East Riding of Yorkshire Council: local authority assessment

How we assess local authorities

Assessment published: 22 October 2025

About East Riding of Yorkshire Council

Demographics

The East Riding of Yorkshire is a county council located in the north of England on the East Coast approximately 200 miles from Edinburgh, London and Rotterdam. The East Riding of Yorkshire covers an area of approximately 930 square miles including urban, coastal, and rural communities. The coastline stretches for 53 miles from Bempton to Spurn Point. The local authority borders North Yorkshire to the north and west, South Yorkshire to the south-west and Lincolnshire to the south across the Humber Estuary. The East Riding also surrounds Kingston-upon-Hull which is administrated by Hull City Council.

The East Riding is home to approximately 350,119 people according to 2023 data. The majority of the population of the East Riding are White (97.35%) with 1.08% of people who are Asian or Asian British, 0.93% who are from a Mixed or multiple background, 0.26% from Black, Black British, Caribbean or African background and 0.37% from Other ethnic groups. There is a higher proportion of the population in the county who are aged 65 or older (26.85%) compared to the England average (18.69%). Population estimates expected this proportion to increase to 34% by 2043 at a higher rate than the Yorkshire and Humber region and compared to national estimates.

The East Riding has an Index of Multiple Deprivation score of 2 (with 10 being the highest and most deprived) and is rated 126 out of 153 (with 1 being most deprived). There are pockets of higher deprivation in Bridlington, Withernsea, Goole and South-East Holderness. Rural communities can also be quite isolated.

The healthy life expectancy in the East Riding was similar to the national average. Women can expect to live around 61.6 years in good health, which is similar to the England average of 61.9 years. Men can expect to live 61.3 years in good health, which is similar to the average for England of 61.5 years. Healthy life expectancy for men and women at 65 are higher than the national averages.

The East Riding is located within the Humber, Coast and Vale Integrated Care System (ICS) and the Humber and North Yorkshire Health and Care Partnership. People in the East Riding were primarily served by hospitals in Hull, York, and Scarborough.

The council has 26 Wards and 67 elected members. The East Riding of Yorkshire had a Conservative leader with no overall majority at the time of our assessment.

In May 2025, the East Riding of Yorkshire became part of the Hull and East Yorkshire Combined Authority alongside Hull City Council. An elected mayor representing Reform UK leads the Combined Authority to oversee decisions devolved from central government to the region.

Financial facts

The financial facts for the East Riding of Yorkshire Council are:

- The local authority estimated that in 2023/24, its total budget would be **£554,757,000.00**. Its actual spend for that year was **£627,810,000.00**, which was **£73,056,000.00** more than estimated.
- The local authority estimated that it would spend **£142,228,000.00** of its total budget on adult social care in 2023/24 Its actual spend was **£165,867,000.00**, which was **£23,639,000.00** more than estimated.
- In 2023/24, **26.42%** of the budget was spent on adult social care.
- The local authority has raised the full adult social care precept for 2023/24, with a value of **2%**. Please note that the amount raised through ASC precept varies from local authority to local authority.
- Approximately **6430** people were accessing long-term adult social care support, and approximately **1330** 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.

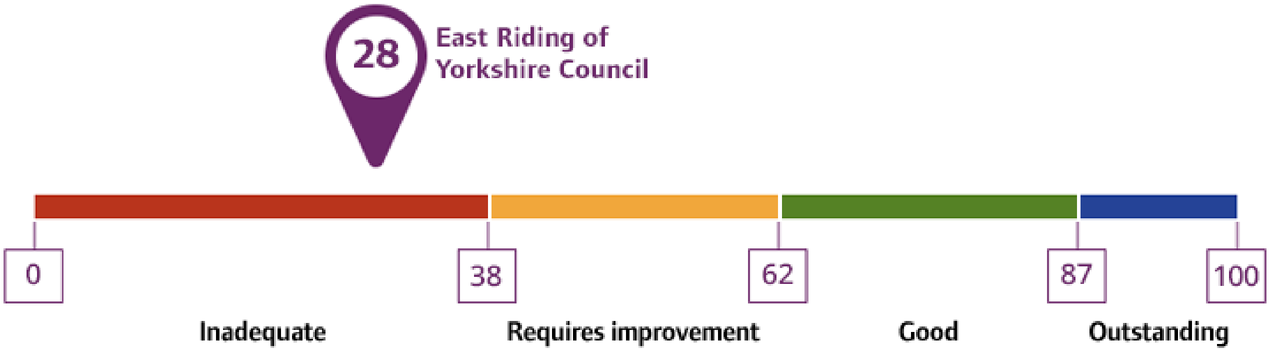
This data is reproduced at the request of the Department of Health and Social Care. It has not been factored into our assessment and is presented for information purposes only.

Overall summary

Local authority rating and score

East Riding of Yorkshire Council

Inadequate



Quality statement scores

Assessing needs

Score: 1

Supporting people to lead healthier lives

Score: 1

Equity in experience and outcomes

Score: 1

Care provision, integration and continuity

Score: 1

Partnerships and communities

Score: 2

Safe pathways, systems and transitions

Score: 1

Safeguarding

Score: 1

Governance, management and sustainability

Score: 1

Learning, improvement and innovation

Score: 1

Summary of people's experiences

We found many people experienced delays in accessing services which affected their experiences and outcomes. There were delays for assessments, reviews, and equipment assessments, including sensory support. While people waited, their needs sometimes escalated, meaning some experienced crisis which risked their wellbeing. However, when people received services in the East Riding, they generally experienced strength-based, person-centered practice that accounted for their needs. National data indicated most people who received support had control over their daily lives and were satisfied with care and support. However, this was not the experience of the majority of people due to difficulties accessing care.

There were delays in timely safeguarding enquiries. While people at highest risk were generally supported quickly, local authority information indicated people experienced delays in enquiries, some disjointed processes, and a lack of confidence and capacity in local authority staff.

Carers in the area who were known to the local authority's dedicated team received services that accounted for their needs, understood the challenges they faced and supported them to care for their loved ones. There was ongoing work to improve the reach of the offer and communication around the support available to help more carers in the area access support.

There was limited reablement care available to support people following discharge from hospital. Fewer people were likely to return to independence or achieve reablement goals because of this. While there were some services available in the community that could support people to remain independent at home, our assessment found the local authority did not support people sufficiently to promote healthier lives and independence.

Some people told us their preferred inclusion and accessibility arrangements were not always followed. There was not enough focus or understanding of the experiences of people with protected characteristics within the local authority to ensure people could equitably access services and achieve the outcomes that were important to them.

There had been significant issues with the capacity of service providers to meet the needs of people in the East Riding. This persisted for some people. Some people in rural areas were more likely to experience significant delays to their care. In some cases, issues were so severe people who could have returned home following a hospital stay had been unable to due to a lack of capacity. More people stayed in residential care provision than needed for longer.

Some people told us they had to complain to get their voice heard. There were some key issues in the information provided to people and the process around paying for care that the local authority was resolving at the time of our assessment. More people were involved with the local authority's efforts to hear people's experiences to design and deliver services. There were a number of partnership boards in place that supported people's voice.

Summary of strengths, areas for development and next steps

People's care and support had not always reflected their right to choice and reviews could be difficult to instigate. Communication could be limited. The local authority did not have a practice framework in place at the time of our assessment to support a unified and cohesive adult social care system in the local authority. Staff demonstrated strengths-based and person-centered practice when completing assessments, developing care plans and reviewing people's needs though difficulties in accessing care meant this was not the majority of people's experience. There was mixed feedback about the availability of training that allowed staff to develop their skills and knowledge. Some quality assurance of activity took place though this was primarily focused on case file audit and not linked to a wide range of quality assurance activity. This limited opportunities to ensure quality within wider service performance, risk and external benchmarking.

People waited for assessments or services, though this was based on risk. People at higher risk were generally responded to quickly. Where needs were identified at the point of initial contact, staff could engage some services in the community to support people while they waited. Where people waited, processes had been recently updated to ensure regular reviews to identify if need or risk had changed. However, this wasn't always effective, and staff described supporting people in crisis. Where these processes had been updated, it was too early to evidence sustained impact.

Staff, partners, people and leaders identified there was more to do to hear from and support seldom-heard communities. There were several examples of the way staff worked with people to meet their needs in respect of their culture, background, and experience. There were, however, some instances where non-verbal communication wasn't always well supported and there was a lack of services available for people from Eastern Europe and Ukraine, despite increasing populations. The intersectionality of people's protected characteristics was not always well understood. Staff had been open about wanting to be more confident to support people from different protected characteristics groups. The local authority had developed a bespoke workshop that was being expanded at the time of our assessment. There was positive commitment to support the prison population through a dedicated team that was improving their experiences and supporting effective release planning. The local authority had limited data about the protected characteristics of their adult social care population which affected their ability to understand people's experiences and outcomes. There was a lack of local strategy and action to reduce inequalities in people's access to care and support, their experiences and outcomes.

Intentions for the care market in East Riding were often unclear. There were limited clear plans in place about the requirements for the market, including the types and amount of services needed. This created an unclear picture for providers in the area about the local authority's commissioning intentions. Quality monitoring of providers had been limited to reactive reviews and there was recently identified work ongoing to visit the 24 care providers who had not been seen in the last 5 years. Capacity within the care market was a significant concern. People faced a lack of home care provision, resulting in short-term residential care that was often extended. We heard several examples of when short-term residential care became permanent as a result of capacity issues within the market. While the majority of people were placed out of area due to choice, the local authority identified there was a disproportionate number of working age and younger adults placed out of county due to a lack of provision. There were also gaps in complex nursing and dementia care.

The partnership with the mental health NHS Trust in the area was working well and investment in senior social workers within the structure had continued to strengthen the relationships between services to support Care Act duties. Operational partnerships with hospitals could be challenging due to the arrangements of health services outside the area. However, there were some concerns that disagreements or delays in partnership funding delayed people's care and support. This meant some people were not discharged from hospital or did not receive the care and support they needed to best support their independence and long-term outcomes in a timely way.

There were positive arrangements to support young people to transition from children's to adult's services which had improved people's experiences. There were examples of working with partners to develop community safe spaces, such as the Wellington Road Community Hub in Bridlington, to meet partnership objectives and deliver services for people who needed them most.

The local authority's safeguarding model changed to a 'hub and spoke' approach about a year before our assessment. There were increased numbers of safeguarding contacts in recent years. The number of safeguarding enquiries (section 42 enquiries) had remained consistent. Some partners felt there was more guidance needed to help them make appropriate contacts and that this training and guidance had dropped off since the change in approach.

The local authority was generally supporting people at highest risk in a timely way. Most people who received care and support said they felt safe. However, there were delays to timely enquiries for people at lower risk. This was primarily as a result of a lack of capacity within local authority teams. There was a lack of confidence to deliver section 42 enquiries from some teams. Use of advocacy was low to support people who lacked capacity. The local authority had committed to a review of their safeguarding model as a response to staff and partner concerns about the approach.

There was a waiting list for Deprivation of Liberty Safeguards applications in the area as a result of a corporate vacancy management process. A lack of staff had created a risk that people's safety and human rights were infringed.

Information security risks existed within local authority data systems which included a reliance on a variety of spreadsheets to manage work a case management system should be able to handle. Staff spent time duplicating across systems, and there were risks information was lost or misplaced in these instances. Work was progressing to improve recording systems.

Several significant leadership changes had taken place over recent years which affected the local authority's priorities, strategies and plans. There were also impacts on some partnership work and staff said leadership had not been visible. Key mechanisms, such as overview and scrutiny committee, corporate risk management and data intelligence, were not considered closely against the local authority's Care Act duties. Some key strategies were delayed or non-existent. These factors limited the local authority's governance and strategic planning to create the environment to deliver the best possible outcomes and experiences for people in the East Riding.

There were many areas of challenge identified in this report that were understood by the senior leadership team. The local authority had identified the need to draw on external support to improve across several areas though much of this was at too early a stage at the time of our assessment to evidence progress and impact.

Theme 1: How East Riding of Yorkshire Council works with people

This theme includes these quality statements:

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

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

Assessing needs

Score: 1

1 - Evidence shows significant shortfalls

What people expect

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

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

The local authority commitment

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

Key findings for this quality statement

Assessment, care planning and review arrangements

When people received an assessment, care plan or review, this was person-centred and strengths-based. However, people's care and support had not always reflected their right to choice and reviews could be difficult to instigate. Communication with people about the progress of their assessment or review had been limited. The local authority did not have a practice framework in place at the time of our assessment to support a unified and cohesive adult social care system in the local authority.

People could access the local authority's care and support services on the phone and online and all contacts were managed through the Information and Advice Hub. The Information and Advice Hub completed initial enquiries, directed people to support in the community and triaged contacts through to other teams within the local authority. In a pilot of collecting feedback following contact with the Information and Advice Hub in 2024, 79.25% of 53 respondents agreed either a little or a lot they could get information and advice about how they can have a good life.

People could also drop in to community venues, such as libraries, where information was available about adult social care. The Carers Support Service had a dedicated building in Beverley town centre near to county hall to support anyone who wanted to drop in for support. Staff said they had regular footfall of walk-in enquiries and self-referrals through this option. Enquiries to teams, including the Carers Support Service, could be made online, though no online self-assessment options were available at the time of our assessment.

When people received an assessment, care plan or review, this was person-centred and strengths-based. Staff we spoke to in the local authority were passionate about building relationships and developing and encouraging people's strengths through their work. Several people told us their care needs were well considered, they were given choices and were helped to understand the implications of those choices, including any contingency planning. People told us they felt listened to and there were clear plans in place to meet their needs in complex situations. Staff told us that a strengths-based approach was a focus within the work they did and this was embedded within their assessment forms. National data reflected this: 70.68% of people were satisfied with care and support, which was better than the England average of 62.72% (Adult Social Care Survey - ASCS, 2024). There was a regular forum to discuss strengths-based working to provide support to staff. The local authority was developing a peer supervision model at the time of our assessment to provide a further mechanism to support staff to deliver effective strengths-based practice.

There were several examples shared with us of restrictive packages of care being reduced which indicated how staff could use assessments, care planning and reviews to consider people's human rights, independence and choice. For example, one individual had been in a care home for a number of years and this had been identified as an inappropriate setting and one they were unhappy about. Local authority functions supported the review of these needs and new packages of care to be developed that supported people's choice and independence. These examples, however, raised some questions about why these more restrictive packages or placements had been agreed initially. The local authority did provide higher rates for more rural packages of care, though feedback we received from some providers indicated that more rural packages had additional time included to ensure packages were financially viable.

In some instances, carers told us requested reviews or considerations of moving placements to be closer to family had been difficult to instigate. One family member told us they had requested a review multiple times and they felt they were given excuses why the review couldn't take place. In another example, a carer said their family member was placed out of area and there was no consideration they could be moved closer. They said the social worker's caseload meant they didn't have the time to consider this. When reviews did take place, carers reported actions were taken quickly and new placements, where needed, were progressed in a timely way.

Questions regarding protected characteristics under the Equality Act 2010 were incorporated into the local authority's assessment documentation. Staff told us they discussed identity with people as part of their assessments. This information had not been mandatory, and some staff had expressed a desire to improve their confidence in talking to people about protected characteristics and incorporating this into assessments and care planning. Staff considered capacity under the Mental Capacity Act 2005 and completed capacity assessments where needed.

Communication had been identified as a challenge. Some people, carers, and partners told us they didn’t always know what was happening regarding their assessment, care plan, or review. A carer, for example, told us there were gaps in the local authority's services, everything was a fight and communication was poor. Several carers told us they felt they had to progress through official complaints, to their MP or to the Local Government and Social Care Ombudsman (LGSCO) to get the support they needed. There were also concerns that documents were not always shared with people as they should, limiting people’s ability to effectively understand and contribute to their own assessment, care plan, or review. This had been a theme of complaints which had been acknowledged by relevant staff, including through the Practice Development Board, and additional guidance had been shared with staff to improve this. A restorative approach to complaints had been implemented to support resolutions through open and honest discussion.

Staff teams worked together or referred to each other, to support planned and coordinated support across different teams. However, teams sometimes described disconnect in understanding each other’s roles or criteria. Some staff queried whether different parts of the service or organisation fully understood their roles or the needs of the people they supported. Some carers expressed frustration with perceived poor handovers and poor communication when there were changes in social workers. This was exacerbated by waits for allocation to a worker. Some staff told us referrals to mental health teams could only come through GPs, rather than through the Information and Advice Hub, which may have created delays for some people.

Assessment teams had the skills required to carry out assessments, including specialist assessments, though we received mixed feedback about the availability of training to support staff to build their skills. Some staff were happy with the training available, but others shared it could be difficult to access. The local authority had standardised their training matrices for staff across the service to better track this. Staff described supportive relationships within their teams that enabled them to ask questions and support each other to support the people of East Riding. Toolkits such as 'what if' cards, describing key topics and learning succinctly, and briefings and forums were in place to support practice. Staff had identified where they wanted to grow their practice, such as relational and trauma-informed practice.

The local authority was without a launched practice framework at the time of our assessment. A practice framework can clearly set out the expectations on practice, including what practitioners do and why, and ensures practice is ethical and evidence-based within the appropriate legal frameworks. This was being drafted, and an early version had been shared with some staff through engagement forums. Plans were developing at the time of our assessment to support the further development of the model and agree how it would be launched and what training was needed.

The local authority had a specific team to support people in the 3 prisons in the area. Staff worked with Category A and Category C prisons to deliver Care Act assessments to prisoners. This specialist team was an example of clearly responding to a need within the area and working in a complex system environment to provide care and support to people under challenging circumstances. The team was a good example of the positive person-focused and strengths-based service people who received services in the local authority area could access.

Timeliness of assessments, care planning and reviews

There were waits for assessments and reviews across the local authority that affected people's experiences and outcomes. The local authority did not set target timescales for the completion of assessments to track the performance of teams and identify any concerns or deviations that warranted further investigation and improvement.

All waiting lists were rated in response to risk, and the local authority was confident high risk concerns were allocated to staff and assessments and care plans were completed in a timely way. Every request for support received through the Information and Advice Hub provided a short, proportionate assessment to enable services to signpost as needed and complete a risk assessment. People received a 'waiting well' letter directing them to community support and to contact the service if their situation changed. Contacts that were not rated at the highest level waited longer. Those rated at the lowest level waited approximately 4 weeks for triage, according to some staff. They could then go on to wait longer once the need for further assessment was identified due to allocation delays.

Local authority data in June 2025 indicated that 616 people were awaiting allocation to the Community Wellbeing Teams. This figure was made up of a mix of 297 people new to the local authority and 336 people who had previously received support and where additional work was required, such as a capacity assessment or a change in need. Some providers told us it was difficult to contact social workers and there were long waits to get social workers allocated. One provider said a lack of timeliness from the local authority had resulted in hospital admissions. Another said they made safeguarding contacts sometimes when they were worried about someone who was waiting for an assessment which escalated their assessment. There were 931 adults awaiting an equipment assessment, of which 222 were awaiting a sensory assessment. One partner agency told us it was difficult for people with sight loss who were not registered blind to get a Care Act assessment. Some people with sight loss said getting an assessment was a postcode lottery.

The local authority completed some targeted work to reduce waiting times and the number of people awaiting assessments. The median waiting time for a Care Act assessment to start with the Community Wellbeing Teams was 18 days from the point of contact with services. The maximum waiting time was 1153 days. Several other significant waits were shared with us of over 800 days, though some of these related to recording issues. The local authority shared the detail of work they had undertaken to tackle the longest waits, including this one. The median was 3 days for the Disability Resource Team to complete equipment-based assessments, with a maximum waiting time of 531 days, and a median of 44 days for sensory assessments, with a maximum wait of 426 days. For Community Mental Health Teams, the median wait time was 42 days, with a maximum waiting time of 820 days. This data related to the June 2024 to May 2025 period. Each team was required to fully review their waiting list every 2 weeks following a process change in March 2025, which included contacting people directly. The local authority had also used their Customer Service Network to contact people which they were looking to expand to support the improvement of waiting times in the county.

People also waited for reviews. National data indicated 48.82% of long term support clients had been reviewed (planned or unplanned), which was similar to the England average of 58.77% (Short and Long-Term Support, 2024). Local authority data indicated the median number of days between when a review was due and when it was completed was 124 for June 2024 to June 2025. The maximum waiting time for a review completed in this period was 1264 days.

Staff told us that staffing levels were a concern and impacted on waiting lists. There were long waits to recruit staff in line with corporate recruitment policies, with one staff member saying it took a year between a staff member leaving and the vacancy being advertised. Capacity issues affected reviews following hospital discharge, with some people remaining in short-term residential care beyond original expectations, resulting in longer stays and poorer outcomes for people.

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

The local authority had an internal Carers Support Service which was well regarded by many of the people we spoke to. Carers described compassionate, effective and skilled staff who provided a consistent point of contact and support for the carers they worked with. National data indicated 38.14% of carers were satisfied with social services, which was similar to the England average of 36.83% (Survey of Adult Carers in England - SACE, 2024).

People came to the carers service in different ways, including picking up leaflets or being referred or signposted by other professionals. However, several carers told us there was not enough information or accessibility to the carers service. Some carers said they knew other carers who weren't aware of the service or informed they could have a carers assessment, despite being known to services since their child was young. One partner, for example, told us they weren't aware of anyone who used their service whose carer had received a carers assessment, despite working with significant numbers of people in the area.

The Carers Support Service had an office in Beverley that provided a physical location for people to walk in and get support. Staff said services in the community regularly referred people to the service. Staff were taking part in community events and sharing information through GP surgeries and other community services, such as Job Centre Plus, voluntary and community sector events, and patient and carer experience forums in hospitals to increase awareness of the service. This included the 'We Care' newsletter, delivered to 4,600 registered cares, online via social media, and posters and other information provided in community venues such as libraries. The local authority told us there were an estimated 47,000 carers in the area, with around 4,500 known to the service at the time of our assessment. Staff in other teams in the local authority referred people with caring responsibilities to the Carers Support Service for carers assessments where identified. Staff told us a significant challenge was people recognising themselves as carers and also reaching out to more seldom-heard communities to ensure support was provided across the population where needed. Leaders recognised the expected population growth for carers in the county in line with the ageing population and the need to ensure all carers across the county had access to the services they needed in the future.

Carers assessments could be delivered in light-touch ways, alongside combined assessments with the cared for person. There were available specialists in dementia and mental health to respond to the needs of carers. Assessments and reviews of care packages considered the carer's needs, alongside their views, interests and outcomes. The median waiting time for a carers assessment to start was 25 days between June 2024 and May 2025. There were 576 people awaiting a carers assessments at the time of our assessment. The maximum waiting time was 213 days.

Carers gave positive examples of receiving packages of care, leisure passes, access to short break holidays and a 'Your Money' service that met their needs. Specific information was available on the local authority's website that was directed to carers and Carers UK digital tools were also available. Several carers told us they didn't have enough time to take advantage of the carer's services available to them. National data indicated 0.00% of carers were accessing training for carers, which was significantly worse than the England average (SACE, 2024), indicating a lack of available training and access to it. One staff member, for example, told us training for carers wasn't adequate and carers weren't always supported to meet people's needs. The Dementia Strategy 2024-2028, 'Hope of a Life Still to be Lived', identified the need for a full review of all training available to people with dementia and their carer partners as an action. This was an example of aiming to improve the access to carer training in the county, in progress at the time of our assessment.

Young carers assessments were provided by children's teams. A young carer is someone under the age of 18 who helps to care for a family member, relative or friend. Primary legislation governing young carers under the age of 18 is the Children and Families Act 2014, which works in tandem with the Care Act to ensure a cohesive approach. This includes the requirement to consider a whole family approach when assessing an adult's needs to consider whether a child or young person is providing care and what impact this has on their wellbeing. The local authority told us young people waited approximately 2 to 3 weeks for an assessment from the date of their referral, which was an improvement on the 6 to 8 week waiting time between August and October 2024. Local authority guidance for adult social care staff highlighted the importance of young carer assessments and provided a link to a 'family directory'. This had no search function and was not easy to navigate to find relevant information about making a referral or supporting a young carer. Information was available on the local authority's website about the process of a young carer's assessment, which indicated a young carers assessment required a referral from a professional or parent or carer and a visit to a face-to-face appointment in a specific children's centre near the Hull border. It was not clear from the information online whether this could be made more accessible for people. In places, the local authority website was confusing about what constituted a young carer: in one definition, a young person cared for someone close to them, and in another it was a parent who was cared for. These issues may have affected how young people, particularly those approaching transition to adult services, perceived themselves as young carers or whether they reached out for support.

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

People were given help, advice and information about how to access services, facilities and other agencies for help with non-eligible care and support needs. The local authority's Your Life, Your Way website provided an online directory of support available in the community. Libraries and other community venues also provided information and advice to meet people's needs, alongside the local authority's contact centre, where staff had been trained to direct people effectively.

The Information and Advice Hub were able to direct people to services in the community to meet their non-eligible care and support needs. Staff shared examples of directing people to the community sector, benefits support services, food banks and where to get furniture and white goods when they had moved to the area. Services were available to support young people when transitioning between children's and adults' services to support independence, including tailored, trauma-informed career planning and links to supported internships or work programmes. An income maximisation service was available for people aged over 50, alongside home and befriending services, to support non-eligible needs.

Eligibility decisions for care and support

The local authority's framework for eligibility for care and support was transparent and clear. Guidance was available to staff that supported eligibility decision making, clearly in line with the national eligibility criteria.

There was no separate appeals process, with eligibility concerns managed through their complaints process. Of the 150 complaints made to the local authority regarding adult social care between June 2024 and June 2025, none appeared to be related to eligibility decisions.

National data indicated 72.59% of people did not buy any additional care or support privately or pay more to 'top up' their care and support, which was better than the England average of 64.39% (Adult Social Care Survey - ASCS, 2024). This indicated for the majority of people, local authority funded care met their needs, and they did not need to purchase additional care and support.

The local authority's website provided some information linked to eligibility. On webpages related to assessments, the local authority described that eligibility decisions would be made but did not clearly articulate or link to these specifically in the language of the eligibility criteria. For example, in information about a carer's assessment, people were encouraged to prepare for their assessment by considering questions that related to the listed outcomes of the eligibility criteria. It was not specifically outlined, however, how this would be used to determine eligibility and therefore could have been clearer for people.

Financial assessment and charging policy for care and support

Some work had begun on paying for care information in response to concerns about financial assessments. One carer described the information provided as a minefield. Information in the 'paying for care' booklet had caused confusion which the local authority was exploring correcting at the time of our assessment.

The local authority shared several complaints made to the LGSCO by people related to financial assessments. These related to delays, communication, and decision making. The local authority received 150 complaints between June 2024 and May 2025: 34 were formal complaints. Of these 23% related to financial processes and transparency and 7% related to direct payments and budget management. This included the need for clear, documented financial discussions to support people and any other relevant individuals to understand contributions to care costs. Complaints were categorized by the main concern so other complaints may have included concerns about financial assessments and complaints resolved outside of the formal process were not analysed in the same way.

At the time of our assessment in June 2025, 158 people were awaiting financial assessment, with a median waiting time to start the financial assessment of 18 days. The local authority told us that assessments were prioritised based on need, with direct payments being allocated promptly to ensure personal budgets and contributions were set before a care package began. The local authority's recording system did not allow for reporting on the completion of financial assessments, only the start date. They told us most assessments once started were completed on the same day, though some could take longer to complete due to a need to consider the persons capacity or a request for further details. Leaders told us financial assessment delays did not impact on the care provided to individuals. Efforts were underway to move financial assessments earlier in the financial pathway, enabling people to make informed choices, understand care costs upfront, enhance transparency, reduce delays in assessments and invoicing, and improve the overall customer experience. Leaders also told us there was more to do to have earlier conversations with people who fund their own care if their funds depleted while they received care and support. The local authority made a 'quick calculator' available online to support self-service. There was mandatory e-learning for staff on paying for care to improve early conversations with people about contributions and financial assessments.

Provision of independent advocacy

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

The advocacy contract provided appropriate advocates for people to participate fully in Care Act assessments and Mental Capacity assessments. The advocacy provider reported an increase in advocacy requests, specifically in relation to reviews, which they attributed to the awareness raising work they had done with staff. It took between 2 and 4 weeks for advocates to be allocated. Staff told us there was an adequate number of available advocates to meet the needs of people.

Guidance for staff completing assessments and reviews for people who used care and support and carers encouraged staff to consider the use of advocates. This didn’t link to guidance on how to request an independent advocate or any considerations about when using an informal advocate may need to be reconsidered, for example in any conflicts of interest. It was not always clear from documentation we reviewed whether independent advocacy had been considered and specifically who acted as an advocate for a person. Staff told us advocacy was prominent in their assessments and one of the first things they considered.

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

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.

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.

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.

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.

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).

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.

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.

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).

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.

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 where 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).

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.

Equity in experience and outcomes

Score: 1

1 - Evidence shows significant 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

While the local authority undertook some work to understand and identify barriers to care and support, actions to reduce inequalities from recommendations were limited. There were significant shortfalls in the identification and recording of people's protected characteristics which limited the local authority's ability to ensure equity in experience and outcomes. More support was needed with seldom-heard communities to understand their experiences and work with those communities to meet their needs.

The local authority undertook work to understand its local population profile and demographics, for example the Inclusion Health Needs Assessment published in November 2024, to understand local needs for care and support. The Inclusion Health Needs Assessment highlighted concerns for key communities in the area, such as veterans, people who were rough sleeping, lesbian, gay, bisexual, transgender and queer people (LGBTQ+), and people from Gypsy, Roma and Traveller communities. The local authority used data alongside insights from professionals, community groups, and people with lived experiences, to develop the Inclusion Health Needs Assessment. This resulted in targeted recommendations for services working with inclusion health groups. Specific needs assessments to understand the experiences and needs of communities within the area were completed, such as the LGBTQ+ needs assessment and the sensory impairment needs assessment.

The local authority had regard to its Public Sector Equality Duty (Equality Act 2010) in the way it delivered its Care Act functions. Equality Impact Assessments were produced to support decision making. Needs assessments and additional consultation and engagement with community groups supported the development of the local authority's Equality Plan, which had recently been updated and published online. Staff told us certain communities had asked for more support from the local authority to help them be a part of the wider East Riding community. A consultation to support the development of the anti-racism strategy, for example, was ongoing at the time of our assessment. While we heard that another service within the local authority had developed anti-racist practice, this had not been developed more widely or specifically for adult social care and was not in place at the time of our assessment. The anti-racism strategy consultation's initial feedback indicated some people described personal experiences of racism in their communities and where improvements in the wider system approach to racism and hate crime were needed. Some staff had experienced racial abuse and had not been clear about the support available to them, highlighting the need for the work to progress.

Staff and leaders understood some of the impact of the specific geography, population age demographic and deprivation in the area on people's experiences. Specific projects, such as an inclusion vehicle had been set up to reach out to people with dementia across the county who found it harder to access services. Transport was described as a key issue by people who used services and recognised by staff and leaders as a key aspect that affected people's experiences of care and support and potential outcomes. The local authority had completed some work as part of the Age-Friendly Network in recognition of the challenges of an ageing population in the area. The Age Friendly Community State of Ageing Report was published in January 2025 and further work was ongoing to move to the 'act and implement' stage of the process in the coming year. Considering the expected population growth in people aged 65 and over in the county, this represented a significant area of action needing to progress to meet the needs of the population.

Recording of information related to equality and diversity for people who received care and support had not been mandatory in local authority recording systems, and completion rates were low. The lack of recording system controls to mandate the inclusion of this information had deprioritised the importance of this information. The local authority told us that in relation to ethnicity data, after 'White English, Welsh, Scottish, Northern Irish or British', the next largest ethnicity groups were where ethnicity was recorded as variations of not known or refused. Sexuality was not recorded in the majority of instances. This limited the local authority's ability to fully understand the needs of the people they supported, which inhibited their ability to plan for and meet those needs. Some staff recognised the need to improve this and were working on developing data reports but this was not in place at the time of our assessment.

There were specific partnership groups in place in the local authority working with people and partners to understand the needs of the local community, for example with people with a learning disability and carers. Some partners said there was more to do for the local authority to learn about seldom heard groups and how best to engage them. This was reflected by some people we spoke to and the local authority. There was a recognition by some carers, for example, that older carers would not be able to challenge the local authority and would have had poorer experiences. People said there was minor involvement in co-production from the Traveller community and no identified actions to increase involvement from the LGBTQ+ community, despite this being an identified need in a recent survey. Further support to engage autistic people in co-production was also highlighted as needed. A lack of the voices of people with a wide variety of experiences in co-production reduced the ability of these groups to meet the needs of the breadth of the population.

There were early plans to develop outreach into parish council meetings and expanding advertising of opportunities to engage with the local authority in supermarkets and pharmacies. There was work ongoing to base some staff such as care coordinators in public facing community venues, such as libraries. However, these plans were at a very early stage. Staff said that it was rurality that most affected the services people received. Some staff told us the impact of the geography of the area isolated communities further. While leaders recognised communities had developed services to meet their own needs, there was more to do to connect into these groups to ensure people were supported and to ensure the right services were available where communities hadn’t developed their own services. For example, one staff group told us about initial work that had been explored with a local Imam for drop-in sessions from adult social care, but these had not yet been arranged. The local authority did not have a centralised strategy or outlined published vision for the voluntary and community sector, including grassroots organisations, to support equality and diversity goals.

Some partners told us there were a lack of services to meet the needs of ethnic minority communities in the area, such as the Muslim community and people from Eastern Europe and the Ukraine, despite rising populations. Some of the staff and leaders we spoke to agreed. Staff added further work was needed with the Gypsy, Roma, and Traveller community: some work was ongoing to build literacy and access to health services but this had not extended to adult social care.

Staff told us they worked hard to advocate for people and they used their assessments as a tool to identify cultural and identity related needs, including sexuality and gender. The prisons team worked closely with diversity officers within prisons to identify and respond in a person-centred way, for example in relation to gender transition. Some staff described the way they responded to communication needs or cultural needs in ways that were responsive, considerate and person-centred. However, some staff had identified that they had not been confident to ask people about their identity and characteristics. This limited the local authority's understanding of people and demographic trends, alongside a lack of holistic assessment. The local authority developed an 'identity and culturally informed care' workshop which outlined the local authority's legal obligations under the Equality Act 2010 alongside the importance of this information in delivering truly strength-based practice. It had been delivered to around 250 staff at the time of our assessment and was being rolled out to all staff.

Inclusion and accessibility arrangements

While some inclusion and accessibility arrangements were in place and used regularly, people reported communication with the local authority was challenging. People who did not use words to communicate were not always well supported and the local authority's website had limited accessibility features to support people to use the tools available.

There were some inclusion and accessibility arrangements in place so that people could engage with the local authority in ways that worked for them. A translation and interpretation service was available through a contracted provider. This included British Sign Language (BSL). A variety of ways of using interpreters, including face to face, over the phone and online were available. Interpreters had been used to support co-production activities to include more voices from the community in shaping adult social care services. Services provided relevant information in ‘easy read’ formats to support people’s access to important documents and support, for example an ‘easy read’ consent form for assessments for people with a learning disability.

Some people and partners told us there was more that could be done to support people who did not use words to communicate. One carer, for example, told us that signs were used with their family member that they did not understand. These had been used to get the person’s view on their services, meaning that their responses had been misinterpreted. They told us they had not received any support to communicate in different ways that might improve their family member’s independence.

The local authority had identified the need to ensure its website met accessibility standards in the Equality Plan 2024-2028. The local authority’s website had limited in built accessibility features and pointed people to using their own browser tools, which were not easy to find, especially where people may be less confident with digital tools. The local authority did signpost people to an external website to search for guidance on how to use accessibility features within web browsers, though this may have deterred some people. There was no clear guidance or signposting on translation features. There was limited information available on the local authority’s website about sensory services, or provided in videos or other media which may have supported people to access the information available on the local authority's website.

Theme 2: Providing support

This theme includes these quality statements:

- Care provision, integration and continuity
- Partnerships and communities

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

Care provision, integration and continuity

Score: 1

1 - Evidence shows significant shortfalls

What people expect

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

The local authority commitment

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

Key findings for this quality statement

Understanding local needs for care and support

The local authority used available information, such as the Joint Strategic Needs Assessment (JSNA) to understand the needs of the population in the East Riding. Key documents, such as the Market Position Statement (MPS), used relevant data and identified that the county's population was expected to grow from approximately 342,000 in 2021 to approximately 360,000 by 2041. This was a lower rate of population growth than the Yorkshire and Humber region. The local authority also understood that the proportion of the population of a pensionable age was predicted to grow at a faster rate than other areas from around 27% to 34% by 2043. The local authority identified this could raise the number of people in need of care and support in the county and add additional pressures to their health and care system, including in terms of provision and workforce.

Staff were able to use appropriate data, such as the JSNA and social care recording systems, to inform risk management and commissioning decisions, including to understand the demand and types of contacts made to services, which provided information on presenting needs. For example, staff told us they had recognised higher demand for carers services and demand data was being used to support longer term planning around 'dementia villages' to meet the future needs of the aging population in the local authority area.

It was not always articulated in published documents how much the local authority used and understood available data to support commissioning activity. For example, the MPS identified that 46,863 people in the area provided 1 hour or more of unpaid care per week, recognising how much this figure had changed in recent years. The document did not include information about the future number of unpaid carers in the area in line with national carer estimates, or further demographic information about carers which would support providers in the area to understand local need. This would have further supported the local authority's commissioning intentions.

The local authority had provider forums in place to understand their experiences and the experiences of people who used services. Quality and contract monitoring included both demographic data and people's views. Some providers however told us they had little opportunity to contribute their views and there were fewer options to do this than there had been previously. Where providers were involved, they felt listened to and valued. The local authority recognised further work was needed to engage seldom-heard communities to better hear their voice in understanding the local need for care and support. Some staff told us that data that would support them to understand equality and diversity was not available and they were working on their data reports to improve the use of this information.

Market shaping and commissioning to meet local needs

The local authority delivered several provider services which offered a wide range of quality services to meet the needs of people, including day services, the Shared Lives programme, a lifeline responder service, reablement and accommodation for people with learning disabilities, mental health conditions, and advanced dementia, for example. Overall, national data indicated that 69.74% of people who used services in East Riding felt they had choice over services, which was similar to the England average of 70.28% (Adult Social Care Survey, October 2024).

There was a recognition that there was an oversupply of care homes in the area which did not always support people with complex needs. There was an identified shortage of nursing provision in the area. Some providers had deregistered nursing beds, and local authority analysis indicated there was increasing complexity which required targeted development to meet this need, including in the recruitment and retention of a skilled workforce. Reshaping the residential care market was identified as a key priority of the Market Sustainability Plan in 2023, which outlined that a base of evidence was being developed to set out the services required in the future. However, staff and leaders told us these issues were still significant concerns.

There were also concerns regarding the provision of home care in the local authority area. Staff highlighted that the home care framework had recently been updated, creating a ‘closed’ framework reducing the number of providers from 50 to 12. This created the opportunity for closer working relationships with the home care providers centred around locality areas and the opportunity for more consistency. The local authority set ‘I statements’ within the framework against which it expected to measure successful delivery. An approved provider list could be used as needed where there were capacity issues or in response to individual choice with framework providers or through direct payments.

The Market Sustainability Plan in 2023 outlined an intention to move away from a ‘time and task’ model of home care to deliver a more outcome focussed approach through a series of pilots with home care providers. Key issues such as capacity and increasing need were clearly identified. However, staff also told us the framework continued to deliver to a ‘time and task’ model and there was still work ongoing to identify providers and pilot activity and the ongoing need for further development in home care. The new home care framework set key principles of person-centred care that promoted independence and choice and an ambition for outcomes-based homecare.

Staff told us the move to 12 framework providers had not reduced concerns across the area about the provision of care, such as across rural locations. In one example, staff said that rurality rather than complexity was the reason some packages of care were delayed or could not be sourced. Additionally, there was limited choice in homecare for people with complex mental health, to the extent that some staff told us they took on further practical and personal support for people beyond their remit.

There was some joint working with internal and external partners on provision within the area. This included working with housing services internally to develop an understanding of the property market and give more people their own front door. One provider, for example, said there was poor provision for extra care housing and supported living. Between March 2025 and the end of May 2025, local authority data indicated 7 people waited for extra care housing for their internally operated services, with an average waiting time of 120 days. There were 2 private providers in the local authority area of extra care housing, but the local authority did not have data at the time of our assessment regarding waits for these services. The local authority identified they were developing a detailed needs analysis of the extra care housing they needed in their MPS and was working with Homes England to deliver further extra care housing, including the recent development of a 34-unit site. However, we received mixed feedback about the join up across local authority departments to support market shaping.. The local authority shared examples of consultation between housing strategy and adult social care regarding the building or extension of provision within the area. However, some staff said they tried to highlight areas of need to new provision but had little control over the new services that opened in the area.

There was some consideration for the provision of services to meet the needs of unpaid carers. Some unpaid carers told us the free ‘sit in’ service was helpful, though it could be limited and they would have liked more hours if they could. Staff were able to support access to respite, including one example when a carer was able to stay in a hotel near to their wider family to support their wellbeing. The local authority also operated a care home for respite, emergency and crisis placements for adults with learning disabilities, for example. There was some close working with leisure services at caravan parks, and a carers cottage, which supported carers to take a break. The local authority confirmed carers could contact the carers support service directly for emergency support, including the ‘sit in’ service, the community wellbeing team if allocated, or out of hours services, including at the weekend or bank holidays. Some staff told us they recognised the need to increase the respite offer for carers. One partner, for example, told us respite didn’t meet the needs of their community where the nearest respite provision was 50 miles away and difficult to access. This was supported by national data: 6.96% of carers were accessing support or services allowing them to take a break from caring at short notice or in an emergency, which was somewhat worse that the England average of 12.08% (Survey of Adult Carers in England – SACE, June 2024). There was a similar picture for other respite care: 6.90% of carers were accessing support or services allowing them to take a break from caring for more than 24hrs which was worse than the England average of 16.14% and 12.62% of carers were accessing support or services allowing them to take a break from caring for 1-24hrs, which was somewhat worse than the England average of 21.73% (Survey of Adult Carers in England – SACE, June 2024). Work was ongoing with neighbouring authorities to further understand what needed to be developed.

Local authority staff told us they considered best practice when designing services, including looking to other local authorities and wider learning from partner agencies when developing their commissioning frameworks, for example. However, while strategic commissioning intentions and a direction of travel were clear to some staff, commissioning strategies were not fully developed or available. The MPS referenced broader strategies, such as the Older People's Housing Strategy, Learning Disability and Autism Strategy and Carers Strategy, which had ended in 2024, though some work was progressing to update these strategies. For example, the Big Plan and Autism Strategy were examples of the way the local authority was working to co-produce strategies with people who had lived experience of learning disabilities and autism, alongside their families and system partners, to understand community priorities to support ongoing development of strategic intentions. Staff told us measurable outcomes in terms of timescales, or the numbers of units or different types of provision had not been quantified.

Ensuring sufficient capacity in local services to meet demand

There was not sufficient care and support available to meet demand for home care, nursing care or for younger adults with complex needs in East Riding. People who used services in the county told us there was a lack of appropriate service provision to meet specialist needs in particular.

The local authority reported weekly on the number of hours and people across the area whose home care packages were outstanding publicly on their online MPS. Significant improvements had been made to reduce the number of people who were waiting for home care packages to start in the last year to 18 months, for example with approximately 1800 hours of outstanding home care in April 2024, to 426 hours of outstanding home care in early May 2025. Publishing these weekly reports online made it easier for providers to see where there was demand to be able to respond. However, capacity issues persisted, especially in more rural areas. In one example, an older person whose home was well adapted to meet their needs was unable to return home following a hospital stay due to a lack of capacity in home care. The package was never sourced, and the person was not able to return home. We were told several similar examples. We heard from staff, leaders and partners who were concerned about the lack of capacity and its impact on people's experiences and outcomes. Capacity concerns increased people's dependence on care and reduced their opportunities for independence at home. Staff told us the homecare framework and other intended improvements to homecare capacity had not fully rolled out leading to inconsistent improvements for people depending on where they lived.

The local authority had 328 placements outside of the local authority area, with 50 of these starting within the 12 months prior to March 2025. One voluntary and community partner told us there was a lack of provision for autistic people meaning the community had tried to meet needs themselves. A carer, for example, said they, and their family member's preference had been an East Riding placement but there was insufficient capacity to meet their family member's needs within the area. They didn't think there was a focus on supporting a return to the area by the local authority. Staff told us that resourcing care packages was a challenge, and they didn't want placements to fail and so considered out of area placements. Local authority data in May 2025 indicated more people aged 18-64 were placed in out of area care homes than in area. If a more local placement became available, social workers would complete a review to explore returning to the local authority area. However, considering delays to reviews for some people, it could be difficult to identify these opportunities. Some staff agreed there was limited capacity to meet the needs of younger adults who had multiple needs, such as physical and mental health, meaning it was sometimes difficult to get the support right for people and their carers the first time. Approximately two thirds of the out of area placements were in neighbouring Hull or York. Local authority data indicated 69% out of area placements were due to personal choice, as people wanted to be near to family, friends or for other reasons, such as to be close to a person's former home

There was a lack of complex residential care, including nursing care. In one example, a staff member described contacting over 100 homes and still being unable to get care that would meet the learning disability and nursing related needs the person had. Some staff were frustrated by the lack of provision to meet complex needs and there was insufficient nursing provision for the size of the population. The local authority identified the number of available nursing beds had decreased and there were a lack of options in the east of the area.

The local authority provided data which showed the average wait for services to begin in East Riding for March-May 2025 was 9 days for home care, 238 days for supported living, 15 days for residential care and 22 days for nursing care. Local authority data did not distinguish what would constitute a reasonable wait for a commissioned care package to start as they based these processes on need and risk. In that way they were unable to confirm the number of times people have had to wait for a service to begin due to a lack of capacity. Between March 2025 and May 2025, on average per month there were 104 outstanding homecare packages, 19 supported living packages, 121 residential care packages, and 4 nursing home packages. While some of these waits related to capacity, they also included the providers own assessment processes, delays in confirming offers, personal preferences, and process issues such as incorrect start dates.

Leaders told us they were working in partnership internally and externally aiming to improve some capacity issues that affected people's waits for care to start. For example, considerations were ongoing regarding the use of housing stock, improving supported accommodation, and the investment in specialist services, including whether existing properties could be improved rather than sold. Partners in health identified there was ongoing demand and capacity modelling linked to hospital discharge. This had contributed to some improvements, for example in the number of people receiving reablement and a reduction in the need for long term care following a hospital stay.

Ensuring quality of local services

The local authority had arrangements in place to monitor the quality of the care and support services that were commissioned for people. Contract and quality monitoring teams operated on a risk basis to prioritise quality monitoring activity, using safeguarding information, complaints, CQC ratings and quarterly provider returns. Staff were able to challenge providers to improve quality regarding person-centred care and additional monitoring visits could be in place where there were concerns. Staff teams adapted their approach to meet the identified concerns, including speaking with people who used services, completing observations of practice, and visiting more frequently or urgently. Where there were quality issues, they agreed improvement plans with providers. At the time of our assessment, the local authority had enhanced work in progress with 12% of providers, which included increased monitoring, formal improvement notices, and suspension notices. Robust arrangements for the quality assurance of internally provided services were in place for both registered and unregistered services.

The model of quality assurance generally reacted to risk and staff and leaders identified they wanted to take a more proactive approach to quality assurance. This had previously not been possible due to capacity. The local authority had completed quality assurance with all 12 home care providers on the ‘closed’ framework over the last year. The contract monitoring toolkit had been completed with 47% of providers on the approved home care provider list, and 25% of the care homes in the area. The local authority was aiming to complete all contract monitoring with all care homes and home care agencies within the 12 months following June 2025. The local authority had identified additional resource to complete monitoring visits for the 24 care homes which had not been visited in 5 years. This included shorter and short notice assessments. At the time of our assessment, 17 of these 24 services had been visited. The local authority was moving from reactive visits to baseline assessments for all providers and setting monitoring timescales for visits.

There had been 2 commissioning embargoes for care homes and 3 for home care services in the 12 months prior to June 2025. Reasons for embargoes included staffing, person-centred care, understanding of mental capacity, governance and a lack of engagement with the local authority. A provider of significant concern protocol had been recently used where a provider was not meeting requirements, to the extent there was an overall high risk to the safety, wellbeing and welfare of service users and the provider was not demonstrating a willingness or capability to improve standards and reduce risk.

The local authority's analysis in their MPS indicated the CQC ratings in East Riding were lower than England as a whole and the Yorkshire and the Humber region. The local authority identified that 63% of homes in the area were rated good or outstanding in May 2025.

Ensuring local services are sustainable

The local authority understood from providers where there were significant pressures linked to wage, food and fuel costs, alongside pressures on home care, uncertainty in residential care demand, recruitment challenges and hospital discharge.

Some staff told us there were regular discussions with providers to understand operational costs, pressures and specific issues that affected their sustainability. Some partners told us there were open and honest relationships with commissioners. The local authority ran sector specific provider forums to keep up to date on issues affecting the market. Analysis in 2023 for domiciliary care, residential and nursing care identified there were significant differences in the average price of care commissioned by the local authority and the result of the fair cost care exercises. Average cost increases of between 11-19% were identified as needed to bring the funding in line. In 2024, a decision was made to offer no fee uplifts to providers in the county in line with a corporate focus on cost reduction, despite analysis indicating rising pressures and demands on the market in line with local authority analysis as part of the cost of care exercises. Action had been progressed following our on site assessment to approve fee uplifts to private providers following a revaluation of the decision making process and the recognised impact on providers.

In the Market Sustainability Plan in 2023, the local authority identified recruitment challenges which affected provision, that some care homes had been unable to operate at full capacity due to shortages of staff and managers, including closing off parts of the provision. The MPS identified there were shortages of skilled workers in every area of care and support. Some providers used the local authority's Choose Care programme, developed and run in conjunction with the sector. Choose Care advertised the opportunities of a career in care, including through recruitment events. Commissioned providers were also able to access free training for their workforce through the local authority. Better Care Fund (BCF) funding had developed a workforce education programme to support building care careers, practice skills, leading well and integration, for example. A workforce plan was in place, developed with partners, to provide ongoing support to the identified risk workforce skill mix, recruitment and retention issues had on the sustainability of the market. Overall there were fewer adult social care job vacancies in East Riding: the proportion of vacancies was 5.78% which was somewhat better than the England average of 8.06% (Adult Social Care Workforce Estimates, October 2024).

Some providers told us that there were delays and challenges in receiving payment for the care they provided. Where changes to packages were agreed with a provider by operational teams, these were not always updated in systems, suspending payments. Similarly, extensions to packages would not always be updated promptly, affecting providers payments. While care for individuals continued, this affected the way providers operated and created an administrative burden that could have been better managed.

Some sustainability processes were in place in which the local authority could provide emergency financial support for providers who were at risk of closure due to financial crisis to support care continuity. Strategic planning guidance was available and utilised to manage provider failure, including how to assess risks early. There were 2 care homes and 3 home care services which ended their contracts with the local authority in the 12 months prior to June 2025 as these services closed. A further 2 care homes ended their contracts due to a change of service type to supported living providers. The local authority told us they worked with their internal service provision to retain staff where providers had exited the market in some instances. The local authority worked with providers who had reached out for support to understand demand in the area, service quality, fees, and business proposals before offering financial assistance. 'East Riding 4 Business' was also a service in place in which organisations could search for national and international funding sources aimed at small to medium enterprises, in conjunction with business advisor support. This made wider business support available to the care market, improving sustainability.

Partnerships and communities

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.

The local authority commitment

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

Key findings for this quality statement

Partnership working to deliver shared local and national objectives

The local authority worked with partners to agree and align strategic priorities, plans and responsibilities for people in the area.

There were partnership boards in place in collaboration with people and partner organisations that supported the development of shared local objectives. The Carers Advisory Group, for example, was chaired by a carer and well attended by carers, services and partner organisations, including people's voice organisations such as the local Healthwatch. This supported the development of the Carer's Strategy, and the delivery of these local plans were accountable to this group. 'Hope of a Life Still to be Lived', the joint Dementia Strategy for 2024-2029, led by the Humber and North Yorkshire Health and Care Partnership, in collaboration with NHS Trusts, local Healthwatch organisations, and voluntary and community sector organisations, had recently been launched. People with dementia and their carers were integral to the development of the local priorities identified within the strategy and the clear, streamlined approach focused on action. Progress was accountable to the Dementia Steering Group, which included people with lived experience.

The local authority had a memorandum of understanding with the Humber Teaching NHS Foundation Trust to deliver community mental health services in the East Riding. This enabled the integration of services to meet mental health needs in the county under the Care Act 2014. Partners shared there were joint transformation objectives that were supporting the progression of services in the absence of an up-to-date mental health strategy. The local authority had invested in senior social workers within the integrated team to support the continued delivery and focus on meeting people's Care Act eligible needs. Staff told us the addition of senior social workers had improved this focus and regular communication helped ensure there was a common direction in practice development, though this remained a separate arrangement. The local authority and the Trust were committed to the continued relationship between their services.

Joint commissioning was an area some partners and leaders felt needed more development between health and the local authority. The instability in strategic leadership within the local authority and wider partnership funding concerns had affected strategic direction. For example, one leader told us that some joint arrangements that had been agreed were at risk due to insecure funding, and further work as a wider partnership was needed on prevention that required ongoing commitment. A community sector partner told us there were lots of strategies that didn't get implemented, citing further work needed to use health inequalities funding as an example. There was some planned work to pool budgets, such as to support the healthy weight strategy.

Arrangements to support effective partnership working

Teams in general had good working relationships with partner organisations, citing multi-disciplinary meetings held regularly. Some of the people we spoke to were clear they had experienced a joined-up approach that meant they didn't need to keep repeating their stories, as information was shared appropriately. The Prison's team, for example, worked closely with probation, relevant other local authorities, the custody teams, substance misuse, health and other relevant agencies as needed, to support release planning. The Futures+ team described good multi-disciplinary work with schools, colleges, residential settings and supported living providers, for example, which supported people to transition from young people's services to adults' services. Due to the local authority's geography and the location of hospitals and prisons in relation to the area, there were specific challenges faced by teams working across complex systems. Staff told us they had to be mindful of different policies and processes between partners, which added additional administrative burdens to their work and sometimes involved navigating conflicts.

Some staff told us working relationships with the police service were different across the area, with some having named officer contacts, and others who had closer relationships with Police Community Support Officers (PCSOs). There were further co-working arrangements with the police and fire and rescue services, where some staff were being based in local authority buildings to improve partnership working, which were being implemented at the time of our assessment.

Staff and partners told us there was some duplication across information systems and an integrated, joint performance reporting model, for example with the Humber Teaching NHS Foundation Trust, would improve the tracking of activity and outcomes and improve efficiency. This reflected wider feedback about the need for clearer performance data, linked to outcomes, to governance structures to ensure sufficient oversight of adult social care delivery. Appropriate governance structures were in place to oversee partnership working, such as through the local authority's overview and scrutiny committee, the Joint Health and Wellbeing Board, and local partnership boards.

Though joint commissioning had been identified as an area for further development by leaders across the local authority and partners, there were some pooled budgets and joint arrangements in place. For example, one partner told us the Better Care Fund had been used to develop a health and welfare community centre in Bridlington under shared health inequalities priorities. The Better Care Fund had also been used to support the improvement of workforce issues in the county for adult social care and health, including exploring new workforce roles, integration and co-working models in health and social care.

Impact of partnership working

Following the introduction of integrated neighbourhood teams, the local authority had commissioned a piece of work into services to identify underperformance themes to relocate funding to best address local need. The local authority and local Healthwatch worked collaboratively, including through weekly update sessions. This reflected a commitment to ensure services were delivering appropriate impact.

Staff we spoke to were glad reablement services had been redeveloped in the area and reported this was improving hospital discharge. Some partners shared that readmission rates into hospital had been high and that there had been partnership work to develop a community and voluntary sector service in response. Partners told us this had reduced the readmission rate from 11% to 6% in June 2025. We were also told that partnership working had positively impacted the discharge to assess process out of hospital, seeing fewer people waiting across the various pathways, from around 200 people to approximately 40 in June 2025.

The local authority was reviewing the performance and impact data it monitored and presented to more clearly focus on outcomes, including the outcomes and impact in relation to partnership working. A number of local authority and partnership strategies were in development at the time of our assessment following the end of the previous version's time period. As these were in development, the impact of the existing strategy, including the impact of partnership working, was being reviewed. The impact of the previous Dementia Strategy was not outlined in the newly launched version, in favour of a more streamlined approach to clearly state agreed actions, timescales, and objectives.

Working with voluntary and charity sector groups

Voluntary and community organisations worked with the local authority in partnership boards and operational working arrangements that supported the delivery of Care Act duties. This included in providing information, advice and guidance, peer support, advocacy and services to people in the county with care and support needs. Voluntary and community sector organisations were represented across various partnership boards, including the Better Care Fund Programme Board, Health and Care Committee, Health and Wellbeing Board and Integrated Commissioning Group. Where organisations were working closely with the local authority, such as on these partnership boards, they told us they felt listened to, consulted and valued. One partner said there had been improvements over recent months: where previously there had been discussion but no action, that this was changing.

There was no overarching, council-wide strategy for working with the sector which some staff and leaders recognised as needed. The local authority intended for their new prevention and early help strategy to be designed and implemented in partnership with colleagues from the voluntary and community sector. Some staff and partners identified it could be difficult to know who to speak to in the local authority as funding came from different directorates. This potentially indicated duplication in funding and activity. In one example, there had been positive work to develop micro-providers in part of the county, but this was separate from adult social care commissioning approaches, meaning a lack of join up for the sector to ensure the delivery of Care Act duties.

The local authority had a primary collaborative relationship with an umbrella organisation to support their relationship with the sector. This aimed to support the sector to access funding as well as support continued development and partnership working opportunities in the area. The arrangements included the use of the Better Care Fund to support smaller voluntary and community sector organisations to become ‘commissioning ready’. There was further work ongoing to gather intelligence from across the sector on the support and impact delivered through the voluntary and community sector in the area.

There was some positive feedback around these umbrella arrangements, though some community and voluntary sector groups said they had limited involvement with this service. Not all organisations we spoke to said they were able to engage effectively with the local authority and some providers said it was harder for smaller organisations to work with the local authority and that only larger organisations were listened to. There were some gaps in the sector identified by staff due to the rural geography of the county which meant, for example, accessing groups or services to support wellbeing and quality of life, were difficult. A number of staff, partners, and leaders said there were more opportunities to work with the voluntary and community sector to meet people’s needs in the community. The local authority identified in it’s Council Plan 2020-2025 that empowering and supporting communities was a key priority through partnership working with the voluntary and community sector. Further work was ongoing and needed to clarify how development in the sector was driven to meet identified challenges in the area in line with Care Act duties.

Theme 3: How East Riding of Yorkshire Council ensures safety within the system

This theme includes these quality statements:

- Safe pathways, systems and transitions
- Safeguarding

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

Safe pathways, systems and transitions

Score: 1

1 - Evidence shows significant shortfalls

What people expect

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

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

The local authority commitment

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

Key findings for this quality statement

Safety management

The local authority understood where there were risks to people's wellbeing across their care journeys, however, these risks were not always consistently assessed across teams. 'Waiting well' processes were not always effective and there was a noted rise in complexity and volume of work which teams were not always resourced to support. More strategic work with partners was needed to reduce the impact of crisis through available resources. Information sharing protocols were in place with partners, though local authority recording systems were limited and not sufficiently robust.

The local authority reviewed all the contacts it received based on risk. This included information and advice and allocation to teams. This aimed to ensure safety was considered for everyone at all stages. Each team assessed risk on receipt to ensure people were prioritised for allocation. The Information and Advice Hub gathered initial information to triage. It was not always possible to gather enough information to make an accurate assessment of risk. Staff said it would be helpful to get a staff member out to visit the person on the same day to get more information which they couldn't always get over the phone but this wasn't always possible. There were sometimes differences between what the Information and Advice Hub considered urgent compared to what Community Wellbeing Teams and others did, for example, with some confusion about how much team capacity contributed to risk decisions. In most instances, this meant a higher risk rating at the Information and Advice Hub than in the Community Wellbeing Teams. Some teams felt the process worked well and accurately reflected the urgency required. Lower risk rated contacts did wait longer for support and were regularly reassessed. People were sent a 'waiting well' letter while they waited which provided helpful contact numbers and support in the community, with a request to contact the local authority if their circumstances changed. Some staff said this didn't always work and they were consistently dealing with escalations and people at the point of crisis. The local authority had updated their approach to ensure full waiting lists were reviewed every 2 weeks. The expectation was this would support a reduction in waiting lists as well as reduce the number of people in crisis. The impact of this process was being assessed at the time of our assessment.

Several staff told us there was a rise in complexity in their caseload, with one team, for example, concerned their existing capacity was not adequate to manage the increasing volume and complexity in the future. The local authority had developed and launched a new model for allocation with some teams which included a complexity calculation. This helped staff maintain caseloads that recognised differences in complexity and accounted for additional time that might be needed to support people in these circumstances. Rather than allocating work to staff solely based on perceived availability, staff who were using the system said it supported their wellbeing and reduced anxiety about allocations. This indicated a proactive approach to safety management by reducing risk of reallocation and transfer. The local authority was expanding this approach at the time of our assessment across teams.

An out of hours service was available to support safety outside of standard office hours. This included Approved Mental Health Professionals (AMHPs) and senior social workers. Initial call handlers received training, a handbook of guidance, and support from staff to effectively direct calls out of hours. Handovers to business hours services were documented in case management systems and via direct handover to allocated staff by email or phone. This supported the effective transition of people’s concerns from out of hours services to business hours services.

Some staff were concerned about the availability of safe beds if people needed to be detained under the Mental Health Act 2007, which impacted some people who had eligible needs under the Care Act. Commissioning of mental health beds is an NHS responsibility. This gap affected the local authority’s ability to effectively support Care Act principles about wellbeing, safety, and the implementation of appropriate community care to meet needs. Staff told us, for example, medical recommendations had expired due to the lack of beds, particularly for people with learning disabilities.

Crisis services were described as limited. This was also recognised as a challenge out of hours for carers. The Carers Strategy 2025-2030 identified that a key outcome was that carers in crisis could access timely and effective support. However, the detail of how this would happen had not been defined or published online at the time of our assessment. A mental health strategy was not in place at the time of our assessment, though leaders and partners told us transformation work continued to progress. Action had been identified within the previous strategy to improve access to crisis support for mental health needs, though without an updated strategy, it was difficult to be clear what impact had been made and what further action was ongoing.

There were information sharing protocols in place with partners to support safe, secure and timely sharing of personal information in ways that protected people's rights and privacy. Some staff, such as those in the mental health teams, were using two recording systems. These systems and external tracking documents, including for the DoLS team, hospital discharge, reablement, and the community wellbeing teams, did not communicate with each other or allow for the easy transfer of information across systems. Some staff told us systems had stopped working and they had lost work. This risked the safety of people's information and impacted on staff capacity to work with people.

Safety during transitions

Transition arrangements ensured that young people experienced an improved transition of their care and support between children to adult services. Hospital discharge processes and pathways were impacted by the geography of the East Riding and people did not receive timely reviews on discharge from hospital. Some people's wellbeing was not well supported following a hospital stay due to a lack of capacity in provision. Named worker arrangements were in place to support some people, including people with a learning disability or autistic people and people placed out of area to support their safety.

There had been significant improvements to the preparing for adulthood pathway for young people transitioning from children's to adults' services. Services began discussing transition for young people from around age 14, with allocation to a named adults' worker from around age 16. The preparing for adulthood forum was a multi-disciplinary meeting in which senior leaders had oversight of young people's transitions. Staff shared this had improved people's experiences as there was sufficient understanding and awareness of the complexity of need experienced. This meant, when availability of support to meet a young person's needs was identified, leaders could respond quickly to progress packages of care. The forum utilised data to review any young person known to services at age 17 to ensure processes had been followed and ensure appropriate referrals were made. This aimed to ensure no-one slipped through any gaps at this transition point. These processes included where young people's primary needs were related to mental health, which also meant there was oversight at a multi-agency level of challenges that specifically affected this group of young people. Some staff told us more work was needed to support young carers before they transitioned to adult services. There was early work in development to work with young carers to improve these services.

There were several hospitals that served people in East Riding, including a number outside of the local authority area. There were specific arrangements in place to manage the complexity of hospital discharges, with adult social care teams collocated in one hospital and roving teams where hospitals were further outside of area. Hospital social work teams completed Care Act assessments, seeing people in hospital and in discharge to assess beds as needed. There were joint arrangements in place with the Integrated Care Board for discharge to assess beds, which enabled people who were medically ready for discharge to come off the ward in preparation for their social care assessment. There were a number of available options available, including spot purchasing using a joint agreement with the NHS. Some staff said these beds were sometimes used for people who were awaiting a care package because they lived in a rural area and it was difficult to source care. Following discharge with a care plan, people were transferred to community teams for further reviews. There were delays to these reviews, specifically when people were discharged to short term residential care, which meant these became long term residential placements. Local authority data indicated between June 2024 and the start of June 2025, 40% of people who were discharged from hospital into short-term services, including respite and rehabilitation, went on to have permanent residential placements.

Some staff described advocating for people as part of discharge discussions including to ensure mental capacity was sufficiently considered in discharge planning. Staff described, for example, assumptions by some hospital staff that people at risk of falls must go into short term residential care. There was further need to ensure understanding of key social care considerations and a strengths-based approach to discharge planning at a partnership level.

We received mixed feedback around how providers were involved in discharge discussions. Concerns related primarily around contacting social workers. One provider, for example, told us there were several instances where someone had been discharged from hospital but the provider could not contact an allocated worker to discuss the person.

People had access to equipment and adaptations to support their hospital discharge, though some staff told us this was easier when people were discharged with a reablement package of care. If people did not go through reablement, it could be harder to access equipment, as there were longer waits through the front door. Hospital services did discharge people with equipment when required.

Supportive handovers were in place with services such as the reablement service. For example, staff described the team visiting someone due to be discharged in hospital to train on the leg brace the person needed.

The local authority had a Futures+ team which was dedicated to supporting people with learning disabilities. Individuals had named workers. This was especially helpful when individuals were placed out of area. Anyone placed in a care home had an annual review from a specific team and people placed outside of East Riding were prioritised for review. Out of area reviews were delivered around the person's needs, for example in person where this best met the person's needs, though predominantly provided over the phone in the majority of instances.

Contingency planning

We received mixed feedback about contingency planning in place for individuals. At a business level, it was not always clear contingency plans had been tested or updated recently. While improvements had been made, some people experienced delays in their care relating to partnership funding which impacted on their experiences and outcomes.

Some people and carers told us contingency plans were in place with regard to the carer’s needs and the needs of the person they cared for. In one example, a carer had regular check-ins with their designated worker and told us they were clear they had an open line to discuss what they needed as and when needed. In other instances, this was not always clear in documents we reviewed. For example, where the carer had complex health needs of their own and had discussed feeling challenged by their caring role, there was no clear consideration of a contingency plan. The Carer Support Service told us they regularly considered contingency plans and provided carer’s cards which detailed carer’s responsibilities to the cared for person. There were also transport services available as necessary to get people to essential appointments and clear processes understood by staff to respond to carers in crisis.

The local authority had an escalation protocol in place and provided evidence of how and when it had been used to ensure care and support continued to be provided for people affected by significant concerns related to a provider. This included in response to major service failures, significant safeguarding concerns, and unexpected or suspicious deaths. In one example of where this had been used, the local authority clearly communicated with people and their families, following a lack of confidence in the ability of the provider to raise service standards. In another example, the local authority was able to minimise disruption and accommodate care choices for people affected. The process identified learning in relation to understanding the rates people were paying, especially where funds had depleted and arrangements had changed.

Specific service contingency plans were in place in line with the local authority’s business continuity policy and corporate plan. Risk was well understood and documented. The local authority’s telecare service had utilised its contingency plan, for example. In other instances, it was not always clear what plans had been put in place or tested for example, or how staff understood contingency plans. For example, some stage 2 contingency plans identified critical functions required IT functionality but not how this would be mitigated or where paper copies of contingency plans were stored or available to ensure they could be enacted in the event of an incident. Some plans did not identify key contacts. Plans we saw were developed in 2021 and it was not clear if these had been tested or updated in the meantime.

We heard some examples of where funding disagreements had delayed people’s care and support. Some staff were concerned Continuing Health Care (CHC) funding disagreements led to delays in care and support. Examples were provided of challenge when double up home care was requested but originally not approved as residential provision was cheaper. Staff told us a person was delayed in hospital for a week awaiting the approval of CHC funding. Another individual plan was challenged following a hospital stay when they were returning to the residential home they had been living in for many years. Staff described a limited sense of urgency and a challenge to advocate on behalf of people. Processes for hospital discharge teams were challenging as they worked across different hospitals in and outside the East Riding across different Integrated Care arrangements, including for CHC funding. One partner told us there were arrangements that were in place where there were funding disagreements, including where NHS Trusts had funded extended arrangements to support decision making. At the time of our assessment, they told us there were no individuals waiting for a funding decision in hospital and work had been undertaken to streamline and improve processes.

Safeguarding

Score: 1

1 - Evidence shows significant shortfalls

What people expect

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

The local authority commitment

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

Key findings for this quality statement

Safeguarding systems, processes and practices

The local authority's approach to managing safeguarding contacts and enquiries had improved over recent years. However, safeguarding enquiries were not always prioritised and there were challenges in staff confidence and delays in processes which meant enquiries were not always timely. Not all staff were clear about roles and responsibilities around safeguarding.

The local authority had responded to concerns from a peer review regarding their safeguarding model and implemented a ‘hub and spoke’ approach and launched the Safeguarding Adults Hub. This was in response to findings in 2022 in which there were 2000 outstanding safeguarding concerns and unallocated enquiries. In this new approach, all safeguarding concerns were reviewed in the Safeguarding Adults Hub by senior social workers and should be risk assessed within 24 hours. Where these resulted in safeguarding enquiries (section 42 enquiries) they were then allocated to the appropriate professional to complete the enquiry: this included partners, providers, and operational social care teams. A section 42 enquiry is the action taken by a local authority in response to a concern that a person with care and support needs may be at risk of or experiencing abuse or neglect.

Some staff expressed concerns about this process, which had been in place for around a year at the time of our assessment. Several staff recognised the benefits of the model, understanding the completion of s42 enquiries by staff who knew the person and the area provided a more person-centred approach. Some staff were positive about the model, appreciating the development and maintenance of key social care skills. Others were concerned s42 enquiries affected the relationships people and their families had with their allocated worker. There were some concerns from staff there was a gap in a shared understanding of all safeguarding roles and a level of uncertainty in the process that was challenging to manage.

The local authority conducted an evaluation of the safeguarding model in April 2025. There were a series of clear recommendations to improve training, practitioner confidence, guidance, and support staff wellbeing for example. Recommendations were made through this evaluation on improvements, though not all actions were robust or clearly progressed. For example, some feedback indicated there were system recording issues such as a lack of case notes or closures without notifications from the Safeguarding Adults Hub to other operational teams, but this was not identified for any further investigation or action. The local authority provided guidance to staff but it was clear from their evaluation there was more to do to ensure staff could attend training and build confidence with the guidance to better support safeguarding activity. A safeguarding practice forum was in place to provide opportunities for staff to get support with any active work.

The local authority's evaluation of their safeguarding model was confident staff had the skills to effectively support safeguarding work. However, there was a difference in this perception for staff. Some staff told us the right level of support around safeguarding concerns and completing safeguarding enquiries was not in place. They said there was a gap in shared understanding of each other's roles in regard to safeguarding. The evaluation indicated the safeguarding training offer was under review and that some bitesize training had not been well attended. This contributed to a lack of practitioner confidence.

Overall, national data indicated people felt safe: 79.58% of people who used services felt safe, which was better than the England average of 71.06% (Adult Social Care Survey – ASCS, 2024). Additionally, 92.12% of people who used services said those services have made them feel safe and secure, which is somewhat better than the England average of 87.82% (ASCS, 2024). This was similar for carers: 86.02% of carers felt safe, which was somewhat better than the England average of 80.93% (Survey of Adult Carers in England, 2024).

Partners could access local authority run training on safeguarding, which was free for their commissioned services. We received mixed feedback from providers and partners about the availability of safeguarding training and learning shared with them following specific enquiries. A cascade training model was in place where some voluntary and community sector organisations had been trained up to deliver safeguarding training to other case sector organisations in the area. National data indicated the suitable skillset of staff completing safeguarding work: 49.35% of independent or local authority staff completed MCA DoLS training which was better than the England average of 37.58% (Adult Social Care Workforce Estimates, 2024). According to the same data, 60.42% of independent and local authority staff completed safeguarding adults training which was significantly better than the England average of 48.70%.

The local authority had arranged a further review of its safeguarding processes in the months following our assessment.

Responding to local safeguarding risks and issues

The local authority worked with the Safeguarding Adults Board and partners to deliver a co-ordinated approach to safeguarding adults in the area. The local authority worked in collaboration with a range of partners and the roles and responsibilities for identifying and responding to concerns were clear. The local authority took an active role in relevant boards and subgroups.

The local authority was a statutory member of the East Riding Safeguarding Adults Board (ERSAB). The ERSAB included the police and Integrated Care Service as statutory partners alongside a range of other partner agencies, including representatives from the prisons in the area, fire and rescue services, and advocacy and community sector organisations. This represented wide involvement in the activity of the board and opportunities to understand the safeguarding risks and issues in the area from a variety of sources. An oversight board was in place to consider children's and adults safeguarding issues and a crime reduction partnership supported a joined-up approach to system understanding of local safeguarding risks and issues.

The local authority, supported by the ERSAB, understood the safeguarding risks and issues in the area. The priorities for adult safeguarding were outlined in the ERSAB Strategy 2022-2025. This identified key priorities linked to safeguarding risks and issues in the area, including engaging with communities and seldom-head communities, modern slavery, transition protocols and improving the experiences of people with a learning disability in safeguarding processes. There had been specific work to reach out to voluntary and community groups in the area to ensure understanding of safeguarding. This had been a key priority of the ERSAB Strategy.

A recent SAR identified improvements in the consideration of alcohol use alongside self-neglect. One partner echoed this for example: they told us there wasn't always a good response to safeguarding concerns related to alcohol or mental health issues. A local authority leader told us alcohol dependence in safeguarding had been identified as a training gap. Training for staff was commissioned in response in conjunction with the voluntary and community sector. The ERSAB had also launched a Multi-Agency Risk Management Procedure (MARM) in May 2025 to facilitate effective multi-agency working with adults at risk of harm and who are deemed to have mental capacity.

Mental capacity was a feature of this and other recent SARs. Some local authority staff identified this was still a concern in some partnership contexts, for example in relation to hospital discharge. The ERSAB Annual Report 2023-2024 identified application of mental capacity assessments as an area for improvement. The ERSAB's learning and development focussed subgroup took forward any partnership training. The local authority had released a variety of guidance documents and 'what if' cards to support their staff to understand mental capacity, alongside other safeguarding concern areas. Hoarding had also been identified as an increasing area of concern. Practitioners from adult social care worked with ERSAB to develop training on hoarding disorder, resulting in e-learning and resources. This supported the hoarding protocol, developed in partnership with a lead from the fire and rescue service. This example indicated a collegiate approach to responding to local safeguarding risks and issues.

The ERSAB had an engagement strategy and was undertaking specific work with voluntary and community sector organisations to increase the participation of people with lived experiences in safeguarding work. This included engaging community advocacy organisations to lead SAR activity in response to people's needs. The local authority chaired the ERSAB's Actions and Assurance subgroup to deliver, monitor and execute the actions relating to SARs. This ensured it was central to progressing actions from SARs.

Responding to concerns and undertaking Section 42 enquiries

Process changes made significant improvements to local authority backlogs related to safeguarding contacts and enquiries in recent years. The local authority's model prioritised people at highest risk. However, there were delays for some people in the progression of safeguarding investigations linked to staff capacity and process delays. Recording and reporting information did not provide a clear picture of enquiry progress.

Leaders told us their safeguarding model meant all contacts were screened within 24 to 48 hours. The median time from receipt of a safeguarding concern to an outcome of the concern (including the decision to progress to a s42 enquiry) was 8 days between June 2024 and June 2025. Activity at this stage included initial fact finding and risk assessment, and initial safety plans where needed. Some staff raised more consistency in these safety plans as an area for development with us and in the safeguarding model evaluation in April 2025. The local authority said that interim plans were dependent on circumstances individual to the contact and context.

Staff told us that the system for recording safeguarding contacts could be convoluted: if staff identified a concern, they had to complete an external form, rather than use the case management system, for this to be triaged and then usually passed back to the originating team on the case management system. Staff told us this created delays.

The local authority set out expectations for external organisations completing s42 enquiries in writing through a letter for every enquiry. This included a checklist to ensure people's voice and outcomes were considered within the enquiry. We received mixed feedback from partners about the safeguarding process. Some partners said it was easy to make a referral, they were talked through the process, and they found the process clear and responsive. Others said the process was less supportive and consistent than previously and they received little practical guidance to understand decision making. One provider said they regularly chased the local authority for outcomes where they had completed the s42 enquiry. The local authority recognised this needed improvement in their self-assessment.

The number of safeguarding concerns received by the local authority had been rising over recent years. According to Safeguarding Adults Collection data for 2024, between April 2020 and March 2021 there were 2,515 safeguarding contacts to the local authority. For April 2023 to March 2024 there were 5,690. One partner told us there had been increased awareness raising of safeguarding across the sector and this had contributed to an increased number of contacts. While safeguarding contacts had increased, the percentage of concerns progressing to s42 enquiry had decreased from the April 2020 and March 2021 period: 37% of concerns progressed to s42 enquiries, compared to 17% of concerns between April 2023 to March 2024. While this conversion rate was lower than in 2020, the rate had remained level at 17% for the last 3 years. The conversion of safeguarding contacts to section 42 enquiries could be due to several factors, and does not, on its own, indicate safeguarding practice. According to local authority data, there were 437 open safeguarding concerns at the time of our assessment at the start of June 2025, with 55 of these progressing through initial fact finding. The remaining 383 were awaiting this initial fact-finding work.

Some staff said due to pressure on caseloads, staff who knew the person and their family often couldn't pick up the enquiry and the intended benefits of the local authority's safeguarding model were not realised. The median wait time for a s42 enquiry to start was 7 days, for the June 2024 to June 2025 period, though there was some evidence there could be significant variation. The local authority's internal evaluation indicated 34% of enquiries commenced within 7 days, and 67% within 28 days. The remaining 33% had significant wait times longer than 28 days. The median time for completion of a safeguarding enquiry was 49 days for internal staff and 6 days when the enquiry was completed by an external organisation. This reflected feedback from staff who said it was difficult to prioritise safeguarding work amongst their wider caseloads.

A weekly report was shared with us showing how leaders tracked safeguarding activity, but this primarily focused on volume and did not track how long activity took or what risk level it related to. For example, the report asserted all concerns were triaged within 24 hours to ensure the immediate safety of the person was attended to, but no data in the report indicated this detail. This made it unclear whether this was actual or aspirational. However, the local authority indicated they had access to on demand data within a PowerBI dashboard where managers could monitor and ensure safeguarding activity was allocated and processed in a timely way. Leaders were confident that waits related to lower risk safeguarding concerns and high-risk concerns were promptly screened and allocated.

The local authority recognised recording functionality improvements were needed within the safeguarding adult's pathway. Their case management system only recorded key episodes which did not always reflect the level of work underway as part of the safeguarding process, or account for when enquiries paused, such as the progression of police investigations, or additional delays that were outside of the control of the practitioner.

The local authority had a Deprivation of Liberty Safeguards (DoLS) team responsible for the processing of applications. This supported the local authority to understand and respond to the risks to people's safety and wellbeing presented by deprivation of liberty. However, current delays in progressing applications meant people's liberty may have been restricted unnecessarily.

The local authority used a mixture of internal and external Best Interests Assessors (BIAs). At the start of June 2025, there were 907 DoLS applications waiting to be allocated to a BIA. The median wait time for the allocation of a BIA was 29 days between June 2024 and June 2025. Staff and leaders told us there had been an increase in applications in the past 12 months and recruitment issues had increased the number of people waiting. The team used the Association of Directors of Adult Social Services (ADASS) tool to support prioritisation in line with recognised practice. The DoLS team reviewed their waiting list regularly to ensure applications were prioritised and reviewing teams regularly reviewed restrictions and applications in care homes as part of their work.

The local authority recorded where applications to deprive someone of their liberty in the community had been approved by the Court of Protection. However, recording of where applications were progressing but not yet approved could be patchy and some staff told us they were not confident it was accurate. This lack of accurate recording potentially risked missing where people's human rights may be infringed as part of Care Act duties, such as in assessments, care planning and reviews.

Making safeguarding personal

Safeguarding enquiries were carried out sensitively. People had the information they needed to understand safeguarding, how to raise concerns when they didn't feel safe, or if they had concerns about the safety of other people. The local authority was updating their concerns portal at the time of our assessment to make it more user-friendly. Use of advocacy to support safeguarding enquiries was low, which affected people's involvement in safeguarding processes.

The local authority implemented a specific safeguarding audit to complement their existing audit activity. This was in response to staff feedback and launched in November 2024. The audit centred around the 6 principles of safeguarding: empowerment, prevention, proportionality, protection, partnership, and accountability. The local authority's safeguarding data for 2023/2024 indicated that 79% of people were asked about the outcome they wished to achieve and 80% had their desired outcome partially or fully met. Principles of making safeguarding personal, including capturing the voice of the person, were present in guidance to internal and external staff when completing enquiries. Staff described ways in which they were considerate of people's communication preferences and consent when progressing safeguarding concerns and enquiries. In one example, staff described working with a provider to ensure there was private time with a person who was experiencing coercive control. This supported the individual's safety while supporting the outcomes and considerations they wanted, ensuring their human rights were respected. The local authority had a good relationship with their legal services, which allowed them to ensure any challenges related to legal obligations within complex situations were considered. In one example shared with us, it was clear there was sufficient consideration of the balance of a duty of care and the person's human rights.

The local authority's website, Your Life, Your Way, had information aimed at the public about keeping adults safe. This included information about the types of abuse, hate and mate crime, and advice about avoiding scams. The information linked to safety in the community and protection from crime and prevention of abuse alongside clear ways to contact services about concerns. This supported people to understand safeguarding and how to raise concerns when they didn't feel safe or they had concerns about the safety of other people. The local authority also outlined the concerns portal was being reviewed to make it more user-friendly for both the public and professionals, providing clarity on how to report quality concerns and safeguarding adult concerns.

Use of advocacy, however, was low. National data indicated 32.91% of people who lacked capacity were supported by an advocate, family or friend, which was significantly worse than the England average of 83.38% (Safeguarding Adults Collection, 2024). Partners and the local authority identified this needed to improve and requests for advocates were not consistent for s42 enquiries. The local authority's advocacy provider sat on the ERSAB to support partnership intentions to improve the involvement of people within the safeguarding process. Further training was expected to be provided to staff around advocacy awareness, the referral process and criteria for an advocate to be involved.

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: 1

1 - Evidence shows significant shortfalls

The local authority commitment

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

Key findings for this quality statement

Governance, accountability and risk management

The senior leadership of adult social care in the local authority had faced significant instability in recent years. This, alongside wider council strategic decision making, had a significant impact on the ability of the local authority to deliver people's experiences and outcomes under the Care Act.

Staff, leaders and partners recognised the significant impact instability within the local authority leadership of adult social care. There had been 5 Directors of Adult Social Services (DASS) in the last 5 years. Partners described a lack of a clear vision and strategy. One partner said this had resulted in conflicting priorities and directions, while another talked about a lack of continuity which had made the implementation of long-term strategies difficult. Some managers within the service described clear priorities under one DASS that had been changed under interim arrangements. One senior leader described prioritisation of saving money over quality, which some staff told us persisted in some processes. People with lived experience of services told us there had been a lack of strategic vision and direction as a result of restructures and unstable leadership. They said this had resulted in abandoned projects which had caused frustration and reduced engagement from the community.

Staff had been affected by senior leadership instability. At the time of our assessment the new DASS, who had been in post for a few months, had made it a priority to meet with all teams and improve the visibility of senior leaders. This had not been staff experience in previous months under previous leadership arrangements. Some staff told us it had been difficult to access management and they hadn’t been listened to by leadership. One team described the instability in leadership had affected their team through changes in direction of where they would be structurally which had created uncertainty.

Some senior management posts had been stable over recent years, which was recognised as helpful by some partners, and particularly in relation to safeguarding activity. Many of the staff, leaders, partners and people we spoke to throughout our assessment were hopeful that the stability of a new DASS, who had already begun to identify and act on issues and outline their intentions, would have a significant positive effect on culture, strategy and outcomes.

Instability had likely affected the position of adult social care as a clear priority against a backdrop of financial decision making corporately. For example, a vacancy management process was introduced to scrutinize requests to recruit in line with identified priorities to better manage the local authority's financial situation. When looking to recruit, teams sought approval through a corporate function. We received some feedback that there was disproportionate scrutiny on adult social care requests. Additionally, it was not clear where risk had been considered to recruiting to registered roles. Vacancies in the Deprivation of Liberty Safeguards (DoLS) team, for example, had resulted in a significant increase in the number of people on their waiting list, potentially infringing on people's human rights. Some staff told us staff in unregistered roles were taking on additional responsibilities and often working more in line with registered roles, in some cases in response to the vacancy management process. While most staff told us they felt supported by direct line management and peers, this created a culture of normalization of working beyond remit. It was not clear that corporate functions beyond adult social care were enabled to consider the impact of these decisions on people's experiences and outcomes or within the context of the local authority's legal obligations under the Care Act or Mental Capacity Act, for example. Some vacant posts had recently been agreed for recruitment to mitigate this issue.

Leaders told us decisions made to offer no fee uplifts for private providers who were commissioned by the local authority to deliver care and support had not been through appropriate governance procedures. Approved within wider budget proposals, there had been no wider discussion at Cabinet, full council, or Health, Care and Wellbeing Overview and Scrutiny Sub-Committee which outlined the reasons for and impact of the decision. This should have included full understanding of the local authority's duties under the Care Act to ensure sustainability of the market. This decision affected local authority relationships with providers and their sustainability, putting packages of care at risk. Following our assessment, the local authority confirmed that this issue had been identified, and additional action had been taken to review and agree uplifts. However, this raised concerns around the governance and accountability arrangements at several levels of the council.

The local authority's corporate risk register highlighted some performance metrics and key issues or considerations regarding risk to services delivering adult social care support. Performance data in this risk profile tended to focus on financial spending and provider activity. It was not clear how wider assessment activity and internal provision was considered within this risk profile, for example. Risk profiles were updated every 3 months and twice a year to Cabinet. Adult social care risk was reported under one overall risk that there was a failure to strategically plan, manage and deliver critical adult social care and health services. Key controls were provided, each of which were rated for effectiveness. However, risks were not aligned against the legal framework the local authority operated under. This made it difficult to assess which key controls were mitigating the more detailed areas of risk as it related to delivery of Care Act and other functions.

Strategic planning

A lack of available and appropriate data had affected the ability of senior leaders to oversee performance and strategically plan. Some leaders told us key data on adult social care performance, including against national outcome measures, had not been reported to Cabinet or Health, Care and Wellbeing Overview and Scrutiny Sub-Committee since October 2023. One elected member told us that while they were confident in the data they received, they weren't receiving everything they should. They said this was needed so they could ask the right questions and challenge where required. Leaders recognised the need for improved performance reporting in order to effectively evidence the impact of programmes of work, supporting the call for investment. Operationally, managers had access to information to understand where there were resource pressures and to manage risk which was reviewed weekly. The local authority was improving their data reporting at the time of our assessment.

There were some examples of where data had been used to inform planning and enabled solutions to be presented. In one example, the local authority were responding to backlogs in the Disability Resource Team by exploring a relationship with a private provider to take on assessments and support in order to reduce people's waits for services. This represented an understanding of risk and capacity. This was ongoing at the time of our assessment.

Some strategic work was not in place, out of date or in progress at the time of our assessment. There was no specific adult social care strategy in place, or strategy for prevention and working with the community and voluntary sector in the county, which some staff had identified as gaps. The Older People's Housing Strategy had ended in 2024, for example. A new housing strategy was in consultation and a learning disability plan was in development with people and partners. While some staff told us they understood strategic direction, commissioning strategies were not outlined in detail. These examples formed a picture of series of gaps in strategic planning that would have provided a framework for performance and the achievement of improved experiences and outcomes for people in the county.

Leaders were aiming to outline key manageable and achievable priorities in terms of transformation and improvement in adult social care. There were 17 key areas of development identified, though further prioritisation was ongoing at the time of our assessment. A very early draft vision document was also in development and had been shared with some senior leaders in the local authority to outline some intended strategic direction. There was a clear intention from leaders to complete meaningful co-production with people, staff and partners to ensure this starter vision was representative and driven to deliver the actions needed to improve care and support outcomes for people and local communities.

Information security

The local authority had arrangements to maintain the security, availability, integrity, and confidentiality of data, in relation to records and data management systems. Information sharing protocols supported the safe sharing of personal information in ways which protected people's rights and privacy.

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

During our assessment, the local authority shared personal information about people who used services in the East Riding with us outside of any personal data we requested. This was raised with the local authority, who conducted a full assessment and action plan in response to those data breaches.

Staff told us there were several documents within the local authority that were used to support operational activity that were not connected to the electronic recording system. The use of these documents represented information security risks as there are fewer access controls, such as two-factor authentication, and they can be less robust, risking data loss. The duplication of recording tasks across systems affected staff capacity and risked further information security incidents and data loss. Leaders recognised using additional systems and documents was not a sustainable position. The local authority was conducting a paperwork review at the time of our assessment to understand and streamline their data systems and make improvements.

Learning, improvement and innovation

Score: 1

1 - Evidence shows significant shortfalls

The local authority commitment

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

Key findings for this quality statement

Continuous learning, improvement and professional development

The lack of a clear practice framework and a minimal quality assurance framework limited opportunities for learning and improvement within the local authority. There was mixed feedback about the availability of training to support ongoing skills development, with some staff sharing they had limited to no access to appropriate training. Co-production was developing. The local authority identified the need to draw on external support to improve across a number of areas.

The local authority had expanded their practice development function recently. This provided dedicated resource to support ongoing activity around the practice framework, guidance, quality improvement, responses to complaints, changes to national practice, and local learning and development. This work was aligned with the Practice Development Board. For example, learning from the Safeguarding Adults Reviews group under the East Riding Safeguarding Adults Board (ERSAB) included short learning briefings and was presented to the Practice Development Board, alongside learning from audits and Domestic Homicide Reviews.

There were regular audits of assessments and case work. Each manager completed 2 per month and there was a specific role within the practice development team to complete additional audits and spot checks. Findings from audits were collated and delivered to the Practice Development Board for wider action and dissemination of learning. Guidance was available to support constructive feedback and learning following audits. A specific audit tool had been launched for safeguarding work. Leaders told us there was service wide ownership and accountability in practice quality. However, the local authority did not have a standalone overarching quality assurance framework indicating how all quality assurance activity came together in place at the time of our assessment. Quality assurance primarily focused on case file audit, and did not appear to include elements such as where thematic reviews, senior leadership audits, supervision audits, external reviews, or performance data were used collectively to contribute regularly to practice quality improvement. Where practice issues were identified, there were clear actions, with 'what if' cards, briefings and learning events for wider service learning. The local authority identified the development and launch of their practice framework, expected in the coming months would include the publication of further audit tools. The practice framework used recognised good practice and evidence to inform its development, alongside consideration of consistency with children's social care practice models.

We received mixed feedback about the ongoing access to learning and support available to staff to support the delivery of Care Act duties. Some staff there was sufficient training and they felt supported to develop professionally. However, some staff said they struggled to make time for training and continuous professional development due to caseloads and staffing issues. Some staff told us there was limited access to training and what was available wasn't always specific to the needs of teams. Some staff said training was often cancelled. In one example, a staff member said they had not had any training in several years. Other feedback related to delivery, which staff said was mostly online and more face-to-face training was needed. Some bitesize learning was in place, for example, to support safeguarding activity but this was not always well attended. Some staff identified they were less confident to support safeguarding activity and safeguarding training was being reviewed at the time of our assessment. The local authority had recently standardized their training matrices across their services to ensure mandatory and repeated training was clear. Staff shared examples of some more in depth training that was being developed, for example mandatory training on carers awareness.

In general, staff told us there were structures, such as supervision, team meetings, and 'huddles' in place to support them at work. Staff had access to champions, for example for carers and technology, which provided specific points of contact for advice to support staff to deliver Care Act duties. Some staff said supervision wasn't as frequent as it should be and they had put practitioner led peer group meetings in place themselves to support their delivery of Care Act duties where there were gaps. Several staff were clear there were supportive team relationships which meant they knew where to go to get support, including from the Principal Social Worker, and do the research they needed to in order to best meet someone's needs.

The local authority had developed a strong Assessed and Supported Year in Employment (ASYE) offer and increased their take up of student placements and apprenticeships to build the opportunities for continued professional development. Some staff said the local authority supported a 'grow your own' approach and staff retention was good.

There had been issues regarding the progression pathways for some care coordinators which had demoralized staff across the organisation. The local authority told us this had been resolved around the time of our assessment and pay issues had been resolved.

The local authority's work with the ERSAB included activity to increase people's involvement in safeguarding work and development. Roles had also been identified and recruited to through Better Care Fund which included to support coproduction.

Partnership groups were in place for carers, learning disabilities and dementia which included people with lived experience, partners and staff to support ongoing strategy development and accountability. For example, the carers strategy was accountable to the Carers Advisory Group. The anti-poverty strategy had been co-produced with the voluntary and community sector. There were co-production activities in commissioning through the redevelopment of the day time activities model and evaluating the homecare tenders, for example.

Some people we spoke to said co-production felt like a buzzword, but most of the people we spoke to involved in this kind of activity said they felt like they were working on solutions, were being listened to and were valued. Some people were clear the local authority had taken steps to make sure those who were involved were included, through transport support, costs, and scheduling. Some partners and people said there was more to do to bring people with lived experience directly to the table, including people from seldom-heard communities. This included enabling everyone to feel confident to contribute. There was collective recognition and active work to improve this. Some leaders, partners and people identified co-production was at its early stages in the local authority and a more joined-up approach would support the areas of good work that were progressing.

‘A good life with dementia’ courses, which were part of a development of a dementia peer support network, with a community organisation worked with people with dementia, provided both a supportive network and an opportunity to shape services. Evaluation of the programme with the Social Care Institute of Excellence (SCIE) was used to support the development of the local authority’s coproduction approach with people who used services and the voluntary and community sector. The local authority had a co-production toolkit to support staff to consider diversity, the different ways to gather feedback, and the intended impact of the work, for example.

The local authority identified the need to draw on external support to improve. This included a peer review that indicated further attention was needed in safeguarding, which had led to the change in model in 2022. The local authority had identified further support to review their approach in the months following our assessment. Staff also told us the prisons team received regular contact from other local authorities to understand their model and approach to support their own delivery.

Learning from feedback

The local authority learned from people’s feedback about their experiences of care and support, and feedback from staff and partners. This informed improvement activity and decision making. The Practice Development Board oversaw findings and actions related to complaints. However, people said to us and the local authority they had to complain to get their voices heard. While positive steps were being taken and improvements made, this raised significant concerns for the number of people who may have had poor experiences but were not sufficiently able, for a variety of reasons, to complain to the local authority.

Themes and trends from the 150 complaints received between June 2024 and June 2025 included the need for clearer communication, and sharing of assessments, support plans and financial discussions and clear case note recording. Practice issues included the need for more training and support to staff about hoarding and self-neglect and knowledge around sensory impairment. The local authority had implemented reviews, practice notes and mandatory training to improve services and outcomes following these issues and was developing further tools to respond to further themes, such as a practice note on assessments for deafblind people. Further work to develop and launch the practice framework over the coming months was also expected to further improve standards and reduce the need for people to complain. Some people said they felt they had no choice but to complain to get their voice heard. The local authority was embedding its restorative approach to disputes to improve people's experiences.

The local authority told us they had started the staff survey again in the year prior to our assessment. This was the first staff survey in 6 years so there had been limited opportunity for staff across the organisation to share their experiences and provide feedback. Staff networks had been set up to share feedback and develop solutions by staff across the local authority. This would provide further opportunities to understand staff experience. There were practice and engagement forums in place for leaders such as the Principal Social Worker to gather staff feedback about their practice needs, however these were limited in the size of the groups.

There were 9 detailed investigations by the Local Government and Social Care Ombudsman (LGSCO) between April 2024 and March 2025, compared to 4 for the average number of detailed investigations for other local authorities of its type. The uphold rate of complaints to the LGSCO was 66.67%, compared to the average uphold rate of its type of 73.36%. The local authority complied with 100% of the LGSCO's findings, with 20% of their remedies late (equating to 1), compared to the national average of 18.2%. This represented an improving picture on the previous year's data, indicating action taken by the local authority in response to complaints and the development of their restorative approach was having an impact.