

Summary report of a DRC formal investigation

Maintaining Standards: Promoting Equality

Professional regulation within nursing, teaching and social work and disabled people's access to these professions

Report of a DRC Formal Investigation

This is a summary of the full report of the investigation, which can be found online at www.maintainingstandards.org

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Contents

Foreword.....	2
Introduction	3
Analysis of Evidence	6
Conclusions.....	23
Recommendations	27
Inquiry Panel Members	34
Inquiry Panel Witnesses.....	35
Bibliography	38
Endnotes	41

Foreword

There should no longer be ‘no go’ areas for disabled people in 21st century Britain.

Yet the Disability Rights Commission’s year-long investigation into the regulation of professionals’ health in nursing, teaching and social work has concluded that this is exactly the situation within great swathes of the public sector. We have found a culture in which disabled people are more likely to be asked ‘what’s wrong with you?’ than ‘what can you contribute?’

The DRC found over 70 separate pieces of legislation and statutory guidance laying down often vague requirements for ‘good health’ or ‘physical and mental fitness’ across nursing, teaching and social work. These regulations have a chilling effect on disabled people, deterring them from entering or remaining in these professions. They drive people underground, where they are reluctant to speak of their disability and do not receive support to which they are entitled; support that could enable them to practice safely and effectively.

Protection of the public is of the highest importance. However, the DRC’s investigation has found that these regulations do nothing to protect the public and may indeed offer a false sense of security.

We recommend the revocation of the legislation, regulations and statutory guidance laying down requirements for good health or fitness of professionals. There are two reasons for this: the negative impact on disabled people; and our conclusion that they offer no protection whatsoever to the public. Further action is also needed to promote equality in these sectors.

We believe that disabled people have an important role to play in our public services, including in the professions of nursing, teaching and social work that form the major focus of this investigation. People who are disabled or have long-term health conditions have a wealth of skills and personal experiences that can enrich the work of the public services.

A framework of professional standards of competence and conduct, coupled with effective management and rigorous monitoring of practice, is the best way to balance the aspirations of disabled people to make their contribution to British life and the protection of the public.

Sir Bert Massie CBE

Chairman

Richard Exell OBE

Lead Commissioner for the investigation

Introduction

Between Spring 2006 and Summer 2007, the Disability Rights Commission (DRC) conducted a formal investigation examining the barriers that disabled people (including people with long-term health conditions)¹ face when entering, and staying in nursing, teaching and social work. Specifically, we have looked at the barriers posed by the statutory regulation of health in these professions. The investigation covered England, Scotland and Wales.

The professions of nursing, teaching and social work have a huge impact on the lives of all British citizens. Their workforces are substantial, with around half a million nurses, 700,000 teachers, and around 80,000 social workers in Great Britain.² It is important that these professions reflect the full diversity of society. The DRC believes that disabled people should be able, and encouraged, to play their full part in these professions.

After a decade of important advances for disabled people in many areas of public life, the barriers faced by disabled people in nursing, teaching and social work are still under-researched and under-discussed. It seems that where disabled people are considered, it is as patients, pupils or clients – and not as professionals.

We were surprised to find that, more than 10 years on from the passage of the Disability Discrimination Act 1995 (DDA), much of the legislation and guidance that regulates entry to these professions does not reflect the DDA, and frequently undermines disability equality. Standards for ‘good health’ or ‘fitness’ determine who can enter and work within these professions. Some of these standards are explicitly set out in legislation, while others are found within guidance governing entry to education or employment.

With the exception of social work and teaching in Scotland, there are generalised health standards in teaching, social work, nursing and other health professions across Great Britain.

The conclusion of our investigation is that these standards have a negative impact upon disabled people’s access to these professions; they are often in conflict with the DDA (as amended in 2005); they lead to discrimination; and they deter and exclude disabled people from entry and from being retained. We therefore recommend that they are revoked.

The DRC agrees that these professions must be regulated for the protection of the public. We support high standards of competence and

conduct, including checks of criminal records, so that we can all feel confident in the professionalism of those who train and practice in these sectors. Disabled people have a strong interest in the protection that the regulatory bodies and these standards of competence and conduct provide.

However, we do not believe that the health standards themselves provide protection to the public. We have scrutinised the reports following high-profile cases where professionals have harmed and killed, and do not believe that regulating the mental or physical fitness of professionals would have prevented these criminal acts. We therefore recommend that they are not extended as a matter of course to other occupations undergoing professionalisation, and that existing health standards across nursing, teaching and social work are repealed.

About the investigation

The formal investigation looked at three main themes:

1. The regulatory frameworks that operate within the nursing, teaching and social work professions, and particularly those that lay down standards for the health or fitness of professionals.
2. The way that health is assessed in practice, at various stages of a professional's career, namely studying, qualifying, registering and working within these professions.
3. The approach that disabled people take towards disclosing their disabilities and health conditions to higher education institutions, regulatory bodies and employers; and the policies and practices of these organisations in relation to disclosure of disabilities and long-term health conditions.

The investigation's methodology had a variety of elements:

- A review of the existing regulatory frameworks covering nursing, teaching and social work (and a range of health professions including medicine, dentistry and the 13 professions governed by the Health Professions Council).³
- Research looking at how universities⁴ and employers⁵ make decisions about disabled people's health within nursing, teaching and social work.
- Research into the factors that affect disabled people's disclosure of

disabilities and long-term health conditions at different stages of the employment journey within these professions.⁶

- Analysis of written evidence on the issues under scrutiny, from organisations involved in the implementation of health standards, and other relevant organisations (such as disability organisations and trade unions).⁷
- An ‘inquiry panel’ stage, chaired by barrister Karon Monaghan, with an expert group drawn from across the nursing, teaching and social work sectors, that questioned expert witnesses about the issues raised by health standards.

Partly because of inevitable limits to time, money and staff resources, and partly because of the context of the Disability Equality Duty, which came into force during the lifetime of the investigation in December 2006, we have focused on nursing, teaching and social work in the public sector and not delivered by private companies.

This investigation has covered three countries and three professions. This summary pulls out the main themes across the professions and countries, and the main differences. Readers who have a specific interest in the detailed findings – particularly the legislation, regulations and guidance –

that relate to a specific country or profession are advised to consult the main report, which can be found at www.maintainingstandards.org.

Analysis of Evidence

Health standards: their origins and effects

The DRC has found that across Great Britain, nursing and other health professions have similar regulatory frameworks, which all include generalised health standards and a requirement for people to disclose disabilities and long-term health conditions. In England and Wales, social work and teaching also have statutory generalised health standards. Scotland differs in that health standards do not apply to social work or teaching.

There is a complex array of primary and secondary legislation and statutory guidance laying down requirements for physical and mental fitness in social work, teaching, nursing and other health professions. Very few of the hundred or so pieces of statutory regulation and guidance refer to the DDA, except in teaching.

We have reviewed and analysed these standards and found that they are not legitimate competence standards,⁸ because they do not determine whether someone is competent to practice in a profession. We found that they frequently lead to discriminatory attitudes, policies and practices.

In nursing, we found that there is a statutory requirement for 'good health and good character' throughout England, Scotland and Wales. There is no acknowledgment of the DDA within the legislation or regulations, and the Nursing and Midwifery Council (NMC) has only just started to address the potentially discriminatory effects of these requirements. However, the NMC and many of the other organisations we consulted as part of this investigation share our view that these regulations are likely to lead to disability discrimination.

In teaching in England and Wales, we found similar health requirements, despite stringent competence standards and requirements for good conduct. The DDA is acknowledged within legislation and guidance but we found that these documents are still likely to lead to discrimination. It is notable that generalised health standards for teachers and trainee teachers were abolished in Scotland in 2004, with no apparent negative effects.

For social work, we found that there is a requirement for 'physical and mental fitness' in England and Wales. This requirement is more stringent for students than for qualified social workers. Once again, the physical and mental fitness requirement does not exist in Scotland, where a

framework of competence and conduct is considered sufficient to protect the public.

We found that within these professions, assumptions are frequently made that disabled professionals would pose a risk to the public. These three professions are ones in which anxieties about risk are understandably high, as nurses, teachers and social workers have regular, often unsupervised, contact with children, people who are ill or in other ways considered vulnerable.

A number of high-profile instances of murder of patients and pupils (for example by the nurse Beverley Allitt, the doctor Harold Shipman and the school caretaker Ian Huntley) have led to an increased focus on regulation, at registration but increasingly in the form of revalidation. These cases continue to haunt the professions, especially nursing where the Allitt case has had the strongest enduring impact.

“I was told I was unfit, as ‘we have to be careful you’re not a Beverley Allitt’ . . . Yes, I usually lie about my mental health, as I’ve had problems when I’ve disclosed, in spite of working in mental health.”

Nurse with depression

The regulation of nursing and the approach taken to the health of nurses has been directly influenced by the report of the Clothier Inquiry, which looked into the crimes perpetrated by Allitt. The regulation of other health professions and social work in England and Wales has also been shaped by the recommendations from that report.

Within the teaching profession, the standards appear to derive from historical concerns about infectious diseases, particularly tuberculosis.

There is a current trend towards widening the scope of health standards to cover previously unregulated professions as a means of ensuring public safety.

During this investigation we felt it was important to explore whether the concerns about risk arising from disability or ill-health were rooted in fact or in prejudice. The DRC’s inquiry panel looked in detail at the Clothier report and found inconsistencies between the evidence and analysis it presented and its findings and recommendations.

The Clothier report revealed that there was nothing in the history of

Beverley Allitt that would have led anyone to predict that she would commit the crimes that she did. Neither had there been a previous diagnosis of a mental health condition. To the extent that the murders could have been prevented, the Clothier report identified inadequate management as the reason they were not. Despite these findings, it made recommendations about health checks for people entering nursing that have led to a wave of regulation across the health and social care professions.

We also looked at the relevant Shipman reports, and agree with their finding that to reduce the likelihood of criminal activity of the kind perpetrated by Allitt and Shipman happening again, what is needed is proper management, supervision, information exchange and prompt action when inconsistencies and issues appear.

A particular outcome of the Clothier report has been the stigmatisation of people who have, or have had, mental health problems. This has led to people being excluded from training and employment and a consequent reluctance on behalf of professionals to disclose information about their mental health. In effect, they are often 'driven underground' by attitudes, policies and practices that are frequently discriminatory. This can mean that they do not receive appropriate treatment, support and adjustments to enable them to practise safely and effectively. This situation is plainly unsatisfactory to all concerned and cannot be said to aid protection of the public.

“Disclosing my mental health history to the regulatory body has proved to be a totally negative experience. I question the knowledge of the caseworker, who has demonstrated no understanding or knowledge of mental health issues. The stupidity of the regulatory body’s approach is demonstrated by the fact that if I had chosen not to disclose there would not have been a problem. Only honest students or staff are being penalised, so the unsuitable candidates are not being identified.”

When we asked relevant organisations about the purpose of generalised health standards, we found the role of these standards in protecting the public was an unexamined assumption, and not one that was based on any evidence. Our evidence told us that identification of health conditions is an irrelevance to public safety. Indeed it appears to be a 'red herring', detracting from the important issues – identified from previous tragic cases – of information exchange and monitoring of conduct.

We asked witnesses to our inquiry panel to give us their perceptions of which particular disabilities or health conditions were likely to present a risk to public safety. Although dyslexia, epilepsy and mental illness were frequently mentioned, witnesses were not able to explain what risk would remain for professionals, disabled or not, who had met these professions' rigorous standards of competence and conduct.

No evidence was presented to us that a diagnosis of mental ill health is a sufficient predictor of unsafe or poor practice for nurses, teachers or social workers. The impact of any condition is particular to the individual and their circumstances. This means that, for some people, mental ill health might raise issues of competence or conduct that could not be avoided through reasonable adjustments. These people would be unable to enter or remain in the profession because of not meeting those standards. For other people, mental illness would be well-managed and therefore irrelevant.

“Where regulatory bodies do have health as a criterion for registration, people suffering from conditions where it is not possible to predict the impact of the disability at any one time, may face particular difficulties. It is important that each case is treated on its own merits. It is the impact of a condition that needs to be judged in relation to the requirements of a particular post.”

Scottish Social Services Council

Generalised health standards encourage a diagnosis-led approach to the assessment of risk, rather than an individualised approach. Occupational health organisations told us that using health diagnoses serves no useful function at all in predicting future conduct or competence or in assessing risk.

Having gathered evidence from a wide range of organisations, including all the relevant regulatory bodies, we have therefore come to the conclusion that requirements for health or fitness of professionals, laid down in legislation, regulation and statutory guidance, should be revoked.

The Government⁹ is increasingly focused on revalidation of registration, particularly following the Shipman inquiry. It has recently proposed that all statutorily regulated health professions have in place arrangements for revalidation, by which professionals must periodically demonstrate their continued fitness to practice.

The Government is also considering the regulation of other healthcare

professionals. The aim is to standardise regulation across the health professions and give the Council for Healthcare Regulatory Excellence (CHRE) a pivotal role. There are, in addition, moves to increase the professionalisation of the whole children's workforce. The DRC does not object to these extensions of professional regulation or to the introduction or extension of revalidation but does not want to see health standards included. We believe that existing and new professional regulation should be based on competence and conduct, and not on health.

The DRC's investigation found only a very few circumstances in which it could be justifiable to consider a person's diagnosis in isolation (and irrespective of competence and conduct), the major example being the diagnosis of blood borne viruses. However, like the Nursing and Midwifery Council (NMC), we recognise that a blood borne virus is not justification on its own for the refusal of registration but should be an issue for employers in relation to particular jobs.

“Student applicants must disclose information about their HIV status to the University. Failure to do so may have implications for considering the applicant's character and conduct.”

Advice from social work regulatory body to a university

This investigation has focused on health related standards and not those relating to character. However, there can be a pernicious relationship between the health and character standards, which affects disabled people. A failure to disclose a disability or long-term health condition can be used as evidence of 'bad character' and can lead to disciplinary action. This is in the context of a culture, particularly within nursing, in which people who are disabled or have long-term health conditions often do not feel safe to disclose.

Role of Government and the Regulatory Bodies

Governments in England, Scotland and Wales, as well as the professional regulatory bodies, have responsibility both for protecting the public and for equality for disabled people. There have been some welcome initiatives, particularly in teaching (such as the setting up of the Disabled Teachers Taskforce). However, in other sectors the relationship between public safety and disability equality goes unexamined.

This investigation has aimed to achieve a balance between these two important concerns, which we believe to be mutually reinforcing, rather

than being in conflict. We expect governments and the regulatory bodies together to consider the conclusions of this investigation, including the recommendation to revoke the current health standards in teaching, social work, nursing and other health professions.¹⁰

“I disclosed the information that I had epilepsy . . . I was sent no information from [the NMC] about disabilities, how they treat it within the NMC, the kind of support that’s offered or anything else.”

‘Disclosing disability research for the investigation’

In 2008, Secretaries of State and Ministers (in Scotland and Wales) will be reporting on actions their Departments have taken to promote equality under the Disability Equality Duty (DED), which was introduced by the DDA 2005. These reports should cover what the relevant regulatory bodies have done to remove barriers to disabled people’s participation in the professions.

Regulatory bodies should remove the health standards that are within their own remits, and should review guidance documents based on statutory health standards. If health standards are removed, there are still likely to be competence standards that have an adverse effect on disabled people. We do not believe that the standards of competence or conduct applied to disabled people should be lower than those for other professionals. However, all competence standards should be reviewed and, where they are found to have an adverse impact upon disabled people, the regulatory body should consider whether they are necessary, and consider how adjustments can be made under the DDA to the way that these standards are assessed.

“The GSCC asked me ‘do you have a physical or mental health condition that may affect your ability to undertake your work in social care?’ I answered openly, honestly and probably naively. Their response has been exclusive, not inclusive; oppressive not supportive. I believe this system to be discriminatory.”

English social worker with bi-polar disorder who had worked in social care for 30 years and was registering for the first time in 2005

For example, English language standards may be genuine competence standards and therefore not subject to the duty to make reasonable adjustments under the DDA. However, reasonable adjustments do apply to the way these standards are assessed and in training people to meet these and other standards. There is a need for clear guidance from the regulatory bodies about making adjustments to enable disabled people to reach the required competencies. Responsibility for this guidance should fall to the regulatory bodies because of their guardianship role in relation to professional standards.

In relation to fitness to practise cases we considered the merit of the existing approach by the regulatory bodies of treating health issues separately to issues of competence or conduct, by having separate hearings. Some of those we spoke to felt there were benefits to the individual concerned, such as holding the hearing in private.

Even with the removal of health standards there are still likely to be competence or conduct cases that have a health or disability element. In practice we heard it is often difficult to distinguish the different elements.

We believe that the DDA provides a sufficient framework for ensuring that conduct or competence cases with a health or disability element are dealt with fairly and sensitively. Such hearings are covered by the DDA, and approaches to reasonable adjustments should take two forms.

First, the regulatory body should consider whether there are disability related reasons for the person's poor performance or unsatisfactory conduct that could be (or could have been) addressed through adjustments – such as additional support in the workplace. These reasons may affect the handling of the case.

Second, the regulatory body would need to consider adjustments to the actual process of the hearing, as required under the provisions for qualifications bodies under Part 2 of the DDA. For example, the hearing could be held in private or the person under investigation could be allowed extra support or other adjustments during the hearing itself.

Higher education

This formal investigation did not include, as part of its scope, the barriers to entry to the professions before the higher education stage. However, we heard from a wide range of organisations that disabled people are discouraged from becoming nurses, social workers and teachers and are sometimes discriminated against before they apply to higher education. Potential students may not have had a chance to get relevant experience through voluntary work, possibly because they have not had access to reasonable adjustments. Others have encountered prejudice in their previous educational careers, or in voluntary work.

“I applied to a local hospital to work shadow but when I went for the pre-shadowing session I was told by the person in charge that as a partially sighted person I could not be a nurse as I wouldn't be able to see the full length of a ward, see the instruments or fill in the paperwork.”

Applicants to higher education have a statutory duty to disclose information about disabilities or long-term health conditions for nursing courses across Britain, and for social work and teaching courses in England and Wales. Procedures are laid down by the regulatory bodies (as well as the Department for Children, Schools and Families (DCSF) in the case of teaching) for the assessment of students' health.

People are often uncertain about what information they have to disclose. Forms and requests for disclosure are often not explicit about their purpose. For example, whether the information is required for making reasonable adjustments, for assessment of a person's health or fitness, or for monitoring purposes. Health questionnaires are frequently intrusive, irrelevant and assume a model of perfect health, asking questions such as: 'Are you free from any physical defect or disability?'. They often make no mention of the DDA.

The regulatory requirement to disclose undermines the DDA, in that it deters people from asking for reasonable adjustments in higher education, which can lead to them being judged as incompetent and unsafe. The health standards foster the perception that they are there to prevent people who are disabled or have long-term health conditions from applying to higher education courses. Universities themselves express concern about the non-specific nature of the health standards and feel that they do not receive sufficient guidance from the regulatory bodies on managing the compulsory disclosure process.

This investigation also found that generalised health standards lead to universities and their occupational health services attempting to pre-judge the ability of disabled people to be able to practice competently and safely at the application stage or at entry to courses. It is important that disabled students – like all students – are given the opportunity to develop the relevant competencies during the course, with adjustments to enable them to achieve them.

“As a dyslexic teacher, the most important thing is that I empathise with the pupils who have special educational needs. When I’m in school I use many of the spelling strategies that are taught through the National Literacy Strategy and pupils comment that it is good to see a teacher using these and other spelling strategies, a dictionary or a spell checker in the classroom and not just seeming to pluck spellings out of the air.”

We found particular barriers for students with dyslexia, especially within nursing. There is a common perception that people with dyslexia cannot read and are therefore automatically a risk. However, the nature of dyslexia varies from person to person and many people with dyslexia develop effective coping strategies, including practices and procedures that can enhance safe working for all nurses.

“In 1999 I was a charge nurse in a mental health and deafness unit and some of the healthcare assistants were Deaf people whose preferred language was sign language. The first language of this unit is British Sign Language. A number of times I found myself shoulder to shoulder with one of my Deaf colleagues, and because of their proficiency in sign language and their cultural understanding, they were much more effective in dealing with the situation than I was. At the time they couldn’t qualify as nurses.”

Course leader, University of Salford mental health nursing course

Requirements for written and spoken English, laid down as competencies by regulatory bodies and universities, can disadvantage deaf students. English language standards, unlike generalised health standards, are likely to be competence standards and therefore the standards themselves do not need to be adjusted under the DDA. However, deaf people may be disadvantaged by these standards, so reasonable adjustments should be made to enable deaf people to have an equal chance of meeting these standards. People who use British Sign Language (BSL) need deaf nurses, social workers and teachers who can communicate directly with

them in their first language, so it is important that deaf people are allowed to train for these professions. We received evidence from a social work course and a nursing course that had successfully integrated and supported deaf students, including first language BSL users.

Occupational health services play a prominent role in deciding whether an applicant is fit to study and practice, particularly in nursing. Some occupational health providers take account of the DDA in their practice and take an active role in suggesting adjustments, while others do not seem to understand their role in supporting universities and employers to meet their DDA obligations.

There are inconsistencies in the use of occupational health services. For example, for nursing courses, some universities use NHS occupational health services while others use services specifically for higher education institutions. Different services are likely to be assessing students for different things, for example whether they can complete the course or whether they are likely to be able to practice as a nurse.

“Problems can arise when attempting to secure practice placements for students . . . Although we have offered a student a place, organisations might not be able, or be willing to offer a placement, eg a family centre operating from a converted council house has no wheelchair access to upstairs offices and meeting rooms.”

Evidence from a university

The investigation found that students often have a particular difficulty with work placements. This can be because of failures by the university to plan properly for placements, or to communicate the need for adjustments, or to cooperate with placement providers in planning adjustments. Placement providers often lack awareness of disability equality and the DDA, particularly the concept of reasonable adjustments. This issue can be exacerbated by the students’ own reluctance to disclose their disability or long-term health condition.

Employment

We looked at what impact the generalised health standards had on employment practice within nursing, teaching and social work. We found that it was occupational health services that were the significant determinant of how nurses, teachers and social workers were assessed. The regulatory bodies have a much smaller role in the regulation of

employment than they do in the regulation of higher education. In teaching in England and Wales there is detailed statutory guidance on the assessment of disabled people's fitness to be employed as teachers. The tone of these documents does not encourage disability equality, and the procedures laid down are likely to lead to discrimination.

“Occupational health (OH) professionals are often put under considerable pressure over the question of whether or not a person has a disability and often feel there is an unreasonable expectation by HR and management that they (OH) alone should make the decisions regarding ‘fitness’ for the job. There is a considerable tendency to ‘medicalise’ the problem and push the problem to OH for decisions – absolving management of their responsibilities.”

Association of Local Authorities Medical Advisers

The investigation found that public sector employers of nurses, teachers and social workers routinely use lengthy, over-inclusive and intrusive pre-employment health questionnaires. These are costly, not useful and potentially discriminatory because they focus on a person's diagnosis and not on the requirements of a particular job. Rejecting someone on the basis of a diagnosis, when this is irrelevant to the job, is direct discrimination under the DDA. Occupational health services used by these employers should instead focus on providing ongoing support for employees to retain them in the workforce.

There are specific jobs where it is necessary to require particular standards of health, for example the absence of a blood-borne virus or physical strength for lifting. However, we consider that any medical requirements or assessments should be very closely linked to the actual tasks to be performed and should be subject to reasonable adjustments.

“I am sight disabled. I was suspended by my employer who said that I was mentally unfit to teach children, when all their medical evidence said that I was perfectly fit to teach. They took this action after they had failed to enlarge documents for me for years and I had instructed a solicitor to help me. I eventually had to leave my job. The local authority then tried to prevent me from working as a supply teacher.”

We conclude that employers should only ask health questions when these are relevant and, to avoid discrimination, not until after an offer of

employment has been made. We believe that the practice of asking irrelevant pre-employment medical questions should be made unlawful. This is the approach in the United States, where the Americans with Disabilities Act (ADA) prohibits medical enquiries or examinations before the offer of a job. Where a disability or health condition means that someone is not able to do the job, the job offer can be withdrawn. In practice, this is likely to be infrequent.

We recommend that employers only use occupational health services that have an enabling, DDA-aware approach to providing these services, focusing on reasonable adjustments rather than the screening out of disabled people. Employers should also ensure that they understand their responsibilities under the DDA. Schools may have particular difficulties as decisions may fall on Head Teachers and governing bodies. Local authorities should support schools in becoming more DDA aware.

The DRC heard about the contribution that disabled people can make to the professions of nursing, teaching and social work. We also received evidence about the discrimination disabled people face working in these sectors. Employers should ensure that they and their occupational health providers support disabled people to enter and stay in employment.

“I have a false arm but it is more comfortable for me not to wear it. During my training, one ward manager made me wear it as she said that my scar was unsightly . . . On one occasion, I was treating a teenage girl who had recently had her arm amputated. Later, she told another member of staff that I had inspired her. I didn’t realise that I had helped her in any way, as she was just coming out of anaesthetic and was quite groggy – and I was just getting on with my nursing.”

Disclosing disabilities and long-term health conditions

For people training and working in nursing, teaching and social work, decisions about disclosing disabilities and long-term health conditions are not simply personal choices. There are two regulatory frameworks that inform these decisions.

First, the health standards themselves lay down requirements for disclosure¹¹ and, in some cases, procedures as well. Second, the reasonable adjustment duty of the DDA requires that higher education institutions, regulatory bodies and employers know about a person’s disability in order to make specific adjustments.

The compulsory requirement for disclosure arising from the health standards causes confusion and anxiety. People may not know whether a particular condition needs to be disclosed, and they may have concerns about the consequences of disclosing, or of not disclosing.

The effect of the health standards is to create an unwillingness to disclose a disability or long-term health condition, which in turn can affect the availability of adjustments and support.

People with fluctuating conditions, such as depression or multiple sclerosis, face particular difficulties around disclosure and may only disclose when they are faced with a crisis in their education, work placement or employment.

“When I re-register in two years’ time, I will have to sign to say I’m of sufficiently good health, . . . but then there may be a time in that period when I’m not and the concern for me is . . . that I’ll have to sign at a time when I’m unwell. . . . So if that comes in when I’m relapsed, how do I sign, what do I say? I’m not sure what they would do.”

Practicing nurse, ‘Disclosing disability research’

People with mental health problems face particular stigma and are sometimes singled out for investigation. This arises out of an association of mental health conditions with risk, reinforced by the recommendations from the Clothier report and the health standards themselves.

Few of the organisations that gave evidence to the DRC were prepared to straightforwardly and unconditionally advise disabled people to disclose their disability within these professions. Some organisations recommend that disabled people have a positive strategy around their disclosure.

This would consist of talking about reasonable adjustments rather than focusing on medical explanations, and having pre-prepared positive messages to counteract any negative reaction. It is imperative that a culture of trust exists within these professions, as disclosure is beneficial to everyone, including patients, pupils and clients.

“I was told over the phone that there was some discrepancy because I declared my HIV status to the GSCC and I hadn’t declared it to the education provider and it called into question my integrity and honesty; traits that a social worker must portray. Therefore it questioned my future . . . to be registered as a social worker. They also said the reason why I’m not registered as yet is because they are getting legal advice on what to do and how to proceed – that scared me to death.”

Tribunal applicant’s evidence to the investigation

“I don’t mind disclosing about my back. I guess for me it doesn’t carry the embarrassment factor. I mean anyone can get physically ill but mental illness is a different thing. There’s a stigma related to it and it’s not something that you talk about.”

‘Disclosing disability research’

“The DDA gives me confidence that I can disclose. I can tell them that I know that I’ve got legal backing should I need it and I’ve got some legal rights so that they can’t discriminate.”

‘Disclosing disability research’

Negative attitudes towards disabled professionals and students do not derive entirely from the health standards. The standards reflect, as much as they promote, negative attitudes towards disability at a societal level and perhaps simply provide a framework for formalising prejudice. They act as a deterrent to professionals who might not feel welcome within the professions anyway. Within these professions, people who are disabled or have long-term health conditions are primarily regarded as vulnerable people who receive help or care – and not as helpers or carers themselves.

In Scotland, where health standards for teachers and social workers have been removed, we found evidence that negative attitudes persist – we were told that ‘the culture on the ground has not changed’.

Nursing as a profession seems to be particularly intolerant of disabled practitioners. This may be linked to the perception of nurses as 'superhuman' and a desire to maintain the boundaries between those who care and those who are cared for. Without doubt, the Clothier report has had a lasting effect. Despite more than a decade of legal and social progress for disabled people, the perception still remains that disability, particularly a mental health condition, automatically means the presence of risk.

Statistics and research

The DRC found a dearth of research or data about disabled professionals within nursing, teaching and social work. This was one of the concerns that prompted us to carry out this investigation. Statistics, where available, suggest that disabled people are under-represented or are present but not disclosing their health or disability status and so are not represented in the figures.

In teaching, across Great Britain, less than one per cent of those on the professional registers have declared a disability. In social work, the equivalent figure is around two per cent.

In nursing, the Nursing and Midwifery Council (NMC) has not yet collected any statistics about disabled people on its register, although it has recently started monitoring in relation to staff. Monitoring is something that the DRC advised qualifications bodies to do in its 2004 Code of Practice as a way of 'determining whether anti-discrimination measures taken by an organisation are effective'. Several regulatory bodies have acknowledged that there are problems with data collection, due to issues of trust and disclosure.

In guidance on the DED, the DRC recommends that it may be appropriate to collect information according to impairment type, as disabled people with different impairments can experience fundamentally different barriers. This formal investigation has found that disabled people in the professions do indeed face different barriers depending upon their type of impairment. For example, people with mental health problems face particular assumptions and have particular concerns about disclosure.

During this investigation, the DRC asked organisations to send in relevant research they had conducted or commissioned to inform their own organisational practice, or to contribute to their understanding of the barriers that disabled people face. Very little research came to light. However, our investigation also revealed the need for further research. We

heard that organisations such as universities need information and guidance from the regulatory bodies, such as guidance about reasonable adjustments. Research, including evidence of good practice, should be undertaken to inform such guidance.

The DRC also heard from a range of organisations about the value of disabled role models within these professions, for other disabled professionals and for disabled patients, pupils and clients. However, we are not aware of any research about the value of role models or of any practical projects or pilots relating to this issue. Similarly, the DRC has not found any evidence about the value of mentoring or networking for disabled people in these professions and few examples of mentoring or networking being used to support disabled people. Research projects and evaluated pilot projects could be used to inform these issues.

There is also a need for further research into the culture within these professions – specifically around attitudes towards disability and how these attitudes might present a barrier to disabled people working or progressing.

Finally, our literature search¹² found little evidence of published or unpublished research about disabled people's perceptions of barriers to entry and training. Regulatory bodies should carry out or commission research of this nature to inform impact assessments about their own policies, procedures, practices and guidance documents.

Gathering disability information – through research or monitoring – is not an end itself, but should be placed in the broader context of promoting disability equality by using the information to help decide where action is most needed, taking such action, reviewing its effectiveness and deciding what further work needs to be done. This can be achieved by involving disabled people in framing the research questions and designing the mechanisms for gathering information. The inadequate research base should not be used as an excuse for delaying change; but without accurate knowledge of the barriers faced by disabled people within these sectors, these barriers cannot be successfully tackled.

Medicine, dentistry and other non-nursing health professions

The DRC's investigation focused mainly on nursing, teaching and social work. However the review of legislation, regulation and statutory guidance commissioned for this investigation, also covered (for reasons of comparison) the health standards, laid down in regulation, in medicine, dentistry and the 13 professions currently regulated by the Health Professions Council (HPC). This review found that similar regulatory frameworks, including discriminatory health standards, also exist across this wider group of health professions.

Evidence received from the HPC demonstrated a model of good practice within the current constraints imposed by the health standards. The HPC draws a crucial distinction between fitness to practice and fitness for a particular job in a particular setting. Registration does not guarantee that someone would be able to practice effectively in all settings. The HPC therefore argues that registration decisions should not be based on the possibility of future employment in a particular place.

"We wouldn't necessarily expect someone to disclose the fact they were HIV positive to us, provided they were abiding by Department of Health guidelines on safe practice. They might decide they want to disclose to their employer so they get back up and necessary safety protocols and anything else that they need to ensure the safety of their patients. I think people might decide to disclose to different people at different times for different reasons."

Health Professions Council evidence to the inquiry panel

The Commission for Equality and Human Rights (CEHR)

This investigation is published in the final month of the DRC's life (September 2007). The CEHR will take over the duties and powers of the DRC and we hope that it will follow up the findings and recommendations of this investigation vigorously.

Conclusions

We conclude that the statutory regulation of 'good health' and 'physical and mental fitness' for students and professionals in nursing, teaching and social work has a negative impact on disabled people and offers no protection to the public. Statutory health standards are discriminatory, and lead regulatory bodies, universities and, in some circumstances, employers to discriminate against disabled applicants, students and professionals.

Disabled people have a crucial role to play in Britain's public services. Further action is needed to promote equality in these sectors, including in Scotland where there are no generalised health standards for teachers or social workers, but where discrimination in these professions persists.

The scope of the protection against discrimination which the DDA offers disabled people has grown very considerably since the DDA originally came into force. It now provides comprehensive anti-discrimination measures across education and training, work placements, registration and employment.

This might be expected to have had a significant impact on policy and practice within the nursing, teaching and social work sectors across Great Britain – and indeed to have raised questions about the very existence and application of health standards. The Scottish Parliament clearly did consider the changed climate created by the DDA when it removed health standards for teachers, following consultation.

It might also be expected that the framework of rights and duties established by the DDA would now be reflected in the huge amount of primary and secondary legislation and statutory guidance which governs entry and retention within the professions. However, with the exception of the teaching profession, this is not the case. There is no mention of the DDA within the legislation, regulations or statutory guidance relating to social work except in Scotland and only occasional reference in the legislation and guidance applicable to nursing.

A radical rethink of the regulatory frameworks is now required if the professions are to maintain standards within a culture which also promotes equality.

The generalised health standards across nursing and social work derive from the Beverley Allitt case and the Clothier report – although the findings of the Clothier report did not demonstrate that any health standards, or

screening for mental and physical fitness, would have prevented the crimes she committed against patients. The standards were nevertheless brought in, extended across other professions, and are still being extended, currently through the Government's White Paper and the professionalisation of the wider children's workforce in England and Wales.

We have found no evidence that the use of generalised health standards is an effective way of assessing or managing risk. These standards, while not solely responsible for the existence of an automatic assumption of risk in relation to disabled people in the professions, provide a statutory basis for these negative attitudes.

The regulatory bodies have different roles within their professions. In teaching in England and Wales, the situation is complex with responsibility for health standards and competence standards spread across the General Teaching Councils, the Training and Development Agency for schools (TDA) and the Government departments.

It is important that, separately for each sector, the statutory and regulatory organisations work together to use available information (and gather further information from data, research, consultation and involvement of disabled people) to inform their policies and practices.

Where regulatory bodies have an advisory function to governments, they should provide advice about the discriminatory effects of health standards, where those standards exist.

All the regulatory bodies, across England, Scotland and Wales, should review their competence standards to ensure that any negative impact on disabled people is eliminated. They should provide guidance on reasonable adjustments and consider what other guidance to provide to encourage others (such as higher education institutions) to adopt an enabling approach to disabled people.

Changes should be made to the legislation establishing the regulatory bodies so that as part of their functions they are required to have regard to the requirements of disabled people. Confusion around the circumstances in which professional regulation takes precedence over the DDA could also be eliminated through changes to primary legislation and regulation covering the professions. Some of the regulatory bodies are currently not listed as having specific duties under the Disability Equality Duty, namely the Care Council for Wales (CCW) and the General Teaching Council for Scotland (GTCS). This should also be remedied.

The DRC has found evidence of discrimination in the higher education sector against students wanting to train in nursing, teaching and social work. This is despite the positive and enabling practice that is often present in the sector, and the genuine desire to widen access to higher education for disabled students. There are real difficulties in marrying up the two approaches – on the one hand the positive encouragement of disabled students into higher education and on the other the regulatory frameworks that require compulsory disclosure and often lead to discriminatory policies and practices.

Universities follow the procedures laid down by statutory and regulatory bodies, but outcomes depend on how the universities or their occupational health services judge a student's or applicant's fitness. The DRC is opposed to the practice of attempting to judge the likely future competence or career success of disabled applicants or students at entry point.

The influence of the statutory and regulatory frameworks requiring physical and mental fitness is less obvious at the employment stage. This is unsurprising, as the regulations covering nursing, teaching and social work are mostly focused on higher education and registration (except in teaching in England and Wales, where regulations are also directed at entry to employment). Nevertheless, there is a widespread practice of health screening, which is frequently not related to the specific job role. This has the potential to lead to discrimination and to deter disabled people from applying for jobs or from disclosing disabilities and long-term health conditions.

The DRC found that the use of pre-employment health screening questionnaires is widespread, although we did not find evidence that disabled people are routinely turned down for jobs solely on the basis of these questionnaires. However, occupational health organisations told us that questionnaires have other drawbacks – they do not promote an enabling approach to disability (as they lead to predictions and assumptions based on diagnosis) and they are a substantial waste of resources. Different occupational health practitioners work to different models. Employers should ensure that they only use occupational health services that are compliant with the DDA and focus on reasonable adjustments.

It is clear from our evidence about the regulatory frameworks, and from DDA cases and personal testimonies, that the threat to a person's career following disclosure is a real one and that safe conditions for disclosure within nursing, teaching and social work do not exist.

We have also seen that the health standards, with their implicit assumptions about the 'risk' from disabled people within these professions, discourage positive organisational cultures. There is evidence that disabled people, where they recognise that they are covered by the DDA, gain real confidence from this legislation and feel empowered to negotiate with their higher education institutions about adjustments as a result of it.

In contrast to this, the DRC's Inquiry Panel heard repeatedly that the regulations requiring good health or physical and mental fitness create a climate where disability is not perceived positively, so affecting people's willingness to disclose and to ask for adjustments.

Historically, there is a paucity of robust and comparable information on disability, with no one satisfactory data source – even at the national level. Within the professional sectors we have investigated, data gathering about disability is very new. One regulatory body has not yet gathered any disability data about its registrants.

Looking more widely at research carried out by other organisations, there is very little to inform the nursing, teaching or social work sectors about the barriers that disabled people face within these professions, or to help organisations to tackle these barriers. Where research of this nature has been carried out, it is not clear how this has informed policy or practice in the relevant sectors or within the organisations that carried out or commissioned the research.

Gathering disability information is not an end itself but should be placed in the broader context of promoting disability equality.

Finally, we conclude that a framework of professional standards of competence and conduct, coupled with effective management and rigorous monitoring of practice, is the best way to achieve equality for disabled people and the effective protection of the public.

Recommendations

The evidence collected for this formal investigation makes a compelling case for the revocation of generalised health standards for professionals in nursing, teaching and social work. It also makes the case for other actions to promote equality for disabled people. Below we summarise the main recommendations of the investigation in relation to who is responsible for them.

Many of these recommendations are things which public bodies should be doing in any event to comply with their Disability Equality Duty – in particular, the need to conduct impact assessments, so that they can ensure that due regard is being taken of disability equality.

The Department of Health and the Department for Children, Schools and Families should:

1. Revoke the statutory regulation of health in nursing across Great Britain and in teaching and social work in England and Wales.
2. Ensure that existing regulation of registration and revalidation are concerned with assessing competence and conduct, with effective methods of monitoring and information exchange.
3. Not extend the regulation of health to other occupations, to students, or through the introduction of revalidation. All extensions and harmonisation of professional regulation should focus on competence and conduct and not include mental or physical fitness or health.
4. Review their guidance to ensure that it is up to date with present legislation and is non-discriminatory.
5. Consider with the relevant regulatory bodies, the findings and recommendations of this report as part of the responsibility of Secretaries of State and Scottish and Welsh ministers to report on action their Departments have taken to promote equality under the Disability Equality Duty in 2008.

The Council for Healthcare Regulatory Excellence (CHRE) should:

6. Take a pivotal role in coordinating the regulation of healthcare professions and quality assuring mechanisms to assess competence and conduct.

The other relevant regulatory bodies across England, Scotland and Wales should:

7. Remove all requirements for good health or physical and mental fitness that are within their remits.
8. Review their statutory disability equality schemes and involvement of disabled people.
9. Carry out impact assessments of:
 - their policies, practices and procedures
 - their processes for assessing fitness to practice, for example fitness to practice hearings
 - English language standards and competence standards in general
 - their main methods of communication with actual and potential professionals.
10. Where competence standards are found to have an adverse impact on disabled people, consider whether they are necessary and, if they are, how adjustments can be made to enable disabled people to meet the required standards.
11. Carry out or commission research on the provision of reasonable adjustments for students (during university based training and work placements) and pull together information about good practice.
12. Issue guidance to help higher education institutions to make adjustments to enable disabled people to meet the competence standards.
13. Review systematically existing publications and examine the quality of advice given verbally to individuals and higher education institutions.
14. Review registration application processes to ensure that disabled people are not disadvantaged and ensure that there are adequate feedback and complaints procedures.
15. Where appropriate, continue to make enquiries in relation to prospective registrants about conditions which are not covered by the DDA, such as alcohol and drug dependence, paedophilia and kleptomania.

16. Not use a failure to disclose a disability or long-term health condition as evidence of 'bad character' or as something that should lead to disciplinary action.

Higher education institutions should:

17. Maintain high professional standards for disabled and non-disabled students alike but not pre-judge the professional competencies of disabled applicants or students.
18. Consider the experiences of those higher education institutions that have enabled deaf students to qualify and practice in these professions, for examples of good practice. Higher education institutions should also consider the research carried out, and advice given, by higher education institutions that have supported nursing students with dyslexia.
19. Properly plan work placements for disabled students. Higher education institutions should take steps to ensure that, with the permission of disabled students, sufficient information about adjustments is shared with work placement providers.
20. Ensure that occupational health (OH) services operate in accordance with the higher education institutions' obligations under the DDA, that they are enabling and focus on reasonable adjustments and not on medical diagnosis. Higher education institutions should ensure that OH services understand that professions include a variety of roles and that a student may be able to undertake some roles and not others.
21. Ensure that disabled people are not expected to meet competence standards at application, or at the beginning of courses, that other students are only expected to meet during, or at the end of, their courses.
22. Carry out impact assessments of:
 - processes for allocating and arranging work placements
 - the provision of occupational health services
 - admission procedures.
23. Monitor the numbers and progress of disabled nursing, teaching and social work students, and monitor according to impairment category if considered relevant. Maximise the reliability of monitoring information

by comparing it to other available disability statistics. Higher education institutions should consider how to use this information to inform impact assessments and action.

Employers should:

24. Not ask irrelevant health questions. Health questions, if relevant to a specific job, should only be asked after an offer of employment has been made.
25. At recruitment stage, prior to a job offer, limit questions about disability to those that are concerned with reasonable adjustments for the recruitment process.
26. Ensure that they use occupational health providers that understand the DDA, work in a DDA-compliant way, and focus on reasonable adjustments rather than medical diagnosis.
27. Monitor staff including the numbers of disabled nurses, social workers and teachers, and monitor according to impairment categories if this is considered to be relevant.
28. Maximise the reliability of monitoring information by comparing it to other available disability statistics. Employers need to consider how to use the information to inform impact assessments and action.
29. Carry out impact assessments of:
 - their provision of occupational health services
 - their recruitment processes (local authorities should also review the advice and guidance, both verbal and written, given to schools about the employment of teachers)
 - the way that work placements are made available to trainee nurses, teachers and social workers.
30. Not use a failure to disclose a disability or long-term health condition as evidence of 'bad character', and not use such a failure to disclose to trigger disciplinary action, unless there are serious concerns about conduct or competence arising from this non-disclosure.
31. Test professionals for the presence of blood borne viruses prior to and during employment only in roles that involve invasive health treatments, such as working within a wound.

Occupational health services should:

32. Review, with employers, the questionnaires used to gather health information and ensure that assessment of health is tailored to particular jobs, and that these assessments are made only after the offer of a job.
33. Be clear about the purpose of their service, for example, supporting employers and employees to achieve health, well-being and productivity at work, mindful of the range of legal and ethical responsibilities of all parties.
34. Ensure a focus on providing long-term support where necessary to enable someone to stay on a course or in a job.
35. Under the leadership of the Faculty of Occupational Medicine, ensure that the practice of all services is raised to the standard of the best and that practitioners receive training on the DDA and disability equality.
36. Consider the recruitment and retention of disabled occupational health professionals.

All organisations¹³ responsible for the promotion of careers in nursing, teaching and social work should:

37. Actively promote entry of disabled people into the professions, for example through websites, literature, advertising, promotional events and through careers services.
38. Use monitoring and research information from regulatory bodies, employers and higher education institutions to determine which groups are under-represented and use impact assessments to identify how they can encourage disabled people to enter the professions. In doing so, they will be fulfilling their disability equality duties.

All relevant organisations should:

39. Take action to tackle the confusion throughout these sectors on what does and does not constitute a 'disability' and who is covered by the DDA.
40. Combat the perception within these professions that disabled people are vulnerable people who receive help or care and cannot be professionals themselves.

41. Tackle the stigma and unwillingness to disclose in relation to many disabilities and health conditions, particularly mental health.
42. Take a sensitive approach both to encouraging disclosure and to handling personal information following disclosure.
43. Make clear why information about disability or long-term health conditions is being collected, who will see it and what use it will be put to.
44. Create an inclusive culture and environment that promotes disclosure, including where:
 - there are role models for disabled people – for example, managers or tutors who are disabled and are open about their disability
 - mistakes made by disabled people, particularly in a learning environment, will be expected and tolerated, as they would with any student or practitioner, and not automatically attributed to disability
 - disability is seen as a welcome difference and not as a deficit
 - reasonable adjustments are made, and disabled students and practitioners are aware that these have been made and aware of other adjustments that might be available to them
 - colleagues, or in the case of higher education, fellow students, also have positive attitudes towards disability and understand that reasonable adjustments are about equality not preferential treatment.
45. Collaborate to increase the very limited evidence base on the experiences of disabled people in these professions, or excluded from these professions, and the limited amount of statistical information available. Research should involve disabled people, not only as respondents.

Regulators and representative bodies within medicine, dentistry and other non-nursing health professions should:

46. Review the findings and recommendations of the DRC's investigation (including the analysis of regulatory frameworks) and consider their applicability to these other professions.

The Commission for Equality and Human Rights should:

47. Adopt the findings and recommendations of this investigation and press government for the revocation of the health standards.
48. Stimulate activities to encourage disabled people to work and stay in these professions and take action to address the barriers we have found.

Inquiry Panel Members

- Karon Monaghan (Panel Chair) Barrister, Matrix Chambers, specialising in discrimination, equality, human rights and European Union law
- Richard Exell OBE Commissioner, DRC
- Agnes Fletcher Director of Policy and Communications, DRC
- Janet Fox Disability Lead, NHS Employers
- Murray Glickman Employment Support Officer, Association of Blind and Partially Sighted Teachers and Students (ABAPSTAS)
- Anne Jarvie Chief Nursing Officer for Scotland (retired)
- Younus Khan Diversity Services Coordinator, RNIB
- Stuart Nixon Clinical Services Coordinator, St Woolos Hospital
- Dr James Palfreman-Kay Manager, Disability Services at Bournemouth University and Chair of National Association of Disability Practitioners
- Professor Jonathan Richards General Practitioner and Professor of Primary Care, University of Glamorgan
- Professor Sheila Riddell Director of the Centre for Research on Education, Inclusion and Diversity (CREID), University of Edinburgh
- Dr John Sorrell Chair, Association of Local Authority Medical Advisors (ALAMA)

Inquiry Panel Witnesses

- Action on Access
- Adult Dyslexia Organisation
- Amanda Bates, Nursing applicant
- Arthritis Care
- Association of Disabled Professionals
- Brighton University
- British Association of Social Workers
- British Dyslexia Association
- Business Medical Limited
- Council for Healthcare Regulatory Excellence (CHRE)
- Department for Education and Skills (DfES), responsibilities later moved to the new Department for Children, Schools and Families and Department for Universities, Innovation and Skills
- Careers Scotland
- Council of Deans
- Department of Health
- General Medical Council (GMC)
- General Social Care Council (GSCC)
- General Teaching Council for England (GTCE)
- General Teaching Council for Scotland (GTCS)
- General Teaching Council for Wales (GTCW)
- Guys and St Thomas' NHS Trust
- Health Professions Council (HPC)
- Higher Education Occupational Physicians/Practitioners (HEOPS)

- Institute of Education
- Institute of Psychiatry
- LLU Plus at London Southbank University
- Mind
- National Association of Schoolmasters Union of Women Teachers (NASUWT)
- National Union of Teachers (NUT)
- Newcastle Occupational Health
- NHS Education Scotland (NES)
- NHS Employers
- Nursing and Midwifery Council (NMC)
- Occupational Health at Work/the At Work Partnership
- RADAR
- Royal College of Nursing (RCN)
- Royal College of Physicians
- Scottish Executive Education Department
- Scottish Social Services Council (SSSC)
- Skill
- Social Services Department, Torfaen Council
- Social Work Team Manager,
- Sensory Services, Trafford
- Special Needs and Psychology Service for
- Essex County Council
- Stephen Wyatt, Retired Head Teacher

- Thompson Solicitors and client
- Training and Development Agency for Schools (TDA)
- Trinity and All Saints College, Leeds
- UNISON
- University and College Union (UCU)
- University of Greenwich
- University of Manchester, Sensory Services
- University of Huddersfield
- University of Lincoln
- University of Manchester, Disability Office
- University of Manchester, Sensory Services
- University of Nottingham
- University of Salford
- Welsh Assembly

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- Research into assessments and decisions relating to 'fitness' in training, qualifying and working within teaching, nursing and social work. Jane Wray, Helen Gibson and Jo Aspland, University of Hull – DRC, 2007.
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- Assessments and decisions relating to 'fitness' for employment within teaching, nursing and social work: A survey of employers. Janice Fong, Chih Hoong Sin, with Jane Wray, Helen Gibson, Jo Aspland and Data Captain Ltd – DRC, 2007.
- The Disability Rights Commission's formal investigation into fitness standards in social work, nursing and teaching professions: Report on the call for evidence. Chih Hoong Sin, Janice Fong, Abul Momin and Victoria Forbes – DRC, 2007.

All reports, including the full report of the investigation, can be found at www.maintainingstandards.org

Endnotes

¹ The umbrella term 'disabled people' is often used in this document. When it appears it refers to all those who have a disability or long-term health condition such that they are likely to meet the definition of disability in the Disability Discrimination Act 1995. This includes people with sensory and visual impairments, learning disabilities, mental health conditions and long-term and/or fluctuating health conditions such as diabetes, HIV, multiple sclerosis and cancer.

² Figures from Labour Force Survey January-March 2007.

³ David Ruebain, Jo Honigmann, Helen Mountfield and Camilla Parker (2006) Analysis of the statutory and regulatory frameworks and cases relating to fitness standards in nursing, teaching and social work.

⁴ Jane Wray, Helen Gibson and Jo Aspland (2007) Research into assessments and decisions relating to 'fitness' in training, qualifying and working within Teaching, Nursing and Social Work.

⁵ Janice Fong, Chih Hoong Sin, with Jane Wray, Helen Gibson, Jo Aspland and Data Captain Ltd. (2007) Assessments and decisions relating to 'fitness' for employment within teaching, nursing and social work: A survey of employers.

⁶ Nicky Stanley, Julie Ridley, Jill Manthorpe, Jessica Harris and Alan Hurst (2007) Disclosing Disability: Disabled students and practitioners in social work, nursing and teaching.

⁷ Chih Hoong Sin, Janice Fong, Abul Momin and Victoria Forbes (2007) The Disability Rights Commission's formal investigation into fitness standards in social work, nursing and teaching professions: Report on the call for evidence.

⁸ A competence standard is defined by the DDA as an academic, medical or other standard applied by or on behalf of an education provider or qualifications body for the purpose of determining whether a person has a particular level of competence or ability.

⁹ The Westminster government has jurisdiction for health regulation across England, Scotland and Wales.

¹⁰ In Scotland, there are no generalised health standards for social

workers or teachers, so the recommendation to revoke these standards does not apply.

¹¹ In teaching and social work in Scotland there are no regulatory requirements to disclose disability to higher education institutions, regulatory bodies or employers, except in employment in social work if health or disability is relevant to a specific job.

¹² Background to the DRC's formal investigation into fitness standards in the nursing, teaching and social work professions: Paper prepared by Chih Hoong Sin, Monica Kreeel, Caroline Johnston, Alun Thomas and Janice Fong, DRC 2006.

¹³ These organisations include NHS Employers, NHS Scotland, the Training and Development Agency for Schools, the General Teaching Council for Wales, the General Teaching Council for Scotland, The Department of Health, the Scottish Social Services Council and National Workforce Group for social work and social care staff in Scotland.

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