Council

23 May 2024

Consultation outcome: English language proficiency requirements for international applicants

Executive Summary

Between October 2023 and January 2024 we consulted on proposals to change the evidence we accept from applicants which demonstrates their English language proficiency.

Our proposals were:

- Removal of the option for applicants to self-declare that they speak English as their first language ("self-declaration").
- Introduction of a "qualifying" list of countries which are majority English speaking (the "qualifying countries list"), defined as 75% of the population speaking English on a regular basis. We would ask that registrants passed their primary qualification in the given country.
- Acceptance of work experience in the UK which is supervised by a registered health or care professional, or registered work experience in a qualifying country, as described in the proposal above.
- Acceptance of approved English tests with a longer list of approved tests, which would also be made exhaustive.

We have analysed the consultation responses and today Council is asked to consider and approve our recommendations on each of the four proposals as set out in the consultation outcomes document.

Early findings were discussed with relevant teams and at the Education and Training Committee (ETC), and a previous version of this paper was discussed and approved by the Executive Leadership Team (ELT).

We have developed the consultation outcomes and decisions document at annexe A which sets out our proposed approach.

Previous consideration	The consultation was discussed by the ELT on 19 September 2023 and the Council on 5 October 2023. The consultation opened in October 2023 and concluded on 19 January 2024. The ETC received an initial summary of the findings at its meeting on 6 March 2024, and their feedback was fed into the drafting of an outcomes paper which was discussed by ELT on 7 May 2024. The ETC also received a written update on the development of the ELT

	and Council papers in May 2024 and provided feedback to inform the final documents.
Decision	The Council is asked to approve the strategic and policy decisions outlined in the paper.
Next steps	A communications and engagement plan is planned and a summary is contained within the main paper at annexe A. Following the Council's decision, we will update stakeholders via a web article and direct engagement work. We will also begin work to put in place detailed implementation scoping, plans and timeframes, with an initial view to implementing the selected proposals by the end of the 2024 calendar year.
Strategic priority	The proposals address the HCPC's priority of promoting high quality professional practice and are included in the 2024-25 Corporate Plan.
Financial and resource implications	If adopted, the proposals will be implemented within the agreed financial year 2024-25 budget and staffing plans. This will be concentrated on the International Registration team but will also impact several supporting teams such as IT and Business Change. Planning for implementation with those teams is already under way and this work features in our 2024-25 Corporate Plan and budget.
EDI impact and Welsh Language Standards	International applicants from some countries would now not be able to self-declare English as their first language. We have also identified cross-cutting impacts for people who would have self-declared but would now take an English test, as there are associated time and financial costs which would impact some groups more strongly. There would be further impacts for people who could have difficulty in accessing documentation, for example refugees or people who had been victims of discrimination in their home country. There are positive impacts for people who speak English to the required standard but not as a first language, and people from countries on our proposed qualifying countries list would benefit similarly. The changes would introduce an objective standard for evidence of proficiency and minimise the risk of subjective decisions. The policy has been assessed against the Welsh Language Standards. There are no identified impacts on the Welsh language, or associated opportunities to promote its use.

	Please see the full EIA at annexe B for further detail on the potential impacts and mitigations.
Authors	Tom Miller, Policy Manager thomas.miller@hcpc-uk.org Madeleine Connor, Senior Policy Officer madeleine.connor@hcpc-uk.org
ELT sponsor	Andrew Smith, Executive Director of Education, Registration and Regulatory Standards and Deputy Chief Executive andrew.smith@hcpc-uk.org

Consultation outcome: English language proficiency requirements for international applicants

Analysis of the consultation responses and our resulting decisions

Contents

1. Foreword

1. The HCPC is the statutory regulator of 15 professions. The HCPC's function is to set and maintain standards for those professions, with the objective of protecting the public.

2. Across our regulated professions, the Health and Care Professions Council (HCPC) sets the English language requirements that prospective registrants ("applicants") must meet to demonstrate that they are sufficiently proficient in English to join the register.

3. In 2022 we began a review of the types of evidence we would accept from new international applicants to demonstrate their English language proficiency. The purpose of the review and consultation was to ensure our approach is robust, clear and fair. Following engagement with internal and external stakeholders, we developed proposals for potential changes.

4. In developing our proposals we sought to ensure any new requirements:

    - support registrants to meet our Standards and do not compromise on safety and high-quality care for service users;

    - continue to support internationally trained professionals to bring their talent, skills and experience to the UK;

    - consider applicants fairly and based on objective criteria, preventing discrimination in respect of their backgrounds or protected characteristics; and

    - are comparable with those of other regulators where possible.

5. We are extremely grateful to all of the stakeholders who participated in the review and provided the valuable insights that have informed the proposed changes to our English language requirements. This engagement has been integral to our understanding of how they can be improved, balancing our priorities of robustness, fairness, and clarity.

6. This document sets out the feedback that we received to the consultation and our decisions. As we implement changes to our English language requirements following the consultation, it will be important for us to monitor their impact. We plan to continue the conversations that we have started with our stakeholders during the pre-consultation and consultation engagement periods. We look forward to supporting applicants and registrants in the effective implementation of the new requirements, and further engaging with all our stakeholders during the implementation phase of the review and beyond.

2. Executive summary

7. Since we began publishing data, numbers of registrants using our international registration route have increased. In 2018 international route applicants accounted for 20% of all new registrations. By 2023 this had risen to 45%.

8. With other regulators having recently updated their English language requirements we also felt that the HCPC should use the opportunity to examine areas where we could improve our own policies, learn from the rest of the sector, and move towards regulatory alignment where practical and appropriate.

9. Under our current English language approach most international applicants rely on self-declaration of English as a first language as their means of evidencing proficiency. Analysis of international applicants joining the register during the 2023-2024 financial year showed that 84.9% (9,943 from a total of 11,706) had declared English as their first language.

10. Following a pre-consultation engagement with our stakeholders, we developed a set of proposals which would change the types of evidence we would accept in support of applicants' proficiency. The consultation ran from 16 October 2023 until 19 January 2024

11. The scope of the proposals was limited. They would only apply to new applications using our international registration route (excluding those applying through our Swiss Mutual Recognition route). This means that there would be no effect on current registrants, and that the proposed changes would not affect people using the UK registration route, renewing their registration, or applying for readmission. The proposed changes would not affect our Standards of Proficiency requirements, or the level of proficiency in English we would expect applicants to demonstrate.

12. The proposals we consulted on were:

    12.1. Removal of the option for applicants to self-declare that they speak English as their first language ("self-declaration").

    12.2. Introduction of a "qualifying" list of countries which are majority English speaking (the "qualifying countries list"), defined as 75% of the population speaking English on a regular basis. We would ask that registrants passed their primary qualification in the given country.

    12.3. Acceptance of work experience in the UK which is supervised by a registered health or care professional, or registered work experience in a qualifying country, as described in the proposal above.

    12.4. Acceptance of approved English tests as is the case at present, but with a longer list of approved tests, which would also be made exhaustive.

13. Our engagement activity and consultation were based on the principle of the proposals rather than detailed explanations of how these should work. More detailed plans for implementation will be developed drawing from the results of the public consultation, taking into account their feasibility as well as our learning from the consultation period. That process begins with this analysis.

14. During the consultation period we held six online workshops to promote the consultation and explain the content. Some sessions were tailored to stakeholder groups such as professional bodies and our Equality, Diversity and Inclusion Forum, whilst others were for a general public audience. We recorded the sessions and made the recordings available on our events page.

15. In addition to this, we also presented the consultation and took questions from attendees at two “Join the UK workforce” sessions run by our Professional Liaison Service. These are information sessions aimed at new registrants who had used the international route, a key group we wanted to inform the consultation outcome, given their recent experiences with our international registration processes.

16. We commissioned work from The Patients Association, who carried out valuable focus group activity aimed at service users. We are appreciative of their feedback, which we have considered, and which will continue to play a role as we develop plans for the proposals at an operational level.

17. The responses we received to the consultation were broadly supportive of our proposals in all areas. There were some questions where there was a broader range of feedback and we explore this in more detail in the sections that follow. The responses gave many thoughtful and well-reasoned insights where we asked for qualitative feedback, much of which will continue to shape the development of the proposals. We would like to thank all of those who have taken the time to respond to us.

3. Introduction

About us

18. The HCPC’s statutory role is to protect the public by regulating healthcare professionals in the UK. We promote high quality professional practice, regulating just under 340,000 registrants across 15 different professions by:

    - Setting standards for professionals' education and training and practice;
    - Approving education programmes which professionals must complete to register with us;
    - Keeping a register of professionals, known as 'registrants', who meet our standards;
    - Acting if professionals on our Register do not meet our standards;
    - Stopping unregistered practitioners from using protected professional titles.

19. We regulate 15 health and care professions:

    - Arts therapists

- Biomedical scientists
- Chiropodists/podiatrists
- Clinical scientists
- Dietitians
- Hearing aid dispensers
- Occupational therapists
- Operating department practitioners
- Orthoptists
- Paramedics
- Physiotherapists
- Practitioner psychologists
- Prosthetists/orthotists
- Radiographers
- Speech and language therapists.

About this document

20. This document summarises the responses we received to the consultation and our decisions.

21. Section 3 details our pre-consultation engagement, and explains how we handled and analysed the pre-consultation engagement feedback to inform the proposals for consultation. Section 4 provides a statistical overview of the responses we received to the consultation and how we have analysed them.

22. Section 5 provides a full breakdown of the answers we received, provides an overview of the work we commissioned to hear from service users, and summarises the changes we have made to our Draft Equalities Impact Assessment (EIA) to create a final version. In this section we also give our response to the feedback we received.

23. Section 6 summarises the decisions required before implementation can begin. Section 7 gives an overview of the next steps required for implementation, communications and engagement, and is followed by annexes at Section 8. These include a copy of the EIA and the full focus group report from The Patients Association.

Pre-consultation development and engagement

24. In 2023 we carried out a range of pre-consultation activity with stakeholder organisations. These included employers, professional bodies, English test providers and educational institutions. We engaged with these stakeholders in online information sessions held on 19 and 20 April 2023.

25. These were informal sessions where stakeholders gave us their thoughts about our current policy and how it might be improved, and where we could draw on their knowledge and experience to inform this consultation. We also engaged with professional bodies through the HCPC Professional Bodies Forum in March 2023 in order to give further introductions to the project and take informal feedback.

26. We developed an informal survey to gather views from stakeholder organisations as part of our pre-consultation engagement, and we received 50 responses. 41 of these (82%) were education providers, 6 (12%) were professional bodies or trade unions, and 1 (2%) was an employer organisation.

27. We asked respondents about recent experiences working with colleagues, in particular their ability to work safely and effectively in English. 37 of the 50 organisations (74%) said that they had not had concerns about any HCPC registrants' ability to work safely and effectively in English, but 13 organisations (26%) said that they had.

28. Of these 13, a combined 71.4% had taken action of some kind to address this. This included 28.6% who had raised a Fitness to Practise concern, 7.1% who had raised an issue elsewhere with the HCPC, and 35.7%who had taken action outside of our processes (for example via disciplinary action as an employer).

4. Consultation outcome: response analysis

29. The following sections describe how we analysed responses to our public consultation and provide an overall breakdown of responses.

Method of recording and analysis

30. Most respondents used our online survey tool to respond to the consultation. They self-selected which stakeholder group they belong to (e.g., registrant, service user, professional body as applicable), and, where answered, selected their response to each consultation question (e.g., yes; no; partly; don't know as applicable).

31. They were also able to give us their comments on the main questions, with some minor exceptions such as "which statement do you most agree with?" questions.

32. Where we received responses by email, we recorded each response in a similar format to those from the online survey. Content from written responses is accounted for in all charts, graphics and statistics cited within this paper.

33. When deciding what information to include in the document, we assessed the frequency of the comments made and identified themes. This document summarises the common themes across all responses and indicates the frequency of arguments and comments made by respondents.

Statistical breakdown of responses

34. We received 526 responses to the consultation. 42 of the responses (8%) were from organisations, and 484 (92%) were from individuals. In addition to our questions about the proposals, we asked respondents several questions about their background.

Organisational responses

35. The following table shows a breakdown of organisational responses, the largest numbers of responses were from employers and professional bodies or trade unions. We also received responses from regulators and test providers. All of the test providers who responded provide tests which are not currently approved by the HCPC.

Type of stakeholder	
Answer Choice	**Response Total**
Educational institution	2
Employer	16
Professional body/trade union	16
Regulator	3
Test provider	4
Other	1

36. Organisations were heavily focussed towards delivering their services on a UK basis or in England alone, and there were no respondents solely active in Northern Ireland.

Where is your organisation active?			
Answer Choice		**Response Percent**	**Response Total**
1	England	26.2%	11
2	Northern Ireland	0.0%	0
3	Scotland	2.4%	1
4	Wales	2.4%	1
5	UK-wide	47.6%	20

6	International	16.7%	7
7	Other (please specify):	4.8%	2
		answered	**42**

Individual responses

37. Of the 484 responses from individuals, 346 (71.49%) were from HCPC registered professionals. 138 (28.51%) of the individual responses were from other groups (see paragraph 43 for more information).

38. Below we have included a breakdown of our registration statistics along with a breakdown of the responses we received from registered professionals.

Registered professionals	**Number of registrants***	**Number of responses**	**Response rate per 1,000 registrants**
Arts therapists	5,800	1	0.2
Biomedical scientists	27,890	31	1.1
Chiropodists/podiatrists	12,250	2	0.2
Clinical scientists	7,640	21	2.7
Dietitians	12,050	22	1.8
Hearing aid dispensers	4,485	2	0.4
Occupational therapists	44,775	25	0.6
Operating department practitioners	16,605	16	1.0
Orthoptists	1,545	1	0.6
Paramedics	37,410	4	0.1
Physiotherapists	74,025	92	1.2
Practitioner psychologists	28,665	15	0.5
Prosthetists/orthotists	1,200	5	4.2
Radiographers	45,900	90	2.0
Speech and language therapists	18,975	18	0.9
If you are dual or multiple registered	-	1	<1
Total	**339,205**	**346**	

** Data obtained in April 2024. Numbers are rounded to the nearest 5.*

39. At least one answer was received from each of our professions. Response numbers were higher for Physiotherapists and Radiographers in particular. Lower numbers were received from several professions where they comprise smaller parts of our overall register: Arts therapists, Chiropodists/Podiatrists, Hearing aid dispensers, Orthoptists,

Prosthetists/Orthotists. Paramedics were under-represented in the individual (as opposed to organisational) responses. Some of the professions mentioned were also covered by responses from professional bodies and trade unions responding on behalf of their membership.

40. We asked registrant respondents to tell us their place of work or activity, which was as follows:

Where is your regular place of work or activity?		
Answer Choice	**Response Percent**	**Response Total**
England	69.9%	242
Northern Ireland	0.9%	3
Scotland	5.8%	20
Wales	1.2%	4
I work across the UK	2.3%	8
I work outside the UK	15.9%	55
I work both inside and outside the UK	1.2%	4
Other (please specify):	2.9%	10
	answered	**346**

41. This showed low percentages of professionals answering from Scotland (5.8%), Northern Ireland (0.9%) and Wales (1.2%). Scotland was better represented against its percentage of the register than Northern Ireland and Wales: based on the data we hold for registered address, we estimate that around 8.3% of registrants have an address in Scotland, 3.4% in Northern Ireland, and 4.7% in Wales.

42. Given that registrants could give a UK registered address but also say that they work across (2.3%) or outside the UK (15.9%), these results are broadly in line with what we might expect to see, and are reasonably reflective of the register itself.

43. As noted above, 138 respondents were not HCPC registered professionals. 99 (71.7%) of these respondents told us that they were applying for registration. The next largest category among non-registrants were the 17 (12.3%) who selected ‘other’ and gave details.

44. 9 (6.5%) were interested members of the public, 5 (3.6%) were students on an HCPC approved course, 4 (2.9%) were relatives of registrants, 3 (2.2%) were carers, and 1 respondent (0.7%) was answering as a person using services.

45. Of these 138 responses from individual non-registrants 62 (44.9%) were answering from outside the UK, 46 (33.3%) were from England, 6 (4.4%) were from Wales, 4 (2.9%) were from Scotland, and none were from Northern Ireland.

46. Of the 484 individuals who answered (i.e. HCPC registrants and other groups), the breakdown by the protected characteristics was as follows:

	All individuals		Registrant respondents		Non-registrant respondents		Register
Age	**Responses**	**Percentage**	**Responses**	**Percentage**	**Responses**	**Percentage**	**Percentage**
Under 20	0	0%	0	0%	0	0%	N/A
20-29	134	28%	66	19%	68	49%	17%
30-39	167	35%	129	37%	38	28%	31%
40-49	99	21%	78	23%	21	15%	26%
50-59	49	10%	46	13%	3	2%	18%
60-69	17	4%	14	4%	3	2%	7%
70 or older	3	1%	1	<1%	2	1%	1%
Prefer not to say	15	3%	12	4%	3	2%	<1%
Total	***484***	**100%**	**346**	**100%**	**138**	**100%**	**100%**

47. The profile of registrant respondents is slightly older than that of all individual respondents.

48. Our registration data in January 2024 indicated that registrants aged 20-29 made up 17% of the register, and 30-39 year olds made up 32% of the register. Whilst still broadly representative of the register, the consultation responses show a slight weighting towards the younger end of our registrant profile.

	All individuals		Registrant respondents		Non-registrant respondents		Register
Ethnicity	**Responses**	**Percentage**	**Responses**	**Percentage**	**Responses**	**Percentage**	**Percentage**
White	181	37%	156	45.%	25	18%	75%
Mixed or multiple ethnic groups	15	3%	7	2%	8	6%	12%
Asian or Asian British	143	30%	83	24%	60	43%	5%
Black, African, Caribbean or Black British	105	22%	77	22%	28	20%	2%
Prefer not to say	28	6%	18	5%	10	7%	1%
Other ethnic group	12	3%	5	1%	7	5%	4%
Total	***484***	**100%**	**346**	**100%**	**138**	**100%**	**100%**

49. Respondents who answered “white” were underrepresented, making up 37.4% of all individual responses and 45.1% of registrant responses, whilst 2021 UK census data

indicates that 82% of residents in England and Wales are white[1]. Answers for Asian, Asian British, Black, African, Caribbean or Black British are all high in comparison to the England and Wales census numbers for Black, Asian, Mixed or "other", which together comprise a total of 18%.

50. Mixed or multiple ethnic group respondents are very slightly above the proportion of registrants at 3.1%, whilst making up 2% of current registrants in January 2024. Asian respondents made up 29.5% of respondents but only make up 12% of the register, and people with black backgrounds made up 21.7% of respondents but only 5% of registrants.

51. Our Equalities Impact Assessment (EIA) identified adverse impacts based on nationality, and that these nationalities are more likely to have higher non-white ethnicity populations. Whilst the respondent profile does not mirror our register, it is much more likely to represent the profile of applicants who might be affected by the proposed changes, or who might have experienced the current systems in place for international registration.

52. We asked the respondents who answered as individuals about the sex that was recorded at birth. The following table shows a breakdown of their answers:

	All individuals		Registrant respondents		Non-registrant respondents		Register
Sex recorded at birth	**Responses**	**Percentage**	**Responses**	**Percentage**	**Responses**	**Percentage**	**Percentage**
Female	272	56%	191	55%	81	59%	71%
Male	184	38%	133	38%	51	37%	26%
Intersex	1	<1%	0	0%	1	1%	0%
Prefer not to say	27	6%	22	6%	5	4%	3%
Total	***484***	**100%**	**346**	**100%**	**138**	**100%**	**100%**

53. Respondents were less likely to give their sex recorded at birth as female (56.2% of individuals and 55.2% of registrant respondents) than professionals on our register, where females made up 71% of registrants. In contrast, males make up 26.1% of the register, but 38% of responses in both categories.

54. Interestingly, the percentages of respondents are more reflective of those of HCPC registrants who join the register via the international route. The percentage of male respondents is 38%, the same percentage made up by male registrants who used the international route. 60% of international registrants are women, who made up 56.2% of individual responses.

55. The following table shows answers to our question about gender identity (as compared to sex recorded at birth).

[1] UK Census 2021, Office for National Statistics: https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/bulletins/ethnicgroupenglandandwales/census2021 (retrieved 21 April 2024)

	All individuals		Registrant respondents		Non-registrant respondents		Register
Does gender identity match sex recorded at birth?	Responses	Percentage	Responses	Percentage	Responses	Percentage	Percentage
Yes	443	92%	316	91%	127	92%	96%
No	18	4%	12	4%	6	4%	0%
Prefer to self-describe	22	5%	17	5%	5	4%	0%
Prefer not to say	1	<1%	1	<1%	0	0%	3%
Total	***484***	**100%**	**346**	**100%**	**138**	**100%**	**100%**

56. Statistics from our register show that 96% of registrants who answered our monitoring question told us that their gender matches their sex assigned at birth, with 795 registrants for whom this was not the case making up less than 1% of the register. 3% of our total registrants preferred not to say.

57. Our individual consultation responses show a higher percentage of “no” answers (3.7%) and those preferring not to say (4.5%). These numbers are at 3.5% and 4.9% respectively for registrant respondents. However, these answers are at small percentages, so the answers still roughly represent the profile of registrants.

58. The following table shows how respondents answered on whether they consider themselves to have a disability. We gave a working definition for this as “a physical or mental impairment which has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities”.

	All individuals		Registrant respondents		Non-registrant respondents		Register
Disability	Responses	Percentage	Responses	Percentage	Responses	Percentage	Percentage
Yes	30	6%	24	7%	6	4%	5%
No	430	89%	303	88%	127	92%	91%
Prefer not to say	24	5%	19	6%	5	4%	4%
Total	***484***	**100%**	**346**	**100%**	**138**	**100%**	**100%**

59. People declaring disabilities were similarly represented (6.2% and 6.9%) in our responses when compared to our current register where this is approximately 5%. Prefer not to say answers (5% and 5.5%) were also around the same profile as our register as a whole, approximately 4%.

60. The following table shows those identifying themselves with the pregnancy and maternity protected characteristic.

	All individuals		Registrant respondents		Non-registrant respondents		Register
Respondents with the protected characteristics of pregnancy and/or maternity	**Responses**	**Percentage**	**Responses**	**Percentage**	**Responses**	**Percentage**	**Percentage**
Yes	14	3%	10	3%	4	3%	5%
No	450	93%	322	93%	128	93%	89%
Prefer not to say	20	4%	14	4%	6	4%	6%
Total	***484***	**100%**	**346**	**100%**	**138**	**100%**	**100%**

61. There was under-representation of respondents who identified themselves with the pregnancy or maternity protected characteristic (2.9% of all individuals and also the registrant subset) when compared to professionals on our register as a whole, where this was 5%. However both of these numbers deal with relatively low percentages, so we would advise caution in drawing conclusions from this data.

62. Again, both numbers are small compared to respondents as a whole, but we acknowledge that specific adverse impacts towards applicants with these protected characteristics were identified in our EIA.

63. The below table outlines the answers we received on religion and belief.

	All individuals		Registrant respondents		Non-registrant respondents		Register
Religion or belief	**Responses**	**Percentage**	**Responses**	**Percentage**	**Responses**	**Percentage**	**Percentage**
No religion/ strong belief	103	21%	87	25%	16	12%	41%
Buddhist	2	<1%	2	1%	0	0%	1%
Christian	229	47%	175	51%	54	39%	39%
Hindu	37	8%	17	5%	20	14%	3%
Jewish	2	<1%	1	<1%	1	1%	1%
Muslim	49	10%	24	7%	25	18%	5%
Spiritual	4	1%	1	<1%	3	2%	2%
Sikh	2	<1%	0	0%	2	1%	1%
Other	9	2%	6	2%	3	2%	1%
Prefer not to say	47	10%	33	10%	14	10%	8%
Total	***484***	**100%**	**346**	**100%**	**138**	**100%**	**102**

64. Individual respondents were comparable by religion or belief to the profile of our registrants, but there were some notable differences. Respondents were more likely (47.3% for individual respondents and 50.6% for the registrant subset) to identify as Christian compared to current registrants (39%).

65. At 10.1%, individual respondents were around twice as likely to be Muslim than registrants (5%), but the percentage for registrant respondents (6.9%) is between the two. Most strikingly, current registrants were around twice as likely to declare that they had no religion or strong belief (41%) than the individual respondents (21.3%) or the registrants who responded to the consultation (25.1%).

66. The following table shows the answers we received when we asked respondents about their sexual orientation.

	All individuals		Registrant respondents		Non-registrant respondents		Register
Sexual orientation	**Responses**	**Percentage**	**Responses**	**Percentage**	**Responses**	**Percentage**	**Percentage**
Heterosexual/ straight	404	84%	284	82%	120	87%	87%
Bisexual	9	2%	7	2%	2	1%	2%
Gay man	12	3%	10	3%	2	1%	1%
Lesbian	6	1%	5	1%	1	1%	1%
Other	5	1%	4	1%	1	1%	0%
Prefer not to say	48	10%	36	10%	12	9%	8%
Total	***484***	**100%**	**346**	**100%**	**138**	**100%**	**100%**

67. 83.5% of individual respondents and 82.1% of registrant respondents identified as heterosexual/straight, while 87% of overall registrants identified the same way in our monitoring statistics. Among all current registrants, identification as bisexual was at roughly 2%, and identification as gay or lesbian were both roughly at 1%.

68. Survey respondents were more likely to identify as gay men (2.5% and 2.9%) than as bisexual (1.9% and 2.0%) or lesbian (1.2% and 1.4%). Prefer not to say answers were comparable to the register as a whole (8%), at 9.9% and 10.4% for individual and registrant respondents. Overall, the answers on sexual orientation provide a fairly representative set of survey responses when compared to our register data.

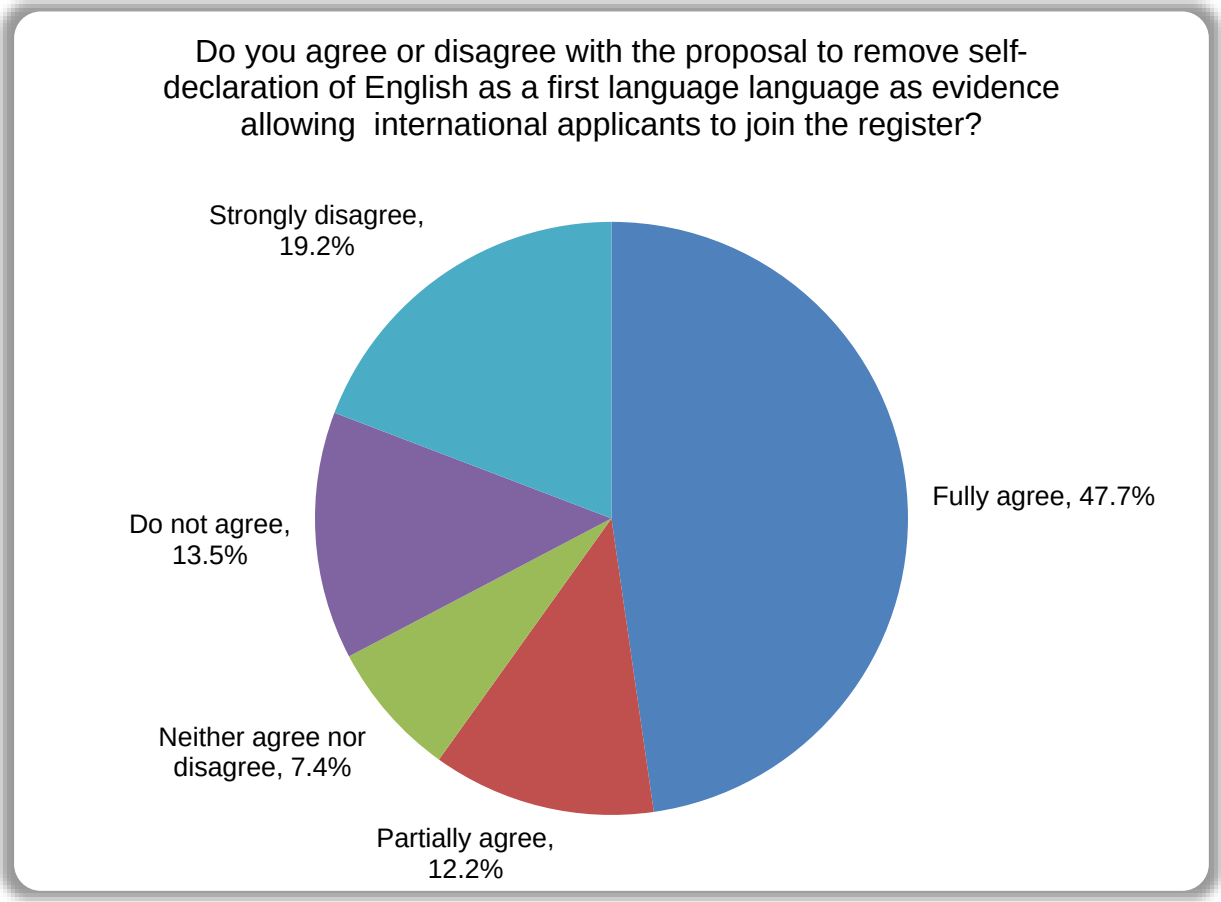
69. Because this consultation was open to the public, future applicants and registrants, we should be wary of drawing conclusions about under or over representation of specific groups. However, based on the responses to our Equality, Diversity and Inclusion (EDI) demographic questions, we have a reasonable degree of confidence that our consultation received responses from a diverse range of voices from a variety of backgrounds, all of which have played an important part in developing our responses.

5. Responses to the proposals

70. This section provides and analysis of the consultation feedback we received on each of our proposals, and adds our response.

Proposal 1: removal of self-declaration of English as a first language

71. In the consultation, we asked respondents about their view on our proposal to remove self-declaration as a way for international applicants to evidence their English language proficiency.



72. This question was compulsory and was therefore answered by all 526 respondents.

73. 251 respondents fully agreed with the proposal (47.7%), with 64 (12.2%) in partial agreement. 59.9% of respondents therefore agreed with the proposal to remove self-declaration. 101 people (19.2%) were in strong disagreement with the proposal. 71 respondents (13.5%) generally disagreed. Therefore 172 (32.7%) of respondents opposed the proposals in total.

74. The smallest percentage of answers (7.4%) was from those who neither agreed nor disagreed. There are many potential reasons for giving this answer, but the relatively low proportion indicates that the proposal has been well understood.

75. Respondents were given a ‘free text’ box to explain their reasoning and give further thoughts. We received 284 comments on this question.

76. People agreeing with the proposal made the point that self-declaration does not provide acceptable evidence of proficiency (or factors that lead to proficiency), and highlighted that self-declaration is open to abuse, relies on good faith, and is essentially subjective.

77. Benefits identified with removing self-declaration included the removal of ambiguity and creating a level playing field for applicants who speak English as a second language. The need for a more consistent and objective alternative was a common theme of the supportive comments.

78. Areas of opposition or potential risks included perceptions that this would drive people towards having to take tests and the associated financial impact.

79. Some respondents felt that removing self-declaration would create potential unfairness towards people from “non-qualifying” countries (as per proposal 2) who may speak English well. Some responses flagged that the alternatives we had proposed risked ignoring people who had been educated in English speaking education systems in countries where English is not spoken by the majority on a regular day-to-day basis, who might currently self-declare. Similar concerns were also raised about the potential for countries with high levels of bilingualism including English to not be included on a Qualifying Countries List.

80. Some who were not in support of the proposal gave arguments that self-declaration should be considered a right, and that the proposal infringes it. Perceived problems were also raised with some of the alternative routes, such as the difficulty for some applicants in achieving the required test scores.

Organisational responses

81. Stakeholder organisations were strongly in favour of removing self-declaration, with 32 responses (76.19%) indicating that they fully agreed with the proposal, and none in strong disagreement.

82. Some employers raised instances of staff with poor English language proficiency. There was a general feeling that the change would make our processes more objective, enhance robustness, and support public protection.

83. 5 organisations disagreed, one in particular argued that self-declaration could remain part of a wider range of options.

Our response

84. We note the overall agreement of consultation respondents with the proposal to end self-declaration. With increasing numbers of international applicants joining the register, we feel that now is an appropriate time to review our requirements, ensuring that the public can be confident that they are robust, fair and clear even as numbers increase.

85. We will adopt the proposal to stop accepting self-declaration of English as an applicant's first language as evidence of their English language proficiency, with implementation of this change to begin in the final quarter of 2024. A timeline for this change will be developed as part of our implementation planning, and the proposal will not be introduced until alternative pathways have been introduced in line with the other consultation outcomes. Alongside our implementation work, we will also develop a communications and engagement plan in order to make sure that individuals and stakeholder organisations are prepared for its introduction.

86. We acknowledge that this may create new barriers for some registrants (please see our Equality Impact Assessment for more information). However, we feel that the move away from self-declaration is proportionate and necessary to ensure the necessary additional safeguards required to fulfil our public protect responsibilities. In designing our other proposals we have sought to minimise the adverse effects by maximising the number of routes that applicants can use to show their English language proficiency and join the register.

87. The impact of the proposal will be subject to routine monitoring by our International Registration team with a particular view towards understanding how different groups may be impacted by this change, and any impact on workforce supply. We will report to our Education and Training Committee on the impact of the changes a year after the full range of proposals have come into operation.

Proposal 2: acceptance of primary qualifications from a list of "qualifying" countries

88. We asked respondents several questions about possible proposals to replace the current system. The first of these was the proposal to develop a Qualifying Countries List. Under this proposal, applicants who had passed a qualification taught and delivered in English in a 'listed' country would be considered proficient.

89. A country would be listed if 75% or more of its residents speak English as a first language (which would be independently assessed).

90. We were interested in whether respondents felt that the measure would protect the public and maintain public confidence, what impact the proposal might have on professionals' confidence in their own proficiency, and whether the proposal was viewed to be proportionate when considering workforce need.

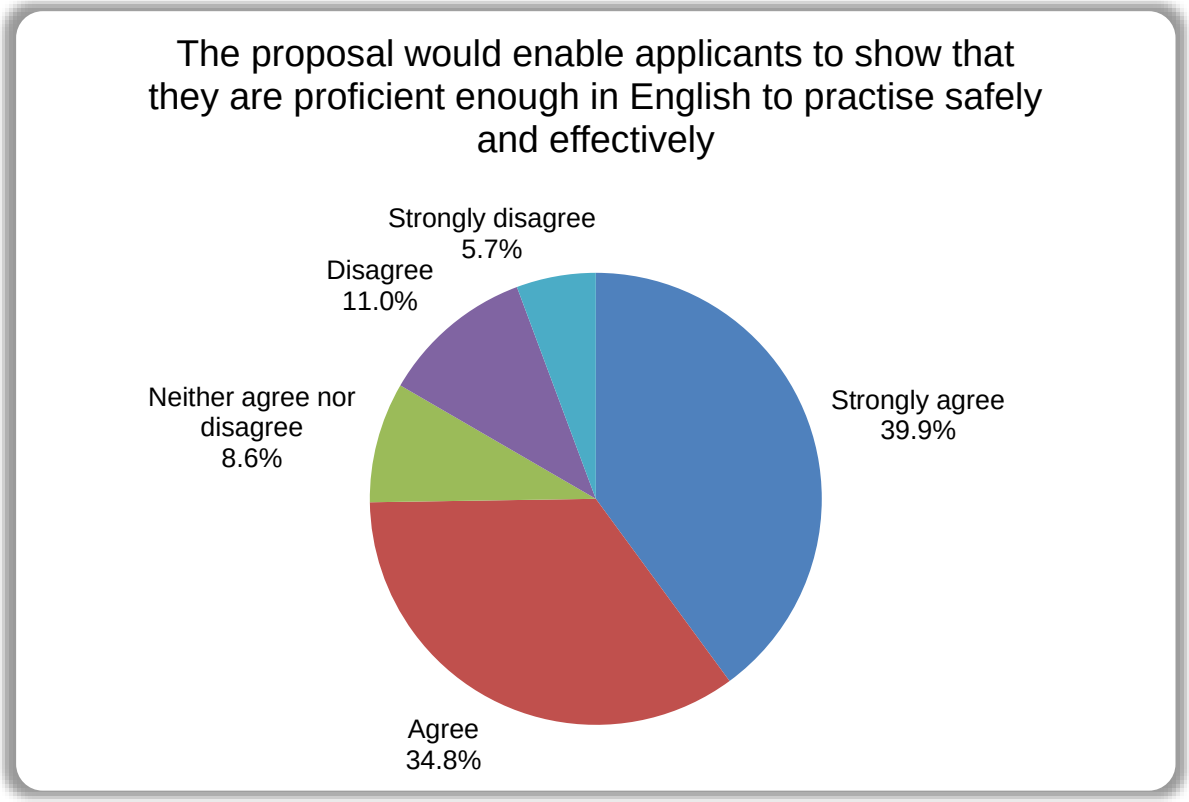
91. In order to then communicate this plainly, we asked respondents to what extent they agreed or disagreed that the proposal would enable international applicants to:

    a) Show that they are proficient enough in English to practise in English safely and effectively

    b) Feel confident in their own proficiency

    c) Easily join the register.

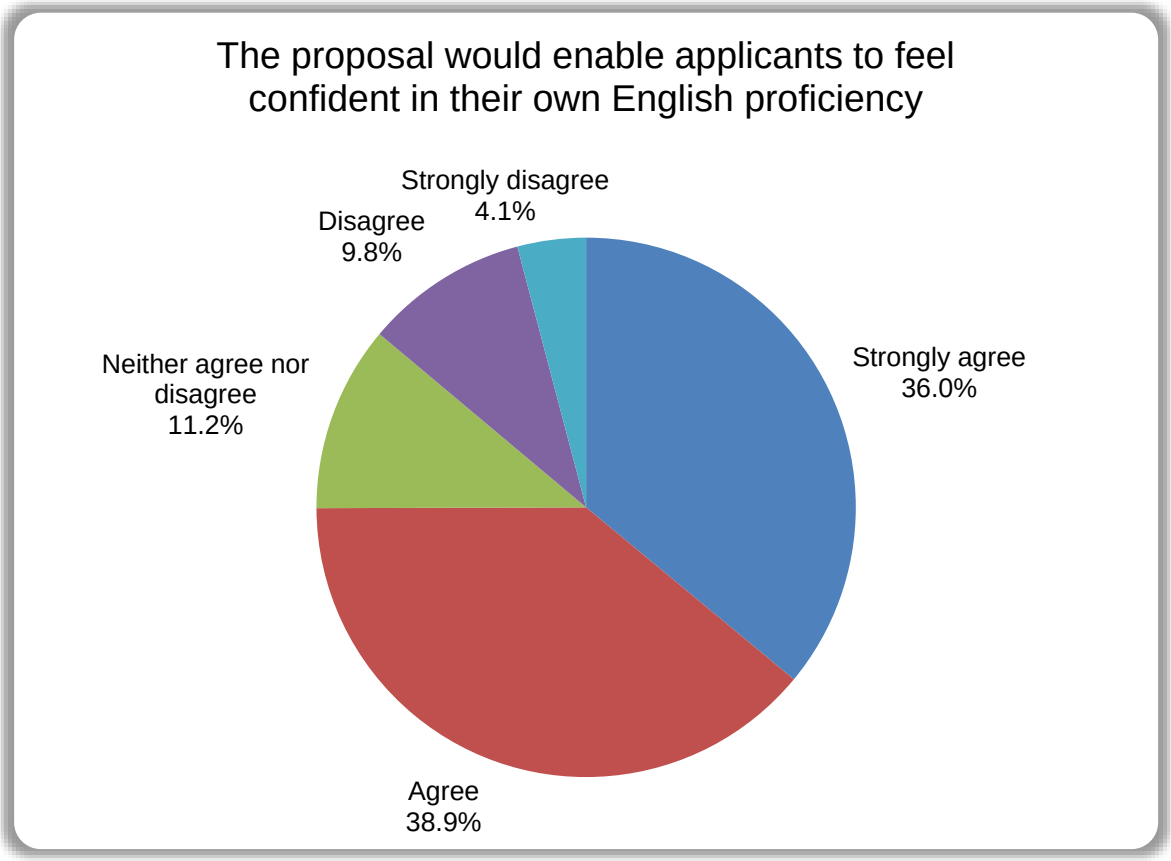
92. These questions did not include options for respondents to give a qualitative response, but a statistical breakdown and interpretation for each statement is provided below.



93. There were 511 responses to this question, with 15 participants deciding to skip.

94. A majority agreed that the proposal would enable applicants to show that they are proficient enough to practise safely and effectively. 382 respondents answered “strongly agree” or “agree” (74.7%). Only 16.7% of respondents disagreed or strongly disagreed with the statement.

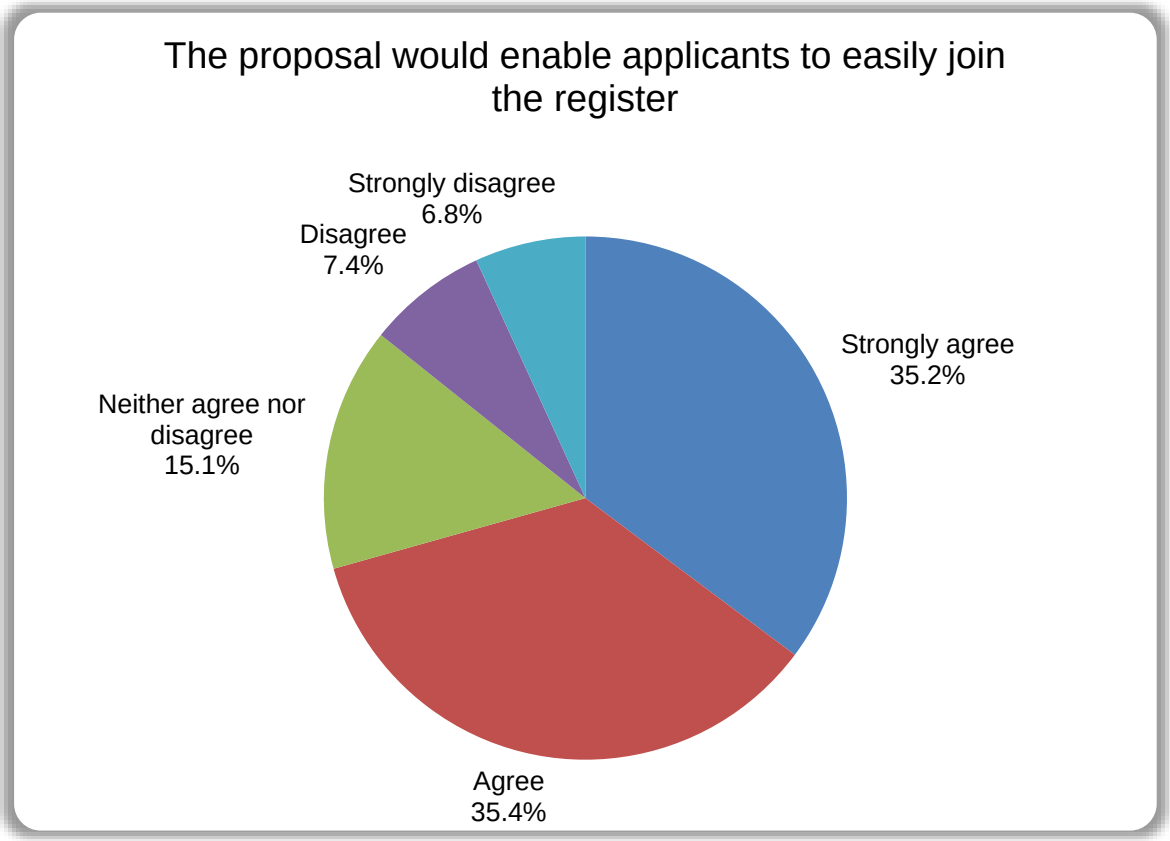
95. This indicates a consensus among respondents that in principle that this would help ensure public protection.



96. 511 participants responded to this question, with 15 choosing to skip.

97. This statement relates less to any immediate decisions arising from the consultation outcome. However, we felt that it would still be useful for us to have an idea of any effect the proposal might have on applicants should it come into effect.

98. Again, the results demonstrate a strongly favourable answer to the statement. 383 participants responded with “strongly agree” or “agree” (74.9%) indicating some level of agreement with the view that the proposals would enable applicants to feel confident in their own proficiency.

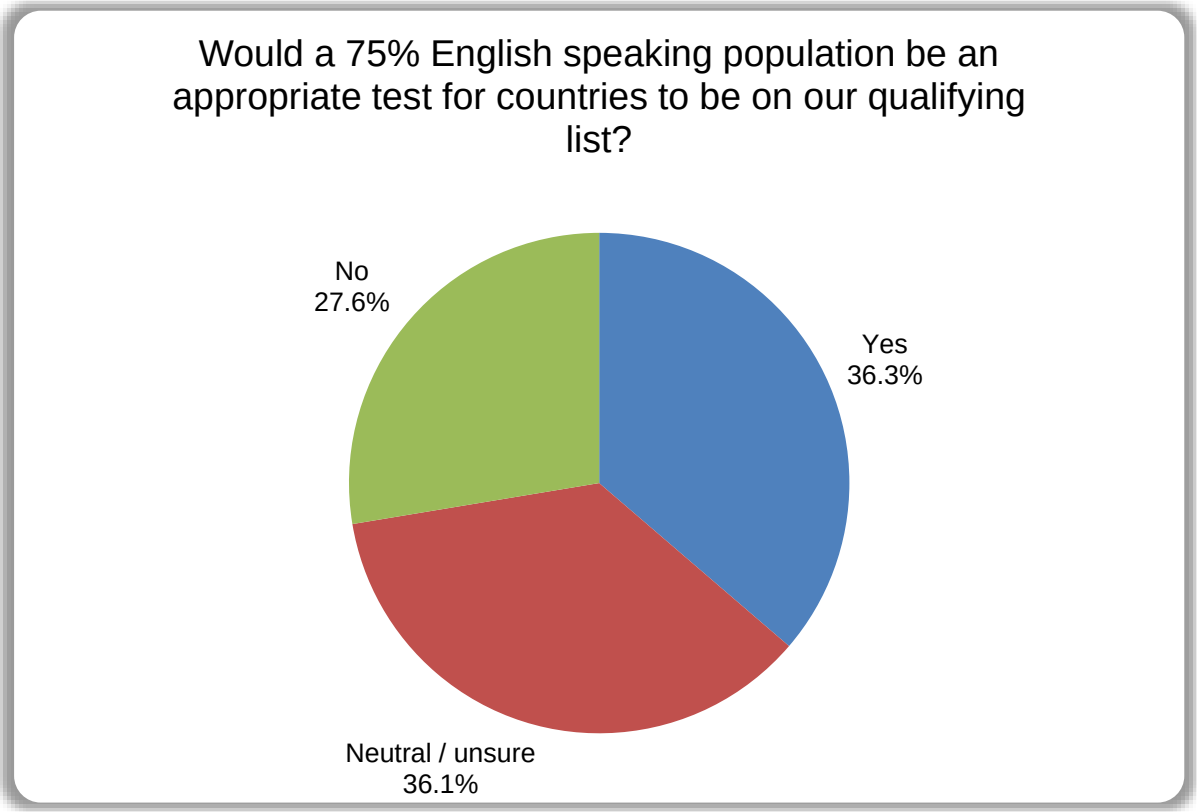


99. 511 participants responded, with 15 choosing to skip.

100. In asking for views on this statement, we wanted to assess the proportionality of the proposal in terms of the impact on applicants. 361 respondents picked one of the agreeing options (70.8%) and therefore felt that the proposal would allow applicants to easily join the register. Notably, more respondents (77, or 15.1%) gave a neutral answer than one which disagreed to some extent with the statement (73, or 13.8%).

101. Taken together with the other questions, this seems to indicate that respondents saw the proposal as workable and useful in terms of allowing entry to the register as well as seeing its value in upholding public protection. Whilst robustness in public protection is our most fundamental policy aim, solutions which are workable and proportionate also fulfil the wider policy goals we aim to satisfy as part of our review.

102. In this part of the consultation, we also asked respondents for their view on our proposed threshold for adding a country to the Qualifying Countries List, namely that 75% of the population are English speaking.



103. 496 participants responded to this question, with 30 choosing to skip. Respondents were asked to explain the reasoning behind their responses or to suggest any preferred alternatives. 228 respondents also left us qualitative feedback in response to the question, and some of the key themes are set out below.

104. The answers generated in response to this question show “no” as the least popular result, with 137 (27.6%) of respondents choosing this option. However, each of the answers received a result that is close to a third of responses. There were 180 “yes” answers (36.3%), but this was very closely followed by 179 “neutral/unsure responses” (36.1%).

105. Whilst this answer shows a slight favour towards supporting the proposals, the answers are close enough to be considered as roughly a third of respondents for each option.

106. We would emphasise that this question directly asks about the threshold for inclusion on the proposed list. When taken with the general support for the ability of the Qualifying Countries List to meet the policy goals above, and an assumption that some kind of threshold would be needed to include a country, a logical conclusion is that respondents are unsure about 75% being where that threshold is set.

107. Some feedback (19 responses) indicated that a threshold is not in principle an adequate way to gauge a given person’s English language proficiency, in some cases making the

complimentary argument that a person could be from a hypothetical 25% of non-English speakers.

108. Some responses made arguments that each individual should be assessed on their individual merits. However, this is expressed via the proposal that we continue to accept English tests (and expand our approved lists), and our proposal for accepting evidence of registrant supervised work experience in the UK or registered work experience in listed countries.

109. Other reasons given for opposing the list suggested the risk of the proposal discriminating against applicants for countries which would not appear on the list if the proposal goes ahead. We accept that applicants gaining professional qualifications in these countries would have fewer options to meet our proposed English language requirements. However, the focus on where qualifications are gained provides a mitigation in itself, as it means that many such applicants would be able to study abroad in a number of countries and still meet our requirements. We have also mitigated against this in our consideration of the proposals as a whole, in particular by also seeking to expand the number of English tests we would approve.

110. We received 7 responses explicitly arguing for a higher threshold to be set (such as 80+), and 12 responses arguing for a lower threshold, typically between 50 and 65%. Higher threshold answers pointed out that risk can be severe even if associated with low numbers of applicants, and can have a high cost in material and financial terms for employers and fellow professionals. Responses suggested a lower threshold pointed out perceived unfairness, and some centred on the concept of ‘majority English speaking’ as meaning more than half of the population.

111. Responses across the categories suggested that some other factors could or should be taken into account, such as the language of a country’s education system, particularly at the level where a primary qualification is taken.

112. Some felt that countries with a lower proportion of regular English speakers might have higher rates of people who speak English as a second language and that this should be taken into consideration. Examples included Israel, Hong Kong, Singapore, South Africa, Canada, and other commonwealth countries.

113. Some responses said that instead of a providing countries list based on assessing statistical risk, we should consider the proficiency and experiences of applicant on an individual basis. Our view is that the only objective and workable way to do this would be to require them to sit an English test, which would be available under our other proposals, and that this is complementary to the logic of a Qualifying Countries List.

114. Several related ideas were suggested, such as requiring applicants to show evidence of clinical placements. We feel that we have given room to a similar approach in the form of registered work experience in listed countries (proposal 3), however we would anticipate

clinical placements overseas to be inconsistent in terms of their length, content, evidence available and general utility in terms of evidencing proficiency.

Organisational responses

115. Stakeholder organisations were more likely to give a neutral/unsure answer than respondents generally. 19 organisations (50%) gave this answer, whilst 10 (26.3%) said yes, and 9 (23.7%) said no.

116. Many organisations said that they did not feel qualified to make a judgement on the matter. Several called for further detail (such as more clarity on how the list would be drawn up and maintained) or made points of detail, for example about how the threshold has similarities and differences with other regulators. Some employers expressed views about the list working on the basis of primary qualifications whereas they would prefer a place of practice.

117. Stakeholder responses in favour of the proposal coalesced around the idea of 75% being a reasonable place to start and forming a balanced assessment around how a list could work. It was seen as practical.

118. Organisations arguing against made some interesting points, for example the fact that excellent professionals can come from anywhere or the potential existence of large non-English speaking minorities in listed countries. Some suggested other mechanisms, such as interviews, or other lists, such as the UK Government list.

119. Whilst stakeholder responses differed from other responses numerically, many of the themes were similar, albeit in more detail.

Our response

120. Having proposed the removal of self-declaration of English as a first language, we were concerned that the proposal if taken alone, would lead to many applicants who could already evidence acceptable levels of English language proficiency having to take English language tests. Some applicants have lived and worked with people and systems in a country where English is overwhelmingly used and understood, and this has been tested academically and/or in clinical settings.

121. In such cases feel that it would be disproportionate to require them to evidence their proficiency via a test which could delay their entry to the register, impose costs in terms of time and resources, and have adverse equality impacts. A Qualifying Countries List is therefore a prudent alternative, to manage risk in a proportionate way.

122. We are pleased to see broad support for the Qualifying Countries List in principle as a way of achieving some of our key policy objectives, as represented by the 74.7% of respondents who signified that they felt that the proposal would enable safe and effective practice, which is the minimum requirement of a robust policy.

123. We also recognise the range of responses to our questions about the threshold for inclusion, and particularly the number of neutral/unsure responses received (at 36.1% of the total). To clarify, the threshold element is based on proportionate systematic risk management rather than providing absolute individual guarantees of proficiency.

124. A requirement for 100% of a given country to be English speaking would not be a viable threshold for inclusion. Census data from 2021 indicates that 91.1% of UK residents speak English as their main language, with 7.1% proficient but not speaking English as a first language. The UK could then be considered to have a proficiency rate of 98.2% on the basis of self-reporting by census respondents. In order to include a country on our list, this example shows that a percentage threshold will need to be set.

125. In deciding an appropriate suggestion for a percentage, we have drawn some influence from the Nursing and Midwifery Council (NMC),which takes a list provided by the UK government and supplements this with a list drawn up based on the 75% threshold.

126. We feel that responses premised on individuals “slipping through the net” (as part of a hypothetical 25%) misread the policy intention behind the proposal, which aims to manage risk at scale in a proportionate manner, rather than make a total and specific assessment of a given applicant’s English language proficiency. We also feel that they fail to take into account the likely effects of English as a culturally dominant language on educational and professional experiences even where a minority does not speak it as a first language.

127. The proposal as stated satisfies our policy goal of increased robustness as it is one of several proposals replacing the current self-declaration system. The proposal is also fairer because it relates to the process of gaining primary qualifications rather than an applicant’s first language, and transparent, because it removes any requirement for *ad hoc* decisions on individual challenges to applicants. We currently carry these out as part of our verification processes for people joining the register when an applicant self-declares English as their first language.

128. English as an academic language or language of instruction should not be considered enough in its own right for an applicant to pass our requirements. This would not depend on an ability to proficiently use English outside of an academic setting, such as in informal environments or conditions that might approximate the demands of professional environments. One qualitative answer illustrated this, citing an example where a person had sat a degree in English but was not proficient enough to practise safely and effectively.

129. Our view is that accepting qualifications taught in English but outside listed countries would increase the risk that professionals were not able to meet the requisite level of proficiency, but we do recognise that the proposal does not provide as many routes for people falling within this group. We have attempted to mitigate this in our proposals by providing more options for applicants, for example by suggesting that a wider range of tests are approved. We are willing to consider further changes to aid applicants of this type if this is supported when the policy is reviewed.

130. We will proceed with the proposal that the applicant has their qualification from a country where 75% (or more) of the population speak English as its first language. We will review this list on a regular and routine basis as our threshold for deciding which countries to include on our initial list. We feel that the consultation responses overall supported this proposal, with neutral “free text” answers falling on both sides of the 75% threshold, or suggesting other ideas, come of which are compatible with the threshold.

131. However, the range of responses to the consultation has shown that objectivity and flexibility will both need to be important principles in how we implement the Qualifying Countries List and the criteria for inclusion.

132. We will seek an independent external agency to collate the initial list and provide an evidence base for each country included. Once an initial list has been adopted and published, we will remain open to making changes and considering additional qualifying criteria once the policy has been reviewed. Considerations could include consideration of lists used by the UK government, official languages, levels of bilingualism, and how languages are used in educational systems, but we would expect a review to identify a well evidenced need for changes of this nature before they could be supported.

133. Our Education and Training Committee (ETC) would be responsible for finalising the Qualifying Countries List as well as maintaining the list following reviews.

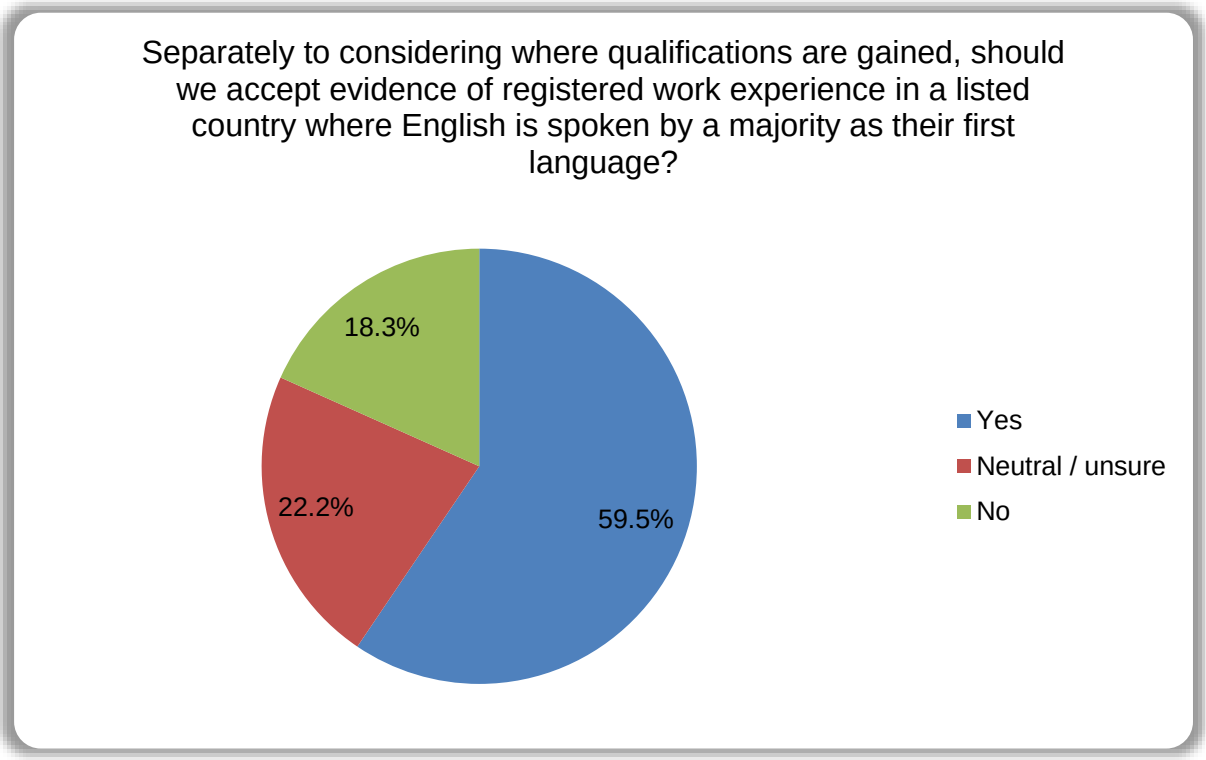
134. The impact of the proposal will be subject to monitoring with a particular view towards understanding how different groups may be impacted by this change, and any impact on workforce supply. We will report to ETC on the impact of the changes a year after the full range of proposals have come into operation.

Proposal 3: acceptance of supervised work experience in the UK or registered work experience in a qualifying country

135. We proposed that applicants be able to demonstrate their proficiency by providing evidence of registered work experience in a qualifying country, or work experience in the UK which had been supervised by a HCPC registrant or another UK registered health or care professional.

136. In the consultation we outlined that we would set minimum criteria for this to be fulfilled, which might include elements such as a minimum time limit of relevant registered employment, and/or the professional role to involve communication with a client group or service users carried out in English.

137. First we asked about registered work experience in a listed country. The following diagram shows a breakdown of opinion on this part of the proposals among those who responded.



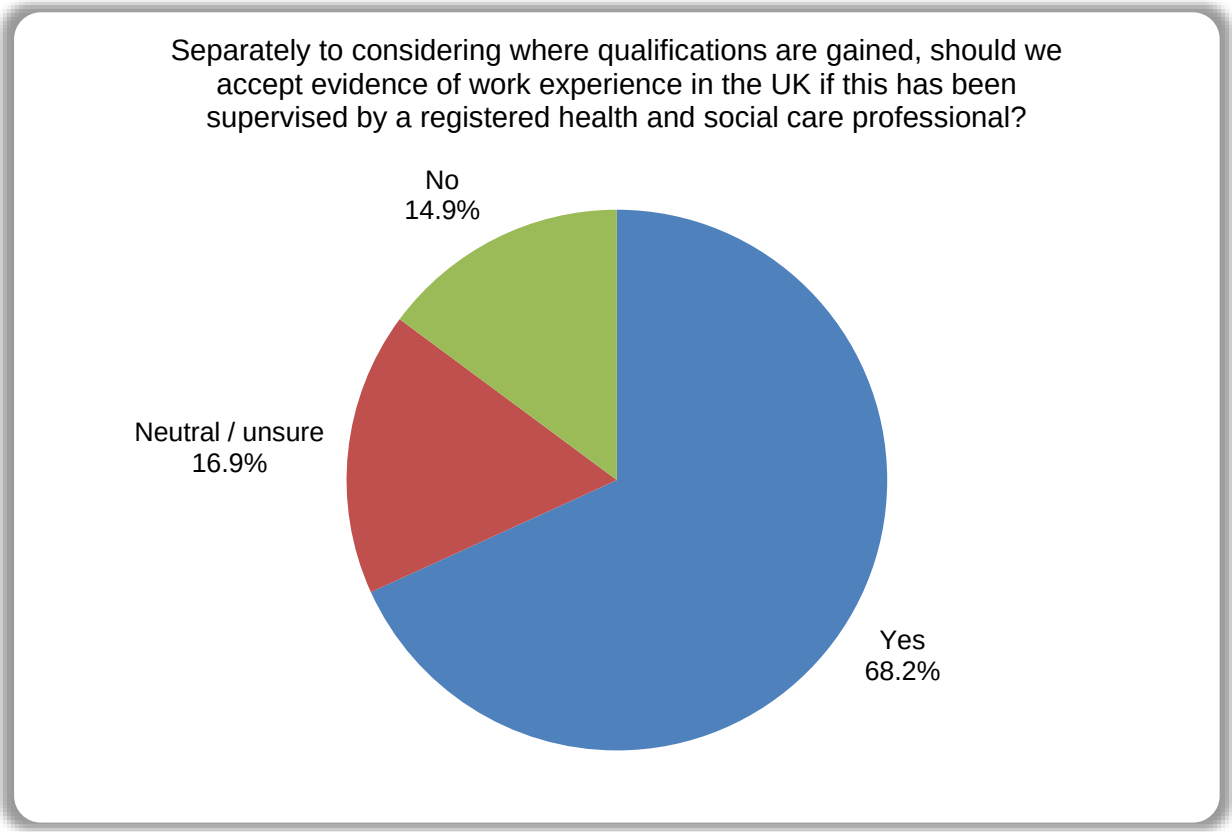
138. 487 participants answered, and 39 skipped the question. There was majority support for this proposal with 290 respondents (59.5%) agreeing, 108 (22.2%) neutral or unsure, and 89 (18.3%) against. We asked people to explain the reasoning for their answers, and 194 respondents left us qualitative feedback.

139. Some supportive respondents felt that the proposal provided a welcome additional route, and that this route in particular provided a good guide to proficiency as it is rooted in a clinical setting. Consistency with other regulators was also highlighted as an important consideration.

140. Across whole range of respondents there were comments calling for or suggesting greater detail, often addressing perceived technical problems with the proposal, or minimum requirements to make it work correctly. This included requests for particular time periods in listed country registered occupations, requirements that the applicant should have worked with patients or undertaken clinical practice, and calls for learning from other regulators and the experiences of employers. Several responses called for greater clarity or detail, for example whether this would have to be in an equivalent role.

141. Objecting responses were varied. Points raised included the idea that this would not actually evidence English language proficiency as a person could have been performing a registered role inadequately, and this could present serious risks about the individual. Some said that working in a country does not necessarily mean that an applicant has become proficient in the English language. Others raised objections similar to some of

those to the countries list, i.e. that a person could have been working in an area which is not English speaking, despite the wider country being majority English speaking.



142. We then went on to ask about work in the UK that has been supervised by a registered professional. 478 participants answered this question, and 48 chose to skip. 326 (68.2%) were in favour of the proposal, 81 (16.9%) were neutral or unsure, and 71 (14.9%) opposed it. 182 respondents also left us qualitative feedback.

143. Positive responses again argued that this was acceptable objective evidence of proficiency, and pointed out that similar schemes exist for other regulators. The additional flexibility offered by the addition of the route was welcome. Some responses favouring the proposal asked that it is made subject to a review period and refined once the option has spent some time in operation.

144. Feedback from the full range of perspectives indicated concern that there needs to be consideration of measures to reduce perverse incentives on the part of those who would sign this evidence off, raising potential vulnerabilities which would require a technical response from us in implementing the proposal.

145. As an example, we would need to make sure that the proposal would be implemented and maintained in a way that would reduce any incentives for discrimination where a reference was sought. We would need to think carefully across professions to make sure that an

appropriate level of seniority and independence is required for a person to fulfil a role as a referee. Some responses argued that a suitable referee would need to show that the person had directly worked with the applicant in order to provide an informed opinion.

146. Some responses pointed out the difficulty referees would face in that the vast majority could not be expected to have an expert understanding of English language proficiency. For this reason it would be difficult for some people to have confidence in their own judgements, and for the same reason, we should adopt caution in our own judgement of references.

147. Measures would also be needed to secure the system from the potential of bribery and corruption in workplaces where an applicant is put into a relationship of reliance on a colleague and perhaps an organisational superior. There would also be a need to avoid the emergence of charging regimes and market-led distortion from unscrupulous overseas recruiters and coaching organisations.

Organisational responses

148. For the element of the proposal around accepting registered work experience in a listed country, 19 (51.4%) organisations answered yes, 11 (29.7%) answered neutral or unsure, and 7 (18.9%) answered no. Organisations who answered “yes” made clear the strength of their support, with some pointing out similarities between the proposal and arrangements at other regulators. However, some employers had misgivings about the proposal as they would prefer testing by default, and one response indicated that this view is widely shared among employer organisations.

149. Some organisations asked us to say more about what type of evidence we would accept, and other queried whether past work in an English speaking country qualifies someone to practise safely and effectively.

150. For the part of the proposal dealing with registrant supervised UK work experience, 17 (47.2%) organisations answered yes, 13 (36.1%) answered neutral/unsure, and 6 (16.7%) answered no. Some organisations called for more detail on training across the language domains, any impacts on Fitness to Practise referrals if a supervising registrant fills in forms incorrectly, duration required, and consideration of power dynamics. Concern was raised about the subjectivity of managers as potential referees, even where motives were good. These are all aspects we would consider in implementation.

151. Some responses pointed out differences between employers in their confidence levels with similar systems, and stressed the need for clear guidance and communication: “Some employers are supportive of this route if the candidates are supervised by a UK registered professional and there is clear accountability and sign off process. Other employers are much less confident, more apprehensive and would prefer a testing by default system. They feel their managers would not be confident in assessing someone's English language abilities.

152. Some supportive responses also flagged concerns despite supporting the proposal, calling for a robust assurance process. Some supportive organisations made suggestions, such a work period of 12-24 months, whilst one response asked how a person would be working in the UK under these circumstances, pointing out that realistically the proposal will affect a small number of people.

Our response

153. There was support for these proposals in the consultation responses, but the qualitative responses we received as free text raised areas which will require further investigation and consideration before we could safely implement the proposal.

154. Responses from employer organisations and individuals suggest that there are gaps in confidence levels and consistency of approach between employers and individual managers in similar systems outside our professions. The proposal would need detailed and comprehensive guidance to be in place before it could be implemented, and to provide a comparable experience between applicants, would potentially require follow up work or training to be provided on a rolling basis. Responses also pointed out that we would need to apply minimum terms for work experience and/or registration.

155. At present, this would be difficult for us to evidence without further research work, and is further impacted by feedback on our EIA, which pointed out that this would be more difficult to evidence for bank and agency staff, and more difficult to achieve for younger applicants.

156. Concerns about inappropriate power relationships and the potential for bribery and corruption are also serious issues which we require further investigation. This may also have adverse effects on our professions and the relationships applicants have in the workplace.

    In addition to the feedback received in the consultation, we have also identified technical challenges independently, for example we foresee considerable technical difficulty in verifying personal references across 15 professions in multiple countries, and the regulators (or equivalents) whose remit or jurisdiction would apply.

157. Even if we developed effective means to carry out this element of the proposal, we also heard from respondents to the consultation that colleagues of applicants are not necessarily well placed to objectively judge an applicant's proficiency in English. Our level of confidence that an applicant would reach our requirements would be lower than if they had objective evidence of (or proxy for) proficiency like a qualification from a listed country or successfully completed an approved test.

158. In order for the concerns raised to be safely and proportionately addressed, we will pause this proposal, pending further research and policy development and a subsequent decisions on whether to continue to pursue it as an option.

159. Given the technical complexity that would be required, any further research or policy development before implementation would follow our review of the other proposals. This would ensure that we also consider whether that there is sufficient need for the proposal alongside the others, using the evidence that will then be available.

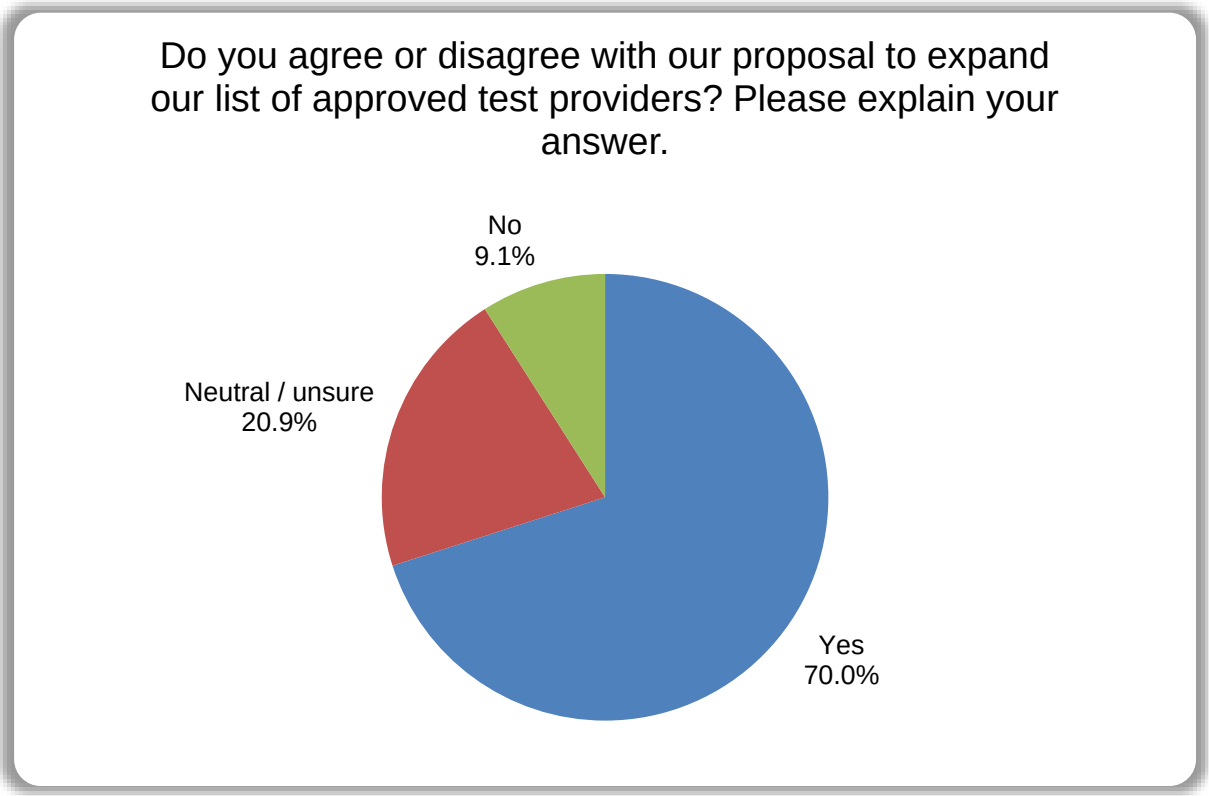
160. We would expect a high overlap of applicant profiles between people who were able to gain a primary qualification in a listed country and people with registered work experience in one, so there is a chance that registered work experience overseas would only be useful to a very limited number of people.

161. Before any implementation could go ahead, operational learning would also be informed by current work being undertaken by colleagues at other regulators where they operate (or have previously operated) similar systems .

162. Further work would consider the detail required in our evidential requirements, internal and external guidance and communications, and measures to prevent discrimination, corruption and undue influence.

Proposal 4: expanded and exhaustive list of approved English tests

163. We asked separate questions about both elements of this proposal: one question (Question 6) asked if respondents agreed with expanding the list of approved tests, which was then followed by a question (Question 7) asking if they would recommend any tests in particular for approval. The next question (Question 8) asked if the list should be exhaustive.



164. 464 participants answered this question (Question 6) and 62 chose to skip. 181 left us qualitative feedback. There was support for the idea of expanding our list of test providers, with 325 responses (70%). 97 (20.9) were neutral or unsure, and 42 (9.1) were against.

165. We also asked respondents to list any particular tests that they would propose for our approval.

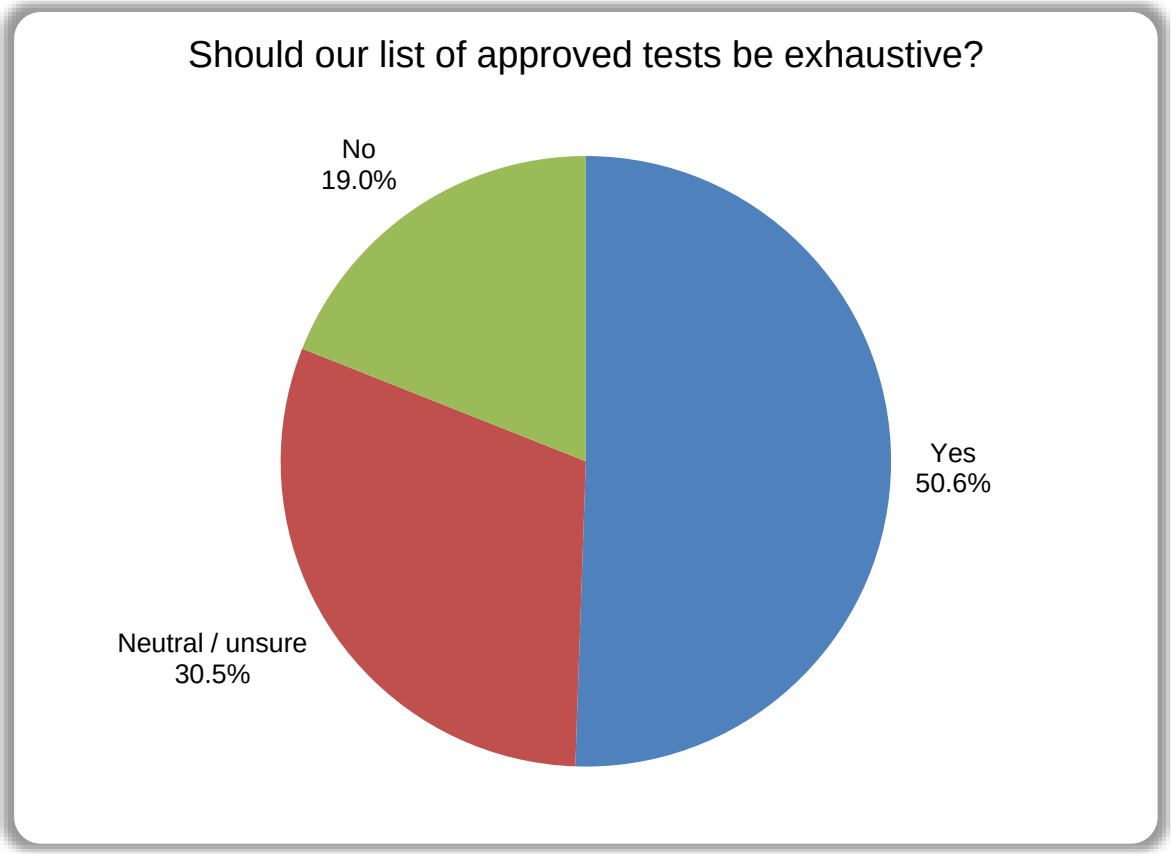
166. Some respondents backing the proposal submitted comments in line with our own rationale set out in the consultation document, for example that this would help reduce barriers and preserve diversity of the health and care workforce, and that the requirement that tests are approved would promote certainty for applicants

167. Comments from respondents to Question 6 sometimes included suggestions that we accept particular tests, which replicated the terms of Question 7 (see below). Some responses gave qualified support but suggested that we limit the number of new tests we approve in order to avoid creating a confusing number of pathways or a system whose outcomes were too difficult to monitor.

168. We received comments from some respondents seeking assurance that newly approved tests would be secure, internationally recognised, that there are clear guidelines and criteria, that they link with elements of clinical practice where possible, that we consider the potential costs of particular tests to applicants, and any additional burden on our registration activity.

169. Some mitigation measures were suggested, for example allowing applicants to combine test scores, and “bridging the gap” with immigration measures set by the Home Office.

170. Tests suggested in answers to Question 7 included OET, Cambridge C1 and C2 and Pearson tests, UK NARIC / ENIC, Ecctis and DuoLingo.



171. 453 participants responded to this question (Question 8), and 73 chose to skip. Qualitative answers were not possible for this question.

172. 229 (50.6%) of responses indicated support for an expanded list of tests being exhaustive, (meaning that we would no longer assess comparability for tests which are not on our list).138 (30.5%) of responses were neutral or unsure, and 86 (19%) were against.

Organisational responses

173. 26 (72.2%) organisations answered yes to expanding the list, and 10 (27.8%) were neutral/unsure. Organisations called for clear criteria for inclusion, monitoring of cost, and asked that tests be secure and fit for purpose.

174. Some organisations called for the required level of attainment to be revised, and several suggested using the tests that their own organisations currently approve. One response

suggested that an extensive list would mean considerable work, and suggested instead that we set a limit of 6 tests and no more.

175. On the question of whether the list should be exhaustive, 18 (52.9%) organisations answered yes, 12 (35.3%) answered as neutral/unsure, and 4 (11.8%) said no. Qualitative answers were not available for this question.

Our response

176. We are pleased to see majority support for a longer and exhaustive list of approved tests and will adopt both proposals.

177. We will maintain our current approved test providers (IELTS and TOEFL) and begin the process of expanding this list. We will develop a list of criteria for tests to be eligible to be on the list. The Education and Training Committee will be the governance mechanism by which test providers are added to the list (and the way this list is maintained).

178. The tests suggested by respondents will all be considered. To assess these requests objectively we will draft a list of criteria that we expect test providers to meet, which will include areas such as security and accessibility. We will also need to provide clear guidance to applicants in advance of the changes, bearing in mind that we will no longer offer to verify comparability with test results that do not match our approved list.

179. The impact of the proposal will be subject to routine monitoring with a particular view towards understanding how different groups may be impacted by this change, and any impact on workforce supply. We will report to the Education and Training Committee on the impact of the changes a year after the full range of proposals have come into operation.

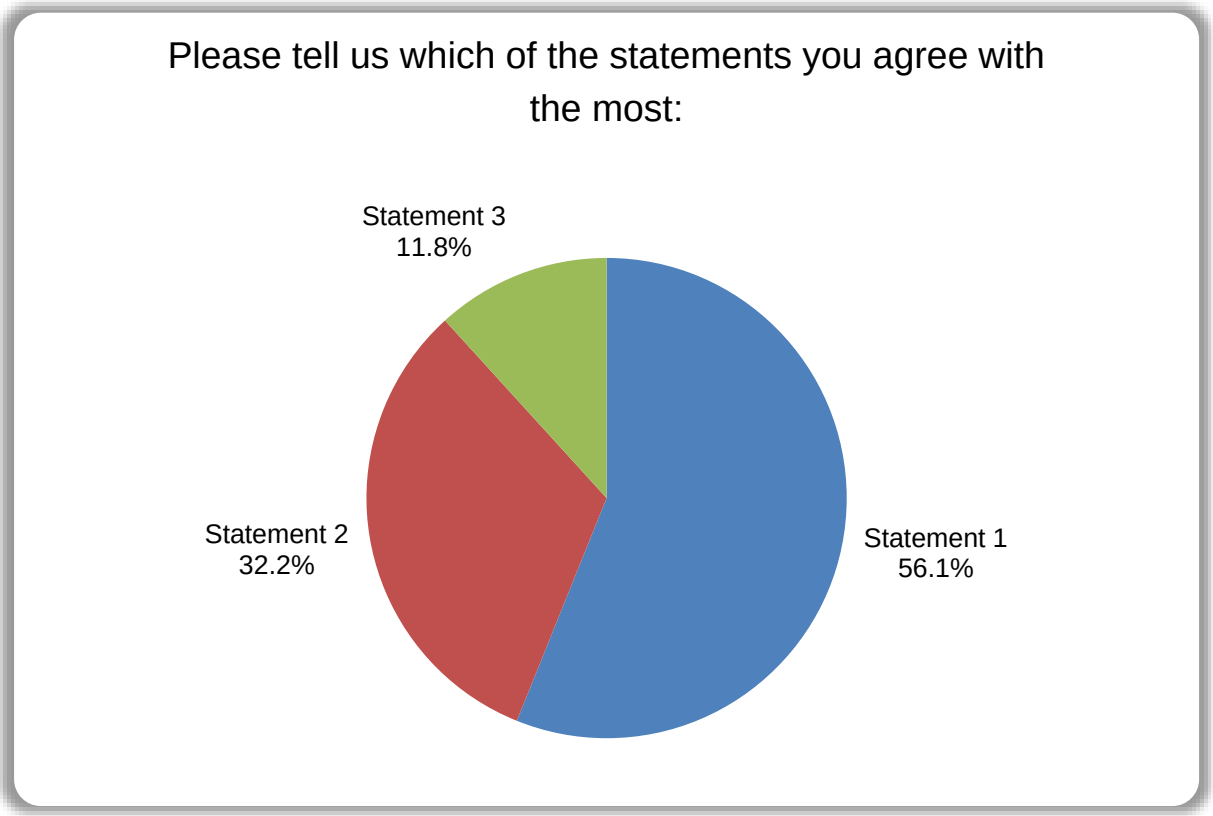
Combined effect of proposals and additional comments

180. We asked respondents a question about the combined effect of our proposals by asking them to identify which of the below statements they most agreed with:

Statement 1) *Overall, these proposals provide greater assurance that applicants' proficiency in English is sufficient for them to practise safely and effectively*

Statement 2) *Overall, these proposals provide the same assurance that applicants' proficiency in English is sufficient for them to practise safely and effectively*

Statement 3) *Overall, these proposals provide less assurance that applicants' proficiency in English is sufficient for them to practise safely and effectively.*



181. 451 participants answered this question, and 75 chose to skip. Qualitative answers were not possible for this question.

182. The statements contextualise the proposals to find out if respondents feel that they represented an improvement in terms of robustness. Statement 1 received support from 253 respondents (56.1%), Statement 2 received support from 145 (32.2%), and statement 3 received support from 53 (11.8%).

183. The consensus was therefore that the proposals as a whole would create a more robust system than that currently in operation, with those who felt that the system would offer less assurance in a small minority at 11.8%.

Organisational responses

184. 18 (62.1%) organisations agreed with statement 1, 6 (20.7%) with statement 2, and 5 (17.2) with statement 3.

Our response

185. We welcome the recognition that the proposals will give greater assurance of safe and effective practice.

Feedback from service users

186. During our consultation we expected a high proportion of responses to come from applicants, registrants and from stakeholder organisations who represent these groups and employers. It was important that this valuable input was balanced and complemented with feedback from people who use health and care services and provide care for those who need them.

187. As a result, we decided to commission some targeted work in order to receive feedback from this group, and approached The Patients Association to carry out focus group activity on our behalf.

188. The Patients Association recruited 10 people to take part, and acted to make sure that this group was broadly representative of service users. More information on the recruitment profile is available in the full report (see annexe B. As the sessions took place in London, there was a bias towards London-based participants, but otherwise we felt that the profile of those taking part was suitably diverse to ensure a range of perspectives were heard.

189. The group discussed a more general set of questions than the formal consultation questions, given that these required some presumed knowledge. Participant comments fell within a number of key themes:

The importance of reviewing the policy

190. Participants felt that it was important to review our current approach for a number of reasons, such as clarity of communication, preserving the safety of both patients and professionals, and the context provided by a rising number of professionals recruited from overseas alongside shortages in professionals from the UK.

191. Participants felt that English proficiency was particularly important given the role of professionals in translating jargon and technical language into plain English and informal conversation.

The impact of English language proficiency on patient experience and patient safety

192. Some participants had experienced problems in their use of services which related directly to a lack of English proficiency from some professionals. For some participants, this was enough for them to discontinue their treatment with the professionals involved.

193. Participants recounted their difficulties in understanding professionals, and the impact this sometimes had, including the need to see someone else because communication was too poor to continue.

The importance of effective communication in patient partnership and shared decision-making

194. Participants felt that effective communication was a key element in their understanding and involvement in decision making. This is a particular challenge because a professional needs to be able to explain clear implications around technical or complicated challenges in health and care.

195. Some participants raised the challenges posed when an interpreter might be needed for patients who don't have a strong command of English, and how this can be further complicated if a professional does not have good English language proficiency.

Views on the proposed changes

196. Participants generally felt that the proposed changes were a good idea to help effective communication between patients and carers and health and care professionals, and the safety of all parties.

197. Participants raised examples of how this could positively impact patient experience, including patients feeling more comfortable and confident communicating with their health and care professionals.

198. However, participants stressed the importance of the Equality Impact Assessment to ensure international health and care professionals were not put at a disadvantage by the proposed changes. They also emphasised the importance of ongoing monitoring, reviews and updates of the policy in response to its impact in real-world context.

Potential risks and benefits to health and care professionals from the proposed changes

199. Here participants argued that professionals should not face disadvantages when registering from overseas. A range of suggestions were made around potential support that could be provided, including online tests to reduce travel disadvantage in home countries, removing factors around cost and accessibility, providing support for those with childcare responsibilities, and making sure that people who fail English tests receive prompt and effective feedback.

200. Single parents, people with a disability and people on a low income were identified as applicants that could potentially face disadvantages by having to take a test if they could no longer self-declare and weren't from a majority English speaking country.

Potential risks and benefits to patients and carers from the proposed changes

201. The participants flagged several groups who might potentially be disadvantaged by the changes. These included deaf people, travellers, and patients with a poor level of English language proficiency. Risks were raised about increasing communication difficulties in telehealth and online appointments.

202. Participants raised their difficulty in obtaining appointments in some parts of the UK and stressed the need to minimise any impact on workforce supply and diversity; there is a need to maintain staffing levels and the level of international recruitment.

Ongoing opportunities for the HCPC to partner with patients and carers regarding changes to their policies

203. It was felt that clear timelines and mechanisms were needed for feedback and review of the proposals, and ongoing collaboration with patients. Specific suggestions were made, including:

203.1. Patient and carer representatives on policy review panels

203.2. Surveys (online and paper)

203.3. Focus groups facilitated by independent organisations e.g. The Patients Association, Healthwatch

203.4. Feedback systems to report good/bad experiences (ongoing, not just at the time of policy reviews).

204. Participants agreed that engagement opportunities needed to be communicated clearly to patients and carers to ensure participation. They suggested:

204.1. Promotion of opportunities

204.2. Direct engagement with minority groups and groups at risk of health inequalities

204.3. Engagement with patient partnership groups, Patient, Advice and Liaison service, and primary care networks.

205. It was suggested that the HCPC should build in early baselines for aspects that it might be interested in evaluating, for example patient experience, applicant pipeline and diversity.

206. The work provides feedback that we have added to our EIA (see annexe B), but many of the wider ranging points about needing to limit adverse impacts to applicants who fall outside of the Qualifying Countries List is something that we have previously anticipated and tried to mitigate when initially drafting the proposals.

207. The report also included useful suggestions for mechanisms we can use to monitor the proposals, feed back, and use to refine the resultant system once in force. We acknowledge these recommendations and further detail will be added in our implementation planning work.

Our response

208. We welcome the role played by the focus group participants in shaping our policy and implementation, and would like to thank them and our partners at The Patients Association for their participation and support.

209. The work carried out indicated the importance of being able to use English language proficiency to translate complex clinical topics into “plain English” explanations for patients and service users. We will use this insight to inform our criteria for approving English language tests.

210. We recognise the importance attached to the proposed changes by participants. We also note the challenge raised regarding potential impacts on workforce supply and diversity. Our most central policy objective is to protect the public by ensuring safe and effective practice. Within this context we are willing to recognise the importance of minimising barriers and adverse impacts, and our own legal duty to make decisions which are reasonable and proportionate.

211. We agree that we should consider the equality impacts of our decisions on service users as well as registrants and applicants. Making sure that all service users can rely on health and care professionals who are capable of practising safely and effectively is our key priority, and we acknowledge that this makes English proficiency of even greater concern for some groups of people with shared protected characteristics.

212. Participants stressed the importance of maintaining workforce supply and diversity. The impact of the proposals we implement will be subject to routine monitoring by with a particular view towards understanding how different groups may be impacted by this change, and any impact on workforce supply.

213. We will monitor the insights provided by applicants as they join the register for any emerging impacts, and will also report to the Education and Training Committee (ETC) on the impact of the changes a year after the full range of proposals have come into operation. Feedback in the focus group suggested some key areas a report might focus on, and we will consider this in our planning.

214. When the changes come into effect, we will inform the organisations and stakeholder groups proposed in the focus groups, and they will be contacted again for any feedback on the changes when we report to ETC. Between these two project milestones, we will also seek feedback from applicants about their experiences. This feedback will also be used to inform our report to ETC.

Equality, diversity and inclusion

215. We published a draft Equality Impact Analysis (EIA) as part of the consultation exercise, along with the main consultation document and the online survey.

216. The document identified impacts on groups of people who shared several protected characteristics, some of which were adverse and some of which were beneficial.

217. The document identified cross-cutting impacts for people who would no longer be able to declare English as their first language and use this to evidence their English language proficiency as a result of our first proposal.

218. This would mean more individuals sitting tests, where they would be adversely impacted by the extra costs this would impose in terms of finance, time and difficulty. People with some nationalities (nationality is considered to fall under the heading of 'race' in the Equality Act 2010) would make up the bulk of the affected group, if their country does not appear on the Qualifying Countries List we suggested as our second proposal.

219. Some groups within this would be further impacted where their protected characteristic made it more difficult to access the necessary resources (for example pregnancy and maternity), or where routes such as sitting a test might present barriers in its own right (such as in the case of certain disabilities and health conditions, or people undergoing a gender transition).

220. Particular obstacles were also identified for discrete groups such as refugees, who make up around 50 applicants a year. Refugees might have difficulty with other proposed routes to evidencing proficiency, for example obtaining evidence of registered work in a qualifying country.

221. There were likely to be positive impacts for people who spoke English fluently but not as a first language, as this would now be treated on an equal basis. People from some black and minority ethnic backgrounds would be expected to benefit from inclusion on the Qualifying Countries List, and all applicants should benefit from having a system where the evidence required is transparent and objective rather than requiring detailed verification or evidential challenge.

222. We committed to updating the EIA by considering feedback from the consultation, and asked respondents to outline any impacts or mitigations that had not already been considered in the draft document. There were 112 responses to this question, with 414 respondents choosing to skip.

223. This resulted in some minor changes to the EIA which have now been incorporated into an updated version. These include the following feedback:

    223.1. Responses which pointed out that older people are less likely to achieve required test scores, and younger people are less likely to have built up the requisite registered work experience or evidence sources required for our proposals regarding registered work in listed countries, or registrant supervised work in the UK

    223.2. The impact of physical disability on accessing testing centres

223.3. The need for the HCPC to take care in approving test providers to make sure that people with certain disabilities and health conditions are adequately supported and receive the required adaptations

223.4. Extra cost for people who have undergone gender transition where they need to provide proof of identity documents

223.5. The potential impact of overrepresentation of people from black and minority ethnic backgrounds among bank and agency workers, who may have greater difficulty evidencing continuous employment under our proposal to accept supervised UK work experience.

223.6. Obstacles in accessing documents similar to those faced by refugees, but for overlapping reasons where a person has been subject to persecution or discrimination for a protected characteristic such as their religion or sexuality.

224. Responses to the EIA question did not suggest new mitigations. Our view is that there are several reasons for this.

225. Many mitigations had already been explored in the original draft of the EIA, and the set of proposals when taken together have been designed to mitigate adverse impacts from withdrawing self-declaration. The full detail of how proposals would work requires operational work and specific responses that it would not be appropriate or practical to consult on. However, we are committed to consider the EIA conclusions in full as we design operational details of the proposals, and any systems and guidance that they will need to rely upon.

226. We are also conscious that monitoring and feedback will be key to reducing any adverse impact on any particular groups, or on our equality duties. A monitoring paper with recommendations will be submitted to ETC a year after the full set of proposals have come into operation.

Our response

227. We welcome the feedback on this question, which has allowed us to expand our draft EIA. We feel that any adverse impacts identified thus far are reasonable and proportionate to the need to ensure public protection. We are keen to mitigate adverse impacts as far as possible, and this has played a role in the thinking behind the initial proposals.

228. We also recognise that there are some areas of positive impact. Greater assurance of English language proficiency will help ensure that all members of the public can receive safe and effective care regardless of their background. Applicants will be given clear and objective requirements to meet, and will be sure that these apply on an equal basis. Applicants who speak English well but as a second language will no longer be prioritised behind native speakers.

6. Summary of decisions

229. We will move ahead with the proposals we consulted on as outlined below, providing additional guidance on factors to further consider arising from the consultation responses.

230. It is proposed that the Education and Training Committee (ETC) will provide the governance route for the creation and drafting of the Qualifying Countries List and the expanded list of English test providers. We will also report to ETC on our progress in implementing the proposals, as well as feedback and reporting. ETC should give particular consideration to the Equalities Impact Assessment (EIA), and to ensuring stakeholder and service user engagement in securing feedback.

Proposal 1: self-declaration

231. In line with the consultation results and our policy objectives, we will stop accepting self-declaration of English as a first language as acceptable evidence of English language proficiency. We will aim to carry out this change by the end of the 2024 calendar year, subject to implementation planning and the actions identified in our EIA.

Proposal 2: qualifying countries

232. In line with the consultation responses and our policy objectives, we will introduce a Qualifying Countries List.

233. Applicants who passed their primary qualifications in one of the listed countries will be able to use this as evidence of their English language proficiency. The list will initially be drawn up on the basis of 75% of residents within a country using English as their first language in order for it to be listed. This will be independently assessed on the basis of expert analysis and input. Approval and maintenance of the list will be decided upon by ETC.

234. We will aim to carry out this change by the end of the 2024 calendar year, subject to implementation planning and the actions identified in our EIA.

Proposal 3: previous registered work in a listed country, registrant supervised experience within the UK

235. We propose that this proposal is paused for more detailed investigation to take place, with a view to a later decision on whether to proceed, and if so, when and how.

236. We note the positive consultation responses regarding this proposal, but also that a range of technical requirements have been made clear to us via qualitative responses and our own internal scoping work. We will aim to decide on whether to proceed and on what basis following further investigation and development, and our assessment of ongoing need for the proposal once the others have been reviewed. ETC will be updated as our work in this area develops.

Proposal 4: extended and exhaustive list of English language tests

237. In line with the consultation responses and our policy objectives, we will introduce an expanded list of approved English test providers. The required levels of attainment will not change, so newly approved tests will need to demonstrate comparability of results.

238. ETC will be responsible for setting a list of wider criteria for inclusion on the list, and the considerations will include security and prevention of fraud, equality, access and support, appropriateness of content, and any other criteria ETC agrees.

239. We will aim to carry out this change by the end of 2024, subject to implementation planning and the actions identified in our EIA.

7. Implementation, communications and engagement

Implementation

240. Applicants and relevant stakeholders should continue to be informed and engaged as the proposals continue to develop at an operational level. Changes should be announced in good time in order to allow applicants, professional bodies, employers and educational institutions to prepare for the implications.

241. We will complete technical scoping for the proposals following this consultation to establish a detailed timeline for implementation. Adopted proposals will not enter operation earlier than the winter of 2024. The implementation process will include time for applicants and other stakeholders to adequately prepare and ensure a smooth transition to the new arrangements.

Communications and engagement

242. We plan to adopt a phased approach towards communication and engagement planning as we move towards greater detail on technical requirements and timeframes. We will finalise a communications and engagement plan to run alongside the implementation of the proposals. We will use a range of channels and messaging to reach our key audiences.

243. The core aims will be to inform to aid preparation, and to influence applicants to manage the risk of peaks and troughs in application numbers. We will seek to engage our audience of stakeholder organisations through existing channels. This audience will primarily draw upon employers, professional bodies and trade unions, educational institutions and English language test providers.

244. Our other main audience will be potential applicants. For this audience, in addition to our usual public channels, we will also carry out mapping of social media and potential sources of influence, to educate applicants about their options in a consistent and transparent way, and to avoid the potential for misinformation to gain traction.

245. We will also carry out further work to understand the views of those who gave a neutral response to our final question about the overall effect of the proposals compared to the current system, and how we can use the insights this provides to make sure that our information is clear and effective.

246. In addition to these main audiences, we will consider our internal communications needs to make sure HCPC colleagues are adequately informed and up to date with how implementation is progressing.

Monitoring, feedback and adaptions

247. The International Registration and Policy and Standards teams will monitor the impact of the changes, providing informal feedback where appropriate. A year after the changes have all come into effect, we will review how the new policy is working and report on that to the ETC, with a particular focus on registration numbers and diversity and any other EDI impacts, especially where these have been identified in the EIA. The report should be accessible to the public, and should involve service users and organisational stakeholders in reaching its conclusions.

8. Annexes

Annexe B: Equality Impact Assessment (EIA)
Annexe C: The Patients Association report
Annexe D: Consultation document

Annex B: Draft Equality Impact Assessment (Level 2)

Section 1: Project overview

Project title: English language proficiency review	
Name of assessor: Madeleine Connor	**Version: V2**

What are the intended outcomes of this work?

This work is intended to strengthen our approach to ensuring international applicants are able to speak English proficiently, supporting our statutory objective of public protection and maintaining public confidence in the ability of those professionals on our register to practise safely and effectively.

We anticipate the proposals will improve our processes for evidencing the English language proficiency of international applicants and ensure our processes continue to be robust, consistent and proportionate. They will also align us (where appropriate) with the approach taken by other professional regulators, including the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC).

Background

The ability to communicate in English is a key requirement to providing safe and effective practice for professionals working with service users in the UK. Our English language requirements set out how applicants applying via the international route can demonstrate their ability to meet this requirement.

Our current process allows applicants to make a self-declaration that English is their first language and the language they use predominantly on a day-to-day basis. We also accept test scores from recognised English language test providers such as IELTS and TOEFL, as well as other tests that are comparable and in line with our Standards of proficiency.

Other regulators in health and social care have recently updated their English language proficiency requirements. The GMC made a minor update to its policy in 2021 to allow applicants to sit an online test before taking its Professional and Linguistic Assessments Board (PLAB1) test. The NMC has made comprehensive changes to its requirements to offer mitigations to applicants who narrowly miss the required test results, and allow 'Supporting Information From Employers' (SIFE) as a form of evidence.

Whilst the General Dental Council (GDC) does allow evidenced self-declaration from those whose qualifications come from the European Economic Area (EEA), our research into the policies or guidance of other regulators shows that HCPC's requirements are unique in allowing self-declaration of English proficiency on the basis of it being a first language, and also unique in respect of allowing an option for self-declaration to all international applicants.

Proposals

We propose removing the option for applicants to self-declare that English is their first language and replace it with a list of countries (maintained by HCPC) where English is used as

a main language. Applicants who have earned their primary qualification in a country on this list will be able to use this as evidence of their proficiency in English.

One of the ways in which we would seek to mitigate negative impacts from the removal of self-declaration would be through allowing applicants who have previously been registered as a health or care professional in a listed country, and so will have already had to demonstrate their proficiency in English, to use this as evidence for HCPC registration. We are also proposing to accept evidence of work in an unregulated role in the UK, where this has been supervised by a UK registered healthcare professional.

Further to this, applicants who have studied in countries that are not included on the list will be able to submit a test score from a published list of examination bodies that HCPC would maintain. Our test score requirements would remain the same[1].

We will not be changing our requirements for the level of English that an applicant must have but will look to change the ways this can be evidenced.

We have sought wide stakeholder input into the development of these proposals and held a public consultation to gather further views.

Consideration of key impacts

We are aware of the potential impact of our changes. We will need to assess the relative accessibility of English language tests, make sure that they take account of differences in learning and cultural context, and avoid creating disproportionate impacts based upon an applicant's nationality.

A key consideration underpinning implementation of the proposals will be ensuring that we work to reduce the negative impacts for those applicants with one or more protected characteristics. This will include ensuring that the requirements are proportionate, sufficient to ensure registrants can deliver safe and effective practice, and that any additional requirements placed on international applicants are in line with our powers and obligations and managed appropriately. The following sections have more information on this work.

Who will be affected?

Should our proposals be approved, once any changes to the English language proficiency process are implemented:

- International applicants will be required to evidence their proficiency in English by passing an approved test, showing a primary qualification gained in a qualifying (majority English speaking) country, or by showing appropriate registered work experience from a qualifying country or supervised work experience in the UK (if and when this proposal is implemented). Those who would previously have self-declared will now need to use one of these routes to evidence their proficiency.
- HCPC employees and partners will need to be aware of the changes in order to follow the process consistently and ensure international applicants are meeting the threshold to gain entry onto the register.
- Employers: a small number of employers have raised concerns about some international registrants' ability to speak English to the required level. The proposed changes would provide additional assurance to employers that overseas applicants have met the minimum standards for registration in working safely and effectively in English.

[1] For all professions except Speech and Language Therapists, at or equal to IELTS level 7.0 with no element below 6.5. For Speech and language therapists at or equivalent to IELTS level 8.0 with no element below 7.5.

- HCPC registrants or registrants from other statutory regulators in the health and care sector may be asked to sign off on applicants' relevant UK work experience (pending further investigation and development of this proposal, and on the condition that we take a decision to implement it).
- Service users and patients receiving services from our registrants will have greater confidence in HCPC registrants' ability to communicate in English, and to practise safely and effectively.

Section 2: Evidence and Engagement

Lack of data should not prevent a thorough EIA. Be proactive in seeking the information you need.

What evidence have you considered towards this impact assessment?

- We have reviewed Equality, Diversity and Inclusion (EDI) data provided by our registration team and have compared the protected characteristics of registrants across the register as a whole with a subset of international applicants who were registered as of February 2023.
- We have conducted desk-based research into the approach taken by other regulators.
- We have looked at data from the NMC's review of their English language policy.
- We have obtained example qualifying country lists from GMC, NMC and the Home Office.
- We have carried out pre-consultation engagement activities with a range of stakeholders, outlined in more detail in the next section.
- We have requested further information from test providers (IELTS and OET)which will be used to inform our pre-implementation work, subject to Council approval.

How have you engaged stakeholders in gathering or analysing this evidence?

Preparatory work

- We held a workshop at the EDI forum on 22 February 2023 to explain to a group of external stakeholders about the changes to the English proficiency process and invite them to share their thoughts on any EDI impacts.
- We held information sessions on the changes to the process (on 19 and 20 April 2023) for contacts from professional bodies, education providers and employers. The changes to the process were explained and initial informal feedback sought to shape our proposals
- We directly sought feedback from professional bodies, education providers and employers in our pre-consultation survey, and a summary has been included in our consultation outcome document.
- We presented on the proposals at our Professional Bodies Quarterly Meeting in June 2023
- We discussed proposals with our Education and Training Committee on 2 August 2023 and sought their feedback.
- We established an internal advisory group, comprising operational and communication colleagues, to gather feedback from them and through them their external contacts.
- We carried out a public consultation on our proposals for the changes to our requirements, and asked respondents to reflect on their impact. Responses were considered and used to further consider the proposals and their implementation.

- During the consultation period, we also commissioned focus group research targeted at service users and carers. A summary of the report from this work is included in our consultation outcomes document, and a full copy will be published alongside it.

Planned work

- We will continue to seek feedback from external stakeholders including professional bodies, overseas applicants, and employers, through our standing meetings and on an ad-hoc basis where necessary.
- Our Policy and Standards and International Registration teams will develop the necessary materials for implementing the proposed changes to our requirements. These will include requirements for qualifying countries and approved test providers, resulting lists of each, as well as new forms and guidance, and changes to our IT architecture. The findings of the EIA will be considered in all parts of this process.
- Our International Registration team will monitor the statistical impacts of any adopted changes and report on these to the Education and Training Committee for consideration of any further action.
- Once the full set of proposals have been in force for one year, we will report to the Education and Training Committee on the impacts of the new requirements and any further strategic or policy changes required.

Section 3: Analysis by equality group

Age (includes children, young people and older people)

The following table provides a breakdown of the age cohorts for our international applicants and registrants.

Age group	Percentage of Int applicants	Percentage of the register
20-29	23.8%	19.15%
30-39	40.5%	30.1%
40-49	26.5%	24.46%
50-59	8.11%	18.91%
60-69	1.8%	7.17%
70+	0.18%	0. 89%

The largest age cohort applying via the international registration route is currently the 30-39 age band. However, this age band makes up a smaller part of the total register, which is more skewed towards older age groups.

Professionals at the start of their careers (most likely to be in the 20-29 age group and the third largest age group in terms of international applicants) and students are more likely to be on a low wage, no wage at all, or in receipt of a student loan. We believe they would be more likely to be negatively impacted by our proposals, which may result in more applicants being required to take a standardised test. Additionally, some applicants may need to repeat a test to achieve scores at sufficient level, increasing their costs.

Evidence suggests that older people, including applicants at the higher end of the age brackets, may be less likely to be able to pass a standardised test.[2] Removing self-declaration and expecting more applicants to submit test scores may negatively impact older applicants.

A few consultation responses noted that whilst older people may statistically be less likely to be able to pass a test, younger applicants may have a disadvantage in that they may not have had as much of a chance to carry out the relevant work experience. They also may be less likely to be able to afford lessons in order to improve their English to take a test.

Mitigations

For both reasons we have sought to minimise the number of people who would now have to sit a test, by proposing a list of qualifying countries.

Our consultation asked respondents to make recommendations to mitigate these concerns and identify any other age-related impacts.

Disability (includes physical and mental health conditions. Remember 'invisible disabilities')

Below we have laid out some statistics about international applicants declaring themselves to have a disability, and how their numbers compare the register as a whole.

Disability status	Percentage of international applicants	Percentage of the register
International applicants who have declared themselves to have a disability	1.23%	5.41%
International applicants who have not declared a disability	96.55%	91.56%
International applicants who preferred not to say	1.42%	2.88%
No information	0.8%	0.14%

Based on the above data, international applicants appear to be less likely than people on the register generally to declare having a disability. This could be due to their age profile, as international applicants are generally younger and so less like to have developed an age-related health condition.

There may also be cultural issues for some international registrants that mitigate against making such declarations. Likewise, it is possible that there are factors which restrict disabled people entering professions in some other countries. International applicants may also be less familiar with the definitions of disability or health conditions used in the UK and so less likely to regard themselves as meeting the definition. Lastly, though EDI data from applications is kept separately from assessors and is subject to strict data governance policies, they may nevertheless be unwilling to trust a regulator with this information because they fearing that it may disadvantage their application to join the register.

Consultation responses considered the impact of the changes on applicants with this protected characteristic. It was suggested that those with a physical disability may find getting to a test centre difficult and may therefore be impacted by the changes.

Responses also emphasised the importance of HCPC in compiling their list of test providers, and that HCPC would need to ensure that test providers chosen have sufficient support in

[2] Assessment of Age-related Changes in Cognitive Functions Using EmoCogMeter, a Novel Tablet-computer Based Approach - PMC (nih.gov)

place for those with neurodivergent and mental health conditions within their testing programmes. Those applicants who have stammers or communication aids may also be disadvantaged by speech assessments.

Mitigations

One challenge identified in developing our proposals is that we need to ensure that applicants with disabilities are not disproportionately disadvantaged.

We will need to make sure that any English language tests delivered by test providers on our maintained list are accessible and that any specific support arrangements are not prohibitively priced or do not create further obstacles for applicants with disabilities.

We have researched reasonable adjustments offered by one of the most popular tests that we currently accept, IELTS.

- To ensure that applicants' English language proficiency is fairly assessed IELTS provide a range of options including: braille papers, lip reading versions of the listening tests, and special arrangements for those with dyslexia, some medical conditions and specific learning disabilities.[3] Candidates can request these special arrangements up to six weeks' prior to taking their test.

- They also offer an online version of the test, 'IELTS Online'[4], allowing candidates a choice between doing it in person or online. While the option of an online test is realistically only suitable for candidates with suitable IT equipment and stable internet, it does offer support for those unable to travel to a test centre for health or disability reasons; it can also reduce their costs. It is not available in every country where IELTs operate, however many of the countries where it is available are ones where English is not the majority spoken language and so it could aid applicants from those countries in the future.

One of the criteria that we propose considering when compiling the list of acceptable tests will be the reasonable adjustments provided for applicants who need them. We recognise that our proposals will mean in principle that more applicants will be required to take a proficiency test and so it will be important to ensure that the route is as accessible as possible.

Gender reassignment

We have included statistics on gender and gender identity below.

Gender orientation	Percentage of international applicants	Percentage of the register
International applicants whose gender identity matches the one they were assigned at birth	97.2%	97.12%
International applicants whose gender identity does not match that which they were assigned at birth	0.31%	0.22%
Prefer not to say	1.51%	2.32%
Prefer to self-describe	0.05%	0.09%

On each of the headings we monitor for this protected characteristic, the proportions of international applicants are fairly aligned to those on the register as a whole. Existing registrants are around twice as likely to select 'prefer not to say' or to self-describe their

[3] Special requirements (ielts.org)
[4] IELTS Online

gender, but the percentages of people selecting these options is so low, that it is difficult to draw conclusions from these comparisons.

Registrants transitioning may be negatively impacted by the changes in the English proficiency process if strengthening the need for a test and consequently increasing their application costs reduces the funds they have available during the application process, for instance if they need to work fewer hours during their transitioning and so receive less income.

One consultation response noted that applicants who have undergone gender reassignment may be disadvantaged by having to provide proof of name changes for identity checks which may incur a further cost.

Mitigations

Our main mitigation against additional cost would be the introduction of a qualifying countries list, which will minimise the number of applicants who will need to sit a test. In respect of those applicants who will need to sit a test, we have asked test providers to share information on any arrangements they have to support applicants in this situation. Once we have this information, we will see how best to work with the providers in promote their use to potential applicants.

We have also investigated whether the proposal will make the application process harder for those who have transitioned and changed their name and gender since they completed an English test. Currently when an applicant presents with a different name to their supporting documentation, we require them to provide a certified document which confirms the change.

We believe this approach would be sufficient for the new process and would ensure that we can effectively verify their identity while minimising as far as practicable the burdens on these applicants.

Marriage and civil partnerships (includes same-sex unions)

Information on marriage and civil partnerships is included in the table below:

Marriage status	Percentage of international applicants	Percentage of the register
Married	51.15%	48.33%
Never married or entered a civil partnership	37.81%	36.13%
Divorced	2.28%	5.31%
Separated but still legally married	0.68%	1.09%
In a civil partnership	1.27%	1.07%
Prefer not to say	5.61%	7.16%

The marital status declared by most international applicants is broadly in line with that declared by those on our registrants.

Mitigations

No differential impacts have been identified specifically relating to registrants who are married or in civil partnerships and so no mitigations have been proposed. We sought feedback on equality impacts in our consultation and will ensure any identified impacts are considered in our analysis and response.

Pregnancy and maternity

From our sample review

- 85.82% of international applicants declare themselves as not falling within the protected characteristic category of pregnancy and maternity, compared with 89.3% of the register as a whole.
- 6.38% of international applicants declare being in this category, compared to 5.09% for those on the register.
- 6.95% of international applicants selected 'prefer not to say' for this category compared to 5.34% for those on the register.

Therefore, the makeup of international applicants is broadly in line with the professionals already on our register for this protected characteristic.

Registrants who are pregnant or who have childcare responsibilities may be negatively impacted by the changes to the process if, for instance they need to work fewer hours as a result of their pregnancy or responsibility and so receive less income and consequently have less funding available to take a language test.

They may also face challenges with securing childcare arrangements and finding time to study for the test, especially if they are required to retake them. They may also have difficulty securing childcare arrangements whilst taking the test, especially if the test centre is far away from where they are living.

This is something that was also picked up on in the consultation responses, noting that circumstances may mean a lower income and may disadvantage those who now have to take a test.

The mitigations outlined within our wider proposals (i.e., accepting evidence around registration and work experience) may also be harder for someone who has childcare commitments, is pregnant or breast feeding or is currently on maternity leave, as they may not have experience gained within the timeframe, as they are more likely to have been out of work for a period of time.

Mitigations

As time pressures are likely to be a key issue for this group, if we implement the proposals for accepting evidence based on registration or work experience, there may be a specific need for extending the periods of time to apply where someone has been pregnant or has recently had children.

We will need to ensure that tests on our maintained list are accessible for applicants who are pregnant or have childcare responsibilities, and that any specific support arrangements are not prohibitively priced or create further obstacles for these applicants.

We have researched the support offered by one of the most popular tests that we accept, IELTS:

- To ensure that applicants' proficiency is fairly assessed IELTS provide a range of options for those who are infant feeding.[5] Candidates can request these special arrangements up to six weeks' prior to taking their test.

- They also offer an online version of the test, 'IELTS Online', allowing candidates a choice between doing it in person or online, which allows some flexibility for those with childcare arrangements.[6] While realistically it is only suitable for candidates with IT equipment and stable internet, it does offer support for those unable to travel to a test centre; it can also reduce their costs. It is not available in every country where IELTs operate, however many

[5] Special requirements (ielts.org)
[6] IELTS Online

of the countries where it is available are ones where English is not the majority spoken language and so it could aid applicants from those countries in the future.

Adopting an exhaustive list of tests we recognise as proposed would mean drafting criteria to ensure that any tests adopted ensure equal treatment, inclusion and accessibility as part of their offer. These aspects would therefore form part of the considerations of our Education and Training Committee in adopting a new list.

Race (includes nationality, citizenship, ethnic or national origins)

We have provided comparative information on race (and its associated legal subcategories) below:

Racial identification	International Applicants	Register as a whole
Asian or British Asian	38.02%	11.46%
White	35.49%	76.04%
Black, African, Caribbean or black British	17.06%	5.57%
Other ethnic group	3%	1.42%
Mixed or multiple ethnic groups	1.99%	2.12%
Prefer not to say	3.66%	3.27%

International applicants are significantly more likely to be classified as being BME (using standard UK data recording categories) than people on the register as a whole, owing to the countries from which most international applicants apply (most prominently India and Nigeria).

As the proposed changes will only affect international applicants, they are more likely to affect applicants who do not identify as white under our EDI categories. Currently just over a third of international registrants select ‘white’ to describe their ethnicity.

We would therefore expect any change to our English language requirements to be more likely to negatively affect people that would be categorised as BME through our application process, as they would no longer be able to self-declare and would have to use other means to evidence their English proficiency.

However, our view is that our legislation requires us to prescribe requirements for English language proficiency for international applicants, and that any means we use to achieve this will adversely affect some people based on their nationality, which also brings into scope considerations around ethnicity.

We feel that our proposals are proportionate and in line with our obligations to ensure that professionals on our register are capable of safe and effective practise in the UK. However, we will also seek as far as practicable to mitigate any negative impacts.

We should also note that several of the countries we are proposing to be on the ‘qualifying countries list’ have majority populations that would be classified as BME in the UK, and so ethnicity alone will not be a determining factor when the proposals are considered in the round.

Responses to the consultation made mention of the fact that those from a minority ethnic background make up a high proportion of bank-only workers who may find evidencing their work experience difficult. Applicants may find relying on testimonials from a single source could create risks of bias or discrimination.

Mitigations

Our proposals would see the creation of a list of countries where English is the majority spoken language (i.e., where 75% of the population speak English as a first language). Applicants who

have obtained their primary qualification in one of these countries, or who have practised in a regulated role within one of these countries, or have worked in a registrant supervised role within the UK would be able to use this as evidence of their English language proficiency. Adopting this approach would mean our process would consider applicants based on the country in which they have obtained their primary qualification or experience.

Using this approach would also mean applicants' individual background or nationality would not be directly considered; rather the approach would be based on the percentage of English speakers in the country where they have studied or worked and not where they were born or brought up.

This change is likely to have a positive impact on those who live in a majority English speaking country but speak a different language as their 'first language' and therefore would be unable to rely on the self-declaration method in our current arrangements.

We are confident that the mitigations proposed, such as not asking applicants to resubmit evidence of their English proficiency if they have already done so in another majority English speaking country, will reduce financial and administrative burdens now placed on international applicants.

We have also spoken to some large test providers about the support they offer to applicants taking tests. This includes access to practice papers and mock exams and accessible options in where the test is taken.

We believe that removing self-declaration and relying more on approved English tests is a proportionate means to balancing the demands placed upon applicants against meeting our statutory objective of protecting the public and ensuring safe and effective practice.

Religion or belief (includes religious and philosophical beliefs, including lack of belief)

We have provided information on religion of belief as below:

Religious or philosophical belief	Percentage of international applicants	Register as a whole
Christian	52.04%	40.95%
No religion / strong belief	15.37%	39.6%
Hindu	12.49%	2.92%
Muslim	8.56%	4.22%
Spiritual	1.43%	2.2%
Buddhist	1.13%	0.75%
Jewish	0.63%	0.59%
Sikh	0.32%	0.48%
Prefer not to say/not recorded/other religion or belief	8.04%	8.29%

From the available data international applicants are considerably more likely to have religious or strong philosophical beliefs than people already on the register.

As such, those with religious beliefs are likely to be affected by the proposals, albeit indirectly, i.e., if they did not train in a country on the list and are required to take a test.

Furthermore, consultation responses noted that applicants with a strong religion or belief may find it harder to access forms of education due to discrimination in their home country.

Mitigations.

We have not identified any specific mitigations for this category.

We will review access considerations made by test providers for people needing to observe religious requirements, such as ensuring that tests do not take place on religious holidays days, as part of the next stage of this work.

Sex (includes men and women)

On our register, 72% of registrants are female and 26% are male. Those who prefer not to say make up 2% of our register.

This compares with 58% female and 41% male of international applicants. Those who prefer not to say made up 1% of international applicants.

Female applicants are paid less on average (via both national and international routes)[7] with the gender pay gap currently assessed at 7.9% between genders. Female applicants are therefore more likely to be negatively impacted by the proposals, as they need to pay for tests rather than making a self-declaration if their primary qualification or work experience is from a country not on our list. Available evidence also indicates[8] that women are more likely to be carers (of children, partners or relatives with ill-health or disabilities) which can impact on their available funds.

As set out above (see pregnancy and maternity), registrants who are pregnant or who have childcare responsibilities may be negatively impacted by the change in process if they need to work fewer hours and so receive less income. Women are also more likely to have been out of work for large periods of time due to these commitments, and so some of the mitigations we have suggested in accepting relevant work experience may not be applicable to them.

It should also be recognised that the figures show that men make up a disproportionate number of international applicants in comparison with the figures on our register and so our proposals would disproportionately affect them. Again, this is also true of existing policy, would be true of any potential change, and is in line with our legislative obligations and standards requirements.

Mitigations

We have not identified any specific mitigations for this category, in particular where English tests are required as an objective test of proficiency. However, mitigating barriers related to potential cost was a motivating factor in introducing other elements of our proposals, such as the qualifying countries list, previous registered work experience in listed countries, and registrant supervised work in the UK

Sexual orientation (includes heterosexual, lesbian, gay, bi-sexual, queer and other orientations)

Sexual orientation	Percentage of international applicants	Register as a whole
Heterosexual/straight	88.51%	87.83%
Bisexual	1.53%	1.96%
Gay men	1.3%	1.32%
Gay women	0.64%	1.43%

Applicants with qualifications from countries where homosexuality is criminalised may be

[7] Gender pay gap in the UK - Office for National Statistics (ons.gov.uk)
[8] Full story: The gender gap in unpaid care provision: is there an impact on health and economic position? - Office for National Statistics (ons.gov.uk)

affected by this change. They may not earn as much as their heterosexual counterparts and have specific emotional or mental health needs as a result of this discrimination in those countries. This was also an issue picked up through the consultation, as responses made mention of how applicants may find it harder to access forms of education due to discrimination in certain countries.

Applicants in this category not from a majority English speaking country may find it harder to get onto the register if they can no longer rely on self-declaration and are required to take a test.

Mitigations

We have not identified any specific mitigations for this category.

Other identified groups

Socio-economic background

Applicants from lower income backgrounds are a key group to consider. Some applicants from this background may be negatively impacted if they are less able to afford the cost of taking a test or are unable to afford the cost of a retake if they do not achieve a required score.

This group overlaps with most protected characteristics, although women, people from black and minority ethnic communities, disabled people, younger workers, and those working part-time or irregular hours (for example due to having caring responsibilities) are those groups that are also in this category most likely to be negatively impacted by the proposed changes if it they are required to use the testing route to join the register.

However, despite the potential narrowing of options that our proposals would introduce, we also anticipate that some of our mitigating options may help some applicants in this group. Those who have already registered in an English-speaking majority country would not be asked to provide further proof of their proficiency in English, and any applicant who had completed the relevant work experience in the UK would be able to use this to evidence their ability to practice safely and effectively in English.

Refugees and asylum seekers

People with refugee status can make a refugee application to join our register. Recognising the particular circumstances of refugees, we ask these applicants to submit as much supporting evidence as possible and a letter explaining why any other documents cannot be supplied. Refugees do not need to pay a scrutiny fee with their application.[9]

The impact upon refugees was noted in consultation responses. One respondent asked whether it was possible for refugees to gain provisional registration whilst they take their English test or gain the relevant work experience.

We currently allow refugees to make a self-declaration of their English language proficiency, and so if we removed self-declaration for all applicants this would also affect refugees. We will continue to consider the impacts of our proposal for this group.

Cultural differences

Some of the responses to the consultation questioned whether the cultural aspects of practising in the UK would be covered within language tests. This is not necessarily something that we would seek to address with our selection of suitable English language tests, but something to consider at employment and recruitment stage.

[9] Eligibility to apply for registration | (hcpc-uk.org)

Four countries diversity

We will be engaging stakeholders across the UK nations to seek their feedback on our proposals. Any issues identified through our consultation and engagement process that are specific to any of the UK nations will be carefully considered and responded to.

Section 4: Welsh Language Scheme

How might this project engage our commitments under the Welsh Language Scheme?

We have found no evidence to suggest that our proposed changes would be affected by our Welsh language obligations, including under the new Welsh Language Standards. Those training within the UK would use the UK registration route and would not be subject to English language requirements to join the register, even if their first language is Welsh. This is because the legislation that underpins our Rules only states that applicants who have trained outside the UK must meet the prescribed levels of English in order to practise safely and effectively and gain entry to the HCPC register.[10]

The HCPC is a UK-wide regulator and so must prescribe levels of language competency to be able to practice across the whole of the UK, so any changes will apply on a UK-wide basis.

Some responses to the consultation made mention of the use of the Welsh language across the UK, and questioned why applicants must prove their English language proficiency when they may use other languages when recruited, in particular Welsh. However, this is mitigated by our legislation– all HCPC registrants must have a prescribed level of English.

[10] The Health Professions Order 2001 (legislation.gov.uk)

Section 5: Summary of Analysis

What is the overall impact of this work?

We expect the proposed changes to have overall positive impacts, providing clarity and consistency for international applicants by removing *ad hoc* challenges to self-declaration and improving clarity about which tests we would accept.

The proposals place the emphasis on objective criteria, such as academic achievement and professional experiences, insofar as they overlap with residency rather than on family background.

They will also benefit those who speak English with the proficiency required in majority English speaking societies, even if English is not their first language.

We acknowledge that there are likely to be negative impacts for some applicants. Nationality and therefore race are linked to English proficiency requirements, and those seeking to join the register through the international route who do not meet the new criteria will be disproportionately impacted.

However, we believe that the changes are necessary to ensure we can continue to meet our public protection obligations. We believe the proposals to be proportionate and have proposed several mitigating measures to reduce or minimise the negative impacts.

Specific considerations

We have recognised in developing this EIA that the proposed changes may negatively impact applicants with one or more protected characteristics, particular those who are earning less due to childcare commitments, on lower earnings due to socio-economic factors, undergoing gender transition, working part time, or living with a disability or long-term health condition that reduces their earning capacity.

A key negative impact across all the protected categories will be the extra costs placed on international applicants who will no longer be able to make a cost-free self-declaration.

A key positive impact of these proposals, including in relation to equalities and protected characteristics, is that they will provide further assurance on the integrity of the register, which performs a vital function supporting the delivery of safe, effective and high-quality health and care services across the UK.

It is important to remember that policy concerning who can join our register affects the public and service users as well as applicants and registrants. The register is relied upon as a record for professionals who meet our standards and can provide safe and effective practice, and so these proposals will contribute to ensuring the public is assured professionals can meet the required standard of English proficiency.

The fifteen professions we regulate provide a range of health and care services to the UK population, and importantly to people at greater need of care because of their protected characteristics, such as disabled people relying on physiotherapy services, pregnant women, or older people relying on audiology services.

Section 6: Action plan

Summarise the key actions required to improve the project plan based on any gaps, challenges and opportunities you have identified through this assessment.

Include information about how you will monitor any impact on equality, diversity and inclusion.

Summary of action plan

Our initial proposals were informed by our pre-consultation engagement sessions directed at stakeholder organisations, and the survey which followed. We sought views on our proposals were during our consultation period and used these to consider the potential impacts, and any proportionate mitigations. They will also be used to inform the detail of our work during the implementation phase, and to direct or monitoring and review processes once any proposals have been adopted.

In pursuing alignment with other regulators in health and social care, our proposals aim to create a balanced system which is robust, clear and fair. In addition, we will seek to minimise and mitigate any adverse impacts.

During the consultation phase, we undertook the following actions to review and improve our proposals where necessary:

- We carried out a full public consultation on our proposals, supported by further stakeholder engagement. The consultation asked respondents a series of questions to obtain feedback on our proposals.

- We sought input from groups of people who share specific protected characteristics and organisations that represent them about the impacts of the proposals in respect of their protected characteristics as well as seeking general feedback on these issues from employers, professional bodies, and service users.

- We commissioned independent focus group research with service users and carers, which was recruited to ensure a diverse group of respondents and to generate responses which could tell us about potential equality impacts and related concerns held by participants.

- During the consultation period, we attended HCPC's EDI forum in order to take informal feedback on how the proposals might impact a range of individuals and groups, and to encourage participants to make a formal response.

- We also presented on the proposals and took feedback at HCPC's Joining the UK Workforce events, aimed at registrants who had recently joined the register using the international route.

- We created an action log to assess and record issues that arise during the development of the consultation. The log included issues or suggestions for change, identifying their origin and status and will be used in the operational planning of the proposals once finalised.

- We will consider this content alongside consultation responses and redraft our policy with any appropriate changes to make sure that all practical mitigations are pursued, on the basis that they guarantee proficiency levels that support safe and effective practice on behalf of service users.

Next steps

- If our proposals are accepted, we will continue to monitor the protected characteristics of people who apply to join our register using the international route, and will review these on a regular basis to identify any emerging trends and take appropriate action to redress any negative effects.

- If the proposal to create a list of qualifying countries is accepted, we will research and create this with outside expertise. The list will be maintained, including adding or removing countries, via our existing Governance structures.

- If the proposal to create an exhaustive list of approved test providers is accepted, we will work with those we have approved to ensure they have appropriate adaptations or mitigations in place for people with protected characteristics. We will compare aggregated EDI data on applicants to the tests they choose to submit as evidence, and following this monitoring process we will review findings and report to ETC.

- We will also continue to take feedback from our EDI forum and external informal feedback from any interested parties, with a view to informing any future policy development in this area.

- We will undertake a review of the proposals and their outcomes once they have been in operation for a year, and where necessary and practical, suggest any further changes to ETC.

Below, explain how the action plan you have formed meets our public sector equality duty.

How will the project eliminate discrimination, harassment and victimisation?

Maintaining the HCPC's ability to be an effective regulator is key to ensuring that registrants and members of the public needing and receiving healthcare are not subject to discrimination, harassment and victimisation. We do this though education and setting the standards we expect for registrants. We also take action where necessary through our fitness to practise powers if there are concerns a registrant may not be fit to practice, which can include if there are instances if discriminatory behaviour.

We recognise that some of our proposals may have differential impacts on specific population groups but believe that these are justified in ensuring that we continue to meet our statutory obligations to protect the public.

In developing our proposals, we have focused on objective ways that applicants can evidence their English language proficiency, providing fairness and clarity to international applicants. We are also seeking, where possible, to provide balanced mitigations for applicants applying in differing circumstances.

How will the project advance equality of opportunity?

This project will ensure that the HCPC is able to continue to effectively manage the Register such that we can be sure all registrants are able to practise safely and effectively in English to provide high quality healthcare.

Our proposals aim to create new routes for evidencing English language proficiency which, when taken together, create a system which is robust, fair and clear. Ensuring that applicants' ability to speak and practise in English to our required levels will meet our legal obligations in order to protect the public and ensure service users can access high quality and safe care from

our registrants, but aim to do so in a way which is proportionate and minimises unnecessary barriers. We recognise that our proposals may negatively impact applicants from some groups with one or more protected characteristics applying via our international application route. However, we have worked to mitigate these by providing as many practical options for applicants as possible, by making sure that our requirements rely on clear and objective foundations and standards, and that risk is balanced in as proportionate manner as far as possible.
How will the project promote good relations between groups? In seeking to set more objective requirements for English language proficiency we have aimed to minimise any impacts related to an applicant's background as far as possible, replacing this with objective measures relating to proficiency. Rather than focussing on an applicant's place of birth or their first language, our proposals address evidence that relates to their likelihood of proficiency, so applicants will now rely on evidence relating to their test results, where their primary qualification was gained, or in the case of the registration / work experience proposal (if this is implemented following further investigation), whether they can show that they are likely to have used English in a comparable professional context. We feel that a clear set of options that can be trusted to be objective and impartial will help to establish mutual respect between applicants who go on to join the register. Throughout the consultation and the pre-planning stages, different stakeholder groups will be asked to come together to share their views on the proposals and collaborate on specific issues. Securing these changes will support equality by maintaining public protection and ensuring positive service outcomes are delivered for the public irrespective of their background, including their protected characteristics.

Reflection completed by: Madeleine Connor, Senior Policy Officer	**Date: 22 April 2024**
Reflection approved by: Tom Miller, Policy Manager	**Date: 30 April 2024**

Patient and carer focus group: Proposed changes to the Health and Care Professions' English language proficiency policy for international applicants

Focus Group Report

January 2024

Contents

1. Executive summary

The ability to communicate in English is a key requirement for providing safe and effective practice for professionals working with patients in the UK. The Health and Care Professions Council (HCPC) and the Patients Association are working together to understand the potential impact on patient experience of HCPC's proposed changes to its policy on English language proficiency for international applicants. This work runs alongside the public consultation on the proposed changes which include removing and replacing the option to self-declare English as a first language and introducing a list of qualifying countries based on clear majority English speaking populations.

A diverse group of patients and carers were invited to share their views and insights on the policy and the proposed changes. They were asked to review a summary of the proposed changes and participate in an online focus group facilitated by the Patients Association.

The Patients Association asked patients and carers to discuss their views on the policy and the role of health and care professional's English language proficiency in their personal experiences of receiving treatment and care. They were asked to share their views on the proposed changes and the potential impact these could have on patients and carers. Participants also shared ideas of how HCPC could continue to partner with patients and carers when changes to their policies were put into practice.

Participants shared that it was important to review and update the policy to support effective communication and safety. The ability to communicate in English is important for positive patient experience, patient partnership and shared decision making.

Overall participants supported the proposed changes and felt that this would create a more robust and clear system that would instil greater confidence in the process for the registering professionals, and patients and carers. However, participants emphasised the importance of not disadvantaging or deterring international applicants who did not come from a majority English speaking country from working and registering in the UK, given the shortages facing some disciplines and long waiting lists and delays in accessing treatment and care. It was noted that if health and care professionals are disadvantaged, in turn the patients are disadvantaged. They also stressed that professional competence, and the ability to communicate effectively to patients and carers, are not determined by having a "perfect" or native level of language.

Participants discussed the importance of gathering and listening to patient and carer's experiences as the policy was implemented and regularly monitoring and reviewing the policy to understand if the changes are having a positive impact on patient experience and the safety of patients, carers and health and care professionals.

The findings suggest that the proposed changes will enhance the policy but stress the need for the equality impact assessment and partnering with patients and carers in the ongoing monitoring and review of the changes.

Addressing the key themes and findings from the focus group should be prioritised as part of HCPC's wider consultation and work to gather views on the proposed changes to the policy. The report includes recommendations for the review of the policy and HCPC's wider work:

1. HCPC to review the proposed changes to the English language proficiency policy based on the findings from the focus group discussion
2. HCPC to review the proposed Equality Impact Assessment for the English language proficiency policy based on the findings from the focus group discussion
3. HCPC to establish timelines and patient and carer engagement mechanisms to ensure patient and carer insights are captured in further reviews and updates to their policy. HCPC's to communicate this widely across established patient networks to ensure diverse participation
4. HCPC to publish and distribute communications materials for patients and carers to inform them about its policies, how it partners with patients and carers, and opportunities for patients and carers to be involved in its work.

2. Introduction

The Health and Care Professions Council (HCPC) is a UK-wide regulator for health and care professionals working in the NHS and private sector. Regulators exist to ensure that health and care professionals deliver safe and high-quality care to patients and the public. HCPC regulate 15 professions including paramedics, chiropodists/podiatrists, occupational therapists, practitioner pyschologists, dietitians and radiographers.

The Patients Association is supporting the HCPC with the review and consultation of its English language proficiency policy for applicants who use the international route to join its register. The policy exists to ensure a standard of

English to allow the professionals on their register to work safely and effectively in the UK. HCPC are consulting on the following proposed changes to the policy:

- Remove and replace the option to self-declare English as a first language
- Introduce a list of qualifying countries based on majority English speaking populations
- Accept previous registration in a majority English speaking country or supervised work experience in the UK
- Create an exhaustive list of approved English language test providers

We facilitated an online focus group of patients and carers with experience of attending appointments and interacting with health and care professionals from the 15 professions regulated by HCPC. The participants were asked questions to gather their insights and views on the proposed changes to the policy for international applicants and the potential impact on patient experience.

This report summarises the focus group process and outlines the findings and key themes from the focus group discussion. Recommendations are provided to inform HCPC's review and update.

The project was funded by HCPC.

3. Aims and objectives

The aim of the focus group was to understand patients' and carers' views on the proposed changes to the HCPC English Language Proficiency Policy for international registrants, and their potential impact on patient experience.

The Patients Association recruited patients and carers for the focus group via Weekly News, our online e-newsletter. We also asked six stakeholder organisations including Maternal Mental Health Alliance, Eat Well Age Well, and Digital Health and Care Wales to promote the opportunity among patient and carer groups who were identified as being potentially impacted by the proposed changes to the policy.

A diverse group of participants were recruited. The participants were vetted to ensure they had relevant experience of attending appointments and/or interacting with health and care professionals from the professions regulated by HCPC in the last three years (see Appendix I).

Phone calls were held with potential participants to confirm suitability. Ten people were invited by email to take part following the vetting calls; they gave

written consent for their anonymous views to be shared. Participants were emailed the focus group briefing pack, which contained the agenda, focus group questions and an illustrated guide to the consultation.

Participants were asked to discuss their experiences and views about the role of English language proficiency in patient experience, their views on the proposed changes to the policy and the potential impact on patient experience. They were also asked to consider potential opportunities for continued engagement between HCPC and patients and carers.

Discussions were facilitated between the full group and in smaller breakout groups to encourage exchange and sharing of perspectives and experience (see Appendix II)

4. Findings and key themes

The findings and key themes from the focus group discussion are summarised below:

1. The importance of reviewing the policy
2. The impact of English language proficiency on patient experience and patient safety
3. The importance of effective communication in patient partnership and shared decision-making
4. Views on the proposed changes
5. Potential risks and benefits to health and care professionals from the proposed changes
6. Potential risks and benefits to patients and carers from the proposed changes
7. Ongoing opportunities for HCPC to partner with patients and carers regarding changes to their policies

1. The importance of reviewing the policy: The participants agreed it was a good idea for HCPC to review the policy. Reasons given to support the need for review included:

- Necessity for health and care professionals to be able to communicate clearly to patients
- Ensuring patient safety
- Ensuring health and care professionals' safety

- The increasing number of international health and care professionals working in the UK.

Participants commented on the ongoing need to recruit international health and care professionals to address the shortages of professionals in particular health and care disciplines which further underlined the need to have a robust English language in place.

Participants said the UK's multicultural society meant it was also important to have bilingual health and care professionals who could communicate effectively with patients and carers who may not have English as a first language. One participant raised that the bilingual abilities of health and care professionals should also be reviewed.

> "I agree with the review because the major language spoken [in the UK] is English, so it is important to reduce language as a barrier between professionals and their patients."
>
> "We must have a framework of confidence that we all understand."
>
> "It's very necessary [to review the policy] due to the lack of medical professionals in the UK and the need for these professionals to be able to speak good English for everyone's safety."

Participants said strong local dialects can sometimes make it difficult to understand English speakers and that the emphasis should be placed on ensuring effective communication for all national and international registrants.

2. The impact of English language proficiency on patient experience and patient safety: Participants shared both positive and challenging experiences of the role that the English language proficiency of professionals has played when receiving treatment and care.

Where participants had experienced challenges because professionals weren't proficient in English, they reported feeling frustrated and unable to get the benefit out of the appointment because they could not understand what was being communicated. Two of the three participants who had challenging experiences said they either did not go back to see the health and care professional or sought another appointment with a different professional because of the impact English proficiency had on communication.

> "I kept on having to say pardon because I didn't understand. And it wasn't just the technical terms that were being used to convey to me the

treatment. I found it so frustrating.... I didn't get the best out of the session, although quite clearly, he was extremely competent"

"I had a challenging experience where I had to be referred to a [second] health care practitioner because I couldn't understand in clear terms what the previous person was saying"

3. The importance of effective communication in patient partnership and shared decision-making: Throughout the discussion, participants emphasised the importance of being able to access health and care professionals that were competent and could communicate effectively with patients and carers. Participants agreed it was not necessary for health and care professionals to have a "perfect" or "Queen's English" level of English language. It was also noted that the ability to speak English proficiently alone does not determine the ability to communicate effectively. Participants commented that there can be individual and cultural differences in how things are expressed, interpreted and understood that can impact the relationship between patients and carers and health and care professionals.

Participants again said interpreters and bilingual health and care professionals are important as the English language proficiency of the patient and carers can present further challenges when communicating in English.

"Communication difficulties can be a challenge, especially when patients have limited English proficiency. It can lead to misunderstandings and a lack of understanding of health conditions and treatment options."

"If the [health and care] professional doesn't have a good command of the English language then they are unable to translate the medical jargon into lay person's language to explain what the issue is. Patients will suffer without this."

4. Views on the proposed changes: There was agreement among the participants that overall, the proposed changes were a good idea to help effective communication between patients and carers and health and care professionals, and the safety of all parties. Participants raised examples of how this could positively impact patient experience, including patients feeling more comfortable and confident communicating with their health and care professionals.

Support was given to removing the option to self-declare English language proficiency in favour of a more robust system. It was noted that a self-

declaration process relies on subjectivity and has the potential for abuse so removing this added an extra "safety protector".

However, participants stressed the importance of the equality impact assessment to ensure international health and care professionals were not put at a disadvantage by the proposed changes. They also emphasised the importance of ongoing monitoring, reviews and updates of the policy in response to its impact in real-world context.

5. Potential risks and benefits to health and care professionals from the proposed changes: Participants stressed that international health and care professionals should not be disadvantaged or deterred from working in the UK and registering with HCPC or other regulators. Emphasis was placed on the importance of providing a system of support for international applicants to demonstrate their English language proficiency, respecting that this was not determinate of their competence in their profession. Suggestions were given of how to address this:

- Removing disadvantaging factors such as cost and accessibility of tests
- Providing online English language centres so travel/location to test centre was not a barrier
- Child-care support for single parents to attend/participate in the test
- Providing feedback and the option to retake the test after a failed result.

Single parents, people with a disability and people on a low income were identified as applicants that could potentially face disadvantage by having to take a test if they could no longer self-declare and weren't from a majority English speaking country.

> "I think [the proposed changes] add that extra sort of nut and bolt...that the level of English is to set a standard, as long as the [potential] disadvantage and equality impact elements are addressed."

6. Potential risks and benefits to patients and carers from the proposed changes: Overall, the participants agreed the policy would improve the patient experience. They said the equality impact assessment was important to ensure groups of patients and carers did not experience unintended disadvantages from the proposed changes. Patient and carer groups they suggested would be more likely to be impacted by the policy and its proposed changes included:

- Deaf people
- People from minority groups such as travellers
- People with limited proficiency of English language.

It was noted that increased use of telephone and virtual appointments could increase the issues of language barriers and understanding of strong accents and dialects for patients and carers.

Participants also raised the challenges patients and carers face accessing appointments in some parts of the UK, with some professions experiencing more shortages than others. The participants stressed the importance of a clear standard of English language proficiency that is established and upheld. However, it was agreed that this needs to be considered alongside the need to address access to care and waiting lists by ensuring sufficient staffing levels and international recruitment.

> "[By improving the process] the patient will then be able to develop the confidence that there is a robust system, and that all applicants are going to be treated equally, and none going to be disadvantaged."
>
> "The system needs to be open, transparent and fair. If the health professionals are disadvantaged, in turn the patient is disadvantaged."
>
> "There needs to be a standard but at the same time there are such shortages, and we need to think about patients being able to access care."

7. Ongoing opportunities for HCPC to partner with patients and carers regarding changes to their policies: Participants agreed that policies are reviewed regularly within clear established timelines. Mechanisms to engage patients and carers to understand their views and experiences should be put in place to inform policy changes. The participants suggested engaging patients and carers in the following ways:

- Patient and carer representatives on policy review panels
- Surveys (online and paper)
- Focus groups facilitated by independent organisations eg Patients Association, Healthwatch
- Feedback systems to report good/bad experiences (ongoing, not just at the time of policy reviews).

Participants agreed that engagement opportunities needed to be communicated clearly to patients and carers to ensure participation. They suggested:

- Promotion of opportunities
- Direct engagement with minority groups and groups at risk of health inequalities
- Engagement with patient partnership groups, Patient, Advice and Liaison service, and primary care networks.

It was also noted that baselines, for example of patient experience, should be established to be able to effectively assess the impact of changes to a policy once implemented.

5. Conclusion

The focus group discussion demonstrated the importance to patients and carers that a robust policy and process exists to determine the English language proficiency of health and care professionals.

Patient safety, patient experience, patient partnership and shared decision making, and health and care professionals' safety may all be impacted by the ability of the professionals to communicate effectively in English.

While the proposed changes to the policy were welcomed by the focus group participants, it is important that any changes are managed and monitored to ensure that they don't disadvantage or deter international health and care professionals from working and registering in the UK. The emphasis throughout the discussions was the importance of patients' and carers' access to competent, skilled health and care professionals who can communicate effectively. Participants felt competence is not determined by "exceptional" or native level of English language.

The impact of the proposed changes on patients and carers should be subject to ongoing monitoring and review by engaging with and learning from the real-life experiences of patients and carers across the UK, including those at risk of health inequalities.

6. Recommendations

1. HCPC to review the proposed changes to the English language proficiency policy based on the findings from the focus group discussion
2. HCPC to review the proposed Equality Impact Assessment for the English language proficiency policy based on the findings from the focus group discussion
3. HCPC to establish timelines and patient and carer engagement mechanisms to ensure patient and carer insights are captured in further reviews and updates to their policy. HCPC to communicate this widely across established patient networks to ensure diverse participation

4. HCPC to publish and distribute communications materials for patients and carers to inform them about its policies, how it partners with patients and carers, and opportunities for patients and carers to be involved in its work.

7. Appendices

i. Participant demographics

Gender identity:	• 6 women • 4 men • 1 participant's gender identity is not the same as the sex they were assigned at birth
Age:	• 2 participants age 18-24 • 3 participants age 25-49 • 2 participant age 50-64 years • 2 participant age 65-79 years • 1 participant age 80+
Sexuality:	• 1 participant is a lesbian/gay woman • 1 participant is bisexual • 8 participants are heterosexual
Ethnicity:	• 2 participants are Black African • 3 participants are white - English/Welsh/Scottish/Northern Irish/British • 1 participant is mixed/multiple - white and black Caribbean • 2 participant are mixed/multiple - white and black African • 1 participant is Asian/British Asian – Indian • 1 participant is Asian/British Asian - Bangladeshi
Religion	• 1 participant is Hindu • 1 participant is Muslim • 4 participants are Christian • 4 participants have no religion
Patient/carer:	• 7 participants are patients • 1 participant is a carer • 2 participants are patients and carers
Geographic location:	• 5 participants live in London • 1 participant lives in the Northeast of England • 1 participant lives in the East of England • 1 participant lives in the South West of England • 1 participant lives in Scotland • 1 participant lives in Northern Ireland

	A Welsh participant was recruited but did not participate in the group.
Disability:	• 7 participants have a disability • 3 participants do not have a disability
Experience of pregnancy:	• 3 participants have been pregnant in the last 3 years
Experience of interactions with health and care professions regulated by HCPC in the last 3 years:	• 1 person has attended appointments with a Chiropodist/podiatrist • 4 people have attended an appointment with a Dietitian • 2 people have attended an appointment with a Hearing Aid Dispenser • 2 people have attended an appointment with an Occupational Therapist • 4 people have attended an appointment with a Physiotherapist • 1 person has attended an appointment with a Speech and Language Therapist • 1 person has attended an appointment with another allied health professional such as radiographer, biomedical scientist, clinical scientist • 8 of the participants had seen the health and care professionals on the NHS • 2 of the participants had seen the health and care professionals in both NHS and private settings

ii. Focus group discussion questions

1. Your views on the consultation:
    i. Do you think it is important for HCPC to review their policy for English language proficiency of international applicants?
    ii. How has the English language proficiency of health and care professionals played a role in positive or challenging experiences you have had when receiving treatment and care?

2. How do you think the proposed changes to the policy might impact the overall experience of patients and carers when receiving care from health and care professionals?
   You may want to consider:
    - Patient safety

- Communication between patients, carers and health and care professionals at in person/online/telephone appointments
- Communication between health and care professionals and your GP

3. Do you think there any specific groups of patients and carers who may be more likely to be impacted by the proposed changes to the policy?

4. How can HCPC continue to ensure that patient and carer interests are well-represented when changes to their policies are put into practice? For example, when evaluating the impact of changes they make to a policy.

iii. Additional participant quotes

The importance of the review:

> "The review is an excellent idea... It is very important for the safety of patients, carers, and indeed for the safety of the doctors that they can understand what their patients are saying, what the carers are saying. Equally, vice versa we need to ensure that we understand the medics."

> "The movement of staff internationally is much more frequent, and professionals are much more willing to travel. So, I think it's good to review [the policy] to make sure that it is fair, complete, comprehensive, consistent and that it does not disadvantage from the patient's point of view on the carer's point of view."

The impact of English language proficiency on patient experience and patient safety:

> "It's important for healthcare professionals to be able to communicate clearly and effectively with patients. so, having a certain level of English proficiency, could be seen as important. However, English is not the only spoken language in the UK. And many people have limited English proficiency for a variety of reasons."

> "Language difference is a big barrier. So, being comfortable with somebody who speaks and understands you well will surely increase the comfort to patients."

Monitoring the impact of the policy:

> “I think it is really important to have this policy and to review this policy. But not just the policy on its own. Actually, we want to think about practice. How this is being applied practically? And both the experiences of patients and carers, and the health professionals, that are engaging in these interactions and communications.”

Examples of the impact of English language proficiency on patient experience and patient safety in other health and care professions:

> “I had an experience with a very competent Indian bowel surgeon and I wasn’t able to understand part of the instructions, and I came away from the appointment slightly frustrated, but probably frustrated at myself that I didn't feel comfortable enough actually stopping and saying, I don't understand. I’m not sure how he felt afterwards he certainly was very confident, very professional and a very good surgeon.”

> “I have an Indian GP. Whose wife is also a GP, and German. I can't stress enough that my treatment couldn't be better. They speak better than me”

Annex D: Consultation document

Consultation on English language proficiency

October 2023

Find out more: www.hcpc-uk.org/consultations/

Contents

Foreword

This consultation document sets out proposals for changing our policy on the types of evidence of English language proficiency that we accept from people applying to join our register through our international registration route. [1]

The purpose of this consultation is to ensure our approach is robust, clear and fair. In consulting we are seeking to ensure any new requirements:

1. support registrants to meet our Standards and do not compromise on safety and high-quality care for service users;

2. continue to support internationally trained professionals to bring their talent, skills and experience to the UK;

3. consider applicants fairly and based on objective criteria, preventing discrimination in respect of their backgrounds or protected characteristics; and

4. Are comparable with those of other regulators where possible.

The proposals in this document would apply to future applications we receive via the international route. If our proposals are accepted, they would not affect professionals who have satisfied our current requirements and already entered the register, or those who meet our readmission requirements. The proposals will not change our Standards of proficiency or the level of English language proficiency we require.

We are grateful to everyone who has helped to shape the proposals via our engagement work. It has provided valuable insights into the current approach, the options for change and the potential impacts on applicants. Our pre-consultation work has been integral to our understanding of the needs and views of professional bodies, employers and educational institutions.

We encourage all interested stakeholders and individuals to formally respond to this consultation, and to take part in the engagement events we are planning. Following the consultation period, finalised proposals will be presented to Council for their consideration.

The consultation will run for 13 weeks from 16 October 2023 to 19 January 2024, and is available to answer here.

[1] Excluding the Swiss Mutual Recognition (SMR) route.

Introduction

About the Health and Care Professions Council (HCPC)

HCPC's statutory role is to protect the public by regulating healthcare professionals in the UK. We promote high quality professional practice, regulating over 300,000 registrants across 15 different professions by:

- setting standards for professionals' education and training and practice;
- approving education programmes which professionals must complete to register with us;
- keeping a register of professionals, known as 'registrants', who meet our standards;
- acting if professionals on our Register do not meet our standards; and
- acting to stop unregistered practitioners from using protected professional titles.

As part of our regulatory function we are responsible for maintaining the integrity of our register and making sure that people who join it can practise safely and effectively, as set out in our Standards of proficiency and Standards of conduct, performance and ethics.

Why we are consulting

Our legislation[2] sets out our legal powers and duties regarding English language proficiency for international applicants. Our Standards of proficiency also require that all those on our register must be able to communicate in English to the required standard for their profession.

It has been some time since we reviewed our English language proficiency requirements and we think that it is appropriate to do this now, particularly in light of an increasing number of international applications to join our register, and to stay in alignment with contemporary circumstances, such as changes to examination providers or processes. We are also aware that other health and care regulators have recently updated their English language proficiency requirements. We think it is important that we learn from peer organisations and that we ensure consistency between regulators wherever this is practical and helps to protect the public.

A key element of our current international application route is that we allow applicants to make a self-declaration of English being their first language and as

[2] See the Health and Care Professions Order 2001 and The Health and Care Professions Council (Registration and Fees) Rules 2003: consolidated legislation available here.

evidence of their proficiency. Research undertaken to develop these proposals has identified that we are unique among health and care regulators in allowing this mode of evidence to demonstrate proficiency.

As well as aligning our approach with other regulators, we believe that the changes we are proposing will ensure we continue to maintain strong public protection, and the application route is administered in a clear and fair manner.

The proposals put forward in this consultation aim to emphasise the role of objective standards of evidence in our international registration process, but also to widen the choices available to applicants for evidencing their English language proficiency. We are also aiming to reduce unnecessary administrative burdens for applications as far as reasonably practicable.

Our current approach to English language proficiency

The standards of proficiency for all but one of the professions we regulate require registrants to be proficient to level 7 (or equivalent) of the International English Language Testing System (IELTS), with no element below 6.5. The requirement is higher for Speech and Language Therapists, who need to have an IELTS level 8 (or equivalent) with no element below 7.5. For the Test of English as a Foreign Language (TOEFL), the minimum scores are 100/120 and 118/120 respectively.

We ask all international applicants to confirm their English language proficiency. However, those applying through the Swiss mutual recognition (SMR) route do not need to provide proof of their English language proficiency unless they are applying for registration as a speech and language therapist.

In the first instance our online process for international applicants using the non-SMR route asks them to declare whether English is their first language. Applicants are advised they must only answer ‘Yes’ if it is the main or only language that they use on a day-to-day basis. Having studied English or undertaken higher education that was taught in English is not sufficient for an applicant to claim that English is their first language.

When English is not an applicant’s first language, they are required to provide certified evidence of a completed English language proficiency test which demonstrates they meet the minimum required levels for the profession they are applying to practise in, in the UK. An applicant will not be accepted for registration with us until they can meet this requirement.

At present we approve two tests, the IELTS test (either the academic or general test), and TOEFL (an internet-based test which cannot be undertaken in the UK).

Applicants may choose to undertake a different test from these two. However, if they choose this option, the alternative test certificate must be accompanied by a statement from the test provider which confirms that the result achieved is comparable to the required IELTS level set for the relevant profession. More information on our requirements is available here.

Our proposals

Our proposals have been developed in collaboration with HCPC's International Registration team and have been subject to extensive pre-consultation engagement with stakeholder groups, including professional bodies, employers and educational institutions, for whom we conducted informal information sessions and survey activity around some draft proposals.

We also carried out internal engagement with our Education and Training Committee, Professional Bodies Forum, and Equality, Diversity and Inclusion (EDI) Forum, and used their feedback to shape the proposals.

Our aims in drafting these proposals have been to:

- address any areas of potential risk in our current approach;
- ensure that we continue to maintain public confidence in our processes;
- make sure that any proposals we put forward include clear and fair criteria for the evidence we can accept to demonstrate English language proficiency; and
- where possible, limit additional burdens on our international applicants and consider impacts on application processing times.

We have outlined the proposals in detail below:

Proposal 1: removal and replacement of self-declaration of English as a first language

We propose that the option for international route applicants to declare that they speak English as their first language is removed, to be replaced with a list of qualifying countries (see Proposal 2).

In making this proposal, we believe that replacing the self-declaration option would make international registration more robust, especially in respect of the increased availability of more objective assessments that focus on an applicant's language capabilities.

We have not identified high numbers of registrants in Fitness to Practise proceedings who have been referred due to English language related complaints. However, the use of self-declaration in this area presents a risk that we think our proposals would address.

As part of our work, we have carried out an Equality Impact Assessment (EIA) on our proposals. We recognise that our proposed changes may negatively impact those applicants who would previously have been able to self-declare but must now use other routes. It could mean that more people would need to sit tests, and we appreciate that the cost of sitting a test could have impacts for people with one or more protected characteristics. Despite this, we feel that moving away from a self-declaration model for assessing English language proficiency is a necessary part of making sure our system is robust and continues to ensure public protection.

We anticipate, however, that our proposal to remove self-declaration will also lead to positive benefits for applicants, including for the following reasons:

- Self-declaration based on first language excludes applicants who may be able to practise safely and effectively in English, but whose first language is not English. For example, applicants who apply from Ireland have undertaken a degree in English and live in a country where the vast majority of people speak English but would not be able to rely on this fact if they spoke Irish (or any other language) as a first language.

- Similarly, for applicants from majority English speaking countries such as New Zealand and Australia, self-declaration may disadvantage second generation immigrants who do not speak English at home, but have studied in English and live in a country where the vast majority of people speak English in daily life.

In consideration of the potential negative impacts on applicants we are proposing new arrangements that aim to mitigate these impacts as far as practicable. This includes measures outlined in the proposals below which aim to provide a range of options in addition to taking a test of English language proficiency. We have also considered other possible mitigations for how we might implement changes, which we will consider in line with our EIA and in response to consultation feedback.

Q1: Do you agree with the proposal to remove self-declaration of English language proficiency as an option for international applicants to join the register?

If you would like to, please explain your reasoning.

Proposal 2: Introduction of a 'qualifying countries list' based on majority English speaking populations

Instead of self-declaration, we propose that one way we allow applicants to demonstrate their English language proficiency will be by providing proof of a primary qualification (i.e., the main academic or vocational qualification required to enter the professional role in question) taken in a country where 75% or more of people speak English. Using third-party evidence, we would maintain a list of qualifying countries where 75% of the population use English as their main language.

If an applicant meets this criterion, there would then be no requirement for them to submit a test score or provide further evidence. Applicants who earned their primary qualification in a listed country could use this as evidence of their proficiency in English, regardless of whether it is their first language.

It is important to note that the applicant's country of citizenship, residence or birth, would be irrelevant in assessing their English proficiency. Where an applicant has completed a primary qualification in a listed country, this would serve as evidence of their proficiency, regardless of the country where they were born or live at the time of their application.

This would offer a route to joining the register that is evidentially robust as it rests on demonstrable proficiency, i.e., an applicant's ability to complete study in English. They will also have trained in health and care systems where English is the predominant language used. We believe that any impacts from reducing the numbers of applicants being able to self-declare would be offset by the numbers of people who would be encouraged to apply under this new arrangement. In addition, this would align HCPC's English language proficiency requirements with those used by the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC), which both maintain a list of this kind.

We are proposing 75% as the metric to align with the list used by the NMC in their recent changes. However, we are aware of other methodologies and lists, for example those used by the UK government or the GMC. We would therefore welcome any views on whether we should opt for a different methodology in light of the different professional groups that we regulate.

Q2: To what extent do you agree or disagree that this proposal would enable international applicants to:

a) Show that they are proficient enough in English to practise safely and effectively?
b) Feel confident in their own English proficiency?
c) Easily join the register?

Q3: Would a 75% English speaking population be an appropriate test for qualifying countries to be on our list? Please explain your reasoning and/or suggest any preferred alternatives.

Proposal 3: accepting previous registration in a majority English speaking country or supervised work experience in the UK.

We understand that if we remove the ability to self-declare, we will be requiring some applicants to take tests who are not currently required to do so. We also recognise that taking tests can be expensive and time consuming.

We therefore want to ensure we offer as many routes as possible for international applicants. To achieve this, we are proposing that where an applicant does not have a qualification from a listed country, they could:

a) provide evidence that they have worked in a regulated health or care profession in a listed majority English speaking country, or;

b) provide evidence of work experience in the UK. This evidence would be supported by a certificate of supervision provided by a HCPC registrant or a registrant with another statutory regulator in the health and care sector.

Outside of the UK, this experience would have to be in a regulated role in the listed country, and proof of their registration would be required, including that proficiency in English was a requirement to join that register. Membership of a professional body would not count as proof of registration.

The applicant would have to have been registered to work in the listed country for at least 12 of the previous 24 months and have spent this time period working in a role that required them to draw on their professional knowledge, skills and experience.

This proposal would also allow a route to registration for international registrants who have not passed a test, whilst maintaining a requirement for them to show that they have achieved an acceptable level of English proficiency in line with our Standards of proficiency.

Inside the UK, applicants would be able to use their work experience in an unregulated role as long as:

- The role draws on the knowledge, skills and experience of the profession they are intending to apply for, including interaction with service users.

- The role is supervised by a HCPC registrant who is registered on the same part of the register as the applicant is applying for.

The applicant would need to provide evidence from their supervisor of their proficiency in English, using the template provided by HCPC for this purpose.

Q4: Separately to considering where qualifications are gained, should we accept evidence of work experience in a listed country where English is spoken by a majority as their first language? Please explain your answer.

Q5: Separately to considering where qualifications are gained, should we accept evidence of work experience in the UK if this has been supervised by a registered health and care professional? Please explain your answer.

Proposal 4: creating a revised and exhaustive list of approved test providers

Under this proposal we would continue to accept internationally recognised tests of English language proficiency but would expand our list of approved test providers. This would increase the options available to applicants wishing to take an approved test.

Currently we accept two tests, the International English Language Testing System (IELTS) and the Test of English as a Foreign Language (TOEFL), but under the proposal, we would consider adding more tests to our 'approved' list, for example the Occupational English Test (OET).

We are seeking views on this proposal and would also welcome recommendations for additional testing systems that could be included in an 'approved list'. Any new tests added must be evidentially robust in how they are administered and authenticated, and should be widely available and accessible.

We are also asking for views on whether we should make this list exhaustive, so that only tests on the list of approved providers would be acceptable to demonstrate proficiency. This would mean that we remove the option for applicants to submit a test from a provider other than IELTS or TOEFL when accompanied by a certificate of equivalence from that provider. However, it would also minimise the burden that people currently face when they need to provide us with evidence that their non-approved test is equivalent to our pass requirements.

We believe that widening the range of tests we accept should help mitigate any impact resulting from removing the option for self-declaration, as well as increasing choice and creating clarity about our requirements for international applicants. Our initial research has shown several viable test providers that could be added to a list, so there is a clear opportunity to make an improvement. However, any changes to our approach will be contingent upon the quality, availability and accessibility of a new test.

Q6: Do you agree with our proposal to expand our list of approved test providers? Please explain your answer.

Q7: In addition to our current approved providers, which test providers should we consider accepting as evidence of English language proficiency?

Q8: Should our list of approved tests be exhaustive?

General views on our proposals

We are also seeking views on the combined effect of our proposals.

Q9: Which of these statements would you most agree with?

1) Overall, these proposals provide **greater** assurance that applicants' proficiency in English is sufficient for them to practise safely and effectively.

2) Overall, these proposals provide the **same** assurance that applicants' proficiency in English is sufficient for them to practise safely and effectively.

3) Overall, these proposals provide **less** assurance that applicants' proficiency in English is sufficient for them to practise safely and effectively.

Equality Impact Analysis

We have provided a draft Equality Impact Assessment (EIA) for the proposals as a separate document.

We strongly encourage respondents to read both documents before submitting a response. We will issue a revised EIA following analysis of responses to this consultation.

Q10: In addition to the equality impacts set out in the Equality Impact Assessment, can you identify any further impacts relating to protected characteristics that we should consider? Protected characteristics consist of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, ethnicity, religion or belief, sex, sexual orientation.

You may also consider other ways in which people's background might mean lead to an adverse impact, for example if applicants are refugees or forcibly displaced people, or how their socio-economic status might affect things.

Do you have any suggestions about how any negative equality impacts you have identified could be mitigated?

List of consultation questions

HCPC currently allows applicants to the register using our international route to self-declare that they speak English as a first language. We are proposing that self-declaration of English as a first language is removed and replaced.

Q1: Do you agree with the proposal to remove self-declaration of English language proficiency as an option for international applicants to join the register?

If you would like to, please explain your reasoning.

As the replacement to self-declaration of English as a first language, we propose an option to evidence proficiency which is based on studying and gaining professional qualifications from a list of majority English-speaking “qualifying countries”.

Q2: To what extent do you agree or disagree that this proposal would enable international applicants to:

a) Show that they are proficient enough in English to practise safely and effectively?
b) Feel confident in their own English proficiency?
c) Easily join the register?

Q3: Would a 75% English speaking population be an appropriate test for qualifying countries to be on our list? Please explain your reasoning and/or suggest any preferred alternatives.

We would like to know about your views on the value of registration and work in the proposed listed countries in supporting applicants’ proficiency in English.

Q4: Separately to considering where qualifications are gained, should we accept evidence of work experience in a listed country where English is spoken by a majority as their first language? Please explain your answer.

We are also proposing that we accept supervised work experience in the UK as an option to evidence proficiency:

Q5: Separately to considering where qualifications are gained, should we accept evidence of work experience in the UK if this has been supervised by a registered health and social care professional? Please explain your answer.

We are considering changes to our list of approved test providers, for example including the Occupational English Test (OET) and potentially other providers. This would mean adding tests from additional providers to our list of approved tests.

We would maintain the current levels of proficiency we require from applicants joining the register, so there would be no change to the level of English required. After expanding the list, we would no longer accept tests from outside the list.

Q6: Do you agree or disagree with our proposal to expand our list of approved test providers? Please explain your answer.

Q7: In addition to our current approved providers, which test providers should we consider accepting as evidence of English language proficiency?

Q8: Should our list of approved tests be exhaustive?

We would value your view on the combined effect of our proposals.

Q9: Which of these statements would you most agree with?

1) Overall, these proposals provide **greater** assurance that applicants' proficiency in English is sufficient for them to practise safely and effectively

2) Overall, these proposals provide the **same** assurance that applicants' proficiency in English is sufficient for them to practise safely and effectively

3) Overall, these proposals provide **less** assurance that applicants' proficiency in English is sufficient for them to practise safely and effectively

Please give us your thoughts on our Equalities Impact Assessment and any other impacts you anticipate, if any.

Q10: In addition to the equality impacts set out in the Equalities Impact Assessment, can you identify any further impacts relating to protected characteristics that we should consider? Protected characteristics consist of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, ethnicity, religion or belief, sex, sexual orientation.

You may also consider other ways people's background might mean an adverse impact, for example if applicants are refugees or forcibly displaced people, or how their socio-economic status might affect things.

Do you have any suggestions about how any negative equality impacts you have identified could be mitigated?

Do you have any general comments on our proposals? Are there any other options, issues or obstacles we should consider?

Q11: Do you have any further comments to make about the proposals and information in the consultation?

How to respond

Please respond using our online platform

Whether you are a registrant, service user or are responding on behalf of an organisation such as a professional body, employer or trade union, we welcome your views on our proposals for English language proficiency requirements for international applicants. Your feedback will be used to develop the proposals before their final publication.

To respond to this consultation and find out more information please visit our website. We encourage responses from all interested parties.

This consultation will close at 23:59 on Friday 19 January 2024.

If you are unable to respond using the online platform, or would like a version in Welsh or in an alternative format, please email **consultation@hcpc-uk.org** or write to:

Consultations
Health and Care Professions Council,
Park House, 184-186 Kennington Park Road
London, SE11 4BU

Next steps

Following the consultation, we will analyse all responses and make any necessary changes to the proposals. Our Council will then discuss the revised proposals.

We will publish feedback on key themes from the consultation and outline any changes we have made along with the revised proposals. We will publish this report and any plans for change in Spring 2024.

Annexes

Annexe 1: **Draft Equalities Impact Assessment**

Data protection policy and privacy notice

Any information included in your response will be treated in accordance with our data protection policy and privacy notice, which is available in full here.