Disabled people working together for real choices

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Disabled Access to Tower Hamlets Primary Care Centres

Introduction

In this short paper we introduce ourselves, explore what the most recent census tells about local Disabled residents, and make some policy/practice recommendations. This is not an academic or policy paper designed to integrated extensive research. It is a mechanism for us to present a small number of key recommendations to the Scrutiny Committee, about which we would be happy to elucidate in the meeting.

About Real DPO

Real DPO is Tower Hamlets oldest and largest Disabled People's Organisation. Our staff and board all share lived experience of Disability. As a user-led organisation, founded on the social model of disability, we recognise the complexity of multiple impairments, of identities that intersect diverse protected characteristics and the experiences of those who were born with impairments, and those who acquired their impairments through illness, injury or ageing.

Real's mission is to:

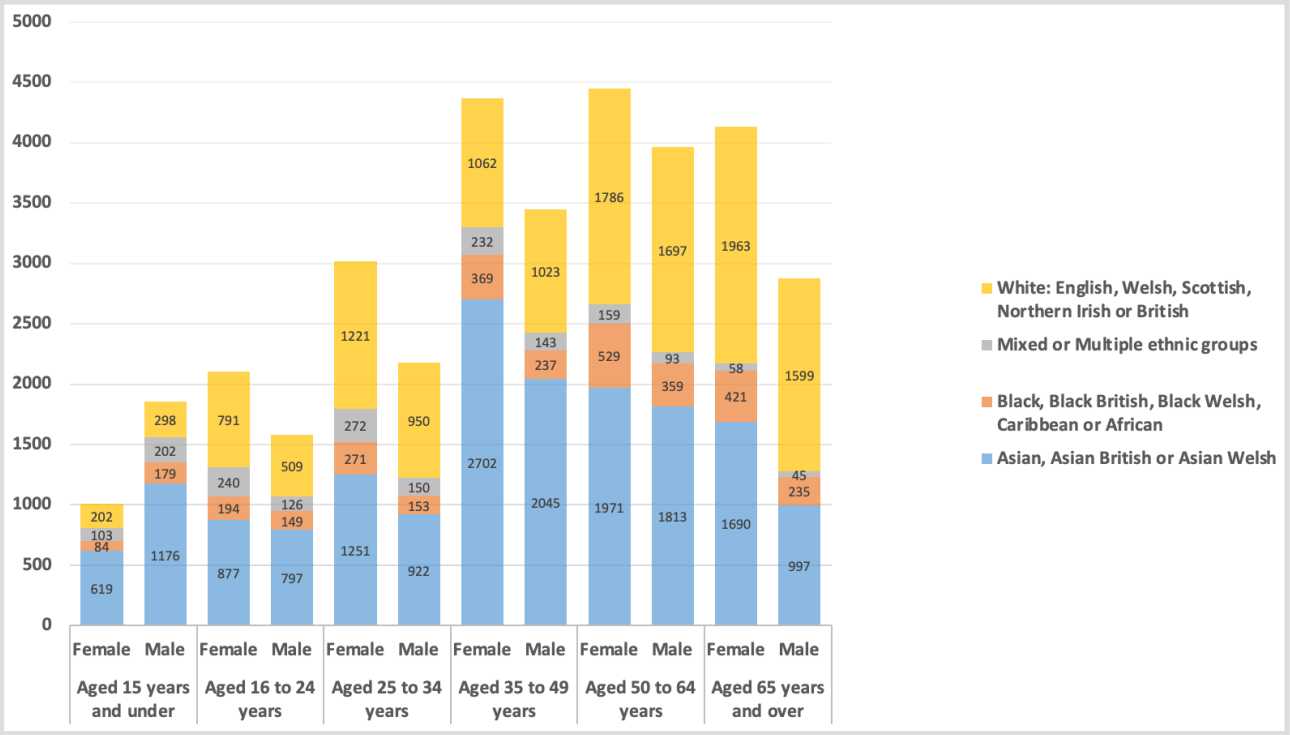
1. Empower D/deaf and Disabled people to lead their best lives, and
2. Promote intersectional equity both in relation to services and in addressing structural barriers: in health and other (integrated) services, in employment and business, in the independent living/benefit/housing/criminal justice systems and in legalisation.

We have a strong track record of delivering high-quality services and campaigns with/for Disabled people in Tower Hamlets and more widely, often in partnerships. We have three thematic teams: Advice, Advocacy, and Engagement, Coproduction & Voice, all of which inform our input to you.

About Disabled Residents

According to the 2021 Census there were just over 40,000 Tower Hamlets residents who met the Equality Act definition of being a Disabled person. The figure below shows the male and female populations in six age ranges, and across the four largest ethnic groupings.

This shows us that most people develop long term conditions or impairments amounting to a disability whilst they are working age. To stay economically active as long as possible they will need help to make the personal health and wellbeing journey, to understand their rights and how to gain reasonable adjustments at work and in services they receive from the council and the NHS, and to address prejudice and discrimination from colleagues, family or on the street. Council and health services will need to have the tools to adjust how they communicate and deliver services to achieve this over time, and how they let residents know this is available. This is particularly true of primary care.



I would draw your attention to the following:

- In the under 15s, more boys are Disabled than girls across all communities.
- From aged 16 onwards more females in each community and each age range are disabled than males from the same community and age range.
- For Asian residents, the 35-49 year olds reported the highest number of Disabled people, and the peak share of the overall Disabled population for that age range.
- For Black residents, it was the 50-64 year olds who reported the highest number of Disabled residents.
- For White residents, the over 65s showed the highest numbers but only slightly above 50-64 year olds.

Key Recommendations

These are based on extensive learning and delivery, and our research. More detailed reports and references can be made available upon request.

We know from our advocacy work that many Disabled individuals locally experience great difficulty accessing primary (and other community health) services. This may be due to sensory impairments, neurodiversity, long term mental health impairments, and/or mobility needs.

In work commissioned by Tower Hamlets Public Health, we have developed co-produced training and change initiatives for primary care. This includes assessment guides, training programmes and guidance, and well as enter and view, and other mechanisms such as involving PPGs. It has been very well received, and has been recently extended, for which we are grateful. Whilst there are models of accessible primary care practice locally, we need more primary care leaders to make this a priority, so that this new work can have maximum impact as widely as possible.

We also recognise that many practice managers and partners need to be empowered professionally to take advantage of such opportunities and to prioritise this work. It is for that reason we are recommending an additional delivery activity is required, through perhaps action learning sets.

There are also systems barriers. The current medical record system does not allow for access adjustments to be properly stored and coded. This means practices cannot check systematically that they are meeting all access requirements or indeed the number of patients and type of adjustments required. There is no way currently to address communications to people who share adjustment needs.

In another programme of work focussed on Accessible Communications, supported by NEL ICB Health Equity Fund, Real worked with Disabled people to assess Council, Primary Care and third sector communications, developing assessment tools, training programmes and a guide . This was very well received, and not only in Tower Hamlets. Yet the take up of the training from within Tower Hamlets Primary Care was disappointing even though this is a statutory requirement.

The NHS Accessible Communications Standard requires all services to provide communications in an appropriately adjusted form. We have found just one practice that has implemented their own form for patients in response to this. We would be pleased to be asked to work with the practice to review take up by patients, and what could be done to improve awareness/access.

Again the key need here is for empowered leadership, both at the practice level and at the systems level. We would ask Scrutiny to highlight both these needs, and are pleased to offer our assistance in both.

There are some broader matters which also influence access to primary care.

We encounter many Disabled people who are living in housing that does not meet their access requirements. There are people who are unable to leave their homes because of it, and this not at all solely a matter of wheelchair access. Many people will also suffer extreme loneliness, often developing additional severe mental health impairments, as well as acute poverty. For some there are insufficient public toilets to visit green spaces, and a sense of exclusion from leisure facilities, as well as a lack of community safety. Other Disabled people rely on family advocates/carers. This will often have significant health/economic impacts for the family carer. These are all social determinants of health, and represent different barriers to accessing primary care, which GPs and staff should be considering when designing and managing their services.