Education and Training Committee, 2 December 2008

# Report on the Disability Rights Commission report 'Maintaining Standards: Promoting Equality'

## Executive summary and recommendations

**Introduction**
The Disability Rights Commission (DRC) conducted a formal investigation examining the barriers that disabled people and people with long-term health conditions face when entering statutorily regulated professions. This paper provides information on the report 'Maintaining Standards: Promoting Equality' (2007), and includes the background to the report and the recommendations it made.

The paper outlines what HPC currently does in relation to the health requirements and equality and diversity. These are analysed in relation to the recommendations, with discussion and analysis of the main recommendation made in the report.

**Decision**
The Committee is invited to discuss the attached paper.

**Background information**
DRC report: www.maintainingstandards.org

**Resource implications**
None

**Financial implications**
None

**Appendices**
None

**Date of paper**
11 November 2008

# Report on the Disability Rights Commission report ‘Maintaining Standards: Promoting Equality’

## Contents

# 1 Introduction

## 1.1 Structure of this paper

This paper provides information on the Disability Rights Commission (DRC) report 'Maintaining Standards: Promoting Equality' (2007). The report was the final act of the DRC before their role and function was taken over by the Equality and Human Rights Commission (EHRC). EHRC also took over the role and functions of the Equal Opportunities Commission and the Commission for Racial Equality.

This paper is separated into different sections to differentiate between the overall report, our current rules and processes, the recommendations from the report, and an analysis of the main recommendation.

Section 2 provides the background to the DRC report and explains the rationale for the recommendations contained in the report.

Section 3 explains our standards and our current requirements about health in terms of the legislation we operate under and highlights the guidance we provide for all stakeholders, including applicants, education and training providers and employers on how they can meet these requirements.

Section 4 contains the recommendations from the DRC report which are appropriate to the HPC. They are listed with an explanation of the work undertaken which is relevant to each recommendation.

Finally, section 5 provides a discussion and analysis of the main issue, revoking the health requirements.

## 1.2 Background

Between 2006-7 the DRC conducted an investigation examining the barriers faced by disabled people entering the professions of nursing, teaching and social work. They concluded that much of the legislation and guidance that regulated entry to these professions did not comply with the Disability Discrimination Act 1995 (DDA).

Although the report's investigation focused on the health standards in nursing, teaching and social work the recommendations it makes are applicable to all statutory regulators. The report made a number of recommendations about how regulators should work in the future, and also commended HPC on our work in the area of disability.

The full reports of this investigation are available online here: www.maintainingstandards.org

## 1.3 Overall conclusions

The review concludes that health standards have a negative impact upon disabled people's access to regulated professions; lead to discrimination; and they deter and exclude disabled people from entry to these professions. The DRC's main recommendation is that all health requirements should be revoked.

The DRC agree that regulation is necessary for the protection of the public. They are supportive of the standards for conduct and competence, and stress that 'disabled people have a strong interest in the protection that the regulatory bodies and these standards of competence and conduct provide' (p.5). However, they argue that there is no evidence that the health requirements provide protection for the public.

## 2 Main issues

This section highlights the main issues from the DRC report. These are in the areas of health standards that all registrants and future registrants must currently meet, the requirements and issues around disclosing disabilities and long-term health conditions, and the need for more research to build up an evidence base. These issues are addressed throughout this report, with specific discussion and analysis of the recommendation to revoke health standards in section 5.

### 2.1 Standards

The DRC report found that the standards set by statutory regulators for physical and mental health did not determine whether someone is competent to practise a profession. They argued that the standards in their present form lead to discriminatory attitudes.

The report makes the following conclusions in this area:

- The health requirements of education providers or qualifications bodies are not legitimate competence standards as defined by the DDA (p.8)[1].
- No evidence base exists for health or fitness requirements for public protection. The report argues that legislation in this area should be revoked (p.11).
- Conduct and competence standards should be reviewed to make sure they are necessary and that they allow for adjustments under the DDA (p.13).
- There is a need for guidance on making adjustments to allow disabled people to meet required competencies, and during fitness to practise investigations (p.14).
- Work placements are a fundamental aspect of pre-registration education and training. The report concludes that placement providers are inconsistent at making reasonable adjustments for students. The report argues that this is down to poor planning by education and training providers, students unwilling to disclose conditions, or placement providers being unaware of disability equality and the DDA. The report suggests further guidance for all is required (p.17).

### 2.2 Disclosure

The report also questions the requirements for disclosing disabilities and long-term health conditions. The report argues that the requirement for health standards creates an unwillingness to disclose which then affects the availability of adjustments and support.

[1] The Disability Discrimination Act establishes competence standards as 'an academic, medical or other standard applied by or on behalf of a general qualifications body for the purpose of determining whether or not a person has particular level of competence or ability' (Chapter 13, 31AB(9)).

The report makes the following conclusions in this area:

- Disciplinary action may be taken against those who have failed to disclose a disability or long-term health condition and this can often be used as evidence of 'bad character'. This is in the context of a culture where the disabled or those with long-term health conditions may not feel safe disclosing (p.12).
- Conditions and disabilities vary widely. The report found there was often an unwillingness to disclose long-term conditions, or only disclosing fluctuating conditions when they arise (p.19).
- Health requirements promote negative attitudes to risk, particularly for those with mental health conditions (p.19).

## 2.3 Statistics and research

The report highlights a concern that there is little research or data about the disabled and those with long-term conditions available.

The report suggests that the following may be considered:

- Data collection according to impairment type. This would provide an evidence base regarding barriers to type of impairment and will help to develop trust regarding disclosure (p.21).
- Research about disabled people's perceptions of barriers to entry and training. Use to inform impact assessments of policies, procedures, practices and guidance documents (p.22).

## 2.4 Good practice

'Evidence received from the HPC demonstrated a model of good practice within the current constraints imposed by the health standards. The HPC draws a crucial distinction between fitness to practice and fitness for a particular job in a particular setting. Registration does not guarantee that someone would be able to practise effectively in all settings' (p.23).

HPC gave evidence to the DRC so they could compare our frameworks and standards with those of nursing, teaching and social work. The report mentions that we have adopted a 'more disability friendly approach' (p.144) and that, where health standards exist, HPC represents a model of good practice. They compliment us on distinguishing between fitness to practise and fitness for particular roles. The DRC also compliment us on producing 'A disabled person's guide to becoming a health professional' which they describe as promoting 'a 'can-do' approach to disabled professionals' (p.145).

# 3 Standards and guidance

This section provides an explanation of our current standards and guidance in relation to the main issues raised in the DRC report. This includes our requirement for a health reference, our fitness to practise requirements, and our equality and diversity scheme, highlighting current practices and recent changes. The relevant publications and guidance are also highlighted.

## 3.1 Standards related to health

Our standards must be relevant to each of our registrants, their health, and any changes that may occur to a registrant. To avoid unlawful discrimination, we must ensure that the standards can be objectively justified.

The standards published by HPC are reviewed on an ongoing and periodic basis, this includes considering whether any standards would have an unnecessary impact on disabled people.

We reviewed the standards of proficiency in 2005-6, the standards of conduct, performance and ethics in 2006-7, and the standards of education and training in 2007-8.

### 3.1.1 Standards of proficiency

The standards of proficiency (SOPs) are the necessary threshold standards for entry to the Register. Part of the consideration of whether a standard is necessary considers whether that standard would be likely to have an unnecessary adverse impact upon a disabled person.

In 2005-6 we reviewed the standards of proficiency for 12 of the professions we regulate. The review was carried out by a professional liaison group, who made sure the specific purpose of each standard was identified and examined the manner in which each standard achieves that purpose.

Employers and education and training providers also have responsibilities under the Disability Discrimination Act to explore reasonable adjustments which might allow a disabled applicant or registrant to meet our standards. Registrants should also make reasonable adjustments to their practice (including negotiating adjustments with their employer) to ensure that they practise safely and effectively within their scope of practice.

We have produced a document ‘Managing fitness to practise’ for registrants and employers to provide guidance on how registrants’ fitness to practise can change over time and the steps that can be taken to remain registered with us.

### 3.1.2 Standards of conduct, performance and ethics

The standards of conduct, performance and ethics (SCPE) published in 2003, required registrants to disclose to us significant changes to their health. However,

this was problematic because of a lack of clarity around what constitutes a 'significant' change to health. It was also problematic because by disclosing this information to us, registrants were demonstrating insight and understanding and demonstrating in turn that they had met another of our standards.

This requirement was removed from our revised standards which became effective from 1 July 2008 and we now ask registrants to provide important information about their conduct and competence.

SCPE standard 12 directly refers to the health of a registrant. The standard requires registrants to show insight and understanding into their health condition by limiting, or stopping, their work if their performance or judgement may be affected by their health.

### 3.1.3 Standards of education and training

A professional liaison group reviewed the standards of education and training (SETs) and SETs guidance in 2007-8. One of the suggested changes was to the guidance attached to the standard requiring education and training providers to comply with any health requirements. The existing guidance states that 'health checks must be carried out as part of the admissions process'. The wording of the guidance was stronger than that required to meet the SET. The PLG amended this guidance in the consultation document.

## 3.2 Health references

Article 5(2)(b) of the Health Professions Order states:
'The Council shall from time to time prescribe the requirements to be met as to the evidence of good health and good character in order to satisfy the Education and Training Committee that an applicant is capable of safe and effective practice under that part of the register'.

Rule 2(b) of the Registration and Fees rules states:
'The applicant shall provide in connection with the application for registration….a reference as to the physical and mental health of the applicant given on the form provided by the Council containing the declaration and information listed in Schedule 4 by the applicant's doctor…'

Our rules prescribe requirements for health references which applicants must provide when applying for admission and readmission to the Register. Registered Medical Practitioners (i.e. Doctors) are asked to complete the health reference and sign a declaration in the following terms 'I am satisfied that the applicant's health does not affect their ability to practise the profession referred to above'.

We've published information for applicants and doctors which explains the health reference process and the decision we are asking doctors to make. In particular, we emphasise that the doctor is not being asked to make a decision about the employability of the applicant or being asked to make judgements based on

blanket assumptions about the nature of the practice of the profession or the nature of the applicant's health condition or disability.

With the permission of the applicant, a doctor may decide to provide additional information on the reference form if they feel this is necessary or relevant. However, we do not require applicants or doctors to provide a detailed medical history or to disclose disabilities or long-term health conditions.

On a small number of occasions where information declared to us by an applicant or registrant, or included on a health reference form, may raise potential concern, we ask a registration panel to consider the case. The panel consists of registrants and lay people, including at least one member of the profession concerned. A registered medical practitioner would also be present on a panel considering a health matter.

To date, we have refused registration to two applicants where the health reference highlighted a poorly managed alcohol dependency problems. One applicant subsequently appealed, providing additional information, and a registration appeals panel decided to grant registration. The second applicant is currently appealing.

### 3.3 Fitness to practise

The Investigating Committee looks at an allegation and decides whether there is a case to answer. If they decide there is a case to answer they must then decide whether the case relates to conduct and competence, or health. Some cases involve conduct, competence and health issues. The committees have slightly different decision making powers; the Health Committee does not have the power to strike off.

The Health Committee deals with cases where the physical or mental health of a registrant may be impaired. In every case referred for hearing, we seek the permission of the registrant to undergo an examination from a relevant registered medical practitioner so that the panel is able to make an informed decision.

The cases considered by the Health Committee are typically those where a registrant has continued to practise whilst unfit to do so and this has directly led to harm or the risk of harm to service users – i.e. it is not the health or disability of the registrant itself that requires us to take action, but the impairment it has contributed to.

The number of cases we deal with is very small – 6 hearings took place in the 2007/08 financial year. 5 of these hearings resulted in a suspension and 1 case was not well founded. Of the 5 suspensions, 1 involved alcohol and the other 4 involved mental health issues. The case not found involved mental health issues.

Our current fitness to practise process is set up to allow for all reasonable adjustments to be made on a case-by-case basis. We make reasonable adjustments as soon as we are aware they are required and at all stages of the process. Adjustments range from making documentation available in appropriate formats, to making sure that the venue for the hearing is accessible.

### 3.4 Equality and diversity scheme

The Council agreed at its December 2007 meeting that an equality and diversity scheme would become effective from 1 January 2008.

This scheme describes the steps we have taken, and will take, in order to ensure that we do not discriminate against people on the basis of:

- Disability
- Age
- Gender
- Sexual orientation
- Race
- Religion

In April 2007, we began collecting demographic data from witnesses and registrants involved in our fitness to practise process. This involved sending an equality monitoring form to complainants and registrants at an early stage in the course of dealing with a complaint.

At the July 2008 Council meeting it was agreed to collect data from applicants for registration. The data that was agreed for collection was under the same six headings that data is collected by fitness to practise. We started collecting this data from 7 November 2008.

Each individual department has detailed action points in the equality and diversity scheme that they are will be responsible for meeting. The following action points relevant to the DRC report are set out for each department:

- Human Resources (HR) / Partners
    - Review practices around employment of disabled employees, particularly around adjustments following a recruitment decision, in consultation with employees.

    - Explore the feasibility of working towards obtaining the ‘two ticks’ symbol which denotes organisations that are positive about disability.

    - Review the complaints and appeals processes for partners, including updating the guidance for appeals panel members to include guidance on equality and diversity issues relevant to their role.

- Facilities
    - Adding induction loops in the council chamber and reception area.

    - Fitting an audio description in the lifts.

    - Ensure that employees working on reception receive training on our arrangements for assisting people with disablities who are visiting our offices.

- Communications
    - Continue to seek the input of groups representing disabled people and other groups when reviewing the style, text and accessibility of our publications.

    - Add to all our publications so that it is clear that all our publications are available in alternative formats (e.g. Braille).

    - Review the layout and content of our website to ensure that it is as accessible as possible. This will include publishing key publications on our website in a range of different languages.

- Policy and Standards
    - To undertake a piece of work, seeking the input of disabled people and of education providers, to assess the impact and effectiveness of our guidance for disabled people, education providers and doctors – 'A disabled person's guide to becoming a health professional' and 'Information about the health reference'.

    - Consider equality and diversity implications when we review our returners to practice requirements.

    - On an ongoing basis, and, formally by the end of the currency of the equality and diversity scheme, we will review our approach on consultation and involvement of external organisations and individuals on issues with relevance to equality and diversity.

- Fitness to Practise
    - To produce a new practice note on disability to ensure that panels are informed about the law and requirements about reasonable adjustments.

    - Review the way in which we schedule hearings to ensure that we identify and accommodate any additional needs at an early stage.

- Collect demographic data from registrants involved in fitness to practise proceedings and from complainants. We will analyse this data and present the findings to our three fitness to practise committees.

- Education
  - To ensure that there are specific requirements for education providers and placement providers to have equal opportunities and anti-discrimination policies and to offer sufficient pastoral support to students.

- Secretariat
  - To further develop the format of Council papers to ensure that these are accessible to all groups.

  - Make sure all new Council members receive equality and diversity training.

- All
  - Each directorate/ department will include an equality impact assessment in their yearly workplans. The workplans set out the planned work for that department in the coming financial year. These will be periodically reviewed by the project team.

The scheme sets out the timescales for when each action point should be met. These points will be reviewed annually and a progress report will be taken to the Council in March 2009. A member of the Executive also regularly participates in the Joint Regulators Equality and Diversity Group.

## 3.5 Publications

We publish guidance documents to provide further information about our standards and processes. The following documents were produced with the benefit of the experience and expertise of individuals from professional bodies, disability organisations, and education providers.

**'A disabled person's guide to becoming a health professional'**
This guide was cited as an example of good practice in the DRC report. We received a number of queries regarding disability and registration and felt that we should provide information appropriate to all people considering, or advising people on, becoming health professionals. The guide provides more information to applicants, advisors, doctors and admissions staff around disability and access to education and training and registration.

**'Information about the health reference'**
We published a guide for people who had questions about the health reference. The guide contains information for applicants and for doctors. This document is

especially useful for applicants with a health condition, those with a disability, or for doctors looking for more information about the health reference.

**'Managing fitness to practise: a guide for registrants and employers'**
The SCPE and SOPs require registrants to manage their own fitness to practise. We produced this guidance to provide further information for both registrants and employers about what we would expect from registrants and employers who feel that a registrant may not be meeting our standards.

**On-going work on health and character guidance**
We are currently considering the information we provide about the process we use to look at an applicant's, or a registrant's health and character. This guidance forms part of the agenda of the meeting of the Education and Training Committee on 2 December 2008.

## 4 Recommendations

The DRC report includes a number of recommendations for all regulatory bodies. The following are the recommendations most applicable to the HPC and, where applicable, how we meet the recommendations. Some of the recommendations are also met by education and training providers and others who support our role.

**i. Remove all requirements for good health or physical and mental fitness.**

To meet this recommendation Article 5 (2)(b) of the Health Professions Order would have to be amended as well as Rule 2(b) of the Registration and Fees Rules.

Section 5 of this paper provides further discussion and analysis of this recommendation.

**ii. Review statutory disability equality schemes and involvement of disabled people.**

The equality and diversity scheme was put in place in 2007. There is a specific action point in our equality and diversity scheme for us to involve disabled people and groups in the development of our policies, consultations and communications strategies (see section 3.4).

In the scheme, there are a number of action points which involve seeking external input on specific tasks. For example, we say that we will continue to involve outside individuals and organisations in reviewing our publications and in reviewing the accessibility of our offices.

At the end of the lifetime of the scheme, we will review the effectiveness of this approach. This might include considering whether a different approach to achieving external involvement is necessary.

**iii. Carry out impact assessments of:**

- **policies, practices and procedures**
- **processes for assessing fitness to practice, for example fitness to practice hearings**
- **English language standards and competence standards in general**
- **main methods of communication with actual and potential professionals.**

We review our policies, practices and procedures on a regular basis and carry out impact assessments as part of these reviews. We are also collecting data on

our fitness to practise processes and will use this to inform an assessment of our current processes.

Within our equality and diversity scheme each department will carry out an impact assessment of their equality and diversity actions. We also have an internal equality and diversity group who look at all internal and external policies and offer general advice on issues of equality and diversity.

**iv. 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.**

Our standards are reviewed by the Council and Committees and on a periodic basis. An example of how this takes place is outlined in section 3.1.

**v. Carry out or commission research on the provision of reasonable adjustments for students (during education based training and work placements) and pull together information about good practice.**

The standards of education and training currently require education and training providers and practice placement providers to have equal opportunity and anti-discriminatory policies in place. The standards also require education and training providers to ensure that all reasonable adjustments and support is made available for students. Information about good practice is also provided by some of the professional bodies.

**vi. Issue guidance to help education providers make adjustments to enable disabled people to meet the competence standards.**

The guidance for the standards of education and training and 'A disabled person's guide to becoming a health professional' both provide guidance in this area. This is also addressed in the equality and diversity scheme outlined in section 3.4.

**vii. Review systematically existing publications and examine the quality of advice given verbally to individuals and higher education institutions.**

All publications are reviewed systematically. Advice given across the organisation is checked and we make sure all employees are up-to-date through training. This is also addressed in the equality and diversity scheme outlined in section 3.4.

**viii. Review registration application processes to ensure that disabled people are not disadvantaged and ensure that there are adequate feedback and complaints procedures.**

We have reviewed our processes in order to put together an equality and diversity scheme and will continue to review them on a regular basis. The data collected from fitness to practice and registrants may help our future assessments.

**ix. 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.**

We consider any information about prospective registrants when they apply to join the Register. If we receive information which needs to be looked at further, the application is examined by the appropriate panel, please see section 3.2 for further information.

**x. 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.**

Failure to disclose a disability or long-term health condition is not in itself evidence of 'bad character'. If we are aware of a disability or health matter we will look at each case on an individual basis. Please see sections 3.2 and 3.3 for more information.

**xi. Take action to tackle the confusion on what does and does not constitute a 'disability' and who is covered by the DDA.**

'A disabled person's guide to becoming a health professional' provides guidance in this area.

**xii. Combat the perception that disabled people are vulnerable people who receive help or care and cannot be professionals themselves.**

'A disabled person's guide to becoming a health professional' helps to address some of the perceptions in this area. It is also important that we continue to review the guidance we provide, and policies to make sure they are appropriate.

**xiii. Tackle the stigma and unwillingness to disclose in relation to many disabilities and health conditions, particularly mental health.**

This is addressed in 'Information about the health reference' and 'A disabled person's guide to becoming a health professional'. We encourage disclosure and support all registrants and potential registrants to inform us of any conditions.

**xiv. Take a sensitive approach both to encouraging disclosure and to handling personal information following disclosure.**

We have done this in 'A disabled person's guide to becoming a health professional' as well as the health and character guidance currently in development.

**xv. 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.**

The equality and diversity scheme is clear about what information we collect. The form used to collect the information from fitness to practise cases and applicants provide clear information about what purpose the data will be used. The information requested about disability requires a 'yes/no' answer, no further detail is currently requested.

**xvi. 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 fellow students, also have positive attitudes towards disability and understand that reasonable adjustments are about equality not preferential treatment.**

These recommendations are more directly met by education and training providers. We also promote disclosure in the work we do and requirements we set, for example the requirement for equal opportunities and anti-discrimination policies in the standards of education and training. HPC employees, Council members and partners have all received equality and diversity training. This training is on-going.

**xvii. 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.**

The statistical information we have begun to collect will start to address some of the limited information available in this area. We will make sure that where possible and appropriate, this information is shared.

# 5 Discussion and analysis

The Equality and Human Rights Commission (EHRC) has asked the Department of Health to revoke current statutory health requirements in health professions regulators' legal frameworks, on the grounds that they put off prospective applicants to regulated professions and they do not identify or reduce the risk to the public of registrants whose fitness to practise is impaired. This is based on the findings of the Disability Rights Commission report 'Maintaining Standards' (2007).

The Department of Health are currently discussing revoking the standards with EHRC and have approached all of the regulators seeking information on how health requirements are used by each regulator and what impact may be caused if the standards were revoked.

## 5.1 'Good Health'

Our requirements around health are linked to our Registration and Fees Rules and fitness to practise. Article 5 (2)(b) of the Health Professions Order 2001 says that the Council shall 'prescribe the requirements to be met as to the evidence of good health and good character in order to satisfy the Education and Training Committee that an applicant is capable of safe and effective practice under that part of the register'.

The term 'good health' has its own difficulties. We do not only register people who are 'healthy' or in what a lay person would call 'good health'. A registrant may well have a disability or long term health condition which would mean that they would not consider themselves to be in 'good health'. However, as long as the registrant or applicant has insight and understanding, and manages their condition or disability appropriately, this will not prevent them from registering.

## 5.2 Insight and understanding

We make no blanket assumptions about long-term health conditions and look at every case on its own merit. When most people advise us of a disability or long-term health condition, we find we do not need to do anything because they are managing their condition.

Insight and understanding is crucial to decisions made in both applications to join the Register and in fitness to practise cases. An applicant or registrant who has insight and understanding into their condition will adapt their practice where necessary to minimise any risk to a service user. On the other hand, there may be applicants or registrants with the same condition, but who fail to follow advice and practise in a way which could harm service users or themselves.

If a condition is well managed, we would not need to be involved at all. Employers may, of course, make their own judgements, which are separate to decisions taken by us. For example, someone may have a condition which is well

managed that prevents them from undertaking certain work. However, this is an employment decision rather than a registration decision and we would never refuse to register someone solely because they had a condition that prevented them undertaking certain work.

## 5.3 Standards and registration

The DRC report says that competence standards are about public protection and that health requirements are not legitimate competence standards, because they do not show that someone is competent to practise the profession. However, we must question whether the intention of the health requirements are to test competence (i.e. knowledge, skills and behaviour), or are to identify fitness to practise issues (i.e. capability)?

The report accepts that there would be two potential negative outcomes if health requirements were removed. Firstly, a lack of guidance from regulators may lead to different approaches to health and disability from education and training providers. Secondly, more responsibility would be put on to employment decisions. The report suggests all regulatory bodies should provide guidance to avoid these outcomes.

As the minimum threshold standards for entry to the Register, the standards of proficiency must be periodically reviewed to make sure they are absolutely necessary and must be in keeping with our rules and legislation. If the health requirement were taken out of the rules and legislation we could still look to see that someone was demonstrating insight and understanding into their individual circumstances through standard 12 of the standards of conduct, performance and ethics: 'You must limit your work or stop practising if your performance or judgement is affected by your health'.

## 5.4 Health requirements and references

We find that there are some potential difficulties with the health reference. Some doctors do not understand the health reference and we receive a number of queries questioning its purpose. Applicants also query its relevance and why the reference is absolutely necessary, especially when they have been charged by their doctor for providing the reference. The guidance we have produced has addressed many of these queries.

The report argues that health requirements promote negative attitudes to those with disabilities and long-term conditions, but, it is difficult to assess whether this is the case. However, not having any specific health reference requirements relating to registration could potentially hamper our ability to only register people who are fit to practise.

We only consider a small number of cases where there is a potential concern and only refuse registration on the grounds of health in an even smaller number of cases.

However, we do not know the extent to which the health reference acts to protect members of the public, by preventing applications for registration in the first place by those who are poorly managing a health condition or disability, and who, if registered, could potentially pose a risk to service users. It is therefore difficult to assess the extent to which the health reference acts as a deterrent to disabled people who pose no risk, and who would be successfully registered if they applied.

## 5.5 Fitness to practise

In our response to the Department of Health consultation on 'Health care and Associated Professions (Miscellaneous Amendments) No 2 Order 2008' we suggested merging the Health Committee with the Conduct and Competence Committee to create a single fitness to practise committee. The investigation of cases would still remain separate, with panels of the investigating committee deciding whether a case should be referred through to public hearing.

In practice, many cases have some kind of health element to them and it is difficult for panels to determine whether health is an incidental, contributory or primary factor in a particular case. This also means that panels are, to some extent, making judgements about what constitutes a health condition. For example, is a registrant with a history of alcohol dependency, who drinks alcohol whilst on duty impaired because of their health or is this misconduct?

There are instances where the committees cross refer cases between each other when health emerges as the primary issue at a hearing, or where a panel of the health committee concludes that health is the issue and refers a case back to the conduct and competence committee to consider the case. This has the potential to delay the determination of the case which could cause stress for the person concerned.

## 5.6 Overall

The committee is invited to discuss the recommendation that regulators should seek to remove health requirements. In particular, the committee may wish to discuss the role of the health reference as a requirement for entry to the Register.