

4 Health, physical and sensory impairments

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4.1 About this chapter

This chapter includes information on the needs of the population relating to general health, lifestyle, long term conditions, physical disability and sensory impairment.

There will be issues relating to health and well-being in each of the chapters and those with an interest in a specific group should refer to the relevant chapter below.

- Children and young people
- Older people
- Learning disabilities and autism
- Mental health: including information about early-onset dementia
- Carers
- Violence against women, domestic abuse and sexual violence
- Secure estate
- Veterans
- Homelessness

Definitions

The World Health Organisation (WHO, 1948) defines *health* as:

‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’

They describes *disability* as:

‘an umbrella term covering impairments, activity limitations, and participation restrictions. An impairment is a problem in bodily function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations. This means that disability is not just a health problem. It is about the interaction between features of a person’s body and features of the society in which he or she lives. Overcoming the difficulties faced by people with disabilities requires interventions to remove environmental and social barriers

The definition of disability in the Equality Act 2010 helps shape the definition further. This refers to disability as a physical or mental impairment that has a ‘substantial’ and ‘long-term’ negative effect on ability to do normal daily activities.

Policy and legislation

Historically, there has been much reliance on a medical model of disability, in which the difficulty disabled people have in joining in society is seen as the direct result of having an impairment.

All the organisations contributing to this population assessment now adopt the **social model of disability**. The lived experiences of disabled people have shown that most of the problems faced are caused by the way society is organised – not an impairment or a feature of someone’s body.

The Cultural model of deafness recognises the position of the British Sign Language community and the central role that sign language has within the Deaf community. The Deaf community is seen as a separate culture to the “hearing world”. The Deaf community – people who use BSL as their first language - experiences language and cultural barriers that cause disadvantage.

The Social Services and Well-being (Wales) Act 2014 reinforces the need to think about the broader aspects of well-being in a person’s day to day life and the ability of a person to participate fully in society. The meaning of well-being for the purposes of the act is set out in section 2 and encompasses a broad definition of well-being, which includes physical and mental health and emotional well-being; protection from abuse and neglect; education, training and recreation; domestic, family and personal relationships; contribution made to society; securing rights and entitlements; social and economic well-being and suitability of living accommodation. Well-being is also defined as including control over day to day life and participation in work.

Safeguarding

Protection from abuse and neglect is noted as one of the key aspects of well-being described above. People with longer term health needs, a physical disability or sensory impairment *may* fall within the definition of an *adult at risk*. People who have communication difficulties as a result of hearing, visual or speech difficulties may be particularly at risk, and may not be able to disclose verbally (Adult Protection Fora, 2013). We should not assume that all adults with a physical disability or sensory impairment are vulnerable, however, but should be aware of potential increased risk factors.

Disability hate crime

In April 2005 the law changed to recognise the seriousness of hate crime. This refers to any offence motivated by hostility or prejudice based on the victim’s disability (or presumed disability). This can range from verbal abuse and bullying through to physical assault.

Disability hate crime is believed to be very under-reported - many people don’t know who to talk to or how to report incidents. We want to empower disabled people to tackle disability hate crime. Our organisations need to work together to help create a culture in which hate crime, and other incidents which might not be criminal, are not tolerated and are reported when they do occur.

4.2 What we know about the population

General health status

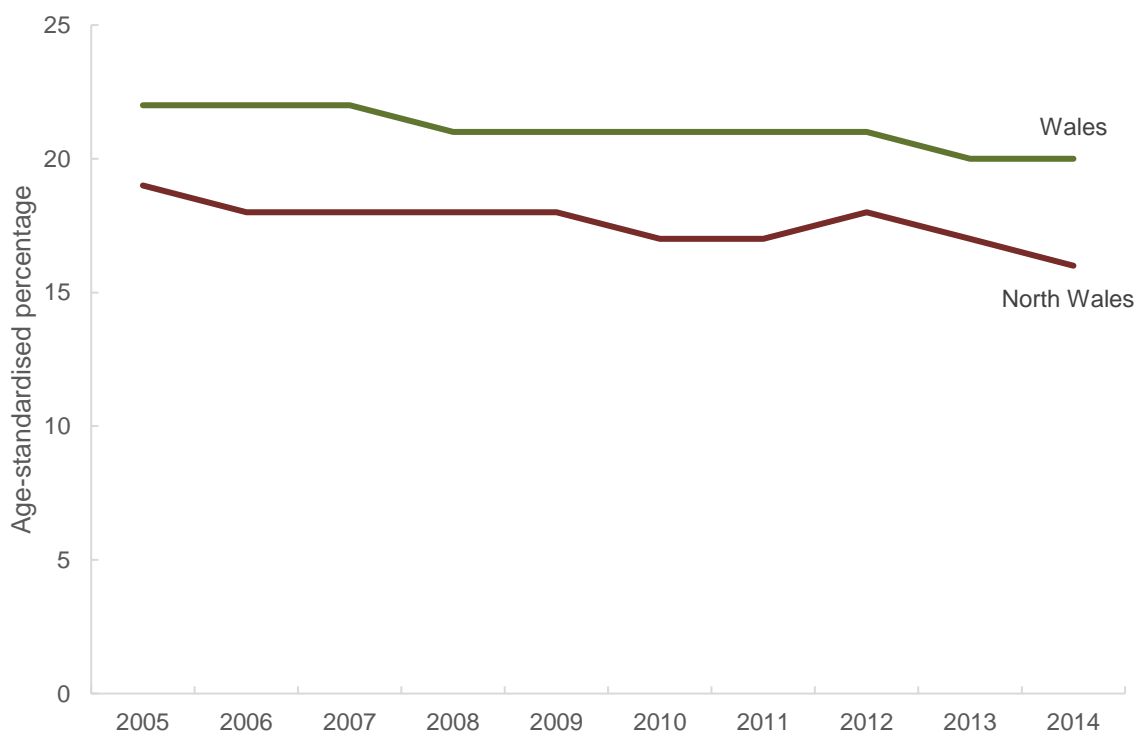
Overall, the North Wales population compares well to Wales in terms of general health status and being limited by a health condition or impairment (Jones *et al.*, 2016). A lower proportion of adults in North Wales report currently being treated for any illness and a lower proportion report their general health status as fair or poor, compared to the Wales average.

Table 4.1 Percentage of adults (age 16 and over) limited by a health problem/disability in North Wales 2013 and 2014

	Currently being treated for any illness	Limited a lot	Limited at all	General health status: fair or poor
Anglesey	47	13	30	15
Gwynedd	47	13	30	15
Conwy	46	13	32	16
Denbighshire	49	14	32	17
Flintshire	47	12	31	14
Wrexham	52	14	31	17
North Wales	48	13	31	16
Wales	50	16	33	20

Source: Welsh Health Survey, Welsh Government

Figure 4.1 Percentage of adults (age 16 and over) who report their health status as fair-poor, 2005 to 2014



Source: Welsh Government, Welsh Health survey

Table 4.2 Percentage of adults who reported their health status as fair or poor, North Wales, 2003/04 and 2004/05 to 2013 and 2014

	2003/04 and 2004/05	2004/05 and 2005/06	2005/06 and 2007	2007 and 2008	2008 and 2009	2009 and 2010	2010 and 2011	2011 and 2012	2012 and 2013	2013 and 2014
Anglesey	17	16	17	18	19	18	16	15	16	15
Gwynedd	17	18	17	16	18	18	16	17	16	15
Conwy	18	16	16	18	16	15	17	20	19	16
Denbighshire	18	18	20	19	19	19	18	17	17	17
Flintshire	18	19	19	17	17	16	19	20	16	14
Wrexham	22	20	21	20	19	19	18	18	18	17
North Wales	19	18	18	18	18	17	17	18	17	16
Wales	22	22	22	21	21	21	21	21	20	20

Source: Welsh Government, Welsh Health survey

Health asset data from the 2011 Census provides an indication of the level of good health across North Wales.

Table 4.3 shows around 80% of people in North Wales report that they are in good health and that their day-to-day activities are not limited (Jones *et al.*, 2016). Gwynedd has the highest proportion of people reporting good health and not being limited by poor health.

Table 4.3 Health asset indicators, age-standardised percentage 2011

	Day-to-day activities not limited (age- standardised %)		Good health (age- standardised %)	
	%	(95% CI)	%	(95% CI)
Anglesey	78.9	(78.2 - 79.6)	80.2	(79.6 - 80.9)
Gwynedd	80.2	(79.7 - 80.7)	81.5	(81.0 - 82.0)
Conwy	79.1	(78.6 - 79.7)	80.2	(79.6 - 80.7)
Denbighshire	77.9	(77.3 - 78.5)	78.9	(78.4 - 79.5)
Flintshire	79.8	(79.3 - 80.2)	80.4	(79.9 - 80.8)
Wrexham	78.1	(77.6 - 78.6)	78.6	(78.1 - 79.0)
North Wales	79.1	(78.9 - 79.3)	80.0	(79.8 - 80.2)
Wales	76.9	(76.8 - 77.0)	77.2	(77.1 - 77.3)

Source: Census 2011 (ONS), Produced by Public Health Wales Observatory

However, the overall rates mask differences in health across the region. Some areas of our population experience greater levels of deprivation and poorer health; and some groups in the population tend to experience poorer health or experience more barriers in accessing health care and support.

Lifestyle

Tobacco

Smoking is a major cause of premature death and one in two long term smokers will die of smoking related diseases. Of particular concern in North Wales is smoking in pregnancy, smoking rates among young people (especially teenage girls) and very high rates of smoking in people diagnosed with mental illness (Betsi Cadwaladr University Health Board, 2015).

In North Wales, 22% of adults aged 16 years and over report being a smoker, compared to 20% across Wales. The Isle of Anglesey and Denbighshire have the highest smoking prevalence, 24%, followed by Conwy and Wrexham, 22% and Gwynedd, 21%; Flintshire has the lowest smoking prevalence, 20%. Rates of smoking vary considerably by area with more deprived areas of North Wales have higher levels of smoking (Welsh Government, 2016).

Smoking prevalence is particularly high among some groups, including lesbian, gay, bisexual and transgendered people; those with mental health problems; people in prison; and those who are homeless (Public Health Wales, 2016a).

Overweight and obesity

Obesity is a major contributory factor for premature death and can lead to both chronic and severe medical conditions including coronary heart disease, diabetes, stroke, hypertension, osteoarthritis, complications in pregnancy and some cancers. People who are obese may also experience mental health problems, bullying, or discrimination in the workplace (Public Health Wales, 2016a).

Overweight and obesity is related to social disadvantage, with higher levels in the most deprived populations.

In North Wales, over half the adult population are overweight or obese. Between 2003/04 and 2014/15, the percentage of adults aged 16 and over who reported being overweight or obese increased in North Wales from 53% to 58%, which is just below the average for Wales, 59%. Across the region, Denbighshire has the highest proportion of adults who are overweight or obese, 61%, followed by Flintshire, 60%. In the Isle of Anglesey and Wrexham, 58% of adults are overweight or obese and 57% in Conwy. Gwynedd has the lowest percentage of overweight or obese adults, 53% (Welsh Government, 2015).

Physical activity

People who have a physically active lifestyle can significantly improve their physical and mental well-being, help prevent and manage many conditions such as coronary heart disease, some cancers, and diabetes and reduce their risk of premature death (Public Health Wales, 2016a).

In North Wales, 34% of adults report being physically active on five or more days in the past week, which is slightly higher than the Wales average, 31%. Across the region, 38% of adults on the Isle of Anglesey and 37% in Gwynedd report being physically active compared to 35% in Denbighshire and 33% in Conwy, Flintshire and Wrexham (Welsh Government, 2015).

Alcohol

Alcohol is a major contributory factor for premature death and a direct cause of 5% of all deaths in Wales (Betsi Cadwaladr University Health Board, 2015). Alcohol consumption is associated with many chronic health problems including: mental ill health; liver, neurological, gastrointestinal and cardiovascular conditions; and several types of cancer. It is also linked with injuries and poisoning and social problems including crime and domestic violence (Public Health Wales, 2016a).

Alcohol also affects the poorest the most, with alcohol-related mortality in the most deprived areas much higher than in the least deprived.

Although alcohol consumption is gradually declining, more than 40% of adults in North Wales self-report drinking above guidelines on at least one day in the past week. Flintshire has the highest proportion of adults aged 16 and over reporting drinking above guidelines on at least one day in the last week, 42%, followed by Denbighshire, 41%, which are just above the averages for North Wales, and Wales, (40%). In Gwynedd, 40% of adults report drinking above recommended guidelines and the Isle of Anglesey, Conwy and Wrexham have the lowest proportions across the region, 38% (Welsh Government, 2016).

Chronic conditions

Chronic conditions are generally those which cannot be cured, only managed; they can have a significant impact for individuals, families and health and social care services (Jones *et al.*, 2016).

It is estimated that around a third of adults in Wales are currently living with at least one chronic condition. Evidence from GP practice registers in North Wales confirms a figure slightly higher than this.

Table 4.4 shows the number and percentage of GP practice patients registered as having a chronic condition (Jones *et al.*, 2016). The Isle of Anglesey has the highest percentage of patients registered as having a chronic condition (39%) and Gwynedd has the lowest (33%). Hypertension is the condition with the highest number of patients on the register.

Table 4.4 Number and percentage of GP practice patients registered as having a chronic condition, 2012

	Anglesey		Gwynedd		Conwy		Denbighshire		Flintshire		Wrexham	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Hypertension (a)	10,910	16	18,560	15	19,320	17	16,330	16	22,970	15	23,050	16
Asthma	4,950	7	8,220	7	7,390	6	6,410	6	9,920	7	9,970	7
Diabetes	3,490	5	5,470	4	5,460	5	4,910	5	5,890	4	5,790	4
CHD (b)	3,050	5	4,660	4	2,670	2	3,150	3	3,120	2	3,400	2
COPD (c)	1,780	3	2,660	2	5,980	5	5,460	5	7,390	5	6,900	5
Epilepsy	450	1	870	1	890	1	800	1	900	1	1,080	1
Health failure	800	1	1,220	1	1,220	1	1,040	1	1,210	1	1,290	1
Total	25,460	39	41,660	33	42,900	37	38,100	38	51,400	35	51,480	36

Notes:

(a) High blood pressure

(b) Coronary heart disease

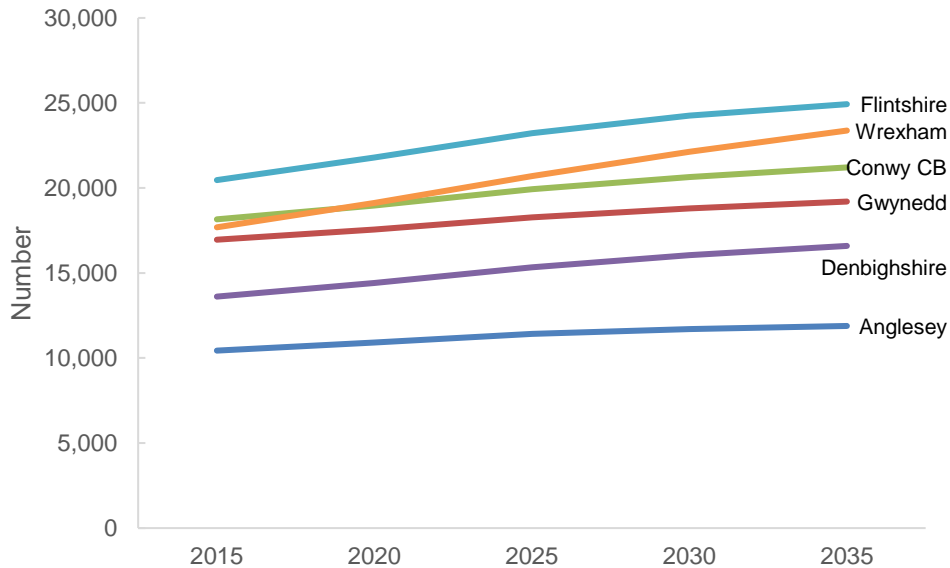
(c) Chronic obstructive pulmonary disease: a group of lung conditions that make it difficult to empty air out of the lungs because airways have been narrowed

Source: Public Health Wales Observatory

While these are common conditions, there are many other long-term conditions which can have a significant impact on a person's ability to participate fully in society and on their general well-being. These include neurological conditions, cancer and the impact of disease such as stroke. More detailed data on specific conditions can be obtained from local councils or the health board. However, for the purposes of this chapter, we have focused on a summary of the general issues that affect well-being. It is what matters to the individual that should be taken into consideration.

The number of people living with a limiting long-term illness is predicted to increase by nearly 22% over the 20 year period to 2035, shown in Figure 4.2. Much of the increase will arise from people living to older age.

Figure 4.2 Predicted number of people aged 18 and over with a limiting long-term illness, 2014 to 2035

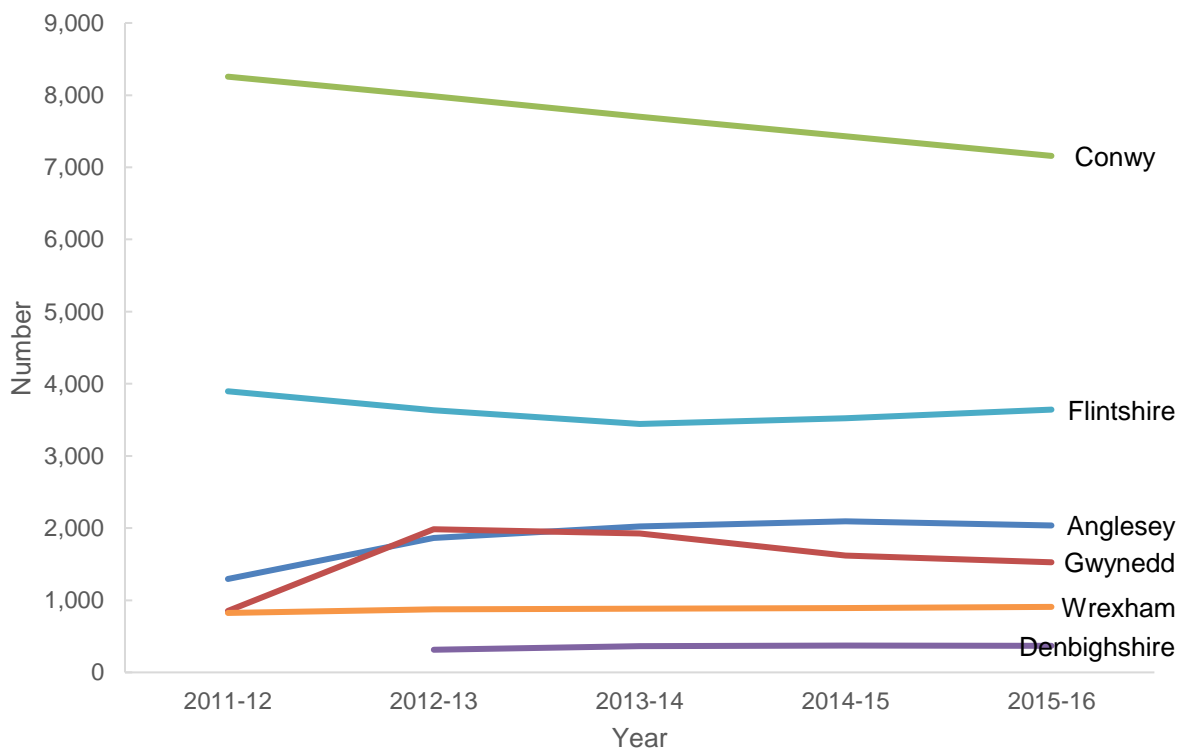


Source: Daffodil (Prevalence rate from taken from the Welsh Health Survey 2012, table 3.11 Adults who reported having illnesses, or limited by a health problem/disability; pop base from WG 2011-based population projections)

Physical disability

Some information concerning physical or sensory impairment (but without visual impairment) is held on local council registers as shown in Figure 4.3. The wide variation in numbers suggests the data is incomplete.

Figure 4.3 Physically/sensory disabled people without visual impairment



Source: Local authority register of persons with physical or sensory disabilities (SSDA900) data collection, Welsh Government

Sight loss, blindness and partial sight loss

Visual impairment is when a person has sight loss that cannot be corrected using glasses or contact lenses (Jones and Atenstaedt, 2015). The National Eye Health Epidemiological Model (NEHEM) estimates using 2011 census population data are shown in Table 4.5. This shows that the estimated prevalence of all vision impairment and low vision in the population aged 50 years and over was slightly higher in North Wales than the all-Wales estimates; the estimated prevalence of severe sight impairment was the same in North Wales as in Wales.

Table 4.5 Estimated prevalence of vision impairment, based on 2011 population estimates, persons aged 50 and over

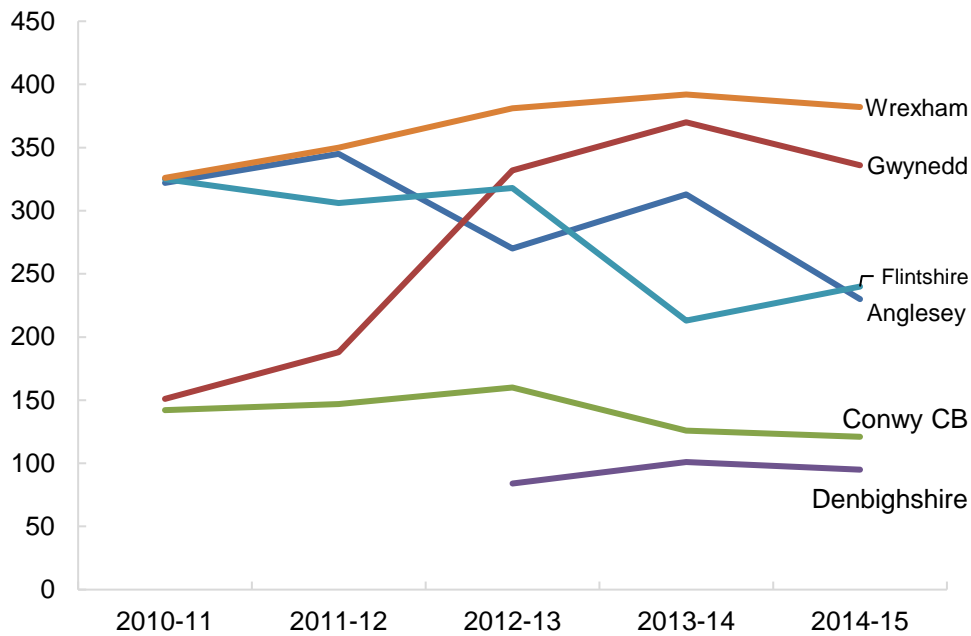
	Impaired vision		Low vision		Severe sight impairment	
	Count	%	Count	%	Count	%
Anglesey	1,320	4.3	1,120	3.7	200	0.6
Gwynedd	2,190	4.5	1,860	3.8	330	0.7
Conwy	2,540	4.8	2,150	4.1	390	0.7
Denbighshire	1,660	4.3	1,420	3.6	250	0.6
Flintshire	2,180	3.8	1,870	3.2	320	0.6
Wrexham	1,930	4.0	1,650	3.4	290	0.6
North Wales	11,830	4.3	10,070	3.6	1,780	0.6
Wales	48,110	4.1	40,960	3.5	7,190	0.6

Counts have been rounded to the nearest 10 persons

Source: Produced by Public Health Wales Observatory, using NEHEM

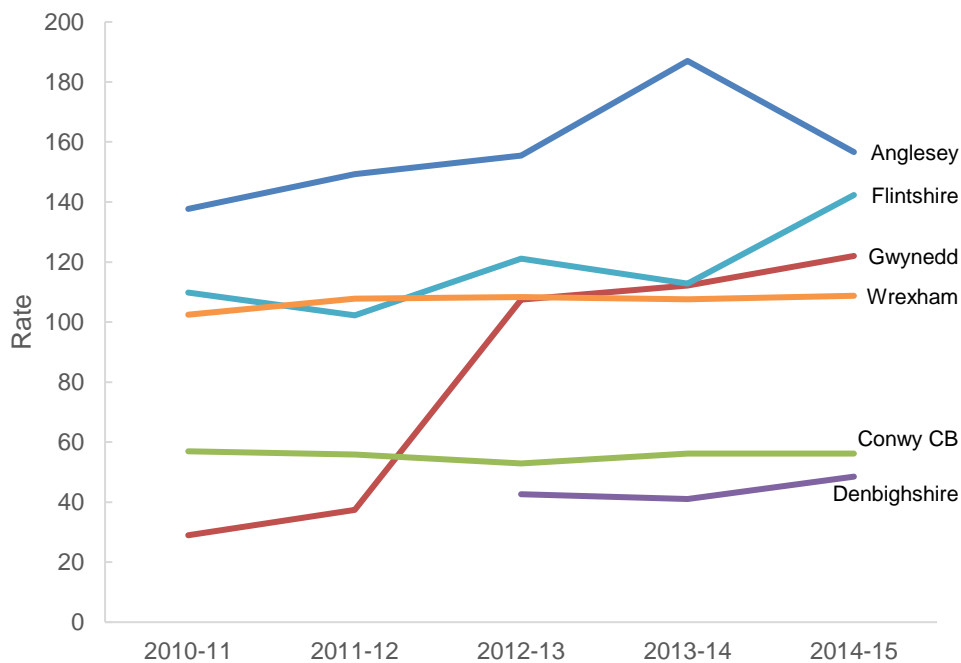
The numbers of people with sight impairment or severe sight impairment can be estimated from the registers held by social services (trend charts are shown in Figure 4.4 and Figure 4.5 respectively). Both charts show the rate per 100,000 population. However, these figures are likely to be underestimates as they rely on self-referral.

Figure 4.4 Number of people with sight impairment



Source: Local authority register of persons with physical or sensory disabilities (SSDA900) data collection, Welsh Government

Figure 4.5 Severely sight impaired people aged 18 to 64, rate per 100,000 population



Source: Local authority register of persons with physical or sensory disabilities (SSDA900) data collection, Welsh Government

The number of people who are newly certified as severely sight impaired and sight impaired is also a useful source of information. This helps us understand the incidence of sight loss.

The total numbers of newly certified visually impairments (CVI) and rates per 100,000 population is shown in Table 4.6 below. There were 267 CVIs issued in total in 2014/15. This represents a decrease on the previous year (324 issued in 2013/14.)

The percentage of people living with sight loss compared to the overall population is however projected to increase from approximately 3.73% in 2016 to 4.92% by 2030 (Welsh Government, 2016).

Table 4.6 Number of people newly certified Severely Sight Impaired and Sight Impaired by age group, 2014-15

	Total number of Certificates of Vision Impairment (CVI)	Rate of CVIs due to age related macular degeneration in those aged 65+ per 100,000 population	Rate of CVIs due to glaucoma in those aged 40+ per 100,000 population	Rate of CVIs due to diabetic eye disease in those aged 12+ per 100,000 population
Anglesey	27	98	12	2
Gwynedd	47	98	12	2
Conwy	45	98	12	2
Denbighshire	36	98	12	2
Flintshire	59	98	12	2
Wrexham	53	98	12	2

Source: RNIB Sight Loss Data Tool

- 149 CVIs due to age related macular degeneration were issued to those aged 65+.
- 45 CVIs due to glaucoma were issued to those aged 40+.
- 15 CVIs due to diabetic eye disease were issues to those aged 12+.

Deafblindness

The term deafblind covers a wide range of different conditions and situations. We use this term for the purposes of this assessment to mean people who have ‘sight and hearing impairments which, in combination, have a significant effect on their day to day lives’.

Deafblindness is also known as dual sensory loss or Multi-Sensory Impairment. People who are deafblind include those who are congenitally deafblind and those who have acquired sensory loss. The most common cause however is older age.

Deafblindness can cause problems with communication, access to information and mobility. Early intervention and support provides the best opportunity of improving a person’s well-being (Sense, 2016).

Estimates of the number of people with co-occurring vision and hearing impairments suggest that by 2030, in the region of 1% of the population of North Wales will be deafblind. The proportion of deafblind people increases significantly with age.

Health inequalities

Recent research has reinforced earlier evidence of the link between socio-economic deprivation and health inequalities. We know, for example, that there are significant differences in life expectancy and in the prevalence of limiting long-term illness, disability and poor health between different socio-economic groups (Public Health Wales, 2016a).

People living in the most deprived communities experience more years of poor health and are more likely to have unhealthy lifestyles and behaviours than people in the least deprived communities. As a result, the most deprived communities experience higher levels of disability, illness, loss of years of life, productivity losses and higher welfare dependency (Public Health Wales, 2016a).

Black and minority ethnic groups are often more at risk of conditions such as glaucoma and may not access health messages due to language or cultural barriers.

Mental and emotional well-being

Older people with sight loss are almost three times more likely to experience depression than people with good vision and the British Medical Journal reports that sight loss is one of the top three causes of suicide among older people (Waern *et al.*, 2002).

Nearly half of blind and partially sighted people feel “moderately” or “completely” cut off from people and things around them (Pey *et al.*, 2006).

Depression in adults with a chronic physical health problem is well recognised and there is a significant amount of evidence on effective care and support. As well as management and treatment, the evidence supports the positive impact of information provision, group physical activities and support programmes (NICE, 2012).

Accessible Healthcare

In May 2013 the Minister for Health and Social Services wrote to all health boards introducing the All Wales Standards for Accessible Communication and Information for People with Sensory Loss. The purpose of the standards is to ensure that the communication and information needs of people with a sensory loss are met when accessing healthcare services. Effective and appropriate communication is fundamental to ensuring services are delivered in ways that promote dignity and respect. The evidence also demonstrates that ineffective communication is a patient safety issue and can result in poorer health outcomes. The standards have informed the objectives of the health board’s objectives within the Equality and Human Rights Strategic Plan (BCUHB, 2016).

Housing needs and homelessness

People living in the most deprived areas have higher levels of hearing and visual impairment, and also long-term health problems, particularly chronic respiratory conditions, cardiovascular disease and arthritis (Public Health Wales, 2016b). People in these areas also may be living in poor conditions.

Housing has an important effect on health, education, work, and the communities in which we live. Poor quality housing, including issues such as mould, poor warmth and energy efficiency, infestations, second-hand smoke, overcrowding, noise, lack of green space and toxins, is linked to physical and mental ill health as well as costs to the individual, society and the NHS in terms of associated higher crime, unemployment and treatment costs (Public Health Wales, 2015). Health problems associated with these issues include respiratory problems, depression, anxiety, neurological, cognitive, developmental, cardiovascular and behavioural conditions, cancers, poisoning and death (Public Health Wales 2016a).

Dealing with hazards such as unsafe stairs and steps, electrical hazards, damp and mould growth, excessive cold and overcrowding, cost around £67 million per year to the NHS in Wales (Public Health Wales, 2015). The wider cost to society, such as poor educational attainment and reduced life chances were estimated at £168 million a year. It was estimated that the total costs to society could be recuperated in nine years if investment was made to address these problems (Public Health Wales, 2016).

Adaptations to housing can help maintain or regain independence for people with physical disability or sensory impairment. There are a range of initiatives which can assist with housing adaptations, some provided through local councils and some through third sector support agencies.

Extra care housing schemes can give a balance between living in a person's own home and having on-site dedicated care and support if needed. Residential and nursing care provides accommodation with trained staff on hand day and night to look after a person's needs.

Inclusive design and planning requirements

Inclusive design aims to remove the barriers that create undue effort and separation. It enables everyone to participate equally, confidently and independently in everyday activities. Inclusive design is everyone's responsibility. This is an important consideration in the development or redesign of facilities and services.

Meeting access needs should be an integral part of what we do every day. We should use our creativity and lateral thinking to find innovative and individual solutions, designing for real people. By designing and managing our environment inclusively, difficulties experienced by many – including people

with a disability or sensory impairment, but also older people and families with small children – can be reduced. Everyone will benefit.

The Design Council sets out five key principles for inclusive design which should be borne in mind which can help achieve an environment that is fit for everyone (Design Council, 2006). They include placing people at the heart of the design process; acknowledging diversity and difference; offering choice; provide for flexibility in use; provide buildings and environments that are convenient and enjoyable to use for everyone. The commitment to overcoming barriers to participation should include using these principles in designing and developing services and in commissioning them from others.

4.3 What are people telling us?

Feedback from service user engagement

Feedback from services users related to two main themes – challenges and unmet needs or gaps in provision.

Challenges

- There is a lack of awareness about safety and access issues for people in local towns and communities (for example, when people park on pavements, it can be dangerous.)
- There still seems to be a lack of understanding and prejudice towards people with disabilities
- Worries that services will be lost because of cuts; when you have a disability like being Deaf, it is a lifelong disability and needs lifelong support. If a service stops, where will people get support?

Unmet needs or gaps in provision

- Transport is difficult for people with disabilities particularly if you use public transport. Very often people who work on public transport don't understand your disability and as a result can be unhelpful and not know how to offer support.

'For example, I think all people who work in public transport should have disability awareness training and have basic sign language'

- There is not enough awareness across council departments in transport, highways, leisure and environment services. It was felt that very often they develop things without thinking about people with disabilities and as a result it means buildings are often inaccessible, pavements do not have drop kerbs, people who are Deaf or blind aren't given provision to communicate or use the service.
- People need to be involved more and listened to.

'I have an idea of how to support the council in recognising dangerous potholes for disabled people and if I had the opportunity to speak with someone from the right department I could help, but I don't think people's skills are used enough to help solve local authority issues.'
- Criteria are getting tighter and it is more difficult to get a service.
- If you do not meet the criteria for services it is difficult to afford to buy for yourself; things are expensive such as equipment and specialist services.
- There are no Deaf specialist care homes or sometimes even care homes that have staff that are trained in sign language, so any people there that are Deaf cannot communicate properly.
- Waiting times to get support or to get things done can be too long.

Additional issues raised included the following:

- It is important communities and people are linked more with services so that they can be asked about what they think.
- People with disabilities don't always feel safe in communities and that is often because other people don't understand the challenges they face. Awareness about the simple issues needs to be raised so that individuals can consider people with disabilities in what they do.

Feedback from the general public including the citizen's panel

Concerns about maintaining your way of life

- The most common concern was maintaining independence, social and leisure activities.
- Accessing services, particularly in rural areas – one respondent commented: 'I've often wondered how I will cope once I am no longer able to drive'.
- Concerns about money and finances, often linked to being able to continue with employment and education – particularly among people who had moved to the UK to work or who had physically demanding jobs.
- A number of people were concerned about how they would access support in an emergency, if living on their own.

What would be important to you?

- Maintaining independence was important to many respondents, including cooking, housework and getting out and about.
- Maintaining social and community involvement was also important, with social groups and clubs and with family.
- Care and support to avoid long stays in hospital.

What do you think could support you?

- About half of respondents said they had no one to support them – for some, this was because their partner or other family member had care and support needs of their own.
- Others said their partner or family would support them – although most people referred to limits on the amount of help they could expect or wanted to ask for.
- Many people referred to support from social care or health care staff.
- A smaller number of people mentioned friends but with similar concerns about how much support they would ask for.
- Local community or volunteers were mentioned by a few.

What support needs do you think may be harder to meet?

- The most frequently mentioned needs related to independence or help with daily living.
- Many also mentioned the difficulty of preventing social isolation and loneliness and for some this was linked with mental and emotional health and well-being.

Feedback from organisations

The reality of loneliness, isolation and feelings of worthlessness and vulnerability, particularly for recently diagnosed individuals, are often exacerbated by loss of employment, economic independence, mobility and self-esteem, and sometimes over time by the breakdown in relationships and the collapse of the family unit.

Supporting people to live with illness and disability in their own homes is really important. Some of the commissioned service providers find it a challenge due to the lack of time allocated for the service delivery in the home. There is also the challenge with how to support people at the time they want and the frequency they want and most often the problem is a lack of funding.

The provision of short term care following surgical procedures was raised as a concern. Problems with access to help, advice and support or care in time of crisis including access to equipment were reported. Supporting people to manage medication administration after surgery or to treat a chronic condition is very important. There is a need for basic logistical issues to be overcome, for example, people can no longer drive or manage their lives through their disability. Transport can be an issue, especially if there are special needs, such as wheelchairs.

Some organisations find the processes in health and social care too complex, which create barriers even where solutions are simple.

Concerns were raised that there does not seem to be an adequate volume of service opportunities to meet the current need in some areas of treatment, which means we may fail to see people in a timely manner. Access to timely interventions and support is what often works best. Delays in accessing care may have a negative physical and emotional effect on patient's lives.

It was reported that historically there has been very little direct NHS support available for people with a long term neurological condition, and what little support there is, is in fact shrinking. A lack of appropriate signposting by health professionals to ongoing support has meant that people have had to find their own way to deal with their condition. For many this is a challenge.

There were concerns that mainstream healthcare funding does not represent the true cost of health services. Meaningful engagement with the health board was perceived to be lacking.

Fair Treatment for the Women of Wales identified a number of issues that their members had identified and that they were able to provide some support with, including:

- Not being taken seriously by clinicians and physical pain not being adequately treated or difficult to access specialist support, for example, women face a diagnostic delay of (on average) 8 years for endometriosis. Symptoms may also not be taken seriously at school or work.
- Lack of support for with fertility issues, accessing mental health services in North Wales is difficult, with waiting times being excessive. Finding alternative sources of support can be challenging, with many women not knowing where to turn.
- Lack of up-to-date information and support from health services – need better signposting from GPs and hospitals, for example, to help with challenges from early menopause
- Challenges maintaining lifestyle and feeling included - relationships with family and friends, social isolation, lack of money, practical support.

4.4 Review of services currently provided

A wide range of care and support services is in place across North Wales to support people with long-term health needs, physical disability or sensory impairment. In all areas, current and future service models focus on early intervention, prevention and reablement; supporting people to remain independent and ensuring people are protected.

Priorities include:

- Enabling people to make best use of informal networks of support
- Further developing the use of telecare and other technology
- Supporting people to experience a greater level of privacy and independence
- Actively enabling people to have a greater community presence (the potential development of community based initiatives such as time banks and social enterprises)
- Taking active steps to encourage progression and promote independence
- Supporting people to take greater control over their support
- Focusing on outcomes and well-being

Prevention and self-management

People should be encouraged and enabled to look after their own health and well-being. We cannot assume that everyone has the personal resources or assets to be confident and knowledgeable in doing so.

The Self Care Forum Manifesto (2015) describes “four pillars of engagement” that can help people have the tools and resources they need to be confident in looking after themselves:

- Lifelong learning: provide education and personal resources at every stage of life to encourage self-care and empowerment
- Empowerment: promote the use of health and care services as a way of supporting personal and home care decisions, blurring the lines between patient and professional
- Information: provide reliable, consistent information, evidence based where possible, to support confident decision-making
- Local and national campaigns: use national and local campaigns to focus on a rolling programme of education with consistent messages

Giving people the information and tools to make positive lifestyle choices and self-care is an essential step to help maintain good health and prevent illness.

This also reinforces the protective factors for well-being, which include feeling in control.

Protecting people from tobacco, warning people about the dangers of tobacco, enforcing bans on tobacco advertising and raising taxes on tobacco are all very cost effective interventions for reducing the prevalence of smoking (Public Health Wales, 2016).

Evidence shows that reducing salt intake promoting public awareness about diet restricting marketing of food and beverages to children and managing food taxes and subsidies are very cost effective in promoting healthy diet and preventing obesity (Public Health Wales, 2016).

'Best buys' to increase physical activity include mass media campaigns supporting active travel brief intervention for physical activity in primary care and promoting physical activity in workplace, schools and communities (Public Health Wales, 2016).

Evidence shows that brief advice on alcohol in primary care is cost effective; every £1 spent on motivational interviewing and supportive networks for alcohol dependence returns £5 to the public sector. Also, introducing a minimum unit price of 50 pence per unit of alcohol would save 53 deaths and 1,400 hospital admissions per year in Wales, with the greatest impact in the most deprived communities and heaviest drinkers (Public Health Wales, 2016).

Tackling the causes of social and economic inequalities that drive health inequalities is likely to be most effective. This may include interventions to ensure a living wage, reduce unemployment, improve the physical environment and provide universal services (accessible to all) while also investing additionally to support vulnerable groups.

Preventing ill health across the population is generally more effective at reducing health inequalities than a focus on clinical interventions (Public Health Wales, 2016a)

Investing in insulation and heating to address cold and damp housing could return savings of nearly £35 million for the NHS in Wales.

Treating public finances as a public health issue could mitigate austerity measures, such as monitoring the impact of all economic and welfare reforms on the public services and public health (Public Health Wales, 2016a). This could be done through using Health Impact Assessment.

Making Every Contact Count

Making Every Contact Count (MECC) is an approach to behaviour change that uses day-to-day interactions that organisations and staff have with people to support them in making positive changes to their health and wellbeing. MECC

enables the opportunistic delivery of consistent and concise healthy lifestyle information and enables individuals to engage in meaningful brief intervention conversations about their health and wellbeing.

Lifestyle factors such as smoking, alcohol, diet and physical activity are some of the biggest contributors to poor health and a major cause of many preventable deaths and illnesses such as heart disease, stroke, type 2 diabetes and some cancers. Evidence suggests that the adoption of a MECC approach across health and care could potentially have a significant impact on the health of our population.

For organisations MECC means providing their staff with the leadership, environment, training and information they need to deliver the MECC approach.

For staff MECC means having the competence and confidence to deliver healthy lifestyle messages, to encourage people to change their behaviour, and to direct them to local services that can support them.

For individuals MECC means seeking support and taking action to improve their own lifestyle by making healthy lifestyle choices and looking after their health and wellbeing.

Information, Advice and Assistance

The Social Services and Well-being (Wales) Act 2014 brings new duties for local councils and the health board to work together to ensure the provision of Information, Advice and Assistance.

In North Wales the six councils and the health board have been working together to develop a Single Point of Access in each county to provide a contact point for people and service providers.

The partner organisations have also contributed to the development of the Dewis Cymru website (www.dewis.wales) Dewis Cymru is the website to use for people who want information or advice about well-being – or want to know how to help somebody else.

The information covers well-being in general, not just health, but including things like where people live, how safe and secure they feel, getting out and about, and keeping in touch with family and friends. No two people are the same and well-being means different things to different people. Dewis Cymru is intended to help people find out more about what matters to them.

Social prescribing

Social prescribing is a means of enabling primary care services to refer patients with social, emotional or practical needs to a range of local non-clinical services, often provided by the voluntary and community sector.

A review of evidence found that suitable referrals to social prescribing initiatives are vulnerable and at risk groups such as: people with mild to moderate depression and anxiety; low income single parents; recently bereaved older people; people with long term conditions and frequent attendees in primary and secondary care (Kinsella, 2015). Social prescribing has been described as having the potential to improve mental health, reduce demand on statutory services, improve community wellbeing and resilience and reduce social exclusion

Social prescribing has the potential to become fully integrated as a patient pathway for primary care practices and to strengthen the links between healthcare providers and community, voluntary and local authority services that could promote health and well-being. These include leisure, welfare, education, culture, employment and the environment. According to (Kinsella, 2015), the evidence on the impact of social prescribing is currently limited and inconsistent. Some initiatives have shown improved outcomes for patients and potential for cost-savings (in the longer term), but few have been subject to economic analysis or rigorous evaluation. For this reason, (Kinsella, 2015) recommends that any new social prescribing initiatives should aim to add to the current evidence base and conduct transparent and thorough evaluation. This includes addressing the questions of when, for whom and how well does the scheme work? What impact does it have? What does it cost? Is it cost-effective?

Domiciliary (home) care

Short term reabling domiciliary care is provided to support new service users or those people who need active reablement support. Longer term domiciliary care should be outcome focused, focusing on what matters to the person. In some rural areas there are challenges to providing domiciliary care because of the low, dispersed levels of demand. See older people chapter for more information.

People can be supported to use Direct Payments to purchase their own support, enabling people to have more choice and control.

Day services

Day services have in the past been somewhat traditional and limited in the variety of activities available. The desired service model is the provision of services that meet the assessed needs of people and help them meet their goals. Community based personalised support, offering a broad range of affordable and accessible activities close to people's homes can be provided to meet the needs of individuals better.

Occupational Therapy Services

Occupational therapy promotes independence through assessment of need, advice on the provision of specialist equipment and adaptations. Occupational therapy can also assist to carers to continue to care safely, for example through advice or provision of equipment or adaptations.

Telecare and assistive technology

Technology provides an opportunity for an inter-connected society – and in terms of care and support, a society where planning, managing and delivering care could be fully integrated.

Telecare is a service that can help reduce the risks associated with independent living by using wireless devices linked from a person's home to a monitoring and response centre. Sensors can be used to monitor the home environment and enable assistance to be summoned in the event of an emergency.

There are opportunities for use of technology in supporting health and healthcare through telehealth and telemedicine. Telehealth enables remote monitoring of health conditions (such as blood pressure) and telemedicine can support remote consultation and diagnosis, to prevent the need to travel to an appointment.

Introduction of equipment may not of itself be sufficient. The Good Governance Institute (2016) noted that “success depends on changing how the public think about their [health and healthcare]. They continue that “for each local pathway of care, and to further support patients with a chronic illness, a wholesale redesign is required if new technology is to deliver promised benefits”.

Respite and short term breaks

Respite or short breaks can provide carers with support and breaks away from their caring role. This can help to maintain independent living for a person with long term conditions, disability or sensory impairment. Increasingly, innovative ways of providing support are being used, such as participation in local groups for daytime activities. More traditional respite services in a residential setting or sitting services can be delivered to the cared for person to provide carers with a break from the caring role. More information is given in the chapter on carers.

Residential and nursing care

The number of people being supported by health and social services to move into care homes has been reducing over time, as support to live at home has improved and more people have the funds to make decisions to move into care homes without statutory funding. As people are better supported to live at home, people are moving into care homes at a later age, so the length of time that people live in care homes ('length of stay') is reducing (in May 2016, this

was on average 25 months) but the needs of people living in care homes are increasingly complex. See the older people chapter for more information.

For adults with long-term needs, physical disability or sensory impairments, it is those who have more complex needs and so need more specialist support who may need residential or nursing care. There are shortages in current provision of specialist residential and nursing care in some areas of North Wales. These may result in some people being placed outside of their home area and potentially outside of North Wales for very specialist care. This may have an adverse impact on their carers, families and friends in terms of increased travelling. Joint approaches to developing the market and commissioning specific services will need to be taken forward.

Extra care housing

The development of Extra Care Housing has provided alternatives to residential care for some people in North Wales; with some units specifically catering for people with dementia in Extra Care. There were 252 people living in extra care in North Wales in 2015.

All extra care schemes within North Wales have been developed to meet lifetime home standards – offering accessible facilities such as level access showers, hi-lo baths with ceiling hoists and wheelchair / mobility scooter storage. Eligibility criteria for the schemes require prospective tenants to have housing related and/or eligible social care needs. Schemes are available for people aged from 55 years - criteria are developed locally. Some offer accommodation for people aged 60 or 65 and over.

Universal health care and support services

Care closer to home is currently somewhat fragmented and often provided by small teams. Evidence suggests that there is variation in quality and outcomes and provision should be able to deliver more consistently at the population level.

There is a wide range of literature on different models in primary and community services which will be reviewed further, together with examples from other areas and other countries to learn what works well and how this could be applied in North Wales. We will seek expert external support and advice in doing so in the next stages of the Care Closer to Home strategy development.

A review of evidence undertaken by Public Health Wales identified models of primary care in other countries, to help understand what great primary care would look like within a holistic integrated health and social care system (“Primary Care In Wales: Rapid review of models and policy”, Public Health Wales, July 2014.) This review found evidence in relation to structure (how we run the system), process (how we provide the service) and outcomes (health and well-being, citizen experience and value for money). Overall messages include the following:

- This is a pivotal time for health care systems globally: the financial crisis has galvanised scrutiny of the value we gain from our investment in health care systems and there is an emerging consensus that current models are not financially, or otherwise, sustainable.
- There is also an emerging consensus that a shift to primary care and population-based approaches are the way forward to improve health and reduce inequalities in health outcomes. Wales is well placed to build on developments to date around GP clusters and wider community services within integrated health boards.
- Primary care teams should include a wider range of members with greater integration with secondary care and social care, including navigation and coordination of a greater range of services.
- Clear outcomes should be the focus of any new model or policy, using a framework for quality primary care such as that advanced by (Kringos, 2010).
- Models of provision characterised by Community Oriented Primary Care principles and citizen engagement are likely to be the most transferable to the Welsh context, as are approaches tailored to tackling the Inverse Care Law and to co-production of health.

The **National Plan for a Primary Care Service for Wales (2015)** asserts that people should receive the majority of advice, investigation, diagnosis, treatment and care in flexible ways and in flexible facilities, delivered by a range of professionals and others, at or close to home, making effective use of modern technology. The care should be responsive and proportionate to the needs and circumstances of each individual and agreed with them through a care plan.

A recent review of the evidence on **moving service into the community** (Policy Research Unit, 2014) suggested that initiatives to improve community based care should be allowed to develop from the bottom up and that no particular ownership model is better than others, although fragmentation of providers may make service provision more difficult. Good multidisciplinary team working depends crucially on communication. Aligning the populations covered by different services may help (which is already the case in North Wales). It also highlighted the lack of information about community service providers in the UK makes it very difficult to gather evidence about cost, required workforce mix or cost effectiveness.

Specialists, who are traditionally hospital-based, can play a greater role in supporting primary care services to care for people close to home and share accountability for population health improvement. Hospital based staff will provide much more specialist support to primary care by phone, email, virtual review, video call, and telemedicine technology and in local clinics. Health

boards will also agree with the Welsh Ambulance Service how paramedics can help to deliver more care at home and in the community.

The **Community Hospitals Strategy Refresh written by the Scottish Government (2012)** evidenced that community hospitals provide clinically effective services that improve the outcomes for patients and support the delivery of services closer to home. The main challenge for NHS Scotland has been to ensure that community hospitals are fully aligned and linked to the wider delivery of services within NHS Board areas. In order to make full use of these valuable resources, it is vital that community hospitals are as effective as possible at delivering pathways of care and have clear links with the broad range of services provided by the NHS and its Partners and in particular, acute hospitals, care homes and social care services.

We know about a third of adults say they find it difficult to make a convenient appointment with a GP. This is reflected in the feedback from the listening exercises referenced earlier in the document. The Welsh Government has made a number of commitments to improve access to a primary care service in the evening and Saturday mornings for working people. Not everyone who seeks an appointment at their GP practice needs to be seen by a GP. Their health and well-being needs may be appropriately met by seeing another health professional, such as a nurse, a pharmacist, and optometrist. Educating the public about when and how to get the right care from the right person at the right time is an important function of primary care clusters, health boards and the Welsh Government as this plan is implemented.

Flexible access refers to a range of different ways of receiving care from the right professional; this might be face-to-face in the surgery or clinic; by phone; online; through remote monitoring of care using telehealth and telecare equipment or using telemedicine to access specialist advice from others such as hospital-based professionals; making appointments; ordering repeat prescriptions and accessing GP held health records online.

More people will be encouraged to use 'My Health OnLine', which allows people to book GP appointments and order repeat prescriptions. This service will be further developed to include online access for people to their GP held health records with its clinical information from their hospital appointments or admissions, including discharge advice and information.

Flexible facilities mean using each community's assets to deliver a much wider range of care from different professionals. As well as more services being offered in GP surgeries, community pharmacies, dental practices and optometry practices, we want to see much more use made of local community facilities like leisure centres, community centres, supermarkets, the high street and shopping centres and will work with partners to identify opportunities to do so.

Carers, including people working in care homes, should feel well informed and supported in meeting the needs of their residents and to avoid inappropriate emergency admissions to hospital. Stronger links with primary care and the new 111 telephone service to access information, advice and assistance and access to primary care will support this.

Underpinning all of the approaches to development of new models for primary and community services must be greater integration across systems, with healthcare teams working with local councils, including social services, the third sector, independent and other statutory organisations. There is a growing body of evidence relating to effective integration of services which needs to be built upon in developing future action plans.

4.5 Conclusion and recommendations

Key messages

While all six local councils and the health board have committed to working to the social model of disability, there is much more work to be done to ensure that the way we work fully reflects this model.

The Social Services and Well-being (Wales) Act 2014 reinforces the need to think about the broader aspects of well-being in a person's day to day life and the ability of a person to participate fully in society.

Focusing on what matters to an individual will help us address the broader aspects better. We will need to work in partnership with people, their families, the third sector and independent providers as well as other public services to achieve this.

The number of people living with a long term condition and the number of people living longer with disability or a sensory impairment is increasing as our population lives longer and the number of older people increases.

We will need to review our organisational priorities and commissioning plans to ensure that we identify better ways of supporting participation and inclusion, and enabling people to maintain their own independence.

We need to focus more on earlier intervention and prevention – taking the actions that the evidence tells us will help people stay healthier and more independent for longer.

We will need to review the more specialised services we provide to ensure that people are able to receive the support they need at the time they need it.

Gaps in service / support

Support for people to live healthier lifestyles and maintain independence is identified as one of the key elements. More emphasis needs to be placed on this by all organisations.

The role of the third sector and independent sector is identified as important in providing broader support networks for people. Organisations need to be mindful of the capacity of these sectors to extend the support they offer.

Some services are sparse in different areas; rural areas have been identified as experiencing shortfalls in provision.

Many of the public sector services are under pressure and while services are available, there may be a waiting list or difficulty in accessing services promptly.

There are barriers for specific groups which need to be addressed – when seeking information, accessing services, or seeking to maintain independence, with support as needed.

Our response

We will seek to collaborate in the design and implementation of effective health improvement programmes with the support of Public Health Wales.

We will aim to give a senior level strategic commitment to implement and embed a sustainable approach to the Making Every Contact Count (MECC) programme in North Wales, providing a culture which encourages and promotes prevention and health improvement.

We will explore the option of using social prescribing as a patient pathway for primary care practices in North Wales to strengthen the links between healthcare providers and community, voluntary and local authority services that could improve health and well-being.

We will take an assets-based approach, identifying what matters to people and supporting them to take control of their lives. We will work with people and the communities in which they live to build on the resources available and support people to connect.

We will seek to strengthen further the social model of disability in all that we do, looking to ensure that our support and our services facilitate participation, respect individual wishes and needs and are inclusive.

We will review the need for our more specialised services to provide care closer to home where possible.

Equality and human rights issues

This chapter raises a number of issues relating to needs which can disproportionately affect people from marginalised groups. These include many who share protected characteristics.

The core factors that influence well-being include promotion of social inclusion. It is known that groups who share the protected characteristics are more likely to experience social exclusion and this will need to be factored into the assessments for individuals.

There may be other issues affecting groups of people who share protected characteristics which have not picked up by this assessment. We would welcome any further specific evidence which may help inform the final assessment. This could be addressed in future population assessment reviews, in the development of the area plan which will follow this assessment, or in the services developed or changed in response to the plan.

Services for people with a long-term health need, physical disability or sensory impairment must take a person-centred approach that takes into account the different needs of people with protected characteristics.

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