Nigel Pearson
Chief Executive
East Riding of Yorkshire Council
County Hall
Beverley
HU17 9BA

7th June 2013

Dear Nigel

Health and well-being peer challenge, 21 – 24 May 2013

On behalf of the peer team, I would like to say what a pleasure and privilege it was to be invited into East Riding of Yorkshire Council to deliver our first pilot health and wellbeing peer challenge as part of the LGA's health and wellbeing system improvement programme. This programme is based on the principles of sector led improvement, i.e. that health and wellbeing boards will be confident in their system wide strategic leadership role, have the capability to deliver transformational change, through the development of effective strategies to drive the successful commissioning and provision of services, to create improvements in the health and wellbeing of the local community.

Peer challenges are delivered by experienced elected member and officer peers. The make-up of the peer team reflected your requirements and the focus of the peer challenge. Peers were selected on the basis of their relevant experience and expertise and agreed with you. The peers who delivered the peer challenge at East Riding of Yorkshire Council were:

- Rob Vincent – Local Government Advisor to Public Health England
- Councillor Steve Charmley – Cabinet Member, Shropshire Council
- Anna Lynch – Director of Public Health, Durham County Council
- Phil Shire – Head of Wellbeing and Social Care, Calderdale Council
- Liam Hughes – Independent Chair of the Oldham HWB and Associate, LGA
- Anne Brinkhoff – Programme Manager, Local Government Association

Scope and focus of the peer challenge

The purpose of the health peer challenge is to support Councils in implementing their new statutory responsibilities in health from 1st April 2013, by way of a

systematic challenge through sector peers in order to improve local practice. In this context, the peer challenge has focused on three elements in particular:

- The establishment of effective health and wellbeing boards
- The operation of the public health function
- The establishment of a local healthwatch

Our framework for our challenge was four headline questions:

1. How well are the health challenges understood and how are they reflected in the Joint Health and Wellbeing Strategy (JHWS) and in commissioning?

2. How strong are governance, leadership, partnerships, voices, and relationships?

3. How well are mandated and discretionary public health functions delivered?

4. How well are the strengths of the Director of Public Health (DPH) and his team being used?

You also asked us to help you define a route-map for an ambitious HWB that can successfully lead and influence improvements in the health system, and to comment on your approach to tackling dementia.

It is important to stress that this was not an inspection. Peer Challenges are improvement focused. The peers used their experience and knowledge to reflect on the information presented to them by people they met, things they saw and material that they read.

This letter provides a summary of the peer team's findings. It builds on the feedback presentation delivered by the team at the end of their on-site visit. In presenting this feedback, the Peer Challenge Team acted as fellow local government and health officers and members, not professional consultants or inspectors. We hope this will help provide recognition of the progress East Riding of Yorkshire Council (ERYC) and its Health and Wellbeing Board (HWB) have made during the last year whilst stimulating debate and thinking about future challenges.

1. Headline messages

ERYC demonstrates strong commitment to improving the health and wellbeing of its residents. We saw a good understanding of the health and wellbeing challenges, informed by data and customer insight and broken down into themes as well as geography. This thorough analysis has informed very clear priorities and a consistent approach to tackling health inequalities.

Relationships between organisations who form part of the health, care and wellbeing system are strong and the HWB is developing well to take on its future role as a system leader.

The transition of public health into the council was well managed and staff are recognising and embracing the opportunities of being part of the Council. They see their role in working beyond the public health team and influencing the wider spend and functions of the system and council. Arrangements for mandated services are in place and understood. Staff across the council are highly motivated, adaptable and creative and there are many examples of joint projects and initiatives.

It is now timely to intensify the expectations on the HWB in driving the delivery of the joint health and wellbeing strategy (JHWS). It should maintain a clear focus on its three priorities. It should continue to develop relationships within the Board and outside, in particular with the major acute and care providers. We urge you to continue thinking ahead and using the HWB to prepare for further integration of health and social care arrangements.

The wider partnership structures need to be lean and focused on the key challenges, including health system change.

2. How well are health and wellbeing challenges understood and reflected in the JHWS and in commissioning?

The health and wellbeing system in East Riding of Yorkshire has a comprehensive and convincing analysis of the health and well-being challenges of its population. The Joint Strategic Needs Assessment (JSNA) provides a shared evidence base of health needs combining an epidemiological approach, comparative analyses, attention to the wider determinants of health, and a corporate approach to health needs assessment. These assessments are available on the website in the form of specific reports, presentations, data profiles and analyses. This allows shared understanding of the local story of health and wellbeing needs that is a crucial platform for integrating services across the wider health, care and wellbeing system.

Data and analyses are shared effectively between partners of the health, care and wellbeing system. The JSNA is part of the East Riding Data Observatory which brings together all needs assessments, including crime and disorder, housing, employment and the Child Poverty Strategy. This systemic data and intelligence is complemented by a systematic data analysis of ward profiles. The combination of depth and breadth provide a rich picture of data and information to inform service planning and commissioning.

The HWB has a clear attention on health inequalities. '*Health and wellbeing inequalities in the East Riding are removed*' is one of three priority outcomes in the JHWS. There is an appropriate focus on improving the wider determinants of health, such as access to good housing, education, employment and leisure. There is clear attention to the promotion and support of healthy lifestyle choices to reduce poor levels of health and promote independence. Geographically, the data clearly identifies major health inequalities between the electoral wards, with wards in Bridlington, Goole and Holderness experiencing lower life expectancy and a range of other health and well-being issues.

Needs analysis is guiding service planning and commissioning decisions. Our discussions with officers highlighted a deep understanding and use of data to guide service delivery. We saw a good balance between the need for a general provision as well as an ability to target areas of greatest needs. Examples are the work of Health Trainers and supporting communities with financial inclusion which are targeted in the electoral wards in Bridlington and Goole. Similarly, the Council is targeting its capital investment to deliver higher health equality, by investing in building a new Leisure Centre in Bridlington.

There are good examples of how the system is reviewing the effectiveness and efficiency of interventions, using existing structures. A comprehensive value for money review of the Alcohol Misuse Services was commissioned by the LSP Resource Group to consider the establishment of a clear alcohol strategy, determine roles and responsibilities of existing multi-agency groups, address financing issues and build an operational management structure which will drive improvements in service delivery. This is a good example of analysis informing investment and dis-investment decisions, and building integrated commissioning teams.

Priorities for health and wellbeing are consistent across the main strategic documents. The three priorities in the JHWS are included in the CCG's Commissioning Plan (2013-14) joint strategic objectives, which sit alongside short term outcomes and CCG local priorities. There is a clear reference to the JHWS and its three priorities in the Council's Business Plan under the corporate priority of promoting health and wellbeing and independence. The challenge for all strategies will be to find balance and accommodation between the short and longer term and between the range of individual corporate priorities.

The role of the HWB has been identified as providing strategic leadership and governance over the health, care and wellbeing system and, as such, the HWB does not directly manage delivery. Its outcomes framework shows a commitment to delivering value for money health, wellbeing and social care services through a range of means, including joint commissioning and whole system transformation. The framework breaks down each priority outcome into a number of medium term priorities and measures and aims and highlights which of the existing partnerships will deliver against these. The current measures/aims are not

specific and lack targets and timescales. This makes it difficult for the HWB to monitor progress and hold partnerships to account for delivery. Given the Council's commitment and expertise in managing transformation programmes we would suggest that it could apply its expertise and techniques to the JHWS. The commitment of the JHWS to '*better care, more locally, within budget, through transformation*' is aspirational and will require careful programme management.

While the JHWS identifies the economic necessity of preventing poor health, it does not place its aspiration within the financial context for the Council and the CCG. Making explicit links between the JHWS, the Council's MTFP and the CCG's Quality Improvement Productivity and Prevention (QIPP) targets within both organisations will highlight the systemic necessities of promoting integration as a means of better value for money. Strengthening links between the JHWS and service plans in the Council and CCG will strengthen the operational links and create a dynamic which makes integration part of the core business rather than an add on.

The peer challenge team welcomed the focus of the Council's Capital Scheme on its organisational priorities and objectives. Given the financial challenges we recognise that the capital programme provides an important opportunity to demonstrate explicit investment in communities to achieve particular outcomes which the relentless focus on efficiencies in revenue budgets no longer permits. Highlighting these as commitments in the JHWS and the JSNA will provide a more correct picture of investments and the availability of community assets.

The challenge team were impressed with the current approach to reviewing the return on investment of alternative interventions as demonstrated in the review on Alcohol interventions as well as the substance misuse service. We would encourage the HWB to build on this approach and commission specific reviews in service areas that fall within the priorities of the JHWS or in areas of greatest spend.

3. How strong are governance, leadership, partnerships, voices and relationships across the health and wellbeing system?

Political and managerial leadership on the health and wellbeing agenda within the Council is strong, committed and pragmatic. Lead members and senior officers articulate health and wellbeing priorities clearly and consistently and this was reflected in the way in which middle managers and front line staff spoke about how they plan and deliver their services. *'The council no longer delivers services – only outcomes'* was a clear message from managers and staff, demonstrating the necessary shift in how and where resources are used in the context of the council's position as a traditionally low funded authority and the financial challenges ahead. The challenge team were particularly impressed with the way the Council's transformation programme supports this shift in

organisational thinking as well as generating savings. The programme principles, including personalisation, use of technology to support independence and targeted delivery, together with the use of Customer Insight tools and CRM data demonstrate a thoughtful approach to the use of business transformation to best-serve East Riding.

Relationships between partners across the health, care and well-being system are good and long standing. A sophisticated partnership infrastructure has been in place for many years and provides a system-wide structure to plan, oversee and deliver joined up services. The HWB has been placed within the existing structure with a clear remit of providing strategic direction and governance. It links with the Children's Trust and Health, Care and Wellbeing Action Group as two delivery partnerships, the latter with a number of further specific sub-groups. This creates rich opportunities for the HWB to influence and shape existing delivery groups.

The CCG and Council are working together well in areas of common interest, in particular addressing the challenging needs and demands of an ageing population. New working arrangements are established to cement these relationships further. For example, the Accountable Officer of East Riding of Yorkshire CCG has recently joined the Council's CMT, and a Health and Social Care Executive, comprising senior officers from the Council and CCG, has been in existence for some time. This provides an integrated operational structure to deliver integration of services. One of the key challenges for system leadership is to ensure that organisations who are part of the system understand and appreciate the needs and constraints of other partners. This is a principal condition to achieve accommodation and longer term change. The challenge team felt that the Council needs to be aware of the immediate and longer term constraints within which the CCG operates.

There is a rich landscape of voluntary and community structures in East Riding. It includes geographical coverage through the seven Local Community Partnerships and a thematic spread of organisations that are providers or provide advocacy. The voluntary and community sector is coordinated through the East Riding Voluntary Action Service. This is an important infrastructure for the system to achieve its ambitions to deliver more locally.

The Council and CCG are thinking ahead and are seizing opportunities to prepare for future integration models. There are many examples that illustrate this, for example a number of joint posts between the Council and the CCG in Children's and Adults Services as well as a commitment to pooled budgets. The Council is working with the LGA's Future Council programme to establish a virtual customer service centre to provide a platform for use by all public sector partners to develop personalised public services to shift the focus of commissioning to the needs of people rather than what the system allows. This preparatory work will enable the system to seize opportunities for further integration when they arrive.

The council has put itself forward as a potential pioneer in the national collaboration for integrated care and support.

Given the configuration of the Acute Trusts within East Riding with most major hospital sites located outside the Council area, partners recognise the need to work at sub-regional level. The challenge team heard about the Hull and East Riding Strategic Partnership Board, the successor of the 'Securing Sustainable Services Programme (SSSP)' which provides a new governance structure to plan ahead for changes in the health and social care system and deal with matters that need cooperation on a sub-regional level, such as innovation, workforce, community assets and co-commissioning and co-provision. The challenge team feel that this partnership has strong potential and would encourage the HWB to champion it. However, there is a need to clarify the mutual expectations and roles and responsibilities of the HWB, the CCG and this new Strategic Partnership Board. For example how does the new Strategic Partnership Board's work impact on the work of the HWB and CCG in East Riding, and presumably their counterparts in Hull?

The HWB has established itself well in the partnership structure and is becoming a sought after forum for engagement. While this is positive in that it shows that organisations recognise its value, there is a danger that its agendas will become overloaded. The challenge team would encourage the HWB to be rigorous in pursuing its own priorities and taking care that its agenda is sharp and focused.

Officers, members and partners we spoke to acknowledged that the partnership landscape in East Riding is rich and has grown over the last decade. We heard many voices who acknowledged that while the individual partnerships and groups are useful and add value, as a whole the partnership system has become too big and resource hungry. Given the significance and complexity of the health reforms the challenge team feels that partners were prudent to wait until the new system is established but we feel that that the consideration now being given to prune the system it is timely.

The health reforms have seen the introduction of NHS England Area teams and the Public Health England Local Centres. While both organisations are still in development it is crucial to clarify relationships and roles and responsibilities to avoid possible duplication of projects or initiatives, and to clarify lines of authority.

Healthwatch East Riding of Yorkshire is provided by Meeting New Horizons CIC, a trading arm of Hull CVS. Recruitment for the role of Chair and Director post is underway with interviews taking place in June. This means that the relationship with Healthwatch is embryonic. Our discussions highlighted considerable ambition which is a strength but which must be matched to the resources available. Looking ahead there is a need to define the relationship between Healthwatch and the HWB and Health Scrutiny. Work is already underway in this

respect with reports to be submitted to meetings of the HWB and Health Scrutiny setting out a protocol between Healthwatch, the HWB and Health Scrutiny.

The roles of Health Scrutiny, the HWB and Healthwatch in the new health policy landscapes have been initially defined and will continue to evolve over time. It is the responsibility of Health Scrutiny, the HWB and Healthwatch to all consider their engagement procedures and how they can support and complement each other's work. ERYC have made a good start to develop these relationships, including a workshop with the Centre for Public Scrutiny in January 2013 for members of the HWB and Health Scrutiny to consider future working arrangements in depth.

"Better care, delivered more locally" is one of the ambitions of the HWB, and people we spoke to made reference to the Local Area Community Partnerships that have been established by the Council. We heard from the CCG that they operate a similar local structure but on different geographical boundaries. These existing structures will be crucial in achieving the ambition but there is a need for greater clarity of expectations as well as roles and responsibilities.

The scale and complexity of the challenges and the system ambition for transformation and integration of health and social care requires strengthened engagement of backbench councillors and primary care providers beyond the CCGs.

East Riding has historically received low levels of public health funding which has resulted in a very low per capita allocation of funding in the public-health ringfenced grants. The position will improve only slowly as the allocations evolve towards a formula-based system. This situation provides challenges for service delivery and a potential risk to business resilience. The council may want to consider sharing specialist or back office functions with the CCG or neighbouring authorities as a means to create efficiencies and/or greater service resilience. There are examples elsewhere, such as the Association of Greater Manchester Authorities approach and that taken by Coventry and Worcestershire, where individual councils are taking a lead on public health specialisms.

4. The Health and Wellbeing Board

The HWB has a good direction of travel. Meeting attendance is strong and the Board has a good representation of the two CCGs.

The peer challenge team observed the May meeting and found engaged, confident and competent discussion on the issues that were closest to the priorities of the HWB, for example the report on reducing health inequalities in East Riding and the update on housing strategy and welfare reform.

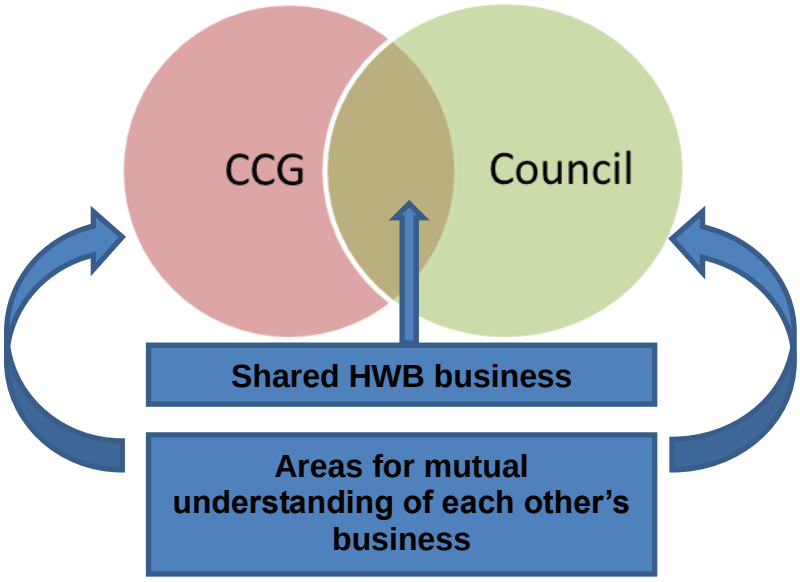
The chairman of the HWB is strong, committed and knowledgeable. This is recognised by members of the Board as well as officers within the council and CCG who speak highly of the Chairman and his ability to lead the Board in a wider sense and chair meetings purposefully. This is a firm foundation for the HWB to develop into a systems leader.

The HWB has invested time in developing the understanding and capacity of its members through the use of workshops. This has paid off in raising knowledge and understanding and cementing working relationships. The challenge team welcomes the plans of the HWB to continue this practice throughout 2013/14 with a range of topics, including a scenario planning event.

The strong developmental work provides a good platform for the HWB to now focus on its key priorities and maximise the scarce time of Board meetings. This will require a determined and pro-active agenda planning process. Protecting discussion time will be an important discipline and the HWB may want to consider how it can operate outside formal meetings, for example using electronic communication to share information, but also to ask for comments or feedback on strategies or reports which don't require Board discussion but are nonetheless important for Board members to be aware of or to consider. This will protect the 'face to face time' for discussion while allowing the Board to consider strategies or plans where it needs to.

The agenda for the May meeting and the work programme for 2013/14 are dominated by Council items which were presented by council officers. Maintaining close involvement of the Chair of the CCG in the agenda setting process would provide an opportunity for this imbalance to be addressed. Diagram 1 illustrates our view for the need of balance between the core HWB business which is significant for all partners, but also the need to understand and appreciate the wider business of its partners. The Board agenda will naturally deal with core business but the HWB needs to find means to ensure that its members are aware of each other's pressures and constraints.

Diagram 1: Balance between direct HWB and its wider understanding organisation in the system[1]



The challenge team questions whether more could be expected from papers and presentations to the HWB. Board papers follow a standard template and include a short executive summary and recommendations. Asking report authors to identify more clearly the main points of conflict, dilemmas or controversies would support discussion and ideas generation as opposed to approving reports.

The HWB has agreed not to include providers in its core membership. However, the priorities of the HWB requires for the main NHS and care providers to be party to some of the discussions at Board level. For example over the combination of provisions for older residents who may require combinations of care, mental health, and physical health interventions.

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1 The diagram is simplified deliberately to illustrate the point about balance of core business but a wider understanding of partners' issues and constraints.

5. How well are mandated and discretionary public health functions delivered?

The council has delivered a safe transition of the public health function. The Director of Public Health (DPH) and his 13 staff have transferred and are now located in the Policy, Partnerships and Improvement Directorate. The council decided to roll over existing commissioned services but have put in place an 18 months planned programme of re-tendering of all public health services, with support from the Council's central commissioning and procurement teams. These arrangements have meant that services are continuing with minimal levels of disruption.

Health emergency planning arrangements are in place and the respective roles and responsibilities of Public Health England (who are responsible for the arrangements themselves) and the DPH (who is responsible for overall assurance) are well understood as is the role of the DPH.

Arrangements for screening and immunisation are clear with the lead commissioner role of NHS England Area Team understood as well as the system oversight and assurance role of the DPH.

Commissioned public health services are targeted effectively to address the health and well-being priorities of the council and the HWB. Many of these services have differential outcome indicators for areas with the greatest health inequalities. An example is the smoking cessation programme, where targets are sharper in wards with the highest prevalence of smoking and lung cancer such as Bridlington, Goole and South East Holderness. This ensures that resources are targeted at areas of greater needs.

Outside the mandated and discretionary public health services the challenge team found a very considerable understanding among managers and officers of the potential for council services to support health and well-being, and the use of data and customer insight to target resources most effectively. We were presented with a range of examples, including the innovative use of library services which evolved into community hubs and offer 'reading on prescription' as well as the establishment of reading groups targeting older people and those suffering from isolation. We heard about good use of technology to allow GPs to book initial assessments in the Leisure centres part of the Live Well project and targeted support on healthy lifestyle issues to caravan dwellers through the rural communities team.

The approved but yet to be appointed post of a public health professional to lead on sexual health will provide clear professional leadership in this area. Over 20 per cent of the ring-fenced public health budget is spent on sexual health services and the council recognises the need to review the provision of these

services. A dedicated professional lead will ensure that contract reviews will apply the necessary professional expertise.

The council is testing new delivery models to maximise impact. Historically, health checks numbers have been low. The council is seeking to address poor performance and devised three pilot projects for the delivery of Health Checks using different providers, ie its own Leisure Services, the Smoking Cessation team and through the Health Trainer service. The programme includes an evaluative framework to test which model suits best the diverse needs of local areas.

As a consequence of the historically low level of spend for Public Health and the low baseline for the ring fenced grant, the Public Health team is small compared to other councils. As with all small teams this provides a risk to service resilience and the capacity to deliver. Given the diverse public health functions and the large range of specialisms, technical expertise is likely to be anchored in one person. It requires extra vigilance and makes the development of links with the PHE Local Centre and perhaps other councils in the region more important.

The interface with Public Health England local centre needs clarifying and developing to ensure there is no duplication and the PH team receives the system support it requires, particularly in relation to the health improvement domain. It is clear that the local centre team is still being established and that there has been little opportunity so far to develop the necessary mutual understanding and working relationships that will be required between it and the PH teams in its patch. Public Health England are an important national and local player, incorporating a large number of previously independent specialist organisations. It provides a gateway to local knowledge and expertise which it will be able to share widely. Local Centres must be seen as an important local resource, providing knowledge and specific services. Much of this needs to be sensitively developed in the local context.

There are concerns about the impact of the planned schedule for the review of all public health contracts on the public health team, particularly at this early stage of integration. While it is acknowledged that the council will provide commissioning support, pursuing this programme will absorb significant capacities of the team at a time where they need to develop their wider contacts, networks and influences across the council. We would recommend for the programme to be reviewed allowing public health staff more time to build links across the wider council and for this to be encouraged and supported by council managers and members. It is crucial that these networks are developed at a very early stage in the transition and integration process as relationships and working practices will quickly become the norm.

6. How well are the strengths of the Director of Public Health and his team being used?

Public health staff have received an enthusiastic welcome into the Council. The public health staff we met were committed, knowledgeable and positive about their transfer into the Council. They welcome the opportunities to cement existing and build new relationships with officers and elected members. Incoming staff are looking forward to sharing ideas and resources with council colleagues and using the knowledge of council officers to inform how services are planned and delivered. There is a high degree of recognition and enthusiasm for the opportunities in influencing the wider council spend beyond the ring-fenced public health budget and staff were up for *'turning the council into a public health organisation'*. This is a very strong basis to work from.

There has been limited loss of expertise at transition. The role of one member of the previous public health team transferred to the Area Team and subsequent to the peer challenge, one member of staff has chosen to take a post embedded in the Area Team. This compares very favourably with national trends and is testimony to strong previous relationships between council and PCT staff.

The DPH is well established and highly regarded by officers and elected members. He plays a key role on the HWB and enjoys its trust with regard to his professional judgments and capability. The DPH is committed to mainstreaming public health across the council and is encouraging his staff to lead on specific services and to go out and build relationships with individual departments and services. He is fulfilling his leadership tasks well.

The council is providing opportunities for the incoming public health staff to influence its wider business. Although at third tier in the Council's organogram, the DPH is a full director and a member of the Corporate Management Team. This provides him with a significant opportunity to influence systematically across the entire council business. The Deputy DPH will take on the role of Chair of the Senior Management Team and is also a member of the Council's Workforce Board. Staff have participated in the bi-annual Away Day of the Policy, Partnerships and Improvement Directorate. These are good examples of how opportunities for integration are offered and seized.

The incoming public health staff are confident about opportunities for continuous professional development within the council. They recognise that the council has strong processes for performance management and staff support. Existing training commitments for individual members of staff are being honoured and the team is planning a Public Health Conference later in the year. This is reassuring as public health staff have to demonstrate continued professional development in order to stay registered on the appropriate national register.

In recognition of the low level of baseline funding and the commitment to tacking health inequalities and improving health and wellbeing, the Council is committed to maintaining levels of funding for public health.

Structurally, the team, led by the DPH, has been transferred as a whole and is now part of the Policy, Partnerships and Improvement Directorate, which is the Council's engine for transformation. This provides the public health team with a good position and support from which to influence and operate across the council, and formally recognises the public health team's strength as a force for transformation, as well as a commissioner of services. This vision was clearly and convincingly communicated to us by the Chief Executive and the Leader but has not been heard fully by all public health staff. Perhaps inevitably so soon after transition, there remains an element of anxiety and a sense of loss of a known NHS operating context amongst the PH Team members. Senior managers may wish to engage more with staff to emphasise the expected influence of the team in making the council a 'health and well-being organisation'.

As mentioned earlier in this report, we were concerned that the ambitious programme of contract reviews will impact on the capacity of the public health staff to establish themselves as key partners and influencers across the council. While there are many long-standing relationships this is not the case across all council services, an example being the economic development function. The peer challenge team recognises the need to review contracts but at the same time, it is crucial to give the public health team some 'head room' to develop relationships across all council services early on in the process.

The process of induction and welcoming needs to be completed. Staff welcomed the induction process about the transactional aspects of their work, such as IT and business processes, which enabled them to quickly find their feet and continue with their work. What might have been underplayed so far is the opportunity to meet senior managers and members from across the council to understand who does what and how things work. Similarly this will be an opportunity for council staff to understand the nature of public health. Everyone the peer challenge team spoke to acknowledged that the NHS and the Council are very different organisations, each with its own distinct culture, norms and values. Acknowledging and exploring these differences in cultures can help to explain experiences in organisational life that might be puzzling or frustrating (although, over-analysis might solidify any divide). The peer challenge team recommends the council to consider the OD implications of the public health transfer and to identify what training is required for officers within the council to understand Public Health and to be able to make every contact count.

'Accommodation' remains a concern among public health staff. This is not about the quality of accommodation but concerns about the appropriateness for staff to do their work. Examples given were the need to make confidential phone calls which is difficult in an open plan office, and the need for storage space and the

opportunity for the team to work more effectively by being co-located rather than dispersed.

7. How well is Dementia tackled?

The prevalence of dementia in persons aged 65 or over is projected to increase by 37% to 2020 and is seen as a key challenge for the health and well-being system in East Riding. The council has a strategic framework in place. Its five year strategy is in accordance with the national dementia strategy. However the strategy is reaching the end of its life and the challenge team were not clear how it is monitored and updated.

The importance of tackling dementia is well reflected in the JHWS and the CCG's priorities and there is a good read across the key strategic documents. The Older People Mental Health Partnership Board, one of the sub-groups of the Health Care and Wellbeing Action Group, provides a multi-agency forum for alignment of services and integrated delivery.

We heard of an impressive set of dementia services that individuals can access without meeting eligibility criteria. Examples are memory cafes, advice and support to carers as well as retailers on how to engage with customers who have dementia, befriending schemes or digital reminiscent schemes. Many of these are commissioned from established providers such as the Alzheimer Society and are delivered in partnership with other providers such as libraries.

We also heard about a sound range of social care services that can respond when the level of individual needs increases. For example the council has a care home for people with challenging behaviour, which now provides an outreach function. It also has productive relationships with care homes and providers of domiciliary care. Specialist training is offered to private care homes and providers of domiciliary care with high take up.

Early diagnosis of dementia has been low but is recognised by the CCG as one of their key local priorities and there is a commitment to raise the rate of early diagnosis to the national average during 2013/14.

In the short time the peer challenge team had on site we were unable to undertake any in depth challenge of this complex area of work. However, we identified four areas for consideration the HWB may wish to consider. These are:

- Given the projections of demand for dementia services, will the strategy be robust enough?

- There are no integrated mental health teams for older people. They are common practice elsewhere, although the peer team recognise that the scale of existing and future demand makes it no longer a specialist provision.

- How easy is it for older people to access mental health services through the Humber Trust's single point of access?

- We heard some frustration over the time taken for the CCG, and its PCT predecessor, to follow through on its earlier commitment to improve early diagnosis, perhaps because there was not a consensus among GPs on the value of early diagnosis unless tangible help and support could then be offered to patients and their carers

Given the complexity and urgency to addressing these challenges the peer team would recommend for the HWB to adopt a programme management approach to addressing these.

8. Other messages from the peer challenge

The peer challenge team would like to share a number of other reflections we made during our on-site week. These don't fit neatly into any of our four headline questions but we feel are important points for us to feed back.

- 'Focus on outcomes - not services' - this was a strong message fed back to us by staff and managers throughout the week. It shows that the council has a clear understanding of the need to shift from providing services it has always provided to using its resources to making an impact on the wellbeing of its communities.

- Your grip on financial strategy is an impressive underlying strength. The peer challenge team was impressed with the promptness, rigour and clarity of the responses to financial challenges, and the track history of achieving the necessary changes without large scale redundancies or negative impacts on service delivery.

- The challenge team experienced the council is an organisation which uses tight resources effectively, has good morale and committed staff. The quality and commitment of staff and focus and 'can do' culture shone through interviews and discussions during the on-site week.

- We saw an organisation that has overcome silo working and has a lot of creative responses to the health and wellbeing challenges. Ideas and innovations are rooted in rigid customer and needs analysis and systematic experimentation which creates the conditions for these new approaches to flourish.

- We heard of lots of examples of good partnership working at the front line. In discussions with partners and staff we picked out many examples such as the work on integrated offender management, the refocus of the work of libraries on targeting specific groups to reduce isolation, the organisation of tailored and parallel events for carers and those cared for in Leisure Centres to meet the needs of both groups.

- Great potential in the Observatory, Customer Insight and Transformation Programme – we were particularly impressed with the engagement of partners in the Observatory, for example the Yorkshire Ambulance Service, and the scope for detailed analysis by bringing together the various needs assessment. An example is access to information on alcohol related disorder through the JSIA.

- We saw considerable evidence of committed approach to building self-reliance in individuals, families and communities. This puts the council in a good place to weather the storms ahead.

9. Moving forward

Based on what we saw, heard and read we suggest the Council and HWB consider the following actions. These are things we think will help improve and develop your effectiveness and capacity to deliver future ambitions and plans and drive integration across health and social care.

1. Focus on your priorities
2. Apply your transformation programme delivery skills to the HWB programme
3. Simplify and link your partnership structures to make sure your energies are focused
4. Engage major health and social care providers as much as you can
5. Ensure that the PH team can fully contribute to the work of the council
6. Build on your analytical strengths so you can evaluate and compare the return on investment
7. Take time to ensure that Healthwatch plays its full part in the health and wellbeing system
8. Continue to think ahead and prepare for possible models of further integration

10. Next steps

The Council's political leadership, senior management and members of the HWB will undoubtedly wish to reflect on these findings and suggestions before determining how the Council wishes to take things forward. As part of the Peer Challenge process, there is an offer of continued activity to support this. We made some suggestions about how this might be utilised. I look forward to finalising the detail of that activity as soon as possible.

In the meantime we are keen to continue the relationship we have formed with you and colleagues through the peer challenge to date. Mark Edgell, Principal Adviser (East Midlands, North East & Yorkshire and the Humber) is the main contact between your authority and the Local Government Association. Mark can be contacted at mark.edgell@local.gov.uk (or tel. 07747 636910) and can provide access to our resources and any further support.
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In the meantime, all of us connected with the peer challenge would like to wish the Council every success going forward. Once again, many thanks for inviting the peer challenge and to everyone involved for their participation.

Yours sincerely

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