How the Better Care Fund helps tackle health inequalities in Merton

Introduction

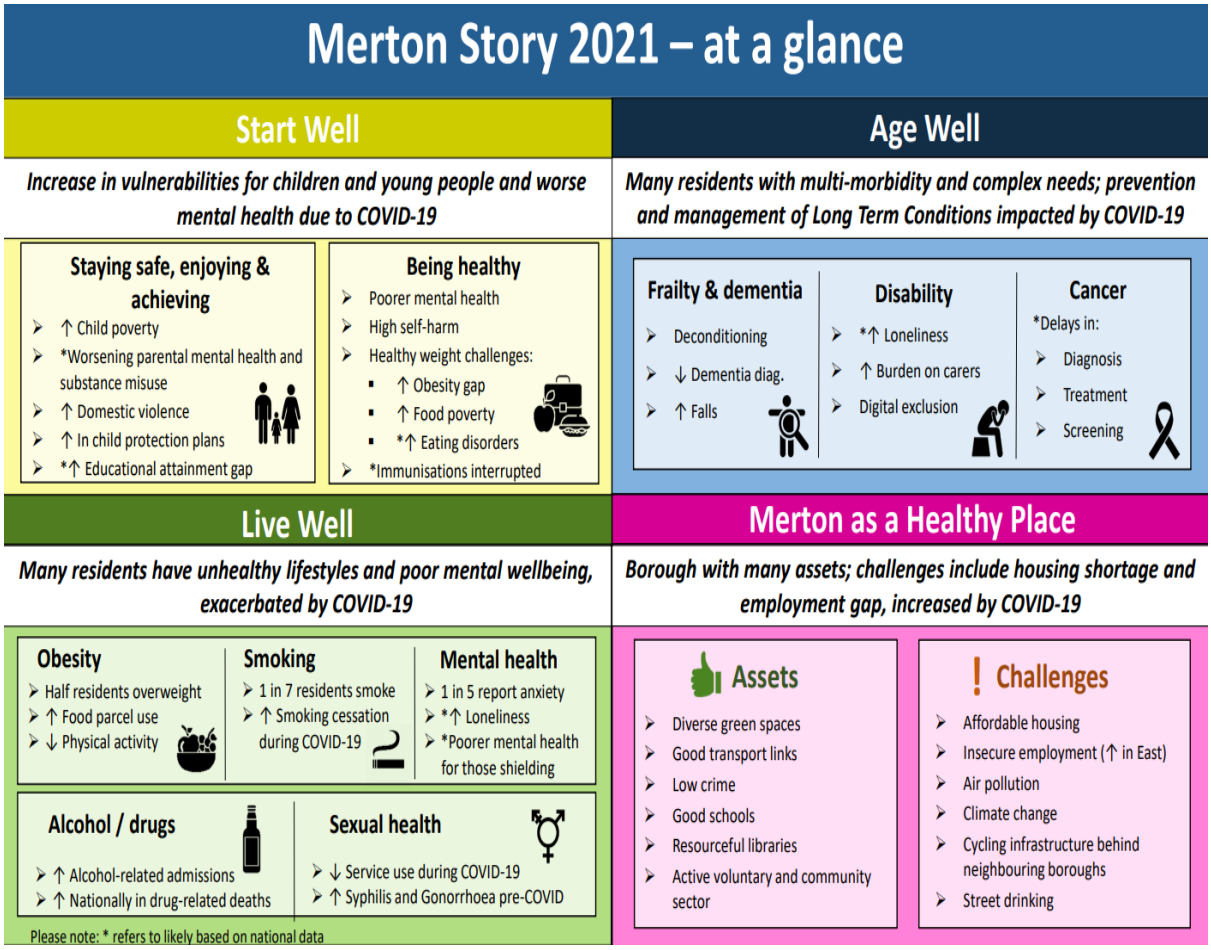
The Better Care Fund (BCF) is one of the government's national vehicles for driving health and social care integration. There are two key policy objectives in 2022 to 2023:

- enable people to stay well, safe and independent at home for longer
- provide the right care in the right place at the right time

Part of the conditions of the BCF requires areas to agree a plan that sets out how health and social care will work together, and use BCF funding, to improve outcomes for each of these objectives.

Alongside the BCF submission for 2022/23, this report summarises how the BCF is currently spent, its impact on tackling inequalities and what are next steps are to help address this key issue.

Health Inequalities in Merton -The Merton Story



The focus of the BCF has been to support those with multi-morbidities and complex needs who are most at risk of hospital admission or requiring long term residential care to remain well and independent at home, and where support is required for this to take place in the community, where possible. This approach has focused on the people who need services most, many of whom will have health inequalities.

Population Health Management and Core 20 Analysis

We now have additional opportunities through population health management and use of Core20 data to support the reduction of health inequalities and potentially target those most at risk with support before their health deteriorates further.

Core20 analysis for South West London indicates 16% of Merton residents are in the Core20 population, of which approximately 29,000 live in East Merton, where there is deprivation in housing and environment, a significant school aged and older working age (44-64) population and is ethnically diverse.

Of this population, 31% have one or more long term conditions and this population is 43% more likely to be obese and 67% more likely to be diagnosed with a mental health condition.

Approaches to support the reduction of inequalities

To enable more people to maintain their independence for longer, in addition to supporting 'Home First' models, we aim to improve the health and wellbeing of Merton residents through enhanced access to community and voluntary sector services and greater sharing of assets and expertise as well as reduce health inequalities.

The workstreams in place to achieve this involve multiple agencies and for 22/23 include:

Proactive and preventative services, Integrated Locality Teams, providing proactive care for those at highest risk by providing personalised care and support in people's own homes. Within this cohort the multi -agency teams are able to prioritise those in greatest need of this approach within the GP practice footprint. BCF funding includes:

- A wide range of services from Central London Community Health, our community provider.
- Health Liaison Social Workers
- Age UK living well co-ordinators and Alzheimer's Society co-ordinators linked to PCNs
- Continued support for the most vulnerable through the Community Response Hub
- Improved response to crises and more effective reablement- working with the expanded rapid response service to respond to crises and work more closely across health and social care offers, including use of 24-hour care for short periods if required (linking to virtual wards as appropriate).

- Increasing the capacity within social work and significant recruitment to the reablement team which includes support for admission prevention.

Key to supporting recovery, especially older, frailer residents is through reducing length of stay in hospital and the BCF funding works to improve discharges through improved joint pathways with integrated teams enabling faster discharges from hospital, with the full implementation of discharge to assess and the focus on increased access to reablement alongside domiciliary packages of care where required.

The aim is to continue to build on this in 22/23 and maintain the flow within the challenges of increased pressures and workforce challenges.

- Funding Intermediate Care provision, working on home first models through increases in rehabilitation and reablement (linked to discharge to assess) to enable faster discharges from hospital. Work has started on a redesign of these services which should enable a more integrated and cost- effective model
- Increase capacity over 7 days and for community equipment
- Daily discharge discussions and escalation meetings to support patients to be as independent as possible.

Support for the most frail and those with the highest need for services –

- Integrated working across agencies to support improved quality of care and reduce unnecessary admissions to hospital by offering enhanced support to care homes including a care home support team which is now in place.

In addition to the approaches highlighted above, we are working with the voluntary and community sector to support older people to re-engage with and access community resources for their health and wellbeing post Covid. Continuing the Community Response Hub, alongside social prescribing and case management through the Integrated Locality Teams, we aim to ensure we have the services in place to deliver services to match people's needs to deliver person centred care.

We know people in East Merton have worse health and shorter lives, so a range of services commissioned through BCF funding support those in most need in this area and where required across the borough.

Areas of specific note include:

- The Community Response Hub which initially started in response to the COVID 19 pandemic, but identified an ongoing need for independent advice and support.
- Living Well Service run by Age UK to improve physical and mental wellbeing
- Funding the voluntary sector to reduce factors that increase the likelihood of presentation to health or social care, including an enhanced lunch club offer, improving heating and insulation, supporting access to benefits and helping with small grants for energy, food and clothing.
- Reducing isolation especially amongst older men through our music workshops- Tuned In (A single has just been produced called Uptown Lockdown)

- Contribution to Social Prescribing, which has a particular focus on those areas and individuals where there is social complexity
- Falls and other prevention initiatives including ‘Merton Moves’ and ‘Happy and Active in Merton’ linking with libraries around digital inclusion
- Support for the Alzheimer’s Society and the Dementia Hub in Merton to support those with Dementia and their carers, funding to support Carers Support Merton, through funding night sitting services from Marie Curie and by contributing to the Ageing Well Programme which invests in and supports Merton’s local voluntary and community infrastructure, bringing together preventative services that provide information, advice and support in the community to strengthen Merton resident’s physical, social, emotional, and economic resilience and works to address inequalities within our borough.

Work to Reduce Inequalities through the Disabled Facilities Grant (DFG) includes:

- Hospital to home assistance and assistance with preventing admission or re-admission to hospital, e.g. blitz cleans, moving furniture and basic equipment e.g. bed/bedding.
- Relocation Assistance and Emergency Adaptations
- Dementia Friendly Aids and Adaptations Grant
- Helping Hand Service for Low Level Hazards
- Help with Energy Efficiency.

Further Activities in 22/23

Merton is addressing health inequalities in a range of ways including use of population health management, both at place and at PCN level and a series of workshops focusing on use of this approach to support those with frailty are about to take place. The aim of this is to help focus our resources on those with greatest need and who may not currently access services and along the priority of those with frailty, look at how we can support CORE 20 plus 5 initiatives. The findings from this work will feed into the longer term ambitions as part of planning for 2023-25.