BCF 2024/25 EoY Template - Metrics

Metric	Definition	For information – Your planned performance as reported in 2024-25 planning				For information – actual performance for Q1	Assessment of progress against the metric plan for the reporting period.	Challenges and any support needs	Achievements – including where BCF funding is supporting improvements	Variation 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
		Q1	Q2	Q3	Q4						
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions.	253.1	211.9	237.5	234.2	12.6	Data not available to assess progress	In the avoidable admission indicator data published by the National BCF team the indicator value drops dramatically during 2023/24 with these extremely low figures continuing into 2024/25. Using these figures the outturn would be 69.80 against a ceiling of 936.7, which is too low to be realistic. The national team has provided support, and the issue is linked to the implementation of Cerner in two acute trusts but see *Mitigation for recovery*.	The Q3 report update remains valid, i.e., proactive case management at neighbourhood level supported by Care Connection Teams and other services within Integrated Neighbourhood Teams to identify people most at risk of admission is a key component of our prevention model. The relevant services, e.g., Reablement, Rehabilitation or Urgent Care intervention, to address need are then identified, depending on level of complexity of need. This includes social prescribing for lower-level needs. Three Same Day Urgent Care Hubs support Hillingdon's three localities with the intention of supporting people with non-urgent health issues and diverting people from A & E. Although outside of the BCF, a health check programme, including for hypertension for which there is a high prevalence in the borough, is a key part of our approach to early identification and prevention.	Not applicable.	The scope to address the data issue is limited as one trust has identified that there are approximately 30,000 records recorded as transfers from other trusts instead of from usual place of residence. This volume of records means that correcting them would be too resource intensive. As this measure will not be a national BCF metric for 2025/26 it is not proposed to commit resources to developing a work around for 2024/25. Collecting meaningful data during 2025/26 to inform reporting on the emergency admissions target and support the setting of any emergency admissions target in 2026/27 would be dependent on a fix being made to the front end of the Cerner PAS system to ensure that transfers are correctly reported. This has been raised with the national team.
Discharge to usual place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence.	92.0%	91.5%	92.1%	91.2%	92.56%	Target met	There were issues faced with Bridging Care capacity during Q3, which was linked to Reablement capacity and was addressed via Discharge Fund. This assisted with recovery of P1 discharge volume.	Not applicable.	Not applicable.	Not applicable.
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				1,949.0	562.5	Target not met	Projections continue to show a reduced number of falls-related attendances at acute trust emergency departments but a higher conversion rate to admissions. This suggests increased acuity of attendees. Data on falls-related attendances and admissions from care homes indicates an increase on previous years. Turnover of staff in care homes presents a challenge for the sustainability of falls prevention training. See *Mitigation for recovery*.	As reported at Q3, a Falls Prevention Service provided by CNWL and funded through NHS additional contribution continues to support people who have fallen and those living with frailty at risk of falling referred via Neighbourhood Teams. Age UK also provides an 8-week, evidence-based falls prevention exercise programme either in people's homes or in group settings at Northwood Health Centre and Riverside Unit. During 2024/25 community-based strength and balance exercise programmes were	The projected outturn is 2,512.85 against a target of 1,949. See *Mitigation for recovery*.	The deep dive into the support model for care homes is in progress and aligns with a broader review being undertaken across the ICS. The effectiveness of investment in the current falls prevention services will be undertaken during 2025/26 and the approach to addressing frailty continues to evolve.

						delivered by the Public Health Team with 524 participants and 5,917 attendances. Falls education workshops in libraries also took place with 117 participants.		
Residential admissions	Rate of permanent admissions to residential care per 100,000 (65+).	701	Not applicable	Target met	Key challenges include a) the high conversion rate of short-term placements to permanent, i.e., 78%, which continues the trend in previous years; b) an increase in number of people aged 85 + living with higher levels of acuity; c) ageing carers also living with their own physical and mental health issues. As previously stated, ASC has a robust process in place to ensure that permanent placements are only made where this is the most appropriate means of addressing assessed need.	The 2024/25 outturn was 199 admissions against a ceiling of 320, which gives an annual rate of 435.71 using the population figure in the planning template against a ceiling of 701 (see cell G15). As previously report, the availability of a high performing Reablement Service and therapy provision through CARS team in community helps to support people in their usual place of residence. Extra care provision acts as a realistic alternative to care home placements. The carer support model also facilitates carers continuing in their caring role.	Not applicable	Not applicable