

# Supporting people to live healthier lives

Score: 1

1 - Evidence shows significant shortfalls

## What people expect

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

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

## The local authority commitment

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

## Key findings for this quality statement

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

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The local authority aimed to work with people, partners and the local community to promote independence, and to prevent, delay or reduce the need for care and support. There were some services that supported the local authority's prevention duty but there were shortfalls particularly in the provision of reablement that significantly impacted people's outcomes.

The local authority did not have a prevention strategy in place to clearly set out its intentions, objectives, and actions on arrangements to prevent, delay or reduce the needs for care and support in the East Riding. The prevention board was not currently running, having been recognised as needing a refocus on the statements, analysis and action needed to strengthen preventative activity in the county and across the partnership of health and care services.

Partners told us access to transport and welfare and advice services was a gap for some people which affected people's ability to attend appointments or have the resources they needed to support wellbeing in the community. National data indicated that 59.04% of people who received short term support no longer required support, which was significantly worse than the England average of 79.39% (ASCOF, 2024). Early consideration was ongoing about a vision for prevention in the county that included a broad remit and join up for public health, housing, leisure and children's services, for example. This was at very early stages and leaders were keen this was cemented into a strategic plan. The Joint Health and Wellbeing Strategy contained a commitment to prevention built around a 'conditions of living' model which recognised the impact of the wider environment on people's individual health and wellbeing. The renewed prevention board was a joint approach between adult social care and public health, indicating there would be a close connection for future preventative activity.

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There was a social prescribing service in the local area in partnership with public health and a community sector organisation. Social prescribing is a way of referring people to local, non-clinical services to support their health and wellbeing. Issues Link Workers could help with included social activities, how to meet new friends, exercise classes to improve mental and physical wellbeing and long-term conditions groups. In some areas, debt and welfare support or supporting residents to implement their own community-based projects was also available. Local authority analysis indicated that, of those people supported by the social prescribing service, 10% had achieved a decrease in the use of formal care services.

The Independence and Advice Hub, which received all adult social care contacts into the local authority, was able to support people to access support in the community. Arrangements were in place to work with a community organisation for minor issues, such as support to fill out forms, or for up to six weeks, for more further support. Further community support was available for people, for example for people with dementia and Alzheimer's disease, that provided information and services as well as social events to support people's wellbeing. National data indicated that 78.02% of people reported they spent time doing things they valued or enjoyed, which was better than the England average of 69.09% (Adult Social Care Survey – ASCS, October 2024). Some was funded by the local authority, with some funded through partnership or fundraising activity.

Making Every Contact Count (MECC) resources were also available. This linked practitioners who were interacting with people across the area, not just in adult social care, with brief interventions that allowed them to share information or support for a variety of issues, such as homelessness, affordable warmth, and eye health. The MECC website for the location view for East Riding contained no information or links. Practitioners needed to access information by topic and then see if support services were available in East Riding.

A 'freedom providers' programme was in place, which developed a directory of providers who met non-social care needs, such as shopping and cutting the grass for people living at home. This support enabled independence at home and improved wellbeing.

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The local authority provided a Carer's Support Service that completed carer assessments and promoted health, wellbeing and independence for the people they supported. The team also included specialist staff to support carers for mental health and dementia in line with recognised need. The proportion of carers who found information and advice helpful was 87.76% which was similar to the England average of 85.22% (Survey of Adult Carers in England, June 2024).

There were 9 available carers support groups across the county that were predominantly run by volunteers which arranged events and provided peer support. They were run or arranged slightly differently depending on local arrangements. Volunteers liaised with the Carers Support Service about the events and applied for funding to run them. Groups linked into the Carers Advisory Group, which worked with partners and the local authority, to improve the experience and outcomes of carers, including in the ownership and accountability of the Carers Strategy. Volunteers were trying to get other groups up and running across the area but had struggled to get enough members to sustain the group. There were recognised challenges in self-identification of carers.

## Provision and impact of intermediate care and reablement services

Provision of reablement services was limited by significant capacity constraints and limited dedicated provision to deliver reablement care within the wider adult social care market. People had limited opportunities to engage in reablement care that affected their experiences and outcomes, resulting in more people requiring long-term care than expected.

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The local authority operated an internal reablement service. Staff could also refer people back to health services for intermediate care that was more health focused. The reablement service had recently been redesigned alongside the development of the 'home first' approach in the county. The intention was that people who were discharged from hospital were supported to retain their independence and reduce their dependency on commissioned services. Staff in the reablement service worked with the person to identify their goals and took a 'doing with' not 'doing to' approach. Partners told us there had been an increase in people receiving reablement and a reduction in the need for long term care. Staff were positive about the offer and felt it supported the management of risk following discharge from hospital. We heard a number of examples of reductions in packages of care, recovery and connection to community through the reablement model that improved people's experiences and outcomes. Where the service was able to support people, it was positive, with several examples provided of positive experiences and outcomes.

There were, however, significant capacity challenges which affected people's opportunities for reablement. Some staff had a different understanding of the reablement team's criteria than the team did, which may have affected referrals. National data outlined 1.73% of people aged 65 and over received reablement or rehabilitation services after discharge from hospital, which was worse than the England average of 3.00% (ASCOF, 2024). Staff told us there was different available capacity across the area, which meant there were some areas of the county, such as Goole, where the reablement team were unable to take on new packages of care.

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Where the reablement team was unable to take on new packages of care, these were offered to private providers under 'shortfall' arrangements while remaining open to the reablement team for monitoring and review. At the time of our assessment, staff told us that there were approximately 200 people identified as open to reablement, but only a third of these were allocated to the internal team. In the month prior to our onsite assessment in June 2025, 123 referrals were accepted by the reablement team, with approximately half of these (60) allocated to the in-house team, and the remaining allocated to 'shortfall' providers. Staff teams told us that the majority of these private providers were not delivering reablement care and 'doing for' rather than 'doing with'. Between June 2024 and June 2025, 24% of individuals supported by 'shortfall' providers achieved full independence according to local authority data. For internal reablement provision in the same period, 63% achieved their reablement potential and goals. In the 3 months prior to our on-site assessment in June 2025, 38% of people were fully reabled through in-house provision, compared to 28% for 'shortfall' provision. This meant that many people identified as having potential to achieve their reablement goals were not accessing services that supported this and were more likely to require long term care, due to the lack of reablement focused provision in the county. Outcomes for the 123 individuals referred in the month prior to our onsite assessment in June 2025 indicated 37% achieved reablement outcomes when allocated to in-house reablement provision, and 38% for 'shortfall' provision, suggesting improvements in the outcomes achieved by shortfall providers.'

Local authority reablement services were able to connect people with occupational therapists, equipment, health partners, and local community services to support recovery. The reablement model was not therapy led but the team did include occupational therapists and occupational therapy assistants. . This may have affected the support available to people and the achievement of long term sustainable reablement. National data indicated 72.55% of people aged 65 and over were still at home 91 days after discharge from hospital into reablement or rehabilitation, which was worse than the England average of 83.70% (ASCOF, 2024).

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People were being discharged from hospital when medically well to short term residential care, which the local authority referred to as respite beds. Staff told us there was an aim for people to receive reablement service while in these placements. However, staff told us that people were often deskilled and lost potential independence because reablement was not available and people were not receiving these services. Reviews were expected as defined in processes within 6-8 weeks. Some staff in locality teams told us they had never completed these reviews in the initial timescale due to their capacity and prioritisation of other work. This meant, for some people, they lost reablement potential and short term residential placements became long term and sometimes permanent.

The local authority recognised in their self-assessment there were opportunities to remodel intermediate and reablement care to support maximizing independence through multi-disciplinary working. Additional resources were in place to identify where there may be opportunities to reduce the number of people who received support from 2 care workers if this was no longer required. Further work was ongoing to review processes, acceptance and inclusion criteria, and access to therapies to improve the reablement offer. Leaders expected to review the reablement offer in the East Riding, recognizing that too many people were not achieving reablement, though no date for this was set at the time of our assessment.

## Access to equipment and home adaptations

People could access equipment and minor home adaptations to maintain their independence and continue living in their own homes though some people waited longer than others.

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There were significant numbers of people on waiting lists for occupational therapy assessments to understand equipment and adaptation needs. At the time of our assessment in June 2025, 917 adults were waiting for an equipment assessment. The median waiting time for an assessment was 3 days, though there were maximum waiting times of over 500 days. Significant work had taken place in the months prior to our assessment to review the waiting list and ensure risk and need was reevaluated for those who waited. Some staff told us there was a trusted assessor model with health partners to provide low-level equipment quickly and reduce the number of people waiting. This did not seem well understood across the service or whether community teams could be trusted assessors as well. The local authority was looking to expand the use of the trusted assessor model at the time of our assessment.

Partners told us that the waits for people with sight loss were significant. In the examples shared with us, some people had waited 2 years for white cane training and 45 weeks for grab rails. People had deteriorated in the meantime, with increased falls and reduced confidence, affecting their mental wellbeing.

Following assessments, there was an equipment contract across Hull and East Riding, which provided a core stock of equipment that met the needs of 80% of the population. More bespoke equipment could be manufactured, and delivery times depended on what equipment was needed and the urgency of need. Same day delivery was available 7 days a week for the majority of equipment, and staff were able to choose the length of the delivery time for each case with the equipment provider. Product evaluations ensured the local authority kept correct stock and were thinking about adaption to what was available as core stock. The local authority had a demonstration room available to support staff and people to learn to use equipment. However, local authority data systems were not set up to monitor the number of people waiting for minor adaptations and was arranged by the type of equipment.

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When people received equipment, they were positive about its impact. One carer said they couldn't have asked for more, and another said that they quickly received replacement equipment quickly when they encountered problems. The local authority had a joiner service that could install minor adaptations as needed: the internal joiner covered the whole local authority area however, and prioritised urgent need. The local authority had access to a provider service that could be used to install equipment if needed.

Staff and leaders identified there was a limited technology enabled care (TEC) offer in East Riding. Some resource had been previously available to support staff to access TEC but this had ended and some was available through private providers. Some staff told us the lifeline service and door sensors were all that was available. An improved TEC offer could support more people to maintain their independence in the community.

Some staff and leaders told us there was high demand and long waits for certain major adaptations. Between June 2024 and June 2025, loans for equipment such as recycled stairlifts, ceiling hoists, or ramps, the average time from receipt of the referral to completed works was around 85 days with a maximum wait of 280 days. Positive working relationships were in place between adult social care occupational therapy teams and housing teams which meant long term adaptation was considered at an early stage rather than people facing additional waits for further assessment.

## Provision of accessible information and advice

People could access information and advice on their rights under the Care Act and ways to meet their care and support needs. This included unpaid carers and people who funded or arranged their own care and support. National data indicated 72.17% of people who used services found it easy to find information about support which was somewhat better than the England average of 67.12% (ASCS, 2024). Additionally, 65.02% of carers found it easy to access information and advice, which was somewhat better than the England average of 59.06% (ASCS, 2024).

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People could get in touch with the local authority through a web portal or via the phone. Information was also available about adult social care from libraries and other community venues in the area to support people who needed face-to-face support or hard copies of information. This could be provided in different formats and languages through the local authority's translation and interpretation contract. Information was provided in 'easy read' format where needed: for example, the local authority's Futures+ team, which supported people with learning disabilities and autistic people, provided some of their documents in easy read as standard.

The local authority's website, Your Life Your Way, provided a place for people to access information and advice to take control of their own care needs. This included information to support independence, such as eating for good health, creating a safe home, aids and equipment, and going into and leaving hospital. Further information was provided regarding assessments, care and support plans, financial assessments, personal budgets and direct payments, and self-funding care. Additional advice and support was provided for adult and young carers as well as shared lives carers. It provided details of the local authority's database of local groups and activities along with local community and care services to search for services and activities in the local area which fit the individual's wants or needs.

The local authority had identified in their Equality Plan 2024-2028 that their website needed to be updated to meet accessibility standards, for example in supporting assistive software. This need had been originally identified in the Needs Assessment for Sensory Impairment in 2021 and was an ongoing action in the Equality Plan published in 2024. The plan identified more guidance and training to be produced to ensure published policies, forms and information documents were accessible and in plain English. The Equality Plan did not set any timescales or accountability for these activities and detailed plans were being developed at the time of our assessment.

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The Carer's Support Service provided a quarterly newsletter to all carers who were known to them covering topics relevant and important to carers. This included updates on processes, care support groups, useful contact information, and bereavement support for example. Carers could also access the Carers UK online toolkit to support emotional wellbeing and self-identification. A booklet was available which contained information about the Carer's Support Service, carers' entitlements and useful resources. The Carer's Support Service had recognised they needed to reach more carers and shared newsletters and leaflets with GP surgeries, especially in more rural areas where digital connections were more challenging. Information was shared in bulk with carers support groups in the community who shared this out to carers in their area.

The Carers Advisory Group was at early stage of developing a 'pathways' document at the time of our assessment as they said this had been missing. The document intended to support carers to understand complex policy, such as details of the Care Act, benefits, future planning and power of attorney, in an easy to understand, summarised way. It also intended to include carers stories to support people to recognise themselves as carers.

## Direct payments

There was a good uptake of direct payments in the local authority for people who access care and support. National data indicated 46.64% of people who used services received a direct payment, which was significantly better than the England average of 25.48% (Adult Social Care Outcomes Framework – ASCOF, December 2024). A high proportion of adults aged 18-64 receiving services had a direct payment (84.09%) which was significantly better than the England average (37.12%) (ASCOF, 2024). Additionally, 18.15% of people who used services aged 65 and over received direct payment, which was somewhat higher than the England average of 14.32% (ASCOF, 2024).

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The local authority made information available to support people to take up and use direct payments. People were told about support in place to manage direct payments, for example through an in-house direct payment support service. People could access their direct payment through a 'virtual wallet' or prepaid card, which provided options to meet people's needs when managing their direct payment. People had options in terms of family or third-party management of their personal budgets and for the budget to be managed by the local authority. Once signed agreements were received by the local authority, payments were processed on a weekly basis, meaning people waited no longer than a week between their agreement of the direct payment and receiving the first payment.

Information and advice on people's role as an employer when taking on a Personal Assistant (PA) was also provided by the local authority online and through the support of the direct payment team. This included a list of assured providers of care people could access and a space to advertise available roles. Staff described recruitment support being available at every stage of the process.

Take up of direct payments for carers was lower than expected at 74.86% (ASCOF, 2024). One carer told us they had received a direct payment but the process had been challenging. They were however pleased with the outcome and felt positive about it in the end. While staff described creative uses of direct payments and personal budgets to support carer wellbeing, such as the purchase of musical equipment to support at home respite, some carers told us they hadn't been told about direct payments, with several saying they had been told they didn't qualify for them.

There were 231 people, including carers, who had stopped their direct payments between June 2024 and the start of June 2025. Of these, 204 were people using services and 27 were carers. The vast majority were recorded as ended due to the direct payment no longer being needed, which encompassed reasons such as service user choice, one off payments ended or that they were no longer eligible for services, among other reasons. This made it difficult to understand any trends or detail for further analysis. Some people had moved into residential care or had moved out of the county.

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