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Executive summary

Introduction

This chapter considers Physical and Sensory Impairment (PSI) in adults aged 18-64.

Defining disability is complex and contentious. The "social model" and the "medical model" define two distinct models. The Government encourages the use of the social model which states that disability is created by barriers in society including the environment, people's attitudes and organisations. The medical model, in contrast, is based on a belief that disability is caused by an individual's health condition or impairment (HM Government, 2015). Most analysis tends to use limiting longstanding illness as the core definition although it should be recognised that limiting longstanding illness covers limitation at any level on activities of any kind whereas disability covers a specified set of activities, therefore prevalence of longstanding limiting illness is higher than disability (Public Health Action Support Team, 2011).

The definition of disabled as defined in the Equality Act 2010 includes those who have a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on your ability to do normal daily activities. The term 'disabled' is used interchangeably in this chapter to include both those with physical and sensory impairments.

The term 'physical impairment' refers to people who have one or more physical impairments. These impairments may be congenital or acquired at any age, be temporary, long-term, or fluctuating. People with physical impairments may often have unique & multi-dimensional requirements. They therefore require tailored services to address them all in a person-centred holistic fashion.

The term 'sensory impairment' encompasses visual impairment (including citizens who are blind and partially sighted), hearing impairment (including those who are profoundly deaf, deafened and hard of hearing) and dual sensory impairment

(deafblindness). The deaf community may self-identify as ‘Deaf’ rather than ‘deaf’ to mean culturally deaf people who use sign language as their first language.

Sensory impairments may, like physical impairments, be congenital or acquired at any age. They are more prevalent with age as are additional sensory or other impairments. Most sensory impairments develop gradually and are often secondary to other disabilities.

Hearing loss and deafness is usually measured by finding the quietest sounds someone can hear using tones with different frequencies, which are heard as different pitches. The person being tested is asked to respond, usually by pressing a button, when they can hear a tone and the level of the tone is adjusted until they can just hear it. This level is called the threshold. Thresholds are measured in units called dBHL: dB stands for 'decibels' and HL stands for 'hearing level'. Anyone with thresholds between 0 and 20 dBHL across all the frequencies is considered to have 'normal' hearing. The greater the threshold level is in dBHL the more significant the hearing loss.

Moderate deafness: People with moderate deafness have difficulty in following speech without a hearing aid. The quietest sounds they can hear in their better ear average between 35 and 49 decibels.

Severe deafness: People with severe deafness rely a lot on lip-reading, even with a hearing aid. British Sign Language may be their first or preferred language. The quietest sounds they can hear in their better ear average between 50 and 94 decibels.

Profound deafness: People who are profoundly will often use British Sign Language for communication which may be backed up with lip reading. The quietest sounds they can hear in their better ear average 95 decibels or more.

Commissioners should be sensitive to the use of these definitions in their work, and the language used, appreciating the contentious nature of applying ‘labels’ and also acknowledging the diversity of experiences and preferences within these groups.

The needs of carers, and people who live in care homes, are considered in separate chapters.

Please also refer to the literature review (available here) carried out by the knowledge resources team which includes more detailed information than can be included here.

Unmet need and gaps

1. We believe there are large numbers of people of working age with long term limiting conditions that limit their daily function to a substantial degree, which include those with physical and sensory impairments. An increase in the number of people working to an older age is likely to impact on this. It is acknowledged that not everyone self-declares disability and this can make quantification difficult.
2. People with physical disabilities or sensory impairments often experience a range of significant physical and psychological inequalities and consultation has shown that people often feel discriminated against.

3. A proportion of these inequalities are likely to be related to comparatively reduced opportunities to participate in education and training at all levels, which can lead to poorer employment outcomes. This suggests policies to support those in education and to keep/find employment would help to mitigate the effect on health inequalities.
4. In addition, this group experience a range of significant barriers in terms of accessing mainstream and specialist health, social and other (including leisure and employment) services and a lack in tailored or specific services for those in need.
5. There appears to be a disparity between the large number of people in 'need' and the relatively small number of people receiving services. A Health Equity Audit that defines inequities in the causes, access to effective services and outcomes for this population could add to the understanding of this.
6. The direct payments/personalisation/care act/prevention agenda is changing the landscape of care provision for this group.
7. At the same time there are significant funding reductions within the local authority.
8. It would be useful to investigate, perhaps through a health equity audit, whether there are any dimensions of inequity in terms of access to social care services (either commissioned or in house provision) for example are people from particular ethnic groups, or men as opposed to women, more or less likely to receive services?
9. A health equity audit of screening, cataract treatment and social care services would help to establish which groups are not accessing services and the extent of unmet need.
10. Consider carrying out a full health needs assessment on people with physical and sensory impairments in order to build a fuller picture to aid future planning- as need is only going to increase.
11. Understand the difficulties for people with physical and sensory impairments in accessing public services.
12. Improve data quality in disability recording, particularly within mental health services, in order that equity of access can be assessed.
13. The full impact of austerity measures on people with physical and sensory impairments remains to be seen and action should be taken to address the current impact.

Recommendations for consideration by commissioners

1. Progress strategies to reduce stigma and support people to self-declare and access services (particularly in underrepresented groups) in order that appropriate adjustments can be made.
2. Improve physical access to public buildings and transport to and from public service locations, placing particular focus on the Urgent Care Centre, Ropewalk House and the Queens Medical Centre (including expediting completion of works between the tram stop and the hospital).
3. Improve communication between services and service users through:
   a) Adhering to the NHS Accessible Information Standard through ensuring appropriate formats are used for written communication and that these needs are highlighted on people's records;

b) Developing alternatives to services reliant on telephone communication (particularly booking appointments); and
c) Increasing the availability of sign in screens, display screens and buzzers in waiting rooms and making sure that these systems are accessible for all.

4. Improve communication between services by, for example, sharing NHS Accessible Information Standard details between primary and secondary care.
5. Improve hospital environments to facilitate people with reduced mobility in terms of equipment that meets access needs and staff who are trained to use it.
6. Work with service providers to improve data quality in disability recording in terms of both status and access requirements.
7. Ensure disability awareness and equality training for health and social care professionals is regular enough to meet staff turnover.
8. Ensure Nottingham City Council maintains its commitment to the British Sign Language Charter.
9. Implement a holistic approach which recognises need as opposed to categories of diagnoses and allows adequate time for citizens with communication impairments to communicate with staff.

What do we know?

1) Who is at risk and why?

Who is at risk of having a physical or sensory impairment?

Poverty, being out of work, and low educational attainment are strongly predictive of the risk of developing disability (Burchardt, 2003), and can also be consequences of a physical or sensory impairment, resulting in a cyclical relationship. Survey data from the Office for Disability Issues (2012a) indicate that 19 year olds in 2009/10 with a disability were less likely to be in higher education than those without (33% and 41%, respectively), while Jenkins and Rigg (2003) found that disability brought an increased risk of poverty and unemployment. The additional costs associated with disability - from technological equipment to domestic help and travel costs (Hill et al., 2015) - can further compound this relationship.

The chance of having a long-standing illness or disability (LSI) is also positively associated with age. Office for National Statistics data (2015) show the self-reported prevalence of both LSI and limiting LSI in 2013 increased with age group, with those aged 75 and over more than four times as likely to have reported an LSI than those aged 16 to 24 (69% compared to 15%) and nearly six times as likely to have reported a limiting LSI (47% compared to 8%). In the GP Patient Survey 2012-2013, 11% of people aged 55 and over providing valid responses reported deafness or blindness (9% deafness; 2% blindness; 1% both), compared to just 5% of all adults (Department of Health, 2014). The increasing risk of disability by age may in part be explained by the increased prevalence of certain medical conditions in older age groups. Around three percent of disability (in those aged 16+) is congenital (Office for Disability Issues, 2008).

People with certain pre-existing conditions are at greater risk of becoming disabled, and risks vary across population groups. National Audit Office analysis (2005) on stroke (a leading cause of adult disability in the UK) found that the risk is higher in people of African or Caribbean ethnicity; age and sex-adjusted incidence rates of first ever stroke were twice as high in black people as in white people. The Royal National Institute of Blind People (2015) reports that almost two thirds of people living with sight loss are female.

Long term conditions (LTCs) can also be both a precursor and a result of disability or impairment. For example, in a study of 6,500 people aged 60 and over (Gregg et al., 2000), those with diabetes were more likely to be physically disabled (i.e. unable to walk one quarter of a mile, climb stairs, or do housework) than those without. A 2011 study found that those with severe hearing loss were almost five times as likely to develop dementia (Lin et al., 2011). In the GP Patient Survey 2012-13 (Department of Health, 2014), 29% of those reporting deafness, 32% of those reporting blindness and 69% of those reporting both, also reported having four or more LTCs in total (deafness and blindness each counting as an LTC), compared to just 3% of those who were neither blind nor deaf.

What are the main causes of physical or sensory impairment?

According to data from the Global Burden of Disease study, the leading causes of Years Lived with (physical) Disability (YLD) in England in 2013 were low back and neck pain (1.3 million YLD), sense organ diseases (445,000 YLD), skin diseases (376,000 YLD) and falls (325,000 YLD). In terms of sensory impairment, hearing loss accounted for 306,000 YLD,

while vision loss accounted for 94,000 YLD (Institute for Health Metrics and Evaluation, 2015).

What are people with physical and sensory impairments at risk of?

As mentioned above, people with physical and sensory impairments are more likely to be living in poverty, be out of work, and have lower educational qualifications. 14% of adults with an impairment reported having less than three close contacts that they could rely on, compared to 8% of adults without an impairment.

People with disabilities are also less likely to participate in leisure activities; Office for Disability Issues (2013) data for 2011/12 showed they were statistically less likely to use a public library service, visit a museum, gallery, archive or historical environment site, engage with the arts, participate in sports or go to the cinema. Sport England (2013) found that 18.2% of adults with an LSI participated in sport for at least 30 minutes per week, compared to 35.2% of all adults. Six themes have been identified as explaining why physical activity is prevented or facilitated among older people with sight loss: disabling environments; organisational opportunities; transport; lack of information; confidence, fear and personal safety; and exercise as medicine (Phoenix, Griffin and Smith, 2015). These themes provide a framework for improving support for participation in leisure activities.

Disabled people are also more likely to face difficulties accessing public services (36% of adults with impairment, compared to 24% of those without (Office for Disability Issues, 2011)). Benefits and pensions was the service proving difficult to access for the highest proportion of disabled adults (34%).

A key barrier to accessing public services was difficulty with transport (Office for Disability Issues, 2011). Disabled people in general reported more difficulties than non-disabled people in using motor vehicles, buses, trains, the underground and taxis. Transport was reported as the top barrier to participation across the board (in employment, education, social and cultural activities and accessing services) for disabled adults – 75% cited this as a barrier.

Evidence suggests that people with a disability are more likely to smoke than those without (Centres for Disease Control and Prevention, 2012; Brawarsky et al., 2002). However, smoking is a key cause of many medical conditions that can lead to disability, for example macular degeneration (Thornton et al., 2005), stroke (Aldoori and Rahman, 1998) and diabetes (The InterAct Consortium et al., 2014; Radzeviciene and Ostrauskas, 2009), and so it may be that smoking is a causal factor for the disability, rather than a result. Smoking may help to explain, in part, the relationship between deprivation and disability, since those in more deprived areas are more likely to smoke (Office for National Statistics, 2014).

People with disabilities, impairments and long-term conditions are also more likely to experience mental health problems (Barnett et al., 2012; Emerson et al., 2008). In the 2012-13 GP Patient Survey, the anxiety/depression score as measured by the EQ-5D health questionnaire was higher for those with deafness (1.7), blindness (1.8) or both (2.0), compared with those without (1.4) (Department of Health, 2014). (These scores are self-reported and so do not reflect the prevalence of formally diagnosed anxiety and depression in these groups, but provide some insight into patients' own experience).

Disabled people may find it more difficult to get treatment for any mental health or substance misuse issues, because of the increased barriers they face in accessing public services including health services (Office for Disability Issues, 2011). Inequity of access to mental

health services was assessed in a study by the University of Nottingham and funded by Nottingham City Clinical Commissioning Group (Murphy and Godbehere, 2015). The study explored equity of access to Improving Access to Psychological Therapies services in the Nottingham CCG area. Due to poor data quality, researchers were not able to meaningfully evaluate equity of access for those with a disability.

Disabled people are at a higher risk of violence than non-disabled people (Hughes et al., 2012), and of being a victim of any crime (Office for Disability Issues , 2012b) and women with a disability are around twice as likely to experience domestic violence as those without (Hague et al., 2011).

2) Size of the issue locally

In the 2011 Census there were a total of 55,382 residents of Nottingham City with a long term health problem or disability which is 18.11% of the total population. Of these, 27,699 (9.06%) found their day-to-day activities were limited a lot and 27,683 (9.05%) found their day-to-day activities were limited a little. The comparable figures for England are 8.31% with day-to-day activities limited a lot and 9.33% with day-to-day activities limited a little. (Source 2011 census table QS303EW). The percentages increase considerably with age (For more detailed information please see: http://www.nottinghaminsight.org.uk/IAS/dataviews/tabular?viewId=1884&geoId=1&subsetId=

The proportion of people with day to day activities limited a little or a lot is higher in the 'white' ethnic groups in Nottingham compared to BME groups. This is at least in part explained by the younger age structure of BME groups in Nottingham. For more information please see: http://www.nomisweb.co.uk/census/2011/DC3201EW/view/1946157131?rows=c_ethpuk11&cols=c_disability

There were 17,230 people claiming Employment and Support Allowance, Incapacity Benefit (IB) and Severe Disability Allowance (SDA) in May 2015. This is 7.9% of the working aged population (aged 16-64). The comparable figure for England is 6.0%. (Source: Nomis labour market profile). 55.5% of these claimants had been claiming for more than 5 years. Only around 4,800 ESA claimants out of 17,230 ESA/IB/SDA claimants are expected to prepare to return to work (Source NCC benefits bulletin November 15).

The highest LSOA level IB/SDA rate in May 2015 was 28.4% (Bilborough East), more than three times the City average (NCC Benefits Bulletin November 15).

It is predicted that 7,788 people in Nottingham City aged 18-64 have a moderate or serious personal care disability. This is based on estimates from the Health survey for England 2001 applied to more up to date population data, and refers to people requiring help getting in and out of bed, dressing, washing, feeding, and use of the toilet. Moderate means this is performed with some difficulty, severe means that the task requires someone else to help. (Source: Pansi, 2015) Projecting Adult Needs And Service Information System, Institute of Public Care[1].

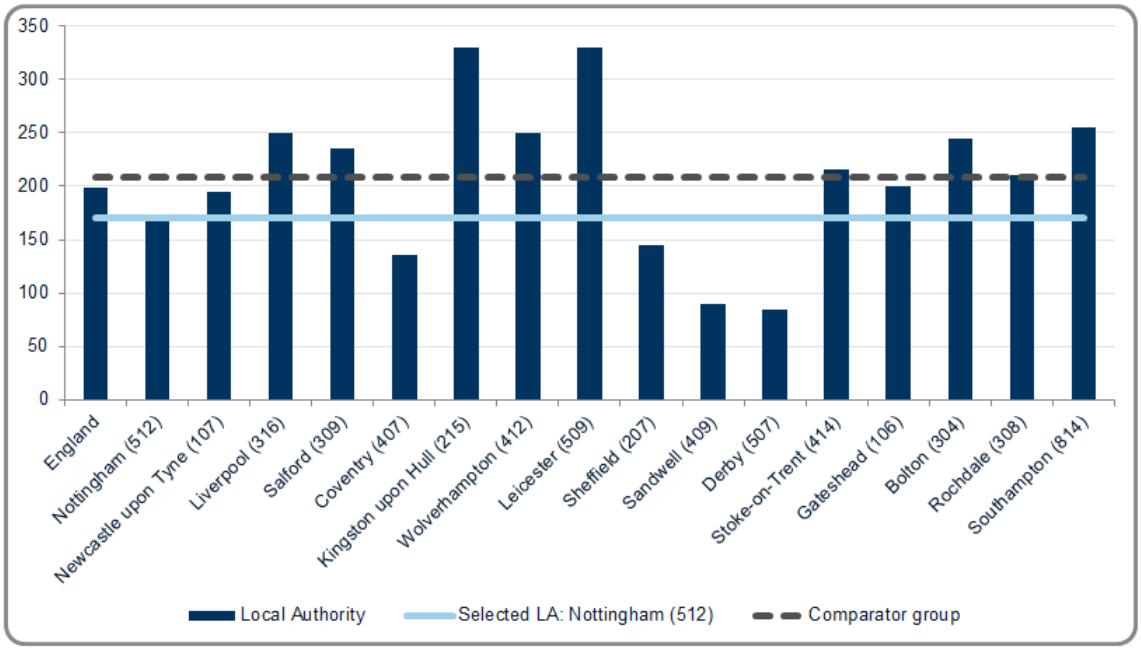
[1] Projecting Adult Needs And Service Information System, Institute of Public Care

By contrast, there were only 381 people in 2014/15 aged 18-64 receiving long term support in the community (as opposed to nursing/residential care) with primary support reason access or mobility or personal care support (Source: SALT return 2014/15 LTS001a Table 1a). The vast majority of service users with these primary support reasons are aged 65 and over.

Overall activity for physical disabilities (personal care support) is shown in figure 2.

Figure 2:

Long Term Support clients with a PSR of Physical Support: Personal care support for selected LA and adults aged 18-64



Data Sources: SALT LTS001a Tables 1a and 1b, 2014 Mid-Year Population Estimates from the Office for National Statistics

SALT comparator dashboard available at
http://www.hscic.gov.uk/media/20557/SALT1415comparatordashboardv1xlsx/xls/SALT_1415_comparator_dashboard_v1.xlsx

Visual Impairment
In Nottingham as at 31/03/2014 there were 235 people aged 18-64 registered with the local authority as being blind or severely vision impaired (Source: SSDA902 return).

Looking at the Public Health Outcomes Framework data for vision impairment (see figure 3) the City has slightly higher than average levels of preventable sight loss due to Age Related Macular Degeneration, but fairly low levels due to glaucoma or diabetic eye disease. However these figures are not age sex standardised so may appear lower than they would otherwise be, due to the young age structure of the City.

The preventable sight loss certifications at 30.9 per 100,000 (96 events) is also a crude rate so although this is lower than England again this may not be the case were it an age standardised rate. This data is calculated by PHE using CVI (certificate of visual impairment) data- this is given by a consultant ophthalmologist, and initiates the process of registration with a local authority and leads to access to services.

Please see section six for future projections.

Figure 3: PHOF data on vision impairment (Source: PHOF data tool, 2016)

Indicator	Period	England	Nottingham	1 - Newcastle upon Tyne	2 - Liverpool	3 - Salford	4 - Kingston upon Hull	5 - Leicester	6 - Sandwell	7 - Wolverhampton	8 - Coventry	9 - Sheffield	10 - Stoke-on-Trent	11 - Southampton	12 - Rochdale	13 - Bolton	14 - Derby	15 - Gateshead
4.12i - Preventable sight loss - age related macular degeneration (AMD)	2013/14	118.8	125.4	139.7	161.1	140.4	111.5	149.7	129.0	102.5	83.1	155.7	14.7	226.8	93.8	105.1	53.0	123.6
4.12ii - Preventable sight loss - glaucoma	2013/14	12.9	9.4	9.1	11.0	8.5	18.9	14.6	11.9	8.4	20.0	11.4	*	24.8	10.8	17.7	4.3	9.6
4.12iii - Preventable sight loss - diabetic eye disease	2013/14	3.4	2.6	2.0	2.2	*	5.9	5.4	6.9	2.3	2.5	3.7	0.0	8.2	5.1	5.1	4.7	*
4.12iv - Preventable sight loss - sight loss certifications	2013/14	42.5	30.9	44.6	44.6	41.8	47.0	52.1	42.6	39.0	34.3	48.6	8.8	64.8	42.9	48.9	26.3	43.5

Source: PHOF, 2016. Nottingham + CIPFA comparators

Hearing Impairment
In Nottingham in 2014 according to Pansi (Projecting Adult Needs And Service Information System, Institute of Public Care) there were an estimated 5,954 with moderate or severe hearing loss, and 49 with profound hearing loss.

As at 31/03/2010 there were 542 people aged 18-64 registered with the local authority as either deaf or hard of hearing. (Source: HoH return 2010, now discontinued) These figures do not reflect the likely true total as registration is purely voluntary with no immediate benefit to the individual.

Access to benefits
People with a long term health problem or disability can apply for benefits to help pay for additional care or personal mobility requirements. Prior to April 2013, people would apply for Disability Living Allowance (DLA), but after this date, people aged 16 to 64 have had to apply for a new benefit called a Personal Independence Payment (PIP). PIP is not taxable and is not a means-tested benefit hence it can be claimed no matter what a person's income is. Existing working age DLA claimants have gradually been invited to apply for PIP, but it is expected to take a considerable period of time to complete the transfer. Younger age groups will continue to apply for DLA while older age groups will apply for Attendance Allowance.

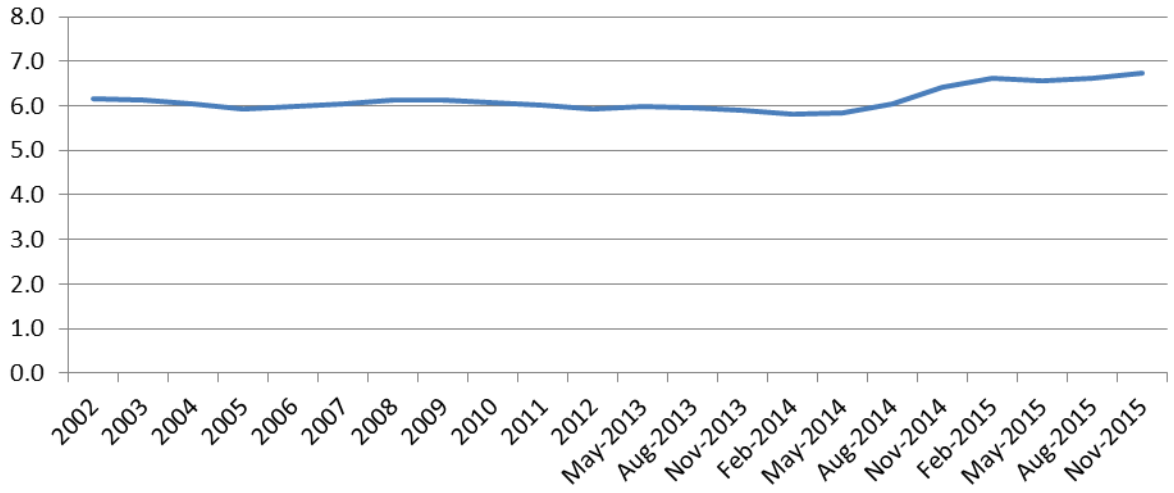
The qualifying criteria for the two benefits are different and the assessment process for PIP has been very controversial. PIP was introduced with the intention of reducing the overall benefits bill and this seems to have resulted in many claims being rejected, but a high proportion of rejected claims have been overturned on appeal. Given the overall aim of reducing payments, it was expected that many claimants would still see reduced levels of entitlement.

This section attempts to look at the impacts of the introduction of PIP in Nottingham on both the overall number of people claiming PIP and DLA and on the amount of benefit that people are receiving. It will also try to assess the impact of PIP on the overall number of working age people claiming benefits.

Claimant numbers and change over time

In November 2015, 14,785 working age people were claiming either Disability Living Allowance or Personal Independence Payment. This is 6.7% of the age group. Chart 1 shows how the claimant rate for these benefits has changed over time. The first half of the chart shows average annual claimant rates from 2002 to 2012. From May 2013 the data is shown for each quarter to show the impact of the introduction of PIP.

Figure 4: Claimant rate for disability benefits over time.



Source DWP via NOMIS and Stat Xplore.

The long term average has been for around 6% of the working age population to be claiming a benefit related to disability. When PIP was introduced in April 2013 there were 13,010 DLA claimants in the City, a rate of 6.0% in line with the long term average. Initially there was a slight fall in the number and proportion of claimants to February 2014 when 12,720 people were claiming either DLA or PIP. Since then both claimant numbers and rates have risen steadily. This is counter to the expectation that overall claimant numbers would fall as a result of the new eligibility criteria for PIP and points to the success that disability rights campaigners and welfare advisors have had in navigating the new system and the appeals process.

Currently, the 14,785 claimants comprise 9,000 people claiming DLA who are awaiting reassessment, 2,445 PIP claimants who previously claimed DLA and 3,340 new PIP claimants.

Payments

In terms of the payments made to claimants, the difference between DLA and PIP is that PIP only has two levels of Daily Living Award compared to three levels of the Care Award under DLA. In effect the lower level of the Care Award has been removed. In April 2013, 4,770 people claimed this level of the Care Award which paid £21.80 per week (2015/16 levels). By November 2015, the number of low level Care Award claimants fell to 3,010 as people were reassessed for PIP. Overall, however, the total number of DLA or PIP claimants increased by 1,775 people. This suggests that people with a low level Care Award were more likely to receive a higher payment than to lose eligibility.

Table 5 shows the total weekly amounts paid to DLA or PIP claimants in May 2013 and November 2015. Both sets of data are calculated using 2015/16 payment rates to ensure comparability as the figures will not be affected by changes in payment rates or inflation.

Table 5: Total weekly payments to DLA and PIP claimants.

Date	May 2013	November 2015	Change	% change
Total weekly payments	£1,033,500	£1,275,300	+£241,800	23.4%
Average weekly payment per claimant	£79.4	£86.3	+£6.9	8.6%
Total claimants	13,010	14,785	1,775	13.6%

Source DWP via NOMIS and Stat Xplore. Payments calculated by Nottingham City Council based on published payment rates for 2015/16 from the DWP.

The increase in the number of claimants along with an increase in the average payment per claim has meant that disability benefit payments have increased by 23.4% since PIP was introduced, an increase of nearly a quarter of a million pounds per week.

The largest increases have been in claimants who qualify for a Daily Living Award but not a Mobility Award or those claimants who qualify for the Enhanced level of both Awards. The only combination of Awards to see a fall in claimants, (apart from the Lower rate of the DLA Care Award which is effectively closed to new claimants and doesn't exist in PIP) is in people who qualify for an Enhanced Level Mobility Award but no Daily Living Award. There has been a corresponding increase in people who qualify for the Standard Mobility Award which suggests around a net total of 130 people have been reassessed to the Standard Award.

(Source: Access to poor health benefits summary, Nottingham City Council, 2016. Available here:
http://www.nottinghaminsight.org.uk/insight/handler/downloadHandler.ashx?node=171002)

3) Targets and performance

There are a range of relevant targets relating to citizens with physical and sensory impairments, and progress against all of these is not reported but can be found in the relevant performance reports or websites.

Adult Social Care Outcomes Framework

The indicators in this framework relate to the quality of and satisfaction with services, of those already in contact with social care services. For full details please see http://www.hscic.gov.uk/catalogue/PUB18657

The Public Health Outcomes Framework contains the following relevant indicators:

4.12i Preventable sight loss- age related macular degeneration

4.12ii Preventable sight loss- glaucoma

4.12iii Preventable sight loss- diabetic eye disease

4.12iv Preventable sight loss- sight loss certifications

The Nottingham City Council plan (2015-2019) contains the following relevant indicator:

Measure number: CP C&F041 - Number of citizens receiving assistive technology service: i – Telecare ii - Telehealth

Vulnerable adult's plan 2012-15. This plan is currently being refreshed but the current version has the following three primary outcomes:

- That citizens should have safer, healthier, happier and live longer lives in which they are able to fulfil their aspirations;
- That citizens have support, advice and information to live with choice, control and dignity, in a place of residence which seeks to meet individual needs;
- That citizens are enabled to achieve their full potential as active parties in their own support and as part of a community wide support systems.

The vision consists of the following three key points:

- That the council will invest in services that reduce need and dependence and lowers cost;
- That the council will develop new and innovative ways in which to make use of all resources in the community;
- That the council will enable vulnerable citizens to remain independent for longer and make choice based personalised services a reality in Nottingham.

4) Current activity, service provision and assets

There are a large number of services to cover in this section therefore these have been split into prevention, early identification, and support and treatment.

4.1 Prevention

It is recognised that it could be viewed as contentious to have a prevention section; however the implication is not that all physical disabilities and sensory impairments are preventable, rather that a proportion may be.

Occupations associated with loud noise, including working in factories and on roadworks, were the most common precursor to hearing problems. This cause has now been minimised as a result of the tightening of health and safety rules. Working in a noisy industry should be less dangerous provided that the correct ear protection is utilised. Recreational loud noise is now the most common cause of hearing problems and it is increasingly affecting younger people.
Source: NHS Choices. Guidance for safer listening can be found here:
http://www.nhs.uk/Livewell/hearing-problems/Pages/tips-to-protect-hearing.aspx

Good maternal care and nutrition can reduce the risk of prematurity, low birth weight and congenital abnormalities including spina bifida. Other factors are also important such as rubella vaccination. Please read the pregnancy JSNA chapter for more information on this.

Stroke is a major cause of disability, please read the JSNA chapter for more information. There are also other chapters such as smoking, diet and nutrition and obesity which are also relevant to stroke prevention which contain information on commissioned services.

Good diabetic blood glucose control reduces the risk of retinopathy which is a major cause of working age blindness. In those with diabetes, retinal screening should be carried out annually in order to detect and manage changes. Please read the diabetes JSNA chapter for more information about local services.

4.2 Early identification

Following an ear examination, GPs and practice nurses can refer patients to a specialist for a hearing test. A range of tests can be used to check the functioning of the ears. These include:

- Automated optoacoustic emissions (AOAE) tests: a computer measures ear responses to clicking noises;
- Automates auditory brainstem response (AABR) tests – nerve response is measured using head and neck sensors;
- Pure tone audiometry tests: a button is pressed when varying sounds can be heard; and
- Bone conduction tests: a vibrating noise sensor tests how well the hearing nerve is working.

Picking up hearing impairment early in infants is important for good outcomes. Early identification of hearing impairment gives children a better chance of developing speech and language skills, and of making the most of social and emotional interaction from an early age. More information on the new-born screening programme is available here: https://www.gov.uk/guidance/newborn-hearing-screening-programme-overview

Please also refer to the early years JSNA chapter for more information.

There are advantages for children and young people and/or adults being identified as having either physical disabilities or sensory impairments in terms of being able to receive support during education, leading to better outcomes at school and better employment chances

There is a full and detailed JSNA chapter covering children and young people with disabilities and learning difficulties- where full details of available services for this group can be found.

Early identification in adults, particularly those in their fifties, is also very important for good outcomes. This is of particular importance because of the link between hearing impairments and dementia in older adults (Lin et al., 2011).

The Nottinghamshire Fit for Work service is designed to support people to stay healthy and in work. It is funded to provide a service for people registered with a Nottingham City GP. A team of workplace health specialists provide an easy to access specialist service which meets the unique needs of individuals who are struggling with health problems and remaining in employment.

Employers have an obligation under the Equality Act 2010 to make reasonable adjustments to support those with disabilities in the workplace and not to discriminate in their recruitment processes.

4.3 Support and treatment

‘Care and support’ is the term used to describe the help some adults need to live as well as possible with any illness or disability they may have. It can include help with things like getting out of bed, washing, dressing, getting to work, cooking meals, eating, seeing friends, caring for families and being part of the community.

It might also include emotional support at a time of difficulty and stress, helping people who are caring for an adult family member or friend or even giving others a lift to a social event.

Care and support includes the help given by family and friends, as well as any provided by the council or other organisations.

(Source: DH (2015) Care and support, Care Act, FAQs)

4.3.1 Unpaid care

This section focusses on care formally commissioned or provided by the local authority. Clearly, a large proportion of care provided is informal and provided on an unpaid basis. Further information on this can be found in the Carers JSNA chapter.

4.3.2 Social care support

The health and care point carry out assessments to see if people with physical and sensory impairments are eligible to receive council services. More information can be found here: http://www.carechoices.co.uk/wp-content/uploads/2014/02/Nottingham-City-Care-Support-Services-Directory-2013-14.pdf

A range of teams then provide these services. These are summarised below:

4.3.2.1 Day Care

Acorn Resource Centre in Hyson Green, based at the Mary Potter Centre, offer interesting and varied activities during the day for people aged 18 and over. More information about the Acorn resource centre is available here: http://www.nottinghamcity.gov.uk/CHttpHandler.ashx?id=45956&p=0

4.3.2.2 Support at home

The Intake Reablement Team are a short-term home care team, focusing on helping people to regain skills that they may have lost, due to hospital admission or illness.

Homecare, support which is provided to people in their own homes to assist with personal care and practical tasks associated with daily living. There is a mix of framework provision funded by direct payments, in addition to internal provision.

Telecare provides a home safety and personal security system designed to enable people to remain living independently in their own homes for as long as possible. Support includes care alarms that, when activated, make a noise as well as flashing and vibrating, doorbells which are very loud and flash and also big button telephones and remote controls.

The Meals at home service provides hot meals up to five days a week, with the option of buying frozen meals for the weekend

4.3.2.3 Support with everyday life

Occupational Therapy, assisting people to be as independent as possible in their everyday lives.

The Adult Sensory team works with people who live in the Nottingham City area who are Deaf, have dual sensory loss or experience difficulty with their vision. The Deaf Service provides support to Deaf people of all ages, different cultures, disabilities and backgrounds.

They provide communication equipment and flashing light/vibrating equipment to alert Deaf people to everyday aspects like: the doorbell, a smoke alarm, a telephone call or a baby crying.

The Dual Sensory Service provides services to children and adults who experience difficulty with both their vision and hearing. This includes blind and partially sighted people who are also deaf or hard of hearing. The service provides specialist knowledge and skills that can enable people to continue with many every day activities such as:

- Helping people to develop skills such as mobility to enable independent travel and daily living activities such as preparing meals
- Providing access to other services and organisations such as Talking Book Machines and the community fire service
- Providing advice and information about applying for special equipment and funding
- Delivering training such as typing, teaching you and those close to you the Deafblind manual and other communication methods
- Access to information such as helping you get your bills in large print

The Visual Impairment Service

The Visual Impairment Service offers a social care and rehabilitation service to children and adults with a visual impairment. The Service is staffed by experienced rehabilitation officers, who have knowledge and skills in rehabilitation that can enable people to continue with many activities, both in their own homes and in their local communities. They can also enable people to learn new skills.

To be certified as severely sight impaired/ blind or sight impaired/ partially sighted a person's GP needs to refer them to the consultant ophthalmologist at the Eye Clinic in their local hospital. A copy of the certificate is then sent to the Team for Registration purposes. The local authority then contacts the individual to give information, advice and to discuss their services.

Nottingham City Council Occupational Therapy Team assists people with disabilities (permanently and substantially disabled) of all ages to be as independent as possible in their everyday lives, through:

- Working with clients to find a new way of doing a task such as preparing a meal or drink, dressing and personal hygiene, getting in, out and around the home
- Providing specialist equipment to aid daily living
- Providing minor adaptations such as grab rails
- Arranging major adaptations such as ramps or stair lifts
- Working with carers to offer advice on the best way to provide support
- With consent, providing signposting to relevant services who may be able to help

Nottinghamshire Deaf Society

Nottinghamshire Deaf Society (NDS) provides a range of support, including:

- Bespoke day centre services through twice weekly five hour sessions supported by a deaf support worker. This includes home visiting by deaf volunteers;

- A welfare rights advice session three times a week delivered in British Sign Language;
- A drop in Interpreting Duty Time Service that can interpret letters and make telephone calls on behalf of the individual; and
- A twice weekly support service via Skype for Deaf people (who cannot use the telephone) and need to access any Nottingham City Council service.

NDS is commissioned to provide a non-chargeable British Sign Language/English Interpreting service and Lip speaking service to people who are deaf and live in Nottingham City and who need support to communicate with a City Council Department including schools and academies or any primary care service such as GPs, opticians or dentists.

More information about Nottinghamshire Deaf Society is available here: http://www.nottsdeaf.org.uk/

Physical and Sensory Impairments

The Sensory Impairments Team works with a number of organisations and agencies to deliver services to people with sensory impairment.

Other provision

A list of companies who provide home care in Nottingham is available in the Care and Support Services Directory 2014/15. https://www.carersfederation.co.uk/wp-content/uploads/2013/11/Nottingham-City-Care-and-Support-Directory-2014-15-.pdf .

4.3.3 Hospital treatment

4.3.3.1 Cochlear implants

The Nottingham Auditory Implant Programme established in 1989, has carried out more than 1,700 implant operations and was the first to provide a child in the UK with a cochlear implant. The Programme follows the British Cochlear Implant Group Quality Standards 2016. Further information on the programme is available at: https://www.nuh.nhs.uk/our-services/services/nottingham-auditory-implant-programme/.

4.3.3.2 Cataract treatment

Nottingham University Hospitals NHS Trust Cataract Clinic is based at the Queen's Medical Centre and was established in 2000 as part of the Government initiative to reduce waiting times for eye surgery. The Clinic treats approximately 4,000 patients per year. Referrals to the Clinic can be made by either a patient's GP or their optometrist.

4.3.3.3 Clinics for other areas of ophthalmology

Nottingham University Hospitals Trust provides a number of services for eye-related problems including: a macular clinic; eye casualty; and a head and neck unit. A full list of available services can be found here: https://www.nuh.nhs.uk/our-services/services/ophthalmology/.

4.3.4 Transport

4.3.4.1 Transport by bus

4.3.4.1.1 Wheelchairs

Nottingham City Transport (NCT) states that it has one of the most accessible bus fleets in the country. All buses meet the legal requirement to have a bay which can accommodate a 'standard reference wheelchair'. Larger wheelchairs cannot be carried. Buses can carry one wheelchair at a time only and if the bay is occupied by any other customer and they refuse to move the driver cannot force them to.

NCT states that the following measures are in place to accommodate people using wheelchairs:

- Drivers park as close as possible to the kerb;
- Drivers will use a ramp or kneel the bus; and
- A bell in the bay area gives a different alert to notify the driver that a customer from the bay will be alighting.

4.3.4.1.2 Mobility scooters

NCT has signed up to the Confederation of Passenger Transport UK Code for Mobility Scooters. Class 2 scooters can be accommodated and scooters are classed as a wheelchair on the buses. In order to use the bus service with a mobility scooter, passengers must have a permit which is issued once NCT has assessed the scooter and provided training. Further information and contact details for arranging a permit and training are available here: https://www.nctx.co.uk/using-the-bus/easy-access-for-everyone/mobility-scooters/.

4.3.4.1.3 Journey assistance cards

NCT has used the CPT Code to develop a range of journey assistance cards that aim to improve interactions between passengers and drivers, particularly in cases of hidden disability. The messages include requesting additional time to take a seat, alerting drivers to a disability and/ or sensory impairment and requiring an alert when a destination is reached.

Journey assistance cards can be downloaded from NCT's website or by contacting the NCT. More information is available here: https://www.nctx.co.uk/using-the-bus/easy-access-for-everyone/journey-assistance-cards/.

4.3.4.1.4 Blind and partially sighted customers

NCT expects its drivers to state their service number and destination when they reach a bus stop. More than 75% of buses have audio stop announcements and all routes will have these by 2017/18. Trained assistance dogs can be carried free of charge. Further detail, including a list of routes with audio announcements, can be found here: https://www.nctx.co.uk/using-the-bus/easy-access-for-everyone/blind-and-partially-sighted-customers/

4.3.4.1.5 Accessible information

Timetables and leaflets can be provided in Braille, large print and audio upon request. The website meets accessibility requirements and is a responsive site. The Travel Centre offers support with planning a journey and orientation slots on out of service buses.

4.3.4.2 Transport by tram

4.3.4.2.1 Wheelchairs

Each tram has two dedicated wheelchair spaces. These include help and stop request buttons.

4.3.4.2.2 Mobility scooters

An industry wide set of regulations for the carriage of mobility scooters is under development. Currently, scooters can be carried if they can board and exit the tram safely and park in a wheelchair space.

4.3.4.2.3 Blind and partially sighted customers

All Nottingham Express Transit (NET) trams have a low floor with wide double doors. White visibility strips and warning sounds for when doors are opening and closing are provided. Electronic signs and audible announcements provide information on the destination and the following stop. NET staff receive disability awareness training and drivers are trained to allow people with visible disability more time to get on and off. Guide and assistance dogs are welcome however, local feedback states that tram ticket machines are not accessible to people with a physical impairment.

4.3.4.2.4 Accessible information

Timetable information is provided in accessible formats (not including British Sign Language) upon request. Further information, including contact details, is provided here: http://www.thetram.net/access-for-all.aspx

4.3.4.3 Transport by train

East Midlands Trains provide the following assistance:

- Help in planning a journey;
- Information on further transport following a train journey;
- Advice on the most appropriate tickets, including discounted fares;
- Help in booking tickets;
- Assistance in getting on and off trains;
- Luggage assistance; and
- Help with transfers between services.

A team of Assisted Travel Advisors is available 24 hours a day, seven days a week. Further information, including contact details, can be found here: http://www.eastmidlandstrains.co.uk/travelling-with-us/accessibility-assistance/

Nottingham Train Station provides station maps in Braille and large print. These can be downloaded or collected free of charge from the station's Information Desk. Further

information is available here: https://www.eastmidlandstrains.co.uk/stations/nottingham-station/

Local feedback states that redevelopment on Station Street has increased the required travel distance to the closest taxi rank on Trent Street and to mitigate this a taxi rank has been set up on Queens Road.

4.3.4 Workforce

4.3.4.1 Training

Nottingham City Council commissions disability equality training which aims to improve staff confidence in working with, and providing a high standard of service for, disabled people.

4.3.4.2 Adult Sensory Team

The Council's Adult Sensory Team works with citizens who are deaf, have dual sensory loss or experience difficulty with their vision. The team works mainly with adults but will also work with children and families. Team members include a social worker, community care officer, rehabilitation officers, equipment officer and communicator guides who work in people's homes and communities. The Team also includes care support advisors, a service support advisor and an eye clinic liaison officer.

4.3.4.3 Disability Involvement Group

The quarterly Nottingham Disability Involvement Group works with Nottingham City Council to ensure its policies, procedures, processes and services are accessible, fairly applied to Disabled citizens, and reach equality standards in line with the aims of the Equality and Fairness Commission.

4.3.5 Access to work

Access to work grants pay for practical support for people with a disability, health or mental health condition. The grant does not have to be repaid, nor does it affect other benefits. Local authorities contribute to the cost of equipment.

4.3.6 Unpaid care

There are 5.41 million people in England providing some level of unpaid care. Of these, 58% are female and 42% are male. Female carers represent 11.9% of the total female population and the same is true for 9% of the male population. These percentages have increased slightly compared to ten years ago. Nationally, 50-64 year old women carry the greatest burden of care. Full details of unpaid carers are provided in the Carers JSNA chapter.

4.3.7 Advocacy

POhWER provides information, advice, support and advocacy to people who experience disability, vulnerability, distress and social exclusion. Information about how to contact the service is available here on the accessible website.

The Care Act

The Care Act (2014) places a duty on local authorities to provide accessible information to citizens about the range of services available to them to meet their needs. Local authorities have to make sure that people who live in their areas:

• receive services that prevent their care needs from becoming more serious, or delay the impact of their needs;
• can get the information and advice they need to make good decisions about care and support;
• have a range of providers offering a choice of high quality, appropriate services.

In Nottingham City this requirement has been partly met through the development and launch of the Nottingham Self-care website, available at:
https://www.nottinghamselfcare.org.uk/

5) Evidence of what works

5.1 Prevention

There are a number of publications related to the treatment of conditions which may lead to physical and sensory impairments, listed below.

5.1.1 NICE guidance

Type 1 diabetes in adults: diagnosis and management (NICE guidelines [NG17], July 2016)
Canagliflozin, dapagliflozin and empagliflozin as monotherapies for treating type 2 diabetes (Nice guidelines [TA390], May 2016)
Low back pain in adults: early management (NICE guidelines [CG88], May 2009)

5.2 Early intervention and treatment

There are a number of publications related to the identification and treatment of physical disability and sensory impairments, listed below.

5.2.1 NICE guidance

Aflibercept for treating visual impairment caused by macular oedema secondary to central retinal vein occlusion (NICE guidelines [TA305], February 2014)
Fluocinolone acetonide intravitreal implant for treating chronic diabetic macular oedema after an inadequate response to prior therapy (NICE guidelines, [TA301], November 2013)
Aflibercept for treating diabetic macular oedema (NICE guidelines [TA346], July 2015)
Glaucoma in adults (Nice guidelines [QS7], March 2011)
Cochlear implants for children and adults with severe to profound deafness (Nice guidelines [TA166], January 2009)
Auditory brain stem implants (NICE guidelines [IPG108], January 2005)
Spinal injury: assessment and initial management (NICE guidelines [NG41], February 2016)
Psoriasis: assessment and management (NICE guidelines [CG153], October 2012)
Epilepsies: diagnosis and management [CG137], January 2012)
Chronic fatigue syndrome/myalgic encephalomyelitis (or encephalopathy): diagnosis and management (NICE guidelines [CG53], August 2007)
Prosthetic intervertebral disc replacement in the cervical spine (NICE guidelines [IPG341], May 2010)
Major trauma: assessment and initial management (NICE guidelines [NG39], February 2016)
Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset (NICE guidelines [NG16], October 2015)
Falls in older people (NICE guidelines [QS86], March 2015
Spinal injury: assessment and initial management (NICE guidelines [NG41], February 2016)
Diabetic foot problems: prevention and management (NICE guidelines [NG19], August 2015)
Mental health problems with learning disability (NICE guidelines [GID-QS10007], January 2017)
Multiple sclerosis in adults: management (NICE guidelines [CG186], October 2014)
Motor neurone disease: assessment and management (NICE guidelines [NG42], February 2016)
Osteoarthritis (NICE guidelines [QS87], June 2015)
Multiple sclerosis (NICE guidelines [QS108], January 2016)

5.2.2 Other guidance

Cochlear Implant Services for Children and Adults (British Cochlear Implant Group, 2016)
This publication provides advice on auditory implantation and quality standards.

5.3 Other NICE guidance

Patient experience in adult NHS services: improving the experience of care for people using adult NHS services (NICE guidelines [CG138], February 2012)
The Government signalled in its White Paper Equity and excellence: liberating the NHS (2010) that more emphasis needs to be placed on improving patients' experience of NHS care. This guidance is a direct referral from the Department of Health. It focuses on generic patient experiences and is relevant for all people who use adult NHS services in England and Wales. The aim of the guidance is to provide the NHS with clear guidance on the components of a good patient experience. This guidance provides the evidence and the direction for creating sustainable change that will result in an 'NHS cultural shift' towards a truly patient-centred service.

Workplace health: support for employees with disabilities and long term conditions (NICE guidelines [GID-PHG58], April 2017)
This guidance is due to be published in April 2017.

5.4 Other guidance

Distinctive, valued, personal: why social care matters: the next five years (Association of Directors of Adult Social Services (ADASS), March 2015)
This document sets out the distinctive role and value of social care in the 21st century, when people are living longer, often with multiple health conditions that need a focus on the whole person and not just a single disease. The report considers why the care system needs to change, what the future will look like, including the role that individuals and communities must play and a joined-up care and health system, and how to get there. The report sets out a model for care and support, based on four key elements: good information and advice to enable people to look after themselves and each other, and get the right help at the right time as needs change; the recognition that people are interdependent and need to build supportive relationships and resilient communities; services that help people get back on track after illness or support disabled people to be independent; and services that are personalised, of good quality, that address mental, physical, and other forms of wellbeing and are much better joined-up around our individual needs and those of the carers.

Ending the other care crisis: making the case for investment in preventative care and support for disabled adults (Scope; Mencap; National Autistic Society; Sense; Leonard Cheshire Disability, May 2013)
This report demonstrates that spending money on social care for disabled people with moderate needs delivers improved quality of life and economic returns. See also: The other care crisis: making social care funding work for disabled adults in England (January 2013).

Evidence-based review: people of working age (RNIB, December 2014)
This review looks in more detail at the experience of blind and partially sighted people of “working age”. It includes a profile of this group, the policies that govern their employment and economic circumstances, and a commentary on what the evidence tells us.

Local action on health inequalities: Increasing employment opportunities and retention for people with a long-term health condition or disability, PHE/UCL (2015)

6) What is on the horizon?

The following estimates have been extracted from the Pansi tool (Institute of Public Care, 2015) which applies Health Survey for England or survey data to ONS population projections. The figures relate to people resident within the Nottingham City Council boundary. For more specific details on each of the estimates please go to the Pansi tool.

	2014	2015	2020	2025	2030
Total population aged 18-64 predicted to have a moderate physical disability	14192	14289	14665	14944	15084
Total population aged 18-64 predicted to have a serious physical disability	3855	3891	4051	4174	4196
Total population aged 18-64 predicted to have a moderate or serious personal care disability	7,788	7,857	8,164	8,369	8,368
Total population aged 18-64 predicted to have a serious visual impairment	138	138	139	140	143
Total population aged 18-64 predicted to have a moderate or severe hearing impairment	5,954	6,014	6,366	6,577	6,531
Total population aged 18-64 predicted to have a profound hearing impairment	49	50	54	56	55

The full impact of austerity measures on people with physical and sensory impairments remains to be seen.

7) Local Views

A large amount of engagement has been carried out and views from some citizens with physical and sensory impairments are summarised below. Please see the full reports for more information.

7.1 Healthwatch Insight report

Healthwatch produced a detailed insight report in 2016 to inform this JSNA update, using a combination of interviews, focus groups and information previously submitted on their service experience database. The contributions of more than 100 people were included.

The key findings were:

- Access to services is a significant issue for people living with a physical and or sensory impairment. These issues were affecting people emotionally and physically which had the potential to form an additional barrier to future access;
- Physical access issues related to buildings and facilities, as well as transport to these facilities, were problematic to both types of impairment. Those service users living with a hearing impairment had an added barrier where access to services was dependent on telephone communication;
- For people living with a sensory impairment, administrative processes followed by health and social care services has resulted in some service users missing appointments or being seen late;
- GPs and hospitals sending notification of appointments through the post did so through letters which are not written in appropriate font, font size and/or colour, making it difficult for service users with a visual impairment to read; and
- Electronic sign in screens, display screens or buzzers to identify when service users are being called to the consultation room in GP services cannot always be seen and/or heard by service users with sensory impairments.

Staff were identified as a positive and a negative in experiences. Positive experiences referenced staff as being helpful and friendly, accommodating physical and communication needs. Negative experiences indicated the opposite and where these experiences commented on impact, over half of the participants talked about how it had a negative effect on emotional wellbeing. People felt that staff did not have any knowledge about their needs which affected how they communicated and the treatment and/or assistance provided. Having to repeat communication with care professionals, due to a lack of continuity in the staff being seen at the same service, exacerbated feelings of frustration.

Further information can be found on the HealthWatch website here: http://www.healthwatchnottingham.co.uk/.

Health and Wellbeing strategy engagement

As part of the Health and Wellbeing Strategy engagement in 2015, one of the groups engaged with was the Disability Involvement Group. The Group highlighted a range of accessibility issues that present barriers (poor design of environment for those who are visually impaired, problem of people parking on pavements, digital exclusion with sign language users unable to access messages, accessible signage, lack of awareness amongst professionals on how to interact with people with disabilities).

“Since the recession there has been a move away from ‘inclusion’ at all levels and ‘there has been a downplaying of equalities meaning that people are marginalised”

Information about the Health and Wellbeing Strategy engagement is available here: http://www.nottinghamcity.gov.uk/CHttpHandler.ashx?id=57523&p=0)

Deaf Wellbeing in Nottinghamshire

The Disability Involvement Group shared a locally written report: Deaf Wellbeing in Nottinghamshire (DWAG, 2014) http://nottsdeafwellbeing.org.uk/onewebmedia/DWAG%20survey%202014.pdf. The Group also shared a literature review covering the health inequalities and issues with access to services experienced by the Deaf community nationally, the report summarises a survey carried out locally. This has a small sample size however it has some important findings which are congruent with national findings.

A quarter of Deaf people surveyed reported having to attend their GP practice in person to make an appointment, and having difficulties accessing and attending hospital appointments. There were high reported levels of anxiety and/or depression- just under half, which backs up national findings that this is the double the rate in the general population.

In addition to the survey, a feedback event (Feb 2016) was held to discuss the results, at which the following views were captured:

• Making complaints to health services is difficult for Deaf people. The process seems to be set up for hearing people using telephones or email.

• Some Deaf people try to cope with appointments without an interpreter because they want things to run smoothly and deal with the health professional directly. However, this often causes more problems than it solves.

• Deaf people wonder why they always seem to be sent to specialist Deaf services, like the CPN Mental Health service for Deaf people. It seems unfair that hearing people get a wide choice of services which Deaf people don't have access to, such as Step 2 Psychological Wellbeing Practitioners and Step 4 Psychology.

• Many Deaf people said that they are unsure what services are available to them. They also discussed how they could find out more, and want to be able to make decisions about what is best, but they continuously struggle to find out information to help them make those decisions.

• Some Deaf people say that it is difficult to build trust with health professionals. This may be because many health professionals don't know how to help develop a Deaf person's trust in them. Perhaps more awareness about the experiences of Deaf people will help them?

What does this tell us?

8) Unmet needs and service gaps

1. We believe there are large numbers of people of working age with long term limiting conditions that limit their daily function to a substantial degree, which include those with physical and sensory impairments. An increase in the number of people working to an older age is likely to impact on this. It is acknowledged that not everyone self-declares disability and this can make quantification difficult.
2. People with physical disabilities or sensory impairments often experience a range of significant physical and psychological inequalities and consultation has shown that people often feel discriminated against.
3. A proportion of these inequalities are likely to be related to comparatively reduced opportunities to participate in education and training at all levels, which can lead to poorer employment outcomes. This suggests policies to support those in education and to keep/find employment would help to mitigate the effect on health inequalities.
4. In addition, this group experience a range of significant barriers in terms of accessing mainstream and specialist health, social and other (including leisure and employment) services and a lack in tailored or specific services for those in need.
5. There appears to be a disparity between the large number of people in 'need' and the relatively small number of people receiving services. A Health Equity Audit that defines inequities in the causes, access to effective services and outcomes for this population could add to the understanding of this.
6. The direct payments/personalisation/care act/prevention agenda is changing the landscape of care provision for this group.
7. At the same time there are significant funding reductions within the local authority.

9) Knowledge gaps

1. It would be useful to investigate, perhaps through a health equity audit, whether there are any dimensions of inequity in terms of access to social care services (either commissioned or in house provision) for example are people from particular ethnic groups, or men as opposed to women, more or less likely to receive services?
2. A health equity audit of screening, cataract treatment and social care services would help to establish which groups are not accessing services and the extent of unmet need.
3. Consider carrying out a full health needs assessment on people with physical and sensory impairments in order to build a fuller picture to aid future planning- as need is only going to increase.
4. Understand the difficulties for people with physical and sensory impairments in accessing public.
5. Improve data quality in disability recording, particularly within mental health services, in order that equity of access can be assessed.
6. The full impact of austerity measures on people with physical and sensory impairments remains to be seen and action should be taken to address the current impact.

7. **What should we do next?**

10) Recommendations for consideration by commissioners

1. Progress strategies to reduce stigma and support people to self-declare and access services (particularly in underrepresented groups) in order that appropriate adjustments can be made.
2. Improve physical access to public buildings and transport to and from public service locations, placing particular focus on the Urgent Care Centre, Ropewalk House and the Queens Medical Centre (including expediting completion of works between the tram stop and the hospital).
3. Improve communication between services and service users through:
   a) Adhering to the NHS Accessible Information Standard through ensuring appropriate formats are used for written communication and that these needs are highlighted on people's records;
   b) Developing alternatives to services reliant on telephone communication (particularly booking appointments); and
   c) Increasing the availability of sign in screens, display screens and buzzers in waiting rooms and making sure that these systems are accessible for all.
4. Improve communication between services by, for example, sharing NHS Accessible Information Standard details between primary and secondary care.
5. Improve hospital environments to facilitate people with reduced mobility in terms of equipment that meets access needs and staff who are trained to use it.
6. Work with service providers to improve data quality in disability recording in terms of both status and access requirements.
7. Ensure disability awareness and equality training for health and social care professionals is regular enough to meet staff turnover.
8. Ensure Nottingham City Council maintains its commitment to the British Sign Language Charter.
9. Implement a holistic approach which recognises need as opposed to categories of diagnoses and allows adequate time for citizens with communication impairments to communicate with staff.

Key contacts

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