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**NORTH WALES** SOCIAL CARE AND WELL-BEING  
SERVICES IMPROVEMENT COLLABORATIVE

# North Wales Population Needs Assessment

## Consultation survey report October 2021



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## Summary

The consultation for the Population Needs Assessment involved people who use care and support services and carers as well as staff who work for the health board, local councils and third sector or voluntary organisations. We used a wide range of information from partner organisations about the needs of people they support. In addition, we carried out a survey which around 350 people took part in during August and September 2021. This report summarises the findings from that survey.

### What works well

There are examples of care and support services working well across North Wales, particularly third sector services. There are also examples of strong partnership working, better access to support and people having more voice, choice and control over how their needs are met.

### What needs to be improved

Examples of where services could be improved, include relationships and communications within and between organisations. Many thought social care services need a complete overhaul along with more staff and better funding. The people who are directly affected by current policy, such as providers and people who use services, need to be involved in finding solutions to this crisis. More early intervention services can help people before they reach a crisis.

Service providers would like longer term funding to enable them to plan and improve staff retention and development as well as clarity around funding streams.

### What changed during the COVID-19 pandemic?

The pandemic exacerbated problems with waiting lists, lack of staff and services. It left many people who use services and carers without support and with their lives severely restricted leading to loneliness, isolation and deteriorating health. The pressures have taken a toll on the mental and physical health of staff.

Not all the impacts were negative. A small number of respondents commented that they had not experienced any change in services. Lockdowns helped some become more self-reliant, spend quality time with family and some pupils, especially those

with social anxieties or bullying issues at school, have benefited from not going to school.

The pandemic accelerated developments to create online methods of programme delivery and has made people more open to using IT options. This has had a positive impact for many people but the digital approach does not suit everyone and may make it difficult, especially for older people, to access and engage with services.

Respondents thought that in the long term it will be important to:

- Fix the problems that existed before Covid
- Support people to re-engage with services
- Support a return to face-to-face services
- Prepare for new and increased demands for services
- Increase mental health support especially for young people
- Continue providing services online
- Support existing staff and boost recruitment

## **Experience of Welsh-language services**

Overall, respondents concluded that provision of the Active Offer is “patchy”. Some reported doing this very effectively. Others reported that they can only make the offer at the point at which users of a service are assessed, rather than when they first make contact. Some were concerned that in practice, the offer is still tokenistic.

Many care homes and domiciliary care providers find it difficult to follow through with the provision of a Welsh speaker: They conclude that more needs to be done to attract Welsh speakers to the profession and to support staff to improve their Welsh.

This needs to include opportunities for both complete beginners and those who need to gain confidence.

## Introduction

This report sets out how we carried out consultation and engagement with people who provide or use care and support services to inform the North Wales Population Needs Assessment.

This report will help inform the Equality Impact Assessments that will be carried out on decisions that use evidence from the Population Needs Assessment. It also provides evidence of how we are meeting the requirements of the public sector equality duty.

## Background

The Social Services and Wellbeing Act (Wales) 2014 requires each region to produce an assessment of the care and support needs of the population in their area, including the support needs of carers by April 2021. The six North Wales local authorities and Betsi Cadwaladr University Health Board (BCUHB) supported by Public Health Wales have produced a population needs assessment for the North Wales region. This is the second assessment we have produced. The first one was published on 1 April 2017.

The report will be used to inform the area plan which has to be prepared jointly between the health board and local councils overseen by the Regional Partnership Board. The area plan must be published by April 2022.

It has been agreed with Welsh Government that there is no requirement to carry out an Equality Impact Assessment on the Population Needs Assessment. This is because the needs assessment is part of the evidence gathering process that informs decision making alongside the Equality Impact Assessment process. The needs assessment will include information about the needs of people with protected characteristics, informed by consultation and engagement, which will help inform new policies, strategies and service changes and understand their potential impact.

Actions and plans developed using the evidence in the Population Needs Assessment will need an Equality Impact Assessment to assess their potential impact.

## Public sector equality duty

The Equality Act 2010 introduced a new public sector duty which requires all public bodies to tackle discrimination, advance equality of opportunity and promote good relations. This means public bodies must have due regard to the need to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited under the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

Having due regard for advancing equality means:

- Removing or minimising discrimination, harassment or victimisation experienced by people due to their protected characteristic.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Taking steps to build communities where people feel confident that they belong and are comfortable mixing and interacting with others.

Councils in Wales also have specific legal duties set out in the Equality Act 2010 (Wales) regulations 2011 including assessing the impact of relevant policies and plans – the Equality Impact Assessment.

In order to establish a sound basis for the strategy we have:

- reviewed performance measurement and population indicator data
- consulted as widely as possible across the North Wales region including with the general public, colleagues and people with protected characteristics;
- reviewed relevant research and consultation literature including legislation, strategies, commissioning plans, needs assessments and consultation reports

More information is available in the background information paper.

This report sets out the consultation carried out for the strategy:

- who we have consulted with;

- how we have consulted; and
- the consultation feedback.

## Consultation principles

A key part of the process is consulting with people who may be affected by the strategy and in particular people with protected characteristics. The protected characteristics are:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion and belief
- Sex
- Sexual orientation
- Welsh language

Case law has provided a set of consultation principles which describe the legal expectation on public bodies in the development of strategies, plans and services. These are known as the Gunning Principles:

1. Consultation must take place when the proposal is still at a formative stage.
2. Sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response.
3. Adequate time must be given for consideration and response.
4. The product of the consultation must be conscientiously taken into account.

Local councils in North Wales have a regional citizen engagement policy. This is based on the national principles for public engagement in Wales and principles of co-production which informed our consultation plan.



# Consultation and engagement

## Consultation process

The aim of the consultation was to identify the care and support needs of people in North Wales and the support needs of carers. The Welsh Government guidance requires that the report include the following population groups:

- Children with complex needs
- Older people, including dementia
- Health, physical disabilities and sensory impairment
- Learning disabilities
- Autism
- Mental health
- Carers
- Violence against women, domestic abuse and sexual violence

We worked with partners, including those working on the Public Services Board Well-being Assessments, to collate and summarise findings from consultations that had been undertaken in the last few years. We have published these summaries as part of a new [North Wales engagement directory](#) to help encourage wider use of findings from local and regional engagement activity. In addition, we carried out a survey to identify any other issues affecting people who use care and support services that we may have missed. This report focusses on the findings from the survey. The survey findings along with findings from previous consultations and engagement activities carried out by local leads informed the final population needs assessment.

## Consultation questions

Due to the wide range of population groups and services that we planned to cover with this survey, the engagement group agreed a small number of open-ended questions so that participants had the opportunity to share what matters to them. This approach had worked well in previous regional consultations, providing a rich source of meaningful data. The consultation questions used were:

## About care and support services

Care and support includes help with day-to-day living because of physical or mental illness or disability for people of all ages. It includes children and young people with experience of foster care or adoption as well as unpaid carers who provide support to family or friends.

1. What do you think works well at the moment?
2. What do you think could be improved?
3. How has support changed due to Covid-19 and what do you think the long-term impact of this will be?

## Welsh language

All care and support services should provide an “Active Offer”. This means providing a service in Welsh without someone having to ask for it. The Welsh language should be as visible as the English language. For more information, please visit Social Care Wales: Using Welsh at work webpages. We would like to hear your experiences of using and/or providing services in Welsh, including:

- the “Active Offer”
  - opportunities for people to use Welsh and,
  - on treating the Welsh language no less favourably than English
4. Please tell us about what is working well at the moment and what needs to be improved

## Project timetable

The timetable for the development of the needs assessment was as follows.

| Month completed | Actions   |
|-----------------|---|
| June 2021       | Project planning and recruitment  |
| October 2021    | Data collection and analysis  |
| October 2021    | Engagement and co-production with people who use services, carers, providers, front-line staff and other stakeholders |
| December 2021   | Write draft chapters and share for feedback   |

| <b>Month completed</b> | <b>Actions</b>   |
|------------------------|--|
| March 2022             | Approval by the Regional Partnership Board, six local authorities and health board |
| April 2022             | Publish  |

## Consultation methods

The consultation methods we used were:

- Online questionnaire circulated widely to staff, partner organisations, people who use services and carers. Alternative versions included an EasyRead version, British Sign Language (BSL) version, young people's version and print version.
- We also advertised the opportunity to take part through a conversation over the phone or an online chat.
- Partner organisations held consultation events.
- We asked partners to send us the reports from any related consultation events or surveys that they had already carried out in North Wales for other projects.

## Promotion plan

The survey was open between 2 August 2021 and 1 October 2021, with an extension to 11 October 2021 for the young people's survey.

Details of the consultation were made available on [our website](#). We promoted the link through steering group members (representing the six local authorities, health and other partners), to people on regional collaboration teams mailing lists including members of the provider portal. A press release was sent out by the Regional Collaboration Team together with the local authorities and health board. Various social media posts were shared on the Regional Collaboration Team Twitter feed as well as LinkedIn pages. Follow-up phone calls were made to encourage people to take part.

Local leads shared the survey widely through a variety of channels. The Regional Collaboration Team shared weekly updates about the number of responses received from each area and population group so that local leads could follow-up with under-represented groups.

In addition, the link to the online survey was sent to the county voluntary councils below, asking them to circulate it to their networks:

- Mantell Gwynedd (Gwynedd)
- Medrwn Mon (Anglesey)
- CVSC (Conwy)
- DVSC (Denbighshire)
- FLVC (Flintshire)
- AVOW (Wrexham)

Information was sent to members of the:

- Regional Partnership Board
- North Wales Leadership Group,
- North Wales Adult Social Services Heads (NWASH),
- North Wales Heads of Children's Services (NWHoCS)
- North Wales Learning Disability Group

Details were shared with to the third sector representatives on the regional population assessment leads network.

There was an event for seldom heard and ethnic minority groups held on 5 October 2021 jointly with the Regional Cohesion Teams East and West and Coproduction Network Wales, which about 40 people attended. Seldom heard and ethnic minority groups were also supplied with the survey together with the PowerPoint workshop presentation for dissemination and response - either by group representatives or individual members directly.

The young people's survey was also shared with Pride Cymru Youth, EYST (Ethnic Minorities and Youth Support Team Wales, Heads of Education and other young people's groups.

## Consultation and engagement review

There were 350 responses to the survey. Around 61% of responses were from people who work for an organisation involved in commissioning or providing care and support services. More people took part in previous engagement activities and those organised by local leads, but this report focusses on responses to the survey.

Table 1 show the areas that participants were interested in.

Table 1 Number of responses by area of interest

| Type of response                    | Number | Percentage |
|-------------------------------------|--------|------------|
| Older people                        | 150    | 44%        |
| Children and young people           | 125    | 35%        |
| Mental health                       | 115    | 33%        |
| Learning disabilities               | 110    | 32%        |
| Physical and/or sensory impairments | 90     | 26%        |
| Carers                              | 90     | 25%        |
| Autistic people                     | 70     | 21%        |
| Total number of responses           | 350    | 100%       |

Some people may have ticked more than one box. Numbers have been rounded to the nearest 5 to prevent disclosure of personal information.

The consultation reached people from across North Wales as shown below.

Table 2 Number of responses by local council area

| Local council area        | Number | Percentage |
|---------------------------|--------|------------|
| Anglesey                  | 80     | 23%        |
| Gwynedd                   | 50     | 14%        |
| Conwy                     | 60     | 17%        |
| Denbighshire              | 75     | 21%        |
| Flintshire                | 135    | 39%        |
| Wrexham                   | 100    | 28%        |
| Total number of responses | 350    | 100%       |

Some people may have ticked more than one box (for example if they lived and worked in different counties). Numbers have been rounded to the nearest 5 to prevent disclosure of personal information.

We also reached people in all age groups apart from those under 16, disabled people including people with a learning disability or long standing illness/health condition, carers, Welsh and English speakers. There were fewer responses from people aged over 75. We had responses from women and men although there were not as many responses from men. We also had a small number of responses from people with different ethnic identity, national identity and sexuality to the majority. We only got a small number of responses from trans people although we will be including findings in the needs assessment from other research and consultation reports about the care and support needs of trans people.

We will make sure to use evidence from previous local and national consultations about the needs of children and young people in the needs assessment due to the low number of responses to the survey. We will also review how we engage with children and young people as a regional team because an online survey with does not seem to be an effective method for this type of consultation.

We are making these limitations clear so that anyone using the needs assessment as evidence can take any additional action needed to eliminate potential discrimination.

We used the equality data to monitor the responses while the consultation was open and encouraged groups representing under-represented groups to share the survey and take part. The consultation deadline was extended by two weeks to allow more time to reach under-represented groups. We also extended response for the young people's survey a further two weeks. The full list of data tables showing the number of responses from people with protected characteristics is included in [appendix 1](#).

As part of this process, we identified many similar consultations being undertaken by partner organisations and concerns around consultation fatigue. To help coordinate, we created a webpage that collated the different surveys and events that we were aware of and let participants know that we were working together to share findings. We also developed an online [North Wales engagement directory](#) to make the findings from these surveys more easily accessible. However, the regional engagement group that oversaw this work recognise that there is more to be done to improve the coordination of consultation and engagement exercises. We need to reduce duplication and make best use of people's time and effort in providing feedback to our organisations.

## Organisations represented in the online survey

Below is a list of organisations whose staff took part in the online consultation.

### Local authorities and health

- Betsi Cadwaladr University Health Board
- Isle of Anglesey County Council
- Gwynedd Council
- Conwy County Borough Council
- Denbighshire County Council
- Flintshire County Council
- Wrexham County Borough Council

### Other groups and organisations

- Action for Children
- Adferiad
- Adra Housing Association
- Age Connects North Wales Central
- Age Cymru Gwynedd a Mon
- Alexander's Pharmacies
- Allied Health Care
- Amber Care Ltd
- Anheddau Cyf
- AVOW
- Awel Homecare and Support
- Caia Park Community Council
- Canolfan Felin Fach Centre Limited
- Carers Outreach Service
- Carerstrust Crossroads
- Cartrefi Conwy
- Castell Ventures
- Centre of Sign-Sight-Sound
- Child development centre
- Citizen's Advice Bureau
- Colwyn Bay Men's Shed
- Conwy Connect
- Co-options
- Corwen Family Practice
- Designed to smile
- Digartref
- Doridale Ltd
- Double Click Design & Print CIC
- DSN
- Epilepsy Action Cymru
- Fairways Care Ltd
- Family Friends
- Flint connections office
- GISDA
- Gresford Community Council
- Grwp Cynefin
- Gwynedd and Anglesey Youth Justice Service
- Gwersyllt Community Council
- HF Trust
- Hollybank Home Care Ltd
- Home-Start Cymru
- Integrated family support service

- Medrwn Mon
- Mental Health Care Ltd (Avalon)
- Menter Fachwen
- MHC
- Newcross health and social care
- Next steps
- North East Wales Mind
- North Wales Advice and Advocacy
- North Wales Community Dental Service
- North Wales Together Learning Disability Transformation Programme
- NW Nappy Collaborative CIC (Given To Shine)
- Offa community council
- Plas Garnedd Care Ltd
- Premier Care Ltd
- Q care ltd Prestatyn
- QEWC Ltd
- Resilience
- Rhyd y Cleifion Ltd
- Same but Different
- Sanctuary Trust
- Stepping Stones North Wales
- Stroke Association
- Summit Care Services
- TGP Cymru
- The Wallich
- Total Care North Wales Ltd
- Towyn Capel Care Homes
- TRAC (part of North Wales Project)
- Ty Ni Family Centre- Flying Start
- Tyddyn Mon
- Vesta Specialist Family Support
- Vision Support
- We Care Too Ltd
- Wepre Villa Homecare Ltd
- Whitehouse Residential Home
- Woodland Skills Centre
- Y Teulu Cyfan



# Consultation findings

## 1. Social care for people of all ages

### (a) In general

#### **What is working well:**

At a strategic level, information flow and co-operation across the Care Inspectorate Wales, Public Health Wales and Welsh Government and Local Authorities has been working well.

Third sector services are thought to be very effective, covering a wide range of support areas, fulfilling the role of many statutory services, and successfully engaging and connecting with those in need. Third sector and statutory sector organisations are developing strong partnerships, particularly in North Wales, and when both are supporting community development. The gradual move to longer term contracts is allowing third sector organisations to invest in staff development and capital projects.

The approach set out in the SSWB Act (Wales) 2014 is generally being followed. Signposting between services and improved networking has led to better access to support. For example, if someone is not eligible for a service, they are signposted to another relevant service to ensure they're not left without help.

The Well-being Network in Anglesey is one example of an effective network. They share a vision of developing services in accordance with the Well-being of Future Generations Act. The joint planning and provision between the Health Board, the Anglesey GP Cluster, Anglesey County Council and Medrwn Môn (and the wider Third Sector) is thought to be extremely successful. The Integrated Care Fund “has been a blessing” for the Network, enabling effective planning and ensuring quality services.

The Single Point of Access provides easy access for some services, and might prove effective for all assessments. The community Hub (Canolfan Ni) is thought to be excellent.

Some people using care services are having more voice, choice and control over how their needs are met, especially through use of direct payments. People are

supported to make choices that are right for them, their families, their priorities and aspirations. People are actively involved in identifying, implementing, monitoring and managing their support, rather than being passive recipients of a service. This creates true co production within the system and real incentives for arrangements to be successful and sustainable.

### **What needs to be improved:**

Relationships between the voluntary and third sector and health and social care professionals need to be improved, since third sector services often seem to be “grossly undervalued” by many health and social care staff. Issues raised by third sector organisations appear not to be taken seriously by some health and social care professionals, in particular when system failures are highlighted that cause significant concern for residents/patients. Third sector staff are not treated with respect, even though their levels of engagement and understanding of the issues are far more in depth.

Community Care Collaboratives were thought to be “too big and are giving a very poor service at present”.

Communication within organisations and between organisations needs to be improved to support effective implementation of the SSWB (Wales) Act 2014:

“There appears to be a huge contradiction between the intentions of the Act and the reality of care for thousands of older people... there is a clear divide between people who need critical care in their own homes, and support to achieve personal well-being outcomes... Whilst empowering people to have greater control over their lives is an embedded principle, it is not appropriate when people are in crisis. If initial support helped people overcome their crisis, then there may be an opportunity to have another conversation about how their needs could be met in different ways going forward. This may free up capacity in the system.”

Service providers would like longer term funding, to be able to plan for “*long term provision that can develop and evolve, whilst maintaining consistency in the workforce*”. Short term contracts can be detrimental to services, as the good workers leave for longer term jobs, and the process of interviewing, appointing and training

has to be regularly repeated. This negatively impacts on consistency, skill development and relationship building.

Some would also like greater clarity around funding streams such as the Integrated Care Framework (ICF) and Continuing Healthcare (CHC) funding. People applying for CHC funding would like there to be less paperwork and for support with the application to be provided, for example, via their social worker.

In general, many thought social care services need more staff and the services themselves need a complete overhaul. Levels of support are poor, waiting lists are long and often services or transport to services are not available. The people who are directly affected by current policy, i.e. providers and service users, need to be involved in finding solutions to this crisis.

One major way forward would be to improve pay and conditions for staff so as to attract more people to the profession. Otherwise it will be impossible to meet the increasing needs of the community. As well as being “very underfunded”, social care seems to be “undervalued by large chunks of society”. Future policy needs to raise the profile of these services and improve their public image, to better reflect their importance and value to society:

“We need positive messaging that supports people’s choices to move into social care. Positive information about the role of Personal Assistants, what they give, but also what they get back in return.”

When recruiting care staff, one service user suggested that paid carers are “vetted more thoroughly” to avoid risks to vulnerable people. A service provider recommended greater specialisation in caring roles, for example by providing additional training for working with migrant workers. Any training, within a 12 or 24 month period from a previous provider, should be able to transfer to new provider/employer in the same way as DBS checks.

Service users would like improved access to social workers, to be able to speak to them when needed. Some thought social workers should be allowed more time to work with and listen to their clients, and should not be allowed to hold another active post. Also referrals to social workers need to be dealt with more quickly.

Other service users felt that more people need to be given the option of direct payments for health and social care support, since few have a choice and level of control at present. They emphasised that choice of care package needs to meaningfully involve the service user, carer/funder and social worker to ensure “client-centred care”. In addition, people pooling their resources get better outcomes together, help to build communities of support, reduce the need for statutory support and are cost efficient. However a change in culture and approach is needed to support such opportunities.

Some respondents suggested that more should be done to reduce any stigma and shame around asking for help, particularly for families experiencing in-work poverty:

“This is a service which enters individual’s homes and families. So it needs to be viewed in a sensitive way, as it does take a lot of courage to request for this help in the beginning!”

Access to services could be improved by “Wider communication of how to contact social care for those who do not have computer skills”.

## **(b) Mental health services**

### **What is working well:**

Several respondents commented that “nothing” is working well in mental health services, concluding that “the system is quite broken”.

A service user was concerned that services tend to focus on prevention or crisis, failing to provide support to people “at all the stages in between”. Furthermore, during crises, people with mental health problems can find themselves caught up in the criminal justice system, resulting in people being “criminalised because of their illness”. The system does not seem able to support people who have mental health problems as a result of past trauma. Many services need to become more trauma informed.

A few services were mentioned as providing positive support including:

- Team Dyfryn Clwyd
- the Mental Health Support services team of Flintshire County Council
- Mind’s Active Monitoring, an early intervention service

- charity services like Samaritans, CRUSE, Relate
- ongoing group support from charities (KIM, Advance Brighter Futures, Mind, ASNEW)
- rehabilitation units to provide support for a return to living in the community

Similarly, some individual professionals were reported to provide excellent care, but generally, “it’s a bit of a lottery” as to the quality of support provided.

One service provider highlighted that it is important for mental health care plans to be regularly reviewed to allow for any improvement or changes in an individual’s needs.

### **What needs to be improved:**

Given the serious concerns about mental health services, not surprisingly many commented that “everything” needs improving, including:

- more mental health service provision
- increased funding to ensure a decent wage for staff and sufficient service provision for each individual client
- improved access for BME communities
- more long-term funding to allow projects to be embedded and to retain staff
- more flexibility – one-to-one sessions as well as group sessions
- higher staffing levels in all services to avoid gaps in care and provide back-up when staff are off-sick
- more local counselling services
- better substance misuse support
- better support for people with Autistic Spectrum Condition (ASC), especially higher functioning or with coexisting mental health issues
- greater access to interventions other than medication
- many more out of hours services where people can “held” when mental health services are closed
- improved referrals to mental health services, to streamline the process, reduce the number of inappropriate referrals and allow e.g. housing managers to refer tenants for specialist mental health support
- more mental health services in the local community
- smaller rehabilitation units for up to six people with 24 hr support

- greater availability of permanent accommodation and supported housing for people who are homeless
- case reviews need to be completed in a timely manner, and caseloads managed more effectively

Service users emphasised the need for many more early intervention services so they can access mental health support when in need, and **before** they reach crisis point. Waiting times were already very long and have only got longer. Currently, people experience added stress with delays, and their symptoms often get worse than they need to:

“I would prefer not to reach crisis. It should be less about having to be in crisis to receive support and more about preventative approaches to keeping me well at home.”

Similarly, gaps in service provision may cause people’s mental health to deteriorate:

“I now am in a waiting list for a new support worker and feel deserted at a crucial time in my wellbeing.”

Some thought greater priority should be given to investment in services for parents with mental health difficulties because of the risk of long term impacts on children and young people.

Two geographical areas reported to be in need of greater funding were mental health services provided by the Betsi Cadwaladr University Health Board (BCUHB), and the mental health support system in North East Wales, as one service provider commented:

“Often people come to us in crisis because they cannot get support, either with their mental health or with the practical issues that impact on their mental health (e.g. housing, debt, poverty, transport, family relationships etc). In order to make a step-change, much more money needs to be put into the system (parity of esteem with physical health) and the way funding is used needs to change so that there is more early intervention.”

One solution is for closer working with third sector services, to provide the stabilisation that service users need before they can benefit from psychological support:

“Peer support, activity and wellbeing groups, mindfulness and CBT based training courses could all support people during their wait and “get them ready” to get the most out of the professional services. It would also provide a valuable step-down after using the services, making leaving easier.”

Such an approach would also help to prevent dependence on the team and enable service users to develop coping skills and strategies. This could help to reduce staff caseloads and budget pressures.

In terms of staff development, students could be more involved to bring new ideas and skills sets to services. Existing staff may benefit from specialist training and support to develop their practice, completing performance and development reviews annually to enable them to deliver a more robust and cost-effective service.

## **(c) Services for people with learning disabilities**

### **What is working well:**

Services for people with learning disabilities are working well where they:

- take a flexible approach
- provide different opportunities for people to have a variety or choice of activities or work placements
- make good use of community facilities and/or groups
- include online and face-to-face activities
- support people to learn new skills to become independent

Service users appreciated the support they had received during the pandemic from “good and helpful staff”. One service user praised their work experience at Abbey Upcycling, and others reported:

“I currently receive support from Livability. They’ve helped me a lot especially through lockdown. Quite a lot of fun was had – they’d ring, we’d play games, had a chat on the What’s App group. My support workers have all been wonderful.”

“The Salvation Army (Wrexham) are providing my son with Till Training Skills, so that he might one day be able to volunteer in a shop. He has been turned

down for this type of work as he lacks these skills. The training is excellent. He has work experience with The Red Cross - this is excellent.”

Service providers commented on how well they are working with other agencies and were grateful for the recent support they received from social services, mentioning the Local Authority at Gwynedd and the BCUHB. BCUHB is acting as host employer for a project that helps people with learning difficulties gain employment, and has developed an “accessible” recruitment pathway for this purpose.

### **What needs to be improved:**

In common with other care services, some respondents commented that much needs to be improved. Council services were described as “poor and too generalised”, and needing “rebuilding from top to bottom”. Again it was suggested that funding be increased, and staff wages improved to reflect their level of responsibility and to encourage them to stay in the job. Waiting times for assessments also need to be reduced.

Support workers could benefit from developing their digital skills to be able to support service users to become connected digitally. In addition, many more social workers and other professionals are needed with specialist skills to support people with complex needs, for example:

“We definitely need more Adult Care Social Workers to help people with a learning disability and autism, like my son. We also urgently need a specialist psychologist for people with a learning disability and autism. There is no-one qualified in Wrexham to do this work. As our son was suicidal, we paid for a specialist psychologist as we were desperate for someone to help him.”

“People with learning difficulties said they would like, “More hours for direct payments please so I can go to other places and more often”, and “a non- judgemental support centre, to access information, ask questions, socialise, and share/talk”.

Carers commented that having regular reviews with service providers would be very valuable to be able to discuss whether any changes to support levels are required and to ensure that care is tailored to the individual. For example, one parent wanted to inform support workers that their child needed to be told to take a jumper off when hot, as this had not happened during hot weather.



Some were concerned that carers/ parents might not ask for the help they need if isolated and “feel a failure”. It is important that social services don’t always focus on “those who shout the loudest”.

Adults with learning disabilities need more opportunities for work experience and training to develop their confidence and skills. While the availability of Access to Work services is patchy, existing services are lacking referrals and would like more to be done at the point at which people leave college, to help match individuals to the opportunities available. The culture of low expectations and poor perceptions amongst employers needs to be challenged and clear pathways into work for people with learning disabilities need to be created. The local authorities could play a key role, but currently employ very few people with learning disabilities.

More bespoke housing is needed to cater for individual needs, particularly adults with learning difficulties and others with complex disabilities. Step up/step down services are needed, where there is a placement breakdown and an individual needs more intense support for a period, rather than admission to hospital.

The involvement of people in the co-design of care and support services is still an area that needs improving, as well as person-centred approaches to increase the service user’s voice and control over own their lives. This could be helped by mandatory training in the values and principles of co-production for all staff, co-delivered by service users.

At a system level, there needs to greater integration of health and social care services, as this has not progressed for learning disability services, since “different models are still in use across the region and joint funding is still an ongoing area of disagreement and dispute”.

## **(d) Services for people with physical and/or sensory impairments**

### **What is working well:**

One service user reported that they are “struggling to get the support they need.”

Others thought that the Accessible Health Service and BCUHB’s diversity work is working well, as well as the provision of aids, adaptations and the befriending service offered by the Live Well with Hearing Loss project.

A service provider commented that partnership work with local social service departments and third sector organisations is strong, which supports delivery of a wide range of quality services, networking and sharing good practice.

### **What needs to be improved:**

Access to information and advice in alternative formats is a big challenge for service users with sensory and physical disabilities, in particular information from local authorities and the NHS. Printed material is not appropriate for many, while the increase in online only access to services and information is a major barrier for others.

For Deaf people in North Wales, the provision of information, advice and assistance (IAA) is described as a “postcode lottery”, where some people can access support Monday to Friday 9am to 5pm, while others are limited to certain days of the week. More generally, Deaf people find it difficult to access many activities, as there is no communication provision.

People with disabilities, especially younger adults with disabilities have limited access to care and support that is person centred. People have to wait too long for assessments and support, and communication with social workers needs to be improved.

Those with disabilities that are invisible, fluctuating or rare, can find themselves excluded from services because they fail to meet certain criteria, such as “full-time wheelchair use”. In fact, many wheelchair users have some mobility. Services are therefore creating a “disability hierarchy”, rather than responding to individual needs.

Again lack of care staff is a concern, which means care is provided at a time that suits the care agency, rather than when the client needs it, and staff sickness and holidays are not always being covered.

## **(e) Services for people with autism**

### **What is working well:**

Few respondents commented on what is working well, and a couple responded that services are too slow and not much support is available.

The Integrated Autism Services (IAS) are thought to be very positive, as well as the use of direct payments.

**What needs to be improved:**

Some respondents thought “everything” needs improving. In particular they recommended that:

- services should be more person centred
- staff should receive specialist training
- waiting times for assessments should be reduced
- communication with services should be improved
- staff could be more open and honest throughout all services
- a Partnership Board Hub should be established for all providers to meet and share information

## 2. Social care for children and young people

### (a) In general

#### **What is working well:**

Across the sector as a whole, respondents described the following as working well:

- positive and trusting relationships with Local Authority managers, social workers and health colleagues, to support collaborative working
- good communication between support providers
- flexibility in working practices, especially though the pandemic
- making a wide range of services available
- funding from the Welsh Government to support the early years
- the passion, resilience and commitment of staff in this sector
- links between care services and schools, School Youth Workers especially have improved the number of young people who get access services
- Post-16 Wellbeing Hubs have engaged with those who have been NEET for a while and helped them into training

Specific mention was made of the services provided by Teulu Mon, which are thought to be “friendly and efficient”, the team around the tenancy at TGP Cymru, who “go above and beyond to help sort things”, and the early years” sector in Flintshire.

The Wrexham Repatriation and Preventative project (WRAP) service was described as working well to increase placement stability for children and young people in foster care, in residential care or going through adoption. It helps carers to work in a more informed way with children who have experienced trauma, and helps the children to process their early traumatic experiences. More generally, the processes in place to approve and support foster carers are thought to be effective.

The general approaches to providing services for children and their families that are thought to work well included:

- working with the whole family holistically, and being adaptive and flexible enough to respond to the needs of each family member at any one time
- tailoring any individual’s care plan to their specific needs

- focusing on recovery to enable people to achieve personal outcomes and become less reliant on services
- using direct payments, including group payments as this provides a cost efficient way of supporting people
- providing support for families in the early years, via the Early Year Hub or Team around the Family
- making good use of community based resources
- making good use of volunteers, as they are accepted as “friends” rather than “someone from a specific agency telling them what to do”

### **What needs to be improved:**

The level of staffing was again raised as a serious concern:

“The local authority is really struggling, and at times they are overwhelmed. They are struggling to fill posts, many of the social workers have high caseloads and there is a high turnover of staff.”

This is detrimental to the children receiving care, as they need consistency and positive relationships. Better workforce planning is needed to deliver quality services and avert a social care crisis. This is likely to require increasing salaries and job benefits, increasing respect for the skills required for this work and finding ways to retain existing staff.

Many respondents commented that more funding is required from the Welsh government to address the staffing issues and to ensure a full range of services can be made available. Many services are not fully funded. Longer term funding is required to provide sustained support to young people. Each child would benefit from having a key worker to help co-ordinate services and meetings, and to support them to ensure their voice is heard throughout. This means moving away from short term project work:

“Funding currently runs year to year, this doesn’t give the project enough time to put in the right support for some young people and some of them need over 6 months of support.”

“Working on a shoe string poses more challenges than solutions... longer term grant awards would ensure better planning and value for money, and improve internal processes e.g. procurement/legal processes.”

Some thought that early intervention, especially where adverse childhood experiences (ACEs) are identified in the family, needs to happen more often. Similarly, early therapeutic intervention for children that are in care is needed to help them deal with the ACEs they have experienced.

Schools could do more to identify and refer children at risk before escalation, particularly as some teenagers are falling through the gaps. Greater provision of edge of care services with appropriately qualified and experienced staff is needed. More local venues are needed to provide therapeutic support for families.

Problems re-emerge when young people leave school, as their support systems stop unless they continue in further education. They often need continued support as they transition to adult services, which isn't often available. This is especially a concern for young people with complex needs. One practical solution would be to increase the availability of single bedroom housing stock, to enable young people leaving supported accommodation to move into a tenancy and receive intensive support.

One group of children thought to be frequently missed by social care services are those with rare diseases. They might only be identified if their condition involves disability or their family has other social care issues. Social care pathways do not seem to be adapted for these families, and are insufficiently sensitive to the challenges, leaving intervention too late or assigning issues to poor parenting too quickly. These concerns could be addressed by creating a register of affected families and increasing professionals' understanding of the conditions.

Greater numbers of foster carers are required to keep up with the demands on the service, especially when families are in crisis. Solutions include increasing the support package for foster carers as well as recruiting and training more carers. This will be cost-effective if it prevents numerous placement breakdowns and reduces the number of children in out of county placements and very expensive residential settings.

Given the scale of concerns about children's services, some suggested that a systems thinking approach to service delivery is required across the Local Authority,

Health Board, and Third Sector, to remove waste in systems and ensure service users don't have to wait a long time for care. The infrastructure to support a more collaborative way of working, such as IT systems, needs substantial investment. More joint working is needed on the Continuing Health Care process and Community Care Collaboratives for children.

## **(b) Services for children and young people with physical/sensory impairments**

Few respondents commented on this issue and those that did commented on healthcare provision.

## **(c) Services for children and young people with learning disabilities**

### **What is working well:**

Few comments were made here. Some mention was made of good support from schools and successful joint working across care organisations.

### **What needs to be improved:**

Recommendations for improvement included:

- more funding and staff
- better communication between services
- more activities made available
- more support for families with children with additional needs, who are violent

## **(d) Mental health services for children and young people**

### **What is working well:**

Respondents described the following as working well:

- collaborative working with local councils to promote services and ensure they reach the maximum number of people
- communication between agencies - police, children services and education
- counselling in high schools
- mental health and well-being apps
- phone lines such as The Samaritans and MIND

Others thought these services are not working well at all, since “it is impossible to get appointment for mental health and child related services”.

### **What needs to be improved:**

A consistent message from many respondents was that there is a massive gap in children’s mental health services, waiting lists are too long and families are struggling.

Specific recommendations for improvements were:

- better access to Child and Adolescent Mental Health Services (CAMHS) and the neurodevelopmental team for young people
- integrating mental health services into schools, especially counselling for primary school children and raised awareness of trauma amongst staff
- increasing the number of Looked-after Children nurses
- joint working between mental health services and other children’s services to streamline care
- increasing psychological support for children, especially those in care and less reliance on medication as an intervention
- more counsellors, especially male counsellors and counsellors speaking Welsh, Polish and other languages
- one stop shops to find out about and access all services in a local area
- making the transition from child to adult services more user-friendly for young people and tailored to the individual’s developmental needs

## **(e) Services for children and young people with autism**

### **What is working well:**

Few respondents identified where services for children and young people with autism are working well, but these included:

- individual educational psychologists
- organisations providing quality support, STAND NW, the Conwy Child Development Centre and Ysgol Y gogarth
- the bespoke tailored support offered to each family/individual



## **What needs to be improved:**

Some respondents concluded that “*everything*” needs to be improved to give more attention, care and support to parents and their autistic children. Waiting lists for autism assessments are “*phenomenally long*” and few services available. Parents said they would like more information about how their case is progressing up the list, and to be given some advice while waiting.

Identified gaps in services included:

- services for children at the high end of spectrum
- respite care once children are 11 years old
- after school facilities with sufficiently trained staff
- services for autistic children with anxiety and communication problems

Parents voiced concerns that teachers in specialist schools are not all qualified and accredited to work with autistic children. They thought that all lessons need to be delivered by teachers who have training in dyslexia, sensory needs, executive functioning difficulties, slow processing and so on. It is especially important for teachers to be trained to recognise and support autistic children with complex needs, who present as socially fine and can mask their problems well. Twenty minutes per week of one-to-one teaching from the additional learning needs co-ordinator is not sufficient.

Parents and carers described, “being left with the results of trauma caused by teachers who don’t understand the pupil’s needs. So as well as caring for our child, we have to fight to try to force school to make provision for our children. We have this tremendous extra burden over and above our own caring role”.

Parents and carers need more respite care themselves as one parent explained, “I am beyond exhausted. I’ve had to leave my specialist nurse job of 23 years to become my daughter’s full time carer, as there’s no support for her”.

Social groups for parents could provide opportunities to discuss common difficulties and share learning about solutions. More support and training is needed to helping parents cope with their child’s autism.

At a system level, service providers would gain from:

- improved networking forums
- secure funding from local authority
- co-ordination and collaboration to prevent competing with one another for the same grants and avoid overlapping services

Parents would like staff across organisations to be working together “so you don’t have to give the same information every time and it’s not someone new every time”.

## 3. Social care for older people

### (a) Older people's services in general

#### What is working well:

Many respondents commented that “nothing” is working well in older people's services:

“Everyone is trying their best, but the money isn't there, either for extra staff or better use of departments, and communication between them all is a huge problem too.”

Some thought there are pockets of examples where services work well, where teams from across different sectors and different organisations work together to meet the needs of older people, and where well-trained and committed staff work very hard in difficult situations.

“I needed care support quickly for my father, when mum went into hospital. Even though they had only recently moved here, their needs were met by a combination of Community Agent, Social Services and Homecare Matters. I was very impressed with the speed their care needs were arranged.”

Specific examples of local services working well included:

- fast assessments for older people in Flintshire
- proactive and dynamic social services in Flintshire
- improved integrated care and support plans in Denbighshire
- excellent care from individual staff in Wrexham Social Services
- support from Gorwel with housing related needs

The approaches to providing care to older people that respondents thought to be working well included:

- offering a variety of support options for people to choose from
- options to engage with services and communities both online and offline
- delivery of bilingual services
- care homes that ensure wellbeing outcomes and independence, and provide the security of overnight care when needed

- support services in people's own homes
- providing older people with low level support, such as information and contact numbers, so that they can help themselves and remain independent

### **What needs to be improved:**

Again a number of respondents thought that "everything" needs to be improved because, "The Health and Social Care system is broken. We have an increasing ageing population and no provision for this".

Many more staff are required. One important gap is the provision of support to older people leaving hospital. People are being discharged from hospital with no care in place, and end up back in hospital because they can't manage:

"More people could be seen, if there was less paperwork. People could be discharged from hospital and mental health wards more quickly, if health colleagues were more aware/familiar with processes involved. Not enough social workers for the amount of referrals that are being received. Urgent cases are dealt with by the duty social worker on that day. Having to have a duty social worker each day, means that the social workers lose a day or so out of each week, which impacts on their ability to oversee their own case load and take new cases."

Some respondents questioned whether there needs to be reconsideration of what's safe in the current context:

"Packages of care that require 4 double-manned visits a day are becoming increasingly impossible to provide. Does there need to be a rethink on what/who can safely be managed at home?"

"I cannot get my husband home. He's been in hospital 16 weeks waiting for care at home to be arranged. He is immobile and cannot do anything for himself, so needs carers four times a day. He's had COVID on his ward on three occasions."

Health professionals would benefit from being able to access live information about which providers currently have capacity to provide this care, to avoid wasting time contacting multiple organisations.

A carer questioned whether the current focus on independence for older people is in fact a mechanism by which to shift responsibilities and costs onto unpaid carers, ignoring the reality that frail, very old people “are only likely to decline mentally and physically”.

Services are aimed at crisis management rather than focussing on preventative support. This results in people being admitted to placements far away from their homes and against the wishes of the family. Further investment in specialised services is required to ensure older people receive the help that they need **before** they reach crisis point.

Some respondents were concerned that older people with high levels of need, such as nursing needs and dementia care, are not receiving adequate levels of care, because only low level care is available. While emergency care is being provided for older people who fall and are injured, a response service is needed for non-injured fallers and for out of hours domiciliary care. Currently if an older person needs additional support due to an unexpected incident such as their carer becoming unwell, they have no access to support whatsoever.

A wider range of suitable housing options is also needed to accommodate the different needs and varying levels of care support of older people.

People using services thought older people’s care needs to be:

- streamlined so that one person can provide a range of support rather than lots of people doing their own little bit of support
- better organised so that the individual’s needs can be met properly
- provided by the same staff member, so “you don’t have to repeat yourself every time” and the staff get to know the individual and their needs
- better monitored to ensure the correct amount of hours are delivered
- more flexible, so they can be delivered only when needed, at a time that suits the client, and can be adapted in response to a change in needs
- longer-lasting, with lengthier review periods, rather than closing cases “at the first opportunity”
- better advertised so that information is available in multiple places and media formats, not only relying on the internet
- needs-led rather than requiring the service user to fit with what’s on offer

- supported by direct payments, so older people can manage their own care, employ their own staff

“As a 92 year old man, I found the home-help service helpful but limited. I became able to do jobs myself, so cancelled the service. I am now wondering whether the service could “wash, clean areas above head height and below knee height”. The point being that my needs change and require reviewing.”

Some thought that improvements to services would come from more effective and extensive joined up working between local authority and private care, and between health and social care services. Communication around hospital discharge from hospital and co-ordination of joint care packages are two of the main issues of concern.

“There is absolutely no joined up thinking or approach between health, social care, charitable and contracted care companies. This means a carer has to try to co-ordinate all these services, which adds to their burden.”

The majority of respondents reported that staff shortages are one of the biggest problems for older people’s services. Few people want to work in the care sector, and salaries are too low, given that older people’s needs are far more intensive than they were years ago.

“A massive recruitment shortage is affecting the end service user, who is vulnerable and elderly, with poor quality of calls, missed calls, and not being able to provide full amount of time agreed in care packages.”

Proposed solutions included:

- increasing staff salaries above minimum wage and improving working conditions to attract more new recruits and retain existing staff
- investing in training and creating a better career structure for care staff with financial reward for developing skills and experience, so that services are provided by trained professionals, rather than inexperienced young people
- posts to become permanent rather than fixed term or reliant on funding
- establishing standard terms and conditions for staff across the sector to improve the stability of the workforce

- supporting and incentivising care agencies to deliver safe, single-handed care and upskilling staff in this, so that double-handed care isn't automatically assumed to be necessary

“There should be a Wales wide approach so that all public and private providers pay the same improved wages to staff. Gwynedd are looking to give the carers more responsibility for their work and thus pay them more. To partly facilitate this, they are going to pay a higher fee to the providers and enforce a set rate per hour for the carers. If this approach were adopted across Wales it would attract and retain more carers and would help solve one of the most important problems with community care at the moment.”

Such changes clearly require more funding from the Welsh Government, so that services can function at their optimum level, and service users are supported with high quality care in a timely manner.

Another suggestion was to adopt an Italian model of “strawberry patch” care providers, whereby small businesses work together to share purchasing and training and then spread out via additional small enterprises.

## **(b) Services for older people with physical/sensory impairments**

### **What is working well:**

Few respondents commented on where services for older people with physical/sensory impairments are working well. They reported the following:

- health and social care staff and the third sector are working more closely together than they used to, partly through the introduction of Community Resource teams
- the new Chief Office of Denbighshire Voluntary Services Council is encouraging better working links between the third sector and social value organisations
- NEWCIS, is providing valuable respite care (though this is limited)

### **What needs to be improved:**

Accessible and affordable housing is desperately lacking, which has a knock on effect on services as people have to access more support. Many new houses are not designed to be accessible. This has a detrimental impact on how disabled people

and older people live. Their only option is residential care, as more flexible and creative options are lacking.

Very little support/counselling/advice is available for people who are having problems coping with loss of hearing and are feeling isolated and or frightened. It is difficult for example to find courses to learn sign language. Services are fragmented and there is no central point of contact for support, information. Social workers who specialise in helping people with hearing difficulties would be helpful.

Staff in a nursing home reported finding it difficult to access social care for their residents, because social workers are closing cases once the individual is admitted to the care home. They said they found the Single Point of Access referrals time-consuming and were concerned about the lack of continuation in care.

Specific recommendations to improve services included:

- better timekeeping
- more staff so that carers are not rushed and the two staff turn up when needed
- better liaison between staff so that the needs of the client are always met
- increased frequency of review of care needs
- actions being taken to ensure matters raised on review are addressed

## **(c) Services for older people with learning disabilities**

### **What is working well:**

Only direct payments were thought to be working well.

### **What needs to be improved:**

Recommendations included allocating more hours of care and increasing the number of staff.

## **(d) Mental health services for older people**

### **What is working well:**

Service users and carers mentioned the following specific services as providing valuable advice and support:

- The Alzheimer's Society
- NEWCIS



- The 24/7 carers in Plas Cnigyll
- Crossroads Health Respite
- The Trio service
- Bridging the Gap scheme for carers
- Dementia Social Care Practitioners
- The Hafan Day Centre

Services work well when they provide respite and support to both the person with dementia and their carer, so they can “have a short break from each other, but be in the same building”. Home visits also work well, particularly to help the carer adapt to living with dementia.

Some carers reported being able to find care quickly when they needed and feeling well-supported:

“When I made a call to “single point of access” I couldn’t have spoken to a more caring person, and I was extremely distressed at the time. Having that access was reassuring - their help will be required again I’m sure.”

Service providers reported that support from social services is working well, particularly the weekly meetings with staff, financial support and PPE provision as well as good communication about what’s happening in the care sector. One respondent highlighted the high quality support from CIW and Flintshire Social Services.

However, a social worker with many years’ commented, “currently I honestly think there is very little that is working well”. Only the Telecare services, along with the fire service, were thought to have been working well to keep older people safe.

### **What needs to be improved:**

Generally more services need to be made available to reduce waiting lists, and referrals improved to make access easier. Specific recommendations for improvement included:

- make a comprehensive list of the existing services more widely available to reach potential service users before a crisis point
- open day centres for a greater number of days per week, including bank holidays and weekends

- end any “postcode lottery” in services such as the free sitting service for people with dementia that is available in Denbighshire, but not Flintshire

To this end, funding of services for older people needs to be equal to those of other service groups. Funding for individual care also needs to be simplified and made consistent. For example, Continuing Health Care funding is reported to lead to different outcomes in similar cases.

Recruitment of care staff for dementia services is difficult:

“The stress has been too much on the staff during the pandemic, no matter what we pay them, they are just utterly exhausted. It puts others off to come into care work.”

The lack of staff means that care becomes task-focused rather than treating service users “as human beings”. Lack of staff in care homes is reducing communication with families and calls are not being answered.

The care provided by domiciliary carers could be improved by ensuring staff are encouraged to work in the field where they have most talent, either working with mental health or physical health. Those working with people with dementia require specialist training and extra time to complete tasks. There is a lack of dementia trained care workers, which should be addressed by the local authorities. Social services need to ensure the agencies they employ to provide dementia care are fulfilling their obligations and following care plans carefully. The profile of the profession needs to be raised to attract a high calibre of staff.

A gap in services exists in relation to short home calls for support with medication. Neither health nor social care services provide calls only for medication, but older people with memory problems do need this vital care.

At a system level, health and social care need to work together more effectively. One suggestion for a joint initiative would be to develop a North Wales Dementia Centre, that can provide pre- and post- diagnostic support to all. This is supported by the All Wales Dementia Standards.

## 4. Services for carers

### What is working well:

A small number of carers reported the following services as working well:

- counselling for carers
- fast carers' assessments and referrals adult social services, as well as their high quality support
- Hafal carers' support
- NEWCIS

However, a similar number reported that "Nothing has worked well" based on their experience of social care services.

"From my initial contact with social services, I have been fobbed off five times... when I was experiencing carer breakdown, with my father's dementia, working full time and shielding. Nothing has improved and I have a list of misinformation, conflicting information, conflict within the team itself etc, etc"

### What needs to be improved:

Several recommendations were made for improving services for carers including:

- ensure carers' assessments are carried out by people who understand the carer's situation
- increase the provision of respite care services, sitting services, night support and day centres
- ensure social workers include respite care in care plans and increase the amount of respite care allowed - "*four hours a month is ridiculous*"
- increase funding for services to improve carers' mental health
- provide carers with training and support to access information and services online
- create peer support groups for carers with different experiences for example a group for parents of disabled children
- involve carers in writing care plans
- include contingency plans in care plans for when the carer can no longer cope and/ or the health of the person being cared for deteriorates

Some carers' felt that they were close to breaking point, which will ultimately cost more than providing them with more support:

“There is zero reliable and dependable mental health support for carers. Unpaid carers are in crisis and this will always have an impact on those being cared for. With better support, I could probably keep my Mum in her own home as I have done for ten years, but if the support level continues to deteriorate, against her will and mine, I will have to put her in a nursing home. This has a social and economic impact for all concerned.”

## 5. What changed during the COVID-19 pandemic?

### (a) How services were affected and the impact on staff, service users and carers

#### Lack of services

Overall, the pandemic is thought to have had the biggest impact on the most vulnerable in society and exposed existing weaknesses in the social care system. It has exacerbated problems with waiting lists, lack of staff and services, and the concern is it has become “*a useful excuse for why services are failing*”. The pressures on health and social care have increased, but no action seems to be being taken to address these very serious issues.

Some of the systemic issues have been made worse during this period, with reports of care becoming more disjointed, lack of co-ordination across the sector, poor planning and unclear lines of responsibility.

“Our contracted care company has a staffing crisis, but some of that is their own making, due to a critical lack of organisation and management skills, rather than COVID.”

Many services initially stopped during the pandemic. They were gradually reintroduced with even fewer staff (who were isolating or off-sick) and with all the limitations created by the need to reduce contact with others and maintain social distancing. Reduced availability of services restricted access to those who were at risk of going into crisis.

#### Impact on service users and carers

Many service users and carers described being left without support and their lives being severely restricted:

“It just stopped everything, so what was a two year wait is now almost four.”

“Services for autistic people or people with learning disabilities went from being barely there, to non-existent.”

“My day services have been closed so I have been very bored during the day.”

“Could not get any help during COVID lockdown, only got allocated a Social Worker after numerous calls and pleas after restrictions were lifted a little.”

“There is a lack of things to do with support for physically disabled people with also a dementia diagnosis. It feels like a very forgotten sector of society.”

“Less people within vehicles for transport, reducing our ability to get people with learning difficulties to and from work.”

Some service users described feeling very lonely isolated as a result and “despairing of the local social service”. Concerns were raised that this has led to “escalation of chaotic lifestyles” and a danger “increased suicides due to helplessness”. Fewer home visits to check people are well may have led to greater numbers reaching crisis point:

“The pressures the care sectors are facing at the moment are stressful and unimaginable. Without appropriate support from vital services, I fear many older people will not be receiving the care they need to help them thrive.”

“The long term effect is it may be too late to help some.”

As time has gone on, the lack of support has led many service users to decline, losing skills and confidence and/or experiencing deteriorating health:

“He has lost all his confidence, which took around 25 years to build. He can no longer use buses on his own or go out alone. I have to go with him because he is so frightened of social interactions since COVID-19.”

“Our son’s mental health has deteriorated. He was already being treated for depression and panic attacks before COVID-19 struck.”

“The lack of face to face contact and stopping of activities had a very serious negative impact which won’t be recovered from as dementia has progressed.”

Children with a learning disability were thought to be particularly vulnerable due to COVID. Parents have kept them at home to protect their health, and so children have missed school and appointments. As a result, problem behaviours are increasing. Any existing problems have been made worse, for example, if a home was too small for the family or unsuitable, this has become even more difficult during lockdown.

Many carers reported feeling like they had been left to “pick up the pieces”, and some felt close to breaking point. Respite care has been limited to emergencies, and 24/7 caring responsibilities have negatively affected carer’s physical and mental health:

“As a carer there is nowhere to go for help regarding finance, mobility or mental health all you get is “well we have nothing at the moment due to COVID”, I can’t see anyone to talk to, no respite from the daily grind.”

This is expected to lead to greater numbers of older people going into care homes.

Restricted visiting to care homes has caused great distress to residents and their families and raised concerns that older people with memory issues may not remember family or friends by the time they are able to see them regularly again. Some care home staff are concerned that experience has changed the culture of care homes in negative ways:

- slightly authoritarian/paternal approaches have developed without visits from family
- homes are likely to have felt much more like an institution without links to the community
- structured testing regimens for staff, residents and visitors as well as the introduction of PPE have created barriers to communication and relationship building with residents

However, the impacts have not been negative for everyone. For some service users, the lockdowns allowed them to become “more self-reliant in their abilities”. Families have spent quality time together which helped them to become more resilient. Some pupils, especially those with social anxieties or bullying issues at school, have benefited from not going to school, but it is proving difficult to help them re-engage.

A small number of respondents commented that they had not experienced any change in services as a result of COVID-19, and had happily continued to receive care from their usual carer or respite services.

### **Lack of community services**

Many community services have ceased, reducing the level of social support in local communities. For example:

- peer support groups for people with mental health problems have stopped meeting, which has made service users more dependent on social services
- school closures, and the loss of after-school clubs has placed a strain on some foster households, increasing tensions and in some cases leading to placement breakdowns
- informal carers have been unable to attend service users in response to telecare alerts during an emergency, because they have been isolating, making it difficult for the service to discharge their duty of care

At the same time, people have also got better at supporting each other, as local support was stepped up during lockdowns, and larger numbers than usual signed up for volunteering. This may improve community resilience if it continues:

“We have seen an increase in community support as a result of COVID, but we can already see that having structures in place to support volunteers and community groups is essential for them to be able to provide their services.”

### **Increased demand for services**

The experience of lockdown has created new and increased demands for services due to:

- higher levels of domestic violence, drug and alcohol abuse
- greater numbers of people with low level mental health problems, which aren't met through the NHS Community Mental Health Team services
- disruption of family life and greater need for parenting support

The demand for support has therefore increased at exactly the time services are most stretched, leaving many people struggling, which is likely to continue for a while to come.

### **Providing services online**

The pandemic accelerated developments to create online methods of programme delivery and has made people more open to using IT options. Examples of where this has had a positive impact include:

- creating more flexible ways to deliver services such as telephone and video counselling services



- support for communities such as Welsh speakers where numbers may have been too small in a local area, but become large enough across a region
- support for communities in isolated areas where transport to services may be limited, or for those who can't leave home as they have caring responsibilities
- support for those who can't travel because of their health condition or a disability, providing opportunities for distance learning and remote working
- new and innovative ways to work with children and young people
- using technology such as FaceTime and WhatsApp to improve communication with service users

However, the digital approach does not suit everyone and may make it difficult, especially for older people, to access and engage with services. Other people simply don't like to use the technology or may not have the means to do so.

Service providers reported that face to face contact is preferable in some circumstances, particularly when making assessments or providing support, when picking up on non-verbal cues is important. Reduced contact has impacted on developing trust and building relationships with service users, especially children and families. This also seems to reduce some people's motivation to engage in support, if it is provided online or by telephone:

“Many organisations moved their face to face services such as parenting courses and domestic violence groups to virtual platforms, which takes away the ‘personal element and many parents have stated that they struggled with accessing support this way.”

“Some families with children have had hardly any social worker engagement and in lots of cases only phone contact, which does not give a full picture of what is happening in a household.”

“It is now virtually which has lost the essence of my job role I am struggling to keep people engaged or getting them to engage.”

Young people who have been socially isolated, now need to interact with people outside of their house and with other people outside of their family circle to help them build up their confidence and self-esteem. They may be in need of face-to-face support, rather than being online.

The lack of face to face support has caused some foster carers to rethink their situation and resign as carers.

Another group who have found the move to telephone based services a barrier are the Deaf community. Deaf people have become more and more isolated, lacking accessible information from local authorities and central government. The widespread wearing of masks has also caused anxieties for those who lip-read.

Other service users, in particular people with learning difficulties and people with dementia, have struggled with staff wearing masks and PPE equipment, as it has made it difficult to recognise their carers. This has improved with familiarity and most now accept this is necessary to stay safe.

### **Impact on social care staff**

Some staff welcomed the opportunity to work from home and found remote visits a more flexible way to work. Several mentioned the following benefits of virtual meetings:

- less time wasted travelling to and from meetings
- better access to information and records for example when all staff are in their office or in meeting with schools
- Multi-disciplinary Team meeting attendance has been better because professionals can attend virtually

They have also benefited from greater access to online training. However, some stated they were looking forward to going back to the office to be able to share practice, gain support from their peers and return to a more structured way of working.

Several providers were very grateful for the support they had received from local authorities to manage COVID-19, in particular the hardship payments to care homes and free provision of PPE, which they hoped would continue. This has had a positive influence on working relationships between the organisations.

Many third sector providers have stopped providing face to face services during the pandemic which has again added to the demand on statutory sector services. Some saw this as “an impossible task given the reduced staff levels, enhanced and

increased demands, greater complexity of cases, reduced community support and programmes and higher expectations from all stakeholders”.

The pressures have taken a toll on the mental and physical health of staff. Many are experiencing burn-out from the demands at work and in their personal lives. They struggle with having to get tested and booking tests for others on top of their daily workload. Many feel frustration at their inability to provide appropriate services. Some have been ill with COVID-19 themselves, which continues to have an impact on their long-term health and may affect their ability to work in future. Others are feeling “tired and demoralised” and considering leaving the care sector.

## **(b) Long-term impacts of the pandemic**

Respondents thought that in the long term it will be important to:

### **(i) Fix the problems that existed before COVID**

Throughout the pandemic, most services were simply focused on “*survival*” and “*avoiding COVID-19*”, for the users of their service and for themselves. As service levels slowly return to “*normal*”, the national crisis in social care is again becoming evident.

“Since COVID, an already struggling system has become almost irreparable.”

The demand for support is increasing at the same time as a backlog in the provision of care needs addressing and staffing levels are low. Staff expect to continue in firefighting mode for some time to come, meaning that more people are likely to reach crisis before receiving support.

“The pandemic has highlighted further the dire situation we are in... long term impact is more and more of our society needing help. I’ve seen working class people desperate for help but the system is failing everybody.”

Many respondents believe that the only solution is to increase social care funding and for longer periods to sustain existing services, develop new ones and employ more people.

## **(ii) Support people to re-engage with services**

One of the expected long term impacts of the lack of support during the pandemic is that service users will have lost faith in services:

“I think some families will not return to services... due to the impact of isolation and changes in behaviours... many of them will not return to education successfully.”

This may mean that people wait to seek help at a more critical stage, rather than at a point where an early intervention could have reduced the need for support. Some concluded:

“There is a need to have planned “re-engagement” for people back into society and for services to ensure everyone is being picked up and not falling through cracks.”

## **(iii) Support a return to face-to-face services**

As a result of isolation during the pandemic, many people of all ages have lost social skills and confidence in being with others. Some respondents therefore recommended planning to provide support to help people return to face-to-face services. Specific groups in need of this support include:

- people using respite care, day and overnight
- older people returning to community activities
- young people, especially years 7 and 8, to be confident with people again

At the same time, staff need to “get out there” and see the people who require care, as they may have become “too used to screens and distant from reality of assessing and responding to unstated needs”. Some mentioned that they are starting to restore face-to-face services, with a gradual re-introduction through to 2022.

## **(iv) Prepare for new and increased demands for services**

Many service users have deconditioned due to the effects of the lockdown, which is now impacting their function significantly, and means they are now placing greater demand on support services in the community. The economic impact of the pandemic is also likely to increase need for support in the immediate future:

“With so many businesses failing to survive, so many families losing loved ones, and huge debts accrued by so many trying to survive financially during the pandemic (increase in food bank use), demand for support will only increase.”

A key group of people who may need intensive support are family carers who are worn out from providing all the care when statutory services weren't available. More carer respite is now needed to give them a break and prevent them from burning out.

Some thought it important not to revert back to previous practice without reflecting on what could be done differently and improved. Also any service redesign needs to meet future needs, not previous needs. New types of services might be required to respond to different support needs that emerge post-COVID. These include services for:

- children and young people with anxiety disorders
- people with long-COVID
- people who have developed OCD or other anxiety conditions during lockdown
- babies and children with developmental delays as a result of being in poor environments during lockdown – this will have an impact on services and on society for years to come.

#### **(v) Increase mental health support especially for young people**

Many respondents are expecting a mental health crisis in the longer-term as a result of the pandemic. Vulnerable people who were left without support may now be experiencing the mental health impacts of that pressure, exactly when waiting times for mental health care are worse than ever before. Specific concerns were raised about:

- people with existing mental health problems whose mental health is deteriorating
- adults with learning disabilities and their families
- people who have experienced trauma/domestic violence during lockdown
- increased family conflict as a result of isolation and financial strain
- young people who have not left their house, had nowhere to go and did not have a network of support
- people who will be fearful of confined spaces with new people
- carers who have developed mental health problems under the strain

- young people who have missed out on their education and started university in lockdown

Many respondents commented that young people's mental health in particular has "suffered greatly and their confidence and communication skills are at an all-time low". The impact of this will be ongoing and evident for years to come in terms of their mental health and education attainment.

#### **(vi) Continue providing services online**

Some of the changes to service delivery are believed to have increased the flexibility and availability of services and seem to be popular among young people, parents, families and carers, who find digital support easier to access. However this is unlikely to suit everyone and therefore a "blended approach" is required going forward.

To ensure people are not excluded by the use of technology it is important to:

- equip people with the necessary skills and access to IT if they wish
- ensure online information and virtual meetings are accessible to all for example, to include BSL speakers and interpreters in Zoom meetings

Some respondents were concerned that the people who do not wish to go digital are not forgotten by services, and that more effort is put into reaching those people, so that they don't "fall through the cracks and risk having no care at all." It will also be important to make sure that going digital doesn't cause people to disengage from services, given the importance service users place on knowing and building relationships with the people in their care teams.

Social care staff emphasised that they also need training and investment in their IT systems, so that they can continue to work and provide support remotely.

#### **(vii) Supporting existing staff and boosting recruitment**

Many respondents were concerned that skilled staff are being lost from the care sector, because they are exhausted from their experience of the pandemic and are now deciding to leave. It was proving difficult to recruit new staff before COVID, and it may be even more difficult now. This is unlikely to change overnight.

Care home staff are worried that their professional reputations have been harmed by the poor management of COVID in care homes:

“This has been the most difficult time for social care in my life time, and we hope that there will be a change with how we are thought of as a group... We felt we were last on the list especially with PPE, and we lacked guidance, or were given conflicting information.”

Since the demands on services are unlikely to reduce anytime soon, many expect there to be an increase in mental health problems and burnout among staff during the next few years. It will therefore be important to improve mental health support and occupational health services for care staff.

On a more positive note some staff thought that working at home, where possible, will provide an opportunity for more flexible working practices and increase productivity.

## 6. Experience of using or providing services in Welsh

### (a) Experience of the Active Offer

Overall, respondents concluded that provision of the Active Offer is “patchy”. Some reported doing this very effectively, for example throughout Denbighshire Social Services and in some services for older people:

“Every individual I work with, is offered the active offer and there are appointed members of staff who have been identified who can assist if needed.”

“All advertisements and notifications have both the Welsh and English versions and even our phone salutation is Welsh first then English.”

Others reported that they can only make the offer at the point at which users of a service are assessed, rather than when they first make contact:

“I think it would be more appropriate for this to be offered at the first point of contact. However, I am aware that the first contact office has a high level of enquiries and as with us all, not enough staff to cope.”

“Our single point of access team give dual greetings. It would be better to have a phone system where you can press 1 for Welsh, 2 for English etc, but with limited staff members speaking Welsh this may mean a longer wait for those people.”

Some were concerned that in practice, the offer is still tokenistic. Many care homes and domiciliary care providers find it difficult to follow through with the provision of a Welsh speaker:

“Staff remain frightened of offering a service in Welsh as in reality it would require a translator.”

“I was offered Welsh worker from the charities I have worked with, but councils always say they can’t just get me a Welsh worker. They have to ask their manager and it seems to be a lot of hassle.”



They conclude that more needs to be done to attract Welsh speakers to the profession and to support staff to improve their Welsh. This needs to include opportunities for both complete beginners and those who need to gain confidence:

“Unless more teams are encouraged to learn Welsh in work time, it will never be a truly active offer.”

“It shouldn’t be looked upon as an opportunity for people to use Welsh. Every service provided should be able to start and end a conversation in Welsh and staff encouraged to make an effort to learn enough Welsh to be able to hold a brief conversation.”

Some respondents said that although they make the Active Offer, to date none of their service users have taken it up. A couple of respondents had not heard of the Active Offer.

## **(b) Providing written information in Welsh**

Many of the respondents confirmed that they provide all their written information, publications, signage, newsletters, emails and so on in Welsh. Some relied on staff to help with translation, others relied on external translators. Some said this was all they could do because none of their staff were Welsh speakers.

While the local authority translation services were found to be quick and efficient, others found that getting all their documents translated was “complex and time consuming” and had caused delays to their work. Cost is a barrier for small non-profit providers, who would like additional support and funding to be able to translate “everything and do it quickly”. Concerns about copyright issues become an issue when translating resources from third parties or the internet.

Some respondents commented that translating written information into Welsh is less of a priority because “most Welsh speakers like to be spoken to in Welsh but don’t like leaflets or forms in Welsh as the language is too formal”. They recommended that improvements must be made in simultaneous translation facilities for virtual meetings, webinars and video calls.

### **(c) Staff speaking Welsh**

Many respondents reported that staff providing care did speak Welsh. However, they ranged in capacity, from fully bilingual services, with multiple native Welsh speakers at all levels in an organisation, through to more informal arrangements:

“Although not all staff speak Welsh fluently, there is usually someone available who does.”

Some services were able to provide training in Welsh, for example for Welsh speaking foster carers. Others stated that, while able to chat with service users in Welsh, their staff felt more confident delivering care and making formal assessments in English. Often staff do not have the same level of confidence with written Welsh:

“All employees have access to Welsh phrases commonly used within care and support environments, to enable staff to speak in Welsh to individuals whom it is their first language.”

“The systems we have do not have the assessment available in Welsh.”

A major barrier is being able to recruit Welsh speakers. This is more of a challenge when seeking staff with specialist skills, and may become more difficult as services come to rely more and more on agency staff.

“Our rehabilitation workers have a specialist qualification. There are very few of them across the UK, so to find a qualified worker is difficult let alone a Welsh speaker.”

“It is hard to attract Welsh speaking-staff in North East Wales which makes it harder to provide the quality of Welsh language support we would like.”

“Employees providing services to the public should be fluent in both Welsh and English – ‘being willing to learn Welsh’ or ‘Learning Welsh’ should not be a sufficient qualification for these posts.”

Many organisations provide Welsh language training to their staff, either formally or informally. Examples included:

- courses offered by the local council or health board
- lunchtime Welsh Language groups

- Welsh speaking staff delivering workshops to their non-Welsh speaking peers

Some thought Welsh speaking courses should be offered to staff on a more regular basis. However, the challenge for many is finding time within their busy and highly demanding working day. The staff said they would need protected time on their rotas to be able to attend classes.

Similarly, there is a severe lack of fluent Welsh-speaking volunteers. Some suggested more classes should be available in the community. The cost of these may again be a barrier to attending, so some thought they should be free.

### **(d) Priority areas for speaking Welsh**

Respondents working in the West of Wales reported that having Welsh speakers to provide care is essential as the majority of the older population are Welsh speaking, and the working language is Welsh:

“Welsh speakers are essential for Anglesey and Gwynedd settings. All the council’s residential homes have Welsh speaking staff, and all staff are encouraged to speak or learn Welsh.”

“More demand is present in the South of Denbighshire, but this is reflected in the skills of the workforce too, for example, 95% of staff in Cysgod Y Gaer are Welsh Speaking.”

Similarly, many adults with a learning difficulty in Gwynedd prefer to communicate in Welsh. This is not an issue for local staff, but can sometimes prove to be a barrier when working across county borders, for example, all regional meetings are held in English, which means some individuals with a Learning Disability cannot contribute.

Some thought there are not enough staff with Welsh speaking skills working in children and young people’s learning disability services, and therefore families do not have the option to speak Welsh. More Welsh speakers need to be employed. Nor are validated Welsh assessments available, so it is not possible to carry out appropriate assessments with children and young people with learning disabilities.

Others highlighted that learning Welsh is particularly important when supporting people with dementia, who often revert back to the language spoken at home as a child. This is vital for building trust with service users:

“I have started entry level Welsh classes, it allowed me a brief introductory conversation with an elderly man with dementia, and a good relationship developed.”

### **(e) Promoting the Welsh culture**

Some organisations in areas where Welsh is rarely spoken showed their support for the Welsh culture in other ways for example celebrating all Welsh days:

“We use a phrase a week for the residents and staff to promote the Welsh language and always celebrate our culture.”

“We greet in Welsh and keep the Welsh spirit up and are proudly Welsh.”

They expressed “weariness” at the thought that everything will have to be bilingual, because “it will just mean more and more paperwork”.

### **(f) Preferences for speaking English**

As many respondents were in favour of speaking English as the number of respondents in support of speaking Welsh. This group concluded that the Active Offer was not applicable to them, because either they or the people using their services did not speak Welsh. This seemed to be especially true for services for children and young people:

“We’ve only received three calls in Welsh in over a decade.”

The English speaking service users expressed concern at not being able to read their case notes in Welsh, and reported feeling uncomfortable when their carers speak Welsh between themselves. Providing all paperwork in both languages is sometimes unhelpful:

“This makes it harder for Dad to follow the information provided. It would be good to have English-only forms once language preference is established.”

The visibility and clarity of information could be improved if the two languages were kept separate. Duplication of documentation is seen as a waste of resource.

“Mum says that making everything bilingual decreases the text size and as her vision is impaired she would prefer it one language in larger text.”

Several respondents felt too much emphasis is placed on speaking Welsh, when other languages are more commonly spoken amongst service users, whose needs are not being met. Some would like more attention to be given to use of Makaton, British Sign Language and Polish, providing interpreters when needed. Plain language options in Welsh are also hard to come by.

## **7. NHS services**

### **(a) What is working well**

Few respondents commented on the health services that are working well. They highlighted the following:

- The service received at Bron Ffynnon Health Centre, Denbigh is commendable, and the care received at Glan Clwyd Hospital's Cardiology department is priceless
- Social care workers value their close collaboration with primary health professionals
- Many were grateful for the support from environmental health and NHS service during the pandemic
- Care workers reported that health services for young people are working well to ensure they receive the correct health support and advice, especially around sexual health advice, getting registered with a GP and referral to Community Dental Services

### **(b) What needs improving**

A range of services were mentioned as needing improving including:

- Improved end of life support particularly at nights.
- Continence products are very poor quality and often use more than predicted.
- Speech and language therapists should give more time to non-verbal children.
- Improve older people's access to dental care to avoid impact of oral conditions and dental issues. This includes care home residents receiving dental care in their care home.
- Artificial Limb and Appliance Services are challenging to navigate and very slow to respond.
- Make greater use of telehealth services to prevent hospital admissions and improve discharge planning and district nurse visits.

- Encourage care home staff to have COVID vaccinations.
- Marches Medical Practice is not large enough for the population of Broughton.

Some health staff commented that poorly functioning computer systems were negatively affecting their ability to provide a quality service.

### **(c) The impact of COVID-19**

Three main areas were mentioned as being negatively impacted by COVID-19, which will be discussed in turn:

#### **Dental care**

During the pandemic, dental care in the community (for example, the tooth-brushing and fluoride varnish programme in schools) was suspended. Plans are in place to restart these services, prioritising the schools with most need, but dentists have the following concerns:

- schools and nurseries are under a lot of pressure already and may not consent to visits
- oral health outcomes for the target group may have worsened – dental health in children will be worse because the programme wasn't delivered last year
- staff in schools will need retraining on the programme
- dental staff feel a loss of morale in 'going backwards' after all of the hard work on this programme over the last 10 years
- community dental services are working at reduced capacity, and waiting lists have grown considerably

Similarly, dental services providing care for those who would find it too challenging to attend a regular dental practice, have not seen their patients for routine check-ups and fear that some people with complex needs will have become even more complex. Recommendations for improvements include:

- improved information online and on social media about what this service provides
- improved collaboration with social care services
- improved record sharing and sharing of information to help with decision making of patients who have complex needs

## GP appointments

Many respondents expressed frustration at not being able to see a GP face to face. They felt this to be a particular issue for older people, who may not be comfortable talking on the phone or are housebound:

“In Mum and Dad’s surgery nobody seems to care about the elderly. Long term, people are going to potentially die earlier than they would if they could get seen by the appropriate clinician on time.”

“Many people are not comfortable talking on the phone, so misdiagnosis or incorrect health care could be given.”

“GP services being restricted has impacted me personally and had a detrimental impact on both my mental and physical health due to not feeling comfortable trying to obtain a face to face appointment... I feel unable to reach out due to the perception of pressure on services and the response from services when enquiring.”

Suggestions for improvements included creating a different system for waiting outside the doctor’s surgery to avoid 'standing in some of the hottest weather'. Others suggested that staff who work at doctors’ surgeries “need to understand mental health and disabilities more and choose words better”. NHS staff seem to have less patience for people who struggle, “which knocks people’s confidence”.

## Waiting lists

Waiting lists for assessments and treatment in the NHS have got longer.

Respondents highlighted the following:

- prolonged delay for Occupational Therapist assessment
- longer waits for ambulance visits, especially to non-injured fallers. Calls are declined, if Welsh Ambulance Service NHS Trust resources under pressure.
- end of life care has diminished, falling mainly on District Nurses and the end stage home care team
- no respite beds available for chronic disease patients needing to give main carers (family) a break
- impossible to access psychology team

People with complex needs are particularly affected as they are likely to be using a wide range of services and are “being failed at almost every touchpoint”.

Another major concern is that people will allow conditions to get very serious before seeking help, because they are afraid to go into hospital. Lack of staff in the community also makes it difficult to keep patients home safely. This leads to increasing pressures because demand for treatment will get greater, adding to the length of time it will take to return to baseline.

Midwives are reported to be especially affected:

“Due to shielding, isolation and illness staff levels are very low. Staff morale is rock bottom. Long term, midwives will leave or be off on long term sickness. Adherence to Birth Rate Plus during COVID restricts management from being able to staff effectively. Maternity care in North Wales is now so short staffed it is becoming dangerous.”

#### **(d) Providing services in Welsh**

Respondents were concerned about the lack of Welsh speaking staff in the NHS and recommended:

- access for welsh training for staff in the NHS
- employing nursing and medical staff who speak Welsh, especially in North West Wales where Welsh is the first language for many young people
- the GP surgery’s answering machine recording is played in English first and then in Welsh. The Welsh needs to come first.

“When my relative was in the Maelor I was told we don’t know what your father is saying as he will only speak in Welsh!”



# Appendix 1: Equality monitoring data

Please note, the tables below reflect the characteristics of the 250 participants who gave answers the equality questionnaire rather than all 350 participants in the survey. For a full picture of the engagement with people with protected characteristics these figures should be considered alongside the list of organisations who responded to the consultation.

In all tables numbers have been rounded to the nearest 5 to prevent disclosure of personal information.

## Age

| Age         | Number | Percentage |
|-------------|--------|------------|
| 16 to 24    | 5      | 2%         |
| 25 to 34    | 30     | 12%        |
| 35 to 44    | 5      | 17%        |
| 45 to 54    | 75     | 30%        |
| 55 to 64    | 60     | 25%        |
| 65 to 74    | 30     | 11%        |
| 75 and over | 10     | 3%         |

## Sex and gender identity

| Sex    | Number | Percentage |
|--------|--------|------------|
| Female | 210    | 85%        |
| Male   | 35     | 15%        |

Less than 5 responses were received from transgender people.

## Disability

In total, 27% of participants said they had a disability. The table below shows the what percentage of these 70 people have each impairment or condition.

| Disability                               | Number | Percentage |
|--|--------|------------|
| Long standing illness / health condition | 35     | 52%        |
| Mental health condition                  | 30     | 42%        |
| Physical impairment                      | 25     | 36%        |
| Sensory impairment                       | 10     | 18%        |
| Learning disability / difficulty         | 10     | 12%        |

### Caring responsibilities

A total of 44% of participants had caring responsibilities. The table below shows the amount of care provided by these participants each week.

| Caring responsibilities | Number | Percentage |
|-------------------------|--------|------------|
| 1 to 19 hours           | 50     | 46%        |
| 20 to 49 hours          | 25     | 23%        |
| 50 hours or more        | 35     | 31%        |

### National identity

| National identity | Number | Percentage |
|-------------------|--------|------------|
| Welsh             | 140    | 56%        |
| British           | 60     | 25%        |
| English           | 60     | 25%        |
| Scottish          | <5     | 2%         |
| Northern Irish    | <5     | 2%         |
| Other             | 5      | 3%         |

The other nationalities included participants who described their national identity as Polish, South African, Canadian and British European.

## Ethnic group

| Ethnic group   | Number | Percentage |
|----------------|--------|------------|
| White          | 245    | 98%        |
| Mixed heritage | <5     | 1%         |
| Indian         | <5     | 1%         |

## Preferred language

| Spoken language        | Number | Percentage |
|------------------------|--------|------------|
| English                | 180    | 74%        |
| Both English and Welsh | 35     | 14%        |
| Welsh                  | 30     | 12%        |

| Written language       | Number | Percentage |
|------------------------|--------|------------|
| English                | 200    | 84%        |
| Both English and Welsh | 20     | 8%         |
| Welsh                  | 20     | 7%         |

## Religion

| Religion    | Number | Percentage |
|-------------|--------|------------|
| Christian   | 125    | 51%        |
| No religion | 100    | 42%        |
| Hindu       | <5     | -          |

## Sexual orientation

| Sexual orientation | Number | Percentage |
|--------------------|--------|------------|
| Heterosexual       | 220    | 91%        |
| Gay or Lesbian     | 5      | 3%         |
| Bisexual           | 5      | 2%         |
| Pansexual/Queer    | <5     | -          |

## Marital status

| Marital status                    | Number | Percentage |
|-----------------------------------|--------|------------|
| Married                           | 125    | 55%        |
| Never married                     | 55     | 25%        |
| Divorced                          | 20     | 8%         |
| Widowed                           | 10     | 5%         |
| Separated                         | 10     | 5%         |
| In a registered civil partnership | 5      | 2%         |