GPC GUIDANCE: THE DISABILITY DISCRIMINATION ACT

Physical adjustments to GP premises required under the Act

Updated January 2010 (original guidance published in 2003)

1. INTRODUCTION

On 1 October 2004, Part III of the Disability Discrimination Act (DDA) 1995 came fully into force in the UK. This section of the Act requires providers of goods, facilities and services (which includes GP practices) to make physical adjustments to their premises to enable disabled people to use their services. This applies not only to patients using the premises, but also to staff employed by practices.

Unfortunately, neither the GPC nor other organisations can give GPs definitive guidance on what adjustments will protect them against any discrimination claims under the act. The general principle is that a service provider has a duty to take reasonable steps to change either the practice or procedure or physical characteristic of a building that makes it difficult for a disabled person to use the service. However, it will be for the courts to decide whether or not a service provider has taken reasonable steps to remove or adjust the feature that has given rise to a claim. The concept of reasonableness will therefore be open to interpretation on the basis of the circumstances of the case. The authoritative document to guide the courts will be the Disability Discrimination Act 1995 *Code of Practice - Rights of Access: services to the public, public authority functions, private clubs and premises* (see –'Further reading', page 6).

Practices are encouraged to involve their PCOs at an early stage of the process. It is always advisable to record meeting discussions and any decisions made regarding compliance with the DDA. This may be required later as evidence that the practice has taken its obligations under the Act seriously and considered how best to implement the necessary changes. Some adjustments that need to be made will be simple ones, such as the installation of a handrail or the removal of an obstruction. Other adjustments will be more expensive and complex, such as the installation of an induction loop at the reception desk or a stair lift. However, practices are encouraged to think creatively about how to avoid the need for expensive changes and always consider whether it is practical to find an alternative way of providing the service or re-locating the point of service, particularly if there is at first sight no funding available from the Primary Care Organisation (PCO) or Health Authority (HA). For example:

- ensuring a reception area is quiet and well lit enough to allow lip reading, while raising funds for an induction loop

- relocating a service to an accessible ground floor level, thus avoiding the need for a stair lift.

It is likely that the courts will take prohibitive costs into account when determining whether the steps taken by a practice could be considered 'reasonable'. Practices are also encouraged to involve PCOs at an early stage. There is more information about this in the following sections.

It would be advisable to record any discussions and decisions taken at practice meetings about complying with the DDA. This would provide evidence that the practice has taken its obligations under the Act seriously and considered how best to implement the necessary changes.

The BMA's Equal Opportunities Committee and Patient Liaison Group have also published guidance, *Disability equality within healthcare: The role of healthcare professionals,* which highlights some of the key measures needed to address inequalities in access to healthcare and health outcomes experienced by disabled people: www.bma.org.uk/employmentandcontracts/equality_diversity/disability/disabilityequalityhealthcare.jsp

2. BACKGROUND - THE DISABILITY DISCRIMINATION ACT 1995

The Disability Discrimination Act 1995 aims to end the discrimination that many disabled people face, and to give them equal rights in terms of employment, access to goods, facilities and services, and buying or renting property or land.

Part I of the Act deals mainly with the definition of disability. It defines a disabled person as someone with 'a physical or mental impairment which has a substantial and long-term adverse effect on his ability to carry out normal day-to-day activities'. It is worth noting that the following are excluded from the definition:

- addiction to, or dependency on alcohol, nicotine, or any other substance (other than in consequence of the substance being medically prescribed)
- the condition known as seasonal allergic rhinitis (i.e. hayfever), except where it aggravates the effect of another condition
- a tendency towards the physical or sexual abuse of other persons.

Part II of the Act deals with the duties of employers and trade organisations towards their disabled employees and members.

The relevant section of the Act, for the purpose of this guidance, is Part III – *Discrimination in other areas - Goods, Facilities and Services*. Its provisions were introduced in three stages:

- since 2 December 1996 it has been unlawful for service providers to treat disabled people less favourably for a reason related to their disability
- since 1 October 1999 service providers have had to make 'reasonable adjustments' for disabled people, such as providing extra help or making changes to the way that they provide their services
- **from 1 October 2004** service providers have had to make other 'reasonable adjustments' in relation to the physical features of their premises to overcome physical barriers to access.

The requirement to make physical adjustments to premises is contained in paragraph 21 (2):

"Where a physical feature (for example, one arising from the design or construction of a building or the approach or access to premises) makes it impossible or unreasonably difficult for disabled persons to make use of such a service, it is the duty of the provider of that service to take such steps as it is reasonable, in all the circumstances of the case, for him to have to take in order to-

(a) remove the feature;
(b) alter it so that it no longer has that effect;
(c) provide a reasonable means of avoiding the feature; or
(d) provide a reasonable alternative method of making the service in question available to disabled persons."

3. WHAT COUNTS AS A PHYSICAL FEATURE?

The DDA defines a physical feature as

"anything on the premises arising from a building's design or construction or the approach to, exit from or access to such a building: fixtures, fittings, furnishings, equipment or materials and any other physical element or quality of land in the premises….whether temporary or permanent".

Physical features will therefore include:

- steps and stairways
- kerbs
- exterior surfaces and paving
- parking areas
- building entrances and exits (including emergency escape routes)
- internal and external doors, gates
- toilet and washing facilities
- lighting and ventilation
- lifts and escalators
- floor coverings
- signs
- furniture
- temporary or movable items (equipment and display racks)
- public facilities (telephones, counters or service desks).

4. WHAT CONSTITUTES 'REASONABLE STEPS'?

The duty to make reasonable adjustments is a legal responsibility under the DDA. It applies to employers and service providers and is intended to make sure that disabled people do not face substantial difficulties in employment or when using services. The DDA defines a reasonable adjustment as a reasonable step taken to prevent a disabled person suffering a substantial disadvantage compared with people who are not disabled. However, it is for the courts to decide exactly what constitutes as 'reasonable'. The Act provides four tests of reasonableness as follows.

1. **The effectiveness in preventing disadvantage.** The more effective an adjustment is in reducing disadvantage, the more reasonable it is likely to be.

2. **The practicality of the step.** If disadvantage can easily be removed by changing the way things are done, or the equipment that is used, then the adjustment is likely to be considered reasonable.

3. **The financial and other costs and the extent of any disruption caused.** When trying to decide whether an adjustment would be reasonable, the cost of the adjustment and any disruption it might cause should also be considered.

4. **The extent of an organisation's financial and other resources.** An organisation with lots of money would be more likely to have to make a reasonable adjustment than one with fewer resources.

The Equality and Human Rights Commission (EHRC; formerly the Disability Rights Commission, disbanded in 2007) suggests that the following factors may be relevant when considering which adjustments are required:

- the effects on other employees: if a reasonable adjustment may affect other employees, their needs may need to be taken into account

- adjustments made for other disabled people: if there are a number of disabled staff who find some aspect of the working environment difficult, then there is a greater need for the employer to make a significant change.

Affordability and feasibility are key factors in deciding what is reasonable in making changes to comply with the DDA. The level of resources available to make the changes is likely to be taken into account, as are other calls on resources. If it can be shown that a major adjustment could divert resources from patient care, this would be a good argument in favour of the practice. However, it would not relieve the practice of the duty to consider the problem. Practices may need to show that they have considered and made reasonable alternative adjustments or alternative ways of providing their services to disabled people.

Further information about making reasonable adjustments at work is available from the EHRC website: www.equalityhumanrights.com/your-rights/disability/disability-in-employment/at-work-making-reasonable-adjustments/

5. WHAT HAPPENS IF PRACTICES DO NOT COMPLY WITH THE ACT?

If a practice has not complied with the Act and cannot justify its failure to do so, a disabled person would be able to bring civil proceedings against the practice in the County Court. If successful, the claimant would be awarded compensation (on which there is no upper limit) for any financial loss suffered, including injury to feelings. The disabled person may also seek an injunction to prevent the practice from repeating any discriminatory act in the future. The court may make a declaration as to the rights and responsibilities of the parties involved, but it cannot order the practice to make physical changes to its premises.

The EHRC provides an independent conciliation service for disabled people and service providers, with a view to settling disputes arising under the Act without the resort to court action. Court action must be brought within six months of the alleged discrimination, but this time limit is extended by a further two months when the EHRC has referred a person to the conciliation service.

In the case of any award of damages to a complainant, it is important to note that these costs will fall to the practice and not to the PCO.

6. CHECKING COMPLIANCE WITH THE DDA

A basic checklist for DDA adjustments is provided in **appendix A**. This is only intended to give an idea of the scale of necessary adjustments which may be required. **This checklist is not a substitute for a full access audit**. A full access audit assesses how easy the practice makes it for disabled people to access and use services at its premises. They are usually divided into two stages: gathering information and making recommendations. A practice might want to do the first of these itself, with the help of the Department of Health (DH) audit checklist[1]. However, the recommendations would need specialist technical advice.

Some PCOs are offering practices full audits**.** GPs should encourage this, as it is a good opportunity to have premises assessed at no cost and draws funding problems to the attention of the PCO in a manner they cannot ignore**.** Employing an access consultant will be expensive, and carrying out such a survey yourself will be time-consuming. That the audit may reveal the need for improvements should not be considered a threat. It is far more risky in the long term to avoid making these improvements, as this could result in a claim against the practice and possibly the award of damages to the complainant. These would fall to the practice, not the PCO.

Acceptance of a PCO audit cannot indemnify the practice against claims, but it could strengthen its case greatly in the event of any claim, as it demonstrates the practice's intent to comply with the Act. It would also be a good opportunity to make a case for PCO reimbursement for the necessary adjustments. Unfortunately, the Department of Health has so far refused to release funding for adjustments, and so PCO funding is entirely discretionary. That a practice has made an application for funding, even if this was refused, would help it to demonstrate that it has taken reasonable steps to comply with the Act.

7. LOCAL ISSUES

Funding for DDA adjustments is a problematic area. The DH has offered no ring-fenced, central funding for compliance with what is a legal (but not an NHS) obligation.

For new-builds, DDA compliance should be built into the building costs and included in the planning of the premises, site and funding arrangements. This should not usually be an issue.

However, for most of the NHS primary care estate, conversion of old premises is likely to be necessary, with attendant planning and funding problems. Under the Act, the provider of the premises is responsible for

[1] Access to Health Service Premises: Audit Checklist (available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009714)

making the necessary changes. GPs and LMCs should strongly encourage PCOs to approve maximum levels of Improvement Grants to fund the necessary changes.

In the interests of providing a high quality service, PCOs will be unwilling to see non-compliant premises in their area. They will also be unwilling to see practices threatened with actions as a result of a complaint brought under the Act, as this would reflect badly on local healthcare provision.

It is therefore in practices' interests to encourage PCOs at an early stage to participate in joint solutions – for example, by suggesting that they fund an access audit. Access audits and the resulting cost estimates should form part of early planning for the PCO budget round, with the assistance and involvement of the LMC.

In the event of discrimination claims, this could lend weight to the practice's argument that it had taken all reasonable steps to raise premises to the level of compliance with the Act within the constraint of available resources.

8. STAFF ISSUES

Employers' obligations towards disabled staff

Employers have an obligation under the DDA towards all of their employees. It is unlawful to treat any employees with disabilities or applicants for jobs with disabilities less favourably because of a reason related to those disabilities. This applies to recruitment, doing the work (including career development and promotion) and redundancy and dismissal. An employee may make a complaint against you, which could be referred to an employment tribunal which may then award them compensation for financial loss or injury to feelings.

As employers, you need to consider whether any employment arrangements or physical features of the workplace put disabled employees at a disadvantage in any way, and then make reasonable adjustments to remove these arrangements or features.

The Disability Rights Commission produced a leaflet giving the following examples of reasonable adjustments:

- **Making adjustments to the premises.** This is covered elsewhere in this guidance, but obviously needs to be extended to include all staff areas.
- **Reallocation of minor duties** to another employee.
- **Offering flexible working hours**, e.g. to avoid rush hours.
- **Allowing absences during working hours**, for rehabilitation, assessment or treatment.
- **Assigning or transferring a job or an employee** to a place of work more suited to their needs. For example, moving a workstation to a more accessible location.
- **Making instructions and manuals more accessible**; e.g**.** providing a Braille version for a blind person.
- **Providing appropriate or additional training.**

This leaflet is available from the EHRC website:
www.equalityhumanrights.com/uploaded_files/reasonable_adjustments_emp7.pdf

It is important to ensure that recruitment procedures do not discriminate against applicants with disabilities. The job specification, applications forms, selection process, assessment technique and terms of employment offered should be designed so as not to disadvantage disabled people.

Staff Training

In view of the role of staff in facilitating disabled patients' access to services, it would be advisable for practices to include in their staff training programmes a basic grounding in the DDA, equal opportunities legislation and recruitment policies. Once again, the demonstration by the practice that it has taken this step could be very helpful in the event of discrimination claims.

Employers are held to be vicariously liable for their employees' actions under the DDA 1995 (and under the Sex Discrimination and Race Discrimination Acts). The argument that the employer had no knowledge of their employee's actions is therefore not an adequate defence under the Act.

9. LEASED PREMISES

Under the DDA, it is the service provider, not the owner of the premises, who must make physical adjustments to the premises if such adjustments are justified. However, where service providers rent premises, they will be obliged under their leases to ask the landlord's permission before making any changes to the premises. The DDA allows for this and states that where an adjustment is reasonable, the service provider must merely write to their landlord informing them that they wish to make changes to the premises under the DDA. It is then up to the landlord to agree or disagree to these changes. If the landlord withholds consent, then the service provider's obligations under the DDA have ended. For their own protection, they should obtain the landlord's response in writing and keep it on file, as well as informing the PCO and LMC in writing.

As it is up to the service provider to make the relevant changes to premises under the DDA, it must bear the cost. Where practices share leased premises, they should share the costs of any work required.

FURTHER READING

Equality and Human Rights Commission guidance on disability and the DDA
www.equalityhumanrights.com/your-rights/disability/

Directgov website – Disability Discrimination Act (DDA) pages
www.direct.gov.uk/en/DisabledPeople/RightsAndObligations/DisabilityRights/DG_4001068

The Disability Discrimination Act 1995
www.legislation.hmso.gov.uk/acts/acts1995/1995050.htm

Planning and access for disabled people: a good practice guide (2006)
www.communities.gov.uk/documents/planningandbuilding/pdf/156681.pdf

Disability Rights Commission DDA 1995 *Code of Practice - Rights of Access: services to the public, public authority functions, private clubs and premises*
www.equalityhumanrights.com/uploaded_files/code_of_practice_rights_of_access.pdf

APPENDIX A – BASIC DDA CHECKLIST

As the introduction states, **this checklist is no substitute for a full access audit** and is only intended to give practices an idea of the scale of necessary physical adjustments.

GROUNDS, PUBLIC OR COMMON AREAS

Even if the grounds around your premises are not practice-owned, the practice will need to ensure that there are no obstacles or impairments to people using sticks, crutches and wheelchairs or to people with visual impairment.

- **Is the pavement outside the premises free of potholes, uneven paving surfaces, etc.?**

If not, you may need to get in touch with the local authority roads department to request repairs.

- **Is all vegetation cut back from paths leading up to the entrance?**
- **Is the route to the building kept free of leaves, snow and ice?**
- **If the route is not level, is there a slip-resistant ramp with handrails available?**
- **Are all paths free of obstacles, such as litter bins?**
- **Are all surgery signs clearly visible?**

Signs should be as visible as possible. Lettering needs to be large to help people with visual impairments.

- **Is external lighting good enough to help people find their way to the premises?**
- **If the practice has a parking area, is there a reserved, wider bay for disabled people?**
- **Is there a safe place to cross the road near the surgery premises?**

ACCESS TO MAIN ENTRANCE

- **Does the practice have alternative access, or a ramp, for people in wheelchairs?**

If the main entrance is not level, or is inaccessible and hard to change in some other way, is there a rear or side entrance where level access is possible?

- **Do the steps have a clearly visible handrail?**
- **Are the steps themselves clearly visible?**

Painting steps a different colour to the surrounding surfaces can make them easier for visually impaired people to see.

- **Is the entrance well lit?**
- **Is there an accessible bell, or entryphone system for people to use if they are having difficulties getting in?**

This would be particularly desirable if access is not ideal.

DOORWAYS

- **Does the door open wide enough for all users?**

Wheelchair users generally need at least 750mm clear opening width (the space available between the door frame and the door in the open position).

If doorways do not meet this specification, the doorway may need to be widened if there is no alternative way in.

- **Is the door-handle low enough for a wheelchair user to reach easily?**

The recommended height is 1000 mm.

- **Are entrance mats flush with the floor so that the surface is even?**

- **If a door closer is fitted, does it have a delayed, or slow-action closure mechanism?**

GETTING AROUND INSIDE THE PREMISES

- **Are there enough signs?**

- **Are signs simple, short and easy to read and located at convenient levels for wheelchair users?**

Signs can be made clearer by using pictorial symbols and visual clues.

- **Are aisles, corridors and areas near doors free of obstacles and wide enough for wheelchairs to manoeuvre?**

- **If there is a change of level, is there a platform lift available? If not, is there a permanent ramp that is wide enough for wheelchairs?**

- **Are internal steps and other potential hazards clearly marked and fitted with a handrail and ramp?**

- **Are all floor surfaces as level as possible, without the need for major adjustments? For example, are mats and joins between different floors etc., flush with the floor and each other?**

RECEPTION/WAITING AREAS

- **Does the reception desk have an induction loop?**

This is an expensive adjustment but may be necessary, particularly at a glass counter.

- **Is the reception area reasonably quiet and located away from any noisy machinery?**

- **Is seating suitable for people with mobility impairments?**

- **Is there waiting space for wheelchair user?**

- **Might it be possible to create a lowered section of the reception desk?**

If not, it would be advisable to provide some means of allowing wheelchairs users to sign forms etc., such as a lower writing shelf or simply a clipboard. Staff could be encouraged to come out from behind high reception counters when a wheelchair user approaches.

- **Are people standing behind reception desk well lit from the front, to make lip-reading easier?**

TOILETS

- **Are the toilets accessible, both in terms of getting to and using them?**

If there is sufficient space available, the toilet may need to be modified to meet full wheelchair accessible standards. You will need technical advice on this.

The following practical suggestions should also be helpful:

- fit grabrails to help people with limited movement, balance or grip
- ensure floor surfaces are non-slip
- install outward opening doors
- avoid shiny ceramic tiles and floors, which may cause reflection and glare.

EASE OF COMMUNICATION WITH STAFF

The premises should make it as easy as possible for disabled people to communicate with the practice staff.

Practice staff should show awareness of the needs and sensitivities of people with hearing impairments. For example in situations where it is not reasonable to install an induction loop, staff should make the effort to communicate in other ways, such as exchanging written notes. Staff could be encouraged not to cover their mouths when speaking to patients in order to help people who lip-read. Allowing extra time when communicating with people who have hearing impairments, and checking accuracy by repeating back to the patient what they have said can also help, as even partially deaf people may lip-read.

Even if few physical adjustments can be made, the attitude and awareness of everyone who deals with patients is a key factor. A clear willingness to anticipate the needs of disabled patients and look for alternative solutions could go a long way to avoid any complaints or legal action against the practice. A disabled patient minded to make a complaint will only be encouraged to do so if they encounter unreasonable, indifferent or insensitive attitudes**.** Clearly, these problems can be ameliorated if your staff are aware of the Act and trained appropriately. Staff training in disability awareness is therefore advisable and demonstrates the practice's clear commitment to take reasonable steps to comply with the Act**.**

Patients with a visual and/or hearing impairment may have problems dealing with an automated electronic appointment system and might require help when arriving and being summoned for an appointment.