MANCHESTER JOINT STRATEGIC NEEDS (BARRIERS) ASSESSMENT
ADULTS AND OLDER PEOPLE

CHAPTER: Key Groups

TOPIC: Disabled People (Social Model of Disability)

1. WHY IS THIS TOPIC 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 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]

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

Published research looking at access to healthcare for men and women with disabilities 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 SignHealth ('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.

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.

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. 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.

More detailed information about the needs and barriers faced by people with learning difficulties is contained in a separate JSNA Topic Report on Adults with Learning Difficulties (in preparation).

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 2017/18, there were 94,098 hate crime offences recorded by the police in England and Wales, of which 7,226 (8%) were disability hate crimes - a 30% increase compared with the previous year. The large percentage increase may suggest that increases are due to the improvements made by the police into their identification and recording of hate crime offences and more people coming forward to report these crimes rather than a genuine increase.

Greater Manchester Police (GMP) 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.

2. THE MANCHESTER PICTURE

People with physical and learning impairments in Manchester

According to the Health Survey for England 2016, around 9% of the population aged 16-64 in Manchester is estimated to have a “moderate or serious” physical impairment (sic). This compares with 11.2% for the North West and 11.1% for England.

Data from the Quality and Outcomes Framework (QOF) shows that there were around 3,080 people (all ages) in Manchester with a learning difficulty known to GP practices as at the end of March 2018, equivalent to 0.48% of patients registered with a GP practice. This is similar to the average recorded prevalence of people with a learning difficulty for GP practices in Greater Manchester (0.51%) and England as a whole (0.49%).

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 or not 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, 2016/17

Age group	Blind/severely sight impaired persons		Partially sight impaired persons	
	Number	Rate per 100,000	Number	Rate per 100,000
0-4	5	12.7	15	38.2
5-17	85	105.4	140	173.7
18-49	360	118.9	330	109.0
50-64	255	372.3	195	284.7
65-74	155	562.0	155	562.0
75 and over	535	2,360.6	540	2,382.6
Total	1,395	257.7	1,375	254.0

Source: SSDA902 Collection, NHS Digital Copyright © 2017 Health and Social Care Information Centre

In 2016/17, there were a total of 2,770 blind or partially sighted people registered with Manchester City Council - a rate of 511.7 per 100,000 population. In the same year, there were a total of 60 new blind or partially sighted people added to the register.

Just over half (55%) of blind or partially sighted people registered with Manchester City Council in 2016/17 were recorded as having an additional disability. Two-fifths (40%) of blind or partially sighted people also had a physical disability and around 13% 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 also 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.

Lesbian, Bi-Sexual, Gay 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.

There is an employment gap between disabled and non-disabled people. The national employment rate for disabled adults is 52.6%, compared with 81.5% for non-disabled people, equating to a 28.9% gap between the employment rate for disabled and non-disabled adults, a 1% reduction in the static 30% gap of the past decade. However, these figures do not show how many people are in insecure employment.

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 November 2018 was 26,650. Nearly 80% of that number (20,770) were in the ESA Support Group and have been assessed by the Department for Work and Pensions as not being fit to work.

At the same period (November 2018), there were just under than 16,000 people in Manchester claiming Disability Living Allowance (DLA). Over 80% of these people had been receiving this benefit for 5 years or more. Around 30% of people claiming DLA were children under the age of 16, 32% were of working age (16-64 years) and 38% were aged 65 and over.

Personal Independence Payments (PIP) provide financial support for people who have extra care or mobility needs (difficulty getting around) as a result of long-term disability or ill-health. PIP is replacing Disability Living Allowance (DLA) for eligible working age people aged 16 to 64. In January 2019, 23.060 people in Manchester were receiving PIP. This compares with a figure of 19,557 people in January 2018.

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 just over 10,200 adults aged 18 and over receiving long term social care support between 1 April 2018 and 31 March 2019. 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 primary support reason (1 April 2018 - 31 March 2019).

Primary support reason	Number of clients	% of all clients
Physical Support	4,295	42.0%
Sensory Support	93	0.9%
Support with Memory & Cognition	320	3.1%
Learning Disability Support	1,267	12.4%
Mental Health Support	4,202	41.1%
Social Support	39	0.4%
Total	10,216	100.0%

Source: Manchester City Council SALT (Short and Long Term Service) Report, 2018/19.

In summary, over this period, there were 1,267 people with learning difficulties recorded as a primary support reason (12.4% of all adult clients) and 4,295 (42% of all clients) with a physical impairment (physical support need). Around 90% of adult clients with a physical impairment were receiving personal care support. The remainder were receiving access and mobility support only.

Over 70% of clients receiving support for a physical impairment were receiving support in a community setting. The proportion of clients receiving support for a learning difficulty in a community setting was higher still (86%). 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.

More information on how Manchester is implementing the Special Educational Needs and Disability reforms introduced in September 2014 is provided in a report to the Children and Young People Scrutiny Committee that was held in January 2019. This report also provides information on the numbers of children and young people with SEND in the local area, data on pupil attainment, attendance and exclusions and comparisons with national data.

Further statistics relating to disability in the city are available in the State of the City Communities of Interest Report 2016.

Lived Experience

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 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 a number of 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 take action.

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 have 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 objective of the Manchester Local Care Organisation is to promote 'independence', reducing the reliance on health and social care provision as people are equipped to safely take more personal responsibility for their own health and wellbeing.

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".

3. WHAT WOULD WE LIKE TO ACHIEVE?

There are a number of 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, published in 2016, showed that enforcement of the Equality Act 2010 remains weak so best practice is essential.

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 of 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 has 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

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.

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 a number of 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.

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.

4. WHAT DO WE NEED TO DO TO ACHIEVE THIS?

Independent Living

The Greater Manchester Disabled People's Manifesto includes a number of relevant recommendations in respect of independent living. This includes 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) have 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

DisabledGo) model, but with offline options to input and retrieve information.

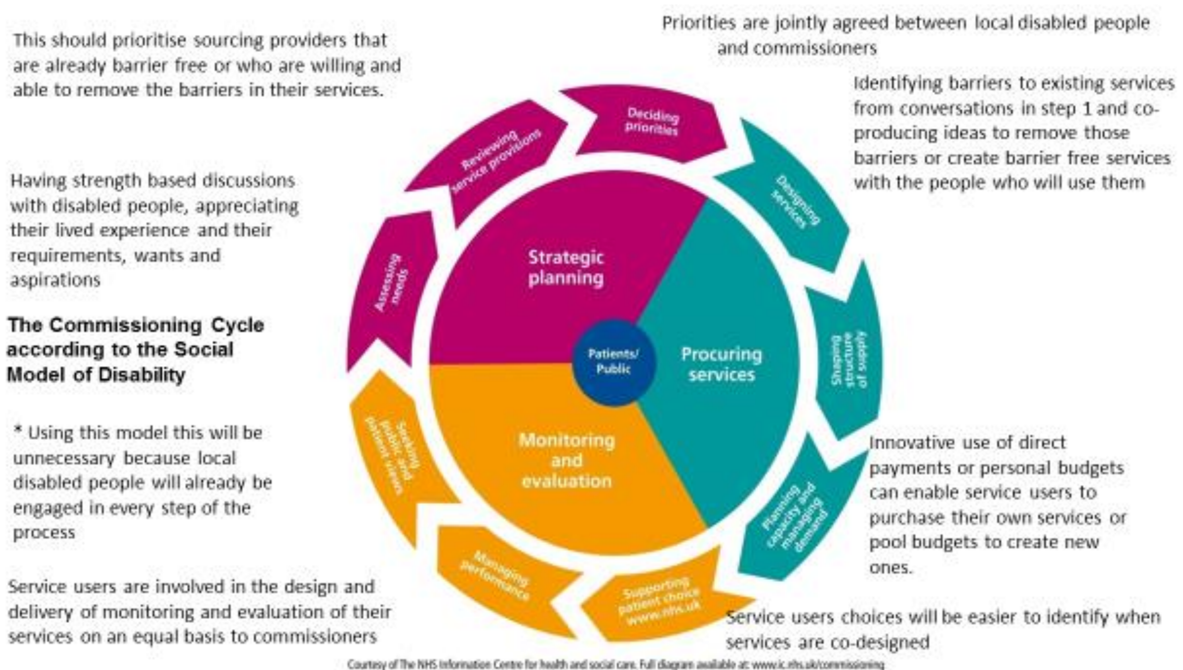
Commissioners need to ensure that all services are accessible and inclusive for all citizens, particularly in terms of the design and redesign of health and care services in Manchester. There are risks associated with not following the legal requirements of the Equality Act, including infringing disabled 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", as long as 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.



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.

5. WHAT ARE WE CURRENTLY DOING?

Manchester City Council

Manchester City Council's broad current Equality Objectives are:

- To know Manchester better
- To improve life chances by taking a joined up approach with public and voluntary sector partners to raise awareness of hate crime and help people feel more confident to report it.
- To celebrate the diversity of the city

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 people with a disability to 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 1st January and 30th 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/BSL Signer is always available for deaf patients but this is not always the case.

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 (OMDP) 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 OMDP 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 a number of 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

i) Full access to our environment, transport system and accessible or adapted housing
ii) Inclusive education and training and equal opportunities for employment
iii) Appropriate and accessible health care provision, equipment & adaptations and personal assistance
iv) Information and money advice
v) 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 OMDP 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 OMDP (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 OMDP 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:

a) Parents'/carers' and children's/young people's views impact on strategic decisions;
b) Excellent local offer, understood and accessible to all leading to improved life outcomes;
c) Young people with SEND have needs met through excellent education, health and care services, jointly commissioned where appropriate;
d) Preparing for Adulthood (PfA) is embedded in Manchester from the earliest years;
e) Highly effective education, health and care plans and reviews improve life outcomes for children and young people;
f) Improved outcomes and standards across education and training
g) 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 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 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 2017, the Manchester State of the VCSE Sector report stated that "The ten per cent of organisations responding to the survey who indicated that equalities and civil rights was a main area of their work were also asked to identify the specific areas within this category in which they operate. The most common responses were gender (63%), age (58%) and disability (47%)."

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) 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:

- Promote the independence and integration of disabled people in society;
- Identify and challenge the discrimination faced by disabled people in society;
- Encourage and support the self-organisation of disabled people;
- Ensure disabled people have equal rights in society and equal access to opportunities.

The GMCDP **Manchester Disabled People's Project** empowers disabled adults (aged 15 and above) who live in Manchester to be in charge of their own lives and well-being by enabling them to learn how to effectively respond to and challenge discrimination, how to express their access needs within their relationships and the wider community; how to advocate for accessibility and fair and equal treatment of oneself and other people and how to resist and challenge disablist discrimination in all its forms.

GMCDP's **Shaping Our Inclusion** project is centred on working with disabled people who are interested in activism, campaigning and leadership. They are working with disabled people to get involved in GMCDP and take on roles such as Executive Board members, leaders, trainers, representatives and activists.

GMCDP provides **an advice/advocacy service** for young people aged 15-25 who live in the City of Manchester, who identify as disabled and are in crisis. Many young disabled people experience (or have experienced) discrimination and barriers because they have impairments.

Breakthrough UK is a disabled people's organisation based in Manchester. Their strategic priorities include:

- Influencing policy e.g. Greater Manchester Devolution to improve disabled people's health and wellbeing;
- Empowering disabled people to develop skills, confidence, autonomy, aspirations and careers through 'peer led' and person-centred support;
- Supporting disabled people's choice and control at whatever stage on their journey towards living independently, working and accessing community services and facilities;
- Engaging and involving disabled people when designing positive, inclusive and accessible services.

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

- Youth Choices;
- Manchester Employment Services;
- Pathways to Independent Living and Pre-Employability group courses;
- Community Connecting, which supports isolated disabled adults to 'have a good week';
- Third-Party Hate Crime Reporting Centre;
- Transport for Greater Manchester Disability Design Reference Group;
- Manchester International Festival Disabled People's Engagement Group;
- Women's Peer Support group.

Breakthrough is also working with Manchester Health and Care Commissioning to understand disabled people's experiences of accessing NHS Health Screening Programmes.

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:

- Our Manchester Disability Plan, chairing the Built Environment Workstream;
- Access audits & access surveys;
- Access Statements & Design and Access Statements;
- Consultancy and contributions to consultations;
- Advice on consulting with disabled people;
- Training and information for organisations & companies & training on access auditing for disabled people;
- Publications;
- Provision of information on the Equality Act, Building Regulation, planning guidance and best practice access standards, including developing materials on writing Design and Access Statements;
- Projects and joint activities with local authorities, regeneration projects & the voluntary & community sector;
- Providing information, advice and consultancy to other infrastructure organisations in the voluntary and community sector in Greater Manchester;
- Active involvement with other disabled people's organisations and with the voluntary and community sector in Greater Manchester.

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 art work.

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:

- Provides spaces for deaf people to socialise and learn;
- Creates opportunities for deaf people through employment and training;
- Devises, gains funding and runs projects that lead directly to positive outcomes for deaf people;
- Influences national and local public policy and seek opportunities to play a role in research and commissioning;
- Works in partnership with others for the benefit of deaf people;
- Promotes deaf culture and the use of British Sign Language (BSL).

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.

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, in particular, 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.

The **North West Disabled People's Organisation Network** is testing the development of Self-Directed Care Co-operatives. The care cooperative will enable two/three groups of up to 10 disabled people, regardless of age or impairment, across the North West to set up a care cooperative as a social enterprise enabling choice and control over who delivers their care and support, by pooling their skills, experiences and costs as a shared employer of personal assistants. A test bed Co-operative in Manchester is planned. Breakthrough UK is the link organisation.

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 in order 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 Mayor** has funded a new Disabled People's Panel to work with him and the Greater Manchester Combined Authority. The Greater Manchester

Coalition of Disabled People (GMCDP) has been commissioned to set up and co-ordinate the panel which aims to shape, challenge and influence policy affecting disabled people across Greater Manchester, by advising and consulting with GMCA.

The 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 black and minority ethnic communities. 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 will be involved in such a senior level of strategic policy-making.

The **Greater Manchester Health and Social Care Partnership** has 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.

6 OPPORTUNITIES FOR ACTION

Actions for Commissioners and Strategic Bodies

Implementation of 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 in to 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 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 OMDP 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 champions 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 are able to 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 off line 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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8 OTHER RELATED JSBA TOPICS

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

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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