Better Care Fund 2024-25 Q3 Reporting Template

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2023-25, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE). Please also refer to the Addendum to the 2023 to 2025 Better Care Fund policy framework and planning requirements which was published in April 2024. Links to all policy and planning documents can be found on

As outlined within the BCF Addendum, quarterly BCF reporting will continue in 2024 to 2025, with areas required to set out progress on delivering their plans. This will include the collection of spend and activity data, including for the Discharge Fund, which will be reviewed alongside other local performance data.

The primary purpose of BCF reporting is to ensure a clear and accurate account of continued compliance with the key requirements and conditions of the fund, including the Discharge Fund. The secondary purpose is to inform policy making, the national support offer and local practice sharing by providing a fuller insight from narrative feedback on

BCF reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICBs, local authorities and service providers) for the purposes noted above.

In addition to reporting, BCMs and the wider BCF team will monitor continued compliance against the national conditions and metric ambitions through their wider interactions with local areas.

BCF reports submitted by local areas are required to be signed off by HWBs, or through a formal delegation to officials, as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS

Please submit this template by 14 February 2025

Note on entering information into this template

Please do not copy and paste into the template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell
Pre-populated cells

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require

Please DO NOT directly copy/cut & paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy & paste', please use the 'Paste Special' operation and paste Values

The details of each sheet within the template are outlined below.

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker
3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Templa
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and capacity and demand from your BCF plans for 2024-25 will pre-populate in the relevant worksheets.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
3. Question completion tracks the number of questions that have been completed; when all the questions in each

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2. Cover

Version 1.0

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will be published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Halton
Completed by:	Louise Wilson
E-mail:	Louise.wilson@halton.gov.uk
Contact number:	0151 511 8861
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes
If no, please indicate when the report is expected to be signed off:	

Checklist

Complete:
Yes
Yes
Yes
Yes
Yes
Yes

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

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5.1 C&D Guidance & Assumptions	Yes
5.2 C&D H1 Actual Activity	Yes
6b. Expenditure	Yes

For further guidance on requirements please refer back to guidance sheet - tab 1.

<< Link to the Guidance sheet

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3. National Conditions

Selected Health and Wellbeing Board: Halton

		Checklist Complete:
Has the section 75 agreement for your BCF plan been finalised and signed off?	Yes	Yes
If it has not been signed off, please provide the date section 75 agreement expected to be signed off		Yes
If a section 75 agreement has not been agreed please outline outstanding actions in agreeing this.		Yes

Confirmation of Nation Conditions			
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in the quarter and mitigating actions underway to support compliance with the condition:**	
1) Jointly agreed plan	Yes		Yes
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes		Yes
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes		Yes
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes		Yes

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4. Metrics

Selected Health and Wellbeing Board: Halton

National data may be unavailable at the time of reporting. As such, please utilise data that may only be available system-wide and other local intelligence.

Metric	Definition	For information - Your planned performance as reported in 2024-25 planning				For information - actual performance for Q2 (For Q3 data,please refer to data pack on BCX)	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs *Please:* *- describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans* ***- ensure that if you have selected data not available to assess progress that this is addressed in this section of your plan***	Achievements - including where BCF funding is supporting improvements. *Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics*	Variance from plan *Please ensure that this section is completed where you have indicated that this metric is not on track to meet target outlining the reason for variance from plan*	Mitigation for recovery *Please ensure that this section is completed where a) Data is not available to assess progress b) Not on track to meet target with actions to recovery position against plan*	Complete:
		Q1	Q2	Q3	Q4							
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	249.0	258.0	263.0	262.0	229.0	Data not available to assess progress	Awaiting clarification from NHSE regarding metric criteria. Current plans are no longer comparable to actuals largely due to the implementation of SDEC (Type 5) this year, as well as updates to National criteria that systems need time to adopt and validate.	Awaiting clarification from NHSE regarding metric criteria. Current plans are no longer comparable to actuals largely due to the implementation of SDEC (Type 5) this year, as well as updates to National criteria that systems need time to adopt and validate.	Awaiting clarification from NHSE regarding metric criteria. Current plans are no longer comparable to actuals largely due to the implementation of SDEC (Type 5) this year, as well as updates to National criteria that systems need time to adopt and validate.	Awaiting clarification from NHSE regarding metric criteria. Current plans are no longer comparable to actuals largely due to the implementation of SDEC (Type 5) this year, as well as updates to National criteria that systems need time to adopt and validate.	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	95.5%	95.5%	95.5%	95.5%	95.0%	Not on track to meet target	Higher acuity and increased pressure to discharge early has resulted lower discharges directly back to normal place of residence than plannned. Halton remain in the top quartile within C&M.	An increase in reablement support at home has allowed for an increase in the number of patients to receive ongoing care in their own home rather than admitting all to a community bed for rehabilitation	Overall for the year, the performance remains at 95% and the 0.5% variance equates to 45 out of 8902 discharges having not returned directly home.	New discharge to assess processes have been implemented nearing the end of Q3, to enhance the home first pathways.	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				1,648.0	469.4	Data not available to assess progress	Awaiting clarification from NHSE regarding metric criteria. Current plans are no longer comparable to actuals largely due to the implementation of SDEC (Type 5) this year, as well as updates to National criteria that systems need time to adopt and validate.	Awaiting clarification from NHSE regarding metric criteria. Current plans are no longer comparable to actuals largely due to the implementation of SDEC (Type 5) this year, as well as updates to National criteria that systems need time to adopt and validate.	Awaiting clarification from NHSE regarding metric criteria. Current plans are no longer comparable to actuals largely due to the implementation of SDEC (Type 5) this year, as well as updates to National criteria that systems need time to adopt and validate.	Awaiting clarification from NHSE regarding metric criteria. Current plans are no longer comparable to actuals largely due to the implementation of SDEC (Type 5) this year, as well as updates to National criteria that systems need time to adopt and validate.	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				600	not applicable	On track to meet target	The number of patients admitted to care homes remains in line with plan, but the acuity and complexity of the admissions has increased following deconditioning within the acute episode.	The care home market remains stable and there hasn't been any increased bed capacity requirements. Trusted assessor arrangements are in place to support placements being made.	Maintaining admission rates in line with the planned capacity levels.	No mitigation is required	Yes

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5. Capacity & Demand

Selected Health and Wellbeing Board: Halton

5.1 Assumptions

	Checklist
1. How have your estimates for capacity and demand changed since the last reporting period? Please describe how you are building on your learning across the year where any changes were needed.	
Our estimates for capacity and demand haven't changed since the last reporting period.	Yes
2. Do you have any capacity concerns for Q4? Please consider both your community capacity and hospital discharge capacity.	
No concerns for Q4 have been identified with from a community or hospital discharge capacity.	Yes
3. Where actual demand exceeds capacity, what is your approach to ensuring that people are supported to avoid admission or to enable discharge? Please describe how this improves on your approach for the last reporting period.	
When or if demand exceeds capacity, additional resources are secured when necessary via agency staff to ensure that people are supported to avoid admission or to enable discharge - This remains the same approach as taken in the last reporting period.	Yes
4. Do you have any specific support needs to raise for Q4? Please consider any priorities for planning readiness for 25/26.	
None identified.	Yes

Guidance on completing this sheet is set out below, but should be read in conjunction with the separate guidance and q&a document

5.1 Guidance

The assumptions box has been updated and is now a set of specific narrative questions. Please answer all questions in relation to both hospital discharge and community sections of the capacity and demand template.

You should reflect changes to understanding of demand and available capacity for admissions avoidance and hospital discharge since the completion of the original BCF plans, including

- Actual demand in the first 9 months of the year
- Modelling and agreed changes to services as part of Winter planning
- Data from the Community Bed Audit
- Impact to date of new or revised intermediate care services or work to change the profile of discharge pathways.

Hospital Discharge

This section collects actual activity of services to support people being discharged from acute hospital. You should input the actual activity to support discharge across these different service types and this applies to all commissioned services not just those from the BCF.

- Reablement & Rehabilitation at home (pathway 1)

- Short term domiciliary care (pathway 1)

- Reablement & Rehabilitation in a bedded setting (pathway 2)

- Other short term bedded care (pathway 2)

- Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)

Community

This section collects actual activity for community services. You should input the actual activity across health and social care for different service types. This should cover all intermediate care services to support recovery, including Urgent Community Response and VCS support and this applies to all commissioned services not just those from the BCF. The template is split into these types of service:

Social support (including VCS)

Urgent Community Response

Reablement & Rehabilitation at home

Reablement & Rehabilitation in a bedded setting

Other short-term social care

Complete:

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5. Capacity & Demand

Selected Health and Wellbeing Board: Halton

Actual activity - Hospital Discharge		Prepopulated demand from 2024-25 plan			Actual activity (not including spot purchased capacity)			Actual activity through only spot purchasing (doesn't apply to time to service)			Checklist
Service Area	Metric	Oct-24	Nov-24	Dec-24	Oct-24	Nov-24	Dec-24	Oct-24	Nov-24	Dec-24	Complete:
Reablement & Rehabilitation at home (pathway 1)	Monthly activity. Number of new clients	45	74	59	49	44	39	0	0	0	Yes
Reablement & Rehabilitation at home (pathway 1)	Actual average time from referral to commencement of service (days). All packages (planned and spot purchased)	10	9	12	7	10	5				Yes
Short term domiciliary care (pathway 1)	Monthly activity. Number of new clients	0	0	0	0	0	0	0	0	0	Yes
Short term domiciliary care (pathway 1)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	0	0	0	0	0	0				Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly activity. Number of new clients	24	23	19	12	11	16	0	0	0	Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	10	4	10	9	6	17				Yes
Other short term bedded care (pathway 2)	Monthly activity. Number of new clients.	8	4	10	6	3	8	0	0	0	Yes
Other short term bedded care (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	10	4	10	7	44	12				Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly activity. Number of new clients	0	0	0	0	0	0	0	0	0	Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	0	0	0	0	0	0				Yes

Actual activity - Community		Prepopulated demand from 2024-25 plan			Actual activity:			
Service Area	Metric	Oct-24	Nov-24	Dec-24	Oct-24	Nov-24	Dec-24	
Social support (including VCS)	Monthly activity. Number of new clients.	17	17	17	15	12	16	Yes
Urgent Community Response	Monthly activity. Number of new clients.	165	165	170	205	199	196	Yes
Reablement & Rehabilitation at home	Monthly activity. Number of new clients.	2	2	2	0	1	1	Yes
Reablement & Rehabilitation in a bedded setting	Monthly activity. Number of new clients.	1	1	1	0	1	0	Yes
Other short-term social care	Monthly activity. Number of new clients.	0	0	0	0	0	0	Yes

Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate

6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The ten changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.

15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care or Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed based intermediate Care Services	Number of placements
Home-based intermediate care services	Packages
Residential Placements	Number of beds
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

See next sheet for Scheme Type (and Sub Type) descriptions

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6. Expenditure

To Add New Schemes

Selected Health and Wellbeing Board: Halton

Running Balances	2024-25 Income	Expenditure to date	Percentage spent	Balance
DFG	£2,175,723	£1,520,710	69.89%	£655,013
Minimum NHS Contribution	£13,484,478	£7,785,744	57.74%	£5,698,734
iBCF	£6,982,074	£5,658,723	81.05%	£1,323,351
Additional LA Contribution	£0	£0		£0
Additional NHS Contribution	£0	£0		£0
Local Authority Discharge Funding	£1,631,460	£1,218,010	74.66%	£413,450
ICB Discharge Funding	£1,281,956	£896,822	69.96%	£385,134
Total	**£25,555,691**	**£17,080,009**	**66.83%**	**£8,475,682**

Comments if income changed
NB. Additonal in year DFG allocation 24/25 = £299,379 - Not reflected in the income

Required Spend

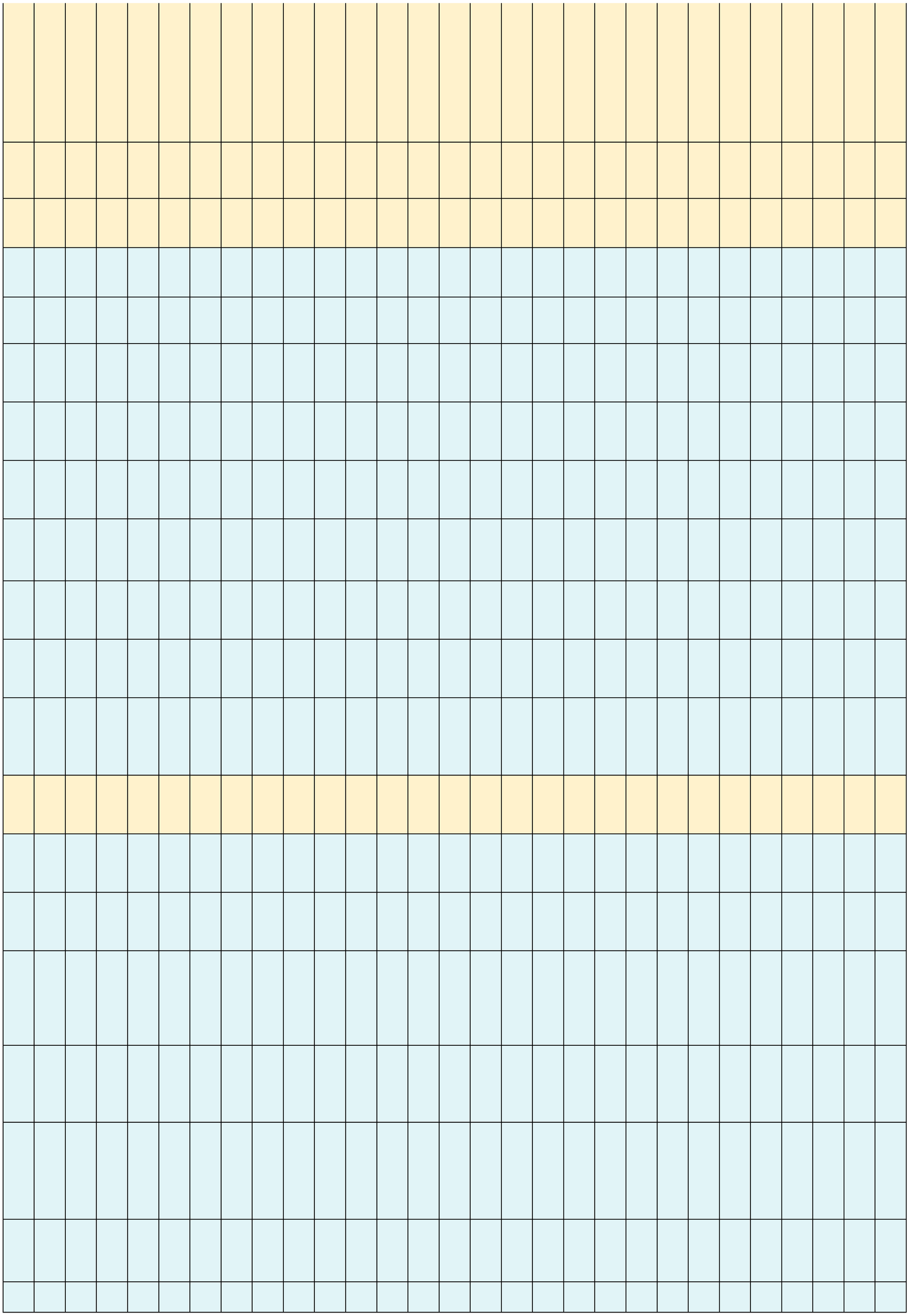
This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

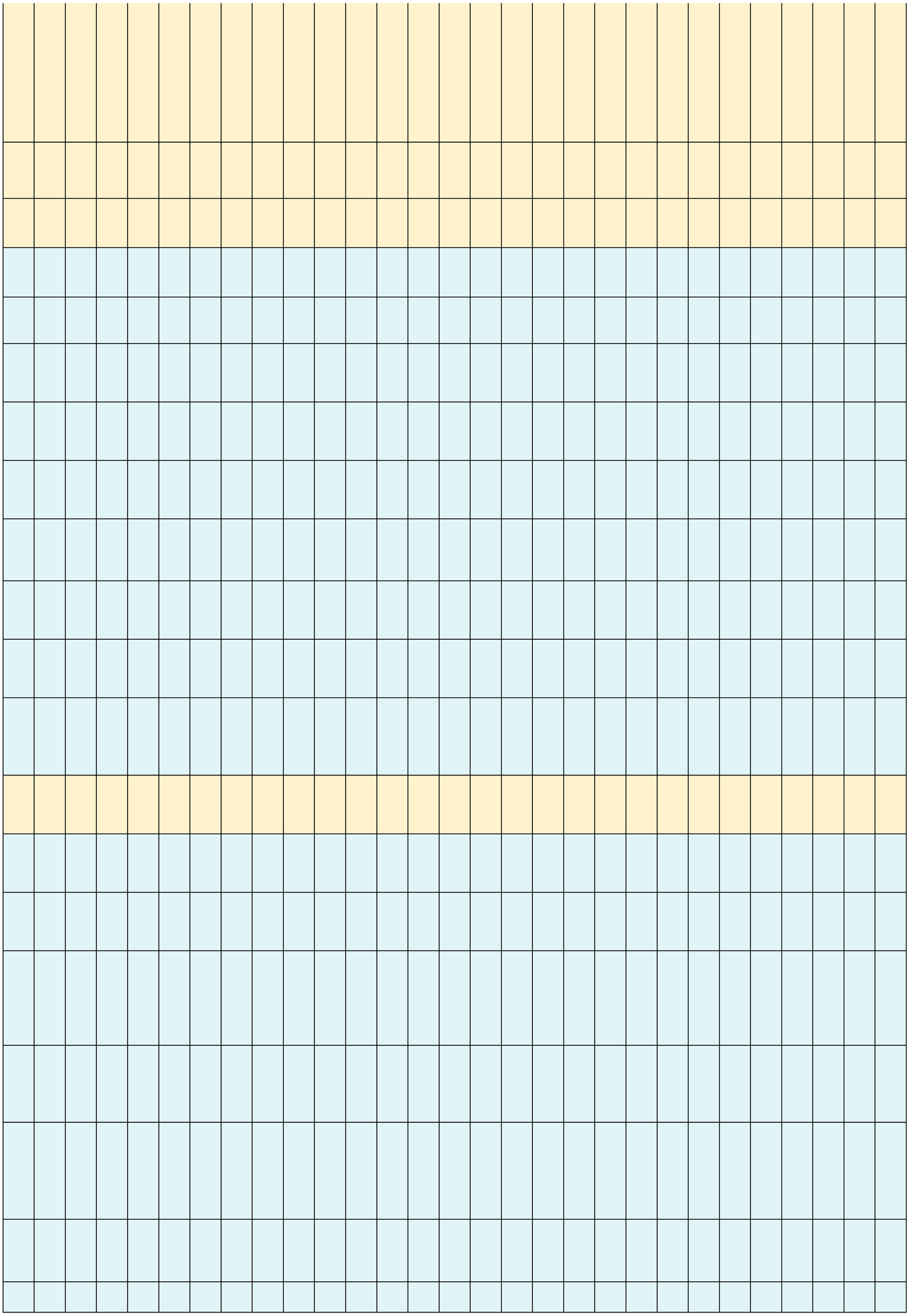
	2024-25 Minimum Required Spend	Expenditure to date	Balance
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£3,831,907	£2,283,591	£1,548,316
Adult Social Care services spend from the minimum ICB allocations	£6,777,080	£5,834,698	£942,382

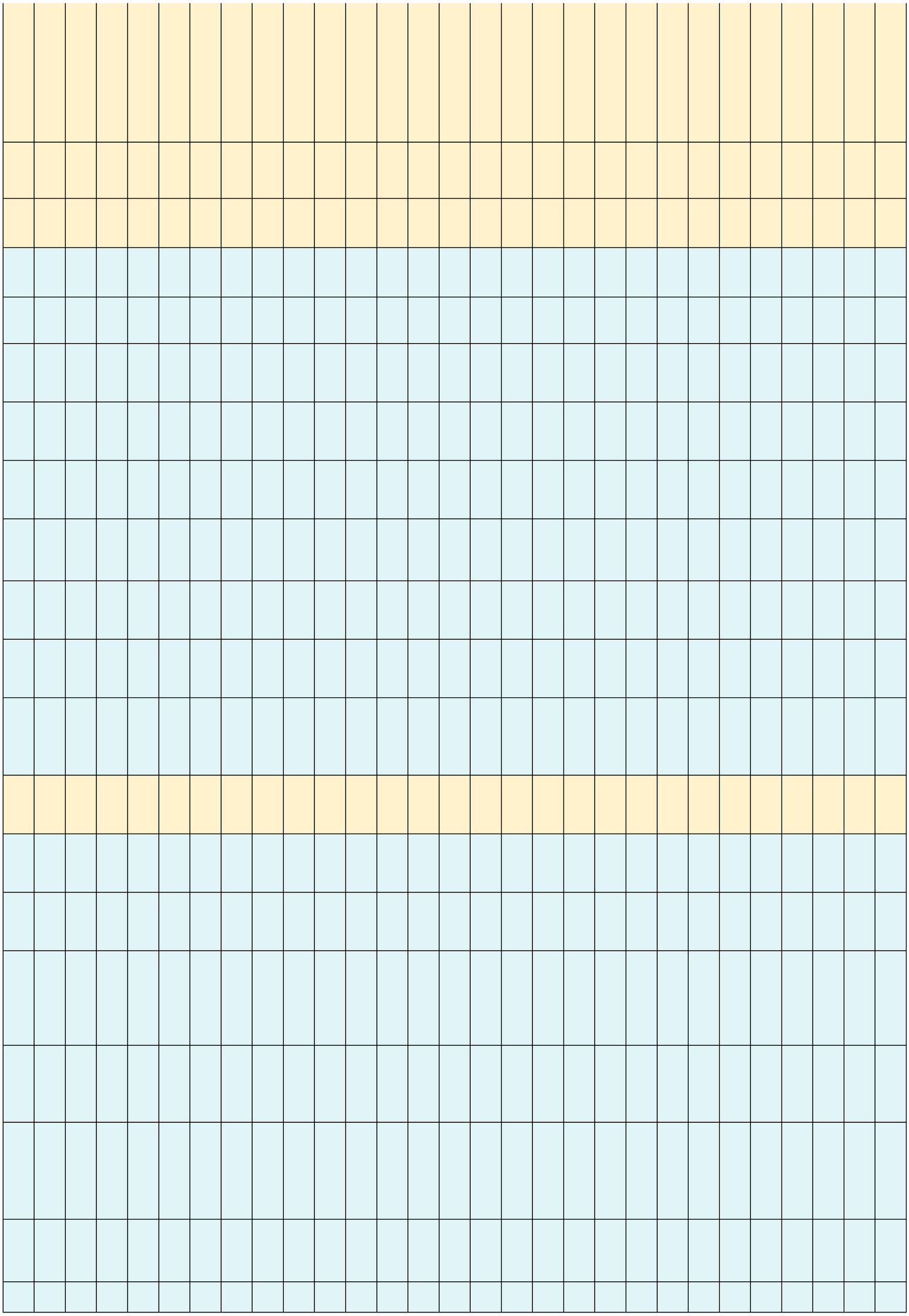
Checklist Column complete: Yes Yes

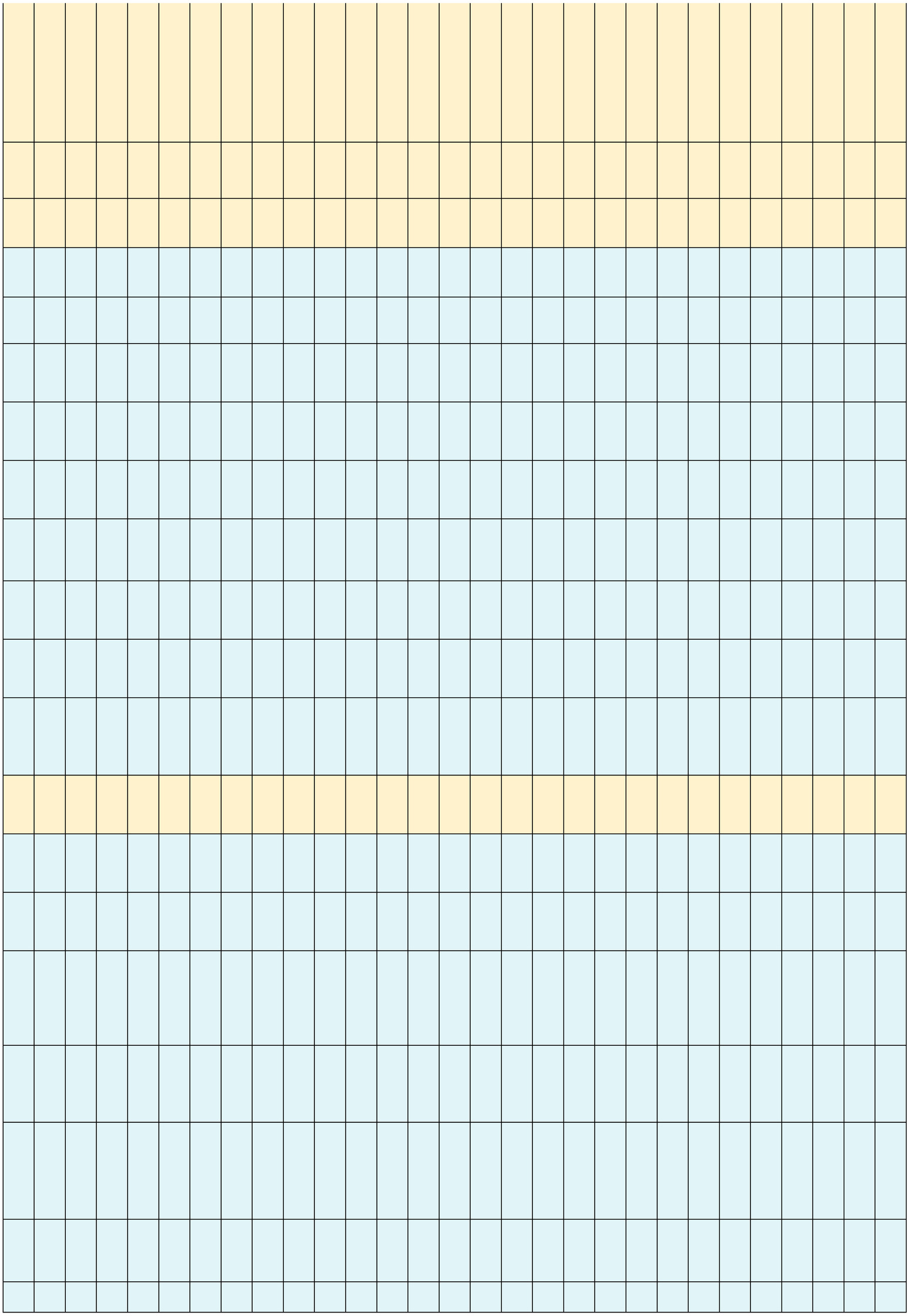
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Planned Outputs for 2024-25**	Outputs delivered to date (Number or NA if no plan)	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Previously entered Expenditure for 2024-25 (£)	Expenditure to date (£)	Discontinue (if scheme is no longer being carried out in 24-25, i.e. no money has been spent and will be spent)	Comments
3	Carers Centre	Carers Centre	Carers Services	Carer advice and support related to Care Act duties		6000	6000	Beneficiaries	Social Care	0	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 358,959	£341,866		Paid upto the end March 2025
3	Halton Home Based Respite Service	Carers Breaks - Care at Home	Carers Services	Respite services		32	38	Beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution	£ 124,740	£90,243		Paid upto the end December 2024
4	Community Respiratorty Team (WHHFT)	WHHFT - Facilitating discharge & extending community offer	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as		0	NA		Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution	£ 152,339	£0		Waiting for invoices to be submitted from NHS Cheshire & Merseyside (Halton Place)
4	Respiratory - Out of Hospital Team	Extending Community Provision	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as		0	NA		Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution	£ 353,571	£0		Waiting for invoices to be submitted from NHS Cheshire & Merseyside (Halton Place)
4	Halton Support at Home Service	Support at Home Seervice - British Red Cross	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess		0	NA		Other	3rd Sector	LA			Charity / Voluntary Sector	Minimum NHS Contribution	£ 9,321	£9,321		
7	Hospital Discharge Team	Integrated Discharge Teams - Warrington & Whiston	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		0	NA		Social Care		LA			Local Authority	Minimum NHS Contribution	£ 734,740	£544,058		
7	ESD Stroke	Stroke Outreach Pathway	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning		0	NA		Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution	£ 190,489	£133,982		
8	Domicilary Care Packages	Maintaining Domicilary Care Packages	Home Care or Domiciliary Care	Domiciliary care packages		132431	104394	Hours of care (Unless short-term in which case it is packages)	Social Care		LA			Private Sector	Minimum NHS Contribution	£ 2,929,396	£2,211,075		
8	Domicilary Care Packages	Maintaining Domicilary Care Packages	Home Care or Domiciliary Care	Domiciliary care packages		42305	42586	Hours of care (Unless short-term in which case it is packages)	Social Care		LA			Private Sector	iBCF	£ 912,518	£901,965		
17	Residentail Care Home Placements	Maintaining Residential Care Home Placements	Residential Placements	Care home		37	27	Number of beds	Social Care		LA			Private Sector	Minimum NHS Contribution	£ 1,399,467	£1,045,292		
17	Residential Care Home Placements	Maintaining Residential Care Home Placements	Residential Placements	Care home		155	113	Number of beds	Social Care		LA			Private Sector	iBCF	£ 5,702,916	£4,390,118		
11	Intermediate Care Bed Based Service	Oakmeadow - 19 Bedded Unit	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		28	28	Number of placements	Social Care		LA			Local Authority	Minimum NHS Contribution	£ 430,630	£322,973		
11	Intermediate Care Bed Based Service	Oakmeadow - 19 Bedded Unit	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		36	35	Number of placements	Social Care		LA			Local Authority	Local Authority Discharge	£ 544,586	£408,443		
12	Intermediate Care Community Services	Reablement/Rehab Services	Home-based intermediate care services	Joint reablement and rehabilitation service (to support discharge)		330	407	Packages	Social Care		LA			Local Authority	ICB Discharge Funding	£ 943,601	£707,701		

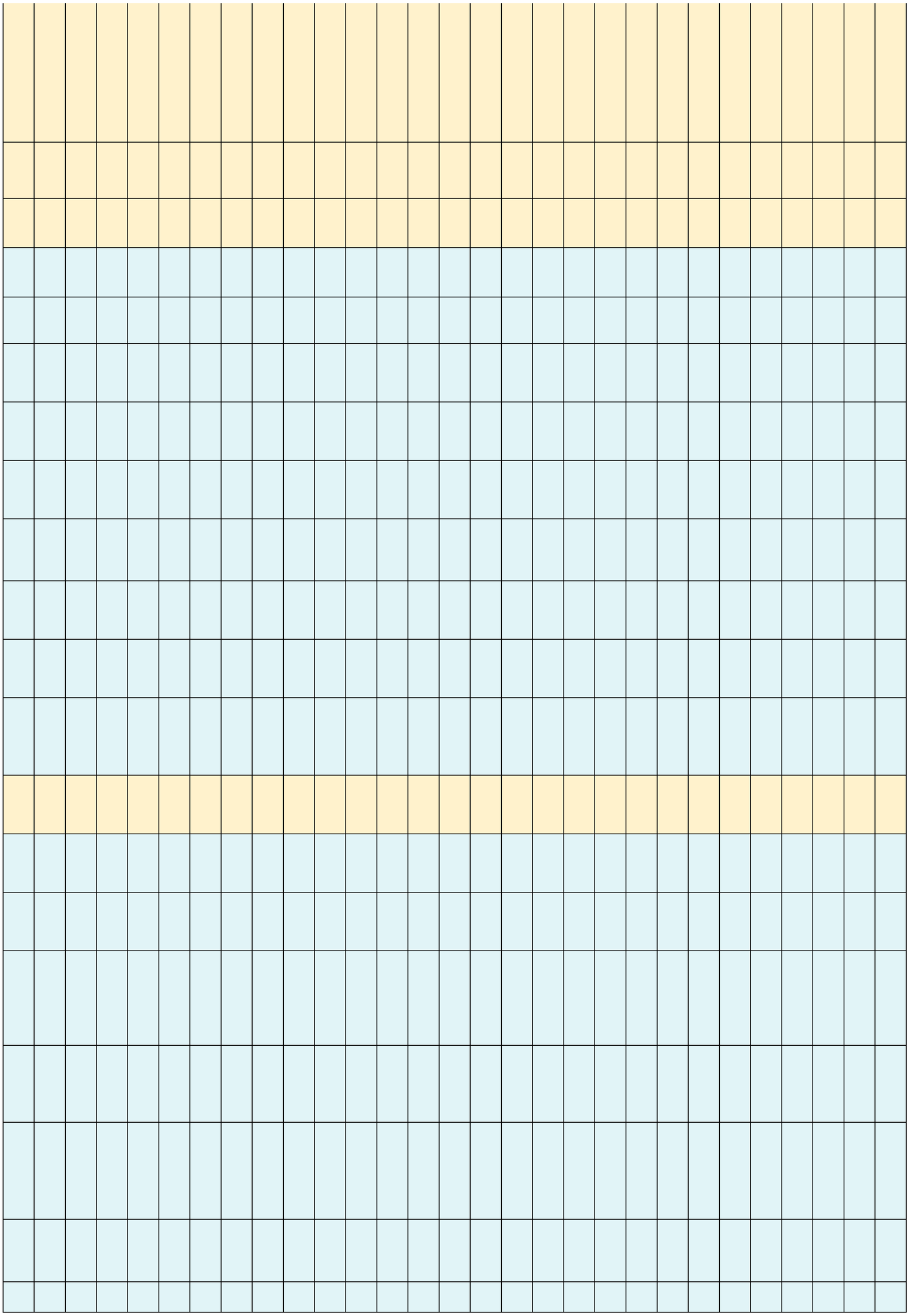
12	Intermediate Care Community Services	Reablement/Rehab Services	Home-based intermediate care services	Joint reablement and rehabilitation service (to support discharge)		180	185	Packages	Social Care		LA			Local Authority	Local Authority Discharge	£ 434,290	£325,718		
16	Warrington Therpay Staff	Warrington Therpay Staff	Prevention / Early Intervention	Other	Preventing admissions to acute setting	0	NA		Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution	£ 197,674	£109,539		
16	Support to Intermediate Care	Bridgewater Community Therapies	Prevention / Early Intervention	Other	Preventing admissions to acute setting	0	NA		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£ 162,195	£0		Waiting for invoices to be submitted from NHS Cheshire & Merseyside (Halton Place)
16	High Intensity User	High Intensity User	Prevention / Early Intervention	Risk Stratification		0	NA		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£ 61,163	£0		Waiting for invoices to be submitted from NHS Cheshire & Merseyside (Halton Place)
5	DFG & Equipment Adaptations	DFG	DFG Related Schemes	Adaptations, including statutory DFG grants		1000	811	Number of adaptations funded/people supported	Social Care		LA			Private Sector	DFG	£ 2,175,723	£1,520,710		
12	Intermediate Care Community Services	Reablement/Rehab Services	Home-based intermediate care services	Joint reablement and rehabilitation service (to support discharge)		87	157	Packages	Social Care		LA			Local Authority	iBCF	£ 366,640	£366,640		
8	Home First Support	Home First Support	Home Care or Domiciliary Care	Domiciliary care packages		98124	60145	Hours of care (Unless short-term in which case it is packages)	Social Care		LA			Private Sector	Minimum NHS Contribution	£ 2,111,215	£1,273,865		
7	Trusted Assessment	Trusted Asessor Role	High Impact Change Model for Managing Transfer of Care	Trusted Assessment		0	NA		Social Care		LA			Local Authority	Minimum NHS Contribution	£ 59,537	£5,327		
6	Mental Health Commissioning	Mental Health Joint Commissioning Role	Enablers for Integration	Joint commissioning infrastructure		0	NA		Mental Health		LA			Local Authority	Minimum NHS Contribution	£ 71,408	£0		Posts not yet recruited to.
19	Development Fund	Development - Other (New Service Developments)	Other			0	NA		Other	Community Health & Social Care	LA			Local Authority	Minimum NHS Contribution	£ 467,448	£0		
7	Care Home - Lead Nurse	Care Home - Lead Nurse	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes	0	0	NA		Social Care	0	LA	0		NHS Acute Provider	Minimum NHS Contribution	£ 83,454	£0		Waiting for invoices to be submitted by Mersey & West Lancs Teaching Hospitals NHS Trust
4	Mental Health Outreach Support	Mental Health Outreach Support	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as	0	0	NA		Mental Health	0	NHS	0		NHS Acute Provider	Minimum NHS Contribution	£ 148,000	£74,000		
7	Trusted Assessment - Mental Health	Mental Health Trusted Assessor	High Impact Change Model for Managing Transfer of Care	Trusted Assessment	0	0	NA		Mental Health	0	NHS	0		NHS Acute Provider	Minimum NHS Contribution	£ 20,000	£0		Waiting for invoices to be submitted from NHS Cheshire & Merseyside (Halton Place)
12	HICAFS	Halton Intermediate Care & Frailty Service	Urgent Community Response	0	0	0	NA		Community Health	0	NHS	0		NHS Community Provider	ICB Discharge Funding	£ 120,000	£120,000		
1	Halton Integrated Community Equipment	Joint Equipment Service	Assistive Technologies and Equipment	Community based equipment	0	4374	3655	Number of beneficiaries	Community Health	0	NHS	0		NHS Community Provider	Local Authority Discharge	£ 652,584	£483,850		
1	Halton Integrated Community Equipment	Joint Equipment Service	Assistive Technologies and Equipment	Community based equipment	0	1458	1218	Number of beneficiaries	Community Health	0	NHS	0		NHS Community Provider	ICB Discharge Funding	£ 218,355	£69,121		
12	HICAFS	Halton Intermediate Care & Frailty Service	Urgent Community Response	0	0	0	NA		Community Health	0	NHS	0		NHS Community Provider	Minimum NHS Contribution	£ 3,418,732	£1,624,203		











Adding New Schemes:

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Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Planned Outputs for 2024-25	Outputs delivered to date (Number)	Units (auto-populated)	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner) (auto-populate)	Provider	Source of Funding	Planned Expenditure (£)	Expenditure to date (£)
