PROFILING THE COMMUNITY IN MERTHYR TYDFIL:

Problems, challenges and opportunities

Wellbeing in Work Partnership

Study 1: Final Report

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Diolch yn fawr i chi gyd.

GLOSSARY

A+E	Accident and Emergency
CMO	Chief Medical Officer
DH	Department of Health
DWP	Department of Work and Pensions
GP	General practitioner
HSE	Health and Safety Executive
IB	Incapacity benefit
JSA	Job seekers allowance
LA	Local Authority
LHB	Local Health Board
LSOA	Lower super output area
NHS	National Health Service
NPHS	National Public Health Service
RCT	Rhondda Cynon Taf
WAG	Welsh Assembly Government
WCfH	Wales Centre for Health
WiW	Wellbeing in Work Initiative

EXECUTIVE SUMMARY

Introduction, aim and methods

- The origin of this report lay in the recommendations of the Wales Health Work Partnership Report that the influence of health on work should be made a major research priority, informed by an evidence-based framework, and be of practical utility and demonstrable benefit to the people of Wales at a Community level.
- The Well-being in Work (WiW) partnership was formed to take forward these recommendations, with local organisations in Merthyr Tydfil and leading academic institutions working together to address the impact of health inequalities on work in the region, with lessons learned having wider implications for other communities in the South Wales valleys, the rest of Wales and the UK.
- The WiW initiative involves a programme of research to be conducted in three phases; 1. Setting the socio-economic context, 2. gathering an evidence base and conducting primary research on the interface between health and work in Merthyr Tydfil, and 3. developing and evaluating interventions to improve well-being at work within the community. The current document reports the findings of Phase 1: Profiling the Community in Merthyr Tydfil: Problems, challenges and opportunities.
- The WiW initiative seeks to encompass the goals and aspirations evident in contemporary policy developments emanating from the UK government, the Welsh Assembly Government and local initiatives.
- Particular attention should be paid to *appropriate* and *timely* interventions in an effort not only to maximise the effectiveness and efficiency of interventions and research projects, but also to minimise preventable dysfunction and ineffective or misguided clinical and occupational interventions.
- In this report, a rigorous, quality baseline has been established, which can be used to assess the extent and nature of change, the potential for replication of projects, and the generation of explicit outputs that could assist in policy formulation and development. This has been accomplished by accessing and scrutinising relevant policy documentation; interrogating statistical databases; and, engaging with the project leads of other relevant initiatives and schemes to ensure that issues and data were not missed.

Policy frameworks

- Key policies relevant to well-being in work in the Merthyr Tydfil area include:

- *Health, work and well-being – Caring for our future*, a strategy document produced jointly by the UK Departments of Health and Work and Pensions, along with the Health and Safety Executive.
- *Wales: A Vibrant Economy (2005*), In Wales, the Welsh Assembly Government (WAG) has sought to use its policies and programmes to promote equality of opportunity, social inclusion and sustainable development, to achieve a more prosperous and fair Wales and one that is fit for the future. WAG economic policies have been formulated as parts of a wider agenda encompassing social justice, environmental improvements, better health, language and learning, and community regeneration. While there have been some successes, there remain areas where above average levels of economic inactivity exist, accompanied by relatively high rates of social, educational and health problems.
- The *Wanless Report* stressed the need for action on a number of fronts to remedy system deficiencies and secure developments in the Welsh health service to ensure improvements in health outcomes for the population. The *Health and Well-being Strategy* demonstrated the need for 'whole-systems' thinking to ensure that fair and sensible priorities were formulated and result in the provision of integrated health and economic policy initiatives to improve the 'health' of the Welsh economy.
- In May 2005, WAG issued *Designed for Life*, which set out its policy aim to 'create a world-class health and social care service in a healthy, dynamic country by 2015.' It stated that the service would be user oriented and based around a whole system approach, supported by targeted performance improvement. WAG also established *Health Challenge Wales* to act as the focal point of efforts to improve health and well-being, recognising that wide range of factors impact on health and well-being and that co-ordinated action can help to create a healthier nation.

- In addition, one of the most significant strategic documents produced in recent times relating to the issue of work and health was *Securing Health Together: A long-term occupational strategy for England, Scotland and Wales,* published by the Health and Safety Executive in 2000. It highlighted three principal reasons for a long-term occupational strategy:
    - To stop people from being made ill by work;
    - To help people who are ill return to work;
    - To improve work opportunities for people currently not in employment due to ill health or disability.

    It set three targets to achieve by 2010:
    - a 20% reduction in the incidence of work-related ill health;

  - a 20% reduction in ill health to members of the public caused by work activity;
  - a 30% reduction in the number of work days lost due to work-related ill health.

  It also emphasised the pluralistic nature of the problems and their solutions, with a need for concerted, concentrated, multi-factorial, multi-dimensional and multi-agency approaches to target collective efforts on the areas that need it most. The framework offered by this document has also informed other Government initiatives, in particular the *Welfare to Work* agenda and the *Pathways to Work* programme developed by DWP.
- The success of the Pathways to Work Pilot schemes were instrumental in driving the welfare reform Green Paper, *A New Deal for Welfare: Empowering people to work*, launched in January 2006. The basic tenet of the Green Paper is to continue progress to breaking down the barriers that prevent people from fulfilling their potential and, through worklessness and economic inactivity, lead to poverty and disadvantage. There is an explicit commitment to reduce the number of people who leave the workplace due to illness, increase the number leaving benefits, and better address the needs of all those on benefits, with additional payments to the most severely disabled people. The intentions are to improve workplace health by the creation of healthy workplaces and increasing access to good quality occupational health support; to facilitate better absence management and early intervention to assist employees who become ill to stay in work, or support recovery and return of those who are unable to remain in work. There is also a clear recognition that there must be partnership working if the proposals are to be successful, with a whole systems approach evident and a culture of collaboration across all stakeholders.
- One of the most important initiatives designed to specifically tackle the issues faced by the Heads of the Valleys communities, including Merthyr Tydfil, was the Heads of the Valleys Partnership Programme - *Heads – We Win…. a strategic document for the Heads of the Valleys, 2005.* It was recognized that a strong, better balanced economy would offer significantly improved life chances, by helping to break down the structural barriers to work which exist in the area, and encourage engagement within wider Heads of the Valleys life.
- While policy documents and discussions have sought to address issues from a broad perspective and employ whole-systems approaches, policy implementation has tended to be fragmented and compartmentalised into conventional and current organisational and departmental structures.

Demographic Context

- The population of Merthyr Tydfil currently stands at 55,400 – a decline of nearly 8% since 1991, against an overall population for Wales of 2.94 million. The percentage of people aged 65 years and over is relatively high in Park, Town and Vaynor compared to the rest of Merthyr and Wales, while over 30% of the population is aged 19 years and under in Gurnos compared with 22% in Park and 25% across Wales – factors which are relevant in relation to the targeting of interventions in Phase II of the WiW initiative. The percentage of people who are single (never married) ranges from 38% in Park to 49% in Gurnos, nearly double the 28% of singletons found across Wales.
- There has been a consistent upward trend in the number of births to women under 25 in Merthyr over the past few years, with 45% of births in 2003 being to younger women, compared to 31% in Wales.
- Life expectancy at birth for males in Merthyr Tydfil was the lowest in Wales at 73.3 years compared with 75.3 years in Wales and 78.5 years in Ceredigion. Among females, the life expectancy at birth was also the lowest in Wales at 78.1 years, compared with 80.0 years in Wales and 81.9 years in Ceredigion and Monmouthshire. The standardised mortality ratio (1999-2003) in Merthyr was 126, relative to Wales (100), with the ratio for males in Merthyr 156 relative to Wales (125) and 99 for females relative to Wales (77).
- The consequences of social exclusion and deprivation are often manifest in crime and drug and alcohol problems, and despite a fall in recent years, Merthyr still has one of the highest rates of reporting drug problems in Wales. In addition, Merthyr has the highest incidence of anti-social behaviour compared to the other areas within the South Wales Police Force region and an overall crime rate of 32.5 offences per 1000 of the population, compared with 24.7/1000 in Wales in 2003-04.
- There are also clear linkages between levels of deprivation and educational attainment. Merthyr has 28% of its communities in the 10% most deprived communities in Wales in relation to education and a report by the Joseph Rowntree Foundation placed Merthyr as the most deprived authority in Wales in relation to performance at GCSE level; the second most deprived area in terms of attainment at Key Stage II; and, the second most deprived in the proportion of 18 year-olds who go on to higher education. In addition, 44% of the population in Merthyr have no qualifications compared to 33% of the Welsh population, with the percentage rising to 57% in Gurnos.

Labour market context

- The percentage of the population in employment in Merthyr (28-31%) is consistently lower than in Wales as a whole (36-37%) and in Great

Britain, where 40-42% of the population are in employment. There are also differences in the structure of employment between Wales and Merthyr – 19% of employees are in categories 1 and 2 in Merthyr compared to over 24% in Wales, and 28% in GB. In contrast 26% of people in Merthyr are employed in categories 8 and 9 compared with 22% in Wales and 19% in GB.

- The percentage of those who have never worked is 7.9% in Merthyr compared to 5.6% in Wales, but there are wide variations across the Borough with 13.5% of people in Gurnos never having worked. The unemployment rate in Merthyr is consistently higher than the Welsh average, and although not the highest in Wales, the proportion of people who are unemployed or economically inactive and who want work is running in excess of 12% of the working population. The percentage of unemployed who have been out of work for more than 15 years in Merthyr is 34%, and the percentage that have been out of work for more than 10 years is 54% compared to 30% and 48% respectively for Wales.
- While there have been pressures on to increase economic activity rates across Wales, the rate in Merthyr (32%) continues to lag behind the Welsh average (25%) and those achieved across GB as a whole (22%). Therefore, taking all of the above indicators into account, it is not surprising that 36% of communities in Merthyr are in the 10% most deprived communities in relation to employment in Wales.
- Over the past few months there has been a decrease in the number of notified vacancies in Merthyr and surrounding areas. There would therefore appear not to be a great demand for employment within the region and it is necessary to carefully consider the approaches and schemes that can result in improvements in the economic activity rate bearing in mind that employment deprivation currently witnessed needs to be addressed.

Economic context

- The Joseph Rowntree report ranked Merthyr as the most deprived community in Wales in relation to both child poverty and working-age poverty. In Gurnos, for example, 37% of the population are in employment while over 13% of the population have never worked. There is a consistently higher percentage of IB claimants in Merthyr who receive IB than Wales and there is a clear difference between Merthyr and Wales in relation to the duration of time which people have been receiving benefits. In two-thirds of the wards in Merthyr more than 25% of the population are in receipt of state benefits – the highest level of state dependence.
- In addition, gross weekly earnings are lower in Merthyr than Wales – although there may be signs that the differential is closing as annual

gross earnings in Merthyr have increased from 85% of the Welsh figure in 2002 to nearly 89% in 2005.
- The Rowntree report stated that around a third of the 50,000 children living in income poverty in Wales live in the Valley areas. In these areas the rate of child poverty is in excess of 30 per cent, with Merthyr ranked as the most deprived area in Wales.

Health status context
- One half of communities in Merthyr are in the 10% most deprived areas in relation to health in Wales. In addition, Merthyr has consistently higher than average rate of people reporting illness and health problems, the lowest Physical Health score for any area in Wales and the second lowest Mental Health score. Disease prevalence in Merthyr is significantly higher than in Wales in hypertension and respiratory conditions but especially in mental health, arthritis, back pain and diabetes. There are nearly 30% more people in Merthyr suffering with long-term illness and 20% more people who have fewer than 21 teeth.
- Merthyr has one of the highest percentages of low birth-weight babies in Wales, while, along with Blaenau Gwent, it has the highest rate of teenage pregnancies in Wales.
- There were in excess of 1.2 million prescriptions provided in Merthyr during 2004-05 at a cost of £12 million – the highest rate per head of any LHB in Wales. However, the cost per item prescribed in Merthyr LHB is one of the lowest in Wales and 20% lower than the highest cost LHB.
- People in Merthyr are more likely to visit their GP or practice nurse, are more likely to have had a hospital out-patient appointment or attended A+E or been admitted as an in-patient, while they are less likely to have been a hospital day patient, or made contact with a pharmacist, dentist, optician or chiropodist relative to the rest of Wales. However, a greater percentage of out-patient appointments not kept at North Glamorgan NHS Trust than in Wales, with particular problem areas being Palliative Medicine, Paediatrics, ENT, Dermatology, Obstetrics, Gynaecology and Psychotherapy. There are more people waiting for an initial out-patient appointment than the Welsh average, but fewer people than average waiting for in-patient admission and day-case treatment.
- Merthyr has higher rates than the Welsh average in smoking and alcohol consumption above the recommended guidelines and lower rates of exercise patterns and consumption of fresh fruit and vegetables.

Community context
- North Glamorgan NHS Trust serves the residents of Merthyr Tydfil and some surrounding valley communities, with Prince Charles, the district general hospital, having a capacity of over 400 beds and 24,000 deaths

and discharges every year. In relation to primary care, there are 5.9 whole-time equivalents GPs per 10,000 population in Merthyr – a similar rate to Wales. However, there are relatively few female GPs and high proportions of GPs aged 55 and single-handed practices, which highlight some of the problems facing primary care services in Merthyr.

- In terms of community care facilities there are 9 residential and other homes provided by the Local Authority and 9 provided by other agencies, while in terms of leisure facilities there are 10 leisure and community centres, 3 swimming pools, a Sports Development Centre and a Climbing Centre.

Conclusions and recommendations

- This report has clearly demonstrated that there are some very real problems in Merthyr in terms of unemployment, low income, poverty in children and adults, poor health status, and a high incidence of risk factors for poor health including smoking, alcohol consumption and poor diet. Remedies for these problems require major investment and cultural change in the region, which probably necessitate a long-term perspective.
- However, in the short to medium term, we can look to help individuals, particularly those in the most deprived situations, which should also contribute to the more gradual overall improvement of the region in terms of reducing deprivation and improving health. This needs to be made a high priority for government, as the deprivation in this region has very serious consequences for the people living in these communities (including child poverty and reduced life-expectancy), and this needs to be tackled with immediate effect.
- When we investigate health and work in Merthyr in subsequent phases, it is likely that there will be relationships between health and work that are general and are likely to apply in other communities, but it is also likely that there are regionally specific cultural factors involved that could be specifically targeted for intervention. However, in light of this report, it is essential that sufficient weight is given to the real practical barriers to work in this community, including the poor health status of people living in this region relative to the rest of Wales and GB as a whole. Interventions that focus on health at work in this community without taking into consideration its socio-economic context are unlikely to succeed.
- The impact of work on health needs to be investigated further in terms of the financial, social, and psychological benefits of work in itself. The harmful effects of worklessness have been well documented, but the evidence for a beneficial effect of work on health has not been well established, although there is some preliminary evidence to suggest a

positive relationship. Workplaces need to become healthier not just in terms of avoiding injury and illness and improving rehabilitation (as emphasised by HSE), but also in terms of promoting good health in practical, cost-effective, sustainable ways.

- On a more positive note, there have been improvements in some of the key variables in this region that are encouraging in terms of the future well-being of the community (e.g. less unemployment, greater income etc). The WiW programme of research will contribute to this improvement of the health and prosperity of people in this region.
- While many of the strategic plans and policy documents relevant to this work acknowledge the need for a 'joined-up' approach to improving the socio-economic conditions in Merthyr and elsewhere, there is limited evidence that anything significant is being done to translate this into real action with meaningful outputs and deliverable outcomes. It needs to be clear what we mean by joined-up approaches and how they can be taken forward to secure improvements for the community in the short-term and from a longer-term perspective.
- We are left with is a notion of Merthyr and its environs as an archipelago of islands. Bridges and communication networks are needed for this community to prosper. The problems are widespread across the community but, as stated above, many of them have a common set of origins, and for which there may be common remedies.
- We propose that subsequent phases do not just look at a person's health at work in isolation. The adoption of a bio-psychosocial model is essential in understanding the complex and dynamic relationship between health and work, looking at the individual within the context of their place, status and role in the community and place of work.

1. INTRODUCTION

The Wales Health Work Report recommended that the influence of health on work should be made a major research priority, which needed to be informed by an evidence-based framework, and be of practical utility and demonstrable benefit to the people of Wales at a Community level. It further recommended the development of a focused and integrated initiative as a vehicle for integrating health and occupational initiatives at a community level. The initiative should enable the design, implementation and evaluation of new initiatives focused specifically on aspects of the health-work interface against a backdrop of a clearly delineated health, economic and occupational profile. Therefore, the Well-being in Work (WiW) partnership was formed to take forward these recommendations, with local organisations in Merthyr Tydfil and leading academic institutions working together to address the impact of health inequalities on work in the region. It was envisaged that the lessons learned would have wider implications for other communities in the South Wales valleys, the rest of Wales and the UK.

It was also advocated in the Wales Health Work Report that potential research should seek to encompass the goals and aspirations evident in contemporary policy developments emanating from the UK government, the Welsh Assembly Government and local initiatives. Particular attention should be paid to *appropriate* and *timely* interventions in an effort not only to maximise the effectiveness and efficiency of interventions and research projects, but also to minimise preventable dysfunction and ineffective or misguided clinical and occupational interventions.

In order to facilitate such research, it was considered essential that a rigorous, quality baseline be established to assess the extent and nature of change, the potential for replication of projects, and the generation of explicit outputs that could assist in policy formulation and development. In addition, a systematic review of the literature was proposed. Due to delays in getting the research started, it was not feasible to conduct a systematic review at this stage. In its place, a literature search was undertaken to underpin subsequent developments within the programme of research. The results of this search are shown in Appendix I.

This report outlines the relevant policy context, the demographic composition of the community in Merthyr Tydfil relative to Wales, an analysis of the labour market context and relative income levels, an assessment of the health status of the population, and finally, a review of the health and social care facilities available to the community. The report

concludes with an overview of the benefits and limitations of adopting this approach to community profiling, and highlights requirements for further research.

2. AIM OF THE RESEARCH

The aim of this study was to establish a baseline of socio-economic and health related information to contextualise subsequent projects and studies in the WiW Initiative, to enable the extent of change following interventions to be assessed and to consider the potential for project replication in other areas.

The specific objectives were to:

- Establish a socio-economic profile of Merthyr Tydfil and its environs, including both macro- and micro-analyses and compare with the rest of the South Wales Valleys area, Wales and the U.K.
- Survey current health-care provision in Merthyr Tydfil at a macro- and micro-level and compare with the rest of Wales and with the UK.
- Examine utilisation rates and trends at primary care facilities within Merthyr LHB from 'existing databases'.
- Survey benefits and employment history and status of people in Merthyr Tydfil and compare with the rest of Wales and the UK.
- Describe and evaluate current occupational and health improvement initiatives, by DWP, Merthyr Tydfil Borough Council, Merthyr Tydfil Local Health Board, North Glamorgan NHS Trust, Welsh Assembly Government in Merthyr Tydfil and private sector employers in Merthyr Tydfil and its environs.
- Interface with other project developments designed to improve health and facilitate engaging in work (e.g Heads of the Valleys Lifelong Learning Project; Heads of the Valleys Economic Development initiative).

3. STUDY DESIGN and METHODS

- A systematic search of the literature was undertaken using rigorous scientific methodology.
- In addition, relevant policy documentation was accessed and scrutinised to access relevant data and issues.
- Statistical databases held by participating organisations (e.g LA, LHB, WCfH, DWP, WAG) and others were accessed to obtain most recent and relevant data.
- Discussions were held with the project leads of other relevant initiatives and schemes to ensure that issues and data were not missed.

4. POLICY CONTEXT

The recommendations of the Wales Health Work Report have been clearly reflected in strategy documents produced both by UK government departments and the Welsh Assembly Government (WAG). For example, the importance attached to joining up the elements relating to the health/work interface was highlighted in a strategy document produced jointly by the UK Departments of Health and Work and Pensions, along with the Health and Safety Executive.

> "While much good work, both inside and outside Government, is already going on to improve the health and well-being of working age people, we need a strategy that will bring together all the elements. If we co-ordinate our approach and identify gaps where we need to carry out further work, then we will achieve much more to help that improvement in health and well-being. *Health, work and well-being – Caring for our future* demonstrates our commitment to making a real difference to the health and well-being of working age people. It also forms a key component of the welfare reform, public sector reform and public health agendas." [1]

In Wales, there has been an attempt to span traditional policy areas and adopt an integrated approach, with WAG using its policies and programmes to promote equality of opportunity, social inclusion and sustainable development. This has been detailed in the *Well Being in Wales*[1] document. The aims of such an approach are to achieve a more prosperous and fair Wales; a Wales that is fit for the future. Of relevance to this study are the five strands that underpin the intended approach to improving well-being in Wales, which are:

- Ensuring that all public policies and programmes, not just health policies, contribute in some way to improving people's health and well being.
- Creating social and physical environments that encourage and support well being.
- Developing people's personal skills and knowledge so that they can take greater responsibility for health and make informed choices for their health and their children's health.
- Strengthening communities as a critical factor in improving people's well being.
- Ensuring health services are effective, efficient and accessible to all, and have a stronger role in preventing illness and disease.

[1] http://www.wales.gov.uk/subihealth/content/wellbeing/wellbeinginwales-e.htm

However, it was noticeable that while policy documents and discussions have sought to address issues from a broad perspective and employ a whole-systems approach, the implementation of policy has tended to be fragmented and compartmentalised into conventional and current organisational and departmental structures. The WiW Partnership aims to nurture and facilitate a joined-up approach, and in this regard has established a network of stakeholder organisations, which have been instrumental in developing the Partnership and the work to date.

The intention of this section of the report to highlight some of the policy frameworks, which impinge on the issues underlying the relationship between health and work, drawing on relevant documentation to contextualise the development of the community profile relating to Merthyr Tydfil and its environs.

ECONOMIC POLICY

Economic policies emanating from WAG need to be viewed in context of its strategic agenda set out in *Wales: A Better Country (2003)* [2], which acknowledges that economic development has to be part of a wider agenda encompassing social justice, environmental improvements, better health, language and learning, and community regeneration. While the intention is highly commendable, the evidence for such a joined-up approach remains in its embryonic phase.

WAG has sought to develop its strategic framework for economic development in the consultation document *Wales: A Vibrant Economy (2005)*[3], in which it focuses on encouraging sustainable growth through helping more people into work, and helping to raise earnings for those in work by maximising the value created in the Welsh economy. In highlighting some of the successes in improving employment levels, reducing unemployment and raising earnings, the document recognises that such gains have not been witnessed across all areas, and there remain geographical areas which need specific attention. Above average levels of economic inactivity tend to be concentrated in areas where other social, educational and health problems have relatively high prevalence levels. The document emphasises the need for partnership working across public,

[2] http://www.wales.gov.uk/themesbettercountry/index.htm

[3] http://www.wales.gov.uk/subitradeindustry/content/wave/wave-e.htm

private and voluntary sectors, and provides, as an example, the development of a regeneration framework for the Heads of the Valleys area.

Among its proposed strategic economic development themes are two aspects which have particular relevance for the overall aims of the WiW initiative;

- supporting job creation and helping individuals to tackle barriers to labour market participation in the world of work.
- investing to regenerate communities and stimulate economic growth across Wales.

HEALTH AND SOCIAL CARE POLICY

The provision of health services and the extent of resources required have been among the most contentious political issues in the relatively short history of WAG, and indeed for virtually all governments in the developed world. The performance of the NHS in Wales has been subjected to both intense media scrutiny and academic debate.

The *Wanless Report* (The Review of Health and Social Care in Wales, June 2003)[4] clearly emphasised that the current situation was unsustainable, and stressed the need for action on a number of fronts to remedy system deficiencies and secure developments in the Welsh health service to ensure improvements in health outcomes for the population. The Assembly has also committed itself to redressing the inequalities in health that exist within Wales and in comparison to the rest of the UK.

The development of health services in Wales over a ten year period was documented in the Assembly's NHS Plan published in 2001 – *Improving health in Wales – a plan for the NHS with its partners*,[5] an ambitious set of proposals designed to improve the health of the people of Wales.

Another feature of health policies has been the focus on collaboration and co-operation across agencies through formal and informal alliances. The very nature of the title of the 10-year plan hinted at partnership, while the First Minister and the Minister for Health and Social Services also paid particular attention to the importance of collaborative ventures.

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[4] http://www.wales.gov.uk/subieconomics/hsc-review-e-htm

[5] http://www.wales.gov.uk/healthplanonline/health_plan/content/nhsplan-e.pdf

> "The Plan is rooted in a set of partnerships. These involve public bodies planning, implementing and working on policies in a joined-up way."
>
> [Foreword by First Minister]

> "…….improving the health of the nation poses challenges that no one organisation can meet. Strong partnerships between the NHS, local government, communities and the voluntary sector are at the heart of our new and inclusive approach to health."
>
> [Foreword by Minister for Health and Social Services]

A variety of innovative multi-agency projects have been developed in Wales during recent years involving collaboration between statutory, voluntary, and independent providers. However, there has been limited awareness among providers about a number of these initiatives. There is a need for wider dissemination of good practice and removal of other barriers to partnership working between health and social care agencies if appropriate patient/client-centred care is to be delivered.

The vision of a seamless system of health-care commissioning and delivery has been advocated as an antidote to the recent experiences of patients moving through a complex maze of inter-organisational, inter-agency, inter-professional, and inter-budgetary organisations, all with competing interests and objectives, to receive their various care components. While there is some evidence of a change in policy direction, WAG expenditure trends and plans do not necessarily reflect a move towards making this different mode of thinking about improving the health of the people of Wales a reality, with emphasis in resource allocation firmly remaining on traditional budgetary areas.

The *Health and Well-being Strategy* [6] demonstrated a commitment to increase the effectiveness, efficiency and financial management of health and social services. The document highlighted the need for these organisations to be more responsive to the needs of increasingly well-informed patients and clients, and ensure better access for those most in need.

Looking to the future, the *Health and Well-being Strategy* indicated that the NHS would have to assess the possible long term impact of advances in genetic science on its services and ways of working, alongside identifying the factors affecting demand for care services. This 'whole-systems' thinking was required at an early stage to ensure that fair and sensible

[6] http://www.wales.gov.uk/subihealth/content/wellbeing/wellbeinginwales-e.htm

priorities are formulated resulting in the provision of integrated health and economic policy initiatives having long-term prospects of improving the 'health' of the Welsh economy.

One of the organisations to emerge during this period was the Wales Centre for Health, which has among its functions, the collation of public health data and evidence to assist in the policy making process and the co-ordination and surveillance of health trends and risks and threats to health and well-being. It is this organisation which has provided the financial support for this project to be undertaken.

In May 2005, WAG released the *Designed for Life* [7] document, which sets out their policy for addressing the issues identified above. It states WAG's ambition to create a world-class health and social care service in a healthy, dynamic country by 2015. It initially draws on the objectives set out in 2001 within *Improving Health in Wales: A Plan for the NHS with its Partners*. Four years on there is a need to take stock of progress to date and build on what has been achieved so far. It asserts that the decision to concentrate on delivering a healthy Wales through partnership was the right one and will pay increasing dividends in the future.

It sets out a plan of action until 2015, to describe the health care and social care services that the people of Wales can expect in 2015, and delivered through a series of 3 year strategic frameworks which will form the context within which annual improvements will take place.

The document details the NHS Wales redesign challenge, philosophy and principles. It states that the service will be user oriented and based around a whole system approach, supported by targeted performance improvement. Commissioning will be driven by clear and rigorous standards of clinical governance. The design components of the strategy are: -

- A national Health and Social Care Strategy incorporating new contracts for primary care providers; changes in social care; technological enhancement and workforce modernisation.
- Services provided to people at home or in their local communities, including the increased use of home based technology supported by local health campuses.
- Acute services will work in concert with primary care to give easy access to the local services that people use most frequently

[7] http://www.wales.gov.uk/subihealth/content/keypubs/pdf/designed-life-e.pdf

including emergency and planned care together with support for chronic disease management etc.
- Specialised and Critical Care Centres will be focused in a few major centres that will have the potential to act as centres of excellence. The services included in these centres will be further considered.
- Highly specialised "tertiary-level" hospital services will link with the specialised centres providing rapid access when needed and to ensure that wherever possible these services can be provided more locally.

These services will look and feel very different to the public, who will have easy access to information about health and social care matters and their own condition. "Grid technology" – a service for sharing computer power and data storage capacity over the internet - will be used to allow faster, better use of all information relating to an individual's care with electronic care pathways and social care records allowing people to monitor their quality of care.

Home will be a health improvement setting and treatment centre using the home monitoring through telemedicine. The latest technology will seek to ensure that hospital admissions are reduced, and return to home will be quicker. Action will be taken at several levels to keep people well and independent. Health improvement will become a growing focus with its own policy and development and will continue to foster efforts to target the causes of poor health.

The NHS, local government and their partners will put their weight behind the effort to strengthen the approach to prevention at all levels. Even greater efforts will be made to help people look after their own health better, based on balancing clearer service entitlements and greater responsibility for health. There will be a concerted effort to maintain people's independence with a range of telecoms equipment devices to help guard against risks in the home.

For those people with significant care needs, technological aids will become widespread giving people the opportunity to remain in their own home. People with long-term conditions will have a multi-agency personal care plan developed that all the relevant agencies understand and support. Individuals will be helped to become 'expert patients' taking a high degree of control over their treatment. Pre-planned care will be organised around the recipient's needs and convenience. There will be more information, a wider range of treatment options and greater certainty in the system.

Strategic Framework No1
The targets for the next three years will be to provide: -

- More prevention through screening, health promotion targeting at risk groups
- Better access through improved waiting times, faster emergency response and streamlined care pathways for the priority disease areas
- Better services for mental health, chronic diseases, children, young and older people's services and cancer
- A new Human Resources Strategy incorporating workforce development and modernising the learning infrastructure
- Enabling change through performance management, research and evaluation, benchmarking, reconfiguration, education and training, financial and clinical leadership, clinical networks, planning and commissioning and information management.

Strategic Framework No2
This strategy will build on the achievements of the previous three years. This will enable the Assembly, service, partners and patients to concentrate on: -

- Setting Clinically Relevant Targets
- Refocusing on wellbeing and health inequalities
- Developing the workforce

Strategic Framework No3
The theme for this strategic framework is ensuring full engagement. This will commence with a strategic appraisal of the seven work-strands identified in the Wanless report: -

- Engagement of individuals and communities
- Re-shaping of services
- Seamless provision
- Evidence based practice
- Improving performance
- Delivery
- Pace of change

The outcome of this appraisal will gauge how far there is still to travel to achieve the vision for 2015, but it is also will help to inform the nature of interventions and programmes that will need to be implemented and assessed if they are to be of relevance within the overall context of health

policy within Wales.

WAG has also established Health Challenge Wales[8] to act as the focal point of efforts to improve health and well-being, recognising that wide range of factors impact on health and well-being and that co-ordinated action can help to create a healthier nation. The scheme was launched in January 2005 and has been a noticeable feature of a number of initiatives which have been badged with the Health Challenge Wales logo. However, it was set in the background of the report produced by the Chief Medical Officer Wales – *Health Status Wales 2004-05,*[9] which highlighted the status of the health of the nation and the work that was required to improve it. Much of the data and information contained in the report and that produced by the Local Government Data Unit Wales and Wales Centre for Health[10] will be utilised and developed in subsequent sections.

WORK and HEALTH POLICY

One of the most significant strategic documents produced in recent times relating to the issue of work and health is *Securing Health Together: A long-term occupational strategy for England, Scotland and Wales,* published by the Health and Safety Executive in 2000.[11] It highlighted three principal reasons for a long-term occupational strategy:

- To stop people from being made ill by work;
- To help people who are ill return to work;
- To improve work opportunities for people currently not in employment due to ill health or disability.

It set itself three targets by 2010, that is to achieve:

- a 20% reduction in the incidence of work-related ill health;
- a 20% reduction in ill health to members of the public caused by work activity;

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[8] http://www.healthchallenge.wales.gov.uk

[9] http://cmo.wales.gov.uk/content/publications/reports/index-e.htm

[10] Health in Wales: A Report on Health in Wales based on the results from the 2001 Census, August 2005. Local Government Data Unit Wales and Wales Centre for Health.

[11] http://ohstrategy.co./pdf_files/8422document.pdf

- a 30% reduction in the number of work days lost due to work-related ill health.

It also emphasised the pluralistic nature of the problems and their solutions, with a need for concerted, concentrated, multi-factorial, multi-dimensional and multi-agency approaches to target collective efforts on the areas that need it most. The role of partnership working was also highlighted, involving Government, Local Authorities, individuals, large and small employers, trade unions and health professionals.

The strategy provides a framework that can be used to achieve its stated goals and by identifying the key areas for action and setting them in train. It highlighted three specific objectives to ensure that:

- Work does not damage the health of workers or members of the public
- People are not excluded from work due to ill-health or disability
- Individuals who have been ill are rehabilitated.

and emphasised that one of the keys to developing this strategy would be the involvement of all those who have an interest in preventing ill health at work, treating ill-health and rehabilitating those who have suffered.

The framework offered by this document has also informed other Government initiatives, in particular the *Welfare to Work* agenda and the *Pathways to Work* programme developed by DWP, which were central to the aim of reducing the rates of workers moving on to, and remaining on, incapacity benefit. The success of the Pathways to Work Pilot schemes [12] were instrumental in driving the welfare reform Green Paper, A New Deal for Welfare: Empowering people to work, [13] launched in January 2006.

The basic tenet of the Green Paper is to continue progress to breaking down the barriers that prevent people from fulfilling their potential and, through worklessness and economic inactivity, lead to poverty and disadvantage. The Green Paper has established three specific targets:

- reduce by 1 million the number on incapacity benefits;

[12] http://www.dwp.gov.uk/asd/asd5/wp26.pdf

[13] http://www.dwp.gov.uk/aboutus/welfarerefrom/docs/A_new_deal_for_welfare-Empowering_people_to_work-Full_Document.pdf

- help 300,000 lone parents into work; and
- increase by 1 million the number of older workers;

There is an explicit commitment to reduce the number of people who leave the workplace due to illness, increase the number leaving benefits, and better address the needs of all those on benefits, with additional payments to the most severely disabled people.

The intentions, outlined in the document, are to improve workplace health by the creation of healthy workplaces and increasing access to good quality occupational health support; to facilitate better absence management and early intervention to assist employees who become ill to stay in work, or support recovery and return of those who are unable to remain in work – key in this is the role of GPs and primary care teams in the management and recording of sickness absence, with possible incentives in place to reward those who take active steps in supporting individuals to remain in or return to work; and, to extend provision of the Pathways to Work programme.

There is also a clear recognition that there must be partnership working if the proposals are to be successful, with a whole systems approach evident and a culture of collaboration across all stakeholders.

OTHER INITIATIVES

One of the most important initiatives designed to specifically tackle the issues faced by the Heads of the Valleys communities, including Merthyr Tydfil, was the Heads of the Valleys Partnership Programme launched by the Minister for Economic Development in November 2004. '*Heads – We Win….*' a strategic document for the Heads of the Valleys, 2005, [14] set out the intentions, namely to develop an area with:

- strong, vibrant and well maintained town centres, linked by good quality public transport;
- a full range of modern leisure, cultural and social facilities;
- significantly improved health care (especially primary health care);
- better quality and more appropriate education and skills training for both children and adults (including access to high quality schools);

[14] http://www.wales.gov.uk/subitradeindustry/content/headsofvalleys/index.htm

- the ready availability of a full range of housing types (including affordable and executive housing) especially within town centres;

all underpinned by strong, clean and safe communities. It was recognised, within the document, that a strong, better balanced economy would offer significantly improved life chances, by helping to break down the structural barriers to work which exist in the area, and encourage engagement within wider Heads of the Valleys life.

It is within this context that the WiW partnership is located, and the remainder of this report seeks to highlight some of the context, issues, problems and challenges, which need to be overcome if the aims of the Welfare Reform Green Paper and other policy initiatives are to prove to be successful.

5. DEMOGRAPHIC CONTEXT

This section of the report outlines the demographic composition of the community, introduces the notion of social exclusion and also contains a description of relative educational performance within Merthyr Tydfil.

DEMOGRAPHIC COMPOSITION

The population of Merthyr Tydfil currently stands at 55,400 – a decline of nearly 8% since 1991, against an overall population for Wales of 2.94 million.[15] The gender split is 48% males and 52% females and mirrors the Welsh split. The structure of the population in each of the wards within Merthyr is highlighted in Table 5.1.

TABLE 5.1: Age distribution of population in Merthyr - 2001

Wards	All People (n)	0-4 years (%)	5-15 years (%)	16-19 years (%)	20-44 years (%)	45-64 years (%)	65 years and over (%)
Bedlinog	3,399	6	15	6	33	26	15
Cyfarthfa	6,141	5	16	6	32	26	15
Dowlais	6,646	6	16	5	34	23	15
Gurnos	5,034	7	17	6	33	22	15
Merthyr Vale	3,925	7	17	6	32	24	15
Park	4,307	4	13	5	31	25	21
Penydarren	5,253	6	17	6	32	23	16
Plymouth	5,005	6	15	5	32	25	16
Town	6,554	5	15	4	32	25	19
Treharris	6,252	6	17	5	34	24	14
Vaynor	3,465	6	14	4	31	27	18
MERTHYR	55,981	6	16	5	33	24	16
WALES	2,903,085	6	14	5	32	25	17

Note: figures may not add up to 100% due to rounding

The noticeable feature is the relatively high percentage of people aged 65 years and over in Park, with higher than average percentages in Town and Vaynor compared to 16% in Merthyr and 17% across Wales. The difference in age structure is also evident at the other end of the spectrum, with over 30% of the population aged 19 years and under in Gurnos compared with

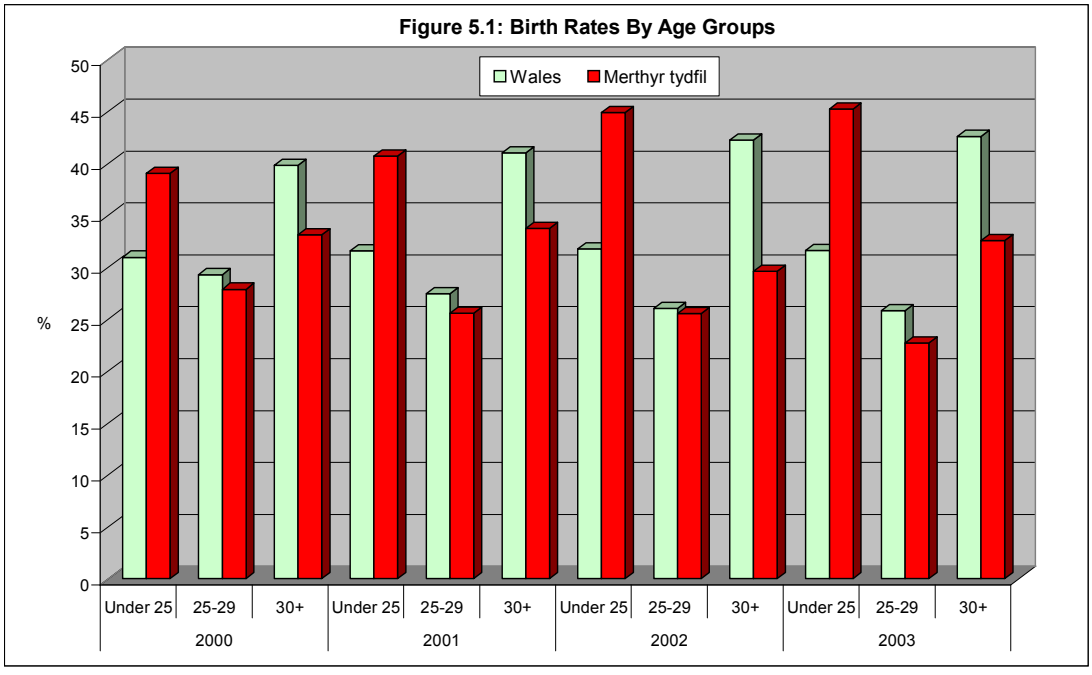
[15] http://www.wales.gov.uk/keypubstatisticsforwales/content/publication/health/2004/hsw2005/hsw2005-ch1/hsw2005-t1-3.xls

22% in Park and 25% across Wales – factors which are relevant in relation to the targeting of interventions in Phase II of the WiW initiative.

In terms of household composition there was general consistency in the proportion of households with dependent children – ranging from 43% in Town, 44% in Park to 53% in Gurnos. The percentage of people who are single (never married) ranges from 38% in Park to 49% in Gurnos, nearly double the 28% of singletons found across Wales, while there was consistency across the Borough in the percentage who are re-married, separated and divorced, in line with figures across Wales. Park has the highest rate of widowed people at 12% with the figure across Wales at 9%.

The age breakdown of dependent children is very similar in Merthyr to the situation in Wales as a whole – 24% pre-school age (25% Wales); 40% primary school age (40% Wales); and, 36% secondary school age (35% Wales).

There has been a consistent upward trend in the number of births to women under 25 in Merthyr over the past few years, with 45% of births in 2003 being to younger women, as shown in Figure 5.1. In Wales, as a whole, the birth rate among younger women has been consistently around 31%. This differential also reflects the number of teenage pregnancies in Merthyr relative to Wales, an issue which will be discussed in more detail in section 8.

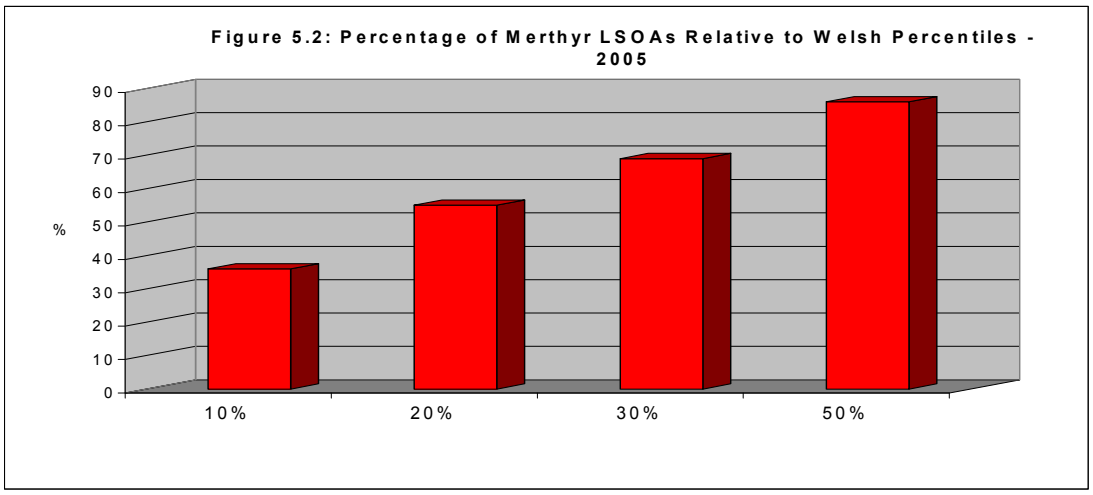


Life expectancy at birth for males in Merthyr Tydfil (2002) was the lowest in Wales at 73.3 years compared with 75.3 years in Wales and 78.5 years in Ceredigion - a difference of 5.2 years compared with Merthyr. Among females, the life expectancy at birth was also the lowest in Wales at 78.1 years, compared with 80.0 years in Wales and 81.9 years in Ceredigion and Monmouthshire – a difference of 3.8 years compared with Merthyr.[16] The Chief Medical Officer of Wales reported that death rates in Merthyr Tydfil were almost 50% higher than in Ceredigion, [17] but, as highlighted, "there can be substantial differences within such areas as well as between them."

The standardised mortality ratio[18] (1999-2003) in Merthyr was 126, relative to Wales (100), with the ratio for males in Merthyr 156 relative to Wales (125) and 99 for females relative to Wales (77). [19]

SOCIAL EXCLUSION

The issue of deprivation and social exclusion runs as a central theme throughout this report. In this section the issue is introduced and an overview taken of where Merthyr sits relative to other authority areas in



16 http://www.wales.gov.uk/keypubstatisticsforwales/content/publication/compendia/2004/dwlas2004/dwlas2004-ch1/dwlas2004-t1-14.xls

17 http://cmo.wales.gov.uk/content/publications/reports/health-status-wales-e.pdf

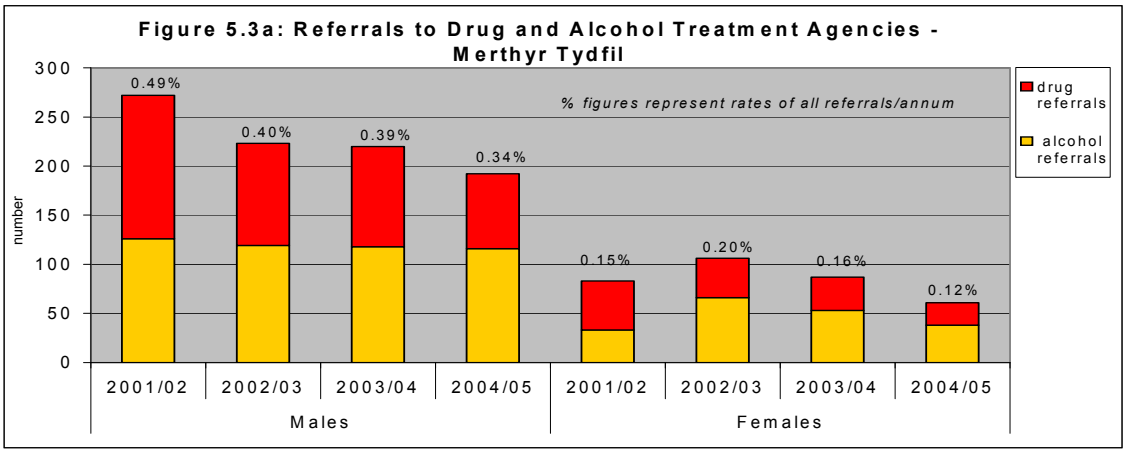
18 Calculated as the number of actual deaths in the period as a percentage of deaths which would have been expected if the population had experienced the sex-and-age specific mortality rates in Wales as a whole during the period.

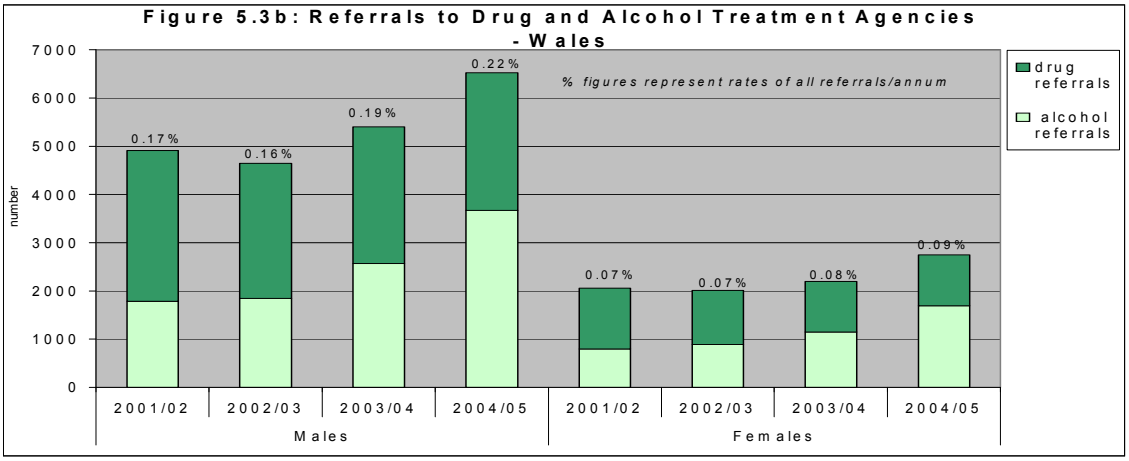
19 http://www.wales.gov.uk/keypubstatisticsforwales/content/publication/compendia/2004/dwlas2004/dwlas2004-ch1/dwlas2004-t1-23.xls

Wales.

Figure 5.2 highlights the percentage of Lower Super Output Areas (LSOAs) within Merthyr in the 10th, 20th, 30th and 50th percentile of most deprived communities within Wales. Thirty-six percent of LSOAs in Merthyr are to be found in the 10% of most deprived communities in Wales; 55% in the 20% of most deprived communities; 69% in the 30% of most deprived communities; and, 86% in the 50% of most deprived communities. There are no Merthyr LSOAs in the least deprived 25% of communities in Wales.[20]

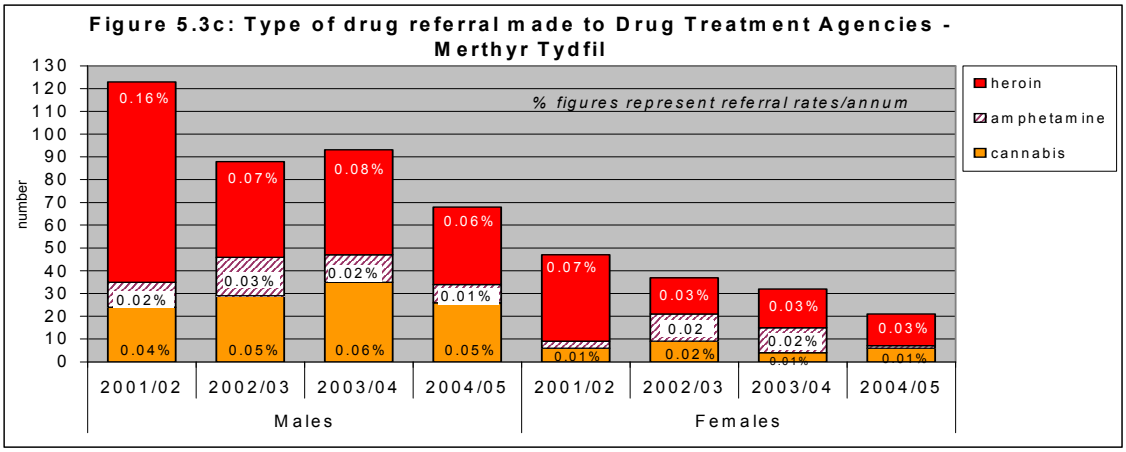
The consequences of social exclusion and deprivation are often manifest in crime and drug and alcohol problems. For example, the number of referrals to Drug and Alcohol Treatment Agencies [21] from Merthyr viz-a-viz Wales is shown in Figures 5.3a and 5.3b.

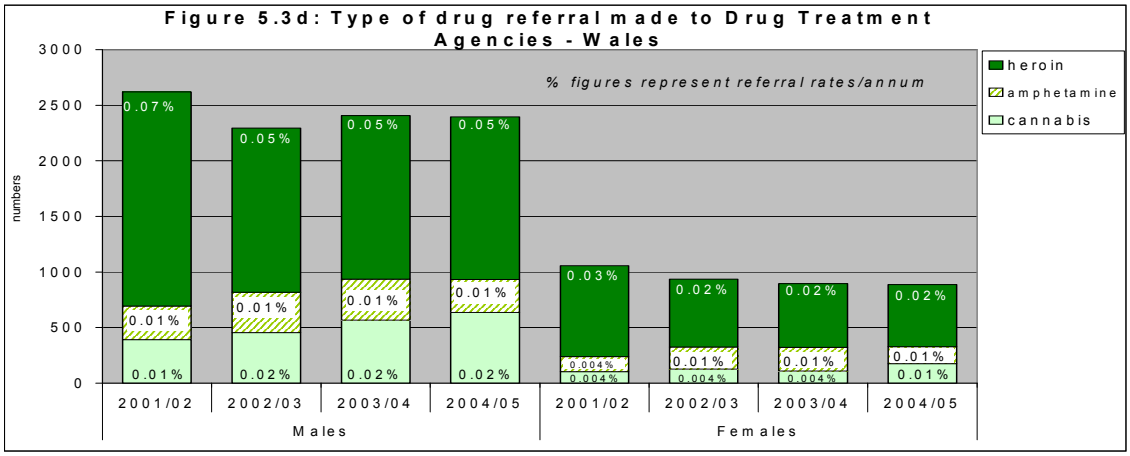




[20] http://www.wales.gov.uk/keypubstatisticsforwales/wimd/wimd2005-analysis/wimd2005-analysis-pt6-r1.pdf

[21] Substance Misuse Report on the Welsh Data Supplied to the Department of Health National Drug Treatment Monitoring System (NDTMS) April 2001 – 31 March 2005. Information Products Unit, Health Solutions Wales, August 2005.



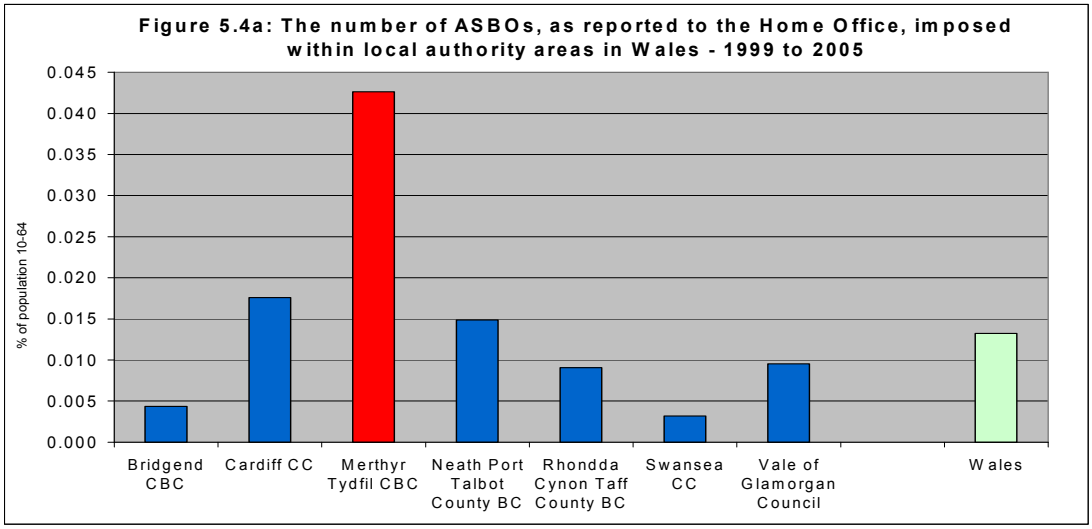


The total number of referrals among males increased from 4,907 to 6,524 and females from 2,062 to 2,748 over the four-year period in Wales – an overall increase of 33%, whereas in Merthyr the numbers fell from 272 to 192 among males and 83 to 61 among females – an overall decline of 29%. Figures 5.3c and 5.3d show that there has been a marked reduction in heroin use in Merthyr compared to Wales, overall. While there are 'health warnings' relating to the quality of the data, [22] and a decline is to be welcomed, Merthyr still has one of the highest rates of reporting in Wales with a European Age Standardised Rate of over 500 per 100,000 population.[23]

[22] The Wales figure may be an underestimate because numbers of referrals recorded in South West Wales are low because the local treatment agencies reported most of their referrals to a Dyfed Powys database which was not compatible with the data collected by Health Solutions Wales. In addition, not all treatment agencies supplied information over the whole of the four year period so that any observed trends may be due to differential coverage.

[23] Substance Misuse Report on the Welsh Data Supplied to the Department of Health National Drug Treatment Monitoring System (NDTMS) April 2001 – 31 March 2005. Information Products Unit, Health Solutions Wales, August 2005.

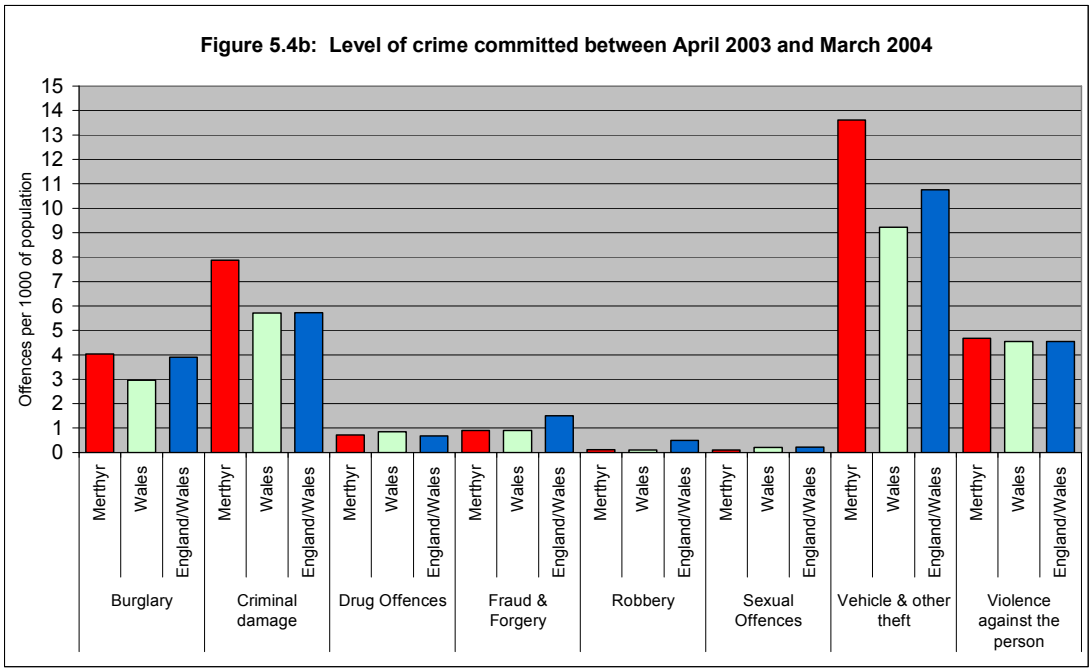
The above average substance misuse found in the Merthyr Tydfil area is reflected in the above average levels of social disorder and crime. Between 1999 and 2005, 270 Anti-Social Behavioural Disorders (ASBOs) were issued in Wales – 43% to 10-17 year olds and 57% to 18+ year olds. The South Wales Police region accounted for 39% of ASBOs issued and Figure 5.4a shows that Merthyr Tydfil has the highest incidence of anti-social behaviour compared to the other local authorities of the region.[24]



During the period between April 2003 and March 2004, the overall recorded crime rate for Merthyr Tydfil was 32.5 offences per 1000 of the population, while the all-Wales level was significantly lower at 24.7/1000 and the national figure for England and Wales was 28/1000. Figure 5.4b shows the crimes for which Merthyr had above average rates – criminal damage and vehicle and other theft, that is theft of a vehicle, theft from a vehicle, theft from the person, theft from shops and other theft and handling.[25] This data also supports earlier evidence of above average substance misuse problems, it has been well documented that a great deal of acquisitive crime is committed to support drug-taking behaviour.

[24] http://www.crimereduction.gov.uk/asbos2.htm

[25] Home Office, Crime Statistics for England and Wales. http://www.crimestatistics.org.uk/tool/Default.asp?region=5&force=9&cdrp=287&l1=0&l2=0&l3=0&sub=0&v=24



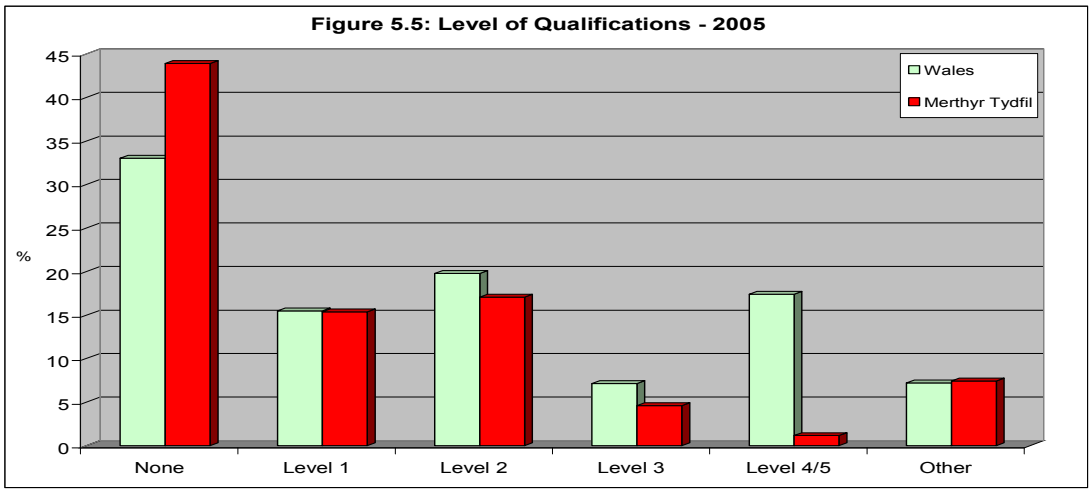
EDUCATIONAL ATTAINMENT

There are clear linkages between levels of deprivation and educational attainment. Analysis of the Welsh Index of Multiple Deprivation data highlights that Merthyr has 28% of LSOAs in the 10% most deprived communities in Wales in relation to education.[26] In addition, a report by the Joseph Rowntree Foundation placed Merthyr as the most deprived authority in Wales in relation to performance at GCSE level; the second most deprived area in terms of attainment at Key Stage II; and, the second most deprived in the proportion of 18 year-olds who go on to higher education. [27]

This data is summarised in Figure 5.5, where it is evident that the level of educational attainment and qualifications achieved is lower than the Welsh average, with 44% of the population in Merthyr having no qualifications compared to 33% of the Welsh population. Within Merthyr there is a wide range in the percentage of people with no qualifications, from 36% in Park to 57% in Gurnos.

[26] http://www.wales.gov.uk/keypubstatisticsforwales/wimd/wimd2005-analysis/wimd2005-analysis-pt6-r1.pdf

[27] Kenway P, Parsons N, Carr J, Palmer G. Monitoring poverty and social exclusion in Wales, 2005. York: Joseph Rowntree Foundation, 2005.



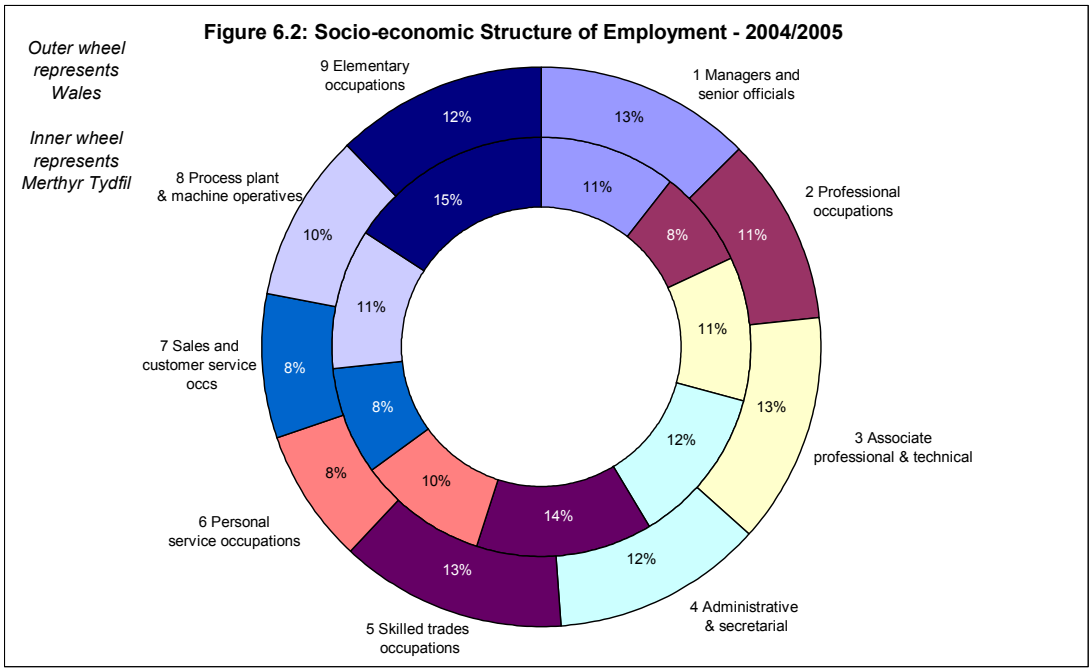
The implications of this data will be considered in the next section of this report but it is important to note that the differential that exists between Merthyr and Wales, and across the borough itself, highlights the need for both careful targeting of interventions, but also for a wider perspective to be utilised in the design and implementation of the interventions in subsequent phases of the WiW initiative.

6. LABOUR MARKET CONTEXT

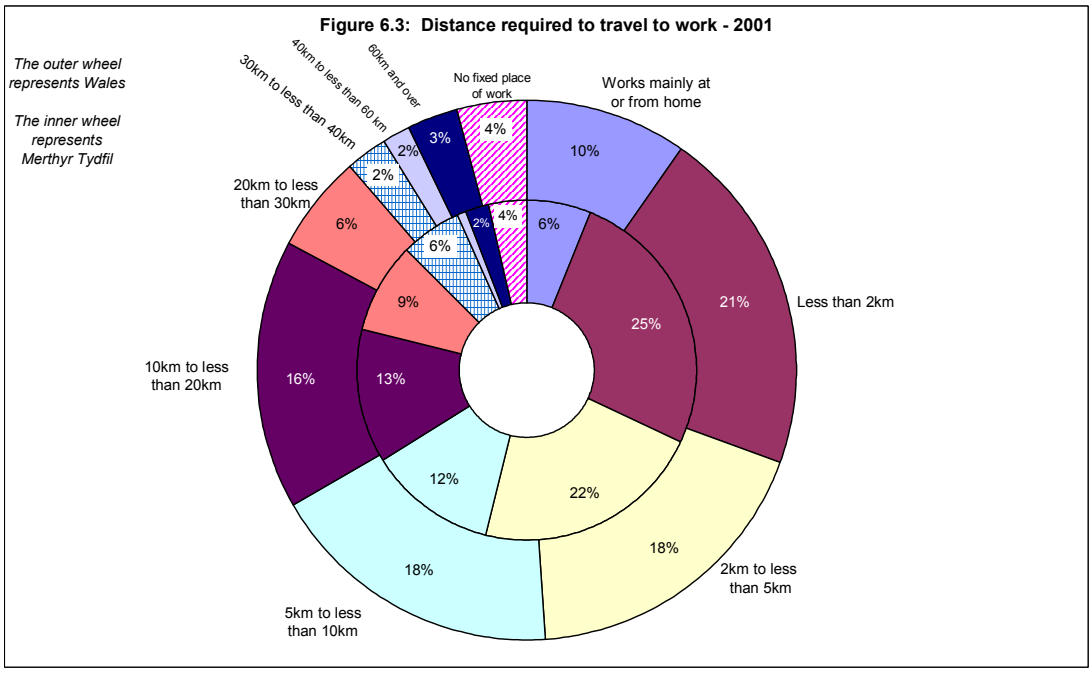
This section of the report provides an analysis of the nature and structure of the labour market within Merthyr relative to Wales. Figure 6.1 demonstrates that the percentage of the population in employment in Merthyr (28-31%) is consistently lower than in Wales as a whole (36-37%) – with a differential of between 5 and 8 percentage points. The situation is even greater when compared with the GB position, where 40-42% of the population are in employment.

Figure 6.2 highlights the difference in structure of employment between Wales and Merthyr – 19% of employees are in categories 1 (Managers and senior officials) and 2 (Professional occupations) in Merthyr compared to over 24% in Wales, and 28% in GB. In contrast 26% of people in Merthyr are employed in categories 8 (Process plant and machine operatives) and 9 (Elementary occupations) compared with 22% in Wales and 19% in GB.

As with previous indicators, there are also wide variations across Merthyr – for example, 12% of those employed in Merthyr Vale are in categories 1 and 2, while 39% are in categories 8 and 9, whereas in Cyfarthfa there are 22% in categories 1 and 2 and 22% in categories 8 and 9.



With regards to the distances people need to travel to get to their place of work, Figure 6.3 shows that people from Merthyr Tydfil are more likely to travel only a short distance to work, with almost half (47%) travelling less than 5km compared to 39% of people across Wales. However, the percentage travelling over 20km to their place of work is higher in Merthyr (17%) compared to Wales (13%). It also appears that there is less opportunity for people in Merthyr to work from home as only 6% do as opposed to 10% across Wales.



The percentage of those who have never worked is 7.9% in Merthyr compared to 5.6% in Wales. However, there are wide variations across the Borough ranging from 5.8% in Merthyr Town to 13.5% in Gurnos. The implications of worklessness have been usefully documented in a review of the literature, [28] with one of the conclusions being that policy measures to encourage employment that were focused on the individual were likely to be undermined by family or communal pressures, while also acknowledging that barriers and constraints to work were complex, multifaceted, deep-rooted and individually varied.

The unemployment rate in Merthyr is consistently higher than the Welsh average, and although not the highest in Wales, the proportion of people who are unemployed or economically inactive and who want work is running in excess of 12% of the working population. The proportion of those economically inactive and who want work who are long-term sick or disabled is running at 40% in Wales, while 25% of this group describe themselves as looking after family or home. Unemployment rates only account for 40% of those who want paid employment, and since unemployment rates have been falling faster than the number of economically inactive people wanting work, the impression has been given of a fall in the number of people wanting work.[29] These percentages are particularly relevant for the design and targeting of interventions in subsequent phases of the research, as a number of issues emerge in relation to the economically inactive proportion of those who want to work – for example, what barriers and constraints confront such a group and what remedies can be instigated in order to remedy the problems?

What is particularly noticeable is that the length of time which people have been unemployed in Merthyr relative to Wales. The percentage of unemployed who have been out of work for more than 15 years in Merthyr is 34%, and the percentage who have been out of work for more than 10 years is 54% compared to 30% and 48% respectively for Wales. These percentages highlight the need for concerted action but involving all agencies and adopting a whole systems approach in targeting and implementing relevant schemes.

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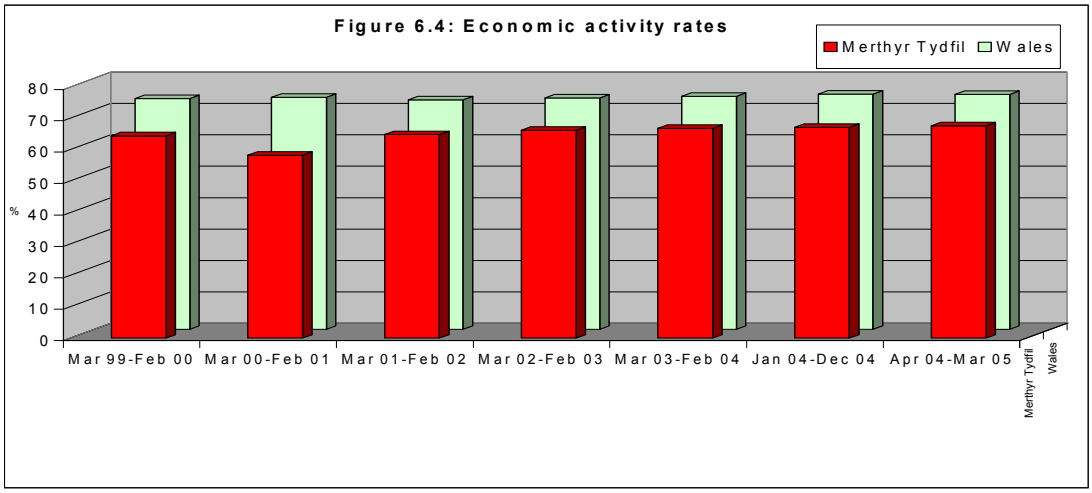
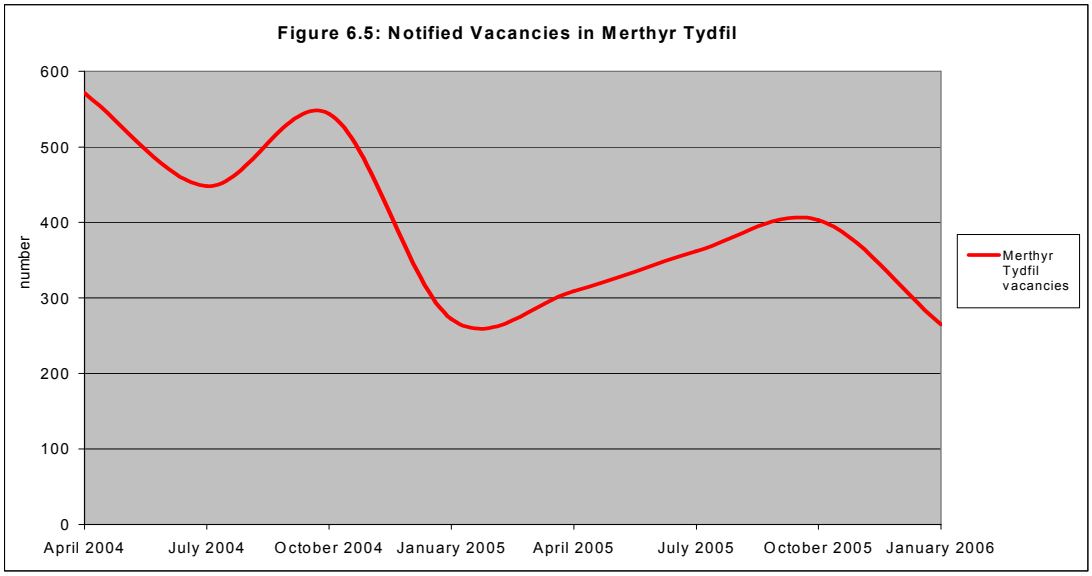
[28] Ritchie H, Casebourne J, Rick J. Understanding workless people and communities: A literature review. Department of Work and Pensions Research Report No. 255. London: Department of Work and Pensions, 2005.

[29] Kenway P, Parsons N, Carr J, Palmer G. Monitoring poverty and social exclusion in Wales, 2005. York: Joseph Rowntree Foundation, 2005.



While there have been pressures on to increase economic activity rates across Wales, the rates in Merthyr continue to lag behind the Welsh average and those achieved across GB as a whole, as shown in Fig 6.4, although there are signs that the differentials are closing. Currently, the percentage economically inactive in Merthyr is 32%, compared with 25% in Wales and 22% in GB.

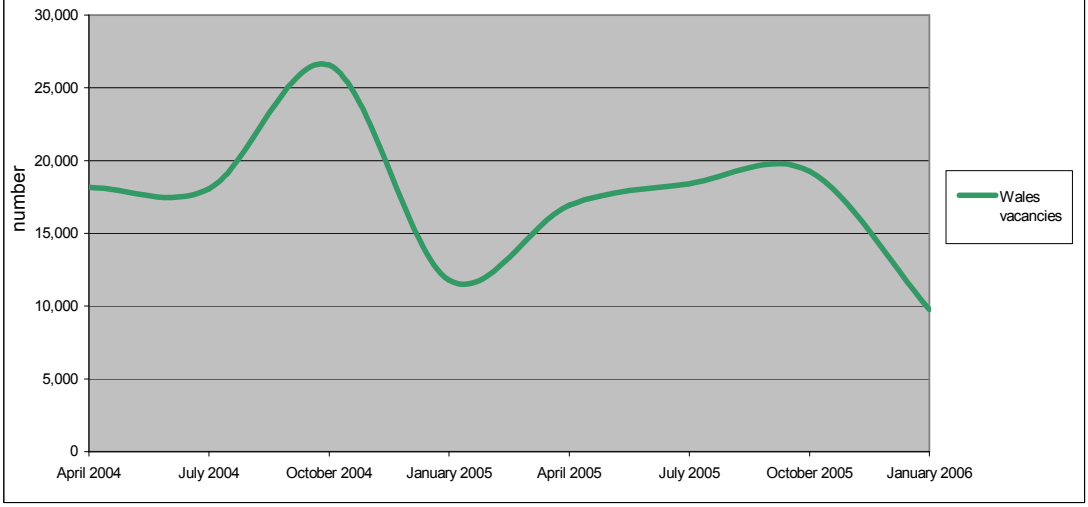
Therefore, taking all of the above indicators into account, it is not surprising that 36% of LSOAs in Merthyr are in the 10% most deprived communities in relation to employment in Wales. [30]



[30] http://www.wales.gov.uk/keypubstatisticsforwales/wimd/wimd2005-analysis/wimd2005-analysis-pt6-r1.pdf - based on the number of claimants of unemployment related benefits, claimants of incapacity benefit, claimants of severe disablement allowance and participants on New Deal for young people and intensity activity period

Over the past few months there has been a decrease in the number of notified vacancies in Merthyr and surrounding areas, as shown in Figure 6.5 above. However, a similar trend is observed in the surrounding areas and at the all-Wales level, as shown in Figure 6.6.

Figure 6.6: Notified Vacancies in Wales



There would therefore appear not to be a great demand for employment within the region and it is necessary to carefully consider the approaches and schemes that can result in improvements in the economic activity rate bearing in mind that employment deprivation currently witnessed needs to be addressed.

7. ECONOMIC CONTEXT

This section considers relative income levels and the proportion of the population who are reliant on state benefits. Analysis of the Welsh Index of Multiple Deprivation data highlights that Merthyr has 19% of LSOAs in the 10% most deprived communities in Wales in relation to income, [31] while the Joseph Rowntree report has ranked Merthyr as the most deprived community in Wales in relation to both child poverty and working-age poverty.[32]

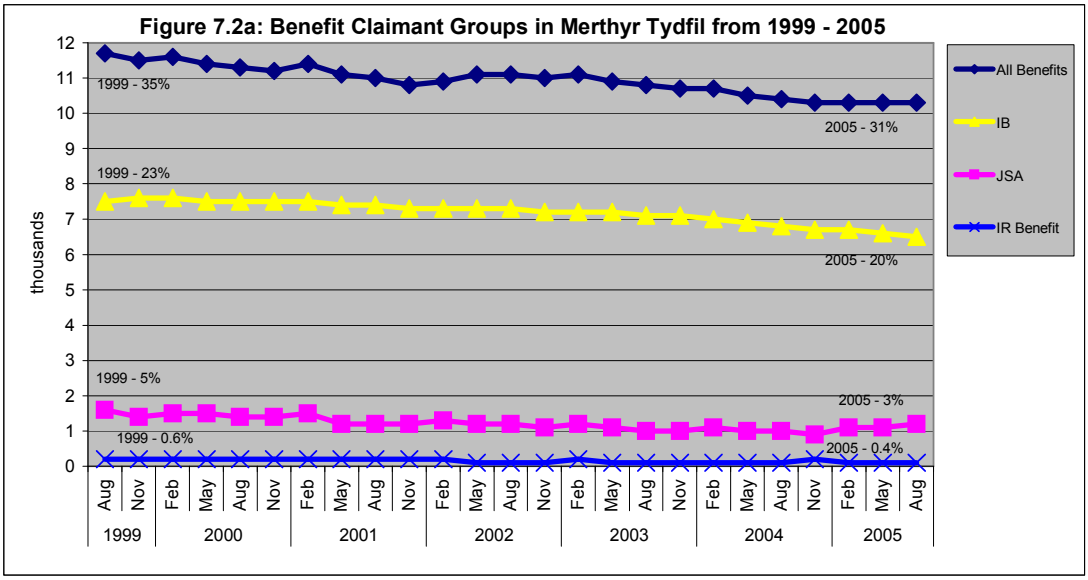
Figure 7.1 portrays the current employment status of the population in Merthyr and Wales. The percentage of the working age population who have never worked in Merthyr is nearly 8% compared to under 6% in Wales, while there are fewer than 50% of the working age population in employment in Merthyr compared to over 57% in Wales.

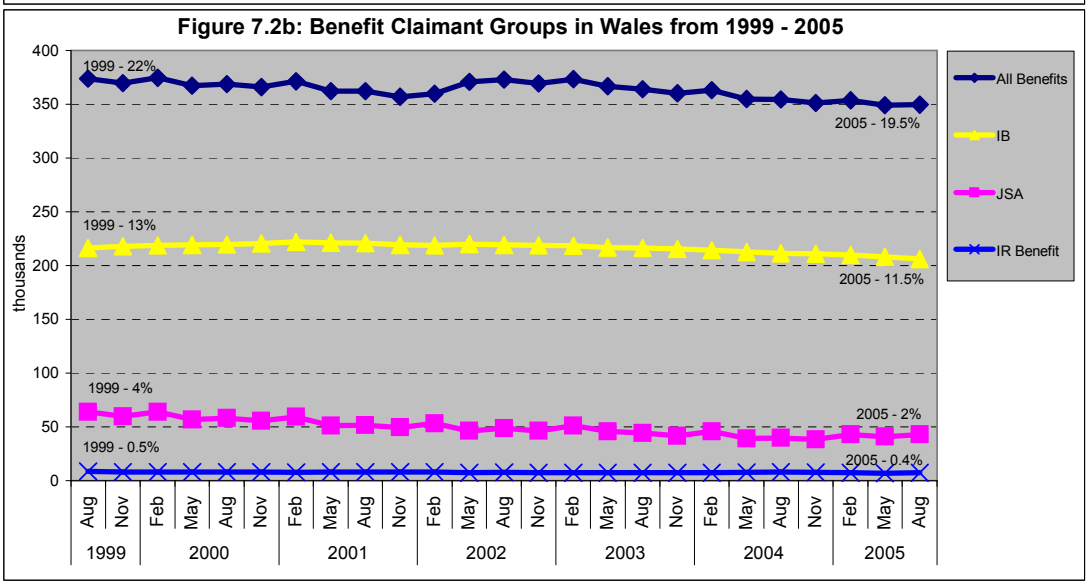
The situation in some communities within Merthyr is even starker. In Gurnos, for example, 37% of the population are in employment while over 13% of the population have never worked.

The numbers on benefits (IB, JSA and income related (IR) benefits) from 1999 to 2005 Merthyr Tydfil and Wales are shown in Figures 7.2a and 7.2b.

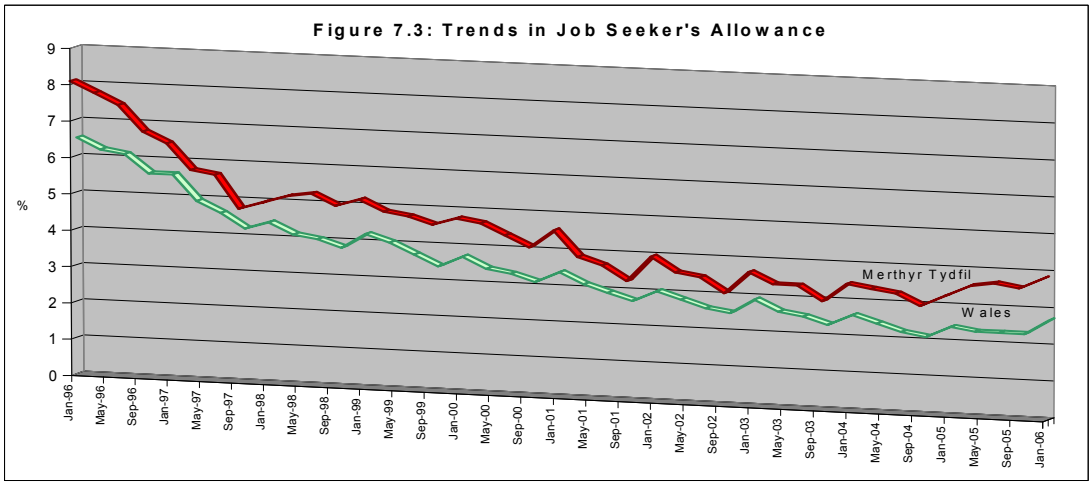
[31] http://www.wales.gov.uk/keypubstatisticsforwales/wimd/wimd2005-analysis/wimd2005-analysis-pt6-r1.pdf

[32] Kenway P, Parsons N, Carr J, Palmer G. Monitoring poverty and social exclusion in Wales, 2005. York: Joseph Rowntree Foundation, 2005.





It can be seen that, despite a decline in numbers and percentages across the piste, the differentials between Merthyr and all-Wales remains fairly constant,



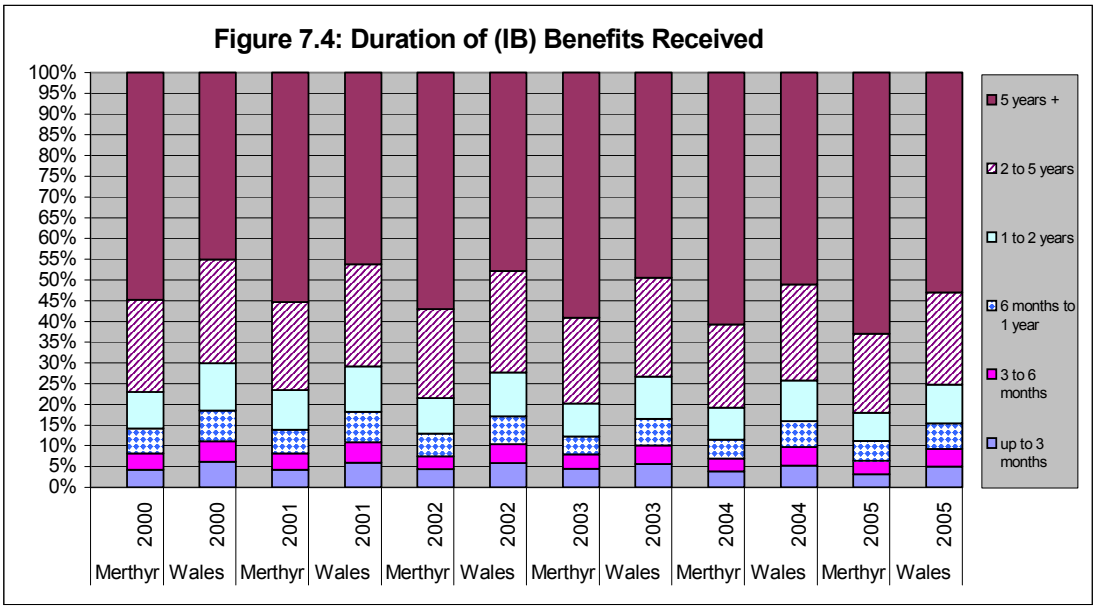
as evidenced in the decline in those on Job Seekers Allowance, as shown in Figure 7.3.

The proportion of IB claimants actually in receipt of benefit is also of interest. 'Claimants' include people in receipt of benefit and also those who are not entitled (but keep submitting medical evidence) or who have had their benefit extinguished. Those who fail the contributions conditions receive a National Insurance Credit (denoted "Credits Only").

TABLE 7.1: Percentage of claimants receiving IB

		2000	2001	2002	2003	2004	2005
		%	%	%	%	%	%
In receipt of IB	Wales	74	73	72	71	70	69
In receipt of IB	Merthyr	79	77	76	75	74	74
Not in receipt	Wales	26	27	2	29	30	31
Not in receipt	Merthyr	21	23	24	25	26	26

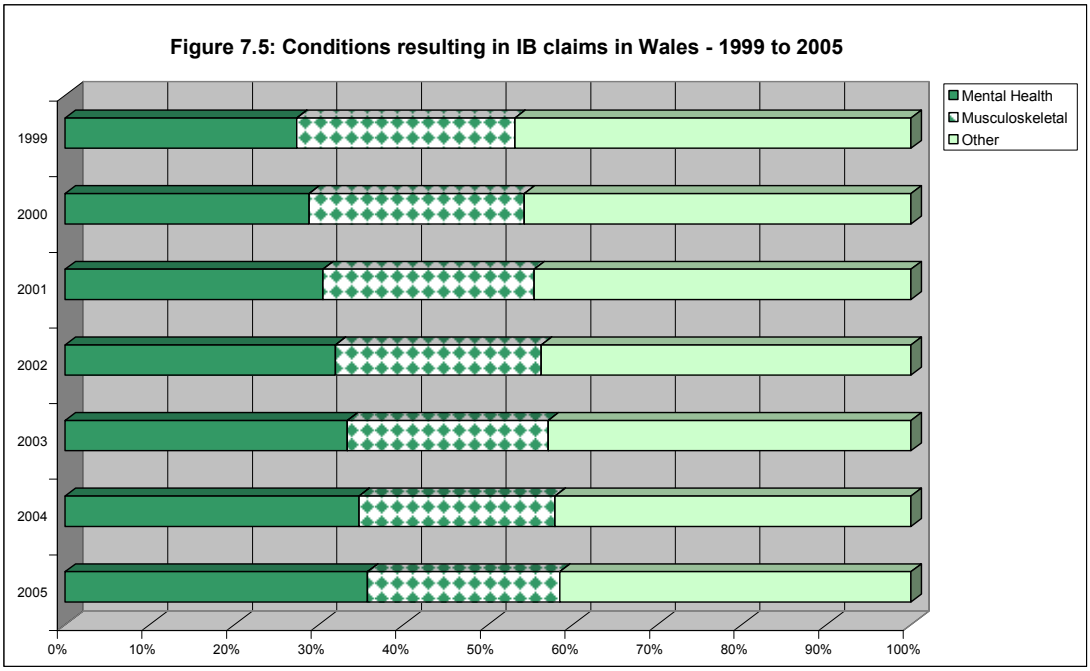
There is a consistently higher percentage of IB claimants in Merthyr who receive IB than Wales – as shown in Table 7.1 – which goes some way to validating the data relating to limiting long-standing illness, to be discussed in Section 8. In addition, there is a clear difference between Merthyr and Wales in relation to the duration of time which people have been receiving benefits as shown in Figure 7.4.



There is no specific data at the Merthyr level relating IB beneficiaries to specific diseases and therefore the prevalence of conditions (ICD-10 codes)

at the Welsh level has been used in relation to the number of IB beneficiaries in Merthyr. The total number of beneficiaries in Wales has fallen from nearly 150,000 in 2000 to 133,000 in 2005, but the number of beneficiaries due to mental and behavioural disorders has risen from 35,200 (24%) to over 40,000 (30%). On the other hand there has been a decline in the number of beneficiaries suffering from musculoskeletal problems from 41,000 (28%) to 34,000 (26%), as shown in Figure 7.5. The figures are slightly different when claimants are considered, with mental and behavioural disorders accounting for 36% of claims in 2005 compared with 29% in 2000 and musculoskeletal problems falling from 25% in 2000 to 23% of claims in 2005.

Figure 7.5: Conditions resulting in IB claims in Wales - 1999 to 2005



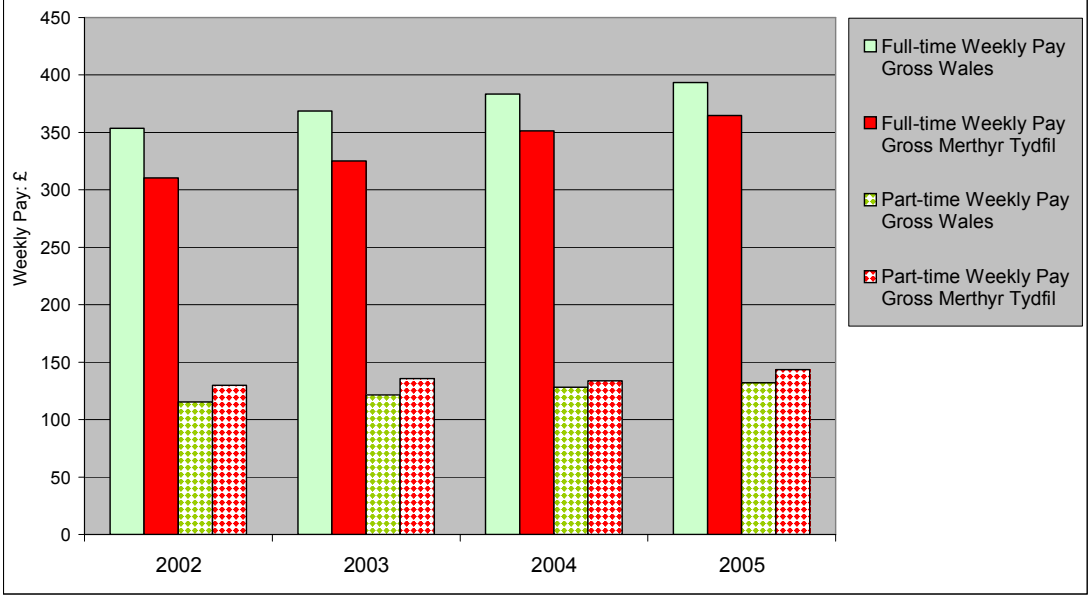
There is a close correspondence between numbers on benefits and income levels within communities. For example, one measure of low income is the proportion of the population in each electoral ward receiving Incapacity Benefit, Severe Disablement Allowance or any of the main means-tested benefits, namely Income Support, Jobseeker's Allowance or the Pension Credit Guarantee. Two-thirds of the wards in Merthyr Tydfil are ones where the proportion of people receiving state benefits exceeds 25 per cent – the highest level of state dependence.[33]

In addition, gross weekly earnings are lower in Merthyr than Wales – although there is a slight difference in part-time earnings – as shown in Figure 7.6 and there may be signs that the differential is closing as annual

[33] Kenway P, Parsons N, Carr J, Palmer G. Monitoring poverty and social exclusion in Wales, 2005. York: Joseph Rowntree Foundation, 2005.

gross earnings in Merthyr have increased from 85% of the Welsh figure in 2002 to nearly 89% in 2005.

Figure 7.6: Gross Weekly Earnings for Wales and Merthyr Tydfil



The Rowntree report [34] stated that around a third of the 50,000 children living in income poverty in Wales live in the six Valley local authority areas of Neath Port Talbot, Merthyr Tydfil, Blaenau Gwent, Caerphilly, Rhondda Cynon Taff and Torfaen. In these areas the rate of child poverty – that is, the proportion of children who are living in income poverty – is in excess of 30 per cent, with Merthyr ranked as the most deprived area in Wales.

The evidence to date highlights the extreme deprivation that exists within Merthyr in relation to employment and income. The next section focuses on the health status of the community, where, according to the Welsh Index of Multiple Deprivation, 50% of the LSOAs in Merthyr were in the 10% most deprived areas in relation to health in Wales.[35]

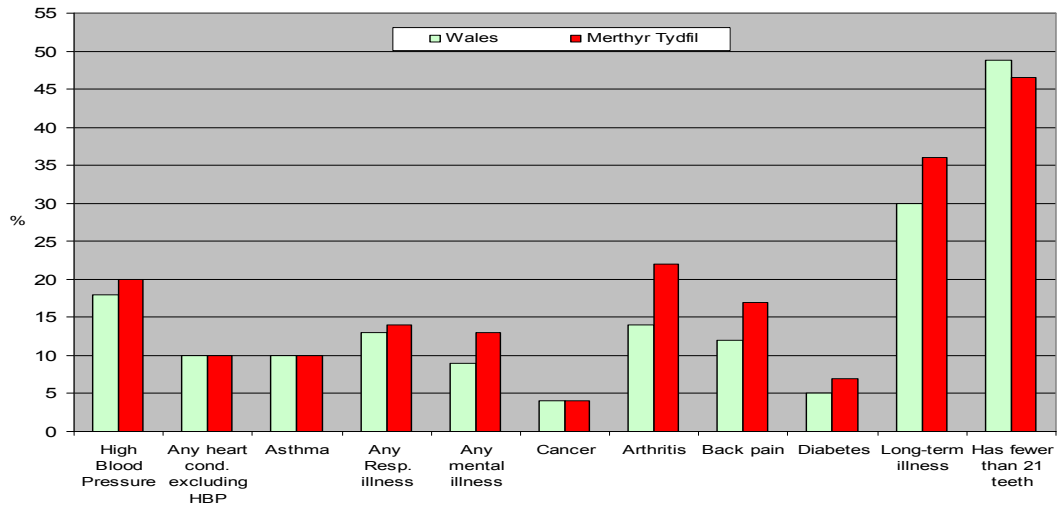
[34] Op cit

[35] http://www.wales.gov.uk/keypubstatisticsforwales/wimd/wimd2005-analysis/wimd2005-analysis-pt6-r1.pdf

8. HEALTH STATUS CONTEXT

Previous sections have reported on levels of overall deprivation and specific components as reflected in the Welsh Index of Multiple Deprivation. In relation to health 50% of LSOAs in Merthyr are to be found in the 10% of most deprived communities in Wales in relation to health status. [36] In addition, Merthyr has consistently higher than average rate of people reporting illness and health problems as shown in Figure 8.1.

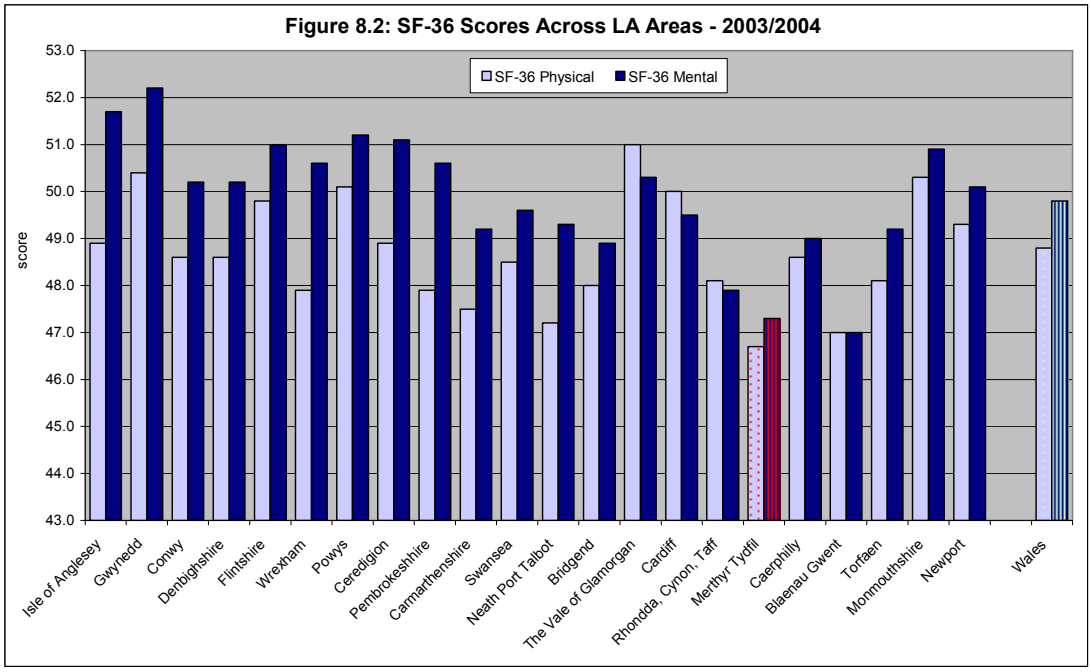
Figure 8.1: Percent of Adults Who Reported Key Illnesses or Health Status - 2003/2004



This is also reflected in the SF-36 scores collected during the Welsh Health Survey, 2003/04,[37] where Merthyr had the lowest Physical Health score for any area in Wales and the second lowest Mental Health score.

[36] http://www.wales.gov.uk/keypubstatisticsforwales/wimd/wimd2005-analysis/wimd2005-analysis-pt6-r1.pdf

[37] http://www.wales.gov.uk/keypubstatisticsforwales/content/publication.health/2005/hs2003-04/hs2003-04.htm



The link between poor health and deprivation is well established and poor health among children is a particularly clear representation of that link. It is also well established that poor health in childhood is a predicator of poor health in adulthood, and the multiple disadvantage that it entails. Merthyr has one of the highest percentages of low birth-weight babies in Wales,[38] while, along with Blaenau Gwent, it has the highest rate of teenage pregnancies in Wales – as shown in Figure 8.3. The 2000-2002 conception rates for the under 16s and 18s in Merthyr Tydfil have remained significantly higher than that of Wales, with conception rates in Merthyr at 14% and 67.2% compared to 9% and 48.7% respectively in Wales. However, although there was a relative decrease in the under 16s conception rates for Merthyr Tydfil (15.6 - 14%), overall conception rates of under 18s for both Wales (46.5 - 48.7%) and Merthyr Tydfil (65.2 – 67.2%) have increased by nearly 2%.[39]

The Rowntree Report [40] has illustrated the full complexity of the issues by reference to teenage pregnancies. First, it points to the disadvantage for the

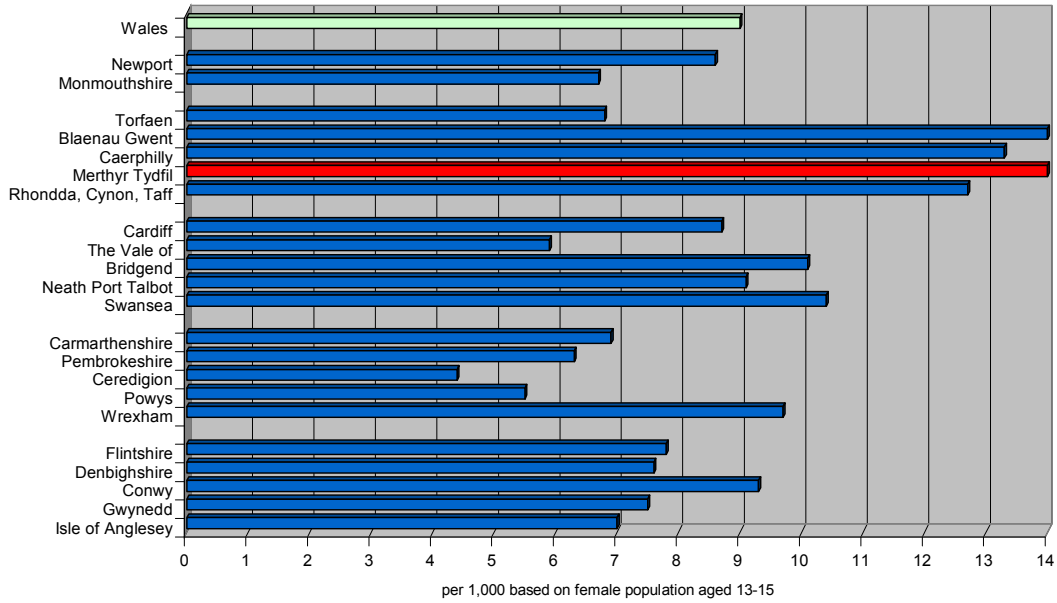
[38] Kenway P, Parsons N, Carr J, Palmer G. Monitoring poverty and social exclusion in Wales, 2005. York: Joseph Rowntree Foundation, 2005.

[39] http://www.wales.gov.uk/keypubstatisticsforwales/content/publication/compendia/2004/dwlas2004/dwlas2004-ch2/dwlas2004-ch2.htm

[40] Op. cit.

child of having a teenage mother. Such a child is more likely to be of a low birth-weight, which in turn means they are more likely to die within the first few weeks of life, or develop certain chronic diseases, such as heart disease or diabetes, in adulthood. The child is also more likely to perform poorly at school, to have educational and emotional problems, and suffer illness, accident or injury. If she is a girl, she is also more likely to become a teenage mother herself. Secondly, it is a marker of the mother's present disadvantage – and the disadvantage that the child is therefore born into, with high risks of being in poverty, being in care, and low educational attainment, which itself is a high risk factor for poor employment prospects, whether unemployment or low-paid employment. Thirdly, it relates to the future prospects of the mother and can be an expression of low aspirations and lack of opportunity – the choice to have a baby may be considered a good option in the circumstances.

Figure 8.3: Teenage Conception Rates



Due to the relatively small number of events it has not been possible to determine the infant mortality rate but it is worth noting that the Rowntree Report indicated that over the years 1998-2001, the infant mortality rate in the most deprived fifth of areas in Wales was 60 per cent higher than in the most affluent fifth of areas. [41]

Disease prevalence has already been referred to briefly in relation to Figure 8.1 but it is worth highlighting the conditions where prevalence rates[42] are

[41] Op cit

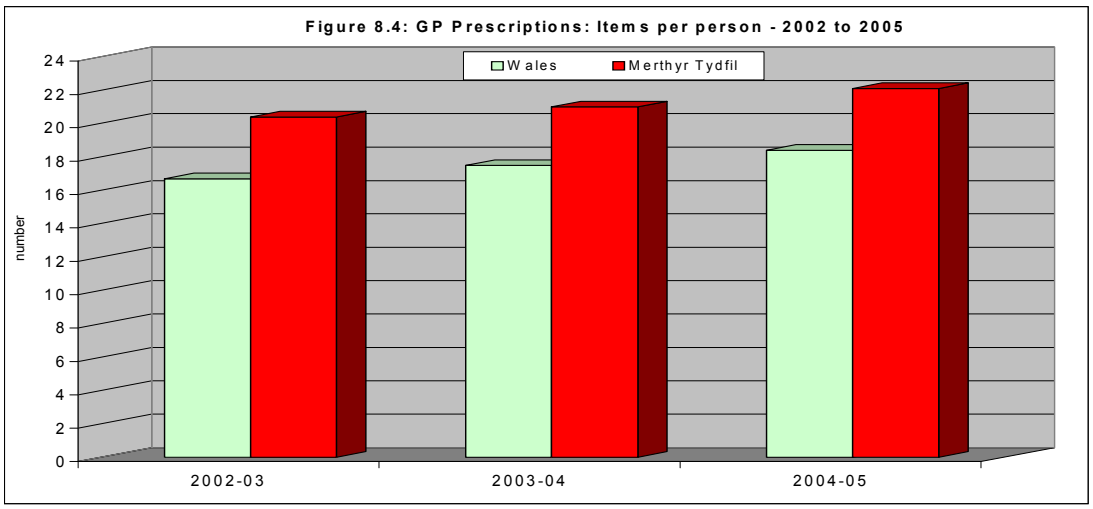
[42] Self-reported as having received treatment - Welsh Health Survey, 2003/04

similar or higher than the Welsh average – expressed as a factor relative to 100 persons in Wales:

- Hypertension – 111
- CHD (other than Hypertension) - 100
- Cancer -100
- Respiratory - 108
- Mental health – 144
- Arthritis – 157
- Back Pain – 142
- Diabetes – 140
- Long-term illness - 129
- Dental (fewer than 21 teeth) - 120

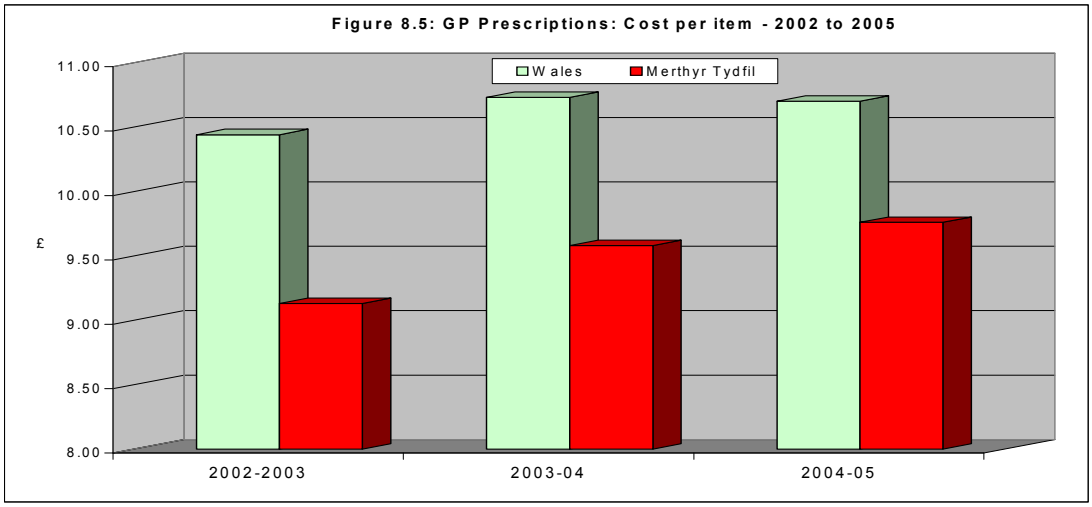
Moreover, when possible differences in disease prevalence between genders were explored, the extent of diabetes and long-term illnesses for men and women were similar. However, females had higher prevalence of arthritis, back pain, poorer mental health, and fewer teeth than males, while a higher percentage of males were reported as having CHD than females.

The relatively high levels of illness and disease are clearly reflected in the rate of prescribing in Merthyr relative to the rest of Wales, as shown in Figure 8.4. What is also significant is that the Welsh prescribing rate per head of population is significantly higher than in England and is a key policy driver for WAG.

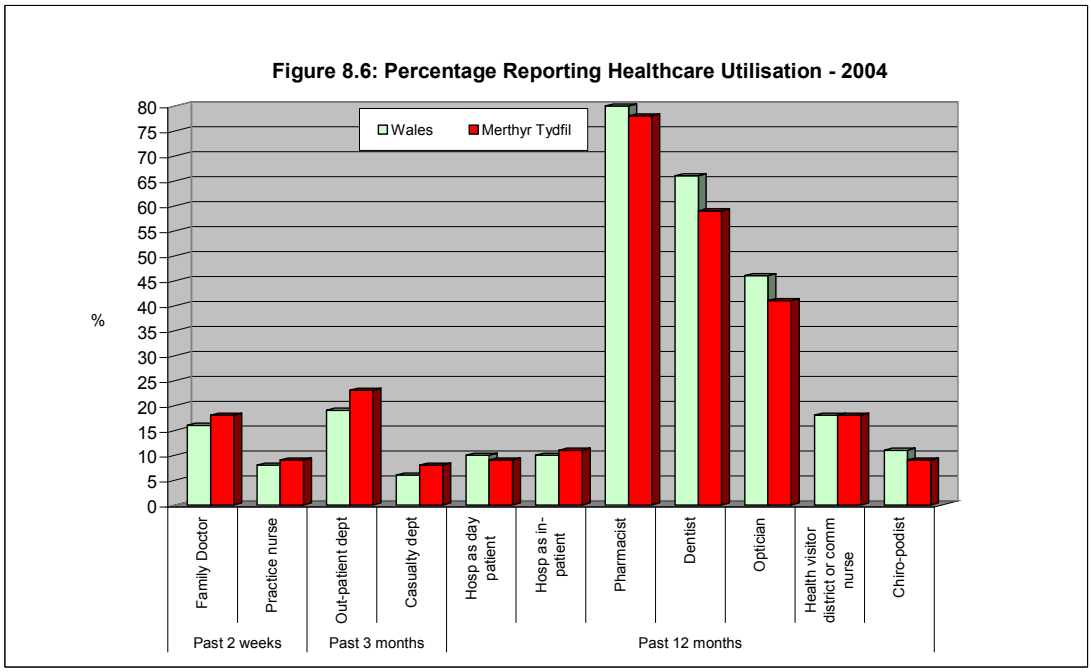


There were in excess of 1.2 million prescriptions provided in Merthyr during 2004-05 at a cost of £12 million – the highest rate per head of any LHB in Wales.

However, it is interesting to observe that the cost per item prescribed in Merthyr LHB is one of the lowest in Wales and, as shown in Figure 8.5, is significantly lower than the Welsh average, and some 20% lower than the highest cost LHB.



In addition, the level of utilisation of healthcare resources and facilities is evidenced in Figure 8.6, where the comparison between utilisation rates in Merthyr and Wales highlight the pressures placed on primary care in Merthyr.

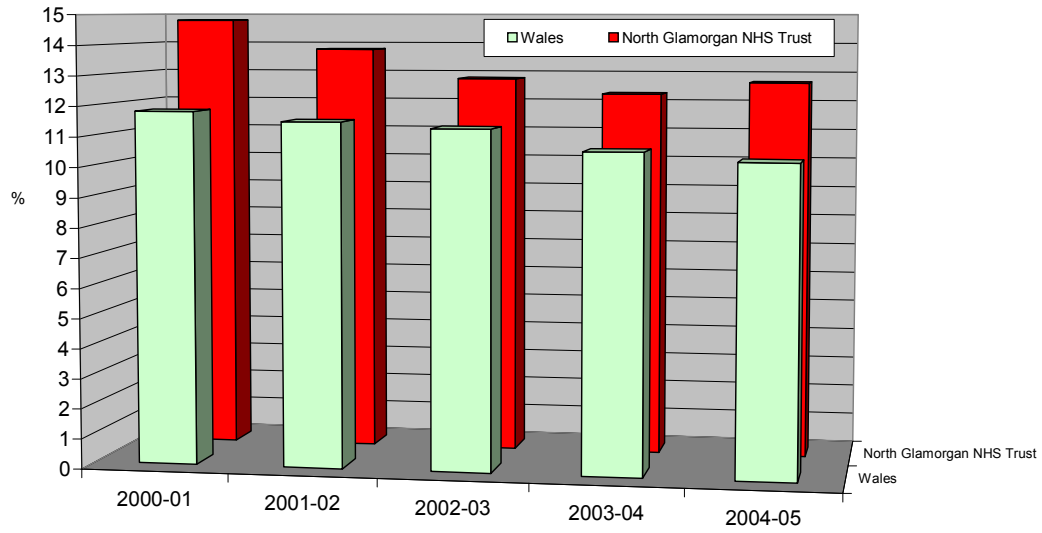


It is the case that people in Merthyr are more likely to visit their GP or practice nurse, are more likely to have had a hospital out-patient appointment or attended A+E or been admitted as an in-patient, while they

are less likely to have been a hospital day patient, or made contact with a pharmacist, dentist, optician or chiropodist relative to the rest of Wales.

The issue of taking responsibility for health and health problems is also one which will need to form part of subsequent phases of the WiW initiative. Figure 8.7, demonstrates that there are a greater percentage of out-patient appointments not kept at North Glamorgan NHS Trust than in Wales, with particular problem areas being Palliative Medicine, Paediatrics, ENT, Dermatology, Obstetrics, Gynaecology and Psychotherapy.

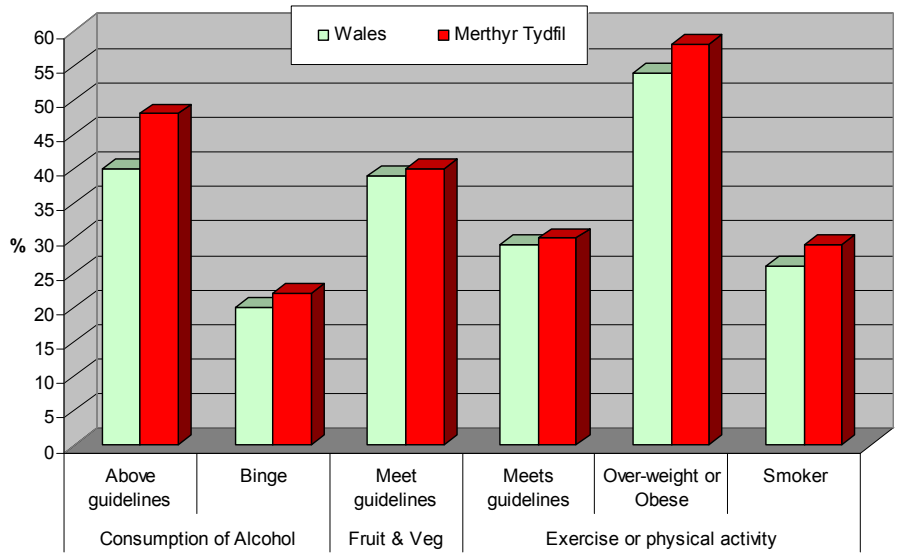
Figure 8.7: Percentage of Out-Patient Attendances Not Kept



While there is a downward trend in the percentage of all out-patient appointments not kept, further analysis highlights that it is follow-up attendances that are the main cause, since the percentage of initial attendances not kept fell from nearly 13% in 2000-01 to just over 8% in 2004-05. However, this is not the trend in psychotherapy, where the percentage of non-attenders increased from 27% in 2000-01 to 50% in 2004-05. In mental illness, while a fall was observed, the percentage is still relatively high compared with other specialties – with nearly 17% of referrals not attending for their initial appointment in 2004-05 (compared with 25% in 2000-01).

In addition, the lifestyle of Merthyr residents does not paint a rosy picture either. As can be seen in Figure 8.8, the indicators point to a negative impact on health status – with higher rates than the Welsh average in terms of smoking and alcohol consumption above the recommended guidelines and lower rates of exercise patterns and consumption of fresh fruit and vegetables.

Figure 8.8: Lifestyle Behaviour 2003-04



However, there may be encouraging signs in relation to exercise. The previous Welsh Health Survey (1998) reported that over 20% of adults in Merthyr did no exercise compared with 13.5% in Wales. The question in the recent Welsh Health Survey was different – meeting approved guidelines - but the percentage in Merthyr (30%) more or less corresponds with the Welsh figure (29%).

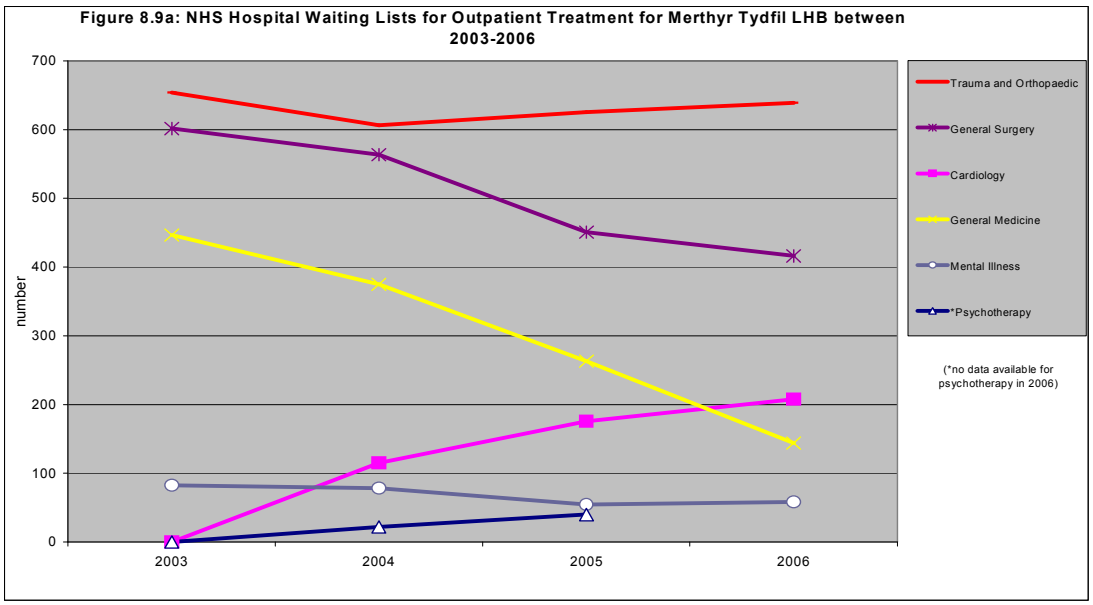
Waiting lists

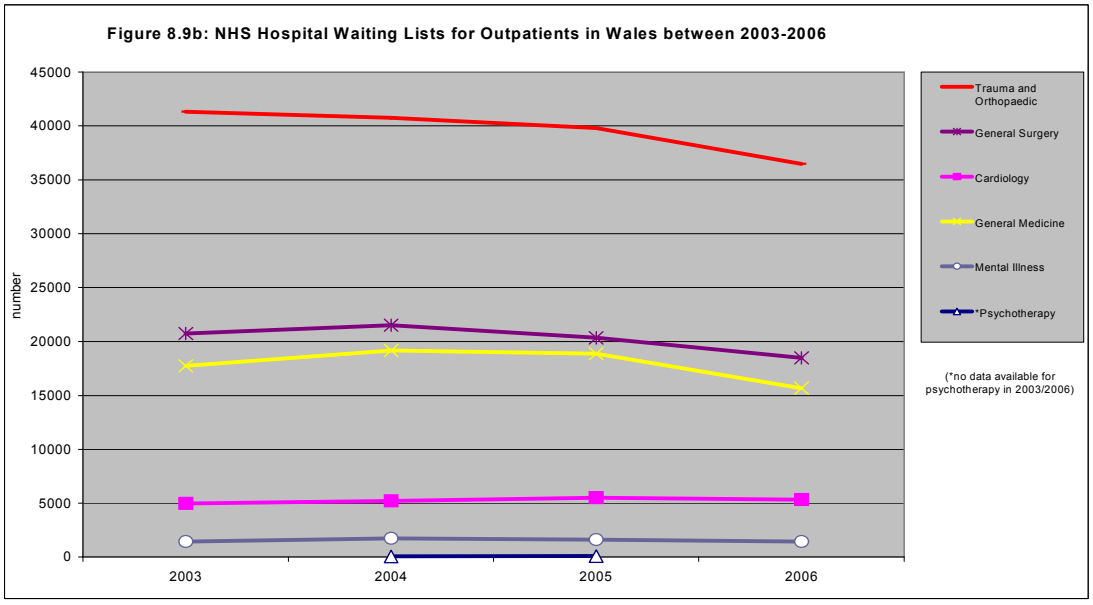
Data relating to waiting lists in the Merthyr LHB area show that there are more people waiting for an initial out-patient appointment than the Welsh average, but fewer people than average waiting for in-patient admission and day-case treatment.

Merthyr residents waiting for outpatient appointments have experienced a rise in waiting times for treatment for trauma and orthopaedics, cardiology, psychotherapy while across Wales such waiting lists are steady or declining – as shown in Figures 8.9a and 8.9b.

There are possible explanations for some of these trends. For example in 2003, Cardiology patients waiting for outpatient attendances were recorded under General Medicine. The waiting lists for Trauma and Orthopaedics is complicated slightly by the 'transfer' of patients referred with back pain directly to physiotherapy. This did not occur for a period in North Glamorgan NHS Trust, but this has now been re-established, although 30%

of physiotherapy referrals have a wait of over 24 weeks in North Glamorgan compared to just over 20% in Wales.





The trend in psychotherapy referrals should be treated with some caution as waiting lists in this area are not normally reported, but as highlighted earlier there are some concerns with regard to the percentage of referrals not attending for their initial appointment in this therapeutic area and mental illness in general.

For Merthyr residents waiting for treatment under North Glamorgan NHS Trust, Figures 10a and 10b shows that they have a longer than average waiting period for access to radiology (consultant referral), dietetics, physiotherapy and occupational therapy (OT). In the case of OT, 145

residents were on the waiting list. All adults were seen within 12 weeks. However, 44% of all referrals had to wait over 72 weeks and these were paediatric referrals. There is a similar pattern across Wales with the majority of adults waiting no longer than 24 weeks for OT but for those having to wait over 72 weeks, the majority are children. Overall, children make up 7% of the 8% of total referrals waiting over 72 weeks across Wales. An examination of paediatric data reveals that across Wales 15% of all child referrals had to wait over 72 weeks compared to 50% in N Glamorgan.

Figure 8.10a: Diagnostic and Therapy Services Waiting Times for all referrals North Glamorgan NHS Trust 2005

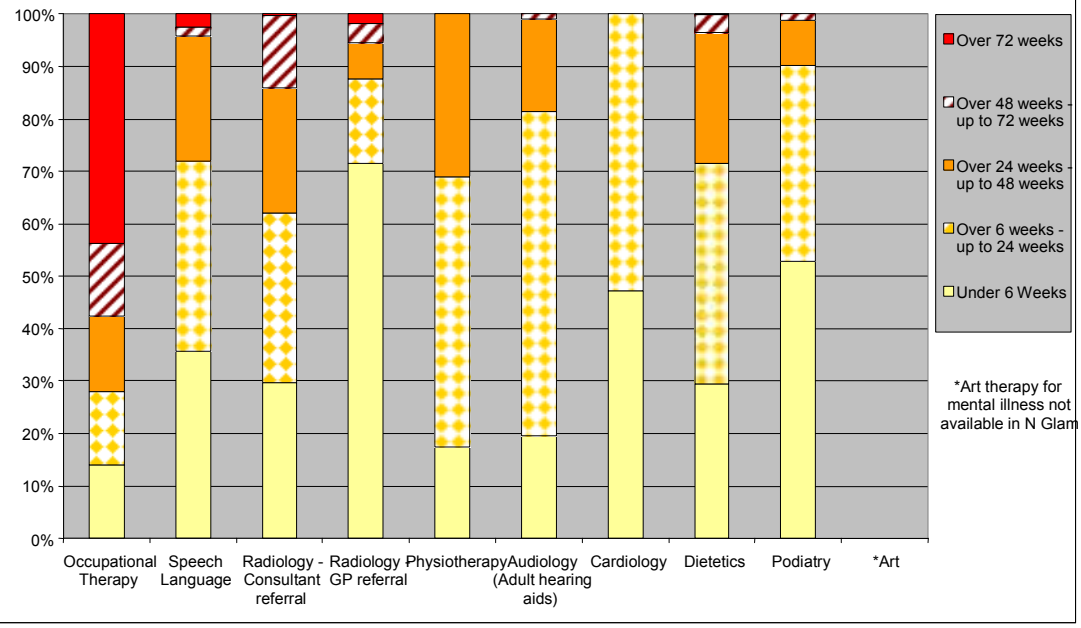
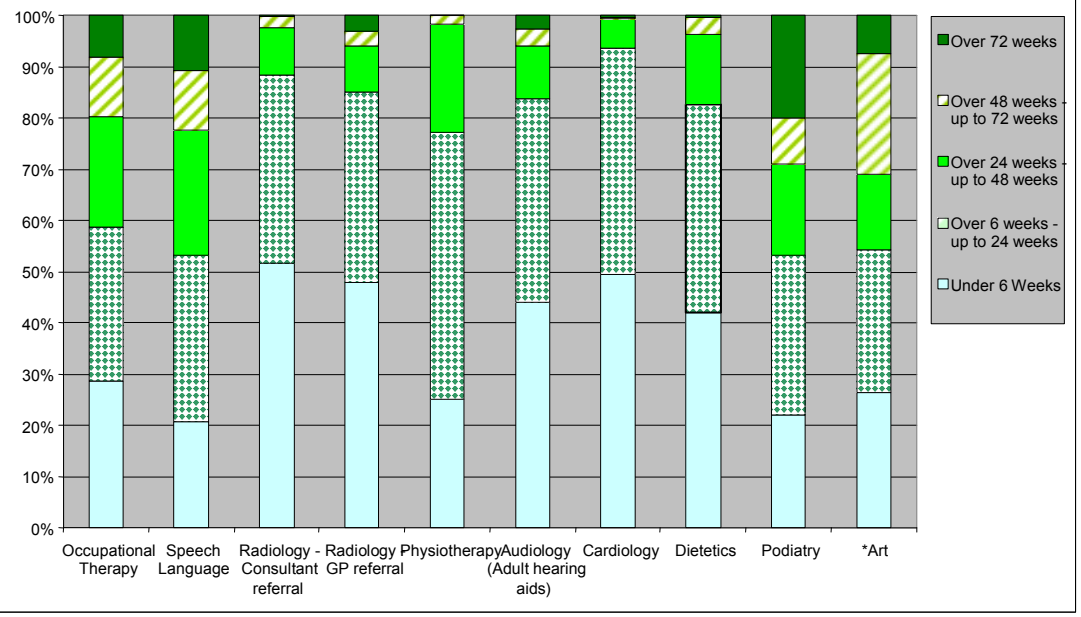


Figure 8.10b: Diagnostic and Therapy Services Waiting Times for all referrals Wales 2005

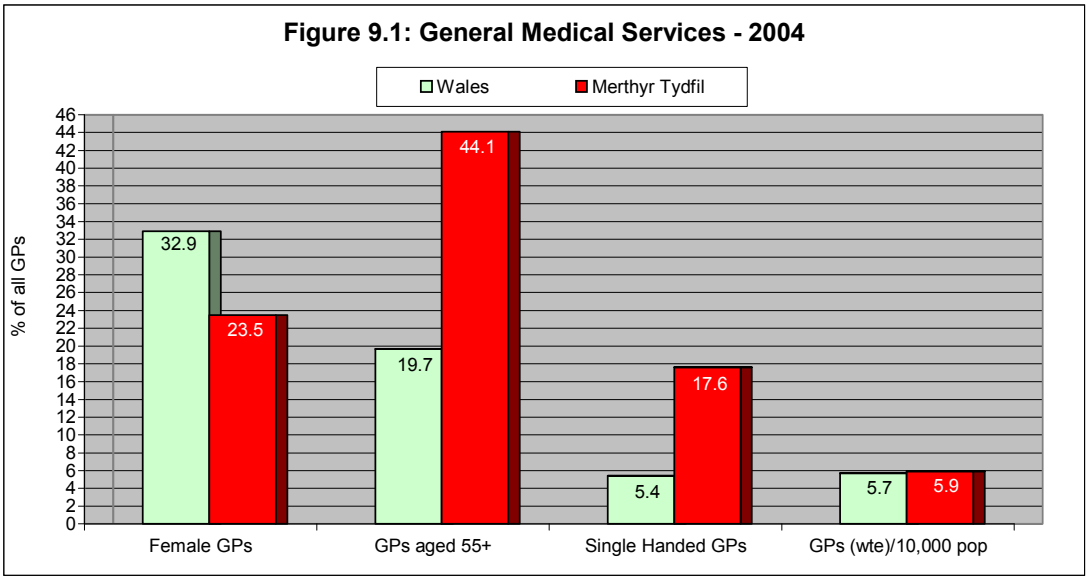


9. COMMUNITY CONTEXT

North Glamorgan NHS Trust serves the residents of Merthyr Tydfil and some surrounding valley communities. There are four hospitals within the Trust – Aberdare, Mountain Ash, St Tydfil's and Prince Charles, which is the district general hospital and has a capacity of over 400 beds and 24,000 deaths and discharges every year.

In relation to primary care, the number of GP (whole-time equivalents) per 10,000 population is similar to Wales – 5.9/10,000 population in Merthyr and 5.7/10,000 population in Wales. However, as Figure 9.1 demonstrates, there are some differentials which are worthy of note.

Figure 9.1: General Medical Services - 2004



The relative lack of female GPs, the proportion of GPs aged 55 and over and the percentage of single-handed GPs highlight some of the problems facing primary care services in Merthyr Tydfil and need to be factored into the design considerations for interventions and programmes during subsequent phases of the WiW initiative.

In terms of community care facilities there are 9 residential and other homes provided by the Local Authority and 9 provided by other agencies, while in terms of leisure facilities there are 10 leisure and community centres, 3 swimming pools, a Sports Development Centre and a Climbing Centre.

10. CONCLUSIONS and RECOMMENDATIONS

This report has clearly demonstrated that there are a wide range of serious problems in Merthyr in terms of unemployment, low income, poverty in children and adults, poor health status, and a high incidence of risk factors for poor health including smoking, alcohol consumption and poor diet. Remedies for these problems requires not only a major investment and cultural change in the region, which probably necessitate a long-term perspective, but also a focussed stepped strategy for implementing change

Tackling social deprivation is recognised as a high priority by government, and a high level of deprivation has certainly been identified in the Merthyr Tydfil area. In the short to medium term, we might adopt an individual-centred approach, focusing particularly on those individuals in the most deprived situations. This would have the additional benefit of contributing to the more gradual overall improvement of the region in terms of reducing deprivation and improving health. There are serious consequences of the deprivation in this region, including child poverty and reduced life-expectancy, and concerted efforts need to be made to tackle these problems.

First and foremost, social deprivation is a consequence of unemployment, and is manifest is the health inequalities we have documented. Although we anticipate that we will establish a number of aspects of the health-work interface common throughout the region, in adopting a local community perspective we also expect to find specific local factors which might serve as targets for intervention.. We expect to find cultural beliefs and attitudes in communities with high levels of deprivation and economic inactivity that contribute to lack of perceived ability or motivation to work. However, in the light of this report, we believe it is essential that sufficient weight is given to the real practical barriers to work at a community level, particularly the demonstrable poor health status in comparison with the rest of Wales and the U.K. Interventions that focus on health at work in this community without taking into consideration its socio-economic context are unlikely to succeed.

The impact of work on health needs to be investigated further in terms of the financial, social, and psychological benefits of work in itself. The harmful effects of worklessness have been well documented, but the evidence for a beneficial effect of work on health has not been well established. Work can vary widely in its nature and quality, and situations where work is particularly beneficial, or indeed harmful to well-being, need to be identified in Merthyr. The WAG/NHS strategic plans indicate that the home will become a setting for health improvement, and the potential for

this to be extended to the workplace should be explored, particularly in our changing society where increasing numbers of people are working & working longer hours, which can make access to healthcare services and engagement in health improvement activities outside the workplace difficult. There is an opportunity to improve the quality of working life in terms both of health and well-being with commensurate beneficial effects both for the individual and the society (in terms of health and productivity). Workplaces need to become healthier not just in terms of avoiding injury and illness and improving rehabilitation (as emphasised by HSE), but also in terms of promoting good health in practical, cost-effective, sustainable ways. We have an opportunity to investigate the potential for organisational changes designed to achieve such goals and believe that designing and evaluating interventions (both on an individual and an organisational level) should be given a high priority.

On a more positive note, there have been improvements in some of the key variables in this region that are encouraging in terms of the future well-being of the community (e.g. less unemployment, greater income etc). The programme of research, to be developed by WiW, will contribute to this improvement of the health and prosperity of people in this region, with the promulgation of appropriate work with its potential benefits for prosperity, health and well-being of the individual and their community, as a pivotal part of this strategy. While many have referred to the need for a 'joined-up' approach to improving the socio-economic conditions in Merthyr, and elsewhere, there is limited evidence that anything significant is being done to translate the words of intent contained in many strategic and policy documents into real action with meaningful outputs and deliverable outcomes.

Having conducted this comprehensive survey into the socio-demographic, health and occupational status of the Merthyr Tydfil community we are left with a picture of Merthyr and its environs as an archipelago of islands. We accept that we also in this report have had for some purposes to elicit data at a "micro" level and in a sense focus on specific issues in a somewhat "compartmentalised" manner. While we believe that this process has been illuminating, this group of islands can never begin to be viewed as a community unless they are linked by bridges and communication networks. The major challenges are widespread across the community and many of them seem to have a common set of origins for which there may be common remedies.

Similarly, in the context of policy initiatives, we need to clarify what it actually meant by "joined up approaches" and how they can be taken

forward to secure improvements for the community in the short-term and from a longer-term perspective.

Having conducted this analysis, it is our firm view that a person's health at work cannot be considered in isolation. In our view the adoption of a bio-psychosocial model is essential in understanding the complex and dynamic relationship between health and work, looking at the individual within the context of their place, status and role in the community and place of work. We believe that the WiW group, with its configuration of key local partners and its academic steering group offers a unique opportunity to operationalise these new initiatives. In subsequent phases of our initiative we hope to take this vision forwards, in a series of sharply focused evaluations and interventions integrated into the bigger picture.

APPENDIX: References

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