Title: Obtaining of information on driving licence holders and driving licence applicants from those other than registered medical practitioners

De-Minimis Assessment (DMA)

Date: 24/01/2022

Stage: Final

DMA No: DfTDMA231

Source of intervention: Domestic

Lead department or agency: Driver and Vehicle Licensing Agency (DVLA)

Type of measure: Primary

Other departments or agencies: Department for Transport

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Summary: Rationale and Options

Total Net Present Value	Business Net Present Value	Net cost to business per year (EANDCB in 2019 prices)
-£2.0m	-£2.0m	£0.6m

Rationale for intervention and intended outcomes

Driver and Vehicle Licensing Agency (DVLA) is required to investigate notifications of medical conditions from driving licence holders or applicants. A driver is asked to provide information about their condition, give details of the doctor who has at any time provided them with medical advice and attention for that condition, and provide DVLA with authorisation to approach a doctor for more information if needed as part of the investigation. In more complex cases, DVLA, with the consent of a driver or applicant, obtains medical information through medical questionnaires directly from an individual's doctor.

Currently, DVLA can only obtain (and pay for) questionnaires signed off by a registered medical practitioner, that is a doctor or consultant, who is licensed to practise with the General Medical Council (GMC) as defined by the Medical Act 1983. Often, the individual's treatment is managed by other healthcare professionals, within the system, but they are not able to sign off subsequent questionnaires. This increases the burden on all doctors through excessive bureaucracy and led to lengthy waits in processing applications. This affects individuals being able to obtain a driving licence. Amending the law to allow information to be provided through medical questionnaires, by the most appropriate registered healthcare professional involved in a patient's care, will reduce this burden and speed up the process for driving licence applicants or holders.

Describe the policy options considered

1. Do nothing. We would continue to only be able to accept information from doctors.
2. Change secondary legislation to amend the list of medical conditions that could undergo an examination to obtain information.
3. Change primary legislation to permit flexibility to use a registered healthcare professional instead of a registered medical practitioner.

Option 3 is the preferred option as it provides greater scope and clarity while minimising the delay to drivers. Option 2 does not meet the policy objectives, but is the only alternative, therefore has not been considered further.

Rationale for DMA rating

The proposal does have an impact on business, as the service currently provided by doctors is outside of NHS contracts and is regarded as private work for which a fee is due. However, this proposal does nothing to prevent a business from continuing with the status quo. What the proposal does is provide flexibility for a business to use as they see fit, allowing them to delegate work appropriately if required. Frequently, questionnaires will continue to be dealt with by doctors, but GP practices and hospital teams will also be able to have them signed off by other registered healthcare professionals, thereby reducing the burden on doctors, and speeding up the process generally. This impact would be considered indirect and is estimated as being below the £5m threshold.

Will the policy be reviewed? **No** If applicable, set review date:

Are these organisations in scope?	Micro	Small	Medium	Large
	Yes	Yes	Yes	Yes

Senior Policy Sign-off:	✓	Date:	03/05/2022
Peer Review Sign-off:	✓	Date:	03/05/2022
Better Regulation Unit Sign-off:	✓	Date:	24/01/2022

1.0. Policy rationale

Policy background

DVLA, acting on behalf of the Secretary of State for Transport, determines fitness to drive for holders of and applicants for driving licences in Great Britain. DVLA administers this statutory function on behalf of the Secretary of State for Transport, who is ultimately responsible for making the decision as to whether a driving licence holder or applicant meets the minimum medical standards for driving.

The medical licensing system is based on a 'self-notification' process and all drivers and licence applicants have a legal duty to notify DVLA of a medical condition that may affect safe driving. In some cases, DVLA will be able to make a licensing decision from the information received from the driver or applicant. However, further evidence may be required, with the driver's consent, from the doctor or healthcare professional involved with the individual's care.

DVLA may gather evidence about health conditions from the driver, their doctors and in some circumstances, commission driving assessments by other specialists. The largest source of expert medical information is collected through specially designed questionnaires completed by doctors, from information held on medical records. DVLA only has authority under Section 94 of the Road Traffic Act 1988 to request this information from a registered medical practitioner, that is a doctor registered and licensed to practise by the GMC.

Existing law does not reflect clinical practice. Some patients are primarily treated by healthcare professionals other than doctors, for example diabetes specialist nurses. Amending the wording of the legislation, to allow registered healthcare professionals other than doctors to also provide information through medical questionnaires, will give; individual GP practices and hospital teams greater flexibility and improve turnaround times. They will be able to decide who the most appropriate healthcare professional is, to provide the medical information needed, to allow DVLA to assess an individual's fitness to drive.

Problem under consideration

The existing law (S94 of the Road Traffic Act 1988) does not reflect current clinical practices. The time taken to gather and assess information, particularly in complex cases, can also lead to lengthy waits for those being assessed as other registered healthcare professionals cannot directly provide DVLA with the information required to assess fitness to drive. Amending the wording of the legislation to allow registered healthcare professionals other than doctors, who may be primarily responsible for managing certain medical conditions, to complete the medical questionnaires will ensure that information is provided by the most appropriate healthcare professional.

All applicants for a lorry or bus licence are required to undergo a medical examination to ensure they meet the minimum health standards to drive larger vehicles. The D4 examination process is not in scope of this proposal. The D4 examination report still needs to be completed by a doctor and paid for by the applicant.

Holders of, and applicants for, bus and lorry licences who declare a medical condition may need to be medically investigated outside of the routine D4 examination process. DVLA may be required to seek further information from their doctor, to be able to assess their fitness to drive in the form of medical questionnaires, following an authorisation given by the driver or applicant. The medical questionnaires relating to HGV licence applicants who declare a health condition are within scope for this proposal.

The proposal will provide greater flexibility to individual surgeries and hospital teams and may improve turnaround times, allowing DVLA to assess fitness to drive promptly. It also supports the Department of Health and Social Care (DHSC's) initiative of 'Reducing GP Bureaucracy'. Prior to the consultation, DVLA informally engaged with several representative bodies from the health sector and the devolved administrations, all of whom have been broadly supportive of the proposal in principle.

A consultation was carried out by DVLA between 8 November 2021 and 6 December 2021. The consultation responses back up the broad support for this proposal in providing flexibility around who can complete DVLA medical questionnaires. Most consultation responses came from members of the public, and around a quarter of responses came from those who are medical practitioners or healthcare professionals. Key feedback, from 411 responses:

- 56% came from members of the public and 44% from an organisation, medical practitioner, or healthcare professional
- nearly 81% of those who responded believed that the proposal would provide greater flexibility for GP surgeries and hospital teams in deciding who should complete questionnaires
- 69% of all respondents believe the proposal will improve efficiency in GP surgeries and hospital teams
- of those respondents who were or represented medical or healthcare professionals, 25% confirmed that other healthcare professionals in their surgery or team had already completed DVLA's questionnaires which then had to be signed off by doctors, the balance did not know. When asked whether they would use the new permissions if the proposal was implemented, 49% confirmed they would, while 17% of the balance stated no and 34% did not know

The proposal is not considered controversial, it has the support the Secretary of State for Transport, professional bodies within the health sector, and devolved administrations.

Rationale for intervention

Currently, medical questionnaires are required to be completed by a doctor who often is not primarily responsible for the management of such medical conditions. This is because information can only be received from authorised doctors, and it is only doctors who can be paid for the provision of that information. In most cases, medical conditions are managed by specialists, for example, a diabetes specialist nurse or general practice nurse, which may not meet the current criteria as set out in legislation, presenting the market failure of excessive bureaucracy which is creating inefficiencies in the system.

This causes issues leading to numerous individuals being involved in the completion of a medical questionnaire, including the direct specialists having to liaise with other practitioners like doctors to sign these questionnaires off to meet the criteria. In some cases where an individual has only been seen by another healthcare professional, the doctor will request that

the individual concerned makes an appointment so they themselves can carry out an assessment before signing off the medical questionnaire. This often leads to numerous individuals being involved to complete the questionnaire, often unnecessarily. Based on feedback from the consultation, around 66% of respondents either agreed or strongly agreed that the proposed approach would help alleviate bureaucracy within the NHS and its GP surgeries, while 19% disagreed and 15% didn't know.

Under the current approach, the time taken to provide evidence for complex cases can lead to lengthy waits for those being assessed. This increases the time and cost associated with those in the healthcare sector responding to questionnaires and ultimately delays individuals receiving confirmation that they are fit to hold a licence. Not only does this place the healthcare system under a period of strain because of the backlog created by the Coronavirus (COVID-19) pandemic, but also adds to the delay experienced by drivers moving through the driver licensing process. During the consultation, the Department asked for the reasons they agreed to the proposal, with 69% of respondents citing efficiency improvements in their responses.

Currently, an average of 267,080[1] medical questionnaires require completion by a GP or hospital doctor from medical records on a yearly basis.

Any increase in the number of professionals able to complete and sign off medical questionnaires, will help alleviate the bureaucracy and resource required to provide DVLA with information to assess fitness to drive.

Policy objective

The policy objective is to provide greater flexibility around who can complete the medical questionnaires and provides information that DVLA needs to assess if an individual with health conditions meets the appropriate health standards for driving. The intention is not to replace the role of doctors in the medical licensing process but to ensure that the most appropriate healthcare professional provides the appropriate information without having a doctor to approve it. It will be up to individual GP practices and hospital teams whether they change the way questionnaires are allocated for completion.

The aim is to reduce the burden on NHS doctors, increase operational flexibility for individual GP surgeries, which aligns with DHSC's aim to 'Reduce GP Bureaucracy', as well as improve efficiency and turnaround times for drivers. This will include professional drivers who are self-employed and those employed by the road haulage industry. Businesses may benefit from a faster turnaround providing more certainty and allowing more effective planning.

Options considered

Option 1 – do nothing

If the legislation is not changed to allow a wider pool of registered healthcare professionals to be authorised to provide information, DVLA will still need to obtain medical information but it will only be doctors who are able to complete medical questionnaires.

DVLA's medical caseload is increasing year on year and the number of cases requiring medical input is increasing as a result. The impact of 'do nothing' would be most acutely felt by doctors, GPs surgeries and hospital teams who will see more requests to complete questionnaires. The current legal requirements prevent GPs and hospital teams having the flexibility to administer their resources effectively to manage the conflicting priorities in clinical practice. The indirect time-saving benefits of having other registered healthcare professionals who can complete the questionnaires would be lost. We recognise that some surgeries

[1] This figure is based on an average of medical questionnaires sent over a 5-year period (2016 – 2021) to doctors for completion from medical records. Although the original volume of questionnaires quoted in the consultation paper was 445,500 this included examination and specialist report requests which are out of scope for this proposal.

and hospital teams will not be able change their processes due to the lack of availability or suitability of other health professionals in completing medical questionnaires.

Drivers are also likely to be impacted by potential delays to the decision on whether they can be licensed to drive where clinical care is prioritised over questionnaire completion. This option does nothing to improve the current waiting time associated with the completion of DVLA's questionnaires.

Option 2 – amend secondary legislation

We could amend The Motor Vehicles (Driving Licences) Regulations 1999 – Regulation 75, to add to the list of medical conditions where information could be gathered through a medical examination instead of through a questionnaire. The law allows the Secretary of State to appoint an appropriate person, possibly someone other than a doctor to conduct the examination. This is currently how DVLA refers drivers for a vision test or an on-road driving assessment.

This may reduce a resource burden on some doctors. However, if drivers are required to be examined this would require accommodation for the examination and the direct costs this incurs.

DVLA's costs would increase, as in most cases DVLA is responsible for paying not only the medical professionals cost, but also costs for the accommodation/facilities to undertake the examination. It is likely to have a negative effect on waiting times.

The requirement to undergo an examination would place a burden on drivers with health conditions. The gathering of data from doctors through medical questionnaire by DVLA has little effect on drivers and requires no effort from them.

If the driver was required to make an appointment and attend an examination this would place a burden on them. There is also potential that an examination would take longer to arrange and so increase the time a driver waits for a licensing decision. This option is therefore not recommended as it does not meet the policy objectives.

Option 3 – amend primary legislation

Amending the legislation to enable a 'registered healthcare professional', for example a specialist nurse practitioner or specialist and specialist nurse consultant to complete DVLA medical questionnaires will provide greater flexibility to GP surgeries and hospital teams around how they manage these requests. It will also remove the requirement that the medical professional referred to in the authorisation must have at some time given medical advice or attention to the driver or applicant, allowing any healthcare professional with the appropriate access to medical records, to complete DVLA medical questionnaires.

This is a permissive change and costs, and benefits will only be experienced by those GP surgeries and hospital teams who choose to change the way that they currently deal with medical questionnaires from DVLA. We believe most of the costs will be one-off costs that will be experienced as a result of the transition to a new way of working. These indirect costs will be around the time taken to familiarise staff who administer the allocation of DVLA medical questionnaires and those who have not previously completed questionnaires who will be able to.

DVLA will see a small cost in familiarising staff with the new rules around who can complete questionnaires. There will also be a small cost in amending wording included in questionnaires that capture the treating healthcare professional's details and in amending the covering letter sent out with the questionnaires that currently advise that they cannot

be completed by anyone other than a doctor. These amendments will be made to system produced questionnaires and letters so there will be no stock wastage to consider.

Option 3 is the preferred option in terms of amending the legislation. While option 2 would reduce the burden on doctors, it would place an added time and cost burden on drivers. Option 3 would provide greater flexibility and remove an unnecessary burden while maintaining at least an equivalent quality of service, which has been evidenced throughout the consultation responses.

Some recurring themes in response to the consultation.

1. Nurses and other healthcare professionals have the knowledge and skills to complete questionnaires.
2. That health professionals are already completing the medical questionnaires and get a doctor to countersign it.
3. The pressure on GPs, including because of the pandemic, means that medical questionnaires cannot be prioritised.
4. Having more professionals able to complete the questionnaires will benefit those waiting for a DVLA decision.
5. The proposal will reduce the burden on doctors.

2.0. Rationale for de-minimis rating

The proposal does have an impact on business as the service currently provided by doctors is outside of NHS contracts and is regarded as private work for which a fee is due. However, this proposal is optional and does nothing to prevent a business from continuing with the status quo. What the proposal does is provide flexibility for a business to use as they see fit, allowing them to delegate work appropriately if required.

There is no significant distributional impact as we are using established and existing business to provide the information and there is no transfer of responsibility to business other than those in the healthcare profession. We do not expect a disproportionate burden on small healthcare businesses within the wider healthcare profession as the status quo will be maintained in that the work will be completed in house by whoever that business decides to allocate it to.

We do not envisage that the potential small indirect positive and negative impacts on individual businesses would lead to a significant overall impact on the primary care sector. The potential savings and costs are extremely small because individual businesses can decide whether they want to use the increased flexibility or maintain their current business processes.

When the changes become established practices, there could be some small individualised social, environmental, financial, or economic impacts. However, these would not be significant and would be considered as indirect, thus not affecting the de-minimis rating. Furthermore, many of the benefits are to the drivers and the businesses employing them, the first of which would be an impact on society and the second would be an indirect impact on businesses which are out of scope of the de-minimis threshold.

We do not anticipate any impact on GP surgeries and hospital teams in terms of increased costs. However, it would be expected that there would be indirect time-saving benefits as more specialised healthcare professionals can complete the medical questionnaires rather than doctors. The benefit will be the difference in the cost of the service (that is, cost of doctors' time minus cost of specialist nurses time). However, this indirect benefit is estimated

at around £0.45m per year. Even if this were to be considered direct it would require a significantly higher benefit to breach the de-minimis threshold.

As some of the medical questionnaires are currently being completed by other healthcare professionals but signed off by a GP, it could be inferred that existing regulations are holding those businesses back as additional steps are taking place to comply with the permissions as they are currently set out. If this is the case, some element of the indirect costs would be direct instead. However, when considering that the familiarisation costs and benefits set out below would instead be direct, this in fact lowers the equivalent annual net direct cost to business from £0.6m to £0.5m, as the expected costs of familiarisation outweigh the benefits from this change.

Therefore, the overall expected impact on businesses is expected to be below the £5m per year threshold given most of the impacts are indirect and small in nature. Even if the impacts were deemed as direct, this would not change the de-minimis categorisation nor move us closer to the threshold.

3.0. Costs and benefits

Unless otherwise mentioned, the analysis presented in this section was done in 2020 prices.

Summary

Costs and benefits have been estimated for option 3 only, as option 2 would not meet the policy objectives of this change and has been excluded from the analysis. The 'do nothing' option remains the comparator for option 3 to represent the counterfactual of no regulatory change.

Monetised costs

- Familiarisation costs would be experienced by all healthcare organisations currently undertaking assessments. This would be in the form of the amount of time it takes for a senior member of the organisation to decide whether there is a more appropriate healthcare professional to provide information.
- For organisations deciding to make use of other registered healthcare professionals we expect there to be training costs to ensure all staff involved understand how to fill out the medical questionnaires correctly. We invited feedback from the consultation to monetise this impact.

Unmonetised costs

- There will be some small costs to DVLA to familiarise staff with the changes which have been omitted from the analysis.
- Further potential costs on businesses were explored during the consultation but none were identified.

Monetised benefits

- Where GPs' surgeries and hospital teams implement the changes, we believe there may be indirect cost benefits to the business based on the cost of doctors' time against the cost of other medical staff, for example specialist nursing staff. This will apply to both the organisations who currently use other healthcare professionals with sign off from a GP and those who do not that will realise these efficiency benefits.

Unmonetised benefits

- Some impacts on society were identified during the consultation. For example, lower costs for DVLA processing, a speedier and more accurate process for drivers and the businesses employing them. However, given their indirect nature these have been excluded from the analysis based on proportionality.
- We expect that there may be administration benefits for GP surgeries and hospital teams as there may be less follow up contact from DVLA by way of reminders and medical questionnaires that need to be returned to be completed and signed by a doctor.
- No further unmonetised benefits to business were identified throughout the consultation.

Costs

Transition costs

DVLA implementation costs

- There will be no additional cost for implementing any new initiatives as this is part of the roles and responsibilities of existing employees within the Change Management Teams in Drivers Medical and Service Management at DVLA. They will ensure any new changes are implemented using DVLA's well established change processes. This initiative would form part of their work portfolio and will be prioritised appropriately and at no additional cost.

Familiarisation costs

- We expect some costs associated with surgeries and clinics familiarising themselves with the new regulation before deciding whether this is a worthwhile pursuit. Doctors who are authorised to provide information themselves may decide not to pass on the authorisation to another healthcare professional. All businesses would be in scope of such costs but those who decide against passing on the authorisation will not be subject to further costs nor benefits.
- We would reasonably expect the person who would be seeking to understand the regulatory change would be the head of a GP surgery or clinic, making the decision of whether to pass the authorisation to another healthcare professional, on behalf of the organisation. We have used the Business, Energy, and Industrial Strategy (BEIS) population estimates, using code 862, which covers both medical and dental practice activities, estimates on the number of businesses are below. Although dental practices are not in scope here, the estimates aren't disaggregated further than this, so this represents an overestimate on the total familiarisation costs[2].

[2] www.gov.uk/government/statistics/business-population-estimates-2021

- For simplicity, we have assumed that this individual would be a single medical practitioner (GP) from a surgery and the time associated with their review would be the extent of the familiarisation costs. These costs have been uprated to include the non-wage labour uplift (NWLU) which would be experienced by the business, as described in TAG A4.1[3]. We have assumed that the time associated with reviewing the legislation would be three hours, based on similar regulatory changes made in DVLA and Driver & Vehicle Standards Agency. This is likely to be a conservative estimate as many of the businesses would already be familiar with the requirements placed upon them and the change being made is simple and clear in nature. Also, affected organisations have been consulted throughout the process.

(1)	Total number of reviewers (1 per business)	24,005
(2)	Hourly pay (Medical practitioner)	£30.99
(3)	Non-wage uplift	26.5%
(4)	Uplifted hourly pay	£39.20
(5)	Hours taken to review	3
(6) = (1)*(4)*(5)	**Total cost (one-off)**	**£2,823,157.24**

- We therefore expect that based on these conservative assumptions there would be around £2.82m direct costs to businesses from familiarising themselves of the change, which would be considered a one-off transition cost.

[3] The non-wage labour uplift (NWLU) captures the costs of employment experienced by the business that are not covered by the salary costs, this includes elements such as national insurance and pension contributions from the employer. Further guidance available in **TAG A4.1.**

Training costs

- There are expected to be some costs associated with surgeries and clinics training their members of staff to undertake the new activities that the regulation now grants. This would include notifying them of the change, training them on how to fill out the forms correctly and the processes that are required of them to undertake. These costs would only apply to those businesses making use of the option to authorise other healthcare professionals to provide information and based on the consultation responses 58% of businesses responding suggested they would make use of the change. This is likely to be an overestimate. As indicated during the consultation, some practices and professionals already use other healthcare professionals to fill out these forms and the training costs might be lower in these instances.
- Prior to the consultation we lacked suitable evidence on the extent of these costs as it depended on the staff involved in both giving and receiving the training. Instead, it was deemed more proportionate to explore these costs during the consultation. When asked during the consultation about extra anticipated training costs because of this change, 38 responses were received from medical organisations with a median response of £500 per organisation. This allowed us to estimate the anticipated level of training costs, summarised below:

(1)	Total number of businesses	24,005
(2)	Average training costs per business	£500
(3)	Percentage of businesses utilising the change	48.5%
(4) = (1)*(2)*(3)	**Total cost (one-off)**	**£5,821,212.50**

- Therefore, we anticipate that based on the responses to the consultation this would impose costs of £5.82m to businesses making use of this change, with some businesses already using a similar process meaning this impact is likely an overestimate. Given that businesses can make the decision to offer this service and therefore experience the training costs, these are deemed as indirect costs to business.

On-going costs

- We do not believe that there will be ongoing costs associated with this proposal. DVLA will not be sending any more questionnaires for completion and propose to pay the same fee regardless of who completes the questionnaire.

Unmonetised costs

- There will be some small costs to DVLA to familiarise staff with the change as they will no longer have to return questionnaires completed by the other healthcare professionals. These have not been monetised as they are costs to the public sector and deemed disproportionate as they do not affect the de-minimis rating.

- During the consultation with industry, we sought to improve the evidence base on familiarisation and training costs. We further sought clarification on wider costs that would be experienced by businesses but no further costs to business were identified. There was some mention of increased costs or fees for this service which would be paid by drivers submitting their applications mentioned during the consultation. Given the de-minimis nature of this change, it was deemed disproportionate to monetise these impacts as the indirect impact on business would be nil as the charge would reflect the costs imposed.

Benefits

Efficiency benefits

Where GP surgeries and hospital teams decide to allow other registered healthcare professionals to provide information, we believe there may be indirect cost benefits to the business. This is based on the cost of doctors' time against the cost of other medical staff, for example specialist nursing staff. When monetising the benefit, there are two effects to consider:

- those who currently benefit from using alternative healthcare professionals to undertake their assessments (yielding some benefit already compared to the counterfactual)
- those businesses who do not currently outsource these and are conducted fully by GPs in the counterfactual

Prior to the consultation we lacked suitable evidence to allow us to present the expected impacts from the efficiencies that this change could present:

- time saved
- healthcare professionals involved
- extent this change would be utilised

Following the consultation, we were able to obtain information to help us produce more robust assumptions for use within the analysis:

- 79 organisations responded to the question on the average time taken to complete a medical questionnaire, which yielded a median result of 20 minutes
- 28 organisations who responded that other healthcare professionals already complete the assessment before seeking sign off from a GP suggested this is the case for a median of 37.5% of assessments (this represents 25% of organisations responding)
- 104 organisations responded to the question on whether they would make use of these permissions (58% of organisations) and indicated that a median of 70% of assessments would be undertaken by other healthcare professionals rather than a GP – higher among those responding who already use at an average of 75%
- some qualitative responses received during the consultation suggested that nurse practitioners and consultants responding to the assessments could be earning higher than the average hourly pay mentioned below, so we have indicated a further sensitivity on higher hourly earnings for this category

- Using the information gathered above we can determine that there is expected to be a 37.5% increase (75% minus 37.5%) in the number of assessments for those currently using other healthcare professionals to do the majority of the assessments. Meanwhile, for the overall level of assessments for those businesses who will use other registered healthcare professionals to provide information, would see an increase of 70% of assessments. This assumes that the number of questionnaires completed by responding organisations are equal which is an assumption necessary in the absence of further evidence. Those making use of the permissions may undertake more assessments than those who do not, providing the incentive for using the permissions granted, potentially understating the impacts.
- Furthermore, we know that currently on average there are 267,080 questionnaires completed per year and using the figures obtained from the consultation, this equates to around 23,794 completed by other professionals but signed off by GPs before the change.

User type	Net increase in assessments	Amount of assessments conducted before change	Amount of assessments conducted after change
Current Users	37.5%	23,794	47,587
New Users	70%	0	43,086
Total	–	23,794	90,674

- Based on the objectives of this change, we have used wage estimates from the Office of National Statistics annual survey of hours and earnings (ASHE)[4], applying the non-wage labour uplift (NWLU) of 26.5% to determine the differential in wage costs which form this benefit. The difference in pay which is used to monetise the cost savings to healthcare organisations is set out below:

Healthcare Professional	Hourly pay	NWLU	Total Hourly pay	Time taken per questionnaire	Cost per questionnaire
Medical practitioners (doctor)	£30.99	26.5%	£39.20	20 minutes	£13.07
Specialist nurse	£19.31	26.5%	£24.43	20 minutes	£8.14
				Net Difference	**£4.93**

- The net difference in pay calculated above can then be applied to the number of questionnaires that would be in scope of being completed by an alternative professional. We have assumed these would be specialist nurses at the wage above but based on the 80th percentile data for nurses (£29.46 after NWLU) we have included a sensitivity case of lower benefits, with a net difference of £3.25.

[4] Annual Survey of Hours and Earnings (ASHE) data is available **here**

User type	Total assessments per year	Cost saving per assessment		Cost saving per year	
		Central	Low	Central	Low
Current users	47,587	£4.93	£3.25	£234,371	£154,509
New users	£19.31	£4.93	£3.25	£212,202	£139,894
Total	**90,674**	**–**	**–**	**£446,574**	**£294,402**

Based on the analysis above we would reasonably expect the benefits relating from efficiency savings to be around £0.45m per year, with a lower bound estimate of £0.29m based on feedback from the consultation. Further efficiencies may arise which aren't captured in these estimates from being able to conduct assessments quicker, carry out more of them or if the cost savings were greater, which would indicate greater benefits. Conversely, if the number of assessments conducted were lower than presented this would reduce the benefits but the likelihood of this is expected to be low given the flexible nature of the change.

Unmonetised benefits

There may be indirect monetised benefits for drivers with health conditions as having a wider pool of people who can complete questionnaires may mean that waiting time for questionnaire completion is reduced and DVLA can make a decision sooner as a result.

During the consultation some benefits to society were identified, including introducing a speedier and more accurate process for medical investigations to occur which would benefit the driver's seeking assessments and benefits to road safety through removing riskier drivers from the roads quicker.

However, given these would impact the public sector and have no bearing on the de-minimis rating this was deemed disproportionate, and no further analysis was conducted.

We expect that there may be administrative benefits for GP surgeries and hospital teams. There may be less follow up contact from DVLA with reminders and rejections of medical questionnaires not completed by a doctor. We sought evidence on this during the consultation which did not yield any suitable evidence to quantify or monetise these benefits. Given this impact would be indirect, it was deemed disproportionate to investigate further as it would have no bearing on the de-minimis rating.

Business impact target (BIT) calculations

Given the optional nature of this proposal only the direct impact on business in the form of familiarisation costs have been included in the BIT calculations. The indirect impacts on business in the form of training costs and familiarisation benefits were included but are considered indirect given business will decide to incur these impacts due to the flexibility of the regulation.

A sensitivity case for a low scenario has been included which captures potentially lower efficiency benefits received by businesses as a result of the change. A high sensitivity has not been included due to not being able to measure an appropriate high value for these benefits. It has been deemed disproportionate to include a sensitivity case on the transition costs, so they have been held constant.

Sensitivity analysis

Given the de-minimis nature of this assessment, limited sensitivity analysis has been conducted. A range has been presented based on feedback from the consultation on the anticipated business benefits, however these are considered indirect and do not contribute to the de-minimis rating.

Risks and unintended consequences

We do not believe that there are a great deal of risks and unintended consequences relating to this proposal, as the change adds flexibility to a current process. GP surgeries and hospital teams can embrace the change as much or as little as they want or need. This change will help free up their time to focus on core activities and delegate to the most appropriate staff members – sentiments which were picked up during the consultation.

Questionnaires are designed to be completed from medical records. Registered healthcare professionals with access to the medical record and training to understand the medical record should be able to complete a questionnaire. There is a small risk that relevant information may not be provided by a specialist as they may not have a full generalist view of a driver's health. However, the questionnaires sent out are medical condition specific, for example, if a driver has both diabetes and a heart condition a separate questionnaire is needed for each condition. However, doctors can provide an objective view in cases of comorbidity that is, where there is a simultaneous presence of two or more diseases or medical conditions in a patient.

An unintended consequence of the proposal could be that the other healthcare professionals are disproportionately impacted by paperwork. We believe that this would be beyond our control as the allocation of medical questionnaires will be entirely up to GPs surgeries or hospital teams who we intend to provide the flexibility to manage DVLA's requests as best suits their needs.

A potential risk identified during consultation and noted by nearly 3% of responses (mainly from members of the public) would be lowering standards and increasing errors which may compromise road safety. While the change seeks to offer flexibility, we would expect delegation to be thoroughly considered and done to mitigate potential risks of unfit drivers passing their assessment. However, if this transpires then it may introduce a risk to road safety as individuals with health conditions deemed unfit may be able to drive. Given the relatively low risk of this, it has not been deemed significant enough to quantify or monetise within this assessment.

A potential risk and cost are indemnity insurance cover for general practice. From 1 April 2019, NHS Resolution has been operating a new state-backed indemnity scheme for general practice in England called the Clinical Negligence Scheme for General Practice (CNSGP). Everyone working in general practice and NHS services will automatically be covered by CNSGP.

CNSGP does not cover non-NHS work and GPs may need to clarify with their indemnity provider what cover is included for GPs and ancillary staff in providing this service. It may be necessary for these individuals (for example specialist nurses) to obtain cover for professional representation and additional indemnity cover for any private work they undertake on behalf of the practice.

It is not known at this stage what additional costs GPs and other healthcare professionals may incur in indemnity cover. While many respondents have offered a figure for indemnity costs these vary widely from £100 to £50,000. Some respondents suggest that the cost of cover will depend on the number of questionnaires completed. Indemnity is clearly a concern and a question over whether the individual healthcare professional will be responsible or their employer or if there would be tax implications for the healthcare professional. It is also suggested that indemnity schemes may not indemnify questionnaire completion as this is considered a high-risk activity. We have no evidence that this is the case as DVLA is responsible for making licensing decisions.

Wider impacts

Equalities impact assessment

DVLA is an Executive Agency of the Department for Transport. We register vehicles for the UK and issue licences for drivers in Great Britain, and where necessary conduct enquiries into the medical conditions of drivers.

All licence holders and applicants are entitled to protection from unlawful discrimination under the Equality Act 2010 in relation to the following ‘protected characteristics’:

- age
- disability
- gender reassignment
- pregnancy and maternity (which includes breastfeeding)
- race
- religion and belief
- sex
- sexual orientation
- marriage and Civil Partnership

DVLA recognises the importance of driving and holding a driving licence and the equality of opportunity to do so. All licensing decisions consider the impact of medical conditions and disabilities in the context of safe driving, the legislation and DVLA’s statutory duties.

DVLA has not been able to identify any evidence that the proposal discriminates against any of the 'protected characteristics' relevant to equality duties. Overall, the proposed measures reduce waiting times and lessen any discrimination associated with the questionnaire process. DVLA is satisfied decisions made:

- impact in a fair way
- are based on the available medical evidence
- is transparent

We continue to work in partnership with patient groups, medical practitioners, and stakeholders to collaborate and co-ordinate on the current medical standards for driving.

	Positive Impact	Negative Impact	Neutral Impact	Reason
Age			X	No impact
Disability			X	No impact
Gender reassignment			X	No impact
Pregnancy and maternity			X	No impact
Race			X	No impact
Religion and belief			X	No impact
Sex			X	No impact
Sexual orientation			X	No impact

Small and Micro Businesses Assessment (SAMBA)

As per the impact assessment, the main impacted group are GP surgeries who currently deal with the medical questionnaires who may delegate to other healthcare professionals should they decide to. Under the Regulatory Policy Committee (RPC) guidance, GP surgeries would be considered as a business and would be in scope of a SAMBA.

Based on the Business Population Estimates[5], using code 862, which covers both medical and dental practice activities, estimates on the number of businesses are below. Although dental practices are not in scope, estimates are not disaggregated further, so overall percentages will be used for this assessment (and assumes they are proportional between medical and dental practices).

[5] www.gov.uk/government/statistics/business-population-estimates-2021

862 Medical and dental practice activities	Number of businesses	Employment (percent)	Businesses (percent)
Micro (1-9 employees)	15,555	22.6	64.8
Small (10-49 employees)	7,935	55.2	33.1
Medium (50-249 employees)	485	12.5	2.0
Large (250 or more employees)	30	9.7	0.1
Total	24,005	100	100

Based on information shown in the table above, around 98% of the businesses are within the small and micro businesses category. This accounts for 78% of those employed in the sector. While this may be skewed by smaller dental practices, included in this category, there are no further disaggregations available.

This information shows that small businesses (GPs) are likely to be disproportionately impacted by the measure. However, given the nature of the regulatory change, it is expected to reduce the burden associated with answering the medical questionnaires. Responding to questionnaires can be delegated to other specialist healthcare professionals, and they will receive benefits in doing so. While there might be some additional familiarisation costs or burden, in line with the analysis undertaken, the overall impact is expected to be beneficial to businesses. This change allows those in scope to continue with their current working practices if they choose to, resulting in no costs or benefits. Businesses are only likely to implement the change that this proposal will facilitate into their working practice when they assess that benefits outweigh the costs. On this basis we do not propose to allow any exemptions for small and micro businesses.

Based on feedback from the consultation, it is anticipated that around 41% of small and micro businesses would make use of the change compared with 58% of businesses that are medium and large. This could be indicative that there is a barrier to small businesses in making use of the change, and this is likely due to not being able to make use of it (by not having any alternative staff) or not going to make use of the change. However, given the nature of the change this policy only creates additional flexibility to use alternative healthcare professionals where possible and small businesses are only likely to make use and indirectly benefit from this should the benefits in doing so outweigh the costs, and would be no different to the counterfactual.

Trade impact

The proposals do not impact on reciprocal recognition or exchange of EU member states or reciprocal licence exchange of designated countries.

4.0. Post implementation review

1. Review status: Please classify with an 'x' and provide any explanations below.

☐ Sunset clause	☐ Other review clause	☐ Political commitment	☐ Other reason	☐ No plan to review

Statutory review not required.

2. Expected review date (month and year, xx/xx):

/ Five years from when the Regulations come into force

3. Rationale for PIR approach:

Rationale for not conducting a PIR:

A PIR is not required as the overarching minimum health standards are still applicable. All licence holders and applicants must meet the standards, specified in law, and holders of driving licences and licence applicants must inform DVLA at any time of a medical condition that may affect safe driving.

The proposal to amend the law in no way affects DVLA's statutory requirement to investigate the impact of a medical condition on safe driving. The proposal only impacts on the administrative means of obtaining relevant medical information from healthcare professionals.