Sheffield City Council: local authority assessment

How we assess local authorities

Assessment published: 21 January 2026

About Sheffield City Council

Demographics

Sheffield City Council is a unitary authority and is recognised as a diverse city with 573,252 people calling it home. Sheffield is England's fourth largest city with the population projected to rise to 648,419 by 2043. It has two universities, with a slightly younger working-age population (63.2% vs 61.5% nationally) and a lower proportion of older adults (16.9% vs 18%). Around 86% of international students are from outside the EU, with overseas students accounting for 26% of Sheffield University's total student population.

Sheffield is ranked 66 out of 153 local authorities (with 1 being the most deprived and 153 being the least deprived). The Index of Multiple Deprivation (IMD) score is 6 (10 is the most deprived). Life expectancy varies by over a decade between the most and least deprived areas. Deprivation is concentrated in eastern wards, while western areas are the least deprived.

Sheffield has some ethnic diversity: 79.1% identify as white (81.7% nationally), with Asian or Asian British (9.6%), Black (4.6%), and mixed or other ethnic groups. Diversity is concentrated in wards such as Darnall and Burngreave, while others remain less diverse. The city also has established Roma, Somali, Yemeni, and Eastern European communities, and a growing LGBTQIA+ population.

There are approximately 60,000 unpaid carers (1 in 10 residents), including 7,000 young carers, with around 20,000 people starting or stopping caring each year.

Sheffield City Council worked with South Yorkshire Integrated Care Board at a Sheffield place level, with section 75 of the National Health Service Act 2006 and Better Care Fund agreements. Sheffield Teaching Hospital NHS Trust provided acute and community health services, and Sheffield Health and Social Care NHS Trust provided mental health and learning disability health services.

Since 2022, Sheffield has a committee governance model comprising of elected members across all 3 biggest political groups in Sheffield: Labour, Liberal Democrat, and Green party.

Financial facts

The Financial facts for Sheffield City Council are:

- The local authority estimated that in 2023/24, its total budget would be **£937,830,000.00** Its actual spend for that year was **£1,032,913,000.00** which was **£95,083.00 more** than estimated.
- The local authority estimated that it would spend **£243,893,000.00** of its total budget on adult social care in 2023/24 Its actual spend was **£271,036,000.00** which is **£27,143,000.00 more** than estimated.
- In 2023/24, **26.24%** of the budget was spent on adult social care.

- The local authority has raised the full adult social care precept for 2023/24, with a value of **2%**. Please note that the amount raised through ASC precept varies from local authority to local authority.
- Approximately **10265** people were accessing long-term adult social care support, and approximately **2730** people were accessing short-term adult social care support in 2023/24. Local authorities spend money on a range of adult social care services, including supporting individuals. No two care packages are the same and vary significantly in their intensity, duration, and cost.

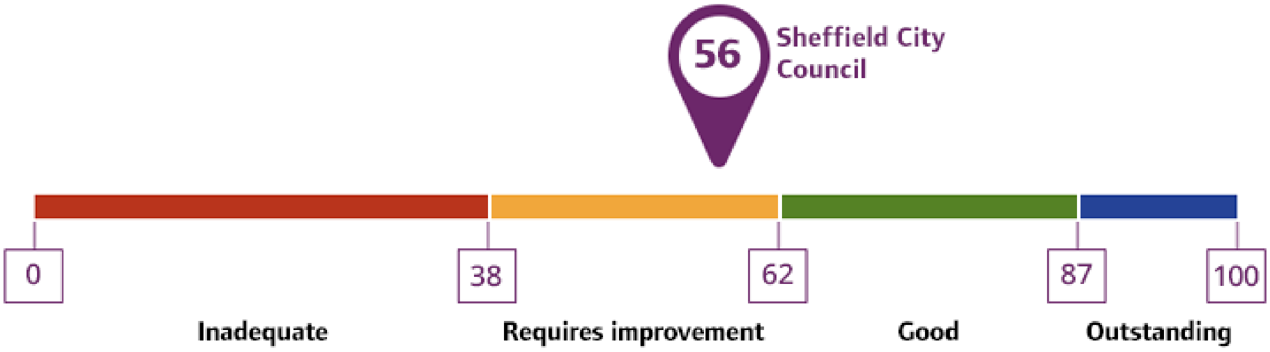
This data is reproduced at the request of the Department of Health and Social Care. It has not been factored into our assessment and is presented for information purposes only.

Overall summary

Local authority rating and score

Sheffield City Council

Requires improvement



Quality statement scores

Assessing needs

Score: 2

Supporting people to lead healthier lives

Score: 2

Equity in experience and outcomes

Score: 3

Care provision, integration and continuity

Score: 2

Partnerships and communities

Score: 2

Safe pathways, systems and transitions

Score: 2

Safeguarding

Score: 2

Governance, management and sustainability

Score: 2

Learning, improvement and innovation

Score: 3

Summary of people's experiences

There was mixed feedback from people about assessment, care planning and review arrangements. Some people felt supported and listened to, others described assessments as feeling rushed or noted issues with continuity. Partners representing people with care and support needs told us some people felt arrangements lacked a person-centred approach, and accessibility was a concern, with some people struggling to make referrals via phone or email and requesting in-person options.

Staff, people and unpaid carers told us processes particularly for people aged 65 and over were frequently interrupted or disjointed. In contrast, people and unpaid carers mostly praised the approach of staff that had been allocated to support them. Unpaid carers told us they had frequent contact with duty teams rather than a consistent social worker, which led to repeated retelling of their circumstances and slowed care planning. In contrast, some people told us their assessment was completed promptly and involved their family.

Some people told us there was a lack of accessible telephone and website options which was seen as a barrier to accessing information and advice. It was said that the local authority had a lot of support available to help people, but this was not communicated effectively.

There was a clear picture of the number of people who received adult social care provided by the local authority in Sheffield, including older adults, people with learning disabilities and people with physical disabilities. People told us direct payments had a positive impact on their wellbeing and independence. However, there was a need to expand offers for short breaks, mental health provision, and supported living options. There were gaps in estimating the self-funder market, limiting full market understanding.

People told us about the benefits of coordinated arrangements. People and unpaid carers told us how local authority staff worked well with partners, attending joint reviews, securing health funding and referring to specialist teams. Voluntary sector organisations were responsive and supportive in Sheffield. Unpaid carers told us the commissioned carers service was a welcome advocate for them. Other organisations funded by the local authority and represented people were praised for their community engagement and feedback mechanisms.

People gave mixed feedback on how effective safety and risk management was in the local authority. There was more to do around ensuring individual contingency plans were effective. Staff told us they included rolling respite offers within individual contingency plans, but acknowledged that if it wasn’t planned, it was difficult to find suitable support at short notice. People and unpaid carers gave mixed feedback around the local authority’s approach to safeguarding and there was a need to improve consistency of these processes.

There was a strong desire among people with lived experience to contribute to service improvement. Some partners representing people and people themselves had seen positive changes. In contrast, some people told us their suggestions were not fully acknowledged or implemented. This suggested a need for stronger feedback loops and clearer communication about how the voice of people is considered and used. There was more to do to incorporate peoples voice into improvements. Whilst the local authority had I statement surveys and co-production frameworks in place, people told us there was more to do to proactively gather experiences and demonstrate how their input had shaped change, to improve outcomes through co-produced design, delivery and evaluation of services.

Summary of strengths, areas for development and next steps

Living The Life You Want To Live as an adult social care vision was embedded in improvements and developments in Sheffield City Council. Staff passionately referenced the coproduced vision when describing the advice and support they provided for local people. Practice development and staff wellbeing were a strength and formed the foundations being built on to deliver the commitment the local authority had set out to achieve.

There were strong corporate governance structures, good performance data. This was complimented by pockets of good practice and innovation which was driving change. However, there was more to do to effectively evidence positive outcomes for people. National data and I statement surveys for people were a core part of performance monitoring in the local authority to understand impacts of processes and practice across adult social care. Some people waited longer than expected for their assessments and reviews, which sometimes disrupted continuity and affected their confidence in support. Service areas and teams could be disconnected with projects and approaches, and communication needed to be strengthened with stable leadership. For example, we found a disconnect between quality assurance, commissioning decisions and workforce development.

There was evidence of the local authority actively seeking out and listening to the views of people who are most likely to experience inequality in experience or outcomes. The Adult Social Care Equality, Diversity and Inclusion (EDI) Plan evidenced resource and progress around the local authority’s planned improvements and ambitions.

Senior leaders were open and transparent about where they wanted to be and a community approach being the right way forward. They understood legal obligations and recognised the work, continuity and dedication needed to take them to the next steps. The interim Director of Adult Social Care was experienced and motivated to support the improvements needed. Senior leaders had clear plans to make services better, but bringing all the different improvement plans together into one joined-up plan was taking time. This meant it was harder to check progress. A political committee system promoted collaborative working. There were mixed experiences around partnership working and a need for wider system thinking. There was a corporate improvement board, dedicated adult social care data and performance staff, and workforce resource to support quality improvements.

Theme 1: How Sheffield City Council works with people

This theme includes these quality statements:

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

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

Assessing needs

Score: 2

2 - Evidence shows some shortfalls

What people expect

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

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

The local authority commitment

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

Key findings for this quality statement

Assessment, care planning and review arrangements

There was mixed feedback from people about assessment, care planning and review arrangements. Some people felt supported and listened to others described rushed assessments or poor continuity of key workers. Partners representing people with care and support needs told us some people felt arrangements lacked a person-centred approach, and accessibility was a concern. Partners told us there could be difficulties making referrals via phone or email and expressed a preference for in-person options. While the local authority did provide in-person support through clinics, walk ins and outreach, feedback suggested these options were not always well-known or easy to navigate for everyone. Staff, people and unpaid carers told us processes particularly for people aged 65 and over were fragmented, with pauses, delays, or interruptions that negatively impacted confidence in the systems. National data showed 60.94% of people were satisfied with care and support which was somewhat worse than the England average (65.39% Adult Social Care Survey, NHS Digital for 2023-2024). These figures alongside feedback suggested coordination and satisfaction in relation to people's wellbeing were areas for improvement. In response to the surveys between 2023 and 2024, senior leaders told us more recent internal reviews and leadership discussions indicated progress was being made. As a result, there had been a stronger focus on improving peoples experiences and aligning performance with national expectations. This suggested that while challenges remained, improvement activity was underway and being monitored. People using services and unpaid carers generally spoke positively about the staff allocated to support them. One person described their worker as being of the highest quality. Another shared how staff took time to understand and reflect their personal preferences during assessment and adapted their approach to support communication needs. An unpaid carer also highlighted how staff engaged meaningfully with the person they supported, noting that the person was pleased to see the staff member again.

Assessment documentation we reviewed demonstrated commitment to person-centred care. For example, recognition of a person's employment history and active involvement of their family as advocates. The care plan was co-produced, ensuring the person retained full control over their care and support, which reflected what mattered most to them.

There was a three-step model to promote strength based approaches in assessment however whilst staff acknowledged strengths were considered, we found this was not consistently applied in all teams. There was more to do to improve alignment of best practice such as strength based and person centred language, assessment, care planning and ensuring care delivery matches assessed needs which senior leaders were working towards. While consistency was still being actively improved, there was a structured quality assurance programme in place supported by practice reviews, audits, and ongoing leadership oversight to embed common language and pathways and enhance people's outcomes.

Timeliness of assessments, care planning and reviews

While many Care Act assessments were completed within the local authority's expected timescales, some people told us they experienced delays in receiving a Care Act assessment. Unpaid carers described frequent contact with duty teams rather than a consistent social worker, which they felt led to repeated retelling of their circumstances and slowed the development of care plans. For example, a carer expressed frustration about the length of time it took to be allocated a social worker, highlighting the impact of perceived delays to timely support. In contrast, some people told us their assessment was completed promptly and with family involvement.

Data provided by senior leaders showed people in Sheffield waited different amounts of time for help. Senior leaders counted waiting times from the first time someone asked for support, not just when they decided a Care Act assessment was needed. This showed the full picture of how long people waited for help, including those who needed early support. In September 2025, 319 people were waiting for what senior leaders called an ‘unallocated task,’ which could be any type of support, not only Care Act assessments. This was fewer than in March 2025, when 382 people were waiting. Senior leaders told us none of these people within this data had safeguarding concerns. Over 12 months, the median waiting time improved from 34 days in March to 32 days in September 2015, which was better than target of 35 days which senior leaders had set to monitor wait times. The maximum wait time recorded was 1,484 days. This was for someone who needed support under mental health law and included legal steps, rather than only waiting for an assessment. Senior leaders told us this did not show what most people experienced.

At the end of March 2025, senior leaders told us 143 people had waited over one month, 16 people over three months, 8 people over six months and some people did not need a Care Act assessment. They planned to change how they recorded things so it was clearer who needed an assessment and who would be signposted for support elsewhere. Staff and partners told us people with mental health needs often waited the longest. More work was needed to understand how waiting affected different groups of people and whether shorter waits made a real difference to people’s lives.

The local authority had a Waiting Well Framework. This was in use across most service areas to make sure people who needed help urgently whilst waiting for an assessment could get this. Triage and review processes were in place within key services to re-prioritise if necessary. Performance monitoring happened through self-service dashboards for teams to review and monitor people that waited. The Response and Enablement Team used a prioritisation scale and a 7-hour rule to ensure urgent needs were met, including arranging emergency short breaks and 24-hour care before longer-term allocation. And, the Approved Mental Health Professional (AMHP) team functioned as a crisis service, particularly when people were not known to any existing team.

People also waited for reviews of their care and support needs. For example, a person told us their review was overdue, the private care provider had made contact with the local authority to carry this out, and whilst a visit was planned at the time of the CQC assessment, this highlighted a need for improved review planning and pro-active follow-up.

In September 2025 the local authority told us 2,662 people had overdue reviews. People had a median waiting time of 174 days which had increased from 139 days in April 2025 and maximum waiting time 1,491 days. Senior leaders told us they had seen a reduction in annual reviews since April 2024. All people with outstanding waits over 3 years had been allocated and reviews completed within 2 years was at 96%. National data showed 73.12% of people with long term support had been reviewed (planned or unplanned). This was somewhat better than the England average (58.77% Short and Long Term Support, NHS Digital for 2023- 2024). The local authority had a reviews plan to ensure the percentage of reviews completed in 1 year increased and set an improving trajectory. Senior leaders told us there was contact with 84% of people receiving long term support during the last 12 months and aimed to leverage these contacts to make them into reviews by means of a Making every contact count approach. Phase 1 of the review plan would address reviews outstanding between 2-3 years and phases 2 and 3 aimed to address long term sustainability through efficiency and automation. Senior leaders told us incorrect recording of reviews on the digital recording system, combined with the transfer of mental health team functions back to the local authority in April 2023, resulted in 698 outstanding reviews and 140 outstanding assessments at the point of transfer. Since then, senior leaders had implemented a prioritisation process to complete these alongside unplanned reviews and reassessments.

There was a Community Review Team which was noted for its flexibility, responding immediately to changes in people's circumstances. Staff shared examples of adjusting home care support quickly, such as modifying night visits for a person to improve sleep and wellbeing. The local authority demonstrated good practice in emergency response and flexible review arrangements. However, delays in allocation, overdue reviews, and inconsistent worker continuity impacted people's experiences and wellbeing, and demonstrated a need for improvement in review activity.

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

There were approximately 60,000 carers in Sheffield (1 in 10 of the population) with around 7,000 being young carers. Senior leaders recognised the caring population was not static; in Sheffield about 20,000 people start or stop caring each year. Unpaid carers who were included in people they cared for assessments and reviews, mostly told us they had positive experiences of working with the local authority. For example, a staff member applied a whole-family approach, ensuring the unpaid carer was actively involved and received appropriate support. The carer reflected that this involvement contributed to achieving a good outcome within a short timeframe, demonstrating good practice in recognising and valuing carers' roles and needs.

Staff told us they could carry out individual assessments of unpaid carers' needs alongside the person's care and support assessment. However, most staff told us this did not happen in practice. Instead, unpaid carers were usually referred to a separate commissioned carers service for assessment. This fragmented approach meant that carers' needs were not always considered in the context of the person's care planning. As a result, decisions and outcomes for the person did not always reflect or support the carer's situation, leading to a lack of coordinated support. There was more to do to consider a whole-family approach and recognition that unpaid carers and the people they care for may have interdependent but distinct needs. Staff told us carers training supported them to identify unpaid carers, but there was a disconnect particularly in sharing information as the carers service did not share digital records with the local authority. The carers service told us unpaid carers referred to them received a welcome pack that contained information about available support and an invitation to seek immediate help if needed. If someone had been waiting for more than a couple of months, there were processes within the commissioned service to provide reassurance. However, this was limited in terms of proactive support and monitoring of risk. Identifying a change in need or risk was mostly reliant on unpaid carers making direct contact if they needed prioritisation, especially in urgent situations, examples given were safeguarding concerns or when the cared for person was approaching the end of their life.

When an unpaid carer was assessed to benefit from a commissioned service to meet their needs, this was passed back to the local authority to carry out a statutory carers assessment to provide short break services at home or within a 24 hour setting. However, unpaid carers, staff and senior leaders told us there were challenges to access options and difficulties in securing places which created stress and unmet needs. Whilst local authority staff were the largest source of referrals to the service, we found staff had very limited knowledge of carers assessments and offers of support specifically for unpaid carers. This risked the local authority overlooking unpaid carers unique needs and supported findings from national data which showed 31.11% of carers satisfied with social services which was somewhat worse than the England average (36.83%)). Whereas 29.77% of carers felt they had encouragement and support which was similar to the England average (32.44% Survey of Adult Carers in England, NHS Digital for 2023-2024).

The local authority was unable to provide a breakdown of referrals or assessment waiting times for young carers or parent carers. Senior leaders told us that data relating to these groups was held within children’s services and was not currently monitored by adult social care. This limited oversight meant that adult social care could not fully identify or respond to the needs of young carers and parent carers supporting adults. There was more to do to ensure that all unpaid carers particularly those who may not be eligible for support through children’s services were visible to adult social care and receive timely, appropriate assessments and support. This gap in monitoring presented a risk of unmet need and was an area senior leaders identified as a priority for improvement, in line with the principles of a No Wrong Door approach. Feedback and review of records found some unpaid carers had not been identified as such, not been offered an assessment, had delays in accessing support and those that had assessment found it did not result in meaningful support. For example, an unpaid carer told us lack of continuity and action left them feeling abandoned. Unpaid carers told us about inconsistent contact, lack of tailored support, and accessibility barriers that could have a negative impact on their role. These issues affected unpaid carers’ emotional wellbeing and ability to sustain their caring role.

In September 2025 the local authority told us 48 unpaid carers deemed as high priority and 352 carers deemed low to medium priority were waiting for a carers assessment which had reduced from 476 carers waiting in March 2025. High priority assessments had a median waiting time of 28 days, with low to medium priority waiting 101 days. The maximum wait time in the previous 12 months had been 268 days for a low to medium priority assessment with a target timescale set by the local authority of 3 to 4 weeks (approximately 28 days). This maximum figure represented the single longest unpaid carer waiting which could include exceptional circumstances such as ongoing work or recording anomalies. Senior leaders told us approximately 160 carers had assessments carried out by the commissioned carers service per month and most people received contact within 1 day. During the 12 months to December 2024, 612 carers assessments and 65 support plans relating to eligible needs were completed. Identification of carers had increased by 43% between 2022 and 2024 and was continuing to grow in line with strategic intentions. Senior leaders told us they were reviewing this trend to inform ongoing commissioning resource.

Partners told us they were concerned about delays in carers assessment and highlighted challenges with sustainable funding to improve timeliness. Unpaid carers could wait longer due to challenges relating to making referrals across different recording systems, gaps in carer information on referral (delaying prioritisation), availability of suitable interpreter, carer availability, and workforce capacity. The carers service contract was monitored through monthly and quarterly updates to the local authority. There was also involvement in a Young Carer, Parent and Adult Carer Strategy Implementation Group and a Carers Operational Group which aimed to see more action on making commitments happen and hold the local authority to account. A delivery plan was initiated in 2024 with a plan to review in 2030. There was a recognition to build the strength and resilience of carers to continue to care for as long as they wish to. However, there was limited demonstratable progress so far. There had been some trials to improve carers experiences when waiting for assessment and support, such as utilising volunteers to complete low priority assessments. Quality checks were completed on sample assessment and support plans. However, the CQC found there was more to be done to strategically identify learning themes and collaborate with the commissioned carers service in terms of quality assurance and practice development for staff and evidence positive outcomes for all unpaid carers.

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

Staff consistently told us all adults were entitled to a Care Act assessment, regardless of whether their care and support needs may be deemed non-eligible or if they self-funded their own care. There was a First Contact service with referral routes and senior leaders monitored monthly contact volumes (over 1,000 contacts on average). However, partners representing people told us some people continued to experience uncertainty about how to initiate referrals and remained unclear on plans to address previously identified gaps.

Staff told us the local authority’s online directory had recently improved and now included a triage tool to help people identify appropriate signposting to other services or self-funded options for meeting non-eligible care and support needs. The directory was described as a centralised resource for advice and information, offering access to support around alcohol and drug use, carers, housing, mental health, benefits, and employment. It was designed to help people navigate their needs independently or with guidance. Staff also shared that they attended service meetings where community, voluntary, and charity organisations presented their offers, helping staff build a clearer understanding of available local support. Anyone waiting for assessment, signposted by staff at initial contact or as part of more formal care and support planning received a letter either electronic or in paper format, they could also send text messages to people to ensure they have the right information at the right time. Staff told us this is where they shared the online directory link to.

People wanting assessment were offered to attend a clinic instead of waiting for a home visit, these were bookable appointments to have a proportionate assessment in a community setting. This made more efficient use of staff time, both in terms of travel and recording of information. As a result, this approach was supporting more people to receive timely help for non-eligible needs. Staff told us that around 70% of people attending clinics did not go on to require further support, as the strength-based conversations held at the first point of contact often helped people to identify solutions and use their own strengths and networks.

There was also a strategic commissioning vision for inclusive community-based opportunities for people with learning disabilities and autism, supporting wellbeing regardless of eligibility status.

Eligibility decisions for care and support

When staff completed Care Act assessments with people, the templates they used showed clear outcomes of eligibility. Staff told us there were processes to ensure people received copies of their assessments and plans which meant their individual eligibility decisions for care and support and outcomes were available to them. There was also an appeals process, and guidance implemented for decisions in relation to Care Act eligibility, how the local authority would respond, and examples of support that could be offered as a result such as, offer of equipment, review or assessment of mental capacity and best interest decisions.

Financial assessment and charging policy for care and support

People gave mixed feedback about the effectiveness of the local authority's processes for assessing and charging adults for care and support. For example, a person told us delays and miscommunication meant they were unaware of their benefit entitlements, resulting in relatives unnecessarily supplementing their income. Another person told us they had received conflicting communication, whereas others appreciated quick resolutions to queries. Financial assessments were usually completed by telephone, email, or post. Staff told us face-to-face options were not routinely offered or used, even though the local authority's guidance supported in-person appointments where identified. Senior leaders told us people could indicate their preferred method when requesting an assessment, but we found this was not consistently reflected in practice.

In September 2025, 125 people were waiting for a financial assessment, a reduction from 138 people waiting in April 2025. For the 12 months to the end of September 2025, people had a median waiting time of 29 days improving from 32 days for the 12 months to March 2025. There was a maximum waiting time over 12 months of 1,929 in September 2025 which had significantly reduced from 3,363 days over 12 months from April 2025. Senior leaders told us the previously reported maximum waiting time reflected a historic one off situation rather than current performance; this involved a recording error relating to a legal process to supporting a person with benefits management which had been resolved. Senior leaders told us maximum wait times included people that were entitled for Section 117 funding under the Mental Health Act that had no contributions to pay, and delays impacting median wait times included people receiving intermediate care, but assessments were not completed until chargeable services were in place. Senior leaders also told us pre-service financial assessments carried out helped people understand potential costs before care begins.

The local authority had a structured financial assessment and charging framework including Fairer Contributions Policy, joint Continuing HealthCare (CHC) policy with health partners, care funding appeals seen at decision making panels and a waiver panel to support people at risk of harm, as a person-centred way of managing risk associated with charging people for their care and support

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In April 2025, 31 care funding appeals over 12 months were seen at a decision making panel with 2 upheld, 9 carried forward and 20 declined, 7 were seen at a revisit and review panel and all were declined. Most appeals related to financial assessment and, or contributions including people who needed assessment due to a reduction in their savings or income. Senior leaders told us these were decreasing in number which was monitored and reported on through formal processes. There were 76 care funding appeals over the past 12 months from April 2025, with 36 upheld. Based on learning from these, a new function had been introduced within the local authority's digital recording system to improve and generate future data on reviews. Of four complaints made to the Local Government and Social Care Ombudsman (LGSCO) from May 2024 to April 2025, three were upheld, including two related to financial assessment errors, suggesting room for improvement in accuracy and consistency. The LGSCO was satisfied that action taken to address these issues were proportionate and fair.

However, improved accessibility, communication and offering more personalised guidance was needed to ensure equity for all people. Staff told us they had introduced a pictorial guide to support people with sensory needs and reflected on translation service use, aiming to make the process more inclusive.

Provision of independent advocacy

When a person could not fully take part in conversation about their needs for care and support and they had no one to help them, the local authority had access to a commissioned advocacy service to support the person's involvement in their assessment and plans. Staff described advocacy as positive, helpful and important. The local authority's website had information on advocacy which was easy to read, included accessibility options, and clearly listed available services.

The local authority had commissioned a seven-year advocacy contract from May 2024, delivered through a partnership of voluntary, community, and social enterprise organisations. These organisations had established links with peer and self-advocacy networks and provided targeted access to underrepresented communities, including people of African and Caribbean heritage. There were also specific advocacy offers for adults with learning disabilities and for people who are deaf. Advocacy providers delivered training to adult social care professionals to support appropriate referrals. Local authorities must arrange for an independent advocate to support a person if they would have substantial difficulty in being fully involved in the assessment, care planning, or review process, and there is no one appropriate to support them (for example a friend or family member). Staff told us they made referrals for statutory advocacy, including Care Act Advocacy, Independent Mental Capacity Advocacy (IMCA), and Independent Mental Health Advocacy (IMHA). An Advocacy Decision Support Tool was available to guide decisions about whether a person may need an advocate.

Feedback from staff and partners highlighted that advocacy was generally offered from first contact with allocated workers, and efforts were made to maintain consistency by assigning the same advocate where possible. However, some feedback showed there could be interpretation of eligibility criteria which did not always fully consider needs that are less visible, such as neurodiversity. For example, one person told us they were denied advocacy despite signs of substantial difficulty, which under the Care Act would normally trigger the duty to provide an advocate. This reinforces the importance of clarity and communication in applying statutory advocacy duties. Partners also told us advocacy was not always easy to access through the local authority, with some referrals not followed up or declined. While improvements have been made, such as funding specialist advocates for people who are deaf, there is more to do to embed consistent practice and evidence positive impacts for all people.

Staff told us people waiting for advocacy referrals typically waited a few weeks, which could delay support during decision-making periods. Senior leaders demonstrated advocacy data was available to show how many referrals were made for specific types of advocacy support. For example, in August 2025 3 people with a learning disability waited up to 36 days and 39 people for Care Act advocacy waited up to 51 days, with people waiting longest for Independent Mental Capacity Advocate (IMCA) support for up to 124 days. Senior leaders told us this was regularly monitored.

Supporting people to live healthier lives

Score: 2

2 - Evidence shows some shortfalls

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

There was mixed feedback from people and unpaid carers about the local authority's arrangements to prevent, delay or reduce needs for care and support. For example, an unpaid carer told us they were being supported to improve their health and caring skills. Another person told us the support they received from the local authority was excellent in promoting their independence. And another person told us how they were supported to remain at home with additional support instead of moving to residential care. In contrast, unpaid carers told us they faced barriers to accessing support, including delays and lack of awareness of arrangements to prevent, delay or reduce needs for care and support. Carers also told us about significant strain, for example, an unpaid carer told us they had only been out socially twice in two years due to the loss of respite care. However, national data showed 82.44% of unpaid carers found information and advice in Sheffield helpful which was similar to the England average (85.22% Survey of Adult Carers in England, NHS Digital for 2023-2024).

There were pockets of developments and community projects making a difference. For example, Sheffield's People Keeping Well Programme had a focus on wellbeing, providing community based prevention activity to prevent and delay people needing to access health and social care services particularly those at greatest risk of loneliness. There were community-based initiatives such as the Move and More programme, falls prevention work, and technology-enabled care (TEC) were helping people stay well and independent.

Housing and Occupational Therapy (OT) teams worked together to prevent, delay or reduce needs for care and support. This includes a specialist health and housing team working with people applying for prioritised housing due to health and social care needs, and a dedicated OT based in the hospital supporting early discharge planning. Strategic leadership is provided through the Housing, Health and Wellbeing Executive Group and Delivery Group, aligning work with the Older People's Housing Strategy, Disabled Facilities Grant policy updates, and Home First Adaptations Team initiatives. For example, a person who had been in hospital for 230 days due to a fear of returning home was supported through regular OT visits and housing updates to move into an adapted home and no longer required formal support. Despite these positive developments, some staff and senior leaders told us that early joint planning between housing and adult social care was not always consistent, and people were often identified at crisis point. Therefore, there remained more to do to embed proactive identification and coordination for all people.

Meaningful employment can help people with learning disabilities maintain independence, confidence, and social inclusion, which can reduce future care and support needs. People told us they valued support that helped them access work and manage their care, but feedback was mixed. For example, a person received tailored assessments and employment support. In contrast, other people were unaware of available services. Informal routes into voluntary and paid work were common, but structured supported employment pathways were not widely known among people with learning disabilities or their unpaid carers. Therefore, some people were not being identified or reached by current arrangements. Staff and senior leaders recognised the importance of employment and transitions into adulthood, housing, and community life. Senior leaders had strategic intentions, however inconsistencies in practice and declining employment outcomes showed gaps in coordination, information sharing, and proactive identification of unmet needs. Local arrangements to prevent, delay, or reduce care needs such as First Contact signposting and enablement services were in place and had a positive impact for those that accessed this support. Senior leaders demonstrated data that enablement supported people to regain independence through activities such as travel training, volunteering, daily living skills, and personalised plans, with records showing people achieved or partially achieved their outcomes.

The Optimised Care Team had expanded since January 2025 with access to specialist training for staff and was having a measurable impact focused on improving peoples options for single handed care. The benefit of reducing support to single handed care is not only cost effective for people who fund their care but can increase choice and control around the frequency and number of formal care staff providing support in peoples own homes and provide more opportunities to manage their health and wellbeing in ways they prefer. Senior leaders told us there were plans to work with health partners to expand the approach to acute hospitals, community health services, and roll out to care homes in 2027. Occupational Therapists (OTs) played a central role in this success. For example, a senior leader told us OT involvement had significantly reduced the need for formal care, in some cases lowering support from four daily visits to one or none, by promoting greater independence. The First Contact Team and Response and Enablement Team used asset and strengths-based conversations to prevent, delay or reduce needs for care and support. Staff told us around 70% of people attending assessment clinics did not go on to require further support. Senior leaders told us a standardised screening tool was introduced in 2024, but staff told us there was more to do to embed consistent use and demonstrate impact on people’s wellbeing.

The local authority demonstrated a commitment to prevention and wellbeing, with services and community partnerships. National data showed 54.45% of people who had received short term support who no longer required support was significantly worse than the England average (79.39% Adult Social Care Outcomes Framework, NHS Digital for 2023-2024). Senior leaders told us this was due to the way the measure is calculated and Sheffield's inclusive approach to reablement access, which supported periods of assessment to identify all peoples needs including those with established needs. However, staff told us there was limited availability of reablement and pressure to end support after only two weeks so that more people could access help. They said this could negatively affect outcomes for people when support ended before they had regained enough independence. Senior leaders had a strategic improvement plan that identified the need to enhance the OT workforce and develop front door and enablement models and develop support for carers for better access to services. Commissioners also had plans to improve housing with support and monitor the impact of technology enabled care. There was a social care operating model, and future plans for investment from the full council budget and through the Better Care Fund. However, at the time of the CQC assessment there was more to do to bring together frontline adult social care practice and expectations to promote a prevent, reduce and delay approach.

Provision and impact of intermediate care and reablement services

The local authority had committed to improving the reablement and intermediate care offer through its Home First transformation, which senior leaders told us had improved timely hospital discharges and reduced long-term support needs.

The local authority had a Community Enablement Team and a Short Term Intervention Team (STIT) as internal home care provider services registered with the CQC. Support was provided based on people’s individual needs. However, staff told us there was limited availability to access the service and due to demand, there was pressure to review and end peoples reablement support after only 2 weeks opposed to tailored responses to ensure they could transfer a person timely to any ongoing care. This could be a source of frustration for staff and could negatively impact outcomes for people when their support was ended or transferred too early. Staff told us they had the opportunity in team meetings to discuss their concerns however the CQC was told meetings were not held consistently and they felt they were not being heard. Senior leaders told us that since April 2025 additional funding and service improvements had increased peoples availability to access reablement services, and this had supported people to be supported for longer when being discharged from hospital. A senior leader also told us there was more to do to see the benefit of therapy influence with reablement and enablement offers. At the time of the CQC assessment the NHS community therapy services worked alongside local authority reablement, and enablement offers but found this offer was fragmented and could result in outcomes being more risk averse. For example, this was seen in the number of people being supported out of hospital that needed the help of two support workers. Senior leaders told us there were aspirations to redesign these services jointly through an adult transformation workstream.

Offers for people returning home with support from acute physical health hospital had improved. Senior leaders told us there had been a move from a fragmented approach to strategic planning and oversight. This included a joint strategy supported by shared data dashboards, a joint transfer hub, and better joint commissioning of home care and assessment beds. National data showed 5.89% of people aged 65 or over who received reablement and, or rehabilitation services after discharge from hospital was significantly better than the England average (3.00%). Additionally, 84.04% of people aged 65 or over were still at home 91 days after discharge from hospital into reablement and, or rehabilitation services which was similar to the England average (83.70% Short and Long Term Support, NHS Digital 2023-2024). Partner feedback was mixed, some felt well consulted with improved outcomes driven by integrated commissioning, while others told us hospital-based assessments still delayed recovery and reduced reablement effectiveness.

There was inequity in the provision of reablement. Staff told us people requiring the intervention of a vision rehabilitation specialist following their initial assessment were waiting up to 18 months. This included the provision of cane training, orientation and daily living skills such as safe kitchen skills. Therefore, people with visual impairments were limited in their ability to maximise their independence and prevent the further deterioration of their skills and confidence whilst they waited. In response, senior leaders told us the waiting list was regularly triaged and staff provided sign posting to various support networks across the city such as social groups listed on the Sheffield Directory. In addition to this, a Sensory Partnership Board was set up at the beginning of the year. This board aimed to improve sensory impairment accessibility of the services provided across the local authority. However, it was too early to understand any positive impacts on people at the time of the CQC assessment.

The local authority's reablement and intermediate care services were delivering positive outcomes, particularly through OT-led models and integrated discharge pathways. However, delays in specialist services and fragmented therapy offers presented barriers. There remained more to do to strengthen therapy input, improve processes, and ensure timely access to rehabilitation to enable all people were supported to their optimal independence.

Access to equipment and home adaptations

People told us about the positive impact equipment had on their lives. For example, access to items such as stairlifts, profiling beds, and bariatric shower chairs enabled people to remain at home with dignity and independence. Between January and November 2024, over 71,000 pieces of standard equipment were issued, and 99.6% were delivered within target timescales. Emergency items arrived the same day, urgent items the next day, and standard items within five days once assessed. This performance had remained consistent since March 2025, showing the local authority monitored contracted delivery against set targets.

People's need for assessments had increased. In September 2025, 579 people were waiting for an equipment assessment, up from 434 in March 2025. People had a median waiting time of 39 days. Senior leaders told us the actual longest a person waited was 76 days in April 2025 over the past 12 months. A previously reported maximum figure of 639 days reflected a recording error. Senior leaders told us this person had an assessment completed within four months, and the persons assessment was kept open to monitor housing adaptations. Senior leaders told us recording processes had since improved so assessments close promptly while still ensuring people felt supported. Progress was monitored against local authority targets of one month for urgent needs and three months for non-urgent needs. These waits, while improved, remained above target for some people and showed the need for time to embed new approaches and demonstrate the impact of monitoring and oversight. Senior leaders told us the local authority had faced a 118% rise in people needing support over six years and continued to experience high referral rates. They told us improvement work had reduced delays overall, with median waiting times falling from 84 days in June 2024 to 55 days in March 2025 and 39 days in September 2025. For instance, the introduction of online triage tools, prioritisation guidance, proportionate assessments, and a new duty system with clinics had stabilised the number of people referred for full assessments over the last year. These changes aimed to manage demand and improve access, but waiting times showed further improvement was needed.

Community equipment clinics were introduced to improve responsiveness and offer people more flexible assessment options. For example, these enabled people to submit measurements and photos to speed up the process. People were not limited to telephone screening or clinic appointments; people could still wait for a home visit depending on preference and level of need. For example, people living with dementia might not be asked to come to a clinic if the unfamiliar environment would not be supportive to their assessment.

Staff told us optimised care training and trusted assessor roles had supported timely provision and reduced reliance on people needing formal care support. Technology-enabled care (TEC) was available such as falls detectors, door sensors, and lifeline alarms helping people remain safe at home. Alarm services allowed people to speak to an operator and receive timely responses, enhancing safety and autonomy. The Lifeline Service also provided six weeks of free TEC support post-hospital discharge, helping to prevent unnecessary hospital admissions working with the ambulance service around falls.

Other improvement work was happening including improved allocation meetings to ensure consistent and fair allocation and closures of work. Similarly, processes improved in relation to young adult referrals alongside a dedicated Principal Occupational Therapist (OT) who led on more proactive and strength-based approaches. There was a new adult social care website to make preventative options and offers clearer for people to navigate. There was also an equipment house newly launched. It enabled people to see the benefits of equipment and learn about how they could use equipment to promote their independence. There was also a triage tool online to support people to independently resolve some issues for themselves.

Despite these improvements, challenges remained. OT workforce changes, including moving resource to support the optimised care work, and staff turnover had meant wait lists had not reduced as much as the local authority had anticipated. Senior leaders told us risks were managed alongside recruitment and capacity-building measures. Staff gave mixed feedback around changes to OT practice. Some staff told us reduced access to OT expertise affected their ability to carry out assessments and led to delays in providing equipment, such as mobile transfer aids, due to limited technical knowledge. Other staff told us while progress was being made, not all staff had fully adapted to new ways of working. The team was described as being in a transitional phase, with OTs developing a shared commitment to improving preventative approaches. The local authority's backlog in Disabled Facilities Grant (DFG) applications for major adaptations was an unintended consequence of reducing assessment waits at pace with a reported 120% increase. In response, senior leaders introduced improvements to the framework for major adaptations, including increasing the number of contractors to address the backlog. Changes were also made to private housing discretionary DFG top-ups, with proposed processes aimed at ensuring clarity and consistency in their use.

The local authority had made progress in improving access to equipment and adaptations, including use of innovation to assess to promote wellbeing and prevent, delay, or reduce needs. However, at the time of the CQC assessment it was too early to evidence equitable access for all people, and continued oversight was needed to ensure timely, person-centred support.

Provision of accessible information and advice

People and unpaid carers could access information and advice in person, by phone and online. However, in Sheffield 62.50% of people who used services found it easy to find information about support. This was somewhat worse than the England average (67.12%). This said, 55.87% of unpaid carers found it easy to access information and advice which was similar to the England average (59.06% Survey of Adult Carers in England, NHS Digital 2023-2024). Some people told us there was a lack of accessible telephone and website which was seen as a barrier to accessing information and advice. For example, a person told us the website was not user friendly and that telephone numbers they had tried to access were incorrect. Another person told us that information lacked the use of plain language and there was very little material produced in easy read format.

Partners also gave negative feedback about access to information and advice on people's rights and ways to meet their care and support needs. For example, a partner representing people told us the biggest issue for the people of Sheffield was the communication between people and the local authority particularly seldom heard people. It was said that the local authority had a lot of available support to help people but that this was not communicated effectively. It was felt that people were not aware of what support was on offer and historical work in this area had lapsed. However, another partner told us how their feedback had supported improvements. They had raised the style of communication in a standard letter template meant that some people did not take up care when they were eligible. This had been raised with senior leaders which resulted in the co-production of a revised letter and a reduction in complaints concerning communication.

The local authority had taken some steps to improve the accessibility and reach of its information and advice offer. A new adult social care website had been launched to make preventative options and services easier to navigate. It included a triage tool to help people identify their needs and explore solutions independently, supporting early intervention and reducing reliance on formal care. However, whilst senior leaders had monitored and acted on performance data and peoples feedback, at the time of the CQC assessment it was too early to evidence any positive outcomes it was having.

The local authority had made improvements to access information and advice, particularly through digital tools and early intervention signposting. There was evidence many people accessed telephone and online options. However, further work was needed to embed and monitor the effectiveness of the new website and strengthen co-production with people to ensure materials were accessible, relevant, and inclusive. Following the CQC site visit, senior leaders introduced changes to telephone systems and website functionality aimed at improving accessibility. Future evaluation would be needed to understand the impact on peoples outcomes which would ensure all people could access and act on information that supported their wellbeing and independence and ensure the local authority was meeting diverse needs.

Direct payments

The local authority promoted direct payments as a personalised care option. National data showed 47.30% of people aged 18–64 received direct payments which was significantly better than the England average (37.12%). And overall, 28.29% of people received direct payments which was somewhat better than the England average (25.48% Adult Social Care Outcomes Framework, NHS Digital 2023-2024). According to the local authority's own data 32% of adults receiving social care accessed direct payments, with people with learning disabilities being the largest group. People told us the positive impact of direct payments on their wellbeing and independence. For example, a person was able to keep familiar personal assistants when transitioning from children's services to adult services. The direct payment ensured they could access things that were important to them and when they wanted such as a snooker academy. This was a person centred approach and gave the person flexibility about when they wanted to do the activity. In another example, direct payments supported a person to purchase electric blinds and an electric garage door. The person was now able to get their arm cycle bike into and out of their garage independently and could access the community without the need of assistance from another person. Staff also shared how direct payments supported culturally appropriate care and activities such as mountain biking, tailored to individual interests.

Senior leaders told us direct payments were central to inclusive commissioning, enabling people to personalise their support and exercise choice and control. This approach aligned with strategic objectives to promote independence and equity. The local authority had invested in infrastructure to support direct payment uptake and retention. This included drop-in sessions for people receiving direct payments to discuss concerns and make changes, these were face to face to ensure equity for people who had difficulty using or communicating on the telephone. For example, staff told us a person attended a drop in session who was quickly able to make a change to their direct payment account with no disruption to the service. There was also a Personal Assistant (PA) register, and PA rates tool allowing people to choose and top up pay based on skills and preferences., a dedicated direct payment social worker and mandatory staff training to improve practice and awareness. Individual service funds (ISF) were an alternative to traditional commissioned services for people unable to take on the full responsibility of a direct payment. Commissioners had worked with creative providers who offered supported living services to find solutions. For example, a person had 15 hours of support to help them engaging in different activities which in turn had led to them receiving some free support through links with the community, opening up new opportunities.

Despite these strengths, there were challenges. Feedback from partners told us that some staff in the local authority did not consistently inform people about direct payments during assessments, limiting informed choice. Another partner representing people told us there could be delays in communication, with responses sometimes taking months and accounts being closed with unresolved debts. While some partners praised prompt set up and audit processes, demonstrating inconsistency across local authority staff. For adults over the age of 65 years only 11.24% received direct payments which was somewhat worse than the England average (14.32% Adult Social Care Outcomes Framework, NHS Digital 2023-2024). The Personalisation and Direct Payments Strategy 2022–2028 was shaped by feedback from people using services and included a repeat of a previous survey, which received five times more responses. Findings showed that 50% of respondents felt direct payments enabled better quality support, 38% said it helped them to be more independent, and 12% valued the increased control. Compared to 2021, fewer people reported difficulties in accessing direct payments. The strategy set out five key objectives, including strengthening personalisation, co-production, and infrastructure to support choice. Senior leaders monitored its implementation, with recent evidence of impact including a 200% increase in registered personal assistants (PAs) and improved access for Asian communities.

In September 2025, over the past 12 months 350 people stopped using their direct payments and 283 people started using direct payments. Senior leaders told us this number could fluctuate and there had been an increase in direct payments uptake, from 1,798 adults in April 2024 to 1,869 in March 2025. Themes relating to people leaving direct payments included people passed away, moved out of area, moved to supported living, day activities and home care frameworks and contracts. The local authority had improvement plans including direct payment monitoring and auditing model, support and guidance for staff in partnership with people and partners, and personal assistant workforce development utilising champions and hosting an annual PA workforce summit for the region. A Personalisation Board, which included people with lived experience, oversaw the use of direct payments in Sheffield and used a performance dashboard to track progress. This governance was supported by monitoring national data, local surveys, and feedback mechanisms such as 'you said, we did'. A new Direct Payment Support Service was introduced, with plans for future user-led delivery. Robust monitoring of the Personalisation and Direct Payments Strategy Delivery Plan further ensured that people's experiences and the impact of services continued to inform the local authority's improvement efforts.

Direct payments were enabling people to live more independently and access personalised support in Sheffield. The local authority had demonstrated innovation and commitment to improving uptake and infrastructure. However, they were aspiring to improve further to ensure consistent advice, accessible information, and robust oversight. Strengthening co-production, improving communication, and addressing gaps in support would help ensure direct payments were a viable and empowering option for all.

Equity in experience and outcomes

Score: 3

3 - Evidence shows a good standard

What people expect

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

The local authority commitment

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

Key findings for this quality statement

Understanding and reducing barriers to care and support and reducing inequalities

Sheffield was recognised as a City of Sanctuary and had two universities which contributed to a transient population and changing demographics. The local authority collected and monitored data by combining public health and adult social care information to identify trends and support future planning for care and support. A senior leader told us the local offer was responsive to diversity and ongoing change, reflecting the evolving needs of the population.

Strategically the city had established an independent Race Equality Commission to investigate and address racial and ethnic inequalities. This led to the launch of the Race Equality Partnership for Sheffield (REPS) in 2024 and the development of Equality Objectives for 2024–2028, as part of a broader Equality Framework that promotes the principle that equality is a shared responsibility. These efforts were supported by a Strategic Equality and Inclusion Board and the Equalities and Engagement Team, helping to embed inclusive practice across the local authority. Members of the strategic leadership team also acted as thematic champions, providing visible leadership, acting as allies and sponsoring activity. Sheffield City Council had also chosen to treat care experienced people as an additional protected characteristic alongside unpaid carers and consider other areas such as socio-economic and poverty, the voluntary and community sector, health inequality and the armed forces within their Equality Impact Assessment processes. LGBTQIA+ stands for lesbian, gay, bisexual, transgender, queer (or sometimes questioning), intersex, asexual, and other sexual identities. Some partners told us there was developing work to improve engagement across key health partners and the voluntary and charity sector that represented people from ethnic minority backgrounds and LGBTQIA+ communities. Action around this was monitored through Annual Equality Reports which demonstrated progress. There was clear evidence of strong corporate commitment to equity, with strategic action to embed inclusive practice across the workforce.

Senior leaders told us the corporate Equality Objectives 2024–2028 shaped adult social care priorities, embedding inclusive practice and accountability. These objectives informed commissioning, workforce development, and service design to reduce disparities and improve equity in outcomes. Annual Equality Reports monitored progress against equality objectives and highlighted actions taken to improve access and experience for people with protected characteristics, supporting transparency and continuous improvement.

The local authority was part of a national Adult Social Care framework to monitor and address disparities in workforce experiences and outcomes for staff from diverse ethnic backgrounds. Locally, there was a strong focus on addressing staff experiences of inequality, with work underway to embed a zero-tolerance approach to racism. Training in cultural competence, unconscious bias, and anti-racism was provided to staff and leaders, with proposals to make this mandatory. Senior leaders consistently recognised the importance of inclusive workplace environments, with national recognition through people management awards. Staff and leaders acknowledged that while the organisation was still learning and improving, there was a clear commitment to open dialogue and cultural development. There was also recognition that supporting staff directly influenced the quality and equity of care delivered to people. There was an extensive Adult Social Care Equality, Diversity and Inclusion (EDI) Plan with evidence of resource and progress to support improvements and ambitions. For example, an engagement toolkit to foster understanding in adult care had been developed to support staff to open up on EDI related conversations. This supported staff to gain further understanding of people's protected characteristics and how these fit into day-to-day practice. This was also part of plans to improve recognition and recording to better understand the needs of people to improve service delivery. Staff were passionate about sharing progress and examples of impact. Tracking of people's experiences showed that individual needs related to protected characteristics were being considered in practice. For example, a person's faith was reflected in both their assessment and support plan. They were supported to attend their place of worship weekly, with recognition of the importance this held for their wellbeing and their valued role within the community. In another example, staff told us how they ensured cultural needs were understood and respected, and how support was tailored to align with a person's religious and cultural values. This not only ensured the care provided was culturally appropriate but also helped to build trust, enabling the person to feel heard and valued, and empowering them to take on new roles in their community. Staff developed and accessed training and proactively sought out community resources to meet individual needs, even where formal systems were not fully in place. This demonstrated a commitment to equity and to reducing barriers for people who may otherwise have faced exclusion or unmet needs.

An analysis of ethnicity data for adult social care referrals helped the local authority to identify groups of people with potentially unmet needs or at risk of poor outcomes. For example, they told us the number of white British people being supported by adult social care was significantly higher than the demographic make-up of Sheffield. Senior leaders told us this indicated people in non-white ethnic groups were under-represented in certain age groups. Dedicated staff supported a range of strategic plans, delivery groups and actions underway to address the risk of unmet needs of those with protected characteristics. For example, ethnicity analysis benchmarked against census data highlighted a significant under-representation of Asian and Asian British people aged 25–49 in accessing long-term care and support services, and the local authority used this evidence to identify inequalities and take action. This led to targeted community engagement through a commissioned self-advocacy group and other forums, improvements to information and advice through community languages, translation software, and interpretation services, and strengthened workforce diversity initiatives.

Partners representing people in Sheffield identified key inequalities, including deprivation and poverty. Funding was in place to support people in meeting basic needs, such as access to food through local food banks. For Roma communities and asylum seekers, the local authority and its partners had shifted from a service-led to a needs-led approach, engaging with community leaders and adopting grassroots methods. This demonstrated progress in tailoring services to people's lived contexts and improving accessibility of support. Despite progress, senior leaders, staff and partners highlighted their awareness of underserved communities (such as people with neuro diverse needs, disabled people and people from the LGBTQIA+ community), gaps in engagement with people who self-fund their own care, and areas where further action was ongoing to reduce inequalities. Intersectionality is a term that can be used to describe how different aspects of a person's identity such as race, class, gender, and other personal characteristics overlap and interact, influencing their experiences and access to support. Partners told us how some ethnic minorities and LGBTQIA+ communities required tailored support for mental health needs and there was ongoing consultation around this.

Senior leaders and partners told us about a history of mistrust between the local authority, the care market. However, senior leaders were listening to better understand people's cultural needs within the wider social care workforce commissioned by the local authority to carry out care and support. Equality impact assessments were referenced in commissioning and service redesign, and this was being rolled out across all programmes. There was a wealth of data, and areas of using data to understand the protected characteristics of the adult social care population, with aspirations to evidence all barriers to care and support and inequalities were reducing. Senior leaders demonstrated examples and robust plans to improve the adult social care approach to evidence how equality and diversity data developed services.

Inclusion and accessibility arrangements

Staff consistently reported that a range of tools were available to support inclusion, including translation services, British Sign Language apps, and advocates to ensure people could engage with the local authority in ways that work for them. The online directory and triage tool helped people including those that self-funded their own care, and unpaid carers find relevant support, and people were reminded of appointments through multiple channels including text, calls, and letters.

The commissioned translation service was provided 24 hours a day, 365 days a year and there was evidence of interpretation used for many languages including Arabic, Urdu, Slovak, Farsi, Somali and Kurdish. People could use telephone, face to face, remote video interpreting and translation and transcription. British Sign Language (BSL) was available via face to face and via remote video.

Staff and senior leaders also told us the Sensory Team provided assessment, advice, information and guidance. For example, links to BSL coffee mornings, and a commissioned video relay service to enable people who were deaf to more easily access services. There were examples of staff working to ensure all people could access care and support that enabled people to live as they wanted. For example, staff within the Sensory Team worked with people with or waiting for migrant status who were also deaf. Staff could internationally sign. They were providing tailored support and training to enable different nationalities to access BSL and integrate more fully into their local community, build relationships, and participate in things such as support services that would otherwise be inaccessible. The local authority partnered with a deaf-owned organisation to provide people with independent, round-the-clock access to interpreters via a web browser or app, making it a flexible tool for everyday use. This initiative supported people who were deaf in accessing services such as benefits and housing in their own language, demonstrating a clear commitment to improving accessibility for the deaf community.

The local authority published documents online such as Sheffield Council Plan, Together We Get Things Done, however there could be an assumption people had internet access and digital literacy, which may not be the case for all. Senior leaders had awareness that some people living in Sheffield were digitally excluded and had aspirations to improve provision of printed copies where appropriate. Some staff and people also told us there could be barriers to engagement and inclusion due to a lack of easy-read materials and limited access to advocacy. The local authority had commissioned a service to work with seldom-heard groups to produce easy-read resources and improve access to information and reduce barriers.

Staff had robust processes to ensure people received their assessments, care and support plans either digitally or paper copy. The new website had also been designed so that it was accessible for people with disabilities, for example being compatible with screen readers such as use of search engine translate technology, a recite service to read the pages and ability to change font size and contrast text. The webpages had also been designed for compatibility with voice recognition software.

Senior leaders had plans to further improve inclusion and reduce inequalities. Plans were underway to expand co-production and embed accessibility standards across services. The local authority aspired to ensure that all people could engage with services in ways that worked for them, regardless of background or communication needs.

Theme 2: Providing support

This theme includes these quality statements:

- Care provision, integration and continuity
- Partnerships and communities

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

Care provision, integration and continuity

Score: 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

According to the local authority's data within its Joint Strategic Needs Assessment (JSNA), Sheffield's population aged 65 and over was projected to rise 27% by 2040. The number of people living with dementia was expected to grow by 16% by the same time. The JSNA referenced groups of people in Sheffield including Bangladeshi, Black African, Black Caribbean, Chinese, Eastern European, Gypsy or Irish Traveller, Indian, Pakistani, Roma, Somali, Yemeni, LGBTQIA+, unpaid carers and people with disabilities. The JSNA was outdated in areas, though a redesign was planned.

Among the adult population in Sheffield, further work was needed to better understand the numbers, identities, and specific needs of autistic adults who may be at risk of isolation and neglect. Analysis within the Joint Strategic Needs Assessment (JSNA) indicated a heightened risk of premature death for autistic people, particularly those with a learning disability, with social factors contributing to this outcome. The Sheffield Autism Partnership Board was developing an All-Age Autism Strategy for the city. Staff highlighted gaps in service commissioning, noting that residential care options were often too restrictive, while supported living did not always provide sufficient help leaving some people without appropriate support. Staff also raised concerns about delays in system navigation, with some people remaining without suitable provision for extended periods. A commissioning project was underway, although there were concerns about the time required to implement change. Staff told us without the right support, people may experience deteriorating wellbeing, increased risks, and potential deprivations of liberty. Senior leaders told us partnership boards such as Autism, Learning Disability, Dementia and Personalisation provided governance and lived experience input, influencing commissioning decisions and shaping strategic priorities to meet diverse needs. A first-year action plan had been developed to guide service commissioning and improve outcomes for autistic people and their families. However, people and partners noted that the aims and direction of the Partnership Board required greater clarity, with more work needed to strengthen governance and define priorities. An estimated 7,000 people in Sheffield were living with dementia, representing 1.21% of the population, slightly lower than the national average of 1.3%. The JSNA indicated that identification and diagnosis rates in Sheffield had been above average but still fell short of the likely true prevalence. The local authority had recognised the wellbeing challenges faced by unpaid carers, noting that caring for someone with dementia could be frustrating and stressful. There was strategic commitment for example, through the Dementia Strategy 2025–2030, which had expanded dementia cafés from four to over forty, supported community-based initiatives, and developed culturally inclusive resources. The commissioned carers service offered a 24-hour advice line and attended monthly panels to ensure carers' voices were heard. The local authority had piloted new respite services and developed commissioning plans aligned with broader wellbeing strategies. However, there remained areas for improvement. Despite strategic intent, access to short breaks remained inconsistent, with carers and staff reporting stress and delays in securing respite, particularly for those caring for people with dementia. National data showed that only 7.74% of unpaid carers had accessed emergency or short notice respite support this was somewhat worse than the England average of 12.08%. Similarly, 12.90% had accessed breaks between 1 to 24 hours, compared to 21.73% nationally (Survey of Adult Carers in England, NHS Digital, 2023–2024). This demonstrated some carers were left without the help they needed to take a break, rest, or manage other commitments putting their own wellbeing at risk. The local authority had recognised these challenges and committed to working with unpaid carers to improve services.

There were estimated to be 16,600 people living with sight loss in Sheffield and predicted to increase to over 20,000 people by the year 2030. The JSNA recognised 50% of people with blindness and serious sight loss could be prevented if detected and treated in time. Sight loss could lead to significant decreases in quality of life and increases the risk of social isolation, poor mental health, falls and injuries, poverty and the need for regular care and support. The estimated number of people with sight loss was lower in Sheffield compared to the average for England, with 2.9% of the population living with sight loss compared to 3.1% nationally. The local authority kept a register of people who were sight impaired and severely sight impaired to ensure their needs are assessed and met. A higher number of Certificates of Vision Impairment (CVI) were issued in Sheffield (58.2 per 100,000 population) than the overall rate for England (41.1 per 100,000 population). The purpose of the CVI is to provide a formal referral route for someone with sight loss to social care services. There had been numerous initiatives to support better identification of need and recording of CVI so that people get access to the support they need. A higher rate of certification indicated a positive response to this work.

There was a need for identification and early intervention to prevent alcohol use becoming misuse. The JSNA identified Sheffield had worse statistics than the England average around alcohol-specific deaths and hospital admissions for alcohol-related conditions. Local data for alcohol-related deaths was generally higher in the geographical areas that experienced greatest deprivation. Hospital admission for mental health needs due to use of alcohol in men was also higher in Sheffield than the England average. Drug use was identified as similar to the England average (with the exception of opiate use only). The prevalence of injecting drug users was estimated to be decreasing nationally and in Sheffield.

There was recognition that people with additional or multiple needs such as mental health challenges or drug and alcohol use could also experience housing-related issues, including homelessness. These overlapping needs added complexity to people' situations and made it more difficult for them to achieve independence from care and support. A senior leader told us the available housing stock was insufficient to meet the needs of people with or at risk of requiring care and support. There were limited adapted properties beyond those recorded through Disabled Facilities Grants, and temporary accommodation was largely reliant on hotels. Rising housing demand meant that some people were not matched with suitable long-term homes. In response, the local authority developed a local plan aimed at significantly increasing housing availability, with a commitment to building new homes over the coming years to create stable and supportive living environments for people across the city. All newly constructed council-owned properties were built to accessible standards, contributing to more inclusive housing models that promote independence.

Market shaping and commissioning to meet local needs

There was a clear picture of the number of people who received adult social care provided by the local authority in Sheffield, including older adults, people with learning disabilities and people with physical disabilities. The local authority had Market Position Statements and engaged with providers through quality assurance processes. However, there was a gap relating to detailed understanding of self-funder market. This limited the ability to fully plan for sustainability, particularly in relation to capacity and affordability for people who arrange their own care. Feedback from people and partners also highlighted a need to improve cultural understanding within care services.

National data showed 66.59% of people who used services felt they had choice over services which was similar to the England average (70.28% Adult Social Care Survey, NHS digital 2023-2024). The local authority worked collaboratively with people, staff, and partners including private providers to better understand needs. For example, commissioning a self-advocacy group to deliver workshops and drama sessions, which helped embed people's voices as a central theme in service development. This led to changes in commissioning, including the creation of a framework involving 40 providers offering a wide range of day activities from traditional centres to more adventurous options such as canoeing and rock climbing giving people greater choice and control.

Strategic intentions could be seen in the overarching Adult Social Care Strategy Living The Life You Want To Live committing to; partnership working to connect people to community and resources around them, provision of temporary support, a shift of resources for more preventative approaches, provision of care and support with accommodation options for care that offered more choice, transformation of care at home, embedding a clear support offer and structure for all carers, and ensuring a good choice of affordable care and support, with a focus on people's experiences and improving quality. There were five Market Position Statements (MPSs) spanning between 2022-2030. Data was used and compared from as early as 2018 to inform the MPSs. The information came from a range of sources dependent on the individual MPSs. Examples included use of data from national statistics, national charities, regional sources such as neighbourhood and children focused data, local services that represent people's experiences, Integrated Care System (ICS) data and the local authority's financial information, adult social care information hub and dashboards and self-assessment.

The Market Position Statements acknowledged trends and outlined commissioning intentions to shift from traditional care such as residential care to supported living, extra care housing, and community-based models. There was acknowledgement to enhance reablement, improve flexibility of short break options, and dementia support, and the need for culturally inclusive services for Sheffield's diverse communities including Pakistani, African, Chinese, Roma, and LGBTQIA+ populations.

The Care Homes Transformation Programme aimed to strengthen contracts and develop accommodation models for people with additional or multiple needs. Early data showed a reduction of 63 residential care beds, and a new care suite model within extra care housing was being developed to reduce reliance on traditional residential care. Technology-enabled care was promoted to support independence, including telehealth, telecare, and self-care apps. However, digital exclusion had not yet been fully addressed. Partners contributed to Market Position Statements and described a series of workshops with the local authority to reflect on ongoing needs in Sheffield. There was a shared ambition to approach things differently, alongside recognition that limited investment sometimes constrained progress. Despite this, the local authority and its partners demonstrated a strong commitment to collaboration. Most partners felt their voices were heard and were motivated to improve outcomes. For example, care provider representatives were actively involved in the Adults Partnership Board, creating opportunities to work jointly with universities, the local authority, and other stakeholders to explore new approaches to delivering inclusive and high-quality care.

Ensuring sufficient capacity in local services to meet demand

There was a recognised need to expand the availability of short breaks, mental health services, and supported living options. Feedback from staff, people using services, partners, and senior leaders highlighted mixed experiences in accessing appropriate support. Staff told us residential care was primarily designed for older adults, and that suitable placements for younger adults were lacking. As a result, high-cost placements outside the council's commissioning framework were sometimes used, which did not always promote recovery or independence. Between June and August 2025, data provided by senior leaders showed that people waited a median of 3 days from referral to start date for home care, 1 day for residential care, 6 days for nursing care, and 34 days for supported living. Senior leaders told us that people accessing home care had consistently low waits throughout 2025, reflecting the success of a new framework and an effective provider market. While contingency measures were in place during the transition, these were not required. However, feedback from staff, senior leaders, people using services, and partners highlighted a mismatch between available services and the needs of people with mental health conditions, learning disabilities, or autistic people. Despite the data, staff reported growing waiting lists and an increased reliance on out-of-area living arrangements. Senior leaders told us out of area living arrangements were centrally monitored including summaries of reasons and key themes. Staff, however, highlighted challenges in maintaining consistent oversight and ensuring that information supported day-to-day care planning and risk management across different locations.

In an example, an unpaid carer described difficulties in progressing supported living for their relative, citing inconsistent communication and a stalled process lasting over two years. This reflected wider concerns about gaps in supported living and specialist provision. Senior leaders identified several reasons for delays in service access, including personal choice, assessment delays, and challenges during transition into adult services. They also noted that where services involved shared living arrangements such as residential care or supported living additional time was often needed to ensure compatibility between people. Around 75% of supported living options were in shared accommodation, while demand was highest for self-contained flats.

There was mixed feedback about hospital discharge. In August 2025, senior leaders told us 17.2% of acute hospital beds were occupied by people who had been assessed by the hospital as ready to leave. According to senior leaders, only two of these people were awaiting the start of home care services. Although there were inconsistencies in how delays were recorded, future improvements in data accuracy were being planned. People could return home with support from either in-house reablement services or private home care providers. Staff involved in both acute and mental health hospital discharges highlighted that the main barrier to timely discharge included limited availability of services for people with mental health needs and reasons outside of adult social care remit such as challenges in accessing suitable housing or accommodation. Temporary step-down beds were available for up to six weeks while housing was arranged, but only four such flats were in use, and the number of people needing this type of support varied over time. Partners and staff told us the ability to move people out of mental health beds in a timely manner had not been good which had driven up out-of-area placements.

In September 2025 263 people were staying outside of Sheffield in local authority funded provision. Within the past 12 months of September 2025 96 new people had been placed out of the area, with 30 of these people outside of the regions of South Yorkshire and Derbyshire. Senior leaders told us placements they offered were to best meet the needs of the person. They recognised the principle of supporting people to get the right services as close to home as possible, and that out of city placements should only be made if there were no appropriate placements within the city. There were market shaping intentions to focus on developing more specialist support and on the creation of new capacity in identified market gaps. This included increasing and expanding their Shared Lives model and provision, developing a Complex and Enhanced Care offer to build local provision and address gaps in the market, increasing short breaks support including through in house provision. The local authority's new Preparing for Adulthood (transitions) policy and procedure and associated market position statement aimed for sufficient local capacity to meet demand for young people coming through to adult services from children's services. For example, the local authority had been working with NHS Integrated Care Board (ICB) on the procurement of a safe space service for people needing help with assessed risks and, or safeguarding. This would provide three beds with wrap around support for a limited period to support assessment and longer-term planning for people. There was recognition of the need to improve support for people being discharged from mental health hospitals and for those living in the community. Senior leaders told us they had commissioned three interim discharge beds to help people awaiting more suitable accommodation or support. This area was under active scrutiny and audit by senior leaders and system partners to provide assurance to people living in Sheffield.

Plans were underway to review shared housing and deregistered care homes, increase self-contained supported living units, and expand provision across the Integrated Care System. A Personalisation Strategy and Direct Payment Toolkit had been co-produced, and a provider fair was held to improve market transparency. Senior leaders recognised the need to address gaps in specialist provision, supported living, and short breaks to ensure sufficient, inclusive and high-quality care capacity.

Ensuring quality of local services

People gave mixed feedback about the quality of care and support services in Sheffield. For example, a person told us their extra care within supported accommodation enabled them to live as they wanted whilst maintaining independence, keeping skills up and provided a safety net should they need it. There was flexibility of support hours depending on the persons need, and continuity with the care staff which worked well for them. Another person told us they were very happy with their care, saying care staff were fantastic supporting them with dignity and respect. They told us their support was flexible, and changes could be made should they want it. In contrast, a person told us they were dissatisfied with the care they had quickly arranged, and care staff support was inconsistent around timings of visits and in some instances providing only telephone support opposed to face to face support where it was due. They told us they had reported this to the local authority after no change from the provider and remained to have no response 7 weeks later. In another example staff had concerns about the lack of quality checks on some home care providers who had attended people post hospital discharge and had left people without the required support or raised concerns. For example, leaving people without any food and drink and not reporting where people had been left without groceries. The local authority did not collect data on the number of people who changed providers or reasons for this.

Staff and partners told us the local authority had quality officers who went out to most services approximately every 4 to 6 weeks and updated a quality monitoring toolkit, including a choking toolkit, and reviewed care plans, daily notes, staffing, training files, accidents and complaints. For example, a provider partner told us following a visit they received a report back quickly with action plans and dates, which they found very useful. The partner recognised the visits could be challenging but rewarding, and as a result they had built supportive links with the local authority. There were examples where direct support around falls and choking risks had resulted in developing tools and training and reduced risks to people in care homes.

Staff told us that after each quality monitoring visit they completed an assessment with a rating and escalated higher risk services to a contracts officer to follow-up, stopping admissions where a care home was rated at highest risk, which reduced risk to people, resolved concerns earlier and maintained safe care. However, some partners criticised the time it could take for the local authority to support providers, suggesting that more direct action should be taken sooner to protect people. In March 2025 there had been 7 embargoes over the 12 months all relating to nursing home provision, with 1 still active in August 2025. Embargoes had been placed in relation to quality and safeguarding concerns as part of quality assurance and risk escalation frameworks. While this reflected active oversight, it also highlighted ongoing risks in the provider market. Risk meetings were held every 3 weeks as an opportunity to discuss risks, concerns and share information including non-contracted services and micro-provider services. Out of area placements and ongoing safeguarding enquiries within provider services were not standard agenda items, partners told us concerns around these areas could also be discussed if required. Senior leaders told us a spreadsheet was being developed to monitor out-of-area placements. Plans were underway to review all contracts, pilot a new organisational safeguarding process, and update the care quality framework. Therefore, at the time of the CQC assessment there were gaps in proactive monitoring of all people supported by local authority funded services.

The local authority applied a risk rating system to care providers, with those identified as higher risk receiving more frequent visits. Action plans were developed collaboratively to support improvement and manage identified risks. Senior leaders told us there was a day activity framework and commissioning officers were supported by quality assurance officers to monitor non-CQC registered services, however staff told us there were gaps in routine monitoring of day services. To help address this, a pilot scheme was introduced involving people from a commissioned self-advocacy group who carried out quality checks. Staff felt that despite these measures, challenges remained in maintaining consistent standards. Staffing shortages in the previous year had led to delays in quality monitoring. Staff also told us that risk assessments sometimes relied more on professional judgement than on consistently applied evidence, which affected the reliability of prioritisation. Senior leaders acknowledged that informal insights could contribute to risk planning, but staff emphasised the need for a more structured and evidence-based approach to improve assurance and consistency.

Senior leaders and key system partners utilised national data of adult social care providers for strategic assurances which they demonstrated as overall quality being above national averages. This was monitored through a Joint Quality Assurance Framework and overseen by the Monitoring Advisory Board. Quality improvement was also supported by operational data dashboards which were also shared with private care providers giving them direct access to performance information to identify risks and address issues early, supporting quality improvement and alignment with local authority priorities. There were thematic forums and collaboration with health and regulation partners. For example, the local authority worked jointly with the Integrated Care Board (ICB) on jointly funded services such as care at night, which improved shared problem-solving and oversight.

Ensuring local services are sustainable

There was mostly positive feedback from partners around the local authority’s arrangements to provide stability for providers. Some were unaware of or unable to access sustainability initiatives and did not discuss this with the local authority. However, most partners told us the value they placed on the consistent providers meetings and the positive difference this made particularly around staff retention, recruitment and through the training Care Academy. For example, a provider told us the local authority had many initiatives in place which could be accessed, this met the duty to support market sustainability and helped some providers maintain staffing levels and continue delivering care. This was supported by national data which showed 5.57% of adult social care job vacancies was somewhat better than the England average (8.06% Adult Social Care Workforce Estimates, NHS Digital 2023-2024).

In August 2025 senior leaders told us they had no provider contracts handed back, or provider exits over the past 12 months. Senior leaders told us this was due to robust and long term contracts being in place, quality assurance oversight and positive relationships which existed between commissioning teams, assessment teams and providers. Partners told us they greatly appreciated the local authority’s public recognition of provider services in Sheffield, particularly through initiatives like the Sheffield Cares Excellence Awards, which celebrated the dedication and professionalism of internal teams, private care providers, and voluntary sector staff. Staff and partners told us this was a boost for frontline staff recognising the value in the wider social care workforce.

Frameworks were open and the local authority were regularly inviting new providers to join. Partners told us the local authority had a lot of data and performance intelligence and worked with providers to understand them, with a real ambition for services to be person centred. Place-based home care models reduced travel time for staff and introduced a workforce-focused contract.

All care rates were below national averages in Sheffield. The local authority demonstrated how they worked with providers through provider forums to meet the challenges of sustainable cost of care in Sheffield and promote fairer contracts and wages. The local authority had a national care costing tool to develop rates of care across their provision. The tool supported fee setting and understanding of profit margins for providers. Providers told us the local authority had approached the rise in costs by meeting with them face to face to discuss this. Providers told us in the past this would have been email correspondence but this year they had a meeting explained their financial difficulties and held an open conversation. Providers noted they didn't get the outcome they needed with regard to financial increases but felt they had been given the opportunity to discuss the impact of the cost of living increases. Staff told us monthly meetings with providers discussed cost-of-living pressures, and supported them with grant-writing, bid applications, volunteer recruitment, and establishing friends and family groups which strengthened community support and enrichment for people they supported. A provider told us how they met with an energy advisor who the local authority had arranged to join a provider meeting. They provided tips which the provider implemented such as energy lighting, insulation and solar panels which saved the business money.

Senior leaders had plans to address sustainability issues through strategy and delivery plans, market oversight, recommissioning homecare services and the new care and wellbeing homecare model which had seen high interest from both existing and new providers to stabilise homecare provision in Sheffield.

Workforce sustainability was a key focus with a Care Sector Workforce Strategy 2023-2026 in place. The authority hosted the regional Personal Assistant Workforce Summit, bringing together councils, providers, and people with lived experience. It was also part of the Self-Directed Support Network and the Northern Individual Employer and Personal Assistant Network, supporting micro-providers and personal assistants. There were ambitions for going improvements including joint work with health as a key system partner to offer alternative student placements with care home providers and homecare. For example, speech and language students within care homes, paramedics and nursing students in homecare to share learning and provide the wider workforce with opportunities in social care. Staff also told us about plans within the Care Academy to deliver on identified needs including specialist training for conditions such as Korsakoff's syndrome, training to improve cultural competence including specific sessions on hair and skin care and core training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards where there were gaps in service resilience.

Partnerships and communities

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 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 demonstrated a commitment to promoting wellbeing, preventing needs, and integrating care through strategic partnerships. Senior leaders and partners had joint strategies and governance frameworks, including monthly executive meetings and shared dashboards. For example, the Fair and Healthy Sheffield Plan underpinned partnership work to reduce health inequalities and improve wellbeing. It aligned local authority strategies with health and care priorities, ensuring actions focused on people most at risk of unmet needs. The Health and Wellbeing Board was described as creating a single version of the truth to improve data sharing, winter planning and work through conflicting priorities between local authority and partners such as how to increase better outcomes for people with mental health needs.

Staff, partners and senior leaders told us the voluntary and community sector (VCS) was widely recognised as a key partner in supporting people's wellbeing. Healthwatch played an important role in sharing people's experiences with the local authority. People with learning disabilities told us there was more to do to improve access to employment opportunities and supported employment pathways. Carers valued the commissioned carers service, but some reported that the support they received was not always consistent or joined up. This highlighted the need for the local authority to strengthen its coordination of care and support to ensure carers and people with care and support needs receive timely, effective, and person-centred services. Progress in developing integrated approaches within mental health services had been slower than in other areas, particularly in reducing delays in hospital discharge. There was more to do to ensure consistent engagement across all sectors. Strategic plans were in place, but lived experience was not always embedded in decision-making. The local authority aspired to strengthen co-production and expand integrated models particularly in hospital discharge and preventative services.

Arrangements to support effective partnership working

People told us about the benefits of coordinated arrangements. People and unpaid carers told us how local authority staff worked well with partners, attending joint reviews, securing health funding and referring to specialist teams.

Partnership arrangements were embedded through formal structures, and arrangements that supported pooled budgets, shared accountability, and coordinated commissioning. The Discharge Programme Board and Better Care Fund (BCF) governance structures supported improvements in acute hospital discharge outcomes particularly for older people. Strategic alignment was evident through joint planning with the Integrated Care Board (ICB), including monthly executive meetings. There was a section 75 (of the NHS Act 2006) agreement to bring together budgets and integrated commissioning enabling targeted interventions such as the Northeast Model Neighbourhood Programme to reduce health inequalities for people in deprived communities. While the Health and Wellbeing Board fostered partnership working through shared data systems and joined up planning.

Impact of partnership working

People told us how partnership working had helped improve access to timely specialist care within their communities. Senior leaders told us there were strong local connections and collaborative working across sectors. The local authority demonstrated integrated relationships with education providers, including universities, as well as health and care services, police, and voluntary and community organisations. However, there was limited evidence of formal evaluation to understand the impact of these partnerships on social care outcomes. Although performance data was shared across agencies, partners told us that differences in how data was collected and used made it difficult to consistently measure progress and limited the effectiveness of joint oversight.

Proactive multi-agency working improved some people's outcomes. Staff consistently reported that co-location with health partners had improved communication reducing delays for people ready to be discharged and improving flow of hospital bed availability for other people needing them. Senior leaders and staff told us how partnership working particularly between housing, police, and social care supported outcomes for adults at risk of harm or abuse. For example, key teams such as safeguarding and mental health had daily contact with the police and described very effective working relationships. Similarly, the Sensory Impairment Partnership Board was highlighted for its inclusive governance and lived experience representation. This was a positive example of co-production shaping future services which was helping to shape the direction of the Board and future services. It included representatives from health, education, transitions, relevant charities and commissioning.

Senior leaders, staff and partners described positive outcomes from acute hospital discharge work, where more people were returning home with support as a result of partnership working. Despite successes, there were areas where the impact of partnership working was less clear or inconsistent. For example, people waiting to be discharged from mental health hospital were not progressing at the same pace despite joined up meetings in place. There were conflicting versions of the challenges faced, but ultimately there was more to do to build strategic relationships in this area and collectively focus on the impact on people waiting to be discharged from mental health hospital and those being placed away from home due to limited availability of appropriate community-based social care support. A formal partnership arrangement between the local authority and the mental health NHS trust ended two years before the CQC assessment, as the local authority needed to refocus on its statutory duties under the Care Act. Staff working across services were recognised for their commitment to supporting people in multifaceted and urgent situations. While there was mutual respect across teams, senior leaders acknowledged the need to strengthen prioritisation of responsibilities, including ensuring Care Act assessments and reviews were completed and that community-based support was effectively developed and delivered.

Working with voluntary and charity sector groups

The local authority commissioned a voluntary organisation that supported the Voluntary Community, Faith and Social Enterprise (VCFSE) sector to lead positive change in Sheffield. The organisation offered a wide range of support and services to over 3,000 groups, helping those starting up, as well as established organisations. People told us voluntary sector organisations were responsive and supportive in Sheffield. Unpaid carers told us the commissioned carers service was a welcome advocate for them. Other organisations funded by the local authority and represented people were praised for their community engagement and feedback mechanisms.

Senior leaders valued the benefit of the voluntary and community sector recognising that groups provided services the local authority could not deliver itself. Examples included commissioning of specialist organisations such as a drop-in centre for people who were homeless and or have needs relating to addictions. This provided people with access to free hot meals and drinks, laundry, clothing store, internet access, information and signposting to other organisations and an outreach programme. In another example, a survivor-led mental health and well-being organisation supported black people with mental health needs. This organisation had resources such as a self-care hub providing accessible and affordable culturally appropriate products including hair care and food. This strengthened inclusion and reflected the needs of diverse communities.

A change programme worked with the voluntary and charity sector to improve lives for people facing multiple disadvantages and strengthened co-production of a new Multiple Disadvantage Strategy 2025-2030. The connected network facilitated the sharing of learning and resources across the voluntary and faith sector to improve the system and services for people experiencing multiple disadvantage. A main aim of the strategy was to join services together and make them accessible and connected for people. It focused on a No Wrong Door approach which promoted joined up working across organisations. It was too early to see any positive impact of the work, but there were plans to regularly review progress and take action needed.

There were a number of community strategic boards where voluntary and charity sector partners told us they had a voice including Health and Wellbeing Board and Stronger Together Board including steering groups and development sessions which strengthened understanding of community needs. An equality impact assessment had taken place around community empowerment and engagement work with voluntary, community and faith sector partners. However, there was more to do to effectively evaluate the impact of voluntary sector contributions to prevent and meet local care needs and promote people's wellbeing. While co-production was referenced, feedback from voluntary groups was not consistently used to shape early intervention and prevention approaches within adult social care delivery but there were the foundations to come together and work differently.

Some smaller organisations told us they had to repeatedly chase the local authority for responses, and that the tone and professionalism of correspondence did not always meet their expectations. They also felt that their role and potential contribution were not fully recognised or understood. A recurring theme was that the local authority did not always engage with the voluntary sector in ways that reflected its strengths or its ability to identify and meet people's needs. In contrast, national charities described more formalised relationships with the local authority, including financial grants to support work on specific issues. These organisations characterised the local authority as a critical friend, enabling effective partnership working and helping them to capture and amplify the voices and experiences of people in their communities. Staff told us that partnership working with the voluntary sector was being strengthened through workforce development and shared learning. Senior leaders told us that contracts with voluntary and community sector organisations were increasingly long term, with one-year agreements extended to five years to provide greater stability.

Theme 3: How Sheffield 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: 2

2 - Evidence shows some shortfalls

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

People gave mixed feedback on how effective safety and risk management was in the local authority. For example, a person praised staff for being proactive and forward-thinking in reducing restrictions which promoted their wellbeing and autonomy. However, another person felt deterioration of their needs could have been prevented through appropriate risk support which suggested a gap in preventative and responsive care planning.

Senior leaders told us safety was part of the corporate culture in the local authority. This was described to include highways and street cleaning to protect local people and communities. Collaboration with the Director of Children's Services and the Preparing for Adulthood (PfA) programme was said to be improving. The Director of Public Health supported community strategy which was said to be beginning to show tangible improvements, especially for people with mental health needs. Elected members were provided with information to scrutinise risks and ensure people's safety remained at the centre of oversight. However, senior leaders and partners told us that more work was needed to strengthen the operational links between adult social care assessment teams and the housing department. The current disconnect was said to hinder coordinated responses to housing-related risks, limiting the ability to manage safety concerns effectively across services. There had been some action in relation to hospital discharge to address this with a housing officer based in the hospital to provide immediate input, smoother transitions and reducing the risk of homelessness or readmission into hospital.

People and unpaid carers had access to local authority support 24 hours a day and 365 days a year. Most service areas had a duty function to respond to immediate risks identified for people not yet allocated to a named worker or when a named worker was not available. The out of hours teams and Approved Mental Health Professionals (AMHP) teams had access to health and care systems to promote continuity. Sharing information is a critical component of safeguarding practices that helps prevent abuse and neglect. It is essential for identifying risks and preventing harm, especially when the risk may not be immediately obvious. Regular meetings happened between the mental health trust and the local authority to share understanding of risks to people, with agreed data and escalation routes. Staff told us where a person was assessed as at high risk of harm they could be discussed at the Multi Agency Safeguarding Hub (MASH) who enabled partner responses to high-risk situations using a structured vulnerable adult risk management scoring tool which indicated how quickly meetings needed to take place. There was a joint health and social care transfer hub to support acute hospital discharges where people were reviewed and then supported by an integrated team out of hospital.

Senior leaders and partners told us that joint working between the local authority and the acute hospital trust had strengthened with agreed shared responsibilities and recruitment of a joint interim discharge lead. This provided clarity on roles and resulted in smoother discharge support and advice for people. However, some partners who represented people told us they were not informed of partnership agreements to support hospital discharges and recommendations had been made to work closer together with the voluntary and charity sector in this area to provide more assurance of safe and coordinated transitions.

The local authority's Information Sharing Protocol was aligned to the Care Act 2014, Data Protection Act 2018, and Caldicott Principles. It enabled lawful, safe sharing of information with partners. There was the need for some staff to access multiple systems such as health or provider records to support risk visibility. However, staff told this was not consistently provided. For example, one staff group described several critical safety issues affecting both staff and people using services, which they attributed to limitations in information sharing and system access. Staff told us where the digital record systems didn't link up, professional relationships made up for this, but it was highlighted if staff didn't have good working relationships, they would be unaware of shared risks. There were concerns about information governance practices to work around issues such as using log ins that were meant for other roles and longer term workers with historic access needing to look up information they were not working on to share information needed. There was acknowledgement training and equipment issues had been an issue. However, these issues were ongoing over 2 years, in response senior leaders told us information sharing had been considered, and historic information was shared from health records onto social care records. Whilst there was a need for staff to pro-actively discuss risks with partners to assess situations outside of digital systems there was more to do to ensure current processes were robust in sharing risks to ensure that people and staff were consistently safe, coordinated, and practice was centred on wellbeing.

Safety during transitions

Transition is a time when the differences and gaps between services and support can be particularly evident and causes problems for people. A joined-up approach across relevant partners and agencies is critical to achieve the best outcomes for young people, adults, unpaid carers and their family and reduce risks of any loss of continuity in care and support. The local authority had processes such as a Business Continuity Plan, an acute Hospital Discharge and Urgent Care Delivery model and Plan, a safeguarding Escalation and Resolutions Policy, a mental health transitions register in place to support young people with mental ill health moving to adulthood. These aimed to support pathways when people moved between services and agencies to enhance people's safety.

People gave mixed feedback about safety when moving between services. For example, a person told us health, mental health, housing and adult social care services worked well together to support them move home and that each service knew what the other was doing demonstrating the benefit of coordinated support. Another person told us they were kept up to date with what was happening with the different teams involved and that each team had all of the correct information about their situation so that they did not need to keep repeating their story. However, some unpaid carers told us about gaps left in provision and no key worker continuity when people transitioned to different services. Other unpaid carers told us about poor coordination between services, which left their loved ones without appropriate support during critical times. These experiences suggested missed opportunities for early intervention and coordinated care.

Transitions for young adults reaching adult services could be inconsistent and was an area for development. For example, a person told us the support they had received between children's and adults services had been proactive, excellent and seamless demonstrating a person-centred approach and good planning for adulthood. However, another person told us they felt there was more to do to share clear information about arrangements when moving between services. They said the onus was on their unpaid carer to make contact and ask the right questions, for example they were not contacted until the person was approaching 18 years old and not told how long the preparing for adult service would support them for which was a source of anxiety. A senior leader told us that in Sheffield, they had work to do to make sure the least restrictive approaches were used when young adults moved to adult services. They said equipment and people's needs were not being checked often enough, which caused gaps in support that needed fixing to make it effective and sustainable.

This was a piece of work the local authority had identified with a report around risks and solutions going through governance processes and regular meetings with health colleagues and children's services were supportive of the need for improved positive behaviour approaches to promote independence and reduce future care needs and support in this area. There had been two recent Safeguarding Adult Reviews (SARs) involving young adults who experienced significant harm. These highlighted concerns about transition processes, including poor continuity of support, lack of direct engagement with the individuals, and unsuitable care environments. Staff and partners told us there was no dedicated service for young adults with additional and, or multiple needs, and that transitions often felt abrupt. While a mental health transitions register was in place, staff described delays and last-minute planning due to workforce gaps. The local authority and system partners had made recommendations to improve transition periods and recognised the need for more flexible criteria when moving to adult services.

Staff consistently told us there was a need to improve internal transfer processes between adult social care teams. It was recognised that some people had needs that were better supported through longer-term relationship building, particularly where there were risks related to self-neglect or hoarding. However, current systems sometimes led to people moving repeatedly between short-term intervention teams and longer-term community teams, which could disrupt continuity of support. Staff described challenges when support broke down, and continued working with people who needed ongoing input, though this reduced their availability to assess and support new referrals. Senior leaders acknowledged that some approaches had been overly protective, though well-intentioned. The local authority was learning from neighbouring areas that were adopting more proportionate assessment models and approaches that supported positive risk-taking and choice. Plans were in place to further equip staff to help people understand and manage their own risks where appropriate.

Contingency planning

Contingency planning, also referred to as emergency planning, was used to outline the support required if an unpaid carer, commissioned service, or the local authority became unable to provide care. An individual contingency plan sets out the specific arrangements for maintaining a person's or unpaid carers assessed care and support needs if their usual care arrangements break down. This includes who will provide care, how risks will be managed, and what steps will be taken to ensure continuity of outcomes. The local authority carried out this planning to reduce the risk of service disruption and prevent market failure, ensuring that clear procedures were in place in the event of a crisis. These procedures included identifying a lead officer, gathering and sharing relevant information, communicating with key partners, assessing risks, supporting transitions, and reviewing actions taken. Practical tools such as summary sheets and template letters supported a person-focused approach to managing disruptions in care delivery. There was adult social care contingency and emergency planning with business continuity testing of Care Act responsibilities to ensure plans in place were effective in the event of failure or threats in critical statutory functions. Where learning had taken place, gaps and training were identified and action taken to prevent risk of harm and maintain continuity of care.

People told us there was more to do around ensuring individual contingency plans were effective. For example, an unpaid carer told us that they had been admitted to hospital twice, each time there had been no contingency plan in place for the person they cared for, and they felt the local authority had a lack of understanding of their role and ability to respond more pro-actively to minimise risks to people including unpaid carers safety and wellbeing. Staff told us they included rolling respite offers within individual contingency plans, but acknowledged that if it wasn't planned, it was difficult to find suitable support at short notice. The brokerage offer did not always support in these situations, although efforts were made. A pilot project aimed at improving information sharing around short break options had not been successful. Assessment staff felt they were best placed to understand individual situations as they arose and were familiar with local care providers. Shared Lives as an offer was considered for short breaks, but staff told us the current offer was unsuitable for older people who may be in a crisis.

Funding decisions or disputes with other agencies did not lead to delays in the provision of care and support. Staff described the local authority's Continuing Healthcare (CHC) team as specialists, helpful and willing to attend joint visits. Emergency funding and Funded Nursing Care (FNC) were available through the Integrated Care Board (ICB) within two weeks and could be used for both community and hospital discharge. Staff described the processes as good.

Safeguarding

Score: 2

2 - Evidence shows some shortfalls

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

Safeguarding practice aimed to help people feel safe, involved, and supported. Most people gave positive feedback about how safe they felt with national data showing 68.70% felt safe and 86.64% said services made them feel safe which was similar to the England averages (71.06%, and 87.82% Adult Social Care Survey, NHS Digital 2023-2024).

Safeguarding is the process of ensuring people at risk are not being abused, neglected or exploited. People and unpaid carers could report a safeguarding concern through the main adult social care routes which included by telephone, face to face or online forms. However, partners representing people told us there were inconsistent processes. For example, there had been times where people had attempted to raise safeguarding risks over the phone and were advised by staff to make a referral online. This provided difficulties and barriers to some people who did not have internet access.

The local authority valued feedback and improved safeguarding through co-produced strategies and forums for people with lived experience. Sheffield had a Safeguarding Adults Board (SAB) and established independent chair who also took on the role of a scrutineer. Subgroups that linked to the SAB included a best practice group chaired by the Principal Social Worker (PSW), a performance and quality group also chaired by senior leader in the local authority and a safeguarding adults forum chaired by people with lived experience. Independent advocacy and Healthwatch representatives were newly invited to the SAB as wider representation for people's voices and scrutiny of services. The SAB had mature data and performance monitoring within a multidisciplinary dashboard that tracked outcomes and utilised data to understand people's experiences. The data was also used to identify underrepresented groups to support a more inclusive and equitable approach to safeguarding. There was well attended multidisciplinary presence of the SAB including the local authority, police, fire and rescue, health, mental health, housing, and chair of the safeguarding adults forum. Care providers were not represented at SAB but had local authority representation within operational processes.

Staff within the Multi-Agency Safeguarding Hub (MASH) demonstrated professional curiosity and a commitment to engaging with adults at risk. The MASH had 24 city-wide partners and 10 core partners operating within a formal agreement. The local authority led virtual huddles utilising a shared communication and collaboration platform to chat, hold meetings and calls, and file sharing in one accessible digital space. Frequent communication between staff and core partners demonstrated a strong commitment to protecting adults from abuse and neglect in Sheffield. Key services shared information to reduce risk, including police, probation, housing, health, children's services, and specialist support. Senior leaders, staff and partners told us as a result of the MASH there were demonstratable improvements to sharing information. These improvements helped identify levels of risk, coordinated support and improved recording of multidisciplinary plans to reduce risk.

Not all people and unpaid carers were supported directly by staff within the Multi-Agency Safeguarding Hub (MASH). The MASH team focused on supporting those not previously known to adult social care. For people or unpaid carers already receiving support, responsibility sat with the team assigned to assess or review their care needs. For people with acute physical health needs, there was a safeguarding duty role aimed at reducing risks and supporting safe discharge back to their usual home. Safeguarding concerns raised outside of standard working hours were managed through on-call arrangements and clear escalation pathways.

Staff outside the MASH shared mixed views about the effectiveness of current processes. Some felt the approach helped bring professionals together to find solutions, while others raised concerns about workforce pressures that made it difficult to allocate safeguarding referrals. There were worries about the potential for missed concerns during handovers, especially when people had to repeat their story to multiple staff members. Staff outside the MASH did not always have the same access to partner agencies, and there was inconsistency in how expertise within the MASH was used for people already known to services.

To improve awareness, staff events had been held to share available resources. All staff supporting people whose risks progressed to enquiry stage could access MASH huddles for advice and information-sharing. Staff told us the MASH approach supported timely action planning and improved communication with professionals, even where risk was not considered high. A Vulnerable Adult Risk Management system was used to track how quickly meetings took place. Partners were also able to raise concerns that could lead to safeguarding referrals, and they valued the MASH's responsiveness, often receiving information within an hour to help manage associated risks.

Senior leaders and staff reported increased confidence in safeguarding decisions, supported by reflective practice sessions and audit meetings. Staff described improvements in how people were involved in safety planning, reflecting a shift towards relational practice that supported participation and empowerment.

Safeguarding training helped staff understand how to take preventative action to reduce risks to adults, improve the quality of referrals, and strengthen the skills needed to investigate concerns. National data showed that 52.55% of the social care workforce in Sheffield (including independent and local authority staff) had completed safeguarding adults training, which was somewhat better than the England average of 48.70%. In relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, 38.44% of the workforce had completed relevant training, similar to the national average of 37.58% (Adult Social Care Workforce Estimates, NHS Digital 2023–2024).

Locally, training was available to the social care workforce, including train-the-trainer courses focused on safeguarding adults at risk. Many sessions were delivered by members of a training pool that included the local authority. However, staff identified areas for improvement, particularly in delivering training to providers where practice concerns had been raised. These included inappropriate use of restrictive measures and decisions made under the Mental Capacity Act without clear competence, which risked inconsistent protection for adults at risk.

The Safeguarding Adults Board monitored training attendance and worked closely with regional authorities and children's social care to promote a whole-family approach and multi-agency working. Staff, senior leaders, and partners spoke positively about well-attended partnership events, including the Mental Capacity Action Network (MCAAN). Outcomes included improved understanding of executive function, particularly in housing and homelessness contexts, and the introduction of a MASH advice line for partners.

There was evidence of preventative work. For example, the Adult Local Authority Designated Officer (LADO) role, a dedicated MASH social work consultant, safeguarding quality assurance manager and a dedicated performance officer were examples of leadership in this area. A LADO was not a statutory role within adults services as it is in children's services. However, the Care Act 2014 statutory guidance requires SABs to establish and agree a framework and process to respond to allegations against anyone who works with adults with care and support needs. A Person in a Position of Trust (PiPoT) could include people who work in paid or unpaid capacity, including personal assistants, celebrities and people undertaking charitable duties with adults with care and support needs. Senior leaders and partners had seen the potential to pilot a dedicated role responsible for prevention, identification and managing allegations of harm against anyone who works with adults at risk. This was in response to gaps identified in formal support for partners. At the time of this assessment the role was being reviewed in terms of impact and performance to decide whether it would be extended in the future.

Responding to local safeguarding risks and issues

The Safeguarding Adults Board (SAB) played a key role in identifying and responding to emerging risks and driving accountability and learning. Scrutiny and assurances were continuous processes throughout the year. For example, the Principal Social Worker took key safeguarding reports to political committee aligning with the SAB delivery plan. There were Safeguarding Audit and Assurance Meetings, quarterly performance reports and the Performance and Quality Subgroup had an agreed framework to monitor and evaluate the effectiveness of safeguarding adults practice across the city, using qualitative and quantitative data and intelligence. This supported the SAB to identify priorities, evidence continuous improvement and monitor themes and trends in relation to abuse and neglect.

In 2023-2024 neglect and acts of omission, followed by financial abuse and then physical abuse were the highest reported types of abuse investigated in Sheffield. Organisational abuse was the fifth most common type of abuse recorded. A person's own home was the most common location of abuse, followed by a care home. According to the SAB data where a risk was identified this was reduced in 67.1% of cases and removed in 24.2% of cases, with risk remaining in 8.7%. A partner told us the SAB sought assurance on organisational abuse concerns and quality monitoring of providers because of historic issues in care homes. During 2023-2024 the local authority had sadly had two deaths of people who lived in care homes that were related to choking. The local authority and partners had undertaken work with care homes to clarify processes for when to contact emergency services, a toolkit to understanding training compliance, and assurances sufficient staff on a shift were able to support any person who had a choking episode. There was also ongoing work around follow up to falls in care homes.

The SAB data dashboard integrated data from the local authority, police, fire and rescue service, and health partners to track trends such as self-neglect, accounting for 16% of concerns, which a partner said was above the national average. Senior leaders and partners told us self-neglect was a concern in Sheffield. Feedback from forums and partners identified areas for improvement. For example, a partner told us about a concern identified around hospital discharge pathways and self-neglect risks. A person had died at home after being discharged with no support. There was a growing emphasis on learning from serious incidents and preventing future harm. The local authority was aware of these issues and had begun to respond, although actions were in the early stages. There was recognition of a need to further embed professional curiosity, as this had been a recurring theme in nine recent reviews and audits completed by the SAB. Staff told us there was a need for the local authority to think differently about self-neglect and referenced best practice and research promoting dedicated and longer-term support to achieve more meaningful outcomes. At the time of the CQC assessment, staff told us they were asked by managers to close support within 28 days, but said realistically this did not happen, as they continued working with people until risks were reduced.

A Safeguarding Adult Review (SAR) takes place following the death or serious injury of an adult as a result of harm, abuse or neglect. The review looks at whether partner agencies could have worked more effectively to protect the adult. In September 2025 the chair of the SAB told us there were 14 ongoing SARs and audits. Senior leaders confirmed that the number of SARs completed in the past 2 years was 2. Whilst there had been delays in completing some SARs, there were processes to understand feedback and links to action plans and learning briefs. The SAB and DACT (Domestic Abuse Coordination Team) produced a quarterly newsletter looking at themes and learning coming from reviews in the city, such a Safeguarding Adult Reviews and Domestic Homicide Reviews (DHRs). For example, one edition of the newsletter focused on professional curiosity. Most staff were confident in understanding of learning from SARs. However, partners including care providers reported variable feedback and learning from safeguarding reviews. Senior leaders and partners recognised a universal multifaceted challenge particularly around application of the Mental Capacity Act, interlinked with the use of drugs and alcohol, mental health needs and impact of psychological trauma. There was an understanding, and work had started to raise more awareness and address silo working. However, this was an area that staff, senior leaders and partners told us processes needed to improve in Sheffield. There were further plans to address this in upcoming safeguarding events.

Transitional safeguarding was a SAB priority following two serious cases involving young adults. Assurance updates were requested in joint executive meetings with children's and adult services. One partner described a cliff edge in support at age 18, noting adult social care had more to do. Children's teams were extending support for care leavers, but concerns remained about rigid eligibility criteria. The SAB aimed to transform mental health services and pathways, overseen by a joint effectiveness subcommittee. Learning from Safeguarding Adult Reviews (SARs) had led to tangible strategic action such as co-produced strategy, multi-disciplinary audit and introduction of the MASH. However, at the time of the CQC assessment there was more to do to evidence learning from SARs beyond events and published documents available on the SAB website. Whilst the local authority demonstrated a responsive and learning-focused safeguarding system, with strong multi-agency collaboration and a commitment to prevention. There was a need to demonstrate that learning was fully embedded such as starting with staff induction, mandatory training programmes, and evidence of prevention of future risks to people.

Responding to concerns and undertaking Section 42 enquiries

Senior leaders told us all safeguarding concerns were screened within 1 working day as a median average. In September 2025, 271 adults at risk were being considered whether they triggered the duty to make a section 42 enquiry. This was similar to 273 adults at risk in March 2025. The local authority measured length of time to complete safeguarding tasks rather than time to start them. It took a median 6 days to complete whether a person met the duty to trigger a section 42 enquiry, which had improved from 7 days compared to March 2025. The maximum time recorded over the last 12 months was 367 days. This maximum figure represented the single longest person waiting which could include exceptional circumstances such as ongoing work or recording anomalies. Senior leaders told us this maximum figure was a recording error, not a delay in safeguarding action, and concerns had already been addressed through delegated responsibilities making the recording of a new enquiry unnecessary.

Section 42 enquiries are the actions taken by a local authority when there is concern that an adult with care and support needs may be experiencing or at risk of abuse or neglect. Within the Multi-Agency Safeguarding Hub (MASH), dedicated screening roles were carried out by unregistered staff to determine whether adults at risk not previously known to adult social care met the criteria for a Section 42 enquiry. These staff worked as part of a wider support network, which included managers and a social work consultant. Some concerns were closed without further action, while certain types of abuse, such as domestic abuse, automatically progressed to enquiry unless the individual was already receiving support from a specialist domestic abuse and sexual violence service, where safety planning and signposting could be completed. In contrast, concerns related to neglect or self-neglect were assessed on a case-by-case basis, with decision-making influenced by multiple factors that were not always clearly defined. The MASH had staff available to respond to urgent requests for visits where concerns were considered low-level, helping to assess immediate risks and close concerns where appropriate. For higher-risk situations, dedicated social workers were available to visit adults at risk, properties, and providers to ensure timely safeguarding responses. For people already known to the local authority, safeguarding screening was carried out by the relevant teams responsible for assessing or reviewing their care and support needs. The safeguarding practice within the MASH demonstrated multi-agency collaboration and proportionate responses. However, concerns remained about the clarity of thresholds and key decision-making roles. There was more to do to strengthen guidance and improve oversight to ensure consistent application of section 42 duties.

In 2023, 5365 safeguarding concerns were received, with 1515 progressing to Section 42 enquiries which was a 28% conversion rate. There was a year-on-year variation of safeguarding concerns received compared to concerns progressed to a section 42 enquiry which suggested fluctuating application of thresholds up until 2024. Senior leaders told us they monitored application of thresholds through national data submissions and there was no indication of a longer-term trend. Partners told us this was a known issue of fluctuating application of thresholds and there was learning from Safeguarding Adult Reviews (SARs) about risks associated with the local authority closing concerns as no further action. Partners saw this as a concern, it had been identified in the SAB annual report and there were future plans to strategically audit as a partnership for evidence and potential further action.

In September 2025 there was 522 people with section 42 enquiry's underway to determine what action, if any, needed to be taken to prevent or stop the abuse or neglect. This had reduced from 602 in March 2025. This included those whose safeguarding enquiry had yet to start as well as those in progress. For the 12 months to the end of August 2025, the median time from contact to completion of a Section 42 enquiry was 67 days, compared to 62 days for the 12 months to March 2025. The maximum timescale recorded during this period was 630 days. Senior leaders told us this was an isolated experience involving a person with mental health needs and an administrative error in recording. The local authority had a target for time from contact to completion of the section 42 enquiry which was 40 days reduced from 45 over 2024-2025. People's experiences revealed both strengths and challenges in how safeguarding risks were managed. For example, a person told us that although they were ultimately happy with the safeguarding outcome, it took over six weeks for the local authority to respond after a concern was raised by the police which negatively impacted their wellbeing at the time.

Processes did not consistently support staff to inform relevant agencies of the outcomes of safeguarding enquiries, even when this information was important for the ongoing safety of the adult at risk or for preventing harm to others. Staff told us while they could contact agencies by email or informally, this relied on staff remembering to do it manually rather than being embedded within formal procedures or checks. Although safeguarding does not replace the responsibility of care providers to deliver safe and high-quality support, local authorities have a duty to work in partnership to protect adults at risk. Strong multi-agency collaboration is essential to ensure timely and effective prevention and response to abuse or neglect. Partners reported delays in receiving safeguarding responses and told us communication about outcomes was often lacking. Some partners described long waits for updates, while others said they received no feedback at all. In contrast, some partners felt supported by duty staff who were available to discuss lessons learned. Training was offered to partners to highlight the importance of feedback and encourage them to challenge the local authority where involvement, communication, or outcome-sharing was insufficient. This aimed to prevent recurrence of similar risks and strengthen safeguarding practice across agencies.

When safeguarding enquiries were carried out by another agency, staff told us the local authority maintained responsibility for overseeing the enquiry process. Within the Multi-Agency Safeguarding Hub (MASH), staff described situations where enquiries were delegated to care homes, home care agencies, or hospitals. A social worker shared learning from another local authority, which contributed to the development of new guidance in Sheffield. A working group was formed, and a pilot was launched within the MASH, later extended across adult social care in consultation with providers. The guidance outlined when it would be appropriate to delegate safeguarding responsibilities, emphasising that this should not apply to all providers. Where delegation was agreed, providers returned information to the local authority, which reviewed the work and determined whether the concern should progress to a Section 42 enquiry with an allocated worker. If delegation was approved, providers were given 28 days to respond, and a duty worker reviewed the outcome. Staff told us this process was generally effective due to regular collaboration with partners, and many concerns were resolved without further action. In some situations, additional work was required, and this was then allocated appropriately. Staff within the MASH also consulted with the commissioning and quality team to identify any similar concerns that might inform decision-making.

Staff and partners told us there were systems and processes to ensure organisational abuse was investigated when it was more than a quality concern. If the quality team had concerns, then an improvement plan could be instigated. Staff could check on the digital recording system if concerns were linked to the same providers and had access to the Adult LADO for support and advice. A partner gave an example of how the local authority's delegation to a health provider around safeguarding responsibilities had been brought back into the local authority due to issues with a backlog and quality. Partners told us the local authority took safeguarding responsibilities seriously and a lot of work was being done around delegated responsibilities with partners.

Deprivation of Liberty Safeguards (DoLS) are legal protections (authorisations) that ensure people who are unable to consent to their care and support arrangements either in hospital or in care homes, are safeguarded. In September 2025, 1369, people were waiting for authorisation of DoLS, this included people waiting renewal consideration. This had increased from 1186 people in March 2025. New people over the past 12 months had a median waiting time of 41.5 days which had decreased from 52 days and a maximum waiting time of 776 days which had significantly reduced from 2030 days when compared to March 2025. The local authority had a separate DoLS team, however workforce challenges negatively impacted waiting lists. Senior leaders, staff and partners told us the local authority had a Waiting Well approach to prioritise referrals including DoLS to ensure safeguarding was consistent and person-centred.

Making safeguarding personal

Making safeguarding personal is an approach to keep the wishes and best interests of the adult at risk at the centre of the safeguarding enquiry and any plans to reduce future risks to them. The principle is to support and empower a person to make choices about how they want to live their own life, seeking to improve quality of life, wellbeing and safety. Where possible, staff who knew the adult at risk best would carry out an enquiry in Sheffield. This aimed to reduce the amount of times people needed to share their experiences and promoted an approach to align actions with the care and support needs they had.

People and unpaid carers gave mixed feedback around the local authority's approach to safeguarding. Some people felt well-informed and involved throughout the safeguarding enquiry process, including being asked for their views. In contrast, other people expressed uncertainty about what safeguarding meant, what signs to look out for, and how to raise a concern. They also highlighted the absence of accessible resources, such as easy-read materials, to help them understand the safeguarding process and how their safety could be supported.

The Safeguarding Adults Board (SAB) used a structured data pack to support the principles of Making Safeguarding Personal. This included data from the local authority and wider partners, brought together to better understand people's experiences and perceptions of safeguarding. Partners told us people were asked about their preferred outcomes during safeguarding enquiries, and the local authority had seen a positive trend in improvement in this area. According to the local authority's data 67.1% of people involved in section 42 enquiries were asked to express a desired outcome(s), and 53% of people who expressed their outcomes said they were fully achieved (2023-2024). The SAB also tracked enquiries and concerns by ethnicity and identified potential gaps in referrals from Asian communities who were underrepresented in both safeguarding concerns and in terms of adult social care access to services.

Staff told us learning from feedback was an area to improve on as it currently wasn't formal process but something they have talked about. Staff told us peoples desired outcomes were recorded at the beginning and end of an enquiry but completing the free text box was not mandatory and qualitative data was not picked up in audits or data dashboards. Senior leaders and partners told us they are reviewing the way the local authority gathered feedback and this was a priority in the SAB strategy and annual report to further improve engagement. The safeguarding adults forum was a mechanism for people to have a voice and their opinions on safeguarding were fed back to the SAB to improve services. For example, service information leaflets, a self-referral form and the importance of the first (telephone) contact with service had also been considered.

Staff told us they considered advocacy support for people at the point of agreeing risks that met thresholds for section 42 enquiries. If the adult at risk didn't have a family or friend to support them, and they lacked mental capacity around the concerns then referrals were made for independent advocacy support. Advocacy support prioritised safeguarding referrals depending on the level of risk. 100.00% of people who lacked mental capacity around their safeguarding concerns were supported by an advocate, family or friend in Sheffield. This was significantly better than the England average (83.38% Safeguarding Adults Collection, NHS Digital 2023-2024). This demonstrated staff understood people's rights, including their human rights, their rights under the Mental Capacity Act 2005 and their rights under the Equality Act 2010 and they were supported to make choices that balanced risks with positive choice and control in their lives.

Staff emphasised the importance of placing the person at the centre of safeguarding practice, taking time to understand their views and wishes. They recognised that while some people may decline support, concerns still needed to be addressed through relationship-building and approaches that worked for the person. Staff acknowledged the potential power imbalance and feelings of being overwhelmed that people might experience during safeguarding interventions. For example, a person with mental health needs who had support at home was reluctant to allow staff into their property following concerns about hoarding. Staff adapted their approach through a virtual assessment, using photographs of the home to understand the situation. Over time, through building trust and rapport, the person felt comfortable accepting support. Staff also told us they used flexible approaches such as meeting people in familiar or neutral settings like coffee shops or GP surgeries. Joint visits were carried out with professionals already known to the person, such as those from drug and alcohol services or housing teams, to build trust and reduce the need for people to repeat their story.

Safeguarding practice in Sheffield was evolving towards a more person-centred and outcome-focused model. However, further work was needed to strengthen feedback mechanisms, improve accessibility, and ensure that learning was consistently embedded into practice. Staff emphasised the importance of supporting people to lead their own lives, recognising that while professionals cannot make decisions for people, they can offer tools and support to help people achieve the outcomes that matter to them. This ethos centred on empowerment, choice, and respect was becoming increasingly embedded within safeguarding systems and practice.

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: 2

2 - Evidence shows some shortfalls

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

The local authority's use of I-statement surveys and performance indicators linked to the Living the Life You Want to Live Adult Social Care Strategy reflecting a commitment to person-centred practice. Some strategic partnership boards included representation from people with lived experience, whilst many had indirect engagement through advisory groups or commissioned services. Oversight of some waiting lists remained inconsistent, which affected the level of assurance around outcomes for individuals. Governance and accountability were supported by multiple mechanisms, including assurance meetings, risk logs, and performance clinics. Councillors played an active role in scrutinising and escalating concerns, particularly in areas such as mental health and Deprivation of Liberty Safeguards (DoLS) performance. While scrutiny was embedded, feedback loops were not always effective in demonstrating how outcomes for people and unpaid carers had improved as a result. Governance framework was embedded at all levels, from frontline service meetings to strategic committees. In terms of how effective governance was most staff told us management listened and acted on concerns, such as development around direct payments, demonstrating a culture of responsiveness. Roles were generally well-defined, with clear escalation pathways. The Chief Executive and councillors oversaw the local authority's leadership and management structure. The Strategic Director of Adult Social Services (DASS), and Director of Public Health reported into the Chief Executive. The Principal Social Worker (PSW) was aligned in the senior leadership structure as independent from operational management. This showed the local authority's commitment to the value and credibility of having a PSW to lead, develop and standardise practice. The PSW had been in role for 2 years and was directly managed by the Director of Quality, Strategy & Partnerships. However, in terms of engagement with frontline staff there was more to be done to connect with staff that did not volunteer to be involved in project work. The Principal Occupational Therapist (POT) was also independent from operational management although was directly managed by the PSW and was newly invited to senior leadership meetings therefore it was too early to evidence any impact the POT role was having on strategic influence. The CQC found there could be blockages of communication, and not all frontline staff were clear about how the local authority was working towards reducing risks where there were shortfalls in carrying out Care Act duties. Strengthening role clarity and engagement across all levels was needed to further enhance accountability and practice development. Overall senior leaders provided assurances around areas for improvement and impact of risks, plans were in place but could be delayed and needed consolidating to ensure they could be meaningfully monitored.

Regular performance reporting, risk registers, and dashboards supported senior leaders to identify issues. The adult social care risk register was reviewed quarterly with 25 high residual risks being monitored. The use of risk priority RAG (Red, Amber, Green) ratings and action plans including in partnership meetings supported joined-up risk identification. Some partners told us they perceived challenges in achieving consistent alignment on managing shared risks, expressing concern that the local authority's focus was more on financial and workforce risks than on risks of harm to individuals. Senior leaders told us the risk register included safety and partnership risks and that joint governance arrangements were in place through the Sheffield Place Quality Committee. Despite these mechanisms, some partners told us that differences in emphasis made it harder to develop joint strategies for reducing system-wide risk. Partners were still working towards a shared understanding of the data and its impact on people.

The Director of Adult Social Care (DASS) and Chief Executive roles had strengthened the voice of adult social care within corporate decision-making. The current DASS, an experienced senior leader, had joined Sheffield City Council in an interim capacity and had been in post for 16 weeks at the time of the CQC site visit. Senior leaders were promoting a culture of learning and development through initiatives such as direct engagement with frontline practice and a coaching approach across the leadership team. This approach was positively received and contributed to a more reflective and inclusive leadership culture.

Strategic planning

Strategic planning was increasingly shaped by people's experiences, with I-statement surveys and complaints data feeding into governance boards. However, gaps such as supported accommodation suggested that strategic planning could better address inequalities and unmet needs. Senior leaders told us data existed on out-of-area placements for people with mental health needs. However, there was more to do to ensure staff, people and partners had clarity on how data shaped future planning and help understand decisions being made. Partners representing people, including the voluntary and charity sector told us they worked in partnership with the local authority to ensure strategies were designed around peoples voices and needs.

The local authority demonstrated a developing strategic planning framework that was integrating performance, risk, and equality data to inform decision-making and improve outcomes for people. The adult social care data dashboard was structured to align outcomes of the vision and strategy, as well as the priorities of the strategic delivery plan. It was reported on monthly with governance oversight at service and directorate leadership team meetings and contained key performance indicators and targets for the service. The Adult Social Care Strategy Living The Life You Want To Live contained a series of co-produced I-Statements which sat under each of the commitments within the strategy. To test progress in meeting these commitments, the local authority carried out a survey each year with a random sample of people receiving services. The 4th survey was currently underway seeing improvement over the 3 years so far from the baseline year.

The local authority used data analysis to inform planning and decision-making. The Director of Adult Social Care (DASS) emphasised a culture of honest appraisal, where performance was critically reviewed rather than assumed to be positive. National performance data had shown year-on-year improvement, and monthly performance clinics reviewed 26 indicators to drive continuous improvement. Managers reported that they received the data needed to understand what was happening within their services. Performance dashboards had been developed collaboratively, enabling teams to better respond to the needs of Sheffield’s diverse communities. The adult social care committee’s 2025-2026 work programme was structured and transparent, showing clear ownership of strategic items. Political leads influenced agenda setting based on emerging priorities such as unpaid carers and autism, ensuring strategy remained responsive to people’s needs. For example, councillors were being briefed weekly with performance information and reports, including areas such as support for carers, which enabled them to scrutinise and influence priorities. There was a political understanding of adult social care, which encouraged open questions, and provided detailed complaints and ombudsman reports annually, ensuring risks and themes were addressed transparently. This strengthened accountability and ensured oversight of key risks.

Staff and partners told us there were challenges related to insufficient workforce capacity and the journey between services was sometimes fragmented, affecting continuity of care. These issues highlighted strategic gaps in risk management and workforce planning, which affected the local authority’s ability to deliver timely care and support. Senior leaders held workforce data and, despite some gaps, were confident that teams had the necessary skills mix. Recruitment to new and vacant posts was complicated by targeted recruitment controls within the local authority. The Director of Adult Social Care (DASS) acknowledged concerns raised by staff and partners and noted that exceptions could be made through a corporate process designed to balance system pressures. There was a commitment to working collaboratively with staff and unions to explore longer-term workforce solutions.

Strategic planning was supported by the Adult Social Care Equality, Diversity, Inclusion and Social Justice Delivery Plan, which included routine Equality Impact Assessments (EIAs) to help build a safe and inclusive care sector. Staff development initiatives, such as the Moving Up programme for ethnic minority staff, reflected a targeted investment in workforce equity and progression.

Information security

The local authority had systems and structures to support the availability, integrity, and confidentiality of data. The Principal Social Worker was also the Caldicott Guardian. A senior role for an organisation which processes health and social care personal data. They made sure that the personal information about those who use the organisation's services is used legally, ethically and appropriately, and that confidentiality is maintained. Caldicott Guardians provide leadership and informed guidance on complex matters to ensure that data systems and records reflected the realities of people and unpaid carers and uphold their rights to confidentiality and dignity.

The adult social care risk register and the corporate risk management framework provided clear governance for data-related risks. For example, there were identified issues with the digital recording system, which affected ability to provide corporate assurance. This was identified as a risk to data availability and continuity of care. Risks were reviewed quarterly and escalated through senior leadership and corporate assurance boards. This ensured visibility and accountability for data integrity and system reliability. Assurance meetings and data clinics supported the integrity of data and ensured that decisions were informed by accurate information. Staff told us they were involved in testing tools such as an Artificial-Intelligence (AI) powered tool that automated the creation of case notes from recorded conversations, with feedback incorporated before wider rollout. This demonstrated a commitment to ensuring that digital systems were fit for purpose and responsive to staff and people's needs. A senior leader told us the local authority was transparent in the public domain in relation to information security and another senior leader told us decisions were made in public with scrutiny, supporting openness in data use and governance.

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

Over the past two years, the local authority had made notable progress in strengthening adult social care through a strategic focus on workforce development, safeguarding, and co-production. Senior leaders described a shift from reactive to proactive improvement, supported by clearer governance, stronger partnerships, and a growing culture of learning. Staff and partners consistently told us that the local authority had become more outward facing, using regional and national networks to benchmark practice and share learning.

Senior leaders worked across national and regional networks to share good practice. For example, when developing a safeguarding hub launched in April 2023, they used learning from police and adult social care frameworks to improve audits. In another example, data and performance leads told us they had strong links with national networks, such as a Standards and Performance Network which supported benchmarking and continuous improvement. The local authority also engaged with universities, charities, and regional networks to benchmark practice and share learning. This strengthened safeguarding standards and created a culture of continuous improvement that supported safer experiences for people.

The local authority participated in peer reviews, research projects, and collaborative development of tools. For example, staff embedded a Sexual Rights Charter with care providers in 2022, co-produced with voluntary and academic partners. Staff initially found sexuality-related issues multifaceted and uncomfortable to address but gained confidence through workshops and resources. Staff told us people living in care homes had care plans that respected identity and sexuality needs, improving dignity and personal choice.

Co-production within adult social care was developing in Sheffield. People with care and support needs and partners shared mixed experiences of their involvement in shaping services and future strategy. People and unpaid carers participated in forums and boards focused on safeguarding, direct payments and personalisation, accommodation, learning disability, and sensory impairment. While some people felt empowered and that their contributions were valued, other people expressed frustration at the lack of a consistent approach to involving people throughout the design, delivery, and evaluation of adult social care. Some described the process as repetitive and lacking progress. There was a recognised need to ensure co-production was meaningful, going beyond simply gathering feedback. Senior leaders told us how the co-production policy set out principles for involving people in design, delivery and evaluation of services, ensuring decisions reflected lived experience and promoted person-centred outcomes. There was an ethos in the local authority to understand peoples experiences but more to do to consistently evidence people’s contributions leading to visible change.

The local authority demonstrated a strong commitment to continuous learning and professional development, fostering a culture that supported staff wellbeing to support an inclusive, capable and responsive workforce. For example, the practice development team had rolled out mandatory anti racism training and for managers and senior leaders training on having difficult conversations about race and culture with staff. A senior leader told us how training had been used in practice to hold sessions around psychological and physical safety when there had been public rioting the previous year which had negatively impacted staff within ethnic minorities. Senior leaders and managers held drop-in sessions and supported staff through regular huddles. As part of this approach, formal team meeting agendas were simplified to create space for open conversations, allowing staff to share how they were feeling and reflect on the impact of events on their wellbeing. Staff had felt supported with the ability to have open conversation and agree actions such as to work in pairs if they would prefer. This was an approach the local authority took forward and continued, for example where there was planned public protests. Senior leaders prioritised supporting staff around issues of discrimination and oppression when working with people with care and support needs and unpaid carers, and the direct positive impact on people around the quality and equity of service delivery they provide.

Staff told us their wellbeing was prioritised. For example, staff described the emotional impact of supporting people through traumatic situations and at risk. They credited their managers with helping them stay grounded and spoke positively about wellbeing activities such as themed team days, informal social events, and opportunities to spend time outside the office to decompress and maintain morale. Staff reflected that feeling supported helped them provide better care and support to others. Wellbeing initiatives such as award events, apprenticeships, and reflective practice models were highly valued. Programmes like Moving Up and progression opportunities contributed to staff confidence and supported workforce retention. The Principal Social Worker (PSW), Principal Occupational Therapist (POT), and practice development staff led improvements in embedding reflective models, enabling staff-led initiatives, and promoting strength-based support planning. Staff told us they felt included in service development, were well supported by managers, and had access to opportunities for learning and professional growth. Senior leaders told us there had been a positive shift in workplace culture, with development projects helping to build stronger relationships and boost morale. This contributed to a more energised workforce and improved the quality of support provided to people with care and support needs.

Staff had access to extensive training and development. Staff told us they had regular monthly supervision. They discussed long term and short plans, what support they needed and career progression. Staff felt supported and had shadowing opportunities to gain further experience, they were encouraged to become champions in areas of interest and had access to a wide range of training opportunities. For example, compulsory training was co-delivered by people with lived experience, dementia training was offered at multiple levels, and staff developed sessions based on research plus peoples and their own experiences of LGBTQIA+ and cultural awareness. There were apprenticeships for those that wanted to become registered staff and supported first year in employment for newly qualified staff. A newly qualified social worker told us they had an interest in hoarding and as a result are now attending specialist training in this area. Another staff member had completed a foundation degree and team leader course, both funded by the local authority. Protected time for learning was provided, and staff were proud of the opportunities available. There were social work consultant roles working alongside managers who supported forums including service manager question and answer sessions, management supervision, individual and team-based reflective supervision. Where there were training gaps, staff told us how they were encouraged to develop sessions and share learning, with many examples rolling out from team based learning to structured sessions delivered across the adult social care department. Staff felt confident and skilled, which improved person-centred care for people.

Innovation was evident in the adoption of an Artificial Intelligence (AI) powered tool that automated the creation of notes in peoples records from recorded conversations. Staff shared that, once fully implemented, the tool would enhance person-centred assessments by allowing them to focus more on active listening and meaningful engagement. They described the approach as helping assessments feel more personal and less transactional, enabling better eye contact and natural conversation. The use of transcripts also reduced the risk of missing important details, helping to ensure that people's voices, preferences, and experiences were accurately captured and reflected in their support plans. Staff felt that the use of technology had the potential to support more person-centred practice by freeing staff to focus on building rapport and understanding of the individual, improve the quality of documentation and also save time. Technology-enabled care supported independence. For example, people with learning disabilities were accessing travel training through a web-based mapping app that provided step-by-step route guidance. The training combined journey planning, route practice with a trainer, and learning to use smartphone apps for navigation and public transport, helping to build confidence and independence.

Hackathons solved operational challenges. Hackathons are events where people, often technology experts, collaborate to solve a problem and build or improve instructions, data, or programs that tell a computer or electronic device what to do and how to perform specific tasks within a limited time, typically a few days. For example, at a recent hackathon, data analysts were invited to solve a problem around Deprivation of Liberty Safeguards (DoLS) waiting lists. Data and processes were provided and within hours, the team had developed a smarter system that automated parts of the process and analysed legislative requirements such as not needing section 12 sign-off within 12 months. A senior leader described this as a successful example of innovation.

Data literacy was prioritised through analytics training and a national data academy. For example, staff built dashboards to analyse service data and identify risks. A structured audit programme under a practice quality framework highlighted strengths in person-centred practice and areas for improvement like consent documentation. A senior leader told us in terms of quality assurance of staff practice in the local authority two years prior they started at a place where audits didn’t happen. They had spent time listening to managers, tweaked and amended, and now implemented audits. For example, Occupational Therapy introduced digital forms for proportionate assessments, reducing delays. Better data and audits had improved decision-making to support improvement of timely responses to enhance safety and quality for people. Learning themes were shared with leaders and staff, supported by resources and forums, and addressed through a comprehensive action plan including training, and guidance updates.

There were identified plans for further improvements. There was a corporate improvement board effective at that level and plans to consolidate the number of improvement plans and ambitions across the adult social care department. This would improve strategic alignment for clearer prioritisation, reduce duplication and enhance workforce and resource efficiencies and ensure there was central oversight to improve monitoring, reporting and accountability. There was dedicated workforce resource to support quality improvements. The local authority merged budgets and commissioned consultancy support to consolidate improvement plans and accelerate transformation. For example, consultancy work provided clear data on prevention and identified opportunities to scale up. This improved efficiency and accountability, ensuring resources were focused on priorities that mattered to people.

Learning from feedback

People gave mixed feedback about how the local authority received their feedback and acted on this. There was a strong desire among people with lived experience to contribute to service improvement. Some people and partners representing people had seen positive changes. For example, a partner told us about a project focused on improving experiences of people from African and Caribbean heritage and other ethnically diverse communities in care homes through the local authority. This project looked at experiences, which led to the creation of an action plan jointly developed by the local authority and partners to improve culturally inclusive services. It was also mentioned that a person with Black ethnicity was recruited as a manager funded by local authority as a result of this work. Senior leaders told us community engagement initiatives strengthened co-production and advocacy for seldom-heard groups, ensuring their experiences informed service improvement. In contrast, some people told us their suggestions were not fully acknowledged or implemented. This suggested a need for stronger feedback loops and clearer communication about how input is used. The local authority had used peoples feedback to develop training offers. For example, they had needed to evidence they learnt from ombudsman complaints. They learnt there was a need to develop mental capacity training which was said to now be in-depth and delivered by a specialist training provider.

Structured feedback mechanisms were in place, including staff surveys. The Principal Social Worker (PSW) led the development of a new supervision template following low staff assurance scores in previous surveys. As a result, the latest survey showed improved scores, suggesting there was learning from feedback to drive improvements. Most staff told us they felt heard and supported. Senior leaders recognised staff were in different places around changes and direction in adult social care. The Director of Adult Social Services (DASS) told us in terms of communication there had been spotlight briefings to meet the DASS in the short time they had been in post. The DASS personally thanked all staff, acknowledging the work they do takes resilience, particularly when they were seeing people coming back into services, with needs and risks around dual diagnosis, addictions, and experiences of poverty.

Complaints were reviewed quarterly by senior leaders, with learning used to inform development. There was recognition there was more to do to involve people with lived experience in developments and learning to deepen understanding and improve outcomes. There were examples of using feedback to improve communication. For example, co-production with a user led organisation, run and controlled by disabled people led to a revised care charging letter, resulting in fewer complaints. Staff had also developed and delivered training in response to identified gaps, such as support planning showing active response to feedback.