| **Title:** | Impact Assessment (IA) |
|---|---|
| Responsible Officers in the New Health Architecture;<br>Proposals for making explicit the checking of language skills for doctors on appointment<br>**IA No:** 5109 | **Date:** 01/01/2011 |
| **Lead department or agency:**<br>Department of Health (NHS Medical Directorate) | **Stage:** Final |
| **Other departments or agencies:** | **Source of intervention:** Domestic |
| | **Type of measure:** Primary legislation |
| | **Contact for enquiries:** Michael Wright 0207 972 1323, Debbie Peters 0113 254 6120 (re language checks) |

## Summary: Intervention and Options

**RPC Opinion:** GREEN

| Cost of Preferred (or more likely) Option | | | | |
|---|---|---|---|---|
| **Total Net Present Value** | **Business Net Present Value** | **Net cost to business per year** (EANCB on 2009 prices) | **In scope of One-In, One-Out?** | **Measure qualifies as** |
| £0.16m | £0.013m | NA | Yes | Zero Net Cost |

**What is the problem under consideration? Why is government intervention necessary?**

The Medical Profession (Responsible Officers) Regulations 2010 designate certain organisations, mainly those delivering healthcare, to nominate or appoint a responsible officer (RO). The changes to NHS architecture mean that designated NHS bodies such as Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) will cease to exist by April 2013. The connections to ROs in these designated bodies will transfer to new organisations who will need to be designated. There is increasing concern that patients may be put at risk of harm through inadequate language skills of some doctors. A national solution is required to improve consistency of decision making on language ability by including accountability in the RO role.

**What are the policy objectives and the intended effects?**

Policy objectives: (1) To ensure the Regulations that came into force in January 2011 are appropriate for the new NHS structures and therefore that the evaluation of fitness to practise and monitoring of conduct and performance of doctors continues. (2) To strengthen the existing approach, ensuring an effective system of checks so that doctors are vetted prior to treating patients, including that doctors have appropriate language skills to provide health care to patients; resulting in improved quality of care and safety to all patients, enhanced public, parliamentary and professional confidence, and bridge perceived gaps in the existing system.

**What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)**

Policy options were considered as part of the original assessment relating to the Responsible Officer policy consultation exercise. This impact assessment is as a result of the consultation exercise and relates to the intended consultation on the Responsible Officer draft regulations.

Option 1: Do Minimum: to designate the NHS Commissioning Board, Local Authorities and specific bodies involved with the employment of doctors to ensure that they appoint responsible officers.

Option 2: To designate the NHS Commissioning Board, Local Authorities and specific bodies involved with the employment of doctors to ensure that they appoint responsible officers. To extend the duties of responsible officers to include the checking of language skills of doctors. This is the preferred option.

**Will the policy be reviewed?** It will be reviewed. **If applicable, set review date:** Month/Year

| | | | | | |
|---|---|---|---|---|---|
| Does implementation go beyond minimum EU requirements? | | | N/A | | |
| Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base. | **Micro** No | **< 20** No | **Small** Yes | **Medium** Yes | **Large** Yes |
| What is the $CO_2$ equivalent change in greenhouse gas emissions? (Million tonnes $CO_2$ equivalent) | | | **Traded:** | **Non-traded:** | |

***I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) that the benefits justify the costs.***

Signed by the responsible Minister: Earl Howe Date: 18.02.13

# Summary: Analysis & Evidence

Policy Option 1

**Description:**

**FULL ECONOMIC ASSESSMENT**

| Price Base Year 12 | PV Base Year 12 | Time Period Years 10 | Net Benefit (Present Value (PV)) (£m) | | |
|---|---|---|---|---|---|
| | | | **Low:** 0.98 | **High:** 1.5 | **Best Estimate:** 1.24 |

| COSTS (£m) | Total Transition (Constant Price) | Years | Average Annual (excl. Transition) (Constant Price) | Total Cost (Present Value) |
|---|---|---|---|---|
| **Low** | Optional | | 0.051 | **0.51** |
| **High** | Optional | | 0.103 | **1.03** |
| **Best Estimate** | 0.00 | | 0.077 | **0.77** |

**Description and scale of key monetised costs by 'main affected groups'**

Costs relate to the use of formal language checks required where the circumstances of the doctor are not sufficient to demonstrate satisfactory knowledge of English. The majority (an estimated 92%) are attributable to applicants to the public sector. These are time costs for the applicants to undertake tests (unless employers determine otherwise for their own benefit) . Pending further investigation, there is not expected to be any consequential impact upon recruitment costs for employers.

**Other key non-monetised costs by 'main affected groups'**

| BENEFITS (£m) | Total Transition (Constant Price) | Years | Average Annual (excl. Transition) (Constant Price) | Total Benefit (Present Value) |
|---|---|---|---|---|
| **Low** | Optional | | Optional | **Optional** |
| **High** | Optional | | Optional | **Optional** |
| **Best Estimate** | NA | | 0.155 | **2.01** |

**Description and scale of key monetised benefits by 'main affected groups'**

Benefits will principally be derived through increased patient safety and reduced litigation. In the absence of data on the likely benefits, conservative assumptions have been applied to estimate the numbers of cases of death and harm and corresponding litigation costs that might be avoided.

Two consultation exercise on the policy, the last of which ended on the 4 January, called for evidence and provided no further data on key monetised benefits.

**Other key non-monetised benefits by 'main affected groups'**

Explicit language checking requirements and guidance should ensure acceptable standards of language competency are demonstrated by doctors and that better quality patient care is provided.

**Key assumptions/sensitivities/risks** **Discount rate (%)** 3.5

Costs: average cost per test at £132, with four hours of applicant time, and 10 - 20% of applicants will require a formal test with a best estimate of 15%.
It is assumed that language testing will not create workforce supply constraints.
Benefits: 1 death, 2 cases of severe harm and 15 cases of moderate harm are avoided over ten years. QALY valued at £60,000. Litigation benefit equivalent to 50% of QALY benefit.

**BUSINESS ASSESSMENT (Option 1)**

| Direct impact on business (Equivalent Annual) £m: | | | In scope of OIOO? | Measure qualifies as |
|---|---|---|---|---|
| **Costs:** 0.15 | **Benefits:** 0.16 | **Net:** 0.01 | Yes | Zero net cost |

# References

(1) Clinical advice and leadership A report from the NHS Future Forum: June 2011
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127542.pdf

(2) Government response to the Future Forum report: DH; June 2011
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127719.pdf

(3) The coalition: our programme for government: May 2010

http://www.direct.gov.uk/prod_consum_dg/groups/dg_digitalassets/@dg/@en/documents/digitalasset/dg_187876.pdf

(4) Equity and excellence: Liberating the NHS: Dept of Health: July 2010
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf

(5) The Health and social Care Bill 2011
http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/HealthandSocialCareBill2011/index.htm

(6) The Future Forum report
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127443

(7) Detailed design proposals for the NHS Commissioning Board; DH; Feb 2012

https://www.wp.dh.gov.uk/commissioningboard/files/2012/01/NHSCBA-02-2012-5-Organisational-Design-Recommendations-Final.pdf

(8) Impact Assessment for the Health and Social Care Bill
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_123583

(9) Liberating the NHS: developing the healthcare workforce

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_129428

(10) IA of the White Paper 'Healthy Lives, Healthy People: November 2010.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121941

(11) Delivering quality in Primary Care: Medical Performers list – language knowledge: 4 February 2010
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111901

(12) World Health Organisation – http://www.who.int/patientsafety/research/methods_measures/human factors

(13) The Medical Profession (Responsible Officers) Regulations 2010 - Impact Assessment

http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Regulatoryimpactassessment/DH_117786

# Evidence Base (for summary sheets)

## A. Problem under consideration

### Background

1. The Medical Profession (Responsible Officers) Regulations 2010 came into force on 1 January 2011. They designate bodies that are required to nominate or appoint a responsible officer. Generally, organisations have a single responsible officer. The Regulations give responsible officers in designated organisations in Great Britain functions relating to the evaluation of fitness to practise. They also give responsible officers, in England, functions relating to monitoring the conduct and performance of doctors. Under the existing Regulations, PCTs and SHAs have prescribed connections to the different groups of doctors.
2. The role of the responsible officer is to support doctors to maintain and improve the quality of care they deliver, and to protect patients in those cases where doctors fall below the high standards they set for themselves. Where a designated body is a PCT in England, responsible officers also manage admission to Performers Lists.
3. Responsible officers in Great Britain are responsible for making fitness to practise recommendations to the GMC in respect of individual doctors. As part of medical revalidation responsible officers in England, Scotland and Wales will also be responsible for making the specific recommendations to the GMC at the point the doctor is required to renew his/her licence to practise.
4. The Future Forum recognised the important role of responsible officers at all levels. In its report on clinical advice and leadership (1) (please see references on page 5) it recommended that "The Department of Health and the NHS CB should ensure responsible officers continue to be in place to support doctors in improving care and ensuring their fitness to practise through revalidation." The Government's response confirmed that it would make sure that there continues to be a responsible officer where they are already present in organisations that provide NHS care, and that the Department of Health would consult on the proposals for responsible officers in the new architecture.
5. The proposed amendments seek to clarify the role of responsible officers in ensuring doctors have appropriate language competence.
6. The proposed policy was subject to consultation from the 18th April to 25th July 2012. The draft Amending Regulations were subject to a second, shorter, consultation from 7 December 2012 to 4 January 2013. This impact assessment has been revised following the results of both of these consultation exercises and is intended to accompany the Amending Regulations prior to their laying in Parliament.. The Impact Assessment focuses on the language checking element of the policy.

### The new NHS Architecture

7. The White Paper *Equity and Excellence: Liberating the NHS* set out the Government's vision for health services. It described a new commissioning architecture for the NHS. Responsibility for local commissioning would rest with Clinical Commissioning Groups (CCGs) supported and overseen by a NHS Commissioning Board (NHS CB) that would hold the CCGs to account.
8. The Health and Social Care Bill 2011 sets out that new structure. The structure with the NHS CB and CCGs was confirmed by the work of the Future Forum, the group established to pause, listen and reflect on the content of the Health and Social Care Bill 2011. The Bill abolishes PCTs and SHAs from April 2013.
9. The new architecture will be in place from April 2013, and there are already significant structural changes in the NHS, with PCTs and SHAs being grouped together in 'clusters'. Although the clusters will be in place, each PCT and SHA continues to have its own legal existence and will have to nominate or appoint a responsible officer.

## Language checking

10. Significant concerns (parliamentary, professional and regulatory) have been raised on the ability of some doctors to communicate competently. These concerns are raising questions about whether public safety is adequately protected by existing systems.

11. Currently, disparate systems exist for checking the language competency for those doctors from EEA member states and those from the wider world. For non-EEA overseas qualified doctors the General Medical Council requires such doctors to undergo language and competency tests before being registered as doctors in the UK. For EEA qualified doctors, the principle of automatic recognition as a result of the Directive on the Mutual Recognition of Professional Qualifications (2005/36/EC), prohibits the GMC from applying such checks prior to registration. The European Commission is reviewing the Directive. However, negotiations on any potential changes, and any subsequent transposition into domestic law is unlikely to be earlier than 2016.

12. A system of local checks is in place in England whereby employers or contracting bodies, as part of the recruitment process, should ensure that doctors they employ or contract with are suitable for their role, and this should include consideration of factors such as their ability to communicate. Health Service Circular 1999/137 in June 1999 (which replaced Personnel Memorandum (87)7) made it clear to all NHS employers that they are responsible for ensuring that the staff they employ have the necessary language and communication skills needed to do their job safely and effectively.

13. Under the Performers List Regulations 2004 there are a number of checks that a PCT is required by law to carry out before admitting a doctor onto its lists. The Regulations include a requirement at regulation 6(2)(b) that a Primary Care Trust must refuse to include a performer in its performers lists where “it is not satisfied he has the knowledge of English, which, in his own interests or those of his patients, is necessary in performing the services..”.

14. In February 2010, PCTs and Strategic Health Authorities were reminded of this legal obligation and guidance was issued by the Department, following the death of David Gray and a subsequent review by the Care Quality Commission.

15. However, there is growing concern that the existing system is not sufficiently robust to ensure doctors have satisfactory language skills and are subject to appropriate language checking prior to taking up a post.

16. These concerns are reflected in the Coalition: programme for government (3) (see page 5) statement in respect of migrants working in the NHS: “We will seek to stop foreign healthcare professionals working in the NHS unless they have passed robust language and competence tests”. We have explored scope for enabling checks on all doctors at the point of registration, but our analysis was that this would not be possible in the case of EEA migrant professionals because of European law. However, there is scope for clarifying the functions of responsible officers to undertake checks in the case of doctors. Responsible officers in England already have a role in the medical recruitment process for their organisations.

17. The proposal aims to address concerns about inconsistency in the application of checks on the language ability of doctors by the introduction of strengthened proportionate checks across the local level. As part of the existing Responsible Officer regulations, responsible officers in England have a role for their designated body in ensuring that medical practitioners have qualifications and experience appropriate to the work to be performed (when entering into contracts of employment or for the provision of services with medical practitioners). However, there is no explicit statutory requirement in relation to language competency and our proposal is to make it an explicit responsibility of responsible officers to ensure that a doctor has sufficient language skills for the work to be performed before appointing a doctor to their organisation.

18. The consultation published in April 2012 made a set of wider proposals in relation to language checking. This central proposal was to require a responsible officer to perform a check of the language competency of doctors. The policy options that were considered are outlined below in ‘Language Checks – options appraisal and details of alternative options that were discounted at the policy development stage’. Having considered the responses to the consultation and the impact of EU law on the proposals, the options for language checking have been restricted to requiring the responsible officer to ensure that medical practitioners have sufficient knowledge of English

language necessary for the work to be performed. These changes in policy have required amendments to be made to the impact assessment, including the removal of those elements relevant to policy that is no longer being pursued.

### Summary of analytical narrative

19. Subject to Parliamentary approval, the Government intends to amend the Regulations to reflect responsible officers in the new structure.

20. The proposed amendments seek to clarify the role of responsible officers in ensuring doctors have appropriate language competence. This will include an explicit requirement for responsible officers to ensure that language competency is verified during recruitment. The Department has announced its intention to propose changes to the language checking system through amendment to the Responsible Officer Regulations, and further proposals to explore scope for providing the GMC with powers to more effectively deal with issues concerning language competency. The Government has taken a decision to prioritise concerns in relation to doctors as this is the health profession where there was considered to be most risk.

## B. Policy objectives and intended effects

21. Key policy objectives are:

- To ensure the Regulations that came into force in January 2011 are appropriate for the new structures and therefore that the evaluation of fitness to practise and monitoring of conduct and performance of doctors continues.
- To ensure that doctors have appropriate language skills that allow them to provide health care to patients, and in doing so protect patient safety, enhance public confidence, enhance parliamentary and professional confidence in the language checking system, and bridge any system gaps in identifying poor language ability.

22. Both objectives are connected to the overall aim of ensuring that patients enjoy good quality and safe health care.

23. The introduction of language checking will in particular support achievement of the following policy objectives:

- Enhance public confidence and protect patient safety

  Having a clearly identifiable person with a mandatory duty to ensure checks are undertaken on the language skills of doctors during recruitment should mean that there is assurance that all doctors have satisfactory skills for the post appointed to. By providing explicit responsibility and guidance to responsible officers, we will expect to ensure that checks are undertaken more consistently. This should result in only doctors who have suitable communication skills being employed and better patient care. Public awareness of this action should result in greater public confidence.

- Enhance parliamentary and professional confidence

  Responsible officers are senior respected doctors who will have overall responsibility for language checking. There will be clear accountability for mandatory checks, and by focusing this at the local level understanding of the specific requirements of the role, proportionality, and established lines of reporting to the GMC.

- Bridge system gaps

  Strengthening local arrangements by explicit requirements on responsible officers will bridge the gap in language checks ensuring that there is clear responsibility for such checks and underpinning the importance of language competency in recruiting.

## C. Policy options

### Base Line Do Minimum Option - NHS Architecture

24. Under the do-nothing option, doctors working for the designated bodies that are affected by the organisational changes described above would not be connected to a responsible officer. The solution is therefore the proposed amendment to the Regulations required to designate new organisations.

25. The do-nothing approach would by contrast mean that the new organisations would not be designated and therefore would not have responsible officers, with the corresponding risk that the functions that responsible officers carry out in terms of evaluation of fitness to practice and clinical governance would not be undertaken. This could potentially lead to a decrease in quality and safety of health care and increased risks to patients. There would be also an issue of inconsistency, since the current Responsible Officer regulations would still affect those organisations that have not been affected by the changes in NHS architecture. That could potentially have costs in that it would establish different standards of clinical governance and evaluation of fitness to practice.

26. Hence, a Do Minimum option is adopted, involving

- ❖ Amending the regulations to reflect responsible officers in the new health architecture, ensuring that clinical governance structures continue to work as they do currently.

27. The case for adopting the Do Minimum option rather than a Do Nothing option was implicitly set out in the Impact Assessments associated with the introduction of the Responsible Officer role (see Reference (13), above). Overall, under a do-nothing option, the duties to appoint responsible officers would not be adapted to the new NHS architecture. This would have the following consequences:

- Regulations recently approved by Parliament would no longer be fit for purpose,
- A large number of doctors including GPs would not have a connection to a designated body and therefore be outside the preferred system for revalidation.

## Language Checks – options appraisal and details of alternative options that were discounted at the policy development stage

28. The following section details the Do Minimum option, the preferred option and other options that were considered at the policy development stage, that were discounted for various reasons. The rationale for discounting the various options is set out below.

## Baseline Do Minimum option – Language checks

**29.** In terms of the language checks the Do Minimum option involves permitting a disparate system to continue. This would not provide sufficient assurance to the public, or satisfactorily safeguard patient safety. Failure to act will result in the existing lack of consistency in the application of checks on the language knowledge of doctors. Checks would continue to be undertaken by employers or contractors, but without explicit requirements about who is responsible within an organisation for ensuring that checks are undertaken prior to a doctor being appointed. This option is the baseline against which the preferred option is assessed in this Impact Assessment.

## Centralised system of checks within the NHS

30. A further policy option was considered which involved centralising language checking so that all checks on doctors seeking to work in a post in the NHS would be undertaken through a centralised body. For the purposes of assessing the feasibility of the option it was assumed that the NHS Commissioning Board would either undertake checks on doctors itself, or commission a separate body to undertake checks on doctors on its behalf.

31. One organisation undertaking checks for all doctors would be more likely result in greater consistency in terms of the required standards for application of checks. However, there would be administrative cost in establishing such a centralised unit, potentially additional/duplicate process through the work undertaken by the employer, and the prospect of administrative delay. As checks would need to be applied to all NHS appointed doctors in a non-discriminatory way, the model would have effectively created an administrative barrier to local appointment of doctors being made until checks had been undertaken. The volumes to be processed would also be considerable and there

would be a risk of creating significant delays in the recruitment of doctors and eroding local recruitment flexibility. Further, the Department's assessment was that there would also be a high risk that such a systematic approach to checking would be applied inconsistently with existing European law, as it would be difficult for a centralised function to ensure that the circumstances of individual would be taken into account and local requirements of the role considered. The viability of this option was therefore ruled out and it was discounted.

### Centralised system of checks undertaken by the GMC

32. We also considered the potential for the GMC, as the regulator of doctors, to administer language controls on all doctors seeking to work in the UK. However, our assessment was that existing European law does not permit competent authorities such as the GMC to undertake systematic checking of language prior to registration. This option was therefore discounted.

### Preferred Option

33. Our preferred option is therefore for the responsible officers to have a duty to ensure that doctors have sufficient language skills for the work to be performed, and checks are completed by either having oversight of the system of checks undertaken by the employer, or undertaking the checks themselves. Further we would intend to ensure effective links to the GMC are made where concerns arise, supported by clear guidance to ensure that minimum standards are applied and there is a greater degree of consistency in approach. This builds on the existing established role that responsible officers have in assurance of the recruitment process for their designated body.

### List and summarise the options assessed in the rest of the IA

34. Options were considered in the earlier impact assessment, and as above. Option 2 represents:

- Amending the regulations to reflect responsible officers in the new health architecture, ensuring that clinical governance structures continue to work as they do currently.
- Introduction of an explicit language checking requirement for responsible officers.

## D. Option 2 Impacts, Costs and Benefits

35. Option 2 includes amending the Responsible Officer 2010 Regulations to reflect responsible officers in the new health architecture, and responsible officers being given an explicit and mandatory duty to ensure that doctors recruited by their organisation are subject to proper vetting on their language competence and have the language skills suitable for the role to be undertaken.
36. This will ensure greater consistency in the overall approach to language checking, by ensuring an explicit requirement for all doctors that have responsible officers. The proposal is to amend Part 3 of the Responsible Officer Regulations, which relates to clinical governance and applies solely to England.
37. Responsible officers are already under a statutory duty to co-operate with the GMC. Following consultation, we have concluded that existing provisions in this case are satisfactory without further amendment. It is envisaged that this would be supported by guidance to ensure language concerns are referred to the GMC in appropriate cases. We are also exploring options to amend GMC powers, which will link into the proposed amendment to the Regulations.
38. The separate proposal to strengthen GMC powers, which is being considered, will require amendment of the Medical Act 1983. At present, the GMC have no explicit powers to take action where concerns arise about the language knowledge of a doctor, either during the registration process, or when recruited prior to any proof of deficient practice. We are exploring options for amending the GMC' s powers to resolve this, and also so that the GMC can carry out checks to verify the language knowledge of a doctor from the EEA where concerns arise. This will complement the proposals in this impact assessment.

39. It is envisaged that guidance, which can adapt to changing circumstances, will be issued for responsible officers. The guidance will not be rigidly prescriptive, but will ensure there are minimum standards in place, and direct proportionality in the application of checks. It is not necessary that all doctors with English as a second language are subject to actual language testing. Wider considerations should come into play as part of checking, for example relevant experience, background and education, as demonstrated by the Department's guidance on "Delivering quality in Primary Care: Medical Performers list – language knowledge": 4 February 2010 (11) (see page 5).

40. Amending the regulations to reflect responsible officers in the new health architecture will ensure that the clinical governance structures continue to work as they do currently. Costs and benefits of the consequential impact were covered under the IA of the Health & Social Care Bill (published in October 2011), the IA of the White Paper 'Healthy Lives, Healthy People' (published in November 2010) ((10) see page 5) and the IA for Liberating the NHS: Developing the Healthcare Workforce.

41. During the course of developing the required changes in policy and the developing the Amending Regulations, we were approached by a number of bodies seeking to be added to the list of designated bodies in the Regulations. During discussions with these bodies the potential costs were highlighted and discussed before the Department agreed to designate them. The consultation on the Amendment regulations, held from 7 December to 4 January, considered the addition of these bodies and, overall, respondents were supportive. The designation of these bodies is in addition to the policy changes pursued by the Department. We consider that there will be similar to those described in the original Responsible Officer regulations Impact Assessment when Responsible Officer regulations were first introduced (13). However, since in this case the designation is at the request of the organisations themselves (rather than imposed upon them), it is considered that any subsequent costs and benefits are outside the scope of this Impact Assessment.

## Costs and Benefits - Option 2

42. Costs and benefits of the consequential changes to the Responsible Officer Regulations in light of the changes to NHS organisational structures mentioned above are covered under the IA of the Health & Social Care Bill: October 2011, the IA of the White Paper 'Healthy Lives, Healthy People' published in November 2010 and the IA for *Liberating the NHS: Developing the Healthcare Workforce*.

43. However, the costs and benefits of introducing a new duty on responsible officers in respect of language checking requirements need to be addressed explicitly. Overall, the costs for changes to language checking are relatively small as the proposal builds on existing processes.

### Costs

*Background*

44. The policy proposal is based on the existing role of the responsible officer in the recruitment process, and solely requires that there is now an explicit responsibility in relation to language. There will also be related guidance issued to ensure greater consistency.

45. We are not proposing that all currently employed doctors should be subject to "tests" of language competence. Responsible officers already have a duty to report concerns they have with doctors to the GMC. This includes doctors who are found to have communication issues, including insufficient knowledge of the English language. The proposal for responsible officers, in England, is that they will need to ensure that every doctor appointed to their organisation has sufficient skills in English to communicate with patients and other professionals. Such assessments are necessary to ensure that the doctor has the satisfactory language skills for the role to be performed. Recruitment checks may be undertaken directly by the responsible officer or delegated to other staff; however, responsible officers will have overall accountability for ensuring that checks are undertaken. We consider that, in a majority of cases, these checks are already occurring as part of the pre-appointment checks that organisations are conducting. This may be via assessment of the information submitted as part of an application or by interview, or otherwise. We think that making this explicit in the regulations will ensure appropriate checks are undertaken more consistently.

46. In most cases, we anticipate that the checks will involve assessing the written evidence provided as part of the application process. This evidence may, for example, include details of language qualifications or tests that have already been undertaken, evidence that a person has studied through the English language medium (e.g. obtained a degree awarded by a UK body), or evidence that a person was raised in a bilingual family etc. In many cases an interview will subsequently take place as part of the normal recruitment process and this should provide a further opportunity to assess a doctor's ability to speak English. However, in cases of doubt about whether a doctor was able to speak English to an adequate level to be able to undertake their duties, it would be possible for an employer/responsible officer to require a test to be undertaken by the doctor. We would therefore expect there to be some increased costs associated with additional tests for doctors who would not be in a position to demonstrate that they could adequately speak English through other means.

47. The likelihood is that where employers and contracting bodies, and responsible officers are presently undertaking satisfactory vetting processes prior to recruitment, the costs in terms of applying a more explicit language checking process will be negligible. It should be clear that in the majority of instances, the application form, documentary evidence or the interview process itself will provide satisfactory evidence of language competency. Therefore, the additional costs of option 2 to the providers (in both public and private sector) are negligible, as we anticipate that basic checks on the suitability of doctors are already being undertaken as part of existing recruitment processes. During the earlier consultation exercise on the policy intent, evidence was requested on the likelihood of increased cost, including increased cost to the private sector; however there was no clear evidence provided to us about increased costs, so we have been required to use estimates. The largest proportion of respondees failed to answer the question or did not know whether costs would increase. Our assessment is that introduction of RO responsibility for language competence will generate costs for some applicants, but should not have cost consequences for employers. Employers will merely add another criterion in candidate selection and adjust application of other criteria accordingly.

*Testing costs*

48. Costs will be incurred where the applicant doctor is not able to demonstrate through the application process that he or she has sufficient knowledge of English and a test is required. Costs may then potentially be incurred by either the individual or employer dependent on preference, and a number of different systems currently exist. In terms of a well established existing system on language testing, the GMC require that all overseas (non EEA) doctors undergo the Professional and Linguistic Assessments Board (PLAB), which applicants pay for. We assume that applicants pay for these tests. (If employers decide to pay for these tests, this will be done on the basis of an expectation of benefit to the employer that would justify any additional opportunity cost to the employer. As that benefit is not included in this assessment, it would not be appropriate to include that opportunity cost.) Below is a table of estimated costs arising from the application of language testing, including the relevant assumptions. We have assumed that overseas doctors will already have been subject to testing by the GMC and that UK trained applicants will all be able to provide evidence that there were able to study in the English medium and will not therefore be subject to further tests. A range of 10 to 20% of EEA applicants requiring language tests was used, with a best estimate of 15%. An estimated 4 hours per applicant (including travel time), costed at £14.20 per hour, was also used. Only the additional costs to the applicant are assumed to be significant. Additional costs to the prospective employer or to the Responsible Officer are assumed to be zero.

49. Assuming a discounting rate of 3.5%, this will lead to a Net Present Cost with a lower estimate of £0.51 million, an upper estimate of £1.03 million, and best estimate of £0.77 million.

**Option 2**
**Include responsibility for language checking for EEA migrant doctors within the RO duties**

| **Monetary costs £m** | **2012/13** | **2013/14** | **2014/15** | **2015/16** | **2016/17** | **2017/18** |
|---|---|---|---|---|---|---|
| | **Y0** | **Y1** | **Y2** | **Y3** | **Y4** | **Y5** |
| Testing costs (lower estimate) | £59,642 | £59,642 | £59,642 | £59,642 | £59,642 | £59,642 |
| Testing costs (best estimate) | £89,463 | £89,463 | £89,463 | £89,463 | £89,463 | £89,463 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Testing costs (higher estimate) | £119,284 | £119,284 | £119,284 | £119,284 | £119,284 | £119,284 |
| **Present value (lower estimate)** | **£59,642** | **£57,625** | **£55,676** | **£53,794** | **£51,974** | **£50,217** |
| **Present value (best estimate)** | **£89,463** | **£86,438** | **£83,515** | **£80,690** | **£77,962** | **£75,325** |
| **Present value (upper estimate)** | **£119,284** | **£115,250** | **£111,353** | **£107,587** | **£103,949** | **£100,434** |

| **Monetary costs £m** | **2018/19** | **2019/20** | **2020/21** | **2021/22** | **Total cost over 10** | **Average annual cost** |
|---|---|---|---|---|---|---|
| | **Y6** | **Y7** | **Y8** | **Y9** | | |
| Testing costs (lower estimate) | £59,642 | £59,642 | £59,642 | £59,642 | £596,419 | £59,642 |
| Testing costs (best estimate) | £89,463 | £89,463 | £89,463 | £89,463 | £894,629 | £89,463 |
| Testing costs (higher estimate) | £119,284 | £119,284 | £119,284 | £119,284 | £1,192,838 | £119,284 |
| **Present value (lower estimate)** | **£48,519** | **£46,878** | **£45,293** | **£43,761** | **£513,379** | **£51,338** |
| **Present value (best estimate)** | **£72,778** | **£70,317** | **£67,939** | **£65,642** | **£770,068** | **£77,007** |
| **Present value (upper estimate)** | **£97,037** | **£93,756** | **£90,586** | **£87,522** | **£1,026,758** | **£102,676** |

Assumptions:

3,159 EEA registrants per year (based on 2011 GMC stats)
Between 10% and 20% (with best estimate of 15%) of EEA registrants require language test @ £132 each
Total applicant time for IELTS language test = 4 hours (performing test = 3 hours, average travel time to test centre = 1 hour), applicant time costed at £14:20 per hour
No additional costs due to: workforce supply constraints; and consideration of language competency in existing recruitment processes.

**50.** No additional costs have been calculated for the GMC as a result of the proposed related changes to its powers to enable it to more effectively take action where concerns arise; however, these costs will be properly explored in a separate impact assessment relating to those changes to accompany the legislative reforms that are being considered. Furthermore, it is assumed that the introduction of language testing will not introduce workforce supply constraints.

*Potential impact on recruitment costs*

51. It is expected that those potential recruits who are found not to possess adequate language skills will be turned down. This might in principle lead to additional recruitment costs as it is possible that a greater number of doctors would need to be considered in order to fill each vacancy. However, it is more likely that demand will be satisfied by a marginal flexing of the application of other criteria: in other words, the next best qualified doctor who has requisite language skills will be employed without additional costs. In the second consultation (held 7 December 2012 to 4 January 2013) we asked respondents whether they could provide additional evidence or analysis on the costs of the revised policy for language checking. Answers to this question were informative, but anecdotal. We are therefore unable to provide firmer estimates of the cost of any additional recruitment so have maintained the assumptions relating to additional recruitment costs that were published at the time of the most recent consultation.

52. We further assume that doctors who fail will decide for themselves whether to undertake additional language training. To do so would be a separate investment decision on their part, which they would base upon their own expected benefit. Therefore, any additional language training costs are outside the scope of this IA.

*Responses to the second consultation (9 December to 4 January)*

53. As already indicated, we asked a specific question on costs of the language checking proposal. As stated, although these responses were informative, they were anecdotal and would not enable us to quantify further the costs for the purposes of this analysis.

## Benefits

54. The policy has the potential to improve patient safety; if those doctors with insufficient communication skills are unable to enter the system, potential cases of death and severe harm could be prevented. We included a call for evidence in our public consultation, but in the absence of response highlighting empirical evidence we have made conservative estimates of the impact that the policy might have. Using data from the National Patient Safety Agency, and assuming that each case of avoidable death, severe harm and moderate harm results in an average loss of life equivalent to 10, 1.7 and 0.8 Quality Adjusted Life Years (QALYs) respectively, we have estimated a total benefit of around £1.6 million over ten years due to such events avoided. This assumes a QALY value of £60,000 per year, and is based on an assumption that 0.002% of cases may be avoided over the ten year period, equivalent to 1 death, 2 cases of severe harm and 15 cases of moderate harm. This assumption has taken into account information provided by the GMC on the small number of fitness to practise cases which included language difficulties, and the death of David Gray.

55. Further to the patient safety gain, it is expected that there will be a corresponding reduction in litigation costs to employers resulting from adverse incidents stemming from poor communication skills. In the absence of available data, we have assumed that this will add a further value equivalent to 50% of the patient safety benefit, or around £0.8 million over ten years.

56. The non-monetary benefits are as follows:

- Responsible officers will have a statutory duty and clarity on their role on language checking. Guidance will encourage minimum but satisfactory levels of consistency. Responsible officers should help processes to be followed through completely by better co-ordination with the GMC;
- Doctors with inadequate language skills will be identified and action taken where appropriate;
- Strengthening of the role at the local level permits consideration of the specific role and an individual's circumstances and is therefore consistent with European law; and
- The greater clarity on checks should provide an incentive for those where English is not their first language to consider their abilities.
- From the information above, in our view, it is evident that the existing system for language checks can be improved in order to increase patient safety by reducing the likelihood of incidents that endanger patient safety, improve the quality of care by assuring better language competency overall, and to reassure the public overall.

## Costs to private sector and small firms

57. When the Responsible Officers Regulations were introduced, the effect in terms of cost for micro / small firms was considered and was expected to be small, as the original regulations were drafted as to minimise the impact on micro / small firms. The current amendment makes explicit requirements on language competency as part of the existing recruitment process. There is no requirement that responsible officers should undertake language checks themselves, but rather responsible officers should provide assurance that such checks are appropriately being undertaken. Where recruitment processes are sufficiently robust this should add little in terms of cost.

58. There may be some related costs in terms of language tests; however, it is a matter for the organisation whether the individual or organisation pays for the language tests in the cases where this is required. Indications are that the individual is likely to pay (there is no expectation that the organisation will be expected to pay for language tests). We assume that applicants pay for these tests. (If employers decide to pay for these tests, this will be done on the basis of an expectation of benefit to the employer that would justify any additional opportunity cost to the employer. As that benefit is not included in this assessment, it would not be appropriate to include that opportunity

cost.) Overall, costs are expected to be minimal as detailed in the costing section. The cost of a test has been estimated at £132 and the proportion of potential tests based on annual EEA migrant data, with a best estimate of 15% (558). Private organisations will not be requiring 15% of all applicants to undertake language tests, but an estimated15% of all applicants where English is not their first language (and where the applicant has not already been recently satisfactorily tested such as PLAB).

59. It is estimated that 8% of doctors work solely in the private sector. This proportion has been used to estimate the total cost of around £15,000 per year. For the reasons given, it is assessed that this cost will be borne by potential applicants. The benefit to the private sector (in terms of better outcomes for their patients) is also estimated proportionately, at £16,000 per year – overall, a net benefit to the sector of around £1,000 per year.

**One in One out**

60. The proposed policy modifies an existing recruitment process, and there should therefore be negligible additional costs (where the recruitment process is sufficiently robust). Costs will be incurred through the use of proportionate language tests. These costs are expected to fall on applicants, and in any case to be extremely small in respect of applicants to private providers and less than the anticipated benefits. Hence, the policy is within scope of one in one out, but with zero net cost to business.

### Risks

61. Risks identified as part of the proposed policy include:

- Loss of local control over language testing of doctors if national guidance is too rigid (leading to the individual circumstances of the doctor and the role requirements not being properly considered);
- Insufficiently comprehensive guidance may lead to inconsistency in decision-making by responsible officers; and
- Responsible officers may become risk adverse and consequently not apply proportionate language testing. A failure to properly consider the individual circumstances of the doctors, and the different ways to check language competency could result in checks being deemed too systematic and potentially not compliant with European law.

## Equality and Human Rights:

#### Equality duties

- Separate Equality Analysis.

#### Social Impacts: Human rights, rural proofing and rural communities

- We do not believe the policy will impact differently on different communities or doctors in rural communities.

#### Impact on others whose natural rights or legitimate expectations might seem to be compromised

- We do not believe the policy will impact on different rights or legitimate expectations

#### Impact on private/voluntary and charitable sector costs and benefits

- The impact for the private/voluntary and charitable sector are included in the evidence base.

## E. SUMMARY AND WEIGHING OF OPTIONS

62. ‘Do nothing’ option: This option is problematic, since it would mean many of the new bodies created by the reorganisation of the NHS would not be covered by the current clinical governance arrangements in terms of Responsible Officers. If not rectified, this would be an unintended effect of these policies and could lead to increased risk to NHS patients. Under the Do Minimum option, involving adjustment of RO regulations to fit the new architecture but not adding language assessment responsibilities, decisions on language checking would continue to be determined locally with differing results throughout England.

63. Option 2: This option represents adapting Responsible Officer Regulations to the new structure of the NHS. Its costs and benefits have been covered in the Health and Social Care Bill IA amongst others as consequential changes. Option 2 also adapts the Responsible Officer Regulations, but extends their duties by requiring checking of the language competencies of the doctors they oversee. The checking of language competency of doctors would be strengthened at local level in order to ensure that doctors have satisfactory language and communication skills, whilst considering European law. This would ensure patient and public safety overall.