Herefordshire Council: local authority assessment

How we assess local authorities

Assessment published: 29 May 2026

About Herefordshire Council

Demographics

Herefordshire is a unitary authority in the West Midlands, bordered by Shropshire to the north, Worcestershire to the east, Gloucestershire to the south-east and the Welsh counties of Monmouthshire and Powys to the west. The city of Hereford is the county town, surrounded by the five market towns of Leominster, Ross-on-Wye, Ledbury, Bromyard and Kington.

Herefordshire is home to approximately 191,000 people across 840 square miles. Rurality poses a challenge for providing services, with 43% of the local population living in the more rural villages and dispersed areas. Herefordshire is the fourth most sparsely populated local authority in England.

The majority of the population of Herefordshire are White British (96.91%), with 1.2% Asian or Asian British, 1.1% from a Mixed or Multiple background, 0.3% Black, Black British, Caribbean or African, and 0.5% from Other ethnic groups. There is a higher proportion of the population in the county who are aged 65 or older (26.97%) than the England average (18.73%).

Herefordshire has an Index of Multiple Deprivation score of 5 (with 10 being the highest and most deprived) and is rated 88 out of 153 (1 being most deprived). There are 12 neighbourhoods in the 25% most deprived areas in the country, with approximately 6,100 older people living in income deprivation, which represents 11% of all people aged 60 or over.

Life expectancy for men and women was better than England average, but the gap was narrowing (83.6 years for women and 79.8 for men, compared with 83.1 and 79.1 nationally). Men in Herefordshire spent 83% of their lives in good health compared to 80% across England; for women the local figure was 81% compared to 77% nationally. People born in the most deprived areas in Herefordshire had a shorter life expectancy by an average of 5.2 years for men and 3.2 years for women.

Herefordshire is located in the Herefordshire and Worcestershire Integrated Care System (ICS). Hereford County Hospital is the only hospital in the county delivering acute and community services.

Herefordshire Council is comprised of 53 councillors representing the 53 wards in the area. Herefordshire is a Conservative run council with a minority administration.

Financial facts

The Financial facts for **Herefordshire** are:

- The local authority estimated that in 2024/25, its total budget would be **£343,697,000.00**. Its actual spend for that year was **£363,335,000.00**, which was **£19,638,000.00 more** than estimated.

- The local authority estimated that it would spend **£85,923,000.00** of its total budget on adult social care in 2024/25 Its actual spend was **£94,342,000.00**, which is **£8,419,000.00 more** than estimated.
- In 2024/25, **25.97**% of the budget was spent on adult social care.
- The local authority has raised the full adult social care precept for 2024/25, with a value of **2%.** Please note that the amount raised through ASC precept varies from local authority to local authority.
- Approximately **3005** people were accessing long-term adult social care support, and approximately **515** 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.

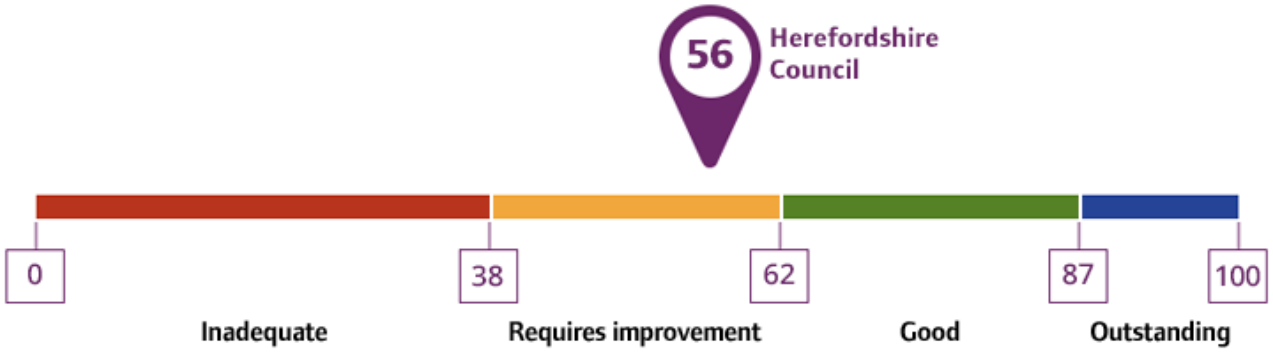
This data is reproduced at the request of the Department of Health and Social Care. It has not been factored into our assessment and is presented for information purposes only.

Overall summary

Local authority rating and score

Herefordshire Council

Requires improvement



Quality statement scores

Assessing needs
Score: 2

Supporting people to lead healthier lives
Score: 2

Equity in experience and outcomes
Score: 2

Care provision, integration and continuity
Score: 2

Partnerships and communities
Score: 3

Safe pathways, systems and transitions
Score: 2

Safeguarding
Score: 3

Governance, management and sustainability
Score: 2

Learning, improvement and innovation
Score: 2

Summary of people's experiences

People could get in touch with the local authority in a number of ways. The local authority had invested in Talk Community Hubs in community venues which provided opportunities for people to connect with support in ways that worked for them. Local authority processes supported people to navigate services that could meet their needs outside of those eligible under the Care Act such as veteran's support and community connection through Talk Community.

People were waiting for Care Act assessments, reviews, and financial assessments. People at highest risk were supported quickly, and there were robust 'waiting well' processes in place. These ensured people were contacted regularly and were often supported by technology enabled care or community services while they waited.

While few unpaid carers waited for assessments, unpaid carers' needs were not always seen as distinct from the needs of the cared for person. Some unpaid carers said they were not offered assessments, that their support plans didn't always meet their needs and there was limited support available for them. There was some feedback unpaid carers were signposted to support by the local authority rather than proactively connected or referred to the available support in the community, which increased the risk unpaid carers were lost between services. Some unpaid carers were struggling and told us they could no longer take part in things they used to enjoy or take a break. Access to short breaks and respite was challenging for unpaid carers. While people could access short breaks in an emergency, longer-term planning was limited.

Sometimes there were delays in hospital discharge which affected people's experiences and outcomes. One family, for example, told us the process was patchy and prolonged, and while they eventually got a good outcome, it took longer than needed. At the time of our assessment, most people accessed the formal reablement offer through hospital discharge and fewer people in the community received reablement care. Delays in discharge processes affected people's reablement goals. For some people, not achieving these reablement goals risked more or longer-term care.

People could wait a long time for occupational therapy services. There was increasing demand and staff could not be sure how long someone might wait for support.

People described seeing clear partnerships working in the support they had received. There were a number of partnership boards in place that supported people's voice in service design, and this was growing at the time of our assessment.

Summary of strengths, areas for development and next steps

Staff were passionate about supporting people in Herefordshire. They understood the area and the specific needs of the people and communities in Herefordshire. This supported strengths-based working. Most of the people and partners we spoke with had good experiences of assessments, care planning and reviews. However, sometimes people and partners said processes felt rushed, and there was a lack of communication from the local authority.

There was increasing demand and complexity of contacts received by the local authority. There was emerging work to develop a more therapy led front door in line with the developments in technology enabled care and the Talk Community approach in the county. There were efficiencies in triage and paperwork and systems that were needed. Some teams told us prioritisation of work was not always clear, which affected allocation.

There was a clear ambition within the local authority and through connections with partners to invest and grow an early prevention approach for everyone, with Talk Community a golden thread throughout this work. The linkages between adult social services, community services, including public health, and housing were clear. This linked into wider networks such as Community Action Networks to engage with communities at a grass roots level.

People waited for assessments. The number of people waiting appeared to be stabilising at the time of our assessment, though several waiting times were increasing. Work to understand demand was in progress. People also waited for reviews. The local authority identified some additional capacity to support overdue reviews. There were concerns about the waits for occupational therapy assessments, however waiting well processes were in place where risk was reviewed on a regular basis.

Staff we spoke with were considerate and aware of the needs of unpaid carers. However, several unpaid carers shared difficult experiences, where their needs were not always well considered as separate to the needs of the person they cared for. There was consistent feedback from the people we spoke with, partners and some staff, that there were limited respite opportunities and unpaid carers struggled to be able to take breaks from their caring role. Unpaid carers described a lack of contact from the local authority, long waits and unclear processes. Some carers told us they experienced significant strain and they were struggling with a lack of support. There were some pilots and developments ongoing to build further opportunities and a new co-produced Carers Strategy which aimed to improve the experiences of unpaid carers.

Staff had a good understanding of advocacy and mental capacity but use of advocacy was low and often at a later stage. This minimised its impact in supporting people at the earliest opportunity to fully engage with adult social care processes and decision making.

There were shortfalls in reablement provision and reablement services were not sufficiently effective to support people to return to their optimal independence. Staff told us there were few examples of where reablement outcomes were achieved. There were process delays and staff capacity issues which meant there were challenges getting the right support or completing work with people. There had been delays at discharge from hospital and in accessing therapy services which affected people's reablement potential. This meant reablement teams were not able to support as many people as they could. The majority of people accessing reablement care in the area did so from hospital discharge, meaning fewer people received reablement care from community sources. We heard some people who would have benefitted from reablement support did not receive it due to a focus on hospital discharge.

Some people could wait a long time for an assessment for equipment and adaptations. There was some work to progress training more trusted assessors and improve processes such as the administrative burden on occupational therapy staff. The technology enabled care offer was growing, and staff clearly described supportive packages that enabled people to stay at home and retain independence in flexible and creative ways. The availability of a 'virtual house' and a facility where people could test equipment were positive opportunities for people to understand the offer.

There had been a significant challenge related to the change in equipment provider. The local authority responded quickly and efficiently to get a service running and effectively reduced the impact on people's experiences and outcomes. There were ongoing concerns that were being resolved at the time of our assessment in relation to equipment stock tracking. There were reported equipment stock gaps and it was not always clear where orders were within processes, making it difficult to be sure who was waiting and for how long. The local authority told us stock gaps had been identified and quickly addressed as part of the transition to the new equipment provider and additional stock was purchased to reduce these issues.

Strategies showed an understanding of improving the experiences of people with protected characteristics. Staff reported no issues accessing interpreters and employed appropriate strategies to support people to access culturally competent care and meet communication needs. Staff, leaders, people and partners all reflected there was more to do to reach and engage with seldom-heard communities. Efforts were made to reach out to communities such as Ukrainian, Polish, and Gypsy, Roma, and Traveller populations through Talk Community. Some people had difficulty using the local authority's website to access information and guidance, though some work was progressing to improve this.

There were sufficient systems in place to understand local need and develop commissioning strategies to meet need. There were gaps, for example, in supporting younger adults with learning disabilities and autism. There was a review of day services and exploring alternatives to out-of-county placements. This showed responsiveness to unmet needs and a commitment to localised, person-centred care. Gaps had been well understood and there was activity to either resolve or plan to meet those gaps at the time of our assessment. The local authority's market position statement was being updated and the previous version reflected a data driven position, which clearly outlined the intentions for the market.

Quality assurance teams had a robust, evidence-based approach to assessing the quality of provision in the market in Herefordshire. The quality assurance framework included monthly reporting, off-site reviews, on-site inspection of services, improvement action planning, and escalation protocols. This was proactive with commissioned providers and an all-age quality assurance strategy was in development.

Some providers reflected that leadership and engagement with them had become more visible and supported them to share challenges that were affecting their sustainability. Providers and staff reflected the impact of recent change programmes and transformation within commissioning services to longer-term strategic relationships. Some support such as with recruitment was in place through programmes such as Herefordshire Cares and digital campaigns through social media, aimed at attracting new entrants into the local care workforce and raising awareness of opportunities in the sector. Some providers told us there was more support needed for them to navigate sustainability challenges in the market, including cost of living and wage pressures.

Operational relationships between teams and across services were working well. The One Herefordshire Partnership provided a strategic forum bringing colleagues together to tackle partnership priorities. There were arrangements to use Better Care Funding in creative ways, such as to support adaptations through the Disabled Facilities Grant.

There were clear ambitions and activity ongoing at a grass roots level and very locally with the community sector as part of Talk Community and Community Hubs activity. This showed the importance assigned to working with the voluntary and community sector. Staff and partners highlighted that local authority tendering processes could be complex, especially for smaller community organisations. Overall strategic direction for the voluntary and community sector was an identified area for development that leaders shared with us.

Staff supporting hospital discharge advocated for people and undertook assessments of care needs. Staff shared several examples where people's needs had deteriorated within the period following hospital discharge that resulted in readmittance to hospital. There had been targeted work to reduce delays to hospital discharge, with delayed discharge at its lowest level in recent years.

Good relationships with the police, health, and the voluntary and community sector amongst others were supporting people who were at risk of or homeless. Further connectivity with drug and alcohol and domestic abuse strategies and activities was also described and partners reflected this could be a growing area of local authority involvement to support safe systems. Positive partnership working engaged young people and their families and supported them before, during and after they moved from child to adult services.

National data indicated that people in Herefordshire felt safe. Safeguarding processes were clear and concerns were triaged quickly. The majority of section 42 enquiries were allocated in a timely way. There were capacity challenges within the safeguarding team and some aspects of the role, such as communicating outcomes or capacity to be more proactive, were limited by the number of staff responsible for triaging work. Recording systems had improved, and there was development work ongoing.

Partners described good working relationships, including with the Safeguarding Adults Board. Arrangements such as the Joint Case Review Group offered opportunities for learning even without formal Safeguarding Adult Reviews. There was identified work to support people who did not meet section 42 thresholds but had complex needs that was beginning at the time of our assessment and considerations around transitional safeguarding approaches which would improve prevention in safeguarding.

Some staff were feeling the effects of smaller teams, long-term sickness absences, and loss of expertise through retirements. Most staff we spoke to felt managers and senior leaders were visible and responsive. For some, there were longer-term and historic issues which suggested their concerns and input had not always been valued or considered within strategic planning and decision making. A staff voice group had been developed, championing better working practices and developing the support offer for staff was in place, alongside a local authority-wide action plan following a recent staff survey, aimed at supporting ongoing improvement.

There was a mixed picture in the use of data to help the service fully understand challenges, bottlenecks and opportunities. Data dashboards were clear, regularly reported and reviewed by appropriate leaders and teams. Staff and leaders understood where improvements to data, recording and reporting were needed and actions were progressing to make these improvements, for example in the occupational therapy, equipment and adaptations waiting list.

Governance mechanisms were clear, and councillors had sufficient opportunity to challenge and support adult social care activity, including through appropriate data, risk assessment and reports. There was a recognition of the importance of cross-party solutions and discussion in light of the political arrangement in the local authority at the time of our assessment. The local authority had a communication strategy in place to support communication across the organisation, which some staff and leaders identified needed to improve. There were a range of mechanisms to keep relevant members updated on key decisions and developments.

At the time of our assessment, the local authority was waiting for a new Principal Social Worker to start. While there were cover arrangements, there were identified areas where this role would support ongoing development and focus, such as ensuring strengths-based practice. Audits and supervision were used as key tools for quality assurance. Reviews were signed off by senior staff, and any practice concerns were said to be addressed through supervision or training. There was engagement with national and local networks to support local development and learning. Learning logs were in place to highlight opportunities and actions related to service wide learning and improvement.

There was a growing environment of coproduction through existing partnership boards, though there was further to go in terms of ensuring this was embedded within the local authority's structures and truly delivering co-production. Some people told us there were ways co-production could improve, including expanding opportunities to hear more voices representing the community. Partners and people told us more was needed on progress and action to capitalise on momentum and people's engagement in order to avoid 'engagement fatigue'.

Most staff said general training and employee feedback mechanisms were strong, though others noted that induction and specialist training were variable and sometimes compromised by staffing shortages. The local authority's corporate induction programme indicated an investment in staff and their role in the organisation and county. Mandatory safeguarding and management training had been introduced and there were offers to engage with specialist courses such as contract management and health and wellbeing diplomas. The 'grow your own' approach within the local authority was well reported and consistently praised. Many staff told us that despite challenges, teams fostered an environment that encouraged learning, peer support and reassurance.

Theme 1: How Herefordshire 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

People could access the local authority's care and support services through multiple channels, including email and via the phone. Talk Community Hubs provided 75 community venues such as libraries across the county where people could go to get information about adult social care. Community connectors supported people to access services that supported their needs. There was, however, no option in place for the online self-assessment of care needs, though the local authority told us people could complete and submit a strength-based assessment form which was shared with an allocated worker. Online self-assessment options were currently being explored by the local authority.

The Advice and Referral Team (ART) was the point of access for all contacts made to the local authority regarding adult social care. ART were able to pass these to the appropriate teams to progress to an assessment where required. Officers in the ART had strengths-based conversations to understand the individual's goals, support needs and risks. People were directed to services in the community through the Talk Community directory, which provided information, advice and guidance. The local authority's recording system included an algorithm which suggested appropriate services that may meet people's needs, though staff retained autonomy to override suggestions. There were processes in place to quality assure decision making by staff within the ART. The local authority was introducing a formal audit process to create a systematic review of decision-making and outcomes, identify patterns and support targeted improvement as needed.

While processes were in place to quality assure decision making in ART, we received mixed feedback that decision making within the referral process was not always efficient and some staff highlighted referrals often came through to the wrong teams or prioritisation wasn't clear. Occupational therapy services, for example, had a senior practitioner in the ART 2 days a week to check the appropriateness of referrals to the service. There was then further re-triage of referrals once they were received in occupational therapy, with some referrals found not to relate to the service. While local authority processes were clear, operationally some staff said there were delays and duplication, which increased the administrative burden on staff and reduced their capacity to support people directly. However, the local authority told us there were occasional errors sending referrals to the correct team or with prioritisation. Staff said this meant some people experienced delays in receiving information, advice and guidance or an appropriate service at the right time. There were mechanisms for some teams ensuring these were identified and resolved on the same day.

The local authority was exploring further developments of the ART to ensure it was more therapy led. A robust service improvement plan identified several actions to support development, including enhancements to the referral process based on a new staff competency framework and further opportunities for staff training in ART, including to become trusted assessors. Action was progressing at the time of our assessment, expecting to be completed by March 2026.

In general, people experienced person-centred and strength-based assessment and care planning that was considerate of their needs. In a recent local authority survey between October 2024 and April 2025, 87% of respondents said they felt listened to, with 94% saying they thought staff were caring and compassionate. As part of our assessment, we saw several examples of thorough assessments and care plans that included people's experiences, wishes and desired outcomes. In one example, documentation highlighted the social worker had worked with the person and their family to identify how the person's skills and strengths could be maintained in their placement as part of discharge planning. Some providers told us overall people's independence was promoted and there was a clear intention to deliver person-centred care. National data indicated 70.23% of people were satisfied with care and support, which was somewhat better than the England average of 65.16% (Adult Social Care Survey – ASCS, November 2025).

People's experiences of care and support ensured their human rights were respected and protected. In the recent local authority survey, 93% of people said, alongside the compassion of staff, that their equality and diversity needs were considered. In one example, the assessment process was completed over different sessions to the person's needs, changing environment and capacity to contribute to the full assessment in one go. Staff shared examples of how people were involved throughout the assessment, care planning and review in decisions. People's protected characteristics under the Equality Act 2010 were understood and incorporated into care planning.

The local authority was without a Principal Social Worker (PSW) at the time of our assessment. The new PSW was due to start in September 2025. There had been interim arrangements in place in recent months, with a focus on quality, and the local authority told us senior practitioners, team managers, and heads of service had combined responsibility for continuous improvement. However, some staff and leaders told us they felt the lack of PSW. This included the need for a focus on ensuring the ongoing improvement in delivery of strengths-based assessments, care plans and reviews.

People shared concerns about the local authority's communication, staff capacity and consistency which affected their experiences. Some people told us they had to chase the local authority for responses and inconsistent staffing had led to emotional fatigue in repeating their story. Some partners, for example, told us they didn't always receive relevant information to support people, such as in emergency situations, knowing who to contact at the local authority, or when a review would happen. This created some instances where coordination with different agencies, services, people and their families was not as clear as it could be. Partners told us while people's reviews were strength-based, they often had to chase the local authority due to delays. The allocation to different staff members limited the long-term continuity and relationships those staff could build with people, their families and care providers. One partner told us when reviews were allocated to different staff, there were differences in expertise and there had been a lack of specialist knowledge for people with a learning disability, for example. They said the lack of continuity hindered effective care planning. The local authority had identified actions to resolve these concerns, including options for people to receive emailed paperwork directly, rather than by hard copy in the post and improving performance monitoring on the time taken to provide feedback or updates.

The local authority had assessment teams who were competent to carry out assessments, including specialist assessments. Staff received appropriate training to conduct assessments, with relevant expertise provided to support development. Staff described peer support, management support and a collaborative approach which enabled them to deliver quality services to people in Herefordshire. Directorate days supported the teams to understand each other's roles, which in turn supported people's experiences of connected services.

Timeliness of assessments, care planning and reviews

There were waits for assessments and reviews across the local authority that affected people's experiences and outcomes. There were shortfalls in the timeliness of reviews and occupational therapy assessments.

Local authority data in August 2025 indicated 161 people were waiting for allocation for an assessment with a social work team. This was a similar figure to the 167 people awaiting allocation for an assessment in April 2025 indicating a fairly stable waiting list. The local authority set a target of 42 days for assessments to start. The median wait time in August 2025 was 62 days over the previous 12 months, with a maximum waiting time of 192 days. The median wait time in April 2025 was 14 days over the previous 12 months, with a maximum waiting time of 98 days. Some teams, such as the county team supporting people with complex needs, had shorter waiting lists. While the number of people awaiting allocation to start the assessment process remained fairly stable, the length of time people waited was increasing.

A 'waiting well' process was in place in which people were regularly contacted to understand if their circumstances had changed. People were signposted to the Talk Community Directory and community organisations to provide support while they waited. Technology Enabled Care (TEC) solutions could also be progressed while people waited for an assessment. In some cases, these solutions supported care planning at a later stage, providing evidence of how well someone was able to manage at home or when a care package may be more effective. Financial assessments could be progressed while people waited if it was evident they would need support in order to reduce waits further down the line. The local authority told us they were experiencing higher demand for support from both community and hospital routes combined with staff vacancies, which contributed to waiting lists. Senior leaders monitored the number of people awaiting allocation monthly. There was exploratory work ongoing to understand and address increasing demand on services.

Care Act assessments could also be completed by occupational therapists (OTs), which often focused on when people's identified needs could be supported by equipment or adaptations to their homes. In August 2025, 474 people were waiting for an assessment for equipment or adaptations, some of whom had eligible needs under the Care Act. There was a median wait time of 53 days for an assessment to be allocated, and a maximum wait time of 458 days. The local authority told us the target timescale for the allocation of urgent referrals was 5 days, but the median for these was 32 days. In September 2025, the local authority provided updated data. This indicated 316 people were waiting for a service under the independent living service, which included front door, TEC and long-term OT teams. Of these, 13 people were waiting at the front door in prevention services with OTs and 264 people were waiting for the allocation of a long-term OT for a full functional assessment. Staff told us they often couldn't tell people how long they would be waiting between contact and assessment but said some people waited over a year. Waiting well processes were in place but these were difficult conversations in which limited updates could be given. People did receive support while they waited and could be signposted to alternative support if needed. There was ongoing work to improve the recording system to help provide further service level data, including details about what individuals were waiting for and indicate whether people were already receiving support while they waited.

People also waited for reviews. Local authority data showed the number of people on the waiting list for care reviews in August 2025 was 567 people. This was an increase compared to the 538 people awaiting review in April 2025. National data indicated 38.41% of long-term support clients had received a review (either planned or unplanned), which was somewhat worse than the England average of 59.13% (Adult Social Care Activity Report, October 2025). Waiting times did seem to be reducing, with the median waiting time in August 2025 of 217 days, compared to 252 days in April 2025, and a maximum waiting time in August 2025 of 947 days.

The local authority had focused on reviewing people who had waited the longest for a review over the three months prior to our assessment by allocating a dedicated staff member and advertising for further support. There were weekly progress reports to provide oversight of overdue reviews. Some teams who had capacity also picked up reviews to reduce delays.

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

The needs of unpaid carers were not always recognised as distinct from the person with care needs. While people did not often wait a long time for a carer's assessment, many people told us they struggled to access support from the local authority, were not offered carers assessments and experienced significant strain as a result of their caring role.

Some unpaid carers had good experiences. National data indicated 46.15% of carers were satisfied with the care they received from social services, which was somewhat better than the England average of 36.83% (Survey of Adult Carers in England – SACE, June 2024). Some staff shared examples of adapting language, completing in-depth assessments, and providing opportunities for breaks within their assessment and support planning for unpaid carers.

Local authority data in August 2025 showed that the number of people awaiting a carers' assessment was 7, with a median waiting time of 47 calendar days and a maximum waiting time of 87 days in the previous 12 months. In April 2025, there were 3 individuals on the waiting list for carers' assessments. The median waiting list time was 10 days and the maximum waiting list time was 18 days during the previous twelve months. The local authority target timescale was 42 days for an assessment to start. While numbers of people waiting were small, local authority data indicated people were waiting longer.

The majority of unpaid carers we spoke to told us they experienced irregular contact and follow-up from the local authority. They said they struggled with unclear processes, long waits and poor communication. In some instances, they told us local authority teams frequently failed to follow up after assessments, leaving families to chase support themselves. In one example, a carer told us they were no longer able to participate in things they enjoyed, and they didn't know how to get a break from their caring role. They said their assessment and care plan provided limited support for them. Others told us they had never been offered a carer's assessment. Partners supported these views. Some partners told us risks around carer stress and breakdown were well reported to the local authority but there was limited recognition and occasional dismissal of their concerns.

National data supported the findings from the unpaid carers who spoke to us. For example, 6.67% of carers felt they had control over their daily lives, which was significantly worse than the England average of 21.53% (SACE, 2024). Additionally, 20.00% of carers reported they had as much social contact as they wanted, which was worse than the England average of 30.02% (SACE, 2024). Some unpaid carers told us they faced financial pressures due to care-related costs and unclear entitlements. This was backed by national data: 53.33% of carers were experiencing financial difficulties because of caring, which was somewhat worse than the England average of 46.55% (SACE, 2024).

The local authority recognised improvements in the experiences and outcomes of unpaid carers in Herefordshire were needed. The local authority told us they were committed to improving unpaid carers' experiences and outcomes. An All-Age Carers Strategy and Carers Partnership Board were in place, which had included unpaid carers in their development and ongoing delivery. The local authority told us the strategy and board were important and recognised in the Council, with full Cabinet approval of the strategy and reporting from the board to the Health and Wellbeing Scrutiny Committee, for example, indicating organisation-wide focus to address the needs of unpaid carers. The board, established in October 2024, had membership from local statutory agencies, voluntary and community organisations, and people with lived experience. The Young Carers Support Squad was in place to focus on young carers. An action plan, based around the recommendations of the All-Age Strategy Carers Strategy was developed and monitored through the Health, Care and Wellbeing Scrutiny Committee. This activity intended to drive improvements in unpaid carers' experiences and outcomes in Herefordshire.

Young carers assessments were completed by the Early Help team within children's services, which included dedicated support staff working with young carers. This team connected young carers with support available in the community, such as clubs. There were no waiting lists for young carers assessments. Guidance for staff on identifying and supporting young carers was clear and comprehensive. Information for young carers was also available, including what services were available and how they could be accessed.

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

People were given help, advice and information about how to access services, facilities and other agencies for help with non-eligible care and support needs. The local authority's Talk Community directory aimed to connect people with services, groups, information and events in Herefordshire. It included information on housing and accommodation, keeping well and staying health, and transport, travel and mobility.

The local authority had community connectors who supported people to access community-based options as part of support planning. This included supporting people from the point of contact in the ART and for people progressing through the assessment and care planning process to meet eligible and non-eligible care and support needs. In one example, staff shared how they completed a joint visit with a veteran support officer to ensure the person's needs as a veteran were well considered within the context of the community support available.

Staff connected into the Talk Community directory and community connectors to support people's non-eligible care and support needs. Additionally, staff considered how best to meet the needs of people who had no recourse to public funds. In one example shared with us, staff utilised a Human Rights Act assessments for an individual in need of mental health support, which enabled them to receive the support they needed when they returned to their home country.

Eligibility decisions for care and support

The local authority's framework for eligibility for people with care and support needs was transparent, clear and consistently applied. Eligibility information, in line with the national eligibility criteria, was available for people who had care and support needs on the local authority's website.

The local authority did not have a separate appeals process for eligibility concerns, using their complaints process to manage this. No complaints regarding eligibility had been received in the 12 months prior to April 2025.

National data indicated 63.72% of people did not buy any additional care or support privately or pay more to 'top up' their care and support, which was similar to the England average of 63.73% (ASCS, 2025). This indicated for the majority of people, local authority funded care met their needs, and they did not need to purchase additional care and support.

Feedback from some unpaid carers and partners indicated unpaid carers were not always offered an assessment of their needs, which raised concerns about the application or clarity of eligibility criteria for unpaid carers. Information was available on the Talk Community directory encouraging self-identification and engagement with the assessment process. The local authority provided a plain language definition of an unpaid carer, alongside a video to support unpaid carer identification, on their website. However, one partner, for example, shared that several unpaid carers contacted them to say they had been told they didn't qualify for a carer's assessment, despite identified needs. These issues were often resolved on an individual basis but raised concerns there was a lack of staff understanding in relation to unpaid carers' eligibility for assessment.

#BBD0E0 »

Financial assessment and charging policy for care and support

The local authority's framework for assessing and charging adults for care and support was clear, transparent and consistently applied. There were clear processes in place to support people's differing circumstances, such as for people who used residential care services and those who didn't. People could complete financial assessments over the phone or in person if needed.

At the time of our assessment in August 2025, the local authority told us 97 people were waiting for a financial assessment, with a median waiting time of 21 days and a maximum waiting time of 154 days. The target timescale for starting a financial assessment was 15 days, meaning on average, people were not receiving a financial assessment within the local authority's target timescale.

The local authority told us there had been an increase in demand for financial assessments, from 1,018 in the 12 months to March 2023, to 1,510 in the 12 months to March 2025. The function of the team was being reviewed at the time of our assessment to ensure there was sufficient capacity to meet increasing demand and improve the timeliness of financial assessments.

Local authority complaints data was provided in categories, though none specifically related to financial assessment or decision making. The local authority received 36 complaints about adult social care between April 2024 and March 2025 as part of their annual report for complaints and compliments. Of these, 7 linked to financial assessments or decision making. Outcomes indicate 57% of financial assessment or decision making complaints were not upheld, compared to 43% upheld or partially upheld. Each included follow up actions or learning for the service, including in relation to timely action and clear discussion around finances.

Provision of independent advocacy

An advocate can help a person express their needs and wishes and weigh up and make decisions about the options available to them. They can help them find services, make sure correct procedures are followed and challenge decisions made by local authorities or other organisations. The local authority had a commissioned advocacy provider in place who supported people to access statutory advocacy.

Evidence of the effective use of advocacy was mixed. Staff demonstrated a good understanding of advocacy and mental capacity and described examples of the way they had used this to support people to fully engage in the assessment, review and care planning process. Some staff said advocates were not available out of hours or not used as often as they should and others were concerned capacity issues with the advocacy provider impacted on their ability to engage advocates. The local authority told us there had been no complaints from teams or providers about capacity and that the advocacy provider was regularly involved in adult social care team meetings, case discussions, and providing guidance and informal training. Some partners told us use of advocacy was low. Some providers, for example, told us advocacy focused on crisis rather than at an early stage to support people throughout the process. One partner, for example, said there was a lack of understanding about the duties around advocacy and more training and upskilling was needed by the local authority. These factors across feedback from staff and partners indicated the use of advocacy by the local authority was not working as effectively as it could and required further consideration.

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

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

The local authority's Talk Community approach was the golden thread in the delivery of their prevention duty. Talk Community was an umbrella term within the organisation and included the online directory, which provided information, advice and guidance to connect people to community resources to support their needs. Community development officers supported an asset-based development approach, working with organisations to identify needs in their local community, develop solutions, and connect with other initiatives in the area. Community Action Networks aligned to the county's Primary Care Networks provided a forum for feedback, co-production, and shared decision making about what was needed in the community, including the police, health agencies, voluntary and community sector organisations, and community members. This was facilitated through the 75 Talk Community hubs across the county, ranging from signposting services in libraries to larger community centres. Community connectors supported people to engage with community resources. Volunteers had been trained to deliver wellbeing walks for example, supporting physical and emotional wellbeing through connection with the county's countryside.

There were clear connections between the local authority's Care Act prevention duty and the wider partnership's activity that prevented, reduced and delayed need. Public health initiatives, such as improving vaccination uptake and working with residential homes to manage and prevent outbreaks of illness, were clearly linked into the prevention offer. People's needs for secure, good quality housing to support wellbeing were clearly considered and care and support needs were integral to forward planning in terms of housing development. These examples indicated how the local authority was taking steps to deliver solutions to improve wellbeing and prevent, reduce and delay needs.

Consideration was given to unpaid carers within the arrangements to prevent, delay or reduce needs for care and support. Specific groups were available, such as a local bowls club for unpaid carers and the local authority used TEC, where available, to support unpaid carers. In one example shared with us, health partners had identified unpaid carers were not attending their own preventative health appointments as they were concerned about care for their loved one. In one Community Action Network, unpaid carers came to share their experience and community organisations were exploring ways to provide volunteers to sit with the cared for person, so the unpaid carer had more time to attend appointments and take breaks. Information specific to unpaid carers was available on the Talk Community network, including information about breaks, assessments and equipment. In some instances, however, unpaid carers told us there were not enough services available and their stress, anxiety and exhaustion were high. In one example, an unpaid carer was referred to groups that didn't exist, which had caused further stress.

National data indicated 80% of carers found information and advice helpful, which was somewhat worse than the England average of 85.22% (Survey of Adult Carers in England – SACE, June 2024). The same national data indicated 6.67% of carers were able to spend time doing things they enjoyed, which was worse than the England average of 15.97%. Some of the priorities of the Carers Strategy 2024-2028 were to enhance the quality and accessibility of information and resources available to unpaid carers, help unpaid carers through TEC, and to support unpaid carers to stay healthy. One of the aims of the strategy was to make Herefordshire a carer friendly county. As the Carers Strategy was fairly recent, more time was needed to progress the actions of the strategy and see the impact on carer's experiences and outcomes.

Investing in prevention was a clear local authority priority. Work to develop a new prevention strategy was ongoing at the time of our assessment. Several recent changes, such as the development of the technology enabled care (TEC) team and associated TEC solutions, the commissioning service restructure and a dedicated local authority lead, were described as key factors of this prioritisation activity. Some staff told us there was further to go to fully embed these changes. For example, the community connector role had recently changed title from community brokers and there was an active move to moving this role from being reactive to proactive. Discussions were ongoing in developing the local authority's single access point to be more therapy led.

Preventative services were having a positive impact on well-being outcomes for people. For example, the local authority's services to support a reduction in long-term rough sleeping was having significant impact, reducing the numbers of people rough sleeping to levels lower than the national and regional averages. Further investment into the Brave programme was supporting a trauma-informed approach to preventing homelessness for people with and without eligible care needs. The local authority reviewed all TEC support to understand where the support had reduced costs to the wider system. This calculation reflected where hospital admissions and care packages had been reduced, highlighting the impact on people's experiences and outcomes. National data indicated 86.75% of people who received short term support no longer required support, which was somewhat better than the England average of 79.39% (Short- and Long-Term Support – SALT, October 2024).

Provision and impact of intermediate care and reablement services

The local authority worked with partners to deliver intermediate care and reablement services primarily in response to hospital discharge. However, reablement services were not sufficiently effective to support people to return to their optimal independence. There were process delays and staff capacity issues which reduced the effectiveness of reablement services.

Adult Social Care Outcomes Framework (ASCOF) data in December 2024 indicated 0.87% of people aged 65 and over received reablement or rehabilitation services following hospital discharge, which was significantly worse than the England average of 3.00%. Additionally, the same data identified 75% of people aged 65 and over were still at home 91 days after discharge, which was somewhat worse than the England average of 83.70%. This meant fewer people received reablement or rehabilitation services and those people were less likely to achieve longer term reablement outcomes.

Staff told us there were few examples of where reablement outcomes were achieved and they didn't regularly see people achieve their reablement goals. Data provided by the local authority for January to August 2025 indicated on average 43% of people required no further care and stayed in their home following reablement care. Further, 29% of people required a package of care with similar or more support compared to their reablement care package or went into residential care.

Reablement primarily focused on hospital discharge. Delays in discharge affected people's reablement potential as their needs changed between their assessment in preparation for discharge and their return home. Some staff told us people were urgently readmitted to hospital regularly due to these differences. Local authority data for January to August 2025 indicated 1 in 6 people (16%) were readmitted to hospital.

Additionally, staff described delays in accessing therapists from partner agencies which meant some reablement support could not progress as some reablement outcomes were not set in a timely way. Staff told us most of the time equipment was in place quickly following hospital discharge but not always, and this caused delays and challenges. Staff described difficulty in getting the support they needed from partners in a timely way to support with medication needs. These factors limited the opportunity for people to achieve their reablement outcomes.

There were additional delays and changes in processes, for example, which affected the reablement team's ability to close cases and support more people. The Home First team (the reablement team) also acted as a stopgap where there were challenges in sourcing provision or emergency situations in which home care was needed to support safety. These issues confused the role of the team and reduced their capacity to deliver reablement support. Some staff shared concerns that people who would benefit from a reablement service, but who came through a community route rather than a hospital discharge route, did not receive reablement care which would help them. In these circumstances, people generally received home care, but it was not focused on reablement. These factors combined to create a confused reablement offer, in which people who needed home care received support from the reablement team due to issues with care provision, and some people who had reablement potential received home care because they had not been discharged from hospital.

In some circumstances, a lack of capacity in Home First to deliver reablement focused care meant the local authority commissioned a package of care from another provider. The local authority told us there were relatively low numbers of commissioned reablement packages from pathway 1 discharges from hospital due to a lack of Home First capacity. Between April and October 2025, 208 people received support from a commissioned provider in these circumstances. It was not clear how reablement outcomes were monitored in these circumstances. Some providers told us collaboration between the local authority and health partners had streamlined processes, though the delays accessing therapists from partner agencies had impacted hospital discharge processes, and prolonged hospital stays had reduced the chances of successful reablement.

The local authority had recognised improvements needed in reablement and was developing a proposal for a therapy led front door to services alongside reviewing and strengthening current provision and service specifications. Additionally, supportive mechanisms were in place to improve the existing reablement offer. The Discharge to Assess board offered multi-agency oversight and strategic direction and daily huddles between core providers, hospital discharge and liaison teams, therapy and social workers supported operational discussions. Further work was ongoing at the time of our assessment exploring the impact of the model and where better data could support improvements further. The local authority was putting a project in place to review the reablement model in Herefordshire in conjunction with partners. Completion of the project, including improvement proposals, was expected in April 2026.

Access to equipment and home adaptations

People could access equipment and minor home adaptations to maintain their independence and continue living in their own homes. However, there were delays in assessments for these services and administrative difficulties which affected people's experiences.

Some providers told us that delays in equipment provision had been common in domiciliary care and people who funded their own care weren't always supported to understand if equipment or minor adaptations would help them. Several unpaid carers shared the impact of home modifications and equipment, but access had been inconsistent and there had been delays. The local authority told us it had not been made aware of significant delays for people returning to or staying in their own homes or any complaints about the equipment service. It said a member of their dedicated team liaised directly with the equipment depot to ensure equipment was in place, unless it was out of stock.

The local authority told us there had been an increase in referrals for equipment and adaptations, and occupational therapy (OT) teams had not been at capacity. This had limited their ability to respond in a timely way to requests for equipment. The Advice and Referral Team (ART), as the local authority's single point of access, was not therapy led at the time of our assessment. There were reported challenges in consistent decision-making regarding equipment and adaptations. The local authority was looking to train more staff as trusted assessors to be able to assess for and access minor equipment in an effort to reduce the workload of OTs and support them to spend more time working with people. They were also developing a therapy led model for ART.

There were data system issues which were adding administrative burden to staff and subsequently affecting people's experiences. In August 2025, 474 people were waiting for an assessment, equipment or adaptations, some of whom had eligible needs under the Care Act. The local authority's data system made it difficult for managers and senior leaders to understand how many people were waiting at the stages of the process. Reported challenges with OT paperwork had been affecting staff for years, creating administrative burden and contributed to staff feeling their roles were undervalued. There was a service improvement plan in place at the time of our assessment which highlighted the local authority's understanding of the actions needed in the service. This included actions to redesign OT paperwork, which was being launched at the time of our assessment. Leaders were also working to improve their understanding of the equipment and adaptations waiting list and activity.

The local authority's previous supplier of equipment gave sudden notice they were unable to operate. Mobilisation of a new provider and associated systems was incredibly efficient, and the local authority supported a fairly seamless handover to the new provider within 6 weeks. This was recent at the time of our assessment and a manual ordering process for ordering equipment was in place. Staff told us some equipment had been delivered quickly but, where the equipment was not in stock, it could take quite some time. A variety of equipment was not in stock regularly, including chairs, bath boards, and perching stools. Staff across teams told us there was no system in place at the time of our assessment they could use that showed available equipment stock or what equipment people might already have in place. If out of stock equipment was requested, staff had to chase this and often had to reorder. Specialist equipment could not be tracked by frontline staff, though the local authority told us these were monitored by the commissioning team. Some staff told us deliveries had to be checked with the person or their family or friends as no updates were provided. This created administrative burden for staff, reduced their capacity to work with people and added stress to families and unpaid carers. The local authority had recognised this challenge and was progressing the implementation of a digital solution at the time of our assessment.

The local authority had recently mobilised a technology enabled care (TEC) team. The team completed holistic assessments in conjunction with the person and their family or unpaid carers. They aimed to provide technological solutions, such as automatic pill dispensers, motion sensors, and falls detection wrist bands. A 'virtual house' was available in which people could take a virtual tour through a house with TEC equipment in place to support them to understand what they could access and how it could help them. People could also go and see various TEC options in one of the residential care homes in the county. Staff provided several examples where technology had been considered and implemented where appropriate to support people to stay at home and maintain their independence. Solutions supported unpaid carers to be reassured their loved ones were safe and well and supported the reduction in care packages. The local authority was exploring whether small care packages of 5 hours or less of home care a week could be better supported by TEC at the time of our assessment. Staff were clear there was more to do to raise awareness of the TEC offer and increase its use at an earlier stage to prevent, reduce and delay need. Increasing the appropriate use of TEC was a key strand of the local authority's commitment to further develop their prevention approach.

Provision of accessible information and advice

People could access information and advice on their rights under the Care Act and ways to meet their care and support needs, including for unpaid carers and people who fund or arrange their own care and support. National data indicated 67.44% of people who used services found it easy to find information about support, which was similar to the England average of 67.88% (ASCS, 2025). Additionally, 60% of carers found it easy to access information and advice, which was similar to the England average of 59.06% (SACE, 2024).

The local authority made several options available so that people could get in touch for information and advice. This included via email, on the phone, through the Talk Community Directory and the network of Hubs, volunteers and community connectors in person in the community. People could request information in hard copy and direct via email. Some partners shared feedback they had received from people that getting in touch on the phone and communication with the right people could be difficult. This made it harder for people to get the information and advice they needed. This was a feature of several of the complaints the local authority received between April 2024 and March 2025 and the local authority had implemented solutions to support improved communication, such as staff voicemails.

Information could be provided in different formats and languages through the local authority's translation and interpretation contract. Staff reported they were able to access interpreters easily. The local authority's websites included accessibility information which supported features such as screen readers, a deaf relay service, and changing the size and colour of web pages to make them easier to read. There were videos as well as text on several webpages, providing different formats to support people's understanding of the information available. However, alternative language options were not clearly marked.

Information and advice could be provided in other formats to meet people's needs. The Young Adults Team, for example, used accessible formats such as easy-read guides, social stories, and life story books to support young people with learning disabilities or autism through the assessment process. Some partners told us, while the website and Talk Community directory were reasonably accessible, they weren't always effective for people with a learning disability and autistic people. They said unless people searched for the right terms then they would not be given the correct information in return. There was ongoing work to improve this, for example, in the Learning Disability Strategy. This identified the development and implementation of information standards that could be rolled out with partners to support people with a learning disability to have access to accessible information and advice to support increased independence and control.

Direct payments

There was good uptake of direct payments in Herefordshire. The local authority performed somewhat better or significantly better in all national direct payments data. Overall according to ASCOF data in 2024, 37.05% of people receiving care and support had direct payments (significantly better than the England average of 25.48%), 57.69% of people aged 18-64 received direct payments (significantly better than the England average of 37.12%), and 18.23% of people aged 65 and over received direct payments (somewhat better than the England average of 14.32%). Additionally, the same national data indicated 100% of carers received direct payments which was similar to the England data.

Direct payments were being used to improve people's control about how their care and support needs were met. People had ongoing access to information, advice and support to use direct payments. Factsheets were available online which provided advice and information for people considering a direct payment, including employing a personal assistant, details about carer's direct payments and using an agency. An easy read version was also available. Local authority processes for supporting people to access direct payments were clear, including in considering people's capacity to consent to and manage a direct payment. Direct payment support providers details were available on the local authority's website and people could approach either their allocated worker or a direct payment officer for advice and support.

The local authority data in August 2025 indicated 509 people were in receipt of a direct payment. In the 12 months prior, 40 individuals had stopped using direct payments. Of these, 47.5% of people moved to a commissioned service, and 32.5% of people moved to residential provision, with the remaining 20% either no longer wanted a direct payment, moved out of area or were no longer eligible.

Equity in experience and outcomes

Score: 2

2 - Evidence shows some shortfalls

What people expect

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

The local authority commitment

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

Key findings for this quality statement

Understanding and reducing barriers to care and support and reducing inequalities

The local authority understood its local population profile and demographics. Strategies showed a clear focus on understanding and improving the experiences of people with protected characteristics. The local authority analysed equality data on social care users and used it to identify inequalities in people's care and support experiences and outcomes. The domestic abuse strategy, for example, highlighted poorer outcomes for people from the Lesbian, Gay, Bisexual, and Transgender (LGBT+) community and thematic reviews mapped incidents against deprivation data to inform targeted activity. Actions were clearly set and linked to identified concerns within strategies. Enhanced services from the community and voluntary sector prioritising support to victim-survivors with protected characteristics or complex needs were in place. The local authority's Inequalities Strategy identified key aims, including reaching communities in which actions included undertaking a community survey to explore the perspectives and lived experiences of the population, and finding new ways to reach people whose voices were seldom heard. Staff, leaders, people and partners all reflected there was more to do to reach and engage with seldom-heard communities as part of ongoing co-production with people with lived experience and unpaid carers.

Specific barriers to care and support were identified for seldom-heard communities. In one example, key challenges in frailty, chronic health conditions and health inequality were identified within the Gypsy, Roma and Traveller community. Leaders shared a pilot programme of targeted intervention through public health had shown positive outcomes for the community. Some partners said there was more work needed to understand and work with the Gypsy, Roma and Traveller community.

Local authority strategies identified communities which faced barriers to care and support in line with the NHS' approach to target health inequalities. This included the 9 local areas in the 20% most deprived in England, people who lived in rural areas, the Gypsy, Roma and Traveller community, and people not registered at a GP. This approach reflected commitment to understanding and addressing inequalities in service access and outcomes for people who faced barriers to care and support in a joined-up way with partner agencies.

The local authority recognised the importance of engaging with seldom-heard groups to reduce barriers they faced in accessing services. The local authority proactively engaged with the people and groups where inequalities had been identified to understand and address the specific risks and issues experienced by them. They worked with the voluntary sector and used community spaces like veterans' centres and homelessness cafes to reach different populations. Efforts were made to engage seldom-heard groups, including the Gypsy, Roma and Traveller community, Ukrainian refugees, and people with sensory impairments.

Rural isolation was identified as a significant barrier to access to services in Herefordshire identified by people, partners and staff and leaders. Herefordshire is the fourth most sparsely populated county in England, with over half its population living in rural areas. One leader shared how rurality could be a driver of inequality beyond traditional deprivation measures. One staff member, for example, told us some areas of the county had a lack of community infrastructure which made access and support from community agencies difficult. At the time of our assessment, the local authority was developing its approach to neighbourhood health, focusing on people with multiple comorbidities and hospital admission patterns. This showed strategic intent to tackle hidden inequalities and improve outcomes through place-based approaches.

The local authority had regard to its Public Sector Equality Duty (Equality Act 2010) in the way it delivered its Care Act functions. Equality Impact Assessments (EIAs) were appropriately used to support decision making. Guidance for staff completing these was clear. Some partners told us recent contracting activity embedded working with seldom heard communities in these arrangements. The local authority aimed to use the tools it had available to understand and reduce barriers to care and support and reduce inequalities.

Local authority staff involved in carrying out Care Act duties had a good understanding of diversity within the area. Appropriate policies were in place, supported by mandatory training on equality and diversity to enable staff to support people effectively. Commissioning staff, for example, had access to data in ways that supported their understanding of communities and deprivation to support effective strategies and further commissioning activity.

Inclusion and accessibility arrangements

There were inclusion and accessibility arrangements in place so that people could engage with the local authority in ways that worked for them.

Staff reported no issues accessing interpreters and employed appropriate strategies to support people to access culturally competent care and meet communications needs. Efforts were made to reach out to communities such as Ukrainian, Polish, and Gypsy, Roma and Traveller populations through the Talk Community service. Specific outreach workers and partnerships with organisations in the voluntary and community sector, fostered at a local level through Community Action Networks, aimed to support services to be inclusive and accessible. One partner, for example, shared how the local authority had used farmer's markets to engage the community where they were. However, staff told us they had previously benefited from access to a Gypsy, Roma, and Traveller liaison worker from a partner agency to help with engagement with this community, but this was no longer available.

Some people told us the council's website could be challenging from an accessibility perspective. We found some parts of the websites had good accessibility features, such as in-built translation, but that wasn't the case in other parts, so there was some inconsistency. The local authority was developing audio information packs, improving website accessibility for screen readers and developing information in braille at the time of our assessment. The local authority had added animations to support people who found reading difficult and included subtitles.

Rurality had been understood as a barrier to some people's engagement in services. For example, one partner told us dementia diagnosis rates in the county were low in part due to some people's fear of losing their driving licence, which would affect their ability to retain their independence when they may be rurally isolated. One person we spoke to told us the recent cutting of a bus service was a significant issue that impacted wellbeing and independence. Some partners reflected that services were not always accessible to people with complex needs, including care and support needs, due to the county's rurality.

The authority responded to rural isolation with initiatives such as the Talk Community Bus, community wheels, and grants for community transport. These measures aimed to ensure that people in remote areas could access services. Leaders praised the strong sense of community spirit in the county, particularly in rural villages. There were efforts made by the local authority to mitigate the impact of rural isolation on people's needs, experiences and outcomes and improve inclusion and accessibility, for example in their development of the rural impact assessment, the development of the Talk Community network, and in the use of different rates to care providers who delivered care and support in rural areas. One partner told us the local authority had a good knowledge of impact of rurality, deprivation and poverty but finding solutions remained difficult. Rurality remained a key challenge.

Additional issues, such as digital literacy and poor mobile signal linked to the county's rurality contributed to digital exclusion. The local authority's Joint Strategic Needs Assessment (JSNA) outlined the impact of digital exclusion on health outcomes, and irregular internet use was more common in more deprived communities and for people aged 65 and over. A 2022 survey highlighted 49% of people who used telecare services did not use the internet. Talk Community Hubs aimed to provide face-to-face help and hard copies of documents for people to access information, advice and support. Further actions within the local authority's Inequalities Strategy regarding digital exclusion included increasing awareness of digital training in libraries, providing free public Wi-Fi in priority sites, and providing electronic devices freely available for use in settings such as libraries, which were progressing at the time of our assessment.

Theme 2: Providing support

This theme includes these quality statements:

- Care provision, integration and continuity
- Partnerships and communities

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

Care provision, integration and continuity

Score: 2

2 - Evidence shows some shortfalls

What people expect

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

The local authority commitment

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

Key findings for this quality statement

Understanding local needs for care and support

The local authority used available data to understand the care and support needs of people and communities. The local authority's Market Position Statement (MPS) clearly utilised available data, including from the Joint Strategic Needs Assessment (JSNA), to understand current and future needs in the county. Population demographic data was mapped and linked directly to intentions for the market. For example, the local authority identified ongoing challenges to the market and care provision which included an increasing ageing population affected by the number of people who retired to Herefordshire and a projected rise in levels of dementia which required more specialist provision than was currently available. The MPS identified how changes in the population of the county would affect the need to increase the proportion of nursing home beds in comparison to the number of residential beds. There were plans in place to realign these numbers with further investment and support put into other accommodation and support models as well.

Local authority strategies clearly linked with available data, supporting a data-driven and detailed understanding of local needs for care and support. For example, the Herefordshire and Worcestershire All-Age Autism strategy identified that there were an estimated total population of 2,170 autistic people in Herefordshire. Of these, 294 were known to adult social care (where autism was recorded, although the local authority recognised this could be higher), and 186 people also had a learning disability. There were 503 unpaid carers supporting autistic people known to carers services. Similar levels of detailed understanding were available in other relevant strategies, such as the Living Well with Dementia Strategy.

The local authority worked with key stakeholders and people with lived experience to understand the care and support needs of people and communities. Commissioners collected feedback from various sources to evaluate quality, identify gaps, and improve services, such as regular satisfaction surveys from individuals and unpaid carers, annual customer surveys and reports from care providers required by service specifications. Commissioners used provider forums, consultation events and partnership boards, which included people with lived experience, to support understanding of people's experience to help shape future provision. For example, work was ongoing to develop a new MPS for 2026-2031, which included engagement with providers to gather their views on the current document. There were further plans to engage with stakeholders and people with lived experience as part of the development of the new MPS. Co-production was evidenced in strategies that informed commissioning activity. The Living Well with Dementia Strategy, for example, clearly evidenced listening to people living with dementia and unpaid carers to understand their experiences of the health and social care system, as well as engaging with rural communities and older people to inform the delivery plan. Some people told us there was further work to do to ensure everyone had the opportunity to engage with partnership boards, which in turn would support further understanding of the care and support needs of the community.

Market shaping and commissioning to meet local needs

People had access to a diverse range of local support options to meet their care and support needs. National data indicated 76.09% of people who used services felt they had choice over services, which was somewhat better than the England average of 70.70% (ACSC, 2025).

Intentions for a diverse and effective market were clearly set out in the local authority's MPS. This document emphasised the strength and contribution of communities in prevention and supporting people's wellbeing across all ages as a key principle within commissioning activity. This intention was clear in the local authority's commitment to the Talk Community approach, and investment in Community Action Networks. An All-Age Market Position Statement 2026-2031, in conjunction with children's services, was in development and was due to be published in January 2026. Benchmarking had been completed to identify best practice and innovative approaches nationally, to inform the Herefordshire approach. This meant the local authority had a clear understanding of current and future intentions for the market, bringing nationally recognised best practice into their considerations to meet local needs.

The MPS 2020-2025 indicated in-county care homes provided a total of 2,113 placements, of which 35% were used by the local authority. The local authority's Market Sustainability Plan 2022-2025 identified capacity to meet demand for complex care in nursing environments in Herefordshire was limited. Some providers shared this view. There had been difficulty in finding placements for people with high needs and controlling the cost of these placements. This sometimes resulted in out-of-county placements, and a reliance upon spot purchasing care at significant cost from dozens of providers, with varying levels of quality and reliability. The local authority told us it commissioned a large block contract with an independent care operator to reduce reliance on spot purchasing to stabilise costs and market demands. The Herefordshire Strategic Care Home Partnership included representatives from all primary care networks, therapy, social workers, commissioning, and wider health organisations such as dental services. Activity included understanding incoming care home planning applications for care homes to work with providers to direct them to where they were needed. The MPS 2020-2025 indicated the local authority supported approximately 850 people to meet their assessed eligible social care needs in a care home, with an approximate split of 60% of people in a residential home and 40% in a nursing home, with 11% of care home placements outside the county. In September 2025, the local authority indicated this position had shifted, indicating actions taken supported ongoing market shaping: 758 people were supported in a care home, with 68% in a residential home and 32% in a nursing home, and 6% of care home placements outside the county.

The local authority recognised too many people with learning disabilities were placed into a residential care home setting. The MPS identified 57% of total residential care home spend in 2020 was for placements for people with learning disabilities and a number of people's needs were met out of county. There was a drive within the Learning Disability Strategy 2018-2028 to ensure that a strengths-based approach focused on outcomes was employed early on during a person's transition into adult services. There were detailed, outcome-focused, strategic commissioning intentions for each of the key priorities with the Learning Disability Strategy. Staff told us there were some gaps in provision for people with learning disabilities, particularly where people had complex needs, which were ongoing at the time of our assessment. The Learning Disability Partnership Board oversaw progress against identified development areas.

Commissioning strategies aligned with the strategic objectives of partner agencies. Strategies such as the Learning Disability Strategy were joint with health, while the Herefordshire and Worcestershire All-Age Autism strategy was a partnership across Herefordshire and Worcestershire local authorities, the Integrated Care System and the police. These strategic partnerships set the environment for partnership objectives within commissioning activity. Specific jointly funded and commissioned work in community equipment and technology enabled care (TEC) and the spot purchase of mental health supported living were in place with clear arrangements for governance and monitoring.

There was clear consideration of the provision of suitable, local housing with support options for adults with care and support needs. Strategic housing and commissioning worked together to understand the local need for suitable housing. The building of an extra care facility was in progress at the time of our assessment, alongside ongoing discussion with developers for 400 inter-generational homes in a regeneration project in north Hereford. Local authority staff worked closely with providers and developers to build homes with adaptations with specific families in mind. Further work to develop the extra care provision within the county with a dedicated lead in commissioning was also progressing. Housing services operated within the same directorate as the adult care and support services within the county, supporting clear alignment of strategic and operational activity.

There was specific consideration for the provision of services to meet the needs of unpaid carers such as a link service to provide practical and emotional support to unpaid carers, help people to protect their health and wellbeing and understand their caring role. While support services for unpaid carers were in place, respite and short breaks for unpaid carers were identified as a significant gap for many of the people, partners, staff and leaders we spoke to.

There were short-term respite options, sitting services, and befriending schemes available to support unpaid carers. National data indicated Herefordshire performed in line with or better than national averages in relation to unpaid carer breaks and respite. Survey of Adult Carers in England (SACE, 2024) data indicated 26.67% of carers were accessing support or services which allowed them to take a break from caring for more than 24 hours, which was somewhat better than the England average of 16.14%. The same data stated 26.67% of carers accessed support or services which allowed them to take a break from caring at short notice or in an emergency, which was better than the England average of 12.08%. Finally, 21.43% of carers were accessing support or services which allowed them to take a break from caring for 1-24 hours, which was similar to the England average of 21.73%.

Some providers told us respite services for unpaid carers had been insufficient. One partner, for example, told us unpaid carers were not entitled to respite in their own right, but rather only in relation to the cared for person's needs. Some unpaid carers were reliant on setting up respite privately, and at high cost, particularly in more rural areas. Another partner, for example, shared they weren't sure how someone got more respite if they needed it. In one example, an unpaid carer told us, while they had access to some replacement care for a few hours, they were in desperate need of a longer break and the allotted time didn't give them much chance to do anything to support meaningful rest.

A lack of respite and short breaks was reflected by several of the staff teams we spoke to. Several staff told us respite and breaks in emergencies were met but there were limited options to be able to pre-book respite. Staff said some block booking was in place, but it was limited and it needed a review to be more suitable and up to date. Staff told us unpaid carers of people with dementia faced specific challenges in accessing respite, as they were often reluctant to leave loved ones with unfamiliar individuals.

A pilot scheme had been introduced to help unpaid carers and people with care and support needs to build trust with volunteers, addressing the challenge of leaving loved ones with unfamiliar people. However, there was a consistent concern around the limited capacity of volunteers, particularly in services supporting unpaid carers. While pilot schemes were introduced to build trust between unpaid carers and volunteers, the lack of available volunteers remained a barrier to growing this preventative support, such as sitting services and befriending. The local authority's TEC offer was growing and expected to be able to support unpaid carers to take more breaks for shorter periods. The local authority was also building their Shared Lives offer to include Shared Days to provide further options to support unpaid carer breaks. In these programmes, an adult or young person who needs long term support is matched with a carefully approved Shared Lives carer. People receive safe, personal care and support, in a place which feels like home. These approaches leveraged wider family networks and community relationships, facilitating preventative support and community-based solutions.

Technology was a cross-cutting theme throughout the local authority's considerations in commissioning. The local authority evidenced a commitment to exploring proactive and predictive technologies to support the wider health and wellbeing of the local population. TEC had been used on an operational basis to support the commissioning of individual packages around the needs of individuals. It was also well considered within plans for the market. Staff told us the supported living review, for example, was looking at test scenarios where TEC would be embedded at a scheme, rather than individual, level. A predict and prevent trial was exploring what equipment could work in the county, bearing in mind limitations linked to rurality and lack of signal. The local authority was exploring how TEC needed to be embedded in services from the point of commissioning to ensure it was fully embedded in ongoing delivery, including how ongoing costs and training, were accounted for within contracts.

The local authority included 'innovation lots' within commissioning activity, for example in the ongoing development of their supported living framework. This provided opportunities for providers to work with the local authority to test new ways of working or new TEC, for example, supporting the local authority to go out to the market to explore alternatives to current models of provision.

Ensuring sufficient capacity in local services to meet demand

Some staff described capacity as a concern for residential provision, including accessing specialist provision. For example, due to the ageing population and numbers of people retiring to the county, there was less capacity for people aged under 65 and there were fewer supported living options. Staff worked with commissioners to explore options, including out of county provision as needed. At the time of our assessment in August 2025, no one was waiting for a supported living service that was not already in supported living, or within a family home in receipt of other services.

There was no data on time taken to source residential and nursing home provision as the local authority's system did not currently capture that information. The local authority were developing this function at the time of our assessment. Some staff told us capacity in residential care could be a challenge, though the local authority told us there was no undersupply of traditional residential or nursing care. The local authority had access to capacity within bed-based enablement care that usually supported people discharged from hospital. The local authority told us they had used this when people had been unable to return home after being discharged. A similar facility commissioned by the Herefordshire and Worcestershire Integrated Care Board was available for anyone awaiting nursing care. This showed the local authority considered contingencies for capacity issues, though they told us these were not regular.

The local authority was exploring the development of bespoke provision at the time of our assessment to meet identified need. The local authority told us there was sufficiency in the market locally in Herefordshire and it did not consider there to be an undersupply of traditional residential care or nursing care. There was ample interest from providers in working within the area locally and new developments, and no delays sourcing traditional provisions were reported at this time. Where a need for a specialist provision was identified, this would be found and sourced on an individual basis.

Staff, leaders and partners we spoke to described challenges due to the rural nature of the county which affected home care provision. Some partners described poor transport links alongside some providers' reliance on care staff who did not have access to their own car as limiting factors of the capacity of home care provision in the county to meet the needs of the population. The MPS identified an unequal distribution of services, with provision concentrated in the city. Some areas of the county were made up of satellite villages that could be difficult for providers to reach, geographically and economically. Some providers who delivered home care described themselves as at capacity.

The comparatively low numbers of people using services and the difficulty developing and maintaining viable rounds of care calls had resulted in delays in allocating packages. Weekly meetings reviewed anyone waiting for a homecare package with relevant staff in commissioning and frontline services to find appropriate solutions, including the interim use of Home First as needed. Brokerage systems linked to mapping software to see hotspots and challenges and supported staff to work with providers to meet packages. These examples of actions taken by the local authority supported improved efficiency in commissioning and more equitable access to care. One partner praised the local authority for reforming its commissioning approach to homecare, particularly in rural areas. Previously, there were up to 30 people unable to access packages, and beds usually reserved for hospital discharge had been used as intermediaries. In April 2025, the local authority indicated over the previous 3 months, 4 people had to wait for their homecare service to begin due to a lack of capacity. On average, these people waited 24 calendar days. In August 2025, over the previous 3 months, 23 individuals had to wait for their homecare service to begin, with an average waiting time of 40 days. However, some staff were clear this was seasonal, and they saw minor increases in waits over the summer holidays due to the availability of care staff. The number of people waiting was decreasing at the time of our onsite assessment.

Commissioning staff described working with neighbouring local authorities to understand their challenges and whether they reflected similar challenges seen in Herefordshire. For example, they were working with Powys and Shropshire local authorities due to similar rurality concerns and to work together to meet gaps.

Local authority data in August 2025 indicated 135 people were living in placements outside of the county, with 9 of these placements made in the last 12 months. There was a higher proportion of people aged 18-64 placed out of county compared to people aged 65 and over. Approximately a third of people placed out of county were supported within a neighbouring authority area, such as Gloucestershire, Worcestershire or Monmouthshire. Of the 9 out of county placements in the preceding 12 months, 56% were due to personal choice to be closer to family, while the remaining were where specialist provision was required. Social work teams continued to monitor and formally review individuals living outside of the area, to ensure their needs are being appropriately met. Staff working in the quality and assurance team worked proactively with other local authorities where there were quality concerns for out-of-country provision. Unscheduled reviews could take place as needed in response. Further development of local authority bespoke provision and the supported living review, among others, were expected to provide further options to support people who may wish to move back to the local authority area if their needs could be met locally.

Ensuring quality of local services

The local authority had clear arrangements to monitor the quality and impact of the care and support services commissioned for people and it supported improvements where needed. A robust quality assurance framework included monthly reporting, off-site reviews, on-site inspection of services, improvement action planning and escalation protocols. All commissioned providers received a comprehensive, evidence-based assessment every 12-18 months, which included direct observations, discussions with people and their families, and data reviews. Unannounced visits were also utilised. In April 2025, 3 providers were embargoed within the last 12 months, with 2 of these related to quality. There had been no embargoes for residential or nursing homes. Providers told us the annual assessments had been thorough and supportive. They received guidance throughout the process, and the local authority helped them identify areas for improvement which was monitored through an improvement plan. Providers described the approach as robust and collaborative.

Risk was monitored and providers were prioritised for review according to risk. Where there were concerns with providers, additional visits or monitoring activity could take place earlier than scheduled. This included where there were patterns of safeguarding concerns within provision. There were clear operational arrangements to connect the quality and assurance of providers with other relevant teams, including safeguarding and strategic commissioning to ensure a holistic understanding.

The local authority had appropriate policies and procedures in place to support large scale investigations. In a recent example of concerns regarding a provider, staff described a collaborative approach to the suspension of a service due to quality concerns. Front line staff, commissioners, brokers, safeguarding, and the Integrated Care Board worked together to review residents and plan contingencies, ensuring continuity of care and safeguarding.

There were no inadequate care providers in the county at the time of our assessment. The local authority indicated in April 2025 77% of home care providers were rated good or outstanding. In September 2025, 79% of residential care providers commissioned by the local authority were good or outstanding. The Market Sustainability Plan identified, while quality was generally good in the area, 43% of local authority commissioned care placements were in homes rated as requiring improvement. Action plans were in place for each of these homes, monitored by the local authority.

There were high numbers of people who funded their own care in the county and so not in local authority commissioned provision. The local authority maintained regular forums with providers, including those not directly commissioned, to support wider quality assurance work.

Ensuring local services are sustainable

The local authority was collaborating with care providers to move towards sustainable fee rates. High numbers of people who funded their own care generally raised fee rates in the area higher than council commissioned fees. The local authority's Market Sustainability Plan 2022-2025 identified high numbers of people who funded their own care contributed to the use of spot purchased beds and variable fee levels, while reducing the negotiating opportunities and providing reduced stability on prices paid. Providers shared challenges related to cost of living and wage pressures with the local authority that affected their sustainability within this wider context. Some parts of the provider sector said they had regular meetings with the local authority, but others had not had the same level of engagement. However, they reflected that leadership and engagement with them had become more visible and supported them to share challenges they faced as businesses in the market. The local authority linked with colleagues in the West Midlands Association of Directors of Adult Social Services (ADASS) network to seek support and work with other local authorities in the region around market sustainability.

The local authority's MPS 2020-2025 identified there had been challenges with the recruitment and retention of care workers nationally that had been exacerbated at the local level by the reduction in the numbers of hours of care being commissioned at the time, and the higher costs of delivering care to a rurally dispersed population. These factors combined to make rural packages economically unattractive for many providers. The local authority recognised that it was difficult to assure continued stability and sustainability. Urban, rural and enhanced rates were available in areas where care was difficult to source to reduce the impact on people and increase the viability of taking on a package of care in more rural areas in particular. Local authority data between April 2024 and March 2025 indicated increasing numbers of people receiving home care, which was an increase on the previous year, indicating identified challenges in homecare were improving As part of recommissioning considerations, the local authority were exploring all options to manage the difficulty in sourcing rural care and supporting the sustainability of providers, including hyper rural rates to tackle challenging areas.

The local authority used available appropriate contracting arrangements, including frameworks, spot purchasing and longer-term contracts, in their commissioning approach. For example, the local authority's secondary home care framework was seen as more flexible and enabled additional domiciliary care providers to join. This provided further opportunities for providers to work with the local authority, with the outcome that the number of packages on the waiting list were reduced.

Some providers had mixed views around council contracts providing stability. They said having a contract with the local authority provided stability in terms of knowing they will get paid. However, where they mostly were used for spot purchases, they didn't know how many people they would be supporting, which reduced the stability provided by the contracting arrangements. One provider said there had been some issues with organisations being paid for services due to purchase orders being incorrect. Some providers told us there had been inconsistency due to commissioning team restructures over recent years and that short-term and interim contracts had made long-term planning difficult. Some providers told us there had been a disconnect between local authority funding and the actual cost of running services, which had strained operations.

However, providers told us responsiveness from the local authority had improved, with more visible leadership and participation in provider forums. Providers had observed a greater presence of senior staff over the past six months, which had helped foster a sense of support and structure. Despite ongoing changes, there had been a clear focus on making systems work more effectively which was expected to support increased stability and sustainability.

Local authority procedures for providers who were handing back commissioned care packages were clear and clearly set out expectations on provider services and local authority staff. No contracts for home care, residential or nursing care, or supported living had been handed back early. Only one care provider had left the market in Herefordshire in the 12 months prior to September 2025.

The local authority understood its current and future social care workforce needs. There were significant workforce challenges due to the rurality of the county, national challenges such as the care sector struggling to compete with the retail sector and NHS in terms of recruitment and an ageing workforce. The local authority area performed better in comparison to the national average in Adult Social Care Workforce Estimates (2025). There was a 4.44% vacancy rate in the care sector in the local authority area, which was better than the England average of 7.04%. There were different recruitment events for the local care sector throughout the year with colleges and different training courses were also available that provider staff could access. A Herefordshire Cares programme was available to support recruitment and there was an associated vacancies site which advertised roles in the area. While these options were available, several providers told us there was limited support from the local authority in recruiting and retaining the social care workforce.

Partnerships and communities

Score: 3

3 - Evidence shows a good standard

What people expect

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

The local authority commitment

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

Key findings for this quality statement

Partnership working to deliver shared local and national objectives

The local authority worked collaboratively with partners to agree and align strategic priorities, plans and responsibilities for people in the area. The local authority had integrated and joint funded care and support with partner agencies to best support people in the area.

Partners shared there was a collaborative nature to health and care in Herefordshire. Arrangements were described as broadly co-terminus, meaning the local authority boundaries aligned with partner boundaries, making relationships more straightforward between partners. The One Herefordshire Partnership brought together the local authority, general practice, Herefordshire and Worcestershire Health and Care NHS Trust, Local Medical Committee, local Healthwatch and the Wye Valley NHS Trust. This partnership aimed to work together to deliver health and care integration at pace and scale. Partners described transparency and partnership around issues such as hospital demand and bed availability, for example, from the local authority. The One Herefordshire Partnership was a key vehicle for partnership planning and delivery against identified priorities, including the Better Care Fund.

There was clear oversight and leadership within these partnership arrangements. For example, the Herefordshire and Worcestershire All-Age Autism Strategy was delivered in partnership with the ICB. An Autism Strategy Oversight Group chaired by the ICB and the Herefordshire Autism Partnership Board provided opportunities for partnership working, including with the voluntary and community sector and autistic people and unpaid carers. The local authority took the leadership and accountability role for a defined section of the strategy.

Staff told us operational partnerships worked well. For example, the hospital liaison team was well integrated with the NHS, co-located in the area's acute and community hospitals. This had contributed to reducing delayed discharges from hospital. Staff across the service gave further examples of working well with health services, including collaborative work with colleagues on palliative pathways, the dynamic support register and care and treatment review processes.

Internal partnerships with housing services worked well. These were supported by organisational alignment of housing under the Director of Adult Social Services (DASS). Positive partnership working and regular meetings with housing services were in place operationally and with wider partners. The continuation of the BRAVE programme to support a reduction in homelessness was in conjunction with health services in order to embed trauma-informed practice within the approach. Adaptation by design in line with identified needs for individual people and families was considered through operational partnerships between local authority services. The care and support needs of the community were clearly considered in the operational and strategic housing activity in the county.

Arrangements to support effective partnership working

There were several examples of clear arrangements to support effective partnership working. A memorandum of understanding was in place, for example, between the local authority and the Wye Valley Trust Occupational Therapy team. This was based on a recognised need to improve the working relationships between medical and social models of therapy as represented by the two organisations. The expectation was this memorandum of understanding would improve the working relationships, setting a clear partnership governance framework.

Joint policies, procedures and structures had also been developed, for example, between the local authority's Approved Mental Health Practitioners (AMHPs) and the mental health trust. For example, the development of a Section 140 policy in line with the Mental Health Act 1983 enabled individuals to be transferred to a health-based place of safety rather than custody while waiting for a hospital bed. This was an example of how roles and responsibilities were clear within partnership arrangements.

Appropriate information sharing was clearly considered. This included through regular multi-disciplinary panel meetings, for example to support young people who transitioned from children's to adults' services. Staff told us the local authority facilitated meetings involving adults' services, children's services, health, and education. These panels met monthly and enabled joint planning and decision-making. The team also had access to the children's case management system, which supported continuity of information and reduced the need for individuals to repeat their stories. Information sharing was also provided through access to service level data. The local authority shared appropriate data with partners, for example with health services to support discharge to assess pathways. A data lake was under development to enhance integration. These examples demonstrated a commitment to working in partnership through appropriate information sharing at an individual and service level to support the improvement of people's experiences and outcomes.

There were several joint initiatives in place which utilised integrated funding and roles, where appropriate, to best support people in the area. In one example, the local authority worked in partnership with the Integrated Care Board (ICB) and police to jointly fund the Identification and Referrals to Improve Safety Programme. The programme included training, support and a referral system to improve practice in relation to domestic abuse. The joint Community Integrated Response Hub with the Wye Valley NHS Trust, in another example, supported people receiving care at home by providing access to a range of community responses. The local authority was also the host authority in the joint commissioning arrangement with the ICB for the integrated community equipment service.

The One Herefordshire Partnership provided system wide oversight of pooled arrangements. Priorities for the 2023-25 Better Care Fund (BCF) included improving their hospital discharge support, unpaid carers' support, partnership and integration and community resilience and prevention. One partner, for example, told us the BCF arrangements enabled improved conversations around care pathways and patient flow with a clear impact on service delivery and coordination.

Several joint arrangements were overseen through the One Herefordshire Partnership. A joint commissioning forum was exploring a health and social care contract for care homes to improve coordination and quality of care. BCF funded discharge to assess work to support improved hospital discharge. A discharge to assess partnership board worked together to improve the service, also funding beds in care homes to assess long term care needs without delaying hospital discharge. Regular meetings between teams, including hospital discharge, therapy teams, and reablement, supported operational partnership working. These operational and strategic examples indicated regular and appropriate arrangements to support partnership working, identifying areas for ongoing improvement and development.

Impact of partnership working

The local authority monitored the impact of its partnership working to inform ongoing development and continuous improvement.

Work on improving the discharge to assess pathway was a whole system approach to design and delivery. The Home First approach has been embedded and there was significant support to improve hospital discharges. One partner was clear this work had reduced hospital discharge delays. Work to further understand the impact and improve hospital discharge pathways was ongoing at the time of our assessment. Significant improvement had been made to pathways, which resulted in the majority of people discharged to reablement care through pathway 1. Recognised issues with the availability of therapists that were hindering some of the effectiveness of the reablement approach had been recognised and funding was identified to recruit more therapists. The local authority and the One Herefordshire Partnership were progressing further work to analyse the available data to understand the longer-term outcomes and impact for people.

Analysis of data as part of this partnership work indicated increased readmissions to hospital related to falls and the subsequent need for more prevention work related to falls in a partnership context. This supported the development of appropriate steering groups to support oversight, relevant analysis resulting in a needs analysis, and an ongoing mapping exercise of community resources. This indicated ongoing development and continuous improvement of the partnership offer to support people's experiences and outcomes.

Working with voluntary and charity sector groups

The local authority worked with voluntary and charity organisations to understand and meet local social care needs.

The local authority provided infrastructure support to the voluntary and community sector to support the building of its capacity and sustainability. The local authority, through their Talk Community development team, collaborated with the voluntary and community sector organisations in the county to support sustainability and income generation. The local authority also made grant funding available to grass roots organisations. Organisations could run groups using the grant or add the funds together with other existing funding to support their communities. The Talk Community model was led by development officers who facilitated Community Action Networks every 6 weeks. This brought their communities, voluntary and charity sector organisations and statutory services together to share ideas and plan forward with their communities. Additionally, a new contract to develop volunteering capacity in the county and connect volunteers with community organisations was in place.

One partner said there was regular and positive communication between the charity and senior leaders, to such an extent they felt able to raise any matters of concern, and there would be feedback about it as well. Voluntary and community sector organisations were part of partnership boards. Leaders identified areas of development for their relationship with the voluntary and community sector, including a clear strategy for the sector across the local authority to improve fragmentation. This played out in considerations of how to develop a more strategic oversight of the sector and the move from traditional grant-funded relationships with the sector and making applications for local authority contracts more straightforward, especially for smaller organisations or pots of funding.

Theme 3: How Herefordshire 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

Safety was a priority for all teams. This included a consistent approach to risk rating waiting lists. Staff told us waiting lists were actively monitored, with regular contact to people to assess changing circumstances and risk. Some staff described weekly management meetings, for example, to support consistency in the management of waiting lists. Teams worked together to allocate urgent cases where capacity was a challenge. Data regarding who waited for services and how long was robust for the majority of adult social care services.

There was a lack of clarity about who was waiting for different services and how long for occupational therapy-based assessments. Waiting lists were prioritised and waiting well processes were in place, which mitigated the impact of this issue and reduced the risk safety diminished while people waited. However, the high number of people waiting and administrative challenges faced by staff, including system processes and paperwork, affected staff's ability to complete waiting well checks efficiently. There was an expectation described by one team, for example, that waiting well calls were in addition to their heavy workload. Staff also told us there was a lack of guidance for how to access the relevant information and scripting for these conversations. These factors reduced the efficacy of the waiting well process, increasing the risk people's safety was not well supported. Leaders were reviewing the OT waiting list, progressing new paperwork for the OT team, and implementing an appropriate equipment stock tracking system at the time of our assessment. This was expected to have a significant impact on this process quickly.

Where people waited for a package of care, this was minimal and there were clear arrangements in place between relevant teams to consider risk, including carer crisis. Alternative short-term solutions were available, such as the use of reablement beds or the Home First team, that could be used in a contingency. Staff told us emergencies were a priority for duty brokerage and systems ensured a timely response to risk. In one example shared by staff, a permanent residential placement was sourced within a working day meaning the person was at the residential home without delay, reducing risks to their safety, wellbeing and of deterioration.

The local authority had clear emergency duty systems in place to operate outside of weekday and business hours. Staff described good working relationships with relevant partners including the police, including in response to mental health needs as all out of hours staff were Approved Mental Health Professionals (AMHPs). There were clear lines of communication between daytime services and the emergency duty team to pre-empt where safety required support or management between the teams.

Good relationships with the police, health, and the voluntary and community sector amongst others were supporting people who were homeless or at risk of homelessness. There was a clear investment in meeting the needs of people with Care Act eligible needs and others, particularly in the ongoing investment in the Brave programme working to reduce homelessness in the county. Staff shared an example of where they had used technology to ensure the safety of one person who was considered to be at risk.

Safety during transitions

The local authority utilised appropriate systems and processes with partners to support and manage people's safety as they moved across their care journeys.

The local authority's young adults team supported young people moving from child to adult services. Staff shared positive partnership working that engaged young people and their families and supported them. There were systems in place to identify young people likely to require care and support as an adult from age 14. Staff told us this allowed for smoother transition and ensured necessary support was in place before a young person turned 18. Young people had allocated workers, but there was a clear ethos of support that utilised experience and expertise across the team. The local authority maintained flexibility in how long they worked with a young person. While some young people were transferred to locality teams once their support felt settled, others remained with the young adults team for extended periods, sometimes beyond age 25, if that met the young person's need. There were clear examples of listening and working with young people and their families, for example working with a young person with high anxiety and sight loss through education and into supported living in line with their wishes.

There was ongoing work to ensure placement sufficiency and choice for young people when they moved to adult services. The local authority was working with young people and their families to develop models of care to best meet their needs. One partner described ongoing anxiety when young people and their families were approaching the move from child to adult services in the available services that were stimulating and supportive.

Local authority staff were based in the county's acute and community hospitals to assess care and support needs as part of hospital discharge processes. Some nursing staff were also working in these teams to support this process. Further assessment took place after several weeks through a dedicated team to understand longer term support needs. Staff were advocates for people and the thorough assessment of care needs within the complex and challenging hospital and discharge environment. One staff member described an example of working closely with housing services to secure an adaptable bungalow to support a safe discharge, highlighting an holistic approach to discharge planning. Daily meetings across staff groups supported safety management and a discharge to assess board allowed for multi-agency oversight of strategy and risk.

Sometimes there were delays in discharge which affected people's experiences and outcomes. There had also been waits for longer term assessments following discharge due to demand on the team completing them. One family, for example, told us the discharge to assess process was patchy and prolonged. While they eventually got a good outcome, which was supported by the local authority, they said it took longer than needed. Some staff shared several examples where people's needs had deteriorated within the discharge process that resulted in readmittance to hospital. Examples included where assessments had originally identified people could walk unaided, for this not to be the case when they were at home, or where more care calls were required due to the person's increased needs.

Local authority data in July 2025 indicated 83.9% of patients were discharged on their discharge ready day. This represented the lowest percentage of delayed discharges compared with previous years and some partners praised the local authority's work to improve this.

The local authority's county team supported people across the county for a wide variety of reasons, including where people had experienced several placement breakdowns, had multiple diagnoses or fluctuating needs. This recognised where people had already experienced several transitions between services which may have been traumatic and required a nuanced response. This provided continuity for people across their care journeys to support their safety and wellbeing.

There were processes in place where people moved to or from the county which included relevant information sharing and follow up. Where people moved placements, some providers said they needed more notice as this wasn't always sufficient and the support they received when someone moved services was varied. This increased the risk the provider was not well prepared to meet the person's needs. However, emergencies were recognised as often unavoidable factors.

Commissioning and social work teams worked together to assure the quality of provision and respond to concerns when someone was placed out of area. The local authority told us social work teams monitored and formally reviewed people's needs when they were placed out of county, in conjunction with people, their families, networks and supporting professionals. People, families, advocates or providers could also request a review of care and support at any time. People placed out of area can be at higher risk due to a variety of reasons, including the infrequency of reviews, support planning and care management and differing quality assurance processes. There was also some dedicated resource in place to reduce waiting times for reviews.

Contingency planning

The local authority undertook contingency planning to ensure preparedness for possible interruptions in the provision of care and support. This included relevant policies and procedures for rapid evacuation of care homes or the failure of a provider organisation. Policies included the sharing of relevant information with partner agencies and where joint work could support contingency plans. The local authority knew how it would respond to different events and carried out mock scenarios to test and ensure the robustness of procedures.

The local authority received very limited notice their equipment provider had to cease trading. The contingency response from local authority teams was rapid and robust, putting a new service in within 6 weeks. There was clear evidence of prioritisation of activity during this emergency management period to ensure there was minimal impact on people's experiences and outcomes. A paper referral process was in place at the time of our assessment and some staff told us there had been minimal impact on their work. Some teams were responsible for responding to emergencies and faults with TEC equipment, for example, for 2 weeks to ensure people remained safe with the equipment in place. A digital system to track equipment stock and delivery remained a challenge, though this was progressing at the time of our assessment and leaders expected this to be resolved imminently.

Local authority contingency planning was recently tested in relation to quality concerns related to a provider. The local authority activated contingency plans considering concerns about people's safety. Alternative plans were put in place for people's care and support. These alternatives were ultimately not used, but highlighted how the local authority worked collaboratively, internally and with other local authorities, to ensure continuity of care would be maintained in an emergency situation and support improvement. Learning was ongoing at the time of our assessment regarding the process and whether people should have been moved at an earlier stage to reduce risk. Clear service improvement plans were in place for the provision and residents which were well monitored, ensuring contingency plans could be reactivated if necessary.

Funding decisions or disputes with other agencies did not lead to delays in the provision of care and support. One partner shared examples of discussions taking place quickly when packages of care needed to be approved where funding was provided across partners. The local authority had processes in place to support people who could no longer fund their own care to support continuity and people's wellbeing.

#BBD0E0 »

Safeguarding

Score: 3

3 - Evidence shows a good standard

What people expect

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

The local authority commitment

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

Key findings for this quality statement

Safeguarding systems, processes and practices

There were effective systems, processes and practices to make sure people were protected from abuse and neglect. National data indicated 73.49% of people who used services felt safe, which was similar to the England average of 70.16% (ASCS, 2025). Similarly, 89.30% of people using services felt safe, which was similar to the England average of 87.81% (ASCS, 2025). Additionally, 86.67% of carers felt safe, which was somewhat better than the England average of 80.93% (SACE, 2024). The local authority worked through established multi-agency structures and with the Herefordshire Safeguarding Adults Board (HSAB) to oversee priorities, themes and outcomes. There was a dedicated safeguarding team and staff representation was ensured within the Multi Agency Risk Assessment Conference (MARAC), Multi Agency Public Protection Arrangements (MAPPA) and Prevent multi-agency meetings.

Multi-agency arrangements were well developed. The local authority was a statutory partner within the HSAB alongside providers and voluntary sector representatives. The HSAB strategic plan had agreed five priorities: self-neglect, exploitation, prevention, neglect and omission, and board effectiveness. Transitions and Making Safeguarding Personal ran as cross-cutting themes. The current strategic plan set aims such as improving recognition of exploitation and providing an exploitation toolkit with delivery monitored via sub-groups, performance data, audit outcomes and an annual report.

The local authority had established multi-agency arrangements for people who did not have eligible care and support needs under the Care Act. For example, the 'breaking the cycle' initiative supported people with multiple disadvantages, and Making Every Adult Matter (MEAM) aligned work and community initiatives such as Talk Community Hubs and Well Space. Mandatory Prevent training, for example, formed part of the safeguarding and extremism response, with a priority to increase frontline understanding of ideologies, including extremism.

Leaders described a wider programme underway to strengthen safeguarding systems based on identified issues. Plans included improving mechanisms to gather feedback from people about the safeguarding process, developing forums and toolkits on self-neglect and hoarding, strengthening community intelligence and safeguarding awareness, and improving data systems. The local authority understood its areas for development, such as strategies for individuals with complex, multiple needs, and they were planning to undertake development work around these areas and other safeguarding processes.

A training and workforce development sub-group promoted a multi-agency competency framework, shared case review learning, commissioned trauma-informed practice training and disseminated the self-neglect and hoarding policy and resources. Between April 2023 and March 2024, 610 delegates attended multi-agency safeguarding courses. This coordinated approach to safeguarding systems and processes ensured people received an effective and joined-up response. Learning and development activity was ongoing. Audits identified improvements required in the complex adult risk management approach, recommended wider use of tools and information-sharing for self-neglect and hoarding, and provided assurance of statutory compliance.

Oversight of development initiatives was expected to improve once the recent recruitment of a Principal Social Worker (PSW) was completed. Within this timeframe, operational managers fulfilled aspects of the PSW role on top of their existing duties. However, some leaders, for example, raised that not having a PSW had meant there was not enough time or focus on oversight of developing and changing safeguarding processes to support identified learning from audits, though a variety of practice improvement work continued without the PSW in post.

A dedicated safeguarding team received all safeguarding contacts, coordinating multi-agency responses and holding functions, including triage, complex case coordination, provider quality assurance and position-of-trust enquiries. Dedicated processes, such as those related to people in a position of trust, and large-scale enquiries, were in place providing clear guidance to staff. A manager or senior practitioner triaged all contacts, identified risk, and determined progression either under safeguarding, via requests for further information, or as welfare concerns. At the time of our assessment, this work was managed by a small team, resulting in an intense and high workload. Staff told us there were previous staffing pressures due to a vacancy and long-term sickness, mitigated by agency workers. As a result, there was an impact on communication with referrers and on staff wellbeing. No initial reviews over the previous 12 months had exceeded the 48-hour target for triage. This reflected that, whilst the workload was intense and communication with referrers could improve, the local authority was assured there was timely triage of contacts.

Staff described a supportive culture for safeguarding practice. Where staff needed support, there was additional supervision, senior oversight of referrals and close collaboration with the safeguarding team to build confidence and ensure safe enquiry management. Staff also described using escalation processes when providers did not act upon concerns, ensuring ongoing risks were addressed.

Providers generally felt that the local authority had skilled and knowledgeable safeguarding staff when contacting them for advice and guidance. Most respondents felt that the safeguarding team was very helpful and that there were clear processes for notifying about safeguarding concerns. However, some staff and partners indicated communication regarding safeguarding referrals was not always clear and safeguarding outcomes were not always fed back to the referrer. One provider, for example, told us that they had to chase adult safeguarding referrals to obtain these outcomes. Another partner also reported submitting referrals via the local authority website and not always being informed of outcomes. This was an identified area of improvement for the local authority and outcomes were provided when requested. Front-line teams found referral routes straightforward, though some also said they needed to chase for outcomes, particularly around reviews.

Responding to local safeguarding risks and issues

The local authority demonstrated a clear understanding of the safeguarding risks and issues within the area. Data showed neglect and acts of omission were the most common concerns, followed by financial abuse. Older people and those with learning disabilities were identified as being at higher risk, and this informed how resources were targeted. The local authority worked closely with safeguarding partners to reduce risks and prevent abuse. This included developing strong multi-agency partnerships with providers, hospitals, advocacy services, and the local authority's quality and review team.

Staff described steady improvements in learning and development, particularly around Safeguarding Adult Reviews (SARs), supported by initiatives such as lunch and learn sessions and dedicated SAR learning days. Learning from SARs was also shared through practitioner forums. Recent changes had also driven improvements, with staff feeling empowered to influence practice and contribute to a culture of continuous learning. In 2023-2024, five SAR referrals were received. Learning from these reviews included strengthening the complex adult risk management process, improving understanding of Mental Capacity Act 2005 duties, and addressing gaps in professional curiosity and recording. The local authority shared a SAR action plan with 5 actions in progress, including recognising the role of family carers, bridging advocacy gaps, and promoting multi-agency working. Good practice was also identified, such as capturing the person's voice and completing robust mental capacity assessments.

Data gathered by the safeguarding team was routinely fed into the HSAB, where self-neglect emerged as a recurring theme requiring early intervention. In parallel, the SAB and Health and Wellbeing Board were working on preventing homelessness and reviewing deaths in the county to gain a broader understanding of local risks.

Responding to concerns and undertaking Section 42 enquiries

The local authority had established clear criteria for what constituted a section 42 (s42) enquiry and when a s42 enquiry was required. A s42 enquiry is the action taken by a local authority in response to a concern that a person with care and support needs may be at risk of or experiencing abuse or neglect. Staff told us that these thresholds were applied consistently, with a clear rationale recorded for decisions, including those cases that did not progress beyond initial enquiry. Data from the Safeguarding Adults Collection in 2024 showed the conversion rate of safeguarding concerns progressing to s42 enquiries was 14%, although this rate had fluctuated between 7% and 11% in previous years. The conversion of safeguarding contacts to s42 enquiries could be due to several factors, and does not, on its own, indicate safeguarding practice. However, this demonstrated that, while most concerns were resolved at the initial enquiry stage, there was a consistent process in place to determine when statutory enquiries were necessary. Where safeguarding enquiries were undertaken by another agency, such as a care or health provider, the local authority retained oversight and responsibility for the enquiry and its outcome, ensuring accountability for the person concerned.

There were clear standards and quality assurance arrangements in place for conducting s42 enquiries. Quality assurance staff described their role in monitoring provider-led investigations, reviewing safeguarding logs, and ensuring protective measures were implemented immediately where risks were identified. Data provided by the local authority in August 2025 showed that there were no safeguarding concerns awaiting initial review, with all referrals considered within 48 hours. In August 2025, there were 8 s42 enquiries awaiting allocation to a worker, and the median waiting time was 10 days. There was a maximum waiting time of 18 days within the 12 months prior to August 2025. Safeguarding plans were in place to reduce future risks for individuals, and ‘safe and well’ checks were used to manage risk for those waiting.

There were 100 people awaiting allocation for Deprivation of Liberty Safeguards (DoLS) applications. The local authority reported actions they had taken to reduce waiting lists, including commissioning additional independent Best Interest Assessors, streamlining assessment using the regional model and using a DoLS priority tool. To ensure that people were safe whilst waiting, the DoLS team reviewed and prioritised urgent cases and planned renewals in advance. Referrals were triaged weekly and high-priority cases were allocated within 7 days. The DoLS team reported structured triage, prioritising urgent cases and planning renewals, with engagement of families and advocacy services and training for providers.

Making safeguarding personal

Safeguarding enquiries in Herefordshire were carried out with sensitivity, ensuring the wishes and best interests of the person concerned remained central to the process. Staff told us they worked to progress enquiries without unnecessary delay, and examples were provided of practice where individuals with capacity were supported to make their own decisions, even when these were considered unwise, with proportionate safety plans put in place to help manage risks.

The local authority consistently reduced risks and involved individuals at risk of abuse or neglect in the enquiries they undertook. Outcome data indicated that 77.7% of people (or their representatives) were asked what they wanted from safeguarding, with 82% of outcomes partially or fully achieved. Risks were reduced for 50% of people, removed for 18% and remained for 14%. The Herefordshire Safeguarding Adults Board business plan also highlighted areas where progress was yet to be made, including a communications strategy to raise awareness and mechanisms for people with lived experience to influence the work of the board.

People were supported to understand what safeguarding meant to them, what being safe looked like in their own lives, and how to raise concerns if they did not feel safe or had worries about the safety of others. The Talk Community website included information aimed at the public about keeping adults safe. This included information on the types of abuse and how to raise a safeguarding concern.

The safeguarding team described a strong commitment to Making Safeguarding Personal, prioritising safe and appropriate contact with individuals. Where direct engagement was not possible, for example in cases involving domestic abuse, creative approaches were used to ensure the person's voice was heard. Staff arranged joint visits where necessary, and information was provided in ways that helped people to understand the safeguarding process and their options.

Partners told us access to advocacy remained a challenge, and the local authority was reviewing data to better understand why advocacy was not consistently provided when there was a duty to refer. For those assessed as lacking capacity in safeguarding, 80% received advocacy according to local authority data. Data from the Safeguarding Adults Collection in 2025 showed that only 18.18% of individuals lacking capacity were supported by an advocate, family or friend. This was significantly worse than the England average of 83.30%. This highlighted a need for further work to fully understand the use of advocacy in the local authority to ensure people could participate in the safeguarding process as much as they wanted to. Work was ongoing through the HSAB to support this.

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

There were clear governance, management and accountability arrangements at all levels within the local authority. These included corporate leadership functions, the Health Care and Wellbeing Scrutiny Committee and Health and Wellbeing Board. The local authority's schemes of delegation for Care Act duties were clear and publicly available, supporting transparency in decision making and clear accountability.

Governance and accountability for action was clear within local authority strategies. For example, the Herefordshire and Worcestershire All-Age Autism Strategy identified the governance in place for the delivery of Care Act duties and the actions identified. An annual action plan was produced for each priority, setting out areas of focus and how the local authority monitored success. Progress was reviewed through the Herefordshire Autism Partnership Board and reported to the relevant Integrated Care System (ICS) programme board. An annual report was presented to the Health and Wellbeing Board and a bi-annual newsletter was produced to keep everyone updated on progress.

There was direction and oversight of commissioning activity under the Procurement and Commissioning Strategy which included reviewing all policies and procedures, ensuring effective risk management of major contracts, regular value for money reviews, and ensuring compliance with the council's procurement and governance standards, controls and procedures through a cyclical programme of internal audit work.

Leaders described challenges in terms of demand increases of 23% in adult social care between March 2023 and April 2024 which presented risks to financial sustainability. Some staff told us rising domestic abuse, carer breakdown and service capacity issues were key factors following the COVID-19 pandemic. The local authority was responding by investing in preventative approaches, such as Talk Community. Further work was being explored, for example, through the Health Care and Wellbeing Scrutiny Committee for a task and finish group to focus on further understanding the demand pressures affecting adult social care, aiming to conclude in early 2026. There was a developing insight into the impact of prevention work with pilot schemes on the use of Technology Enabled Care (TEC), for example. These showed indicative cost savings and improved outcomes for people, including hospital admission avoidance. This activity indicated an ambition to understand the impact of prevention work on local authority pressures and people’s experiences and outcomes.

Adult social care leadership was predominantly described as consistent and visible, such as when attending service visits with frontline staff. Senior leaders were often described as approachable. Roles and responsibilities within the senior leadership team were clear and there were identified mechanisms to support the role of adult social care within the local authority's wider functions. The Director of Adult Social Services (DASS) oversaw housing, public health, and cultural services alongside Care Act functions, supporting integration of the wider determinants of health and wellbeing within adult social care.

Some partners told us there was further work needed to improve the flow of information and communication through local authority structures and out to partners. Some staff felt this internally, with their voice not always well heard in contribution to service developments or transformation. This was supported by the employee survey in 2024 which indicated 45% of the staff who responded did not feel involved in making decisions about key changes and 39% did not feel able to influence change within the local authority. One leader shared a similar view for example, where some regular meetings had lapsed and that communication across the local authority generally could be improved. This affected some staff and partners experience of the governance and leadership in the local authority.

There were some leadership roles, such as the Principal Social Worker and Director of Public Health, which either had recent changes or were vacant, which were noted by some staff and partners. One partner described this as posing challenges to institutional knowledge and continuity. Some staff described a lack of dedicated leadership risked slowing progress on embedding strengths-based and person-centred practice or the integration of some functions within the local authority. However, these senior roles were filled or recruitment processes were nearly complete at the time of our assessment and there was reflection from staff and some partners on the positive effect this was beginning to have.

The local authority's risk register robustly identified risks to adult social care delivery in the county. These included risks to market sustainability and stability, challenges due to rurality, and risks of not meeting statutory obligations to deliver effective safeguarding. Risk registers identified the impact of the risk, existing risk controls and further actions required to continue to mitigate the risk. The local authority's risk approach, recent review of risks and accountability was clear. An overarching visual representation of adult social care's risks at the beginning of the register provided an efficient way of highlighting risk.

Senior and corporate leaders maintained clear assurance on oversight of performance and escalated concerns. Some partners told us there were good relationships with senior leaders to support this oversight. The local authority was well represented on partnership boards to support oversight and escalation of risks if appropriate and as required, including the One Herefordshire Partnership, the Integrated Care Board and the Integrated Care Partnership Assembly. Progress on the Inequalities Action Plan, for example, would be reported to the One Herefordshire Partnership, the Integrated Care System Health Inequalities Collaborative, and Herefordshire Health and Wellbeing Board.

The local authority's political and executive leaders were well informed about the potential risks facing adult social care. Political leaders had significant experience within the health and social care system, enabling their understanding, support and challenge to the local authority. The council operated without an overall political majority, requiring cross-party support for decision-making. This was clearly in place, for example in the cross-party working group to explore housing in the county. There was no opposition lead role for adult social care which meant that scrutiny was conducted through the Health Care and Wellbeing Scrutiny Committee, which was well attended. This arrangement ensured accountability. One leader told us there was still some work to do to find the balance between avoiding micromanagement while still ensuring accountability when following up actions.

Political and executive leaders told us they received regular briefings on adult social care, for example on performance, home care and the Joint Strategic Needs Assessment (JSNA). This enabled informed scrutiny and supported the shaping and monitoring of strategic decisions, such as the proposal for a council-run care home and intergenerational care models.

Strategic planning

The local authority had some operational and strategic business intelligence and performance reporting frameworks in place to support understanding of risks and performance within considerations of adult social care strategies and plans. There were clear areas for development, such as improving the reporting of the waiting list for occupational therapy and equipment and adaptations. Some work to understand the impact of adult social care activity was in place, for example in assessing the cost savings from TEC. There were areas where further work was needed to understand impact, such as reablement, in terms of outcomes for people that were not in fully place at the time of our assessment. This work would support the ongoing improvement of services. The local authority told us they had a performance management framework with quality monitoring arrangements in place and performance reporting systems at service and team level. Arrangements included reporting systems measured against key local and national indicators to demonstrate delivery against their Care Act duties and maintaining risk registers. A new performance management system was being introduced to streamline reporting processes and improve consistency and efficiency.

Local authority and partnership strategies and action plans were in place and up to date. This provided clear strategic direction for activity. The Learning Disability Strategy, for example, had robust outcome-focused, strategic commissioning intentions framed in line with the themes of the strategy. These supported an understanding of existing and new resources, activities, outputs and intended outcomes, with space to understand the wider social impact. An improvement plan was in place for occupational therapy services in recognition of the challenges faced and developments needed and a project scope had been developed to support the review of reablement services in the county. These examples indicated the local authority had recognised the need to make improvements and was progressing action to do so. It was too early, however, for the impact of this work to be felt.

Challenges persisted in relation to recruitment and retention to ensure teams were sufficiently resourced to be able to appropriately allocate resource to meet local needs. This was a concern for the majority of staff groups we spoke with, who recognised increasing demand and smaller teams. Some staff were worried, describing the situation as overwhelming and unsustainable. Some staff said they thought new training and restructuring would improve capacity and reduce pressure, but there was concern about sustainability if there were sickness absences. Some teams said they were not fully staffed for several years and recent loss of operational managers was impacting on staff wellbeing. Some staff recognised structural change was needed but these service changes had progressed slowly, reflecting some lack of clarity in strategic direction for some staff.

The local authority had actions in place, such as international recruitment and using the apprenticeship levy to attract occupational therapy apprentices, for example. Some staff told us they knew leadership teams were aware of capacity gaps, and they were encouraged to share their ideas for solutions. There was ongoing work with the Local Government Association (LGA) to contextualise the local authority's workforce strategy specifically for adult social care. The local authority was holding waiting lists for several teams, indicating demand and resource pressure was affecting people's experiences and outcomes. This remained a live area of challenge for the local authority, though mitigation and action was in place.

Information security

The local authority had arrangements in place to maintain the security, availability, integrity and confidentiality of data, records and data management systems. Information sharing protocols were in place with relevant partners and staff completed mandatory annual training in information security. Work was ongoing to make further improvements to case management systems.

Information on the local authority's website in relation to information security provided details of how to access records held about people. Sharing of information was in accordance with the Data Protection Act 2018 and the General Data Protection Regulations (GDPR). Specific privacy notices were available for adult social care and retention schedules were available. Information was shared with health systems to support partnership working.

The local authority's risk register identified in April 2025 their case management and financial database systems were fragmented and needed to be more aligned. Some staff and partners identified where case management systems needed to improve or where improvements were progressing at the time of our assessment, such as some safeguarding information and occupational therapy waiting lists. Leaders identified improvements needs to reduce administrative burden and provide further support for predictive data modelling. This was an identified priority to improve their database systems in their transformation plan.

Learning, improvement and innovation

Score: 2

2 - Evidence shows some shortfalls

The local authority commitment

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

Key findings for this quality statement

Continuous learning, improvement and professional development

There was a culture of continuous learning and improvement within the local authority. Staff had ongoing access to learning and support so that Care Act duties were delivered though had mixed experiences of being able to access these. Coproduction was improving at the time of our assessment, with further developments identified.

Peer support, supervision and shared learning supported staff to deliver Care Act duties within teams. Staff described training days across the service to promote their understanding of different teams and roles and strong sense of community and belonging. 'Lunch and learn' events encouraged knowledge sharing and professional development and staff described sessions with external organisations or teams to support their knowledge. Management and peer support, through open discussion around the people supported, was regularly available in and out of formal supervision. This supported their wellbeing and the environment in which staff were supported to deliver better experiences and outcomes for people. However, some staff told us they felt the impact of smaller teams. For some this meant they were concerned about knowledge lost to the organisation, tasks were difficult to juggle or in team support or capacity for learning and development had been impacted.

The local authority introduced a learning hub for staff, following feedback, to provide access to learning and events. The learning offer for staff included online and face-to-face training courses to support the delivery of Care Act duties. A standard offer for staff included relevant training on autism, safeguarding and mental capacity, for example. Training offers were updated in response to identified learning needs, such as audit findings, complaints and team feedback. The local authority was also aiming to develop specialist knowledge in response to identified need, for example, in fetal alcohol disorder, contract management and health and wellbeing diplomas.

Staff provided mixed feedback about their experiences of training. While some staff felt that general training and employee feedback mechanisms were strong, others noted that induction and specialist training were variable and sometimes compromised by staffing shortages. More informal mechanisms, such as shadowing opportunities, could be limited or unavailable where workload was high, though these were available for some.

The local authority had recognised challenges in relation to recruitment, but many staff shared how the local authority delivered a 'grow your own' approach to career progression to support retention. The local authority supported apprenticeships and several staff we spoke with were progressing through this route or had good experiences of local authority supported development from unregistered roles through to registered positions and into management roles. This supported the continuous improvement and professional development of the adult social care workforce.

The local authority's quality assurance framework set out key activities, including practice observations, case file and supervision audits to support continuous improvement. This included relevant senior and operational management oversight. Staff told us that quality assurance and oversight was embedded across processes, with senior practitioners and team leaders reviewing and signing off work. In safeguarding, social workers' information gathering was signed off by senior practitioners, although staff told us a formal audit process was not in place at the time of our assessment. While the local authority was without a Principal Social Worker (PSW) at the time of our assessment, arrangements were in place to continue to promote legal literacy, person-centred practice, and case law awareness in conjunction with the Principal Occupational Therapist role. A learning log was in place to support the identification of learning and associated action, providing accountability for ongoing improvement.

There was a growing culture of coproduction with people with lived experience through partnership boards with the local authority. For example, some unpaid carers told us they were able to influence policy and support unpaid carers, particularly through boards like Making It Real and the Carers Partnership Board. Several people and leaders told us there had been a renewed focus on co-production.

Feedback from several people indicated the partnership boards needed further development. For example, some people questioned the lack of physical disability-focused partnership board and strategy. Others told us the Making It Real board, for example, was too broad in focus. Several people and partners told us more was needed to strengthen feedback loops with the local authority to show the impact and delivery of action because of co-production. One partner, for example, described this as the local authority being in danger of engagement fatigue from the community, which could put some people off. Some partners described inconsistency from the local authority in its approach to co-production, with some teams more signed up than others. This suggested further work was needed to clearly define and embed coproduction within the local authority's structures.

There was clear impact from the co-production work taking place in Herefordshire. The Carers Strategy, for example, was developed through co-production and accountable to the Carers Partnership Board for progress. In another example, care experienced young people were involved in consultation groups for recommissioning their supported accommodation services. The young people worked with the local authority to write the service specification aims, objectives, outcome statements, and questions for the tender. Young people undertook adapted evaluation training and took part in the evaluation panel to award the contract.

The local authority worked with peers and system partners to influence and improve how care and support was provided. The local authority participated in workshops focused on future strategies aligned with the NHS ten-year plan, using data to assess local needs and demands and understand how care and support provision could be improved. The local authority's transformation plan outlined development of the area's prevention strategy, for example, was in progress through multi-agency stakeholder groups that were identifying gaps in services, case study deep dives and community engagement.

The local authority's monthly quality assurance forum reviewed the progress of identified learning from peer practice reviews, practice audits, complaints, ADASS networks and lessons learned workshops under their learning log. One partner, for example, told us the local authority looked to neighbours to understand practice to support their own development and learning. Some staff had identified the recruitment of a PSW was needed to support the embedding at pace of evidence-based practice, such as strengths-based practice, within the local authority.

The local authority drew on external support to develop and improve as necessary. This included activity with the Local Government Association (LGA) to support the development of their existing authority-wide workforce strategy to best meet the needs of adult social care. The subsequent workforce delivery plan outlined a series of actions to progress the improvements in line with the local authority's specific challenges in relation to the adult social care workforce. The local authority engaged in peer reviews as part of their quality assurance framework, using qualitative and quantitative methods to evaluate the quality of their services. Relevant staff engaged in appropriate regional and national networks, such as the national Principal Occupational Therapists group and the West Midlands Association of Directors of Adult Social Services (ADASS) market sustainability group. The use of external standards and frameworks, such as the LGA's employer standards, demonstrated a commitment to continuous improvement and alignment with national best practice.

Learning from feedback

The local authority learnt from people's feedback about their experiences of care and support, and feedback from staff and partners. This informed strategy, improvement activity and decision making at all levels.

The local authority co-produced a questionnaire called Person's Voice, which provided people with an opportunity to give feedback about their recent experiences of care. People's feedback was shared with relevant staff and used to improve the services they provided. Evidence from this questionnaire was used to support service direction and strategy alongside targeted engagement and support from partnership boards. Some people we spoke with told us, for example, the local authority had begun addressing accessibility issues, such as adapting Making It Real board materials for visually impaired individuals and simplifying leaflet language in response to direct feedback. In another example, the young adults team moved away from using language around transitions following feedback from a young transgender person using services that this felt confusing to them. Some staff teams described ongoing work to improve opportunities for people with lived experience to feedback about their experiences, especially where this could be challenging, such as in a mental health context.

Local authority leaders were responding to staff feedback. Some staff identified recent improvements in feeling listened to, though they'd experienced an historical lack of consultation. The local authority developed a 'you said, we did' document, outlining where staff feedback had improved services. For example, in response to feedback about line management leadership capability and capacity, the local authority brought in additional leadership and management apprenticeships and a review of induction. This resulted in a one day per month management induction program for all new or promoted managers. This was evident in the feedback received from staff who told us line management generally contributed well to a supportive and collaborative work environment.

Compliments and complaints were managed by a corporate complaints team, with monthly reports of themes and outcomes provided to the leadership team and fed into the quality assurance framework's learning process. The local authority received 36 complaints related to adult social care between April 2024 and March 2025. Service failure was the highest area of complaints throughout the year (29%), followed by 24% where the complainant disagreed with the local authority's decision. Learning from complaints and any action taken was clear and included action for individual staff members and more broadly, such as identified training needs.

There were 2 detailed investigations by the Local Government and Social Care Ombudsman (LGSCO) between April 2024 and March 2025, compared to 4 for the average number of detailed investigations for other local authorities of its type. The uphold rate of complaints to the LGSCO was 0% compared to the average uphold rate of its type of 74.25%. The local authority complied with 100% of the LGSCO's findings, with 0% of their remedies late, compared to the national average of 17.3%. These figures represented timely and appropriate action in response to complaints.
