

maintaining standards

promoting equality

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

Disability
Rights
Commission

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 practise 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

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Executive Summary

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 Britain². 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.

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

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 practise 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.

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.

- 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 appropriate sections of this report.

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 the social work, nursing and teaching professions: Report on the call for 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 standards⁸, 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

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”

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.

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.

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.

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 practise.

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.

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.

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

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

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

10 In Scotland, there are no generalised health standards for social workers or teachers, so the recommendation to revoke these standards does not apply

should consider whether they are necessary, and consider how adjustments can be made under the DDA to the way that these standards are assessed.

For example, English language standards may be genuine competence standards and therefore not subject to the duty to make reasonable adjustments under 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.

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.

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.

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 practise, 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 practise as a nurse.

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.

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.

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 inquiries 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.

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 disclosure 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.

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.

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 search¹¹ 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

11 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 Kreel, Caroline Johnston, Alun Thomas and Janice Fong, DRC 2006

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 practise and fitness for a particular job in a particular setting. Registration does not guarantee that someone would be able to practise 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.

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.

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, practises and procedures
 - their processes for assessing fitness to practise, 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 practise 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 organisations¹² 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.

12 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

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.

Chapter 1 – Background to the Formal Investigation

1. In May 2006 the DRC launched a formal investigation into the barriers that disabled people face entering, and staying in, nursing, teaching and social work, focusing on the barriers arising from the statutory regulation of these professions. During this general formal investigation, the DRC has worked with a very wide range of organisations and individuals to lift the lid on a complicated and previously under-researched set of issues.
2. In teaching, social work, and nursing and across other health professions such as medicine and dentistry, there are health related standards that determine who can enter and remain within these professions. Some of these standards are explicitly set out in legislation, whilst others are found within guidance covering entry to education or employment. With the exception of teaching and social work in Scotland, generalised health standards apply to nursing, teaching and social work across Great Britain. The DRC had particular concerns about the way that these standards affect disabled people's access to and retention in these professions, and felt that it was the DRC's role to question whether these standards are compatible with the DDA and whether they act to deter or exclude disabled people. Protection of the public is clearly at the heart of professional regulation so it

was important to also consider whether the current frameworks serve the interests of the public. This investigation, therefore, set out to analyse in detail the relevant regulatory frameworks, their purpose and effect, and to make recommendations for reform of professional regulation.

3. Through this investigation the DRC aimed to pull together, for the first time, much needed information about the experiences of disabled people studying, qualifying, registering, and practising within these professions. The differences and similarities of regulation and practice across the professions, and across England, Scotland and Wales, were used to explore good and bad practice and to make recommendations for change to policy, practice and attitudes towards disabled people as professionals.
4. This formal investigation has now been completed. This report presents the DRC's findings and recommendations and is published in accordance with paragraph 7(4) of Schedule 3 of the Disability Rights Commission Act 1999. Our recommendations were listed in the preceding section.

Purpose and Scope

5. The DRC undertook this investigation because of serious concerns about disabled people's participation within the professions of nursing, teaching and social work¹³. Statistics from across these professions, where available, suggested that

13 Initial evidence was gathered from a number of different sources and was set out Chih Hoong Sin, Monica Kreeel, Caroline Johnston, Alun Thomas and Janice Fong (2006) Background to the Disability Rights Commission's Formal Investigation into fitness standards in social work, nursing and teaching professions. See appendix B for full details of this paper and other papers published by the DRC for this investigation.

disabled people, including those with long-term health conditions, were under-represented; or were present but not disclosing their disability status and so not represented in the figures. The DRC's legal and casework teams had dealt with a number of cases that raised concerns about the effect of statutory regulation laying down general health requirements. A literature search¹⁴ also suggested that disabled people faced a culture within these professions, whereby they were normally seen as people who received help or care, and not as helpers or carers themselves.

6. The scope of the investigation was determined by a number of factors. The DRC has jurisdiction across England, Scotland and Wales, so it was important to look at regulation and practice across these countries. In England and Wales, these three professions – nursing, teaching and social work – have similar regulatory frameworks which all include generalised health standards and a requirement for people to disclose health conditions and disability. In Scotland, there are differences for teaching and social work, which warranted exploration and comparison. They are professions in which anxieties about risk are high. Professionals have regular, often unsupervised, contact with children, people who are ill or in other ways deemed to be 'vulnerable' and there is currently an increased focus on regulation, at registration but also in the form of re-validation, in the aftermath of the Shipman and other inquiries.
7. Nursing, teaching, social workers between them, employ very large numbers of people in the public

14 The scope and search terms of the literature search are laid out in the Background evidence paper, DRC 2006. The most significant relevant literature is also reported in the paper. See appendix B for details

sector – with around half a million nurses, around 700,000 teaching professionals, and around 80 000 social workers in Great Britain¹⁵. These professions are significant in everyone's lives, but can particularly affect the life chances of disabled people as patients, pupils or clients. It is important, therefore, that they reflect the full diversity of society in order to provide disabled people with the services that they deserve, and to lead the way in challenging myths and stereotypes about disability.

Formal investigations

8. The DRC was established as an independent body in 2000, by Act of Parliament, to stop discrimination and promote equality of opportunity for disabled people. The DRC's goal is a society where all disabled people can participate fully as equal citizens. Under the Disability Rights Commission Act 1999, the DRC was empowered to conduct a formal investigation for any purpose connected with the performance of its duties under section 2(1) of the Act.
9. Those duties are:
 - To work towards the elimination of discrimination against disabled people
 - To promote the equalisation of opportunities for disabled people
 - To take such steps as it considers appropriate with a view to encouraging good practice in the treatment of disabled people
 - To keep under review the working of the DDA

15 Figures from the Labour Force Survey, Great Britain, January-March 2007

10. The terms of reference, which the DRC is required to publish at the launch of the investigation, were:
- To investigate the regulatory framework that determines whether people are considered mentally or physically suitable to study, qualify, register or work within the occupations of nursing, teaching, social work, (and, for good or poor practice comparisons, other regulated health professions). To make recommendations for changes to the regulatory frameworks for nursing, teaching and social work where these are considered not to be compliant with the DDA – particularly the new disability equality duties that require action by public authorities to promote equality for disabled people, as defined in the Act.
 - To investigate the implementation of these regulatory frameworks in nursing, teaching and social work in terms of compliance of policies and processes and the quality of decision-making. To make recommendations for changes to policy and practice in relation to decision-making if discrimination is found or best practice identified that promotes equality of opportunity for disabled people.
 - To investigate the experiences of people with impairments and long-term health conditions studying or working within nursing, teaching and social work in relation to disclosing information about their impairments and long-term health conditions. To make recommendations for changes to policies and practices on disclosure within nursing, teaching and social work that would encourage people with impairments and long-term health conditions to disclose such information.

Methodology

11. This investigation has, within a short time frame¹⁶, lifted the lid on a complex web of regulations, policies, practices and attitudes that contribute to systemic discrimination against disabled people studying, registering and working within nursing, teaching and social work and those who may be considering entering those professions.

12. Following two years of initial research and evidence gathering, the DRC launched this investigation by commissioning a review of the primary and secondary legislation and statutory guidance, that governs health standards (and other relevant standards that impact on disabled professionals) within teaching, social work and nursing and other health professions, such as medicine and dentistry¹⁷. This has been published on DRC's website as "Analysis of the statutory and regulatory frameworks and cases relating to fitness standards in nursing, social work and teaching" prepared on behalf of the DRC by David Ruebain and Jo Honigmann, Levenes Solicitors; Helen Mountfield, Matrix Chambers; Camilla Parker, Mental Health and Human Rights Consultant, November 2006. The purpose of this review was to explore the interaction of the professional regulatory frameworks with the DDA, and to uncover the differences and similarities in approach between professions, across England, Scotland and Wales and at different career stages (higher education, registration and employment). Regulations covering professionals registering and

16 The DRC Act dictates that formal investigations must be completed within 18 months.

17 A wider group of professions was looked at for this part of the investigation for purposes of comparison.

working in GB from EU and non-EU countries were also considered.

13. The regulatory review also collected and analysed legal cases and some complaints concerning disability discrimination or health standards within this wider group of professions. The DRC has been informed of further cases and complaints of disability discrimination within these professions in the course of carrying out this investigation. Some of the cases brought to the attention of the DRC through the case review and through other sources are included in this report.
14. The DRC believed, from its early evidence gathering, that the cause of disabled people's apparent under-representation in these professions was unlikely to be simply the regulations themselves. The interpretation of these regulations by higher education institutions, regulatory bodies and employers also warranted exploration. A project looking at how decisions are made about disabled people's fitness to study and work within nursing, teaching and social work was commissioned and carried out by a team from the University of Hull and the Social Care Workforce Research Unit, King's College. This has been published online at www.maintainingstandards.org as "Research into assessments and decisions relating to 'fitness' in training, qualifying and working within teaching, nursing and social work". This research was supplemented by a survey of employers, published as "Assessments and decisions relating to 'fitness' for employment within teaching, nursing and social work: A survey of employers" by Janice Fong, Chih Hoong Sin, with Jane Wray, Helen Gibson, Jo Aspland and Data Captain Ltd.
15. We also commissioned a research project looking at disabled people's attitudes towards disclosing

disability. This was carried out by Nicky Stanley, Julie Ridley and Alan Hurst at the University of Central Lancashire and Jill Manthorpe and Jessica Harris at the Social Care Workforce Research Unit, King's College London. It has been published online at www.maintainingstandards.org as "Disclosing disability: Disabled students and practitioners in social work, nursing and teaching". The purpose of this research was to explore the factors that contributed to disabled people disclosing, or not disclosing, information about their disability to higher education institutions, regulatory bodies or employers within these professions.

16. At the half way point in the investigation, a call for evidence went out to key organisations involved in the implementation of professional regulations, and organisations representing people affected by these regulations (such as trade unions and disability organisations). Evidence was requested across four themes – views on the professional regulatory frameworks and the DDA; policy and guidance documents relevant to disabled people or to the implementation of generalised health standards; relevant research carried out, commissioned or known to the organisations; and relevant statistics about disabled professionals, students or registrants. A full report is published as "The Disability Rights Commission's formal investigation into fitness standards in social work, nursing and teaching professions: Report on the call for evidence" by Chih Hoong Sin, Janice Fong, Abul Momin and Victoria Forbes.
17. In January 2007 an Inquiry Panel was convened, chaired by a barrister, Karon Monaghan. The panel was made up of people with knowledge of the three professions, disability issues, occupational health, higher education and the regulatory contexts across

England, Scotland and Wales¹⁸. The panel heard evidence from around 45 organisations, including regulatory bodies, government departments, trade unions, researchers, disability organisations, employers, higher education institutions and occupational health organisations. The Panel also heard the personal experiences – positive and negative – of disabled people studying or working within nursing, teaching and social work.

18. The involvement of individuals and relevant organisations has been highly valued throughout this investigation. The regulatory bodies for teaching, nursing and social work across England, Scotland and Wales¹⁹ were consulted prior to the investigation and were invited to contribute to relevant evidence gathering stages, including the Inquiry Panel. They all gave their support to the investigation. Under the Disability Equality Duty, many of the regulatory bodies covering nursing, teaching and social work are listed as public bodies subject to the specific duties. The DRC has reviewed the Disability Equality Schemes of these organisations²⁰ and has made recommendations within this report about how the regulatory bodies can promote disability

18 See Appendix C for a list of Inquiry Panel members

19 Nursing and Midwifery Council (NMC), General Social Care Council (GSCC), Scottish Social Services Council (SSSC), Care Council for Wales (CCW), General Teaching Council England (GTCE), General Teaching Council Wales (GTCW), General Teaching Council Scotland (GTCS) and Training and Development Agency for Schools (TDA). A Glossary is provided in Appendix E.

20 GSCC, NMC, GTCE, TDA and SSSC. Other regulatory bodies including CCW, and GTCS are not currently listed as organisations with a specific disability equality duty. The GTCW and Council for Healthcare Regulatory Excellence (CHRE) were added as scheduled bodies with specific duties from 6 April 2007.

equality. However the DRC's assessments of these schemes have not been included, as this is part of a separate statutory process.

19. Disabled people's organisations, trade unions, higher education bodies, occupational health organisations and the regulatory bodies have also fed in to a reference group that helped to shape the investigation. Disabled people have also contributed their experiences through a web-based form, and by emailing the DRC. The DRC's black and minority ethnic (BME) advisory group and its Mental Health Action Group have also been consulted.
20. The research projects and other strands of work that made up this investigation form an important body of work that shines a light on an under-researched field. The main findings from these projects and from the DRC's Inquiry Panel have been brought together in this report to inform the conclusions and recommendations. The separate research reports which the DRC commissioned as part of this investigation, and other reports of evidence are listed in Appendix B and published at www.maintainingstandards.org
21. The DRC is very appreciative of all the organisations and individuals who have contributed to this investigation, including those individuals who volunteered to be part of the Disclosing Disability research project; organisations that responded to the other research projects; individuals who completed the DRC's web-based form, and who contacted the DRC project team or helpline with their experiences; those who participated in reference group meetings; those who sent in written evidence and those who gave oral and British Sign Language (BSL) evidence to the Inquiry Panel. In particular the DRC would like to thank all the members of its Inquiry Panel and the

chair Karon Monaghan, who contributed their professional expertise and personal experiences and committed so much time and hard work to the investigation. Richard Exell, DRC lead Commissioner for this investigation, also made a valuable contribution.

22. Finally, we would like to acknowledge all the members of staff who worked incredibly hard to complete the investigation before the end of the DRC. The team comprised Abul Momin, Agnes Fletcher (project director), Alun Thomas, Breda Twomey, Carol Stewart, Caroline Johnston, Cathy Casserley, Catriona Nicholson, Chih Hoong Sin, Chris Oswald, Gemma Holloway, Gloria Adoch, Jackie Driver, Janice Fong, Joanna Owen, Jonathan Holbrook, Karen Jones, Katie Grant, Kirsty Ginn, Laura Pollitt, Lisa Boardman, Monica Kreel (project manager and report author), Nick O'Brien, Nicola Pazdzierska, Patrick Edwards, Steve Haines, Tony Hawker, Vicky Forbes and Will Dingli.

Structure of the Report

23. Part 1 of this report provides an overview of the regulatory frameworks which impact on disabled people wanting to study or work within nursing, teaching and social work. We carried out a detailed review and analysis of the legislation, regulations and statutory guidance covering these professions (and other health professions) and this is summarised in Chapter 2. We believe this is the first time this has been done, and noticed during the investigation that organisations working in these sectors had often taken these regulations as given and had not critically appraised them. This section is fairly technical, but we felt it was important to clearly demonstrate where the requirements for mental and physical fitness stem from, and to question their validity. In Chapter 3 we

look at the way the DDA gives rights to disabled people training, registering and working in these professions and places obligations on all the relevant organisations, including the new DED. This deals with some crucial issues about the way the DDA interacts with the professional regulations and questions whether professional regulations “override” the DDA.

24. In Part 2 we move on to look at how the statutory and regulatory frameworks operate in practice. In Chapter 4 we look at how they contribute to a culture where disability is associated with risk, drawing on the findings of previous Inquiries, such as the inquiry into the crimes of Beverley Allitt. We look at the role of the regulatory bodies themselves, in Chapter 5, and we present our findings about the current functions and practices of these bodies. The investigation’s findings about practice within higher education and employment are discussed in Chapters 6 and 7 respectively. An issue that affects every stage of disabled people’s careers is the decision about when and how to disclose their disability status, and how much to reveal. This is dealt with in Chapter 8. Our findings about the kinds of information about disabled professionals that organisations have gathered through monitoring and research are presented in Chapter 9, where we also question why so little research has previously been done.
25. In Chapter 10 we draw together our conclusions.

Use of evidence

26. All the evidence sources – research, the regulatory review, written evidence, oral evidence from the Inquiry Panel, and stories and cases sent in through the website – have been drawn on for all sections of this report. The Inquiry Panel was a crucial stage of the investigation as it gave us a chance to probe

some really difficult and sensitive issues. We heard some shocking stories of discrimination, as well as examples of good practice. This has been a general formal investigation, and it is not our intention to point the finger of blame at specific organisations.

We are aware that organisations, especially employers and universities, are trying to operate within a framework not of their own making. Where evidence is sensitive and appears to implicate an organisation or reveals personal details, we have not named the organisation or the individual (although the DRC holds complete records). Where oral evidence from organisations or individuals has been quoted directly in this report, they have given their permission.

Chapter 2 – The Regulation of Nursing, Teaching and Social work

1. Early on in this investigation we set out to explore both the nature and extent of the regulations that set standards for physical and mental fitness (as well as other standards affecting disabled people) in the nursing, teaching and social work professions, and the way that these regulations are put into practice.
2. These regulatory frameworks are fully described in the review prepared for this investigation: “Analysis of the statutory and regulatory frameworks and cases relating to fitness standards in nursing, teaching and social work”²¹. For comparative purposes this review also included regulations covering medicine, dentistry and the 13 professions covered by the Health Professions Council. It was the first comprehensive review of these regulations and revealed a complex array of primary and secondary legislation and statutory guidance relating to health standards. These frameworks were further explored through our analysis of written evidence provided to the investigation, and during the Inquiry Panel hearings.

21 Ruebain et al. See Appendix B for details

3. Our investigation has discovered that:
 - Although entry to (and retention within) each of the three core professions is subject to the application of health standards, there is inconsistency between the professions.
 - In relation to teaching and social work, there are striking differences between the position in England and Wales (where there are general health standards for entry into and employment in these professions), and the approach taken in Scotland (where there are not).
 - In spite of their considerable volume, the regulations and guidance concerning health standards – in relation to nursing and social work in particular – make remarkably little reference to the DDA, or to the need to avoid discrimination in general.
 - There is very real potential for adherence to the regulations, and to the related guidance, to result in unlawful discrimination against disabled people.
 - There is significant doubt as to whether ill-health, where it does not result in either incompetence or misconduct, should be a registration or fitness to practise issue.

4. This chapter of the report is intended to provide a critical overview of the regulatory frameworks that determine whether people are considered mentally or physically suitable to study, qualify, register or work within the professions of nursing, teaching, social work.

Nursing

The Regulations

5. The Nursing and Midwifery Order 2001 provides for the regulation of nurses and midwives by the Nursing and Midwifery Council (NMC) across England, Scotland and Wales. The Order makes provision for the NMC:

- to keep and publish a register of qualified nurses and midwives.
- to set the standards and requirements to be satisfied before a person may be admitted to the register or parts of it, being the standards it considers necessary for safe and effective practice under that part of the register. Those standards may include requirements as to good health and good character.
- to prescribe the requirements to be met as to the evidence of good health and good character in order to satisfy the Registrar that an applicant is capable of safe and effective practice as a nurse or midwife.
- to establish the standards of education and training necessary for admission to the register, and to make arrangements to ensure that those standards are met, and to approve qualifications, courses and institutions which meet its standards.
- to establish and keep under review standards of conduct, performance and ethics expected of registrants and prospective registrants, to issue guidance on these matters, and to make arrangements to ensure that action is taken when the fitness to practise of a nurse or midwife is

impaired by reason of (amongst other things) misconduct, lack of competence or ill-health.

6. The 2001 Order also empowers the NMC to investigate and determine whether the fitness to practise of a registrant is impaired (and provides for the establishment of committees including the Investigating Committee, the Conduct and Competence Committee, and the Health Committee). The rules and procedures governing such investigations and determinations are set out in the Schedule to the Nursing and Midwifery Council (Fitness to Practise) Rules 2004.
7. The requirements for registrants to be of good health and good character are further specified in the Nursing and Midwifery Council (Education, Registration and Registration Appeals) Rules 2004. These Rules also contain the NMC's requirements as to who can provide a supporting declaration as to good health and good character.

Guidance

8. The regulations are supplemented by a considerable amount of guidance on entry into training and registration for nursing. This includes:
 - "Requirements for Evidence of Good Health and Good Character", NMC Guidance 06/04. Further guidance on this issue was approved by the NMC in September 2006.
 - "Standards of Proficiency for Pre-Registration Nursing Education", NMC Guidance 02/04.
 - "Standards of Proficiency for Pre-Registration Midwifery Education", NMC Guidance 03/04.
 - "Reporting Unfitness to Practise: A Guide for Employers and Managers", NMC Guidance 04/04.

In addition, the NMC has published a “Position Statement” on the DDA (see paragraph 25 below).

Demonstrating “good health”

9. As the NMC Guidance 06/04 makes clear, “Evidence of good health and good character must be met, not only for initial entry to the register but also at each renewal of registration and for readmission following a lapse in registration, or restoration following a striking-off order under the fitness to practise procedures.” As to testing for “good health”, the Guidance advises that “Good health will normally be checked through a health questionnaire completed by the applicant and assessed by a local occupational health (OH) department. Where an applicant declares an illness, the OH department doctor either undertakes a medical examination or seeks further information from the applicant’s GP, or possibly both. Once the OH assessment has been done, the programme providers are advised as to the fitness of the applicant to undertake the programme.”

10. The language of the Guidance is unhelpful, in that it treats illness presumptively as a negative indicator in so far as access to training is concerned and accordingly it is something to be “declared” (much like a criminal record). Where a “health problem” arises during training, then again the Guidance indicates that an occupational health assessment will be required, so that:

“If a new or existing health condition, such as unstable epilepsy, diabetes or depression, were to develop or become worse, but was likely to respond to treatment, then perhaps a break in education would be required. Once the student had recovered they should be reassessed by the OH [occupational health] department to determine if they are fit to return to education.”

11. The concept of “good health”, the Guidance says, is a “relative” one. It is unclear what this is intended to mean but the Guidance says that:

“In other words, a registrant may have a disability, such as impaired hearing, or a health condition, such as depression, epilepsy, diabetes or heart disease, and yet be perfectly capable of safe and effective practice.”

12. The implication appears to be that a health impairment or disability will usually operate as an impediment to access to training and registration. The Guidance goes further in identifying certain diagnoses “which would be likely to affect a practitioner’s ability to practise safely and effectively.” It notes that: “The reasons people are currently removed from the register on grounds of ill health include serious mental ill health, drug addiction or alcoholism, all of which cause the individual to be a risk to themselves or to their patients and clients.”

13. The Guidance makes particular reference to infections, such as HIV, Hepatitis B or Hepatitis A. It states that:

“An individual who is infected with, for example, HIV, Hepatitis B or Hepatitis A might be precluded from being able to practise in some posts. However, such an infection would not preclude them from being registered. It is essential, therefore, that registrants applying for posts or registering with an agency are aware of and comply with good health requirements for employment as well as for registration.”

14. This is especially interesting because, as we observe below, the evidence heard by the investigation’s Inquiry Panel points to the fact that a diagnosis of a blood borne virus is the only diagnosis per se (that is

irrespective of competence or conduct) which might justify a restriction on practice. The NMC recognises that a BBV is not a good reason for non-registration.

15. In September 2006, the NMC approved further guidance on the “good health and good character” standards²². The Guidance falls into three parts (Guidance for applicants to pre-registration education programmes; Guidance for pre-registration students; Guidance for UK students applying for entry to the register, and Guidance for registrants)²³. We welcome the fact that this guidance refers to the DDA, including the NMC’s own obligations under the Act, and that it reflects a more positive attitude towards disabled practitioners. For example it makes the following statements about disability:

“The NMC recognises that the nursing and midwifery workforce is likely to benefit from reflecting the diversity of society, including those with direct experience of disability or health issues. Registration is a ‘licence to practise’ and it is for employers to make their own assessment on fitness for employment.”

“The NMC does not have a ‘list’ of acceptable or unacceptable health conditions. One person who has a health condition may be affected differently from another person with the same condition. The NMC advises that in all cases individual assessment of health conditions and disabilities is carried out. To

22 Apparently with the involvement of “stakeholders with a variety of disabilities”, NMC Disability Equality Scheme, pp 7 and 10.

23 This guidance was not available at the time of undertaking our analysis of the statutory and regulatory frameworks and cases relating to fitness standards in nursing, teaching and social work, which was published in November 2006

support this the NMC also advises that practice and education staff involved in selection, recruitment or making a decision related to the good health of a registrant should have disability equality training”.

16. Nevertheless, the new guidance continues to emphasise the need for “good health”, stating that “[g]ood health is necessary to undertake practice”, and that “health must be sufficient for the person to be capable of safe and effective practice without supervision”²⁴. This, again, led us to consider the issue of whether health is relevant at all where a nurse meets the required competencies, and complies with conduct requirements.

17. The new guidance also continues to emphasise the need for disclosure and, whilst this is important (and recognised in the guidance as being so) for reasonable adjustments, the obligation appears to go further:

“Disclosure is important; you may consider that your disability or health condition would not affect your capability for safe and effective practice; however you would not necessarily at this stage possess sufficient understanding of the demands that will be made of you as a nurse or a midwife. Disclosing your disability or health condition enables early assessment of your specific needs and provision of information about what reasonable adjustments may be available to support you in your programme. Disclosure is also a step towards developing your professional behaviour, working towards meeting the requirements identified in the Code.”

24 Paragraph 2.7, emphasis in the original.

18. The reference to the Code (referred to further below) suggests that a failure to disclose may have negative results not just in terms of impeding adjustments but also that it may constitute professional misconduct.

Protecting the public

19. The NMC has issued Guidance to employers and managers in the document Reporting Unfitness to Practise: A Guide for Employers and Managers, NMC Guidance 04/04. This guidance identifies the NMC's "primary aim" as being "to protect the public". It identifies the matters which might "impair" fitness to practise as including "physical or mental ill health" and identifies, in particular, "alcohol or drug dependence and untreated serious mental illness" as "conditions that might lead to a finding that a registrant's fitness to practice is impaired". Apart from health, misconduct and incompetence are separately described as matters which might affect a person's fitness to practise. This makes it clear that ill health per se, in the NMC's view, without any association with misconduct or incompetence, may impair fitness to practise.
20. The NMC Code of Professional Conduct: Standards for Conduct, Performance and Ethics²⁵ provides that a registered nurse or midwife must act to identify and minimise the risk to patients and clients and continues:

"You must act quickly to protect patients and clients from risk if you have good reason to believe that you or a colleague, from your own or another profession, may not be fit to practise for reasons of conduct, health or competence. You should be aware of the

25 NMC 2002, as amended 07/04

terms of legislation that offer protection for people who raise concerns about health and safety issues”.²⁶

Health standards and reasonable adjustments

21. The NMC has published “Standards of Proficiency for Pre-Registration Nursing Education” (NMC 02/04)²⁷ and these set out standards of proficiency and standards of education required for pre-registration nursing education programmes and apply in England, Scotland and Wales. A similar set of standards apply in respect of midwifery. Standard 2 concerns general entry requirements for admission to approved pre-registration programmes and entry to the register, and sets out requirements for literacy and numeracy and for good health and good character. The literacy and numeracy requirements, if not reasonably adjusted, obviously have the potential to disadvantage certain disabled candidates, including candidates with specific learning disabilities and British Sign Language (BSL) users²⁸. In addition, the Guidance states that:

“Students who declare on application that they have a disability should submit a formal assessment of

26 It can be noted too that Clause 2.2 provides that: “You are personally accountable for ensuring that you promote and protect the interests and dignity of patients and clients, irrespective of gender, age, race, ability, sexuality, economic status, lifestyle, culture and religious or political beliefs”. Disability is not mentioned.

27 <http://www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=328>

28 Though if these requirements are competence standards, the duties to make adjustments to these standards would not apply, see Chapter 3, paragraph 11 below.

their condition and specific needs, from a GP or other medical or recognised authority, to the relevant Occupational Health department. The programme providers should apply local policy in accordance with the Disability Discrimination Act 1995, for the selection and recruitment of students/ employees with disabilities. Where appropriate, the institution's student support services should also be involved. The NMC would require evidence of how such students would be supported in both academic and practice environments to ensure safe and effective practice sufficient for future registration."

22. This means disabled people, where they disclose disability status²⁹, must submit a formal assessment of their condition and specific needs from a GP or other medical or recognised authority and thereafter the NMC will require evidence directed at ensuring "safe and effective practice". No such requirements are imposed upon non-disabled students and these requirements are linked to disability status alone, not functional ability or competence. This requirement therefore has the potential to lead to direct discrimination³⁰.

Comment

23. The NMC's Guidance (06/04) indicates that Parliament introduced the requirement for evidence of good health and good character into the 2001 Order to enhance protection of the public following a number

29 As mentioned above if they do not disclose relevant information they risk the sanction of disciplinary action or even, according to the NMC Guidance, the threat of criminal action.

30 See Chapter 3, paragraph 4 below for further discussion of direct discrimination

of high-profile cases involving the health and character of doctors and nurses. This requirement, together with the achievement of standards for entry to and maintenance on the register and compliance with the Code, helps – it is claimed – to ensure the fitness to practise of all those on the Nursing and Midwifery Council's register.

24. The “high-profile cases involving the health and character of doctors and nurses” included the case of Beverley Allitt, which, this formal investigation has found, still haunts the nursing profession. The development of the rules addressing entry into nursing and the approach taken to the “health” of nurses has been directly influenced by the report of the Clothier Inquiry into the crimes of Beverly Allitt. The findings of the Clothier Inquiry are addressed in some detail below (see Chapter 4 and Appendix A) because of the scarring effect they have had on the regulation and the culture of the nursing profession.
25. The NMC Guidance came into effect in August 2004 – nine years after the enactment of the DDA and the year after the DDA was amended to outlaw disability discrimination by qualifications bodies. Nevertheless, there is not a single mention of the DDA or disability discrimination in this important guidance, although it is mentioned in the more recent guidance (see paragraph 15 above). However, the NMC has published a “Position Statement”³¹ on the DDA.

This is an unusual way to deal with the application of law to a public body. This statement expresses the following view of the application of the DDA to the NMC:

“The NMC is pleased to register all those applicants who have achieved the competencies required of a

31 Available at <http://www.nmc-uk.org/aDisplayDocument.aspx?DocumentID=356>

pre-registration programme. In order to register, applicants have to declare and have confirmed by the leader of their programme that they are of good health and character sufficient to ensure safe and effective care. The NMC believes that, while it may be possible for an individual with a health problem/ disability to achieve the stated competencies and be fit for practice on completion, it does not necessarily follow that the individual is subsequently employable in all fields of practice. Opportunities will be available during a student's programme for them to consider the wide range of opportunities open to them on qualification, identifying those which best match their skills and abilities."

26. The tone of this statement appears to be based on negative assumptions about disability, which may derive from the effects of the Clothier Inquiry, or from societal attitudes towards disability or towards nurses. In any event we also heard evidence that most registered nurses – whether disabled or non-disabled – are unlikely to be suited to every area of practice, given the diverse nature of jobs within the profession, and so we are concerned that disabled people are singled out in this way in the NMC's position statement.
27. Whilst few people would question the need for nurses – or, for that matter, other professionals – to be of "good character", health standards (which are the subject of this investigation) raise more complex issues. The concepts of "character" and "health" are, of course, quite separate. However, they appear to be linked in the regulations and guidance relating to nursing, and we have found that there can be a pernicious relationship between the health and character standards. For example, NMC Guidance 06/04 states:

“It is a criminal offence for anyone knowingly to make a false declaration of good health or good character, either as to their own health or character or as a third party signatory. Good health and good character relate to fitness for registration not for a particular role. Registrants who subsequently discover that a declaration made in good faith was in fact false should inform the Council in writing immediately.”

28. We have discovered that a failure to disclose an impairment or long-term health condition can be used as evidence of “bad character” and could, potentially, lead to disciplinary action. We found this worrying given other evidence about the culture within the nursing profession, in which disabled nurses may not feel safe in disclosing a disability. This is explored further in Chapter 8 of this report.
29. The question of whether ill-health, where it does not result in either incompetence or misconduct, should be a registration or fitness to practise issue is discussed in Chapter 4. Outside of BBVs, or analogous conditions³², in respect of specific areas of clinical practice, impairments or long-term health conditions do not appear to us to be relevant except in triggering the need for reasonable adjustments.

Teaching

The Regulations – England and Wales

30. Section 141 of the Education Act 2002 permits the making of regulations which may provide that various prescribed activities may be carried out only “by a person who satisfies specified conditions as to health

32 The existence of which the DRC’s Inquiry Panel was not able to identify.

or physical capacity". Those activities include the provision of education or activities carried out under a contract for a Local Education Authority or school governing body or Further Education institution, which regularly bring the person into contact with children.

31. Two sets of regulations have been made under section 141: the Education (Health Standards) (England) Regulations 2003³³ and the Education (Health Standards) (Wales) Regulations 2004³⁴. For all material purposes, the two sets of regulations are identical. Regulation 6(1) provides that:

"a relevant activity may only be carried out by a person if, having regard to any duty of his employer under Part 2 of the DDA, he has the health and physical capacity to carry out that activity".

32. Regulation 7 provides that if it appears to an employer that a person may no longer have the health or physical capacity to carry out a relevant activity, the employer must offer the person an opportunity to submit medical evidence and make representations, and must consider these and any other medical evidence available. The employer may require the person to submit himself or herself for medical examination. If the person fails to submit to such an examination without good reason or refuses to make available medical evidence or information sought by the medical practitioner, the employer may reach a conclusion on the matter, including a conclusion that the person no longer has the health or physical capacity to carry out that relevant activity, on such evidence and such information as is available.

33 SI 2003/3139

34 SI 2004/2733

33. Section 142 of the 2002 Act³⁵ permits the Secretary of State in relation to England, or the Secretary of State and the National Assembly for Wales concurrently in relation to Wales, to direct that a person may not carry out various prescribed activities (providing education in a school; at a Further Education institution; or under a contract with a Local Education Authority; or taking part in the management of an independent school; or undertaking work of a kind which brings a person regularly into contact with children and is carried out at the request of a relevant employer).
34. Section 142(4) specifies the only grounds upon which such a direction may be made. These include a direction “on grounds relating to the person’s health”. Section 143 provides that bodies such as employment agencies, contractors or voluntary organisations must not arrange for an individual who is subject to a direction under section 142 to carry out work in contravention of a direction.
35. Section 3 of the Higher Education Act 1998³⁶ requires the General Teaching Councils for England and Wales to establish and maintain a register of those eligible to

35 Section 142 will be repealed by the Safeguarding Vulnerable Groups Act 2006, s 63(2), Schedule 10 when brought into force.

36 See the General Teaching Council for Wales Order 1998 SI 1998/2911 which effectively applies many of the same provisions to the General Teaching Council for Wales as those applicable to the General Teaching Council for England, under the Teaching and Higher Education Act 1998, including section 1(4) (“(4) In exercising their functions, the Council shall have regard to the requirements of persons who are disabled persons for the purposes of the Disability Discrimination Act 1995”). See too, section 8 of the Teaching and Higher Education Act 1998 which applies material provisions under the Act in relation to the General Teaching Council for England, to the General Teaching Council for Wales.

teach³⁷. Eligibility for the register is also laid down in this section, and in regulations made under section 3D. A person is not eligible for registration if he or she is barred from teaching and unless at the relevant time the relevant GTC is or was satisfied as to his suitability to be a teacher. Otherwise, the GTC is required to award Qualified Teacher Status to those who fulfil the criteria of the Education (School Teachers' Qualifications) (England) Regulations 2003³⁸ as amended (in England). These provide, in summary, that the GTC must award Qualified Teacher Status to persons who (a) hold a first degree or equivalent qualification granted by a United Kingdom institution or an equivalent degree or other qualification granted by a foreign institution; (b) have successfully completed a course of initial teacher training at an accredited institution in England; (c) have undertaken any period of practical teaching experience for the purposes of that course of initial teacher training wholly or mainly in a school, city college, academy, independent school or other institution (except a pupil referral unit) in England; and (d) have been assessed by the accredited institution as meeting the specified standards³⁹. Like provision is made in respect of Wales by the Education

37 Also, section 11 amends section 218 of the Education Reform Act 1988 so that it can be a requirement of being a teacher that the person be registered with the GTC.

38 SI No 1662/ 2003.

39 Or who has a qualification recognised pursuant to Article 3 of Council Directive 89/48 EEC. In addition, provision is made entitling others to registration, including persons who have successfully completed a course of initial school teacher training at an educational institution in Scotland or Northern Ireland; persons registered as teachers of primary or secondary education with the General Teaching Council for Scotland; persons awarded confirmation of recognition as a teacher in schools in Northern Ireland and persons granted an authorisation to teach at certain times and a relevant recommendation, in certain circumstances.

(School Teachers' Qualification) (Wales) Regulations 2004 in Wales⁴⁰.

36. One of the GTCs' statutory functions is to advise on various matters, including medical fitness to teach. In addition, the Councils have a particular duty to advise the Secretary of State on any matter relevant to a decision as to whether the power to prohibit an individual from teaching should be exercised in a particular case⁴¹.

Guidance – England and Wales

37. The Department for Education and Employment (as it then was) issued Circular 4/99 ('Physical and Mental Fitness to Teach of Teachers and of Entrants to Initial Teacher Training') on 12 May 1999, providing "guidance on procedures for assessing the physical and mental fitness to teach of those applying for teacher training and existing teachers". The Circular explains the purpose of the health standards under the heading 'Protecting the Health, Education and Welfare of Pupils', as follows:

"Teachers and those training to become teachers need a high standard of physical and mental health to enter or remain in the teaching profession, as teaching is a demanding career and teachers have to act in loco parentis for the pupils in their charge. The health, education, safety and welfare of pupils are important in deciding on an individual's fitness to teach." (B1.1)

38. For this reason, the Circular states that Initial Teacher Training (ITT) providers need to assess the medical

40 SI 2004/1729.

41 Repealed by the Safeguarding Vulnerable Groups Act 2006, s 63, Sch 9, Pt 1, paras 2, 3, Sch 10 when in force.

fitness of entrants to teacher training and employers need to assess the medical fitness of those seeking work which falls within the definition of “relevant employment”⁴². The Circular refers to the DDA and observes that:

“Disabled staff can make an important contribution to the overall school curriculum, both as effective employees and in raising the aspirations of disabled pupils and educating non-disabled people about the reality of disability. Many disabled people will be medically fit to teach, though employers may have to make reasonable adjustments under the DDA to enable disabled people to carry out their duties effectively.”
(B.2.1)

39. Nevertheless, a medical assessment is required for entry to ITT and then again at entry to employment. As to ITT, the Circular imposes a competency threshold as follows:

42 “Relevant employment” means employment (which includes engagement not under a contract of employment, for instance as a supply teacher) of the following types:- employment by a Local Education Authority, as a teacher (either at a school or further education provider) or as a worker with children or young people; employment (whoever the employer is) as a teacher at a maintained school, a non-maintained special school, a further education institution which is either maintained by a Local Education Authority or is in the further education sector, and until 1st September 1999 at a grant-maintained school; and employment by the governing body of a maintained school, a non-maintained special school or a further education provider or until 1st September 1999 at a grant-maintained school as a worker with children or young people’ (A.2.3).

“Admissions staff for courses of Initial Teacher Training should ensure that all successful candidates have the necessary competencies for entry to the teaching profession, taking account of the criteria for such courses in DfEE Circular 4/98, Requirements for Courses of Initial Teacher Training” (C.1.1) (now the “Qualifying to Teach” standards⁴³).

40. However, in addition to meeting the competencies required, “providers’ selection and admissions procedures should ensure that all entrants to training have the physical and mental fitness to teach, based on the advice of the provider’s medical adviser” (C.1.3) and “all entrants to courses must be able to communicate clearly and grammatically in spoken and written English, and where appropriate, Welsh” (C.1.2). Specific learning difficulties are particularly identified as requiring consideration⁴⁴. Before final acceptance on a course, all candidates offered a firm or conditional place on a course of ITT are required to complete and return to the provider a declaration of health questionnaire (C.2.1).
41. A trainee whose health deteriorates during training is required to consult the college medical adviser about “any implications for continuing training or for teaching in the future”. Individuals are specifically advised that they “should not judge their own fitness to teach outside the context of trivial and self limiting ailments.” (C.10.1).

43 See ‘Analysis of the statutory and regulatory frameworks and cases relating to fitness standards in nursing, teaching and social work’ (Ruebain et al, DRC 2006)

44 “It is essential that where a candidate has a specific learning difficulty (such as dyslexia), this should not interfere with the candidate’s ability to teach effectively and to secure effective learning in the written work of their pupils or trainees. The onus is on the candidates to prove that their condition does not limit their capacity to teach” (C.1.2).

42. The Circular also indicates that sanctions might apply to those who do not declare impairments, so that:

“It is improper for candidates to declare a specific learning disability on a confidential medical questionnaire but not to declare it in their application” (C.1.2)

43. Also, under the heading: Failure to disclose relevant medical information and providing false information, it states:

“If a trainee is found to have: failed to disclose information which would otherwise have made them ineligible; given false information, including appropriate information about medical problems which arise during training; failed to comply with conditions imposed by the provider’s medical adviser such as regular monitoring or check-ups during the course; a provider will need to consider removing a trainee from a course” (C.11.1).”

44. Also, according to Circular 4/99, on appointment as a teacher:

“a Local Education Authority or governing body must not appoint anyone to, or continue to employ them in, relevant employment unless he or she has the health and physical capacity for such employment” (D.1.1).

45. To this end, “all employers of teachers should take advice from a medical adviser acting for the employer” and “for newly qualified teachers, the prospective employer’s medical adviser should obtain details of the applicant’s medical history from the medical adviser to the training provider, with the written consent of the teacher” (D.2.1).

46. In addition, of course, appointment to a teaching post in England and Wales (like Scotland) requires that a candidate be registered as a teacher.

47. Circular 4/99 also gives guidance to medical advisers. This states, amongst other things, that:

“The purpose of the provider’s declaration of health questionnaire is to decide a candidate’s medical fitness for teaching and prospect of giving efficient service in a profession that is very demanding both physically and mentally. The provider’s medical adviser should consider sympathetically the full facts of the case where there is an unfavourable medical history and particularly where a candidate is currently free from signs or symptoms of disease. Deformity or permanent disability should not of themselves make up medical reasons for rejection. Given reasonable adjustments by employers and/or changes by trainers similar to those falling within an employer’s duty of reasonable adjustment, it may be possible for such individuals to carry out all their duties effectively” (App 1.1).

48. The Guidance requires the medical adviser to classify a candidate in one of three categories:

- Those who are in good health and free from conditions which might be likely to interfere with efficiency in teaching;
- Those who are in generally good health but who suffer from conditions which are likely to interfere to some extent with their efficiency in teaching either all subjects or certain specified subjects, though these conditions are not serious enough to make the candidate unfit for the teaching profession. This includes those whose disability could require employers to make reasonable

adjustment to enable them to provide effective and efficient teaching; or

- Those whose condition is such as to make them unfit for the teaching profession. Candidates should not normally be included in this category unless they have a psychiatric or physical disorder likely to interfere seriously with regular and efficient teaching of either general subjects or the subject in which they intend to specialise eg PE or science subjects, or if they have an illness which may carry a risk to the safety or welfare of the pupils (App 1.3).

49. The guidance advises medical practitioners that:

“It is not within the scope of this guidance to provide detailed assessment of the impact of all medical conditions on fitness to teach, but key considerations are:

- the prevention of abuse of children;
- the requirement for teachers to have sound judgement and insight, and
- the requirement for teachers to be able to respond to pupils’ needs rapidly and effectively” (App1.5).

50. Alongside Circular 4/99, guidance is provided to Occupational Health Practitioners (who will in practice be undertaking the medical assessments referred to in Circular 4/99) in a document entitled “Fitness to Teach: Occupational Health Guidance for the Training and Employment of Teachers” (2000)⁴⁵. This guidance is said to “complement” Circular 4/99. It gives the reasons for addressing “the issue of fitness to teach” as centring around the requirement to:

45 Published in December 2000 and commissioned by the Department for Education and Employment.

“ensure the health, safety, well-being and educational progress of pupils; provide an efficient service which will facilitate learning for pupils; manage any risk to the health of teachers which may arise from their teaching duties including ensuring that those duties do not exacerbate pre-existing health problems; ensure the health and safety of other teachers and support staff is not adversely affected by a colleague being unfit; enable all, including those with disabilities, who wish to pursue a career in teaching to achieve their potential within the bounds of reasonable adjustment.”

51. The same document identifies the “fitness criteria” as follows:

“To be able to undertake teaching duties safely and effectively, it is essential that individual teachers:

- Have the health and well-being necessary to deal with the specific types of teaching and associated duties (adjusted, as appropriate) in which they are engaged.
- Are able to communicate effectively with children, parents and colleagues.
- Possess sound judgement and insight.
- Remain alert at all times.
- Can respond to pupils’ needs rapidly and effectively.
- Are able to manage classes.
- Do not constitute any risk to the health, safety or well-being of children in their care.
- Can, where disabilities exist, be enabled by reasonable adjustments to meet these criteria.”

Guidance is provided to ITT providers in the TTA’s (now Training and Development Agency for Schools, TDA) document, “Able to Teach: Guidance for Providers of Initial Teacher Training on Disability Discrimination and Fitness to Teach”⁴⁶.

46 Teacher Training Agency, April 2004. The Training and Development Agency for Schools has since usurped the functions of the Teacher Training Agency.

Consistent with the themes developed in Circular 4/99 the guidance states that:

“Teachers and those training to become teachers need a high standard of physical and mental fitness to enter or remain in the teaching profession: teaching is a demanding career and teachers have a duty of care towards the pupils in their charge. The health, education, safety and welfare of pupils must be taken into account in deciding on an individual’s fitness to teach.”

52. It also repeats the “fitness criteria” seen in “Fitness to Teach”, set out above. “Able to Teach” does describe the DDA (albeit as it was when the guidance was published⁴⁷).
53. Importantly, in addition to the health-related standards, there are competence standards in place for determining whether a potential registrant meets the requirements for qualification as a teacher. The document “Qualifying to teach: Professional Standards for Qualified Teacher Status and requirements for initial teacher training⁴⁸” (known as QTS Standards) sets out the standards that must be met for the award of qualified teacher status and the requirements for initial teacher training. It identifies a number of competencies, in each case identifying a broad overarching competency (for example “teaching and class management”) and then specific competencies which must be demonstrated.
54. The QTS Standards are fixed with some precision. The accompanying guidance, Qualifying to teach:

47 Therefore without reference to the DED.

48 (2006) Formulated by the Secretary of State with the GTC advising only in respect of the same check

Handbook of Guidance⁴⁹ sets out extensive guidance on assessing these competencies. However, as to the “Requirements for initial teacher training” it requires ITT providers to “ensure that all entrants have met the Secretary of State’s requirements for physical and mental fitness to teach, as detailed in the relevant circular.” The competence standards are therefore overlaid by generalised health requirements which we have set out above.

Regulation of teachers in Scotland

55. In Scotland, the regulatory framework is quite different. The requirement to demonstrate medical fitness for entry into teaching or employment was removed in 2004.

56. The General Teaching Council for Scotland (GTCS) has a duty under the Teaching and Higher Education Act 1998 to establish and keep a register of persons who are entitled to be registered and who apply to be registered as teachers in Scotland. Conditions for registration include either that the person is a certified teacher, or has fulfilled requirements prescribed by the Secretary of State and has been duly recommended by a governing body for registration, or that he fulfils prescribed requirements or, (in the case of a person who is not entitled to be registered under those paragraphs), “his education, training, fitness to teach and experience are such as, in the opinion of the Council, warrant his registration”⁵⁰. Section 8 of the Act requires the GTCS from time to time to prepare and publish a statement specifying the principles to which they will

49 Spring 2006, published by the Training and Development Agency for Schools.

50 section 6(2)(c)

have regard in considering whether a person's education, training, fitness to teach and experience "warrant" registration. The Teaching Council (Scotland) Act 1965 (as amended) that established the GTCS⁵¹ requires that in exercising its functions the Council must have regard to the requirements of disabled people.

57. The GTCS also has a duty to keep under review the standards of education, training and fitness to teach, appropriate to persons entering the teaching profession and to make recommendations with respect to those standards to the Scottish Ministers. These include, in particular, matters which relate to the Secretary of State's power to make regulations concerning fitness of trainee teachers to become teachers (in relation to the admission of students to courses of education and training for teachers in relevant institutions and the recommendation of students by the governing bodies of such institutions to the GTCS for registration).
58. The Teachers (Education, Training and Recommendation for Registration) (Scotland) Regulations 1993 provide that a person should not be admitted to a teacher training course if the principal of the relevant institution providing the course is of the opinion that the applicant should not be admitted on grounds of "personal unsuitability" to be a teacher and unless he satisfies the requirements for admission determined by the Secretary of State (published annually in the Memorandum on Entry Requirements to Courses of Teacher Training in Scotland).
59. These requirements used to provide that the applicant had to satisfy the medical officer of the relevant institution (at both training and registration stages) that, in accordance with directions given by the Council, he

51 section 1(3)

or she was “medically fit to teach”. Following a decision that the justification for such a criterion for the protection of children’s health no longer existed⁵², the medical fitness criteria for registration were removed by the Teachers (Medical Requirements for Admission to Training and Registration) (Scotland) Amendment Regulations 2004⁵³ (see paragraph 63 below).

60. The GTCS has published a General Code of Practice dated June 2002. It has also published “Standard for Full Registration” which sets out the standard expected of fully registered teachers. These standards contain a list of competencies that a teacher must demonstrate for full registration. They include understanding and applying in an educational context, the principle of equality of opportunity and social practice and the need for anti-discriminatory practice.
61. The GTCS’s Code of Practice on Teacher Competence (2002) provides a definition of competence in terms of the Standard for Full Registration (SFR) and explains the steps in the process for dealing with cases of short-lived under-performance and long-running under-performance. This defines the professional knowledge and understanding, professional skills and abilities and

52 Ruebain et al, DRC 2006 and see also medical standards consultation (April 2004), Scottish Executive, www.scotland.gov.uk/consultations/education/medicallyfit.pdf

53 SI 2004/390. These regulations, essentially, amend the Teachers (Education, Training and Recommendations for Registration)(Scotland) Regulations 1993 (above) by removing the requirements for medical fitness. These regulations also amended the Teachers (Entitlement to Registration) (Scotland) Regulations 1991 removing the requirement for medical fitness of nationals of Member States of the EU who wish to register with GTC Scotland.

professional values and personal commitment which all fully registered teachers should “be able to demonstrate in their professional activities” and which are described in the SFR.

62. The Protection of Children (Scotland) Act 2003 makes provision for the Scottish Ministers to create and maintain a list of persons who are unsuitable to work with children because they are at risk of harming them. A person cannot be registered with the GTCS if they are on this list.

Comment

63. The difference in approach to health standards for teachers in England and Wales on the one hand, and in Scotland on the other, is remarkable. In Scotland, the decision to remove the criterion requiring a prospective teacher to be “medically fit to teach” followed a consultation issued on 2 February 2004. The consultation paper noted that:

“Initially these medical standards were introduced mainly for the protection of children; classically, from infectious diseases such as tuberculosis. This is now very rare and full medical examinations are really only helpful in very advanced cases. Other infections of a chronic and potentially infectious nature, including HIV, would require laboratory testing, and symptoms would appear over the three or four years of the course. Thankfully today very few people are carrying life threatening infections that might be potentially dangerous.”

“There was also a concern that a psychiatric problem could arise which could endanger the children. Again medical examinations are not very helpful in this respect and cannot predict with any degree of certainty the possibility of a dangerous candidate.

A past history is very much more helpful. It often happens that mental health instability becomes evident during the course being undertaken, revealed by the pressure encountered in studying for a degree".⁵⁴

64. The consultation paper also noted that "in recent years the main purpose of medical examinations has moved away from blocking applicants, to identifying those who might have a problem and offering them help" yet the health standards were predicated on a medical rather than social model of disability. The consultation paper concluded that:

"Given that the [GTCS] has no responsibility for ensuring that employers comply with the requirements of the DDA, it is anomalous that admission to the register – which relates to a person's capacity to be a teacher – should be dependent upon a person's medical/physical condition. It is suggested that, if it were deemed necessary that teachers undergo a medical examination, it would be more appropriate that this was considered to be an employment related issue rather than a registration issue."

65. In England and Wales, meanwhile, Circular 4/99 continues to be of considerable significance. However, the Circular is now very out-of-date (referring to legislation since repealed), and has been in the process of being reviewed for some time. The DfES, now DCSF, is currently consulting on revised guidance to replace Circular 4/99 and the DRC has been invited to comment. The proposed guidance as drafted is, however, predicated on the assumption

54 Medical Standards Consultation", as above, paragraphs 4 and 5, <http://www.scotland.gov.uk/consultations/education/medicallyfit.pdf>

that a “health and physical capacity” standard will continue to apply and that much of the existing guidance will remain in place⁵⁵

66. The “Fitness to Teach” guidance which has been issued to complement Circular 4/99 adopts a more focused approach to addressing “fitness” than that seen in Circular 4/99. It is also more helpful in that it focuses on the particular work a teacher might be required to do in any specific post and makes prominent the requirement to make adjustments. Further, “Fitness to Teach” states that:

“providing a blanket list of conditions that are incompatible with teaching duties is not appropriate. Cases should be considered on an individual basis.”

67. In contrast, however, the guidance goes on to identify a list of impairments the diagnosis of which would, in effect, bar a person from practice as a teacher, for example:

“a confirmed diagnosis of schizophrenia will usually make a career in teaching impossible”

As to bi-polar affective disorder “where there is doubt the candidate may need to be rejected”

Also:

“depression is not usually a risk to the safety of a teacher’s charges so where there is doubt it is reasonable to allow him/her the benefit of this but

55 See “Fitness to Teach Guidance for Employer and Initial Teacher Training Providers 2007” Department of Education and Skills, SPS07_79. At the time of the DRC’s Inquiry Panel, neither the TDA or the GTC had been consulted on it.

she/he should be kept under review and counselled that recurring episodes may make it necessary to change career”.

68. Adherence to this advice is likely to give rise to direct discrimination. The advice goes on to list a whole series of impairments, in some cases expressing a view as to the likelihood of these impeding access to the profession.

69. Annexed to the guidance is a “Sample Pre Employment Questionnaire”. This contains twenty five questions, asking about specific diagnoses and asking very broad questions, including:

“Have you ever had any illness, medical problem or disability that may currently affect your ability to work safely as a teacher?”

“Have you ever been treated in hospital?”

Have you seen a doctor in the last year for any⁵⁶ kind of health problem?”

70. It is difficult to imagine how any adult might answer all of the questions in the negative, and the value of pre-employment questionnaires of this nature is explored further in Chapter 7. However, the medical approach in the guidance reflects the emphasis in the regulatory framework in England and Wales on mental and physical health and the significance of “diagnosis” in assessing whether a person is considered fit to teach.

71. One positive aspect of the regulatory framework in England and Wales is that, unlike the previous legislation⁵⁷ which prohibited the employment of a

56 Emphasis as in the original.

57 The Education (Teachers) Regulations 1993.

teacher in relevant employment “unless he or she had the health and physical capacity for such employment”, the Health Standards Regulations specify particular activities which a person may only carry out if he has the health/physical capacity to carry out that activity, and the capacity is to be assessed having regard to any duty of his employer under Part 2 of the DDA. This means that the legislation now focuses on specific activities rather than “employment as a teacher” overall and makes specific reference to the fact that capacity must be judged having regard to the non-discrimination and reasonable adjustments duties in the DDA.

Social Work

Regulation and guidance – England and Wales

72. The Care Standards Act 2000 establishes the General Social Care Council (GSCC) in England and the Care Council for Wales (CCW)⁵⁸. Under this Act these bodies have statutory duties in relation to registering and regulating social care workers, and in publishing codes of conduct and practice in relation to them. Social care workers for these purposes are defined as including social workers⁵⁹.
73. Sections 56 and 57 of the 2000 Act require each Council to maintain a register of social workers and social care workers, who must apply to the Council for registration. Section 58 provides that where the Council is satisfied that the applicant (a) is of good

58 The GSCC and the CCW were established by the Care Standards Act 2000.

59 As well as managers and those providing personal care in their homes, and others as may be prescribed by regulations.

character; (b) is physically and mentally fit to perform the whole or part of the work of persons registered in any part of the register to which his application relates; and (c) satisfies conditions relating to training, conduct and competence conditions, it must grant the application, either unconditionally or subject to such conditions as it thinks fit; and in any other case it shall refuse it. The Councils must also have regard to whether a person is included in a barred list in considering whether a person is of good character.

74. The General Social Care Council (Registration) Rules 2005⁶⁰ address the registration of social workers and prospective social workers by the GSCC. Applicants for registration must provide, among other things, evidence of physical and mental fitness to practise “in the field of social care work in which the applicant wishes to work” (regulation 4(3)(a)(iii)). Reflecting the statutory framework, regulation 4(10) provides that the Council shall grant the application for registration if it is satisfied of the relevant conditions, namely (in essence) as to the applicant’s good character and conduct; the applicant’s physical and mental fitness to perform the whole or part of the work of a social worker or social care worker; that the applicant’s competence is such as to make that applicant suitable to perform the work of a social worker and that the applicant has successfully completed an approved course.

60 Made by the GSCC, in exercise of its powers under the Care Standards Act 2000.

61 Rule 14(4) enables the Council to “refer to the Registration Committee matters relating to the applicant’s good character and conduct and physical and mental fitness to perform the whole or part of the work of a social worker” so as to enable the Committee to determine whether it is satisfied as to these matters

75. For registration as a student, the fitness requirements appear more absolute: in regulation 4(4) a student entrant must provide evidence as to good character and conduct; and physical and mental fitness to practise as a social worker (that is, without any reference to “part of the work of social worker or social care worker”).⁶¹ Further, the “physical and mental” fitness standards apply rather differently to social work students. For social work students, the relevant university will decide whether to admit someone onto the relevant course, although they will inform the student that to practise as a social worker they will need to be able to register with GSCC (or other regulatory body). At the first stage the student will be asked to fill in a “social work degree enrolment form”. Under the heading “Impairment Capacities” it offers a series of tick boxes which ask the student to indicate whether they have any impairments. For qualified social workers, the application form is very similar and includes a health declaration question, a health report consent form and an equal opportunities monitoring form (that asks about disability).
76. The Care Council for Wales (Registration) Rules 2005 deal with registration of social workers or social care workers and student social workers or social care workers by the CCW. Evidence as to the applicant’s “good character, as it relates to the applicant’s fitness to practise” is required. Applicants must also provide evidence of good conduct, physical and mental fitness to practise in social care work or the field of social care work in which the applicant wishes to work, and of competence.
77. Section 59 of the Care Standards Act requires the Councils, by rules, to determine circumstances in which and the means by which a person’s entry on a register may be removed, suspended or amended.

Further, section 65 permits the Councils to make rules requiring registered persons to undertake further training. Sections 58, 63 and 67 establish criteria for registration of social workers and social care workers including rules that relate to the completion of an approved course. The General Social Care Council Approval of Courses for the Social Work Degree Rules 2002⁶² establish the criteria and procedure for accrediting social work courses. In particular, they cover the various components of the required standards and the provision of relevant information, including as to candidates' medical fitness and character in terms of their suitability to work in social work. The provisions apply to England.

78. Section 62 of the Act requires the Councils to prepare and publish Codes of Practice laying down standards of conduct and practice expected both of social care workers⁶³ and, materially, of persons employing or seeking to employ them. The GSCC and CCW have both issued Codes of Practice for social care workers and employers of social care workers (2002, GSCC and CCW). The Codes for employers contain some (albeit limited) reference to health by providing that employers should put in place and implement written policies and procedures that promote staff welfare and equal opportunities for workers and, while ensuring that the care and safety of service users is the priority, provide appropriate assistance to social care workers whose work is affected by ill health or dependency on drugs and alcohol, and give clear guidance about any limits on their work while they are receiving treatment.

62 At <http://www.gsc.org.uk/NR/rdonlyres/841C5287-921D-4DDE-B8A5-10F62C97D16F/0/EdandTrRules9may2003.pdf> made pursuant to Sections 63 and 66 of the Care Standards Act 2000.

63 Social workers are included under this term.

79. The Codes for social care workers provide simply that such workers comply with employers' "health and safety policies, including those relating to substance abuse" without any further explicit reference to health.

Regulation of social workers in Scotland

80. By virtue of section 43 of the Regulation of Care (Scotland) Act 2001 the Scottish Social Services Council (SSSC) is established to promote high standards of conduct and practice among social service workers and in their education and training, including by the approval of courses as set out in subsequent "rules". Part 1 of the Act establishes the Independent Scottish Commission for the Regulation of Care to regulate a very wide range of care services. Part 3 sets out the functions of the SSSC in registering and regulating social care workers in Scotland, and in publishing codes of practice.
81. Section 45 of the 2001 Act permits the SSSC to regulate entry to the register, and section 46 provides that it shall not register a person unless satisfied that the applicant meets the statutory requirements of "good character" and competence and meets the Council's educational and training requirements. This is significantly different to the requirements in England and Wales, as there is no requirement for physical and mental fitness.
82. Section 53 permits the SSSC to make Codes of Practice for Social Workers. Section 56 permits the Scottish ministers to pass regulations relating to registration, and section 57 permits the SSSC to make rules.
83. The Regulation of Care (Requirements as to Care

Services) (Scotland) Regulations 2002⁶⁴ specify that providers of care services shall not employ any person in the provision of a care service unless that person is fit to be so employed. A person who is “not physically and mentally fit for the purposes of the work for which the person is employed in the care service” is to be treated as not fit to be so employed. This concerns specific work at a specific service, rather than imposing a condition for entry to the profession, training, registration or generally for employment.

84. The Scottish Social Services Council (Registration) Rules 2006 regulate the registration of social workers and social service workers in Scotland. These rules require that for registration an applicant⁶⁵ must provide evidence as to good character, as it relates to the applicant’s fitness to perform the work expected of persons registered in that part of the register in which registration is sought; and good conduct and competence.

Comment

85. As with the teaching profession, there are significant differences between the way that social workers are regulated in England and Wales on the one hand, and in Scotland on the other. In Scotland, unlike in England and Wales, there is no specific requirement to demonstrate any physical or mental fitness in order to obtain registration, as the assessment of fitness is regarded as a matter for employers to determine.

64 SSI 2002/114 as amended

65 The position of students is also addressed but there are no material differences; rule 4(2)(d), and 4(3)(a)(i).

86. In addition, under Section 43(2) of the Regulation of Care (Scotland) Act 2001, the SSSC has an express duty to promote equal opportunities in the exercise of its functions, a duty that does not appear within the Care Standards Act 2000, covering England and Wales.
87. In relation to England and Wales, we heard evidence that the requirement for physical and mental fitness, as set out in Section 58 of the Care Standards Act 2000, has been controversial since it was first proposed⁶⁶. The GSCC expressed the view, however, that it is their duty to implement it in a way that is consistent with the DDA and that they believe they have found a way to do so. In so far as registration is concerned, according to the GSCC, they have made a “policy decision that where a medical condition was deemed relevant, [they] would normally remind the applicant, when registering them, of their duty to work safely within the boundaries of their health condition and to inform their employer, if this was relevant. Mostly this has been done simply as advice at the point of registration rather than through the imposition of formal conditions on registration”⁶⁷. Nevertheless, the fact remains that the Councils have a statutory duty to refuse registration if they are not satisfied that the applicant meets these conditions⁶⁸.

66 BASW written evidence to DRC and evidence to DRC’s Inquiry Panel. Also comments from the DRC’s Mental Health Action Group

67 GSCC written evidence to the DRC

68 Section 58. There is a right of appeal, under section 68, in relation to registration decisions.

Chapter 3 – Health Standards and the Impact of the Disability Discrimination Act

1. We have already noted that the regulatory regimes governing health standards in the nursing, teaching and social work professions make only scant reference to the DDA. Nevertheless, this Act – which has been significantly extended and amended in recent years – is very relevant to the application of these standards to disabled people. This chapter provides an overview of the way in which the DDA impacts upon the application of health standards.⁷⁰ In essence, the DDA applies in two distinct ways: first, it imposes duties on individuals and organisations not to discriminate against disabled people in performing certain functions. Second, since December 2006, it has imposed wider obligations upon public authorities to work towards disability equality.

70 This is a complex area of law, and it is not our intention to give a detailed analysis of the DDA's provisions in this report. The DRC has published a range of Codes of Practice which provide in depth guidance on the operation and effect of the Act's provisions in respect of different areas of activity.

Duties under the DDA

2. It is important to note that the DDA imposes duties on a range of organisations involved in the assessment and application of health standards. These include:
- Employers and prospective employers of nurses, teachers and social workers⁷¹.
 - Further and higher education providers concerned with the recruitment and training of student nurses, teachers and social workers⁷².
 - Organisations which provide work placements to such students in the course of their training⁷³.
 - Each of the regulatory bodies which are relevant to this investigation – such as the Nursing and Midwifery Council and the Care Council for Wales – in registering individuals as being fit to practice as nurses, teachers or social workers. The DDA applies to such organisations⁷⁴ in this regard because they are “qualifications bodies”⁷⁵.
 - Organisations performing any of the above functions which are “public authorities”, and thus subject to the disability equality duty (see paragraph 15 below).

71 Detailed guidance on the application of the DDA to employers is provided in the DRC’s Code of Practice on Employment and Occupation (http://www.drc.org.uk/library/publications/employment/code_of_practice_-_employment.aspx).

72 Detailed guidance on the application of the DDA is provided in the DRC’s Code of Practice (revised) for providers of post-16 education and related services (http://www.drc.org.uk/library/publications/education/code_of_practice_post_16.aspx).

73 See Chapter 9 of the DRC’s Code of Practice on Employment and Occupation.

3. It is self-evident that a particular organisation may be performing a range of functions (it may be a placement provider as well as an employer, for example), and so will be subject to more than one set of duties under the DDA. Nevertheless, whilst the precise statutory provisions are located in different parts of the DDA depending upon the nature of the function in question, (and leaving aside for a moment the over-arching disability equality duty), the basic structure and content of the duties is the same in each case. It comprises:
- a duty not to discriminate against a disabled person in performing the relevant functions. Unlawful discrimination occurs if an organisation's treatment of a disabled person amounts to "direct" discrimination or to "disability-related" discrimination (these concepts are explained in paragraphs 4 and 5 below).
 - a duty to make reasonable adjustments in relation to disabled people (see paragraphs 6 to 10 below).
 - a duty not to subject a disabled person to harassment for a reason which relates to his disability.
 - a duty not to victimise a person for doing something which is protected for this purpose under the DDA.

74 And to the TDA and DfES (now DCSF) in connection with their operation of the "Skills test" within the teaching profession in England and Wales

75 Such organisations fall within the DDA's definition of a qualifications body because they each hold a register of those who can practice within their respective professions (registration being a qualification which is needed for, or facilitates engagement in, the particular profession). Detailed guidance on the application of the DDA to qualifications bodies is provided in the DRC's Code of Practice on Trade Organisations and Qualifications Bodies (http://www.drc.org.uk/library/publications/employment/code_of_practice_trade_organ.aspx).

Forms of discrimination

4. “Direct discrimination” occurs where a disabled person is treated less favourably than others – not having the same disability – are (or would be) treated in the same circumstances, and where the treatment is on the ground of the person’s disability. Where less favourable treatment arises out of an organisation’s generalised, or stereotypical, assumptions about disability or its effects it is likely to be direct discrimination. Direct discrimination cannot be justified, and so this kind of treatment is always unlawful.
5. “Disability-related discrimination” also arises out of the less favourable treatment of a disabled person. However, while direct discrimination generally occurs when the reason for the less favourable treatment is the disability itself, disability-related discrimination occurs when the reason relates to the disability but is not the disability itself. It is therefore a wider category of less favourable treatment. This type of treatment may be justified (in which case it does not amount to discrimination), but only where it can be shown that the reason for it is both material to the circumstances of the particular case and substantial.

Reasonable adjustments

6. A failure to comply with a duty to make reasonable adjustments also amounts to unlawful discrimination. It should be noted that such a failure cannot now be justified⁷⁶.

76 The defence of justification in relation to reasonable adjustments is now restricted to the DDA’s provisions on goods, services and facilities (Part 3 of the Act). It is likely that any claim relating to the application of professional standards would be brought under the DDA’s provisions on employment and occupation (Part 2) or education (Part 4).

7. A duty to make reasonable adjustments applies in respect of all of the activities mentioned in paragraph 2 above⁷⁷. The duty arises whenever a provision, criterion or practice applied by or on behalf of the organisation in question, or any physical feature of premises it occupies, places a disabled person at a substantial disadvantage compared with people who are not disabled. Where the duty arises, the organisation must take such steps as it is reasonable for it to have to take in all the circumstances to prevent that disadvantage – in other words it has to make “reasonable adjustments”.
8. The duty is subject to certain limitations. In particular, it only applies in circumstances⁷⁸ where the person or organisation who would have to make an adjustment knows, or could reasonably be expected to know, that the disabled person is indeed disabled, and that he or she is likely to be placed at a substantial disadvantage. In the case of an applicant or potential applicant for a job (or for a work placement, entry to a course, or registration with a regulatory body as the case may be), the duty only arises if the organisation knows, or could reasonably be expected to know that the disabled person concerned is, or may be, an applicant. This gives significance to the issue of disclosing disability. For the disabled applicant, student or

77 The nature and scope of the duty differs in certain respects in its application to further and higher education providers compared with its application to employers, work placement providers and qualifications bodies. These differences are explained in Chapter 5 of the DRC’s Code of Practice for Providers of Post 16 Education

78 For further and higher education institutions there is also an “anticipatory duty” in respect of physical features

employee, reasonable adjustments will not be available unless the organisation which needs to make them knows that he or she is disabled and at a disadvantage. Disabled people therefore need to feel confident that disclosing disability – on a job or college application or within a workplace – will lead to adjustments rather than to discrimination.

9. In addition, those who are subject to the reasonable adjustments duty need to ensure that they have proper procedures for collecting and handling information from disabled people about their impairments or health conditions. Such information may come through different channels, such as from a doctor or nurse engaged in providing occupational health services for the organisation, or from a line manager, tutor, or human resources manager. Any such information will need to be brought together so as to make it easier for the organisation to fulfil its duties under the DDA, although confidentiality clearly needs to be respected in this process.
10. On occasion it will also be necessary for organisations to work together in ensuring that reasonable adjustments are made. For example, it would be reasonable to expect the provider of a work placement to co-operate in this regard with the higher education institution sending the student.

Competence standards

11. A further limitation on the duty to make reasonable adjustments applies in respect of what the DDA terms “competence standards”. In short, qualifications bodies and further and higher education providers are not obliged to make adjustments to the application of a competence standard to a disabled person. The standard must

still be applied in a non-discriminatory manner, of course, and where qualifications bodies or higher education institutions seek to show that less favourable treatment of a disabled person is justified⁷⁹, this has to be done by reference to special criteria⁸⁰.

12. A “competence standard” is an academic, medical or other standard applied for the purpose of determining whether or not a person has a particular level of competence or ability. It is important to identify whether a particular measure or standard constitutes a competence standard – irrespective of the label attached to it by the organisation in question – because this will determine whether a duty to make adjustments arises⁸¹. In relation to medical standards, physical abilities may constitute “competence standards” for certain narrow areas of work – for example, having a certain standard of manual dexterity will be required to carry out specific medical procedures. However, a general requirement for good health or for physical and mental fitness will

79 Justification is only relevant where the treatment in question would otherwise amount to disability-related discrimination, as treatment which amounts to direct discrimination (because it is based on generalised or stereotypical assumptions about a disability or its effects, for example) will necessarily be unlawful.

80 Justification is only possible where it can be shown that the competence standard is (or would be) applied equally to people not having the disabled person’s particular disability, and that its application is a proportionate means of achieving a legitimate aim.

81 Chapter 8 of the DRC’s Code of Practice gives examples to illustrate when standards might properly be described as competence standards.

not be a competence standard if it does not determine a particular level of competence or ability.

13. There is generally a difference between a competence standard and the process by which attaining that standard is determined. For example, the awarding of many qualifications depends on passing an examination. Having the required knowledge to pass that examination is a competence standard, whereas the process of sitting the examination may not involve or impose such a standard. This is an important distinction because, for a disabled candidate, the method of assessment may need to be adjusted whereas the academic standard itself (the competence standard) would not need to be.

14. A key issue for this investigation has been whether generalised health standards, for example requirements for “good health” or “physical and mental fitness” (overviewed in the previous chapter) meet the definition of a competence standards for the purposes of the DDA. As explained above, they will only do so to the extent that they are a genuine determinant of a particular level of competence of ability. Generalised health standards, where they do not constitute genuine competence standards, are not excluded from the reasonable adjustment duty, either in the way they are tested or in the application of the standard itself. Further, where the standards are applied differentially, to the disadvantage of disabled people, then they are likely to be directly discriminatory and therefore unlawful (whether or not they meet the definition of competence standards).

The Disability Equality Duty

15. Following the enactment of the Disability Discrimination Act 2005 (which inserted new provisions into the 1995 Act), public authorities have new duties, over and above the duties described above. In particular, in carrying out its functions, every public authority must have due regard to the following:
- the need to eliminate unlawful disability discrimination
 - the need to eliminate harassment of disabled people
 - the need to promote equality of opportunity between disabled persons and others
 - the need to take steps to take account of disabled people's disabilities even where that involves treating disabled people more favourably
 - the need to promote positive attitudes towards disabled people
 - the need to encourage participation of disabled people in public life.
16. This general DED applies to public authorities generally which, for these purposes, include bodies "...certain of whose functions are functions of a public nature" and will therefore embrace certain commercial and voluntary sector bodies which are, whether under a contract or other arrangements, in effect exercising a function which would otherwise be exercised by the state – and where individuals have to rely upon that person for the exercise of the governmental function⁸². Whether functions carried out by a private or voluntary

82 Detailed guidance on the application of the DED is provided in the DRC's Codes of Practice on The Duty to Promote Disability Equality (http://www.drc.org.uk/library/publications/disability_equality_duty/the_duty_to_promote_disability1.aspx).

sector organisation are “functions of a public nature” is ultimately a matter for the courts, but such functions are likely to include those which regulate the standards for entry into the professions.

17. In addition, specific disability equality duties are imposed by regulations made under the DDA⁸³. The public authorities listed in Schedule 1 to the Regulations (which include many of the regulatory bodies, further and higher education providers, as well as many of the employers, with which this investigation is concerned) are required to publish a Disability Equality Scheme (and to take the steps identified in the scheme within three years of its publication). A Disability Equality Scheme must state:
- the steps the authority will take towards fulfilment of its general duty
 - the ways in which disabled people have been involved in its development
 - the authority’s methods for assessing the impact or likely impact of its policies and practices on equality for disabled people
 - the authority’s arrangements for gathering information about the effect of its policies and practices on disabled people in employment (including recruitment, development and retention), education, service provision and public functions more generally and for making use of such information in complying with the general duty.

83 Disability Discrimination (Public Authorities)(Statutory Duties) Regulations 2005 SI 2005/2966. See also Disability Discrimination (Public Authorities) (Statutory Duties)(Scotland) 2005, Scottish SI 2005/ 565.

The DDA's relationship to regulations governing health standards

18. Nothing is made unlawful by the DDA if it is required by an express statutory obligation⁸⁴. This means that the DDA is not prioritised over other legislative measures. However, this exception only applies where a statutory obligation is specific in its requirements, and it is therefore of narrow application. Acts done pursuant to a statutory discretion are not excluded from the effects of the DDA. With the exception, arguably, of the health standards applied by the GSCC and CCW, none of the generalised health standards with which this investigation is concerned are applied in necessary performance of a statutory obligation. Instead, the legislative schemes grant permissive powers to the regulatory bodies (and the Secretary of State) to introduce such standards⁸⁵. Consequently, their application to disabled people is subject to the duties under the DDA outlined above.

Conclusion

19. The scope of the protection against discrimination which the DDA offers disabled people has grown very considerably since the Act 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 with the nursing, teaching and social work sectors across Great Britain – and indeed to have raised questions about the very existence and

84 DDA, section 59.

85 The health regulations applicable to employment and teaching are made expressly subject to the DDA, see Chapter 2 above.

application of health standards. The Scottish Parliament clearly did consider the changed climate created by the DDA and removed health standards for teachers, following consultation.

20. 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, we have found this not to be the case. There is no mention of the DDA within the legislation, regulations or statutory guidance relating to social work and only occasional reference in the legislation and guidance applicable to nursing. As we shall explain in the remainder of this report, a radical rethink of the regulatory framework is now required if the professions are to maintain standards within a culture which also promotes equality.

Chapter 4 – Health standards as an approach to managing risk

1. The DRC felt it was important to explore the origin and purpose of the regulatory frameworks laying down generalised health standards (reviewed in Chapter 2). During the Inquiry Panel phase of the investigation, we had the opportunity to ask the relevant regulatory bodies what they considered the origin and the purpose of these standards to be, and it became apparent that they had not previously considered this question in any detail, nor had they considered whether the maintenance of these standards was proper and lawful. The assumption from most of the organisations we talked to⁸⁶ was that these standards were given in law and therefore beyond their influence or remit. However, to the extent that the regulatory bodies had considered the fundamental purpose of health standards, they told the DRC that these standards were there for the protection of the public.
2. We do not underestimate the importance of public

86 This assumption was not exclusive to regulatory bodies – most organisations we talked to including, for example some trade unions, professional bodies, and universities held the same view.

protection, so were particularly interested in whether the goal of protecting the public was being served by the health standards currently in place. This was one of the key priorities for the DRC in considering the findings and recommendations arising from this investigation. The DRC also fully recognises that the core function of each of the regulatory bodies with which we are concerned is the protection of the public⁸⁷, and we were aware, even before the investigation was launched, that the recent and continuing expansion of professional regulation has been driven by concerns about public safety. Previous cases where professionals, or those in a caring role, have been responsible for catastrophic incidents have heightened these concerns. These cases, and the reports, policies and practices arising out of them were referred to in all the evidence strands of the investigation, and in particular by organisations giving evidence to the DRC's Inquiry Panel. For this reason, Karon Monaghan, chair of the Inquiry Panel decided to review the findings and

87 "The main objective of the [Nursing and Midwifery] Council in exercising its functions shall be to safeguard the health and well-being of persons using or needing the services of registrants" (Article 3(4) of the Nursing and Midwifery Order 2001 (SI 2002/253); "It shall be the duty of the [Social Care] Council[s] to promote(a) high standards of conduct and practice among social care workers; and (b) high standards in their training." (section 54(2) and (3), Care Standards Act 2000); "The principal aims of the [General Teaching] Council for England in exercising their functions are—(a) to contribute to improving the standards of teaching and the quality of learning, and (b) to maintain and improve standards of professional conduct amongst teachers, in the interests of the public" (section 1(2), Teaching and Higher Education Act 1998).

recommendations of previous inquiry reports⁸⁸ relating to the cases of Beverley Allitt, Harold Shipman, and Ian Huntley⁸⁹, and the inquiry relating to the death of Victoria Climbié.

3. The reports relating to Allitt and Shipman have proved significant in several ways. They have highlighted the occasions on which the public interest has been very seriously jeopardised by the activities of individual practitioners and provided a narrative which reveals what steps, if any, might have been taken to prevent or mitigate the effects of the incidents concerned. They have also affected the professions' perception of disability and its relationship to risk to the public. The connection between the findings and the consequent policies and practice affecting disabled practitioners has not always been coherent. The Inquiry reports are discussed in detail in Appendix A, but below we explain the effects of these reports on professional regulation and the culture within nursing, teaching and social work (and other professions). This formal investigation has also gathered evidence and opinions from a wide range of organisations about the association of disability and risk, and about the effectiveness of using medical diagnosis as a predictor of risk. This evidence is presented below.

88 The Allitt Inquiry: Independent Inquiry relating to Deaths and Injuries on the Children's Ward at Grantham and Kesteven General Hospital during the period February to April 1991", (1994) HMSO ("The Clothier Report"); "The Victoria Climbié Inquiry: Report of an inquiry by Lord Laming" (2003) HMSO; "The Bichard Inquiry Report" (2004) HMSO; "The Shipman Inquiry Report" (the first report and the fifth report) (2002) and (2004) Cm 6394.

89 The reports from the inquiries relating to the murders committed by Ian Huntley and the death of Victoria Climbié were found not to be significant for this investigation.

4. Generalised health standards within nursing appear to derive from the Clothier Report and its recommendations⁹⁰. In social work, health standards brought in to reflect the arrangements applicable to the other main regulatory bodies were contentious⁹¹ when they were introduced. In relation to the introduction of health standards for social workers, the Department of Health wrote, in 2000:

“The driving force behind the GSCC is protection for service users, their carers and the general public and raising standards of service provision. What we want to achieve with this health test is to prevent people from registering, or remaining registered with the GSCC if they are not physically and mentally fit to perform the whole or part of the work of a social worker. Having a health test is a common feature of regulatory bodies. We are therefore putting social workers on the same footing as other professions rather than treating them differently⁹².”

5. Within the teaching profession, the standards appear to derive from historical concerns about infectious diseases, particularly tuberculosis, but concerns about “physical and mental fitness” are reflected in regulations from 1993⁹³ and in statutory guidance⁹⁴ from 1999.

90 Evidence to DRC’s Inquiry Panel from several organisations who mentioned the Allitt case, and NMC guidance 06/04

91 BASW written evidence to the DRC, BASW evidence to DRC’s Inquiry Panel, and information from the DRC’s Mental Health Action Group.

92 Letter from John Hutton to BASW – received as written evidence

93 The Education (Teacher) Regulations 1993 refer to “health and physical capacity

94 Circular 4/99

6. The Government has taken up many of the recommendations of the Shipman Inquiry in its recent White Paper, "Trust, Assurance and Safety"⁹⁵, and plans to widen the scope of regulation to cover previously unregulated health professions, to provide for periodic re-validation (re-registration) and potentially for student registration across all health professions in England, Scotland and Wales. The White Paper proposes that "common standards and systems should be developed across professional groups where this would benefit patient safety". The relevance for this investigation is that a wider group of students and practitioners working within the health sector would become subject to generalised health standards. The DRC has also learned that guidance is being drafted⁹⁶ to ensure that existing legislation (Education Act 2002 covering England and Wales) which allows for the regulation of the Early Years Professional workforce (but in practice has focused on teachers) is applied consistently to this wider group of students and employees⁹⁷.

It is therefore timely to consider the roots of these regulatory frameworks and to question whether identifying ill health or disability is an effective way to reduce or eliminate risk.

95 "Trust, Assurance and Safety – The Regulations of Health Professionals in the 21st Century" (2007) Cm 7013

96 By the Children's Workforce Development Council (CWDC)

97 Although the development of new guidance gives the opportunity for a fairer application of existing rules to Early Years Professionals (and to trainees), such guidance is likely to have the effect of reinforcing the requirements for physical and mental fitness.

7. The Clothier Report was the outcome of the Allitt Inquiry⁹⁸, following the conviction of Beverley Allitt on charges of four murders, three attempted murders and six charges of causing grievous bodily harm. As is well known, Beverley Allitt was a nurse at the time the crimes for which she was convicted were committed and her victims were all children and patients in a children's ward at Grantham and Kesteven General Hospital. Unsurprisingly the case attracted a huge amount of media attention and public interest.

8. The Clothier Inquiry initially considered Allitt as an individual, considering her personality, health, training and entry to the nursing profession⁹⁹. The Inquiry looked in particular "for two possible warning signs"¹⁰⁰. Firstly, whether Beverley Allitt's behaviour and attitudes "revealed anything unusual about her personality" and secondly whether there was evidence in her medical history that "her attitude to her own health was such that she should not be entrusted with responsibility for the health of others"¹⁰¹. The Clothier Report made it clear that:

"If by excluding people with certain clearly definable characteristics we could be sure of excluding those who might harm vulnerable patients, then it would be worth taking the risk which such a policy would entail of incidentally excluding some people who would have made good nurses. The problem lies in determining which, if any, of Allitt's characteristics are clear indicators of possible danger".¹⁰²

98 It was carried out on the instructions of the Secretary of State for Health and was chaired by Sir Cecil Clothier.

99 Clothier Report, paragraph 1.8

100 Paragraph 2.1.2

101 Paragraph 2.1.2

102 Paragraph 2.1.4

9. The DRC would agree that if excluding people with certain clearly definable characteristics would guarantee the exclusion of people who might harm patients, then such a policy might be justified. This would require very careful consideration as there is always the danger of over inclusiveness in any barring rule. Any such rule would have to be proportionate, but the public interest would weigh very heavily in support of such a rule. However, as the Clothier Report makes clear, what the Beverley Allitt case showed was that there were no clearly definable characteristics apparent in her which would have alerted anyone to the risk that she later presented. Although she had a history of “incurring minor injuries”, the Clothier Report stated “it is very common to seek attention in this way and a similar tendency can be seen, and was seen at the time, in other teenagers. It is not an indication of secret murderous intent”.¹⁰³

10. Although Allitt was later (that is, after she had committed the crimes) labelled with a diagnosis of Munchausen’s syndrome (and also Munchausen’s syndrome by proxy), the Clothier Report found that there was nothing in the history of Beverley Allitt that would have led anyone to predict her behaviour or her crimes. It is also important to note that there had been no previous diagnosis of a mental health condition, or mental ill health. The Report found that death and injury could have been prevented by better monitoring, supervision and the exchange of information on conduct, although it is likely that even with proper and efficient management structures in place, the earlier deaths and injuries perpetrated by Beverley Allitt could not have been prevented. The report itself acknowledges that not every kind of criminal behaviour can be predicted and prevented:

103 Paragraph 2.2.6

“expert evidence from independent persons points to the conclusion that a determined and secret criminal may defeat the best regulated organisation in the pursuit of his or her purpose”¹⁰⁴.

This is an important observation because it reminds us that predicting the most extreme examples of human behaviour – “the statistical outliers”, as they were described to the DRC’s Inquiry Panel¹⁰⁵ – is not possible. However, proper management, supervision and prompt action upon clues or evidence of misconduct will reduce the likelihood of the most serious criminal activity occurring or continuing.

11. Despite these findings of the Allitt Inquiry, the Clothier Report made a number of recommendations for the health screening of nurses. Significantly, too, for subsequent practice within the nursing profession it adopted the suggestion of the Chairman of the Association of NHS Occupational Physicians (ANHOPs) that applicants who show one or more of the following, namely excessive absence through sickness, excessive use of counselling or medical facilities, or self harming behaviour such as attempted suicide, self laceration or eating disorder, should not be accepted for training until they have shown the ability to live an independent life without professional support and have been in stable employment for at least two years¹⁰⁶.
12. The Clothier report itself recommended that its “recommendations might usefully be applied to other professions which give access to patients”¹⁰⁷.

104 Paragraph 1.12

105 Evidence to DRC’s Inquiry Panel from Dr John Meehan

106 Paragraph 5.5.16

107 Paragraph 5.5.3

Further, the Bullock report into the events leading to the trial of Amanda Jenkinson¹⁰⁸ endorsed the recommendations in the Clothier Report and recommended that they be extended to cover all health care professionals. In addition to the cases of Beverley Allitt and of Amanda Jenkinson, the other case that was found to be of direct relevance to this formal investigation¹⁰⁹ was that of Harold Shipman. The Shipman Inquiry reports have led to further scrutiny of professional regulation and one outcome has been the White Paper, "Trust, Assurance and Safety" (see also Appendix A for further information about the Shipman Reports).

13. The Shipman Inquiry reports identified personality traits such as "profound dishonesty"¹¹⁰, as well as Shipman's early addiction to pethidine¹¹¹. On the basis of the evidence to the Shipman Inquiry of psychiatrists, it appeared that Shipman may have had "a rigid and obsessive personality; may have been "isolated" and may have had 'difficulty in expressing emotions'; 'poor self-esteem' and that 'for most of his adult life, he was

108 Amanda Jenkinson was a nurse who was convicted and then acquitted on appeal of causing grievous bodily harm with intent to a patient, having allegedly sabotaged the patient's intensive care ventilator: "Report of the Independent Inquiry into the Major Employment and Ethical Issues Arising from the Events Leading to the Trial of Amanda Jenkinson", Nottingham: North Nottinghamshire Health Authority (1997) Bullock, R. It can be noted that the Bullock Report is not available on the internet and is not available in the usual libraries. It was a Report predicated on the guilt of a person subsequently acquitted.

109 Although the Climbié and Soham Murder Inquiries drew conclusions about systemic failures within social work, education and in relation to the police.

110 Paragraph 13.41, First Report.

111 Paragraph 13.47, First Report.

probably angry, deeply unhappy and chronically depressed'.¹¹² However, the Inquiry Report made it clear that these traits were not in themselves enough to explain why Shipman became a serial killer and, on the evidence available, the psychiatrists could not explain how these characteristics could lead to such extreme conduct.¹¹³ It concluded that it could "shed very little light on why Shipman killed his patients"¹¹⁴. The Inquiry and First Report placed emphasis on ensuring that "a doctor like Shipman would never again be able to evade detection for so long", rather than on eliminating the possibility that someone with serious criminal intent would be able to practise¹¹⁵. What the Shipman inquiry found was that the measures in place that might have revealed at an earlier stage that Shipman was killing his patients were not properly effective.

14. The Shipman Inquiry made no recommendations about the assessment of health of doctors for registration or re-registration. The Fifth Shipman Report notes that "it is clear beyond argument that Shipman would have done well in an appraisal, as it currently operates. He would have produced evidence that many aspects of his clinical care were of a high standard. He could have produced the results of audits; the topics would have been chosen by himself and he would not have conducted an audit into the mortality rate amongst his patients" and so on¹¹⁶. The Report states instead that "another Shipman" might be detected

112 Paragraph 13.50, First Report.

113 Paragraph 13.51, First Report.

114 Paragraph 13.57, First Report.

115 Paragraph 14.20, First Report.

116 Paragraph 26.200 Fifth Report

by clinical governance activities, namely “a framework through which National Health Service organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish”¹¹⁷.

15. In conclusion, the Clothier Report was the only significant report¹¹⁸ of recent years that made specific recommendations for managing risk to the public through the use of health criteria as part of professional regulation (although the Shipman Inquiry has led to proposal for broadening regulation). Having carefully considered the Clothier Report, Karon Monaghan, who chaired the DRC’s Inquiry Panel, came to the conclusion that the recommendations of the Clothier Report did not follow logically from its findings, and that the report was therefore “extremely flawed”. Nevertheless it appears that the “good health and good character” requirements for health professionals were brought in because of the recommendations of Clothier. NMC guidance 06/04 states:

“Why has good health and good character been introduced?

Parliament introduced the requirement for evidence of good health and character into the [Nursing and Midwifery] Order [2001], to enhance protection of the public, following a number of high-profile cases involving the health and character of doctors and nurses.”

117 Paragraph 26.203 and paragraph 12.2.

118 The Bullock report endorsed its recommendations but was based on a case that turned out to be a miscarriage of justice.

16. In relation to the “two year rule”, recommended by Clothier, the Department of Health published guidance in 2002 on mental health and employment in the NHS¹¹⁹ which contradicts this recommendation. This guidance included the following statements:

“Recent tragedies, however exceptional, in which health professionals have killed or assaulted patients, have focused attention on the implications of psychiatric problems at work (Clothier 1994). However the Clothier report raised unrealistic expectations that psychiatric screening could be an effective filter and diverted attention from other more important factors contributing to the case.”

“A further outcome of the Clothier report has been the stigmatisation of people who have experienced or are experiencing mental health problems, leading to the use of inappropriate criteria to exclude people from employment and a reluctance on the part of NHS employees with mental health problems to disclose this information, where appropriate. This often results in additional worry for them and potentially jeopardises employment if non disclosure is subsequently discovered.”

“The government believes people who have a disability or an impairment should be able to participate fully in society and live as independently as possible. For most people of working age the chance to get and keep a job is central to their independence and participation in society. The same should be true for people who have a disability or impairment.¹²⁰”

119 “Mental Health and Employment in the NHS” (2002), Department of Health, 2002

“An opinion was expressed to the Clothier Inquiry into the case of Beverley Allitt that suggested no applicant for a post in the NHS, who had a previous mental health problem, should be accepted for employment unless they had been free of drugs and other support for a period of at least two years.”

“This proposition was not taken up by the Department of Health but has been accepted by some occupational health professionals and used as a reason for recommending some applicants be refused posts. This guide supersedes previous guidance on the subject and makes it plain that all cases should be judged on an individual basis. It will not be acceptable to use the ‘2 year rule’ as a reason for refusing employment”¹²¹.

However the DRC has received evidence that the two year rule is still applied by some occupational health practitioners in the assessment of those applying for nursing training and also sometimes in operation within the social work profession¹²².

17. Given the DRC’s understanding that the generalised health standards were rooted in a desire to protect the public, we were keen to find out from all the relevant organisations whether they concurred with this view, and if so whether they felt that generalised health standards were a proven method of reducing risk to the public. The DRC was surprised to note that most organisations consulted as part of this investigation had not previously considered this question. Although conditions such as dyslexia,

120 p 9

121 p 29

122 Evidence to DRC’s Inquiry Panel from NHS Education Scotland

epilepsy and mental health conditions were frequently mentioned as impairments that would give rise to concerns about public safety, organisations (including those that issued guidance on these issues) were not able to explain how that risk would arise given comprehensive and properly applied standards for competence and conduct.

18. The investigation heard that generalised health standards encourage a diagnosis led approach to the assessment of risk. We also heard repeatedly that diagnosis cannot be understood without a personal narrative because the impact of any mental health condition or impairment is particular to the individual and their circumstances. Two expert psychiatric witnesses, for example, told the DRC's Inquiry Panel that a diagnosis of mental illness did not create or signify risk¹²³. Mind, the mental health organisation, called mental health diagnoses "contentious and variable"¹²⁴. Disability organisations and others expressed real concerns about reducing any disability to a particular diagnosis or label. This applied beyond mental health, for example, to MS, epilepsy or dyslexia¹²⁵. In the words of one witness, diagnosis "tells you nothing"¹²⁶. It is always important to consider the person's individual circumstances, which may include both their functional impairment and the barriers that they face in their particular job (or while training), and their coping strategies.

123 Evidence to DRC's Inquiry Panel from Dr John Meehan and Dr Max Henderson

124 Mind evidence to DRC's Inquiry Panel

125 The DRC heard from ADO, BDA and universities that a diagnosis of dyslexia covers a very wide spectrum of learning differences or difficulties.

126 Evidence to DRC's Inquiry Panel from Nottingham University

19. Evidence from psychiatrists, from occupational health practitioners and from other organisations also told us that using health diagnoses and testing or screening for health served no useful function at all in relation to predicting future conduct or competence or most importantly, assessing future risk. The DRC therefore considers that whilst it is proper for government departments and regulatory bodies to be concerned about a person's behaviour or conduct, as well as their competence, they should not be advocating frameworks or systems of assessing people's suitability for professional life based on diagnosis.

20. The one partial exception to this we identified was that the existence of a blood-borne virus (BBV) might be material to risk in specific areas of clinical practice where a professional is required to carry out exposure prone procedures (EPPs) that is, to work inside a wound or body cavity¹²⁷. Interestingly, it is the one condition which does not exclude a nurse from registration, and the DRC agrees that this should not be a registration issue, as it relates to specific functions and not to ability to practise in general. As seen above, the NMC Guidance provides that:

127 EPPs are procedures where there is a risk that injury to the worker may result in exposure of the patient's open tissues to the blood of the worker. These procedures include those where the worker's gloved hands may be in contact with sharp instruments, needle tips or sharp tissues inside a patient's open body cavity, wound or confined anatomical space where the hands or fingertips may not be completely visible at all times. It is fairly uncommon for health care workers to have BBVs that require restrictions from carrying out EPPs – evidence to DRC's Inquiry Panel from Dr Linda Bell, Chairperson of the PABS Pre-employment sub-group, a Scottish Executive Health Department Short-Life Working Group

“An individual who is infected with, for example, HIV, Hepatitis B or Hepatitis A might be precluded from being able to practise in some posts. However, such an infection would not preclude them from being registered.”¹²⁸

The NHS too has appropriate arrangements to ensure safe practice by those with BBVs. There may be conditions analogous to BBVs, in that the mere diagnosis of the condition (irrespective of considerations of competence or conduct) identifies a risk, but during the course of the formal investigation the DRC heard very few examples of how such risks would arise¹²⁹. Where such risks do arise they could be dealt with in relation to specific employment or work placements.

21. Otherwise, we consider, in the light of the extensive evidence we received on this issue, that in relation to any of the professions we studied, an academic, competence and conduct framework (with reasonable adjustments, where appropriate, including as to how any standards are to be achieved) with a focus on the skills actually needed is entirely sufficient to meet the needs of the profession. Competencies should be reviewed to ensure that they are designed around the skills and knowledge needed for that profession, bearing in mind that there are a variety of job roles within each profession and that most people – whether disabled or not – would not be suited to all of them. Testing a person for their competencies and ensuring

128 NMC Guidance 06/04, pp 3-4

129 For example we heard of a health care worker with recurrent chest infections due to cystic fibrosis, who would present a risk to certain patients and would need to be restricted from working in certain hospital areas or with certain types of patients – evidence from Dr Linda Bell

that those who commit serious acts of misconduct cannot practice is a much more rational basis for regulating the profession than arbitrary health standards. A diagnostic label is valueless in measuring competence and conduct. Health might be material to compliance with competence or conduct standards, or may not be, but diagnosis is irrelevant in determining competence or conduct.

22. Even in the case of blood-borne viruses (BBVs), they are very unlikely to create a risk (with reasonable adjustments) in most jobs although may create a risk in specific jobs. The proper time rationally therefore to test for a BBV, or to ask for a declaration of BBVs, is at entry into a particular job, for which the tasks to be performed have been clearly identified. This approach to BBVs is recognised and supported by the Department of Health and the NMC.
23. Additionally, it is important to note that the relevant Inquiry Reports looking into tragic events in the caring professions (and in particular the Clothier Report) found that diagnosis or medical assessments would not have prevented the deaths and injuries that occurred. Instead, these reports found that monitoring, supervision, and the efficient and appropriate exchange of information on conduct and outcomes may have mitigated the severity of those events. There is, then, a very real danger that the generalised health standards contribute towards creating a false sense of safety.
24. When the DRC, through its Inquiry Panel, asked relevant organisations about the value of health standards operating independently of competence or conduct, they were not able to offer any coherent explanation as to their value. Many organisations (including regulatory bodies) did not support the continuation of these standards. Such support as

there was from some organisations was predicated on the fact that they existed in law and that it was beyond the remit of that organisation to change them. The vast majority of the organisations that we talked to had not considered the purpose or effectiveness of the standards in any detail before, if at all. Neither had they considered in detail the question of how these standards impact on disabled people. The DRC was surprised at this, particularly for organisations that were responsible for writing guidance on the application of the standards and are now subject to the DED.

25. As mentioned above, the health standards for teaching in Scotland have been repealed and none exist in relation to social work in Scotland. Both the GTCS and the Scottish Executive gave evidence that they were not aware of anything lost by their repeal in teaching¹³⁰. The Scottish Social Services Council (SSSC) too, believes that the regulatory framework within which it operates is sufficient to deal with risk, by focusing on competence and conduct, and only considering health where it has an impact either on competence or conduct:

“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 post¹³¹”

130 Evidence to DRC’s Inquiry Panel from GTCS and Scottish Executive Education Department Teachers Division

131 Written evidence from SSSC

Health standards and attitudes towards disability

26. In reviewing statutory and non-statutory documents for this investigation, the DRC noticed a prevailing negative attitude towards disability, including an assumption that disability is likely to have a negative effect on a person's ability to train or practice. For example, we saw NMC guidance¹³², which appeared to be underpinned by a negative assumption, stating that a registrant "may have a disability and yet be capable of safe and effective practice in nursing", suggesting to the reader that the normal expectation would be for disability to be a barrier. In teaching, the National Union of Teachers (NUT) made a similar observation about document 4/99:

"The way in which Circular 4/99 is constructed results in the circular, and the framework which flows from it, supporting the medical model of disability and a 'deficit' model. The overall tone of Circular 4/99 suggests that disabled staff are a very small number of staff and the way in which disabled staff are referred to is paternalistic and confused. For example, the circular says that "disabled staff can make an important contribution to the overall school curriculum, both as effective employees and in raising the aspirations of disabled pupils and educating non-disabled people about the reality of disability". This sentence suggests that the default position will be that disabled staff are not "effective" employees".¹³³

27. It is hard to imagine language of this kind being accepted or permitted if were used, say, in relation to female professionals. While the DRC recognises that regulatory bodies have – in some cases very recently

132 NMC guidance 06/04 (see Chapter 2, paragraph 9 above).

133 Written evidence from NUT

and possibly in response to the DRC's formal investigation – reviewed their guidance, we are concerned by these underlying assumptions and underlying messages that disabled people's ability to work in these fields competently and safely is somehow in doubt. It is particularly concerning when these ambivalent messages about disabled people come from the regulatory bodies themselves, or from government departments.

28. The DRC received a considerable amount of evidence¹³⁴ about negative attitudes towards people with mental health problems within these professions, and that a history of mental ill health was considered an indicator that someone may not be fit to study, register or work. For example:

“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, England 2000)¹³⁵

“At the end of my student year I had to complete a medical form. I was then interviewed by a doctor, who had to gauge whether I was physically and mentally fit to be a teacher. One of the problems was that the medication used to control my long-term medical condition is also used as medication against depression. . .” (Teacher, Scotland, 2003 – before the health standard for teaching was removed)¹³⁶

“Disclosing my mental health history to the [regulatory body] has proved to be a totally negative

134 Through Disclosing Disability research, through written evidence, Inquiry Panel, from website and through evidence of legal cases

135 sent to DRC through website

136 Evidence sent to DRC through website

experience. I question the expertise 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/staff are being penalised, so the unsuitable candidates are not being identified" (Student with depression, 2006)¹³⁷

29. There are deep-seated beliefs about the connection between disability and risk. Mental health is frequently referred to, but we heard similar prejudice about a range of other impairments and health conditions including dyslexia (particularly in relation to nursing), epilepsy, sensory impairments, mobility impairments, and long-term health conditions that may cause fatigue. The DRC came across the following cases (amongst others) that appear to reflect these beliefs:
- A university wanted to defer an applicant's entry to a nursing course. When asked to provide a justification for this, the university stated that the claimant's deafness might create a risk to patient safety. This could arise in "circumstances of considerable ambient noise, individuals' faces covered by masks and an emergency in progress". (Nursing, Scotland – 2005)
 - A student with a mental health condition was informed by the university that it normally expected applicants to be drug and psychotherapeutic intervention free for a period of two years¹³⁸ before commencing the course but

137 Evidence sent to DRC through website

138 This case also demonstrates that the now abandoned "two year rule" arising from the Clothier and Bullock reports has influenced practice within social work.

that this would not be necessary providing the university received a supportive letter from a consultant psychiatrist. This psychiatrist would be asked to affirm whether or not the person was fit to be a trainee social worker and whether the applicant would pose a risk to him/herself, other students or staff, or the trainee social worker's client group. The university argued that in requesting such information it was exercising its duty to determine fitness for purpose and a duty of care to the applicant, staff and other students. (Social work, England – 2003)

- A student on a teacher training course was told that she was not suitable, on health grounds, after disclosing that she had a mental health condition (borderline personality disorder), even though the student's consultant psychiatrist supported her. The university stated that, in accordance with General Teaching Council for Scotland's regulations, it could not allow her to train as a teacher until it had received confirmation that she was fit to teach from the university's own occupational physician, who did not support her continuing participation on the course. (Teaching, Scotland 2003 before the health standard was removed in 2004)
- A woman was refused a place on an adult nursing course. This was on the basis of an occupational health report that had raised concerns about her ability to complete the course due to her dyslexia. (However, the report stated that with support the claimant would be able to do quite well academically, and pass her clinical assessments). In response to a request for further information, the university stated that it was required to make an "unreserved statement that a student completing the course is a fully fit and proper person to function as a nurse". The university also

stated that if the claimant were to be registered she would be licensed to work in any and every clinical environment, including areas where the speed and pressure of work would not allow the claimant to utilise the strategies she had developed to cope with her dyslexia. The university believed that the claimant would not have been able to operate universally and safely as a nurse once she had completed the course.
(Nursing, England – year unknown)

30. There was considerable anxiety expressed directly or reported to the DRC's Inquiry Panel about the "risk" of nurses with dyslexia. The response appears to be based on the prejudice that nurses with dyslexia might pose a risk in administering medicine or understanding clinical instructions, the consequences of which could be life threatening. However, the DRC has found that although literature exploring the experiences of nursing students with dyslexia is "exceptionally limited", there have been no empirical studies "identifying nurses with dyslexia as unsafe in their practice".¹³⁹ There is, though, some evidence of "hyper vigilant practices" – people with dyslexia working "exceptionally safely" because they build in extra checks within their working practice, out of a fear of making mistakes.¹⁴⁰ Nurses with dyslexia, and those working to support them, have also identified a range of practices and procedures that can enhance safe working for all nurses, such as using standard forms for passing on telephone

139 Morris D and Turnbull P (2006) Clinical experiences of students with dyslexia, *Journal of Advanced Nursing*, Vol.54, No.2, pp. 238-247 cited in the Written Evidence from the Adult Dyslexia Organisation

140 Evidence to DRC's Inquiry Panel from Adult Dyslexia Organisation

messages or for handover notes. This was summed up by the phrase “dyslexia friendly – user friendly”, meaning that practices that enable a nurse with dyslexia to work safely and competently, would contribute to a safe working environment for all nurses. This is relevant because research shows that nurses who do not have dyslexia may also have difficulty with record keeping and drug calculations¹⁴¹ .

31. For student nurses with dyslexia, good practice was identified at a number of universities, whereby these students are properly supported at university and on work placements, and hospitals receive training and support around dyslexia¹⁴². The DRC does not believe that dyslexia and nursing is an exception to the general principle that properly enforced standards of competence and conduct are sufficient to ensure safe practice.
32. The DRC received evidence that health standards can discourage disabled people from applying to train in these professions¹⁴³. One university told us that they had received a number of enquiries to the effect of “I have a disability, can I apply to do the course?”¹⁴⁴ The Royal College of Nursing told the DRC that:

141 Taylor H, 2003. An exploration of the factors that affect nurses’ record keeping. *British Journal of Nursing* 12 (12) 751-758, cited in *Research in assessments and decisions*, Jane Wray et al, DRC 2007

142 Examples given were University of Southampton and University of Nottingham

143 Evidence to DRC’s Inquiry Panel from trade unions, from ANHOPS, and from universities

144 Written evidence from Bishope Grosseteste University in relation to teacher training

“The RCN also support nursing students and our advisers and officers tell us that the requirement to be of “good health” can be problematic for many students and potential students. We believe that some potential nurses could be put off training by an image that nurses have to be ‘super human’. This is an image created by the media but also by the nursing community itself”

And that:

“There are many groups of staff who have significant difficulties applying to become, training as and working as registered nurses. Those we are most concerned about include staff with experience of mental ill health, those with blood borne infections (HIV and Hep A & B as examples), people who have illness such as ME and Fybromyalgia and those with dyslexia.¹⁴⁵”

33. We heard evidence about the deterrent effect of these standards even from regulatory bodies themselves. The GSCC told us that disabled people were, or were likely to be, put off from applying for entry into the professions. In written evidence, the GSCC stated that although it does not believe that the regulatory framework would disadvantage disabled people, it recognises that disabled people are likely to have the opposite perception, and as a result the GSCC has “attempted to provide re-assurance to anyone who might feel that their registration will not be accepted”.
34. Several organisations¹⁴⁶ expressed the view that while they may not feel that health standards in themselves have a negative impact on disabled people, the way in

145 Written evidence from RCN, which represents 400 000 members across the UK

146 Including ALAMA, University of Brighton, University of Bradford, Health Professions Council, BMA, Chief Nursing Officer Welsh Assembly

which they are interpreted or implemented can be discriminatory. The vague wording of health standards, for example the requirement for “good health and good character”, is likely to lead to a variety of interpretations and to decisions that are based on subjective judgements¹⁴⁷. The way that the standards are implemented within higher education and employment, and the role of the regulatory bodies in ensuring that disabled people are not discriminated against, and not deterred from entering these professions are explored below in subsequent chapters of this report.

35. In addition to the effect of these standards in creating a climate that excludes people from entry or progression, there is also a profound effect on the willingness of disabled people to disclose their disability (where they are able to keep this hidden), which in turn has an effect on the availability of adjustments. Issues around disclosure are dealt with below in Chapter 8.
36. Nevertheless it would be unreasonable to place the blame for all negative attitudes towards disabled practitioners in the professions (or students aspiring to join the professions) on the health standards. These standards, as laid out in statutory and non-statutory documents, may also be reflecting prevalent negative attitudes towards disability. They provide a tool to act out negative attitudes and operate as a deterrent to practitioners who might sometimes not be welcome in the profession anyway. The DRC received evidence which led us to conclude that such attitudes sometimes exist independently of the health standards¹⁴⁸ and that attitudinal change was itself

147 Several universities told the investigation that there was not enough guidance to help them implement these standards in a way that was non-discriminatory

important. In Scotland, where generalised health standards for teachers have been removed, there is evidence that negative attitudes towards disabled people continue. For example, Skill told the DRC that in teaching courses in Scotland, “the culture on the ground has not changed in these institutions”, and that teachers and student teachers are still encountering problems¹⁴⁹.

37. The culture of nursing, in particular – paradoxically given its core “caring” functions – seemed often to be intolerant of disability.¹⁵⁰ Scullion, for example, asserted that “disability has only recently appeared on the equal opportunities agenda within health” and that within the health professions it may be viewed as a medical phenomenon “synonymous with illness, deviation or dependence”¹⁵¹. The media promotes an unhelpful image of nursing, but the profession perpetuates these attitudes:

“I hear this perception that nurse equals superhuman, I hear it so many times – qualified nurses who develop a health problem or disability in the course of their career and need to take time off. When they return to work, they’re told: ‘Oh, you can’t be a nurse if you are not one hundred per cent fit’, whatever that might be”.¹⁵²

38. This model of nursing eschews perceived “weakness” within the profession. Those requiring “care” are patients;

148 Evidence of negative attitudes towards disability was found in the three professions. See for example, Background paper, Chih Hoong Sin et al, DRC 2006. Also. evidence to DRC’s Inquiry Panel from a range of organisations including Mind, Skill, ADO.

149 Evidence to DRC’s Inquiry Panel from Skill

150 The culture in which doctors practise, in contrast, seems to be more supportive of colleagues and there appear to be more systems in place to support doctors (GMC evidence to DRC’s Inquiry Panel).

151 Background paper, Chih Hoong Sin et al, DRC 2006

152 Evidence to the DRC’s Inquiry Panel from RCN

nurses deliver it and any perceived blurring of the boundaries is unwelcome and threatening to the self image of nursing.¹⁵³ Without doubt too, the Beverley Allitt effect is significant. The Allitt case feeds into an anxiety about disabled or “unwell” people in the profession, as we have described above.

39. In social work too, previous research has drawn attention to attitudinal barriers and it is claimed that “disabled people are at times expected to remain in the position of being helped, rather than becoming a helper” Negative attitudes from clients towards disabled people “are sometimes not challenged or are used as an excuse to discriminate against disabled employees”¹⁵⁴.
40. Across all three professions, there is a belief that the work is demanding and requires “stamina”; and that disabled people may not have the necessary attributes. For practitioners with mental health problems, there is a misconception that they would not be able to cope with stressful situations. However we heard evidence that that there is no direct

153 Evidence to the DRC’s Inquiry Panel from Mind told us how this arises in the context of mental health services “We have heard stories of mental health nurses who have then themselves become service users. They talk about how the nurses, when they have been inpatients, have been particularly uncaring and unpleasant to them and treating them almost as a traitor to the profession because they have made the profession vulnerable to this boundary being breached”.

154 Sapey, Orton and Turner 2004 Sapey B, Turner R (Lancaster University) and Orton S (SWAP) (eds) (2004) Access to Practice: Overcoming the Barriers to Practice Learning for Disabled Social Work Students. SWAPItsn.

relationship between stress and mental health conditions – for many people with mental health problems, work stress is not a factor in triggering a relapse.

41. The DRC noted that within guidance or other documents from regulatory bodies or other organisations there was an overall lack of positive messages¹⁵⁵ about disabled people working within these professions. However, we heard from a range of organisations that disabled people have particular qualities to offer to the professions.¹⁵⁶ Being careful to avoid stereotyping, these may include empathy for other disabled or vulnerable people deriving from the experience of being disabled (and perhaps being marginalised and discriminated against), or simply being a role model for patients, service users or pupils. For example, in teaching:

“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”. (Newly qualified graduate in first teaching job)¹⁵⁷.

155 Except for Skill publications “Into Nursing” and “Into Teaching” and Skill website, which feature positive case studies. See <http://www.skill.org.uk/>

156 Evidence to DRC’s Inquiry Panel, from Unison, University of Salford, University of Manchester, Skill and others.

157 Written evidence from the Adult Dyslexia Organisation.

And, for example, in nursing:

“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”.¹⁵⁸

Conclusion

42. 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 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, through the Government’s White Paper and the professionalisation of the wider children’s workforce. There is no evidence that the use of generalised health standards is an effective way of determining or managing risk. These standards, while not solely responsible for the existence of antipathy towards disabled people in the professions, reinforce this view and provide some objective justification for it. They are evidently important in affecting the culture of the professions and the general attitude towards disabled people within them.

158 “Can’t do nursing with one hand!” Experiences of nurse Nikki Heazell reported in Background paper, Chih Hoong Sin et al, DRC 2006

Chapter 5 – The role of regulatory bodies

1. Since 2004¹⁵⁹, the regulatory bodies¹⁶⁰ covering nursing, teaching and social work in England, Scotland and Wales have had obligations under the DDA as qualifications bodies¹⁶¹ because they hold professional registers, and registration is a qualification which is needed for, or facilitates engagement in, a particular profession or trade. The Training and Development Agency for Schools (TDA), although it does not hold the professional register, operates the skills test that teachers must pass – separately from their teacher training – in order to be recommended for registration. This means that it is also a qualifications body. As these organisations, including Council for Healthcare Regulatory Excellence (CHRE), are public authorities, they are also covered by the disability equality duty (DED). Below we look at evidence we have received about how these organisations have responded to these duties.

Nursing

2. The NMC first published guidance on “good health and good character” in 2004. Since the start of the

159 The change came in as an amendment to the DDA 1995

160 NMC, GSCC, SSSC, CCW, GTCE, GTCS and GTCW

161 Excluding the CHRE

DRC's formal investigation it has reviewed this guidance and approved new guidance in 2006, in order to meet obligations under the specific disability equality duty¹⁶². The NMC told the DRC that since the Nursing and Midwifery Order (2001), does not define the NMC's responsibilities for people with disabilities and long-term health conditions, the NMC decided to consider these as an aspect of its good health requirements and to address its DDA obligations as part of the revised guidance. The NMC also states that it chose the social model of disability over the medical model, to inform its new "good health and good character" guidance. The DRC notes and welcomes the fact that this guidance refers to the DDA, including the NMC's own obligations under the DDA, and that this guidance reflects a more positive attitude towards disabled practitioners. However the new guidance still requires universities to check and assess the health of disabled people, separately from their conduct or competence, so still has the potential to lead to discriminatory practice.

3. Evidence from the higher education sector shows that this sector has difficulty in interpreting the "good health and good character" requirements and that universities are concerned that decisions about whether someone is fit to train or fit to practise are often made subjectively at a local level. They also expressed concern that they did not know what would constitute a reasonable adjustment to meet these requirements.¹⁶³ We also heard that the good health and good character requirements are interpreted very differently by different universities¹⁶⁴. The issue of

162 Decision of the NMC (06/16), pp10-11

163 For example, written evidence from University of Brighton

164 Universities' evidence to the DRC's Inquiry Panel, which demonstrated good and bad practice

how guidance is interpreted by higher education institutions is discussed below in Chapter 6.

4. Research commissioned by the DRC showed that disabled people sometimes perceived the regulatory bodies to be remote and threatening organisations¹⁶⁵. Evidence from individuals and from universities shows that there is not enough information for disabled people about the processes around disclosure to regulatory bodies, for example, how an individual's case would be (or was being) dealt with. For example:

"I disclosed the information that I had epilepsy ... I was sent no information from them [the NMC] about disabilities, how they treat it within the Nursing and Midwifery Council, the kind of support that's offered or anything else".¹⁶⁷

5. The DRC also heard that for practising nurses, the NMC's role in removing nurses from the register can be used as a threat and can lead to discrimination by employers¹⁶⁸. However, NMC guidance on reporting issues of "unfitness"¹⁶⁹ (whether for conduct, competence or health reasons) does not mention the DDA and does not advise employers about how to ensure that they do not discriminate in carrying out this function.

165 Disclosing Disability, Nicky Stanley et al, DRC 2007

165 Written evidence to the DRC from University of Bradford

167 Disclosing Disability, Nicky Stanley et al, DRC 2007

168 Written evidence from RCN, and evidence to DRC's Inquiry Panel from RCN

169 Reporting unfitness to practice: a guide for employers and managers <http://www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=65>

6. For people with fluctuating conditions (including, for example mental health conditions and MS), the requirement for nurses to re-register and to declare that they meet the good health and good character requirement every three years was a real source of worry. For example:

“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 that 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”.¹⁷⁰

7. It is important to note though that in relation to nursing the DRC did not find, during its investigation, any evidence of complaints of disability discrimination against the NMC in the use of its powers to remove people from the register (or to refuse re-registration). However we came across cases and complaints where the “good health and good character” requirements were used as justification for discrimination against disabled people being refused entry onto higher education courses.
8. The NMC publishes “Fitness to Practise, Annual Reports”. During 2003-2004, the annual report shows that the Health Committee dealt with 250 cases and 40.5% of those cases concerned mental illness and only 4.5% concerning “physical illness”. The remaining cases concerned drug and alcohol abuse. The prominence of mental illness in fitness to practice cases raises the possibility of direct discrimination, although the DRC does not have any information about the detail of these cases and therefore does not know, whether or not disability discrimination was a

170 Disclosing Disability, Nicky Stanley et al, DRC 2007

factor. It would be advisable for the NMC to look closely at the issues raised by these cases and the way that these cases are reported. The DRC notes that this annual report refers to “allegations” of depressive illness, suggesting that having an illness is something analogous to a criminal act.

9. The 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 such as the NMC to do, in its 2004 DDA Code of Practice as a way of “determining whether anti-discrimination measures taken by an organisation are effective”¹⁷¹. The other regulatory bodies relevant to this investigation¹⁷² have all been monitoring registrants for disability equality purposes since 2004. The NMC has told us that it will shortly start to do this in compliance with the DDA 2005, (DED).

10. The NMC has published a Disability Equality Scheme, identifying the NMC’s duties under the DDA. It states that the NMC “have not yet established concrete measures by which to assess the impact of all our functions upon the promotion of equality of opportunity for people with disabilities and the elimination of unlawful discrimination”¹⁷³. Much of the Scheme identifies what the NMC propose to do through its action plan. This action plan identifies that over three years the NMC will take certain steps to meet its general equality duties under the DDA and is built around several core areas including regulation.

171 DDA Code of Practice, Trade organisations and qualifications bodies 2004 DRC/TSO

172 Except the CHRE which does not hold a register

173 p 6

The action plan, however, suggests that as to the “health and good character” requirements, adequate action has been taken by the Decision of the NMC (06/16) approving its new Guidance¹⁷⁴

Teaching

11. Although good health is a requirement for entry to initial teacher training and for remaining on the GTCE’s or GTCW’s registers, these regulatory bodies have only a limited role in determining who is and isn’t considered fit to teach (by advising the Secretary of State on a decision to prohibit an individual from teaching). The responsibility for “mental and physical fitness” lies with DCSF, both through guidance documents that it issues, and also in relation to individual cases. In Wales the National Assembly and the DCSF share these functions. The situation is clearly different in Scotland because generalised health standards for teachers have been removed.
12. In 2005, the GTCE convened a Disabled Teacher Taskforce to:
 - Raise awareness of the current policies and practices that cause difficulties for disabled students to access teacher training and enter the teaching profession.
 - Encourage national organisations to act on removing barriers and promoting opportunities for disabled people entering the teaching profession, either unilaterally or through collaborative projects.
 - Develop a programme of action, which guides national partners to make progress leading to fewer barriers and more opportunities for people with disabilities entering the profession.

174 pp10-11.

13. Members of the Taskforce include statutory agencies such as DCSF, TDA, GTCW and GTCS, as well as disabled people's organisations. Pulling these organisations together to agree a framework for action is a positive approach to looking at disability equality issues within teaching, and is it to be recommended for others professions. The Taskforce supported the DRC's investigation and the DRC agreed to feed its findings from this investigation to the Taskforce. It is important that three General Teaching Councils take forward information gathered from the Taskforce, to inform their policies and practice. The GTCE also has a statutory role in advising the DCSF (and in the case of the GTCW, the National Assembly for Wales) on matters relating to the teaching profession, including medical fitness to teach. The DRC would, then, expect the GTCE and GTCW to advise government on the DRC's findings and recommendations concerning the statutory health requirements for teachers.
14. The GTCE has recently started monitoring for disability amongst its registrants but has concerns about the completeness and quality of data relating to both disability and ethnicity. Figures for 2006 show that only 0.15 % of newly qualified teachers have disclosed a disability. The GTCE acknowledges within its disability equality scheme this poor data is a hindrance to moving forward on disability equality issues.
15. The GTCW gave us registration data for 2006/7 only, which show that seventy seven newly qualified teachers who registered in this year declared a disability, comprising only 0.2% of registered teachers that year. The GTCW conducted research about the teaching workforce in Wales and produced an action plan¹⁷⁵,

175 Action plan for the recruitment and retention of teachers in Wales, GTCW 2003 www.gtcw.org.uk/documents/recruitment/GTCW%20Retention.pdf

which included specific recommendations to address the barriers faced by disabled teachers. The report stated that:

“In 2000/01 students with disabilities were under-represented on ITET [Initial Teacher Education and Training] courses in Wales at 4% of all trainees. This includes students registered as dyslexic. This compares with an estimated 11% of the economically active UK population. However it may not be a useful comparison as the requirements for undertaking a course of ITET and achieving QTS [Qualified Teacher Status] include certain health requirements which may exclude many individuals who are registered as disabled”.¹⁷⁶

The DRC recommends using data to inform policy and action. Analysis of data, such as the data comparison made above, would indicate to us that the health standards should be questioned (for example, through an impact assessment) rather than used as an uncritical explanation for the exclusion of disabled people.

16. The GTCW also participated in research carried out by Teaching and Disability Wales¹⁷⁷ which raised concerns about the requirements for physical and mental fitness and the difficulties faced by higher education institutions trying to implement these standards. It is not clear how GTCW acted on these findings.
17. The GTCS sent us statistics for applicants to the Teaching Induction Scheme which showed that in 2006 there were only 31 applicants that had disclosed a disability, comprising 1.1% of applicants. It has

176 Cited in written evidence to DRC from GTCW

177 Reducing barriers to participation by people with disability in the teaching profession, TADW 2003, www.newport.ac.uk/tadw

published an Annual Statistics Digest for 2005¹⁷⁸ which includes registration data broken down in terms of gender and age, but not disability or ethnicity.

18. We note that the GTCS is the only regulatory body covering these three professions that has a duty through its establishing legislation to “have regard to the requirements of persons who are disabled persons for the purposes of the Disability Discrimination Act 1995”. We have also noted above that some organisations consider that the removal of health standards in 2004 has not changed attitudes to disabled teachers in Scotland. The GTCS should consider how it can use research, monitoring data and involvement of disabled people to fulfil its own duty. It is surprisingly not yet covered by the specific Disability Equality Duty.

19. The Training and Development Agency for schools (TDA) is a qualifications body as it operates the Skills test which all students need to pass as part of the requirement for the award of Qualified Teacher Status. It also has responsibility in England for setting professional standards for teachers. Following consultation with the DRC and other organisations, the TDA has recently revised these standards and removed the requirement for “spoken English”, which disadvantaged British Sign Language users while maintaining its standard for literacy. This change has recently been approved by DfES (now DCSF) and the new standards are operational from September 2007. The TDA also has responsibility for promoting the teaching profession in England but the DRC has not received any evidence that the TDA has taken steps to specifically promote teaching as a career to disabled people.

178 On GTCS website www.gtcs.org.uk

Social work

20. The GSCC told this investigation that although the requirement set out in the Care Standards Act 2000 for mental and physical fitness was controversial when it was proposed, it nevertheless believes that it has found a way of implementing these provisions in a non-discriminatory way, consistent with the DDA. It considered its guidance, issues of confidentiality, and consulted the DRC about its approach before instituting new registration procedures. In written evidence, GSCC stated:

“Our approach to this issue was first to consider what type of health condition may have an effect on an individual’s ability to work safely as a social worker. We defined a set of criteria which would guide applicants as to the issues which we might need to know about in order to meet our statutory duty.”

21. The health conditions identified by the GSCC in its registration guidance are: conditions that may cause seizures; conditions that may result in short-term memory loss or lapses in memory; treatment or medication you are taking that may result in short-term memory loss or lapses in memory; serious communicable diseases; serious mental ill health, or its treatment; and substance dependence including substance dependence for which you are receiving treatment.

22. The GSCC also told the DRC:

“We made a policy decision that where a medical condition was deemed relevant, we would normally remind the applicant, when registering them, of their duty to work safely within the boundaries of their health condition and to inform their employer, if this was relevant. Mostly this has been done simply as

advice at the point of registration rather than through the imposition of formal conditions on registration”.¹⁷⁹

23. The GSCC gave evidence to the DRC explaining how shortly after these procedures were implemented, it refused registration to a number of people in relation to health because the assessment was, on medical advice, that they presented a risk to service users either because their condition was not deemed to be well managed or because they did not have sufficient insight into their condition. Three cases relating to individuals with bi-polar disorder were taken to the Care Standards Tribunal on appeal and the GSCC lost these cases. The GSCC told the DRC that because these cases raised issues relating to discrimination arising from the statutory requirements it was important for the GSCC to “draw these issues to the attention of government”.

24. One of these cases concerned a man who had worked in social care for 30 years, was employed as a social worker by a local authority, and had a diagnosis of bi-polar disorder that he had lived with for 17 years. He challenged the GSCC’s decision that his registration in 2005 should be subject to conditions, and also challenged the delays in processing his application. In his evidence he stated:

“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 and to have discriminated against me”.¹⁸⁰

179 Written evidence from GSCC

180 From witness statement of applicant, sent to the DRC for this investigation

25. The DRC has received evidence that leads us to believe that the GSCC is still finding it difficult to apply the statutory requirement for mental and physical fitness in a way that does not lead to discrimination. We received a number of complaints¹⁸¹ about delays and intrusive procedures for investigating fitness. For example:

“My university has not been concerned about my fitness to practice due to my mental health problems, so they have let me take the MA in social work, which I have nearly completed. However, the GSCC is now investigating my fitness to practise. I am most annoyed not because they are investigating me as I appreciate they need to put the welfare of vulnerable service users first, but rather because of the ways in which they are doing so. I first alerted the GSCC to my mental health status in October 2005, yet they have only begun their investigation recently¹⁸², which is making it difficult for me to register with agencies and find employment. Had they acted sooner, this would hopefully not be a problem. Also, they have been contacting members of staff at my university asking for confidential information without my permission. I have been treated with suspicion despite my total willingness to be open and honest with them, and I feel it is an ironic example for the social care council to be setting – it is totally inappropriate. I decided to be open with the GSCC about my mental health problems, as I feel it would be inappropriate and unprofessional of me to do otherwise. I hoped that because I have nothing to hide or to be ashamed of, the GSCC would investigate my fitness in partnership with me and my university and practice setting. However, they have... made me feel as though I have something to be

181 Sent to the DRC via its website

182 Information received in August 2006

ashamed of and punished for, rather than recognising the additional expertise my experience gives me as a practitioner”

The DRC received three other very similar complaints about GSCC procedures following disclosure of mental health conditions, such as depression, to the GSCC.

26. The DRC also heard at length about a DDA case¹⁸³ against the GSCC being taken by a social work student with HIV who was subjected to lengthy delays to his registration, because he disclosed information about his HIV status to the GSCC but had not disclosed to his university (as he did not believe that his HIV status was relevant to his fitness to study or practise as a social worker). This anomaly was picked up by the GSCC who informed the student’s course leader that “student applicants must disclose information about their HIV status to the University – and that failure to do so may have implications for considering the applicant’s character and conduct”¹⁸⁴. The course leader expressed concerns that a letter to the university from the GSCC about this student implied that the Care Standards Act 2000 (requiring mental and physical fitness) superseded the requirements of the DDA. The course leader was also concerned that this case (and the lack of guidance from the GSCC) meant that she did not know whether she should be advising applicants to the social work course to declare health conditions that she considered to be irrelevant to the profession, because the GSCC may subsequently withhold or delay the students’ registration.

183 Evidence from social work student and his solicitor to the DRC’s Inquiry Panel

184 Evidence sent separately to the DRC in relation to this case

27. In relation to the GSCC's disability equality duty, it has produced a single Diversity Equality Scheme with a two page action plan covering all the diversity grounds. The scheme does not address issues relating to disabled people as registrants, but focuses on disabled people as service users (ie clients of social workers) and as employees of the GSCC. As part of its action plan for the scheme the GSCC makes a commitment "to identify all relevant policies and functions, carry out impact assessment and develop action plans for developing function and policy". Additionally, on its website the GSCC states:

"We are aware that there have been some concerns about parts of our legislation and questions about whether it is discriminatory in relation to health requirements. . . it is possible that this scheme will need to be reviewed in light of their recommendations and that their report will inform a review of our legislation by Government."

28. The DRC considers that, in the light of the findings and recommendations of this investigation, the GSCC focuses closely on its registration functions, policies and procedures around registration as part of its Diversity Equality Scheme.
29. The GSCC has started to carry out disability monitoring of students and registrants. The GSCC told us that it does not hold data relating to all applicants for registration, because many decline to fill in the monitoring form. The data provided shows that around 2% of qualified social workers have stated that they are disabled. It is interesting to note that these figures are much lower than the figures in their data packs relating to disabled students and as part of their disability equality duty the GSCC could use this information to consider issues around disclosure in relation to its registration function.

30. The Care Council for Wales gave evidence to the DRC¹⁸⁵ that applicants for entry onto the register of social care workers are asked to disclose any health condition on application that they feel might affect their ability to undertake their social care duties and again, on renewing their registration and on notifying them of any changes to their health. Their evidence stated that 120 risk assessments have been carried out on declarations of health. No applicants for registration have been refused registration or had conditions imposed because of physical or mental health conditions. Post registration, if any alleged misconduct is considered to have been caused or contributed to by physical or mental ill health, the matter will be considered by a Health Committee which sits in private.¹⁸⁶ The DRC has not heard any complaints relating to the CCW's policies or practices in carrying out its registration function. The CCW believes that it meets its DDA duty to review its competence standards, and also ensures that decisions made about "application, renewal, refusal or removal do not discriminate against disabled people. The Council will review its conditions or standards to ensure that the potential for denying a disabled person the possibility of meeting the standards in the first place, is fully recognised and addressed".
31. The CCW monitors for disability and has recorded that around 78% of registrants have returned equal opportunities monitoring forms and out of those, 2.2% have declared a disability.
32. The requirement for mental and physical fitness does not apply to social work registration in Scotland. The SSSC told the DRC¹⁸⁷:

185 CCW written evidence to the DRC

186 Ibid.

187 Written evidence to the DRC from SSSC

“An individual’s mental or physical fitness may be an issue in so far as the condition may have an impact on the conduct or competence of a worker. The SSSC has on occasion asked an individual to undergo medical (including psychiatric) assessment. The SSSC has no powers to require such assessment; all such assessments have been undertaken voluntarily. In a situation where misconduct is alleged, where an individual explains his/her behaviour as being attributable to ill/health disability, the Council may obtain an independent health assessment to ascertain whether the relevant condition is appropriately controlled.”

“Where regulatory bodies do have health as a criterion for registration [as is the case for social work in England and Wales], 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 need to be judged in relation to the requirements of a particular post”

33. The SSSC goes on to say:

“The regulatory framework for social service workers in Scotland is compatible with the Disability Discrimination Act. As described above, health is not a criterion for registration with the SSSC. The SSSC looks at conduct and competence in general terms. It is for the employer to check the impact of an individual’s physical or mental condition on his/her suitability for a particular post and to make reasonable adjustments under the DDA”¹⁸⁸

This is a model of regulation that the DRC strongly endorses.

188 Written evidence to the DRC from SSSC

34. In responding to requests for cases under the DRC's case review, the SSSC gave an example of how the issue of a person's mental health had arisen as part of consideration of an applicant's competence or conduct, rather than as an issue in isolation. The applicant had been convicted a number of years previously of causing damage to property (and was subsequently detained under the Mental Health Act). The applicant cited a long-term mental health condition as a factor contributing to the incidents. The SSSC obtained a psychiatric report and was satisfied that the condition was under control, his life circumstances had changed significantly and that the applicant did not pose an increased risk. The application for registration was accepted.
35. The SSSC has started to monitor its registrants for disability. Figures from 2005 show that there were 160 disabled registered social workers comprising 2.4% of all registered social workers in Scotland in that year.

Other Health Professions

36. The DRC also received evidence from the Health Professions Council (HPC) about how it interprets and operates health standards across the 13 professions that the Council regulates in England, Scotland and Wales¹⁸⁹. We believe that this is a model of good practice within the constraints of generalised health standards. The HPC is required to set standards of education, training, conduct and performance and to

189 The thirteen professions currently regulated are arts therapists, biomedical scientists, chiropodists/podiatrists, clinical scientists, dieticians, occupational therapists, operating department practitioners, othoptists, paramedics, physiotherapists, prosthetists and orthotists, radiographers and speech and language therapists.

ensure that such standards are met. The Health Professions Council (Registration and Fees) Rules 2003 require all registration applicants to provide a reference as to their physical and mental health, including a declaration that the referee is satisfied that the applicant's health does not affect his/her ability to practise in the profession to which the application relates. The HPC has published Standards of Proficiency including both generic elements, which all registrants must meet, and profession-specific elements. However, it has also published a "Disabled Person's Guide to becoming a Health Professional." Through the publication of this Guidance and its work around the health related standards, the HPC has adopted a more disability friendly approach. It told the DRC that the DDA is compatible with the HPC's regulatory framework, provided that the Standards of Proficiency are the focus of any decision made about someone's fitness to practise in a profession. This will, however, only work provided if in a regulator's standards are modern, clear, outcome-focused, and have been carefully assessed to ensure that they are the threshold standards required for registration, and do not contain any element which is unnecessarily discriminatory.

37. The HPC told us that any decisions reached need to be taken about individuals, with detailed individual assessment of how the Standards of Proficiency can be met. As a regulator, the HPC is concerned that the standards are met, and not how they are met. Meeting the standards can include any reasonable adjustments that an education provider, or employer or anyone else wishes to put into place. The HPC is simply concerned that the standards are met, and that practice is safe and effective.
38. The HPC also recognised that there is an important distinction between fitness to practise, and fitness for a particular job in a particular setting. Registration

does not guarantee that someone would be able to practise effectively in all settings. It is therefore vital that registration decisions are not made based on a perceived possibility of future employment in a particular place.

39. Their Disabled Person's Guide to becoming a Health Professional advises that:

"We do not want to have a definite list which might prevent some people from registering. We want to make sure that decisions are made about individuals ability to meet our standards and practise safely"

"We need to know that these standards are being met, but we do not need to know how the standards are met. What this means is that registered health professionals can make adjustments in their own practice to meet our standards without being concerned that they can't be registered with us".¹⁹⁰

40. This promotes a 'can-do' approach to disabled professionals. It is not over rigid or formalistic. It encourages inclusiveness and reasonable adjustments. Consistent with this more progressive approach, the HPC does not insist on disclosure for its own sake:

"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 the back up and necessary safety protocols and anything else that they need to ensure the safety of their patients. I think

190 HPC Guide, Disabled Person's Guide to becoming a Health Professional, p 12.

people might decide to disclose to different people at different times for different reasons”.¹⁹¹

41. The DRC explored with all the regulatory bodies consulted through this investigation the possible effects of repeal or removal of generalised health standards and found two potential negative outcomes. One potential outcome would be a lack of guidance from the regulatory bodies about issues relating to health or disability, which could lead to different approaches in different higher education institutions¹⁹². Another concern was that more responsibility would be shifted onto employment decisions.
42. The DRC therefore strongly recommends that, even if the generalised health standards are repealed, the regulatory bodies issue guidance on reasonable adjustments, in particular in training and education, and the impact of disability on practice. This guidance must be consistent with the DDA and promote the objectives contained within the DED, as is required by law. We also recommend improvements to occupational health practice in employment. Higher education issues are considered below in Chapter 6 and employment issues are looked at in Chapter 7.
43. In relation to removal from the register the DRC heard the view that the existing approach by regulatory bodies of treating health issues separately to issues of competence or conduct, by having separate hearings, was designed so that health and disability issues could be dealt with more benignly. We also heard that it is often difficult to clearly draw

191 Evidence to DRC’s Inquiry Panel from HPC.

192 Evidence DRC’s Inquiry Panel from NHS Education Scotland

boundaries between different types of cases. In practice, where someone has a health issue that brings their fitness to practise under scrutiny for the purposes of possible removal from the register, investigation is normally triggered by concerns about competence or conduct.

44. As we have already argued, we do not believe that health should be considered as an issue in itself, for registration, re-registration, or removal from the register. If health standards are removed, there are still likely to be conduct or competence cases related to health or disability. The DRC is clear that for the sake of public protection, standards for disabled professionals should not be lowered, and the DDA does not require this. However, under the DDA there is a requirement for reasonable adjustments to the way that standards are assessed. For fitness to practise cases involving health conditions or impairments covered by the DDA, 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 should consider adjustments to the actual process of the hearing. 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. Making adjustments to the actual hearing would be a requirement of the qualifications body provisions of Part 2 of the DDA¹⁹³, which prohibit discrimination in withdrawal of a qualification (or registration), or in

193 Amended in 2004

varying the terms on which a person holds a qualification (or registration). Discrimination, of course, includes a failure to comply with a duty to make reasonable adjustments.

45. The argument that the current system of hearings is a more compassionate approach for professionals who have health or disability related reasons for conduct or competence issues does not, in our view, justify the maintenance of a separate health standard as disabled people now have a right to reasonable adjustments that would ensure that their cases were dealt with appropriately.
46. Even with the removal of generalised health standards, there will be specific competence standards that impact on disabled people differentially and could lead to discrimination. This investigation received evidence about English language standards and noted that these may have an adverse impact on first language BSL users. At the same time the DRC heard evidence about the contribution that BSL users can make to nursing, teaching and social work. It is therefore important, given regulatory bodies' and higher education institutions' responsibilities under the DED, that they review their competence standards and, where these standards are found to be necessary and legitimate, that they offer guidance on how disabled people can be supported through the use of adjustments to meet these standards, so that the standards can be fairly applied.
47. This review should follow the process and principles described in the Code of Practice: Trade Organisations and Qualifications Bodies (2004), DRC, in particular:

"If unlawful discrimination is to be avoided when the application of a competence standard results in less

favourable treatment of a disabled person, the qualifications body concerned will have to show two things. First, it will have to show that the application of the standard does not amount to direct discrimination. Second, it will be necessary to show that the standard can be objectively justified. This is more likely to be possible where a qualifications body has considered the nature and effects of its competence standards in advance of an issue arising in practice. It would be advisable for qualifications bodies to review and evaluate competence standards.”

“This process might involve:

- identifying the specific purpose of each competence standard which is applied, and examining the manner in which the standard achieves that purpose;
- considering the impact which each competence standard may have on disabled people and, in the case of a standard which may have an adverse impact, asking whether the application of the standard is absolutely necessary;
- reviewing the purpose and effect of each competence standard in the light of changing circumstances – such as developments in technology;
- examining whether the purpose for which any competence standard is applied could be achieved in a way which does not have an adverse impact on disabled people, and
- documenting the manner in which these issues have been addressed, the conclusions which have been arrived at, and the reasons for those conclusions”.¹⁹⁴

194 Code of Practice: Trade Organisations and Qualifications Bodies (2004), DRC Paragraph 8.41

48. The DRC also considers that, adopting the model seen in section 1(4) of the Teaching and Higher Education Act 1998 and section 1(3) as amended of the Teaching Council (Scotland) Act 1965, all the regulatory bodies (including the CHRE because of its overarching functions) should be subject to a duty in their establishing legislation “to have regard to the requirements of persons who are disabled persons”.
49. We consider that, for the avoidance of doubt, the regulatory schemes provided for in, or under, the legislation addressing fitness to practise in the professions should be made expressly subject to the DDA. This avoids the confusion around the impact of the DDA on regulatory schemes which have a basis in legislation, and will avoid a situation where these regulatory schemes override or are assumed to override the DDA (because of Section 59¹⁹⁵) The DDA, in the main, covers them (as described above) but such a change would avoid confusion. Presently, the fact that the regulatory schemes have a legislative context can promote the belief that the DDA does not affect them. If the regulatory schemes provided for in or under the legislation addressing fitness to practice were made expressly subject to the DDA, it would be clear to all that the schemes had to be compliant with the DDA.
50. Where responsibility for regulation is spread across public bodies (most notably in the case of teaching), each should be made statutorily responsible for coordinating action in order to promote disability equality. The interrelation between the various powers to regulate the professions afforded to different public bodies (in particular in relation to teaching) makes allocating and identifying

195 As explained above at Chapter 3, paragraph 18

responsibility for disability equality very difficult. This should be remedied by the identification of clear lines of responsibility.

51. The DRC was surprised to note that the Council for Healthcare Regulatory Excellence (CHRE) was not originally a scheduled body in the Disability Discrimination (Public Authorities)(Statutory Duties) Regulations 2005 SI 2005/2966 and accordingly was not required to prepare a Disability Equality Scheme. This has changed since the making of further regulations adding the CHRE as a scheduled body from 6 April 2007.¹⁹⁶ The Care Council for Wales (CCW) and the General Teaching Council for Scotland (GTCS) are still not scheduled bodies. We can find no explanation for this. We strongly urge that this deficit be remedied. The CCW and the GTCS have important responsibilities in relation to the regulation of all the professions with which we are concerned. It is critical that their functions are performed in a way which complies with the DED (to which they are subject) and the requirement to produce and act upon a Disability Equality Scheme will facilitate that.

Conclusion

52. The regulatory bodies have different roles within their professions. In teaching in England and Wales, responsibility for health standards and competence standards is spread across the GTCE, GTCW, TDA and the government departments. It is important that separately for each sector, the statutory and

196 2007/618. These regulations also added the Cyngor Addysgu Cyffredinol Cymru (The General Teaching Council for Wales) which, for reasons too which are unclear, was not originally a scheduled body (though the GTCE was so scheduled).

regulatory organisations work together to use available information (and gather further information from data, research, consultation and involvement of disabled people) to inform the policies that they operate, and their practices. Where regulatory bodies have an advisory function to governments, they should advise government about the discriminatory effects of health standards, where health standards exist. All the regulatory bodies, across England, Scotland and Wales should review their competence standards, to ensure that any negative impacts on disabled people can be reduced or removed. They should all provide guidance on reasonable adjustments and should consider what other guidance to provide to encourage others (such as higher education providers) to adopt an enabling approach to disabled people in (or wanting to enter) nursing, teaching and social work.

53. 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 legislative change. Some of the regulatory bodies are currently not listed as having specific duties under the Disability Equality Duty, namely CCW and GTCS. This should be remedied.

Chapter 6 – Higher Education

1. The regulatory frameworks for nursing, teaching and social work¹⁹⁷ impact strongly on the higher education of future professionals and this investigation has received a large amount of evidence from this sector. The DRC has heard from a wide range of organisations – including universities, occupational health organisations and disabled people’s organisations – about the impact of generalised health standards and procedures for assessing health at entry to higher education. We also received evidence about the particular issues faced by Deaf students (ie those who use British Sign Language, BSL) and students with dyslexia; and we heard about the difficulties faced by disabled students with a range of impairments when they move onto, or between, practice placements. These issues related to the training of professionals are discussed below.
2. Although the DRC did not look in detail at the barriers that operate before the higher education stage¹⁹⁸,¹⁷ we heard evidence that even before disabled people apply for higher education courses, they have already been discouraged and sometimes discriminated

197 See above at Chapter 2

198 The DRC considered looking at other issues, for example advice given by careers services, but did not have the capacity to do so as part of this formal investigation. Other public sector organisations could carry out further research about barriers at various career stages as part of their information gathering for disability equality schemes.

against. One issue is that potential disabled students may not have had a chance to get relevant experience through voluntary work, sometimes because they have not had access to reasonable adjustments. Others may have had some relevant workplace experience, but these experiences were negative. One student told the investigation:

“I am registered as partially sighted and was on an access to nursing course at a local college. The staff made studying extremely hard as I was repeatedly asked ‘do you think you’re up to this?’ 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. I gave up the access course and thoughts of training to become a nurse”.¹⁹⁹

3. Across the three professions, applicants to courses are asked to disclose disability through the admissions processes, such as UCAS, NMAS and GTTR²⁰⁰. The way that the UCAS form is devised could lead applicants to feel confused about the purpose of this request for information about impairment or disability, and confused about whether disclosure was compulsory or not (especially if the disabled applicant did not want to request adjustments).
4. Applicants are also required to disclose information about their health or disability to universities at the

199 Evidence sent to the DRC through the website. This experience happened in England in 2005.

200 The admission service for universities; Nursing and Midwifery Admissions Service and Graduate Teacher Training Registry respectively

application stage. This disclosure is required by universities to meet their statutory obligations (social work and teaching), and regulatory requirements of the NMC (nursing). Procedures are laid down by the regulatory bodies (as well as the DCSF or DIUS in the case of teaching) for the assessment of students' mental or physical fitness. The exception to this, as we have seen, is for social work and teaching students in Scotland.

5. One university in England²⁰¹ uses an "admissions health disclaimer" which states:

"The DoH [Department of Health] and GSCC require academic institutions to ensure the fitness and suitability of those people wishing to train as qualified social workers during and at the point of entry to the profession. In line with the code of practice for social workers and the requirements for registration with the GSCC, we ask you to inform us of any physical, mental, emotional or legal difficulty that might affect your ability to either carry out our studies or undertake the work placements as part of this degree programme. This information will help us to provide any additional support you may need as a student at the university. Moreover, if you have a disability and need any reasonable adjustments for the interview please indicate below. . ."

6. Through this investigation, the DRC has learned that higher education institutions also ask for a declaration of health and/or disability before or at the admissions interview²⁰². This could potentially be used to inform the decision about whether to offer the applicant a

201 The university told the DRC that it is currently reviewing this form

202 Research into assessments and decisions, Jane Wray et al, DRC 2007

place although it may just be part of the university's system for gathering information relating to reasonable adjustments for the course or for the interview.

7. Shortly after starting a course in teaching, nursing or social work, in line with guidance from the regulatory bodies (and DfES/ DCSF), students are generally required to disclose again, either by signing a self-declaration of health, or by filling in a health questionnaire. Research²⁰³ commissioned for this investigation shows that for nursing and teaching courses, the main method for obtaining health information is the use of a self-completed health questionnaire, but for social work it usually takes the form of a self-declaration of good health. This is consistent with the guidance from the different regulatory and statutory bodies²⁰⁴.
8. The DRC has seen an example²⁰⁵ of a health questionnaire based on statutory guidance (4/99) used by one university in England for teaching and education related courses that involve placement in a school. It is very intrusive and over-inclusive and asks the student to state if they have "ever had" any of 25 different health problems, including menstrual or gynaecological problems, thyroid or gland problems, any blood disease, kidney disease or bladder trouble,

203 Research into assessments and decisions, Jane Wray et al, DRC 2007

204 Surprisingly there is evidence from a university in Scotland that a self-completed health questionnaire is required for entry to teaching. This may be a mistake on the part of the survey respondent, or a reflection of the fact that the university is not aware of the removal of the health requirement for trainee teachers in Scotland.

205 Sent as part of written evidence from a university

any allergy or depression. The form asks separately – “Have you ever had treatment by radium or radiotherapy or with chemotherapy?”, “Are you able to recognise and distinguish all the various colours?” “Are you free from any other physical defect or disability?” “Have you ever left employment on grounds of ill-health or unsatisfactory attendance?”

9. The declaration of health form and accompanying guidance makes no mention of the DDA, although the concept of reasonable adjustment is possibly addressed in the question “Do you need or would it assist you to have any special provision made to enable you to fulfil your training and/or subsequent employment?”²⁰⁶

The student is required to sign a multiple declaration at the bottom of the form that includes:

- “I understand that this form will be received by the academic registrar, and if deemed necessary, referred to the occupational health consultant at [name of] Hospital”
 - “I understand that I may be responsible for the expenses of any medical examination or report which may be required
 - “I understand that failure to disclose information or giving false information may result in termination of my offer and subsequently of my course.”
10. It is not surprising that the university told the DRC that students can perceive the fitness to teach requirements as a barrier to entering initial teacher training, and that the department receives a number

206 A separate Declaration of Disability form addresses reasonable adjustments using the same disability/impairment categories as the UCAS form

of enquiries to the effect of “I have a disability, can I apply to the course?”²⁰⁷ This university also commented that “the fact that the regulatory framework exists appears to foster perceptions that it is there to prevent disabled people from applying – work needs to be done to overcome these perceptions.”

11. The DRC has also heard several examples of good support for students, once they are on a course. For example

“On day one X came in and said, ‘my name is X, I’m the Disability Officer, none of you need to tell me now in this group ... but if anybody has a disability issue or they have something that they want to speak about then come along to my room’, and I think that that was done in the most effective way, because she told us right at the start ... so when I did feel I needed someone it was easy for me to go along and see her.”²⁰⁸

12. Research commissioned for this investigation about entry to training for these professions found that there is a “clear link between the regulations, the guidance issued by the regulatory bodies and how decisions are made about fitness”. It showed that “education providers are following the current guidance laid down by the regulatory bodies”²⁰⁹. Whilst the guidance is clear in that it tells universities when and how they should undertake health checks or ask for disclosure, organisations told the DRC that it is not detailed enough to enable them to make

207 Written evidence from the same university

208 Social work student, reported in *Disclosing Disability*, Nicky Stanley et al, DRC 2007

209 Research into assessments and decisions, Jane Wray et al, DRC 2007

objective decisions about whether someone is fit to undertake a course. Universities have also expressed concern that they do not receive any guidance from the regulatory bodies about how to deal with the compulsory disclosure process²¹⁰ and how to support students through this.²¹¹

13. The difficulties this causes are evident in documents sent to the DRC by universities, where there is a huge amount of detail about facilities and reasonable adjustments that the university provides for its students (for example, offering information in alternative formats, support with the Disabled Students Allowance, and counselling services), but very little evidence of specific guidance around the DDA and the health or fitness requirements of the regulatory bodies. This was also borne out in the research commissioned by the DRC which found:

“While all education providers have attempted to address their obligations under the DDA by having generic policies on disability, not all education providers were found to have policies that addressed the particular difficulties of balancing fitness requirements and the requirement for disclosure with the rights of disabled people... Currently, there is insufficient detail in policies produced by most institutions to address this”.²¹²

14. There are several possible explanations for this lack of clarity around procedures for making decisions about

210 For example, written evidence from University of Bradford in relation to social work.

211 Although evidence shows that some universities are attempting to provide this support during the course, for example when a student starts a new module. For example, written evidence from University of Brighton

212 Research into assessments and decisions, Jane Wray et al, DRC 2007

health or fitness within higher education. It is likely that course tutors, university administration and occupational health services find it difficult to marry together two apparently contradictory approaches to disability. Universities are required to operate standards that are not of their own making. These standards contradict the widening participation agenda²¹³ and the enabling approach to disabled students in higher education evident in many universities. Higher education institutions may also believe that statutory health or fitness requirements override the DDA, or they may regard generalised health standards as competence standards which do not need to be adjusted.

15. For nursing courses in particular, occupational health plays a prominent role in making decisions about an applicant's fitness to study²¹⁴. For teaching and social work courses, the role of occupational health services is less prominent although still referred to by about half of the teaching and social work courses that responded to the DRC's research. However the use of occupational health does not necessarily indicate a medical approach to making decisions about someone's fitness to study as different occupational health services operate in different ways. Some occupational health providers are very DDA-aware and take an active role in suggesting and discussing adjustments, whilst we heard that others do not seem to understand their role in ensuring that the institution meets its DDA obligations. The DRC, through its Inquiry Panel, heard about inconsistencies

213 For example see circular letter to higher education institutions from HEFCE
http://www.hefce.ac.uk/pubs/circlets/2005/cl02_05/

214 Research into assessments and decisions, Jane Wray et al, DRC 2007

in the way that occupational health services are provided to universities. For example, for nursing courses some universities use NHS occupational health services, while others use services for higher education institutions. The different services are likely to be assessing students for different things – either looking at whether someone is fit to complete the course or fit to be a nurse²¹⁵. Several organisations mentioned this confusion about whether universities should be checking for fitness for purpose (ie being able to complete the course) and fitness to practise (being able to work within all areas of the profession).

16. Research commissioned by the DRC²¹⁶ found that under half of all education providers surveyed had a formal procedure for making decisions regarding fitness to undertake or continue on a course and this was usually in the form of a fitness committee or assessment panel. Having formal processes such as these may provide an opportunity for issues or adjustments and support to be considered, but we do not have any evidence about whether such panels are, in fact, enabling for disabled people. This is an area that warrants further research. The DRC would also like to see the involvement of disabled people in making these decisions. We found that teaching courses are less likely to involve disabled people in making decisions about suitability for courses than nursing or social work courses.²¹⁷

215 Evidence to the DRC's Inquiry Panel from NHS Education for Scotland

216 Research into assessments and decisions, Jane Wray et al, DRC 2007

217 Research into assessments and decisions, Jane Wray et al, DRC 2007

17. The DRC heard detailed evidence from a nursing applicant²¹⁸ who was effectively barred twice from entering nursing:

“In 1999, I applied for an Accelerated Nursing Diploma for graduates. I informed both the university I applied to and the relevant Occupational Health department that, due to missing fingers, I have limited dexterity; I was transparent about my situation at every stage of the application. I met with Occupational Health staff who asked me to complete a few “practice” clinical skills. They concluded that I displayed adequate manual dexterity, and with a letter of support from them, I was accepted onto the course.”

“However, when I started the course, university staff voiced great concern that I would not be able to wear gloves for particularly dextrous clinical procedures as the spare fingers might “get in the way”. When I enquired who I should speak to about the situation, the university sent me to Occupational Health, but unfortunately, although they had initially supported my application, they didn’t seem to know what to do with me either. Their advice was basically to find a different career, and on one occasion I was even asked by an Occupational Health nurse whether my Mum felt bad about the way that I looked (I have a facial difference).”

18. In 2006, the same applicant decided to “test the water again”. She received a positive response from admissions staff and was referred to a lecturer with a specific remit for disabled students. She also received positive advice from the NMC – their

218 Written evidence, including an article “Never the Twain...” written by nursing applicant, Amanda Bates, and evidence to the DRC’s Inquiry Panel.

response was that “universities should arrange an informal interview for disabled potential applicants, held in the spirit of safety and openness, in which relevant issues can be discussed”. The applicant arranged a pre-application interview with the designated lecturer, as advised.

“I was given no indication as to what the meeting would entail and indeed little preparation seemed to have been put into it. I was led to a clinical skills room by the lecturer (only she and I were present) where I was asked to demonstrate my dexterity in tasks such as attaching a needle to a syringe and opening packs of gloves. I completed all the tasks set and as a result, I was told that I could apply, but that I might fail some of the competencies required for registration... not the most encouraging outcome. I was also told that it would be too expensive to provide gloves that fitted my fingers. I do not know what her costings were to reach this conclusion. There was no suggestion of the Disabled Student’s Allowance (DSA), or indeed any other form of an alternative (less expensive) adjustment.

“... she then said that she needed to double-check the list of competencies required for registration. She left the room and a few minutes later returned with a booklet detailing the competencies. She mused them for a minute or so, and then advised me against applying for Adult Nursing (having told me 5 minutes previously that I could apply) as the “spare” fingers on the gloves could compromise the effectiveness of certain clinical skills. It was then suggested to me that I try the Mental Health Branch instead.”

19. This case highlights the problem of universities or occupational health services attempting to judge the ability of someone to practise competently and safely at the application stage or at the beginning of the

course²¹⁹. All students would have difficulties in meeting competencies before they have learnt how to do so, but disabled students appear to be judged more harshly, having to prove competency at the outset. This amounts to discrimination, as a competence standard is being applied differentially to disabled students (on application to the course) and non-disabled students (during the course, or at the end of the course), purely on the basis of a person's disability. One occupational health doctor commented, of his own experience as a medical student, "if someone put a stethoscope on me on day one I wouldn't be able to hear a heart murmur"²²⁰

20. Within each of these professions there are a variety of roles, and the applicant or student may not know what they are suited to, or what they want to do, until they have finished the course. The approach from some universities is more cautious than at others, with tutors and occupational health services trying to predict whether someone will succeed on the course and succeed in practice. This is motivated firstly by not wanting to "let students down" by allowing them to spend possibly three years on a course when they will not be allowed to register, or be able to get a job. The DRC heard the view that:

"A person's health status is important both on entry to the profession and beyond. That is, the student must be 'registerable and employable'. It is ethically unacceptable to accept a student for training – who

219 Evidence to the DRC's Inquiry Panel from Scottish Executive, Nursing, Midwifery and Allied Health Professional Directorate

220 Dr Hamish Paterson, Clinical Director of Newcastle Occupational Health

even if they manage to get through the student stage – would then find themselves unable to get a job at the end of it”²²¹

Universities may also be reluctant to waste a funded place on someone who will not be able to complete the course, to register, or who will have difficulty in finding work.

21. However, the DRC has real concerns about an approach that attempts to predict disabled people’s likely chances of success on the course or in their careers before they have had a chance to prove themselves, especially in a context of negative assumptions about the capabilities of disabled people. This is likely to lead to discrimination, if disabled people have to demonstrate competency in specific tasks or skills at any earlier stage than for other applicants or students. Predicting future outcomes is also likely to lead to particular disadvantages for people with fluctuating or degenerative conditions²²², as there is a danger that occupational health services will make these predictions based on diagnosis. Disability organisations gave us a clear message. They labelled the attitude that disabled students should be protected from later failure or rejection as “paternalism”, and told the DRC that disabled students – like all students – must be allowed to try, and to fail, as well as to succeed²²³.

221 Written evidence from Equality Challenge Unit (ECU)

222 Written evidence from SSSC, and evidence to the DRC’s Inquiry Panel from Mind and others

223 Evidence to DRC’s Inquiry Panel from Radar

Work placements

22. Trainee nurses, teachers and social workers all spend some part of their training time on practice placements. The DRC heard evidence indicating that disabled students who may have been well supported at university can often experience disadvantage at this stage²²⁴. This occurred sometimes because of failures by the higher education institutions to properly plan for placements, or to communicate the need for adjustments or co-operate with placement providers in planning these adjustments. There appears to be a lack of clarity around placement providers' obligations to make reasonable adjustments²²⁵, and a lack of knowledge on the part of the placement provider about disability equality, the DDA and reasonable adjustments²²⁶.

One university told the DRC²²⁷:

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

23. The organisation, Skill, and others also raised the issue of the attitudes and awareness of workplace

224 Evidence to DRC's Inquiry Panel from Skill, UCU and GTCE

225 Written evidence from Bishop Grosseteste University based on research amongst disabled students, which reported that there is a need for better liaison between the university and placement provider

226 Evidence from UCU and from Unison

227 Written evidence from University of Kent

assessors – that they need to understand their obligations under the DDA, particularly in making adjustments to enable the student to demonstrate competency. Skill told us that having workplace assessors who were, themselves, disabled would help to spread a better understanding of disability.

24. Issues around disclosure and the placement providers' knowledge of the student's disability compound these difficulties. Education institutions should take steps to ensure that enough information about the need to make adjustments is shared with placement providers (with the permission of the disabled student), to the extent necessary to ensure that these adjustments are made without a student having to go through repeated disclosures to the placement providers. This is subject to the need to respect confidentiality²²⁸. It is usually possible to pass on information about adjustments without passing on any medical information. Disabled students on practice placements are likely to feel uncomfortable about disclosing to their new colleagues on the placement and may prefer to disclose selectively, only to those who need to know.
25. The DRC learned that in May 2005, a case was reported to the Royal College of Nursing about a student with dyslexia who had been forced to wear a badge during a practice placement which said "I am a disabled student".²²⁹ This clearly represents the extreme end of bad practice in relation to disclosure on work placements.

228 This approach to sharing information is in line with the DRC's Code of Practice on employment and occupation

229 Jean White, 2006, "Supporting pre-registration nursing students who are dyslexic in clinical practice", quoting from Nursing Standard 2005a p7. Written evidence sent to the DRC from Office of the Chief Nursing Officer, Wales

Dyslexia

26. The operation of health and competence standards to those with specific learning difficulties (dyslexia in particular) requires separate mention. Looking at statistics for students in higher education it is interesting to note that the proportion of students with a diagnosis of dyslexia in higher education is very high as compared to the proportion of students with other disabilities. In fact, where figures are broken down into impairment type, dyslexia often makes up around half of disabled students²³⁰ and can give the impression that more progress has been made on disabled people's access to higher education than is actually the case for most impairment groups.²³¹ Evidence from the higher education sector shows that there has been progress made on properly accommodating students with dyslexia, and because of the availability of this support more students with dyslexia are willing to disclose. However, this should not mask the fact that dyslexia is often seen negatively within nursing and teaching, and often seen to be incompatible with practice within these professions²³². Assumptions made about dyslexia (for example relating to risk and incompetence) create barriers to entry to courses²³³ and the existence of generalised health standards promote a climate where people with dyslexia can be judged at entry to courses, rather than after they have had a chance to prove their competence on the course, with reasonable adjustments to enable them to achieve these competencies.

230 For example see GSCC's data packs

www.gsc.org.uk/About+us/Statistics/

231 Evidence to DRC's Inquiry Panel from amongst others, UCU

232 Evidence to DRC's Inquiry Panel evidence from UNISON (who also mentioned dyspraxia in the context of nursing and concerns about drug administration).

233 Written evidence and evidence to the DRC's Inquiry Panel from Adult Dyslexia Organisation (ADO)

English language standards

27. In Chapter 2 we noted that requirements for written and spoken English, laid down as competencies by regulatory bodies and universities, can disadvantage Deaf students (including students who use British Sign Language, BSL). There are slightly different legal implications here, as explained previously. English language standards, as opposed to generalised health standards, are likely to be competence standards, but nevertheless may lead to discrimination²³⁴. First language BSL users²³⁵ are effectively being expected to be bi-lingual and have told the DRC that they are disadvantaged because of this requirement. The DRC's Inquiry Panel heard evidence about a social work course²³⁶ and a nursing course²³⁷ which have successfully integrated and supported Deaf (sign language users) students, who had qualified, registered and gone on to work as social workers and nurses. The course providers explained that with the right adjustments it was possible for Deaf students to meet the other competencies. Deaf people have a need for Deaf teachers, nurses and social workers who can communicate to them in their first language. The course leader for the University of Salford mental health nursing course told the DRC's Inquiry panel: "In 1999 I was a charge nurse [in a mental health and deafness Unit in Manchester] and basically some of the healthcare assistants were Deaf people whose first and preferred language was sign language. The

234 There are also issues around the cost of adjustments, as the Disabled Students Allowance is not sufficient to pay for the necessary amount of sign language interpretation

235 Evidence to DRC's Inquiry Panel from University of Manchester and from a social work team manager in Trafford

236 University of Manchester

237 University of Salford

first language of this Mental Health 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 of what was going on, they were much more effective in dealing with the situation than I was. Ethically I found that slightly uncomfortable because at the time they couldn't qualify as nurses".²³⁸

28. The DRC would advise, then, that regulatory bodies and universities review their competencies in the light of the experiences of university courses that have enabled Deaf students to qualify and practice. However, it is important that Deaf practitioners (or any disabled practitioners) are not pigeon-holed as they don't not necessarily need or want to work within specific disability "niches".²³⁹

Conclusion

29. 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 a 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

238 The DRC was told that this was the motivating factor in setting up the Deaf Peoples Access Nurse Education Project

239 And in fact, we heard evidence from the University of Manchester that in the case of Deaf social workers these "niches" are not clear cut as Deaf service users are likely to have hearing family members who will also need to be communicated with.

regulatory frameworks laying down standards for health or fitness that require compulsory disclosure and often lead to discriminatory policies and practices.

30. 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 judging disabled applicants or students at entry point for their future competence, or for their likely success within a professional career.

Chapter 7 – Employment

1. In carrying out this investigation the DRC explored whether the health standards had any effect on employment practice within these professions, and how decisions are made about fitness for work. What we found was that occupational health practice – irrespective of any fitness or health standards – was a much more 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 relation to training in these professions.
2. Given this background, then, the investigation has inevitably drawn evidence from occupational health practitioners and organisations, and we are particularly grateful for the co-operation of this sector in our evidence gathering. We have also carried out research with employers, and heard evidence from employers, trade unions and disabled professionals themselves. This evidence is reflected in our findings below.

Role of regulatory bodies and health standards in employment

Nursing

3. Within nursing the regulatory body for England, Scotland and Wales, the NMC, only has a very limited role in relation to employment as its primary role is to set standards for training and maintain standards of those on the register. The NMC specifically states that

“Registration is a ‘licence to practise’ and it is for employers to make their own assessment on fitness for employment” (NMC guidance 06/16).

4. However it offers some guidance to employers, for example in the document “Advice sheet on employers’ responsibilities” which advises employers (amongst other things) that “a systematic process of support and supervision should be in place to help identify problems with the performance of staff. Employers should implement good employment practice to ensure the early identification of staff health problems”²⁴⁰. This document does not offer any advice to employers about equality issues or the DDA.
5. The NMC also offers guidance to employers on reporting issues of “unfitness” to the NMC²⁴¹. Although this document states that fitness to practise may be impaired by mental or physical ill-health it does not mention the DDA at all, which is worrying given that the RCN²⁴² told the DRC that this is an area where potential discrimination can occur:

“We support the NMC’s statement that health conditions and disabilities are not automatically incompatible with registration and are encouraged by their commitment to treat all issues on an individual basis. This is of special concern where the framework allows people other than the registrant to report concerns or complaints. Our members tell us that line management often threaten to ‘report to the NMC’

240 <http://www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=1567>

241 Reporting unfitness to practice: a guide for employers and managers <http://www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=65>

242 Written evidence to the DRC

over matters relating to ill health and disability, where the nurse is, perhaps not complying with management action for other reasons...Our concern here relates to the subjectivity of the test for “good health and good character” and that this opens up possibilities for direct and indirect discrimination.”

6. The only clear advice offered by the NMC in relation to assessment for employment is part of the NMC’s guidance 06/04²⁴³ which discusses practitioners with blood borne viruses. This document, which refers to the Department of Health guidance on serious communicable diseases states that:

“An individual who is infected with, for example, HIV, Hepatitis B or Hepatitis A might be precluded from being able to practise in some posts. However, such an infection would not preclude them from being registered. It is essential, therefore, that registrants applying for posts or registering with an agency are aware of and comply with good health requirements for employment as well as for registration.”

Teaching

7. For the teaching profession in England and Wales, there is statutory regulation concerning fitness at entry to employment but this stems from the DfES (now DCSF) rather than the GTCE or GTCW. The relevant health standards for entry to employment are set out in the document 4/99 and related guidance for occupational health. These documents have been considered in Chapter 2 above and although they explicitly refer to employers’ obligations under the DDA and to the need for reasonable adjustments, it is

243 <http://www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=219>

the view of the DRC that they are still likely to lead to discrimination. The NUT told us:

“the way that Circular 4/99 is drafted does not make it clear enough that the regulatory framework set out in Circular 4/99 is subject to Disability Discrimination Act 1995...This is not a clear explanation of the law and ignores the clear statutory duty on employers to make reasonable adjustments in order to facilitate access for disabled teachers to continuing employment”.²⁴⁴

8. Medical advisers (occupational health practitioners) are advised to classify applicants into three categories – those in good health, those with conditions but who can nevertheless practise as teachers with reasonable adjustments, and those who are unfit to teach. There is also specific guidance to occupational health practitioners in *Fitness to Teach: Occupational Health Guidance for the Training and Employment of Teachers*²⁴⁵, which goes into detail about the implications of specific medical conditions and impairments. Annexed to this guidance is a sample pre employment questionnaire, containing 25 broad questions, including: “Have you seen a doctor in the last year for any kind of health problem? If so please give reason(s)”; “Are you waiting for any treatment, operation or investigation?” and “Are you on any medication at present?”
9. The DRC has not been able to establish the extent to which this occupational health guidance is followed by OH practitioners in relation to teachers, but has seen evidence that the three category approach is

244 Written evidence from NUT

245 DfEE 2000

frequently used by occupational health practitioners providing advice to employers in the public sector²⁴⁶.

10. There appear to be no regulations or statutory guidance that refers to the health of teachers in Scotland, now that the generalised health standard for the training and employment of teachers in Scotland has been removed²⁴⁷.

Social work

11. In social work in England and Wales, Section 62 of the Care Standards Act 2000 requires the Councils to prepare and publish codes of practice laying down standards of conduct and practice expected of social care workers and of those employing or seeking to employ them. The GSCC and CCW have both issued codes of practice for social care workers and employers of social care workers (2002, GSCC and CCW), which contain limited advice on health issues but do not advise employers on assessing fitness.
12. In Scotland,²⁴⁸ regulations specify that providers of care services shall not employ any person in the provision of a care service unless that person is fit to be so employed. A person who is “not physically and mentally fit for the purposes of the work for which the person is employed in the care service” is

246 Dr John Ballard, “Pre-employment Health Screening”, *OH at Work* 2006; 3(3): 18-25 and *OH at Work* 2006; 3 (4): 22-30

247 This is notable, because for social workers in Scotland there are still some requirements for health that relate to specific employment.

248 The Regulation of Care (Requirements as to Care Services) (Scotland) Regulations 2002 (SSI 2002/114 as amended)

to be treated as not fit to be so employed.²⁴⁹ As noted above (in Chapter 2, paragraph 83) this relates to specific work at a specific service, as there are no generalised health standards for training or registration of social workers in Scotland, only a requirement for good conduct and competence.

Pre-employment health screening

13. Across nursing, teaching and social work the process of assessing fitness to work starts at the pre-employment stage. A survey of employers carried out for this investigation²⁵⁰ found that all responding employers indicated that they asked applicants for a declaration of health and/or disability. 68 out of 69 responding employers indicated that such a declaration was solicited “on application form”. Only one indicated that it solicited such information “at commencement of employment”. No responding employer indicated that it first solicited this information after short listing, during an interview, after the job had been offered or at any other stage. Almost half of the employers surveyed (46%) across these three professions use self-certification health questionnaires issued with the application form. Self-declarations of good health, and health references are also used by 23% and 17% of responding employers respectively.²⁵¹

249 Regulation 7 of the Regulation of Care (Requirements as to Limited Registration Services) (Scotland) Regulations 2003 (SSI 2003/150) makes similar provision in relation to limited registration services.

250 Employers’ survey, Janice Fong et al, DRC 2007

251 Figures from the Employers’ survey, Janice Fong et al, DRC 2007

14. Previous research, and evidence given to the DRC by occupational health practitioners, has indicated that health questionnaires are often poorly constructed²⁵². As with the sample questionnaire provided in the "Fitness to Teach" document, they often ask questions that are irrelevant in assessing fitness for any job (such as questions about menstrual problems or family history). Questionnaires are generic, that is, not tailored for specific jobs. Within the NHS, for example, individual Trusts will have their own questionnaires, but these will operate across all job roles.

15. The DRC regards the lengthy intrusive pre-employment questionnaires used regularly by public authorities as inappropriate, lacking in usefulness, and potentially discriminatory, because of their focus on diagnoses which are irrelevant to the work. They are also considered by many occupational health practitioners to be a waste of resources, as occupational health departments have to sift through the information contained within them. The DRC heard from occupational health practitioners who felt that their services could be better used in providing on-going support for employees to keep them in the workforce²⁵³. In the United States, the Americans with Disabilities Act has prohibited any health or medical inquiry before a firm offer of a job has been made.

252 Dr John Ballard, "Pre-employment Health Screening", OH at Work 2006; 3(3): 18-25 and OH at Work 2006; 3 (4): 22-30, and evidence to DRC's Inquiry Panel from Dr John Ballard, and Dr Linda Bell, occupational health practitioner

253 Evidence to DRC's Inquiry Panel

16. The purpose of pre-employment screening is unclear but there appears to be a culture whereby certain public sector employers assume that they need detailed knowledge of an applicant's health history²⁵⁴. Some research has previously been carried out on this²⁵⁵, and some is on-going²⁵⁶, but assessing fitness for the job, predicting sickness absence²⁵⁷, health and safety issues, and DDA issues (either identifying whether people are covered by the DDA or assessing the need for adjustments) are all possible reasons for screening. Employers are sometimes unclear whether they are collecting this information for health and safety reasons (either to protect the applicant, other employees or the public), for DDA purposes or even for disability monitoring purposes.
17. The DRC heard evidence and accepts that there can be a role in specific jobs for enquiring about, or testing for, specific conditions (for example, blood-borne viruses) or physical capacities to ensure that a person can carry out a specific job safely. However, we consider that any such tests should be closely linked to (and objectively justified by) the tasks to be performed and be subject to reasonable adjustments.
18. A related issue, as we have seen within higher education, is that the purpose of asking for information about disability or health is often not communicated adequately to the applicant. Job

254 Evidence to DRC's Inquiry Panel

255 Dr John Ballard, "Pre-employment Health Screening", OH at Work 2006; 3(3): 18-25 and OH at Work 2006; 3(4): 22-30

256 Evidence to DRC's Inquiry Panel from Newcastle Occupational Health

257 However, the Inquiry Panel also heard that there is no evidence that medical diagnosis enables an accurate prediction of sickness absence.

applicants are required to fill in the forms by employers, and are told that “failure to disclose any information may lead to managerial actions being taken in the future”²⁵⁸. This would signify to a disabled applicant that the information was being asked for to screen people out, rather than to enable the employer to consider adjustments. It is important, then, that the purpose of any health assessments is identified and made explicit to candidates to ensure they do not operate to discourage those disabled practitioners who are qualified to do the job.

19. We noted that evidence from occupational health practitioners told us that very few disabled people were being turned down by occupational health based on pre-employment health screening²⁵⁹. However it is hard to know how managers or HR departments deal with the information that is fed back to them from occupational health. As mentioned above, research conducted for this investigation²⁶⁰ shows that an overwhelming majority of employers in the three professions covered by this investigation require pre-employment health screening of some form prior to a job offer. Other research involving different samples of public sector employers shows that around 25% of employers in the NHS, and about 40% of other public sector employers²⁶¹ require pre-employment health questionnaires to be returned before the job offer is made²⁶². In order to ensure

258 Evidence to Inquiry Panel from Newcastle Occupational Health

259 For example, evidence to Inquiry Panel from Dr Ira Madan

260 Employers’ survey, Janice Fong et al, DRC 2007

261 Figures from Dr John Ballard, collected as part of “Pre-employment Health Screening” research

262 The figures are not directly comparable as the two research projects differ in terms of objective, sample and instruments used.

that judgements about suitability are not tainted by knowledge of an impairment or health condition it is important that any health assessments that might be needed pre-employment should be made after (and as a condition of) an offer of employment.

20. At the recruitment stage, prior to a job offer, it is normally only necessary to ask about disability in the context of reasonable adjustments (either for the interview or for employment), unless there is a very specific health requirement for a job, such as the absence of blood-borne viruses and specific nursing roles. The DRC does not consider it necessary, as was suggested by the Clothier Report, that occupational health or other medical records should follow an employee through his or her career. This may deter openness, create fear and importantly it will not help identify risk. The DRC's Inquiry Panel heard from occupational health practitioners and psychiatrists who told us that a diagnostic label is not by itself a predictor of risk to others or the disabled person. A competence and conduct approach to professional regulation would ensure that people who were not able to practice safely or effectively were not on the professional registers and therefore not employable within these professions.

Responsibility for decision-making

21. The employment provisions of the DDA place the responsibility of making decisions about employment with the employer and not with the medical adviser, such as an occupational health doctor or nurse. The DDA Employment Code of Practice states:

“where medical information is available, employers must weigh it up in the context of the actual job, and the capability of the individual. An employer should also consider whether reasonable adjustments could

be made in order to overcome any problems which may have been identified as a result of the medical information²⁶³”

22. Across the professions, but particularly in relation to nursing and social work, occupational health departments play a significant role in making decisions about applicants and employees’ fitness to work²⁶⁴. For teaching applicants, the local education authority (where relevant) is also involved. However, in relation to the final decision about whether or not to employ someone with an impairment or health condition, evidence suggests that a wider spectrum of personnel are involved and that employers retain control of the final decision in the majority of cases²⁶⁵.

23. For teachers, the way that these decisions are made is less clear cut. For community schools in England, the local authority is the employer, although many of the recruitment and employment responsibilities are delegated to the school. The responsibility for decisions, therefore, falls on the Head Teacher and board of governors. However, the local authority has a role to play in providing support (such as HR advice, and DDA-aware occupational health services). The NUT told the investigation:

There is a low level of understanding of the definition of “disability” within schools and among governing

263 DDA Code of Practice, Employment and Occupation 6.15 DRC/TSO 2004

264 Employers’ survey showed that across the 3 professions 72.5% of employers indicated that they would seek occupational health advice in deciding if an applicant was fit to be employed. In nursing, this figure was 100% of responding employers

265 Employers’ survey, Janice Fong et al, DRC 2007

bodies and local authorities as employers. This means, therefore, that the 'Fitness to Teach' regulations are not applied by heads and governors with due regard to the DDA, because there is a patchy level of understanding about what the DDA requirements mean in practice and about who is covered by the term 'disabled' when interviewing and managing disabled teachers²⁶⁶

Head Teachers and boards of governors clearly need to have sufficient understanding of the DDA implications of their decisions and this applies especially to foundation schools and academies which have a much greater degree independence from the local authority.

24. The DRC heard, too, that issues around reasonable adjustments can be harder to resolve within a school context – both because of funding concerns and because of knowledge and awareness. For example:

"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"²⁶⁷

266 Written evidence to the DRC from NUT

267 Evidence sent to DRC's website from teacher whose DDA case went to the Court of Appeal, where she was successful. See also Review of Statutory and Regulatory Frameworks, David Ruebain et al, DRC 2006. See also [2004] EWCA Civ 859

Another teacher reported:

“I have now had to change schools, since I was being discriminated against, along with many other teachers, and I lost the will to fight against the new management. However, things at my new school are not much better and I just feel like giving up as a teacher . . . It may seem radical but when you have to go upstairs to use the phone, get a cup of coffee or to get access to your classroom before 8.30 in the morning, with my condition it is becoming more and more favourable to give up. I have tried . . . discussing the situation with my line manager and head teacher”²⁶⁸

Improving practice

25. The DRC’s Inquiry Panel heard extensively about the relationship between occupational health and employers, with concerns from occupational health organisations that they do not work closely enough with employers. Occupational health organisations told us that their members did not want to be given the role of dealing with employers’ difficult cases (which may or may not relate to health), or of making judgements about whether an employee is covered by the DDA. There was also concern about the role they are expected to play in predicting sickness absence, based on medical information.
26. The Association of Local Authority Medical Advisers (ALAMA) told the DRC that it was concerned that many employers delegate decisions about fitness to work to occupational health professionals who have very little knowledge of exactly what the regulatory frameworks are for each profession. ALAMA told us that:

268 Case study from NUT’s written evidence

“occupational health professionals are often put under considerable pressure over the question as to 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”.²⁶⁹

27. NUT raised a similar issue:

“Occupational health professionals at times make recommendations that fit too easily with employers’ prejudged conclusions about the fitness of teachers for continued employment. A decision on an employee’s employability [is difficult to challenge] once an occupational health report has been made. In the light of this barrier, it is clearly vital that occupational health fulfil a role which is consistent with the spirit of the DDA”.²⁷⁰

28. Occupational health organisations told the DRC that their role should be more integrated into the workplace and that they need to work more closely with employers. For example an OH doctor told us of his experiences providing OH services to an NHS Trust:

“An occupational physician should be part of the organisation, know who to talk to and how to get things organised – not sat in an office in a medical centre not even being in the hospital, or even knowing the department. Last Thursday we spent all

269 Written evidence to the DRC from Association of Local Authority Medical Advisers (ALAMA)

270 Written evidence to the DRC from National Union of Teachers (NUT)

day looking around the Acute Psychiatric Department of the local Trust. I was amazed at the working conditions and environment. I thought, thank God we went round. You should be doing that on a daily basis".²⁷¹

29. We were told that this approach is also the most effective way for occupational health to support the management of sickness absence – by understanding the causes of the absence that are often related only loosely, or not at all, to a health condition or impairment.²⁷²
30. It is especially important that OH departments or providers work with employers around reasonable adjustments. As noted in Chapter 3, there is no justification in law for a failure to make reasonable adjustments and they always need to be considered by the employer, even if the employer later decides that there are no reasonable adjustments that could be made, or that would be effective. This would apply even in a situation where occupational health has advised that someone is unfit. It is of concern, then, that the three category approach (classifying people as fit, fit with adjustments, or unfit) is still used by 40% of occupational health providers in the NHS and the rest of the public sector, when feeding back to employers about pre-employment assessments.

A further 10% of these providers feed back simply that someone is fit or unfit²⁷³.

271 Evidence to DRC's Inquiry Panel from Newcastle PCT Occupational Health

272 Evidence to DRC's Inquiry Panel from Newcastle PCT Occupational Health

273 Dr John Ballard, "Pre-employment Health Screening", OH at Work 2006; 3(3): 18-25 and OH at Work 2006; 3 (4): 22-30

31. The DRC strongly favours an approach to occupational health which provides an opportunity for the employer, occupational health practitioner and the disabled applicant or employee to discuss reasonable adjustments, in line with good practice and with the DDA Code of Practice. The Code advises that employers making decisions about the employment of disabled people “should seek the views of the disabled person about their capabilities and about reasonable adjustments²⁷⁴. Within an employment context, unlike the higher education context, the involvement of disabled people in discussions and decisions about fitness for the job is rare²⁷⁵.
32. Having heard evidence from occupational health organisations, the DRC is aware of the current development by these organisations of good practice models and endorses them. For example, the PABS²⁷⁶ group, sponsored by the Scottish Executive Health Department is working on an approach to occupational health assessment that moves away from a medical model of assessing fitness and recognises that knowledge of a specific diagnosis is only important as a starting point for understanding someone’s functional limitations within a specific job. This group is working on a questionnaire with the minimum amount of questions, which relate to how a person sees themselves, any functional problems that they have and any reasonable adjustments they need, instead of “99 questions on various aspects of their

274 DDA Code of Practice Employment and Occupation
DRC/TSO 6.16

275 Research into assessments and decisions, Jane Wray et al,
DRC 2007; and Employers survey, DRC 2007

276 Scottish Executive Health Department, Occupational
Health group, peer review audit and benchmarking sub-
group (known as PABS)

health in the past". They told us that they want to focus on functional ability rather than on medical diagnosis because "in employment, medical diagnosis really doesn't matter, it is the function that is the key issue and what adjustments they might require"²⁷⁷.

33. It is vital that the old model used for assessing fitness based on diagnosis or medical history is replaced by a functional model, with the emphasis on the identification of reasonable adjustments. The DRC supports further work by occupational health organisations to develop good practice that promotes the social model of disability, compliant with employers' DDA and DED duties. Occupational health providers should have adequate training on disability and the duty to make adjustments. Employers should ensure that the occupational health services they use, and their own processes for interacting with these services and making decisions are DDA compliant. Public sector employers of nurses, teachers and social workers should review all their health and disability related policies in the light of the DED to ensure that they promote reasonable adjustments and inclusiveness.

Conclusion

34. 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

277 Evidence to the Inquiry Panel from Dr Linda Bell, occupational health consultant.

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 put disabled people off applying for jobs or from disclosing disability.

35. 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 waste of resources for occupational health practitioners who have to assess them. Different occupational health practitioners currently work to different models. Employers should ensure that that they only use occupational health services that are DDA and disability aware and focus on reasonable adjustments.

Chapter 8 – Disclosing Disability

1. Throughout this investigation we heard that disabled people feel anxious about disclosing their disability to regulatory bodies, to higher education institutions and to employers, because they assume that this information will be received negatively. There are deep-seated assumptions about disability and risk, reinforced by the professional regulations and guidance. This chapter looks at the requirements to disclose, and the factors that encourage disabled people to do so.
2. The definition of disability we have used throughout this investigation is the DDA definition, “a physical or mental impairment which has a long-term and substantial effect on a person’s ability to carry out normal day-to-day activities”. This definition is broad enough to include people with obvious physical impairments as well as hidden impairments and long-term health conditions.
3. People with visible impairments may have fewer options about disclosure or non-disclosure, but will still need to decide whether to declare their disability on application forms, or registration forms and will have to consider how much information they want to share with education institutions, regulatory bodies or employers. Where people have multiple impairments, they may decide to disclose some information, but keep other information about a more stigmatised

condition, such as a mental health condition, secret. For example:

“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”.²⁷⁸

4. This investigation has found that for disabled people in teaching, nursing and social work, decisions about disclosing disability are not simply personal choices. As described in Chapters 2 and 3 of this report, there are two potentially conflicting regulatory frameworks that inform these decisions. First, the generalised health standards themselves lay down requirements for disclosure and, in some cases, procedures for disclosure 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.
5. As we have seen above the NMC sets out in guidance²⁷⁹ a requirement for disclosure at the points of entry to training, registration and re-registration. In teaching, statutory guidance²⁸⁰ for England and Wales requires disclosure of disability in order to assess fitness at entry to training and to employment. For social workers, the registration rules for England and Wales covering students and qualified social workers require evidence as to

278 Disclosing disability, Nicky Stanley et al, DRC 2007

279 06/04 “Requirement for evidence of good health and character”

280 Physical and Mental fitness to teach of teachers and entrance to initial teacher training – Department for Education and Employment – 1999

physical and mental fitness to practise. Even where social workers (or student social workers) consider that their disability or impairment does not affect their fitness to practise, there is still a risk in not disclosing as that person's honesty and integrity may be brought into question if they decide not to disclose, resulting in a situation where they fall foul of the "good character" requirement.

6. We have noted that the reasonable adjustment duty of the DDA arises in respect of employment, all employment related activities such as work placements, and qualifications bodies (including regulatory bodies that hold professional registers), only when the organisation knows of a disabled person's disability. Further and higher education institutions also have a duty to make reasonable adjustments, although this duty breaks down into features that are focused on meeting the needs of individual disabled people (for which they would need to have knowledge of a person's disability) and other features that are anticipatory and aimed at disabled people in general.
7. Without information about a disabled person's needs, the institution – whether employer, qualifications body or in some circumstances a higher education institution – may not have an obligation to make adjustments and may not know what adjustments to make. This creates an imperative for disclosure in situations where a disabled person is disadvantaged without adjustments, and the DRC advises through its DDA codes of practice that organisations take a sensitive approach both to encouraging disclosure and to handling information following disclosure.
8. Qualified nurses, teachers and social workers applying for jobs are required to fill in intrusive pre-employment health questionnaires, often asking

for information that is irrelevant to the job they are applying for, or to any job. As well as these formal processes, students, registrants and employees will need to evaluate each situation they find themselves in, and consider when and where to disclose information about their disability, and how much to say. This is described in research commissioned for this investigation as a series of decisions and negotiations²⁸¹. Changing from a higher education to a work placement environment, or from work placements into employment presents the disabled person with fresh decisions about disclosure. It is likely that disclosure is required again in any new environment in order to get adjustments made and to avoid the disadvantage that would arise if the adjustments were not made. Specific difficulties and barriers faced in education, work placements or employment are key triggers for disclosure, but when disclosure comes part way through the programme or placement, it is more difficult for higher education institutions or placement providers to ensure that appropriate adjustments are put in place²⁸².

9. An issue that surfaced throughout this investigation was that students and practitioners are often uncertain about what types of disability, impairment or health conditions need to be disclosed. The DRC recognises that around half of people covered by the DDA do not recognise themselves as disabled²⁸³, and people with conditions such as heart disease or cancer, relate better to the term “long- term health condition”²⁸⁴ rather than the term “disability”.

281 Disclosing disability, Nicky Stanley et al, DRC 2007

282 Evidence to DRC’s Inquiry Panel from several witnesses

283 Grewal et al (2002) Disabled for life, Attitudes towards, and experiences of, disability in Britain, DWP Research Report 173

284 Disclosing disability, Nicky Stanley et al, DRC 2007

10. There is a further group of people who recognise their rights under the DDA but would be reluctant to label themselves as disabled. For example, Deaf people who use British Sign Language often consider themselves to be a linguistic group instead – “Deaf people are sign language users first and issues of impairment come second”.²⁸⁵ Students and practitioners with dyslexia also find the existing labels difficult to accept. Some people with dyslexia describe it as a learning difference that means doing things in a certain way, rather than as a disability. One person described dyslexia as a “social inconvenience” rather than as a disability or impairment and certainly did not perceive it to be a long term health condition.²⁸⁶

11. Within nursing, teaching and social work, the DRC heard of several cases in which disabled people faced sanctions from employers, universities or regulatory bodies, because they had not disclosed information about their disability, because the wording of the question did not match their experiences. In one DDA case taken by a nursing student, the university referred to the fact that the claimant had not disclosed his condition, but he responded that he had not ticked the box saying that he had a ‘psychiatric illness’ as Aspergers Syndrome is not a psychiatric illness²⁸⁷. In another case a university said that a nursing applicant, with a hearing impairment, had not declared a disability on her application form. She responded that she ticked “no” to the question on “disability/special needs” as she did not regard herself as disabled²⁸⁸.

285 Evidence to the DRC’s Inquiry Panel from University of Manchester

286 Disclosing disability, Nicky Stanley et al, DRC 2007

287 Review of Statutory and Regulatory Frameworks, David Ruebain et al, DRC 2006

288 Review of Statutory and Regulatory Frameworks, David Ruebain et al, DRC 2006

12. This investigation has also found that disabled people often feel uncertain about the relevance of their impairment or long-term health condition to the specific context in which they are being asked, and therefore do not know whether to disclose or not. The GSCC registration form, for example, asks applicants:

“Do you have a physical or mental health condition that may affect your ability to undertake work in social care?”

Where students are asked to disclose only relevant information they need to make their own judgement about whether their impairment would affect their training or practice, and the student’s view of what is relevant may well be different from the institution charged with making the assessment.

13. The regulatory review commissioned by the DRC identified how the uncertainty around requirements to disclose can have negative consequences. In one case, a social worker was dismissed from her training post, because she had not disclosed her statement of special educational needs in her application. She was informed that the non-disclosure of her dyslexia/dyspraxia was a breach of trust under the Code of Practice for Social Care Workers. The application form asked applicants whether they had a disability. At the time the claimant completed the application form she had no reason to suppose that her dyslexia/dyspraxia was a disability as she had not received any assistance for this for about nine years.²⁸⁹

289 Review of Statutory and Regulatory Frameworks, David Ruebain et al, DRC 2006

14. During the investigation, the DRC received evidence²⁹⁰ about a social work student whose registration with the GSCC was delayed by six months over and above other students who applied for registration at the same time, because he had revealed his HIV status in his registration form to the GSCC, but not to the university:

“I was told over the phone that there was some discrepancy because I declared my HIV status to GSCC and I hadn’t declared to it 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”.²⁹¹

15. Within the sample used for the “Disclosing disability” research only three of the participants (out of 60) interviewed had not disclosed at all within their professional settings, but the experiences and extent of disclosure of the remaining 57 was very varied²⁹².

290 Papers sent by a solicitor, by Unison, and by a higher education institution; and evidence to the Inquiry Panel from a tribunal applicant and the applicant’s solicitor

291 Tribunal applicant’s evidence to DRC’s Inquiry Panel

292 This was a qualitative study, with a self-selecting sample, which sought to explore issues around disclosure. There are difficulties in carrying out quantitative research, to ascertain rates of non-disclosure because of the very nature of the issue. Organisations should consider how to explore non-disclosure through their own research and information gathering, and through comparisons of their own and external data. This was not something the DRC was able to do within the timeframe of this investigation.

Whilst some described having disclosed fully at every opportunity within their profession, others had disclosed only one of a number of impairments or health conditions, disclosed only at particular stages of their careers, or to particular organisations or individuals within them, or had understated the extent of their disability. Participants' accounts of their experiences of disclosing disability across England, Scotland and Wales, and the reactions they met from organisations following disclosure, were classified by the researchers into positive, negative and mixed. Around a third of the accounts were positive, a third negative and the remaining third were mixed stories of good and bad experiences. Practising nurses and student social workers were the professional groups more likely to convey a negative story around their experiences of disclosure.

16. The reasons for participants' decisions to disclose or not to disclose in different contexts were further explored in the study. One of the main barriers identified to disclosure was the uncertainty and confusion about disclosure procedures and the resultant fear that applicants would not be successful in their chosen career if they disclosed²⁹³. Disclosure was regarded by some disabled students and practising professionals as a high risk strategy. People with mental health problems reported that they faced particular stigma, and this unsurprising finding was supported by written evidence and evidence to the DRC's Inquiry Panel where organisations frequently revealed that they associate mental health conditions with risk. Despite a fear of the consequences of disclosing, a desire for honesty, or a fear of the consequences of not disclosing influenced students' and practitioners' decisions.

293 Disclosing disability, Nicky Stanley et al, DRC 2007

17. Students and practitioners want to retain control of information that they disclose (ie not have information passed between agencies without their consent). They need reassurance about the disclosure procedures, about who will see the information and about how it will be used. Students and practitioners within nursing, teaching and social work saw their relevant regulatory body as remote and potentially threatening – some participants describing it as “Big Brother”. The process of disclosure to the regulatory body was experienced as impersonal and there was a sense that the consequences of such disclosure²⁹⁴ was beyond the control of the disabled person. They also expressed concern that they received little in the way of an individualised response from regulatory bodies or information concerning the consequences of disclosure²⁹⁵. Disabled people may not see any benefits from disclosing to a regulatory body, especially if they do not require any adjustments in relation to the registration process (for example information in an alternative format).

18. In the employment sphere, there are contractual obligations not to lie on application forms or health questionnaires. This influences disabled people’s decision to disclose even if they fear that assumptions about, for example, sickness absence will be made about them. Practising nurses, teachers and social workers also expressed concern about the consequences of non-disclosure on their ability to practise safely, and felt that by disclosing, the onus was shifted onto the employer to make adjustments to their working environment²⁹⁶.

294 Disclosing disability, Nicky Stanley et al, DRC 2007

295 Disclosing disability, Nicky Stanley et al, DRC 2007

296 Disclosing disability, Nicky Stanley et al, DRC 2007

19. Research commissioned by the DRC shows that knowledge of the DDA gives disabled professionals confidence about disclosing disability²⁹⁷.
For example, one social work student reported:
- “It [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. They can’t turn round and say, ‘you’re not fit to practise’”²⁹⁸
20. Within the education or work environment, disabled people wanted to see evidence that the institution was prepared to support disabled people, and evidence that there were other disabled people in the same higher education institution or workplace. These were found to be important factors that encouraged disclosure²⁹⁹. Established practitioners, with a track record of achievement in a particular job, felt less vulnerable and more confident in disclosing. The converse of this is that those new to the professions – students, people on practice placements and new employees – are likely to feel more anxious about revealing information about health or disability. After disclosure in a particular workplace, it can take time for an employee to win the support and confidence of colleagues. The sense of security that an employee develops over time in a particular workplace following disclosure is often not carried across to a new work setting. The perceived risks of disclosure within a new setting can mean that people prefer to stay within a job. This would clearly constrain disabled professionals in their career progression.

297 Disclosing disability, Nicky Stanley et al, DRC 2007

298 Disclosing disability, Nicky Stanley et al, DRC 2007

299 Disclosing disability, Nicky Stanley et al, DRC 2007

21. Disabled people must be able to feel that they have control over the information that relates to them and their disability³⁰⁰, so they need reassurances about the purpose of the disclosure and about processes that follow disclosure. The institution asking for information about disability should be clear about whether this is for the purpose of assessing fitness, for reasonable adjustments, or for disability monitoring. The DRC saw evidence from universities of good practice, for example forms asking for information about disability that clearly explained the reasons for asking, and in some instances, provided additional information about support offered to help the disclosure process³⁰¹. In the employment sphere, however, we have seen that occupational health pre-employment questionnaires are often very unclear, partly because a single form may be used for several purposes, but also because the forms are ill-considered and not specific to the job.
22. The DRC also found that students are not given sufficient information about procedures following disclosure, that is, they are not told how their disclosure of disability will be dealt with. For example, one university's form states:

"the university may have a legal obligation to pass on (or not to pass on) this information. Advice on this issue can be sought from the relevant professional body, and/or the University's Data Protection Officer"³⁰².

300 Disclosing disability, Nicky Stanley et al, DRC 2007 and Wray J., Fell B., Stanley N., Manthorpe J., Coyne E., 2005. The PEdDS Project: disabled social work students and placements. The University of Hull. Available at: www.hull.ac.uk/pedds/documents

301 Written evidence to DRC

302 Written evidence from a University

We also heard from universities that they in turn do not receive sufficient information from the regulatory bodies about how to support students with the compulsory disclosure process³⁰³.

23. Within higher education, students expressed concern about the need to repeatedly disclose to different work placements. The duties to make adjustments are separately imposed on universities and on placement providers, so it is important that education providers take steps to ensure that enough information about the need to make adjustments is shared with placement providers (but not necessarily any medical information about the student's impairment or condition), so that students do not need to repeatedly disclose. However, universities should respect students' rights to confidentiality and seek permission to pass on information.

24. Disability organisations, unions and student advisors told the DRC's Inquiry Panel about their advice to disabled students and professionals on the issue of disclosure. Organisations agreed that there were positive reasons for disclosing disability, especially in relation to being able to get reasonable adjustments in higher education or in work. It was also considered preferable for information about a person's disability to come from the disabled person, in terms that the disabled person themselves set out – with an emphasis on abilities, needs and rights rather than an emphasis on medical conditions or functional deficits (ie things that the person cannot do). These organisations also recognised that the stress resulting in keeping a condition hidden from tutors, employers, or colleagues is an important issue for disabled people.

303 Written evidence from University of Bradford

25. However, it was striking that 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 strategy would consist of talking about reasonable adjustments rather focussing on medical explanations, disclosing to particular individuals, and having pre-prepared positive messages about disability. The Adult Dyslexia Organisation³⁰⁴ explained that it would advise people with dyslexia studying or working within these professions to assume that the reaction to disclosure would be negative, but to be ready with “three positives” to counteract any negative reaction. Mind told the DRC³⁰⁵ that it would explain the pro’s and con’s of disclosure, but would not give firm advice or direction about this issue.
26. Disability organisations, unions and student advisors expressed the view that while it is for individual disabled people to make the day-to-day decisions on disclosure; the onus should be on universities, regulatory bodies and employers to create “safe conditions” for disclosure and a positive organisational culture regarding disability. Most importantly, the DRC was told that organisational culture has a huge influence on whether, and how much, disabled people are willing to disclose. A “positive organisational culture” was described as having the following characteristics:³⁰⁶

304 Evidence to DRC’s Inquiry Panel

305 Evidence to DRC’s Inquiry Panel

306 Evidence to the DRC’s Inquiry Panel from ADO, Mind, Skill, Radar, and findings from *Disclosing Disability*, Nicky Stanley et al, DRC 2007

- An environment where there are role models³⁰⁷ for disabled people – managers or course tutors who are, themselves, disabled and have disclosed their disability to staff and students.
- Mistakes made, particularly in a learning environment, by disabled people will be expected and tolerated, as they would with all students and practitioners, and not readily attributed to disability.³⁰⁸
- 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 are aware of other adjustments that might be available to them.
- Colleagues (or in the context of higher education, fellow students) also have positive attitudes towards disability and understand that reasonable adjustment is about equality, not about preferential treatment.

307 Several witnesses mentioned the importance of role models but interestingly a literature search undertaken by the DRC in 2005, reported in Chih Hoong Sin et al, DRC 2006, revealed very little published research about the value of disabled role models to disabled people in an education or employment context.

308 Evidence to DRC's Inquiry Panel from Adult Dyslexia Organisation

Conclusion

27. 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.

Chapter 9 – Statistics and research

1. In this chapter we explore the issues around gathering evidence and data about disabled people in nursing, teaching and social work, in the light of what we have learnt from conducting this investigation. An important factor in triggering the DRC's formal investigation was that, despite indicators that disabled people were facing barriers entering professions such as nursing, teaching and social work, there was very little data or research to enable us to analyse the problem. The DRC considered that a formal investigation would help to focus attention on this area and lift the lid on issues that had been previously under-explored.
2. In early 2005, the DRC carried out a literature search to identify evidence across England, Scotland and Wales of disabled people's career paths from their early career aspirations through to job retention within these professional sectors³⁰⁹. The initial search was not restricted to issues around health standards as the intention was to gain an overview of the wider evidence base around disabled people's professional careers, to enable the DRC to identify key barriers³¹⁰. From this search only 42 documents were identified as being relevant.

309 Background paper, Chih Hoong Sin et al, DRC 2006

310 Both the initial and updated searches were run across the following databases British Library Inside Web, Ingenta, DRC Electronic Library Catalogue, British Humanities Index, Applied Social Sciences Index and Abstracts, Medline, Web of Science

3. Leaving aside guidance documents, papers written from a medical rather than sociological perspective, and news stories based on personal testimony, there was very little research to be found about disabled people within these professions. The material that was relevant often pointed to barriers related to perceptions of disabled people's fitness to study or work in these professions.
4. The relative lack of data or research was in itself an interesting finding that pointed to cultural issues within these professions that have been looked at as part of this investigation. Disability has only recently been recognised as an equalities issue within the health sector^{311 312}, and the culture within both nursing and social work appears to be one where there is discomfort about boundaries between professionals and patients or clients being blurred. The fact that disabled people are reluctant to disclose, partly because of generalised health standards, affects the information gathering process, but also the profile of disabled people's concerns within these professions. This may result in disabled people's issues being marginalised, and issues being seen as individual rather than institutional problems.
5. The statistics from across these professions, as well as anecdotal evidence from organisations working within these professions, raised concerns that disabled people were either under-represented within nursing, teaching and social work, and/or were not

311 Scullion P (2000) Disabled people as health service employees. How to break down the barriers, *Nursing Management*, Vol.7, No.6, pp. 8-13

312 Clinton M, Robinson S and Murrells T (2004) Creating diversity in the healthcare workforce: The role of pre-registration nurse education in the UK, *Journal of Health Organization and Management*, Vol.18, No.1, pp. 16-24

disclosing disability which would affect the reliability of the reported statistics. As part of this formal investigation, the DRC explored existing data in a number of ways. We looked at how data was collected, explored barriers to data collection and compiled data that was sent to the DRC. (See Appendix F for tables of statistics relating to disabled nurses, teachers and social workers).

6. Through the call for evidence we asked organisations to send in their data, and to explain how the data was gathered, including the wording of questions used on the monitoring form or other formats for soliciting such information. Seventeen organisations sent in data as part of this exercise; and other organisations sent us datasets following meetings or their appearances at the DRC's Inquiry Panel. Out of these 17 organisations, it was interesting to note that many of them only started collecting data very recently. The earliest data was from 1996. We also noted that no organisations were able to send us the full range of data that we asked for.

Regulatory bodies

7. The regulatory bodies, as we have established, have a key role to play in improving access to the professions. Statistical information about the number of disabled people on the professional registers is a vital step in bringing about change. Surprisingly, then, the NMC has not previously carried out disability monitoring of its registrants, and is only just starting to do this (from December 2006), presumably to meet its disability equality duty. The remaining regulatory bodies that hold registers provided statistics, presented below.
8. In teaching, according to figures provided by the GTCE, there were 815 disabled newly qualified teachers in 2006 making up 0.15% of all newly qualified teachers

in England. Figures provided by GTCW showed that there were 77 disabled registered teachers accounting for 0.2% of all registered teachers in Wales in 2006. According to GTCS statistics, there were 31 disabled applicants to the Teacher Induction Scheme in Scotland in 2006, accounting for 1.1% of applications.

9. For social work, the statistics were similarly low. In England the GSCC's figures demonstrated that there were 1,489 disabled qualified social workers comprising 1.95% of all qualified social workers in 2006. The CCW's data showed that there were 94 disabled social work registrants – 2.15% of social work registrants in Wales in 2006. The SSSC's figures showed that there were 160 disabled registered social workers comprising 2.4% of all registered social workers in Scotland in 2005.³¹³
10. Around half of the organisations that sent us monitoring data had statistics broken down into impairment type, although different impairment categories were used across the responding organisations. For organisations covered by the specific DED, the DRC's code of practice³¹⁴ advises that:

“Disabled people with different impairments can experience fundamentally different barriers, and have very different experiences according to their impairment type. It will often be necessary therefore to monitor outcomes according to impairment type to capture this information.”

“Whether or not it is appropriate to collect

313 Written evidence to DRC

314 DED Code of Practice

http://www.drc.org.uk/employers_and_service_provider/disability_equality_duty/explaining_the_duty.aspx

information according to impairment group will depend upon whether an authority is ready and able to make use of that information. . . 315”

11. This means that even for organisations covered by the specific DED (such as the regulatory bodies), the DRC recognises that those organisations must make their own decisions about whether to monitor according to impairment type. However, where impairment information is available, the importance of having this detail of data in relation to these professional sectors soon becomes apparent. For example, statistics for student social workers show that out of registered students (degree course) 40%³¹⁶ of those declaring a disability are those with dyslexia and only 6%³¹⁷ of those declaring a disability have a mental health problem³¹⁸. This indicates likely under-disclosure and/or under-representation of those with mental health problems, even within the population of disabled student social workers who have disclosed. It may also reflect the reality that we have already discussed, that those with dyslexia are more likely than some other disabled students to be supported in higher education giving them an incentive to make themselves known, in order have access to adjustments.
12. Only two of the organisations that sent us data told us that they collect data in such a way that it can be cross-referenced with other variables (eg age, gender or ethnicity).

315 3.66 and 3.67

316 This corresponds to 3.67% of all registered social work degree students

317 This corresponds to 0.59% of all registered social work degree students

318 GSCC data pack 2005-6

<http://www.gsc.org.uk/About+us/Statistics/>

Disability questions

13. Different definitions of disability, and the way in which these definitions are expressed in questions, can lead to wildly divergent estimates of disabled people in any population. For the purposes of monitoring, questions need to be based on the same assumption so that in bringing different monitoring statistics together, organisations can be confident that they are comparing like with like. Around half of the organisations that sent data to the DRC asked disability questions based on the definition of disability in the DDA. Some organisations, for example, explain the DDA definition of disability (importantly, as the definition is wider than a commonsense assumption of what “disability” means) and ask individuals to tick a box if they feel that this definition applies to them.
14. The DRC’s evidence gathering guidance³¹⁹, written to advise organisations in meeting their DED duties, suggests three possible models of questions to use, depending on the purpose. The first is the model mentioned above (based on the DDA definition); the second is a question about impairment type; and the third is a question about barriers faced by the respondent. The DRC is not prescriptive about what type of question should be asked, but explains in its guidance that the organisation should make that decision itself, based on the purpose of the evidence gathering. More than one question can be used in combination.
15. This investigation has found considerable confusion amongst higher education institutions, employers and

319 DRC (2006) The Disability Equality Duty. Guidance on Gathering and Analysing Evidence to Inform Actions, London: DRC.

regulatory bodies about the different purposes of asking for a disclosure of disability. This is not surprising, as under the current regulatory frameworks of generalised health standards and the DDA (including the DED) some organisations may need to ask for disability information for three separate purposes – assessing fitness, asking about adjustments and monitoring. Given the negative culture towards disability perpetuated by the health-related standards, combining a monitoring question with a fitness assessment question is likely to lead to under-disclosure for the purpose of monitoring. Such an approach would clearly make it harder for public authorities to fulfil their DED duties.

16. The DRC guidance on evidence gathering for the purposes of the DED notes that “Any questions which are going to be used to monitor the numbers and experiences of disabled people who are employees or service users should be carefully introduced to explain why you are collecting this information, the use it will be put to and assurances about confidentiality. It is also important to emphasise the commitment of your organisation to promote equality of opportunity and to explain how you will publish the anonymised information you have gathered. Experience shows that setting out the context for questions in this way significantly increases response rates”³²⁰.
17. Some organisations relevant to this formal investigation have acknowledged³²¹ that as their disability statistics (where they exist) are reliant on people’s willingness to disclose, they may under-

320 DRC (2006) The Disability Equality Duty. Guidance on Gathering and Analysing Evidence to Inform Actions, London: DRC. (p. 44)

321 In written evidence and to the DRC’s Inquiry Panel

report the incidence of disability³²². One organisation told the DRC that although it asks a disability question, it does not present statistics on disabled people, as perceived “under-reporting and under-disclosure by members” render these figures unreliable. The organisation is currently seeking to redress this by explaining the purpose of monitoring and the meaning of the definition to members³²³.

18. Another organisation that collects statistics on disabled people offered the following cautionary remark in interpreting the statistics it provided:

“Although every effort is made to encourage prospective and current students to disclose a disability, we are aware that there will always be an element of under reporting as many students do not wish to disclose a disability and others are not aware that they are considered to be disabled under the DDA”³²⁴.

19. The handling of “non-responses” can also affect the interpretation of disability statistics. Where there is no recorded answer, it is important to distinguish whether this is because an individual has been given the opportunity to respond but chose not to, or whether an individual was not asked (possibly because an organisation has only recently added disability monitoring to other monitoring, and some people were never given the opportunity to answer this question). This has implications for the assessment of coverage, and hence on establishing

322 Hurstfield J, Aston J, Mitchell H and Ritchie H (2004) Qualifications Bodies and the Disability Discrimination Act, Institute for Employment Studies Report 417, Brighton: Institute for Employment Studies

323 Written evidence from NUT

324 Written evidence from Institute of Education

with any confidence the likely number or proportion of disabled people within a population.³²⁵

20. Disclosure of disability is not a one-off event and may be requested, or indeed required in law, numerous times. Disabled people make decisions about disclosure depending on the perceived risks and benefits of doing so³²⁶. This leads to further challenges in interpreting different sets of data collected by the same organisation, under different circumstances and for different purposes. One organisation gave us this example:

“Some students disclose a disability to the Disabilities Support Office in order to obtain support, but request that this information is not included in their student record, despite assurances that this information will remain confidential”³²⁷.

Research

21. Given the small amount of existing research that the DRC discovered in its own literature searches, we wanted to know if there was any additional research that could inform the investigation. As part of the call for evidence, organisations were asked to provide details of any published or unpublished research that they had carried out or commissioned. Another reason for asking questions about research was that we wanted to understand whether organisations, in pursuance of disability equality, were taking steps to find out about barriers faced by disabled people within their institutions (or within the profession more generally), to use this information as a basis for

325 This issue was raised by the GTCE who expressed particular concern about the reliability of their data

326 Disclosing disability, Nicky Stanley et al, DRC 2007

327 Written evidence from Institute of Education.

action. However, having asked for information about research projects through our call for evidence and through contact with organisations as part of the Inquiry Panel, we have not become aware of any significant amounts of additional research that we did not know about when we embarked on this formal investigation. There is no rich seam of information about disabled people in nursing, teaching or social work that is being used to drive change in these sectors. In fact, there is very little. Below we have presented our findings about the kinds of research that organisations have undertaken, or are in the process of carrying out or commissioning. Published research in the public domain has been reviewed in the DRC's background paper.³²⁸

22. The DRC was interested in research about (or including) disabled people within nursing, teaching and social work; and research relevant to specific organisations only. In relation to profession-wide research, we found that two of the regulatory bodies have carried out general research relating to the workforce, that have some findings relevant to disability. For example, the SSSC told us that they are carrying out research on the views of service users and carers regarding the skills requirements for social services workforce. The GTCW conducted research about the teaching workforce in Wales, with the aim of producing an action plan on the recruitment and retention of teachers, and also participated in research looking at the barriers to disabled people entering and progressing in the teaching profession³²⁹. The only national research initiated by

328 Background paper, Chih Hoong Sin et al, DRC 2006

329 Reducing barriers to participation by people with disabilities in the teaching profession, TADW 2003
www.newport.ac.uk/tadw

a statutory body looking at disabled professionals that we are aware of is a piece of work commissioned by DfES to look at the impact of (amongst other issues) disability on teachers careers³³⁰. This involved a postal survey of over 2000 teachers, and interviews with teachers and school governors and two organisations representing disabled teachers³³¹. This research found that disabled teachers are more likely than other groups to think about leaving the profession, and that over 40% of teachers surveyed believed that disability would negatively influence a teacher's career progression. The DfES did not give any indication about how they had used this research.

23. The GSCC referred to a research project carried out by the University of Hull, which looked at disabled social workers and their experience of practice placements and led to national guidance³³² produced by the same university for disabled students and those involved in their education and practice placements.
24. Two unions and a professional body³³³ had also conducted research that touched on issues relating to their disabled members. For example, the RCN

330 Janet Powney et al, University of Glasgow in conjunction with Heidi Safia Mirza, CRES, "Teachers' Careers: the Impact of Age, Disability, Ethnicity, Gender and Sexual Orientation, DfES, 2003.

<http://www.dfes.gov.uk/research/data/uploadfiles/RR488.doc>

331 ABAPSTAS and BATOD. BATOD is an association of Deaf and hearing teachers of Deaf children

332 This guidance was directed at the social work sector generally (in England and Wales), not specifically for students at the University of Hull.

333 NASUWT, NUT and RCN

carried out a survey of its members generally (ie not just disabled members) to look at nurses' well-being and working lives, that resulted in a number of recommendations for employers. It found that 40% of disabled nurses had experienced bullying. NUT told the DRC that it had conducted a poll of teachers, but the DRC has received no further information about this work. NASUWT told the DRC that it had undertaken detailed research and consultation with disabled members, but once again the DRC did not receive any further information.

25. Overall, very little evidence was sent to the DRC of surveys or research conducted by organisations to inform their organisational practice. This may be because this research was considered to be too informal (for example taking the form of consultation) to pass onto the DRC's investigation. Or it may be because very little research of this type has been carried out. It is also difficult to identify from the evidence of national research that we know about, how national organisations, such as the regulatory bodies, government departments or unions, have used the information gained from their own or other organisations' research to influence policy or practice.

Conclusion

26. 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 that are the subject of this formal investigation, 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, there is very little to inform the sector about the barriers that disabled people within these professions face, or to help these organisations in tackling 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.

27. Gathering disability information 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.

Chapter 10 – 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 with 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 and only occasional reference in the legislation and guidance applicable to nursing.

A radical rethink of the regulatory framework 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 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 assumption of automatic risk in relation to disabled people in the professions, provide a statutory basis for it.

The regulatory bodies have different roles within their professions. In teaching in England and Wales, responsibility for health standards and competence standards is spread across the GTCE, GTCW, 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 the policies that they operate and their 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 can be eliminated. They should provide guidance on reasonable adjustments and consider what other guidance to provide to encourage others (such as higher education providers) 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 legislative change. 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 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 mental and physical 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. 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, there is very little to inform the sector about the barriers that disabled people within these professions face or to help these organisations in tackling 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 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 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.

Finally, we conclude that a framework of professional standards of competence and conduct, couple 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.

Appendix A – Earlier Inquiries

1. During the Inquiry Panel stage of the DRC’s formal investigation, witnesses frequently referred to the case of Beverley Allitt and the recommendations of the Clothier report³³⁴ in connection with concerns about public safety. The Chair of the Inquiry Panel, Karon Monaghan, reviewed this report and other relevant reports³³⁵ in order to understand the origins and purpose of the health regulations. Below we present her assessment of these reports.

The Clothier Inquiry into the crimes of Beverley Allitt

2. The Clothier Inquiry followed the conviction of Beverley Allitt on charges of four murders, three attempted murders and six charges of causing grievous bodily harm. As is well known, Beverley Allitt was a nurse at the time the crimes for which she was convicted were committed. Beverley Allitt’s victims were all children and, at material times, patients in a children’s ward, Ward 4 at Grantham and Kesteven General Hospital (“GKGH”). Unsurprisingly the Beverley Allitt case attracted a huge amount of media attention and public interest.
3. The Inquiry was carried out on the instructions of the Secretary of State for Health and was chaired by Sir Cecil Clothier. The Report that followed has become

334 The Allitt Inquiry: Independent Inquiry relating to Deaths and Injuries on the Children’s Ward at Grantham and Kesteven General Hospital during the period February to April 1991”, (1994) HMSO (“The Clothier Report”);

335 The Victoria Climbié Inquiry: Report of an inquiry by Lord Laming” (2003) HMSO; “The Bichard Inquiry Report” (2004) HMSO; “The Shipman Inquiry Report” (the first report and the fifth report) (2002) and (2004) Cm 6394.

known as the “Clothier Report”. The terms of reference for the Inquiry included the following:

“1.1 To enquire into the circumstances leading to the deaths of four children and injuries to nine others on Ward 4 at GKGH during the months of February to April 1991 (inclusive);

To consider the speed and appropriateness of the clinical and managerial response within the hospital to the incidents and to make recommendations;

To examine the appointment procedures and systems of assessment and supervision within the hospital and Mid-Trent College of Nursing and Midwifery respectively, including an examination of the occupational health services available to both the college and the hospital and to make recommendations”.³³⁶

4. The Clothier Inquiry decided that they should “first address [themselves] to [Beverley Allitt] as an individual, considering her personality, health, training and finally her entry to the nursing profession”³³⁷. In this regard the first sections of the Clothier Report focus on Beverley Allitt herself. The Inquiry looked in particular “for two possible warning signs”³³⁸. Firstly, whether Beverley Allitt’s behaviour and attitudes “revealed anything unusual about her personality” and secondly whether there was evidence in her medical history that “her attitude to her own health was such that she should not be entrusted with responsibility for the health of others”.³³⁹ The Clothier Report made it clear that:

336 Paragraph 1.7, 1.2 and 1.3.

337 Paragraph 1.8.

338 Paragraph 2.1.2.

339 Paragraph 2.1.

“If by excluding people with certain clearly definable characteristics we could be sure of excluding those who might harm vulnerable patients, then it would be worth taking the risk which such a policy would entail of incidentally excluding some people who would have made good nurses. The problem lies in determining which, if any, of Allitt’s characteristics are clear indicators of possible danger”.³⁴⁰

5. The DRC would not disagree that if excluding people with certain clearly definable characteristics would guarantee the exclusion of persons who might harm vulnerable patients, then such might be justified. This would require very careful consideration – there is always the danger of great over inclusiveness in any barring rule – and any such rule would have to be proportionate but the public interest would weigh very heavily in support of such a rule. However, as the Clothier Report makes clear, what the Beverley Allitt case showed was that there were no clearly definable characteristics apparent in her which would have alerted any person to the risk which she thereafter presented.

6. As to Beverley Allitt’s school career, as the Clothier Report finds, there were no grounds on which her school ought to have discouraged her from her chosen career as a nurse: “She was hard-working and dependable, and had shown no signs of dishonesty or cruelty”.³⁴¹ As the Clothier Report observes, “[t]he only point of interest was her tendency to incur minor injuries. But it is very common to seek attention in this way and a similar tendency can be seen, and was seen at the time, in other teenagers. It is not an indication of secret murderous intent”.³⁴² The

340 Paragraph 2.1.4.

341 Paragraph 2.2.6.

342 Paragraph 2.2.6.

relevance, of course, of this observation is that Beverley Allitt was in due course suggested to have the (controversial) condition “Munchausen syndrome” (or the related, and even more controversial, “Munchausen syndrome by proxy”). It has been suggested from time to time that this explained her crimes.

7. At college, Beverley Allitt’s injuries and illnesses became more frequent but there was still nothing in her general behaviour indicating that she posed the risk that she went on to pose.³⁴³ Beverley Allitt then joined South Lincolnshire School of Nursing. She provided references, including from her school, but not from her pre-nursing course and so the recent sickness record she had built up was not brought to the attention of her interviewers at the school of nursing.³⁴⁴ The Clothier Report observed that “we cannot know what the affect on this process would have been if Allitt’s recent sickness record had come to light”³⁴⁵ but goes on to state that “there was no reason at that time to link Allitt’s own health record with the danger she later presented to the children on Ward 4”.³⁴⁶ It appears that any fair observer would conclude that her journey into nursing school was likely to have been unaffected by the knowledge of her sickness record, therefore.
8. Notwithstanding this, the Clothier Report recommends in consequence of their finding that Beverley Allitt “found it so easy to conceal” her recent sickness record³⁴⁷ that “for all those seeking

343 Paragraphs 2.3.4 and 2.3.6.

344 Paragraphs 2.4.1 to 2.4.3.

345 Paragraph 2.4.4.

346 Paragraph 2.4.5.

347 Paragraph 2.4.4.

entry to the nursing profession, in addition to routine references, the most recent employer or place of study should be asked to provide at least a record of time taken off on grounds of sickness".³⁴⁸ There is no rational explanation arising from the Report's findings to justify this recommendation. However, it points to the fact that those undertaking the Inquiry saw a relationship between health and risk and that perception did indeed become the central theme of their report and the focus of many of its recommendations thereafter.

9. Beverley Allitt continued to have absences attributable to sickness during her nurse training. Indeed such was the extent of her absence that although she had passed her exams to become an enrolled nurse in 1990, due to the amount of sickness absence she had experienced she had not completed the required number of days experience on the wards.³⁴⁹ Her training was therefore extended and at her request, it appears, she was permitted to continue her training on Ward 4 (as the report notes this seemed to have little to do with the gaps in Beverley Allitt's experiences arising from her absence and more to do with preference and availability).³⁵⁰ Beverley Allitt in fact applied in a general recruitment round for GKGH, in December 1990 but failed to meet the required standard. She was not offered a job but this decision was irrespective of her health record.³⁵¹

However, thereafter, essentially because of a coincidence of circumstances, Beverley Allitt came to be employed on Ward 4. This arose in particular

348 Paragraph 2.4.4.

349 Paragraph 2.5.9.

350 Paragraph 2.5.10.

351 Paragraph 2.6.2.

because she had “seemed to fit in well with the team on Ward 4 and worked hard”³⁵² and there were vacancies for nursing staff and a shortage of staff and so as a short term measure funds were made available to create an enrolled nurse post for which Beverley Allitt was interviewed. There were some irregularities in the interview process, in particular apparently no application form was completed and no reference obtained but, as the Inquiry found:

“It is unlikely that there would have been anything in either the application form or the other reference to warn of Allitt’s criminal tendency, but this points to a lack of rigour in the procedures for her appointment”.³⁵³

10. Beverley Allitt then started work on Ward 4 but two “important checks” had not been carried out.³⁵⁴ First, although the offer of appointment was subject to a satisfactory health screening, Beverley Allitt was not screened before commencing work.³⁵⁵ As the Report observes, Beverley Allitt was nevertheless passed fit for employment, though there was some considerable delay in notifying Ward 4 of the same (indeed the confirmation did not come until after her arrest) and “it is doubtful whether it would have made any difference to the course of events”.³⁵⁶ Secondly, a criminal records check was not undertaken and indeed the form requesting the same was not completed until after the incidents on Ward 4. However, again as the Report notes, she “had no previous convictions” and accordingly it could have

352 Paragraph 2.6.8.

353 Paragraph 2.6.9.

354 Paragraph 2.6.11.

355 Paragraph 2.6.11.

356 Paragraph 2.6.12

made no difference to the outcome.³⁵⁷ There were therefore failures in the appointment process but none of them were material insofar as their relationship with the events that followed is concerned. As the Clothier Report says “even had everything been done correctly, it is unlikely that Allitt would have been eliminated from the nursing profession”.³⁵⁸

11. In its review of the events leading immediately to the death and injury of the victims of Beverley Allitt, the Clothier Report identifies the clues to Allitt’s activity that emerged and the delay in acting upon them.³⁵⁹ These obviously required explanation. The Clothier Report identify the failures as cumulative and derive from the absence of action “upon information which was there to be seen” and attributable to a general lack of “the qualities of leadership, energy and drive in all those most closely connected with the management of Ward 4”.³⁶⁰ These failures included failures in effective communication and the absence of clear definitions of responsibility and accountability.³⁶¹ As the Clothier Report emphasises:

“it is not possible to predict every kind of criminal behaviour and guard against it, particularly when that behaviour was unprecedented as it was in this case, at least in the United Kingdom. However, the

357 Paragraph 2.6.12.

358 Paragraph 2.6.17.

359 Especially the blood test results in the case of Paul Crampton, provided on 12 April 1991 (before the death of the last child killed and before the injury caused to 3 others) which showed that Paul Crampton had been injected with exogenous insulin (paragraph 4.19.2).

360 Paragraph 4.19.3.

361 Paragraph 4.19.5.

Grantham experience demonstrates the danger of assuming that there must be a natural explanation even where one cannot be found. We now know that child abuse and murder can be and have been perpetrated in hospital. However unlikely it may seem at the time, we conclude that when faced with a clinical history in a child that defies rational explanation, constant awareness of the possibility of unnatural events is essential.”

12. In summary, therefore the Clothier Report found that there was nothing in the history of Beverley Allitt that would have permitted anybody to predict that she would commit the crimes she did. Neither had there been a previous diagnosis of a mental health condition, or mental ill health. To the extent that the events that did occur could have been prevented (in particular the later death and injury), the report identifies, essentially, inadequate management (in various manifestations) as the reason that they were not prevented. The report itself acknowledges that not every kind of criminal behaviour can be predicted and prevented. On the Report’s findings, then, one can only conclude that the likelihood is that even with proper and efficient management structures in place, the earlier deaths and injuries perpetrated by Beverley Allitt could not have been prevented. This is an important observation because it reminds us that predicting the most extreme examples of human behaviour is not possible and that what will reduce the likelihood of the most serious criminal activity occurring or continuing is proper management, supervision and prompt action upon clues indicating the same.
13. Notwithstanding the findings made, the Clothier Report considers in some detail Beverley Allitt’s mental health in a chapter headed “General Themes”.³⁶²

362 Chapter 5.

A number of matters “which are peripheral to the disaster, but which may have some bearing on the course of events”³⁶³ are addressed. The Clothier Report starts with the assumption that attacks in hospital on patients by nurses or mothers – “unnatural crimes”, as the Clothier Report describes them³⁶⁴ – “must be rooted in some form of mental instability”. Whether this assumption is right depends on the meaning to be given to the expression “mental instability”. However, the “mental instability”³⁶⁵ identified by the Clothier Report as relevant in the Beverley Allitt case was the illness “Munchausen’s syndrome”.³⁶⁶ As the report notes, notwithstanding all the absences and illnesses apparently experienced by Beverley Allitt at the time she was recruited into nursing work, “there were insufficient grounds ... for making a formal diagnosis of Munchausen’s syndrome”. In particular, the evidence showed that it is not uncommon for young people to “enjoy the attention which injury attracts”³⁶⁷. The report concludes unequivocally that “there were insufficient grounds for suspecting the serious disorder or behaviour that characterises Munchausen’s syndrome at the time that Allitt was recruited as an enrolled nurse to Ward 4”.³⁶⁸ This unequivocal finding makes the recommendations that follow in relation to health, as addressed below, baffling.³⁶⁹

363 Paragraph 5.1.1.

364 Paragraph 5.2.1.

365 Paragraph 5.2.1.

366 Paragraph 5.3.3.

367 Paragraph 5.3.3.

368 Paragraph 5.3.4.

369 It should be noted that 7 of the 12 recommendations made address the identification and monitoring of health in nurses, pages 128 to 130.

14. The Allitt Inquiry also considered the even more controversial diagnosis of Munchausen's syndrome by proxy.³⁷⁰ The Clothier Report states again in this context that there were no grounds for believing that anyone was in a position to predict "the danger in which Allitt's employment as a nurse would place her patients"³⁷¹ and nor do they find the expression "Munchausen's syndrome by proxy" helpful, in any event in the context of their inquiry. They point in particular to the "remarkable degree of confusion in the medical literature as to its precise meaning".³⁷²
15. Having made these series of unequivocal findings the Clothier Report then conversely concludes that:
- "Whilst in this section we have stated that Allitt's progression from her erratic early medical history to that bizarre disorder that we classify as Munchausen's syndrome could not have been predicted, we recommend that no candidate for nursing in whom there is evidence of major personality disorder should be employed in the profession".³⁷³
16. There is no description of the expression "major personality disorder" and no exploration of the

370 Identified at this stage by the now discredited Professor Roy Meadow who has since been struck off by the General Medical Council in consequence of the misleading evidence he gave during the course of the Sally Clark trial which led to her imprisonment for the murder of her children, convictions for which she has since been acquitted on appeal. Professor Roy Meadows, of course, gave evidence too in the cases of Angela Cannings and Donna Anthony, both of whom were freed on appeal after having been convicted of murdering their children.

371 Paragraph 5.4.10.

372 Paragraph 5.4.10.

373 Paragraph 5.4.11.

condition Munchausen's syndrome and its relationship, if any, to personality disorder. The expression personality disorder is itself controversial in psychiatry³⁷⁴. To the extent that a person exhibits behaviours or attitudes that are symptomatic of the manifestations or characteristics sometimes described in psychiatry as "personality disorder", the likelihood is that they would not be functioning sufficiently to complete the training required for nursing in any event. The Clothier Report does not explore any of the issues around personality disorder or define what it means by the term. It makes no link between the events that occurred on Ward 4 in consequence of the criminal activities of Beverley Allitt and a pre-existing diagnosis or a description of "personality disorder" (as there was no such pre-existing diagnosis or description).

17. The Clothier Report also identifies that "Allitt's sickness record is relevant ... only insofar as it might have provided a clue to her personality disorder and its disastrous consequences"³⁷⁵. It observes that there was a failure to communicate this information between certain interested parties, in particular the school of nursing and the occupational health (OH) department during Allitt's training.³⁷⁶ Given its earlier findings that there was nothing in Allitt's medical history which would have disclosed any diagnosis of Munchausen's syndrome or provided any basis for predicting risk, it is difficult to see quite how relevant this is to its findings. Nevertheless the Clothier Report observes that "pooling their information might have stimulated further exploration of the underlying cause of her repeated

374 Evidence to DRC's Inquiry Panel from Dr. John Meehan

375 Paragraph 5.5.3.

376 Paragraph 5.5.7.

complaints”.³⁷⁷ However, it seems extremely unlikely that pooling information or further exploration would have produced any helpful indicators and, more particularly, changed the course of events. Nevertheless, the Report goes on to make a number of findings and recommendations relevant to health, and in particular mental health, which have had a very lasting and negative impact on access to the nursing profession.

18. Firstly, the report recommends that “as a general rule ... nurses should undergo formal health screening when they obtain their first post after qualifying. This represents the first opportunity to review the effect which the stress of nursing may be having on a nurse’s mental and physical health”.³⁷⁸ Secondly, they recommend that consideration be given to whether any records of absence through sickness from any institution which the applicant has attended, should be made available to OH departments and that procedures for management referrals to OH should make clear “the criteria which should trigger such referrals”.³⁷⁹
19. The Clothier Inquiry also, importantly, adopted the suggestion of the Chairman of the Association of NHS Occupational Physicians that applicants who show one or more of the following, namely excessive

³⁷⁷ Paragraph 5.5.7.

³⁷⁸ Paragraph 5.5.13. It can be noted that Allitt’s own GP informed the Inquiry that had Ward 4 had access to Beverley Allitt’s full medical records before deciding to appoint, from him, he doubted whether “he would have expressed any reservations about her suitability for employment as a nurse”. She had no history of psychiatric illness according to him (paragraph 5.5.20).

³⁷⁹ Paragraph 5.5.14.

absence through sickness, excessive use of counselling or medical facilities, or self harming behaviour such as attempted suicide, self laceration or eating disorder, should not be accepted for training until they have shown the ability to live an independent life without professional support and have been in stable employment for at least two years³⁸⁰. This recommendation is particularly startling. The Chair of the Association of NHS Occupational Physicians apparently advised the Clothier Inquiry that it is “very difficult to assess psychological health, and in particular to detect those with personality disorder”.³⁸¹ However, the indicators just described “are better guides than psychological testing”. The suggestion that a person should demonstrate the ability to live an independent life “without professional support” as a requirement for access on to nursing, encourages those who may have mental ill health at a particular time but a desire to access nursing to dispense with the support that might be available.

This is completely antithetical to that which one would properly understand to be an appropriate response by a professional individual with mental health difficulties (namely, demonstrating insight, accessing appropriate therapeutic support etc). Nor is there any indication why “excessive absence through sickness” should lead to a suspicion of personality disorder (as opposed to a suspicion of illness) such as to justify a person’s exclusion from nursing. This suggestion, was, nevertheless endorsed by the Clothier Report which concluded that such an approach:

380 Paragraph 5.5.16.

381 Paragraph 5.5.16.

“would allow those young people who are going through a temporary phase of attention-seeking behaviour during the maturing process to develop and stabilise”.³⁸²

20. The Clothier report acknowledges that this might be “unfair punishment” to those who are ready for a career in nursing, for an “unhappy period in their lives”³⁸³, but concluded that “we consider that this risk would be outweighed by the benefits. Not only might patients be protected from the minority among this group who might harm them, but the candidates themselves might be spared the stress of nursing until they were better able to cope”³⁸⁴. Given that there was nothing in the history of Beverley Allitt, as the Clothier Report unequivocally observes more than once, which would have indicated that she suffered from a personality disorder, Munchausen’s syndrome or any other condition which might have caused concern or operated as a predictor of risk, these recommendations bear no relationship to the narrative in Beverley Allitt’s case. This is especially important given their negative impact on disabled people and the nursing profession more generally and are inexcusable. The reference to the benign objective of protecting “candidates themselves” again does not bear any relationship to the findings of fact made by the Inquiry. It is not suggested, for example, that Beverley Allitt committed the crimes that she did because of some personality vulnerability aggravated by stress or anything of that sort. As with its conclusions on personality disorder, this observation is unsupported by the factual findings and is ill thought out. Requiring an applicant nurse to have

382 Paragraph 5.5.17.

383 Ibid.

384 Ibid.

been without professional support for at least 2 years as a condition of admission is barely one which is likely to help in mitigating the effects of stress upon any particular individual.

21. The Clothier Report makes further recommendations in relation to access to full medical histories on employment, again noting though that this “would not necessarily reveal the presence of serious personality disorder, let alone a capacity for murder”.³⁸⁵
22. The Clothier Report emphasised that all their “expert evidence from independent persons points to the conclusion that a determined and secret criminal may defeat the best regulated organisation in the pursuit of his or her purpose”³⁸⁶. Further, all the evidence before the Inquiry apparently indicated that there was little realistic opportunity for identifying in advance those people who are “statistical outliers”. Though this conclusion is unequivocal and repeated more than once, the report nevertheless appears to struggle with the starkness of such a conclusion and perhaps the recognition of their own limited utility in such circumstances, and so struggles to find something in Beverley Allitt or in the minds of individual criminals that might be identified and which might indicate a propensity to commit serious crime. The Clothier Report then makes a number of recommendations in

385 Paragraph 5.5.21. Note again, however, Allitt’s own GP informed the Inquiry that had Ward 4 had access to Beverley Allitt’s full medical records from him before deciding to appoint, he doubted whether “he would have expressed any reservations about her suitability for employment as a nurse”. She had no history of psychiatric illness according to him (paragraph 5.5.20).

386 Paragraph 1.12.

relation to health. These bear no relation to the findings of fact and nor do they appear to have any real foundation in psychiatry or indeed any other discipline.

23. The Clothier Report has had lasting impact. Its effect has been more broadly felt than in the context of nursing. The Clothier report itself recommended that its "recommendations might usefully be applied to other professions which give access to patients"³⁸⁷. Further, the Bullock report into the events leading to the trial of Amanda Jenkinson³⁸⁸ endorsed the recommendations in the Clothier Report and recommended that they be extended to cover all health care professionals. We therefore wish to make it clear that in our view the Clothier Report is of no usefulness in identifying the issues that might arise in assessing the requirements for access to any of the professions.

Other Inquiry Reports

24. In addition to the Clothier Report, there have been other relevant inquiries, concerning the protection of

387 Paragraph 5.5.3.

388 Amanda Jenkinson was a nurse who was convicted and then acquitted on appeal of causing grievous bodily harm with intent to a patient, having allegedly sabotaged the patient's intensive care ventilator): "Report of the Independent Inquiry into the Major Employment and Ethical Issues Arising from the Events Leading to the Trial of Amanda Jenkinson", Nottingham: North Nottinghamshire Health Authority (1997) Bullock, R. It can be noted that the Bullock Report is not available on the internet and is not available in the usual libraries. It was, of course, a Report predicated on the guilt of a person subsequently acquitted.

the public and professional regulation and practice, arising out of tragic and high profile cases. Below, we consider the following:

- “The Victoria Climbié Inquiry: Report of an inquiry by Lord Laming” (2003) HMSO (into the death of Victoria Climbié);
- “The Bichard Inquiry Report” (2004) HMSO (into the death of Holly Wells and Jessica Chapman³⁸⁹);
- The Shipman Inquiry Reports (the first and fifth reports of Dame Janet Smith) (2002) and (2004) Cm 6394 (into the murders by Harold Shipman).

25. Apart from the Shipman Inquiry, the other Inquiries did not involve criminal activity by health or social care professionals. However, both the Climbié inquiry and the Bichard inquiry heard evidence of significant failings, in the first place in the context of social work and in the second place in the context of social work and education. They seemed to us, therefore, to be relevant.
26. The Climbié Inquiry Report made numerous recommendations addressing social workers and their responsibilities and training needs. It made no recommendations directed at assessing the health of social workers. This reflects the findings in the report that the key flaws in the care of Victoria Climbié were attributable to institutional and management failings:
- “the suffering and death of Victoria was a gross failure of the system and was inexcusable. It is clear to me that the agencies with responsibility for Victoria gave a low priority to the task of protecting children. They were under funded, inadequately staffed and poorly led.”

389 “The Soham Murders.”

“It is not to the handful of hapless, if sometimes inexperienced, front-line staff that I direct most criticism for the events leading up to Victoria’s death. While the standard of work done by those with direct contact with her was generally of very poor quality, the greatest failure rests with the managers and senior members of the authorities whose task it was to ensure that services for children, like Victoria, were properly financed, staffed and able to deliver good quality support to children and families.”

27. Issues relating to the availability of services outside of office hours; the use of agency and locum staff; training and supervision and practical guidance, were all highlighted by the report.³⁹⁰
28. Similarly the Bichard Inquiry Report which examined the events, in particular as to the application of child protection procedures, leading up to the killings of Jessica Chapman and Holly Wells by Ian Huntley found systemic and corporate failures in the way intelligence was managed by the Humberside Police Force³⁹¹ and by Social Services, and serious errors by the Cambridgeshire Police Force in checking information, as well as errors in the recruitment process adopted by the school on the appointment of Ian Huntley.³⁹²

Accordingly no recommendations were made in relation to the health of practitioners.

29. The Shipman Inquiry Report is rather different, of course, because it concerns criminal acts done by a medical practitioner and so its subject is more

390 Paragraphs 1.55 to 1.67.

391 Paragraph 8.

392 Paragraphs 24, 30

analogous to that of the Allitt inquiry. Importantly Shipman was known to have developed a pethidine addiction early on in his career and it became known that he had been obtaining the drug illicitly to feed his habit.³⁹³ After successfully withdrawing from pethidine, Shipman was diagnosed as suffering from a “moderately severe depressive or melancholic state”. He was treated with anti-depressant medication, still at a very early stage in his career. During the course of subsequent criminal proceedings in relation to the illicit obtaining of pethidine, Shipman indicated that he had no future intention to return to general practice or work in a situation where he could obtain supplies of pethidine.³⁹⁴ As is well known, he did so nevertheless. Thereafter there were continuing indications of drug abuse (blackouts and seizures),³⁹⁵ the GMC having decided not to take disciplinary proceedings against Shipman.

30. The Shipman Inquiry had some difficulty in understanding why Shipman murdered at all and why so many patients, not least because Shipman refused to take part in the Inquiry and therefore psychological and psychiatric assessments were not available to it. Psychiatric evidence was nevertheless called by the Shipman Inquiry but in the end this did not permit Dame Janet Smith (the Report’s author) to attempt any detailed explanation of the psychological factors underlying Shipman’s conduct.³⁹⁶ She concludes, “in short, if one defines motive as a rational or conscious explanation for the decision to commit a crime, I think Shipman’s crimes were without motive.

393 Paragraph 1.11, First Report.

394 Paragraph 1.15, First Report.

395 See, paragraph 1.18, for example.

The psychiatrist warned me that it is possible that, in Shipman's own mind, there was a conscious motivation. All I can say is that there is no evidence of any of the features that I have observed, in my experience as a Judge, that commonly motivate murderers".³⁹⁷

31. Amongst the personality traits identified by Dame Janet Smith, however, were Shipman's profound dishonesty³⁹⁸ and his early addiction to pethidine.³⁹⁹ On the basis of the evidence before the Inquiry, and in particular having regard to the evidence of the psychiatrists called to give an opinion to the extent that they could, it appeared that Shipman may have had "a rigid and obsessive personality; may have been 'isolated' and may have had 'difficulty in expressing emotions'; 'poor self-esteem' and that 'for most of his adult life, he was probably angry, deeply unhappy and chronically depressed'".⁴⁰⁰ Importantly, however, as the Inquiry Report makes clear, these traits are not in themselves enough to explain why Shipman became a serial killer and on the evidence available the psychiatrists could not explain how these characteristics could lead to such extreme conduct⁴⁰¹. Dame Janet Smith concluded therefore that with regret she could

"shed very little light on why Shipman killed his patients"⁴⁰². Interestingly, and revealingly, towards

396 Paragraph 13.9, First Report.

397 Paragraph 13.18, First Report.

398 Paragraph 13.41, First Report.

399 Paragraph 13.47, First Report.

400 Paragraph 13.50, First Report.

401 Paragraph 13.51, First Report.

402 Paragraph 13.57, First Report.

the end of the First report, Dame Janet Smith states that:

“By the end of the inquiry, I hope to be able to make recommendations which will seek not only to ensure that a doctor like Shipman would never again be able to evade detection for so long, but also to provide systems which the public will understand and in which they will have well-founded confidence”.⁴⁰³

32. The recognition that the best that might be achieved by rigorous enquiry and effective recommendations would be that another Shipman would not be able to “evade detection for so long” highlights the reality acknowledged in the Clothier Report, that however rigorous the systems in place might be, a committed murderer might nevertheless get through. What the Shipman inquiry found was that the measures in place which might have been expected to reveal that Shipman was killing his patients at an earlier stage were not properly effective (and the second to fifth reports are concerned with the various institutions and mechanisms that might have uncovered Shipman and discovered the killings earlier but which failed to do so).
33. Dame Janet Smith makes no recommendations in relation to the assessment of health of doctors, in particular for registration or re-registration. Indeed as to any personal assessment, she notes in her Fifth Report that “it is clear beyond argument that Shipman would have done well in an appraisal, as it currently operates. He would have produced evidence that many aspects of his clinical care were of a high standard. He could have produced the results of audits; the topics would have been chosen by himself

403 Paragraph 14.20, First Report.

and he would not have conducted an audit into the mortality rate amongst his patients” and so on.⁴⁰⁴ She observes instead that “another Shipman” might be detected by clinical governance activities, namely “a framework through which National Health Service organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish”.⁴⁰⁵

34. The Clothier Report therefore,⁴⁰⁶ is the only significant report in recent years that we have identified that has made recommendations focused solely on the health of potential practitioners as a means of measuring their suitability for entry into the profession, in particular for the purposes of protecting the public. For the reasons we have given above the Clothier Report is extremely flawed.

404 Paragraph 26.200.

405 Paragraph 26.203 and paragraph 12.2.

406 With the Bullock report that endorsed its recommendations, in relation to a case, as it turned out, centred on a miscarriage of justice.

Appendix B – Full titles of research and evidence reports carried out as part of the formal investigation

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

Analysis of the statutory and regulatory frameworks and cases relating to fitness standards in nursing, teaching and social work. Prepared on behalf of the Disability Rights Commission by David Ruebain and Jo Honigmann, Levenes Solicitors; Helen Mountfield, Matrix Chambers; Camilla Parker, Mental Health and Human Rights Consultant. DRC, 2006.

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

Disclosing disability: Disabled students and practitioners in social work, nursing and teaching. Nicky Stanley, Julie Ridley, Jill Manthorpe, Jessica Harris and Alan Hurst, University of Central Lancashire and the Social Care Workforce Research Unit, King's College London. DRC, 2007.

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 papers can be found at www.maintainingstandards.org

Appendix C – Members of DRC’s Inquiry Panel

Karon Monaghan (Panel Chair)

Barrister at Matrix Chambers, specialising in the fields of discrimination and equality, human rights and EU law, and predominantly known for her work in discrimination law.

Richard Exell, OBE

Commissioner, Disability Rights Commission

Agnes Fletcher

Director of Policy and Communication, Disability Rights Commission

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, Royal National Institute of the Blind (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)

Appendix D – Formal Investigation Inquiry Panel Meetings

30 January 2007

- Association of Disabled Professionals
- Royal College of Nursing
- Amanda Bates, Nursing applicant

13 February

- Adult Dyslexia Organisation
- British Dyslexia Association
- LLU Plus at London Southbank University

14 February

- Mind
- Skill
- Arthritis Care
- Thompsons Solicitors and client

16 February

- University and College Union (UCU)
- University of Greenwich
- UNISON
- RADAR

22 February

- Institute of Education
- University of Lincoln

23 February

- National Union of Teachers (NUT)
- University of Nottingham

1 March

- Health Professions Council (HPC)
- Brighton University
- Action on Access (HEFCE funded project)
- University of Manchester
- University of Salford

2 March

- Occupational Health at Work/the At Work Partnership
- Disclosure research project from University of South Lancashire & Kings College London

6 March

- NHS Education Scotland (NES)
- Council of Deans
- University of Huddersfield
- Trinity and All Saints College, Leeds
- Scottish Social Services Council (SSSC)

7 March

- Business Medical Limited
- Careers Scotland
- General Teaching Council for Scotland (GTCS)
- Scottish Executive Education Department

9 March

- British Association of Social Workers (BASW)
- Newcastle Occupational Health
- University of Manchester, Sensory Services
- Social Work Team Manager, Trafford
- Guys and St Thomas' NHS Trust

20 March

- Social Services Department, Torfaen Council
- Welsh Assembly

29 March

- Royal College of Physicians
- Special Needs and Psychology Service for Essex County Council
- NHS Employers
- Stephen Wyatt, Retired Head teacher

2 April

- Training and Development Agency for Schools (TDA)
- General Teaching Council for England (GTCE)

3 April

- National Association of Schoolmasters Union of Women Teachers (NASUWT)
- Department for Education and Skills (DfES)
- Nursing and Midwifery Council (NMC)

11 April

- General Medical Council (GMC)
- Higher Education Occupational Physicians (HEOPS)

12 April

- General Teaching Council for Wales (GTCW)
- General Social Care Council (GSCC)

24 April

- Department of Health
- Council for Healthcare Regulatory Excellence (CHRE)
- Nursing and Midwifery Council (NMC)

1 May

- Institute of Psychiatry

Appendix E – Abbreviations used in this report

ADO	Adult Dyslexia Organisation
BASW	British Association of Social Workers
BBV	Blood borne viruses
BDA	British Dyslexia Association
BSL	British Sign Language
CCW	Care Council for Wales
CEHR	Commission for Equality and Human Rights
CHRE	Council for Healthcare Regulatory Excellence
DCSF	Department for Children, Schools and Families
DDA	Disability Discrimination Act
DfES	Department for Education and Skills
DH or DoH	Department of Health
DRC	Disability Rights Commission
GMC	General Medical Council
GSCC	General Social Care Council
GTCE	General Teaching Council for England
GTCS	General Teaching Council for Scotland
GTCW	General Teaching Council for Wales
HEFCE	Higher Education Funding Council for England
HEI	Higher Education Institute
HEOPs	Higher Education Occupational Practitioners
HPC	Health Professions Council
HR	Human Resources
OH	Occupational Health
NASUWT	National Association of Schoolmasters Union of Women Teachers
NES	NHS Education Scotland
NMC	Nursing and Midwifery Council
NUT	National Union of Teachers
RCN	Royal College of Nursing
SSSC	Scottish Social Services Council
TDA	Training and Development Agency for Schools
UCU	University and College Union

Appendix F – Statistics provided

Table 1 – statistics provided as part of Call for Evidence for Formal Investigation

Organisations	Collect statistics?	Number (years)	Proportion	Coverage	Most recent	Role of disabled people	Impair cat.	Cross ref.
Skill	No answer							
NASUWT	No answer							
Council of Deans	No answer							
BASW	No answer							
NMC	N/A							
DfES	N/A							
SEHD	N/A							
BAT of the Deaf	Not collect							
Scot. Ex. Educ. Dept	Not collect							
RCN	Not collect							
NUT	Not collect							
Institution 1	Yes, cannot provide							
Scope	Yes	242 (total organisation)	15.22			Employees	No	No
GTCE	Yes	815	0.15	2006	2006	Newly qualified teachers	No	No
Institution 2	Yes	177	Unstated	Unstated	2006	Nursing students	Yes	No
Institution 3	Yes	45	12	2003/4 – 2006/7	2006-07	Newly qualified teachers	Yes	No
Institution 4	Yes	(0304-0906 coh)16	4.84	Unstated	Unstated	Nursing students	Yes	No
Institution 5	Yes	240 (total University)	3.5	2003/4 – 2005/6	2005/6	Students	No	No

Institution 6	Yes	244 (total University)	Unstated	2003/4 – 2005/6	2005-06	Students	Yes	Yes
SSSC	Yes	160	2.4	2005	2005	Social work registrants	No	No
CCW	Yes	94	2.15	2001/2 – 2005/6	2006	Social work registrants	Yes	No
GTCS	Yes	31	1.1	2006	2006	App. TIS (Teac Ind Sch)	No	No
Institution 7	Yes	247 (total organisation)	4.85	2005 – 06	2005-06	Employees	No	No
Institution 8	Yes	33	15.86	2003 – 2007	2003 – 2007	Social work students	Yes	Yes
GSCC	Yes	1489	1.95	Unstated	2006	Qualified social workers	No	No
GTCW	Yes	77	0.2	2006	2006	Registered teachers	No	No
Institution 9	Yes	610 (total University)	6	1996/7 – 2005/6	2005-06	Students	Yes	No
HESA	Yes	Post grad – 9,410 Undergrad – 45,245 All levels – 54,830	5.11 6.38 6.12	2005-06	2006	Students	Yes	Yes
UCAS	Yes	Applicants – 24,517 Accepted – 19,713	5.51 5.47	2001 – 2005	2005	Students	Yes	Yes
NMAS	Yes	Applicants – 2,426 Accepted – 1,278	7.43 8.47	–	2006	Students	Yes	Yes
AGCAS*	Yes	Disabled graduates 13,960	7	2001 – 2005	2005	Full-time Graduate Students	Yes	No
GTRR	Yes	Applicants – 23,086 Accepted – 18,814	5.6 5.4	2002 – 2006	2006	Students	Yes	Yes
ECU	Figures provided for different institutions							

*AGCAS draws on data from HESA

Table 2 – Percentage Disabled in Great Britain across teaching, social work, nursing and health professions

Career/profession	Total Numbers in GB (disabled and non-disabled) professionals	Percentage stating that they are disabled
Health professionals	310 711	5.6
Nurses*	488 291	13.2
Secondary education teachers	374 926	12.3
Primary and nursery teachers	342 512	9.0
Social workers	79 693	12.4

Source: Labour Force Survey, 2007, using LFS definition of disability. Age range is 16-59 (female) and 16-64 (male).

* Nurses are at associate professional level according to LFS.

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From October 2007, the Commission for Equality and Human Rights will cover all equality issues. Visit the website www.cehr.org.uk for contact details



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