2024-34 Prevention Plan
Adult Social Care

Barking & Dagenham

one borough; one community; no one left behind

Introduction and summary

Preventing, reducing and delaying the need for social care can change the direction of people's lives. To be successful, prevention needs everyone to take action – as the root causes of care and support needs are much broader than the care system itself.

This Prevention Plan sets the commitment from adult social care and the local authority to prevent, reduce and delay the need for adult care and support over the next 10 years, as well as the priorities and actions from the wider partnership. The three objectives of the plan are:

1. To identify and engage residents.
2. To reduce crisis demand through early help.
3. To increase the independence and wellbeing of local residents.

The objectives in this plan are the same as the objectives held in relation to developing integrated, local models of working; recognising that the two are closely linked. Indeed, this Prevention Plan can be seen as part of a wider system change, interfacing with other plans that include those on health inequalities and proactive care. The plan is also part of achieving the vision in adult social care for people with support needs to lead safe, happy healthy lives; providing support that that keeps people well and as independent as possible.

The plan covers the next 10 years, recognising that prevention is a long-term commitment and that the impact often needs time to emerge. It will be reviewed annually to ensure it reflects changes in the wider environment and that the plan continues to align to partnership and local authority priorities and insights.

Section 1 of the plan describes the rationale for change, our shared definition of prevention, the national and local picture and action that has been taken in recent years to progress prevention.

Section 2 sets out the actions that will be taken by adult social care and the local authority to reach our objectives and articulates the related priorities and actions from the wider partnership. Actions are framed around the themes of 'prevent', 'reduce' and 'delay'. Some the actions are about continuing what we already do, whilst others require us to do things differently. The diagram opposite summarises these differences: To move towards effective prevention, adult social care will prioritise technology, culture change, early help and community-driven, local support.

Section 3 looks at how prevention can be measured and identifies opportunities for social care to learn from and further develop our approach.

When the priorities and actions in this Prevention Plan are agreed, further work will then be carried out to:

- Add clear timescales to the plan, including a delivery plan in year 1 with clear roles and responsibilities.
- Agree the governance of the plan.
- Articulate what a successfully delivered plan will look like from the perspective of residents and people who need social care.

Technology

Utilise tech in its broadest sense to build evidence, take targeted action, and enable residents to use care and other technology to stay well.

Culture change

Build a prevention-focused culture, where prevention is embedded in conversations and in policy.

Early help

Articulate a clear, accessible offer of support with and for people who are just below the eligibility threshold for adult social care.

Community

Develop community-driven, integrated, local support – co-producing and utilising community organisations and networks.

Section 1

Background

1. Rationale for change – why we need a plan

- **Prevention reduces the risk of disease, disability and death**. This is particularly pertinent in Barking and Dagenham, where residents suffer worse health and wellbeing than peers in most other areas of London and England. Adult social care supports a higher proportion of the population compared to the London average and adults are more likely to have a long-term health condition than their counterparts in other areas.

- **Prevention can help people live safe, happy, healthy lives.** Preventative activity can enable people to be as independent as possible and achieve the outcomes that are important to them.

- **Prevention will help us manage a rising demand for adult social care due to a growing, ageing population with complex needs**. A focus on prevention and managing demand will ensure that the right resources are there for people when they need more intensive care and support. This focus will also help prevent the breakdown of unpaid care, recognising that the same drivers of increased demand for support will mean a potential increase in demand on unpaid carers. As stated in the 2023 Director of Public Health report: "Driving our social care demand is essential to how we effectively manage the local system. Early intervention and diagnosis are critical to deal with issues before they impact negatively on a person's health and wellbeing and the wellbeing of the community".

- **Prevention will help us address the significant financial and system pressures facing adult social care**. The cost of late intervention is estimated at £16.6 billion per year across the UK (source). Putting a focus on prevention aims, in the long term, to decrease the demand for high-cost services which will lead to reduced use of resources and lower costs.

Summary of health and care needs

- Approximately 219,000 people live here - an increase of 18% in ten years. We have high levels of 'churn' and the population is expected to grow further in future.
- 3,045 adults received long-term support through 2022-23 from adult social care. We support a higher proportion of our older residents compared to the England average and, as a young borough, supporting working-age adults with support needs has been a particular area of growth in recent years.
- There are an estimated 14,000 unpaid carers in the borough, and only a small proportion access support. The number of unpaid carers and the level of care they provide may increase in tandem with an increased demand for support.
- The experiences of our communities, residents, people who need social care and carers make it clear that we need to put a focus on engagement, early help and promoting independence. Insights are summarised in Section 4.
- Healthy life expectancy from birth was 58 years for men and 60 years for women in 2018-20, compared to a London average of 63.5 and 64 years respectively
- The wider determinants of health – social isolation, housing, employment, deprivation – are challenges in LBBD overall and for people who need social care. Environment and wider determinants of health determine 50% of poor health.
- Health behaviours, particularly smoking and poor diet and physical activity, are challenges in the borough. Health behaviours determine 30% of poor health.
- Long-term conditions are a major driver of health and social care needs. An estimated 38,000 cases are unidentified and therefore unmanaged.
- Multiple unhealthy behaviours and health conditions makes supporting individuals more complex and costly. An estimated 13% of LBBD residents have two or more health conditions. Research highlights the importance of services taking a holistic approach.

2. Definitions and scope

Definition

The focus of this plan is around preventing adults' support needs from developing or increasing; recognising that this can improve the quality of people's lives and reduce demand on services.

There is no single definition of prevention in health and care – and none is provided in statutory social care guidance - which can make it challenging to understand the current picture and agree future action. However, the 2014 Care Act provides a useful framework for understanding prevention. Statutory guidance suggests prevention can be broken down into three main approaches:

- **Prevent:** Primary prevention and wellbeing. This is generally a universal offer, aimed at those with no support needs to help prevent them developing
- **Reduce:** Secondary intervention and early intervention. This is more targeted, aimed at those with an increased risk of needing support
- **Delay:** Tertiary prevention and formal intervention. This is aimed at minimising the effect of disability or deterioration for people with support needs.

This plan is shaped around these headings.

Scope

This Prevention Plan is focused on adult social care and action to prevent, reduce and delay adults from developing care and support needs. However, successful prevention in adult social care requires action to be taken across the local authority, partners and communities. For this reason, the plan articulates both social care and wider partnership actions and commitments.

Whilst the focus is on adults, effective long-term prevention needs to start young, particularly when looking at the wider determinants of physical and mental health and adverse childhood experiences. This plan should therefore be considered as part of a wider, life-course approach to prevention, with the actions for children and young people articulated in the partnership 'Best Chance' strategy.

Finally, as previously noted, the plan covers a 10-year period in recognition that prevention is a long-term commitment and that the impact often needs time to emerge. However, the plan will be reviewed annually to ensure it reflects changes in the wider environment and that the plan continues to align to partnership and local authority priorities and insights.

3. The national policy picture

This section summarises both local authority statutory duties on prevention and the wider policy and research environment across health and social care:

- **2014 Care Act.** The Care Act is core legislation in adult social care. The Act describes our statutory duties in relation to prevention, setting out that local authorities must ensure preventative services are provided. This prevention duty relates to adult social care and is applicable to all adults living in Barking and Dagenham.

- **2023 National Major Condition Strategy** case for change and strategic framework focuses on prevention, earlier diagnoses and treatment for six groups of major health conditions responsible for 60% of death and illness in England: cancers; cardiovascular disease, musculoskeletal disorders, mental ill health, dementia and chronic respiratory disease.

- **2019 NHS Long Term Plan** sets out new commitments for action that the NHS itself will take to improve prevention, including in relation to smoking, obesity, alcohol, air pollution and health inequalities. The plan confirms the role of the NHS in secondary prevention, by detecting disease early, preventing deterioration of health and reducing symptoms to improve quality of life.

- **A ‘Prevention is Better than Cure’ government vision** was published in 2018, highlighting the importance of prevention being at the heart of health. This was followed by a government consultation in 2019 that has not since progressed.

- **Research** – Whilst research has been carried out on a number of issues relevant to prevention, there is limited national research on prevention in adult social care specifically. The Social Care Institute for Excellence notes that “Evidence about what works in prevention remains under-developed so local policy-makers lack information about how best to invest their resources (Allen and Glasby, 2013; Miller and Allen, 2013; Curry, 2006 reported in Marczak et al. 2019).”

4. The local picture

This Prevention Plan is part of a wider, system-wide approach and commitment to prevention – articulated in a range of wider plans that are summarised below:

- **Joint Health and Wellbeing Strategy**. Outcomes for 'ageing well' include "be able to manage their health, including health behaviours, recognising and acting on symptoms and managing any long-term conditions" and "Have increased opportunities to have an early diagnosis of health conditions and be provided with appropriate care to manage a condition before it becomes more serious" and priorities include "Addressing wider determinants of health".
- **System priorities for Baking and Dagenham 2024-24.** Draft health and care partnership priorities are:
  - Development of locality and integrated neighbourhood teams across health, care and community / voluntary sector partners taking an all-age approach; and
  - Developing a proactive and prevention approach to delivery of services.
- **Adults and Communities Strategy 2024:** Work has started to develop a partnership strategy to articulate shared priorities and how we will achieve these with communities. This Prevention Plan forms part of this wider strategy.
- **The 2023-26 Corporate Plan** from the local authority includes a principle of 'prevention and early intervention' to be applied to work across the whole council.
- **Adult social care vision and values:** The vision for adult social care in Barking and Dagenham is living safe, happy, healthy lives, with support that keeps people well and as independent as possible.
- **2023 Adult social care improvement plan:** The improvement plan includes actions to prioritise prevention.
- **Director of Public Health report 2023** recommends shared outcomes on three topics, one of which is: "Preventing and managing long term conditions, ensuring early diagnosis and pathways are clear to support early intervention",
- **Joint Strategic Needs Assessment 2023** includes information on current health and care needs in the borough.

Insights and people's experiences

Insights from residents, people with lived experience of support and partners in relation to prevention include the following:

- Community, families and connections are important.
- There is a need to consider the affordability of healthy lifestyles and activities.
- Information and advice helps people get issues resolved at an early stage but is often not easy to understand. It can be hard to know what support is out there and what activities area available locally.
- Help at an early stage is important and could be more accessible.
- Technology has a role to play in helping people stay well and connect with others.
- Proactive help and communication is helpful.
- The quality of conversations between staff and residents is important.
- Behaviour change takes time.

5. What action has been taken so far?

A range of work has been carried out over the 12 months to lay the foundations of this plan. This includes:

5.1 Gathering expert insights

- An adult social care prevention needs assessment was carried out in November 2023, summarising local evidence and needs.
- A peer review of care and health support to adults with a learning disability and autism took place in February 2024.
- Insight work into how to develop the front-door of adult social care was carried out in March 2024.
- A programme engagement with partners, residents and people with lived experience of care has taken place over the last year to understand what works well and where improvements are needed.

5.2 Reviewing core activity and plans

- A review of the Better Care Fund is being planned for 2024.
- Work has started to develop an umbrella partnership Adults and Communities Strategy, of which this Prevention Plan forms part.

5.3 Strengthening joint working

- Joint working between health, social care and community partners has been strengthened through our place-based partnership, the work and emerging priorities of the Adults Delivery Group.
- Work to strengthen early help through developing integrated, locality-based multi-disciplinary teams has started, and work to develop integrated commissioning is underway.

5.4 Developing technology

- Over the last year, social care has changed from offering only Careline to offering a wider range technology-enabled care focused on data-led prevention, used by over 3000 residents.

5.5 Insights and improvements in adult social care

- The Adult Social Care Improvement Plan was agreed in October 2023 and is now being implemented. This includes improvements to information and advice related to social care, via website updates, new printed information and developing the ‘front door’ of adult social care.

Section 2

Prevent, reduce and delay

6. Primary prevention

Definition Primary prevention is generally a universal offer open to all, aimed at those with no support needs to help prevent them developing.

What do we need to think about? Preventing care needs from developing means working as a whole system and acting at an early stage.
The wider determinants of health and health lifestyles are both critical issues, particularly given that the environment and wider determinants determine 50% of poor health and health behaviours determine 30%

Technology	Culture change	Early help	Community
1. **Care technology**: Develop a comprehensive universal care technology offer aimed at preventing care needs developing. 2. **Information:** Produce new information for residents on digital technology that supports health and wellbeing, and how residents can access this directly.	4. **Conversations:** Agree and roll out training so prevention and strengths-based practice is embedded in resident conversations. 5. **Staff in universal services:** Upskill staff working in council universal services to focus on working with communities at an early stage, through training and support 6. **'Prevention first' culture:** Agree actions to further build a prevention-first culture with council staff and residents, utilising community organisations and networks. This can include self-care, resilience and how and when to get support.	8. **Health in all policies**: Work with public health to ensure a 'health in all policies' approach across the local authority. 9. **Wider determinants**: Work with colleagues to agree and carry out plans to improve social isolation, housing and employment. 10. **Health behaviours:** Work with colleagues to carry out plans to tackle smoking and obesity as primary risk factors associated with health conditions with high levels of prevalence in the borough, co-deigning healthy lifestyles support with communities. 11. **Planning:** Use research on demographic change to prepare and plan for future social care demand.	12. **Information:** Develop more local, accessible information on staying well with communities, targeting people with low health literacy. This includes via an online community and family hubs site. 13. **Universal activity:** Review universal and/or community wellbeing activities (e.g. council resident events) so healthy lifestyles promotion is built-in. 14. **Access:** Work with communities to continually understand and improve access to support services.

Partnership action: The partnership action needed in this area relates to the wider determinants of health, health behaviours, tackling health inequalities, promoting culture change through information and advice, and improving access to early help.

7. Reduce

Definition Secondary intervention and early intervention. This is more targeted, aimed at those with an increased risk of needing support.

What do we need to think about? Reducing care and support needs by targeting those at-risk means working closely with communities and continually using evidence and insights to make a difference. It also means ensuring there is robust support to unpaid carers. Early intervention is important here, particularly as long-term conditions are a major driver of health and social care needs, and that an estimated 38,000 cases are unidentified and therefore unmanaged.

Technology	Culture change	Early help	Community
1. **Proactive, predictive approaches**: Develop an approach or tool that utilises data and insights and enables proactive outreach, helping people at-risk before needs develop. 2. **Share knowledge**: Keep up-to-date on changes in digital technology that can support targeted prevention work.	2. **Targeting in adult social care:** Develop resources and training so staff – including those in the 'front door' of adult social care - can provide targeted information and advice on self-care and early help.	3. **Early help from social care**: Articulate and develop the early help offer for residents from social care. This includes information and advice, equipment, adaptations, technology, and support to connect with communities. 4. **Focus on reablement and intermediate support:** Develop reablement as a robust early help offer to support people to regain independence. 5. **'Below threshold' offer:** Articulate and develop the offer for people with support needs who are just below the threshold for social care to stay as independent as possible. This includes older people, people with complex needs, with a learning disability or autism. 6. **Unpaid carers:** Carry out the Carer Charter so carers have information and advice to help them look after their own mental and physical health, are supported to maximise their income and to continue to work or study. 7. **Falls prevention:** Work with health colleagues to implement the Falls Prevention Delivery Plan. 8. **Early diagnosis**: Work with partners to improve the detection and diagnosis of long-term conditions.	9. **Locality model:** Build targeted prevention into plans for integrated locality and neighbourhood teams, asset based-community development and coproduction with communities – so early help is easy to access. 10. **Social prescribing:** Work with colleagues to develop the role of social prescribers to put the right early help in place with communities.

Partnership action: The partnership action needed in this area relates to delivering the Carer Charter Action Plan, the development of locality and integrated neighbourhood teams, falls prevention, and long-term condition identification and support. There are also interfaces with NEL Joint Forward Plan aims to invest in primary care resources and infrastructure.

8. Delay

Definition Tertiary prevention and formal intervention. This is aimed at minimising the effect of disability or deterioration for people with support needs.

What do we need to think about? Delaying the need for greater support for people with support needs means taking a proactive and holistic approach, recognising that people often have complex issues and multiple health conditions and focused on supporting people to be as independent as possible.

Technology	Culture change	Early help	Community
1. **Care technology:** Develop a comprehensive range of care technology aimed at people with support needs being as independent as possible. 2. **Integrated data:** Integrate data and insights from care technology and elsewhere into a single system, enhancing holistic support to people with support needs.	3. **Holistic approaches**: Provide support to staff to take a holistic approach when working with people with complex needs. 4. **Complex needs:** Share good practice and learning on how best to support people with complex needs to be as independent as possible.	5. **Wider support:** Work with communities and colleagues to enable wider community support and connections for people with support needs (e.g. peer support). 6. **Healthy lifestyles and social care**: Work with colleagues to articulate a clear offer of healthy lifestyle support targeted people using adult social care. 7. **Support from adult social care:** Ensure prevention is core part of future social care commissioning – including reablement, homecare, direct payment support, equipment and adaptations, and accommodation-based support. 8. **Unpaid carers**: Carry out the Carer Charter Action Plan so carers can access a range of support, including breaks from caring.	9. **Proactive care**: Work with health partners to carry out the proactive care programme, to provide personalised and co-ordinated support and interventions for people living with complex needs. 10. **Direct payment market**: Co-design community support with adults with a learning disability or autism to develop a community-led market for people with a direct payment in social care. 11. **Local, community care:** Build prevention into plans to develop more integrated support available in local communities – making sure early help is easy to access.

Partnership action: The partnership action needed in this area relates to delivering the Carer Charter Action Plan, the development of locality and integrated neighbourhood teams, the proactive care programme and long-term condition support and management. There are also interfaces with hospital admission avoidance work.

Section 3

Understanding and measuring prevention

9. Understanding and measuring the impact

A 2019 research report from the London School of Economics report looks at the effectiveness of preventative activity related to social care and concludes:

- There is currently limited evidence on the effectiveness and cost-effectiveness of preventative activity related to adult social care.
- Existing evidence is concentrated on reablement, telecare, falls prevention and wellbeing/isolation.
- The report notes that this lack of evidence 'may lead to underinvestment in prevention in the current climate of financial austerity with long-term negative consequences for the users' outcomes and the effectiveness of the system'.
- The challenges with measuring the effectiveness of preventative action include:
  - It is difficult to measure what would have happened without the activity, and to establish cause-and-effect given the impact of other factors.
  - The impact of some interventions is likely to take considerable time to emerge.
  - There is no consensus on what prevention is, making it harder to build a comprehensive evidence base.
  - Prevention often needs system-wide action that requires system-wide measurement.
- The report notes that "there is an untapped potential to employ experimental set-ups and control groups when piloting new interventions".

Measuring the impact of specific initiatives

New initiatives carried out through this plan will consider experimental set-ups and control groups in order to more effectively evaluate the impact of new preventative activity.

Understanding the impact of the Prevention Plan

The three core contextual measures to monitor over the lifetime of the plan are:

- Healthy life expectancy in Barking and Dagenham
- People receiving long-term adult social care as a percentage of the population
- The percentage of adult social care users who say support improves their quality of life.

Once the Prevention Plan has been finalised, a more detailed set of contextual measures to understand the current picture and how it is changing over time will be agreed.

10. Opportunities for learning

At the end of 2023, a partnership Prevention Task and Finish group identified three key areas of focus in relation to prevention:

- Social isolation.
- Early diagnosis and intervention.
- Learning disability and autism.

Work is going on across the partnership on each of these areas, providing an opportunity for learning for social care (and partners) in relation to prevention.

Social isolation

42% of respondents to a 2022 survey sent to social care users in Barking and Dagenham said they have as much social contact as they want. 15% said they were often or always lonely – compared to 8% of the general population in a 2024 ONS survey. People who need adult social care are more likely to have loneliness risk factors, including health conditions, older age or being an unpaid carer.

Insights and work to be carried over 2024 by Care City and the wider B&D Collective is focusing on social isolation following hospital discharge and is likely to have wider applicability, informing how we can tackle social isolation and loneliness overall in social care. Actions to tackle social isolation suggested by the Task and Finish Group included further utilising digital technology, improving the quality of conversations between staff and residents, ensuring people know what local activities and out there, and ensuring the built environment promotes social connections.

Early diagnosis and intervention

As previously noted, long-term conditions are a major driver of health and social care needs, and an estimated 38,000 cases are unidentified and therefore unmanaged. The GP registered population with mental illnesses is much lower than estimates, raising the question of potential unmet need. 548 adults with mental health as a primary need got long-term support from adult social care in 2022-23.

Actions arising from the 2023 Director of Public Health Report provide an opportunity for learning for social care in relation to prevention. Additional actions suggested by the Prevention Task and Finish group included monitoring the impact and outcomes of targeted resident health and wellbeing pop-up events, ensuring people know where to go for help at an early stage, and improving health literacy.

Learning disability and autism

There are an estimated 3,271 adults with a learning disability in Barking and Dagenham, of which 753 have a moderate or severe disability, and an estimated 1.527 autistic adults (PANSI). 518 adults with a learning disability as a primary need got long-term support from adult social care in 2022-23.

Many of the actions articulated in this plan will directly impact on adults with a learning disability and autistic adults. In addition, linked strategies for adults with a learning disability and/or autism will be developed over 2024. Emerging priorities are listed below, and will provide an opportunity to test and learn from preventative approaches:

- Improving understanding and acceptance of learning disability and autism
- Improving accessibility
- Improving housing
- Improving employment
- Improving the transition to adulthood
- Having a clear pre- and post- autism diagnosis support offer
- Ensuring there are targeted health interventions.

Appendix I: Inequalities summary

Wider determinants of health

- **Employment:** Regional insights indicate that people aged 16-24, people who are disabled and people from a Bangladeshi, Black “mixed/multiple” and “other ethnic groups are more likely to be unemployed.
- **Overcrowding:** Research indicates that people of a Bangladeshi, Pakistani or Black African ethnic background experience higher rates of overcrowding.
- **Social isolation:** People with a disability or long-term health condition, people going through a ‘disruptive life event’ (e.g. bereavement, unemployment, migration) are more likely to experience social isolation. Personal risk factors include being aged 16-24 or over 50, being LGBT+ or being an unpaid carer.

Mental health

- People from deprived areas, LGBT+ people, older people, people with a long-term condition or learning disability are at a higher risk of mental health issues.
- Other risk factors include discrimination, child neglect and abuse, unemployment, poor quality work, debt, drug and alcohol misuse, homelessness, loneliness and violence.
- People from Black, Asian or minority ethnic backgrounds are less likely to engage with mental health services other than at a time of crisis.
- Locally, there is evidence indicating Asian ethnicities are underrepresented in mental health referrals by 12% and in admissions by 15% (NEL MHLDA Provider Collaborate Report, 2024)

Healthy life expectancy and long-term conditions

- The prevalence of multiple conditions is higher, and the age of onset is younger in those living in more deprived areas. There is currently a 6.4-year difference in healthy life expectancy between the least and most deprived males and a 5.8-year difference between the least and most deprived females with the borough (2023 DPH report).
- The likelihood of having one or multiple long-term conditions increases with age. One report suggests a picture of earlier frailty in LBBD. (NIHR, frailty among older adults, 2020).
- Residents of Black ethnicities develop a long-term health condition over five years earlier than their White neighbours (2023 DPH report)
- Life expectancy and deaths from certain diseases (e.g. morbidity in cancer, dementia and Alzheimer’s) are highest in White residents (2023 DPH report).
- The 2021 Census indicates that a significant proportion of the local population originate from Romania and Lithuania. It may be useful to look in more detail at the health needs and experiences of these communities, building on a previous 2010 report.
- Self-reported health is a key indicator for healthy life expectancy. Self-reported bad health is more prevalent in LBBD for those aged 65+ and people of a White British ethnic background (the two are possibly linked). Self-reported bad health was most likely to be reported in Becontree, Heath, Parsloes and Valance wards (2021 Census)
- Demographic change in LBBD indicates that those aged 35-39 make up a significant proportion of the population. This cohort will soon enter the age band at which long term conditions often appear.
- The proportion of the LBBD population from an Asian ethnic background increased from 15.9% in 2011 to 25.9% in 2021. As members of the Asian ethnicity are overrepresented in certain long term health conditions, such as diabetes, this demographic change will affect public health need within the borough

Interfaces

- There are many interfaces between the risk factors described here. For example, there is evidence that physical and mental health are closely connected and affect each other through a number of pathways.

Appendix II: Adult social care activity - summary

- In 2022/23 in Barking & Dagenham, 3,045 adults received long term support through the council during the year. 1,275 were aged 18-64, and 1770 were aged 65+.
- This equates to 9.3 adults per 1,000 aged 18-64 and 91.1 adults per 1,000 aged 65+ received long term support during the year. The figures for England are 8.5 and 51 respectively.
- The number of clients in long-term support as a proportion of the population has grown slightly between 2017-18 and 2022-23. The figure is slightly higher than the England benchmark overall. Our 65+ clients in long-term support as a proportion of the population has benchmarked high for a number of years (see below tables).
- 6419 contacts were made with the Adult Intake Team in 2022-23, of which 26% led to an adult social care or safeguarding referrals. 1239 referrals to adult social care were made in 2022-23
- Requests for support as a percentage of the population is higher than England and London benchmarks, although the local figure has been decreasing in recent years.
- Spend and outcomes in relation to short-term support was comparatively low in 2022-23, likely impacted by both recording and service design. Work to pilot and develop reablement in 2023-24 is intended to help address this.

Clients in long-term support as % of population	
LBBD – 2017-18	LBBD – 2022-23
1.78%	1.96%
England – 2017-18	England – 2022-23
1.96%	1.87%

Ranking against all LA's – clients in long-term support as proportion of population		
Aged 18+	Aged 18-64	Aged 65+
57	43	9