Driver & Vehicle Licensing Agency

Driver Services

Summary:
Post-Implementation Review (PIR) of the Motor Vehicles (Driving Licences) Regulations 2011

Interactive document
April 2017

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Title: Review of The Motor Vehicles (Driving Licences) Regulations 2011 SI No. 2516	**Post Implementation Review**
IA/PIR No: IA No. DFT00010	**Source of intervention:** European
Lead department or agency: Driver & Vehicle Licensing Agency	**Type of regulation:** Secondary Legislation
Other departments or agencies:	**Type of review:** Statutory
Contact for enquiries: Mark Davies: 01792 783981	**Date of implementation:** 15/11/2011
	Date review due: November 2016

Summary

1a. What were the policy objectives and the intended effects? (If policy objectives have changed, please explain how).

The regulations are designed to maintain road safety standards in respect of people who have diabetes, whilst allowing them to drive if their condition is adequately controlled. This requires an on-going balance to be struck between road safety expectations and expert medical opinion, which is constantly evolving in light of scientific advances and improved treatments – implemented through longstanding domestic and European legislation. Annex III of the 2nd European Directive, which came into force on 1 January 1997, specified the principles for the minimum medical standards required for driving and these are transposed into UK law. The directive has the additional wider purpose of setting common standards so that licences can be mutually recognised across the European Union.

The European Commission's Driving Licence Committee considered amendments to the standards and, in 2009, it adopted revised minimum medical requirements in the form of directives: 2009/112/EC and 2009/113/EC ("the medical directives") that came into force on 15 September 2010. The regulations updated UK law to meet the revised standards and to comply with our compliance obligations under mutual recognition. The review clause was made in respect of Regulations 2 and 3 of the 2011 amending regulations and not the parent legislation.

The regulations made four changes to the minimum medical standards for driving with diabetes. Three of the changes raised the minimum standards required to drive, and the fourth relaxed the rules on the requirements for the licensing of vocational (Group 2) lorry and bus drivers. It was not the primary purpose of the new rules, but it was a logical expectation that, where the standards were raised, more people would be refused a licence, and where the standards were made less onerous, more people would be allowed to drive.

The new rules were not designed to achieve any numerical targets in terms of road safety or the number of people who would be allowed to drive or refused entitlement to drive. The figures in the impact assessment that supported the regulations in 2011 were estimates of the possible trends that could ensue and were not intended as a policy objective.

1b. How far were these objectives and intended effects expected to have been delivered by the review date? If not fully, please explain expected timescales.

The principles of the directive were transposed into UK law through the regulations, which came into effect on 15 November 2011. At the same time, DVLA issued amended guidance – the 'At a glance guide to medical practitioners', and informed key stakeholders. The regulations, and their impact on individual cases, became effective on receipt of licence renewal applications or notification of the condition from licence holders. In the former this would have fully taken effect within three years of the amending regulation coming into force as those with the condition would have only been licensed for a period of not less than one year and no more than 3 years. Drivers notifying the Secretary of State of the condition will fall within the requirements with immediate effect. Consequently, the effects of the regulations are expected to have fully materialised at the time of this review.

2. Describe the rationale for the evidence sought and the level of resources used to collect it, i.e. the assessment of proportionality.

This PIR has been conducted on the basis of a low level of evidence.

In assessing the level of evidence that would be considered proportionate, the agency considers that the regulations are low risk and likely to have a low impact. This is because they represent a relatively minor adjustment to existing measures that were already designed to ensure that people with a diabetic condition were only allowed to drive if there was reasonable confidence that they were safe to do so. The changes were not expected to result either in a significant number of people losing or regaining their entitlement to hold a licence. The regulations merely sought to apply the latest thinking of medical experts in Europe as well as those in the UK sitting on the Secretary of State's Honorary Medical Advisory Panel, in reaching a fair decision in each individual case.

3. Describe the principal data collection approaches that have been used to gathering evidence for this PIR.

DVLA has not collected bespoke data to measure the actual impacts of the regulations against the estimates set out in the impact assessment. It was never the intention of the directive or the subsequent regulations that there would be particular numbers of people who would be, or not, allowed to drive as a result of the changes. Therefore, some subjective analysis was undertaken in conjunction with stakeholder consultation to confirm the broad understanding that the regulations have implemented the directive effectively. This review appears to show this, although this is based on a low level of evidence and through a similar level of official and stakeholder resource.

A small team from the DVLA Strategy, Policy and Communications Directorate was allocated to conduct the review with some occasional support from Business Support Teams and Analytics Team.

The DVLA has some data showing the number of licence applications refused on the basis of a diabetic condition and has also conducted informal analysis of ministerial and official correspondence. To provide figures for refused applications DVLA could only estimate the totals based on the condition specific medical casework records collated by the Drivers Medical Business Support Unit.

DVLA consulted with the key organisations representing diabetic drivers, Diabetes UK and The Independent Diabetes Trust, as well as road safety lobbyists and industry groups; the Freight Transport Association, the Road Haulage Association and the Confederation of Passenger Transport. Views were also sought from a selection of Member States (Germany, Netherlands and Sweden). All engagement was through email and attached explanatory letters. Original engagement was followed by reminder letters. Responses were received from only three of the key stakeholders (Diabetes UK; the Independent Diabetes Trust and the Road Haulage Association) and from the licensing authorities in Germany and Sweden. These latter responses were limited to how they had transposed the directive into their respective domestic legislation and administrative procedures.

4. To what extent has the regulation achieved its policy objectives? Have there been any unintended effects?

The regulations are considered to have achieved their objectives, although one unintended effect has been identified and has been addressed. (see last paragraph).

Impact on driver licenses

It was anticipated that the regulations would lead to some people being refused a licence where the medical standards for driving were raised, whilst some people would become able to drive where standards were made less onerous (although affecting the number of people able to drive was not an objective of the regulation). DVLA records show that in 2010 (pre November 2011 when amending regulations came into force) 113 applications were refused. In subsequent years the number of refusals were as follows:

2011	515
2012	1,199
2013	864
2014	694
2015	811
2016	558

This indicates that the numbers of drivers impacted by the regulations were broadly in line with the estimates made in 2011. The Impact Assessment (IA) of July 2011 predicted that 706 to 1,410 drivers may lose entitlement.

Implementation of the regulations

Administrative implementation was restricted to amendments to internal staff work guidelines, staff training, updated DVLA literature, application forms and the 'At a Glance' guide to medical practitioners. The level of official correspondence concerning the impact of the changes was low. Both the DVLA customer contact centre and business areas have reported little or limited feedback from customers relating to the changes, which might suggest an understanding of the new requirements as a result of successful communication of the changes to our customers and stakeholders.

Impact on road safety standards

Whilst it is virtually impossible to measure the extent to which the outcomes of individual decisions on drivers' fitness to hold a licence might have improved overall road safety standards, DVLA and other stakeholders do remain alert for cases where the failure of existing medical standards and safeguards might be highlighted by individual cases. In that respect, these regulations have not resulted in any evidence that road safety has been compromised. Inevitably, there have been cases where people have had licences revoked, and others where people have been able to resume driving. Each of those people will have their own views as to the merits of the decisions reached.

Official correspondence and dialogue with key stakeholders and EU counterparts suggests that the legislation has met its broad objectives in maintaining confidence in road safety standards across Europe, as well as facilitating the free movement of drivers. The DVLA received responses from both Diabetes UK and the Independent Diabetes Trust that were broadly supportive of the regulations and agreed that they had generally worked fairly and effectively to transpose the requirements of the directive. They were both supportive and appreciative of the work by the DVLA/DfT to propose the amendments to the directive that will come into force in 2018. A response was received from the Road Haulage Association, supporting the measures to relax the criteria for Group 2 drivers.

Unanticipated effects

An assessment of official and ministerial correspondence regarding diabetes and driver licensing has not identified any significant issues other than the position of drivers who have suffered hypoglycaemic attacks only whilst asleep. The Secretary of State's Honorary medical panel on Driving and Diabetes Mellitus accepts that such individuals represent a low risk of danger to both themselves and other road users solely on this basis. All individuals with diabetes mellitus still however have a requirement to monitor and effectively manage their condition to minimise any possible impact on road safety. This adjustment is already under way and, in the circumstances, a more rigorous and expensive analysis of the position would not be cost effective.

The regulations have the effect of barring individuals from driving for at least a year if they have suffered two hypoglycaemic attacks requiring the assistance of another person in any 12 month period. It is acknowledged that the rule, designed to provide some clarity as to the definition of a 'severe' condition, has failed to recognise the special circumstances of people who have attacks only whilst asleep. Medical experts agree that hypoglycaemia should not be classified as severe when it occurs during sleep because it is more difficult to recognise the warning symptoms and to treat the event appropriately.

The UK has taken action through the EU REFIT procedures to refine the directive and the UK regulations. From 2018, attacks whilst asleep will not be defined as severe. The length of the bar imposed as a result of other severe cases will also be shortened if there is medical support. The directive for the amendment to the medical Annex (2016/1106) was published on 8 July 2016 and is due to come into force in 2018. Steps are being taken to amend UK regulations to cater for this amendment.

For more details on the proposal and its approval and adoption see 4.4.4 (Unintended Effects) and 5.2 (Next Steps) on the background information supplement.

5a. Please provide a brief recap of the original assumptions about the costs and benefits of the regulation and its effects on business (e.g. as set out in the IA).

The original Impact Assessment (IA) estimated an average annual cost of between £137K and £200K pa for DVLA, to cater for an increase in transactions and medical examination fees, with a corresponding average benefit of between £14k and £21k when transaction levels fell. The IA assumed that the costs of updating various forms and information leaflets would be £100,000 to cover the changes that were made to the rules on diabetes, epilepsy and eyesight standards. £30,000 of this was assumed to be required as a one-off cost for the amendments relating to diabetes.

There was no clear indication as to the number of people that would be affected, and to what extent. As a consequence it was not considered possible to estimate the value of the benefit that would be derived by people who might be able to resume driving.

5b. What have been the actual costs and benefits of the regulation and its effects on business?

Please highlight how these differed from the original assumptions and any reasons which explain these differences.

No major impacts on business have been identified, although it is inevitable that each licensing transaction will have its own impact on individual businesses. No attempt has been made to measure these impacts – the over-riding issue is that the correct decision is made in each case to ensure that individuals can drive safely. In that respect, further analysis to evaluate the implications of individual cases would not seem proportionate.

However, the relaxation of Group 2 standards has meant that some insulin dependent lorry and bus drivers are now eligible to be considered to apply for a licence. The total number of Group 2 drivers with insulin treated diabetes in 2016 is currently 18, 253 (as of 21/5/2016). Prior to the relaxation of the Group 2 medical standards, these drivers would not have eligible to hold a Group2 licence.

This should benefit the road haulage and passenger transport industry, who have estimated the shortage of HGV drivers to be in the region of 45,000. However, there is no data available to the DVLA to confirm or evaluate the actual benefits of this assumption.

6. Assessment of risks or uncertainties in evidence base/ other issues to note

What are the main limitations to the evidence base for the PIR?

Are there any other issues which should be considered when this PIR is reviewed?

Given the light touch nature of this review it is important to recognise its limitations in being able to conclusively determine the impact of the regulations. For example:

- The PIR is limited in its ability to assess whether the regulations have caused an improvement in overall road safety standards. In addition, the data collected is limited in its ability to assess the relationship between the regulations and the numbers of licences being awarded, revoked or refused. The data collection methods mean that we cannot be sure of any causal relationship between the regulations and the number of refusals shown above.
- Lack of responses from some key organisations mean that we cannot be sure that communications from Diabetes UK and the Independent Diabetes Trust are representative of all key organisations. Responses from Industry stakeholders have been limited, focusing mainly on the unanticipated consequences in relation to severe night-time attacks.
- Information from other EU member states has also been limited to a description of administrative and legislative processes. There has been little indication of the reaction of their domestic stakeholders, although there was strong support for the UK REFIT proposals.

7. Lessons for future impact assessments

The major weakness identified is the failure to make a clearer definition of the objective of the regulations, and to consider how that might actually be measured. To this end, DVLA will now consider how it should gather data to measure how effectively it is dealing with future cases involving asleep hypoglycaemic attacks.

8. What next steps are proposed for the regulation (e.g. remain/renewal, amendment, removal or replacement)?

Apart from the unintended consequence which has already been identified, the regulations appear to have met their objectives of applying the recommendations of the Honorary Medical Advisory Panel, and in meeting the UK's obligation to align UK's medical standards with the European Directive. Subject to the proposed amendments regarding asleep attacks the regulations should remain in place. The medical standards are now set in legislation, rather than in administrative guidance alone, and give effect to the clearer standards now required by EU law. This gives greater legal transparency and certainty, with a theoretical, if marginal, impact on road safety. The PIR has not found any evidence that the regulations have created any additional burden on business.

In conclusion, diabetes interest groups, who were involved in discussions with the DVLA and Secretary of States Honoury Medical Panel appear broadly satisfied with the way the that the directive was transposed in to UK law. Whilst expressing reservations on the specific changes regarding night time hypoglycaemic attacks, industry representatives are also satisfied with the solution in place to address that problem.

Sign-off for Post Implementation Review:

I have read the PIR and I am satisfied that it represents a fair and proportionate assessment of the impact of the policy.

Signed: **Ben Walker** Date: **1 December 2016**

Evaluation Centre of Excellence team
DfT

Evidence base

Please provide additional evidence in subsequent sheets, as required.

Strategy, Policy and Communications Directorate

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