Brighton & Hove City Council

Cabinet Member Meeting

Title:	**Adult Social Care & Health Cabinet Member Meeting**
Date:	**5 December 2008**
Time:	**4.00pm**
Venue	**Committee Room 3, Hove Town Hall**
Members:	**Councillor:** K Norman (Cabinet Member)
Contact:	**Caroline De Marco** Democratic Services Officer 01273 291063 caroline.demarco@brighton-hove.gov.uk

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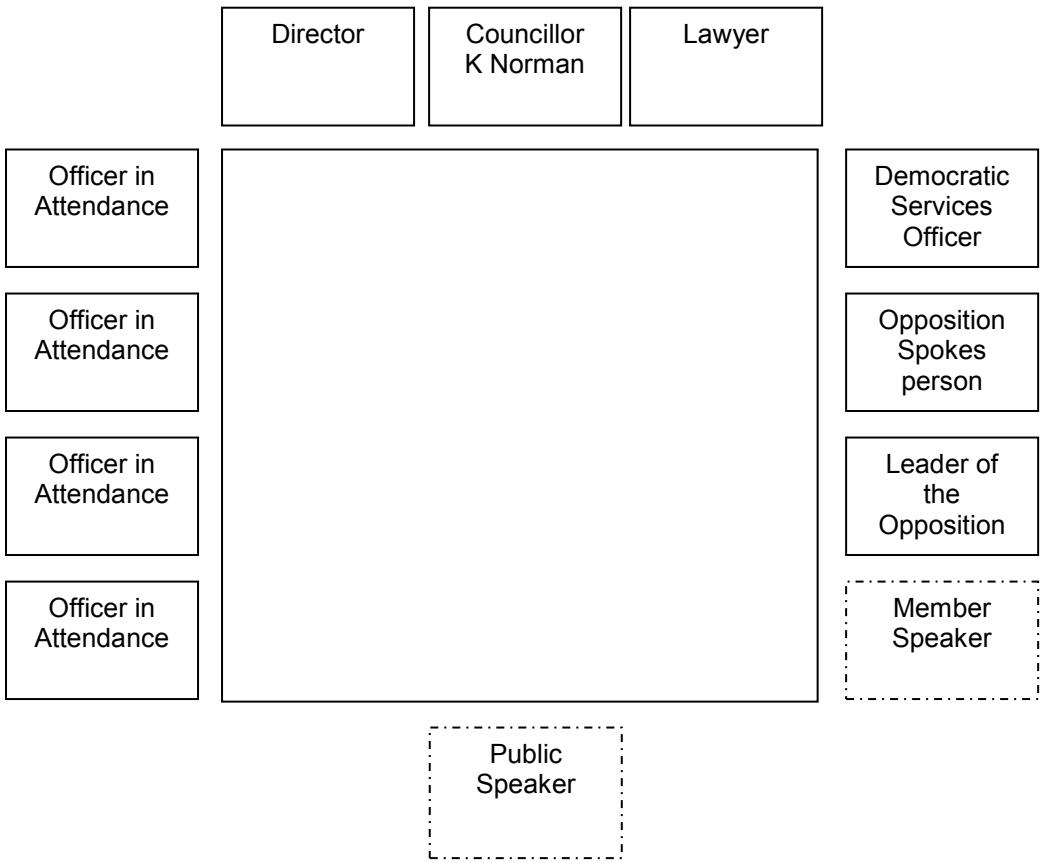

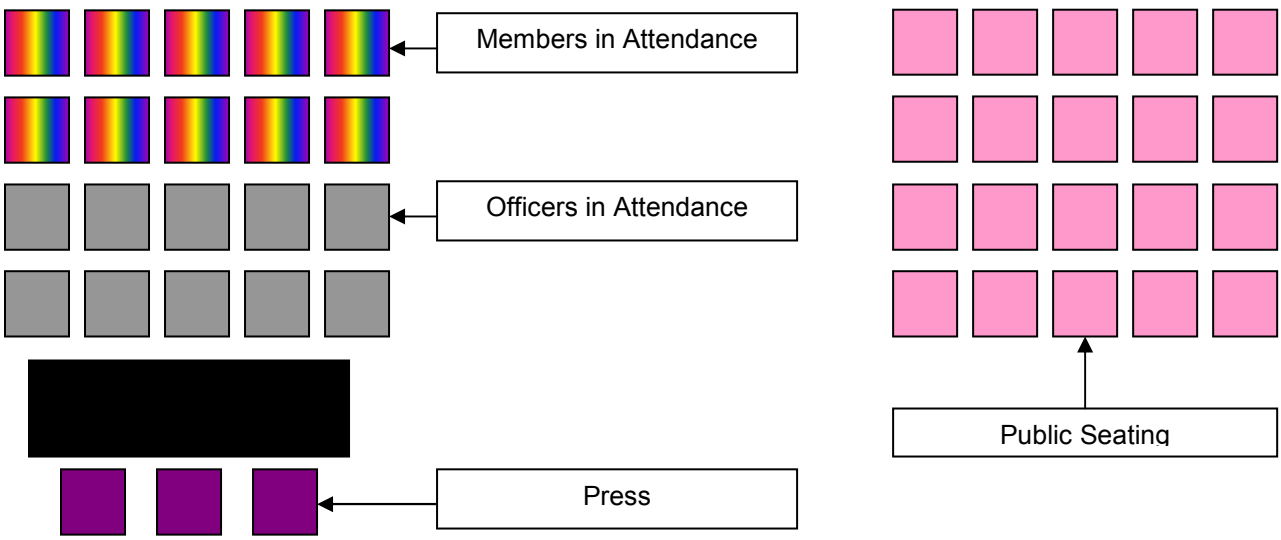

AGENDA

Part One **Page**

30. PROCEDURAL BUSINESS

(a) Declarations of Interest by all Members present of any personal interests in matters on the agenda, the nature of any interest and whether the Members regard the interest as prejudicial under the terms of the Code of Conduct

(b) Exclusion of Press and Public - To consider whether, in view of the nature of the business to be transacted, or the nature of the proceedings, the press and public should be excluded from the meeting when any of the following items are under consideration.

NOTE: Any item appearing in Part 2 of the Agenda states in its heading either that it is confidential or the category under which the information disclosed in the report is exempt from disclosure and therefore not available to the public.

A list and description of the categories of exempt categories is available for public inspection at Brighton and Hove Town Halls.

31. MINUTES OF THE PREVIOUS MEETING 1 - 6

Minutes of the meeting of the meeting held on 11 September 2008 (copy attached).

32. CABINET MEMBER'S COMMUNICATIONS

33. ITEMS RESERVED FOR DISCUSSION

(a) Items reserved by the Cabinet Member

(b) Items reserved by the Opposition Spokesperson

(c) Items reserved by Members, with the agreement of the Cabinet Member.

34. PETITIONS

No petitions have been received by the date of printing the agenda.

35. PUBLIC QUESTIONS

No public questions have been received by the date of printing the agenda.

36. DEPUTATIONS

No deputations have been received by the date of printing the agenda.

37. LETTERS FROM COUNCILLORS

No letters have been received.

38. WRITTEN QUESTIONS FROM COUNCILLORS

No written questions have been received.

39. NOTICES OF MOTIONS

No Notices of Motion have been received.

40. PHYSICAL DISABILITY STRATEGY 2009-2012 — 7 - 92

Report of Director of Adult Social Care & Housing (copy attached).

Contact Officer: *Karin Divall* *Tel: 294478*
Ward Affected: *All Wards*

The City Council actively welcomes members of the public and the press to attend its meetings and holds as many of its meetings as possible in public. Provision is also made on the agendas for public questions to committees and details of how questions can be raised can be found on the website and/or on agendas for the meetings.

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For further details and general enquiries about this meeting contact Caroline De Marco, (01273 291063, email caroline.demarco@brighton-hove.gov.uk) or email democratic.services@brighton-hove.gov.uk

Date of Publication - Thursday, 27 November 2008

ADULT SOCIAL CARE & HEALTH CABINET MEMBER MEETING	Agenda Item 31 Brighton & Hove City Council

BRIGHTON & HOVE CITY COUNCIL

ADULT SOCIAL CARE & HEALTH CABINET MEMBER MEETING

4.00pm 11 SEPTEMBER 2008

COMMITTEE ROOM 3, HOVE TOWN HALL

MINUTES

Present: Councillor K Norman (Cabinet Member)

PART ONE

15. PROCEDURAL BUSINESS

15 (a) Declarations of Interests

15.1 There were none.

15b Exclusion of Press and Public

15.2 The Committee considered whether the press and public should be excluded from the meeting during the consideration of any items contained in the agenda, having regard to the nature of the business to be transacted and the nature of the proceedings and the likelihood as to whether, if members of the press and public were present, there would be disclosure to them of confidential or exempt information as defined in Schedule 12A, Part 5A, Section 100A(4) or 100 1 of the Local Government Act 1972 (as amended).

15.3 **RESOLVED -** That the press and public be not excluded from the meeting.

16. MINUTES OF THE PREVIOUS MEETING

16.1 **RESOLVED** – That the minutes of the Adult Social Care & Health Cabinet Member Meeting held on 16 June 2008 be agreed and signed by the Cabinet Member.

17. CABINET MEMBER'S COMMUNICATIONS

CSCI (Commission for Social Care & Inspection) Annual Review Meeting

17.1 The Cabinet Member reported that the CSCI Annual Review Meeting had recently taken place. The meeting had gone well and results were expected in late October.

Vernon Gardens

17.2 The Cabinet Member reported that the Council had funding of £1,000,000 to develop extra care housing for the under 65's at Vernon Gardens. 10 units would be developed. This was excellent news for the City. The scheme should be up and running by March 2010.

18. ITEMS RESERVED FOR DISCUSSION

18.1 **RESOLVED** – All items were reserved for discussion.

19. PUBLIC QUESTIONS

19.1 There were none.

20. WRITTEN QUESTIONS FROM COUNCILLORS

20.1 There were none.

21. PETITIONS

21.1 There were none.

22. DEPUTATIONS

22.1 There were none.

23. LETTERS FROM COUNCILLORS

23.1 There were none.

24. NOTICES OF MOTIONS REFERRED FROM COUNCIL

24.1 There were none.

25. MATTERS REFERRED FOR RECONSIDERATION

25.1 There were none.

26. REPORTS FROM OVERVIEW & SCRUTINY COMMITTEES

26.1 There were none.

27. FAIRER CONTRACTING.

27.1 The Cabinet Member considered a joint report of the Director of Adult Social Care & Housing, Brighton & Hove City Council and the Director of Quality & Engagement, Brighton & Hove PCT concerning work to produce a joint PCT/Council contract for residential care homes and care homes with nursing, in order to drive up quality of

care, and to cease placing service users in poor homes. Clinical standards, additional to CSCI standards would be used to rate nursing homes (for copy see minutes book).

27.2 The Cabinet Member was informed that fee levels would be made in a separate report alongside the Adult Social Care & Housing budget strategy for 2009/10.

27.3 **RESOLVED** - (1) That there be in principle agreement to the proposals listed below:

a) The new Joint Council and PCT pre placement contract for both residential care homes and care homes with nursing from 1 April 2009
b) The Preferred Provider Scheme which is included in the contract
c) Individually negotiated fees
d) The Incentive Scheme

28. MODERNISATION OF DAY CARE SERVICES FOR OLDER PEOPLE

28.1 The Cabinet Member considered a report of The Director of Adult Social Care & Housing which made recommendations resulting from the Value for Money Review of Day Services for Older People. The aim of the review was to ensure that Older People's Day Services met the needs of current and future service users, are modernised in line with the Personalisation agenda and provide good value for money (for copy see minutes book).

28.2 The Cabinet Member reported that neither Councillor Lepper, the Opposition Spokesperson or Councillor Mitchell, the Leader of the Opposition were able to attend the Cabinet Member Meeting. Councillor Mitchell had submitted the following question.

"We fully understand the need to review services from time to time in order to ensure that resources are targeted most effectively. However, this report seems to simply focus on making a case for reducing the number of Day Centres and is obviously budget driven in order to deliver a saving. No alternative proposals have been included for increasing the viability of the Centres and we are concerned that these proposals will restrict choice."

28.3 The Director of Community Care (Adult Social Care) explained that the whole idea of Self Directed Support was to allow people to choose their social activities. The remaining services would provide better value for money. The General Manager Provider Services concurred. She emphasised that the review would increase choice rather than restrict choice. The aim was to be more community activity based.

28.4 The Cabinet Member reported that Councillor Mitchell had submitted a further question as follows.

"In addition, the section relating to transport gives no assurances that the community transport service will continue and given the issue of transport is so integral to this service we would have expected firm proposals for its future as part of this package of proposals. Given these concerns we do not feel that the recommendations in their present form should be agreed."

28.5 The Director of Community Care (Adult Social Care) explained that the recommendations would provide for the different needs of service users. There would still be some people who would need to use day services and traditional transport.

28.6 The Cabinet Member reported that more detailed replies would be sent to Councillors Lepper and Mitchell.

28.7 The Director of Adult Social Care & Housing confirmed that the Cabinet Member was being asked to agree the model of service delivery. Transport options would be brought back to a Cabinet Member Meeting at a later date.

28.8 **RESOLVED** - (1) That plans be taken forward to modernise the service, as set out in the service model on page 18 of the agenda, with a focus initially on day services for older people with mental health needs. That the service be targeted at older people with a higher level of need; Functional or organic mental health needs, carer relief, physical disability or requiring short term support/reablement.

(2) That short-term reablement day services be developed and implemented as part of the wider Adult Social Care Personalisation agenda.

(3)That voluntary sector/community provision be developed and implemented for the Combined Day Services, with an initial focus on CDS West (Muriel House). That officer's work with Housing Management and the third sector to build on the work taking place in the Local Area Agreement (LAA) areas and to develop alternative services.

(4) That options for transport will be further explored and brought back to the Cabinet Member Meeting as a report at a later date.

29. SELF DIRECTED SUPPORT STRATEGY

29.1 The Cabinet Member considered a report of the Director of Adult Social Care & Housing which explained that Self Directed Support was a new way of delivering social care which formed a major part of the three year Adult Social Care personalisation programme. It was based on a new national policy initiative that was being piloted nationally. Self Directed Support was a way of redesigning the social care system so that the people eligible to receive services take control of them (for copy see minute book).

29.2 The Director of Community Care (Adult Social Care) explained that the proposals would put service users at the centre of assessment and would allow them to decide how best to meet their needs. There would be choice about how to use funding streams.

29.3 The Interim Head of Adult Social Care (Operations) paid tribute to David Nicholls, the author of the strategy who died in July 2008. She stressed that a great deal of time and effort had been put into the work on the strategy.

29.4 **RESOLVED** - (1) That the strategy is agreed in principle, subject to the approval of the Joint Commissioning Board on 15 September 2008.

(2) That work in developing an implementation plan is taken Forward to deliver the strategy in stages over a three year period, with evaluation and review of each stage as it proceeds.
A draft project outline is attached as an appendix to the report.

The meeting concluded at 4.45pm

Signed Chair

Dated this day of

ADULT SOCIAL CARE & HEALTH CABINET MEMBER MEETING	Agenda Item 40 Brighton & Hove City Council

Subject:		**Physical Disability Strategy 2009-2012**		
Date of Meeting:		**5th December 2008**		
Report of:		**Director Adult Social Care & Housing**		
Contact Officer:	Name:	**Karin Divall**	**Tel:**	**29-4478**
	E-mail:	Karin.divall@brighton-hove.gov.uk		
Key Decision:	Yes	Forward Plan No. ASC 4247		
Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT

1.1 A strategy framework has been drawn up which outlines the development of services for adults with physical disabilities over the next three years. The strategy is based on national and local policy and incorporates views that have been collected from service users and carers and has been developed in consultation and engagement with service users.

1.2 It is intended that this strategy will be an interim document pending further development of the Joint Strategic Needs Assessment.

2. RECOMMENDATIONS:

2.1 That the Cabinet Member note and endorse the attached framework strategy.

2.2 That the Cabinet Member agree the further development of the strategy informed by an updated Joint Strategic Needs Assessment and completion of a full Equalities Impact Assessment.

2.3 That the Cabinet Member receives a further report in March 2009 following finalisation of the strategy and further consultation.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 The PCT, as lead commissioner for services in the City for adults with physical disabilities, has been working with the local authority, and a wider representative stakeholder group, to develop this strategy. The strategy which identifies demand and need for services and provides the opportunity to develop better commissioning and improved management of limited resources across the health and social care sector.

The strategy identifies the local and national drivers for change. An assessment of need based on demographic information, local activity and trends. It then maps out the future direction including:

- Involvement and engagement
- Person centred care and self directed support
- Promotion of independence and extended living opportunities
- Increased opportunities for local; citizenship and community participation
- Improved commissioning for alternatives to high cost residential, nursing and complex rehabilitation and care management.

4. CONSULTATION

4.1 The strategy has been developed by a steering group with representation from the statutory and voluntary sectors. A period of engagement and consultation was led by the PCT and took place during October and November 2008 with key stakeholders including voluntary sector and communities of interest, Disability Equality Scheme steering group and service users groups, relevant clinical groups and networks.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 The strategy is expected to be delivered within health and social care budgets however elements of the action plan may require further investment and will be subject to detailed business cases and a value for money approach. The strategy sets out objectives and where a changed approach is proposed. The expectation is that through service modernisation efficiency savings will be generated which will fund the new approaches

The PCT currently spends £420m in providing health care across Brighton and Hove. A significant proportion of this health care is provided to the working age population with physical disabilities. A key part of the Physical Disability Action Plan will be to establish baseline funding streams for physical disabilities and to ensure that these can be clearly linked with appropriate healthcare outcomes.

Expenditure across social care on physical disabilities (adults under 65) is approximately £9m. A proportion of the City Council's capital budgets on adaptations and Disabled Facilities Grants is applied to physical disabilities.
Finance Officer Consulted: Anne SilleyJonathan Reid Date: 25/11/08

Legal Implications:

5.2 The Physical Disability Strategy has been developed in accordance with national and local policy and follows a comprehensive analysis of assessed need within Brighton and Hove, taking into account the outcome of consultation with relevant stakeholders.

The Strategy should therefore ensure that the Council continues to be able to meet its statutory duties to service users, in accordance with individual need, and in compliance with the Human Rights Act.

Lawyer Consulted: Hilary Priestly *Date: 11/11/08*

Equalities Implications:

5.3 An Equalities Impact Assessment Checklist has been completed for this strategy and this has identified the need to increase access to services and wider representation for service users and their carers. A full EIA will be completed before the Strategy is finalised.

Sustainability Implications:

5.4 The strategy aims to improve access to and quality of services for disabled people without additional impact upon the environment.

Crime & Disorder Implications:

5.5 A higher proportion of disabled people are subject to abuse and hate crime than for the City population as a whole and this strategy aims to support disabled people to access support, advice and services that will address this inequality.

Risk and Opportunity Management Implications:

5.6 Demand for, expenditure on and unit costs of services for adults with physical disabilities has been increasing year on year and future growth is a financial risk. This strategy provides an opportunity to work across health and social care to strengthen commissioning and deliver improved value for money and reduce the financial risk and to meet the council priority of better use of public money.

Corporate / Citywide Implications:

5.7 This strategy meets the council corporate priority of reducing inequality by increasing opportunity. It is relevant to disabled people who live, work and use services from across the council and this strategy will apply equally to disabled people from across the City.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 The strategy has been developed to address the financial risk and to develop improved demand planning, the alternative would be no strategy which would present a financial risk.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 The framework strategy has been developed by the Primary Care Trust in partnership with the local authority. Further work is required following the completion of the Joint Strategic Needs assessment and Equality Impact assessment. The Cabinet Member is now asked to agree the framework and the completion of additional work and consultation on behalf of the local authority,

prior to their presentation to the Joint Commissioning Board, and a further report back in March 2009.

SUPPORTING DOCUMENTATION

Appendices:
1. Physical Disability Strategy

Documents In Members' Rooms
1. Physical Disability Strategy

Background Documents
1. None

Draft Physical Disability Strategy

Independent Living and Personalised Care

2009-2012

Contents

Tables

Figures

Acknowledgments

This strategy has been developed with contributions from:

- Service user and carers
- Representative of organisations of disabled people
- Members of a Strategy Steering Group
- Disability Equality Scheme steering group and service users group
- Integrated Service Improvement Programme (ISIP) workshop members
- Care Services Improvement Partnership (CSIP)

Executive Summary

The joint Physical Disability Commissioning Strategy sets out the future direction of physical disability services in Brighton and Hove from 2009- 2012.

The purpose of this strategy is to strengthen independent living, to deliver personalised care and create greater citizenship opportunities for people with a physical disability.

Whilst the principles and aims of the strategy are relevant to all age groups and people with other disabilities this strategy focuses on the needs of adults (18-65yrs) with a physical disability. Therefore it will be important to cross-reference this strategy with other key areas of work[1] to ensure a comprehensive approach to the development of services, efficiency and best use of resources.

This strategy incorporates a range of disabilities cognitive, mobility, sensory, and communication. Disability may arise as a result of accident, illness or congenital disorders. An individual's disability may be a static condition, one, which fluctuates or changes, or due to a progressive condition. If disability is as a result of illness a range of health conditions may be the cause: neurological, circulatory, respiratory and musculoskeletal. Therefore this strategy must be relevant and sensitive to a broad range of individual needs.

The development of the strategy has been informed by national and local policy and guidance, a public health assessment of the needs of the local population, and listening to the views of disabled people and their carers.

The strategy has five overall objectives:

- **To actively involve and engage physically disabled people and their carers in the future planning and development of services.**
- **To develop personalised and self directed care**
- **To promote independence and extend opportunities for independent living**
- **To improve support to those with complex and higher dependency care needs**
- **To increase opportunities for local citizenship and participation in communities**

[1] Key areas of work are included at Appendix A

For each of the five objectives the strategy identifies desired outcomes, the relevant local priorities and key actions for this strategy. The key actions of this strategy include:

Strengthened service user and carer engagement and involvement

- To widen and strengthen the involvement of service users in the planning development, monitoring and review of future services through the development of inclusive structures.
- To develop a service user led centre for independent living to provide a focal point to community information, support and opportunities.

Further development of personalised and self-directed care

- To strengthen the one-stop shop approach to information, advice and advocacy services.
- To strengthen health promotion and well being initiatives for those with long-term neurological conditions through the introduction of designated health trainers and Expert Patient Programmes.
- To develop self care and management by increasing take up of self directed care including Direct Payments and individual budgets.
- To deliver timely, responsive, accessible and person centred care.

Increased support to individuals and their families to maintain independence and independent living

- To strengthen the focus of services on reablement and rehabilitation to support independent living. Ensuring services are delivered as close to home, with appropriate access and re-access to support as needs change.
- To improve management of hospital discharge and return to independent living through improved access to short term support services.

- To ensure appropriate access to community support services, adaptations, and equipment and mobility services to support independence and independent living.

To improve support to those with complex and higher dependency care needs

- To agree a commissioning framework across social care, housing and health, which develops capacity within the city to support those with complex needs. including: improved access to short term services for those in transition (e.g. those leaving hospital or specialist rehabilitation services or children's care services) and longer term support services for those who wish to return to the city from out of area placements and those wishing to remain living independently within their own homes

- To develop quality supported and adapted housing options including the development of extra care housing to support those with complex care needs to continue living independently within their own homes

- To explore further integrated working for those with complex health and care needs to ensure appropriate and greater coordination of care

- To develop local slower stream rehabilitation opportunities for people leaving hospital following spinal injury, acquired brain injury and stroke to facilitate greater independence and a return to independent living.

- To strengthen current procurement initiatives to ensure high quality and value for money care is purchased for the city's population

Increased opportunities for local citizenship and partnership

- To increase opportunities for employment and training to include support for finding and retaining employment, accessing training and retraining opportunities.

- To ensure that people with a disability are able to access the city's wide range of mainstream community activities.

- To develop a centre for independent living model which will develop strong links with the wider community and develop further opportunities for citizenship.

Delivering the Strategy

To successfully deliver this strategy a whole systems approach is required. A cross-representational Physical Disability Commissioning Strategy Steering Group will be established to steer and monitor implementation of the strategic action plan. Due to the wide-ranging scope of the strategy a project management approach will be taken to implement the key actions of the strategy.

1 Setting the scene

1.1 Introduction

Brighton and Hove City Primary Care Trust (B&H PCT) has, together with Brighton and Hove City Council, jointly developed a three-year strategy (2009 to 2012) to improve opportunities and support services to people with a physical disability.

The strategy encompasses the whole health and social economy of Brighton and Hove, and must be read in conjunction with local disability schemes[2], which provide the local plans for ensuring equality of opportunity for disabled people.

National and local policy sets out the direction for the delivery of health and social care and this strategy outlines how local services will develop to meet national policy whilst ensuring the most effective use of resources.

1.2 Scope

This is a strategy which looks specifically at physical disabilities, whilst the principles and aims of the strategy may be relevant to people with other disabilities it is necessary to refer to the relevant individual plans for information on other detailed work programmes. To assist this other relevant strategies and areas of work are listed in Appendix A.

The term physical disability is a broad term, which incorporates a number of disabilities and causes of disability. This strategy is not restricted by cause or type but rather incorporates cognitive, physical, and sensory disabilities and disability caused by accident, illness or congenital disorder. The strategy is also relevant to a wide range of health conditions, (e.g. neurological, circulatory, respiratory and muscular skeletal) and long-term conditions[3]. This broad remit demands that the strategy is responsive and relevant to a wide range of individual needs.

The strategy is based on the social model definition of disability, which shifts the focus from impairment (the medical model) to the recognition of the impact of social and environmental barriers for people and how these can restrict and exclude people with a disability from mainstream society[4].

Specific focus is given within this strategy to the needs of adults 18-65yrs with a physical disability, and the related adult support services. This is to ensure that sufficient focus is given to the specific issues this age group face in relation to work, family, social and personal life.

[2] http://www.brightonhovecitypct.nhs.uk/pct/howwework/equalities/documents/DisabilityEqualitySchemeDraft17.pdf

[3] which are defined by the Dept of health as a condition "that cannot, at present, be cured, but can be controlled by medication and other therapies,

[4] Social model of disability: Disability within the social model is defined as "the loss or limitation of opportunities to take part in society on an equal level with others due to social and environmental barriers".

1.3 Key Strategic Objectives

The Government's vision for disabled people is set out in Improving The Life Chances of Disabled People[5] It states:

"By 2025, disabled people in Britain should have full opportunities and choices to improve their quality of life and will be respected and included as equal members of society"

To improve the life chances of people locally the following key objectives have been identified:

- **To actively involve and engage physically disabled people and their carers in the future planning and development of services**
- **To develop personalised and self directed care[6]**
- **To promote independence and extend opportunities for independent living[7]**
- **To Improve support to those with complex and higher dependency care needs**
- **To increase opportunities for local citizenship and participation in communities by improving access to the city's services and facilities e.g. education, employment, leisure and other activities**

*Throughout the strategy recognition and consideration of the support needs of carers: both carers of disabled people and disabled people as carers themselves will be evaluated.

[5] Improving the Life Chances of Disabled People, Prime Minister's Strategy Unit 2005

[6] Person centred care: This is where the individual is central to the decision making and planning of care and has choice as to how their needs are met

[7] Increasing disabled people's opportunities to live independent lives at home, at work and in the community

1.4 Key Principles

This strategy is underpinned by the following key principles:

- Services should be designed and developed in partnership with users and carers.
- The strategy must ensure that the needs of those more traditionally excluded[8] are fully considered.
- Services commissioned must provide high quality, evidence based care and represent value for money.
- The commissioning plan will seek to sustain a balanced financial position across the local health and social care economy.

1.5 Key Challenges

Key challenges for the strategy are:

- Ensuring that the plan is responsive and flexible in order to address a wide range of disabilities and individual needs.
- Achieving the necessary coordination and integration of commissioning plans and support systems to ensure a shared approach.
- Delivery of the plan and significant service improvements within a financially challenged local health economy.

1.6 Risks and mitigating factors

Assessment of need – Forecasting future demand on services is a significant challenge due to uncertainty over future disability trends and the limitations of existing data. This strategy's assessment of need is largely based on national data applied to the local population. This has enabled an estimate of local incidence, and prevalence rates and expected type and level of disability locally. Improved record keeping across the local health economy is required to facilitate a more robust analysis of future needs.

Financial Plan – Across the local health economy key services for physical disability experience a consistently high level of demand. As treatment and technology advances and more people with complex needs are supported to live at home the demand on services and existing budgets has increased. This has led to significant pressures within both health and social care budgets.

[8] Including disabled people from black and minority ethnic communities, and disabled people who are lesbian gay, bisexual or transgender

Mitigating Factors

The Joint Strategic Needs Assessment (JSNA) and associated three year costed plan (included at Appendix D) highlights the key budget lines for physical disability services. To mitigate the recognised financial risks above, work will continue to further assess need and identify spend against physical disability

A Physical Disability Steering Group will be established to monitor implementation and financial impact of the proposed initiatives.

2 Drivers for Change

2.1 National context

This strategy is developed in the context of national legislation, policy and initiatives aimed at achieving full equality for disabled people by 2025[9] and a government drive to give a right to independent living.

It is also developed at a time of major reform within health and social care that will shape the way services are delivered in the future, giving renewed priority to:

- Good prevention services and early-targeted intervention;
- Supporting those with more long term needs;
- Equality of citizenship and reducing health, social and community inequalities;
- Improving access to community services, integrated and personalised care
- Greater integration and joined up working between health and social care services.

The main guiding legislation and national policy for the Physical Disability strategy include:

- The Disability Discrimination Act (1995)
- The Disability Equality Duty (2005)
- World Class Commissioning and the Darzi Review “Our NHS, Our Future” (2007)
- Our health, our care, our say: a new direction for community services' (DOH (2006)
- Putting People First: A shared vision and commitment to the transformation of Adult Social Care
- Long-term conditions National Service Framework (DOH 2005)

[9] Equality 2025 - the UK Advisory Network on Disability Equality is a network of disabled people, who will act as a reference group for the government to ensure input from disabled people at the start of policy development. The intention is that policy changes across all government departments will be referenced by the network and therefore validated by disabled people.

- National Stroke Strategy (2007)
- Improving the Life Chances of Disabled People, Prime Ministers Strategy Unit, 2005
- Transforming Community Equipment Services Project, (DOH 2006)
- Standards for Services for people who are deafblind or have a dual sensory impairment in partnership with the Department of Health
- Stepping Away for the Edge, Improving Services for Deaf and Hard of hearing

Local context

In addition to key national policy the strategy is developed in line with the city's overall strategic plan for local health and social care services. Several key documents set out the future direction for services across the city.

Brighton & Hove City Council Corporate Priorities set the framework for this strategy and are to:

- **Protect the environment while growing the economy**
- **Better use of public money**
- **Reduce inequality by increasing opportunity**
- **Fair enforcement of the law**
- **Open and effective leadership**

Brighton & Hove City Council (Adult Social Care) is taking forward an ambitious Personalisation Programme with the vision of creating an integrated range of effective services and opportunities. Delivering timely and appropriate responses to individuals' needs and aspirations, which support people to lead fulfilled and healthy lives. The city is committed to empowering people to make informed choices about the sort of support that suits them and to achieve the outcomes they want to maximise their independence and quality of life. This includes safeguarding those people whose independence and well being are at risk of abuse and neglect.

To deliver this vision, services are being re-designed to offer:

- clear advice and information through multi skilled contact points
- self assessment, easy access to simple services (e.g. equipment, community services, telecare)

- identification of and signposting to partnership solutions to improved quality of life
- self directed support options at all stages for all social care users
- an integrated approach to reablement for the majority of social care users
- a robust care management service for those who need it
- a professional and effective process to safeguard vulnerable adults

The new service will work to a set of key principles, including:

- a service that enables people to make decisions and choices wherever possible
- a service that facilitates independence whereby people can access the appropriate resource at the right time and move on
- a service that is flexible and designed to meets changing needs
- a service that listens to people's views and is open to change
- a fair service for all parts of the community that does not discriminate on the basis of income or background
- a service that represents good value for money for the community and the person using the service

The Primary Care Trust (PCT) has developed its **Strategic Commissioning Plan** for **2008-2013** – this is the overall commissioning plan for the city's health care services. It sets out the plans for improving health care services to ensure "High Quality Care for All" in line with World Class Commissioning and the Darzi Review and the three key principles of: better health and well being, better care and better value for all, underpinned by the organizational competencies to deliver them. The PCT has identified six key overall commissioning goals for the next five years. The goals are for:

1. Average life expectancy to increase above expected trends with biggest gain in the most deprived areas

2. Children grow to adulthood with maximum life chances and best possible health

3. Improve quality and response for mental health, sexual health, alcohol and drugs services

4. Improve quality and response in primary care services

5. Improve quality of life for people living with long term conditions

6. To have a range of services nationally recognized as best practice

Healthier people excellent care for NHS South East Coast (2008) – sets out a shared vision and recommendations for health services in the South East Coast region over the next 10 years.

Other key local strategies with which the physical disability strategy is cross-referenced are summarised in Appendix A and include:

- Older Peoples Commissioning Strategy (2007-2010)
- Strategy for Self Care
- Housing Strategy
- Strategy for Self Directed Support
- Carers Strategy
- Extra care housing strategy

3 Local assessment of need

To inform the development of this strategy local demographic information and disability trends were reviewed and existing use of key services were analysed.

Forecasting future demand on services for people with physical disabilities is difficult due to uncertainty over future trends, and the use of measures which give only a partial indication of levels of disability and dependency. Whilst condition specific incidence rates are available this does not indicate incidence of disability or type and level of disability**.**

Due to these difficulties most forecasting models of future health and care are based on current levels of need[10].

Overview:

- Projections based on national data suggest that there will be a small increase in demand on services by those between 18-64 yrs over the next two years, and a further small increase up to 2015.
- However greatest demand is and will continue to be from the older age range. National and local data demonstrate how the prevalence and severity of disability increases with age. Within the working age population greatest demand is amongst the 45 and over age group.
- National studies[11] and local service demand show that the most common type of disability and area of need are locomotor disability and mobility services followed by need for help with personal care.
- Service use data suggests that the City has a higher than *average* prevalence of Acquired Brain Injury (ABI) and Multiple Sclerosis.
- Although services are reporting high levels of demand, local study of recent activity shows that for some services the level of uptake is lower than expected when applying national prevalence data to the City's population[12].

[10] The Parliamentary Office of Science and Technology[10] acknowledges the difficulty in forecasting future demand;

[11] Health Survey for England and 2001 census population baseline

3.1 Local Demographic Information and Trends

Brighton and Hove has an estimated resident population of 253,500[13], of whom 172,000 are aged between 18 and 64 years. A high proportion of the population are young adults, as shown in the chart below.

It is predicted that the local population will increase to 257,000 by 2012 (representing an increase of 2.2% between 2007 and 2012), and to 265,000 by 2018. The expected change varies between age groups, as illustrated by the thin bars in the chart below. The greatest increase is expected in 45 to 54 year olds.

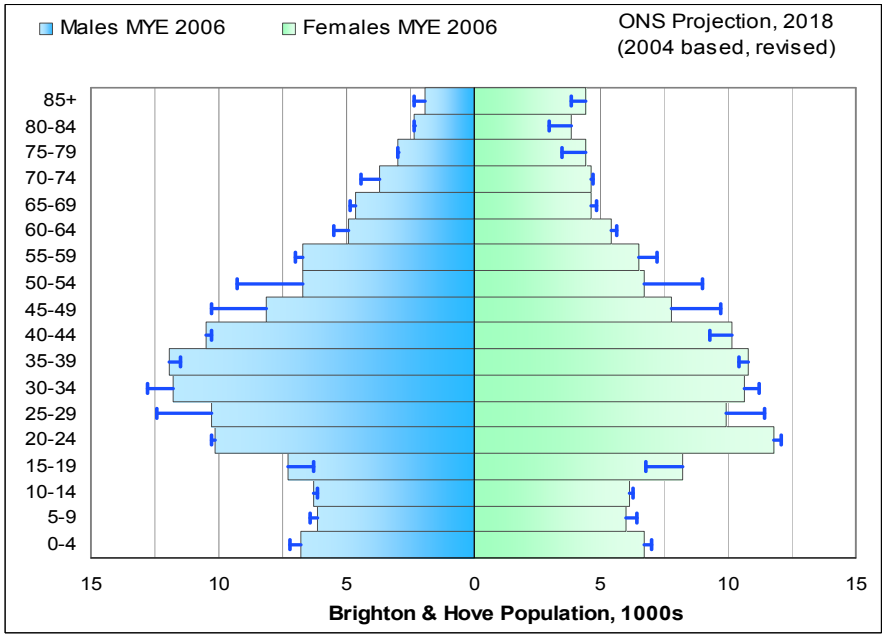

Figure 1: Population Pyramid showing Brighton and Hove City Mid-year Estimates (MYE) for 2006 and Projections for 2018 by age and sex[14]

The City has an unusually and increasingly diverse population compared to other areas on the South East Coast with15% of residents were born outside England. Between 2001-2004, the proportion of residents from Black and Minority Ethnic Groups increased by 35%, compared to an increase of 13% nationally. There are a relatively high proportion of people who are from the lesbian, gay, bisexual or transgender (LGBT) groups.

Brighton and Hove City faces substantial socio-economic issues. The Index of Multiple Deprivation 2007 identifies Brighton and Hove City as the 79th most deprived authority in England (out of 354), with 9% of all Super Output Areas[15] (SOAs) in the City falling within the 10% most deprived SOAs in England and 8 SOAs falling in the 5% most deprived.

[13] National Statistics 2007 mid-year estimates

[14] Source Office for National Statistics

[15] Super Output Areas

3.2 Prevalence of physical disability

The Health Survey for England 2001 (HSE)[16] provided information at a national level on the number of people who have disabilities. It reported both physical and sensory disability by severity and enables local level estimation of numbers of people expected to have physical disability.

The survey illustrates how the prevalence and severity of disability increases with age. Nationally, 7.5% men and 8% of women of working age report having moderate disability, and 2.5% of men and 2% of women of the same age group report having serious disability. In those aged 85 and above, 72% of men and 73% of women have a moderate or severe disability.

The HSE also reports on the proportion of disability by type of disability. It shows locomotor disability accounting for highest proportion of disability with 38% of the total, followed by personal care disability (23%), communication (20%), hearing (12%) and sight (7%).

The Projecting Adult Needs and Service Information System (PANSI)[17] uses sources including the HSE and population estimates and projections to produce 2008 estimates, and projections to 2025, of the numbers of people with physical disabilities at Local Authority level. The estimated number of Brighton and Hove residents with physical and personal care disabilities is shown in the table below.

	2008	2010	2015
Total no of people predicted to have a physical disability			
• moderate physical disability	13,981	14,219	14,562
• serious physical disability	3,361	3,425	3,488
No. of people predicted to have a personal care disability			
• moderate personal care disability	7,642	7,749	7,912
• serious personal care disability	1,293	1,321	1,357

Table 1 - Predicted numbers of men and women aged 18 to 64 years with moderate and serious physical disability, and moderate and serious personal care disability, in Brighton & Hove in 2008, 2010 and 2015 (Source: PANSI 2008)[18].

[16] DoH Health Survey for England 2001 – HSE comprises a series of annual services. Physical disability was the specific focus topic for 1995 and 2001

[17] www.pansi.org.uk

[18] People with a personal care disability are included in the total no of people with a physical disability. Personal care includes getting in and out of bed, getting in and out of a chair, dressing, washing, feeding, and use of the toilet. A moderate personal care disability means the task can be performed with some difficulty; a severe personal care disability means that the task requires someone else to help.

3.3 Condition specific incidence and prevalence rates

Physical disability can arise from a wide range of conditions, which affect people in varying ways. Estimating the prevalence of physical disability in a population based on disease / condition prevalence is difficult as different people will be affected in different ways.

In the UK, stroke is the main cause of disability. In the Brighton and Hove City population, it is estimated that there will be 560 strokes per year. The incidence of stroke increases with age and it is estimated that there will be fewer than 40 strokes per year in those aged under 65. The total prevalence of stroke is estimated to be 4518, of whom 1450 will have a moderate or severe disability[19]. PANSI estimates that in 2008 there are 46 male and 81 female Brighton and Hove residents aged 18-64 years who have had a stroke and require help with daily activities. These figures are expected to increase slightly to 47 males and 86 females by 2015. In contrast to stroke the age profile for other ABI shows a higher occurrence in the younger age group[20].

The city has a high reported prevalence of Multiple Sclerosis (MS). Based on the application of national incidence and prevalence rates, Brighton and Hove City would be expected to have 17 new diagnoses per year, and 300 local residents living with MS. However the MS specialist nurse manages over 400 active cases. This may be explained by the age distribution of the local population, which has a higher than average proportion of young adults.

PANSI estimates that there are 111 people aged 18 to 64 years with a serious visual impairment[21] in Brighton and Hove City in 2008, and this figure is expected to increase slightly to 115 by 2015.

3.4 Local Activity data

- A snapshot study of activity[22] of the care first information system identified 1011 service users (aged 16-64) with a physical disability of these; 986 were in receipt of services and 25 were being assessed. During 2005/06 1453 people received a service.

- Activity showed a significant increase in both the number of people assessed and in receipt of services over a two-year period. The greatest increase was seen within the Community Occupational Therapy Assessment Service (35% &

[19] DOH (2007) Asset Tool Kit for commissioners

[20] ABI National Guidelines

[21] Based on a review of the literature conducted by RNIB; this prevalence refers to estimated numbers predicted to require help with daily activities

[22] Due to issues of data reliability two years of activity from April 2004-March 2005 and from April 2005-December 2006 was examined

62% respectively) followed by the Physical Disability Assessment Team (26% & 41% respectively). In contrast, assessment activity within sensory services had dropped (40 to 11) but the number in receipt of services remained stable (95 to 94)[23].

- The ethnic breakdown of those receiving services reflected the census profile of B&H city with 90% of service users being white British, white Irish or white other[24]. Overall the majority of clients were aged over 45 years.

- The Brighton and Hove Housing Needs Survey 2005[25] examined disability issues in relation to housing need. The survey results implied that 11,316 households include at least one household member with a walking difficulty but who do not use a wheelchair, and a further 1,765 household included a wheelchair user. The results were not broken down by age group and applied to all ages. Further analysis showed that 73% of households with a wheelchair user did not live in a suitably adapted property, indicating a major mismatch between houses adapted and those where wheelchair users lived. In exploring support needs of disabled people 74.1% of wheelchair users needed help looking after their home.

Overall it is recommended that more detailed recording of activity is conducted and trends analysed over a longer time period to fully understand disability trends and demand and uptake of services across the city. To facilitate this, future recording of activity should include a core dataset including:

- Detail of nature or type of disability (e.g. locomotor, personal care, cognitive) and whether long term, progressive or fluctuating

- A record of date of birth to reduce risk of double counting and to highlight service pressures within specific age groups

- A distinction between the number of new referrals and re referrals to a service

- Further analysis of the Education Department's information on statement of needs to establish whether there is an upward trend in numbers of young people entering adult services.

- Good monitoring of carers needs including young carers and consideration of disabled people's needs who have parenting and/or caring responsibilities.

[23] The reasons for this are unclear and may reflect data issues rather than actual changes in service provision

[24] In 2004-05 almost 10% of service users had no ethnicity code recorded, this dropped to under 1% in the 2005-06 period.

[25] Brighton & Hove Housing Needs Survey – 2005 Table 7-3 Nature of Disability or Limiting Long term illness page 72

4 Overview of Performance and finance

Services are measured against a number of national and local standards. Overall the city has a varied picture of performance with some services performing highly and showing real strength and others requiring further improvement.

The Health Care Commission assesses the overall health performance of the city. Health targets include condition specific and cross cutting performance targets. The most relevant performance measures for physical disability are a combination of performance targets and quality standards.

Priority targets and service objectives are included within the PCT Annual Operating Plan. Priority is give to the following targets:

- Tier 1 Vital signs and performance against existing and new national targets
- Tier 2 Vital signs and targets within the Local Area Agreement
- Tier 3 Vital signs and other local plans

The position in Adult Social Care is currently under review. The Commission for Social Care Inspection (CSCI) is leading a national consultation to inform the future performance management of Adult Social Care. Early indications are that there will be a strengthened focus on evidence of local delivery of the White paper "Our Health, Our Care, Our Say" national outcomes. A National Indicator Set (NIS) will apply within which the thirty-five Local Area Agreement targets will be critical. In addition Councils will continue to collect the Performance Assessment Framework (PAF) indicators during 2008/09 until the consultation is complete.

The National Operating Framework (2008) outlines the key priorities and "vital signs" on which local health and social care services will be monitored. Relevant targets include:

- Percentage of patients seen within 18 weeks for admitted and non-admitted pathways
- Patient experience of access to primary care
- Adults helped to live at home.
- Proportion of people with long term conditions supported to be independent and in control of their condition (NIS 124)
- Timeliness of social care assessment (NIS 132)
- Timeliness of social care packages (NIS 133)
- Adults and older people receiving direct payment and/or individual budgets per 100,000 population (aged 18 and over) NIS 130 and a LAA target

- Proportion of carers receiving a carers break or a specific carers service as a percentage of clients receiving community based services (NIS 135 and a LAA target)
- VSA14: Quality stroke care (outcome: Reduction in stroke related mortality and disability) Patients who spend at least 90% of their time on a stroke unit and higher risk TIA cases who are treated within 24 hrs
- Also in 2009 two additional service user experience indicators are planned: NIS 127 regarding satisfaction and NIS 128 regarding dignity and respect

Local Authority - Key performance indicators

More detailed analysis of key performance indicators shows some variation in performance for physical disability service.

- The city performs well in terms of those helped to live at home with over 90% helped to live at home and a steady increase in the number of people helped to live at home is shown.

2001/02	2002/2003	2003/04	2004/05	2005/06	2006/07	2007/08
3.8	4.5	4.3	3.9	6.2	6.8	7.6

Table 2 People with a Physical Disability helped to live at home (per 10,000 aged 18-64) Trends in Brighton and Hove[26]

- The City has a stable and low number of people with a physical disability living in long term residential care (only 7%) but a poorer performance with regard to unit cost. For both residential and nursing home care unit costs are shown to be above the unitary average and close to the outer London boroughs' average

	2002	2003	2004	2005	06/07
Brighton and Hove	3.67	3.47	3.07	3.42	3.57
IPF Comparator group	3.31	4.34	3.84	3.51	n/a

[26] The Local Authority score very highly on 'professional support' element of this PI, the definition has been tightened this year and will have an impact on our performance.

England	2.89	3.38	3.15	3.01	2.95

Table 3 Long stay supported residents receiving residential and nursing home care; rates per 10,000 population 18 - 64; source KIGs

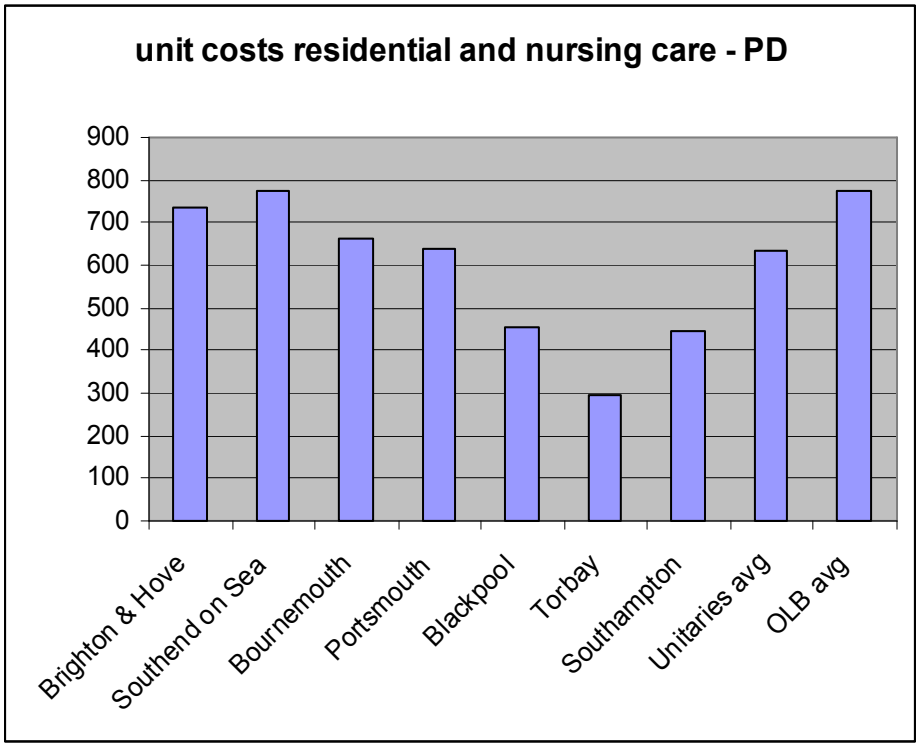

Table 2 Unit Costs residential and nursing home care for people with a physical disability

- Increasing the number of people accessing direct payments is a key priority for the city and performance in the city is improving with an increasing number of people receiving care via direct payment 36 (2006) 54 (2007) and 65 by March 2008)

Finance

PCTs and Local Authorities receive budget allocations based on a weighted capitation formula, which includes population need, size and age structure and variation in the cost of providing care.

Health spend – Capturing the relevant health expenditure for physical disability is difficult because of the broad range of health specialities, care groups and diseases covered. Key health spend incorporates acute hospital services, rehabilitation and specialist neurorehabilitation services, health continuing care spend, primary and community services.

Local Authority spend - The local authority community care budget currently supports 800 people with substantial and critical care needs with their care and

accommodation needs. This budget has been under continuing year on year pressure as people with higher dependency care needs remain living in their own homes.

In addition there are jointly commissioned and S75 services including the integrated community equipment service and intermediate care service.

The PCT and the Local Authority also have a number of contracts with the third sector and independent providers. The Joint Strategic Needs Assessment (Appendix C) captures the key budget lines for physical disability services.

The Physical Disability commissioning strategy must maintain performance where services are performing highly and support the delivery of new targets across the local health and social care economy. A further comprehensive needs analysis will inform work streams and monitoring of the associated action plan will ensure alignment of performance and financial reporting, budget planning and commissioning.

5. Service profile and future priorities

This section profiles current service delivery and highlights the future direction for service development, identifying local priorities for service improvement, key actions for delivery and desired outcomes.

A three-year action plan will be developed to steer implementation and monitor progress. Each work programme of the action plan will incorporate an Equalities Impact Assessment (EIA).

Five overall strategic objectives:

- **Strengthened involvement and engagement of disabled people and their carers in future service planning and development**
- **Strengthened person centred care and increased self directed support**
- **Promotion of independence and extended independent living opportunities**
- **Improving support to those with complex and higher dependency care needs**
- **Increased opportunities for local citizenship and participation in local communities**

Objective 1: Strengthened Involvement and engagement of disabled people and their carers in future service planning and development

Future direction:

World Class Commissioning places service user engagement and involvement at the centre of commissioning plans. The involvement of people with a physical disability and their representatives is key to ensuring the delivery of appropriate and responsive services. It is important to provide opportunities for people to voice their views on the services they have received and to influence the way services are planned for and provided in the future.

Local Position:

Locally work is underway to strengthen the involvement and engagement of service users and carers through the development of Local Involvement Networks (LINks[27]),

[27] LINkS Local Involvement Networks

and partnership working with the voluntary sector to widen service user engagement and representation.

Local priorities:

- To develop effective and inclusive structures to enable people with a disability, their carers and representatives to be fully involved in the planning and development of services, ensuring that those traditionally excluded are included and supported to fully participate
- To ensure user feedback is a central part of our planning and monitoring of services
- To secure appropriate user representation on key programmes of work

Key Actions:

- We will agree with service users and carers a model for future engagement to ensure full involvement in the implementation and monitoring of the physical disability strategy
- We will develop a service user led independent and healthy living centre

Desired Outcomes:

- Increased number of people engaged in the planning and development of services with representation and involvement from those traditionally excluded
- High quality, responsive services which reflect and meet individual need
- A reduction in health and care inequalities

Objective 2: Person centred care and self directed support

Future direction:

National policy[28] has been driving a reform of the way care is delivered with a strong emphasis on choice and personalised care, earlier intervention and prevention, streamlined assessment and the development of empowerment models of care and initiatives for consumer-directed care or self-directed support.

Local position:

Care navigation, coordination and management – To support this reform of care access to high quality information, care navigation and support services is required. Disabled people and their carers have told us that they were at times unaware of existing support and were unclear where to go for advice and help. Service users and their carers have asked for clear and easily accessible information[29] and for easier and faster access and re-access to services.

Locally a number of initiatives to improve signposting, care navigation and management have been introduced. The city has developed a number of models of care management including community matrons, a case management team and a number of specialist nurse posts. Integrated Care Pathways[30] (ICPs) have been developed across services to improve patient experience and ensure smooth transition between services and delivery of care[31]. Local protocols are in place for transitional care planning to ensure coordinated planning of care between children's and adult's services from the age of 14 years.

Self care and self directed support - The local authority social care transformation programme will transform the way care is delivered in the city, facilitating clearer and faster access to support and developing a stronger focus at assessment and review on reablement.

Currently personal care is purchased either through Direct Payments or the care management service. Uptake of Direct Payments in the past has been slow, but is now increasing. A detailed review of current systems was completed and nine

[28] The NSF for LT conditions, TCCP, Our health our care our say), Putting People First

[29] PCT DES , MS Stakeholder event

[30] A care pathway is the journey that individuals may expect to access the assessment and care interventions from the statutory and non-statutory agencies. The Chronic Disease Management strategy defines an ICP as a "multidisciplinary outline of anticipated care placed in an appropriate timeframe, to help a patient with a specific condition or set of symptoms move progressively through a clinical experience"

[31] Care pathways hare been developed for the following health conditions: stroke, chronic Obstructive Pulmonary Disease, Cellulitis, intravenous antibiotics, Management of infections, Heart failure, Falls, Urinary problems/catheters

recommendations are being followed to increase the local take up of Direct Payments. This includes building further flexibility into the scheme and further investment in the Direct Payment support service.

The target for 07/08 was for 70 services users with physical disability to be in receipt of a direct payment and for 08/09 the target was increased to 140. Progress against targets is overseen and driven by a cross agency Direct Payment Implementation Group.

The current national piloting of Individual Budgets[32] extends individual choice and control further. Users of social care services will receive a single assessment the purpose of which is to assist people to identify their need for support, how they wish these to be met and to determine the resource allocation. People will be able to choose from a range of services such as equipment, home care, housing adaptations and low level preventative services. Currently a pilot for individual budgets is underway within Adult Learning Disability services.

A Self Directed Support strategy will be completed during 09/10, which will outline the city's plan for the future extension, and development of self directed support options.

Local priorities:

- To develop clearly visible and integrated information services, which are responsive and accessible to the needs of people with a physical disability and their carers.
- To strengthen focus on earlier interventions and prevention services and initiatives.
- To improve co-ordination and management of long term health conditions through the development of integrated care pathways and personalised care plans to improve patients' experience of care.
- To increase the use of self directed support options, with more people purchasing care through Direct Payments and the introduction of individual budgets for people with a physical disability
- To deliver faster and more responsive assessment and review services with a strengthened focus on the promotion of independence and reablement.

Key Actions:

- We will develop a one-stop shop approach to information services through the centre for independent living. This will provide a focal point for support and advice to the wider community.

[32] Our health, Our Care, Our Say

- We will review current delivery of advice and advocacy services to ensure that they are relevant and fully accessible to disabled people, and are supporting people to manage self-directed care and increase opportunities for independent living.

- We will develop stroke prevention services in line with the national stroke strategy.

- We will introduce Expert Patient Programmes for those with long-term progressive neurological conditions and ensure that the wider expert patient programme is accessible, relevant and appropriate to people with a disability and peoples' cultural needs.[33]

- We will develop a self-care strategy to achieve optimum quality of life and health outcomes.

- We will recruit designated health trainers focused specifically on the health needs of those with long term neurological conditions to help people maintain health and remain living independently in their own homes.

- We will work with people to develop personalised care plans.

Desired Outcomes:

- Reduction and minimalisation of disability
- Increased number of people empowered to manage their health and care needs
- More streamlined interventions and improved co-ordination between services
- Improved access and reaccess to support
- Reduced number of unplanned hospital attendances and admissions and reliance on higher dependency care

[33] Ensure balanced programme in terms of age, gender, rate

Objective 3: Promotion of Independence and extended independent living opportunities

The Putting People First[34] vision and framework for a personalised adult care system supports independent living for all adults. To effectively promote independence and extend opportunities for independent living a whole systems approach to health and care is required with integrated care pathways and coordination of resources. A number of local services are key to the promotion of independence and independent living. These include specialist and general rehabilitation services, housing and primary and community services.

3.1 General and specialist rehabilitation – Rehabilitation following injury or severe illness can help to prevent or reduce long term disability, increase personal independence and bring quality of life benefits.

Rehabilitation is a complex process involving a range of approaches: clinical, social, vocational and educational. Therefore care must be well coordinated with clear referral processes, strong partnership working and good communication and team working across care pathway.

Specialist neurorehabilitation[35] services –The National Service Framework (NSF) for Long Term Conditions provides clinical evidence of the effectiveness of rehabilitation and emphasises the importance of flexible and responsive services which allow re-access to care as needs change[36].

A Sussex wide review of specialist neurorehabilitation is currently tasked with developing a commissioning framework to secure access to a comprehensive and integrated range of services for the adult population of Sussex.

Within the city of Brighton and Hove a broad range of specialist neurorehabilitation services are delivered. Services provided include a post acute inpatient service, an outpatient service and mobility service, a multi disciplinary community rehabilitation team and a vocational rehabilitation service. In addition other specialist services are spot purchased from the independent and voluntary sector including slow stream rehabilitation and/or specialist placements and specialist community outreach and day care.

For Brighton and Hove the key priorities are to ensure early access to appropriate specialist services and timely, smooth transition between services ensuring that care

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[34] Putting People First a shared vision and commitment to the transformation of adult social care (2007)

[35] The British Society of Rehabilitation Medicine (BSRM) [35] provides a conceptual and service definition of rehabilitation:

Conceptual definition: A process of active change by which a person who has become disabled acquires the knowledge and skills needed for optimal physical, psychological and social function

Service definition: The use of all means to minimise the impact of disabling conditions and to assist disabled people to achieve their desired level of autonomy and participation in society

[36] Eleven evidence-based quality requirements (QRs) are established throughout the patient care pathway. QR 4-6 are concerned with rehabiltation, adjustment and social integration

is person centred and provided as close to home as possible. Key issues to be addressed within the strategic action plan will include management of transfer of care and hospital discharge, access and reaccess to specialist support, and longer-term rehabilitation.

3.2 Housing and Housing with care - Suitable and decent housing is fundamental to the promotion of independent living and social inclusion. Providing accessible and adapted accommodation in the community with appropriate housing support is essential if people are to be supported to remain living independently in their own homes with their families and in their own communities. Key areas of housing support include accommodation to facilitate hospital discharge, access to accessible and adapted properties, and the provision of housing with care.

Managing hospital discharge – the under 65 population are seen to account for a significant proportion of local hospital discharge delays i.e. an average of 13.6% of total Brighton and Hove delays from acute care. This rate has risen by 15% over a two-year period (from 144 delays in 2005/06 to 169 delays 2006/07).

The Transitional Care Service[37] has experienced protracted delays for younger adults due to the complexity of individual need and limited available options for moving on. From January 2006 records show there have been 8 placements for under 65's with stays ranging from three weeks to 17 months.

Accessible and adapted properties – access to accessible and adapted property is key to supporting independent living. Following a service review wheelchair accessible properties are now designated for those with mobility disability and more support is given to those who are vulnerable to bid for accessible and adapted properties. The Housing Adaptations Service is responsible for completion of major and minor adaptations within public sector housing and major adaptations for the private housing sector[38]. This is an integrated case management service comprised of occupational therapists, technical and administrative staff.

Major adaptations are funded through two main sources the national Disabilities Facility Grant (DFG) for private sector housing and the Housing Revenue Accounts (HRA) for public sector housing. Completing major adaptations can be a lengthy process as the DFG requires a full tendering process for any works to be completed Whilst individual budgets will not initially include the DFG, a loosening to current ring-fencing will provide greater flexibility. Future priorities will be to improve access to accessible and adaptable accommodation through management of existing stock and optimum use of the DFG allocation, streamlining assessment and improving wait times for delivery of major adaptations.

Housing models with care and support - For those with more complex needs who are unable to live at home the development of extra care housing can offer people

[37] interim care/short term placement to facilitate hospital discharge

[38] The Integrated Community Equipment Service currently provides all minor (i.e. <£1,000) adaptations in the private sector.

an alternative to residential or nursing home care. Extra care housing has the potential to provide greater opportunities for independent living and increased choice and control over the care and support received through the delivery of personally tailored services.

Existing extra care housing services are primarily aimed at older people, however a successful central application in 2008 will enable the development of ten extra care flats specifically designed for adults under 65yrs with a physical disability.

3.3 Community equipment and assistive technology - The city's Integrated Community Equipment Store (ICES) is a jointly commissioned service within a Section 75 agreement for the provision of equipment. The Daily Living Centre (DLC) provides information and advice on equipment and is a demonstration centre for items of equipment. Telecare and assistive technology is provided as part of the Carelink service. Demand for community equipment has risen dramatically and a particular increase has been seen from the acute sector as more people are supported to live at home.

As of 2007 Telecare had received a total of 317 referrals for Telecare devices across all age ranges. The majority of requests were received directly from current CareLink users. Twenty-four installations had been completed including: smoke alarms, bed/chair occupancy sensors, property exit sensors, and temperature extremes sensors. Installs are scheduled for flood detectors, medication reminders, medication dispensers and bogus caller alerts.

Local priorities

- To improve access and reaccess to rehabilitation and reablement models of care including clinical, social, vocational and educational rehabilitation

- To ensure that care is well coordinated and delivered in the most appropriate setting, and as close to home as possible

Key Actions

- We will agree a commissioning framework for neurorehabilitation services across Sussex incorporating acute, post acute and community services, supported by a clinical network and local commissioning plans

- We will strengthen the neurorehabilitation earlier supported discharge model to provide more care closer to home and improve throughput from acute services.

- We will agree integrated care pathways and multi agency management of hospital discharge for people under 65 years

- We will develop extra care housing for adults under 65yrs

- We will increase use of assistive technologies telecare and telehealth to support independent living
- We will ensure carers of people with long term conditions have access to flexible, planned and emergency respite care

Desired Outcomes:

- Better health outcomes and improved well being
- Increased functional independence and reduced reliance on more higher dependency care models
- improved personal experience of care through greater choice and control improved wait times and more streamlined support

Objective 4 - Improved Support to those with complex and higher dependency care needs

For those with multiple and complex disabilities it is important to ensure that there is choice as to how needs are met, that the care received is of high quality and evidence based and that opportunities for independence and independent living are maximised.

A broad range of care options is required to meet the needs of individuals and to support independent living. Services must be person centred, responsive and flexible to changing needs.

Support to people in transition- support maybe required to assist people when leaving hospital or specialist rehabilitation services or when moving from children's services to Adult Social Care.

Within the city two to three young people are referred from Children's services each year. Generally their needs are very complex and specialist and currently there are a limited range of options to support the needs of this age range. As a result young people may remain within the family home or often need to move to residential care outside of the city for their needs to be met.

For those leaving hospital or specialist services and returning to independent living a wider range of support options are required including short-term support services, and access to supported and adapted housing.

Care home placements. Whilst this strategy aims to reduce reliance on higher dependency care access to high quality 24 hr care within the city is required as part of a broad range of care services.

Currently care home placements are purchased by the Local Authority or Health (via continuing care) jointly or by individuals funding their own care. All placements are purchased through spot contracts and from a range of independent providers.

The number of people with a physical disability living out of the city in care home placements whilst small has remained constant for a number of years and accounts for about a quarter of the allocated funding in physical disability adult social care services.

Continuing health care funds an increasing number of placements for those with a physical disability. Over the past two years the costs of placement activity has increased significantly.

Intensive personal and live in care

The number of people living at home with intensive care packages is again very small but accounts for just under half of the allocated adult social care funding Personal care is provided by the independent sector and the local authority home care service. The local authority service focuses specifically on hospital discharge, complex needs, terminal care and prevention of admission.

A study of Local Authority placement activity showed:

- 05/06 a total of 98 placements over the year, with up to 45 placements at any one time. There was a turnover of 53 placements over the year and a turnover of 4 placements monthly.
- A snapshot study[39] showed 41 longer-term placements 22 within residential homes and 19 in nursing homes. Of which 41% were provided within Brighton and Hove
- 05/06 had a high average unit cost of £804 for people with a physical disability between 18 and 64 years (nursing home council contribution averaging at £611 per week and residential care at £977 per week)
- 390 home care packages were delivered during the course of the year with 280 care packages delivered at any one time.
- Of home care packages delivered 35% were low cost packages of care (weekly cost less than or equal to £50) 22% were medium cost packages of care (weekly cost £50-£100) and 10% were high cost packages of care (weekly cost greater than £500).
- Of the 28 high cost packages of care, the cost ranged from £500 to £2,250 per week with an average total weekly cost of £44,556..

[39] Snapshot study

- All live in care was provided in the independent sector, by a total of 17 independent providers. Only two specialist agencies provided a brokerage service for live in care

- Health funded a total of 17 ABI or physical disability placements. Weekly contributions ranged from £126.72 to £1,845 with a total weekly cost of £14,640 and a total annual cost of £667,330.

Local Priorities:

- To develop local alternative models of care which enable people to remain or return to more independent living so reducing reliance on longer term care options and providing value for money for the city

- To ensure all providers endorse a strong ethos of independence and provide opportunities where possible for greater independence, moving on and a return to independent living

Key actions:

- We will agree a commissioning framework across social care, housing and health, which develops capacity within the city to support those with complex needs. To include: improved access to short term services for those in transition (e.g. those leaving hospital or specialist rehabilitation services or children's care services) and longer term support services for those who wish to return to the city from out of area placements and those wishing to remain living independently within their own homes

- We will explore models for further integrated working for those with complex health and care needs to ensure that people's needs are being met most appropriately and to facilitate a greater focus on independence and independent living.

- We will develop quality supported and adapted housing options as an alternative to higher dependency care options

- We will develop local slower stream rehabilitation opportunities for people leaving hospital following spinal injury, acquired brain injury and stroke to facilitate greater independence and a return to independent living.

- We will strengthen current procurement initiatives to ensure high quality and value for money care is purchased for the city's population

Desired outcomes:

- Increased individual choice through a broader range of care options
- An increased number of people with complex needs supported locally within the city
- Improved service user experience of care through smoother transition between care services
- Improved quality and value for money services within the city

Objective 5: Increased opportunities for local citizenship and participation

The Disability Discrimination Act legislates that disabled people must enjoy the same rights and opportunities as other members of the community to participate in education, training, employment and leisure. Government policy is leading a welfare reform, demanding further action to support disabled people in the labour market e.g. The Pathways to Work[40] pilots introduced by the Department of Work and Pensions to encourage and assist people on Incapacity Benefit to return to work.

Access to mainstream activities and services is key to enabling people to participate in social, family and community life. People with a physical disability may need support to maximise opportunities and our services will need to address how best to achieve this.

Employment support and vocational rehabilitation support – a number of services are provided locally to support people whilst in work and to help people start and return to work. Coordination of services and improving access to relevant services will ensure that people are supported and have increased working opportunities.

Transport - Disabled people and carers have requested increased flexible transport options to assist them in their every day lives. They have told of the difficulties they have in attending health appointments and of a loss of independence with inflexible transport arrangements. Carers have told of difficulties coordinating transport with care arrangements and in attending health appointments with the person they care for.

Day Care - the local authority and independent providers currently provide Day care. The local authority day care service is at Montague House. The service has an average total of 73 service users with most people using the centre between two and three times a week. The majority of service users are aged between 56 and 65

[40] Pathways to Work Dept of Works and Pensions - Pathways to Work provides a single gateway to financial, employment and health support for people claiming incapacity benefits.

years. The service facilitates external training courses selected by service users and hosts the low vision clinic. Specialist day care and outreach work is commissioned through the independent voluntary sector.

Local priorities:

- To increase access to mainstream employment,trainingand leisure opportunities
- To support carers in their caring role so that they are able continue to manage own health, everyday lives including work

Key Actions:

- We will develop a centre for independent living to deliver a one stop shop approach to independent living, improving access to information, advice and support for the city's disabled community. This will involve a multi agency review of current services to compliment and maximise resources.
- We will coordinate and promote existing support services to maximise opportunities for greater access to employment, training, community and leisure opportunities
- We will link with the Disability Equality Scheme review to scope existing accessibility to mainstream activities and include a review of our existing transport links.

Desired Outcomes:

- Improved health and wellbeing and a reduction in health and social inequalities
- Increased number of people and their carers participating in employment, training, other meaningful daily activities
- Improved access to mainstream community resources and activities

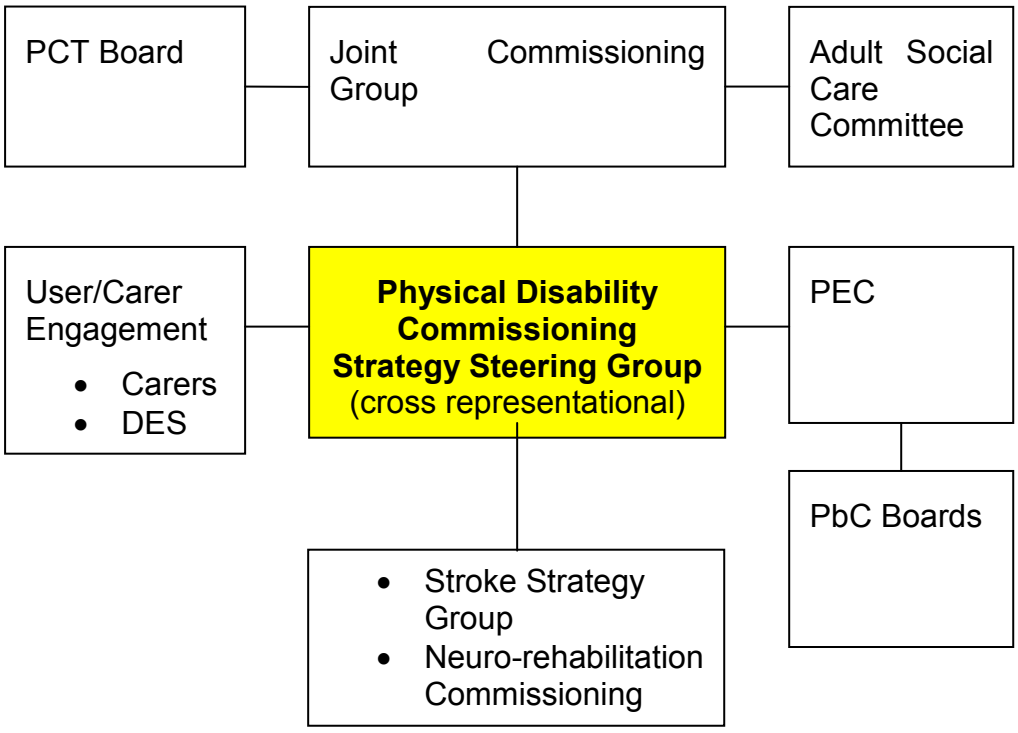
6. Next Steps

Implementation and Governance

A Physical Disability Commissioning Strategy Steering Group will be established to lead the implementation of the Physical Disability Strategy and associated three-year action plan. The steering group will be responsible for the annual work plans and the monitoring of key projects.

The group will have representation from across the local health economy and will secure appropriate public and provider engagement.

The steering group will be accountable to and report on progress for all key projects to the Brighton and Hove City PCT Board, Brighton and Hove Local Authority Adult Social Care Committee and the Joint Strategic Commissioning Group.



Appendices

Appendix A – Relevant policy, strategy and legislation

Appendix B – Public Health Report

Appendix C – JSNA and Three Year costed plan

Appendix A - Relevant Policy, strategy and Legislation

1. National Guidance -The main guiding legislation and national policy for the Physical Disability strategy are as follows:

The Disability Discrimination Act (DDA) 1995 and The Disability Equality Duty (05)
Since Dec 96 it has been unlawful to treat disabled people less favourably than other people for a reason related to their disability. Reasonable adjustments must be made to ensure equity of access for disabled people this is to include adjustments to the physical environment to overcome physical barriers, and adjustments to the way services, and goods are provided. Since December 06 public bodies have had a duty to promote disability equality

World Class Commissioning and the Darzi eview "our NHS, Our Future" (07)
Provides the vision for future excellence in NHS commissioning with the overall objective of adding life to years and years to life. The three key principles outlined are: better health and well being , better care and better value for all, underpinned by the organizational competencies required to deliver

NHS Improvement Plan; Putting People at the Heart of Public Services (05)
Introduced the next stage of the modernisation of the health service and shift to personalised care, a focus on health and well being not only illness and further devolution of decision making to local organisations.It outlined the governments commitment to improving the care and quality of the life for people with long term conditions with a health service designed around the patient.

Choosing Health – 2004 public health white paper outlines key principles for supporting the public to make healthier and more informed choice about health

The Health and Social Care Planning Framework 05-06 and 07-08 and National Standards, set the framework for the planning and commissioning of future services and introduced a standards driven system. A number of core developmental standards were set

Our health, our care, our say: a new direction for community services' (DOH 2006)
The white paper set the strategic direction for health and social care services and introduced a number of initiatives to bring about a major shift in the delivery of care.. Health and social care services are to become more person-centred, flexible and responsive to individual needs, people are to have greater choice and control over the way in which their needs are met and how services are delivered and improved.

Putting People First: **A shared vision and commitment to the transformation of Adult Social Care** Sets out the direction for adult social care over the next 10 year; the shared aims and values which will guide the transformation of adult social care. It recongises the need to work across services and agendas with users and carers in order to transform people's experience of local support and services. Emphasis is given to access to univeral services, early intervention and prevention, choice and control and social capiotal (ensuring people are able to participate in communities)

Improving the Life Chances of Disabled People, Prime Ministers Strategy Unit (05) This report outlines how improving the life chances of disabled people must consider four key areas. They are by helping disabled people to achieve independent living, by improving support for families with young disabled children, by facilitating a smooth transition into adulthood and by improving support and incentives for getting and staying in employment. Strategy for disabled people is led by the Office for Disability Issues which reports to the Minister for Disabled People.

In addition to the above a number of national quality standards and best practice guidance are relevant to the physical disability strategy such as:

National Stroke strategy Dec 2007 outlines the vision for future improvements to and development of stroke care. The strategy includes a 10 point action plan and 20 Quality Markers to drive service improvements in the delivery of stroke care

The NSF Long term Conditions 2005 introducing a ten year programme of change to be fully implemented by 2015. The aim of the NSF is to ensure that services are patient-centred. Whilst the NSF has a focus on neurological conditions, the standards and 11 quality requirements are also relevant to other long-term conditions as well

Other relevant clinical guidelines and service standards include:

- Royal College of Physicians (RCP) Guidelines for Stroke,
- National guidelines for Acquired Brain Injury
- National Institute for Clinical Excellence (NICE) (including guidelines for :Multiple Sclerosis, Epilepsy)
- Standards for services for people who are deaf/blind

2. Relevant local strategies - in response to national policy and guidance the following local documents are relevant to physical disability services:

Disability Equality Schemes - Locally disability schemes have been developed by all major trusts.Our commissioning responsibility is to ensure that contracts and service level agreements reflect and contribute to the aims of local schemes and:

- Address equality issues with clear policies for tackling discrimination experienced by disabled people
- Support disabled people to achieve their full potential

Strategic Commissioning Plan - outlines the overall commissioning plan for the city's health care services. It sets out the plans for improving health care services in line with World Class Commissioning and the Darzi Review

Older Peoples strategy (2007-2010) –provides a three year plan for the commissioning of health and social care services for older people in Brighton and Hove.

Extra care housing strategy - the development of extra care housing is consistent with the strategic aims of *Our health, our care, our say* and *Putting People First* in ensuring that people: have a better quality of life; exercise maximum control over their lives; are enabled to live independently; and, are treated with respect and dignity.

Discussion paper for proposed reablement model for Brighton and Hove Adult Social Care and Housing Service - This paper sets out a clear direction for adult social care in Brighton and Hove where people will be supported to learn or re-learn skills that enable them to accommodate their condition and hence maximise and sustain their independence. This approach will form an integral part of responding to the social care needs of people with a physical disability and will complement the rehabilitation services provided through the health service.

Housing Strategy 2008 -2013 Consultation Draft - healthy homes, healthy lives, healthy city The Housing Strategy is an overarching document that focuses and co-ordinates a number of other housing related strategies The citywide housing strategy has 3 overall priorities that reflect the basic housing needs of the city: Improving housing supply, Improving housing quality and Improving housing support

Self Directed Care Strategy

Self Care Strategy (05-08) - Currently being refreshed

Carers Strategy - Joint commissioning strategy under development

3. Supporting legislation

Key legislation to supporting the strategy include

- National Assistance Act 1948
- Chronically Sick & Disabled Persons Act 1970
- NHS & CCA 1990
- Community Care (Direct Payments) Act 1996
- Disability Discrimination Act 1995
- Disabled Person (Services, Consultation and Representation) Act 1986
- Human Rights Act
- Race Relations Act
- Carers Act
- Housing legislation

Estimating the prevalence of physical disability in working age adults in Brighton & Hove

The purpose of this paper is to provide estimates of the numbers of working-age people with physical disability in Brighton and Hove. The main focus of the paper is on working age adults. The paper includes information about people in older age groups and makes comments about information about young people in transition to the adult services.

Although it would be helpful to have information about the incidence of physical disability as well as prevalence, this is not routinely available at the general population level and therefore prevalence estimates have been used. While the incidences of specific diseases which may lead to physical disability are available, the incidence of disability associated with the condition is not always available.

Most of the information presented is from national data sources applied to the local population.

1. Definitions of disability

Physical disability affects a wide range of people in a wide range of ways; it can arise as a result of an accident, illness or congenital disorder and may be caused by a range of health conditions such as neurological, circulatory, respiratory and musculo-skeletal disorders. It can affect a person suddenly such as stroke or over a period of time as in multiple sclerosis. It may be a static condition or one which fluctuates as with rhematoid arthritis. Conditions that lead to physical disability can arise at any stage of life. Some people are affected by more than one condition or have an additional sensory impairment, while others experience significant periods of ill-health as a feature of the disability.

The World Health Organisation (WHO) began the process of defining disability with the International Classification of Impairments, Disabilities and Handicaps (ICIDH). This framework described four terms: pathology, impairment, disability and handicap (see Table 1) (WHO, 1980).

Table 1: Framework of international classification of impairments, disabilities and handicaps

Term	Definition
Pathology	Abnormalities or changes in the structure or function of an organ or organ system.
Impairment:	Any loss or abnormality of psychological, physiological, or anatomical structure or function.
Disability:	Any restriction or lack (resulting from impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.
Handicap:	A disadvantage for a given individual, resulting from an impairment or disability that limits or prevents fulfilment of a role that is normal, depending on age, sex, social or cultural factors' (WHO, 1980).

Within this framework, which is often called the medical model of disability, a person's functional limitations (impairments) are cause of any disadvantages experienced and these disadvantages can therefore only be rectified by treatment or cure.

The International Classification of Functioning, Disability and Health (WHO, 2001) has evolved from the ICIDH and allows for a dynamic rather than static or linear assessment of the interaction between functioning and disability, where: functioning refers to all body functions, activities and participation, while disability refers to impairments, activity limitations and participation restrictions.

The social model of disability is defined by the Union of Impaired People Against Segregation as:

> *"The disadvantage or restriction of activity caused by a contemporary social organisation which takes little or no account of people who have a physical impairment and thus excludes*

them from the mainstream of social activities". (Union of the Physically Impaired Against Segregation. Fundamental Principles of Disability, London, 1976.)

It shifts the focus from impairment onto disability, using this term to refer to disabling social, environmental and attitudinal barriers rather than lack of ability. The social model of disability makes the distinction between 'impairment' and 'disability' (see Table 2).

Table 2: Social model definitions of Impairment and Disability

Term	Definition
Impairment	An injury, illness, or congenital condition that causes or is likely to cause a long term effect on physical appearance and / or limitation of function within the individual that differs from the commonplace.
Disability	The loss or limitation of opportunities to take part in society on an equal level with others due to social and environmental barriers.

2. The population of Brighton & Hove

When making predictions about the prevalence of conditions such as physical disability in a population it is essential to define what that population is. There are a number of different sources of information about the population of Brighton & Hove. The 2001 Census was the last accurate measure of the resident population the city. However, over the past five years the population profile will have changed as the population ages, through births and deaths, and through migration in to and out of the city. The Office for National Statistics (ONS) produces population projections based on fertility, mortality and migration trends over the past 5 years at a national level. These are released on a regular basis, the most recent release being the 2004 mid-year estimates. In addition to these projections, the Brighton & Hove City Council (BHCC) has produced Local Population Projections that are also trend based, but have taken into account what are considered more realistic trend based assumptions for the city of Brighton & Hove (council doc). Although these Local Population Projections were intended to be used to inform future service planning and are based on local data, they are limited in their usefulness in estimating disability prevalence as they do not provide separate estimates for female and male populations. These estimates also aggregate the working age population to encompass all people from 18 years of age to retirement age (BHCC research briefing six), this is different for women (60) and men (65) making age specific estimates difficult.

Comparing the estimated changes in the population of the ONS with the BHCC projections (Table 3) shows that there is very little difference in the actual numbers of the total population (0.2%) and of the working age population (4%) although this comparison will not be entirely accurate due to the differences in the age groups.

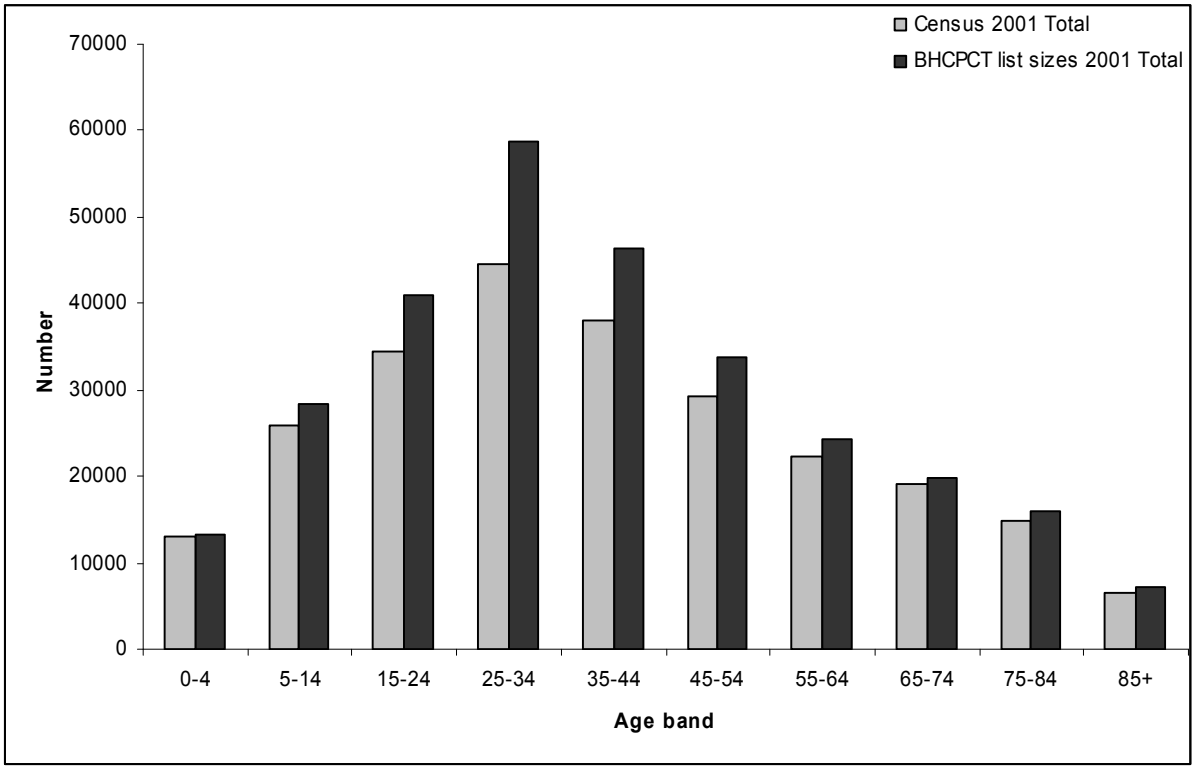
Table 3: Differences in ONS and BHCC population for Brighton & Hove in 2004

Age Group	2001 Census population	ONS 2004 mid-year estimates		BHCC 2004 projections		
		Population	% difference from census	Population	% difference from census	Percent difference from ONS mid-year estimate
All ages	247 817	251 900	+1.6%	252 450	+1.9%	+0.2%
Working age*	168 535	174 900	+3.8%	167850	-0.41%	-4.0%

*ONS & Census – working age 15-64 for men and women
BHCC – working age 16-64 for men and 16-60 for women

A further complication to estimating the population of Brighton & Hove is the difference between the resident population of the city and that of the Primary Care Trust registered population. There are greater numbers of patients registered with the PCT than were recorded in the 2001 Census (Figure 1).

Figure 1: Differences in the 2001 PCT registered population and the 2001 census population for Brighton & Hove, by 5-year age-band



As can be seen in Figure 1 the greatest difference between the census and PCT population is in working-age adults, in particular in those aged 25-34 where there is a 19% difference. Brighton & Hove has a highly mobile population, particularly in this age group. Some of the excess is likely to be due to patients who have registered with a practice and then not notified practices when they have moved to another GP either within the city or elsewhere, so called 'ghost patients'. However, the bulk of these patients are likely to be individuals live outside the boundaries of Brighton & Hove but who are registered with one of the cities GPs either because they work in the city or because they have retained their GP after moving out of the city. As practices move towards restricting registrations to those people who live in close proximity to the practice discrepancy between the populations should diminish.

For this piece of work most of the predictions of levels of disability in Brighton & Hove are based on the 2001 Health Survey for England (see Section 3). As a preliminary step, the population used as a baseline is the 2001 census. Estimates based on other population sources will be calculated once it is agreed which are felt to be the most appropriate. These numbers will be slightly different to the expected currently due to changes in the population. However, the estimated difference in population in 2004 when compared to the 2001 census is small for both the total population and the working age population (see Table 3) meaning that any differences in estimated prevalence of physical disability within the city will also be small.

3. Data sources

3.1 National

3.1.1 2001 Census

The 2001 Census included a question about disability focussed on long term and limiting long term illness. The question used was:

> *Do you have any long-term-illness, health problem or disability which limits your daily activities or the work you can do?*

Though helpful, the question is a broad one and therefore cannot be considered as a pure measure of physical disability.

3.1.2 Health Survey for England

The Health Survey for England (HSE) comprises a series of annual surveys which began in 1991. The series is part of an overall programme of surveys commissioned by the Department of Health and is designed to provide regular information on various aspects of the nation's health. Each year there are a 'core' set of questions and bio-medical measures included in the survey, and each survey has a specific focus topic that is periodically repeated. Physical disability has been the focus of the 1995 and the 2001 HSE.

All surveys have covered the adult population aged 16 and over living in private households in England and children have been included since 1995. The HSE does not provide information on that part of the population living in communal establishments, such as care and nursing homes. Although this limitation is most relevant to older people with physical disability, those people of working-age with severe physical disability living in these establishments may be under represented in the survey.

The 1995 HSE provided baseline data for disability prevalence. However, the 2001 HSE provides the latest estimates of the prevalence of disability among those living in private households. It aimed to provide a representative sample of the population and involved interviews with 15 647 adults (aged 16 and over) and 3993 children aged under 16 (HSE 01).

The Health Survey used an adaptation of the World Health Organisation (WHO) classification system for impairments, disabilities and handicaps, and questions were adapted from the WHO protocol which was designed to estimate the percentages of the population experiencing different levels of long-term disability, with two levels of severity:

- Low (moderate)
- High (serious)

Responses to questions were scored on a scale of 0-2, where 1 and 2 indicated disability and 0 indicating no disability.

The disability questions in the HSE 2001 covered limitations in functional activities (seeing, hearing communication, walking and using stairs) and activities in daily living (getting in and out of bed or a chair, dressing, washing, eating and toileting). These were grouped into five disability types:

- Locomotion;
- Personal care;
- Seeing;

- Hearing; and
- Communication

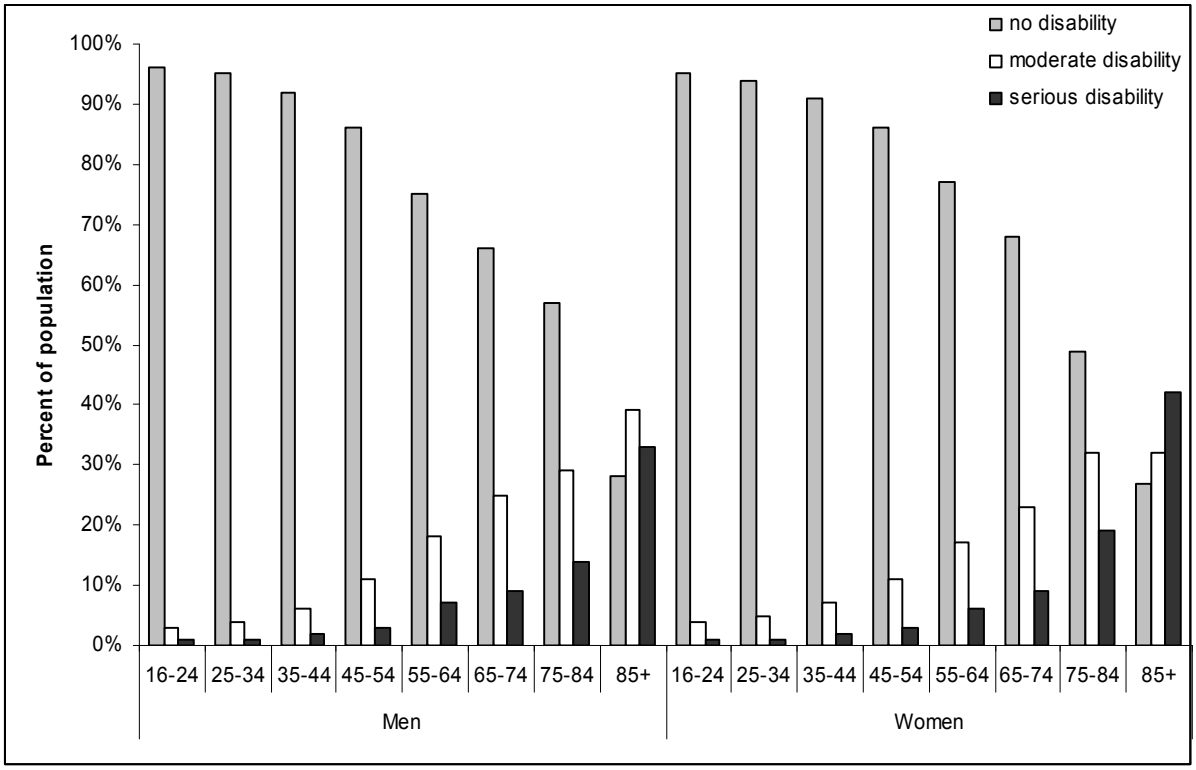
Mental illness was not included.

3.1.3 Findings of the Health Survey for England 2001

3.1.3.1 Prevalence of all disability

- Eighteen percent of males and females of all ages reported having at least 1 of the five types of disability.
- 5% reported having a serious disability.
- The prevalence and severity of disability increases with age for both men and women (Figure 1) with the mean age of those reporting at least one disability 62 compared to 44 for those respondents reporting no disability.

Figure 2: National prevalence of disability* severity by age and sex



* includes locomotor, personal care, hearing, sight and communication disabilities

- For respondents of working age (16-64) the percentage of severe disability was 2.4% for men and 2.1% for women and for moderate disability this was 7.5% for men and 7.3% for women.
- For those aged 65 and over the percent of moderate and severe disability increases for both men and women to 13% and 27% respectively.
- For those respondents age 75 years and over the prevalence of disability was greater in women than men; and for those aged over 85 seven out of ten respondents had at least 1 disability, with 42% of women and 33% of men reporting a serious disability.
- Figure 3 illustrates the number of people estimated to have at least one moderate or serious disability in Brighton & Hove by sex and age. For men the highest numbers reporting

moderate disability occur between the ages of 55 and 74 with serious disability rates highest between 55 and 84. For women the highest numbers of individuals reporting moderate disability occurs slightly later, between the ages of 65 and 84, with serious disability numbers highest in ages 75 and over.

Figure 3: Age profile of those with moderate and serious disability - estimated number using Brighton & Hove 2001 Census population

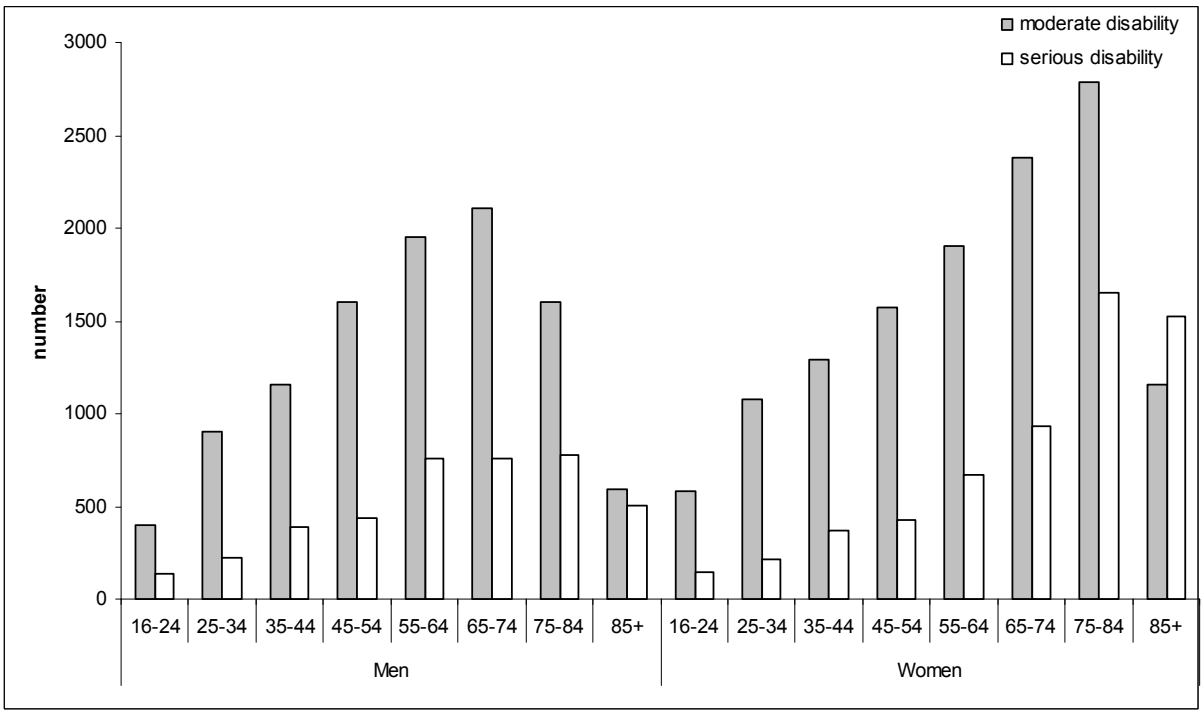


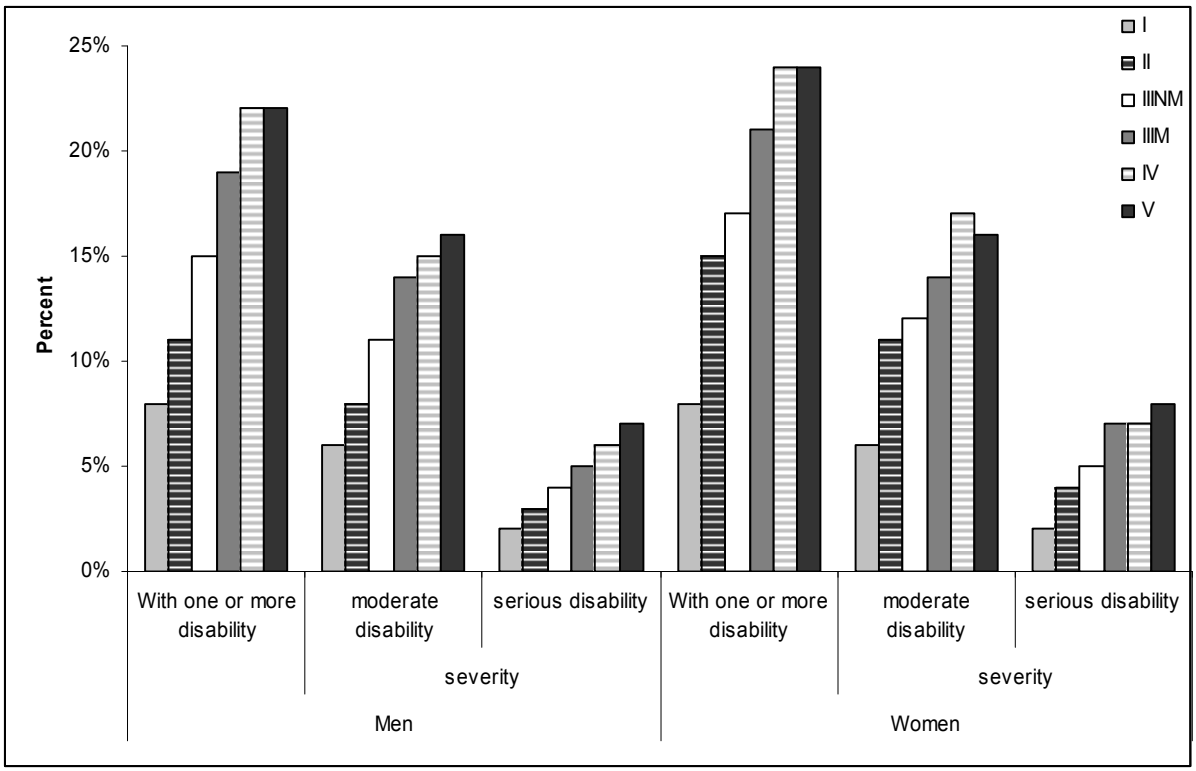
Table 4: Estimates number of people in Brighton & Hove with no disability, moderate disability and serious disability, by age and sex – estimated from 2001 Census population

	men		Women	
	Working age (16-64)	65 and over	Working age (16-64)	65 and over
no disability	72498	9131	71804	12270
moderate disability	6009	4302	6431	6321
serious disability	1939	2035	1832	4105

3.1.3.2 Social Class

There is a strong relationship between disability and social group, with those in lower social groups (IIIM, IV and V) reporting higher rates of disability and more severe forms of disability than those in higher social groups (I, II and IIINM) (Figure 4).

Figure 4: Percent of population reporting one or more disability by severity, sex and social group.



3.1.3.3 Type of disability

Physical disability

There were two forms of physical disability assessed in the HSE:

1. Locomotor disability

Locomotor disability was assessed by asking the participants in the survey whether they required any level of assistance in walking 200 metres, climbing 12 stairs without resting and retrieving things from the floor. Locomotor disability was the most commonly reported type of disability.

- 12% of men and 14% of women reporting this type of disability with 3% men and 4% women reporting serious disability (Figure 5).
- For working age adults 5% of men and women reported having moderate locomotor disability, with 1% of men and 2% of women of the same age reporting a serious locomotor disability.
- This increased in the over 65s with 22% of men and 24 % of men reporting moderate locomotor disability and 9% men and 14% women reporting serious locomotor disability.
- For respondents over 85 32% of women and 22% of men had serious locomotor disability.
- Table 4 gives the estimated numbers of people with serious (2390) and moderate (8496) locomotor disability.

Figure 5: Number of adults expected with physical disability by age – estimated number using Brighton & Hove 2001 Census population

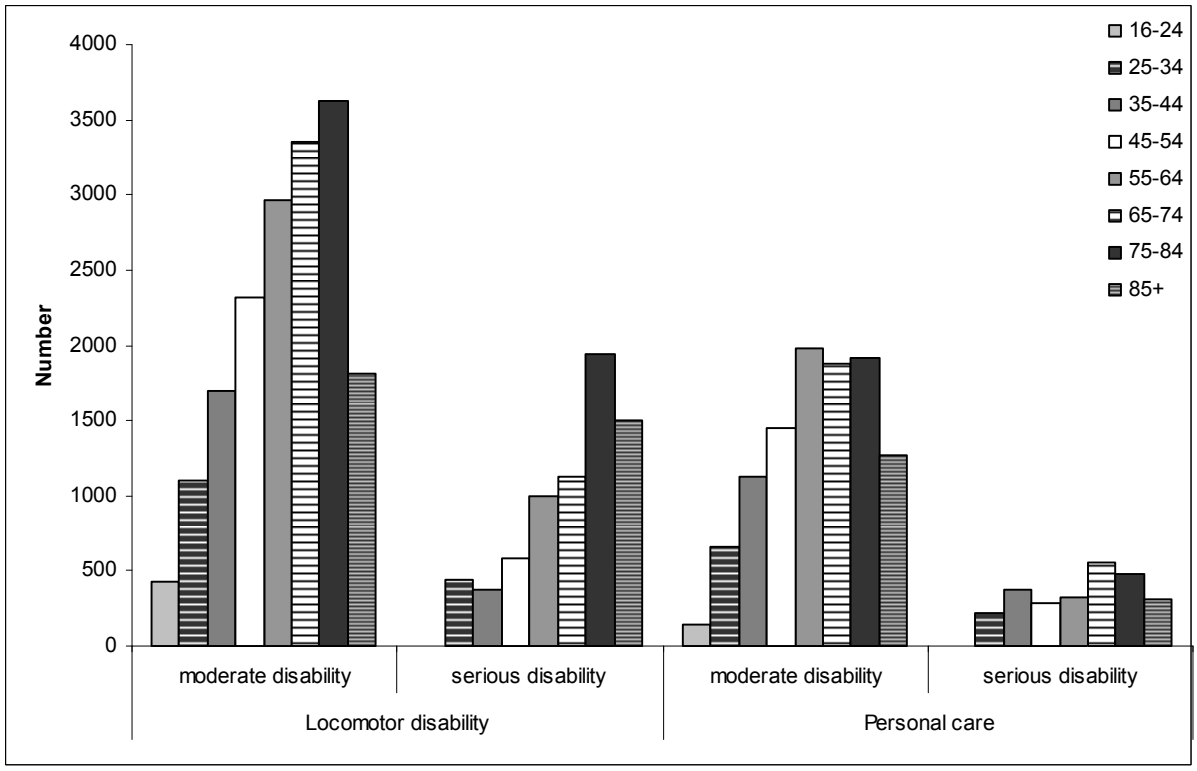


Table 4: Estimated number of people in Brighton & Hove with moderate and serious disability by sex and disability type – estimates based on the 2001 census population fro Brighton & Hove

Disability type	Moderate			serious		
	Men	Women	Total	Men	Women	Total
Locomotor	4146	4350	8496	1143	1247	2390
Personal care	2508	2855	5363	781	439	1220
Sight	804	913	1717	108	112	220
Hearing	2085	1278	3363	108	0	108
Communication	804	585	1389	434	0	434

2. Personal care disabilities

The inability to perform self-care tasks or Activities of Daily Living without help is widely used in social surveys as a measure of physical dependency (HSE01). Personal care disabilities were the second most common type of disability reported in the survey. Activities of Daily living include getting in and out of bed or a chair, dressing, washing, eating and toileting.

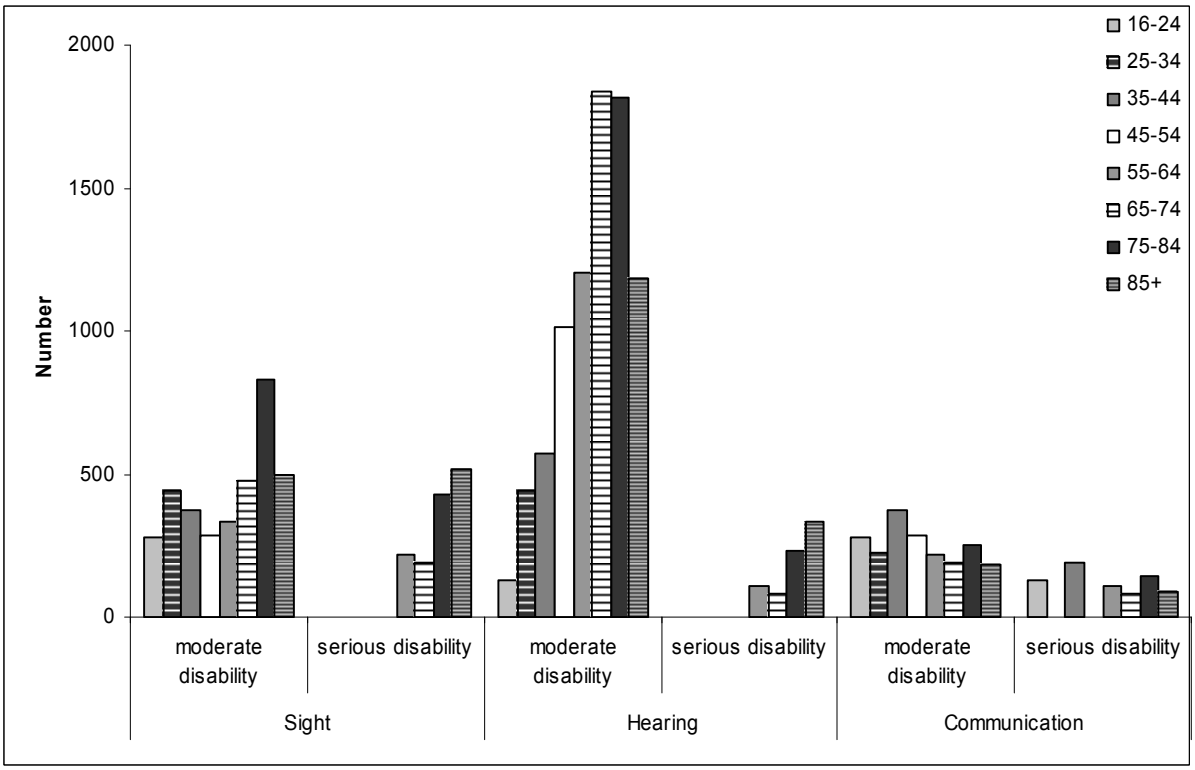
- Figure 5 illustrates the number of people estimated to have at least one personal care disability in Brighton & Hove, by severity.
- Table 4 gives the estimated numbers of people with serious (1220) and moderate (5363) personal care disability.
- Overall 6% of men and 7% of women reporting this type of disability. 1% of men and women were unable to perform any of the Activities of Daily Living.
- 3% of man and 4% of women of working age reported a moderate level of personal care disability with 1% of men and o.5% women in this age group reporting a serious personal care disability.

Other Disabilities

There were three other types of disability measured in the HSE 2001, hearing, sight and communication. The proportion of individuals reporting these types of disabilities were small, especially for those of working age. See Figure 6 for estimates of people in Brighton & Hove with one of these disabilities by severity.

- Working age men reported a higher rate of hearing disability (3%) than women (2%)
- The prevalence of sight and communication disabilities was low, with only 1% of working age men and women reporting any type of sight disability. Only 1% of men and women across all age groups reported having a communication disability, it has been acknowledged that this may be an under-representation as there may be a non-response bias in this group.
- See Table 4 for the number of people estimated to have sight, hearing and communication disabilities in Brighton & Hove.

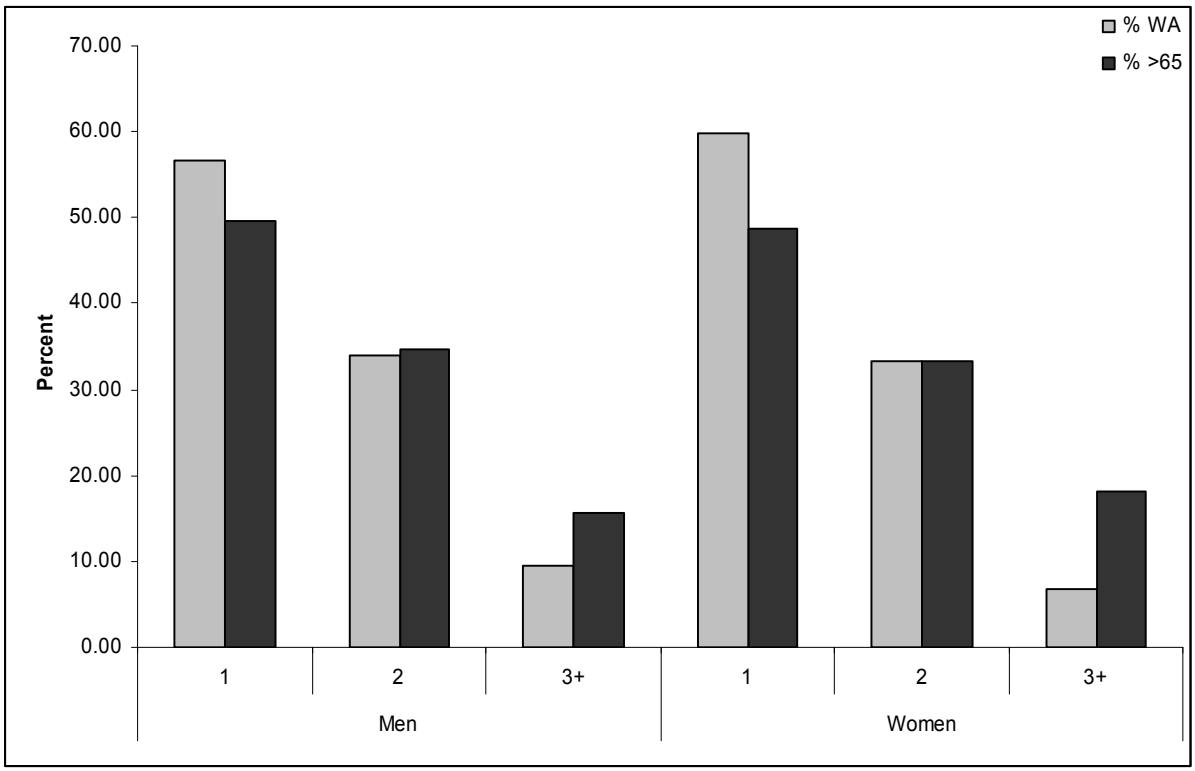
Figure 6: Number of adults expected with other disabilities by age – estimated number using Brighton & Hove 2001 Census population



3.1.3.3 Number of disabilities

- Overall 55% of those respondents with a disability had one disability, with 33% reporting two disabilities and 10% 3 or more disabilities.
- Figure 7 illustrates the relationship between age and number of disabilities, 58% of working age people with a disability have a single disability compared to only 49% of those aged 65 and over. Eight percent of working age respondents reported having 3 or more disabilities, less than half that of those over 65 reporting the same number of disabilities (17%)

Figure 7: Percent of respondents with at least one disability by number of disabilities identified, age and gender.



3.1.4 Other national data sources

There are a range of academic studies which have estimated the prevalence and incidence of various conditions associated with physical disability. These can be used to estimate the prevalence and incidence of specific conditions in Brighton and Hove (see Section 4).

3.2 Local Data

3.2.1 Limiting long-term illness, results from 2001 census

The results for Brighton & Hove from the 2001 census are summarised below in Table 5

Table 5: Numbers of people in Brighton & Hove identifying as having a limiting long-term illness in 2001 census, by age and sex

	Males				Females			
	0 to 15	**16 to 49**	**50 to 64**	**65 +**	**0 to 15**	**16 to 49**	**50 to 64**	**65 +**
Population	*20,865*	*64,459*	*18,520*	*16,053*	*20,406*	*64,650*	*18,473*	*24,405*
With Limiting Long-Term Illness	**1,204**	**6,602**	**5,107**	**7,850**	**873**	**6,073**	**4,762**	**12,468**
Good or Fairly Good Health	979	3,861	2,569	4,677	698	3,428	2,545	7,382
Not Good Health	225	2,741	2,538	3,173	175	2,645	2,217	5,086
Without Limiting Long-Term Illness	**19,661**	**57,857**	**13,413**	**8,203**	**19,533**	**58,577**	**13,711**	**11,937**
Good or Fairly Good Health	19,545	56,912	13,077	7,948	19,439	57,429	13,337	11,577
Not Good Health	116	945	336	255	94	1,148	374	360

According to the 2001 census 22 544 adults of working age identified themselves as having a limiting long-term illness in Brighton & Hove (Table 5). This figure is much higher than the estimated figure of 16 211 working age adults having at least one moderate or serious disability derived from the HSE01 results (Table 4). This is unsurprising as the census question is much broader in its remit than the HSE

3.2.2 Health counts

In 2003 a local lifestyle and social capital survey, *Health Counts*, was sent out to a 2% sample of the Brighton & Hove population. The survey included questions on general health perceptions, functional status and well being. Compared to the census, a higher proportion of people in the lifestyle survey reported a limiting long-term illness (33% compared to 18.2%). This may be a result of the higher proportion of older people responding to the survey.

This data could be analysed further to examine the responses of those respondents who identified themselves as having a limiting long-term illness.

3.2.3 Disability benefit claimant

The Disability Living Allowance (DLA) provides income support for adults and children who require assistance with personal care or have difficulty walking because of physical or mental disabilities. Incapacity Benefit (IB) Allowance provides income support to those people under the state pension age who cannot work because of illness or disability. The numbers of people registered for these allowances gives some limited information about the level of disability in Brighton & Hove.

Table 6 provides a breakdown, by age, of the number of people claiming the two types of disability allowance in Brighton & Hove in August 2004.

Table 6: Number of disability allowance claimants in Brighton & Hove, August 2004

Allowance	Disability living				Incapacity benefit and severe disablement					
Age band	**0-16**	**17-59**	**60+**	**Total**	**Under 30**	**30-39**	**40-49**	**50-59**	**60+**	**Total**
Number of claimants*	1310	6050	2800	**10 260**	1280	2905	3245	3745	1310	**12 585**

**snapshot taken from www.neighbourhood.statistics.gov.uk/dissemination, August 2004*

The number of person's claiming these allowances of working age are 8850 for DLA and 11 175 for IB (to claim IB a person must be of working age, therefore all claimants aged under 30 have been included). It is possible that claimants of DLA will also be receiving IB so it is difficult to determine from these figures the exact number of persons claiming some kind of disability allowance.

3.2.4 Data from Brighton & Hove City Council

Using the Care First information system the City Council has information about residents of Brighton and Hove with physical disability who have been assessed and also those people who have received a service. Not everyone within the city with a physical disability will be in contact with social services.

There are several potential local sources of information about children with physical disability. The education department and the new children's trust may be able to provide information on young people in transition to adult services. Information on the number of children with special needs can also be provided by the Compass database. The latter is a database of children with

special needs. Parents can self-refer and register their children. The parent's views on the severity of their child's condition may differ from the views of the professionals involved in their child's care.

At the end of March 2006 there were 1011 clients aged 16-64 were identified as having a physical disability, of these 986 were in receipt of services and 25 were being assessed. During the financial year 2005/06 1453 clients received a service. During this period no clients transferred from children's services.

A more detailed breakdown of the number of clients and the types of services accessed for the period 2004-05 to 2005-06 was obtained from Care First. However, there were many difficulties in extracting client data from the care first system and there were concerns raised about the accuracy of some of the detail and how it reflected actual service provision. Because of these difficulties and the limited number of years data available the data following should be interpreted with care as it may not reflect the whole picture.

Over 90% of clients were helped to live at home (92.1% 2004-05; 94.4% 2005-06), with only 7% of clients requiring long-term residential care. Of those receiving long-term residential care a larger proportion were male, this was reversed for those receiving help to live at home.

Table 7: Gender breakdown of clients helped to live at home or in long term residential care 2004/05 and 2005/06

	2004-05		2005-06	
	Male	**Female**	**Male**	**Female**
Helped to live at home	46.2%	53.8%	44.7%	55.3%
(n)	(308)	(358)	(448)	(555)
Long term residential care	59.6%	40.4	56.7%	43.3%
(n)	(34)	(23)	(34)	(26)

As can be seen in Table 8 the average length of stay was unsurprisingly much higher for residential services (2.9 years) than for community based service (1.5 years).

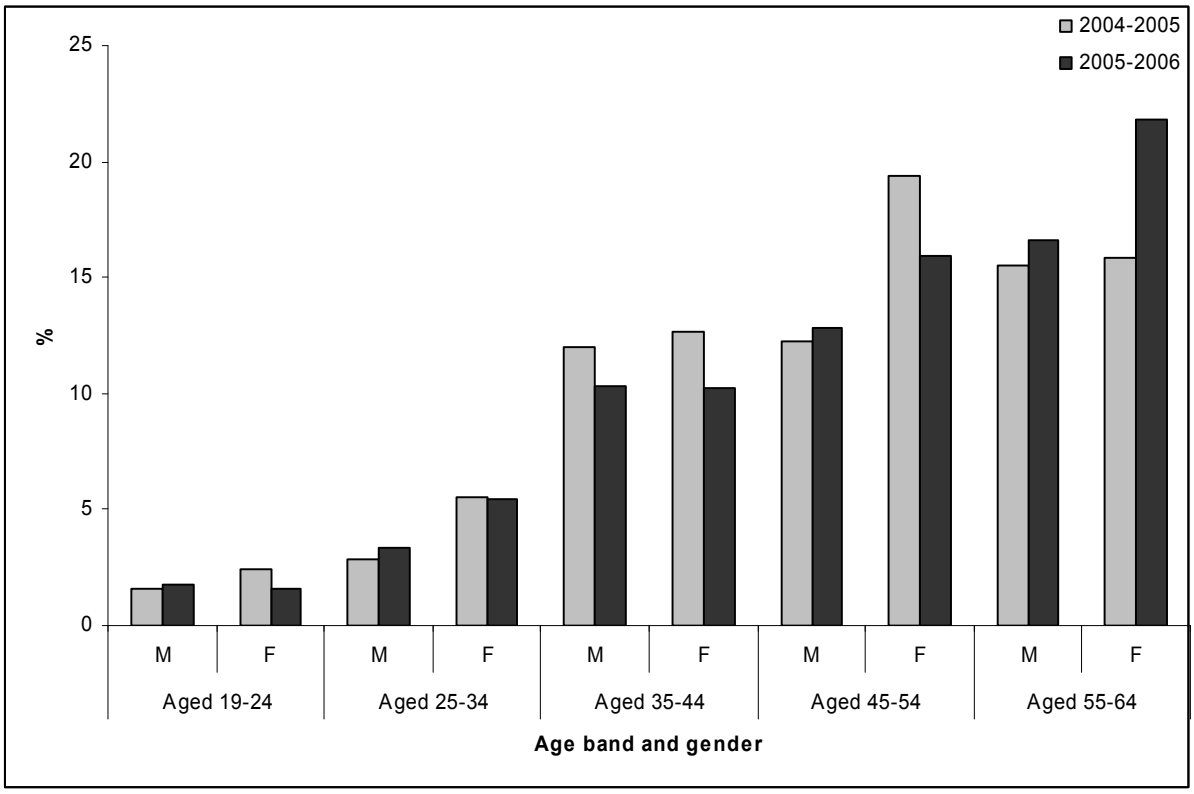
Table 8: Maximum, minimum and average length of stay for community based and residential services, 2004-05 and 2005-06

Length of Stay	**Community based Services**	**Residential Services**
Days	533	1075
Years	1.46	2.94
Minimum length of stay (days)	0	0
Maximum length of stay (days)	3974	6323

The ethnic breakdown of clients receiving care reflected the census profile of Brighton & Hove City with over 90% of clients being white British, white Irish or white other. In 2004-05 almost 10% of clients had no ethnicity code recorded, this dropped to under 1% in the 200-06 period.

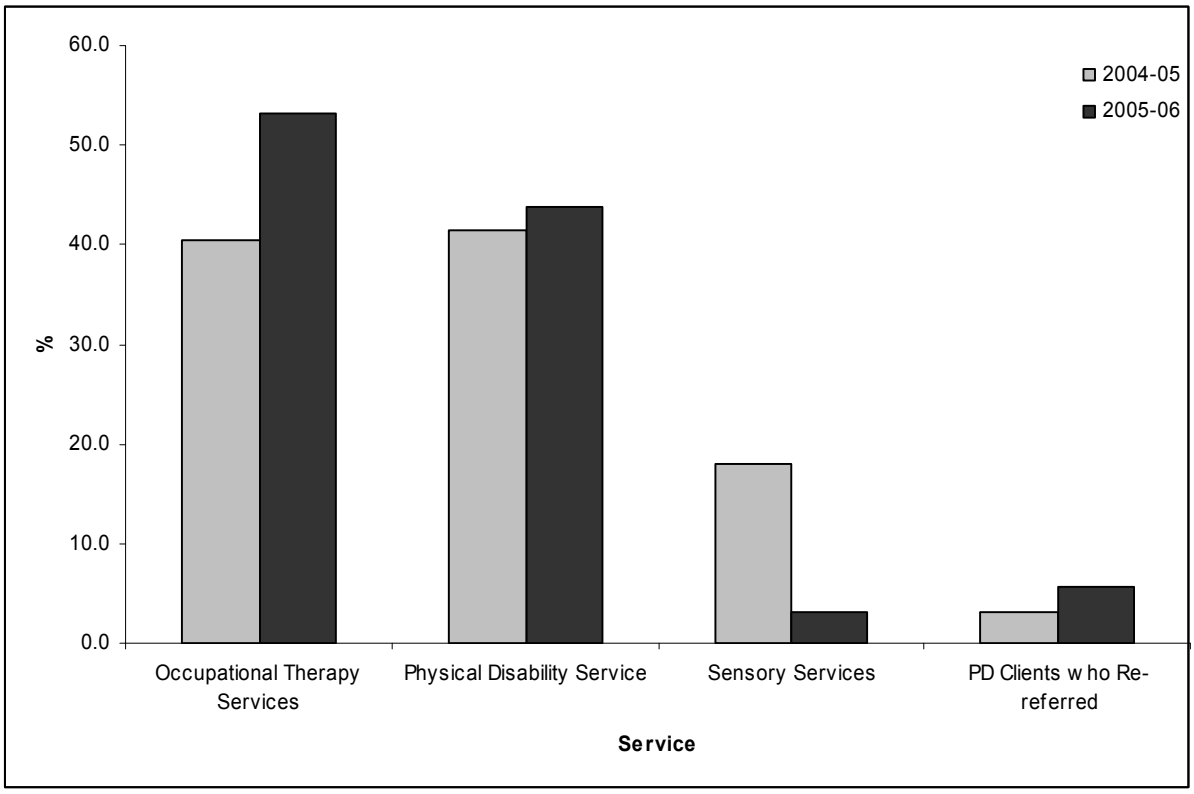
Overall the most clients were aged 45 and over (Figure 8). However, more men than women fell into the 45-54 age group. There were very few clients aged under 34.

Figure 8: Age breakdown of clients receiving services, 2004-05 and 2005-06



The main services clients were assessed by were occupational therapy and physical disability services, which accounted for over 80% of cases during the two years (Figure 9). There was a marked drop in the proportion of clients accessing sensory services in 2005-06 (3.1%) compared to 2004-05 (18%) an drop in absolute numbers of 29 (11 compared to 40) the reasons for this are unclear and may reflect data issues rather than actual changes in service provision.

Figure 9: Summary of clients assessed by service, 2004-05 and 2005-06



4. Specific conditions

4.1 Stroke

Stroke is defined as a neurological impairment of sudden onset that is caused by a disruption of the blood supply to the brain. Numerically stroke patients make up the greatest number of people requiring neurorehabilitation after an acute event.

4.1.1 Stroke epidemiology

In a population of 100 000, there will be approximately 200 first-ever and 40 recurrent strokes per year, of these 30% will die in the first month and of the survivors 65% will recover and be capable of living independently whilst 35% will be significantly disabled (8). Stroke occurs more commonly in people aged over 65. However, in those aged under 65 there are approximately 20 strokes per 100 000 population per year.

In a population the size of Brighton & Hove (approximately 250 000) the estimated number of strokes per year in those aged under 65 would be 40, with approximately 600 new and recurrent strokes occurring in the population as a whole.

According to the HSE 2004 the national prevalence of stroke for working-aged adults (16-64) in 2003 was 2.14% for men and 1.78% for women (ref).

4.2 Multiple sclerosis

Multiple Sclerosis (MS) is a chronic inflammatory demyelinating disease of the central nervous system leading to progressive impairment of various systems (27). There are three forms of the disease:

- Relapsing/Remitting MS: symptoms come and go with periods of health or remission followed by sudden symptoms or relapses (80% of patients at onset).
- Secondary progressive MS: follows on from relapsing/remitting MS. There are gradually more or worsening of symptoms with fewer remissions (approximately 50% if those with relapsing/remitting MS develop secondary progressive MS during the first 10 years of their illness).
- Primary progressive MS: from the onset of the illness symptoms gradually develop and worsen over time (10-15% of patients at onset). (28)

Patients with MS may develop a wide range of functional impairments and disabilities that will impact on their quality of life and degree of handicap (27).

4.2.1 Multiple sclerosis epidemiology

Between 3-7 people per 100 000 population are newly diagnosed with MS each year and about 100-120 people per 100 000 population have MS (28). It has been estimated that 15 years after onset 15% of MS patients will need walking aides and 29% will require the use of a wheelchair (27).

MS is most commonly diagnosed in adults between the ages of 20-40 years of age and women are almost twice as likely to be diagnosed as men (36)

4.3 Rheumatoid arthritis

Rheumatoid arthritis (RA) is a chronic inflammatory disease of the joints (Piptone & Choy 2003). . In time, affected joints typically become damaged. It is usually a chronic relapsing condition, but its course can vary from a mild disease to a severe destructive form in a few years (Young et al). Each relapse leads to damage to the joints and the amount of disability that develops usually depends on the amount of damage done over time (ref). In a minority of cases the disease is constantly progressive and severe joint damage and disability develop rapidly.

4.3.1 Rheumatoid arthritis epidemiology

Approximately 1% of the population have rheumatoid arthritis (RA). Women are two to three times more likely to develop RA than men with one study finding an incidence of 36 per 100 000 population for women and 14 per 100 000 for men (Symmons et al 1994). The disease most commonly develops between the ages of 30 and 60, with approximately 80% of total cases occurring between the ages of 35 and 50 (ref).

Estimating disability levels in RA patients is difficult because of the remitting/relapsing nature of the disease. It has been estimated that 11-14% of patients with RA will require a joint replacement within 5 years (Young, 2000 & Eberhardt, 1997). An English study found that although 60% of RA patients were still in paid employment after 5 years, the level of work disability was 22%, and was higher in manual workers (Young, 2000).The prevalence of severe disability due to RA is 130 per 100 000 population (OTBPH).

4.4 Other conditions

There are a number of conditions that can lead to physical disability some of which are outlined below:

4.4.1 Neurological conditions:

- **Parkinson's Disease:** The annual incidence of 20 per 100 000 generally occurs in older people, but covers the age range of 55 and over (Association of British Neurologists, 1992). Of the 180 per 100 000 with the disease, about 40 % have severe disability (OTBPH).

- **Motor Neuron Disease:** an annual incidence of 2 per 100 000 and a median survival of 1.5 years leads to a prevalence of 6 per 100 000 (Motor Neuron Disease Association), with severe disability. This disease is usually progressive and rapidly fatal, but some patients experience a milder attenuated course.

- **Cerebral palsy, spina bifida, and other muscular dystrophies**: The incidence of cerebral palsy (2 per 1000) and muscular dystrophy (1.3 – 3.3 per 10 000) have remained relatively stable, the prevalence of these conditions (200 and 90 per 100 000 population, respectively) has increased with improved survival (Brett and Lake 1991; Lipkin 1991).
  The incidence of live births with spina bifida, in contrast, is decreasing as it can now be diagnosed antenatally. The prevalence is now less than 2 per 100 000 school leavers (Ward 1994).

4.4.2 Trauma

- **Brain injury:** Traumatic brain injury (TBI), as a result of head injury, is another leading cause of neurodisability. Unlike stroke, a large number of patients with traumatic brain injuries are likely to be young with a normal, or near normal, life expectancy, but with high residual levels of disability (12). As acute and emergency services have improved in their treatment of head injury, increasing survival rates, the need for rehabilitation services has also increased (13)

  Head injuries requiring hospitalisation occur in the UK at the rate of about 300 per 100 000 population annually (4), of these approximately 250-280 will be mild, 15-20 moderate and 5-10 severe (12&13). Within these numbers there are difference in the rate of head injury between urban and rural areas, and there are peaks at 15-24 years of age and >75 years (4). Estimating the numbers of people with residual problems from head injury is difficult (4, 12&14). However, it has been suggested that approximately 150 per 100 000 population have persistent disability resulting from head injury (12,14) although these are likely to be conservative estimates.

- **Spinal cord injury**: Spinal cord injury is less common than brain injury with an annual incidence of traumatic spinal cord injury of 2 per 100 000 population.

4.4.3 Locomotor conditions

- **Osteoarthritis**: The prevalence of severe disability due to osteoarthritis is 300 per 100 000 population (OTBPH)

- **Amputation**: The National Amputee Statistical Database report annually on the number of patients referred to prosthetic service centres around the UK. In 2002/03 there were a total of 5718 new referrals, this was consistent with the number of from the previous years and gives a rate of approximately 9.5 per 100 000 population nationally (24).

  In 2002/03 lower limb amputations accounted for 92% of all amputations with upper limb accounting for 5% and congenital amputations accounting for the remaining 3%. The most common cause for upper limb amputation was trauma, lower limb amputations were most frequently the result of conditions that cause a defective blood supply to the limb, most commonly diabetes (75% of all cases) (24).

5. Summary

- Physical disability can arise from a wide range of conditions, which affect people in varying ways. Estimating the prevalence of physical disability in a population based on disease/ condition prevalence is difficult as different people will be affected in different ways and at different rates.
- The Health Survey for England 2001 provided information on the number of people who have disability at a national level. It provided information about both physical and sensory disability by severity and allows local level estimations of numbers of people expected to have physical disability
- The prevalence and severity of disability increases with age. The Health Survey for England reported that in 2001 90% of males and 89% of females of working age (16-64) report having no disability, this falls to 28% of men and 27% of women in the oldest age group (85+).
- To estimate the prevalence of physical disability in a population, that population must be defined. There are several sources of information about the working-age population of Brighton & Hove, the 2001 Census although the most recent accurate record of the population of Brighton & Hove is now 5 year out of date. However, when the ONS 2004 mid-year estimate and the 2004 local Brighton & Hove City Council population projections are compared to the census data there is little difference in the working age population. Comparisons of the Local Authority population and the registered PCT population show that there is a large difference between the two, particularly in the working age population. |
- Nationally, 7.5% men and 8 % of women of working age report having moderate disability and 2.5% of men and 2% of women of the same age group reporting serious disability. In Brighton and Hove this would equate to 6009 men and 5849 women with moderate disability and 1939 men and 5849 women with a serious disability.
- Of the five types of disability identified in the Health Survey for England locomotor disability was the most prevalent, followed by personal care disability. Based on the national figures the estimated number of people with moderate locomotor disability in Brighton & Hove equals 4146 men and 4350 women, and for serious locomotor disability 1143 men and 1247 women.
- In comparison to estimates based on the HSE, the 2001 Census, which asked about limiting long-term illness, found 22 544 adults of working age with either a long-term illness, health problem or disability that limited daily activities. This number is higher than the estimated number of people with physical disabilities in Brighton and Hove, but this is to be expected as the question is much broader in its remit.
- The 8850 Disability Living Allowance and 11 175 Incapacity Benefit claimants in Brighton & Hove in August 2004 reflects the estimated number of people with either a serious or moderate disability.
- The information from the Care First database about the number of working age adults receiving services for physical disability in the city illustrates that only a small proportion are accessing these services.
- There are a wide range of studies on the epidemiology of conditions that may result in physical disability. These may be used to estimate the prevalence of these conditions in Brighton & Hove, but may be limited in their application as people with these conditions have varying requirements depending on the progression of the condition.

Brighton & Hove City TPCT **Brighton & Hove City Council**

Joint Strategic Needs Assessment

Services for working age adults with physical disabilities

Planning for the City – 2008/09 to 2010/11

Contents

Introduction

This report is one of a series using the planning principles and structure of the Joint Strategic Needs Assessment (JSNA), as set out in the *Commissioning Framework for Health & Wellbeing* (Department of Health, 2007). In conjunction with the ongoing *Commissioning Strategy for People with Physical Disabilities*, and the Sussex-wide *Neuro-Rehabilitation* Strategy, this report is intended to be used as the basis for planning budgets, services and consultation programmes across health and City Council services, for the years 2008/09 to 2010/11.

The process of producing this report has highlighted that much of the detail on activity, financial and service-modelling, that is required for effective commissioning, is held in separate places across the agencies. While the *Commissioning Strategy* will bring much of this together, it is proposed that a joint workshop – of Adult Social Care, Housing, Health, and CYPT for appropriate client-groups – reviews how best to collect and collate this data.

<u>Key Themes</u>

- The JSNA forecasts an increase in the client-population over the next 3-5 years, partly as a result of the transitional clients currently known to Children's services, and partly as a result of the forecast increase in Brighton's population of working age adults. This equates to a net £200K (estimated) annual increase.
- Care-pathways are under review – for rehabilitation services, interim care, and for post-hospital domiciliary support or access to appropriate housing.
- The unpredictable number and nature of clients' needs (due to Acquired Brain Injury or other conditions), and the potentially high cost of support to individuals, will inevitably result in fluctuations in spending profiles between years, and will therefore require flexibility in the service-packages provided.
- Joint working between Adult Social Care, Housing, Health, and CYPT is essential to achieve these changes most cost-effectively

Specific actions

- Development of Extra Care Housing (potentially 4 units in the first instance; Invest to Save project via reduction in long-term placements and high-cost domiciliary care packages etc.), and improvements in access to appropriate adapted and accessible housing
- Extending the opportunities for more local rehabilitation and neuro-rehabilitation – including investment in community neuro-rehabilitation and corresponding reduction of existing bed-provision; extension of Community Rehabilitation Teams; and re-enablement focus and vocational rehabilitation within existing services such as home care and day-care
- Review of residential home provision (Wanbrough House) and development of market
- Transitional/interim care facilities to facilitate early hospital discharges; net revenue savings to be calculated; review of continuing care packages
- Implementation of ICES strategy review
- Development of self-directed care, via Direct Payments or individual budgets
- Development of advocacy service
- Establishment of Joint Commissioning Group (comprising PCT, adult social care commissioners, OTs, housing, CYPT, Disability Federation; and provider input from SDH – generic and neuro-rehab – and BSUH) to take these initiatives forward

1. Current population and demographic information

From the local data currently available and the broad scope of physical disabilities, it is difficult to provide a comprehensive study of local demographic information in relation to physical disability. Within many services clinical diagnosis, cause and level of disability are not routinely recorded. Therefore long-term recording is required to illustrate movement of service users and trends, to assess future demand and plan service development, over and above the local activity data available.

The principal areas of focus for this JSNA have been:

- Conditions requiring neuro-rehabilitation; stroke patients would be the majority of clients, but this group also includes patients with Acquired Brain Injury (ABI), patients with MS, and patients following limb amputation
- Sensory disabilities
- Users of wheelchair services, arising from a range of conditions

As this list indicates, physical disabilities cover a broad range of conditions and service-requirements. The starting-point of this review has therefore been to focus less on the initiating condition and more on the requirements of the service-user (physical, psychological, vocational, economic, transport etc.) and of their carers and families, regardless of the cause.

The majority of the information presented in this report is from national data sources applied to the local population[1]. However, the estimated local prevalence rate is seen to correlate across a number of data sources and is therefore a robust estimation of our local prevalence rate of physical disability.

Brighton and Hove City has a resident population of 247,817 and a working age population[2] of 168,535, 68% of the total. The PCT's Public Health report indicates that by 2010 9.6% (16,179) of the working age population of Brighton and Hove will have a moderate to serious disability. The majority of these (77%, 12,458) will have a moderate disability, whereas a significantly smaller proportion (23%, 3,721) will have a serious disability.

The Health Survey for England (HSE) 2001[3] (Figure 1) reports that locomotor[4] disability was the most commonly reported disability (38%) and personal care[5] the second (23%). In addition, a small proportion of working age adults reported sight, hearing or communication disabilities.

The ethnic breakdown of people with physical disabilities receiving services reflects the census profile of the city, with 90% of service users being white British, white Irish or white Other.

The 2001 census predicts that, while the population for Brighton and Hove will increase by 7% to 2010, the working-age population will increase by 13% - rising to 71% of total population by 2010. This would result in a predicted increase in the number of working age adults with some form of severe or moderate disability to 18,967 (HSE estimate), illustrated in Figures 1, 2 & 3.

Young People with Physical Disabilities

Forecast transitional numbers from the Children & Young People's Trust (CYPT) suggest an increase of 4 clients in 2008/09, and of 5 and 6 in each of the two subsequent years, over and above the expected annual rise due to demographic growth.

Figure 1 – Projected changes in disability status of working age adults compared to total population, based on 2001 HSE and 2001 Census and ONS population projection data.

[1] National data sources include the Census 2001 and DH Health Survey for England

[2] Working age population is defined within Public Health report as 16-64 years

[3] DH Health Survey for England 2001 – HSE covers a range of services each year. Physical disability was the specific focus topic for 1995 and 2001

[4] Locomotor disability was assessed by asking participants in the survey if they required any level of assistance in walking 200 meters, climbing 12 stairs without resting and retrieving things from the floor

[5] Personal care disability was assessed by ability to perform self care tasks or activities of daily living, eg getting in and out of bed or a chair, dressing, washing, eating and toileting

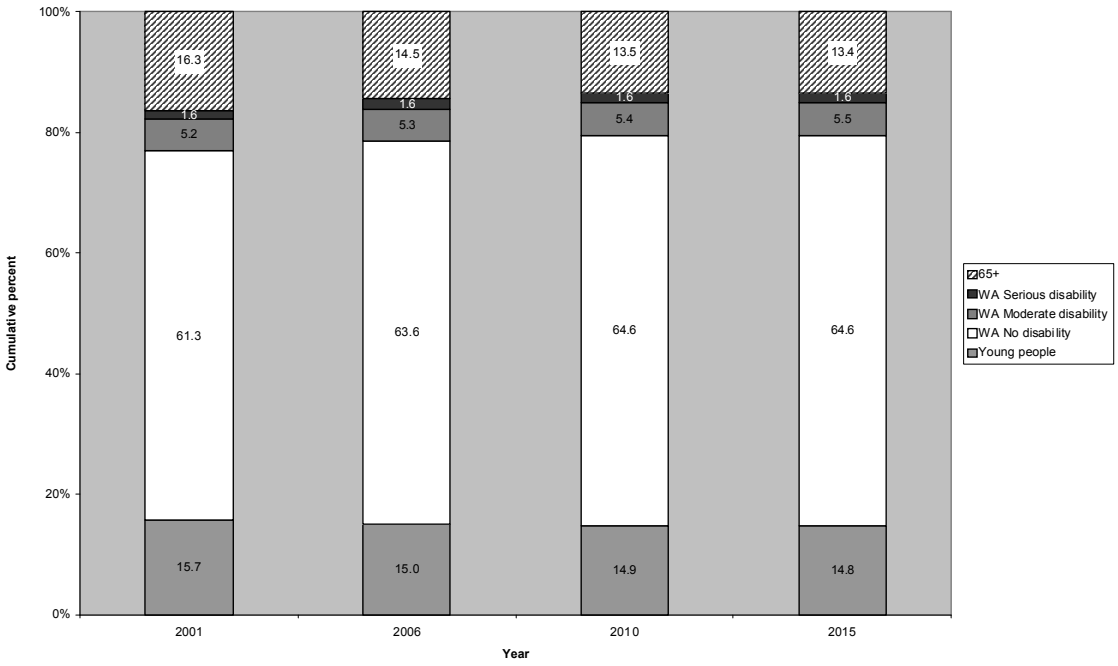


Figure 2 - Percent of working age and over 65s with no disability, moderate disability and serious disability, based on 2001 HSE and 2001 census data.

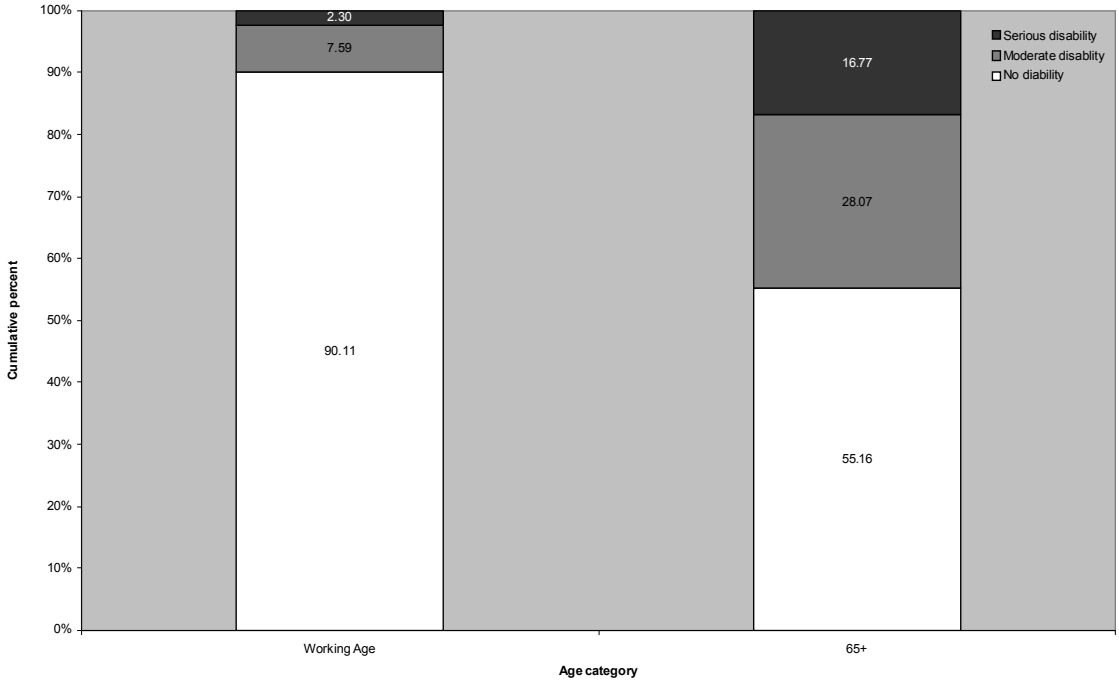


Figure 3 - Predicted numbers of men and women with moderate disability and serious disability in Brighton & Hove in 2010 and 2015, based on 2001 HSE prevalence and ONS population projections.

	Men		Women	
	Moderate disability	Serious disability	Moderate disability	Serious disability
2001 (Census)	6,009	1,939	6,431	1,832
2010	7,017	2,264	7,598	2,090
2015	7,017	2,264	7,598	2,090

2. Current usage of health, social care and housing services

Health

There is little detail on current usage of healthcare, analysed by physical disability. For acute services, there is some detail on access to Multiple Sclerosis services (91 admissions in 2006/07 for 45 patients), and 415 hospital admissions for stroke and TIA. Development of Extra Care services will reduce the current bed-requirements. The following table shows provision of specialist neuro-rehabilitation services in 2006/07:

Service	**Commissioning arrangements**	**Activity 06/07**
Inpatient unit SRCS	Jointly commissioned service with West Sussex PCT (AAW). Total capacity 52 beds – 10% of total OBD accessible by other Sussex PCTS	06/07 total activity 18,232 OBD (96% capacity) B&H 45% of above: 8,204 OBD equates to 23 beds
Community O/P service SRCB	Block SLA with SDHT B&H alone	1,171 new referrals OP Active users 562 (waiting time for access to service 4 wks) Prosthetics regional service (active caseload 1,220) Orthotics - to be included
Community Rehabilitation team	Block SLA with SDHT B&H alone	Extended team will deliver total of 45-55 rehab programmes at any one time with 240-250 delivered over the year
Specialist seating and wheelchair	(B&H & Lewes/Havens area)	Total number of active wheelchair and seating patients: 5,009

service		
LENS Vocational rehabilitation		128 clients per year
Continuing care commitments		ABI total: 15 CC patients (7 new clients in 06/07) and steadily increasing
ABI coordinator	Shared funding with ES CC	
TBI Nurse BSUH	Roald Dahl /BSUH	OP Concussion clinic

Additional information on community services support will be available through the review of South Downs Health activity (due to be completed December 2007).

Social Care

Figure 4 - 06/07 LA Community Care Services – under 65s

Assessment Services	**Social Care packages including live in care**	**RH&NH placements**	**T&I placements**	**Day care activity**	**ICES S31 Not age specific**
	396 care packages; approx 11% (44) high cost (£500+ per week)	98 in year; average 49 at any one time with 10 people receiving respite residential care	Approx 1 per month	Montague House: 73 service users mostly attending 2/3 times per week	

A review of social services day-care is currently underway.

A prospective trend analysis of social care data is not possible at this stage. Social care activity information is now collated monthly against DOH performance indicators and includes the following information for physical disability:

	2004/05	2005/06	2006/07
Numbers of assessments undertaken	222	354	
Number in receipt of services	491	802	

Numbers in receipt of sensory services	40	11	
Helped to live at home 18 – 64 yrs	92.1%	94.4%	
Long term care 18 – 64 yrs	7%	7%	

Figure 1 below indicates that there was a significant increase (23%) in the number of people assessed over the two year period (222 for 2004-05; 354 for 2005-06). The Community Occupational Therapy Assessment team (COTA) increased assessments by 35% and the Physical Disability Assessment Team (PDAT) by 26%.

Figure 6 below indicates that there was also a significant increase (62%) in the number in receipt of services (491 for 2004-05; 802 for 2005-06); COTA increased number in receipt of service by 62% and PDAT by 41%. However, the data indicates a marked drop in the proportion of service users accessing sensory services (40 in 2004-05; 11 in 2005-06) but a stable number in receipt of services (95 in 2004-05; 94 in 2005-06)[6].

[6] The reasons for this are unclear and may reflect data issues rather than actual changes in service provision

Figure 1 - Number of assessments undertaken 18-64 year olds by Physical Disability Team Community Occupational Therapy Assessment and Sensory Services

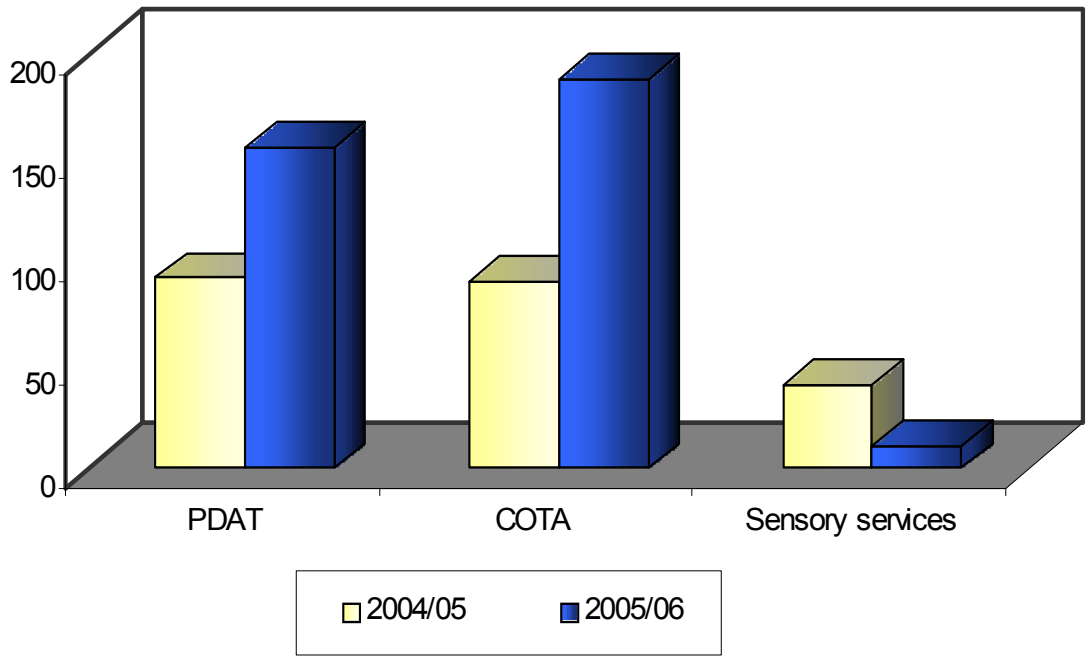
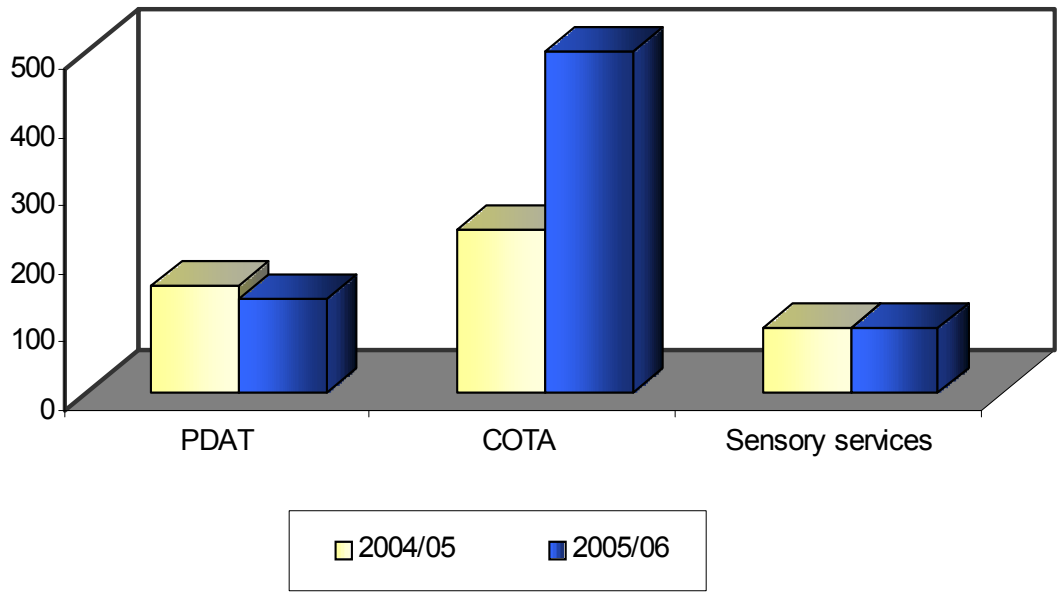


Figure 2 - Number in receipt of services



Safeguarding adults : people with physical and sensory disability; rate of referrals and completed cases per 10,000 population

	Referrals 05/06	Completed cases 05/06	Referrals 06/07	Completed cases 06/07
Brighton and Hove	1.59	0.77	3.94	2.53
England	4.64	2.52	N/K	N/K

Housing

Long stay supported residents receiving residential and nursing home care; rates per 10,000 population 18 - 64 ; source KIGs

	2001	2002	2003	2004	2005
Brighton and Hove	3.53	3.67	3.47	3.07	3.42
IPF Comparator group	3.38	3.31	4.34	3.84	3.51
England	2.93	2.89	3.38	3.15	3.01

People with a Physical Disability helped to live at home (per 10,000 aged 18-64) - Trends in Brighton and Hove

2000/01	2001/02	2002/2003	2003/04	2004/05	2005/06	2006/07
3.9	3.8	4.5	4.2	3.9	6.1	6.8

Brighton and Hove's performance is very high for this national performance indicator. From most recent validated comparative data 2005/06 B&H was seen to be the 24th highest performer out of 150 Councils.

The Brighton and Hove Housing Needs Survey 2005[7] examined disability issues in relation to housing need. The largest group of disabled people were those with a walking difficulty (52.3%); 8.1% of households contained a member who was a wheelchair user, suggesting 1,765 in the City as a whole.

Further analysis showed that 73% of wheelchair users did not live in suitably adapted premises, indicating a major mismatch between houses adapted and those where wheelchair users lived. In exploring the support needs of disabled people, 74.1% of wheelchair users needed help looking after their home.

Housing development

The City has made significant progress against targets established in the Housing Strategy (2005-2007) with 300 new builds a year, 10% of which are wheelchair accessible homes.

The current allocation system for public sector accommodation does not ring-fence adapted housing stock for people with disabilities, and they are therefore eligible to bid for both adapted and non-adapted properties.

Whilst this extends choice, a service review conducted in September 2006 recognised the importance of meeting the needs of people with a physical disability. As a result, wheelchair accessible properties will be ring-fenced for those with mobility disability and more support will be given to those who are vulnerable to bid for properties.

The table below based on the allocations waiting list in July 2006 shows the number of applicants waiting for wheelchair accessible housing.

Property	Applicants
1 bed	12
2 bed	8

[7] Brighton & Hove Housing Needs Survey – 2005 Table 7-3 Nature of Disability or Limiting Long term illness

3 bed	9
4/5 bed	4

Applicants waiting for wheelchair accessible housing (July 2006)
Major adaptations

The number of accessible and adapted properties within the city is not currently known. Categorisation of all properties and development of a data base is planned within the next 18 months. A project officer has been appointed to complete this work.

The Housing Adaptations Service is responsible for the completion of major and minor adaptations within public sector housing and major adaptations for the private housing sector[8]. This is an integrated case management service comprised of occupational therapists, technical and administrative staff. The integration was the result of evidence on the best way to manage an adaptations service, and recent DoH guidance commends this model. During 2006/07 approximately 600 major and minor public sector adaptations were completed.

Funding for major adaptations is received through two main sources. First, the national Disability Facilities Grant (DFG) funds major adaptation within the private sector and this can be a lengthy process as the DFG requires a full tendering process for works. However, in 2006/07, the integrated major adaptations team significantly increased the number of adaptations approved (158) and completed and raised the spend against the DFG budget of £825,000. For the first time spend matched the DFG allocation. The budget for 2007/08 has increased to £868,000.

A recent national review of the DFG has recommended that the grant remains ring fenced and mandatory. Individual grants will be uplifted from £25,000 to £30,000 with immediate effect and a future rise to £50,000 is possible. Whilst individual budgets will not initially include the DFG, a loosening to current ring-fencing will provide greater flexibility.

The second source of funding is via the Public Sector Housing Revenue Account (HRA). The capital budget for public sector adaptations (2006/07) was £750,000, with the cost of minor adaptations approx £120,000 per year. Following the recent housing stock decision, the Housing Department will be reviewing the public sector HRA capital. A proactive investment approach for adaptations is planned.

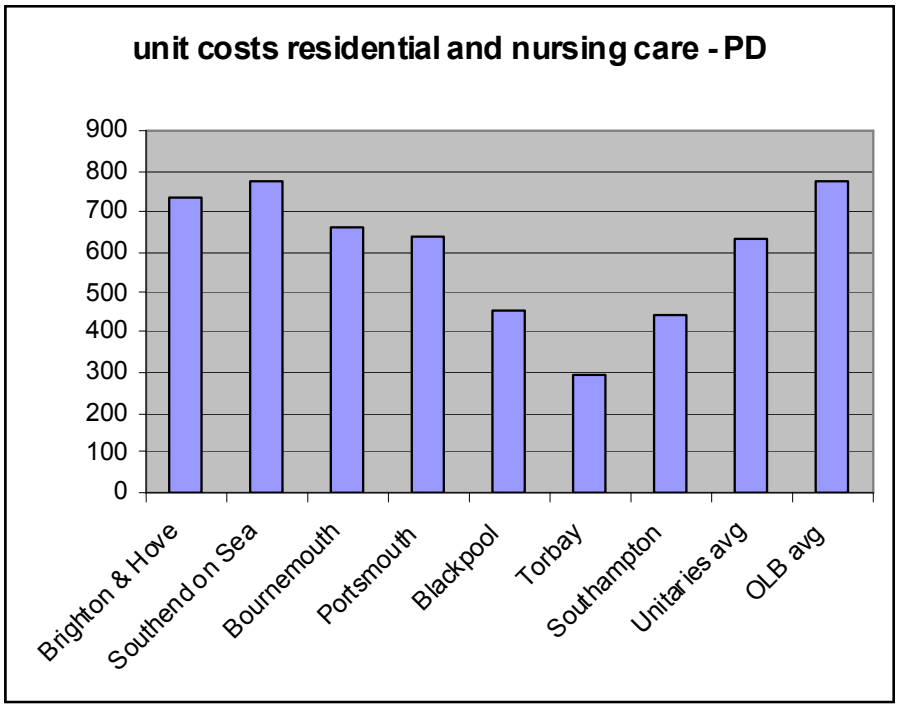
[8] The Integrated Community Equipment Service currently provides all minor (i.e. <£1,000) adaptations in the private sector.

3. Current Expenditure on Services (only LA expenditure age specific)

Services	**Budget 06/07**	**Actual Expenditure (gross) 06/07**	**Variance**	**07/08 Annual budget value (net)**
Local Authority community care	£3,274,740	£4,026,000	£751k overspend	£3,738,000
Specialist Neuro-rehabilitation (Gross indicative contract value 05/06) SDHT	£5,095,923 (jointly commissioned service B&H 55% ES 45%	£5,758,933	£663K overspend	£4,892,000 (jointly commissioned service) B & H (55%) - £2.7M
PCT Continuing Care packages	ABI Complex PD	(final total still to be agreed)		
SDHT OT	£642,469			
SDHT PHYSIO	£950,457			
SDHT SALT	£444,704			
Voluntary sector contracts	£302,189			
Housing	HRA £750,000 and DFG £825,000	HRA £816,000 and DFG £989,000		HRA £750,000 and DFG £972,000

Consistently high overspend on LA PD services and specialist neuro-rehab services (LA budget variance 05/06 £669,917)

Unit Costs residential and nursing home care for people with a physical disability.



As shown above Brighton and Hove's unit costs are well above the unitary average and close to the Outer London boroughs average. Unit costs broken down per service are shown below

Personal Social Services Expenditure and Unit Costs 2006-07

Client group and service	Weekly unit cost	Client numbers
Residential and Nursing care for adults with physical disability per person	£893	
Nursing Care for adults with physical disability per week (LA contribution only)	£740	
Residential Care for adults with physical disability per person	£1,043	
Home care for adults with physical disability per person	£160	
Adults with physical disability receiving direct payments	£312	
Adults with physical disability per day care session	£22	

Personal care support

The number of physically disabled people on direct payments in Brighton and Hove was 36 for 2005/06.

The cost of intensive personal care support for adults with physical disability is high with an average total weekly cost of £44,556. In 2005 390 home care packages were delivered during the course of the year. At any one time 280 care packages were delivered.

Figure 3 - Snapshot study of home care costs <£100 – 01/01/2006

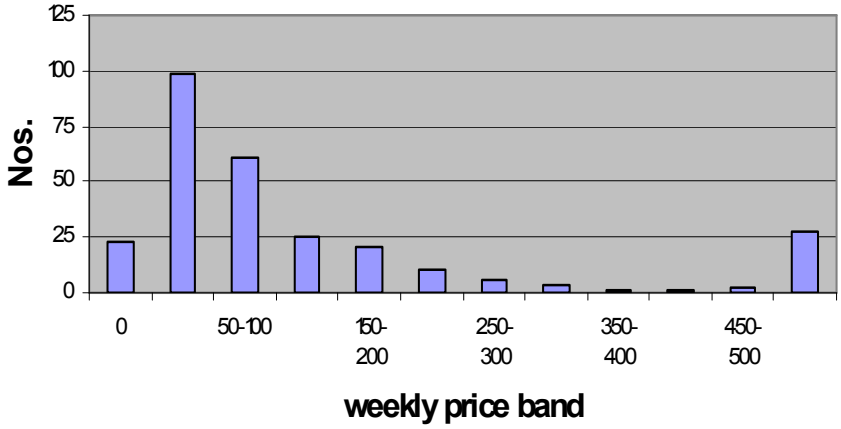
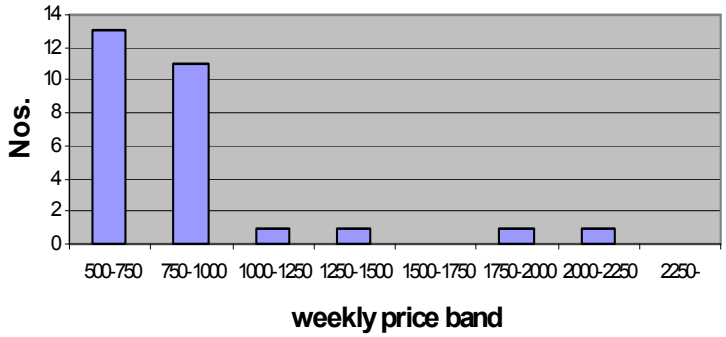


Figure 4 - Snapshot study of home care costs above £500 - 01/01/2006



4. Known User views

A recent survey identified:

- Want a social model of disability adopted which is a broader view of disability, shifting focus from lack of ability to social and environmental barriers (DES service user group)
- Access to specialist support and clear pathways with access to support (MS Society)
- Clear information and initial support – at point of diagnosis
- Access to psychological support and counselling
- One contact point for services – signposting, single point of access
- Reduced waiting times for services
- Carers – easier access to respite care in emergency and clear out-of-hours support
- Flexible transport options for hospital visits

5. Current initiatives (funded, underway or imminent) to meet forecast needs

Current initiatives (included within the draft PD strategy) are as follows:

- **Stronger Involvement and engagement of disabled people and their carers in future planning and development of services**

0 Develop mechanisms and support for continued and meaningful engagement and involvement
1 Continued collaboration and development with the Disability Federation

- **Timely, responsive and accessible assessment and delivery of care**

0 integrated information services and improved signposting
1 Advocacy service for younger people with PD and ABI
2 Improving support to those with complex and longer term health and social care needs
3 Greater coordination between services and possible single point of access
4 ABI care management model

- **The promotion of independence and extended independent living opportunities**

0 Rebalance provision of specialist neuro-rehabilitation services to provide more at a local and primary level; develop the clinical assessment and review service for neuro-rehabilitation. The Sussex-wide strategy is due for completion for consultation by December 2007.
1 Implementation of extended CRT
2 Development of care pathway to enable access to transitional and interim beds and housing solutions to facilitate discharge

3 Explore development of supported living options as alternative option to long term care and high cost placements

- **Increased opportunities for involvement in mainstream community activities and citizenship**

0 Development of Rehabilitation care pathway to maximise social integration and opportunities vocational strategy
1 Ensure transport arrangements are flexible and can support plan

Appendices

1– Details of services available to Brighton & Hove residents
2 – Stroke Pathway Map (March 2006; shortly to be revised with introduction of Rapid TIA Service

Appendix 1 – Details of services available to Brighton & Hove residents

Neuro-rehabilitation Services

A broad range of specialist neuro-rehabilitation services are delivered locally. These are provided by the Specialist Rehabilitation services at South Downs Health Trust (SDHT) and include an inpatient unit, an outpatient and mobility service, a community rehabilitation team and a vocational rehabilitation service.

Sussex Rehabilitation Centre, Shoreham (SRC,S) – post acute inpatient unit based at Southlands Hospital. Jointly commissioned by B&H PCT and West Sussex PCT. SRC-S provides post-acute neurological rehabilitation following Stroke and other Acquired Brain Injuries, amputation and chronic neurological disabilities.

Sussex Rehabilitation Centre, Brighton (SRC,B) - provides a neuro-rehabilitation outpatient and mobility service and delivers out patient neuro-rehabilitation, orthotics, prosthetics, specialist seating and wheelchair services.
The outpatient neuro-rehabilitation service provides follow up for patients discharged from the inpatient unit **(SRC,S).** Patients are seen by the Consultants in Rehabilitation Medicine under whose care they were at SRC-S. Patients can also be referred by other Consultants and by GPs in East Sussex.

Prosthetics – There is a regional, Sussex-wide service under a longstanding SLA covering many PCTs. The service offers specialist assessment and review, prescription, provision and maintenance of prosthetic limbs and also a rehabilitation facility for more complex cases. The multi-disciplinary team includes a Consultant in Rehabilitation Medicine, prosthetists, specialist therapists and nurses, clinical counsellors and engineering personnel.

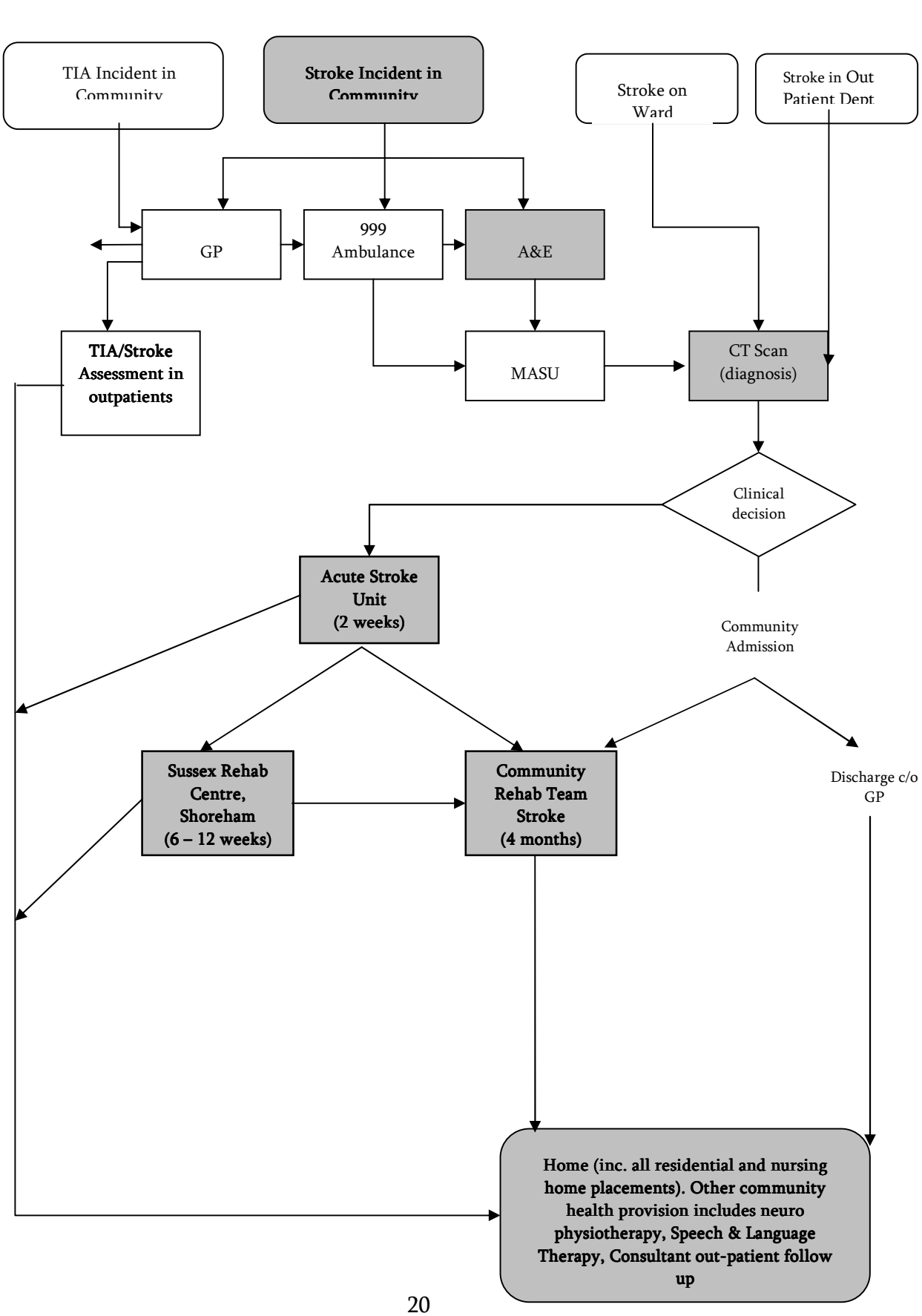
The **Orthotics Service SRC,S and SRC,B** is provided by SDHT for the inpatient and outpatient service.

The **Community Rehabilitation Team (CRT)** is multidisciplinary and therapist-led and is comprised of occupational therapists, physiotherapists, speech and language therapists, nurses and rehabilitation assistants. Referrals are accepted directly from the acute stroke unit, SRC-S, GPs and from rest homes (but not nursing homes). The team currently supports between 45-55 rehabilitation programmes at any one time.

Non-neurorehabilitation services

Currently there are limited opportunities for ongoing maintenance rehabilitation or re-access to rehabilitation for non-neurological conditions. The Intermediate Care Service provides short term (approximately six weeks) rehabilitation to facilitate discharge from hospital or to prevent admission. The transitional care services provide rehabilitation within a residential setting.

Appendix 2 – Stroke Pathway Map (March 2006; shortly to be revised with introduction of Rapid TIA Service)



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Shading shows 'significant' steps along the pathway