Care Quality Commission

Torbay Council: local authority assessment

How we assess local authorities

Assessment published: 17 December 2025

About Torbay Council

Demographics

Torbay is a unitary authority in the South West of England. It has a population of 140,126, making it one of the smallest local authorities in England. It has an index of multiple deprivation (IMD) score of 8, with 1 being least deprived group and 10 in the most deprived group. Compared to other local authorities in the South West region it has the highest IMD score, meaning Torbay is more deprived overall than its regional neighbours.

The population is made up of 17.71% age 0-17 (national average 20.78%); 55.01% age 18-64 (national average 60.48%); 27.29% age 65 and over (national average 18.73%). There is a very high proportion of people over 65 in Torbay, than national average, a lower working age population and a lower population of young people and children. The majority ethnic group is White 96.12% (national average 81.05%) with the next ethnic group being Asian and Asian British 1.6% (national average 9.61%), followed by Mixed or Multiple at 1.5%. The overall health index score (2021) showed the local authority had a value of 95.7 which indicates worse overall health than the national average (which would see a value of 100).

Torbay is part of 'One Devon' integrated care system alongside Plymouth and Devon local authorities and partner NHS organisations. The ICB is very large compared to the size of the local authority. Since 2005 Torbay Council has contracted the Torbay and South Devon NHS Foundation Trust to deliver its social care services under a comprehensive Section 75 arrangement (A Section 75 agreement is a legal arrangement under the National Health Service Act 2006 that allows NHS bodies and local authorities in England to pool budgets, delegate functions, and integrate services, especially in areas like adult social care, public health, and children's services), with the local authority retaining some strategic commissioning functions.

There is a minority Conservative administration, with a leader and cabinet model of governance.

A new Director of Adult Social Services has been appointed in recent months.

Financial facts

- The local authority estimated that in 2024/25, its total budget would be **£262,017,000.00**. Its actual spend for that year was **£252,700,890.00**, which was **£9,316,110.00** less than estimated.
- The local authority estimated that it would spend **£66,276,000.00** of its total budget on adult social care in 2024/25 Its actual spend was **£67,255,890.00**, which is **£979,890.00** more than estimated.
- In 2024/25, **26.61%** of the budget was spent on adult social care.
- The local authority has raised the full adult social care precept for 2024/25, with a value of **2%**. Please note that the amount raised through ASC precept varies from local authority to local authority.

- Approximately **3520** people were accessing long-term adult social care support, and approximately **2210** 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

Torbay Council

Good

Quality statement scores

Assessing needs

Score: 2

Supporting people to lead healthier lives

Score: 3

Equity in experience and outcomes

Score: 2

Care provision, integration and continuity

Score: 3

Partnerships and communities

Score: 3

Safe pathways, systems and transitions

Score: 3

Safeguarding

Score: 3

Governance, management and sustainability

Score: 2

Learning, improvement and innovation

Score: 3

Summary of people's experiences

People and carers gave us positive feedback during our assessment and records we reviewed showed positive experiences across all areas in the assessment. Unpaid carers were particularly positive about support and services available to them. We spoke with 'ambassadors' who had strong relationships with council officers and elected leaders and they gave us examples of impact on services and genuine co-production. There was a real sense of listening, involvement and power-sharing with ambassadors from different groups such as carers, people with learning disabilities and autistic people.

National data used in the report generally showed a positive picture. Most data showed performance around the national average, for example in the proportion of people satisfied with care and support. Unpaid carers data showed significantly higher numbers of unpaid carers accessed support or someone to talk to in confidence, than national average. There was also a high proportion of people who received short term support, who no longer needed support, and a high proportion of people accessing reablement. Although fewer people remained at home after 91 days following a hospital stay than the national average. Direct payments were well used and available for carers, but less so for people with care and support needs.

Waiting times were evident but not usually high and we heard some impact on people from waiting times for assessments and reviews, although we saw how the local authority provided waiting well information and used triage and risk prioritisation. Higher waits were experienced for annual reviews than other assessments. Staff and partners said the proportion of people going into residential care services had been high. However, work was underway to change this, with reablement facilities already effective, and extra care housing being built.

Summary of strengths, areas for development and next steps

The local authority was achieving many outcomes well and there were some areas for improvement. Adult social care staff had been fully contracted to the NHS trust to merge functions and teams in 2005. The experience of staff differed depending on which team they were in. Many staff reported consistent social care leadership and strength-based practice, but some reported a lack of consistency and a more health focus on their leadership and working culture. People’s experiences were universally positive, however, and carers reported very high satisfaction to us. Alongside good performance in national data, this local authority has achieved an overall ‘Good’ rating in this assessment.

Access to the local authority's social care service was equitable and strength-based with the Voluntary Community and Social Enterprise sector embedded in the 'front door'. Arrangements could be complex, however, and sometimes processes were described as complicated in assessing people's needs. We found some waiting lists for services, but these were risk-managed, however there were higher levels of care plan reviews outstanding. Actions had been taken to reduce waits for people which were starting to make an impact and the local authority had made efforts to simplify the 'front door' with a current review ongoing.

Tackling deprivation and generating economic growth was a key driver for the local authority in its support for people and generating better health and wellbeing. They had a range of advice and support available and were consistent in describing their efforts to improve people's lives through housing and employment. Reablement was improved with a new facility for step-up and step-down support to avoid hospital admission, with wrap around support. The technology enabled care offer had been enhanced to support people at home. Hospital discharge rates were excellent and reablement was offered to a high proportion of people. There was a focus on reducing bed-based care and people moving to long-term care placements, which had started to make an impact.

The local authority were able to describe some efforts to reach seldom heard groups and their co-production work was good. There was a strategy to tackle issues such as domestic abuse and there was a new equality, diversity and inclusion strategy. They had recruited an equality and diversity lead and recent equality impact assessments had been undertaken. However, this work was quite new and had not been embedded at the time of our assessment. The local authority also relied on census (2021) data to understand diversity within its population, partly as a result of limitations with the electronic systems they used.

The care provided in the local authority was generally good quality and there were systems and processes to manage and monitor placements and relationships with providers. There was less availability locally for people with specialist needs, those with mental health needs and supported housing, however staff reported an ability to place people. There were two all-age extra-care facilities in development and a clear intention to shape the market.

Partnerships and the deep level of co-delivery, overall, was a strength, with some challenges noted. Partnerships with the VCSE were strong and delivering, with significant numbers of VCSE organisations working in the area, supported by a commissioned infrastructure organisation. Within statutory health and care services there was sometimes a health model prevailing, but we saw impact and benefits of co-location and multi-disciplinary teams on people and carers. Partners worked well together, had strategic alignment and understood the challenges and demonstrated plans to improve.

The out-of-hours services worked well, including access to Approved Mental Health Professionals (AMHPs). Hospital discharge was swift and identified risks prior to discharge and embedded teams supported safe discharge. Transitions from children's to adults services provided a clear and safe pathway for young people and a strength-based approach. There was a multiple and complex needs alliance, which linked housing with health and social care to ensure people were safe. There was some feedback about gaps for people with complex mental health needs.

Safeguarding processes were effective, although we heard about some Deprivation of Liberty Safeguards (DoLS) waits for decisions, although these were risk managed. The local authority learned from Safeguarding Adults Reviews (SARS) and there had been a significant reduction in outstanding SARs action in recent years, alongside a more defined threshold for SARs. Leaders and partners listened to people in their safeguarding work and had worked with the Scrutiny committee. Hoarding and cuckooing and emerging safeguarding themes were being addressed by the system.

There had been a lack of visibility of social care leadership in some teams, partly due to health focus of management and delegated arrangements with mixed supervision practices. Although we heard about a recent change in approach and greater visibility with the new Director of Adults Services. We found elected leaders were well briefed and involved in oversight and governance arrangements. Partners were embedded and represented on governance boards and committees, and we saw risk and governance delivery arrangements between the local authority and the Torbay and South Devon NHS Foundation Trust. The electronic recording system had limited improvement work on governance, management and accountability and this was being addressed at the time of our assessment.

Recruitment and retention was reported as positive by staff and there was energy and optimism for the future in the staff teams. Integration had allowed rotational posts between hospital and community work, and they had a good team culture between the multidisciplinary teams. Leaders, alongside the Integrated Care Board, commissioned an external consultancy as a delivery partner to support improvement in reablement and intermediate care. There was a good level of provision of training available to staff and Ambassadors (people with lived experience) trained as facilitators. Co-production with people, particularly Ambassadors, was a genuine listening and power sharing arrangement, with people reporting they had shaped and impacted positively on services.

Theme 1: How Torbay Council works with people

This theme includes these quality statements:

- Assessing needs
- Supporting people to live healthier lives

- Equity in experience and outcomes

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

Assessing needs

Score: 2

2 - Evidence shows some shortfalls

What people expect

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

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

The local authority commitment

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

Key findings for this quality statement

Assessment, care planning and review arrangements

Assessment and care planning arrangements were generally effective although sometimes complicated. There were multiple access points, multi-disciplinary teams with health partners and person-centred approaches across services. The integration of Voluntary Community and Social Enterprise (VCSE) support and triage systems helped meet a wide range of needs. There were some challenges around telephone-based assessments and some delays to approvals and increasing demand.

From the point of initial contact with the local authority, people said their views and those of their unpaid carers were listened to and helped shape the assessment process. In one example, strong personal and family preferences were noted and acted upon, with the local authority offering reassurance about future care arrangements. People described their assessment as person-centred, with outcomes identified through consultation with family members and care providers who knew the person well. Multiple visits were noted, incorporating family and unpaid carer voices.

Staff ensured the person's needs and preferences were represented and respected, even when the person could not communicate with them directly. People also said their assessments were strength-based, allowing them to explore their long-term goals and aspirations for independence. The local authority was described as transparent, honest, and respectful. Adult Social Care Survey data (2024-2025) showed 80.90% of people felt they had control over their daily life (national average 77.62%), 67.42% were satisfied with their care and support (national average 65.39%), and 47.94% reported having as much social contact as they wanted which was similar to the national average (45.56%).

Staff and partners described a range of arrangements in place to support effective assessment and care planning. Adult Social Care was said to have multiple access points, including a commissioned community helpline. A short-term triage team managed lower-risk cases, while complex care teams handled higher-risk cases. Additional referral pathways, such as those for carers services, safeguarding, and Deprivation of Liberty Safeguards (DoLS) were evident. Although some staff said access to services, or the 'front door', was complex at times.

Referrals for adult social care came from carers, people in the community, health and social care coordinators, and self-referrals. We heard digital platforms had been trialled to improve the front door but had not been widely adopted. Staff said this was because people preferred telephone contact. Staff said telephone-based assessments could be challenging, especially when trying to understand someone's living conditions, for example, staff said people sometimes underreported their needs. However, staff said they arranged in-person visits when necessary. Despite these challenges, people said assessments were person centred and comprehensive. Multidisciplinary teams supported social workers by also producing detailed assessments, although we heard risk assessments remained the responsibility of social workers.

Some staff highlighted delays caused by internal approval processes, particularly where referrals had to be signed off by a single senior worker. Mental health referrals were said to bypass this step. Staff working in housing and complex needs forums described holistic assessments involving housing, health, and social care professionals, which were seen as effective. Some staff described their work as increasingly crisis-driven and said some processes were complex, particularly around Mental Capacity Act assessments.

Occupational therapists adopted a strengths-based and preventative approach, combining clinical assessments with education and signposting to community resources. Sensory services accepted referrals from a wide range of sources and used a triage system to prioritise cases, with reassessments undertaken regularly to reflect changing needs. The Sensory Team provided specialist support for people with hearing and sight impairments, including functional assessments and equipment provision.

Partners also raised concerns about the limitations of telephone-based assessments but said the community helpline was successful in supporting people with a variety of needs. Local authority data showed the community helpline signposted 84% to VCSE support with 10% of contacts requiring formal Care Act assessments. Partners also said referrals were triaged and allocated appropriately.

Timeliness of assessments, care planning and reviews

The local authority had risk prioritisation and waiting well measures in place, with improving waiting times for assessments in short term and complex teams. However, there had been significant waiting times for care plan reviews. The local authority had taken steps to address these through additional resources and process redesign, with key involvement from external providers and VCSE partners.

Timeliness was evident in a care record we reviewed where the assessment was completed within three to four weeks of initial contact. The person was already receiving care, which was reviewed and confirmed as appropriate. Carers reported that reviews of their assessments were done, and said informal contact could trigger a review. However, data from the Adult Social Care Finance Report (ASCFR)/Short and Long-Term Support (SALT) (2023-2024) showed only 44.44% of long-term support clients were reviewed (planned or unplanned) which was somewhat lower than the national average (58.77%). Partners told us there had been delays in assessments and reviews. One partner said the local authority had responded by working with community partners to carry out low-level reviews to help reduce the backlog. Urgent support was delivered well and some staff said system transformation had helped to reduce delays. Skilled practice leads were highlighted as enabling this progress.

Data provided by the local authority in April 2025 showed that across Adult Social Care, 3,691 assessments had been started in the previous 12 months, with 3,565 completed and 3,454 authorised, indicating most people were receiving assessments in a timely manner. However, local authority waiting list data for April 2025 showed 923 people were waiting for a review, with a median wait of 241 days and a maximum wait of 1,594 days. This had improved by September 2025 slightly to 916 people waiting, and a median wait of 190 days with a maximum wait reduced to 1140 days. For the Complex Care team, in April 2025, 85 people were waiting for an assessment, with a median wait of 20 days and a maximum of 180 days, against a target of 28 days. By September 2025 this had fallen to 44 people waiting with minor changes to median and maximum waits. In April 2025 the short-term team had 135 people on the waiting list, with a median wait of 4 days and a maximum of 144 days, also against a 28-day target. By September 2025 these had fallen to 83 people on the list, with no change to median wait times and maximum waits had fallen to 116 days.

To support people during these waits, the local authority had implemented a 'Waiting Well' pack, which included practical guidance on preparing for assessments, links to services, and information for young carers. A sample letter sent to people indicated they should expect contact within 8 weeks and included accessibility options such as translation and easy read formats. A risk assessment matrix was also used to monitor and manage risks while people waited.

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

Unpaid carers were well supported, heard, and understood. Carers described having an assigned worker or consistent contact with someone they trusted at the carers service. They said communication was easy and well maintained, with regular contact and follow-ups. All carers we spoke with confirmed they had received a carers assessment and had been supported, for example with cleaning services, benefit advice, or emotional support. Carers gave examples of how they had found or been offered support through GP practices, libraries and hospitals. They described how each person they cared for received their own individual assessment and said staff often went above and beyond to support them. Data from the Survey of Adult Carers in England (2024-2025) found there was a similar proportion of carers (35.42%) satisfied with social services as the national average (36.83%).

Staff said carers' assessments were consistently delivered in a conversational, holistic, and person-centred way. They gave carers the time and space to share their experiences fully. Staff reported carers frequently said the most valuable part of the process was feeling listened to, rather than the paperwork itself. Staff said assessments covered the carer's own health and wellbeing separate to the needs of the person they cared for, which often led to referrals for services such as occupational therapy. Carers were routinely given information packs, and leaflets about emotional support. Staff said consistently that the aim was to identify how carers could be supported.

Staff also said they had strong links with the carers centre and carried out either combined or separate carers assessments. They identified carers early and included contingency planning in their support packages, with budgets available to ensure respite could be accessed directly when needed. Leaders reported staff were responsive to carers' needs, offering support including training, respite, and emotional wellbeing services.

Partners said carers assessments were completed by carer support workers based in GP practices, while more complex assessments were carried out by the local authority. Carers Ambassadors (people with lived experience of unpaid caring) said there was a group for family carers which supported them and hosted events. They said the carers organisation strongly advocated for carers and had helped influence practical changes, such as the introduction of a blue badge system. However, some feedback from partners suggested that not all carers felt listened to during assessments.

Data provided by the local authority showed they largely met targets for carers assessments. As of September 2025, the waiting list for carers assessments was low, with only 3 people waiting. The median wait time was 1 day, and the maximum wait was 36 days, with previous data showing similar figures.

For Parent Carers, referred via the Children's Multi-Agency Safeguarding Hub (MASH), there was no waiting list, and assessments were allocated immediately, with a maximum wait of 5 working days. Young Carers were also referred via MASH and allocated within a week, with assessments completed within 4 to 6 weeks depending on availability. Longer waits were attributed to difficulties in contacting families.

The Carers Strategy 2024–2027 outlined a strong framework for identifying and supporting carers, involving them in service delivery and evaluation. However, it noted improvements were needed in supporting the cared-for person and in referrals to the Young Carers Service from Adult Social Care, Mental Health, and Substance Misuse teams. The strategy highlighted 81% of mental health carers felt not at all or not very supported. The local authority's self-assessment reported that 83% of carers were happy with their assessments. Carers had direct access to support at GP surgeries, and direct payments were well used and appreciated. The local authority had high numbers of carers and was identified as the sixth highest area nationally for carers providing over 50 hours of care per week. Despite this, the local authority had somewhat fewer carers not in employment because of their caring role (22.00%), than national average (26.70%) according to The Survey of Adult Carers (2024-2025).

The Survey of Adult Carers (2024-2025) data showed the local authority generally benchmarked well with carers outcomes. For example, the proportion of carers (54.89%) accessing a support group or someone to talk to in confidence, was much higher than the national average (32.98%). Also, somewhat more (91.67%) carers had enough time to care for other people they are responsible for than national average (87.23%).

Unpaid carers' needs were assessed well through person-centred and supportive approaches. Staff demonstrated a strong commitment to listening and providing support and carers consistently reported feeling supported and understood. The system included multiple access points and low waiting times.

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

People with lower-level needs not eligible under the Care Act were generally well supported through a coordinated approach involving the VCSE and commissioned services. Staff and partners recognised the importance of bridging gaps in provision, and the community helpline played a key role in identifying and responding to these needs.

Staff said that while their primary focus was on assessing eligible needs under the Care Act, they recognised the importance of supporting people with lower-level needs. Partners confirmed support for non-eligible needs was being actively addressed. A local Voluntary, Community and Social Enterprise sector (VCSE) infrastructure organisation described their role as one of 'holding the space' between the local authority and the VCSE, providing information, guidance and support where non-eligible needs were identified. It was commissioned by the local authority to deliver the community helpline, which acted as part of the front door to adult social care assessment. When people contacted the helpline, a strengths-based conversation was conducted to determine eligibility. Where needs did not meet Care Act thresholds, people were signposted to appropriate services within the VCSE.

Processes showed this approach was embedded and effective. Metrics indicated around 84% of calls resulted in needs being met by the VCSE sector. This demonstrated an infrastructure for supporting people with lower-level needs, reducing pressure on statutory services while ensuring people still received timely and relevant support.

Eligibility decisions for care and support

The framework for eligibility decisions was fair, transparent, and consistently applied. People were generally well informed and involved in the process, and staff followed clear procedures aligned with national legislation. While some partners raised concerns about cost-based decisions in some cases, formal complaints and appeals were not evident.

People said they experienced person-centred and strength-based assessments, even in complex cases. One example showed a person with limited communication was supported through recognition of their strengths. Decisions were made transparently and with clear communication. People also reported feeling involved in discussions and planning, and Adult Social Care Survey (2024-2025) data showed 68.16% of people did not pay privately or top up their care, which was somewhat better than the national average (64.39%) which together indicated equitable access to funded support.

Staff said they followed a clear and robust process for determining eligibility, aligned with the Care Act. They reported eligibility decisions were communicated clearly to people, including when people did not meet the criteria. Public information was provided through the ‘Waiting Well’ pack, which included references to relevant sections of the Care Act and regulations. It explained how eligibility was determined and offered guidance for carers.

Partners said while the framework was generally followed, advocacy staff had challenged decisions where cost appeared to override best interest considerations. Process data supported the view that eligibility decisions were managed consistently. In the 12 months to April 2025, the local authority received 15 formal complaints and 41 concerns. However, none of these related to eligibility determinations. The local authority confirmed that no appeals had been made regarding eligibility or funding decisions, and a robust complaints system was in place and accessible. Staff followed a structured triage and allocation process, and eligibility pathways were documented clearly in guidance shared across health and social care. The eligibility framework was also supported by a process document from Torbay and South Devon NHS Trust, who delivered social care services on behalf of the local authority, which outlined consistent processes and pathways for staff.

Financial assessment and charging policy for care and support

The charging framework was generally transparent and consistently applied, with staff committed to fairness and clear communication. Most people were assessed promptly, and accessible formats and advocacy support were available.

Staff said financial assessments were generally fair and aimed at ensuring people were not asked to pay more than they could afford. Although an online self-assessment tool had been trialled, it was discontinued due to reported complexity and as a result of feedback. Instead, staff preferred to visit people and explain the process in person, offering materials in accessible formats such as large print, Braille, easy read, and with translation support. Social workers could also refer people to advocacy services.

Staff said complaints were received, particularly about Personal Independence Payment (PIP) and Disability Living Allowance, although these were government-led benefits. Complaints also arose when people were discharged from hospital and expected care to be free for 4 weeks but were later charged, often due to confusion about when financial assessments had been completed and charges applied. Staff said they tried to resolve these issues by conducting retrospective assessments within 4 weeks and, where errors were due to social worker communication, they had written off some charges.

Staff also described their internal processes as responsive. Financial assessment requests were triaged and contact made within 48 hours, with assessments typically processed within 15 days. Referrals came from hospitals, intermediate care, enablement services, and directly from people. Staff used a contact grid within the case management system to track progress and prioritise new referrals.

Staff said people often found the distinction between health-funded crisis care and chargeable ongoing social care confusing. To address this, staff had made efforts to explain financial responsibilities clearly from the outset.

As of September 2025, the median waiting time for financial assessments was 18 days, with a maximum wait of 93 days, which showed a slight improvement from April 2025. The waiting list stood at 136 people, down from 184. However, for individuals lacking mental capacity, delays were significantly longer due to the need for Court of Protection or appointeeship processes, with a median wait of 222 days and a maximum of 819 days.

The local authority's charging policy provided clear guidance for staff, outlining how charges were calculated based on individual circumstances, including income, benefits, and living costs. The framework was aligned with the Care Act and included thresholds for financial eligibility and self-funding. While the Waiting Well pack offered public information on eligibility, it did not include details on financial assessments or support for people lacking capacity.

Provision of independent advocacy

Advocacy was available and well-integrated into the local authority's processes, with staff reporting timely access and clear referral pathways. However, partners highlighted inconsistencies in uptake and accessibility, particularly for those without professional support or awareness of their rights.

Staff said access to advocacy was good, with a clear referral process in place. Once allocated, people were said to receive advocacy quickly, including Care Act advocates and Independent Mental Capacity Advocates (IMCAs). Staff also reported they could discuss cases directly with the advocacy service, which supported timely and informed decision-making.

Partners offered a more mixed view. They said the local authority had an established and consistent relationship with the advocacy consortium, particularly in implementing the Care Act. Despite this, partners raised concerns about limited self-referrals, which created access barriers for people who were unaware of their rights or lacked professional support. Some also felt social care advocacy was underused, citing complaints and feedback suggesting people were not receiving advocacy as often as they should.

Supporting people to live healthier lives

Score: 3

3 - Evidence shows a good standard

What people expect

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

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

The local authority commitment

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

Key findings for this quality statement

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

The local authority demonstrated an effective approach to preventing, reducing, and delaying the need for formal care, through a combination of person-centred practice, integrated service delivery, and commissioning community-based support. People consistently described positive experiences of support that placed their wishes and wellbeing at the centre of decision-making. For example, one person, was supported to remain in sheltered housing, with a view to protect their mental health, with contingency planning and regular contact in place. Carers reported feeling well supported, with access to therapies, short breaks, and emergency respite. They appreciated being asked about future planning and felt encouraged to use available services when needed. The Adult Social Care Survey (ASCS) 2024-2025 data showed a somewhat higher proportion of unpaid carers (89.11%) found information and advice helpful, than the national average (85.22%).

Staff across services described a strong commitment to early intervention and holistic, strengths-based working. Mental health and learning disability teams shared examples of avoiding unnecessary care home admissions and enabling people with higher needs to live independently through reablement and technology. The transitions to adult services team supported young people to build independence, while sensory teams provided early advice, equipment, and peer support to reduce isolation and promote confidence. Staff also described the use of direct payments to enable personalised support and community access and highlighted the value of co-producing services with families and carers. Staff working in hospital discharge and reablement services described integrated, person-led approaches that prioritised returning people home with appropriate support, rather than referring to a care home. Services like a recently established reablement support facility was helping to provide reablement and wrap around support and reduce the need for care home admissions. Although it was new it was making an impact on facilitating timely hospital discharges and avoiding care home admissions. Positively, the Adult Social Care Outcomes Framework (ASCOF) 2024-2025 found significantly more people (90.17%) who received short term support no longer need support than the national average (79.39%).

The commissioned carers service said early identification of unpaid carers and their needs was a priority for them and they co-produced strategies to prevent carer breakdown, including research with Healthwatch to identify early indicators of crisis. They also supported young adult carers with tailored services, including education and employment support. Initiatives like the ‘MyBay’ card provided practical benefits in the local community and helped carers feel recognised and valued. A welfare advice partner addressed financial hardship and debt which had been identified as key drivers of crisis, by helping people maximise income and access benefits. Local community organisations supported people with broader health and care needs, housing challenges, and experiences of social isolation. Leaders described a place-based approach linking housing, health, and employment, with specific initiatives for mental health, suicide prevention, and domestic abuse. Community-based services like the Community Helpline and Community Café and Help Hub improved access to information, social opportunities, and volunteering for people in a preventative way to support wellbeing.

The Better Care Fund Plan focused on reducing hospital admissions, improving patient flow, and promoting recovery at home. The Technology Enabled Care Service (TECS) supported independence through digital tools and remote monitoring and there were plans to expand and personalise the offer. The local authority acknowledged the need to better communicate the benefits of TECS to people. The Waiting Well initiative and Waiting Well pack provided guidance for people awaiting assessments, promoting choice and control. The Carers Strategy and Market Position Statements outlined a clear vision for early help, high-quality homecare, and community support. The Integrated Commissioning Team, working with the NHS and VCSE, intended services to be shaped collaboratively and aligned with public health goals.

The local authority also recognised the importance of addressing digital exclusion, addressing mental health issues, and the identification of unpaid carers. Plans included forming a digital inclusion group, improving carer identification systems, and enhancing community-based support for mental health, domestic abuse, and sexual violence. The local authority committed to co-producing strategies with victims and communities to ensure services were responsive and inclusive. The Joint Health and Wellbeing Strategy and Devon 5-Year Joint Forward Plan set out long-term ambitions to improve outcomes through digital transformation, workforce development and population-based care. These included shared digital records, reduced workforce vacancies, improved employment rates for people with long-term conditions, and enhanced access to same-day services and community-based support.

Provision and impact of intermediate care and reablement services

People experienced reablement and intermediate care that prioritised safety, wellbeing, and personal preferences. More people accessed reablement in the local authority than national average, however more people returned to care or hospital settings after discharge.

We saw an example where a person was supported through a full pathway, from hospital to intermediate care and nursing home, with clear communication and a trial return home. Another person had avoided eviction through coordinated support from housing officers and enabling providers, showing how reablement extended beyond recovery from hospital to protect mental health and stability.

Data from the Adult Social Care Outcomes Framework (ASCOF/SALT) found a much greater proportion of people (7.40%) who were 65 years and over, received reablement/rehabilitation services after discharge from hospital, than the national average (3.00%). However, it also found the proportion of people 65 years and over who were still at home 91 days after discharge from hospital into reablement/rehab (73.26%) was lower than the national average (83.70%). Leaders said this was partly explained by more people being provided with reablement, due to the integrated nature of the service. However, it may also reflect a higher proportion of people entering long term care, rather than going home with support.

Staff and leaders said there was a strong commitment to short-term, strengths-based reablement focused on recovery and independence. Staff said reablement helped people regain confidence and reduce dependency, although they noted limited capacity and a perception reablement was mainly linked to hospital discharge rather than available more broadly in the community. The new local reablement facility was widely praised for its step-up and step-down model, use of technology and accessible location, helping people return home more quickly and avoid unnecessary long-term care placements.

Staff also described the benefits of integrated working with NHS staff which they said enabled rapid responses and improved outcomes, especially in crisis and end-of-life care. We heard examples where care packages and equipment had been arranged within hours. Commissioning staff reported improvements particularly over the last year in provider flexibility, with more agencies offering enabling care, enhancing support and crisis response.

Partners said people they supported had spoken positively about reablement and intermediate care. They had recognised the role of dedicated carers teams and Voluntary Community and Social Enterprise sector (VCSE) contracts in improving transitions and continuity of care.

The local authority reported 78.8% of people regained full independence after reablement, and 75% of those admitted to the rehabilitation centre had returned home without needing ongoing support. Strategic investments such as the new reablement facility, technology enabled care, and community-based hubs, demonstrated a commitment to prevention and recovery. The local authority acknowledged inconsistencies between hospital and community-based reablement and identified this as a priority in its commissioning plans. Other initiatives, including the drug and alcohol service had complemented reablement efforts by addressing wider determinants of health (other factors that can affect a person's health, such as social relationships and employment) and housing. Supported living and extra care housing had also contributed to enabling independence.

Access to equipment and home adaptations

People were generally able to access equipment and minor home adaptations through the local authority, with urgent needs prioritised and standard items delivered promptly. Staff worked in integrated teams to ensure responsive and person-centred care, and partners supported access through VCSE arrangements.

People described how replacement beds, rails, and specialist mattresses were provided, contributing to safety, comfort, and reduced risk of harm. For example, a routine maintenance check had identified unsuitable equipment, prompting an occupational therapy review. People felt their physical safety was prioritised, and equipment was selected appropriately.

Staff said access to equipment was prioritised based on urgency. The Principal Occupational Therapist explained rapid response equipment could be delivered within 2 hours, with next-day delivery available for standard catalogue items. Urgent cases were triaged daily, with assessments carried out within 72 hours, while non-urgent cases had a maximum wait time of 12 weeks. Staff noted that co-location with health professionals, including occupational therapists and nurses, had significantly improved responsiveness and enabled more person-centred care. They also described how people were given clear self-purchase guidance, including specifications, costs, and demonstration videos, which empowered them to make informed choices and promoted dignity. Where Disabled Facilities Grants (DFGs) were used, staff recorded outcome measures such as confidence ratings before and after adaptations.

Partners said carers had benefited from equipment and adaptations that supported their caring role, and Voluntary Community and Social Enterprise sector (VCSE) contracts had helped improve access and continuity of care. However, they also noted rural areas faced challenges in sourcing equipment and care packages due to limited local provision, which could exacerbate isolation and unmet needs.

Processes showed the local authority had a transparent approach to equipment and minor adaptations. According to data provided by the local authority dated April 2025, the waiting list for equipment stood at 103 items, with an average wait time of 7 days and a maximum of 434 days. For minor adaptations, the waiting list included 45 items. Service level agreements included rapid response within 2 hours, next-day delivery, and standard delivery within 3 to 5 days. A triage system was in place to manage high referral volumes, with urgent cases assessed within 4 to 6 weeks and routine needs within 6 to 12 weeks. The local authority also provided holistic, strengths-based assessments aimed at supporting independence in all aspects of daily life, including physical, psychological, social, and environmental factors.

Provision of accessible information and advice

People were generally able to access information about their rights and ways to support their wellbeing. They had been informed about waiting times and advised to contact services if their circumstances changed, which helped ensure timely and risk-based access to services. Carers felt reassured by Waiting Well materials, which explained assessment processes, eligibility, and financial responsibilities. These resources helped people understand their rights and what to expect, promoting transparency and trust. Data from the Adult Social Care Survey (2024-2025) found 69.33% of people who used services found it easy to find information about support which was the same as the national average (67.12%). Data from the Survey of Adult Carers in England (SACE) (2024-2025) showed a somewhat higher proportion (66.02%) of carers found it easy to access information and advice than the national average (59.06%).

Staff said referrals came through the service front door, where people were signposted to appropriate services such as Voluntary Community and Social Enterprise (VCSE) organisations or local community hubs. Partners said the community helpline had developed during the COVID-19 pandemic intended to provide a 'one call fits all' model, making it easier for people to access the right services quickly. They said information was available on both the local authority and NHS websites but acknowledged that navigating these could be challenging for some. The community hubs, such as the one at a local library, allowed people to request assessments in person.

The local authority reported that people accessed information, guidance, and support through their community offer, which included an integrated contact centre and an emergency duty service. Over the past year, they had supported 1,912 people with advice and received 15,368 contacts, of which 13,456 progressed to assessments or reviews. Their improvement project aimed to reduce formal care assessments by strengthening partnerships with the VCSE. They provided a Disability Information Service offering free, confidential advice on self-care and independent living, including a hospital drop-in. Accessibility was enhanced through tools like text-to-speech, translation, picture dictionaries, and screen magnification.

People waiting for assessments received an online information pack explaining the process and answering frequently asked questions. The Carers Service webpage and newsletter offered clear, navigable resources, including information on mental health, dementia, benefits, and events. The Carers Strategy linked to various policies and strategies and was hosted on the Torbay and South Devon NHS Trust website. The “One Devon” website also provided comprehensive resources for carers and young carers, including support on finances, training, and wellbeing. The Waiting Well pack included information for people on how to wait well and prepare for assessments. It referred to young carers and contained links and good information on how to meet needs and access services.

Direct payments

Direct payments experiences were mixed. There were complicated systems and fewer people than national averages utilising direct payments, although work was underway to address these challenges which were well understood by the local authority.

People reported positive experiences with direct payments. They described how they had enabled participation in carers' activities, supported independence through equipment and provided support such as respite and outdoor activities. People and carers appreciated the flexibility, with examples including holidays supported by additional carers, gym memberships and social outings. We saw examples of people managing their own direct payments to maintain choice and control in their lives and examples where direct payments allowed greater personalisation and continuity of care workers. However, Adult Social Care Outcomes Framework/Short and Long Term (2024-2025) data showed fewer people using services (19.33%) received direct payments than the national average (25.48%) and the proportion of carers receiving direct payments was 94.12%. Most carers we spoke with had received and used direct payments, either as one-off or regular payments.

Staff acknowledged the benefits of direct payments but also highlighted challenges. These included inconsistent pay rates, variable quality among personal assistants (PAs) and people reporting difficulties with holding employer responsibilities. To address these issues, the local authority had begun to build a vetted pool of PAs and revised contracts. A company was available to help manage direct payments and PA employment, and staff knew where to seek advice. Staff said that while they could set up direct payments, the process was not straightforward. Leaders recognised the need for development in this area and were working to improve the process, infrastructure and guidance. Partners agreed work was underway to review the direct payments process and to understand any barriers to their uptake.

In the meantime, the local authority had revised policies, and updated documentation. They published support materials and had engaged with stakeholders, direct payments recipients, and health partners. Draft guidance documents outlined responsibilities, financial review processes, and administrative terms. Employment resources, including checklists and contract templates, were provided to help direct payments recipients manage their responsibilities as employers. A handbook had been developed to support relationships between direct payments recipients and PAs, covering employment policies, training, health and safety, and equal opportunities.

Equity in experience and outcomes

Score: 2

2 - Evidence shows some shortfalls

What people expect

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

The local authority commitment

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

Key findings for this quality statement

Understanding and reducing barriers to care and support and reducing inequalities

The local authority made considerable efforts to remove barriers to inclusion and understand the needs of its population, and this was reflected in the experiences and perspectives shared by people, staff, and partners.

People described a noticeable shift in how the local authority engaged with them over recent years. Ambassadors (people with lived experience of a social care need) took on active roles in holding both the council and NHS to account, offering ideas and feedback that have led to tangible changes. One example was the installation of wheelchair access at a local beach, which followed a walkaround with staff to assess accessibility needs. This demonstrated a meaningful commitment to co-production and showed that the local authority leaders were willing to listen and act on lived experience.

There was also recognition from people that leadership attitudes had evolved. The involvement of the council leader had led to improved relationships and responsiveness. People said their input was being taken seriously, and staff had undergone training, led by ambassadors to better communicate and engage with them. Practical improvements, such as the introduction of free public toilet access cards for disabled people, were seen as direct outcomes of this improved collaboration.

Staff echoed many of these sentiments, showing a deep awareness of the barriers faced by different groups and a proactive approach to addressing them. They highlighted that many carers, particularly younger ones, did not identify as carers and therefore missed out on support. To counter this, staff promoted education and outreach, coded carers on GP registers, ran carers groups in community venues, and engaged with the public at events. These efforts were aimed at ensuring equitable access to support, even for those not yet known to the system.

Digital exclusion was another issue raised by staff, particularly affecting older residents who struggled with online forms and websites. A reliance on digital systems was seen as creating inequity in access and staff recognised the need for more accessible service pathways. They also described co-production as central to their work, with ambassadors and community representatives influencing training and service design.

Staff said there were some improvements to make, including improving referral rates to advocacy services, creating clarity around direct payments, and improvements to housing and dual diagnosis services. They said people with both mental health and substance misuse needs often fell between services, and housing systems were difficult to navigate, with strict rules and consent processes that disadvantaged adults with care and support needs.

Partners said the local authority had a strong understanding of its population, supported by the Joint Strategic Needs Assessment (JSNA). The JSNA identified key challenges such as an ageing population, deprivation, teenage pregnancy, self-harm, and a high prevalence of learning disabilities and neurodiversity. Inequalities in life expectancy and healthy life years were also identified, and partners said the local authority worked with Voluntary Community and Social Enterprise sector (VCSE) organisations to address these issues and ensure seldom-heard voices were represented.

Partners said the local authority prioritised housing, employment, dementia, and healthy ageing and engaged regularly with underrepresented communities. Engagement had been extended into deprived areas, with joint initiatives such as additional primary care services and VCSE support for frequent emergency department attenders. They said co-production was embedded alongside Healthwatch and the VCSE Assembly, and the local authority had a long-standing commitment to engagement, including through its 10-year plan.

However, partners also said transition planning for young people was not always proactive, and some had missed out on support. Employment was highlighted as a persistent issue for people with learning disabilities, with concerns the local authority was aware but not taking sufficient action to address it. Digital exclusion and communication barriers were seen as persistent issues, particularly for those without internet access or with specific communication needs.

Partners also noted positive efforts to reach underrepresented carers, including men and ethnic minorities, through activities and ambassador roles. Activities such as fishing and football were commissioned by the local authority and had good attendance. A Carer Ambassador was being recruited from the Chinese community, and further engagement with male carers was planned. Some partners said the local authority still had limited data to fully identify and address inequalities.

The local authority’s policies and processes supported many of these efforts. The Inclusion Plan, Carers Strategy, and Health and Wellbeing Strategy outlined commitments to equity, co-production, and data-informed service design. The Trauma-Informed Practice Project and Equality Diversity and Inclusion (EDI) Ambassadors supported inclusive practice and representation. The Homelessness and Rough Sleeping Strategy identified hidden homelessness.

The local authority responded to national and global concerns about racial inequality by conducting a Racism Review. This led to the creation of a dedicated inclusion role and a set of recommendations aimed at improving ethnic diversity data, workforce representation, and trust within communities. Internally, the local authority had implemented several initiatives to support inclusion. It created a Healthy Ageing Partnership and developed a Supported Housing Pathway for young adults. The Carers Strategy 2024-2027 and Young Carers' Under 25 Strategy targeted underrepresented groups, including ethnic minorities and refugees, and demonstrated good partnership working.

The local authority had made progress in removing barriers to inclusion and understanding its population's needs. People, staff, and partners all described positive changes, particularly in leadership engagement, co-production, and practical service improvements.

Inclusion and accessibility arrangements

The local authority demonstrated a proactive and increasingly embedded approach to inclusion and accessibility. People were empowered to shape services; staff had adapted communication and service design to meet diverse needs and partners recognised engagement efforts. Formal policies and demographic data also supported inclusive planning.

People said they had been meaningfully involved in improving accessibility and shaping services. Learning Disability (LD) Ambassadors had created a training board game based on real-life barriers, which led to changes, such as adjusting appointment times to accommodate bus pass usage. Carers said there was clearer communication because of initiatives such as Carers Rights Day and felt their voices were heard by leadership, particularly the Director of Adult Social Services (DASS). Carers had contributed to editorial boards, legal training, and service evaluation, helping to make rights more visible and accessible. Ambassadors from underrepresented groups had also participated in large-scale events and policy reviews, helping to identify unmet needs and influence service design.

Staff said they had implemented a range of initiatives to improve accessibility. LD and Autism Ambassadors had helped redesign the adult social care website, leading to the addition of an accessibility toolbar and improved navigation. Interpreter services, including British Sign Language (BSL), had been available out of hours, supporting emergency responses and ensuring communication was inclusive. The Sensory Team worked with people with learning disabilities, dementia, and dual sensory loss, adapting communication methods using BSL, Braille, lip reading, and assistive technology. Staff also supported carers and families to better understand sensory loss, fostering empathy and improving care. The community hub had been strategically located near public transport links to improve physical accessibility for residents with mobility challenges.

Partners said they had seen improvements in outreach and engagement, particularly with underrepresented communities. The local authority had responded to gaps in engagement by working with the Polish school and recruiting ambassadors from ethnic minority groups, including the Chinese community. Carers services had been promoted at Pride events and tailored to male carers through partnerships with men’s clubs, using activities such as fishing and football to encourage participation.

However, partners also identified persistent barriers. Digital exclusion continued to be a significant barrier, especially for people who are deaf or not online, with no formal alternatives in place. Some partners said the local authority lacked sufficient data to fully identify where barriers and inequalities existed. Others said that while feedback was often collected, communication about resulting actions was inconsistent.

The local authority kept a collection of easy read documents covering key adult social care topics, and interpreter services were available in multiple formats, face-to-face, remote, and by telephone. Mapping tools had been used to track demographic changes, such as the rise in speakers of Bulgarian, Romanian, Hungarian, and Portuguese languages, informing accessibility improvements. Equality impact assessments were used to identify and mitigate adverse impacts on residents with protected characteristics. Data from the Census had been used to identify areas with high levels of non-English-speaking households. The Inclusion Partnership Board had brought together people with lived experience from LGBTQ+, autistic, and ethnic minority communities to act as critical friends, review policies, and deliver awareness training.

Theme 2: Providing support

This theme includes these quality statements:

- Care provision, integration and continuity
- Partnerships and communities

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

Care provision, integration and continuity

Score: 3

3 - Evidence shows a good standard

What people expect

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

The local authority commitment

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

Key findings for this quality statement

Understanding local needs for care and support

The local authority worked collaboratively with local people, stakeholders, and partners, and used a wide range of data, policies, and strategic planning to understand and respond to the local needs for care and support. People described being listened to and having their preferences respected, such as one person who was supported to return home despite having high levels of need. Carers spoke positively about the range of support available, including access to exercise classes, day trips, and education sessions, which suggested the local authority was responsive to the needs of unpaid carers. The local authority was actively engaging with people, staff, and partners, and was using robust data, policies, and procedures to understand and respond to care and support needs. There was a clear commitment to person-centred care, creative problem-solving, and service improvement. However, there were still some gaps in provision for people with complex or higher-level needs, mental health issues, and housing.

Staff said they considered where people want to live, including proximity to family, cultural needs, and personal interests. They described efforts to source care out of area when necessary, including contacting other local authorities and conducting their own due diligence. However, they acknowledged challenges in finding appropriate care for people with higher levels of certain needs, such as those with mental health issues, learning disabilities, or substance misuse problems. Data provided at the time of the assessment by the local authority, showed 10.7% of all long-term placements were out of area, and just 8.2% of those with mental health needs were placed into Nursing or Residential care out of area, with most remaining within Devon to maintain proximity to support networks.

Partners and leaders in the local authority said hospital discharge performance had been very strong, with timely discharge rates among the best nationally and the lowest length of stay in the region. However, it was acknowledged the pressure to discharge quickly had led to too many people entering long-term care, and strengthening reablement and independence-focused services was identified as a key priority. This aligned with staff feedback who were working to reduce reliance on spot purchasing and increase ‘home first’ approaches.

Partners described creative approaches to replacement care, such as working with a short break provider and with hotels to offer discounted stays for unpaid carers. Partners also highlighted the lack of a specialist learning disability service within adult social care, which had led to a need to bridge gaps in provision. This was being addressed through a service which integrated care planning for people with learning disabilities and their carers, particularly as the carer population ages. The service also supported carers who themselves had learning disabilities.

Housing was an area of concern. Staff and partners said finding suitable housing, particularly for people with learning disabilities could be a challenge. However, partners acknowledged that the local authority was aware of this and had plans to develop new housing. The local authority was commissioning 171 new units of extra care accommodation across 2 multi-generational housing developments, which will support up to 200 people. These will complement the existing 108 units of rented and shared ownership accommodation, with support provided across all 4 schemes.

The local authority's policies and procedures further demonstrated a strategic approach to understanding and meeting care needs. They reported having robust contracts with home care providers and strong relationships with supported living and care home providers through contract management and quality assurance processes. Providers had named contract managers or quality assurance officers, and they received few contract queries or requests for rate uplifts.

Commissioning strategies were informed by the Joint Strategic Needs Assessment (JSNA), which highlighted key priorities such as supporting people over 65 with complex needs and dementia, people of working age with severe and enduring mental illness, and people with learning disabilities and autism. The JSNA showed the area had higher levels of need than the national average, particularly among the 18–64 age group, and higher rates of long-term support through residential care.

The JSNA also identified significant health inequalities, including high rates of mental illness, self-harm, suicide, and preventable deaths, particularly in deprived areas. These findings were reflected in the local authority's market position statement, which outlined plans to reduce reliance on residential care, increase supported living options, and promote independence through early support, equipment, and digital technology. The local authority aimed to avoid placing working-age adults in residential care and to delay older people's entry into care through better home care alternatives, reablement and extra care housing.

For people with learning disabilities and autism, the local authority planned to improve access to employment and training, commission outcome-based day opportunities, and ensure more skilled providers were available. Positive Behaviour Support and Crisis Planning training were being commissioned to support workforce development. Similar plans applied to people with mental health needs, with a focus on reducing residential care use and expanding housing choices.

Market shaping and commissioning to meet local needs

Positively, the Adult Social Care Survey (ASCS) (2024-2025) found 77.04% of people who used services felt they had choice over services, which was somewhat better than the national average (70.28%). The Survey of Adult Carers in England (SACE) (2024-2025) found a similar (18.05%) proportion of unpaid carers accessed support or services allowing them to take a break from caring for greater than 24hrs, to the national average (16.14%); 17.29% of carers accessed support or services allowing them to take a break from caring for 1-24hrs which was similar to the national average (21.73%) and 13.53% of carers accessed support or services allowing them to take a break from caring at short notice or in an emergency, which again was similar to the national average (12.08%).

The local authority had explained its strategic intent through a range of planning documents and frameworks. The Commissioning Plan outlined priorities and a 2-year work programme aligned with the Adult Social Care Transformation Plan, with timeframes added as each programme begins. This approach allowed accountability and progress tracking. The Big Plan co-produced with people with learning disabilities, had influenced wider commissioning across health, housing, and social care, and the co-produced Autism Strategy was at the time of our assessment, in the community engagement phase, demonstrating inclusive planning.

The Adult Social Care Commissioning Blueprint set out ambitions to expand supported living and extra care housing, develop outcome-based day opportunities for people with learning disabilities, and support young people transitioning to independence. For people with mental health needs, the local authority aimed to reduce reliance on residential care and commission more supported living, aligned with rehabilitation and recovery models. For people with dementia, the plan included reducing residential care use by 200 beds, increasing nursing care beds for complex dementia by the same number, and commissioning specialist dementia personal assistants to support the use of personal budgets and direct payments. Training in advanced dementia and cognitive stimulation therapy for carers, was also planned.

The Strategic Needs Assessment underpinned these commissioning decisions, using a wide range of data sources to identify demographic pressures, service gaps, and health inequalities. The Draft Market Position Statement 2025 built on previous strategies and included plans for refreshed day activities frameworks, an updated direct payments policy, and capital projects to deliver extra care homes, including a new day centre.

The Qualitative Capacity Plan 2024–2025 acknowledged current limitations in supported living due to housing supply and capital constraints and outlined a 2-year redesign of the commissioned market to improve affordability and reduce high-cost spot purchasing. The 10-year Adult Social Care Commissioning Blueprint provided a long-term vision for market transformation, supported by co-located commissioning teams from the local authority and NHS, enabling high levels of collaboration.

The Integrated Adult Social Care Commissioning Plan 2025–2027 detailed commissioning intentions across reablement, residential care, and domiciliary care, with new specifications for specialist, standard, and reablement homecare. It also identified commissioning concerns with plans and timescales to address them. The Better Care Fund Narrative Plan highlighted support for hospital discharge and sustainable community-based care, and a shift from time-and-task models to independence-focused reablement, using technology.

The local authority provided further detail on current supported living provision following our assessment. There were 22 supported living providers delivering 333 units of accommodation and there were 108 units of extra care housing available across 2 schemes. The supported living sector was predominantly used for people with learning disabilities, with some provision for those with severe and enduring mental illness. Extra care housing was currently used 80% for older people and 20% working-age adults with disabilities or mental health needs. The local authority was actively expanding extra care provision. While there were some gaps in specialist provision, particularly in reablement, dementia care, supported living, and services for people with complex or higher-level needs, the local authority was actively addressing these through strategic commissioning and market shaping.

Ensuring sufficient capacity in local services to meet demand

The local authority had a responsive and generally sufficient care system, supported by strategic planning, strong provider relationships, and active market shaping. While most people receive timely and appropriate care, there are clear pressure points, particularly in supported living, mental health, and services for people with complex and higher-level needs. The local authority was aware of these challenges and had robust plans in place to address them which were taking effect at the time of our assessment.

Staff said care packages were generally arranged quickly and efficiently, with only a small number of people waiting for support at any given time. Staff described a clear process for matching referrals to providers, supported by systems and weekly market intelligence updates. However, they acknowledged supported living placements were more difficult to source, particularly for people under 65, due to limited options and some provider suspensions. Mental health and supported living were consistently highlighted as areas with insufficient capacity. Staff also noted that while intermediate care facilities were available, hospital discharge pathways sometimes defaulted to bed-based care. Despite these challenges, staff described strong collaboration across teams, including occupational therapy and quality assurance, and gave examples of responsive service development, such as the creation of a young person's service.

Partners echoed many of these observations. They said the care market had sufficient overall capacity, but pointed to gaps in specialist provision, particularly in reablement, dementia care, supported living, and services for people with complex learning disabilities, autism, and mental health needs. Mental health services were described as under-resourced, and there were concerns about insufficient services for adults with learning disabilities and autism.

Policy and procedural evidence provided a more comprehensive view of capacity planning. Data showed short average waiting times for homecare (5.5 days), residential care (6.5 days), nursing care (7 days), and supported living (68 days), with the latter being the most pressured area. Out-of-area placements were relatively low, with most remaining within the South West, and driven by proximity to family, specific needs, or personal choice.

The local authority was actively reshaping the market through its Integrated Adult Social Care Commissioning Plan, Capacity Plans, and Market Position Statements. These included expanding extra care housing, reducing reliance on residential care, and investing in dementia-capable services. A planned reduction of 200 low-capacity residential beds was planned to be offset by modernisation and enhancement of existing services. Reablement services were being scaled up, with new contracts launching in October 2025, and a move toward a trusted assessor model. The local authority was also improving support for carers through short-term care at home and block-purchased short breaks, and exploring technology and artificial intelligence solutions to improve access to advice and information.

The Qualitative Capacity Plan outlined a shift toward housing-based models of care and a strength-based approach. The local authority expected demand for long-term home care to decrease beyond 2025 because of this redesign. It had successfully matched home care supply with demand, despite market pressures, and continued to use Fair Cost of Care funding to support sustainability and close fee gaps.

Ensuring quality of local services

The local authority was adequately ensuring services were high quality. People's feedback suggested the quality of care was high and consistent. One person we spoke with described proactive involvement in care decisions and consistent support from social workers, even during multiple transitions between services and accommodation. Another said their supported living arrangement fully met their needs, enabling them to live comfortably despite higher levels of need. These examples reflected positive outcomes and suggested the system delivered person-centred, high-quality care.

Staff and partners, however, acknowledged variability in service quality. Staff said providers were beginning to adapt by diversifying and expanding their offers. Staff described strong multidisciplinary working and triage processes that helped reduce reliance on long-term care. Examples were given of successful transitions with reductions in support levels through person-centred planning.

Monitoring of provider quality was described as ongoing and data-driven. Staff reported using case management systems, care documentation, falls reports, and a risk tool that tracked ambulance calls, 111 calls, and accident and emergency department attendances. Dashboards were used to identify safeguarding themes, and low levels of provider reporting triggered monitoring and follow-up. These mechanisms suggest the local authority took a proactive approach to identifying and responding to risks. Partners highlighted the importance of joint commissioning arrangements and described monthly meetings which involved the local authority, Integrated Care Board, and Torbay and South Devon NHS Foundation Trust to discuss market conditions and quality. This collaborative structure supported a shared oversight.

Policy and procedural evidence reinforced the presence of robust quality assurance arrangements. The local authority reported 88% of care homes and 81.8% of community services were rated good or outstanding. They had a Provider Quality Support Policy and a co-located Integrated Commissioning Team that included clinicians who contributed to quality monitoring, training, and gave advice. Regular provider forums and newsletters were used to share best practice, market risks, and funding opportunities. Providers had regular contact with contract or quality assurance officers.

The local authority had taken action where concerns had arisen. Three embargoes were in place, 1 for nursing care due to safeguarding concerns and 2 for residential care due to safety and quality issues. One residential home had its suspension lifted after improvement, and another was working to a quality improvement plan. No home care providers handed back contracts, and only 1 supported living provider did so due to internal financial concerns. Three residential homes handed back contracts, 2 due to changes in care models and one for financial reasons. In 1 case, a provider with significant quality and financial issues was supported through the Provider Quality Support Protocol, and the provider reported a positive experience with the Quality Assurance Team.

Digital transformation was also supporting quality monitoring. The Integrated Care System Digital Strategy included plans for shared records and a unified infrastructure. Achievements included the launch of the One Devon Dataset and the Devon and Cornwall Care Record. These tools were expected to enhance operational oversight.

Ensuring local services are sustainable

Services were sustainable in the local authority. Adult Social Care Workforce Estimates 2025-2026 showed a positive picture of workforce stability with a somewhat better performance in adult social care job vacancies with 4.70% of adult social care job vacancies, compared to the national average 8.06%. Staff turnover rates (0.27) were similar to national average (0.25) as were staff sickness rates (5.23) compared to national average (5.33).

Staff said there were some staffing shortages, however, they described resilience and pride in their teams, with strong peer support and there was positive feedback from carers and people. Partners said there were sometimes delays in allocating community social workers post hospital discharge. These delays had led to extended stays in short-term placements.

From a policy and strategic perspective, the local authority had recognised sustainability as a pressure and were actively working to improve it. They were using Market Sustainability and Improvement Funding to uplift provider fees across all sectors, aiming to support recruitment, retention, and quality delivery. Fee rates were expected to increase in 2024–2025, with the intention to stabilise the provider market.

The local authority had outlined plans to expand capacity through apprenticeships and internships, publish practice quality standards, and enhance the role of technology in reducing impacts of workload. Additionally, they were participating in regional initiatives to support international recruitment, including digital tools and platforms to connect international recruits with employment opportunities.

The Education and Development Strategy set out a 5-year plan for workforce development across the Integrated Care System, including adult social care. This strategy aimed to address recruitment challenges and build a skilled, resilient workforce. A separate workforce development plan was also being created to support the integration of commissioning functions. The local authority was investing in digital transformation to support sustainability. This included shared records, unified infrastructure, and a population health management process.

Partnerships and communities

Score: 3

3 - Evidence shows a good standard

What people expect

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

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

Partnership arrangements had been effective in promoting integrated, person-centred care. The approach demonstrated a strong commitment to co-production, prevention, and integrated care.

People said the small size of the local authority area had helped foster strong relationships and a sense of belonging, which people felt had contributed to more responsive and collaborative care. Feedback from people suggested services had been welcoming and had felt joined-up and easy to navigate. Partners, staff and leaders said adult social care had been completely integrated with health since 2005 under a Section 75 agreement, and broadly agreed this had enabled more coordinated care, improved outcomes, and allowed a better use of shared resources. Partners said progress on Integrated Neighbourhood Teams had continued, with a strong focus on prevention, reablement, and shifting care from hospital to community settings and dementia and healthy ageing had been identified as priorities for future delivery.

Partners had played an active role in reshaping the Learning Disability Partnership Board and establishing the Autism Board, both of which had been designed to amplify the voices of people with lived experience. Autism Ambassadors had helped set agendas and hold board members to account, which partners described as an example of good practice. Partners also told us about forums such as the Torbay Inclusion Partnership and the Special Educational Needs and Disabilities Employment Forum, which had included people with lived experience and supported inclusive decision-making. While partners had praised strong internal relationships and co-location of teams, some expressed concern about the future of Voluntary Community and Social Enterprise sector (VCSE) infrastructure funding.

Staff said they worked well in multidisciplinary teams and integration had strengthened links between services and improved understanding across sectors. The movement of occupational therapists between health and social care was seen as particularly beneficial. Staff described the joint workplace culture as inclusive, reflective and welcoming. Newer staff felt it was a supportive environment.

Strategic partnerships between education, adult social care and health partners had supported joined-up delivery and inclusive practice. Staff said they valued opportunities for career-specific and postgraduate training and had appreciated the local authority's commitment to wellbeing. Staff also highlighted improvements in hospital discharge through the home-first approach, supported by a well-established discharge-to-assess model. They said efforts to reduce paperwork through technology and artificial intelligence were welcomed.

Arrangements to support effective partnership working

Arrangements were in place and working well to support effective partnership working. Partners said relationships with the local authority had been strong and improving, they said the Deprivation of Liberty Safeguards (DoLS) team had maintained collaborative relationships with advocates and responded promptly to concerns. Healthwatch described proactive engagement from the Director of Adult Social Services, who had ensured their involvement in agenda setting and strategic planning. They said the local authority approached them first when launching new initiatives, such as the adult social care strategy and worked with them to engage local communities. Other partners also highlighted the effectiveness of joint governance arrangements and co-located commissioning teams, which had supported high levels of collaboration across NHS strategies and improved management of the Better Care Fund.

Staff said the Autism Partnership Board was an example of effective partnership working, where agendas had been co-produced with Autism Ambassadors, council representatives, and health partners. Staff said the arrangements to support partnership working were well-established. They highlighted some operational challenges including issues around equipment, documenting people's care across multiple electronic systems and occasionally demand exceeding capacity. Availability of housing and the local rehousing process also posed difficulties. Despite these challenges, staff demonstrated resilience in the multi-disciplinary team environment, maintaining open communication, managing expectations, and welcoming more consistent contact routes.

Leaders described the Integrated Care Organisation model as deeply embedded, with co-located teams and shared risks. They said it had often been impossible to distinguish between health and social care staff, reflecting the depth of integration. Joint funding protocols introduced after a peer review in 2024 had helped to clarify financial responsibilities and reduce inappropriate assessments in complex or higher-level of need cases. Innovation in housing-with-care provision also demonstrated effective partnership working. Staff said the design of new extra care housing schemes followed accessibility standards and would offer support 24 hours a day.

Staff described excellent partnership working with external stakeholders, including the Police for Multi Agency Risk Assessment Conference and domestic abuse cases, health colleagues, GPs, and Voluntary Community and Social Enterprise (VCSE) providers. They said there had been a good flow of information and risk plans were arranged quickly to keep people safe. Leaders described commissioning arrangements as 3 pillars: the NHS trust's market management team, the local authority's strategic commissioning team, alongside the NHS Devon Integrated Care Board (ICB). This structure had supported improved relationships with primary care partners and provided a better oversight of adult social care.

The local authority reported having an integrated health and social care offer in place for 20 years, with delivery delegated to the Torbay and South Devon NHS Foundation Trust, while retaining strategic commissioning responsibilities. They had been part of the One Devon Partnership, formed with other local authorities and health partners, with shared aims to promote health and wellbeing. This had been underpinned by the Devon Plan, the Joint Forward Plan, and the Integrated Care Strategy. The Provider Quality Support Protocol provided a multi-disciplinary approach to quality assurance and service improvement, involving strategic commissioners, safeguarding teams, regulators, and providers.

The Better Care Fund arrangements had been governed through local partnerships, with shared responsibility for planning, review, and capacity management. These arrangements had helped address urgent care and system flow challenges, particularly around delayed discharges.

Impact of partnership working

People experienced coordinated and consistent support across settings, with care personalised to meet their individual needs. Records showed multi-agency input from enabling providers, housing teams, and welfare support alongside social care, had helped people achieve positive outcomes and reflected a system working holistically to support people.

Staff said integrated working with the NHS had been a major strength, enabling faster interventions, shared learning, and innovation. Co-location with health colleagues had supported quick referrals, joint safeguarding meetings, and multi-agency responses mobilised quickly. Staff said they valued strong Voluntary Community and Social Enterprise (VCSE) links and described coordinated support for carers in hospital wards and GP practices. Staff said they worked closely with discharge teams and occupational therapists to create bespoke packages of care, helping people return home safely and reducing readmissions. Access to shared systems had improved visibility and coordination, allowing staff to address social care needs even in health-led cases.

Leaders said tackling deprivation was a local partnership priority, with joint leadership aligning vision and resources to keep people well. They described finances between the NHS and local authority as a single budget, enabling integrated delivery and reducing handoffs. Leaders also highlighted broader structures such as the Pride of Place board and regeneration partnerships, which had brought together health, education, police, and business sectors to deliver wider social and economic benefits.

Partners said integration had improved health outcomes, including reduced urgent care admissions and shorter hospital stays. They praised the Section 75 agreement for enabling delegated funding and described a positive recent shift in adult social care's visibility and multidisciplinary collaboration. However, they were aware of high long-term care conversion rates following hospital discharge. Leaders across the system had commissioned an independent review to assess the wider health and cost benefits of the integrated model and rebalance the system toward independence-focused care.

Partnership working had led to improved outcomes, enhanced coordination, and a system-wide commitment to integrated, person-centred care. Staff felt supported, leaders had aligned vision and resources, and partners described clear benefits.

Working with voluntary and charity sector groups

The local authority demonstrated a strong approach to working with the Voluntary Community and Social Enterprise (VCSE) sector. People benefited from co-produced services and good levels of VCSE support. Staff described responsive, collaborative working. Leaders embedded VCSE voices into strategic planning and partners felt recognised and involved. People had experienced meaningful engagement through co-production, particularly in relation to carers. Carer Ambassadors noted the high number of carers in the local authority providing over 50 hours of care weekly, and the local authority had responded by co-producing a replacement care offer and monitoring its impact through surveys and ongoing involvement.

Staff said they worked closely with VCSE organisations to support a wide range of needs. They described joint work for example with armed forces charities, outreach at community events, and collaboration with schools to support young carers. Co-location with VCSE partners in the integrated arrangements had enabled faster decision-making and collaboration. Staff clearly valued the VCSE sector's role in housing advocacy and support for marginalised groups and highlighted the benefits of shared training and integrated working.

Leaders said the VCSE sector had been integral to strategic planning and community engagement. They described working in a power sharing way with local communities, supported by connectors and community builders. Public Health leaders emphasised the VCSE's role in addressing deprivation and supporting ageing populations. The sector comprised over 800 organisations, with 250 focused on health and wellbeing. With the local authority being one of the smallest nationally, this was a wide range of support. Leaders referenced platforms such as the Continuous Improvement Board and the Learning Disability and Autism Partnership Boards as key spaces where VCSE voices had shaped delivery.

VCSE partners felt valued and increasingly involved, particularly since the COVID-19 pandemic. They described early engagement in planning, co-production of strategies and regular forums for feedback. Healthwatch partners said they were proactively involvement in the local authority, including participating in the Health and Wellbeing Network and Board. However, partners spoke about short-term contracts and a lack of financial sustainability with limited tender notices. Engagement with smaller grassroots organisations had also been challenging, though the local authority had supported joint tendering and capacity building.

Processes reinforced VCSE collaboration through contracts and governance structures. The Community Wellbeing Contract had enabled VCSE-led delivery of helplines, community hubs, and community coordination. The Local Area Partnership had supported joint working on health and employment priorities. Co-delivered projects such as the LGBT+ Survey and the Domestic Abuse and Sexual Violence Strategy had embedded lived experience and engagement. The Devon 5-Year Joint Forward Plan included the VCSE sector as part of a wider integrated system, and strategies like the Homelessness and Rough Sleeping Strategy promoted multi-agency planning and peer advocacy.

Theme 3: How Torbay Council ensures safety within the system

This theme includes these quality statements:

- Safe pathways, systems and transitions
- Safeguarding

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

Safe pathways, systems and transitions

Score: 3

3 - Evidence shows a good standard

What people expect

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

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

The local authority commitment

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

Key findings for this quality statement

Safety management

People experienced care that prioritised safety, with risks such as carer breakdown identified and addressed early in the assessment process. Ensuring safe, familiar environments and reliable support arrangements had been central to maintaining wellbeing. People said they were reassured by the continuity of care and the proactive coordination between services, which helped prevent crises and supported recovery. The use of risk-positive approaches enabled people to regain independence while maintaining safeguards.

Staff said safety was embedded throughout care journeys via a range of mechanisms. Daytime and out-of-hours Approved Mental Health Professionals ensured continuity and responsiveness, supported by effective handovers, shared training, and peer supervision. Environmental assessments, safeguarding assessments, and secondary triage helped identify risks such as hoarding, self-neglect, and housing concerns, which were addressed proactively, particularly during hospital discharge planning. Front door staff played a clear role in crisis response, maintaining direct contact with people and prioritising urgent cases and worked closely with Voluntary Community and Social Enterprise (VCSE) partners. Multi-agency ‘spotlight’ meetings allowed effective shared ownership of complex or higher need cases such as dementia, homelessness, and domestic abuse.

Staff described practical safety management measures, for example engaging in mediation to preserve care packages, organising adaptations to support independence and carefully managing transitions into adult services safely. However, some staff raised concerns about gaps in provision for people with complex mental health needs, particularly those experiencing suicidal ideation, which they felt could feel unsafe and outside their professional remit. Integration with health colleagues had largely supported timely interventions and reduced duplication, though some staff had expressed concern about blurred professional boundaries and the need to preserve the distinct identity of social care.

Leaders said safety had been addressed at both population and service levels. Integrated occupational therapy rotations and collaboration with intermediate care teams had reduced reliance on double-handed care and enabled early intervention. Housing stability and availability was recognised as a key risk factor, with concerns about reliance on private rentals, limited specialist housing, and the condition of older homes. Leaders described efforts to support people through supported housing, hostels, and floating support services. Suicide prevention remained a clear priority, and broader risks in drug and alcohol services for young people were identified. The Multiple Complex Needs Alliance (Growth in Action) had helped link housing with health and social care, ensuring people were not housed in unsafe or unstable conditions.

Partners said there were positive transitions between children’s and adult services and this was achieved by a dedicated team, who provided a clear and effective pathway for young people. However, some partners also identified a need for greater consistency to prevent people from slipping through service gaps. Transition planning had been supported by an action plan, including a central tracking log, quarterly reviews, joint meetings with education providers and training for children’s social care practitioners. Webinars for carers and young people and post-transition surveys helped identify good practice and areas for improvement. Some partners said there was sometimes an underuse of community intelligence, particularly from VCSE groups. They said warnings about hoarding for example had not always been acted upon by statutory services, leading to missed opportunities for early intervention.

Processes demonstrated a robust framework for safety and risk management. Monthly scrutiny of service quality and safety data by the Adult Social Care Continuous Improvement Board had supported operational oversight and informed planning, particularly for out-of-area reviews. Two social workers had been assigned to prioritise these reviews, supported by a checklist aligned with Association of Directors of Adult Social Services guidance. Any indication of an ‘Inadequate’ Care Quality Commission rating triggered joint responses through contract monitoring and operational teams. The integrated multidisciplinary model had enabled seamless access to care and support, with systems in place for risk and incident management. Waiting Well documents had provided clear contact routes and safeguarding pathways, increasing confidence and ensuring people knew how to act quickly if they or others were unsafe.

The local authority had been effective in prioritising safety and managing risks across care journeys. There had been a clear commitment to proactive safeguarding, supported by integrated working.

Safety during transitions

People experienced transitions that were well managed and person-centred. In complex or higher-need cases, for example those involving multiple accommodation moves and hospital discharges, the local authority was described as helpful and supportive, with effective communication. Risks were clearly communicated, and people understood decisions such as the need for continued nursing care. Prompt assessments, follow-up communication, and provision of equipment had helped ensure safety. In a case we reviewed, there was effective joint working between Adult and Children’s Services in support of a family. Transitions from children’s to adult services had been supported through weekly panels and 6-monthly information-sharing meetings, though data systems had only been partly effective in tracking progress. Staff had used joint funding arrangements and checklists to challenge decisions and ensure appropriate support.

Staff said they worked within a culture of safe transitions, where leaders had promoted reflective practice to enable this. Weekly triage practices and allocation of referrals had ensured people were placed with the most appropriate team. Emergency responses had been swift and effective, with for example, the Emergency Duty Team stepping in to support unpaid carers during crises. Staff described clear handover processes between out-of-hours and day services, including written documentation and phone calls to maintain continuity. They said they were advocates for safe, personalised care and supported positive risk-taking, helping people make informed choices about risks. One example involved a young person transitioning from foster care to supported living, with an 8-week transition period that led to increased independence and reduced support needs.

During periods of high system pressure (eg. OPEL 4), we heard hospital managers had sometimes prioritised discharge speed over safety, resulting in readmission (OPEL 4 refers to the highest level of operational pressure within the NHS's Operational Pressures Escalation Levels (OPEL) framework). Staff described examples of advocating for people when health partners wanted to discharge quickly. Unpaid carers had been identified at crisis points and met the same day to provide reassurance and guidance.

People experienced coordinated, person-centred support; staff had advocated for safe practice and responded swiftly to emergencies; leaders had addressed systemic risks and supported integrated planning; and partners recognised improvements while identifying areas for further development.

Contingency planning

People experienced contingency planning with arrangements in place to ensure continuity of care during emergencies. One unpaid carer preparing for surgery had received support to establish both immediate and backup care plans, which helped reduce anxiety and maintain stability. Contingency was actively planned in people's care records.

Staff said they used flexible approaches to manage disruptions. Multi-agency forums supported collaborative planning for people with complex or higher-level needs and when equipment delays occurred, people remained on caseloads or waiting lists with clear measures to monitor risk. In some cases, care input had been temporarily increased to safeguard wellbeing. The national collapse of an equipment company had disrupted equipment supply chains, requiring rapid adaption. Emergency equipment remained available during this time, but routine items often required self-purchase.

Leaders said contingency planning was achieved by oversight and risk management. The Provider Failure Policy outlined procedures for managing service disruptions, including requirements for providers to maintain continuity plans, registers of supported individuals, and financial health checks. In the event of provider failure, a commissioning manager was appointed to oversee safety, with a checklist of responsible officer actions. High-risk services were monitored by the joint commissioning committee, and providers were expected to give 6 months' notice for planned closures to allow safe transitions. Partners said contingency planning had improved hospital discharge practices, helping avoid unnecessary admissions and promoting recovery through trauma-informed approaches and collaboration with Voluntary Community and Social Enterprise (VCSE) organisations.

Processes supported contingency planning through integrated systems and early risk identification. Intelligence on provider failure had been gathered through safeguarding data, incident reporting, contract management and quality assurance meetings, in collaboration with Torbay and South Devon NHS Foundation Trust and the Care Quality Commission. One example involved the closure of 2 care homes, which had been managed within 6 weeks using an integrated commissioning approach that ensured people remained safe throughout. These events demonstrated the local authority's ability to respond effectively to service disruptions.

Safeguarding

Score: 3

3 - Evidence shows a good standard

What people expect

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

The local authority commitment

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

Key findings for this quality statement

Safeguarding systems, processes and practices

There were effective systems, processes, and practices in place to protect people from abuse and neglect. The local authority worked closely with the Safeguarding Adults Board and partners to deliver a coordinated approach, and there was a strong multi-agency safeguarding partnership with clear roles and responsibilities. Information sharing arrangements were robust, enabling timely and proportionate responses.

People who used services described adult social care as responsive, and we heard examples of safeguarding being embedded in practice. Staff consistently said safeguarding was not just about process but about communication, reassurance, and setting expectations with carers and families. The Adult Social Care Survey (2024-2025) found a similar proportion of people who used services in the local authority felt safe (71.16%) as the national average (71.06%) and a similar proportion of people (86.14%) who used services say those services made them feel safe and secure as the national average (87.82%).

Staff described a workplace culture of learning and development, with access to mandatory safeguarding training, Safeguarding Adults Reviews (SARs) training, and specialist sessions around emerging safeguarding trends and needs. Joint training with children's services and integration with NHS systems supported cross-sector learning. There was a clear ethos that safeguarding was everyone's responsibility. Occupational therapists were well-trained and actively involved in safeguarding investigations. The Sensory team worked jointly with social workers and occupational therapists to support people with sensory loss, reducing risks associated with isolation.

There were formal processes such as the Single Point of Contact (SPOC), Section 42 thresholds (the criteria for initiating a safeguarding enquiry for an adult under the Care Act 2014), and risk enablement frameworks, alongside professional judgement and supervision. The SPOC team played a central role in triaging safeguarding referrals, which were received from a wide range of sources including the public, GPs, ambulance services and NHS 111. Referrals were rated using a Red–Amber–Green (RAG) system to indicate urgency, and allocated within an average of 7.09 days, with a maximum of 15 days. The SPOC team used multiple electronic systems to gather intelligence, including local authority, NHS, and GP records, although staff noted some duplication due to a lack of system integration.

Leaders provided oversight. The Director of Adult Social Services attended the Safeguarding Adults Partnership Board and received exception reports. Monthly meetings with the Principal Social Worker (PSW) (who was also the Head of Safeguarding) and the Delivery Committee ensured a clear line of sight over safeguarding practice and SARs. Leaders expressed confidence in the robustness of the system and its ability to respond to concerns.

Partners agreed safeguarding responsibilities were overseen by senior leaders, including the NHS Trust Chief Nurse and PSW. The multi-agency Torbay and Devon Safeguarding Adults Partnership Board (TDSAP), shared with Devon County Council, included the local authority, Integrated Care Board, and NHS Trust. Healthwatch sat on the board and contributed to reforming the agenda to ensure partner priorities were addressed. A standing group of people with lived experience provided feedback on safeguarding processes, and the Board chair actively engaged with people and staff. Learning from SARs was shared across services, and complex cases had led to system-wide improvements, particularly in discharge pathways and specialist provision for people with learning disabilities and autism.

Some partners said safeguarding referral forms could be cumbersome and possibly inaccessible to the public. The local authority's safeguarding webpage, however, provided accessible information on abuse, exploitation, and how to access support, alongside links to events and resources. Annual reports from the TDSAP and the local authority were publicly available, and the partnership's business plan for 2025–2027 outlined strategic priorities, including improving safeguarding practice in key risk areas and developing joint protocols with children's services.

Responding to local safeguarding risks and issues

The local authority demonstrated a strong understanding of safeguarding risks and took action to prevent abuse and neglect. The local authority had a clear picture of local safeguarding issues and responded effectively to emerging risks and learned from serious incidents to improve practice.

People’s experiences reflected timely and coordinated safeguarding responses. In 1 case, an urgent referral led to a multi-agency response that ensured the person received support at a critical time. The assessment recognised the person’s strengths and independence while ensuring complex or higher-level needs were met, demonstrating a strengths-based and person-centred approach.

Staff and leaders showed a clear understanding of key safeguarding risks in the area. Housing-related concerns such as hoarding and unsafe environments were frequently raised, with examples provided of joint working between housing officers, environmental health, and adult social care to mitigate risk. Leaders acknowledged a lack of specialist housing but described targeted work on hoarding and self-care, supported by a welfare advice organisation co-funded with a neighbouring authority. The local authority also recognised the safeguarding risks associated with coercive and controlling relationships and identified the need to update operational guidance to improve consistency in decision-making.

The local authority responded to high-risk areas such as the backlog of Deprivation of Liberty Safeguards (DoLS) assessments by recruiting 12 independent Best Interest Assessors (BIA) and implementing a blended model using in-house and independent BIAs. This resulted in a reported 150% increase in monthly allocations. The backlog was reduced by 8.8% between July and August 2025, and performance was monitored monthly through the Delivery Committee chaired by the Divisional Director and Service Improvement Board chaired by the DASS. Community DoLS applications were triaged using the Association of Directors of Adult Social Services (ADASS) prioritisation tool, with high-risk cases allocated immediately. Monthly reporting and governance oversight ensured transparency and accountability.

Lessons from Safeguarding Adult Reviews (SARs) were actively used to improve practice. Leaders described how themes such as self-neglect had prompted learning, including a self-neglect conference, practice briefings, and the introduction of welfare checks at the front door. Reflective commentary was used to help staff understand the implications of SARs. The local authority also contracted an advocacy organisation to quality check Section 42 processes and gather feedback from people who had experienced safeguarding interventions. Early feedback from this indicated people felt safe, involved, and engaged.

Partners confirmed the local authority was accountable and open to scrutiny. The Safeguarding Adults Board (SAB) Chair described a thematic SAR review on self-neglect and hoarding involving 6 cases, including 2 from the local authority. Practitioners participated in focus groups to identify barriers and inform improvements. Since 2022, the joint Devon and Torbay SAB had overseen 17 SARs with 160 recommendations, 85 of which were fully completed. Outstanding SARs for adult social care in Torbay were in single digits, and the local authority was described as a good partner in holding others to account. Processes provided robust evidence of the authority's commitment to safeguarding. The SAR Core Group, part of the joint Safeguarding Adults Board with Devon (TDSAP), maintained oversight of SARs and reported quarterly to the Board. Completed SARs were published with learning and recommendations, and policy and guidance were regularly updated to reflect new knowledge and trends. Risk indicator and assessment tools were promoted to ensure consistent awareness of safeguarding concerns.

Healthwatch reported close collaboration with the SAB Chair and participation in board meetings. They helped to reform the agenda to ensure partner priorities were addressed and contributed to a standing group of people with lived experience. The SAB Chair described collaborative work to embed trauma-informed and strengths-based practice more deeply across the system.

The local authority's integrated health and social care system enabled rapid responses to adult abuse concerns, with multi-agency triaging directing cases to appropriate professionals. The Single Point Of Contact (SPOC) service acted as a central contact point, reducing duplication and delays. Best Practice meetings supported staff development, and safeguarding improvement groups addressed emerging themes such as hidden harm, financial abuse, and predatory marriage.

The TDSAP's strategic priorities included embedding SAR learning into practice, improving engagement with people supported, and promoting person-led, outcome-focused safeguarding. Partners were expected to take part in the SAR process and make sure any learning was clear, practical, and could be acted on, with specific goals, measurable outcomes, and realistic timescales.

Responding to concerns and undertaking Section 42 enquiries

The local authority demonstrated a strong approach to applying Section 42 safeguarding thresholds, with clear systems, guidance, and oversight mechanisms in place to ensure consistency and person-centred practice. Evidence from people's experiences, staff, leaders, partners, and processes showed safeguarding concerns were identified and responded to appropriately.

People's experiences reflected that safeguarding concerns were recognised and addressed effectively. One person described how reassurance and continuity of support helped reduce risk and maintain stability. Another received urgent multi-agency interventions, including 24-hour support, with safety planning that considered complex or higher-level medical needs. These examples demonstrated safeguarding was not only reactive but also embedded in care planning and risk management.

Staff described a culture of openness and support in navigating safeguarding decisions. Supervision, peer support, and regular audits were used to maintain quality and consistency, with feedback shared across teams. The Single Point Of Contact (SPOC) team played a central role in triaging referrals, which were rated based on risk. High-risk cases triggered immediate action, and average waiting times from SPOC to allocation were low (4.4 days), although 56% of open Section 42(2) enquiries remained open beyond 90 days, indicating delays in completing enquiries.

To address this, the local authority introduced Level 3 safeguarding training, reintroduced training on chairing Section 42 meetings and large-scale enquiry practice, and embedded learning from Safeguarding Adults Reviews (SARs) into operational practice. The SPOC team and Safeguarding Adult Professional Practice Teams held bi-monthly best practice sessions, enabling thematic reflective learning and review of emerging issues. These sessions also supported a full consultation and revision of SPOC operational guidance.

The SPOC operational guidance (v7) clearly outlined the application of Section 42(1) thresholds and required that any decision not to proceed to a Section 42(2) enquiry be recorded with a rationale and approved by a manager. A flowchart supported decision-making, and trauma-informed practice was embedded into guidance to ensure decisions considered the impact of trauma on individuals' engagement with services. The electronic system was amended to capture enquiries that ceased at Section 42(1), allowing for analysis of unmet needs and threshold decisions.

Business Intelligence data supported oversight of SPOC operations and case allocation. Weekly quality assurance huddles helped to identify emerging trends and risk across the care market. While the average transfer time from SPOC to allocation was low, the absence of a formal target timescale for completing enquiries was noted, potentially impacting consistency in meeting Making Safeguarding Personal obligations.

The local authority's commitment to transparency and continuous improvement was evident in its safeguarding data reporting. In 2023–24, 1,000 safeguarding concerns were reported, with a 26% increase in enquiry activity. Neglect and acts of omission were the most common concerns. The local authority engaged adults with lived experience to provide qualitative feedback, and each Section 42(2) enquiry received scrutiny from a management panel.

Making safeguarding personal

The local authority demonstrated a strong and person-centred approach to safeguarding enquiries, with clear evidence that they were carried out sensitively, proportionately, and with the wishes and best interests of the person at their centre. The local authority also showed a commitment to improving public understanding of safeguarding and ensuring people knew how to raise concerns. Safeguarding Adults Collection data (2024-2025) showed a somewhat higher proportion of people lacking capacity were supported by an advocate, family or friend (96.67%) as the national average (83.38%) which was a positive sign in Making Safeguarding Personal (MSP).

Staff consistently described safeguarding as embedded in practice, with a strong focus on MSP. They said people were always at the centre of the referral process, with their voices heard and desired outcomes considered. Where people declined to proceed with safeguarding, staff followed clear processes including capacity assessments and consultation with professionals in the person's life. Staff described how they respected people's autonomy while ensuring safety was promoted.

The Principal Social Worker, who was also Head of Safeguarding, described early engagement with adults at risk and utilising external advisers to improve practice. Data analysis had been developed to reflect a person's journey, including how long they had been in the system, waiting times for decisions, and whether their outcomes had been recorded which demonstrated a commitment to transparency and continuous improvement.

Partners confirmed improvements in MSP. Healthwatch reported a positive change in how the local authority responded to safeguarding referrals, moving from generic automated responses to personalised communications that explained decisions and offered signposting. This was seen as a significant step forward in making safeguarding personal and closing the feedback loop with referrers and the public. The Safeguarding Adults Board prioritised MSP in the current year, holding workshops to explore the person's voice and experience. Plans were underway to establish a Community Reference Group to raise awareness of safeguarding among diverse communities, including those where English was not their first language.

Processes in place further supported the local authority's effectiveness in MSP. The Single Point Of Contact (SPOC) operational guidance instructed practitioners to consider consent, mental capacity, and executive function, and to apply trauma-informed practice. Legal support was available to staff, and guidance covered a wide range of safeguarding scenarios including domestic abuse, self-neglect, and large-scale abuse. The local authority's website provided accessible information on safeguarding, including definitions of abuse, exploitation, and how to access support.

Performance data provided by the local authority at the time of the assessment, showed 93% of adults who gave feedback said their outcomes were met fully or partially, and 91.1% of safeguarding enquiries resulted in risk being removed or reduced. However, only 76.4% of people were asked about their preferred outcomes, below the 90% target. The local authority said this was due to recording issues, which had since been addressed. Additionally, only 17.3% of people consented to give feedback, below the 20% target.

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

People had responsive and respectful engagement, staff felt supported and involved in improvement work, and partners recognised a shift toward collaborative governance. While some areas such as consistency of management and leadership practices, contingency planning, and specialist provision could be developed further.

People’s experiences reflected positively on governance and service management. They described thorough assessments, timely communication, and respectful engagement. Unpaid carers had been offered assessments with clear explanations of their rights, and equipment provision had been handled smoothly. Co-production had been evident in many initiatives, which demonstrated transparency and a commitment to continuous improvement. However, some people felt contingency planning needed to be more consistently embedded, and carers’ needs more fully explored in future reviews.

Staff and leaders said governance and accountability had been well-established and inclusive, supported by clear structures and delegated responsibilities, but with some mixed experiences. Leadership had been described as strategically aligned and values-driven, with the Director of Adult Social Services (DASS) credited for improving responsiveness and visibility of adult social care over recent months. Staff reported feeling supported and engaged through monthly Key Performance Indicator tracking, service meetings, and transformation groups. The Principal Social Worker maintained links with improvement boards and senior leaders, promoting strengths-based practice. However, some staff noted inconsistent management practices and a disconnect from senior leadership, suggesting there was a need for more consistent leadership across all levels. For example, there were some limitations in tracking outcomes at the front door and a lack of case auditing, which could hinder learning and oversight and there was a mixed experience with the consistency of supervision in different staff teams.

There was structured governance around divisional directors and integrated roles, including a joint operational lead within the NHS Trust. Oversight was provided through the Continuous Improvement Board and strategic meetings, with alignment across adult social care, health, housing, and safeguarding. The Section 75 Joint Executive Group had overseen statutory responsibilities, risk registers, and performance metrics. Risk management frameworks had been independently audited, and a review was planned to strengthen assurance and validate mitigation actions. Key risks such as workforce capacity, market sustainability, and mental health commissioning, had been jointly reviewed and fed into service improvement plans.

Partners said the current DASS had fostered a collaborative governance culture, described as open and inclusive. Regular meetings strengthened relationships and improved oversight of Care Act duties. Healthwatch said their involvement was embedded across governance boards, with feedback actively received and acted upon. However, partners noted operational success sometimes relied too heavily on individual relationships, experiencing some service instability following key personnel changes. They also highlighted gaps in specialist provision in social work teams, particularly in learning disability services, although the local authority had responded by embedding expertise within the Complex Care team.

Strategic planning

Strategic planning was adequately set out in the local authority and with its partners. People said their experiences reflected a system that was increasingly responsive and inclusive. They had seen improvements in how carers' needs were considered, with assessments clearly explained and co-produced initiatives, such as the Waiting Well documents demonstrating a commitment to transparency and planning. People felt their feedback was being used to shape services, though some noted that more consistent follow-through was needed in areas like contingency planning and dementia support.

Staff and leaders said strategic planning had been guided by performance data, financial pressures, and transformation goals. Leadership had been visible and inclusive, with clear accountability across adult social care, health, housing, and safeguarding. Staff described structured risk management and regular Key Performance Indicator (KPI) tracking, with deep dives into priority areas such as Deprivation of Liberty Safeguards (DoLS) and carers. They had used electronic case management systems to capture data on unpaid carers, although they noted that figures sometimes didn't fully reflect the work being done. Staff acknowledged resource pressures, especially around replacement care and dementia, but remained committed to meeting needs effectively.

Leaders said strategic planning had been strengthened by benchmarking, assurance meetings, and alignment with transformation plans. The Director of Adult Social Services (DASS) led consultancy-supported reviews that addressed long-standing concerns, and the Director of Public Health had linked planning to broader themes like housing, digital inclusion, and physical activity. Governance structures such as the Health and Wellbeing Board supported cross-sector strategies. Leaders also recognised data gaps in ethnicity and protected groups, showing awareness of inequalities and the need for improved data to inform future planning.

Partners said the local authority had maintained a long-term strategic vision, even during political change. The Section 75 agreement and 3-way working arrangement with the Integrated Care Board and the NHS Trust had improved alignment and oversight. Carers were now treated as a protected characteristic in equalities impact assessments, and policies were routinely reviewed to avoid adverse impacts. Healthwatch and Voluntary Community and Social Enterprise (VCSE) partners had seen increased engagement and co-production, though implementation varied. Strategic planning also addressed unemployment and health inequalities through a co-produced VCSE partnership, connecting people to wider support services. Employment had been prioritised in learning disability and autism strategies, with ambassadors leading and defining this work.

Processes had reinforced strategic planning through integrated frameworks and data-driven decision-making. Plans such as the Integrated Adult Social Care Commissioning Plan, Joint Health and Wellbeing Strategy, and One Devon Integrated Care Strategy had aligned priorities across systems. These strategies addressed mental health, homelessness, substance misuse, and domestic violence, supported by the Joint Strategic Needs Assessment and Market Position Statement. The local authority's long-term vision, set out in a 20-year strategic plan, aimed to guide consistent action and align the whole council behind shared goals.

Information security

The local authority recognised the need for improvement and were making changes to the case recording system at the time of the assessment. Strategic documents such as the Devon Plan and One Devon Integrated Care Strategy outlined ambitions for unified digital infrastructure, standardising frontline systems and improving data sharing across health and care. These improvements were still in development and not yet embedded in daily practice.

Staff said that current IT systems were outdated, fragmented, and difficult to work with. The legacy electronic case management system undermined staff confidence in data accuracy, particularly around waiting list reviews. Staff across services reported poor interoperability between health and social care systems, which created barriers to communication and slowed practice. Sometimes this had reduced efficiency and time available for direct care. Staff expressed frustration at the lack of access to modern tools like Artificial intelligence-supported documentation systems and said financial constraints had in the past limited digital innovation.

Leaders said they had heard these concerns during staff engagement sessions and acknowledged the need for sustained investment in digital infrastructure. While digital transformation was underway and a new case management system was being rolled out, feedback had indicated that current arrangements did not yet ensure consistent data quality, security, or accessibility. Staff called for clearer timelines and more robust support to reduce operational delays and improve service delivery.

Learning, improvement and innovation

Score: 3

3 - Evidence shows a good standard

The local authority commitment

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

Key findings for this quality statement

Continuous learning, improvement and professional development

The local authority demonstrated a strong commitment to continuous improvement and learning. People felt involved as equal partners, staff generally described a reflective and well-supported culture, and partners recognised strategic alignment and co-production efforts.

People said they felt involved in shaping services and strategies. Carer ambassadors described positive experiences of co-production, for example around improving access to direct payment grants, embedding carers support workers in GP practices, and getting clearer information through initiatives like Carers Rights Day and the orange lanyard system in the hospital (registered unpaid carers wear an orange lanyard, to identify them to staff and improve communication). Carers said leaders were visible and accessible, particularly the new Director of Adult Social Services (DASS), and felt their feedback had been valued in service and strategy development. Carers had contributed to designing feedback tools and shaping the carers strategy, which included clear targets and commitments to publish progress regularly. They had asked to be recognised earlier, receive timely assessments, and be involved in care planning, which the local authority had committed to monitor through audits and feedback.

Staff and leaders said there was a strong culture of learning, professional development, and team support. Mental health staff, including Approved Mental Health Professionals (AMHPs), reported regular supervision, access to specialist training, and a shared responsibility for risk. Occupational therapy teams described positive learning environments with rotational posts, peer supervision, and training. Champions had supported internal expertise, and informal learning had been fostered through peer collaboration and involving people with lived experience. The Principal Social Worker led a workforce development programme, supporting apprenticeships, degrees, and leadership development. Staff also participated in structured programmes and health coaching and felt supported to grow professionally. Some staff said they had limited supervision, and shared some concerns about recognition and career progression.

Partners said they recognised the local authority's commitment to workforce development and integration, particularly following leadership changes. The appointment of a new DASS and NHS Chief Executive recently had strengthened collaboration and stability. Divisional director roles had supported joint leadership and system-wide improvement. Partners said co-produced initiatives like the Big Plan and other strategies were impactful, although some felt co-production was still emerging and not yet consistently embedded. Some partners said consultation processes were too top-down and lacked meaningful input from underrepresented groups.

Processes had supported continuous improvement. The Learning and Development Policy outlined availability of financial support for qualifications, with training delivered via specialist platforms. The Integrated Workforce Plan and Education Strategy had supported protected learning time and specialist training. The local authority had tracked involvement in improvement projects using a co-production ladder and committed to rolling out mandatory anti-racism, unconscious bias, and de-escalation training. The Inclusion Strategy and Racism Review had demonstrated a commitment to equity, and the LGBT+ Survey had led to recommendations for further workforce training. Staff surveys identified areas for improvement, including around tackling low morale, stress, and career development, with action plans.

Learning from feedback

The local authority demonstrated a growing and increasingly embedded culture of learning from feedback. People felt heard and involved, staff used feedback to shape services and training, and partners recognised improvements in services and culture.

Carer ambassadors had gathered feedback from across the local authority, reporting high satisfaction with carers services. They said the ‘you said, we did’ approach was valued which was evident in publications like Signpost for Carers, and they described meaningful involvement in editorial boards, legal training, and service evaluation. Learning disability ambassadors contributed to large-scale events and co-produced the Big Plan, which now included an action plan focused on health, housing, employment, and day services, they felt their involvement was impactful and worthwhile.

Staff and leaders said feedback had become central to service improvement and strategic planning. Elected leaders highlighted the positive impact of a peer review in 2024 in strengthening the work of the local authority, and staff had used Care Quality Commission feedback to improve the adult social care education offer. Staff described a culture of continuous learning, with feedback influencing service design such as maintaining peer support groups and introducing creative tools. Carers services had used feedback to develop hospitality schemes, gifted holidays, and educational booklets. Staff also identified gaps in dementia support and advocacy, which they planned to address through future development. However, some staff noted that action plans lacked clear ownership and timelines, which could limit impact.

Partners said they had seen improvements in how feedback was used, particularly in carers services. Healthwatch reported that feedback led to better dementia training, with plans to replicate successful models. Carers organisations worked with the local authority to improve messaging and carer recognition. However, some partners felt co-production was still emerging and not consistently embedded. Concerns were raised about top-down consultation processes, lack of follow-through on issues like transport. While partners were often approached for intelligence, they said feedback was not always acted upon or communicated back clearly.

Processes showed the local authority had formal mechanisms for gathering and responding to feedback. The carers strategy included regular surveys and quarterly progress updates. The Written Statement of Action for Special Educational Needs and Disabilities services had been co-produced with families, and the Preparing for Adulthood audit used Ofsted and CQC criteria. Feedback was tracked using a co-production ladder, and training offers were adapted based on input. However, some staff survey action plans lacked named leads and deadlines, which could affect accountability.