City of York Council

Strategy for the Development of Services to Support People with a Physical and/or Sensory Impairment

1st draft April 08

Chapter 1

EXECUTIVE SUMMARY

This will be the first strategy to take a long term view of the services that people with physical and/or sensory impairment will need in York. This document begins to identify the priorities to deliver the vision of services that people with physical and/or sensory impairment want.

There is a growing emphasis on the strategic commissioning role of both local government and health agencies. Changing services takes time: time to plan; to identify investment opportunities and funding; and time to develop new models and pathways. If we can identify now the changes needed over the next 10-15 years, we can give clearer messages to providers so enable them to take up the challenge, we can plan the best way to change and invest in our resources. And we can work with people with physical and/or sensory impairment so that they can continue to shape the services for the future.

Prevalence studies show that the increase in the number of people with physical and sensory amongst adults aged 18-64 over the next 20 years will not be significant, though this may be affected by social life-style changes, for example, higher levels of alcohol consumption and an increase in obesity, that lead to more people being affected by long term conditions.

Alongside this, the number of children surviving with complex conditions are rising, but there is limited detailed national and local data available about children specifically with physical and sensory impairments. As more people with learning disability live longer into adulthood, this will have an impact on sensory impairment assessment and support services, as there is increased prevalence of sensory impairment amongst this group. Demographic changes and prevalence studies show a marked increase (approximately 49%) in the number of older aged 65+ with a sensory impairment.

The Independent Living Review was set up in 2006 to help implement the government's aim that all disabled people should have the 'same choice, freedom, dignity and control over lives as non-disabled people'. The Review informed the draft Independent Living Strategy (ILS) issued by the government in March 2008.

Disabled people told the Review that one problem they faced was a lack of understanding of what independent living actually means. To help overcome this, the ILS offers the following definition:

Independent living does not mean doing things for yourself or living on your own. Instead it means:

- *Having choice and control over the assistance and/or equipment needed to go about your daily life*

- *Having equal access to housing, transport and mobility, health, employment and education and training opportunities.*

This is something we need to be sure that we understand to ensure future services are developed to fit in with this definition. We also need to ensure we incorporate the messages from the national Independent Living Strategy consultation into this strategy as they emerge.

This strategy looks at how services need to change and develop to fulfil the aspirations of disabled people.

Making changes at a local level will demand: a culture shift across all sectors - statutory, voluntary, community and commercial - to recognise that it is the way society is currently structured that disables people, and to work towards the eradication of this. It will also demand a willingness to totally rethink and restructure current support services which serve to promote dependence and/or institutionalisation, and replace them with services that promote independence and inclusion.

Chapter 2 identifies who this strategy is for and what it's overall aim is.

Chapter 3 looks at the strategic context, and the national and local policy drivers which will help shape services.

Chapter 4 begins to describe the current and future disabled population.

Chapter 5 begins to review the quality and quantity of current provision and identifies where services need to change.

Chapter 6 begins to identify the gaps and begins to consider what future services might look like, and gives some indication of the initial actions to move in that direction.

Chapter 7 is a suggested format for an action plan which identifies the priority areas for development.

Similarly to the Council's Long Term Commissioning Strategy for Older People the strategy still has some gaps:

- At this stage the strategy is not council wide, nor is it a joint strategy with local health services, though this is an ambition for the future. A Partnership Board framework has been proposed to bring agencies and representatives of people with disabilities together in a formal framework for future planning.

- There are information gaps which will require us to think about what information we need to start and collect and how.

- There is no formalised route for further consultation with customers. This may be rectified through the work being done by other colleagues

in the Council to re-establish the Disabled Person's Forum, which in turn it is hoped will lead to the development of a Centre for Independent Living (CIL) for York.

- The strategy will need to be developed to form commissioning plans for delivery over the more traditional 3-5 year timescales.

- We will need to look at how to influence and support the development of the right services across all sectors.

Other possible headings in this Chapter include:

Key messages from needs analysis
Key messages from service mapping
Changes needed over the next 10-15 years
Plans for delivery

Chapter 2

INTRODUCTION

Vision

Part of the further consultation will be used to confirm the vision underpinning the strategy.

Two possibilities are:

More specifically for people with a disability:

'People with physical and sensory impairments should have full opportunities and choices to improve their quality of life and will be respected and included as equal members of society.'
(Improving the Life Chances of Disabled People 2005)

More generically to include vulnerable people at risk of loosing their independence:
" a society where all citizens are respected and included as equal members, and where everyone has the opportunity to fulfil their potential"
(Consultation on The Independent Living Strategy 2008)

Whose strategy is this?

This is the first strategy for People with Physical and Sensory Impairments requiring social care services to be commissioned, funded or provided by the City of York Council.

Physical and sensory impairments include:

- People with physical impairments, whether the condition is congenital, acquired or progressive
- Deaf people and people with a hearing impairment
- Blind people and people with a visual impairment
- People with serious ill-health and/or long term conditions
- People with HIV/AIDS

Improving the Life Chances of Disabled People 2005 recognises that disability is subject to a number of different definitions. It offers the following definitions and concepts to help.

Disability is defined as the disadvantage experienced by an individual as a result of barriers (attitudinal, physical, etc) that impact on people with impairments and/or ill health.

Disability is distinct from both:

Impairment, a long-term characteristic of an individual which affects their functioning and/or appearance and may give rise to pain, fatigue, communication difficulties, etc; and

Ill health, the short-term or long term effect of disease or sickness.

Many people who have an impairment or ill health would not consider themselves to be disabled.

Alternative terminology speaks of “long-term conditions” or “chronic disease”, both of which focus primarily on permanent ill health.

What does this strategy aim to cover?

The strategy sets out the issues and priorities for Adult Social Services to enable the delivery of customer sensitive support and services to people with physical and sensory impairments over the next 10 years.

The strategy will help us plan to meet needs and promote access to the full range of services that many people take for granted.

We have developed the strategy in consultation with customers of services, potential customers and service providers across the statutory, voluntary and private sectors. However, this strategy is at present primarily a City of York Council, Adult Social Services document.

We involved these stakeholders in the work to gather information about needs and about current services.

We undertook analysis of this information, and information from the Census, from our own management information systems, and the Primary Care Trust’s information systems. This information has been used to develop an action plan. We will be returning to our stakeholders to share and explain the action plan so that it can be agreed.

The strategy considers services that will be provided as a result of a social care assessment of need and also services that people with physical and sensory impairments may want to purchase or organise themselves. The Council’s primary concern is to ensure that funded services are targeted at the people who most need them, and that they are providing quality outcomes at the right price.

To do this we need to make sure that the statutory, voluntary and private sectors are providing services that people want and need, from preventative services through to services that are meeting complex care needs.

Most of the data used in the strategy relates to people age 18 to 65 years. This strategy does not look specifically at older people, people with a learning disability or people with mental health problems. We recognise that these customer groups will access services that people with physical and sensory

impairments use, and so any equality impact assessments for services will need to consider issues relating to these groups.

Specific services for older people will be considered through the Long Term Commissioning Strategy for Older People, and specific services for people with a learning disability will be considered through a Commissioning Strategy for Learning Disabilities. The Mental Health Services are commissioned through a joint mental health strategy and delivered through the integrated services, managed by the Primary Care Trust.

Our objective is to provide services that are not age restricted, but based on need.

The strategy provides a framework for the Council in the development of services, both as a provider of services, as a purchaser of services and in an enabling and influencing role within the local community.

It will provide a statement of intent, and it will lead to the development of delivery plans for the short to medium term, as well as the longer term vision over the next 10 to 15 years.

The strategy is intended to be an open statement for customers and providers of service to understand our intentions and our ambitions. It will provide a focus for future reviews to enable us to track progress and allow us to review our assumptions. The development of the strategy will allow customers to see where they may wish to influence and contribute to future service developments, and it will offer providers a steer for developing new services.

Chapter 3

NATIONAL AND LOCAL POLICIES AND DRIVERS

Brief picture of services for People with Physical and Sensory Impairments

Social care services for people with physical and sensory impairments are provided through the City of York Council's Housing and Adult Social Care Directorate. They are managed through the Adult Services Division, although some people with physical and sensory impairments will be supported by the Learning Disability Service if their primary needs are concerned with their learning disability, Mental Health Services if their primary needs are concerned with their mental health, and Older People Services if their primary needs are concerned with ageing.

Both the assessment teams and the in house service providers are organised on a locality basis, with some city wide services.

At present services working with people with physical and sensory impairment which are managed jointly with health services are the Occupational Therapy (OT) and the Community Equipment Loan Service (CELS).

During 2006/07 840 people with physical and sensory impairment age 18 to 64 years received community based services (compared with 4,000 over 65 years), and 47 people with physical and sensory impairment age 18 to 64 years were supported in residential or nursing home care (compared with 777 over 65 years). Will update this with 2007/08 data when available.

Just over £3.5m was the net cost spent on care services for people with physical and sensory impairments age 18 to 64 years by the Council in 2006/07 (compared with £21m spent on people over 65 years). With approximately £1m spent on nursing and residential care placements, supported and other accommodation, £1m spent on home care and day care, £362,000 spent on direct payments and £158,000 spent on equipment and adaptations. The remaining £1m was spent on other services, including assessment and care management and meals. Will update this with 2007/08 data when available.

Independent sector providers of physical and sensory impairment services in York range from big national private sector groups, through small businesses to charitable and voluntary organisations. Providers come together in a number of forums to enable partnership working.

Primary health care is provided through 47 GP surgeries and community services managed by the local Primary Care Trust (North Yorkshire and York Primary Care Trust). Acute care is provided primarily through York District Hospital, which has Foundation Trust status.

City of York Council retains control of the public housing stock in all but the North East of the City. In this area the old Ryedale District Council stock was transferred before the creation of the Unitary Authority in York, to Ryedale Housing Association.

In 2006 the Council invited people with a disability to come together as a group to influence Council decisions and to make its services more accessible and appropriate for disabled people. Unfortunately the Disabled Persons Forum has not been able to fulfil its potential as there has been some difficulties with establishing the forum. An event which took place on 28.03.08 has started the process of re-establishing the forum so that disabled people can have more of an opportunity to influence Council decisions and service developments.

National and local policy context

National policy

There is a wide range of government policy, guidance and legislation relevant to this strategy. Key recent legislation and guidance is outlined below.

'Improving the Life Chances of Disabled People' crosses Government Departments and is a long term disability strategy until 2025. Within this policy, the government has identified four key goals as the most important determinants of disabled people's life chances:

- To empower citizen's with choice and control over how additional needs are met
- To support families with young disabled children
- To ensure smooth transitions into all aspects of adulthood
- To improve employability

In each of these areas the vision is based on:

- Removing barriers to inclusion
- Meeting individual needs, and
- Empowering people

'Improving the Life Chances of Disabled People' promotes the development of 'individualised budgets'. Pilot work on this has taken place nationally, primarily within learning disability services, through "In Control", a collaborative venture between statutory services, central government and the voluntary sector (www.in-control.org.uk).

Individualised budgets are more than the current system of direct payments. The intention is that in time different sources of funding will be included in an individual's budget, for example, Independent Living Fund, Supporting People monies, Disabled Facilities Grant, Access to Work etc.

'Improving the Life Chances of Disabled People' also includes a requirement for local authorities to establish user-led Centres for Independent Living by 2010. A Centre for Independent Living (CIL) is an organisation which provides innovative services which allow disabled people to gain choice and control over every aspect of their lives. The key feature is that they are run and controlled by disabled people.

The exact nature of the services provided by a CIL will vary according to local circumstances, as will their relationship with statutory agencies. 'Improving the Life Chances of Disabled People' expects that each CIL will provide services to all disabled people regardless of the nature of their impairment, and to all ages. It goes on to say that services such as information and advice, advocacy and peer support, assistance with self assessment, support in using individual budgets, support to recruit and employ personal assistants, disability equality training, and consumer audits of local services should be provided.

The '**National Service Framework for Long Term Conditions** has a particular focus on people with neurological conditions and brain and spinal injury, but many of the quality requirements have relevance to a wide range of long term conditions and impairments.

It identifies quality requirements which must be achieved by 2015:

- A person centred service
- Early and specialist rehabilitation
- Community rehabilitation and support
- Vocational rehabilitation
- The provision of equipment and accommodation
- Palliative care
- Supporting family and carers

The **White Paper, Our health, our care, our say** has four overarching aims:

- Better prevention services with earlier intervention
- More choice
- Tackling of health inequalities and improved access to community provision
- More support for people with long term needs

Structural changes are also announced, with increased emphasis on support in the community, which will affect the way services are commissioned and aligned. The Local Area Agreement becomes one of the key mechanisms for joint planning and delivery.

Objectives within the White Paper that have direct relevance to people with physical and sensory impairments include:

- Range of initiatives to support GP's to help patients remain in or return to work (Ch 2)
- Expectation that direct payments will expand, plus individualised budgets to be introduced (Ch 4)
- Acceleration of self-directed care and increased investment in Expert Patient programme (Ch 4 and 5)
- Development of outreach services to tackle conditions early and prevent hospitalisation (Ch 4)
- Central government to encourage health and housing to work together to prevent housing issues exacerbating health problems (Ch 4)
- End of life care networks, bringing together primary care, social care, palliative care and hospital based care (Ch 4)
- Support for people with longer term needs, services to be seamless, proactive, with greater focus on early intervention and prevention (Ch 5)
- Information prescriptions to be routine by 2008 (Ch 5)
- All Primary Care Trusts and Local authorities to have established joint health and social care managed networks or teams to support integrated care for people with most complex conditions (Ch 5)
- Mobilise use of assistive technology, including monitoring of health status at home to prevent admission (Ch 5)
- Increase numbers of people supported to live at home (Ch 6)
- Improvement of home adaptations service (Ch 6)
- Strengthening of mechanisms for public engagement (Ch 7)

The national **Equalities** policy agenda had direct pertinence to the development work that will result from this strategy, including the Disability Discrimination Act and the Equality Standard for Local Government.

The Disability Discrimination Act 2005 introduced a general duty which applies to all public authorities. The basic requirement for a public authority when carrying out their functions is to have due regard to the following:

- Promote equality of opportunity between disabled people and other people

- Eliminate discrimination that is unlawful under the Disability Discrimination Act

- Eliminate harassment of disabled people that is related to their disability

- Promote positive attitudes towards disabled people

- Encourage participation by disabled people in public life

- Take steps to meet disabled people's needs, even if this requires more favourable treatment

Most public authorities also have a set of specific duties to comply with, which will help them to met their overall general duty. The Disability Rights Commission Statutory Codes set out the specific duties in detail, and they centre on the framework of the production of a Disability Equality Scheme.

The equality legislation not only requires a wide range of services to tackle disability issues, but also requires that disabled people's individual needs are considered on the basis of their gender, ethnicity, religion, sexual orientation, etc. These principles are also a key theme of 'Improving the Life Chances of Disabled People' and the White Paper, 'Our health, our care, our say'.

The **National Carers Strategy, Caring for Carers 1999**, has three main strands to it:

Information for carers, so that they become real partners in the provision of care to the person they are looking after, with wider and better sources of information about the help and services which are available to them.

Support for carers, from the communities in which they live, in the planning and provision of the services that they and the person they are caring for use, and in the development of policies in the workplace which will help them to combine employment with caring.

Care for carers, so that they can make real choices about the way they run their lives, so that they can maintain their health, exercise independence, and so that their role can be recognised by policy makers and the statutory services.

The National Carers Strategy is currently being updated.

Central Government continues to strengthen policy, guidance and legislation for people with disabilties, recent additions include **Putting People First**, a shared vision and commitment to the transformation of adult social care, and the recently published five-year **Independent Living Strategy** which is jointly

owned by six government departments and sews together over 50 government commitments into a co-ordinated approach that seeks to realise equality for disabled people.

Local policy

The strategy for people with physical and sensory impairment fits within a range of other strategies.

Local Strategic Partnership

The Local Strategic Partnership for York set out its vision for the city in its Community Strategy (2004-2024). It includes the Healthy City objective, for York to be "a city where residents enjoy long, healthy, independent lives through the promotion of healthy living and with easy access to responsive health and social care services."

The Local Area Agreement (LAA) is effectively the delivery plan for this vision during 2007-2010. The Healthier Communities and Older People Block notes a number of priorities and challenges over the next three years:

- reduce inequalities in health and the determinants of health;
- reduce the incidence/impact of Coronary Heart Disease, respiratory disease and cancer;
- reduce the number of people who smoke;
- improve the overall physical activity level within the city;
- reduce levels of obesity;
- reduce levels of binge drinking;
- improve community mental health;
- help more people to live independently in their own home;
- reduce the number of falls suffered by older people; and
- increase the number of carers who are supported by statutory and voluntary agencies.

City of York Housing Strategy

The Council's Housing Strategy 2006-2009 aims "to enable everyone to have a decent home at a price they can afford within a safe, inclusive and thriving community." Safe, secure, well maintained and affordable housing is a basic

need. Good housing promotes, amongst other things, health and well-being. In contrast, poor housing is directly linked to ill health.

Long-term Commissioning Strategy for older people

Housing and Adult Social Services Long Term Commissioning Strategy for Older People 2006-2021 will help the council to plan to meet the challenges of an ageing population and show how care and support services need to develop to meet the changing needs and aspirations of older people over the next 10-15 years.

It contains data about the ageing population which can and should be used to inform and influence policy and planning work for younger adults with a physical and sensory impairment, particularly where the focus is on better prevention services with earlier intervention. Some of the relevant data is detailed below.

It recognises that the older someone is the more likely they are to experience one or more sensory impairment. In York in 2003 only 270 people over 65 were registered blind (210 in 2006) and 395 registered partially sighted (420 in 2006). We would expect however that there could be around 5000 older people in York experiencing sight loss in relation to macular degeneration alone. In 2007 national statistics reported that 105 people over 65 were registered deaf and 780 registered hard of hearing.

The Long Term Commissioning Strategy also highlights a range of general population data about older people's health and well-being related to long term health conditions:

- most older people die from cancer or circulatory system problems, eg, heart attack, stroke, however cancer diminishes as a cause towards older old age to be replaced by respiratory problems.

- A third of older people report difficulties with hearing as compared to 28% reporting difficulties with their sight.

- Just under a third of all women and men aged between 55 and 74 are clinically obese.

- Two-thirds of the population aged over 65 have foot problems of which a quarter of the population over 65 have problems that need professional foot care although they do not receive it.

Need to consider any issues from the LD strategy related to PSI data.

Chapter 4

REVIEW OF NEED AND DEMAND

This chapter begins to explore the potential needs of the population.

It would be fair to say that we have experienced some difficulties in getting hold of clear, concise and up-to-date information about the local disabled population. It's not so much that information doesn't exist, rather it isn't brought together centrally in a widely accessible format. Improving the systems and processes for collecting local information to enable more effective planning and service development is an area that this strategy is well placed to influence.

The population analysis below uses national census data, local information, prevalence and projection data to identify current and future populations and related needs. When looking at the data it is important to note the following:

- Some surveys are based on, or include, health status, for example the Census. Disability and ill health should not be combined, for example, someone who has one leg is not 'ill', they have a physical impairment

- Some surveys do not distinguish between different types of impairment, and provide generic figures about 'disability', including learning disability, long term conditions, physical and sensory impairments, and people with mental health problems

- Many older people experience increasing frailty and a reduction in hearing and sight due to the ageing process, but many would not define themselves as having a physical or sensory impairment

- People of all ages may not apply the terms 'disabled' or 'physical or sensory impairment' to themselves, because these terms are still associated with stigma

- Surveys use different definitions of 'disability' and different questions, which can prompt widely differing responses.

National prevalence of physical and sensory impairment

Long term limiting illness and disability

In the 2001 Census, one in six people in the UK (10.3 million) living in a private household reported having a limiting long-term illness or disability (this figure includes all impairments, not just physical and sensory impairment).

There was a steady increase by age for both males and females. Below age 30, rates were less than 10 per cent but were more than twice this for those aged 45 to 59. Rates virtually doubled again at ages 60 to 74, reaching 41 per cent for men and 38 per cent for women.

The most commonly reported impairments for both men and women are problems of the back or neck, the heart or circulation, legs or feet or breathing problems.

Long term conditions

Taken together, neurological conditions are common, for example, 8 million people in the UK experience migraine.

According to 'Improving the Life Chances of Disabled People' (Prime Minister's Strategy Unit 2004), altogether, approximately 10 million people across the UK have a neurological condition. These account for 20% of acute hospital admissions and are the third most common reason for seeing a GP.

An estimated 350,000 people across the UK need help with daily living because of a neurological condition.

Sensory impairment

Visual impairment

The Royal National Institute of Blind People (RNIB) report that about two million people in the UK self-define as having a sight problem or seeing difficulty.

The majority (85%) of people with sight problems are aged over 65. The older you are the more likely you are to have a sight problem. Most people with sight problems have started to lose their sight in later life. Numbers are set to double over the next 25 years, due in part to the growing ageing population, but also to an increase in underlying causes such as diabetes.

For the working age population, their best estimate is that there are in the region of 275,000 people aged between 16 and 65 with significant sight loss.

For children, there are in the region of 25,000 children with sight problems which are disruptive to lifestyle, and about 12,000 of these children also have other disabilities.

It is not possible to establish an absolutely precise estimate for the total number of people with sight problems in the UK. The RNIB estimate that there might be up to an additional 20% that should be registered but are not (up to an additional 74,000). Assuming that they exist, nothing is known about the age profile of the group, the nature of their sight loss or the reason that they are not registered.

In 2006, The Information Centre, part of the Government Statistical Service, reported on the number of people Registered Blind and Partially Sighted. They reported that 64% of blind registrations and 70% of partially sighted registrations had an additional physical disability nationally. Also, that 24% of blind registrations and 22% of partially sighted registrations had an additional

hearing disability nationally. The distribution by age of those with additional disabilities applies in the main (74% of blind registrations and 80% of partially sighted registrations) to people who were 65 or over.

Hearing impairment

The Royal National Institute for Deaf People (RNID) estimate there to be about 9 million deaf and hard of hearing people in the UK. About 688,000 of these are severely or profoundly deaf (approx 7% of deaf people).

41.7% of all over 50 year olds will have some kind of hearing loss. This increases to 71.1% of over 70 year olds.

Each year, 840 babies are born in the UK with significant deafness. One in 1,000 children are deaf at 3 years old. 20,000 children aged 0 to 15 years are moderately to profoundly deaf, and 12,000 children aged 0 to 15 were born deaf.

There are an estimated 50,000 British Sign Language users in the UK. The ratio of fully qualified interpreters to sign language users is 1 to 275. There are 2 million people with hearing aids, of which 1.4 million people use them regularly. There are 921 hearing dogs that have been trained by Hearing Dogs for Deaf People.

There are 23,000 adults with tinnitus to a degree that has a severe affect on their ability to lead a normal life.

Deafblindness

Deafblind people have a combined sight and hearing loss, which leads to difficulties in communicating, mobility and accessing information. Deafblind people are sometimes called dual sensory impaired people.

Deafblindness can be due to several causes, such as Ushers Syndrome, Rubella (German measles) and problems caused by premature births.

Deafblind UK report that there are about 24,000 people in the UK who are deafblind; some are totally deaf and totally blind, other deafblind people have some hearing and vision. These figures do not take into account the large number of older people who are losing both their sight and hearing. So the number of people with a combined sight and hearing loss could well be as high as 250,000.

Equality dimensions

Age

For most impairments, the number of people in the UK who reported a limiting long standing illness or disability increases with age (General Household Survey 2002).

Gender

For disabled adults of working age, the pattern of impairment is broadly similar across gender. However, hearing impairment is more common amongst men of all ages (General Household Survey 2002).

There will be a higher number of older women affected by long term conditions, sensory impairments, and illnesses that may result in physical impairments, due to the fact that women live longer than men.

Ethnicity

Differences in age structure account for much of the variation in prevalence across ethnic groups, as in the UK Black and Minority Ethnic (BME) groups tend to have a younger population. However, even after allowing for this age effect, people of Indian, Pakistani, Bangladeshi and Chinese origin remain less likely to report that they are disabled. These lower rates may be influenced by cultural differences in self-reporting across ethnic groups.

Despite the lower levels of reported long term illness, disability or health condition, disabled people of BME origin are more likely to experience disadvantage. There is evidence to show that families from BME groups with disabled children have a lower take-up of services, and often feel less informed or able to access the system (Nazroo, James Y. (2002) 'Ethnicity, Class and Health', Policy Studies Institute).

A higher proportion of the BME population also live in deprived areas and poor housing, and fall into disadvantaged groups where a higher incidence of impairment would be expected.

Some conditions are more prevalent amongst certain racial groups, for example, sickle-cell anaemia mainly affects people of Black African or Caribbean decent, Cystic Fibrosis mainly affects white Europeans.

Trends in disability prevalence

The Department of Health undertook a comparison of the Health Survey for England, between 1995 and 2001 (Trends in Disability Prevalence Amongst Adults). This showed that changes in disability prevalence were small, and not statistically significant for any of the age and sex groups. The same study examined other prevalence studies, but found it difficult to make any historical comparisons because of the range of issues with data highlighted earlier.

'Improving the Life Chances of Disabled People' states that over the last 30 years there has been an increase in the number of people reporting disability, and that since 1975, the number of adult reporting has increased by 22% from 8.7 million to 10.7 million people. However, this in large part relates to reported increases in mental illness and behavioural disorders.

Amongst children, the increase is even larger, at 65%, from 476,000 disabled children under the age of 16 in 1975, to 772,000 in 2002. Possible

explanations include children with complex conditions surviving longer, and improved diagnosis/reporting.

A range of social life-style trends may lead to increased incidence of long-term conditions (for example, rising levels of obesity amongst the population)

Evidence demonstrates that there is an increase in prevalence of hearing and visual impairment amongst people with a learning disability (Kiani 2005). As more people with a learning disability live longer into adulthood, this will have an impact on sensory impairment assessment and support services.

Local prevalence of physical and sensory impairment

The 2001 census asked people about general health and limiting long term illness.

The census information shows that 30,064 (16.6%) people in York consider they have a health problem or long-term illness. This is lower than the national average (18.2%).

A further 14,487 (8.0%) people describe their general health as 'not good'. Again this is lower than the national average (9.2%).

However, it must be remembered that this information is not specific to physical and sensory impairment.

Demographic profile

The census information for York is broken down by Ward:

Ward	**All people**	**With limiting long-term illness (LLTI)**	**% with LLTI**
Acomb	7729	1321	17.09%
Bishopthorpe	3802	658	17.31%
Clifton	12017	2081	17.32%
Derwent	3540	612	17.29%
Dringhouses and Woodthorpe	10733	1791	16.69%
Fishergate	7921	1289	16.27%
Fulford	2595	507	19.54%
Guildhall	6676	1276	19.11%

Haxby and Wiggington	12468	2113	16.95%
Heslington	4122	302	7.33%
Heworth	11743	2126	18.10%
Heworth Without	3786	697	18.41%
Holgate	11564	1866	16.14%
Hull Road	8269	1277	15.44%
Huntington and New Earswick	12089	2425	20.06%
Micklegate	10994	1797	16.35%
Osbaldwick	3149	598	18.99%
Rural West York	10286	1390	13.51%
Skelton, Rawcliffe and Clifton	12160	1574	12.94%
Strensall	7862	1168	14.86%
Westfield	13690	2665	19.47%
Wheldrake	3899	531	13.62%
Total - York	**181094**	**30064**	**16.60%**

What this shows is that 6 Wards: Fulford; Guildhall; Heworth Without; Huntington and New Earswick; Osbaldwick; and Westfield have above the national average number of people who consider they have a health problem or long-term illness.

It also highlights Heslington as the Ward with the least number of people who consider they have a health problem or long-term illness.

Number of people registered Blind and Partially Sighted

In 2006, The Information Centre, part of the Government Statistical Service, identified the **Number of Blind people registered with City of York Council by age group:**

Age	0 to 4	less than 6	
	5 to 17	less than 6	
	18 to 49	30*	
	50 - 64	20*	
	65 to 74	50*	
	75 or over	180*	Total 260*

They also identified the **Number of Partially Sighted people registered with City of York Council by age group:**

Age	0 to 4	0	
	5 to 17	10*	
	18 to 49	50*	
	50 to 64	35*	
	65 to 74	35*	
	75 or over	385*	Total 510*

*numbers rounded to the nearest 5

The Information Centre statistics also show:

Since 2003 there have been 25 new blind registrations in York, all of whom were 75 or over. There were 55 new partially sighted registrations, 40 of whom were 75 or over. The remaining 15 registrations were distributed between people aged 5 to 74 years.

In total, 90 people who are registered Blind have an additional disability. 65 people have a physical disability and 15 people are hard of hearing. The remaining 10 people have either a mental health problem or a learning disability. 75 of the people who are registered Blind who have additional disabilities are 65 or over. The remaining 15 are aged 0 to 64.

In total, 145 people who are registered Partially Sighted have an additional disability. 115 people have a physical disability and 20 are hard of hearing. The remaining 5 people have a mental health problem. 135 of the people who are registered Partially sighted who have additional disabilities are 65 or over. The remaining 10 are aged 5 to 64 years.

Number of people registered Deaf or Hard of Hearing

In 2007, the Department of Health identified the **Number of Deaf people registered with City of York Council by age group:**

Age	**All Ages**	**240***
	0 to 17	**10**
	18 to 64	**130**
	65 to 74	**30**
	75 or over	**75**

They also identified the **Number of Hard of Hearing people registered with City of York Council by age group:**

Age	**All Ages**	**895***
	0 to 17	**Less than 5**
	18 to 64	**115**
	65 to 74	**130**
	75 or over	**650**

*includes some cases where the age was not known.

The statistics show that since 2004 there has been a decrease in both the number of people registered deaf, and hard of hearing. The greatest decrease being those people registered as hard hearing age 65 or over.

Number of people with physical and sensory impairment known to HASS

The table below illustrates the **number of completed assessments** for people 18 – 65 years over the past five years by primary client group.

Will update this with 2007/08 data when available.

	2002/03	**2003/04**	**2004/05**	**2005/06**	**2006/07**
Physical disability, frailty and/or temporary	615	347	302	296	336

illness					
Hearing impairment	16	9	4	2	14
Visual impairment	15	8	14	17	14
Dual sensory loss	1	0	0	0	0

The table below illustrates the number of clients 18 – 65 years **receiving services** over the past five years by primary client group. Services include community based services, residential and nursing care.

Will update this with 2007/08 data when available.

	2002/03	**2003/04**	**2004/05**	**2005/06**	**2006/07**
Physical disability, frailty and/or temporary illness	657	698	758	817	787
Hearing impairment	31	31	43	18	22
Visual impairment	34	39	42	46	38
Dual sensory loss	1	0	1	1	0

What this shows, is that HASS works with a very small number of people with physical and sensory impairments when compared with the 2001 Census data, which identified 30,064 people in York who consider themselves to have a health problem or long term illness.

National prevalence of disabled children

In the same way that it is appropriate to consider older people and their health and well-being needs in relation to this strategy, we need to consider what we know about children and young people.

There are some problems in identifying children with physical and sensory impairment:

- Children with physical and sensory impairments may not be known to Children's Services and then present to Adult Services when they become adults.

- There is a tendency to rely on statementing as a vehicle for identifying disabled children; children with physical and sensory impairments will not go through this route if they do not have particular learning needs.

The Office for National Statistics reported in 2001 that 114 per 10,000 live births had congenital abnormalities. Higher notification rates were noted for mothers under 20 and over 40 years, for babies born weighing less than 2,000g, and were more common in twins than in singletons.

In 2000, slightly more boys (19%) than girls (17%) aged under 20 years reported having a mild disability. Rates of severe disability were consistently higher for boys than girls; in 2000, 11 per 10,000 males and 5 per 10,000 female under 17 years.

The distribution of children and adolescents with a mild disability is higher for families from a semi skilled and unskilled manual background. The highest prevalence of severe disability is among semi skilled manual backgrounds.

The most common condition reported by under 20 year olds with a longstanding illness or disability was asthma, with 42% of total impairments in 2000.

In 1999 and 2000 the predominant disability conditions among severely disabled children and adolescents were autistic spectrum disorders and behavioural disorders.

In 2000 women born in West Africa and the Caribbean had the highest percentages of babies weighing under 1,500g.

There were no consistent sex or class differences in acute illness or in specific aspects of health, but there were differences between minority ethnic groups. Children from Indian, Pakistani, Bangladeshi and Chinese backgrounds were less likely than other ethnic groups or the general population to report acute sickness.

Differences also exist between ethnic groups for overweight and obesity in children. Indian and Pakistani boys were more likely to be overweight than boys in the general population. Afro-Caribbean and Pakistani girls were more likely to be obese than girls in the general population.

Chapter 5

REVIEW OF SERVICES

This chapter begins to explore the demand for and supply of services, analyse gaps in provision and look at how those may be addressed over the next 10-15 years.

Basic information that is available from HASS is that:

- In 2006/07 840 PSI customers 18 to 64 years received community based services …
- In 2006/07 47 PSI customers 18 to 64 years were supported in residential or nursing home care

Further analysis is required to be more precise on which services, which homes, how many customers provided with a service?

Will need to look at activity/contract monitoring information for:

- *YBPPS*
- *Deaf Society*
- *Resource Centre for Deafened People*
- *Supporting People*
- *Independent Living Fund/Direct payments*
- *Any others?*

This is not yet available.

Chapter 6

GAP ANALYSIS AND DESIGN OF FUTURE PROVISION

This chapter starts to identify the strategic priorities and issues with current services that need to be taken into account when shaping future services.

Summary of Issues raised through consultation

This is a summary of some of the issues through consultation at the event on the 9th November 2007 and subsequently through the focus groups. This considers a broad view of services as experienced by people with a disability or impairment.

What was raised as currently working well for those people involve in the consultation were:

Care & Support

- *Single Assessment Process, where this is in place;*
- *A multi professional approach for some long term conditions;*
- *crisis intervention*
- *aids and adaptations supporting people with independence;*
- *specialist social workers in hospital for clinics;*
- *homecare service following hospital discharge;*
- *direct payments – offers more choice and control*
- *the emphasis on keeping people at home*
- *community organisations*

Vocational Support

- *support with interview preparation, CV, Benefits advice and ongoing support*
- *general support, for example, help with form filling*
- *placements and voluntary opportunities*
- *job coaching, good but short term*
- *disabled people are starting to be recognised locally as full employees*

What was raised as currently not working well for those people involve in the consultation were:

Care & Support

- *access to support at an early stage*
- *lack of staff skilled in communicating with deaf and blind people*
- *a lack of focus on healthy lifestyles*
- *lack of preventive services*
- *social well-being – think beyond health*
- *lack of information readily available in a suitable format*
- *equipment like smoke alarms not always available (in sheltered accommodation)*
- *long term sustained support*
- *services open outside office hours for those who work*

- *service users not having sufficient 'self directing' support*
- *signposting to all services*
- *resources being maximised by integration of different services*
- *some age related criteria for services creates artificial barriers*
- *eligibility criteria set too high*
- *individual needs are fitted into a system*
- *insufficient information about Individual Budgets*
- *opening a bank account for direct payments can be difficult*

Vocational Support

- *support within the workplace*
- *access to education/higher education*
- *work place aids and equipment not always good*
- *benefit issues can make it difficult for people getting work*
- *individual aspirations may not be met or recognised*
- *people are sometimes steered towards low paid work*

Participation & Involvement

- *meaningful consultation with action & outcomes*
- *the development of a Centre for Independent Living (CIL)*
- *having to book an interpreter means having to wait*
- *people's attitudes to people with a disability*
- *would like to be able to use facilities used before becoming disabled*
- *Problems with access to facilities physically and at times when everyone else uses them;*
- *Difficulties with access to, the availability and the cost of transport to support access to community facilities.*

The lessons from the consultation broadly cover the need for services to improve on:

- provision of information to enable informed choices to be made
- a broad provision of services to help people remain independent
- self-directed care & support when independence is at risk
- access to a greater variety of community facilities and vocational support
- involvement and participation in both individual and community service design.

Centre For Independent Living

Recommendation 4.3 of Improving the Life Chances of Disabled People 2005 states that each locality should have a user-led organisation modelled on existing Centres for Independent Living (CIL) by 2010.

CILs are grassroots organisations run and controlled by disabled people. Their aims are to assist disabled people take control over their lives and achieve full participation in society. For most CILs their main activity, and source of income, is running support schemes to enable disabled people to

use Direct Payments. Such schemes may involve; advice and information; advocacy and peer support; assistance with recruiting and employing Personal Assistants; a payroll service; a register of PAs; and training of PAs.

In May 2007 DH published design criteria for User Led Organisations (ULO).

City of York Council, through HASS commissioned an independent report into the design of an appropriate CIL for York.

This report has been considered through the Social Inclusion working group along with options for the structure and the development of the CIL.

Given the importance of the centre as a user led facility the council has engaged with the University to support the development of a renewed Disability Forum that could work with the council to develop a CIL.

When available this centre will be crucial to inform and support people with a disability towards the independent lifestyles of their choice.

Chapter 7

ACTION PLAN

This chapter begins to draw together the messages from consultation with the citizens of the City over the last five years, and from our recent consultation sessions with customers of services, potential customers and service providers across the statutory, voluntary and private sectors.

We have organised the issues raised in a table using the seven outcomes from the 'Our health, our care, our say' White Paper:

- Improved health and emotional wellbeing
- Improved quality of life
- Making a positive contribution
- Increased choice and control
- Freedom from discrimination and harassment
- Economic wellbeing
- Maintaining personal dignity and respect

This table is a beginning, it will help us plan and prioritise activity and make links to areas of work already underway.

We recognise that more research is required to support longer term objectives, in particular, we need to know more about our disabled population and analyse the impact of demographic changes, we need to map in more detail the current activity across all sectors, and analyse what is working, what is not working and were the gaps are, and we need to try and understand what impact particular developments may have on the way services are commissioned and delivered, for example the expansion of direct payments and the introduction of individual budgets.

The themes for the action plan are the 7 White Paper Outcomes

The aspiration is taken from the Key Lines of Assessment to Standards of Performance Document CSCI March 2008

What this theme includes is a brief summary of what evidence is required to demonstrate performance/good practice

1. Improved health and emotional wellbeing

The aspiration:
Enjoying good physical and mental health (including protection from abuse and exploitation). Access to appropriate treatment and support in managing long term conditions independently. There are opportunities for physical activity. Partnerships between agencies demonstrably improve reach across the community and accessibility to services, activities.

What this theme includes:

- Disabled access to and support within primary and acute health services
- Long term conditions diagnosis and treatment
- Rehabilitation services
- Health promotion for people with physical and sensory impairments

Need to include any work in progress, from LAA, the messages from consultation and which group/forum might need to note and take the various actions forward.

2. Improved quality of life

The aspiration

Access to leisure, social activities and life long learning and to universal, public and commercial services. Security at home, access to transport and confidence in safety outside the home. Partnerships between agencies demonstrably improve reach across the community and accessibility to services, activities.

What this theme includes:

- Provision of accessible housing and supported housing
- Access to transport
- Access to services and information

3. Making a positive contribution

The aspiration
Maintaining involvement in local activities and being involved in policy development and decision-making.

What this theme includes:

- Participation in community life and democratic processes
- Consultation and involvement

4. Increased choice and control

The aspiration
Through maximum independence and access to information. Being able to choose and control services and helped to manage risk in personal life.

What this theme includes:

- Quality of community care assessments/reviews/self assessment
- Direct payments and individualised budgets
- Transition from children to adult services/interfaces with other client groups eg. mental health, learning disability
- Disabled parents – support with parenting
- Support and information for carers

5. Freedom from discrimination and harassment

The aspiration
Equality of access to services. Not being subject to abuse.

What this theme includes:

- Tackling discrimination and harassment of disabled people
- Equality Impact assessments on service provision

6. Economic wellbeing

The aspiration

Access to income and resources sufficient for a good diet, accommodation and participation in family and community life. Ability to meet costs arising from specific individual needs.

What this theme includes:

- Accessing/maintaining employment and Life Long Learning
- Provision and availability of benefits advice

7. Maintaining personal dignity and respect

The aspiration
Keeping clean and comfortable. Enjoying a clean and orderly environment. Availability of appropriate personal care.

What this theme includes:

- Supporting people to live at home, including personal care and communication support
- Low level and preventive services
- Integrated community equipment services/Telecare