

Topic information	
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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.