Coventry City Council: local authority assessment

How we assess local authorities

Assessment published: 27 May 2026

About Coventry City Council

Demographics

Coventry is a metropolitan city in the West Midlands with a population of over 369,000. The population has increased by 8.9% since 2011 with those aged over 65 increasing by around 15% and those aged 18–64 rising faster than the national average. Coventry has a younger age profile than England overall with 86% of residents aged 0–64 compared to 81% nationally.

Coventry is one of the country's more deprived local authorities with an Index of Multiple Deprivation score of 10 (where 10 is most deprived). Deprivation is concentrated in inner-city wards such as Foleshill, Hillfields, and St Michael's, while suburban areas like Earlsdon and Wainbody are less deprived. The gap in healthy life expectancy between the most and least deprived parts of the city is significant, reflecting inequalities in health outcomes.

The population of Coventry is more ethnically diverse than the England average. Around 34% of residents are from a Black, Asian, or other minority ethnic groups, compared to 19% nationally. The breakdown is approximately 66% White, 18% Asian/Asian British, 9% Black/Black British, and 6% Mixed/Other ethnicities.

Coventry is within the Coventry and Warwickshire Integrated Care System (ICS), which spans Coventry and Warwickshire local authorities.

Coventry is a Labour-led metropolitan authority with a majority of councillors.

Financial facts

- The Local Authority's total spend was **£654,019,000** in 2024/25 in comparison to a total spend of **£620,790,000** in 2023/24. In 2024/25, **22.71%** of the spend was spent on adult social care. Spend figures are net current expenditure (total service expenditure) sourced from Outturn Data and are not adjusted for inflation.
- The Local Authority's total spend on Adult Social Care was **£148,514,000** in 2024/25, compared to a total spend on Adult Social Care of **£147,196,500** in 2023/24. The Local Authority spent **£52,025,292** (adult social care spend) per 100,000 adults in 2024/25. Spend figures are net current expenditure sourced from ASC Finance Returns and are not adjusted for inflation.
- The Local Authority has raised the full Adult Social Care precept for 2024/25, with a value of **2%**. Please note that the amount raised through the Adult Social Care precept varies from Local Authority to Local Authority.
- Approximately **4810** people were accessing long-term Adult Social Care support, and approximately **2655** people were accessing short-term Adult Social Care support in 2024/25. 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.

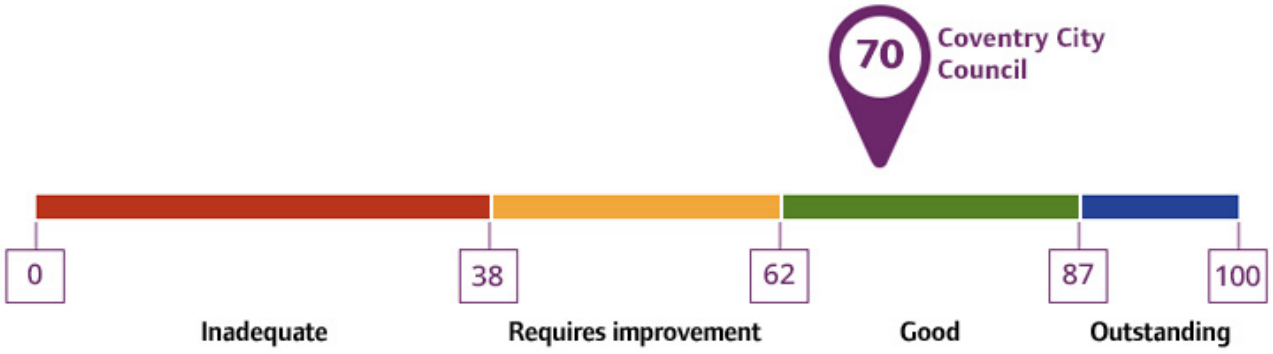
This data is reproduced at the request of the Department of Health and Social Care. It has not been factored into our assessment and is presented for information purposes only.

Overall summary

Local authority rating and score

Coventry City Council

Good



Quality statement scores

Assessing needs

Score: 3

Supporting people to lead healthier lives

Score: 3

Equity in experience and outcomes

Score: 2

Care provision, integration and continuity

Score: 2

Partnerships and communities

Score: 3

Safe pathways, systems and transitions
Score: 3

Safeguarding
Score: 3

Governance, management and sustainability
Score: 3

Learning, improvement and innovation
Score: 3

Summary of people's experiences

People were supported in a strength-based and person-centred way, with most people satisfied with their care and support. People's independence was being promoted which helped to reduce the need for long-term services. Access to the Coventry Dementia Partnership Hub and The Pod were providing positive outcomes for people. People were supported to access independent advocacy so their voices could be heard.

Some people could experience waits for assessments, occupational therapy assessments and reviews. People were prioritised so those with the most urgent needs were supported first. People accessed equipment in a timely manner once assessed, which supported their independence. There were waits for larger adaptations, however. Most people did not face significant waits for financial assessments to be completed.

Most people accessed local care provision in a timely manner, but some people accessed services outside of the City due to a lack of local provision. Specialist services, such as those for autistic people or those with high level nursing needs, were more difficult for people to access locally.

Unpaid carers had mixed experiences of the local authority, but most unpaid carers were positive about the support they received directly from the commissioned carer's service and were able to access timely carer assessments. Most unpaid carers did not access short breaks, but the local authority had expanded support options to support people to access breaks. Unpaid carers and people were supported with contingency planning and access to emergency support.

Most people who used services found it easy to find information about support. Some people found services difficult to navigate when accessing social care for the first time, but this improved once allocated a worker. People's cultural needs were also being supported. Digital exclusion was a risk for some people, including communities where literacy rates were low, but the local authority had a digital inclusion offer which was made available to people where this was identified as a risk.

Young people had mixed experiences of transitions, with a need to ensure there were no gaps in support for people when transitioning to adult services. People told us children and adult services worked well together, however. People were supported to be discharged from hospital smoothly. Most people at risk of abuse were supported to stay safe.

People were involved in co-production and feedback activity to help inform decision making and future approaches.

Summary of strengths, areas for development and next steps

There were governance systems which supported Care Act delivery. Delivery was informed by clear strategic direction and planning. Oversight was supported by use of performance data. Staff were supported with their continuous professional development. The leadership team was visible and approachable, but there was opportunity to ensure staff were fully involved and informed about changes.

A practice framework was supporting person-centred and strength-based approaches, with local authority survey data showing most people who responded were supported to live as independently as possible. People's voice was supported in assessments, including through independent advocacy where required. Inclusive practice was being promoted, and cultural needs were being met, including through direct payment use. The local authority and commissioned services were taking steps to support communities to better understand the adult social care (ASC) offer but impact of this work was still embedding.

People with sensory impairments were supported by a specialist team and accessibility arrangements. There was a positive approach to improving support to people who were Deafblind.

There were waits for some people for assessments, reviews and occupational therapy (OT) assessments. Waits for assessments were decreasing and review completion rates had increased. There were systems to mitigate risk and prioritise people while they waited. Staff workloads were becoming more difficult to manage effectively. A Workforce Strategy Action Plan was aiming to address this through recruitment, retention and management of absence. Access to equipment was timely and a strong technology-enabled care (TEC) offer was supporting people's independence.

There was strategic alignment between the local authority and health partners. Integrated arrangements were supporting strong partnership working and provided smoother experiences of health and social care support. Discharge arrangements were supporting transitions and less people accessing long-term residential services. Reablement uptake was high, but national data showed the proportion of people aged 65 and over discharged from hospital into reablement and who remained in the community within 12 weeks of discharge was worse than national averages. There could be challenges for people with mental health needs accessing services when ready for discharge from mental health hospitals.

There were positive working relationships with the voluntary, community, faith and social enterprise (VCFSE) but an opportunity to further embed the VCFSE in strategic conversations. Steps were being taken to better support smaller VCFSE organisations to access funding. The VCFSE supported preventative approaches.

The Coventry Dementia Partnership Hub and The Pod were positive examples of a preventative approach which promoted people's independence and wellbeing.

There was understanding of the local market to meet people's care and support needs, and the market was being shaped to better support people. People could access care provision locally, but out of city placements were sometimes needed for more specialist needs where this may not have been the person's choice. Plans and strategies supported short and long-term market development and outlined how gaps would be addressed. There were robust care provider quality assurance arrangements to help keep people safe. There was engagement with care providers and support for their sustainability.

Safeguarding risks were screened in a timely manner and to risk assess and keep people safe effectively. People were kept at the centre of safeguarding enquiries, but partners were not always informed of the outcomes of safeguarding enquiries. This was being addressed with system prompting and compulsory justification required for not communicating outcomes.

Learning from practice was well embedded as a wider health and social care system. This helped to inform system-wide programmes to enhance integrated delivery of services. There was learning following complaints, external reviews and serious incidents. Systems were supporting oversight and embedding of learning. People's feedback was gathered to support service improvements. Co-production supported strategic planning and delivery and was being further strengthened.

Theme 1: How Coventry City Council works with people

This theme includes these quality statements:

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

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

Assessing needs

Score: 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 support and services through the local authority's front door, Adult Social Care Direct, which was part of the early help service. People and professionals could request support by phone, online referrals or through self-assessments. Adult Social Care Direct then either supported the person through signposting or triaged referrals to appropriate teams. For example, the local authority had short term services to promote people's independence following a referral, such as short-term enablement, occupational therapy and a learning disability promoting independence team. Short term assessment teams were organised into Local Integrated Teams (LITS), which were integrated with health professionals, and this supported multi-disciplinary approaches to supporting people. A staff team told us as part of the early help front door service, initial checks and triage took place, with staff typically making a same-day second call to clarify need and risk where required using a risk-rating tool. They told us these systems ensured people were quickly assessed and directed to the right support, improving safety, reducing delays, and promoting independence from the outset.

There were also long-term support teams, where ongoing care and support needs were present. Mental health services were hosted by the local mental health trust, which had its own front door with social work input. Systems were in place to redirect requests for mental health related services when received by adult social care. Staff teams told us there were strong pathways in place with good communication between teams which supported appropriate care and support for people.

There was a strength-based and person-centred approach to assessment and support which continued to develop. A leader told us this was being supported by a practice framework and there was continued investment by the local authority to support strength-based training. For example, staff were trained to undertake motivational interviews to support outcome-focused conversations. A staff team told us they used motivational interviews and worked collaboratively with people and families to co-produce holistic support plans. Another team told us how they focused on a person's assets. In a specific example, a person who was a keen gardener had been supported to re-engage with their interest through a local group. Strength-based practice was also supported by a toolkit for practitioners, which had a range of useful resources for staff to support communication and strength-based conversations. This was supporting people to be empowered to stay independent and connected.

Most people were satisfied with their care and support. National data from the Adult Social Care Survey (ASCS) for 2024/25 showed 66.84% of people were satisfied with care and support. This was similar to the England average (65.16%). The ASCS also showed 82.45% of people felt they had control over their daily life. This was somewhat better than the England average (77.31%). The local authority's Experience Survey for 2025 also showed most people were positive about the support they had received. For example, of 167 surveys completed, 82% of people felt they were supported to live as independently as possible and 76% were happy with the support they received.

This was also reflected in feedback from people. For example, people and their loved ones told us the assessment process was supportive, compassionate, understood and respected independence and enabled people to live how they wished. In an example, a person's family members were supported by a staff member to be placed together in a specialist home, which prevented a potentially upsetting separation. However, some people told us initial contact with the local authority was not always a positive experience. There was some feedback it could be difficult to access support and services and contacting social care initially was confusing and overwhelming. Once an allocated worker was assigned in these instances, there was improvement in communication and support. Despite this, most people had a positive experience of assessment and support.

Partners also told us person-centred approaches to assessments and reviews were ensuring people had the correct support. They told us staff were not only removing risks for people but were compassionate and mindful of the support people needed.

Timeliness of assessments, care planning and reviews

There were some waits for assessments. This could delay people in accessing support they needed. Local authority data showed, as of September 2025, 71 people were waiting for an assessment, with a median waiting time of 27 days. Over the preceding 12 months local authority data showed the longest wait for an assessment, which was for a person with a learning disability, had been 595 days which presented a significant wait. However, the current maximum wait had reduced to 99 days. The target completion time was 28 days. Waits were measured from the day it was decided a person required an assessment to the day the assessment was started.

The local authority told us waits were due to increases in the number of contacts received and requests for assessments, some staffing capacity challenges and additional interventions or waiting times for other services (such as occupational therapy) could impact priority ratings for assessments.

Local authority data showed there could be longer waits for annual reviews. As of 12 September 2025, 909 people required a planned annual review with 34 of these reviews in progress. The local authority had completed 66.6% of reviews for people receiving long term support over the previous year and 85.7% of reviews in the last 18 months. As of 19th September 2025, the median wait time for an annual review was 166 days and the maximum wait time was 524 days. National data from the Adult Social Care Activity Report (2024/25) showed 69.98% of long-term support clients had been reviewed (planned or unplanned). This was similar to the national average of 59.13%. This demonstrated a trajectory of improved performance, increasing from 55.6% of reviews completed in 2023/2024.

In their data submission, the local authority highlighted they were focused on outstanding reviews and prioritising outliers. They identified themes contributing to longer waits, including capacity and skill mix within teams when undertaking reviews for people they described as having complex needs, the need to manage reviews alongside high-priority work, and individual circumstances which had impacted the timeliness of reviews.

Waits for assessments and reviews risked impact on people, but processes were supporting risk to be screened to ensure those at most risk were supported first. A risk-based prioritisation tool supported decisions on timeliness of intervention with referrals risk assessed and triaged within 1 working day. Data dashboards also provided staff, managers and leaders with oversight of waits for people. Senior leaders were confident there were timely responses to urgent risk.

The local authority also applied 'waiting well' procedures to support people while they waited for assessments. For example, a staff team told us they completed frequent calls to people who were waiting to check for any changes in need which could impact on prioritisation. A leader told us waiting well procedures helped to maintain contact with people and a recently introduced waiting well pack was being provided to people so they had information while they waited. Procedures were also in place for people who could not be contacted, with priority visits considered where needed.

There were ongoing plans to reduce waits for people as much as possible. A senior leader told us this included a combination of combatting absence levels in staffing to increase capacity, to use data and technology to improve flow (such as the implementation of a new case management system) and through the use of transcription tools which were being formulated to reduce time taken for staff on administration.

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

The needs of unpaid carers were recognised as distinct from the person with care needs. Assessments, support plans and reviews for unpaid carers were undertaken separately, although carers could choose a joint assessment with the person they supported where this was their preference.

The local authority recognised the need to continually improve the carer offer and this was being supported by the Coventry Carers' Action Plan (2024-2026). The plan had been adopted instead of a strategy, with a leader telling us this decision was taken as there was a need for a framework with real meaning and tangible outcomes for carers. They told us this was a coproduced plan using carer groups. The plan set out clear actions with timescales, with set overarching priorities. Priorities included: "Empower carers with flexible respite options, ensuring they can take breaks", "Deliver the right support, at the right time, and in the right place" and "Maximise the reach of carers assessments to benefit more carers". This offered a clear direction of development work for the local authority.

The local authority had a commissioned service who provided services for unpaid carers, which included assessments and a range of other support. The commissioned carers service completed most carer assessments, but assessments were also completed internally by the local authority where the cared for person was already being supported by local authority staff or was awaiting allocation. Unpaid carers could also complete a self-assessment tool which was validated by the commissioned carers service.

There were mixed experiences for carers. For example, national data from the Survey of Adult Carers in England (SACE) for 2023/24 showed 32.61% of carers were satisfied with social services. While this was similar to the England average (36.83%) this showed a need to further develop the carers offer, as most carers were not satisfied with social services. However, carers we spoke with who had received assessments praised the local authority's commissioned carers service, although they had limited or no direct contact with the local authority. Some unpaid carers told us they had been supported to access a range of creative support, such as a dishwasher, carpet cleaning accessory and a laptop, all of which had supported them in their caring roles. The local authority's 2024/25 Real Time Survey of carers also showed 75% were happy with the support they received, 82% had been involved and listened to in the planning of their care and 85% were treated with kindness, dignity and respect.

There was an opportunity to ensure the offer of a carers assessment and review was consistent. For example, a carer told us they had not been offered a carer's assessment despite being identified as a carer. Some other carers also told us they had also not been made aware they could request a review of their support in the event there was a change in circumstances which impacted on their caring role. However, in a positive example, a carer's potential burnout had been recognised and they were supported to access a carer's assessment so support could be put in place.

The commissioned carers service offered access to support groups and training for carers. Some unpaid carers told us they were aware of the support and some had accessed these groups. National data from SACE (2023/24) showed 33.94% of carers accessed a support group or someone to talk to in confidence. This was similar to the England average (32.98%). A leader also told us there was an information and advice and training offer for carers, including bespoke support from an occupational therapist embedded within the partner service. A carer told us they had accessed dementia awareness training which had supported their understanding. National data from Survey of Adult Carers in England (SACE) (2023/24) showed 5.50% of carers accessed training, which was similar to the England average of 4.30%.

There was generally timely access to carer assessments. When assessments were completed internally, as of 12 September 2025, the median wait was 7 days and the maximum wait was 16 days. The maximum wait for completion during 2024/25 was 35 days. Comparatively, data for the commissioned service as of 31 August 2025 showed 5 carers waiting for an assessment, with a median wait of 8 days and a maximum waiting time of 43 days. The local authority outlined some carers preferred to delay their assessments which could affect wait time data. Despite this, the data suggested most carers were receiving an assessment in a timely manner.

The local authority continued to develop its identification of carers including young carers so they could access guidance and support. A leader told us there was always a need for more resources to support identification but outlined steps the local authority was taking to improve this. The Unpaid Carer's Action Plan (2024-2026) outlined actions to improve identification of carers, including reducing barriers for what they described as hidden carers and working with partners to identify carers. There were positive examples of work to improve identification. For example, the local authority had supported a scheme which offered unpaid carers free bus passes and this had supported wider identification. A hospital liaison worker, who was part of the commissioned partner service, was also supporting identification on hospital wards. There had also been close work with GPs to identify and refer carers, which a leader told us had contributed to increased identification.

Young carer support was also provided by the same commissioned carers service, which supported smoother transitions for young carers into adulthood. A partner told us there was close working with schools and universities to support transitions, raise awareness, and provide tailored emotional and practical support. Working with schools and colleges to identify and promote support for young carers was also an action within the Carer's Action Plan.

The local authority had also commissioned a further digital support platform for carers. This had been in place since February 2025 and supported the identification and support of carers. As of 31 August 2025, 3179 carers were said to have used the platform, resulting in the creation of 3328 self-help plans. The local authority also analysed use of the service, for example they identified increased activity on Saturday mornings, which highlighted the need for a platform that supported carers outside conventional local authority working hours. A staff team told us this offer was strengthening support for carers, helping to sustain their wellbeing and continue in their caring roles.

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

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

The local authority's Coventry Information Directory was also available to people and staff. This online resource enabled people to review what local services were available to them. Local authority data showed over 17,000 users had accessed this service within a 1-month period, highlighting it was being used frequently. A staff team worked to keep this resource updated.

People and unpaid carers told us they were signposted and supported to access services. For example, a person told us they were supported to access financial support including access to benefits. Staff teams also told us how they signposted people to local services such as befriending services, local faith centres and community spaces.

Eligibility decisions for care and support

The local authority's framework for eligibility for care and support was transparent. There was guidance for staff which outlined eligibility must be determined at the point of assessment and this was reflected in eligibility criteria being applied consistently.

An Assessment and Eligibility document, which was a short guide available publicly, set out the assessment and eligibility process and how to undertake a complaint if people disagreed with a decision. This was also available in easy-read format.

People followed the local authority's complaints process when there was a formal challenge of the outcome of their assessment. In 2024/25 the local authority received 1 complaint which was an appeal against a decision around how the local authority met identified need. This was partially upheld which led to services being adapted to better meet the needs of the person.

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 and transparent and consistently applied. A Financial Assessment Standard Operating Procedure was up-to-date and outlined the financial assessment process for staff.

Local authority data showed as of 31 August 2025, 76 people waiting for a financial assessment, which included 38 new people. As of 12 September 2025, the median wait time for people was 19 days and the maximum wait time was 79 days. Over the 12 months preceding this, the longest wait was 98 days. Data also showed average waits for people varied, with a peak median wait of 36 days in May 2025, but a lowest median wait of 11 days in August 2025. The data showed, in general, people were not experiencing significant waits, but some people waited longer.

Information submitted by the local authority showed no complaints or appeals were made specifically around financial assessments over the previous year. Only 4% of complaints were said to be of a financial nature in 2024/25. There was continued work to support people's experiences of financial assessments, with a staff team telling us exploration work on self-service portals was taking place, but presented a challenge as they needed to be accessible for people during roll-out.

Staff teams supported people to undertake and understand financial assessments. This included people with depleting funds. The local authority had adopted an approach where people with depleting funds, who currently were over the nationally set social care threshold of £23,250 for financial support, could request support prior to their funds going below this level. The local authority outlined as these referrals were kept open, this could impact on the maximum wait data, but this was a more person-centred approach and stopped people needing to re-refer.

Provision of independent advocacy

The local authority commissioned an advocacy partner to support people to access independent advocacy, which supported people to participate fully in care assessments and care planning processes. An advocate can help a person express their needs and wishes and weigh up and make decisions about the options available to them. They can help them find services, make sure procedures are followed and challenge decisions made by local authorities or other organisations.

There had been a consistently high need for advocacy services, with an increase in statutory and non-statutory referrals. There had been a high rate of referrals, for example, for Relevant Person's Paid Representatives (RPPRs), who are appointed to support people subject to Deprivation of Liberty Safeguards (DoLS) authorisation. The commissioned advocacy service's Adult Advocacy Annual Report (2024/25) outlined this had led to a waiting list being adopted. The local authority had re-commissioned its offer in 2025 with increased funding to manage increasing demand. The commissioned advocacy service also used a prioritisation tool to support people with the most urgent needs to receive advocacy first. The report outlined close working between the contract commissioner and the partner service to understand referral trends.

The local authority supported staff to understand advocacy and how to make referrals with a guide provided by a commissioned service. Staff teams understood the need for advocacy. A person also told us entitlement to advocacy had been discussed with them before the assessment process, but this was not needed as they had family to support them.

Staff teams told us they felt the local authority had a good advocacy offer for people, which supported people's voice, choice and inclusion. They told us the offer was expanding to improve inclusivity. For example, there was said to be improved cultural competency and consideration of other organisations who could support people from different backgrounds through social care processes. A staff team told us young people had the opportunity to retain their advocate from being under 18 which supported continuity for them. Arranging advocacy was also said to be straightforward and could be put in place in a timely manner.

Supporting people to live healthier lives

Score: 3

3 - Evidence shows a good standard

What people expect

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

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

The local authority commitment

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

Key findings for this quality statement

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

The local authority worked with people, partners and the local community to make available a range of services, facilities, resources and other measures to promote independence, and to prevent, delay or reduce the need for care and support.

The local authority's approach to prevention was underpinned by the Adult Social Care 5 Year Plan (2025-2030) and Health and Wellbeing Strategy (2023-2026). This was being further strengthened by the embedding of the Warwickshire Integrated Care System (ICS) Prevention Framework, which informed prevention work as a wider system. The strategic documents outlined a system focus on life-course approaches to prevention and the support of people to live healthier lives for longer. Other strategies driving prevention included the Suicide Prevention Strategy (2023-2030), Drugs and Alcohol Strategy (2023-2033) and the Living Well with Dementia Strategy (2024-2029).

There was a promoting independence approach which cut across a range of council services, which included adult social care (ASC), housing and public health. A senior leader told us public health was increasingly supporting ASC and neighbourhoods to promote healthier lives. For example, there had been joint commissioning of wraparound and preventative services, such as befriending support and services aimed at reducing social isolation. Senior leaders recognised, there was always more to do to strengthen prevention but consistently told us there was a commitment to prevention, early intervention and promoting independence. Data provided by the local authority showed for 2024 60% of people who accessed short term support to maximise independence went on to not require further services. There was continued focus for the local authority to increase this further and to reduce use of residential services.

ASC pathways were organised to support a prevent, reduce, delay approach. For example, enablement for people with short term needs was provided by multi-disciplinary Local Integrated Teams (LITs). The LITs included both local authority and health staff who worked together to consider options to support independence or reduce need, such as equipment, technology or reablement. Similarly, people with a learning disability and autistic people, including young people who transitioned to adult services, accessed support to promote independence. A staff team told us how this pathway prevented referrals to more long-term teams. They told us about people who had accessed services which had allowed them to live independently, access employment and build their skills. These pathways supported people to access short-term services, before consideration of long-term support.

The local authority worked with the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector to support their prevention offer and people's independence. At the time of the assessment, the VCFSE prevention offer was being re-commissioned, and the ASC 5 Year Plan outlined this as an opportunity to re-focus the role of the commissioned VCFSE. There was some mixed feedback from partners on how well the local authority was supporting prevention through the VCFSE. For example, a partner also told us they felt there was a need for more consistent and strategic investment in the VCFSE's prevention offer, as funding could be more reactive and ad-hoc. Another partner told us the local authority commissioned the VCFSE extensively to support prevention services and recognised the difficulty in the balance between funding for prevention services and other statutory duties in the current economic climate.

Positive examples of the commissioned and grant funded VCFSE offer included Good Neighbours scheme, which provided befriending services and social groups. The Coventry Dementia Partnership Hub provided resources and connections for people and their families affected by dementia. The Help and Connect service supported autistic people and people with a learning disability to build their independence skills. A staff team told us the re-commissioned offer was being further developed with input from people with lived experiences. For example, they told us there had been feedback on a need for more peer support for autistic people and people with dementia and this was being considered as part of the offer.

There was specific prevention work to prevent and reduce escalating needs for people, including those who experienced rough sleeping, homelessness, substance misuse and mental health needs. For example, a rough sleeper outreach team built relationships and supported people to access accommodation while also linking them with services, such as ASC and mental health services which helped to prevent people's needs from escalating. In a positive example of impact, a person's family member told us they were very grateful to the local authority to support the person to not be rough sleeping and find accommodation where they were happy. A staff team also told us about work with people being discharged from hospital when they had no fixed accommodation. They also told us discharge planning included consideration of support from the housing team to ensure suitable accommodation was sourced which reduced the risk of readmission.

The Pod was another positive example of a welcoming community space to support prevention for those with mental health needs. The Pod was a local authority operated and Integrated Care Board (ICB) funded service. The Pod gave people access to secondary mental health services and had worked with 96 people in 2024, which included people with forensic histories and people who had experienced substance misuse. A person told us how The Pod had signposted them to a local VCFSE group which supported men's mental health. Another person told us staff at The Pod were very knowledgeable and offered guidance for them. Their visits to The Pod had helped to rebuild their confidence and inspired them to take part in training to support employment.

Specific consideration was given to unpaid carers as being at risk of decline in their independence and wellbeing. The Carer's Action Plan supported the expansion of services to prevent escalating need for unpaid carers by increasing support for them. For example, the commissioned carers partner provided training, counselling, peer support, activities, information and advice. A partner told us advisors from this service had a presence in the community which enabled early intervention and support for carers. Carers were positive about the support of the provider, with a carer telling us the provider had made a real difference to their life, making them a lot less stressed and improved their health and wellbeing

National data showed there was a continued need to support carers to live healthier lives. For example, the Adult Social Care Survey 2023/24 showed 12.73% of carers able to spend time doing things they enjoy, which was similar to the England Average of 15.97%. The survey also showed 25.45% of carers who reported that they had as much social contact as desired which was somewhat worse than the England Average of 30.02%. The local authority was developing its services to further improve experiences for unpaid carers.

Provision and impact of intermediate care and reablement services

The local authority worked with partners to deliver intermediate care and reablement services that enabled people to return to their optimal independence, but there was opportunity to improve effectiveness. Local integrated teams brought together health and social care professionals to support people to access reablement. This included a step-up offer from the community and an offer to support people being discharged from hospital to regain their independence.

National data showed there was a strong uptake of reablement services for older people. The Adult Social Care Outcomes Framework Client Level Data (ASCOF-CLD) for 2024/25 showed 16.40% of people aged 65+ received reablement services after discharge from hospital. This was better than the England average (5.77%).

Reablement was therapy-led, with OTs overseeing progress of people's recovery where appropriate. Professionals from LITs worked closely with designated care providers to support people to regain their independence. A staff team told us reablement supported people to regain independence at home and therapy-led assessments helped reduce or expand care packages based on the person's recovery. In a positive example of impact, a person's family member told us how reablement had supported the person to reduce their care and support needs so they could be cared for by the family rather than formal services.

National data suggested there was opportunity to improve effectiveness of the reablement offer for people. ASCOF-CLD data for 2024/25 showed 53.66% of people aged 65 and over discharged from hospital into reablement and who remained in the community within 12 weeks of discharge. This was worse than the England average of 60.66%. ASCOF-CLD data also showed 68.66% of people who received reablement during the year, who previously were not receiving services, where no further request was made for ongoing support. This was somewhat worse than the England average of 77.16%. A senior leader told us the local authority had recognised a recent drop in the number of people remaining at home following short term services and this was being investigated with health partners. This showed more people could be at risk of requiring long-term services following discharge from hospital.

Access to equipment and home adaptations

People could experience waits to access equipment and minor home adaptations. Once equipment was accessed, this supported people to maintain their independence.

Occupational therapy (OT) was well embedded across the local authority with OTs placed across the service. This supported a multi-disciplinary approach to providing support. A leader told us this supported OT expertise to be available at every stage of people's care journey, from the early prevention stage and this helped to prevent deterioration or unnecessary hospitalisation for people.

There were waits for people accessing OT assessments. Data provided by the local authority as of 12 September 2025 showed 404 people waiting for an OT assessment. The median wait for an assessment was 40.5 days and a maximum wait of 138 days. The local authority had set a target of 28 days, but this data suggested most people were waiting longer than this. This also showed longer average waits for people than data provided in April 2025, where the median wait was 25 days and the maximum wait was 94 days.

The local authority was taking steps to try and reduce waits for people. For example, clinic-based assessments offered an alternative to assessments in people's homes. A leader told us this facilitated quicker access to therapy services, where people could often access equipment on the same day. A staff team also told us the use of clinics had helped to streamline support. A red, amber, green (RAG) prioritisation system was also supporting those with the most urgent needs to access assessments first. They told us people who were at immediate risk without intervention were visited the same day. Trusted assessors and OT assistants also supported people to access basic equipment while they waited for an assessment, which supported their safety and independence.

The local authority's Integrated Community Equipment Service (ICES) provided equipment for children and adults services, as well as health and social care services. The equipment store was accessible for staff which supported equipment to be picked up quickly in appropriate cases. Access to equipment was timely for most people. Data provided by the local authority, which included equipment for children, showed over 92% of equipment issued within 5 days (against a target of 90%), and 95% within 7 days for 2024/25. The local authority outlined waits over 7 days were often related to paediatric specialist equipment.

In a positive example, a staff team told us about the importance of basic equipment in keeping people safe. Following a discharge from hospital, a person was provided with a toilet frame within 24 hours to help reduce identified risks and keep them independent. Another person also told us their equipment delivery was well co-ordinated and had supported their discharge from hospital.

The local authority's equipment offer, including their Technology Enabled Care (TEC) offer, supported people to remain independent in their own homes. Staff teams gave us examples of how equipment supported people. For example, a staff team told us about a person who needed support with prompting for their medicines. The local authority installed virtual care, which involved a video call from a support worker at a set time to remind the person. This was said to have supported the person to stabilise their life and start considering employment. Staff also gave other examples of technology such as ring doorbells and alarm sensors supporting people to return to or remain at home.

The local authority recognised there had been longer waits for adaptations in people's homes, such as through Disabled Facilities Grants (DFGs). A leader told us people were waiting around 18 months, and the local authority had completed an external review and internal audit focused on reducing waits. Following this work, a new Housing Assistance Policy was introduced as well as a streamlined referral process from OT into the adaptations pathway. The local authority also worked closely with the social housing provider and a leader told us this had reduced delays for Disabled Facilities Grants for its tenants to help people remain in their homes. A prioritisation framework also supported those in most need of having their adaptations reviewed first. Appropriate cases were said to be escalated through a priority panel. While there was continued work to reduce waits for adaptations, people were waiting for extended periods.

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.

The local authority's information and advice offer was a mixture of telephone, digital and in-person resources. For example, people could contact the local authority front door by phone and be signposted or given advice on support they may have been eligible for. Online, the local authority website and the Coventry information directory provided links to a range of information about services in a central place. Information was also provided in community settings, such as GP surgeries, libraries and local hubs. A partner also told us the local authority had online newsletters which were informative and were said to be sent to over 5000 people and unpaid carers.

National data showed improvements in people's access to information and advice. The Adult Social Care Survey for 2024/25 showed 73.40% of people who use services found it easy to find information about support. This was somewhat better than the England average (67.88%). The proportion of people showed almost a 10% increase from the previous year, where this was 64.00%. Some partners, however, reflected some people found it difficult to access information despite the different avenues available for information and advice. For example, a partner told us some people did not know what was available to them and were missing out on support, with some people not being reached. Another partner told us the system was difficult to navigate for people and with a broad front door it was difficult to know where to go without prior knowledge or signposting.

National data showed there was a continued need to support carers access to information and advice. For example, the Survey of Adult Carers in England (2023/24) showed 59.74% of carers found it easy to access information and advice. This was similar to the England average (59.06%). However, the survey also showed 89.14% of carers found information and advice helpful. This was somewhat better than the England average (85.22%). The local authority's Real Time Experience Survey results for 2024/25 also showed 72% of unpaid carers agreed information they have needed to support them in their caring role was easily available. This suggested unpaid carers could face barriers in accessing information which could support them in their caring role, but once this was accessed, it supported them.

The local authority recognised there was a continued need to improve their information and advice offer so people understood what was available to them. A leader told us they understood not all people were finding information and advice easily and steps were being taken to improve this. They told us, for example, to promote the adult social care offer further, the website was being improved. They told us there was monitoring of which pages were being used the most and these were then brought to the homepage for other people to access more easily. People's experiences of accessing the website were also being used to make improvements. A person told us people could feel overwhelmed by the volume of information available and there was work to streamline this further.

The local authority highlighted there were a range of adult social care sites spread across the city to allow walk-in contact opportunities. However, some partners told us about the challenges people faced due to the loss of face-to-face hubs and there was opportunity to enhance this offer. For example, a partner said without accessible face-face-contact points, people could be excluded, especially those with limited access to phone or limited digital confidence.

The Coventry Dementia Partnership Hub was a positive example of information and advice being embedded in the community and demonstrated how face-to-face provision was valuable to people. The hub opened in 2023 as a place where people and their families could go for information, advice and support from pre-diagnosis onwards. The hub had been created following engagement and co-production events and continued to be developed by a steering group. A person told us a key role of the steering group was outreach and promoting the hub across the city and in the media, which the local authority had fully supported. The hub was having a positive impact for those living with dementia and their families. A person told us they regularly spoke with staff at the hub to gain information and advice on a range of issues and they found the face-to-face support useful.

Direct payments

Direct payment uptake was in line with national averages and the local authority had taken steps to strengthen their offer.

National data from ASCOF-CLD (2024/25) showed 21.86% of care users received direct payments. This was similar to the England average (24.51%). The data also showed 32.60% of care users aged 18–64 received direct payments. This was similar to the England average (35.53%). Finally, it showed 12.71% of care users aged 65 and over received direct payments. This was similar to the England average (13.64%). This demonstrated a slight drop from the ASCOF-CLD 2023/24 figures for each of these measures.

Leaders were confident in their offer and told us where uptake was lower, this was more a reflection of people choosing to remain on a managed service, rather than direct payments not being offered. A leader also told us the Direct Payment Strategy (2024-2029) was supporting staff training and strengthening relationships with a commissioned direct payment partner. The commissioned service offered a range of support around direct payments, for example, help recruiting a personal assistant, choosing and using a care agency, managing money and keeping accurate records and payroll.

There had also been a focus on improving uptake of direct payments for carers. A leader told us this had increased, supported by training for staff internally and at the commissioned carers partner. There had also been a new carers direct payment leaflet developed to expand information available about the offer for carers. Most carers we spoke with knew about direct payments, demonstrating this was being discussed with staff and the commissioned carers partner. The local authority's data showed in 2024/2025 there was a slight increase in direct payment uptake for carers, with an 18% increase from 2023/24.

A staff team told us direct payment offer was effective but set up could take a considerable amount of time. They told us the responsibility of employer status could be a barrier to uptake. However, another staff team told us set-up was efficient. Local authority data showed for the period April to September 2025, the maximum wait time for a person's direct payment to be set up was 131 days and the median wait time was 46 days.

There was ongoing work to further understand and improve uptake of direct payments. For example, a leader told us following the introduction of a direct payment feedback survey, which was collecting feedback on people's experiences, there were plans to include direct payment users in a steering group to support improvements to the offer. Following analysis of survey results, a leader told us there was an action plan around timeliness of direct payment set up and enhancing the personal assistant market. Uptake was also analysed, which showed an overrepresentation of people from ethnic minority groups. A leader told us this was related to personal assistants recruited from within people's communities. As a result, the local authority had expanded translated information around direct payments for people from these communities.

Staff were supporting people and carers to access flexible support options and positive outcomes through direct payments. For example, staff told us people were able to access homecare or a day centre, which were not commissioned services, when this was their preference. Other people had been supported to access activities, such as art classes or support which was in line with their cultural preference. The direct payments survey, which had 42 responses as of 7 November 2025 (7% of DP users), 74% of respondents expressed satisfaction with the support they were receiving via a Direct Payment.

Equity in experience and outcomes

Score: 2

2 - Evidence shows some shortfalls

What people expect

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

The local authority commitment

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

Key findings for this quality statement

Understanding and reducing barriers to care and support and reducing inequalities

The local authority was committed to reducing inequalities faced by people and was deepening its understanding of barriers for different communities. The local authority had developed plans to support this work and the impact of this continued to embed.

Coventry became the first Marmot City in England in 2013. A Marmot Place or City recognises health inequalities are shaped by social determinants of health and works to understand local inequalities, strengthen the health equity system and develop actions with associated monitoring and evaluation. Leaders told us how being a Marmot City had underpinned wider strategy, including the Council-wide One Coventry plan and the Health and Wellbeing Strategy (2023-2026). Partners also told us the City had a proud status as a Marmot City and this had been used to focus on health inequalities, working with transient and seldom-heard communities, for example.

Partners told us about inequalities across Coventry, including health inequalities in more deprived areas, and how this was being used to help plan services. A partner told us population growth in some areas was contributing to deprivation and rising demand for health services. As a result, the local authority, along with health partners were focusing resources to reduce inequalities. For example, partners told us how local authority and Integrated Care Board (ICB) resources for integrated neighbourhood teams were being weighted and focused towards areas with greater deprivation to help reduce inequalities. While this approach was still being embedding, the local authority was taking steps to target inequalities present in more deprived areas.

The local authority gathered and analysed population and equality data on people to understand any inequalities in access to adult social care (ASC) services. The local authority had, for example, identified specific groups needing further support to improve access to services, such as people who are Deafblind, people with dementia, people with learning disabilities, migrant communities and carers. Partners also highlighted inequalities faced by communities, where Black communities faced mental health inequalities and other ethnic minority groups could face barriers where cultural and linguistic barriers influenced engagement levels. There was ongoing work to tailor outreach for identified groups at risk of inequity. For example, the local authority had identified there was an increased demand for mental health support from migrants, such as asylum seekers and those with No Recourse to Public Funds (NRPF). As a result, a full-time social worker had been placed in the migration team to offer Care Act support for these people to access services where required. A partner highlighted, however, migrant communities could still feel underserved, especially where English was not their first language. The local authority continued to take steps to reduce inequalities and barriers faced by these groups.

There was recognition from the local authority of a need to reduce barriers to accessing support and it was deepening its understanding of underrepresentation. The local authority's ethnicity representation data showed people aged 65 and above receiving long term support was in line with 2021 Census data. There was more of an underrepresentation for people aged 18-64 across Asian, Black and Other ethnicities. A staff team told us about recent research involving people from Black, Asian and Mixed ethnicity communities who were engaged to understand barriers to accessing ASC, but the impact of this was not yet evident. In another example, a partner shared there was proactive work by the local authority to engage with people, which included focus group work with Lesbian, Gay, Bisexual and Transgender or other identity community (LGBT+) to support trust building. The local authority was developing its understanding of barriers to equitable experiences of ASC but the impact of this work was not yet embedded.

The local authority was expanding engagement with seldom-heard groups, and this supported people to access support. The local authority's commissioning approach to equity in access to ASC outlined how there was ongoing connections with a range of faith and community groups, as well as further development of the VCFSE to support links with communities. For example, a leader told us it was recognised people who identified as Black may be less likely to access dementia support. However, the local authority, through its work with the Coventry Dementia Partnership Hub, was expanding its support. Another leader told us there was a diverse offer at the hub and engagement with community groups around dementia to understand cultural differences and barriers to support. A person also told us there had seen a steady increase in people from diverse backgrounds accessing support from the hub and how this had been supported by local authority engagement with communities in faith settings, such as churches and mosques, for example. However, there was an opportunity to further expand the diversity of voices to understand and improve people's experiences of services. For example, a person told us there was opportunity for more representation from Eastern European and Afro-Caribbean communities in formal stakeholder groups. The local authority was taking steps to further understand their communities and to help them access support.

The local authority was taking steps to address inequalities experienced by people and this work continued to embed. For example, a leader also told us, through the Learning Disability Partnership Board and the use of experts by experience, an action plan around improving the experiences of people with learning disabilities had been developed. This included the need for an expansion of physical activities for these people, for example. There was also ongoing work to support increased rates of annual health checks with partners for people with learning disabilities, with 80% of people registered with a learning disability receiving a check for 2024/25 in Coventry and Warwickshire (compared to 77% in 2023/24).

The local authority was taking steps to further embed its inclusive practice. An external practice review, with a focus on inclusive practice and cultural competence, took place in March 2025 which highlighted a need to further embed cultural competence to identify and address the impact of oppression and discrimination within assessments and support plans. Assessments and support plans we reviewed showed staff were considering cultural needs as part of people's strengths and support. Staff teams also told us how they supported people's cultural needs, such as accessing support to attend faith centres including churches and a Gurdwara. A staff team told us how they challenged commissioned services to support culturally appropriate care, such as meeting dietary requirements. There was said to be an expectation of care providers to be flexible to support cultural needs, with some providers telling us how they were supported by the local authority to provide culturally appropriate care.

The local authority was supporting staff and managers with training and guidance to support inclusive practice. Examples included training which supported understanding of autism, and a programme of Social Graces training commenced in October 2024. Social Graces included training around Gender, Geography, Race, Religion, Age, Ability, Appearance, Class, Culture, Ethnicity, Education, Employment, Sexuality, Sexual Orientation and Spirituality. The ASC Organisational Health Check (2024/25) showed staff were asked about their confidence in practice being culturally competent and inclusive. The average rating was 8, and over half (57%) scored themselves 8 or higher (out of 10). The local authority continued to support staff to embed inclusive practice.

The local authority had regard to its Public Sector Equality Duty (Equality Act 2010) in the way it delivered its Care Act functions. There were 4 equality objectives (2025-2028) and progress against the objectives was reported annually to the Cabinet Member for Policing and Equalities and the Council's Scrutiny Co-ordination Committee. The local authority also assessed the impact of their decision making on different groups of people with protected characteristics through Equality Impact Assessments (EIAs). For example, prior to re-commissioning the commissioned carers service, there was clearly considered impact on people's protected characteristics, such as race. The EIA highlighted underrepresentation of ethnic minority groups accessing services for carers, but also steps to address this such as promotion of messages in faith and community centres. A partner also told us, through the commissioned service, there was a specific support group which was a dedicated support space for ethnic minority communities. The local authority was considering the impact of its decisions and using this information to support inclusivity.

The local authority supported diversity and inclusion in its workforce. The local authority had an action plan to support inclusion within the workforce. There was ongoing work, for example, to increase diversity in leadership positions in ASC and support inclusive recruitment and retention. An ASC Workforce Board also included representatives from staff networks to enable inclusive conversations and challenge non-inclusive approaches. This was supporting staff teams which were reflective of the communities they worked with.

Inclusion and accessibility arrangements

There were appropriate inclusion and accessibility arrangements in place so that people could engage with the local authority in ways that worked for them, for example British Sign Language (BSL), interpreter services, large print, easy read materials and text message services. This meant people with communication, sensory and cultural needs were able to access information, assessments, and support in a way that was meaningful and inclusive.

People's experiences demonstrated inclusive arrangements which supported meaningful outcomes for them. For example, we heard a person's assessment arrangements were adapted to individual needs, such as providing a different language spoken assessor enabling clear conversation and trust. A further example involved an autistic, profoundly deaf and nonverbal young person, and staff used BSL flexibly to enable a full assessment of care needs. This resulted in support to reduce isolation, promote independence and develop functional skills.

The local authority had a wide range of approaches to reduce engagement barriers. For example, the Coventry Interpretation and Translation Unit (CITU) service provided rapid language support, including same day interpreters, on demand telephone translation, covering 362 languages, including Arabic Sign. Leaders also told us, in response to emerging needs, public information was produced in six main languages spoken in Coventry, later expanding to Arabic following consultation with partners. Staff told us they identified communication and cultural needs during assessments and arranged appropriate support for people who could not speak English. These included visual tools and face to face visits, enabling people with reduced literacy to share their views.

Accessible information was provided in formats which supported people with varied communication needs. Staff used easy-read leaflets during home visits, including materials on preparing for adulthood, DoLS and adult social care processes, helping people and families to understand their rights and next steps. Easy read materials were also used to promote accessibility of information at large during large community events.

People with sensory needs were being supported with accessibility needs, but there was some feedback that accessibility could be further developed. The local authority, for example, used technology to support communication with people who had sensory needs, such as text relay or read aloud assessments. People also accessed British Sign Language (BSL) interpretation to support their assessments. The local authority also had a tool for their webpages which made online content more accessible for people with dyslexia and those with mild visual impairments. However, a partner told us online platforms could be difficult to navigate for people who were visually impaired and phone-based alternatives were not always well advertised. The local authority had resources to support people with sensory needs and there was a continued need to ensure information remained accessible for people.

There was a commitment to support people who were Deafblind. A leader told us there had been work to systematically meet the statutory need to support deafblind people, who were recognised as one of the most marginalised groups. Another leader told us storytelling approaches were included in public information to increase visibility and representation of people with Deafblindness. We heard from staff who had completed Level 3 deafblind assessor training and delivered a bespoke communicator guide service, ensuring people received specialised and equitable support. These practices ensured Deafblind individuals could access support in ways that respected their communication and support needs.

The local authority had a focus on reducing the risk of digital exclusion. Some partners told us there were challenges around digital accessibility, such as for communities where literacy rates were low, for example. In response to this risk, digital inclusion was being promoted through Cov Connects, a local authority-led digital initiative aimed to reduce the digital divide in Coventry by improving digital access through provision of devices, sim cards and developing digital skills. Staff and leaders also told us about ongoing work to reduce digital exclusion so information accessible to people. For example, a leader told us how unpaid carers were supported through a digital skills programme and could access a free laptop which could support with employment opportunities. Wi-fi and computers were also available free of charge via community hubs. Additionally, the local authority ensured non-digital routes remained available such as leaflets, in person events and telephone support, recognising increasing digital options could impose a risk to people with limited digital confidence.

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: 2

2 - Evidence shows some shortfalls

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 used data and insight to understand local needs. A staff team told us the Joint Strategic Needs Assessment (JSNA), Census, demographic data, and system-wide surveys supported understanding of the market, for example. This data and insight also supported strategic documents, such as the Market Position Statement (2024-2029) and the Commissioning Strategy (2025-2030).

The Market Position Statement set out current and anticipated demands on adult social care (ASC). For example, the local authority reported demand for ASC was generally increasing, with people presenting with what senior leaders described as increasing complexity of support and an anticipated growth in the older adult population. There were clearly set out projections by 2032 based on service type, which identified a need for more development of nursing care, for example. Public health data also showed projected yearly increases in the number of autistic people and people with moderate or severe learning disabilities. A senior leader told us market development was a challenge due to changing levels of need in the community, including increased complexity in need and more younger people accessing support. The local authority was effectively using data and insight to support understanding of the market and planning for future services.

The local authority also worked with key stakeholders to better understand their market. For example, a staff team told us how commissioners worked with frontline teams to better plan services. Partners also told us provider forums supported information sharing so the local authority better understood local needs, although there was some feedback that providers would like the opportunity for more forums and forums which reflected their specific service type. They also told us there were strong relationships where feedback was sought by commissioners as well as engagement events which supported local communities to give views on local needs. Another example of stakeholder engagement was the feedback gathered to inform the Carers Action Plan 2024-2026. This had outlined challenges for carers, such as the need for further short break options, which were a focus of the plan. The local authority was using stakeholder information, as well as data, to help direct its commissioning intentions.

Market shaping and commissioning to meet local needs

The local authority's commissioning strategies and market shaping plans supported commissioning activity to meet local needs. For example, as well as the Commissioning Strategy and Market Position Statement, the local authority had specific market development plans for mental health needs, learning disability and autism, as well as older people, physical and sensory impairment needs. The development plans had a focus on promoting independence, cost-effective care and a move away from traditional models of care to help release funding for other models. The local authority recognised a need to further embed outcomes-based commissioning to better focus support people to reach their chosen outcomes. For example, the Market Position Statement outlined a need to ensure homecare was delivered in a reablement manner to promote independence. The local authority continued to develop their market and commissioning approach to better support people's needs.

The local authority used a mix of commissioned external services and internal services to support people. For example, the local authority had provision for residential short breaks, housing with care schemes (for people 55+) and day opportunities for people with learning disabilities and autistic people, as well as an expanding shared lives service. Other external services were commissioned through a mix of spot purchase and framework arrangements. There was a supported living and day opportunities framework, for example, and there was also a homecare framework with further plans to introduce a new homecare framework.

The local authority had some examples of market shaping to help address local gaps, including through an increase of options for supporting people's independence outside of residential settings. For example, specialist training had been rolled out to upskill supported living providers in supporting people with increased needs. Supported living options had also been expanded. For people with learning disabilities and autistic people, there had been an increase in 56 units of supported living over the previous 3 years to support a wide array of needs. Also, over the previous 3 years, 93 supported living flats and 52 medium-term hybrid beds delivering recovery-focused reablement programmes for people with mental health needs were established. Local authority data showed, for people with mental health needs, in 2020 37% of in-city placements were in long-term residential settings, but this had decreased to 26% in 2025. There were also 13% of people in medium-term hybrid flats. Supported living use had also gone from 17% of people in 2020 to 54% in 2025. A staff team told us audits and identification of themes from people's experience had helped to shape mental health services and the local authority had gone from needing to place people out of area for supported living to giving people a choice locally, which reduced the risk of people moving frequently between services. This demonstrated how shaping was supporting local choice and promoting people's independence.

There was mixed feedback from partners about future planning and market shaping. For example, some partners told us they were involved in joint commissioning work, with open and trusting relationships. However, others told us commissioning could feel more reactive than proactive. For example, a partner told us the local market could feel slow to adapt to local need and there was a lack of choice for people. National data from the Adult Social Care Survey for 2024/25 also showed 67.93% of people who use services felt they had choice over services, which was similar to the England average (70.70%). The local authority continued to develop their market to further support people's choice.

There was a need to ensure carers were effectively supported to access breaks. National data from the Survey of Adult Carers (SACE) in England for 2023/24 showed 14.02% of carers accessed support or services allowing them to take a break from caring at short notice or in an emergency. This was similar to the England average (12.08%). SACE also showed 14.81% of carers accessed support or services allowing them to take a break from caring for more than 24 hours. This was similar to the England average (16.14%). Finally, SACE showed 23.85% of carers accessed support or services allowing them to take a break from caring for 1 to 24 hours. This was similar to the England average (21.73%). This showed most carers were not accessing breaks from their caring roles.

The Carers Action Plan (2024-2026) outlined steps being taken to improve access to breaks for unpaid carers. For example, there had been a recommissioning of the short breaks offer. A leader told us the offer was supporting prevention, with a mix of a flexible offer from the commissioned carers partner, commissioned and spot purchased bed-based breaks, through direct payments and through the introduction of Mytime. Mytime was a further opportunity to access free short breaks, through local hotels and leisure facilities for example. Some unpaid carers told us the Mytime offer had increased opportunities for a break from their caring role, which supported carers' wellbeing. A partner also told us flexible short breaks could be tailored to people's and unpaid carers' needs, with support delivered at home or in other settings. Unpaid carers were supported to attend special events such as weddings, for example, because of temporary support arrangements. A leader told us there was more to be done to improve access to breaks, with them aware of feedback of a need for more joint break options for the unpaid carer and cared for person, for example. The local authority was taking steps to better shape their offer for unpaid carers, but this remained an area for development.

Ensuring sufficient capacity in local services to meet demand

The local authority had capacity to support people to access residential and homecare services, but some services, including services for independent living and specialist services for people with higher or multiple associated needs were not always available.

Residential, nursing and homecare services were generally accessed in a timely manner. A staff team told us framework agreements and block bed arrangements helped maintain sustainability and flexibility, particularly during periods of peak demand. Information provided by the local authority stated residential and nursing care was accessible within 2 days but could be longer for where a specific service had been identified by the person or their family and it did not have availability. For homecare, people had support in in place within 0- 2 days from the request to the start of the support.

There was a continued opportunity to address gaps in independent living options for people, but recent market development had increased capacity. The local authority's market development plans highlighted access to affordable housing with care options for older people, as well as independent living for people with learning disabilities and people with mental health needs as a development focus. Staff teams also told us accommodation for under 55s and those with physical disability needs, were gaps. Despite this, local authority data showed there were consistent vacancies in supported living for people with mental health needs and people with learning disabilities following the development of this market. Where appropriate for people's needs, supported living and housing with care options were also accessed in a timely manner. The local authority was responsive to where gaps emerged with a leader telling us, for example, there had been emergency provision sourced to support people who required wheelchair access to accommodation to help meet local need.

Some services could be more difficult to source within Coventry and required people to live outside of the city. For example, a senior leader told us there was opportunity to further develop services around specialist needs. The Market Position Statement also highlighted challenges in sourcing care for people with high level nursing needs or specialist support. Some staff teams also told us about these challenges. For example, there was said to be opportunity to further develop local provision for autistic people as it could be difficult to find appropriate support within the city. Staff teams also told us there were some local gaps for people with additional mental health needs such as support for people who came into contact with the law and required specilised and high intensity care. This meant people could rely on services outside of Coventry when this may not have been their choice.

Data provided by the local authority showed that, as of 31 August, 251 people were in long-term residential placements outside of Coventry, with 52% placed in Warwickshire and 21% in the wider West Midlands. Between 1 September 2024 and 31 August 2025, 107 people were placed in residential or nursing services outside of Coventry. Of these placements, 51% were due to complex needs, 22% followed a Best Interest decision, and 13% were based on individual preference. The local authority defined complex needs as requiring a higher level of care due to multiple associated learning disabilities, dementia, and/or mental health needs. They reported that while local provision was generally available, out-of-city placements were sometimes required to meet these specialist needs. They also explained that the category of complex health needs could include Continuing Healthcare, pathway 3 hospital discharges, and Fast Track placements, which were commissioned across the wider Coventry and Warwickshire Integrated Care System footprint. Pathway 3 hospital discharges were for people who were likely to require long term residential or nursing care on discharge from hospital.

Of the 107 placements, the local authority confirmed 44 were short-term (41 commissioned by Coventry and Warwickshire ICB). Of the remaining 63 long-term placements, 19 followed a Best Interest decision, 32 were based on the person's choice, and 12 were due to mixed reasons, including safeguarding. When health-funded pathways ended, people were reassessed and in-city options were discussed, although some chose to remain out of area. As of 18 March 2026, 249 people were placed out of city in long-term care, with the local authority reporting 195 had resided outside of Coventry for over 12 months as their choice.

The Market Position Statement and Commissioning Strategy outlined a focus on reducing out of city placements. Local and locality-based delivery of services was a strategic focus of the Commissioning Strategy emphasising the important of local community connections. The Market Position Statement also outlined the need to address gaps in local provision to reduce out of city placements which were not people's choice. Market development plans also set out plans over both 2 and 5 years to increase local capacity across a range of service provisions. A staff team also told us out of city placements following a hospital discharge were minimal and when this did happen, they were supported back into the city quickly where appropriate. There were clear plans to address gaps in local provision, but some people were supported out of area when this may not have been their choice.

Ensuring quality of local services

The local authority had clear arrangements to monitor the quality and impact of the care and support services being commissioned for people and it supported improvements where needed.

The local authority hosted a joint quality team with the Integrated Care Board, which was supported by a Quality Assurance Framework. The framework clearly outlined and defined the local authority's approach to supporting provider quality. The framework applied to contracted providers within and outside the city, as well as non-contracted providers where there were concerns about quality or safeguarding concerns. A staff team told us providers were visited at least once a year, with quarterly follow-ups for nursing providers, and more frequent visits where risk was identified. This supported both a proactive and responsive approach to safety and oversight. A staff team also told us how joint arrangements supported clinical health colleagues to contribute to assessments and oversight, such as nursing home providers. This supported a robust approach to support local quality and respond to risk.

There were clear systems to support oversight and action planning in response to concerns. For example, there were regular internal and multi-disciplinary meetings where concerns were discussed. A staff team told us multi-disciplinary approaches included key partners such as GPs, local health trusts and the fire service. Themes of risk were also shared with CQC to support regulatory activity. Another staff team told us how meetings enabled a coordinated response to risk and this supported providers to improve their care and support for people. Where increased risk to people was identified, the local authority took steps to keep people safe. For example, a staff team told us contracts were suspended or embargoed where concerns were identified. This supported focused improvements in standards for the people they already supported. They told us these were lifted once providers demonstrated improvement, which helped maintain standards and continuity for people.

Providers were supported to improve where risks or concerns were identified. Staff told us there was structured support for providers, including improvement plans, close monitoring and clear written expectations. Staff shared 3 providers had moved from an Inadequate CQC rating to Good in the previous 3 months. They told us, in an example, there was a multi-disciplinary approach which encouraged improved care planning, leadership and compatibility considerations at a service. In a further positive example of quality improvement, a provider told us the local authority offered clear guidance, regular contact and direct access to staff to support their improvement. This demonstrated a collaborative approach to improving quality.

As of 29 September 2025, there were no current embargoes placed on care providers. During 2024–25, the local authority imposed 15 embargoes affecting 11 providers following proactive contract management and intelligence-led reviews. Data showed 10 embargoes were placed on home care and supported living services, and 1 on residential and nursing homes. Of these embargoes, in 10 providers there were quality concerns and 1 provider had health and safety concerns. The local authority outlined the embargoes placed followed scheduled contract management meetings or a triangulation of information leading to an unplanned management meeting. Embargoes were put in place while underlying concerns were investigated or resolved. All providers were supported to make improvements and all embargoes were lifted by the time of the assessment.

Ensuring local services are sustainable

The local authority understood its current and future social care workforce needs, with a Market Sustainability Plan (2023) outlining local sustainability challenges and pressures. Following a survey of care providers, the local authority found for care homes, the highest reported priority concerns were in relation to the recruitment of staff, followed by staff retention and financial running costs.

The local authority was taking steps to support its provider market to address these sustainability challenges. For example, a provider support pack had been introduced which included guidance and resources and checklists to support sustainability such as recruitment, retention and reducing business costs. The local authority also worked with a range of local and regional partners to strengthen recruitment, skills development and business sustainability across the care sector. This included an employability hub at the Coventry Job Shop, where the Employer Engagement Team provided free, tailored recruitment support and training, for example. Providers told us they felt supported with recruitment, such as through sponsorship schemes and through the Job Shop.

National data from the Adult Social Care Workforce Estimates (ASCWE) for 2024/25 showed a staff turnover rate of 0.18. This was somewhat better than the England average (0.24%). ASCWE for 2024/25 also showed, 11.17% of ASC jobs were vacant. This was worse than the England average (7.04%). This demonstrated some of the local challenges with recruitment for care providers.

The local authority worked with providers to set fees. Some providers told us about financial constraints they faced but told us there was transparency and strategic involvement in long-term planning with the local authority such as engagement in rate-setting consultations. A staff team also told us yearly uplifts were announced and providers had the opportunity to challenge these.

The local authority also supported care providers and their staff to access workforce development opportunities and training. Provider forums and bulletins made information available for providers around opportunities and best practice updates, for example. Some providers told us they felt supported to access training and development and support. For example, some providers told us they had been supported to access specialist training requested for their staff when requested. Other areas of training and support referenced by providers were around mental health training and culturally appropriate care. In addition, the Coventry and Warwickshire Skills 4 Growth programme helped small and medium-sized care organisations address workforce skill gaps through customised training, while wider local authority teams such as adult education provided further courses and bespoke workplace training such as medication control and moving and handling. The local authority was supporting local providers to access training and development opportunities which supported sustainability.

The local authority's data showed there were no early contract hand backs from residential or nursing homes during the period reviewed. A home-care contract was handed back in 2024-25 due to financial pressures, affecting 11 care packages, and a residential contract was handed back between 1 April and 31 August 2025 because the owner retired. This demonstrated providers leaving the market was minimised for contracted providers.

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 agree and align strategic priorities, plans and responsibilities for people in the area. Key strategies across partnerships demonstrated shared priorities, which included the Health and Wellbeing Strategy (2023-2026) and the Integrated Care Strategy (2023), for example. The strategies prioritised integration, prevention and collective action as a system. A partner told us there was a joint focus on prevention and early intervention to tackle the root causes of health inequity and to make services more effective and inclusive.

The local authority was working closely with system partners to support shared delivery of local priorities. For example, as part of delivery of the Integrated Care Strategy, the local authority worked with health and care partners to develop the Integrated Care Delivery Plan (2023/24-2027/28) which provided detail of operational delivery of strategic priorities. For example, the Improving Lives system transformation, which involved the local authority and health partners, had supported the development of multi-disciplinary and community-based teams to support hospital discharge and short-term support to people in the community. Integrated services were launched in June 2024, with further expansion of this approach being developed as part of the Community Integrator Programme. This demonstrated a strategic alignment in integrated approaches to delivery between the local authority and its health partners.

Place-based arrangements were also supporting governance, oversight and integrated decision making. The Coventry Care Collaborative was a place-based formal structure which brought health and social care partners together. This sat under the ICB and was linked to Integrated Care Partnership (ICP) priorities. The collaborative included representation from the local authority, the ICB, local health trusts, the voluntary, community, faith and social enterprise (VCFSE) sector and Healthwatch, for example. The Collaborative met regularly and was given responsibility for commissioning urgent care, community services, overseeing the Better Care Fund (BCF), Continuing Healthcare (CHC) and ensuring continuity across organisational boundaries. A senior leader told us there was close work between partners at the Collaborative and a partner told us how these arrangements supported shared governance, accountability and resource allocation between the local authority and its key partners.

There were also arrangements to support multi-agency partnership boards with more specific delivery of strategic priorities. For example, the local authority was a member of the Learning Disability and Autism Collaborative, which was chaired by health leaders and an expert by experience. The Collaborative had oversight and responsibility for system objectives, as well as oversight of the Coventry and Warwickshire Partnership Boards for autism and learning disabilities. These boards consisted of multi-disciplinary professionals and experts by experience. The Autism Partnership Board, for example, provided oversight of delivery of the Joint Strategy for Autistic People (2021-2026). From this strategy, for year 4, actions were either completed, closed or on track to be completed in the timescale of the strategy. A partner was also positive about partnership board arrangements, telling us it put the person at the centre of focus. The local authority was working closely with system partners to help improve outcomes for people through partnership arrangements.

Arrangements to support effective partnership working

The local authority and its partners were further embedding integrated arrangements to support the delivery of health and social care. The local authority was part of the One Coventry Integrated Team (OCIT), launched in June 2024, which incorporated a range of teams and services. Integrated arrangements included local integrated teams (LITs), which provided multi-disciplinary short-term support for people in the community and people discharged from hospital. Integrated arrangements were also being further developed towards integrated neighbourhood working. A leader told us how LITs provided the initial footing for future integrated arrangements with current arrangements having been in place for over a year. They told us about further development of the approach, including a joint training programme for all staff within LITs which was being developed for all staff to support a consistent approach with a focus on Care Act principles such as strength-based practices. The next stage of integration, through the Community Integrator Programme, was being trialled in a specific area of Coventry before a wider roll-out of an integrated neighbourhood approach. The programme was being closely evaluated to support improvements of the approach. This demonstrated a commitment to integrated arrangements which worked closely within the neighbourhoods they supported.

The local authority also had further integrated arrangements, such as a Section 75 (s75) NHS Act (2006) arrangement for the delivery of mental health services. Mental health services were hosted by the local mental health NHS trust, which meant social care staff were part of integrated teams with health colleagues. There was oversight and governance from a strategic board which included leaders from across the partnership. The board, along with subgroups, agreed to any significant strategic or service changes and provided oversight of performance against targets and improvement planning. A partner told us the agreement had longevity, maturity and openness, with the local authority and local trust meeting challenges head on. A leader also told us the local authority maintained line management responsibility for its staff as part of the agreement and they valued the integration and benefits from the integrated team. Staff were also positive about arrangements, with integrated working described as flexible and supporting joint working with health colleagues, which aided the identification of needs and swift decision making about support.

The s75 Annual Report, produced by the Coventry and Warwickshire Partnership Trust, highlighted further areas for development within the integrated mental health arrangements. For example, the report highlighted although co-location of services had been achieved in most areas across Coventry and Warwickshire, teams could still operate in parallel rather than as cohesive units. The report outlined there was ongoing work to further ensure alignment with plans to also strengthen joint leadership.

Outside of formal integrated arrangements, staff teams told us about strong partnership working. For example, staff teams told us joined-up working with health partners was supported by regular multi-disciplinary team meetings with primary health professionals. This created valuable opportunities to connect and discuss people's needs. A team told us there was long-standing partnership working, with buy-in from every agency involved, with opportunities for challenging conversations between partners. This strengthened multi-agency collaboration, leading to more coordinated care and better outcomes for individuals.

Governance systems were in place to support arrangements to work with partners to use pooled budgets to jointly fund services, such as through the BCF. For example, governance decisions for the BCF were approved through the Health and Wellbeing Board and governance of the implementation of the BCF was through the Adult Commissioning Group which was an agreed s75 arrangement. The Better Care Fund Narrative Plan for 2025-2026 outlined national objectives with specific local priorities. There were a range of priorities, which included progressing the Community Integrator programme, developing the approach to home adaptations and technology, improving support for unpaid carers and building upon work to reduce avoidable admissions, for example. The plan was developed with engagement between the local authority and key stakeholders, which included the VCFSE and health partners.

The local authority worked with partners to support funding decisions for people's care and support, but reaching agreements could be a challenge. Leaders told us they recognised some of the challenges around funding decisions but told us staff were being supported to feel more comfortable when disagreements arose and when people were being advocated for. For example, there was training for staff to develop their expertise around Continuing Healthcare (CHC) and there were clear routes for escalations where there were disputes. A staff team also told us there were ongoing pressures from CHC decisions, but disputes were resolved constructively. Another staff team also told us there were situations where there could be disagreements but told us they were supported well by the local authority to be part of this decision making. The local authority continued to support people to access health funding where eligible, but delays due to disputes risked delays in funding and uncertainty for people. There was a continued need to work closely with partners to resolve disputes in a timely manner.

The local authority worked with partners to improve information sharing to support better informed and smoother decision making. A priority of the BCF for 2023-2025 was the further implementation and take up of an integrated care record in social care. A review of progress against this priority outlined this was now in place and allowed health and social care to have visibility of partner information, through a supplementary ICT system that drew data from separate systems. This would help ensure that decisions on care, support or treatment were made in the knowledge of all health and care information held. However, there was some mixed feedback from staff about information sharing between partners. Some staff teams told us there were still some challenges with duplication and information sharing. However, other teams told us the transition to new systems, including the integrated care record, had helped to streamline communication and improved access to shared information. The local authority had taken steps to improve information sharing and this continued to embed to support informed decision making about people's care and support.

Impact of partnership working

The local authority monitored the impact of pooled budgets and evaluation showed positive improved outcomes for people, supported by the transformative Improving Lives approach. There was monitoring of outcomes of the Better Care Fund against national metrics, all of which had been met for 2025. This included rates of avoidable admissions per 100k of population; emergency hospital admissions due to falls in people aged 65 and older per 100k, and long-term support needs of people age 65 and over met by permanent admission to residential and nursing care homes, per 100k population (65+). BCF metric monitoring initially showed the % of people, resident in the Health and Wellbeing Board area, who were discharged from acute hospital to their normal place of residence had not met the target. However, the local authority highlighted data recording issues with this metric and outlined the target had been met in a report to Cabinet Member in October 2025. Further data analysis also showed a downward trend in admissions to residential services. This demonstrated the positive impact of pooled funding on preventing admissions and promoting independence.

Leaders, staff and people's feedback also demonstrated the positive impact of partnership working and integrated arrangements. For example, a staff team told us integrated teams were improving integration and reducing duplication between teams which supported smoother care and support journeys for people. Another staff team told us about a positive example of intermediate care support, where a person who was at risk of homelessness was supported to regain their independence. The person was then supported by a joined up approach with the housing team and accommodation was found for them within an hour, along with a care package, food and medication. The local authority also provided data on people's experiences of the OCIT between 1 May 2025 and 31 Oct 2025. This showed of the 44 respondents, 95.45% had a positive experience, with 2.27% having a negative experience. Collection of feedback was stated to be offered at each stage of a person's journey with the team. A person's relative also told us how they were supported by their social worker to access other health services to support positive outcomes, for example. This again demonstrated the impact of close partnership working in supporting people to achieve positive outcomes.

The local authority also worked with partners to evaluate the impact of s75 arrangements through both oversight arrangements and partner-led annual reports. For example, the s75 Annual Report for 2024-2025 highlighted achievements of the integrated approach, such as supporting people to positive outcomes through multi-disciplinary work. It was also highlighted, however, there was a need to further develop data recording around waiting times for social care interventions for people with mental health needs so these could be accurately monitored. There was a recorded aim to report data through a dashboard in 2025/26. The local authority continued to work with partners to develop and improve formal integrated arrangements, but there was an opportunity to ensure people's experiences of services were monitored effectively.

There was close working between partners to understand local need, such as through a population health management (PHM) approach. For example, a population health management approach was being used to help plan integrated team arrangements, to target inequity and support a tailored approach to neighbourhood working. Some partners told us there were strong partnerships across the population health management related data. A partner told us work on inequalities was mature, intentional, and evidence based. While inequalities remained significant, the next stage of the journey would focus on using data and evidence to demonstrate real impact. This helped ensure that efforts to reduce inequalities were collaborative and grounded in lived experience.

Working with voluntary and charity sector groups

The local authority worked with voluntary and charity organisations to understand and meet local social care needs and this approach was being further developed with key partners, such as the ICB.

The local authority had supported the establishment of a VCFSE collaborative in 2025 which was led and resourced by the ICB. This was overseen by the System Strategy and Planning Group (SSPG) on which the Director of Adult Social Care and the Director of Public Health sat. The VCFSE collaborative was created to bring together the sector for a single-entry route of contact and engagement and to have a representative voice at a system level. The collaborative was intended to reduce duplication while also supporting the VCFSE to contribute to the design and delivery of integrated care. This approach was still embedding, with a recognised need to increase membership for Coventry-based organisations. This demonstrated an approach to better support the VCFSE to have a voice in local decision making and processes.

Most partners told us they had a good working relationship with the local authority. For example, a partner told us there were healthy working relationships even when there were disagreements. Another partner told us their close relationship was supporting understanding of local needs and more targeted support for people, which was part of the wider prevention agenda. Other partners told us of regular meetings with the local authority which supported oversight of activity, with a partner telling us a data dashboard set up by the local authority was supporting data sharing and greater insight into their performance.

The local authority took steps to involve the VCFSE in strategic conversations, such as through relevant boards or the development of strategies. There was VCFSE representation at, for example, the Coventry Care Collaborative. A senior leader told us there was an emphasis on involving a range of stakeholders to improve delivery of services and there was a vital role of the VCFSE in filling service gaps and supporting vulnerable people. Another leader told us VCFSE expertise strengthened community-led solutions and supported a more sustainable system.

There was mixed feedback from partners on how well the VCFSE sector's voice was used in strategic conversations. Some partners highlighted they were involved with specific development activities with the local authority, and there had been positive impact of these activities, but they felt there was a need for broader engagement with the sector. Another partner told us that although they were involved in strategic forums, but they were not always kept informed of developments and that their input was valued but sometimes lacked follow-through or visibility in decision-making processes. However, a partner also told us they contributed in a range of strategic forums at a health and care system level. There remained further opportunity to ensure organisations were embedded in strategic conversations and supported in decision making.

The local authority worked closely with the VCFSE to support communities, with commissioned services and grant funding available. For example, the local authority was recommissioning its VCFSE prevention provision at the time of the assessment, where funding had remained stable from the previous year. There were, however, financial and sustainability challenges for the VCFSE sector, especially for smaller organisations. Some partners told us there was a vibrant sector, but smaller grassroots organisations did not always receive support, funding or recognition compared to some larger organisations. A partner also told us the local authority was aware of this and actively engaged with those smaller organisations to strengthen sustainability and ensure a balanced approach to market development. This was reflected in the VCFSE Collaborative development, which aimed to support better funding streams for the sector, with further support to access funding opportunities.

Theme 3: How Coventry City Council ensures safety within the system

This theme includes these quality statements:

- Safe pathways, systems and transitions
- Safeguarding

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

Safe pathways, systems and transitions

Score: 3

3 - Evidence shows a good standard

What people expect

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

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

The local authority commitment

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

Key findings for this quality statement

Safety management

The local authority had established robust arrangements to manage safety across people's care journeys. Leaders demonstrated a clear understanding of where people could be most at risk, including during hospital discharge, out-of-hours support and when care arrangements changed. Systems were in place to identify, escalate and mitigate risks, and there was effective oversight to ensure people did not experience unsafe delays or gaps in support.

The Emergency Duty Team worked across children's, adults' and housing services and had access to all 3 electronic systems. This ensured all relevant information was visible to day teams so risks were not missed. Staff and leaders told us there were strong safety arrangements across adult social care (ASC) services during the day and out of hours. For example, the emergency duty team used location sharing and lone working devices and always had managers and a strategic lead on call to guide complex decision-making. Daily handovers and quick allocation to specialists such as Approved Mental Health Professionals (AMHPs), social workers and practitioners in children's and housing services meant essential information was shared promptly so all relevant details were considered to support the person. Partners also told us support was available out of hours, such as to help prevent crisis situations.

The local authority had effective systems of oversight and risk mitigation for people who were waiting for support. Leaders used performance dashboards to actively monitor people's waits and prioritisation tools supported those in most need to get support. Staff told us risk was actively managed for people waiting for services through regular welfare checks, triage and prioritisation, with urgent cases allocated promptly. They told us welfare checks were undertaken every 4 weeks for people who had not yet been seen, for example. Leaders monitored the list closely and received regular updates to ensure nobody was waiting in unsafe circumstances.

There were systems to support safe care and support planning and to help mitigate risk to people. For example, there were multi-agency forums and panels which coordinated support for people at highest risk, including those at risk of homelessness. For example, between 1 April 2024 and 30 April 2025, of 145 closed discussions about people at multi-agency forums, homelessness was prevented overall for 81% of people. Staff could also access panels which offered professional advice when people were at high risk and needed support to manage this. A leader told us attendees included senior practitioners, the Mental Capacity Act lead and the Principal Social Worker as chair. The panel included a focus on accessibility to enable the person and/or their carers or representatives to fully and meaningfully participate should they have wished to. The panel was not a decision-making tool but provided advice on how staff could try and mitigate risk. A staff team told us how the panel had supported them with ideas on how to move people's support forward. These systems were supporting staff to help keep people safe.

Safety during transitions

The local authority had processes and policies in place to support safe transitions across people's care journeys. Care and support were planned with people and partners to maintain safety and continuity.

Arrangements were supporting transitions between children's and adult services. The local authority had a standalone transitions team who engaged with and completed assessments for young people. Oversight and referrals began from age 14, although a staff team told us timescales of support varied based on the level of support needed for the person. There was early planning for young people who had higher levels of commissioned support through children's services, for example. A monthly operational transitions meeting which involved children's and adult services, mental health, and commissioning enabled early oversight of young people who would potentially need adult services. Staff also told us they attended meetings with children's services, partners as well as young people and their families prior to the person reaching age 18, for example, Education and Health Care Plan meetings. Staff told us that close communication between children's and adults workers supported families to understand the transitions process. The local authority also outlined their outreach approach to help identify more people eligible for services. For example, adult social care (ASC) had visibility at the SEND Partnership Board alongside partners. The transitions service also visited schools and engagement events to help raise the profile of available services.

While systems were in place to support transitions, there was mixed feedback from people on their experiences. For example, a person's family told us the assessment was carried out promptly and overall, the process was smooth, although the family occasionally had to repeat information to professionals. Staff had also discussed the types of support available, including communication assistance, carers, family support, and advocacy services. However, another family told us while children's and adults services worked well together, there had been some gaps in support. They told us some reviews of support had to be chased and there was a lack of awareness of all the services available to the person. There was a need to ensure there was consistency in young people's and their families' experiences of transitions.

Hospital discharge arrangements were supporting smooth transitions for people. The Adult Social Care Discharge Team worked 7 days a week and there were shared dashboards between ASC and health, which supported discharge flow. A triage tool was used to prioritise high-risk discharges and staff paused discharges when placements were uncertain. Leaders and staff told us there were clear escalation routes for delays, including escalation to advocacy and commissioning teams, and staff told us they checked with providers around availability and competency before placements were agreed. Staff explained that when concerns arose following discharge, the Emergency Duty Team carried out immediate checks, explored support networks and arranged safe and well visits with partners. A hospital liaison worker for unpaid carers, who was part of the commissioned partner service, was also supporting unpaid carers to access support for their caring roles following discharge of the cared for person. Where a person had more complex discharge needs, such as safeguarding risks or needed more support in decision making, social workers coordinated multidisciplinary input to plan support effectively. A person also told us hospital and local authority staff explained what was happening throughout the discharge process and staff worked well together to offer a joined-up service.

Partners, including care providers, were positive about discharge arrangements. A local authority employed care home liaison officer was completing trusted assessments to support smoother transitions from hospital settings to residential care homes. Some providers told us about seamless transfers from hospital, with a provider telling us hospital discharges were smoother due to the work of liaison officers and social workers. Partners also told us discharges ran smoothly and collaboratively supporting better outcomes for people. Transparency between services was said to have supported flow with people accessing safer more coordinated care as a result.

There was some risk of interruptions in care and support when people accessed services from hospital, but the local authority took steps to manage this. Staff told us some people transferring to care homes from hospital were managed by the Integrated Care Board (ICB) and were health funded. They told us this meant some people were placed outside of Coventry, as the ICB covered both Coventry and Warwickshire, and this sometimes meant people returned to Coventry if they later became ASC-funded. Staff teams took steps to support people back to Coventry to access local services where appropriate.

Transitions from hospital for people with mental health needs were supported by integrated arrangements. A leader told us transitions for people with mental health needs were a continued area for development. A partner also told us there could be challenges in capacity to complete discharges following Care Act assessments. However, staff told us arrangements were supporting safe and smooth transitions for people discharged from hospital. They told us information sharing from ward rounds, weekly section 117 (Mental Health Act) panel meetings and daily hospital discharge meetings to support urgent allocation supported oversight, for example. A specialist social worker was located at a local mental health unit and updated team managers directly on people's discharge planning and associated risks. Staff also told us they undertook challenging conversations if disagreeing with discharge timescales and undertook the role of critical friend to health colleagues. Brokerage was also co-located with staff and this enabled quick access to discharge pathways.

Contingency planning

The local authority had undertaken contingency planning to ensure it was prepared for a wide range of potential disruptions to care and support services. There was clear and structured emergency planning, resilience, and business continuity arrangements at both strategic and operational levels.

The local authority had a Critical Service Plan for adult social care which supported internal business continuity. A wider Emergency Response Plan also included measures for external consequences of emergencies. The Critical Service plan outlined steps to be taken in response to service disruption and responsible parties for related actions. This supported effective contingency arrangements for the services.

Where providers experienced financial instability or where services were at risk of closure, the local authority implemented structured interim plans to maintain care delivery. In an example provided by the local authority, a residential service gave notice due to financial viability concerns. An action plan was put in place to ensure ongoing care, clear communication with residents and their families and continuity of staffing while alternative arrangements were identified and this helped to keep people safe. Providers confirmed that the local authority actively monitored business continuity plans, particularly during periods of increased system pressure such as winter months. Providers told us the local authority communicated sector wide risks, including equipment and system failures, enabling providers to review and adapt their contingency plans promptly. A provider described how the local authority responded to suspected provider failure, offering clear advice on safety and contingency planning while coordinating support to safeguard people using services. Providers described this proactive engagement improved preparedness and helped maintain a safe care environment.

The local authority had contingency arrangements for people who received support from unpaid carers. Carers told us contingency arrangements through the commissioned Carers' Response Emergency Support Service (CRESS) gave them peace of mind. CRESS maintained support at home for up to 72 hours during emergencies or important appointments.

The local authority also took steps to support people where decisions around care funding were outstanding. Leaders told us continuity of care was prioritised and interim arrangements were consistently used while decisions were being made. They explained these arrangements were designed to ensure people continued to receive safe and timely support regardless of financial or contractual uncertainties.

Safeguarding

Score: 3

3 - Evidence shows a good standard

What people expect

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

The local authority commitment

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

Key findings for this quality statement

Safeguarding systems, processes and practices

There were safeguarding systems, processes and practices in place to protect people from abuse and neglect. The local authority had local Safeguarding Adults Practice Guidance and delivered its duties in line with the West Midlands Multi-Agency Policy and Procedure for safeguarding.

The local authority worked closely with the Safeguarding Adults Board (SAB) to provide clear strategic leadership and deliver a coordinated approach to safeguarding adults. The Board provided effective independent oversight and held the local authority to account through challenge, quality assurance activity and performance monitoring. The local authority actively contributed to the Board's work, including its subgroups which aligned local safeguarding arrangements with the Board's strategic priorities. This collaborative approach ensured safeguarding activity across the area was joined up, supported governance and focused on improving outcomes for people at risk.

Clear pathways were in place for receiving and prioritising safeguarding concerns, supported by management oversight. Safeguarding responsibility was embedded across all teams rather than held within a single specialist service, supporting safeguarding to be everyone's business. The local Mental Health NHS Trust also undertook safeguarding enquiries for people known to them. A Section 75 (s75) Safeguarding Board, which included representation from the local authority, supported oversight of the performance of the NHS Mental Health Trust in their delegated safeguarding duties.

There were systems to support oversight and assurance of safeguarding activity. For example, a safeguarding performance scorecard was completed quarterly to provide the SAB with oversight of safeguarding activity and people's outcomes across safeguarding partners. Quality assurance arrangements were also in place to support learning and improvement. This included SAB multi-agency themed audits, local authority end-to-end process audits and dip sampling for example. Audit activity also included delegated safeguarding activity completed by the NHS Mental Health Trust. Audit activity supported improvements to processes. For example, a staff team told us safeguarding cases were audited by the safeguarding lead and feedback was given on audit findings during supervision processes. As a result of auditing, forms had been recently revised to enable a more structured recording approach and collation of information in a central form which was consistent across teams. Oversight and assurance arrangements were in place to support quality and improvement.

National data provided by the Adult Social Care Survey (ACSC, 2024/25) showed 72.61% of people who used services felt safe which was similar the England average of 70.16%. The survey also showed 86.44% of people who used services said those services had made them feel safe and secure, which was similar to the England average of 87.81%. For carers, the Survey of Adult Carers England (SACE) showed 79.09% reported that they felt safe which again was similar to the England average of 80.93%. Leaders told us they monitored these national indicators closely to assess how effectively people felt protected.

Responding to local safeguarding risks and issues

There was a shared understanding of safeguarding risks and emerging issues across the local area.

Leaders and staff told us the local authority took learning from serious abuse and neglect seriously and embedded it into everyday practice. Over the previous 24 months, 10 Safeguarding Adult Review (SAR) referrals had been received with 2 meeting the criteria for a full review. These were overseen through a SAR tracker, which monitored referrals, decisions and statutory compliance with SAR processes. Staff told us learning from SARs and serious case reviews was shared through team meetings, practice forums, targeted learning events, provider meetings and recorded training sessions. Managers said these opportunities helped staff reflect on practice and understand how outcomes for people could have been improved. Providers told us the local authority offered clear guidance, reflective learning and follow-up support after serious incidents, which helped improve practice and promote accountability.

The local authority used data and insight to understand emerging local risks. For example, the local authority highlighted an increasing prevalence of self-neglect locally, which included hoarding. Demonstrating the use of data to understand local risk trends, the local authority shared self-neglect made up 14.2% of safeguarding enquiries in 2024/25, compared to 12.5% in 2023/24 and 11.5% in 2022/23. This was the 4th highest abuse type behind neglect/acts of omission, financial and physical.

The local authority took steps to respond to local risks and to help keep people safe by developing its support, services and guidance. Multi-agency support was made available through panels for people at high risk of harm, including self-neglect, for example. A leader told us the panel used a person-centred approach to discuss people's needs and align support between partners to help people stay safe. There was also guidance for staff for self-neglect and hoarding, for example. A best practice framework and toolkit was available which supported staff with practical methods and approaches, and staff told us there was access to learning events around self-neglect following a SAR related to self-neglect in 2023. The local authority also commissioned a specialist hoarding therapy service, which was occupational therapy-led and undertook intervention and treatment planning for people. A staff team told us the hoarding support model was also being redesigned to have a more co-ordinated and joined up approach with partners. In a positive example of staff support, a team told us how they effectively supported a person at risk of self-neglect due to hoarding. The person was supported into a short-term placement to mitigate an immediate risk of homelessness. Frequent engagement with the person also supported risk mitigation and their decision making on whether they wanted to return home.

There was some disparity in people's access to safeguarding. For example, The SAB Quality Assurance and Performance subgroup monitored data in relation to the number of safeguarding concerns and enquiries by age, gender and ethnicity via the performance score card. This revealed, there was underrepresentation of minority ethnic groups accessing safeguarding support. In Coventry, 8% of safeguarding concerns and enquiries were raised in relation to people who identified as Asian and 3% for those who identified as black which signified an underrepresentation compared to the ethnicity data for the local population. A key priority of the SAB Strategic Plan 2024/25 outlined a strategic ambition for safeguarding to be accessible for all. The SAB was undertaking assurance activity which involved auditing, further interrogation of the data and an evaluation of translated resources and their effectiveness. While understanding was being deepened, there was a continued need to support people from all backgrounds to understand safeguarding and for senior leaders to be assured all adults at risk were being identified and responded to.

Responding to concerns and undertaking Section 42 enquiries

There was clear understanding of what constituted a safeguarding concern and when the legal threshold for a Section 42 safeguarding enquiry had been met. Guidance, decision-making tools and flowcharts supported staff to assess risk.

Staff told us safeguarding concerns were screened promptly, often on the same day, with most decisions on how to progress a concern made within 48 hours. Staff told us decision making involved a 2-stage process of immediate safety checks followed by information gathering. Local authority data showed 88% of initial reviews were completed within a 2-day timescale. As of 31 August 2025, no concerns were awaiting initial review, with median and maximum waits of 0 days. Most reviews were completed within 2-day timescale, with mean average waits ranging from the same day to 3 days, influenced by periods of high demand, staffing capacity or difficulties contacting referrers.

The local authority also provided data on allocation and completion of s42 enquiries. As of 12 September 2025, there were 5 s42 enquiries for people awaiting allocation of a worker following screening. The median and maximum wait for allocation was 3 days. The target allocation time was within 7 days. Staff told us the screening process supported prioritisation of enquiries based on risk. Further data was provided on the completion of s42 enquiries. In 2024/25, 70% of Section 42 enquiries were concluded within 3 months and 89% within 6 months, with enquiries reaching 6 months reviewed by the Safeguarding Adults Coordinator. Longer timescales were stated to be small and usually because of ongoing risk factors. Other themes relating to people waiting longer for s42 enquiries to be completed included capacity in teams to prioritise s42 enquiries, responses of parties involved with the enquiry and skill mix of staff to ensure the enquiry could be undertaken robustly.

There was a multi-agency approach to safeguarding with clear roles and responsibilities for identifying and responding to concerns. A staff team told us there was close working with the police, fire service and housing where required for example. The local authority also asked partners to undertake s42 enquiries and staff told us the local authority still retained responsibility in these cases. A Causing Others to Make Enquiries template and guidance were available to support both staff and partners to understand their roles. Providers told us the local authority worked collaboratively, particularly in complex or high-risk cases.

Safeguarding plans and actions to reduce future risks for people were in place and were acted on. Staff gave examples where these plans resulted in safer living arrangements, improved monitoring, and reduced harm. They told us where risks changed, plans were reviewed and updated to reflect people's current needs and circumstances. In a positive example, a person told us safety had been a concern for their family member and the social worker involved identified the risks quickly and arranged a safer environment for them and safeguarded them effectively.

Staff and leaders told us those involved in safeguarding work were suitably trained, skilled and supported to carry out their safeguarding responsibilities effectively. Safeguarding training was delivered across adult social care and partner organisations including mandatory safeguarding training, Mental Capacity Act training and aligned training for occupational therapists. Staff told us safeguarding was understood as a shared responsibility, supported through regular supervision, same-day management oversight and access to specialist safeguarding advice.

There was a need to ensure partners were kept informed of outcomes following safeguarding referrals. Some partners told us they did not always receive outcomes, with a partner telling us this could create anxiety. Some partners also told us they sometimes had to chase outcomes after safeguarding enquiries were closed. Despite this, the local authority outlined systems were in place to keep referrers informed of outcomes, as outlined in their Safeguarding Adults Practice Guidance. This included verbal feedback in most cases but also using a written feedback template so written communication was available where needed. A one-page guide for care providers also included contact information for providers to enquire about outcomes. While processes supported staff to communicate outcomes, there was some inconsistency in keeping relevant agencies informed of the outcomes of safeguarding enquiries when it may have been necessary for the ongoing safety of the person concerned or recommendations that could prevent harm to others.

The local authority recognised it received a relatively high number of safeguarding concerns for their population size and as a result there was a potential demand risk. It was outlined improved data collection and significant referrals from the ambulance service contributed to higher numbers. Despite this, concern numbers had reduced, with the Safeguarding Adults Collection (2024/25) showing 5735 concerns received for 2024/25 (compared to 6795 the previous year). The conversion rate for concerns to s42 for 2024/25 was 18.40%, compared to 19.94% the previous year. In response to rising concerns, a Practice Tool to Aid Decision Making was available for partners to support understanding and reduce inappropriate referrals. Partners told us there were clear pathways for seeking advice and escalating concerns which gave them reassurance and supported early intervention.

Deprivation of Liberty Safeguards (DoLS) were prioritised based on level of risk, using an adapted Association of Directors of Adult Social Services (ADASS) tool. As of 12 September 2025, DoLS data showed there were 131 DoLS applications which had not yet been allocated to a Best Interest Assessor (BIA). The median wait was 18 days, and the maximum wait was 115 days. This data did not, however, represent the entire timeframe for an application to be granted or not granted. Data provided also showed for 2024/25, 39% of applications were granted within 3 months and 98% within 6 months. For 2025/26, up to 12 September 2025, this rate had improved, with 92% granted within 3 months and 99% within 6 months. A staff team told us strong relationships with care homes had improved the quality of referrals and responsiveness during triage. This collaboration helped streamline processes and enhanced the accuracy of information received. There was improving performance in actioning DoLS applications to reduce the risk of people being deprived of their liberty unlawfully.

Making safeguarding personal

Safeguarding enquiries were carried out sensitively, keeping the wishes and best interests of the person concerned at the centre.

Local authority data suggested most people were having positive outcomes following safeguarding enquiries. The Self-Assessment (2024/25) stated 87% of people were asked about their outcomes and 94% of people fully or partially achieved their outcomes. The local authority had also expanded its approach to better understand people's experiences of safeguarding. A safeguarding experience survey had been launched in April 2025. At the time of the assessment, 30 responses were collected. Of the respondents, 97% said they felt fully involved and included during the safeguarding process, and their views and wishes were listened to and 87% respondents said the most important things that they wanted to see happen were achieved. As response rates increased, there were plans to draw themes from feedback. This data suggested most people were being supported to achieve their chosen outcomes.

Staff told us they worked in line with principles of 'Making Safeguarding Personal' (MSP). They said this meant placing the person at the centre of Section 42 enquiries. The dispersed approach to safeguarding also meant people known to the local authority could be supported by staff and teams they already knew and an MSP toolkit was made available to staff within safeguarding guidance. SAB audits also showed MSP was embedded in practice across the local authority and partners. Audit findings showed consistent person-centred practice with people's wishes, consent and outcomes clearly recorded and reflected in safeguarding plans. Leaders also explained there had been strong oversight of Section 42 enquiries to ensure responses were proportionate and focused on wellbeing, prevention and positive outcomes. Practice guidance supported staff to work sensitively at the person's pace, and to act in their best interests when they were unable to make specific decisions independently.

Safeguarding information was available to the public through local authority and Safeguarding Adults Board resources. This explained what safeguarding was, what being safe meant for different people, and how concerns could be raised. Staff said they routinely shared this information and adapted it to meet people's communication needs. They described proactive work to improve understanding of safeguarding, including engagement with community groups, health services and voluntary organisations. Information was provided in different languages and formats to support accessibility. Clear language and visual prompts were used to help people understand risks and how to report concerns. Leaders said learning from this engagement informed ongoing improvements in how safeguarding information was shared.

Staff told us mental capacity assessments were completed when there was uncertainty about a person's ability to make decisions. When people lacked capacity, best interest decisions were made with involvement from advocates, or family and friends, which was consistent with best practice. National data provided by the Safeguarding Adults Collection (2024/25) showed 90.54% of people lacking capacity were supported by an advocate, family or friend. This was somewhat better than the England average of 83.30%.

Theme 4: Leadership

This theme includes these quality statements:

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

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

Governance, management and sustainability

Score: 3

3 - Evidence shows a good standard

The local authority commitment

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

Key findings for this quality statement

Governance, accountability and risk management

There were governance, management and accountability arrangements at all levels within the local authority, and these provided visibility and assurance on the delivery of Care Act duties including risks to delivery. There were clear lines of communication to support oversight of performance between the ASC Directorate, Corporate Leaders and local authority Members. For example, the Director of Adult Social Care (DASS) met with the Chief Executive and Lead Member for adult social care (ASC) regularly to discuss performance. There were regular data and insight reports on performance which supported senior leadership to have oversight. There was also an ASC risk register which outlined key risks to the service. Senior leaders demonstrated their knowledge of current challenges and risks, such as waits for services for people. Governance systems were supporting oversight and assurance on ASC delivery.

Directorate structures supported closer working between different functions of the local authority in their Care Act duties. Adult social care (ASC), public health and housing were all part of the same directorate, with public health being added to the directorate within the previous year. A senior leader told us work between ASC and public health was developing, with them telling us there was an ambition for more specific work with ASC. Leaders told us, however, housing and public health being part of the same directorate as ASC had been effective and helped prevention work, such as work around rough sleeping and homelessness. There had also been joint commissioning of preventative services, such as social isolation support and carer support. Work from public health on the Joint Strategic Needs Assessment also helped to guide ASC commissioning and planning based on local needs. Senior leaders also told us how directorates were supporting ASC in their delivery through joint working. A leader told us while in the past there was a risk of silo working, directors were now working as a team and were understanding of each other's positions. Directorates were supportive of ASC and structures were developing closer work between ASC, public health and housing.

The ASC leadership team was visible, capable and compassionate and had clear roles, responsibilities and accountabilities. There was an open and transparent approach which supported accountability, with key documentation published publicly, such as the ASC Self-Assessment and Annual Report for example. Leaders were confident they were visible to staff, and this was supported through Let's Talk sessions as well as other staff briefings. Staff also told us leaders such as the Principal Social Worker were visible and approachable. The Principal Social Worker worked in the same office space as staff, rather than a separate area, which supported a more open culture with accessible leadership. A person who was part of the co-production activity also told us senior leaders were approachable, engaging and supportive.

The local authority supported arrangements for scrutiny of decision making. For example, there was a Health and Social Care Scrutiny Board which met regularly and had a Work Programme for 2025/26, which outlined agenda items relevant to ASC. Agenda items for scrutiny included the ASC Self-Assessment and Annual Report (2024/25) and the impact of the Improving Lives approach, for example. A leader told us cabinet members who were part of the Scrutiny Board were well briefed and were robust with their questioning and minutes from Board meetings showed ASC systems and reports being scrutinised. A leader told us the scrutiny agenda was set through a mix of board member suggestions, relevant ASC reports at the time and priorities of cabinet members for ASC and health, for example. They also told us scrutiny discussion was enriched by members bringing lived experiences of people they represented to discussions. Systems and performance were scrutinised to support ASC to be held to account.

Strategic planning

The local authority had an overarching strategy called the One Coventry Plan (2022-2030), which included a strategic aim of 'Improving outcomes and tackling inequalities within our communities'. ASC was accountable for contributing to the delivery of the plan, through measures such as the number of people supported into ongoing care services, effectiveness of short-term services and people's satisfaction with ASC. In line with this approach was the strategic ASC 5-year plan (2025-2030), which was focused on enhancing support for people while facing increasing demand in terms of volume and complexity of need. A senior leader told us the 5 year plan was informed by engagement with people with lived experience. The plan outlined the successes of strategic work over the previous 5 years. For example, the Improving Lives Programme, which had supported the establishment of local integrated teams which was supporting more people to receive care in their own homes. The plan also outlined the areas of focus for the next 5 years such as prevention, support for unpaid carers, personalising the experience of care and support, new models of commissioned support and integrated care with health partners, for example. Delivery plans were also in place to deliver on strategic objectives. There was a commitment to measuring the impact of the plan through a range of performance indicators. The plan complemented other key strategic documents, such as the Commissioning Strategy (2025-2030), market development plans and the Coventry and Warwickshire Integrated Care System Vision.

There was oversight of data, performance and risks which helped to influence strategic direction, allocation of resources and the delivering of the actions needed to improve care and support outcomes for people and local communities. For example, the Joint Strategic Needs Assessment was helping to inform strategy and commissioning decisions. A Performance and Insight Team also supported ASC in managing their data by developing and maintaining performance dashboards and providing bespoke reports on as-needed basis, for example. ASC and corporate leadership had access to a range of data through dashboards to evaluate performance effectively through regular meetings. For example, people's waits for assessments were shared to support oversight and scrutiny. A leader told us meetings supported transparency, allowed timely problem-solving, and ensured that strategic goals were being met. Other leaders told us performance information supported tracking of performance against strategic priorities and ensured decision making was informed by current operational realities.

The local authority allocated resources to support their Care Act duties in the context of financial challenge. The ASC Risk Register outlined risks to manage budgets and deliver savings with growing demand as a high risk. Senior leaders acknowledged there was challenge in managing resources for ASC. They told us there was strong oversight and scrutiny and they understood and forecasted where resources would be used. A senior leader also told us prevention work was delivering savings so there was no need for a reduction in services. For example, they told us the expanding technology offer was reducing care hours and supporting savings. Data provided in the local authority Self-Assessment (2024/25) showed 1782 virtual care calls a month, which involved remote monitoring of people and supported people to stay at home. Other investment demonstrated a commitment to supporting ASC, such as the expansion of unpaid Carer Support, expansion of integrated approaches with health and market development.

The local authority also allocated resources to support reduce waits for services for people in the context of increasing demand and complexity, but this was more effective in some areas of the services than others. For example, people's waits for assessments had reduced between May 2025 and September 2025, with median waits falling within target timeframes, demonstrating improved performance. The local authority cited enhancement of the early help offer to reduce the need for assessments and targeted use of capacity for the longest waits. Financial assessment completion waits had also demonstrated a significant improvement, supported by streamlined administrative processes. However, occupational therapy (OT) assessment waits remained longer for people, with an increase in waits between May and September 2025 which reflected a large increase in referrals for assessment. There had been the introduction of OT clinics and the use of a direct booking system to help reduce waits, but this had not been effective in reducing overall waits. There remained strong systems for oversight of people's waits through data dashboards and regular meetings, with clear systems to prioritise and support people's safety while they waited.

The local authority outlined staffing capacity and vacancies could also contributed to waits for people. Staff teams and leaders told us increasing complexity was impacting on workloads and some staff told us their workloads were difficult to manage. The ASC Workforce Healthcheck (2024/25) also reflected this. It showed most staff (65%) felt their caseload was fair and manageable, which was a drop from previous healthchecks (73% in 2022, 81% in 2019). Less than half of staff (48%) also said they had sufficient time to work effectively with people on their caseload most of the time. The Adult Social Care Workforce Strategy (2023-2026) and associated action plan were taking steps to address these challenges, with a focus on recruitment and retention, management of sickness absence, and staff learning and development. A senior leader also told us there was a plan to support staff resilience to help reduce sickness absence as this was contributing to the workloads teams faced and waits for services for people. The local authority continued to take steps to support their staff, but some capacity challenges remained.

Information security

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

The local authority ensured integrity and confidentiality of data through General Data Protection Regulation (GDPR) compliance. There was also training related to GDPR and cyber security for staff to support information security. Access to case management systems and data dashboards was subject to approval to ensure appropriate access, depending on role and seniority. A leader also told us there were regular data Protection Impact Assessments (DPIAs) to test effectiveness of arrangements.

The local authority also applied cyber-security systems which supported protection of personal information. For example, a secure email system supported people's information to remain confidential. Other procedures to support security included a 'clean desk' policy so information was not left accessible and double authentication which supported access security to systems.

Learning, improvement and innovation

Score: 3

3 - Evidence shows a good standard

The local authority commitment

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

Key findings for this quality statement

Continuous learning, improvement and professional development

There was a positive and inclusive culture of continuous learning and improvement. The local authority was a learning organisation which continually developed its delivery of Care Act duties, along with its key partners, steered by its leaders.

The local authority worked with people and partners to promote innovative ways of working that improved people's experiences and outcomes. Staff and partners told us the local authority collaborated well with health and voluntary, community and social enterprise (VCFSE) organisations. Joint programmes such as the Improving Lives Programme and mental health transformation work were developed with partners and informed by learning from practice. Senior leaders told us successful learning was shared across the system. This meant people benefited from services that were more joined up, proactive and responsive to their needs. Partners also told us the local authority was innovative, particularly for work around population health management, digital solutions and integrated neighbourhood working.

The local authority had a Practice Development and Learning Improvement Framework which supported embedded learning. A leader told us the framework captured all learning and supported ownership of learning being shared, as well as checks learning was embedded. The framework brought together learning from audits, complaints, compliments, safeguarding reviews and feedback from people through surveys, for example.

Staff told us there was a learning culture where their views were listened to and respected. They told us they were being supported by colleagues, managers and senior leaders, especially when working with complex situations. The Adult Social Care Healthcheck Survey (2024/25) showed most staff felt able to raise concerns with managers (79%) and work issues were shared openly (77%). Learning was built into daily work through audits, supervision, team meetings, feedback loops and reflective discussions. Staff teams told us audit findings helped them understand what was going well and what needed to improve. Staff told us this helped them take responsibility and work more consistently. Bringing It All Together sessions and workshop-style meetings helped them understand and apply improvement themes beyond their own service areas. Alongside management meetings and supervision, this supported staff to deliver safe, effective and person-centred Care Act practice.

The local authority was enhancing its co-production approach. The Involvement, Engagement and Co-production Approach outlined a commitment to using people's voice to develop services. People's voices were supporting strategic direction. For example, the Autism Strategy was created through structured involvement of people with lived experience. The coproduced delivery of the strategy was also being supported by a commissioned partner which was supporting autistic people to become experts by experience. A wider co-production workplan for autistic people and people with learning disabilities was supporting activity, such as a range of autism awareness raising and service signposting resources, for example. In a further example, the Coventry Partnership Dementia Hub was also developed through a thorough co-production approach, bringing together people with lived experience and partners across health, the voluntary sector and the local authority to create an innovative one-stop model which supported independence and positive outcomes for those affected by dementia. There were also some areas of co-production which continued to develop, for example, a leader told us the local authority was gathering people to support direct payment improvement work but this was not yet fully developed.

Partners also told us about continual improvement in co-production, engagement and outreach work. A partner told us there had been a shift in the last 1–2 years in improving proactive outreach. For example, the local authority was said to have increased their attendance at community events and meetings, encouraged return engagement from residents, maintained strong visibility and valued the contribution and experiences of people. Examples of outreach work included the development of focus groups for Lesbian, Gay, Bisexual and Transgender and Other (LGBT+) communities and visits to hospital outpatient departments. Another partner told us carers were actively involved in shaping new projects and reviewing digital resources, including the website, which was updated based on carer input to improve accessibility and relevance. Finally, a partner told us how the local authority had supported them to gather young people's voice on their experiences an area of focus highlighted by a leader.

The local authority prioritised continuous professional development (CPD) for its staff. Staff and leaders told us CPD was supported by a wide range of training including Care Act legal training, safeguarding, mental capacity, deprivation of liberty and continuing healthcare. For example, a staff team told us they received more than the minimum required training hours, specialist supervision and regular group learning sessions, which helped them work confidently in complex areas. The Adult Social Care Organisational Health Check (2024/25) showed 84% of staff respondents agreed there were relevant opportunities to enable them to meet their CPD needs and 82% said their training and development needs were identified through supervision and appraisal. However, some areas for development included staff getting the opportunity in their supervision for reflection and emotional support (61% felt they did) and staff agreeing their induction prepared them for their specific role in the Council (67%). Responses on induction demonstrated a 16% increase from the previous survey (2022/23) following targeted work around this. The local authority continued to support CPD for its staff.

Staff were also being supported to gain qualifications to support their development. The local authority had an apprenticeship scheme which leaders told us supported staff to qualify and progress. Since 2022, 6 degree-level apprenticeships had been completed and 7 were in progress. Occupational therapy assistants and social workers told us they were supported to gain qualifications and remain with the local authority, helping build a skilled and stable workforce.

The local authority shared learning, best practice and innovation with peers and partners. Staff told us that learning was shared regionally and nationally including work on technology enabled care (TEC) and neighbourhood working. Occupational therapy staff told us their TEC programme had been replicated by other local authorities which showed wider impact. Senior leaders told us the local authority had been newly accepted into the Neighbourhood Health Implementation Programme, a national programme that brought together 42 local authorities to improve support for people with multiple long-term conditions and higher health risks. This programme provided resources, coaching and learning networks to help local authorities join up National Health Service care with voluntary and community groups to reduce inequalities. Leaders said this meant the authority would both share its own best practice nationally and learn from others. Managers also told us about involvement in professional networks which supported shared learning across health and social care.

Learning from feedback

The local authority consistently gathered feedback from people, staff and partners and used it to inform strategic planning, service improvement and day-to-day decision making.

The local authority used local surveys alongside national measures to better understand peoples lived experience. The local authority sought feedback from people following assessments, reviews and safeguarding activity through real-time surveys and targeted questionnaires. A person told us they received regular surveys where they could comment on the quality of the support they received. They told us their comments were valued. Feedback was reviewed alongside performance and quality assurance data at quarterly Quality and Experience Review meetings chaired by leaders. A leader told us learning from ombudsman investigations fed into the review meetings, for example. They told us how this had in one instance supported whole family guidance to be put in place for staff following an investigation outcome. Partners also told us feedback was welcomed and used to influence service development, including communication, access and culturally appropriate care. This meant decisions were informed by lived experience, not only performance data. This helped ensure services were better aligned with people's needs and improved their experience of adult social care.

The local authority sought feedback from staff to support service improvements, but there was an opportunity to further develop this at an organisational level. The local authority completed staff health checks every 2 years which were used to develop workforce action planning. The Adult Social Care Organisational Health Check (2024/25) showed, for example, only 13% of staff completely agreed they felt consulted and involved in proposed local authority changes, with 67% in partial agreement. The remaining 20% did not agree at all. The local authority had a range of engagement forums for staff which included Let's Talk sessions, which were led by senior leaders and were aimed at strengthening openness and staff voice. Leaders told us staff survey feedback showed supervision had become too task-focused, so supervisory training was introduced to strengthen reflective practice. A staff team also told us how their feedback to leaders had improved lone working arrangements, with an emergency button put in place to help keep them safe, for example.

Learning took place when things went wrong. Staff told us learning from safeguarding adult reviews, Learning from Lives and Deaths – People with Learning Disabilities and Autistic People (LeDeR) reviews, serious incidents and Local Government and Social Care Ombudsman (LGSCO) outcomes were routinely shared through training, team briefings and daily updates. Managers told us ombudsman decisions were reflected on within teams and used to inform changes to guidance and practice. When mistakes happened, they were discussed openly to improve communication, strengthen assessments and enhance safeguarding responses.

The local authority had 5 detailed LGSCO investigations between 01 October 2024 and 30 September 2025, compared with an average of 4 for similar authorities. The uphold rate was 80%, below the national average of 85.92%. The local authority had complied with all recommendations and met timescales with no late remedies. In 2024/25, the local authority received more complaints and compliments than the previous year, which they told us was linked to increased referrals. Complaints increased from 59 to 85 and compliments rose from 173 to 185. Complaint themes included standards of care and communication. These were reviewed through Quality and Experience meetings and used to support learning and improvement.
