



EQUAL LIVES

North Yorkshire 5 year Strategy for People with Physical and Sensory Impairments

Refreshed version 2011 – 2016

FULL VERSION

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Foreword.

This document updates and revises the North Yorkshire Strategic Partnership's (NYSP) Physical and Sensory Impairment (PSI) 'Equal Lives' Strategy which we launched in June 2007 for the period 2007-2010.

The vision for improving the quality of life for disabled people in the county remains the same but we have now reviewed and amended some of our priorities to develop an annual action plan with greater focus on specific issues.

The North Yorkshire Strategic Partnership

The North Yorkshire Strategic Partnership (NYSP) brings together the principal public sector agencies responsible for promoting the economic, social and environmental wellbeing of communities in the County, together with the voluntary sector and business community and each of the district level strategic partnerships.

NYSP comprises a number of thematic partnerships each dealing with an aspect of the communities needs, a steering group, a local area agreement management group and a wider partnership. NYSP has a strategic plan and action programmes called the **Sustainable Community Strategy (SCS) for North Yorkshire 2008/18**, and is responsible for the development and delivery of the local area agreement (LAA).

Further information about the NYSP is available at
www.nysp.org.uk

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Section 1: Introduction

1.0 This is the **Equal Lives** strategy for **People with Physical and Sensory Impairments** in North Yorkshire. Its main aim is to ensure services are planned and delivered in ways that enable people with Physical and Sensory Impairment to exercise choice and control over how their additional needs are met, and to promote access to the full range of services that many people take for granted.

2.0 The overarching long-term vision is¹:

People with physical and sensory impairments should have full opportunities and choices to improve their quality of life and will be respected and included as equal members of society

3.0 Section 6 sets out the broad themes and aspirations, using the seven key headings of the 'Our Health Our Care Our Say' White Paper:

- Improved Health
- Improved Quality of life
- Making a positive contribution
- Exercise of choice and control
- Freedom from discrimination and harassment
- Economic well-being
- Personal dignity

These outcomes have also been adopted by the North Yorkshire and York sub-regional multi-agency framework for people over 50 ('Planning for Older Age') and are also used as the framework for the Local Areas Agreements in North Yorkshire.

4.0 This Equal Lives strategy spans the next five years and covers people with physical and sensory impairments and their carers. The document will be monitored regularly to ensure it is current to reflect the issues that affect disabled people.

¹ Taken from 'Improving the Life Chances of Disabled People' 2005. See section 5 paragraph 1.0) for further information

Physical and sensory impairments include:

- People with physical impairments, whether the condition is congenital, acquired or progressive
- Deaf people and people that are hard of hearing
- Visually impaired and blind people
- Deafblind people
- People with serious ill-health and/or long term conditions
- People with HIV/AIDS

The primary focus is on people of working age and their carers, but areas of service development may include older people, young disabled people in transition, people with learning disabilities or mental health problems where this is considered relevant and effective.

5.0 The strategy was developed by the Physical and Sensory Impairment Partnership Board, which is a multi-agency partnership, led by Adult and Community Services, NYCC. A full list of members is included in Appendix I.

The Physical and Sensory Impairment Partnership Board does not work in isolation, but will make strategic links and work on shared actions and interests with other forums. It will also strive to work in accordance with the North Yorkshire Voluntary Sector Compact²

6.0 The Physical and Sensory Impairment Partnership Board was established in June 2007 at the recommendation of the Adults Strategic Partnership, which is one of the thematic partnerships of the North Yorkshire Strategic Partnership.

The thematic partnerships include:

- Adults
- Children and Young People
- Healthy Communities
- Economy & Enterprise
- Safer Communities
- Stronger Communities

² This agreement signed by all members of the NYSP, includes a commitment to work together to develop strong, positive relationships with voluntary and community organisations, built on the shared principles of trust, mutual respect and understanding

It is not only the Adults Strategic Partnership which is relevant to the aims and objectives of the Equal Lives strategy. All partnerships develop joint priority targets and indicators that are directly relevant to people with physical and sensory impairments and are set out in the Equal Lives Action Plan.

7.0 Each agency involved in the Physical and Sensory Impairment Partnership Board is expected to evidence progress against their achievement of the strategic objectives and actions set out in the Action Plan priorities that will be reviewed annually. It is recognised that current organisational reforms will require a flexible approach but the progress will be monitored by the Board, and reported annually to the NYSP Adults Strategic Partnership.

8.0 One of the key objectives of the Physical and Sensory Impairment Partnership Board is to ensure it effectively involves people with physical and sensory impairments and their carers, and gives them a strong voice in the way services are planned and delivered. Mechanisms for involving disabled people and the voluntary and community sector have been established by development of four area based PSI Reference Groups (see section 7).

A note on terminology:

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

Disability is distinct from both:

- **impairment** – a long-term characteristic of an individual which may affect their functioning and / or appearance and may give rise to pain, fatigue, communication difficulties, etc; and
- **ill health** – the short-term or long-term effect of disease or sickness.

Section 2: Underpinning values

1.0 The social model of disability

The Physical and Sensory Impairment Partnership Board adopted the 'social model of disability' as its underpinning value base. In the social model, 'disability' is shown as being caused by 'barriers' or elements of social organisation that take little or no account of people who have impairments. Society *disables* people who have impairments because the way it has been set up prevents them from taking part in every day life. The solution lies in changing society to ensure discrimination and lack of access are tackled.

The Physical and Sensory Impairment Partnership Board has developed a full definition of the social model, which is included in Appendix II.

2.0 What the social model means in practice

A paternalistic approach to disability and associated service provision has long influenced statutory service provision and many charitable organisations, and this does not put disabled people in control of the services they need. Since the inception of the welfare state, many of the services that have been developed have served to promote dependency and separate people from mainstream society. In addition, some disabled people will have themselves internalised the negative messages about disability that are entrenched in society.

Thus, developing practices and services according to the principles of the social model will necessarily be a long term process. It is also dependent on changes at a national government level, as several existing policies and systems serve to undermine the proposed vision for disabled people – this is clearly acknowledged and outlined by the government in 'Improving the Life Chances of Disabled People'³.

³ Prime Minister's Strategy Unit 2005

Making changes at a local level will therefore demand:

1. **A culture shift across all sectors (statutory, voluntary, community and commercial) to recognise that it is the way society is currently structured that disables people, and to work towards the eradication of this.**
2. **A willingness to totally rethink and restructure current support services which serve to promote dependence and/or institutionalisation, and replace them with services that promote independence and inclusion.**
3. **A willingness to engage with policy development at a national level, and promote positive change for disabled people, to enable them to realise their rights as citizens.**
4. **The empowerment of disabled people to realise their potential, and put them in control of the support they need.**

3.0 **Other equality dimensions**

It must also be recognised that disabled people come from a range of backgrounds, and that their experience of disability may be affected by their gender, age, sexual orientation, or ethnicity. Also some people may experience multiple impairments – for example, some people with physical and/or sensory impairments may also have a learning disability or a mental health problem. Services should be delivered and developed in ways that recognise these different needs and experiences.

Key Objective

The Physical and Sensory Impairment Partnership Board will seek evidence from its member organisations of the ways in which they are promoting equality, and developing services in keeping with the underpinning values of the social model of disability.

Section 3: The disabled population and future trends

1.1 What this section includes

This section provides a population analysis of people with physical and sensory impairments. It uses national census data, local information, prevalence and projection data, to identify current and future populations and related needs.

1.2 A note on national surveys on disability

National surveys will necessarily be used to measure existing populations and project future populations. However, there are a number of problems and health warnings with this data in relation to physical and sensory impairment:

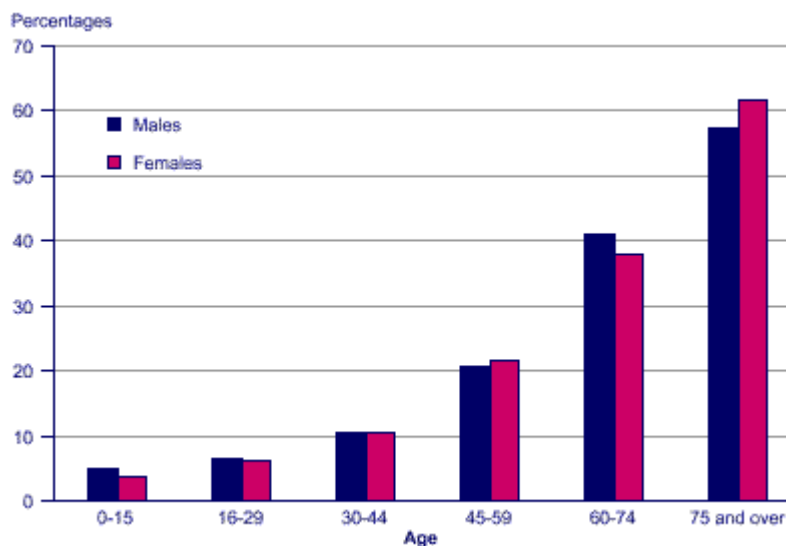
- some surveys are based on, or include, health status (the census). Disability and ill health should not be combined; for example, someone who has one leg is not 'ill' – they have a physical impairment
- some surveys do not distinguish between different types of impairment, and provide generic figures about 'disability', including learning disability, long term conditions, physical and sensory impairments, and people with mental health problem
- many older people experience increasing frailty and a reduction in hearing and sight due to the aging process, but many would not define themselves as having a physical or sensory impairment
- people of all ages may not apply the terms 'disabled' or 'physical or sensory impairment' to themselves, because these terms are still associated with stigma
- surveys use differing definitions of 'disability' and different questions, which can prompt widely differing responses. A literature review (commissioned by the RNIB) of all UK population based visual impairment studies provides a good example of this, where two studies estimating the population of people aged 16-64 with a visual impairment differed over two-fold (0.8% compared with 2%). The choice of which study is used to estimate data will therefore obviously have a significant impact on any projection of population/needs.

2.0 NATIONAL PREVALENCE OF PHYSICAL AND SENSORY IMPAIRMENT

2.1 Long term limiting illness and disability

2.1.1 In the 2001 Census, one in six people in the UK (10.3 million) living in a private household reported having a limiting long-term illness or disability (it must be noted that this includes all impairments, not just physical and sensory impairment). There was a steady increase by age for both males and females. Below age 30, rates were less than 10 per cent but were more than twice this for those aged 45 to 59. Rates virtually doubled again at ages 60 to 74, reaching 41 per cent for men and 38 per cent for women. Rates virtually doubled again at ages 60 to 74, reaching 41 per cent for men and 38 per cent for women. Rates virtually doubled again at ages 75 and over, reaching 57 per cent for men and 62 per cent for women.

Table 1: Prevalence of limiting long-term illness: by age and sex, UK, Census 2001



2.1.2 The most commonly reported impairments for both men and women are problems of the back or neck, the heart or circulation, legs or feet or breathing problems (see Table 2).

2.2 Long term conditions

2.2.1 Taken together, neurological conditions are common. For example, 8 million people in the UK experience migraine. Altogether, approximately 10 million people across the UK have a neurological condition. These account for 20% of acute hospital

admissions and are the third most common reason for seeing a GP⁴.

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

2.3 Sensory impairment

2.3.1 Visual impairment

The RNIB report that about two million people in the UK self-define as having a sight problem or seeing difficulty. 85% of these are aged over 65, and numbers are set to double over the next 25 years. This is due in part to the ageing of the population, but is also due to an increase in underlying causes such as diabetes.

2.3.2 Hearing impairment

There are estimated to be about 9 million deaf and hard of hearing people in the UK. About 698,000 of these are severely or profoundly deaf⁵ (i.e. 7.75% of deaf people). The number of people with a hearing impairment is rising as the number of people over 60 increases.

2.3.3 Deafblindness

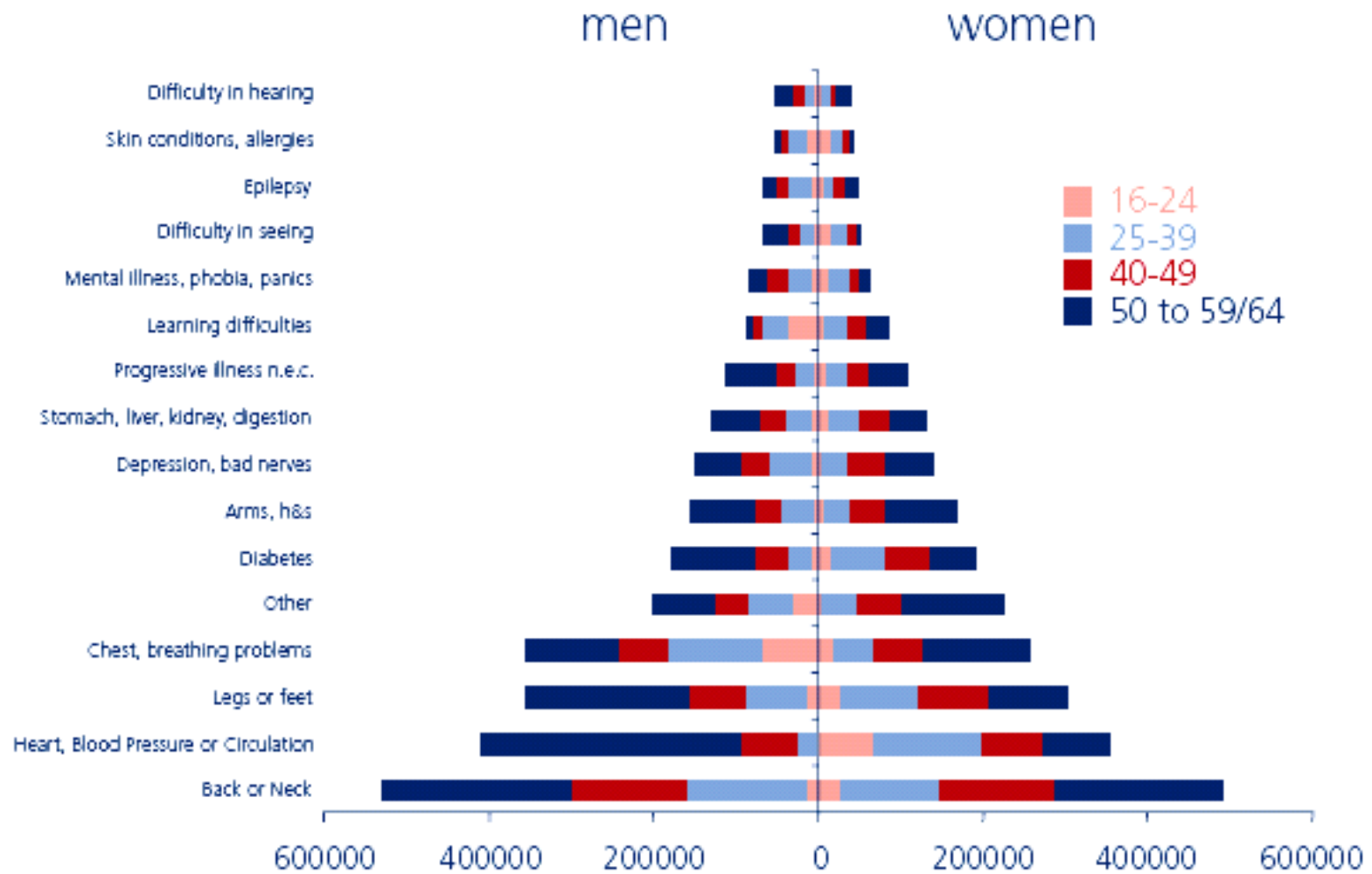
There are about 23,000 deafblind people in the UK; some are totally deaf and totally blind, other deafblind people have some hearing and vision. Deafblindness can be due to several causes, such as Ushers syndrome, rubella, and problems caused by premature births.

A further 250,000 people experience some degree of dual sensory impairment, many in older age. Of all the people in the UK over 75 who have a visual impairment, around half of these will be hard of hearing as well.

⁴ Improving the Life Chances of Disabled People (Prime Minister's Strategy Unit 2004)

⁵ Royal National Institute for Deaf People

Table 2: Number of disabled adults by gender, age and impairment, GB

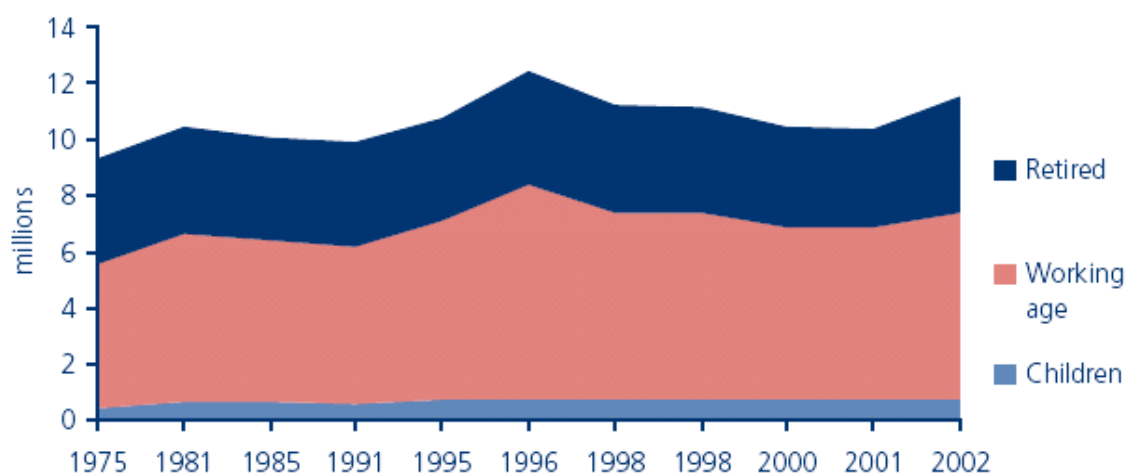


Source: Annual Local Area Labour Force Survey 2001-02

2.4 Disability and age

2.4.1 For most impairments the prevalence increases with age – see Table 3 below.

Table 3: No. of People who reported a limiting long standing illness or disability by age, UK



Source: ONS (2004) Living in Britain: Results from the 2002 General Household Survey

2.4.2 The most marked demographic change in North Yorkshire's population will be the estimated rise in the population of those over 65 years of age. In North Yorkshire, the number of people who are 65 and over will increase from 111,400 (18.8%) in 2006 to 152,400 (23.7%) in 2018.

The increase in size of this group of people is anticipated to vary between districts, for example a 36% increase is forecast in Scarborough Borough with an almost 50% increase in Selby District. We must recognise and support the key role that this part of the community plays in supporting and sustaining a strong local economy, for example through participation in volunteering, community work and often as unpaid carers. We will therefore work to support and promote a healthy and active older community within North Yorkshire, ensuring that they have access to key services, feel safe within their communities and are able to become more involved in healthy, recreational activities.

However, we must also recognise that a considerable increase in the number of older people living in North Yorkshire will necessarily also create substantial challenges for social and health care providers across the county. Partners are working together to transform services to fit with this changing world and these will be driven through North Yorkshire's Strategic Commissioning for Independence, Well being & Choice Strategy. The partners will also work together to deliver the 'Putting People First' concordat.

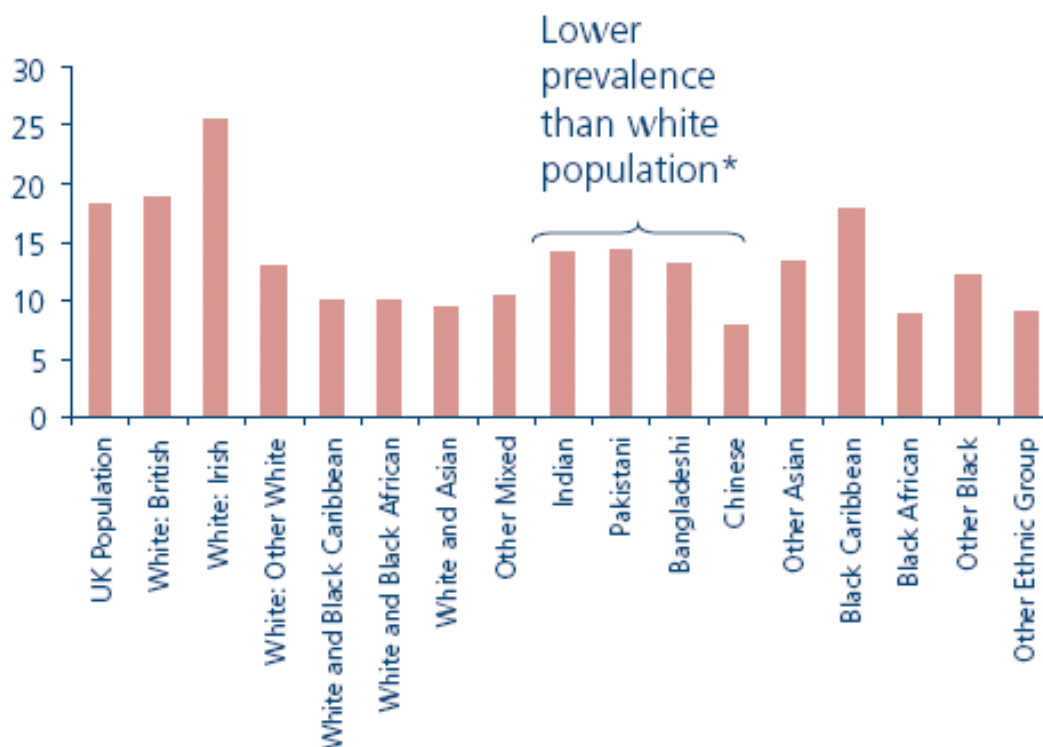
2.5 Disability and gender

- 2.5.1 For disabled adults of working age, the pattern of impairment is broadly similar across gender. However, hearing impairment is more common amongst men of all ages: in 2002/03 19% of men and 13% of women in the UK reported hearing difficulties (General Household Survey 2002)
- 2.5.2 There will be a higher number of older women affected by long term conditions, sensory impairment, and illnesses that may result in physical impairments, due to the fact that women live longer than men (see Table 2).

2.6 Disability and ethnicity

- 2.6.1 Differences in age structure account for much of the variation in prevalence across ethnic groups, as in the UK Black and Minority Ethnic groups tend to have a younger population. However, even after allowing for this age effect, people of Indian, Pakistani, Bangladeshi and Chinese origin remain less likely to report that they are disabled (see Table 4). These lower rates may be influenced by cultural differences in self-reporting across ethnic groups.

Table 4: Percentage of people reporting a limiting long-term illness in England and Wales by ethnic group



Source: Census 2001, Office for National Statistics

* Statistically significant difference from the White British population after allowing for age

2.6.2 Despite the lower levels of reported long-term illness, disability or health condition, disabled people of Black and Minority Ethnic origin are more likely to experience disadvantage. There is evidence to show that families from Black and Minority Ethnic groups with disabled children have a lower take-up of services, and often feel less informed or able to access the system⁶. A higher proportion of the Black and Minority Ethnic population also lives in deprived areas and poor housing, and fall into disadvantaged groups where a higher incidence of impairment would be expected.

2.6.3 Some conditions are more prevalent amongst certain racial groups (eg. sickle-cell anaemia mainly affects people of Black African or Caribbean decent, Cystic Fibrosis mainly affects White Europeans).

2.7 Trends in Disability Prevalence

2.7.1 The Department of Health undertook a comparison of the Health Survey for England, between 1995 and 2001⁷. This showed that changes in disability prevalence were small, and were not statistically significant for any of the age and sex groups. The same study examined other prevalence studies, but found it difficult to make any historical comparisons because of the range of reasons outlined in 1.2 on the reliability of the data.

2.7.2 'Improving the Life Chances of Disabled People' (Prime Minister's Strategy Unit 2004) states that over the last 30 years there has been an increase in the number of people reporting disability, and that since 1975, the number of adult reporting has increased by 22% from 8.7 million to 10.7 million people. However, this in large part relates to reported increases in mental illness and behavioural disorders. Amongst children, the increase is even larger, at 62% – from 476,000 disabled children under the age of 16 in 1975, to 772,000 in 2002. Possible explanations include children with complex conditions surviving longer, and improved diagnosis/reporting.

2.7.3 A range of social life-style trends may lead to increased incidence of long-term conditions (for example, rising levels of obesity amongst the population can lead to increased risk of diabetes and heart conditions).

⁶ Nazroo, James Y. (2002) 'Ethnicity, Class and health', Policy Studies Institute

⁷ Trends in Disability Prevalence Amongst Adults

2.7.4 Evidence demonstrates that there is increase prevalence of hearing and visual impairment amongst people with a learning disability⁸. As more people with a learning disability live longer into adulthood, this will have an impact on sensory impairment assessment and support services.

⁸ Kiani 2005

3.0 DEMOGRAPHIC PROFILE: NORTH YORKSHIRE

3.1 The 2001 census asked people about general health and limiting long term illness. The information for North Yorkshire shows that the percentage of population who consider they have a health problem or limiting long-term illness is lower than the national average in all districts of North Yorkshire except Scarborough. However, it must be remembered that this information is not specific to physical and sensory impairment.

Table 5: Health/long term limiting illness of North Yorkshire population: census 2001

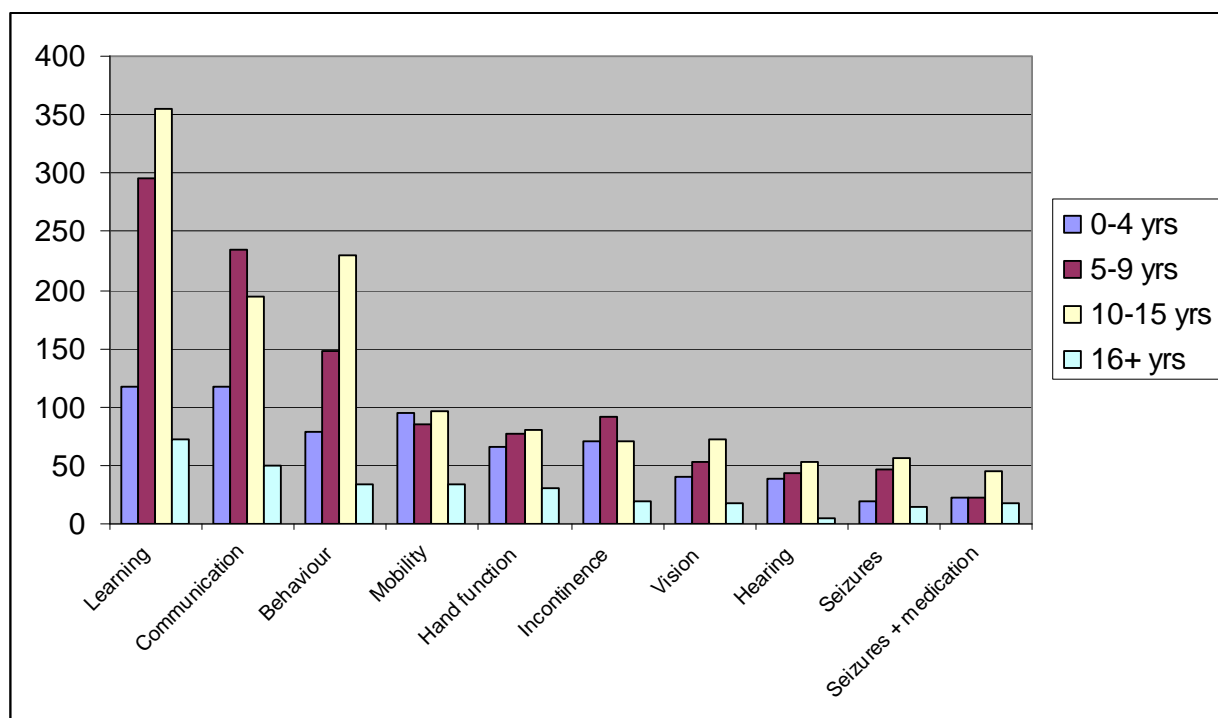
District	Health - Good % of population	Health – fairly good % of population	Health - not good % of population	Has a limiting long-term illness
Craven	70.1	21.7	8.2	17.2
Hambleton	71.8	20.7	7.6	16.0
Harrogate	72.2	20.6	7.2	15.6
Richmondshire	73.0	20.3	6.7	15.2
Ryedale	69.4	22.8	7.8	16.8
Scarborough	65.4	24.2	10.4	21.6
Selby	70.5	21.5	8.0	16.1
England & Wales	68.6	22.2	9.2	18.2

3.2 Disabled Children in North Yorkshire

There are a range of problems in identifying children with physical and sensory impairment in North Yorkshire:

- Children with physical and sensory impairments may not be known to Children’s Services and then present to Adult Services when they become adults
- There is a tendency to rely on statementing as a vehicle for identifying disabled children; children with physical and sensory impairments will not go through this route if they do not have particular learning needs
- In 2005 a North Yorkshire census of disabled children was carried out, with the co-operation of a range of agencies. Table 8 outlines the age and number of children and those requiring support with daily living functions. Further work is required to extrapolate information from this census, relating to children with physical and sensory impairments.

Table 6 – Support required with daily living functions by age



Note: children may be recorded under more than one category

3.3 The largest number of Disability Living Allowance claimants in North Yorkshire are aged 17 to 59 (see table 7 below).

Table 7: Number of Disability Living Allowance Claimants 2001- 2003

Variables	Claimants Aged 16 and under			Claimants Aged 17-59			Claimants Aged 60 and over			TOTAL 2003
	2001	2002	2003	2001	2002	2003	2001	2002	2003	
Area										
Craven	155	155	165	690	740	785	515	530	580	1,530
Hambleton	260	280	295	1,140	1,225	1,225	820	870	930	2,445
Harrogate	375	390	420	2,050	2,110	2,180	1,410	1,475	1,535	4,135
Richmondshire	145	165	175	585	605	645	435	450	465	1,285
Ryedale	150	155	150	615	660	705	510	530	555	1,415
Scarborough	475	520	515	2,475	2,670	2,835	1,845	1,975	2,155	5,510
Selby	250	265	270	1,060	1,135	1,190	770	810	855	2,320
North Yorkshire	1810	1930	1990	8615	9145	9565	6305	6640	7075	18640

Disability Living Allowance can be paid to people over the age of 65 years, but they must claim for the first time before their 65th birthday.

4.0 IMPACT OF DEMOGRAPHIC CHANGES

4.1 Physical impairment

Because of the reasons outlined in 1.2, it is difficult to predict changes in prevalence of physical impairments amongst people aged 18-64. Demographic changes, available prevalence data, social life style trends, medical advances, etc, make modelling over future years extremely problematic. However, national evidence clearly suggests an increase in the number of children with complex conditions surviving into adulthood. Further data analysis and development work is required to more accurately predict the impact of this on adult services.

4.2 Hearing impairment

Table 8 sets out a projection for 2020 for the number of people with a hearing impairment. **These figures should be treated with caution**; as evidenced in paragraph 1.2, statistics on the prevalence of sensory impairment vary significantly.

Table 8: projected number of people with a hearing impairment

Age profile	Whole population 2001	No. with hearing impairment	No. profoundly deaf	Whole population 2020	No. with hearing impairment	No. profoundly deaf	% deaf population for this age group ⁹
Under 45	314,705	18,882	n/a	287,600	17,256	n/a	6%
45-64	151,510	27,272	n/a	177,900	32,022	n/a	18%
65-74	53,896	15,091	n/a	81,500	22,820	n/a	28%
75+	49,549	21,802	n/a	73,800	32,472	n/a	44%
Whole population	569,660	91,145	7,063	620,800	99,328	7,698	16%

This shows:

- An increase in the number of profoundly deaf people of 8%
- An increase in the number of people with a hearing impairment amongst all age groups except the under 45s
- A very significant increase in the number of people with a hearing impairment aged 65+ (from 36,893 to 55,292 – an additional 18,399). This represents an increase of approximately 49%.

⁹ Based on General Household Survey, Living in Britain 2002

4.3 Visual impairment

Table 9 sets out a projection for 2020 for the number of people with a visual impairment. **These figures should be treated with caution;** as evidenced in paragraph 1.2, statistics on the prevalence of sensory impairment vary significantly.

Table 9: projected number of people with a visual impairment

Age profile	Whole population 2001	No. with visual impairment based on % in final column	Forecast percentage increase in population 2020	No. with visual impairment based on % in final column	% visual impairment for this group ¹⁰
16-64 in private households	363,829	5,094	372,400	5,214	1.4%
65-74 in private households	53,896	2,156	81,500	3260	4%
75+ in private households	49,549	4,856	73,800	7,233	9.8%
TOTALS	467,274	12,106	527,700	15,707	
	Current number (2005/06)		Projected units required by 2020		
People in residential/nursing accommodation	2,450	661	3,675	992	27%

This shows:

- A significant increase in the number of people with a visual impairment aged 65+ who live at home (from 7012 to 10493 – an additional 3,481). This represents an increase of approximately 49%.
- A significant increase in the number of people with a visual impairment aged 65+ who are likely to live in residential or nursing accommodation (an additional 331). This represents an increase of approximately 50%.

¹⁰ Based on Health Survey for England DH 2000/2001

4.4 Dual Sensory impairment

Table 10 sets out a projection for 2020 for the number of people with dual sensory impairment. This estimation is based on the SENSE calculation of 40 deafblind people per 100,000 population

Table 10: projected number of people with dual sensory impairment

Population North Yorks 2001	Estimated population deafblind people	Population North Yorks 2020	Estimated population deafblind people
570,000	228	620,800	248

This estimate does not take into account the large number of older people who have some form of hearing and sight impairment. Table 11 sets this out, using 6% incidence for people aged 60-74 and 12% for people aged 75+ (based on SENSE estimates).

Table 11: projected numbers of people with some form of dual sensory impairment

Date	Population North Yorks	Estimated population 60 - 74 with combined sensory impairment	Estimated population 75+ with combined sensory impairment	Total 60+ with combined sensory impairment
2001	570,000	5,159	5,946	11,105
2020	620,800	7,542	8,856	16,398

This shows very significant increases in the numbers of older people with dual sensory impairment by 2020:

- 2,383 people aged 60-74
- 2,910 people aged 75+
- Total 5,293 aged 60+ (an increase of approximately 48%)

5.0 SUMMARY OF KEY ISSUES

5.1 There are difficulties making projections of the population of adults with physical and sensory impairments and long term conditions (see 1.2), and underlines that this summary should be regarded with caution.

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

- 5.3 The numbers of children surviving with complex conditions are rising, but there is limited detailed national and local data available about children specifically with physical and sensory impairments.
- 5.4 As more people with learning disability live longer into adulthood, there will be an impact on sensory impairment assessment and support services because of an increased prevalence of sensory impairment amongst this group.
- 5.5 Demographic changes and prevalence studies show a marked increase in the number of people aged 65+ with a sensory impairment (approximately 49%).
- 5.6 Even if sufficient data were available to project future numbers of people with physical and sensory impairments, it is not straightforward to link this to projections about levels and types of need. The face of social care is shifting: national policy changes and pressure from the disability movement means there is a move away from traditional services such as day services and residential care towards a model that supports the individual to independent living. In addition, an increased focus on rights, and challenges enabled through the Equality Act 2010, should also mean that more and more public and private services are accessible, which in theory should lessen the demand for formal care and support services. The development of Telecare may also decrease demand for home care services for some groups of disabled people.

Section 4: Carers

1.0 Who are carers?

A carer spends a significant proportion of their life providing unpaid support to family or, potentially, friends. This could be caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems.

(‘Carers at the heart of 21st century families and communities’, HM Government 2008)

A young carer is a child or young person under the age of 18 carrying out significant caring tasks and assuming a level of responsibility for another person which would normally be taken by an adult

(Princess Royal Trust for Carers)

A parent carer is a parent or guardian who is likely to provide more support because their child is unwell or has a disability. Parents will often see themselves only as a parent rather than a carer but, if their child has additional care needs, they may be entitled to additional services.

2.0 Facts about carers

2001 Census shows:

- There are 5.2 million carers in the UK (one in ten of the population)
- 68% of carers provide care for up to 19 hours a week
- 11% provide care for 20-49 hours a week
- 21% care for 50 or more hours per week
- Nationally, 175,000 young people (under 18) provide care. Of these 13,000 provide over 50 hours of care per week
- Women are more likely than men to provide care: 58% female compared with 42% men.
- People aged 50-59 are most likely to be carers.
- The economic value of the contribution made by carers in the UK is a remarkable £87 billion per year.

(‘Valuing carers – calculating the value of unpaid care’, Leeds University and Carers UK, 2007)

For the first time ever, the 2001 census asked a question about whether people provided unpaid care for a family member or friend and for how many hours. The resulting picture was a massive 5.2

million carers in England and Wales, including over a million carers providing more than 50 hours of care per week.

(Census 2001)

A survey conducted for Carers Week 2009 by YouGov found that the public ranks carers alongside the emergency services in terms of their contribution to society. Six out of seven people (86%) believe that carers make a valuable contribution, only behind nurses (91%) and firefighters (90%).

(Carers UK)

3.0 **Legislative basis**

A range of legislation has been introduced to promote support for carers; key legislation is listed in section 5, paragraph 5.0 and Appendix II. Of particular relevance to this strategy is the National Service Framework for Long Term Conditions, which has a Quality Requirement that relates to carers:

“Carers of people with long-term neurological conditions are to have access to appropriate support and services that recognise their needs both in their role as carer and in their own right.”

4.0 **Carers in North Yorkshire**

North Yorkshire has a multi-agency Carers Strategy which pre-dates the 1999 National Carers Strategy, and this was updated in 2000. A work-plan was developed in 2005, and a range of improvements were made to carer information, assessment and support. Carer outcomes and indicators are also included in the Adults Strategic Partnership Local Area Agreement.

Carers UK states that 1 in 8 adults are carers and for North Yorkshire, this would represent a figure of 54,000 adult carers in our communities.

The North Yorkshire Joint Strategic Needs Assessment identifies that, for September 2008, 2,032 carers were receiving support and/or services from the County Council’s Adult and Community Services directorate. In April 2009, this figure increased to 3,857. There are more than 3,000 Carers Breaks funded by North Yorkshire County Council (the County Council) per year, and the Carers’ Resource centres across the County report contact with approximately 16,000 carers at any one time.

The National Carer Strategy will provide a clear plan of action for 2011 to 2015 by the end of 2010 and this will inform the North Yorkshire County Council and NHS North Yorkshire and York Joint Carers Strategy.

Section 5: National Priorities

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

- Improving the Life Chances of Disabled People 2005
- National Service Framework on Long Term Conditions 2005
- White Paper, Our Health Our Care Our Say 2006
- Equalities policy agenda
- Putting People First (2007)
- Carers at the Heart of 21st Century Families and Communities: A caring system on your side. A life of your own' (2008)

1.0 **'Improving the Life Chances of Disabled People'**¹¹ crosses Government Departments and is a long term disability strategy until 2025. Within this policy, the government has identified four key goals as the most important determinants of disabled people's life chances:

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

In each of these areas the vision is based on:

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

'Improving the Life Chances of Disabled People' promotes the development of **'individualised budgets'**. Pilot work on this has taken place nationally, primarily within learning disability services, through "In Control" (www.in-control.org.uk), a collaborative venture between statutory services, central government and the voluntary sector. Individualised budgets are more than the current system of direct payments. The intention is that in time different sources of funding will be included in an individual's budget (e.g. Independent Living Fund, Supporting People, Disabled Facilities Grant, Access to Work etc).

¹¹ Prime Minister's Strategy Unit 2005

'Improving the Life Chances of Disabled People' also includes a requirement for local authorities to establish user-led **Centres for Independent Living** by 2010. This model of service provision should form the basis of a range of support services.

- 2.0 The '**National Service Framework on Long Term Conditions**',¹² has a particular focus on people with neurological conditions and brain and spinal injury, but many of the quality requirements have relevance to a wide range of long term conditions and impairments.

It identifies quality requirements which must be achieved by 2015:

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

- 3.0 The **White Paper, Our Health Our Care Our Say** has four overarching aims:

- better prevention services with earlier intervention
- more choice
- tackling of health inequalities and improved access to community provision
- more support for people with long terms needs

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

Objectives within the White Paper that have direct relevance to people with Physical and Sensory Impairments include:

- Range of initiatives to support GPs to help patients remain in or return to work (Ch 2)
- Expectation that direct payments will expand, plus individualised budgets to be introduced (Ch 4)
- Acceleration of self-directed care and increased investment in Expert Patient programme(Ch 4 and 5)
- Development of outreach services to tackle conditions early and prevent hospitalisation (Ch 4)

¹² Department of Health 2005

- Dept of Health and Office of the Deputy Prime Minister to encourage health and housing to work together to prevent housing issues exacerbating health problems (Ch 4)
- End of life care networks, bringing together primary care, social care, palliative care and hospital based care. (Ch 4)
- Support for people with longer term needs – services to be seamless, proactive, with greater focus on early intervention and prevention (Ch 5)
- Information prescriptions to be routine by 2008 (Ch 5)
- All Primary Care Trusts and Local Authorities to have established joint health and social care managed networks or teams to support integrated care for people with the most complex conditions (Ch 5)
- Mobilise use of assistive technology, including monitoring of health status at home to prevent admissions (Ch 5)
- Increase numbers of people supported to live at home (Ch 6)
- Improvement of home adaptations service (Ch 6)
- Strengthening of mechanisms for public engagement (Ch7)

4.0 The national Equalities policy agenda has direct pertinence to the development work

The Disability Discrimination Act 2005 introduced a general duty for all public authorities to have due regard to do the following:

- promote equality of opportunity between disabled people and other people
- eliminate discrimination that is unlawful under the Disability Discrimination Act
- eliminate harassment of disabled people that is related to their disability
- promote positive attitudes towards disabled people
- encourage participation by disabled people in public life
- take steps to meet disabled people's needs, even if this requires more favourable treatment.

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

The equality legislation not only requires a wide range of services to tackle disability issues, but also requires that disabled people's individual needs are considered on the basis of their gender, ethnicity, religion, sexual orientation, etc. (for example, a disabled Muslim man may have difficulty obtaining personal care support because insufficient male personal care staff are employed). These principles are also a key theme of 'Improving the Life Chances of Disabled People' and the White Paper, 'Our Health, Our Care Our Say'.

In 2010, a new piece of legislation The Equality Act 2010 will replace the Disability Discrimination Act (DDA). The Equality Act includes the legal definition of a disabled person who is protected from discrimination. This definition is slightly different from the definition used in the DDA. It will make the law easier to understand. The Act will deliver improved protection from discrimination for disabled people as part of strengthened and streamlined discrimination law. Amongst the new areas of protection for disabled people are:

- protection from discrimination that occurs because of something connected to a person's disability ("discrimination arising from disability")
- protection from discrimination that happens because of a person's association with a disabled person, or because a person is wrongly perceived to be disabled
- protection from disability-related harassment in respect of access to goods and services and in larger private clubs.

For more information on the Equality Act visit the Government Equalities Office website: www.officefordisability.gov.uk

- 5.0 The second national strategy for carers – 'Carers at the Heart of A life of your own' was launched in June 2008. The Coalition Government has recently announced the 'refresh' of the current National Carer Strategy with a view to producing, before the end of this year, a clear plan of action for 2011 to 2015.
- 6.0 Putting People First (2007) is a reform of public services that establishes a collaboration between central and local government, the sector's professional leadership, providers and the regulator. It sets out shared aims and values to guide the transformation of adult social care, and work across agendas with users and carers to transform people's experience of local support and services.

Section 6: Local priorities and actions

1.0 Ongoing research and consultation

1.1 As set out in section 2, a key priority of this strategy is to promote a cultural shift in understanding of disability (according to the principles of the social model), and to put disabled people more in control of their services. This will be a long term process.

1.2 More work is required to support the longer term objectives:

- We need to know more about our disabled population and understand the impact of demographic changes
- We need to analyse the current activity across all sectors, and recognise what is working, what is not working and where the gaps are.

2.0 Actions over the next three years

2.1 Principal areas of work which are already known and planned are set out in the tables A-G below¹³, using the seven key themes of the 'Our Health Our Care Our Say' White Paper:

- A** Improved Health
- B** Improved Quality of life
- C** Making a positive contribution
- D** Exercise of choice and control
- E** Freedom from discrimination and harassment
- F** Economic well-being
- G** Personal dignity

The strategy covers the next three years (2011-2015). An annual plan will be developed by the PSI Board of the issues they consider a priority.

2.2 Additional actions will become evident with new government directives but in the current economic climate it is evident that reduced financial commitments require that any identified actions will have to be delivered within the available resources.

¹³ Several of the outcomes identified under these themes could equally well fit under more than one heading, but they are only referred to once to avoid duplication.

A: IMPROVED HEALTH

The aspiration

People with physical and sensory impairments are supported to enjoy good physical and mental health, and have access to appropriate treatment and support in managing long term conditions.

1.0 What this theme includes:

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

2.0 National evidence of the need for change

Disability and impairment should not be confused with ill health. However, some impairments can be a result of illnesses (eg. a limb removal due to cancer, or long term hearing loss due to an ear infection), and some long-term conditions will have a progressive impact, resulting in different and fluctuating impairments at different stages of the condition (eg. Multiple Sclerosis).

There is also national evidence that disabled people may be more at risk of ill health, due to a range of factors:

- disabled people are more likely to experience economic disadvantage, and income is one of the most significant indicators of health status
- disabled people do not currently enjoy the same access to exercise facilities or green spaces as the general population
- the isolation that some disabled people experience can put them at increased risk of depression
- some health services may not be fully accessible to disabled people, either through the built environment (eg. inaccessible sexual health clinics; mental health service buildings) or through attitudes, practices and procedures (eg. a deaf person who has past experience of a lack of sign language communication support at their GP may result in the person avoiding contact with health services in future). This could be further compounded for black and minority ethnic disabled people who feel their cultural or language needs have not been taken into account.

The Long Term Conditions National Service Framework also evidences the need for a range of service improvements for people with long term neurological conditions and spinal or head injuries.

3.0 Principal areas of work: See Action Plan

B IMPROVED QUALITY OF LIFE

The aspiration

People with physical and sensory impairments have access to suitable housing, appropriate transport, and the full range of universal, public and commercial services.

1.0 What this theme includes:

- Provision of accessible housing and supported housing¹⁴
- Access to transport
- Access to services and information

HOUSING

H 2.0 National evidence of the need for change

- Economic disadvantage experienced by disabled people makes it more difficult for them to meet their housing needs through privately renting or buying. This increases dependency on social housing.
- Between 1997 and 2003 nationally there has been a 44% increase in the number of homeless households in priority need because a household member has a physical impairment
- Much of the housing stock is physically unsuitable for people with mobility impairment. Inadequate housing can exacerbate a range of conditions (eg asthma).
- According to a survey of housing in England in 2000¹⁵ a total of 181,000 households contained people with a serious medical condition or disability whose accommodation is not suitable for them. 27% of these people said they could not afford to undertake alterations.
- Disabled people in the private rented sector are the most likely to be living in housing unsuited to their needs.
- Many disabled adults living in institutional settings, such as registered nursing and care homes, or with relatives, are unable to establish sufficient 'points' for social housing, preventing their move to independent living.

¹⁴ Provision of supported housing is through the Supporting People programme in conjunction with the 7 Housing Authorities. This programme offers vulnerable people the opportunity to improve their quality of life by providing a stable environment which enables greater independence. It delivers strategically planned housing-related support services which complement existing care services. Supporting People is a working partnership of local government, health and probation services, service users and support agencies.

¹⁵ Office of the Deputy Prime Minister (2004) English Survey of Housing

- The Lifetime Homes Standard has not been integrated into the decent homes standard and pressures concerning housing density are leading to smaller dwellings unsuited to people using wheelchairs.

TRANSPORT

T 2.0 National evidence of the need for change

- Disabled people travel a third less often than the general public, and over a third of those who do travel experience difficulties, the most common being getting on and off trains or buses¹⁶
- As a result of economic disadvantage, disabled people are disproportionately reliant on an affordable, accessible public transport system.
- One in four households includes a disabled person, and 60% of these don't have access to a car, as opposed to 27% of the general population¹⁷.

T 3.0 Principal areas of work: See Action Plan

ACCESS TO SERVICES AND INFORMATION

A 2.0 National evidence of the need for change

- Under half of all pubs and clubs have an accessible toilet. Three-quarters of businesses have one or more entry problems for disabled people¹⁸
- Of the thousand public websites tested by City University's Centre for Human Computer Interaction Design, 81% failed to meet the basic accessibility criteria laid down by the Web Accessibility Initiative¹⁹

A 3.0 The Disability Discrimination Act 2005 was the cornerstone for ensuring access to services and information to be updated by the Equality Act 2010, and the production of Disability Equality Schemes will be a key vehicle for all member organisations of the Partnership Board to address this over the coming months.

A 4.0 Principal areas of work: See Action Plan

¹⁶ Dept of Work and Pensions (2002) 'Disabled for Life? Attitudes towards and experience of disability in Britain'

¹⁷ Leonard Cheshire, 2003

¹⁸ Scope 2000

¹⁹ Disability Rights Commission 2004

C MAKING A POSITIVE CONTRIBUTION

The aspiration

People with physical and sensory impairments are able to actively participate in the community, and be involved in policy development and decision making.

1.0 What this theme includes:

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

2.0 National evidence of the need for change

- Disabled people are more likely to be targeted as objects of voluntary and community activity. Policies and practices do not pay enough attention to enabling disabled people to be active citizens, or to supporting disabled people to help themselves²⁰.
- Disabled people represent 20% of the population but have a particularly low representation in public appointments – currently an average of around 3% across England, Scotland and Wales.
- Only 6% of all volunteers are disabled people.
- Real or perceived disincentives in the benefits system prevent significant numbers from contributing to society in ways other than paid employment.
- On Election Day 2005 campaign volunteers surveyed over 2,000 polling stations in the UK and found that 68% of polling stations could be inaccessible to a disabled person²¹

3.0 Involvement of disabled people

- All public authorities have a duty to develop a Disability Equality Scheme (See section 5, paragraph 4.0), and they are required to effectively involve disabled people in the production of these.
- This activity will be going on during the life of this strategy. Public authorities involved in the Physical and Sensory Impairment Partnership Board will therefore be engaging disabled people in ways over and above the actions specified.

²⁰ 'Improving the Life Chances of Disabled People', Prime Ministers Strategy Unit , 2005

²¹ Polls Apart UK

4.0 Supporting organisations OF disabled people

The Physical and Sensory Impairment Partnership Board is concerned to do what it can to support organisations OF disabled people. Supporting organisations OF disabled people is an important issue because:

- it empowers disabled people
- it provides positive role models, rather than perpetuating the image of disabled people being passive recipients of charity
- it supports the goal of developing Centres for Independent Living, managed by disabled people
- it provides more employment opportunities for disabled people

5.0 Principal areas of work: See Action Plan

D EXERCISE OF CHOICE AND CONTROL

The aspiration

People with physical and sensory impairments are enabled to achieve maximum independence, through people being able to choose and control services, and manage risks to their personal lives.

Carers are supported, to enable choice and control in their own lives, through the provision of information, breaks and services.

1.0 What this theme includes:

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

2.0 National evidence of the need for change

‘Improving the Life Chances of Disabled People’²² has stressed that it is not impairment or illness that inevitably create dependency and lead to a poor quality of life:

- Services provided in response to the need for assistance can be disabling in themselves; sometimes they are delivered in ways that make it easier for the service provider rather than in ways which fit in with the service user’s life or encourage independence²³
- Some support services are run on a 9 to 5 basis, making it difficult for disabled people in employment to access them.
- Consultation with young disabled people in transition to adult services said their main concerns were: not being consulted or listened to; having no friends or finding it difficult to maintain friendships; being made to feel like a burden, with no contribution to make²⁴
- Disabled parents can experience difficulties accessing their entitlements to support under community care legislation. This

²² Prime Ministers Strategy Unit, 2005

²³ S Cunningham ‘Disability, Oppression and Public Policy, Independent Living 2000

²⁴ Morris, J ‘ Social exclusion and young people with high levels of support needs’, Journal of Critical Social Policy Vol 21 (2) 2001

can lead to them having to rely on their children for assistance i.e. their children become 'young carers'.

- Some people move into residential care against their wishes, because appropriate housing and support is not available. There is no entitlement to live at home instead of in institutional care. Nationally, the numbers of people with physical and sensory impairments in residential care, having initially fallen, are now increasing:

Local authority supported residents in staffed residential and nursing care at 31 March (1997–2002)²⁵

People aged under 65	1997	1998	1999	2000	2001	2002
Physically/sensorily disabled adults	10,356	8,734	9,094	9,690	9,498	9,755

- The financial costs of caring can be significant. Research by Carers UK found that 77% of their survey respondents were worse off financially as a result of becoming carers.
- The 2001 census showed that over 3 million carers combine work with caring responsibilities (1 in 8 workers).
- Carers providing 50+ hours per week are more than twice as likely to be 'not in good health' (2001 census). 'Carers UK' research found that half of the respondents providing substantial care had suffered a physical injury since they began caring often due to having to lift or handle the disabled person.
- It is difficult to demonstrate causal links between caring and health. However, substantial evidence exists to show that there is a strong link between providing high levels of care and physical and mental ill health. The evidence shows that this is due to the lack of appropriate support, isolation, financial stress and lack of information.

3.0 A note on Centres for Independent Living (CIL)

A Centre for Independent Living (CIL) is an organisation which provides innovative services which allow disabled people to gain choice and control over every aspect of their lives. The key feature is that they are run and controlled by disabled people.

'Improving the Life Chances of Disabled People' (Prime Minister's Strategy Unit 2005) recommends the development of CILs in each locality to provide services **to all disabled people regardless of the nature of their impairment, and to all ages.**

²⁵ National Statistics/Department of Health (2003) Health and Personal Social Services Statistics, National Statistics.

The nature of the services provided and relationship with statutory agencies will vary but the organisations should provide services such as:

- Information and advice
- Advocacy and peer support
- Assistance with self assessment
- Support in using individual budgets (including cash payments) to meet needs
- Support to recruit and employ personal assistants
- Disability equality training, and
- Consumer audits of local services

Establishing CILs in a rural environment is a significant challenge but work is underway to develop this model of service provision.

4.0 Principal areas of work: See Action Plan

E FREEDOM FROM DISCRIMINATION AND HARASSMENT

The aspiration

People with physical and sensory impairments are free from discrimination and harassment, and have access the necessary support where this occurs.

1.0 What this theme includes

- Tackling discrimination and harassment of disabled people

2.0 National evidence of the need for change

- Disabled people are more likely to experience hate crime or harassment. Around a quarter of all disabled people surveyed said that they have experienced hate crime or harassment²⁶
- One in four disabled people surveyed fear being alone after dark, compared with one in ten non-disabled people.

The Crime Prosecution Service will monitors hate crime against disabled people.

3.0 Principal areas of work: See Action Plan

²⁶ Disability Rights Commission 2003

F ECONOMIC WELL-BEING

The aspiration

Agencies work in partnership to maximise disabled people's income, and to promote access to employment and training.

1.0 What this theme includes:

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

2.0 National evidence of the need for change

- Disabled people are less likely to be employed than non-disabled people. Only one in two disabled people of working age are currently in employment compared to four out of five non-disabled people
- The income of disabled people is, on average, less than half that of non-disabled people. Almost a third of working-age disabled adults live in income poverty. This is higher than a decade ago, double the rate for working age non-disabled adults and higher than the rates for either pensioners or children.
- 17% of disabled people said they had experienced actual discrimination in the workplace²⁷
- One in eight young disabled people (13%) said they had been turned down for a paid job and told it was for a reason related to their disability²⁸

3.0 Principal areas of work: See Action Plan

²⁷ 'Attitudes and Awareness', Dept of Work and Pensions, 2002

²⁸ Disability Rights Commission 2002

G PERSONAL DIGNITY

The aspiration

People with physical and sensory impairments are able to keep clean and comfortable, enjoying a clean and orderly environment.

1.0 What this theme includes:

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

2.0 National evidence of the need for change

- Delays in providing appropriate adaptations or equipment can result in people becoming dependent on personal care, who can find it difficult to manage without this assistance when the adaptation or equipment has eventually been provided.²⁹

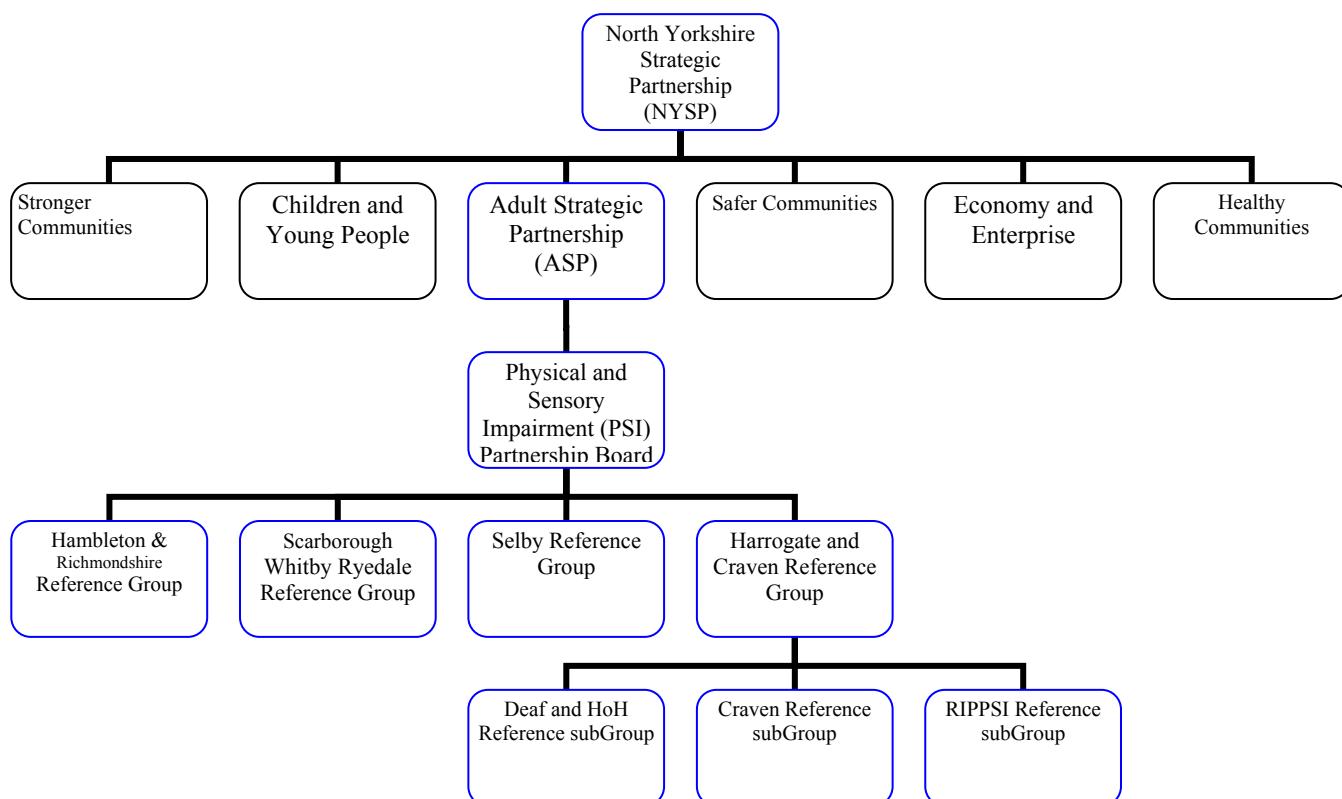
3.0 Principal areas of work: See Action Plan

²⁹ Heywood, F. 'Money Well Spent: The effectiveness and value of housing adaptations', Policy Press , 2001

Section 7: Ongoing Involvement

- 1.0 People with physical and sensory impairments, carers, and interested organisations, are involved in influencing the work of the Physical and Sensory Impairment Partnership Board and the ongoing implementation of the Equal Lives Strategy.
- 2.0 Four Reference Groups have been established in North Yorkshire: Selby; Hambleton/Richmondshire; Harrogate/Craven, and Scarborough/Whitby/Ryedale. These Reference Groups meet regularly to bring forward issues of concern to people with physical and sensory impairments, and to help scrutinise progress on the strategy.

The structure chart of NYSP, PSI Board and Reference Groups is shown below.



- 3.0 The Physical and Sensory Impairment Partnership Board now has a Chair and Deputy Chair that has been elected by Reference Group Board members and is supported by an officer of NYCC Adult and Community Services.
- 4.0 Further information on the NYSP, Physical and Sensory Impairment Partnership Board and the Reference Groups is available on the NYSP website: www.nysp.org.uk.

Section 8: Monitoring

- 1.0 Actions are developed as an annual Equal Lives Action Plan.
- 2.0 The Physical and Sensory Impairment Partnership Board will report progress on the Action Plan to the Adults Strategic Partnership on an annual basis.
- 3.0 Updates will also be made to the Physical and Sensory Impairment Reference Groups by the elected members that attend each PSI Board meeting.

Appendix I Physical and Sensory Impairment Partnership Board Membership

Chair: Reference Group elected member.

Deputy Chair: Reference Group elected member.

North Yorkshire County Council
Voluntary sector representative
Disabled people's representatives
Carer representative
JobCentre Plus
District / Borough Councils
North Yorkshire and York PCT
Acute Health Sector
North Yorkshire Ambulance Trust
North Yorkshire Fire and Rescue Service
North Yorkshire Police

Appendix II The social model of disability

What is Disability?

'Disabled people' are people of all ages. They may have physical or sensory impairments, long-term health conditions, learning disabilities or mental health difficulties. It is widely accepted that disabled people have fewer opportunities and a lower quality of life than non-disabled people. Any action taken to deal with or remove the disadvantage experienced by disabled people depends on what is believed to be the cause of the disadvantage. There are two different ways of explaining these causes:

- the individual model of disability
- the social model of disability

The Individual (or medical) Model of Disability

The society we live in tends to consider disability to be a tragedy for the individual and a burden for the family and society. This is based on the 'individual model' of disability. This model focuses on the lack of physical or mental functioning and uses a clinical way of describing an individual's disability. This model leads to a dehumanising view, where only the nature and severity of the impairment is important, together with the extent to which the difference can be put right. It casts the individual as victim.

When people such as policy makers and managers think about disability in this individual way, they tend to concentrate their efforts on 'compensating' people with impairments for what is 'wrong' with their bodies by targeting 'special' welfare benefits at them and providing segregated 'special' services for them and so on. It can also affect the way disabled people think about themselves. Many disabled people internalise the negative message that all their problems stem from not having 'normal' bodies, and can be led to believe that their impairments automatically prevent them from participating in society.

The Social Model of Disability

The 'social model' of disability requires a change in society's values and practices in order to remove the barriers to participation which truly dis-able people. The social model has been worked out by disabled people who feel that the individual model does not provide an adequate explanation for their exclusion from mainstream society – because their experiences have shown them that, in reality, most of their problems are not caused by their impairments, but by the way society is organised and the barriers that exist.

These barriers can be:

- prejudice and stereotypes;
- inflexible organisational procedures and practices;
- inaccessible information;
- inaccessible buildings; and
- inaccessible transport.

These barriers have nothing to do with individual people's bodies. They are created by people, which means that it is possible to remove them.

Organisations can take a social model approach to disability by identifying and getting rid of the disabling barriers within their control. These include management practices, the way work is organised and the design of buildings. They can also assist disabled service users and employees to get around other barriers over which the organisation has no direct control.

It is clear that change is possible and is starting to happen - eg. changing steps into ramps, information in Braille, accessible web-design. A barrier free society will gain the full benefit of the talents and contributions of all its citizens.

Examples of what disables people ...

"I can't speak; I am disabled by the fact that you won't take the time and trouble to learn how to communicate with me."

"I can't hear. I am disabled by the fact that you won't provide a British Sign Language Interpreter at meetings."

"I can't walk. I can get through the door of my local village community centre in my wheelchair because it is ramped, but I am disabled by the fact that it's impossible for me to use the computer facilities because the desk is not height adjustable."

"I have a learning disability. I am disabled by the fact that you don't produce your leaflets in easy-to-read language and symbols, so that I can find out about the services you offer."

"I have a mental health problem. I am disabled by the fact that I find it very difficult to find work, because many people just assume I can't hold down a job."

The following diagram outlines the changes in culture and practice that need to take place, from the individual model to the social model:

Shifts in thinking about disability		
FROM	TO	
Disability is an individual problem	▶	Disability is a problem in society
Differences in abilities are inadequacies	▶	Differences in abilities are assets
Seeing deficits	▶	Seeing strengths
Special service provision	▶	Accessible mainstream services
Society choosing for 'them'	▶	Disabled people choosing for themselves
Professionals know best	▶	People have different kinds of knowledge
Charity based	▶	Rights based
Patient	▶	Citizen
Institution orientated	▶	Community orientated
Us and them: exclusion - tolerance	▶	All of us: inclusion - valuing
Individual (or medical) model of disability - control or cure	▶	Social model of disability - change environment and attitudes

Appendix III

Glossary of Terms

NYSP	North Yorkshire Strategic Partnership
NYCC	North Yorkshire County Council
ASP	Adult Strategic Partnership
PSI	Physical and Sensory Impairment
ACS	North Yorkshire County Council Adult and Community Services
BES	North Yorkshire County Council Business and Environmental Services
IPT	North Yorkshire County Council Integrated Passenger Transport
HaRPSI	Hambleton and Richmondshire Physical and Sensory Impairment (Reference Group)
Change-N-Yorkshire	Scarborough, Ryedale and Whitby Reference Group
LINKs	Local Involvement Networks
CIL	Centre for Independent Living
SES	Supported Employment Services
W&S DAG	Whitby and Scarborough Disablement Action Group
NYFVO	North Yorkshire Forum of Voluntary Organisations
CSCI	Commission for Social Care Inspection
SMOD	Social Model of Disability
CBL	Choice Based Lettings
JES	Joint Equipment Store
CAB	Citizens Advice Bureau
RipPSI	Ripon Physical and Sensory Impairment Group
HoH	Hard of Hearing (Reference Group subgroup)
RNIB	Royal National Institute of the Blind
PCT	Primary Care Trust
VI	Visual Impairment