Reasonable adjustments in nursing and midwifery

A literature review

March 2009

Undertaken on behalf of the Nursing and Midwifery Council

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1. Introduction

The Nursing and Midwifery Council (NMC) commissioned this literature review of guidance relating to reasonable adjustments in the workplace and education setting for nurses and midwives and other relevant health professionals in November 2008.

The objective was to identify and review guidance that already exists, and to identify examples of good guidance and gaps in guidance. This is consistent with the NMC's remit. The NMC's core function is to establish standards of education, training, conduct and performance for nursing and midwifery and to ensure these are maintained. The Council's key tasks include maintaining the register of nurses and midwives eligible to practice in the UK, to quality assure nursing and midwifery education and consider allegations of lack of competence or unfitness to practice due to ill-health.

In conducting the literature review the following criteria was used. Literature was reviewed that was:

- aimed at the health education sector and employment in the health sector;
- national, regional or local;
- related to nursing and/or midwifery and to other related healthcare professions (including social work);
- produced by a range of healthcare regulators;
- used in other countries, e.g. the United States.

A comprehensive search and analysis was carried out, which revealed a mixed picture. This included some examples of good guidance and practice, and these are identified in the body of the report and in the summary. They are set in the context of a report on the broad results of our review. The report also highlights gaps in guidance in line with the aims of the research.

In the course of undertaking the review of guidance, which included email and telephone discussion, a range of individuals representing organisations, particularly Schools of Nursing, commented that they would strongly welcome national guidance on reasonable adjustments from the Nursing and Midwifery Council.

2. Context

This review of guidance forms a part of the Nursing and Midwifery Council's response to its obligations under disability equality legislation – (the Disability Discrimination Act 1995, the Disability Equality Duty introduced by the Disability Discrimination Act 2005, and the Special Educational Needs and Disability Act 2001).

It also forms part of the Council's response to the former Disability Rights Commission's Formal Investigation into the regulation of professionals' health in nursing, teaching and social work, *maintaining Standards: Promoting Equality published in September 2007*. As the proposal for this literature review pointed out, the NMC has embarked on an extended piece of work to improve the approaches to health and the guidance provided about how nursing and midwifery competencies can be met using reasonable adjustments.

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

The report criticized the prevalence of health and fitness regulations that ignored the requirement to make 'reasonable adjustments'. [1] It reported finding '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'. The report argued that 'these regulations do nothing to protect the public and may indeed offer a false sense of security'.

The DRC noted that generalised health and fitness standards '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' and recommended that they are revoked. The report notes that the NMC shared the DRC's view that the statutory requirements for 'good health and good character' are likely to lead to disability discrimination

This literature review has found a varied picture in terms of the provision of guidance on reasonable adjustments in training and employment. There are some examples of good guidance, a number of cases where organizations appear to be in the process of reviewing and changing their practices, and cases of a failure to make any reference to reasonable adjustments or support for disabled applicants, and use of discriminatory language and approaches.

[1] Maintaining Standards Promoting Equality, Disability Rights Commission, September 2007

2.1 Nursing and Midwifery Council – reasonable adjustments

The DRC recommended regulatory bodies to 'carry out or commission research on the provision of reasonable adjustments for students (during university based training and work placements)', with a view to producing guidance. This literature review forms part of the NMC's positive response to this recommendation.

Prior to this, the NMC ran a series of events across the UK in spring 2008 on the theme of 'Have your Say on Equality and Diversity' which encouraged nurses, midwives and Higher Education Institute staff who train nurses and midwives to consider issues including: collection of monitoring data; nursing standards including the good health and good character standard; how the NMC can communicate more inclusively and the role of the Fitness to Practice panellist and how to recruit a more diverse group of panellists.

All of these topics have a relevance to improving the ability of the NMC to meet its obligations under disability equality legislation and to be able to provide high quality guidance on reasonable adjustments. The report of the events summarized that 'Registrants are still wary of disclosing any health needs due to fear of reprisal and therefore may not be getting the support they require' while 'reasonable adjustments were not seen to be routinely made and procedures appeared to vary across Trusts'[2]. Participants requested guidance on 'what constitutes reasonable adjustments' among other things.

The NMC also established an Expert Panel of Disabled People, which is actively involved in the discussion on reasonable adjustments and professional competencies.

2.2 Competence

The report of the Have your Say events also noted the need to amend the 'good health' standards so that they focus on competency to do a job. The NMC's website[3], introducing its guidance on good health and good character, notes: 'If you have a disability or a health condition, or a conviction or a caution, it will not necessarily prevent you from entering a programme or from registering as nurse or midwife or from continuing your career as a nurse or midwife. However if you have a disability or a health problem you may need to seek advice about whether you can be adequately supported to be capable of providing safe and effective practice without supervision'.

This language forms part of the background to this review. The NMC clearly wishes not to discriminate. However, discussion of 'good health' risks being confusing and unintentionally off-putting to disabled people and misleading generally. Although health and disability are different issues, the language tends to couple them together

[2] Have Your Say on Equality and Diversity Report, the Focus Group uk, On behalf of the Nursing and Midwifery Council, June 2008.
[3] http://www.nmc-uk.org/aArticle.aspx?ArticleID=2603

and roll them up with the issue of good character. Whatever qualifications are made, the invitation is for those less informed to focus on health rather than competence.

We have found examples of different language being used by other regulators. For example, a search on the General Medical Council's website[4] for 'competence standards+disability' links to a page titled 'competence standards' from the GMC's *Gateways to the Professions* guidance document for medical schools on how to encourage disabled students.

The document explains that competence standards set out the:

'academic, medical, or other standards applied by or on behalf of an education provider for the purpose of determining whether or not a person has a particular level of competence or ability. Competence standards must be reviewed from a disability discrimination perspective and must describe relevant and genuine competences that are strictly necessary for course completion… Reasonable adjustments do not have to be made to competence standards, but they do have to be made to the way that the standards are assessed or performed. It is important, particularly in examinations, to recognise that disabled doctors sometimes use different clinical methods to detect abnormality. So, for example, students with hearing loss may have to experiment with different combinations of electronic stethoscope and hearing aids until the process works effectively for them. Further, being able to answer a crash call summoning a resuscitation team to an emergency might not constitute a genuine competence standard, if reasonable adjustments could be made to the working environment or tasks so that answering such calls was not a necessary task for a particular team member.'

The page itself has links to the GMC's disability equality scheme and the GMC document *Tomorrow's Doctors* the GMC's guidance on undergraduate medical education. The site tells medical schools that they 'should therefore prepare a statement of genuine competence standards for potential applicants and for the different stages of the course and be prepared to negotiate on an individual basis the ways in which these competences will be demonstrated by disabled students.'[5]

[4] http://www.gmc-uk.org/education/undergraduate/undergraduate_policy/gateways_guidance/5_4_competence_standards.asp
[5] http://www.gmc-uk.org/education/undergraduate/undergraduate_policy/gateways_guidance/5_5_tomorrows_doctor.asp

3. Literature review – methodology

Literature for the review was identified via:

- Web based searches of the sectors the NMC wished to review guidance within, including the relevant national and regional government sources, the NHS, the healthcare regulatory bodies, particularly in health, health care and social work. Further, searches were undertaken of relevant professional representative bodies and trade unions, higher education institution and advisory sites, schools of nursing and other educational and training sites, a range of local employer sites, disability and equality organizations and networks.

- Web based search of academic databases, including Academic Search Premier, ZETOC, Science Direct, Web of Science, Omnifile FT Mega, JSTOR, and searches using Google and Google Scholar.

- Identifying and sourcing references for literature in key individual publications including the DRC's Formal Investigation, guidance and research by the GMC and similar organizations in the field, and NMC literature and contacts provided by Natalie Salmon.

- Use of web based discussion forums to place requests for information. For example, the web-list 'DIS-FORUM' was useful in this regard. Approaches by email were made to a range of relevant disability, equality, representative and professional organizations to probe for literature, known examples and experiences.

- Direct approaches to individuals and organizations in the field such as a range of regulatory and representative bodies, the RCN, RCM, the Employers Forum on Disability, members of the NMC's Expert Panel and to schools of nursing. A wide range of individuals in organizations which responded were personally discussed with. Many of these provided helpful information. A number of individuals helpfully passed on sources and links, including individuals at educational institutions, in NHS Trusts and workplaces.

- Approaches to international organizations such as the Exceptional Nurse website in the United States (and Donna Maheady, founder of www.ExceptionalNurse.com.) and organizations in Australia, Canada and Ireland.

We extend our thanks to all those who have helped in the course of conducting this literature review.

4. The legal framework

The primary legal framework which affords rights to disabled people in employment and occupation, education and in their relationship with qualification bodies, is contained within the Disability Discrimination Act 1995 ('the DDA'). The DDA was amended by the Special Educational Needs and Disability Act 2001, which extended non-discrimination provisions to the education sector.

The DDA protects people with a wide range of disabilities and health conditions from unfair discrimination. The Act identifies that a person is disabled if he or she has 'a physical or mental impairment which has a substantial and long term adverse effect on his ability to carry out normal day-today activities'. The definition also includes all people with HIV, cancer and multiple sclerosis from the point of diagnosis.

The DDA imposes five obligations towards disabled people. These are:

- not to directly discriminate on grounds of a person's disability;
- not to treat less favourably for a reason relating to a person's disability, without justification;
- to make reasonable adjustments;
- not to harass a disabled person;
- Not to victimise anyone.

In addition, part 5A of the DDA places significant obligations on public authorities (including the Nursing and Midwifery Council) to promote disability equality.

4.1 Direct Discrimination

Sections 3A(5) and 28S(10) of the DDA explain that the treatment of a disabled person by an employer, trade organisation, qualifications body or education provider amounts to direct discrimination if:

- it is on the grounds of his/her disability;
- the treatment is less favourable than the way in which a person not having that particular disability is (or would be) treated, and
- the relevant circumstances, including the abilities of the person with whom the comparison is made, are the same as, or not materially different from, those of the disabled person.

4.2 Disability related discrimination

Section 3A(1) and 28S(1) of the DDA defines disability related discrimination as arising where:

- It is for a reason related to a person's disability
- the treatment is less favourable than the way in which the employer, trade organisation, qualifications body or education provider treats (or would treat) others to whom that reason does not (or would not) apply, and

- the employer, trade organisation, qualifications body or education provider cannot show that the treatment is justified.

The treatment cannot be justified if reasonable adjustments could have been made which would have meant that the material and substantial reason for justifying for the treatment would not apply.

4.3 Reasonable adjustments

Sections 4A(1), 14B(1) and 28T requires employers, trade organisations, qualifications bodies and educational providers to make reasonable adjustments to provisions, criteria or practices and to any physical feature of premises that would otherwise place the disabled person at a substantial disadvantage compared with people who are not disabled.

The Code of Practice gives the following example to illustrate the obligations:

"A student with HIV wants to take a nursing course. The education provider assumes that his condition will create a health and safety risk and refuses him a place. If the college had obtained further information about the student's condition and the associated risks, it would have been able to put adjustments in place to ensure that there were no unnecessary health and safety risks"[6].

4.4 Some relevant examples

Cases from *Background to the Disability Rights Commission's Formal Investigation into Fitness Standards in Social Work, Nursing and Teaching Professions* illustrate some common concerns around training and employing disabled nurses, and some key principles for responding to these concerns in a fair and appropriate way within the legal framework of reasonable adjustments :[7]

- **Initial concerns can generally be resolved through further investigation:**

A university wanted to defer an applicant's entry to the nursing course because of her hearing impairment. The university said that they were concerned that her deafness might create a risk to patient safety: in 'circumstances of considerable ambient noise, individual faces covered by masks and an emergency in progress'. The university added:

> 'Because of the nature of the requirements in student training it is necessary that experience across the whole spectrum of care is achieved to enable the individual to enter on to the NMC [Nursing and Midwifery Council] Register and to practice'.

[6] http://www.equalityhumanrights.com/en/publicationsandresources/Pages/CodeofPracticepost16education.aspx page 83

[7] Background to the Disability Rights Commission's Formal Investigation into Fitness Standards in Social Work, Nursing and Teaching Professions, Chih Hoong Sin et al. (DRC 2006)

Once the case was taken up by the Disability Rights Commission the university subsequently gave the applicant a start date and unconditional offer. (Case settled, Scotland – 2005):

- **It is essential to consider the potential for reasonable adjustments**

Another applicant was refused a place on an Adult Nursing course on the basis of an occupational health report that had raised concerns about her ability to complete the course due to her dyslexia. This was despite the fact that the report stated that with support the claimant would be able to do quite well on the academic side and pass her clinical assessments. The university took the approach that 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. Thus the claimant would not have been able to operate universally and safely as a nurse once she has completed the course.

However, once the DRC took up the case it was accepted that the relevant circulars and guidance should not be interpreted as allowing the refusal of access to a course based on perceived future risk which has not been assessed, and that the NMC circular does not require confirmation of good health and good character prior to commencement of course, nor require automatic entry to the register on completion. In addition, the university had given no consideration of its duty to carry out reasonable adjustments. A joint expert (with experience of dyslexia and nursing treatments) was instructed. In the light of this report, the university offered the claimant an unconditional place on the course and some financial compensation. (Case settled, England – year unknown):

- **It is important to seek advice from appropriately qualified experts, considering reasonable adjustments**

An applicant with Asperger's Syndrome was refused permission to continue on a nursing course in the light of advice from a doctor that he could not successfully undertake the course. However, following a second opinion from an occupational health practitioner, who advised that the claimant could continue the course with additional support from a tutor and counsellor, the university invited the claimant to continue he course and discuss the level of support required. However, the claimant decided to find another university where he could continue his studies. (Nursing, England – 2003-2004):

- **Proper consideration needs to be given to the reasonableness of adjustments**

A caller to the DRC, had Amniotic Band Syndrome, which means that she has missing fingers on both hands. She had been advised not to apply for a place on an adult nursing course on the basis (having checked the competencies required for registration) that the 'spare' fingers on the surgical gloves could compromise the effectiveness of certain clinical skills. It was suggested that it would be too expensive to provide gloves that fitted the claimant's fingers. The caller had been given no information on how this was calculated, nor any consideration of the availability of Disabled Students Allowance or Access to Work (the funding for adjustments for

employees provided through Job Centre Plus). Assessing the reasonableness of an adjustment requires consideration, amongst other factors, of the availability of sources of funding, and of course an accurate assessment of the costs of an adjustment. (Resolution unclear. Nursing, England – year unknown):

- **Where Guidance exists it is not always followed**

A nursing student contacted the Royal College of Nursing (RCN) as she had been tested as Positive for HIV and the university was trying to prevent her from continuing the course. The RCN supplied her with the Department of Health guidance on 'infected health care workers'. The Department of Health's Guidance on Health Clearance for Serious Communicable Disease (2003) proposes that trainee nurses would not be required to undertake screening for blood-borne viruses, because they are not required to undertake 'exposure prone' tasks before registration, whereas student midwives, doctors and dentists would be required to do this.)

The review includes one case concerning the *registration* of a nurse.

- The Court of Appeal decision in R on the application of Hamilton and (1) the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and (2) Nursing and Midwifery Council[8] concerned the registration of Ms Hamilton, a state registered nurse and midwife. Ms Hamilton's registration had been suspended on health grounds by the UKCC in May 1999 – for an unspecified period – because she had been diagnosed with bi-polar affective disorder. The Health Committee had found that Ms Hamilton's practice was seriously impaired by reason of her mental condition. In May 2000 she applied for the suspension to be terminated.

  This was refused because: '…we are persuaded that the weight of medical evidence indicates that you do suffer from a psychiatric disorder, and what gives us particular concern is that you lack insight that would enable you to recognise and manage your condition, should you have a relapse. The medical advice is that it would benefit you to be in formal contact with the psychiatric service, and we consider this to be a minimum requirement before any further application for the termination of your suspension is made.'

  Ms Hamilton sought a judicial review of this decision but her claim was rejected. She then appealed to the Court of Appeal. A key issue before the court was the absence of any express power in the NMC's rules to terminate suspension conditionally. It only had two options – to terminate the suspension of the registration or not to do so. The Court of Appeal approached the legal issues 'on the footing that there was cogent expert evidence to the effect that Miss Hamilton was currently symptom free but at risk of relapse, and that the consequent risk to the public was capable of being met if, but only if, acceptable counselling and monitoring measures were put in place.'

  The Court of Appeal accepted that Ms Hamilton 's case fell into category requiring the Health Committee only to be satisfied that the risk of relapse would be adequately contained – if there was evidence before them that satisfies them that it

[8] 23rd October 2003

will be, they could terminate the suspension. Although the Health Committee had no power to terminate suspension on express conditions, the Court of Appeal considered that where there is evidence that arrangements for containing the risk of relapse could be, but have not been made, they could adjourn. Thus the Court of Appeal considered that the (then existing) rules provided a solution that would have enabled Ms Hamilton to have secured the termination of her suspension from the register within a relatively short time. Accordingly the appeal was dismissed.

4.5 Victimisation

Sections 55(1) and (2) of the DDA prohibits victimisation. This is defined as arising when an employer, trade organisation, qualifications body or education provider treats someone (the victim) less favourably than he treats or would treat other people in the same circumstances because the victim has:

- brought or given evidence or information in connection with proceedings under the Act (whether or not proceedings are later withdrawn), or
- done anything else under or by reference to the Act, or
- alleged that someone has contravened the Act (whether or not the allegation is later dropped), or
- because the person believes or suspects that the victim has done or intends to do any of these things.

The victim does not have to be disabled to experience victimisation.

4.6 Harassment

Section 3B(1) and Section 28SA(1)3 of the DDA prohibit harassment, defined as where, for a reason that relates to a person's disability, another person engages in unwanted conduct that has the purpose or effect of violating the disabled person's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for him.

4.7 The Disability Equality Duties

Section 3 of the DDA 2005 inserts new sections 49A – 49F to the DDA 1995. These impose a general duty on every public authority to have due regard to the need to:

- promote equality of opportunity between disabled persons and other persons;
- eliminate discrimination that is unlawful under the Act;
- eliminate harassment of disabled persons that is related to their disabilities;
- promote positive attitudes towards disabled persons;
- take steps to take account of disabled persons' disabilities, even where that involves treating disabled persons more favourably than other persons;
- encourage participation by disabled persons in public life.

Regulations require each listed authority (such as the NMC) to publish a Disability Equality Scheme, which will set out how they intend to fulfil their general duty and set out certain things that must be done in relation to this.

4.8 How these legal requirements apply to the nursing sector: Competence standards

Sections 14A(5) and 28S(11) of the DDA define a competence standard as an academic, medical or other standard applied by or on behalf of a Qualification Body or an Education Provider for the purpose of determining whether or not a person has a particular level of competence or ability.

Competence standards are, effectively, entry and assessment criteria. Reasonable adjustments do not have to be made to competence standards. However, they do need to be made to the way that the standards are assessed or performed. For example, a competence standard may involve effective use of a stethoscope; students with hearing loss may have to experiment with different combinations of electronic stethoscope and hearing aids until the process works effectively for them.

In addition, the application of a competence standard can only legally justify less favourable treatment if the qualifications body or education provider can show that the standard is (or would be) applied equally to people who do not have the individual's particular disability and that its application is a proportionate means of achieving a legitimate aim.

Furthermore, some requirements or conditions will not constitute competence standards because their purpose, whilst entire legitimate, is not to demonstrate a particular level of relevant competence or ability. For example, it may be that there is a requirement to undertake a certain skill or ability within a fixed period of time. The reasonable adjustment duty of the DDA will apply to such requirements falling outside the legal definition of 'competence standards'.

Finally it should be noted that the application of a competence standard is not a defence to direct discrimination. The Trade Organisations and Qualifications Bodies Code of Practice (paragraph 8.39) states that the application of a Competence Standard involving medical requirements which are based on stereotypical assumptions about the health and safety implications of disability generally, or about particular types of disability, is likely to be directly discriminatory and therefore unlawful.

However, *genuine* concerns about health and safety may be relevant to the justification of a Competence Standard concerning a medical requirement, (paragraph 8.40). Care thus needs to be taken therefore to ensure that any purported standard does not amount to direct discrimination and can be objectively justified[9].

[9] Guidance given in the Trade Organisations and Qualifications Bodies Code of Practice includes: 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

The DRC's examination of the legal background of medical standards stares: 'It is not clear that in all the circumstances these requirements relate to the ability to do the job in question and where these do not, they will therefore not constitute genuine competence standards. Such health or physical /mental fitness requirements are therefore more likely to give rise to direct discrimination. If for example, a qualifications body, such as the NMC, refused to register a disabled person on the basis that because of their disability they could automatically not satisfy a good health or fitness requirement (that is, on the ground of their disability) but registered a person with a different disability or no disability with the same qualifications, this would amount to direct discrimination'. [10]

4.9 How does the DDA relate to other legislative requirements?

Section 59 of the DDA provides that nothing is made unlawful by the Act if it is required by an express statutory obligation. However, as the statutory Codes make clear it is only in cases where a statutory obligation is specific in its requirements, leaving an employer, trade organisation or a qualification body with no choice other than to act in a particular way that the provisions of the Act may be overridden: 'The provision in Section 59 of the Act is thus of narrow application, and it is likely to permit disability discrimination only in rare circumstances'.

4.10 Northern Ireland

While the DDA extends to the whole of the United Kingdom, separate secondary legislation and Codes of Practice exist for Northern Ireland. Schedule 8 of the DDA sets out the modifications which apply to its application in Northern Ireland.

The Special Educational Needs and Disability (Northern Ireland) Order 2005 (SENDO) covers disability discrimination in the field of education. SENDO extends protection to young disabled people in schools and disabled persons in further and higher education, providing equivalent protection to the contained in SENDA for other parts of the United Kingdom.

Disability Discrimination (NI) Order (DDO) 2006 requires public authorities to develop disability action plans which set out how they will promote positive attitudes towards disabled people and encourage the participation of disabled people in public life. Section 75 of the Northern Ireland Act 1999 introduced new duties on public authorities to promote equality of opportunity and good relations in relation to disabled people, as well as on other ground

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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; documenting the manner in which these issues have been addressed, the conclusions which have been arrived at, and the reasons for those conclusions. This approach also reflects the requirements of the disability equality duty – in particular, the need to assess activities for their impact upon disability equality.

[10] Background to the Disability Rights Commission's Formal Investigation into Fitness Standards in Social Work, Nursing and Teaching Professions, Chih Hoong Sin et al. (DRC 2006) p. 42

4.11 European law

The European Employment Framework directive (Article 16) provides that 'member states shall take the necessary measures to ensure that:

'Any laws, regulations and administrative provisions contrary to the principle of equal treatment are abolished;

'Any provisions contrary to the principle of equal treatment which are included in contracts or collective agreements, internal rules of undertakings or rules governing the independent occupations and professions and workers' and employers' organisations are, or may be, declared null and void or are amended.'

The DRC Review comments: 'It is possible that some of the legislation referred to in this report may be contrary to the principle of equal treatment and, as such, that steps would be needed to address this.'

4.12 Relevant health legislation

The Nursing and Midwifery Order 2001 (made under the provisions of the Health Act 1999 as amended) established the Nursing and Midwifery Council (NMC). The NMC's principal functions are to establish and maintain standards of education, training, conduct and performance for nurses and midwives. Its remit applies to England, Scotland and Wales.

The Nursing and Midwifery Order 2001, which established the Nursing and Midwifery Council, requires that there should be evidence of 'good health and good character' on the part of nurses for the purposes of registration. The 'Nursing and Midwifery Council (Education, Registration and Registration Appeals) Rules 2004' set out further procedures, amongst other things, as to who may give evidence as to "good health and good character'.

However, no further detail as to what these mean is given. Part 4 of the Order also mentions that the NMC should establish the education and training standards and the requirements to be satisfied for admission to and continuing participation in, such education and training, which may include requirements as to good health and character.

The 'Nurses Agency Regulations 2002' (for England) and the 'Nurses Agency (Wales) Regulations 2002' regulate nursing agencies and, essentially, require that a person wishing to be registered to provide a nurses agency must be "physically and mentally fit" to carry on the agency, as must be the registered manager and any nurse supplied.

The 'Regulation of Care (Requirements as to Care Services) (Scotland) Regulations 2002' regulate health care professions including nurses and, similarly, refer to the need for 'fitness'; particularly to 'physical and mental fitness' where someone is employed in the provision of care services.

The NMC's 'Standards of proficiency for pre-registration midwifery education guidance', (March 2004) established fifteen standards relating to pre-registration midwifery education, including good health and good character. In relation to good health and good character, the guidance details further procedures, including routine health screening and occupational health assessments. The NMC's 'Standards of proficiency for pre-registration nursing education', (February 2004), almost mirror those for pre-registration midwifery education.

The NMC's 2004 'Standards of Proficiency' for pre-registration nursing and midwifery state that the NMC requires evidence of how disabled people will be supported in both the academic and practice environments. In addition, the NMC's 2004 UK 'Standard and Framework for Quality Assurance of education programmes leading to the registration or recordable qualifications with regard to nursing, midwifery and specialist community public health nursing', specifically mentions the need for support mechanisms for students.

The NMC's 2004 'Standards of Proficiency' for pre-registration nursing and for pre-registration midwifery provide that programme providers should, in relation to the selection and recruitment of disabled students or employees, apply their own policy in accordance with the DDA.

5. Policy context – some key issues that emerged

A number of particular issues arise in relation to the literature.

5.1 Understanding of disability

How disability is understood is critical to challenging discrimination against disabled people and delivering workforces and services that are inclusive, productive and holistic. In the last 25 to 30 years the social model of disability has become widely accepted and forms the basis of challenging disability discrimination. This framework distinguishes between impairment and disability. It contrasts with medicalised approaches, whereby people are viewed through the prism of impairment. The social model can help to address the lack of awareness that limits the potential of disabled nurses and midwives to be employed fairly and equally.

Considered via the social model: 'the poverty, disadvantage and social exclusion experienced by many disabled people is not the inevitable result of their impairments or medical conditions, but rather stems from attitudinal and environmental barriers'[11]. A person is disabled by their impairment as a result of how societies and social structures are organized and from the attitudes, assumptions, rules and regulations that result from and sustain these structures.

The social model is a significant challenge to the prejudice and discrimination against disabled people. As has been pointed out, 'the social model of disability is not static, it is a way of understanding the relationship between disabled people and contemporary society, and the disadvantages they face'[12]. The dynamic and flexible potential of the social model is reflected in much of the guidance on reasonable adjustments, and in the benefits – to individuals, patients, employers and employee and training cohorts – where it is put into practice. With regard to social work the same source considers that 'the social model of disability has become the most important challenge to the way in which disability is understood by social workers' and to the ways in which 'social services departments respond to the problems of disablement'.

In regard to nursing and midwifery, the social model and equality legislation, also offers a challenge to exclusionary and prejudicial attitudes. An academic review of the experience of disabled registered nurses said that 'prior to 1995, it was still the accepted management practice, in both the private and public sectors, to terminate the employment of persons significantly affected by an adverse change in their health status'[13]. The same source details the sorts of attitudes that lay behind such practices:

'I couldn't employ a nurse in a wheelchair because clearly how would she get around, and how quickly could she respond to situations', Nurse Director, October 1999.

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[11] The Duty to Promote Disability Equality, Disability Rights Commission, 2005

[12] Access to Practice, Overcoming the barriers to practice learning for disabled social work students, Sapey, Turner, Orton, 2004

[13] Fit for nursing? A qualitative analysis of disabled registered nurses' and other health professionals' views on health and illness in relation to nursing employment, A. Grainger, February 2008.

'I don't take on lame staff and I don't expect my colleagues to take mine either...I have in the past allowed a nurse to stay on because occupational health advised...It was a disaster.' Nurse manager, October 1999

Attitudinal change has been pushed forward by the DDA and subsequent anti-discrimination legislation. While the legislation incorporates a more limited formal definition of disability, as a whole it focuses on the social barriers that exclude and 'make' people disabled. As a result – and as is being felt in nursing and midwifery education and employment – it 'provides an essential tool to removing disabling barriers'[14].

5.2 Clients or colleagues?

Related to the issue of how one understands disability and disability discrimination, is the degree to which disabled students and employees in nursing and midwifery, and in the broader area of health and social work professions, are seen as 'clients' rather than as workers. With regard to social work researchers have identified a tendency not to see disabled people as having 'a legitimate professional identity in a context where they are more usually characterised as service users', a tendency with 'may act as a significant career barrier for social workers with disabilities'[15]. A case study graphically illustrated the point: 'a circular from the Chief Executive's department was tabled for discussion at the meeting of senior managers of the disability service. This asked all managers to review their access to people with disabilities as the authority wished to improve its provision and to be able to claim to be an equal opportunity employer. After a very brief discussion all the managers agreed that this did not apply to their department as people with disabilities were their clients, not their employees.[16],

This paternalistic tendency could be considered to be reinforced in a situation where competence standards for professional practice are, in part, assessed in terms of 'health' and 'disability' per se. Again both the DDA and the broader concept of the social model of disability are tools for challenging assumptions which will tend to deter and discourage disabled people.

5.3 Data

A review of the literature reveals a lack of empirical data about the proportions of disabled people in working as or training to be nurses or midwives and who are disabled. Concerns were expressed (e.g. in the NMC's recent 'Have your Say' consultation events, and in the Expert Panel meetings[17]), about likely limitations of any data collected – people often do not identify as disabled thereby the figures can

[14] Access to Practice, Overcoming the barriers to practice learning for disabled social work students, Sapey, Turner, Orton, 2004
[15] Access to practice, SWAP, 2004.
[16] Ibid.
[17] Have Your Say on Equality and Diversity Report, June 2008; Expert Panel of Disabled People, meeting 12 June 2008. Also see: The Employment of Disabled People in the Public Sector: A Review of Data and Literature Hirst, Thornton, Dearey, Social Policy Research Unit, University of York, and Sue Maynard Campbell, Equal Ability Limited, for the DRC, November 2004

understate the real situation, a fear of discrimination (even if anonymity is assured) may lead to non-disclosure) – but these concerns do not outweigh the difficulties created by a lack of any meaningful quantitative data. Such lack makes measurement of change impossible and the very fact of collecting it, if done well, can be part of a positive process of validation and promotion of equality – the process of conducting this review has underlined the need for data collection.

5.4 Monitoring

Connected to the issue of collection of data is that of monitoring change. Some examples of data collection with a view to providing a basis for monitoring change were found. For example, the General Dental Council undertook collection of data on the profile of the dental Register and found this revealed that a 'very small percentage of our registrants consider that they are disabled'. As the GDC noted, the small proportion showed the importance of equality measures, including 'the education of the dental team'. Monitoring of the pattern of change and the implementation of policies, based on data collection, is essential to allow for judgement on the success of otherwise of policies.

5.5 Disclosure

It is obvious that unless registrants declare a disability, there is not the opportunity for training providers or employers to consider and provide reasonable adjustments. However, it is also clear that considerable apprehension exists among student and qualified nurses and midwives about the potential negative effects they will experience if they disclose. Research into the experiences and conclusions of disabled professionals in disclosing concluded that 'disclosure of disability was considered to be a high risk strategy which could have the effect of excluding an individual from training or employment and affect progression in the professions'[18]. Insofar as discrimination continues to pervade the profession, a proportion of disabled people will, where possible, fail to disclose, and therefore sometimes deprive themselves of support that would make enhance their personal and professional experience. A determined push by the NMC will be required to help promote a culture of non-discrimination and the inclusion of disabled people as nurses and midwives.

5.6 Resources

Promoting equality for disabled people in accessing and retaining professional employment is not simply a matter of social justice. It also has significant positive resource implications. The nursing and midwifery professions are entitled to choose from the widest range of potential recruits. Excluding or discouraging applicants who have disabilities that are no impediment to their potential professional competence means imposing an unnecessary limitation on the resources available to the profession. Additionally, the profession and health care delivery can benefit from the

[18] Disclosing Disability: Disabled students and practitioners in social work, nursing and teaching , Stanley et al, Social Care Workforce Research Unit (for DRC), September 2007.

attributes that many disabled people will carry with them – an argument in favour of the greatest workforce diversity in general. As one disabled nurse explained: '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.[19]' Disabled professionals may serve as both role models for other disabled people and, aided by increasing numbers and visibility and backed by a strongly non-discriminatory ethos by managers and regulators, raise awareness and improve attitudes in ways that can have diverse positive benefits.

Furthermore, as disability is associated with age, many qualified nurses and midwives will become disabled in the course of their working lives. Experienced nurses and midwives will have accumulated a range of skills that represent an investment of time and money by their employers and by them as individuals. There is no need for this skill base to be lost if employers can understand how 'reasonable adjustments' can secure staff retention.

5.7 Nursing competencies and reasonable adjustments

The need for clear guidance on necessary professional competencies for nurses and midwives is a further issue that arises from a review of the guidance'. The legal context and NMC's commitment to a non-discriminatory competency based standards system that 'does not rely on the language or categories of 'good health' standards'[20] has already been set out.

Some strong examples of competency based standards have been identified in this review. The **General Medical Council**'s guidance has been referred to above, and is further analysed in detail in section six below. It includes explanation of what is meant by a measurement of competency: 'a requirement that a student should be able to complete a task within a certain time would only constitute a genuine competence standard if speed is an intrinsic part of the task'[21]. This points to the need for consideration of what a competency or reasonable standard would be: if clear records have to be kept does it matter how they are kept? These are issues that are actively being addressed by nursing schools around the country. The **University of Ulster**[22] is an example of an HE body that has given consideration to ensuring competence standards do not explicitly or inadvertently discriminate and urges institutions to 'examine 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 points out that 'stating that a certain personal, medical or health-related characteristic is necessary or preferable can lead to discrimination if the characteristic is not necessary for the course'.

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[19] Maintaining Standards Promoting Equality, Disability Rights Commission, September 2007
[20] Briefing Note – Good Health Standard follow up on DRC report, NMC, 2008
[21]. At: http://www.gmc-uk.org/education/undergraduate/undergraduate_policy/gateways_guidance/5_5_tomorrows_doctor.asp
[22] Developing Competence Standards, Staff Guidance Booklet, University of Ulster, http://www.equality.ulster.ac.uk/staff-guidance.html With thanks to Angela Getty, Equality and Diversity Officer.

5.8 Health and safety

Research on the experience of disabled social work students reported misuse of 'health and safety' arguments to not employ disabled students[23]. The DRC's Code of Practice says that 'health and safety issues must not be used spuriously to avoid making a reasonable adjustment'[24]. The GMC's guidance points out that: 'Risk management should be an ongoing process undertaken in consultation with disabled students. However, health and safety must not be used as an excuse to avoid making reasonable adjustments'[25]. The better guidance documents identified in this research, raise a warning against use of 'health and safety' or 'risk' arguments to defend discriminatory practices.

5.9 Occupational Health services

Occupational health services have a central role in assessing disability and recommending adjustments in training and workplace settings. Therefore it is important that such services are well informed on disability equality and that occupational therapists are adequately trained to assess the needs of disabled employees and recommend appropriate reasonable adjustments.

The DRC's report of its Formal Investigation sounded a note of caution, saying that: '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'. It underlined this concern saying 'There are inconsistencies in the use of occupational health services. For example, for nursing courses, some universities use NHS occupational health services while others use services specifically for higher education institutions. Different services are likely to be assessing students for different things, for example whether they can complete the course or whether they are likely to be able to practice as a nurse'.

The NMC may therefore wish to include guidance or considerations about minimum standards for occupational health services in its final conclusions or guidance in this area.

5.10 Enforcement

The literature gathered in this report shows that the approach to employment equality for disabled people and to reasonable adjustments varies greatly between workplaces and education providers. Guidance from the NMC would play an important role in setting clear standards. However, enforcement of the legal obligations on employers will remain important – perhaps even increase in the context of greater clarity on what must be done. The Royal College of Nursing's *Disability Equality Scheme* calls on

[23] The PEdDS Project: disabled social work students and placements, Wray et al, The University of Hull, 2005
[24] http://www.equalityhumanrights.com/en/publicationsandresources/Pages/CodeofPracticepost16education.aspx
[25] Gateways to the Professions, Advising medical schools: encouraging disabled students, GMC and Department for Innovation, Universities and Skills, February 2008.

‘regulatory bodies within health and social care to bring monitoring compliance within the scope of their inspection regimes’[26]. This may be a proposal the NMC wish to consider.

[26] Disability Equality Scheme, RCN, February 2007

6. Review of guidance

The terms of reference for this literature review were to identify and collate guidance relating to reasonable adjustments in the workplace and education setting for nurses and midwives and other relevant health professionals. The literature search found a very mixed picture in terms of existing guidance. This included some very clear policy and good, practical and accessible guidance – such as provided by the General Medical Council, the Chartered Society of Physiotherapists and some local schools of nursing and education providers.
With regard to nursing, a number of examples of policy, and to some extent practical guidance on reasonable adjustments, were found at the level of training and education.

Guidance specific to midwifery was not found. It was more difficult to locate examples of guidance in use in employment than in relation to training and placements for students.

A particular thread of guidance exists in relation to students with dyslexia. This is a positive development in itself, but draws attention to the scarcity of broader disability guidance of a practical character or in relation to a range of impairments. The British Dyslexia Association estimates that up to 10 per cent of the workforce may have dyslexia and feedback from nursing schools in the course of preparing this report has been that students with dyslexia often form a significant single block in a learning environment. These factors may partly explain the particular attention given in the literature. Another may be the concern specifically in nursing about accurate recording and communication, assumptions about which can lead to discrimination against people with dyslexia and other learning disabilities, to people who are Deaf, or with other impairments or conditions. Feedback from sources discussed with suggested it may also be a positive reaction to past criticism over attitudes and practices towards individuals with dyslexia.

6.1 General Guidance on employment of disabled people in health

The **Department of Health** published *Looking beyond labels: Widening the employment opportunities for disabled people in the new NHS in 2000*[27], which sets out the obligations of NHS employers to avoid disability discrimination in health service employment and explains reasonable adjustments. In regard to job descriptions and recruitment, the advice is 'Do not introduce selection criteria such as "must be in good health". Disability is not the same as ill health. Employers who view a disability as a health or sickness problem, and do not give any consideration to possible adjustments, may run the risk of litigation under the DDA' – advice contradicted the next year by the terms of the Nursing and Midwifery Order 2001. Under 'staff retention' reasonable adjustments are considered. Some nursing specific examples are given, such as under:

[27] Looking beyond labels: Widening the employment opportunities for disabled people in the new NHS, Department of Health, 2000.

‘A psychiatric nurse with contact dermatitis is issued with special gloves to wear whilst he is working.

‘A nursing auxiliary with a hearing impairment is provided with a badge that says "lip reader please speak clearly’.

General legal requirements for education providers along with advice on what is meant by reasonable adjustments, preparation of placements for disabled students, practical advice and case studies, and good practice, was set out in advice from the **Department for Education and Skills** (DfES) in 2002. *Providing Work Placements for Disabled Students*[28] explains that ‘institutions must take action to ensure disabled students have the same opportunities as others to benefit from work placements’. The guidance identifies key issues that should be considered in terms of reasonable adjustments, such as flexibility, monitoring, discussion and involvement of the student in deciding the adjustment.

The guidance refers to nursing to point out that while ‘all placements are covered by the DDA...certain professional vocational courses, such as medicine, nursing and teaching, have particular accreditation requirements which are controlled by external bodies, not by the institution’. It advises that ‘institutions are not expected to make adjustments that might prevent the work placement component of the course being accredited’ and ‘these issues should be discussed with students at the admissions stage so that any necessary alternative ways of assessing courses can be explored’ but underlines that ‘The DDA does not require institutions to make adjustments that would compromise the maintenance of academic or other standards appropriate to the course or learning programme’. Further explanation is not given and none of the case studies refer to nursing (although adjustments for social work placements are included). This creates a somewhat negative impression of the potential for adjustments in the nursing context. The **DfES** also produced *Finding out about people’s disabilities – a good practice guide for further & Higher Education Institutions*, in 2002. This sets out summary guidance on legal obligations to anticipate students needs and to make reasonable adjustments.

The **Quality Assurance Agency for Higher Education (QAA)**, established in 1997, is intended to provide independent assessment of how higher education institutions in the UK maintain their academic standards and quality. QAA produced guidance in 1999: *Code of practice for the assurance of academic quality and standards in higher education*[29]*.* This was prior to the extension of the DDA to education, but included advice on vocational placements, including that institutions should seek ‘placements in accessible contexts’; provide ‘experiences where comparable opportunities are available which satisfy the learning outcomes’; work with placement providers ‘to ensure accessibility’ and provide support; before, during and after placements that takes account of the needs of any disabled students, including transport needs’.

[28] Providing Work Placements for Disabled Students – A good practice guide for further and higher education institutions, Department for Education and Skills, 2002.
[29] http://www.qaa.ac.uk/academicinfrastructure/codeOfPractice/section3/COP_disab.pdf. Also relevant is the Code of Practice on Placement Learning (2001) http://www.qaa.ac.uk/academicinfrastructure/codeofpractice/section9/default.asp

The **Department of Health** published *Mental Health and Employment in the NHS*[30] in 2002. It states: 'NHS employers should ensure their policies and procedures comply with the Disability Discrimination Act 1995' and that 'No applicant should be refused employment on health grounds unless expert occupational medical advice has been sought' and that 'No person should be refused employment, or have their employment terminated on mental health grounds without the NHS employer first having made any adjustments that it would be reasonable to make in relation to that person in accordance with any duty placed upon them by the DDA'.

The report attempted to correct the myths and prejudices encouraged by the Beverly Allitt case and responses to it, particularly the Clothier Report, published in 1994. It set out legal responsibilities, suggestions on awareness-raising, and contains *Guidance to Employers on Advertising Posts, Recruitment, and Interviewing of People with Mental Health Problems*, within which it refers to reasonable adjustments. No precise workplace or training guidance is given. Practical and accessible advice on reasonable adjustments for people with mental health issues is provided by a range of sources, most of which are not specific to nursing[31].

The former Disability Rights Commission's report of its Formal Investigation commented on the negative impact of the response to the Beverley Allitt, noting that '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'[32]. As the report points out, this can mean that individuals 'do not receive appropriate treatment, support and adjustments to enable them to practise safely and effectively'. As the NMC will be aware, the DRC's examination of the Clothier report 'found inconsistencies between the evidence and analysis it presented and its findings and recommendations'.

The **DoH** has also produced practical guides, such as *Guidance for line managers in managing mental distress and illness in the workplace*[33], which offers best practice guidance for line managers. This offers advice on avoiding discrimination, and supporting people with mental health problems including through simple adjustments, but is not specific to nursing or medical professions.

Updated guidance in relation to health care workers who are HIV positive or have AIDS was issued by the **Department of Health** in 2007[34]. This points out that it is 'unlawful to discriminate against disabled persons including those with symptomatic AIDS or HIV infection in any area of employment, unless the employer has justification

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[30] Mental Health and Employment in the NHS, Department of Health, October 2002

[31] Such as RADAR (www.radar.org.uk), Equality and Human Rights Commission (www.equalityhumanrights.com), MIND (www.mind.org.uk), Scottish Association for Mental Health (www.samh.org.uk).

[32] Maintaining Standards Promoting Equality, Disability Rights Commission, September 2007

[33] Line Managers' Resource – Guidance for line managers in managing mental distress and illness in the workplace, Shift/Department of Health, October 2007.

[34] HIV Infected Health Care Workers: guidance on management and patient notification, Department of Health, February 2007.

because of a material and substantial reason. The restriction of such a worker for the purpose of protecting patients from risk of infection, such as the requirement to refrain from performing exposure prone procedures, would justify such discrimination. However, the employer who knows that the worker is disabled has a duty to make reasonable adjustment, e.g. by moving the worker to a post, if available, where exposure prone procedures could be avoided'.

It further points out that 'Occupational physicians are well placed to act as advocates for the worker on issues of retraining and redeployment, or, if indicated, medical retirement' and goes on to say that 'occupational health departments have a key role to play in developing local policies for the management of infected health care workers' future employment'. These points on the role of occupational health services highlight the importance of ensuring that occupational health workers are themselves adequately trained to assess the needs of disabled employees and recommend appropriate reasonable adjustments.

The document states that states that 'General nursing procedures do not include EPPs [exposure prone procedures]. The duties of operating theatre nurses should be considered individually. Theatre scrub nurses do not generally undertake exposure prone procedures. However, it is possible that nurses acting as first assistant may perform EPPs' and that the 'only exposure prone procedures routinely undertaken by midwives are repairs following episiotomies and perineal tears: category 1 in the case of first degree lacerations; category 2 in the case of second, third and fourth degree lacerations. Repairs of third and fourth degree tears are normally undertaken by medical staff who may include general practitioners assisting at births in a community setting'.

The front page of the nursing section of the **NHS Careers** website has no reference to disability and reasonable adjustments but states: 'All HEIs must satisfy themselves that applicants to pre-registration programmes are of good health and good character sufficient for safe and effective practice as a nurse. All HEIs will require satisfactory health clearance for all applicants. If you have a particular problem that you think may affect your ability to work or study, or if you have any questions about health requirements, contact the HEI(s) to which you plan to apply. For guidance regarding communicable diseases, visit the Department of Health website'[35]. We consider that this guidance would be improved by separation of professional competence requirements from reference to health, and by a positive reference to disability, making it clear that reasonable adjustments are available.

NHS Employers have produced *Returning to Work, Working Longer, Working Healthier in the NHS*[36], which is described as a 'toolkit which recognises that people within our workforce may have complex mental or physical health conditions that - whilst not hampering their full contribution at work - may benefit from greater understanding, adaptations or work design. Included in these complex situations would be chronic conditions like arthritis, asthma or diabetes, or stress and clinical depression. Often these conditions could be better supported at work, which may enable people to work longer, not seek Ill Health Retirement, and help the NHS as a

[35] http://www.nhscareers.nhs.uk/details/Default.aspx?Id=1944
[36] http://www.nhsemployers.org/pay-conditions/pay-conditions-2619.cfm?frmAlias=/workplaceadjustments/

good employer to attract and retain talent'. The toolkit is said to be a 'decision making tool that may be used by anyone in an HR role, line manager position, occupational health, trade union rep, individual employee or potential employee. The framework helps people to ask a series of appropriate questions to enable them to find answers and solutions to unique sets of issues'. There are two 'checklists' for employers. The checklist entitled Fit for the present has a section on '*When considering chronic medical conditions/disability*'.

The checklist questions are:

'What polices do we need to develop to support and enable employees who develop chronic long term conditions, and who may require adjustments at work in the future?
How can occupational health help us to consider these potential future issues?
How much do we understand about long term chronic medical conditions (e.g. arthritis, diabetes) and can we learn from some of the services we provide to patients with long term conditions as to how we can support our own employees?
What organisations could we contact/work with who can advise us about employing and retaining staff with a long term chronic condition or a disability (e.g. Employers' Forum on Disability, Remploy)?
Do we need to establish any relationships with organisations that can help us and our employees with long term medical conditions?
What plans do we have to attract returners to work who may have a chronic condition or a disability?
Do we know about the Expert Patient Programme (and other similar programmes) which enable better self management for people with chronic conditions? Where is the local expert patient programme that staff could potentially use if they develop a long term condition in the future?'

The website of the former **Disability Rights Commission**[37], contained a range of general guidance on reasonable adjustments, such as *Guidance for Qualifications Bodies*[38] which explains the responsibilities of qualifications bodies, including the NMC, from October 2004 and gives a number of examples of discrimination, reasonable adjustments and links to the relevant Codes of Practice.

Into Nursing and Midwifery – positive experiences of disabled people, has been produced by **Skill**[39] and contains practical ideas about routes into nursing, support available and six case studies of disabled students or nurses. The case studies are the most positive feature of the publication. They are very positively and accessibly presented, and an example of the fact that there is no substitute for disabled people talking directly about their own experience.

[37] Now incorporated into the Equality and Human Rights Commission

[38] http://83.137.212.42/sitearchive/drc/employers_and_service_provider/employment/guidance_for_qualifications_bo.html

[39] www.skill.org.uk The National Bureau for Students with Disabilities, Skill is a national charity promoting opportunities for young people and adults with any kind of impairment, learning difficulty or health condition in post-16 education, training and employment.

The pamphlet is a good example of simple, effective presentation of information for disabled people – particularly the significant space given to disabled nurses and midwives to speak for themselves.

The pamphlet would be improved by more explicitly setting out the meaning of and right to 'reasonable adjustments' in training and at work. As with other publications reviewed, it attempts to explain the meaning of 'good health' requirements.

We quote from two examples of the case studies:

'I am a midwife working for Liverpool Women's Hospital NHS Trust...During my midwifery training, at the age of 24, I became ill and was diagnosed with neuromafibromatosis...a genetic disorder...Day-to-day activities affected are mobility, coordination, balance, manual dexterity, ability to lift/carry objects and hearing...My disabilities meant that my work as a rotational midwife in all the clinical areas had to cease. However, new opportunities...came along...The adjustments/equipment I have in place are: reduced hours, flexible working, a reserved car space, an electric office chair which can take me on and off site, a wheelchair accessible workstation, electronic office equipment, and a headset for the telephone.'

'When I applied to do nursing the second time, one university, out of four that I had applied to, was willing to see beyond my deafness and I was truly impressed by their positive attitude towards me...My support was funded by the NHS student bursary which had a fund for disabled students...the experiences I had whilst on placements...were mainly positive...I felt so useful when it came to lip-reading those who could not use their voice as they had a tracheotomy in place and staff would be calling me over to assist them with their communication skills! Being deaf also gives me the advantage of being visually aware and heightened observational skills...As for worst experiences, I would say there are some but every nurse faced them regardless of whether they were hearing or deaf. It was mainly pure ignorance...Once I was working on a maternity ward...and on my first day, the handover was given by a tape recording...an older midwife looked at me with disdain and remarked that deaf people should not be nursing. I replied by saying that narrow-minded people should not be allowed to work as nurses!'

Skill has also expressed concerns about how nursing competencies are assessed: 'it is appropriate for qualification bodies to outline the competencies required by registrants, it is not appropriate to state prescriptively how these should be achieved. Particularly for disabled people, there might be reasons why practice is modified in order to be effective' and has given some practical examples: 'with regard to communication, a deaf nurse would need to meet the communication requirement, but could demonstrate this using British Sign Language with an interpreter. Equally, someone with a specific learning difficulty, who found it difficult to make hand-written notes, could use a computer to demonstrate their management of care'[40].

[40] Skill response to NMC Consultation on the future of pre-registration nursing education, January 2008

Strategies for Creating Inclusive Programmes of Study (SCIPS) has produced suggestions for reasonable adjustments, as advice to teachers and trainers, covering a range of disciplines, including nursing. In relation to nursing, reasonable adjustments and case studies covering students with 'auditory difficulties, language comprehension difficulties, memory/recall difficulties, mobility difficulties, motor/manual dexterity difficulties, organizational difficulties, stamina'[41]. Some of the case studies (e.g. nursing with mobility difficulties) are from sources in the United States. Case studies, illustrating adjustments made in practice, on dyslexia are of nurses/student nurses in Britain[42].

6.2 Healthcare regulatory bodies and professional bodies

Guidance by the healthcare regulatory bodies ranges from that which is up to date and which appears to have taken into account the DRC's investigation and its legislative context through to that which appears oblivious of the DDA and contrary to its spirit and content. Examples of the former, with guidance that, firstly, exists, and, secondly, is non-discriminatory in tone include the General Medical Council and the Health Professions Council.

The **Council for Healthcare Regulatory Excellence** is 'an independent body accountable to Parliament' whose 'primary purpose is to promote the health, safety and well-being of patients and other members of the public'[43]. The Council's website states that its function is to 'scrutinise and oversee the health professions regulators, working with them to identify and promote good practice in regulation, carry out research, develop policy and give advice'. However, the CHRE said it held no guidance on reasonable adjustments or disability.

Relevant **regulatory bodies** for medicine, health and healthcare were reviewed for guidance held. Websites were checked and in a number of cases the organisations were telephoned. Entry requirements of the **General Osteopathic Council** include 'a medical certificate of fitness'. Applicants are also told that they should 'be physically fit'[44]. The Code of Practice of the **General Chiropractic Council** says that members 'must seek and follow proper advice as to whether or how they should modify their own practice when patients may be at risk due to the chiropractor's own mental or physical health'[45]. No reference to guidance on reasonable adjustments was identified at the time of the review.

In the case of the **Royal Pharmaceutical Society**, no guidance was found on the website, but a note to a meeting of the society in 2005 was located on the website[46]. This records that the Society became a qualifications body in October 2004 and notes

[41] http://www.scips.worc.ac.uk/subjects_and_disabilities/nursing/nursing_hearing.html
[42] http://www.scips.worc.ac.uk/subjects_and_challenges/casestudies/nursing/nursing_language.html
[43] http://www.chre.org.uk

[44] http://www.osteopathy.org.uk/careers/entry_requirements.php
[45] http://www.gcc-uk.org/files/link_file/COPSOP_Dec05_WEB(with_glossary)07Jan09.pdf
[46] http://www.rpsgb.org/pdfs/coun0502-C-10.pdf

its obligations with regard to the DDA, its awareness of guidance from the DRC and a process that had been initiated to determine precise obligations to existing members and those applying to be registrants. The note says that commissioned consultants had surveyed disabled members of the Society, using the Pharmaceutical Journal. The consultants had advised the Society of the 'anticipatory duty', including 'the need to confirm what competencies are needed for the practice of pharmacy and how they could best be assessed' and 'the need to distinguish between setting the competencies and the mechanics of how they were assessed'. The paper noted that the Society wanted to look at what other bodies, such as the Health Professions Council, produced by way of guidance. No further information was located on the website and telephone contact with the Society did not result in guidance on reasonable adjustments being identified.

No guidance was identified for the General Optical Council or Pharmaceutical Society of Northern Ireland.

The **Health Professions Council** (HPC)[47] regulates the members of 13 health professions: arts therapists, biomedical scientists, chiropodists/podiatrists, clinical scientists, dietitians, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, prosthetists/orthotists, radiographers, speech and language therapists[48].

The Society produced *Managing Fitness to Practice – a guide for employers and registrants* (July 2007). This is very broad guidance. It advocates 'professional self-regulation' by registrants being self-aware about their own levels of competence and how these can vary. It states that registrants are expected to 'restrict or adapt their practice if anything (including their health, a disability, their skills or anything else) may affect their fitness to practise. This is a general expectation which applies to all registrants, not only those who consider themselves to have a health or disability issue, or those registrants who have told us about their health or disability'. An example is given:

'An example of how this might work in practice is taken from section 2b.5 of the standards of proficiency, which says that registrants must: **"be able to maintain records appropriately**
– be able to keep accurate, legible records and recognise the need to handle these records and all other clinical information in accordance with applicable legislation, protocols and guidelines".

'A registrant who knows that people cannot usually read her handwriting may take steps to print her notes in block capitals, or to type them up, to make sure that her colleagues can use them effectively. In this way, she is taking reasonable steps to adjust her practice to make sure that she meets the standard.

Other examples of registrants who may make adjustments to meet this standard include a registrant with sight difficulties who needs assistant or special software to

[47] www.hpc-uk.org
[48] See also advice and some examples of reasonable adjustments in placements and workplaces collated by the Training Strategy Group, Division of Clinical Psychology and the Professional Practice Board, published by the British Psychological Society, 2006

help them take their notes, or a registrant with dyslexia who might prefer to keep electronic notes. In each case, the registrant would have taken reasonable steps to make sure that they met this part of the standards of proficiency.'

The guidance points out that in the spirit of 'self-regulation' registrants could discuss 'reasonable adjustments' for disability with their employers, as one of a set of options ranging from getting medical help through to removing oneself from practice or the professional register. It advises registrants that they have certain rights under the DDA but does not go into detail. It advises employers that they have responsibilities under the DDA, including to make reasonable adjustments, but does not go into detail: 'We do not place any legal responsibility on you to change your employees' working conditions. We hope that as a good employer you would be flexible enough to support and keep an employee. As an employer, you also have certain duties under the Disability Discrimination Act, which may be relevant depending on the nature of the case. For example, by law, all employers must consider "reasonable adjustments" for disabled employees. Altering working hours or conditions can be considered a reasonable adjustment.'

The HPC has also produced *A disabled person's guide to becoming a health professional – a guide for prospective registrants and admissions staff* (August 2007)[49]. The guidance sets out the role of the HPC, the difference between being registered and being employed as a health professional, sets out legal protections, goes through a range of issues such as disclosing disability, standards of proficiency and scope of practice, and gives a number of examples of reasonable adjustments. The structure is clear and comprehensive and contains a number of case studies, though the specific guidance on potential reasonable adjustments – albeit that each case is an individual one – is limited. The case study examples relate to specific professional and competence issues.

For example, the guide addresses 'Meeting our standards' and says 'We need to know that these standards are being met, but we do not need to know how the standards are met'. It gives an example, as follows:

'A biomedical scientist uses British Sign Language (BSL), and has a BSL interpreter who works with her so that she can communicate with her colleagues. Using the BSL interpreter means that she can communicate effectively. So, she can therefore meet the standard of proficiency which says that anyone who registers with us must:
'be able to demonstrate effective and appropriate skills in communicating information, advice, instruction and professional opinion to colleagues, patients, clients, users, their relatives and carers'.

As an example of a potential reasonable adjustment to meet the requirement to 'maintain records appropriately' the following example is given:

[49] *A disabled person's guide to becoming a health professional – a guide for prospective registrants and admissions staff* , HPC, August 2007

‘If the person registering has dyspraxia (developmental coordination disorder), they may negotiate extra time with their employer to produce the patient records. This would be a reasonable adjustment.

‘Other examples of people who may make adjustments to meet this standard include someone with a sight difficulty who uses a dictaphone or adapted laptop computer to help them take their notes, or someone with dyslexia who might prefer to keep electronic notes. In each case, the person registering has taken reasonable steps to make sure that they met this part of the standards of proficiency.’

Examples of wrong information

The guidance sets out examples of incorrect information that disabled people may be given, saying ‘People may have different ideas about the abilities that you need to become a health professional, but sometimes these ideas are not true’. An example of incorrect information is:

‘**A person who uses a wheelchair is interested in becoming a radiographer. Her friends have told her that she cannot become a radiographer because she would not be able to get up stairs to the different wards.**
This is incorrect advice, because to be registered with us as a radiographer, the applicant needs to meet the professional standards for that profession. Being able to get up and down stairs is not a professional standard. (If she did become registered, it would be her employer’s responsibility under the Disability Discrimination Act to make reasonable adjustments that allowed her to practise.)’

A further example is given:

‘Admissions staff at a university are discussing someone who has applied to their chiropody and podiatry course. The applicant has told them that she has limited upper-body strength and the staff are concerned that she could not be a chiropodist because if she had a patient who became unconscious, she would not be able to move them.
If the admissions staff made a decision on this basis, it would be likely to be unlawful for
three reasons.
Firstly, because they would need to contact the applicant and get more detailed information,
such as an occupational health assessment or risk assessment (or both) before making assumptions about what she couldn’t do. Under the Disability Discrimination Act, the admissions staff need to avoid treating the applicant less favourably, and avoid using stereotypes and judgements on what disabled people can do.

The second reason is that the admissions staff would need to explore what reasonable adjustments could be made for the person to complete the course. They would need to make their decisions with the reasonable adjustments in mind.
The final reason why this would be unlawful is because being able to move an unconscious patient is not part of what makes someone a chiropodist. It is not in the professional standards for chiropody.'

Disclosure and good practice

The guidance encourages disclosure, reminding individuals of their legal rights against discrimination and sources of help if they think they have been treated unfairly. It also takes people through the different stages of post-graduation registration, health references and screening, and encourages disabled people to present the positive enhancements to their skills that being disabled may have meant.

In the advice for admissions staff, the guide also gives a number of practical examples under each theme. It discourages discriminatory assumptions and gives examples of how this can be done. It deals with 'practice placements' and points out that:

'It is important to realise that students **do not** need to be able to do all types of practice placement before they can register with us. Some disabled students may not be able to complete certain types of practice placement, but there may be other placements in which they would be able to learn and practise successfully. You should not assume that students cannot complete placements, or make judgements about certain disabilities.

Example – not making assumptions about the appropriate adjustment

A course team were considering the practice placements for a student occupational therapist who had a speech difficulty after having a car accident and a tracheotomy some years previously.
The speech difficulty meant that, when meeting new people, the student occasionally used strategies such as writing down what he wanted to say, to make sure that people understood him. The student had found that once staff, colleagues and students had some experience of communicating with him, they could understand his speech without him having to write it down.
The course team met the student to discuss the placements that would be most helpful to him. He said he was worried about practice placements and the barriers which he might face. The course team discussed with him the adjustments they could make. In particular, they offered to visit him before the placement started. They mentioned that all students on placements were visited at least once. They suggested to him that they could visit him during his first week, and again later in the placement if this would be helpful to him, and provide reassurance.
The staff discussed with him one particular placement available, which dealt exclusively with adults with communication disabilities. They discussed with him whether this placement would be appropriate or useful, as the patients' understanding of his speech could be a barrier to his learning on the placement and to the patients' treatment.

The student suggested that writing, his usual method of communicating with someone who could not understand his speech, may not be effective in this situation. They decided with the student that this placement was unlikely to be the most useful one, either for the student's learning or for the patients. However, this was not a barrier to him completing the course. The team agreed that there were other placements which he could complete and also agreed that avoiding this placement would not have a negative effect on his learning.
This example shows how you need to find placements which give your disabled students the best chance of showing how they meet our standards.'

The guidance points out that this example 'does not replace your extra responsibility to tackle inaccessible placements. You need to make sure that your placements are suitable for disabled students and also that you have a process for tackling placements that are not. Organisations that provide practice placements also have a direct duty not to discriminate against disabled people under the Disability Discrimination Act 1995.'

Some of the professions regulated by the HPC have developed or are in the course of developing their own guidance and policy.

For example, the **College of Occupational Therapists** runs an *online forum* for disabled occupational therapists, students and others in the field[50]. Discussions thread at the time of review included reasonable adjustments for blind therapists, those with physical impairments and mental health issues.

A well supported online forum of this type is a good practical tool which could be emulated by the NMC and promoted to members of the NMC register.

The College has also published a number of guidance documents including *Guidance on disability and learning* and *Responsibilities of the placement provider.* The former sets out legal responsibilities and protections and gives some examples of good practice. It sets out the responsibilities of placement providers and HEs to make reasonable adjustments, saying:

'There is also a duty to make reasonable adjustments in terms of provision for disabled students on practice placements. An example of this would be that where an HEI provides a laptop to a visually impaired student in the classroom, or to complete work, it would be reasonable to allow them access to a laptop during a practice placement as well' and that 'the duty to make reasonable adjustments applies…in the same way…to a university. The duty applies to both in respect of any provision applied for on behalf of the disabled student and to any physical feature of the premises occupied by the placement provider.

Examples of this that the code of practice supplies are:

[50] http://www.cot.co.uk/forum/intro.php

• Allowing a disabled person a part-time placement if their condition does not allow them to work full-time
• Providing an additional work station for the disabled student's assistant (if they have one)
• Giving a student with learning disabilities personal instructions on health and safety rather than written information.'[51]

A good example of guidance is that developed by the **Chartered Society of Physiotherapy**. *Supporting disabled physiotherapy students on clinical placement*[52] sets out advice for universities and learning environments, clinical placements and students. It was developed following the extension of legal obligations to education in 2002. Its focus is on supporting disabled students in clinical placements but it points out that the information will also be appropriate to workplace settings generally. The introduction points out that it was widely discussed among CSP members before publication and well received. The legislative framework is presented in an accessible and positive manner and there is considerable information on Access to Work and other support that is available, relevant organizations and the positive case for making reasonable adjustments. Each section – academic settings, clinical settings and advice for the student – is well structured, covering key issues as well as the different stages at which these can come up (from staff training, itemizing issues for regular staff meetings, systems for anticipating and planning placements through to detailed consideration of the kinds of issues that may come up at different stages, such as disclosure, policy on adjustments and practicalities of adjustments).

The issue of disclosure is dealt with, with it being pointed out that the 'academic setting must engender and atmosphere of safety and openness to encourage students to disclose appropriate information about their disability'. It is stressed that students do 'have the right not to disclose their disability or requirements'. Departments are encouraged to ask all students whether they have support requirements in advance of placements, and, in an atmosphere of having promoted a positive, inclusive culture towards disabled students and employees, thereby encourage disclosure.

Detailed information is provided on how to plan placements well so that they are most likely to work for disabled students. Universities are encouraged to plan placements for disabled students first, so as to allow sufficient time for support measures to be put in place. At the same time, the guidance warns against the negative impact if only certain 'special' hospitals or settings are seen as reserved as appropriate for disabled students. Monitoring is encouraged, as students' needs may change:

'A student with a visual impairment who initially requires a personal assistant support worker to facilitate mobility around a new environment may find that this is unnecessary once s/he is familiar with routes and staff members'.

51 http://www.cot.co.uk/members/publications/list/education/free/disability_learning/pdf/disability_learning0904.pdf

52 *Supporting disabled physiotherapy students on clinical placement*, Chartered Society of Physiotherapy, 2004

Chapter 4 of the guidance groups different impairments into five sections: dyslexia, visual impairments, mental health difficulties, 'students who are deaf or hard of hearing', and medical problems and physical disabilities. Overall, sections cover background issues, different manifestations and characteristics of impairments that should be considered, how to plan for these, practicalities of support (e.g. tutors, mentors and assistants), practical strategies and adjustments, placement management. Key issues such as record keeping are addressed, with the appropriate adjustments that can be made for blind students, and other students.
The sections vary in length, with that on physical disabilities being the most general, with the document noting this is a very wide ranging category. The following is an example of guidance provided in this section.

The following may be some of the issues that Clinical Educators would need to consider:

Physical access to the workplace itself and navigation around the premises
Availability and type of public transport especially if the placement is in the community
Availability of parking spaces for disabled users
Location and security of specialist equipment
Modification of treatment techniques possibly including the help of a Personal Assistant
Flexible working practices

The CSP's guidance is a useful model – and, if used, would be improved by the use of more case studies covering a wider range of disabled students, and by greater attention to students with mobility and physical impairments. Such examples are covered elsewhere in the literature.

Radiographers are a third group regulated by the Health Professions Council. The **Society of Radiographers** had a motion submitted to their 2006 Annual Delegates Conference, by the Society's Disability Network, which noted 'targets introduced by the Government to reduce waiting times to 18 weeks for any condition by December 2008' and called 'upon UK Council to highlight the importance of retaining highly skilled and experienced radiographers with disabilities and support the recruitment of disabled students by making reasonable adjustments to work environments and practices.' No specific guidance on reasonable adjustments in clinical practice for students or qualified radiographers was found on the society website.

A 'position paper' resulting from a conference of **Health Professionals Wales**[53] in 2005 usefully itemized good practice for making reasonable adjustments in practice for disabled health students. These included:

'Adjustments should, where possible, be agreed in advance of placement between education, service and the student. Adjustments must be kept under constant review throughout the student's placement and revised where necessary.

[53] Making reasonable adjustments in clinical practice for disabled health students, position paper, Jean White, Health Professions Wales, March 2006

Assumptions about impairments and what adjustments should be made should be avoided. It should not be assumed that what worked for one person with a specific type of difficulty would work for someone else with the same type of difficulty.

Adjustments need to be flexible in order to meet individual needs while ensuring the student can satisfy the standards of education and training required. Solutions should be reasonable and practicable not just possible. Students, education and service providers should evaluate all adjustments made so that lessons may be learnt.

Staff need to be open and non-judgmental and be prepared to learn with progress.

If both service and education agree that an adjustment needs to be made which has a cost implication, an agreement between the education and service provider should be established which indicates who is responsible to bear the cost.

If a placement provider is not able to make adjustments an alternative placement should be sought…the student should not be penalised.

Staff involved in determining what adjustments should be made in a specific placement area should have access to support and guidance…

Establishment of trust based Disability Advisory Groups to advise on and support staff with disabilities…

Education and Service Providers should use specialist disability organisations to advise ...'

The **General Dental Council**'s *Fitness to Practise Procedures*[54] note that 'The Dentists Act 1984 (as amended) Order 2005 lists the following as impairing a registrant's fitness to practise: misconduct; deficient professional performance; adverse physical or mental health'. The GDC commissioned a review of the GDC's education-related functions in 2007. The GDC document *The First Five Years*[55] reflects the outcomes of the review. The document notes that implementation of the review's recommendations 'will mean a change from the GDC's former focus on detailed prescription of the specific topics and subjects which should feature in dental school curricula, and how these should be taught to students, to an emphasis on the *learning outcomes* which form the profile of the newly-qualified dentist. This approach acknowledges that expertise in developing and implementing comprehensive and innovative curricula and programmes, which will deliver the outcomes the GDC requires in ways that do not necessarily rely on the traditional dental hospital model, lies with dental schools.'

It goes on to specifically note that:
'Technical skills should be tested before students are allowed to treat patients. These tests must show that students can work safely before they treat patients under supervision'; and

[54] The GDC's Fitness to Practise procedures, GDC, December 2008
[55] The First Five Years – third edition (interim) 2008, General Dental Council, December 2008

‘Certain infectious diseases are a risk to patients. In conformity with Departments of Health guidelines, all dental students must be immunised against blood-borne viruses, where appropriate vaccines exist, before commencing care of patients which involves exposure-prone procedures’.

It adds that:

‘Reasonable adjustments are expected to be made for disabled students in enabling them to achieve the outcomes required, for example, to methods of teaching and learning and to the assessments through which a student demonstrates these outcomes’. The document sets out the competencies – the ‘generic and specific learning outcomes’ – required for registration. It estimates that development of new ‘outcomes based guidance’ for dental schools will take about two years. It could be expected for this guidance to include detailed guidance on reasonable adjustments for disabled students and dentists in training and clinical practice.

The GDC have developed a *Disability Equality Scheme*[56] which refers to the training of dental students and the needs of registered dentists. The Council undertook collection of data on the profile of the dental Register using ‘the broad headings of the 2001 Census’. This reported that a ‘very small percentage of our registrants consider that they are disabled: dentists 2.2%; dental care professionals 2.1%’. These are very low proportions. The Disability Equality Scheme notes that ‘It is clear from this [the statistics] that the education of the dental team, in which we must consider educational priorities alongside patient protection, has major implications for disability equality and will need careful consideration.

The First Five Years sets out the Council’s requirements on the content and scope of the five year programme for dental (dentist) undergraduates. *Developing the Dental Team* sets out curricula requirements for dental care professionals. All courses of instruction for GDC registrants must meet these requirements and have our approval’.

It further notes that ‘Alongside education, there are issues around our registration system which only allows those who have completed the dental or DCP course, which includes areas such as cardiopulmonary resuscitation, to be registered. Some disabled students may not be able to do this. A separate issue is that of dentists who, for example, become blind and, although they cannot practise, could work in areas such as dental public health. The Registration Committee has the management and treatment of health issues on its programme of work, and disability issues will be considered in parallel with that work. Dealing with students’ and registrants’ issues could be a large area of work and all disability rights will have to be considered in the context of patient protection. The work will have to be scoped and is expected to be built on over three years.’

The **General Medical Council** has produced guidance which is positive in its approach to the importance of encouraging disabled people as medical students and doctors. It covers reasonable adjustments to clinical practice with a small number of cases studies cited, and an appendix on examples of reasonable adjustments.

[56] The General Dental Council Disability Equality Scheme, undated but contains the GDC Disability Equality Scheme 2007, www.gcc-uk.org

Gateways to the Professions, Advising medical schools: encouraging disabled students has been produced from a partnership led by the GMC, financially supported by 11 medical schools and with match-funding from the Department for Innovation, Universities and Skills (England). The project board included 'representatives of the GMC, the medical schools, the BMA Medical Students Committee, Skill: the National Bureau for Students with Disabilities, the Equality Challenge Unit for higher education, the Office for Public Management (as agents for the Department) and the Association of UK University Hospitals'. The guidance sits alongside a number of other important documents including a supplementary review of disability legislation[57], Tomorrow's Doctors and Good Medical Practice. It is aimed primarily at medical schools.

The guidance sets out arguments for an inclusive approach, cross-references other GMC publications and a wide range of other sources, tackles the relationship of disability, ill-health and fitness to practice, and sets out the legal duties and the social model of disability, all in a very clear manner.

The document sets out what the GMC understands by 'competence standards'. It refers to *Tomorrow's Doctors*, which explains that to graduate, doctors must be able to perform 'safely and effectively a list of 18 clinical and practical skills' and explains that 'Although adjustments cannot be made to these standards, reasonable adjustments can be made to the method of learning and the assessment by which the student demonstrates these skills. Likewise, specific conditions around these standards might be adjusted. For example, a requirement that a student should be able to complete a task within a certain time would only constitute a genuine competence standard if speed is an intrinsic part of the task'.

It further explains that 'in some circumstances it might be reasonable to waive the requirement for a particular qualification, especially if there is evidence that the applicant has achieved the necessary level of competence in another manner' and advises that 'Medical schools should therefore prepare a statement of genuine competence standards for potential applicants and for the different stages of the course and be prepared to negotiate on an individual basis the ways in which these competences will be demonstrated by disabled students'. It is stressed that 'Medical schools have a duty to ensure that they have clearly identified which entry requirements are genuine competence standards (and so lawful under the Disability Discrimination Act) and which are not'.

It advises that all medical schools should review their disability equality training programmes and that:

'**All admissions staff** must be aware of the need to make reasonable adjustments. They should also be trained in communicating with a wide range of disabled people and encouraging them to disclose in confidence.
Teaching and ancillary staff also need to know what is expected on:

- making teaching and learning more accessible to disabled students

[57] Gateways to the Professions, Advising medical schools: encouraging disabled students. Supplement: review of disability discrimination legislation, GMC and Department for Innovation, Universities and Skills, February 2008. Along with other documents, available at www.gmc-uk.org

- how to put reasonable adjustments in place
- what advice and support services are available for disabled students.

Occupational health staff should also be considered for disability awareness training and be able to advise on making reasonable adjustments.'

The document covers the entire 'journey' from pre-application to qualification and practising. It states that:

- Disabled people should be encouraged to apply and reasonable adjustments made to the application process;
- Course information should positively identify disabled people with the profession and make clear that reasonable adjustments can be made;
- Accessible technologies should be offered;
- Advice on choosing medical schools offered;
- Applicants 'invited to disclose their impairments, and be told why they are being asked. It should be made clear that it will have no effect on the decision;
- At interview stage letters of invitation 'should ask if the applicant has any accessibility requirements for the interview. There might be a requirement, for example, for questions to be written, or for physical access arrangements to be made, or for lip-reading or large print information. At this stage, and at all stages, it is important to ask about the person's requirements rather than the impairment. For example, the question should enable a candidate to say that the room should not have fluorescent lighting, not that they have epilepsy'.

Similar points are made with regard to conducting the interview and selecting.

Under 'identifying student requirements' after selection, the guidance stresses the importance of making preparations in advance of the course beginning – a point stressed throughout the best of the guidance and applied to courses as well as clinical placements and workplaces.

An example is given:

> 'About six months before I was due to start at Cambridge, the new dean contacted me, asking if I would like to meet up. I mentioned about adapted stethoscopes, and she soon had the technician at the clinical skills department on the case. He did quite a bit of research, and came up with a number of options for stethoscopes that would be useful. I went back a couple of months later, and was able to try out the stethoscopes that most interested me.' Medical student

A further example cites the procedures used at the University of Aberdeen:

‘The University of Aberdeen has recently introduced a new admissions procedure which gives all medical applicants and students access to occupational health services. Occupational health staff will only assess students who have a confirmed place to study at the University of Aberdeen. The purpose of this procedure is twofold: to identify the need for any reasonable adjustments that would enable students to complete their course; and to ensure that patients are not put at risk by, for example, students with a blood-borne virus infection conducting exposure-prone procedures. Recommendations relating to adjustments in the clinical and educational setting will be made by the occupational health advisers and the university’s disability advisers. Both services will continue to support students, as necessary, throughout their studies. In the exceptional situation where any serious issues of health or disability may not be compatible with achieving the outcomes set out in *Tomorrow's Doctors*, the relevant Occupational Health report would be considered by the Admissions Dean in consultation with the Associate Dean (Undergraduate Medicine) and the Head of School of Medicine.’

The guidance deals with ‘preparing the physical environment’, saying that ‘Medical schools and their universities should be planning continually for the reasonable adjustments they need to make, whether or not they have disabled students. They should anticipate the requirements of disabled people and the adjustments that may have to be made for them’. This would lead to an audit of the physical environment, with an access plan and adaptations undertaken.

Support systems for disabled students could include ‘buddy systems’ and well-trained ‘personal tutors’. The DRC’s post-16 Code of Practice is cited at length in advising how to ensure an inclusive learning environment.

In considering clinical placements, a check list of questions suggested by the DRC are again cited. These questions raise issues of preparation and training that are likely to make placements work for disabled students:

‘Have work placements been audited for accessibility? Are tutors aware of the barriers the environment may pose for disabled students?
Have work placement providers been trained in disability equality or how to work with disabled students?
Are students invited to disclose an impairment or health condition when placements are being organised? Are they asked about any particular needs?
Are disabled students supported in finding placements that meet their requirements?
Are arrangements made to ensure that disabled students can take personal assistants or purchase assistive technology if necessary?
Are placement providers clear on who will take responsibility for paying for and making adjustments?
Do tutors keep in touch with disabled students on placements so that they can take action if problems arise?
If a placement cannot be made accessible, what alternative learning opportunities are available?’

Clinical supervisors ‘should have training in disability equality made available to them’.

The guidance rightly comments that 'relatively little has been written about disabled students and clinical placements'. It points to the guidance prepared by the Chartered Society of Physiotherapy and to *Access to Practice: Overcoming the barriers to practice learning for disabled social work students* (reviewed below).

The guidance references a publication by the **Royal College of Physicians**, *Doctors with Disabilities: Clearing the Way*, which makes the following recommendations for the first meeting between the educational supervisor and the trainee:

- Ask all trainees, not just those who seem to be disabled, if they have any health problems;
- Be frank when asking about the disability rather than avoiding talking about it.
- Respect clinical confidentiality.
- Find out what the trainee finds challenging, and the ways in which he or she manages such situations. For instance, some trainees need time away from work within their working week, and others make a more effective contribution if they work intensively for three days.
- Ask them what adjustments, if any, they need to be made; for example, slowing their ward rounds, or help in carrying notes, recognition of hypoglycaemia by colleagues, etc.
- Ask if they need pre-arranged sick leave where they can sort out their health-related issues, make any necessary adjustments to on-call rotas or night duties.
- Get them to outline realistically the practical procedures which they might be unable to perform.
- Talk to them about professional exams and their special requirements for those exams.
- Discuss their long-term goals and try to help them choose a specialty in which their disability will not interfere in their career progression.

It further cites the *Guide to postgraduate speciality training in the UK* (known as the Gold Guide), which states that: 'In placing trainees, Postgraduate Deans or their representatives must take into account the needs of trainees with specific health needs or disabilities. Employers must make reasonable adjustments if disabled trainees require these. The need to do so should not be a reason for not offering an otherwise suitable placement to a trainee.[58]'

The guidance encourages the Medical Royal Colleges to review their examination arrangements against a policy background such as the Consideration of Disabilities and Special Needs in MRCP (UK) Examinations of the Federation of the Royal Colleges of Physicians, which sets out the following provisions:

- Candidates should provide information about their disability or additional needs
- The Board can then agree to make appropriate arrangements which might include:
    - extension of the registration and completion period

[58] http://www.mmcwales.org/specialty-training/gold-guide

- enlargement of exam scripts
- use of scribe or communication assistant
- use of appropriate aids during the clinical examination
- extra time for assessments.

- An arbitration process in case of dispute should be provided.

It cites some cases and the reasonable adjustments agreed, including:

> ‘A trainee was training for a double CCST* in respiratory medicine and clinical pharmacology. His MS (known about at appointment) deteriorated such that he was unable to perform bronchoscopies (particularly as he had optic nerve problems). However, he was encouraged to focus on the clinical pharmacology, which he completed successfully, and, in view of his progressive disability, accepted the advice that a career in the pharmaceutical industry was safer than direct patient contact. He was successful in completing the relevant CCST.’
> ** Certificate of Completion of Specialist Training*

‘One deanery reported the following case:

> ‘In another case, a trainee who had a malformed upper limb was excused from cardiac compression and intubation during CPR training’.

An appendix lists examples of reasonable adjustments.

Personal perspective – Consultant in public health medicine
After experiencing juvenile chronic arthritis, I tried to ignore the familiar feeling of painful stiff joints I experienced in my second year as a consultant in public health medicine.
I was then diagnosed as having rheumatoid arthritis, which rapidly deteriorated.
I became disabled before the DDA was passed. My boss was supportive, saying I could have whatever equipment I needed, but I didn't know what was available. Neither did my occupational therapist or occupational health service. I struggled until I met a disabled person who used voice-recognition software; he told me how to get this funded through Access to Work. As a result of an Access to Work assessment, I was supplied with the software and other equipment such as arm and leg rests.
I had problems getting to CPD events because I cannot drive for long distances and there are lots of barriers for disabled people using public transport. More recently, I had to withdraw from a national training course because the hours were excessive. I've no problem working full-time, but a course that has 16-hour days is a problem.
In terms of staying in work, I've had most help from other disabled people – none of them doctors. They introduced me to the social model of disability, which locates disability in society, not individuals. Addressing disability means tackling the barriers in society that exclude disabled people, be they environmental, attitudinal, or physical barriers.
If my condition deteriorates, I'll explore funding for a personal assistant at work to carry things and drive my car. This funding is available to disabled people but many health professionals are not aware of it; this means they could advise people to give up work, not knowing that many barriers to employment can be overcome.
Dr Joyce Carter

The Royal College of Obstetrics and Gynaecology

To support disabled doctors, the Royal College of Obstetrics and Gynaecology explains that it:

- has a mentoring system for doctors who may need extra support
- provides specific advice on returning to work after absence
- provides extra support for disabled doctors on a case-by-case basis
- attempts to provide as much assistance as is practicable if it has received a specific request from an examination candidate. For example, in the past the College has given extra time in examinations to candidates with dyslexia, has permitted the use of a keyboard to a candidate with a hand injury, has provided a separate examination room to a candidate suffering from a nervous condition, and has made special provision for those who are hearing impaired.

The College states that as a general rule, it aims to be as compassionate and supportive as possible within the bounds of feasibility

The **Council of Heads of Medical Schools** notes that the 'a disability...need not be a bar to becoming a doctor if the student can fulfil the rigorous demands of professional fitness to practise as a newly qualified doctor. Students with disabilities should seek

advice from medical schools well before the deadline for UCAS submissions'[59]. It adds that 'mmedical schools have agreed that the selection process for medical students must be transparent, involve procedures that respect obligations under relevant diversity and equality legislation'. Advice on students with dyslexia is somewhat contradictory. Recommendations on 'Students with Specific Learning Disabilities including Dyslexia' state that while the 'usual practice in medical schools is to allow students with specific learning disabilities additional time in the written component of exams in accordance with the usual policies of the University', there is 'only very limited scope for alternative arrangements for these students in clinical examinations, since they are designed carefully to assess examinees against specific standards of fitness to practise'[60]. As this paper has already noted, in actual fact, speed would have to be relevant to the standard of competency or to 'fitness to practice' to make it not appropriate for reasonable adjustments to be made. It is not clear if this paper, from 2005, has been overtaken by subsequent developments.

The **Royal Medical Benevolent Fund** has produced a short document, which as well as briefly setting out a range of types of reasonable adjustment, points out that 'there's no limit on the compensation an employment tribunal can award for disability discrimination, so the penalty for not making reasonable adjustments could be high'[61].

Following the DRC's formal investigation, the **Council of Deans of Health** produced *Guidance Notes on Disability Issues in Relation to Healthcare Education*[62], to be 'used in conjunction with current institutional policy on disability issues and is designed to enhance best practice'. The Council is the 'voice of the deans and heads of UK university facilities for nursing, midwifery and the health professions' and therefore has an influential role to play. Guidance on the website clearly sets out the obligation to make reasonable adjustments, the relationship to competence standards and explains that every nursing and midwifery course should make good information available to potential students on the availability of reasonable adjustments and of support, such as Disability Support Allowance.

The guidance includes some examples of reasonable adjustments and of what these could mean in practice, for example: 'Can shift pattern be individualised? Yes, also practice experiences may need to be adjusted to accommodate a student but still offer the opportunity for professional competencies to be achieved. Student may need to avoid respiratory ward for example or have practice experience near public transport/parking rather than a 20 minute walk'. The Council's website also contains other useful documents. *Advice for Students with dyslexia during their clinical placement*[63]*,* written by a third year student nurse, contains advice on reasonable

[59] Guiding principles for the admission of medical students, Council of Heads of Medical Schools, Revised November 2006
[60] Recommendations on Selection of Medical Students with Specific Learning Disabilities including Dyslexia, Council of Heads of Medical Schools, 2005.
[61] Helping Doctors with Disabilities – An Employer's Guide to Reasonable Adjustments, Royal Medical Benevolent Fund.
[62] Guidance Notes on Disability Issues in Relation to Healthcare Education, Council of Deans of Health, www.councilofdeans.org.uk At the time of this literature review the Council of Deans was in the process of updating its guidance in time for the forthcoming academic year.
[63] Advice for Students with dyslexia during their clinical placement, Louise Fisher, May 2007, http://www.councilofdeans.org.uk/data/sites/2/GalleryImages/docs/Advice%20for%20students%20with%20Dyslexia%20during%20Clinical%20Placement.pdf

adjustments and very good practical examples, from the individual disabled nurse's experience, on how to manage dyslexia in the clinical setting. The advice covers issues such as understanding the impact of stress, note-taking, managing handovers, drug calculations and abbreviations.

6.3 Social Work

The professional standards for social work training were criticised alongside those for nursing by the DRC's Formal Investigation. The **General Social Care Council** 'welcomed' (14 September 2007) the DRC's report, but in doing so the Council's chair, Sir Rodney Brooke, chose to stress the responsibilities that lie with the individual: 'The Code of Practice for Social Care Workers sets out the standards of professional conduct and practice required of social care workers as they go about their daily work. This includes an individual's responsibility to inform their employer about any personal difficulties that might affect their ability to do their job competently and safely'[64].

The DRC reported that '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'[65]. The report recommended the removal of discriminatory standards, the development of data, guidance and evidence-based policy, and concluded that 'a framework of professional standards of competence and conduct, coupled with effective management and rigorous monitoring of practice, is the best way to achieve equality for disabled people and the effective protection of the public'.

On checking the current entry requirements for social work, they were found to continue to differ between England and Wales on the one hand and Scotland and Northern Ireland on the other. Degree entrants in England must 'have satisfied health checks' and in Wales 'must be medically fit and suitable for social work'. In Scotland and Northern Ireland no such requirements are listed[66].

The **Professional Education and Disability Support (PEdDS)** project at the University of Hull, between 2003 and 2005, researched the 'experiences of disabled students in placements in order to inform and produce best practice guidance in this area', explaining that 'Social work was chosen as the key discipline to investigate as it has had a long association with anti-discrimination and inclusionary practices'[67]. The research coincided with the formation of a new social work award and relatively new

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64 www.gscc.org.uk/News+and+events/Media+releases/2007+archive/GSCC+welcomes+Maintaining+Standards+Promoting+Equality+report+from+the+Disability+Rights+Commission.htm

65 Maintaining Standards Promoting Equality, Disability Rights Commission, September 2007

66 From *Matrix showing the variations of requirements for the social work degree for the four UK countries* with information prepared by 'SWAP (Higher Education Academy Subject Centre for Social Policy and Social Work), with assistance from the Northern Ireland Social Care Council (NISCC), Scottish Social Services Council (SSSC), Care Council for Wales (CCW) and the General Social Care Council (GSCC) http://www.swap.ac.uk/docs/degree_uk_matrix_collated_jan09.pdf

67 *The PEdDS Project: Disabled social work students and placements*, Wray et al, The University of Hull, 2005, www.hull.ac.uk/**pedds**/

professional social care body, the General Social Care Council (GSCC) with the 'aims of making the social work workforce and profession more accountable to the general public and working to increase the number of entrants to a profession that has a shortage of qualified staff'[68].

The research report pointed out that 'whilst there is a wealth of literature on the nature of placements and types of 'work based' learning, information regarding how best to support disabled students remains fairly limited. This is particularly the case with professional education'. At the time of the PEdDS final report (2005) the researchers pointed out that the then newly established regulatory body, the General Social Care Council, 'has no specific policy regarding disabled students and no across-the-board definition of "fit-to-practice"...'. A search for this review of the GSCC website and telephone call contact found no specific guidance on reasonable adjustments in workplace settings.

The researchers record that, to receive GSCC accreditation, social work programmes had to sign a 'Statement of Agreement' which included that they 'should select candidates who are literate and numerate and carry out criminal conviction and health checks on applicants'. At the same time, the CSCC required universities to: 'use broad access and recruitment policies which make sure that they select students from all sections of the community' and 'prevent unjustifiable discrimination and disadvantage in all aspects of their work that we regulate'[69]. If an applicant declared a health condition, the Council would say if this was relevant. Examples of relevant conditions included conditions which cause seizures, such as epilepsy; conditions that could result in short term memory loss or lapses in memory; serious communicable diseases, such as hepatitis B, hepatitis C and HIV; mental ill health such as serious depression[70].

Where there is doubt about an individual's 'fitness to practice', the GSCC may appoint a medical adviser and seek their input. This procedure has been outlined in the Council's '*Guidance for General Social Care Council appointed Medical Advisers'* (2003b). A medical report is obtained and the applicant is invited to provide more information surrounding the nature of their condition such as: whether their condition has affected their performance in either their current or previous employment; any action already taken by their employer in respect of their health; any change in circumstances since they submitted the application form. If the GSCC considers individual is 'unfit' it might impose conditions on practice.

Students noted that reasonable adjustments were often 'apparently simple modifications', but with the lack of such adjustments 'having a substantial impact for that student'. The recommendations in the report include common themes that arise repeatedly in the wider literature and are worth quoting in full:

'There is a need to break down the stigma that inhibits early disclosure: this ultimately assists with planning and may lead to fewer placement breakdowns for disabled students. Students need to be informed at an early stage of the benefits of disclosure:

[68] Ibid.
[69] Ibid, reference given GSCC, 2002c:10
[70] Ibid, reference given GSCC, 2003b

such benefits need to be specific and deliverable, for example, assistance with IT, flexibility regarding placement timing, hours or assessment.

'Pre-placement planning is essential for disabled students on placement, this entails ensuring reasonable adjustments are in place and placement staff are briefed (with consent from the disabled student). It also includes 'finding out' what the student needs and what impact their disability has on them and their practice (one dyslexic student for example, is not the same as another).

'Confidentiality needs to be maintained for disabled students by establishing 'who needs to know' and achieving clarity about who informs the placement of a student's disability. There is a need for a consistent approach to fitness to practice issues between the university departments and the General Social Care Council. Such an approach could offer guidance and support on distinguishing between competence and disability.

'Social work academics and practice assessors/teachers need more training on disability awareness, knowledge of approaches to supporting students with specific disabilities and understanding of the impact disability can have on a student's placement learning. Social work programmes and partner agencies need to develop policies and guidelines to assist in supporting disabled students. Such policies should identify communication channels between different stakeholder groups as well as responsibilities.'[71]

The report is produced alongside a *Best Practice Guide: disabled social work students and placements*[72], which contain guidance for students, practice assessors and teachers, academic staff and disability support staff in higher education. Key recommendations for practice assessors and teachers cover provision of advice, anticipation of additional work, on whether competence standards are relevant, provision of disability awareness training, good communication, provision of information on support (adjustments) available, provision of opportunities to plan with students, monitoring and review. The guidance noted that 'many examples of reasonable adjustments located in this research were found to be simple or straightforward, such as the provision of a laptop computer funded by the GSCC.' It stresses that 'some of the adjustments may involve physical adaptations and resources, but the majority are about increasing awareness and sensitivity to student needs and the nature of adjustments'.

Placements required 'continued negotiation, flexibility and goodwill' – an observation that could apply even more strongly to employment longer term. In guidance to academic staff, proper planning is again stressed, with the point stressed that 'If the student has disclosed their disability at the outset, it is the academic department's responsibility to ensure that sufficient planning time is available to meet a student's needs on placement'. The guidance encourages written agreements on the reasonable adjustments to be provided, allowing for clarity and for subsequent monitoring. These are all points that could apply to nursing, both in training and employment.

[71] The PEdDS Project: disabled social work students and placements, Wray et al, The University of Hull, 2005
[72] *Best Practice Guide: disabled social work students and placements,* Wray et al, University of Hull, 2005. Supported by SWAP, the Practice Learning Taskforce, British Association of Social Workers

Access to Practice (2004)[73] commissioned and edited by **Social Policy and Social Work (SWAP)**, 'the UK subject centre for social policy and social work and one of the Higher Education Academy's 24 discipline based centres' was produced as guidance to help increase the number of disabled students taking up social work degrees. Case studies are used to exemplify barriers potentially inherent in training requirements and the potential reasonable adjustments. For example, on the requirement to be 'able to communicate clearly and accurately in spoken and written English', examples are considered and social work education providers are urged to consider the reasonable adjustments they may have to make for Deaf student or some students with dyslexia.

The document similarly stresses that any health requirements need to be checked to ensure they are not a bar to disabled people, and risk assessments individualized so they are not a way 'to remove disabled people from the workplace rather than adapt the environment to their needs'. The Council was urged to consider the content, aim and application of competence standards. As far as the competence of trainers is concerned, the report stated that 'It is essential that practice assessors have undertaken disability equality training and are aware of the way their own prejudices could affect the judgements they might make about disabled students'. The guidance touches on how such awareness training can have all round affects – allowing disabled people in all walks of life to be considered as active subjects. However, a paternalistic view of disabled people – as people 'in need' per se – has specific implications for disabled employees if their colleagues, managers and educators, when the disabled person is actively trying to operate out of the supposed-to-be-subservient 'in need' box. Awareness-raising can also help deal with the resentment that can arise from other students and workers – a reaction that some of the disabled nurses we spoke to also drew attention to. Resentment that disabled students are being given 'expensive and sophisticated IT equality' for instance 'shows a lack of understanding that true equality true equality of opportunity can only be brought about by providing students with impairments with the tools and support they need to bring them to the same starting points that others have for tackling their work'[74].

Unimaginative interpretations of rules and regulations are considered. For example, the case of a blind social work student where there are concerns that physical signs of, for example, child abuse may not be noticed. The guidance asks: 'would it be a "reasonable adjustment" to not expect Jason to undertake such key aspects of the child protection role alone and are there other roles within the child protection team that he could do without placing others at risk'. Educational institutions are urged to bear in mind that the GSCC position is that 'social workers need to be fit to undertake all or part of the work of a social worker'.

<u>Example of how not to misuse 'health and safety'</u>

A case is considered, of a disabled second year student going on placement in a hospital, to illustrate misuse of 'health and safety' and the pragmatic methods used by placement coordinators to tackle the situation:

[73] Access to Practice, Sapey et al, Social Policy and Social Work, 2004
[74] Access to Practice, Sapey et al, Social Policy and Social Work, 2004, p45

‘Hannah was in the second year of her postgraduate DipSW course. She wanted to work with older people and a placement was arranged at a hospital for older people with mental health
problems. When the practice teacher was told that Hannah had spina bifida, she became very concerned about her ability to get around the hospital buildings and the risks that some of the stairs and obstructions in corridors would pose to her. She did not think the hospital was a suitable environment for a disabled person to work in. The placements coordinator in the HEI felt that this was an excuse but with placements being such a scarce resource she dare not confront the practice teacher head on. Instead she made it clear that Hannah had not experienced too much difficulty in the University environment which was also quite badly designed and encouraged the practice teacher to talk with Hannah about her concerns.
The practice teacher, to her credit, did this and soon found that Hannah was quite capable of ensuring her own safety. Hannah was offered the placement and passed it very well.’[75]

The guidance notes that it is one thing getting on to a social work training course but ‘it is a common experience that finding placements is another matter’.

A case study is cited of reasonable adjustments in both training and placement:

‘Frank had a progressive hereditary visual impairment. While on the course he had sufficient vision to manage the academic work, with the help of quite sophisticated aids, some of which were computer-based. His work placements comprised first in a residential home for older people and next in a hospital. Both settings were well suited for a student with a visual impairment. He was able to input assessments directly onto computer, thereby making best use of his remaining vision. The placements were highly satisfactory on both sides and he is now working as a manager in a resource centre for visually impaired people.’

The case illustrates the power of information and communication technologies[76].

Recognising discrimination: The guidance draws attention to the existence of double standards when discrimination is encountered with a case where a disabled social worker was subjected to abuse by a client, but nothing was done in response to the worker’s complaint and he was expected to continue to work with the client. When a separate complaint was subsequently made about the client’s racist abuse, the client was immediately informed that the behaviour was not acceptable[77].

[75] Access to Practice, Sapey et al, Social Policy and Social Work, 2004, p34
[76] Access to Practice advocates TechDis as a ‘useful source of information on ICT’ which ‘should be the first port of call for anyone in education who has a question relating to disability and technology’. www.techdis.ac.uk
[77] Access to Practice, Sapey et al, Social Policy and Social Work, 2004, p38

The need for planning

As with much of the literature the need for planning to allow for reasonable adjustments in workplace settings is stressed:

> 'Jane was told by her placement tutor that, as a visually impaired person, she would be given the same priority for placement allocation as other non-disabled students with particular needs to consider, such as student parents. Details were confirmed just one month before the placement was due to start. It was impossible to fund and organise appropriate office IT equipment and make suitable transport arrangements in this time. Although these arrangements were finally sorted out, she started the placement at a disadvantage.'

Educational departments and placement providers are urged not to plan on a one by one basis simply but to 'audit placements systematically for accessibility for students with a range of impairments, as part of the work which precedes a university-placement agreement'. Questionnaires and other tools to collect and order information, and focus thinking, are encouraged.

These points could equally be applied to central systems that provide advice on nurse and midwifery training and education. A key idea that emerged from discussion with one disabled nurse was the use that could be made of the Skills for Health website, where the skills for each job has a KSF profile linked to performance reviews. The site could be adapted to provide information on reasonable adjustments as a component on the matrix – a powerful, centralised tool providing information. In general the organisations providing information, regulation, training or employment for nurses and midwives need to provide positive, non-discriminatory information on disability equality and reasonable adjustments in an easy to locate, accessible form[78].

A range of other issues are covered, with examples of reasonable adjustments in practice settings given – flexibility over work patterns and timetabling; tackling inaccessible physical environments or making adjustments to deal with them; responsibilities for funding – and a checklist for planning, running and monitoring placements.

6.4 Other medical profession representative organisations

The **British Medical Association** has produced *Disability Equality in the Medical Profession*[79], which includes advice on promoting medical careers to disabled people, supporting and retaining disabled students, supporting doctors who are newly impaired and retaining disabled doctors. The document follows a motion passed at the BMA 2006 annual meeting calling on the BMA to work with the GMC and others to ensure that 'individuals with disabilities have appropriate access to medical education;

[78] Thanks to Bethan Siviter, member of the Nursing and Midwifery Council's expert panel and a working disabled nurse.
[79] Disability Equality in the Medical Profession, BMA, July 2007

doctors with disabilities are enabled to have fulfilling and rewarding medical careers'. The report was published in conjunction with another BMA report *Disability equality within healthcare: the role of healthcare professionals,* the focus of which is disabled users of health services. The report strongly advocates the social model of disability and notes the influence of 'the culture in the medical profession where doctors are traditionally viewed as having to be flawless and fully fit' and the effect this is likely to be having in increasing under-reporting of impairment by doctors out of fear that 'this may adversely affect career progression'[80]. These are all comments that feature in the literature on nursing and other health professions.

Data is presented showing a disproportionately low number of people who identify themselves as having an impairment applying to pre-clinical medicine and a review of the medical workforce in Scotland is cited, which 'found that disabled people have particularly low success rates in applying to study medicine, and therefore remain a largely untapped resource of potential doctors'[81]. An appendix also presents NHS data on the proportion of disabled doctors, based on a sample analysis and, as this report points out, 'heavily reliant on doctors' willingness to disclose'. Despite these health warnings, the fact that any kind of data exists – able to be improved upon – is a contrast to the lack of data on nurses and midwives.

The report recommends that 'all staff in an organisation, including senior management, receive an appropriate level of disability equality and etiquette training'. The report cites the awareness training provided by NHS Fife is given.

The report usefully collects a number of existing pieces of research and guidance. It comments that 'disabled students are often unaware of the reasonable adjustments that can be made to allow them to study and practise medicine. There is also no national source of information as to whether a particular impairment will preclude a disabled person from studying and practising medicine'[82]. Further research into the barriers that deter disabled people from applying to study medicine and who enter courses is recommended.

The limits to the GMC's authority and the issue of who is responsible for integrating disabled students into the medical profession is highlighted, with it being said that 'an examination of admissions to UK medical schools for disabled applicants found a lack of parity in the way different medical schools evaluate'. The report expresses concern over whether those making judgements on competency, including occupational health services, are competent to do so, pointing out that data on the levels of occupational health provision to medical schools in the UK. An examination of the provision of occupational health services in all UK universities found significant variation in their practise and performance. Occupational health services were found commonly to be provided on a less than full time basis, covering large populations with limited numbers of staff, and were poorly represented on relevant university committees

[80] Disability Equality in the Medical Profession, BMA, July 2007, p9.
[81] The source cited is: Scottish Executive (2002) *Future practice – a review of the Scottish medical workforce*. Edinburgh:
Scottish Executive.
[82] Disability Equality in the Medical Profession, BMA, July 2007, p14.

involved in policy making'[83]. The report pushes for more guidance from the GMC, which may have been reflected in the GMC's Gateways to the Professions document published the following year.

In considering reasonable adjustments, the report notes that 'As 70 per cent of disabled people will acquire their illness or impairment during their adult life or while in work, it is reasonable to suggest that a substantial proportion of doctors will acquire an impairment at some point during their career. With continued progress in disability equality and further advances in technology, doctors who acquire an impairment have a much better chance of remaining within the medical profession provided there is adequate support available'. The appendices cite the former DRC's advice on approaching reasonable adjustments and the report cites a number of case studies. Some of these, edited in some cases, are as follows.

Personal perspective – Final year medical student
Being visually impaired makes being a medical student that little bit harder than it is for everyone else, because of that, I need extra support, and have to be super-motivated, which I am most of the time. But there's no way I could have achieved what I have without my family and friends' help and consideration.
In the hospital setting I can't do things like test someone's urine as the writing on the bottles is too small, or check a drug vial myself which seem like insignificant things really, just a question of reading and not really much to do with my clinical competence. I can't assess x-rays or work shifts and long hours as my vision gets worse when I'm tired and in artificial light. I'm not great at fundoscopy, but I'm hoping modern technology will invent some kind of USB ophthalmoscope to plug into a laptop – I'm getting a USB otoscope soon which is exciting. But when I've finished my hospital years and can go into a field where my sight isn't so essential, all these things won't matter.
My medical school have been very kind and helpful to me. The staff are usually told in advance about me and can be very supportive: allowing me to stick my head right up to screens in theatre, giving me PowerPoint notes etc.
With a bit of technology, a bag full of magnifiers, a good bunch of friends and a lot of determination, I think I can become just as good a doctor as any of my colleagues.
Jemma Saville

[83] The sources cited are: Venables KM, Allender S & Mayhew A (2003) Occupational health services in Higher Education: first annual report of a project supported by the HEFCE Good Management Practice Programme, Oxford University Press; Venables KM & Allender S (2004) Occupational health services in Higher Education: second annual report of a project supported by the HEFCE Good Management Practice Programme, Oxford University Press; Venables KM & Allender S (2005) Occupational health services in Higher Education: third annual report of a project supported by the HEFCE Good Management Practice Programme, Oxford University Press.

General Practitioner

My diagnosis of MS presented abruptly with an episode of transverse myelitis during December 2002, whilst I was on duty for our local GP cooperative.

I was five months into a new GP principal post at a well respected training and teaching practice having been a GP principal for 12 years previously at a different practice. When initially diagnosed a colleague of mine commented that I should be 'vague' about the diagnosis to my GP colleagues.

However, on return to work I explained the nature of my illness and the impact I felt it may have on my work. As my new practice was several miles away it seemed wise at the time to look for alterative work nearer home. Having been an established GP principal locally, finding a different job was feasible, and in May 2003, with the help of the Flexible Careers Scheme, I commenced sessions at a different training practice. In addition, in view of my experience of a very fragmented MS service locally I commenced negotiations with the primary care trust (PCT) / acute trust for training as a general practitioner with special interest (GPwSI) in neurology, specifically in MS...

Following my diagnosis I was surprised that attitudes to a doctor with MS seemed as unpredictable as the disease. These are in general three main groups:

• firstly some are honest about their own reaction to and ignorance of this chronic and incurable disease but sympathise and are supportive

• the second group feel uneasy with a professional with an impairment having concerns that they may be unable to fulfil their duties

• the third group exclude the colleague completely from any contact and would not employ a doctor with an impairment. This last group represent a large minority and the distress caused probably accounts for the incidences of non-disclosure by healthcare professionals.

In my work as a GPwSI and writing articles in the BMJ and GP magazines I have had correspondences from colleagues with MS. Several from GPs who have not told their work partners of their diagnosis for fear of a reaction, and a few from consultants who feel that their respective trusts may not sympathise. Most sad was a note from a newly qualified GP who was unable to obtain a post because of her honesty on her CV. Being an established and respected GP principal before my diagnosis certainly helped me personally.

Dr Neale Pimenta

Cardiff postgraduate deanery
As part of their role, the associate dean must identify the issues relevant to the disabled doctor, and the job, and to help solve any problems that may be interfering with the doctors training by modifying the training programme accordingly. Heather Payne, the associate dean says:
'Depending on the disability, we may call on the help of assessments from specialists including occupational health, psychiatry, occupational psychology, management, human resources, and speech and language specialists.'
'The modification is usually common sense, for example, if shift work precipitates mental illness in a trainee, then the trainee will need a supernumerary post with no on-call for a period. Someone with severe asthma might not be able to work in pathology (all the chemical fumes). A doctor with epilepsy who cannot drive would require a taxi to outlying clinics.'

6.5 Nursing and midwifery organisations

The **Nursing and Midwifery Council**'s guidance *Good health and good character: guidance for educational institutions*[84] sets out what is meant by these terms in relation to fitness to practice. The document clearly sets out that good health does not mean that disabled people will be barred from nursing as a career: 'The NMC does not have a 'list' of acceptable or unacceptable health conditions. If a student declares a disability or health condition their case will be considered on an individual basis to determine whether their fitness to practise is impaired'. Despite this, the terminology provides room for confusion, alienation and misinterpretation. There is no obvious case for the benefits of using the terminology of 'good health', as opposed to terms such as 'necessary professional competencies'. The terminology obliges the NMC to repeatedly explain that being disabled does not necessarily mean not being in 'good health' or failing to be fit to practice, and yet the terminology ensures confusion persists.

The difficulty that the terminology creates for the NMC was acknowledged in a research report published by the Disability Rights Commission: 'what "good health" means in terms of individual ability and whether this includes disability...is often open to interpretation...the NMC is constrained by the legislation of the Nursing and Midwifery Order which does not differentiate between these two concept'[85]. The problems created for the NMC are evident on its website. Despite the kinds of clarifications cited, the website explains, under 'Good Health', that 'The occupational health department will check that you are healthy enough to meet the requirements of the programme....If you are offered a place it is your responsibility to notify the university if your health or disability status changes'. The terminology of 'good health' places the NMC in the impossible position of having to repeatedly attempt to reassure potential registrants that this will not mean disabled people will be excluded, but the

[84] Good health and good character: guidance for educational institutions, NMC, June 2008
[85] Research into assessments and decisions relating to 'fitness' in training, qualifying and working within Teaching, Nursing and Social Work', Wray et al, funded by DRC, April 2007. In line with the FI, this report looks jointly at teaching and social work as well as nursing. It notes that generalised health standards for teachers and trainee teachers were abolished in Scotland in 2004.

language itself makes it impossible for such reassurances to convince. The DRC's Formal Investigation found that the good health standards as then applied were discriminatory in spirit but not in law, and were not required to measure competency[86]. The knock on difficulties that may be encouraged by the 'good health' terminology can be seen, for example, in the disability policy document for candidates and students to the school of nursing at the University of Aberdeen. That document states: 'The School of Nursing and Midwifery embraces a commitment to eliminate discrimination that treats individuals less favourably because (s)he has a disability, and acknowledges that each student, having been assessed through Occupational Health as having a satisfactory health status for the purpose of Nursing and Midwifery occupation shall, where appropriate have reasonable adjustments in place to maximise the learning environment'. This statement, interchangeably using 'disability' and 'health', is very confused[87].

The NMC is currently exploring the implications associated with removing the good health requirements.

The guidance sets out the NMC's understanding of reasonable adjustments: 'The NMC's overriding concern in considering 'reasonable adjustments' will be whether a nurse, midwife or specialist community public health nurse is capable of 'safe and effective practice without supervision'. The programme provider will need to consider how reasonable any adjustments would be and make a decision about providing them' and references the former Disability Rights Commission for further information. This text could be more positive in tone, and this report will hopefully provide the opportunity to update it with examples.

The **Royal College of Nursing** (RCN) has produced a number of policy documents. In a foreword to *Workability 2*[88] Beverley Malone points out that a failure to tackle disability discrimination means a huge loss of skills and talent, and a new approach must overcome 'any latent perceptions of disabled people as passive recipients of care' and also 'support disabled young people coming into the profession – *we need them,* both for the skills they will employ in a lifetime of nursing and for the inspiration they will bring to other disabled people as they get on with the job'. The document considers together 'illness', 'disability' and 'rehabiliation'. While many impairments can be temporary, the approach slightly skews its focus in the direction of a medical model of disability, of 'getting ill people back to normal fitness'. However it comprehensively sets out legal obligations, provides information on practical assistance available (such as Access to Work), explains the two ticks scheme, gives a positive business case for a non-discriminatory approach and exemplifies key principles using a small number of case studies. For example:

'Seleema had been nursing for 25 years when her hearing started to fail. Working in a noisy outpatient's clinic, she found it hard to understand callers on the telephone and

[86] Briefing note – good health standards follow up on DRC report, NMC

[87] Disability Policy for Candidates and Students, School of Nursing and Midwifery, Robert Gordon University Aberdeen, 2005. It should also be noted that the document includes information on a pre-course health assessment. This states that 'candidates with active eczema/dermatitis evident on the hands, wrists and/or forearms are unlikely to be suitable'. At the very least this would leave this body open to charges of discrimination under the DDA.

[88] Workability 2 – Getting on with the Job! Royal College of Nursing, 2003. Update of Workability, RCN, 2000.

sometimes didn't even hear it ringing. Worried about these routine duties, she approached RCN WING and was directed to her local Disability Employment Adviser. The DEA sourced an adapted telephone with flashing lights and an enhanced earpiece, and provided funding towards it. Her employers agreed to pay their small share of the equipment costs – in fact, they were delighted at how little it cost to keep Seelema's quarter century of experience at work on the unit.'

In *Guidance for mentors of student nurses and midwives*[89], the RCN deals briefly with reasonable adjustments. It particularly highlights dyscalculia and dyslexia, providing more detailed advice on potential adjustments. A literature review hinted at the reasons why the RCN may have chosen to single out this area: 'between 3% and 10% of the nursing population admit to having dyslexia'[90]. The literature review draws attention to a range of interventions, work organisations, technological aids and awareness training that could be used as reasonable adjustments in clinical settings. It nevertheless concluded that there continued to be a lack of research and recommended, among other things, that: 'The NMC needs to collect data about disabilities when surveying registered nurses. Nurses with expired registration should be asked if a disability was the reason'.

The RCN's **Work Injured Nurses Group (WING)** provides examples of reasonable adjustments in its newsletter[91]. For example:

'A district nurse with epilepsy was told that her seizures meant no driving – she felt that meant loss of her job. But Access to Work (AtW) worked to provide transport, and with some simple re-coordination her role became more focussed on the surgery, improving the services patients received'.

The positive impact for patients of being treated by nurses, and other health care professionals, who are disabled is stressed: disabled nurses, working and integrated into the healthcare environment, provide patients with positive role models and can have an inspirational and encouraging impact. This point is made in the literature from the United States, where the Americans with Disabilities Act predated the UK legislation and has had longer to impact on nursing and other professions. We consider reasonable adjustments in other states separately.

The **RCN**'s *Disability Equality Scheme* calls on employers to review their treatment of employees in light of their legal obligations and to make reasonable adjustments, and further calls on 'regulatory bodies within health and social care to bring monitoring compliance within the scope of their inspection regimes'[92].

The **Royal College of Midwives** (RCM) has no formal written guidance but have a policy of providing support to individual midwives who are or become disabled and seek support. One officer[93] gave two cases she had personally dealt with as examples. In the first case the RCM worked with a member who was Deaf and

[89] Guidance for mentors of student nurses and midwives, RCN, 2007
[90] A review of the literature into dyslexia in nursing practice, Dale and Aitken, RCN, 2007
[91] WING quarterly, winter 2008/09
[92] Disability Equality Scheme, RCN, February 2007
[93] Jeanne Tarrant, Team Manager for the North of England.

required provision of specialized equipment. The RCM provided support to the member and suggestions and encouragement to her employing Trust to deliver the reasonable adjustments required. The reasonable adjustment was made and the case concluded satisfactorily. The second case involved a midwife who had suffered a back injury during her employment. The case was considered to be more difficult to find a reasonable adjustment. The agreed outcome involved the midwife taking up a role in research, auditing midwives.

Jeanne Tarrant from the RCM pointed out that the attitude of Trusts varied greatly and whether or not an individual Trust had a positive and supportive attitude towards retaining and supporting the skills of disabled midwives made a huge difference to the outcome. Still too many Trusts had the approach that a disabled midwife should resign from the profession. She also pointed out that in cases where the adjustment involved moving to a different job, a successful outcome would depend on a job being available. Ms Tarrant concluded that the RCM worked to support members in obtaining reasonable adjustments as far as possible, but that strong guidance from the Department of Health was needed to support nurses and midwives, help standardize the practice in Trusts and support the work of organizations like the RCM.

6.6 Nursing and midwifery training bodies

A search for guidance being followed by schools of nursing was undertaken. This involved: a web search using academic search engines, Google and Google scholar; email enquiries to Schools of Nursing; discussions with members of the NMC's Expert Panel and follow up of suggested sources; follow up of references in already surveyed sources. This research revealed that while there is a general awareness of obligations under the Disability Discrimination Act – at university-wide level – the translation of this into guidance on the use of reasonable adjustments varies enormously. Information about practical support available for disabled nursing students is sometime very hard to find on websites even where the school has a policy.

Education providers show an understanding that each disabled person is 'unique' and that reasonable adjustments will need to be tailored to meet the needs of the individual. However these efforts need to be supported by a strong institutional awareness of the positive case for recruitment of disabled people as nurses and midwives and a proactive practice that promotes inclusion and anticipates and prepares for requirements. A number of schools of nursing said that they would strongly welcome national guidance, including those which have developed proactive local practice. A number of institutions also indicated that they are in the course of developing their own policy on reasonable adjustments[94]. We present here the most developed examples of policy and guidance that we have been able to locate to date within the terms of this project.

The **Open University** provides one of the most easily accessible HE sites on inclusive learning in general[95]. The site promotes the Universal Design for Learning, developed by the Centre for Applied Special Technology[96] in the United States, and taken

[94] For example, Schools of Nursing at Bournemouth and Plymouth.
[95] http://www.open.ac.uk/inclusiveteaching/index.php
[96] http://www.cast.org/

forward in Britain by Sheffield Hallam University. The **OU** site spans legislation, policy, practical guidance, how to identify and tackle barriers and provision of inclusive teaching. It covers approaches to clinical placements, including by providing video interviews to support case studies and specific issues. Information specific to nursing is limited although much of the information on approaches to disability, disclosure and the availability of Disability Support Allowance, reasonable adjustments and the approach to practical settings such as laboratories would be applicable to nursing. The site is very accessible and in this sense a model that could be used by the NMC and advised to nursing schools, to be suitably adapted.

The **Deaf Peoples' Access to Nursing Education Project**[97] ran at the **University of Salford** between 2000 and 2006. Although the project closed after its agreed six year funding period, Deaf students remain part of the regular student cohort, with an average of two Deaf students likely to be within the 120 strong annual nursing student intake into the mental health nursing programme.

The project was initiated to encourage Deaf people to train as mental health nurses, in the context of the lack of such staff in the NHS services for Deaf people with mental health problems: there are three specialized NHS units and a number in the independent sector. At Salford, the course organizers work with Deaf students going into placements in both Deaf and hearing environments. If interpreters are needed for the student's use on placement, Salford organizes these with funding available via Access to Work.

Naomi Sharples, Director of Mental Health and Learning Disability Nursing at Salford, explained that:

'the system relies on well organized contact between the course organizers and the placement providers, and on that basis, the placements have always run very well.'

Common adjustments have included:

Provision of note takers
Availability and use of portable alarm systems if a student feels they may not be able to easily see the fire alarm in a placement venue
Availability of regular meetings to discuss complex course information or other issues through, face to face, in BSL.
(These 'clinical tutorials' are an important part of the course and personal tutors are trained to be aware of the potential needs of Deaf students and the usefulness of tutorials.)

The course organizers consider the project to have been a great success, and the ongoing training of Deaf nurses in mental health nursing, as providing an important resource for Deaf patients.

[97] With thanks to Naomi Sharples, Director of Mental Health and Learning Disability Nursing

The **School of Nursing at Salford** is also actively developing its wider practice and guidance in relation to disabled students, with the aim of ensuring inclusivity. Contacts at the School confirm that guidance on reasonable adjustments from the NMC would be very helpful. Currently the school has no overall set of detailed guidance on reasonable adjustments in clinical settings, but do consider individual students needs on a case by case basis, seeking to ensure reasonable adjustments are made[98].

Sheffield Hallam University, via the **Faculty of Health and Wellbeing**, has a project running (to September 2009) to develop a systematic approach to support disabled students moving into work placements. . The outcome will also guide the work of university admissions tutors[99]. Sheffield Hallam has also produced guidance for nursing, social work and other health profession students on disclosure of disability, which explains their right to reasonable adjustments[100].

The guidance acknowledges fears of discrimination and attempts to encourage students to disclose by demonstrating an understanding of the positive qualities that a disabled student may bring to nursing:
'you may have high levels of empathy with disabled patients and in some instances can be a reassuring presence for them'; 'if you have a hearing impairment your other communication skills may be strong, such as attention and use of eye contact or body language'[101].

Students who have disclosed disability are asked for consent that this information can be shared with relevant personnel including to the placement provider[102].

The nursing school also provides a basis for ongoing discussion between the student and mentors in the form of an 'accessibility solutions meeting' for disabled students, linked to a weekly progress meeting held with all nursing students. The school is developing a post of 'clinical advocate' who would support students, mentors and practice staff.

The Faculty of Health and Wellbeing has developed a new system to consider and process reasonable adjustment requests for students who disclose disability: via a **Reasonable Adjustments Panel for Clinical Placement.** Panels consist of four members: the Pre-Registration Programme Manger (who Chair's the Panel), the course leader for the student's course, Director of Placement Learning or Deputy, and the Nurse Director / Lead Nurse. An administrator takes notes. The practice is for the panel to 'be convened at the earliest opportunity' to consider requests for reasonable adjustments. Where cases are 'short term' or where 'limited adjustments are required' decisions can be made on Chair's action. In other cases the university Disability Coordinator is required to advise on the need for reasonable adjustment and present

[98] With thanks to Wendy Hayers, School of Nursing, w.hayers@salford.ac.uk
[99] Further information from Sara Morris-Docker, Senior Lecturer Nursing, s.morris-docker@shu.ac.uk
[100] Disability disclosure for students on a nursing, social work or allied health professional education, Programme, Faculty of Health and Wellbeing, Sheffield Hallam University, 2008
[101] Disability disclosure for students on a nursing, social work or allied health professional education, Programme, Faculty of Health and Wellbeing, Sheffield Hallam University, 2008
[102] As with other training providers (e.g. the Open University), policy is to encourage the student to undertake this themselves, to develop experience in negotiating reasonable adjustments in the workplace.

the proposal to a meeting of the panel. The policy is that the student 'will be advised verbally and in writing within 5 working days of the outcome'[103].

The Course Management Team has central responsibility managing agreed adjustments, including: 'where a change or extension to a placement is required, which may require modification to the Plan of Training this will be actioned and monitored by a designated member of the Course Management Team'. The policy clearly states steps to keep the student informed, how the student can appeal decisions and how the policy will be reviewed.

This model appears to be innovative and an example of good practice.

The Faculty at Sheffield Hallam provided a menu of frequently considered reasonable adjustments. These include, but are not limited to, the following:

Placement circuit limited (to reduce travel burden)
Placement shift type limited
Supported travel provided, (e.g. taxi to place of work funded by DSA)
Placement shift length limited, hours per week stipulated, with or without set days-off given (training plan extended)
Full night shifts not required, must be replaced by shift options that allow students to demonstrate experience of full 24 hour service (e.g. twilight/very early shifts can be arranged)
Tailored training plan, pre-arranged for whole or part programme agreed by Subject group disabled student support panel
Specialist placement learning support (coaching), hours provided in placement setting only
Personal non specialist/ mentorship support recommended (provided by DSSP), identified non specialist mentor able to visit ward[104]

Research was conducted within the **Division of Nursing** at the **University of Nottingham** in light of NMC advice that it was for individual nursing schools to develop their own practice on reasonable adjustments. The research revealed a lack of consistency across different clinical sites[105] and was used to draw up initial guidance. Nottingham has produced two pieces of guidance: *Protection of Nursing Students with a Disability in Clinical Practice* and *Making reasonable adjustments for students in clinical practice*. The former has been in actively implemented since March 2008 and sets out a risk assessment policy to be followed when students inform the school that they have a disability. Professor Mark Avis, Head of Nursing, Midwifery and Physiotherapy at the School[106] explained that 'most of the students we have with

[103] *Pre Registration Nursing Programmes, Reasonable Adjustments Panel for Clinical Placement*, Faculty of Health and Wellbeing, Sheffield Hallam University, October 2008. With thanks to Lynne Gell, Senior Lecturer and Pre-registration programme manager at Sheffield Hallam, L.Gell@shu.ac.uk
[104] *Suggested menu of frequently considered reasonable adjustments for application to Student nurse training plans*, with thanks to Sara Morris-Docker.
[105] Objective Structured Clinical Examinations OSCE - reasonable adjustments for students with disabilities within the Division of Nursing, Bradley, Roberts and Walsh. Extract of paper, Fourteenth Learning & Teaching Conference, University of Nottingham, 14 January 2009
[106] With thanks to Professer Mark Avis for information provided: mark.Avis@nottingham.ac.uk

a disability would probably not need a full risk assessment, as it is probable that they need only very minor adjustments'. The guidance on reasonable adjustments was produced after consultation with the School's local Practice Learning Committee with representatives from practice as well as the Disability Unit of the University. At the time of writing it was about to be implemented. The document sets out the process to be followed when a student has a disability and if reasonable adjustments are needed. The key steps are:

- Information is provided to the Disability Liaison Officer (DLO) and Health and Safety Officer, resulting in discussion between the DLO and the student to ascertain suitable adjustments;
- A meeting between the student, placement staff (student mentor or clinical manager), DLO and /or personal tutor;
- An Action Plan is agreed detailing the recommended reasonable adjustments.
- The situation is reviewed as necessary by the student and the student mentor in the placement area with changes if appropriate.
- If placement staff fail to undertake the requested assessment or the recommended adjustments the personal tutor/programme leader or student should contact the DLO and the HSO. Similarly placement staff should contact the student's personal tutor if the student does not keep to the Action Plan.
- The action plan is reviewed for the next placement, meetings held with new placement staff (student mentors) prior to placement commencement if required, and the action plan amended as required.

The School of Nursing has an informative website on dyslexia and workplace learning[107]. The site explains that 'legislation means that educational establishments must make reasonable adjustments for disabled students, which includes students with dyslexia. This also applies to work placements'. It contains accessibly presented information about dyslexia, its practical impact, case studies by students and how they have fared in workplace settings, and a set of guidelines 'which students and mentors can adopt in practice settings'. These include practical strategies for 'documentation', 'handover', 'drugs charts', 'instructions and procedures' as well as guidance on 'things that mentors can do' and 'things that schools of nursing can do'. The latter include 'consider having longer clinical placements if necessary' and 'consider matching students with dyslexia and other learning needs to mentors with aptitude in supporting such students'.

A presentation by Lucy Foley of the **Scottish Disability Team**[108] records 'strategies suggested by schools of nursing', including 'Develop a statement of core requirements; Make pre-course information more explicit; Ensure all relevant staff engage with disabled students/applicants in a manner which enables informed choice; Consider alternative pathways; Share good practice between institutions; Discuss with professional/validating bodies'.

[107] http://www.nottingham.ac.uk/nursing/sonet/rlos/placs/dyslexia2/7.html
[108] Now part of the Scottish Funding Council, http://www.computing.dundee.ac.uk/projects/sdt/default.asp

The **School of Health Nursing and Midwifery** at the **University of the West of Scotland**[109] provided information on their disability policy, which they explained developed from a long-standing, publicised commitment to equality and diversity. They said it had enabled them to support, currently and in the past, 'for example, students with a wide range of enabling support needs related to 'dyslexia, dysgraphia, dyspraxia, dyscalculia, visual, hearing and speech impairment, lower and upper limb amputation, rheumatoid arthritis, epilepsy, multiple sclerosis, diabetes, depression, bipolar disorder, Asperger's syndrome'.

The school explained that anticipatory adjustments are embedded into the structure, organisation and assessment of clinical placements. The school's policy is to encourage disclosure, following which a disabled student is invited to meet with the school's Enabling Support Co-ordinator (nurse lecturer). They explained that, in partnership, they review the student's abilities and identify individualised support and need for further referral.

The school will purchase necessary clinical equipment 'e.g. electronic stethoscope' and fund services such as speech therapy. Referrals and communication of support needs to placement areas are made with the permission of the student. To provide balance, communication of the student's proficiency and good practice accompany the request for adjustments.

Evaluation of placement experiences includes evaluation of 'reasonable adjustments' and an annual review of support provided to disabled students is also undertaken.

The school explained that their decision-making on what adjustments are 'reasonable' is grounded in 'competence standards'.

The school was able to provide a number of examples of reasonable adjustments' put in place within clinical placements.

These include:

[109] With thanks to Clare Owens, University of the West of Scotland

A student with a chronic condition had difficulty in working in cold temperatures. Community placements were programmed outwith the winter months.

A student was fatigued during an exacerbation of a chronic condition. The student was able to continue programme. Placements during this time were selected to enable the appropriate experience to be gained in an area where the pace and workload were lessened and shift work not required. The Student also worked reduced hours per week during this time. Programme had 'catch-up weeks' where the time missed in placement was made-up.

A student with dyslexia had some difficulties with reading and writing. The student was issued with a pocket magnifier and coloured overlay to aid reading. Other adjustments included use of an electronic spellchecker and word list, assistance from the mentor in identifying core requirements of, for example, admission and progress records. The student was also to ask for help where required and have writing checked when required. Attendance at the 'Pathways to Success'[110] programme was continued during clinical experience (further development of reading and writing skills).

A student with a mental health condition had an acute episode. It was judged not possible / safe for this student to continue attending clinical practice and so accepted 'interruption to the programme' with bursary. The student was later able to recommence initially on reduced hours. There was also a need to explore with the student issue of personal and professional limitations and boundaries. Pastoral care was offered and additional support was put in place to further develop understanding of working within level of proficiency.

A student with alteration in gross and fine motor dexterity had difficulty performing some clinical skills using the usual methods. Additional, lecturer facilitated skill lab time was organised for the student. This time was used to apply the principles of the skill to adaptations to the skill performance to accommodate the student's mobility. Referral was also made for further aids. The student's mentor was informed of adaptations and request for practice and supervision of specific skills.

The **School of Nursing Midwifery and Social Care** at **Edinburgh Napier University** has a system of disability contacts for each nursing and midwifery programme, and designated contacts for students with some specific impairments (hearing, diabetes and epilepsy). Following disclosure of disability, the school's procedures include review by occupational health services, discussion with a disability contact and possibly a meeting with the 'special needs' team. The special needs team would agree a report for any necessary 'financial support for software, additional equipment or additional study skills support is undertaken by the Special Needs Team'. Review meetings take place between the special needs team and individual disability contacts each term.

[110] Pathways to Success' Programme - Individualised student -led learning support developed and led by a School lecturer. Open to all students but also offers support to students with specific learning needs

The school provided the following examples of support that could be required or provided, some of which are relevant to workplace settings.

Students with a hearing impairment

- Powered stethoscope for BP classes - which can also be used for OSCE's
- Loop system in most campuses for hearing aid users
- Module leaders alerted to individual needs of students for positioning for lip reading and other requirements in the classroom setting
- Written instructions given in assessment setting rather than simply verbal instructions
- Extra time if reading time for instructions necessary
- Personal Emergency Evacuation Plan (vibrating fire alarm for use on campus and clinical placements - organised in conjunction with fire officers)
- Attendance at hospital evacuation session + universities
- Clinical placements - Allocations are asked not to place student in potentially difficult areas where lip reading may be a problem e.g. theatres
- In the case of some students, the placement area has been reviewed along with the student re-suitability and safety with layout and equipment used (e.g. can student hear alarms in HDU)
- Adjustment has been made in the past to buzzer frequency as student's own hearing aids were unable to tune in with this.

Students with dyslexia

- Copies of overheads/lecture notes in advance of class to enable student to prepare
- Explanation of key terminology
- Reduced reading list
- Note taker
- Permission to tape record lectures
- Proof reader
- Spelling/grammar allowance for exams/written coursework
- Study skills support
- Coloured overlay (if student has scotopic sensitivity)
- An individual assessment if students have specific difficulties in the clinical area and provision of appropriate equipment.

Students with diabetes

- will require regular meal breaks,
- may need to take short break to check blood glucose if feels low
- may need time off for extra diabetes clinic appointments, if requiring education about blood glucose control and practice placements
- may not be scheduled for fixed night duty but could negotiate with to work a shift with a mentor
- Clinical staff should be aware that stress can cause hypo and hyperglycaemia.

Students with epilepsy

- Advice/guidance about balancing activities e.g. academic work and practice
- Exams extra time may be required if there are issues related to concentration and medication
- Lecturers/Clinical staff may be advised that the student is prone to seizures
- Clinical staff may be advised that the student is not able to work alone
- Students may be unable to undertake scheduled night duty
- May need time off for appointments if requires referral to consultant/specialist nurse practitioner for advice about managing epilepsy.

Focus on dyslexia

Dyslexia and other learning disabilities are the subject of specific focus by a number of schools of nursing and health professions. The **University of Southampton School of Health Sciences** has produced guidance which 'sets out some of the challenges that might occur on placement and suggests strategies that can be adopted by mentors/supervisors and students working together to ensure that "reasonable adjustments" are in place'[111]. The advice echoes that given by the **Open University** and other HE bodies.

Work collated at **Keele University School of Nursing** covers similar points: identifying support needs of students with dyslexia, advising students in clinical settings, technical and practical aids and organisational adjustments[112]. Contacts at Keele confirm that while the school has had very few disabled applicants other than those with dyslexia (a trend it is thought may change in light of the DRC investigation) that those who have applied have been supported using the same basic approach, that 'reasonable adjustments must enable independent practice and maintain educational/practice standards'[113]. The availability of reasonable adjustments for students with dyslexia is highlighted and easy to find on the Keele School of Nursing and Midwifery website (integrated into the section on 'clinical placements').

Southampton's guidance is structured to be relevant to students on health and social care courses, not solely nursing. After setting out some of the key barriers students may experience, the guidance suggests strategies for mentors/supervisors and for students. These span issues of memory, organization, time management, reading, writing, spelling, language and motor skills. The full list of strategies for use on placement can be seen in the document. Examples for mentors/supervisors in relation to memory, organization and time management include:

[111] Supporting dyslexic students on practice placements, School of Health Sciences, University of Southampton, www.southampton.ac.uk/studentsupport/ldc
[112] See presentation by Sarah Traylor, Disability Liaison Officer, School of Nursing and Midwifery, Keele University. No case studies are presented. s.e.a.traylor@nur.keele.ac.uk
[113] With thanks to Sarah Traylor, Student support lecturer, School of Nursing and Midwifery, Keele.

'Do not give too many instructions at once, particularly if the instructions are only given verbally; Give instructions in both written and verbal form wherever possible; If a task involves following a sequence, this could be set out clearly on a wall chart, manual or instruction sheet'.

Examples in relation to 'reading' include 'being 'dyslexia friendly': write in a logical sequence; avoid small print; use bullet points in preference to sentences; use simple words, and space the information so it is not cramped; avoid overuse of jargon or uncommon words' and 'use colour and space on whiteboards to differentiate sections'.

For students, strategies include (for 'writing and spelling') include 'use a recording device' and 'use a small personal dictionary or electronic speller' and 'use a laptop or PC for writing case notes'. Under 'motor skills' supervisors are encouraged to 'demonstrate skills more than once at the beginning of a placement' and students to 'write the sequence down in the form or a diagram or flow chart'.

Middlesex University's School of Health and Social Sciences has produced literature linking an encouragement to disclosure of dyslexia to promotion of the potential for reasonable adjustments. The *Practice placement disclosure document for student nurses and midwives with dyslexia or other specific learning disability* sets out a range of possible support measures and reasonable adjustments for using in workplace settings[114].

The **Association of Dyslexia Specialists in Higher Education** (ADSHE) produced guidance for nurse learners with dyslexia in practice settings[115]. Again this sets out potential effects and/or barriers and strategies for mentors and learners. It also highlights the skills that those with dyslexia may bring to the learning process. For example, considering 'documentation', learner strategies include 'write notes early/as you go along; seek a quiet environment; use dictionary; use a client handover sheet', and mentor strategies 'help develop client handover sheet; review; help develop and discuss use of memory aids used by students; give concise instructions'.

There is also a range of other relevant research literature, some specific to nursing: e.g. *Understanding dyslexia and nurse education in the clinical setting* [116]outlines strategies which amount to reasonable adjustments. The authors recommend that schools of nursing carry out an 'audit to ensure that employees with dyslexia are not at a disadvantage'; while this is a good idea, a wider brief would be served by undertaking a disability audit. They further recommend a review of clinical procedures using 'small, specific steps', allowing 'students to jot down notes to help remember essential steps or order of items', 'writing notes on scrap paper before transferring them to a chart', and records adjustments that would also equally apply to good practice for clinical practice more widely. For example, it points to the importance of anticipation and proactive planning.

[114] Copies and further information from p.sumner@mdx.ac.uk
[115] Guidelines to support nursing learners with Dyslexia in Practice, Stainer and Ware, ADSHE, 2006
[116] Understanding dyslexia and nurse education in the clinical setting, Sanderson-Mann and McCandless, Nurse Education in Practice, 2006 (6)

A literature review undertaken for the **Royal College of Nursing**[117] thoroughly collates existing research on dyslexia and nursing practice, and includes examples of reasonable adjustments in practice settings. It includes practical examples of when reasonable adjustments have failed and the consequences in terms of legal action and compensation that may result from a failure to attempt reasonable adjustments. The report draws attention to sources of funding support (including Disabled Students Allowance and Access to Work) – sources that need to be made known to students. The report itemizes a range of available technical support, workplace adjustments and case studies of individual nurses in working environments. *Overcoming invisible barriers to learning in the clinical areas*[118], originating from a workshop at the **University of Salford** also collates strategies for supporting students in clinical placements.

A research project, led by Dr Shea Palmer at the **University of the West of England** and funded by the Higher Education Academy, was established to develop a *web resource of case study information on reasonable adjustments to prevent discrimination against disabled students*[119] in nursing, midwifery and allied healthcare professions. The researchers found a low initial response rate to the draft research model: 7.4 per cent; those consulted included admissions tutors at all Scottish Nursing, Midwifery and Health Professions Council-accredited programmes. The project report (July 2007) also records that only 13 case studies were submitted (compared to a target of 68), despite apparently extensive advertising and invitation to submit. There may be a number of reasons for this, but one may be an indication of poor experience of reasonable adjustments.

6.7 NHS Trusts

Information on the website of the NHS Business Services Authority advises that it is 'essential' that managers give 'due consideration' to reasonable adjustments 'where an employee is declared unfit to continue working in their current position'. It is stated that if no reasonable adjustments are identified redeployment should be considered[120].

A sample selection of **NHS Hospital Trusts** were contacted to seek any guidance they had on reasonable adjustments for nurses and midwives in particular, or for staff more widely. In the time available, it was not possible to do a comprehensives survey. Therefore we looked at three blocks of Trusts which we considered might identify good practice.

Firstly, the five hospital Trusts in the North East Strategic Health Authority were contacted because the authority (and some PCTs in the region) had previously been identified by the Disability Rights Commission as performing strongly in response to disability equality obligations.

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[117] A review of the literature into dyslexia in nursing practice, Dale and Aitken, RCN, 2007
[118] Bernadette Burns, University of Salford: http://www.ece.salford.ac.uk/proceedings/papers/53_07.pdf
[119] http://www.health.heacademy.ac.uk/resources/disabilitydb
[120] July 2008, http://www.nhsbsa.nhs.uk/Documents/NHSBSACorporatePoliciesandProcedures/Redeployment_Policy.pdf

Gateshead Health NHS Foundation Trust published a Disability Equality Strategy in December 2006 and reported on it in 2007. The report[121] covers employment and advised that a 'guidance note for making reasonable adjustments for disabled members of staff has been developed'. No specific guidance for nurses, midwives or other clinical staff was identified. The Trust's 'action plan' sets out some specific 'outcomes'.

For example:

- 'Managers who recruit people with disabilities ensure that support and access requirements are in place prior to employment commencing', where the 'action required is to 'Ensure managers contacting HR are referred to Occupational Health and Access to work for consultation';

- 'People with disabilities are represented at all levels of the organisation', where the action required is 'Regular monitoring and reporting of staff with disabilities to ensure representation';

- 'Support is available for employees who become disabled while employed. Reasonable adjustments are made to ensure continued employment' where the action required is 'Re-deployment register is maintained' and 'New job descriptions are assessed by Occupational Health for suitability for redeployed staff ' and 'risk assessments are carried out when a member of staff becomes disabled'. Progress was reported as 'ongoing' (although these 'actions' do not seem sufficient for the required outcome. The latter would presume actions such as 'reasonable adjustments have been made for disabled staff' or 'all staff are made aware of the potential for reasonable adjustments and positive images and case studies have been disseminated'). The action plan does include an outcome 'Staff to understand what support is available for people with disabilities' with action being to develop an intranet site, awareness and 'disability champions'.

Northumbria Healthcare NHS Foundation Trust provided a copy of their policy on reasonable adjustments for staff. This was not specific to nurses and midwives, nor did it contain practical examples or case studies of reasonable adjustments made for staff in workplace settings. The policy acknowledged the Trust's legal obligation and contains a 'non-exhaustive list of potential reasonable adjustments'.

These were as follows:

[121] Gateshead Health NHS Foundation Trust, Disability Equality Scheme, Annual Report, 2007

- making adjustments to premises e.g. altering doors, changing taps, altering lighting etc.
- allocating some of the disabled persons duties to another person
- transferring the disabled person to fill an existing vacancy. This could involve the recruitment process being suspended until the disabled employee has been considered for the post
- altering the disabled persons working hours
- assigning the disabled person to a different place of work
- allowing the disabled person to be absent during working hours for rehabilitation, assessment and treatment.
- providing the disabled person with training
- acquiring or modifying equipment
- modifying instructions or reference manuals

South Tyneside NHS Foundation Trust stated that they did not have 'one individual policy for making reasonable adjustments for disabled staff but the Trust's commitment to this important and legal requirement is encompassed in several documents'[122]. The Trust referred to their policy as follows: 'All disabled applicants who meet the essential person specification criteria are guaranteed an interview. If appointed, we would undertake a workplace assessment and make any reasonable adjustments to accommodate their working to the maximum of their potential. If an employee becomes disabled as defined under the Disability Discrimination Act or if an existing disabled employee develops difficulties, we would refer for assistance to our Occupational Health Physician who would also organise a workplace assessment. A decision would then need to be made by the relevant senior manager, with advice from the Personnel department, as to whether the recommended adjustments are reasonable and can be actioned'. The only reference to reasonable adjustments in the Trust's Single Equality Scheme was under communications in relation to members of the public. No reference to reasonable adjustments was identified in the disability statement in the Trust's Annual Report.

Secondly, we looked at a hospital Trusts brought to our attention by NMC officers or members of the Expert Panel.

Liverpool Women's NHS Foundation Trust has an employee who is a *Specialist Midwife/Disability Advisor*. The Trust's website explains that this post has 'been developed over the last 11 years' and the 'Disability Advisor is herself a disabled woman, nurse and midwife'. This officer is open to disabled patients to contact to help with 'an assessment of need, a history of the impairment and individual needs will also be discussed to seek ways to overcome any obstacles and remove barriers'.

But the *Disability Advisor* 'also provides support to employees of the Trust' and will:

[122] Single Equality Scheme; Equality & Diversity Policy; Sickness Absence Policy; Annual Report; Recruitment and Selection guidelines, www.stft.nhs.uk

Offer support, confidentiality and a 'safe place' to come

Perform a needs assessment, identify risk factors and individual needs in the workplace

Advice and inform managers of their corporate responsibility to comply with Disability Discrimination Act (DDA) (1995)

Liaise with Occupational Health, Directorate Managers, Human Resources, union representatives and other relevant personnel if required

Provide written reports when requested

Provide information on 'Access to Work' and other support agencies, advice on financial benefits and relevant networks

Accompany to meetings if required by the individual, to be an advocate if necessary

Give input on the sickness and absence training to particularly explore the implications for disabled employees and their rights under the DDA (1995).

This was the only example identified in this research of a dedicated specialist disability adviser available as a first line of advice for nursing and midwifery staff. We have had reports of officers in other trusts who have disability advice as part of a wider job remit, and of trusts where diversity or generic equality advisers or teams exists, with disability as a component. However, this is the only trust identified in this research where a dedicated disability advisor has been identified. We consider this provision of a dedicated member of staff an example of good practice.

Discussion with the Disability Advisor[123] identified that most staff who seek her services simply require basic information and support. However, if they need a change in their working conditions – via reasonable adjustment – the following process is typical. The Disability Advisor will, in a meeting with the staff member, identify how the individual sees their needs being met. The Disability Advisor will form an initial view on potential reasonable adjustments and hold a meeting with the manager to advise on these. The needs identified may then go to Occupational Health services for action. The individual may need representation from their trade union. They may require advice and/or referral to Access to Work and on benefits to which they are entitled, to complement earnings. They will be provided with advice on other organizations that can provide support or information. The member of staff is able to have ongoing meetings with the Disability Adviser to discuss their situation and as a source of support. The Disability Advisor believed that on the whole the service worked well.

Hertfordshire Partnership NHS Foundation Trust[124] *Single Equality Scheme* refers to the obligation to consider 'reasonable adaptations' for disabled employees. The

[123] Jackie Rotherham (jackie.rotheram@lwh.nhs.uk), who is a disabled nurse and a member of the NMC's Expert Panel of Disabled People.
[124] http://www.hertspartsft.nhs.uk/

Trust's *Guide for Supporting staff with a Disability* sets out 'guidance for staff to be fully supported if they have a disability or in some cases a long term illness'. It provides information on Access to Work, and specifically on transport, support workers, adaptations and specific support for staff with mental illness. The guidance is generic and not focussed specifically at nursing and/or midwifery. However, nursing staff are referred to in one of the practical examples given: 'a nurse who has controlled epilepsy and is able to perform his/her job (after a risk assessment has been conducted), but is not allowed to drive – would be provided with a driver to take him/her to all his/her community appointments. The costs for this service do not come out of NHS budgets'.

Steps to access the Trust's service are set out clearly. They include showing how the involvement of Access to Work is triggered and explaining that an assessment could agree support for the individual in performing their job or 'an assessment for suitable alternative work'. It explains that elements for which funding is available could include 'paid transport and/or a support worker' or 'physical adaptations, e.g. a partially sighted person could be given a much larger computer screen and adapted software; a deaf person could be given a special adapted telephone; someone with a back injury could be able to access a special chair. The Trust is able to choose and recruit an appropriate person to conduct these duties; we do not have someone imposed on us'.

Thirdly, on our behalf, the **Employers Forum on Disability** (EFD) contacted Trusts which are members of the Forum.

Imperial College Healthcare NHS Trust said that they do not have a policy on making reasonable adjustments, but that a section of the Trust's intranet entitled 'Disability Confidence' provides advice[125]. The site explains the legal obligation to make reasonable adjustments for employees who fit DDA definitions, and points out that 'this is often a very straight forward process, and most adjustments cost no money or as little as £50' although that in some cases issues can be more complex. A number of resources are listed, such as links to Access to Work, to the EFD's online guide, *Managing Attendance and Disability*, and to the Shaw Trust, a charity which supports disabled people looking for and in employment, along with a model form on reasonable adjustments, based on information of the Employers' Forum on Disability, and information on different impairments and potential adjustments (such as asthma, back injury, mental health, and dyslexia). Managers and employees can also contact the Deputy Head of Recruitment and Administration for advice, who informed us that her 'general approach is to link people with a Work Step provider as each case is different and they have access to a range of resources and the most up-to-date information, as well as being able to navigate through the Access to Work process'[126].

The **London Ambulance Service**'s Disability Employment Policy sets out the obligation to make reasonable adjustment and cites a number of practical examples. Examples cover adjustments to premises, re-allocation of some duties, transferring a disabled person to fill an existing vacancy (including retraining if appropriate), altering working hours, changing work stations, allowing absences for rehabilitation, assessment or treatment, acquiring or modifying equipment, providing a reader or

[125] www.imperial.nhs.uk/learningforwork

[126] With thanks to Janice Beamish, Deputy Head of Recruitment and Administration, Imperial College Healthcare NHS Trust.

interpreter. However, none of the examples are applied to or drawn from typical practice of a nurse working in the Ambulance Service, and it is therefore unknown how this works in practice. The document cites the service's support for Job Centre Plus' 'Two Ticks' programme, and commits to:
'interview all disabled applicants who meet the minimum criteria for a job vacancy and consider them on their abilities; ensure there is a mechanism in place to discuss, at any time, but at least once a year, with disabled employees what can be done to make sure they can develop and use their abilities; make every effort when employees become disabled to make sure they stay in employment'[127].

Resulting from contact by the EFD, **NHS Direct** also informed us that they 'have no specific guidance at the moment but it is something we will be looking at in the near future so I look forward to seeing what you produce. Any guidance we will produce will cover all staff groups and not just our nurse advisors. At the moment we refer to best practice in EFD guides or use Access to Work advice when making reasonable adjustments'[128].

[127] Disability Employment Policy, London Ambulance Service, June 2007
[128] With thanks to Louise Campbell, National HR Advisor, NHS Direct. NHS Direct: **www.nhsdirect.nhs.uk**

7. International examples: reasonable adjustments in other countries

Inquiries were made through nursing bodies and equality organizations in the following countries: USA, Australia, Canada and Ireland. These countries were chosen because they all have long-standing and well-developed legislation prohibiting disability discrimination and requiring reasonable adjustments. In the time available it was not feasible to supplement these enquiries with web-searches, aside from in the USA, where early enquiries revealed that it would be profitable to concentrate efforts. The following sets out any relevant information received.

7.1 United States

The Americans with Disabilities Act 1990 prohibits employment discrimination against 'qualified individuals with a disability.' Disability is defined as a physical or mental impairment that substantially limits 1 or more major life activities; a record of such impairment; or being regarded as having such impairment.

As well as prohibiting direct and indirect discrimination there is a requirement to provide 'reasonable accommodation' to the known 'physical or mental limitations' of an otherwise qualified individual with a disability, unless to do so would cause undue hardship. A qualified individual is defined as one who is capable of undertaking the fundamental requirements of the job, if necessary with the assistance of reasonable adjustments.

ADA requires employers and educational institutions to make reasonable accommodations to the environment, program, or job that would allow the person who is disabled an opportunity to attain the same level of performance as persons who are not disabled, or to engage in equal benefits and privileges as those who are not disabled. Accommodations include redefining a job; modifying facilities for accessibility; providing special equipment, assistive aides, or support; and allowing the use of a working dog.

All private employers, state and local governments, and educational institutions that employ 15 or more individuals must comply. Institutions of higher education must consider admitting candidates who are disabled if they receive federal funds, if the candidate has a reasonable chance for employment, if auxiliary aids make the difference between successful program completion and failure, and if the cost of accommodations is not an undue burden.

Many nursing training programmes in universities and colleges in the United States follow guidelines set out by the **SREB (Southern Regional Educational Board) Council on Collegiate Education for Nursing (CCEN) Board of Directors**[129]. In the early 1990s, the SREB Council on Collegiate Education for Nursing Board of Directors

[129] http://www.jan.wvu.edu/media/nurses.html

formed a task force to develop guidelines for nursing education programs to use in complying with the 1990 Americans with Disabilities Act (ADA).

For the purposes of nursing programs' compliance, a 'qualified individual with a disability' is one who, with or without reasonable accommodations or modifications, meets the essential eligibility requirements for participation in the program. CCEN advises that nursing institutions may therefore 'want to begin by defining the essential eligibility requirements for participation in its nursing program'.

In developing the core performance standards, the CCEN defined nursing as 'a practice discipline with cognitive, sensory, affective and psychomotor performance requirements. Each standard is accompanied by an example of an activity that a student would be required to perform in the typical collegiate nursing-education program. Each standard, if adopted, must be reflected in the course objectives'.

CCEN advises that 'programs must not base admission or continued enrolment on the standards but instead should use them to assist each student in determining whether accommodations or modifications are necessary' and if a student requires accommodations to meet a standard the 'program must determine, on an individual basis, whether the necessary accommodations or modifications can be made reasonably'.

Core performance standards for admission and progression given by CCEN are:

Issue	Standard	Examples of necessary activities (not all-inclusive)
Critical thinking	Critical-thinking ability sufficient for clinical judgment	Identify cause/effect relationships in clinical situations, develop nursing care plans
Interpersonal	Interpersonal abilities sufficient for interaction with individuals, families and groups from various social, emotional, cultural and intellectual backgrounds	Establish rapport with patients/clients and colleagues
Communication	Communication abilities sufficient for verbal and written interaction with others	Explain treatment procedures, initiate health teaching, and document and interpret nursing actions and patient/client responses
Mobility	Physical abilities sufficient for movement from room to room and in small spaces	Move around in patient's room, work spaces and treatment areas;

		administer cardiopulmonary procedures
Motor skills	Gross and fine motor abilities sufficient for providing safe, effective nursing care	Calibrate and use equipment; position patients/clients
Hearing	Auditory ability sufficient for monitoring and assessing health needs	Hear monitor alarm, emergency signals, auscultatory sounds and cries for help
Visual	Visual ability sufficient for observation and assessment necessary in nursing care	Observe patient/client responses
Tactile	Tactile ability sufficient for physical assessment	Perform palpation, functions of physical examination and/or those related to therapeutic intervention (such as insertion of a catheter)

The **Job Accommodation Network (JAN)** at the US Department of Labour[130] provides advice on accommodation and compliance with Americans with Disabilities Act (ADA). It includes a section on Nurses with Disabilities. The site reports that there are 2.9 million registered nurses in the United States.

The site gives a list of possible accommodations available for nurses with disabilities and stresses that 'numerous other accommodation solutions may exist'. It suggests considering the following questions:
'1. What limitations is the nurse experiencing?
2. How do these limitations affect the nurse and the nurse's job performance?
3. What specific job tasks are problematic as a result of these limitations?
4. What accommodations are available to reduce or eliminate these problems? Are all possible resources being used to determine possible accommodations?
5. Has the nurse been consulted regarding possible accommodations?
6. Once accommodations are in place, would it be useful to meet with the nurse to evaluate the effectiveness of the accommodations and to determine whether additional accommodations are needed?
7. Do supervisory personnel and employees need disability awareness training?'

[130] http://www.jan.wvu.edu/media/nurses.html

The site provides a considerable range of suggestions on possible ways to 'accommodate' disability. As these are very practical and comprehensive, we list them at length (although not in full).

They include:

'Cognitive Impairment', such as 'Memory Deficits', accommodations suggested are:
- Allow the employee to tape record meetings and provide written checklists
- Provide type written minutes of each meeting
- Provide written instructions and allow additional training time

'Difficulty Reading and Writing, accommodations suggested are:
- Use speech recognition or word-prediction software if handwriting is poor or difficult
- Use a personal data assistant to help with spelling
- Seek areas of employment where charting is done by computer or in settings where reading/writing may be decreased, for example in an operating room
- Use dictation equipment and/or scribes

Motor Impairments, such as 'Difficulty Lifting or Transferring Patients' accommodations suggested are:
- Transfer aids
- Team lifting
- Height adjustable examination tables
- Walk-up changing tables that allow a child to be assisted in climbing to the changing table/examination table height.

'Use of One Hand', accommodations suggested are:
- One-hand syringes
- One-hand IV pole
- One-handed keyboards and keyboard software

'Access to Building and Work Environment', accommodations suggested are:
- Install ramps, automatic doors, and internal and bathroom doors that push open
- Lower shelves and provide access to file cabinets
- Provide preferred seating during training, classes, and meetings

'Maintaining Sterile Technique for Nurses Who use Wheelchairs', accommodations suggested are:
- Wash and dry hands, apply clean gloves, and manoeuvre to area; when gloves are removed hands will remain clean
- Keep extra clean gloves in pockets
- Use a strap or belt to secure self in chair when leaning forward to assess patient, perform wound care, etc.

A range of accommodations are suggested for nurses with 'psychiatric impairment' or 'mental illness' such as (but not only):
- Reduce distractions in work environment
- Provide to-do lists and written instructions
- Allow time off for counselling

- Provide clear expectations of responsibilities and consequences
- Provide sensitivity training to co-workers
- Allow telephone calls during work hours to doctors and others for support
- Provide information on counselling and employee assistance programs
- Allow work during shifts that are less demanding

Sensory Impairments such as 'speech impairments', accommodations suggested are:
- Word prediction computer software
- Text telephones (TTY or TDD)

Vision Impairments, accommodations suggested are:
- Monitoring Vital Signs
- Talking thermometers
- Talking scales
- Talking blood glucose monitors
- Talking blood pressure monitors
- Talking watches
- Provide signage in large print and Braille
- Text-enlargement computer software
- Hand or stand magnifiers for printed material
- Closed-circuit television (CCTV)
- Reduce glare via glare guards on computers and adjust lighting or blinds
- Electronic note-taking devices with speech or Braille output

For Deaf/Hard of Hearing impairments, accommodations suggested are:
- Blood pressure monitors with displays showing pulse and blood pressure
- Graphic auscultation systems
- Equipment with digital displays
- Vibrating alert to signal a monitor's alarm
- Written notes
- Email, instant messaging, speech recognition software
- Interpreters
- Augmentative communication devices
- Basic sign language training
- Text telephones (TTY or TDD)
- Assistive listening devices
- Communication Access Real-time Translation (CART) services
- Computer-assisted note taking
- Tape recording meetings
- Video conferencing

For telephone communication:
- Amplification (enhancing volume)
- Clarity (adjusting sound frequency)
- Headsets; HATIS manufactures the only headset available that is specifically designed for use by individuals with a moderate to profound hearing loss and who wear behind the ear (BTE), t-coil equipped hearing aids. For more information regarding HATIS products, go to http://www.hatis.com.
- TTY or TDD

Responding to Fire or Emergency Alarms
- Vibrating pagers

- Lights hard-wired to alarm system

The site also sets out a series of **'situations' and the 'solutions'** that were reached. These include:

A nurse with bilateral hearing loss has been using an amplified stethoscope that requires her to take her hearing aids in and out. She called JAN seeking a stethoscope that will work with her hearing aids in. JAN referred the nurse to a company who makes a stethoscope that can be used with a direct audio input port. The stethoscope was purchased.

A nurse with fibromyalgia syndrome working in a county health clinic experienced a great deal of fatigue and pain at work. The nurse typically worked evening shifts but her doctor recommended a schedule change so she could regulate her sleep patterns. Accommodations suggestions included changing her shift from evening to day, restructuring the work schedule to eliminate working two consecutive twelve hour shifts, reducing the number of hours worked to part time, and taking frequent rest breaks.

An operating-room nurse with chronic fatigue syndrome had difficulty rotating schedules. She was accommodated with a permanent day schedule.

A resource nurse with multiple sclerosis needed changes to her workstation and schedule. The employer made the workstation wider and added an adjustable keyboard tray. The employer also allowed periodic rest breaks and moved the employee closer to the restroom and break room to help reduce fatigue.

A nurse with insulin-dependent diabetes and hypoglycaemia was having problems regulating her condition (specifically, eating regularly while at work). Her schedule was altered by eliminating the evening rotation until her blood glucose levels could be controlled on a consistent basis. The employer reported this as a very effective accommodation. Cost of accommodation: none.

Exceptionalnurse.com

Another excellent source of advice on nursing as a disabled person in the United States is the website of **Exceptional Nurse** (http://www.exceptionalnurse.com/).

The site contains a huge range of information, including advice and suppliers of practical aids (such as stethoscopes for people with hearing loss, speaking thermometers and computer equipment).

It also has sources of research, job advertisements, the law, details of personal experiences and case studies, specific impairments and accommodations, training and education, and much else. The site is maintained by Donna Maheady, author of

Leave No Nurse Behind: Nurses Working with disabilities[131] and *Nursing students with disabilities change the course*[132].

Leave No Nurse Behind collects personal stories by eleven disabled nurses on how they overcame discrimination and found ways, including through 'reasonable accommodations' to continue with their careers.

They include the following cases.

Marianne Haugh, RN, BSN, who is a staff nurse on the paediatric unit of the Rehabilitation Institute of Chicago. Marianne Haugh has spina bifida and uses a wheelchair. She explained that she faced a lot of prejudice when trying to gain employment after her training. In her current job she says 'I use my wheelchair for long distances, such as in the hallway, but I do walk in my patients rooms. The only accommodation that RIC has really had to make for me is getting me latex-free sterile gloves to use for suctioning. Since I have a latex allergy, I try my best to stay away from latex as much as possible. But latex gloves are still in use there, so I carry around a box of clean latex-free gloves with me everywhere. For the most part, my patients have been very accepting of a nurse with a wheelchair.'

Morag MacDonald, RN, MSW, who currently works as a clinical case manager at Capitol Region Mental Health Centre in Hartford, Connecticut. Ms MacDonald is profoundly Deaf. She has practiced as a nurse for 28 years, working on spinal cord, paediatric and mental health units. She explains: 'As a student, I had to take off my hearing aids each time I needed to use my amplified stethoscope. Now, there are blood pressure machines that do not require the use of a stethoscope. I am now experimenting with stethoscopes that record on a PDA. There are now also clear surgical masks being tested for visibility that would make it easier to read lips.'

Mary Tozzo, RN, MS, who is a clinical nurse educator who teaches at a hospital in south Florida. Ms Tozzo is legally blind. Having retinitis pigmentosa, her eyesight deteriorated over a period of years. She struggled without any accommodations in employment for years, and when she enrolled in graduate school was 'surprised to find that some schools had a disability services office, and they provided accommodations for people like me'. When the 'screen and keyboard were a strain to read…my counsellor came to the rescue with a large monitor and keyboard with oversized print overlays installed in the classroom…throughout the years, the Office of Disability Services adapted their accommodations to my declining vision. I was able to read most of my textbooks with magnifiers until the last year. When that became too difficult, the DS office enlarged my texts on a photocopier'.

Susan Fleming, RN, BSN, MN, CNS, who has worked as a nurse in hospital settings for more than 20 years and is currently clinical nursing instructor at Washington State University's Intercollegiate College of Nursing. Ms Fleming has one hand. She explained that 'Even with my left hand completely missing, I became competent in starting IVs, giving injections, performing CPS and applying sterile dressings. As an

[131] Leave No Nurse Behind: Nurses Working with disabilities, Donna Carol Maheady, iUniverse, Inc, 2006
[132] Nursing students with disabilities change the course, Donna Carol Maheady, 2003

accommodation, I use a haemostat and keep scissors in my pocket, along with a large pair of sterile gloves'.

Sheila Sirl, RN who works as a legal nurse consultant in an attorney's practice. Sheila was diagnosed with primary progressive multiple sclerosis after some years working as a nurse. After illness and rehabilitation, she faced discrimination 'almost universally, when recruiters from the medical field heard that I was in a wheelchair, their interest in me quickly cooled'. She finally obtained a job in as a legal nurse consultant for an attorney: 'I would be able to work at home some days, taking in other work as it came along'. She has 'a great deal of contact with clients…an aspect of nursing that I had loved'. Sheila's conclusions from her experience include that 'A disabled nurse looking for work also has a responsibility to examine the job she is seeking…It's important for the nurse to go in with a good idea of any accommodations that may be needed…Perhaps the most important thing a disabled nurse can do for herself is to form her own self-image. Don't allow others to define you…'

7.2 Australia

Little information on guidance on reasonable adjustments was found for Australia. Longer time available and a more extensive search – including more time to locate, contact and speak with key individuals – may have produced more material. We cannot be certain. We contacted, by email, a range of organizations including the Australian Human Rights and Equality Commission, the Royal College of Nurses Australia, the Australian Nursing and Midwifery Council and the Australian Nurses Federation. The only reply received from these organisations was from the Royal College of Nurses Australia, which included our request in the organisation's weekly electronic newsletter.

Elizabeth Reale, Federal Professional Research Officer and Librarian, of the **Australian Nursing Federation**, advised that while universities have policies on access for students with disabilities and there is federal legislation covering disabled access to public buildings, and reasonable adjustment, how these applied in nursing was unclear[133].

Elizabeth Reale provided two anecdotal examples:

- a vision impaired registered nurse (with limitations restricting practice to areas of ability) who worked in a health facility with vision impaired patients;

- a nursing student who was quadraplegic. She was able to complete the theoretical component of her undergraduate nursing degree but was unable to complete the clinical component. She attained her qualification, but was not able to be registered, and worked in an area of health research.

[133] The Australian Federal Government Site *JobAccess – help and workplace solutions for the employment of people with disability* seemed to contain no specific or practically focussed references to nursing and midwifery. The page dealing with reasonable adjustments can be found at: http://www.jobaccess.gov.au/JOAC/Employers/Before_you_start/Frequently_Asked_Questions/Reasonable_adjustments.htm

We were fortunate to be advised of other contacts through the US-based site www.exceptionalnurse.com. In particular this led to a reference contained in course information by the **University of Melbourne**.

The University's **School of Nursing and Social Work** sets out its policy on reasonable adjustments in its information on course content and requirements. Under 'ability requirements' the following information is given: 'It is University policy to take all reasonable steps to minimise the impact of disability upon academic study and reasonable adjustments will be made to enhance a student's participation in the University's courses. Students who feel their disability will impact on meeting this requirement are encouraged to discuss this matter with the Course Coordinator and the Disability Liaison Unit'[134].

[134] https://app.portal.unimelb.edu.au/CSCApplication/view/2009/514-761

8. Summary

8.1 The Nursing and Midwifery Council (NMC) commissioned a literature review of guidance on reasonable adjustments in the workplace and education setting for nurses and midwives and other relevant health professionals. The aim was to review existing guidance, identify examples of good guidance and of gaps in guidance.

Literature was reviewed that was:

- aimed at the health education sector and employment in the health sector;
- national, regional or local;
- related to nursing and/or midwifery and to other related healthcare professions (including social work);
- produced by a range of healthcare regulators;
- used in other countries, for example. the United States.

8.2 A very comprehensive search was undertaken and we are confident that the good practice identified will considerably assist the NMC in taking its discussion forward. Naturally, despite this, some examples of good practice may have eluded our search and organisations may wish to forward on to the NMC any guidance that they consider contains important examples.

In line with the terms of reference for the literature review, our primary aim was to identify good practice. The NMC will be able to draw on this in its own discussions and practical policy development.

8.3 In this summary we are highlighting simply a few of the best examples found in order to draw attention to particular features that they demonstrate.

8.3.1 The General Medical Council, Chartered Society of Physiotherapy and Health Professions Council have all produced guidance that, in differing ways, is relatively comprehensive. By this we mean guidance that is *holistic* – for example, presenting information both for people who may be interested in training, for current professionals and for managers, employers and/or trainers. These examples also cover disability in a broad sense, considering a *broad range of impairments or disabling situations*.

They are also holistic in looking at the issues that potentially arise at *different stages* in ensuring reasonable adjustments will be successfully delivered. The best guidance therefore stresses issues such as: everyone *understanding the positive case* for reasonable adjustments; adequate *training, staffing and resources*; *early planning* for placements and any situation in which adjustments have to be delivered; good channels of *communication*, for example, between schools of nursing and placement providers; encouragement of *disclosure* by having a publicised anti-discrimination policy that is shown to deliver; systems for *monitoring* and changing policies.

In different ways, the best guidance also *addresses important professional issues* that can be a source of confusion. The GMC guidance, for example, explains the relationship between professional competencies and reasonable adjustments, and in the course of doing so, decouples competence from the language of health or fitness:

Tomorrow's Doctors explains that to graduate, doctors must be able to perform 'safely and effectively a list of 18 clinical and practical skills' and explains that 'although adjustments cannot be made to these standards, reasonable adjustments can be made to the method of learning and the assessment by which the student demonstrates these skills.

'Likewise, specific conditions around these standards might be adjusted. For example, a requirement that a student should be able to complete a task within a certain time would only constitute a genuine competence standard if speed is an intrinsic part of the task'.

'Medical schools have a duty to ensure that they have clearly identified which entry requirements are genuine competence standards (and so lawful under the Disability Discrimination Act) and which are not'.

Most importantly, we consider these examples of good practice because they provide well explained, *practical advice and examples or case studies* of reasonable adjustments in practice. In doing so, they debunk stereotypes about disability and provide much needed examples – most importantly to disabled potential or actual professionals – of the potential for inclusion and support.

The Health Professions Council demonstrates how reasonable adjustments can help meet the professional requirement to maintain records appropriately by a practical example:

'someone with a sight difficulty who uses a dictaphone or adapted laptop computer to help them take their notes, or someone with dyslexia who might prefer to keep electronic notes. In each case, the person registering has taken reasonable steps to make sure that they met this part of the standards of proficiency.'

The Chartered Society of Physiotherapy demonstrates the need to monitor practice by a practical example:
'A student with a visual impairment who initially requires a personal assistant support worker to facilitate mobility around a new environment may find that this is unnecessary once s/he is familiar with routes and staff members'.

The most comprehensive as well as practical advice in this regard however is that identified outside of the UK, and specifically in the **United States**.

Good guidance included information about and signposts to practical advice such as Access to Work – repeatedly cited as a crucial source of support for employees, including nurses and midwives who were disabled – and to disabled students grants and other resources.

8.3.2 A number of **Schools of Nursing** have in the absence of standard national guidance proceeded to develop local guidance. These vary considerably, *often reflecting local circumstances or requirements* to which schools have needed to respond. For example, a number of schools have developed guidance specifically on dyslexia and similar impairments, such as Southampton, Keele, Middlesex and Nottingham. The practical advice on adjustments for dyslexia may be more advanced for a number of reasons, but can be used as a model for the detailed information needed for disabled students and professionals in total.

The schools at Napier and the University of the West of Scotland were examples of institutions that provided concrete examples of adjustments for wider ranges of disability, although in the case of Napier the focus was particularly on hearing, dyslexia, diabetes and epilepsy. The integration of Deaf students at Salford's school of nursing resulted from a six year funded project, the outcome of which is ongoing integration of Deaf students into the student cohort, supported by rounded and well informed practice, leading to reasonable adjustments in clinical settings. Salford's clarity on *specific reasonable adjustments*, stress on the importance of *well organised communication* and *positive drive for representation* of Deaf people at all stages of the learning, practising and teaching environment are examples of good practice.

A number of other educational bodies have developed good practice policy on other specific issues, such as Sheffield Hallam's guidance on disclosure or the University of Ulster's guidance on competence standards, which stand as examples of good practice. Sheffield Hallam's *reasonable adjustments panel for clinical placement* is an innovative system which we would recommend as a good practice to consider building upon.

8.3.3. Of the guidance identified in a small sample of **NHS Trusts**, a particular example of good practice which should be highlighted is that of **Liverpool Women's NHS Foundation Trust**, which funds a post of a dedicated Disability Adviser. This is a well advertised post – easily found on a search of the Trust's website which explains that the post-holder is herself a 'disabled woman, nurse and midwife'. Supplementing written guidance by this kind of personal source of additional expertise will greatly assist users – whether disabled individuals or their line managers.

8.3.4 A final key issue, essential for ensuring guidance that is well-informed and will work, is to ensure *involvement, engagement and networks of disabled people*. There are various examples given in the report. For example, the website of the US-based **exceptionalnurse.com** is excellent and allows disabled nurses to link up, learn from each other and results in a site of excellent legal, professional and practical advice . The **College of Occupational Therapists** has an online forum which facilitates discussion between disabled professionals. The RCN's **Work Injured Nurses Group** is another example of a network for disabled members.

8.4 Overall this literature review identified a very mixed picture, with some examples of good practice, much that is patchy or incomplete, and some examples of bad practice and lack of compliance with legal obligations. From these results we conclude that there is a clear need for national guidance to be developed by the NMC.

A range of schools of nursing in particular commented that they would strongly welcome national guidance from the Nursing and Midwifery Council on reasonable adjustments. This guidance would have the advantage of starting from a clear policy base, being informed by existing good practice, (and thus be more likely to be comprehensive). Such guidance would set a minimum base line of good policy and we believe that that it could have a profoundly educational and progressive impact: in particular encouraging disabled people, both those who become disabled in their working life and young people and others who may be potential entrants to the profession, that they have a future in nursing and midwifery.

8.5 From the literature reviewed we can conclude that the following are key issues to be considered in drawing up guidance.

8.5.1 At the level of policy:

- Explaining a clear, positive case for an inclusive profession and therefore reasonable adjustments – telling everyone how nursing and midwifery will benefit individual students, nurses and midwives, will gain and retain skills and will benefit patients – by having nurses from widest base of experience and giving positive role models.

- Based upon the social model of disability, that is explaining that 'disability' is not 'ill-health'; that while 'impairments' are real, how we choose to organise society creates 'disability'.

- Setting out legal obligations in an accessible way.

- Using language about professional competence that is not off-putting and creates maximum clarity.

- Having the potential to monitor change and success, by collecting data.

8.5.2 **At the level of practical elements of guidance:**

- Ensuring a *holistic* policy that thinks through the issues that may arise at each stage for an individual and an organisation, from first expression of interest through employment and career advancement.

- Being *comprehensive* - advice that addresses reasonable adjustments that may be needed for the widest range impairments and situations that disabled people may confront and bring to the professional setting.

- Stressing *anticipation* and early *planning*

- Providing guidance on *the practical system* for organising support for disabled students, nurses and midwives in relation to reasonable adjustments needs, requests and delivery.

- Addressing *key issues* such as disclosure and that relevant staff are *adequately trained* on disability and reasonable adjustments.

- Proving a wide range of *practical examples*/case studies and positive stories.

- *Promoting good practice* on individual issues – such as Trusts and employers and educational institutions having dedicated nursing and midwifery disability advisers trained to deal with reasonable adjustment advice and processes.

- *Tailoring advice* so that it is relevant to nursing schools, placement providers and employers as well as to individuals.

- *Involving* disabled students, nurses and midwives and facilitating networking to swap experiences, feel supported and help draw out lessons for future policy.

- *Advertising*: ensuring a policy is easy to locate, is well promoted and is accessible in language and format.