Joint Strategic Needs (Barriers) Assessment

Children and Young People / Adults and Older People

Theme - Key Groups

Topic - Disabled People (Social Model of Disability)

Date - January 2022

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Why is this important?

Introduction

This topic report focuses on disabled adults, children and young people and is written through the lens of the Social Model of Disability. Although, in line with legislation, this report forms part of the Manchester Joint Strategic Needs Assessment, the focus throughout is on identifying and removing disabling barriers present in society (rather than people's impairments) and therefore it is more accurately described as being a Joint Strategic Barriers Assessment (JSBA) rather than a needs assessment.

The report describes to all commissioners and planners of public services (not just health and social care), why a barrier removal approach based on the Social Model of Disability should be used. It provides evidence that will enable commissioners to work with disabled people to plan and develop better, more inclusive programmes that recognise and remove disabling barriers from the outset.

Most local and national research data on disabled people tends to follow a deficit-based, medical approach that is focused on the details of individual impairments, rather than on disabled people's lived experience of social barriers. Research methodologies also draw on very different definitions of disability and data collection is often very limited and, as a result, there may be gaps in terms of the availability of reliable evidence about the impact of social barriers on disabled people and their solutions. This report draws on some broader statistical evidence from non-social model research approaches and methodologies, but this is not necessarily an endorsement of such approaches.

What is the Social Model of Disability?

Manchester City Council adopted the Social Model of Disability in 1991, the first local authority in the country to do so. The Social Model of Disability was developed in the 1970's by disabled people as an alternative to the prevalent medical model. It is based on the premise that people with impairments encounter barriers that have been created by a society which has not taken disabled people into account when designing and delivering services. It is these socially constructed barriers which disable (i.e. exclude) people, not their impairments. The Social Model of Disability is all about recognising potentially disabling barriers, and then taking action to remove them.

Commissioners of services for disabled people, whether specialist or mainstream have traditionally used the medical model of disability (also known as the 'individual' or 'deficit' model). It views an individual with an impairment as the 'problem' and therefore 'in need' of modifications or support to 'cure' or 'fix' that individual problem. It is that person who doesn't fit in with existing policies, procedures, or practices. The medical model is still commonly used in health and social care settings and when assessing benefits, where only aspects of a person are considered, rather than identifying structural barriers to their full participation in society and dealing with people holistically.

Using the medical model can lead to assumptions being made about a disabled person's abilities or requirements based on their impairment e.g. there are many different ways in which visually impaired people experience the world and there are many common

conditions which affect how a visually impaired person sees objects and people in different ways. Similarly, neuro-diverse people will experience and understand people, information, and environments in different ways, as will people with dementia, wheelchair users, people with mental health issues and other disabled people.

The Social Model seeks to move the focus of attention away from a person's impairment towards a better understanding of their access and participation requirements. Rather than asking people about the ways in which are they are disabled or what 'disability', medical condition or impairment they have, the focus should be on asking whether they have any access requirements or reasonable adjustments, whether they face any barriers in accessing a service or event and what their communication requirements are.

The Social Model frames disability as something that is socially constructed and created by physical, organisational, and attitudinal barriers which can be changed and eliminated. Viewed through this lens, disability is the name for the social consequences of having an impairment. People with impairments are disabled by society and disability is therefore a social construct that can be changed and removed.

The term 'impairment' refers to an individual's physical, sensory or cognitive difference (e.g. being visually impaired, experiencing bipolar or having a learning difficulty).

Key disabling barriers from a Social Model approach include:

- Attitudinal barriers: These are social and cultural attitudes and assumptions about people with impairments that explain, justify and perpetuate prejudice, discrimination and exclusion in society; for example, assumptions that people with certain impairments can't work, can't be independent, can't have sex, shouldn't have children, need protecting, are "child-like", are "dangerous", should not be seen because they are upsetting, are "scroungers" etc.

- Physical barriers: These are barriers linked to the physical and built environment, and cover a huge range of barriers that prevent equal access, such as stairs/steps, narrow corridors and doorways, kerbs, inaccessible toilets, inaccessible housing, poor lighting, poor seating, broken lifts or poorly managed street and public spaces.

- Information/Communication Barriers: These are barriers linked to information and communication, such as lack of British Sign Language interpreters for deaf people, lack of provision of hearing induction loops, lack of information in different accessible formats such as Easy Read, plain English and large font.

This gives us a dynamic and positive model that tells us what the problem is and how to fix it. It takes us away from the position of "blaming" the individual for their 'shortcoming'.

The Social Model of Disability states that "impairment is, and always will be, present in every known society, and therefore the only logical position to take, is to plan and organise society in a way that includes, rather than excludes, disabled people." (Barbara Lisicki, 2013 cited in Inclusion London's Factsheet on The Social Model of Disability)

Disabling social barriers contribute hugely to avoidable disadvantages experienced by many disabled people, for example:

- Poorer health outcomes

- Social isolation
- A higher risk of being exposed to violence
- Restricted participation
- Reduced quality of life
- Lower educational achievements
- Reduced economic participation and lack of employment opportunities
- Higher rates of poverty

Commissioners and planners are in an excellent position to change this by ensuring that barriers are designed out of programmes and services.

The Social Model, in highlighting the barrier, often simultaneously identifies the solution to the barrier, for example:

- Barrier - the intercom in a block of flats does not have a video camera, therefore deaf/hard of hearing residents cannot establish who is seeking entry.
- Solution - Install an intercom system with video for deaf and hard of hearing residents.
- Additional benefits - Older people and other people who may feel vulnerable feel more secure in the accommodation.

By using the Social Model of Disability, individuals are empowered by respecting and incorporating their own experiences. It provides an enabling framework for disabled people to explain their requirements and explore inclusive opportunities that will best support their requirements and aspirations. It provides an opportunity to work together towards making Manchester fully inclusive and barrier free.

Health of disabled people

Health inequalities often start early in life. Difficulties in getting effective and appropriate healthcare when it is needed can make a person's health worse and affect their quality of life. The World Health Organisation (WHO) has summarised some of the barriers that can result in health inequalities experienced by disabled people. These include:

- Limited availability of accessible services
- Access barriers
- Inadequate skills and knowledge of health workers
- Poverty
- Inaccessible transport
- Poor communication
- Negative attitudes
- Diagnostic overshadowing and under-shadowing[1]

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[1] Diagnostic overshadowing is a term used to describe the under-diagnosis of mental ill health in people with a learning disability. The term has also been used when physical illnesses are overlooked in people experiencing mental ill health. Diagnostic overshadowing can lead to delays in treatment for physical health conditions in people with mental ill health, leading to increased mortality and poorer treatment outcomes

Published research looking at the [experiences of disabled people in the UK](#) has shown that disabled people report worse access to healthcare, with transportation, cost and long waiting lists being the main barriers.

Across Britain, disabled adults report much lower rates of good health overall compared with non-disabled adults. A report from the Equality and Human Rights Commission ('[Being disabled in Britain 2016: A journey less equal](#)') states that:

"Disabled people are more likely to experience health inequalities and major health conditions and are likely to die younger than other people. The extent of these health inequalities is difficult to assess because of limited data on outcomes for disabled people collected by NHS providers and commissioners. Accessibility of services is problematic, and disabled people are less likely to report positive experiences in accessing healthcare services."

The Equality and Human Rights Commission's report on the [state of equality and human rights in 2018](#) highlights that health inequalities and barriers to accessing healthcare are a significant reason why disabled people are four times more likely to die of preventable causes than the general population. Research from the Deaf health charity Sign Health ([Sick of It: How the Health Service is Failing Deaf People](#)) shows that Deaf people are twice as likely as hearing people to have undiagnosed high blood pressure and are also more likely to have undiagnosed diabetes, high cholesterol and cardiovascular disease.

All of the health and wellbeing inequalities facing disabled people have been further exposed and exacerbated by Covid-19. In February 2021, the Office for National Statistics (ONS) published a report on [Coronavirus and the social impacts on disabled people in Great Britain](#) which showed that:

- A larger proportion of disabled people (78%) than non-disabled people (69%) aged 16 years and over said they were worried (very or somewhat) about the effect that the coronavirus (COVID-19) was having on their life
- Disabled people indicated more often than non-disabled people that coronavirus had affected their life in ways such as their health (35% for disabled people, compared with 12% for non-disabled people), access to healthcare for non-coronavirus related issues (40% compared with 19%), well-being (65% compared with 50%) and access to groceries, medication and essentials (27% compared with 12%).
- Feeling stressed or anxious, bored and worried about the future were the most frequently cited well-being concerns among both disabled (67%, 62% and 57% respectively) and non-disabled people (54%, 63% and 52% respectively) in February 2021. Feeling bored has been reported increasingly by both disabled (43% to 62%) and non-disabled (42% to 63%) people with well-being concerns since September 2020.
- Among people who indicated coronavirus affected their well-being, disabled people specified that the coronavirus was making their mental health worse more frequently than non-disabled people (46% for disabled people and 29% for non-disabled people), they are feeling like a burden on others (25% and 10%), they are feeling stressed and anxious (67% and 54%) or they are feeling lonely (49% and 37%).
- Disabled people had on average poorer well-being ratings than non-disabled people across all four well-being measures (life satisfaction, feeling that things done in life are worthwhile, happiness and anxiety).

- For both disabled and non-disabled people, life satisfaction and happiness ratings were poorer in February 2021 than in September 2020. All well-being ratings of disabled and non-disabled people remained poorer in February 2021 compared with a period prior to the coronavirus pandemic (the year ending June 2019).
- Disabled people tended to be less optimistic than non-disabled people about life returning to normal in the short term. Around a fifth (20%) of disabled people compared with over a quarter (27%) of non-disabled people thought that life will return to normal in less than six months.
- Positive sentiment towards the vaccine was high among both disabled and non-disabled people. At the time of publication, 94% of both disabled and non-disabled people reported they had now either received at least one dose of a coronavirus (COVID-19) vaccine, were awaiting one, or would be likely (very or fairly likely) to have a vaccine if offered

The lived experience of disabled people during the COVID-19 pandemic is a piece of government commissioned research with disabled people published in September 2021. This also highlighted disabling barriers emerging through the pandemic:

- during the pandemic, participants have felt increased levels of shame and guilt about their 'disabled' identities and the needs that accompany them
- participants' experiences and perceptions of being classified as 'vulnerable' during COVID-19 have differed markedly
- participants have felt particularly vulnerable when receiving social and healthcare services during the pandemic
- lockdown restrictions and other actions mandated by the government, aimed at stemming the spread of COVID-19, have given some participants the impression that their needs do not matter
- the pandemic has exposed and exacerbated the existing inequalities experienced by our disabled participants
- some participants felt that COVID-19 restrictions have conflicted with their disability access needs
- participants felt that people in wider society have often been able to 'cherry pick' the COVID-19 rules they are going to abide by, because they have more freedom to do so, whereas disabled people cannot, mainly due to new and existing social barriers
- COVID-19 has presented new challenges for some of our participants in terms of living independently, reducing their ability to choose suitable support options
- for some participants, independent living choices have been uninterrupted during the pandemic

Office for National Statistics (ONS) figures show disabled people have made up about three-fifths of COVID-related deaths in England and Wales. Updated estimates of coronavirus (COVID-19) related deaths by disability status showed that between 24 January and 20 November 2020, the risk of death involving the coronavirus (COVID-19) in England was 3.1 times greater for more-disabled men and 1.9 times greater for less-disabled men, compared with non-disabled men. Among women, the risk of death was 3.5 times greater for more-disabled women and 2.0 times greater for less-disabled women, compared with non-disabled women.

BBC research with 3,351 disabled people (Disabled people forgotten during COVID) also highlighted the impact of COVID:

- 2,604 said mental health had got worse

- 2,427 impairment had deteriorated
- 683 had seen all their appointments cancelled / unable to attend
- 241 had not left house at all

On broader themes, the government commissioned [UK Disability Survey](#) provided insights across a wide range of topics, including perceptions and discrimination, housing, employment, education, shopping, leisure, and public services. The survey identified that:

- Public perceptions of disabled people were a significant barrier to participation in areas, including employment and education. Most disabled people responding to the survey felt that public attitudes towards disabled people were unhelpful.
- Over half of disabled people reported worrying about being insulted or harassed in public places, and a similar proportion reported being mistreated because of their disability.
- Many disabled people and carers reported that they live in homes which do not meet their needs to live independently or to provide care, or that they have needed to make significant adjustments to their homes to meet accessibility requirements.
- Accessibility challenges extend beyond the home, to public buildings and spaces. Over a quarter of disabled people often had difficulty accessing public buildings, while 1 in 3 disabled respondents often had difficulty accessing public spaces. Accessibility barriers faced by disabled people ranged from a lack of disabled or changing places toilets to a lack of ramps. Shops, bars, restaurants, and cafes were venues where accessibility barriers were commonly encountered.
- Many disabled people and carers who had experienced difficulty accessing public buildings also reported difficulty accessing important public services.
- Only 1 in 10 disabled people agreed that disabled people are given the educational opportunities they need to thrive in society.
- Over half of disabled people in employment reported that they would like more help finding and keeping a job. Of those in employment, half of disabled respondents felt their employer was flexible and made sufficient reasonable adjustments, and half of carers felt their employer was supportive of their caring responsibilities. Only a quarter of disabled people and carers felt they had the same promotion opportunities as their colleagues.

Health promotion and prevention activities may miss opportunities to reach disabled people and don't put in specific targets to reach them. For example, disabled women receive less screening for breast and cervical cancer than non-disabled women. People with intellectual impairments and diabetes are less likely to have their weight checked. Young disabled people are more likely to be excluded from sex education programmes.

Social/physical isolation, loneliness, and a lack of integration into the community is also increasingly identified as a significant public health risk. It can affect anyone, but disabled people are at a higher risk due to a lack of accessible information, transport, and local activities. A report by the New Policy Institute on [Disability and Poverty](#) shows that disabled people have higher poverty rates than the rest of the population and that almost half of people in poverty in the UK are in a household with a disabled person or are disabled themselves. This means that disabled people often face many barriers to social participation and leisure opportunities. Feedback from local VCSE organisations suggests that many community activities in Manchester are not accessible to disabled people due to inadequate communication and support. In the Lived Experience section below, we

describe how these existing barriers have been amplified by COVID, with examples from Manchester based disabled people who are working with Breakthrough UK.

Poor health, immobility and living in a deprived area all add to isolation. The Marmot Review ('Fair Society, Healthy Lives') highlights that there is a strong link between social isolation, loneliness and poor physical and mental health. "Individuals who are socially isolated are between two to five times more likely than those who have strong social ties to die prematurely".

Many disabled people have been affected by cuts to government benefits and services in recent years. A UN Committee investigation found that welfare reform was limiting disabled people's ability to choose where they live, causing "reduction in their social interaction and increased isolation".

A study by the Independent Living Strategy Group (ILSG) found that 41% of disabled people responding to a survey had experienced a substantial increase in charges over the last couple of years and that nearly half (43%) had had to cut back on their spending on food to pay for care. Around two-fifths of respondents (40%) said they had had to cut back on heating costs to pay for care and support.

Health of people with learning difficulties

People with learning difficulties have poorer health than the general population. A lot of this is avoidable. Research and statistics published by Mencap shows that the life expectancy of people with learning difficulties is shorter than for the general population, by 18 years for women and 14 years for men in England and some studies indicate that the gap is much higher. The annual report of the Learning Disabilities Mortality Review (LeDeR) Programme highlights that men with learning difficulties live 23 years less than the general population and women with learning difficulties live up to 29 years less.

The 'Being Disabled in Britain 2016' report from the Equality and Human Rights Commission shows that people with learning difficulties are five times more likely to end up in hospital for preventable issues that can be treated by their GP. A survey by Dimensions involving people with learning difficulties, their support teams and GPs showed poor quality of primary health care due to a lack of GP training.

The final report of the Confidential Inquiry into premature deaths of people with Learning Disabilities (CIPOLD) found that 38% of people with learning difficulties died from an avoidable cause (amenable death), compared to 9% in a comparable group of people.

Government research on the deaths of people with learning difficulties from Covid, based on the deaths reported to LeDeR, showed the COVID-19 death rate for people with learning difficulties was 240 deaths per 100,000 adults with learning difficulties. This is 2.3 times the rate in the general population for the same period. However, after adjusting for under-reporting the estimated rate was 369 per 100,000 adults, which is 3.6 times the rate in the general population.

Disabled people and crime

Nationally, around 40% of disabled children and adults aged 16-34 have reported being a victim of crime, compared to 30% for non-disabled children and adults.

In 2020/21, there were 124,091 [hate crime offences recorded by the police](#) in England and Wales, of which 9,208(%) were disability hate crimes - a 9% increase compared with the previous year.

Greater Manchester Police (GMP) most recently available [hate crime and hate incident data](#) for the 6 month period to the end of June 2019 shows that there were 248 disability hate crimes and 309 disability hate crimes and incidents across all police subdivisions in Greater Manchester. This represents 5.5% of all hate crimes and 6.0% of all hate crimes and incidents. The number of disability hate crimes during the first 6 months of 2019 is 2% higher than the number seen over the same period in the previous year.

In Manchester, there were 30 hate crimes and 41 hate crimes and incidents reported over the same period, representing 2.1% of all hate crimes and 2.5% of all hate crimes and incidents in the city. The number of disability hate crimes during the first 6 months of 2019 is 7% lower than the number seen over the same period in the previous year.

The Manchester Picture

Disabled people in Manchester

- Only half of working-age disabled adults in Manchester are employed, which is lower than the national average.[2]
- In 2020, 37% of disabled people in Greater Manchester reported that their housing was not accessible or only partially accessible, with considerable implications for their ability to live independently.[3]
- In 2020, the Greater Manchester Big Mental Wellbeing Conversation (GMBMWC) was launched to understand the needs of people across the city-region and hear what they think is most important for their mental wellbeing. This showed that disabled people in Greater Manchester have worse outcomes regarding mental wellbeing. It also found that disabled people often prefer different kinds of support improve their mental wellbeing. Further research is being carried out to understand this better.
- Greater Manchester Disabled People's Panel (GMDPP's) 2020 GM Big Disability Survey involving over 900 disabled respondents found that inequalities in mental wellbeing between disabled and non-disabled residents have been exacerbated by the COVID-19 pandemic. Key findings were:

  - 90% of respondents said that the pandemic has had a negative impact on their mental health.
  - 80% of respondents were not included in the official shielded group, yet 57% of those had support needs. For example, many could not get online supermarket food delivery despite needing to shield.
  - 56% of respondents had experienced some difficulty sourcing Personal Protective Equipment (PPE).
  - 62% of respondents have experienced one or more health visit being stopped due to Covid-19.
  - Accessibility of the hubs was a problem, 46% found them inaccessible with deaf people being the worst excluded.
  - Disabled people are less satisfied with their care plans since the outbreak of Covid-19. Prior to the outbreak, 23% were dissatisfied, this dissatisfaction increased to 43% during the Pandemic.
  - 37% said that their housing was not accessible or only partially accessible.
  - 83% of disabled people were worried about how they would be treated in hospital because of attitudes to disability.
  - 47% found government advice unclear and many commented that the lack of a British Sign Language interpreter or conflicting language made official announcements inaccessible.
  - Digital exclusion was a problem, especially as a lot of the emergency response used digital platforms.
  - A third of disabled people believe that their local authority is not doing anything significant whilst 76% of disabled people are dissatisfied with the help provided by the government.

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[2] Office for National Statistics, 2020. Annual Population Survey (data for the year to September 2020).
[3] Greater Manchester Disabled People's Panel, 2020. GM Big Disability Survey: Covid-19, p.23.

People with physical and learning impairments in Manchester

According to the latest data from the [Health Survey for England 2019](#), published in December 2020, around 9% of the population aged 16-64 in Manchester was estimated to have a "moderate or serious" physical impairment (sic) compared with 11.2% for the North West and 11.1% for England. The 2020 Survey was suspended due to COVID.

Data from the [Quality and Outcomes Framework (QOF)](#) shows that, in 2020-21, there were 4,762 people recorded as a having a learning difficulty on GP patient registers in Manchester - an average of 56 people per practice. In the previous year (2019/20), there were 3,246 people record as having a learning difficulty on GP patient registers (an average of 38 people per practice). The big increase in the number of people recorded is likely to be due to improvements in data quality linked to COVID.

People with sensory impairments in Manchester

Prevention of sight loss will help people maintain independent lives as far as possible and reduce the need for social care support, which would be necessary if sight was lost permanently. Research by the Royal National Institute for Blind People (RNIB) suggests that 50% of cases of blindness and serious sight loss could be prevented if detected and treated in time. The risk of sight loss is heavily influenced by health inequalities, including ethnicity, deprivation and age. Sight loss can increase the risk of depression, falls and hip fractures, loss of independence and living in poverty.

The Law Commission report on Adult Social Care (May 2011) recommended that local authorities should maintain a [register of blind and partially sighted people](#). Completion of a Certificate of Vision Impairment (CVI) by a consultant ophthalmologist, initiates the process of registration with a local authority and leads to access to services.

Please note that people who have a CVI from an ophthalmologist can choose whether to be included in their Local Authority's register of blind or partially sighted people. This means that registration is not automatic and not everybody that has been certified as having vision impairment is recorded on a Local Authority register.

Table 1: Number of blind/severely sight impaired persons and partially sight impaired persons on the register in Manchester by age group, 2019/20

Age group	Blind/severely sight impaired persons		Partially sight impaired persons	
	Number	Rate per 100,000	Number	Rate per 100,000
0-4	8	22.1	7	19.4
5-17	37	42.2	37	42.2
18-49	372	121.4	360	117.5
50-64	274	370.6	218	294.9
65-74	192	653.2	164	557.9
75 and over	512	2,310.3	545	2,459.2
Total	1,395	251.0	1,331	239.5

Source: Manchester City Council, 2021

In 2019/20, there were a total of 2,726 blind or partially sighted people registered with Manchester City Council - a rate of 490.5 per 100,000 population. In the same year, there were a total of 140 new blind or partially sighted people added to the register.

Just under half (46%) of blind or partially sighted people registered with Manchester City Council in 2019/20 were recorded as having an additional impairment. Around 28% of blind or partially sighted people also had a physical impairment and 12% were also hard of hearing.

Long-term health conditions and impairment (as defined by the 2011 Census)

According to the 2011 Census, around 89,360 Manchester residents reported that they had a long-term health problem or impairment (called 'disability' in the Census) which limited their daily activities either 'a lot' or 'a little'. This equated to 17.8% of Manchester's surveyed population, which was slightly higher than the 17.6% reported for England as a whole.

At 9.4%, Manchester has a higher proportion of residents whose daily activities are limited 'a lot' when compared to the national figure of 8.3%. However, at 8.3% the proportion of Manchester's residents whose daily activities are limited 'a little' is lower than the national average of 9.3%. The fact that the proportion of Manchester residents who reported that their day-to-day activities that are limited 'a lot' is notably higher than the national average suggests that the proportion of people with significant support requirements is greater in the city than nationally.

While direct comparisons with 2001 are difficult due to a differing question style in the earlier census, Manchester and other large urban conurbations have shown a reduction in the proportion of disabled people and people with long term health conditions reporting that their daily activities were limited.

Table 2: Percentage of disabled people and people with long term health conditions whose daily activities are 'limited a lot', 'limited a little' or 'not limited'.

Degree of limitation	Manchester	England
Day-to-day activities limited 'at lot'	9.4%	8.3%
Day-to-day activities limited 'at little'	8.3%	9.3%
Day-to-day activities not limited	82.2%	82.4%

Source: Census 2011, ONS, Crown Copyright

The proportion of Manchester residents who reported that they had a limiting long-term health condition or impairment between different black and minority ethnic (BAME) communities, and between faith groups.

Long-term health conditions in black and minority ethnic groups

The JSNA topic report on black and minority ethnic (BAME) communities shows that men from the White Gypsy or Irish Traveller, Mixed White-Black Caribbean, White Irish and Black Caribbean groups had higher rates of reported limiting long term illness than White British men. In contrast, Bangladeshi, Arab and Pakistani men reported lower rates of limiting long-term illness than White British men. White British women had similar rates of illness as White British men. White Gypsy or Irish Traveller women had the highest rates of limiting long term illness, almost twice that of White British women. Pakistani and Bangladeshi women also had worse health than the White British group. In contrast, Chinese, Other White and Black African women had lower rates of limiting long-term illness than White British women.

The JSNA topic report on Faith and Health shows that Manchester residents from one of the main religions covered in the census question (Christian, Buddhist, Hindu, Jewish, Muslim, Sikh and 'Other') were more likely to report that they had a long-term health problem or impairment that limited their day-to-day activities than those who stated that they had no religion (with the Hindu population being the main exception to this rule).

People from Christian and Jewish faiths were the most likely to report having a limiting long-term health problem or impairment. In both cases, age is likely to be the main explanatory factor. Levels of poor general health and limiting long-term health problems both increase with age and people identifying themselves as having a religion were, generally speaking, older than those who did not, with the Christian and Jewish faiths having the oldest population of all.

The poorer levels of reported long term health problems in people from certain faiths is reflected in the poorer health outcomes associated with Coronavirus (COVID-19). For example, data from ONS on deaths involving COVID-19 by religious group published in May 20201 indicates that, in England, people identifying as Muslim, Hindu, Sikh, or Jewish had higher age-standardised mortality rates (ASMRs) for deaths involving coronavirus (COVID-19) than those identifying as Christian in the period 24 January 2020 to 28 February 2021.

Lesbian, gay, bi-sexual, and transgender

National research carried out by the [Social Care Institute for Excellence (SCIE)](#) in partnership with Regard (a LGBTQI+ disabled people's organisation) based on a survey of more than 50 LGBTQI+ disabled people in England who control their own support packages, as well as 20 in-depth interviews, showed that more than a third of LGBTQI+ disabled people had experienced discrimination or received poor treatment from their personal assistants because of their sexual identity or gender identity. Researchers also found that many LGBTQI+ disabled people had not come out to their personal assistants because they feared discrimination. More than half said they never or only sometimes disclosed their sexual orientation or gender identity to their PAs.

Almost a third said they felt they had been discriminated against by their local authority on the grounds of their sexual orientation or gender identity and more than 90% said their needs as an LGBTQI+ disabled person were either not considered or were only given some consideration, when they were assessed or reviewed by their local authority.

Employment and skills

At the time of the 2011 Census, there were 19,415 economically active people in Manchester who identified themselves as disabled or who have a long-term health condition that limits their daily activities. This represents approximately 5% of the city's working age population. The proportion of economically inactive working-age Manchester residents who identify as long-term sick or disabled (6.6%) is higher than the national average of 4%.

Table 3: Percentage of economically inactive working-age residents (16-74 years) who are long-term sick or disabled

	Number of economically inactive residents	% economically inactive residents long-term sick or disabled
Manchester	382,932	6.6%
England	38,881,374	4%

Source: Census 2011, ONS, Crown Copyright

Although this is far from always the case, the statistics also show that disabled children and adults in Manchester are more likely to live in poverty, have fewer educational qualifications, be out of work, be a victim of crime, have difficulty accessing transport and buildings, and experience a poorer quality of life than their non-disabled peers.

Around half of disabled people aged 16 to 64 years (52.1%) in the UK were in employment compared with around 8 in 10 (81.3%) for non-disabled people (July to September 2020); disabled people with autism were among those disabled people with the lowest employment rate.[4]

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[4] [Outcomes for disabled people in the UK - Office for National Statistics (ons.gov.uk)](#)

Data from the ONS Annual Population Survey (APS) also show that there is a gap in the employment rate between people aged 16-64 with a long-term health condition and the overall employment rate in this age group. In 2019/20, there was a 13.5 percentage point gap between the employment rate in people with a long-term health condition in Manchester and the overall employment rate in the city. This is higher than the gap found in England as a whole (10.6 percentage points). Although these figures are slightly different from those given in the previous paragraph, they show a similar picture of lower rates of employment in disabled people compared with non-disabled people,

The gap for people with learning difficulties is much higher. In 2019/20, there was a 65.3 percentage point gap between the employment rate in working age people with learning difficulties in Manchester and the overall employment rate in the city. However, this is lower than the gap found in England as a whole (70.6 percentage points).

Disability related benefit claimants

According to the Department of Work and Pensions, the total number of people in Manchester claiming Employment Support Allowance (ESA) as at February 2021 was 22,488. Just over 83% of that number (18,682) were in the ESA Support Group and have been assessed by the Department for Work and Pensions as not being fit to work: https://stat-xplore.dwp.gov.uk/webapi/jsf/tableView/tableView.xhtml

In the same period (February 2021), there were 13,060 people in Manchester receiving Disability Living Allowance (DLA). Just over 73% of these people had been receiving this benefit for 5 years or more (9,310). Around 38% of people claiming DLA were children under the age of 16, 20% were of working age (16-64 years) and 37% (4,769) were aged 65 and over.

Personal Independence Payments (PIP) provide financial support for people who have extra care or mobility needs (difficulty getting around) because of long-term disability or ill-health. PIP is replacing Disability Living Allowance (DLA) for eligible working age people aged 16 to 64. In July 2021, 29,925 people in Manchester were receiving PIP. This compares with 19,557 people in January 2018 and 23,060 in January 2019.

The Nomis website states, "Under Universal Credit a broader span of claimants are required to look for work than under Jobseeker's Allowance. As Universal Credit Full Service is rolled out in particular areas, the number of people recorded as being on the Claimant Count is therefore likely to rise."

In September 2021, 7.5% of people aged 16 and over in Manchester (29,205 people in total) were claiming Universal Credit, compared with 5.6% of people in the North West and 5.0% in Great Britain.

Access to long term Adult Social Care services

Data collected by Manchester City Council as part of the Short and Long Term Service (SALT) report shows that there were 7,390 adults aged 18 and over receiving long term social care support between 1 April 2000 and 31 March 2001. The table below shows this data broken down by the primary support reason.

Table 4: Adults in receipt of long term social care support from Manchester City Council by age and primary support reason (1 April 2020 - 31 March 2021).

Primary support reason	18-64 years	65+ years	18+ years	% clients 18+
Physical Support	955	3,600	4,555	61.6%
Learning Disability Support	1,100	195	1,295	17.5%
Mental Health Support	765	350	1,115	15.1%
Support with Memory and Cognition	30	310	340	4.6%
Sensory Support	10	35	45	0.6%
Social Support	25	15	40	0.5%
Total	2,885	4,505	7,390	100.0%

Source: 2020/21 SALT (Short and Long Term Service) Statutory Return, Table LTS001B, All settings.

In summary, over this period, there were 1,295 people aged 18 years and over with learning difficulties recorded as a primary support reason (17.5% of all adult clients) and 4,555 (61.6% of all clients) with a physical impairment (physical support need).

For those in a community based setting, around 85% of adults aged 18-64 with a physical support requirement were receiving personal care support. For people aged 65 and over with a physical support requirement, just under 79% of adults were receiving personal care support. In both age groups, the remainder of people with a physical support requirement were receiving access and mobility support only.

At the end of 2020/21, just under 53% of adults aged 18 and over receiving long-term support in a community setting were doing so because they had a physical support requirement. Around 25%of adults in this age group receiving support in this setting had a learning difficulty. In both cases, the delivery mechanism for this support was predominantly through a council-managed personal budget.

Children and young people

Nationally, it is estimated that children and young people defined as having 'Special Educational Needs' (SEN) have higher rates of absence from school and exclusion from school. This is also the case in Manchester, where for example in 2017/18 Manchester pupils missed 4.7% of school sessions. For pupils with an Education, Health and Care Plan (EHCP) the absence rate was much higher (10.2%).

There has been an improvement in the percentage of pupils with an EHCP achieving at least a pass in English and Maths over the past three years. However, there is still a large gap between these pupils and those with no SEN. Around 53% of disabled children and adults and those with long-term conditions have either no qualifications or qualifications below GCSE grades A-C.

In July 2019, 10.8% of 16 to 18 year olds with SEN were not engaged in education, employment, or training, compared to 3.6% of all 16 to 18 year olds.

Statistics on [schools, pupils and their characteristics](#) published by the Department for Education shows that, as at January 2019, there were around 87,500 pupils being educated in Manchester schools, of whom 14,200 (16.2%) were SEN. This compares with 14.8% nationally. Half the school-age population with high levels of SEN reflected by an Education, Health and Care Plan attend a mainstream school and half attend a special school. These figures have not changed much over the last five years.

Most children and young people with SEN have Speech, Language and Communication Needs. 'Autistic Spectrum Disorder' is the most common impairment for children and young people with a Statement or EHC plan in Manchester (30%). This is slightly higher than the national figure of 29% (2019 School Census).

Please note that this relates to children and young people educated in Manchester schools, not all of whom are Manchester residents. Similarly, not all children and young people living in Manchester attend a school within the Manchester City Council area.

[A JSNA Topic Report on disabled children and young people and children and young people with special educational needs (SEND)](#) was published in September 2020. The report describes how Manchester's population is growing significantly and the number of children and young people with SEND is growing in line with the population increase. It also outlines the current offer in Manchester for children and young people with SEND and sets out the recommendations have been used to inform the Local Area SEND Action Plan.

Further statistics relating to disability in the city are available in the [State of the City Communities of Interest Report 2016](#), an update to which will be prepared in 2022, following the publication of data from the 2021 Census.

Lived experience

Disabled people still face huge barriers and inequality in Manchester, and these have increased further during the pandemic. The onset of COVID-19 has clearly highlighted the inequalities already facing disabled people and has exacerbated how society is still unfair for many.

Disabled people in Manchester reported the following barriers to Breakthrough UK in the summer and autumn of 2021:

Digital barriers

- When organisations set up online services, there are barriers faced such as unknowledgeable staff, which can cause anxiety.
- Disabled people who have 'pay as you go' phones often do not have the funds to use the internet which includes use of video chats (skype/teams), WhatsApp, book activities online and apps.
- Disabled people report feeling very overwhelmed using apps as the digital industry is constantly changing interfaces and access.
- Digital access remains a barrier for many disabled people. This is for a variety of reasons, including digital poverty, inaccessible platforms, lack of control over equipment and lack of digital skills. Many Breakthrough UK clients only have access to

mobile phones instead of tablets/laptops/computers, which makes digital sessions more difficult.

Barriers to accessing healthcare

- Disabled people report that they don't feel confident (or were not aware of how) to book dental or doctor's appointments through an online booking system or over the phone. These routes are not accessible to everyone.
- Many Breakthrough UK clients don't have access to the internet and are struggling to get through to doctor's surgery over the phone. Communication is now limited as people cannot attend the practice without an appointment and many do not feel comfortable calling, or using the phone is not accessible. (Breakthrough UK's work with GP practices in Manchester in 2020 on the Accessible Information Standard showed that there was limited knowledge within some GP practices on how to make digital more accessible. The use of alternative methods of contact were also inconsistent, with some practices having multiple ways to get in touch but others only having one way (telephone usually). However, practices are very keen to change this and learn).
- GP practices often look unwelcoming. For example, a lot of them look like they are closed due to multiple signs put up covering windows.
- Minimal NHS services available – no space at doctors/dental surgeries for new patients.
- A particular issue with finding spaces at NHS dentists has emerged.
- Lists are full.
- Lack of mental health support services. Breakthrough UK's clients report being put on medication and then not offered any further support.

Information

- Mis-information and inaccessible information on Covid-19 vaccinations, boosters and rules.

Independent living and access to community life

- Many disabled people are not receiving in-home support, which means they are losing independence, choice, and control in their day-to-day life.
- Social housing / support staff are not facilitating the independence they potentially could, which means that some disabled people lack confidence attending meet up/activities.
- Lack of available accessible activities in the city.
- Activities (especially in Manchester City Centre) are hosted in the evening times after it has gone dark, which presents barriers to many disabled people because of personal assistance and transport arrangements.
- Infrastructure barriers. There is a higher turnover of social workers, lack of continuity of wider support and a lack of contact with them. This is indicative of pressures within wider workplaces. The impact on disabled people includes long waits for face-to-face services, lack of continuity and irregular correspondence.
- Loss of support. One individual said they are not able to access the support hours they need to live independently. This is causing anxiety, fear, and decreased confidence, as well as restricting their activities.

- General access to services is low due to COVID. Limbo period for everyone as services continually change and react. It is not obvious which services will re-open as providers do not react with a universal strategy or timeline. Access to relevant, nearby services becomes lower.
- Many disabled people working with Breakthrough UK report feeling socially isolated. It is hard for people to know what services and activities are currently open and, if they are open, they are on reduced/different hours so it's hard to keep track. Indoor group activities are particularly affected.
- There is anxiety over joining new organisations or getting more involved with current organisations.

Wellbeing

- Isolation and social distancing concerns. Some individuals have spent the last 18 months in their homes so lack confidence wanting to leave and join activities, as well as being worried for their health and safety with different COVID variants spreading quickly.
- Disabled people are also concerned about the implications of weakened immunity to other viruses after many months of shielding.
- Mental health support services are oversubscribed with long waiting lists and a lack of access to appropriate mental wellbeing support is resulting in people lacking confidence going outside, taking part in things and socialising.
- There has been an increase in the numbers of disabled people making crisis contact and reporting suicidal feelings.
- COVID restrictions are making people anxious. Disabled people are unsure if it is safe to go out now that restrictions are beginning to lift.
- Disabled people are concerned for their health if services go back to face to face

Transport

- Lack of confidence with traveling on public transport and changes in tram, train, and bus services across the city. Public transport is now becoming crowded, especially in the City Centre, and this is a big barrier to disabled people going out.
- Disabled people had expected going back to work with face coverings still being used on public transport, and with a lower number of people on that transport. This is not happening. Changes affect their confidence in going back to work.
- Safety is flagged as a key issue. Breakthrough UK's clients have repeatedly said that they face harassment on a regular basis from members of the public, especially on public transport.
- Many disabled people are being turned down for concessionary bus passes in the city, even when they were previously eligible.

Money

- Some disabled people are struggling with lack of support in relation to their household bills.
- Some disabled people report lack of access to their own money, with benefits being paid into relative's bank accounts.
- People require more support with benefits applications.

- More accessible financial advice services are needed.

Employment

- Disabled people accessing Breakthrough UK's employment service said that it's very difficult to get legal advice, especially in relation to the benefits system and how to find out about accessible advice services.
- Breakthrough UK's clients said that they are afraid to apply for jobs due to COVID-19 and they are not sure if the office environment is COVID safe or how staff members will behave.
- Concerns over digital tech when applying for jobs, for example, not having a full understanding of current computer software. This creates huge concern.
- Concern about benefits (ESA/PIP/UC) and how going back to work will affect this, especially if work is then affected by more COVID changes.
- All ESA clients have been concerned about the hours they are allowed to work as they are reliant on ESA and are scared to work more and lose that option. PIP makes this issue worse. Some are only seeking under 16 hours due to the impact of their impairment. Many feel they can only work a small number of hours, at least in the initial stages of moving back to work. Finding low hours work at present is difficult as many part time hours are 20+ as the employment market reacts to changes.

Solutions to barriers to disabled people, prevalent due to COVID-19

The information and recommendations below have been drawn together by disabled lived experience experts from panels and forums which are facilitated by Breakthrough UK. This panel is made up of Manchester based disabled people who provide guidance to system leaders in the city to remove disabling barriers, based on their own lived experience.

Information and advice around COVID-19

COVID-19 has created a lot of fear and anxiety for disabled people around the pandemic, but also significant areas around it, including vaccinations, testing, how to stay safe, receiving help and advice and support to isolate. Whilst it is acknowledged that improvements have been made in attempts to make information and advice more accessible through sounding boards and accessible messaging, lived experience experts feel much more can be done to make this information fully accessible and to reach out to more isolated members of the community who are disabled people to ensure they are receiving vital information and support surrounding COVID-19. This means further investment and resources being committed to the development of a wider range of information in a plethora of accessible formats - audio, braille, text services, British Sign Language, and easy read.

Panel members also recommend having more community outreach, in recognition that not everybody has access to smart devices, televisions, tabloids or feels digitally included or capable. Many disabled people have retreated from society and continued to electively shield, so we encourage commissioners to think about going the extra yard, finding a way to engage perhaps by simply knocking on the door and enhancing community collection

opportunities to re-engage people - especially around delivering key messages of support, information and advice.

There is a need to consider how support is delivered when delivering and receiving information for disabled people. Autistic people, people with mental health impairments and neuro diverse individuals need additional support to be considered and that support needs to be personalised to suit the individual, not the system. We feel this requires further training for frontline staff to understand the diverse needs of disabled people.

For example, GPs are a valued source of a lot of information, but if a disabled person is not fully supported accessing information that they are often effectively excluded and are not able to make the correct decisions, for example around vaccination uptake. Lived experience members also feel there needs to be greater training in the community and holistically with health professionals around engagement with disabled people, delivery of information and in terms of best interest decisions.

They advocate a community toolkit/resource pack to go alongside the one proposed for the health service. This toolkit should be fully accessible, widespread and delivered across all members of the community, including disabled people's organisations and developed in a number of accessible formats. Services which develop and promote information should be fully co-produced with disabled people and disabled people's organisations such as Breakthrough UK, GMCDP and the others mentioned below – and with stakeholders involved in the disabled persons COVID sounding board, amongst others. We should also look to consider good practice from all the regions in the UK and across the world. Try to learn from the experiences of others regarding disabled people and how to remove barriers.

Websites need to be considered in detail for accessibility, including screen readers. The NHS website is considered not to be fully accessible in many areas. Working directly with disabled people's organisations and individuals would provide a direct source of information to help remove those barriers.

Co-producing with disabled people and disabled people's organisations
Engagement with disabled people needs to be fully supported. Consider lead-times, funds and resources needed to get that support in place and to ensure discussions and meetings are conducted in the right environment. Our lived experience advisors need every attempt made to think about sensory requirements, accessible information, personal assistance support, British Sign Language interpreters/other forms of communication support, and to individualise that support to make sure you get the best out of that meeting and discussion. Commissioners and professionals in the process should engage directly with the disabled people they are consulting with, recognising that they are the experts in terms of their support they require. Renumeration should also be considered to value the disabled people involved in the process, their time and expertise.

Transportation and travel

There is a huge amount of anxiety and fear around engaging within social situations and in particularly accessing public transport. Our experts feel that the guidance is not clear and is not being followed by members of the public. This is creating a significant barrier to people accessing public transport and therefore the opportunities to engage with employment, education, and independent living.

Our lived experienced experts also feel that there is very little enforcement and marketing of the promotion of guidance and good practice in and around public transport in Greater Manchester. For example - on social distancing, wearing of masks, understanding exemptions, what the rules are on the trams and the buses, and promoting simple messages such as being kind. We feel much more can be done around positive delivery of these areas which will make disabled people feel safer and better understood. This good practice should be available in many formats and marketed across a widespread network of disabled people's and community organisations so that people throughout the entire community of Manchester can understand and benefit from it.

Many of our lived experience advisors experienced hate crimes in their initial attempts to access public transport. We also feel there should be better development of reporting of negative instances and encourage disabled people to provide feedback of the positive and negative transport experiences as a learning tool and a development opportunity during COVID-19. This would encourage more disabled people to engage with public transport.

Many concessionary passes have been refused to disabled people who have historically been considered eligible recently particularly around applications regarding autistic individuals. Disabled people's organisations are working with Transport for Greater Manchester on this to help to better understand the needs and eligibility of these individuals. We want to promote a more liberal and better considered acceptance policy for those applications going forward. We recognise that this process has already started.

Exemptions

Many disabled people have reported experiencing attitudinal barriers and hate crimes around exemptions - for instance not wearing a mask or making an informed decision around not having the vaccination. Our lived experience experts believe helping the public to understand exemptions better would help to prevent such negative attitudes and hate crimes. Social media campaigns, television campaigns amongst others would help to remove that stigma and help society as a whole gain a better understanding.

Support to isolate

It is felt the services offering support to isolate should be designed and considered specifically around the needs of disabled people when being delivered to disabled people. Many disabled people who have tested positive for COVID-19 are already on or below the poverty line, are experiencing great anxieties and mental wellbeing challenges due to the pandemic, have difficulty accessing and understanding what support is available; and need services and solutions which have been coproduced with disabled people they are designed for and intended to support. Our proposed solution would be to re-engage on this, connecting with more disabled people's organisations / sounding boards to help develop and tailor that service.

Digital inclusion

It is felt that the current programme in Manchester looking at the barriers of disabled people around digital inclusion is a fantastic project and needs to be fully resourced, funded and supported. It's very important that disabled people, and the people who

support disabled people, have training around technology which is up-to-date and compatible to their home environment. Disabled people must be fully supported during training, in every aspect. This includes the environment people are trained in, considering all access needs. We must inform people that the training is available in an accessible, easy to reach manner, ensure the right equipment is available, to ensure that the pace, materials, and delivery are fully accessible to the individual. In short, what are the individual needs of the person receiving the training? Ensure it is delivered on time.

Make sure that tech options are not the only options available to people to access health care and so on. Face to face and phone options are still much needed. Open back up drop-in centres etc

The hidden issues

Lived experience experts feel that the voices of disabled people are not being heard as well as they could. This is enhancing mental distress in the disabled people's community, fear, anxiety, and lack of understanding around COVID-19. We feel we can work with commissioners to break down these barriers by better community engagement, developing more peer support groups with a better understanding about how to reach disabled people. Working alongside disabled people's organisations to develop what exactly that should look like, providing advocacy to ensure that the voices, issues and removal of barriers are fully understood by all professionals and commissioners committed to the removal of such barriers.

Employment

We need to focus on the removal of barriers and encourage disabled people to seek employment opportunities which will work for them and their challenges during the pandemic. Develop a local toolkit for employers to understand good practice around employing disabled people. For example, flexible working, reasonable adjustments, trial periods, supporting homeworking, feeling safe travelling to work, flexibility and understanding diversity in recruitment processes and in workplace practices. One of our experts with lived experience engagement groups is in the process of working with the Good Employment Charter to develop such a toolkit. But this toolkit may not be accessible to everybody, so we encourage commissioners to consider investing in other opportunities to access and connect with disabled people and employers such as videos, social media, tabloid promotions to stimulate employment for disabled people in the market. Employers need to keep the flexible approach to working that many took up during Covid.

Education

It is felt education authorities, schools, universities and colleges should work more directly with their disabled students to understand and remove barriers to returning to classroom environment, travel, digital inclusion and to understand and develop generic support needed during and after the pandemic. These findings should be used as a shared learning opportunity for all communities.

After care services

Many disabled people do not have a firm understanding of Long Covid. It is felt that many services are not providing after-care for disabled people. We feel that mental health challenges are experienced after the initial phases of services. Therefore, consider aftercare services to 'check in' with disabled individuals. It is felt that this would prevent more long-term health problems associated with Covid alongside reducing significant mental distress issues occurring because of the holistic impacts of COVID-19. Digital inclusion is considered another area which would benefit from an after-care service. Checking in whether disabled people have understood and are benefitting from the investment made in training and equipment issued.

Date capture

Capturing of data can be made easier and more accessible for disabled people. Capturing information once and spreading it across services will have a long-term benefit to all stakeholders and individuals. Working alongside disabled people and disabled people's organisations will provide detailed information around the best way to achieve this. Renumeration should be considered to value the organisations and individuals involved in the process.

Shared learning and continuous development

As alluded to earlier, we feel it's very important that all aspects of the community share learning and experience of removing barriers. It's essential that we continuously develop strategies and understanding of how to promote solutions and remove barriers for disabled people - but also all members of the community throughout COVID-19. This learning should be a considered as a local, regional, national, and worldwide process.

Facts not myths

The uptake of the vaccination, good practice during COVID-19 and dispelling myths is an essential part of returning to a 'normal' society. We feel that commissioners and service providers should continuously focus on this area and spread and develop facts with the support of disabled people's organisations. There is a huge amount of vaccine resistance relative to the overall population in the disabled community which experience experts feel is largely due to poor and non-accessible delivery of facts and the myths and fears which are then being endorsed in disabled people's communities.

'Care' and support, the PA marketplace

There is national recognition of the difficulties in terms of recruitment of skilled support professionals and personal assistants. Brexit and the pandemic have heightened these difficulties. Lived experience experts advise that commissioners should consider the promotion of job opportunities in this area, the payment profiles of care and support workers and personal assistants to ensure they are competitive with other industries who are competing for the services of people in terms of employment. Suggest relaxations on the immigration laws following Brexit to support people from Europe and worldwide into positions of employment into the care and support industry.

In 2020, Breakthrough carried out a digital inclusion survey with disabled people they were working with. Whilst most Breakthrough clients have access to a phone (not all internet enabled though), fewer than half are able to access social media such as Facebook, Twitter from home, even if supported by another member of the household. A quarter said that they could access video applications like Skype or Zoom. Only 20% had access to a computer, laptop, or tablet. Access barriers include educational and literacy barriers, as well as access to the technology itself. Additionally, many clients of Breakthrough UK live in low income households and rely on library facilities if they need to use a computer for applications etc. This has far reaching implications for how information is relayed, the reliance on particular platforms and the ability of people to use internet-based processes to apply for essential items such as food and benefits.

Between 2009-11 and 2012-14, there was an overall increase across Britain in the percentage of disabled and non-disabled adults who reported having difficulty accessing services in the areas of health, benefits, tax, culture, sport, and leisure. In Manchester, most disabled people have excellent support from both health and social services, but this is not universally the case. Disabled people report that the loss and reduction of support services has had a significant impact on them over the last few years.

As part of the original work to develop the Our Manchester Disability Plan (OMDP), disabled people, carers, family members, professionals and representatives from voluntary and community sector groups and disabled people's organisations (DPOs) were asked to share their real life experiences of disability across a range of key themes:

1. Health and Wellbeing
2. Staying safe
3. Getting off to a good start
4. Choice and control
5. Independence in your home
6. Community opportunities
7. Involvement
8. Advocacy

The material in this section is a summary of the information gathered through several engagement workshops with more than 200 people that took place in two phases between April and September 2014. A further phase of work took place between January and March 2015.

A detailed summary of the issues raised by people involved in the engagement process is available as a supplementary report that should be read alongside this topic paper. The table below shows the top 10 issues highlighted by disabled people in respect of the things that they perceived to not be working and the things that were working well.

Rank	"What's Not Working?"	"What's Working Well?"
1	Inaccessible services e.g. leisure, public sector, and community due to design, knowledge, and attitudes	Accessible public and community transport e.g. stagecoach, travel passes

2	Inconsistent, inflexible, and inaccessible community and public transport provision	Knowledge and confidence to self-advocate with services
3	Lack of empathy, poor attitude, and knowledge of health care professionals for both disabled people and carers	Promoting services and signposting people via different methods e.g. multi-agency events, partnership boards, local 3rd sector providers, radio, family information service, shop mobility etc.
4	Poor perceptions on service quality i.e. access, time and capacity	Aids and assistance in my home and school
5	Assessments/reassessments not person centred, don't enable choice and not done in timely manner	Structured activity for disabled people e.g. computer classes
6	Not enough appropriate and accurate and user friendly promotion and signposting of services available to disabled people and carers in the community	Good provision of annual health checks (for LD people) and others with long term conditions
7	Barriers to getting and keeping a job due to employer attitudes, inflexibility and assumptions and benefits for both disabled people and carers	Leisure providers offering accessible and lower cost services for disabled people e.g. cinema, swimming,
8	Public sector cuts affecting provision particularly preventative services	Inclusion and personalisation within schools
9	Lack of suitable and accessible private and social housing for disabled people and allocation of suitable properties	Targeted services to support disabled people to get into employment/self-employment
10	Challenging and inconsistent transition process across all agencies from childhood to adulthood. Support post-18 is inadequate.	Good opportunities to volunteer which, in turn, improves health and wellbeing e.g. Imperial War Museum, Factory Youth Zone

Two issues, inaccessible public transport and inaccessible services were particularly prominent in terms of the things the people thought were not working. These issues cut across all impairment types and ranged from inaccessible or inflexible designs of buses and trams to poor attitudes such as lack of knowledge and training from bus drivers or members of the public. Problems with inflexibility of community buses were raised several times. Universal services, such as leisure centres, were cited as being inconsistent and inflexible e.g. guide dogs not allowed in leisure centre.

Issues in respect of community opportunities featured strongly in the top ten issues noted by disabled people as making a positive impact. Support from the voluntary and community sector, disabled people's organisations, and public sector services, is clearly working for some disabled people. Other positive aspects of community opportunities such as supported employment schemes, inclusion within mainstream education and regular health checks.

The ability to advocate either directly or with support is seen as very positive and given the range of barriers, systems and process that disabled people need to successfully navigate, this highlights the key role that advocacy brings to enable that. All these areas reinforce the relationship with independent living principles.

The accessibility of transport and leisure services were seen by people in both a positive and negative light. However, the numbers of disabled people reporting bad experiences with transport and leisure services were significantly higher than those reporting positive experiences. This suggests that there is some inconsistency in terms of the design and delivery of these services across the city and, although efforts to improve accessibility of transport and universal services are being felt, improvements are still required.

Disabled people have also raised the need for greater enforcement to underpin the intent to procure ethically and responsibly. The Social Model of Disability and accessible information standards should go into the definition of social value used by the council and others who procure public services.

The provision of reasonable adjustments to enable disabled people to take part in activities should not be based on perceptions of cost as many changes cost little or nothing to make. For example, the accessibility of buildings could be rated 1 to 5, like food hygiene, with 1 being not at all accessible and 5 being completely accessible

Employment

Disabled people report that having support from a peer who understands the barriers they face is extremely useful as many deaf and disabled people in the city believe that finding and keeping work is hard. They have low confidence about finding meaningful work and feel that employer attitudes can be discriminatory. Some local employers have adopted a more target driven approach in recent years, resulting in rigid employment practices and systemic disabling barriers.

Disabled people accessing employment support often know little or nothing of their employment rights at first, particularly of reasonable adjustments and the Access to Work scheme. Flexible working remains an important support for disabled people. Cuts have resulted in 'specialised' employment support being decommissioned and the abandonment

of the [Right to Control](#) initiative (a rights-based approach to support and services for disabled people that started in 2010). This means that disabled people have little control over how their employment support is directed.

Information and communication

People feel confident and empowered when they get communication support. It enables them to get the same information as everyone else and to make informed choices about their health. However, it's not all about provision of support. People said listening like an equal, with courtesy and respect, empathy, consideration, like the disabled person knows their own mind and has the ability to make their own decisions is the most important thing in being treated by health and social care professionals.

Much more needs to be done to ensure that deaf and disabled people are consistently asked about their information and communication requirements, that these are recorded and acted upon, and organisations know how to produce and promote accessible formats. There is an over reliance on online information, which excludes a high number (at least one in five) of disabled people who experience digital exclusion (Ofcom 2017).

Information aimed at the public is often inaccessible and full of jargon. People do not find it easy to find out about their rights and options or be able to easily speak to a person with the authority to act.

Lack of communication support (e.g. insufficient interpreters, too few key services using them, or interpreters not being booked due to budget constraints) is a key issue for local deaf people. 73% of deaf people surveyed felt excluded from wider community involvement because of communication barriers - leading to social isolation, low self-esteem, and a negative impact on people's wellbeing. More deaf awareness and British Sign Language (BSL) training is required in schools and services. Communication barriers, such as lack of accessible appointment systems at GPs, are also a big issue.

Other issues and themes

As well as the points above from disabled people and representatives of their organisations, members of the OMDP Health and Social Care Workstream also made the following points:

i) There needs to be more support for disabled people who are also carers.

ii) There is poor discharge planning for people with newly acquired impairments e.g. amputations.

iii) There needs to be more forward planning for young people with mental health issues to prepare for adulthood and help support them over their whole lives, not just at specific times which are convenient for the services that support them.

iv) The NHS Accessible Information Standard may improve things for disabled people but how will its effectiveness be monitored?

v) Citizens aren't 'hard to reach', its information about services citizens can't access.

vi) The MCC Website is very hard to access, navigate and search.

The 'Taking Charge Together' research with so called 'hard-to-reach' groups in Greater Manchester found environmental/social barriers (transport, housing, skills/education and social connections) directly affected people's health or their ability to adopt healthy behaviours. This is highly significant when a key vision of the Manchester Local Care Organisation is for people 'to live healthy, independent and fulfilling lives', with a core priority to ensure 'system resilience by keeping people well in the community'.

Manchester People First held a series of 6 health workshops. In these workshops, Learning Disabled people talked about the barriers they face going to and keeping medical appointments and also created a video.

Members gave the most common reasons why people with learning difficulties struggle to attend medical appointments:

- Support: travel and travel planning, letters, advocacy if need be, need for gender specific support.
- The professionals: No jargon. Explain medication. Speak to me, not support workers. Understand the effects of my impairment when I ring or call. Be more patient. Don't cancel at the last minute. Consider screening me for everything at my annual health check.
- What stops me attending: Give me information in a way I can understand. Appointments should be close to me. Travelling may be difficult or too expensive. Make sure I have the right equipment, such as a hoist or rise and fall bed. Useful meaningful pictures for signage e.g. skeleton for a fracture clinic.
- Knowing my body: This can help me to avoid getting very ill. Need to be confident about talking about my body without embarrassment – someone of the same sex would be good

Research carried out by Manchester Metropolitan University in collaboration with Breakthrough UK and Venture Arts research ('A Breakthrough Venture: (re) building value in the lives of disabled people') found that restrictions on funded support constrained the independence of disabled people. One participant found "his ability to access the community is severely restricted by the care package he receives".

In 2019, Breakthrough UK carried out an engagement project with local disabled people about their experiences of statutory NHS screening programmes. Key recommendations from this under the Pillars of Independent Living were:

Appropriate and accessible information

- Ensure that the infrastructure is in place to support the full implementation of the Accessible Information Standard (AIS) - and additionally the collection and transfer of access requirements from GP through to third party providers.
- Share information on people's requirements for language interpretation /
- other communication support.
- Share accessible information format requirements with screening providers and the administration staff who are scheduling appointments.
- Provide front line staff with Deaf Awareness Training and Disability Equality Training so that appropriate information is given, the right questions are asked,

support is offered appropriately and a culture of the person being the expert on their own requirements and being in control is respectfully maintained.
- Provide information in a range of formats and media about accessible ways to get screened. Don't rely solely on online information.
- Provide a range of staffed contact and communication options e.g. voice, text, email or letter – in the person's preferred format.
- Ensure that up to date Access Statements are available for each screening centre.
- Provide local dialect British Sign Language and community language information on each screening type and disseminate through community groups.
- Offer myth busting sessions and accessible information from partners
- such as Cancer Research, Macmillan, Jo's Trust, and culturally appropriate community organisations.
- Ensure guidance sent to people about to have screening is a) in the right format / language and b) written in easy to understand language.
- Ensure that home kits can have Braille labelling if required.
- Prenatal testing should be carried out in a sensitive manner, the parents should be given full information regarding risks and accuracy of testing and should not feel pressured into undergoing tests.
- Create a targeted accessible publicity campaign about the AAA test and what it is.

An adequate income

- Reimburse travel costs where this is a barrier to attendance.

Appropriate and accessible health and social care provisions

- Offer extra time at appointments where this is an access requirement.
- Go above the requirements of the AIS to ensure that known access, as well as information requirements, are passed on to screening providers in advance.
- Promote options for alternative screening methods where conventional tests are not accessible.
- Offer appointments at flexible times.
- Provide a smooth, clear system for the booking of interpreters and confirmation of appointments. Ensure providers are accountable for booking appropriately qualified interpreters accurately and in a timely way.
- Add information to community language posters on how to book a British Sign Language interpreter.
- Consider the viability of at-home screening.

A fully-accessible transport system

- Arrange appointments close to the person's address wherever possible.
- Provide accessible parking close to centres, with level access to the building.
- Make sure screening locations are close to accessible public transport stops.
- Appointments offered at times when people can use their concessionary travel passes.

Full access to the environment

- Have a rolling programme of access audits for screening centres.
- Provide directions in the right format and easy to follow, pictorial maps.
- Ensure that screening centres are within accessible reach from outside the building from transport and parking locations.

Adequate provision of technical aids and equipment

- Ensure screening centres with a range of access equipment, for example hoists, and rise and fall beds are widely promoted.
- Encourage people to contact screening centres beforehand to talk through their access and support requirements.
- Provide height adjustable chairs for mammograms.
- Offer eye tests in a range of positions.
- Have differently sized speculums available for cervical screening.
- Consider the implementation of a pilot for DIY home conducted smear tests.

Adequate provision of personal assistance

- Promote support options to disabled people who do not have anyone to
- assist them to do the kit.
- Commission support to assist people with completing screening if required, particularly for bowel screening.
- Welcome and provide space in screening centres for Personal Assistants.
- Make contracted PAs and support workers accountable for ensuring that people receive their invites and are supported to attend screening.
- Requirements to assist people with statutory screening programmes should be written into contract standards for support providers, including Shared Lives.

Availability of independent advocacy and self-advocacy

- Welcome advocates and provide space in screening centres for them.
- Check whether people require an advocate at the point of referral.
- Ensure providers know how to signpost people to advocacy options.
- Ensure self-advocacy organisations have full information on screening types in a range of formats, especially easy read.
- Provide information on options and venue accessibility in a range of formats so that people can self-advocate, including on risks of not having screening.
- Provide accessible information on self-checking in a range of formats (and physical models for groups, if available).
- Offer follow up assistance to disabled people who have never attended screening appointments.
- Involve disabled people in the design, development and evaluation of new screening services and centres.
- Respect people's stated choices about screening participation.

Availability of peer counselling (peer support)

- Peer support groups should be available and should be informed by a social model of disability perspective.
- Provide easy read, jargon free information on screening to key community peer groups.

What would we like to achieve?

There are several pieces of legislation, standards and guidance which are consistent with the Social Model of Disability's approach to removing barriers that create obstacles to the positive development of an accessible, inclusive city for all citizens.

Equality Act 2010

Many aspects of the Equality Act 2010 cite the Social Model of Disability as a measure of discrimination and most disabled people's organisations in the UK use this as a fundamental approach in their campaigns and activities. The Equality Act requires service providers to make reasonable adjustments and to remove or modify barriers - and to anticipate the needs of disabled people to ensure that disabled people are not discriminated against in comparison with non-disabled people. The Equality Act also has specific elements relating to employment, education, transport, housing and other areas which might affect disabled people and there are also additional duties for local authorities and public bodies.

Medical model terminology is used in the Equality Act but much of the guidance uses a barrier removal approach. It is important to not rely on doing the minimum that you have to do under the legislation and follow guidance and best practice in order to create an inclusive and barrier free environment, in collaboration with disabled people and their organisations. The report of the House of Lords Select Committee on the Equality Act 2010 and Disability, first published in 2016, showed that enforcement of the Equality Act 2010 remains weak so best practice is essential. A follow up report to this, published in September 2021, reiterated many of its original conclusions and recommendations.

The Public Sector Equality Duty requires public bodies to eliminate unlawful discrimination, harassment, victimisation, and other conduct prohibited by the Equality Act. Under the Public Sector Equality Duty 2011, public bodies in Manchester are required to publish information annually to demonstrate that they are complying with the general equality duty in all areas of their work. Information must be included on how their policies and practices affect people who share a relevant protected characteristic.

United Nations Convention on the Rights of Disabled People (UNCRPD)

The Convention on the Rights of Persons with Disabilities is an international human rights treaty of the United Nations intended to protect the rights and dignity of disabled people. The UK is a signatory and its articles should underpin all our work. Parties to the Convention are required to promote, protect, and ensure the full enjoyment of human rights by disabled people and ensure that they enjoy full equality under the law. The Convention has served as the major catalyst in the global movement from viewing disabled people as objects of charity, medical treatment, and social protection, towards viewing them as full and equal members of society, with human rights. It is also the only UN human rights instrument with an explicit sustainable development dimension. The Convention was the first human rights treaty of the third millennium.

Article 25 of the UNCRPD reinforces the right of disabled people to attain the highest standard of health care, without discrimination.

The Right to Independent Living (Article 19 of the UNCRPD) is not yet enshrined in direct law in the UK. The Independent Living Strategy Group has issued a [position statement](#) calling for this to be changed so that all disabled people can live in the community with the same choices, control and freedom as any other citizen. The Equality and Human Rights Commission published [draft proposals](#) that would provide a new legal right to independent living for disabled people.

Design standards and regulations

Building work is guided by Part M of the Access to and Use of Building Regulations 2010. This includes Volume 1 ('Dwellings') and Volume 2 ('Building, other than dwellings'). These documents prescribe mandatory minimum levels of compliance for the use of and access to buildings. The document includes many useful diagrams on how to show compliance with the regulations.

British Standard (BS) BS 8300:2018 offers best-practice recommendations on how architectural design and the built environment can enable disabled people to make the most of their surroundings. Part 1 covers the external environment and Part 2 covers buildings, including such things as access routes to and around buildings, car parks and garaging, as well as setting-down points, entrances, ramps, corridors, lifts, and signage.

The Blue Badge parking scheme

The [Blue Badge parking scheme](#) provides a national system of parking concessions for people who face significant barriers to travel either as drivers or passengers. The scheme also applies to 'registered' blind people and disabled people who regularly drive a vehicle but cannot turn a steering wheel by hand.

Blue badges allow parking concessions on public roads but also in many other places such as hospitals and retail parks/shopping centres as well. Most places provide accessible parking bays; some are free whereas others still require a payment, but the space tends to be nearer the entrance. When a badge is issued, the citizen will receive a booklet with their badge which explains all the rules about where they can park and their responsibilities for use.

The [eligibility criteria](#) used by the Blue Badge scheme has recently been expanded to cover some people with hidden impairments. The new criteria came into force on 30 August 2019.

The Accessible Information Standard (AIS)

All organisations that provide NHS care and/or publicly-funded adult social care are legally required to follow the Accessible Information Standard (AIS). The AIS sets out a specific, consistent approach to identifying, recording, flagging, sharing, and meeting the information and communication support requirements of disabled people who are patients,

service users, 'carers' and/or parents. Local implementation of the standard is currently very patchy.

The Accessible Information Standard is made up of a [Specification and Implementation Guidance](). In August 2017, revised versions of the Specification and Implementation Guidance were issued, following a post-implementation review of the Standard.

Inclusive language and user involvement

Our language carries many messages. It categorises, labels, and reinforces stereotypes and can both disempower or enable us. It conveys how we feel about other people, allowing us to connect or to put up barriers, and can influence how we deal with situations. Words are important for both building relationships with other people and for how we think about ourselves. Under the Social Model of Disability, "disability" is a political term which describes disabled people's exclusion and experience of barriers. The Greater Manchester Coalition of Disabled People (GMCDP) has published on the [preferred terminology and language]() that should be used to describe disabled people.

Greater Manchester Equality Alliance is a coalition of organisations and individuals drawn from a wide range of communities of experience across Greater Manchester. In 2021 Greater Manchester Equality Alliance co-designed [Inclusive Language Guidance](), including language around disability

The ['Beyond the Usual Suspects' report]() draws on the findings of a three-year national research and development project supported by the Department of Health, which aimed to find out how inclusive user involvement could be achieved. This project was particularly interested in looking at why certain groups of 'seldom-heard' service users experience barriers to involvement and how these barriers can be overcome.

NHS Equality Delivery System 2 (EDS2)

The NHS Equality Delivery System (EDS2) supports local NHS organisations, in discussion with local populations, to review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS2, NHS organisations can also be helped to deliver on the Public Sector Equality Duty. [Good practice case studies]() are also available.

The Care Act 2014

The Care Act 2014 made several significant changes to how local authorities assess, commission, and deliver a more holistic and personalised range of adult social care services. There is a much greater emphasis on wellbeing, and local authorities now have a duty to promote wellbeing in the specific areas below:

- Personal dignity, including treating people with respect
- Physical and mental health and emotional wellbeing
- Protection from abuse and neglect

- Control by the individual over day-to-day life, including choice and control over how their care and support is provided
- Participation in work, education, training, or recreation
- Social and economic wellbeing
- Domestic, family, and personal relationships
- Suitability of living accommodation
- The individual's contribution to society.

Manchester chose not to enforce the easements to the Care Act allowed under the Coronavirus Act 2020.

Developing and commissioning services

One of the aims in developing this topic report is to support commissioners across and beyond health and social care to understand disability better, and take action to remove, the barriers that disabled people in Manchester face when going about their daily lives. Disabled people face barriers all the time, so it is important that commissioners and planners are supported to understand these issues and are therefore better informed when planning and developing services.

One way of doing this is to support commissioners and planners to understand the Social Model of Disability and use it as a guiding principle throughout the commissioning process, as outlined below. In addition, there is no reason why wider partners outside of health and social care could not use this topic report in the same way.

What do we need to do to achieve this?

Independent living

The Greater Manchester Disabled People's Manifesto included several relevant recommendations in respect of independent living. This included ensuring that:

- Disabled people have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement.

- Disabled people have access to a range of in-home, residential, and other community support services, including personal assistance, necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community.

- Community services and facilities for the general population are available to disabled people on an equal basis and are responsive to their needs (see Article 1.19 of the Care Act 2014 Statutory Guidance).

- All commissioned and contracted providers should fulfil the Equality Act duties and demonstrate a proven track record and a continuing commitment to providing accessible and inclusive services and to employing disabled people.

The Manifesto also calls on commissioners to engage directly with Manchester DPO's about the impact on disabled people's independent living in relation to the pooling of Social Care budgets and the merging of health and social care.

Accessibility standards

Design for Access 2 (DfA2) are Manchester standards for accessible buildings are supplementary to national planning and building regulations. DfA2 standards were developed in partnership with the city's disabled children and adults' organisations to ensure that we draw on the invaluable experience and expertise existing within Manchester.

The Manchester Disabled People's Access Group (MDPAG) produced a set of Guidelines for Accessible Meetings and Events which were initially published by the Community Network for Manchester (CN4M) and are now available from MDPAG. These guidelines are complementary to DfA2 and include a set of handy checklists alongside detailed advice and information about for what to consider and plan for before, during and after meetings and events, including checking people's access requirements, accessible child care, communication support, accessible information (incl. clear print guidelines) and organising rooms etc.

Health and social care integration

Specific recommendations from the local disabled people who were involved in [Breakthrough UK engagement on the neighbourhood approach](#) include:

- Information on key changes should be cascaded through disabled people's organisations, existing meetings, and local groups. A 'piggybacking' approach to engagement where information is shared with existing groups of disabled people works better than arranging stand-alone meetings

- Alternative formats need to be clearly available, with standard print Word versions also distributed electronically so that groups can create their own copies and formats as required.

- There needs to be a better system of communicating key information about local community resources, advice, and key rights around independent living to disabled people. This is especially important to people in the city who newly acquire an impairment. Historically, this work has been done by disabled people's organisations, but many are lacking capacity to do this at present.

- Disabled people gave lots of examples of communication breakdowns between teams involved in their support. Good communication between health and social care teams is already a core component of the approach in principle. Close monitoring is required to ensure this is happening in practice.

- Peer support is hugely important to disabled people's health and wellbeing. Disabled people's groups need to be supported and resourced, irrespective of whether they are hosted by disabled people's organisations, impairment specific groups or via patient experience models.

- Awareness raising on the nature of adjustments required by most disabled people and that they are rarely costly. The anticipatory duty of health and wellbeing related service providers to make reasonable adjustments under the Equality Act needs more robust enforcement. This is already a statutory duty for health and social care providers, alongside the Accessible Information Standard (AIS).

- EDS2 is one lever that can be used to increase compliance with the Equality Act, but this would not be applicable to all community wellbeing and leisure providers. The Accessible Information Standard must be implemented fully across all statutory provision. There needs to be a consistent approach to asking, recording, and acting upon people's access requirements for information, in line with the requirements of the AIS and to perform well under EDS2.

- The work of the Manchester Advocacy Hub needs stronger promotion. This statutory advocacy will not meet all needs however, and consideration should be given to commissioning and supporting work which enables disabled people to develop skills to self-advocate in health and social care provision.

- Manchester should consider the adoption of Inclusion London's three questions into the Single Trusted Assessment process ('How do you want to live?', 'What stops you living that life?' and 'What do you need to help you live that life?')

- The assessment should use a Social Model of Disability approach (i.e. focus on removing barriers that stop the person fully participating in society), be a 'real world test', be based on the presumption that the disabled person is the expert on their impairment and how it affects them, be co-designed with disabled people and incorporate training on the Social Model of Disability to assessors.

- Set up an accessible mechanism for disabled people to peer review health, social care and wellbeing related venues based on the AccessAble (formerly Disabled Go) model, but with offline options to input and retrieve information.

Commissioners need to ensure that all services are accessible and inclusive for all citizens, particularly in terms of the design and redesign of health and care services in Manchester. There are risks associated with not following the legal requirements of the Equality Act, including infringing disabled people's civil and human rights and legal challenges to service areas, and therefore demonstration of compliance with the Equality Act by providers before contracts are awarded is important.

Disabled people have expressed support for service models based on a local hub with various practitioners on the same site including doctors, dentists, and physiotherapists. This has been popular because it is more streamlined, quieter and less anxiety provoking to use than traditional services. One person said that the holistic approach of his community health provider made a huge difference when he came out of hospital.

Many disabled people are keen on the idea of having co-located neighbourhood teams and "seeing the same person every time", if getting there is accessible.

Commissioners and the commissioning cycle

There is strong case for using the Commissioning Cycle as a framework for considering how barriers that disabled people face can be overcome when planning and developing services. Below is an example of a barrier related Commissioning Cycle which could be used by commissioners and planners when developing services. This approach can be the basis of co-design/co-production with the aim that it is adopted by Manchester Health and Care Commissioning and the Manchester Local Care Organisation.

This should prioritise sourcing providers that are already barrier free or who are willing and able to remove the barriers in their services.

Having strength based discussions with disabled people, appreciating their lived experience and their requirements, wants and aspirations

The Commissioning Cycle according to the Social Model of Disability

* Using this model this will be unnecessary because local disabled people will already be engaged in every step of the process

Service users are involved in the design and delivery of monitoring and evaluation of their services on an equal basis to commissioners

Priorities are jointly agreed between local disabled people and commissioners

Identifying barriers to existing services from conversations in step 1 and co-producing ideas to remove those barriers or create barrier free services with the people who will use them

Innovative use of direct payments or personal budgets can enable service users to purchase their own services or pool budgets to create new ones.

Service users choices will be easier to identify when services are co-designed

Deciding priorities

Reviewing service provisions

Assessing needs

Designing services

Strategic planning

Patients/Public

Procuring services

Shaping structure of supply

Monitoring and evaluation

Seeking public and patient views

Managing performance

Planning capacity and managing demand

Supporting patient choice www.nhs.uk

Courtesy of The NHS Information Centre for health and social care. Full diagram available at: www.ic.nhs.uk/commissioning

Whilst there are legal considerations to factor in as a commissioner, the user experience is central. For that reason, it is important to ensure that a co-production approach with disabled people is used right from the start of the commissioning process e.g. using the commissioning cycle of 'Analyse, Plan, Do and Review'. People with lived experience have a better understanding of what needs to be improved and how we can work together to achieve a sea change in behaviours and attitudes to disabled people.

Using this approach will help to ensure that all key risk factors are virtually eliminated. This must be resourced so that the process is accessible throughout, enabling full participation for everyone. This approach should be embedded in the daily activity of commissioners, through the actions outlined in Section 6 of this topic paper.

What are we currently doing?

Manchester City Council

Manchester City Council's broad Equality Objectives for 2020-2024 are:

- Objective 1 - Knowing Manchester Better
- Objective 2 - Improving Life Chances
- Objective 3 - Celebrating Our Diversity

In 2015, Manchester City Council achieved the 'Excellent' standard in the [Equality Framework for Local Government (EFLG)](#), a national equalities benchmarking tool run by the Local Government Association (LGA).

The Blue Badge parking scheme is designed to help disabled people park closer to their destination. Blue Badge 'standards' are set by the Department for Transport and govern who is and isn't eligible for a Blue Badge. There are two routes to obtaining a Blue Badge: a) those who are automatically eligible and b) those where a further 'assessment' needs to be carried out.

Locally, administration of the [Blue Badge Service](#) is carried out by Manchester City Council. Two teams are responsible for the processing of badges in Manchester. A team of business support staff, based at Harpurhey District Office, are the main administrators of the scheme and process all the automatic eligibility applications, send out the renewal reminder letters and deal with all queries and replace lost/stolen badges. Assessment staff within the Manchester Service for Independent Living (MSIL) team, based at Poland Street, deal with those applications that need further assessment.

Manchester currently has 16,438 badges on issue. Between 01 January and 30 June 2019, 3,206 Blue Badges were issued in Manchester. Around 38% of these badges (1,214) were issued to people with a walking disability or registered blind, of which 69% were new applications. A further 1,136 badges (36%) were issued to people receiving a Personal Independence Payment and 820 (26%) to people receiving Higher Rate Mobility Allowance.

Manchester Locality Plan

Manchester is embarking on a radical programme of work to change the lived experience for disabled Manchester citizens. The ambition is for Manchester to be a fully accessible city that puts disabled people at the front of change projects and creates an inclusive and co-productive approach as a default.

Work to improve the lives of disabled people is complementary to the work to improve the health and wellbeing of Manchester residents as set out in the Manchester Locality Plan. Disabled people who face a range of barriers cannot equally access appropriate and timely health and social care services and are therefore disadvantaged through no fault of their own. There are some good examples whereby GPs in primary care will ensure that a

translator / British Sign Language Signer is always available for deaf patients, but this is not always the case.

Our Manchester Strategy – Forward to 2025

In 2021 the Our Manchester Strategy underwent a reset at the halfway point of the strategy. For Manchester to achieve its vision, we will refocus our efforts on these priorities to 2025.

Through each priority below runs Manchester's commitment to build a more equal, inclusive and sustainable city for everyone who lives, works, volunteers, studies and plays here. Only by working together can we achieve our vision by making an impact on our priorities of making Manchester:

- A thriving and sustainable city
- A highly skilled city
- A progressive and equitable city
- A liveable and zero-carbon city
- A connected city

See details of Manchester's priorities.

Our Manchester Disability Plan

Manchester City Council's Our Manchester Plan focuses on helping people to make the changes in their lives that will see them become more independent. The approach doesn't begin by asking 'What's wrong?' Instead, it asks, 'What's right?' and 'What matters to you?' In this way, Our Manchester becomes:

- a way people can develop into happier, healthier, and wealthier people making a good life for themselves and their family.
- proactive, pre-emptive, and creative, focusing on a person's or community's strengths and opportunities.
- a partnership of local people and organisations developing new answers to how we can deliver public services.

Our Manchester is also pioneering Strengths Based Development Co-design work, including the development of a new Strengths Based workforce development programme, involving disabled people's organisations in its development.

The Our Manchester Disability Plan – now known as the Our Manchester Disability Equality and Inclusion Partnership (OMDEIP) - has been co-produced by local disabled people, disabled people's organisations, public sector organisations and other voluntary sector organisations and is written from the perspective of the Social Model of Disability. The Plan provides a shared vision on how services must be reshaped to ensure that no further barriers are created for disabled people and that accessibility for all, on whatever activity or topic, is central to our approach to planning and delivering services for disabled people. The main aim of the OMDEIP is to develop actions which will remove the barriers in society that stop disabled people from playing a full part in society.

The plan also relates to several basic rights that disabled people have identified, which if fully met would enable them to fully participate in society. These rights (also known as 'Pillars of Independent Living') are set out in the box below:

Pillars of independent living

1. Full access to our environment, transport system and accessible or adapted housing
2. Inclusive education and training and equal opportunities for employment
3. Appropriate and accessible health care provision, equipment and adaptations, and personal assistance
4. Information and money advice
5. Advocacy and peer counselling

These rights identify the foundations which disabled people need so they have the same opportunity to live an independent life and be as fully integrated in society as non-disabled people. Independence doesn't mean disabled people doing everything for themselves. It means having choice and control over how they live their lives, what support they receive, and if any, how that support is provided. It is striking how similar some of these rights are to the wider determinants of health.

Governance and delivery of the OMDEIP is overseen by a multi-agency Partnership Board. It also includes an Engagement Group which ensures local disabled people are at the heart of the co-productive development of the plan. Through the established governance structure, a series of workstreams have been established which are focused on delivering the objectives of the plan.

As a starting point, the broad objectives of the OMDEIP (grouped under the Pillars of Independent Living) are:

- Appropriate and accessible information: Information is made available to suit any disabled person's communication preferences e.g. easy to read, Braille, audio, email, large print.
- An adequate income: Timely provision to appropriate financial and welfare advice to maximise a person's income.
- Appropriate and accessible health and social care provision: Health and social care organisations and services to take a person-centred approach to meeting needs. Services need to be accessible to ensure that all communities can access timely health and care support.
- A fully accessible transport system: Manchester's transport system is fully accessible to disabled people, and regular feedback is received to rectify any accessibility issues.
- Full access to the built environment: Planners and developers need to comply with and actively contribute to the standards set in the Equality Act 2010. Disabled people want to access the same community and city facilities that everyone else can.
- Adequate provision of technical aids and equipment: Access to timely technical aids and equipment is available to disabled people of all ages as required. Services for children and young people are the same as those for adults where necessary.

- Availability of accessible and adapted housing: A range of suitable types of adapted accommodation is available that meets the needs of different disabled people and their families. Co-ordination and allocation of the city's social- rented adapted housing stock should be improved.
- Adequate provision of personal assistance: Disabled people who are entitled to a personal budget (social care) are actively supported to have a personal assistant who is appropriately trained to provide the right support.
- Equal opportunities for employment: The city's employers promote equality of opportunity so that disabled people can access work and they are actively supported through reasonable workplace adjustments.
- Availability of peer support: Where appropriate, organisations create opportunities for disabled people in similar circumstances to share experiences and receive mutual peer support.
- Availability of independent advocacy and self-advocacy: For disabled people to be able to self-advocate, they need to be supported with confidence-building skills and encouragement.

A second area of work for the OMDEIP will be to look at the standards set out in the draft Access All Areas standards, agreeing those that will be formally adopted across the city, and creating a reference library to support development of the plan. This will ensure that all future work and projects will adhere to these standards.

The Manchester City Council Local Delivery Pilot Steering Group has £1.5 million over 3 years to develop approaches across the system to reduce inactivity and tackle inequalities. Increased accessible activity for people with learning difficulties is a key focus of this pilot, including people in supported housing in the chosen places.

Disabled children and young people

Manchester's Children and Young People's Plan ('Our Manchester, Our Children') covers the period 2016 to 2025 and outlines how children and young people matter in Manchester. It places children at the heart of its vision for Manchester to be in the top-flight of world-class cities by 2025 and aims to open up new opportunities for children and young people in the fields of education, work, leisure and family life. It is also a partnership plan, jointly held by all the city's agencies and organisations that work with children and young people.

The Special Educational Needs and Disability (SEND) Board, chaired by the Director of Education, provides governance of SEND in Manchester and is also the children and young people's workstream of the OMDP Board. The SEND Board is responsible for evaluating progress in implementing the reforms and identifying key areas for development. The Board has agreed the following outcomes and oversees the work plan which partners are working together to deliver:

- Parents'/carers' and children's/young people's views impact on strategic decisions.
- Excellent local offer - understood and accessible to all leading to improved life outcomes.
- Young people with SEND have needs met through excellent education, health and care services, jointly commissioned where appropriate.
- Preparing for Adulthood (PfA) is embedded in Manchester from the earliest years.

- Highly effective education, health and care plans and reviews improve life outcomes for children and young people.
- Improved outcomes and standards across education and training.
- A highly skilled workforce across all stakeholders improves outcomes for children and young people.

Manchester Local Care Organisation (MLCO)

The Manchester Local Care Organisation (MLCO) has a key role in creating accessible local provision for disabled people and promoting holistic ways of working that address all of the pillars of independent living in disabled people's lives.

The MLCO focuses on four ways of working:

- Promoting healthy living - helping people to stay well through prevention, supporting them to lead healthier lives and tackling health issues before they escalate.
- Building on vibrant communities - using all the resources available in the wider communities that people live in and identify with in a true neighbourhood approach, improving population health and wellbeing.
- Keeping people well in the community - helping people who have existing health needs and complex health issues to stay as well as possible in their homes through 12 integrated neighbourhood based teams and citywide services.
- Supporting people in and out of hospital - ensuring community-based care helps people to avoid unnecessary hospital admissions; or to discharge them from hospital care, quickly and safely as soon as they are ready if they do need time in hospital.

The MLCO Neighbourhood Team Leads have a key role to play in bringing people together, to deliver services for disabled people in a new way, identifying and promoting the use of local assets and support neighbourhood teams to work with local community groups and residents to co-produce local neighbourhood action plans and projects.

The MLCO currently holds many contracts with VCSE organisations. This is a substantial resource with significant work going on with disabled people across the city.

Manchester University NHS Foundation Trust (MFT) Disabled People's User Forum

The purpose of the Disabled People's User Forum is to listen to the views and experiences of disabled people and enable them to influence decision making within Manchester University NHS Foundation Trust's (MFT) hospitals. This aims to improve the access to, experience of, and quality of health care for disabled people within MFT hospitals. The members of the forum are:

- A disabled person who has used MFT's services.
- A disabled person who is a member or governor at MFT.
- Someone who has experience of the barriers faced by disabled people when using MFT's healthcare services and has ideas for how these can be removed.
- People able to attend up to 4 meetings per year.

Carers and advocates are welcome at the Disabled People's User Forum. The meetings are chaired by a member of the Equality and Diversity Team and are also attended by other relevant MFT teams such as Estates and Facilities.

Voluntary, Community and Social Enterprise (VCSE) sector initiatives

In 2021, the Manchester State of the VCSE Sector report found that 47% of organisations were involved in community development work, including work with communities to tackle inequalities and disadvantage. The 2021 report had a particular focus on the impact of Covid, Black Lives Matter and Brexit on the sector.

There is a rich diversity of work involving disabled people across the VCSE sector in Manchester, particularly among disabled people's organisations. Some key examples are given below. For more examples, see the Manchester Community Central Directory.

Greater Manchester Coalition of Disabled People (GMCDP)

Greater Manchester Coalition of Disabled People (GMCDP) is a Disabled People's Organisation, which is controlled and run by disabled people only. All Executive Council members and staff positions are only available to disabled people. GMCDP aims to:

- campaign to promote the rights of disabled people and our inclusion in society,
- provide information of use and interest to disabled people,
- run events, members' meetings, and training courses,
- encourage and support the self-organisation of disabled people, and
- take part in consultations with voluntary and statutory organisations to ensure that equality and accessibility is embedded into the development of policies and services.

The GMCDP Advice and Advocacy project provides support for disabled people of any age living in Greater Manchester with a focus on obtaining Personal Independence Payment (PIP).

GMCDP have produced some helpful information for disabled people related to the current coronavirus (COVID-19) pandemic, including an emergency self-advocacy leaflet giving information about your rights to treatment (also available in easy read), an emergency hospital passport which can be printed and used if someone is admitted to hospital, and are running events via Zoom, which can be accessed through a computer, smartphone or landline phone.

GMCDP has founded the Disabled People's Archive which contains thousands of historical documents and photographs as well as video and audio tapes, banners, posters, placards, badges, t-shirts, reports, rare books, leaflets, and campaigning materials spanning many decades. It has all been donated to the archive by individuals and disabled people's organisations. The archive is in partnership with Archives+, stored at Manchester Central Library.

GMCDP convenes the Greater Manchester Disabled People's Panel. The Panel has launched their own website: GMDisabledPeoplesPanel.com

GMCDP has formed a Housing Working Group. This is a member-led group that proposes, plans and organises our campaigning strategy and work about housing issues. The group has responded to consultations around accessible housing, Personal Emergency Evacuation Plans and homelessness as well as making links with other organisations in Greater Manchester who are working in housing.

GMCDP runs a Young Creatives Programme which gives Manchester's young disabled people the opportunity to explore GMCDP's archives on the Disabled People's Movement, one of the largest in the UK, plus the young people involved developed their skills and knowledge in performance, writing, tech theatre and design. This project is in conjunction with the Contact Theatre and Archives+.

GMCDP is running a project called, Powerful Together! It is for disabled adults in Manchester (city). This project will provide people with a variety of peer-support spaces, workshops, and training sessions that aim to teach resistance and how to challenge disablist discrimination in all its forms, using fortnightly gatherings. The gatherings will be split into 3 sections: community and network building, expertise workshops, and advocacy training.

Manchester Disabled People's Access Group (MDPAG)

Manchester Disabled People's Access Group (MDPAG) is an organisation of disabled people who work with disabled people, businesses, architects and designers, the public sector, and the voluntary and community sector in Greater Manchester and elsewhere. They promote best practice in accessible and inclusive design and access standards through membership and project activities, through access consultancy, contributions to consultations, training for disabled people and for organisations, publications and campaigns.

The Access Consultancy provided by the Group has experienced access auditors who can provide:
- Access audits, surveys, appraisals
- Information and website audits
- Design and access statements
- Policy reviews
- Customised training and advice
- Consultation with disabled people

Venture Arts

Venture Arts is a progressive visual arts organisation based in Hulme that strives for learning disabled people to engage with and be recognised in art and culture. They work with learning disabled artists to create and show new visual artwork. They provide a social and stimulating environment for learning disabled people to develop their artistic talents using learner-led methods.

Manchester Deaf Centre

Manchester Deaf Centre seeks to maintain services that are demonstrably effective in making real change in the lives of deaf people. Where there are gaps in provision or innovative ways of doing more and doing it better; they devise projects that answer that need and respond to what they learn from working with, and as part of, the deaf community. To achieve its vision, the Manchester Deaf Centre run the following services:

- The Children and Young People Service works with children and young people up to 25 years (except for up to 30 years for those who need additional support), and welcome Deaf, Hard of hearing and Deafblind children and young people to join in our varied work.
- The Wellbeing, Advocacy, Information, Training, Employment and Enterprise (WAITE) service commenced in March 2020, in response to the unmet needs of the D/deaf communities for better health and well-being communications as a 'One Stop' service.
- British Sign Language – Manchester Deaf Centre delivers a range of educational courses in various settings, including accredited courses for Levels 1, 2 and 3 in British Sign Language.
- Deaf Awareness sessions including Workplace Training and Development.
- The service supports Deaf Awareness Week and share hints and tips regarding deaf awareness and how people can improve their knowledge.
- You can also book a British Sign Language Interpreter.

Manchester People First

Manchester People First is a self-advocacy group for people aged over 18 with learning difficulties who live in Manchester. They support people to speak up for themselves so they can have a bigger say in how their lives are lived by offering training to members and organisations who work with adults with a learning disability, as well as giving members somewhere of their own to meet their peers, learn and socialise. They give their members:

- Training
- A way of getting their voices heard by the big bosses of services
- A place to meet and make friends
- Information in a way they understand

And they do this by having:

- Workshops and training sessions
- Meetings and events
- Drop-ins and social events
- Making things accessible

They do this so people can make informed choices about their own life.

Manchester Hearing Voices Network

Manchester Hearing Voices Network is part of a wider network of Hearing Voices groups in Britain and internationally. The Manchester group has been meeting initially at the Harpurhey Neighbourhood Centre and Day Centre. The group is free to attend and open to anyone who hears voices, sees visions, or has other unusual sensory experiences. It's friendly and everyone who attends goes out of their way to help people feel at ease. The group welcomes people whether they have a diagnosis or not, and members may also have other issues that they are struggling with (including unusual beliefs, self-harm and bipolar). The group can offer one to one support before or after the meetings if members prefer, so they can feel more at ease when they choose to attend the group.

Breakthrough UK

Breakthrough UK is a Manchester based disabled people's organisation. We are led by disabled people and we support other disabled people to work and live independently.

We work to influence national and local public policy to bring about social change and removed discriminatory barriers to disabled people to ensure that they can play a full, active, and equal role as citizens in all aspects of society.

Breakthrough UK's vision is of a society upholding the rights, responsibilities, and respect of disabled people. In Manchester, Breakthrough's face-to-face projects include:

- Manchester Digital Employment Service
- Pathways to Independent Living, digital inclusion, and employment focused group courses
- Community Connecting which supports isolated disabled adults to 'have a good week'
- Health Connecting which supports disabled people in Manchester to reconnect with their communities and access health services in their local community following COVID-19
- Third-Party Hate Crime Reporting Centre
- Payroll and personal budget service
- Transport for Greater Manchester Disability Design Reference Group
- Manchester International Factory Disabled People's Engagement Group
- Manchester Disabled People's Engagement Panel
- Peer support groups
- Training and consultancy for organisations

Breakthrough UK were instrumental in ensuring Community Hub support for Greater Manchester residents was accessible, with our Greater Manchester Community Hub text service. The dedicated text service is operated by a Breakthrough member of staff and removes communication barriers for those people who find phone calls and online forms a barrier. The text service has been helping on average 70 enquiries a month.

Breakthrough's COVID recovery and equity work has included the setting up and facilitating of the Disabled People's Engagement and Sounding Boards in Manchester, one of several Sounding Boards bringing together marginalised groups to highlight inequalities around the pandemic. The Sounding Board, which held its first meeting in

December 2020, has eight member organisations and has covered topics ranging from shielding and social distancing to vaccinations and hospital visiting.

A key part of the Sounding Board project was the translating of the most important official Covid messages and announcements, into accessible communications. These were shared on our [COVID Accessible Information Hub](). Through this, Breakthrough UK and other Manchester disabled people's organisations have been supporting the work of COVID Health Equity Manchester (CHEM). Outcomes from this collaboration include:

- Access checklist for vaccine sites
- Deaf Vaccine Hour (event)
- Pop up vaccine centre – with Deaf Centre
- Shared longlist of community concerns
- Clear question and answer sheet for Neuro Diverse people
- Health / communication passports proposed to be re-launched
- MFT Exploring staff training and access journey
- Shielding survival guide

The Manchester Disabled People's Engagement Panel

The Manchester Disabled People's Engagement Panel consists of 14 Manchester-based disabled people who have lived experience of disability or long-term health conditions. We use those direct experiences to make the City of Manchester a more accessible place, as part of Breakthrough UK's work as one of the leading disabled people's organisations.

Convened by Breakthrough UK, the panel are presently halfway through a lottery funded, 'leaders of the future' project and have connected with a plethora of Manchester-based commissioners and organisations of influence to affect positive physical, attitudinal, and educational change for disabled people. We have worked with Manchester City Council in numerous areas including panel discussions around employment, housing, city strategies, parks, and leisure amongst others.

Our panel has also worked with the Greater Manchester's Combined Authority, via The Good Employment Charter and the Growth Company supported a recent employment webinar to provide support, help, tips and advice to employers Manchester-based employers are all successes and opportunities to remove barriers in employment of disabled people.

Disability Design Reference Group (DDRG)

[Disability Design Reference Group (DDRG)]() is a disabled people's involvement group facilitated by Breakthrough UK on behalf of Transport for Greater Manchester (TfGM).

Many disabled people rely on public transport as their only means of travel for daily living, so it is important that it is as accessible and barrier free as possible. The DDRG is made up of disabled people from across Greater Manchester who have lived experience of a wide range of barriers that prevent disabled people from enjoying access to all aspects of society and public transport infrastructure and services.

The DDRG members provide input to TfGM and its partners on project design for public transport infrastructure and services across Greater Manchester based on their own individual and collective lived experiences. Their input assists TfGM to ensure that, as far as possible, an inclusive and barrier-free public transport environment is developed across Greater Manchester.

Since the DDRG was formed, it has proved itself to have an important role in helping to remove barriers to public transport and travel, ensuring as many people as possible are able to use public transport services. The DDRG has also received industry recognition for the effectiveness of its involvement of disabled people when it was awarded the 'Putting Passengers First' award in the 2015 National Rail Awards. Judges praised the group's attention to detail, good quality feedback and excellent design improvements.

Community Explorers

Community Explorers are people who work in VCSE organisations in Manchester and have given their time and expertise to work in partnership with Manchester Health and Care Commissioning. By using their knowledge, skills, networks and connections with assets in the community they are able to raise awareness of the on-going experiences and issues that affect local people and allow them to take ownership of their health in a way that meets their needs, and maximises their aspirations, skills and abilities using a strength-based approach. It is also an opportunity to develop collaboration between VCSE and public sector organisations.

In return, Manchester Health and Care Commissioning works with Community Explorers to actively involve VCSE services in the development and co-production of services in Manchester by providing information, data and opportunities for joint funding to build capacity of the VCSE structure to develop and support these local assets. Community Explorers meet monthly and move around each of the localities in Manchester.

Greater Manchester and other partnership activities

External partners (e.g. Greater Manchester Combined Authority, Public Health England, NHS England etc.) can provide support for this important work. Disabled people living in Manchester do not confine their lives to the Manchester area but move fluidly across geographical borders to visit family, friends and pursue personal activities. It is therefore necessary to work across Greater Manchester and beyond to address the challenge of becoming a truly accessible city. If all partners embraced this work, the results would be significant and make a real difference.

The Greater Manchester Disabled People's Panel (GMDPP)

The Greater Manchester Disabled People's Panel (GMDPP) was created as an initiative between Disabled People's Organisations and the Greater Manchester Mayor Andy Burnham. It aims to ensure that disabled people's involvement in all aspects of running and planning for the future of the city region is better represented.

Its member organisations are majority led and staffed by disabled people from across Greater Manchester's 10 boroughs, committed to the Social Model of Disability, with strong engagement with their local community, and successful representation of diverse

groups, including LGBT+ and communities facing racial inequality. Those taking part receive an involvement fee from the mayor's office.

Manchester is the first city region in the UK to introduce a disabled people's panel that is involved in such a senior level of strategic policy-making.

The Greater Manchester Health and Social Care Partnership set a learning disability employment target that has an ambition of 7% of people with learning difficulties in employment across all of the Greater Manchester boroughs by 2020. The target is included in the Greater Manchester Learning Disability Strategy and was highlighted in a letter to the Chief Executives of all local authorities in the city region.

The strategy was signed off by the GM Health and Social Care Board in August 2018 and contains 10 key priority areas which are:

- Working with people with Learning Difficulties and their families to shape the strategy and plans
- Supporting people to speak up for themselves and their peers ensuring they get the care and support they need
- Creating services that give people with complex needs greater choice and control
- Improving health outcomes for people with Learning Difficulties
- Creating a sense of belonging not isolation
- Improving housing options so that people with Learning Difficulties can live as independently as possible
- Supporting people with Learning Difficulties into work
- Developing health and care staff across Greater Manchester so they are skilled to meet the needs of people with Learning Difficulties
- Helping children and young people with Learning Difficulties and their families
- Supporting victims of crime with Learning Difficulties and helping offenders with Learning Difficulties make different choices

To progress implementation of the key commitments within the GM Learning Disability Strategy, all localities within GM were asked to work with their local Learning Disability Partnerships Boards to ensure actions were underway in local areas to deliver the new strategy. In addition, a collective 100-day Challenge programme took place between September and December 2018 in order to accelerate implementation of the strategy and look at where positive changes aligned to the priorities could be made, particularly around the area of employment.

The Greater Manchester Health and Social Care Partnership developed a Greater Manchester Autism Strategy ('Making Greater Manchester Autism Friendly 2019-2022'). The vision of the strategy is to make Greater Manchester a place where autistic people and their families can get a timely diagnosis with support, meet professionals with a good understanding of autism, find services, organisations and employers that make reasonable adjustments when required, where people can feel safe, have aspirations and fulfil their potential, and become a full member of the local community.

Opportunities for action

Actions for commissioners and strategic bodies

Implementation of the JSNA

- Develop a Governance Framework with strong leverage to take this JSNA into account in business planning as well as commissioning.

- Set up a working group, including local disabled people, to set appropriate outcome measures and monitor the implementation and use of this JSNA across all relevant sectors.

Barrier-free procurement

- A timetable should be developed in collaboration with disabled people to enable a transition to a barrier removal approach to commissioning. It is suggested that procurement with the VCSE in 2020 is used as a test bed for this approach.

- Resource co-production into the procurement process to enable disabled people to fully participate in the planning of new projects and services, and beyond this through service delivery and evaluation. This includes allowing sufficient time for involvement before major scoping decisions are made, resource to ensure that the design process is fully accessible to all and that all partners are rewarded for their expertise. Where procurement involves the VCSE, allocate up front money to allow successful bidders to do their own coproduction work and avoid call-off contracts.

- Ensure that sufficient time is built into the procurement process in order to conduct meaningful Equality Impact Assessments and co-production as new work is planned and adjust project specifications accordingly.

- Ensure that procurement criteria fully embed the Wellbeing Principle under the Care Act - a holistic perspective.

Social value

- Incorporate the Social Model of Disability and Accessible Information Standards into the definition of social value used by the council and others who procure public services.

- Only offer tenders to contractors who can evidence a track record of removing disabling barriers. Include this requirement within Social Value criteria in the procurement process to ensure barrier free environments are the norm.

Monitoring and evaluation

- Provide a range of accessible and anonymous opportunities, including offline, for disabled people to rate health and social care providers without affecting any support offered.

Training

- The Our Manchester Disability Plan (OMDP) Health and Care Workstream should support Manchester Health and Care Commissioning and the Manchester Local Care Organisation (MLCO) to develop a programme of mandatory training for all staff groups on the Social Model of Disability, delivered by disabled people's organisations.

Collaborative working with Our Manchester Disability Plan workstreams

- Use evidence generated by OMDP workstreams to develop partnership working with commissioners. Align this to the workstream's current action plan.

Compliance

- Create a local framework to ensure the Equality Act and Accessible Information Standard are properly enforced, particularly the anticipatory duty to make reasonable adjustments. Coproduce this framework with local disabled people and adopt a champion's approach.

Increasing employment and skills

- Build on the ground-breaking work locally by Working Well to focus a commissioning priority on projects that further disabled people's careers and promote sustainable employment.

- Contracts for small-scale employment support projects for disabled people should only be awarded to bidders where at least 50% of disabled staff are employed across all levels of the organisation.

- Support the growth and development of peer led models of employment support for disabled people as part of the service 'offer' from commissioners.

Data

- Require funded providers to provide data about disabled people's active participation in their communities.

- Strengthen the measurement of social impact. There is a lack of evidence of the benefit of public sector procurement in the city through the work of their supply chains. Increase the accountability of subcontracted employers and businesses by requiring them to make annual data available about their social impact.

- Seek annual guidance from VCSE organisations via a survey about numbers of disabled people they are working with who are not eligible for statutory support, including details of barriers they face to community participation and impact of austerity measures.

Strategic priorities

- Ensure that strategic policy issues raised by the Greater Manchester Disabled People's Mayoral Panel are considered in strategic planning.

- Set combatting loneliness and isolation of disabled people as a key strategic priority for commissioners in the city.

- Support the development of self-directed Care Co-operatives by 2021, building on the work of the current test bed in Manchester.

- Adopt the 12 Pillars of Independent Living as one of the guiding principles underpinning current and future iterations of MHCC's Operational Plan and other related plans and strategies in order to ensure that the needs of disabled people living, working or visiting Manchester are properly and comprehensively considered.

Information

- Promote appropriate terminology guidelines for use by services, where relevant, to promote the respect of and independence of disabled people.

- Ensure that commissioning organisations and departments will include the provision of accessible information and communication in their brief and in relation to other aspects of their services.

- Promote accessible appropriate signage and wayfinding services through planning provision, within health and social care provision and in all other services working in Manchester.

Actions for providers

- Demonstrate compliance with the Accessible Information Standard and anticipatory duty to make reasonable adjustments.

- Gather annual data on social impact of contracted work, including evidence of removal of disabling barriers and examples of how they have worked with disabled people to ensure people are more involved in their communities.

- Improve processes to ensure that health and social care professionals know when they are visiting a deaf person and can pre-arrange appropriate communication provision without delaying appointments.

- Ensure that an effective system is place so that British Sign Language interpretation is available whenever required at meetings, services and work related appointments. Ensure contact lists of organisations who provide communication support such as sign language interpretation, lip speaking, and palantypists are checked at least bi-annually.

- Work with local deaf people to investigate and adopt accessible forms of technology, such as Skype, WhatsApp, text messages and videos with sign

language interpretation. Use these to communicate key information, community resources, and information on rights.

- Provide a forum on and offline which allows people to rate the accessibility of buildings and programmes involved in providing support to disabled people. These should be rated 1 to 5, with 1 being not at all accessible and 5 being completely accessible

Training

- Provide deaf awareness training and basic sign language training for frontline staff to help them communicate effectively.

- Provide training to ensure that all front line staff understand how to take action to remove disabling barriers. As part of this work, we hope to develop a training offer for partners, but this would include the provision of appropriate funding.

Assessment and information sharing

- Ensure information about people's access and support requirements is shared appropriately between different agencies involved in providing aspects of care and support for a disabled person

- Ensure that the single assessment process comes from a Social Model of Disability perspective, i.e. the focus should be on removing barriers that stop the person fully participating in society, and be based on the presumption that the disabled person is the expert on their impairment and how it affects them.

- Ensure that disabled people have the tools to make a genuine choice about their healthcare and the lifestyle they want. Make information on choices and rights available in a range of formats, including offline and in easy read.

Actions for VSCE organisations

- Demonstrate compliance with the anticipatory duty to make reasonable adjustments.

- Gather annual data on social impact of contracted work, including evidence of removal of disabling barriers and examples of how they have worked with disabled people to ensure people are more involved in their communities.

- Provide data to commissioners about numbers of disabled people they are working with who are not eligible for statutory support, including details of barriers they face to community participation and impact of austerity measures.

- Constructively highlight disabling barriers and potential solutions to organisations and hold organisations to account when they do take action to remove barriers.

- Share information and advice on options and support disabled people to advocate for their rights.

Actions for disabled people and allies

- Find out about the Social Model of Disability and how to advocate for barrier removal.

- Play an active role in the development of projects and programmes by getting involved in design forums or co-production projects.

- Get actively involved with the Our Manchester Disability Plan and/or with a disabled people's organisation

- Constructively highlight disabling barriers and potential solutions to organisations and hold organisations to account when they do take action to remove barriers.

- Share information and advice on options and support disabled people to advocate for their rights.

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Other related JSNA topics

- Black and minority ethnic (BAME) communities
- Faith and Health

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Date: November-December 2021

It is hoped that you have found this topic paper useful. If you have any comments, suggestions or have found the contents particularly helpful in your work, it would be great to hear from you.

Responses can be sent to jsna@manchester.gov.uk