Haringey Better Care Fund 2025/26

Metric & Performance Update

(Q1 – Q3)

Health and Wellbeing Board

20th February 2026

Haringey LONDON

Better Care Fund

The Better Care Fund (BCF) is a national programme designed to support the integration of health and social care services, enabling local systems to work together more effectively. Its core purpose is to deliver person-centred, sustainable care, and to improve outcomes for residents and carers.

In Haringey, the BCF underpins a partnership between the North Central London Integrated Care Board and the London Borough of Haringey supported through a Section 75 agreement.

This arrangement helps drive integration and maintain the borough's commitment to delivering health and social care aligned with national and local strategies.

BCF Objectives

The BCF 2025/26 policy objectives focus on two overarching goals:

- supporting the shift from sickness to prevention
- supporting people living independently and the shift from hospital to home

These objectives are designed to enhance the integration of health and social care services, ensuring that people receive the right care at the right time and in the right place. The key elements of these objectives include:

Shift from Sickness to Prevention –

This objective emphasises the importance of preventive care to reduce the incidence of illness and the need for acute care services. By focusing on prevention, the BCF aims to improve overall health outcomes and reduce the burden on healthcare systems.

Supporting People Living Independently and the Shift from Hospital to Home –

This objective aims to enable individuals to live independently in their own homes for as long as possible. It includes initiatives to improve discharge processes, enhance community-based care, and reduce the reliance on hospital and long-term residential care

Headline BCF Metrics for 2025/26

The BCF for 2025/26 focuses on three headline metrics:

Emergency Admissions (65+)

The metric measures Emergency hospital admissions for people aged 65+, per 100,000 population. This includes unplanned admissions through A&E, GP referrals, or other urgent pathways.

This metric matters because high rates indicate gaps in prevention, frailty support, or urgent community care. Reducing avoidable admissions relieves hospital pressure, supports independence, and aligns with the BCF shift from hospital to home.

Discharge Delays – DRD to Discharge

The metric measures how efficiently patients leave hospital by tracking
(1) the percentage discharged on their Discharge Ready Date (DRD)
(2) the average days delayed for those not discharged on time.

This metric matters because reducing delays improves patient outcomes, prevents deconditioning, frees up beds, and supports the BCF goal of faster, safer transitions from hospital to home.

Admissions to Long Term Residential or Nursing Care (65+)

The metric measure the number of people aged 65+ whose long-term support needs lead to permanent admission to residential or nursing care, per 100,000 population.

The metric matters because lower admissions signal strong prevention, early intervention, and independence-focused support. It directly reflects the BCF aim of helping people stay well and live at home for longer.

Supporting BCF Metrics for 2025/26

The supporting BCF measure for 2025/26 focus on:

Avoidable Admissions (65+)

The metric measures unplanned hospitalisations for chronic ambulatory care sensitive conditions (ISR rate per 100,000 population).

This metric matters because high rates indicate gaps in prevention, long-term condition management, and community support. Reducing avoidable admissions lowers hospital pressure and improves independence and outcomes.

Falls 65+

The metric measure emergency hospital admissions due to falls in people aged 65+, measured per 100,000 population.

The metric matters because falls lead to loss of independence, long stays, and higher long-term care demand. A high rate signals gaps in prevention, mobility support, home adaptations, and timely clinical intervention.

Summary of progress against Metrics (Q1 – Q3)

Headline Metric	Target	Q1	Q2	Q3
Emergency Admissions (65+)	Monthly target range of admissions is between 415 to 504. Admissions per quarter: Q1 - 1328, Q2 - 1350, Q3 - 1317	✔ On track Admissions remained lower than plan in April and May however higher number of admissions in June.	✔ Mostly On track Higher admissions in July however August showed improvement with admissions falling, slight increase in September	✘ Not on track Admissions increased into Oct however remained steady in Nov before spiking in Dec linked to winter pressures
Discharge Delays (DRD → Discharge)	92% discharged on Discharge Ready Date	✔ On track Performance was above target for all months across the quarter.	✔ On track Performance was above target for all months across the quarter.	✔ Mostly On track Performance was above target for Oct, and was slightly below target in Nov and Dec linked to winter pressures
	Avg Days from DRD to Discharge ≤ 7.5 delay days	✔ On track Delays remained below the target for all months across the quarter.	✔ On track Delays remained below/or on target for July and August with Sep slighty above target.	✔ On track Delays remained below target for Oct and Nov with Dec above target.
Residential Admissions (65+)	36 per quarter → 144 annually	✔ On track Placements remained below the target for all months across in quarter.	✔ On track Placements remained below the target for all months across in quarter.	✔ On track Placements remained below the target for all months across in quarter.

Emergency Admissions Narrative

Quarter 1 - On Track

Emergency admissions remained below the planned threshold in April (434 vs 440) and May (444 vs 474), demonstrating a strong start to the year.

However, June showed a noticeable rise to 482 against a plan of 415, reflecting a +67 variance, signalling the early impact of seasonal illness and increased frailty presentations.

While Q1 sits on track, the increase in June indicates emerging pressure that required monitoring into Q2.

Quarter 2 – Mostly On Track

Quarter 2 began with higher-than-planned admissions in July (511 vs 504), continuing the upward trend seen at the end of Q1.

August then showed improvement, with admissions falling to 435 vs a plan of 439.

In September, admissions rose again to 431 vs 408, indicating fluctuating demand linked to late-summer illness and increased acuity.

Performance across the quarter was therefore variable but still aligned with expectations for Q2.

Quarter 3 – Not on Track

Quarter 3 reflects winter pressures. October admissions rose to 569 vs a plan of 456, creating early winter strain across urgent care pathways.

November remained above plan 476 vs 476 plan, before peaking again in December at 519 vs 480 reinforcing known seasonal trends of viruses, increased frailty, and higher acuity.

Overall, Q3 indicates the performance was not on track, this was driven by a spike in flu cases which led to increased emergency admissions which was reflected in both local and NHS data.

Discharge Delays Narrative

% Discharged on Discharge Ready Date:

Quarter 1 - On Track

Performance remained consistently above the 92% target, with April at 93.5%, May at 92.1%, and June at 92.1%.

Quarter 2 - On Track

Quarter 2 maintained strong performance, with rates of 93.7% (Jul), 93.1% (Aug) and 93.6% (Sep) all comfortably above the 92% threshold.

Quarter 3 – Mostly On Track

Quarter 3 started with strong performance, with rates of 93.6% in Oct however then fell to 89.6% (Nov) and 87.9% (Dec) which were below the target. This due to an increase in hospital activity related to winter pressures and flu outbreak.

Average Days from DRD to Discharge:

Quarter 1 - On Track

Delays remained well below the 7.5-day target, with April at 4.4 days, May at 4.9, and June at 6.5.

Quarter 2 - On Track

Results were mixed but still near or below target: 7.5 days in July (on target), 4.1 days in August,7.6 days in September (slightly above target).
The slight rise in September reflects early seasonal pressures.

Quarter 3 - On Track

Results were mixed but still near or below target: 6.8 days in Oct, 6.7 days in Nov, 8.6 days in Dec (s).

The rise in December reflects winter pressures and flu outbreak.

Issues Affecting Performance (Q2 – Q3)

1. Data Quality Issues within the NHS - Coding problems caused the Q2 emergency admissions performance to appear better than reality. These issues were resolved by mid Q3.

2. Staff Shortages & Recruitment Efforts - Gaps in staffing across the system were causing slower responses and some rejected referrals. LBH are recruiting additional therapists to support Discharge to Assess (D2A)

4. Lack of NHS System Access – Not all LBH staff have had NHS email access to speed up the process of sending documentation this is being progressed to resolve.

5.Referral Criteria - Delays caused by rejected referrals so planning on having training to improve the overall quality of referral content.

6.Seasonal Flu & Winter Pressures - Significant spike in flu activity, matched by national UKHSA data. This led to increased emergency admissions, particularly in older people.

7.Increased Patient Acuity - More severe underlying illness in presenting patients. Despite good admission avoidance, total admissions increased due to clinical acuity, not pathway failure.

8.Complex Discharge Cases - These cases drove discharge delays: Patients waiting for care home placements, Mental health–related delays, Court of Protection cases and Housing and homelessness delays

Q1 – Q3 Accomplishments

Emergency Admissions

- Avoidable admissions kept at lowest levels (Q1–Q2).
- Admissions Avoidance Workshop delivered (Q2).
- Winter vaccination & infection control guidance shared (Q2).
- UCR digital tool (Docobode), escalation process, Virtual Ward step-up acceptance (Q2).
- SPOA/ICC pathways reducing conveyance (Q2).

Discharge Delays

- Exceeded 92% DRD discharge target (Q1–Q2).
- Improved ward visibility speeding up interventions (Q3).
- Recruitment of therapists + workforce expansion (Q2–Q3).
- Referral criteria training completed (Q3).
- Staff given NHS emails to improve integration (Q2–Q3).
- Hoarding & deep clean framework improving discharge flow (Q2).

Current Risks Areas and Planning for Q4

Risk Area / Action	Timescale	Lead / Partners
Early Discharge planning on admission, with estimated discharge dates (EDDs)	Ongoing	ASC / Health
Increased capacity for 7-day working	To be finalised in Q4	ASC / Health
Escalation: Daily joint operational calls between ASC, hospital discharge teams, and brokerage. Platinum every Tuesday, Wednesday, Thursday. Weekly escalation across the Localities.	Ongoing – Daily	ASC / Health
Community Reablement Service (CRS), urgent discharges within 4–6 hours, supporting both hospital flow and community recovery	On-going into Q4	ASC
System-Wide Winter Flow Monitoring: Working with NCL	To be finalised in Q4	NCL Partners
Step-down flats to provide short-term accommodation for people who are medically fit for discharge but not yet ready to return home	Ongoing	ASC
Ensuring reablement and homecare capacity sufficient to meet the demand	Current	ASC Ops and Commissioning
Scoping the options for residential and nursing capacity for over the winter	Current	ASC Ops and Commissioning
Social Care Workforce planning	Complete	ASC

Next Steps

Progress

- Haringey meets daily with the Integrated Discharge Team huddles improving communication and shared decision-making.
- Earlier recognition of patients likely to face complex or prolonged discharge.
- Senior escalations are working well and presence at the Long Length Of Stay focus weeks.
- Brokerage providing strengthened advice on market conditions, provider suitability and interim options.
- Planned face to face workshop on the 12/02/2026 to discuss specific areas that need enhanced collaboration.

Next steps

- Implement agreed escalation triggers.
- Maintain daily IDT focus on longest-stay patients.
- Hold Whittington–Haringey–CHC alignment session.
- Strengthen early Haringey involvement at Emergency Department and admission.
- Work on specific areas of focus following workshop that is planned in February.
- Integrated Front Door with rapid triage of new referrals