Care Quality Commission

Warwickshire County Council: local authority assessment

How we assess local authorities

Assessment published: 20 February 2026

About Warwickshire County Council

Demographics

Warwickshire is a two-tier local authority in the West Midlands region of England, comprising 5 districts: North Warwickshire, Nuneaton and Bedworth, Rugby, Stratford-on-Avon, and Warwick. The county has a population of approximately 632,207 (Office for National Statistics, mid-2023). Warwickshire ranks 121st out of 153 local authorities in the Index of Multiple Deprivation (IMD), indicating relatively low overall deprivation. However, significant inequalities persist, particularly in parts of Nuneaton and Bedworth, where some neighbourhoods fall within the most deprived 10% nationally.

The population of Warwickshire grew by 10.6% between 2011 and 2021, reflecting steady growth across the county. People aged 65 and over make up 20.6% of the population, while 20.5% are aged 17 and under. People aged 18–64 account for 58.9%. Ethnically, the area is predominantly White (89.1%), with Asian and Black communities forming the largest minority groups. The proportion of residents born outside the UK has also increased since 2011, with growth in communities from Eastern Europe and South Asia.

Warwickshire County Council is part of the Coventry and Warwickshire Integrated Care System (ICS), which includes Coventry City Council and NHS partners across the region. Delivery is structured around 3 Place-based Partnerships; Warwickshire North, Rugby and South Warwickshire.

Following the May 2025 local elections, Warwickshire County Council is under no overall control, with Reform UK emerging as the largest party. Reform UK secured 23 of the 57 seats. The council leader is a Reform UK councillor, appointed with support from the Conservative group, which now holds 9 seats.

Financial facts

The Financial facts for Warwickshire County Council are:

- The local authority's total spend was **£886,919,000** in 2023/24, in comparison to a total spend of **£795,605,000** in 2022/23. In 2023/24, **24.36%** of the spend was spent on adult social care.
- The local authority's total spend on adult social care was **£213,888,565** in 2023/24, compared to a total spend on adult social care of **£180,511,000** in 2022/23. The local authority spent **£43,434,618** (adult social care spend) per 100,000 adults in 2023/24.
- The local authority has raised the full adult social care precept for 2023/24, with a value of **1%**. Please note that the amount raised through the adult social care precept varies from local authority to local authority.
- Approximately **8,845** people were accessing long-term adult social care support, and approximately **2,685** people were accessing short-term adult social care support in 2023/24. Local authorities spend money on a range of adult social care services, including supporting individuals. No two care packages are the same and vary significantly in their intensity, duration, and cost.

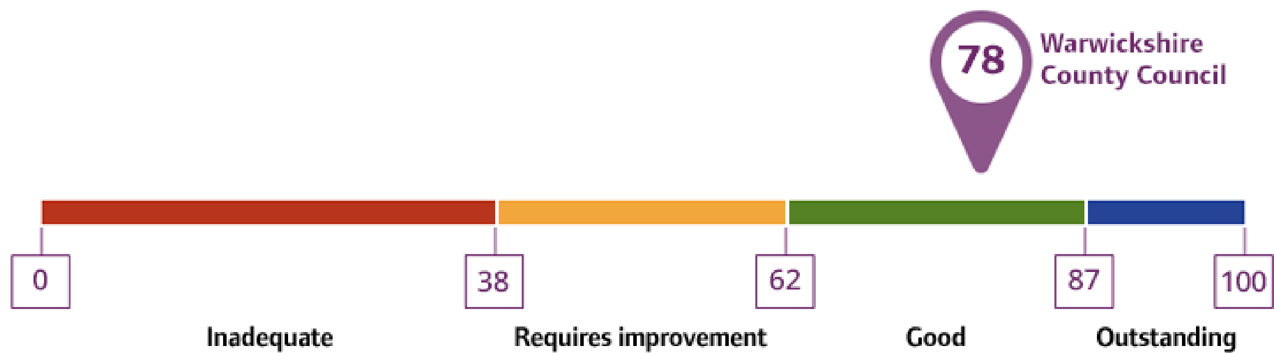
This data is reproduced at the request of the Department of Health and Social Care. It has not been factored into our assessment and is presented for information purposes only.

Overall summary

Local authority rating and score

Warwickshire County Council

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: 4

Summary of people's experiences

People who used services and their unpaid carers generally felt happy with the care and support they received from Warwickshire County Council. They told us they received care and support which suited their needs, goals and preferences and were able to find the advice and information they needed to make choices about their care.

Assessments were carried out in a person-centred way, with staff taking time to understand each person's situation. Most people felt listened to, were involved in decisions and said their views were respected. Waiting times for assessments were typically short, and reviews were used to adjust care when needs changed.

People were supported to live healthier lives through a wide range of preventative services. Short-term support such as reablement helped many people regain independence, with Warwickshire performing better than the national average. Many people were able to stay in their own homes for longer, through the care, support and equipment provided. They felt this helped them stay independent.

People said they were treated with respect, and their rights were protected. Staff considered people's cultural, religious and communication needs, and built care around their routines. Advocacy services were well-established and helped people speak up and take part in decisions.

People said they felt safe using the services. They were helped to understand and manage any risks they faced. People had access to clear information about staying safe, and what to do if they were worried about their own or someone else's safety.

Summary of strengths, areas for development and next steps

Data showed Warwickshire County Council performed well in several areas of adult social care. The Adult Social Care Outcomes Framework (ASCOF) reported 99.43% of people who received short-term support no longer needed ongoing care, which was significantly better than the England average of 79.39%. This showed how effective Warwickshire's reablement and recovery-focused services were in promoting independence and reducing long-term reliance on care. Satisfaction levels were also high, with 88.31% of people saying they were satisfied with their care and support, compared to the national average of 62.72%. Review activity was strong, with 84% of people receiving long-term support having had a review in the past year. These figures highlighted effective prevention, timely reviews, and positive outcomes for people.

Processes across assessment, care planning, and review were well-structured and person-centred. Staff described using guided conversations, tailored tools, and inclusive approaches to understand people's needs. Initial contact was responsive, and assessments were carried out by skilled teams with access to interpreters and specialist knowledge. Carers received separate assessments and support, with no waiting list and quick follow-up. Advocacy services were well-established and helped people take part in decisions, especially in complex cases.

Strengths included the use of integrated teams like Home Environment Assessment and Response Team (HEART), which supported people to live safely at home through housing adaptations. Preventative services were effective. For example, occupational therapists provided timely equipment and home adaptations, from simple aids like toilet frames to complex interventions. These helped people stay safe at home, reduced carer strain, and prevented hospital admissions or care home placements. Carers were supported through emergency services and community outreach, which helped prevent crisis situations.

Leaders had created a strong learning, improvement and innovation culture across adult social care. Staff used data confidently to monitor performance and drive change. For example, the safeguarding dashboard helped leaders monitor safeguarding activity across the system, identify patterns, and ensure timely responses to risk. It supported strategic oversight and informed reflective practice. The provider viability dashboard was used to track provider performance and identify where delays in reassessments or care changes might be impacting people's experience. This helped the local authority target support and improved coordination. The financial assessment process also showed innovation, with the Better Care Finance online form enabling people to complete assessments independently and view indicative costs.

Workforce development was well-supported, with flexible training, access to managers for decision-making support, and reflective practice sessions. Staff described a culture of learning and collaboration, with leaders listening to frontline experience and using feedback to improve services. These approaches helped build confidence, improve access, and ensured care remained responsive and person-centred.

Areas for development included improving consistency in provider engagement during reviews, particularly in supported living settings. Some providers felt excluded from reassessments or reported delays in care changes. A few carers were unaware of their entitlements or felt unsupported during transitions and staff noted signposting to emergency carer support could be strengthened.

Next steps included continuing to reduce waiting times for assessments and reviews, improving consultation with providers, and strengthening outreach to carers. The local authority planned to build on its data systems to monitor equity and improve visibility of underrepresented groups. Staff were already working with partners to improve signposting and access to services. These actions aimed to address gaps, improve coordination, and ensure people received the right support at the right time.

Theme 1: How Warwickshire County Council works with people

This theme includes these quality statements:

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

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

Assessing needs

Score: 3

3 - Evidence shows a good standard

What people expect

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

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

The local authority commitment

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

Key findings for this quality statement

Assessment, care planning and review arrangements

People accessed coordinated, person-centred care and support which reflected their strengths, goals, and preferences. The local authority assessed and reviewed people's health, care, wellbeing, and communication needs in ways that upheld their rights and supported independence.

People accessed care and support through multiple channels, including online, telephone, and self-assessment options. Staff used guided conversations to explore needs and offered face-to-face, virtual, or trusted assessor routes depending on the person's situation. Assessment teams were skilled and included specialists in mental health, learning disabilities, autism, and sensory needs. Inclusive practice was supported through interpreters and tailored tools such as one-page profiles. Staff used peer networks and local knowledge to connect people to community resources.

The approach to assessment and care planning was strengths-based and focused on what mattered most to each person. Staff considered cultural, religious, and communication needs and built support around individual routines and goals. People were involved throughout, and their views were clearly recorded and respected. Care records showed risks were identified and addressed, and family concerns were considered. Data from Adult Social Care Survey 2024 (ASCS) showed 88.31% of people were satisfied with care and support which was significantly better than the England Average of 62.72%. 75.06% of people felt they had control over their daily life which was similar to the England Average of 77.62%.

Initial contact was personalised and responsive. Staff took time to understand each caller's situation through open conversation rather than rigid triage, reducing the need for people to repeat their story. The customer service centre was well monitored and staffed by adult social care practitioners, supported by qualified social work managers who demonstrated strong knowledge and a commitment to strengths-based practice. Staff provided tailored advice, signposting, or resolution at first contact wherever possible. Feedback was actively gathered through questionnaires, with consistently positive results. The Principal Social Worker listened to calls to understand frontline experience and ensure quality.

Staff were well-trained and supported to deliver holistic assessments. Training covered the Care Act and practical processes, with flexible learning and access to social work managers to support confident decision-making. Referrals were triaged and prioritised to ensure timely access to essential equipment and support. For example, people accessed assessments and equipment through a clear, risk-based pathway. Referrals via the Adult Social Care Contact Centre, GPs, or emergency services were reviewed by a duty manager who set timeframes and allocated cases based on urgency and capacity.

Care and support were planned and coordinated across housing, health, and voluntary sector partners. One example was the Home Environment Assessment and Response Team (HEART) in Warwickshire, which supported people to live safely and independently at home through housing adaptations, repairs, and equipment. The service was nationally recognised as a strong model of integrated housing and social care. Unlike many areas where these functions operated separately, HEART combined roles such as housing assessment officers and occupational therapy assistants. Of around 1,700 annual referrals, approximately 1,300 assessments were completed by these integrated teams.

Reviews for people living in their own homes were managed flexibly and responded to changes in people's needs or risks. Staff typically carried out reviews at 1, 4, and 6 weeks, continuing until care was effective. While there was no fixed community review team, some teams had dedicated roles to support this work. Reviews often led to changes in care, such as one case where increased support was arranged after discussions helped reduce the risk of verbal abuse. Where urgent changes were needed, staff acted quickly through duty arrangements before a full review took place.

Timeliness of assessments, care planning and reviews

Assessment and care planning arrangements were timely and up to date. People experienced reviews that supported recovery and promoted independence. In one example, a care package was adjusted from 2 carers to 1 per visit to reflect improved mobility. The person had direct access to their social worker and could contact them when needed, which helped maintain continuity and responsiveness.

Data provided by the local authority in October 2025 reported 379 people were awaiting allocation for an assessment. Of these, 241 had been waiting less than 28 days and 243 were already receiving support. The median wait time was 19 days, with the longest wait recorded at 57 days. The local authority took active steps to manage and reduce waiting times, including actions to minimise risks to wellbeing while people waited.

The Occupational Therapy (OT) team reported waiting lists were at their lowest. Routine referrals were typically seen within 3-4 weeks, and urgent cases were allocated within 1-2 weeks. Reablement OTs triaged referrals to free up frontline capacity, supported by increased OT assistants. Although there was no formal 'waiting well' process, people received letters with signposting and were advised to contact the local authority if their needs changed. Self-assessment tools and a rise in self-purchase trends helped reduce pressure and supported timely access to equipment. In mental health services, staff reported no waiting lists across the county, including the crisis team, which responded almost immediately to concerns.

Data from the Adult Social Care Finance Report (ASCFR) and Short and Long-Term Support (SALT) 2024 showed that 66.46% of long-term supported clients had received a review (planned or unplanned), which was better than the England average of 58.77%. The local authority's 'Review Compliance' data dashboard helped staff monitor review activity. It showed that of 7,046 people receiving long-term support, 5,932 (84%) had received a review in the last 12 months. The remaining 1,114 had been reviewed within the last 24 months. The median wait time for review was 177 days. The dashboard was updated daily and allowed practitioners to drill down to individual cases and take action.

Staff described reviews as thorough, personalised, and responsive to changing needs. They involved conversations with people, families, and care staff, and considered safety, choices, activities, and care plans. Reviews for people with learning disabilities identified gaps in support hours and improved daily living arrangements, for example reuniting families. Staff used feedback loops through peer groups and support planning to keep the person's voice central. In one case, this helped a person with Parkinson's join community groups and feel less isolated.

The dedicated Review team prioritised residential and nursing care home reviews using data to identify overdue assessments. They built rapport through regular visits and cluster reviews and maintained continuity by allocating the same worker where possible. This strengthened relationships and improved the quality of person-centred reviews. Conversations during reviews informed adjustments to care hours and ensured all Care Act domains were considered. Duty teams picked up reviews flexibly, with contingency planning and safeguarding embedded in support plans.

Staff also told us the local authority used case notes and Deprivation of Liberty Safeguards (DoLS) assessments to inform reviews, with input from the DoLS team improving coordination. In the Disability team where staff supported people with physical and sensory needs, reviews were carried out by phone and through visits. After 6 weeks, assessments were reviewed to check how care plans were working. The reviewing team revisited people when needed and reviewed all care packages over a 12-month period. Straightforward requests were handled quickly, while the more complex ones were set aside for further work.

Providers gave mixed feedback on review arrangements. Many described a positive and responsive approach, with planned reviews involving senior care staff and families. A named social worker model helped improve continuity, though gaps emerged when staff were unavailable. Reviews were usually timely, and providers were generally invited to participate, enabling two-way feedback. However, some providers reported delays in reassessments, inconsistent use of the Mental Capacity Act, and limited consultation in supported living.

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

The local authority recognised the distinct needs of unpaid carers and ensured their assessments, support plans, and reviews were undertaken separately.

Unpaid carers were actively supported through a commissioned partnership with an external organisation which delivered Care Act duties on the local authority's behalf. This improved engagement, widened access to support, and enabled delegated authorisation of direct payments. Internal teams provided training and oversight, and satisfaction was monitored through national and local feedback tools.

In 2022, the universal carers offer was retendered to a single provider covering both children and adult services. This brought a community-based model with strong local partnerships and outreach to underrepresented groups. Carers were identified early and included in assessments, with staff routinely asking about their role and needs. Carers could choose assessment formats such as face-to-face, telephone, or messaging and were supported through online options where travel was difficult.

Triage processes recognised carers' needs even without formal assessment. Staff escalated carer breakdowns swiftly and arranged overnight care package adjustments. Carers received tailored equipment, practical training, and referrals to specialist services. Support extended across transitions, with access to respite, emergency care, and direct payments. Professionals linked families to hospital teams and informed GPs of caring roles.

The commissioned provider delivered assessments, supported young carers through transitions, and had introduced co-produced e-learning for parent carers. Feedback from most carers was positive, with many reporting increased visibility, trust, and impact. Carers received a range of support, including non-means-tested direct payments for cleaning or short breaks, respite and holiday funding, sitting services to enable breaks, annual support via the Carers Response Emergency Support Service (CRESS) offer, and access to information and resources through the Bridgit Care app.

The local authority promoted its carers offer through refreshed webpages, targeted campaigns, and branded materials. Strategic outreach included school assemblies, GP partnerships, and workshops. Staff made referrals on behalf of carers who didn't identify with the role and offered flexible feedback options.

Data provided by the local authority in October 2025 showed no waiting list for adult or young carers. The commissioned provider contacted carers within 2 days of referral, offering advice and scheduling assessments. Young carers waited no more than 7 days, and parent carers had a median wait of two weeks.

All the unpaid carers we spoke with had received a carers assessment and support from the partner organisation; however, a few were unaware of their entitlements. Some carers experienced inconsistency in assessments, particularly during transitions from children to adult services, with some feeling unsupported; others described positive contact when assessments were offered proactively.

One partner told us despite comprehensive provision for carers by the local authority, some carers had reported feeling unsupported, highlighting a disconnect between service design and lived experience. They recommended greater involvement of voluntary and community organisations to better meet carers' needs.

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

People were given help, advice and information about how to access services, facilities and other agencies for help with non-eligible care and support needs.

Staff provided clear information and guidance to help people access services, facilities, and community resources when they did not meet Care Act eligibility. People told us they felt well-informed and understood the decision. A dedicated Hospital Social Care team supported people during hospital discharge by exploring informal networks and bridging gaps before formal eligibility. People received the same assessment process, including financial advice and access to tools like the Warwickshire Care Services Directory.

Customer service staff directed callers to appropriate services, offered interim support such as equipment, signposted and encouraged them to call back if needs changed. Teams across services also signposted people respectfully and promptly, offering contact details for alternative support and maintaining dignity. The Disability Transitions team referred people to short-term community services for housing, life skills, wellbeing, and financial advice, with flexible routes and strong links to education and housing providers. Dementia support included trained providers, new day services, and community initiatives like cafés and singing groups. Resources were listed on the Living Well with Dementia Warwickshire website, with practical aids and signposting.

Partners also played a key role, for example in supporting unpaid carers. The commissioned provider offered counselling through grant funding and told us they prioritised meaningful, person-centred engagement over a transactional approach. Monthly working groups helped keep the Bridgit app responsive to carers' needs.

Eligibility decisions for care and support

The local authority applied its eligibility framework for care and support consistently, transparently, and in line with the Care Act. Decisions were timely, well-documented, and rarely contested.

Eligibility decisions were supported by clear processes and confident frontline practice. Staff routinely followed the conversation model, asked appropriate questions, considered advocacy needs, and documented their analysis for managerial oversight. Audits added further assurance, and leaders confirmed that most people were found eligible, with few disputes. Adult Social Care Survey (ASCS) 2024 data showed 71.91% of people did not pay privately or top up their care which was better than the England average of 64.39%, suggesting confidence in the support provided.

There was no separate appeals process for eligibility decisions. People were encouraged to raise concerns with their allocated worker and, if unresolved, follow the complaints procedure. No complaints were received in the past year relating to eligibility, assessments, or funding.

A leader explained that, in considering the comparatively lower rates of requests for support, demand for adult social care services remained consistently low over time, particularly in the south of the county. While a higher proportion of self-funders contributed to this, the area's relatively strong health indicators, and the range of preventative services on offer were a more significant factor. Access issues with the website and telephone system were acknowledged but did not appear to be driving the lower demand.

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. From March 2025, the local authority developed two pathways for financial assessments. It introduced an online form called the BetterCare Finance Form, which allowed people to create an account, log in, and complete their financial assessment independently. This gave them an indicative amount of what they might need to pay. The second pathway involved staff referrals through the local authority's recording system. Once referred, the Financial Assessment team contacted people within 2-3 days to help complete the form by telephone or video call.

The online form was first trialled in Stratford-upon-Avon. Following the trial, the local authority consulted staff and people using the service to improve the process and provide clearer guidance. Staff created video tutorials, added links to relevant benefits, and updated the website wording. Staff reported that both people and teams benefited from this approach. Some people completed the form in advance to understand potential costs, and social workers could view the person's progress in the system, reducing the need to contact the financial team.

Since January 2025, 1,152 people used the BetterCare Finance Form to complete a financial self-assessment, and 722 of these submitted the form for a formal financial assessment. There was no waiting list. The median time from request to appointment was 15 days. The longest wait was 56 days, which occurred at the request of the person's representative.

The new system reduced waiting times and improved access to financial assessments. People who needed urgent help were offered a phone assessment within a week. They were also given clear information about care costs, which meant support could be arranged quickly. The local authority arranged face-to-face assessments for people with specific needs, such as deaf people using British Sign Language, with interpreters and social workers present. The form could also be converted into different languages, helping people stay independent throughout the process.

Provision of independent advocacy

People accessed timely, independent advocacy through a jointly commissioned contract between Warwickshire and Coventry. The arrangement began in April 2025 and covered both statutory and non-statutory adult advocacy, with a primary focus on statutory services. Experts by experience shaped the contract to ensure it supported local needs and enabled people to participate fully in care assessments and planning.

Advocacy in Warwickshire had been well-established and worked effectively. Staff and partners described clear referral routes, consistent support, and a collaborative culture. The provider responded well to referrals and delivered a high-quality service. They aimed to maintain continuity by keeping the same advocate where possible. Interpreters and support for people with hearing loss were available, and any delays were resolved using council-funded interpreters or language-matched support workers.

The local authority continued to fund advocacy despite rising costs, helping people, including those with disabilities, learning needs, and caring roles to speak up, challenge decisions, and access the support they needed. The provider played an active role in complex cases and maintained a strong presence in relevant settings, including a high volume of Independent Mental Capacity Act referrals.

To raise awareness and build staff confidence, the provider delivered training and reflective practice sessions focused on eligibility and complex decisions. Strategic leaders and board members championed advocacy across services. Most recently, the provider worked with the safeguarding adults board on homelessness, aligning with wider strategic aims to ensure partners understood when and how to use advocacy effectively.

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 proactively with people, partners, and communities to make a broad range of preventative services, resources, and support available. These arrangements were strengths-based, person-centred, and responsive to people's wider needs, with specific consideration given to unpaid carers and those most at risk of declining independence and wellbeing.

Warwickshire's short-term support services were highly effective in helping people regain independence. Data from the Adult Social Care Outcomes Framework (ASCOF) 2024 showed 99.43% of people who have received short term support no longer required support which was significantly better than the England average of 79.39%. This demonstrated strong local performance in preventing, delaying, or reducing the need for longer-term care.

Preventative services had a positive impact on well-being outcomes for people. For example, occupational therapy played a vital role in preventing long-term support needs by promoting independence through timely equipment and environmental adaptations. Minor items like stand aids and toilet frames reduced reliance on carers, while more complex input helped people with significant needs remain safely at home.

Mental health teams used holistic assessments to understand underlying issues, including social factors, and shared an example of a person whose suicidal thoughts were linked to untreated trauma. After targeted support, medication was reduced, wellbeing improved, and they engaged in more meaningful activities which gave them a sense of purpose, connection, and self-worth.

Staff working with people with learning disabilities focused on wellbeing and used creative approaches to build independence. One autistic young person was supported to move from charity shop volunteering to a gardening project, with a personalised passport to explain communication needs. This helped prevent future needs by building the young person's confidence, routine, and sense of purpose through meaningful activity. Supporting the move to a more suitable volunteering role, alongside a personalised communication passport, promoted independence and reduced the risk of social isolation, anxiety, or crisis. These proactive, tailored interventions strengthened wellbeing and reduced the likelihood of needing more intensive support later on.

A leader told us Public Health operated across various areas and used a life course approach to influence outcomes in health, wellbeing, and social care. For example, Public Health supported older adults with learning disabilities by ensuring access to screenings and immunisations, such as breast cancer screening. This approach helped prevent future needs by identifying and addressing health issues early, reducing the risk of more serious illness or crisis later on.

Carers were supported through services like the Carers Response Emergency Support Service (CRESS). It was designed to provide urgent, short-term support when an unpaid carer experienced a breakdown or emergency, especially outside of normal service hours. For example, if a carer becomes suddenly ill or is unable to continue caring, CRESS could step in to ensure the person they support remained safe until longer-term arrangements are made. It was a key part of preventing crisis and reducing the risk of hospital admission or care home placement. However, staff noted that signposting to this service could be improved.

The local authority had taken steps to identify people with needs for care and support that were not being met. For example, one team supported a person living in poor conditions, isolation, and financial hardship. Following a hospital admission, staff arranged a deep clean, resolved housing and benefit issues, backdated pension, provided a mobile phone, and set up weekly cleaning, all of which significantly improved their wellbeing beyond social care needs. Staff told us they valued face-to-face contact, especially for those new to care, and highlighted the role of voluntary and community sector partners in identifying unmet needs. While some staff felt system pressures limited the ability to focus consistently on prevention, the examples shared demonstrated clear impact, helping people stay well, avoid crisis, and live more independently.

Provision and impact of intermediate care and reablement services

The local authority worked with partners to deliver intermediate care and reablement services that demonstrated a strong, person-centred approach which delivered timely, effective support and helped people regain independence.

Warwickshire's reablement service was well established and closely monitored, with a dashboard used to track referrals, outcomes, and longer-term impact. The service followed a strengths-based model, offering short-term support after illness, injury, or hospital discharge, with clear referral and triage processes in place. Until recently, the Community Recovery Service was delivered under the STS Max model (Short-Term Support – Maximising Independence), which provided intensive, time-limited rehabilitation to help people regain independence and avoid ongoing care.

In 2023-24, Warwickshire was selected as 1 of 6 national sites for the Intermediate Care Frontrunner Programme and was the first to launch a new intermediate care model for Pathway 1 discharges home. Pathway 1 discharges refer to people leaving hospital who were well enough to go home but still need some short-term support to recover. This new approach increased capacity, improved people's recovery outcomes, reduced hospital stays and streamlined referral processes. It also sped up care package sourcing and allowed other services to focus more on prevention and community support. The local authority recognised that measuring the full impact of preventative services remained difficult due to the complex links between different parts of the system.

Data from the Adult Social Care Outcomes Framework (ASCOF) 2024 showed 4.36% of people aged 65+ received reablement or rehabilitation services after discharge from hospital which was better than the England average of 3.00%. Furthermore, 93.55% of people aged 65+ were still at home 91 days after discharge from hospital into reablement or rehabilitation which was significantly better than the England average of 83.70%. Data provided by the local authority in June 2025 showed 76% of people were reabled to no ongoing service with around 70 people at any one time being supported by the service.

Staff described a responsive and person-centred reablement service which prioritised safety, independence, and timely support. Hospital discharge and reablement teams adapted quickly to delays and communication gaps, using daily update meetings and same-day interventions to keep people safe. Reablement assistants monitored wellbeing through daily observations, balancing individual preferences with family concerns, and used telecare and assistive technology tools to enhance reassurance and enable early intervention.

The reablement team focused on building people's confidence from day 1, supporting them to regain routines and achieve personal goals, such as one example where a person wanted to independently sit outside again. Referral response times were swift, with most accepted within an hour and scheduled for the same or next day, helping reduce hospital readmissions. While referral screening was robust, staff noted that community referrals often lacked detail compared to hospital referrals. The reablement customer portal improved transparency and reduced family stress by allowing relatives to view visit schedules directly. Staff managed disruption to calls proactively and prioritised dignity, with one example showing how timely support helped someone in pain regain confidence. The many examples given by the reablement service showed clear impact and a commitment to continuous improvement.

Access to equipment and home adaptations

People could access equipment and minor home adaptations to maintain their independence and continue living in their own homes. Data provided by the local authority showed between April and August 2025, equipment was delivered promptly, with an average wait time of 3 days and a median of just 1 day, indicating most requests were fulfilled quickly. The default target for equipment orders was 5 working days. The longest recorded wait was 73 days, which related to a minor adaptation in a supported living setting. The external commissioned equipment provider and the local authority reported no waiting lists. On average, the service delivered around 140,000 pieces of equipment annually to approximately 22,300 people, demonstrating a high-volume, responsive system.

The local authority worked in partnership with the NHS to deliver the Integrated Community Equipment (ICE) service, which provided equipment, minor adaptations, and technology-enabled care to help people live independently at home or in their communities. This was supported by the external provider, with equipment provision based on assessments carried out by the ICE team. Equipment provision helped prevent hospital admissions and supported timely discharge, aligning with the local authority's priorities to keep people safe, healthy, and connected. One person told us they felt heard and safer after receiving a wrist alert and tailored support.

A partner told us digital devices and dongles were distributed in partnership with Warwickshire County Council to help carers and their families access online support and educational resources. The fire service also collaborated to conduct safe and well visits and install fire alarms in people's homes, enhancing safety.

To strengthen their offer, the local authority had piloted the 'TEC Me Home' project as part of their work to strengthen technology-enabled care in Warwickshire. The project used activity sensors to monitor people's routines after hospital discharge, helping carers feel reassured and enabling professionals to assess whether the level of care was right. It formed part of a wider effort to build a more innovative care market, alongside other trials using similar technology in reablement and care home settings. Feedback from people, families, and practitioners involved in the TEC Me Home pilot was positive, and no improvement areas were identified.

Staff worked proactively to improve access to equipment and adaptations, using technology, feedback, and creative problem-solving to support people's independence and dignity. For example, staff trialled new equipment such as a sit-to-sit device, which aimed to reduce reliance on hoists and two-person care, and they were developing processes to embed its use. Staff gave us examples of creative solutions which included using a digital device for communication instead of reliance on 24-hour care and mobile apps that were used to track care calls and enhance safety. Staff told us they used their laptops to take photographs in people's homes to assess space which supported the accurate ordering of appropriate equipment and prevented delays. The AskSara tool helped people self-assess and access equipment independently, and there were plans underway to create a demonstration of equipment and training space for staff and partners.

Reablement staff told us equipment access was rapid and responsive. Urgent items like grab handles and key safes were sourced the same day, with fallback stock available in their office. This enabled timely safe discharges from hospital and reduced risk, even when formal delivery was delayed.

The Home Environment Assessment and Response Team (HEART) had a positive impact on equipment provision in people's homes by delivering timely, tailored adaptations when needs exceeded what adult social care could meet directly. Occupational therapy teams referred Disabled Facilities Grant requests under trusted assessor arrangements, ensuring full assessments were shared and urgent cases could be escalated. While standard waiting times were around 12 months, staff used smaller adaptations and practical support to maintain independence in the interim. Housing assessment officers combined occupational therapy and housing expertise to reduce repeat visits, and although initial visit times were longer than desired, approvals averaged just 7 days compared to 46 nationally, with completions at 61 days versus 118 nationally. A 2-year capital project was launched to recruit more staff and improve assessment speed, resulting in a 5% increase in referrals and a 23% rise in completions last year.

While most equipment was delivered promptly, staff identified challenges around delivery delays, limited access to plus-size items, and administrative burdens. These were addressed through regular feedback to commissioning, targeted training, and tracking systems. Staff prioritised urgent needs, used recycled equipment where appropriate, and considered cost-effectiveness through supplier quotes, ensuring timely and efficient support for people with complex needs.

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. This included unpaid carers and people who fund or arrange their own care and support. Staff demonstrated strong commitment to providing accessible, timely advice and support, using a mix of digital tools, printed materials, and direct communication. Care records showed people received clear documents containing information, for example on financial advice, community support, and how to contact adult social care if needed.

People described positive experiences with tailored adjustments, such as receiving digital reading devices, trialling software, and using speech-to-text tools. They told us information for meetings was shared in advance, so they could speak with others to prepare. Adjustments were made for communication challenges, such as offering telephone calls instead of emails. However, some people said they often did not know where to go and signposting was sometimes poor.

The local authority had successfully embedded AskSara and SearchOut Warwickshire as accessible, self-help digital tools which supported people to live independently and stay well. These tools offered clear benefits in terms of personalised advice, reduced waiting times, and improved access to community support. The local authority's website was described as user-friendly, jargon-free, and included out-of-hours contact details.

AskSara was promoted as an award-winning, easy-to-use website that helped people access smart technology and related services. People could interact with the tool online and receive a free, impartial report with tailored advice based on their responses. AskSara looks like a survey, guiding people through questions to generate personalised recommendations. This approach reduced the need for formal assessments, saving time for both the local authority and the public. Between March 2024 and February 2025, AskSara was accessed an average of 200 times per month. Following targeted engagement with health and social care professionals, usage rose to 344 in February 2025, a 29% increase and the highest since launched in 2019.

The local authority also provided online access to the SearchOut Warwickshire directory, which helped people find local community organisations, services, and events. The aim was to support people to stay active, healthy, and connected.

Clear communication and plain language were prioritised in frontline practice. Staff across services actively supported people by signposting to relevant resources using AskSara, local directories, and printed materials, connecting people with befriending, dementia, and autism-specific support. Staff recognised the importance of explaining things simply to ensure people understood their options and felt supported. They told us information could be provided in accessible formats such as large print, Braille, easy read and different languages.

Partners confirmed the local authority had commissioned a range of preventative and accessible services to support people's wellbeing and independence. While digital tools and helplines were praised for their impact, they told us gaps remained in the visibility and accessibility of service information.

One partner reported that wellbeing hubs and a 24/7 helpline were commissioned to prevent mental health needs from escalating into crisis. These services offered advice and redirected people to appropriate support, contributing to early intervention. However, the same partner noted that information about available services was not sufficiently accessible, especially for people in crisis, making it harder to get timely help.

Another partner highlighted a strong online presence through social media, newsletters, and self-referral platforms. This ensured carers could access relevant information quickly. The Bridgit app was commissioned to offer practical tools and mental health support, with feedback loops in place to improve its effectiveness. A third partner said interpreters were requested and booked through the local authority to support accessibility.

Data from the Adult Social Care Survey 2024 showed 68.75% of people who used services found it easy to find information about support, which was similar to the England average of 67.12%. Similarly, 84.15% of carers found information and advice helpful, also similar to the England average of 85.22%. However, the Survey of Adult Carers in England 2024 showed only 53.09% of carers found it easy to access information and advice which was worse than the England average of 59.06%. This suggested that while the quality of advice is broadly positive, the accessibility of information particularly for carers remained a challenge. This aligned with wider feedback we received from people using services, unpaid carers and partners, who highlighted some issues with visibility, signposting, and navigation of support pathways, especially during times of crisis.

Direct payments

There was good uptake of direct payments, and they were being used to improve people's control over how their care and support needs were met. People had ongoing access to information, advice, and support to use direct payments.

Data provided by the local authority in October 2025 showed 1,035 people were drawing on a direct payment. Adult Social Care Outcomes Framework (ASCOF) 2024 data showed 21.33% of people received direct payments (England average 25.48%), 37.19% of adults aged 18–64 received direct payments (England average 37.12%) and 9.22% of adults aged 65+ received direct payments (England average 14.32%). Although national benchmarking showed slightly lower uptake than the England average, staff confidence, feedback, and local examples demonstrated direct payments were being used effectively as part of personalised care options.

Direct payments were monitored through a newly developed dashboard which tracked uptake and reasons for ending payments. On average, 79 payments were cancelled each year, with 95% of those having been active for more than 6 months. Most cancellations were linked to escalating care needs or changes in personal circumstances.

Staff shared examples which highlighted the flexibility and creativity enabled by direct payments. One family used a direct payment to employ a personal assistant (PA) who spoke their language, supporting culturally appropriate care. Another used the payment to help a person remain at home rather than move into residential care. In complex cases, such as hoarding, staff worked with partners to build tailored support networks using direct payments. Staff consistently reported that the open approach and flexible use of funds allowed for holistic and non-traditional solutions.

The local authority supported staff through a dedicated direct payments team, which provided training and targeted advice on assessments and reviews. Pre-payment cards were introduced to reduce the administrative burden for people using direct payments. A commissioned support service offered practical help with employment advice, payroll, and PA recruitment. Recent work to promote the PA role led to a social media campaign and wider awareness-raising. An indicative direct payment rate was used, but when people's needs or circumstances dictate, such as those living in rural areas or requiring health-related support, the personal budget was changed to take this into account.

Unpaid carers accessed direct payments through the external partner organisation, commissioned by the local authority. Delegated authorisation allowed payments of up to £2,000 per person. Carers used direct payments creatively, including one-off and regular payments for wellbeing activities and household tasks. Examples included holidays, yoga classes, and club memberships. Additional support for carers included financial advice, training, and seasonal wellbeing offers, with young carers benefiting from inclusive activities.

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

Warwickshire County Council took clear and proactive steps to understand and reduce inequalities in care and support. Equality, Diversity and Inclusion was a clear strategic priority. The local authority used local data and community insight to identify where people were experiencing poorer outcomes and worked with partners and people who draw on care and support to make services more inclusive and accessible.

The local authority recognised Warwickshire included both affluent and deprived areas. People living in the most deprived communities often had shorter lives and spent more years in poor health. For example, men in the least deprived areas lived over 9 years longer than those in the most deprived, and women lived 5 years longer. These differences were linked to preventable issues such as smoking, alcohol use, obesity, and low physical activity.

To understand these challenges better, the local authority produced a series of Joint Strategic Needs Assessments (JSNAs). These reports looked at the needs of specific groups, including adults with learning disabilities, older people, young carers, and people from ethnic minority backgrounds. The JSNAs helped the local authority and its partners plan services and target resources where they were most needed.

One report found that many adults with learning disabilities were not registered with a GP or receiving annual health checks. Another highlighted that people with multiple protected characteristics such as being from an ethnic minority and having a disability often experienced the poorest health outcomes. The local authority also looked closely at the needs of groups such as refugees, asylum seekers, and Gypsy, Roma and Traveller communities, and used this insight to improve access to care and support. For example, staff carried out Care Act assessments and Human Rights reviews for asylum seekers, including those with no recourse to public funds and a partner organisation supported asylum seekers by offering translation and guidance, helping to overcome language barriers and raise awareness of available services.

The local authority worked closely with unpaid carers, including young carers, through the Carers Forum. It supported pop-up events in schools and libraries and deployed carer champions in rural areas to improve visibility and access to support. It also used data to understand the impact of rural isolation, especially for older people who did not drive, and used this to inform planning decisions.

The local authority’s Health and Wellbeing Strategy (2021–2026) set out clear actions to reduce health inequalities. These included designing new housing with green spaces, promoting fair access to local amenities, and encouraging inclusive recruitment. The Health and Wellbeing Board also launched a “Call to Action” initiative to encourage local employers to support staff wellbeing and reduce workplace inequalities.

The local authority had regard to its Public Sector Equality Duty (Equality Act 2010) in the way it delivered its Care Act functions. For example, it developed a programme called ‘Meeting the Social Care Needs of Warwickshire’s Diverse Communities,’ which focused on equality, diversity and inclusion in adult social care. This work was led by the Principal Social Worker and supported by Human Resources and equality teams. It aimed to create a culture where staff felt safe to speak up, learn, and improve. Staff received regular updates and took part in Cultural Diversity Sessions, which helped build confidence and understanding across the workforce.

Healthwatch undertook focused work to understand and engage with people living on boats, recognising them as a distinct and underserved community. Following this, the local authority worked with Healthwatch, Primary Care Networks, and the Canal & River Trust to build on those insights. Through this joint outreach, the system identified barriers to health and care access linked to mobility, digital exclusion, and the lack of a fixed address. This led to improved awareness across the partnership and early efforts to adapt service models. The work with people living on boats demonstrated a commitment to inclusive practice and highlighted the need for flexible registration and outreach approaches to reduce inequalities and improve outcomes.

Across all of this work, the local authority showed it listened to people, used evidence to guide decisions, and took practical steps to reduce inequalities and improve outcomes for those most at risk of poor care.

Inclusion and accessibility arrangements

The local authority made sure people could access adult social care in ways that worked for them. Staff and leaders took practical steps to remove barriers and promote inclusion, tailoring support to meet people's communication, cultural, and personal needs.

Staff took a proactive approach to inclusion. Quality assurance checks helped ensure assessments captured cultural and personal information. While system updates were still underway to record pronouns, staff were coached through peer support and supervision to ask respectful questions and understand their importance. Warwickshire's workforce had become more diverse, and staff felt supported in discussing national issues and cultural considerations. This helped create a more inclusive and responsive service environment.

Digital tools also improved accessibility. AI-powered translation pilots and website features helped people whose first language wasn't English to access services online. The online BetterCare Finance Form included a language translation facility. Staff could access British Sign Language (BSL) interpreters to support people from the deaf community. However, one partner told us, the Accessible Information Standard was inconsistently applied, and BSL interpreters struggled with jargon. They added digital tools like AskSara and the Bridgit app were not universally accessible. A leader told us, these apps had formed a helpful part of the wider offer and had increased accessibility for many people.

Staff and providers told us interpreter delays sometimes created challenges, but staff had responded creatively. They used their own language skills to bridge gaps and gained help by reopening a Sikh community hall with help from bilingual colleagues to support cultural and social needs.

Staff and leaders told us they worked with service providers to improve culturally competent care; they used their Market Position Statements to highlight gaps and involve providers. The Business Intelligence team analysed data on care home occupancy, workforce, and demographics. This helped shape commissioning plans and identified cultural barriers and access issues for some groups. Providers responded by offering different food options, creating prayer rooms, and improving care staff awareness of cultural practices. Cultural and religious preferences were respected in care planning, for example, flexible scheduling supported outdoor washing before prayers and meal adjustments during Ramadan. In many communities, caring for older relatives was seen as a family responsibility. Occupational therapy and moving and handling training helped empower carers, and staff held open conversations about alternative ways to support caring roles. In one example, a person was supported to maintain independence through tailored equipment, avoiding formal care and respecting their preferences.

Personal Assistants and direct payments were used flexibly to meet people's needs. For example, a Polish-speaking provider was identified to support someone's communication needs. Care packages were tailored to gender and cultural preferences. Providers arranged park visits for people who enjoyed feeding birds, supported church attendance, and helped an ex-army veteran attend a poppy parade.

Staff used a range of tools to support communication, including PECS cards, one-page profiles, fidget tools, and easy-read reference cards. Picture Exchange Communication System (PECS) cards are visual communication tools used to support people, especially those with autism or communication challenges to express their needs, wants, and ideas. Providers were encouraged to offer interpreters for those with hearing impairments and produce easy-read versions of key documents. For autistic people, providers shared profiles in advance and adapted activities to ensure inclusion.

Co-production played a key role in shaping inclusive services. Experts by experience helped gather views from the wider community, for example, through a survey to inform an e-booklet for neurodivergent people and producing an information video featuring a person with learning disabilities. Experts by experience also took part in meetings both online and in person, with many subgroups involved, for example some members had joined the safeguarding committee to review experiences and help improve practice.

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

Between 2017 and 2020, Warwickshire adopted a place-based approach to its Joint Strategic Needs Assessment (JSNA), dividing the county into 22 areas to better understand local needs and inform service design. This work led to the creation of the Monitoring Health Inequalities dashboard, which continues to provide up-to-date data at county, district/borough, and JSNA geography levels.

The JSNA informed Warwickshire's Health and Wellbeing Strategy, commissioning plans for Integrated Care Boards (ICB), and transformation plans for the local health economy. There were arrangements to commission services on behalf of Coventry and Warwickshire Integrated Care Board (ICB) and an integrated commissioning arrangement with South Warwickshire University NHS Foundation Trust (SWFT). This arrangement played a key role in integrating social care and health within Warwickshire.

Warwickshire had lower rates of requests to support long-term people within the working-age adults' group (18–64) compared to the England average of 1,785. People in these groups were supported by many partners, including local authorities, public health, the Voluntary, Community, Faith and Social Enterprise sector (VCFSE), local communities, and health services. The older population was projected to increase by 19.8% between 2018 and 2043, meaning almost a quarter of the population would be aged 65 and over, with dementia prevalence higher than the national average. Older people receiving a service accounted for 67%, and it was anticipated that older people and people with disabilities made up most of the budget expenditure.

Warwickshire was generally regarded as an affluent area, ranked 121 out of 153 on the Index of Multiple Deprivation. However, there were pockets of deprivation, with 6 of the 339 localities ranked in the top 10%. Providers told us the local authority had a strong understanding of its diverse population, recognising differences in deprivation, culture, and health needs between the North and South of the county. Senior leaders told us the care market was well managed, with strong provider relationships and robust arrangements in place. While some risks existed, these were managed effectively to support providers and develop the market.

The local authority had a structure to support services to meet people's needs. These included teams for older people (the largest group), learning disabilities, physical disabilities and sensory needs, and a specialist safeguarding service. There was a hospital discharge team linked to reablement and prevention networks with health and the VCFSE sector. Joint commissioning arrangements with NHS partners and the ICB included joint posts and co-produced strategies. Coventry and Warwickshire Partnership NHS Trust (CWPT) had a Section 75 agreement to jointly deliver mental health services. A disability transitions team supported children moving from the children with disabilities service to adult services, reflecting effective joint working on the preparation for adulthood pathway. Public Health advised and influenced system-wide thinking on preventing ill-health with a focus on tackling inequalities, underpinned by Warwickshire's Health and Wellbeing Strategy.

The local authority continued to work with local people and stakeholders and used data on population cohorts, activity levels, care provision, and prevention opportunities to forecast demand. A long-term plan was developed through a joint commissioning group, focusing on specific populations such as those with autism or disabilities. Priorities included creating an integrated health space and managing the budget on behalf of the ICB.

The local authority worked with district and borough housing authorities to address a rise in self-neglect, low-level hoarding, and behaviours which challenged services, that affected health, social care, and housing. Staff highlighted challenges in finding wheelchair-accessible housing or placing people in an emergency. The Housing Partnership Board established a joint escalation approach to manage issues more effectively. A new housing complex was due to open in Nuneaton to address accessibility concerns and other issues, such as homes not meeting decent standards. However, housing challenges varied across the county: in South Warwickshire, rural land and high costs made development difficult and affected affordability, while in the North, demand for services was high. Work was in progress to continue working with people through a co-production approach to ensure services continued to meet the needs of people in each geographical area as well as service need.

Market shaping and commissioning to meet local needs

The local authority shaped and developed the care market so people could access a wide range of local support options that were safe, effective, affordable, and high quality to meet their care and support needs. Everyone was able to get the care and support they needed when, where, and how they needed it. Data from the Adult Social Care Survey in October 2024 showed 67.18% of people using services felt they had a choice over services, which was similar to the England average of 70.28%.

Commissioning arrangements were integrated with Coventry and Warwickshire through the Integrated Care Board and NHS Trust to support hospitals. The Trust told us the partnership worked well, with collaboration on commissioning and agreement on which partner was best placed to manage contracts. For example, the commissioned hospice in South Warwickshire was run by the local authority rather than the acute trust. Public health, housing, and the voluntary and community sector also worked together to align services with the diverse needs of local communities and different areas.

A Market Position Statement was used to identify gaps in 5 areas and inform providers about opportunities to support the market. The local authority said they were moving to online Market Position Statements to bring all areas into one accessible location. This would allow real-time updates and a more interactive approach.

The local authority worked with health partners on the 10-year health plan, linked to the delegation of services to the local authority. One development was the integration of the equipment contract, previously managed by the Integrated Care Board. This was part of an enhanced offer for assistive technology, linking this agenda to wider service specifications and creating more opportunities to use technology to support independence.

The Business intelligence team used Power BI dashboards and national data to understand the market. For example, extra care services were reviewed, and work with providers had begun, alongside engagement with experts by experience on the specification. Senior leaders had a good overview of the care market and described it as stable, with successful commissioning reforms. There were developments in reviewing and re-procuring the care at home offer for adults, including set rates to help manage costs and a new element for night support. Residential and nursing care costs were individually negotiated, and market pressures were actively managed, noting a high demand for nursing in the north of the county. The brokerage team sourced and coordinated home care packages with no waiting times. A pilot for brokering nursing and residential placements in the north was underway to see how this could be expanded across the county. Providers spoke positively about the local authority, citing stable teams, regular forums, and professional communication. However, some providers felt decision-making on wider issues was too removed. For example, one care home used acoustic night monitoring and lighting to reduce falls significantly. This was shared with other local authorities and organisations, but Warwickshire County Council had not engaged with them to understand the model or consider its wider benefits.

Accommodation capacity remained a challenge, but work was underway to develop long-term homes for people with complex needs, respite care, and specialised supported housing. Work on shaping the Supported Living model included collecting referral data to understand demand and support levels. Feedback from providers, staff, and people living in existing accommodation was used to influence developments and address market gaps. New schemes were planned over the next few years, including mixed models for mental health and learning disability in areas such as Nuneaton, Southam, Leamington Spa, Bedworth, and Rugby.

There was specific consideration for services to meet the needs of unpaid carers. Several commitments were made through commissioning a provider to deliver the unpaid carers strategy, recognising their vital role in the care system. However, gaps were identified in unplanned respite. A flexible short-break service, known as CRESS (Carers Response Emergency Support Service), was created to support carers during emergencies, such as medical treatment or family events, knowing their cared-for person would be supported. Data from the Survey of Adult Carers in England showed 16.00% of carers accessed support or services allowing them to take a break at short notice or in an emergency, which was better than the England average of 12.08%. Further data showed 19.80% of carers accessed support or services allowing them to take a break for more than 24 hours, compared to the England average of 16.14%. Despite these figures being above the England average, further work was identified to develop the use of direct payments for a more flexible approach to planned respite.

Ensuring sufficient capacity in local services to meet demand

There was enough local service provision to meet demand, and people rarely needed to use services outside their local authority area unless their needs could not be met locally. Out-of-area placements were mainly used for people with mental health needs or complex needs. In November 2025, local authority figures showed 343 people were placed out of county, with 239 of these in neighbouring counties. All placements were monitored, and it was noted some were short-term mental health recovery placements in Coventry, which was within the Mental Health Trust footprint and part of the commissioning pathway.

In 2025, the local authority refreshed the Working Age Adults Framework for specialist supported living for people with disabilities, mental health needs, and complex needs. This brought 26 new providers into the market for people needing behavioural support and 18 new providers for those with complex health needs. Further work was underway to increase specialist provision for mental health needs in South Warwickshire, with two schemes in development to provide between 16 and 20 self-contained flats.

Relationships with providers were strong, and care packages were often sourced within a day, especially for hospital discharges. The Brokerage team matched care packages with available vacancies and respected people's preferences wherever possible. Staff submitted detailed requests, including times and any language, gender, or cultural requirements. The Brokerage team then used a geographical mapping tool to find suitable providers. If several providers could meet the requirements, options were shared with staff so the person could choose their preferred provider. Once agreed, the support was arranged, and a contract was completed by the Brokerage team. Spot contracts were also used when needs could not be met through existing arrangements or to support a more bespoke need.

Providers involved in the new home care contract, due to start on 1 December 2025, were linked to a dedicated broker, and meet-and-greet sessions with the commissioning team were arranged. This helped everyone understand their roles and supported strong working relationships for successful delivery.

A pilot project had been set up to source residential and nursing placements in the north of the county. When providers confirmed they could meet a person's needs, staff were informed, and the provider carried out an assessment before operational staff put contractual arrangements in place. The pilot highlighted a shortage of dementia-specific care homes, which was taken forward by commissioning teams for future planning and market review.

Support for hospital discharges reflected good resources to help people return to their usual place of care or access reablement opportunities. Any gaps which delayed discharges were shared with commissioners through quarterly meetings with providers and staff. This had led to targeted commissioning, including the piloting of 10 rehabilitation beds in the north.

The local authority jointly commissioned services and accommodation with the Integrated Care Board and NHS Trust partners and worked with providers to address accommodation gaps for young people in South Warwickshire, particularly for sole properties. Developments such as new bungalows and collaborative work aimed to provide flexible solutions, including direct payments and personal assistants. One provider supporting people vulnerable to domestic abuse offered accommodation for those who could not manage in shared living, such as men, people with care needs, live-in carers, and members of the LGBTQ+ community.

Risks were monitored to identify early warning signs and prevent service disruption. For example, the move from using care homes to using more supported living, had resulted in empty places for some care homes. The local authority had worked with these homes to help them understand future demand so they could adapt their offer to more closely match the requirements.

Ensuring quality of local services

The local authority had clear arrangements to monitor the quality and impact of commissioned care and support services and supported improvements where needed. People receiving care had their support routinely reviewed. One person told us they initially had an issue with a care company, but the concerns were shared and addressed, and they later reported receiving good care. A range of methods was used to manage quality assurance. The Brokerage team provided early indicators, such as delays in responding to packages, and staff could report quality issues. Quarterly meetings were held with partner organisations, including the Care Quality Commission (CQC) and the Integrated Care Board (ICB), to share concerns, emerging themes, or potential risks. All issues were logged on an electronic dashboard and risk-assessed, including data on the number of people affected, and the level of concern was triangulated to prioritise actions.

The local authority worked closely with Quality Assurance Teams within Coventry and Warwickshire ICB under a shared quality assurance strategy for care services through joint commissioning. The See Hear Act Strategy, first developed in 2016 and reviewed in April 2025, set out the approach to quality assurance. It was delivered by the Quality Assurance and Improvement Team, who carried out visits to commissioned services to check quality, support improvements, and share good practice. The strategy used tools such as the See, Hear and Act checklist, provider quality returns, and customer feedback from surveys, complaints, and compliments. It also included a Peer Reviewer programme, enabling people with lived experience to contribute to assessing service quality. However, following a quality monitoring visit, providers highlighted the absence of scoring and thematic feedback in the report, which they said hindered benchmarking. They also said provider forums lacked strategic ownership and clear escalation routes, limiting their influence on wider decision-making. Staff were aware that some providers were advocating for this approach and, having considered it, had decided not to progress it due the challenge of making it authentic and comparable. They described always aiming to give clear, actionable feedback with agreed expectations and timescales to providers.

The quality team had access to occupational therapists (OT) who responded to challenges around equipment, moving and handling, or training needs. For example, incorrect hoist use was flagged, leading to better training and improved outcomes. The OTs also advised on bed rails, safety alerts, and quality issues to prevent recurrence.

The local authority operated a Service Escalation Panel (SEP) to manage providers with serious concerns, defined as risk level 3 (serious) or above. The Operational SEP monitored level 3 risks, while the Strategic SEP oversaw levels 4 and 5, ratified decisions, and ensured senior leaders were sighted on any concerns. During 2025, 15 providers had been reviewed by the panel, with enforcement actions such as placement restrictions applied where necessary, and risk levels regularly reviewed. Providers told us they were supported when risks were identified, with training, guidance and ongoing monitoring. Each provider was linked to quality assurance officers and contract managers for consistent support. When risks emerged, meetings were held to decide who should respond and schedule interventions. For example, when a provider faced a carbon monoxide risk, a risk assessment was completed, and the infection control team was involved ensuring alarms were installed and repairs completed. Where providers failed to improve or engage, the SEP framework was applied, which could lead to placement restrictions, contract management processes, and commissioning actions such as issuing a default notice with an action plan.

The local authority aimed to quality assure all out-of-county placements in line with the See, Hear, Act Strategy. It identified 3 types of placements: framework providers, non-framework providers, and incoming placements to Warwickshire. Framework providers had gone through a procurement process and were included in the standard quality assurance approach. Non-framework providers were monitored using written, observational, and numerical data to identify higher-risk areas, with intelligence gathered from social worker visits, other commissioners, and CQC. Additional data was collected where needed, and in-person visits were carried out only by exception. Significant concerns were referred to the SEP. For incoming placements, where the local authority undertook quality assurance, intelligence was shared with the commissioning body; if not, the commissioning body was informed to make its own arrangements.

Between 2024 and 2025, the local authority managed several provider suspensions and market exits across supported living, domiciliary care, and residential/nursing homes. Reasons included quality concerns, safety issues such as carbon monoxide leaks, staffing shortages, and contractual failures like lack of 24-hour nursing cover. During this period, multiple providers exited the market or returned care packages, all managed in a timely manner, while suspensions were used to prevent unsafe placements and mitigate risks.

Ensuring local services are sustainable

The local authority worked with providers and stakeholders to understand current trading conditions and how providers were coping. Engagement and monitoring arrangements gave early warnings of potential service disruption or provider failure, and contingency plans were in place to ensure continuity of care.

Provider monitoring focused on viability and identifying early warning signs. The local authority used a commercial credit monitoring tool to track provider financial risk, tracked new publications such as County Court Judgements, changes in directors, and underlying trends. When credit ratings dropped significantly, especially for high-value providers, they contacted providers for assurance. A provider viability indicator was developed using Power BI, integrating data on ratings, occupancy, workforce, international recruitment, and agency use. A weighted scoring system flagged high-risk providers for further action.

The local authority worked with care providers to ensure the cost of care was transparent and fair, while supporting long-term sustainability. Fair cost of care exercises for home care and residential care providers were completed in 2022 through wide engagement, including events, emails, and toolkits. Following this, home care worker uplifts were linked annually to the national living wage, and other costs were tied to the consumer price index.

The local authority supported providers with fee structures and National Insurance costs. Providers told us the local authority was transparent in supporting wider costs and had developed a quicker approach to ensure payments were processed when spot contracts were purchased. Providers could also negotiate fees and staffing levels for people with high needs being discharged. However, some sustainability pressures remained, with some voluntary community and social enterprise sector groups not receiving annual uplifts, leaving them to subsidise services to maintain standards.

Providers were supported with recruitment through a learning and development programme, which included a platform to advertise jobs and proactive engagement with overseas workforce licences. Recruitment fairs were organised with the Department for Work and Pensions, universities, and colleges to widen reach. Regular newsletters shared training opportunities, funding options, and grants (for example, for training, internet upgrades, flood resilience). Dementia training was delivered in extra care settings, focusing on non-pharmaceutical approaches. Training for provider staff aged 55+ in maths and English was provided in partnership with local colleges, delivering 30 Level 3 Health and Social Care diplomas. The peer mentorship programme, initially a 1-year pilot, was sustained for 4 years, showing its long-term value in supporting mental health provision.

The Escalation Framework included actions when providers exited the market for reasons unrelated to quality or safety. A provider failure checklist ensured all key activities were completed, and the Strategic Service Escalation Panel supported the process to protect people using these services. Each provider had a Business Failure Contingency plan, reviewed annually or after an incident. A recent example was when a provider had a power outage; the plan was implemented, and generators were used to ensure people's safety.

Partnerships and communities

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 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 align strategic priorities and responsibilities, demonstrating mature and embedded partnership working which supported both local and national objectives and improved outcomes for people.

Warwickshire County Council worked collaboratively with health, housing, emergency services, and voluntary sector partners to deliver shared objectives. This was underpinned by a robust Joint Strategic Needs Assessment (JSNA) process, which involved consultation with over 2,000 residents and 300 organisations. The JSNA informed commissioning priorities and shaped strategies such as the Health and Wellbeing Strategy 2021–2026, which focused on prevention, resilience, and reducing inequalities. Life course JSNA reports, such as Empowering Futures: Growing Up Well in Warwickshire were developed to provide live, interactive data and insight across age groups, supporting targeted planning and continuous improvement.

The local authority integrated aspects of its care and support functions with partner agencies where this reflected best practice and demonstrated improved outcomes for people. A Section 75 agreement with NHS partners supported delegated delivery of mental health services, with co-located teams and shared responsibilities for aftercare. Staff were employed and managed by the local authority, and the arrangement was described by a Trust leader as well-tempered and transparent, with no concerns raised. Similarly, the Home Environment Assessment and Response Team (HEART) operated under a Section 101 agreement, bringing together 5 district and borough councils with the County Council to deliver housing adaptations and improvement agency responsibilities. This was one of the first shared services of its kind nationally and enabled consistent, responsive support for people needing adjustments to remain safely at home.

The Better Care Fund (BCF) further supported joint working across health and social care. It funded programmes such as Hospital to Home, intermediate care, carer support, and discharge planning. Shared dashboards monitored discharge pathways, and joint-funded posts enabled responsive coordination. Leaders shared their BCF 2025-26 plan with us which outlined Warwickshire's strategic vision for integrated health and social care, structured around BCF priorities. While some parts of the BCF plan focused more on planned activity than lived experience, it did demonstrate strong governance, pooled budgets, and a clear commitment to prevention and reablement.

Public Health played a central role in partnership delivery. Five dedicated teams led work on health protection, mental health and harm reduction, children and young people, inequalities, and prevention. These teams mobilised services such as substance misuse support, vaccination uptake, and weight management programmes. Public Health also contributed to joint posts and business cases, helping shape the JSNA and drive prevention initiatives like the stop smoking service. Their work was aligned with the Health and Wellbeing Board and supported by community engagement, including visual storytelling and public contributions to the Director of Public Health's annual report.

Operationally, partnership working was embedded across services. The Fire Service supported joint visits and safe-and-well checks, particularly for people reluctant to engage, helping build trust and access. They also played a key role in the Hospital to Home programme, transporting people safely from hospital and helping them settle back into their homes. This reduced discharge delays, eased pressure on hospital beds, and supported emotional wellbeing by ensuring people returned to a warm, safe environment with practical help and follow-up support. The Emergency Duty team worked closely with police, hospitals, and mental health crisis teams to provide safe, multi-agency responses. Occupational therapists were embedded in learning disability teams, rotating intake responsibilities and advising on adjustments. These examples showed how integrated working supported timely, person-centred interventions and reduced reliance on formal care.

Overall, Warwickshire's partnership model reflected national best practice and delivered improved coordination, shared accountability, and more personalised support for people.

Arrangements to support effective partnership working

The local authority had clear and well-established arrangements to support effective partnership working, with shared governance, accountability, and pooled resources contributing to improved outcomes for residents.

Information sharing and quality assurance were embedded through regular forums, strategic boards, and shared systems. For example, data dashboards were used to guide assessment processes and enable targeted working, with staff receiving dedicated training and support. Weekly meetings and steering groups allowed providers and commissioners to raise concerns, share feedback, and monitor progress. The Safeguarding Adults Board and Multi-Agency Safeguarding Hub arrangements further demonstrated effective multi-agency coordination, with timely referrals and clear escalation routes. Strategic forums such as the Integrated Care Board, Health and Wellbeing Board, and Warwickshire Care Collaborative enabled system-wide engagement and oversight.

Formal governance arrangements supported joint working across health, housing, and social care. Section 75 agreements underpinned integrated commissioning, and the local authority had sustained these arrangements over time. The Housing Hospital Liaison service and the Community Integrator model showed how shared responsibilities and place-based approaches helped prevent escalation and improve patient flow. The Dual Diagnosis Policy and refreshed homelessness protocols also reflected joined-up planning across complex needs.

The local authority made good use of pooled budgets to deliver better outcomes. The Better Care Fund (BCF) was used to jointly fund services such as Hospital to Home, falls prevention, intermediate care, and carer support. Investment was closely monitored through joint boards and performance reviews, ensuring funding reached the right communities. This contributed to improved discharge pathways, reduced care home admissions, and more seamless integration across health and social care. The Learning and Development Partnership, also funded through the BCF, supported workforce development across the provider market, helping services build capacity, retain staff, and deliver safe, high-quality care. The partnership also oversaw international recruitment support and coordinated training needs analysis to shape future provision.

Warwickshire County Council had strong and well-organised partnership arrangements that helped deliver support focused on people's needs. While some areas identified opportunities for further integration, the overall system was built on mutual trust, shared goals, and good teamwork across organisations.

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. Leaders were able to demonstrate tangible impact of partnership working across Warwickshire's adult social care system. Joint initiatives between the local authority, health services, housing teams, emergency services, and voluntary sector partners had helped to stop services working in isolation and embed collaborative practice into day-to-day operations. Examples such as co-located teams, shared assessments, and cross-agency funding models showed how integrated working had improved access, responsiveness, and continuity of care.

Multi-agency approaches to self-neglect and hoarding enabled more effective engagement with people who were previously hard to reach, while partnerships under the Housing Act duty to refer ensured timely support for those at risk of homelessness. Preventative services delivered through community helplines, wellbeing workshops, and digital platforms extended support beyond office hours and into local spaces. This approach increased accessibility, reduced barriers to support, and strengthened early intervention. By offering preventative services outside traditional hours and in familiar community settings, people could seek help when they needed it most, without waiting for formal appointments or navigating complex systems. This would likely reduce crisis escalation, ease pressures on statutory services, and promote emotional wellbeing by meeting people where they are.

The local authority and their Voluntary, Community, Faith and Social Enterprise (VCFSE) partners demonstrated a maturing system of joined-up care, with shared leadership, devolved decision-making, and a commitment to improving outcomes through collaboration. Leaders described partnership working as strong, well-embedded, and beneficial to residents. Collaboration across health, housing, public health, and social care enabled joined-up planning, shared oversight, and more responsive frontline delivery. Strategic forums supported consistent decision-making, while place-based partnerships and joint committees helped align priorities. Practical impacts included improved hospital discharge processes, better support for people with no recourse to public funds, and more future-proofed housing. Multi-agency responses to fire-related deaths had led to clearer guidance and better engagement with emergency services. Overall, leaders felt partnership working strengthened assurance, promoted independence, and supported continuous improvement.

Partners described their relationship with the local authority as collaborative, responsive, and rooted in shared values. Joint initiatives supported emotional wellbeing, improved hospital discharge planning, and strengthened outreach to underserved groups. Pilot schemes enabled property adaptations for people with physical and sensory needs, shaped by lived experience. Feedback from community organisations influenced adult social care practices, with co-production built through trust and ongoing engagement. Partners valued the local authority's active involvement in meetings, peer groups, and service development, describing it as a critical friend. While some partners noted challenges around communication and funding pressures, they welcomed opportunities to deepen collaboration and improve inclusion. Overall, partnership working was seen as a driver of innovation, connection, and better outcomes for local people.

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. They provided funding and other support opportunities to encourage growth and innovation. For example, Warwickshire County Council worked with voluntary and community sector partners to co-produce a peer mentorship programme for young adults, embedding lived experience and youth voice at every stage. The programme was developed in collaboration with local charities and the Children and Young People's Board, ensuring it reflected the real needs and perspectives of those transitioning between child and adult mental health services.

Alongside this, the local authority promoted visibility and engagement with voluntary sector organisations through community pop-ups and wellbeing events, helping to raise awareness and strengthen local connections. The mentorship model offered one-to-one and group support, helping young people build confidence, develop coping strategies, and access community resources in a safe and inclusive environment.

Warwickshire's adult wellbeing service was delivered through a partnership between the local authority and a range of Voluntary, Community, Faith and Social Enterprise (VCFSE) organisations. Together, they offered a single access point for mental health and wellbeing support for adults, including drop-in hubs, helpline support, online counselling, and community-based activities. The model enabled multiple access routes such as, digital, phone, and in-person contact and was supported by resource packs and outreach to local venues and leaders to promote mental health awareness. Volunteers and peer support played a key role in reducing isolation and strengthening community resilience. This approach reflected a preventative, co-produced model that embedded lived experience and supported early intervention.

A local homelessness charity, working in partnership with the Warwickshire County Council, supported people in the Warwickshire and Coventry areas to rebuild their lives through stable housing and meaningful daily activities. Those supported took part in running a community shop, collecting donated items, and helping with household tasks. This approach helped boost confidence, build new skills, and raise funds to sustain the service. It made a lasting difference by reducing isolation and enabling people to reconnect with their community.

Staff described strong and varied partnerships with VCFSE groups which helped deliver tailored, dignified support. These links promoted independence, routine, and emotional wellbeing, particularly through services that respected personal preferences, such as helping people rehome items rather than discard them. Teams signposted to VCFSE and health services when people weren't eligible for formal support and arranged advocates who sometimes joined meetings to discuss housing and care options. Joint visits and multi-agency meetings supported continuity and clarity, especially during transitions to care homes. Carer support was proactive and well-connected, with timely referrals helping to prevent breakdowns in informal care. A political leader told us the VCFSE partners viewed the local authority as an engaged and reliable collaborator and raised no concerns about the relationship. A partner told us, the local authority demonstrated a genuine commitment to improving outcomes for unpaid carers, aligning with the organisation's goals to support carers in leading fulfilling lives and being recognised and valued.

Theme 3: How Warwickshire County Council ensures safety within the system

This theme includes these quality statements:

- Safe pathways, systems and transitions
- Safeguarding

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

Safe pathways, systems and transitions

Score: 3

3 - Evidence shows a good standard

What people expect

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

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

The local authority commitment

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

Key findings for this quality statement

Safety management

Safety was a priority for everyone. The local authority understood the risks to people throughout their care journeys and identified and managed these risks proactively. Policies and procedures were aligned with partner organisations, and monitoring was ongoing, with feedback from people using or experiencing the service. There was senior-level oversight and a strategic approach to managing and reducing safety risks.

The joint development of the Community Recovery Service (CRS) with the NHS trust had led to reduced hospital stays and readmissions, and supported discharges, which were often completed in under two days. Positive feedback had been received from both partners and people on the impact of the service. Reablement was also available, providing a well-managed service with built-in reviews at 2 and 4 weeks. These enabled timely adjustments, with social care staff coordinating care packages and ensuring a smooth handover for longer-term support.

The local authority worked proactively with partner agencies to agree roles, responsibilities, and accountabilities for shared priorities such as the Better Care Fund, Continuing Health Care (CHC), and hospital discharge duties. Joint protocols, including Memorandums of Understanding for CHC and Section 117 aftercare, supported collaborative funding decisions and clarified responsibilities between health and social care. This enabled a "care first, funding later" approach, where support was put in place without delay, even when eligibility or funding arrangements were still being determined, helping to reduce disputes and improve working relationships.

Joint arrangements with NHS partners were in place to meet duties under Section 140 of the Mental Health Act. This included an approach to suitable aftercare and placements for people discharged from hospital under specialist mental health orders. The agreement set clear expectations for notification, planning, funding, and accountability among agencies.

There was a collaborative approach to transitions, with education, health, and social care partners delivering a person-centred approach for young people moving into adulthood. Multi-agency working included children's disability services, transition nurses, CHC, care leaver advisors, and community learning disability teams, ensuring timely assessments and continuity of care. The Preparing for Adulthood Guidance outlined the local authority's approach to managing both out-of-county and cross-border placements, in relation to Care Act duties and considerations of ordinary residence. The guidance detailed coordinated funding, information sharing, risk management, and continuity of care.

The local authority's approach aimed to ensure continuity of care when people moved between services, using the principle "Stay with Me" to promote consistent relationships and support people's pathways. Information-sharing protocols ensured safe, secure, and timely sharing of personal information, while protecting people's rights and privacy. From the initial request, information was triaged, risk-rated, and shared with the most appropriate staff to avoid repetition for people.

An approach had been developed with some providers from the main homecare contract, which was used to create a block contract specifically for hospital discharge. Homecare support was offered for up to six weeks, and when longer periods of support were needed, people continued with the same provider. Despite these new arrangements, some providers and staff reported confusion around the discharge pathways, particularly the inconsistent use of step-down beds and unclear processes for returning people to care home placements. This highlighted the need for clearer guidance and improved coordination in these areas.

Warwickshire's Ordinary Residence Guidance set out internal procedures for determining and reviewing responsibility under the Care Act for people receiving care across borders. The guidance supported staff to manage placements, coordinate funding, share information, and manage risks.

Safety during transitions

Care and support were planned and organised with people, alongside partners and communities, in ways that improved safety across care journeys and ensured continuity of care. This included referrals, admissions, discharges, and transitions between services.

Hospital discharge processes and pathways ensured people were discharged safely. One person we spoke with had experienced several hospital admissions and discharges, which they described as well-coordinated, with the right equipment and timely referrals to other services. Discharge pathways had been strengthened through face-to-face holistic assessments, trusted assessor referrals, and collaborative decision-making with health professionals. This enabled safer, person-centred transitions from hospital to home or care settings.

Despite winter pressures and fluctuating demand, delays were mitigated through clear communication, consistent staffing, and co-produced planning. Providers told us that when people transferred between services, this was coordinated well, with strong communication and partnership working.

There was an established pathway for autistic people and people with a learning disability. This included a 12-point discharge protocol to support professionals in acute settings when admitting and planning hospital discharges. Autistic people in Coventry and Warwickshire, or those awaiting a diagnosis, could access personalised support through the all-age Community Autism Support Service (CASS).

When people needed a change in accommodation after a hospital admission, support was provided through the Housing Hospital Liaison Service. This service worked across hospitals and the community to promote safe discharges and supported people who were homeless or had new housing needs due to medical issues, hoarding, or neglect of home conditions.

Unpaid carers were considered throughout. Healthwatch had engaged with carers in 2021 about their discharge experiences, which informed the carers action plan and the retender of the Carer Wellbeing Service in 2022. Further support was provided through the Accelerated Reform Fund, which helped embed carer support in hospitals via a Hospital Carer Liaison Service. This service signposted people to community groups, resources, and any identified statutory services. The Carers Response Emergency Support Service (CRESS) was introduced to provide unplanned respite, enabling carers to attend appointments or take a break to support their wellbeing.

Transition arrangements began early to ensure seamless care and support when responsibility moved from children to adult services. A Preparing for Adulthood pathway, underpinned by guidance, supported staff from adult and children's teams to work closely and collaboratively with young people and their families. The team was supported by a Power BI dashboard tracking all young people allocated to the Children with Disabilities Team from age 14. Since its introduction, referrals for 14 and 15-year-olds had increased significantly, reducing the risk of late referral and enabling earlier transition planning.

Young people were typically allocated to staff at age 16 and assessed before turning 18, with strong family engagement and advocacy support. Staff used a strengths-based approach, prioritising young people's aspirations and involving them in shaping their plans, including chairing their own reviews. Flexible solutions addressed complex needs or accommodation issues, such as supported living. Occupational therapists provided continuity through shared digital records, enabling early liaison around equipment. This also supported Education, Health and Care (EHC) plans and property moves, helping young people and adults experience safer, more coordinated transitions.

A bespoke case file audit was developed to evaluate delivery and outcomes of the transition pathway. Oversight and ongoing development continued through joint training and learning. Parents moving into the role of unpaid carers were supported early with legal guidance around the Mental Capacity Act and provided with detailed transition packs. However, some parent carers told us communication could be improved around information and service opportunities compared to children's services.

The local authority had an out-of-hours team that provided support and continuity for people needing help outside standard working hours. The service covered both children and adult services, and following a recent review, staffing levels were increased. Managers continued to record and review workflow and any emerging themes.

Staff told us there was a clear handover between daytime and out-of-hours teams to ensure people's needs were followed up. This was supported by a specific referral form to ensure all required details were included. Staff also told us managers were supportive and always available when incidents occurred or when senior guidance was needed. People needing mental health assessments were able to access support from AMHPs within the crisis team.

Specific consideration was given to protecting the safety and wellbeing of people using services located away from their local area, or when moving between local authority areas. These placements were only used when local options weren't available. Local authority data showed these placements were typically for people with complex learning needs, dementia, or specific mental health support. Many out-of-area placements were in bordering counties, and placements for people with mental health needs were linked to the pathway approach with Coventry. When used, these placements were carefully assessed and regularly reviewed to ensure they continued to meet the person's needs.

Contingency planning

The local authority had a planned approach for responding to unplanned events and potential interruptions in the provision of care and support. It understood how to respond to different scenarios and worked proactively with providers, partner agencies, and neighbouring authorities to minimise risks to people's safety and wellbeing.

Providers were expected to maintain contingency plans, which were monitored by the local authority. The local authority used a detailed Managing Business Failure Checklist to respond to sudden provider collapse. This included roles, key contacts, financial assessments, safeguarding risks, and placement continuity planning. The checklist supported rapid mobilisation and minimised disruption to care, with clear communication routes and data verification.

Warwickshire's Emergency Management Plan provided clear direction for major incidents, including those affecting adult social care. It outlined civil contingency responsibilities, gold/silver/bronze command structures, and multi-agency coordination during declared emergencies. The Emergency Management Plan complied with national legislation and clearly defined the roles of key public bodies, such as the local authority, NHS, and emergency services in responding to major incidents.

Contingency arrangements were also embedded in frontline practice. Staff told us that carers could access the Carers Response Emergency Support Service (CRESS), which offered up to 35 hours of sitting support and was integrated into care assessments. Respite was increased for some families, and contingency plans were included in assessments, with named contacts identified for emergencies. However, feedback from carers showed mixed experiences, some felt assured by the emergency carers card, while others had not been offered one or were unsure how it worked. Some carers also felt options for respite and breaks could be improved.

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

The safeguarding system demonstrated strong, well-embedded processes with timely responses, clear accountability, and effective multi-agency collaboration. Roles and responsibilities were clearly defined, and safeguarding concerns were triaged without delay through a dedicated adult safeguarding team. Structured pathways supported consistent decision-making, and all cases were allocated promptly. Initial risk assessments typically met the two-working-day target, and safeguarding practice was embedded in monthly audits using dedicated tools, including for self-neglect. Quality assurance was promoted through peer discussions, managerial oversight, and live dashboards which tracked performance and outcomes.

Multi-agency working was a clear strength, with active representation at the Multi-Agency Safeguarding Hub, where professionals from adult social care, police, health, and other services worked together to share information and make timely decisions. The local authority also participated in the Multi-Agency Risk Assessment Conference, which focused on protecting people at high risk of domestic abuse through coordinated safety planning. In addition, the authority contributed to the Multi-Agency Public Protection Arrangements, which supported the management of people who pose a risk to others, including those with a history of serious offending. A joint escalation protocol was in place to support lawful, rights-based decision-making under the Mental Capacity Act, helping prevent disputes and ensuring consistent safeguarding practice across agencies.

The move to a dedicated Safeguarding Adults Board in 2024 reflected a commitment to adult safeguarding as a distinct priority. The Board's Strategic Plan 2025–2028 focused on awareness, prevention, and person-centred practice, with progress monitored through subgroups and regular meetings. Lessons from Safeguarding Adults Reviews were shared through briefings and training, and advocacy referrals were actively supported.

Partners described the system as responsive and collaborative. They highlighted early identification of concerns, improved staff awareness, and effective mobilisation in response to risk. Some partners raised accessibility issues, such as the need for an online referral portal, which was acknowledged by safeguarding leads. Providers reported strong relationships with the safeguarding team and confidence in raising concerns, though some noted gaps in feedback on outcomes.

Data from the Adult Social Care Survey 2024 supported the effectiveness of safeguarding arrangements. It showed 76.85% of people who used services felt safe, which was better than the England average of 71.06%. Likewise, 93.03% of people who used services said those services made them feel safe and secure, which was also better than the England average of 87.82%. Data from the Survey of Adult Carers in England 2024 was also positive. It showed 79.41% of carers felt safe, which was also similar to the England average of 80.93%. The system demonstrated a mature safeguarding culture, underpinned by strong leadership, robust processes, and a commitment to continuous improvement.

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.

In 2023–2024, adults in Warwickshire faced a range of safeguarding risks, with the most common being financial abuse, physical abuse, and self-neglect. Safeguarding activity increased significantly, with a 10% rise in concerns and a 58% increase in formal enquiries. Most alleged perpetrators were known to the person, and the main support needs identified were physical support, memory and cognition, and learning disabilities. The local authority also responded to complex risks such as exploitation, mental health and substance misuse, and high-risk behaviours among adults who had capacity but were living in unsafe conditions. New guidance and multi-agency processes were developed to manage these risks.

Lessons were learned when people had experienced serious abuse or neglect, and action was taken to reduce future risks and drive best practice. In 2023–2024, the Warwickshire Safeguarding Adults Board (WSAB) reviewed 5 cases through its Safeguarding Adults Review (SAR) process, with 1 progressing to an Alternative Learning Review. The reviews identified recurring themes including a lack of professional curiosity, disguised compliance, poor use of escalation procedures, and challenges linked to self-neglect. One case highlighted important learning around mental health, self-harm, hoarding, transitions between services, and the need for a 'Think Family' approach. Lessons learned from SARs were actively shared with frontline teams through training, briefings, and updated guidance, helping to strengthen safeguarding practice across partner agencies. A senior leader told us learning from reviews led to clearer processes for developing and sharing learning plans, with the Principal Social Worker playing a key role in embedding these across teams. Practice improved through targeted sessions on self-neglect, hoarding, and positive risk-taking, supported by bitesize reviews and briefing notes that ensured learning was accessible and acted upon. The WSAB provided robust governance, with a clear strategic plan, active subgroups, and an independent chair to ensure scrutiny and accountability.

A partner shared that, following key learning from SARs, professionals were advised to strengthen their understanding of safeguarding issues by reading briefings on adult self-neglect, the Mental Capacity Act, and home invasion. They were encouraged to use the West Midlands Self-Neglect Guidance and the Exploitation Toolkit, alongside resources from the local safeguarding website, to help recognise signs of exploitation. Where adults were difficult to engage and faced serious risks, staff were prompted to consider convening a Vulnerable Adult Risk Management (VARM) meeting. Communities were also urged to report concerns about exploitation directly to the police, and to use Crimestoppers to share information about county lines and cuckooing. These actions aimed to improve awareness, strengthen safeguarding responses, and promote collaboration across agencies and the wider public.

Responding to concerns and undertaking Section 42 enquiries

Safeguarding practice in Warwickshire was strong, with clear thresholds for Section 42 enquiries and a well-understood process for determining when formal safeguarding action was required. Staff applied these thresholds consistently, with clear rationales and outcomes recorded for all initial enquiries, including those that did not progress. All safeguarding staff were qualified to undertake Section 42 enquiries, supported by peer discussion, managerial oversight, and flexible, person-centred approaches that prioritised relationships and responsiveness. Quality assurance was embedded through structured case sign-off, peer group forums, and oversight arrangements that promoted professional curiosity, shared learning, and confident decision-making.

Staff across teams demonstrated responsive and collaborative safeguarding practice. For example, one team coordinated support for a person facing financial and substance misuse, leading to a Section 42 enquiry and a move to supported living. Another team responded to an anonymous neglect concern involving cuckooing, working with police and housing to secure the property, freeze bank accounts, and relocate the person safely. Staff working with people with learning disabilities described safeguarding as effective, with enquiries carried out jointly or escalated to the safeguarding team when needed. Quality assurance staff linked safeguarding with broader service improvement, logging outcomes, sharing learning through forums and newsletters, and feeding insights into training.

Between 2020 and 2023, the number of adult safeguarding concerns rose from 2,275 to 4,140, with the proportion of cases progressing to formal Section 42 enquiries ranging from 7% to 17% peaking in 2020 and increasing again to 11% in 2023. The most common safeguarding themes in 2023–2024 were financial abuse, self-neglect, and physical abuse, with most alleged perpetrators known to the person. As of October 2025, no one was waiting for a response after raising a safeguarding concern; all were triaged immediately and allocated where needed. Data provided by the local authority in October 2025 showed 170 concerns open, 71 enquiries open, and 20 safeguarding plans in place and acted upon to reduce future risks.

As of October 2025, there were 560 outstanding Deprivation of Liberty Safeguards (DoLS) assessments in Warwickshire, all classified as low priority in line with guidance from the Association of Directors of Adult Social Services (ADASS). The median wait time was 55 days, with the longest low-priority case waiting 152 days. The longest wait for a high-priority case was 8 days. Using ADASS priority ratings enabled the local authority to benchmark its performance against nationally recognised standards. DoLS had recently been incorporated into the data system, with business intelligence teams taking over statutory returns and ongoing discussions underway with DoLS management about future reporting requirements.

Where safeguarding enquiries were conducted by another agency, such as a care or health provider, the local authority retained responsibility for oversight and outcomes. Relevant agencies were informed of safeguarding enquiry outcomes when necessary to protect the person's ongoing safety.

A recent Child Safeguarding Practice Review involving a parent with a learning disability supported by adult social care highlighted gaps in how the local authority assessed and supported adults with parenting responsibilities. In response, 4 actions were taken: staff were reminded of their duty to consider parenting roles during Care Act assessments; new guidance was developed to support best practice; stronger links were built with children's services to clarify roles and responsibilities; and commissioners explored options for specialist support providers.

Providers told us safeguarding processes worked well overall, supported by strong relationships, clear discussions, and improved oversight. They highlighted better escalation routes, stronger record-keeping, and effective feedback loops, particularly in sharing learning from Safeguarding Adults Reviews. Provider survey responses reflected a positive approach to safeguarding and access to guidance, though some providers noted mixed experiences in understanding outcomes and follow-up actions, suggesting room for improvement in closing the loop.

Partners shared varied experiences in responding to safeguarding concerns and undertaking Section 42 enquiries. One partner told us practitioners acted on safeguarding concerns observed during assessments, ensuring both carers and cared-for people were protected. They described effective joint working with the local authority to support young carers, especially following changes to their caring role, and noted home visit assessments helped identify and escalate risks. However, another partner highlighted challenges with the safeguarding referral process, describing it as convoluted, particularly under arrangements where referrals were directed to mental health teams. They felt this could confuse families and reported difficulty in determining whether cases met the Section 42 threshold.

Making safeguarding personal

Making Safeguarding Personal (MSP) is a national initiative which places people at the centre of adult safeguarding. It focuses on what matters most to a person, rather than simply following a process. MSP is grounded in the Care Act 2014, which requires safeguarding to promote wellbeing and uphold 6 key principles: Empowerment, Prevention, Proportionality, Protection, Partnership, and Accountability.

Safeguarding enquiries were carried out sensitively and without delay, keeping the person's wishes and best interests at the heart of the process. Staff described a strong culture of strength-based practice. Conversations began openly, and wherever possible, staff spoke directly to the person and involved advocates when needed. Peer discussions, known as strength-based discussions, helped maintain a personalised approach. Staff routinely asked people what outcomes they wanted to achieve and ensured they remained central throughout.

As soon as a concern was raised, the person was informed and offered support. Safeguarding was always transparent and never carried out in secret. When referrals were made, staff checked whether consent had been given. If not, the referral still proceeded, but staff asked the referrer to speak with the person.

People had access to the information they needed to understand safeguarding, what being safe meant to them, and how to raise concerns, whether about themselves or others. They were supported to participate in the safeguarding process as much as they wished, with access to advocacy where needed. People were also helped to understand their rights, including their human rights, rights under the Mental Capacity Act 2005, and the Equality Act 2010. They were supported to make choices that balanced risk with positive control in their lives.

Data from the Safeguarding Adults Collection 2024 showed 85.71% of people who lacked capacity were supported by an advocate, family member, or friend, which was similar to the England average of 83.38%. Locally, the Warwickshire Safeguarding Annual Report 2023–2024 showed 61.8% of people were asked about the outcomes they wanted, demonstrating commitment to the principles of Making Safeguarding Personal.

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

Warwickshire County Council had a stable adult social care leadership team with clear roles and responsibilities. Senior leaders were visible, approachable, and actively involved in governance, performance, and frontline practice. Warwickshire was described by staff as a great place to work. They described a supportive culture where concerns were listened to and escalated confidently, and leaders were seen as compassionate and capable. Staff felt more valued and empowered, compared to other local authorities they had worked for, reflecting a well-embedded leadership model that promoted trust, accountability, and service quality.

There was clear operational management and workforce governance in place. Structured recruitment and retention strategies such as progression pathways, targeted campaigns, and streamlined vacancy tracking which helped stabilise staffing and reduce reliance on agency workers. These actions supported service continuity and contributed to the delivery of Care Act duties. Governance and accountability were embedded across strategic, political, and operational levels. The creation of a dedicated Social Care and Health Directorate, with strengthened senior leadership, enabled focused oversight and closer integration with health services. Performance was regularly monitored through directorate meetings, scrutiny committees, and elected member engagement, ensuring visibility of risk, finance, and delivery against plans.

Warwickshire had clear and well-structured risk management arrangements, with internal and external escalation routes in place. Risk oversight was robust, with daily monitoring taking place. These mechanisms enabled leaders to identify and respond to risks quickly and in coordination with partners, supporting service continuity and transparency. This approach reflected good governance and aligned with Care Act duties and integrated system leadership. Evidence from the corporate risk summary and adult social care risk reports confirmed that risks were actively monitored and escalated when needed.

Cross-sector governance was evident in the co-produced Strategic Housing Action Plan, which aimed to improve outcomes for people with learning disabilities and autism. Strategic safeguarding priorities and the Adult Social Care Innovation and Improvement Programme Board reinforced a system-wide focus on quality, prevention, and continuous improvement. The local authority's layered governance model spanning strategic boards, operational teams, and partnership forums demonstrated shared accountability and integration, particularly through joint commissioning and Section 75 arrangements. The Quality Assurance Framework and risk reports supported systematic performance monitoring and identification of vulnerabilities. Overall, the governance infrastructure provided a solid foundation for managing risks and sustaining service quality.

Senior leaders described a confident and reflective system, underpinned by visible leadership, a collaborative culture, and data-informed decision-making. Governance was strengthened through regular engagement with staff, scrutiny committees, and people with lived experience. Performance was tracked through dashboards aligned to the strategic vision for adult social care. The Director of Social Care and Support, Principal Social Worker, and Principal Occupational Therapist played active roles in shaping practice and embedding quality assurance. Leaders emphasised a values-led, high-trust culture where professional judgement was respected and person-centred care remained a priority. Frontline staff reported strong managerial support, active knowledge sharing, and co-location with NHS teams all contributed to workforce stability and integrated practice.

Partners described a governance system built on collaboration, stability, and shared accountability. They highlighted positive early engagement with new political leadership and a shared willingness to address operational challenges together. They told us, robust structures enabled delegated decision-making and cross-sector representation, with joint decision-making being supported through formal governance boards, with active involvement from adult social care leaders and the use of shared data platforms to drive quality improvement. Overall, partners expressed confidence in the system's ability to collaborate effectively, share intelligence, and maintain service continuity through well-established governance arrangements.

The local authority's political executive members were also visible, approachable, and actively engaged in adult social care, with structured meetings and open dialogue that supported trust and accountability. Risks were monitored and reflected in the corporate risk register, and senior leaders used this intelligence to inform decisions. The Lead Member for Adult Social Care had received strong officer support and sought frontline insight, showing growing awareness of service pressures. However, members noted that adult social care was not consistently prioritised in wider council discussions. This indicated that while executive oversight was strong, political integration and strategic influence were still developing.

Strategic planning

The local authority used information about risks, performance, inequalities, and outcomes to shape its adult social care strategy and deliver meaningful improvements for people. The adult social care priorities, safeguard, support, and satisfy were closely linked to the council's wider goals, helping ensure services promoted safety, independence, and positive experiences. This alignment gave the Social Care and Health Directorate a clear framework for strategic planning, making it easier to set priorities, direct resources to where they were most needed, and measure progress across different areas of people's lives.

For example, the Adult Social Care Strategy (2024–2030) focused on helping people live well and independently, using information about risks, performance, inequalities, and outcomes to guide its decisions. Leaders looked at data from service reviews, audits, and community feedback to understand where people were struggling and what support made the biggest difference. It used this insight to shape its priorities, fund preventative services, and co-produce action plans with local people and partners. Resources were targeted at areas of greatest need like early help, digital tools, and support for unpaid carers, and progress was tracked through dashboards and national comparisons. Governance structures ensured people's voices were heard and services kept improving.

In particular relation to unpaid carers, the Adult Social Care strategy demonstrated a clear commitment to unpaid carers through a co-produced approach focused on person-centred care, equity, and governance. Leaders used data on risks, inequalities, and outcomes alongside lived experience and service feedback to identify where carers faced barriers and to shape responsive, preventative support. Resources were allocated to areas of greatest impact, such as respite, peer networks, and digital inclusion, with carers actively involved in designing and reviewing services. Performance was monitored through outcome dashboards and benchmarking, ensuring continuous improvement and transparency. Governance structures embedded carer voice in decision-making, evidencing a culture of learning, partnership, and accountability.

The local authority had not developed a standalone carers strategy but had embedded a robust carers action plan within the Adult Social Care strategy, ensuring alignment and oversight through a dedicated steering group. The action plan remained in draft, with ongoing work to strengthen the carers pathway and integrate priorities. Progress included clearer strategic alignment and governance, while challenges centred on finalising the action plan and ensuring carers' needs were fully reflected without a separate strategy. The approach aimed to embed carers support within broader system improvement rather than isolate it.

Warwickshire County Council had worked with Coventry City Council to develop a joint Autism Strategy which aimed to improve support for autistic people of all ages. They used information about risks like late diagnosis and poor transitions, alongside performance data, feedback, and national research to understand where services were falling short. Inequality data helped them identify gaps in access to health, education, and employment, and they used this insight to shape priorities and direct resources to areas of greatest need. The strategy focused on early identification, reasonable adjustments, and inclusive communities, with autistic people and families involved in designing and reviewing services. Progress was tracked through a delivery plan and regular updates to senior leaders, ensuring services kept improving and people's voices were heard. Unpaid Carers told us how they had supported the development of the Autism strategy to support the structure. A project lead guided the experts by experience and professionals and looked at work streams. This work was linked to the learning disability partnership which was co-chaired by people with lived experience. Initially the meetings were every 6 weeks, and support was available encouraging questions and ideas.

Partners, staff and unpaid carers highlighted some challenges. These included issues around communication and coordination between health and social care, particularly in relation to Continuing Healthcare and discharge pathways. Strategic planning for transitions, respite, and emergency support for carers (especially at the interface between children's and adult services) was also cited as having shortfalls. However, we found the overall approach to strategic planning was robust. It was grounded in evidence about risks, performance, inequalities, and outcomes, which enabled adult social care to be more targeted, inclusive, and effective. By aligning its priorities with the council's wider strategic goals and embedding co-production throughout, the Social Care and Health Directorate was able to direct resources to where they were most needed, design services around lived experience, and monitor progress transparently. This strengthened the system's ability to safeguard people, support independence, and deliver care that genuinely improved outcomes for people and communities.

Information security

The local authority had effective arrangements in place to maintain the security, availability, integrity and confidentiality of data, records and data management systems. These arrangements were aligned with legislative requirements and supported compliance with the General Data Protection Regulation (GDPR). Leaders consistently emphasised the importance of information governance as integral to daily practice across the directorate. Staff demonstrated a sound understanding of information security protocols, including password protection and access controls. Access to systems was appropriately restricted to trained personnel, with tiered permissions ensuring only authorised staff could view or edit specific data. Mandatory training and regular reminders reinforced a culture of accountability and risk mitigation in relation to data handling.

Learning, improvement and innovation

Score: 4

4 - Evidence shows an exceptional standard

The local authority commitment

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

Key findings for this quality statement

Continuous learning, improvement and professional development

Warwickshire County Council demonstrated an inclusive and values-led culture of continuous learning and improvement. Staff across adult social care had regular access to learning opportunities, reflective spaces, and structured supervision, which supported safe and effective delivery of Care Act duties. For example, one team held twice-daily peer groups to support real-time learning. Across the Social Care and Health Directorate, all staff received supervision every 4-6 weeks, embedding professional development into everyday practice.

Leaders modelled a learning culture through visible and responsive engagement. Warwickshire was described by staff as a great place to work with senior managers regularly joining team drop-ins, shadowing frontline staff, and maintaining open-door support. The Director of Adult Social Care shared regular updates through 'Pete's Tweets' short, informal messages that celebrated good practice, highlighted priorities, and offered encouragement. Staff described them as friendly and down-to-earth, helping simplify complex messages and connect teams to the wider vision. These updates contributed to a culture of openness and learning, where staff felt informed, valued, and supported. Staff reported feeling heard, with wellbeing embedded in team culture and supervision.

Continuous professional development (CPD) was well-supported. Staff described Warwickshire as a great place to grow professionally. Staff accessed tailored CPD pathways, apprenticeships, and secondments, including for non-qualified roles. Feedback from staff highlighted the positive impact on retention and progression. Workforce planning was informed by live data, with "grow your own" strategies and targeted recruitment shaped by business intelligence. Staff told us they were proud of the life-changing impact of their role, supporting independence, empowering people, and delivering meaningful outcomes. A strong sense of team belonging, low turnover, and visible wellbeing initiatives like wellbeing champions and in-person meetups fostered a supportive culture.

The local authority worked collaboratively with people and partners to promote innovation. The distinction between co-design and engagement was well understood, and people with lived experience helped shape frameworks, recruitment, and service design. Experts by Experience played a central role, supported by commissioned partners and dedicated co-production workers. Their input led to tangible improvements, including the co-produced autism e-booklet, inclusive language changes, and redesigned services such as Carers Response Emergency Support service (CRESS) and the night care element of the new home care contracts. Following this external input, the local authority strengthened its internal capacity by recruiting its own co-production leads. Leaders recognised gaps in representation and took active steps to broaden engagement, including rural carers and parent carers. Co-production reference groups reviewed strategic themes and actions, ensuring lived experience shaped decision-making.

Equality, Diversity and Inclusion (EDI) was clearly prioritised as a strategic area for innovation and improvement, with strong foundations in workforce culture, inclusive practice, and data use. It was embedded in the adult social care strategy and supported by dedicated roles working in partnership. Staff reported feeling safe and able to be themselves, and leaders encouraged deeper conversations to build confidence and reflection. Public Health provided robust data support, helping to improve action planning and monitor accessibility. EDI was built into forms and advice materials, with a focus on wider social factors as well as protected characteristics. The local authority's workforce broadly reflected the local population, and further progress was planned to improve this through dialogue and commitment to national standards.

Staff and leaders engaged with external research and embedded evidence-based practice. The Director of Adult Social Care's national leadership in data and intelligence exemplified outstanding practice. As Chair of the National Strategic Data & Intelligence Network, they championed the use of client-level data to drive equitable, evidence-based decisions. Their influence ensured Warwickshire adopted cutting-edge tools such as live dashboards and predictive modelling, and shared learning nationally to improve outcomes. This strategic, transparent approach reflected a deeply embedded commitment to collaboration and measurable impact.

Innovation was supported through digital tools such as the Bridgit app, Mytime platform, and internal data dashboards, which enhanced access and insight for carers and practitioners. The Bridgit app is a digital support tool designed to help unpaid carers access personalised advice, resources, and services in real time. Warwickshire County Council launched it in partnership with West Midlands Association of Directors of Adult Social Services (ADASS) to improve carer support across the region. The Mytime platform is a national initiative designed to give unpaid carers access to complimentary leisure, cultural, and educational activities donated by local businesses and organisations. It connects carers with opportunities for short breaks and wellbeing experiences, helping them recharge from their demanding roles. The introduction of a financial assessment tool, developed in response to high complaint volumes had improved staff workflow, reduced waiting lists, and increased satisfaction.

The local authority actively participated in peer review and sector-led improvement, drawing on external support when needed. It contributed to regional and national networks including ADASS, Healthwatch, and the Care Quality Commission, sharing and adopting best practice. Collaborative work with police and providers strengthened safeguarding and quality monitoring, with innovative dashboards used to identify risks and inform action. Free training offered to care providers received excellent feedback and was widely recognised as a strong example of sector-leading practice. It was praised for its relevance, accessibility, and positive impact on quality of care.

Learning from feedback

Warwickshire embedded feedback into its strategic and operational improvement processes. People who drew on care, their carers, staff, providers and partners were regularly invited to share their experiences, which informed decision-making at all levels. Feedback was integrated into live dashboards, enabling agile responses and service development.

The local authority actively learned from incidents, complaints, and compliments. Safeguarding audits, dashboard feedback loops, and thematic reviews were used to improve practice. A 100% compliance rate with Ombudsman recommendations reflected a strong commitment to learning when things went wrong, with upheld complaints informing staff training and process improvements. The average uphold rate for this authority type is 79.57%.

The local authority used a feedback app (and paper and online versions) for people to rate and comment on their experience of adult social care. This feedback was displayed on a dashboard, allowing teams to explore the details and use the insights to shape future training, improve information and advice, and support service development.

Learning from good practice and when things went wrong was systematic. Case audits, complaints, and compliments were routinely reviewed and used to improve practice. Thematic reviews and Safeguarding Adult Reviews informed training and policy, with clear evidence of learning being embedded. Quality Assurance teams worked closely with operational teams to refine tools and monitor impact, including audit-informed updates to assessment forms.

'You Said, We Did' actions from staff surveys, particularly around supervision and hybrid working demonstrated a responsive culture. Leadership visibility improved in response to staff survey feedback, with widespread evidence of progress shared during our site visit. Staff reported high morale and wellbeing, supported by wellbeing champions and regular check-ins.

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