

# Consultation outcome: English language proficiency requirements for international applicants

Analysis of the consultation responses and our resulting decisions

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## **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 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 Patients Association focus group report.

## **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 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 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
		<b>answered</b>	<b>42</b>

### *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.

<b>Registered professionals</b>	<b>Number of registrants*</b>	<b>Number of responses</b>	<b>Response rate per 1,000 registrants</b>
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
<b>Total</b>	<b>339,205</b>	<b>346</b>	

\* 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 and 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:

<b>Where is your regular place of work or activity?</b>		
<b>Answer Choice</b>	<b>Response Percent</b>	<b>Response Total</b>
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
<b><i>answered</i></b>		<b>346</b>

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:

Age	All individuals		Registrant respondents		Non-registrant respondents		Register
	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%
<b>Total</b>	<b>484</b>	<b>100%</b>	<b>346</b>	<b>100%</b>	<b>138</b>	<b>100%</b>	<b>100%</b>

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.

Ethnicity	All individuals		Registrant respondents		Non-registrant respondents		Register
	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%
<b>Total</b>	<b>484</b>	<b>100%</b>	<b>346</b>	<b>100%</b>	<b>138</b>	<b>100%</b>	<b>100%</b>

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<sup>1</sup>. 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:

Sex recorded at birth	All individuals		Registrant respondents		Non-registrant respondents		Register
	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%
<b>Total</b>	<b>484</b>	<b>100%</b>	<b>346</b>	<b>100%</b>	<b>138</b>	<b>100%</b>	<b>100%</b>

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).

<sup>1</sup> UK Census 2021, Office for National Statistics:

<https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/bulletins/ethnicgroupenglandandwales/census2021> (retrieved 21 April 2024)

Does gender identity match sex recorded at birth?	All individuals		Registrant respondents		Non-registrant respondents		Register
	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%
<b>Total</b>	<b>484</b>	<b>100%</b>	<b>346</b>	<b>100%</b>	<b>138</b>	<b>100%</b>	<b>100%</b>

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”.

Disability	All individuals		Registrant respondents		Non-registrant respondents		Register
	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%
<b>Total</b>	<b>484</b>	<b>100%</b>	<b>346</b>	<b>100%</b>	<b>138</b>	<b>100%</b>	<b>100%</b>

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
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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%	
<b>Total</b>	<b>484</b>	<b>100%</b>	<b>346</b>	<b>100%</b>	<b>138</b>	<b>100%</b>	<b>100%</b>	

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.

Religion or belief	All individuals		Registrant respondents		Non-registrant respondents		Register
	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%
<b>Total</b>	<b>484</b>	<b>100%</b>	<b>346</b>	<b>100%</b>	<b>138</b>	<b>100%</b>	<b>102</b>

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.

Sexual orientation	All individuals		Registrant respondents		Non-registrant respondents		Register
	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%
<b>Total</b>	<b>484</b>	<b>100%</b>	<b>346</b>	<b>100%</b>	<b>138</b>	<b>100%</b>	<b>100%</b>

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.

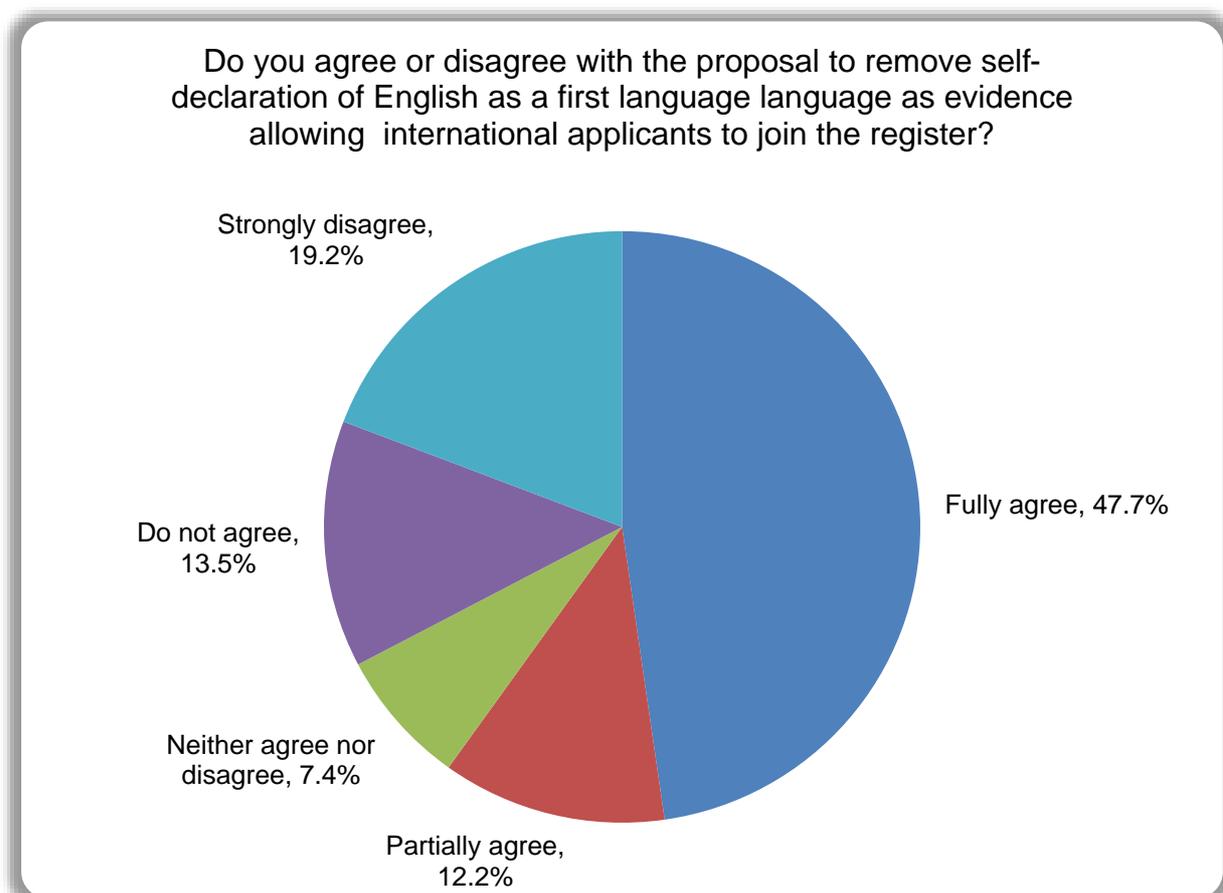
69. Because this consultation was open to the public, future applicants and registrants, we should be wary of drawing conclusions about under or over representation of specific groups. However, based on the responses to our Equality, Diversity and Inclusion (EDI) demographic questions, we have a reasonable 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 an 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**

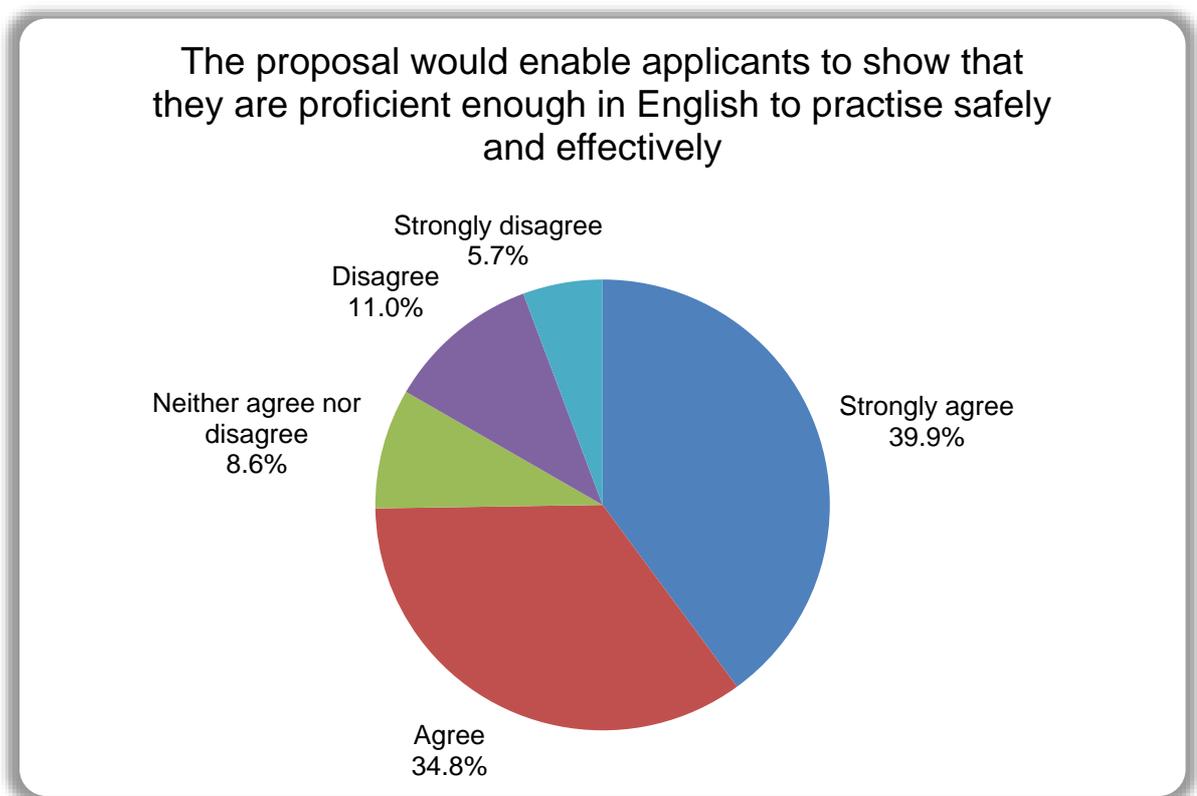
84. We note the overall agreement of consultation respondents with the proposal to end self-declaration. With increasing numbers of international applicants joining the register, we feel that now is an appropriate time to review our requirements, ensuring that the public can be confident that they are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

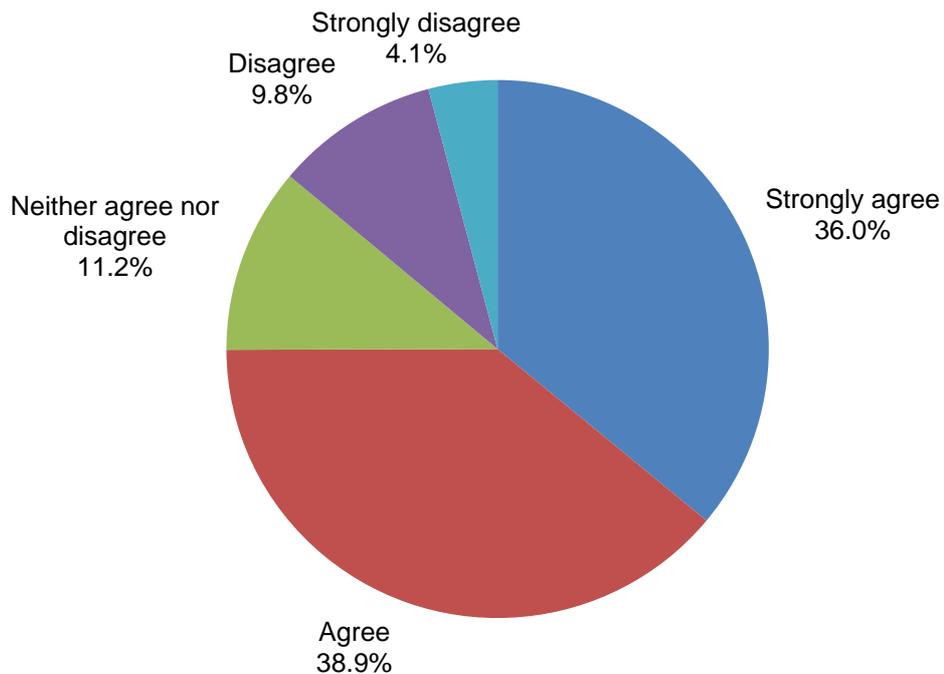


93. There were 511 responses to this question, with 15 participants deciding to skip.

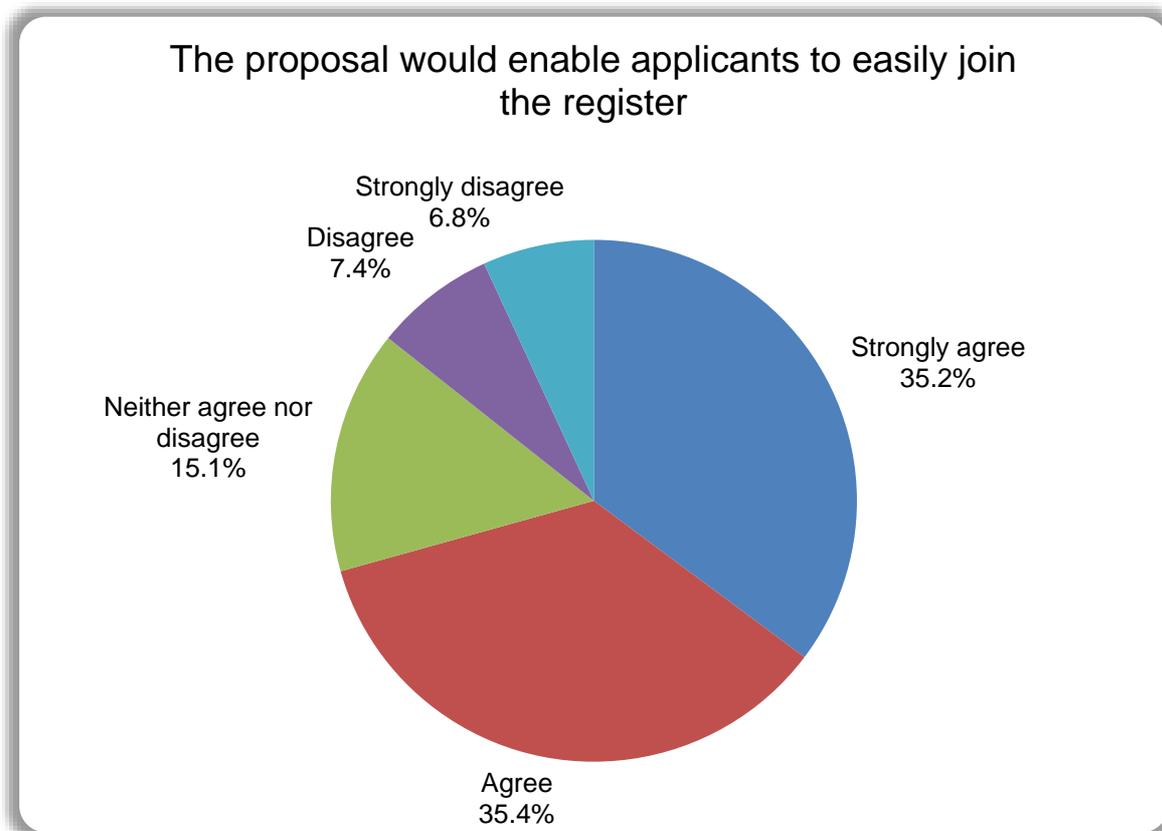
94. A majority agreed that the proposal would enable applicants to show that they are proficient enough to practise safely and effectively. 382 respondents answered “strongly agree” or “agree” (74.7%). Only 16.7% of respondents disagreed or strongly disagreed with the statement.

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

The proposal would enable applicants to feel confident in their own English proficiency

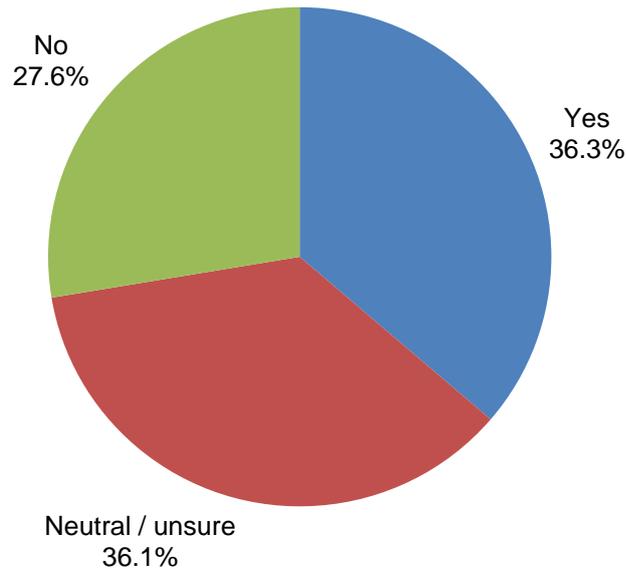


96. 511 participants responded to this question, with 15 choosing to skip.
97. This statement relates less to any immediate decisions arising from the consultation outcome. However, we felt that it would still be useful for us to have an idea of any effect the proposal might have on applicants should 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.

Would a 75% English speaking population be an appropriate test for countries to be on our qualifying list?



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.

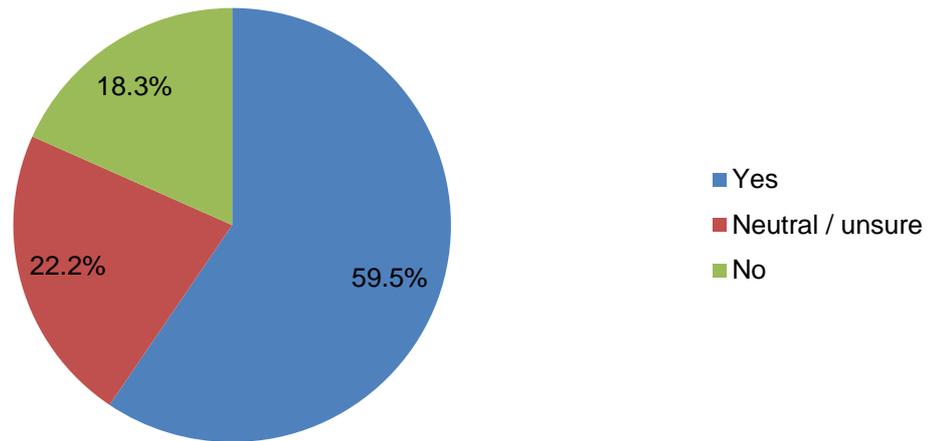
123. We also recognise the range of responses to our questions about the threshold for inclusion, and particularly the number of neutral / unsure responses received (at 36.1% of the total). To clarify, the threshold element is based on proportionate systematic risk management rather than providing absolute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

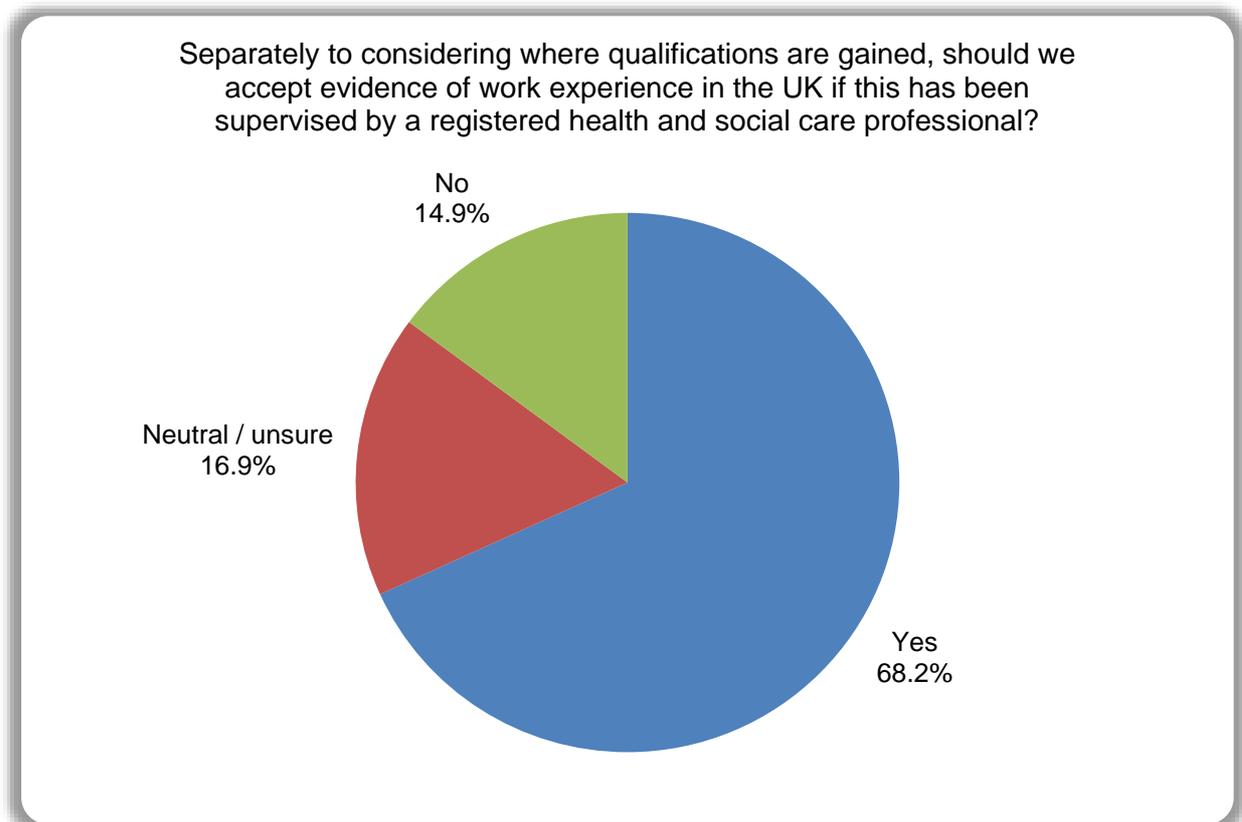
135. We proposed that applicants be able to demonstrate their proficiency by providing evidence of registered work experience in a qualifying country, or work experience in the UK which had been supervised by a HCPC registrant or another UK registered health or care professional.
136. In the consultation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

Separately to considering where qualifications are gained, should we accept evidence of registered work experience in a listed country where English is spoken by a majority as their first language?



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.

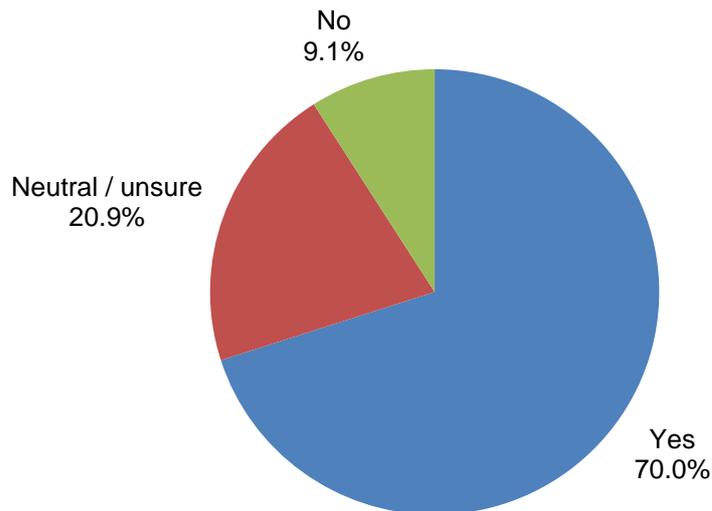
157. Even if we developed effective means to carry out this element of the proposal, we also heard from respondents to the consultation that colleagues of applicants are not necessarily well placed to objectively judge an applicant's proficiency in English. Our level of confidence that an applicant would 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 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**

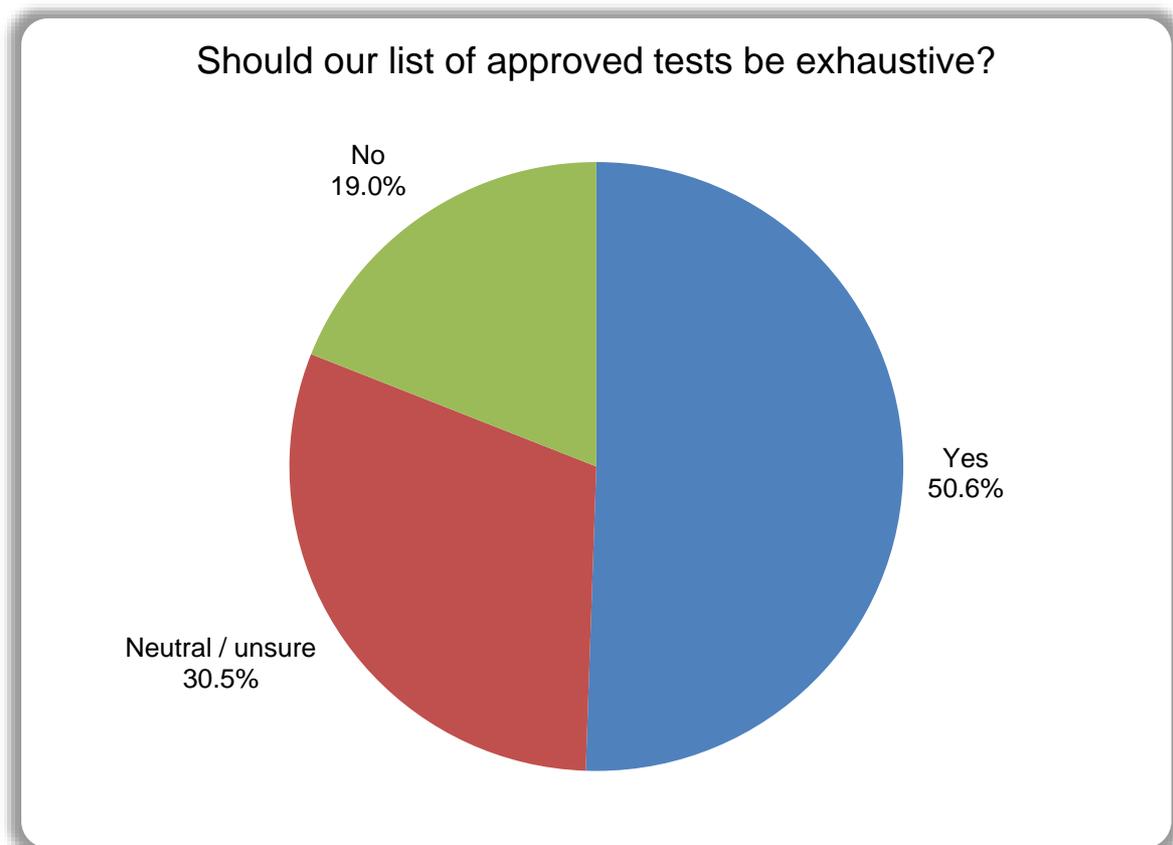
163. We asked separate questions about both elements of this proposal: one question (Question 6) asked if respondents agreed with expanding the list of approved tests, which was then followed by a question (Question 7) asking if they would recommend any tests in particular for approval. The next question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

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



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**

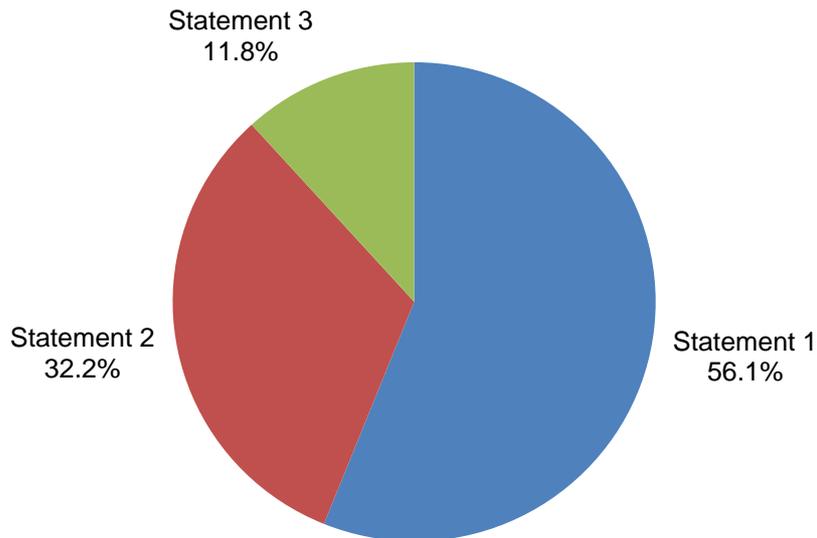
180. We asked respondents a question about the combined effect of our proposals by asking them to identify which of the below statements they most agreed with:

*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.*

Please tell us which of the statements you agree with the most:



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 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 eg 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 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 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 adaptations**

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: Patients Association report
- Annexe D: Consultation document