ADULT Social Care

Appendix A.

Metric performance information, Better Care Fund 2025-26

Camden

ADULT Social Care

This pack sets out:

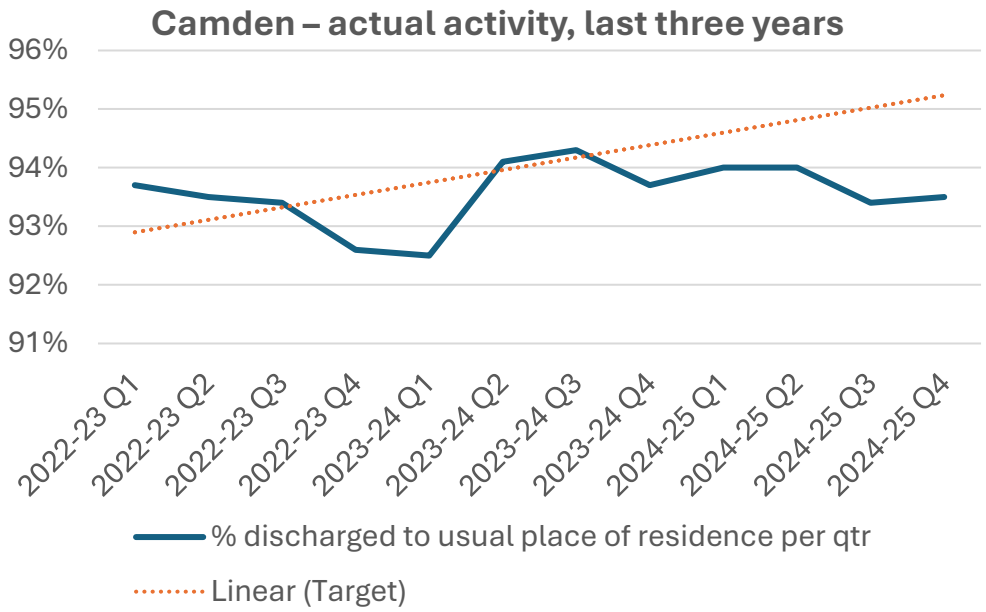
1. Camden performance against 2024-25 BCF metrics (slides 3-7)
2. A summary of changes to demand for intermediate care services (8-10)
3. BCF metrics for 2025-26 Plan (11-12)

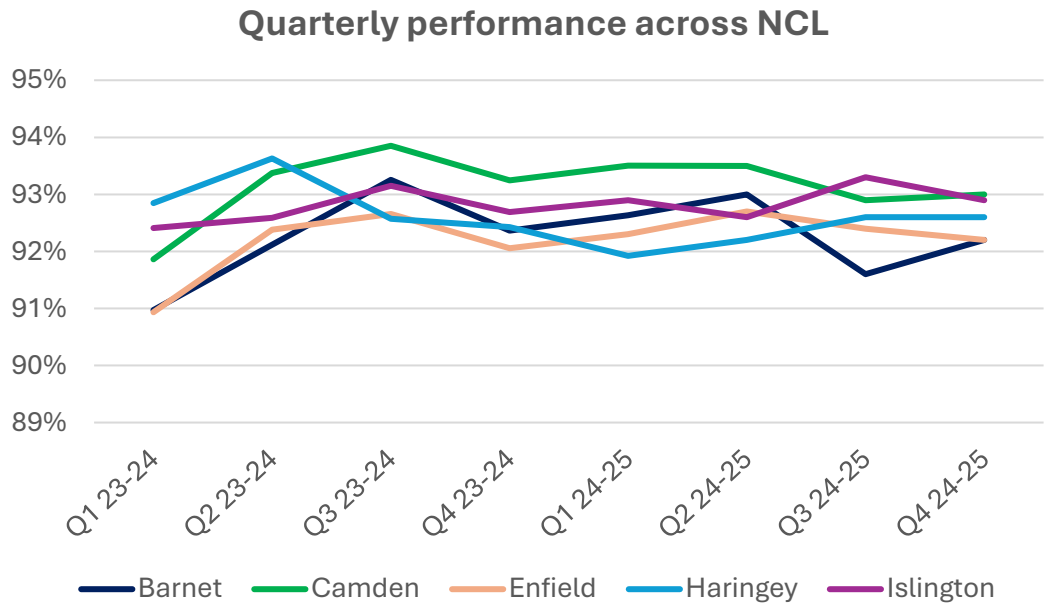
Camden

Camden performance against 2024-25 BCF metrics

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 ↑

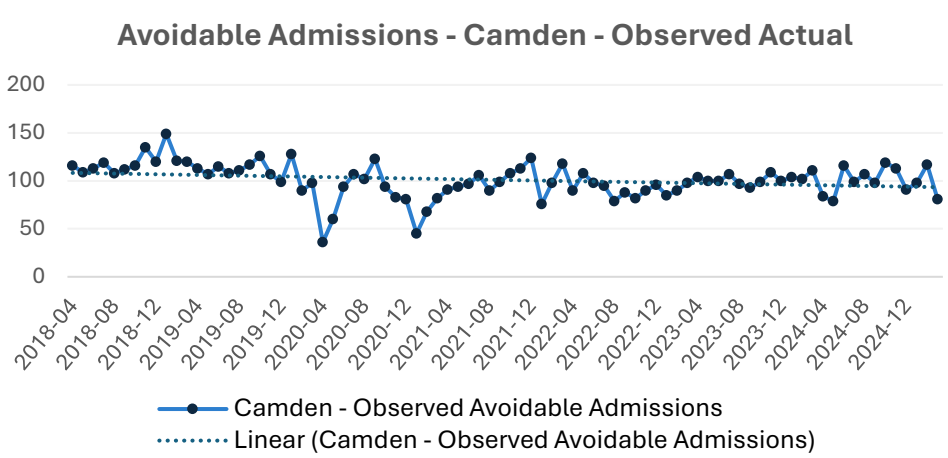


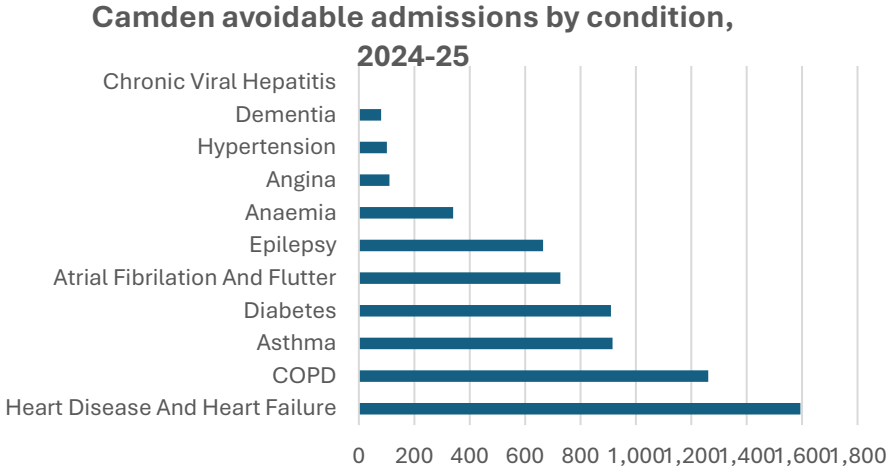


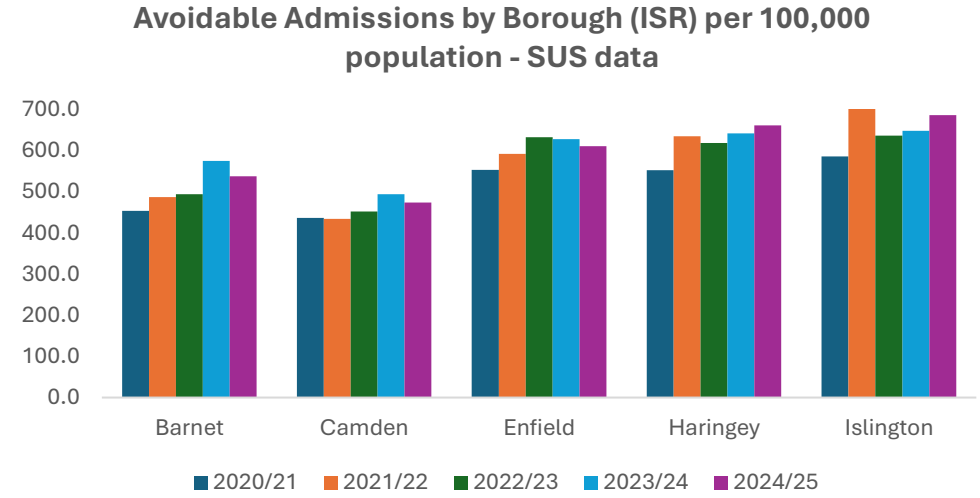
Performance of this metric fluctuates month-on-month. While performance over a 12-month rolling basis has plateaued, there has been an improvement since the start of the two-year plan. Across North Central London, Camden has had the best performance over three of the last four quarters.
This metric will be discontinued for 2025-26, however additional investment into schemes such as Rapid Response and NCLs Admissions Avoidance and Discharge programme of work will support this further.

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, a weighted rate per 100,000 based on the age breakdown of the population, as used in the BCF publication.



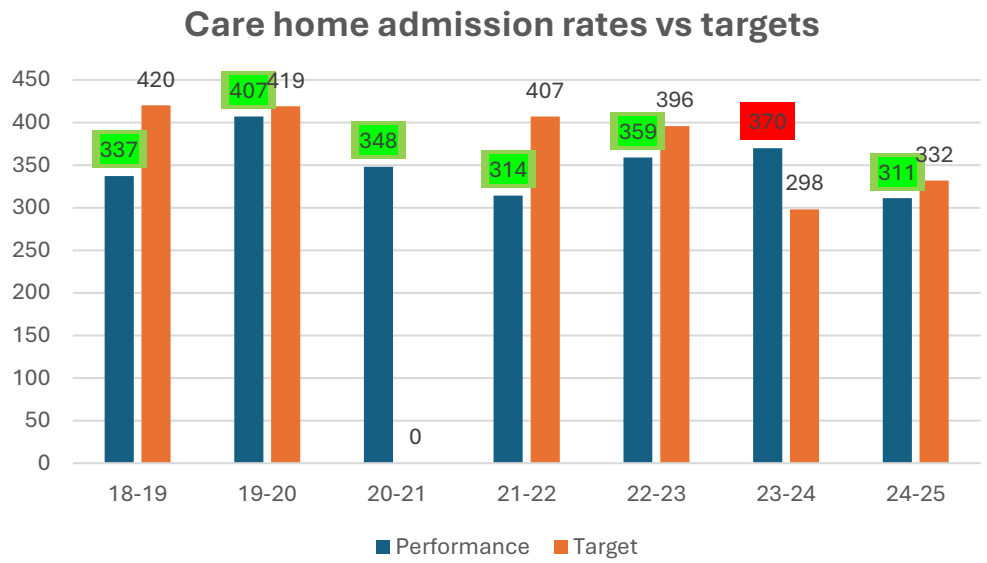


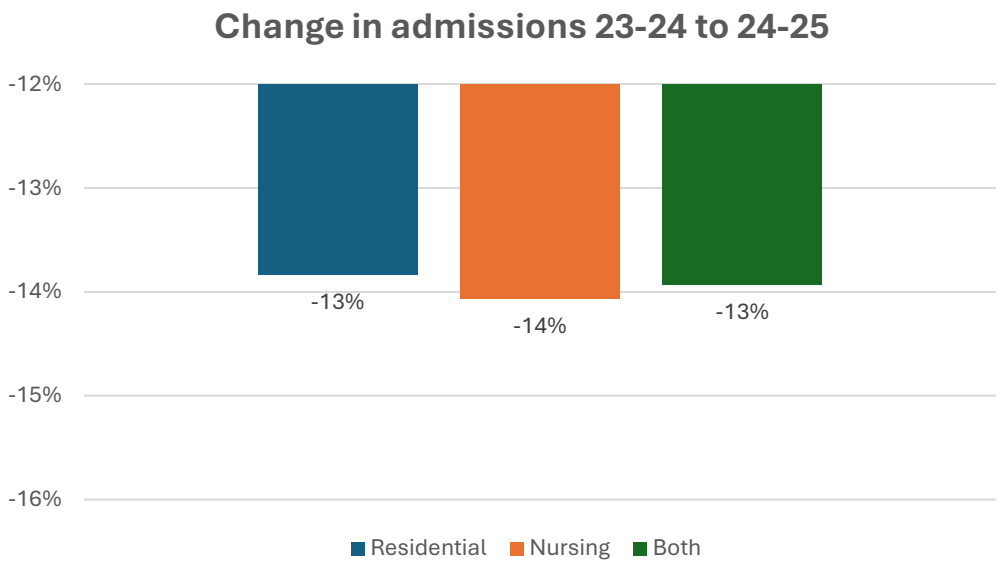


Avoidable admissions have begun to reduce in Camden, following a slight increase in admissions in 2023-24 and Camden continues to be the strongest performing borough in NCL. Schemes such as Urgent Community Response will continue to support this direction of travel. As in previous years, the two highest 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 🡻.



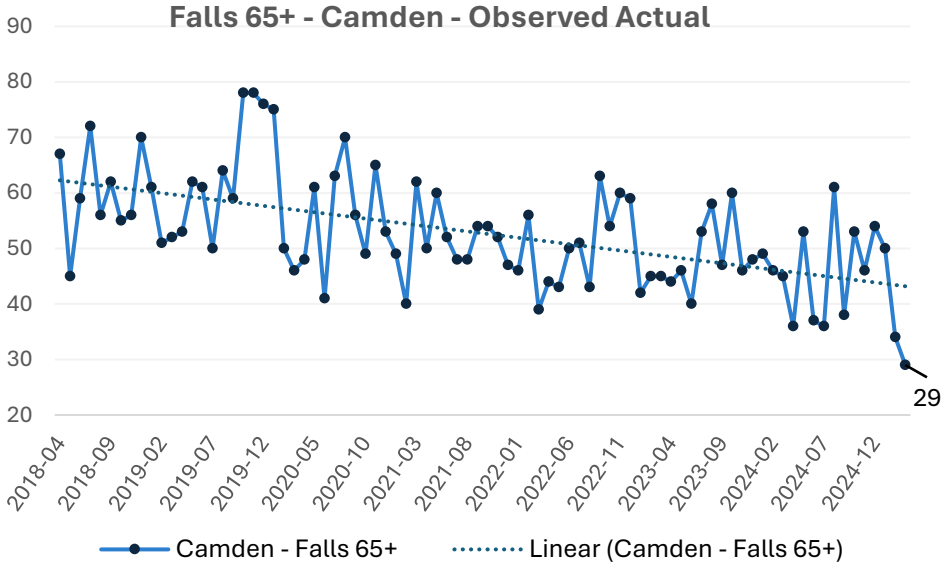


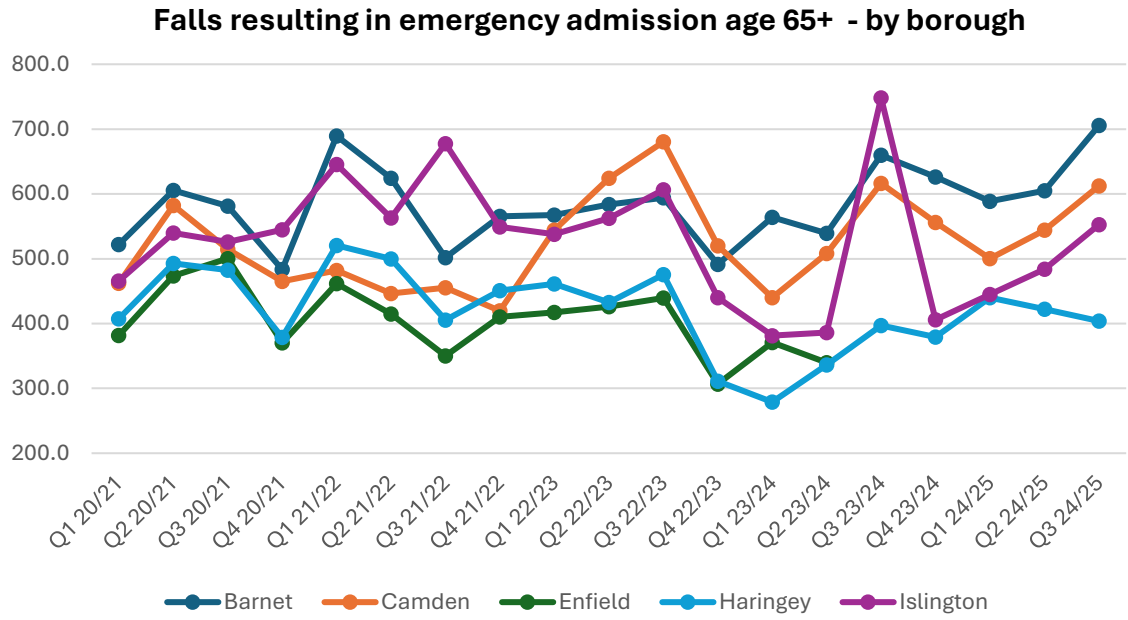
Targets	
2024-25	**2025-26**
332	322

The target for 2024-25 was met, continuing a trend of strong performance against target, which was bucked in 2023-24. 2024-25 saw a continuous drop in residential admissions and a drop in nursing admissions toward the end of the year, although admissions can fluctuate seasonally. A stretch target has been set for 2025-26.

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 ↓.



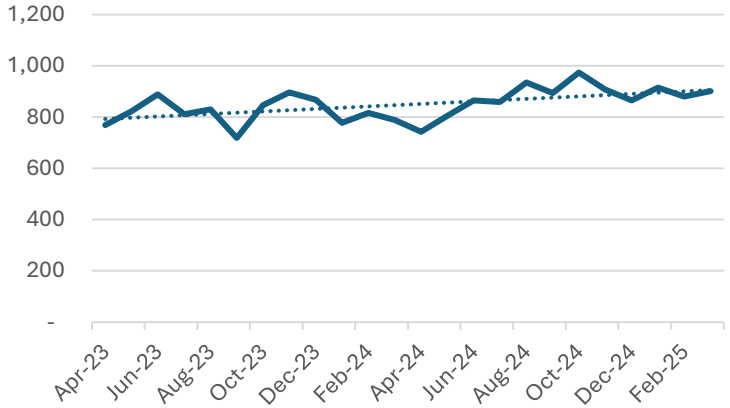


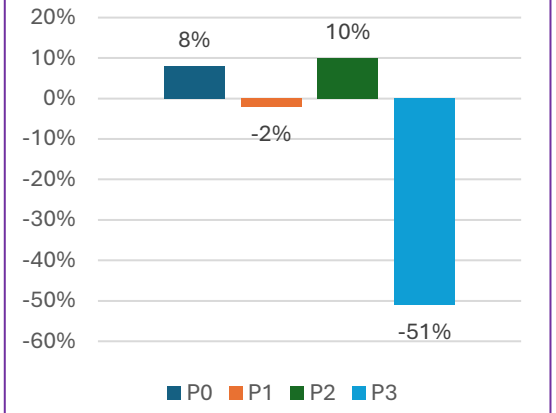
This metric measures the rate that people aged 65 or above are admitted to hospital because of a fall. Performance has been improving steadily over the last five years. The performance is influenced firstly by the number of people 65+ having a fall, then by how many of these people are conveyed to hospital, and finally by how many are admitted.

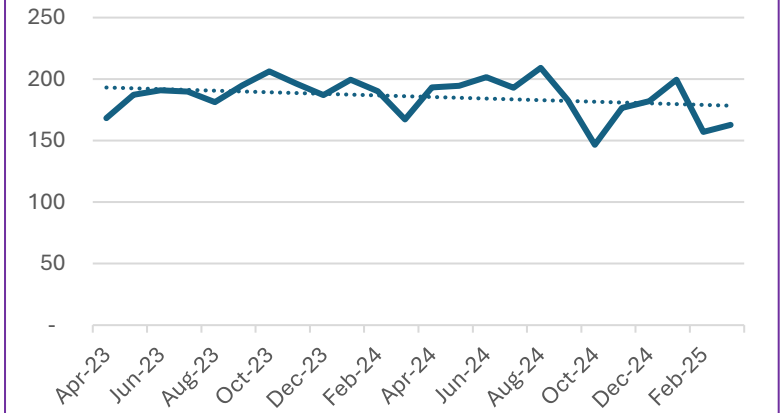
Changes to demand for intermediate care services by pathway, 2024-25

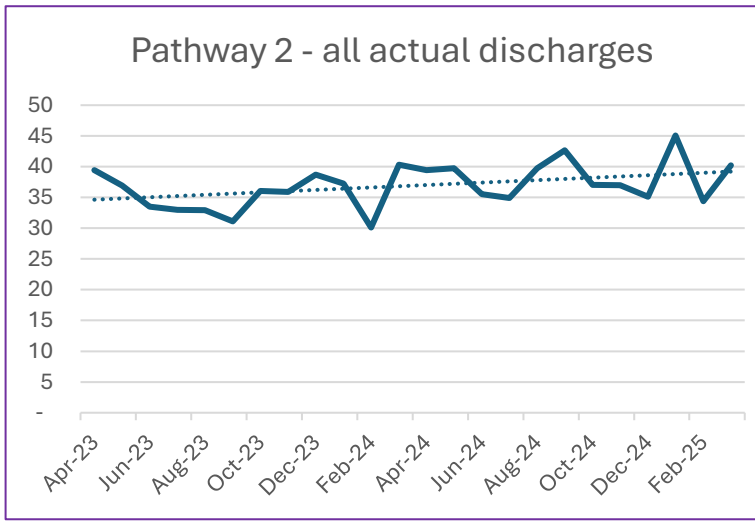
Intermediate Care – Capacity and Demand

(see next slide for pathway definitions)

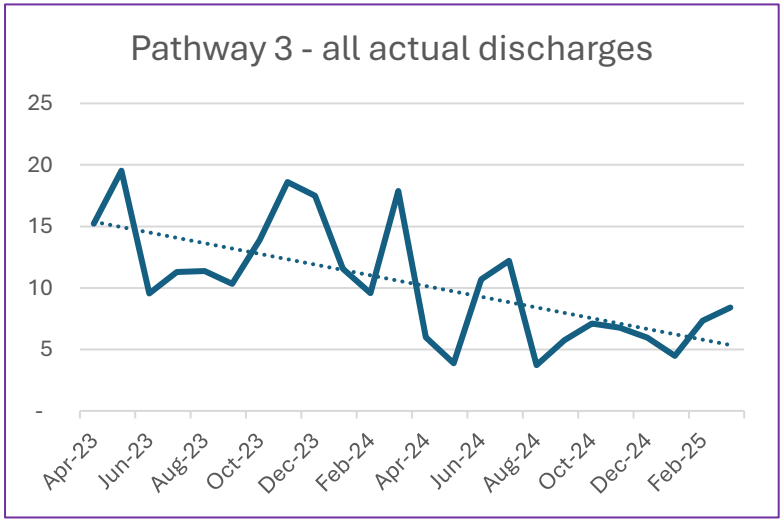








Activity fluctuates considerably each month and numbers are small. However, overall there has been a decrease in demand for care home placements (P3). While there is a small decrease in demand for homecare/ reablement placements from 2023-24 (P1), demand is still significantly higher than in 2022-23 (1,926 in 2022-23 v 2,199 in 2024-25).



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

Metrics for 2025-26

Metrics, 2025-26

Three mandatory headline metrics will form part of the quarterly reporting for 2025-26, just one of which was part of quarterly reporting for 2024-25. There are six optional indicators which can be used to understand performance against the metrics, but reporting against these is not required.

Those 'red' metrics/supporting indicators are those we already report on in the BCF, either as a metric or as part of capacity and demand reporting.

Headline Metrics	Supporting Indicators
These are mandatory metrics that HWB areas must use as part of planning for 2025/26. It is expected that local goals will be set for each of these metrics.	**HWB areas may also use supporting indicators to better understand the drivers of their performance against BCF objectives and specific local priorities. We recommend using the six indicators set out below, but additional indicators can be adopted locally.**
1. Emergency admissions to hospital for people aged 65+ per 100,000 population.	• *Unplanned hospital admissions for chronic ambulatory care sensitive conditions* • *Emergency hospital admissions due to falls in people aged 65+*
2. Average length of discharge delay for all acute adult patients, derived from a combination of: Proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD) For those adult patients not discharged on DRD, average number of days from DRD to discharge.	• *Patients not discharged on their DRD, and discharged within 1 day, 2-3 days, 4-6 days, 7-13 days, 14-20 days and 21 days or more.* • *Average length of delay by discharge pathway.*
3. Long-term admissions to residential care homes and nursing homes for people aged 65+ per 100,000 population.	• *Hospital discharges to usual place of residence* • *The proportion of people who received reablement during the year, where no further request was made for ongoing support*