Care Quality Commission

City of York Council: local authority assessment

How we assess local authorities

Assessment published: 5 December 2025

About City of York Council

Demographics

City of York Council is a unitary authority and is recognised as a city with heritage and culture that attracts international tourism. It has two universities and is the most densely populated (7.7 people per hectare) area in North Yorkshire. York is ranked 145 out of 153 local authorities (with 1 being the most deprived and 153 being the least deprived). The Index of Multiple Deprivation (IMD) score is 1 (10 is the most deprived). At ward level, there is greater variation with Copmanthorpe the least deprived ward, and Westfield the most deprived.

The city of York has a population of 206,780 with 27,021 being full-time students and 9,854 people aged over 80. It has a predominantly white population 92.77%, which was significantly above the England average of 81.05%. People who did not identify as ‘white’ were in the minority with 1.84% of people identifying as ‘Mixed or multiple’, 3.76% as Asian or Asian British, 0.96% as ‘other’ and 0.65% identify as Black, Black British, Caribbean or African. It has a higher percentage of adults in ages 18-64 (63.98%) and 65+ (19.28%) than the England averages. Proportionally, it has slightly fewer children than the England average (Office of National Statistics ONS, 2023).

Boys born in York can expect to have an average life expectancy of 79.8 years, which is 0.7 years longer than nationally. Girls born in York can expect to have an average life expectancy of 83.6 years, which is 0.5 years longer than nationally. In York, life expectancy can differ a lot between the most deprived and the least deprived wards. In 2020 and 2021, men living in York’s most deprived wards lived for 8.2 fewer years than their counterparts in the least deprived wards. For women, this gap was 4.7 years.

Across the whole population, 17% of people were ‘disabled under the equality act’, this included 6% of people who said their day-to-day activities were significantly limited.

York and North Yorkshire Combined Authority was launched from 1 February 2024. A combined authority is where a group of councils work together across a larger area. The City of York Council worked at a local level to deliver services for local people. The combined authority delivered on a wider scale across both areas, working in partnership with the two unitary authorities to deliver the devolved investment. The City of York Council was part of Humber and North Yorkshire Integrated Care System.

The political make-up of the council at the time of the Care Quality Commission (CQC) assessment was 24 councillors representing the Labour party, 19 councillors representing the Liberal Democrat party, 3 councillors representing the Conservative party and 1 independent councillor.

Financial facts

The Financial facts for City of York Council are:

- The local authority estimated that in 2023/24, its total budget would be **£244,497,000.00**. Its actual spend for that year was **£269,928,000.00**, which was **£25,431,000.00 more** than estimated.
- The local authority estimated that it would spend **£66,513,000.00** of its total budget on adult social care in 2023/24. Its actual spend was **£75,338,000.00**, which was **£8,825,000.00 more** than estimated.
- In 2023/24, **27.91%** of the budget was spent on adult social care.
- The local authority has raised the full adult social care precept for 2023/24, with a value of **2%**. Please note that the amount raised through ASC precept varies from local authority to local authority.
- Approximately **2560** people were accessing long-term adult social care support, and approximately **605** 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.

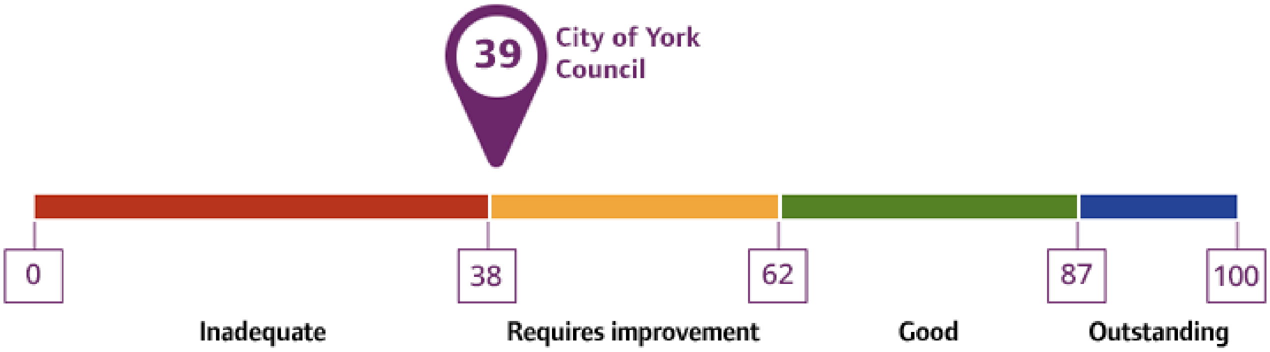
This data is reproduced at the request of the Department of Health and Social Care. It has not been factored into our assessment and is presented for information purposes only.

Overall summary

Local authority rating and score

City of York Council

Requires improvement



Quality statement scores

Assessing needs

Score: 1

Supporting people to lead healthier lives

Score: 2

Equity in experience and outcomes

Score: 2

Care provision, integration and continuity

Score: 1

Partnerships and communities

Score: 2

Safe pathways, systems and transitions

Score: 1

Safeguarding

Score: 1

Governance, management and sustainability

Score: 2

Learning, improvement and innovation

Score: 2

Summary of people's experiences

People were mostly positive about the staff that supported their assessment and care and support planning. They described staff as helpful, kind and considerate. However, people told us there was a need to repeat conversations as they could be transferred to or contacted by multiple staff. There was mixed feedback and findings from people and unpaid carers about the quality of assessments and care planning that took place. Some people told us the local authority focused on ‘budgets’ over person centred care.

Most people told us they knew how to contact the local authority, but they did not have copies of their care and support plans. More needed to be done to evidence effective contingency processes around people’s experiences and ensure consistency of preparedness for possible interruptions within people’s individual care and support.

Local area coordinators linked people to their local communities specific to the persons preferences. They worked with local charities, food banks, health social prescribers and police in relation to community safety to signpost and ensure people were connected to the right services at the right time. People told us about the benefit of them working with local area coordinators. This approach helped people receive the right support at the right time and encouraged conversations about what a good life looked like for people.

People gave mixed feedback about the effectiveness of the local authority’s processes for assessing and charging adults for care and support. Some people were unhappy about delays around decision making and poor communication of the contributions they needed to pay, with some being charged incorrectly and needing to be resolved through formal complaints. Whereas some people told us about the ease of the process and described it as timely, clear, transparent and consistently applied.

People and unpaid carers could access information and advice in person, by phone and online. However, some people told us accessing information and advice in person or by the phone could be challenging and the online options were not always up to date and could be difficult to navigate and understand. The local authority addressed inequity around digital exclusion through their ‘Digital Friendly York’ partnership and strategy. The partnership of organisations supported people in York to get online and learn skills using the internet and its benefits. People could be offered reused devices and learning free of charge.

People told us there was more to do to understand the experiences and specific needs of people. For example, people who were transgender with a diagnosis of autism and, or mental health needs.

Most people from seldom heard groups told us they didn’t feel listened to, and the local authority did not engage with them in ways that worked for them. For example, a group of people from the LGBTQIA+ community and people with learning disabilities were ‘worried’ and ‘feared’ the lack of understanding in York.

Some people with sensory needs, people with learning disabilities and autistic people told us their preferred inclusion and accessibility arrangements were not always followed. People told us there was more to do to include people who were not able to access online services, recognising some general information in easy read and audio was available but online only and they did not know where to access physical copies.

Specialist aids and equipment to support the independence of people who had sight loss, hearing loss or dual loss could be provided to people following an assessment by a commissioned service separate to a person’s care act assessment or review. People told us there were challenges with this including waits, criteria was not always clear, and support and care planning was not joined up. The local authority had gathered some peoples experiences with sensory support needs and found a need for better promotion of sensory support services to ensure they reach out to all people. Some people with a sensory impairment were not aware of the range of support available or how they could access or use it.

People told us in terms of involvement with senior leaders, in general they usually worked to meet with existing groups and their advocates at places and times to suit and offered accessibility such as language and BSL translators where applicable. However, an example was given around accessibility for people with learning disabilities who were invited to engage via a questionnaire that they said was not easy to understand due to confusing language. People felt that this particular consultation exercise was not effectively accessible. In response to this, staff had made acted on feedback and were improving ways to ensure consultation was accessible and inclusive as possible utilising audio CD, braille, and easy read depending on each persons preferred way of communication.

People and unpaid carers told us about their care and support and the quality of services in York. Some people told us they had no concerns about the care they received, we heard how services supported people to remain as independent as possible and made people feel safe. In contrast, we heard how timings of care could be cut short or be unreliable, meeting peoples specific needs could be challenging and training needed to be improved. The local authority had gathered feedback about people’s experiences, in one survey almost two thirds of people were ‘extremely’ or ‘very’ satisfied with their care and support.

People told us about the benefit of having stable arrangements for care and support and how this had a positive impact on their wellbeing. However, people and unpaid carers told us how the local authority’s current processes ended peoples care if they had a stay in hospital which caused distress and longer stays in hospital when some declined to change to a new provider.

There had been no learning disability partnership board for a number of years, but action had been taken to create a new model with the first meeting held in May 2025 (one month before the CQC site visit). As a result, people who were invited to attend told us they did not feel listened to, felt the local authority representative did not understand the meaning of partnership with people and there was a lack of leadership around learning disability agenda. People wanted to be involved in the planning of bringing together a partnership board and shaping future strategy and plans. In contrast, there were many examples where local people participated in voicing their opinions. This included an older people's assembly, self-advocacy forum, disability rights forum, ‘connecting our city’ partnership, and citizen groups. Some people had been involved in workforce interviewing, strategy, and contract tenders around topics such as drug and alcohol use, homelessness, mental health, carers and visual and hearing needs.

People told us they didn’t feel the local authority learnt from feedback and there was a lack of communication to gather direct feedback about their experiences of care and support which could inform improvement activity and decision making at all levels. The local authority had started a pilot to gain more widespread feedback within teams with results finding not all people were aware they could give feedback including complaints. Senior leaders and staff were taking action, and the new Principal Social Work position would be leading on coproduction and quality assurance in adult social care to bring together systematic learning and evidencing any success of this once in post.

Summary of strengths, areas for development and next steps

The corporate ‘One City For All’ plan (2023 to 2027) set an ambition to increase opportunities for everyone living in the city of York to live healthy and fulfilling lives. The Chief Operating Officer (COO)supported the Director of Adult Social Services (DASS) creating links between Adult Social Care and the rest of the council and was supportive of partnership working with NHS partners. Children’s services in York had recently been rated ‘outstanding’ by Ofsted following an improvement journey. The adult social care directorate was keen to keen to take the learning from children’s services and apply it in adult social care. There was an adult social care ambition board led by the COO, transparent improvement and risk plans and dedicated transformation resource to take them to the next level of improvement. The DASS started in 2024 and was steering the transformation required with adult social care to deliver good outcomes for local people and was restructuring the department to support them in delivering in adult social care coproduced vision and strategy.

Strategically there was a lot of activity, but workforce issues had delayed improvement. There had been a lack of consistent senior leadership in York over the last few years both within senior leadership in adult social care and politically. The absence of a Principal Social Worker for 8 months had left gaps in practice oversight and evidencing learning which needed to be improved. There was a need to focus on key priorities such as reducing waiting lists, building a stable workforce, ensuring effective and reliable data to support decision making and evidence that changes were sustainable.

A new Assurance Forum was embedded, and there were multiple projects underway. However, at the time of the CQC assessment there was a lack of coordinated strategy. There was a draft adult social care strategy that was going through consultation, but more to do to ensure all strategies were effectively monitored and having a positive impact on peoples outcomes.

There were gaps in market shaping and commissioning to meet local needs. The self-funding population in the City of York was a competitor in the care provider market due to the large number of people who paid privately for their care. There were significant gaps in provision, there was little evidence of progress around the Market Position Statement and Commissioning Strategy that concluded this year, and workforce issues meant this was unlikely to change very quickly. There had been some progress but not enough particularly according to providers who did not feel involved. Strategic relationships with care providers and health and integrated care system leaders continued to evolve to improve working together. However, working relationships with partners were not always positive. There were developing foundations in place with partners to strengthen relationships. The DASS was addressing many issues and had been very involved on leading and understanding where improvements were needed but this was work in progress and had not yet delivered the changes required.

Systems and practice did not reflect effective management of safeguarding and potentially left people at risk. There was more to do to ensure front door processes were effective to respond to people's needs and provide senior leaders assurances needed. Processes had begun to improve, for example duty staff were starting to work more closely with call handlers. There were ambitions for improved strategic direction particularly around how the local authority gathered and acted on feedback, learning and a need to embed coproduction with people with care and support needs to deliver Care Act responsibilities.

Staff told us where they received feedback, this was discussed in team meetings to share learning. Although there was more to do, staff were committed to serving people in the City of York, there was an ethos of wanting to learn through people, staff, partners feedback and analysis so that Care Act duties could consistently be delivered safely and effectively. The DASS had the passion, commitment, expertise and energy to deliver what was required but there was more to do to collectively within the senior leadership team to deliver and embed developments, learning and ensure staff, people and partners were an integral part of changes.

Theme 1: How City of York 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: 1

1 - Evidence shows significant 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

The local authority had Customer Contact Workers who people could contact to access care and support services as well as share new information about risk or potential safeguarding concerns. Staff told us if a person did not appear to have an adult social care need, they could signpost the person or referrer to another service and the information would not need to be reviewed by a duty worker or manager. However, people and partners told us there were concerns about eligibility information shared with them and right to request assessment when people first contacted the local authority. For example, one person told us they had to 'fight' for care and support to be assessed, and another person called the adult social care telephone number and staff who answered the phone told them they could only help with them with personal care, they were not passed on to a specialist and said they had been given the wrong advice.

Staff and partners highlighted that people often needed to use specific terminology to access advice or support. For example, one partner noted that people were expected to understand or use ‘professional language’ during initial contact, which created a barrier for those unfamiliar with such terms and, in some cases, prevented them from receiving the support they needed. Staff told us if a safeguarding referral was made it could lack the detail they needed, and this would get ‘sent back’ to the Customer Contact Workers and in some cases not returned. Some action had been taken to address this, such as Customer Contact Workers beginning to link more closely with ‘duty workers’ to share skills and expertise. We were also assured that staff had regular supervision with a registered social work manager and had immediate access to advice and support from a team of managers should they themselves identify the need to. Whilst there were management checks for the quality of the contacts and responses there were no formal audits to assure senior leaders that people were consistently given the right advice and directed to the right service including those outside of the local authority. Senior leaders told us staff competency checks happened through agreed processes for people who progressed to another internal team. However, there was a need for senior leaders to evidence any effectiveness of the current function particularly around actions taken when people first contacted the local authority and understand any negative outcomes for people such as unmet need or risks.

People’s referrals could be transferred to duty workers or specialist teams to wait for an assessment or respond to any urgent need identified. For example, if a person had a learning disability or a mental health need, the request for assessment or review would go directly to those teams. People, staff and partners gave mixed feedback about peoples’ experiences of being supported by teams whilst they waited for assessment. People told us there was a need to repeat conversations as they could be transferred to or contacted by multiple staff. There were processes to allocate ongoing assessment, intervention and, or safeguarding work to the same worker. However, staff told us new allocations often took place based on availability rather than familiarity to prioritise demands within teams.

People were mostly positive about the staff that supported their assessment and care and support planning. They said staff were helpful, kind and considerate. One person told us their allocated social worker was ‘excellent’ and helped them reconnect with their family, they said they listened to them and provided support, information and advice which in turn improved their quality of life and ability to interact with their family. However, there was mixed feedback and findings from people and unpaid carers about the quality of assessments and care planning that took place. National data showed 60.53% of people were satisfied with care and support which was similar to the England average (62.72%, NHS Digital for 2023-2024). One person told us it was important to them that their care plan was ‘like their bible' and they saw it as a place where their needs, including communication needs, could be in one place. They said this helped them to be understood and receive the care they needed, what they wanted to achieve and how they wished to live their life. However, they felt there were important things to them missing within their plan which the local authority was acting on. Another person told us their needs were not fully met because of the inflexibility of traditional ways of supporting needs such as offering a set four visits a day with 1 hour in a morning and 30 minute visits thereafter. Whilst the person was grateful to remain at home despite their challenges, they did not feel the support provided was meeting their needs fully, they told us the most recent assessor 'talked me down' when they asked for a change in the way they were supported. They said there was not enough time to attend to their personal care and additional communication needs at midday which was having a negative impact on their well-being.

The local authority had more to do to ensure all options to mitigate people's risks and meet needs was explored with them, and there was consistent collaborative working with the person, their network and relevant professionals. Quality checks of assessments took place on a one-to-one basis with staff through manager approvals on the digital recording system. Some people, partners and staff told us the local authority focused on 'budgets' over person centred care. However, we heard from staff and leaders, this was changing, and action had been taken to support this such as their assurance forum. Staff told us the forum was supportive, with one staff member reflecting that previous 'high cost' assurance processes had felt like being cross-examined. In contrast, they now felt that senior leaders were kind and encouraging in their approach, which was reported to be having a positive impact on staff practice and outcomes for the people they support. Staff were passionate about a preventative and strength-based approach to assessment and intervention; there was an understanding that 'bringing' people into services was not always the best solution. Some staff found the forum was a reassurance that they had tried everything with the person first, whereas some staff felt the forum still had restrictive processes that needed more development. For example, small and short-term increases in care needed to go through the same rigorous processes and checks as a new care package. We consistently heard from staff there were concerns about the delay in approval due to a need to book a slot to be heard at the new forum. Staff told us the forums had become busier and now had a 2-3 week wait as they booked up quickly and a manager also needed to authorise on the digital system before a forum. This was a source of some staff having reservations that the local authority was 'finance led' in its approach to meet people's needs. Some changes had recently been introduced, such as duty and reablement staff having the ability to provide support first. However, there remained to be some negative impacts on people's experiences supported in other teams. For example, a person with mental health needs was unable to access support from a specialist provider because the social worker was waiting for an available slot.

Timeliness of assessments, care planning and reviews

There were delays in carrying out a Care Act assessment. In June 2025 the local authority told us 303 people were waiting for a care act assessment (45 of these were said to be 're-assessments'). Reaching highest in March 2025 where 325 people were waiting (of these 82 people had allocated workers the updated data equivalent was not provided for June 2025 resubmission of data to compare). People had a median wait time of 75 days and maximum waiting time of 1,492 days. This continued to increase over time from the lowest maximum wait time in December 2023 which had been 975 days. Senior leaders told us recruitment to staff vacancies had contributed to the trend of more cases being allocated. However, the number of assessments with an allocated worker that had 'not started' indicated a need for practice guidance around process & digital recording on the adult social care recording system. Staff and partners told us people who were self-funded, people with sensory needs, and people with mental health needs waited longer for assessment. Staff and partners had concerns about the local authority's workforce capacity to reduce and sustain waiting times within a reasonable range.

When people waited for assessment, they could be directed to preventative services this included connecting them to voluntary and health services in their own communities. Urgent visits could be carried out by a worker on duty and if there was an imminent risk they could refer to teams such as rapid response, urgent care, and the emergency duty service. There was a live feature on the digital recording system to oversee wait lists which could be accessed by all staff and leaders. This did not extend to an overview of levels of risk, but team managers used 'Red, Amber, Green (RAG)' ratings within specific teams, and a draft 'case prioritisation tool' was being piloted in the community team which staff and senior leaders told us was having a positive impact. The local authority had plans that were being led by transformation projects to formalise the action taken when people waited for assessment such as giving people an indication of how long they might wait and carrying out more proactive checks opposed to prioritising any changes of need based on professionals, people or unpaid carers who may contact the local authority. There were plans for a Quality Assurance Framework and quality of practice tool along with new supervision process to be implemented and embedded once the Principal Social Worker post was in place. However, at the time of the CQC assessment there was more to be done to understand the impact that waiting for assessments had on different groups of people and evidence of any positive impact on people's outcomes.

People did not know when their care would be reviewed. Some people had been reviewed without prior notice to invite a preferred person to support them and their care provider, and specialist assessors were not in attendance. National data showed 47.02% of people with long term support had been reviewed (planned or unplanned). This was similar to the England average (58.77%, NHS Digital for 2023- 2024). In June 2025 the local authority told us 881 people had overdue reviews which had slightly increased over the time during the year. People had a median waiting time of 507 days which had dropped from 538 days in March 2025, and maximum waiting time of 2,388 days. The highest maximum wait time in the previous 12 months had been 2,424 days in November 2024. Senior leaders had treated this as a priority and there was a multidisciplinary project approach to reducing waiting lists for care reviews, whilst this had not made progress in reducing demand at the time of the CQC assessment there was evidence it was beginning to make a positive difference to some people's lives. There were projected impacts for the work, and the risk measuring tool ensured a standardised approach to prioritisation. Senior leaders told us the transformation projects underway were based on performance indicators which provided visibility on the improvement trajectory.

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

National data showed 50.54% of unpaid carers accessed a support group and, or someone to talk to in confidence, which was better than the England average (32.98%, NHS Digital for 2023-2024). And 33.33% of unpaid carers were satisfied with social services which was similar to the England average (36.83%, NHS Digital for 2023/24). Unpaid carers feedback was mostly positive; however, we found there was more to do to ensure adult social care staff identified and involved unpaid carers and young carers (not known to children's services) of adults with care and support needs, and those assessed were offered a review of their needs. Unpaid carers told us they appreciated it when staff listened to them and were positive about the carers service and local groups. A carer told us how a pottery class with other carers provided much needed community engagement, reduced isolation and improved their emotional resilience to continue with their role. Another carer told us they received their own care plan and were supported with applying for benefits and a blue badge which they said made them feel recognised and relieved financial pressure.

Staff could carry out carers assessments alongside people's care and support assessments. There were also options for unpaid carers to have separate carers assessments if they preferred. The local authority had link workers and options to self-refer. In June 2025 the local authority told us 146 unpaid carers were waiting for a carers assessment this had significantly increased from the lowest wait time over the year which was 44 unpaid carers waiting assessment in June 2024. Unpaid carers had a median waiting time of 63 days. The highest maximum wait time in the previous 12 months had been 2,282 days in May 2024. However, after a drop in June 2024 to 272 carers waiting, this steadily increased to a maximum waiting time of 607 days in June 2025. Senior leaders told us there were some historic data issues that had an impact on the accuracy of the longest recorded waiting time.

Senior leaders told us the carers service had a 4-week target to complete carers assessments and 'usually met this, although currently operating at up to 8 weeks'. All referrals, whether made to the local authority or carers service, were said to be discussed jointly at a fortnightly meeting (unless they were specified no consent to discuss with either agency). At the joint meeting individual circumstances were screened as to whether they were suitable for the carers service or needed to be with the local authority assessors, the carers service was said to assess approximately 5 new carers per fortnight with a contractual limit of 148 per year.

The local authority did not provide a breakdown of the number of young carer or parent carer waits when asked. However, they told us the carers service managed all referrals for young adult carers (where the carer is 18-25), to support with the transitions process from young carers. Staff told us about positive work to support both young carers and parent carers in preparation for transition to adult services. A partner told us there was close working between the carers service and children's services for advice and support to enable a collaborative approach.

Senior leaders formally monitored national data in relation to carers experiences and had invested additional funding into the carers service, the previous Carers Strategy had lapsed but a coproduced review was underway, and a guide was being developed to promote carers breaks. This was formally monitored within the adult social care ambition board chaired by the Chief Operating Officer of the council which showed the importance the local authority placed on unpaid carers roles.

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

People were signposted to the 'Live Well York' website or referred to voluntary, charity or health services to meet non-eligible care and support needs. This mostly took place at initial contact with the local authority through self-assessment, online, telephone or a professional's referral.

The local authority also had a corporate Local Area Coordination Team to help people to access community services and build their support networks. People were encouraged to make first connections themselves, but they could also receive requests from adult social care staff to start a discussion about the support they could provide. The team engaged in research exploring the effectiveness of preventative support including neighbourhood networking within place-based hubs. This research highlighted how the Local Area Coordination (LAC) model enabled connections between people, communities and services through a non-hierarchal and relational approach which helped to build trust between services and people. The LAC played a key role in early intervention and supporting people with non-eligible needs under the Care Act 2014. However, people could also have support from LAC if they had established needs. Staff spoke positively about the role of Local Area Coordinators particularly the support they could provide for people deemed ineligible for housing support as they had close working relationships and were able to advocate for the support they needed. LACs also linked people to their local communities specific to the persons preferences. They worked with local charities, food banks, health social prescribers and police in relation to community safety to signpost and ensure people were connected to the right services at the right time. There was no criteria and no time limit to the length of time people could be supported by LAC. However, staff and people told us there was a need for more roles due to some geographical areas not being covered and a lack of flexibility in matching with some peoples specific needs.

Eligibility decisions for care and support

Most people and unpaid carers told us they did not have a copy of their assessment or care and support plan. This meant eligibility decisions for care and support and outcomes were not clear. There was general digital information on the local authority website, however for people who did not use the internet there was a risk they may not understand nor seek clarity around decisions about their eligibility for care and support. For example, a person and their unpaid carer told us alongside formal home care support, they had asked for shopping support. The person was willing to pay for shopping support additionally if that was needed, however they were told this was not something the local authority could help with. They were not provided with any additional information and advice, and they did not receive a copy of their care and support plan. The unpaid carer had not been identified by the local authority during the discussion and felt they had no choice but to continue with the shopping support they were providing. They were aware they could call the local authority in an emergency but did not know the telephone number or what options there were to support carers in an emergency or planned event. In contrast, another person told us how they were supported to prepare meals, attend the gym and carry out household chores. This showed some inequity in some people’s experiences of advice, support and decisions about their care and support.

Senior leaders told us appeals were monitored and responded to informally and formally depending on the stage and criteria. The local authority received 27 adult social care complaints during 2024. These were identified into broad categories; disagree with policy, disagree with assessment, inappropriate action, lack of action, and quality of communication with some individual learning recorded. There was more for the local authority to do to evidence assurances that people understood and were supported to appeal eligibility decisions and evidence any strategic outcomes and learning that was having a positive impact. Senior leaders told us they encouraged staff to work with people and their unpaid carers to resolve any issues at the earliest possible point, and to jointly agree on the persons care and support plan. We were told if the person remained unhappy with the outcome and an agreement could not be reached, this could be managed through the local authority’s corporate complaints processes.

Financial assessment and charging policy for care and support

People gave mixed feedback about the effectiveness of the local authority's processes for assessing and charging adults for care and support. Some people were unhappy about delays around decision making and poor communication of the contributions they needed to pay, with some being charged incorrectly and needing to be resolved through formal complaints. Whereas some people told us about the ease of the process and described it as timely, clear, transparent and consistently applied. Partners told us the local authority could do more to support people's understanding around financial assessments. For example, discussions about contributions could be left to care providers when people had not had this clearly explained to them. Another partner told us how people received letters and invoices without explanation. The charging information policy was available in a booklet; however, it was not available in an easy read version.

The local authority had public information posted on their website providing some information about paying for care and support, financial contributions and options to request a financial assessment. However, the information was limited, and people could not understand their contributions without delay. Senior leaders aspired to offer an online financial assessment tool to allow people to work out their potential contribution in a timelier way, but this had not been implemented at the time of the CQC assessment. In June 2025, 266 people were waiting for a financial assessment. This increased from 160 people waiting in May 2024 reaching the highest number of people waiting in March 2025 (298) and then seeing a slight decrease. People had a median waiting time of 54 days which had steadily increased and a maximum waiting time of 416 days which had more than doubled since August 2024 (192). The highest maximum wait time in the previous 8 months was 487 days in June 2024. Senior leaders told us delays were caused by challenges in determining financial contributions due to people's individual and additional needs, and staff shortages.

Provision of independent advocacy

Where someone could not fully take part in conversation about their needs for care and support and they had no one to help them, the local authority had access to a commissioned advocacy service to support the person’s involvement in their assessment and plans. Partners told us there was close working relationships across the local authority at board level and with all teams within adult social care. There were quarterly meetings to bring concerns, themes and trends, and the 'voice’ of the person within monitoring based on performance and outcomes including through peoples feedback and case studies. People shared their experiences with feedback such as ‘you made such a difference’, ‘you helped me understand what the care plans said’, ‘this really helped me, you listen to me’, ‘no one would have listened without your help’, and ‘this could change my life’ demonstrating the positive impact advocacy support had on them.

Partners told us the local authority’s senior leaders welcomed challenge on people’s behalf and provided timely and thorough responses. There was an advocacy hub, older citizens advocacy, and a self-advocacy forum in York which focused on issues-based discussions, relationship building, and engaging activities. People, senior leaders and partners told us forum members had contributed to several consultations, including adult social care developments such as direct payments. There were also funded plans to develop a Parental Advocacy Peer Support group, specifically for parents with learning disabilities.

Between January 2025 and April 2025 146 people were said to have had their rights upheld through independent advocacy and the average wait time for advocacy depending on the need and prioritisation, was within 2 days for Care Act advocacy support, including safeguarding advocacy, and up to 10 weeks for people needing a Relevant Person's Representative (RPR) within Deprivation of Liberty Safeguards processes to ensure people’s rights were protected and that they were involved in decisions about their care However, advocacy referrals had reduced compared with previous years, particularly Care Act advocacy, and there was a concern that people due a review of their care were not being supported by advocacy due to adult social care staff shortages. There was also a need to improve timeliness of advocacy referrals, with partners telling us how people’s needs increased and require more support the longer they were not supported. Staff, partners and people with care and support needs told us out of area advocacy was also an area of concern. Staff and partners confirmed there were processes to overcome these issues with agreements to ‘spot purchase’ advocacy for people being supported out of area. Some staff commented that they didn’t use advocacy regularly. There was more to do to ensure the local authority was referring all people who needed independent advocacy and ensure staff had the support, training and oversight to fully embrace the benefit of people participating fully in assessment, review and planning processes.

Supporting people to live healthier lives

Score: 2

2 - Evidence shows some shortfalls

What people expect

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

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

The local authority commitment

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

Key findings for this quality statement

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

There was mixed feedback from people and unpaid carers about the local authority's arrangements to prevent, delay or reduce needs for care and support. For example, one person told us delays in responding and lack of follow up had resulted in an unpaid carer feeling overwhelmed with their role and as a result were unable to maintain hobbies which had a negative impact on their physical and mental wellbeing. A group of people representing people with lived experience told us they had raised concerns about not having enough investment in preventative services without a satisfactory response from the local authority. In contrast, a person told us they had received great support including food vouchers, a grant for a freezer and practical community links which led to an increase in their confidence, and they were now independently carrying out all their shopping. National data supported this mixed feedback, showing 50.00% of people reported that they had as much social contact as they wanted with people they like, which was somewhat better than the England average (45.56%, NHS Digital 2023- 2024).

Local Area Coordinators (LACs) played an important role within the communities of York to signpost people to appropriate services and connect them with the right resources to manage their health and wellbeing. Staff, senior leaders and people told us about the benefit of people working with local area coordinators. This approach helped people receive the right support at the right time and encouraged conversations about what a good life looked like for people. LACs built professional relationships with people to identify a person's hopes for the future and then supported them to achieve their own goals. LAC support extended from sustaining housing tenancies, to reducing isolation. For example, one older person’s story highlighted how a trusted relationship with a LAC led to reduced isolation and improved mental health through engagement with community services and health trainers, as well as lifestyle changes like quitting smoking and regular gym attendance and a strong sense of regained control and improved quality of life. Staff, partners and people told us there was a need to expand the role across all geographical areas in the City of York, and gave examples of staff changes, geographic boundaries and digital sharing of information restrictions having an inequitable response to all people’s needs. Again, national data supported the mixed feedback showing 55.05% of people who said help and support helped them think and feel better about themselves which was worse than the England average (62.48%, NHS digital 2023-2024). There was more to do to further embed the support across adult social care and to focus more on supporting people with their social care needs. Senior leaders identified a need to further develop ‘front door’ preventative approaches and processes to ensure adult social care was ‘everyone’s business’ in the local authority. However, at the time of CQC assessment there were delays in this being progressed. There were clear examples of output from the LAC preventative work, but further work was needed to evidence strategic impact and outcomes for people at risk of developing or increasing adult social care needs. The local authority had gathered some feedback from people who had been supported by LACs showing 93% of people felt they achieved their goals, 89% felt more able to manage their health and wellbeing and 86% said they wouldn’t have made the changes without the support.

Early intervention linked with the Health and Wellbeing Strategy, however, there was no clear, co-produced prevention policy, strategy or delivery plan informed by local data and aligned with strategies and priorities of local partners. National data showed there was more to do as 60.11% of people who had received short term support and no longer required support was significantly worse than the England average (79.39%). Whilst the local authority was working on an Adult Social Care Strategy to bring together frontline practice and expectations to promote a prevent, reduce and delay approach, there were pockets of developments and community projects making a difference. For example, people told us about the local authority supporting a national charity to develop a 'Slipper social', this was an initiative to give out free slippers to reduce unnecessary falls based on evidence and was said to be very successful in attendance. There was an occupational therapy led Falls Team within the local authority which focused on home safety and mobility, but more to do to embed a standardised screening tool to measure preventative impact.

The local authority gave specific consideration to people at greatest risk of a decline in their independence and wellbeing. There was specific development for some groups of people in their local communities, such as mental health hubs and a frailty hub designed with people and partners to connect people to services to enhance early intervention and strengthen people's support networks. There were some challenges in delivery such as gaps in workforce but a clear enthusiasm to make the changes to the way the local authority and partners delivered these services to improve outcomes for people.

People with experiences of dementia had been involved in the development of the Dementia Strategy, and there was a sense of pride around the work taking place including the support for people waiting for diagnosis and to enable people to live independently. However, partners told us, whilst there was direct dementia support to people affected by dementia in the local authority, there was still more to do to improve education and the support that was available for people. A partner told us people living with dementia often experienced crisis before they are accessing any form of support, and many people were only accessing support towards the end of their life. They felt the local authority needed to focus more on the progressive nature of dementia including within strategy. There was a funded dementia advisor and trained volunteers, but adult social care assessors needed to further consider the impact and support that could be offered within communities and the voluntary and charity sector to enable people to continue to live within their homes and community. The local authority aspired to create a framework for dementia training to ensure all staff receive training relevant to their role so that the workforce had the right skills, behaviours and values, and build a sustainable network of peer-led groups across the York area.

There were poorer health outcomes in the City of York for people with needs relating to their drug and, or alcohol use, partners told us service and community models were designed with this in mind. We heard about joint work with the local authority housing team around supported housing within a housing first model. This was based on the belief that everyone has a right to a safe and stable home, and that stable housing is a fundamental need to address other challenges they may be facing such as mental health needs and substance use. Senior leaders told us how this approach supported a shift led by the Rough Sleepers Strategy, from hostels to independent living, and a focus on prevention before crisis management. The local authority used a Homeless Prevention Grant to fund navigators and housing-related support roles to link directly with people at risk of homelessness and work with them to take up opportunities on offer. Senior leaders told us adult social care was committed and supportive of the housing approach and services and this was an integral part in developing strategy. The local authority was also working towards DAHA accreditation which is the Domestic Abuse Housing Alliance. Local authorities with and without housing stock can be accredited to ensure they deliver safe and effective responses to domestic abuse. The accreditation is the UK benchmark for how housing providers should respond to domestic abuse to which the local authority demonstrated a commitment to supporting victims and survivors of domestic abuse.

Provision and impact of intermediate care and reablement services

The local authority commissioned a private home care provider for reablement support in people's homes and had an inhouse extra care housing offer with 10 flats for people requiring 24-hour intermediate care support with occupational therapy (OT) input from the local authority OT team. There were also health services to support intermediate care offers, such as the Community Response Team, which was clinical health support and York Integrated Care Team (YICT) which had a more holistic approach to ensure concerns identified were addressed early to prevent crisis situations including readmission into hospital or care homes where avoidable.

From a hospital discharge perspective, national data showed 1.91% of people aged 65 and over received reablement and, or rehabilitation services after discharge from hospital which was somewhat worse than the England average (3.00%, NHS Digital 2023-2024). The local authority's brokerage team attended discharge meetings to assess reablement readiness, this had initially been a pilot but was extended due to its success.

There was more to do to ensure services were equitable and consistently offered to ensure more people accessed support to enable them to return to their optimal independence. Some staff told us not all people could access reablement support including people who self-funded their own care, people reaching the end of their lives but not rapidly deteriorating, and people with mental health needs including those affected temporarily by delirium following a stay in hospital. Some staff felt the reablement offer was lacking for people with mental health needs, concerns included no offer to promote practical skills for people such as meal preparation including nutritional advice and support, examples given were the current reablement offer could 'only warm up microwave meals' highlighting a specialist reablement offer for people was needed. Some staff said this put them off referring people for reablement as the service was not suitable. In contrast, other staff told us reablement was an 'amazing resource' and gave examples of people with established needs becoming independent, avoiding the need to be supported by longer term formal services.

National data showed, of those people who did access reablement or intermediate care support 92.59% of people aged 65 and over were still at home 91 days after discharge from hospital. This showed the effectiveness of the support when people were able to access it and was somewhat better than the England average (83.70%, NHS Digital). Staff in the local authority's Intensive Support Service Team monitored people's progress during reablement, while the Discharge to Assess Team reviewed the progress of individuals who had moved from hospital to a care home. Staff and partners told us that more work was needed to demonstrate the positive impact of current systems on people's experiences. For example, there was no consistent approach to setting and reviewing personalised goals, which raised concerns about people potentially becoming dependent on services or being charged for care that had not been reviewed in a timely manner.

Senior leaders wanted to improve prevention advice and offers for all people at risk of, or with care and support needs in York. There had been workshops with the acute physical health hospital trust to develop discharge to assess hospital pathways particularly to further promote more people returning home opposed to transferring to care homes from hospital. They were also exploring with the provider market, additional intermediate care to increase the number of people with a higher level of need who could be supported to return home following a period of 24-hour support. There were plans to move towards a shared care record to avoid duplication with health partners and support services to be more seamless for people and their unpaid carers. However, it was too early to understand any positive impacts on people at the time of the CQC assessment.

Access to equipment and home adaptations

There was mixed feedback from people about assessment and provision of equipment. Occupational Therapists (OTs) and those working within the therapy led teams were praised for their respectful and person-centred approach, people said they were treated with dignity and that OTs took the time to listen to their views, understand their circumstances, and explore their strengths and personal goals. The Be Independent Team (internal equipment and telecare) worked with the Falls Prevention Team. Staff told us there was good collaboration between internal housing, learning disability services, reablement, hospital discharge and review teams which promoted a 'team around the person' approach. A wide range of equipment such as level access showers, stair lifts, walking frames, grab rails, falls pendants, and key safes were provided to people with, or at risk of care and support needs which promoted their independence and quality of life. For example, one person told us about a device that allowed them to open their door remotely, reducing risks to them associated with physically getting up to answer the door.

However, several areas for improvement were identified particularly the need to provide accurate timeframes for people who were waiting for assessment or equipment. For example, a significant delay in the provision of equipment resulted in an extended hospital stay, which resulted in a negative impact on a person's wellbeing and showed a need for improved partnership working to benefit people's own outcomes. In June 2025, 96 people were waiting for an occupational therapy assessment. People had a median waiting time of 76 days and a maximum waiting time of 334 days. The highest maximum wait time in the previous 12 months had been 397 days in September 2024. Staff and managers used performance reports showing allocations and waiting lists compared to set timescales. Priority 1 was urgent moving and handling assessments, supporting hospital discharge and people identified at high risk. Senior leaders told us all priority 1 cases met the target of 48-hour response. However, priority 2 and 3 which included identified risk but being managed were overdue up to 17 weeks compared to targets set (between 2-12 weeks). Managers led on overseeing waiting lists and used 'off system' spreadsheets to monitor risk and prioritise allocations. In feedback collected by the local authority people reported knowing who to contact if their needs changed, or if they required further advice. However, there was more to do to ensure senior leaders had strategic assurance particularly around those people who may not identify a change in need. Partners representing people told us delays in assessment and, or equipment could put people at risk and referred to escalating situations that had led to the need to make safeguarding referrals.

In June 2025, there were 302 orders of equipment for people waiting to be delivered which had slightly reduced since December 2024, with a median waiting time of 5 days and the maximum waiting time of 33 days. The highest maximum wait time in the previous 12 months had been 214 days in February 2024. Targets were set at 1, 2 or 5 days depending on the item and urgency. Most people received their equipment within set targets and senior leaders told us delays in access to the property, and items not in stock were reasons people waited longer. Staff and senior leaders told us about fragmented contract arrangements for equipment providers with some future partnership solutions to improve this. However, at the time of the CQC assessment this had not progressed.

Accessibility gaps were also noted. The local authority commissioned a private provider to complete sensory assessments and maintain the sight loss register on behalf of the local authority, however there were waits for this specialist support and the specialist knowledge was not always incorporated into people's wider care and support planning. For example, an older person who was registered blind and had significant hearing loss lacked alert systems for doorbells and smoke alarms to support their independence, particularly at night when hearing aids were removed. They and their unpaid carer identified this as a safety risk, and the Care Quality Commission (CQC) recommended a review of the equipment in place to ensure the person's needs were adequately met. Senior leaders responded to the concern and confirmed current equipment in place would alert the telecare system rather than the person themselves, however the person was not aware of this and on review of their needs their usual home care provider, specialist sensory provider and preferred people (unpaid carers) they would like at their review had not been invited to ensure care and support was joined up and equipment in place was effective for the person's needs.

There was more to do to embed innovative approaches around assessment and provision of equipment. For example, one person reported that a cloud-based virtual assistant device did not meet their expectations, which contributed to feelings of loneliness and isolation. There was a need to ensure that technology solutions were tailored to individual needs and preferences. Senior leaders and staff told us they did not have a defined vision of 'what good looked like' nor how current practices aligned with Care Act duties within a strategic framework. They told us there had been workforce gaps and changes resulting in some low staff morale and fragmented practice due to lack of physical base, stable management, and funding. Some of the challenges had meant reviews for equipment had been missed, however there were leaflets to mitigate some risks in relation to this. Staff told us there was OT practitioner led support through drop-in sessions, training, and resource links to research and best practice. Senior leaders had plans to improve digital and technology services further focusing on prevention, self-help, and online support.

Provision of accessible information and advice

In the City of York 68.10% of people who used services and 61.19% of carers found it easy to find information about support. This was similar to the England average (67.12%, and 59.06% NHS Digital 2023-2024). National data also showed 84.85% of carers found information and advice helpful which was similar to the England average (85.22%, NHS Digital 2023-2024).

People and unpaid carers could access information and advice in person, by phone and online. However, some people told us accessing information and advice in person or by the phone could be challenging and the online options were not always up to date and could be difficult to navigate and understand. The local authority addressed inequity around digital exclusion through their ‘Digital Friendly York’ partnership and strategy. The partnership of organisations supported people in York to get online and learn skills using the internet and its benefits. People could be offered reused devices and learning free of charge. The ’Live Well York’ website included a digital service directory providing details of; voluntary and charity sector offers, local authority and health services, and care home, homecare and micro-providers in York. Filters were available to narrow down the options available with over 850 listed. Senior leaders told us the website was monitored and showed in 2024 the site was used over 43,000 times and had a feedback quality rating of 84% satisfaction. Be Independent was another online platform which offered people a ‘one stop shop’ space with access to Adult Social care referrals, getting help with meal preparation, adapting their homes, managing their money, adaptations, information on supported living, fall prevention and occupational therapy. This platform offered people services and referral pathways independently without the need to go through adult social care to access these services.

People could also be given support and advice by their allocated workers. A person told us they were given advice and information from local authority staff around staying well by utilising small aids that met person's needs and to understand what they were entitled to around benefits, adaptations and financial assistance. Another person told us they had information and advice to maintain their independence around completing essential forms. They said the support provided was explained in a way they could understand, although it did take a few months to be allocated the worker who provided the help. In contrast another person told us they had asked their allocated worker for advice and information about maintenance of their home but felt ignored and did not get the information they needed. Staff used the ‘Live Well York’ website when working with people, however, they told us there was a gap since a dedicated coordinator post had been lost. This had been jointly funded with a wealth of information and shared responsibility which they told us now had a negative impact on the quality of the website. Staff were also aware of a leaflet for people who could not access the website but there was no easy-read option, and easy-read options for information and advice was lacking but an area the local authority was working on to improve.

Direct payments

There was more to do to break down barriers around accessing and utilising direct payments. The local authority did not have direct payment specialists, all social workers carried out this function. There was negative feedback from people about the uptake of direct payments. For example, a person told us they had poor access to information, advice and support to use direct payments which had caused them distress and had a negative impact on their wellbeing. They said, 'there is no clear information about what I can spend direct payments on, I have done research on other local authorities to understand this myself'. The person wanted clear boundaries for what they could use the direct payment for to reduce some of the administration involved and help them feel more in control of their decisions. They said there was no leaflet they were aware of, and the local authority had not contacted them to consult around any improvements needed. Another person told us direct payments were required to be used for some services, for example where a person needed transport to access services, this could only be arranged through direct payment. The person had a learning disability and needed support with quality issues around the taxi service, but they were told the local authority could not support with this as it was a direct payment and not a contracted service with them. Another person told us there was a disability bus pass, but these had a waiting list and not everyone with disabilities knew about the bus pass or support they could get for transport in the city.

Staff, people and partners consistently told us direct payments were not well understood in York and people found them confusing. This meant some staff avoided offering direct payments. However, when people did access them, we were told of the benefits this could have. For example, a person told us their direct payment was being used to improve their control for how their care and support needs were met, covering a broad range of support including a mix of traditional personal assistance support, advocacy and more flexible means of accessing the community and improving their wellbeing. The overall mixed feedback was supported by national data, as the percentage of people aged 18-64 who received direct payments (42.04%) was somewhat better than the England average (37.12%). However, 9.01% of people aged 65 and over received direct payments, which was somewhat worse than the England average (14.32%, NHS Digital 2023-2025).

Between February 2024 to January 2025, 48 people had regular direct payments stopped, this did not include people who had died. This was approximately 17%, compared to 14% of new direct payments, meaning there was a decrease in the number of direct payments over 12 months. Senior leaders told us direct payment numbers in York were steadily decreasing and there was more to do to ensure flexible and creative use of direct payments. Most people moved to commissioned services. Whilst senior leaders told us the reasons for this were not yet fully understood, they said approximately 30% of people who moved from direct payments to home care did so due to safeguarding concerns and, or changes in their mental capacity which resulted in breakdowns in arrangements with personal assistants or micro providers. Senior leaders told us this was particularly concerning when people of working age with physical disabilities moved into a care home from a direct payment. This work was being overseen by the adult social care ambition board and improvement plan. The aim was to increase numbers of people in receipt of direct payments and address reasons why people end use of direct payments. This included improving transitions with children's services and health, supporting people with mental capacity changes, and sharing positive examples through increased training for staff and people to promote the use of direct payments, including within supported living and care home settings in which there were currently none. Senior leaders told us there had been several skills sessions and regular direct payment clinics held for staff to support them with direct payments and new practice guidance. However, there was no evidence of this effectively being embedded in practice at the time of the CQC assessment to positively impact people in York. The ongoing work was being coproduced with people who use services to improve people's satisfaction and fully address people's concerns and barriers to accessing direct payments.

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

Senior leaders, people and partners from the charity and voluntary sector told us about the demographics of York. York was described as having both ‘extreme wealth and extreme poverty’. A partner told us this ‘could create a false picture and make some people less visible’. We heard about fear of safety in some areas, digital exclusion, loneliness and isolation. The local authority had Joint Strategic Needs Assessment (JSNA) data identifying life expectancy in York had declined for males at below national average and there was a gap of over 10 years (for both males and females) between the least and the most deprived areas in York. Health outcomes were lower than expected. There was a growing and aging population, and approximately 10,000 people in York lived in 20% of the most deprived areas in England.

In terms of seldom heard groups, voluntary and charity partners told us in York there were refugees and asylum seekers, LGBTQIA+ people, autistic people, people with learning disabilities, people living with dementia, unpaid carers, gypsy and, or traveller communities, people with drug and, or alcohol related needs, Nigerian and Polish nationalities. LGBTQIA+ stands for lesbian, gay, bisexual, transgender, queer (or sometimes questioning), intersex, asexual, and other sexual identities. Intersectionality is a term that can be used to describe how race, class, gender and other personal characteristics 'intersect' and overlap. People told us the local authority had more to do to understand the experiences and specific needs of people from seldom heard communities. For example, people who were transgender with a diagnosis of autism and, or mental health needs. Staff had limited confidence and understanding of their local communities and wider themes that negatively impacted people who were most likely to experience inequality.

Most people from seldom heard groups told us they didn't feel listened to, and the local authority did not engage with them in ways that worked for them, this resulted in issues such as stigmatisation and a need to 'change culture', 'peoples attitudes' and 'people to be accepted for who they are' which people told us was not being addressed effectively. For example, a group of people from the LGBTQIA+ community and people with learning disabilities were 'worried' and 'feared' the lack of understanding in York. We heard about individual action from people within forums such as the York LGBT Forum exploring what it meant to be an older LGBTQIA+ person fearing and facing, living and dying with dementia and LGBTQIA+ people 'closeted' and living in care homes, and an interfaith group to improve LGBTQIA+ rights in York. People told us a large care home provider in York had successfully initiated LGBT resident meetings where nationally people living in care homes could talk to each other, share stories, support each other and bring back shared strategies back to their own care home to promote openness. They told us the local authority used to offer training, but this had stopped, and they believed it was a gap that needed to be filled.

The local authority funded a self-advocacy forum, however senior leaders recognised this did not represent all people and they wanted to see greater diversity in the forums. Partners told us the local authority had significantly improved engagement with seldom heard groups like people who were homeless, travellers and the LGBTQIA+ community. However, they saw gaps for some people accessing adult social care such as underdeveloped engagement and support for people who were deaf and people who were neurodiverse. Whilst there were specialist adult social care teams for people with learning disabilities and people with primary mental health needs, staff and partners told us workforce pressures and longer waits for assessment and support could negatively impact people with specific needs. For example, one autistic person told us they had a mixed experience of care and support in the local authority. Previously, they had been supported by staff within the specific learning disabilities team, which in their opinion had the wrong skills and as a result did not meet their needs, which negatively impacted their wellbeing. In contrast, the person told us the most recent staff that supported them had 'the right values, they don’t need to have specific training just an openness to listen and a non-judgmental approach, that is a massive thing [persons allocated worker] works together and I respect that'. They told us the staff approach had made a positive difference to their experience, describing them as 'new school' and 'a breath of fresh air', opposed to experiences they had previously, they said 'she has got the heart, its empathy'.

In 2017 the City of York became the first Human Rights City in the United Kingdom, a vision senior leaders were proud of, putting fundamental rights at the heart of the local authority’s policies and aspirations. The local authority had regard to its Public Sector Equality Duty (Equality Act 2010) with a Human Rights and Equalities Board that worked across Adult Social Care and Housing. There was a council wide equalities group with equality impact assessments were completed prior to recommissioning services. There was also an ambition to become ‘a nonracist’ council by 2030, there had been leadership events, signing of an anti-racist pledge. The local authority had a Resident Engagement Strategy which was developed to support a council-wide approach (named 'Our Big Conversation') to coproduction with local people to shape the plan. The strategy set out the need to collect data about people taking part in engagement activities, and analysis to identify gaps in representation and ensure inclusive and diverse engagement. There was a commissioned piece of work from an equal rights charity to develop a five-year Anti-Racism and Inclusion Strategy and action plan to support implementation and monitor progress within strategic boards. There was a focus on allyship, and anti-racism based on research to improve recruitment and engage workforce. Staff told us that the local authority was a supportive and inclusive environment and felt they could be themselves at work. Some anti racism training had been delivered with more in progress, and Equality, Diversity and Inclusion (EDI) champions were being explored. One senior leader told us ‘EDI is a baton we all carry.’ Another told us ‘we put people at the heart of what we do, and our philosophy is making things person centred, doing right by people.’

Some senior leaders and partners told us the local authority used a data-driven approach to understand local needs and inequalities. A senior leader told us they standardised methods to record protected characteristics across children's social care, adults social care, human resources, education and commissioning. This gave senior leaders confidence in the data quality they held. An example was the local authority's ability to see recruitment versus population demographics, and this was reported into corporate diversity and equality groups. Senior leaders demonstrated live system information available at ward level this demonstrated how adult social care performance and data information was seen alongside protected characteristics data. Senior leaders told us data sharing between public health and adult social care was transparent. There was more to do around using data on peoples protected characteristics within commissioning which would support use of data on service uptake among different demographic groups.

There was more to do to evidence any positive impact and outcomes for people with care and support needs in relation to its delivery of its Care Act functions. Senior leaders spoke passionately and confidently about their commitment to implement a social model of disability recognising disability is something that is created by an inaccessible society. Allyship is an active, ongoing commitment to support equity, inclusion, and justice. It's about doing the work, not just saying the words. There were aspirations to reduce barriers for people with disabilities when accessing services with plans to provide Disability Equality Training to staff over the next 12 months. An interim senior leader within adult social care was leading on allyship, anti-racist practice and poverty truth impact work in the absence of the vacant assistant director post. There was also a new adult social care practice model which focused on equality issues but in the absence of a Principal Social Worker it was recognised there was more to do to embed all the work in progress within frontline teams. Most staff could not confidently name their seldom heard groups in York; some told us processes to support them working with people from diverse communities didn't exist and that understanding and reducing barriers to care and support and reducing inequalities was not something that was discussed. We found staff were not sure what additional support was available nor how people's protected characteristics were recognised and understood. Some staff felt frustrated that mandatory training focused on subjects they didn't feel was relevant to their role and told us protected time for training around cultural competence would be beneficial. This would aim to empower staff to effectively and respectfully work with individuals and communities from diverse cultural backgrounds. At the time of the CQC assessment health and social inequalities were not incorporated into operational practice, intersectionality of peoples protected characteristics were not always understood and there was no evidence that any work had been embedded in people's care and support to make a positive difference to people's experiences.

Inclusion and accessibility arrangements

People with sensory needs, people with learning disabilities and autistic people told us their preferred inclusion and accessibility arrangements were not always followed. Staff told us there was no digitally accessible formats nor easy read options for peoples care and support plans. One person told us the local authority did not provide them with information in a format that they were able to understand and as a result they did not understand their care and support. Another person told us they did not have a copy of their assessment or support plan and had not had the support to carry out the assessment they would have wanted if they had notice to plan. People told us there was more to do to include people who were not able to access online services, recognising some general information in easy read and audio was available but online only and they did not know where to access physical copies. Another had used resources on the webpage but had not always found everything they needed. A senior leader told us one local area coordinator (LAC) was trained in changing things into easy read but not all staff within adult social care were aware of this. LACs could be a link for people to access information in ways that worked for them. People could find their local area coordinator if the area they lived in had this support via business cards on community notice boards with details of different LACs and the ward they cover alongside their picture.

There was a Digital Friendly York Strategy which considered use of the internet and ‘digital exclusion.’ One partner told us the local authority had a focus on combatting digital exclusion and they had received increased levels of funding to increase people’s accessibility to second-hand technology devices. However, one group of people told us hard copy information was not always available, and it was really important to them to have telephone numbers to ring to feel included and access the local authority.

Staff and people told us people and unpaid carers could come to the reception desk at the local authority offices and a duty or named worker could come and speak to them. However, the building did not have a lay out that was supportive of autistic people’s needs such as not having a quiet private room to speak to reception staff and being told to wear a lanyard around the neck despite offering to carry it instead.

There were interpreter services so that staff could refer people to engage with their assessments and interventions provided through the local authority in ways that worked for them. Staff gave mixed feedback about the arrangements, some told us it was quick and easy to access, and others told us there was a lack of suitable language translation services.

Specialist aids and equipment to support the independence of people who had sight loss, hearing loss or dual loss could be provided to people following an assessment by a commissioned service separate to a person's care act assessment or review. Partners, staff and people told us there were challenges with this including delays in assessment criteria was not always clear and support and care planning was not joined up. There were options for British Sign Language (BSL) support for people's assessments, however staff told us care support was more difficult. For example, one staff told us a person was not able to have BSL care workers but was able to have a BSL worker who was occasionally contracted to ensure effective communication between the local authority, care provider and the person. The local authority had gathered some peoples experiences with sensory support needs and found a need for better promotion of sensory support services to ensure they reach out to all people. Some people with a sensory impairment were not aware of the range of support available or how they could access or use it. Therefore, there was a need for flexible and improved ways of communicating, options to visit services, better access to interpreter services and BSL learning, and the ability to access services when they needed them rather than having to wait.

People told us in terms of involvement with senior leaders, in general they usually worked to meet with existing groups and their advocates at places and times to suit and offered accessibility such as language and BSL translators where applicable. However, one example was given around accessibility for people with learning disabilities who were invited to engage via a questionnaire that they said was not easy to understand due to confusing language. People felt that this particular consultation exercise by the commissioning team was not effectively accessible. In response to this, learning was applied, and a sensory commissioning survey was shaping a new contract. Staff had made this as accessible and inclusive as possible utilising audio CD, braille, and easy read depending on each persons preferred way of communication.

For those people that preferred information was available online and people could text, or email to refer to or contact the local authority. Staff and people told us this was helpful particularly for autistic people who may not prefer to speak over the phone.

Senior leaders valued the voice of people within their improvement work and told us about continued work through co-production, to ensure that the City of York local authority is an inclusive organisation.

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: 1

1- Evidence shows significant shortfalls

What people expect

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

The local authority commitment

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

Key findings for this quality statement

Understanding local needs for care and support

The local authority used data from their Joint Strategic Needs Analysis (JSNA) and from data collected by hospitals and surveys that fed into strategies to understand the care and support needs of people and communities. The 'Our City Health Narrative' annual summary of the York JSNA linked to the vision set within the Health and Wellbeing Strategy, for example one of the ten goals was to reduce loneliness from 25% to 20%. The local authority aimed to become a health generating city and reduce the gap in healthy life expectancy over the next 10 years by tackling the causes of ill health in poorer communities. It set out future health predications including how population growth would impact the proportion of adults with a major illness growing by 38% by 2040, 52 people a day attending accident and emergency services, an extra 600 people per year requiring social care and an extra 1235 people per year seeking care in mental health services. They identified York had higher levels of loneliness, the need for mental health support was rising in older adults, 25% of people aged 65 were digitally excluded and 800 falls related admissions per year.

Up to 12% of adults had a mental health diagnosis of depression or anxiety conditions, and 0.8% of people had a diagnosis of a serious mental illness within some geographical areas of York. A sub-group of the Health and Wellbeing Board, the York Mental Health Partnership (YMHP) led on delivering the expired All-Age Mental Health Strategy 2018-2023. This included a community approach 'Connecting Our City', housing, and meeting additional needs. In the 2023-2025 All Age Commissioning Strategy the local authority identified a need to improve community-based offers of support so only the most appropriate people with mental ill health were supported in hospitals and care homes. A key challenge was the lack of specialist housing and support options particularly for people with multiple and, or additional needs. Senior leaders identified a need to have a Housing with Support Strategy, this had been delayed due to lack of capacity and progress was being monitored within their ambition board and plan. There was also work underway to transform a mental health resettlement project moving to a housing first model.

The proportion of the estimated number of people living with dementia (who had a diagnosis) were lower in York than regional and national rates. This did not necessarily mean there were fewer people living with dementia and did not include people who were yet to receive a diagnosis. Partners told us current strategic plans were not person centred and did not uphold people's human rights and sense of self. For example, they said the day services approach did not meet the needs of people or unpaid carers and more needed to be done in meeting people with multiple and, or additional needs. Current care home options had limited availability for specialist support, capacity and skills and had high costs relating to the self-funding market in York. York's All Age Market Position Statement (MPS) 2023-2025 showed a predicted 13% increase in the number of people living with dementia between 2023 and 2030. The local authority aimed to work alongside partners (including providers) to support the market and meet the population needs to address an insufficient capacity for dementia care, offer flexible support and ensure access to a range of affordable activities that reflect people's interests.

Falls were the largest cause of emergency admission to hospital in older adults, and a common factor that triggered a permanent move to care homes. Emergency hospital admissions for falls in York were statistically similar for people aged 65 to 79 years but higher than average in those over the age of 80. Staff told us there was a need for more capacity for overnight support to meet people's needs at home. They spoke positively about the 24-hour home care option which they had seen benefit people to remain at home and safe over a period of assessment or ill health to avoid unnecessary hospital or care home admission. The All-Age Commissioning Strategy had a focus on commissioned services preventing ill health by working on a community level to ensure a preventative approach with this being the first priority. There were aspirations to increase the effective use of equipment and technology to enable people to maximise their independence and to support the home first approach whilst preventing dependency on statutory services.

Within York over 1,500 people were registered as having a learning disability. This was 0.4% of all people compared to national estimates that suggest 2% of people in the United Kingdom had a learning disability and the local authority acknowledged potential gaps in health reporting of this. There was an expired All Age Learning Disabilities Strategy 2019-2024 which was coproduced with people with learning disabilities, carers and partners. The local authority had some specialist care homes to support people with learning disabilities and predicted the number of people with learning disabilities would increase by 3% over the next 10 years, with the 18-24 age group seeing the largest increase by 11%. The Market Position Statement set out an aim to ensure people with learning disabilities remained as independent as possible and had choice and control over how they were supported to live their lives. The transforming care programme in York aimed to ensure people with learning disabilities' needs were met as early as possible. An accommodation plan for adults with learning disabilities projected approximately 67 people would need alternative accommodation in the next five years. The local authority recognised the need for appropriate apartments and bungalows as a primary focus, whilst improving other options such as independent living programs and the provision of additional care. However, at present, staff and partners told us there was a lack of support for people with learning disabilities in their communities and criteria was constantly moving to access any support that was available.

Staff, partners and people with care and support needs told us there were some gaps in the local authority's understanding of local needs for care and support, particularly people who self-funded their own care, autistic people, people with diagnosed or undiagnosed neurodiversity, and people with visual and, or sensory impairment.

Market shaping and commissioning to meet local needs

The All-Age Commissioning Strategy 2023-2025 publicly set out the local authority’s responsibilities and how each ambition linked to the city of Yorks council plan 2023-2027 and Yorks All Age Market Position Statement 2023-2025. A key priority was to model a home first and reablement approach to focus on prevention, increase extra care and home care availability, and work towards a reduction of long term care by utilising strength based approaches. Other key priorities included improving people’s outcomes and embracing digital technology. However, there was more to do to evidence progress of strategies and ambitions to demonstrate better outcomes for people.

Senior leaders were aware of responsibilities to ensure the York care market was sustainable, diverse and high quality. The Market Position Statement (MPS) outlined how the local authority planned to achieve this, including services arranged and paid for by people who fund or arrange their own care. Senior leaders told us there was a need for value for money to cut down on costs for people now and in the future. There was a shortage of care homes with nursing including additional dementia support and 24-hour support for people under the age of 65 particularly people with a learning disability, autistic people and, or people with a brain injury.

There was consideration for the provision of services to meet the needs of unpaid carers. The expired York Carers Strategy 2019- 2024 was produced by the York Carers Strategy Group which included people, unpaid carers and partners. Research found there were around 19,000 adult carers in York (11,000 female and 8,000 male) however this figure did not include young carers, and the local authority predicted the figure to be much higher. The All-Age Commissioning Strategy 2023-2025 linked the Health and Wellbeing Strategy principles which included to recognise and promote unpaid carers roles in York. The local authority set out commissioning aspirations to work with unpaid carers to design services that focused on outcomes, rather than outputs. The MPS encouraged commissioners, people with care and support needs, carers and partners to work together to explain what care services and support was needed and why. The local authority aimed for carers support services to reach out to isolated and hidden carers, support carers to manage caring for someone and lead a good quality of life. It committed to supporting carers to maintain their own health and wellbeing and to feel confident in their caring role. In York 9.68% of carers accessed support or services which allowed them to take a break from caring at short notice or in an emergency, this was similar to the England average (12.08%). However, 13.98% of carers who accessed support or services allowing them to take a break from caring for 1- 24hrs was somewhat worse than the England average (21.73%, NHS Digital 2023-2024). This suggested the strategy had not met its ambitions. Partners and staff told us the gaps in providing short-term breaks for unpaid carers was a concern and meant unpaid carers and people's needs were not always met. There was internal provider services run by the local authority such as a community offer at Majorie Waite Court for people with dementia and, or over the age of 60 and Flaxman which provided short stays for people with learning disabilities. The local authority carried out a survey with unpaid carers which received negative feedback due to the limited replacement care options and, or lack of availability. In response to this the local authority recognised the challenges carers faced and were exploring alternative short break models.

There were gaps in market shaping and partners told us there was no strategic engagement with providers and commissioning staff capacity was stretched. However senior leaders told us they were addressing this through the new provider forum, and increased provider visits to listen to what they can do to meet needs and challenges. This did not include the voluntary and charity sector which partners told us negatively affected planning and integration of services. There had also been delays or changes due to leadership roles and restructures such as some gaps within the commissioning, contract monitoring, brokerage and quality roles during an active restructuring of the workforce. At the time of the CQC assessment there was a newly appointed and jointly funded (with the Integrated Care Board) assistant director of commissioning, and ongoing discussions to improve the workforce particularly to share and grow skills within the teams.

Senior leaders told us there was learning around the benefit of coproduction and gave an example of a shifted mindset for how they commissioned and around being more provider led. For example, 1 year ago they went to market for discharge to assess beds and no providers bid so commissioning went to providers and asked what stopped them bidding and a lot said the specification was not flexible enough and the key performance indicators were not achievable. This led to the local authority and ICB commissioners working with providers to re-draft the specification and build in more flexibility. Although the local authority had missed an opportunity the first time around, when they did work with providers it resulted in a contract now being successful.

The York Integrated Community Model Joint Delivery Board was newly established. The objective of this group was to provide oversight of the design and delivery of York's integrated community model. There had been one meeting at the time of the CQC assessment, but senior leaders told us the joint delivery board would monitor and steer the direction of travel of the integrated community model to nurture the evolution of a multi-agency approach, enabling joint planning, decision-making, and policy development across the York health and social care system. It was the intention for a clinical governance group formed of members from acute and community services to report into this board. This would bring health and care commissioners together in York to optimise outcomes and the health of the York population, by making the best quality spending decisions. The intention was to work to improve poor funding decisions in the system and reduce duplication of resource use, unclear commissioning outcomes, lack of prioritisation, and gaps in unmet population health need.

Ensuring sufficient capacity in local services to meet demand

There were gaps in supported living, specialist dementia care, mental health support and carer break options. Partners consistently told us there was not sufficient range of provision of services in the area to meet people’s needs, which were said to be connected to gaps in staff capacity and a fragile workforce culture and partners said they were not aware what the local authority were doing to meet the demand. The local authority had a developing brokerage service which did not include support for people with mental health needs or support for people who self-funded their care. Partners and staff told us people experienced delays in sourcing care and agreeing services, but these were often people who self-funded and arranged their own care.

Between October 2024 and December 2024, people waited an average of 10.4 days from referral to start date for home care, an average of 12.3 days for residential care, and 14.1 days for nursing home care. In June 2025 the local authority provided additional data showing between May 2024- June 2025 people waited a median average of 10 days from referral to start date for home care, 36 days for residential care, and 33 days for nursing home care. Of those people the local authority supported, senior leaders told us people received multiple offers for home care usually on the same day requested, and the majority of offers started without delay. The offer of care home support took longer, this was said to be due to providers carrying out their own assessments, people visiting the home before deciding, correspondence around costings and waiting for funding approval. People, staff, partners and senior leaders told us there were times when demand for support outweighed availability and this impacted on people's choice and therefore increased wait times.

Senior leaders told us discharge to assess pathways reduced waits for people and the reporting of delayed transfers of care was discussed daily with daily escalation calls to discuss specific information where needed about people who could be delayed. The local authority had brokerage support within the hospital function demonstrated in the overall home care and care home data above. Staff told us there could be long waits for people due to care provision capacity, which was a source of frustration, particularly for care home options. There was local authority and health rapid response services that could provide specialist support within 2 hours as a priority to prevent and reduce hospital bed delays.

Staff told us there was a lack of supported living accommodation. In January 2025, 22 people were waiting for supported living accommodation and the average time people waited was 224 days, with a maximum wait of 730 days. By June 2025, 29 people were waiting for supported living accommodation and the average time people waited was 168 days with a maximum wait of 204 days. Senior leaders told us supported living had a longer transitional period and process to ensure a person's compatibility with other people that live in the home as well provider requirements. There was a newer resource creating 54 homes that was described as wonderful. However, parent carers needed more support and often took on advocating for properties alone. There was a project called the Cozy Home Project in which parent carers formed a coalition and a piece of land was identified owned by the local authority and consultation was taking place with the commissioning team. Staff told us how long waits negatively impacted people who wanted to move on and be independent.

Senior leaders told us there was strategic planning for future demand and they were working closely with staff and health commissioners to address capacity to meet demands relating to hospital admissions, mental health, learning disabilities, and homelessness. They also told us there were 44 additional homes coming on board for older adults and looking at how to bridge the gap for adults with complex needs. The additional mental health hubs would also bridge support needed in the community to support people to remain at home and as independent as possible. There was also development work ongoing with children's services to plan for young people who would need supported living when they transitioned to adult services.

There was a need for people to use services or support in places outside of their local area. Staff, senior leaders and some partners told us where support was being accessed from outside of the area there were actions to support the person to come back to York. However, people did not have the same awareness. For example, a person with care and support needs was accessing specialist support outside of York due to the service not being available in the area, they were not aware of any plans to provide it in the local area which was a source of frustration. Some staff told us 'we don't have placements, availability, its expensive, complex mental health we don't have it'. For example, a person placed 85 miles away from York was currently unable to return because the support they needed was not available in area. Another staff member told us about a person being supported 95 miles away due to needing specialist support. They said, 'it's getting the support as well, yes we can get property, but we need providers that are confident and trained'. Staff also told us about the challenges of when the local authority was legally responsible to fund care for a person, but they wanted to move out of area. Some staff felt funding often came before the person and placing people out of area was not the best for people as they couldn't support them as needed. They explored providers in York but often found no provider could provide the high-level needs around mental health. In January 2025 there were 201 local authority funded or partly funded people in out-of-county placements, the highest being care homes followed by supported living accommodation. 53 people were supported out of county in the last 12 months with 17 of these being temporary initial decisions. Senior leaders told us the small size of the city had an impact on availability of support but supporting people's rights to live where they wanted was a priority. Senior leaders also told us people who received joint funded support with the NHS may be required to access support outside of York to ensure any assessed additional health needs particularly relating to learning disability, autism and, or mental health who would otherwise be in, or at risk of being in hospital. When this happened, the local authority worked with the NHS via a Dynamic Support Register process to support people wherever possible to return back to York.

Ensuring quality of local services

People and unpaid carers told us about their care and support and the quality of services in York. Some people told us they had no concerns about the care they received, we heard how services supported people to remain as independent as possible and made people feel safe. In contrast, we heard how timings of care could be cut short or be unreliable, meeting peoples specific needs could be challenging and training needed to be improved. The local authority had also gathered feedback about people's experiences, in one survey almost two thirds of people were 'extremely' or 'very' satisfied with their care and support. Where there were issues, these were raised by staff with providers on behalf of the person.

The local authority had recently moved from a nationally recognised provider quality assurance tool to an internal model. Staff and partners gave mixed feedback about the effectiveness of this change, and the local authority was working on designing a new tool with providers' input. There was a drive to reduce paperwork and have more focus on the experience and feedback of people who use care services and staff who support them. This was to ensure monitoring and developments would be based on what quality means to people and the impact it was having on people and staff. Senior leaders told us this had not resulted in any gaps in monitoring the quality of services. Between September 2024 and mid-January 2025, 31 people changed providers. The local authority recorded these reasons as; people requesting to change due to dissatisfaction of the quality care; people who had a change in need including nursing or additional dementia care; people said to have 'challenging behaviour' for example due to dementia related needs; providers 'serving notice'; providers own staffing issues; the local authority ending contracts with a provider relating to safeguarding or quality concerns; where the provider could not meet times requested missing calls or were late; and 'personal choice' due to provider staff communication issues not having English as first language. Partners and staff told us in the last year there had been a breakdown of communication between the local authority and providers. There had been some staff changes which meant there was less experience within key roles to commission and then monitor the quality of care for people. A providers' forum had been reinstated and although there was more to do to support participation this was beginning to have a more positive impact. Staff and partners told us about weekly operational meetings where concerns could be raised, and solutions discussed to support timely transfers to new care providers. Professionals, including assessment staff such as social workers and Best Interest Assessors, could contact the commissioning and contract staff via a webpage to give feedback on care homes where quality related concerns did not meet safeguarding thresholds. In June 2025 the local authority told us in the past 3 months they had no people who changed providers, which evidenced some of the improvements were making a positive difference.

Staff, senior leaders and partners told us about ‘early alerter meetings’ which included the local authority, health commissioners and the Care Quality Commission (CQC). These took place every 3 months to agree multidisciplinary support and share essential information about levels of risk to prevent or reduce quality or potential safeguarding concerns within provider services that could impact people using them. Staff and partners told us attendance from social work teams was not consistent and this could have an impact on the information shared to collectively rate risks and agree next steps. Staff told us about a ‘do not place’ list that was shared with staff including those that worked out of hours to make sure people did not transfer to any providers at significant risk. Senior leaders identified the risk to people using services where the service was of insufficient quality. To mitigate this risk there was a new strategic joint commissioning forum with health partners and a new joint commissioning assistant director.

Ensuring local services are sustainable

People told us about the benefit of having stable arrangements for care and support and how this had a positive impact on their wellbeing. However, people and unpaid carers told us how the local authority’s current processes ended peoples care if they had a stay in hospital which caused distress and longer stays in hospital when some declined to change to a new provider. Senior leaders told us care was ended with an existing care provider if a hospital stay was 5 days or over. Staff and partners shared the frustration about these ‘rules’ which they said were cost and process driven opposed to promoting choice and person-centred practice.

The local authority completed a fair cost of care exercise for home care and care home providers which showed the variation was negatively impacted by the self-funding market and high costs in York. Partners told us fees were too low, but they had seen improvements in the local authority's engagement around this. In the Market Sustainability Plan it highlighted the local authority did not have a standard fee rate for home care providers again this was said to be due to the self-funding market and the fragility of local services because of the variation in costs. Individual provider request for fee increases was being facilitated by grant monies and through the council internal processes to help market sustainability at the time. However, not all providers were aware of this. Some partners told us they used to have funding from the local authority, but this stopped. Despite providers' making efforts to engage, they had not been involved in market negotiation and fees. We heard senior leaders were responsive to contact but staffing capacity was not always there. Senior leaders told us their fee uplift process was coming to an end, and staff were speaking with all providers about this. Senior leaders told us the local authority did now have a standard framework rate for home care providers.

Partners told us the local authority had a home first ethos and preventative approaches meant providers were aware there would be a need to reduce care home capacity. Larger services were said to be very expensive and the pressure on budgets needed to be addressed by commissioners. According to CQC data, July 2025 there were 80 active care provider locations and there had been 6 care provider locations that had become de-active or left the market in the last 12 months. In January 2025 the local authority had 5 providers with risks resulting in returning contracts. 4 were in York, 1 was out of area and of these 2 were care homes, 2 were home care and 1 supported living provision. Reasons for contracts being handed back included sale of property following extended period of quality concerns, ceasing operating for personal reasons, unable to recruit a registered manager and closure due to maintenance reasons following extended period of quality concerns. In June 2025 the local authority told us in the past 3 months they had no providers with failure risks or returning contracts.

Delayed contracts, re-tenders and decisions where the local authority did not keep to their own time frames was an area of concern for partners. Partners told us the local authority needed to better understand their services and the risks these issues could have around the sustainability of the service they offered. For example, a partner told us they had to escalate issues to get a response about a contract which ended on a weekend out of fear of closing the service and losing jobs. Another partner told us contracts had not been renewed or ceased in a timely manner with one lapsed over a month without resolution.

The Market Sustainability Plan identified recruitment was a risk to a sustainable market in York. Partners told us they had limited to no help towards staffing including living wage, sick pay and travel time. A partner told us contracts failed to account for increasing costs such as the National Living Wage, leading to sustainability concerns. The Local Authority had information about a wide range of courses and training programmes for registered managers of services and other managers in adult social care provider services. The courses focused on developing effective leadership skills, such as leadership through the inspection process, effective supervision and facilitating a positive work culture. Funding for training was available through the Department of Health and Social Care. A senior leader told us the local authority did work with providers to look at ‘rotas and biggest gaps.’ Therefore, there were shortfalls in how the local authority currently understood and supported its current and future workforce needs. There was more to do to work in partnership with system partners including care providers and other agencies, to develop, support and promote a joined-up workforce plan to support sustainability of local services.

Partnerships and communities

Score: 2

2 - Evidence shows some shortfalls

What people expect

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

The local authority commitment

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

Key findings for this quality statement

Partnership working to deliver shared local and national objectives

Healthwatch was a key strategic partner alongside the ICB and local authority within York Health and Care Partnership (YHCP) to champion the voices of people in York working with the carers service, disability rights forum, young people transitioning between children and adults' services, parent carer forum, and the views of people living in care homes. However, people told us there were no specific local authority and people partnership boards led by people with care and support needs. For example, there had been no learning disability partnership board for a number of years, but action had been taken to create a new model with the first meeting held in May 2025 (one month before the CQC site visit). As a result, people who were invited to attend told us they did not feel listened to, felt the local authority representative did not understand the meaning of partnership with people and there was a lack of leadership around learning disability agenda. People wanted to be involved in the planning of bringing together a partnership board and shaping future strategy and plans. They had previously been involved in an All-Age Learning Disability strategy 2019-2024 but were not involved or aware of any review or new strategy consultation, involvement, or co-production. Senior leaders told us Health and Wellbeing Board representatives had met with groups who self-advocated and understood the importance of mending relationships which would include considering accessibility of current and future options to improve and embed people's involvement.

Staff shared positive experiences of working with colleagues in primary care services and the police, highlighting strong collaborative relationships. However, they also noted some challenges in partnership working with other providers, including community nursing, the ambulance service, and mental health teams, particularly around safeguarding responsibilities. Staff also identified difficulties in coordinating with the Integrated Care Board (ICB) regarding mental health services and joint or health-related funding. Additional concerns were raised about hospital discharge processes, especially in relation to 'home first' approaches and trusted assessment principles, as well as duplication or lack of clarity around the roles of health and social care occupational therapy services. This resulted in mixed feedback from people about the effectiveness of partners working together. For example, one person told us about a joined-up meeting that involved them and relevant partners including therapy, housing, provider and an advocate and as a result an increase in care was tailored to their specific needs. In contrast, another person told us they had transferred between internal adult social care teams and been referred to an NHS mental health team to help with alcohol use, misuse of prescription medication and traumatic events, they told us in terms of meeting these needs they felt staff ‘passed the book’ and as a result ‘nothing came of it’ which resulted in them putting in a formal complaint and now they receive a direct payment to help with some of these challenges.

York had a Joint Health and Wellbeing Strategy 2022-2032 with a clear vision ‘In 2032 York will be healthier, and that health will be fairer’ based on facilitated local community groups who hosted conversations with local people. Prevention, equity and partnership working were ambitions and priorities set out to support delivery of the strategy alongside annual reports and joint forward planning. Actions and plans were clear and publicly available in the format of ‘what we said we would deliver ‘and ‘what we have delivered’, and for future priorities ‘what we will deliver’ and ‘how we will deliver this’. There had been key achievements against priorities in 2024-2025 including the launch of the first Mental Health hub, the expansion of the frailty hub, streamlining of hospital discharge processes and investment in a home first approach, initiatives for asylum seekers, and an integrated dementia community support model. Plans for 2025-2026 were clear and had mechanisms to monitor progress this included: delivering the vision for an integrated neighbourhood model, and revised partnership agreement with a joint committee to plan and commission services together. The development of a joint committee in York for April 2025 supported senior leaders to align the government’s 10 Year Health Plan with priorities to be fit for the future: from hospital to community, from analogue to digital, and from sickness to prevention by working towards joint commissioning of effective and efficient out of hospital and prevention services. The local authority alongside key partners in the NHS, care providers and voluntary and charity sector had been published in the NHS Fit for the future: 10-year health plan for England in July 2025 highlighting the good work with primary care to improve triage and navigation in York for people identified as frail (using appropriate assessment tools).

Senior leaders and partners told us there was more to do to build on partnership working in all areas. For example, work had started to improve areas across hospital discharge work. One senior leader said it had been hard ‘to get a foot in the door but things were now more positive and constructive’ and another said partnerships in this area had been ‘challenging but fruitful’. Partners had each recognised their own part in some of the challenges, and clear vision, principles and modelling of what was needed was resulting in seeing some benefits in operational work. Due to gaps in senior leadership at the time of the CQC assessment the Director of Adult Social Care had taken a key role to support improved ways of working including being a point of operational escalation over the past 6-9 months. Working together had supported timely and safe discharges and built foundations for future improvement work.

There was also more to do to deliver joined up multidisciplinary support at a neighbourhood level within people’s communities. Plans had started with pockets of good partnership working to build on. For example, between Local Area Coordinator’s (LACs) and NHS social prescribers and how these roles did not duplicate in York but instead complimented how they worked to improve people’s outcomes.

Arrangements to support effective partnership working

The local authority worked with the Integrated Care System (ICS) in shaping intentions and ensuring they meet the needs of the local population through collaboration among social care, health care and the voluntary and community sector representatives. The Integrated Care Board (ICB) operated within 6 places aligned to the 6 local authorities it worked with, of which York was one. The local authority and the ICB had a number of temporary shared integrated posts seen as a mutual benefit to a commitment to place based working. Further integrated roles were being explored at the time of the CQC assessment, to embed and support partnership decision making and delegation. Senior leaders understood statutory responsibility around integration with partners and people's involvement. Adult social care had not had the strong strategic partnership connections that other areas within the local authority had such as children's services, however over the past 12 months the Director of Adult Social Care had prioritised this and had an ethos of 'it takes a whole system to deliver good outcomes for adults'.

Partners told us about improved day-to-day contact with senior leaders, with some key partners sharing office space which further supported development of partnership working. Key areas that were being prioritised included joint commissioning functions and joint funding agreements. Senior leaders told us the local authority and ICB were actively reviewing NHS Continuing Health Care (CHC) processes to clarify funding arrangements and streamline processes. The joint commissioning forum which reported into the newly formed joint committee within the place board was a space senior leaders could work through ‘knotty issues’ with professional relationships said to be strong enough to come to a sensible collective solution, rather than what is right for one partner. Funding relating to NHS Continuing Healthcare (CHC) and section 117 of the Mental Health Act was an area for development to clarify arrangements and streamline processes. Senior leaders and key system partners told us how they had not been ‘good partners’ with a historic blame culture. However, each identified a need to get their 'own house in order'. As a result, they were role modelling behaviours and promoting the need to be 'present’ and refer back to current policy including dispute policy. There was joint training scheduled with social care and NHS staff, there had also been a discussion within a joint session across frontline hospital discharge and local authority staff with a set rule of engagement promoting a safe space for professional challenge which senior leaders told us was making a positive difference at each session. One partner told us, ‘looking at what is right for the population, this is the biggest change over the past 12 months’.

There was a new section 75 of the NHS Act 2006 agreement signed with a plan and goals to consolidate strategic partnership working. There were also plans to re-establish the Better Care Fund (BCF) Performance and Delivery Group to improve oversight of the BCF spend, and review delivery to ensure they were getting best value. The BCF had been used to develop and implement the frailty hub, support equipment contracts and availability of reablement and social care beds to support hospital pressures. There were further plans to expand access to direct payments to offer further flexibility and choice, and develop community and support offers through joint commissioning the right services at the right time. However, there was more to do to evidence any positive impact current delivery was having. For example, senior leaders told us there were two equipment services and there was more to do to streamline ways of working to evidence benefits. Senior leaders told us they were drawing on good practices from other organisations to balance what might work, how different models made a difference and how this is measured in terms of financial benefits and people's outcomes. There was also more to do around sharing information and data. The local authority told us data could be inaccurate therefore at the time of the CQC assessment there were no automatic data sharing processes in place with key system partners. However, where requested they provided specific data into around 12 partnership boards, and this was an area the local authority wanted to make improvements to provide better outcomes and enhance the wellbeing of people who needed care and support and unpaid carers.

Impact of partnership working

The mental health hub was a partnership initiative that was jointly monitored and evaluated. People experienced a lack of joined up working around their mental health needs, and staff told us there were no longer formal arrangements for integrated working within community and hospital teams. Whilst joint working continued with the NHS, staff told us social care was seeing a rise in demand in requests for assessment noting ‘1 in 3 people have a mental health issue'. The mental health hub was co-designed with people and partners to be flexible and look at the needs of people when they were well, in preparation for when they were not. It offered people who may have waited, an alternative to traditional support to identify and achieve goals to improve their mental health. Senior leaders and partners told us about the success of the first mental health hub from 2024. For example, one partner told us ‘one of the things that has been really strong [was] the move to a system wide partnership approach’ moving to the hub model of working. There was a mental health joint delivery board between the local authority, NHS, providers and voluntary and charity sector that had supported mutual respect and equal partnership for system change. This informed ongoing development and continuous improvement and as such with specific project support and funding there were plans for a phased approach to create two more mental health hubs in York, one being a 24-hour 7-day-a-week model to effectively respond to more people’s needs in the community. However, at the time of the CQC assessment there was more to be done to evidence any positive impact on people’s outcomes. Staff had ideas for further improvements but didn’t always feel listened to. Senior leaders and partners told us there had been some delays with progressing to next phases due to some data gaps, workforce capacity and understanding of future neighbourhood model ways of working.

There was also a frailty hub in York. Staff and partners told us about the benefits to people although there was mixed feedback about the effectiveness of the combined convenance meeting, some felt there was more to do to ensure clear direction around joint delivery. The York Community Frailty Hub had been established in November 2023 to tackle fragmented care for older frail people in the community. It brought together primary, community and hospital NHS care, adult social care, the ambulance service, and voluntary and charity sector into one coordinated system. The service was made up of 3 key parts: a frailty prevention team, a discharge support team, and a frailty crisis response team. The crisis response team helped reduce avoidable hospital admissions through a dedicated advice and guidance line and rapid multidisciplinary community response. Through the further development of the frailty hub, they had developed a proactive place-based model of delivery, integrating the community health and social care offer. This involved proactive identification of people with additional needs, for example frailty and multiple long-term conditions, using data provided by their population health hub. There was a service level agreement between partners, with the local authority providing a full-time social worker with no additional case work. Partners told us this way of working provided necessary multidisciplinary response to people's needs. A partner told us having everyone in the same space helped to build relationships across partners and as a result made joined up working easier. People had access to a holistic assessment, plan and review carried out by the right professional resulting in the delivery of a range of health and social care interventions to support them to remain well and maintain their independence at home. The frailty hub also served as an alternative to calling 999, offering early advice to people, unpaid carers and professionals. A national charity organisation was commissioned to physically support people home on hospital discharge, support with independent living and link people to their community offers. A carers service was also commissioned to respond to signs or risks around carer breakdown and provide support options. There was also a reablement offer and a specialist dementia advisor. Frontline staff gave multiple examples of positive responses and outcomes from working with the frailty hub and saw it as a valuable community support offer. For example, a person was reaching the end of their life and there was no bed availability at the local hospice, a community social worker was struggling for options that supported the person’s and families wishes. They rang the frailty hub for advice, and the nurse took a lead immediately and supported the person to stay at home with the right care for both them and their family. A partner told us that providers had been involved from early stages and been very supportive with regard to development of the frailty hub. They said, ‘providers were crying out for a new approach’, they saw the model as innovative which brought partners ‘on the same journey’. Senior leaders told us in terms of evidenced outcomes, shared access to records across partners was said to have positively reduced timescales from 7 hours to 3 hours response, 90% of people discharged with the frailty hub support did not return to hospital within a timeframe, and a focus on reducing people with ‘no criteria to reside’ in hospital had reduced high length of stay from 25% to 14% and in 84% of cases, the York Community Frailty Hub had helped paramedics avoid hospital transfers by providing advice after an ambulance was dispatched, enabling people to be safely supported in the community rather than in hospital. However, one partner told us there were still barriers around sharing of social care data and colocation of social care workforce. This informed ongoing development and continuous improvement, and partners were looking to further expand the service and integrate more teams to offer a single point of access across Primary Care Networks (PCNs).

Working with voluntary and charity sector groups

The local authority identified social connections were an important part of living well. In a survey completed by local people, 75% of people felt they belonged to their local area in York. However, 89% felt it was important to belong to the local area. Taken together this suggested that at least some people in York would value more community belonging. People and unpaid carers gave mixed feedback about what was on offer in York to meet their local needs. Most unpaid carers told us they did not know about or couldn’t access voluntary or charity forums or groups. For example, one unpaid carer told us, ‘I’ve only recently heard about them’ and another told us ‘we did have coffee mornings, but we don’t do them now’.

Senior leaders told us York had a 30-year history of investing in community development and neighbourhood-based grants that helped build community capacity through the funding of community and social action projects to build strong and trusted relationships with people within their communities. York Centre for Voluntary Service (CVS) held a voluntary, community and social enterprise (VCSE) Alliance forum focused on health and social care which supported the engagement of the sector around local authority service developments. York CVS was an umbrella organisation that supported over 300 voluntary communities and social enterprise groups in York including befriending, food aid, carers support, and mental health support. Senior leaders and partners told us York CVS represented the voluntary and charity sector on several partnership boards which included the Health and Wellbeing Board, the Safeguarding Adults Board, the Health and Care Partnership and equalities, disabilities, and human rights groups to support inclusive strategic planning. However, some partners told us York CVS was not always treated as an equal partner with the local authority.

Partners told us financial strain negatively impacted the voluntary and charity sector which posed risks about sustainability of the sector in York. Some partners told us they had good relationships strategically with senior leaders and operationally with frontline staff. However, there was a lack of understanding overall about the services they provided which had affected development of contract specifications and inappropriate referrals. For example, one partner told us the local authority had the right intention, but this did not always translate to practice. There had been some work to further build on understanding such as shadowing but partners felt this was left for them to arrange rather than a strategic approach to embed ways of working and monitor effectiveness. One partner told us delays in renewing contracts, sometimes days before they were due to end had significant negative impacts on sustainable workforce, continuity and future planning. This often-meant charity organisations utilised their own funds opposed to local authority funds whilst waiting for contracts to be renewed or risk services not being recommissioned by the authority. Another partner told us felt they lacked meaningful connections with the frontline assessment teams. There was more to be done to strategically plan and involve the voluntary and charity sector and people who use these services when designing or reviewing care services. Where there were contract monitoring meetings with commissioned organisations partners told us these were 6 monthly but actions were not always followed up from the local authority, there could be gaps in clarity which could be frustrating for partners and partners did not feel these strategically directed the local authority. A senior leader told us the local authority was working with VCSE organisations to ensure support services are in place to prevent and delay the need for care through market shaping with VCSEs. This had been a recognised gap as the system did not tap into the VCSEs, approximately a year ago the VCSEs came to the local authority and said they could bridge some of the gaps and they were now involved with the frailty hub via NHS social prescribers. They had also stepped-up engagement with groups and 2 months ago they conducted a test exercise and asked for feedback about what the local authority could do better. They came back with examples of changing terminology, more clarity around time frames around commissioning cycles and funding streams which the local authority was now addressing.

In contrast, partners gave examples of the range of partnerships and groups that they were involved in, and that had enabled them to help shape services and decisions. They told us there was an appetite in York to involve the voluntary and charity sector and a dedication to cross sector working. Examples provided were the Financial Inclusion Steering Group (a cross-sector group tackling financial exclusion), the Anti-Poverty Strategy, Advice York and Digital Friendly York (both led in partnership by the local authority, VCSE and a commissioned service). One partner had also influenced the Social Value Framework, developing a section with other VCSE organisations about how to involve the VCSEs in tendering.

Partners recognised senior leaders wanted to hear their voices at board level and senior leaders and partners told us there was a strong recognition that there is a lot the local authority could not do without voluntary and charity partners on board.

Theme 3: How City of York 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: 1

1 - Evidence shows significant 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

Senior leaders told us risk management was a priority for adult social care in York. Staff had training on safety planning to prevent future risks to people. A senior leader told us risk management balanced with positive a risk-taking approach was a key principle within their practice model and although the model was still being embedded senior leaders told us they felt assured risk was well managed and understood.

Staff told us safeguarding concerns and, or enquiries were prioritised and the digital recording system clearly identified this to allow staff and managers to oversee priority risks to be addressed. In contrast, partners told us there were concerns about responses to urgent situations. For example, a partner told us when they reported a situation to the local authority it was not actioned in a timely way, and this resulted in a person being admitted to hospital which they felt had been avoidable. Another partner told us the local authority had a significant lack of staff resources, and it took staff 3 days to come back to them about an urgent situation even after leaving 4 voicemails. They said staff turnover resulted in poor training; lack of experienced staff and people were being left at risk. There was more to do to ensure all team processes around risk management were consistent and embedded, and a draft case prioritisation tool was being piloted, monitored and progressed as an improvement project. Senior leaders told us all teams had waiting lists that were reviewed weekly as a minimum with new work screened as it came in and this could be escalated to senior leaders. There was a duty function to respond to immediate risks identified for people not yet allocated to a named worker. However, the local authority did not currently hold any performance data on live level of risk in relation to waiting lists, and there was more to do to also ensure proactive contact for all people waiting was happening.

A one-off feedback exercise had taken place to ask people about how they felt the local authority dealt with risks once they had been allocated a named worker. This found people felt safe and supported to understand and manage any risks according to the local authority's feedback within the review team. There was also positive feedback around addressing concerns and identifying and implementing the necessary changes to ensure safety when people had an assessment or initial review of their needs.

To promote a positive risk-taking approach whilst balancing mitigation of individual risks to people the local authority had an assurance forum for senior leader oversight and support. Staff and senior leaders told us for urgent responses such as unallocated duty work, reablement transfers or hospital discharge. This would be agreed outside of the assurance forum and oversight would be agreed through the digital recording system alternatively to a panel discussion approach.

Sharing information is a critical component of safeguarding practices that helps prevent abuse and neglect. It is essential for identifying risks and preventing harm, especially when the risk may not be immediately obvious. There was a live interface programme that connected adults, children’s and education data sources so at practitioner level they could see key information to support safety in the system. This was called ’single view’. By sharing information, staff could ensure that people at risk were identified and acted upon promptly, thereby protecting their safety and well-being. Some information was also shared to ‘shared care record’ to share some information with health teams, however senior leaders and staff told us there was more to do to move this forward. Senior leaders, staff and partners had issues they were working on around the need to work more closely with health and the need for shared care records and an ‘understanding of the truth’ within trusted assessment approaches.

Issues of risk sat within the risk register which senior leaders told us was regularly shared and reviewed. For example, the local authority identified increased waiting list including increased backlog of annual reviews as a strategic risk. Senior leaders told us they were able to respond to risk when usual mitigation hadn't worked. For example, they had recognised a rise in safeguarding concerns and Approved Mental Health Professional (AMHP) work, as a result they worked with staff and made changes to practice and the allocation of staff resources. However, there were examples where staff and partners felt risks were not effectively managed at the time of the CQC assessment. There was a function for emergency duty response out of hours, this was supported by a City of York contact centre who would triage referrals made about adults at risk and make decisions about whether to send a request for urgent support to the neighbouring local authority who supported this function or decide whether it should wait for normal working hours teams to respond. There were communication and reporting systems in place to support effective information sharing. However, staff and partners told us that responses could vary depending on competing demands. For example, a partner described the out of hours safeguarding switchboard as occasionally unresponsive. Staff and partners also told us that out of hours AMHP cover for York was provided by a neighbouring local authority. While this arrangement ensured statutory duties under the Mental Health Act were met, staff described challenges in securing timely out of hours mental health assessments, particularly due to limited availability of professionals and delays in accessing Section 12 doctors. Senior leaders acknowledged that these issues were influenced by national workforce pressures and work was underway to address local system working, and decision-making out of hours remained based on immediate risk and the support available to reduce harm.

Safety during transitions

Transition is a time when the differences and gaps between services and support can be particularly evident and problematic. A joined-up approach across relevant partners and agencies is critical to achieve the best outcomes for young people, adults, unpaid carers and their family and reduce risks of any loss of continuity in care and support. The local authority had processes such as preparing for adulthood processes, frailty hub intermediate care processes, a roadmap for people with depleted funds and utilised an NHS choice on discharge policy for people being discharged from acute physical health hospital. These aimed to support pathways when people moved between services and agencies to enhance people's safety. However, people, staff and partners gave mostly negative feedback about the effectiveness. Senior leaders told us there was a focus around the importance of smooth transitions for people moving through services and the need to listen to people's experiences.

A parent of a young person known to children's social care told us they found it difficult to find and access information about the transition to adult social care and was anxious and not clear about what impact this could have on them as a parent carer and how their loved one would have their needs met. A partner identified a gap in advocacy referrals for young adults transferring to adult social care. Senior leaders told us processes supported automatic transfer of young carers to a young adult carers service. However, another partner told us that young carers were often 'forgotten' in terms of strategic planning to prevent, delay or reduce risks when compared to care leavers transitioning to adult services. We heard transitional safeguarding processes were robust, but a third partner told us there was more for adult social care to do around 18-25 years exploitation risks particularly for care leavers. Senior leaders told us digital resources were available on the local authority webpage. There were plans to carry out further work with children's services and other key partners such as the police, however this had been delayed due to partner resources. Staff told us there was engagement from children's services but a need for more work to be done to review preparing for adulthood processes in the adults team with a need to focus more on evidence-based practice which was taking place with support of a local university.

The Care Act places a duty on local authorities and the NHS to work together to ensure the safe and timely hospital discharge of people with care and support needs. The NHS and local authorities should use the best evidence available, develop and apply local processes that ensure all people with care and support needs to achieve appropriate, timely and safe hospital discharge. Arrangements for physical health hospital discharges had mixed feedback from people and unpaid carers. There were two complaints that had been referred for ombudsman, one was partly upheld due to issues relating to hospital discharge from out of area hospital to home. A partner told us unpaid carers regularly fed back the 'pressure' to accept care that they were not happy with when a loved one was being discharged from hospital due to the lack of choice. And unpaid carers told us 'they [cared for person with dementia] had an assessment without us knowing, nobody prepares you, you learn as you go', another told us poor communication and planning led to confusion and distress. In contrast, other unpaid carers told us care could be well coordinated and a smooth hospital discharge which reduced strain on them. And a person told us they were kept informed of discharge arrangements and when they arrived home an assessment was carried out to listen to them and their unpaid carer about what they needed.

Staff told us there were competing priorities between health and local authority staff when it came to hospital discharge. We heard there was more to do to work as an integrated function to support strength-based practice. Staff told us funding could be a barrier when people could have a primary health need. There were options to consider health funding on hospital discharge, but it was very hard to agree and was often refused. This meant people waited until the care was reviewed out of hospital and staff 'spent a lot of time fighting' for the right assessments and funding for a person. Therefore, there was more to do to build on operational and strategic relationships to ensure processes were joined up for those involved. Not everyone who transferred to a care home had an assessment and, or decisions for next steps within 28 days of hospital discharge. When this happened, staff told us they kept in contact with people. Usual practice was to visit the person at 2 weeks to assess mental capacity and look at support needed but they would go sooner if they were made aware of a person improving and wanting to go home. Partners told us processes around hospital discharge did not promote people's independence and choice with people often remaining in long term care home support. Partners also told us there was poor communication with the local authority and they often gave providers incorrect or missing information about people's needs, especially for people reaching the end of their life but not rapidly deteriorating which caused confusion and delays. Staff told us end of life processes between the local authority and health were challenging, some felt current processes could be very unfair and undignified due to not being able to access the correct support and funding, or services not having the ability to support someone as prognosis was not clear. Staff told us some people died before they received the correct support. Senior leaders and key partners told us there was more to do around some areas of hospital discharge work between the local authority and the NHS trust. There was ongoing improvement work around promoting a discharge to assess and home first approach to avoid making long-term decisions in hospital.

For mental health hospital discharges, staff told us there were no social workers within the vacant mental health discharge posts therefore there was no dedicated resource to engage with inpatients and support them to transfer back to the community. There were plans for one social worker to move over and another social worker starting in July. Hospital staff had ‘30,60,90 meetings’ where from a health perspective they raised a request for social care assessment for a number of people who needed help and intervention. A person gave us their experience of mental health hospital discharge. They told us they received mixed messages and discharge planning was slow, describing it as ‘everyone seems to be dragging their heels’ they felt unprepared which was a source of worry for them. Staff told us there was a need to Improve the pathway to recovery and hospital discharge and that this was something in development. Staff were aware there was a multi-agency discharge event planned to see where the processes could be improved. There were challenges around people who were unable to access support and struggle to engage with services. A partner told us delayed transfers of care were often due to a lack of placements to meet the needs of a person at the time, but also local authority staffing capacity to assess and support the pathway to recovery. Another partner also told us there were concerns around delayed discharges for hospitals, with prolonged disputes between social care and health around funding care and placements. We heard people were ‘stuck essentially on hospital wards [which was] detrimental and frequently not the least restrictive option’.

Contingency planning

Funding decisions and disputes did lead to delays in the provision of care and support. There was also a lack of effective processes to support people who arranged and funded their own care, this meant people could be misinformed of what could happen when there was a depletion of a person’s finances and could lead to a move between services of their choice. Staff consistently told us about the frustration of this, particularly in relation to hospital discharge and reablement where people were not getting the advice and support needed to ensure people and unpaid carers were prepared for possible changes in need and options of provision of care and support in the future. People who self-funded their own care did have a choice to utilise local authority assessment and planning functions, but this came at a cost of £600 per interaction and often deterred people and partners from referring into the local authority, along with long waits to seek the support they may need. For example, staff told us if a person who had savings above the threshold wanted the local authority’s support, they had to pay £600, but if they went into hospital shortly after they had to pay another £600. There was also an administration fee to reset packages of care. Staff had fed this back to managers but told us there had been no change as yet, but the manager was working with finance and legal staff to make improvements. Senior leaders were sighted on the concerns and told us the draft adult social care strategy identified a want to support as many people as possible. There was a vision to reduce the number of people in care homes, increase the use of the shared lives service, and work more with people who self-funded their care including from a preventative approach.

Contingency plans, also known as emergency plans, agree and show what support is needed if an unpaid carer, paid services or local authority were unable to look after the person or groups of people with care and support needs. The local authority has a business continuity incident management plan for adult social care. The aim of the plan was to ensure a coordinated, structured and timely response to any incident or crisis. The plan covered loss of staff, loss of premises access, and loss of critical technology. The local authority also had a separate provider failure policy. In response to any incident or crisis the local authority's incident management plan stated an incident management team would be set up. If there was impact on the wider directorate then the corporate business continuity plan should be activated, and the Strategic Resource Team would coordinate a corporate solution to the problem.

Staff told us contingency planning happened with people and unpaid carers, this was part of strength-based conversation and planning. For example, people discussed unexpected situations, what to do in an emergency and were provided with the duty telephone number and any relevant voluntary and charity sector numbers. However, staff told us there was not any formal contingency planning in place for specific needs. Most people told us they knew how to contact the local authority, but they did not have copies of plans. More needed to be done to evidence effective contingency processes around people’s experiences and ensure consistency of preparedness for possible interruptions within people’s individual care and support.

Safeguarding

Score: 1

1- Evidence shows significant shortfalls

What people expect

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

The local authority commitment

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

Key findings for this quality statement

Safeguarding systems, processes and practices

Contacting the local authority and receiving a timely response was an area of concern for people, unpaid carers and partners in relation to high risk. There were options to raise a safeguarding referral via an online form or by telephone to Customer Contact Workers. The local authority had a complaint that had gone to ombudsman that showed a person was not getting a response in relation to a safeguarding concern they had. Another person told us they only had a response after seeking advice from the Safeguarding Adults Board.

Partners told us there were difficulties relating to the local authority interpretation of statutory thresholds of safeguarding and they did not always feel supported to manage risks to people if it was screened as not meeting criteria or they were waiting for a response. There was some internal guidance for staff but not an agreed partnership tool to define thresholds and examples for referrers and staff that received contacts to improve consistency. Staff told us they often had to request safeguarding concerns were removed from the digital system due to being inappropriate. Senior leaders told us there were robust processes staff needed to follow to permanently delete information from peoples records, and whilst quantitative data was collected to understand the number of concerns that did not progress to an enquiry, there were risks that were not being progressed to be triaged by the safeguarding team due to what senior leaders described as queries around increasing or reviewing a person's care and support needs rather than being a safeguarding concern. However, there were no audits taking place around what was screened out and whether there was any learning to take forward with staff and, or referrers to improve people's wellbeing and reduce risk of harm and abuse.

There was a safeguarding team that worked on the referrals sent by the Customer Contact Workers. However, staff and partners told us there could be 'bouncing back and forth' of referrals back to Customer Contact Workers if there was not the right information to determine if the referral met the threshold for a safeguarding enquiry. Customer Contact Workers were tasked to go back to the referrer with advice from the safeguarding team. Staff and partners told us where referrals lacked details such as a person's name within a named provider service, they could accept the referral but would ask the Customer Contact Workers to find out more information. However, partners told us where an anonymous referrals were made staff told them '[they] can't do anything without a person's name'. Staff understood the concerns associated with not actioning all risks alerted to them and said they would ring the referrer 'we do dig, and we play detective if we can, if there is an address or name'. However, staff told us these processes and practice could be improved, sighting practice is now better than it was.

Safeguarding training promotes an understanding of what preventative actions can be taken to reduce risks to adults. It also aids the quality of referrals made and the skills and knowledge required to investigate concerns for people with care and support needs and their unpaid carers. National data showed of the social care workforce (independent and local authority staff) in York 35.35% completed safeguarding adults training, this was worse than the England average (48.70%). The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions for people who may lack the mental ability to do so for themselves, 25.00% of the social care workforce (independent and local authority staff) in York had completed Mental Capacity Act and Deprivation of Liberty Safeguards (MCA, DoLS) training which was also worse than the England average (37.58%, Adult Social Care Workforce Estimates, Skills for Care 2024). Partners consistently told us there was more to be done around training support. A partner told us they had reached out for someone to visit their service to talk to them about safeguarding processes in the local authority but were told there was no staff capacity to do this. In response, senior leaders told us events were available during Safeguarding week (twice yearly).

Staff told us safeguarding referrals were poor quality, such as they didn’t include risk mitigation, whether the person consented or whether there were any concerns around mental capacity. Referral forms had been revised to try and improve the standard of referrals and contact details, but they still ‘chased’ professionals. Staff told us it was difficult to know who to contact across health partners and streamlining of contact processes in health made this challenging as they often had to go through switchboards or call centres. They had not seen improvements needed and felt safeguarding referrals were often used to refer to adult social care instead. In contrast, staff told us they had good working relationships with the police who often supported joint visits. Staff also worked across primary care and utilised GP surgeries as a safe place for people at risk to visit.

Senior leaders told us they supported partners to reduce inappropriate referrals by publishing guidance including a safeguarding and falls protocol. The safeguarding team also had an unregistered staff member who worked directly with providers in relation to safeguarding referrals. They had carried out sessions with providers around 'how to make a good safeguarding referral' and providers could contact the worker directly for information and advice. The Safeguarding Adults Board had future plans to develop a multi-agency safeguarding adults training offer, and quality assure partner agency training to improve everyone's knowledge and understanding. However, at the time of the CQC assessment there was more to do to work with staff and partners to develop the best way to achieve the standard of support described within the CQC quality statements aligned with the Care Act 2014.

Responding to local safeguarding risks and issues

The City of York had a Safeguarding Adults Board (SAB), and independent chair. Partners told us there was now strong leadership and multidisciplinary attendance of the board including health, housing, advocacy and voluntary and charity sector representatives. A partner told us there had been a need over the past 11 months to focus on 'getting back to basics' of the governance structures and partnership working. The local authority identified a need to improve availability of multi-agency performance data and for quality assurance of safeguarding practice which was progressing through the safeguarding quality and assurance subgroup of the board. Challenge panels provided an opportunity for members of the SAB to attend meetings to answer questions about how they assure themselves they are performing well in key areas and how they aimed to make improvements. For example, members were asked how they cascade learning from safeguarding adults reviews and how learning was embedded in practice.

In 2023-2024 neglect, followed by physical abuse, and then psychological abuse were the highest reported types of abuse investigated in the City of York. Organisational abuse was the fifth most common type of abuse recorded. A person's own home was the most common location of abuse, followed by a care home or a mental health hospital, with 589 enquiries carried out as a service provider as the source of risk to the person or people. According to the SAB data where a risk was identified this was reduced in 83% of cases and removed in 14% of cases, with risk remaining in 3%.

1 of 6 objectives set by the SAB was around transitional safeguarding. Transitional Safeguarding in York was an approach to safeguarding for people aged 17 years and above. Adult social care had led on the development and agreement of a joint transitional protocol with the Children's Safeguarding Partnership. Operationally they worked with children's services and other partners to implement these arrangements. This involved setting up and leading a strategic and operational group to oversee this work, reporting to the board on a regular basis to ensure there was a consistent, safe and all-age approach to young people transitioning into adult services and support. There were actions set to seek assurance on the embedding of the Transitional Safeguarding Protocol and multi-agency operational arrangements.

Adult social care reviewed and improved their contributions to domestic abuse processes. Local authority staff had mandatory and bespoke training to ensure recognition of domestic abuse and making referrals appropriately. Staff and leaders told us there was mandatory induction and training in different areas of safeguarding including mental capacity act, community deprivation of liberty safeguards, transitional safeguarding and legal literacy training. Learning resources were also developed by the legal team and made available to the workforce.

Staff and partners told us there were challenges for people with needs relating to drug, alcohol use, and, or mental health needs which could result in homelessness and, or self-neglect. There was ongoing work to support people who didn’t attend appointments and the need for staff to identifying the reason people may not attend appointments was important to understand as it may indicate underlying issues or inequalities. Staff told us about the need for a supportive approach, and this took time to build trust with adults at risk. For example, one adult at risk of self-neglect took 20 days to build a rapport with, they communicated through letters as that’s what they wanted. There were future strategic aims to establish ways of responding to preventing the rise in homelessness and self-neglect, and a Rapid Review Panel which reviewed deaths of homeless people.

A Safeguarding Adult Review (SAR) takes place following the death or serious injury of an adult as a result of harm, abuse or neglect. The review looks at whether partner agencies could have worked more effectively to protect the adult. There were no Safeguarding Adults Reviews completed during 2023-2024, however a Review and Learning subgroup were leading and overseeing two ongoing Safeguarding Adults Reviews. These began in 2023- 2024 and related to neglect in care settings both involving older adults. Senior leaders told us early lessons had been acted upon to prevent abuse and neglect in the future. However, previous SARs relating to deaths between 2018 and 2022 had found similar themes in learning needed. They all included learning around applying the principles of the mental capacity act, improvements needed around partnership working and escalating concerns early to prevent further risks to the person. The local authority had open action plans showing action points with target completion dates of 2020-2024, with action points remaining outstanding. Most staff could not give the CQC examples of learning from SARs, but they did say if they had similar issues to previous SARs their managers would direct them to recommendations 'to take the right action'. One member of staff remembered concerns about multiple referrals coming in and no organisation taking responsibility, they thought there was learning from this but couldn’t expand on the wider impact and whether any changes resulted in reduced risks for others. Safeguarding staff told us they were due to have learning about SARs in an upcoming development day. A partner told us safeguarding lessons learnt including SARs learning no longer happened, this used to be discussed within forums, but this had come to an end. Whilst senior leaders told us learning from SARs was shared in staff team meetings as a standard agenda item, partners told us the adult social care senior leadership team gaps had had a negative impact on evidencing impact of learning from safeguarding adult reviews SARs. There were aspirations for the vacant Principal Social Worker role to pick up this work once they started. However, at the time of the CQC assessment there was more to do to evidence learning from SARs beyond published documents available on the SAB website. There was a need to demonstrate that learning was embedded and preventing future risks to people.

The local authority, alongside partners, recognised at times professionals may disagree about the decisions or actions taken to keep an adult at risk safe. There were plans to create a Multi-Agency Risk Management framework in York. This had not been progressed at the time of the CQC assessment. However, there was a multiagency escalation process to ensure all organisations were able to report issues to achieve professional resolution. A culture of professional co-operation and open partnership working meant that sometimes there was a need to raise concerns about the practice or decisions of staff across the partnership. This supported all staff to raise concerns about the safety and wellbeing of adults at risk and to act promptly.

Responding to concerns and undertaking Section 42 enquiries

In June 2025, the local authority told us 22 people were waiting for initial safeguarding concerns to be triaged. People had a median waiting time of 3 days and maximum waiting time of 10 days. The highest maximum wait time in the previous 12 months had been 38 days in June 2024. Senior leaders told us the management of safeguarding concerns could be delayed due to volume of work coming into the team, however they told us cases were prioritised daily and responded to as soon as ‘practically possible.’

Once a person was transferred to the safeguarding team, partners told us staff were knowledgeable and approachable about safeguarding, but processes could be slow depending on the level of risk. For example, people with unexplained bruising therefore potential risk of physical abuse and, or neglect were dealt with quicker to avoid any ongoing harm. National data showed 71.72% of people who used services felt safe which was similar to the England average (71.06%). Additionally, 85.35% of people who used services said those services had made them feel safe and secure this was also similar to the England average (87.82%, NHS Digital 2023-2024).

Section 42 enquiries are 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. In June 2025 12 people were waiting for safeguarding enquiries to start which had reduced over the year. People had a median waiting time of 8 days and maximum waiting time of 154 days. The highest maximum wait time had been 163 days in June 2024. In December 2024, the local authority told us people with learning disabilities waited the longest followed by people with mental health needs. The local authority set its own target of an enquiry being undertaken within 20 days. However, the maximum wait times demonstrated the local authority was not meeting its own targets. They also set ‘Outcome Reviews’ targets which should be held regularly to check if the agreed actions in the Safeguarding Plan had taken place and whether any further action was needed. The frequency of the review should be decided based on the situation and level of risk (4- 12 weeks/up to 84 days) and that reviews should always take place where there is ongoing risk of harm. The safeguarding team could put together immediate safety plans and advise allocated social workers within community and specialist teams as skilled staff. Staff told us not all staff were familiar with safeguarding recording processes and there was some impact on the data around waiting times due to this. For example, staff could record on case notes instead of 'starting' the workflow step that recorded wait times. This could impact on some groups of people appearing to wait longer for an enquiry to be started and completed. Staff were aware of safeguarding timescales held by the local authority, they told us they did not always meet these and waiting lists were overseen by team managers which they said was improving the management of risks. Some staff wanted the safeguarding team to carry out all enquiries. However, staff told us a lack of staff resource was the reason this could not happen, and the current practice was in place to keep people safe. Staff consistently told us there was good support and training to carry out safeguarding enquiries. When transferring the work outside of the safeguarding team staff worked flexibly to 'co-work' cases, particularly around complex situations.

Processes did not support staff to inform relevant agencies the outcomes of safeguarding enquiries when it was necessary to the ongoing safety of the person concerned or recommendations that could prevent harm to others. Staff told us they could email agencies or informally contact them, but it was something they had to remember to do rather than built into process and checks.

When safeguarding enquiries were delegated to other agencies such as care providers, mental health services, or acute hospitals staff told us the local authority retained overall responsibility by reviewing and scrutinising the reports. However, staff and partners described delays in partners completing the actions delegated to them. Staff also told us the safeguarding process did not sufficiently reflect the principles of Making Safeguarding Personal, particularly in terms of achieving outcomes that aligned with what the person wanted. This was not necessarily a lack of reporting, but rather a gap in ensuring that the person’s desired outcomes were consistently met. Each hospital had a safeguarding specialist that dealt with enquiries within the NHS trusts. Staff said they did not give feedback to the specialists, and this is something that should happen, but it wasn’t. The processes in the mental health trust were said to be working better. Before anything is delegated to a provider the safeguarding team triaged to 'check if it’s appropriate', if a provider was listed as an organisational concern, they would not delegate responsibilities, this included GP surgeries, physical and mental health providers.

Staff and partners told us there were systems and processes to ensure organisational abuse was investigated when it was more than a quality concern. Staff could see trends and themes through the digital recording systems such as 'patch' searches and anything that had previously been triaged even if it had not met for an enquiry at the time to be carried out. They also had a spreadsheet with all providers which staff said was a quicker and visual way to check and a '2 prong approach' and a useful tool. There was ongoing communication with contracts and commissioning team around safeguarding concerns, building rapport and improving standard of care in provider services. Staff told us at risk providers were discussed in team meetings, and they received updates on suspensions to inform decision-making.

In February 2025 278 people were waiting for authorisation of Deprivation of Liberty Safeguards (DoLS), this had reduced from December 2024 when 433 people had been waiting. People had a median waiting time of 127 days this had risen from median of 82 days in December 2024 and maximum waiting time of 1,268 days which had slightly reduced from 1,427 days in December 2024. The highest maximum wait time in the previous 12 months had been 2,101 days in May 2024. Processes had changed over the 12-month period to ensure assessments were not allocated before they were ready to be allocated to Best Interest Assessors (BIAs) and a best practice tool had been reimplemented which impacted data collection. Therefore, between March 2025 until the CQC site visit the local authority did not have any updated data to share with us. Senior leaders and staff told us processes supported them to maintain priority reviews and re-prioritise cases as high if any concerns are identified, however there remained risk due to more people requiring assessment than staff could work with. There was more to do to ensure human rights were respected and protected whilst people waited.

Making safeguarding personal

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

The local authority had leaflets, posters, animations and videos to raise awareness and understanding of safeguarding using simple terminology. This included easy to understand information about cuckooing (being exploited in your own home), hidden harms, tricky friendships, what to do about self-neglect and spotting the signs of financial abuse. Staff also told us there was outreach support in libraries, and health centres, police and health commissioners were aware of safeguarding team. Staff could work in ways that worked for people such as using text, access to translation services, and if needed had support from specialist teams for advice.

According to the local authority's data 94% of people involved in section 42 enquiries were asked to express a desired outcome(s), and 79% of people who expressed their outcomes said they were fully achieved. 46% of people lacked mental capacity to be involved in section 42 enquiries (2023-2024). Staff told us they considered advocacy support for people at the point of agreeing risks that met thresholds for section 42 enquiries. If the adult at risk did not have a family or friend to support them, and they lacked mental capacity around the concerns then referrals were made for independent advocacy support. Advocacy support prioritised safeguarding referrals depending on the level of risk. 86.55% who lacked mental capacity around their safeguarding concerns were supported by an advocate, family or friend in York. This was similar to the England average (83.38%, NHS Digital 2023-2024). There was more to do to ensure staff and partners understood people's rights, including their human rights, their rights under the Mental Capacity Act 2005 and their rights under the Equality Act 2010 and they were supported to make choices that balanced risks with positive choice and control in their lives.

The local authority gathered people's outcomes at the end of an enquiry. This was completed by staff on the local authority's digital recording system and lacked evidence of effectiveness as did not measure outcomes from the beginning, and during the enquiry in comparison. Staff told us they asked for feedback where they could and diverted people to Healthwatch. Healthwatch sent reports from the feedback gathered included 'do they feel safe', and staff told us they discussed the data and graph outcomes in team meetings but there was more to do to demonstrate how this influenced practice or improved future outcomes. Therefore, at the time of CQC's assessment, learning and improvement around people's experiences in safeguarding work remained limited. Senior leaders aspired to develop opportunities for community engagement so that the voices of adults with lived experience were heard and this could help inform future practice.

Theme 4: Leadership

This theme includes these quality statements:

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

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

Governance, management and sustainability

Score: 2

2 - Evidence shows some shortfalls

The local authority commitment

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

Key findings for this quality statement

Governance, accountability and risk management

There was mixed feedback about the effectiveness of leadership owing to the instability over the past 7 years. However, the CQC found the local authority transformation was being driven by person centred values. Leadership roles had needed to find out 'truths' over the past 12 months and had prioritised a fully coproduced Adult Social Care Strategy which was nearing sign off after months of public, staff and partner consultation 'to get this right' as a foundation to good governance to manage and deliver good quality, sustainable care, treatment and support.

There were many people that participated in local authority forums and co-production groups, however they had mixed feedback about their influence within leadership. Some people were proud to tell us about the local authority's human rights perspective which was a foundation to listen and involve all people and this was having a positive impact and improving outcomes for people. In contrast, unpaid carers in York told us services felt stretched and gaps in the system were filled by carers, this was having a negative impact on unpaid carers wellbeing and reduced their confidence in the leadership of the local authority.

There were governance, management and accountability arrangements at corporate level in the local authority, adult social care had importance at this level which made working together positive and a supportive environment for senior leaders. The Council Plan 2023-2027, One City for All set out the local authority’s vision to achieve a healthier, fairer, affordable, sustainable and accessible city. The acronym 'EACH' represented the four core priorities of the council's vision: Equalities, Affordability, Climate and Health. The plan emphasised health and wellbeing for local people and focussed on early intervention and prevention with the aim of delaying needs and reducing inequalities.

However, there was more to do within adult social care to evidence effectiveness of visibility and assurance on quality, sustainability and risks to the local authority and people when carrying out its Care Act duties. Adult social care had an experienced Director of Adult Social Services (DASS) who had a strategic corporate function and been in position for over 12 months. There had been 5 DASS' in 7 years which had resulted in instability and a loss of focus on priorities. A senior leader described the current DASS as 'a breath of fresh air,' with the 'right values' to instil a good culture within the organisation. Whilst most staff, partners and senior leaders were assured by the appointment, some staff remained to have reservations and felt it would take time to see lasting and effective improvements. The DASS understood their role particularly in fostering positive leadership behaviours and had spent a significant amount of time with staff teams and middle management roles to understand the organisation through listening, observing and direct communication. They had identified some systemic issues, but also what they described as 'myth and legend' issues where they were able to work with staff use right based approach to make changes that were beginning to have a positive impact on staff morale and confidence in leadership. A rights-based approach in social work emphasises the importance of human rights in practice, aiming to empower people and communities while promoting social justice and equality. Partners told us they were assured by adult social care leadership and although there could be strategic differences they 'spoke the same language' noting good working relationships and a proactive approach to getting the basics right. However, the senior leadership team within adult social care temporarily remained in an instable position as a restructure was underway to align roles similar to other departments governance structures and allow opportunities to integrate further with health. This meant many posts were interim, with some covering both senior leadership and team management level positions. Most staff felt well supported by line managers however some told us team meetings could be missed as a result of management absences and competing demands. The Principal Social Worker (PSW) role had been restructured to allow for a protected role, the position had been vacant for 8 months, the gap had led to work that needed to be done around embedding and driving change, but a successful appointment was due to start. There was also recruitment underway for an additional assistant director, and senior leaders were positive about the number of strong applicants which they were hopeful would take them to the next steps in improvement.

There was more to do to evidence effectiveness of adult social care risk management and escalation arrangements. Senior leaders told us they were accountable within their roles, and staff were described as conscientious and hardworking. Senior leaders told us adult social care had ‘a lot of new staff’, and they were experiencing high turnover in staff that affected recording data outcomes. The local authority had interim senior leadership posts to support more resources to deliver change and transformation with decision making authority. There had been gaps in quality assurance due to the vacant PSW role, however some senior leaders had shared aspects out between them such as the transformation lead and heads of service. However, at the time of the CQC assessment assurances were often taken through direct communication or checking of live systems opposed to robust monitoring and analysis of data and insight.

Members of the public attended the health and wellbeing board with issues about health and access to services. Senior leaders told us they valued people’s voice and scrutiny at board level. The local authority’s councillors were informed about service development and potential risks facing adult social care. However, scrutiny was in development around sharing knowledge, expertise and meetings were in its infancy, but the focus was to work together to prioritise the interests of the people of York.

Strategic planning

There was a draft Adult Social Care Strategy which was being coproduced with local people. Senior leaders told us this work was not being rushed as it was the basis of a vision to put people at the centre of care. 11 priorities were chosen to align with goals from the City of York Council Plan and the Health and Wellbeing Strategy. The focus was on areas that had been identified for improvement or development and included ideas from the ‘Making it Real’ Framework, created by Think Local Act Personal, a group dedicated to improving health and care with input from people with care and support needs.

Previous poor planning and lack of evaluation of projects and initiatives had a negative impact on some staff trust and confidence in adult social care strategic planning. Adult social care as a department led or were involved in many separate strategies. This meant they had future plans and agreed steer as to what was needed. However, there was more to do to evidence the effectiveness of how strategies were managed and applied. Effective strategies could provide clear direction, focus efforts, and improve coordination, but there was evidence of previous and current poorly managed strategies which had resulted in wasted resources, reduced workforce confidence, and little to no progression in some areas. There was a need for senior leaders to focus efforts which they believed would start with a central Adult Social Care Strategy. An Adult Social Care Assurance and Ambition Board with dedicated adult social care reporting was in place, this was said to be in early days, but senior leaders were confident this would provide the strategic level of direction needed.

The Director of Adult Social Services (DASS) was passionate about driving change and embedding good practice to improve outcomes for people. They voiced a need to support as many people at home for as long as possible because that's what people wanted. They were also driving change to provide safe and effective services and wanted York to be known for this. 'Doing the right thing' for people and embedding rights based social work practice was core to delivering good quality, sustainable care, treatment and support. They had clear performance measures they would monitor such as seeing the number of people in care homes reduced, increased shared lives support, and successful planning with people who arrange and self-fund their own care. The DASS was clear they would know when the draft Adult Social Care Strategy had been well implemented, when people, staff and partners would no longer be talking about the past and issues they are currently moving away from would be a distant memory.

The local authority's workforce planning was a concern. Plans were underway to realistically join up resources with partners and improve workforce culture and efficiency. However, this was in its infancy and whilst plans shown to the CQC were moving forward there was still more to do to for this to consistently support the delivery of good outcomes for people.

There was a need for strategy to improve data sharing and collaboration across key partners including internal partnership working with public health, children's and housing which was a key area of focus. There was a corporate and central data and performance team that stored high level department data in a live system as a 'score card'. Depending on role permissions roles from across the council including managers, HR, councillors, senior leaders could see service dashboards set against service KPIs which was said to inform strategy and strategic decision making. Councillors were demonstrated to have access to a reduced amount of data; however senior leaders told us specific data was usually requested separately for scrutiny purposes to ensure accuracy and consideration of challenges. Senior leaders told us there was an expectation all business cases for change or funding were expected to be evidenced with performance data, for example the development of the mental health hubs.

There were methods for strategic reporting among senior leaders, but specifics within adult social care were still being embedded and developed. Senior leaders told us there was a need to review the effectiveness of the model used in collecting data, there was recognition at times there could be too much data. Additional corporate business intelligence capacity had been recruited to. This would aim to improve analytical management, bring together sources of data held in different places such as improvement programmes and market shaping, and developing baseline key performance indicators (KPIs) for projects to drive service improvement for better outcomes for people. In the interim senior leaders gave examples of how current methods of sharing intel resulted in timely actions taken.

Information security

The local authority had arrangements to maintain the security, availability, and confidentiality of data, records and data management systems. This included cyber security measures to safeguard against unauthorised access, as well as broader information security practices to maintain confidentiality, integrity, and availability of information. They were registered with the Information Commissioner's Office (ICO) for data protection and had business continuity plans to respond and manage information security risks to delivery of Care Act duties.

Staff told us how they used mandatory training to apply learning, such as anonymising care records when sending to providers for requests for support. There were plans to strengthen assurances by including discussion about data protection and data sharing principles within a new supervision template to ensure effective information sharing and GDPR compliance.

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

Adult social care had seen many changes, developments and ideas with the changes in leadership. Some staff were frustrated with gaps in management impacting the demands they faced and told us gaps in workforce meant ideas for improvements were not always successful. There was more to do to implement new approaches, templates, training and practice to evidence positive outcomes for people in York.

There had been positive changes that were making a difference to practice and staff morale. For example, staff and senior leaders told us there had been a high cost panel where staff had to complete a 27 page off system document and staff were not invited to attend. Staff were not receiving feedback and had no way of learning from panel decisions and outcomes. Senior leaders listened to staff challenges and ideas for improvements. This set an ethos of involving staff and people in changes needed. Workshops were held with staff to give space and time to engage. There was a need to understand the ‘myth and legend’ in some places, but an agreement came together to avoid a financial driven panel and instead create an environment for sharing ideas, good practice and learning from a multidisciplinary perspective. The implementation of the new assurance forum was also being used to pull out systemic issues and see where practice was improving. Whilst it was still in pilot stage and was due to be reviewed senior leaders saw it as powerful for staff to see a tangible difference and be part of the solution. There was recognition staff wanted cultural change and wanted to know what senior leaders were doing about the issues they raise. The Director of Adult Social Services (DASS) was a strong advocate of rights based practice they led by example and saw the benefit in working directly with staff to unpack any case law, or what the Care Act says. Evidence based practice was important to the department and staff were encouraged to challenge senior leaders in this professional way. The DASS had seen positive results to staff wellbeing including a reduction in staff sick absence which had halved in a year.

Staff consistently told us they found it difficult to find time to prioritise continuous professional development beyond mandatory training due to workload pressures. There was a new workforce development lead and training matrix monitoring system in place this generated a regular reports for strategic oversight which was beginning to make a difference. Staff did have opportunities to gain further qualifications including a Practice Educator course. The local authority worked closely with the local universities to support newly qualified social workers in their Assessed and Supported Year in Employment (ASYE). Staff also had membership for online research resources which showed the local authority's commitment to embed evidence-based practice and expertise in the organisation. However, there was a gap in practice development framework particularly for specialist teams, commissioning staff, and occupational therapy.

Where resources allowed there were pockets of utilising best practice to improve. For example, staff had used research across NHS England and Skills for Care which looked at recruitment and retention of social care professionals. One of the recommendations was to ensure Anti-racist Practice and Allyship was addressed and promoted within the workplace. Allyship referred to the active commitment of staff to support and advocate for people who could be marginalised or underrepresented to challenge injustice and promote equality, creating a more inclusive and equitable environment. With funding and a social work manager taking a lead, two sets of training were created and delivered one for senior leaders; and one for frontline staff and supervisors. Feedback from the training was fed into an Anti-Racist Implementation Strategy and formed the basis for an action plan which was jointly developed with a member of staff from children's social care. This clearly set out themes, what the local authority wanted to achieve and how it would be done. Next steps included incorporating the training into the induction process, creating spaces for reflective practice and the development of an Allyship forum.

There was protected resource to drive transformation. A new corporate transformation lead started 4 months prior to the CQC site visit, and an established adult social care head of assurance and improvement position was in place. There had been significant movement at pace around many projects and pilots over the past 12 months with more plans to monitor and embed to further improve. However, there had been little to no audit and assurance work on practice outside of projects and pilots over the 8 months during the Principal Social Worker vacancy. Checks were carried out on a 1:1 basis with line management, and the assurance forum provided an overview. There was a need to drive forward the draft Quality Assurance Framework which set out audit and learning aspirations. This would provide much needed evidence of measurable improvements that would provide senior leaders assurances needed around Care Act duties being delivered.

The social model of disability is about removing barriers to create inclusive and equitable communities for people. Senior leaders told us how this model of including people in decision making had a long history in the City of York. There were many examples where local people participated in voicing their opinions. This included an older people's assembly, self-advocacy forum, disability rights forum, ‘connecting our city’ partnership, and citizen groups. However, not all people felt involved or listened to by the local authority which suggested there was more to do to reach and effectively engage people.

‘Connecting Our City’ was a partnership not managed by one organisation, there were two independent chairs, executive leads from each statutory partner, voluntary, and charity representatives, local people and the Director of Adult Social Services (DASS) was lead for adult social care. A senior leader told us they were part of a steering group linked to the partnership, there was a coproduction work stream linked to gather feedback from people about their experiences of care and support which was a clear message within the work to inform strategy, improvement activity and decision making. There was also a draft Autism Strategy and draft Adult Social Care Strategy that was being worked on, there was an ethos in the local authority to work on things well to get it right. People told us where they had been involved in interviewing, strategy, and contract tenders around topics such as drug and alcohol use, homelessness, mental health, carers and visual and hearing needs.

However, coproduction as an approach within adult social care needed to be developed and embedded to actively listen, promote and support learning that improves people's social care experiences and outcomes. For example, people with learning difficulties and, or disabilities had not been involved at strategic level within recent years, with the learning disability board in the last few months being relaunched. There was more to do to involve people, carers, including with seldom heard groups and internal staff at all stages of adult social care work through design, delivery and evaluation, rather than simply requesting ‘feedback.’

Learning from feedback

People told us they didn’t feel the local authority learnt from feedback and there was a lack of communication to gather direct feedback about their experiences of care and support which could inform improvement activity and decision making at all levels. Local Government Social Care Ombudsman (LGSCO) had 3 detailed investigations over the year (average number for this authority type is 4), and an uphold rate of 66.67% (average uphold rate for this authority type was 71.86%). The local authority had started a pilot to gain more widespread feedback within teams with results finding not all people were aware they could give feedback including complaints. Senior leaders and staff were taking action at team level, and the new Principal Social Work position would be leading on coproduction and quality assurance in adult social care to bring together systematic learning and evidencing the success of this once in post.

Staff told us where they received feedback, this was discussed in team meetings to share learning. Although there was more to do, staff were committed to serving people in the City of York, there was an ethos of wanting to learn through people, staff, partners feedback and analysis so that Care Act duties could consistently be delivered safely and effectively.

The local authority gathered and monitored staff feedback. In January 2024 and again in March 2025 there were staff surveys focusing on leadership, wellbeing and teamwork, much of the feedback was positive. However, some of the survey results highlighted concerns that senior leaders were addressing. For example, access to learning and development opportunities, meeting with line managers to discuss work and priorities, changes at team level communicated and managed. Some areas had seen improvements such as staff having the tools and resources to do their job effectively and having a clear vision to meet challenges of the future. However, feedback on whether staff felt they had a manageable workload had increased to 35%, and staff having belief action would be taken as a result of feedback had increased to 28%. As a result, the local authority ran sessions with staff to discuss the outcome of the staff survey and agree next steps as priorities. Senior leaders visited staff at team meetings, there were staff engagement sessions, and managers engagement sessions monthly, as well as specific workshops held to help develop the transformation programme projects over the last year. For example, the one team spent time looking at how to make their role more efficient. Over the past 6 months they made changes to processes that were not needed or had 'lesser value' to make job more effective to support people in a timelier way. As a result of improved ways of working senior leaders were able to strategically use some of the additional workforce to benefit demand in other teams with the aim to meet Care Act duties.