

Understanding population-level need for Adult Social Care support in Tower Hamlets

Adult Social Care JSNA Chapter

Final version - edited July 2024



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Headline messages and recommendations



Headline messages



In almost all areas, trends in self-reported health and disability are reflected in trends in social care need – this means preventing ill-health is the best way of reducing future need for long-term adult social care support.



Socio-economic conditions in Tower Hamlets increase and shape patterns of social care need, with residents living in more deprived areas more represented in services. Need also varies by ethnic group: for our older adult population, residents in Bangladeshi, Black African and Black Caribbean ethnic groups are more represented in social care services relative to other ethnic groups.



Prevalence of long term conditions and multimorbidity are significantly higher in social care service users across all ages, contributing to ill-health. In younger age groups, prevalence of modifiable risk factors (smoking, obesity) are also higher in social care service users than in the population as a whole. This presents opportunities and priorities for prevention.



Despite this, there are indications those receiving adult social care support were less likely to have attended a GP appointment compared with the population overall, raising possible issues around management of long term conditions.



Social care services in Tower Hamlets are seeing two major trends: an increase in the number of service users aged 18-64 (with falling numbers of older adults), and an increase in the intensity of home care support for older adults that isn't reflected in younger ages. Combined, these factors are driving increases in the amount of support provided.



Proposed whole-system recommendations for addressing social care need in Tower Hamlets



Recommendation	Identified by:	Priority	Division lead
Additional analysis/expanding our understanding of social care need			
Continue to look at patterns of health and disability at a population level in Tower Hamlets, as a means of understanding potential future need for adult social care support and population groups with high need.	Stakeholder workshop	Medium	Public Health, ASC
Explore possible "under-representation" of service users living in most deprived areas, and ensure commissioning and service planning in social care considers area deprivation	Project group; stakeholder workshop	High	ASC, Public Health
Improve data recording in Adult Social Care around protected characteristics and health conditions to improve understanding of population level need for care and inequalities. Participate in NEL initiatives to link primary care and social care datasets to understand health needs of social care service users.	Project group	Low	ASC, Public Health
Conduct additional analysis to understand drivers behind male/female gap in health and social care outcomes	Project group; stakeholder workshop	High	Public Health, ASC
Develop a series of research questions that build on the findings from the JSNA Chapter, to use qualitative methodologies to understand social care need, working with an academic partner	Project group	High	All
Addressing risk factors associated with increased need for adult social care support			
Develop a prevention strategy for Adult Social Care that links into wider prevention plans within THT, with a focus on factors driving social care need (e.g. reducing modifiable risk factors, improving LTC management, reducing multimorbidity). Target prevention for population groups with high need for social care support	Project group (in development)	High	All
Improve pathways for prevention-focused services (e.g. smoking cessation, weight management, Communities Keeping Well) to link with ASC cohorts and at-risk cohorts, focused on key risk factors associated with social care need: multimorbidity, social isolation/living alone, deprivation, age-related factors.	Stakeholder workshop	Medium	All
Develop training for social care practitioners and encourage practitioners to have MECC conversations around key health risk factors – e.g. on the Vital 5 – as part of routine care. Also embed this approach into Tower Hamlets Connect and Initial Assessments process.	Stakeholder workshop	High	Public Health, ASC
Amplify current support around social isolation and loneliness, particularly for those receiving social care support and for those who live alone, and identify opportunities for any additional services to meet these needs across public health and integrated commissioning.	Stakeholder workshop	Medium/Low	Public Health, ASC
Supporting the health of those who currently need social care support, or who may need support in future			
Support the Localities and Neighbourhoods programme in developing approaches to integrated working across health and social care services.	Stakeholder workshop	High	All
Improve access to GP appointments for social care service users through early access appointments/developing improved pathways.	Stakeholder workshop	High	Integrated Commissioning, ASC
Review the value of NHS contributions for social care support where LTCs/ multimorbidity are a factor in support need; and ensure equity across NEL Places, and appropriateness to need.	Stakeholder workshop	Medium	ASC, NEL ICB.
Expand work with the Carer's Centre in Tower Hamlets to design health interventions that support the health of carers and those in receipt of unpaid care, and ensure outreach and pathways to support carers to access routine preventative services.	Project group	Low	ASC, Integrated Commissioning, NEL ICB
Improve support plan review process to consider how easily care can be stepped up/down as needs change.	Stakeholder workshop	Medium	ASC, Barts, NEL ICB.
Continue to support pilots within reablement that facilitate closer working between health and social care service teams.	Stakeholder workshop	Medium	ASC

Background and conceptual framework



Background



Why we have developed an Adult Social Care JSNA Chapter:

- Tower Hamlets has high demand for adult social care services given population demographics. Short and Long Term (SALT) data returns show Tower Hamlets has the second highest rate of long term social care service users per 100,000 population for adults aged 65+.¹
- Tower Hamlets also has relatively high adult social care spend, both per head and overall, relative to the demographic profile of the borough.¹
- While population health data suggests high levels of need for “adult social care support” (e.g. high rates of self-reported disability and unpaid care provision), to date there hasn't been an attempt to explore the relationship between population health and wellbeing, adult social care need, and health and care service utilisation in Tower Hamlets.
- The JSNA chapter explores population-level need for adult social care support and the factors associated with this, with a view to understanding how services meet needs and where there may be opportunities for prevention-focused approaches to improving health and care outcomes.

Our approach to developing this report:

- We developed a conceptual framework (see below) to shape this report, guided by literature on how to understand ‘Need’ in adult social care, and by input from our Steering Group.
- This report brings together insights from public datasets (including the Census, Carer's Surveys and other insights), health data from primary care, Local Authority Adult Social Care data and outputs from the Whole Systems Dataset Project (WSDP) linked data, to explore the inter-relationships between health needs and social care needs in Tower Hamlets. We have also relied on academic literature to provide insights into factors that drive social care need, and to build the evidence based around prevention approaches to reduce social care need.
- This is principally a quantitative report, with some qualitative insights collected from staff working across the health and care system in Tower Hamlets, in Local Authority public health, adult social care and integrated commissioning.
- We have adopted a broad approach to “social care need”, considering unpaid care and self-funded care as essential elements of the care infrastructure in the borough. However, limited data across these two domains has restricted our ability to explore this in detail.
- We also attempt to predict how need for Local Authority funded social care support might change in future, noting the large number of modifiable factors that influence this (including demographic changes and changing socio-economic and health conditions).



Principles of the Adult Social Care JSNA chapter



Population-level view of adult social care support 'need' in Tower Hamlets – *not* just focused on those already receiving Local Authority support



Placing need for adult social care support within its wider context – health, socio-economic and demographic factors



Consideration of unpaid or informal care and self-funded care as part of the broader "care infrastructure" in which social care needs are met, while recognising limited data and insights exist in this space



Analysis of inequalities as a central objective for this work



Adopting a prevention-focused approach to recommendations – identifying opportunities for whole-system approaches



We developed a conceptual framework to explore the relationship between social care need, and demand for and supply of support

- The conceptual framework has been developed using principles for defining need, demand and supply in healthcare, while accounting for the different landscape in adult social care.^{2,3}

CONTEXTUAL FACTORS DRIVING NEED FOR ADULT SOCIAL CARE (SCOPE PART B)[#]

- Health characteristics – e.g. long term conditions, multimorbidity, frailty
- Socio-economic characteristics – deprivation, housing, employment
- Demographic characteristics

NEED FOR ADULT SOCIAL CARE (SCOPE PART A)

DEMAND FOR CARE (SCOPE PART C)

ADULT SOCIAL CARE SUPPORT (SCOPE PART D)^{*}

POPULATION GROUPS ASSOCIATED WITH NEED FOR ADULT SOCIAL CARE SUPPORT (SCOPE PART A (ii)):

OLDER ADULTS (AGED 65+)

ADULTS WITH A LEARNING DISABILITY

ADULTS WITH A PHYSICAL DISABILITY

ADULTS WITH MENTAL HEALTH NEEDS

ADULTS WITH OTHER NEEDS

CARERS

INFORMAL CARE

SELF-FUNDED CARE

LOCAL AUTHORITY FUNDED/DELIVERED CARE

CROSS-CUTTING AREAS IDENTIFIED IN SCOPE:

- Inequalities (scope part E)
- Future need for ASC support (scope part F)
- Recommendations (scope part G)

[#] Includes populations with risk factors associated with ASC support need but not currently in need of support

^{*} Three broad types of care listed but may not cover all care arrangements and are often overlapping



Based on the conceptual framework, a scope was defined for the ASC needs assessment



In scope:

- a)  Contextual factors associated with need for adult social care support
- b)  Population-level need for adult social care support, through three broad “lenses”:
 - I.  Wider measures of ASC support need: Activities of Daily Living (ADL) and self-reported health
 - II.  Population groups associated with ASC support needs (e.g. adults aged 65+)
 - III.  Populations that we know are currently receiving adult social care support, through Local Authority and through other means (self-funders, informal care etc)
- c)  Demand for Local Authority provided/funded adult social care services in Tower Hamlets
- d)  How ASC support needs are currently met, both through Local Authority provision and wider support
- e) Inequalities in adult social care support, in relation to wider health and social inequalities in Tower Hamlets
- f) How social care support needs in Tower Hamlets are likely to change in future
- g) Recommendations for ASC service design and delivery, and opportunities for primary and secondary prevention

Out of scope:

- 1. A service evaluation of adult social care services – though the process and outcomes of services will be considered.
- 2. Financial analysis or cost-benefit analysis of adult social care services.
- 3. Detailed insights into the process for adult social care delivery – though an overview of services will be in scope.
- 4. Children's social care services may be considered as part of understanding the transition to adult social care, but this will not be explored in detail.

Governance

The development of the scope was done through consultation across Tower Hamlets Council's Public Health, Adult Social Care, and Integrated Commissioning teams, with input from Tower Hamlets Together, Carers Centre Tower Hamlets and additional relevant stakeholders through sub-groups of the THT Executive Board, Living Well and Promoting Independence. Recommendations from the report were also developed in consultation with partners listed above.



Methodology – further details in Appendix B



- This needs assessment has gathered information from various sources, including publicly available datasets on population demographics (such as the 2021 Census), primary care and adult social care datasets, insights from relevant academic literature, and qualitative insights from senior commissioners and practitioners in Adult Social Care.
- We recognise that resident involvement, particularly from those who are impacted by adult social care in Tower Hamlets either directly or indirectly, is invaluable in understanding need for social care support and the impact of services on residents. Given time restraints during the production of this report, we have not included an expanded qualitative approach to collect service user views. To address this in future, we have included in the recommendations that identified “research questions”, informed by the findings of this report, are explored using qualitative methods with the support of a research partner. We are also aware that there are existing processes for collecting service user insights, for example through the Adult Social Care Service User Survey (ASCS) that can and should be used to provide some insight in this regard.
- Qualitative insights from service professionals have been collected through group sessions and interviews with staff working across Adult Social Care, Public Health and Integrated Commissioning, as well as from wider partners through the governance structures for the project on slide 10.
- Further information on analysis conducted in each chapter of this report is detailed in the additional methodology notes in Appendix B.
- Where possible, in addition to the technical information we have attempted to highlight where there may be methodological limitations with the analysis and/or where caution should be applied to interpret findings in the main body of the report. This is particularly relevant in sections relating to the Whole Systems Dataset Project (WSDP), and analysis reflecting changes in social care service provision and intensity over time. Where this is noted, we would suggest findings are taken as indicative of broad trends, given issues around data quality and methodological limitations.



Understanding demographic, socio-economic and health factors that drive social care need in Tower Hamlets



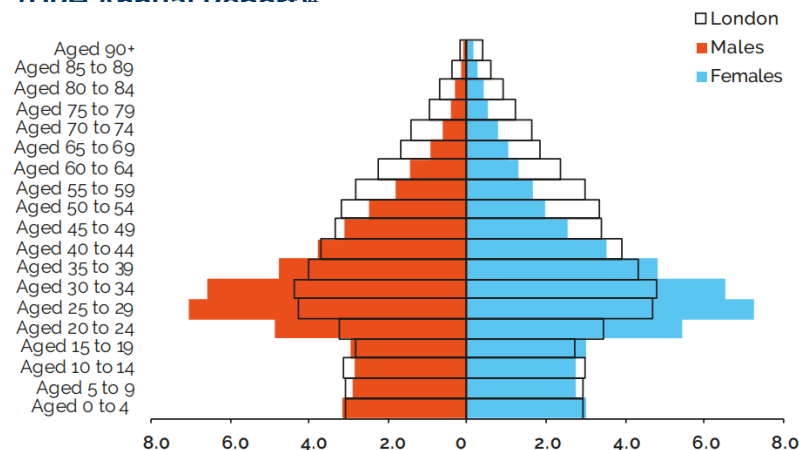
Demographic and socio-economic factors impact health and social care need



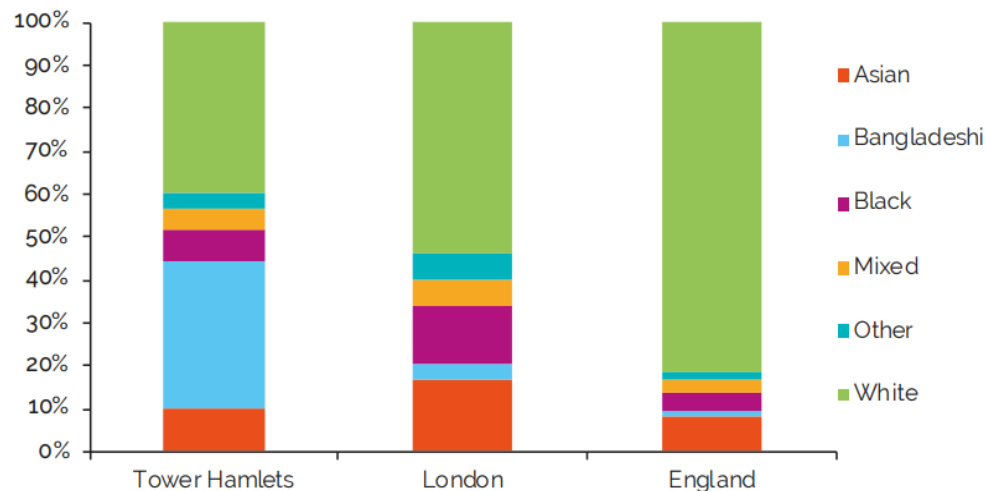
- **Context to Tower Hamlets demography – three important factors⁴:**

- **Age;** one of the youngest Local Authorities in England, with relatively few older adults (age 65+).
- **Ethnic group diversity:** with around 34% of residents in the Bangladeshi ethnic group, the highest proportion of Bangladeshi residents in the country.
- **Deprivation:** 50th most deprived Local Authority in 2019; 10th most deprived in 2015.

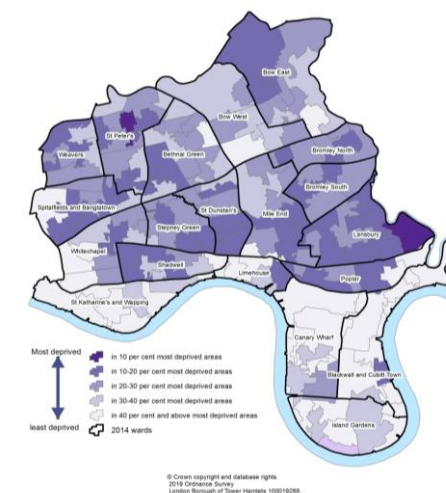
Proportion of population per 5-year age band by gender, Tower Hamlets and London, 2021 Census (DPH Annual Report)⁴



Ethnicity distribution in Tower Hamlets, London and England, 2021 Census (DPH Annual Report)⁴



2019 LSOA IMD deprivation map, Tower Hamlets (Borough Profile 2020)⁵

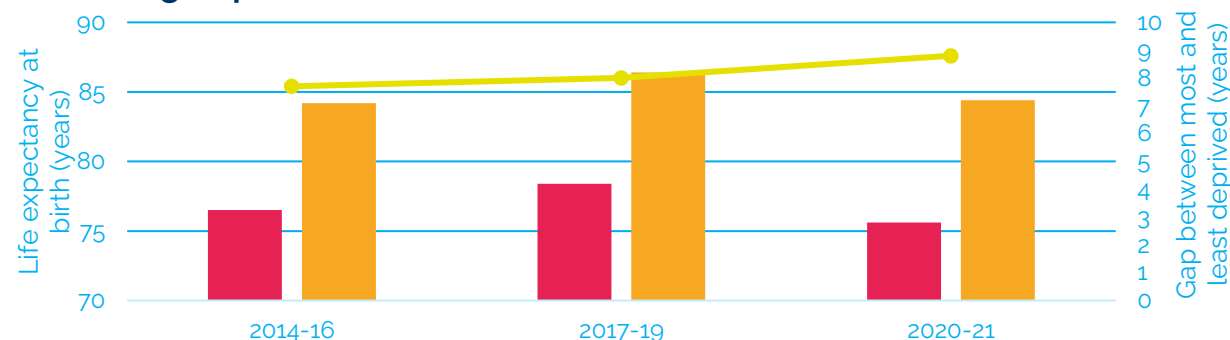


While life expectancy has increased in Tower Hamlets overall, inequalities in life expectancy between the most and least deprived groups have widened

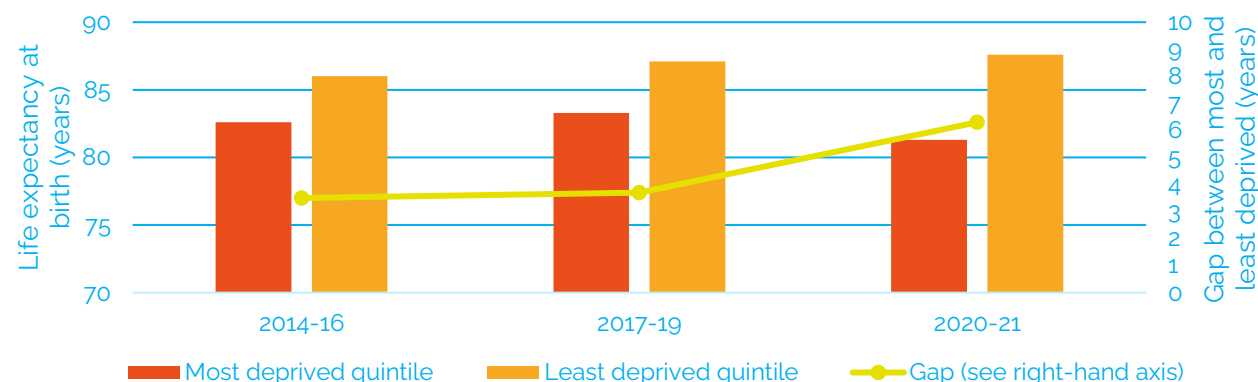


- There has **been a steady increase in life expectancy for both males and females in Tower Hamlets since the start of the 21st century**, with exception of a small drop at the start of the COVID-19 pandemic. In 2018-20, the average life expectancy at birth was 79.9 years for males and 83.3 years for females in Tower Hamlets^{6,7}.
- **Inequalities in life expectancy between residents living in the most and least deprived areas in Tower Hamlets have widened.** In 2020/1, males living in the most deprived areas in Tower Hamlets has a life expectancy 8.8 years shorter than males in the least deprived areas. For females, the equivalent gap is 6.3 years⁶.
- For both males and females, **the gap has increased since 2014-16 i.e. the life expectancy for those living in the least deprived areas has increased faster than among those living in the most deprived areas. Concerningly, there is some evidence life expectancy has *fallen* in the most deprived areas since 2017-19⁶.**

Male overall life expectancy at birth in Tower Hamlets and gaps in life expectancy between most and least deprived quintile (OHID Fingertips dashboard⁶),



Female overall life expectancy at birth in Tower Hamlets and gaps in life expectancy between most and least deprived quintile (OHID Fingertips dashboard⁶),

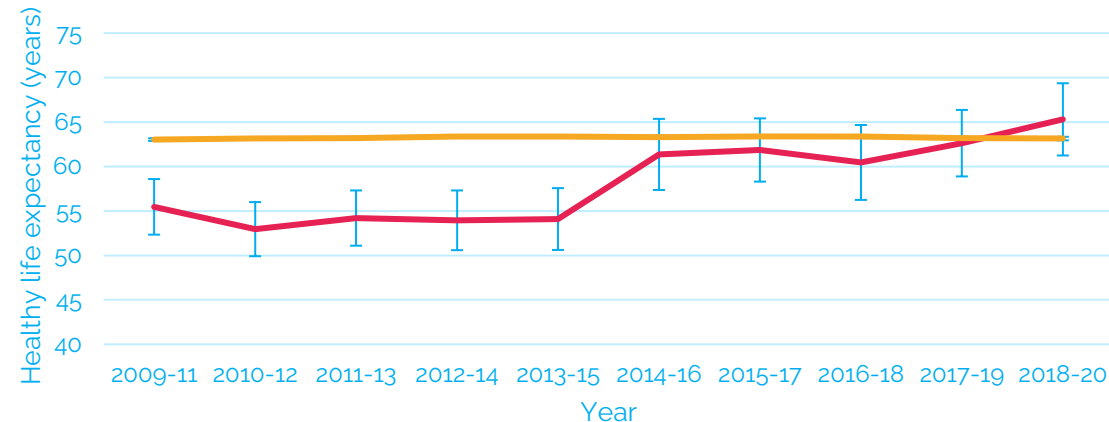


Females in Tower Hamlets live fewer years in good health compared with males. This is an unusual trend in healthy life expectancy expectancy

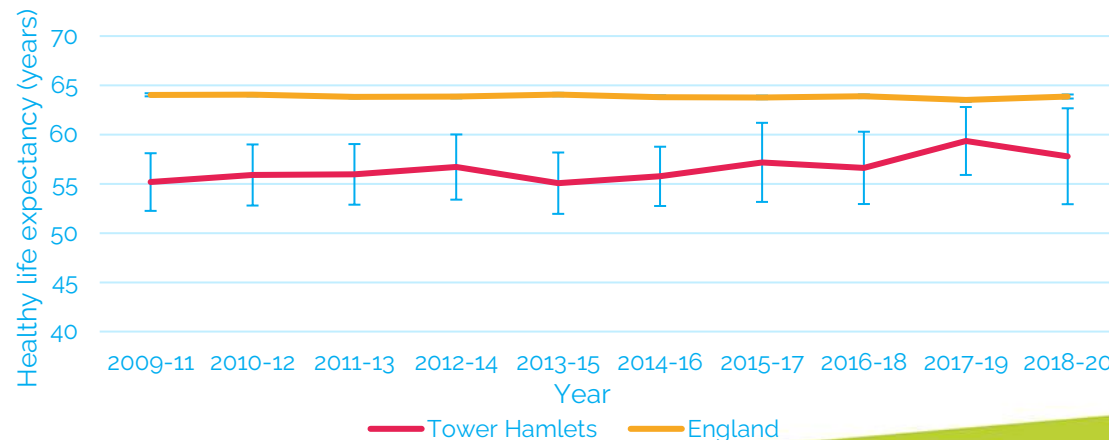


- **There is a known disparity in healthy life expectancy between males and females in Tower Hamlets;** on average, females live 7.5 years fewer in good health than males^{6,8}. This is not the case elsewhere; across London, females live an average 1.2 years **more** in good health).
- Overall life expectancy is similar between sexes, so the sex differential in healthy life expectancy is not driven by mortality differences, but by sex differences in self-reported health.
- **Self-reported health is poor in Tower Hamlets;** the proportion of residents (9.5%) who report being in "Bad" or "Very bad" health is 83% higher than the national average⁹.
- **These patterns in healthy life expectancy are reflected in those receiving social care support - there are higher proportions of females than males in receipt of social care support in older ages.**

Male healthy life expectancy at birth, Tower Hamlets and England averages (OHID Fingertips dashboard)^{6,8}.



Female healthy life expectancy at birth, Tower Hamlets and England averages (OHID Fingertips dashboard)^{6,8}.

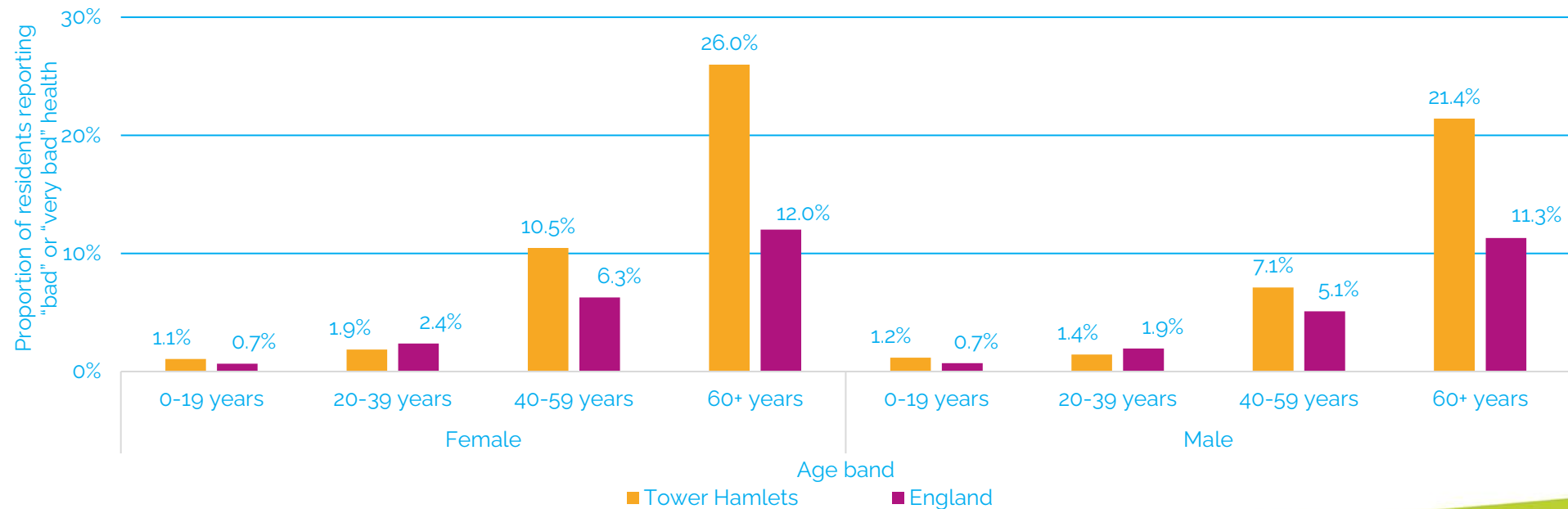


Female self-reported health is worse than males' in Tower Hamlets, and is worse than London and England averages



- Except for those aged 20 to 39, across all age bands a **higher proportion of Tower Hamlets residents report being in poor health compared to England**. A **greater deviation from the national average was seen in females compared with males**; this is particularly stark in older females (aged 60+)⁹.
- A higher proportion of female Tower Hamlets residents (11.6%) reported being in "Bad" or "Very bad" health compared to male residents (8.5%). **The proportion of females in Tower Hamlets who report themselves in poor health is substantially higher than the proportion of females in London overall**. The gap for males is much smaller⁹.

Proportion of people reporting "Bad" or "Very bad" health in Tower Hamlets and England, by age and sex (2021 Census).

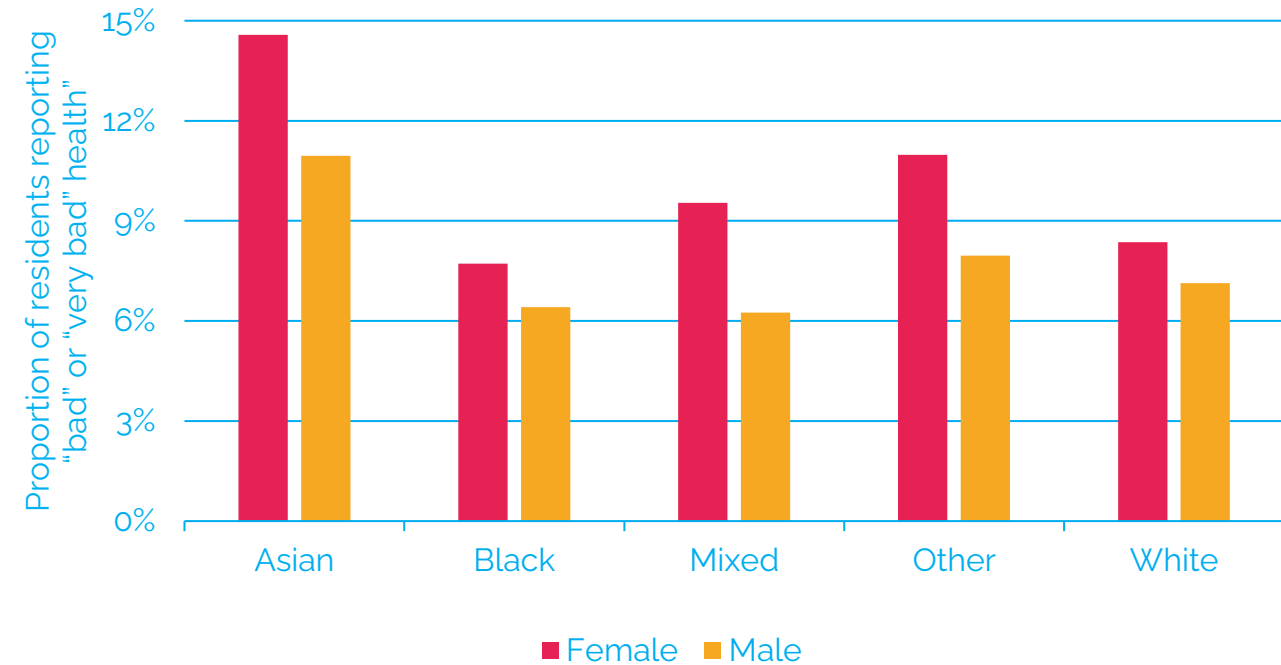


Female self-reported health is worse than males across all ethnic groups, with largest variations in Asian and Mixed ethnic groups



- Asian residents in Tower Hamlets had the highest proportion of respondents reporting “Bad” or “Very bad” health of any ethnic group in Tower Hamlets.
- Larger **differentials in self-reported healthy by sex** were **seen in Asian and Mixed ethnic groups** compared with White ethnic groups⁹.
- These findings **partly reflect those receiving social care support** in Tower Hamlets – there are a higher proportion of Bangladeshi females than males receiving social care support in older ages. However, Black residents (particularly females) have low rates of poor self-reported health but are over-represented in social care services compared with other ethnic groups.

Age-standardised proportions of Tower Hamlets residents reporting “Bad” or “Very bad” health, by sex and ethnic group (2021 Census)⁹.

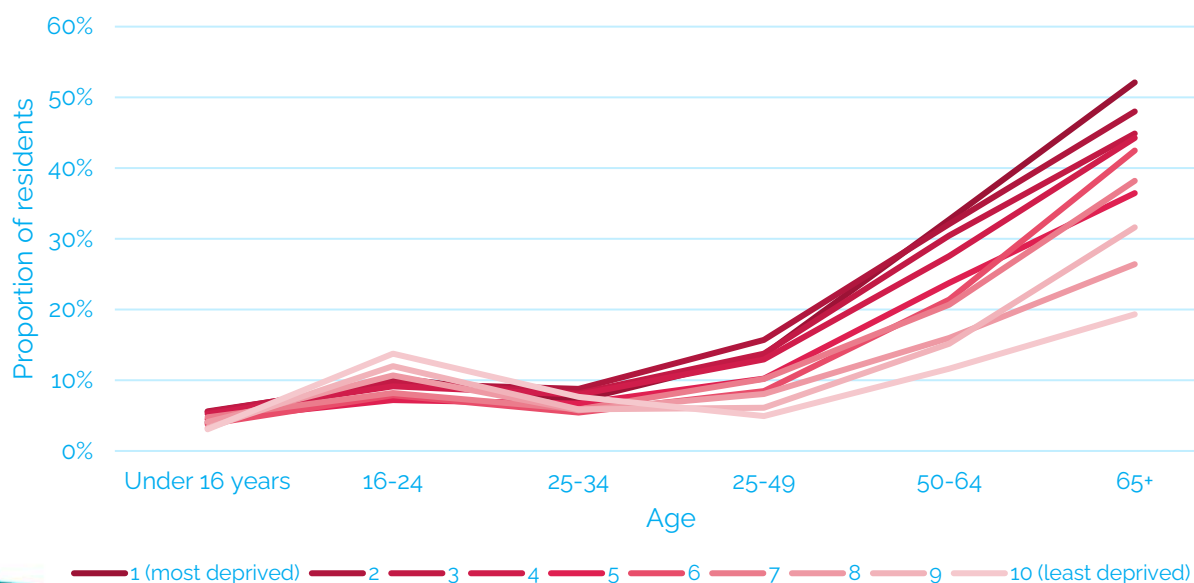


The proportion of residents living with a self-reported disability increases with age, and those living in the most deprived areas have higher rates of disability in older age groups



- Census data shows the impact of social inequalities on rates of self-reported disability. In Tower Hamlets, while rates of self-reported disability by deprivation decile are broadly similar in age bands up to 35, **by age 50 to 64 residents in the most deprived decile are almost three times more likely to have a self-reported disability than those in the least deprived decile.**
- In older adults (aged 65+), over half of Tower Hamlets residents living in the most deprived IMD decile have a self-reported disability, 2.5 times higher than those living in the least deprived decile⁹.**
- As with self-reported health, inequalities in self-reported disability are also reflected in social care service users, where those living in more deprived areas are over-represented in services.

Proportion of Tower Hamlets residents with a self-reported disability, by age band and national IMD deprivation decile (2021 Census).



Proportion of residents aged 65+ with a self-reported disability, by national IMD deprivation decile (2021 Census)⁹.

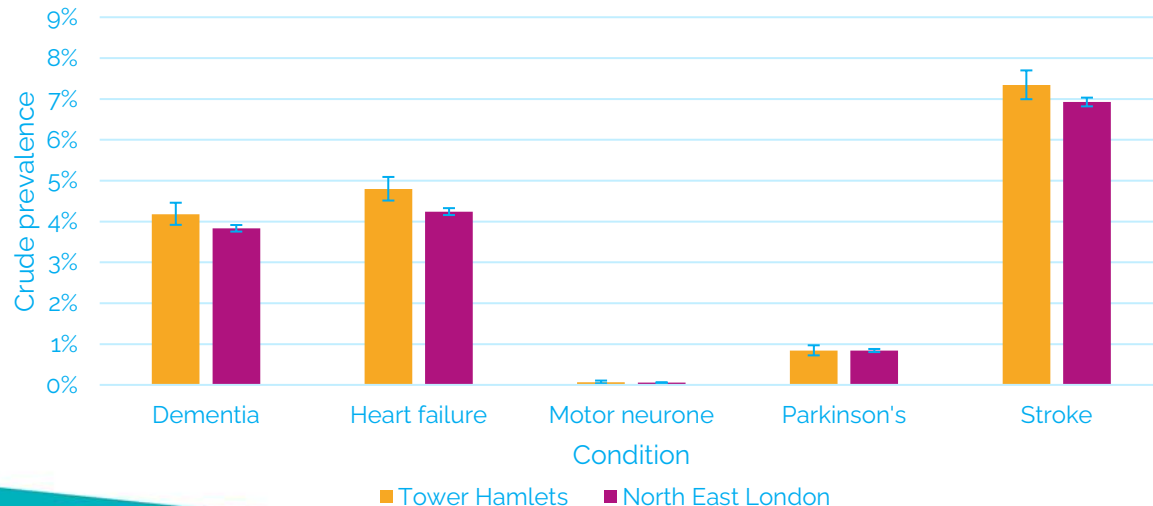


Older adults in Tower Hamlets have slightly a higher prevalence of conditions most strongly associated with social care need compared with neighbouring boroughs, but this is not significant

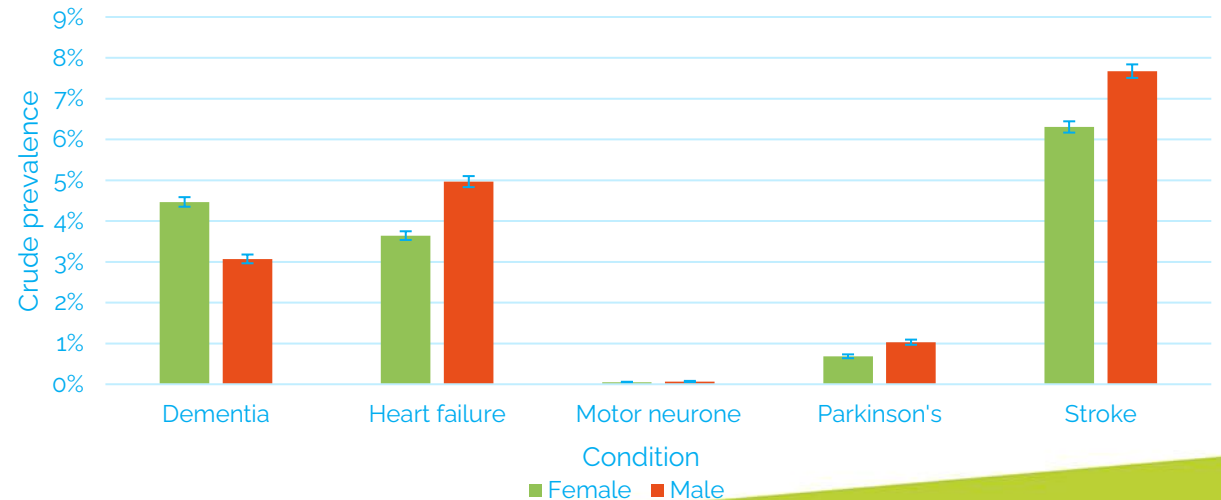


- 2018 data from the Health Foundation explores the link between social care need (defined as needing support performing Activities of Daily Living) and long-term conditions – with the **five conditions most strongly associated with social care need being motor neurone disease or MS, Parkinson's, dementia, heart failure and stroke**¹⁰. The data below compares prevalence of these conditions in Tower Hamlets with North East London in adults aged 65+.
- In Tower Hamlets, older adults (aged 65+) have a higher crude prevalence of conditions associated with social care need compared with older adults in North East London, but this is not significant in most cases.
- Males in Tower Hamlets have notably higher prevalence of heart failure, Parkinson's and stroke** compared with females. Conversely, prevalence of dementia is higher in females.

Crude prevalence of long term conditions associated with high social care need, in Tower Hamlets and North East London residents aged 65+ (East London Database 2022-23).



Crude prevalence of long term conditions associated with high social care need in Tower Hamlets residents aged 65+, by sex (East London Database 2022-23).

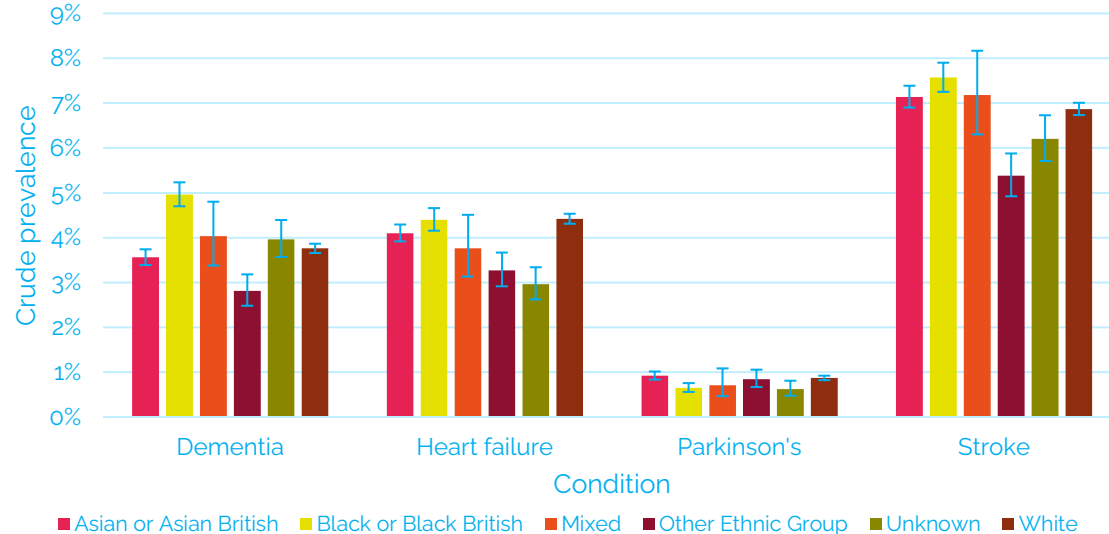


Black residents and those living in more deprived areas have the highest prevalence of conditions most associated with social care need

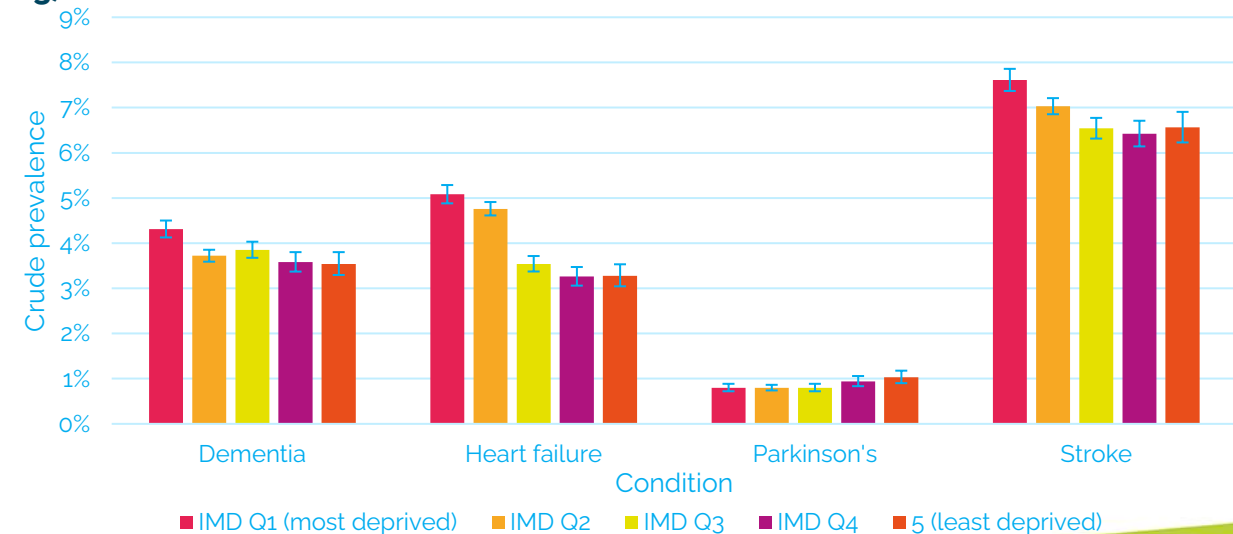


- Prevalence of conditions associated with high social care need **varies by ethnic group and by deprivation**. Prevalence of dementia is higher in Black ethnic groups, while those in Other ethnic groups have low prevalence of dementia, heart failure and stroke.
- Those living in **more deprived areas have a higher prevalence of dementia, heart failure and stroke** as recorded in primary care records, while the reverse is true for Parkinson's.
- Motor neurone disease – another condition associated with ASC need - has been removed from the analysis below due to very low prevalence.

Crude prevalence of long term conditions associated with high social care need in Tower Hamlets residents aged 65+, by ethnic group (East London Database 2022-23).



Crude prevalence of long term conditions associated with high social care need in Tower Hamlets residents aged 65+, by national IMD deprivation quintile (East London Database 2022-23).

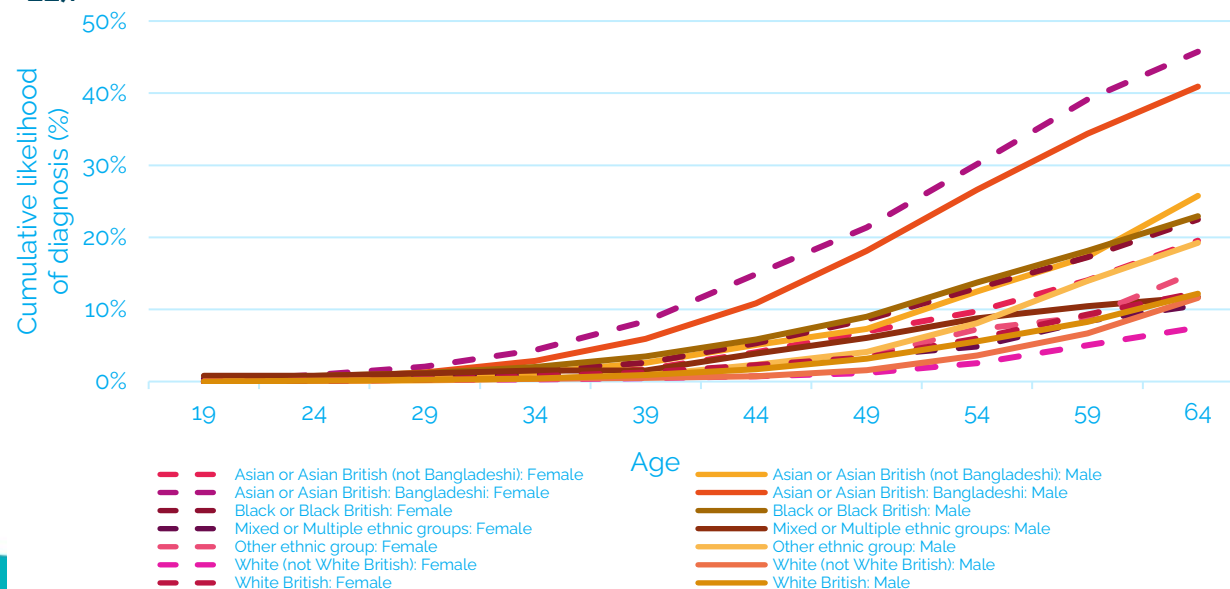


In Tower Hamlets, likelihood of diagnosis of many conditions varies between ethnic groups – this may contribute to differences in social care need

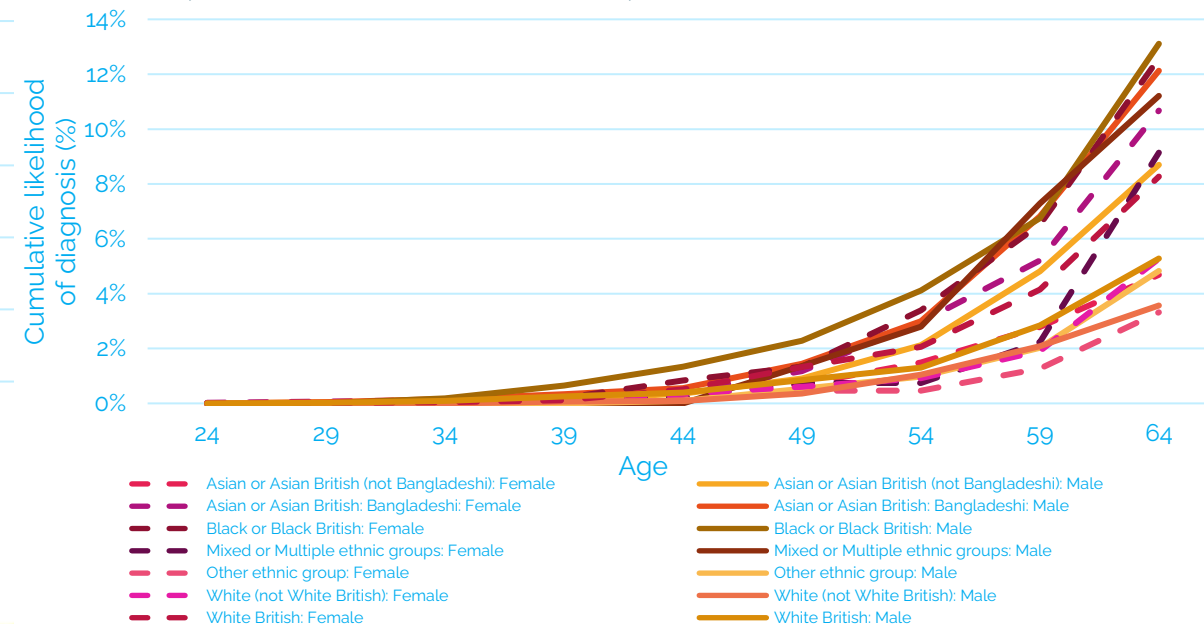


- For many conditions associated with an increased need for adult social care support (e.g. stroke, diabetes, CKD), Bangladeshi residents are more likely to be diagnosed with the condition overall, and are more likely to be diagnosed earlier in life, compared with other ethnic groups.
- In general, **this gap in likelihood of diagnosis widens as age increases** (up to age 64), meaning those in the Bangladeshi ethnic group are more likely to be diagnosed earlier and live for longer with conditions than other ethnic groups.
- This trend is not consistent across all conditions.** For example, residents in White ethnic groups have a higher likelihood of being diagnosed with cancer and chronic obstructive pulmonary disease (COPD).

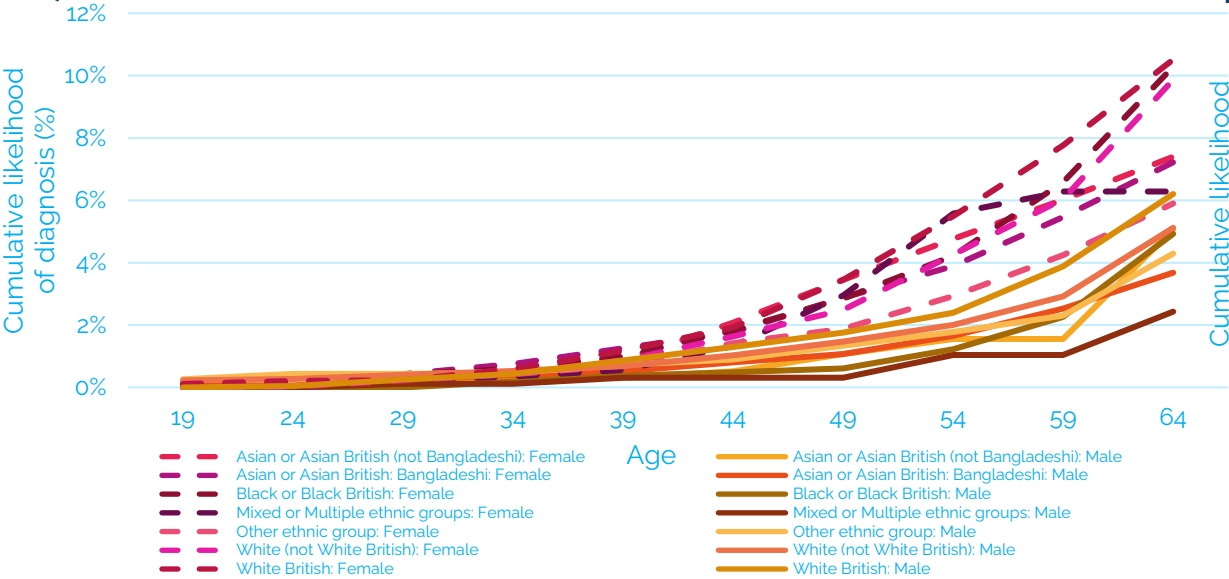
Cumulative likelihood of being diagnosed with diabetes by age, ethnic group and sex, Tower Hamlets residents (East London Database 2021-22).



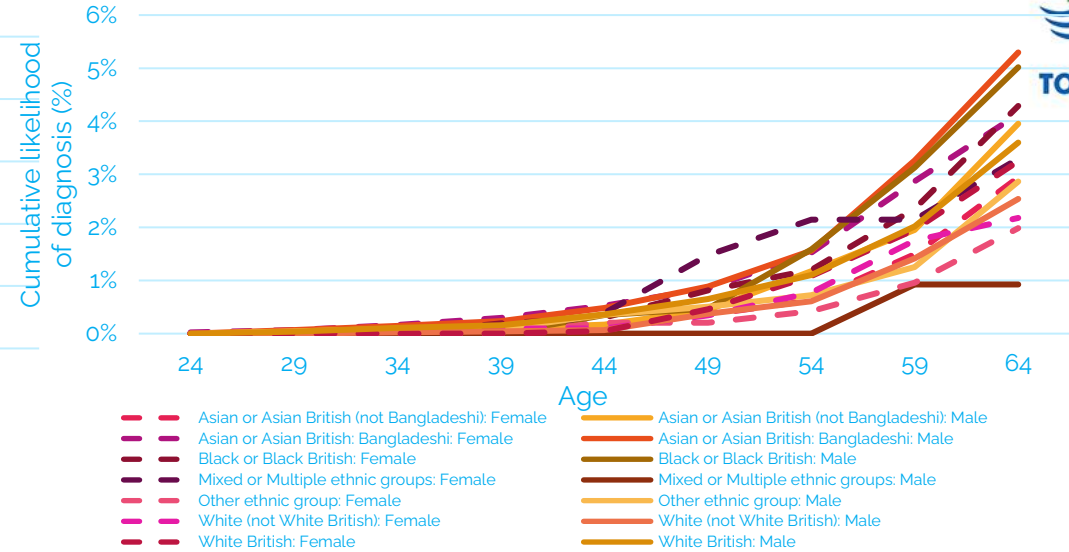
Cumulative likelihood of being diagnosed with chronic kidney disease (CKD) by age, ethnic group and sex, Tower Hamlets residents (East London Database 2021-22).



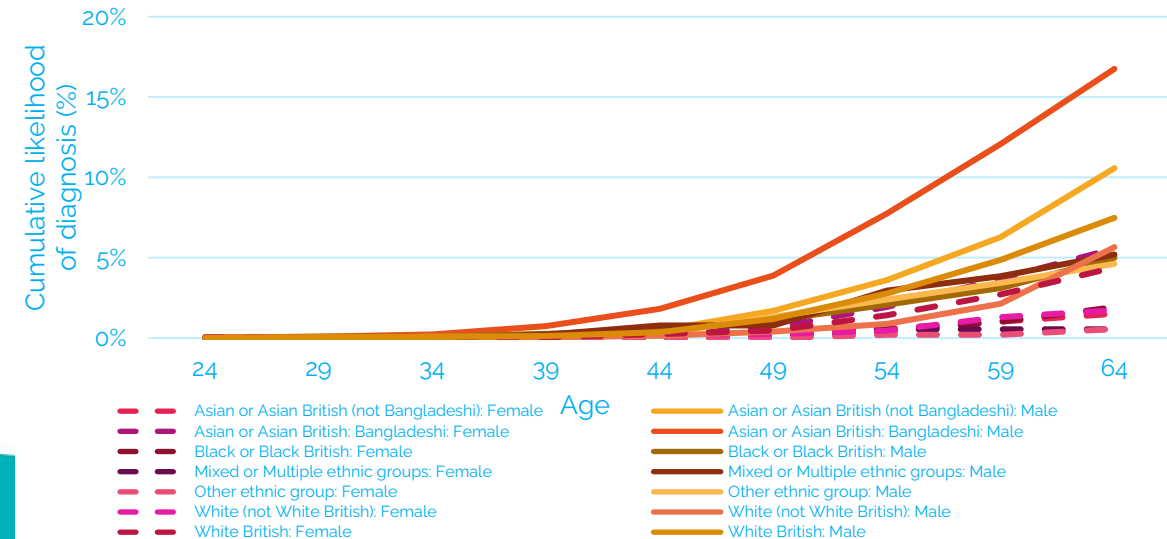
Cumulative likelihood of being diagnosed with cancer by age, ethnic group and sex, Tower Hamlets residents (East London Database 2021-22).



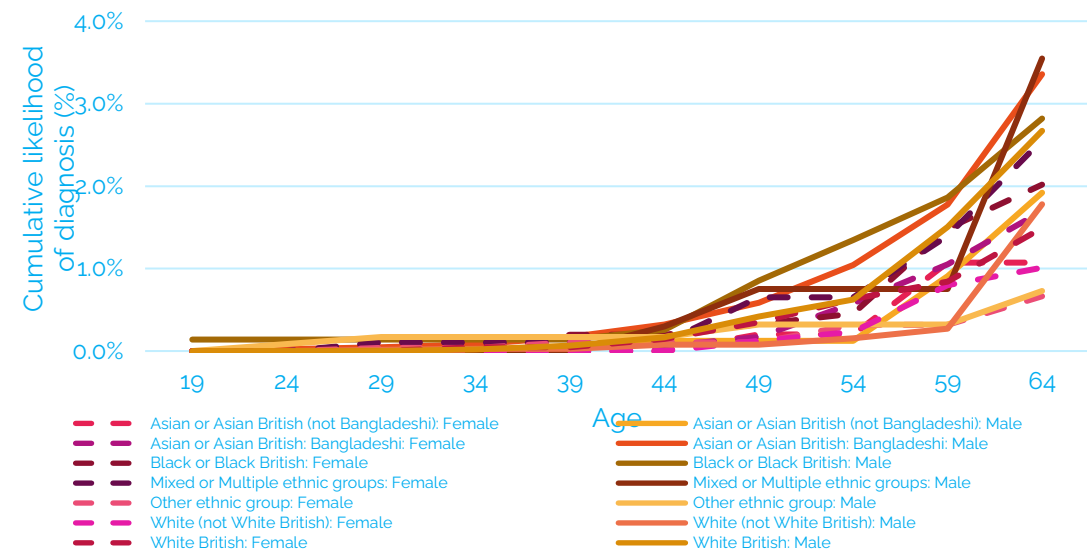
Cumulative likelihood of being diagnosed with stroke/TIA by age, ethnic group and sex, Tower Hamlets residents (East London Database 2021-22).



Cumulative likelihood of being diagnosed with coronary heart disease (CHD) by age, ethnic group and sex, Tower Hamlets residents (East London Database 2021-22).



Cumulative likelihood of being diagnosed with congestive heart failure (CHF) by age, ethnic group and sex, Tower Hamlets residents (East London Database 2021-22).

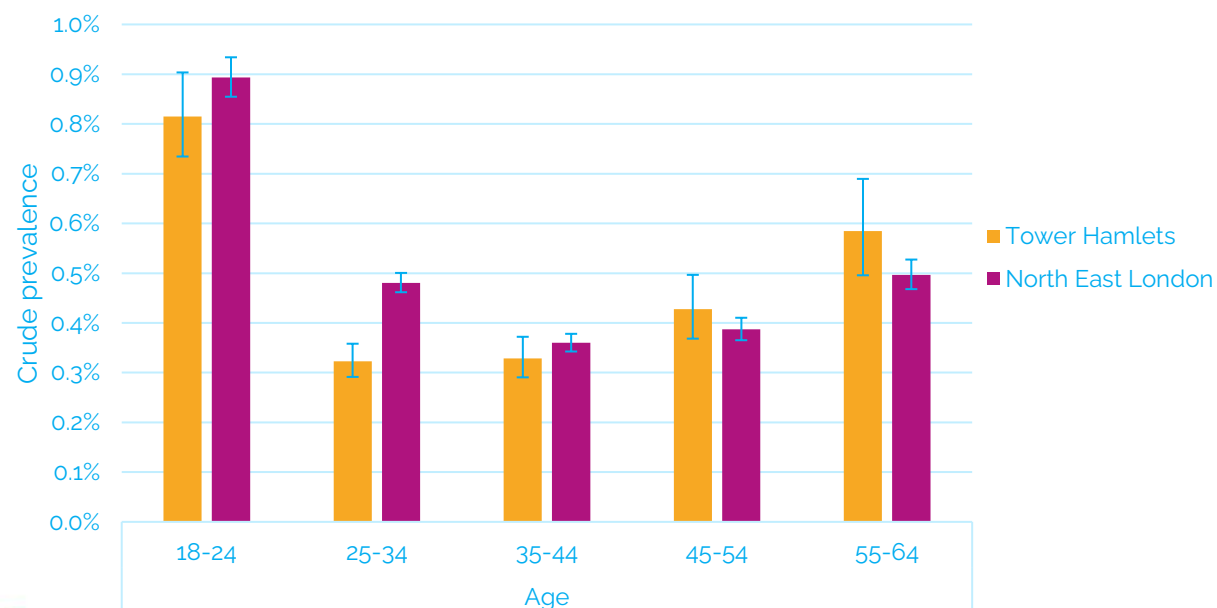


Prevalence of learning disabilities is lower in Tower Hamlets residents aged 18-64 compared with neighbouring boroughs

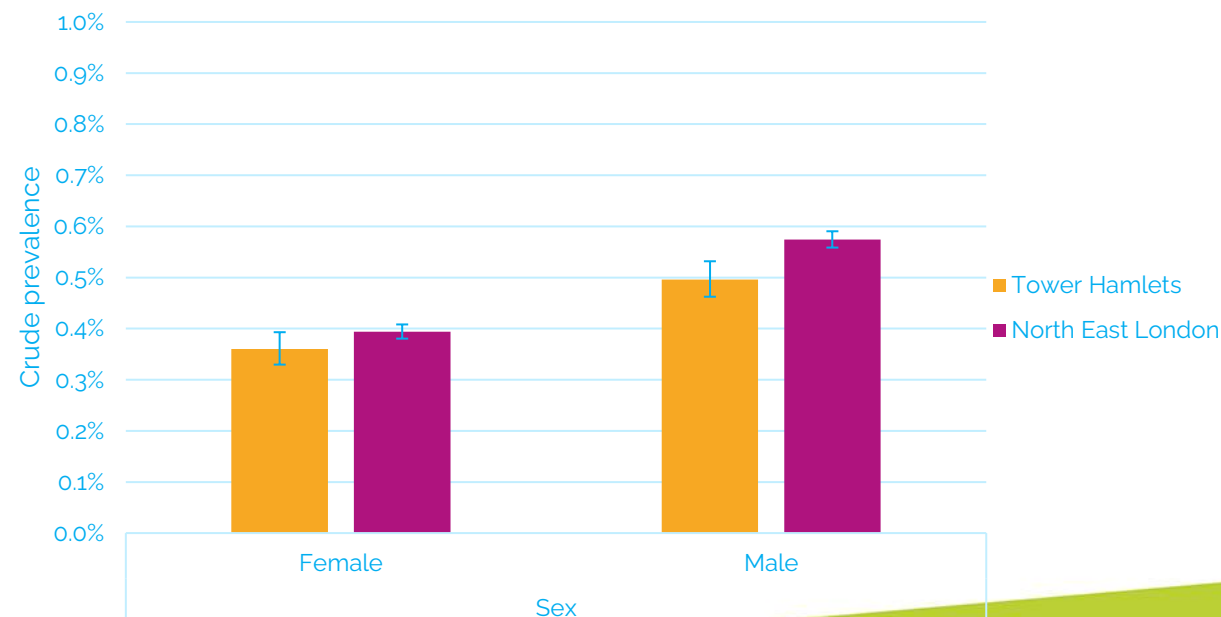


- **Prevalence of learning disabilities is higher in males compared with females.** This trend is observed both in Tower Hamlets and across North East London.
- Coding of learning disabilities in general practice means breakdowns to specific conditions is challenging. **There are 979 Tower Hamlets residents aged 18 to 64 on the Learning Disability Register**, but we know this doesn't include many individuals with diagnosed learning disabilities.

Crude prevalence of Learning Disabilities in Tower Hamlets and North East London residents aged 18 to 64, by age band (East London Database 2022-23).



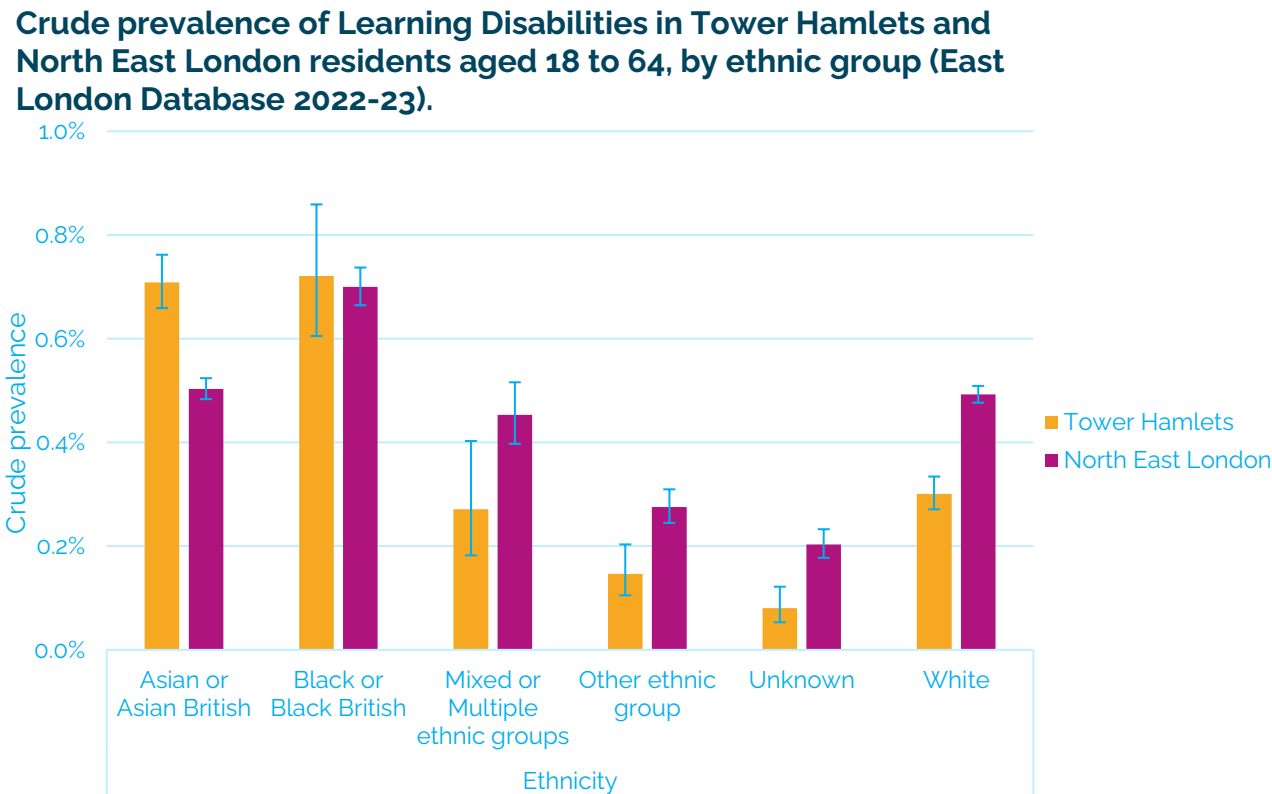
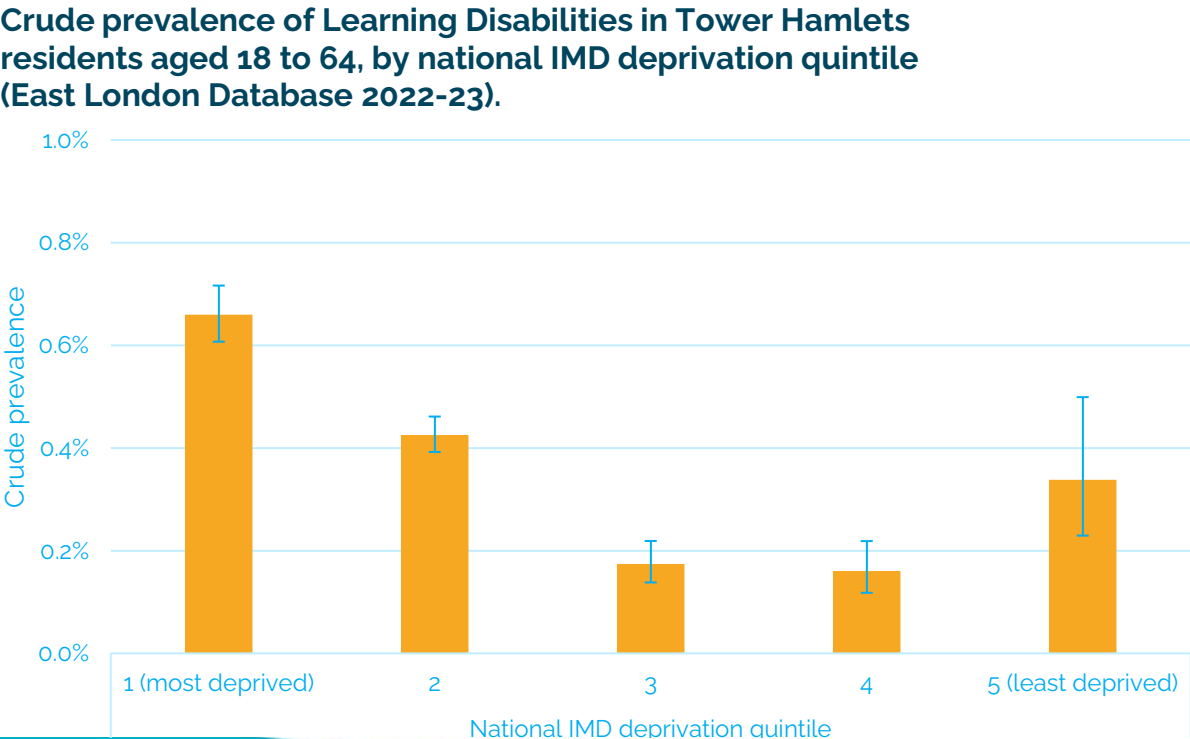
Crude prevalence of Learning Disabilities in Tower Hamlets and North East London residents aged 18 to 64, by sex (East London Database 2022-23).



Prevalence of learning disabilities are higher in certain ethnic groups, and in areas of higher deprivation



- **Prevalence of learning disabilities in adults aged 18 to 64 living in the most deprived 20% of areas is over four times higher than for than those living in quintile 4.** Prevalence is higher in the least deprived quintile compared with those in quintiles 3 and 4. This may be due to a small proportion of the Tower Hamlets population living in the least deprived areas nationally meaning data is distorted by small population sizes.
- By ethnic group, **prevalence of learning disabilities in Asian and Black ethnic groups are over two times higher than in all other ethnic groups.**
- **Prevalence of learning disabilities in the Asian ethnic group in Tower Hamlets is notably higher than in North East London.** The reverse is true for White, Mixed and Other ethnic groups.



Prevalence of severe mental illness (SMI) is higher in Tower Hamlets than in most North East London boroughs, with SMI patients also having higher prevalence of LTCs

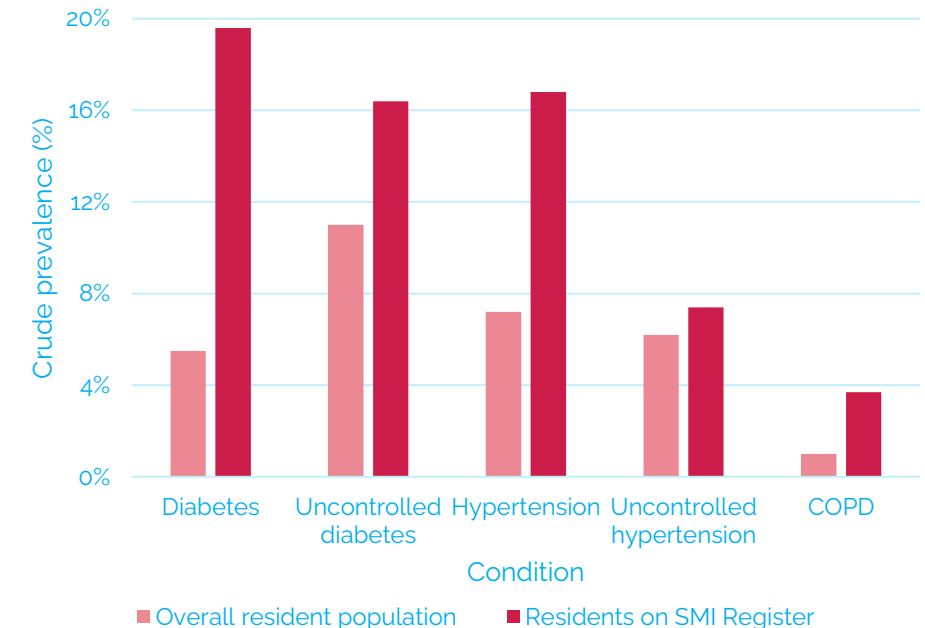


- The SMI Register is a primary care register that includes all individuals with a diagnosed schizophrenia, bipolar and other forms of psychoses.
- **In 2021-22, there were 4,864 people on the SMI register in Tower Hamlets.** This is higher than the total for any other borough in North East London – and prevalence is second highest behind Hackney^{8,11}.
- **Residents on the SMI Register have a higher prevalence of key long term conditions compared with the wider resident population in Tower Hamlets.**
- In addition to higher prevalence of long term conditions, we know patients on the SMI Register have a high prevalence of obesity (35.2% prevalence) and smoking (34.9%).

Number of residents on SMI Register and crude prevalence by North East London borough (OHID Fingertips 2021-22)^{6,11}.

Borough	Patients on SMI Register (2021-22)	Prevalence of SMI (2021-22)
Barking and Dagenham	2,142	0.83%
Hackney	4,795	1.44%
Havering	1,913	0.71%
Newham	4,857	1.08%
Redbridge	3,233	0.91%
Tower Hamlets	4,864	1.29%
Waltham Forest	3,791	1.17%

Prevalence of selected long term conditions in overall resident population and patients on the SMI register, Tower Hamlets residents (East London Database 2021-22).



Estimating social care need in Tower Hamlets using Activities of Daily Living



Understanding social care need through Activities of Daily Living



- In comparison to healthcare need, **evidence is comparatively limited on measuring population-level social care need** in academic literature.
- Some research uses rates of people reporting issues performing Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living. Issues performing ADLs and IADLs are self-reported and is collected (primarily) in the Health Survey for England (HSE)¹².
- The HSE asks all respondents aged 65 and over, for each ADL and IADL, whether they could carry out the activity on their own, manage on their own with difficulty, only do the activity with help, or could not do at all. If participants indicated that they needed help for any ADL or IADL, they are asked whether they had received any help in the last month. **This is a helpful proxy for estimating social care need, as it can be consistently measured across those in receipt of formal care support through a Local Authority, other forms of care, and those with unmet needs¹².**
- Activities covered under (Instrumental) Activities of Daily Living are covered below:

ADLs:

- Having a bath or shower
- Using the toilet
- Getting up and down stairs
- Dressing or undressing
- Getting in and out of bed
- Washing face and hands
- Eating, including cutting up food
- Taking medicines

IADLs:

- Doing routine housework or laundry
- Shopping for food
- Getting out of the house
- Doing paperwork or paying bills



Estimating social care need in Tower Hamlets using Activities of Daily Living (1)



- The Health Survey for England provides data by age, gender and deprivation on the proportion of people who needed help – but does not report to Local Authority level. Using the national estimates provided by the HSE in 2021, we can calculate three estimates of the number of people who may report issues performing one or more ADL/IADL in Tower Hamlets, through adjusting national estimates that account for variations by¹²:
 - Age and gender
 - Deprivation (IMD) and gender
 - An age-adjusted weighted proportion using age and gender estimates and applying deprivation estimates to weighted population.

Estimates of number and proportion of older adults (aged 65+) in Tower Hamlets who report issues with performing Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).

Estimates derived from Health Survey England 2021 data (population estimates calculated using population numbers from 2021 Census)^{9,12}.

Tower Hamlets estimate (using 2021 data) adjusted for:	Activities of Daily Living			Instrumental Activities of Daily Living		
	Males	Females	Persons	Males	Females	Persons
Age and gender	2,056 (27%)	3,412 (35%)	5,489 (31%)	N/A	N/A	N/A
Deprivation and gender	2,952 (38%)	3,724 (38%)	6,675 (38%)	3,175 (41%)	4,953 (51%)	8,128 (47%)
Deprivation, age and gender	2,952 (38%)	4,463 (46%)	7,415 (42%)	2,653 (34%)	4,953 (51%)	7,606 (44%)

* Data by age and gender for IADLs only available for 2016 so has been excluded from this table.

- The estimates suggest there are around 2-3,000 males aged 65+ in Tower Hamlets who have issues in performing ADLs, and between 2,500 – 3,200 who have issues performing IADLs. Estimates are higher for females – around 3,400 – 4,500 with issues performing ADLs, and 4,900 – 5,000 performing IADLs.
- Using population estimates from the 2021 Census suggests that between **31-42% of older adults in Tower Hamlets have issues in performing ADLs**, and **44-47% have issues performing IADLs**.



Residents in the oldest age groups and living in the most deprived areas are most likely to need support performing ADLs



- When broken down by 5-year age band and deprivation quintile, estimates for Tower Hamlets show that the majority of residents projected to have issues performing ADLs live in areas of high deprivation. This is consistent with the deprivation profile of Tower Hamlets, given a large number of the older adults in the borough live in areas of high deprivation.
- Age increases your likelihood to report issues performing ADLs, although there are typically more 65 to 69 year olds projected to report issues than older age groups due to a higher overall population size in these age groups.

Estimates of number of older adults (aged 65+) in Tower Hamlets who report issues with performing Activities of Daily Living (ADLs) by national IMD deprivation quintile and 5 year age band

National IMD deprivation quintile	Projected number of Tower Hamlets residents aged 65+with issues performing ADLs							
	Aged 65-69		Aged 70-74		Aged 75-79		Aged 80+	
	Males	Females	Males	Females	Males	Females	Males	Females
1 (most deprived)	428	631	317	505	197	355	295	587
2	464	636	307	461	191	300	305	479
3	80	89	45	71	37	41	47	60
4	69	71	51	51	30	33	32	43
5 (least deprived)	23	20	10	12	8	5	5	10



Understanding who is currently using Adult Social Care services in Tower Hamlets

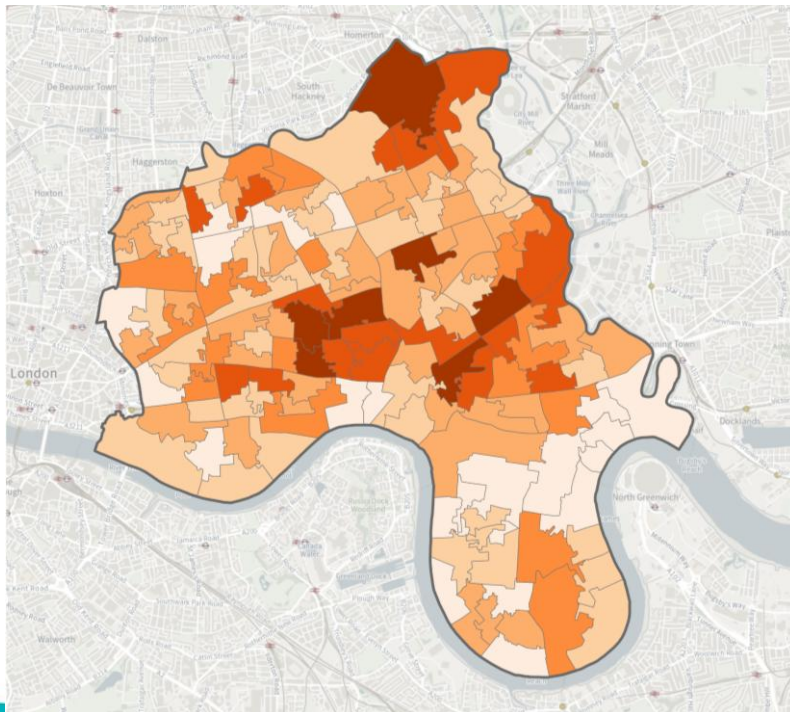


Stepney Green, Mile End, Poplar and Old Ford have the highest number of adult social care service users

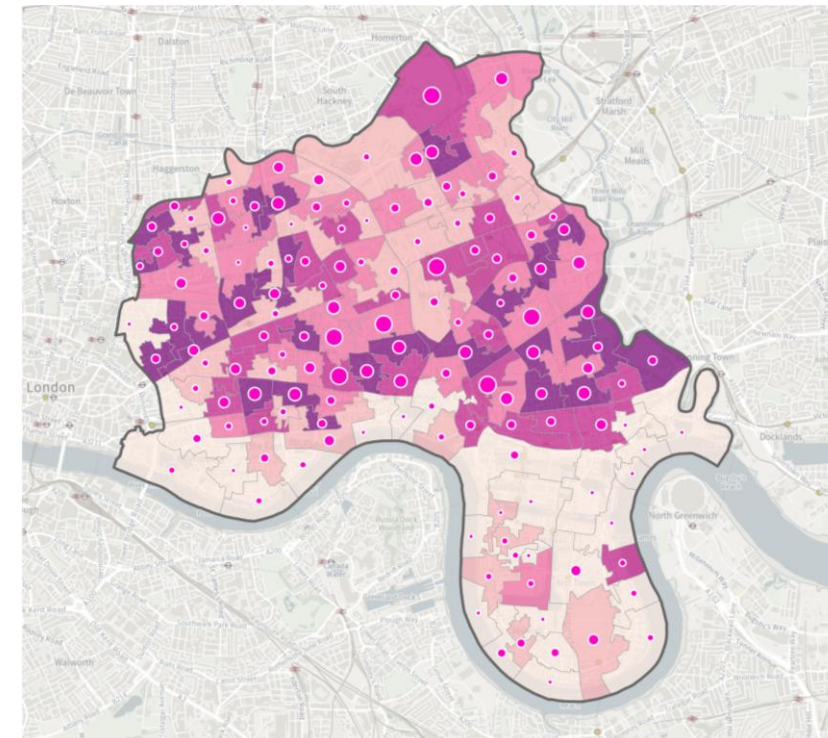


- Maps have been produced using the listed primary residence of adult social care service users. Primary residence may not be updated, for example when an individual moves into residential care, so may not be fully representative.
- The number of service users may also be influenced by the location of residential care settings in the borough, where primary residence of the service user is listed as the residential setting. There are three care homes for older adults around Stepney Green, and a large number of service users in their LSOA areas. This does not seem to be the cause of high numbers of service users in the far north east of the borough.

Number of current Adult Social Care service users by Lower Super Output Area (Mosaic).



Number of current Adult Social Care service users by Lower Super Output Area (circles), mapped with Tower Hamlets Relative Deprivation Quintile (Mosaic).



Adult Social Care Service Users with Primary Residence in Tower Hamlets

All Service Users

- 1 - 10
- 11 - 20
- 21 - 30
- 31 - 40
- 41 - 60
- 61 - 94

Index of Multiple Deprivation 2019

TH Relative Deprivation Quintile

- 1 (Most deprived)
- 2
- 3
- 4
- 5 (Least deprived)

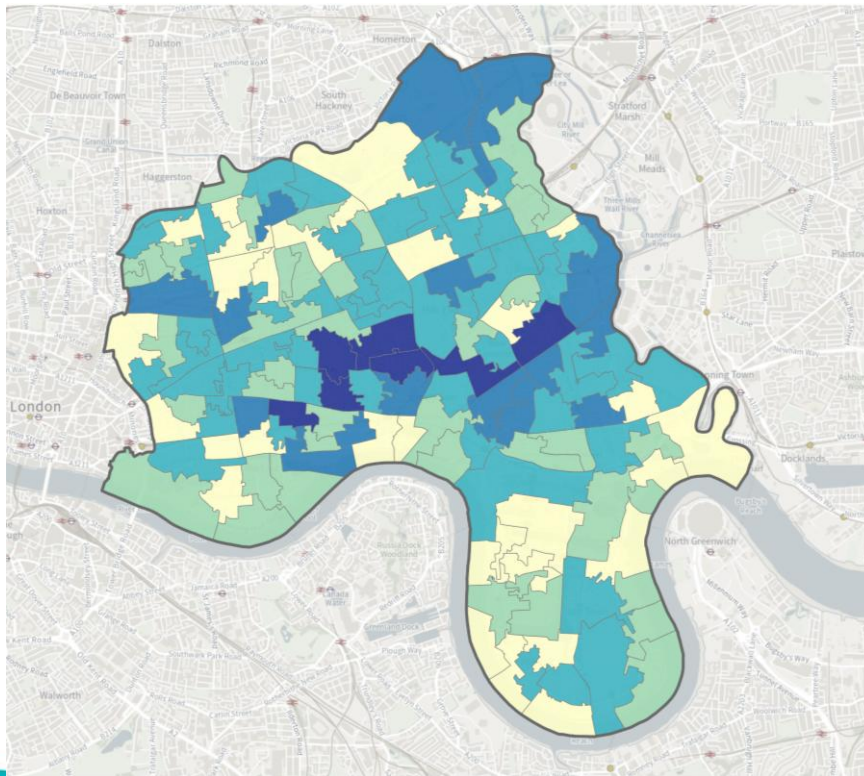


The patterns of service users by area are broadly similar across age bands



- Patterns of service use by area are broadly consistent across age groups. Although there is some indication that care homes are represented in higher numbers of service users for older adults, around Limehouse/Poplar and Stepney Green, there are also a large number of 18 to 64 year old service users in LSOA areas.

Number of current Adult Social Care service users aged 18 to 64 by Lower Super Output Area (Mosaic).

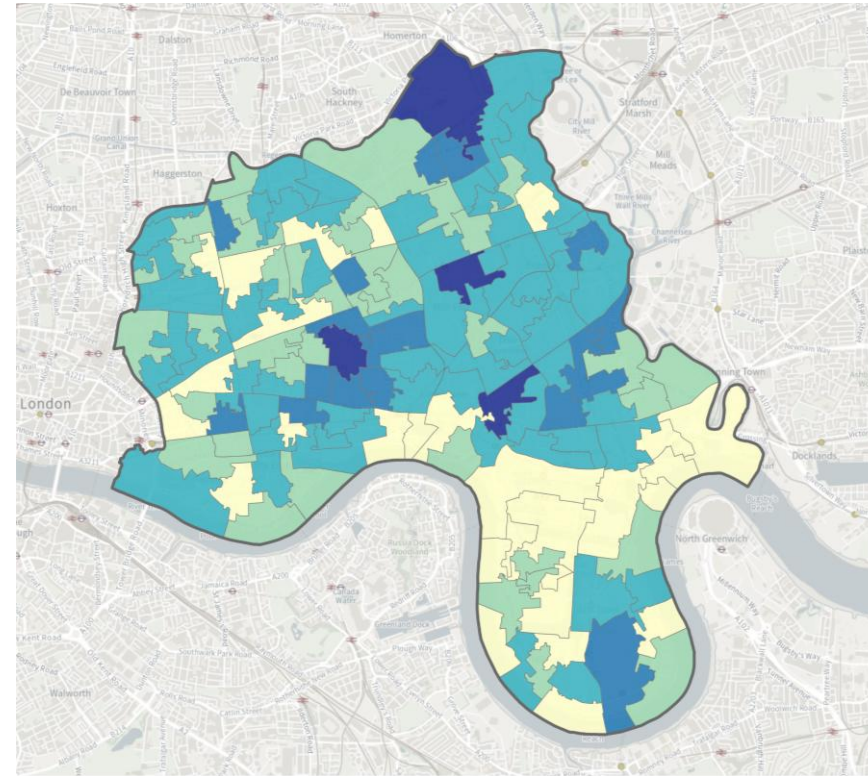


Adult Social Care Service Users with Primary Residence in Tower Hamlets

Users 18 to 64 year old

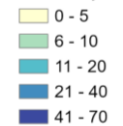


Number of current Adult Social Care service users aged 65 and over by Lower Super Output Area (Mosaic).



Adult Social Care Service Users with Primary Residence in Tower Hamlets

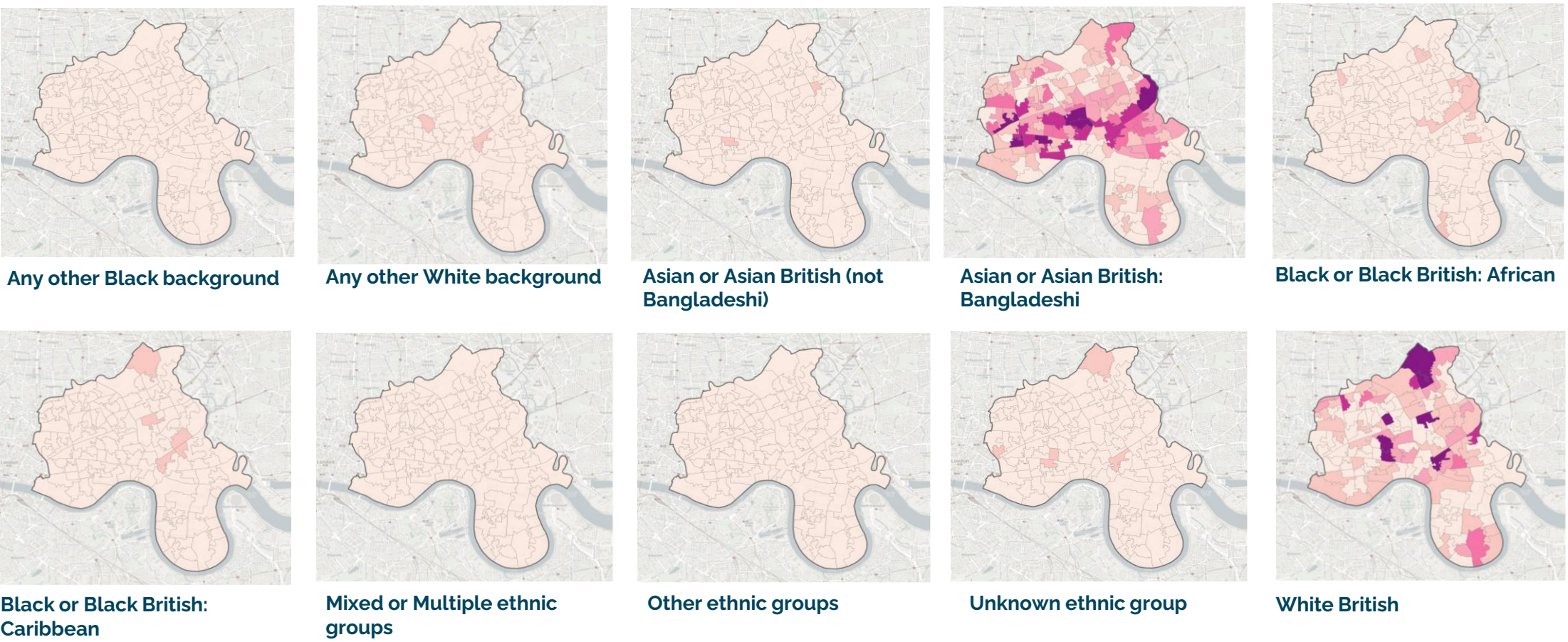
Users 65 years old and older



With exception of Bangladeshi and White British ethnic groups, most areas do not have a large number of residents in receipt of social care services in the same ethnic group



Number of current Adult Social Care service users in each ethnic group by Lower Super Output Area (Mosaic).

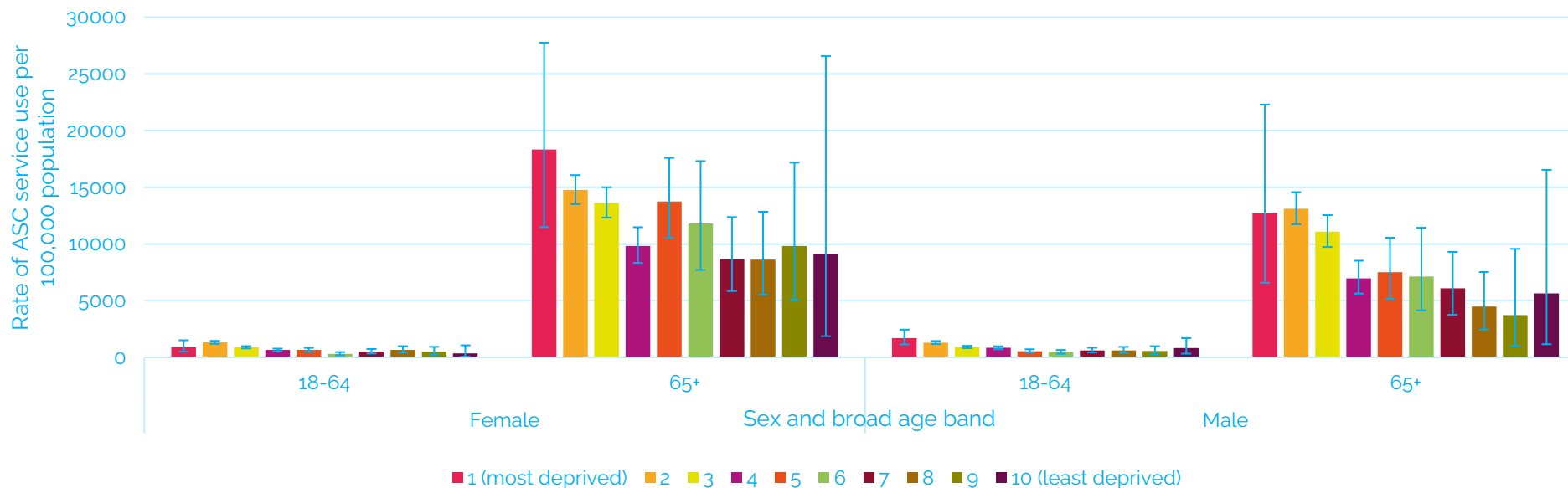


Tower Hamlets has a high number of residents living in areas of high deprivation – and a higher proportion of residents in deprived areas use adult social care services



- The deprivation distribution of areas in Tower Hamlets means **most residents in receipt of social care support live in areas of higher deprivation.**
- Using census data for population denominators also allows us to estimate the *rate* (per 100,000 population) of social care service use among population sub-groups.
- **Residents living in more deprived areas have a higher rate of social care service use, compared with residents living in less deprived areas.** This will be influenced in part by the financial eligibility for Adult Social Care support, meaning a greater number of individuals in the least deprived areas will not be eligible for Local Authority funded care. As this data only covers those in receipt of local authority care, self-funded or informal care will not be shown in this data.
- SALT returns for Tower Hamlets show the rate of adult social care service users per 100,000 population in 2022/23 as 11,025 for **adults aged 65+, the second highest rate of any Local Authority in London and over twice the England average (5,185 per 100,000 population)².**
- For **adults aged 18 to 64**, the rate is 770 per 100,000 population, **in line with London averages (810 per 100k) and lower than the England average (850 per 100k)¹.**

Rate of Adult Social Care service use per 100,000 population in Tower Hamlets, by broad age band, sex and national IMD deprivation decile (Mosaic, population numbers from 2021 Census⁹).

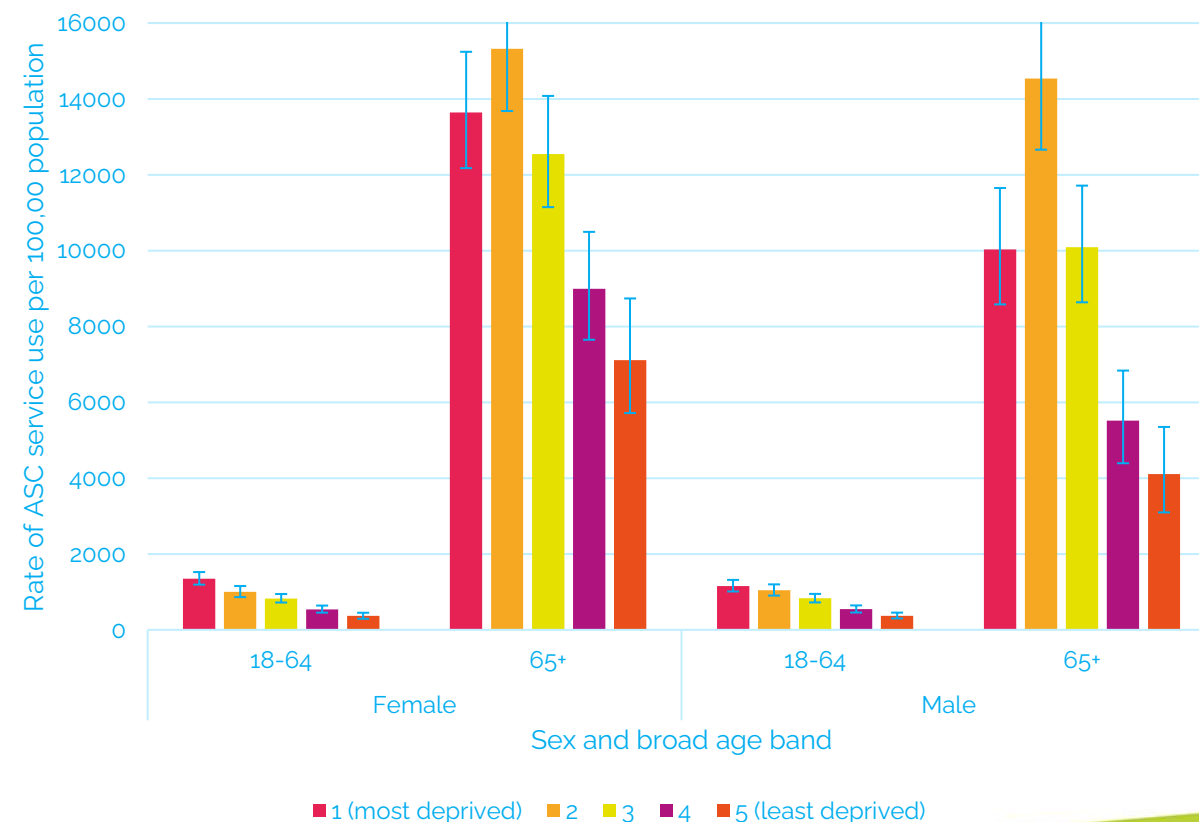


Older adults living in the most deprived areas *relative* to other Tower Hamlets residents have a lower rate of service use than those in lower relative deprivation



- Analysis using national Index of Multiple Deprivation (IMD) deciles (as on the previous slide) is limited in Tower Hamlets, as a large number of residents live in deprived areas in the national distribution – mainly IMD deciles 2 and 3.
- **Using Tower Hamlets Relative Deprivation Quintiles (i.e. ranking neighbourhood areas according to their deprivation levels *relative* to other areas in Tower Hamlets rather than against all areas nationally) allows us to take a locally comparative how deprivation affects social care need.**
- Using relative deprivation quintiles, there is still a clear association overall between deprivation and use of social care services. **However, older adults (aged 65+) living in the 20% of areas with the highest deprivation relative to other residents (quintile 1) had a lower rate of service use than older adults living in the next 20% of areas (quintile 2).** This pattern is observed for both male and female older adults, but is **particularly significant in males**.
- **This could be driven by several factors**, for example awareness of social care services, issues around service navigation, or support needs being met through other means (e.g. due to living with family who can provide care).
- This trend is not seen in adults aged 18-64, where rates of service use increase consistently age relative deprivation increases.
- Discussions with social care commissioners highlighted the wide range of support that exists for residents outside of adult social care, meaning individuals may meet their health or social care needs through other means. This includes, for example, information and advice services, social prescribing, and a wide range of health services delivered through primary care.

Rate of Adult Social Care service use per 100,000 population in Tower Hamlets, by age band, sex and local relative deprivation quintile (Mosaic, population numbers from 2021 Census) (ASC users registered as resident in Tower Hamlets only).



In the most deprived areas, there are fewer older adult service users in the White British ethnic group compared with those in less deprived quintiles



- We can explore this “under-utilisation” of adult social care in the most deprived areas in more detail by looking at the ethnic groups of service users by relative deprivation and age band.
- Highlighted in yellow are the number of service users aged 65+ in the two largest ethnic groups: Bangladeshi and White British. **In the most deprived relative deprivation quintile, individuals in the Bangladeshi ethnic group make up around 36% of all service users, compared with 27% of service users in quintile 2.** For the White British ethnic group this trend is reversed; around **30% of service users in quintile 1 are White British, compared with around 43% in quintile 2.**
- Unfortunately, we are not able to access census data that would allow us to look at ethnic group and deprivation by LSOA area, to compare the rate of social care service use by multiple characteristics.

Ethnic group	Tower Hamlets Relative Deprivation Quintile													
	18 to 64 year olds							Aged 65 and over						
	1 (most deprived)	2	3	4	5 (least deprived)	Not TH resident	Unknown	1 (most deprived)	2	3	4	5 (least deprived)	Not TH resident	Unknown
Any other Black background	12	5	16	<5	<5	11	<5	7	5	<5	<5	<5	<5	<5
Any other White background	15	11	13	8	6	13	5	22	27	24	17	13	16	<5
Asian or Asian British (not Bangladeshi)	27	14	22	18	10	11	<5	22	20	17	14	11	5	<5
Asian or Asian British: Bangladeshi	255	190	203	132	64	72	15	176	145	135	86	31	10	5
Black or Black British: African	48	31	45	18	19	33	<5	26	24	21	9	13	8	<5
Black or Black British: Caribbean	17	12	16	13	<5	24	<5	29	39	30	11	<5	8	<5
Mixed or multiple ethnic groups	8	7	11	6	10	16	<5	<5	<5	7	<5	<5	<5	<5
Other ethnic group	12	11	11	5	9	5	<5	6	10	5	<5	<5	<5	<5
Unknown	26	21	20	14	9	17	<5	51	31	42	16	11	12	<5
White British	72	84	77	52	50	93	8	145	234	179	88	57	118	5

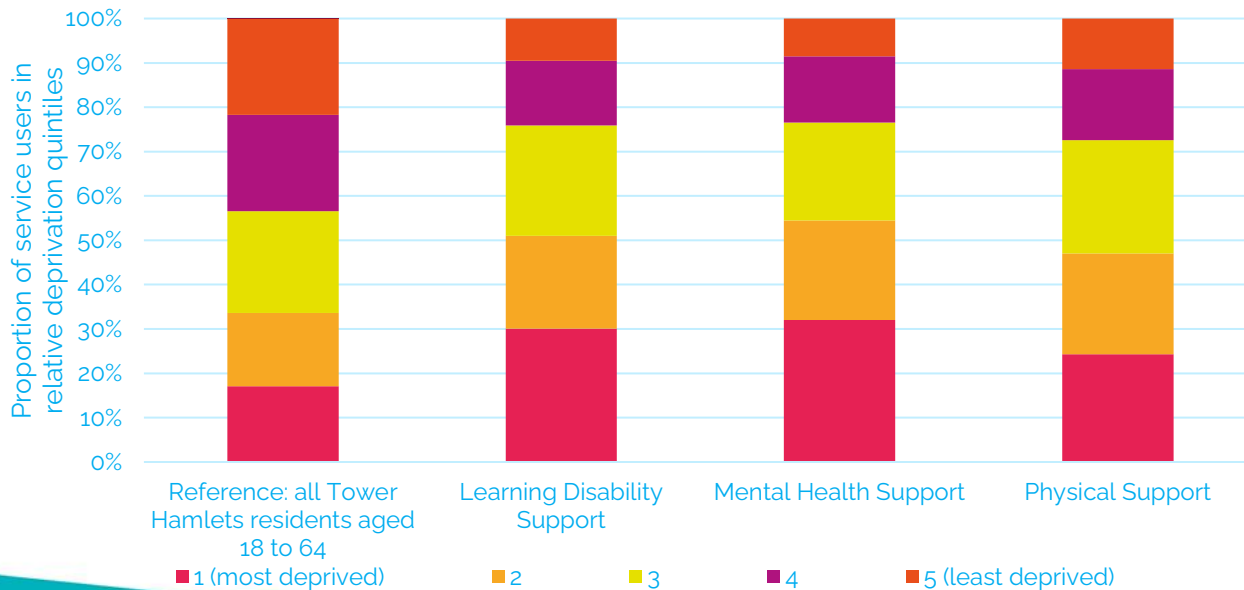


Learning disability and mental health support have a higher proportion of service users living in more deprived areas, particularly age 65+



- This unequal distribution suggests **deprivation drives increases in specific support needs more than others**, and/or that different **services are more/less accessible to those living in areas of higher deprivation**.
- **Across all ages and support reasons, residents living in the 40% of areas of highest deprivation relative to other Tower Hamlets residents were over-represented in services compared with the rest of the population.** Over-representation is most marked for those with mental health and social support listed as a PSR.
- Service users who are not Tower Hamlets residents or where residence is unknown have also been excluded from this analysis, as well as service users with PSRs where there are fewer service users.

Relative deprivation distribution in Adult Social Care service users aged 18 to 64 who are known Tower Hamlets Residents, by Primary Support Reason (Mosaic).



Relative deprivation distribution in Adult Social Care service users aged 65+ who are known Tower Hamlets residents, by Primary Support Reason (Mosaic).

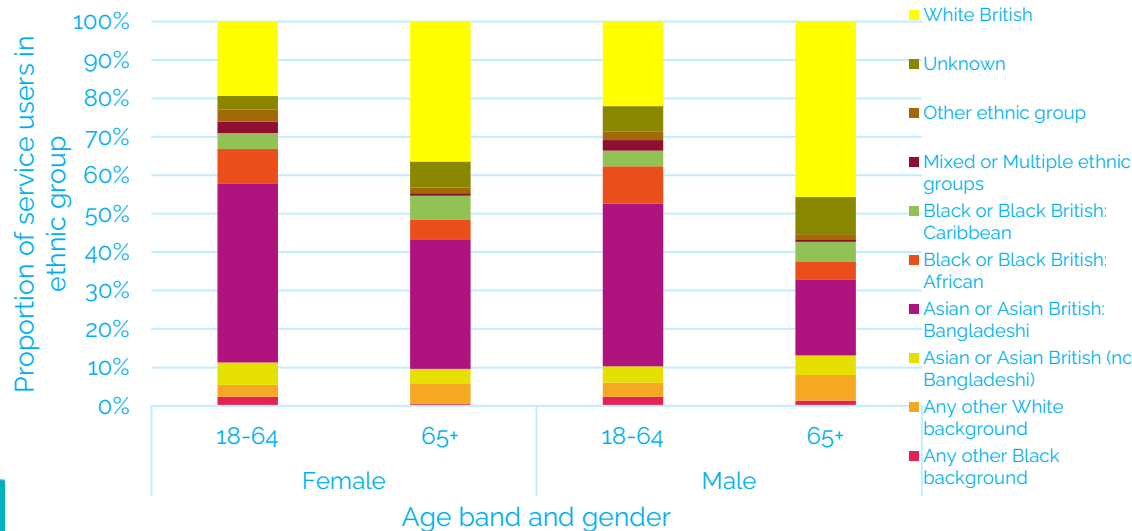


White British residents make up the greatest proportion of ASC users aged 65+, but have a lower rate of service use than some other ethnic groups

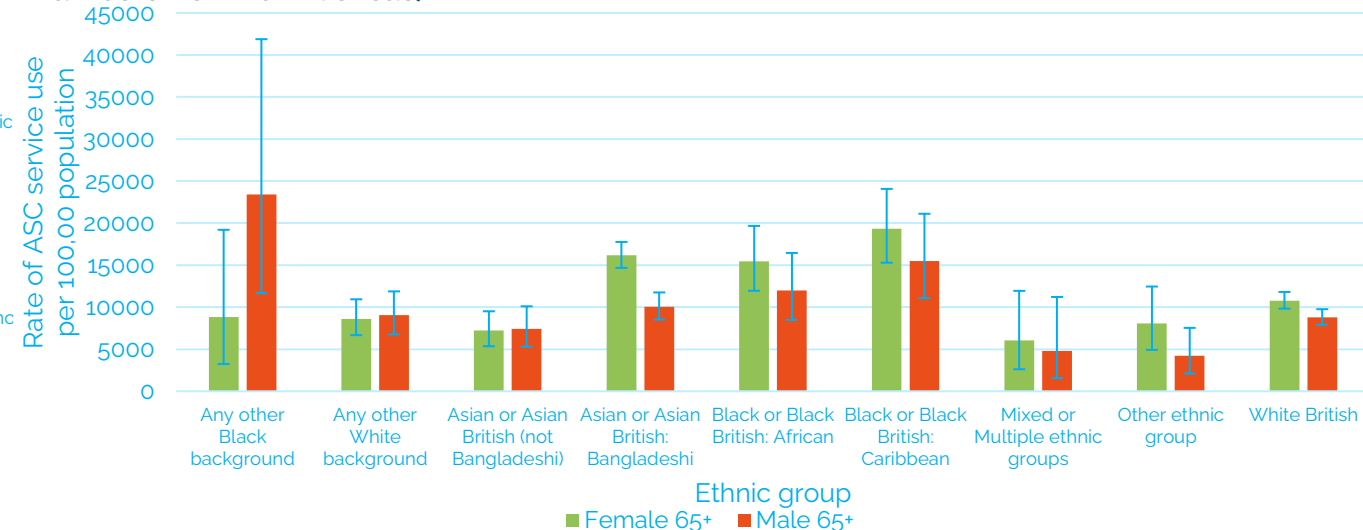


- In older adults, White British is the most represented ethnic group for both males and females, while Bangladeshi female residents aged 65+ make up a significantly higher proportion of service users in this age group compared with males in the same age group.
- **Aged 65+, Bangladeshi, Black African and Black Caribbean residents have a higher rate of service use than other ethnic groups.**
- **In addition, the rate of service use for females in these ethnic groups is higher than in males (this is also true for White British and mixed/multiple ethnic groups, though to a lesser extent).** The reverse trend in the Any other Black Background ethnic group is likely due to very small population sizes.
- **This male/female gap is proportionately largest in the Bangladeshi ethnic group.** The higher proportion of females receiving support is consistent with healthy life expectancy data, which shows females have poor rates of self-reported health despite having a higher overall life expectancy.
- This trend is not seen in 18 to 64 year olds, where across most ethnic groups males have a slightly higher rate of service use compared with females.

Ethnic group distribution of Adult Social Care service users, by age and gender (Mosaic) (unknown gender excluded).



Rate of Adult Social Care service use per 100,000 population in Tower Hamlets residents aged 65+, by ethnic group and sex (Mosaic, population numbers from 2021 Census).

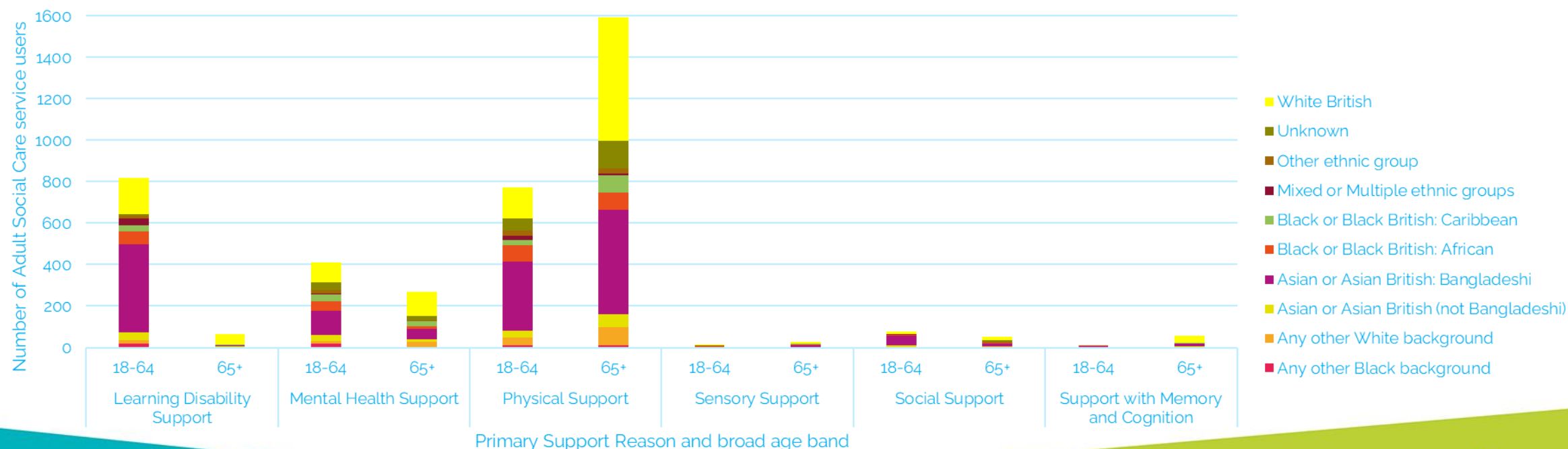


Primary Support Reasons of service users are strongly influenced by age



- The **majority of service users aged 18 to 64** have **learning disability, mental health support or physical support** listed as their **Primary Support Reason**.
- In **older adults, 77% of service users have physical** support as their listed PSR.
- As service users can only have one listed PSR, this gives us a limited view of the support needs of service users. It also **doesn't provide complete insights into the type of support received** (for example, home care or residential care).

Number of Adult Social Care service users by broad age band, Primary Support Reason and ethnic group (Mosaic) (selected PSRs only).

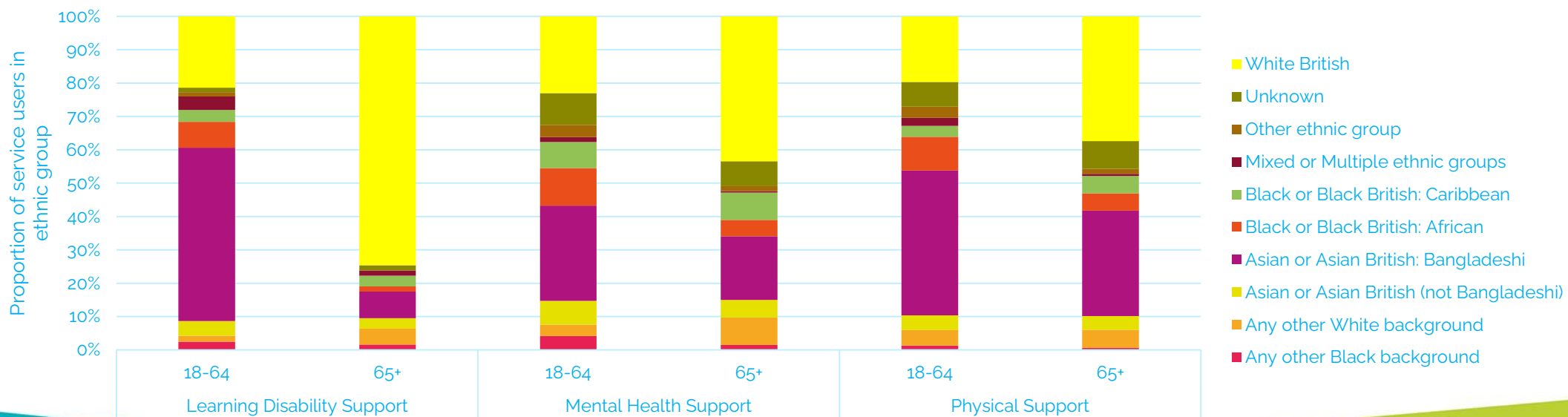


Service users in the Bangladeshi ethnic group make up a lower proportion of users with mental health as their listed Primary Support Reason (PSR), compared with other PSRs



- For 18 to 64 year olds, **service users in the Bangladeshi ethnic group make up 52% of service users with Learning Disability as their listed PSR, and 43% of those in the physical support PSR, but only 29% of those in the mental health support PSR.**
- This trend is matched in older adults; **Bangladeshi residents make up 32% of service users aged 65+ in the physical support PSR, but only 19% of service users in the mental health support PSR.**
- The Learning Disability support PSR has a markedly different ethnic distribution in older adults compared with younger adults. In 18 to 64-year olds with LD as their listed PSR, over half were Bangladeshi, yet **only 8% of service users aged 65+ in the LD PSR are Bangladeshi** (and more than 75% are White British).

Ethnic group distribution of Adult Social Care service users, by Primary Support Reason and broad age band (Mosaic) (selected PSRs only).

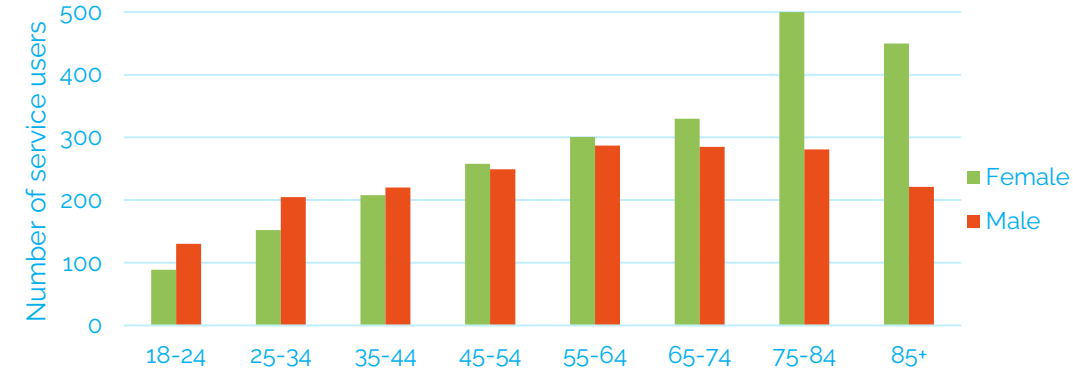


Aged 75 and above, there are twice as many females as males in receipt of social care support – and females in this age group have a higher rate of service use than males

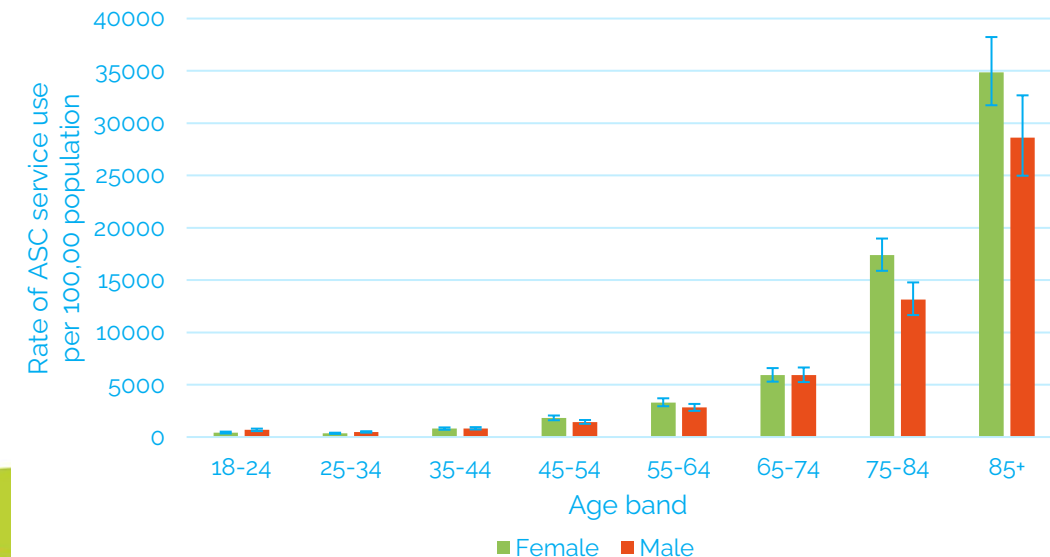


- Unsurprisingly, given known patterns of adult social care need, **the rate of social care service use increases exponentially with age**.
- In **younger age groups, there are slightly more males than females in receipt of adult social care support**. However, for those **aged 75 and above there are significantly more females than males in receipt of support**.
- This **in part reflects population demographics** – there are more females than males in the oldest age groups in Tower Hamlets, and females have a higher life expectancy than males overall.
- However, **females in the oldest age groups (75+) also have a higher rate of service use than males**. These two factors mean there are around twice as many females aged 75+ receiving social care support, compared with males.
- This could be driven by several factors. We know, for example, that females have poorer self-reported health than males, and have a lower healthy life expectancy despite a higher overall life expectancy.

Number of Adult Social Care service users by age and gender (Mosaic).



Rate of Adult Social Care service use per 100,000 population in Tower Hamlets residents, by age and sex (Mosaic, population numbers from 2021 Census⁹).

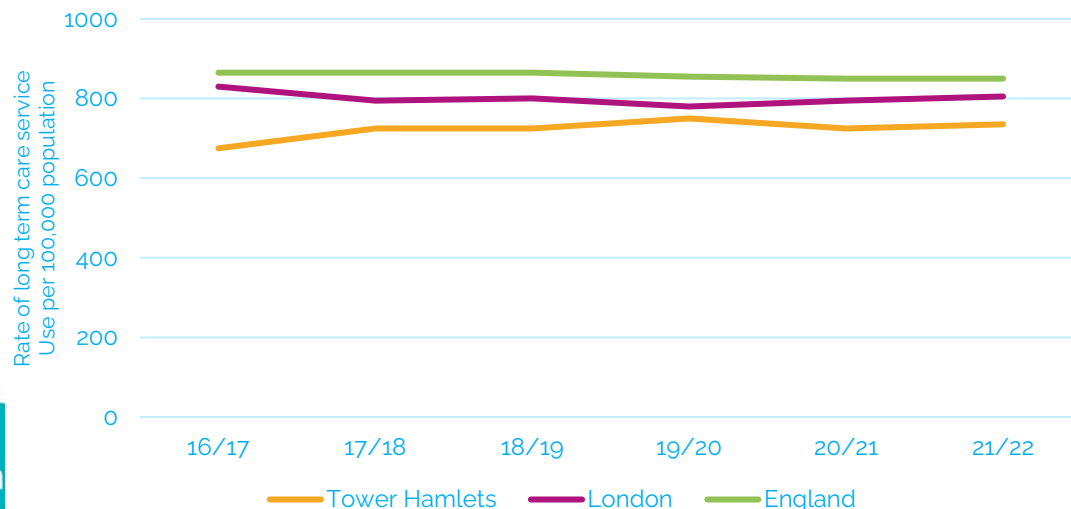


The rate of service long term care service use has been consistently higher in older adults in Tower Hamlets compared with London and England, but this gap is narrowing



- Short and Long Term (SALT) data returns report have reported on the rate long term care service users per 100,000 population for 18 to 64-year olds and adults aged 65+ since 2016/17. This analysis uses a different classification of “service users” than elsewhere in the report, as the focus is on recipients of long term care only. It is also unclear what population denominator is used in this analysis.
- For 18 to 64 year olds, the rate of service use in Tower Hamlets has remained broadly consistent since 2016/17, and is slightly below London and England averages. This suggests the increase in service users in this age group (covered later in the report) is driven by increases in population sizes for this age group rather than increasing need.
- For older adults, Tower Hamlets has historically had a far higher rate of service use than London and England averages, with the rate of service use more than two times higher than England in 2016/17. This gap has narrowed in recent years, due to a sharper fall in the rate of service use in Tower Hamlets compared with other areas.

Rate of long term care service use per 100,000 population for adults aged 18 to 64 in Tower Hamlets, London and England, 2016/17 to 2021/22 (SALT returns¹).



Rate of long term care service use per 100,000 population for adults aged 65+ in Tower Hamlets, London and England, 2016/17 to 2021/22 (SALT returns¹).



Understanding differences in factors that drive social care need among service users – findings from Whole Systems Dataset Project (WSDP)



Using the Whole Systems Dataset Project (WSDP) to understand social care need in Tower Hamlets



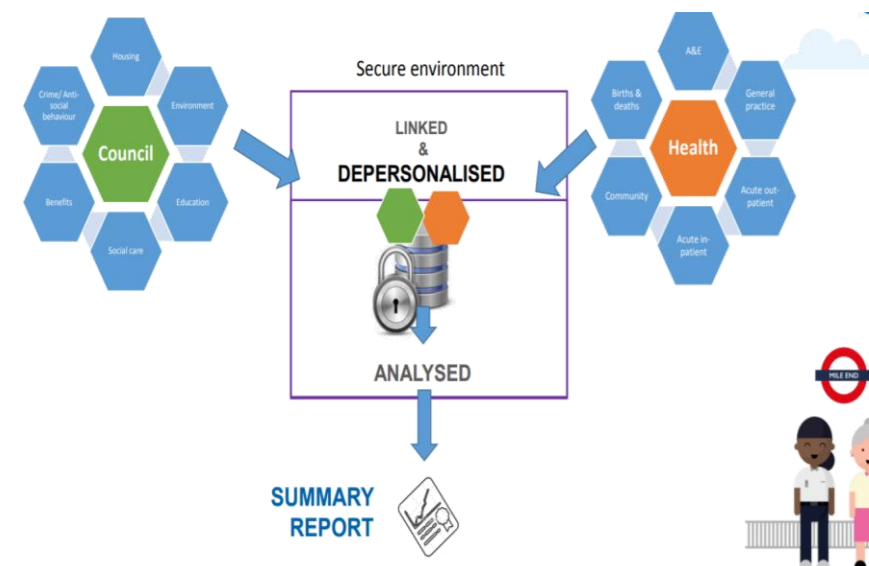
Background to the Whole Systems Dataset Project (WSDP)

- The Whole Systems Dataset Project (WSDP) was a project led by the Public Health division in Tower Hamlets Council, and supported by various partners including the UCL Institute of Health Equity and the Tower Hamlets Together Partnership. The project ran from 2016 to 2018 to link, on a single use basis, Local Authority datasets (including Adult Social Care data) and health data, including primary care and secondary care data^{13,14}.
- The **aim of the project was to produce a dataset that could explore the interrelationships of various factors that are relevant to the health of populations**, by understanding service use and health outcomes across a wide range of health and Local Authority domains. Some initial analysis of the linked data was done in 2019, with a series of case studies produced.^{14,15}

Using outputs from the WSDP to understand factors associated with social care need

- The original individual-level datasets built from the WSDP were destroyed, per the initial WSDP programme arrangements. However, some aggregate outputs were retained **that allow us to explore how adult social care service users in Tower Hamlets compare with the wider resident population across a range of variables related to health and socio-economic conditions**^{13,14}.
- There are several limitations with the dataset:
 - The data is from 2017/18 meaning it is now several years out of date. We are therefore not able to measure the impact of the COVID-19 pandemic on social care need
 - Our ability to validate the analysis is limited without access to the individual level data.
 - Although the data does provide breakdowns by adult social care service type, small population numbers mean we have excluded this from the analysis. We are also not able to break down findings by service user demographics, other than broad age classifications.
 - Age breakdowns are given from age 19 rather than age 18, though we do not anticipate this will significantly impact findings.
- For further information on the WSDP, please see the technical information in Appendix B.

Process map for Whole Systems Dataset Project (WSDP) linked datasets¹⁴,

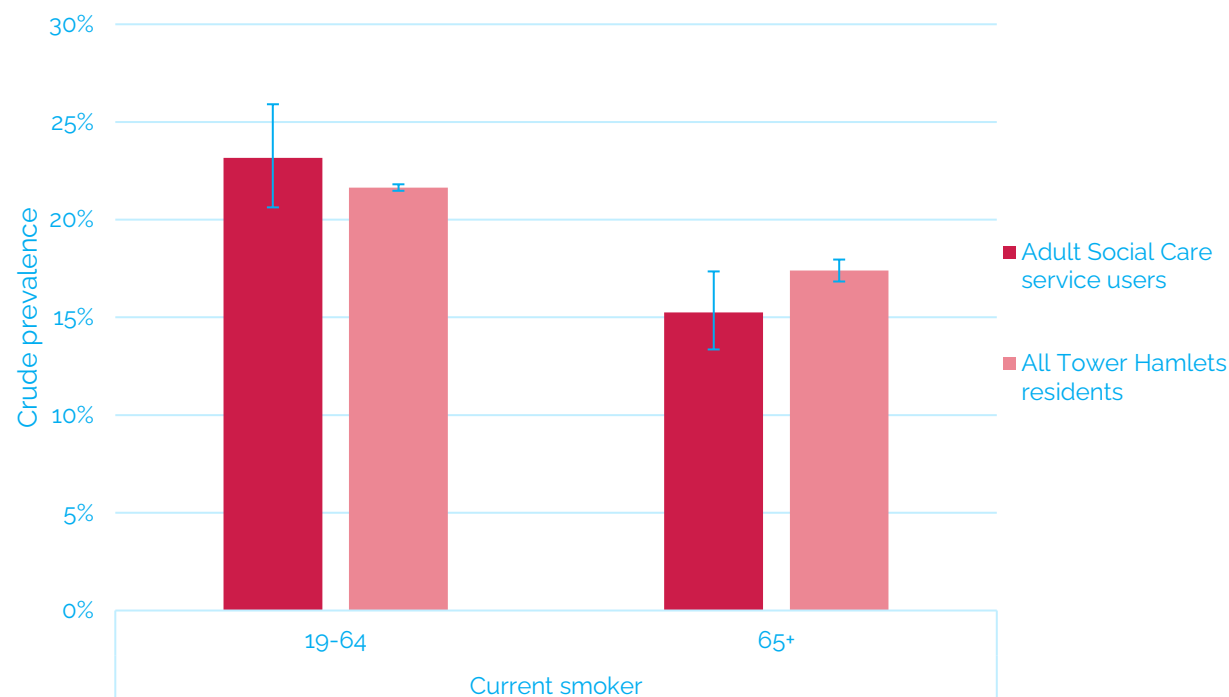


Smoking prevalence in adult social care service users is broadly similar to the general population – but higher in some service types



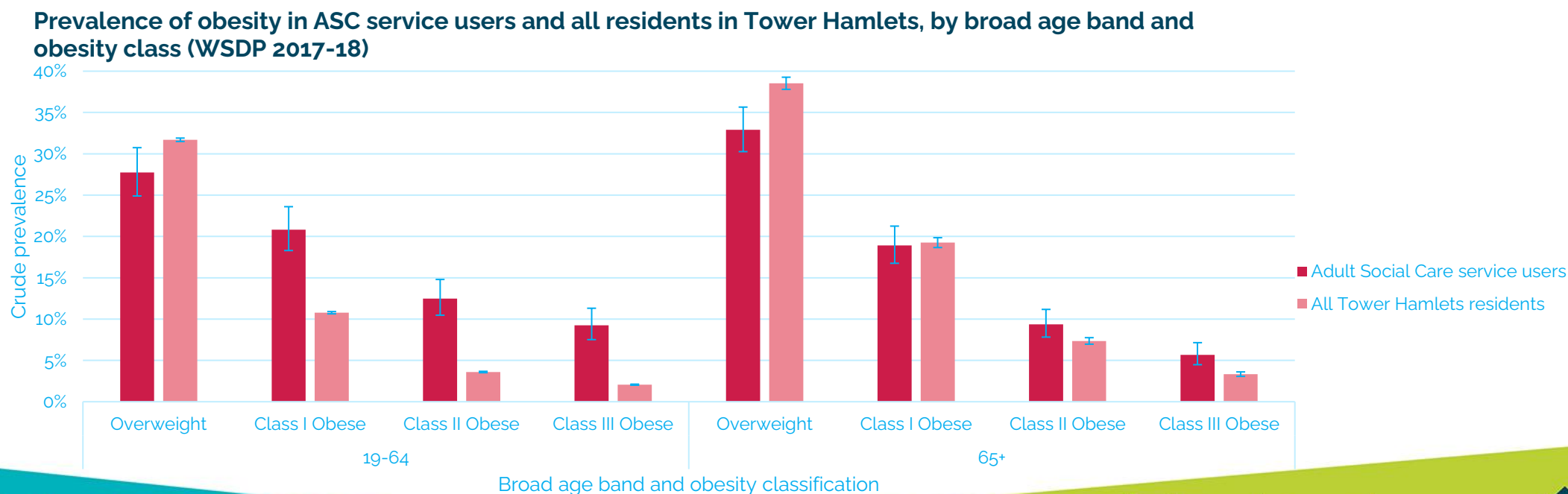
- Smoking is a significant health risk factor and is **associated with conditions that through their contribution to poorer health outcomes influence adult social care need**.
- “Active smoker” prevalence is taken from primary care data in the WSDP, where recording may not always be consistent.
- In adults aged 19-64, **smoking prevalence in the Adult Social Care service user population was slightly higher than recorded prevalence in the overall population**. For older adults, smoking prevalence in service users is slightly lower than the resident population.
- Smoking prevalence was notably **higher in adult social care service users receiving Extra Care/sheltered housing support, and those in residential care and supported living**.

Smoking prevalence for ASC service users and all residents by broad age band, Tower Hamlets (WSDP 2017-18).



Prevalence of overweight/obesity is higher in adult social care service users aged 19-64 than the overall population, but around the same in older adults

- WSDP data shows that around **70% of adult social care service users aged 19 to 64 were classed as overweight or obese** – compared with **around 48% in the overall resident population**.
- In addition, 19-64 year-old service users were notably more likely to have Class 2 or 3 obesity; prevalence of Class 2 obesity was around 3.5 times higher than in the overall population, and Class 3 obesity prevalence was around 4.5 times higher.
- For older adults, prevalence of overweight or obesity was around the same in adult social care service users as in the general population (67% vs 68%).** Prevalence of Class 2 and Class 3 obesity was higher in adult social care service users aged 65+, although the difference between service users and the resident population was less significant than in younger adults

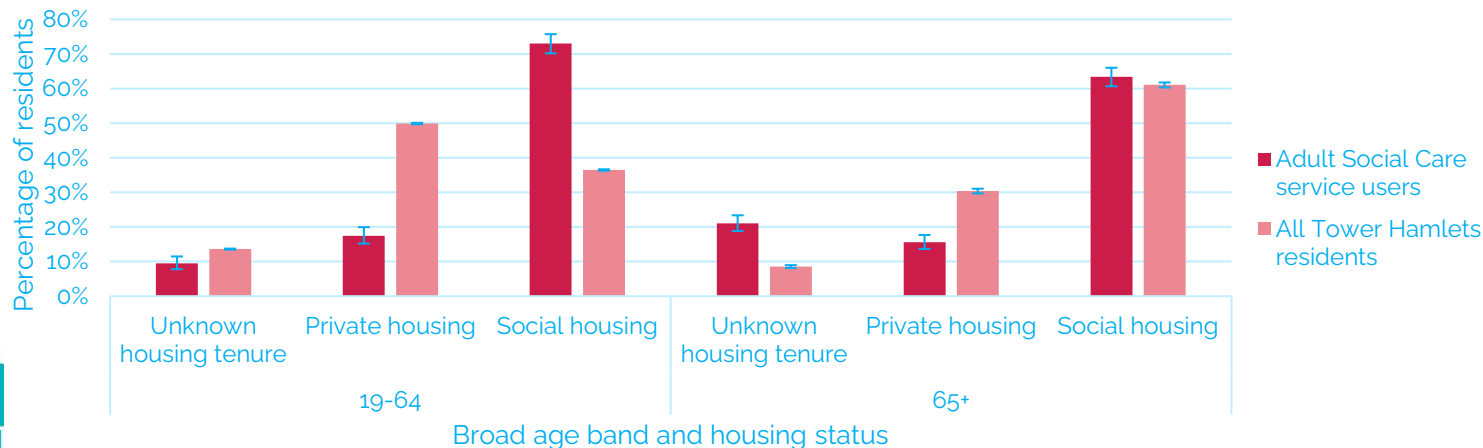


Adult social care service users were more likely to live in social housing and more likely to live alone across all age groups

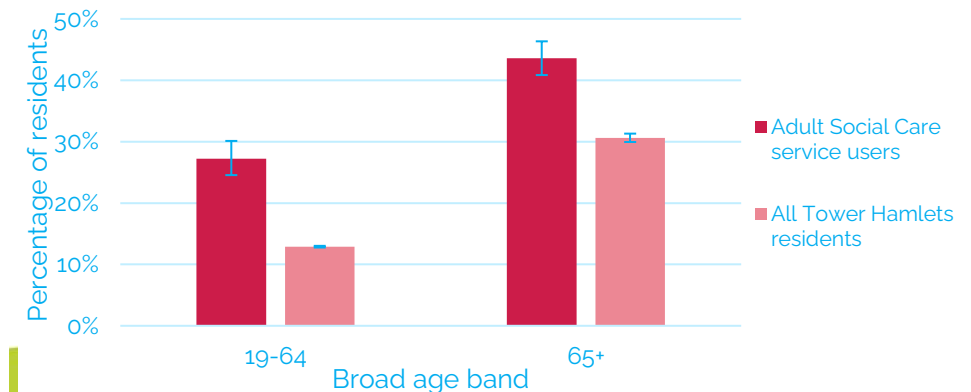


- Living arrangements influence whether an individual has appropriate support around them to manage their needs, and can delay or reduce reliance on Local Authority social care services¹⁶. Living alone is also a risk factor for social isolation, which is associated with increased risk social care need¹⁷⁻¹⁹.
- WSDP data shows **adult social care service users aged 19-64 were twice as likely to live alone compared with overall residents (27% vs 13%). In older adults, around 44% of ASC service users lived alone, compared with 33% of residents overall** in that age group.
- There is a range of support in place across Tower Hamlets that may be relevant for individuals who live alone, including a wide range of voluntary services. For example, the Connection Coalition in Tower Hamlets brings together partners to address social isolation.
- Social care practitioners highlighted that support for individuals may be influenced by whether they live alone. This may include installing alarm systems for falls, or other forms of adaptation that address issues arising from living alone. Tower Hamlets also use a strengths-based approach to care, that encourages individuals to consider who may be able to support them to meet their needs, including friends and neighbours.
- In Tower Hamlets, WSDP data shows that, for adults aged 19-64, **over 73% of service users lived in social housing (compared with 36% of residents overall in that age group)**. This **gap is less visible in older adults**, but housing status was unknown for 20% of service users in that age group.
- Social care practitioners highlighted that the quality and appropriateness of an individual's housing, and the ability to make appropriate adaptations, is a significant factor in addressing social care needs. Service users often have issues in homes where adaptations to suit their needs can't be made, or are living in homes that are overcrowded and compound existing care needs.

Housing status of ASC service users and overall residents by broad age band, Tower Hamlets (WSDP 2017-18).



Proportion of ASC service users and overall residents who live alone, by broad age band, Tower Hamlets (WSDP 2017-18).

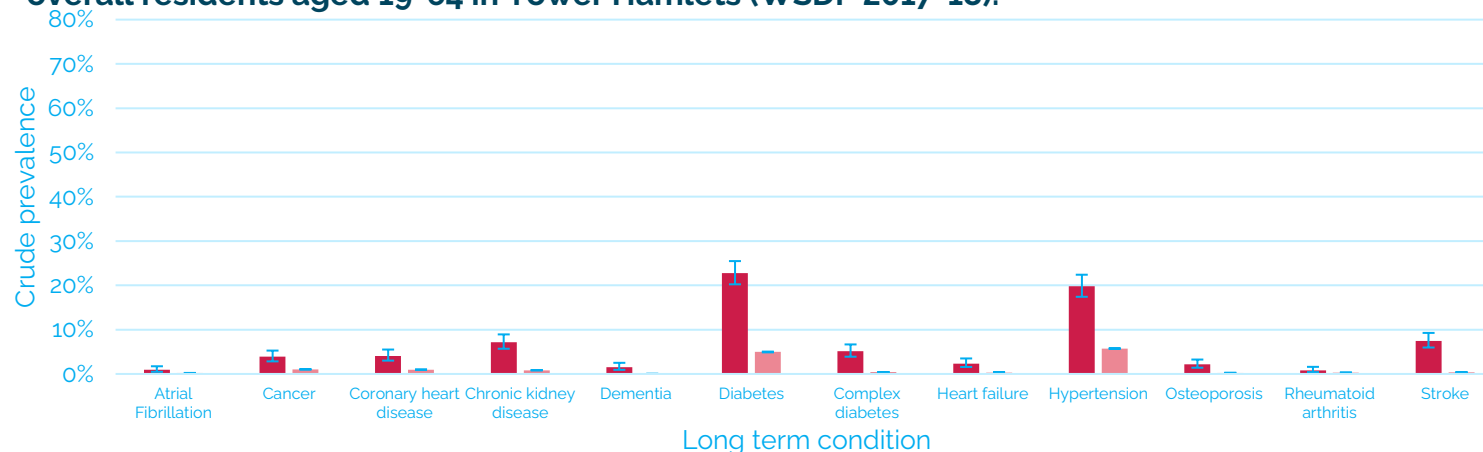


Prevalence of most long-term conditions are significantly higher in Adult Social Care users, in both working age and older adults

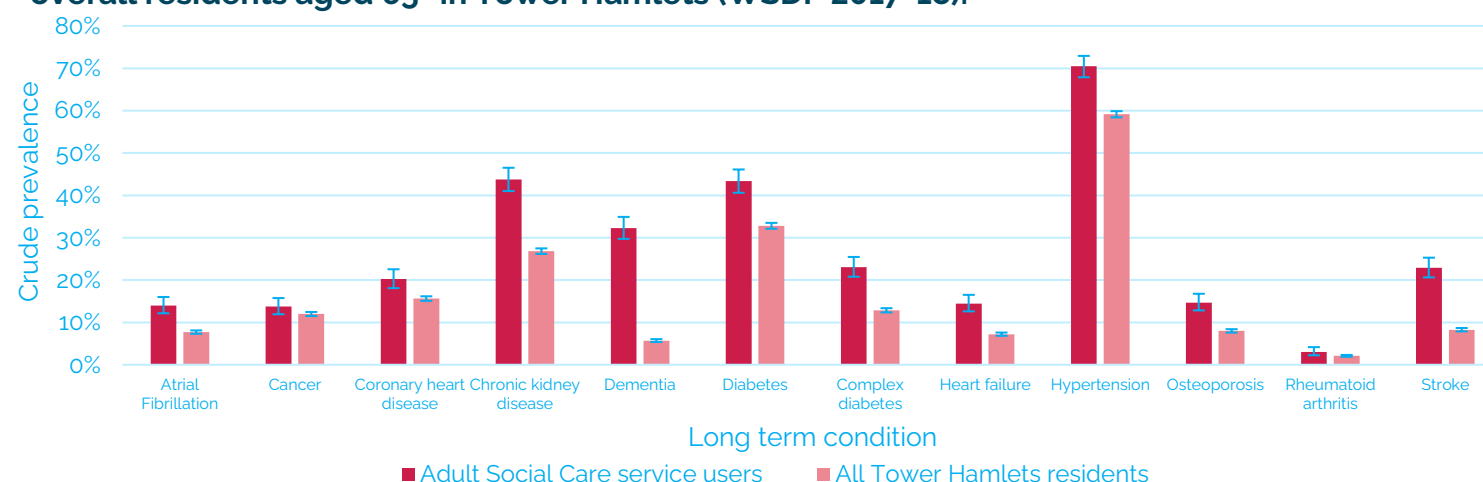


- Many long term conditions are associated with **increased need for adult social care support**, either through being the proximal “cause” of care need, e.g. in the case of dementia or strokes, and/or through contributing to ill-health as with hypertension¹⁰.
- **Across every condition and across every age band, prevalence of long-term conditions was higher in adult social care service users compared with the overall resident population.**
- For 19-64 year olds; prevalence was at least 2.77 times higher in ASC service users for every condition, and 20 and 70 times higher for stroke and dementia respectively. This gap is more expected for conditions that are strongly associated with social care need (stroke, dementia), but there are **significant differences in prevalence for more commonly occurring conditions like hypertension and diabetes**, that may not be the primary drivers of social care need but contribute to ill-health.
- In older adults, trends are similar but gaps in prevalence are less pronounced due to overall higher prevalence across all conditions. **Hypertension, diabetes and CKD were particularly common in service users aged 65+, with prevalence over 40% for each of these conditions.**

Prevalence of long term conditions in Adult Social Care service users and overall residents aged 19-64 in Tower Hamlets (WSDP 2017-18).



Prevalence of long term conditions in Adult Social Care service users and overall residents aged 65+ in Tower Hamlets (WSDP 2017-18).

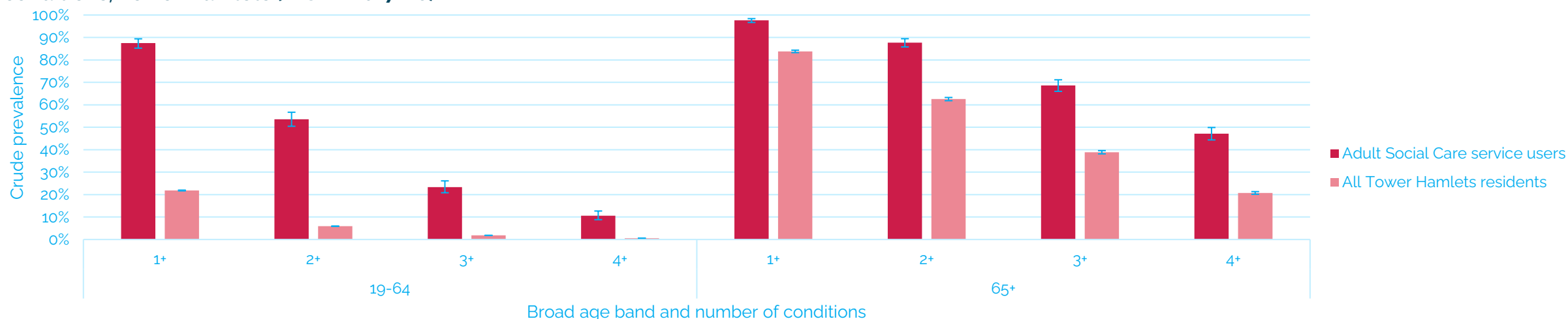


Multimorbidity prevalence is also higher in ASC service users – nearly half of service users aged 65 and over have 4 or more long term conditions



- WSDP data shows that as well as having a higher prevalence of all long term conditions, **service users were more likely to have multiple long term conditions (MLTCs) compared with the resident population**. For **19-64 year olds, 87% of ASC service users had at least one LTC**, compared with 22% of residents overall. Service users were also **more likely to have several conditions; 23% had 3 or more conditions; 11% had four or more** (compared with 2% and <1% respectively in the resident population).
- In older adults (aged 65+), almost all service users had a diagnosed long term condition (98%; 84% in resident population). Prevalence of 3+ and 4+ conditions show marked differences with the resident population – 69% of ASC service users have 3 or more LTCs (39% in resident population), and 47% have 4 or more (21% in residents overall).**
- Adult social care practitioners highlighted the importance of long term condition management in reducing social care needs, and many cases in which ineffective management of conditions has increased needs for individuals. As individuals are often diagnosed with conditions earlier in life in Tower Hamlets, this can exacerbate health and social care needs.
- A previous estimate of multimorbidity in Tower Hamlets in 2012/13 estimated multimorbidity prevalence (for 2+ and 3+ conditions) to be significantly below those reported by the WSDP^{20,21}. However, WSDP findings for multimorbidity (2+ conditions only) are broadly consistent with findings from a large cohort study in England, which estimated multimorbidity prevalence using a similar methodology to the WSDP²². For a full list of conditions included in the WSDP analysis, see the technical information in Appendix B.

Prevalence of Multiple Long Term Conditions (MLTCs) in ASC service users and all residents by broad age band and number of conditions, Tower Hamlets (WSDP 2017-18).

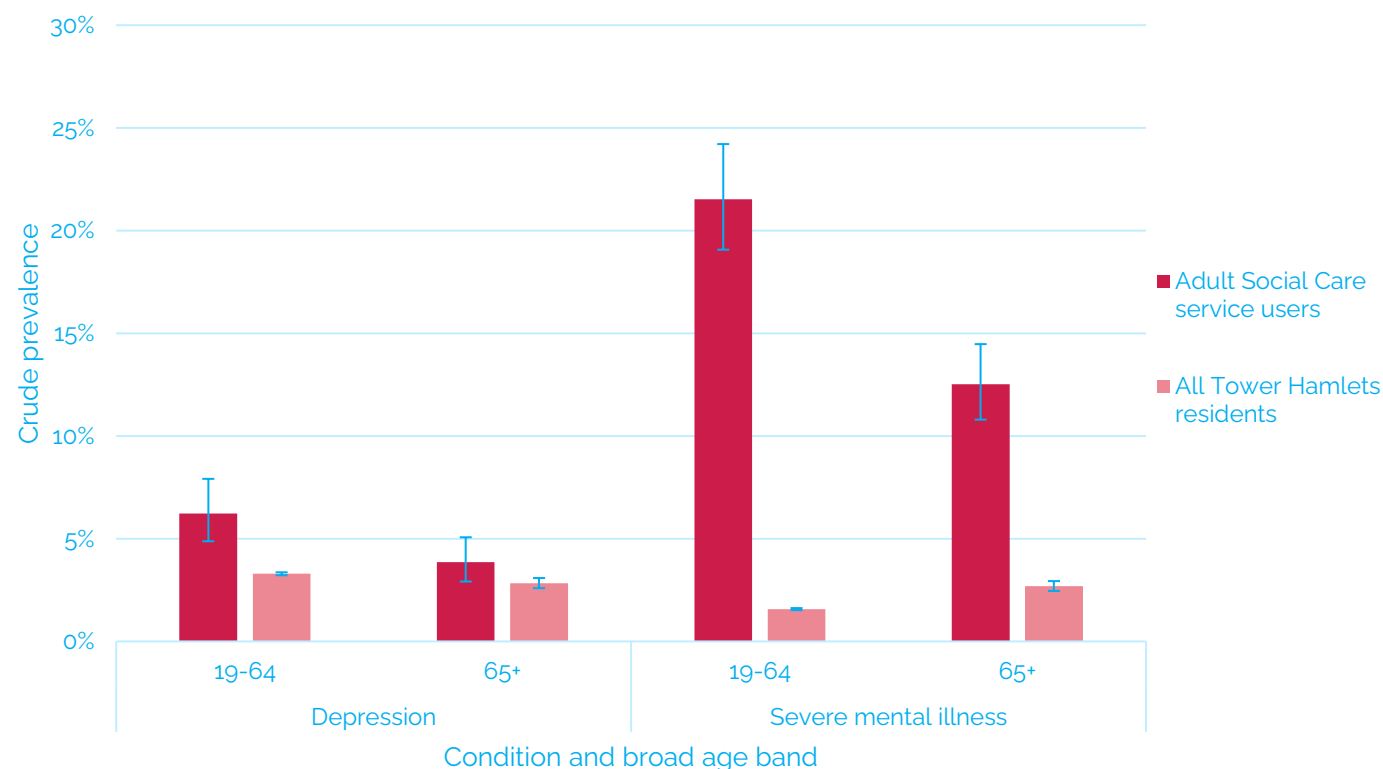


Prevalence of depression and severe mental illness (SMI) were higher in service users than residents overall, across all age groups



- In addition to long-term conditions covered previously, **prevalence of depression and severe mental illness were also higher in adult social care service users compared with the resident population overall.**
- This was most significant for **SMI in service users aged 19 to 64, where prevalence was nearly 14 times higher than in the overall resident population.** This is not surprising, given the role adult social care play in supporting individuals with mental health needs.
- We know that **prevalence of depression has increased in Tower Hamlets since 2017-18**, so this data should be treated with caution. Published data on the prevalence of depression for 2017/18 is also than recorded prevalence in the WSDP⁶.

Prevalence of depression and severe mental illness in ASC service users and all residents by broad age band, Tower Hamlets (WSDP 2017-18).

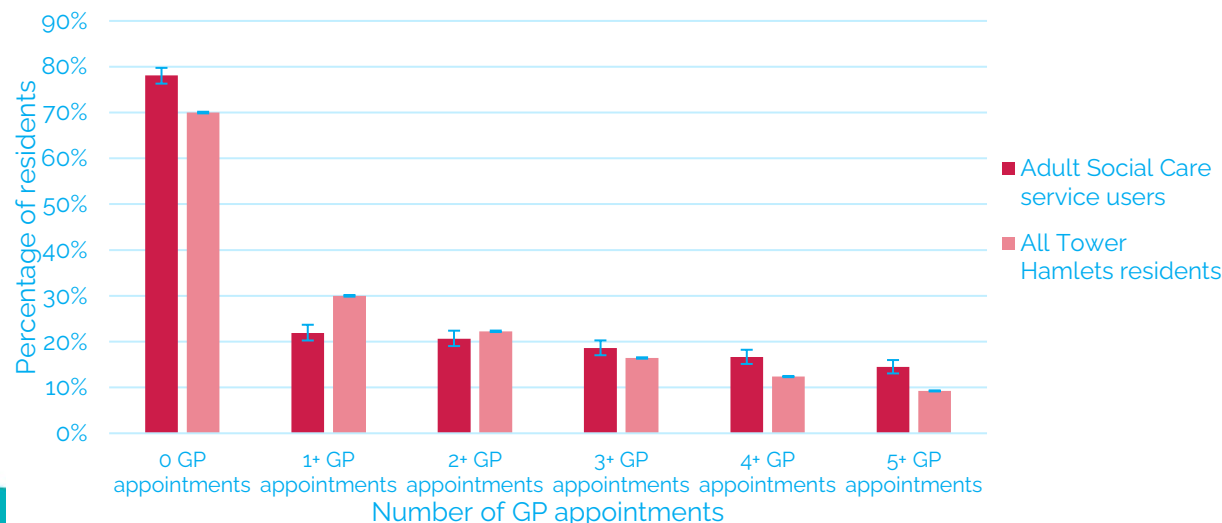


Despite most service users having multiple conditions, a higher proportion had no GP appointments in the previous 12 months compared with the overall resident population

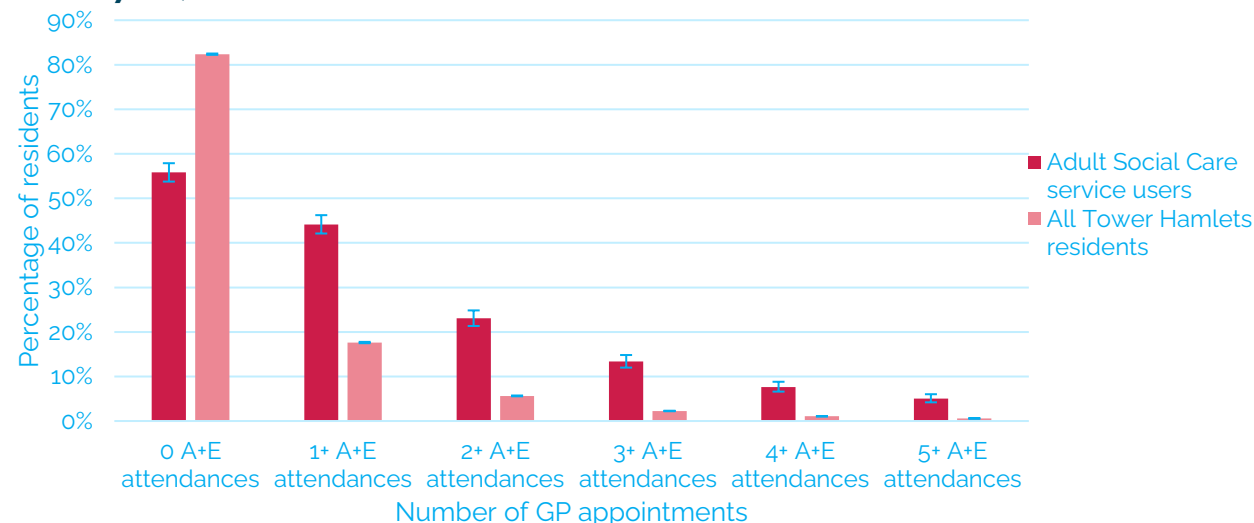


- Across all ages **78% of service users hadn't attended a GP appointment in the previous 12 months, compared with 70% of the population overall.** However, **service users who have had one or more GP appointment are much more likely to have had several appointments compared with the resident population.**
- In some areas in Tower Hamlets, there have been examples of effective MDT working across primary care and adult social care to address needs through an integrated approach. There is an ambition to use this model in other areas, given the link between health need and social care need. Neighbourhood mental health teams are also in place in Tower Hamlets, that bring together primary care, NHS Trusts and adult social care to support an integrated approach to meeting mental health needs.
- **A+E attendances are notably higher in service users compared with the resident population** (44% vs 18%). This is likely influenced in part by age demographics of service users compared with the resident population as a whole.
- Due to challenges with the WSDP data, we are unable to break these findings down by age band.

Number of GP appointments attended in 12 month period by Adult Social Care service users and all residents, Tower Hamlets (WSDP 2017-18).



Number of A+E attendances in 12 month period by Adult Social Care service users and all residents in Tower Hamlets (WSDP 2017-18).



Changing patterns of Adult Social Care support in Tower Hamlets

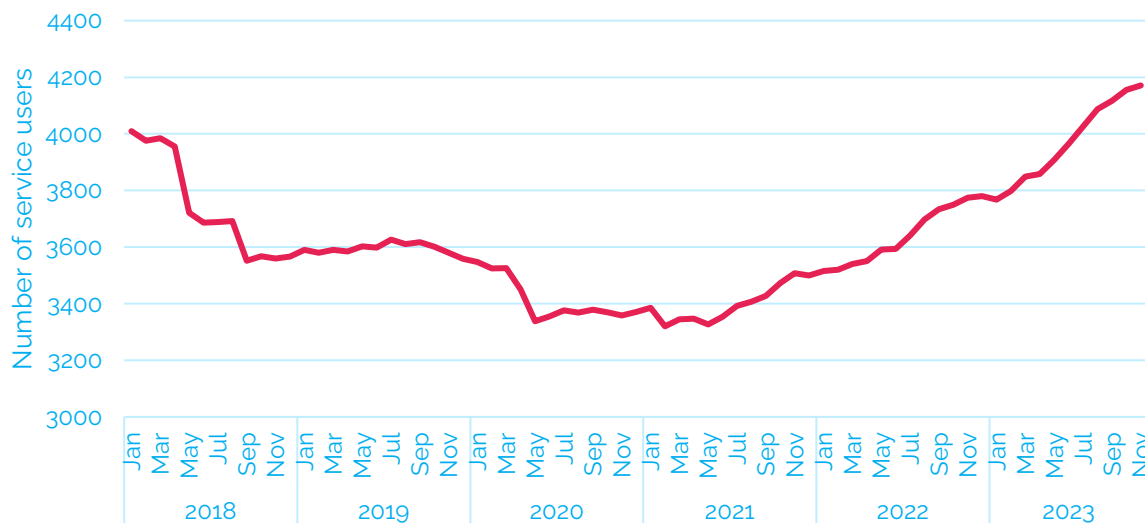


The total number of service users has increased steadily since 2021, following a fall in the number of older adults being supported from 2018 to 2021

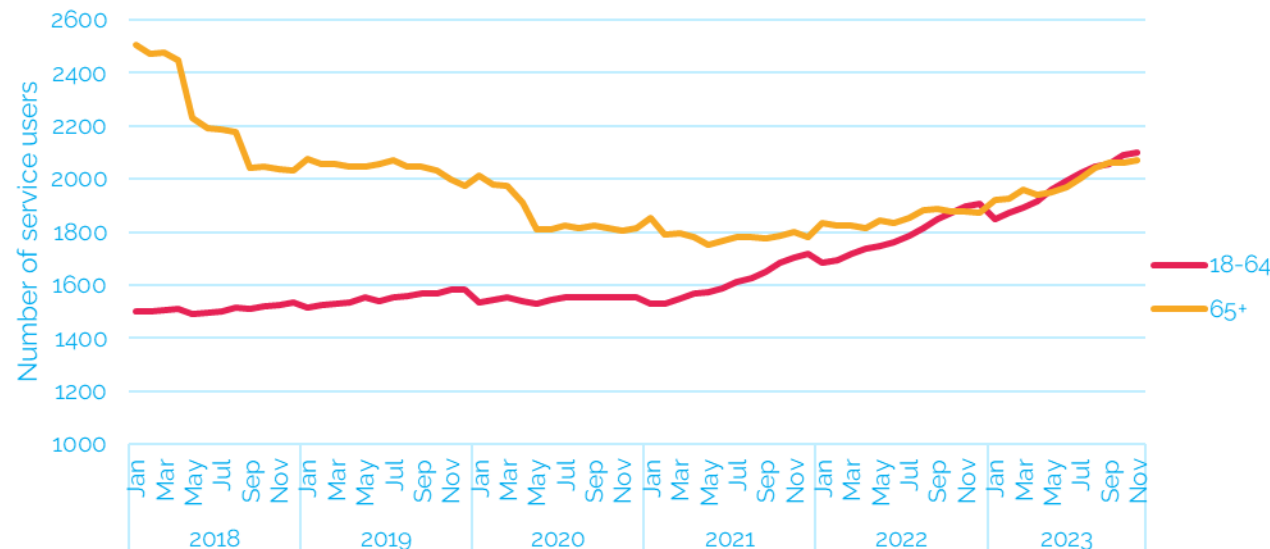


- The total number of service users supported in each month fell between January 2018 and May 2020, driven by a significant drop in older adults being supported.
- Since mid-2021, the number of service users has steadily increased, as the drop in older adults being supported has levelled off and the number of 18 to 65 year olds supported has continued to increase.
- **The total number of service users supported in November 2023 was 4,171 – equating to a 25% increase in service users since May 2020.**
- This only represents adults in receipt of a package of support from adult social care, so excludes those “known to ASC” but not receiving a package of support.

Number of adult social care service users per month in Tower Hamlets, January 2018 - November 2023 (Mosaic).



Number of Adult Social Care service users in Tower Hamlets by broad age band, January 2018 - November 2023 (Mosaic).

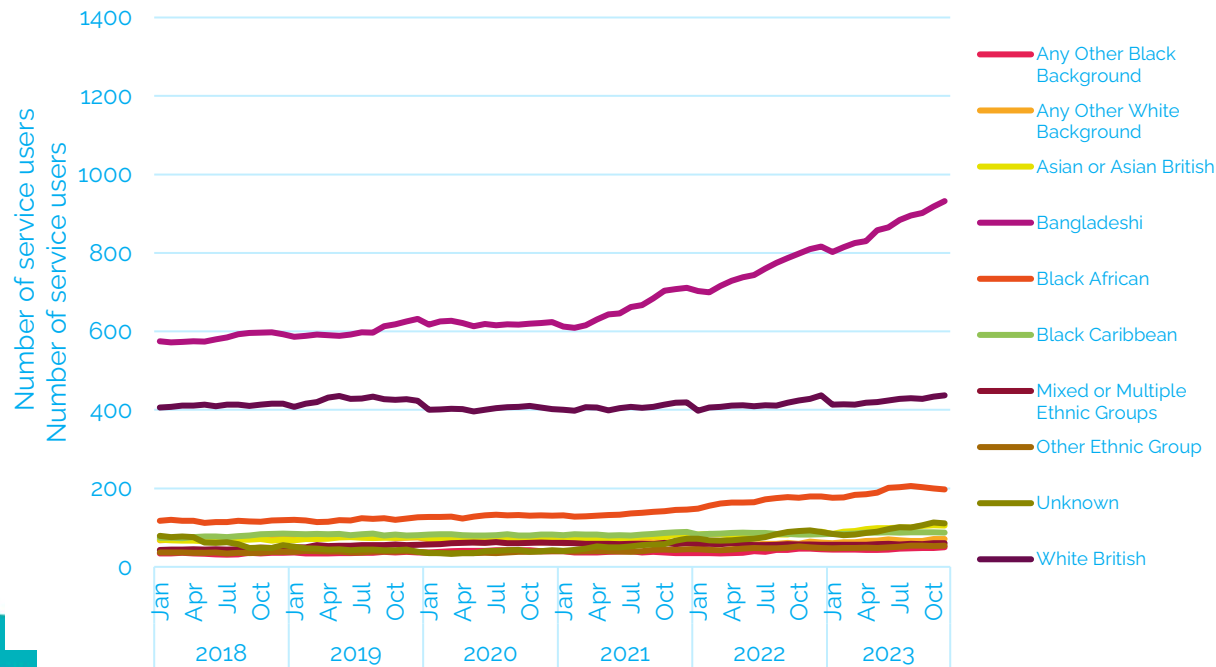


The increase in service users aged 18 to 64 is being driven by significant increases in Bangladeshi service users

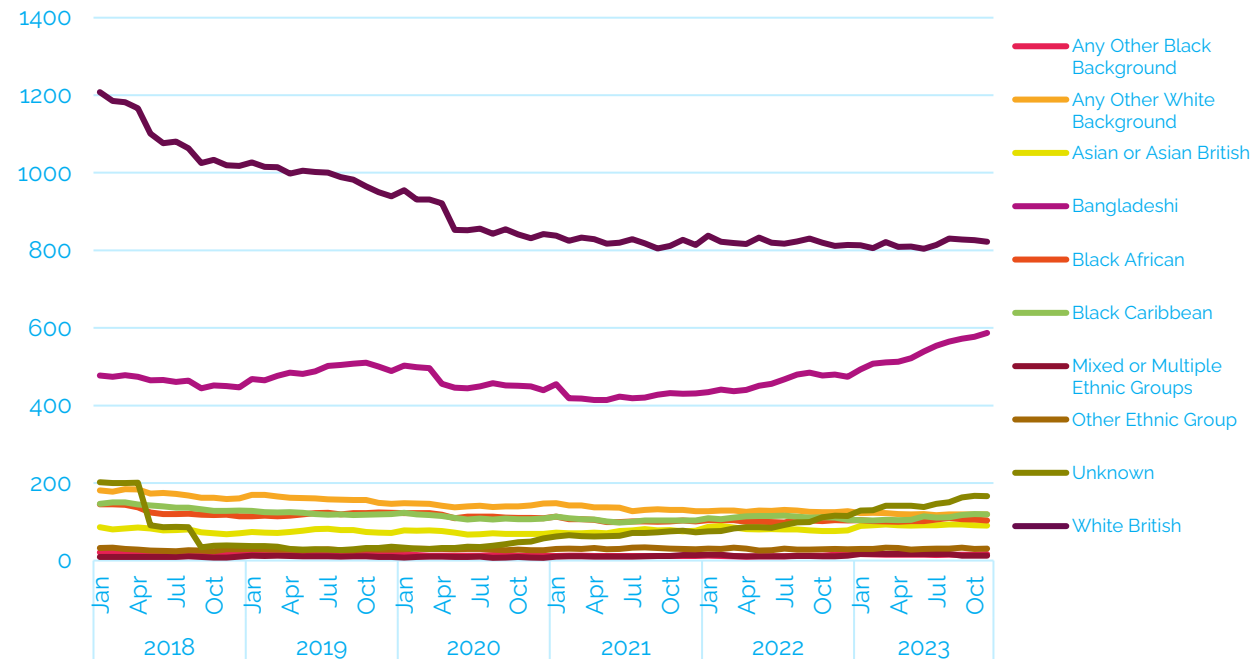


- For **18 to 64-year olds** there has been increases in the number of service users across all ethnic groups, but this is particularly pronounced for the Bangladeshi ethnic group (932 in November '23 vs 575 in January '18).
- Service users in the Black African ethnic group have also increased significantly relative to overall population size, while the number of service users in the White British ethnic group has remained relatively constant,
- For **older adults (aged 65+)**, the number of service users in the White British ethnic group has fallen since 2018, with similar trends seen across other ethnic groups. Conversely, **there are now more service users aged 65+ in the Bangladeshi ethnic group compared with 2018** (though the rate of increase is lower than in younger ages).

Number of Adult Social Care service users in Tower Hamlets aged 18 to 64 by ethnic group, January 2018 - November 2023 (Mosaic).



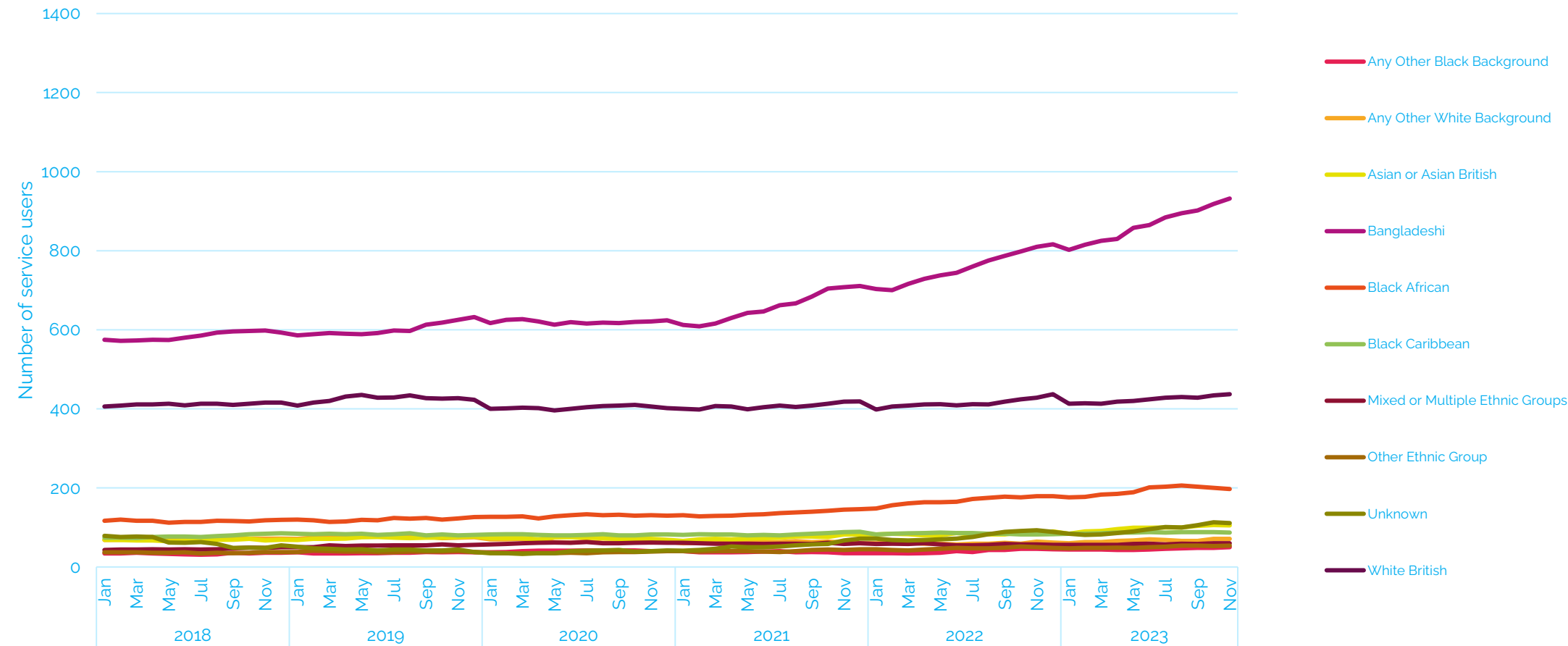
Number of Adult Social Care service users in Tower Hamlets aged 65+ by ethnic group, January 2018 - November 2023 (Mosaic).



The increase in service users aged 18 to 64 is being driven by significant increases in Bangladeshi service users (detail)



Number of Adult Social Care service users in Tower Hamlets aged 18 to 64 by ethnic group, January 2018 - November 2023 (Mosaic).



The increase in service users is consistent across age groups up to 65, while the drop in service users over 65 is highest in the oldest age groups



- The adjacent table shows the change in the number of service users by ten-year age band between January 2018 and November 2023. **There have been consistent increases in the number of service users across the age bands up to age 65** – particularly for young adults and those in middle ages (35-54).
- The trends in younger age groups are broadly reflective of population growth in these age bands, though the rate of increase is significantly larger than population growth during this time.
- The reverse trend is true in **over 65's, where there has been decreases in the number of service users across all age bands, and the largest proportionate decreases in the oldest age groups.**

Number of Adult Social Care service users in Tower Hamlets in January 2018 and November 2023 by 10-year age band (Mosaic).

10-year age band	Number of adult social care service users		
	January 2018	November 2023	% change
18-24	147	219	+49.0%
25-34	269	358	+33.1%
35-44	286	429	+50.0%
45-54	332	507	+52.7%
55-64	468	591	+26.2%
65-74	665	613	-7.82%
75-84	952	783	-17.8%
85+	890	671	-24.3%

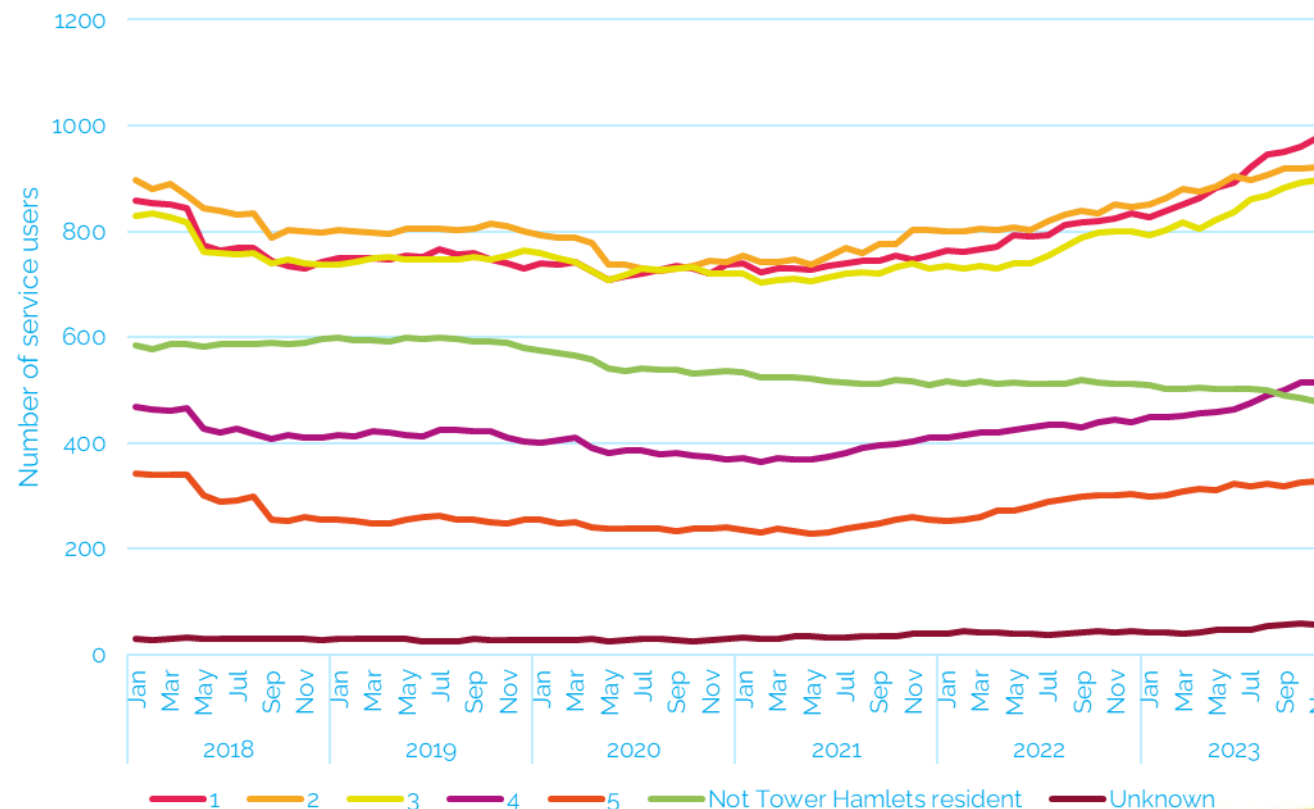


There is no clear association between the increase in social care service users and deprivation



- Broadly, the trend in the number of service users by Tower Hamlets relative deprivation quintiles has been broadly **consistent**, with the exception of those in the least deprived 20% of areas, where there has been a slight drop in the number of service users.
- The number of service users with a listed residents outside of Tower Hamlets has fallen steadily since 2018.

Number of Adult Social Care service users in Tower Hamlets by relative deprivation quintile, January 2018 - November 2023 (Mosaic).

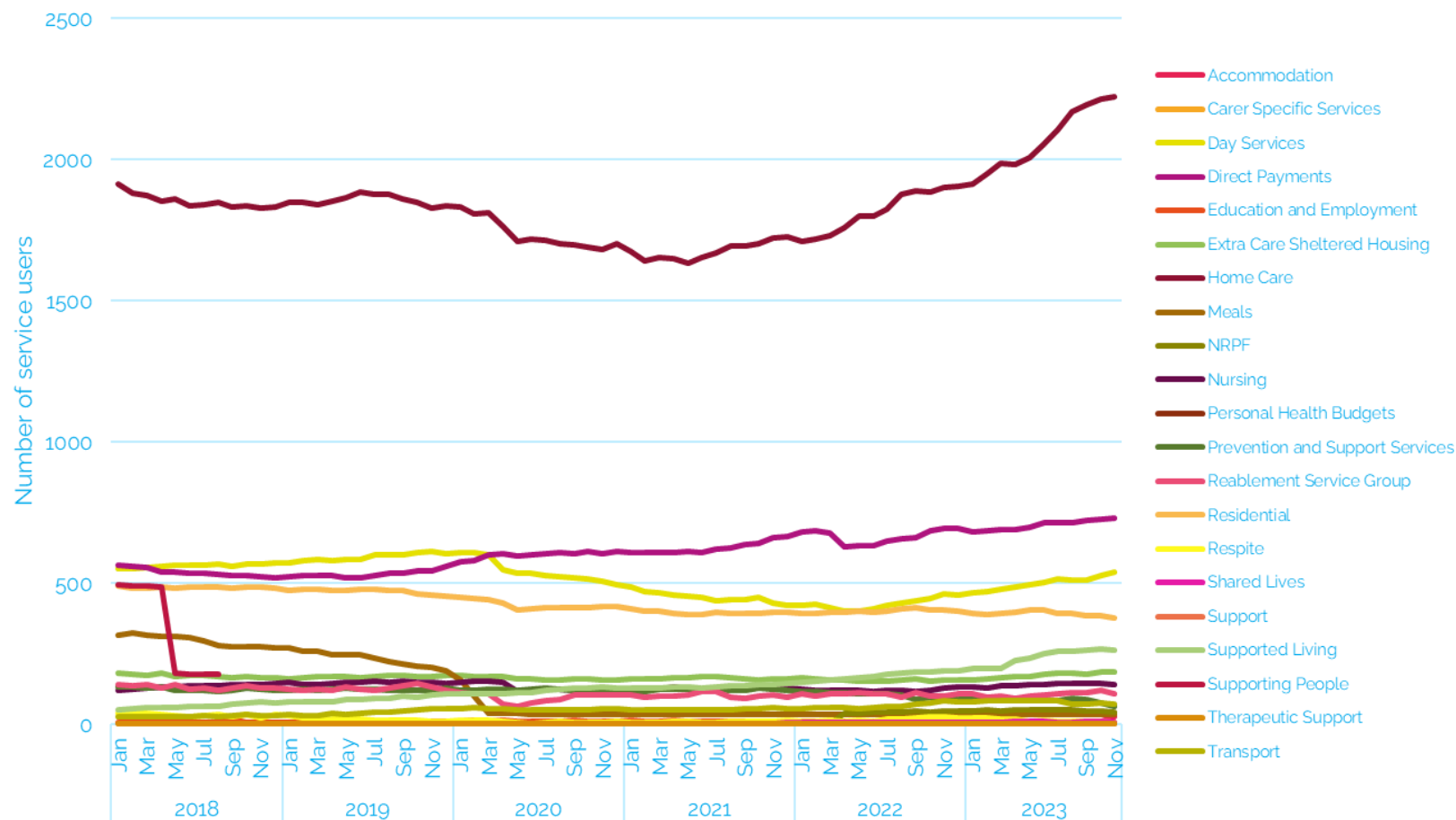


Increases in service users are being driven by an increase in the number of people receiving home care support



- Looking at the number of service users per month by service type, there has been an increase in the number of service users receiving home care since mid-2021 – from 1,635 service users in May '21 to 2,221 in November '23 – a 36% increase.
- Other service types have seen increases in services (see next slide).
- There are several reasons that the number of individuals receiving home care support has increased in the previous three years. Closure of day services during the COVID-19 pandemic may have increased need for home care support.
- There is also an **ambition in Tower Hamlets to support more individuals in their home where possible**, meaning home care is preferred to residential care options (this is also seen in the drop in service users receiving residential care). Feedback from service users has highlighted that home-based care is generally preferred.
- Many service users receive multiple services and, where more than one service is received in a given month, are counted in *all* service totals they received.

Number of Adult Social Care service users by service type and month, January 2018 – November 2023 (Mosaic).

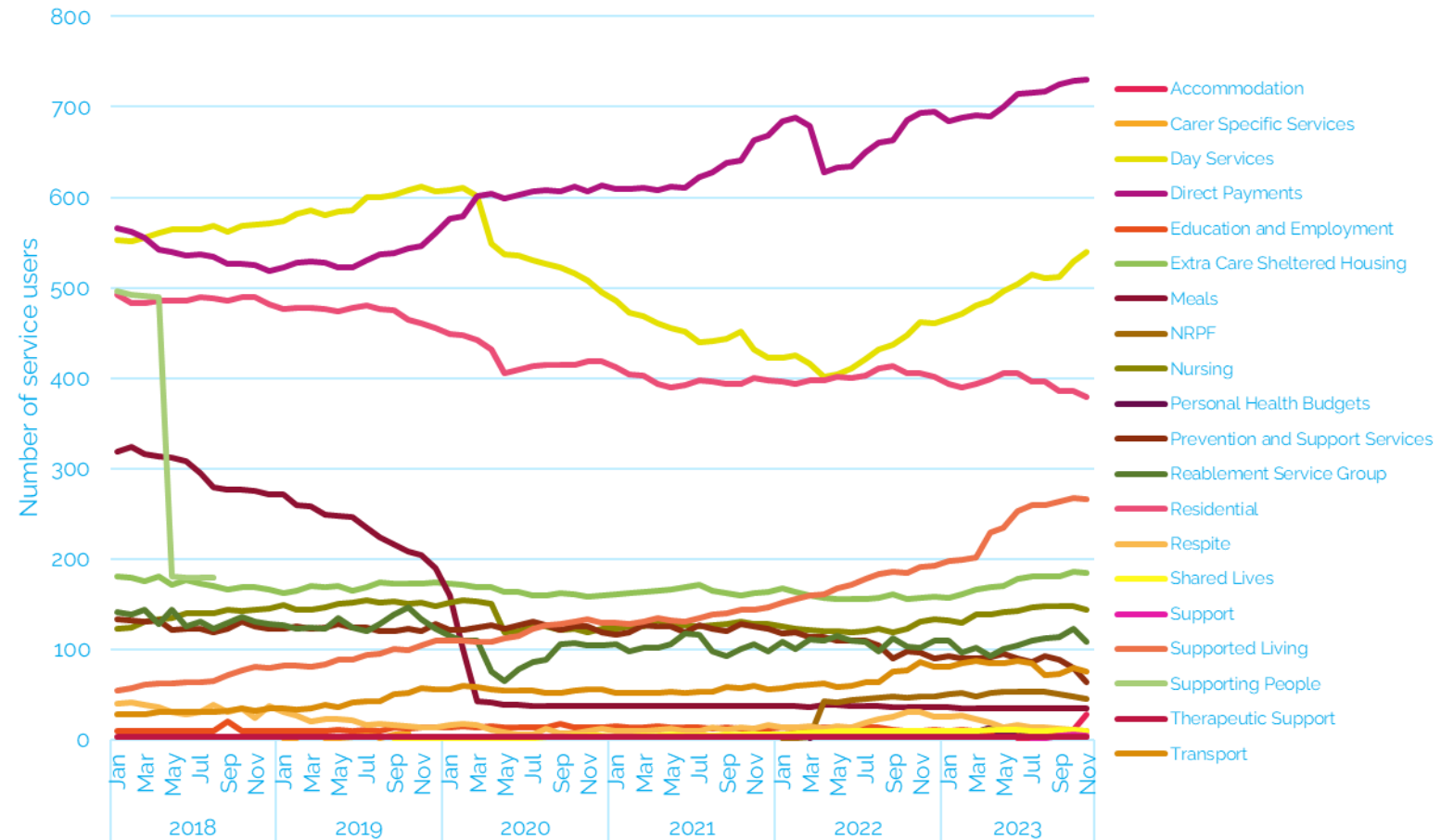


There has been notable increases in direct payments and supported living care in the last five years



- There are notable increases in two services in particular:
 - The number of service users in **supported living** increased from 54 in January 2018 to 266 in November 2023 – **a 393% increase**.
 - The number of service users receiving **direct payments** increased from 566 in January 2018 to 730 in November 2023 – **a 29% increase**.
- Day services fell during the COVID-19 pandemic due to the closure of many services**, but since 2022 have seen an increase in individuals being referred to services on re-opening.
- Conversely, the number of service users in **residential care** has decreased from 492 in January 2018 to 379 in November 2023 – **a 23% decrease**. As noted in the previous slide, this is driven by an ambition to, where possible, continue to support individuals in their home in Tower Hamlets.
- Other services have remained relatively consistent.

Number of Adult Social Care service users by service type (excluding home care) and month, January 2018 – November 2023 (Mosaic).

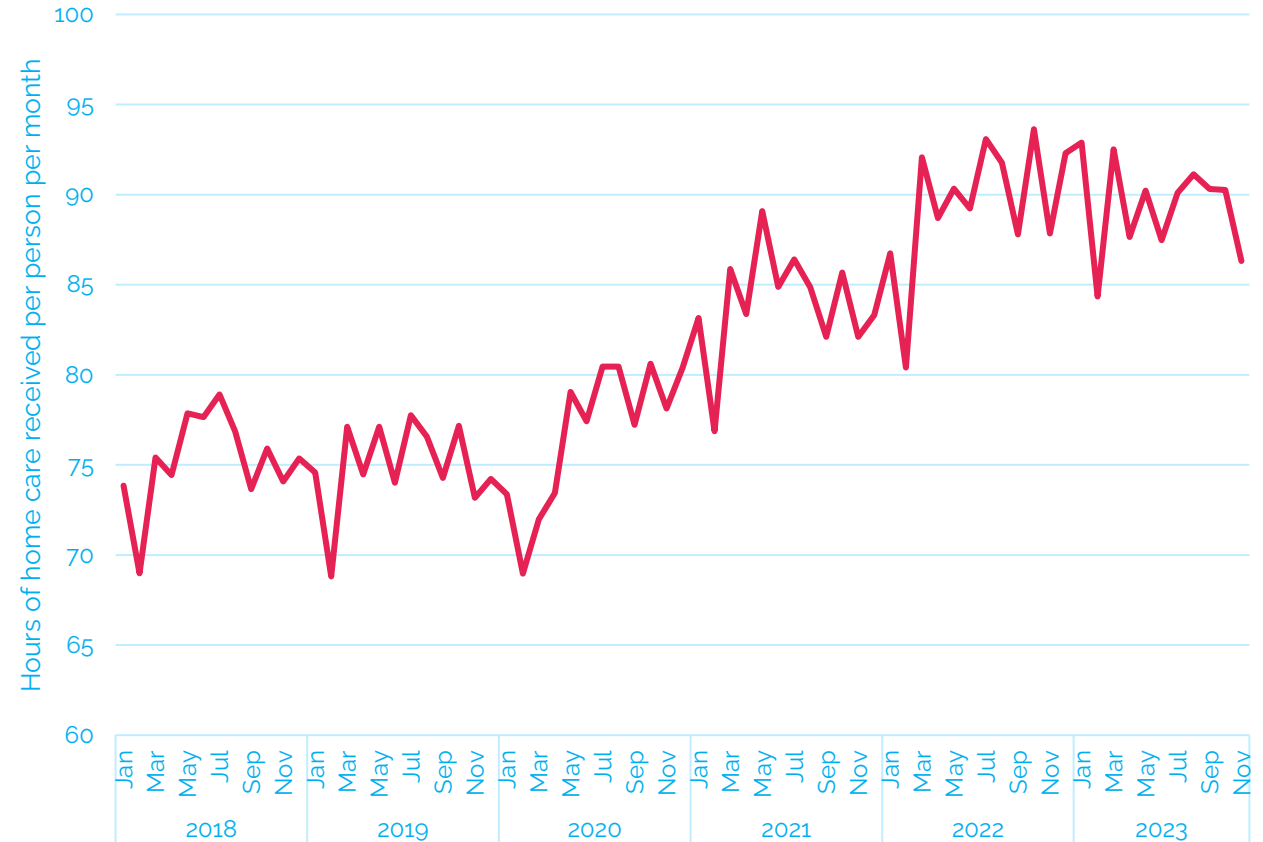


As well as increasing numbers of service users receiving home care, the intensity of the support they are receiving is also increasing



- To understand how intensity of service use has changed over time, we explored how the number of hours of home care service users received per month has changed since 2018.
- **There has been a significant increase in intensity of home care support per person since early 2020.** Service users were receiving an average of 90 hours of home care per month in October 2023, up from 74 hours in December 2019 - **a 21% increase.**
- Adult social care practitioners have noted that part of this **increase is driven by an increase in discharge to assess**, which is routinely a high-intensity service that was introduced at the beginning of the COVID-19 pandemic. Although D2A is a short term, high intensity service, once high intensity provision is in place it can be challenging to reduce this level of care on a longer-term basis,
- Feedback has also noted that there has been **increasing “complexity” in social care support for service users in recent years, driven by a range of factors including :**
 - **Lack of management of health conditions resulting in complications**
 - **Service users with alcohol and substance dependence**
 - **An increase in hoarding cases**
 - **Supporting service users with no recourse to public funds.**
- While “complexity” is not necessarily analogous to intensity of support, it may be these factors are partly driving increases in support intensity, for example through the need to double up care.

Hours of home care received per home care service user per month, January 2018 – November 2023 (Mosaic).



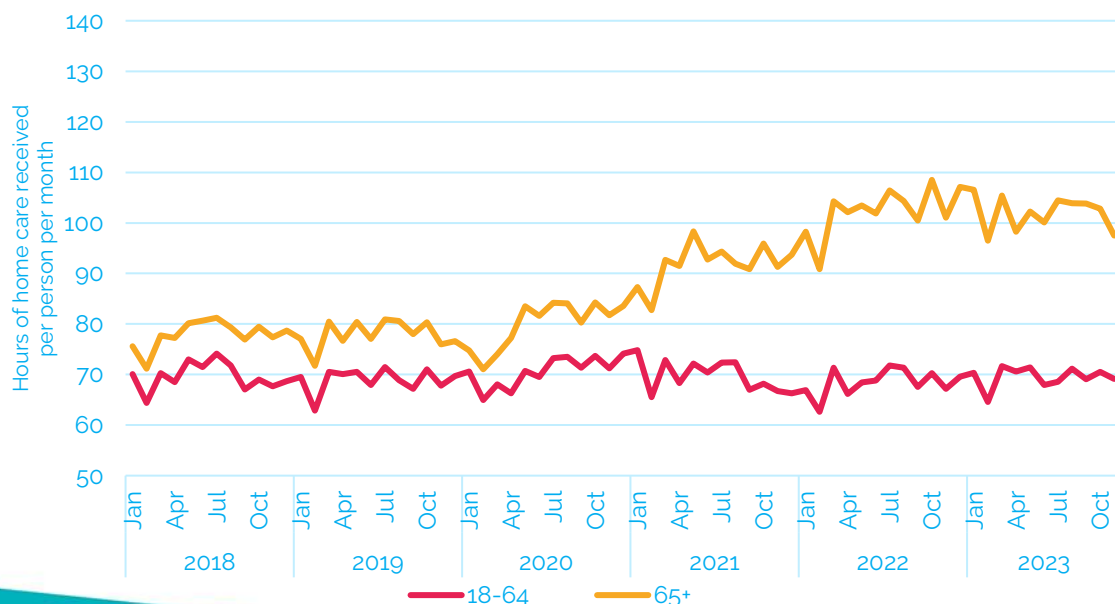
Increasing intensity is driven by service users aged 65+ - with the highest increases in the oldest age groups



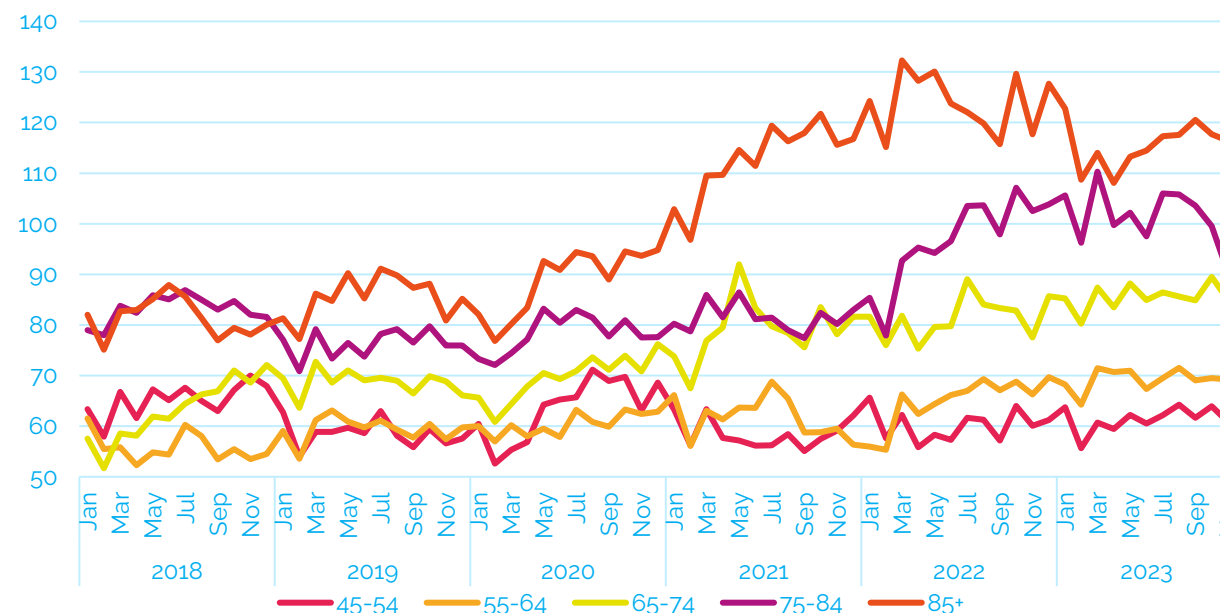
TOWER HAMLETS

- Unlike the number of service users, where increases are largely in 18 to 64-year olds, **increasing intensity in home care is almost exclusively being driven by older adults (aged 65+)**. This is most notable in the oldest age groups, with **intensity of home care support for service users aged 85+ increasing by 38% between December 2019 and October 2023**.
- The patterns of intensity by age reflect social care practitioner feedback, particularly around the provision of discharge to assess packages since 2020. Practitioners note the high number of service users receiving 24 hour care, caused by complex comorbidities. In some cases this support can be part-funded by NHS Continuing Healthcare, but this is not always possible.
- Intensity of support in older adults is higher in females than males**, and this has been a consistent trend since 2018. Increasing intensity of support in older adults has proportionately impacted males and females equally. In younger adults, there is no observed gap in intensity of support between males and females.

Hours of home care received per home care service user per month by broad age band, January 2018 – November 2023 (Mosaic).



Hours of home care received per home care service user per month by 10-year age band (aged 45+), January 2018 – November 2023 (Mosaic).

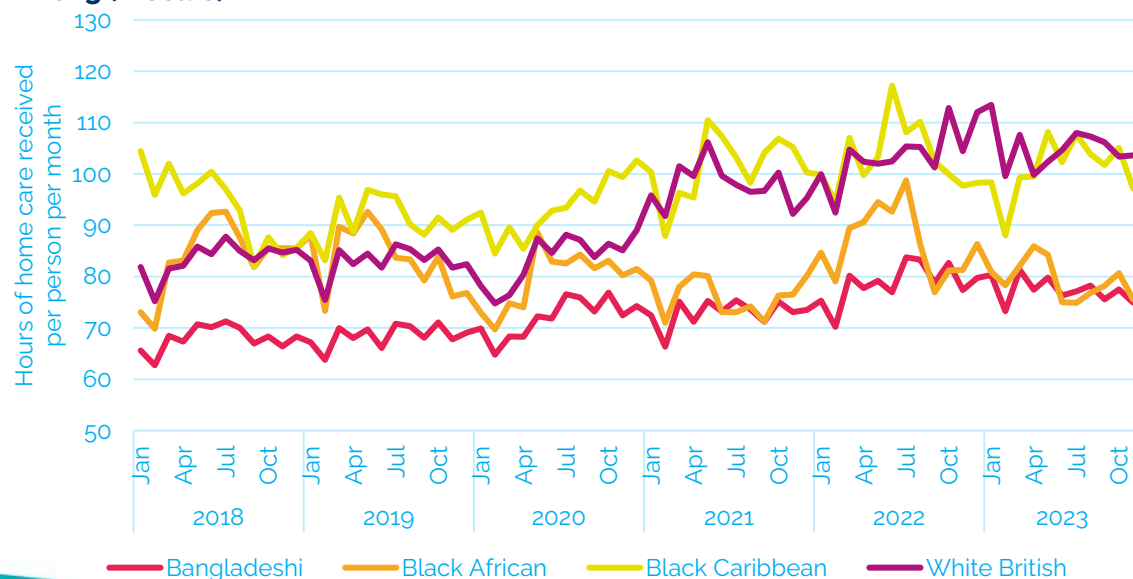


Changes in intensity have differed across ethnic groups, with Black Caribbean and White British service users receiving the highest intensity support

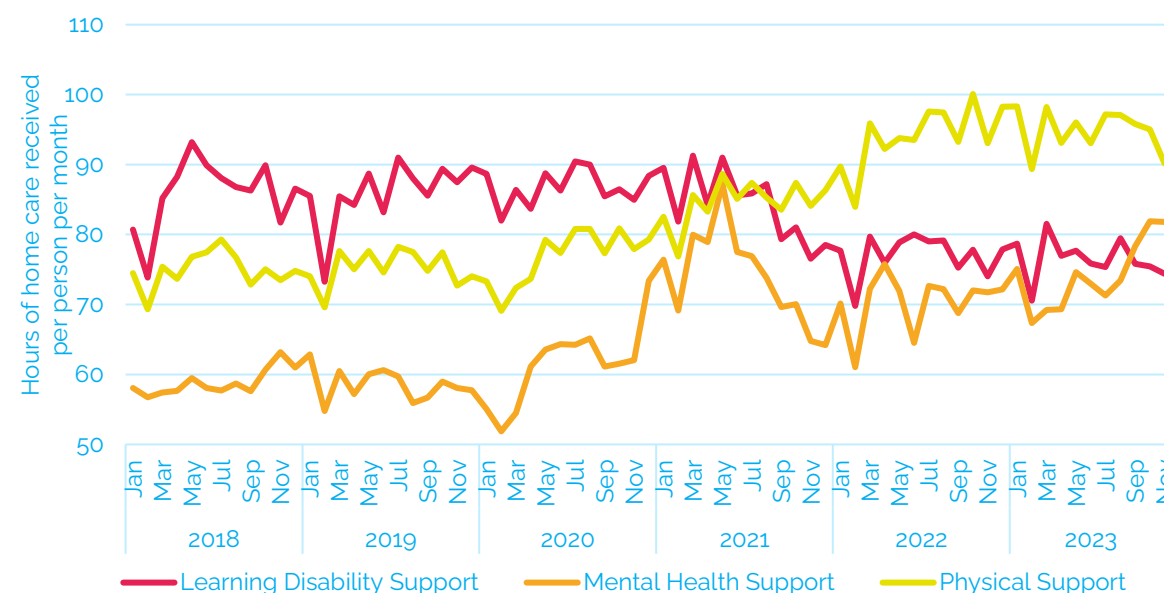


- Since 2020, **service users in the Black Caribbean and White British ethnic groups have consistently received among the highest intensity of home care support**, while service users in Bangladeshi and Black African ethnic groups have received the lowest intensity support. This is influenced by the age profile of service users.
- By Primary Support Reason, intensity of home care has **increased for those with mental health support and physical support listed as their PSR**, while **intensity has fallen for those with learning disability support as their PSR**.

Hours of home care received per home care service user per month for four largest ethnic groups, January 2018 – November 2023 (Mosaic).



Hours of home care received per home care service user per month by Primary Support Reason (three largest PSRs only), January 2018 – November 2023 (Mosaic).

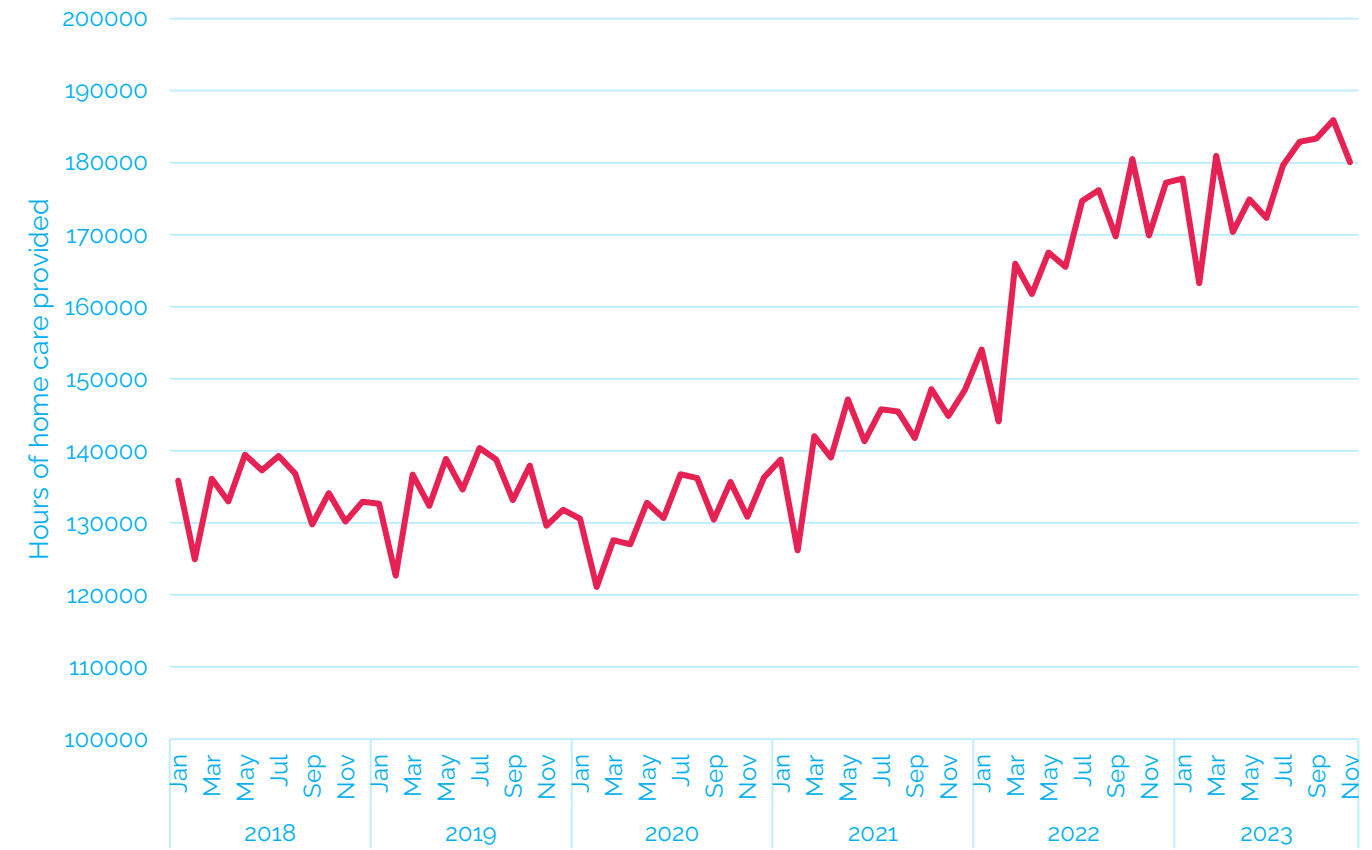


A combination of increasing home care service users and intensity of support has resulted in significant increases in total amount of support provided



- Previous slides have highlighted the rising number of service users since 2021, as well as increasing intensity of home care support for service users aged 65+.
- The combination of these factors means that the total amount of home care support provided has increased significantly since 2019 – from around 132,000 hours in December 2019 to nearly 186,000 hours at its peak in October 2023. **This represents a 41% increase over this period.**

Total hours of home care support delivered per month by Adult Social Care, January 2018 – November 2023 (Mosaic).



Demand for Adult Social Care services



Recorded contacts have increased over the previous three years, with one-off service requests the most common outcome of contacts



- The number of contacts recorded denotes interactions with social care, Tower Hamlets Connect and other related services. This does not necessarily correspond directly to demand, as contacts can be raised for many reasons that may not be driven by changing/increasing need.
- **Tower Hamlets Connect was established in July 2021 as a “single point of access” and to refer people to appropriate advice and information**, or an assessment or further support if required²³.
- The **most common outcome of a contact in 2023 was a one-off service request**, followed by information and advice and D2A support plan. Initial assessments are the fifth most common outcome from contacts,
- **Despite an increase in the number of contacts year on year in the previous three years, this has not translated to a significant increase in the number of initial assessments or reviews.** This may be due to Tower Hamlets Connect increasingly diverting individuals to information and advice, who may previously have been referred for assessment.
- This may be also be due to occasional waiting lists for initial assessments, though feedback from social care practitioners highlighted that this is not likely to be a significant factor.

Number of recorded Adult Social Care contacts, assessments and reviews, 2020/21 to 2022/23 (Mosaic).

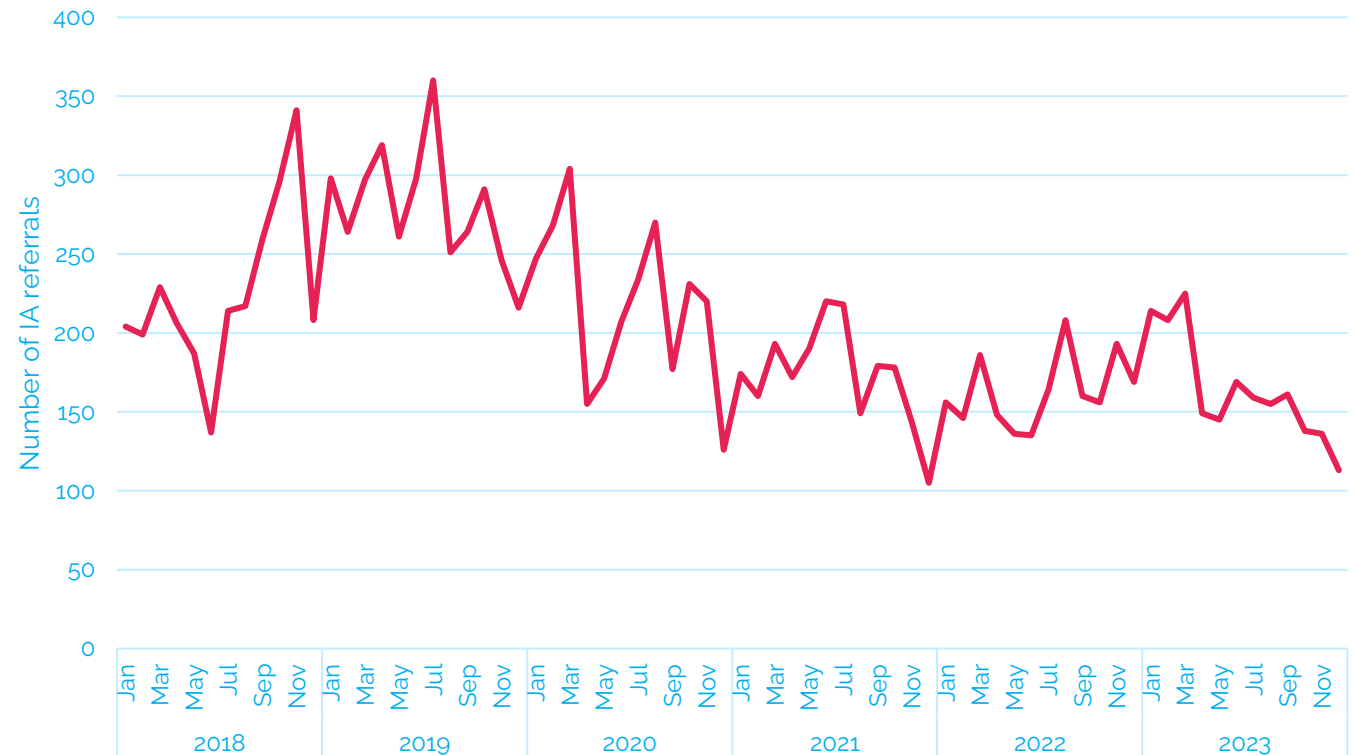


Despite an increasing number of contacts, the number of contacts with an outcome of initial assessments has not increased



- As noted previously, the number of contacts has increased steadily year on year, but this has **not resulted in increases referrals to initial assessments**, which may be due to Tower Hamlets Connect referring residents to advice and information or other services rather than social care.
- Since the introduction of Tower Hamlets Connect, contacts referred to assessment has remained broadly consistent.

Number of Adult Social Care contacts where outcome was referral for assessment, January 2018 – November 2023 (Mosaic).

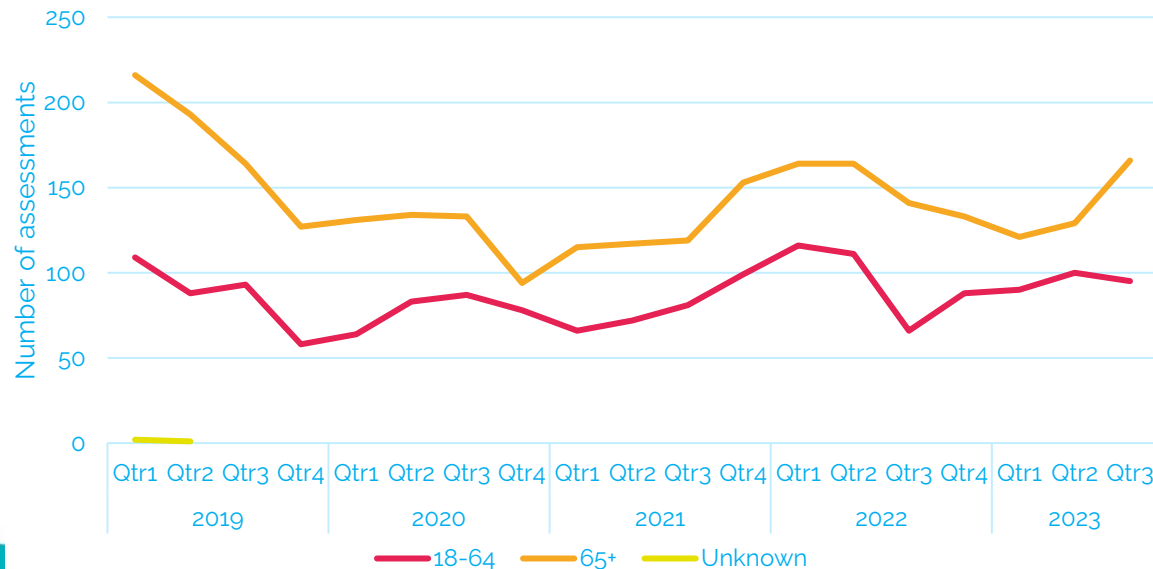


Increasing numbers of service users aged 18 to 64 are not reflected in a significant increase in initial assessments

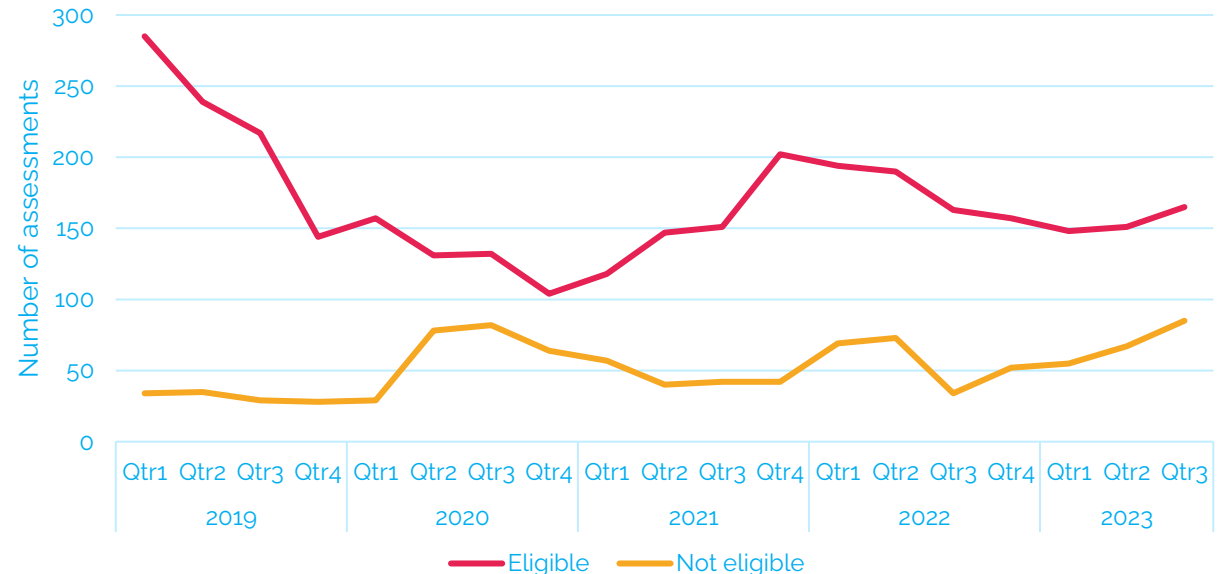


- Across all ages, the number assessments with an “eligible” outcomes has remained relatively consistent since mid-2021.
- The number of initial assessments conducted in part reflects capacity to conduct assessments, and therefore may not be a true reflection of expressed demand/need for social care.

Number of Adult Social Care Initial Assessments (IAs) conducted by broad age category of individual assessed, January 2019 – September 2023 (Mosaic).



Number of Adult Social Care Initial Assessments (IAs) conducted by eligibility outcome, January 2019 – September 2023 (Mosaic).

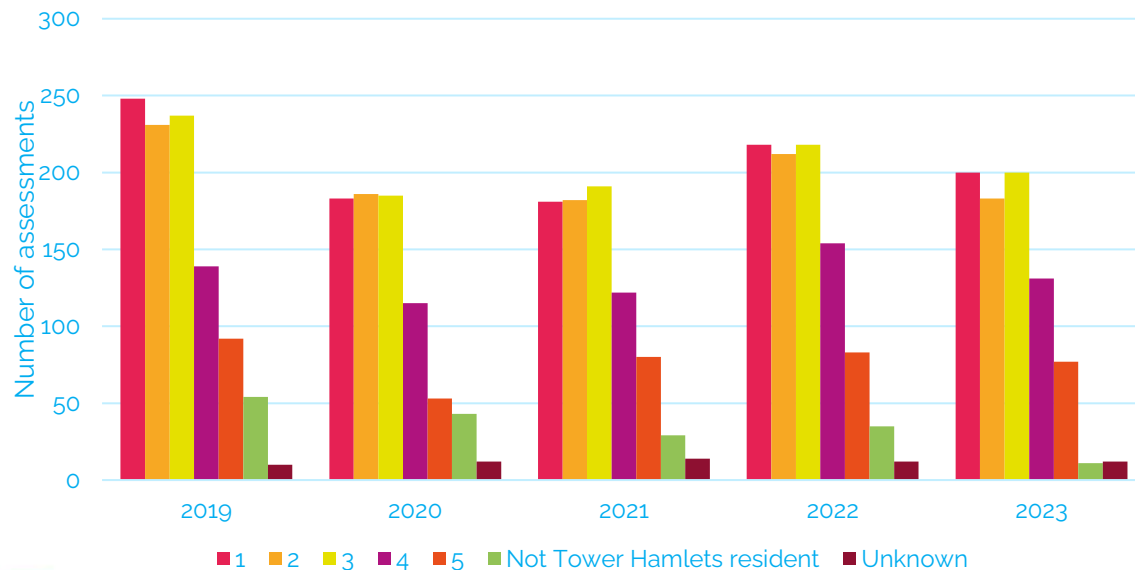


The number of initial assessments conducted is broadly consistent across the most deprived 60% of residents

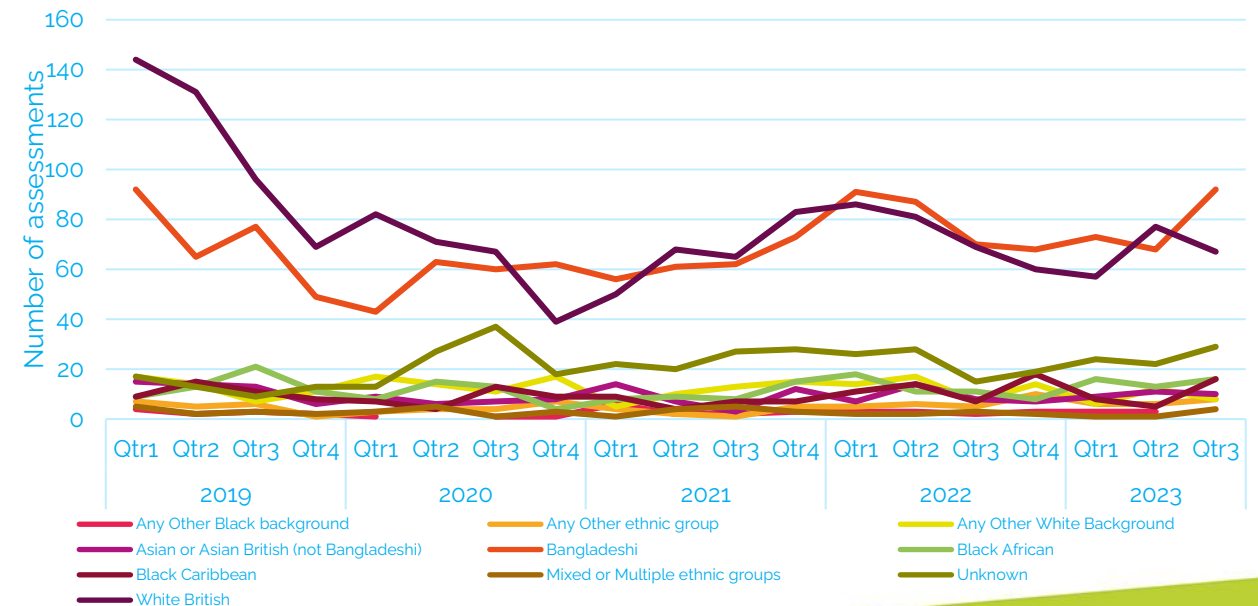


- Trends in the number of **initial assessments** have remained broadly consistent across all relative deprivation quintiles. The number of assessments conducted for individuals who are not resident in Tower Hamlets has decreased over time.
- **Individuals in the Bangladeshi and White British ethnic groups make up the majority of those who received an initial assessment in the previous 5 years.** The drop in assessments in 2019 and 2020 was largely driven by a sharp reduction in the number of assessments for White British residents, while the number of assessments for Bangladeshi residents has remained broadly consistent.

Number of Adult Social Care Initial Assessments (IAs) conducted by relative deprivation quintile, January 2019 – December 2023 (Mosaic).



Number of Adult Social Care Initial Assessments (IAs) conducted by ethnic group, January 2019 – September 2023 (Mosaic).

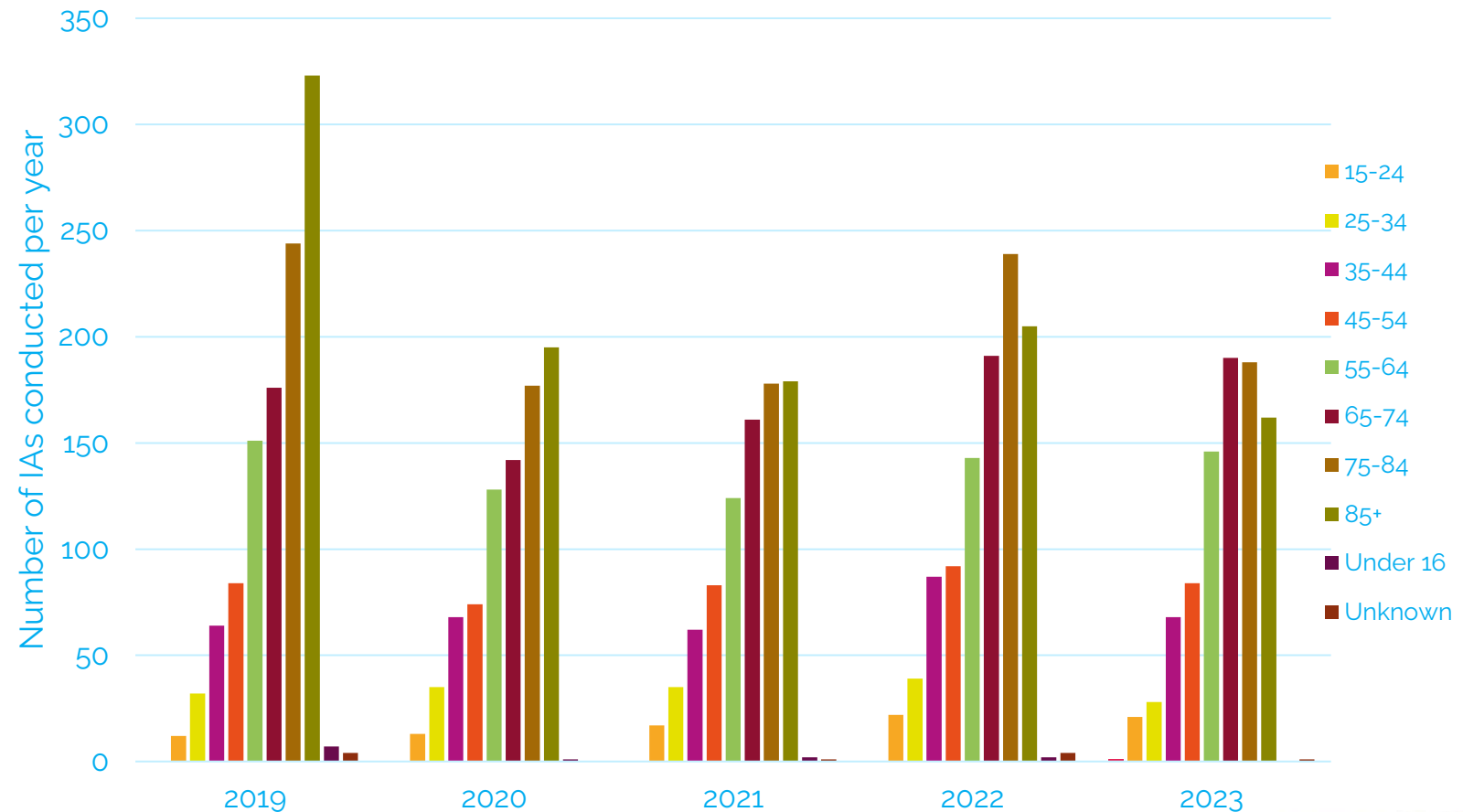


The drop in assessments between 2019 and 2020 was driven by a reduction in assessments for those in the oldest age groups



- **The number of initial assessments conducted broadly increases as age increases**, though in more recent years the number of assessments for 65-74 year olds and 75-84 year olds has overtaken the number of assessments for those aged 85+.
- **There a significant drop off in the number of assessments conducted for those in the oldest age groups** (this perhaps helps to explain trends seen in the number of service users by ethnic group, given the demographic profile of those in the oldest age groups in Tower Hamlets).
- This drop in the number of older adult service users was reflected in practitioner feedback, who noted the marked change in the age profile of service users in recent years.
- Most other age bands show broadly consistent trends in the number of initial assessments over time.

Number of Adult Social Care Initial Assessments (IAs) conducted by ten-year age band, January 2019 – December 2023 (Mosaic).



Carers in Tower Hamlets

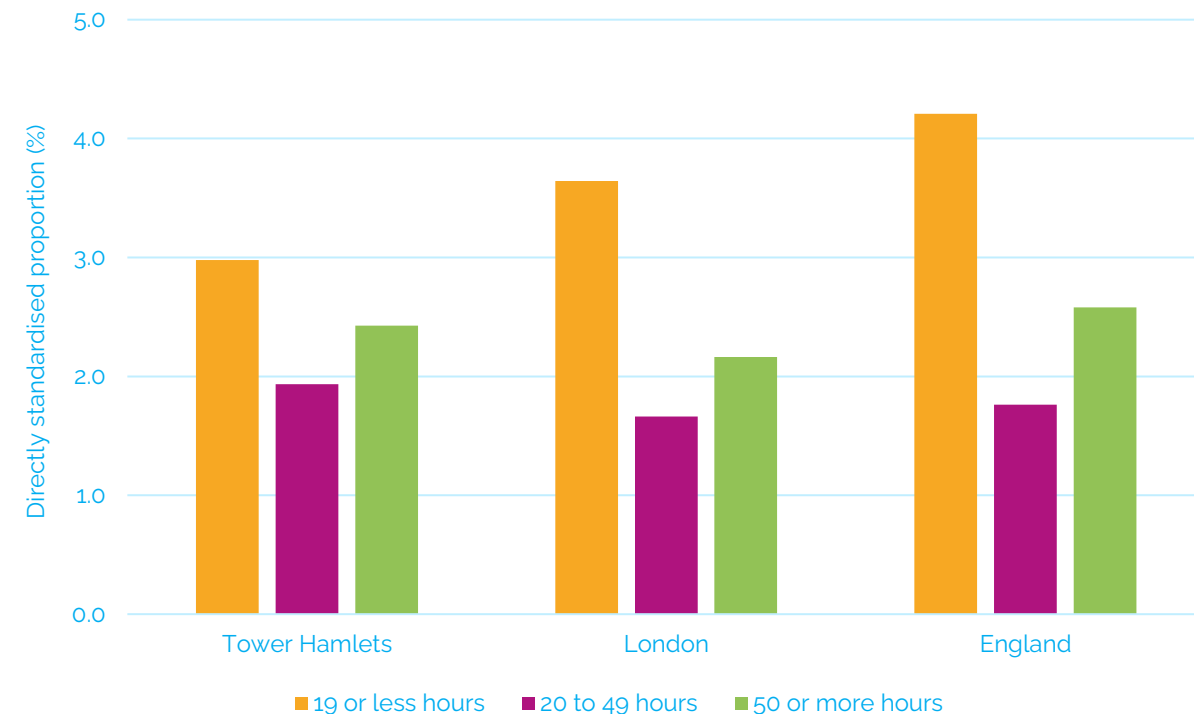


Tower Hamlets has a higher proportion of carers providing more hours of unpaid care per week than London and England averages



- Unpaid care provision plays a unique role in social care need, given it both meets need (either as an alternative to or a support of Local Authority provision), and generates need, given some carers are themselves eligible for support.
- There is relatively limited data on provision of unpaid care. The Census asks questions about unpaid care provision, allowing us to understand the extent and intensity of care provision and its resulting impacts, but does not ask about receipt of care – meaning it has limited uses in assessing whether (and how) social care need is met for recipients⁹.
- In total, **there are around 18,500 residents in Tower Hamlets aged 5 and over who provide unpaid care**; with the carer rate the fourth highest in North East London, similar to the London average and higher than the England average. There are more carers in the middle age brackets, reflecting population demographics⁹.
- Tower Hamlets has a higher proportion of carers who provide more intensive hours of care than both London and England averages. As this doesn't present data on number of care recipients, it is not possible to identify whether this is driven by more complex individual recipient need (i.e. more hours per week of care are required to meet needs than other areas), or more people within the population with at least some support needs (and carers are providing support to more than one person)⁹.

Directly standardised proportion of population providing unpaid care, by hours of care provided per week (Census 2021)

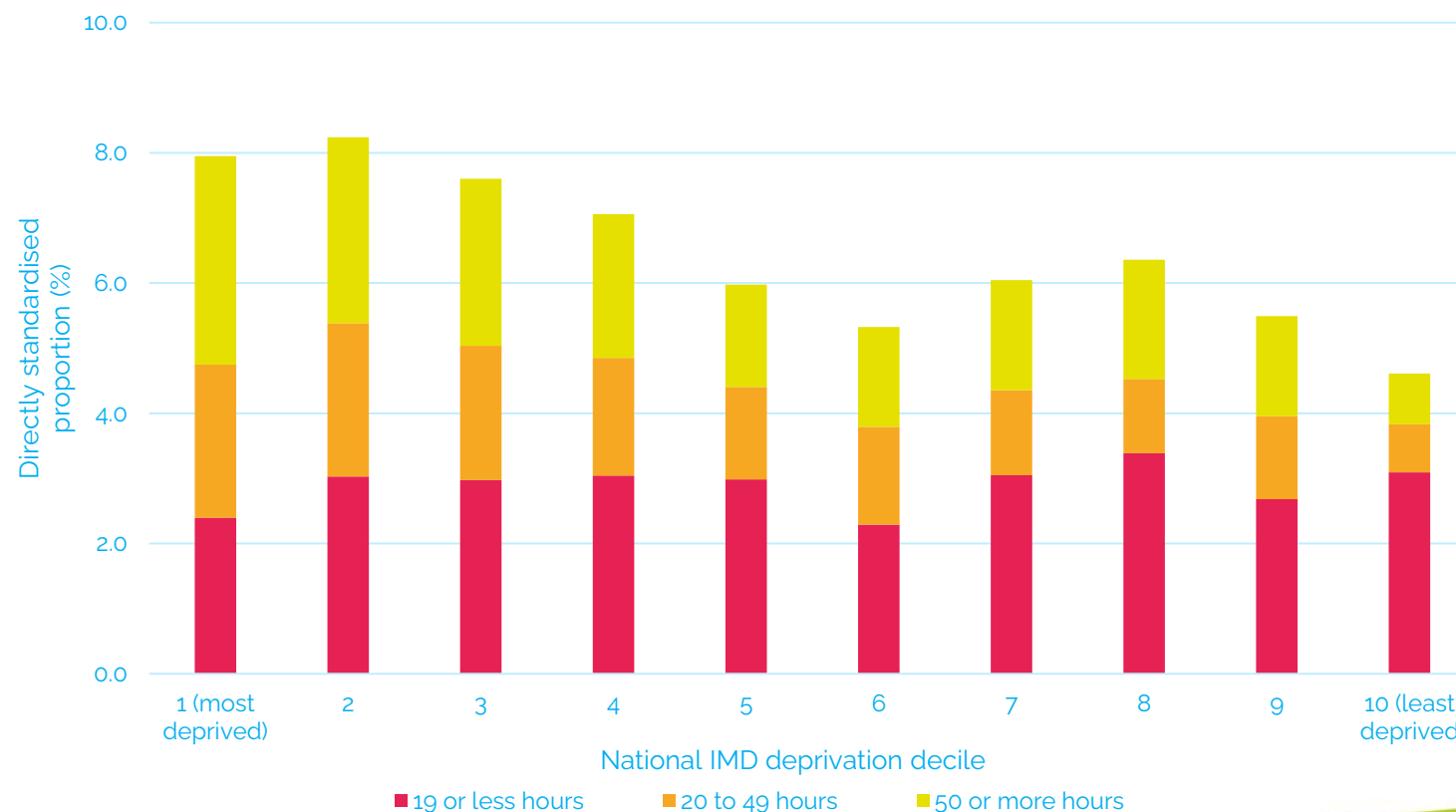


A higher proportion of residents living in more deprived areas provide unpaid care compared with those in less deprived areas



- There is a deprivation gradient in provision of unpaid care. **In Tower Hamlets, those living in more deprived areas have a higher rate of unpaid care provision than those living in less deprived areas**, and of those providing care are more likely to be providing more intensive support (20+ hours per week)⁹.
- **In this sense, inequalities in social care need have a compounding impact**; both increasing the number and impacts of social care needs for individuals in areas of higher deprivation, and resulting in higher rates of unpaid care provision (with resulting health and social care impacts for carers) in the same areas.

Directly standardised proportion of population providing unpaid care, by hours of care provided per week and national IMD deprivation decile, Tower Hamlets (Census 2021).

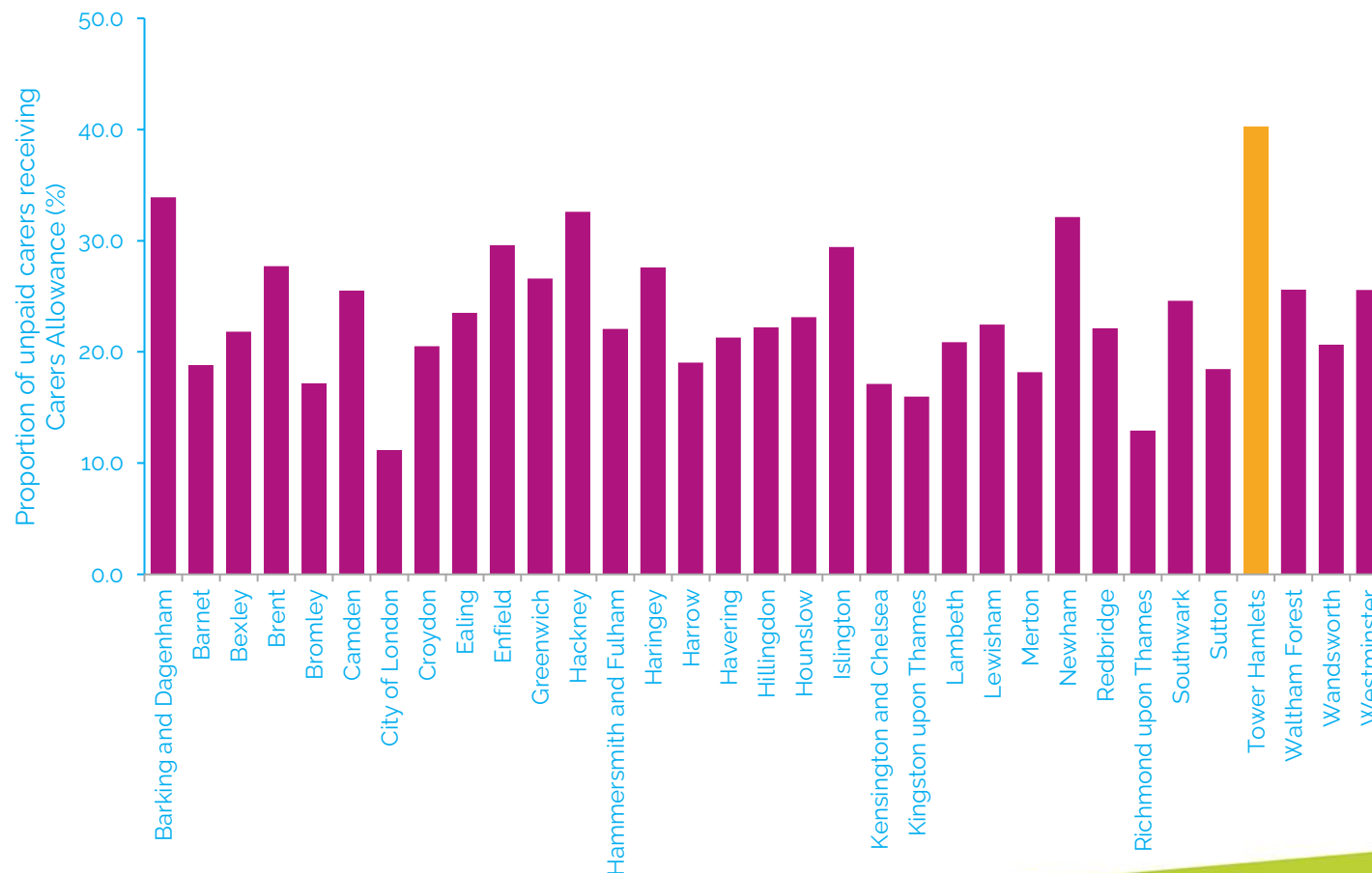


Carers Allowance claims show in Tower Hamlets has a high and increasing number of carers claiming allowance



- Carers Allowance eligibility and claims can be used as a proxy measure of the intensity of unpaid care provision and the socio-economic conditions of carers. The Allowance is a benefit available to carer who provide more than 35 hours of care per week *and* whose earnings are less than £139 per week after deductions²⁴.
- **Over the last 5 years (May 2018 to May 2023), the number of people with entitlement to Carers Allowance in Tower Hamlets has increased by 22% to 7,500 residents.** This is a **faster rate of increase than seen in England (7%) and London (11%)**. The age-standardised rate of Carers Allowance claimants is substantially higher than any other London borough, reflecting patterns of deprivation and care intensity²⁴.
- 40.2% of carers in Tower Hamlets claim Carers Allowance. This is significantly higher than both London (23.8%) and England (24.5%).

Proportion of unpaid carers receiving Carers Allowance, Tower Hamlets (orange) and all London boroughs (purple).

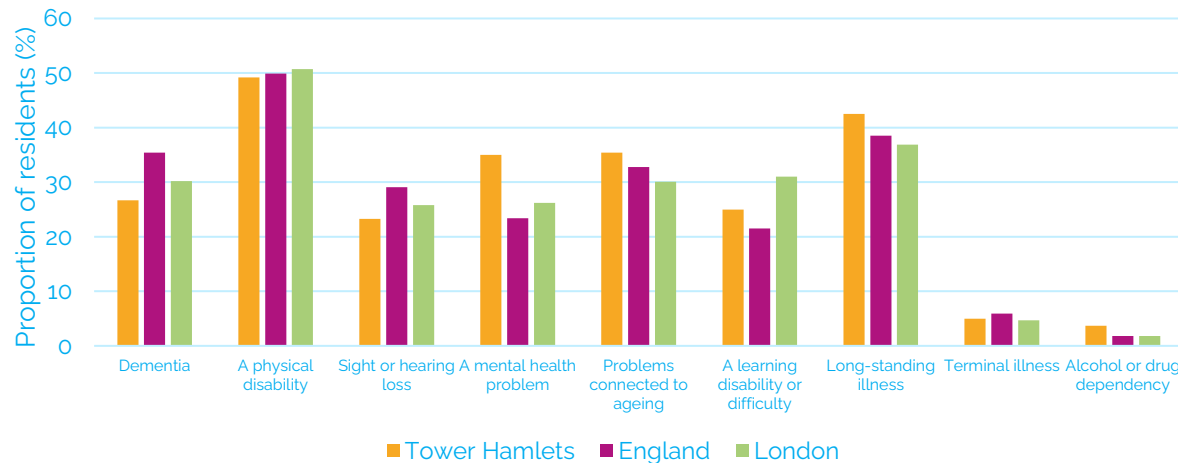


Carers in Tower Hamlets are more likely to be supporting those in receipt of care with mental health needs than other areas

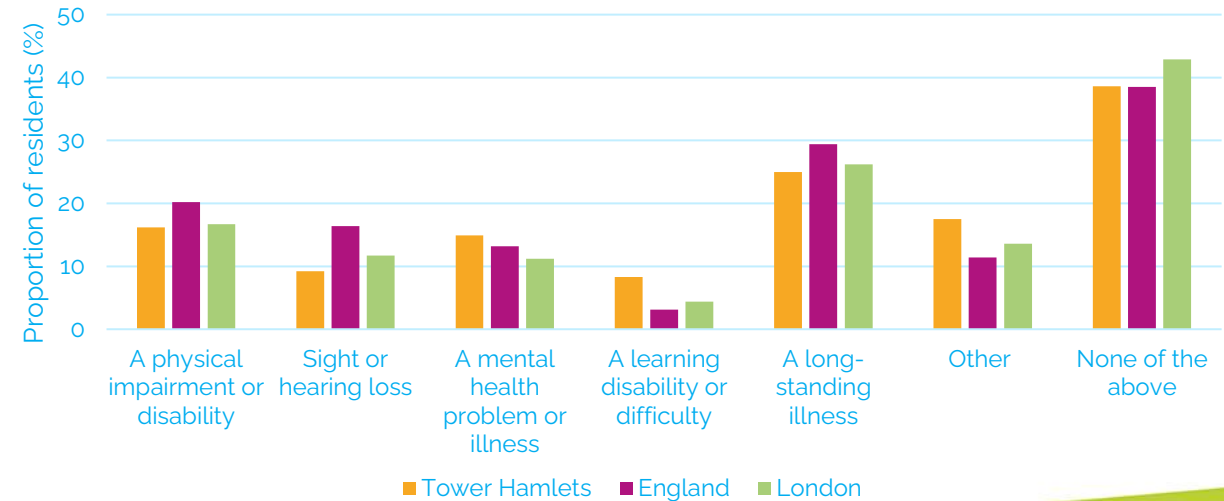


- The Carers Survey reports on the health conditions of recipients of unpaid care and their carers. 2021-22 data shows that **35% of carers in Tower Hamlets were supporting someone with a mental health problem – notably higher than the London (26%) and England (23%) averages**²⁵.
- While making up a small proportion of respondents, **carers in Tower Hamlets were over twice as likely (3.7%) to report supporting someone with alcohol and drug dependency than London (1.8%) and England (1.8%) averages**²⁵.
- On conditions of carers themselves – carers in Tower Hamlets were more likely to report they had a mental health problem or illness, or learning disability or difficulty, than London and England averages²⁵.

Percentage of care recipients with conditions as reported by their carers, Tower Hamlets, London and England (Carers Survey 2021/22²⁵).



Percentage of unpaid carers with self-reported conditions, Tower Hamlets, London and England (Carers Survey 2021/22²⁵).

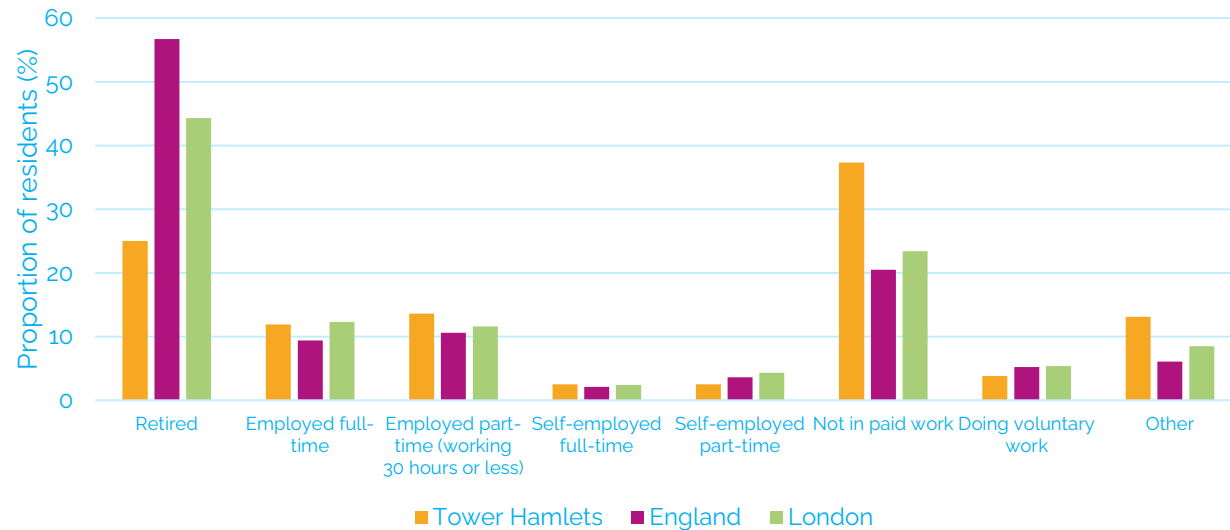


Carers in Tower Hamlets were more likely to not be in paid employment due to the impact of their caring responsibilities: the impact of caring on carers is heavier here.

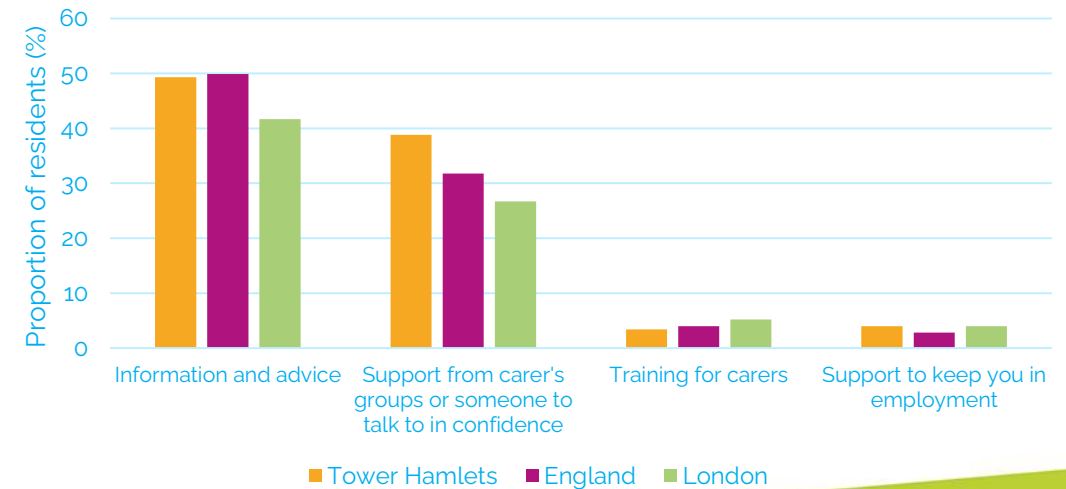


- The Carers Survey asks about the employment status of carers, as well as their additional caring responsibilities and impact on other areas of life related to wellbeing. **Tower Hamlets carers were notably more likely to report that they were not in paid employment, and more likely to report that this was due to their caring responsibilities (38% of total respondents) compared to London and England averages²⁵.**
- In addition, **Tower Hamlets carers were more likely to report caring for multiple people, and more likely to have children under 18 than London and England averages**, and other North East London boroughs²⁵.
- Further information, including type of support received from services, and wider impacts on carer wellbeing, can be found in the Carers Survey results.

Employment status of unpaid carers, Tower Hamlets, London and England (Carers Survey 2021/22²⁵).



Reported support received from social services by unpaid carers, Tower Hamlets, London and England (Carers Survey 2021/22²⁵).

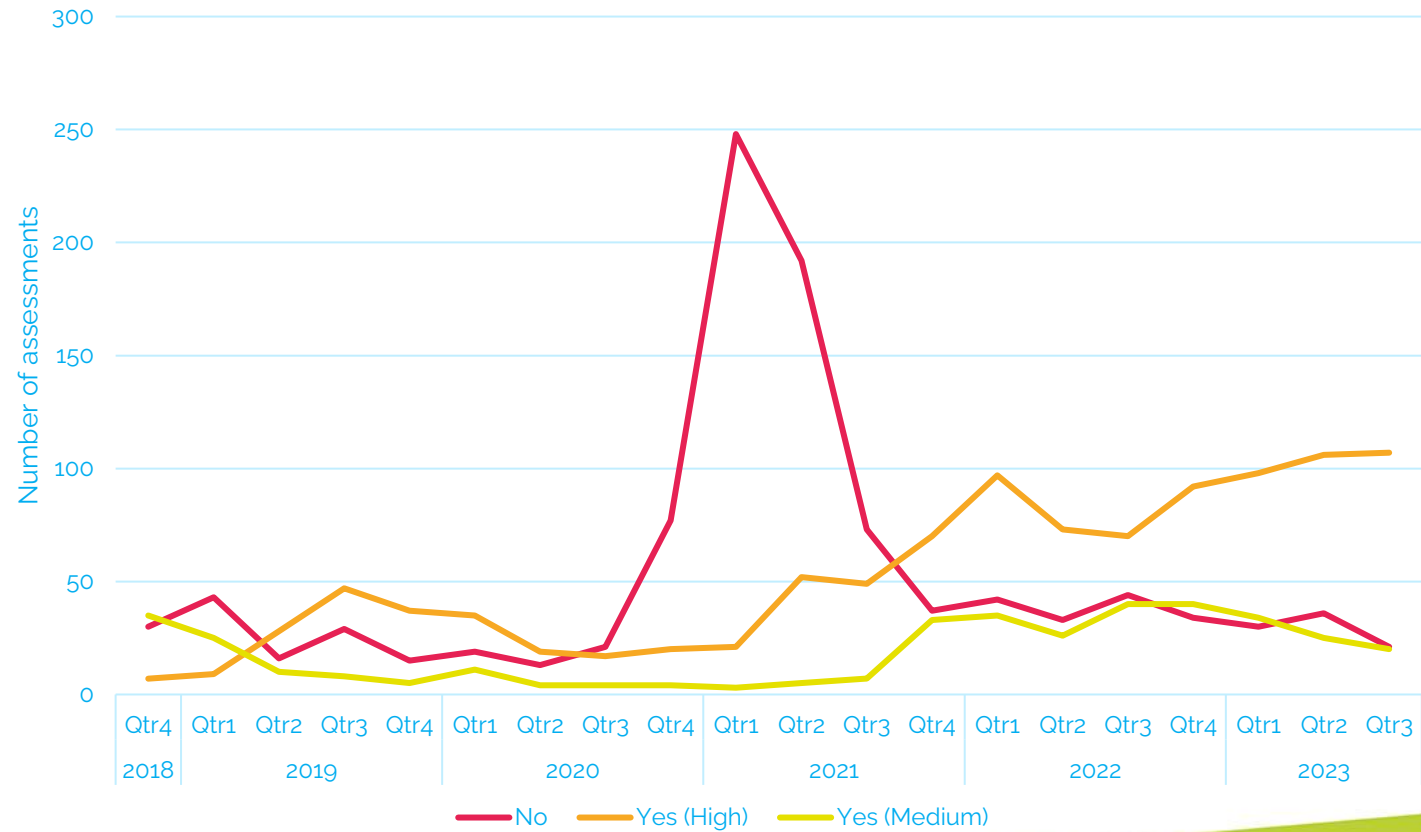


The number of residents who have received a Carers Assessment has increased in the previous five years – and increasing proportions are deemed to be in “high” need



- Since October 2018, there has been an increase in the **total number of Carers Assessments conducted**, with particularly notable increases from early 2021 onwards.
- After early 2021, **increases are most notable in the number of assessments with a “high need” outcome**, rising from 21 in Q1 2021 to 107 in Q3 2023. High need outcomes are given when assessments determine carers are eligible for support and have more urgent/higher intensity support needs.
- There is a very sharp rise and subsequent sharp drop in the number of ineligible assessments from late 2020 to mid to late 2021 – this may be due to issues in data reporting.
- **The trends seen in numbers of Carers Assessments reflects the increases in number of social care service users from early 2021 onwards.**
- Social care practitioners highlighted the importance of proactive identification of individuals who may benefit from a Carers Assessment, particularly when conducting initial assessments for social care service users,

Eligibility outcome of Carers Assessments conducted per quarter in Tower Hamlets by level of need, October 2018 – October 2023 (Mosaic).

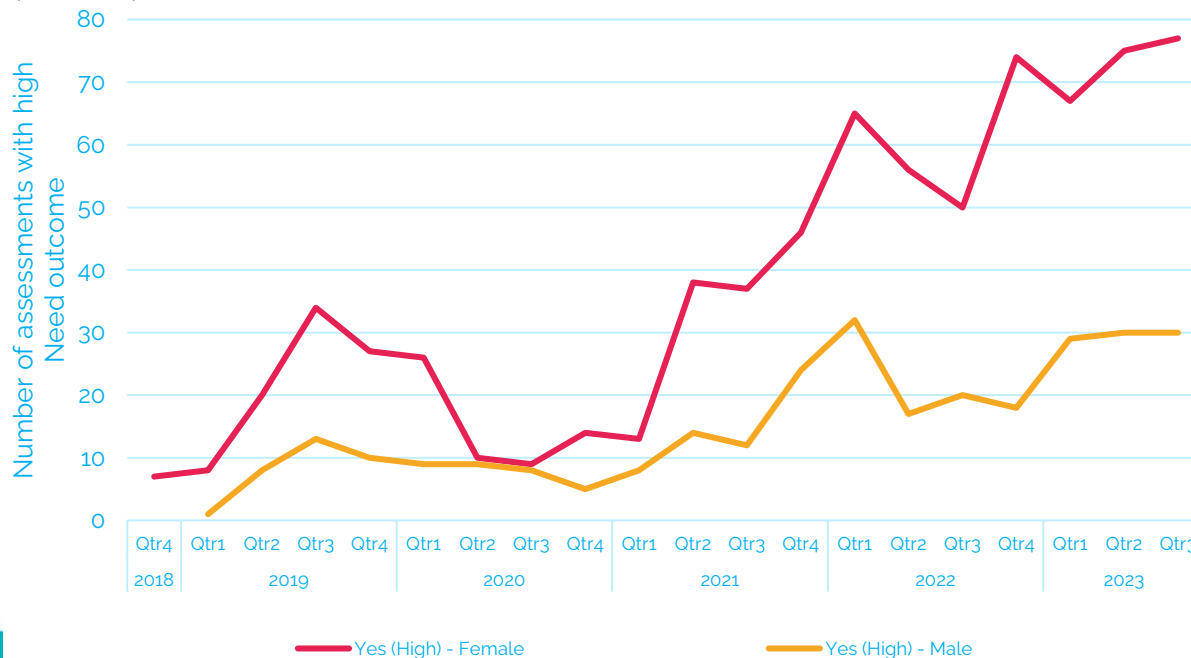


The increase in number of “high need” assessment outcomes is being driven by increases in female carers, and those in ages 35-64

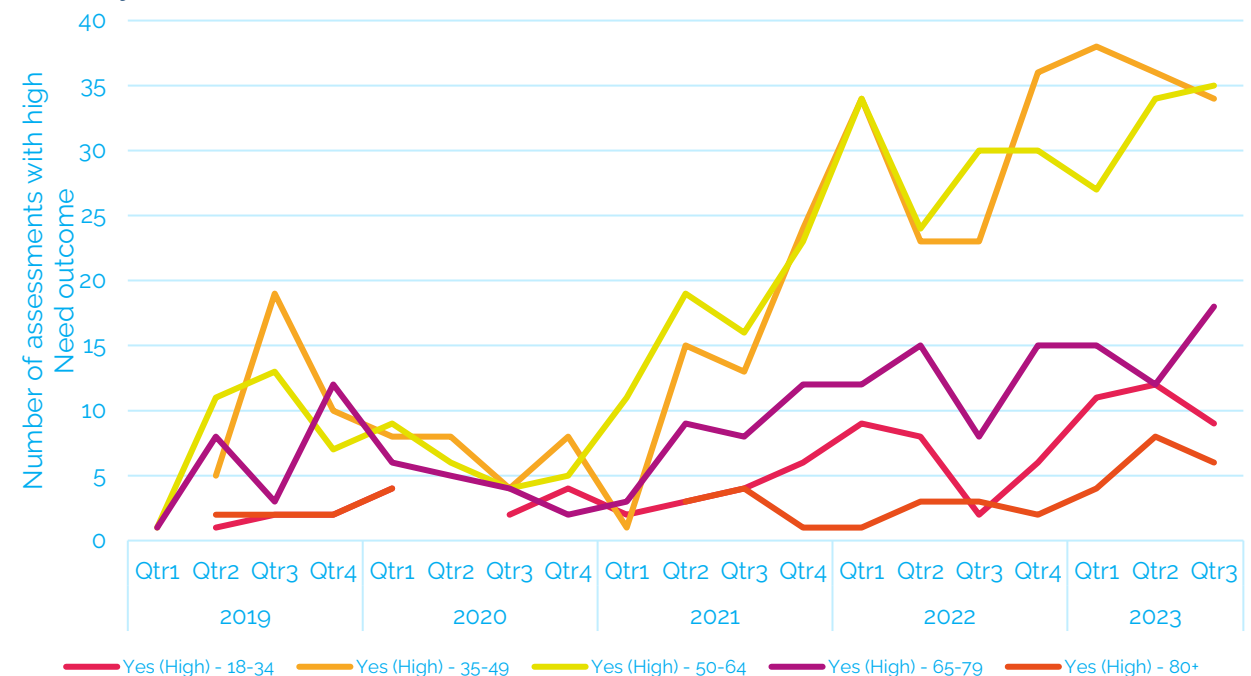


- While increases in the number of carers assessments with a “high need” outcome are reflected in both male and female carers, the rate of increase is notably higher in females, with a greater than 5-fold increase in the number of high need outcomes between Q1 2021 and Q3 2023.
- When looking at age band, rates of increase are highest in age bands 35-49 and 50-64 – noting this will be influenced in part by population sizes.

Number of Carers Assessments with “high need” outcome per quarter, by gender of carer, October 2018 – October 2023 (Mosaic).



Number of Carers Assessments with “high need” outcome per quarter, by broad age band of carer (excluding under 18 and unknown ages), January 2019 – October 2023 (Mosaic).

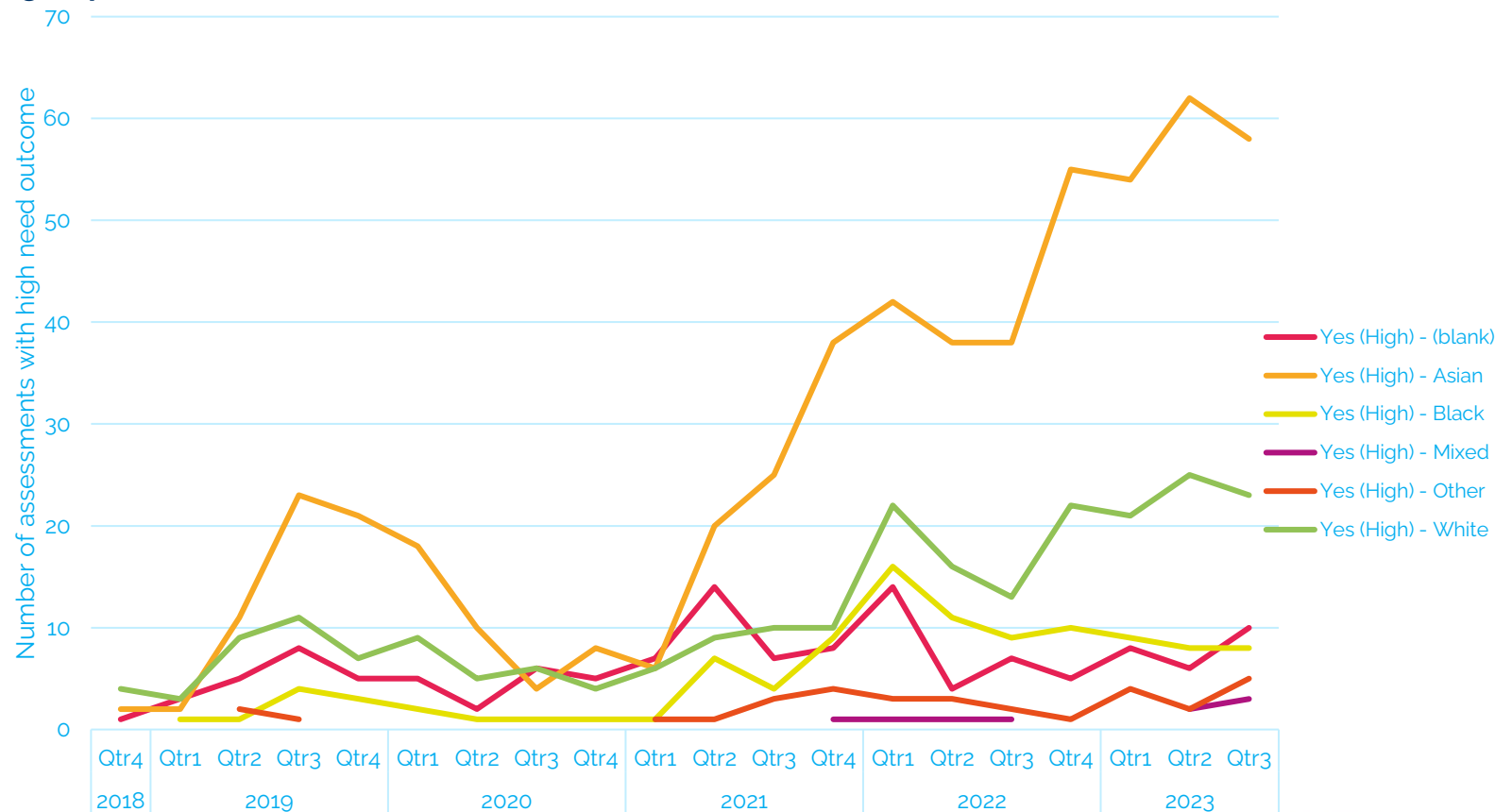


Carers in the Asian ethnic group have seen the largest increase in the number of assessments with a “high need” outcome



- Perhaps most profound is the difference in rates of increase by ethnic group. **Carers in the Asian ethnic group sees a substantial increase in the number of assessments with a “high need” outcome, while there are comparatively smaller increases in the White and Black ethnic groups, and little to no increases in others.**
- When broken down by age and gender, **rates of increase in Asian females providing care are driving this observed difference.**

Number of Carers Assessments with “high need” outcome per quarter, by ethnic group of carer, October 2018 – October 2023 (Mosaic).

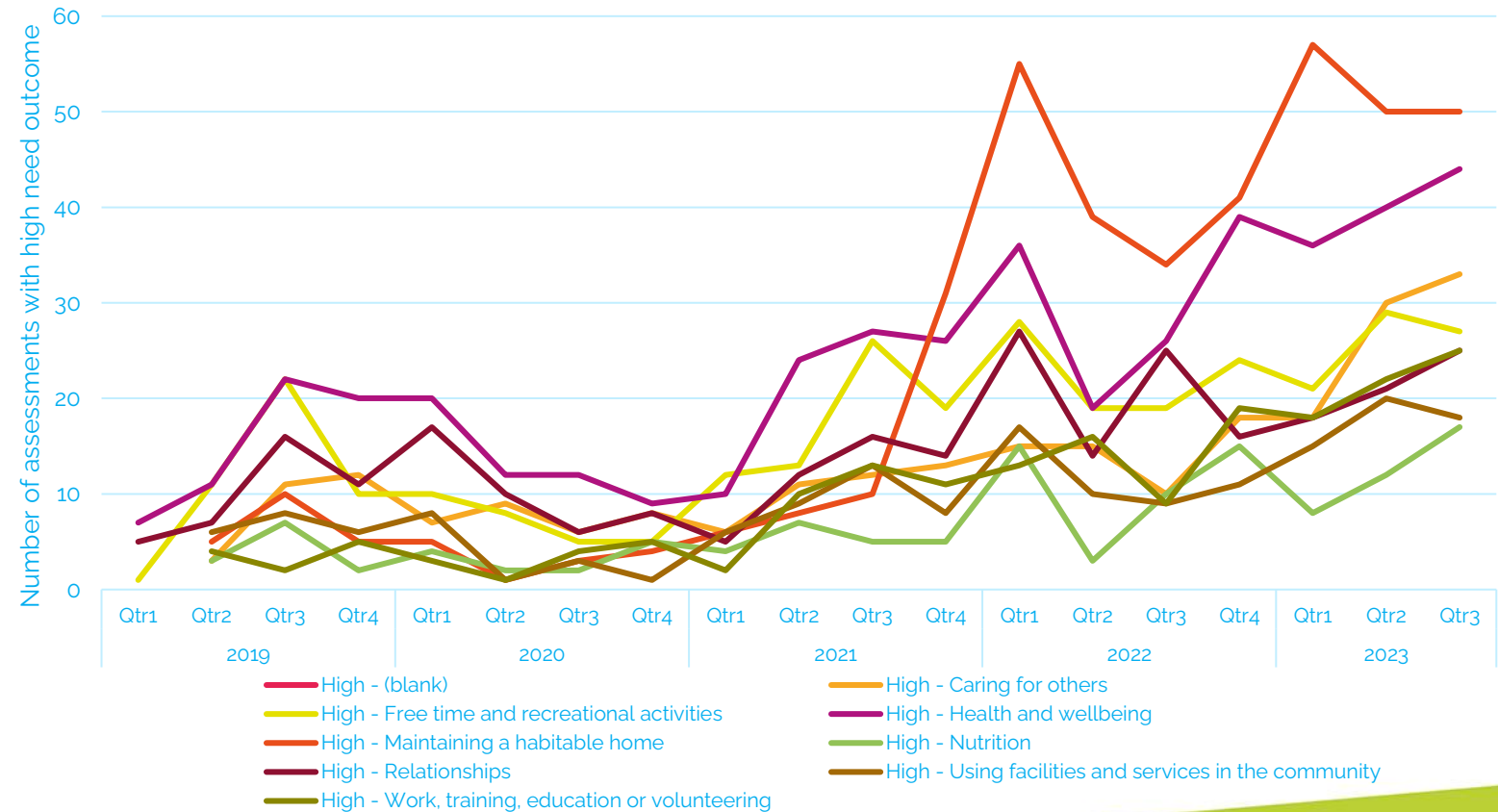


Maintaining a habitable home and health and wellbeing were “outcomes” with the highest number of “high impact” assessment outcomes



- There is a sharp increase in the number of people where maintaining a habitable home is deemed as high impact in early 2022, and has remained the most common “outcome” with a high impact assessment since early 2022.
- High impact assessment outcomes increased across all other “outcomes”, but at a slower rate.

Number of Carers Assessments with “high need” outcome per quarter, by need for support with outcome, October 2018 – October 2023 (Mosaic).



Predicting future need for adult social care support in Tower Hamlets



Predicting changing patterns of need for adult social care is challenging, given the number of dependent variables



Challenges in predicting future need for adult social care in Tower Hamlets

- To support future planning for adult social care services, there is a **need to understand how patterns of social care need may change in future**, accounting for demographic changes in the population as well as other factors that drive social care need, including patterns of health and disability.
- This is challenging given **there are significant uncertainties in how factors that affect social care need may change**. Need is also largely shaped by political decision-making around social care, which can change eligibility for social care support and the broader socio-economic conditions that influence need.
- In addition, there is significant variation in population estimates for Tower Hamlets, with this variation particularly pronounced for older adults (aged 65+). Given this age group have high levels of social care need, uncertainty in population estimates results in significant uncertainty when predicting how social care need may change across the population.

Developing a model to predict how need may change in future

- Recognising these uncertainties, **we have developed a model for predicting future social care need, that accounts for several factors associated with increasing or decreasing need at a population level**. The model accounts for:
 - **Population age, gender and ethnic group profile** – using the patterns of population between the 2011 and 2021 Census (though noting significant uncertainties in predicting migration patterns and other factors that influence this). The model assumes patterns of population growth will be similar to the patterns seen between the 2011 and 2021 Census⁹.
 - **Rate of adult social care service use by ethnic group and age in Tower Hamlets** – using insights on patterns of social care need presented in this JSNA chapter.
 - **Self-reported health status by age, gender and ethnic group** – which shows reductions in the proportion of individuals reporting poor health between the 2011 and 2021 Census. The model assumes this trend will continue as it did between the two Census periods⁹.
 - **Population deprivation** – using a weighted average adjustment based on the change in the population from mid-year population estimates and the rate of service use by deprivation presented in this JSNA chapter²⁶.
- The model has been built such that it can be regularly updated as we learn more about changes in the population. **Given current uncertainties, results should be seen as indicative based on the information available at a point in time.**



Need for adult social care is expected to continue along existing trends

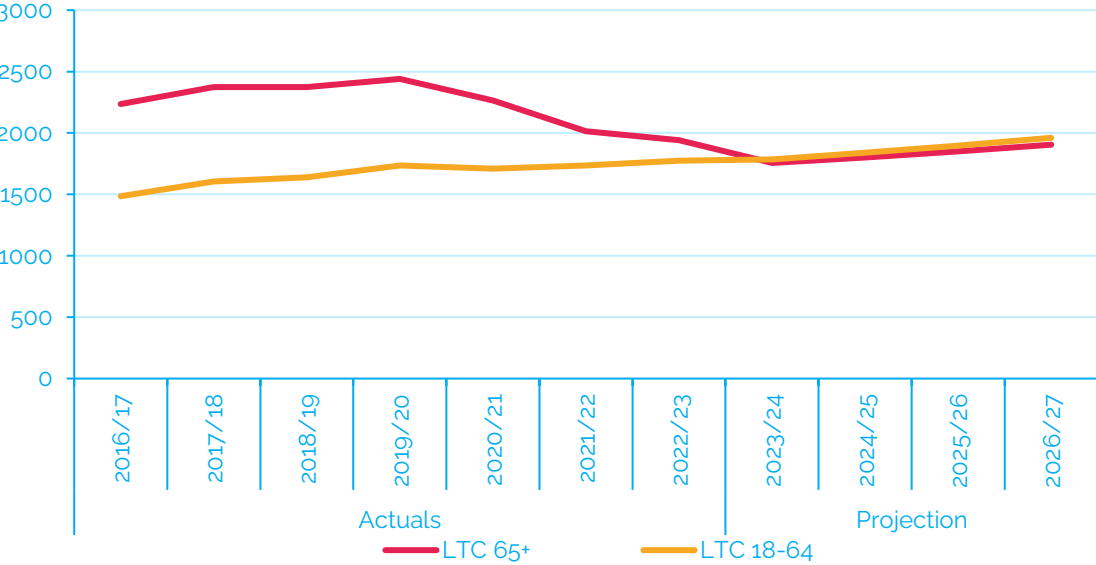


- Results from the modelling suggest that **demand for adult social care is likely to broadly continue along existing trends** (see rate of change in table below).
- This is projected despite expected population growth in both adults aged 18 to 64 and ages 65+ over coming years, due to improvements in health in the population across all ages expected to offset this increase.**
- The graph below shows how this translates to projected number of social care service users to 2027. The number of service users differs to those reported elsewhere in this report as actual number of service users was taken from SALT returns (which uses a different methodology to calculate service users¹). **This shows that the split of service users between the two broad age bands will remain broadly consistent to 2027.**
- Overall, a crude estimate for demand for long term care is likely to be in the range of 1,800 to 2,000 service users aged 18 to 64, and 1,800 to 1,950 service users aged 65+.

Projected rate of change in demand for long term care support from adult social care services, by broad age band and factor influencing change, Tower Hamlets

Trend	Age 18-64	Ages 65+
Population Changes		
Males	0.007	0.01
Females	0.008	0.04
Improvements in Health		
Males	-0.007	-0.06
Females	-0.007	-0.04
Overall		
Males	0.001	-0.045
Females	0.001	-0.001

Population weighted projection of number of service users in receipt of long term adult social care support in Tower Hamlets to 2026/27



“Prevention” in adult social care – evidence and effective practice



Despite forming one of seven core responsibilities in the Care Act, prevention in social care is an under-researched field of practice



- The Care Act 2014 identifies 'promoting individual wellbeing' and 'preventing needs for care and support' as the first two of seven responsibilities for Local Authorities²⁷. The Care Act Statutory Guidance describes prevention as about the care and support system actively promoting independence and wellbeing²⁸.
- SCIE recognise the importance of the three core approaches to prevention²⁹:
 - **Prevent** (*primary prevention*) - applied to everyone, focused on conditions that avoid the need for care
 - **Reduce** (*secondary prevention*) – targeted at individuals at risk of developing needs to slow this process or prevent further needs.
 - **Delay** (*tertiary prevention*) – aimed at individuals with complex health conditions to minimise the effects, support them to regain skills and reduce needs wherever possible.
- **SCIE also highlight the importance of whole-system approaches to prevention** – across social care commissioners and practitioners as well across the wider health and care infrastructure²⁹.
- Despite the central role of prevention in social care, existing literature highlights that this is an under-researched area, and that the evidence base needs to be supported by robust evaluation of local practice. The remaining slides in this chapter will summarise available evidence around approaches to prevention in social care^{30,32}.

Model for a whole-system approach to prevention (SCIE)²⁹



Motivations for and approaches to prevention activity

- Research has highlighted that there is a **lack of shared understanding across health and social care around what "prevention" includes**, and where responsibility for prevention in Local Authorities sits.
- Research by Tew et al (2019) shows that **financial pressures are the primary driver for Local Authorities delivering prevention activity**, despite mixed evidence on cost-saving potentials of preventative interventions³⁰.
- **Most Local Authorities deliver a broad range of preventative activity within social care, public health, and across wider council infrastructures.** Councils have adopted different approaches to integration of prevention agendas, with some developing "prevention strategies" to varying degrees of success. While the benefits of integrated health and care services are generally recognised, there is a paucity of evidence on how services should implement prevention with health partners, and the effectiveness of shared approaches^{30,31}.



Common conceptualisations of “preventative interventions” often differ across public health and social care, but are linked

Aims of prevention in public health:

Public health typically speaks of the “three tiers” of prevention, to prevent disease **ill-health form occurring, detect disease early** and **prevent progression**, and support **rehabilitation following ill-health or disease**.

Preventative interventions in public health³³:

Primary prevention – preventing ill-health from occurring:

- Improving the **wider determinants of health** – housing, air quality, poverty
- **Vaccinations**
- **Stop smoking and weight management** services
- **Health promotion** activity

Secondary prevention – early detection of disease and preventing progression of ill-health:

- **Screening** programmes (e.g. breast cancer screening)
- **Health checks**
- **Targeted stop smoking/weight management** programmes for people with existing health needs
- **Social prescribing**, referring individuals to a range of community support for health/care needs

Tertiary prevention – supporting rehabilitation following significant disease or ill-health:

- **Rehabilitation programmes** following major conditions
- **Chronic disease management** programmes

As “health need” and “social care need” are interrelated (but not analogous), prevention objectives **can be** linked and complementary

Prevention activity delivered by adult social care is principally concerned with secondary and tertiary prevention, using person-centred models

Aims of prevention in social care:

In contrast to public health, adult social care often adopt a person and/or service-led conceptualisation of prevention, rather than a population-level view. Wistow and Lewis suggest two aims of prevention in social care³⁴:

- **Deliver services which prevent or delay the need for care in higher-cost, more intensive settings**
- **Develop strategies and approaches that promote the quality of life for older people and their engagement**

The description of prevention in the Care Act encourages a wider view of prevention, that stretches beyond what is routinely delivered by adult social care, and uses models of primary, secondary and tertiary prevention.^{28,30}

Preventative interventions delivered by adult social care³⁰⁻³²:

- **Information and advice** – referring individuals to access appropriate support that are relevant for their needs (and diverting from higher intensity support)
- **Telecare** – alarm and monitoring systems that support individuals to stay safe and independent at home
- **Equipment and home adaptations** – adjustments to support individuals to perform activities in their home independently.
- **Reablement** – temporary support after illness or hospital discharge to support recovery and regain independence



Developing the primary, secondary and tertiary prevention model in the context of social care and healthcare need



Primary prevention of health and social care need

Supporting the health and wellbeing of all residents to reduce population-level social care need.

Primary prevention activities includes a wide range of activity across health and social care (e.g. health promotion, healthy environments agenda) and wider council activities (e.g. housing, cost of living support).



Secondary prevention of health and social care need

Early detection of health and social care needs, to provide timely interventions that promote independence and prevent worsening needs.

This includes health (e.g. screening, social prescribing) and social care interventions (e.g. information and advice) that focus on those with new or low level existing needs, that may worsen in future.



Tertiary prevention of healthcare need

Supporting those in receipt of social care support to manage their health, prevent worsening conditions and support rehabilitation.



Tertiary prevention of social care need

Enabling those in receipt of social care support to live independently, preventing worsening care needs where possible and identifying appropriate support packages for individuals.



Prevention of factors associated with social care need – social isolation and loneliness

Relationship to social care need	Evidence-based preventative interventions that address social isolation / loneliness			What we have in place in Tower Hamlets
	Primary prevention	Secondary prevention	Tertiary prevention	
Social isolation and loneliness are associated with negative health impacts. Evidence shows individuals experiencing loneliness^{35,36}: • Have higher blood pressure • Are more likely to develop conditions including dementia • Have higher rates of poor mental health, including higher rates of depression • Have higher health and social care use	Evidence on primary prevention of social isolation or loneliness is limited. National surveys on loneliness identify the following groups are at particular risk of loneliness³⁵: • Young people • Those with poor mental wellbeing • People with a disability or long-standing health condition • People not living with a partner • Gay, lesbian, or bisexual people and people who chose 'other' when asked about their sexual orientation • People on lower incomes • People who were out of work • Those who have recently moved to their current address • Women (as compared to men) GLA commissioned research on loneliness highlights five key factors association with severe loneliness in London³⁷: • Poverty/income deprivation • Being single or living alone • Living with a disability • Going through life changes or being a new resident in London • Feeling different or experiencing prejudice It also identifies increasing social connectedness and addressing structural drivers as preventative interventions for loneliness. The report suggests possible "primary prevention" interventions to increase social connectedness: • Building contact and neighbourliness into the built environment • Supporting hyper-local digital groups • Encouraging and enriching interactions with essential workers • Using libraries as community spaces • Improving individuals' abilities to address loneliness in their communities	WHO have compiled existing evidence and gaps relating to specific interventions³⁸. Effectiveness of interventions to address social isolation or loneliness is highly dependent on local context. Several services (e.g. befriending) that show some short term improvements to isolation/quality of life often show limited long term impacts, or are not evaluated.³⁹ A recent systematic review of what works in addressing loneliness found⁴⁰: • Social support interventions – including befriending schemes, mentoring and peer support services, educational and social skill development programmes, ICT programmes and social prescribing. The review found consistent evidence that social support interventions can improve loneliness in the short term. There is less evidence of the long term impact for social support interventions (but this is highly dependent on local context). • Social interaction interventions – aiming to reduce loneliness by increasing opportunities for social contact and growing networks, including arts/music activities and general group-based activity. The review found consistent evidence that these interventions reduced loneliness in the short term. • Psychological interventions – non-pharmacological support/treatment. There was strong evidence these interventions reduced loneliness in the short term.	There is some evidence of interventions designed to reduce social isolation or loneliness in populations with existing health needs, with mixed success. Interventions tend to be largely similar to those covered in secondary prevention, with adaptations to reflect the needs of target populations.	Evidence A health needs assessment factsheet on loneliness and social isolation in older people in Tower Hamlets was produced in 2016, covering the profile of loneliness in Tower Hamlets and what is in place to address this⁴¹. Since then, an additional report has been produced focusing on "what works" to address loneliness and isolation, with particular focus on the Tower Hamlets population (not published). Interventions The Connection Coalition Tower Hamlets brings together an alliance of statutory and voluntary organisations in Tower Hamlets that are working to address loneliness, to provide a strategic and coordinated approach to activity⁴². There are many initiatives addressing loneliness and social isolation in Tower Hamlets. The Bringing Residents Together Directory sets out organisations and initiatives operating in this space – with general as well as targeted interventions (directory not published). The Just Say Hello campaign was launched in Autumn 2023 across Tower Hamlets, encouraging residents to have conversations with one another and for organisations to use dedicated resources to promote the campaign⁴². The Mayor's Grants programme has funded 21 projects directly related to loneliness between December 2023 and March 2027, with most funding going to addressing loneliness in older adults, and a smaller number for other groups. It is recognised that while there is a lot of provision in place for addressing loneliness in older adults, loneliness in younger adults is relatively underserved.

Prevention of factors associated with social care need – long term conditions and multimorbidity



Relationship to social care need	Examples of preventative interventions that address LTCs and multimorbidity			What we have in place in Tower Hamlets
	Primary prevention	Secondary prevention	Tertiary prevention	
While it is possible to have a long term condition and not require social care, those with social care need are very likely to have one or more long term condition¹⁰. 70% of total health and care spend in England is attributed to people living with long term conditions^{43,44} People with multimorbidity have a disproportionately high need for social care, due to their health status, issues including economic instability, housing issues, resulting disablement and mobility issues, and frailty⁴⁵⁻⁴⁷.	The Major Conditions Strategy outlines key risk factors for conditions, including behavioural risks, metabolic risks and environmental risks⁴⁸. There is extensive evidence on the effectiveness of interventions that reduce incidence of long term conditions. Examples include (but are not limited to) Reducing poverty/deprivation - Prevalence of multimorbidity is higher and the age of onset is younger in those living in more deprived areas. More deprived populations have higher prevalence of modifiable risk factors for social care; however some evidence shows the difference in the top five modifiable risk factors for multimorbidity account for less than half of the socioeconomic difference in prevalence^{49,50}. Increasing physical activity - Physical activity is known to reduce the risk of many long term conditions, alongside managing existing conditions⁵¹. Smoking cessation - Smoking accounts for 122,000 deaths per year, 70% of these deaths are caused by lung cancer, COPD and vascular disease⁵². Tackling air pollution - Poor air quality is the largest environmental risk factor for health and disproportionately impacts those in the most deprived areas. The three main conditions air pollution is related to are respiratory conditions (e.g. asthma), CVD and lung cancer^{53,54}.	Secondary prevention focuses on the early detection and management of long term conditions to limit health impacts and reduce multimorbidity. NHS Health Checks - NHS Health Checks are offered to adults aged between 40 and 74 every five years, with an aim of identifying risk factors and early detection of common diseases. There is strong evidence that early diagnosis of common long term conditions reduces risk of life changing incidents such as heart attack, stroke and dementia^{55,56}. Population-level screening - Screening is used for early detection of conditions, and is mostly targeted at population groups with a higher risk of these conditions. The NHS has several adult screening programmes; three cancer screening programmes (bowel, cervical, bowel), abdominal aortic aneurysm screening and the diabetic eye screening programme. Screening is estimated to save 10,000 lives each year in England^{57,58}. Continued engagement in protective activities - Continuing to support individuals with LTCs to engage in protective activities such as physical activity can improve LTC management and prevent worsening conditions. This can be through wider efforts to increase physical activity or through targeted intervention⁵¹.	Tertiary prevention focuses on effective management of long term conditions and rehabilitation. Personalised care - Personalised care planning has been shown to be effective in improving the physical and psychological health status of patients, as well as improving abilities to self-manage conditions^{59,60}. Rehabilitative programmes - Rehabilitative interventions are recommended for several conditions, and can improve quality of life for patients and reduce symptoms in the case of, for example, COPD⁴⁸. - WHO have produced several resources related to supporting rehabilitative activity, recognising that one in three individuals globally are living with a condition that could benefit from rehabilitation⁶¹. - Reablement has been shown to increase independence of individuals after a health incident and reduce future health service utilisation⁶²	Evidence Tower Hamlets has high rates of long term conditions including diabetes, heart disease and COPD, contributing to greater ill-health and worsening social care need. This disproportionately impacts particular population groups in Tower Hamlets, contributing to inequalities in life expectancy. Several health needs assessments have been conducted in the borough that cover long term conditions and related factors⁶³: - Cancer - Cardiovascular disease (not published) - COPD - Coronary heart disease - Heart failure - Diabetes (not published) - Physical activity Interventions We have a range of support in place for residents to prevent and manage long term conditions. This includes: Primary prevention Health promotion campaigns that address risk factors for long term conditions, including smoking, alcohol and substance misuse and low rates of physical activity. - Delivering the Communities Keeping Well programme, a targeted co-produced intervention with communities to support healthy lifestyles and prevent LTCs. - Commission smoking and weight management services - Supporting leisure service insourcing and ensuring services are health promoting. - Tower Hamlets Council have a range of initiatives to tackle poverty and address rising cost of living⁶⁴. Secondary prevention NHS Health Checks have good uptake in Tower Hamlets, delivered through primary care. There is also targeted hypertension casefinding delivered through community pharmacies. Screening is in place in Tower Hamlets, but we are aware we have particularly low uptake of cancer screening. - We commission targeted smoking and weight management services for residents at particularly high need of poor health outcomes. Tertiary prevention - Cardiac rehab services are in place in Tower Hamlets, although we know there are limited referral routes and eligibility. - Reablement services in Tower Hamlets support individuals who have had a health incident to regain independence.



Prevention of factors associated with social care need - dementia

Relationship to social care need	Evidence-based preventative interventions that address dementia			What we have in place in Tower Hamlets
	Primary prevention	Secondary prevention	Tertiary prevention	
Dementia covers a range of conditions with symptoms associated with an ongoing decline of cognitive functioning. Health Foundation data shows around 55% of individuals living with dementia aged 65+ need support with ADLs¹⁰. In 2021, it was estimated 540,000 people in the UK were caring for someone with dementia⁶⁵ Social care costs (state funded and private) related to dementia care annually were estimated to be £15.7bn in 2020, while unpaid care was estimated to cost £13.7bn. This is 45% and 40% of total spending on dementia care in the UK⁶⁶. While dementia prevention is addressed in similar ways to other long term conditions, the high impact of dementia on health outcomes and social care use mean this has been separated from other conditions.	Primary prevention of dementia focuses on changes to modifiable risk factors that are associated with several non-communicable diseases e.g. diabetes, CVD and some cancers. NICE identify several mid-life preventative approaches: Promoting healthy lifestyles - This includes increasing physical activity, preventing tobacco use, reducing alcohol-related risk and increasing wider health promotion activity⁶⁷. - Dementia prevalence has been associated with several long term conditions commonly diagnosed earlier in life, which in turn are linked to behavioural factors noted above. This means dementia prevention can be supported by broader activity around prevention of long term conditions⁶⁸. Service organisation and delivery - This includes delivering behaviour change services, increasing accessibility of services and providing training⁶⁸. Addressing deprivation and education attainment - As well as modifiable risk factors, deprivation and educational attainment have been associated with dementia risk in a large UK Biobank study (as well as other factors including living alone)⁶⁹.	Secondary prevention of dementia focuses on control of risk factors – particularly for high-risk groups – as well as early diagnosis. Control of risk factors Prospective studies of populations at risk of Alzheimer's Disease has shown that AD pathology is detectable decades prior to clinical diagnosis, creating windows of opportunity for control of risk factors⁷⁰. There is some evidence that controlling diabetes and hypertension can reduce the risk of dementia in higher risk groups. Early diagnosis Literature emphasises the importance of early diagnosis of dementia, despite challenges around variety of symptoms and conditions⁷¹.	Tertiary prevention aims to increase quality of life and wellbeing while delaying the worsening of health and care needs. Emphasis is placed on early intervention given this is where the greatest impacts of tertiary prevention is seen. This includes: 1. Drug interventions to improve or maintain function after neuronal damage. Evidence on the effectiveness of drug treatments are mixed^{72,73} 2. Non-drug interventions, such as cognitive stimulation therapy and reminiscence therapy, have shown some effectiveness. Other interventions include innovative case management and specialised assistive technology. 3. Information provision, with person-centred advice⁷¹ 4. Holistic post-diagnostic care that addresses cognitive, psychological, medical, environmental, social and cultural needs⁷⁴.	Dementia prevalence presented in this report shows that Tower Hamlets has a slightly higher dementia prevalence in older adults (aged 65+) compared with the North East London average. Prevalence is also higher in females, and in more deprived areas. Primary prevention of dementia in Tower Hamlets As noted, primary prevention of dementia is aligned with preventative approaches for other long term conditions covered in this JSNA Chapter. Early diagnosis - Diagnosis and early support for dementia is led by primary care. - There is also a Diagnostic Memory Clinic in Tower Hamlets, which is a multidisciplinary team based in Mile End Hospital which provides initial assessment and diagnosis of dementia and cognitive impairment. This includes geriatric medicine, neuropsychology and psychiatry, and including a social work care coordinator. - Tower Hamlets has an estimated dementia diagnosis rate of 71.8% (i.e. the diagnosis rate is 71.8% of estimated prevalence of dementia in the population after accounting for age and sex), the highest rate in North East London and third highest in London⁶. Care support for individuals with dementia - Following a dementia diagnosis, individuals are encouraged to have a needs assessment conducted (if not done already) to identify support needs. In early stages of the condition, it is likely care can be provided at home (and individuals may not need support at all). - In early stages, a range of support is considered including tech enabled solutions, and referrals to reablement to support continued independence. - In later stages of the condition, Tower Hamlets can support residents through Extra Care housing or residential care, where appropriate. - There is also a wide range of support available through VCs organisations for Tower Hamlets residents, including through Age UK, the Alzheimer's Association and Dementia UK.

Prevention of factors associated with social care need – mental ill-health



Relationship to social care need	Examples of preventative interventions that address mental ill-health			What we have in place in Tower Hamlets
	Primary prevention	Secondary prevention	Tertiary prevention	
Together with substance misuse, mental ill-health accounts for 21.3% of the overall morbidity burden in England. Prevalence of common mental health disorders was 18.9% in England in 2014, and there are over half a million people in England living with severe mental illness (SMI)^{75,76}. Mental ill-health is linked to social care need. People with long term conditions, for example, are at increased risk of poor mental health that contributes to their care needs. Similarly, those with SMI have a life expectancy up to 20 years less than the general population, largely driven by poor physical health^{75,77,78}. Social care play a role in meeting the care needs of individuals with mental illness, supporting individuals to live safely and independently^{79,80}.	Primary promotion in mental health focuses on stopping individuals from developing problems with their mental health. Example interventions include: Mental health promotion - This includes population-level campaigns such as Mental Health Awareness Week, or education programmes in schools or workplaces⁸¹. - Previous studies have shown that mental health promotion can improve mental health, reduce risk of mental disorders and produce social and economic benefits⁸². Promotion is particularly effective when it leverages existing assets used or trusted by target populations, whether setting-based or by working with or through trusted individuals/information sources.⁸³ Addressing the wider determinants of mental ill health - Mental (ill-)health is significantly influenced by the social, economic, environmental and cultural contexts people live in. These determinants drive health inequalities in mental health, for common mental disorders and severe illness⁸⁴ - Previous mapping of mental health interventions has found while there is extensive evidence on interventions addressing individual and social determinants of mental health, there was very little on broader determinants e.g. structural or environmental factors^{85,86}. Supporting social connectedness - Individuals who experience social isolation or marginalisation are more likely to experience mental ill health. This is psychosocially and structurally driven. - Interventions that address social isolation, and/or structural drivers of isolation/marginalisation, can improve mental health (see section on social isolation for example interventions)⁸⁷.	Secondary prevention focuses on people who are more likely to develop mental health problems, because of demographic characteristics or through experiences they've had⁸¹. It also focuses on early intervention and treatment for those with mental health conditions. Improving access to mental health services - Diagnosis and early treatment for mental ill health is an important element of preventing worsening needs. However, in 2016 it was estimated that only one in three people in England experiencing a mental health condition had access to the support they needed^{88,89}. Access to services is also unequally distributed – for example Black adults are the least likely ethnic group to report being in receipt of medication, counselling or therapy relating to mental ill-health⁹⁰. - There has been some effective work at a national level to increase access to mental health services, such as psychological therapies, through routine monitoring and integration with wider care services⁹¹. Supporting early intervention - Early intervention services can improve access to treatment and offer better management of conditions than standard treatment pathways, for example after a first episode of psychosis⁹².	Tertiary prevention in mental health focuses on helping those in mental ill-health stay well and improve quality of life. This includes⁸¹ Addressing wider needs of individuals living with mental illness - Many individuals living with severe mental illness experience social marginalisation and economic hardship as a result of their illness. Educational and consumer contact interventions that tackle stigma towards people with SMI can be effective in reducing stigma.⁹³ Other interventions that address structural and environmental barriers to health for those with mental illness may also be effective. - People with mental health conditions also have higher rates of physical health conditions. NHS England recommend several interventions to improve the physical health of those living with SMI⁹⁴. Supporting carers 1.5 million people in the UK look after someone with a mental health problem⁹⁵. - Support for carers that provides information about mental illness, coping techniques and peer support have shown positive outcomes.⁹⁶ Carers groups have also promoted the importance of support for carers from adult social care services⁹⁵.	Tower Hamlets has a high prevalence of common mental illness (including depression and anxiety) in adults of all ages, including older adults, relative to England averages. Tower Hamlets also has rates of premature mortality for individuals living severe mental illness (SMI)⁶. Tower Hamlets Mental Health Strategy - The Tower Hamlets Mental Health Strategy 2019-2024 details the borough's approach to meeting residents' mental health support needs. The strategy covers three themes. Theme one: to raise awareness and understanding of the importance of mental health and wellbeing covers mental health promotion activity in the borough, as well as work to address the wider determinants of mental ill health. Theme two: to ensure early help is available in times of crisis covers access to information, advice and support relating to mental health, with a focus on early intervention. Theme three: to ensure the provision of high quality mental health care and treatment covers approaches to improving access to mental health support, delivering personalised care and supporting the physical health of individuals with mental health needs. Supporting carers in Tower Hamlets - Tower Hamlets provides support to carers through the Carer's Centre. Support includes a Carer's Assessment, alongside a range of advocacy, support and respite activities⁹⁷. - Support is also available from a range of other organisations across the borough⁹⁸. Targeted services to address wider health needs - In Tower Hamlets, people with severe mental illness (SMI) have higher rates of risk factors for poor health like smoking and obesity as well as social exclusion. - There is a national programme incentivising primary care to conduct annual physical health checks with adults with SMI - in Tower Hamlets, the uptake of these checks has been lower than the target level (58% vs 70% in 2023-2024). - There are also low rates of bowel cancer screening and breast cancer screening; cervical cancer screening is slightly. - A working group was established in 2023 to oversee the implementation of new interventions to address these gaps, including new staff to increase uptake of the annual health checks, community-led health promotion work and a specific project focused on increasing access to physical activity.

Prevention of factors associated with social care need – housing and the wider built environment



Relationship to social care need	Examples of preventative interventions that address associated housing and built environment			What we have in place in Tower Hamlets
	Primary prevention	Secondary prevention	Tertiary prevention	
Lack of availability of affordable housing, overcrowding, HMOs and an increase in evictions and homelessness have been reported to increase people presenting at children's social services – with similar trends expended for adults⁹⁹⁻¹⁰¹. Housing is a determinant of health and consequently social care need – for example, damp (common in poor quality housing) has been associated with increased prevalence of respiratory conditions, physical pain and other conditions^{102,103}. Home improvements can improve health and reduce healthcare utilisation^{103,104}. Housing with care is an essential option for those with social care need to live in appropriate accommodation that meets their care and support needs¹⁰⁵. For those in receipt of residential care, the quality of their local built environment can influence wellbeing¹⁰⁶. As well as housing, the wider built environment (for example, access to green spaces and transport) impacts health in several ways, and is associated with other risk factors for social care need such as physical activity rates and social connectedness¹⁰⁷.	Primary prevention focuses on population-level approaches to improving health outcomes associated with housing. Existing research identifies several opportunities for improving housing and health – in turn reducing social care needs: Improving the safety and quality of housing - Improving the quality of housing at a population level can reduce the burden of ill-health and mitigate future social care need. The UK Government has worked with HACT to develop standards for public health and housing – with several areas related to safety and quality¹⁰⁸. - There is specific guidance for addressing mortality and illness associated with cold homes, which includes identifying individuals and groups at risk, assessing heating and insulation needs, and developing a tailored year-round programme to implementing changes^{109,110}. Increasing access to affordable housing - This is an under-explored area in research – as is the link between deprivation and social care need (though available evidence suggests a strong link)¹¹¹. - The association between housing costs and poverty is well-established. The Joseph Rowntree Foundation estimate that an extra 3.1 million people in the UK are in poverty after housing costs – one million of these are in London¹¹². Design neighbourhoods and urban spaces for health - There is strong evidence that the built environment impacts on health. This is relevant for social care as urban design can build social connectedness, increase uptake of health protective behaviours such as physical activity, and improve access to support. There is no direct evidence on the link between building healthier places and preventing social care need¹¹³⁻¹¹⁵. - Public Health England have developed an evidence resource that cites principles for designing healthier places – including on building healthy neighbourhoods, healthier food environments, developing natural and sustainable environments and healthy transport¹¹⁶. - Housing LIN have produced a practice briefing on active ageing and the built environments, with case studies of practice from Local Authorities¹¹⁷. WHO have also produced a guide for building age-friendly cities¹¹⁸.	Secondary prevention focuses on supporting the housing and care needs of those at risk of social care need, or those with low level existing social care needs. Interventions that reduce homelessness - People experiencing homelessness experience poor health outcomes and often have unmet health and social care needs^{119,120}. - LGA have produced guidance on the role for adult social care in addressing the needs of those experiencing homelessness. This includes improving partnership working, co-production, Care Act Assessments, safeguarding, workforce trainings and development, and improving commissioning¹²⁰. - More widely, Crisis have produced guidance on preventing homelessness, with suggested targeted interventions with populations at increased risk of homelessness¹²¹. Homeless Link have also produced resources on ending homelessness. Improving housing for those with higher risk of social care need - Many people at increased risk of social care need can benefit from home adaptations. There is some evidence that effective home assessments can significantly reduce falls in older adults at risk¹²². - Preventative home adaptations for those at risk of social care need can maintain independence and improve health and wellbeing. Care and Repair England have produced guidance and best practice on implementing home adaptations¹²³. - DLUHC and the Ministry of Housing have guidance available for Local Authorities on supporting the housing needs of older and disabled people, which covers how to identify housing requirements, ensuring accessible and adaptable housing, and specialist housing for older people¹²⁴. - LGA have resources for local authorities to support effective housing for people with a learning disability or autistic people¹²⁵.	Tertiary prevention focuses on supporting the health and environmental conditions for those in receipt of social care support. Many interventions overlap with those in secondary prevention, particularly with respect to home adaptations. Housing with care and support - While SCIE recognise that where feasible individuals should be supported in their home, there will always people who need specific care or support in housing with care/support options. They set out seven principles for high quality housing with care: person centred and outcome focused, community connectedness, strong leadership culture and workforce, adopting innovation, enabling choice and control, promoting equality and co-production¹⁰⁵. - There is a range of guidance published on housing with care, for example the supported housing statement of expectations published in 2020¹²⁶. Integration of housing and social care support - Although there is limited evidence specifically related to integration of housing and social care services, other evidence (for example around homelessness service integration) suggests this may be an effective approach for preventing worsening of health and social care needs.	Spatial Planning JSNA - The Spatial Planning Joint Strategic Needs Assessment, published in November 2023, sets out the association between planning and health in Tower Hamlets. - The JSNA covers five themes: neighbourhood design, housing, natural and sustainable environments, transport and food environment⁶³. It sets out the current challenges with respect to spatial planning and health, e.g. overcrowded housing, housing appropriateness. - The JSNA also sets out related provision in place in Tower Hamlets, including the Local Plan, work around housing for vulnerable groups, and access to green spaces. Tower Hamlets Local Plan - The new Tower Hamlets Local Plan is currently being developed, using a range of evidence including an assessment of the borough's health needs¹²⁷. - This evidence includes a local housing needs assessment, published in October 2023, that assesses the need for housing in the borough both now and in the future. Tower Hamlets Housing with Care Strategy - The Housing with Care strategy 2023-2033 was developed by Adult Social Care to set out a forward vision for housing with care in the borough. It sets out the Council's commitment to supporting people in their homes where possible, and providing additional support for prevention and early intervention, but providing high quality housing with care options for residents where this support is needed. This includes supporting Extra Care and Shared Lives options, alongside meeting future demands for nursing care¹²⁸.



Recommendations and priorities for prevention in adult social care in Tower Hamlets



Developing recommendations with health and care partners in Tower Hamlets



- On Wednesday, 10th April 2024, the project group who produced the Adult Social Care JSNA Chapter delivered a workshop for health and care leaders across Tower Hamlets. The aims of the workshop were to:
 1. Enable stakeholders to consider and develop a shared understanding of the key findings from the Adult Social Care JSNA Chapter.
 2. Develop a shared conceptualisation of “prevention” as it relates to adult social care, and use this to identify the implications of the JSNA findings for prevention across health and care partners in Tower Hamlets.
 3. Agree changes we want to see in Tower Hamlets, and finalise the JSNA Chapter recommendations.
- There were two breakout sessions on the day. Firstly, there was a discussion of key findings from the ASC JSNA Chapter, and implications for health and care practice in Tower Hamlets. Outputs. The outputs from this session have been used to develop recommendations for the ASC JSNA Chapter, alongside insights from the report authors. These recommendations can be seen on slide 93.
- In addition, there was a session on identifying priorities for an adult social care “prevention action plan”, to incorporate into planning for a strategic document that builds on the JSNA Chapter recommendations around prevention as it relates to adult social care services and service users in Tower Hamlets. The outputs from this session are presented on slides 94-97.



Proposed whole-system recommendations for addressing social care need in Tower Hamlets (1)



Recommendation	Identified by:	Priority	Division lead
Additional analysis/expanding our understanding of social care need			
Continue to look at patterns of health and disability at a population level in Tower Hamlets, as a means of understanding potential future need for adult social care support and population groups with high need.	Stakeholder workshop	Medium	Public Health, ASC
Explore possible "under-representation" of service users living in most deprived areas, and ensure commissioning and service planning in social care considers area deprivation	Project group; stakeholder workshop	High	ASC, Public Health
Improve data recording in Adult Social Care around protected characteristics and health conditions to improve understanding of population level need for care and inequalities. Participate in NEL initiatives to link primary care and social care datasets to understand health needs of social care service users.	Project group	Low	ASC, Public Health
Conduct additional analysis to understand drivers behind male/female gap in health and social care outcomes	Project group; stakeholder workshop	High	Public Health, ASC
Develop a series of research questions that build on the findings from the JSNA Chapter, to use qualitative methodologies to understand social care need, working with an academic partner	Project group	High	All
Addressing risk factors associated with increased need for adult social care support			
Develop a prevention strategy for Adult Social Care that links into wider prevention plans within THT, with a focus on factors driving social care need (e.g. reducing modifiable risk factors, improving LTC management, reducing multimorbidity). Target prevention for population groups with high need for social care support	Project group (in development)	High	All
Improve pathways for prevention-focused services (e.g. smoking cessation, weight management, Communities Keeping Well) to link with ASC cohorts and at-risk cohorts, focused on key risk factors associated with social care need: multimorbidity, social isolation/living alone, deprivation, age-related factors.	Stakeholder workshop	Medium	All
Develop training for social care practitioners and encourage practitioners to have MECC conversations around key health risk factors – e.g. on the Vital 5 – as part of routine care. Also embed this approach into Tower Hamlets Connect and Initial Assessments process.	Stakeholder workshop	High	Public Health, ASC
Amplify current support around social isolation and loneliness, particularly for those receiving social care support and for those who live alone, and identify opportunities for any additional services to meet these needs across public health and integrated commissioning.	Stakeholder workshop	Medium/Low	Public Health, ASC
Supporting the health of those who currently need social care support, or who may need support in future			
Support the Localities and Neighbourhoods programme in developing approaches to integrated working across health and social care services.	Stakeholder workshop	High	All
Improve access to GP appointments for social care service users through early access appointments/developing improved pathways.	Stakeholder workshop	High	Integrated Commissioning, ASC
Review the value of NHS contributions for social care support where LTCs/ multimorbidity are a factor in support need; and ensure equity across NEL Places, and appropriateness to need.	Stakeholder workshop	Medium	ASC, NEL ICB.
Expand work with the Carer's Centre in Tower Hamlets to design health interventions that support the health of carers and those in receipt of unpaid care, and ensure outreach and pathways to support carers to access routine preventative services.	Project group	Low	ASC, Integrated Commissioning, NEL ICB
Improve support plan review process to consider how easily care can be stepped up/down as needs change.	Stakeholder workshop	Medium	ASC, Barts, NEL ICB.
Continue to support pilots within reablement that facilitate closer working between health and social care service teams.	Stakeholder workshop	Medium	ASC

Summary of workshop outputs: developing an adult social care “prevention action plan” (1)



Primary and secondary prevention of health and social care needs

What should we be looking to achieve through a prevention action plan?	What interventions should we be delivering in order to meet this ambition?	What do we already have in place? Where are the gaps?
Risk factors for poorer health and increased social care needs:		
Housing: ensuring residents live in homes that support their health and wellbeing, and strengthening the link between housing and social care to identify both housing and social care needs.	- Identification of home-based equipment and adaptation needs by housing teams could mitigate worsening social care needs. - Housing teams may know who is living alone and require other forms of community-based support.	Housing teams in LBTH Council have support worker roles that could be utilised further to identify social care needs, and links with social care could be strengthened to address these needs.
Living alone/social isolation: supporting existing activity to address social isolation, and providing continuous and holistic support for those living alone or at risk of isolation across social care, community and health services.	- Cross-system approach to identifying those who may be experiencing social isolation – across Council and other community services. - Central role of social prescribing and health and wellbeing coaches to support those who are living alone/experiencing social isolation but may not be known to ASC.	- Adult social care already look at community resource as part of assessments designed to develop meaningful connections in community. - We need to evaluate this support. - There is an issue around who follows up when people are referred into community services – should this be done in primary care? - ASC also assess risk for those who live alone, and build this into support plans. - Connection Coalition brings together Council, VCS and other services to address issues around social isolation – opportunities to strengthen social care role within work around social isolation.
Alcohol and substance misuse: highlighted as driver of social care need, vision for a joined up approach to treatment, and integrated care that includes social care and support for carers.		
Supporting carers: ensuring carers are supported with their health and wellbeing, alongside providing support for their caring responsibilities.	Integrated health and wellbeing support delivered through the Carer's Centre – opportunity for Carers health checks and better link into primary care.	The Carer's Centre deliver initiatives focused on carer's health and wellbeing – these could be supported by ASC/primary care where links are not already in place.
Prevention and management of health conditions:		
Prevention of long term conditions: focus on the Vital 5 modifiable risk factors for ill-health at a population level with social care playing a key part in the approach to long term condition prevention through closer interactions with public health and primary care.	- Embedding “Be Well” approach to prevention into Tower Hamlets Connect pathways and Adult Social Care Initial Assessments. - Adapted Vital 5 resources for social care to use in initial assessments and when providing routine care.. - Social care making referrals into other health and community interventions that focus on long term condition prevention.	- Gap in clear messaging about preventing / mitigating Vital 5 risk factors for social care staff to disseminate and reinforce at regular intervals. - MECC questions are covered in initial assessments, but these are not always asked and there are issues around follow-up where issues are flagged. - Could be opportunities for adult social care to link into Communities Keeping Well – a programme focused on long term condition prevention in Tower Hamlets..
Effective management of long term conditions: shared understanding of LTC management so social care can effectively support primary care (and vice versa).	- Social care understand how long term conditions are managed through primary care and can provide advice/support in interactions (through TH Connect, Initial Assessments). - Social care services are commissioned with management of conditions in mind, with commissioning models leveraging opportunities for closer working relationships between social care and primary care.	Long term conditions are managed principally through primary care. Gap in social care understanding/involvement in process for LTC management for service users, which limits ability to support effective and coordinated management.
Improving early diagnosis and support for people living with dementia: working with existing integrated service to support early diagnosis and management.	Focus on earlier diagnosis and intervention, with individuals receiving timely assessment and integrated support across health and social care.	- Tower Hamlets has a diagnostic memory clinic that links with social care. - There are currently some issues around timelines for diagnostic assessment.

Summary of workshop outputs: developing an adult social care “prevention action plan” (2)



Preventing worsening social care needs for existing social care service users

What should we be looking to achieve through a prevention action plan?	What interventions should we be delivering in order to meet this ambition?	What do we already have in place? Where are the gaps?
Social care workforce development:		
Training social care workforce to implement preventative approaches: ensuring all staff have the knowledge, skills and training to work in a preventative way, focusing on outcomes for individuals.	• Training for coaching style conversations delivered by social care staff – identifying needs and working to address these. • Embedding strengths-based approaches of social care support, building on existing work. • Staff trained to recognise loneliness/social isolation and have the tools to address this.	• Social care currently use a strengths-based model to build on existing support and prevent worsening needs where possible. • Tower Hamlets Connect deliver a front door screening service where a greater focus on prevention- focused activity could be implemented, including referrals to public health commissioned services or identifying possible home-based equipment or adaptations that would reduce need for long term care.
Integrating and improving services:		
Working with providers to support reablement approaches: ensuring through commissioning that providers are adopting preventative approaches to care wherever possible.	• Commissioning adaptation/assistive technologies that allow for step up and step down of care. • Supporting training for providers in reablement/strengths-based approaches.	• There is currently a gap in training for social care providers on reablement/prevention that would support implementation of approaches. • There is an opportunity to embed preventative or reablement approaches into provider commissioning.
Effective integration across social prescribing and social care: integrating support across primary care, social care and community based support.	• Working across social prescribing and social care to support independence and reduce reliance on services where possible. • Developing role of social prescribing and social care in supporting health needs of carers – particularly mental health.	• There is some currently some interaction between social prescribing and social care (particularly in MDT working) but this could be expanded. • To support carers, there needs to be closer working between social prescribing and the Carer's Centre – Carer's Centre already doing a lot of work around health of carers that could be supported/built on.
Process for evaluating interventions and pilots focused on delivering “prevention agenda” in social care: allowing us to build on learnings through commissioning of services.		• There is a lot of existing activity supporting “prevention” in social care but not delivered consistently – and limited evidence for what is working effectively. • Need resources and capacity to establish pilots that can be evaluated, as well as evaluation expertise.



Summary of workshop outputs: developing an adult social care “prevention action plan” (3)



Preventing healthcare needs for existing social care service users

What should we be looking to achieve through a prevention action plan?	What interventions should we be delivering in order to meet this ambition?	What do we already have in place? Where are the gaps?
Approach to preventing healthcare needs:		
Prevention delivered early in social care interactions: going beyond information and advice to identifying and addressing health needs alongside social care support.	- Tower Hamlets Connect and Initial Assessments are able to identify healthcare needs effective provide advice and support to access appropriate services to support health needs. - Social care practitioners are confident in discussing healthcare needs with service users and know how to refer into services.	There could be opportunities to learn from expert patient programmes and think about relevance for social care service users, particularly around self-management
Asset-led: supporting existing roles within the health and care system, such as social prescribing, social care practitioners and health and wellbeing coaches, and moving towards the goal of social care service users receiving appropriate support and being able to self-manage conditions.	- Social prescribing, health and wellbeing coaches and social care practitioners have strong relationships with one another and work together to meet varying needs of service users. - Technology enables join-up between services and/or can support service users in self-management of health conditions. - We need to identify opportunities to leverage AI and other assistive technologies within routine care provision,	There are already a wide range of roles supporting health and social care needs in Tower Hamlets – gap is in ensuring these services are running to the same goals and are integrated,
Working with service users as equal partners: services and service users both working together to identify and address healthcare needs.	- Continued focus on strengths-based approaches within social care service delivery. - Involving residents in decision making around their care and support planning across their interactions with the health and care system.	Opportunity to work with the Carer's Centre around carers assessments to understand how carers might be supported – including where social prescribing could play a role. Currently Carer's Centre manage assessments and deliver programmes around health and wellbeing – but gap in understanding of how best to support these and similar programmes.
System-wide approach: strengthening relationship between primary care, acute care and social care, along with residents.	Providing the right care at the right time on discharge from acute care.	- There is a quality improvement project ongoing involving joint triaging between reablement and intermediate care teams – can learn from this approach to understand relevance for other areas. - Multidisciplinary working across social care and primary care is already embedded in some areas in Tower Hamlets. This approach needs to be evaluated and if effective rolled out to other areas in the borough. - Potential to further strengthen links between health and adult social care at the “front door” – particularly in Tower Hamlets Connect and initial assessments.



About this JSNA Chapter



About this Adult Social Care JSNA Chapter



This JSNA Chapter on Adults Social Care was produced by LBTH Public Health team, led by Liam Flannigan, Jeremy Hooper, Carmel Black, Hannah Choi and Liam Crosby.

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The JSNA Chapter is sponsored by LBTH Health and Adult Social Care Directorate Leadership Team (DLT), who will take forward the recommendations.

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Appendix A - Identifying contextual factors associated with Adult Social Care need

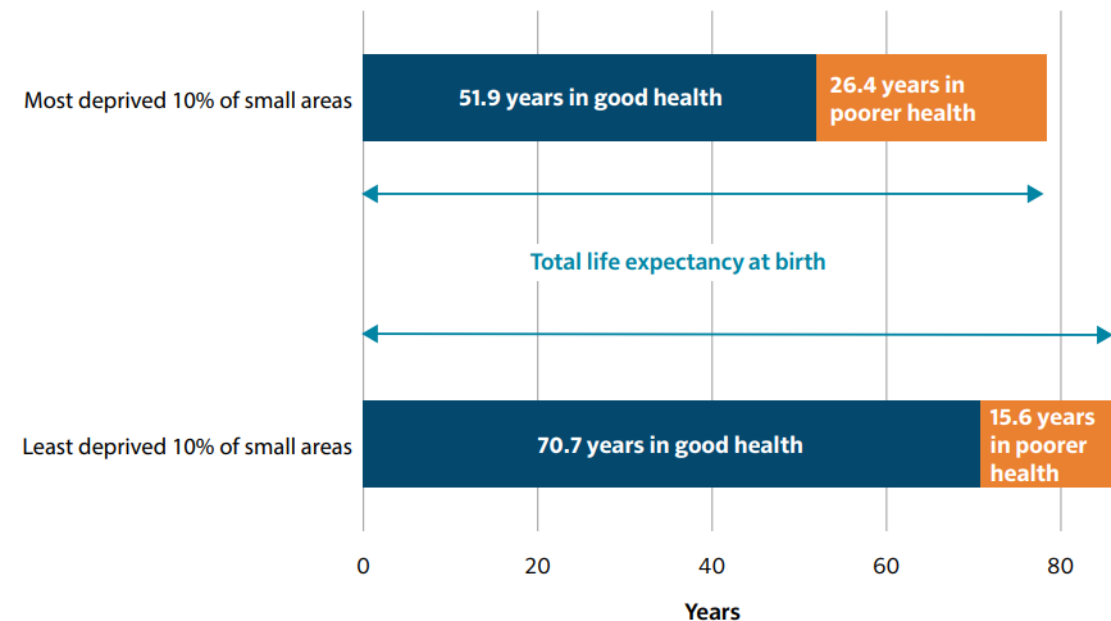


Deprivation is a significant driver of health inequalities and social care need



- The link between deprivation and ill-health is well established, and translates into greater need for adult social care support – particularly for those in older age groups¹²⁹⁻¹³².
- **Those living in the most deprived areas have a shorter life overall life expectancy at birth, and live significantly longer in ill-health** – as seen in the chart to the right taken from the CMO's Annual Report on health in an ageing society¹²⁹.
- Deprivation impacts health in multiple and compounding ways. Analysis by the Health Foundation shows that, across most common conditions, **rates of diagnosis are higher for people living in more deprived areas are higher compared with those living in less deprived areas**. The impact of deprivation on health increases drastically in middle ages and continues for older adults¹³³.
- This is reflected in rates of reported issues with performing Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). Older adults (65+) living in the most deprived areas are more than twice as likely to report issues performing ADLs/IADLs than those in the least deprived areas, and are significantly more likely to report unmet need in performing activities¹².

Inequality in life expectancy and healthy life expectancy at birth for females in the most and least deprived areas in England, 2018 to 2020 (taken from CMO Annual Report 2023)¹²⁹.

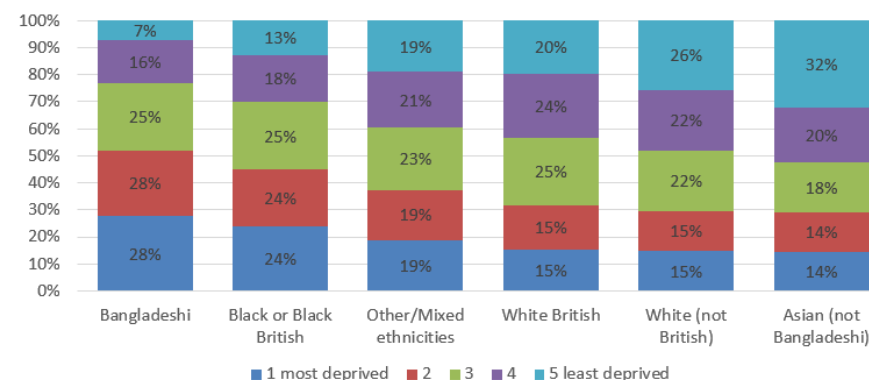


Health and social care outcomes vary by ethnic group

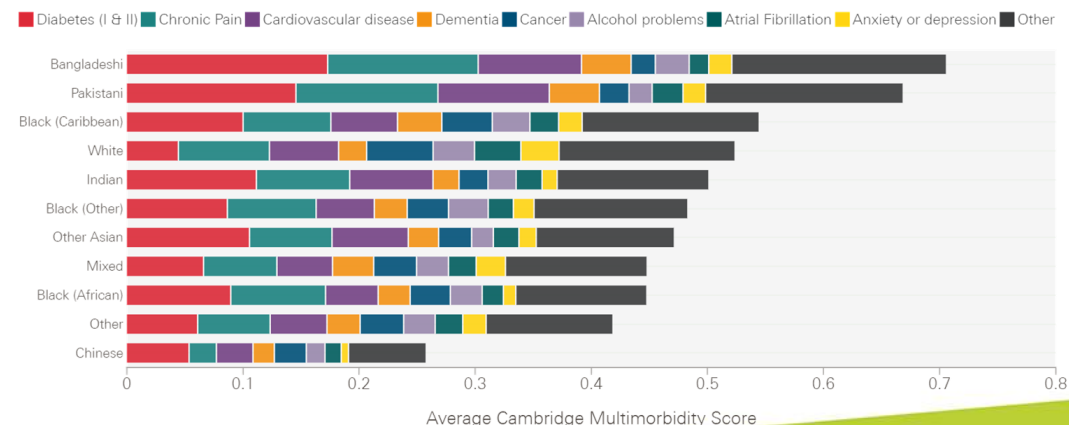


- **Similar to patterns seen in health outcomes by deprivation, national data shows there are notable differences in rates of diagnosed illness by ethnic group.** In England, people from Bangladeshi and Pakistani ethnic groups have more diagnosed chronic pain, diabetes, dementia and CVD compared with other ethnic groups (conversely, White populations have more diagnosed anxiety, depression, alcohol problems, atrial fibrillation and cancer)^{133,134}.
- **In Tower Hamlets, residents from some ethnic groups are more likely to live in areas of high deprivation** (top right graph). The intersecting impacts of ethnic and deprivation-related inequalities drives poorer health (and consequently social care) outcomes for residents from some ethnic groups in Tower Hamlets.
- **As well as higher rates of diagnosed ill-health, research has highlighted barriers to social care access for some ethnic groups, driven by challenges with service navigation, accessibility of information (including digital information), and poor awareness/promotion of services¹³⁵⁻¹³⁷.** Previous research on perspectives of social care for individuals in Bangladeshi, Pakistani and White ethnic groups found that all three groups felt there was a need to 'fight' for services. In addition, some respondents in Bangladeshi and Pakistani ethnic groups found self-advocating for care challenging when English was not a first language¹³⁶.

IMD deprivation distribution within broad ethnicity categories for Tower Hamlets residents (2021 Census)¹¹.



Age-standardised diagnosed illness (average Cambridge Multimorbidity Score) by ethnicity and condition in England (Health Foundation)¹³³.

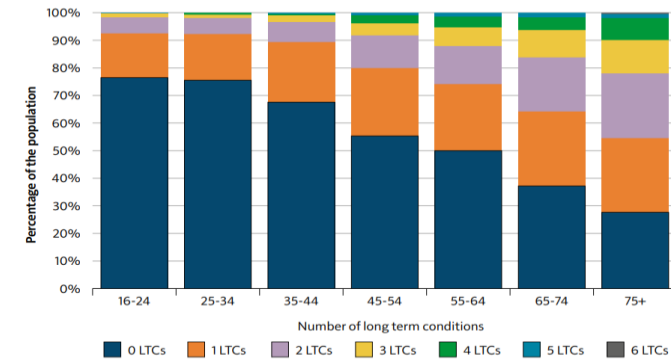


Multimorbidity is a significant driver of ill-health and social care need in older ages

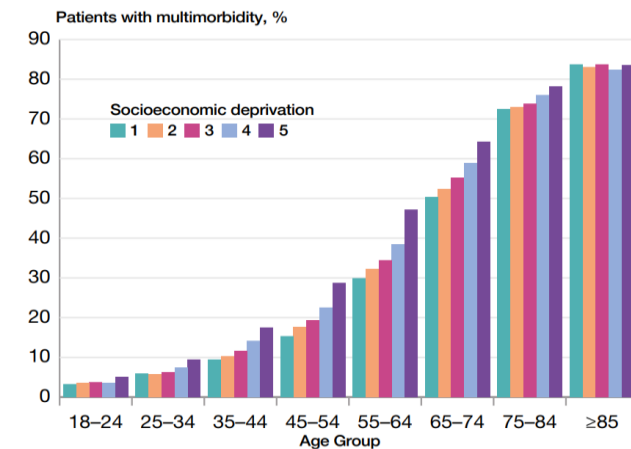


- Multimorbidity is a growing challenge for health and social care systems, with **many older adults in England live managing two or more long term conditions**^{45,129}. There is recognition that many health and care services are not set up to adequately address multimorbidity, with primary and secondary care services being generally single disease focused or looking at groups of similar conditions¹³⁸.
- **The impact of multimorbidity on health is significant, contributing to functional decline, lower rates of wellbeing and higher rates of disability.** While management of conditions is a concern for health systems, the non-biological impacts of multimorbidity contribute significantly to social care need, by reducing the ability of individuals to live independently and perform Activities of Daily Living (ADLs)^{45,139}.
- **The CMO Annual Report demonstrates both the impact of age on the prevalence of multiple long-term conditions (top right), and the inequalities in prevalence of multimorbidity by age (bottom right)**¹²⁹.
- Given the deprivation profile of Tower Hamlets, the bottom graph is significant - a greater proportion of residents are more likely to develop multiple long-term conditions, and to develop MLTCs earlier in life than those in less deprived areas.

Percentage of the population with 0 to 6 long-term conditions by age in 2018 in England (CMO Annual Report)¹²⁹.



Prevalence of multimorbidity (2+ conditions) by age and deprivation (CMO Annual Report)¹²⁹.



Appendix B – Methodology and technical information



Methodology - 1



Below summarises the methodological approach taken in each chapter of the needs assessment, including limitations in approach and caveats.

Understanding demographic, socio-economic and health factors that drive social care need in Tower Hamlets:

Life expectancy and healthy life expectancy data was taken from the OHID Fingertips dashboard. 2021 Census data was used for data on self-reported health and disability, using the [Custom Dataset](#) function. Primary care data was used to estimate prevalence of key long term conditions, learning disabilities, and SMI (and associated LTC prevalence), as well as the age of diagnosis estimates. Prevalence estimates are calculated using primary care records for 2022/23, with extracts taken as of 1 April 2023 (SMI data and age of diagnosis analysis uses 2021/22 data). Where possible, prevalence estimates are compared with prevalence estimates for North East London. Population estimates for primary care data differ to population estimates in the Census. For the age of diagnosis analysis, data was extracted from the 2021/22 East London Database to look at the age of diagnosis for a number of long term conditions in the previous five years. The population studied was all residents of Tower Hamlets who are registered to a GP practice within the NEL ICB area and were between the ages of 15 and 79 on 1st April 2022. The cumulative likelihood measure is adapted from the Kaplan-Meier survival curve. Analysis takes age-specific probabilities of receiving a diagnosis (within a 5 year age band), and multiplies these to give a cumulative likelihood of having a diagnosis, by age x. There is some bias in the dataset as residents who have died within the period won't be included in the analysis. Equal counts of a conditions may not lead to equal cumulative likelihoods as the probabilities of receiving a diagnosis within a 5 year period are based on the counts of a condition and the number of people in each age band. The probability for a count in an age band where the population in the age band is high will be lower than the same count where the population is low. As the probabilities are multiplied together, this can affect results. As Tower Hamlets has a relatively young population, this means conditions that affect a younger demographic will result in lower cumulative likelihoods. However, when comparing demographics within a specific condition, counts are broadly similar across demographics and comparison between cumulative likelihoods is valid.

Estimating social care need in Tower Hamlets:

Analysis estimating "social care need" in older adults uses findings from the Health Survey for England 2021 survey, which reports the proportion of older adults with issues performing ADLs/IADLs by age, gender and deprivation. Three estimates have been produced on the number of older adults in need of social care support in Tower Hamlets, after weighting according to local population demographics. The percentage of older adults in need of ADL/IADL support has been calculated using a population denominator of all adults aged 65+ from the 2021 Census.

Understanding who is using Adult Social Care services in Tower Hamlets:

All analysis uses Adult Social Care service user data taken from Mosaic. Current service users were defined as any individual who received a package of care in November 2023. This excludes any individual with no active package during this time period, as well as individuals who may be "known to Adult Social Care" but not in receipt of a package of care (for example, those known to Adult Safeguarding).

Deprivation was identified using the Ministry of Housing, Communities and Local Government [IMD 2019 lookup](#) with service users' listed primary postcode. Where postcode was unknown or deprivation could not be identified in the lookup, deprivation was marked as "unknown". For relative deprivation analysis, we ranked each LSOA area (2011 boundaries) in Tower Hamlets by IMD deprivation rank, and produced deprivation quintiles from this ranked dataset. Service users with a primary postcode outside of Tower Hamlets were classed as "Not Tower Hamlets residents". It should be noted that, for various operational reasons, service user postcodes may not be updated if their residence changes, and for service users in residential care in particular the deprivation analysis may use the postcode of their residential care address, which may be different to the area they were resident in prior to receiving residential care. Where maps of service users are shown, these are done using 2011 LSOA boundaries to allow 2019 IMD deprivation to be mapped.

Elements of this section explore the "rate of Adult Social Care service use per 100,000 population". For this analysis, population estimates were taken from the 2021 Census, and broken down by population sub-group as appropriate. The Census was used as the population estimate for two reasons; first, it allows a more granular breakdown of population by sub-group that is not possible with other population estimated (e.g. the ONS mid-year population estimated). Secondly, the Census is the most rigorous estimate of the population, and previous work has shown that other estimates, such as the ONS mid-year estimates, often misrepresent the number of Tower Hamlets residents, particularly for older adults. We do, however, recognise there are limitations with this approach, most notably that the Census is from March 2021 while service user data is taken during November 2023, and we have not accounted for possible population changes during the intervening period. As such, this analysis should be interpreted with these caveats in mind,



Methodology - 2



Understanding who is using Adult Social Care services in Tower Hamlets (continued):

For ethnic group analysis, we have used an adapted ONS 10-ethnic group classification, which uses the standard 6- group classification as a basis but separates Asian or Asian British: Bangladeshi from all other Asian ethnic groups; separates Black or Black British: African, Black or Black British: Caribbean and all other Black ethnic groups into three distinct categories; and separates White British from other White ethnic groups. This allows for more focused ethnic group analysis to reflect the population demographics of Tower Hamlets. Adult Social Care service user data, captured in Mosaic, is not collected using ONS ethnic group classifications, so data has been recoded to match this 10-group classification. Where data coding has been limited, some working assumptions have been made (for example, where a service user has "Caribbean" listed as their ethnic group, this has been recoded to "Black or Black British: Caribbean" despite incomplete information available on their ethnic group. This has been done to allow a working analysis to take place, though appropriate caveats should be made in this regard.

Similarly, some analysis uses gender as a sub-group breakdown, as this is routinely collected by Adult Social Care (and sex is not recorded). When calculating the rate of Adult Social Care service per 100,000 population we use population estimates from the Census based on sex, as the Census does not collect appropriate data on gender to allow us to produce a population estimate. To calculate the rate of service use per 100,000 population, in the absence of aligned data we have agreed a crude methodology that calculates the numerator using reported gender and the population denominator using reported sex. This is a known inaccuracy that makes the assumption that the gender reported to Adult Social Care is the same as sex assigned at birth. However, this approach gives us an indicative analysis, and we will explore how to improve data collection processes that will improve quality of reporting in future.

Understanding differences in factors that drive social care need among service users – findings from Whole Systems Dataset Project (WSDP):

All findings in this section are produced from the Whole Systems Dataset Project (WSDP). This was a project led by the Public Health division at the London Borough of Tower Hamlets (LBTH). Partnering organisations included the UCL Institute of Health Equity, and the Tower Hamlets Together (THT) partnership whose members include: London Borough of Tower Hamlets (LBTH), Bart's Health NHS Trust, East London Mental Health Foundation Trust, Tower Hamlets Clinical Commissioning Group, Tower Hamlets Council for Voluntary Service, and Tower Hamlets GP Care Group. The WSDP brought together datasets from the Local Authority and health to generate a linked, depersonalised and aggregated dataset to explore the inter-relationships between population health, social and economic characteristics. Data included includes, from the Local Authority: housing, crime, environment, education, social care, and benefits; and from health: A+E, primary care, acute inpatient, acute outpatient, community services, and births and deaths. Data was linked using common identifiable information across datasets, then depersonalised and analysed to produce a summary report. The [Privacy Notice](#), [guidance for creating a WSDP](#) (including the legal arrangement for the project), and [Summary Report](#) are publicly available..

For the analysis in this report, no authors had access to original individual-level datasets produced by the WSDP as these were destroyed, per original project protocols. Analysis was produced using retained aggregated and anonymised datasets. Relevant cross-sections of the dataset were selected, focusing on those datasets where Adult Social Care service users could be compared to a wider resident population. In the dataset, "Adult Social Care service user" is defined as all individuals who were in receipt of social care support on a single day in August 2017 (and therefore uses a different methodology to elsewhere in the report). In all calculations, the denominator is the patient population of Tower Hamlets (total 320,000 in the dataset) with the selected characteristics (for example, the percentage of Adult social Care users in social housing is calculated using a denominator of: all patients listed in Tower Hamlets who have been identified as an Adult Social Care service user). Given the nature of the dataset, we are limited in our analysis to the aggregations of data that have been retained from the original project, and as such have limited scope for more expansive analysis using the WSDP.

For the multimorbidity analysis, conditions included are: asthma, depression, epilepsy, atrial fibrillation, cancer, CHD, CKD, COPD, dementia, diabetes, hypercholesterolaemia, heart failure, learning disability, any mental health condition (including depression, anxiety and conditions classed under severe mental illness), osteoporosis, PAD, rheumatoid arthritis and stroke/TIA.

As we are unable to access the original datasets, it is not possible for us to verify the validity of the data. We are also aware that statistics presented deviate from published statistics (for example, mental health statistics), which may be due to different time periods for the data or due to differences in methodology. As such, findings should be treated as experimental and indicative rather than a "true picture" of health and socio-economic conditions. Where appropriate, we have highlighted this in the main report.



Methodology - 3



Changing patterns of Adult Social Care need in Tower Hamlets:

For this section of the report, Adult Social Care service users are defined in line with the methodology description for "Understanding who is using Adult Social Care services in Tower Hamlets", as are breakdowns by sex/gender, deprivation and ethnic group.

Services in Mosaic are recorded with a start date, and end date, and for home care, a weekly number of hours. e.g. User 1, Home Care, element start 10/03/2023, element end 26/06/2023, 10.5 hours per week. Where data presents the number of service users over time, this is calculated as the number of service users who were logged as having received a service during that month (this may exclude individuals who have been classed as service users in other returns e.g. SALT, but did not receive a service in that month). Where age breakdowns are provided, the age of the service user is calculated as their age at the beginning of the relevant month, and thus the age band of an individual service user may change over time.

When breakdowns are given by service type, this is calculated as the number of individuals receiving each service, and therefore individuals will be counted in multiple service types if they are receiving multiple, different services. As such, the total number of service users by service type is greater than the number of service users overall.

Length of package is calculated using the recorded length of service in Adult Social Care datasets. This may misrepresent service provision where, for example, packages are recorded as ended and immediately restarted.

"Intensity of home care service use" is calculated using number of hours of home care delivered per service user per month, using data routinely collected by Adult Social Care. Calculations are done on a day-by-day basis, then aggregated to monthly. This analysis is likely to be a slight under-representation of true intensity of home care, as service users who received a package of care for only part of the month are included as a service user in the denominator for the whole month. The accuracy of this data is also dependent on the quality of recording of data, and the regularity with which data is updated, the impact of which is difficult to ascertain. Given these uncertainties, we suggest this data is treated as indicative and appropriate cautions in interpretation are applied.

Demand for Adult Social Care services in Tower Hamlets:

Findings in these section have been developed principally using data on Initial Assessments recorded by Adult Social Care. This excludes re-assessments for existing social care users. Where changes over time are presented, analysis looks at the Initial Assessments conducted per quarter. Demographic breakdowns are done in accordance with the approach detailed elsewhere in this methodology note. Contacts are also reported in this section. A contact can be logged for a wide range of reasons that may or may not require the intervention of Adult Social Care services, and therefore in isolation cannot be assumed to be representative of "demand" for social care.

Carers in Tower Hamlets:

Findings in this section are from mixed sources. The number of unpaid carers, including demographic breakdowns and intensity of provision, are taken from the 2021 Census (using Custom Datasets). Details on Carer's Allowance payments has been taken from XXXX. We also conducted some analysis on the Carer's Survey 2021-22, which provides breakdowns of results by Local Authority. There were around 240 respondents to the Carer's Survey in Tower Hamlets in 2021/22, meaning this represents a relatively small proportion of all those providing unpaid care in the borough.

Data on Carer's Assessments are taken from Adult Social Care data. All Carer's Assessments in Tower Hamlets are conducted by the Carer's Centre Tower Hamlets. Ethnic group reporting is different to elsewhere in the report, as data is only collected using the ONS 6 ethnic group classification. Changes over time look at the number of assessments conducted in each quarter. We have used the outcome of the assessment as broadly indicative of the level of need, and split those with "high" need out from others who were deemed eligible after assessment. This may not be entirely reflective of the social care needs of the person in receipt of care, as there are a number of other factors taken into consideration during assessments.



Methodology - 4



Predicting future need for adult social care support in Tower Hamlets:

This section uses a wide range of data including population projections and insights from the JSNA Chapter to predict how demand for adult social care is likely to change. Readily available population projections has several limitations within Tower Hamlets, firstly it overestimates in particular the population aged 65 and over. Secondly there is no breakdown by ethnic group. The variation in population size and the variation in demand by ethnicity mean the results from a traditional modelling approach would be subject to substantial levels of uncertainty. This analysis therefore uses a model which calculates a relative number which indicates whether demand is likely to be increasing or decreasing. The model uses historic changes in population by age and ethnicity alongside our current understanding of demand for social care. In addition, the model includes adjustment factors which support accounting for changes in relative deprivation and self-reported health status. The current inputs to the model are:

- Population growth by age, gender and ethnic group using the growth seen between the 2011 census and the 2021 census. This takes the percentage growth by age and sex in the 10 years between the Census', divides this growth by ten to take a per-year growth percentage, and multiplies this by the current rate of service use for each population sub-group.
- Reduction in self-reported health status as Bad or Very Bad by age, gender, and ethnic group. The general health data is not available for the Bangladeshi ethnic group in the 2001 census data so we have had to calculate an overall Asian figure which we have used for both Asian and Bangladeshi within the model. Again, as these are 10 year figures the proportions have been divided by 10 in the modelling.
- A deprivation weighted average adjustment based on the change in population in the mid year estimates using the current proportion of demand for ASC services by deprivation. The proportion of people living in more affluent areas has increased, as demand for ASC services is lower in more affluent areas this shift in population is likely to have a negative impact on the demand for services. We calculated a weighted average of this measure which takes account of the population in each decile and the current proportion of demand for ASC services and calculates the difference between the 2 years of population estimate.

There are several assumptions made in this projection analysis that mean findings should be treated with caution.

1. The modelling reflects a position with respect to demand and does not take into account the cost of care. Assumptions about the impact changes in demand will have on the cost of care should be considered separately.
2. The modelling assumes current policy with respect to Social Care provision remains the same. Should there be a different approach to the provision of social care nationally or locally this is likely to impact on the demand for services.
3. The estimate range provided assumes growth in the population which is similar to that seen between the 2011 and the 2021 Census, if growth is higher or lower in particular gender, age and ethnic groups. This could be monitored over the coming years by looking at Electoral Registrations to GP Registrations or other sources to determine how the population is growing.
4. Assumption in the model around improvements in general health currently place a downward pressure on demand based on the reductions in Bad or Very Bad as seen between the 2011 and 2021 Census by Age Band, Gender and Ethnicity. This could potentially be monitored over time using the Local Residents Survey or other surveys within the Borough.
5. The deprivation adjustment used IMD2019, this is currently being updated which is expected to be published later this year. This may impact changes with respect to population in the different deciles which may impact the adjustment factors.

