Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Haringey

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	159.6	139.7	157.1	134.0	Q1 23/24 figures are being compiled, but limited window to influence outputs. Plan for Q2-Q4 shows gradual improvement, even though we anticipate seasonal variations over remaining three quarters. Anticipate gradual annual ISR improvement due to investment in community solutions & engagement with commuities - see tables	See BCF Narrative which maps solutions to influence metrics - many of our community solutions enable people to come forward for triaging, diagnosis & help earlier and to enhance proactive management of conditions & independence, including self-management
	Number of Admissions	330	289	325	-		
	Population	268,647	268,647	268,647	268,647		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Indicator value	133	128	126	120		

[>> link to NHS Digital webpage (for more detailed guidance)]

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,857.4	1,819.0	1,608.0	Q1 23/24 figures are being compiled, but limited window to influence outputs. Plan for Q2-Q4 is to improve as we invest in our AW awareness raising (which includes module on improving falls management) and roll out of our falls prevention programme in 2023/24. See tables in BCF Narrative to map schemes to metrics	See BCF Narrative which maps solutions to influence metrics. We believe that our early help/preventative community solutions (e.g active ageing) etc. will improve people's risk of falls, alongside some wider specific falls prevention services being developed for 2023/24 (outside of BCF Plan) - see BCF Narrative Proactive & Planned Care sub-section
	Count	490	509	450		
	Population	27,961	27961	27961		

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	92.3%	93.1%	93.1%	94.2%	Q1 23/24 figures are being compiled, but limited window to influence outputs. Plan for Q2-Q4 is to improve as we invest in our P1 Home First solutions (see Local Plan). See tables in BCF Narrative to map schemes to metrics.	See BCF Narrative - our current and planned investment in Home First, P2 beds and longer-term community solutions enable people to return and stay at home rather than move to long-term care home provision on discharge.
	Numerator	3,770	3,871	3,864	3,670		
	Denominator	4,085	4,158	4,152	3,896		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Quarter (%)	93.0%	93.5%	94.2%	95.0%		
	Numerator	3,854	3,760	4,008	3,875		

	Denominator	4,144	4,021	4,255	4,079		

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	387.9	341.8	374.6	371.4	2022-22 estimate based on actual return. Anticipated to make steady progress on reducing care home admissions in 2022-23 as part of our continued drive towards Home First solutions; at same time, but we are seeing increase complexity of cases of	See BCF Narrative - our current and planned investment in Home First, P2 beds and longer-term community solutions enable people to return and stay at home rather than move to long-term care home provision. However, we are aware of
	Numerator	111	104	114	116		
	Denominator	28,618	30,430	30,430	31,234		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)		75.2%	75.6%	78.2%	2022-23 estimate figure based on sample of cases.	See BCF Narrative - our current and planned investment in Home First, P2 beds and longer-term community solutions enable people to return and stay at home rather than move to long-term care home provision or return to hospital.
	Numerator	0	173	180	223		
	Denominator	0	230	238	285		

Please note that due to the demerging of Cumbria information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.