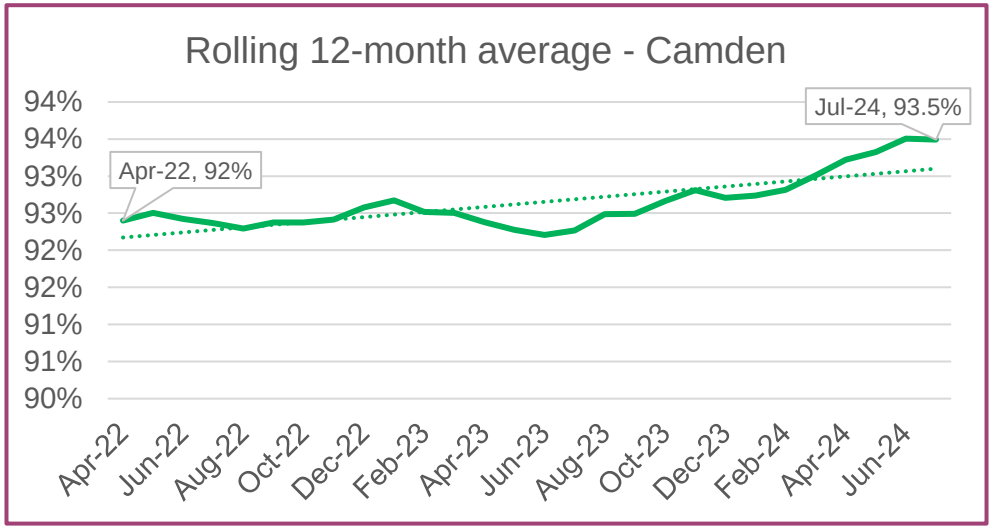
Appendix 1 - Metric performance information

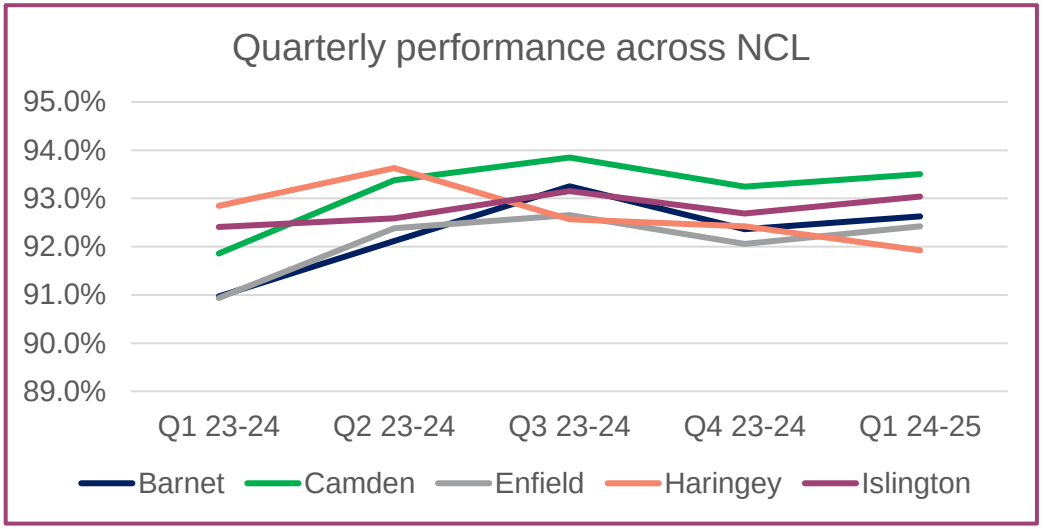
Better Care Fund 2024-25

This pack sets out current Camden performance against the four BCF metrics and provides a summary of changes to demand for intermediate care services.

Metric 1 – Discharge to usual place of residence

This metric measures the percentage of people discharged from hospital to their usual place of residence, which is normally their own home, but could be a care home. A higher value is better ↑



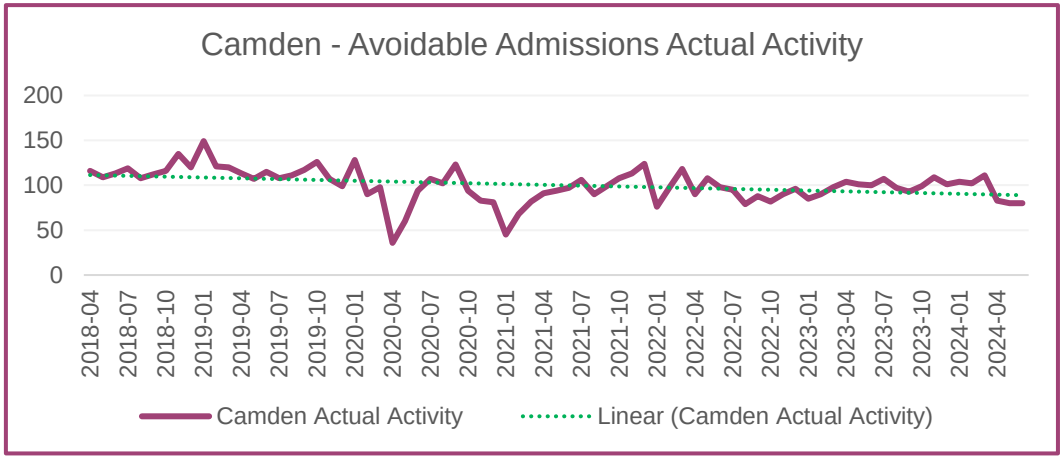


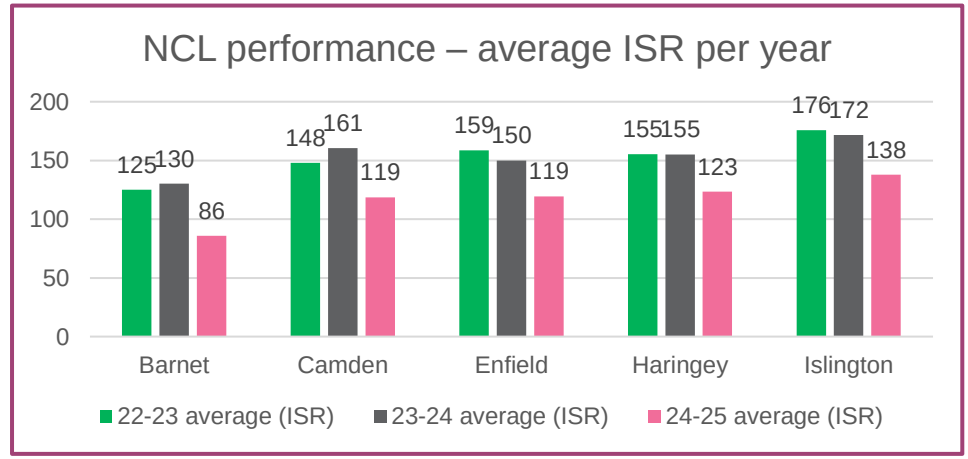
2024/25	Planned targets
Q1	93.9%
Q2	94.2%
Q3	94.5%
Q4	94.5%

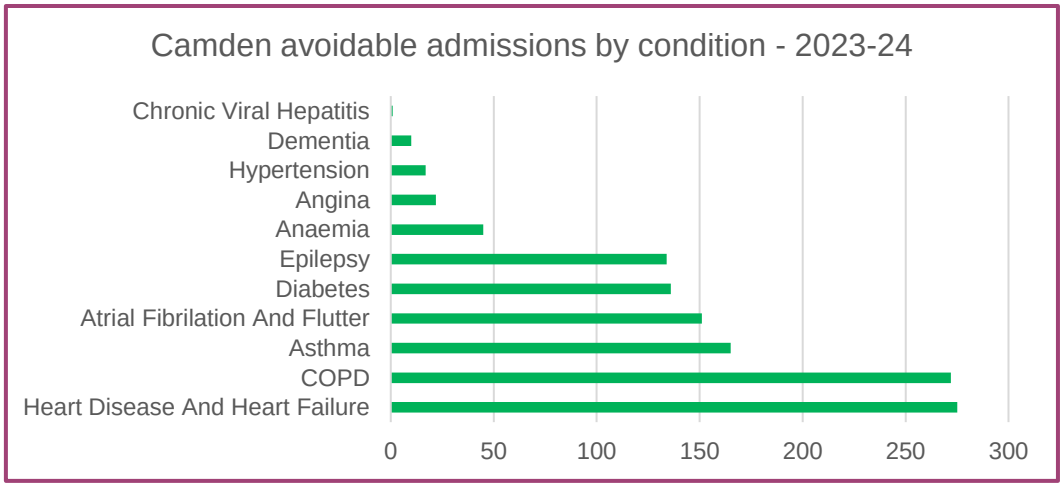
Performance of this metric fluctuates month-on-month, but performance over a 12-month rolling basis shows a clearly improving trend.
Across North Central London, Camden has had the best performance over the last three quarters.
Targets are based on the ambition to progress towards 95% by 25-26, with consistent quarter by quarter improvement to reach this ambition, apart from quarter 4 when a flatline has been built in to manage winter pressures.

Metric 2 – Reducing Avoidable Admissions (per 100,000)

This metric measures the rate of emergency admissions to hospital for people with conditions that should be managed in the community, e.g., diabetes, angina, dementia. A lower value is better ↓.
ISR = Indirectly Standardised Rate. This is a weighted rate per 100,000 based on the age breakdown of the population, as used in the BCF publication.



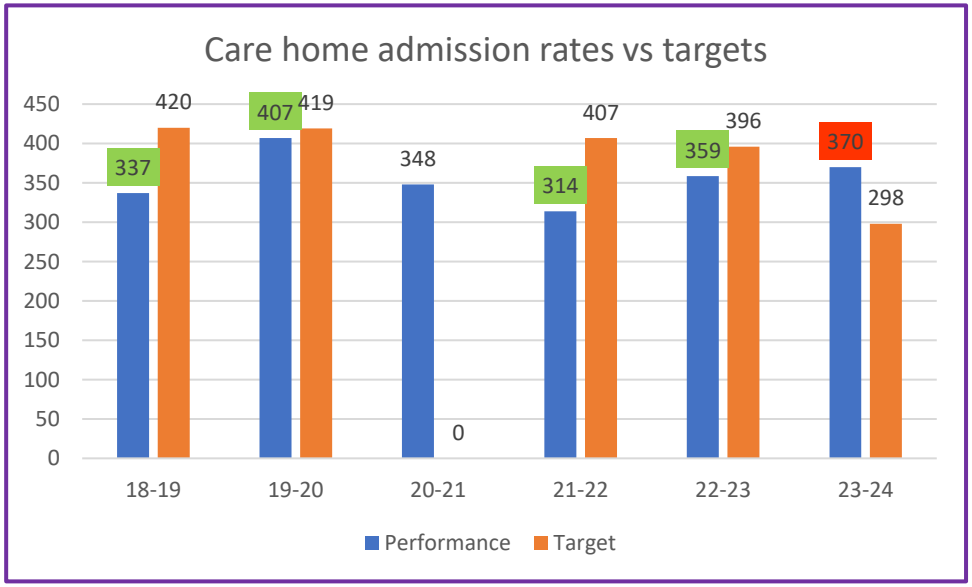


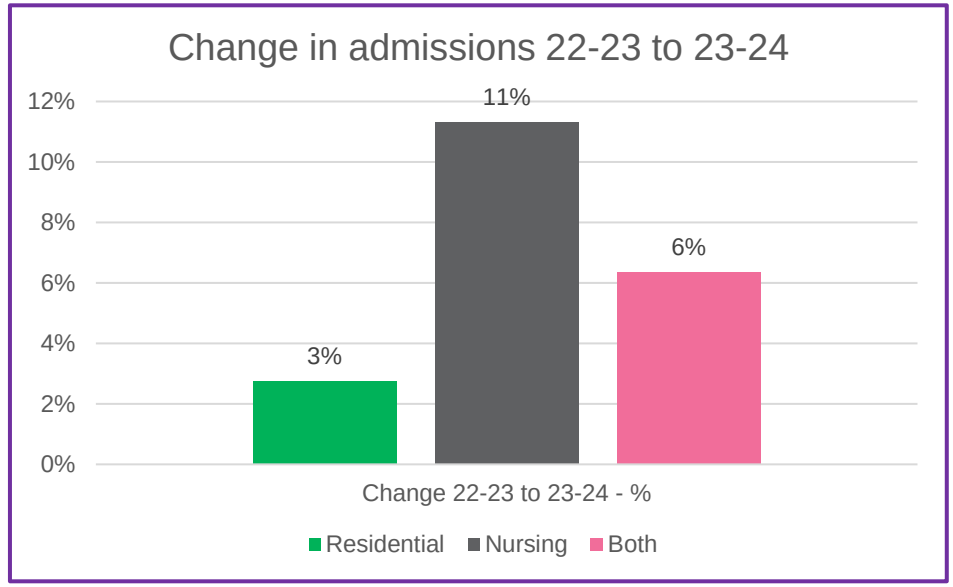


Actual avoidable admissions have been decreasing over the last few years, but the rate of admissions increased slightly in 2023-24. The first quarter of 2024-25 has seen a large reduction in the admissions rate across NCL, although historically there have been some data issues with this metric.
The two highest causes of admissions are COPD and heart disease/failure.

Metric 3 – Care home admissions

Rate = annual rate (per 100,000 65+ population) of **Council supported** older people whose long-term support needs are best met by admission to residential and nursing care homes. A lower value is better ↓.



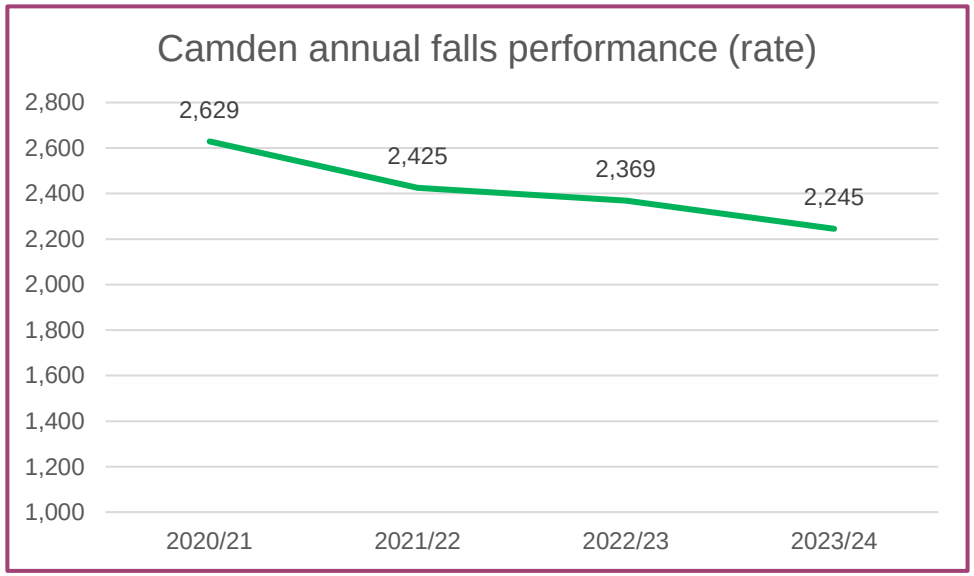


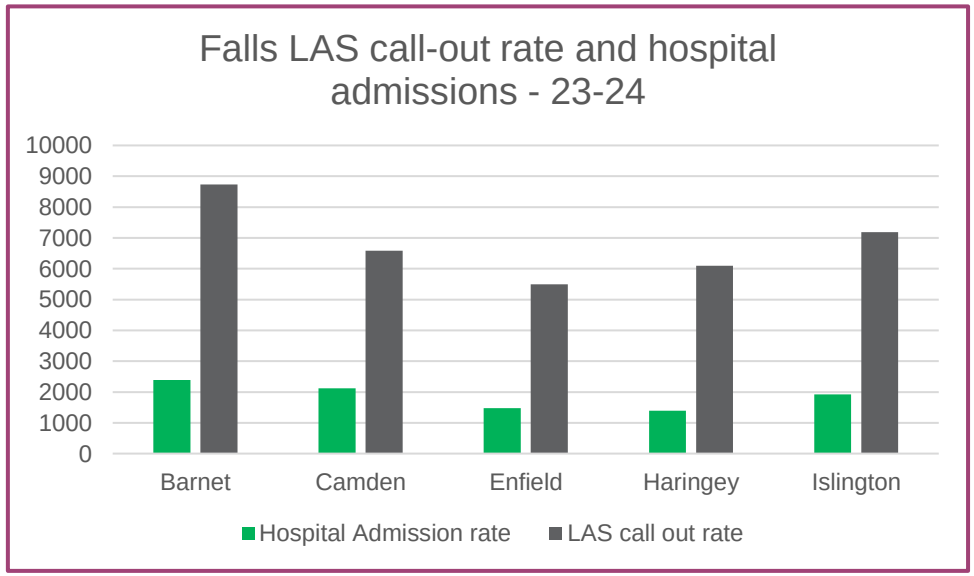
Proposed Target 2024-25	
Original	**Revised**
299	333

Since 2018-19 performance had been consistently strong and below the annual targets set. An ambitious target was therefore agreed for 2023-24. Unfortunately, this target was not met, due largely to the increased demand seen for nursing care home placements. A revised target for 2024-25 has therefore been set which is still considered ambitious.

Metric 4 – Falls

Reducing the number of emergency hospital admissions due to falls in people over 65 (rate per 100,000 population)
A lower value is better ↓.



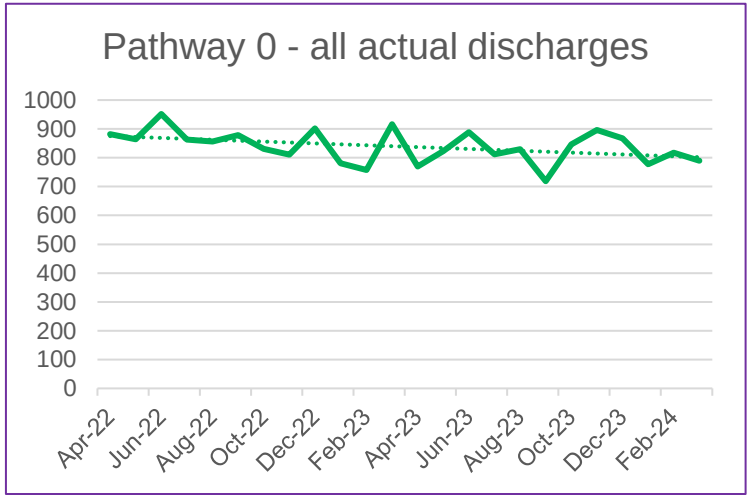


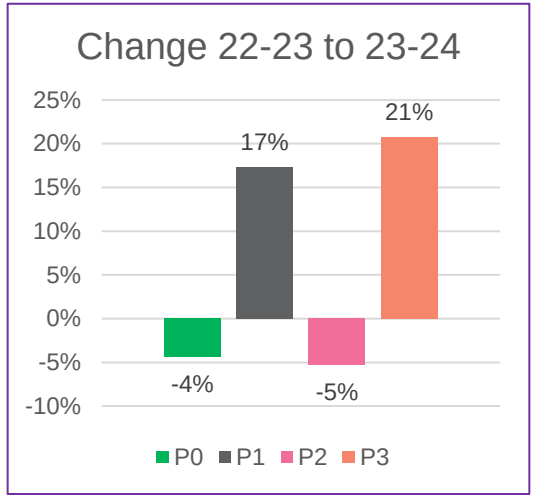
	Proposed Target 24-25
Rate	1,893
Count	473

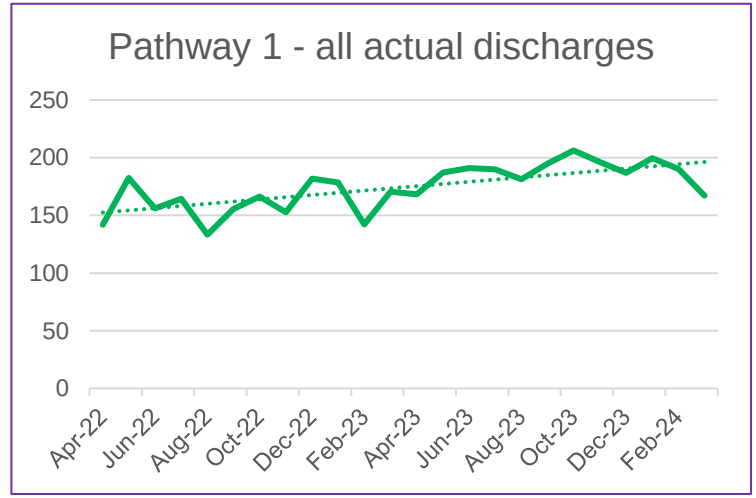
This metric measures the rate that people aged 65 or above are admitted to hospital because of a fall. Performance has been improving steadily over the last four years. The performance is influenced firstly by the number of people 65+ having a fall, then by how many of these people are conveyed to hospital, and finally by how many are admitted. As can be seen in the chart above, across NCL the proportions of people admitted to hospital after a fall are low compared to ambulance service call outs.

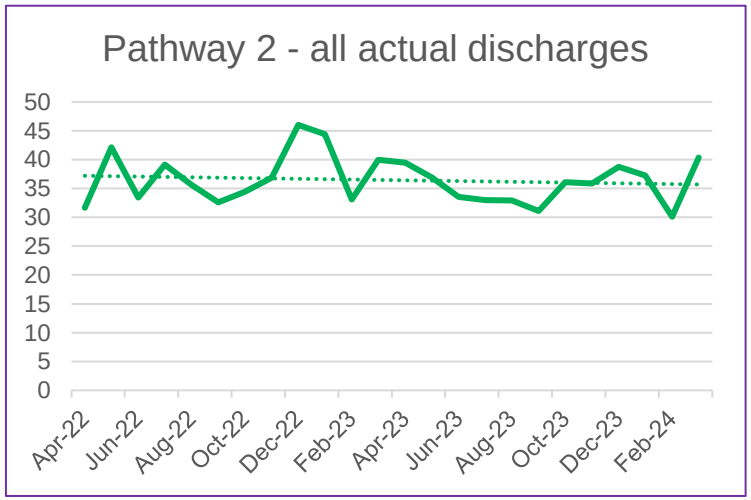
Intermediate Care – Capacity and Demand

(see next slide for pathway definitions)

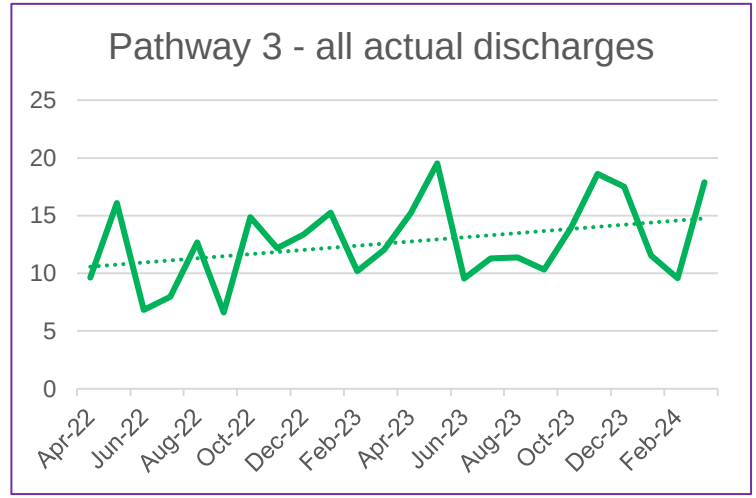








While activity fluctuates considerably each month, there are clear trends when comparing activity over different years. These show clear increases in demand for homecare/reablement (P1) and care home placements (P3).



Discharge pathway definitions

- **Pathway 0**: discharges home or to a usual place of residence with no new or additional health and/or social care needs
- **Pathway 1**: discharges home or to a usual place of residence with new or additional health and/or social care needs
- **Pathway 2**: discharges to a community bed-based setting which has dedicated recovery support. New or additional health and/or social care and support is required in the short-term to help the person recover in a community bed-based setting before they are ready to either live independently at home or receive longer-term or ongoing care and support
- **Pathway 3**: discharges to a new residential or nursing home setting, for people who are considered likely to need long-term residential or nursing home care. Should be used only in exceptional circumstances