LEGAL ASPECTS OF OCCUPATIONAL THERAPY

Second Edition

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Emeritus Professor of the University of Glamorgan

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Foreword

Occupational therapists practising in the early part of the twenty-first century, whether employed in health, social care or the private and voluntary sector, are working in a constantly changing environment, constructed and framed by legislation and legal rulings. Clients and patients are at the centre of practice, challenging practitioners who are providing services within new organisations and structures whilst responding to the needs of local communities.

Modernisation has had a major impact on public services and the way they are delivered. Occupational therapists have worked hard to improve access to their services, developing new roles responsive to patient need, redesigning the way services are delivered and embracing equality and diversity. Occupational therapists have long understood that those patients and clients receiving care are well informed about the quality of their local services and want to be active partners in making decisions about their own care.

Public trust in professionals has been shaken by public scandals; this has informed the modernisation of professional regulation to ensure fitness to practice and make sure that the public are protected. Occupational therapists have to demonstrate their competence, be clear about their professional and managerial accountability, be actively involved in risk management and be sure that clear governance structures are in place to underpin their work.

To both new and established practitioners the pace of change and new initiatives can seem daunting, however; change is happening across the whole of the United Kingdom with the devolution agenda and the impact of European legislation. The practice of occupational therapy is constantly developing. Many practitioners are aware of the need for a sound evidence base for practice; they are scanning the horizon and promoting new ideas to improve the delivery of health and social care wherever it is delivered now and in the future.

In the preface to this second edition of this book the author sets out its aims 'against the complex background of major organisational and legal changes'. Bridgit Dimond encourages occupational therapists to use the book and makes it clear that practitioners do not have to have legal knowledge. The legal frameworks within which occupational therapy practice is delivered are set out clearly in a readable and practical format.

I commend this book to occupational therapists. It is an essential practice guide, just as essential as an anatomy, physiology or psychology textbook. It will ensure informed practice in its widest sense and make sure that practitioners have a mature understanding of the framework within which they practise.

Kay East
Chief Health Professions Officer
Department of Health

Preface to second edition

The aim of the second edition of this book is to provide an updated outline of the law relating to occupational therapy practice which is of direct relevance to occupational therapists (OTs). The second edition of this book addresses the law relevant to occupational therapy against the complex background of major organisational and legal changes in health and social care. Significant changes have occurred within the NHS and social services and in statute and case law over the past few years and this second edition attempts to cover these from the perspective of the OT. Unfortunately some legal developments awaited in the first edition are still awaited, such as legislation covering decision making on behalf of mentally incapacitated adults and a new Mental Health Act.

As for the first edition, no previous legal knowledge is required and a similar format is followed for this edition. Many other areas could have been included such as pain management and palliative care, but limitations on the book's length have meant that this was not possible. It is hoped that it will prove a book for readers to dip into according to their needs and will prove the foundation for an ongoing development of legal knowledge.

Language is an important vehicle for demonstrating current philosophies and attitudes. I have preferred to use the term 'patient' or 'client' as appropriate to the context, rather than the term 'service user' which, to my mind, places those who receive health and social care on a par with railway commuters or gas and electricity consumers. Whilst the politically correct modern terminology does not recognise that certain individuals 'suffer' from specific conditions or are regarded as physically or mentally disabled, the law has not yet caught up with the modern language. Thus compensation is paid in negligence cases for 'pain and suffering'; the Chronic Sick and Disabled Persons Act 1970 is still the principal legislation on the duties of local authorities; the Disability Discrimination Act 1995 defines what is meant by a 'disabled person'; the Mental Health Act 1983 is concerned with the compulsory admission of those with mental disorder and with mentally disordered offenders; and the more recent Carers and Disabled Children Act 2000 still uses language which may not be acceptable to many occupational therapists.

I have therefore adopted the strategy that where legislation is being referred to, or cases cited, it is necessary to use the language used in that legislation. However, where the context permits, people are referred to as having disabilities or mental health issues, rather than being physically or mentally disabled.

Finally, modern usage suggests there are no 'elderly' people, instead there are 'older persons'. This may not be linguistically correct, since an 18 year old is an older person in relation to a person below 16, but again where the context permits I have bowed to political correctness. Perhaps by the third edition, the law may have moved on.

Preface to first edition

Occupational therapists in the past have not sufficiently conveyed to the general public the complexity, extent and significance of their work in health and social care. Their contribution extends from the field of special care babies to the care of the elderly and bereaved and all intermediate stages of health, illness and social need, between birth and death. The legal issues which may arise are therefore vast and cover many areas of specialist law. It has been my task to provide the occupational therapist practitioner, student, manager and those in related professions and posts with an introduction to the laws which relate to the practice of occupational therapy. It is assumed that the reader will have no previous legal knowledge and a glossary has been provided to explain some of the technical legal language. It is essentially a book which is concerned with the practical aspects of the law as it applies to occupational therapy and examples of the specific legal concerns are derived to a considerable extent from the many questions raised with me by occupational therapists across the country. The anticipation is that this introduction to the law will enable the occupational therapist to develop the knowledge and awareness of the legal implications of her practice so that she can protect both her client and herself.

Terminology in relation to gender always causes concern and I have recognised the fact that the profession is mainly female and thus referred to the occupational therapist as she or her. This should be interpreted as including he and him. Persons cared for by occupational therapists are variously called 'patients, clients, residents, customers and consumers' and I have in the main used the term client, but where the context makes other terms more appropriate I have used these.

The statutory changes which took place in 1990 with the introduction of the internal market into health care and the developments within community care are still working their way through the role and profession of the occupational therapist. Further major changes are to come with a major reorganisation of the regulation of the professions supplementary to medicine. It is hoped that the knowledge obtained from this book on the law applying to occupational therapist will enable the reader to meet these challenges and continue to develop a comprehensive and high quality service to her clients.

Acknowledgements

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Finally, I would like to record my indebtedness to my family and friends who encouraged me in this work, in particular, Bette who read the typescript with her usual thoroughness and prepared the index and tables.

Abbreviations

ACAS	Advisory, Conciliation and Arbitration Service
ACOP	Approved Code of Practice
ACPC	Area Child Protection Committee:
ADL	activities of daily living
AHP	Allied Health Professions
AOMH	Association of OTs in Mental Health
BAOT	British Association of Occupational Therapists
BCMA	British Complementary Medicine Association
CAFCASS	Child and Family Court Advisory and Support Service
CAM	complementary and alternative medicine
CDRP	Crime and Disorder Reduction Partnerships
CHAI	Commission of Healthcare Audit and Inspection
CHC	Community Health Council
CHI	Commission for Health Improvement
CNST	Clinical Negligence Scheme for Trusts
COPE	Committee on Publication Ethics
COREC	Central Office for Research Ethics Committees
COSHH	Control of Substances Hazardous to Health
COT	College of Occupational Therapists
CPA	care programme approach; comprehensive performance assessment
CPD	continuing professional development
CPPH	Commission for Patient and Public Involvement in Health
CPR	Civil Procedure Rules
CPS	Crown Prosecution Service
CPSM	Council for Professions Supplementary to Medicine
CSCI	Commission for Social Care Inspection
DEE	Department for Education and Employment
DfES	Department for Education and Skill
DFG	disabled facility grant
DHA	district health authority
DISC	Disability and Information Centre
DNR	do not resuscitate
DoH	Department of Health
DRC	Disability Rights Commission
DSS	Department of Social Security
EC	European Community
EHR	electronic health record

EPIOC	electrically powered indoor/outdoor wheelchairs
EPR	electronic patient record
EWG	external working group
FHSA	family health services authorities
GDC	General Dental Council
GMC	General Medical Council
GSCC	General Social Care Council
HAI	hospital acquired infection
HASAW	Health and Safety at Work Act 1974
HEIs	Higher Education Institutes
HIS	hospital information system
HPC	Health Professions Council
HRDG	Health Records and Data Protection Review Group
HSC	Health and Safety Commission
HSE	Health and Safety Executive
IADL	instrumental activities of daily living
ICAS	Independent Complaints and Advice Services
ICP	integrated care pathways
IM&T	information management and technology
JP	Justice of the Peace
JVC	Joint Validation Committee
LA	local authority
LOLER	Lifting Operations and Lifting Equipment Regulations
LREC	Local Research Ethics Committee
MCA	Medicines Control Agency
MDA	Medical Devices Agency
MHAC	Mental Health Act Commission
MHRA	Medicines and Healthcare Products Regulatory Agency
MHRT	Mental Health Review Tribunal
MREC	Multi-Centre Research Ethics Committee
NAI	non-accidental injury
NAO	National Audit Office
NAPOT	National Association of Paediatric Occupational Therapists
NCSC	National Care Standards Commission
NHSLA	National Health Service Litigation Authority
NICE	National Council for Clinical Excellence
NMC	Nursing and Midwifery Council
NPSA	National Patient Safety Agency
NSF	National Service Frameworks
OOS	occupational overuse syndrome
OT	occupational therapist/occupational therapy
PACS	picture archiving and communication systems
PALS	Patient Advocacy and Liaison Service
PCT	Primary Care Trust
PUWER	Provision and Use of Work Equipment Regulations
PVC	persistent vegetative state
QAA	Quality Assurance Agency for Higher Education
RADAR	Royal Association for Disability and Rehabilitation
RAE	research assessment exercise

RCP	Royal College of Psychiatrists
REC	Research Ethics Committee
RIDDOR 95	Reporting of Injuries, Diseases and Dangerous Occurrences (Regulations) 1995
RMO	responsible medical officer
RSI	repetitive strain injury
SENDA	Special Educational Needs and Disability Act
SHA	strategic health authority
SOAD	second opinion appointed doctor
SRSC	Safety Representatives and Safety Committees (Regulations)
SRV	social role valorisation
SSD	social services department
SSI	Social Services Inspectorate
UKCCSG	United Kingdom Children's Cancer Study Group
WDC	Workforce Development Confederation
WFOT	World Federation of Occupational Therapists
WRULD	work related upper limb disorder

Chapter 1
Occupational Therapy

In attempting to identify the legal issues relevant to occupational therapy practice, I was immediately confronted by the problems in defining occupational therapy and identifying the scope and content of occupational therapy practice. To link the work of the occupational therapist (OT) in caring for the mentally disordered with anorexia or in looking at feeding regimes and working with dietitians, with the role in assessing and prescribing for wheelchairs, seemed impossible. Similarly, what has the work of the OT in special care baby units in common with that of her colleague in a forensic psychiatric unit? To provide a definition of occupational therapy which covers such diverse activities is a major challenge. This was taken up in a major review conducted by Louis Blom-Cooper in 1989 into the theory and practice of occupational therapy.

The report[1], which was commissioned by the College of Occupational Therapists (COT), explored the changing demographic pattern and the growth in recognition of the need for a support service like occupational therapy to assist people to regain or develop their full potential.

Definition of occupational therapy

The first definition of an occupational therapist used by the Association of Occupational Therapists[2] was:

> 'Any person who is appointed as responsible for the treatment of patients by occupation and who is qualified by training and experience to administer the prescription of a Physician or Surgeon in the treatment of any patient by occupation.'

Occupational therapy was defined by the Council for Professions Supplementary to Medicine (CPSM) booklet[3] as:

> 'the treatment of physical and psychiatric conditions using specific selected activities in order to help people who are temporarily or permanently disabled to recover independence and cope with everyday life. Therapists work in one of three main areas: with the physically disabled, with those with mental health problems, and with people who have learning disabilities.'

This is much narrower than the definition which Blom-Cooper suggested in his Commission of Inquiry. The Commission's report adapted the definition of occupational therapy used by the COT and recommended its adoption:

> 'Occupational therapy is the assessment and treatment in conjunction and collaboration with other professional workers in the health and social services, of people

of all ages with physical and mental health problems, through specifically selected and graded activities, in order to help them reach their maximum level of functioning and independence in all aspects of daily life, which include their personal independence, employment, social, recreational and leisure pursuits and their interpersonal relationships.'

Stereotypes and core philosophy

The Blom-Cooper report discussed the outdated stereotypes of the profession associated with basket making and looked at changing the name to get away from the myths and out-of-date attitudes to the profession. It considered that the most suitable name would be 'ergotherapy', but recognised the limitations of this name because of its association with ergonomics and being too narrow. In the end the report abandoned the task of suggesting a name and made no recommendation on the title. The COT issued a statement on definition in May 1990[4] in line with that suggested in the Blom-Cooper report. It identified four facets of the therapeutic role:

- prevention
- habilitation and rehabilitation
- retraining and maintenance
- readjustment.

It also defined the other roles of the OT, i.e. the advisory and educational role and the management role.

In 2000 the COT suggested that an appropriate definition of the work of an occupational therapist would be:

'Occupational therapists treat people of all ages with mental and physical problems through meaningful occupation to improve everyday function and prevent disability.'[5]

The heart of the OT's function has been widely debated. Thus Phillips and Renton[6] ask whether assessment of function should be the main aim of the OT's role. Jenkins and Brotherton[7] discuss an attempt to find a theoretical framework for occupational therapy. Some valuable insight into the philosophy behind occupational therapy as a profession was obtained from the third edition of Turner *et al.*'s classic work on occupational therapy[8]. The underlying thoughts and common links were identified as:

- individuals are each in a state which they wish to improve;
- the therapist uses activity as the medium for this improvement;
- individuals are aiming for the restoration or achievement of the skills required for daily life and have the capacity for change needed to achieve this;
- each person is an individual and inherently different from any other.

In order to achieve these objectives the OT must be skilled as a teacher, as a craftsman, as a purchaser and assessor of equipment and clients, as a therapist in understanding all mental and physical conditions, as a communicator, as a provider of health care, and so on. The law impacts upon them all. In their fifth edition the editors of this work note that there has been an enormous change in culture which

'has seen a growth in the need for occupational therapists to demonstrate that their interventions are based on sound clinical reasoning, with a specific brief to provide evidence for the efficacy of their practice. The introduction of clinical governance,

evidence-based practice and quality audit has shaped the remit of therapists in health, social care and private practice.'

The legal implications of this significant cultural change are enormous and can be seen throughout this text.

Annie Turner[9], in her first chapter on the history and philosophy of occupational therapy, suggests that a philosophy on which to base the profession's practice, theory and research could consist of the following concepts:

- People are individuals and inherently different from one another
- Occupation is fundamental to health and well-being
- Where occupational performance has been interrupted a person can:
  - Use occupation and/or activity to develop the adaptive skills required to acquire, maintain or restore occupational performance
  - Modify their occupations and/or activities to facilitate occupational performance

Occupational therapy and the spiritual dimension

In the Casson Memorial Lecture 2001 Gwilym Wyn Roberts[10] considered the future development of higher level practice and stated that occupational therapy needed to consider a spiritual context of our work, our values and how we value ourselves.

The spiritual content and context of occupational therapy has been widely debated, including the influence of Eastern and Western philosophies[11]. Some have turned to Zen Buddhism as the foundation of occupational therapy practice. Kelly and McFarlane[12] emphasise the value of Chinese philosophy in providing the basis for a new, modified, holistic approach to occupational therapy. They also show the extent to which the principles are already being used, albeit indirectly, in occupational therapy management and treatment, for example the general systems theory and sensory integration theory. Lorraine Udell and Colin Chandler[13] discuss the role of the occupational therapist in addressing the spiritual needs of clients and note that in order to further discussion on this issue it is necessary to consider:

- The extent to which spirituality has an impact upon health and well-being
- The question of whether spirituality is a necessary component of holistic care
- The specific training and guidelines that would be needed.

This philosophy also has importance in relation to the terms in which the OT views her relationship with her client and the rights of the client. Non-interference and self-help are important features of a client centred therapy.

This concern with the philosophy of the OT is taken further by Barnitt and Mayers[14]. They show that the starting point would appear to be an incompatibility in that humanists believe that individuals, not God, are responsible for their own existence while Christians look to God for rules and principles to guide behaviour.

Cunliffe[15] asks what rights patients have with a treatment containing philosophy, theory or spiritual belief. The answer must be that it is impossible to divest the therapy from any such content and, as Cunliffe emphasises, it is important that within occupational therapy the patients have a right to be informed of the philosophy, or spiritual belief, contained in the treatment. He adds descriptively that 'there is no difference between the surgeon's knife and a treatment belief that cuts theoretically, psychologically or spiritually in the wrong place'.

Inevitably OTs have become concerned with the relevance of occupational therapy to issues relating to the quality of life[16].

Katrina Bannigan[17] urges every occupational therapist to communicate passionately what she or he does 'so that our vision shines through'.

Core knowledge and skills required by OTs

This ongoing debate as to the philosophy and function of occupational therapy will have a major impact in determining the relevant skills required.

The Blom-Cooper report identified the core knowledge and skills required by OTs under four headings, shown in Figure 1.1. (Reference should also be made to Chapter 5 on education and definition of core skills and competencies.)

Figure 1.1 Core knowledge and skill required by OTs.

(1) Knowledge of the intelligence, physical strength, dexterity and personality attributes required to perform the tasks associated with a whole gamut of paid and unpaid occupations and valued leisure pursuits.
(2) The professional skill to assess potentialities and limitations of the physical and human environments to which patients have to adjust, and to judge how far these environments could be modified and at what cost to meet individual needs.
(3) Pedagogic skills required, first to teach people how to acquire or restore their maximum functional capacity, and second to supervise and encourage technically trained instructors and unqualified assistants in their tasks of implementing and monitoring therapeutic recommendations.
(4) The psychological knowledge and skills to deal with anxiety, depression and mood swings which are the frequent aftermath of serious threats to health or of continuing disability, and to motivate, or remotivate, those with temporary or persistent disabilities to achieve their maximum capacity.

Problems identified in the Blom-Cooper report

In discussing the attempt of the profession to establish its professional identity and autonomy, major problems were identified in the Blom-Cooper report:

- The dominant position of the medical profession in the provision of health care and the social work profession in the provision of social services
- The dependence of OTs on doctors and social workers for access to their clients
- The false and damaging stereotype that other staff and the public have of their function
- The pronounced female composition of the profession
- Questions over occupational therapy's efficacy, a matter of increasing importance in the internal market.

There is unfortunately no clear evidence since the Blom-Cooper report was published, that all these weaknesses have been corrected. Whilst the internal market has been abolished, occupational therapists still need to show value added to the quality of life of their patients/clients and that they are a service which can provide significant benefits. Both the consultants and the clients must be convinced of the benefits which OTs can bring in the rehabilitation and social and health care of the vast majority of patients and clients.

Conclusions of the Blom-Cooper report

The report considered the role, function and organisation of the profession and reached the following conclusions:

- Occupational therapy is needed as an integral part of health and social service provision
- Although there is room for devolution of some of the work at present performed by trained OTs to their helpers and clerical staff, there will be a continuing and expanding need for fully professional OTs
- Further consideration should be given, in the long term if not in the immediate future, to the creation of a united profession of rehabilitation therapist, permitting post-qualification specialisation
- In the decade following the report and increasingly into the twenty-first century occupational therapy should be largely relocated in the community care services.

Recommendations in the report addressed to the COT cover the topics shown in Figure 1.2.

Figure 1.2 Recommendations of the Blom-Cooper report.

- number and norms
- deployment
- recruitment
- preparation
- qualifying standards
- negotiating machinery
- professional enhancement

Developments since the Blom-Cooper report

The Blom-Cooper report was written at a time when the Government of the day had not indicated its intentions following the response to its White Paper, *Working for Patients: Caring for the 1990s* or following the Griffiths report, *Care in the Community: Agenda for Action*, 1988. It was therefore impossible in that uncertainty for the proposals of the inquiry to be precise. Since that time there have been fundamental changes in the organisation and management of health and social care; these are considered in detail in Chapters 17 and 18. These developments include: the implementation of the NHS and Community Care Act 1990 and major changes in relation to the management of health care; the introduction and the abolition of the internal market; the establishment of NHS trusts; primary care trusts and care trusts and the introduction and the abolition of GP fundholders. New unitary authorities for local government with social services taking over responsibility for the purchase of places for clients in nursing and residential homes for those admitted after 1 April 1993. Significant new institutions of inspection for health and social care have been set up and were established in April 2004.

These major structural changes in the organisation of the NHS present significant challenges for the OT. A useful analysis of the impact of organisational change upon the role and future of occupational therapy is given by Chris Lloyd and Robert King[18]. They consider that whilst the scope and complexity of the restructuring of the NHS present considerable challenges, OTs are well placed to meet these. The core values of the profession are congruent with community-focused, client-centred and outcome-oriented models of service delivery. In addition, the emphasis on enable-

ment occupation provides opportunities to add new roles to occupational therapy. OTs have the skills that are consistent with working at the level of case management and in health promotion.

Occupational therapy and physiotherapy

Blom-Cooper suggested that consideration should be given to the creation of a united profession of rehabilitation therapist. This idea has not in general found favour but the relationship between occupational therapy and physiotherapy has led to closer communication between the professional associations of OTs and physiotherapists. Whether there is unnecessary duplication of skills between occupational therapists and physiotherapists is considered by Janet Golledge[19], who emphasises that occupational therapists should be using purposeful activity and occupations as their therapeutic media, with limited use of activity. (These distinctions are explained in earlier articles[20].) Activities could be used by physiotherapists, but not purposeful activity or occupation. This is where the two professions could see the distinctions in their therapeutic media. She notes however that the enduring concern is whether managers, purchasers and users of health care can understand the distinctions sufficiently. The establishment of the Health Professions Council and the greater flexibility that it can give to the recognition of new state registered professions may facilitate closer associations between physiotherapy and occupational therapy.

Client-centred occupational therapy

Thelma Sumsion[21] discusses the definition of client-centred practice that was developed from 67 OTs participating in nine focus groups; 165 components of client-centred practice were generated and analysed to form seven themes. The final definition was:

> 'Client-centred occupational therapy is a partnership between the client and the therapist that empowers the client to engage in functional performance and fulfil his or her occupational roles in a variety of environments. The client participates actively in negotiating goals which are given priority and are at the centre of assessment, intervention and evaluation. Throughout the process the therapist listens to and respects the client's values, adapts the interventions to meet the client's needs and enables the client to make informed decisions.'

The author states that if therapists are working according to this definition, they should be able to ensure that clients do feel like valued human beings.

From interface to integration

In January 2002 the College of Occupational Therapists published a consultation paper on a strategy for modernising occupational therapy services in local health and social care communities[22]. This considered a new model of a community-based OT practice and sought responses to this concept. The College stated that:

> 'The development of a new community-based occupational therapy general practitioner model is central to its wish to resolve the problems around the interface

between health and social care. We see this as pivotal to an integrated approach that enables services to be developed as a continuum that is focused on, and responsive to, the needs of all service users and their carers.'

The COT considered that this model would assist the OT in responding to the current national and country-specific Government policies and priorities including:

- Promoting independence (COT prefers the term 'inter-dependence')
- Preventing avoidable or unwanted dependence
- Addressing social isolation
- Reducing waiting lists
- Delivering on the objectives and standards in the National Service Frameworks
- Working in partnership with individuals and their carers
- Working collaboratively
- Eliminating duplication
- Supporting public health and prevention
- Seeking to provide services on an increasingly sound evidence base
- Supporting value for money and best value regimes
- Promoting recruitment and retention.

The consultation ended in April 2002 after which it was the intention of COT to publish a series of occasional papers focusing on key implementation issues to facilitate ongoing dialogue and development. At the time of writing publication of these papers is awaited.

Conclusions on definition of occupational therapy

Edward Duncan[23] analyses the core skills required of an OT working in mental health and concludes:

> 'It is time for the profession to move from its adolescent identity crisis, within which at times it appears to be stuck, to its rightful sense of a coming of age. This step, as painful for a profession as it is for an individual, would allow the fruitless search for a prescriptive definition of what and what is not occupational therapy to end. Studies of occupational therapy and the further development of an understanding of occupational performance could then develop.'

A similar attitude is revealed in a light-hearted paper, but dealing with a very serious topic, in which Adam Goren[24] explores the identity of the occupational therapist and concludes that it

> 'is still a profession in its youth, unsure of its own identity, sensitive to its own environment, rebelling against its own conformity, (and in need of some direction and boundaries), highly adaptable, creative, curious and impressionable'.

He suggests that this youthfulness may also be the key to a more sensitive, nourishing and mature way of working with clients and patients.

The debate on the role and function of occupational therapy may possibly never end. There is perhaps a danger of too much navel gazing, too much worrying about what OTs should call themselves and their work. Perhaps, as Edward Duncan suggests, it is better to move on and provide the service.

The HPC has published proficiencies for each of the professions registered by it.

Each registrant has a copy of these proficiencies and it is clearly incumbent upon each person to ensure that they maintain and develop their competence. (See Chapter 5 for further discussion on this.)

From the legal perspective it is clear that any book which attempts to be relevant to all aspects of the role of the OT needs to be comprehensive and far reaching in its coverage, and it is hoped that this book will provide the necessary framework.

The future

Recently we have seen the epic work of Ann Wilcock in tracing the journey of occupational therapy from the earliest times to the present day[25]. Her concluding hopes for the work are that it

> 'will encourage a greater range of questions, research and initiatives to facilitate the growth and direction based on in-depth and investigative practices'.

The two volumes of the history of occupational therapy sponsored by the British Association and College of Occupational Therapy should give OTs a sense of their history and their significance in the field of health and social care. In spite of major changes since 1989, the recommendations of the Blom-Cooper report are still of value, and perhaps another inquiry to establish what now needs to be done in the light of changing circumstances would be an advantage. Major changes to the professional registration machinery and the nature of professional conduct proceedings were introduced in 2002 and these are discussed in Chapter 3.Their impact upon the status and role of the occupational therapist needs to be evaluated. The recent initiative of the College of Occupational Therapists to develop new core professional standards[26] to define standards for processes that are central to all practising occupational therapists in all settings will foster the unity of the profession and assist in identifying those practices which are central to all occupational therapists. These new core standards will be supplemented by clinical guidelines or practice guidance which may be relevant to a specialist group working in a particular clinical area or care group. Both the core standards and the clinical guidelines will be referred to throughout this book, since they are pertinent to the reasonable standard of professional practice which the law requires of all health professionals.

Questions and exercises

1 How would you define the core work of the OT?
2 How appropriate do you consider the present title of occupational therapy is for the profession? Would an alternative title be more suitable?
3 Do you consider the personal beliefs and philosophies of OTs are relevant to their work? To what extent, if any, should they be taken into account by prospective employers?

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Chapter 2
The Legal System

For the most part, this book describes the law which applies to England and Wales. It also applies to Scotland and Northern Ireland in most respects, but as devolution takes effect the differences are becoming more marked. To those who have never studied the law, it can be perplexing. The jargon, the complexity of answers to the simplest questions, can place a significant barrier between the ordinary health professional and lawyers. However, all health professionals and health service managers have to work within the context of the law and therefore have to know the basic legal principles which constrain or empower them, and also have a clear understanding of the point at which it is essential to bring in legal advice and support. The College of Occupational Therapists has published a useful step-by-step guide for OTs involved in court proceedings.[1] This chapter provides an introduction to the basic terms used and a description of the framework within which the law is implemented. The glossary provides an explanation of some of the technical terms used in this book. The following topics are covered in this chapter:

- Sources of law
- European Community Law
- The European Convention of Human Rights
- Civil and criminal law
- Types of civil action
- Public and private law
- Legal personnel
- Procedure in civil courts
- Procedure in criminal courts
- Accusatorial system
- Law and ethics

Sources of law

Law derives from two main sources: statute law and the common law (also known as case law or judge made law). The sources of law are illustrated in Figure 2.1.The statute law is based on legislation passed through the agreed constitutional process. Legislation of the European Community (EC) now takes precedence over the Acts of Parliament of the UK Government (see below). Statutory instruments drawn up on the basis of powers delegated to ministers and others supplement the Acts of Parliament. Decisions by judges in courts create what is known as the common law. A recognised hierarchy of the courts determines which previous decisions are binding on courts hearing similar cases. Figure 2.2 shows the civil court system and Figure 2.3 shows the criminal court system.

A recognised system of reporting of judges' decisions ensures certainty over what was stated and the facts of the cases. It may be possible for judges to 'distinguish'

Figure 2.1 Derivation and sources of law.

Statute Law

EC Regulations

Acts of Parliament/Statutes
made by House of Commons
House of Lords
Royal Assent

Statutory Instruments
made by relevant Ministry
laid before Parliament

Common Law

EC Court rulings

House of Lords – cases on important points of law

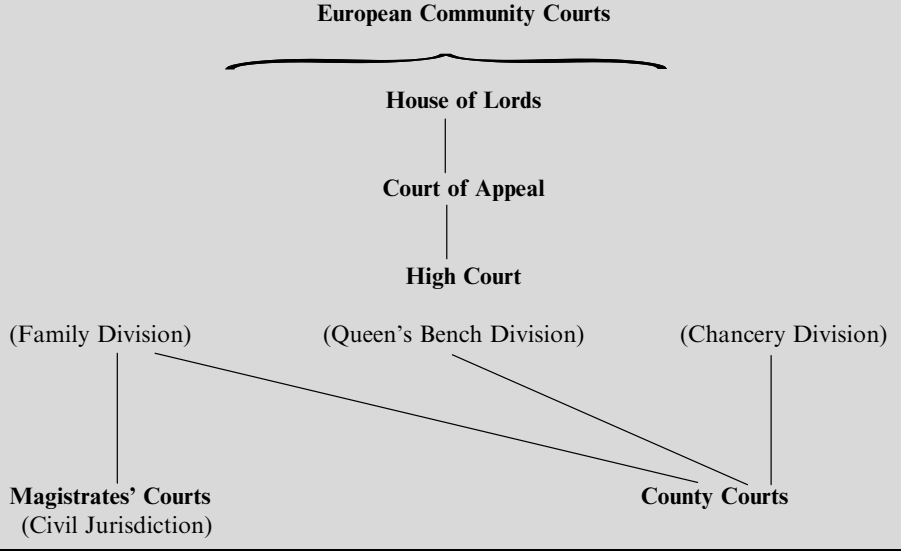
Court of Appeal

High Court/Crown Court

Decisions binding on basis of rules of precedent and hierarchy

Statutes and statutory instruments as well as previous cases are interpreted by judges and the decisions become part of the common law

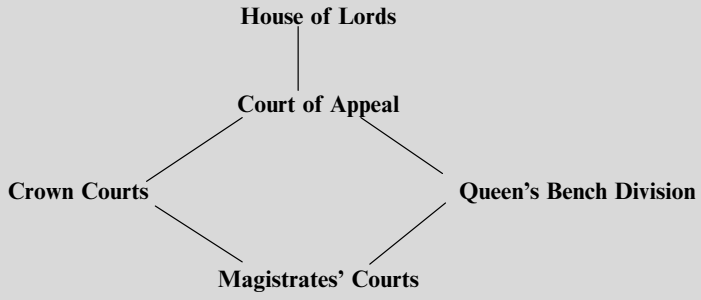
Figure 2.2 Simplified diagram showing the hierarchy of the civil courts.



previous cases and not follow them on the grounds that the facts are significantly different. For example, before the Occupiers' Liability Act 1984, which defined the liability of the occupier towards trespassers, such liability was based on decisions made by judges on particular facts. Cases which involved harm to children, where the occupier had been held liable, were not binding on a judge hearing a case involving an adult so that the occupier was not liable to the adult trespasser. The earlier cases relating to children were 'distinguished'.

Judges are, however, bound by statutes and, if the result is an unsatisfactory situation, this may only be remedied by new amending legislation. The registration of OTs is governed by the Health Care Professions Order which was passed under the

Figure 2.3 The hierarchy of the criminal courts.



Health Act 1999 which in turn amended the Professions Supplementary to Medicine Act 1960. Following these changes the Health Professions Council replaced the Council for Professions Supplementary to Medicine in April 2002. The new regulations will have to be interpreted by judges in court cases if disputes in relation to the meaning of the legislation arise. Thus law develops through a mix of statutory promulgation and common law decision making.

European Community law

Since its signing of the Treaty of Rome, the UK has accepted that it is bound by the legislation of the European Community. It must therefore observe the Treaties of the European Community, and is bound by regulations made by the European Council and the European Commission. The regulations have direct application to member states, unlike the European Directives which must be incorporated into UK law by the passing of regulations to be effective. (This does not apply to their application to state authorities.) Appeals can be made to the European Court of Justice on issues relating to EC law. It is also possible for the UK courts to refer an issue to the European Court of Justice for a specific point on the interpretation of EC law to be determined.

The European Convention on Human Rights

The European Convention on Human Rights provides protection for the fundamental rights and freedoms of all people. It is enforced through the European Court on Human Rights in Strasbourg. The decisions of the court are binding on all countries which are signatories to the Convention, of which the UK is one.

The UK, although a signatory, has only recently incorporated the Convention into UK law as a consequence of the Human Rights Act 1998. The Act came into force on 2 October 2000 in England, Wales and Northern Ireland, and in Scotland on devolution. As a consequence of the Human Rights Act applicants who allege a breach of the articles by a public authority or by an organisation exercising functions of a public nature, can take their case to the courts in the UK as well as to the European Court of Human Rights in Strasbourg. The Articles of the European Convention of Human Rights can be found in the Appendix of this book. The rights of the client are discussed in Chapter 6. The articles of the Convention also apply to those employed by public authorities and the implications of this are considered in Chapter 19.

Civil and criminal law

The civil law governs disputes between private citizens (including corporate bodies) or between citizens and the state. Thus contract law and the law of torts (civil wrongs which are not breach of contract), rights over property, marital disputes and the wrongful exercise of power by a statutory authority all come under the civil law. Actions are brought in the civil courts in relation to an alleged civil wrong by a claimant (formerly known as the plaintiff) who sues a defendant. The person bringing the action has to prove the defendant's liability on a balance of probabilities.

Criminal law relates to actions which can be followed by criminal proceedings in which an accused is prosecuted. The sources of criminal law are both statutory and the common law; thus the definition of murder derives from a decision of the courts in the seventeenth century whereas theft is defined by an Act of Parliament of 1968 as amended by subsequent legislation. A prosecution is brought in relation to a charge of a criminal offence and heard in the criminal courts, where those prosecuting have to prove beyond reasonable doubt that the accused is guilty. In the magistrates court, the magistrates decide if, on the facts, guilt has been established and if so they sentence the accused. They also have the power to commit the accused to the crown court for sentencing by the crown court judge (in cases where the crime demands a greater punishment than the magistrates have power to give; (certain offences can only be heard in the crown court and are known as indictable only offences). In the crown court, the jury decide if the accused is guilty, and if so the judge sentences. Some of the principal differences between a civil case and a criminal case are shown in Figure 2.4.

Figure 2.4 Differences between civil and criminal hearings.

	Criminal hearings	**Civil hearings**
basis of action	a charge of a criminal offence	an alleged wrong by one person against another
action brought by	Crown Prosecution Service (CPS) – occasionally a private prosecution	the person wronged (the claimant) or if a child, a person on his/her behalf
standard of proof	beyond reasonable doubt	balance of probabilities
facts decided by	Magistrates Courts – the magistrate(s) Crown Court – the jury	the judge
law applied by	Magistrates Courts – the magistrate(s) (lay magistrates advised by legally qualified clerk) Crown Court – the judge	the judge(s)

There is an overlap between civil and criminal wrongs. Thus touching a person without his consent may be a civil wrong, known as trespass to the person; it may also be a crime, a criminal assault or battery. Similarly, driving a car carelessly may lead to criminal proceedings for driving without due care and attention and also lead to civil proceedings for negligence if it can be established that the driver was in breach of a duty of care owed to a person who was injured as a result. Gross negligence by a health professional, which causes the death of a patient, can lead to criminal prose-

cutions for manslaughter. Thus in one case[2] an anaesthetist failed to realise that a tube had become disconnected and he was prosecuted in the criminal courts and convicted of manslaughter. There would also be civil liability for compensation in the civil courts. The anaesthetist would be personally liable for the negligence which caused the death of the patient but in practice compensation to the family would be paid by his employer because of its vicarious liability for negligence by employees in the course of their employment (see Chapter 10 on negligence and vicarious liability). The Law Commission[3] has recommended that the law should be changed to enable it to be made easier for corporations and statutory bodies to be prosecuted for manslaughter and this may lead to more criminal charges being brought in connection with deaths which arise from gross negligence. Proposals for legislation on an offence of corporate manslaughter were to be published at the end of 2003 but at the time of writing are still awaited.

Both criminal proceedings and civil proceedings could thus arise from the same set of facts or incident.

Types of civil action

Figure 2.5 illustrates some of the kinds of civil action which may be brought. In this book we are principally concerned with the law relating to negligence, breach of statutory duty and trespass to the person. The OT should be aware, however, of the civil law relating to defamation and nuisance.

Figure 2.5 Types of civil action.

- Negligence
- Nuisance
- Defamation
- Breach of statutory duty
- Trespass (to the person, goods or land)
- Breach of contract

Public and private law

Another distinction in the classification of laws is that of public and private law. Figure 2.6 illustrates the differences between the two.

Figure 2.6 Differences between public and private law.

Public Law	**Private Law**
Matter of public concern e.g.	*Matter arising between individuals (people or organisations) e.g.*
• protection of children	• purchasing a house
• public nuisance	• suing for personal injury
• how statutory duties are carried out	• suing for breach of contract

Public law deals with those areas of law which are seen to be public concern and where society intervenes in the actions of individuals. In contrast, private law is concerned with the behaviour of individuals or corporate bodies to each other,

without interference of the state. The Children Act 1989 covers both private law and public law relating to children. Care proceedings, protection orders and child assessment orders are part of the public law; orders in relation to children made following divorce, such as with whom the child is to live, are part of the private law. Thus the Cleveland Report[4] was concerned with the public law – the duty of the Social Services Department to take action to protect children. In contrast, a dispute over whether consent has been given for a child to have treatment would be part of private law. Remedies differ according to whether the matter is seen as a question of public law or of private law.

Public and private law overlap where individuals feel aggrieved by decisions taken by a public body directly affecting them. Such an individual can challenge the decision-making authority or tribunal by a process known as 'judicial review'. Thus if a person detained under the Mental Health Act 1983 were to appeal unsuccessfully to a Mental Health Review Tribunal (MHRT) and considered that the decision not to discharge him was based upon a failure to apply the correct law, he could apply to the High Court, Queen's Bench Division for the decision of the MHRT to be reviewed[5]. However, this course is not recommended where an Act of Parliament lays down a procedure for challenging the decision of a statutory body. For example, in the case of *Gossington* v. *Ealing Borough Council*[6], Mr Gossington applied for judicial review of the decision of London Borough of Ealing to provide him with five hours of home help per week instead of the original ten hours. The judge held that the Act provided for an application to the Secretary of State if the local authority had failed to carry out its statutory functions. The Secretary of State could, after any necessary inquiry, make an order declaring the local authority to be in default. The applicant had not exhausted the other available routes open to him to remedy the wrong he felt that he had suffered and therefore his application for judicial review was refused.

Legal personnel

If patients believe they have a claim for compensation because of the actions or omissions of health professionals, after possibly seeking advice from the patient advocacy team sited in the hospital or its equivalent for the community or primary care trust, they could ask a solicitor to take the case. A solicitor is a professionally qualified person (usually a law degree or the Common Professional Examination followed by the Law Society's professional examinations and completion of a legal practice course) who tends to have direct contact with the client.

The solicitor may seek the opinion of a barrister (known as counsel) on liability and the amount of compensation. A barrister will usually have a law degree (or the Common Professional Examination) and must complete the examinations set by the Council for Legal Education. The barrister must be a member of an Inn of Court and complete a term of apprenticeship, for a year, known as pupillage. Traditionally the barrister has had the role of conducting the case in court and preparing the documents, known as pleadings, which are exchanged between the parties in the run up to the court hearing. However, increasingly the right of solicitors to represent the client in court has been extended until it is now possible for solicitors with special training and recognition to undertake the work formerly undertaken by barristers alone, and conversely law firms sometimes employ people qualified as barristers 'in house'. Probably the final result of these developments will be a single legal profession. The Lord Chancellor's Advisory Committee on Legal Education recommended a com-

mon vocational training for all would-be lawyers and this, if implemented, may eventually lead to a single profession.

Procedure in civil courts

Lord Woolf conducted an inquiry[7] to determine how access to justice could be simplified and speeded up with the judge having more control in its early stages. Significant changes were brought into effect on 1 April 1999 to implement the changes recommended by Lord Woolf. These are considered in more detail in Chapter 13. The procedures in the County Courts follow a similar pattern.

Procedure in criminal courts

Magistrates, who are either lay people known as justices of the peace (JPs) sitting in threes (the bench) or legally qualified persons known as stipendiary magistrates (who sit alone), can only hear charges which relate to minor offences known as summary offences or offences such as theft which can be heard either as summary offences or on indictment triable either way. Only the crown court (with judge and jury) can hear charges of offences which can only be made on indictment (indictable only offences). Such offences are the most serious, e.g. murder, rape, grievous bodily harm, and other offences against the person. The magistrates, however, have a gate-keeping role in relation to these offences and oversee committal proceedings where they decide whether there is a case to answer and if the case should therefore be committed to the crown court for the trial to take place. In criminal cases, the Crown Prosecution Service (CPS) has the responsibility for preparing the case, including statements, witnesses, etc. for the prosecution in criminal cases. New reforms to limit jury trial, to enable an accused to be charged with the same offence after an earlier acquittal, and to allow evidence of previous convictions to be made known to the jury, were enacted in the Criminal Justice Act 2003.

Accusatorial system

A feature of the legal system in this country is that one side has the responsibility of proving that the other side is guilty, liable or at fault of the wrong or crime alleged. This is known as an 'accusatorial' system (or sometimes 'adversarial') and applies to both civil and criminal proceedings. In civil proceedings the claimant, i.e. the person bringing the action, has to establish on a balance of probability that there is negligence, trespass, nuisance or whatever civil wrong is alleged. In civil cases (apart from defamation) there is no jury and the judge has the responsibility of making a decision on disputed facts and of determining whether the claimant has succeeded in law in establishing the civil wrong.

This system, where one party to a case confronts the other party, also applies in criminal cases where the prosecution attempt to show beyond all reasonable doubt that the accused is guilty of the offence with which the defendant is charged. The magistrates, or the jury in the crown court, determine the facts and whether the prosecution has succeeded in establishing the guilt of the accused, who is presumed innocent until proved guilty. The role of the judge in the Crown Court is to chair the proceedings, intervening where necessary in the interests of justice, and advising on points of law and procedure.

The accusatorial system contrasts with a system of law known as 'inquisitorial' where the judge plays a far more active role in determining the outcome. An example of an inquisitorial system in the UK is the coroner's court. Here the coroner is responsible for deciding which witnesses would be relevant to the answers to the questions which are placed before him by statute (i.e. the identity of the deceased and how, when and where he came to die). The coroner asks the witnesses questions in court and decides who else can ask questions and what they can ask. As a result of this 'inquisition' the coroner, or a jury if one is used, determines the cause of death.

Some may feel that an inquisitorial system of justice is fairer since the outcome of the accusatorial system may depend heavily upon the ability of the barristers representing the party in court. However, the strengths of the accusatorial system probably outweigh the weaknesses. There are after all many challenges to the decisions of coroners. The case management approach implemented as a result of Lord Woolf's reforms keeps the adversarial system but ensures that, where appropriate, expert witnesses have a responsibility to the court. These reforms are considered in Chapters 10 (negligence) and 13 (giving evidence in court).

Law and ethics

Law is both wider and narrower than the field of ethics. On the one hand the law covers areas of practice which may not be considered to give rise to any ethical issue, other than the one as to whether the law should be obeyed. For example, to park in a 'no parking' area would not appear to raise many ethical issues other than the decision to obey or to ignore the law. On the other hand, there are major areas of health care which raise significant ethical questions where there appears to be little law. For example, elective ventilation of a corpse in order to keep the organs alive for transplant purposes raises considerable ethical issues for health professionals and relatives, but, provided the requirements of the Human Tissue Act and the Transplant Acts are satisfied, there is no legal issue. At any time, of course, a practice which is considered to be contrary to ethical principles can be challenged in court and the judge will make a determination, on the basis of any existing statute law or decided cases, of what the legal position is.

Situations may arise where health professionals consider the law to be wrong and contrary to their own ethical principles. In such a case they have personally to decide what action to take, in full awareness that they could face the effects of the criminal law, civil action, disciplinary procedures by their employers and professional proceedings by their registration body.

In certain cases, however, the law itself provides for conscientious objection. Thus no one can be compelled to participate in an abortion unless it is an emergency situation to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman (Abortion Act 1967 section 4(2)). Similar provisions apply to activities in relation to human fertilisation and embryology where the Human Fertilisation and Embryology Act 1990 provides a statutory protection clause. However, a health professional may have strong ethical views about the need to save the life of a mentally competent adult who is refusing a life-saving blood transfusion, but the law does not permit the overrule of a refusal made when an adult is mentally competent. It is inevitable that any discussion of the function of occupational therapy should be concerned with the ethical or philosophical beliefs of the therapist who is providing the treatment and this is considered in Chapter 1. One issue

which would appear to have ethical rather than legal dimensions (though legal issues could arise, particularly if the OT was charged with theft,) is the ethical problem of an OT accepting gifts. This is considered by Jani Grisbrooke and Rosemary Barnitt[8]. They conclude that the offer of a gift can be ambiguous, but guidance that gifts should never be accepted is difficult to operate in practice and the OT needs to use ethical reasoning skills in taking the appropriate action.

The Code of Ethics and Professional Conduct[9] for Occupational Therapists (see Chapter 4 for discussion of this) is an example of ethical principles being required of registered practitioners.

Reference should be made to the list of recommended further reading for books on ethics. Students must be aware of both legal and ethical dimensions to their practice. This book is concerned with providing the reader with the necessary legal knowledge and understanding of the legal framework within which practice takes place.

Questions and exercises

1 A client has consulted you about the possibility of bringing a claim for compensation. What advice would you give on the procedure which would be followed and the steps which should be taken?
2 Draw up a diagram which illustrates the difference between civil and criminal procedure.
3 Turn to the glossary and study the definitions of legal terms included there.
4 In what ways do you consider that a conflict between an ethical belief and the law should be resolved?

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Chapter 3
Registration and the Health Professions Council

In this chapter we consider the statutory basis of the occupational therapist and discuss the provisions for registration and the role of the Health Professions Council (HPC) (which replaced the Council for Professions Supplementary to Medicine (CPSM) in 2002). The following topics are covered:

- Background to the establishment of the HPC
- Health Professions Council (HPC)
  - Fundamental functions
  - Committees
  - Consultation with registrants
- Registration machinery
- Protected titles
- New professional groups
- Non-registered support workers

Background to the establishment of the HPC

Review of 1960 Act

A review of the Professions Supplementary to Medicine Act 1960 was undertaken by JM Consulting Ltd under a steering group chaired by Professor Sheila McLean. Following a consultation document issued in October 1995, a report was published in July 1996[1]. The report described the weaknesses of the Professions Supplementary to Medicine Act, identifying two broad areas of weakness:

- In the powers provided by the 1960 Act
- In the statutory bodies and working arrangements.

It explored the developments which had taken place since 1960 including:

- The development of primary care
- The introduction of the internal market
- The use of multi-disciplinary teams and the possibility of non-state registered professionals being employed in the NHS by GPs
- The growth of private sector provision
- The changes which have taken place within the professions including strong professional associations with regulations for discipline.

The inappropriateness of the term 'Professions Supplementary to Medicine' was also considered. Other changes included:

- The new professions who have sought state registered status
- Developments within higher education and degree status for many professions, and education provision being made outside the NHS
- Changing attitudes in society and public expectations.

The recommendations included the establishment of a Council for Health Professionals and Statutory Committees with a panel of professional advisers.

Implementing the proposals

The Government accepted the recommendations of JM Consulting Ltd and in the Health Act 1999 took the preliminary steps to implement the new system for registration and professional control. A consultation paper was published in August 2000[2], inviting comments within three months on the legislative proposals. It stated that modernising professional self-regulation should be seen as a component part of a wider strategy to modernise the whole of the NHS to help deliver better health and faster, fairer care. A draft order was published in April 2001[3] and was issued as a statutory instrument in 2002.

The new scheme

In April 2002 a new Health Professions Council replaced the Council for Professions Supplementary to Medicine and its twelve boards, and currently regulates 120,000 health professionals. The key objectives of the reorganisation are:

- To reform ways of working, by requiring the Council to:
  - treat the health and welfare of patients as paramount
  - collaborate and consult with key stakeholders
  - be open and pro-active in accounting to the public and the profession for its work
- To reform structure and functions by:
  - giving wider powers to deal effectively with individuals who present unacceptable risks to patients
  - creating a smaller Council, comprising directly elected practitioners and a strong lay input
  - linking registration with evidence of continuing professional development
  - providing stronger protection of professional titles
  - enabling the extension of regulation to new groups.

The Council is charged with the strategic responsibility for setting and monitoring standards of professional training, performance and conduct.

The consultation paper[2] quoted from the NHS Plan that the key tests for regulatory bodies are that they must be:

- Smaller, with much greater patient and public representation
- Have faster, more transparent procedures
- Develop meaningful accountability to the public and the health service.

The consultation paper stated that the GMC had been asked to explore the intro-

duction of a civil burden of proof and other reforms. It recommended that the procedures adopted by the new HPC would need to be consistent with those agreed for doctors.

The consultation paper also stated that there needed to be formal co-ordination between the health regulatory bodies, and therefore a UK council of health regulators was to be established (see below). Its initial task would be to help co-ordinate and act as a forum in which common approaches across the professions could be developed for dealing with matters such as complaints against practitioners.

Health Professions Council (HPC)

The Government proposed that the HPC should initially consist of 23 members (12 practitioners, i.e. one from each of the professions covered) and 11 lay members (who may or may not be members of other professions, not covered by the HPC). In addition there are 12 alternate Registrant members who attend instead of Registrant members when they are absent. The emphasis is on a smaller more effective body.

Fundamental functions of the HPC

These are set out in Schedule 3, para. 8(2), to the 1999 Health Act and are not transferable by Order to another body:

- Keeping the Register of members admitted to practise
- Determining standards of education and training for admission to practise
- Giving advice about standards of conduct and performance
- Administering procedures (including making rules) relating to misconduct, unfitness to practise and similar matters.

Section 60 of the Health Act 1999 enables an Order in Council to make provision for:

- Modifying the regulation of any profession 'so far as appears to be necessary or expedient for the purpose of securing or improving the regulation of the profession or the services which the profession provides or to which it contributes'
- 'Regulating any other profession which appears to be concerned (wholly or partly) with the physical or mental health of individuals and to require regulation in pursuance of the section.'

There is also an overarching duty of the HPC to

> 'treat the health and wellbeing of persons using or needing services, as well as to work in partnership with employers, educators and other regulatory bodies'[4].

The HPC statutory committees

There are four committees of the Council, known as the statutory committees:

- Education and Training Committee
- Investigating Committee
- Conduct and Competence Committee
- Health Committee.

The last three of these are also referred to as the Practice Committees (see Chapters 4 and 5 for the work of these Practice Committees)

All committees are to be chaired by a member of Council and each Committee will have at least one lay member. They will make recommendations and decisions in consultation with the Council.

Flexibility is built in so that the Council may establish other committees to discharge its functions and can establish professional advisory committees whose function is to advise the Council and its statutory committees on matters affecting any of the relevant professions.

The HPC non-statutory committees

The HPC has established the following as non-statutory committees:

- Communications Committee,
- Finance and Resources Committee
- Audit Committee
- Registration Committee.

Consultation with registrants

The Council shall inform and educate registrants and the public about its work.

Before establishing any standards or giving guidance the Council must consult representatives of any group of persons it considers appropriate, including:

- Representatives of registrants or classes of registrants
- Employers of registrants
- Users of the services of registrants
- Persons providing, assessing or funding education or training for registrants and potential registrants.

The Council shall publish any standards it establishes and any guidance it gives.

Registration machinery

One of the main functions of the Council is to establish and maintain a register of members of the relevant professions. This entails establishing from time to time the standards of proficiency necessary to be admitted to the different parts of the Register, being standards the Council considers necessary for safe and effective practice under that part of the Register. The standards of proficiency required for the registration of an occupational therapist can be seen on the HPC website[5] (see also Chapter 5). They cover professional autonomy and accountability, skills required for the application of practice and knowledge, understanding and skills.

The Register will show, in relation to each registrant, such address and other details as the Council may prescribe. The required details prescribed by Council were set out in the rules which came into force on 9 July 2003[6]. These include:

- The full name of the registrant
- His registration number

- His last known home address (but this shall not be included in any published version of the register without his consent)
- Any qualification of the registrant which has led to his registration.

The Registrar may also enter on the Register any other information which is material to a registrant's registration. The Registrar is required to keep the Register in a form and manner which guards against falsification and shall take all reasonable steps to ensure that only he and such persons as have been authorised by him in writing for the purpose shall be able to amend the register or have access to the version of the register which contains entries not included in the published version.

To be effective and enable practitioners to progress in their profession, there shall be one or more designated titles for each part of the Register indicative of different qualifications and different kinds of training, and a registered professional is entitled to use whichever of those titles is appropriate in his case in accordance with set criteria.

The Council, having consulted the Education and Training Committee, can make rules in connection with registration, the register and the payment of fees.

The Council shall make the register available for inspection by members of the public at all reasonable times and shall publish the register in such manner and at such times as it considers appropriate. Rules relating to parts of entries in the Register came into force on 9 July 2003[7]. Schedule 1 sets out the different parts. Occupational therapists are registered in Part 6 of the Register.

Application to be registered

A person seeking admission to a part of the register shall be registered if the application is made in the prescribed form and manner and she:

- satisfies the Education and Training Committee that she holds an approved qualification awarded:
  - less than five years ago
  - more than five years ago, but she has met specified requirements as to additional education, training, and experience
- satisfies the Education and Training Committee that she meets the Council's prescribed requirements as to safe and effective practice
- has paid the prescribed fee.

The Rules[6] which came into force on 9 July 2003 require the applicant to provide a reference as to their good character by a person who is not a relative and is a person of standing in the community, such as a registered professional, doctor, solicitor, accountant, bank manager, JP, head of the educational college or religious official. (A Character Reference Form is provided under Schedule 3 to the Rules.) The applicant must also provide a reference as to their physical and mental health from their doctor, unless that doctor is a relative. (A Health Reference Form is provided under Schedule 4 to the Rules.) Alternative arrangements are laid down where these requirements are not possible.

Provisions for renewal of registration and readmission require the applicant to meet any set requirements for continuing professional development within the specified time.

The Rules[6] cover the procedure to be followed in applications for registration and

provisions for amendments to the register and for renewal of registration. Rules also cover the circumstances in which a registered professional's name may be removed from the register on her own application or after the expiry of a prescribed period.

Provision is made for definition of approved qualifications and European Economics Area qualifications.

The Registration period for those who were initially registered under the Council of the Professions Supplementary to Medicine is the date on which her last renewal of registration under the 1960 Act would have expired. Otherwise a person's first registration period begins on the day she is first registered and ends in the second calendar year after the year in which she was registered, on the date shown in column 2 of Schedule 5. For occupational therapists the date is 31 October 2003.

Character and health references

The HPC requires each applicant for registration, or registrant for re-registration, to provide a statement of good character and good health. Further information about who would be eligible to provide such references is obtainable from the HPC website (www.hpc-uk.org). The HPC requires a person 'of professional standing in the community' to be the person providing the reference.

Appeals

Appeals can be made under Article 37 against the decisions of the Education and Training Committee where an application for registration, readmission or renewal or the inclusion of an additional entry has been refused or where specific conditions have been imposed on an applicant. There is also a right of appeal if the name of a registered professional has been removed on the grounds that she is in breach of a condition in respect of continuing education. The appeal lies to the Council.

Under Article 38 an appeal can be made from any decision of a Practice Committee or any decision of the Council under Article 37 to the appropriate court. Proposals for a Health Professions Independent Appeals Tribunal were not included in the final statutory instrument (Health Professions Order 2001 SI 2002/254). Rules relating to appeals on registration matters came into force on 9 July 2003[8]. These cover the service of documents, the period during which an appeal can be made, the notice of appeal, acknowledgement by the Council of the appeal notice, notice of hearing and the duties of parties and representatives to inform Council if they intend to attend. The Council can hear the appeal itself (with a quorum of 7 with registrants and lay members but the registrants cannot exceed the number of lay members by more than one) or appoint an appeal panel (with at least three persons, one of which must be registered in the same part of the Register as the appellant, one of which must not be a registrant under the HPC or GMC, and (where the health of the professional is in issue) a registered medical practitioner). A preliminary meeting can be held in private with the parties. The appeal panel can determine an appeal without an oral hearing and may take into account written representations. A hearing can take place without the presence of the appellant provided that the appeal panel is satisfied that all reasonable steps have been taken to give notice of the hearing to the appellant. The hearing should be held in public unless the appeal panel is satisfied that, in the interests of justice or for the protection of the private life of the health professional, the complainant, any person giving evidence or any patient or client, the public

should be excluded from all or part of the hearing. The Rules cover the order of the proceedings and the procedure to be followed.

Offences

It is an offence to:

- falsely claim registration with intent to deceive
- use a title to which one is not entitled
- falsely represent oneself to possess qualifications in a relevant profession.

It is also an offence fraudulently to procure registration or after registration fail to comply with any requirement imposed by the Council or a Practice Committee.

Protected titles

The consultation paper recommended that a registrant should be entitled to use the designated title corresponding to the part or parts of the Register in which he is registered, whether alone or prefixed by the word registered, and that no other person should be so entitled. The consultation paper noted that this provision could be unfair to non-state registered practitioners who practise lawfully and safely and suggested 'grandparenting' arrangements to enable the registration of those who can show that they have practised lawfully, safely and effectively for a number of years, and if appropriate pass a test of competence for that purpose. Alternatively, such persons could be required to undertake some additional training or experience before admission to the Register. To pass oneself off as registered is an offence under Article 39. The offence is committed whether such representation is express or implied.

The HPC, following consultation, has agreed on a list of titles which it will ask the Privy Council to protect. Occupational therapist is included in the list.

Grandparenting

In accordance with the above recommendations, in preparation for a time when the title 'occupational therapist' becomes a legally protected title and those using that title must therefore be registered with the HPC, interim arrangements have been set in place to enable those who have not followed an approved course to take advantage of the HPC grandparenting arrangements which will provide advice for their becoming recognised as registered professionals. A helpline has been set up by the HPC[9].

Employment within the NHS and by local authorities

Occupational therapists and the other professions registered under the Health Professions Council must be registered to be employed by NHS organisations and local authorities. Directions have been issued to NHS trusts, primary care trusts and special health authorities[10] and to local authorities[11]; these came into force on 1 August 2003. Department of Health guidance is provided on the directions and interim arrangements for non-registered staff[12] and these also apply to staff used by contractors and to self-employed persons.

New professional groups

New groups of health professionals, including complementary or alternative therapies, can be added to the jurisdiction of the HPC. On 3 April 2003 the HPC voted to recommend to the Secretary of State that the operating department practitioners should be the first new profession to be regulated by the HPC. The HPC has published guidelines setting criteria on opening new parts of the Register[13]. It has stated that an occupation will only be eligible for regulation if it involves invasive procedure, clinical intervention with the potential for harm, or the exercise of judgment by unsupervised professionals which can substantially impact on patient health or welfare. Occupations where these activities are already regulated by other means will be ineligible. Once the Council has approved an application, an HPC recommendation and an accompanying report to regulate the profession are submitted to the Secretary of State. If the Secretary of State agrees with the application, an Order will be drawn up under section 60 of the Health Act 1999, submitted for consultation, if necessary amended and then placed before Parliament.

For non-registered support workers and the General Social Care Council (GSCC), see Chapter 5.

Council for the Regulation of Healthcare Professions

As a result of the NHS Reform and Health Care Professions Act 2002 (sections 25–29) a Council for the Regulation of Health Care Professionals has been set up. This new Council is a corporate body with the following functions:

- To promote the interests of patients and other members of the public in relation to the performance of their functions by the GMC, GDC, NMC, HPC and other health professional registration bodies
- To promote best practice in the performance of those functions
- To formulate principles relating to good professional self-regulation, and to encourage regulatory bodies to conform to them
- To promote co-operation between regulatory bodies; and between them, or any of them, and other bodies performing corresponding functions.

Powers of the Council

The Council has the powers to do anything which appears to it to be necessary or expedient for the purpose of, or connection with, the performance of its functions. Examples are given in the Act as to what this could include:

- Investigate and report on the performance by each regulatory body of its functions
- Recommend changes to the way in which the regulatory body performs any of its functions.

The Council will not, however, be able to do anything in relation to a case of any individual who is the subject of proceedings before a regulatory body or about whom an allegation has been made to the regulatory body.

Schedule 7 of the NHS Act makes provision for the finer detail of the Council such as its membership, appointment and procedure.

Directions to a regulatory body

Each regulatory body must co-operate with the Council. The Council may direct a regulatory body to make rules, if it considers that desirable for the protection of members of the public. Rules made under these directions must be approved by the Privy Council or by the Department of Health before coming into force. The regulatory body must comply with the directions of the Council.

Investigation of complaints about a regulatory body

Regulations may also be made by the Secretary of State on how the Council can investigate complaints made to it about the way in which a regulatory body has exercised any of its functions. These regulations may cover: who is entitled to complain, the nature of complaints which the Council must or need not investigate, matters which are excluded from the investigation, requirements to be complied with by the complainant, making of recommendations and reports by the Council, confidentiality of information supplied to or obtained by the Council, the use which the Council may make of such information, payments to persons in connection with investigations and privilege in relation to any matter published by the Council in the exercise of its functions under the regulations. The regulations can also cover powers to be given to the Council requiring persons to attend before it, give evidence or produce documents and the admissibility of evidence in accordance with the rules of civil proceedings in the High Court.

Referral of professional conduct decision to High Court

Where the Council is of the view that a decision by the regulatory body in professional misconduct proceedings as specified in the Act is unduly lenient or a relevant decision should not have been made, and it would be desirable for the protection of members of the public for the Council to take action, the Council may refer the case to the High Court (or Court of Session in Scotland). The High Court has the power to dismiss the case, allow the appeal and quash the relevant decision, substitute any other decision for the decision of the committee or person concerned, or remit the case to the committee or other person concerned to dispose of the case in accordance with directions from the court.

The High Court held on 29 March 2004 that the Council for the Regulation of Healthcare Professions had the right to refer cases to court even after an acquittal by the appropriate regulatory body. The GMC had challenged the CRHCP's right to refer the case of Dr Ruscillo to the court. This judgment, unless overturned on appeal, will apply to all those health registration bodies under the CRHCP, including the HPC.

At the time of writing it is too early to determine the impact of the Council for the Regulation of Healthcare Professions upon the HPC and the other regulatory bodies. It is likely that the existence of the overarching Council will lead to greater uniformity in standards, professional practice, discipline and other procedures across all registered health professions.