

Disability equality within healthcare

The role of healthcare professionals

June 2007



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A publication from the BMA Science & Education Department, the equal opportunities committee and the patient liaison group.

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This report was prepared under the auspices of the equal opportunities committee and the patient liaison group of the British Medical Association, whose membership for 2006/07 was as follows:

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BMA equal opportunities policy statement

The British Medical Association is committed to equality in the provision of its services to its members and stakeholders. This ensures that all members, those applying for membership, and other service users will receive the highest possible standards of service from the BMA, irrespective of race, ethnicity, gender, sexual orientation, marital status, age, disability, chronic illness, religion or beliefs.

Our equal opportunities policy has been developed to ensure that BMA members and staff are fully aware of our commitment to provide equality of opportunity in all of our functions. Furthermore, the BMA will monitor the implementation and application of our equal opportunities policy and ensure that it reflects and meets the requirements of the increasingly diverse membership, which we seek to serve.

BMA members may obtain further guidelines about equal opportunities from the BMA website at www.bma.org.uk or by contacting the Science and Education Department at info.science@bma.org.uk

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Abbreviations

BME	Black and minority ethnic
CEHR	Commission for Equality and Human Rights
CRE	Commission for Racial Equality
DDA	Disability Discrimination Act
DED	Disability Equality Duty
DRC	Disability Rights Commission
EOC	Equal Opportunities Commission
GMC	General Medical Council
LGB	Lesbian, gay and bisexual
MMC	Modernising Medical Careers
PCO	Primary Care Organisation
PCT	Primary Care Trust
PMETB	Postgraduate Medical Education and Training Board
RNID	Royal National Institute for the Deaf
SHA	Strategic Health Authority

Foreword

Recent changes to disability discrimination legislation in the UK have focused attention on the need to promote disability equality within society. In its role as a trade union and professional body for doctors, the British Medical Association (BMA) is particularly concerned that disabled doctors and medical students should not be discriminated against in employment, medical education or training. The association is equally aware that through contact with disabled patients and service users the medical profession can have a significant impact on the experiences of disabled people within healthcare services. BMA policy is grounded in the belief that a National Health Service (NHS) must be free from discrimination. Furthermore, the NHS should aim to provide equitable access to healthcare and work towards ensuring equality of health outcome for all patients. There is evidence, however, that disabling barriers exist within healthcare systems and that significant inequalities, in terms of access to health services and health outcomes, are experienced by disabled people.

In 2006 the BMA annual representative meeting resolved:

'That this meeting believes that the BMA must engage with the royal colleges, PMETB and the GMC to ensure that:

- (i) doctors are aware of their duties under the Disability Discrimination Act;*
- (ii) doctors have an understanding of the social model of disability as well as medical models;*
- (iii) individuals with disabilities have appropriate access to medical education;*
- (iv) doctors with disabilities are enabled to have fulfilling and rewarding medical careers.'*

This report is concerned with points (i) and (ii) of the above BMA policy. It discusses disability equality among patients and within healthcare provision; aims to raise awareness among doctors of their responsibilities under the Disability Discrimination Act (DDA) and of ways in which they can help to break down disabling barriers. The report acknowledges that healthcare organisations must act as the drivers for addressing disability equality and need to implement effective policies and provide the infrastructure and support which will enable healthcare professionals to tackle problems on the ground. While the report focuses on the policy context of meeting the needs of disabled people in healthcare, some practical examples are also included and it is hoped that it will be a useful reference document for healthcare professionals, particularly general practitioners (GPs), who want to find out about how they can meet the requirements of the DDA.

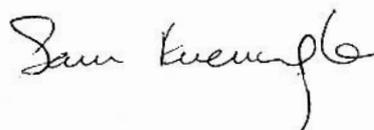
The report highlights the idea that in striving towards disability equality it is often insufficient simply to ensure that an equal service is provided to everyone. Often it is more appropriate to provide an *adapted service* in some circumstances in order to remove barriers to achieve equitable access and health outcomes. Consideration is given to how working within a context of the social model of disability will help to provide services with greater flexibility.

The report discusses ways in which healthcare service providers and healthcare professionals can inadvertently contribute to disabling barriers, and suggests actions that can be taken by both individual practitioners and organisations to help remove and reduce such barriers. Much of the report focuses on general practice, particularly given the role of GPs as independent contractors and the support they may need in addressing disability equality within their own practices. The monitoring, organisational and policy-making roles of NHS organisations are discussed in the context of current legislation as well as in the context of developing good practice. The need for effective disability equality training as a learning mechanism to help raise awareness about disability equality and increase the level of competence in providing services to disabled people among medical students and doctors is also highlighted.

In conjunction with this report, the forthcoming BMA web resource *Disability equality in the medical profession* (July 2007) looks in detail at the barriers faced by disabled doctors and medical students. The findings and recommendations of the resource are pertinent to this report about patients because the ability of healthcare professionals to address disability equality within service provision depends on good relations between employees and the creation of a working environment that is fully accessible and responsive to the needs of disabled people. The BMA welcomes your views on the matters discussed in these reports, both of which can be freely accessed via the BMA website, www.bma.org.uk



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Executive summary

It is estimated that around 11 million adults in the UK are disabled. There is evidence that inequalities in health outcomes and access to healthcare among disabled people continue to exist. Doctors recognise that they have an important role to play in addressing disability equality. Section one introduces the social model of disability which highlights that it is barriers within society which 'dis-able' people with impairments and not the impairments themselves. Applying this model to healthcare means that adopting a more holistic approach to disability which looks beyond standards and targets, and works in partnership with disabled people, is likely to be more effective in addressing health inequalities experienced by disabled people.

Section two highlights the requirements of the Disability Discrimination Act 1995 and 2005 which make it illegal to discriminate against disabled people in the provision of healthcare. All service providers, including those in general practice, have a duty to promote disability equality and are required to make reasonable adjustments to the way they deliver healthcare and to the physical features of their premises to meet the needs of disabled people. NHS organisations, excluding GP practices, also have a duty to produce a disability equality scheme to demonstrate and report on how they will tackle disability equality and how they will consult with disabled people throughout service design.

Some of the health inequalities experienced by disabled people are discussed in section three. While more comprehensive and robust data are needed on health inequalities, there is evidence that disabled people experience various inequalities in health outcomes when compared to non-disabled people and that access to healthcare services is often inequitable. The results of a formal investigation by the Disability Rights Commission show, for example, that people with mental health problems and/or learning difficulties are more likely than other citizens to 'experience major illnesses, to develop them younger and die from them sooner'. Access barriers can also be significant and include inappropriate communication and information systems which can prevent disabled people from knowing what services are available, how to access them or how to use them effectively. Poor physical access or poorly designed buildings and facilities can also create significant barriers for people who have mobility impairments, for example.

Ways in which disabling barriers in healthcare can be broken down are identified in section four. The importance of leadership and commitment from UK health departments, all NHS organisations and the medical profession is highlighted, as is the critical role that commissioning can have in creating responsive services that meet the needs of disabled people. Improving the communication skills and attitudes of healthcare staff towards disabled people is one of the most significant disabling barriers that must be broken down. Increased provision of disability equality and etiquette training should be supported by all NHS organisations and within undergraduate and postgraduate medical education. All policies aimed at breaking down disabling barriers, including implementing disability equality training, will be most effective if disabled patients and service users are consulted and involved at every opportunity.

The report concludes with a list of recommendations which highlight some of the key measures needed to address inequalities in access to healthcare and health outcomes experienced by disabled people.

1: Introduction

It is estimated that 11 million (around one in five) adults and 770,000 children in the UK are disabled.¹ This number is likely to rise as the population ages which will lead to an increased incidence of long-term conditions, such as arthritis. This, coupled with enhanced legal provisions relating to disability discrimination, means that the rights of disabled people can no longer be ignored and the focus on the need to mainstream disability equality into policy-making will intensify.

This document is concerned with the status of disability equality within healthcare service provision; there is evidence that as yet the needs of disabled people have not been fully recognised within healthcare services and that inequality and disabling barriers continue to exist. While healthcare professionals strive to provide the highest level of care for all patients, recent changes to the legislative framework have formalised the requirement to specifically address the health and access needs of disabled patients. Members of the medical profession recognise the impact that they can have on the experiences of disabled patients and service users and are always looking for ways to improve the services they provide. The BMA believes that addressing disability equality will only be effective if doctors and all other staff are adequately supported by the national health departments and National Health Service (NHS) organisations, through policy change and the provision of appropriate resources and funding. While national and local standards relating directly to diversity and health inequalities or indirectly to patient care can be used to assess the performance of healthcare organisations and hold them to account, it must be recognised that a more holistic approach to disability, beyond targets, is needed if efforts to improve the health outcomes of disabled people are to be effective.

Working in partnership with disabled people is imperative if improvements are going to be made. Involvement of disabled people throughout healthcare is needed, from general practice through to specific consultation on national policies which might impact on disabled service users. The partnership framework between the Department of Health (DH) and the Disability Rights Commission (DRC) on disability is an important example.² This framework identifies three priority areas for partnership and sets out the action needed to help create a health service which is accessible and responsive to the needs of disabled people. Two of these areas are promoting inclusion and equality, and access and communication (see box 1).

Box 1: Department of Health/Disability Rights Commission framework for partnership action on disability 2004/05, priorities for joint action

A: Promoting inclusion and equality

We aim to foster a culture which promotes the rights, independence, choice and inclusion of disabled people by improving and strengthening the extent to which disabled service users, carers and the wider disabled community can influence service design and delivery.

B: Access and communications

We aim to improve access to information and services, communications and levels of awareness of disability issues, in particular by supporting NHS and social care providers to meet the requirements of existing and forthcoming legislation.

Source: DH and DRC (2004) *Framework for partnership action on disability 2004/05*.

The third area of this partnership framework is employment, with a stated aim to improve the recruitment, employment, retention and career development of disabled people in the NHS. The BMA wholly recognises the significant advantages of having a diverse workforce within the health service, including the benefits this can have on patient care and the ability of the NHS to engage with diverse service users. Legislation also makes it illegal to discriminate against disabled people in employment, recruitment or education, and thus healthcare employers and educational institutions have an obligation to promote equality among their staff or students. The BMA has produced a separate web resource about disability equality within the medical profession which looks in detail at barriers faced by disabled medical students and doctors: *Disability equality in the medical profession* will be available on the BMA website from July 2007. Further discussion about disability equality in healthcare employment is, therefore, beyond the scope of this report.

Disability in context

Traditionally, the aims of medicine have emphasised a desire to cure or effectively treat an individual's symptoms or illness. The notion of a long-lasting or permanent impairment does not, therefore, always sit comfortably within medical training or in service design. In order to address disability equality within healthcare service provision a shift in the approach to disability is needed. This shift should be away from thinking about a person's impairment as a problem which inhibits their ability to live a 'normal' life, towards considering the person first and foremost and recognising that it is the environment, rather than the impairment, which is disabling. This shift is characterised theoretically as a move away from traditional models of disability towards the social model of disability.

The social and traditional models of disability

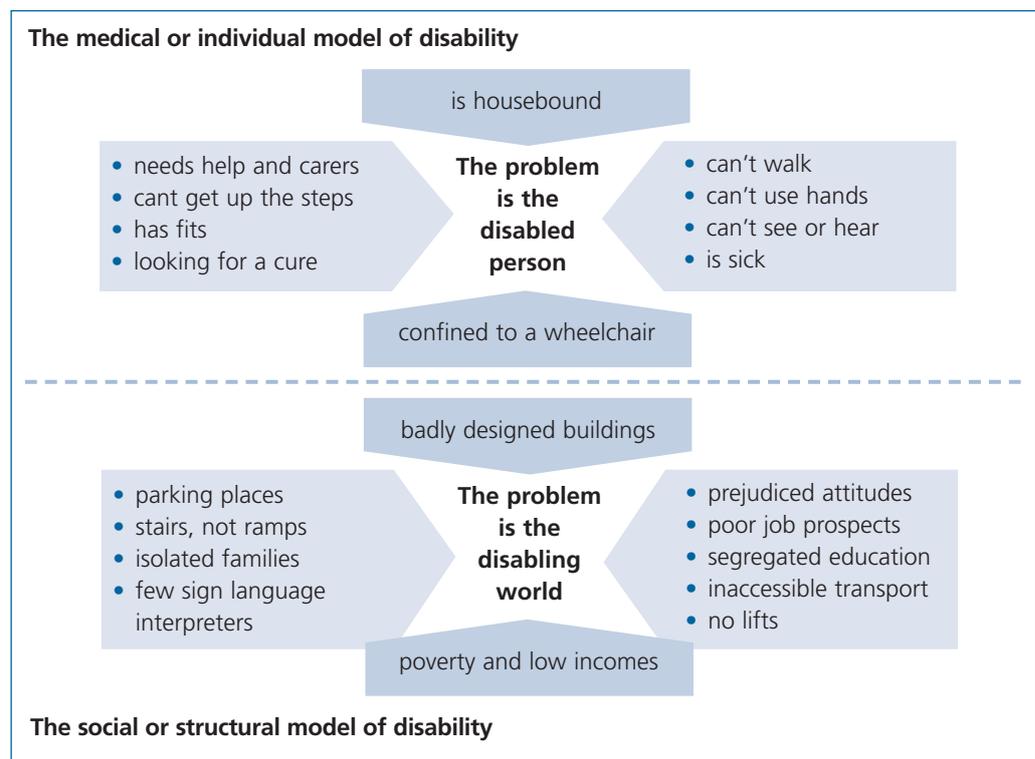
Included within the traditional models of disability are viewpoints that see disabled people as having medical problems and expect that they will have to 'make the best of and accept that there are many things they cannot do'.³ According to these traditional views, disabled people may feel that they are a burden on those around them and a problem for doctors who cannot cure them. These models are pervasive throughout much of society, particularly within medicine, and affect the ways in which we think about and engage with disabled people. This way of thinking is criticised for disempowering disabled people; some descriptive statements typical of this approach include:

- you are a sufferer
- you are the problem
- your disability needs curing
- you cannot make decisions about your life
- you need professionals to look after you
- you can never be equal to a non-disabled person.³

The social model of disability which has been developed by disabled people, challenges the ideas within traditional models. It describes 'disability' not as a medical concern but as one where people who have impairments are 'dis-abled' by daily barriers in society, for example, in the way we design and build our towns and cities, the way we organise our social activities and in the attitudes that we perpetuate, which favour non-disabled people over disabled people.⁴ The social model looks beyond a person's impairment to all of those factors which affect their ability to be fully active in society. It empowers disabled people to recognise and overcome disabling barriers, resulting in increased independence and self-esteem. Whereas the traditional model focuses on the 'problems' of being disabled, the social model focuses on the 'problems', or barriers, in society. By highlighting barriers, behaviours and attitudes that cause problems for disabled people, the social model focuses on solutions through eliminating these barriers within society.³ These different approaches also affect the confidence of disabled people; from a traditional model approach disabled people are more likely to have low self-esteem or feel guilty or a burden because they are

disabled. In contrast, the social model approach encourages the disabled person to feel comfortable with their difference, in control of their situation and able to identify and challenge discrimination.⁵ Figure 1 uses illustrative examples to compare the traditional (referred to in the diagram as the medical or individual model) and social models of disability.

Figure 1: Diagram to compare the traditional model and social model of disability



Source: Disability Rights Commission, Citizenship and disability, Lesson 3, Worksheet 2.
At www.drc.org.uk/citizenship

Thinking about disability using the social model enables a broader understanding of the ways in which disabled people can be discriminated against. The notion of discrimination is a key feature of the social model as it describes how 'disabled people do not face disadvantage because of their impairments but experience discrimination in the way we organise society. This includes failing to make public services, education, work and leisure accessible, failing to remove barriers of assumption, stereotype and prejudice and failing to outlaw unfair treatment in our daily lives'.⁶

2: Disability discrimination legislation

This chapter briefly discusses the main requirements of disability discrimination legislation in the UK. It then looks in more detail at the implications of this legislation for the healthcare services and providers. See appendix 1 for a more detailed description of the relevant legislation.

The legislative framework

The two main pieces of legislation relating to disability discrimination are the Disability Discrimination Act 1995 (DDA 1995) and the Disability Discrimination Act 2005 (DDA 2005) which amends the DDA 1995. England, Scotland and Wales are each fully covered by both the DDA 1995 and DDA 2005. Specific amendments to the DDA 1995 mean that in Northern Ireland the same principles apply but there are different arrangements for promoting and enforcing its implementation. The DDA 2005 also applies slightly differently to Northern Ireland, which also has its own additional anti-discrimination legislation (see appendix 2 for a brief overview).

Disability discrimination

The DDA 1995 prohibits discrimination on the grounds of disability in relation to employment, education and the provision of goods and services. It also places a duty on employers and educational institutions to make reasonable adjustments to ensure that disabled people are not placed at a substantial disadvantage in comparison to non-disabled peers and colleagues.^a Service providers, including those within healthcare, must also make reasonable adjustments for disabled people and are required to take steps to:

- change any practice, policy or procedure which makes it impossible or unreasonably difficult for disabled people to make use of their services
- provide an auxiliary aid or service if it would enable (or make it easier for) disabled people to make use of their services.⁷

Failure to make a reasonable adjustment for a disabled person, where that failure cannot be justified, is considered to be direct discrimination within the law.^b

The DDA 1995 covers physical, learning, sensory and mental impairment and defines a person as being disabled if their impairment has a substantial adverse effect on their ability to carry out 'day-to-day activities', for example affecting mobility, speech, hearing or eyesight, memory or the ability to concentrate, learn or understand.^a The definition, as amended by the DDA 2005, has now been extended to cover many long-term and progressive conditions. For the majority of these, such as arthritis and diabetes, a person is regarded as having an impairment the moment their condition has some effect on their ability to carry out day-to-day activities. In the specific cases of cancer, HIV infection and multiple sclerosis, however, individuals are considered as disabled from the point of diagnosis.

^a For further discussion of the employment and education requirements of the DDA in relation to the medical profession see *Disability equality in the medical profession* (BMA, 2007).

^b Indirect discrimination on the grounds of disability is not recognised within UK law. All discrimination on the grounds of disability is considered to be direct discrimination.

Promoting disability equality

The amendments of the DDA 2005 have moved the legislative framework beyond just discrimination to establish legal requirements relating to *promotion* of disability equality within public bodies. The DDA 2005 establishes the Disability Equality Duty (DED) which came into effect in December 2006. This duty has two parts, the general duty and a set of specific duties.

- The **general disability duty** requires all public bodies to actively promote disability equality.
- The **specific disability duties** require all public authorities listed in the regulations to:
 - produce and publish a Disability Equality Scheme and action plan setting out how the organisation will promote disability equality
 - involve disabled people in producing the Scheme and action plan
 - demonstrate that they have taken the actions outlined in the Scheme and achieved appropriate outcomes
 - report on progress and review and revise the Scheme in order to promote disability equality.⁹

The role of the Commissions

The DRC is an independent body set up by the Disability Rights Commission Act 1999 to stop discrimination and promote equality of opportunity for disabled people in England, Scotland and Wales. It has been the role of the Commission since 2000 to supervise and advise on the implementation of disability discrimination legislation. The DRC has set the goal of 'a society where all disabled people can participate fully as equal citizens'.¹⁰

From October 2007, the responsibilities of the DRC will be transferred to the Commission for Equality and Human Rights (CEHR). This new Commission was established by the Equality Act 2006 and aims to bring together expertise on equality, diversity and human rights in one place. As well as disability, the CEHR will assume the responsibilities relating to gender and race equality, as currently held by the Equal Opportunities Commission (EOC) and the Commission for Racial Equality (CRE) respectively. It will also cover areas of equality relating to age, sexual orientation, religion or belief and also human rights. Further information about the CEHR can be found on the website www.cehr.org.uk

It is illegal to discriminate on the basis of a person's disability, race, gender, marital/civil partnership status, sexual orientation, or religion or belief in the provision of goods, services and facilities, as well as within employment. Age discrimination is only prohibited within employment. The establishment of the CEHR acknowledges that people are not defined by one diversity category alone and that discrimination can occur on multiple grounds. For example, black or minority ethnic disabled people may be discriminated against because of their impairment and race.

A single body, the Equality Commission, exists in Northern Ireland to promote equality of opportunity and challenge discrimination in respect to nine diversity strands, including disabled people, provided for within legislation in Northern Ireland.

Implications for healthcare services

In meeting the requirements of the DDA 1995 and 2005 healthcare providers will not only ensure that they are compliant with the law but are also likely to have a significant impact on patient care, the accessibility of the health service and consequently the health outcomes of disabled patients. The DRC describes how the 'acid test' of the NHS 'is not whether it works for people who are generally healthy but whether it benefits those with the shortest life expectancy, the greatest problems accessing services and the biggest risk that poor health will stop them taking part in society'.¹¹ The key to using these legal requirements to help meet the needs of disabled people is for flexibility to be built into the

approach of healthcare service providers. It is vital that disabled people are listened to and that consideration is given, preferably in partnership, to how a service could be appropriately adjusted.

There follows a discussion of the implications of the DDA 1995 and 2005 for different healthcare organisations. It should be noted that some of the legal requirements for GP practices are different to those for other healthcare organisations including NHS employers and contracting bodies. This section should provide GPs with a useful overview of what is expected of them.

Preventing discrimination and making reasonable adjustments

The DRC advises that, as prescribed by the DDA 1995, disabled people, regardless of their impairment, have the right of equal access to NHS services. This includes the right to information, for example about treatment options, complaints procedures or appointments, in a form which is accessible, and the right of access to surgeries, hospitals and mobile units.¹²

Since 1999 all service providers have been required to make reasonable adjustments in order to meet the needs of disabled users, such as providing extra help or making changes to the way services are delivered. Since 2004 this requirement has been extended to 'physical features'. Failure of service providers to make reasonable adjustments could, therefore, lead to loss of reputation or even litigation. While there is no definitive answer to what constitutes a 'reasonable' adjustment, the use of this phrase within the law enables some flexibility to allow different solutions in different situations. It is very important to acknowledge that the expectation of what constitutes 'reasonable' adjustments will vary across different healthcare settings. The DDA 1995 code of practice advises that this may vary according to the:

- type of services provided
- nature of the service provider and its size and resources
- effect of the disability on the individual disabled person.

Further, factors when considering what is reasonable include:

- whether taking particular steps would be effective in overcoming the difficulty that disabled people face in getting access
- the extent to which it is practicable for the service provider to take the steps
- financial and other costs of making the adjustment
- the amount of disruption caused by taking the steps
- money already spent on making adjustments
- the availability of financial or other assistance.¹³

The adjustments that will be expected within an individual general practice surgery will, therefore, be different to those expected within a hospital or by large healthcare organisations such as a primary care trust (PCT). This is particularly true with regard to making adjustments to 'physical features'. Whereas a hospital would, for example, be expected to install lifts, ramps and accessible signage, and have fully accessible waiting rooms and bathroom facilities, a GP practice may not have the means or appropriate facilities to do so, at least not without significant cost or disruption to the services they provide. In such circumstances, however, GPs should consider alternative adjustments that may help make their services more accessible. Examples might include:

- allowing people to wait outside or in other areas of the surgery if waiting areas are inaccessible
- using a downstairs room for a consultation if someone is unable to use the stairs
- ensuring that corridors and entrances are free from clutter
- improving lighting to help people with visual impairments.

The BMA has produced guidance for GPs on the physical adjustments to premises that are required by the DDA.¹⁴ It includes information about what constitutes 'reasonable adjustments' and 'physical features' and how to check compliance with the DDA. This guidance can be accessed from the BMA website.

Adjustments are also needed to meet the needs of people with hearing, sight or communication impairments, learning difficulties or mental health problems as well as those with mobility impairments. Improving communication and information provision are two example areas where adjustments may be needed:

- Enabling communication – It may be necessary to install modified equipment, such as a telephone with a text display or an induction loop for people who have a hearing impairment. Alternatively, in many practices it may be reasonable to have a portable induction loop available or to use a fax machine to make appointments. Some patients may also require some form of interpretation service including, sign language or lipspeakers. While primary care organisations (PCOs), NHS trusts and health boards should support the provision of these services locally, they may not always be available when needed. An alternative, which may be preferred in many cases, is for a patient to be accompanied by someone they know who may assist with communication.
- Providing information in an accessible format – This may include, for example, having large print, easy print or pictorial versions of all information resources. While GP surgeries may not have leaflets in large print, they could offer to print off a larger version of the leaflet for individuals when needed. Alternatively, a PCO, trust or health board may have central stocks of easy read, Braille, audio or pictorial information that can be ordered when necessary.

In many ways the most important, and perhaps the hardest, adjustments to make are those relating to the attitudes of staff and the ways in which they communicate with disabled people. The key to breaking down attitudinal barriers is to recognise the need for an inclusive approach, and the importance of not making assumptions about a person's impairment and asking the individual person about their access requirements. Providing training is an adjustment that might be needed to break down these barriers which will enable staff to recognise when flexibility may be needed, for example, when making appointments or registering new patients. Staff should also bear in mind that many impairments are hidden and thus it is equally important not to assume that no adjustments are needed because there is no visible sign of a person's impairment.

It is often the case that the adjustments required will be very straight forward. In many cases, GPs and other service providers can be reassured that the adjustments needed are things that they would usually do anyway when someone has particular access requirements. Adopting a flexible and inclusive approach to the design of policies, procedures and facilities and working in partnership with individuals and groups of disabled people will help to ensure that the access needs of all disabled people are appropriately considered.

Meeting the requirements of the Disability Equality Duty

While delivering high standards of healthcare and working towards the elimination of health inequalities forms part of the core business of healthcare services, the introduction of the DED in December 2006, as provided by the DDA 2005, legally enforces the responsibilities of healthcare service providers in relation to disability equality. The duty also reflects the social model of disability and applies it to the functions of a public authority by recognising the active steps that are needed to promote equality for disabled people.¹⁵

The general duty requires all providers of public services to promote disability equality actively and when carrying out their functions to have due regard to the need to:

- promote equality of opportunity between disabled people and other people
- eliminate discrimination that is unlawful under the DDA
- eliminate disability-related harassment^c
- promote positive attitudes towards disabled people
- encourage participation by disabled people in public life
- take steps to take account of disabled persons' disabilities, even where that involves treating disabled persons more favourably than other persons.¹⁵

All public healthcare organisations and providers or those acting on behalf of a public authority, including GP practices and independent sector contractors, are bound by the general duty.¹¹ As with the requirement to make reasonable adjustments, the duty to promote disability equality acknowledges that it is not necessarily sufficient to provide an equal service to everyone. In order to meet the needs of all individuals and progress towards achieving equitable access and equality of health outcomes, services and the ways in which they are delivered may need to be adapted.

A DRC, document *Health and the Disability Equality Duty, guidance for public authorities working in the health sectors in England and Wales* (2006) provides detailed explanation and some excellent examples within healthcare on each of the areas listed above.¹⁵ Box 2 gives an example from this guidance relating to participation of disabled people in public life. This guidance also reminds those working in the healthcare sector that the general duty applies to all functions, not just service delivery and employment and thus the impact on disabled people must be considered, for example, when drafting clinical and good practice guidelines. The general duty also requires due regard to be paid to disability equality when public authorities in the health sectors are commissioning and procuring goods or services.

^c Harassment is a very broad concept which can take many forms, from direct verbal abuse to comments which make an individual feel uncomfortable, intimidated or degraded. Disabled people may be subject to considerable harassment in daily life. This may occur in schools, at work, when receiving services, or at home.

Box 2: Example of promoting disability equality in healthcare as required by the general Disability Equality Duty

Participation in public life

The general duty requires public authorities to have due regard to the need to encourage participation by disabled people in public life. Disabled people bring valuable experience and skills to the work of healthcare organisations. Such participation will encourage positive attitudes towards disabled people and may lead to a reduction in harassment and discrimination.

The public are already encouraged to participate in the governance of public authorities working in the health sector.

Examples include:

- patients' associations
- market research focus groups
- user groups for a service provided by a health authority
- membership of boards
- government public appointments.

Public authorities will need to ensure that disabled people are well represented on these groups.

Patient and Public Involvement (PPI) Forums enable people to have a say in how local health services are provided. It is important that disabled people can have an active voice on PPI Forums – or indeed in any comparable involvement mechanism. It is important that this includes involving those disabled people who are often overlooked in engagement processes, such as:

- BSL users
- people with high support needs
- people with learning disabilities
- people with mental health conditions who are regular users of primary healthcare services.

Source: DRC (2006) *Health and the Disability Equality Duty, guidance for public authorities working in the health sectors in England and Wales*.

The specific duties created by the DDA 2005 only apply to those public authorities that are listed in the accompanying regulations. In healthcare these include:

England¹⁶

- Department of Health
- NHS trusts – including acute, mental health, care and ambulance trusts
- Primary care trusts
- Strategic health authorities
- Special health authorities – eg Health Protection Agency, National Patient Safety Agency

Scotland¹⁷

- NHS National Services Scotland
- Health boards
- Special health boards – eg Scottish Ambulance Service, NHS Education for Scotland

Wales¹⁶

- Welsh Assembly
- Local health boards
- NHS trusts

Other organisations, including the General Medical Council (GMC) and the Medical Research Council, are also bound by the specific disability duties.

Each of these health-related public authorities is duly required to identify and work towards closing inequality gaps. They must also produce a Disability Equality Scheme, in which they are required to:

- indicate how progress in closing gaps of inequality will be tracked over time
- set out plans for action to close these gaps
- put in place processes for ensuring that disability equality is given sufficient weight in decision making.

In Northern Ireland the DDA 2005 has brought the public sector duty into force, which requires disability equality to be mainstreamed into public policy. It also requires public authorities to promote disability equality and encourage participation by disabled people in public life. These authorities, which include hospital and community trusts, the four regional health and social services boards and the Department of Health, Social Services and Public Safety, must also submit a Disability Action Plan to the Equality Commission by June 30 2007 showing how they propose to meet the new duties.¹⁸

It is important to note that, while individual GP practices do have a general duty to promote disability equality, they are **not** bound by the specific duties and are not required to produce a Disability Equality Scheme.

Guidance and information on implementing the disability equality duty

A number of resources are available for healthcare organisations which provide guidance on fulfilling the DED. Two complementary guidance documents for the health sector, particularly for those in strategic positions, are available from the DRC, one of which applies to England and Wales and the other to NHS health boards in Scotland.^{15, 19} This guidance reinforces the point that meeting the disability equality duty means more than just revisiting existing gaps in access. It emphasises that health providers need to identify and address health inequalities, for example the high rate of early mortality, poor screening levels and high obesity among some disabled people.¹⁵ The DH and NHS Employers have also both produced practical guidance for NHS organisations on producing a Disability Equality Scheme. In their web-based guidance, NHS Employers provides summary information on the

nine essential elements of a Scheme that are required for it to comply with the regulations (see box 3).²⁰ The DH guidance document *Creating a disability equality scheme: a practical guide for the NHS* provides more detailed information about meeting all the requirements of the DDA, making the appropriate adjustments and producing a Scheme.²¹ The target audience of this guidance includes equality and policy leaders as well as other key senior personnel within acute and mental health NHS trusts, PCTs, SHAs and ambulance services. The Scottish Executive Health Department, together with the DRC, has taken a more holistic approach to providing information about addressing disability equality in healthcare service provision, through their joint *Fair for all* initiatives and website,²² available at www.drc.org.uk/fair4all/

Box 3: Essential elements of a Disability Equality Scheme

Introduction: The Scheme should start with an introduction.

Involvement: How disabled people have been involved in developing the Scheme.

Mapping: Employers need to cover what arrangements will be put in place for gathering information about the organisation's performance on disability equality.

Impact assessment: This should outline how an organisation will assess the impact of its disability equality policies and procedures and how the information will be used to make improvements.

Assessing existing policies: This covers how existing policies and procedures will be assessed for any impact on disability equality.

Action plan: This is a three-year plan of how the organisation intends to promote disability equality and mainstream all its functions and policies.

Engagement: The Scheme needs to outline how the organisation intends to involve other stakeholders.

Monitoring: Organisations need to show how the effectiveness of the action plan will be monitored and reviewed in subsequent schemes.

Reporting progress: How and where progress will be reported should also be covered in the Scheme, including progress on the action plan, results of impact assessments and monitoring.

Source: NHS Employers website, *Producing a Disability Equality Scheme*.

At www.nhsemployers.org/excellence/excellence-1365.cfm (accessed February 2007).

The guidance documents mentioned above are useful reference tools for organisations during the production of a Scheme and can also be used to ensure that all of its components are being appropriately applied and that effective monitoring and review of policy is maintained.

Progress in implementation

While all healthcare organisations were required to have published their Disability Equality Scheme in December 2006 there is evidence that not all public bodies met this deadline. In March 2007 the Office for Disability Issues published its commissioned study which audited the compliance rates of public bodies required to publish a Scheme. Overall the results were positive and showed that 72 per cent of the public bodies involved in the audit had published a Scheme by the end of January 2007 and that 75 per cent of these showed evidence that disabled people had been involved in the production of the Scheme.²³ For the health sector, 73 per cent of the PCTs within the sample had produced a Scheme while only 63 per cent of other NHS bodies, including NHS trusts, foundation

trusts and SHAs, had done so. Importantly, the majority of healthcare organisations which had produced a Scheme demonstrated that they actively involved disabled people during the production process and that, in the main, consultation directly with disabled service users was employed (92 per cent of PCTs and 87 per cent of other NHS bodies with a Scheme).

Responsibility for ensuring compliance and assessing standards

Regional and local NHS organisations all have their own responsibilities to ensure that the needs of disabled people within their localities are supported and that all services, including primary, secondary and community care as well as health promotion activities, are accessible and inclusive. It is vital, for example, that disabled people are considered when services are commissioned and that the implementation of national and local healthcare policies are monitored and evaluated in terms of their impact on disabled people. In England, for example, the remit of SHAs includes developing plans for improving local health services and making sure that these services are of a high quality and are performing well. As part of this remit they are responsible for monitoring the delivery of equality and diversity objectives, including those relating to disability equality, by PCTs and NHS trusts in their region.

Additionally, the health departments in England, Wales and Scotland have overall responsibility for ensuring that the access and health requirements of disabled people are embedded into all strategic healthcare planning including central initiatives, such as the patient choice agenda and care closer to home. The Secretary of State for Health, the Welsh Assembly and the Scottish Minister for Health will be required to publish a report every three years, starting in December 2008, which should:

- give an overview of the progress made by public authorities in the health sector in relation to disability equality
- set out proposals for co-ordination of action by those public authorities in the health sector to bring about further progress on disability equality.¹⁶

In England, the Healthcare Commission is also responsible for assessing the quality of public healthcare services and organisations and the progress of national healthcare standards. Accordingly, it is important that the Commission considers equality, including disability equality, as an integral part of these functions.

3: Health and access inequalities

This section provides a contextual background to the legislation changes, the requirements to address disability equality in healthcare and the importance of the role of healthcare professionals by considering some of the inequalities that exist and how these are demonstrated by the experiences and health outcomes of disabled people.

In order to assess whether progress is being made on disability equality in healthcare the initial situation must first be assessed; baseline data are therefore required. At a broad strategic level the government and the devolved administrations aim to reduce health inequalities in two key areas: infant mortality and life expectancy.²⁴ Despite these stated aims, however, data exist categorised only by gender, age and geography in relation to infant mortality and life expectancy. No systematic data are available by disability, ethnicity, sexual orientation, transgender and religion or belief. The lack of data, even on these basic indicators, greatly hinders any assessment of where health inequalities exist among disabled people, as well as other groups. The more data that are collected, the easier it is to get a better picture of health and access inequalities. Evidence on broader clinical outcomes for a wide range of diseases and conditions and on the patterns of health service usage disaggregated by and within different equality strands is needed if an effective evaluation is going to be made. The final report of the comprehensive Equalities Review published in 2007 highlights this lack of systematic, quantitative data as a significant barrier to addressing health inequalities.²⁴ In light of this, various different sources are referred to herein to identify some of the evidence which can help to eliminate where current health and access inequalities exist for disabled people.

Health inequalities

A number of studies have shown that disabled people experience various negative health inequalities compared to those who are not disabled.^{11, 25-29} Such health inequalities among disabled people are demonstrated by a greater risk of certain conditions, an increased likelihood of having major health problems, lower and shorter survival rates after diagnosis and even lower life expectancy rates. The secondary health problems experienced by disabled people are sometimes a direct result of their impairment, for example caused by side effects of medication, by excessive pain or by a suppressed immune system. An American study demonstrates this by comparing the incidence of 16 different secondary conditions, such as muscle spasms, sleep problems, asthma and problems getting out/around, among the disabled and non-disabled population.^{4, 27} The study found that disabled people had a significantly greater risk for 14 out of the 16 secondary conditions; the highest risk was for chronic pain in muscles and/or joints. The impairment-related health needs of disabled people, whether they are direct or secondary, mean that in the main they are likely to use health services more frequently than non-disabled people over their lifetime. It is essential from both the patient experience point of view and the constraints of funding and planning, therefore, that services are as efficient and effective as possible.

There is evidence that in addition to their impairment-related health needs, disabled people experience further health inequalities. While such health problems are not medically caused by a person's impairment they can be significantly influenced by the disabling barriers within society. Examples of these contributing factors are social deprivation; lack of access to, and information about, health services, treatment options or health promotion; or poor attitudes and communication skills of health and social care professionals. Diagnostic overshadowing, whereby a person's health problems are attributed to their impairment even where they are completely unrelated,¹¹ can also occur when a health professional does not see past a person's impairment. In such a situation the true health needs of an individual are unlikely to be identified.

^d In this study 'secondary conditions' are defined as preventable physical, mental and social disorders resulting directly or indirectly from an initial disabling condition.

DRC formal investigation 2006

Health inequalities are not experienced to the same extent across the disabled population and some groups are affected more than others. A review document published in 2004 by the DRC found a weight of evidence that indicated 'serious inequalities in health outcomes' of disabled people and in particular those with learning difficulties or mental health problems.²⁹ The DRC presented evidence, for example, which showed that:

- people with learning difficulties die younger than other citizens. One study found they were 58 times more likely to die before the age of 50 than the general population³⁰
- people who are psychiatric outpatients are nearly twice as likely to die prematurely as the general population from a range of (often) preventable conditions, and the different rates cannot be accounted for by suicide alone.³¹

Following this background work the DRC undertook a formal investigation into the nature and causes of physical health inequalities experienced by people with mental health problems and/or learning difficulties in England and Wales; in particular it focused on what is being done and what should be done, to reduce these inequalities through primary care.¹¹ The investigation involved a combination of consultation and evidence collecting techniques including questionnaires, focus groups, in-depth area studies, analyses of GP databases and statistics, a formal inquiry panel and roadshow events. The final report of the formal investigation was published by the DRC in September 2006. The findings show that people with learning difficulties and/or mental health problems are more likely than other citizens 'to experience major illnesses, to develop them younger and die from them sooner'.¹¹

Box 4 gives some examples of the DRC's findings relating to physical health inequalities experienced by people with mental health problems and/or learning difficulties. The full report can be found on the DRC website at www.drc.org.uk/healthinvestigation

Box 4: Examples of physical health inequalities experienced by people with mental health problems and learning difficulties

People with mental health problems

- There are higher rates of ischaemic heart disease, stroke, high blood pressure and diabetes among people with schizophrenia or bipolar disorder compared to the rest of the population.
- People with schizophrenia are 90% more likely to get bowel cancer and 42% more likely to get breast cancer (women only).
- 31% of people with schizophrenia and chronic heart disease (CHD) are diagnosed under 55, compared to 18% of others with CHD; these figures are 41% and 30% respectively for diabetes.
- After five years, 28% of people who have had a stroke and have schizophrenia have died, as have 19% of people with bipolar disorder, compared with 12% of people with no serious mental health problems.

People with learning difficulties*

- People with learning difficulties have higher rates of respiratory disease at 19.8% than the remaining population (15.5%).
- People with learning disabilities are more likely to be obese. The rate of obesity in all those with their body mass index (BMI) recorded was 28.3% in people with a learning disability, as compared to 20.4% for the remaining population.

* These figures were determined from area studies rather than through analysis of GP clinical databases as recording of learning difficulty in primary care is poor.

Source: DRC (2006) *Equal treatment: closing the gap, a formal investigation into physical health inequalities experienced by people with learning disabilities and/or mental health problems.*

In 2004 NHS Scotland published a health needs assessment report of people with learning difficulties in Scotland.²⁶ Within the report it was found that life expectancy for people with learning difficulties is lower than for the rest of the Scottish population. It describes how there are a higher number of, and more complex, health needs among people with learning difficulties and that a greater proportion of these are unmet by the services provided.²⁶

Further to the DRC formal investigation Mencap, the UK's leading charity working with people with learning disabilities, published a report which claims that people with a learning disability face institutional discrimination at every level of the health service.³² The report *Death by indifference* (2007) was produced following their *Treat me right!* campaign, launched in 2004, which exposed the unequal healthcare that people with a learning disability often receive from healthcare professionals. *Death by indifference* describes six deaths – which Mencap believes were avoidable – of people with a learning disability. Mencap has called for an independent inquiry into the cases described in the hope that the underlying causes of their deaths can be better understood.

Access inequalities

As well as unequal health outcomes, disabled people may also experience inequalities in access to healthcare services. Lack of access is both an indicator of health inequality and a contributory cause of it. Disabled people may for different reasons find it difficult or be denied access to various healthcare services. Access barriers are experienced at different points throughout a person's healthcare journey and come in many different forms. Inappropriate communication systems or inaccessible information

may prevent some disabled people from being aware what services are available, how to access them or how to use them effectively. Poor physical access or poorly designed buildings and facilities can also create significant barriers for people who have mobility impairments, for example.

The 2004 DRC background paper *Discriminating treatment? Disabled people and the health service* lists evidence from a number of sources which indicates that disabled people experience inequalities in access to different healthcare services (see examples in box 5).²⁹

Box 5: Example evidence of access inequalities experienced by disabled people

- Breast screening uptake is 76% for all women in the UK within the appropriate age range but between just 17% (family care) and 52% (formal care) for women with learning disabilities.
- Uptake for cervical screening is 85% for women aged 20-64 but between just 3% (family care) to 17% (formal care) for women aged 18 and over with learning disabilities.
- Disabled people are four times more likely than the general population to find dentists' offices inaccessible or inadequate, and twice as many find their doctor's surgery inaccessible.
- 40% of visually impaired people consider that their GP is not fully aware of their needs. This rises to 60% when considering other surgery staff. 95-97% never receive health advice, letters or prescriptions in preferred formats such as Braille or large print.

Source: DRC (2004) *Discriminating treatment? Disabled people and health services*. DRC background paper.

The subsequent DRC formal investigation found that two of the main barriers for people with learning difficulties and/or mental health problems are in seeking and accessing primary care and health promotion support, including health checks and screening.¹¹ People with mental health problems tend to have as many standard tests as the general population, while those with learning difficulties are less likely to receive such tests. The DRC is, however, encouraged that incentives have been introduced for annual or regular physical health checks for people with mental health problems since the new GP contract was introduced; and that as of April 2006 the same has been true for people with learning difficulties. The DRC also found that while evidence shows that targeted health promotion interventions (such as smoking cessation) are effective for people with mental health problems; such targeted activities are relatively rare. Box 6 gives some examples of barriers when seeking or accessing primary care that were identified by the formal investigation.

Box 6: Evidence of disabling barriers when accessing primary care identified by the DRC formal investigation

• **Registering with a GP**

A small minority of people with mental health problems and/or learning disabilities were not registered with a GP at all. Sometimes people became frustrated when trying to register with a GP and felt they were being viewed as a difficult or overly demanding patient.

• **Receptionists**

In some instances people with learning disabilities and/or mental health problems felt that reception staff did not understand the effect their condition had on their lives.

• **Making appointments**

Many people found it making an appointment a frustrating experience. This was often for reasons related directly to their impairment, for example if they had difficulty with communication or found it challenging to deal with people on the phone.

• **Information**

Frequently information was not provided in a format that was accessible for people with learning disabilities, either within a surgery or when sent out to patients.

• **Waiting rooms**

Some patients were not comfortable in waiting rooms and found long waits, in particular, difficult to deal with.

Source: DRC (2006) *Equal treatment: closing the gap, a formal investigation into physical health inequalities experienced by people with learning disabilities and/or mental health problems.*

It should be acknowledged that, while GPs want to provide the best possible service to their patients, where resources and funding are limited or where making adjustments may cause disruption to services it may not be possible for some practices to make vast or significant adjustments to improve accessibility. This may be particularly true in terms of adjusting physical features of their practices, such as refurbishing waiting and reception areas or making buildings accessible through the use of ramps, for example. There is a clear need for PCOs to provide advice and support for GPs when they are considering the adjustments that they are able to make. In some circumstances such significant adjustments to premises will not be expected and in other areas of provision finding more simple ways to create greater flexibility in services will significantly help to accommodate people with different access needs. When making or waiting for appointments, for example, GPs and their staff will often work in partnership with a patient to agree suitable arrangements, such as booking double slots or allowing someone to wait outside before their appointment. While GPs may be able to adjust some of their information resources as needed, the BMA considers that PCOs should take a lead on ensuring that accessible information is widely available locally, including the provision of pictorial resources for people with learning difficulties who require them. PCOs should also be responsible for ensuring that all people with significant health needs have access to some form of primary care support. This may mean making specific arrangements for individuals who are abusive or aggressive and therefore cannot be registered with a general practice. They should also, however, support local GPs to ensure that appropriate principles are applied when the decision is taken to remove a patient from a list and when that patient is looking to register with another practice. Identifying health and access inequalities and the barriers that contribute to them is vital. If a disabled person repeatedly has a negative experience within a healthcare setting their expectation of the service that should be offered may fall. Crucially this will affect the level of trust that they have in the people that treat them which in turn may impact on the way they utilise services and could negatively affect their health as a result.

Poor accessibility not only disadvantages the patient but can have a significant impact on service delivery, through lost time and appointments and inefficient service. This is of course true for all NHS users not just those who are disabled. The RNID, for example, estimates that on average missed appointments by deaf and hard of hearing people due to poor communication costs the NHS £20m a year.²⁸ Box 7 illustrates some other examples of the extent to which poor communication negatively impacts upon access to health services by deaf and hard of hearing people.

Box 7: Example findings from the RNID national report into deaf and hard of hearing people's experiences of the NHS

General practice

- 28% of deaf and hard of hearing people found it difficult to contact their GP surgery to get an appointment because of hearing loss.
- 24% of patients had missed an appointment because of poor communication – such as not being able to hear staff calling out their name – 19% of whom had missed more than five appointments.

Secondary care

- 42% of deaf and hard of hearing people who had visited hospital (non-emergency) had found it difficult to communicate with staff. This increased to 66% among British Sign Language (BSL) users.
- 70% of BSL users admitted to A&E were not provided with a BSL/English interpreter to enable them to communicate.

'When I was moved on to a ward the information about my hearing loss was not transferred on to the board above my bed' (hospital patient, Wales)

Source: Royal National Institute for the Deaf (2004) *A simple cure – a national report into deaf and hard of hearing people's experiences of the National Health Service.*

Other diversity groups

In some instances the health and access inequalities experienced by disabled people may be more complex where an individual is also a member of other diversity groups. These may occur because of the specific needs of those communities, such as language, for cultural reasons or because of poor health and healthcare information within those communities. Health promotion activities may not be tailored to or targeted at specific groups. It may also be the case that within certain communities there are specific, unmet health needs or higher incidence of certain impairments. African-Caribbean or South Asian people who live in the UK, for example, are at least five times more likely to have diabetes than the white population.³³

The DRC investigation found that experience varied across different groups of people and that some groups with mental health problems or learning difficulties faced different and sometimes increased or complex barriers within health services. The report specifically mentions problems experienced by children and young people, older people, people from black and minority ethnic (BME) communities and those with multiple impairments.¹¹ In many cases the journey through the healthcare system experienced by certain groups varies greatly as trust, information and attitudes of staff have a significant impact. In highlighting health inequalities the results of the DRC investigation not only demonstrate the need to develop policies and services that target the unmet health needs of people with learning difficulties and/or mental health problems but that within such policy work at local, regional and national levels there is a need to specifically target certain further disadvantaged groups.

Health and access inequalities among disabled people from BME backgrounds have been the subject of a number of other pieces of work which have found similar disparities in experiences. Research carried out in Leeds, for example, found that while there had been improvements in the healthcare experiences of BME disabled people, problems concerning communication, racism and disabling attitudes (both from staff and within their own communities), seemed prevalent.²⁵ A lack of cultural sensitivity within health services was also an observed concern among BME disabled people. Problems of social isolation and lack of information within minority communities are also highlighted as contributing to a lack of familiarity, knowledge and trust, which consequently affects access to services. A 2005 census of inpatient mental health service users was carried out by the Healthcare Commission with the aim of improving ethnic monitoring data in order to provide baseline national information for the first time.³⁴ The findings of this *Count me in* census demonstrated significant inequalities. It showed, for example, that black African and Caribbean people are three times more likely to be admitted to hospital with mental health illness compared with the average for all patients and up to 44 per cent more likely to be detained under the Mental Health Act.³⁴

Lesbian, gay, bisexual and transgender (LGBT) disabled people may also experience health inequalities or access barriers on the basis of their impairment and/or because of their sexual orientation or because they are transgender. The charity Stonewall, which works towards equality and justice for lesbians, gay men and bisexuals, identifies a number of health trends and risk factors within different sections of the LGB community. There is, for example, a high incidence of mental health problems, including depression, among LGB people which can be contributed to by experiences of homophobia, bullying and rejection.³⁵ LGB people may face additional disabling barriers making it hard for them to access mainstream mental health services that are not lesbian and gay friendly or where staff may have judgemental attitudes towards LGB sexual orientation. Alternatively LGB people may access such services but not disclose their sexual orientation, either because they choose not to or because they find it a difficult subject to raise. This could result in inappropriate care being provided or compound the mental health problems that they are having.³⁶ There is significant evidence that there are higher levels of health risk behaviours among lesbian, gay and bisexual populations. Smoking rates, particularly among lesbians, and drug use, particularly among gay men, are higher compared to

heterosexual people.³⁷ The failure of preventive healthcare messages, such as stopping smoking, to engage LGB people means that they are less likely to be receptive to those messages. Stop smoking campaigns that, for example, state that 'smoking makes you unattractive to the opposite sex', do not communicate with LGB people.³⁸ There is also evidence that the sexual health needs of lesbians are sometimes ignored in discussions with health professionals as it may be, wrongly, assumed that women do not exchange fluids during sex and so cannot contract sexually transmitted infections. Lesbians are less likely than heterosexual women to practise breast self-examination or to have cervical smear tests despite the existence of certain risk factors. Disabled LGB people may have further unmet health needs related to these factors. Thus there is an imperative to remove disabling access barriers and a need to target this group specifically. Regard is a national organisation of disabled lesbian, gay, bisexual and transgender people which aims to raise awareness of disability issues within the LGB and T communities, and to raise awareness of sexual orientation issues within disabled communities.³⁹ While transgender people are a very small minority (around 1 in 12,000), it should be noted that they may be equally if not more vulnerable to the impact of disabling barriers where, for example, they have mental health problems. Policies relating to the healthcare support for people going through gender-reassignment are under continual development at present; further information which may be useful for healthcare professionals can be found on the Press for Change website at www.pfc.org.uk

The DDA 2005 includes people living with HIV under the definition of disabled people and thus it is unlawful to discriminate against them in the provision of goods, services and facilities, including healthcare. Stigma and prejudice can prevent people from publicly acknowledging their HIV status; such prejudice or the fear of potential prejudice, can result in people failing to access services or in inappropriate care and support being provided.⁴⁰ It is likely that certain groups will be disproportionately affected by such disabling barriers; for example 43 per cent of those diagnosed with HIV are gay or bisexual men, and 38 per cent are black African.⁴¹

The likelihood of impairment and poor health increases as we get older, therefore the aging UK population will create more challenges in terms of addressing the needs of disabled people. The DRC investigation found some examples of older disabled people experiencing poor physical health and inequalities in access to healthcare, particularly where policies were ineffective or poorly supported within residential care or during longer hospital stays. These included people in supported living finding it difficult to keep GP appointments because support workers are not always available. Evidence was also found of adverse effects of some medication contributing to poor physical health. Anti-psychotic drugs can lead to weight gain and obesity, heart problems, low blood pressure, osteoporosis, seizures, involuntary movement disorders and in some cases sudden death. In recent inspections, nearly half the care homes in England and Wales for older people and younger adults did not meet minimum standards for providing medication.⁴²

It should not be assumed that adjustments made to adult services will be sufficient or appropriate to meet the needs of disabled children and young people, as well as their parents and families. Evidence from the DRC investigation suggested that it is important for service providers to consider the needs of the whole family as this may have an impact on, for example, the need for home visits or altered waiting arrangements.¹¹

In 2006 the BMA published *Child and adolescent mental health – a guide for healthcare professionals* which examines the mental health problems experienced by children and young people aged between five and 17 years and considers strategies for providing care.⁴³ The report highlights a number of practical, social and psychological barriers to receiving appropriate mental health care experienced by children and young people. Practical barriers, such as locations and opening times, mean that service provision needs to be flexible and innovative in order to reach young people. It can be helpful, for example, to combine Child and Adolescent Mental Health Services (CAMHS) with other services aimed at young people such as general and sexual healthcare. Problems relating to the stigma attached to mental health problems can be greatly increased because of a lack of understanding among young people about what mental health is. Stigmatisation can have a negative impact on people's willingness to seek treatment.

Recommendations made in this BMA report include the following.⁴³

- Innovative [mental health] services are needed to meet the needs of young people, and access to such services must be improved. Examples include providing a range of venues that differ from the traditional clinical setting, and easy access to a mixture of services.
- The media should be encouraged to portray those with mental health problems in a positive light, including children and young people.
- Current strategies to address stigma and discrimination against those with mental health problems must be fully implemented. They should be monitored to ensure that they are adequate and effective.

When thinking about adjustments to services for disabled children and young people it is vital that both parents and children are consulted about what might be most appropriate; while ensuring that parental prejudice about disability does not adversely affect the service provision for their children. As well as the needs of disabled children, the needs of disabled parents must also be considered within healthcare service provision. It may be necessary, for example, to adjust maternity services for some disabled people so that information is available in an accessible format. Once a child is born, disabled parents may also need extra support and advice on how they can make appropriate adjustments and how their own impairment may need to be taken into account when considering how they care for their children. Their own access needs will also need to be met when they accompany their child to any healthcare appointments.

4: Breaking down disabling barriers in healthcare

This section of the report identifies some of the ways in which disabling barriers in healthcare can be broken down. While the main focus is on how health and medical professionals can contribute to reducing disabling barriers, initially a brief discussion is given to the strategic and organisational barriers and levers for change. Finally, the important role of disability equality and etiquette^e training is highlighted as an important mechanism for instigating attitudinal change.

Leadership

Leadership by healthcare organisations, senior management and the medical profession is essential if efforts to tackle health outcome and healthcare access inequalities among disabled people are going to be successful. It is vital that there is a stated commitment at the highest possible level and that this is filtered down throughout all healthcare organisations in order that disability equality becomes mainstreamed as a part of the core business values and objectives. Having diversity, or even specific disability, champions or advocates at senior levels within healthcare organisations can therefore help to challenge and change cultural behaviours. Champions are not, however, a substitute for inclusive policies and procedures adhered to by all staff in an organisation, and should not be used to allow others to abdicate their own responsibilities. An important role of champions will be to ensure that healthcare professionals and service providers have access to the appropriate advice and support to assist them in addressing inequalities and advocating that an organisation provides adequate resources, funding and support for any training, information and refurbishments that are needed.

Since 2006 the status of equality and diversity has been significantly promoted within DH activities. Equality and diversity is, for example, firmly placed within the NHS Operating Framework for 2007/08⁴⁴ and all NHS chief executives and boards now have specific objectives relating to equality and diversity. Equality impact assessment and screening is also now systematically carried out and no policy can be disseminated unless this has taken place. The UK health departments and the NHS have a responsibility to ensure all of the independent contractors that they employ, whether they are providing support or healthcare services, have equality and diversity clauses written into their contracts and that they meet the relevant standards.

Tackling health inequalities within the population must be a priority for the DH, the Scottish National Executive Health Department, NHS Wales Department and the Northern Ireland Department of Health, Social Services and Public Safety. This is also true for regional organisations such as SHAs, health boards, local health boards and health and social services boards (Northern Ireland). Given the stark health and access inequalities that exist among some disabled people, and the impact that these can have on other parts of their life, addressing disability inequalities in particular must be prioritised and mainstreamed. The DH response to the DRC formal investigation and the Mencap report *Death by indifference* (2007) has shown that there is a commitment at this level to look at health service provision for a group of people that evidence shows is often the most poorly served and valued by the health service. In March 2007 the Secretary of State for Health ordered an independent inquiry looking at the matters around the standards of care for people with learning difficulties. The DH has also published a response and action plan following the DRC investigation which allocates actions relating to each of the DRC recommendations to different departments within the DH to be carried out in 2007.⁴⁵

^e Etiquette is used in preference to awareness. Awareness is always useful but it is mainly about knowledge. 'Etiquette' is about what staff actually do in practice when seeking to provide equality of service outcomes for disabled people generally or for those with specific impairments. (GB Disability Training and Consultancy (2007) *A National Framework for Disability Equality & Etiquette Learning (DEEL) for Health and Social Care Services*. Launched by the DRC and DH.)

On a very practical level the BMA would like to see PCOs providing more advice and support to GPs as they make adjustments to their services, policies and procedures that will help to promote disability equality. In particular, it must be acknowledged that some practices, especially smaller ones, may find it very difficult to make physical adjustments to make their premises more accessible. This may either be because their existing premises are designed in a way or are too small so that such refurbishments are unworkable; because the resources and funding needed to make the adjustments are not available; or because it is not possible to carry out the work without causing disruption to the services that they provide. PCOs must take a lead role in supporting premises development in their locality as this can have a significant impact on the accessibility of healthcare services for disabled people.

In order to maintain momentum in this area it is critical that the CEHR is able to effectively build on and take forward the health and independent living area work that has been developed by the DRC, when it formally assumes its responsibilities in October 2007. The BMA would, for example, like to see the CEHR take a lead and offer guidance on matters surrounding the collection of monitoring data on disability, including having such data broken down according to impairment type.

The duties of a doctor are formalised in the GMC document *Good medical practice (GMP)* which includes entries about how doctors relate to patients and the need for good communication. A recent example of leadership by the DRC, is the work they have done with the GMC to produce supplementary guidance to *GMP* which draws out the specific implications for disability equality which permeate throughout the document. In recognition that a doctor's duty to promote disability equality in their work goes beyond how they communicate and the relationships they have with patients, practical guidance for doctors on a significant number of the statements within *GMP* are included.⁴⁶ An example of this is given in appendix 3. This guidance is available on the DRC website, www.drc-gb.org

Leadership from within the medical profession is also vital. As the trade union and professional body for doctors the BMA is able to use its position to contribute to healthcare policy. The BMA recognises the importance of addressing disability inequality and the impact that healthcare professionals can have both directly through changes in behaviour and values among those involved in service provision and by influencing policy and procedures to help reduce and remove disabling barriers. The mechanisms within the new GP contract are used to recognise the high standards of care within general practice. The ability of practices to opt to provide additional enhanced services is a mechanism which could be used to promote equality of health outcomes among disabled people. There is some evidence, for example, that annual health checks for people with learning difficulties can result in improved health outcomes for this group; provided that relevant resources and funding are available from primary care contracting bodies this is an enhanced service that GPs may choose to provide for these patients. The BMA will continue to engage with the DRC and the DH on these matters during contract negotiations.

The BMA believes that improving the provision and availability of effective disability equality and etiquette training for all healthcare and medical staff is essential. The association urges those involved in development and delivery of curricula within medical schools, postgraduate deans and medical royal colleges to recognise the need for such improvements within medical education and training, particularly in light of the increasing prevalence of long-term conditions and the inequalities within the population. Both the GMC and the Postgraduate Medical Education and Training Board (PMETB) should also ensure that disability equality is a highlighted theme within curriculum standards that they set for undergraduate and postgraduate medical education respectively.

At an individual level medical professionals must acknowledge the impact that they can have on promoting disability equality, tackling discrimination and removing disabling barriers within healthcare services. Campaigning work from medical professional organisations will be vital in empowering individual doctors to tackle disability equality.

Commissioning healthcare services

Commissioning healthcare services in the NHS is a process where a PCT or practice contracts another organisation to provide a service on its behalf. For example, a PCT could commission a GP practice or hospital trust to provide a certain service and, similarly, a GP practice could commission another provider to undertake a certain service for its patients. Commissioning is also referred to as procurement.

The health sector has enormous purchasing power and commissioning is an inherent part of the functions of health service providers.²⁴ As such, commissioners in the health sector should ensure that due regard is given to disability equality and the requirements of the DDA and the general DED. All contracts with commissioned bodies should include a requirement to comply with the provisions of the DDA and should clearly identify what evidence is needed to demonstrate compliance.¹⁵ The DRC has produced guidance for all public sector commissioners which considers the implications of the duty for procurement and outlines a step-by-step guide to help them comply with the duty throughout the procurement process.⁴⁷ Appendix 4 summarises some of the DRC's key guidance points for supporting commissioning in healthcare.

The effective commissioning of services can be a vital lever for change in improving services for disabled people. The crucial role of commissioning is acknowledged by the DH in their response to the DRC formal investigation⁴⁵ and is supported in the NHS operating framework which says PCTs should 'review how commissioning should be tailored to meet the needs of disabled people, people with learning disabilities, people from black and minority ethnic communities, and people from different gender, sexual orientation and age groups'.⁴⁴ The DH is also currently developing a commissioning capability framework, which represents a significant opportunity to improve the service provision for disabled people. Successful commissioning, however, along with implementation of the duty, are both dependent on good quality, comprehensive information about the full range of actual and potential patients or service users. Monitoring data are essential to be able to identify where health inequalities and problems with accessing health for disabled people might exist. It is also impossible to ignore the importance to promote the involvement of disabled people in the development of services. This can have two positive effects, by providing both the voice of service users, or potential users, and to hold the organisations who commission services accountable for achieving greater equality.²⁴

Organisational and environmental disabling barriers

A number of organisational and environmental disabling barriers in healthcare can be identified from the discussion about access inequalities in section 3 of this report. Such disabling barriers can include:

- lack of information in a format that is accessible within health services
- poor access to buildings and facilities
- lack of appropriate facilities
- inappropriate systems: eg appointments procedures, inability to record access needs permanently in secondary care
- poor linkage and information between different services
- poor attitudes of some healthcare staff
- poor health education and information within the community.

Most of these barriers are influenced by inappropriate policies and structures at an organisational level within health services. Policies on patient communication and information systems, linkage between services and premises and building facilities are the responsibility of all NHS organisations. Now that these organisations are required to implement a Disability Equality Scheme, they will all need to demonstrate how such considerations have been integrated into their planning. As part of their remit, for example, SHAs have a monitoring role in relation to ensuring that equality and diversity objectives are delivered by health service providers. The BMA believes that this role should be actively pursued by SHAs, particularly in relation to disability equality.

So, how can healthcare organisations break down these organisational and environmental disabling barriers? One important aspect is to listen to what disabled people say that they want from health services and about how they want to be treated. Engaging disabled people in planning, policy and service delivery is an essential requirement of the DED. In accordance with the legislation, disabled users and groups must participate in the production of each public healthcare organisation's Scheme.

A study published by the Joseph Rowntree Trust in 2004 called *One town for my body, another for my mind* looked at the support needs within health, rehabilitation, mental health and social care services for people with both mental health problems and physical impairments.⁴⁸ This research demonstrates the importance of consulting directly with disabled people as part of service planning. The report finds that there is often a disjointed service across, and poor communication between, different healthcare settings and that services rarely address needs relating to both mental health and to physical impairment. Box 8 lists the six characteristics of services identified in this study as being those that people felt would meet their needs.⁴⁸

Box 8: What do people want from services?

- recognition of access needs
- recognition of the impact of impairment and disabling barriers
- being treated as a 'whole person'
- flexible services that respond to individual and changing needs
- being listened to and treated with respect
- easy access to services, including preventative and early intervention services.

Source: Morris J (2004) *'One town for my body, another for my mind', Services for people with physical impairments and mental health support needs*. London: Joseph Rowntree Foundation.

As well as asking disabled people what they want from health services the BMA considers it to be vital that population data are collected at a local level regarding the health needs and outcomes of disabled people. The results of the DRC investigation give an indication about what type of data it would be useful to collect. Information, for example, on smear tests and the incidence of diabetes among different groups of disabled people would be very useful for local health services to have. It may also, for example, be useful for a PCO, NHS trust or health board to know how many people in the local area who are deaf or have a hearing impairment would benefit from having a sign language interpreter or other communication support available at a consultation. These data are needed in order to assist with planning and commissioning services for the local population and also to evaluate progress and identify barriers which may not have been broken down. Such data will also help the development of targeted health promotion initiatives.

Information on the health and access needs of local disabled people should be used to improve service design and delivery in line with the social model of disability rather than the traditional model. Treating disabled people according to the traditional model is unsatisfactory as the emphasis is on the condition and on finding the causes and cures. Impairments are often permanent and thus the incurability of the impairment can become the focus within this model and this can prevent the disabled person from getting on with their life and can cause frustration among the healthcare practitioners involved in treatment and care. It must be appreciated that the physical, mental and emotional impact of an impairment on a disabled person is not static and will affect different people in different ways in different situations. If services are designed along the lines of the social model of disability the dynamic relationship between the doctor and patient becomes more important and there will be a greater emphasis on working in partnership to find positive ways to improve the life of the disabled person.⁴⁹ Further in-depth discussion of the ways in which organisational disabling barriers in healthcare can be broken down is beyond the scope of this report. For further information and detailed recommendations see the DRC report of their formal investigation into health inequalities.¹¹ While it is important that services are flexible and that changes in attitudes must accompany all other adjustments, there are a number of reference resources which show the sort of adjustments that should be made within health services and by those working in the NHS. The Scottish Consumer Council, for example, has produced a short 'dos and don'ts' checklist which covers communication, the importance of consulting with disabled people, training and meeting the needs of different groups.⁵⁰ Two guidance documents called *You can make a difference* have also been jointly produced by the DRC and the NHS; one looks at hospitals and the other is for primary health services.^{51, 52} They include information for staff as well as ideas about how to improve the journey of disabled people through NHS services. Appendix 5 gives some examples from the two documents. Useful guidance for GPs about how they can fulfil the requirements of the DDA 1995 has also been produced by the BMA and can be found on the website at www.bma.org.uk

Staff attitudes and communication skills

In addition to organisational, logistical and physical disabling barriers a recurring theme in many commentaries is the extent to which poor attitudes and communication skills among healthcare staff has a negative impact on the experiences of disabled users. This is applicable to all NHS staff and members of the medical team including receptionists, healthcare assistants, and nurses, as well as doctors. Some examples have already been mentioned in this report, and many more are evident from research. While barriers relating to attitude and communication skills are in many ways linked, they do not always show up in the same way or cause the same problems. NHS employers and GP partners, as independent contractors, must bear in mind that they are required under the DDA to make reasonable adjustments in order to provide an equitable service to disabled people. While some physical and organisational adjustments may take time and resources, adjustments in attitudes and communication methods are often simple to implement and may in fact only require some staff training, as well as the will to make the changes. The example set by senior staff is of great importance in enabling cultural change to be permanent within an organisation.

Communication barriers are often not related to individual staff members but may be the result of poor planning or a lack of resources. For example, the absence of a permanent or portable induction loop in a GP practice or on a hospital ward, the lack of Easy Read information or the absence of talking maps in a hospital will in most situations be out of the control of an individual healthcare worker. On the other hand, the failure of a GP or receptionist to go directly over to a deaf patient when it is time for their appointment rather than just shouting out into the waiting room is the responsibility of the individual member of staff and is easily rectified. While it is not expected that all healthcare professionals should be proficient in different communication techniques, it is their duty to

consider that a service user may have particular communication needs and to find out what these are where necessary. In many cases communication barriers could be broken down if patients were able to record their needs permanently on their healthcare record; indeed this is true of all access needs.

Research shows that poor attitudes among workers within the health sector can contribute significantly to disabled people feeling isolated, disempowered and disengaged with healthcare services.^{11, 25, 29, 48} When thinking about poor attitudes toward disabled people, the sort of problems that might exist include:

- not acknowledging the existence of disabling barriers within the health service
- not realising that in order to achieve equal outcomes it is often necessary to treat people differently, by making adjustments
- making assumptions about someone's wishes, about what is best for them or about how capable they are of making their own decisions
- not listening to someone nor seeing beyond someone's impairment
- patronising a disabled person because of their impairment
- speaking directly to someone's personal assistant or interpreter rather than to them.

*'The biggest experience of discrimination I have had is by able bodied people. They decide what is good for you and what is not good for you, and I'm thinking "sod it, I'll do what I need to do"'*²⁵

*'As far as the diabetic clinic goes, initially I wasn't very happy. I think the typical doctor's scenario of "I'm telling you do this", and it's a very talking down kind of attitude. How can you know better than us? We know better than you. It's my body, I'm living with it every day, I know what happens.'*²⁵

Poor listening and communication by healthcare professionals can also increase the likelihood of diagnostic overshadowing. Patient care is more effective when a more holistic approach is adopted which enables a healthcare professional to look beyond a person's impairment and therefore open up communication by working in partnership with the patient.

Disability equality training in medicine

Organisational change is certainly needed if the health and access inequalities experienced by disabled people are to be addressed effectively. The BMA urges that such changes are implemented and sees the introduction of the DED as an ideal opportunity for the needs of disabled people to be integrated into healthcare planning and policy decisions. In addition to organisational change, the BMA believes that there is a considerable need to incorporate disability equality and etiquette learning into both undergraduate and postgraduate medical education. In order for this to be effective and appropriate, it is essential to recognise the best practice principle of involving disabled people in the development and delivery of disability equality training. It is also vital that organisational support and funding is provided for the implementation of training for all staff that deal with patients, not just healthcare professionals. Given the importance of primary care in tackling health and access inequalities of disabled people, PCOs should consider how they can best support GP practices while training programmes are implemented, this may include supporting cover arrangements while some staff are out of the office so that services are not disrupted.

Through a lack of engagement with disability equality, doctors can contribute to the discrimination, social exclusion and stigma experienced by disabled people.⁵³ A 2005 discussion article in *Medical Education* describes how 'one of the barriers often cited as contributing to the health inequalities experienced by disabled people concerns the personal attributes of healthcare professionals. These include discriminatory attitudes and a lack of appropriate knowledge and skills due to deficits in education and training'.⁵³

It is vital that the medical workforce is informed about the needs of disabled people, including those with hidden impairments, and that they treat people with respect and work in partnership with disabled people and personal assistants.²⁶ The 1997 report of a survey of the educational needs of health and social service professionals by the Disability and Rehabilitation Open Learning Project found considerable learning gaps among healthcare professionals when it came to meeting the needs of disabled service users.⁵⁴ Accompanying this was dissatisfaction among disabled people and their families with the quality of service and the attitudes of healthcare and social service professionals. Disabled respondents to this survey also felt that health professionals needed to improve their communication and coping skills and that there should be greater emphasis on behavioural skills, as well as clinical ones. When forced to think honestly about their skills healthcare professionals came to recognise the shortcomings in their skills base:

*'Professionals' initial response to their education needs is that they want to improve their clinical skills and knowledge. Yet in small group interviews, GPs in particular mirrored the views of the [disabled] users in recognising that they have neither the skills nor knowledge to deal with complex human behaviour and emotions. Neither can they cope with the feelings of inadequacy and failure they often experience when faced with the reality of chronic conditions and disabilities for which they can provide neither relief nor cure.'*⁵⁴

The DRC also identifies poor disability awareness among healthcare professionals as a significant disabling barrier. One of the recommendations made by the report of the DRC formal investigation into the physical health inequalities experienced by people with learning difficulties and/or mental health problems is that the governments in England and Wales should 'spearhead (with partners) medical and nursing training that explicitly tackles "diagnostic overshadowing" and unequal treatment at undergraduate, postgraduate and continuing professional development levels. They should provide incentives for training through the GP appraisal system'.¹¹ This recommendation is echoed by NHS Scotland who concluded that the learning difficulties component of all pre-registration healthcare professionals' training should be reviewed and developed, building on an existing competency framework.²⁶

Medical education has, for a long time, been dominated by teaching about the causes and cures of acute disease.⁵⁵ As the population ages and the pattern of healthcare needs shifts towards chronic disease and long-term impairments, however, it is vital that medical education incorporates such trends.⁵⁶ In addition to learning about the medical aspects of long-term conditions and impairments, healthcare professionals must be equipped with the skills and knowledge in order to assist people in living their lives with their impairments. As with service delivery, (see previous section) the BMA considers that in order for disability equality and etiquette training to be effective in enabling healthcare professionals to understand and move towards meeting the needs of disabled people, the social model of disability should be integral to its design. Using the social model in teaching should enable medical professionals to use their knowledge, skills and expertise to identify positive ways to improve the life chances of disabled people.⁵⁷

Disability equality and etiquette training should address some of the practical aspects of communicating with and meeting the access and health needs of disabled people. Such training should enable increased disability competence among doctors and other healthcare professionals. Disability competence is not, however, just about understanding practical access issues but is also about treating all patients with respect, not making assumptions about how someone wants to be treated and being able and willing to ask questions when necessary. This type of skill can also be learned through broader equality and diversity training rather than that specifically focused on disability. The BMA considers that there is a need for improved diversity training within the undergraduate medical curriculum and through into postgraduate education and continuing professional development. Increased understanding by healthcare professionals about the diverse needs of the population is vital in order to maintain high standards of care and health outcomes of patients. The use of strong positive disabled trainers to deliver courses can help to address the anxiety felt by healthcare professionals who may not have had much experience with disabled people.

Undergraduate education

Disability is a core theme in undergraduate medical education. The GMC document *Tomorrow's doctors* sets out the curricula outcomes, content, structure and delivery methods for undergraduate medical students in the UK.⁵⁸ One of the content areas covered is disability and rehabilitation, which includes knowing about the rights of disabled people and about managing chronic disease. Another content section covers communication skills and requires graduates to be able to communicate effectively with individuals regardless of their impairments (see appendix 6).

While disability is a recognised theme in the undergraduate medical curriculum the way in which it is taught and incorporated into medicine courses varies widely across different medical schools in the UK. Studies of undergraduate teaching have identified a need for an improved approach to teaching of disability, and in particular, teaching about the psychological aspects of chronic illness and the need for a multidisciplinary approach.⁵⁹ A review of the teaching of disability and rehabilitation in the UK found that teaching was patchy, sporadic and rarely had clearly defined aims and objectives.⁶⁰ The attitudes of medical students reflect the concepts of disadvantage and dependence on the traditional model of disability. A study which for example explored the words which medical students related with the term 'disability' found that it was predominantly associated with depersonalised or negative words, and that a short course on disability appeared to change these associations.⁶⁰

While teaching is patchy there have been a number of innovative projects aiming to develop curricula that engage students in the subject of disability, find ways of exploring the social model of disability and ways to challenge students' perceptions of disabled people.⁵⁵ A common theme of such initiatives is that they involve disabled people directly, either as teachers, in curriculum development and/or through direct contact with disabled people's lives. Box 9 describes two case studies, one from the University of Bristol Medical School and one from Leicester University.

Box 9: Teaching about disability to undergraduate medical students

- **Enabled by disabled people**

Medical students in Bristol participate in a four-day programme which uses disabled trainers to deliver and evaluate the course. Students are required to use a problem solving approach to develop understanding and an appreciation for the different communication skills that are needed.

- **Learning from lives**

An alternative approach in Leicester, involves third year students completing a one-month placement, including an induction week led by a disabled trainer and a length of time working within a rehabilitation setting. Students are encouraged to challenge the importance of disability equality and the differences between the medical and the social models.

Source: Dieppe P, Anderson E, Byron M et al (2006) Teaching doctors about disability. *BMJ Careers Focus* **333**: 113-5.

The Health Council of The Disability Partnership has produced the booklet *One in four of us – the experience of disability* which can be used in undergraduate medical education.⁶¹ This booklet uses examples to help to present a disabled person's perspective, particularly how they might feel in a scenario in which they cannot access services or in which they experience someone's negative or discriminatory attitude.

Maintaining disability competence

Having graduated from medical school it is vital that doctors regularly update their knowledge and skills relating to disability competence. This is necessary to ensure firstly that they understand any changes in the law and appreciate the rights of disabled patients and secondly so that they are able to maintain high standards of patient care and are able to effectively respond to changes among their patient populations. As the incidence of chronic disease continues to increase over time, an applied practical understanding of disability equality and etiquette among the medical profession will become even more essential.

Doctors in training

Modernising Medical Careers (MMC) has responsibility for setting the curriculum for doctors in the first two years after graduating from medical school, during foundation years 1 and 2. Good communication skills form a significant part of the core competencies that newly qualified doctors are expected to demonstrate. In addition to this there are a number of specific references to understanding the needs of disabled patients; these all fall under the core competencies expected of foundation year 1 doctors (see appendix 7).

During specialist and general practice training it is the different medical royal colleges which determine the curricula in accordance with the standards set by the PMETB. It is important that diversity awareness, including that of disability, is included in specialist training and royal colleges should incorporate it into examinations and assessments. Given that experiences in primary care can have such an impact on a disabled person's perception of health services it is encouraging that the GP training curriculum contains specific sections on the care of people with mental health problems and on the care of people with learning difficulties, and another on promoting equality and valuing diversity.⁶² Another important example is the specialist training curriculum developed by the Royal College of Ophthalmologists in which the concept of being able to recognise and assist people with impairments and in particular people with sight impairments is highlighted in a number of the different learning outcome areas, including communication, practical skills and attitudes and ethics.⁶³

The Royal College of General Practice has also formally endorsed a learning pack for GP trainers developed by the DRC as a follow-up action to the *Closing the gap* formal investigation. The learning notes accompany a DVD produced by the DRC, and can be used in conjunction with task sheets to enable facilitators to design a training session which will help practitioners meet their duties and improve services for disabled people.⁶⁴ The RCGP has been involved in the dissemination of these notes to GP trainers which are also available on the DRC website.

Continuing professional development

All doctors have a duty to maintain their knowledge and skills and to engage in continuing professional development (CPD) activities throughout their careers and as a requirement of annual appraisals. The BMA believes that more CPD courses covering areas of diversity should be made available. It is vital that in covering disability, courses do not simply focus on the medical aspects of conditions and impairments but that the social model is used to inform learning related to communication and attitudes of health professionals.

Disability equality and etiquette training in practice

While curricula and other professional guidelines require that doctors maintain good communication skills and are competent when dealing with the needs of different patients, including disabled people, there has been little practical guidance on how such training should be delivered. It is only recently that useful frameworks looking at the content and outcomes of disability equality training have been developed. One thing that is clear within such frameworks is the significant level of active involvement

by disabled people, in terms of curriculum development and delivery and evaluation, required to ensure the effectiveness and credibility of true disability equality and etiquette training.

Different differences

A research group called Partners in Practice (PiP) published *Different differences* in 2005, a document which outlines a framework for developing and delivering curricula for teaching about disability to medical students, doctors, nurses and allied health professionals as well as other front line NHS staff.⁶⁵ The framework was developed through a consultative process by a group which included a high proportion of disabled people. Some of the key findings of this PiP research include:

- there is a need for champions at a senior level within higher education institutions to endorse the credibility of the disability equality message
- disability education should be developed around the social model and should also give participants opportunities to focus on practical ways to remove and recognise disabling barriers
- using disabled tutors has a powerful impact on students.⁶⁵

One very useful part of the framework is a list of 15 essential disability equality learning outcomes. These provide ways of assessing and evaluating the effectiveness of any training. The outcomes include:

- recognise the rights of disabled staff
- recognise that disabled people's particular health needs may not be related to their impairment
- a recognition that not all problems have a medical solution
- an ability to see a disabled person as capable of making rational life decisions.⁶⁵

National Framework Disability Equality and Etiquette Learning (DEEL)

Another such framework, and one which has the potential to prompt significant progress in this area, has been developed by a reference group run jointly by the DRC and the DH, of which the BMA is a member. The National Framework for Disability Equality and Etiquette Learning (DEEL) was launched in Spring 2007. It provides a single point of reference for those within health and social care seeking to provide systematic and comprehensive training and education in this field. The DEEL framework aims to develop a learning structure which will provide outcomes that:

- represent best practice in disability equality
- meet the legal requirements of disabled people; and
- ensure high quality services to health and social service users.⁴⁹

The framework has been established in order to help healthcare providers to fulfil their duty under the DDA 2005 and to help them to demonstrate disability competence among their staff and within their services. The framework is not prescriptive in terms of content or method of learning; rather it describes three outcome levels which each imply a different level of disability competence (see box 10).

Box 10: Outcome levels from DEEL

- A **Novice** level denotes at least some systematic introduction to disability equality and that staff understand that disabled people have a legal right to equality of service outcome.
- A **Learner or Improver** level denotes that staff are acquiring the ability to assist disabled people with greater confidence and where they need to go to for additional advice or resources.
- A **Competent or Champion** level where staff can demonstrate that they not only avoid discrimination towards disabled people, but that they can influence policies, practices and procedures within the organisation, and tackle and remove barriers.

Source: GB Disability and Training Consultancy (2007) *A National Framework for Disability Equality & Awareness Learning*. Launched by the DRC and DH.

The three levels of DEEL outcomes are illustrated within the context of health and social care in seven areas:

- understanding disability
- implementing disability equality
- the role of services
- general disability etiquette
- impairment specific disability etiquette
- carer issues
- protection of disabled adults.

Under each section there are a number of indicators each with a corresponding example for each outcome level. The table below shows an example indicator from three of the different areas.

The framework is meant as a living document and will continue to be adapted to reflect good practice as it develops further. It is also hoped that a resource section listing courses which fit the DEEL framework will be added as a useful reference for individuals or organisations seeking appropriate training opportunities. It is accessible from the DRC and the DH websites, and from October 2007 will be found on the CEHR website.

Table 1: Example indicators from the National Framework of Disability Equality and Etiquette Learning

	Novice	Improver	Competent
Understanding disability:			
The social model of disability – barriers	Can identify barriers that disabled people may experience when accessing services	Treats the barriers as the problem, rather than the disabled person	Able to identify and effectively challenge barriers that are attitudinal, institutional or environmental/physical This includes communication and access to information
Implementing disability equality:			
Personal awareness of the disability competency of organisation and colleagues	Becoming aware of good and bad practice	Able to clearly identify good and poor practice including barriers and solutions	Able to promote best practice and to challenge poor practice
The role of services:			
Understanding the role of medical services	Understands the negative effects of the pressure on disabled people to be cured	Recognises disabled people must be involved in making decisions about their healthcare – using advocates if necessary	Offers disabled people choice and control over possible medical interventions, explaining benefits and risks

Source: GB Disability and Training Consultancy (2007) *A National Framework for Disability Equality & Etiquette Learning*. Launched by the DRC and DH.

The DRC is also working with Skills for Health to map these competences to National Occupational Standards. Skills for Health is an organisation which works with healthcare employers to ensure that staff are equipped with the right skills to support the development and delivery of healthcare services.⁶⁶ It is hoped that the DEEL framework will be used during the development of educational tools and training programmes, whether they be specifically on disability or more generally about equality and diversity or perhaps on the topic of communication skills. The BMA is keen that a greater portfolio of training on subjects relating to equality and diversity, disability competence and communication skills should be available to doctors throughout their careers. This should take the form of CPD but should also be incorporated into formal specialist training and assessment. The BMA welcomes the DEEL framework and believes that it will be a useful tool for educational development. The association hopes that medical schools, postgraduate deans and royal colleges, as well as NHS organisations, will take a lead and utilise the DEEL framework when developing curricula and training relating to disability equality and etiquette.

5: Recommendations

The following recommendations highlight key measures needed to address inequalities in access to healthcare and health outcomes experienced by disabled people. In particular, they include actions which can be taken by the medical profession as well as healthcare organisations, service providers and education developers and deliverers.

Disability equality in healthcare

- The BMA, the medical royal colleges and the GMC should promote the use of the social model of disability in service planning and in medical education, training and practice. The medical profession should take a lead role in actively promoting disability equality in healthcare service provision.
- Diversity champions, or specific disability champions, at senior levels within primary and secondary care organisations should help to ensure that a culture of promoting disability equality permeates throughout the NHS. They should promote the importance of having a flexible approach and of engaging with disabled individuals and groups representing people with impairments. They should act as a point of reference for employees and contractors and ensure that appropriate advice and support are provided.
- Public health and health promotion campaigns should engage with disabled groups and be adapted to target different diversity groups, particularly where specific inequalities are identified.
- All service providers should consider ways to improve the whole patient journey through healthcare for disabled people and ways to engage all members of the healthcare team in tackling disability inequalities.
- All service providers should record the access needs of their disabled patients so that staff are aware of what particular arrangements are needed.
- Primary care has a vital role in promoting equality of access and equality of health outcome for disabled people, effective engagement with disabled is an imperative. GPs and practice managers should make sure that consideration is given to what adjustments may be needed and how practice policies and procedures may be more flexible in meeting the needs of disabled patients.

Education and training

- NHS employers should make sure that all healthcare and medical professionals, as well as other front line staff working in the health service, are given the opportunity to receive disability equality and etiquette training. This could be learning to National Framework DEEL novice level.
- Contracting bodies in primary care should support GPs and practice managers in providing an opportunity for all members of staff, including receptionists, to receive training in disability equality and etiquette. This could be learning to National Framework DEEL novice level.
- NHS employers and contracting bodies should ensure that all staff involved in developing and monitoring the implementation of an organisations' Disability Equality Scheme together with all diversity champions should receive necessary training which is appropriate to National Framework DEEL competent level.
- The GMC should promote more consistent teaching within undergraduate medical curricula which is based around the social model of disability and, where possible, uses disabled tutors. Teaching should highlight the concept of disabling barriers and the need for a more holistic approach to treating patients with impairments.
- The PMETB, medical royal colleges and education deliverers should develop standards for, and guidance on, the delivery of disability equality and etiquette training within postgraduate medical education. The DEEL framework should be adopted as a disability competence framework to underpin all training related to disability in postgraduate medical education.

- The GMC, the PMETB, medical royal colleges and education deliverers should ensure that the content and learning outcomes of disability equality training are evaluated and that assessment is meaningful. Disabled people should be involved in the development and, where possible, in the delivery of courses.
- The medical royal colleges should encourage further development of continuing professional development courses and materials relating to disability awareness and equality.
- The BMA and the royal colleges should encourage their members to participate in continuing professional development activities which will help to improve and maintain a doctor's disability competence.

Implementing disability discrimination legislation

- National health departments should carry out equality impact assessments of their healthcare policies to ensure that the rights and needs of disabled people are taken into account within central healthcare planning and initiatives.
- Healthcare organisations responsible for planning and commissioning local healthcare services should ensure that the needs of disabled people in their area are fully considered. The legal requirements of the DDA 2005 should be used to provide a framework to facilitate a more holistic approach to promoting disability equality in healthcare services.
- Disability Equality Schemes produced by healthcare organisations should make specific reference to how inequalities in health outcomes and access will be tackled. Policies should continue to be evaluated and revised over time, and in conjunction with disabled people. It is important that the processes underpinning each Scheme are transparent and that senior staff are accountable for delivering improvements.
- SHAs in England, health boards in Scotland, local health boards in Wales and health and social care boards in Northern Ireland should collect regional data on the health and access needs of disabled people within local populations. These data should be broken down by impairment and other diversity strands. They should be used by commissioners of healthcare services to inform appropriate service provision.
- Effective performance management mechanisms should be put in place to monitor progress on disability equality. SHAs, health boards, local health boards and health and social care boards should monitor healthcare organisations in their region to assess whether they are compliant with the general and specific duties placed on public bodies by the DDA 2005. They should maintain an overview on matters relating to equality and diversity within healthcare and ensure that national standards and priorities are met.

Appendix 1: Overview of disability discrimination legislation in Great Britain

The Disability Discrimination Act 1995 (DDA 1995) makes direct discrimination on the grounds of disability unlawful in Great Britain. The DDA 1995 was amended by the Disability Discrimination Act 2005 (DDA 2005).

The DDA 1995 prohibits discrimination on the grounds of disability in relation to employment, education and the provision of goods and services. Under the DDA 1995, discrimination occurs where:

- a disabled person is treated less favourably than someone else
- the treatment is for a reason relating to the person's disability
- the treatment cannot be justified.⁵⁶

According to the DDA 1995 a person is disabled if they have:

- a mental or physical impairment
- this has an adverse effect on their ability to carry out normal day-to-day activities
- the adverse effect is substantial
- the adverse effect is long lasting (meaning it has lasted for 12 months, or is likely to last for more than 12 months or for the rest of their life).⁸

The DDA 1995 covers physical, learning and mental impairment. When referring to 'normal day-to-day activities', at least one of the following must be affected:⁸

- mobility
- manual dexterity
- physical coordination
- continence
- ability to lift, carry or move everyday objects
- speech, hearing or eyesight
- memory or ability to concentrate, learn or understand
- understanding the risk of physical danger.

The DDA 2005 extended this legal definition of a disabled person to include people who are effected by long term conditions. For the majority of progressive conditions, a person will be regarded as having an impairment the moment their condition has some effect on their ability to carry out at least one of the above activities. Those with cancer, HIV infection or multiple sclerosis are considered to be disabled from the point of diagnosis.

The DDA 1995 places a duty on employers and educational institutions to make reasonable adjustments to ensure that disabled people are not placed at a substantial disadvantage in comparison to non-disabled peers and colleagues.^f Service providers must also make reasonable adjustments for disabled people and are required to take steps to:

- change any practice, policy or procedure which makes it impossible or unreasonably difficult for disabled people to make use of their services
- provide an auxiliary aid or service if it would enable (or make it easier for) disabled people to make use of their services.⁹

^f For further discussion of the employment and education requirements of the DDA in relation to the medical profession see Disability and the medical profession (BMA, 2007).

⁹ Indirect discrimination on the grounds of disability is not recognised within UK law. All discrimination on the grounds of disability is considered to be direct discrimination.

Where a physical feature makes it impossible or unreasonably difficult for disabled people to make use of services, a service provider also has to take reasonable steps to:

- remove the feature; or
- alter it so that it no longer has that effect; or
- provide a reasonable means of avoiding it
- provide a reasonable alternative method of making the service available.⁷

If any organisation covered by the DDA 1995 fails to make a reasonable adjustment for a disabled person and that failure cannot be justified this will be considered as direct discrimination within the law.⁷

The DDA 2005 establishes the Disability Equality Duty (DED) which came into effect in December 2006. Under the general duty, all public bodies are required to actively promote disability equality. Further, the specific duties, which apply to those specific public bodies listed in the regulations, requires that a Disability Equality Scheme must be developed, published and implemented setting out how the organisation will promote disability equality. Disabled people must be involved in producing a Scheme and the related action plan. Public bodies are required to demonstrate that they have taken the actions outlined in the Scheme and achieved appropriate outcomes. They must report on progress and review and revise the Scheme in order to promote disability equality.

The Disability Rights Commission (DRC) is an independent body, set up by the Disability Rights Commission Act 1999 to stop discrimination and promote equality of opportunity for disabled people. It has been the role of the Commission since 2000 to supervise and advise on the implementation of disability discrimination legislation.

From October 2007, the responsibilities of the DRC will be transferred to the Commission for Equality and Human Rights (CEHR). The CEHR was established by the Equality Act 2006. This new Commission will also assume the responsibilities relating to gender and race equality, as currently held by the Equal Opportunities Commission (EOC) and the Commission for Racial Equality (CRE) respectively. The CEHR will also cover areas of equality relating to age, sexual orientation, religion or belief and also human rights.

Appendix 2: Northern Ireland disability discrimination legislation

While the DDA (1995) and each of the other anti-discrimination acts apply to Great Britain, separate legislation and Codes of Practice are required for Northern Ireland. In Northern Ireland, the DDA 1995 is amended by the Disability Discrimination Act 1995 (Amendment) Regulations (Northern Ireland) 2004, the Disability Discrimination (Northern Ireland) Order 2006, the Special Educational Needs and Disability (Northern Ireland) Order 2005 and the Special Educational Needs and Disability (Northern Ireland) Order 2005 (Amendment) (Further and Higher Education) Regulations (Northern Ireland) 2006. The Equality Commission for Northern Ireland (ECNI) was established as an independent public body under the Northern Ireland Act 1998 to work towards the elimination of discrimination, promote equality of opportunity, and review relevant legislation.⁶⁷ The duties and powers of the ECNI were extended in relation to disability matters following the introduction of the Equality (Disability, etc) (Northern Ireland) Order 2000 (EDO). This requires the ECNI to:

- work towards the elimination of discrimination against disabled people
- promote the equalisation of opportunities for disabled people
- take steps to encourage good practice in the treatment of disabled people
- keep the DDA 1995 and part II of the EDO under review
- assist disabled people by offering information, advice and support in taking cases forward
- provide information and advice to employers and service providers
- undertake formal investigations
- prepare statutory codes of practice providing practical guidance on how to comply with the law
- arrange independent conciliation between service providers and disabled people in the area of access to goods, facilities and services.⁶⁸

Section 75 of the Northern Ireland Act 1998 requires public authorities to have due regard to the need to promote equality of opportunity between persons with a disability and persons without.¹¹⁸ Any public authority is duty bound to produce an equality Scheme stating how it proposes to fulfil its duties, and is required to carry out an equality impact assessment and publish the results. Public authorities must also undertake a consultation process that is inclusive of any individuals likely to be affected by the equal opportunities policy. The DDA 2005 has brought this public sector duty on disability in Northern Ireland into force. The ECNI is responsible for ensuring and monitoring effective implementation of the statutory duties of section 75 of the Northern Ireland Act 1998.

Further information is available from the ECNI website at www.equalityni.org

Appendix 3: Good Medical Practice supplementary guidance on disability equality

The following extract is taken from the DRC *Good Medical Practice supplementary guidance on disability equality*, showing the detailed explanation for paragraph 2 of the GMC's *GMP* document.

Paragraph 2, Good clinical care must include:

a) Adequately assessing the patient's conditions, taking account of the history (including the symptoms, and psychological and social factors), the patient's views, and where necessary examining the patient.

What this means in practice for a disabled person is that firstly the person's way of communicating should be established as soon as possible. The doctor should ask the patient about their condition before examining them. The doctor needs to take account of the disabled person's impairment but not to the detriment of the patient. For example, if a doctor is examining a person who is deafblind they should take account of the communication needs of the patient before he/she undertakes the examination.

This has two practical implications which can appear to conflict:

1. Not perceiving them purely in terms of their impairment – what is sometimes referred to as 'diagnostic overshadowing'.
 2. Recognising at the same time that the impairment might cause a health inequality which needs to be addressed by some additional action.
- For example, a person with a sight difficulty needs non-impairment related services such as cancer screening like anyone else, or they may actually need this more because they may be less likely to detect essential signs of tumours (eg skin discolouration or blood in faeces).
 - A person with a learning disability may need elective services such as family planning advice just like anyone else, but in addition they should receive annual health checks (in line with 'Valuing people' national guideline) because as a group they face very high health inequalities that can shorten their life expectancy. They also need more time and a more flexible approach to a thorough examination as many conditions may go unrecognised and undiagnosed due to lack of communication.
 - It is also important not to make assumptions about a disabled person's life. For example, women with a learning disability may have an active social life which includes sexual relationships. They should not therefore be omitted from cervical screening simply because of assumptions that they cannot be sexually active or would not understand about sexually transmitted diseases.
 - Likewise if consultation relates to a long-term condition which is a disability under the Disability Discrimination Act the patient should be listened to with great care. They are likely to be as much an expert on their condition as most frontline medical staff.

Source: DRC (2007) *Good medical practice supplementary guidance on disability equality*. Available at www.drc-gb.org

Appendix 4: DRC guidance on supporting commissioning processes in healthcare

Steps that will assist organisations in ensuring that they meet their obligations when commissioning or procuring goods or services include:

- reviewing commissioning frameworks or procurement terms and conditions to include information about the Disability Discrimination Act 2005
- including a requirement in every contract that the commissioned body or the goods and services procured must comply with the anti-discrimination provisions of the Act
- clearly identifying where relevant, what evidence the commissioning body or contractor should gather for the authority to demonstrate its compliance with the general or specific duties
- ensuring that disability equality is appropriately reflected, and given due weight, in the specification, selection and award criteria, and the contract conditions. For goods and services this must be done in a way which is consistent with applicable EC and UK procurement rules
- ensuring that contractors fully understand any disability equality requirements of the contract
- monitoring performance of disability equality where relevant to the contract
- providing training for all staff involved in procurement or commissioning so that they fully understand the provisions of the Act and the relevance of the Disability Equality Duty to their area of work.

Source: DRC (2006) *Health and the Disability Equality Duty: guidance for public authorities working in the health sectors in England and Wales*.

Further information on public sector commissioning and procurement can be found in the DRC document *Procurement and the Disability Equality Duty: implications of the Disability Equality Duty for public procurement and the management of public sector contracts*.

Appendix 5: Examples of adjustments in healthcare service provision

The following extracts are taken from two guidance documents, *You can make a difference*, which include practical examples of ways to improve the journey of disabled people through NHS primary and secondary care services.

Making an appointment

- Make sure you understand how to use Textphone or TYPETALK so that you can help people with hearing impairments to make an appointment.
- Provide details of local transport and in particular details about disabled access.
- Find out what assistance the disabled user requires. It is important that you pass this information on to colleagues so that it can be acted upon.

Waiting areas

- There should be enough space for a wheelchair user to be alongside a seated companion.
- You can usually let the patient know it is their turn for an appointment by approaching them discreetly to inform them of this.

Assessment or treatment areas

- Communicate directly with the service user, even if they have someone with them, unless informed otherwise.
- Ensure that you know how to use hoists and other assistive equipment.
- Use plain, simple language when giving a diagnosis or explaining a treatment procedure, and take time to explain it.
- Make sure that equipment is accessible to disabled people.

Referral on to wards and other treatment areas

- Ensure that a person's requirements are again passed on between departments.
- It is important that the patient is kept fully informed of why and where they are being sent, and how long they can expect to be there. This includes informing them about facilities such as nearby toilets.
- Escort the patient to the next department if they have difficulty going alone, or request this.
- Avoid further impairing disabled service users. For example, a badly placed IV drip can prevent someone using sign language.
- Check that a patient's auxiliary aids are within reach.

Sources: DH, NHS & DRC (2006) *You can make a difference, improving hospital services for disabled people* and DH, NHS & DRC (2006) *You can make a difference, improving primary care services for disabled people*.

Appendix 6: Communication skills and disability and rehabilitation curriculum content in undergraduate medical education

The following extract is taken from *Tomorrow's doctors* which outlines the curriculum requirements for undergraduate medical education.

Communication skills

20 Graduates must be able to communicate clearly, sensitively and effectively with patients and their relatives, and colleagues from a variety of health and social care professions. Clear communication will help them carry out their various roles, including clinician, team member, team leader and teacher.

21 Graduates must know that some individuals use different methods of communication, for example, Deafblind Manual and British Sign Language.

22 Graduates must be able to do the following.

a. Communicate effectively with individuals regardless of their social, cultural or ethnic backgrounds, or their disabilities.

b. Communicate with individuals who cannot speak English, including working with interpreters.

23 Students must have opportunities to practise communicating in different ways, including spoken, written and electronic methods. There should also be guidance about how to cope in difficult circumstances. Some examples are listed below.

a. Breaking bad news.

b. Dealing with difficult and violent patients.

c. Communicating with people with mental illness, including cases where patients have special difficulties in sharing how they feel and think with doctors.

d. Communicating with and treating patients with severe mental or physical disabilities.

e. Helping vulnerable patients.

Disability and rehabilitation

31 Graduates must know about the following.

a. The rights of people with mental or physical disabilities.

b. How the opportunities available to disabled people can be affected by society's view of them.

c. The potential strengths and contributions of such individuals.

32 They must also recognise the importance of responses to illness and providing help towards recovery, as well as managing chronic disease and relapse, and reducing or managing impairments, disabilities and handicaps.* They must be aware of issues surrounding the needs of parents with children who have mental or physical disabilities.

* **Note:** The unnecessary use of the term 'handicaps' in this extract taken from *Tomorrow's doctors*, highlights the need for the social model to be applied much more widely within all aspects of medicine. The use of such language in a key GMC document undermines the progressive work done by others on curriculum development in relation to disability equality.

Source: GMC (2003) *Tomorrow's doctors, recommendations on undergraduate medical education*.

Appendix 7: Foundation year 1 core competencies

The following extract is taken from the foundation years curriculum as developed by Modernising Medical Careers.

1.1 History taking, examination and record keeping skills

- demonstrates clear history taking and communication with patients
- appreciates the importance of clinical, psychological, social and cultural factors particularly those relating to ethnicity, race, religion, sexual orientation, gender and disability
- incorporates the patient's concerns, expectations and understanding
- takes history from patients with learning disabilities and those in whom English is not their main language.

1.3 Understands and applies the basis of maintaining good quality care and ensuring and promoting patient safety

(i) Always maintains the patient as the central focus of care

- takes particular care in dealing with vulnerable patients such as children, young people, the elderly, patients with learning disability or mental ill health (ensures that they understand all clinical and administrative information).

3.0 Relationships with patients and communication

(i) Demonstrates appropriate communications skills

- seeks appropriate assistance when dealing with patients with special communication needs whether related to disability or language.

6.0 Professional behaviour and probity

(i) Consistently behaves with a high degree of professionalism

- knows and respects the rights of children, people in same-sex relationships, the elderly, people with physical, mental, learning or communication disabilities.

Source: Modernising Medical Careers (2005) *Curriculum for the foundation years of postgraduate education and training*.

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