JOINT STRATEGIC NEEDS ASSESSMENT

ADULTS AGED 18 TO 64 YEARS WITH PHYSICAL DISABILITIES

REFRESHED VERSION FEBRUARY 2009

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Acknowledgement

The contribution of Claire Turner, Specialist Trainee in Public Health to this document is acknowledged.

1. Executive Summary

1.1. Key Themes

- The social model of disability highlights that disabled people face social, environmental and attitudinal barriers which can restrict their activity and participation in society. Policies that increase independence and enablement are important in supporting good outcomes for people with physical disabilities.

- Evidence highlights that people with physical disabilities experience disadvantage in many aspects of daily life. They are more likely to live in poverty as well as experience problems with hate crime and harassment, housing and transport.

- The specific needs of people with physical disabilities who are members of groups that potentially experience additional barriers to participation, such as Lesbian, Gay, Bisexual and Trans (LGBT) people, people from Black and Minority Ethnic (BME) communities, and Gypsies and Travellers, should be taken into account in service planning and delivery.

- It is estimated that approximately 14,000 Brighton and Hove residents aged 18 to 64 have a moderate physical disability, and 3,400 have a severe physical disability.

- In the 2001 census, a higher proportion of Brighton and Hove residents aged less than 65 reported having a limiting long term illness compared with the England average, and a higher than average proportion of residents aged 16 to 74 reported that they were permanently unable to work.

- Approximately 6,700 local residents aged 18 to 64 are expected to have a moderate personal care disability, and 1,300 are expected to have a severe personal care disability.

- The number of people with a physical disability aged 18 to 64 living in Brighton and Hove is expected to increase by between 3.5% and 5.0% between 2008 and 2015.

- Brighton and Hove has a young age distribution and a reduction in the number of older people living locally is projected. Therefore the proportion of all people with physical disabilities who are aged less than 65 years is likely to increase. The young age distribution of the local population means that for health conditions which are typically

young onset, such as multiple sclerosis, there are likely to be a higher than average number of new diagnoses in the local population each year compared with other authorities with a similar sized population.

- One in twenty adults aged 18 to 64 in Brighton and Hove receive Disability Living Allowance (DLA), however the rate varies considerably by geographical area. In the electoral wards of East Brighton and Queens Park one in twelve receive DLA.

- Residents with a physical disability are more likely to live in a home in disrepair and are more likely to be fuel poor.

- Households with a disabled member are more than twice as likely to rent from a local authority or social landlord (37 per cent of all households with a disabled member live in social housing, compared with 15 per cent of all households living in social housing across the City). The City has a large private rented sector, and there may be barriers to fitting adaptations for people with physical disabilities living in these properties.

- Historically Brighton and Hove has had a relatively high number of people with physical disabilities living in long stay residential and nursing care. Since 2003 the number has fallen considerably. However the cost of this care has increased rapidly in recent years and is high compared with other local authorities.

- During the same period the number of people with physical disabilities helped to live at home by Brighton and Hove City Council has increased considerably, and local performance is higher than the England average.

- In 2006/07 the rate of in Brighton and Hove residents with physical disabilities aged 18 to 64 receiving direct payments was low compared to the national average, however since this data was published the actual number receiving payments locally has increased from 39 in 2006/07 to 65 in 2008/09.

- The proportion of homelessness acceptances with physical disability as their priority need in Brighton and Hove is consistently two to three times higher than the England average, indicating a high level of need locally.

- More than 200 applicants on the housing register require a property that is partially or fully adapted for wheelchair use. Of the 88 requiring a fully adapted property, 76% are aged less than 60 years.

1.2. Recommendations

- Ensure that service planning takes into account the projected increase in the size of the population aged under 65 with physical disabilities
- Ensure local people with physical disabilities are involved in planning and development of services
- Ensure that services provide high quality information at the initial point of access to promote independence and enablement
- Ensure those involved in service planning and delivery consider and respond to the needs of specific groups including as BME groups, LGBT people and gypsies and travellers,
- Improve access to accessible and adapted housing
- Ensure the needs of carers of people with physical disabilities are considered in service planning and delivery
- Increase the number of local people in receipt of direct payments
- Consider how knowledge of the needs of local people with physical disabilities can be improved, including improved data collection, and include this information in the next version of this Joint Strategic Needs Assessment.

2. 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 published by the Department of Health[1].

In conjunction with the Strategy for People with Physical Disabilities, and the Sussex-wide Neuro-Rehabilitation Strategy, this report is intended to be used support budget and service planning for the year 2009/10 and 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 relevant agencies.

This is intended to be an interim report and it is planned that a revised JSNA will be produced by 2010/11.

3. Defining physical 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.

The Disability Discrimination Act (DDA) has a broad definition of disability, describing it as:

> *a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities*[2]*.*

The Equality and Human Rights Commission defined a physical impairment as

> *a condition affecting the body, perhaps through sight or hearing loss, a mobility difficulty or a health condition*[3]*.*

The World Health Organisation (WHO) began the process of defining disability with the International Classification of Impairments, Disabilities and Handicaps (ICIDH)[4]. This framework described four terms: pathology, impairment, disability and handicap (see Table 1).

Table 1: Framework of international classification of impairments, disabilities and handicaps [4]

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 the 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[5] 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 has been defined 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"[6].*

It shifts the focus from impairment to disability, using this term to refer to disabling social, environmental and attitudinal barriers rather than a 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.

The 2005 report by the Prime Minister's Strategy Unit, Improving the Life Chances of Disabled People[7], noted that the types of barriers faced by disabled people include:

- **attitudinal**, for example among disabled people themselves and among employers, health professionals and service providers;
- **policy**, resulting from policy design and delivery which do not take disabled people into account;

- **physical**, for example through the design of the built environment, transport systems, etc, and
- those linked to **empowerment**, as a result of which disabled people are not listened to, consulted or involved.

4. Limitations of locally available data describing physical disability

The available data describing the numbers of people with physical disabilities, and their needs, are subject to a number of limitations.

People with physical disabilities have highly diverse needs. This is because of a number of factors including:

- Different types of impairments, and in those with the same conditions, different severity, disease stage and the impact of other health conditions
- Socio-economic differences, meaning that some people have a higher risk of facing barriers limiting their participation
- Different social and environmental barriers faced by individuals.

Some of the data presented to estimate the numbers of people with physical disabilities in Brighton and Hove are derived from national studies and applied to the local population. Where appropriate, data has been compared across different sources ensuring that the best possible estimate is presented.

Some of the available data relates to impairment rather than disability and reflect the medical model of disability, which is less useful than the social model in guiding the planning of services to respond to users' needs.

Data relating to impairment and disability is often not available broken down by age group so presented data sometimes relate to all ages, rather than adults aged less than 65.

Within many services, client need, the severity of disability and/or the clinical diagnosis are not routinely recorded.

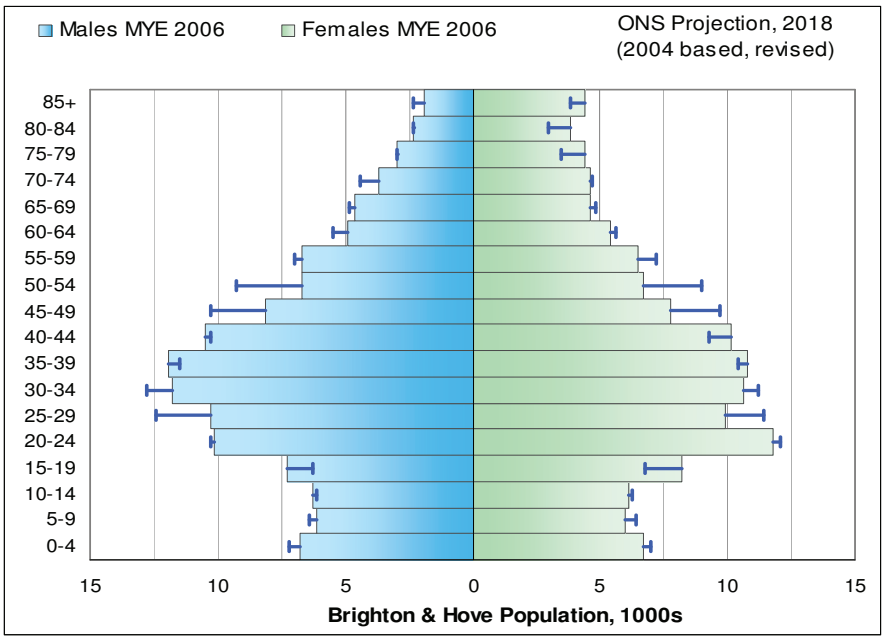
Some data is not available broken down by ethnic group, and very little data is available broken down by sexual orientation or transgender status.

5. The population of Brighton and Hove

It is estimated that 253,500 people live in Brighton and Hove of whom 172,000 are aged between 18 and 64 years[8]. A high proportion of the population are young adults, as shown in Figure 1 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 Figure 1 below[9]. The greatest increase is expected in 45 to 54 year olds. In contrast to most other Local Authorities the number of older people is predicted to reduce by 2018.

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



It is estimated that the lesbian, gay, bisexual or transgender (LGBT) communities make up one in six of the population[10].

15% of the city's population was born outside England, a higher than average proportion that for the South East region and for England. At the same time, the Black and Minority Ethnic population, at 5.7%, is comparatively low, suggesting that those not born in England are

predominantly from white European backgrounds. In 2008 the most populous European communities were from Spain and Poland [10].

Brighton and Hove City faces substantial socio-economic issues[10]. 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 (SOAs) in the City falling within the 10% most deprived Super Output Areas in England and eight SOAs falling in the 5% most deprived.

Definition

The term Super Output Areas (SOAs) refers to a way of classifying geographical areas that was developed to analyse the results of the 2001 Census. SOAs were defined to include a similar population size and contain communities with similar social characteristics. The lower layer SOAs referred to in this analysis typically contain a population of around 1500 people. There are 164 SOAs in Brighton and Hove.

6. The prevalence of physical disability

6.1. Estimated prevalence of disability

The Health Survey for England 2001[11] 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 a physical disability. The Health Survey used an adaptation of the World Health Organisation (WHO) classification system for impairments, disabilities and handicaps. It is used to estimate the proportion of the population experiencing different levels of long-term disability, with two levels of severity:

- Low (moderate)
- High (serious)

The disability questions in the HSE 2001 enquired about limitations in functional activities (seeing, hearing communication, walking and using stairs) and daily living activities (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

The survey results illustrate how the prevalence and severity of disability increases with age. Nationally, 8% of men and 9% of women aged 16 to 64 years report having a moderate disability, and 3% of men and women of the same age group report having a serious disability. Within this broad age range, the proportion with disabilities increases with age.

The survey also reports on the proportion of disability by type of disability. It shows locomotor disability accounting for the 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)[12] was designed to help local authority commissioners of social care to explore the impact that expected changes in the structure of the population, and in the incidence and prevalence of certain conditions, may have on the number of people with physical disabilities. The programme uses sources including national HSE data and Local Authority population estimates and projections to produce estimates for 2008, and five yearly projections from 2010 to 2025, of the numbers of people with physical disabilities at local authority level.

Definitions

Incidence: a figure describing the number of people newly diagnosed with a health condition in a defined period of time (e.g. in one year)

Prevalence: a figure describing the total number of people living with a condition at one time

The estimated number of Brighton and Hove residents with physical and personal care disabilities is shown in Table 3 below. The data show that by 2015 the numbers of people with a moderate and serious physical disability are projected to increase by 4.2% and 3.8% respectively.

Table 3: Predicted numbers of people 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 (i)

	2008	2010	2015	Change 2008 to 2015
Total no of people predicted to have a physical disability				
• moderate physical disability	13,981	14,219	14,562	4.2%
• serious physical disability	3,361	3,425	3,488	3.8%
No. of people predicted to have a personal care disability				
• moderate personal care disability	7,642	7,749	7,912	3.5%
• serious personal care disability	1,293	1,321	1,357	4.9%

(i) 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.

Figures 2 and 3 below present the same data by age group, and also show the projections up to the year 2025. They highlight that the prevalence of disability increases with age, and that the projected increase in the number of people with a disability will be greatest in people aged 45 and above.

Figure 2: People aged 18-24, 25-34, 35-44, 45-54 and 55-64 predicted to have a moderate or serious physical disability, Brighton and Hove, projected to 2025

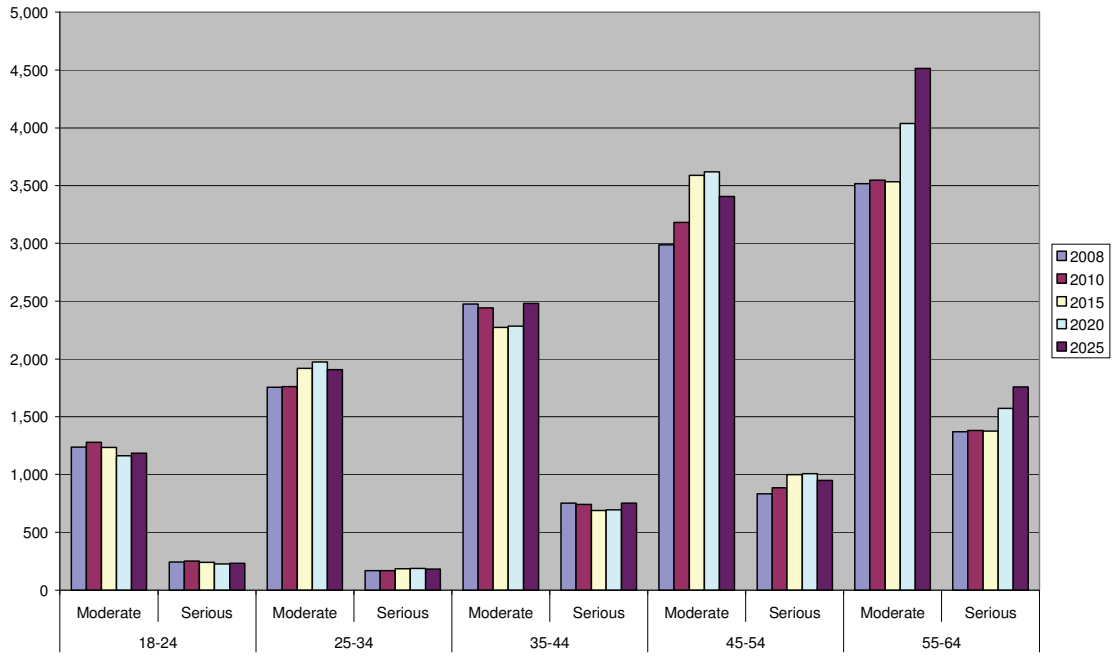
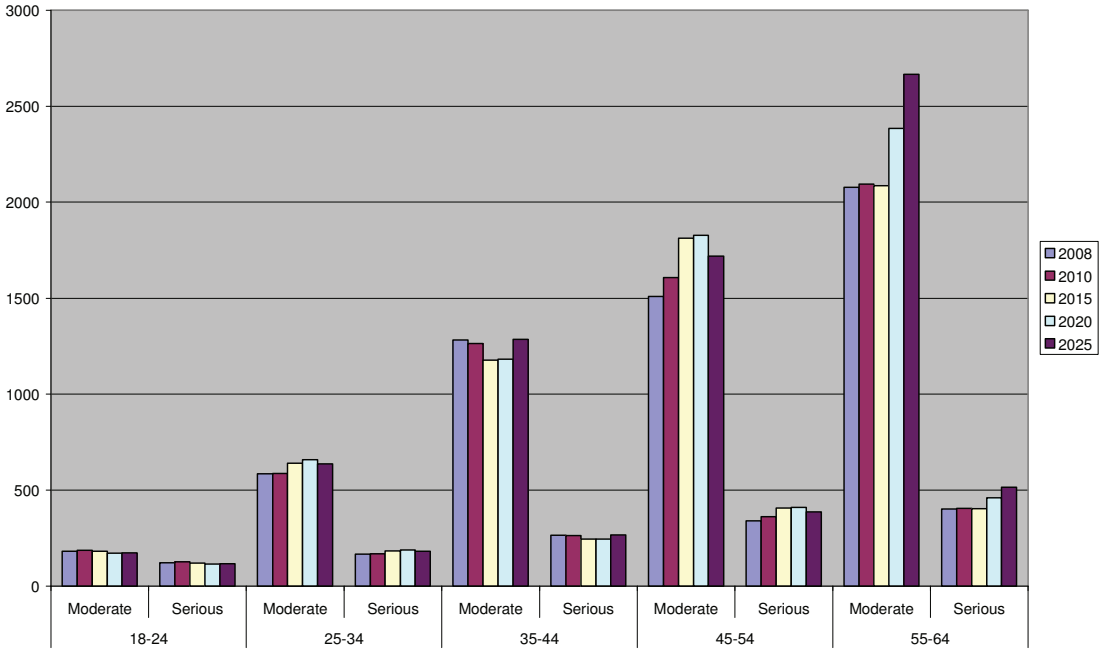


Figure 3: People aged 18-24, 25-34, 35-44, 45-54 and 55-64 predicted to have a moderate or serious personal care disability, Brighton and Hove, projected to 2025



Relatively limited information is available comparing the prevalence of physical disabilities between local authority areas. The 2001 census included a question on limiting long term illness[13]:

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

17.5% of Brighton and Hove residents defined themselves as having a limiting long term illness, which is similar to the average for England and Wales (17.6%), although higher than the average for authorities in South East England (14.8%).

Definitions

Standardised ratios are the ratio of the number of events observed in a population (e.g. Brighton and Hove) to the number that would be expected if the population had the same distribution as a standard or reference population (e.g. England and Wales).

For example, men in Brighton and Hove have a Standardised Illness Ratio of 105.7. This means that there are 5.7% more men with a limiting long term illness than would be expected if men in the Brighton and Hove population had the same rate of limiting long term illness as men in England and Wales. Therefore the local rate is higher than the England and Wales average.

Standardised illness ratios were calculated by gender and age (Table 4). The ratios for those aged less than 65 in Brighton and Hove were higher than the ratios in surrounding local authorities (except Hastings) and higher than both the England and England & Wales averages.

Analysis of the 2001 census results also provides detail on the proportion of people unable to work because of long-term sickness or disability. Respondents were classified as "permanently sick" if they ticked yes to having a limiting long term illness (see above) and the following question[14]:

> *"Last week, were you any of the following: permanently sick or disabled?"*

Standardised permanent sickness ratios were calculated by gender and age. The ratios for those aged 16 to 74 in Brighton and Hove

were higher than the ratios in surrounding local authorities (except Hastings) and higher than the England average (Table 4).

Table 4: Standardised illness ratio (aged <65) and standardised permanent sickness ratio (16-74). South East Local Authorities and National averages (Source 2001 Census)

	Standardised illness ratio (<65)		Standardised permanent sickness ratio (16-74)	
	Males	Females	Males	Females
Brighton and Hove UA	**105.7**	**101.9**	**106.0**	**99.1**
Adur CD	89.2	91.4	72.2	78.2
Arun CD	88.3	88.0	76.1	76.8
Chichester CD	73.1	68.7	51.4	48.6
Crawley CD	78.5	87.1	55.6	69.4
Eastbourne CD	102.6	100.2	90.2	91.6
Hastings CD	125.9	118.1	135.6	125.4
Horsham CD	59.5	61.9	35.7	40.8
Lewes CD	82.8	82.8	64.4	70.2
Mid Sussex CD	58.9	62.9	37.4	46.2
Rother CD	89.8	86.4	77.9	73.0
Wealden CD	69.8	70.5	50.0	54.3
Worthing CD	91.7	89.4	85.5	81.2
SOUTH EAST	**77.2**	**78.6**	**60.3**	**63.7**
ENGLAND	**98.1**	**98.2**	**96.2**	**96.2**
ENGLAND AND WALES	**100.0**	**100.0**	**100.0**	**100.0**

6.2. Physical disability and specific population groups

6.2.1. LGBT groups

The Count Me In Too Survey[15], conducted in Brighton and Hove in 2006, surveyed more than 800 people from the Lesbian, Gay, Bisexual and Transgender communities. 97.5% of respondents were aged between 16 and 65. 15% of the sample identified themselves as having a long term health impairment or physical disability. As applies to the statistics in the whole population above, respondents identifying themselves under this category cannot be disaggregated by physical, sensory or mental disabilities or long term health impairments. 4% of the sample identified themselves as deaf, hard of hearing, deafened or deaf-blind.

6.2.2. BME groups

Black and minority ethnic groups are less likely to report impairments than the White population, but they are more likely to experience poor outcomes if they are disabled[16].

In 2006/07 9.0% of physically disabled adults receiving a service were from BME groups. This is proportionate to the population aged 18 to 64 of whom 9.6% are estimated to be from BME groups [12].

6.2.3. Gypsies and travellers

A 2005 survey of the housing needs of gypsies and travellers in Brighton, Hove and Sussex[17] found that 35% (22/62) of households in permanent accommodation and 28% (n=18/64) of households on sites had a member with a disability or a long term illness.

7. Specific health conditions resulting in impairment

Table 5 presents data on the incidence and prevalence of specific conditions and diseases that can result in significant levels of physical disability.

For the purposes of this document conditions have been separated in to three distinct categories:

- neurological;
- locomotor;
- and sensory.

The national rates have been applied to the Brighton and Hove population to produce estimates of the number of people affected by these conditions in the local population.

Most condition-specific studies do not differentiate between different age groups. Where possible, incidence and prevalence rates for adults aged 18 to 64 years are highlighted in this report. However, for most conditions the rates presented refer to the whole population.

As described earlier in this report, Brighton and Hove has an unusual age distribution, with a high proportion of people aged 20 to 44 and a lower proportion of older people. This means that where a condition is more common in younger adults there is likely to be a higher number of people affected by the condition than the national data would suggest. For example, based on the application of national incidence and prevalence rates, Brighton and Hove City would be expected to have up to 17 new diagnoses per year, and up to 300 local residents living with Multiple Sclerosis. However the local Multiple Sclerosis specialist nurse reports a caseload of over 400 active cases, which may be explained by the age distribution of the local population.

Additional detail on the incidence and prevalence of specific conditions is presented in Appendix 1.

Table 5: National data on incidence and prevalence of conditions associated with impairment; and estimated number of people affected in Brighton and Hove

Condition		National data: (rate per 100 000[1] population)		Local application of national data: estimated number of people affected in Brighton and Hove	
		Incidence	Prevalence	Incidence	Prevalence
Neurological	Acquired Brain Injury including Traumatic Brain Injury[18]	175	1,200	445	3,045
	Spinal cord injury	2	50	5	125
	Young onset stroke (<65)	20		40	
	Epilepsy	24-58	430-1,000	60-150	1,090-2,535
	Motor neuron disease	2	7	5	20
	Multiple sclerosis	3-7	100-120	10-20	250-300
	Parkinson's disease	17	200	45	510
	Huntington's disease[19]		13.5		35
	Muscular dystrophy		50		125
	Cerebral palsy		186		470
	Spina Bifida		2		5
	Myalgic encephalomyelistis		300-500		760-1270
Locomotor	Rheumatoid arthritis[20]	770	1,960	1,950	4970
	Osteoarthritis	7620	12,770	19,315	32,370
	Amputation[21]	9.5		25	
Sensory	Deaf or hard of hearing aged 16 to 60[22]		4,100		6,870
	Mild to moderate deafness aged 16-60		3,900		6,535
	Severe to profound deafness aged 16-60		200		335
	Serious visual impairment [12]				110

8. Uptake of Disability Living Allowance (DLA) by electoral ward

Statistics on the uptake of DLA provide an indicator of the geographical distribution of need across the City. However caution should be used when interpreting this data because the population of disabled people in receipt of disability related benefits is smaller than the number of people with disabilities.

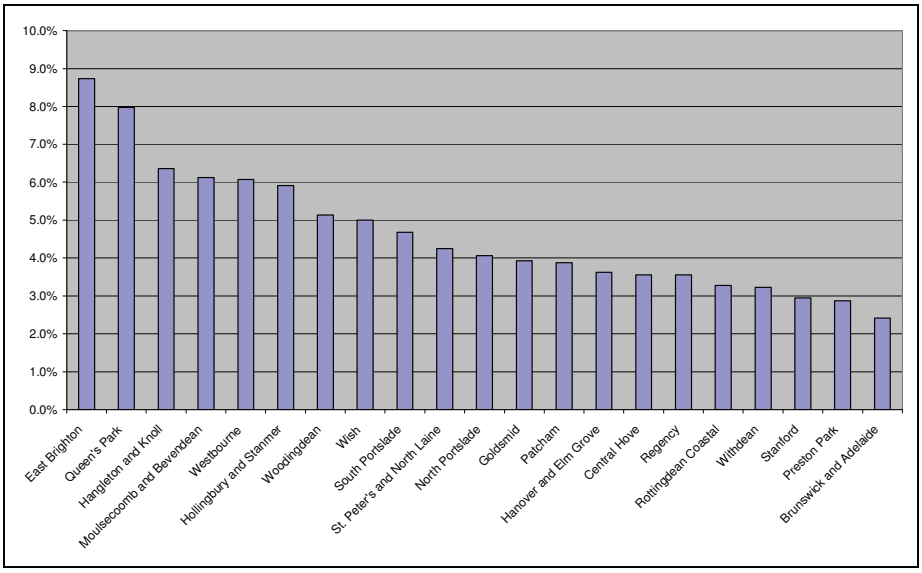
Definition:

Disability Living Allowance provides a non-contributory, non means-tested and tax-free contribution towards the disability-related extra costs of severely disabled people under the age of 65. The allowance has two components: a care component - for people who need help with personal care and are likely to go on needing that help; and a mobility component - for people who have walking difficulties and are likely to continue to have those difficulties.

In May 2008 approximately 8,500 local residents aged 18 to 64 years received payment for DLA[23], equivalent to 5% of the population in this age group.

The proportion of the population receiving the benefit varied considerably by electoral ward, from 2.4% of those aged 16 to 59 years in Brunswick and Adelaide to 8.7% in East Brighton. This variation is illustrated in Figure 4 below.

Figure 4: Uptake of Disability Living Allowance by electoral ward 16-59 year olds May 2008



(Source: DWP statistics; National Statistics ward population estimates 2006)

9. Barriers faced by people with physical disabilities

9.1. Improving the Life Chances of Disabled People

A report published by the Prime Minister's Strategy Unit in 2005, Improving the Life Chances of Disabled People[7], reviewed the evidence on the barriers and disadvantage faced by people with disabilities. It concluded that disabled people experience disadvantage in many aspects of daily life.

The report found that, compared with non-disabled people, disabled people are:

- more likely to live in poverty – the income of disabled people is, on average, less than half of that earned by non disabled people;
- less likely to have educational qualifications – disabled people are more likely to have no educational qualifications;
- more likely to be economically inactive – only one in two disabled
- people of working age are currently in employment, compared with four out of five non-disabled people;
- more likely to experience problems with hate crime or harassment – a quarter of all disabled people say that they have experienced hate crime or harassment,
- more likely to experience problems with housing
- more likely to experience problems with transport – the issue given most often by disabled people as their biggest challenge.

However, the cause of this appears to work in both directions: people are also more likely to become disabled if they have a low income, are out of work or have low educational qualifications.

A report published in 2007, Developing Appropriate Strategies for Reducing Inequality in Brighton and Hove[24], examined the barriers faced by disabled people locally and the extent to which inequality was being addressed.

Definitions

Incapacity benefit: a weekly payment for people who become incapable of work while under State Pension age. Assessment for eligibility includes a Personal Capability Assessment

Employment and Support Allowance: From 27 October 2008 this benefit replaced Incapacity Benefit and Income Support paid on incapacity grounds for new claimants. The principle of Employment and Support Allowance is that everyone should have the opportunity to work and that people with an illness or disability should get the support they need to engage in appropriate work, if they are able.

The report found that:

- Disability and Incapacity Benefit levels are high across the city. More than 50% of all working age people on benefit claim as a result of incapacity. New Incapacity Benefit claimants are 30% more likely to be aged 25 to 44 than the national average.
- There are knock on effects for carers. 22,000 people provide unpaid care across Brighton and Hove (this figure refers to carers and people cared for of all ages. 30% provide care for over 20 hours and nearly 20% for more than 50 hours per week). Around 40% providing care were economically inactive
- Disabled groups are likely to experience long term issues. People with long term limiting illnesses claiming Incapacity Benefit have been claiming for more than 5 years.
- Disabled people have a higher risk of experiencing hate crime. A survey by the Disability Rights Commission found that almost half who took part in the survey had experienced verbal abuse, intimidation or physical attacks because of their disability.

The report concluded that:

- People caring for disabled people may also be excluded from taking up employment, education or training opportunities.
- The introduction of the Employment and Support Allowance benefit is important. Tailored support is provided to help those with a health condition or disability to return to employment, while providing financial and other support where this is not possible.

- Human resources policies in local public and private sector employers are important to support disabled people.

- The policy agenda of Direct Payments is important in supporting good outcomes in people with physical disabilities.

The Brighton and Hove Private Housing Stock Condition Survey 2008[25] confirmed that there is a strong association between disability and income, as 27% of households with a disabled resident had a household income below £10,000 per annum, compared with 11% where there is no person with a disability. This represents approximately 3,700 such dwellings in Brighton and Hove. The residents of these dwellings may not only have physical difficulty dealing with repairs or adaptations to their home, but may be less likely to be able to afford alternative provision.

9.2. Housing needs of people with physical disabilities

Good housing is a key to independence for those with physical disabilities. Having independence in this context means having choice and control over the assistance and/or equipment needed to go about daily life and having equal access to housing opportunities.

Housing problems are compounded by much of the city being hilly preventing full wheelchair accessibility. Many homes were built in the 19th century and subsequently converted into flats, often with small rooms and narrow stairways making accessibility and adaptation difficult.

The 2005 Housing Needs Survey[26] found that 19.8% (22,362) of households in Brighton and Hove contain someone with a disability or long term illness.

The household composition and tenure patterns of disabled people reflect the fact that they are older, on average, than the general population. Over half of all disabled household members were over the age of 60 including 28% over the age of 75.

The largest group of people with physical difficulties were those with a walking difficulty (53.2%), a figure that the 2008 Private Sector Housing Stock Survey also confirms. 8.1% of all households reported that they contained a member who was a wheelchair user, suggesting 1,765 in the City as a whole.

Table 6: Proportion of households with a resident with a long term illness or disability

Tenure	Proportion of the population of Brighton and Hove living in this tenure (%)	Proportion of this group with a disability (%)	Estimated number of households including people with a disability
Owner occupied – with no mortgage	26%	23%	6,764 (31%)
Owner occupied with mortgage	36%	9.2%	3,654 (17%)
Privately Rented	23%	14.1%	3,544 (16%)
Housing Association (RSL)	5%	48.8%	2,521 (12%)
Local Authority	10%	44.3%	5,534 (25%)
All Tenures			22,017 (100%)

Source: Housing Needs Survey 2005

Table 6 highlights that households with a disabled member are more than twice as likely to rent from a local authority or social landlord (37 per cent of all households with a disabled member live in social housing, compared with 15 per cent of all households living in social housing across the City).

Brighton and Hove has the sixth largest private rented sector in the country (Stock Condition Survey 2008) and a relatively high proportion of disabled people live in the private rented sector (16%). This can mean that dwellings may potentially be unsuitable for adaptation and where some landlords may be reluctant to give permission for any adaptations to be undertaken.

The 2008 Stock Condition Survey found that compared to the general population, residents with a physical disability where more likely to live in a home in disrepair (12% compared to the Brighton and Hove

average of 7.7%) and more likely to be fuel poor (6.3% compared to 4.9%).

Brighton & Hove has a housing stock profile that is older than the national picture with 65.7% built before 1945, compared to 43.4% in England as a whole, many properties of which are difficult to adapt for people with mobility needs (Stock Condition Survey 2008).

9.3. Needs of specific population groups

As highlighted earlier in this report the term people with physical disabilities and sensory impairments describes a highly diverse group with a wide range of individual needs and experiences. The social model of disability, and the personalisation agenda, require that services ensure need is defined at the individual level and not prescribed by factors such as impairment type. However research highlights the need for services to take into the needs of specific groups that are potentially excluded or marginalised:

- Count Me in Too[15] identified that LGBT people with disabilities report a high level of need in relation to housing and safety. They also reported significant health issues, including mental health needs and discrimination by health services.

- Although people from BME communities are less likely to report impairments than the White population, they are more likely to experience poor outcomes if they are disabled[16].

- The 2005 Survey of Gypsies and Travellers[17] highlighted the issue of need for adaptations, including ramps outside, handrails, other alterations for access and bath / shower / toilet adaptations.

9.4. Views of service users

Consultation with, and surveys of, service users and their carers has highlighted the following needs. Users and carers 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 (Disability Equality Scheme service user group)

- Access to specialist support and clear pathways with access to support (MS Society Care Pathways review)

- Clear information and initial support – at the point of diagnosis

- Services to take into account communication needs and ensure information is provided in an appropriate understandable manner.

- People involved in service provision to understand the special needs and cultures of different vulnerable service users (not just a minimum amount).

- Services provided at home to be informed services that meet mental, physical and sensory needs.

- Choice to be given to service users.

- The discharge process from hospital to be pro-active in supporting the special needs of vulnerable people returning home or entering care.

- Access to psychological support and counselling

- One contact point for services.

- Reduced waiting times for services

- Easier access to respite care to support carers in emergencies and clear out-of-hours support

- Flexible transport options for hospital visits

The national Personal Social Services Survey of Adults Receiving Community Equipment and Minor Adaptations in England (2007-08)[27] identified that a high proportion of service users were satisfied with the local service (77%; the same value as the England average), although a higher proportion reported that the waiting time experienced had caused problems.

The Count Me in Too survey of LGBT people[15] highlighted the problems of access to services reported by deaf people.

10. Data on health, social care and housing services

10.1. Health

Limited data on health service activity related to people with physical disabilities is available.

Table 7 summarises service activity for adults (excluding older people) for the most recent three years. The data suggest a significant increase in referrals to the community rehabilitation team which reflects an expansion of this service to meet local needs.

Table 7: Service Activity 2006/07 to 2008/09; Adults aged 18-64 years; South Downs NHS Trust

		2006/07	2007/08	2008/09 *
Community Neuro-Rehabilitation Team	Referrals	71	113	139
Community Matrons	Referrals	41	48	86
District Nursing	Referrals	1,729	1,830	1,709
Intermediate Care Service	Referrals	267	358	320
Occupational Therapy	Referrals	1,570	1,737	1,967
Sussex Rehabilitation Centre (Shoreham)	Inpatient admissions	84	115	76

* Projected full year out-turn based on 10 months activity

10.2. Social Care

Social care activity information for physical disability and sensory services is presented in Tables 8 and 9.

Table 8: Social care assessment and service activity 2006/07 – 2008/09

		2006/07	2007/08	2008/09 (until Dec 2008)
Numbers of assessments undertaken 08/09	Physical disability	37	51	45
	Sensory Services	36	62	*148 (tbc)*
	Occupational Therapy	-	198	82
Number in receipt of services	Physical disability	299	285	371
	Sensory Services	50	76	*259 (tbc)*
	Occupational Therapy	781	786	-

Table 9: Other Community Care Services – adult aged under 65

Residential Home and Nursing Home placements	Transition placements	Day care activity
98 in year 2006/07; average 49 at any one time with 10 people receiving respite residential care	Approx 1 per month	Montague House: 73 service users 2006/07, mostly attending 2/3 times per week

10.2.1. Supporting people to live at home

Table 10 shows that historically Brighton and Hove has a had a relatively high number of people living in long stay residential and nursing care, however since 2003 the number has consistently fallen.

In contrast, Table 11 shows that the number of people helped to live at home has increased considerably. Brighton and Hove's performance is very high for this national performance indicator. In 2007/08 Brighton and Hove was the joint seventh highest performer out of 150 Councils.

Table 10: Long stay supported residents receiving residential and nursing home care (Rates per 10,000 population aged 18 to 64 years)

	2001	2002	2003	2004	2005	2006	2007	2008
Brighton and Hove	3.5	3.7	4.5	3.8	3.6	3.0	2.5	2.4
Institute of Public Finance comparator group of local authorities	3.6	3.3	4.3	3.8	3.5			
England	2.9	2.9	3.4	3.2	3.0			

Source: Key Indicators Graphical System

Table 11: People with a Physical Disability helped to live at home (Rates per 10,000 population aged 18 to 64 years)

	2003/04	2004/05	2005/06	2006/07	2007/08
Brighton and Hove	4.2	3.9	6.1	6.7	7.6
England	4.2	4.2	4.5	4.5	4.7
SE England	3.9	3.7	4.3	4.6	5.0

Source: CSCI Performance Assessment Framework

10.3. Housing Need in Brighton & Hove

10.3.1. Homelessness

As overall homelessness in the city has been reducing in the last few years, there has also been a reduction in homelessness amongst those with physical disability as the main priority need. However, at least one household every week is accepted as homeless with

physical disability as the main reason for priority need. Brighton and Hove City Council has recognised that there is a shortage of adapted temporary accommodation in the City for homeless applicants while they are waiting for suitable permanent accommodation and as a result the City Council is funding the adaptation of six self contained flats for this client group, with more to come following feasibility studies.

Figure 5: Homeless Households with Physical Disability as the Reason for Priority Need, Brighton and Hove: 2001/02 to 2007/08

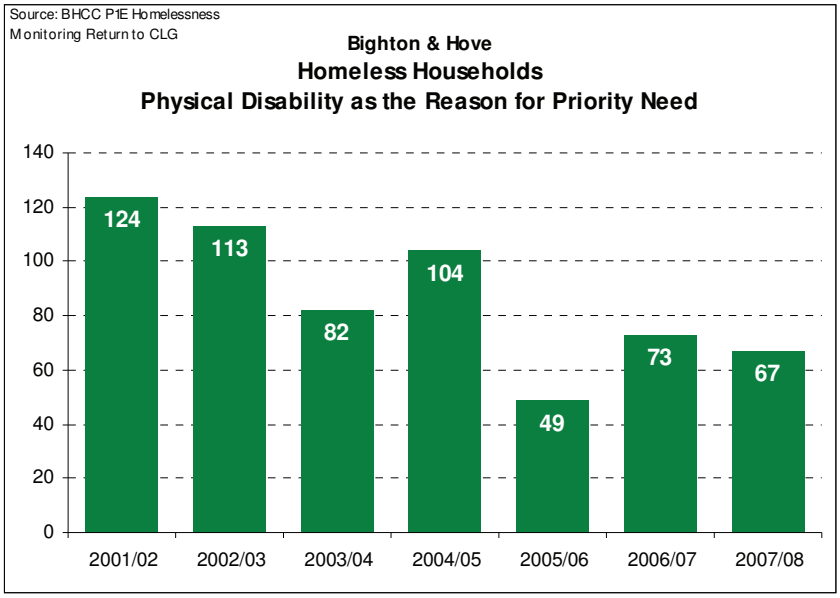


Table 12 highlights that the proportion of homelessness acceptances with physical disability as the priority need in Brighton and Hove is consistently two to three times higher than the England average.

Table 12 Proportion of homelessness acceptances with physical disability as the priority need, Brighton and Hove and England: 2004/05 – 2007/08

2004/05		2005/06		2006/07		2007/08	
England	Brighton & Hove	England	Brighton & Hove	England	Brighton & Hove	England	Brighton & Hove
5.1%	13.6%	4.9%	9.6%	4.9%	15.2%	4.9%	15.3%

Source: DCLG Homelessness Statistical Release Table 4 & BHCC P1E Homelessness Return to ODPM

10.3.2. Access to Social Housing

A service review carried out in September 2006 on the way households accessed social housing has resulted in wheelchair accessible properties being ring fenced for those with a mobility disability and more support is given to those who are vulnerable to bid for suitable homes.

In 2007/8 32 fully adapted wheelchair accessible properties became available for letting (Table 14), of which three in four (24) were owned by housing associations. Currently there are 88 applicants waiting for this type of accommodation (Table 13), demonstrating that demand far exceeds supply of this type of property. There is an almost equal need for one and two bedroom properties and a smaller demand for larger family homes.

For those waiting for accommodation that is partially adapted for wheelchair use (e.g. the property will have internal and external level or ramped access, but some parts of the property may not be fully wheelchair accessible) the level of demand in comparison to supply is more severe with 126 households waiting (Table 13) but only 24 properties becoming available a year (Table 14). Of this group the greatest need is for one bedroom properties.

The majority of those waiting for fully wheelchair adapted accommodation are aged less than 50.

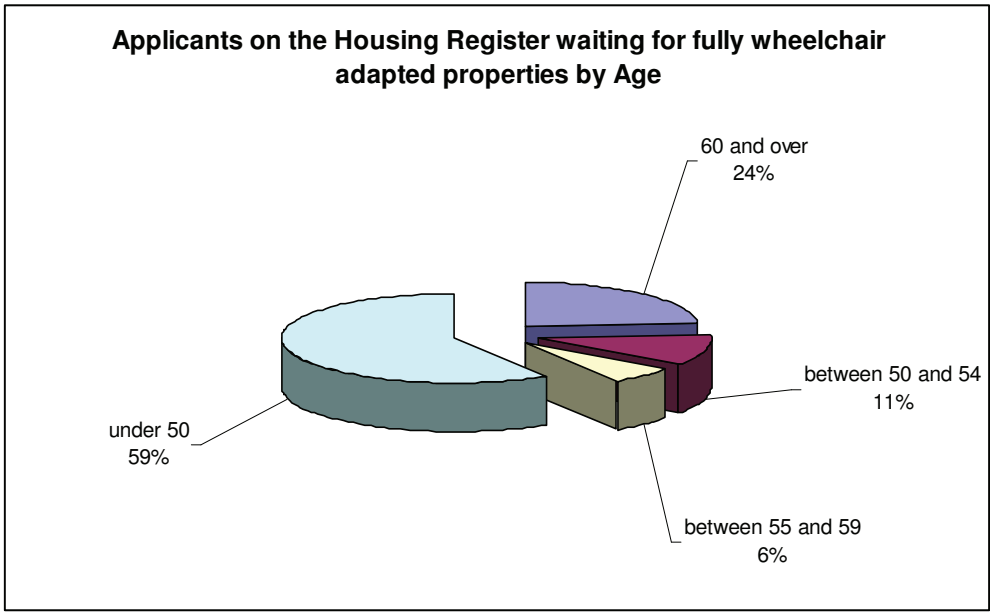
Table 13: Those on the housing register requiring disabled adapted accommodation (at 27 January 2009)

Type of property required	Number of Bedrooms Needed				
	1	2	3	4	Total
Fully adapted for wheelchair use	37	36	9	6	88
Partially adapted for wheelchair use	82	28	10	6	126
Total	120	66	22	16	

Table 14: Lettings 2007/8 to disabled adapted property

Type of property	Sheltered (older People)	Number of Bedrooms				
		1	2	3	4	Total
Fully adapted for wheelchair use	1	9	12	8	2	32
Partially adapted for wheelchair use	8	12	3	1	0	24
Total	9	22	17	12	6	

Figure 6: Applicants on the Housing Register waiting for fully wheelchair adapted properties by age; January 2009



Source: Locata

10.3.3. Adaptations to Homes

In order to address the specific housing needs of residents with a disability, Disabled Facilities Grants (DFG) are a mandatory

requirement for local authorities to provide to support people to live at home[i].

DFGs are subject to means testing and an assessment by an Occupational Therapist. The most needed adaptations are for the redesign of the bathroom, followed by grab/hand rails. Currently there is a long waiting list of those needing adaptations. The House Condition Survey estimates that 6,950 adaptations are currently needed by households with a disability.

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[ii]. 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 Department of Health guidance commends this model.

During 2006/07 approximately 600 major and minor public sector adaptations were completed.

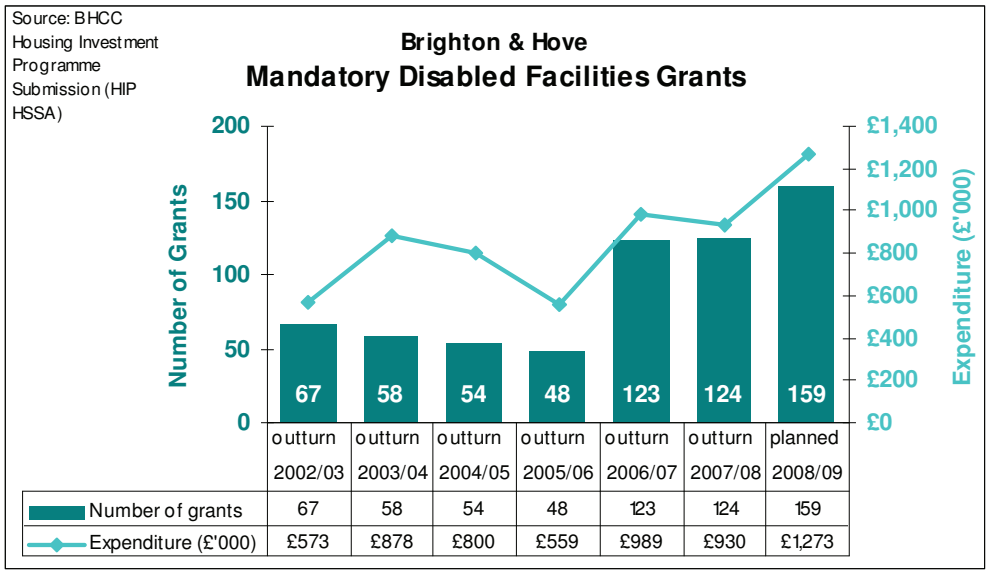
Funding for major adaptations is received through two main sources. First, the DFG funds major adaptation within the private sector and this can be a lengthy process as the DFG requires a full tendering process for works.

In 2007/08 124 grants were processed with a total expenditure of £930,000. The average payment per grant was around £8,000. The number of grants processed during 2007/08 is the same as 2006/07 and double that for the years prior to this. The number of grants planned for 2008/09 is 159 with a planned expenditure of £1,273,000.

[i] See table 10 highlighting Council performance in enabling people to live at home

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

Figure 7: Mandatory Disabled Facilities Grants, Brighton and Hove: 2002/03 to 2008/09



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 local decision on the Council's housing stock, the Housing Department will be reviewing the public sector HRA capital. A proactive investment approach for adaptations is planned.

10.3.4. New Housing Development

Planning policy expects all new homes in the city to meet the Lifetime Homes Standard with a further 10% of the affordable housing meeting the authority's Accessible Homes criteria (a higher specification wheelchair standard).

During 2007/08 there were 159 affordable homes completed through joint working with our partnership organisations. Of the 159 dwellings completed, 18 (11%) were fully adapted wheelchair homes.

11. Current Expenditure on Services

11.1. Expenditure on adult social care and housing

Expenditure by Brighton and Hove City Council is summarised in Table 15. In addition, between 2008 and 2011, Stroke Grant to the value of £94,000 per annum has been invested in the Community Rehabilitation Team to improve outcomes for people following stroke.

Table 15: Adult Social Care and Housing annual budget 2007/08 and 2008/09

Services	07/08 Annual budget value (net)	2008/09 annual budget (net)
Local Authority community care	£3,738,000	£4,581,000
LA mainstream e.g. Assessment, Occupational Therapy, Montague House day centre, daily living centre		£2,234,000
Housing:		
Housing Revenue Account (public sector housing)	£750,000	£830,000
Disabled Facilities Grant (private sector)	£972,000	£1,200,000

The unit cost of services are summarised in Table 16. The unit cost of services for people with physical disabilities per head of population is comparable to other unitary authorities with similar populations as shown in Figure 8.

Table 16: Personal Social Services Unit Costs 2007-08

Type of care	Unit	Cost
Residential and nursing care for adults with physical disabilities		
Residential and nursing care for adults with physical disabilities	Per person per week	£993
Nursing care for adults with physical disabilities	Per person per week	£791
Residential care for adults with physical disabilities	Per person per week	£1,163
Home care		
Adults with physical disabilities receiving home care	Per person per week	£174
Direct payments		
Adults with physical disabilities receiving direct payments	Per person per week	£234
Day care		
Adults with physical disabilities receiving day care	Per person per week	£201

Figure 8: Unit cost of services for people with physical disabilities per head of population 2007/08 (provisional data)

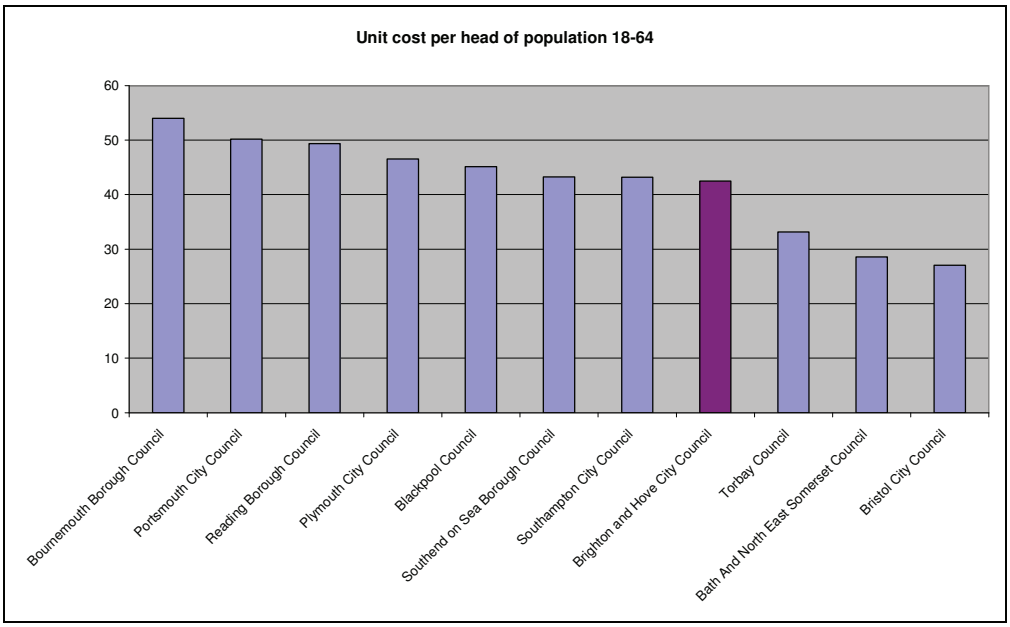


Figure 9 highlights that the unit costs for residential and nursing home care are very high compared to other authorities. These unit costs have increased rapidly in recent years, as illustrated in Table 17.

Figure 9: Unit Costs for residential and nursing home care for people with a physical disability 2007/08

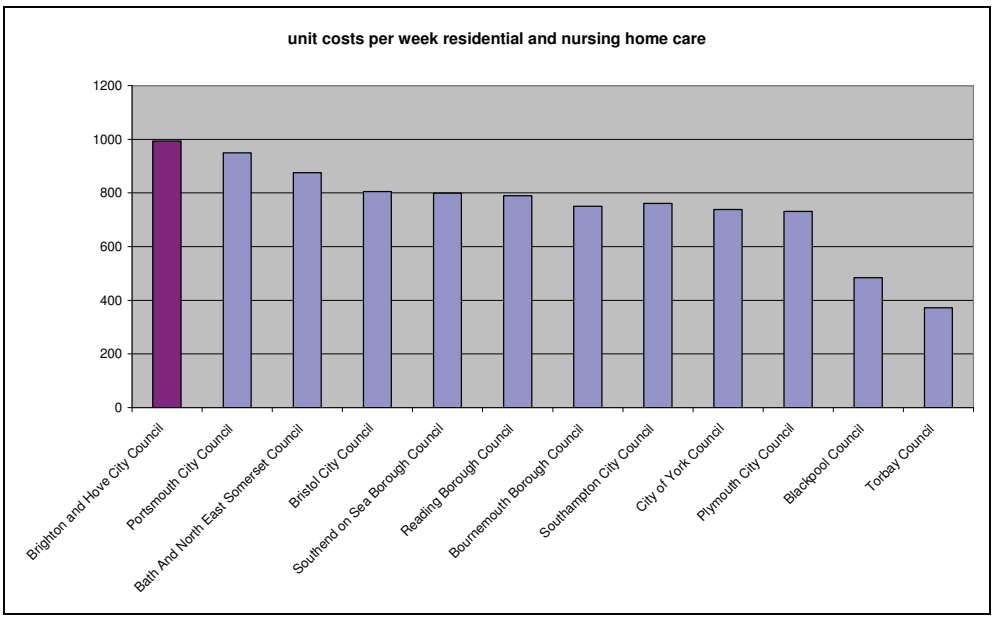


Table 17: Unit costs per week residential and nursing home care for Brighton and Hove 2004/05 to 2007/08

2004/05	2005/06	2006/07	2007/08
£734	£804	£893	£993 (provisional)

In 2006/07, the most recent year for which comparative data is available, in Brighton and Hove there was a lower than average rate of adults with physical disabilities aged 18 to 64 receiving direct payments (31 per 100,000 compared with 56 per 100,000 in England).

However, local data below shows that the number of physically disabled people receiving direct payments in Brighton and Hove has increased from 39 in 2006/07 to 65 in 2008/09 (Table 18).

Table 18: Number of Brighton and Hove residents in receipt of direct payments 2005/06 to 2008/09

2005/06	2006/07	2007/08	2008/09
36	39	54	65

11.2. Expenditure on health services

Establishing the overall level of health expenditure on adults with physical disabilities and their carers is challenging, and a key element of the costed action plan within the accompanying strategy is to continue work to establish the baseline funding for this service user group. This is vital, because much of the NHS Brighton and Hove expenditure is across wider programmes of care (e.g. primary care) or related to specific conditions (care pathways), rather than analysed by service user grouping.

In total, NHS Brighton and Hove spends over £430m per annum on commissioning healthcare, across the spectrum from primary care to palliative care, as well as support for carers and advocacy services. Within primary care, for example, NHS Brighton and Hove spends £45m – but a significant proportion of this funding is for primary care practitioners who will provide support to adults with physical disabilities.

However, some specifically identifiable areas of expenditure can be identified of particular relevance to this client grouping, and these are shown in the table below.

Table 19: Estimated Health Spending on people with physical disabilities (excludes general health services)

Service area	Total budget (£ 000)	Service activity relating to 18 to 65 year olds (%)	Estimated spend
Sussex Rehabilitation Service			
• Brighton	2,553	37%	945
• Shoreham	2,285	40%	914
Community Rehabilitation Team	732	45%	329
Integrated Community Equipment Service	1300	25%	325
Intermediate Care	1,300	17%	221
Continuing Care: Physical Disabilities	965	70%	676
Continuing Care: Neurorehabilitation	800	70%	560
Physical disability: specific PCT budgets	150	100%	150
			4,120

Of particular note is the Rehabilitation Centre, and NHS Brighton and Hove and South Downs Health are working on the Strategic Outline Case for establishing future funding requirements for this service.

12. Appendix 1: Incidence and prevalence of specific conditions

12.1. 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 neuro-rehabilitation after an acute event.

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. Stroke occurs more commonly in people aged over 65 and it is estimated that there will be approximately 40 strokes per year in those aged under 65. It is estimated that there are 4518 people in Brighton and Hove who have had a stroke, of whom 1450 will have a moderate or severe disability[28].

For adults aged 18-64 years it is estimated that in 2008 there are 46 male and 81 female Brighton and Hove residents 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[12].

12.2. Multiple sclerosis

Multiple Sclerosis (MS) is a chronic inflammatory demelinating disease of the central nervous system leading to progressive impairment of various systems[29]. 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)[30]

Patients with MS may develop a wide range of functional impairments and disabilities that will impact on their quality of life and degree of disability. 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 [29].

MS is most commonly diagnosed in adults between the ages of 20 and 40 years of age and women are almost twice as likely to be diagnosed as men[31].

Based on the application of national incidence and prevalence rates, Brighton and Hove City would be expected to have up to 17 new diagnoses per year, and up to 300 local residents living with MS. However the MS specialist nurse is reported to manage 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

12.3. Rheumatoid arthritis

Rheumatoid arthritis (RA) is a chronic inflammatory disease of the joints[32]. 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[33]. 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. In a minority of cases the disease is constantly progressive and severe joint damage and disability develop rapidly.

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[34]. 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[35].

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[36]. 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[33].The prevalence of severe disability due to RA is 130 per 100 000 population[37].

12.4. Other conditions

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

12.4.1. Neurological conditions

12.4.1.1. 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[38].

12.4.1.2. 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.

12.4.1.3. 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[39],[40].

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[41].

12.4.2. 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[42]. As acute and emergency services have improved in their treatment of head injury, increasing survival rates, the need for rehabilitation services has also increased.

Head injuries requiring hospitalisation occur in the UK at the rate of about 300 per 100 000 population annually, of these approximately 250-280 will be mild, 15-20 moderate and 5-10 severe[43]. 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[44]. Estimating the numbers of people with residual problems from head injury is difficult[42]. However, it has been suggested that approximately 150 per 100 000 population have persistent disability resulting from head injury[45] 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.

12.4.3. Locomotor conditions

12.4.3.1. Osteoarthritis

The prevalence of severe disability due to osteoarthritis is 300 per 100 000 population[38].

12.4.3.2. Amputation

The National Amputee Statistical Database report annually on the number of patients referred to prosthetic service centres around the UK[46]. In 2005/06 there were a total of 5000 new referrals, this was a reduction on the number from the previous years and gives a rate of approximately 9.5 per 100 000 population nationally

In 2005/06 lower limb amputations accounted for 91% of all amputations with upper limb accounting for 5% and congenital amputations accounting for the remaining 4%. 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 (72% of all cases)[47]. Over half of all amputations take place in those aged over 65. The median age of men undergoing amputation is younger (66 years) than women (69 years). Those undergoing upper limb amputation have a younger age profile than those undergoing lower limb amputations, with 60% under 55 years of age. This is a reflection of the aetiology of the condition (mainly trauma).

12.5. Visual impairment

PANSI estimates that there are 111 people aged 18 to 64 years with a serious visual impairment [iii] in Brighton and Hove City in 2008, and this figure is expected to increase slightly to 115 by 2015[12].

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

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