Committee/Meeting:	Date:	Classification:	Report No:
Cabinet	9 February 2011	Unrestricted	

Report of:	Title: Transforming Adult Social Care and commissioning as market shaping and development
Corporate Director Adults Health and Wellbeing Originating officer(s) Deborah Cohen, Service Head Commissioning and Strategy, AHWB	Wards Affected: All

Lead Member	
Community Plan Theme	**Safe and Supportive Community**
Strategic Priority	**4.1 Empower older and vulnerable people and support families** **4.3 Focus on early intervention**

1. INTRODUCTION / SUMMARY

1.1 This paper gives a general update on the transformation of adult social care and, within this context, focuses on the commissioning aspects of the programme.

1.2 The specific focus of the paper describes:

- The changing relationship between the local authority and the social care market. This will increasingly be about commissioning as market development and facilitation rather than market management; and;
- The key strategic aim to shift resources from long term care into **prevention services.**

Definition of Prevention

1.3 Within this paper any service that can be accessed without meeting eligibility thresholds is included under the broad banner of "prevention services". This means that prevention services include:

- Citizen access, information, advice and signposting services
- Early intervention services (eg community equipment, attendance at LinkAge plus)
- Support to independence pathways (e.g. re-ablement, telecare, community equipment).

1.4 The distinction between preventative services and long term care services in practice can be blurred as some long term services (for example attendance at a day service) will prevent a service user from relapse or further deterioration.

And some service users with long term care needs will choose to access "prevention services" such as LinkAge plus. Putting this aside, the approach taken here is a distinction drawn on whether it is necessary to meet eligibility criteria or not to access a service

Changes in Social Care

1.5 Local authorities have already largely moved away from being primary providers of care to commissioners and purchasers of care. This is the case in Tower Hamlets where approximately 70% of spending is through commissioning rather than direct service provision. This paper describes the **next shift** from being commissioners and direct purchasers of care to a role of facilitation and development of the market for care and support options. This will grow as individual service users increasingly act as commissioners on their own account through the use of personal budgets. As a local authority our role will be to understand local needs and aspirations, as we will no longer control demand for specific services.

1.6 This shift is also closely tied to the widening of expectation of services provided by local authorities. While local authorities retain their statutory obligations to assess need under the NHS and Community Care Act 1990, and to provide/commission services for those who meet eligibility criteria under FACS[1], local authorities are expected to offer (commission) services to others who not only do **not** meet FACS criteria but may not have even been assessed. These services are the services referred to as "prevention" services above.

1.7 It is important to note that the strategic changes in social care firmly underpin the package of efficiency proposals that are being made in the budget setting process for 2011/12. Given the current financial climate, to achieve the strategic aim of shifting some existing resources out of long term care and into prevention services, means that the way existing resources are deployed has to change over a period of time. In putting together a package of savings within the Directorate we have deliberately 'sheltered' pre-FACS services in line with this strategic aim, whereas significant savings have been attached to the domiciliary care and day services re-commissioning processes where in addition current provision is above benchmarks.

Timetable for Change

1.8 It will take at least 5 years for these changes to work themselves fully through the system, and the local authority will continue to commission many services directly for at least the next 2 to 3 years. This means that the process of change will be iterative as increasing numbers of service users opt to take personal budgets and to use them on mainstream services and other services that are not directly commissioned by the Council. An extensive engagement exercise with stakeholders across the Borough has recently been held to raise awareness and increase understanding of the introduction of personal budgets.

[1] FACS = Fair Access to Care Services

1.9 All of the existing social care contracts in the Directorate will be reviewed through a number of work-streams which are listed in section 12, and it has been necessary, through the Competition Board, to request extensions of a number of these contracts to allow the full re-tendering to take place.

1.10 The commissioning of services funded by Supporting People (SP) (housing related-support) is the subject to a separate strategy. However significant parts of the SP spend are on preventative services and SP is therefore relevant to the considerations here

2. DECISIONS REQUIRED

2.1 Cabinet is asked to:

- Note the general progress on our implementation of the transformation of adult social care.
- Endorse the proposed approach to re-shaping social care commissioning.
- Agree the strategic aim of shifting some resources from long term support into prevention services.
- Note the need to review some contracts to allow time to carry out the different work streams
- Note the need to change the way commissioning is carried out and the current reorganisation of Commissioning staff now underway within AHWB.

3. REASONS FOR THE DECISIONS

3.1 The reasons for the decisions are set out in full through the main body of the report, as well as previously in the introduction / summary. These include:

- The national policy context and changes in commissioning due to the transformation of adult social care
- The financial imperative to shift resources into preventative services to contain our spending on longer-term services
- Present and future need for services in Tower Hamlets

4. ALTERNATIVE OPTIONS

4.1 As above, the unfeasibility of alternative options are set out through the main body of the report. In particular in relation to shifting resources into preventative services as is noted in section 11.2, any alternative approach would be likely to increase future costs, with demand escalating out of control, ensuring that people would only come into contact with health and social care services in a state of crisis, leading to the requirement for intensive, high-cost services such as residential care, intensive home care or hospital admission.

5. BACKGROUND

Putting People First

5.1 The background to the changes outlined in this paper can be found in the policy *Putting People First*[2], which was published in 2007, and is about the transformation of adult social care so that services are delivered in a way that ensures that users of services "exercise maximum control over their own life…and participate as active and equal citizens, both economically and socially". This has an impact both on assessment and care management services and on commissioning which is the subject of this paper.

5.2 This means moving away from the traditional assessment and care management model of service delivery to a model whereby service users have sufficient information and support to assess their own needs and then to be in control of how those services are delivered. This may be through the medium of an individual/personal budget which enables the service user to make their own arrangements for the services they need.

5.3 This puts service users into the role of purchaser or "micro-commissioner" and to do this effectively there has to be a thriving market offering a diverse range of services locally from which the service user can purchase and access their own support. This changes the role of the local authority which has up to now commissioned blocks of services on behalf of service users and then directed service users into these blocks which might meet individuals' needs to a greater or lesser extent.

5.4 This means that commissioning has to move into the role of market facilitation and development. As a local authority our role will be to understand local needs and aspirations, as we will no longer control demand for specific services. In this context it becomes important to differentiate between need and demand for services.

5.5 This shift in role to develop a local social care market is challenging requiring different skills from staff and gives rise to different organisational risk. This is discussed further below.

PPF Milestones

5.6 Since the publication of the original policy a self improvement framework has been issued to help local authorities deliver the PPF Milestones and each authority is expected to report progress against these milestones. Milestone 5 is called "Local Commissioning". This says:

---

[2] *Putting people first: a shared vision and commitment to the transformation of adult social care (DH Dec 2007).* At the heart of the Putting People First initiative is the focus on the personalisation of adult social services. This basically means thinking about care and support services in an entirely different way. This means starting with the person as an individual with strengths, preferences and aspirations and putting them at the centre of the process of identifying their needs and making choices about how and when they are supported to live their lives. It requires a significant transformation of adult social care so that all systems, processes, staff and services are geared up to put people first. This is not about creating more personalised versions of existing services, but about new, more adaptive solutions, that will require the support of the whole council to deliver.

Councils need to ensure the development of a diverse and high quality market in care and support services to offer real choice and control to service users and their carers.

Commissioning strategies based on the local JSNA, and in partnership with other local commissioners, providers and consumers of services should incentivise development of diverse and high quality services, and balance investment in prevention, early intervention/reablement with provision of care and support for those with high-level complex needs.

User-led initiatives and a much wider range and scale of services to address local need should emerge, in a market that is increasingly populated by individual purchasers.

5.7 Milestone 3 is about Prevention Services and this says:

This milestone looks at a whole system approach to prevention, intervention and cost effective services. This includes the support available that will help any citizen requiring help to stay independent for as long as possible. A key part of this is ensuring council-wide and partnership approaches to universal services e.g. leisure, adult education, transport, employment, healthy living and health improvement (backed by targeted intervention), along with housing and supported living options.

Examples of intervention include reablement type services that help people regain independence to live in their own home. It also helps people to avoid becoming dependent on council provided services with national studies demonstrating many people finish reablement services with either a reduced need for care, or no ongoing requirement at all.

It is important that the council and the NHS are jointly investing in early intervention and prevention and monitoring the effectiveness of services together eg. Joint interventions at best include telecare, case finding/case co-ordination and joint teams for complex and end of life care. Being able to evidence these types of savings is crucial, and reablement type services should form an intrinsic part of any Putting People First operating model.

Demographic Pressures

5.8 Section 9 describes the key demographic pressures facing social care. The data paints a picture of rising need for which there will not be a commensurate increase in resources. This therefore requires a different response through the development of a prevention strategy.

5.9 The evidence around the importance and effectiveness of preventative services is extensive and growing including evidence from sources as wide ranging as the National Institute for Clinical Excellence (NICE), the Department of Health, the Joseph Rowntree Foundation and many peer-reviewed research exercises and published articles. This work has shown that in the medium-to-long term, responding to the financial situation through cuts in non-statutory (preventative) services or raised eligibility criteria would not be a cost-effective approach. Indeed, such a strategy would be likely to increase future costs, with demand escalating out of control, ensuring that people would only come

into contact with health and social care services in a state of crisis, leading to the requirement for intensive, high-cost services such as residential care, intensive home care or hospital admission.

6. MARKET DEVELOPMENT - OVERVIEW

6.1 Social Care development over the next 3 to 5 years has to address the continuing implementation of *Putting People First*, the consequences of demographic change (chapter 7), and extreme pressures on public sector finances. This translates into the following drivers of change:

- The imperative for greater choice and control for people who use services and carers, and a consequent requirement for more diverse markets of support options (PPF)
- A stronger emphasis on evidence-based prevention, and consideration of the needs of the ***whole*** population (including people purchasing their own care), not just the minority already eligible for publicly funded care as a means of limiting the pressures on budgets from demographic change (chapter 7)
- Increasing the role of mainstream / universal Council services in health and social care
- A greater emphasis on the role and value of community and social capital, including social enterprises and user led organisations
- The need to find significant efficiency savings.

6.2 Local authorities have already largely moved away from being primary providers of care to commissioners and purchasers of care. This is the case in Tower Hamlets where approximately 70% of spending is through commissioning rather than direct service provision. The way forward described in this paper is to make the shift to facilitate and develop a market of care and support options without continuing to rely on our existing direct purchasing power, as individual service users increasingly act as commissioners through the use of personal budgets. As a local authority our role will be to understand local needs and aspirations, as we will no longer control demand for specific services

6.3 This shift in role to develop a local social care market will be a challenging one given that social care services are subject to market forces which in themselves may not produce the desired range of services across all levels of service user need. If local people are to have access to a broad and high quality range of support options, then this will require the right balance of relationships, responsibility and risk between local authority, providers and service users.

6.4 To empower individuals to make choices and to direct their own care, will be essential. This will include the systematic collection and updating of market information for service users and carers, and for professional staff, including brokerage staff and advocacy staff. An example of such information might be the CQC ratings of care providers, and this will be supported through technical enablers, using website and information portals located across the borough.

6.5 The definition of market development used in the Directorate is as follows:

"Based on a good understanding of need and demand, market facilitation is the process by which commissioners ensure there is sufficient appropriate provision available at the right price to meet needs and deliver effective outcomes both now and in the future"[3]

6.6 The Institute for Public Care describes market development as a three stage model or process[4]:

- **Market intelligence** – the development of a common and shared perspective of supply and demand, leading to a published market position statement. This will also be an iterative process where the information on people's preferences, choices and purchasing decisions is systematically incorporated into on-going market development.
- **Market structuring** – putting in place the right framework to give the market available to Tower Hamlets residents the right kind of shape. This might include: an approach to sharing financial risk with service providers in the context of a reduced number and value of block contracts; development opportunities for new providers such as user led organisations; targeted improvement for specific sectors; outcome based contracts; training and development; quality assurance frameworks; business and management support; community catalogue and purchasing infrastructure.
- **Market intervention** – specific commissioning intentions and activity both in areas which are 'pre-FACS' such as preventative services and in areas where we will such a better deal for people who use services by buying blocks of services ourselves.

7. THE TOWER HAMLETS APPROACH

7.1 The following table sets out the features of an 'ideal market' [taken from the national market development forum (2010) – future social care market discussion paper 1] and how we are, and propose to, address these areas.

	Features of the ideal market	Actions to achieve this
1	Local authority has a wider view of the care market than just what it commissions directly, and will have the capacity to conduct market research	• On-going JSNA process, including market research • Provider forums for discussion and feedback

[3] Institute of Public Care (2009) Transforming the Market for Social Care vol. 2, p4

[4] Institute of Public Care (2009) Transforming the Market for Social Care vol. 2, p5. Market development was also a key part NHS World Class Commissioning framework, where effective commissioning: [from WCC competencies DH 2007]

- Translates strategy into short-, medium- and long-term investment requirements, allowing providers to align their own investment and planning processes with specified requirements
- Is aware of market trends and behaviours, and shows knowledge of and acts on current gaps in the market to provide patients with a choice of local providers
- Creates incentives where necessary for market entry, including understanding the requirements of full cost recovery
- Stimulates provider development matched to the requirements and experiences accrued from user and community feedback"

	and run initiatives to stimulate the market. Market intelligence is the basis for a constructive relationship with providers and people who use services	• Membership of pan-London forums for information exchange and possible join work • Providing independent support where appropriate to potential suppliers when issuing tenders (as per SITRA and the Supporting People Framework Agreement)
2	Mechanisms will be in place to the ensure that the individual choices people make can feed back into the market development process	• Framework-I • Access to Resources Team will have a systematic methodology for capturing 'unmet need' data.
3	All services will be person centred, offering choice and control.	• Commissioning Framework and intentions • Roll-out of personal budgets • Pilot of Independent Support Planning and Brokerage service will widen choice • Review of day opportunities in each service user group to deliver improved focus on being person centred
4	Local authority will publish a 'market position statement' which describes predictions of future demand, a quantitative and qualitative picture of the current state of supply, the areas where services need to develop, identified models of practice and information regarding pricing.	• Market position statement to be published by March 2011 • To be updated annually to reflect changes in the market / changes in demand
5	Service users and carers will have good unbiased access to quantitative and qualitative information about the kinds of support available to them, at what price, which they can in turn comment upon. They should also have information that illustrates the kinds of choices that other people have made and the outcomes they experienced.	• Community Catalogue • Information and advice strategy • Role of user-led organisations
6	There will be less use of 'traditional' residential care	• Mental health and learning disability accommodation and resettlement strategies • Expansion of availability of Extra Care Housing • Supporting People Framework Agreement for managing housing related support contracts
7	There will be an expansion in the number of people using personal assistants	• Training and accreditation programme • Domiciliary Care Service Specification will enable delivery of Personal Assistant type services

		• Community Catalogue will provide access to local PAs, plus links to other London networks
8	Both the way that services are commissioned and delivered will take account of people's social capital and will seek to build these reserves where they are not available.	• Self Directed Assessment and Support Planning / Brokerage services will take full account of individual's circle of support / social capital • E-marketplace / Community Catalogue solution will have future ability to allow peer to peer exchange and sharing of services / skills / resources • Time-banking schemes will be explored during 2011 as a means of building social capital
9	There will be a programme to drive up quality across the sector	• Improvements to contract management • Quality Assurance for Commissioning • Provider training and accreditation programmes run by LBTH
10	There will be a greater focus on payment for care by the outcomes it delivers rather than by cost and volume.	• All new contracts (including Domiciliary Care) will focus as far as possible on outcomes as well as inputs/outputs
11	There will be fewer block contracts for most services – while Adults Health and Wellbeing will maintain aggregate investments in some types of provision, the increasing numbers of people with control over their own budgets alongside self-funders, and an increase in individual purchasing will see new models of contracting develop.	• Re-tendering rounds e.g. homecare • Advice and assistance provided to local 3rd sector organisations to enable them to develop sustainable business plans for the medium term.
12	There will be a greater emphasis on combined preventative health and social care with more holistic care provision delivered by multi-disciplined organisations	• Integrated Care Executive and Health and Wellbeing board – joint commissioning opportunities. • Proactive and enabling approach to be taken to the changes to the NHS set out in the White Paper (Community Health Services / Public Health) • Early engagement with developing GP consortia

8. SRATEGIC CONTEXT FOR COMMISSIONING WITHIN TRANSFORMING ADULT SOCIAL CARE PROGRAMME

8.1 In Tower Hamlets our local vision is: "To shift from a service based approach in the kinds of support people use now towards support that is personalised and community based, so that by 2011 everybody will be given the opportunity to meet their needs in a way that is personalised and effective for them."

8.2 To deliver the vision the Programme needs to deliver:

- A transformed customer journey and business processes that delivers Self-Directed Support
- A transformed market place that enables customers to exercise real choice
- A transformed (internal and external) workforce that has the skills and knowledge required to deliver Self-Directed Support customer journey
- A resource allocation process and financial processes that ensure a financially sustainable directorate
- Users involved in a way that ensures that the TASC implementation meets their needs
- Technology that supports the workforce and customers in operating the Self-Directed Support process

We will do this by:

a) providing universal services from a range of organisations including: the Local Authority, Primary Care and other public, voluntary and private agencies;
b) focusing on early intervention and prevention to increase independence - such as reablement services;
c) increasing choice and control by enabling and supporting our eligible customers to participate fully in their own assessment and support planning as well as identify outcomes which are important to their physical and mental well-being;
d) encourage social capital by supporting and stimulating social networks and community-based support groups

8.3 ***A transformed customer journey:*** The Directorate's work has focussed on developing a new operating system for social care whereby people become more adept at self-assessing and self-managing their health and support, within the context of personalised and person centred service responses. We are establishing what our new operating model will look like and determine which people, processes and systems need to be in place to support our new structure. This means that we need to redesign the way we have traditionally organised ourselves, this will require the restructuring of our Assessment and Care Management functions. Formal consultation with staff is due to be undertaken in January.

8.4 ***The New Customer Journey*** will see the current older peoples, physical disabilities and vulnerable adults team along with the occupational therapy service come together to form a new single adults service. The new adults service will be staffed by Social workers, Occupational Therapists and other social care "officers". The three different services being developed are :

- **First Response** will seek to resolve 80% of people's concerns at first contact through information/advice giving and speedy provision for simple levels of support. People who need additional support will be passed on to shorter term support.

- **Shorter Term Support** will identify services provided by the council and services elsewhere that can help prevent people from needing ongoing support. This service will deliver a program that seeks to help people maximise their independence. For people that remain in need of (and are eligible for) ongoing support they will be eligible for longer term support.

- **Longer term Support** will work with people to explore choices available to them for how their eligible needs can be supported. This service will work with the person to produce a support plan that describes the outcomes that are important to the person, and how they can stay in control of the support they receive. People if they choose to, will be able to receive a cash personal budget to pay for their support.

The new Customer Journey is shown in Appendix 1.

In addition to the work we are doing in adults service we will be working with both **learning disabilities** and **mental health services**, (which are both services integrated with health) to ensure that the customer journey in these

8.5 This pathway is radically different from the way current services are delivered. While local authorities retain their statutory obligations to assess need under the NHS and Community Care Act 1990, and provide/commission services for those who meet eligibility criteria under FACS[5], local authorities are expected to offer (commission) services to others who not only do not meet FACS criteria but may not have even been assessed. In this paper all services open to people without FACS criteria being applied are referred to as "prevention services".

8.6 This means that the way we use our resources has to change and this underpins our strategy to shift resources over a period of time from long term services to prevention, early intervention, and support for independence. While some of the changes above will be delivered through the re-organisation of in-house teams, the implications for commissioning include:

- Understanding the market for these services and commissioning services that historically have not been commissioned but have been funded opportunistically out of specially designated pots of money. Many of these services are not just funded from Adult Social Care. For example

[5] FACS = Fair Access to Care Services

Mainstream Grants funds advice services.

- Developing specific strategic plans for commissioning preventative services, information and advice, and advocacy, as well as longer-term options, within the overall context of the shift of resources mentioned above.
- Aligning commissioning to the target operating model and away from traditional care groups.

8.7 There is also the overarching requirement for efficiency savings and these changes provide the opportunity to review all current contracts and spot purchasing arrangements. It will take a number of years for these changes to roll out. For example individuals will not initially be able to use a personal budget to purchase residential and nursing care which means there will continue to be block contracts for many of these services. Similarly as a market facilitator we can help improve value for money for individual service users by putting in place framework agreements that individuals can access.

8.8 Integrated commissioning with the NHS will continue to be a priority locally and nothing in this paper proposes any changes to the arrangements currently in place.

9. PRESENT AND PREDICTED FUTURE NEED FOR SERVICES

9.1 Adults Health and Wellbeing works closely with colleagues in Public Health to track changes in the demographics of the local population and of need within the Borough. This work paints a picture of growing need which will not be met by a commensurate growth in resources. This means finding other ways to meet need through a strategy of increasing preventative services.

9.2 Over the last three years a huge bank of demographic information has been assembled, however only the key issues are presented here. The linkage between the growth in population and the preventative strategy is described in chapter 9.

Key Demographic Issues

1. The Tower Hamlets population is forecast to grow significantly over the coming years, and the demand for long-term social care services will rise accordingly if we continue to provide services in the same way.

2. The need for learning disability services will increase by a faster rate than the general population increase.

3. The need for services for those who are over 85 and / or have dementia will increase significantly.

4. **Demand** for, and take up of, long-term services is likely to remain comparatively high.

5. The increase in people with health and wellbeing needs is likely to lead to a substantial increase in the number of people providing unpaid care and in need of carer support services.

6. If current levels of **demand** for services continue, projected use of longer-term AHWB services will rise by about 20% over the next ten years.

9.3 ***There are estimated to be 187,000 adults aged 18 years and over living in Tower Hamlets in 2010, predicted to rise to over 192,000 in 2011, 208,000 in 2015 and over 227,000 by 2020.***

Age Group	2010	2015	2020	2025
18-64 years	168,902	188,871	206,483	223,547
65-84 years	15,656	16,039	17,471	20,128
85 years and over	2,357	2,816	3,217	3,748
Total Adult Population	186,915	207,726	227,171	247,423

9.4 ***The need for learning disability services will increase by a faster rate than the general population increase.***

- Currently, around 670 adults use social services in Tower Hamlets for learning disabilities[6].
- Prevalence of learning disabilities and complex needs is higher in the Bangladeshi population than others[7].
- As the younger population (of whom a larger proportion are Bangladeshi) ages, we can assume that the proportion of the adult Tower Hamlets population with a learning disability will increase substantially.
- This potential increase is in addition to the overall population.
- As the life expectancy of people with learning disabilities increases (especially for people with Down's syndrome) there will be an increase in the number of adults with a learning disability in Tower Hamlets, as well as the number of older people with a learning disability (therefore potential increased demand for services).
- This increase in older people with a learning disability is likely to result in an increase in the number of people in Tower Hamlets with early onset dementia and complex needs.

9.5 ***The need for services for those who are over 85 and / or have dementia will increase significantly***

- The population aged 85 and over will steadily increase over the next 15 years, reaching almost 3,800 by 2025[8].

[6] LBTH AHWB SWIFT Data 2009/10.
[7] Emerson, E. et al. (1997) Is there an increased prevalence of severe learning disabilities among British Asians? Ethnicity and Health, 2, 317-321.
[8] © GLA 2009 Round Population Projections

- Currently, 60% of the Tower Hamlets population aged 85 and over use social services (over 1,400 people in 2009/10).
- 43% of people in this age group report at least one fall during the last 12 months[9].
- Between 6 and 13% of people in this age group require support with continence issues.
- Around 85% of people in this age group have moderate or severe hearing loss.
- Between 35 and 50% of people in this age group are unable to manage at least one mobility activity on their own.
- Around 16% of people in this age group have dementia[10].
- Around 37% of people in this age group have a limiting long term illness and live alone[11].
- This is likely to contribute to an increase in the number of people using services for physical disability, sensory impairment and dementia, not least because of local and national strategise to improve the rate of diagnosis of dementia in primary care and other settings.

9.6 ***Demand for, and take up of, long-term services is likely to remain comparatively high.***

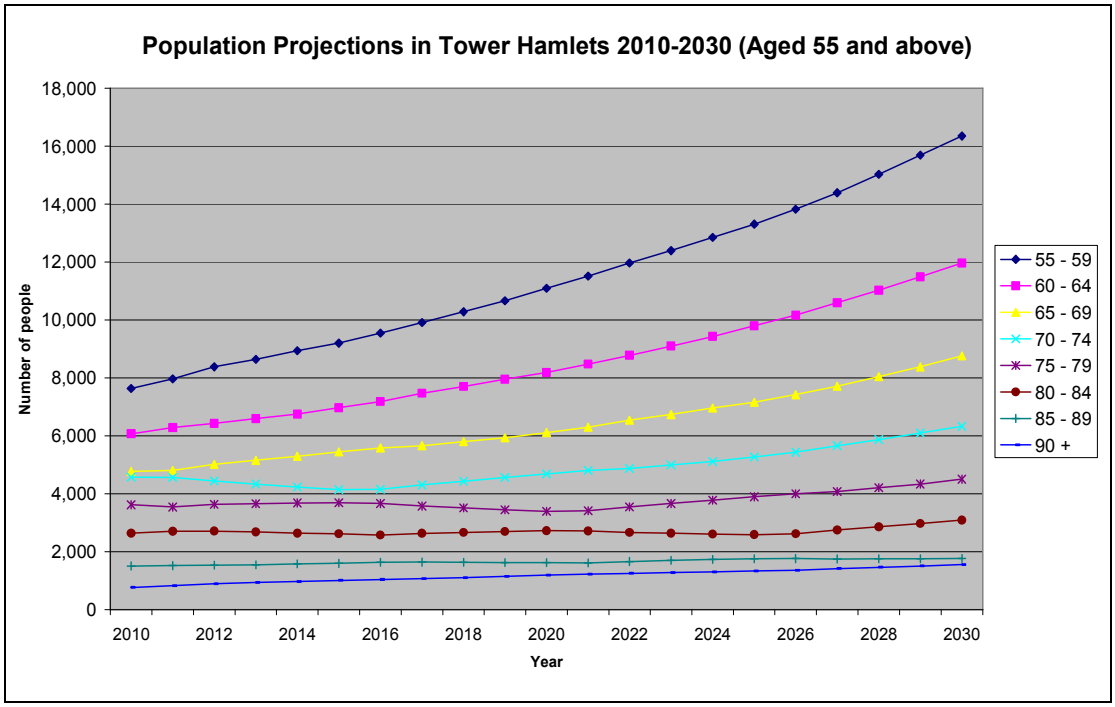
9.6.1 A larger proportion of the older population (aged 65 and over) in Tower Hamlets used long-term social care services in 2009/10 (20%) than other similar boroughs such as Hackney (17% of older people); in Newham (16% of older people), Lambeth (19%) and than the Greater London average (15%)[12].

9.6.2 Comparisons with other boroughs with similar levels of deprivation, simply in terms of need, do not give any obvious explanation for this. According to Census data, the proportion of older people in the borough who live alone is 47% which is similar to Newham (46%), Lambeth (48%) and lower than Hackney (55%)[13].

9.6.3 Since the older population is expected to grow substantially over the coming years, in line with general expected population increases[14], the need for pre-FACS / preventative services and interventions will become of paramount importance to mitigate an otherwise burgeoning demand for long-term social care services.

Population projections of those aged 55 and over in Tower Hamlets, 2010-2030. © GLA 2009 Round Population Projections

[9] POPPI, 2010.
[10] Older People and Mental Health Joint Strategic Needs Assessment, 2009.
[11] POPPI 2010.
[12] NHS Information Centre, NASCIS 2009/10
[13] Census 2001
[14] © GLA 2009 Round Population Projections



9.7 ***The increase in people with health and wellbeing needs is likely to lead to a substantial increase in the number of people providing unpaid care and in need of carer support services.***

9.7.1 There are currently over 9,000 people providing 20 hours or more of unpaid care per week, of whom around 5,800 provide 50 hours or more per week[15]. Even taking into account the most crude population projections (and not potential increases in the proportion of the population caring), there will be almost 10,000 people providing 20 hours or more of unpaid care per week in 2015, increasing to over 11,500 by 2025

9.8 ***If current levels of demand for services continue, projected use of longer-term AHWB services will rise by about 20% over the next ten years:***

9.8.1 The following table applies GLA population projections to our current service user data[16]. A full breakdown is provided in Appendix 1.

Age Group	2010	2015	2020	2025
18-64 years	3,009	3,365	3,678	3,982
65-84 years	3,398	3,481	3,792	4,369
85 years and over	1,403	1,676	1,915	2,231
Total Adult Service Users	7,810	8,522	9,385	10,582

[15] 2001 Census data applied to GLA 2009 Round Population Projections
[16] Data from SWIFT 2009/10; proportions applied to GLA Population Projections.

10. CURRENT COMMISSIONING OF SERVICES

Commissioning spend on Prevention Services

10.1 Currently £4.6m of the total £65m adult social care commissioning spend is on pre-FACS services (information and advice, advocacy and preventative services). This is **7%** of the total social care commissioning budget, and includes Carers Grant funding, mainstream grants and PCT funding for Link Age Plus. To this total can be added the reablement service, costing approximately £1.5m, which is in- house, and approximately £160,000 for the current annual cost of equipment for Telecare and occupational therapy linked to the reablement service[17]. It should be noted that there is no published benchmarking information to date on this area of social care spend.

Category	£'000s	Types of services
Information, advice and advocacy	857	Information, advice, care group specific advocacy, welfare rights.
Prevention and early intervention	3,740	Lunch clubs, LinkAge Plus, handyperson services, befriending and bereavement services, respite, job brokerage and supported employment
Total before reablement	**4,597**	
Reablement	1,500	Homecare, occupational therapy
Equipment for telecare and reablement	160	
TOTAL	**6,257**	

10.2 It should be noted that in practice the distinction between prevention and long term support is artificial as some service users with long term care plans will also access prevention services (for example an Older Service User who meets FACS thresholds and has a long term package of care may also choose to attend a local LinkAge Plus centre).

10.3 The analysis at this stage does not include Supporting People and a similar exercise is being undertaken to determine the proportion of SP grant is spent on those who are FACS eligible[18].

10.4 The only statutory services included within the above are the Independent Mental Health Advocacy Services (IMHA Service) and the Independent

[17] Important to note that staff costs for both occupational therapy / community equipment and telecare are not included here – for several reasons related to more complicated grant funding or joint arrangements with other directorates and the NHS, and a more detailed analysis required on staff time allocated to pre-FACS services. This is being covered in full through the transforming adult social care programme workstreams.

[18] For the sheltered housing schemes that we have surveyed, 38% of tenants in receipt of SP services were also FACS eligible and receiving a care package. For one LD service surveyed to date 85% were also FACS eligible and receiving a care package. Extrapolating this out to the whole Older People and Learning Disabilities SP budgets suggests that 46% (or £646,364) of SP funding for this groups is going towards those who are not FACS eligible.

Mental capacity Advocacy Service (IMCA Services which have a combined contract value of £205,866.

Analysis of Providers

10.5 Our provider landscape is extensive with over 450 providers being used (this includes all residential placements outside the borough). The size of contracts is equally wide-ranging, with in addition grant funding programmes providing a number of very small grants. We have a significant number of locally based providers. The vast majority of our block contracts for information and advice, prevention, advocacy and day services are with third sector providers, accounting for approx £6-7m, and a significant proportion of our homecare market is with the local third sector. A limited number of services are also provided in house (re-ablement).

Analysis of Quality and Value for Money

10.6 A significant amount of information and analysis is available about our use of services registered by the Care Quality Commission – residential care homes, domiciliary services and nursing agencies. External evaluation of our commissioning and placements have shown that we are succeeding in our policy of using only regulated services rated 'Good' or 'Excellent'. No 'Poor' services are used locally, while those that have previously been rated 'Adequate' have been re-rated as 'Good'. A single 'Poor' service is used outside the borough subject to a clear choice by a resident.

10.7 The same external evaluation found that domiciliary care procured by commissioners was almost entirely rated as 'Good' and that in a recent survey of homecare users 92 per cent of nearly 600 people surveyed reported they were 'always' or 'usually' happy with the way their care worker treats them.

10.8 Assessing the quality of services which are not CQC registered has been difficult to achieve in a comprehensive way. A number of services do not operate within a specific quality framework. However we know from user surveys that satisfaction levels are generally very positive, although the shortcomings of this approach are recognised. This is a challenge for the future role of commissioning listed in the table in chapter 4 (point number 9 refers to the need to establish accreditation systems).

Initial Market Analysis

10.9 Overall the current market could be described as amalgam of historic arrangements rather than strategic design. For example contracts expire at different times and different services have different proportions of spot and block purchasing.

10.10 The balance between statutory and non-statutory services or long-term and preventative services in terms of commissioning spend is weighted towards long-term, FACS eligible support, reflecting policy pre Putting People First.

10.11 As stated above it is intended to move this balance by transferring more resources towards preventative services. In line with this strategic aim, pre-FACS services have been "sheltered" from efficiency targets, with significant savings attached to the domiciliary care and day services re-commissioning programmes where current provision was above benchmarks.

10.12 The information and advice market in Tower Hamlets as a whole is very extensive, but fragmented and many of AHWB commissioned services are care group specific which may lead to duplication in services whereas more generic services might be just as good and more cost effective.

10.13 AHWB is only one commissioner among several, reflecting existing grant funding arrangements and funding streams rather than strategic design. The consolidation into a small number of bigger contracts and / or joint commissioning with other Directorates/NHS will be explored along with the aim of encouraging a networks, user led organisations or and third sector start-ups.

10.14 The advocacy market is similarly extensive in the borough although to a certain extent hard to distinguish from the information and advice market. Advocacy services have not generally been commissioned either with a clear focus or within a quality framework. Again there has been a focus on commissioning for particular groups rather than effective and inclusive generic provision.

10.15 The "specialist" market for prevention and early intervention services is small and comprising the in-house reablement (homecare) service, LinkAge plus, and a significant network of very small lunch clubs funded through Mainstream Grants. Some of these clubs are starting to provide extra services. A proportion of this funding is time limited which will force a strategic review across the whole lunch club network. However the broader prevention market could be described as very extensive with a whole range of initiatives on offer across sport, leisure, culture, adult education services etc.

10.16 The long term care is largely provided through contracts with residential care, homecare (domiciliary care), and day care with an undeveloped market in personal assistants.

10.17 There is a highly developed, mature market for Domiciliary Care services across Greater London. This market is varied, with a mix of small (local), medium (regional) and large (national) suppliers from both the private and 3rd sectors. This ensures that the market place is highly competitive. The Council currently has contractual relationships with 16 suppliers, 5 from the private sector and 11 from the 3rd sector. These suppliers range in size and geographic coverage. A number of the 3rd sector organisations started as small local organisations that have been supported over a number of years by the Council to increase their capacity.

10.18 Day Services are provided by mainly third sector providers including two local Tower Hamlets providers. There is a work-stream underway to modernise

day services through a re-commissioning programme.

10.19 The market for personal assistants is expected to increase with the increase in personal budgets and will be a new area for commissioners, with close attention to be paid to quality assurance and safeguarding.

11. SHIFTING RESOURCES FROM LONG TERM SUPPORT TOWARDS PREVENTION AND EARLY INTERVENTION

11.1 Achieving this strategic aim is at a time of a retrenchment in spending is challenging. Yet it might be argued given the demographic pressures outlined in chapter 6 above that there is no alternative if services for the most vulnerable are going to be able to keep up with need. However as difficult as this is, it might be noted that the Care Quality Commission in their recent inspection report recognised the strong starting point with already significant shifts in resources from old style residential care towards community based services and reablement.

11.2 The evidence around the importance and effectiveness of preventative services is extensive and growing. Evidence from sources as wide ranging as the National Institute for Clinical Excellence (NICE), the Department of Health, the Joseph Rowntree Foundation and many peer-reviewed research exercises and published articles, have shown that in the medium-to-long term, responding to the financial situation through cuts in non-statutory (preventative) services or raised eligibility criteria would not be a cost-effective approach. Indeed, such a strategy would be likely to increase future costs, with demand escalating out of control, ensuring that people would only come into contact with health and social care services in a state of crisis, leading to the requirement for intensive, high-cost services such as residential care, intensive home care or hospital admission.

11.3 Set out below are the key strategies that will be followed to develop over a period of time our prevention services:

- **Working jointly with NHS partners** building on our existing partnerships. One of our key preventative services, Link Age Plus, is jointly funded with NHS Tower Hamlets and there is growing partnership work on tackling health inequalities underpinned by our Joint Strategic Needs Assessment.

- **Sheltering existing investment from overall efficiency savings**

- **Promoting co-production with communities** by, for example, encouraging community-based initiatives set up with other funding or social enterprises, with seed corn investment from the local authority.

- **Streamlining procurement** bringing together 'preventative' services which are currently commissioned from several different places in a larger mainstream market. This will mean exploring opportunities not just with the Council but with other local authorities (for example the Supporting People framework re tender is being conducted jointly with Newham).

- **Increasing support for carers** including those who are caring for people who are already eligible for social care.

12. NEXT STEPS

12.1 Our next steps include:

I. **Reorganising the commissioning section** of the Directorate to enable one section to deal primarily with transactional commissioning, thereby freeing up resources to develop our strategic commissioning capacity. This has already started. There is an efficiency target attached to this work.

II. **Developing specific strategies and commissioning priorities** in areas such as Learning Disabilities day services and dementia (see below).

III. **Publication of our market position statement and commissioning intentions** by 31st March 2011 as required by the Putting People First milestones.

Forward re-commissioning plan

12.2 The following table provides an overview of our current re-commissioning work-streams.

Re-commissioning Work stream	**Timescales**	**Efficiency targets attached**	**Work streams with contracts which will require review**
Domiciliary Care	New contracts in place June 2011		Extensions already in place
Supporting People	Framework agreement in place July 2011		already been to Competition Board
Learning Disability day options	New contracts in place by end 2011-12		(although significant proportion of spend is on spot basis)
Advocacy	New contracts in place by end 2011-12	X	
Information and advice	New contracts in place by end 2011-12	X	
Prevention Services	New contracts in place by end 2011-12	X	- significant separate piece of work on

			Handyperson Services
Mental Health day options	New contracts in place by end 2011-12		
Carers	New contracts in place by end 2011-12	X	
Older People Day Options	New contracts in place by end 2011-12		- earlier attempts to retender some of these services not successful due to poor quality of responses
Residential Care PD and LD resettlement and Care Funding Calculator	N/a – placements are spot purchased		X

13. COMMENTS OF THE CHIEF FINANCIAL OFFICER

13.1 In line with the Putting People First publication in 2007, outlining the transformation of adult social care, this paper sets out the change in commissioning arrangements required within the Adults Health and Wellbeing Directorate.

13.2 As per paragraph 2.1, Cabinet is asked to:

- Note the general progress on our implementation of the transformation of adult social care.
- Endorse the proposed approach to re-shaping social care commissioning.
- Agree the strategic aim of shifting some resources from long term support into prevention services.
- Note the need to review some contracts to allow time to carry out the different work streams.
- Note the need to change the way commissioning is carried out and the current reorganisation of Commissioning staff now underway within Adults Health and Wellbeing.

13.4 The authority has received the Transforming Adult Social Care grant for the last three financial years (2008/2009 through to 2010/2011) in order support the transformation agenda.

The grant is fully committed to support the programme and is expected to be fully utilised during the current financial year. Any residual balance may be carried forward into 2011/2012 in line with the grant conditions. The capital funding received from the Department of Health (£175,000) is expected to be

utilised in full in 2010/2011.

13.5 The transforming adult social care agenda puts service users into the role of a purchaser/"micro commissioner" and therefore the authority will be required to become the developer of a social care market as opposed to a direct commissioner.

13.6 As per section nine (9.2), demand for long term Adults Health and Wellbeing services is expected to rise by 20% over the next ten years. The expected rise is likely to see an increase in the number of people providing unpaid care, who will subsequently require carer support services provided by the Council. The growth will not be able to be aligned with an increase in resource and therefore the Authority will need to set a strategy of increasing preventative services to minimise the demand for long term care needs.

13.7 The report proposes a strategic objective to move resources within the Directorate from long term services to preventative services (see section eleven). A movement of budget from one Directorate vote to another will need to be carried out inline Financial Regulations and the scheme of delegation (section B8). As necessary approval will be required by Cabinet, where these exceed £250,000. Any virements in excess of £100,000 approved by the Director of Adults Health and Wellbeing will subject to noting to Cabinet.

13.8 The Directorate has submitted as part of the 'Service Options Review' a number of saving proposals which were considered by Cabinet in January 2011. Due to the change in commissioning role required by the Directorate, these have focussed on domiciliary care and day service commissioning budgets where current provision is above benchmarks (see paragraph 1.7).

13.9 The restructure of the Directorate's Commissioning division is currently at formal consultation which when implemented in full (2011/2012), will provide efficiency savings in line with the 'Service Options Review'.

13.10 Section 12.2 of the report sets out the commissioning contracts which are due to expire on the 31st March 2011, which will require an extension while recommissioning arrangements take place. The extension of the contracts will be subject to agreement by the Authority's Competition Board. The funding for the contracts will be met through and commissioned in line with Directorate resources.

14 CONCURRENT REPORT OF THE ASSISTANT CHIEF EXECUTIVE (LEGAL SERVICES)

14.1 The Council is obliged under section 47 of the NHS and Community Care Act 1990 to assess the needs of persons who appear to need community care services and decide whether those needs call for the provision of any such services. Community care services include arrangements for promoting the welfare of persons aged 18 or over who are "blind, deaf, dumb or who suffer

from mental disorder of any description", under section 29 of the National Assistance Act 1990 or section 2 of the Chronically Sick and Disabled Persons Act 1970.

14.2 The report proposes preventative arrangements to promote the welfare of persons who may become, but are not yet, eligible for community care services. The Council is empowered by section 111 of the Local Government Act 1972 to do anything calculated to facilitate, or that is conducive or incidental to the discharge of any of its functions. There seems a reasonable argument that prevention is conducive to the exercise of the Council's community care powers, as it helps ensure that the Council's limited resources may be better targeted to those who need them.

14.3 The decision to focus on prevention may be justifiable by reference to the Council's well-being power. The Council is empowered under section 2 of the Local Government Act 2000 to do anything which it considers likely to promote the social, economic or environmental well being of Tower Hamlets, provided the action is not otherwise prohibited by statute. This power includes the ability to incur expenditure or to give financial assistance to or enter into arrangements or agreements with any other person. The power may be exercised in relation to, or for the benefit of: (a) the whole or any part of Tower Hamlets; or (b) all or any persons resident in Tower Hamlets. In exercising the power, regard must be had to the Community Plan. Any conclusions regarding well-being and links to the Community Plan would need to be evidenced.

14.4 Personalisation is a significant element of transforming adult social care and includes the provision of personalised budgets and direct payments to service users or other suitable persons to secure community care services assessed under section 47 of the NHS and Community Care Act 1990 or services for carers under section 2(1) of the Carers and Disabled Children Act 2000.

14.5 The making of direct payments under section 57 of the Health and Social Care Act 2001 was enabled by the Community Care, Services for Carers and Children's Services (Direct Payments) (England) Regulations 2009. It is essential that the Council complies with the 2001 Act and the 2009 Regulations in the transformation of adult social care, as well as the requirements of any legislation under which the obligation to provide services arises. The Government has published statutory guidance on direct payments, to which the Council is required to have regard in implementing its direct payments system. This includes guidance on the operation of any resource allocation system. It will be for officers to ensure these requirements are met.

14.6 The proposals in the report appear generally consistent with the Council's obligation as a best value authority under section 3 of the Local Government Act 1999 to "make arrangements to secure continuous improvement in the way in which its functions are exercised, having regard to a combination of economy, efficiency and effectiveness".

14.7 The Service Agreements that are proposed to be extended are for Part B

services within the meaning of the Public Contract Regulations 2006 and therefore the provisions of those regulations do not apply. However, the Council does need to take into account the EU principles of transparency, non discrimination and equal treatment. It appears clearly from the report that the proposed extensions are interim arrangements and that detailed consideration is being given to re-procuring these services which will be done in full compliance with all relevant legislation.

15 ONE TOWER HAMLETS CONSIDERATIONS

15.1 Understanding the equalities implications of the Transforming Adult Social Care programme is one of the strategic priorities of the Council's Single Equality Framework for 2010/11. A strategic level Equality Impact Assessment (EqIA) of the programme as a whole is currently being conducted in conjunction with the corporate Scrutiny and Equalities Team. Key issues across the programme are being considered within different workshop sessions involving senior managers, frontline staff and members of the community. An interim report will go to the TASC Programme Board by March 2011, with a final action plan for the programme being delivered in the spring. We aim to ensure that all those requiring care or support are afforded the benefits of increased choice and control, experience the shift in power away from professionals and services, and are more able to access mainstream options and participate more fully in society. In this sense the transformation of social care will bring very significant gains in the widest and most fundamental ways for some of our most vulnerable and disadvantaged residents.

15.2 Shifting resources into preventative services will bring many gains including tackling health inequalities, supporting many community-based organisations, and tackling social isolation by providing opportunities for people to meet together and get out and about in their local areas. There is no specific impact assessment as such at this stage of this broad strategic aim for a number of reasons:

- As a key strategic aim of the transformation programme as a whole, across both commissioning and service provision, it is in part covered through the strategic level EqIA described above
- In relation to the use of resources, the emphasis is as explained on protecting our existing investment in, and provision of, preventative services in the broader context of significant savings being made across the commissioning budget as a whole. In this sense, by “doing nothing” we will in fact increase our proportionate spending on preventative services.
- Specific commissioning decisions will be made over time via the processes outlined in section 12.2 which will either be the subject of separate or further reports to Cabinet (such as for example Learning Disabilities Day Opportunities which is on the agenda for this meeting) and / or be dealt with via the competition board and through procurement procedures.

16 SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

There are no specific environmental implications from these proposals

17 RISK MANAGEMENT IMPLICATIONS

17.1 Given the transformational scale of this programme, risks are inevitable. Overall, they are managed and mitigated through rigorous programme management. The major areas of risk are personal – risk to individuals –and organisational –financial risks to the Council. If individuals are to be allowed to make real choices about how the support they want to help them live their lives, they must also be allowed to take risks. There is a national debate about the relationship between social care's responsibility to empower people to make their own choices, and its responsibility to safeguard vulnerable people from the risks of exploitation, abuse, or other risks to wellbeing into which those choices may lead them.

17.2 People who have a personal budget will be regularly reviewed to ensure they are able to continue to manage their allocation in a way that meets their support needs. These reviews will check and ensure that personal budget expenditure is being spent on what was agreed in the persons support plan. The reviews will also check that the person is not being abused or exploited.

17.3 We have a robust programme management framework in place with effective governance arrangements. Our Programme Board provides key alignment with corporate objectives and resolves escalated risks and issues. This Board comprises our Directorate Management Team as well as representatives from THINk (a user-led organisation) and Tower Hamlets PCT. Below this governance tier sits the Implementation Management Group comprising all Work stream Leads of the Programme which focuses on strategic approach, budgets, benefits and escalated risks and issues that cannot be resolved on an individual project level. We have a supportive Programme Office that manages the governance structure and acts as a key thread between the groups that form the Programme.

18 CRIME AND DISORDER REDUCTION IMPLICATIONS

18.1 There are no specific crime and disorder implications from these proposals. However in relation to safeguarding vulnerable adults, the challenge is to introduce more choice and control without exposing people to serious risk or harm. Whilst doing this we do not want a focus on safeguarding that limits people's ability to make real choices. In the new Customer Journey we will be educating people about risk, and working with people to minimise risk. We will want to manage risk in partnership with people. The Preventative approach that is a key element in personalisation will extend to Safeguarding and we will be investing in empowering organisations and individuals to recognise, prevent, report, avoid and complain about abuse in all its' forms.

19 EFFICIENCY STATEMENT

19.1 The Council's Transforming Adult Social Care Programme seeks to offer greater choice, independence and control to our residents in need of social care information or support. We aim to enable residents to become more independent and make better use of the resources in the community as well as the council's resources. The report proposes a strategic shift from long term commissioning budgets to preventative services, the impact of which is incorporated throughout the report.

20. APPENDICES

Appendix 1 – Customer journey diagram
Appendix 2 – Overview of engagement activities
Appendix 3 – Population projections applied to current AHWB service use data
Appendix 4 – expected number of adults in Tower Hamlets with disabilities or long-term conditions

Appendix 1

CUSTOMER JOURNEY

IN

OUTcomes

One number to call

Write, fax or email

Visit our office

First Response Service

1200 contacts per month

Will resolve 80% of contacts

Will complete contacts within 5 days

Equipment and Support

Keeping people safe

Information and advice

Hospitals

Other Services

Shorter Term Support

Maximising independence

6 week remit

Agenda to prevent need for long term care

Information and advice

Independence

Children to Adults

Longer Term Support

Carry out self-directed assessments for long term care

Enable choice and control (support planning)

Facilitate the delivery of Personal Budgets

Equipment

Support

Personal Budgets

Appendix 2 – overview of engagement activities:

Customer engagement: We have worked in partnership with people who have support needs, unpaid carers and other Tower Hamlets residents to transform adult social care.

We have been out to over twenty different customer forums over the last six months to discuss the changes being made to social care, including the Older People's Reference Group, the Alzheimer's Society Carers Forum, the Tower Hamlets Interfaith Forum and Rainbow Hamlets. To get more in-depth feedback on particular issues with transformation we have recently set up a customer Reader's Panel to focus on our information and publications; and a Customer Steering Group to focus on market shaping and commissioning. We are also working with the Housebound Older People's Reference Group to ensure we are hearing the views of people not able to attend customer forums; as well as enabling people to give feedback via the Tower Hamlets website and in response to the articles we have submitted in a variety of newsletters. The resulting feedback and views that we hear from customers are compiled and submitted to Work stream Leads on a monthly basis to consider and respond to; and in turn, customers are informed as to what difference their feedback has made. For example, the feedback people have given us on what makes a good social care professional is being used to inform the review of staff competencies and the design of future staff learning and development programmes.

We are continuing to work in partnership with THINk to make these changes. The feedback gained through a customer event organised by THINk in March 2010 resulted in five "Customer Engagement Principles" for the programme, which in turn has been used to inform the new organisational values in the Directorate.

We are also working in partnership with people with support needs to put these changes into place. As part of work on transformation and engagement, five service users from learning disability services are currently leading on the development and production of a DVD, which is intended to explain Personal Budgets to people with support needs. We are also working with three service user volunteers in new work placements to assist us with communication and engagement work.

***Provider engagement*:** Adult social care has a range of existing forums with local service providers to enable good communication and engagement between the Directorate and the third sector. We have set up a Personalisation Provider Network has been set up to focus on transformation, and continues to meet on a regular basis. A programme of support and training has also been provided and is ongoing.

Member engagement: Post the Mayoral election, plans have been put in place to engage Members in the development and progress of the Adult Social Care Transformation Programme. Short updates have begun to be included into the Member Briefing and these will continue on a regular basis.

Alongside this, two Member workshops are being planned. The first of which, will take place on December 13 and the second will take place in February (date to be confirmed). Topics that will be covered will be:

- What adult social care is and does
- Demographic pressure in Tower Hamlets
- The transformation of adult social care
- Why we are changing
- The impact on local people - case studies
- Value for money
- Question and Answer Session

The outcome of these events is that members will feel informed about social care and can influence the changes ahead. Importantly, these workshops will support Members in answering potential queries from constituents that may arise as a result of the changes.

Appendix 3 – Population projections applied to current AHWB service use data

Age Group	2010	2015	2020	2025
18-64 years	3,009	3,365	3,678	3,982
65-84 years	3,398	3,481	3,792	4,369
85 years and over	1,403	1,676	1,915	2,231
Total Adult Service Users	7,810	8,522	9,385	10,582

This is crudely broken down in the following way:

Numbers of people using AHWB services for learning disabilities

Age Group	2010	2015	2020	2025
18-64 years	620	693	758	821
65-84 years	51	52	57	66
85 years and over	3	4	4	5
Total Adult Service Users	674	749	819	892

Numbers of people using AHWB services for mental health conditions (including dementia)

Age Group	2010	2015	2020	2025
18-64 years	613	685	749	811
65-84 years	158	162	176	203
85 years and over	39	47	53	62
Total Adult Service Users	810	894	978	1,076

Numbers of people using AHWB services for other vulnerable adults

Age Group	2010	2015	2020	2025
18-64 years	61	68	75	81
65-84 years	99	101	110	127
85 years and over	121	145	165	192
Total Adult Service Users	281	314	350	400

Numbers of people using AHWB services for physical disability and sensory impairment (including frailty)

Age Group	2010	2015	2020	2025
18-64 years	950	1,062	1,161	1,257
65-84 years	2,369	2,427	2,644	3,046
85 years and over	960	1,147	1,310	1,527
Total Adult Service Users	4,279	4,636	5,115	5,830

Numbers of people using AHWB services for substance misuse

Age Group	2010	2015	2020	2025
18-64 years	53	59	65	70
65-84 years	6	6	7	8
85 years and over	1	1	1	2
Total Adult Service Users	60	66	73	80

Appendix 4 – expected number of adults in Tower Hamlets with disabilities or long-term conditions

Expected numbers of adults (aged 18-64) with disabilities based on national estimates (www.pansi.org.uk)[19]

Type of Disability	Numbers Expected 2010	Numbers Expected 2015	Numbers Expected 2020	Numbers Expected 2025
Moderate Physical Disability	10,940	12,234	13,374	14,450
Serious Physical Disability	2,671	2,986	3,265	3,534
Serious Visual Impairment	119	133	145	157
Moderate or Severe Hearing Impairment	3,796	4,244	4,640	5,023
Profound Hearing Impairment	25	28	31	33
Learning Disability	4,543	5,080	5,553	6,011
Moderate or Severe Learning Disability	999	1,117	1,221	1,322
Complex or Severe Learning Disability	278	311	340	368
Down's Syndrome	114	128	140	151
Autistic Spectrum Disorder	1,883	2,106	2,302	2,492
Common Mental Disorder	29,172	32,621	35,663	38,603
Borderline Personality Disorder	812	909	993	1,075
Antisocial Personality Disorder	657	734	803	869
Psychotic Disorder	724	810	885	958
Early Onset Dementia	36	40	44	48
Alcohol Dependence	11,154	12,472	13,635	14,760
Drug Dependence	6,291	7,034	7,690	8,324

Expected numbers of older people (aged 65 and over) with disabilities based on national estimates (www.poppi.org.uk)[20]

Type of Disability	Numbers Expected 2010	Numbers Expected 2015	Numbers Expected 2020	Numbers Expected 2025
Limiting Long Term Illness	9,498	9,805	10,758	12,589
Moderate or Severe Visual Impairment	1,535	1,603	1,758	2,035
Moderate or Severe Hearing Impairment	7,565	7,919	8,617	10,027
Profound Hearing Impairment	187	189	207	248
Learning Disability	360	377	407	477
Moderate or Severe Learning Disability	47	57	62	63

[19]NB: Prevalence rates have been applied to GLA population estimates for adults and will differ from figures quoted by PANSI, which are based on ONS population estimates.

[20] NB: Prevalence rates have been applied to GLA population estimates for older people and will differ from figures quoted by POPPI, which are based on ONS population estimates.

Depression	1,477	1,546	1,697	1,958
Severe Depression	468	490	538	620
Dementia	1,225	1,282	1,411	1,623

Local Government Act, 1972 Section 100D (As amended)
List of "Background Papers" used in the preparation of this report

Brief description of "background papers"	**Name and telephone number of holder and address where open to inspection.**
None submitted	n/a