Cover

Q4 2016/17

Health and Well Being Board	**Tameside**
completed by:	Ali Rehman
E-Mail:	alirehman@nhs.net
Contact Number:	0161 342 5637
Who has signed off the report on behalf of the Health and Well Being Board:	Members of the Health and Wellbeing Board

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

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Budget Arrangements

Selected Health and Well Being Board:	Tameside

Have the funds been pooled via a s.75 pooled budget?	Yes
If it had not been previously stated that the funds had been pooled can you now confirm that they have now?	
If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	

Footnotes:

Source: For the S.75 pooled budget question, which is pre-populated, the data is from a previous quarterly collection returned by the HWB.

National Conditions

Selected Health and Well Being Board: Tameside

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these have been met, as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed?

Condition	Q1 Submission Response	Q2 Submission Response	Q3 Submission Response	Please Select (Yes or No)	If the answer is 'No', please provide an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed?
1) Plans to be jointly agreed	Yes	Yes	Yes	Yes	
2) Maintain provision of social care services	Yes	Yes	Yes	Yes	
3) In respect of 7 Day Services - please confirm:					
i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	Yes	Yes	Yes	Yes	
ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be	Yes	Yes	Yes	Yes	
4) In respect of Data Sharing - please confirm:					
i) Is the NHS Number being used as the consistent identifier for health and social care services?	No - In Progress	No - In Progress	No - In Progress	No	The testing and roll out of Liquidlogic's Personal Demographic System has been stalled due to the decision by NHS Digital in December 2016 to put a hold on all current applications for approval whilst they amended their Governance process. Tameside have been in regular contact with NHS Digital and have also had support from
ii) Are you pursuing Open APIs (ie system that speak to each other)?	Yes	Yes	Yes	Yes	
iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	Yes	Yes	Yes	Yes	
iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	Yes	Yes	Yes	Yes	
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Yes	Yes	Yes	Yes	
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes	Yes	Yes	Yes	
7) Agreement to invest in NHS commissioned out-of-hospital services	Yes	Yes	Yes	Yes	
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes	Yes	Yes	Yes	

National conditions - detailed definitions

The BCF policy framework for 2016-17 and BCF planning guidance sets out eight national conditions for access to the Fund:

1) Plans to be jointly agreed
The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with health and social care providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. Furthermore, there should be joint agreement across commissioners and providers as to how the Better Care Fund will contribute to a longer term strategic plan. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences. The Disabled Facilities Grant (DFG) will again be allocated through the Better Care Fund. Local housing authority representatives should therefore be involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing.

2) Maintain provision of social care services

Local areas must include an explanation of how local adult social care services will continue to be supported within their plans in a manner consistent with 2016-17.

The definition of support should be agreed locally. As a minimum, it should maintain in real terms the level of protection as provided through the mandated minimum element of local Better Care Fund agreements of 2015-16. This reflects the real terms increase in the Better Care Fund.

In setting the level of protection for social care localities should be mindful to ensure that any change does not destabilise the local social and health care system as a whole. This will be assessed compared to 2015-16 figures through the regional assurance process.

It should also be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) Agreement for the delivery of 7-day services across health and social care to

Local areas are asked to confirm how their plans will provide 7-day services (throughout the week, including weekends) across community, primary, mental health, and social care in order:

• To prevent unnecessary non-elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week;
• To support the timely discharge of patients, from acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care. If they are not able to provide such plans, they must explain why.

The 10 clinical standards developed by the NHS Services, Seven Days a Week Forum represent, as a whole, best practice for quality care on every day of the week and provide a useful reference for commissioners (https://www.england.nhs.uk/wp-content/uploads/2013/12/clinical-standards1.pdf).
By 2020 all hospital in-patients admitted through urgent and emergency routes in England will have access to services which comply with at least 4 of these standards on every day of the week, namely Standards 2, 5, 6 and 8. For the Better Care Fund, particular consideration should be given to whether progress is being made against Standard 9. This standard highlights the role of support services in the provision of the next steps in a person's care pathway following admission to hospital, as determined by the daily consultant-led review, and the importance of effective relationships between medical and other health and social care teams.

4) Better data sharing between health and social care, based on the NHS number
The appropriate and lawful sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a consistent identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.

Local areas should:
• confirm that they are using the NHS Number as the consistent identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary security and controls (https://www.england.nhs.uk/wp-content/uploads/2014/05/open-api-policy.pdf; and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA), and if not, when they plan for it to be in place.
• ensure that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights. In line with the recommendations from the National Data Guardian review.

The Information Governance Alliance (IGA) is a group of national health and care organisations (including the Department of Health, NHS England, Public Health England and the Health and Social Care Information Centre) working together to provide a joined up and consistent approach to information governance and provide access to a central repository guidance on data access issues for the health and care system. See - http://systems.hscic.gov.uk/infogov/iga

5) Ensure a joint approach to assessments and care planning and ensure that,
Local areas should identify which proportion of their population will be receiving case management and named care coordinator, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by care coordinators, for example dementia advisors.

6) Agreement on the consequential impact of the changes on the providers that are

The impact of local plans should be agreed with relevant health and social care providers. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. This should complement the planning guidance issued to NHS organisations.

There is agreement that there is much more to be done to ensure mental and physical health are considered equal and better integrated with one another, as well as with other services such as social care. Plans should therefore give due regard to this.

7) Agreement to invest in NHS commissioned out of hospital services, which may
Local areas should agree how they will use their share of the £1 billion that had previously been used to create the payment for performance fund.
This should be achieved in one of the following ways:

- To fund NHS commissioned out-of-hospital services, which may include a wide range of services including social care, as part of their agreed Better Care Fund plan; or

- Local areas can choose to put an appropriate proportion of their share of the £1bn into a local risk-sharing agreement as part of contingency planning in the event of excess activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services including social care (local areas should seek, as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 15-16);

This condition replaces the Payment for Performance scheme included in the 2015-16 Better Care Fund framework.

8) Agreement on local action plan to reduce delayed transfers of care (DTOC)

Given the unacceptable high levels of DTOC currently, the Government is exploring what further action should be taken to address the issue.

As part of this work, under the Better Care Fund, each local area is to develop a local action plan for managing DTOC, including a locally agreed target.

All local areas need to establish their own stretching local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts. This target should be reflected in CCG operational plans. The metric for the target should be the same as the national performance metric (average delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both) per month.

As part of this plan, we want local areas to consider the use of local risk sharing agreements with respect to DTOC, with clear reference to existing guidance and flexibilities. This will be particularly relevant in areas where levels of DTOC are high and rising.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with the relevant acute and community trusts and be able to demonstrate that the plan has been agreed with the providers given the need for close joint working on the DTOC issue.

We would expect plans to:

• Set out clear lines of responsibility, accountabilities, and measures of assurance and monitoring;
• Take account of national guidance, particularly the NHS High Impact Interventions for Urgent and Emergency Care, the NHS England Monthly Delayed Transfers of Care Situation Reports Definition and Guidance, and best practice with regards to reducing DTOC from LGA and ADASS;
• Demonstrate how activities across the whole patient pathway can support improved patient flow and DTOC performance, specifically around admissions avoidance;
• Demonstrate consideration to how all available community capacity within local geographies can be effectively utilised to support safe and effective discharge, with a shared approach to monitoring this capacity;
• Demonstrate how CCGs and Local Authorities are working collaboratively to support sustainable local provider markets, build the right capacity for the needs of the local population, and support the health and care workforce - ideally through joint commissioning and workforce strategies;
• Demonstrate engagement with the independent and voluntary sector providers.

Footnotes:
Source: For each of the condition questions which are pre-populated, the data is from the quarterly data collections previously returned by the HWB.

Plan, forecast, and actual figures for total income into, and total expenditure from, the fund for each quarter to year end (in both cases the year-end figures should equal the total pooled fund)

Selected Health and Well Being Board: Tameside

Income

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£3,855,000	£3,855,000	£4,795,000	£4,795,756	£17,300,756	£16,941,000
	Forecast	£3,855,000	£3,855,000	£6,500,000	£3,090,756	£17,300,756	
	Actual*	£3,855,000	£3,855,000	£6,788,103			

Q4 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£3,855,000	£3,855,000	£4,795,000	£4,795,756	£17,300,756	£16,941,000
	Forecast	£3,855,000	£3,855,000	£6,500,000	£3,090,756	£17,300,756	
	Actual*	£3,855,000	£3,855,000	£6,788,103	£2,802,653	£17,300,756	

Please comment if there is a difference between the forecasted / actual annual totals and the pooled fund	N/A

Expenditure

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£3,855,000	£3,855,000	£4,795,000	£4,795,756	£17,300,756	£16,941,000
	Forecast	£3,855,000	£3,855,000	£4,795,000	£4,795,756	£17,300,756	
	Actual*	£3,365,751	£3,401,754	£6,788,103			

Q4 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£3,855,000	£3,855,000	£4,795,000	£4,795,756	£17,300,756	£16,941,000
	Forecast	£3,855,000	£3,855,000	£4,795,000	£4,795,756	£17,300,756	
	Actual*	£3,365,751	£3,401,754	£6,788,103	£3,745,148	£17,300,756	

Please comment if there is a difference between the forecasted / actual annual totals and the pooled fund	The pooled fund was £17.301m in 16-17, the annual total agrees with the pooled fund arrangement

Commentary on progress against financial plan:	All funds were spent in accordance with national conditions and locally agreed priorities to support hospital discharge and independent living.

Footnotes:
*Actual figures should be based on the best available information held by Health and Wellbeing Boards.
Source: For the pooled fund which is pre-populated, the data is from a quarterly collection previously filled in by the HWB.

National and locally defined metrics

Selected Health and Well Being Board: Tameside

Non-Elective Admissions	Reduction in non-elective admissions
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	We have increased our reduction in non-elective admissions throughtout the year. Our focus on Home First builds on our schemes to avoid Non-elective admissions. We have seen an increase against plan in regards to Ambulatory Emergency Care and the Alternative to Transfer and Integrated Urgent Care Team are providing alternatives to A&E attendance and admissions. We are using practice level risk

Delayed Transfers of Care	Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	There has been a reduction in the number of people delayed in December 2016 onwards. Our Home First model includes a discharge to Assess process that has reduced DTOCs. Improvements in home care have reduced delays due to social care. The key issue is more complex patients requiring care home placements and families waiting for homes of choice. Work is ongoing to recduce delays due to

Local performance metric as described in your approved BCF plan	Newly diagnosed patients on primary care dementia registers
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Our Dementia Diagnosis rate for 16/17 is not yet available however our practices are continuing their work to identify new patients and provide appropriate support. Dementia is currently an area the CCG has been assessed in the IAF as performing well.

Local defined patient experience metric as described in your approved BCF plan	Overall satisfaction of people who use services with Their Care and Support. The original submission used financial years building on a baseline of 61.6 from 2013/14 and had a Q4 14/15 position of 64.6 15/16 out-turn was 58.74
If no local defined patient experience metric has been specified, please give details of the local defined patient experience metric now being used.	
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Annual - Adult Social Care Survey The information in the template needs to be amended, the 61.6 relates to 2013-14 out-turn and the 64.51 relates to 2014-15 out-turn. The 15/16 out-turn was 58.74. The out-turn for 4th Quarter 2016-17 is 60.38%.

Admissions to residential care	Rate of permanent admissions to residential care per 100,000 population (65+)
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	4th Quarter 2016-17 permanent admissions to residential and nursing care 65+ is 241 for the period April 2016 - March 2017.

Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	This indicator is an annual indicator and no further data is available, the measure captures all service users 65+ who have been discharged from hospital into reablement / rehabilitation service for the period October 2016 - December 2016 and then a follow up review is completed during January - March 2017 to see if they are still at home 91 days later. The out-turn figure 2016-17 is 81.76%.

Footnotes:

For the local performance metric (which is pre-populated), the data is from submission 4 planning returns previously submitted by the HWB.

For the local defined patient experience metric (which is pre-populated), the data is from submission 4 planning returns previously submitted by the HWB, except in cases where HWBs provided a definition of the metric for the first time within the Q1 16-17 template.

Year End Feedback on the Better Care Fund in 2016-17

Selected Health and Well Being Board:	Tameside

Part 1: Delivery of the Better Care Fund
Please use the below form to indicate what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

Statement:	Response:	Comments: Please detail any further supporting information for each response
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Neither agree nor disagree	The Care Together integration plans for Health and Social Care within Tameside and Glossop have been developing over three to four years and the BCF was only a small part of the plans and it has been the whole system plans rather than the BCF that has driven the integration
2. Our BCF schemes were implemented as planned in 2016/17	Agree	The implementation of the transformed services has continued.
3. The delivery of our BCF plan in 2016/17 had a positive impact on the integration of health and social care in our locality	Neither agree nor disagree	The Care Together integration plans for Health and Social Care within Tameside and Glossop have been developing for many years and we now operate as a Single Commissioning (CCG and TMBC) and an Integrated Care Foundation Trust. The BCF was only a small part of the plans and it has been the whole system plans rather than the BCF that has driven the integration
4. The delivery of our BCF plan in 2016/17 has contributed positively to managing the levels of Non-Elective Admissions	Neither agree nor disagree	The teams and proactive work that is designed to reduce NEL are parter of the wider health and social care integration not just within the BCF. Much of the work was already being developed and some teams were already integrated although funding was separate
5. The delivery of our BCF plan in 2016/17 has contributed positively to managing the levels of Delayed Transfers of Care	Neither agree nor disagree	The teams that support reduced DTOC whilst part of the BCF were already integrated and part of the wider Care Together Plan. The increase in Home First and Discharge to Assess has reduced the level of Delayed Transfers of Care particularly in an acute bed.
6. The delivery of our BCF plan in 2016/17 has contributed positively to managing the proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Neither agree nor disagree	The service was already delivering good outcomes for people and this has been maintained
7. The delivery of our BCF plan in 2016/17 has contributed positively to managing the rate of residential and nursing care home admissions for older people (aged 65 and over)	Neither agree nor disagree	The wider integration work around Home First has reduced the need for more complex packages of care in someone own home and as the team work with people whoare more complex they may be able to reduce the need for a care home admission

Part 2: Successes and Challenges
Please use the below forms to detail up to 3 of your greatest successes, up to 3 of your greatest challenges and then categorise each success/challenge appropriately

8. What have been your greatest successes in delivering your BCF plan for 2016-17?	Response - Please detail your greatest **successes**	Response category:
Success 1	The development of the voluntary sector offer to local people as part of a wider health and social care offer is a key element to our integration plans and build on the success of the over 75s work that was funded through BCF	3. Collaborative working relationships

Success 2	The role of Pharmacists in the wider care of people working across primary and secondary care has been developed building on the learning from the over 75s work that was part of the BCF	4. Integrated workforce planning
Success 3	The integrated teams and wider focus on Care Together has faciliatated more cross organisational development and fostered greater understanding which has resulted in improved holistic care for people	4. Integrated workforce planning

9. What have been your greatest challenges in delivering your BCF plan for 2016-17?	Response - Please detail your greatest **challenges**	Response category:
Challenge 1	The development of integrated data and information systems across health and social care remains a challenge.	7. Digital interoperability and sharing data
Challenge 2	The BCF metrics tend to focus on immediate benefits rather than the longer term benefits that come form increased integration around proactive care.	5. Evidencing impact and measuring success
Challenge 3	The BCF was a very small part of our Care Together plans has meant it is impossible to attribute success to the BCF schemes as individual schemes	5. Evidencing impact and measuring success

Footnotes:

Question 11 and 12 are free text responses, but should be assigned to one of the following categories (as used for previous BCF surveys):

1. Shared vision and commitment
2. Shared leadership and governance
3. Collaborative working relationships
4. Integrated workforce planning
5. Evidencing impact and measuring success
6. Delivering services across interfaces
7. Digital interoperability and sharing data
8. Joint contracts and payment mechanisms
9. Sharing risks and benefits
10. Managing change

Other

Additional Measures

Selected Health and Well Being Board: Tameside

1. Proposed Metric: Use of NHS number as primary identifier across care settings

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	No	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

2. Proposed Metric: Availability of Open APIs across care settings

Please indicate across which settings relevant service-user information is currently being shared digitally (via Open APIs or interim solutions)

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Shared via Open API	Shared via interim solution	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Hospital	Shared via interim solution	Shared via interim solution	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Social Care	Not currently shared digitally	Not currently shared digitally	Shared via Open API	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Community	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Mental Health	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Shared via interim solution	Not currently shared digitally
From Specialised Palliative	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Shared via interim solution

In each of the following settings, please indicate progress towards instillation of Open APIs to enable information to be shared with other organisations

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	Live	In development	In development	In development	In development	Unavailable
Projected 'go-live' date (dd/mm/yy)		31/12/2017	31/12/2017	31/12/2017	31/12/2017	01/01/9999

3. Proposed Metric: Is there a Digital Integrated Care Record pilot currently underway?

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	No pilot underway

4. Proposed Metric: Number of Personal Health Budgets per 100,000 population

Total number of PHBs in place at the end of the quarter	13
Rate per 100,000 population	6

Number of new PHBs put in place during the quarter	2
Number of existing PHBs stopped during the quarter	0
Of **all** residents using PHBs at the **end** of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	85%

Population (Mid 2017)	222,966

5. Proposed Metric: Use and prevalence of Multi-Disciplinary/Integrated Care Teams

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the non-acute setting?	Yes - in some parts of Health and Wellbeing Board area
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the acute setting?	Yes - in some parts of Health and Wellbeing Board area

Footnotes:

Population projections are based on Subnational Population Projections, Interim 2014-based (published May 2016).
http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Population figures were updated to the mid-year 2017 estimates as we moved into the new calendar year.

Narrative

Selected Health and Well Being Board:	Tameside

Remaining Characters	31,937

Please provide a brief narrative on overall progress, reflecting on performance in Q4 16/17 and the year as a whole. A recommendation would be to offer a narrative around the stocktake themes as below:

Highlights and successes

What would you consider to be your most significant area of success, or development since the last quarter? What has contributed to this improvement?

Challenges and concerns

Does the information on National Conditions and Supporting metrics point to any issues or areas of improvement? Are there any new anticipated challenges for the coming quarter?

Potential actions and support

What actions could be taken and what support could be offered to address performance challenges and capitalise on successes for subsequent quarters?

Our Transformation Plans are being implemented at both commissioner and provider levels , with the Single Commission comprising NHS Tameside and Glossop CCG and TMBC and the Tameside and Glossop Integrated Care NHS Foundation Trust both fully operational.

Our Integrated Neighbourhood and Home First plans are providing a strong foundation for improving the health and wellbeing of our local population and supporting people who need additional care to remain at home for as long as possible.

The wider integration work has a strong focus on building community assets with the local voluntary sector being fully integrated into the wider health and social care offer. This whilst not part of BCF as such has built on some of the initiatives that the local GPs developed through their over 75s offers that were part of the BCF.