READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT CARE & HEALTH SERVICES

TO:	**Reading Health and Well-being Board**		
DATE:	**9 October 2015**	**AGENDA ITEM:**	**11**
TITLE:	**Reading joint strategic needs assessment position statement**		
LEAD COUNCILLOR:	**Cllr Hoskin**	**PORTFOLIO**	**Health**
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1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This document provides an interim, high-level position statement on the health needs of the people of Reading. We shall produce a comprehensive joint strategic needs assessment (JSNA) for 2016-19 in the coming months.

2. RECOMMENDED ACTION

2.1 Committee members are asked to note this position statement and to make observations.

3. POLICY CONTEXT

3.1 Local councils are required to publish joint strategic needs assessments (JSNAs). Reading Borough Council's current JSNA will be replaced by an updated, much fuller document in Spring 2016.

4. CONTRIBUTION TO STRATEGIC AIMS

5.1 JSNAs act as a repository of information that supports the development of policy and actions to meet the overall direction of the council its corporate plan priorities:

1. Safeguarding and protecting those that are most vulnerable;
2. Providing the best start in life through education, early help and healthy living;
3. Providing homes for those in most need;

4. Keeping the town clean, safe, green and active;

5. Providing infrastructure to support the economy; and

6. Remaining financially sustainable to deliver these service priorities.

This high-level position statement identifies key issues in relation to the health well-being of Reading's population.

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 Section 138 of the Local Government and Public Involvement in Health Act 2007 places a duty on local authorities to involve local representatives when carrying out "any of its functions" by providing information, consulting or "involving in another way".

6.2 This duty has been met by presenting this high-level interim position statement to the borough's health and well-being board. The development of an updated full JSNA will include wider discussion and consultation.

7. EQUALITY IMPACT ASSESSMENT

7.1 Under the Equality Act 2010, Section 149, a public authority must, in the exercise of its functions, have due regard to the need to—

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

8. LEGAL IMPLICATIONS

8.1 None relevant

9. FINANCIAL IMPLICATIONS

9.1 There are no immediate financial implications of this high-level interim position statement but there are likely to be from any work subsequently undertaken if decisions are made to change current levels of service provision.

10. BACKGROUND PAPERS

10.1 None

Reading joint strategic needs assessment position statement

1. Introduction

This document provides an interim, high-level position statement on the health needs of the people of Reading. We shall produce a comprehensive joint strategic needs assessment (JSNA) for 2016-19 in the coming months. An initial data specification for this can be found in Appendix 1 and an implementation plan in Appendix 2; most of the data listed here are already available in the current JSNA.

The headline issues are:

- Reading's people generally experience poorer health and more can be done to encourage and enable healthier lifestyles to reduce the risks of largely avoidable disease and disability – services need to be targeted and tailored to reduce health inequalities in the borough;
- most mental ill health has its origins in child and young-adulthood and, especially in view of Reading's proportionately younger population, we need to be sure that we are doing all that is reasonable, within available resources, to reduce the risks of people developing long-term mental health problems; and
- Reading would appear to be providing above-average levels of social care services; it is important to ascertain the reasons for this and that other service provision is appropriate for the composition of the local population.

1.1 Context

The purpose of a JSNA is to provide a comprehensive repository of information and an appraisal of relevant evidence to help inform service development and prioritisation processes. JSNAs are not intended to be policy statements or service commitments but to be used as tools to enable the development of these.

2. Reading's population

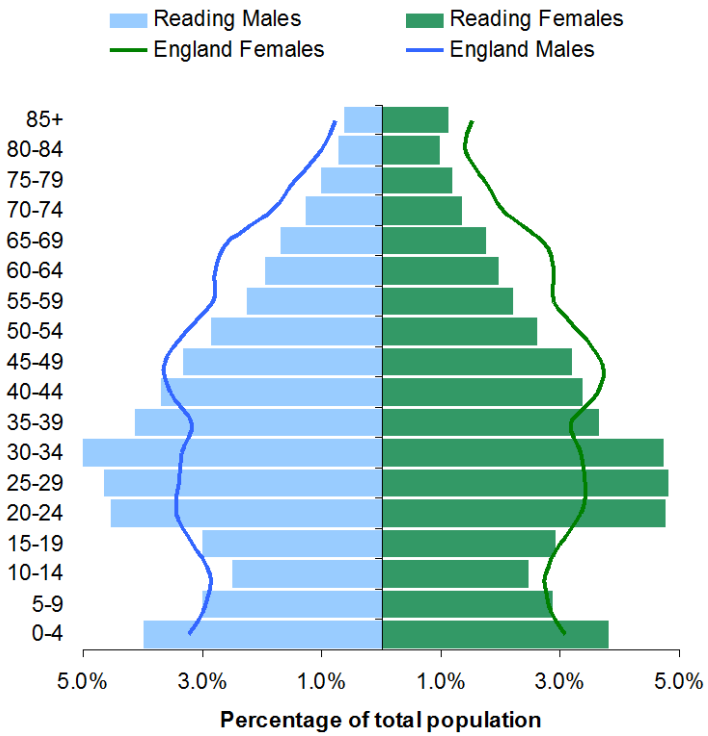
2.1 Population age structure and changes

Reading's population differs from the national average in having higher proportions of pre-school children and younger adults, particularly women of childbearing age (as is shown in Figure 1) and this has significance for service need particularly in terms of pre-school and early-years support, sexual health, pre-natal and maternity services, healthy lifestyles, and health and social care need.

Table 1 shows how the borough's population has changed between the censuses in 2001 and 2011, and the proportionate changes between these two censuses and the previous one (in 1991).

These population changes do not account for new housing developments. However, there is evidence that more people are moving to Reading from abroad than are emigrating; more are leaving for other parts of the UK than are coming to Reading; and that more babies are being born in the borough than people dying. The local population is therefore getting bigger and the proportion of people in it who were born abroad will also increase. In the coming 5-10 years, we can probably also expect there to be proportionately more young adults and more people in their sixties and seventies than at present. This is likely to have a particular impact on the need for social care services and, to a lesser extent, on housing services. Simply because there will be more children in the borough, the councils children's services can also expect to have to meet greater needs. There is likely to be a similar impact on health care and voluntary sector service providers.

Figure 1: Reading population health pyramid: mid-year estimates for 2012



Source: Office for National Statistics mid-year population estimates

Table 1: Changes in Reading's population in recent years

Population age (years)	Reading 2011	Reading 2001	Reading change 2001-2011 (%)	Reading change 1991-2001 (%)
All ages	155,700	144,400	8.8	7.1
0-14	28,500	25,100	13.5	0.8
15-19	9,800	9,000	8.8	3.4
20-29	29,700	29,700	0	-3.6
30-59	63,500	57,300	10.8	23.0
60-74	15,500	14,300	8.3	-7.7
75+	8,700	8,800	-1.2	4.8

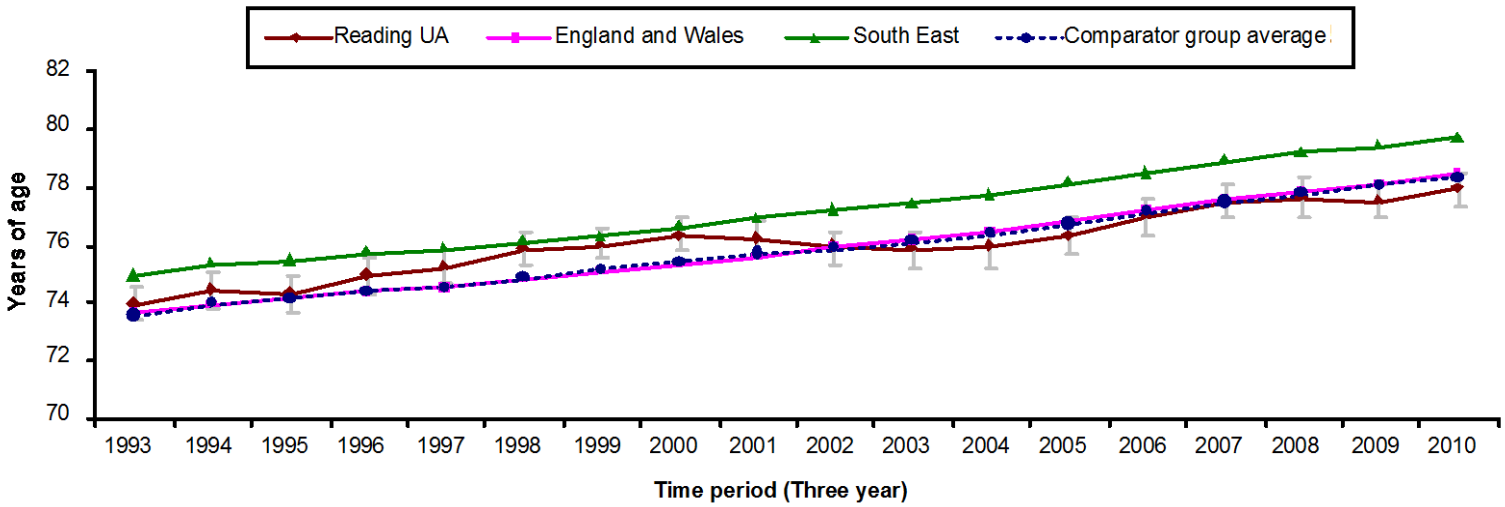
Source: Office for National Statistics, 2011 Census Table

2.2 Life expectancy

This oft-quoted measure is a prediction of how long a person is likely to live (usually calculated from birth) based on prevailing mortality patterns. Measuring likely quantity rather than quality of life, it is a way of expressing general population health. As elsewhere in the country, life expectancy is generally increasing, mainly due to better nutrition and living standards and reductions in infant mortality (with the impact of health and social care interventions being quite small in comparison). Currently, life expectancy in Reading from birth for males is 78 years and 83 years for females. As

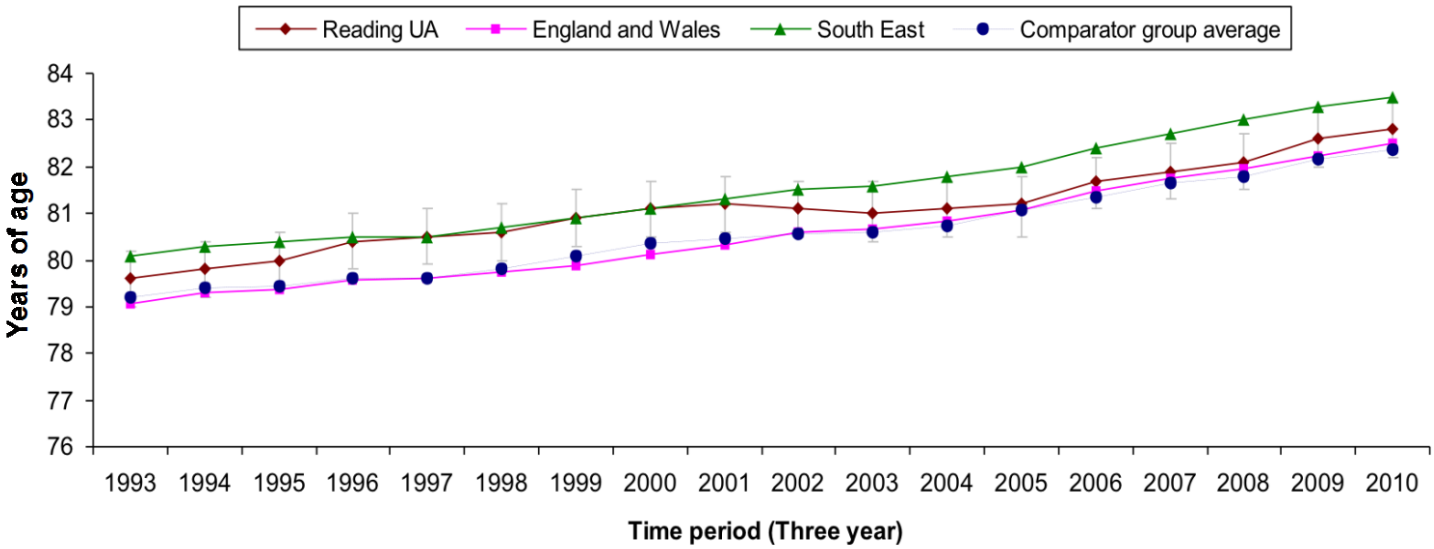
shown in Figure 2, this is below the national and regional averages – for most years being statistically significantly so,[i] with the trend for females being similar, as shown in Figure 3. Life expectancy, and other measures, at an electoral ward level in Reading are shown in Table 2.

Figure 2: Trends in male life expectancy



Source: Berkshire Central Public Health Team

Figure 3: Trends in female life expectancy



Source: Berkshire Central Public Health Team

i 'Statistical significance' is a mathematical way of determining whether an event (such as a death rate) is 95% or more likely to be due to a real effect rather than to have occurred by chance.

Table 2: Some key health-related comparisons of Reading's wards, ranked by deprivation

Ward	Index of Multiple Deprivation	Proportion of population from Black and minority ethnic groups (%)	All-cause mortality rate per 100,000 aged <75 years (2008-10)	Life expectancy at birth (years): males (2008-10)	Life expectancy at birth (years): females (2008-10)	Emergency hospital admission rate per 100,000 (2010/11)
Whitley	33.0	30.8	138.6	76.6	80.6	99.0
Norcot	27.9	32.3	121.7	77.0	80.5	93.7
Church	27.1	31.0	135.1	75.7	80.7	83.3
Battle	26.7	51.5	108.0	78.3	82.8	92.2
Abbey	26.5	53.7	153.4	74.4	81.9	96.0
Southcote	25.8	26.4	97.7	77.5	84.2	91.1
Minster	23.2	40.9	136.4	73.6	79.3	88.7
Katesgrove	22.5	47.4	113.8	79.0	84.1	80.0
Caversham	21.1	25.3	97.1	78.7	83.7	81.5
Kentwood	18.3	23.5	103.5	77.4	81.4	90.1
Redlands	17.1	40.7	97.9	77.7	84.0	66.5
Tilehurst	15.6	15.8	97.6	79.0	84.4	90.1
Park	15.0	49.7	127.5	76.8	81.9	77.5
Peppard	8.8	16.8	63.2	81.5	87.0	66.3
Thames	5.5	15.2	69.4	82.1	85.7	65.7
Mapledurham	4.7	11.3	52.4	84.7	88.0	58.3
Reading	19.9	34.7	107.1	78.0	83.1	82.5

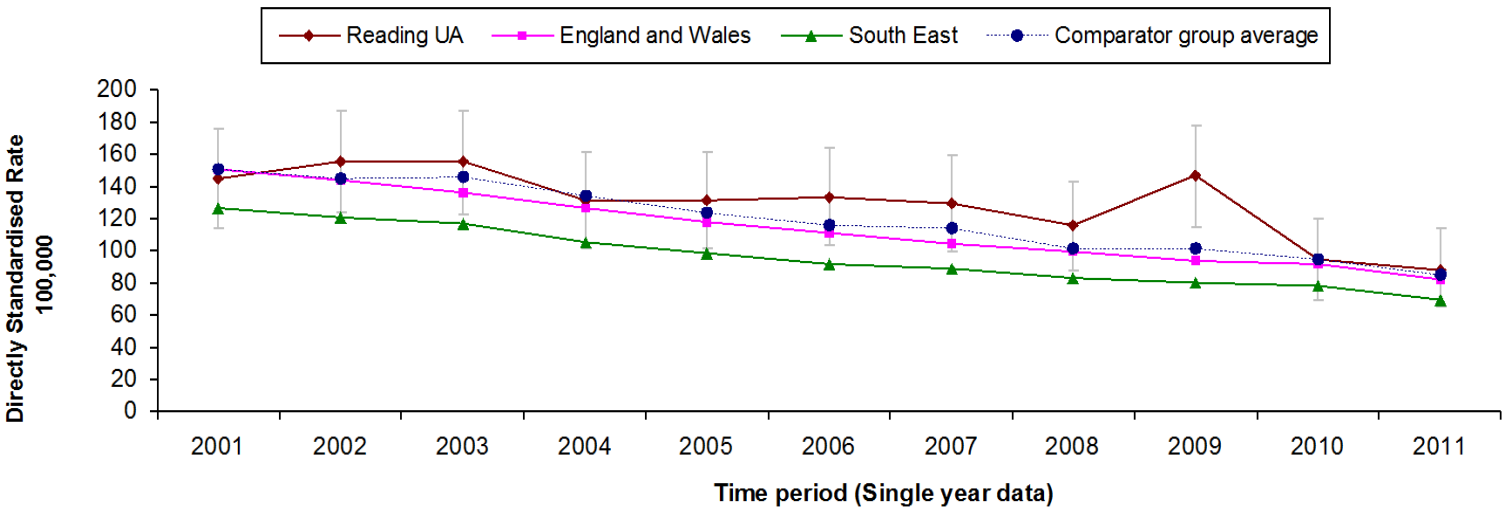
Source: Berkshire Central Public Health Team ward profile dataset

The key points to note from Table 2 are that there is a trend of increasing life expectancy (and lower premature death rates) with increasing affluence and that the health equality differences within the borough are quite large. For example, a boy born to parents living in Mapledurham ward expect to live eight years longer than one born at the same time to parents in Whitley ward. Emergency hospital admission rates also tend to occur more often from the more deprived areas implying a likely combination of people experiencing poorer health and having different healthcare-seeking behaviours. Just as there is variation between individual wards and Reading as a whole there will be variations within wards with pockets of deprivation and affluence existing side by side. Such intra-ward variations are likely to be the cause of some wards that are, overall, more affluent, having higher premature death rates than some others that are less affluent. We will need to undertake more detailed analyses of various measures at sub-ward level to enable greater understanding of relevant differences and – crucially – how population-level interventions should be targeted and tailored to better ensure that people can benefit from them.

3. Deaths from cardiovascular disease

Cardiovascular disease, essentially heart attack and stroke, is the leading cause of death in Reading. For men, such deaths are generally higher (although not always statistically significantly so) than the south east of England, England and comparable local authority areas, as shown in Figure 3.

Figure 4: Death rates from cardiovascular disease in men aged under 75 years 2001-2011



Source: Berkshire Central Public Health Team

Cardiovascular disease is essentially preventable. The World Health Organisation considers that, worldwide, 80% of heart disease and stroke can be prevented,[1,2] and such a large reduction may not be possible in England (because much has been done already) there remains considerable scope to reduce disability and death from this disease.

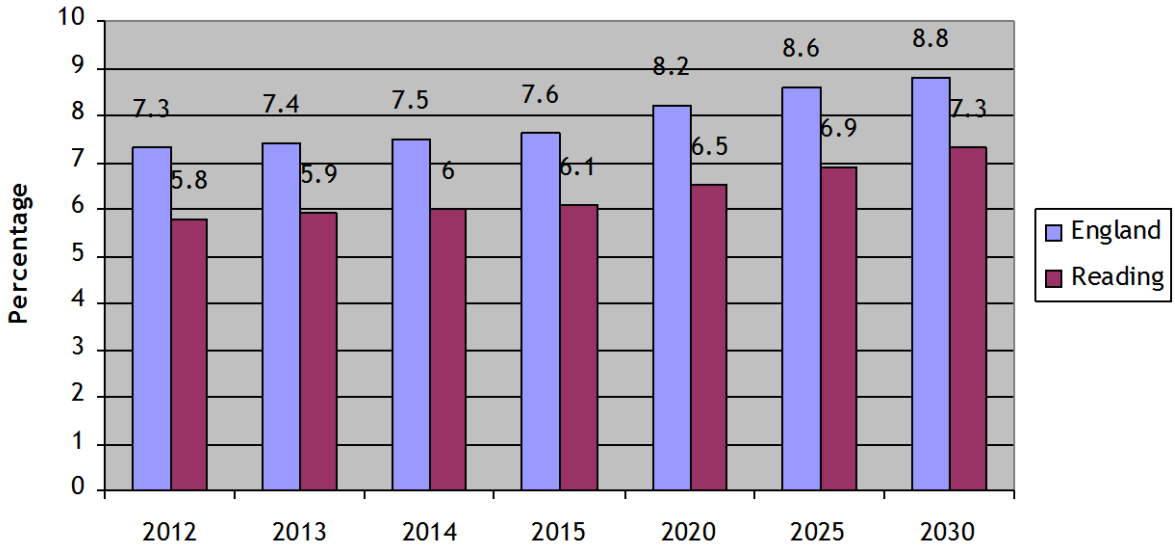
4. Diabetes

Few people die of diabetes but many die because of it: diabetes doubles the risk of premature death, and is a major risk factor for cardiovascular disease, kidney failure, visual impairment and damage to the blood vessels and nerves of the lower limbs often necessitating amputation. [3] These complications have severe consequences for the sufferer and significant cost implications for health and social care services.

As shown in Figure 4, whist the estimated prevalence of diagnosed and undiagnosed diabetes in Reading is below the national average, the rate is increasing (as it is nationally)

and if unchecked will become increasingly problematic. Most diabetes is related to obesity and is thus eminently preventable.

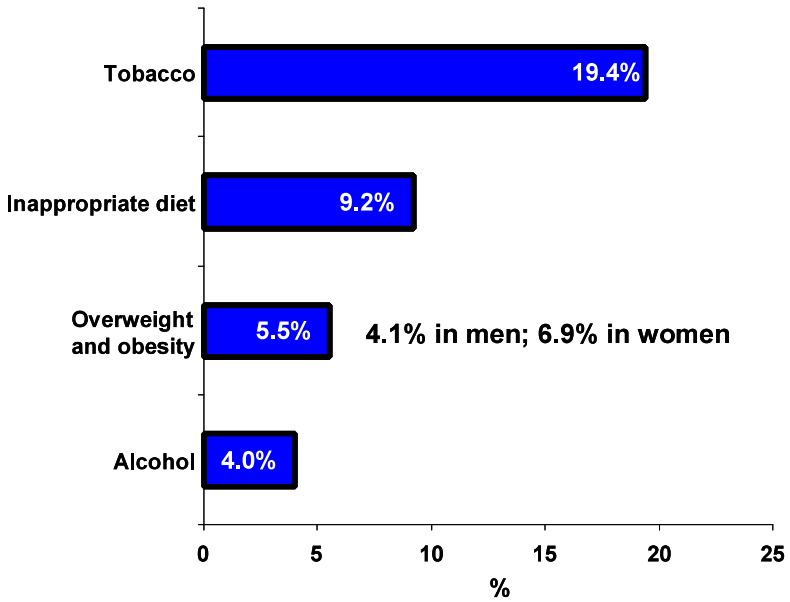
Figure 5: Estimated prevalence of diagnosed and undiagnosed diabetes in Reading



5. Cancers

The incidence of cancers in Reading has been much the same for several years and approximates to the national average.[4] However, about a third of cancers can be attributed to just four lifestyle choices, as shown in Figure 5,[5] and are thus largely avoidable.

Figure 6: The proportion of cancers in the UK attributable to different exposures



Encouraging and enabling people to adopt healthy lifestyles that reduce their risk of developing avoidable cancers is, obviously, desirable.

6. Mental well-being

Just as the World Health Organisation defines health as being not just an absence of disease but a complete sense of physical, mental and social well-being, so mental health is more than an absence of mental illness: it is a state of emotional wellbeing in which an

individual realises their own abilities, can cope with normal life stresses, can work productively, and make a contribution to their community.[6]

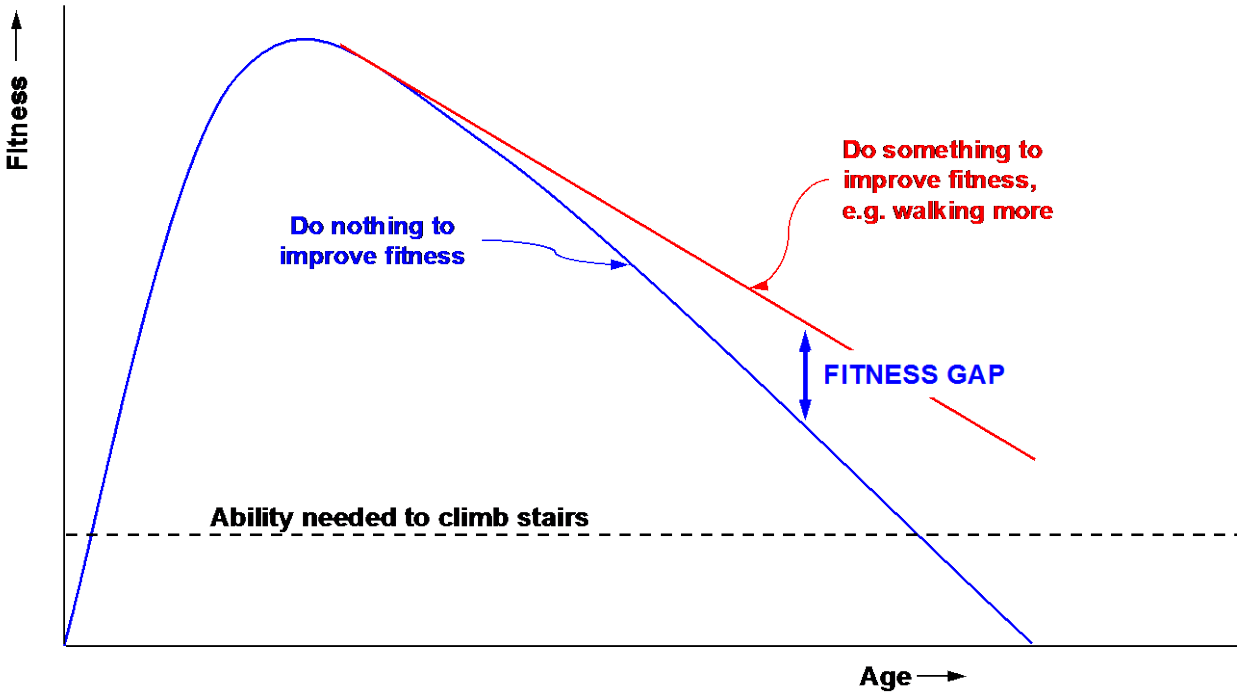
Twenty-eight per cent of people supported by Reading Borough Council's adult social care services have mental health problems as a main factor putting them at risk. And an estimated 29.3/100.000 people in Reading develop a psychotic mental illness each year compared with an average for the south east of the country of 19.8, and for England as a whole of 24.2.[7] The prevalence of most less-severe mental illnesses in Reading does not differ significantly from regional and national averages. However, it would be prudent to explore mental health issues in greater detail to ensure that, within the available resources, the provision of support and services is appropriate: significantly, half of all lifetime diagnosable mental illnesses begins by the age of 14 years and three-quarters by the mid-20s; promoting mental health can save money in both the short and long-term[8] as well as reduce suffering.

7. Physical activity

Whilst there are data that show Reading people to be as physically active in their everyday lives as the average this does not mean that this is sufficient to reduce the risk of avoidable and delayable conditions such as cardiovascular disease, diabetes, depression, dementia and physical dependency. Rather like quitting smoking, it is never too late to get some benefit, and all people of all ages would benefit from being more physically active in their everyday lives. Even small amounts of regular physical activity sufficient to make one slightly out of breath and/or sweaty and with an increased heart rate (five times a week for 30 minutes at a time) can reduce the risks of avoidable disease and disability, often much more so than by using medication.[9]

The impact of this was discussed in a book by Professor Sir Muir Gray where he depicted how being more physically active (such as simply walking more) slowed the inevitable decline in physical fitness that occurs with age. Crucially, being more physically active also delays the time at which one becomes physically unable without help to climb stairs; or to be able to get up, wash and dress unaided each morning; or to prepare a simple meal daily meal. This is depicted in Figure 6, taken form this book.[10]

Figure 7: The effect of age on the ability to undertake everyday tasks and how to reduce this



8. Social care provision

In 2014 /15 adult social care supported 2,890 people, including 510 carers and performs well overall in supporting people at home, as shown in.

Figure 8: Adults receiving social care services per 100,000 in 2013/14

Adult social care community-based provision in Reading would appear to have a lower eligibility threshold than councils of similar size and the England average. This is supported by the data on how frequently we supply very small packages of care. For residential and nursing homes, Reading appears to be comparable to other councils. For satisfaction indicators on quality of life (from the annual survey of social care users) the council performs above average at around 70%. However, there is also a mixed picture in some specific areas. For Direct Payments, Reading performs less well and has very low numbers of around 9%. It also has a higher than average number of permanent placements into residential and nursing care for younger adults. Other areas of need also give a mixed picture: the number of people with learning disability in employment is low at 5%, for example, but it is high for people with mental health problems.

The number of carers seeking support is now increasing, but from a low base given the very high value placed on the contribution that carers make to supporting vulnerable people in our community.

The picture is thus of a system still adjusting to the national eligibility standard imposed in the Care Act from April 2015, and the need to be modernised to over personalised unique packages of care consistently and routinely.

9. Implications

This position statement JSNA is brief, and is intended only to highlight key issues. There are many other issues that need to be explored in detail (as do those highlighted here) and this will be undertaken in the coming months culminating in the publication of a full JSNA for 2016-2019.

Meanwhile, there are several issues in terms of health and well-being need that need consideration:

- overall, the people of Reading experience poorer health and are more likely to die prematurely –
  - a high proportion of illness, disability and death in the borough is either avoidable or, at least, delayable,
  - there is potential to reduce this and – through targeted work in the more deprived areas tailored to peoples cultures, values and beliefs – to reduce inequalities in health;

- the borough's proportionately large younger population (including women of child-bearing age) means that there is a greater need than in many other places to ensure adequate provision of advice, support and services to enable children to have the best start in life and for services for children, pregnant women and families bringing up children;

- there *may* be a need to do more to help to avoid the risk of mental health problems developing in child and young-adulthood and to provide more training of front-line personnel and 'low level' services to avoid the need for specialist mental health care;

- the Care Act place duties on local authorities to promote 'wellbeing' and to focus on 'prevention' to help people live the most fulfilling lives they can. Meeting these duties will need to show a shift from a reactive response to helping people to maximise their independence and self-care, that is, prioritising preventative activity; and

- the provision of social care services is higher in some areas such as residential and nursing homes. This needs to change to ensure that more people are supported to live independently for longer in their own homes and communities.

10. Recommendations

Pending the completion of a full JSNA for 2016-19, which will identify a wider range of issues, and in more detail, consideration should be given to:

- reviewing the current provision of assessment of need for, and the commissioning of services intended to encourage and enable large numbers of people to live healthier lives and thus reduce the risk of avoidable disease and disability, especially to ensure that such services are appropriately targeted at those who can benefit most;
- reviewing the levels of mental ill-health amongst children and young people and identifying whether more needs to be done, within the resources available, from a preventive perspective; and
- reviewing the provision of social care services to ensure that these maximise opportunities to enable people to be as independent as possible for as long as possible, and to be able to provide appropriate care when needed within the resources available.

Appendix 1: Initial specification for full JSNA dataset

Note: many of these data are already available from the Berkshire public health team and can be found in various JSNA analyses for the borough although these are not easily accessible on the Reading Borough Council website.

1 Demography

1.1 Data needs for trends and comparisons:

- population pyramid with national comparison
- population by main age groups (children and young people [0-19]; young; women of childbearing age; 'middle-aged' adults; 'young older' adults, 'old older' adults – whatever is conventional)
- changes in population by age groups and gender from 2001 and 2011 censuses with population projections in different age groups
- birth predictions over coming years
- ethnicity breakdown, including ward maps
- trends in ethnicity
- deprivation levels by ward and by LSOA in maps
- trends in deprivation over the last few years
- data on internal and international migration
- are asylum seeking/refugees and migrant workers an issue in Reading?
- lone households by ward

1.2 Mosaic (or other) data to show different population groups, characteristics and lifestyles

1.3 Life expectancy

- show life expectancy by ward/LSOA divided into deprivation tertiles/quartiles or quintiles showing trends against national averages

2 Social and environmental context

2.1 Data needs – all with regional and national comparisons

- working-age population
- employment/unemployment data
- types of employment
- benefits (different types) claimants – tables and ward
- educational achievement in schools
- school absence measures
- special educational needs
- NEET numbers by ward
- air quality and traffic metrics plus maps
- estimated deaths related to air pollution
- deaths and serious injuries on the roads
- housing data
- crime data
- attitude survey results
- Homelessness

- Social care user population (adults and children)

3 Infant mortality

3.1 Data needs

- trends in infant mortality in Reading compared with
- ward-level data to show any outliers
- smoking in pregnancy rates
- breast feeding rates

4 Main causes of death

4.1 Data needs

- all-age all-cause mortality trends
- under-75 years all-cause mortality trends
- trends in top ten causes of death – including a breakdown of the main cancers
- comparisons with England
- 'scarf diagrams' for males and females showing main causes of deaths

5 Specific causes of death

Cardiovascular disease – divided into acute coronary syndrome and stroke as appropriate

Cancers: breast, lung, colorectal

Respiratory disease and COPD as a separate topic

5.1 Data needs

- mortality by ward/LSOA shown on a map
- mortality by ward/LSOA divided into deprivation tertiles/quartiles or quintiles showing trends against national averages
- trends in mortality for borough against England
- trends in hospital admissions

6 Excess winter deaths

6.1 Data needs

- trends in excess winter deaths and comparisons against England

7 Health protection

7.1 Data needs

- trends in incidence of flu-like illness and comparisons against England
- incidence of childhood communicable diseases for which routine immunisation is available
- trends in TB incidence and comparisons against England
- immunisation rates for all childhood immunisations, seasonal flu for children, older adults and those in other at-risk groups – with trends

8 Main causes of illness and disability

8.1 Data needs

- long-term conditions such as diabetes, hypertension, hyperlipidaemia, overweight, obesity, asthma, COPD, CVD (not mortality), heart failure, chronic kidney disease,

degenerative joint disease, back problems, fractured neck of femur (as a proxy for falls), depression, anxiety, severe mental illness (including schizophrenia and psychotic mental illness), dementia, neurological conditions (such as Parkinson's disease, multiple sclerosis, myalgic encephalopathy – all by ward?
- data on re-ablement activities
- data on home adaptation services (to link with falls data and other data)
- loss of work because of illness

8.2 Diabetes – data needs

- prevalence trends and comparisons against England
- trends in amputations because of diabetes and comparisons against England
- trends in diabetic retinopathy including blindness and comparisons against England
- trends in cost of diabetes treatment (NHS) and cost implications for social care

8.3 Chronic kidney disease – data needs

- prevalence trends and comparisons against England
- trends in cost of CKD treatment (NHS) and anything on cost implications for social care

8.3 Overweight and, separately, obesity – data needs

- separately, child and adult trends in prevalence
- trends in bariatric surgery and comparisons against England

9 Mental health

9.1 Data needs

- trends in hospital admissions for mental health problems
- ditto unipolar depressive disorders
- ditto bipolar disorders
- ditto schizophrenia and related disorders
- ditto number of people per 1,000 using adult and elderly NHS secondary mental health services
- trends in referrals to and use of IAPT services
- number of people per 1,000 on a care Programme Approach
- trends in the number of people by ward on a GP register with severe and enduring mental illness
- trends in rates of people with dementia
- trends in ratio of recorded/expected diagnoses of dementia
- Children and adolescent mental health servcies
- Mental Health Act assessments
- Employment (ASCOF)
- Numbers of people in settled accommodation (ASCOF)

10 Sexual health

10.1 Data needs

- numbers of people attending GUM services anywhere in England plus trends over as many years as possible
- ditto but for local area trusts with whom we have contracts
- numbers and trends in new diagnoses in chlamydia infections in Reading with comparisons with regional and national data
- ditto gonorrhoea, herpes, syphilis and genital warts in Reading with comparisons with regional and national data

- number of newly-diagnosed HIV infections in Reading (with comparisons with regional and national data), ditto AIDS diagnoses and HIV/AIDS deaths with trends over as many years as possible
- prevalence of HIV in Reading in Reading with comparisons with regional and national data
- age-specific STI diagnoses made in GUM clinics for gonorrhoea, chlamydia and genital warts
- Teenage pregnancy rates

11 Trends in relevant GP QoF data and other data that may be available

11.1 Data needs

- Quality Management and Analysis System (QMAS) data from Reading GP practices

12 Acute hospital activity data

12.1 Data needs

- A&E attendance
- outpatient new referrals
- average length of stay for various conditions
- elective spells
- non-elective spells
- readmissions
- admissions from nursing homes and from residential homes
- admissions avoidance data, including activity with the First Stop Bus service

13 Physical activity

13.1 Data needs:

- APHO borough profiles
- data concerning use of local facilities for sport and physical activity

14 Drugs and alcohol

14.1 Data needs:

- trends in hospital admissions for drug-related mental health or behavioural disorder
- NHS admissions where there was a diagnosis of poisoning by drugs
- impact of alcohol use on different aspects of people's
- trends in hospital admissions for men and women due to alcohol-related conditions
- estimated number of drug misusers in Reading with national comparison
- UK estimates of alcohol drinking prevalence including binge drinking
- drug trend data for 'number in effective treatment', treatment rates, and number completing treatment for opiate and Crack cocaine users, for opiates, for Crack, and for non-opiate drugs with national comparators and, if possible, comparator borough figures
- ditto for all drug users in effective treatment
- main drugs of use by people in effective treatment over the last few years
- numbers and proportions of non-opiate users in effective treatment for different durations in Reading and comparator (cluster) boroughs
- ditto for completing treatment
- opiate drug users in treatment and proportion completing treatment by duration of treatment
- trends in number of people misusing alcohol in primary treatment in Reading
- trends in smoking and alcohol consumption and in obesity in England

- Deaths
- People in justice system accessing treatment
- Children and Parents D and A

15 Safeguarding – children and adults

15.1 Data needs:

- numbers of (separately) children and adults with safeguarding issues
- types of safeguarding issues for (separately) adults and children including numbers and trends
- domestic violence data
- childrens data on pathways (CIN data)
- Mental Capacity Act and DoLS

16 Smoking and smoking cessation

16.1 Data needs:

- estimates on prevalence and trends over as many years as possible
- smoking in pregnancy data and trends
- data on quits
- trends in quits
- tobacco control data – what is available
- data on illegal sales of tobacco (under age) and the use of illicit tobacco in Reading

17 Learning disability and autism

17.1 Data needs

- trends in prevalence
- numbers (and trends) in adults with learning disability known to GPs
- ditto receiving services
- ditto known to councils and NHS
- numbers and trends in school-age resident (moderate LD)
- ditto severe LD
- ditto profound and multiple learning disability
- numbers and trends in people with autistic spectrum disorder
- data on numbers of people with LD approaching transition (and ? trends)
- data on GP-completed health checks for people with learning disability and/or autistic spectrum disorder?
- where possible, for each of these data, to have comparisons with England
- Add SEN data (not under 2)
- Challenging behaviour (ex Winterbourne)
- Social care services data
- Employment (ASCOF)
- Settled accommodation (ASCOF)
- More transitions data- type and needs
- Costs of provision

18 Physical disability

18.1 Data needs

- numbers and trends in people with physical disability receiving services by primary client group
- ethnicity breakdown of physical disability
- Services by type/reason (SALT)

- Age/sex data
- Costs of provision

19 Children and young people

19.1 Data needs

- child poverty measures (relative and absolute) and trends plus national and comparator council comparisons – numbers and rates
- child poverty measures by ward and LSOA
- data on child poverty and lone parent families
- data on child poverty and families of three or more children
- looked after children metrics
- safeguarding data
- Children in need
- Children with disabilities
- Troubled families data
- NEET data
- Outcomes for care leavers
- Outcomes
- Young carers

20 Older people

20.1 Data needs

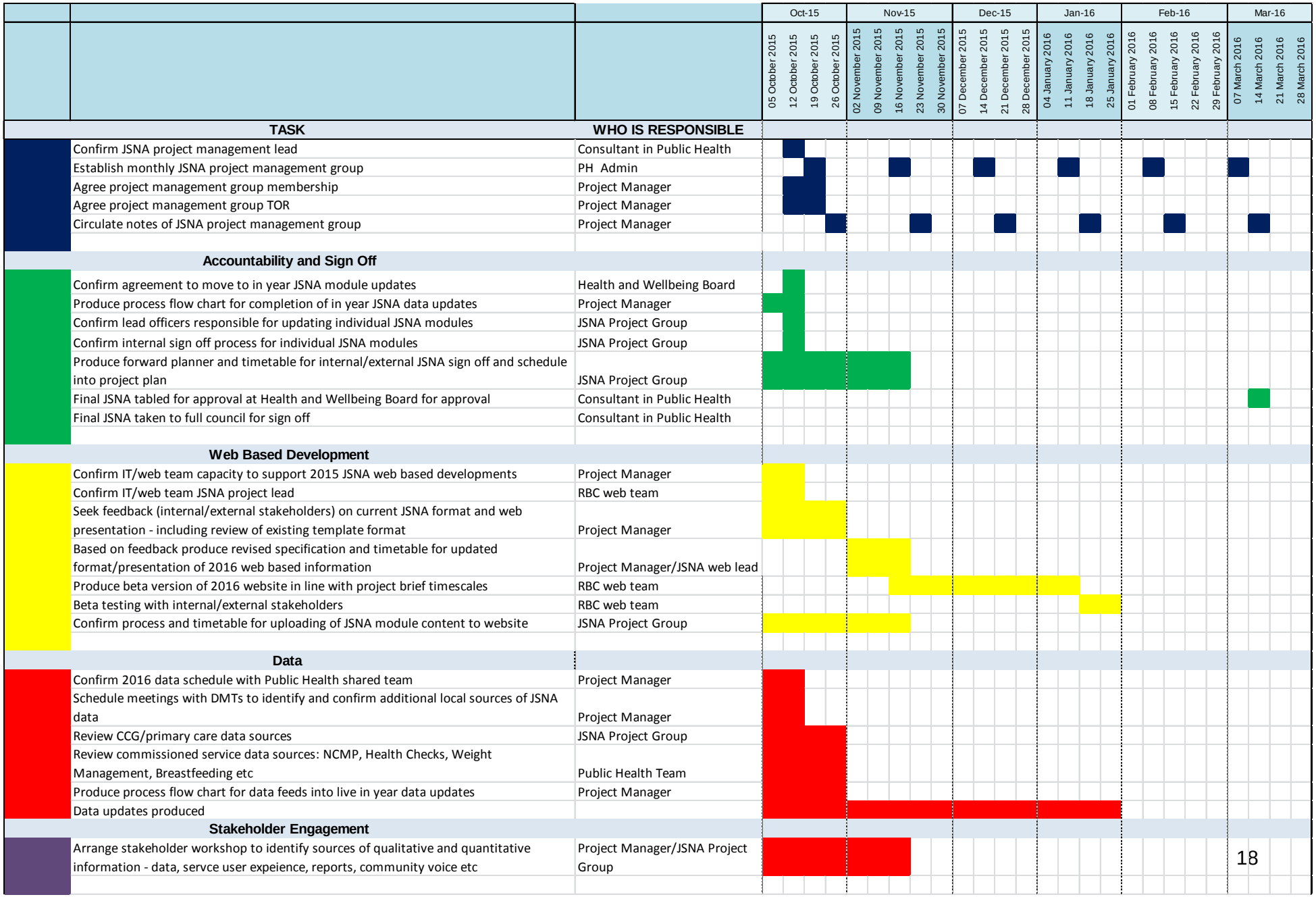
- population data for older people by age band and projections
- data on older people living alone
- ditto having own transport
- inpatient admission rates for injury/falls (use fractured neck of femur and wrist as proxies) – trends
- adult social care data – numbers receiving care packages by type of care and/or type of need – also trends
- safeguarding data
- end of life care data
- Residential and nursing care
- Community services
- Remove safeguarding

21 Carers

21.1 Data needs

- known numbers
- receiving GP/other assessments for personal needs
- distribution of known carers by ward/LSOA
- Carers services numbers/type

Appendix 2: Proposed full JSNA implementation plan



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