



**Independence, inclusion and support: our integrated
commissioning strategy for adults with physical disabilities,
sensory needs and long-term conditions**

2011 – 2014

City of Bradford MDC

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NHS

Bradford and Airedale

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Executive Summary

OUR VISION

'The Physical Disabilities and Sensory Needs Partnership envisages Bradford as a district where

- people with physical and sensory disabilities live, work and participate in their local community;
- those individuals are recognised as equal and can enjoy the same life opportunities, chances and rights as their non-disabled peers and neighbours.

This vision can be achieved through ensuring services, facilities, individuals, communities and society are truly inclusive and accessible; not extraordinarily or exceptionally but universally and ordinarily.'

This is the first long-term commissioning strategy for the people of Bradford district who have a physical disability, sensory impairment or long-term condition. This strategy describes our priorities for how services and investment will change in the next three years, responding to the challenges we face in health and social care. It starts with the vision developed by our local partnership, led by people with disabilities, and the key messages from what people tell us about life experiences and services. It then considers national and local policy, the changing population and other key information, before moving on to the next steps and commissioning priorities.

This strategy looks at how services need to change and develop to fulfil the aspirations of disabled people. Making changes at a local level will challenge all organisations, whether statutory, voluntary, community and commercial. This is to ensure that people who have a physical and/or a sensory impairment have support that promotes personalisation, independence and inclusion, and does not create dependence and/or institutionalisation. The strategy promotes working in partnership to support people to self-manage conditions, access timely and appropriate information and deliver real value for money across all services. We wish to involve service providers to enable them to take up the challenge, and we can plan the best way to change and invest in our resources. We want to shape our district to be a good place for people with disabilities to live, and shape our care market to offer good quality, value for money, effective services.

Social action research took place in 2010, asking local disabled people about their experience of living here and of local services. Many of the people involved in the research experience a decent quality of life in the district citing *independence*, *social inclusion* and *support* as key to this positive experience. However, some experiences are less positive and people find gaps in access to information, professional awareness and understanding of disability.

Inclusion means playing a full part in the life of the district, realising people's potential to contribute to society in many ways, with good information being the first step to people having access to social and community life, to universal services and to care services. This means producing information in the right formats, and removing the obstacles to access that disable and disempower people. Living with a physical or sensory impairment should not restrict people to a narrow world of care services and specialist provisions; the social model of disability emphasises that social barriers create disabilities. When people do use health and care services, there must be genuine choice and control. *Independence* means that health and care services must support people to manage long-term conditions, recover and

rehabilitate from illness and injury, and offer solutions that promote independent living. *Support* for people living with disabling conditions, refers both to having inexpensive but important help that makes all the difference; and for people who need care services, to have choice and control over service delivery.

National and local policy supports these messages from people with disabilities. Social inclusion is promoted by legislation on disability discrimination, equality and human rights. Personalisation is a policy that has been strengthened by successive governments, and promotes information and access, prevention and early intervention, and choice and control over services. Integration of services and working in partnership is a sustained policy theme, promoting person-centred care, good management of long-term conditions, and best use of resources. Above all, commissioning activity must focus on achieving outcomes with and for people with disabilities – real improvements in quality of life as a result of public investment. This strategy will only be useful and relevant if it can tackle the challenges posed by decreasing public sector funding, alongside increasing need in the local population. Bradford district will have increasing numbers of working age adults in the coming years, and the prevalence of disabling conditions is increasing. At the 2001 census, the district had more people than the national average who self-defined as having a 'limiting long-term illness'; this is likely to be the case in the 2011 census and beyond. Children of South Asian family origins have a slightly higher prevalence of disabling conditions at birth, and this shows up at local population level as children achieve adulthood. This highlights further challenges for the district: for children's and adults' services to manage transitions before and after age 18, and to support family carers of children and adults with disabilities, regardless of ethnic background.

Commissioning in health and social care means making the best use of resources to achieve outcomes for vulnerable people. For example, the council currently spends over £15m per year on services to people with physical disabilities and sensory needs, of which 29% is spent on residential and nursing care. The local NHS funds £10.4m per year of continuing health care to physically disabled people, of which 82% is spent on nursing home care. NHS Bradford and Airedale (the primary care trust – PCT) spends £27m on problems of vision and hearing in primary and secondary care per year. This strategy looks at how we can pool our resources within health and social care, across all public services, within our communities, and across geographical boundaries, to meet the challenges described.

This strategy defines eight commissioning priorities:

- 1 Information and access for all
- 2 Support with employment, skills and learning
- 3 Integrated management of long-term conditions
- 4 Housing, assistive technology and support at home
- 5 Transitions from children to adults
- 6 Reconfiguration of day services
- 7 Specialist services and pathways for rehabilitation and care
- 8 Regional commissioning for HIV and AIDS

This strategy has been produced jointly between the Council, the PCT, local disabled people and carers. The document aims to reflect the views of disabled people captured at events such as 'Easier Access', voluntary sector consultation and the views of the Physical Disability and Sensory Needs Partnership for the Bradford district. Our commissioning approach must consistently reflect the shared vision for people with disabilities, to work together to respond to the challenges ahead.

1. Introduction

What is this strategy for?

This strategy outlines the vision and associated commissioning intentions for the City of Bradford Metropolitan District Council and NHS Bradford and Airedale in addressing the needs of people with physical disabilities, sensory needs and long-term conditions. A successful strategy will bring people together to work towards shared goals, and is especially important in difficult times for public services. It will also show we can achieve better use of resources to make real differences in quality of life and opportunity for people with disabilities. It aims to shape Bradford district as a good place to live, and our local service provisions to offer the best possible choices of good quality care and support.

Definitions and scope

There is no single definition of the word “disability” and the strategy adopts the definition from the Disability Discrimination Act 1995:

'A physical or mental impairment that has a substantial and long-term impact on the ability of a person to carry out normal day to day activities'

For the purpose of this strategy, disabled people refers to those who have one or more physical disabilities, sensory impairment or long-term condition which may be congenital or acquired at any age; and as acknowledged by the Disability Discrimination Act, may be temporary or longer-term, stable or fluctuating. To avoid repetition of statement the strategy will use the term 'disabled people'. It includes but is not limited to

- *Physically disabled*, for example those who have impairment of the muscular-skeletal system.
- *Visually impaired* - those with impaired vision including the blind.
- *Hearing impaired* includes people who are hard of hearing, and may use hearing aids; people who are deaf and people who self-define as belonging to the deaf community.
- *Deafblind* - those with a degree of vision and hearing loss significantly affecting daily living, communication and mobility.
- *Severe and complex needs* - those with multiplicative multi-sensory impairment, severe physical disability and learning disability/mental health needs.
- *People living with HIV/AIDS*.
- *People with acquired brain injuries* - these may be acquired through exacerbations of existing conditions, through acute episodes such as strokes or through trauma to the head during a car accident, assault or projectiles such as a bullet.
- *People living with one or more long-term conditions and consider themselves disabled* – for example, cardio-vascular conditions, diabetes, chronic respiratory illness, multiple sclerosis, musculo-skeletal conditions causing chronic pain (eg back pain). This strategy is concerned with managing such conditions well, where possible to the extent that people might not consider themselves 'disabled'.

This strategy focuses on younger/'working age' adults aged 18-64 with a disability. However, need is not defined by age, and our approach is flexible and includes services - for example equipment, stroke care and sensory impairment - which serve many people aged 65 and over. It recognises the increasing prevalence of physical disabilities, sensory needs and long-term conditions in late middle age and older age.

People may have impairment(s) for predominantly one of three reasons:

1. One has an impairment from birth/childhood and move into adulthood with that impairment.
2. One acquires an impairment in adulthood through onset of an illness or condition, for example arthritis, stroke, motor neurone disease, macular degeneration.
3. One suffers from an accident or trauma that results in an impairment, for example road traffic accident, injuries sustained from a fall, or serious assault.

Public health and long-term conditions

This strategy does not cover the full range of interventions and services to keep the population healthy, prevent and manage long-term health conditions. Bradford district will be required to produce a joint health and well-being strategy, based on the Joint Strategic Needs Assessment, as part of new arrangements under the local Health and Well-Being Board. Health and social care commissioners must understand benefits and costs across the whole system, and the impact of social conditions and individual behaviours on the development of long-term conditions and consequent disabilities in middle age and later life.

Our values - the social model of disability

Two ways of thinking about disability can help us to understand the importance of having the right values and approach. A *medical model* views disability as a feature of the person, directly caused by a health condition. A *social model* of disability, on the other hand, sees disability as a socially created problem – an individual might have a physical or sensory impairment, but it is the world around us that creates obstacles to living one's life and causes disability. Bradford district's Strategic Disability Partnership has adopted the social model of disability, with disabled people leading the way in challenging discrimination and promoting independence and access.

This approach emphasises the importance for people with disabilities to have access to the right health care – to rehabilitate from traumatic injury, manage a long-term condition, or simply to access mainstream health care - but refuses to define people's lives in medical terms. A fulfilling life in adulthood means removing obstacles - whether in our attitudes and discriminatory approaches - or physical barriers. It means promoting choice and control over, for example, accessible accommodation, meaningful activities, employment opportunities, learning opportunities and social life.

Commissioning principles

Our approach to commissioning is that the challenges we face call for a renewed emphasis on person-centred support. We will achieve the best quality and value for money by ensuring that people can use available resources to choose what is most important and what works best for oneself; by joining up services to avoid duplication; and by promoting social inclusion and independence. We want to attract new providers to the district, and for existing providers to respond to the challenge of improving both quality and productivity. A person-centred approach means commissioning for outcomes. This means that people will want to choose services which make a positive difference to health, well-being and quality of life; and to have the information to help make the right choices.

We will take a place-shaping approach, working with citizens, community groups and service providers to improve the experience of living in the Bradford district – *the creative use of powers and influence to promote the general well-being of a community and its citizens.*¹

¹ Lyons Inquiry Into Local Government: *Place-shaping, a shared ambition for the future of local government.* Sir Michael Lyons, 2007.

What's in this strategy

It is the intention that this document gives an overarching direction for making decisions and transforming services. The strategy document gives clear and consistent messages about how we will respond to the challenges we face, and the action plan will set out the specific things we will do. This strategy document sets out:

- what disabled people have told us about experiences of services and aspirations for the future;
- supply of services, including analysis of spending;
- national and local policy, highlighting consistent themes over the past decade and key changes since May 2010;
- challenges and opportunities, including demographic information and managing cuts in public expenditure;
- how this is drawn together, to set out “commissioning priorities” which we will have to address now and over the next three years.



Outcomes framework

The following combines the national frameworks for the NHS, adult social care and housing-related support. All our commissioning activity must be justified by its achieving the following:

Choice and control

Promoting personalisation and enhancing quality of life for people with long-term conditions, care and support needs.

- a. People have choice and control and experience services which are personalised to their individual needs. Self-care is enabled where this is possible.
- b. People experience an integrated approach to their care, across primary, secondary and social care services
- c. People have ready access to good information about the support and services available to keep healthy, well, independent and active. This will include services beyond those traditionally delivered by health and social care such as leisure, cultural and educational services.

Health and well-being

Helping people to recover from episodes of ill health or following injury; preventing deterioration, delaying dependency and supporting recovery.

- d. People's home environments support their health and well-being.
- a. People have access to support that prevents unnecessary or early dependence on services, e.g. services with a low level prevention focus, information, falls prevention, telecare and telemedicine, equipment and adaptations.
- b. People experience rapid access to high quality services: right place at earliest time (applies across primary, secondary and social care, as well as preventative services).

Economic well-being

- c. People are supported to maximise their incomes through good welfare benefits advice, education and training and support to stay or return to employment.

Safety and dignity

Ensuring a positive experience of care and support; treating and caring for people in a safe environment and protecting people from avoidable harm.

- d. People have their rights and dignity respected and are not subjected to discrimination, prejudice or abuse.

Enjoy and achieve

- e. People experience services which support them to enjoy a good quality of life.



2. What do people with disabilities tell us?

2. What do people with disabilities tell us?

Bradford district has developed the involvement of people with disabilities over the last 10 years, setting up our Strategic Disability Partnership in 2006. The Easier Access event, held annually, is now in its seventh year and growing as a flagship event for involving disabled people and carers. We want this to continue and develop, especially to understand the impact of the changes proposed in this strategy. Service users and carers must have opportunities to shape and influence strategy and services. People's experience must be at the centre of how we understand and measure service quality.

In 2010, 120 people with disabilities attended the Easier Access event and confirmed that they value being involved in planning, design and delivery of services. Key messages and priorities reflected were:

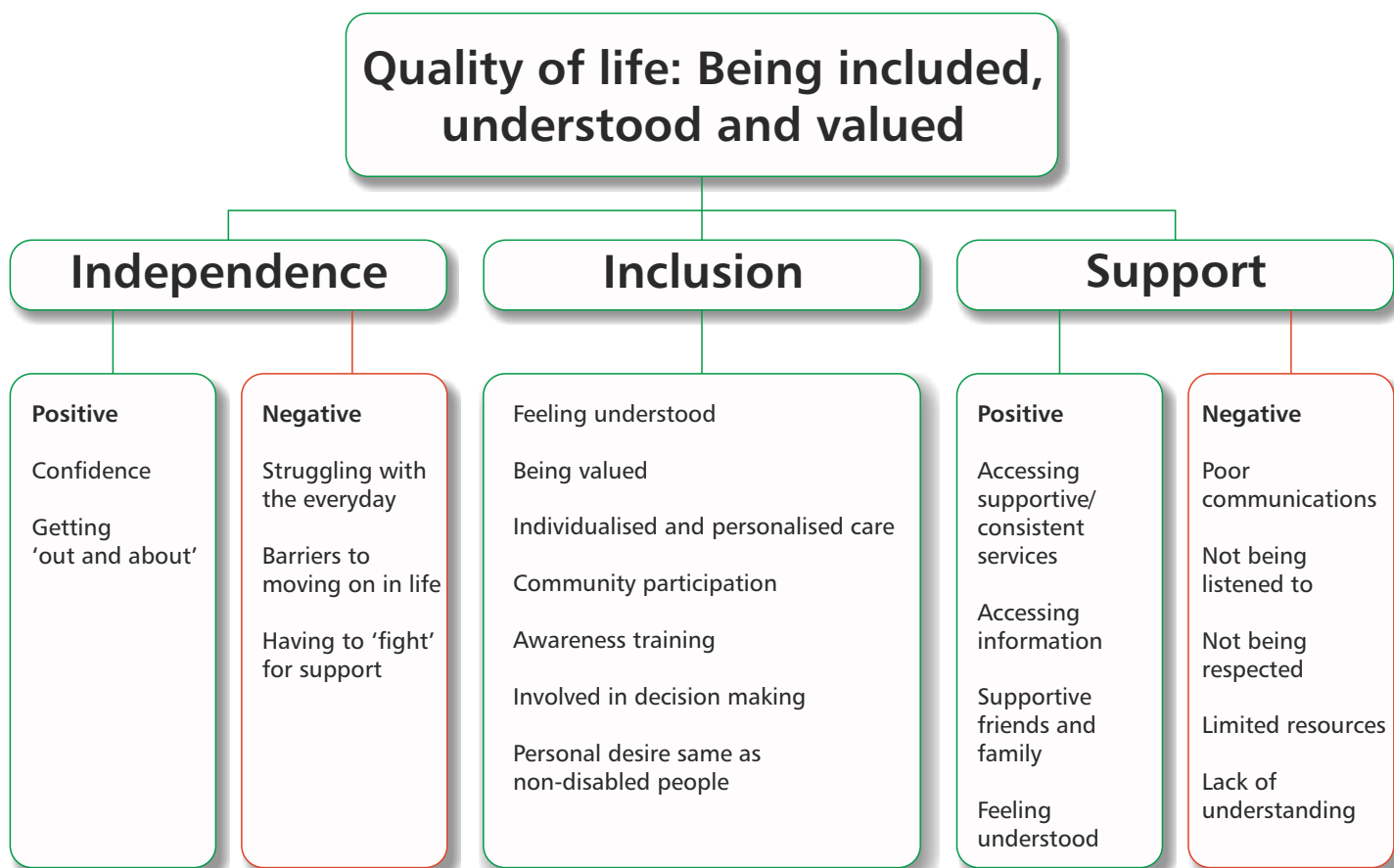
- the importance of information, transport, accessible environment and buildings;
- better joining-up of services, not having to tell the same information to several different professionals;
- the value of partnership working, for example, disabled people training local police about hate crime;
- people value the opportunity to be active citizens and visible members of communities, and not to be stereotyped as dependent.

In April 2010, *It's good that you are listening*, a social action research project, was commissioned with the University of Bradford. The aim of the research was to explore the subjective lived experiences and future aspirations of disabled people in Bradford district. It involved methodologies such as focus groups, structured interviews and questionnaires, all of which were carried out and facilitated by disabled people.

The three month public consultation invited people to comment on their experience of living in the district and receiving services; and on personal expectations, outcomes they wish to achieve and aspirations for the future.



In this research it was evident that there were three broad themes that appeared to reflect what many of the participants expressed in relation to how they experienced quality of life in Bradford, namely; *independence*, *inclusion*, and having *support*. Thus the three emergent themes represented how the participants talked about quality of life and what it meant for them. For example, being able to live independently was described and talked about as a positive aspect of living here. However, often respondents faced obstacles and independent living was desired but not always experienced. A 'thematic map' shows the positive and negative aspects of people's experiences:



Independence

Being able to live with the same freedom of choice as non-disabled people was an important factor that underpinned many respondents' perceived quality of life:

'Since I learnt sign language I can do more things like my own shopping'

'Here in Bradford I have my own place and I am independent. I like this.'

'Independence is very important, it's vital.'

Frustration about obstacles to everyday activities was a common theme expressed by nearly all of the respondents. Respondents expressed issues and difficulties with accessing services, getting on buses, booking appointments, calling a bank, going shopping, crossing the road, walking out of the front door, and many more:

'I've always got a problem at the doctors. The visual display doesn't work and they shout my name but I can't hear so it delays me for sometimes an hour.'

Good quality of life, was for many equated with being independent which meant being able to 'get out and about':

'My volunteer who befriends me means I can get out more and experience new and different things.'

'I like Bradford because there are good services, buses come all the time, disabled/access buses come to your home.'



Inclusion

Disabled people aspire to the same things as non-disabled people. It was found in this research that respondents expressed desires to travel, find work, participate, and live independently. Respondents wanted a voice, to be involved as active and valued citizens, and involved in making decisions.

'It's good that you are listening to our views because we've all got them.'

'A lot of decisions don't take into account our views.'

'A lot of groups focus on people being able to manage their lives, I don't think many groups ask about people's goals.'

'I think we as disabled people would have more insight into what disabled people want.'

'Take the labels off us. As a disabled person through no fault of my own, I have been left totally deaf to right ear due to 22 years' service in the army. As soon as I was discharged (on medical grounds) from the army, the powers to be in Civilian Street stuck the label on me of being 'disabled'.'

Support

Lack of information can also create barriers to accessing services, which caused frustration for many respondents. Accessible information came up time and time again as the biggest barrier to timely, helpful and meaningful support. Barriers to accessing universal, mainstream services such as GP appointments, can be seen as obstacles to *inclusion*. This coupled with a lack of awareness and training of many professionals, meant disabled people were denied the same level of service as their non-disabled peers. Some of the following examples give concern about people not being treated with dignity and respect.

'I feel I don't have a long time with the doctor and he wants me out because I'm a deaf person'

'I want to communicate with them in my language'

'Getting to diagnosis at hospital and being told nothing about how to get help and information about support services, they just deliver the bad news and leave you to it.'

'I went to hospital and just because I am blind they asked me to get in a wheelchair'

'My interpreters couldn't stay for the whole appointment and it was the important part that they missed; when they told me my results!'

'The worst services are when hearing people talk and then don't explain. Two home care workers turn up and talk to each other, then another two at lunch time, two more at night time. They talk together and not to me and I don't know what is going on. Then they would go for a smoke and leave me.'

The three themes of *independence*, *inclusion* and *support* are adopted as the title of this strategy, and throughout this strategy they are applied to specific services and our proposed plans and priorities for change.



3. The bigger picture

National policy context

The following are key themes from national policy over the past decade. They accord with the social model of disability, and the messages from people with disabilities about independence, inclusion and support:

- The Disability Discrimination Act and the rights of the whole population of disabled people to access universal services such as transport, leisure, housing, shops and equality in employment and the workplace.
- The importance of information, people knowing what's out there and available. Information available in a format that can be accessed by the individual in a timely and prompt manner.
- Prevention and early intervention for people at risk of or experiencing problems affecting physical ability, sensory ability and wider health and well-being.
- Health and social care services offering high quality, flexibility and responding to individual needs.
- Rehabilitation and reablement following, for example, diagnosis of sensory loss, amputation, brain injury, stroke.
- Joined-up services, especially to enable self-management of long-term conditions – for example, chronic obstructive pulmonary disease (COPD), diabetes, multiple sclerosis, heart disease.
- Providing services at home, or closer to home; reducing admissions to hospitals and care homes.
- Choice and control – deciding how to spend the funding allocated for your care and support needs.
- Stimulating the provider market to enable real choice for people; an increased role for social enterprise and the voluntary sector.
- Quality, dignity and safeguarding; developing the workforce to ensure quality services.
- Support to and breaks for families and carers.
- A focus on outcomes – real results for people.
- The importance of commissioning, to understand the needs of local population and achieve best use of resources.

These themes run throughout policy and guidance, in particular:

- *Disability Discrimination Act (2005)*
- *Improving the life-chances of disabled people (Cabinet Office, 2005)*
- *National service framework for long-term conditions (DH, 2005)*
- *Our health, our care, our say (DH, 2006)*
- *Putting people first: a shared vision and commitment to the transformation of adult social care (DH, 2007)*
- *A new deal for welfare – empowering people to work*
- *Vision 2020, the national eye care strategy*
- *Transforming community equipment services (DH, 2006)*
- *Standards for services for people who are deafblind, or have a dual sensory impairment*

2010 onwards

The change of government in May 2010 has led to new policy and significant reforms, though there is much continuity with the above key themes:

- The white paper – *Equity and excellence - liberating the NHS* (July 2010) heralds major changes to the NHS, including GP consortia proposed to take on commissioning responsibilities, and local authorities responsible for public health. The support of the previous government for the 'third sector' is developed into the ambition for a large-scale social enterprise sector within health and social care. Personal health budgets will be piloted, and competition for provision of health services opened up to 'any willing provider'.
- *A vision for adult social care; capable communities and active citizens* (November 2010) based on seven principles. *Prevention, personalisation, partnership, protection, people (workforce), plurality* (diversity of provision) can all be seen as developments from *Putting people first*. *Productivity* is set alongside quality to emphasise that commissioners and providers are expected to set high standards regardless of spending pressures.
- *Transparency in outcomes* documents for both the NHS (July 2010) and adult social care (November 2010) have defined a new set of outcomes, aligned for health and social care. They envisage replacing 'top-down' performance management with councils and GP consortia being accountable to local communities, using measures centred on the experience of people using services.
- A social care reform bill is planned for late 2011, following a Law Commission review of the legal framework, and a review of funding of long-term care.
- *National carers' strategy refresh* – promoting breaks for carers of vulnerable people, including funding through direct payments.

Personalisation

Personalisation means thinking about care and support services in an entirely different way. People with physical disabilities have been at the forefront of the movement to have care needs met through direct payments rather than traditional care packages. Many physically disabled people in Bradford were the early adopters of direct payments. *Our health, our care, our say and Putting people first* emphasise that personalisation means social inclusion, building the strength of communities to support vulnerable people, and a range of options for people to have individual accounts control how funding is used for care and support. This can go beyond what are traditionally seen as social care services. The *Vision for adult social care* reinforces the importance of 'capable communities', and emphasises that direct payments are the preferred form of individual account. Pilot sites for "the right to control" intend to give disabled people a legal right to control and choose how they use a wider range of budgets, including Access to Work and Disabled Facilities Grant.

Local policy and strategic direction

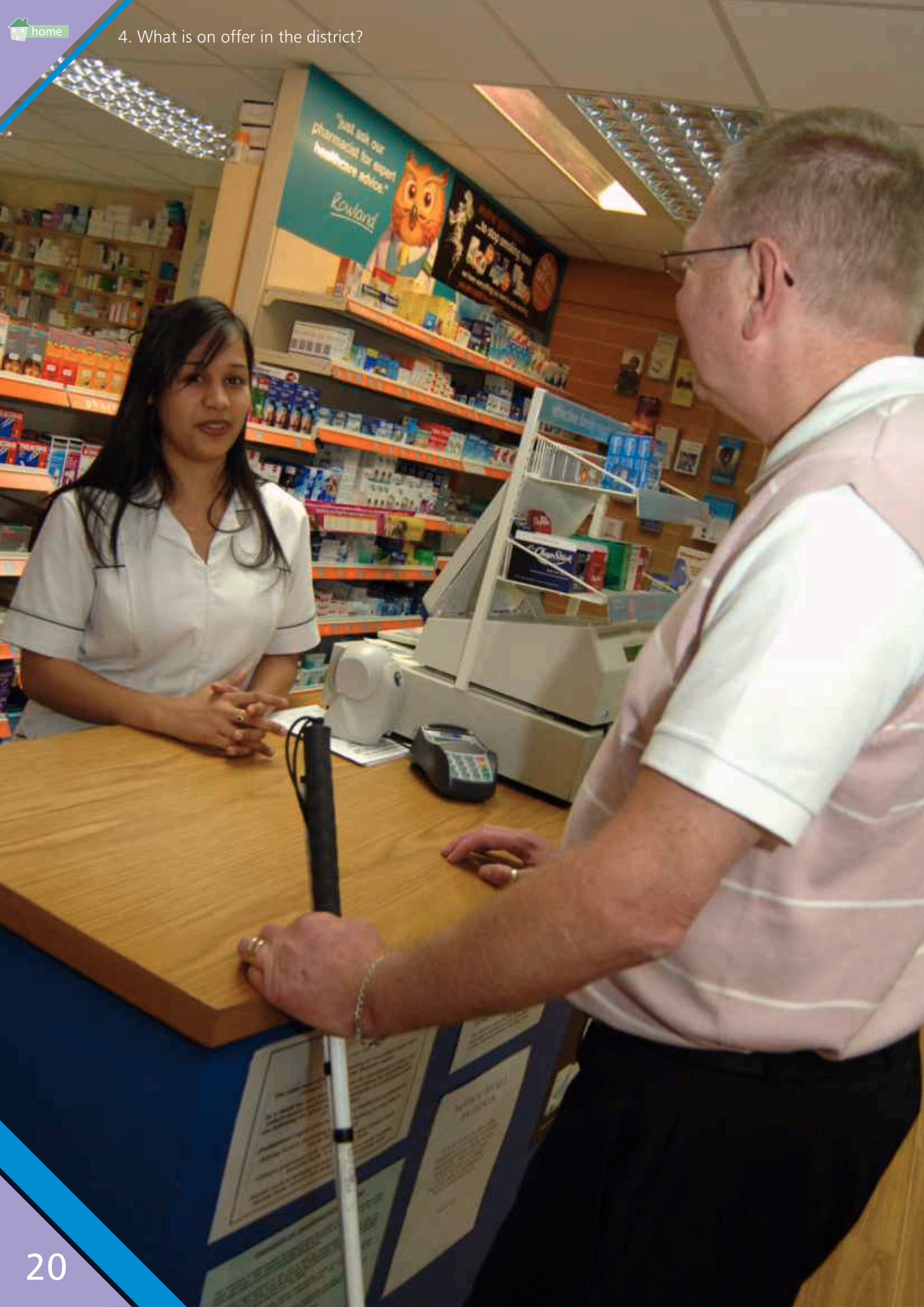
People with physical disabilities and sensory needs are represented at the district's Physical Disability and Sensory Needs (PDSN) partnership and Strategic Disability Partnership (SDP). The priorities set for this partnership working are all important elements for social inclusion and independence:

- Access to information
- Mobility planning
- Employment action
- Hate crime
- Inclusive design, lifetime homes and neighbourhoods

Further priorities identified locally are:

- Resolution of the council's Health Overview and Scrutiny Committee, (September 2010) on the needs of people with acquired brain Injuries (ABI). These include the identification of and response to ABI in emergency services; and rehabilitation, day services and long-term support which can meet the distinct needs of people with ABI..
- The 'Bradford Benchmark' (Council Executive decision from October 2009), developing a standard to assure quality of care provision across all sectors.
- The QIPP programme for long-term conditions, to improve self-management, reduce hospital admissions, re-admissions and length of stay; initially focussing on people with breathing difficulties.
- *Being positive in Bradford* – An analysis of the social support needs of people affected by HIV/AIDS in the district.
- *Caring matters – think carer*, our local integrated commissioning strategy for carers.





4. What is on offer in the district?

The council and NHS currently commission a wide range of services for disabled people with the public, community and voluntary sector. This chapter of the strategy aims to give a broad overview of that provision, and the use of resources to fund the current levels of services.

The following information about available services is presented broadly according to levels of need. Some services do not fit neatly into this model as they provide support to people with wide-ranging needs – for example, housing related support, home-care, sensory assessment, equipment provision and benefits advice - can be equally useful for people with low to moderate needs as those with more substantial needs. A full list of all the different services in the Bradford district is provided in Appendix 1.

Services that meet the general needs of people with long-term conditions in Bradford district:

- Bradford has developed a strong Physical Disability and Sensory Needs Partnership which looks at the wider agenda for disabled people. An updated action plan for the Partnership is due to be published in 2011. Key areas include:
 - Information about conditions, 'expert patient' support.
 - Long-term conditions management
 - Personalised care planning with GPs
 - The OUR project, social support for people affected by HIV/AIDS
 - Involving disabled people
 - Transport services
 - Primary care services (general practitioners, community health services, pharmacy, opticians and dental services)
 - Secondary health care, including outpatient clinics
 - Ambulance and fire services
 - Employment support
 - Assistive technology
 - Neighbourhood services
 - Community development
 - Adult education – 'lifelong learning'



Services that meet the needs of people with disabilities – relatively low levels of need

These services may be some of the first types of services disabled people come across when asking for help. These services also offer support to people with more complex needs.

- Access to information about care and support, for people with disabilities and for carers:

“We want accessible information advice and support available to us as and when we need it. Getting the information about how to help yourself is sometimes the hardest part.”

- Interpreting, translation, transcribing, talking media:

“At Eccleshill Medical Centre they send you a letter saying your BSL interpreter has been booked. I like this, when people properly understand your needs, its fantastic!”

- Peer support and befriending
- Projects and campaigns to tackle discrimination and stigma – for example, anti stigma and awareness raising bus advert campaign for HIV/AIDS services; Disability awareness seminars delivered in local primary and secondary schools, delivered by disabled people.

- British Sign Language (BSL) classes, including parents of deaf children

- Community care assessment and self-directed support

- Housing-related support

- Adapted housing, equipment, aids and adaptations

- Practical support and housing-related support

- Financial and benefits advice

- Day services

- Advocacy and self-advocacy

“If people understood the barriers more, it'd go a long way to us feeling included.”

- Specialist support – for example, eye care liaison officer based at the Bradford hospitals, stroke coordinators linked to all district hospitals

- Transport

“Good transport is important to maintaining your independence, it's vital.”

Blue badge scheme; access bus; free city bus; community transport schemes; mobility component of Disability Living Allowance.

Services that meet the needs of people with personal care and more complex needs

Many of these services are designed to promote independence, so people may have substantial needs at the point of accessing the service but recover physically or develop new skills and coping strategies – for example, being newly diagnosed as deaf or blind, or following an amputation, accident or traumatic illness (like a stroke or heart attack) that results in disability.

Enablement and early intervention

- Intermediate care
- Enablement services, including sensory needs rehabilitation officers, equipment.
- Integrated community teams such as the community head injury rehabilitation team
- Health Partnership Project

Long-term care in the community

- Home care
- Day care
- Support groups and shared activities.
- Telecare - "safe and sound"
- Stroke care
- Carer support
- Integrated care services

Interveners and communicator guides – personal assistants who support people with profound sensory and communication needs to communicate with others

Use of resources

The following are the key points from analysing current spending and activity (see Appendix 2):

A relatively low number of people with complex needs require a high proportion of service spend; 25% of purchased care spend arises from the 6.5% of the service-users whose care costs above £400 per week; and there are 68 people with fully-funded NHS care with an average care cost above £1,100 per week. The people receiving this care are among the most vulnerable in the district, and commissioners must look carefully at quality and dignity of care alongside ensuring value for money. There is a particular challenge for predicting and managing spending, as children with complex needs grow into adulthood. Similar considerations apply to major adaptations funded by Disabled Facilities Grant, with an average cost of £11,000 per adaptation.

The district has an above average proportion of its service spend on people funded to live in care homes, and a below average spend on assessment and care management services². The Department of Health's work on use of resources in adult social care, has shown that this is a consistent pattern; well-resourced care management may contribute towards maintaining people at home.

Long-term conditions are estimated to account for 70% of NHS spending, and local work on the NHS's quality, innovation, partnership and prevention (QIPP) has focused on people with chronic breathing difficulties. NHS costs for obstructive airways disease are calculated as £1.4m per 100,000 weighted population in the Bradford district, of which 35% is hospital admission costs³. This highlights the benefits of working together to prevent these conditions (for example, by public health work for smoking cessation), manage conditions – for example, using GP care planning and telehealth - and alternatives to hospital admissions.

² Now known in the district as "access, assessment and support"

³ NHS Yorkshire and Humber, QIPP resource pack (June 2010)

4. What is on offer in the district?

Significant resource is committed to 'blocks' of traditional service, which do not always offer the opportunities and choices people want. We invest over £800,000 per annum in one day centre, of which 40% is transport costs from people attending from across the district.

Gaps in services

Our commissioning approach is generally that it is neither affordable nor desirable to create distinct specialist services for all conditions. This leads to too many boundaries between services, gaps where people do not fit neatly, and difficulties in getting the right capacity and managing fluctuations in demand. However, the following are highlighted from looking at supply against evidence of need:

- Integrated services to avoid hospital admissions
- Rehabilitation services that can meet specialist needs eg, acquired brain injury
- Alternatives to day care, closer to home and community-based
- Domiciliary care and support services which can meet the range of specialist needs
- Advocacy services for people with dual-sensory impaired and profound communication impairment
- Limited support for the voluntary sector to offer peer support, practical support and social activity.





5. Opportunities & Challenges – Needs Analysis

Context

There is no absolute method for identifying all disabled adults in the Bradford district. Varying definitions, reaching individuals and families, and changing circumstances make measuring disability imprecise and likely to produce under-estimates. This section seeks to provide estimates of need, indicate where the greatest need is likely to exist, evidence of unmet need within particular sections of the population, and anticipate increased future demand. Bradford district is very diverse and disabled people are no exception, with individual background, circumstances, and the impact of health conditions and impairments meaning that stereotyped assumptions cannot be made about individuals.

As the adult population grows, the population of disabled people will increase. Caution is exercised when using national prevalence data to attempt to estimate the local prevalence of disabilities as local factors for Bradford means that prevalence is above national average for many conditions. This makes it important for both individual well-being and a sustainable future, that we tackle public health issues such as smoking cessation, alcohol and obesity; preventive initiatives such as reducing accidents, better management of diabetes, stroke, COPD and heart disease. These will become part of the local authorities remit in managing public health in the future.

Both low birth weight and pre-term births have an increased risk of ill-health and disability throughout their life. Advances in medicine and technology have enabled more children to survive life-threatening circumstances, resulting in more children with complex health needs. Increased numbers of children are surviving infancy with severe and complex needs moving through transition into adulthood. Overall the numbers of people with disability are increasing as people with disabilities live longer. The increase in the number of children with severe and complex needs presents a significant challenge to local authorities. With increasing numbers of young disabled people coming into services for adults, and long-term conditions in middle age increasing risks of disability, it is vital that this strategy not only supports and integrates health and social care services but links to the districts strategy for disabled children, transitions, older people and carers.

What we know about Bradford's population, the challenges

Bradford's population is increasing and it is estimated that it will continue to increase in the foreseeable future. Bradford has a total population of around 512,000. The district is an ethnically diverse community and has a rich mix of ethnic groups and cultures. It has the highest proportion of non-white ethnic backgrounds of any district in Yorkshire. Bradford is one of the country's most rural metropolitan councils. Issues such as good transport links, access to the internet for information and mobility and accessibility too in many of the district's 'hilly' areas are therefore likely to affect an increasingly large proportion of Bradford district's disabled population.

Bradford experiences high levels of deprivation. According to the index of multiple deprivation 2007, the district is the most deprived local authority area in West Yorkshire and 32nd most deprived in the country. In 2004, 43% of the population of the Bradford district lived in the most deprived 20% of wards in England (with 30% living in the most deprived 10% of wards). Further evidence of the diversity of Bradford is that some of these deprived neighbourhoods are adjacent to much more affluent areas (11% are in the “most affluent” deciles).

The incidence of disability

Information taken from the Bradford 2008 Joint Strategic Needs Assessment (JSNA) shows that; in the 2001 Census 86,486 people in the Bradford district, (18.5% of the population) considered that they had a long-term limiting illness. This is widely used as a proxy indicator for levels of disability. The figure for the district is slightly higher than the UK average figure of 18.2%. Appendix 4 summarises figures and projected changes to the demographic picture of disability in the district, using (with the caveat above) national prevalence data. Over the period of the current spending review, the number of working-age adults in Bradford district will rise by 2.9%. The number of people of south Asian origin aged 50-64, who are at increased risk from diabetes and smoking-related conditions, will increase by 25% from 2010-2015.

Disabilities and welfare benefits

In May 2006, 25,150 people in Bradford between the ages of 16 and 65 were claiming incapacity benefit or severe disability allowance. Of these people, 27% were under the age of 30. Proposed changes to the benefits system will impact on the number, amount and type of benefit that many disabled people receive, not least reforms to Disability living allowance and Incapacity benefits and their respective replacements being introduced; personal independence payment and employment and support allowance.

Long-term conditions

In 2001 18.5% of the population (86,486 people) considered they had a long-term illness with more recent data showing the numbers increasing. The British household panel survey includes a question asking whether or not people agree with the statement '*My health limits my activities often*'. In the 2002 survey, the percentages of people interviewed who agreed with the statement responses to this question were as follows:

- 5% of people aged 16-49
- 16% of people aged 50-64

If we apply these prevalences to Bradford's population projections there is a 12% overall projected increase in the number of people whose activities will be limited by health in the next 15 years. Long-term conditions represent:

- 69% of health and care spend;
- 77% of inpatient bed days;
- 55% of GP appointments and
- 68% of outpatient and A&E appointments;
- The average annual health cost of someone without a long-term condition is around £1,000; this rises to £3,000 for someone with one condition and to £8,000 for people with three or more conditions;
- 170,000 people die prematurely of long-term conditions each year;
- Significant variation across PCTs exists in emergency hospital use.

In Bradford work has begun on addressing the care pathway across all long-term conditions through the NHS QIPP (quality, innovation, prevention and productivity) programme. The main aims of this work are to reduce hospital admissions, reduce the re-admission rate and reduce the length of stay when a person is admitted to hospital. There are increasing numbers of people who have more than one long-term condition, particularly older people, yet face an increasingly fragmented specialised response. In future rising demand will far outstrip the current service model

- 60% increase in the number of patients with multiple long-term conditions by 2016
- 252% rise in over 65 year olds by 2050
- 188% rise just in diabetes by 2050

Changes to current practice in one primary care setting in Bradford have identified savings of over £1m per 10,000 patients, through personalised care planning for people with multiple conditions and use of telehealth.

Long-term neurological conditions

It is suggested that 5.8% of the national population are affected by neurological disorders. This equates to around 29,700 locally. To arrive at reliable figures for the district, better recording and diagnosis of conditions is needed. Prevalence data does not provide sufficient reliability to accurately predict neurological and long-term condition rates in Bradford. Long-term neurological conditions can be broadly categorised as follows:

- sudden onset conditions, for example traumatic brain injury and acquired brain injury or spinal cord injury, followed by a partial recovery;
- intermittent and unpredictable conditions, for example epilepsy.

A long-term neurological condition results from disease of, injury or damage to the body's nervous system (that is, the brain, spinal cord and/or the peripheral nerve connections) which will affect the individual and their family in one way or another for the rest of their life. A significant number of people with an acquired brain injury are left with long-term physical impairment, cognitive difficulties and long-term difficulties in emotional and social adaptation.

The National framework for long-term conditions has highlighted acquired brain injury as a national healthcare priority. There are significant uncertainties in the data relating to acquired and traumatic brain injuries. No forecasting of new incident rate or prevalence (existing and ongoing cases) rate exists. Nor is there a forecast into the future, this reflects weaknesses in counting and coding and makes it difficult to effectively plan services.

Sensory needs and ageing

Approximately half of all visually impaired residents are over age 75, and the ageing process increases the likelihood of deterioration in vision and hearing. Demographic information is extremely important in influencing and shaping the types of services that are made available to these individuals. The likelihood is that the majority of those residents over age 75, a very significant number will have 'acquired' their visual impairment through the natural ageing process and therefore will not be adapted to formal blind language alternatives such as Braille and Moon. They will begin to rely on hearing for communication and accessing information, but often the ageing process affects this too. They will not have had mobility training in their lives up to the point of losing their sight and therefore will be experiencing major changes in their communication, mobility and social skills to cope with sight loss.

Of those residents aged 18-49 years the division is more evenly spread between congenital sight loss (existing impairment from birth or before acquisition of language) and acquired sight loss (often through illness, injury or trauma).

Evidence suggests that over 50 per cent of sight loss is due to preventable or treatable causes, in the older population this is thought to increase to as much as 70 per cent. There are significant adverse health impacts associated with sight loss, such as increased risk of depression and falls. People with sight loss are also likely to have additional disabilities and are likely to live alone. These factors indicate that those affected by sight loss are among the most vulnerable and isolated. Locally the NHS spends £22.1m on problems of vision and £5m on problems of hearing, in primary and secondary care.⁴

In addition to problems of vision, work has been carried out looking at unmet needs of people with hearing difficulties in the district:

- Approximately 14,000 people in Bradford aged between 55 and 74 years old have a hearing problem which causes moderate or severe worry, annoyance or upset.
- Approximately 16,000 people in Bradford aged between 55 and 74 years old have a bilateral hearing impairment of at least 35dBHL.
- 3,500 people in Bradford aged between 55 and 74 years old currently receive interventions such as hearing aids.

Bradford District Public health data 2008-09



Deafblindness is defined as a combined hearing and sight loss that causes problems with mobility, communication and access to information. Most older deafblind people have some level of hearing and sight, but a loss to both senses combines to create a serious disability.

Children with physical disabilities and sensory needs

Further data comes from children born in the district with disabilities, with a higher prevalence amongst children of south Asian family heritage. The number of paediatric neurodegenerative conditions being treated in Bradford has risen from just eight in 1986 to 45 today. Bradford's high rate of such conditions was confirmed in a 2004 study, further work is required on the prevalence of physical and sensory disability at birth and survival into adulthood, this work is underway with the 'Born in Bradford' project established through the Bradford Teaching Hospitals NHS Trust.

There are more children born in Bradford than elsewhere in the UK with deafness, cerebral palsy, neurodegenerative disorders, primary micro and inborn errors of metabolism. Some of the underlying factors are low birth weight, poverty and genetic disorders.

- Bradford children are nearly two and a half times as likely to be deaf than the UK population as a whole, this increases to almost five times more likely for children of Asian ethnicity.
- The prevalence of cerebral palsy is approximately 79% above the European average at 3.87 per 1000 children in Bradford
- There are a disproportionate number of children with neurodegenerative conditions.
- There is a significantly increased prevalence of other serious medical conditions which can be categorised as conferring a disability.

Conclusions

Within Bradford district there are generally higher levels of need than nationally, particularly in city centre areas, including a large cohort of individuals with a sensory impairment. Bradford's population is set to grow which will increase demand on services; particular areas of growth are in the populations of younger people with disabilities, and older (65+) people. The significant cuts in public spending will make it difficult to manage these demand pressures. This strategy proposes that this must be addressed by a local approach based on the national policies of *Putting People First* and *A Vision for Adult Social Care*. Service user expectations and aspirations have changed and will continue to change as more people are in receipt of an individual budget and are exercising more choice and control over their care and support. These expectations and aspirations will shape and reconfigure services as much as weight of numbers.



6. The way forward

This strategy seeks to support commissioning decisions which will ensure a radical transformation of services for physically disabled and sensory impaired people and their carers. Services which do not make a contribution to the outcomes described in this strategy will ultimately be decommissioned, and investment redirected to services which do.

The following principles will apply to all strategic commissioning activity over the next three years and underline the intentions of the NHS and social care partners to:

- give disabled people the opportunity to take control of one's own care and to influence wider service development;
- disabled people are involved in decision making and can influence commissioning strategy and service design from the outset;
- work with all our partners to integrate services, making best use of all the resources in the district;
- invest in public health, and management of long-term conditions, learning about 'what works' to inform future investment;
- ensure people's rights and dignity are respected and we tackle discrimination, prejudice and abuse, both in service settings and in our communities;
- deliver services as close to home (or as conveniently) as possible;
- promote equality, diversity and localism for people with disabilities;
- shape the health and social care market, to ensure that the needs of individuals can be met by available services, meeting the challenges of a diverse and growing population.

In the next chapter are the commissioning priorities for delivering our vision, meeting changing needs and expectations in line with the social model of disability. The proposed actions are aspirational and ambitious in the current financial climate and regarding the amount of change required. The next steps for this strategy will be to consult on its content and priorities, and develop an action plan which focusses on the next 12 months, taking us closer to where we want to be in the years to come.





7. Commissioning priorities

Priority 1: Information and access for all

Disabled people have said many times that ready access to good information and advice goes a long way to improving quality of life.

Information should be in appropriate formats and community languages about all services available to keep healthy, well, independent and active.

Actions:

- Development of accessible information and an 'easy read charter'
- Disabled people have equal access to services regardless of condition-specific pathways, impairment or location within the district
- Get organisational sign up to the principles of better information for disabled people, across sectors.
- Disability awareness training is available for health and social care, education and police professionals and other partner agencies.
- Participation in training and awareness is actively promoted and encouraged by senior managers, commissioners and GP consortia across all health and social care provision and more widely across all agencies and sectors.

How will we know we are successful

- Information about health and social care services is available at the point of need through a range of formats and media
- People have choice and control, and experience services which are personalised to their individual needs. Self-care is enabled where this is possible.
- People experience services which support them to enjoy a good quality of life
- Services meet the widest range of needs to the general population of disabled people, encouraging and supporting people to remain independent and not increase dependency on services

Priority 2: Support with employment, skills and learning

It is recognised that employment is one of the biggest factors in determining a person's quality of life. Employment is the best route out of poverty, and promotes social inclusion and mental and emotional well-being. Research has shown that many disabled people are dependant on benefits for financial support. Many feel there is little support to access employment and knowledge of how employment affects benefits is inadequate.

Actions:

- Develop support mechanisms for disabled people to gain and sustain employment and that work places are accommodative and inclusive places for disabled people
- Increasing access to paid and voluntary employment.
- Increase the range of skills-based day-time activities, opportunities to volunteer and experience work.
- Local employment strategies will include the support needed for disabled people to maintain employment, ensure employers make reasonable adjustments (DDA) and will recognise the skills and talents disabled people can offer the workplace.
- Access to and maintenance within education will be a key component in transitional planning for young disabled adults.
- Local leads to work in partnership with disability employment advisors to ensure that disabled people get the support they need.



Priority 3: Integrated management of long-term conditions

Long-term conditions represent 69% of spend on health and care, 77% of inpatient bed days, 55% of GP appointments and 68% of outpatient and A&E appointments. As people become more ill and less able to manage their condition they risk becoming more dependent on services for support.

Actions:

- Continued involvement of the NHS and council in the QIPP programme to implement; risk profiling, personalised care planning and integrated care teams.
- Develop the social care workforce to better support people to self manage long-term conditions

How will we know we are successful

- People experience rapid access to high quality services: the right place at the earliest time (applies across primary, secondary and social care, as well as preventative services)
- People experience an integrated approach to their care, across primary, secondary and social care services
- Services will be flexible, integrated and coordinated around the needs of the disabled person.
- People are supported to stay out of hospital where practicably possible
- Reductions in admissions, re-admissions and length of stay

Priority 4: Housing, assistive technology and support at home

Many disabled people are very independent and don't like or want to rely on family and carers to help them in their day-to-day living. Adaptations help people stay in their own home and live an independent life. Equipment and adaptations can change someone's quality of life and avoid dependency on other services/people.

Support is at home it should be delivered by skilled PAs, staff and carers who are aware of both the individual disability and how they can help people do more for themselves.

Actions:

- Enable people with disabilities to access accommodation options and housing related support options to give greater choice.
- Allow for greater flexibility in the way services are delivered in people's own homes.
- Place emphasis on enabling and prevention to promote independence.
- Increase the use of telecare, telehealth and touch screen technology to make health and social care services more convenient and accessible to disabled people
- People's home environments support their health and well-being.
- Adaptations are easily organised and carried out to enable people to live in their own homes.
- Developing and shaping the health, social care and support market, to ensure providers have the specialist knowledge and skills for the full range of specialist needs.



Priority 5: Transitions from children to adults

As the population of younger people and number of children surviving with complex medical conditions grows in the district, the number of young people with sensory impairment, physical disability and complex needs will increase. Addressing the needs of those aged 16-25 to enable a smooth transition from childhood to adulthood is a priority area of work that involves many partner agencies

Actions:

- Ensure that services adapt to meet a new generation of expectation and aspiration
- Understand the needs of young people entering the health and social care market as adults, both through individual assessments and understanding the collective impact of an age cohort on demand for accommodation, care and support.
- To co-ordinate relevant services for adults to contribute to transition reviews for young people aged 16+, where a significant social care need is identified, through active profiling, in order to facilitate the smooth handover to adult services.

Priority 6: Reconfiguration of day services

Bradford has a long history of supporting adults with physical disabilities in a day service setting. We are looking at ways of further improving our services to meet people's needs better. We must provide services which start with the wishes, aspirations and needs of the individual. We need to continue to change our services to meet the changing needs and expectations of people with disabilities. We want to support people more in the community, rather than in a venue or centre.

Actions:

- Review of Whetley Hill Day Centre, linking to review of adult services' transport arrangements.
- Developing options for skills-based day services, support at evenings and weekends, supporting people to travel independently and meaningful daytime activity in local communities, towns and city.



Priority 7: Specialist services and pathways for rehabilitation and care

Many disabled people have severe and complex disabilities. It is acknowledged that these conditions can require highly specialised and intensive support through rehabilitation and continued care and support. It is also recognised that these individuals represent some of the most vulnerable in society and may have the greatest reliance on services.

Actions:

- Review of specialist rehabilitation services for acquired and traumatic brain injuries, the care pathways and supporting people in the community without the need for placement out of area.
- Developing the choice of providers of specialist services to meet the needs of those who are most vulnerable, at risk or with specific and complex needs.
- To ensure people with physical disabilities have a full range of options in meeting their leisure, educational and social needs along with the general population and have access to mainstream community activities.
- Integrated workforce planning, to develop the skills and knowledge required.
- Provide appropriate specialist and timely rehabilitation, closer to home, to enable people with physical disabilities to develop and maintain independence.
- Review advocacy services for adults and consider options for specialist provision for people with profound dual sensory and communication impairment.
- Work with the local carers' strategy Caring matters, think carer to support carers in their caring role, including opportunities for individual accounts and short breaks.

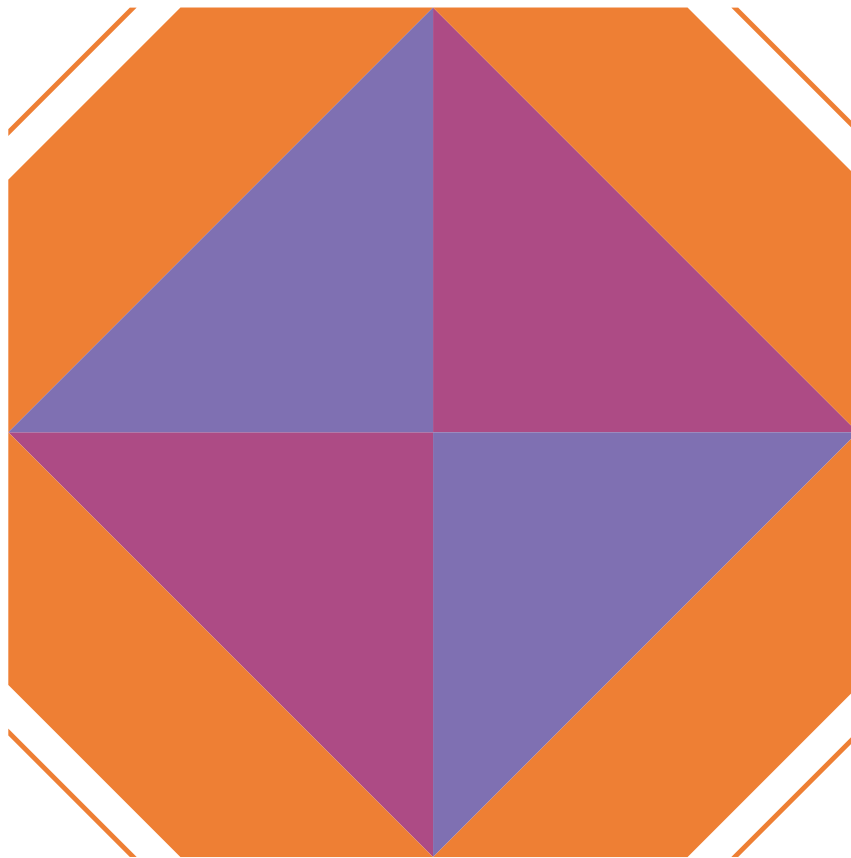
Priority 8: Regional commissioning for HIV & AIDS

The increasing evidence supports preventative and early intervention models of service delivery in this area. Public health information supports the development of services aimed at early identification and diagnosis of HIV. Regional demographic data is similar in trend and 'at risk' populations are the same across localities, there are greater efficiencies and a better user experience to be gained from working in a regional approach to service commissioning.

Actions:

- Commission co-ordinated and equitable services for prevention, early intervention and social support across the region through one single contract
- Commission fast testing across the region to increase the uptake of tests leading to early diagnosis and early treatment
- Increasing the support available to at risk populations and linking to the wider sexual health agenda





City of Bradford MDC

www.bradford.gov.uk

City of Bradford Metropolitan District Council
Olicana House
Chapel Street
Bradford BD1 5RE

www.bradford.gov.uk

NHS

Bradford and Airedale

NHS Bradford and Airedale
Douglas Mill
Bowling Old Lane
Bradford BD5 7JR

www.bradford.nhs.uk

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