when a person needed a Gujarati-speaking carer, arranging a smooth handover to ensure continuity of care. Similarly, locality reviews described how an out-of-borough placement was arranged for a person who wanted to live in a Spanish-speaking environment. These actions meant people could communicate in their preferred language, which improved their sense of belonging and wellbeing.

Digital inclusion was another area where the local authority acted to remove barriers. Co-production feedback highlighted that people who were not online faced significant challenges in accessing health and social care. In response, the local authority funded initiatives such as 'Connect to Tech', which provided home visits and training sessions to help people use technology. This not only enabled people to access online resources but also reduced isolation by helping them stay in touch with family through video calls. In terms of impact, this meant people who were previously excluded could engage with services and maintain social connections.

The local authority also recognised that some communities faced cultural or social barriers to accessing support. For example, voluntary sector partners reported that symptoms of dementia were sometimes viewed as a natural part of ageing rather than a medical condition, which delayed help-seeking. To address this, public health initiatives such as the health bus were used to raise awareness of dementia and its risk factors across all communities. This proactive approach helped people understand their health needs earlier, improving access to timely support.

Equality and diversity were embedded in workforce development and commissioning processes. Staff told us they received training on equality and diversity and had access to forums that supported inclusion. The local authority introduced cultural competency training for commissioning staff and planned to extend this across the provider market. These measures strengthened the ability of staff to deliver care that respected people's cultural and personal identities, which improved the quality of assessments and support planning.

Progress over time was evident in the evolution of equality strategies. Earlier self-assessments acknowledged gaps in data collection on protected characteristics, which limited the ability to identify inequalities. In response, the local authority adapted contract monitoring workbooks and developed Power BI dashboards to capture more granular equality data. This improved understanding of who was accessing services and where barriers remained, enabling targeted actions to reduce inequalities.

The local authority also worked with partners to reach seldom-heard communities. For example, engagement funds were used to support small voluntary organisations to hold targeted events with residents, gathering intelligence about health and wellbeing issues. This information helped the local authority direct resources to areas of greatest need. Similarly, the Borough of Sanctuary initiative provided dedicated support for refugees and asylum seekers, including workers with expertise in housing and health. These actions ensured that people from marginalised groups were not left behind and could access care and support that met their needs.

Theme 2: Providing support

This theme includes these quality statements:

- Care provision, integration and continuity
- Partnerships and communities

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

Care provision, integration and continuity

Score: 3

3 - Evidence shows a good standard

What people expect

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

The local authority commitment

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

Key findings for this quality statement

Understanding local needs for care and support

The local authority worked with local people and stakeholders and used available data (for example the Joint Strategic Needs Assessment (JSNA) to understand the care and support needs of people and communities. This included people who were most likely to experience poor care and outcomes, people with protected characteristics, unpaid carers and people who fund or arrange their own care, now and in the future.

The local authority collaborated extensively with local people, stakeholders, and partners to understand care and support needs. They engaged with voluntary sector organisations, Healthwatch, carers' groups, and providers to gather lived experiences and feedback. For example, Healthwatch Richmond reported that views of people with lived experience and unpaid carers were gathered during a dementia day services review and used to shape service redesign. A partner confirmed that the local authority consulted widely with the voluntary sector, including specialist organisations, to ensure services reflected community needs. Richmond Carers Centre highlighted that the local authority invested in the local community by commissioning the carers hub contract, demonstrating a commitment to carers' needs. Another partner noted joint efforts to address workforce sustainability through apprenticeships and career pathways across health and social care. Providers also confirmed that the local authority communicated local needs through a care home manager forum and supported recruitment via job fairs and events.

The local authority also worked internally across teams to anticipate future demand and shape services. Commissioning teams consulted providers on the Market Position Statement, using population growth and health service data to predict demand for 2030. They undertook a deep dive into older people's care home provision, mapping needs and developing tools to help social workers match people to appropriate placements. Leaders acknowledged challenges in housing, mental health, and dementia care, and initiated projects to address gaps, including plans to increase dementia nursing beds. Data and performance teams integrated insights from Power BI, NHS capacity trackers, and safeguarding information to monitor risks and enable early intervention.

People described how they relied on a community group, Friendship, Independence, Support and Help for older people (FISH), for support before being allocated a social worker. They said, "That's where I learnt most – they were amazing. We felt they were our only support until we were allocated a good social worker." While helpful, the group was not enough to provide proactive, personalised, preventative support. This example illustrates how community engagement and feedback informed the local authority's understanding of gaps in dementia support.

The local authority also demonstrated collaborative working through initiatives such as the Right Bed Right Care project. This involved commissioners, brokers, and providers reviewing over 125 residential care cases, mapping provision, and creating tools to support social workers in identifying needs. The aim was to use AI to match people's needs to suitable care homes. Similarly, the Provider Relationship Survey gathered feedback from providers on priorities, challenges, and opportunities, which informed commissioning strategies and service models.

Richmond's JSNA provided a comprehensive overview of population needs and informed strategic planning. It predicted a population increase to 206,080 by 2034, with the largest growth among those aged 80 and over. Life expectancy was above London and England averages, but healthy life expectancy declined among females. The JSNA highlighted inequalities, noting that males in the least deprived areas lived 5.3 years longer and females 1.2 years longer than those in the most deprived areas. It identified unpaid carers' needs for emotional support, contingency planning, housing engagement, and financial advice. The JSNA estimated 2,778 older people with moderate or severe visual impairment and 928 with registrable eye conditions. It also reported health inequalities for people with learning disabilities, including variation in GP registration and access to mainstream services. While most residents reported happy and satisfied lives, a subset experienced low levels of happiness and high anxiety. The JSNA's "Community Voice" section highlighted development needs in mental health support, carer support, disability services, reducing health inequalities, and preventing digital exclusion.

Market shaping and commissioning to meet local needs

People had access to a diverse range of local support options that were safe, effective, affordable and high-quality to meet their care and support needs. The local authority ensured that people could access a variety of care and support options that were tailored to peoples needs. Services were designed to be safe, effective, and affordable, while maintaining high standards of quality. These options included home care, supported living, residential care, and community-based services. Adult Social Care Survey (ASCS) data showed 72.73% of people who used services felt they had choice over services, which was broadly similar to the England average of 70.28%. This indicated that most people experienced a level of autonomy in selecting services that met their preferences.

Commissioning strategies were aligned with the strategic objectives of partner agencies, including health, housing, and public health. This collaborative approach ensured that services were integrated and responsive to local needs. Commissioning strategies included the provision of suitable, local housing with support options for adults with care and support needs including supported living. This helped maintain independence and improved quality of life for people requiring care.

There was specific consideration for the provision of services to meet the needs of unpaid carers. The local authority recognised the critical role of unpaid carers and incorporated their needs into commissioning plans. Services were developed to provide respite and emergency support for unpaid carers. Data from the Survey of Adult Carers in England (SACE) 2023/24 showed 12.90% of carers accessed support or services allowing them to take a break from caring at short notice or in an emergency, similar to the England average of 12.08%. Similarly, 15.63% accessed support for breaks longer than 24 hours, similar to the England average of 16.14%, and 21.54% accessed support for breaks between 1–24 hours, similar to the England average of 21.73%. These figures demonstrated that local provision was broadly in line with national averages, though opportunities remained to expand flexible respite options.

The local authority commissioned models of care and support that were in line with recognised best practice. Commissioning focused on outcomes rather than tasks, giving providers flexibility to deliver services in ways that met people's preferences. This approach promoted person-centred care and innovation. For example, the local authority commissioned for outcomes rather than specifying rigid service tasks. Outdated models of care were decommissioned where necessary to release funding for new, evidence-based approaches that improved outcomes for people.

Commissioning staff supported new and innovative approaches to care provision, where this led to better outcomes for people. Commissioning teams encouraged innovation and supported providers in adopting new models of care. This included piloting technology-enabled care, integrated service delivery, and community-based initiatives. Examples included introducing digital platforms for care coordination and monitoring, improving efficiency and responsiveness; supporting providers to develop flexible care packages tailored to people needs rather than standardised service blocks; and collaborating with voluntary and community sector organisations to expand local support networks.

Ensuring sufficient capacity in local services to meet demand

There was sufficient care and support available to meet demand, and people could access it when, where and how they needed it. The local authority reported that a wide range of services was available to meet diverse needs, and these were sustainable and coordinated. People experienced smooth transitions and continuity of care through joint working with partners. For example, staff told us they kept people at home whenever possible and sourced specialist placements promptly when needs increased. Brokerage teams were available at weekends and had undertaken training with provider forums, which improved relationships and responsiveness. Examples such as the hospital discharge team sourcing care packages early for people with complex needs showed that proactive planning reduced delays. This meant people could leave hospital sooner and return home safely, which improved their experience and reduced stress.

The local authority highlighted that its home care innovation platform and reablement contracts were well embedded, with no current waits for home care or reablement. The average time to enable hospital discharge had been reduced by two days. This helped people return home more quickly, supporting independence and reducing anxiety about prolonged hospital stays.

There was sufficient capacity for unpaid carers to have access to replacement care for the person they cared for, in both planned and unplanned situations. People told us respite care was limited, although social workers acted when needed. A voluntary sector partner said there needed to be more choice in respite for unpaid carers. They noted the local authority was reviewing dementia day service provision and hoped this would improve support for unpaid carers. This work aimed to give unpaid carers better access to planned and emergency respite, reducing stress and helping them maintain their caring role.

The local authority provided extra care housing for older people and supported living schemes for people with learning disabilities and mental health needs. For example, there were 66 extra care units across two schemes, 88 supported living units for people with learning disabilities, and 109 units for people with mental health needs. Specialist placements were sourced when required, such as for younger people with complex needs. The local authority worked with providers to co-design services and used market insights to maintain a strong, sustainable provider market. This ensured people with specific needs could access appropriate care locally.

Challenges remained in finding placements for young people with autism and people with complex needs. Staff told us that accommodation for these groups was limited, although new supported living frameworks and developments were underway. Partners highlighted gaps in preventative services such as transport and social engagement, which were underfunded despite their role in delaying care needs. Recruitment and retention of care staff were also issues, linked to housing costs. The local authority responded by zoning tenders, incorporating travel costs, and commissioning creative solutions through expert panels to increase supported housing supply. These actions aimed to reduce spot purchasing and improve local capacity.

Interim beds were available through block booking, and brokerage teams acted promptly to source care packages. This reduced waiting times and helped people return home sooner, improving recovery and wellbeing.

There was minimal need for people to use services or support in places outside of their local area. When support was being accessed from outside of the area, there were plans to provide it in the local area, so that people could move back there if they wished to do so. The local authority aimed to place people within the local area unless they wished to live elsewhere. When out-of-area placements were needed, these were usually close to home and often in neighbouring boroughs. For example, a person was placed in Surrey when their needs increased and could not be met locally. The local authority reported that 85% of placements were within Greater London. They were working to improve local specialist capacity through new supported living developments and investment in dementia and mental health services. This meant people could stay near their support networks or return to the borough if they wished.

Some services were commissioned jointly with other agencies. In these instances, there were clear roles and accountabilities for monitoring the quality of the services being provided and the outcomes for the people using them. Joint commissioning arrangements supported continuity of care and smooth transitions. Policies and procedures set out clear roles for monitoring quality and outcomes, including checks on safeguarding and service standards for out-of-area placements. Strategic partnerships with health and voluntary sector organisations enabled co-produced plans, such as dementia strategies and mental health commissioning plans. These arrangements ensured accountability and improved service quality, which benefited people by providing consistent and safe care.

Ensuring quality of local services

The local authority had established clear and robust arrangements to monitor the quality and impact of the care and support services it commissioned for people, ensuring that improvements were supported where needed. These arrangements were underpinned by strong governance and assurance frameworks designed to maintain oversight of service quality and outcomes.

Monitoring was carried out through a structured programme of contract management, which included regular quality assurance visits, formal contract reviews, and performance monitoring meetings. These processes enabled the local authority to assess compliance with contractual obligations, regulatory requirements, and local quality standards. Oversight was informed by a combination of quantitative and qualitative data, drawing on safeguarding alerts, complaints, and provider performance metrics, alongside feedback from people who used services, their families or carers. This approach ensured that the local authority not only tracked measurable outcomes but also understood the lived experiences of those receiving care.

A risk-based methodology was applied to prioritise oversight, meaning that providers identified as higher risk, whether due to Care Quality Commission (CQC) ratings, incident reports, or workforce instability, received enhanced monitoring and tailored support plans. The local authority also worked collaboratively with health partners, CQC, and provider forums to share intelligence and coordinate improvement actions, ensuring that concerns were addressed promptly and effectively. These measures helped identify quality issues at an early stage, reducing risks to people and driving better service outcomes.

In addition to monitoring, the local authority actively supported providers to improve quality through a range of targeted interventions. This included offering training opportunities, workshops, and access to best practice resources to strengthen leadership, workforce capability, and care delivery standards. Where concerns were identified, the local authority worked closely with providers to co-produce quality improvement plans, setting out clear actions, timelines, and monitoring arrangements to ensure progress was achieved.

To promote sustainability within the care market, the local authority supported providers with initiatives focused on recruitment and retention, digital transformation, and business continuity planning, helping to maintain resilience and stability across services. Learning from feedback was central to this approach; insights from complaints, compliments, and engagement with people who used services were systematically reviewed and used to inform commissioning decisions and provider development. Furthermore, the local authority encouraged innovation and co-production, working with providers to adopt new models of care and involving people with lived experience in shaping service improvements.

Through these combined efforts, the local authority demonstrated a proactive and collaborative approach to ensuring high-quality care and support, underpinned by strong governance, continuous learning, and a commitment to improving outcomes for people.

Ensuring local services are sustainable

The local authority collaborated with care providers to ensure that the cost of care was transparent and fair. The local authority worked with providers to make sure costs were clear and reasonable. For example, brokerage teams used a cost benchmarking system to check that fees offered value for money for people and the local authority. Commissioners also negotiated fee structures in partnership with providers rather than imposing rates. This approach meant people received care at a fair price and providers could maintain services without compromising quality.

The local authority's contracting arrangements were efficient; they provided stability for providers and allowed them to plan ahead. Contracts were designed to give providers security and continuity. For example, voluntary sector partners said contracts awarded for five years gave them stability and confidence to plan long-term services. Commissioners also agreed fixed hourly rates and inflationary uplifts for the duration of framework agreements. This enabled providers to manage financial planning and sustain services, which helped people experience consistent care without disruption.

The local authority worked with providers and stakeholders to understand current trading conditions and how providers were coping with them. Engagement and monitoring arrangements enabled the local authority to get early warnings of potential service disruption or provider failure; contingency plans were in place to ensure that people had continuity of care provision in this event. The local authority maintained regular engagement with providers through forums and surveys to identify risks early. For example, provider forums met quarterly to discuss workforce issues, cost pressures and tendering processes, with commissioners attending to address concerns. The local authority also used a Market Viability Tool to monitor risks such as vacancies, safeguarding concerns and leadership issues, and to map alternative capacity. These actions meant the local authority could respond quickly to challenges and ensure people continued to receive care even when providers faced difficulties.

Data provided by the local authority showed there were no delays in sourcing homecare, supported living or extra care services. It also showed that 12 people waited for residential or nursing care due to capacity issues, with an average wait of 12 days for a care home placement. The locality authority identified pressures in dementia bed availability but secured 77% of placements without delay. Similarly, information on contracts handed back and reasons was monitored through quality assurance processes, though no widespread failures were reported.

The local authority understood its current and future social care workforce needs. It worked with care providers, including personal assistants and other agencies, to maintain and support capacity and capability. The local authority recognised workforce challenges such as high turnover and skills gaps and took steps to address them. For example, the workforce strategy for 2024–2027 set out actions to improve recruitment and retention, including international recruitment, apprenticeships and supported placements. The local authority collaborated with providers through a Workforce Working Group, which was established in 2024, and offered access to training resources. It also partnered with the South West London Social Care Academy Hub to promote careers and provide pathways into employment. These measures helped sustain workforce capacity so people could access care when needed.

Richmond's Market Position Statement highlighted a high turnover rate of adult social care staff, at 29.4%, higher than the London average of 19.6%. In response the local authority priorities included building a resilient workforce, improving collaboration and supporting provider sustainability. Similarly actions they had taken included developing career pathways, promoted equality and inclusion, and created a recruitment site for providers. National data from the Adult Social Care Workforce Estimates 2024/25 showed 57.16% of adult social care staff with a care certificate in progress or partially completed, or completed, similar to the England average of 57.67%.

There were also additional social care workforce development plans. For example, the local authority aimed to engage 230 employers, bring 600 people into training and 500 into employment by March 2025. Additional initiatives such as the Great Employer Programme focused on improving organisational culture and retention. There was also a Provider Workforce Group which supported co-produced actions on recruitment, retention and apprenticeships.

Partnerships and communities

Score: 3

3 - Evidence shows a good standard

What people expect

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

The local authority commitment

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

Key findings for this quality statement

Partnership working to deliver shared local and national objectives

The local authority worked collaboratively with partners to agree and align strategic priorities, plans and responsibilities for people in the area. The local authority had strong strategic relationships with health partners, voluntary organisations and community groups. Leaders described long-standing partnerships that supported shared priorities and joint planning. For example, the local authority worked with partners through the Learning Disability Partnership Board, which included people with lived experience. This board reviewed the Big Plan 2023–2028 and quality checked areas such as employment, housing and transport accessibility. Feedback from these sessions shaped improvements, such as making parks and public spaces more accessible.

Staff surveys showed 97% of staff understood organisational values, including those that emphasised community engagement. This alignment strengthened co-produced care and collaborative planning. For instance, the local authority embedded a ‘Connect Better’ value into team culture, which improved relationships with residents and partners. These changes cultivated a workforce that worked more closely with communities, supporting better outcomes for people.

Partnership forums also evolved over time. Providers told us relationships with the local authority had previously been strained but had become collaborative. They felt listened to and respected and were able to challenge decisions when people’s needs changed. This shift in relationship built trust and improved joint working.

The local authority also worked across borough boundaries to deliver shared objectives. For example, voluntary sector partners described joint commissioning of domestic violence and sexual health services with neighbouring boroughs. This approach ensured resources were used effectively and people received consistent support. These collaborative arrangements meant people experienced services that were better aligned to their needs. Strong levels of co-production gave people a voice in shaping priorities, which included the introduction of an unpaid carer representative on the Health & Wellbeing Board.

Stronger provider relationships reduced delays and improved care quality. Joint commissioning ensured people had access to essential services without duplication or gaps.

The local authority had integrated aspects of its care and support functions with partner agencies where this is best practice and when it showed evidence of improved outcomes for people. The local authority integrated care and support functions with health partners to improve outcomes. For example, the Urgent and Emergency Care Board brought health and social care professionals together to address challenges such as frailty and hospital discharge. This collaboration led to the development of virtual wards and the nightingale service, which supported people with lower level needs to leave hospital quickly and safely.

Better Care Fund reports showed progress in reducing discharge delays. The local authority worked jointly with neighbouring boroughs on the Effective Discharge workstream, which reduced the average time between referral and discharge. This improvement helped people return home sooner, reducing stress and promoting independence.

Integration extended to digital systems. Acute trusts told us the local authority trained staff to use new electronic record systems, replacing spreadsheets and improving communication. This supported a single version of the truth across organisations, reducing errors and delays in care planning.

The local authority also collaborated with equipment providers to prioritise urgent cases. For example, quarterly reports showed that closer working with the equipment service reduced delays in delivering critical items, improving outcomes for people with urgent needs. Integrated working reduced hospital stays and improved discharge processes, meaning people returned home sooner and with the right support. Digital integration improved communication, reducing duplication and errors. Joint work on equipment delivery ensured people received essential items quickly, supporting safety and independence.

Arrangements to support effective partnership working

When the local authority worked in partnerships with other agencies, there were clear arrangements for governance, accountability, monitoring, quality assurance and information sharing. Roles and responsibilities were clear. The local authority had strong strategic relationships with health partners and the voluntary sector, which supported integrated care and innovation. Leaders described long-standing positive relationships and worked to understand changes in primary care networks and integrated care structures. For example, the safeguarding adults board maintained close working arrangements despite changes within the police service and staff turnover, ensuring people received the right care in the right place.

Processes reinforced accountability and quality assurance. The local authority used structured feedback routes, such as joint consultative committees with unions and departmental forums, to shape policy and strengthen workforce ties to community priorities. Quality assurance teams worked closely with care providers and operational staff where risk panels and improvement plans were in place. This partnership-based approach ensured sustained service improvements and reinforced shared accountability for care quality. In terms of impact, these arrangements meant people experienced more coordinated care and safer transitions. For example, joint planning and commissioning with health, housing and voluntary sector partners improved service design and outcomes, meaning people had access to services that better met their needs and reduced delays in care delivery.

The local authority used opportunities to pool budgets and jointly fund services with partners to achieve better outcomes. The local authority worked with partners to pool resources and jointly commission services where this could meet shared objectives. For example, domestic violence and sexual health services were jointly commissioned with neighbouring boroughs, ensuring people could access specialist support without duplication of effort.

The Better Care Fund was used to improve hospital discharge processes and reduce delays. For instance, joint work under the Effective Discharge workstream reduced the average time between referral and discharge across the borough. This meant people returned home more quickly, reducing the risk of hospital-related complications and improving recovery.

Pooling budgets also supported innovation. The local authority held a section of the public health budget to provide micro-grants to voluntary and community organisations, targeting areas of greatest need. This funding enabled local groups to deliver services that had maximum benefit for people, such as improving access to sexual health and substance misuse support. In terms of impact, these arrangements meant people experienced quicker access to care and more tailored support. Joint funding allowed services to be designed around local needs, reducing inequalities and improving health and wellbeing outcomes.

Impact of partnership working

The local authority monitored and evaluated the impact of its partnership working on the costs of social care and the outcomes for people. This informed ongoing development and continuous improvement. The local authority had developed strong and collaborative relationships with health partners, which shaped how care was delivered and improved outcomes for people. Care records showed that health professionals were involved in planning and monitoring care. Staff monitored skin integrity and referred concerns to community health teams, ensuring that health needs were addressed promptly. Staff described these relationships as positive and gave examples of how they worked together to resolve urgent issues. For example, a review team identified a person with significant pressure sores and immediately involved district nurses and GPs to arrange continuing health care quickly. This approach demonstrated how joint working reduced delays and ensured people received the right support at the right time.

Partners confirmed that these relationships were embedded at all levels. Acute trust leaders described daily contact with social work teams and said they could easily resolve operational issues by picking up the phone. They explained that regular meetings focused on improving services, such as developing digital solutions to enhance communication and streamline referral pathways. They believed these strong connections had reduced hospital admissions and created opportunities for innovation. This meant people experienced smoother transitions between services and avoided unnecessary stays in hospital, which improved their overall experience of care.

Partnership working extended beyond health and social care to address wider needs in the community. One partner told us the local authority had worked hard to create a marketplace for the VCSE organisations of all sizes. There was a 'local first' culture and opportunities specifically for smaller grass roots organisations. For example, the cost-of-living grant programme to support debt management, the public health engagement fund, and focussed work with asylum seekers and refugees. The sector was also supported to be innovative and to collaborate with each other.

Other initiatives included low-cost counselling and gardening services, which became popular and helped people maintain wellbeing. These services were complemented by digital inclusion training, which supported disabled people to stay connected and access information. By meeting social and emotional needs alongside health care, these projects improved quality of life and reduced isolation.

Integrated recovery hubs provided wrap-around support for people with complex needs. One partner described how teams worked together to support a person who was homeless and alcohol dependent. Social workers made daily efforts to find the person and build trust, while health professionals ensured safety and access to treatment. Regular case updates were shared at senior levels, showing how leadership remained connected to people's experiences. This collaborative approach meant people who faced significant challenges received consistent and coordinated support, which helped them feel safer and more valued.

The local authority also supported projects that placed people at the centre of decision-making. For example, one initiative brought professionals together to access medical records and link people to the most appropriate referral pathways. This integration ensured that care was tailored to people circumstances and avoided duplication. Partners highlighted that these arrangements created potential for innovation, such as developing digital tools to improve communication between teams. These improvements meant people experienced care that was more responsive and better aligned to their needs.

Through monitoring and evaluation, the local authority learned from these examples and used the insights to inform continuous improvement. Strong partnerships reduced costs by preventing unnecessary hospital admissions and avoiding delays in care. More importantly, they improved outcomes for people by ensuring timely support, addressing wider needs, and creating a more joined-up experience of care. This commitment to collaboration and learning demonstrated how partnership working had shaped a system that responded to people's needs and supported their wellbeing.

Working with voluntary and charity sector groups

The local authority worked collaboratively with voluntary and charity organisations to understand and meet local social care needs. The local authority provided funding and other support opportunities to encourage growth and innovation. Partnership working with voluntary and charity organisations had been a key feature of local social care. These collaborations helped identify and respond to a wide range of needs beyond statutory services. For example, during the pandemic, voluntary organisations set up food banks with support from the local authority. Food deliveries and volunteer networks not only addressed immediate needs but also uncovered additional issues such as mobility challenges and financial concerns. This led to referrals for unpaid carers' support and benefits advice, ensuring people received holistic assistance.

Examples such as low-cost counselling and gardening services offered by voluntary partners demonstrated how funding and commissioning from the local authority encouraged innovation. These services became popular and helped people maintain wellbeing and independence. In addition, digital inclusion training was provided to disabled people through commissioned projects, reducing barriers to accessing online services and improving connectivity.

Collaborative projects also focused on integrated care. For instance, multi-professional teams worked together to place people at the centre of planning. They accessed medical records and coordinated referrals, ensuring timely and appropriate support. This approach reduced delays and improved people’s experience by making care more seamless.

These examples showed how local authority support enabled voluntary and charity organisations to expand their role, address diverse needs, and innovate in service delivery. As a result, people experienced better access to practical help, emotional support, and digital resources, which improved their quality of life and reduced isolation.

Theme 3: How London Borough of Richmond upon Thames ensures safety within the system

This theme includes these quality statements:

- Safe pathways, systems and transitions
- Safeguarding

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

Safe pathways, systems and transitions

Score: 3

3 - Evidence shows a good standard

What people expect

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

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

The local authority commitment

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

Key findings for this quality statement

Safety management

The local authority understood the risks to people across their care journeys. Risks were identified and managed proactively, and the effectiveness of these processes in keeping people safe was routinely monitored. The views of people who use services, partners and staff were listened to and considered. The local authority recognised delays in assessment and support as a key risk and aimed to improve through better oversight and review of duty systems. These measures helped ensure smoother and more responsive transitions in care, especially at key life stages. For example, the Adults Quarterly Report highlighted that oversight of duty systems was strengthened to reduce delays and improve responsiveness. This meant people experienced fewer gaps in care and safer transitions.

Risks during short-term care and discharge transitions were also identified. Service concerns showed that reablement services received 16% of Richmond’s concerns, with issues such as failed visits and poor communication. Actions were taken to reduce missed or late appointments, which reduced risk during recovery periods and improved safety for people returning home.

Staff feedback confirmed that safety was prioritised during urgent situations. For example, emergency duty teams described how they constantly re-prioritised according to risk, focusing on safeguarding and Mental Health Act assessments. This approach ensured that people in crisis received timely intervention, reducing harm and maintaining dignity. Staff also gave examples of escalating care when transport was unavailable for a person at risk of homelessness, which prevented exposure to unsafe conditions.

Partner feedback was mainly positive, and we heard that assessments were detailed and changes in need were addressed promptly, with providers notifying via the provider portal or in an emergency to duty. However, some partners' feedback reflected concerns about prioritisation. For example, some providers said emergency responses were not always effective and that focus appeared greater on hospital discharges than care homes. This suggested there may be some inconsistency in the local authority's responsiveness. However, we found the local authority had measures in place to address these concerns, such as through the improvements in performance around reviews and in safeguarding pathways.

Risks identified by the local authority included delays in assessment, missed visits during reablement, and lack of emergency resources out of hours. These were managed through improved oversight of duty systems, monitoring service concerns, and strengthening rapid response services. For example, the rapid response team achieved 96% of calls within the two-hour expectation, preventing unnecessary hospital admissions and keeping people safe at home. Monitoring through quarterly and end-of-year reports ensured actions were tracked and improvements sustained.

Policies and processes about safety were aligned with other partners involved in people's care journey. This enabled shared learning and drove improvement. The local authority worked with health partners to align urgent care responses. For example, the rapid response service partnered with ambulance teams to stabilise people at home and avoid hospital conveyance. This collaboration ensured timely intervention and reduced disruption to people's lives.

Information from national health checks showed strong mechanisms for staff to raise safety concerns and fair case allocation, supporting shared accountability across agencies. These processes helped reduce avoidable harm and delays during transitions, demonstrating that alignment with partners improved outcomes for people.

Information sharing protocols supported safe, secure and timely sharing of personal information in ways that protected people's rights and privacy. The local authority used the Better Care Fund to develop mechanisms for sharing information across health and social care. For example, summary documents showed improvements in secure data exchange, which supported coordinated care and reduced duplication. This meant people experienced smoother transitions and avoided unnecessary assessments, protecting their privacy while ensuring timely support.

However, feedback from emergency duty teams indicated gaps in communication with daytime teams, as handovers relied on system notes rather than direct dialogue. This limited opportunities to clarify urgent issues, which could affect continuity of care. Addressing these gaps would strengthen information sharing and further protect people's safety.

Safety during transitions

Care and support were planned and organised with people, together with partners and communities in ways that improved their safety across their care journeys and ensured continuity in care. This included referrals, admissions and discharge, and when people were moving between services. Transitions from children to adults' services were not consistently planned or supported. Evidence showed that when young people turned 18, many of the clubs and breaks they previously attended stopped. For example, unpaid carers told us all activities their family member attended before adulthood disappeared once they reached 18. While some families received direct payments to arrange additional care, this placed responsibility on unpaid carers to fill gaps. This created uncertainty and additional pressure for families, reducing continuity of care and limiting opportunities for young people to maintain social connections and independence.

The local authority explained that a separate protocol and pathway for transitions had been co-produced with young people and their families and partners. The transition protocol included five core principles to support transitions between children’s and adult services including personalisation, preparation, transparency, independence and partnership. The transitions pathway was monitored by a specialist Transitions Board which included two parent carer representatives. Staff worked closely with colleagues from Achieving for Children to make the transition as smooth as possible.

Transition arrangements were generally well planned, with structured tracking processes, regular multi-agency meetings, and strong collaboration between children’s and adults’ teams. Staff provided examples of successful transition work including supporting young people into supported accommodation and meaningful employment. However, we found support during transition was not consistently effective. People’s experiences varied with some reporting positive support and others highlighted difficulties accessing specialist services and a lack of a multi-disciplinary approach. Communication with carers was also highlighted as an area that could be improved. Partner’s experiences also varied with some reporting positive experience of transition however some partners reported fragmented provision within mental health services, which weakened outcomes for young people and left some feeling unsupported. Although planning pathways existed and were routinely reviewed, impact on people varied, in particular for young people with mental health needs, whose experiences remained inconsistent.

Processes to support safe hospital discharge were in place but varied in effectiveness. The local authority recognised delays in assessment and support as a key issue and aimed to improve oversight of duty systems to ensure smoother transitions. For example, quarterly reports highlighted actions to reduce delays and improve responsiveness at key life stages. These measures aimed to reduce risks associated with delayed discharges, supporting people to return home safely and avoid unnecessary hospital stays.

Reablement services played a role in supporting safe discharge, but concerns were raised about communication and missed visits. Service concerns reports showed 16% of issues related to reablement, including failed visits. Actions were taken to monitor and reduce these issues, which improved safety during short-term care and discharge transitions. Addressing these concerns reduced risks during vulnerable recovery periods and supported better outcomes for people leaving hospital.

Partnership working through urgent community response services also helped prevent unnecessary hospital admissions. For example, the local authority told us a rapid response service achieved 96% of calls responded to within two hours, stabilising people at home and avoiding conveyance to hospital. This enabled people to remain in familiar environments, reducing stress and promoting recovery.

Specific consideration was given to protecting the safety and well-being of people who were using services which were located away from their local area, and when people moved from one local authority area to another. There was limited evidence of structured arrangements for people placed out of area or moving between local authorities. Staff described situations where they relied on negotiation with families when resources were unavailable, such as when a person returned to an unsafe home over a weekend. This reliance on informal arrangements increased risks for people and placed additional pressure on families.

There was no evidence of a consistent approach to providing named workers or advocates for people moving between areas. Emergency duty teams reported challenges in accessing resources across local authority boundaries and highlighted that they often had to escalate issues without clear pathways for inter-authority communication. This lack of coordination could lead to delays in care and increased vulnerability for people during transitions.

Emergency duty teams prioritised safeguarding and Mental Health Act assessments but faced resource constraints, particularly out of hours. Digital care technology was available, but the absence of a responder service which could be accessed by everyone in Richmond meant some people could not access out of hours support, increasing the risk of unnecessary hospital admissions.

Contingency planning

The local authority undertook contingency planning to ensure preparedness for possible interruptions in the provision of care and support. The local authority knew how it would respond to different scenarios; plans and information sharing arrangements were set up in advance with partner agencies and neighbouring authorities to minimise the risks to people's safety and wellbeing. The local authority had a structured approach to managing risks and emergencies. It developed a range of policies and plans to ensure continuity of care and support during disruptions. For example, the provider failure procedure, reviewed in December 2023, set out clear definitions of provider failure and included immediate actions such as forming a multi-agency steering group to coordinate responses. This group involved health, social care, commissioning and quality assurance leads, which helped reduce delays and confusion during critical incidents. This meant people continued to receive safe care even when providers could not deliver services.

The local authority also created a comprehensive resilience policy and plan in 2024. These documents outlined processes from emergency response through to recovery and regeneration, with defined roles and responsibilities for all stakeholders. For instance, the resilience plan included action cards for each role, from strategic to operational levels, ensuring clarity during emergencies. This supported timely decision-making and reduced risks to people's wellbeing during service disruptions.

Further measures included a humanitarian assistance plan, which provided for psychological first aid and practical support for people and families affected by major incidents. For example, the plan required the immediate set-up of a humanitarian assistance steering group following a disruption. This approach helped people feel supported and safe during stressful situations.

The local authority also tested and reviewed its business continuity plans regularly. For example, the commissioning continuity plan identified risks that could affect service delivery and outlined immediate and longer-term actions. Staff were able to work remotely if needed, and emergency lists of people receiving services were available in case of IT failures. These steps ensured people continued to receive essential care without interruption.

Partners confirmed the effectiveness of these arrangements. For example, a voluntary sector partner reported that emergency respite was arranged quickly for a person after several falls in one week. This change in environment supported the carer, ensured the person's safety and helped the local authority assess ongoing support needs. This demonstrated that contingency planning had a positive impact on people's safety and wellbeing.

Funding decisions or disputes with other agencies did not lead to delays in the provision of care and support. Evidence from policies and partner feedback indicated that the local authority prioritised people's needs over organisational disputes. For example, the resilience and recovery plan, developed in collaboration with key stakeholders, included clear objectives to maintain essential services during emergencies. This meant that disagreements about funding or responsibilities did not delay care. Instead, the local authority focused on joint working and rapid decision-making to ensure people received timely support.

Safeguarding

Score: 3

3 - Evidence shows a good standard

What people expect

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

The local authority commitment

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

Key findings for this quality statement

Safeguarding systems, processes and practices

There were effective systems, processes, practices to make sure people were protected from abuse and neglect. The local authority had clear safeguarding procedures that ensured concerns were screened promptly and responded to according to risk. For example, safeguarding referrals were RAG-rated, with high-risk cases addressed within 24 hours and moderate risks within five days. This approach meant people at immediate risk received timely intervention, reducing harm and promoting safety.

Processes were strengthened through audits and adaptations to forms, which included immediate risk indicators and proportionality checks. Safeguarding teams reviewed referrals to confirm appropriateness and achieved outcomes in 99% of cases. This improved confidence in safeguarding decisions and helped maintain trust in protective services.

National data from the Adult Social Care Survey 2023/24 showed 69.75% of people who used services felt safe, similar to the England average of 71.06%. In addition, 86.42% of people who use services said services made them feel safe, similar to England average of 87.82%. Carers also reported positive experiences, with 81.82% feeling safe, aligning with national figures. These findings indicated that safeguarding processes had a tangible impact on people's sense of security.

The local authority worked with the Safeguarding Adults Board and partners to deliver a co-ordinated approach to safeguarding adults in the area. The Safeguarding Adults Board provided strategic oversight and worked collaboratively with partners to implement priorities such as prevention, making safeguarding personal, and quality assurance. For example, the annual report highlighted achievements in raising awareness of self-neglect and hate crime through short videos, aiming to increase early referrals. This proactive approach helped prevent harm and supported people before risks escalated.

Partners described strong engagement and responsiveness. Advocacy organisations reported timely communication and clear outcomes from safeguarding teams. Healthwatch and voluntary sector partners valued the ability to discuss concerns openly, which supported shared accountability and improved safeguarding responses.

The Board also sought continuous improvement by reviewing how data was presented and ensuring community forums reflected local needs. This commitment to transparency and inclusivity strengthened trust and ensured safeguarding strategies were shaped by lived experience.

There was a strong multi-agency safeguarding partnership, and the roles and responsibilities for identifying and responding to concerns were clear. Information sharing arrangements were in place so concerns were raised quickly and investigated without delay. Safeguarding coordinators worked across departments and boroughs, liaising with partners and leading statutory enquiries. For example, joint provider risk panels brought together local authority staff, health partners, and regulators to address provider concerns and agree actions. This collaborative approach ensured risks were managed effectively and decisions were defensible.

Information sharing was embedded in processes. For instance, safeguarding meetings included families and maintained confidentiality while sharing investigation outcomes. Partners confirmed that safeguarding procedures were clear and easy to follow, with monthly risk panel meetings reviewing cases and wider implications. These arrangements meant concerns were escalated promptly, and investigations were rigorous.

All staff involved in safeguarding work were suitably skilled and supported to undertake safeguarding duties effectively. The local authority monitored training compliance and competency through audits and governance boards. For example, a Care Governance Board report noted a 96% completion rate for safeguarding training but identified gaps in refresher training for locum staff. Actions were taken to improve attendance at forums and ensure staff maintained up-to-date knowledge.

Despite these efforts, data from the Adult Social Care Workforce Data 2024/25 highlighted challenges. Only 22.82% of independent / LA staff completed Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training, compared to the England average of 46.27%. In addition, 29.43% of independent / LA staff completed safeguarding adults training, below the England average of 60.68%. This indicated a need for continued focus on training compliance to maintain high standards of practice.

Staff feedback showed a positive safeguarding culture, with most feeling confident to raise concerns and challenge unsafe practice. Staff surveys reported that 77% of staff felt able to use whistleblowing procedures and 81% felt confident challenging poor practice. This culture supported early identification of risks and reinforced the local authority's commitment to protecting people from harm.

Responding to local safeguarding risks and issues

There was a clear understanding of the safeguarding risks and issues in the area. The local authority worked with safeguarding partners to reduce risks and to prevent abuse and neglect from occurring. The local authority had a clear picture of safeguarding risks through analysis of data, feedback from events, and themes from Safeguarding Adult Reviews. This informed strategic priorities for the next five years, which focused on multi-agency learning and improving practice across the partnership. For example, the strategic plan addressed risks such as self-neglect and hoarding by introducing a community forum and preventative work. This approach helped partners respond earlier and reduce harm.

Staff development was prioritised to strengthen safeguarding practice. For instance, the local authority created short learning sessions and podcasts to embed learning from safeguarding incidents and reviews. Managers reported these sessions were useful when safeguarding concerns did not meet the threshold for a review. This ensured staff could reflect on practice and apply learning in future cases, improving decision-making and safeguarding responses.

Partnership working supported risk reduction. For example, safeguarding leads engaged with providers and the voluntary sector to share learning and improve referral quality. They delivered sessions on what makes a good safeguarding referral and visited community groups to raise awareness of abuse and reporting processes. This helped people access support earlier and reduced the likelihood of harm escalating.

The local authority also monitored emerging risks through a safeguarding risk log. This identified issues such as workforce pressures, mental health concerns, and financial abuse linked to the cost-of-living crisis. Actions included joint workforce planning, awareness campaigns, and collaboration with partners such as the fire service. These measures aimed to prevent abuse and neglect and protect people from harm.

Lessons were learned when people had experienced serious abuse or neglect, and action was taken to reduce future risks and drive best practice. Learning from Safeguarding Adult Reviews was shared promptly and embedded into practice. For example, following a review into transitional safeguarding, the local authority developed an action plan to improve information sharing between children's and adults' services and ensure care leaver status was central to transition planning. This reduced the risk of gaps in support when young people moved into adult services.

Another review highlighted risks for people with alcohol dependency. It found that mental capacity assessments were not time-specific, which meant cognitive impairments were overlooked. In response, the local authority identified the need to strengthen multi-agency expertise in complex capacity assessments. This helped ensure people received appropriate support and reduced the risk of harm.

The local authority also improved family involvement in reviews and had created clear guidance and a leaflet explaining the purpose and process of reviews. This supported transparency and helped families contribute to learning, which informed better practice.

Learning was shared through reflective sessions, podcasts, and newsletters. For example, after a review identified the importance of trauma-informed practice, the local authority ran targeted sessions and worked with partners to embed this approach. This improved staff understanding of how trauma affects people's lives and supported more compassionate and effective safeguarding responses.

Responding to concerns and undertaking Section 42 enquiries

The local authority had clear guidance on what constituted a Section 42 safeguarding concern and when enquiries were required. Staff applied this consistently, and there was a clear rationale and outcome from initial enquiries, including those that did not progress to a Section 42 enquiry. For example, managers described how short learning sessions were used effectively when safeguarding concerns did not meet the criteria for a review, ensuring staff understood thresholds and acted appropriately. This clarity helped people receive timely responses and avoided unnecessary escalation.

Power BI data showed an average of 1,748 safeguarding concerns and 484 Section 42 enquiries. This indicated thresholds were applied appropriately. For example, safeguarding leads explained that they shared learning themes from deep dives with providers to improve referral quality. People were safeguarded without unnecessary processes, reducing delays and focusing resources where most needed.

When safeguarding enquiries were conducted by other agencies, the local authority retained responsibility for the enquiries and the outcomes for people. Safeguarding leads described how they worked with community safety teams on homicide reviews and ensured learning was embedded across agencies. This oversight meant people's safety remained the priority and accountability was clear.

There were clear standards and quality assurance arrangements for conducting Section 42 enquiries. Learning from reviews was shared with partners before publication and cases were selected carefully to ensure relevance. For example reviews highlighted gaps in practice, such as people with alcohol dependency who were not homeless not being prioritised for support, and mental capacity assessments not being time-specific, leading to missed cognitive impairments. These issues meant some people did not receive timely or appropriate safeguarding responses. Learning from these reviews had informed changes to practice, improving outcomes for people with complex needs.

Data showed timely allocation for most enquiries: in July 2025, one person awaited initial review with a median wait time of zero days and a maximum of 11 days; two Section 42 enquiries awaited allocation with a median wait time of zero days and a maximum of 12 days. This demonstrated effective monitoring and reduced risks for people.

The local authority monitored safeguarding activity through risk logs and strategic priorities. For example, risks such as workforce pressures and lack of referrals for community deprivations of liberty were mitigated through joint workforce planning and prioritisation. This proactive approach helped maintain safeguarding standards and reduced risks for people during periods of increased demand.

Safeguarding plans and actions to reduce future risks were in place and acted on. For example, following a review, actions were taken to improve information sharing between transitional panels and ensure care leaver status was integral to planning. These changes supported smoother transitions and better protection for people moving between services.

Providers reported receiving outcome reports with recommendations to prevent recurrence, although some noted this was more consistent when concerns progressed to Section 42 enquiries. Improved communication helped agencies respond effectively, but inconsistency risked gaps in safeguarding for people.

Data showed that from June 2024 to June 2025, 181 new DoLS referrals were assessed, with a median wait time of 15 days and a maximum of 49 days. In July 2025, 11 DoLS referrals awaited allocation, with a median wait time of 15 days and a maximum of 49 days against a target of 21 days. While most referrals were allocated within target timescales, longer waits for some referrals highlighted the need for continued monitoring to ensure people’s rights were upheld promptly.

Making safeguarding personal

Safeguarding enquiries were carried out sensitively and without delay, keeping the wishes and best interests of the person concerned at the centre. Safeguarding practice showed a strong focus on people's wishes and best interests. For example, care records and social worker reflections confirmed that a Mental Capacity Assessment took place to ensure decisions were made in the person's best interests. The assessment was person-centred and involved the person and their representative positively. Although the person lacked capacity to make decisions, their views were considered, such as feelings about their family home. Decisions balanced the need to find the least restrictive option with the need to secure safety and wellbeing. Examples such as safeguarding teams working with providers during care placement breakdowns demonstrated collaborative approaches to maintain safety while respecting rights. Staff described how safeguarding referrals were managed even when they did not meet statutory thresholds, with onward referrals to community groups and domestic abuse organisations to reduce risk. This approach helped people feel supported and safe during complex situations. These actions meant people experienced safeguarding that respected their rights and preferences, reduced unnecessary restrictions, and promoted trust in protective services.

People had the information they needed to understand safeguarding, what being safe meant to them, and how to raise concerns when they didn't feel safe or they had concerns about the safety of other people. The local authority improved communication with people about safeguarding processes. For instance, safeguarding-related complaints highlighted concerns about poor referral and dissatisfaction with outcomes. In response, the local authority explained the purpose of safeguarding screenings and subsequent actions more clearly. This promoted better understanding and helped maintain trust in protective services. Partners also reported positive engagement. For example, a voluntary sector partner described how the local authority asked for the person's views and wishes during a domestic abuse referral and supported them to develop their own safety plan. This helped the person feel in control of the safeguarding process. Clear communication and personalised approaches meant people understood safeguarding, felt confident to raise concerns, and trusted the local authority to act in their best interests.

People could participate in the safeguarding process as much as they wanted to, and people could get support from an advocate if they wished to do so. People were supported to understand their rights, including their human rights, rights under the Mental Capacity Act 2005 and their rights under the Equality Act 2010 and they were supported to make choices that balanced risks with positive choice and control in their lives. Evidence showed people were supported to participate in safeguarding. For example, safeguarding teams described how advocacy was used in reviewing a financial safeguarding referral, alongside best interest and mental capacity assessments to ensure decisions were lawful and person-centred. Staff and leaders confirmed improvements in safeguarding practice, including training on domestic abuse and self-neglect to build confidence in applying the Mental Capacity Act. A safeguarding adult's review led to the creation of a multi-agency panel for self-neglect and hoarding, attended by fire services, police, health partners, and social care teams. This collaborative approach helped balance risk with positive choice and control for people. These actions meant people could participate fully in safeguarding, access advocacy when needed, and make informed choices that respected their rights and promoted independence.

National data from the Safeguarding Adults Collection for 2023/24 showed positive performance in advocacy and rights-based support. 100% of people lacking capacity were supported by an advocate, family, or friend, significantly better than the England average of 83.38%. This ensured people who lacked capacity were not disadvantaged and had representation in safeguarding decisions, promoting fairness and equality.

Safeguarding and DoLS processes evolved over time. For example, Community DoLS guidance was updated in 2023, and a screening tool was embedded to manage applications by priority. Training sessions, webinars, and templates were introduced to build workforce confidence. Staff reported improvements in community DoLS practice, though acknowledged ongoing challenges with court applications. These developments strengthened safeguarding governance and improved consistency, helping people experience safer, more rights-based care.

Theme 4: Leadership

This theme includes these quality statements:

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

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

Governance, management and sustainability

Score: 3

3 - Evidence shows a good standard

The local authority commitment

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

Key findings for this quality statement

Governance, accountability and risk management

There were clear and effective governance, management and accountability arrangements at all levels within the local authority; these provided visibility and assurance. The local authority demonstrated a proactive approach to meeting Care Act duties through structured feedback mechanisms and continuous learning. For example, feedback from people was gathered using postcards and online surveys, and findings were analysed to shape priorities for improvement. The Adults Quarterly Report showed learning from complaints was thematically grouped to track systemic issues, supporting accountability and evidence-led governance. This meant people's voices influenced service design and improvements, ensuring statutory duties were met in a way that reflected their needs.

Leaders told us collaborative working within committee structures provided constructive challenge to officers. Regular meetings and reporting structures kept leaders informed and engaged, and they actively requested detailed data which has led to frequent updates on transformation programs and the participation of Healthwatch at committee meetings enabled people's views to be highlighted. Leaders explained there were strong strategic relationships with health partners, voluntary and community sector, and Healthwatch and effective use of the Better Care Fund and well-established funding arrangements.

Governance arrangements included regular monitoring of provider performance and escalation of concerns. For instance, the Service Concerns End of Year Report highlighted that 165 service concerns were processed and resolved without escalation to complaints or safeguarding, evidencing proactive resolution and early intervention. Year-on-year comparisons were used to track provider performance, and targeted monitoring was introduced for high-risk providers. This data-led approach allowed timely service adjustments, reducing risks to delivery and sustaining quality. People benefited from improved reliability and responsiveness in care provision.

National data and local dashboards provided visibility of people's experiences. For example, the Resident Experience Dashboard showed 78% of people rated their interaction with the local authority as good or very good, and between 55% and 88% said they felt more independent after receiving support. Partners such as Healthwatch noted strong engagement when planning public health services, which helped ensure services were shaped around people's needs. This improved trust and satisfaction and supported better outcomes for people.

There was a stable adult social care leadership team with clear roles, responsibilities and accountabilities. Leaders were visible, capable and compassionate. The leadership team demonstrated visibility and capability through collaborative initiatives and strategic oversight. For example, professional standards teams held quarterly meetings to review complaints and compliments, and annual Safeguarding Adult Board meetings with partners set annual priorities. Leaders also engaged with academic institutions to support workforce development, including the ASYE programme, which had progressed 45 staff to senior roles. This stability and investment in leadership capability meant people experienced services delivered by skilled and accountable teams, fostering confidence in care quality.

There were clear risk management and escalation arrangements. These included escalation internally and externally as required. Risk management processes were embedded in governance structures. For example, the Care Governance Board monitored complaints data for the Community Equipment Service, noting 565 complaints in a 49-week period and requiring ongoing oversight until improvements were achieved. Escalation routes included Ombudsman involvement, where the local authority had 12 complaints upheld out of 14 investigations, but also provided remedies before escalation in 25% of cases, compared to a 12% average nationally. This proactive approach reduced risks and ensured people's concerns were addressed fairly and promptly.

The local authority's political and executive leaders were well informed about the potential risks facing adult social care. These were reflected in the corporate risk register and considered in decisions across the wider council. Political and executive leaders demonstrated awareness of risks through strategic engagement and partnership working. For instance, the local authority and the integrated care board jointly funded a co-production group to involve people and unpaid carers in service recommissioning. Housing initiatives, such as the demonstrator programme, brought together internal teams, external investors, and people with lived experience to address future housing needs. These actions reflected a commitment to mitigating risks and planning for sustainability, ensuring decisions across the wider council supported people's independence and wellbeing.

Strategic planning

The local authority used information about risks, performance, inequalities and outcomes. The local authority analysed risks and performance data to shape its strategic priorities. For example, the Joint Health and Wellbeing Strategy was co-produced with partners and focused on tackling inequality, prevention, and community empowerment. This approach reflected learning from audits and needs assessments, such as the post-pandemic mental health review which identified high dementia prevalence and gaps in care planning. These findings informed the Health and Care Dementia Strategy 2022–2031, which set out pathway priorities from diagnosis to end-of-life care. Similarly, the Suicide and Self-Harm Prevention Strategy was developed after local analysis showed suicide rates in Richmond were higher than the London average, despite being lower than England overall. These strategies demonstrated how the local authority used evidence to target areas of greatest need. Examples such as the development of an all-age autism strategy for Richmond and Wandsworth showed how the local authority responded to identified inequalities for autistic people. Progress was monitored through governance boards, and actions were embedded in service plans.

The local authority also created a Workforce Strategy for 2024–2027 to address recruitment and retention risks highlighted in annual surveys, ensuring sustainable delivery of care. The local authority set clear objectives to build a resilient and sustainable workforce and collaborate with adult social care and health partners to align workforce planning and delivery. These included tracking internal workforce trends, revising recruitment approaches to attract diverse talent and a focus on career progression, training and workplace treatment which included a commitment to fostering an inclusive environment. The local authority planned to work with partners to map outline pathways to enhance career alignment in integrated roles and facilitate shared learning across the local authority, NHS and voluntary providers.

In terms of impact, these plans meant people experienced services designed around local needs, with clearer pathways for dementia, mental health, and autism support. This helped reduce uncertainty and improved access to care for those most at risk.

The local authority used performance and demand data to allocate resources effectively. Service plans highlighted investment in safeguarding capacity, recovery of mental health assessment backlogs, and implementation of a demand management plan focused on early intervention. Examples such as the recommissioning of dementia-friendly initiatives and additional lunch opportunities to 469 extra meals weekly showed how resources were directed to reduce isolation and improve wellbeing for older people. Evidence from staff surveys informed equality, diversity and inclusion actions, leading to improved feedback and targeted workforce development.

The local authority also supported unpaid carers through programmes like the Carers Development Plan and Carers Strategy, which aimed to ensure unpaid carers were identified and supported. Actions included creating carer champions, improving assessments, and developing contingency planning. These priorities were resourced through collaborative partnerships and dedicated funding streams. In terms of impact, this meant people and unpaid carers received more timely support, reducing stress and improving quality of life. Targeted investment in prevention and community-based services helped people remain independent for longer and reduced reliance on crisis interventions.

The local authority delivered a wide range of actions based on identified risks and outcomes. For example, integrated work reduced occupational therapy waiting times and improved hospital discharge through transfer of care hubs. Collaborative work with mental health services led to crisis prevention pathways and reduced delays for people in hospital. Digital initiatives, such as the launch of a recruitment site and increased referrals for care technology, supported modernisation and choice. Examples such as the Richmond Moves campaign, which enabled over 2,000 people to become physically active, demonstrated how public health actions improved wellbeing.

The local authority also strengthened safeguarding practice through thematic audits and peer reviews, using findings to inform workforce training and celebrate good practice. In terms of impact, these actions meant people experienced safer, more responsive services and improved health outcomes. Integrated working reduced delays and supported continuity of care, while digital and community initiatives enhanced independence and participation in local life.

Information security

The local authority had arrangements to maintain the security, availability, integrity and confidentiality of data, records and data management systems. They implemented compliance with the Information Security Standard (ISO27001) and supported audit preparations to maintain robust governance. For example, the local authority led on compliance activities and introduced new processes to strengthen data handling and confidentiality. These arrangements were supported by timely statutory returns and budget monitoring, which demonstrated effective oversight of data management systems.

Evidence from service planning documents showed that the local authority introduced self-serve automated processes using Power BI and developed Client Level Data reports to meet national submission requirements. These innovations reduced manual handling of sensitive information and improved accuracy in reporting. This meant people's records were managed securely and efficiently, reducing risks of data breaches and ensuring timely access to accurate information for care planning.

The local authority also implemented a single training system for social care, covering classroom, virtual and e-learning courses. Training ensured staff understood data protection responsibilities and maintained confidentiality when handling records. For example, training supported compliance with safeguarding and information governance standards. This helped protect people's personal information and gave assurance that their data was treated with care and respect.

Learning, improvement and innovation

Score: 3

3 - Evidence shows a good standard

The local authority commitment

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

Key findings for this quality statement

Continuous learning, improvement and professional development

There was an inclusive and positive culture of continuous learning and improvement. The local authority fostered a culture where learning and improvement were embedded in everyday practice. Staff described regular reflective sessions, peer reviews, and professional development groups that encouraged open discussion and shared learning. For example, managers introduced peer reviews instead of traditional audits, which staff felt created a more holistic and supportive approach. This helped teams learn from each other and improve practice collaboratively.

Evidence from staff surveys showed that belief in the organisation's commitment to innovation increased, with more staff feeling poor performance was addressed effectively. This reflected a willingness to adapt based on feedback, which supported responsive and innovative service delivery. The local authority also acted on staff feedback to improve systems and processes, such as reviewing communication and work planning structures to help staff manage workloads more effectively. These changes supported consistent and uninterrupted care delivery, improving people's experience of timely and coordinated support.

The impact of this culture was seen in improved outcomes for people. For example, staff said that when they raised concerns about duty systems affecting consistency, the local authority introduced permanent duty roles. This meant people experienced greater continuity and familiarity, which improved their journey through care.

Local authority staff had ongoing access to learning and support so that Care Act duties were delivered safely and effectively. Staff had access to a wide range of training and development opportunities, including over 100 in-house training courses covering safeguarding, mental health, dementia, and trauma-informed assessment. The local authority also provided specialist workshops, such as those on the Mental Capacity Act and safeguarding prioritisation for newly qualified social workers. These sessions ensured staff understood legal duties and could apply them confidently in practice.

Supervision was structured to support reflective practice, caseload management, and professional development. Guidance emphasised equality, diversity, and inclusion as part of the supervisory relationship, creating a safe environment for critical reflection and challenge. This approach helped staff maintain professional standards and deliver safe, person-centred care.

The impact of these measures was evident in performance improvements. For example, audits showed 76% of assessments were completed within 30 days, and Mental Capacity Act audits rated 85% of cases as good or excellent following targeted learning events. This meant people received timely assessments and decisions that upheld their rights and wellbeing.

There was support for continuous professional development. The local authority invested in structured career pathways, including apprenticeships, Best Interest Assessor and Practice Educator qualifications, and leadership programmes. Staff described opportunities for mentorship, coaching, and action learning sets, which supported progression and confidence in complex decision-making. For example, the local authority introduced an early careers management programme for new senior social workers and a leadership pathway for managers. Staff also had access to external learning through partnerships with universities, which offered additional training and research-informed practice updates. These opportunities helped retain staff, with retention rates for newly qualified social workers increasing from 40% to 89% in one year. This investment in development created a stable and skilled workforce, which improved continuity of care and the quality of support for people.

The local authority worked collaboratively with people and partners to actively promote and support innovative and new ways of working that improved people's social care experiences and outcomes. Innovation was encouraged and supported at all levels. For example, the local authority trialled robotic process automation and artificial intelligence (AI) to reduce administrative tasks, saving 3,300 contacts and allowing staff to focus on higher-risk conversations. Staff also tested an AI bot to check on people and escalate changes in need, which sped up responses and freed frontline teams to focus on direct support. Feedback from people shaped these innovations, such as adjusting the bot’s introduction and speed to make it more accessible.

Digital and care technology projects were co-produced with people to ensure solutions met real needs. For instance, people advised on medication technology and helped design communication for automated calls. These innovations improved people’s experience by making services more responsive and reducing delays in care. A care technology project involved people in identifying gaps and testing solutions, such as technology to support medication management. Their input ensured the system was inclusive and practical. This collaboration meant people received technology that worked for them, improving independence and safety at home.

Co-production was embedded throughout the local authority’s work. Co-production was a consistent feature across commissioning, service design, and strategic planning. People and unpaid carers described being involved early in projects, such as reviewing day services, trialling care technology, and shaping commissioning decisions. For example, people influenced the design of supported accommodation by stating they wanted their own front door, which was incorporated into the final model. The local authority supported this approach through a co-production charter and regular engagement forums. Unpaid carers and people with lived experience sat on boards and strategy groups, ensuring their voices informed decisions. This involvement helped challenge assumptions and create services that reflected real experiences. In terms of impact, this approach meant services were more person-centred and responsive. For example, people’s feedback on carers’ assessments led to the return of a single, streamlined form, reducing confusion and improving the experience for unpaid carers.

The local authority shared learning, best practice and innovation with peers and system partners to influence and improve how care and support was provided. The local authority engaged in sector-led improvement and knowledge exchange through regional networks and partnerships. For example, it launched a mentoring programme connecting staff with professionals across 14 London councils and shared best practice through professional forums and newsletters. These initiatives promoted a learning culture and supported continuous improvement across the wider system.

Staff and leaders engaged with external work, including research, and embedded evidence-based practice in the organisation. Leaders and staff worked with universities to embed research-informed practice and develop the workforce. For example, the local authority collaborated with Kingston University on anti-oppressive practice and safeguarding modules and engaged in research on culturally responsive services to address barriers for ethnic minority groups. This engagement ensured practice was informed by current evidence, improving the quality and inclusivity of care for people. The local authority partnered with universities to co-deliver training on safeguarding and equality, diversity, and inclusion. This partnership strengthened staff knowledge and confidence, leading to more culturally competent and legally compliant practice.

The local authority actively participated in peer review and sector-led improvement activity. The local authority drew on external support to improve when necessary. The local authority took part in self-assessment and peer challenge workshops, which identified strengths and areas for development, such as improving multi-agency responses to self-neglect and hoarding. It also commissioned external safeguarding reviews to ensure decision-making aligned with best practice and Care Act duties. These reviews highlighted strengths in risk management and partnership working and informed changes to streamline safeguarding processes.

This openness to external scrutiny and learning demonstrated a commitment to continuous improvement and accountability, ensuring people received safe and effective care.

Learning from feedback

The Local authority learnt from people's feedback about their experiences of care and support, and feedback from staff and partners. This feedback informed strategy, improvement activity and decision making at all levels. The local authority actively sought feedback from people, staff, and partners to shape services and improve outcomes. For example, feedback from people highlighted that some letters were difficult to understand. In response, the local authority changed the wording in letters and amended debt explanation leaflets to make them more person friendly. This helped people better understand financial information and reduced confusion.

Examples such as the demonstrator housing programme showed how the local authority worked with internal and external experts, social investors, and people with lived experience to plan future housing. People consistently said they wanted their own front door and bathroom, and this feedback influenced the design of new supported accommodation. This meant people had more choice and control over their living arrangements, improving independence and dignity.

Partners also described strong engagement. Voluntary sector organisations told us the local authority listened to residents when developing its public health prevention offer, which enabled services to be planned around people's needs. Another example was the carers survey, which influenced the carers strategy. This ensured unpaid carers' voices shaped priorities, leading to more responsive support.

The local authority also used national survey data and local feedback to identify themes. For example, analysis of the national user and carer survey informed improvement priorities, while local feedback identified concerns about home care standards and communication. In response, the Quality Assurance and Commissioning teams worked with providers to improve quality. This helped ensure people received safer and more consistent care.

The local authority introduced a feedback postcard and online survey system to capture people's experiences. For example, the postcard asked whether people felt more enabled and in control after assessment and invited suggestions for improvement. Feedback from this process was reported twice yearly to senior management and led to changes such as revised communication protocols and robotic automation of email processing. These changes improved responsiveness and clarity, making it easier for people to access timely support.

Another example was the co-production work on direct payments paperwork. People and partners said the process was confusing, so the local authority worked with them to streamline it. This reduced complexity and helped people manage their support more easily, promoting independence.

There were processes to ensure that learning happened when things went wrong, and from examples of good practice. Leaders encouraged reflection and collective problem-solving. The local authority had systems to learn from complaints, compliments, and service concerns. For example, quarterly meetings reviewed complaint trends and safeguarding priorities, while compliments were logged and used to highlight good practice. Staff were recognised through thank-you letters, promoting a culture of reflection and improvement.

Learning from complaints was analysed and grouped thematically to track systemic issues. For instance, delays, communication failures, and financial misunderstandings were identified as key themes. This enabled targeted improvements and supported equity across services. When concerns were raised about provider performance, the local authority introduced targeted monitoring and early interventions. This proactive approach reduced escalation and improved care quality, meaning people experienced safer and more reliable services.

Examples such as the Care Governance Board's review of the Community Equipment Service showed leaders monitored high-risk areas and required ongoing improvement plans. Although remedial actions were not always specific, the service remained a standing agenda item until improvements were achieved, demonstrating accountability and commitment to learning.

The Local Government Social Care Ombudsmen (LGSCO) 2024/25 data showed the local authority had a 1 detailed investigation and there was a 100% uphold rate. Compliance with remedies was 100%, with no late remedies or incidents of late compliance. The local authority also provided a satisfactory remedy before LGSCO involvement in 25% of cases, compared to an average of 12% for similar organisations. This indicated a proactive approach to resolving complaints early, reducing the impact on people and ensuring fair outcomes.