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Safety First: Mobility of Healthcare Professionals in the EU

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Witness names without a question reference refer to written evidence as listed in Appendix 2.

SUMMARY

The mobility of healthcare professionals can bring significant benefits to patients and professionals alike as well as to the EU and the healthcare professions more generally. However, the Mutual Recognition of Professional Qualifications Directive which governs mobility within the EU currently fails to command the confidence of patients and professionals. UK regulators have expressed strong concern that the current system forces them to admit individuals who do not meet standards required of UK or non-EEA professionals to be considered fit to practise, and there have been a number of high profile incidents illustrating the dangers of the current system.

Encouraging mobility should never be at the expense of patient safety. This must at all points be the overriding concern. We consider that the Directive as it currently stands strikes the wrong balance. We welcome the Commission's review of the Directive and urge all parties, including the UK Government, to act to ensure swift change to remedy serious failings in the current regime which place patients at unacceptable risk. Such changes would not represent a barrier to free movement but rather would strengthen it by working to rebuild confidence.

It is essential that qualifications and skills of professionals are adequate and reflect modern practice. The requirements currently set out in the Directive are not sufficient to ensure this. Training requirements in the Directive need updating and should be accompanied by required competencies where appropriate. We believe that a move towards an increasingly competence based approach would be desirable. It is also essential that competent authorities are able to assure themselves that an individual who has not practised for a number of years is fully conversant with current practices.

Competent authorities in the host Member State must be able to access relevant information regarding the professional history of an individual and seek answers to any queries they may have. Whilst there is a sound mechanism for the exchange of information in the Internal Market Information System (IMI), in order to assure patient safety, communication needs to be enhanced and become more routine. Use of the IMI should be compulsory for the healthcare professions and we believe is likely to represent a simpler and more cost-effective option than the proposed European professional card.

Communication is especially important as regards fitness to practise information and to ensure individuals cannot use the Directive to circumvent restrictions placed on their practice. We argue that an alert should be issued to all Member States at the point at which a fitness to practise case is brought against an individual. However, this will only be effective if sharing of the necessary categories of information is not restricted by data protection legislation.

The ability to communicate effectively in the language of the host Member State is critical to safe and effective practice. The Directive as it currently stands fails to ensure that all professionals meet the necessary standards. Competent authorities should have the ability to satisfy themselves as to the language competence of all professionals at the point of recognition. This is particularly important in the case of professionals who are self-employed. Where there is an employer, it is vital that their ability to test applicants proportionately according to the specific requirements of the job is not restricted.

Safety First: Mobility of Healthcare Professionals in the EU

CHAPTER 1: INTRODUCTION

1. The Mutual Recognition of Professional Qualifications Directive (MRPQ Directive)[1], agreed in 2005, is a fundamental component of the Single Market. It allows professionals to have their qualifications, obtained in one Member State, recognised in another and thus allows them to be employed anywhere within the Single Market irrespective of where they have trained. The Directive applies to the European Economic Area (EEA), which includes EU Member States along with Norway, Iceland and Liechtenstein. The Directive was transposed into UK law in 2007.

2. The MRPQ Directive replaced several earlier Directives, including the Directive on a General System for Recognition of Professional Diplomas and a number of separate Directives including those covering nurses, dentists, veterinary surgeons, midwives, architects, pharmacists and doctors. This brought a large number of professions under the umbrella of the one Directive.[2] There are currently over 800 regulated professions across the EU with two systems for recognition of qualifications; the 'general system' and 'automatic recognition'. Box 1 sets out further detail.

BOX 1

Systems of Recognition under the MRPQ Directive

The system of automatic recognition applies to seven professions; doctors, dentists, general care nurses, midwives, pharmacists, veterinary surgeons and architects. For these professions there are harmonised minimum training requirements (listed in an annex to the Directive) and Member States are obliged to recognise automatically qualifications which meet these criteria.

The general system governs the majority of professions covered by the Directive. Under this system, qualifications are grouped into 5 levels, which differentiate according to level and duration of education. Qualifications are recognised if an individual's level of professional qualification obtained in one Member State is at least equivalent to the level immediately below that required in the host country. Recognition must also be granted to migrants whose profession is not regulated in the country of origin but who have worked full-time in that profession for two years.[3] Where there are substantial differences in training requirements between Member States the host country may impose compensation measures, requiring the applicant either to complete an adaptation period or take an aptitude test.

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1 Directive 2005/36/EC on the recognition of professional qualifications

2 The Directive replaced 77/452/EEC, 77/453/EEC, 78/686/EEC, 78/687/EEC, 78/1026/EEC, 78/1027/EEC, 80/154/EEC, 80/155/EEC, 85/384/EEC, 85/432/EEC, 85/433/EEC and 93/16/EEC and 89/48/EEC

3 http://ec.europa.eu/internal_market/qualifications/directive_in_practice/generalsystemen.htm. For further information see Article 11.

Benefits and risks of mobility

3. This report starts from the principle that the aim of facilitating the mobility of healthcare professionals is a positive one. It is generally acknowledged that the free movement of services provides significant benefits for the EU as a whole, for its individual Member States and for its citizens. None of our witnesses sought to question this.

4. EU citizens have the right to move freely within the Union and professionals can gain personally and professionally from this process. It can bring exposure to different training and professional environments and promote the cross-fertilisation of ideas. Mobility of healthcare professionals, and in particular the system of automatic recognition, has encouraged the raising of professional and training standards in many countries. Patients can, therefore, potentially benefit from a greater breadth of experience.

5. Mobility is also important to the EU's competitiveness. Promoting the mobility of services features prominently in the Europe 2020 Strategy and the New Agenda for Skills and Jobs and has been highlighted by the Commission as a priority as part of the re-launch of the Single Market.[4] The free movement of professionals also allows Member States to fill gaps in their workforces. This is increasingly important in light of an ageing population and health workforce in many countries. The UK in particular has a long history of reliance on internationally trained healthcare professionals, although the number of those who have trained in EEA states is less significant than the number of migrant professionals who have trained elsewhere in the world.[5] There is a lack of data regarding the number of UK health professionals who take advantage of the Directive to work in other Member States, but it is generally agreed that the UK is more significant as a destination country than as an exporter of professionals elsewhere.[6]

6. Although the framework of the MRPQ Directive is considered to have been broadly successful there have been a number of concerns. Despite the provisions of the Directive, mobility of professionals within the EU is still low. Intra-EU trade in services represents only 25% of overall trade in the EU. This is particularly low given that the services sector represents 70% of gross domestic product.[7] Individuals seeking to make use of the provisions of the Directive continue to face difficulties, with the 2010 EU Citizenship Report identifying "burdensome and unclear procedures" as one of the main obstacles EU Citizens encounter in exercising their rights across borders.[8] Furthermore, there have been particular concerns with regard to the cross border provision of services where public safety is at stake, notably in the healthcare professions. Whilst the aim of reducing unnecessary barriers to freedom of movement is laudable, there are clear risks associated with it. These can result from the sometimes significant differences in professional training, standards and cultures between Member States. Language and communication barriers can also present dangers as can the potential for

4 COM (2010) 682

5 DH/BIS

6 GMC, NMC, GDC

7 COM (2011) 367

8 EU Citizenship Report 2010: Dismantling the obstacles to EU citizens' rights, COM (2010) 603

individuals deemed unfit to practise to attempt to circumvent restrictions imposed upon their freedom to practise.

7. The number of incidents which have occurred as a result of failures of the Directive may be considered statistically low but where they have occurred the results have been devastating.[9] Confidence in the Directive, particularly in relation to those professions which are covered by automatic recognition, has been severely undermined as result, leading to a fear in some quarters that mobility has been prioritised over public safety.

8. Our witnesses were all agreed that the Directive was in need of reform and the Commission told us that it fully accepted that "these rules need to be reviewed and modernised".[10] This process began in March 2010 when the Commission launched an evaluation of the Directive. This was followed by a public consultation launched in January 2011.[11] The Green Paper *Modernising the Professional Qualifications Directive* was published in June 2011, during the course of this inquiry.[12] The Commission is expected to come forward with a legislative proposal by the end of 2011. The timetable for agreement and eventual implementation is difficult to predict but if a new Directive were to be formally agreed in 2013, concrete effects of transposition into Member States' legislation might be expected in 2017.[13]

A separate Directive?

9. The need to ensure the primacy of patient safety is agreed upon. Some of our witnesses suggested that the best way to take account of this would be to remove the healthcare professions from the scope of the MRPQ Directive, which would be covered by a separate legislative instrument. However, it was also acknowledged that this was unlikely to prove realistic.[14] The Commission confirmed that it would be looking to maintain the overall framework for the movement of professionals and that they considered any break-up into profession-specific Directives to be a retrograde step.[15] We consider that if the broad framework of the Directive is to be maintained it is essential that the specificity of the healthcare professions and the overriding importance of patient safety be recognised. We believe that it is possible to ensure patient safety within the framework of the MRPQ Directive if derogations from the broader system are permitted where necessary. Our conclusions are therefore based on this premise.

Structure and scope of the report

10. This report is confined to the operation of the MRPQ Directive in so far as it relates to the healthcare professions. Where we advocate or reject options this is done with no consideration as to their suitability for other professions. Much of this report is focused on those healthcare professions which are

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9 See for example Dr Rory Gray, Dr Stuart Gray

10 Q 105

11 http://ec.europa.eu/internal_market/consultations/docs/2011/professional_qualifications/consultation_paper_en.pdf

12 COM (2011) 367

13 Commission presentation at RCP Roundtable 11 July 2011, http://www.rcplondon.ac.uk/sites/default/files/jurgen_tiedje_presentation_by_european_commission.pdf

14 Q 55

15 Q 108

covered by the system of automatic recognition. However, many of the conclusions are also relevant to those covered by the general system such as psychologists or physiotherapists.

11. In chapter 2 we examine the process of recognition of qualifications, how this should be modernised and related issues including continuing professional development, re-validation, partial access and temporary and occasional work. In chapter 3 we examine issues of administrative cooperation, particularly relating to the sharing of fitness to practise information. Chapter 4 considers the subject of language competence and how this can best be assured. Finally, Chapter 5 considers the proposed European professional card, one means by which the Commission has suggested the sharing of information might be improved. In each of these areas we respond to suggestions put forward in the Commission's Green Paper. This report both puts our recommendations to the Government and represents the Committee's response to the Green Paper.

12. The members of the Social Policies and Consumer Protection Sub-Committee who conducted the inquiry are listed in Appendix 1, showing their declared interests. We are grateful to all those who submitted evidence and in particular to those who provided oral evidence; the witnesses are listed in Appendix 2. The Call for Evidence we issued is at Appendix 3.

13. **We make this report to the House for debate.**

CHAPTER 2: AUTOMATIC RECOGNITION, TRAINING AND ACCESS

14. The system of automatic recognition of qualifications applies to most healthcare professionals; doctors, general care nurses, dentists, midwives and pharmacists. Member States are required to recognise professionals from other Member States upon presentation of particular qualifications, which satisfy minimum training conditions laid down in the Directive. As a case study, we include in Appendix 4 the minimum training requirements for nurses responsible for general care.

15. In this chapter we consider views on the automatic recognition system as currently designed and options for its modernisation. We then turn to the related issues of return to practise and re-validation, continuing professional development, compensation measures, partial access and finally temporary or occasional practice.

Automatic Recognition and training requirements

16. Most witnesses felt that the automatic recognition system as a general concept worked well.[16] The Commission also noted that automatic recognition had been responsible for the raising of training standards in many Member States in order to enable professionals in their countries to benefit from it.[17] All of our witnesses, however, agreed that the automatic recognition system as it currently functions was not fit for its intended purpose and the Commission itself accepted the need for review and modernisation.[18] Most felt that the criteria for automatic recognition needed to be reviewed and that the minimum training requirements should be overhauled.[19] Two reasons were given: that the training requirements did not represent modern practice and that automatic recognition assumed a comparability of training which was not always the case.

17. It was recognised that there was a lack of knowledge about the nature and content of medical education and training in other Member States, compounded by differences in standards and conventions between Member States.[20] For example the Royal College of General Practitioners (RCGP) noted that in general practice there was "no universal agreement as to what the role should involve—GPs and their equivalents in other countries perform a widely varying range of roles".[21] Whilst GPs in the UK are central to the health system and require knowledge across medicine, in other Member States they are not required to maintain such broad knowledge as patients may seek advice from specialists instead.[22] We heard from the GMC that, in some Member States, GPs would not normally treat children.[23] The

16 Alliance Boots, BDA, BMA, EFN, GDC, GMC, GOsC, GHP, HPC, Emma McClarkin MEP, MPS, NHS European Office, RCGP North East Scotland Faculty, NMC, RCGP, RCN, RCP, RPS

17 Q 105, Alliance Boots, EFN

18 Q 105

19 Q 83, GMC, NHS European Office

20 GMC

21 RCGP

22 RCGP

23 Q 54

Nursing and Midwifery Council (NMC) offered the example of babies being delivered almost exclusively by gynaecologists in some countries, but by midwives in others.[24] Different practices across Member States were also a feature of dentistry and hospital pharmacy.[25]

18. Views were divided on the minimum training duration requirements. Many concluded that a decision on fitness to practise should be based on the skills or competences acquired rather than on duration of training.[26] For example the General Medical Council (GMC) felt that the current focus on the inputs rather than on the outputs of medical training was of "limited practical value in providing assurances about the standards of medical education and training undertaken".[27] There was support, though, for the maintenance of some element of minimum training duration alongside the substantive training requirements, particularly from nursing organisations. The European Federation of Nurses Associations (EFN) wished to maintain the reference to 4,600 hours but to remove the alternative option of three years. It was also considered that the current proportions for the teaching of theory (at least one third) and clinical practice (at least 50%) should be maintained. Extension from 10 years to 12 years of the length of time that nurses should spend in general education was also supported.[28]

19. There was clear support for revision of the Annex setting out the minimum content of training programmes.[29] The Green Paper recognises the need for modernisation, acknowledging that some of the training conditions date back as far as thirty years, during which time the healthcare professions have evolved substantially. In terms of changes that have faced the nursing profession in recent years but that were not reflected in the Annex, the NMC mentioned the growing importance of information technology, changes in the lengths of stay of hospital patients and a trend towards community care management of long term conditions, rather than a focus on acute care. In the Directive there is no mention of long term care, or of public health, obesity, diabetes or oncology. As regards midwifery, there is no mention in the Directive of postnatal mental health, or of foetal monitoring.[30] The EFN agreed and suggested that knowledge about national healthcare services and laws could also be included as a competence.[31]

20. Interestingly, there are anomalies in the Directive between the general competencies required for different professions. The Royal College of Physicians (RCP) suggested that additional competencies for doctors could include communication skills, team working and ethics, all with relevance to patient safety.[32] Ethics are currently part of the existing competences required to be taught to nurses, midwives, dentists and "where appropriate" pharmacists, but not to doctors. Similarly, knowledge of the legislative

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24 Q 87

25 BDA, GHP

26 Q 54, Q 74, BMA

27 GMC

28 RCN, EFN

29 Annex V, Directive 2005/36/EC on the recognition of professional qualifications

30 Q 102

31 EFN

32 RCP

framework is currently required only for midwives, nurses, dentists and pharmacists. It should be added that in some cases knowledge of ethics and the legislative framework are included in both the body of the Directive and the Annex setting out minimum training requirements, but in other cases are only included in the Annex.

21. Looking to how the debate on competences and minimum training requirements might be resolved in the Directive, the Commission suggested that "to replace duration entirely by an analysis of individual competences would be a very radical change" and told us that most Member States would prefer a mixture of duration and competences.[33] Various witnesses agreed that, at least in the short to medium term, a minimum training duration requirement ought to be maintained, possibly moving to a fully competence based approach over the longer term.[34]

22. The nature of any competence based approach remained far from clear in the light of our evidence and, indeed, there was a trend towards a flexible approach at the EU level that left substantial flexibility to Member States and employers. The Minister argued, for example: "it is essential that the suitability of a healthcare professional for the specific role they are going to undertake is assessed by employers".[35]

23. Various witnesses emphasised the role of induction by employers and the importance of professionals being given an understanding of the nature of the health delivery structure in the relevant Member State and the role of the individual in that structure.[36] Alliance Boots highlighted that it requires EEA trained pharmacists in their employment to undertake a period of up to 12 weeks of supervised practice before working unsupervised. This period is designed with the intention of communicating differences in pharmacy practice in the UK, both legal and ethical, and how to avoid common problems.[37] There was significant support amongst witnesses for a compulsory induction period for those "who may not have a full knowledge of the specificities of the healthcare system they wish to work in".[38]

24. It was also considered by witnesses that improving standards could be achieved by sharing best practice through informal networks, possibly through a particular European forum to oversee co-ordination of medical education and training, which could carry out an audit of basic and specialist medical qualification.[39] Emma McClarkin MEP, Rapporteur on the Directive for the European Parliament's Internal Market and Consumer Protection Committee, agreed that an informal approach would be welcome, through networks of Member States. Above all, it was important that Member States should retain the flexibility to develop their own standards and training curricula, not least because "the curriculum in a Member State should be designed to meet the needs of that state's population".[40]

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33 Q 109

34 RCP, RCN

35 Q 145

36 QQ 149-150, NALM

37 Alliance Boots

38 BDA, BMA, NCAS, RCGP, RPS

39 GMC, GMC 2

40 RCS, GDC, GMC

25. Some witnesses advocated the development of Europe-wide curricula on a voluntary basis, helping to drive up standards in Member States currently without curricula.[41] The RCP took this one step further, suggesting that a single European Qualification would ultimately be acceptable, but as a minimum standard allowing Member States to go beyond it. In a view closer to a mandatory harmonisation of qualifications, Howard Young, Emeritus Professor and former Vice Dean of the School of Postgraduate Medical and Dental Education at Cardiff University, favoured the establishment of transferable cross border qualifications at specialist level, requiring some harmonisation of medical training.[42]

26. **We agree that the concept of automatic recognition of the qualifications of health professionals is welcome, aiding mobility and helping to improve training standards. However, patient safety must be the overriding concern. The system can only function with confidence for patients, professionals and regulators if it reflects modern practices.**

27. **There are clearly instances where the Directive is out of step with modern practice. We therefore agree that the minimum training requirements and training durations in the Annex of the Directive ought to be reviewed and amended. We would welcome the inclusion of more practical competencies alongside minimum training durations but recognise the reality that an entirely competency based approach across the EU is unrealistic at present.**

28. **It is clear to us that an audit of current training practices and curricula around the EU, above and beyond the minimum training requirements, would be helpful. While we reject the development of a single European curriculum, the sharing of information among educational establishments and practitioners may lead to the development of curricula that are more aligned, while allowing Member States to fit curricula to their national circumstances. In the longer term, this might assist in the move towards a more competency based approach.**

29. **In terms of the broader competences that we would wish to see included in the Directive, we recommend that anomalies between the different healthcare professions be removed, while recognising the different roles of each profession. It is reasonable to expect that healthcare professionals are aware of medical ethics and the legislative framework and it is therefore unacceptable that understanding of these two vital issues is not required of all automatically recognised healthcare professionals, including doctors to whom the requirement does not currently apply.**

30. **We stress the importance of adopting a flexible approach, respecting the responsibility of Member States for delivery of healthcare and education policies. Employers, including agencies, must accept a degree of responsibility. We would support an obligation in the Directive for employers to provide a period of induction. Such an**

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41 RCS, RCN

42 Professor Howard Young

obligation would fall on the competent authority to oversee should the professional intend to operate in a self-employed capacity, such as some pharmacists, dentists and general practitioners. A particular role of induction must be to inform the professional of the health delivery structure in the Member State and the applicable legislative framework.

Professions not covered by automatic recognition

31. Outside the automatically recognised professions, qualifications are recognised on a case by case basis. There was little support for the extension of automatic recognition to those healthcare professions not covered by the system. There can be particular difficulties where a profession is regulated in some Member States but not others, as is the case with osteopathy for example. The General Osteopathic Council (GOsC) highlighted work it was undertaking with European colleagues to develop a European standard which, whilst not overriding national legislation, would provide a benchmark for countries currently without any legislative mechanisms.[43] The Health Professions Council (HPC), responsible for professions outside the automatic recognition regime, noted similarly that there was no agreement on training for professions such as physiotherapists. The HPC was clear that it would not wish to see an extension of automatic recognition, considering the current system offered it "great advantages" and preferred to retain the ability to assess each applicant on a case by case basis. In particular it was concerned that extending automatic recognition, even if it should prove possible, to some of the professions it regulated could result in a lower threshold.[44]

32. **We do not advocate the extension of the automatic recognition principle beyond the healthcare professions that are currently covered but we emphasise the need for flexibility in the regulatory framework to allow for future extension.**

Return to practise and revalidation

33. Under the current framework, any individual who meets the minimum training requirements should have their qualifications automatically recognised, regardless of when the qualification was awarded. The General Pharmaceutical Council (GPhC) considered this to be a "risk area" where fewer requirements were able to be made of EEA professionals than those trained in the UK or migrating from elsewhere.[45] The NMC also believed there was an issue to be addressed, noting that it was required to register nurses who had not had practice experience within 20 years.[46] The Commission agreed with the need for reform, telling us that "we should not allow healthcare professionals to have automatic recognition on the basis of a diploma that may have been acquired many years ago", a view shared by the Minister.[47]

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43 GOsC, DH/BIS

44 Q 42, HPC

45 Q 23, Q 29, GPhC

46 Q 83, Q 95

47 Q 106, Q 151

34. A number of witnesses suggested that the Directive should incorporate a systematic revalidation requirement, under which professionals would be required to apply for revalidation every few years.[48] This is currently under development in the UK for both doctors and dentists.[49] It was noted by the RCP, however, that the proposed revalidation process in the UK "goes beyond anything envisaged in the rest of the EU".[50]

35. **It is unrealistic at present to require Member States to introduce systems of revalidation for all healthcare professionals. Nevertheless, it is crucial that competent authorities are able to assure themselves, through testing if necessary, that an individual who has not practised for a significant length of time is fit to practise. This necessity must be reflected in the Directive.**

Continuing Professional Development (CPD)

36. There was widespread support for the inclusion of a requirement for regular updating of skills and knowledge, or continuing professional development (CPD) in the Directive, with the exception of one witness who warned that its value could be limited.[51] The General Dental Council (GDC) described CPD as "vitally important". Similarly, nurses and midwives in the UK are required to undertake a specific number of hours of CPD and a specific number of practice hours every three years. Yet, as the NMC explained, the absence of a CPD requirement in the Directive meant it was obliged to register EEA professionals who failed to meet standards required of UK professionals.[52] Regulators and representatives from across the health professions agreed that it should be included, including the HPC.[53]

37. The Green Paper was largely silent on the issue although the Commission assured us it realised that "something needs to be done".[54] The Minister was supportive of a requirement on Member States to ensure that all healthcare professionals undertake CPD.[55] The EFN suggested this might be achieved through an amendment to Article 22 of the Directive, which currently obliges Member States to ensure that individuals "are able to keep abreast of professional developments to the extent necessary to maintain safe and effective practice".[56]

38. There was a difference of opinion, though, on whether standards should be laid down at EU level and it was recognised that CPD is more common in some Member States than others. For example research undertaken for the GDC indicated that only eight Member States have a CPD scheme in dentistry.[57] While the RCP took the view that doctors should be able to

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48 Q 32, Q 77, RCP

49 Q 77

50 RCP

51 NALM

52 Q 95

53 Q 44, Q 82, BMA

54 Q 112

55 Q 152

56 EFN

57 Q 27

demonstrate that they have participated in CPD to an agreed minimum standard, both the GMC and Royal College of Surgeons (RCS) warned against the introduction of any common standards, even at a minimum level.[58]

39. **We recommend a strengthening of Article 22 in order to oblige Member States to require healthcare professionals to undertake CPD. Such a strengthening can only function in reality if those Member States that do not operate CPD across healthcare are assisted in their efforts to do so. We recommend that different approaches to CPD be considered alongside the informal sharing of information relating to the content of training courses. Given its importance to healthcare professionals outside the automatically recognised professions, we would also welcome a reference to CPD in the general framework of the Directive.**

Compensation measures and partial access

40. Article 14 of the Directive permits Member States to require applicants to complete an adaptation period of up to three years or to take an aptitude test in certain circumstances, for example where a particular professional activity does not exist in the applicant's Member State of origin. We received limited evidence in relation to these compensation measures. The EFN and Royal College of Nursing (RCN) advocated their maintenance but stated that they should be proportionate. It was noted that bridging courses to help bring nurses up to the standards of automatic recognition had proved useful.[59]

41. Related to compensation measures, we heard concerns from some witnesses regarding "partial access" to professions. The Court of Justice of the European Union laid down this concept in a 2006 ruling which stipulated that partial access to a profession must be given if there was no valid public interest reason to prohibit it.[60] Partial access allows the scope of a professional's activities to be limited to those reflected in the qualification gained in their home Member State. Many witnesses expressed concern that any extension of the system of partial access to healthcare professionals could compromise patient safety as it could mean that an individual whose training or qualifications did not merit full recognition could still practice in the UK.[61] The RCN took the view that it would be impossible to ensure that they only practised within the scope of their competence. The HPC explained that partial access was used in healthcare professions outside the automatic recognition regime but that this was based on mutual trust and relevant documentation. It considered that "there is a risk, but you can mitigate against it".[62]

42. In evidence to us, the Commission explained that the Court had recognised the right of Member States to deny partial access if there are overriding reasons of public interest such as public health. The Commission accepted

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58 GMC, RCS, RCP

59 EFN, RCN,

60 Case C-330/03, 19 January 2006

61 RCS, BMA, NHS European Office, RCN, EFN

62 Q 45

that it may be necessary to articulate this in the revised Directive, with particular reference to health professionals.[63]

43. **We heard no support for application of the principle of partial access to healthcare professions subject to automatic recognition. We therefore concur with the Commission that it would be helpful to make the right of Member States to deny partial access in the interests of patient safety explicit in the text of the Directive. We see substantial risk in application of the principle to healthcare professionals falling outside the automatic recognition regime.**

Temporary and occasional practice

44. The Directive allows professionals to move to another Member State to practise their profession on a temporary or occasional basis. This concept is not defined and should, according to Article 5(2) of the Directive, "be assessed case by case, in particular in relation to its duration, its frequency, its regularity and its continuity".[64] Professionals moving for such purposes are subject to the standard rules of registration, but we heard concerns that they could not be audited for compliance with CPD or revalidation requirements set at a national level.[65]

45. Most of those who offered comments to us on this subject wished to see greater clarification of the meaning of the term and its implications.[66] On the other hand, the NHS European Office considered that interpretation of the term should be left to the discretion of the regulator.[67]

46. Some witnesses expressed scepticism about the concept itself. The RCP considered it to be unacceptable from a patient safety perspective and feared that evidence of good standing may not be investigated in the same way as for permanent registration.[68] The HPC considered however that a medical professional travelling with a sporting team for an event should be able to undertake their duties without undue regulatory hindrance. While acknowledging that the numbers involved were currently very small (of 20,000 on the HPC register only 200 are registered as temporary), it nevertheless had some concerns that those individuals "might not necessarily be here on a temporary or occasional basis".[69]

47. **Registration and continuing training and assessment of those performing healthcare duties in another Member State on a temporary or occasional basis must be no less stringent than for those registering on a permanent basis. If that were to be the case, clarification of the term "temporary or occasional" would not be so important. But if the concept is to be maintained, guidance on its interpretation would be helpful.**

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63 Q 122

64 Directive 2005/36/EC on the recognition of professional qualifications

65 Q 32, Q 43

66 Q 168, BMA, Alliance Boots

67 NHS European Office

68 RCP

69 Q 43

CHAPTER 3: ADMINISTRATIVE COOPERATION AND FITNESS TO PRACTISE

48. The assurance that individuals are fit and competent persons to practise is essential for both patient safety and confidence in the mobility of healthcare professionals. There should be no suggestion that the Directive allows an individual deemed unfit to practise or who has had restrictions imposed on their practice in one Member State to circumvent this by moving to another Member State unaware of the situation. Article 56 of the Directive states that "competent authorities of the host and home Member States shall exchange information regarding disciplinary action or criminal sanctions taken or any other serious, specific circumstances which are likely to have consequences for the pursuit of activities under this Directive".[70]

49. In order to assure patient safety there has to be both willingness and ability on the part of the competent authority in each Member State to share relevant information, a trusted mechanism by which this can be done and the confidence that information will be shared in a timely manner at the appropriate stage. We heard evidence that the system as it currently functions has inadequacies in all of these respects.

50. In light of these gaps there has developed an informal agreement between some competent authorities. The Healthcare Professionals Crossing Borders (HPCB) group is an informal partnership of professional healthcare regulators across Europe, which has developed a 'Memorandum of Understanding' between its signatories on information exchange.[71] There are currently 11 bodies who have undertaken to abide by the agreements on both reactive and proactive exchange of information and a further three who participate in the agreements relating to reactive information exchange.

Sharing of information between competent authorities

51. The Internal Market Information System (IMI) is commonly used to facilitate the exchange of such information between competent authorities (see Box 2).

BOX 2

The Internal Market Information System (IMI)[72]

The IMI is a secure online application which allows national, regional and local authorities to communicate quickly and easily with their counterparts abroad. It enables users to:

- identify the right authority to contact in another country
- communicate with them using pre-translated sets of standard questions and answers.

For example this would allow a UK regulator to contact a body in Hungary, asking their question in English. The Hungarian authority would read and respond to the question in Hungarian, but this would be made available to the UK authority in English.

Use of the IMI is compulsory for some professions, but not for those, including the healthcare professions, which are excluded from the Services Directive.[73]

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70 Directive 2005/36/EC on the recognition of professional qualifications

71 http://www.hpcb.eu/activities/documents/MoU_Master_2010.pdf

72 http://ec.europa.eu/internal_market/imi-net/about_en.html

52. Our witnesses expressed significant enthusiasm for, and confidence in, the potential of the IMI.[74] However the majority felt this was not currently exploited, raising serious patient safety issues. The existence of the IMI in itself is not sufficient to ensure that fitness to practise information is disseminated. In the UK, the GMC, NMC, GDC, GPhC and HPC all proactively share fitness to practise information with other Member States, often also making this information publicly available on their websites. However, there was concern that competent authorities in other Member States did not always adopt similar practices. The GMC described current use of the IMI as largely reactive and limited to the initial point of recognition of qualifications. It had also experienced difficulties in obtaining responses to their queries from some Member States.[75] The GPhC told us that in the absence of all competent authorities routinely sharing fitness to practise information it was unable to be confident that there was not somebody on their register practising in the UK who had been "removed or suspended from registration elsewhere in Europe because of a conduct or patient safety issue".[76] There was significant support amongst our witnesses for making use of the IMI mandatory for competent authorities of healthcare professions in order to assure proactive exchange of fitness to practise information, something the Government also advocated.[77]

53. The Green Paper recognises the need for a proactive alert system for health professionals and sets out two options for exploiting the potential of the IMI to achieve this. These are set out in Box 3.

BOX 3

Options for an Alert System

Option 1 would place an obligation on competent authorities to share fitness to practise information but would limit it to circumstances where there was clear evidence that a health professional subject to sanctions in the Member State of origin was migrating to another Member State. An alert would then be shared with that specific Member State and any others where there was considered to be sufficient likelihood of them seeking to practise.

Option 2 would issue an alert to all Member States at the point at which an individual loses the right to practise.

54. The Commission itself noted that option 2 would "protect patients in a much more effective way".[78] Our witnesses agreed. As the Government explained, the home Member State may not always be aware of one of its nationals establishing themselves in another Member State and their obligations under Article 56 thereby being triggered.[79]

55. **It is essential that competent authorities are able to satisfy themselves that individuals who have had restrictions placed on their freedom to**

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73 Directive 2006/123/EC on services in the internal market

74 See for example Q89, DH/BIS, NHS European Office

75 GMC

76 Q 13

77 DH/BIS

78 COM (2011) 367

79 DH/BIS

practise in one Member State are not able to circumvent these by establishing themselves in another Member State. We consider the current situation to be unacceptable. The provision of an adequate framework for the proactive sharing of fitness to practise information is key to building confidence in the free movement of healthcare professionals. We recommend that use of the Internal Market Information System be made compulsory for competent authorities of all healthcare professions. We favour option 2 in the Green Paper as offering a greater degree of protection to patients.

Data protection

56. The success of any alert mechanism is necessarily dependent on competent authorities in Member States being able to share that information. Although the Directive obliges competent authorities to provide relevant information, it restricts this by making it subject to EU legislation on data protection and processing.

57. The Commission told us that it did not consider that it would be "particularly difficult" to ensure a compulsory system for the exchange of fitness to practise information which was compliant with data protection legislation.[80] Despite this, we heard concerns that restrictions resulting from data protection legislation were currently presenting serious challenges to the exchange of information. The NMC considered it to be the "main barrier to more extensive sharing" whilst the GMC told us it "cannot be right" that privacy laws were used to justify not informing them when a doctor's fitness to practise was impaired.[81] The GDC also highlighted the fact that some competent authorities, for example those in Hungary and Poland, were of the view that data protection legislation prohibited them from publicising suspensions or restrictions on practice.[82] The BMA believed that data protection issues needed to be addressed and resolved as a matter of urgency, a position with which the majority of witnesses agreed.[83]

58. Some of the domestic data protection legislation on the sharing of information in Member States is more restrictive than the framework set by the EU and it was the Government's understanding that this was where most difficulties lay.[84] The Memorandum of Understanding produced by the HPCB group notes that "because of the legal constraints that exist in some countries, some of the Member State competent authorities that are signatories to this memorandum are currently unable to participate in the proactive aspects of information".[85] It is worth noting that if the proactive sharing of certain categories of information was required under the Directive, this would take precedence over any domestic law which might currently restrict this. The current EU framework also appears to provide flexibility for

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80 Q 115

81 Q 54, GMC

82 GDC

83 BMA, GDC

84 DH/BIS 2

85 http://www.hpcb.eu/activities/documents/MoU_Master_2010.pdf

the sharing of sensitive personal data on public interest grounds.[86] The GPhC believed that finding a resolution was a question of "establishing common ground between European regulators on the overall legal principles and approach to be followed; there may also be a question of will and culture as well, to ensure that we are all taking a more consistent approach to getting the balance right between privacy on the one hand and public protection on the other".[87]

59. **We consider that the provision of a proactive alert mechanism for the sharing of fitness to practise information will be ineffective if it is not accompanied by changes to the current restrictions on data which can be shared. We recommend that there be a specific article in the Directive dealing with administrative cooperation within the healthcare professions which would require the sharing of categories of information agreed to be critical to patient safety. This should ensure that the sharing of information is not obstructed by reference to data protection legislation in individual Member States. We commend the work of the Healthcare Professionals Crossing Borders group as a good starting point for consideration of these necessary categories of information.**

Appropriate point of information exchange

60. The need for competent authorities to share information when an individual has had restrictions imposed on their freedom to practise is undisputed. However, fitness to practise cases can be lengthy, with significant delays between initiation and conclusion. There is therefore the potential for individuals to move between Member States in this period. We asked witnesses at what stage they believed sharing of information with other Member States was appropriate and how this should be balanced against the right of professionals to be presumed innocent until found guilty of a professional or criminal offence.

61. The Green Paper does not directly address this issue but the options set out are for when an individual "has been subject to sanctions barring him from exercising his profession".[88] The system currently used by the signatories to the HPCB agreement is that when information is requested of a competent authority, they are not required to provide it in circumstances where no final decision has been taken because the case is under investigation, a temporary sanction has been imposed pending a final decision or where the individual concerned has appealed the decision against them.[89] However, this does not restrict the ability of signatories to share this information if they so wish.

62. By contrast, the GDC told us how it communicated such information with UK healthcare organisations, informing them when investigations into an individual begin and end and of any outcomes impacting upon their registration status. It believed that this system would be transferable to the

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86 Directive 95/46/EC on the protection of individuals with regard to the processing of personal data and on the free movement of such data

87 Q 13

88 COM (2011) 367

89 http://www.hpcb.eu/activities/documents/MoU_Master_2010.pdf

European level.[90] The GPhC believed that an alert should be triggered whenever an individual was removed or suspended from practise, even if this suspension was temporary, pending a full hearing of the case.[91] The Minister acknowledged that there was a need to protect individual professionals from vexatious complaints but felt that information should be exchanged at as early an opportunity as possible. She suggested that limiting sharing of information simply to the neutral facts of any case would be the most constructive and equitable way forward.[92]

63. Respondents to an RCN questionnaire, while supporting greater exchange of information relating to fitness to practise and disciplinary cases, also highlighted that, from the individual migrant's point of view, clarity about what appeal systems were in place was needed. The RCN also emphasised that in order for any exchange mechanism to be successful there would need to be a "clearer shared understanding of definitions and national legal frameworks, since certain actions which would result in removal from the register in one country might not be treated in the same way in another".[93]

64. **In deciding at which point to share information, as well as what information to share, the overriding concern must be patient safety. There should be an obligation on competent authorities to share promptly information relating to fitness to practise cases where there is a risk to patient safety from the point at which a case is initiated. This should be limited to a neutral account of the established facts of the case and the allegations. Competent authorities of Member States should then have discretion to act in accordance with their national systems as to whether an individual should be temporarily suspended whilst investigation is ongoing. It is essential that the Internal Market Information System is regularly updated in order to ensure that the rights of individuals are respected and to ensure that those who have had cases against them dismissed should not face discrimination.**

Differences in structure of competent authorities

65. There are considerable differences between Member States in the way in which competent authorities are structured and function. These differences fall into three main categories. First, in some Member States there are no formal or compulsory regulatory systems for some health professionals, for example nurses in some regions of Spain.[94] Second, in many countries there is no single regulator, the roles being undertaken instead at a local level. Finally, in many Member States the regulating body simultaneously functions as the trade union or professional body.[95]

66. The Commission appeared largely unconcerned about the differences, telling us that it did not "mean that things in other countries are left to the law of

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90 GDC

91 GPhC

92 Q 142, Q 160

93 RCN

94 Q 84, Q 118

95 These functions are separated for health professions in the UK. For example the GMC is the medical regulator whilst the BMA is the professional organisation.

the jungle".[96] However, we heard concerns about the potential implications for sharing of fitness to practise information on all three accounts. It was apparent that there was a lack of understanding of systems in different Member States and consequently who was responsible for holding and disseminating fitness to practise information. The Government considered that this potentially posed a threat to patient safety. In their response to the Commission's consultation the Government suggested the development of focus groups composed of representatives from competent authorities, professional bodies and educational institutions in order to enhance mutual understanding and potentially work on ways to align national practices.[97] Similar work with a particular focus on the sharing of fitness to practise information might also be useful. For example the Council for Healthcare Regulatory Excellence (CHRE) explained how it was currently working with the London School of Economics to develop an online International Observatory on the Regulation of Health Professionals which will provide competent authorities with analytical information on how health professional regulation works in other countries and to support regulatory improvement and development.[98]

67. The lack of a distinction between the regulating body and representative body was raised by a number of our witnesses as a serious concern because of the potential conflict of interest. Emma McClarkin MEP described it as having resulted in instances when information on fitness to practise had not been passed on to the host country, threatening patient safety".[99] The Government also saw the lack of distinction as a problem, the Minister telling us that "there should be a clear separation of professional regulation from professional representative functions ... having the unions and regulator connected in that way just will not work".[100]

68. However, we heard differing ideas on what action, if any, it would be appropriate for the EU to take with regard to any harmonisation of regulatory systems. Emma McClarkin MEP, whilst arguing that there was a "clear need to increase transparency and to enforce a duty on competent authorities" to share information, felt that "Member States must remain entitled to organise professional bodies as they see fit". By contrast the Minister told us that that she would like to see the need for "a move towards" a distinction between professional regulation and professional representation articulated in the Directive.[101] The GMC too considered that this would be "a very constructive step forward".[102]

69. **Each Member State should provide a single contact point for competent authorities from other Member States. This should facilitate contact with the most appropriate body with regard to fitness to practise information.**

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96 Q 118

97 DH/BIS

98 CHRE

99 Emma McClarkin MEP

100 Q 162

101 Q 169

102 Q 73

70. **Regarding differing models of regulation, the focus must be on delivering the necessary outcomes. However, there is clearly a potential conflict of interest where a regulator simultaneously acts as a professional body, acting in the interests of its members. We consider it would be helpful to move towards a common understanding among Member States as to the distinction between a representative and regulatory role, while respecting national legal systems and traditions.**

71. **We do not consider harmonised models of regulation to be realistic. It is however essential that competent authorities understand systems in other Member States and how to work effectively with them. Each Member State should therefore inform the Commission and other Member States of its legislative, administrative and regulatory arrangements for fitness to practise criteria and the sharing of information. This information could then be used as the basis for identifying and promoting best practice, potentially encouraging a movement towards greater alignment of national systems.**

CHAPTER 4: LANGUAGE COMPETENCE

72. Communication is central to the work of healthcare professionals and can be considered a facet of fitness to practise (see chapter 2). Healthcare professionals are frequently required to employ communication skills which extend beyond a basic understanding of the language(s) of the Member State they are practising within. They need to be able both to understand precise medical terminology and to communicate effectively with colleagues and patients. Communication with patients requires particular skills. Ruth Marsden, Vice Chair of the National Association of LINks Members[103] described it from the patient perspective: "healthcare is a service of intimacy at a time of vulnerability ... this can rob even the most articulate and composed of individuals of the ability to respond cogently".[104] The complexities and multi-faceted nature of communication with patients was also stressed by the regulators and professional bodies. The RCGP noted that "having experience or qualification in English is not the same as being able to participate fully in the GP consultation in that language, let alone cope with a consultation with a patient for whom English may not be the first language".[105] Professor Sir Peter Rubin of the GMC made a similar point, telling us "it is one thing to take an IELTS test[106] ... in written English, but speaking to a very distressed patient or their distressed relatives is a very different situation".[107] In many settings the ability to communicate colloquially can be equally as important, as on occasion can be the ability to understand local or regional dialect.[108]

73. The Directive as it currently stands requires those benefiting from mobility under the Directive to have "knowledge of languages necessary for practising the profession in the host Member State".[109] Nevertheless, concerns about the restrictions on the ability of competent authorities to test language competence were expressed to us by regulators, employers and patients alike. It is difficult to assess accurately the scale of the problem. Emma McClarkin MEP suggested that there had only been "occasional" problems identified by competent authorities.[110] The HPC similarly told us that although there was no room for complacency and that greater flexibility on language testing would be desirable "we do not have the evidence in terms of numbers".[111] However others highlighted that communicative competence had been at the heart of a number of fitness to practise cases brought against healthcare professionals. The National Clinical Assessment Service noted that language competence in a number of cases referred to it had in its view "placed patient safety at unacceptable risk".[112] The GPhC in a recent review of fitness to

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[103] LINks (Local Involvement Networks) are the current statutory organisations to support patient and public involvement in health

[104] NALM

[105] RCGP

[106] International English Language Testing System

[107] Q 81

[108] NALM, RCGP

[109] Article 53, Directive 2005/36/EC on the recognition of professional qualifications

[110] Emma McClarkin MEP

[111] Q 47

[112] NCAS

practise cases identified two examples involving language competency whilst the GMC identified five cases.[113] The issue of communication is clearly also of concern to patients and the Patients Association highlighted that it was one of the most frequently raised issues on their helpline.[114] The Commission acknowledged that language testing was an "important and controversial issue" where there was "considerable public concern".[115]

Language testing at the point of recognition

74. Healthcare regulators in the UK are currently prevented from systematically testing language ability at the point of registration. Primary responsibility for ensuring language competence is instead left to the employer. This is different to the systems which the regulators apply to migrants from non-EEA states. For example the NMC and GMC require all non-EEA applicants to pass a language test to a specified level.

75. Our evidence revealed some confusion regarding what exactly was permissible at the point of registration and the origin of restrictions. The general understanding among our witnesses was that regulators could check language only on an *ad hoc* basis when they were alerted to an issue and therefore had reasonable doubt about an individual's language competence. The Commission was clear that testing is permissible under certain circumstances, guidance on which is provided in a Code of Conduct.[116] However, the NMC told us this guidance from the Commission, along with that from national authorities, was "ambiguous" and other witnesses agreed that there was a serious lack of clarity.[117] Some witnesses suggested that some of the restrictions had arisen as a result of UK 'gold plating'.[118]

76. Witnesses generally commended the Commission's engagement with the issue of language competence in the Green Paper, which set out two options for consideration. (See Box 4)

BOX 4

Options for Language Testing

Option 1 would make clarifying changes to the Code of Conduct.

Option 2 would amend the Directive with respect to health professionals covered by automatic recognition who have direct contact with patients. It would permit a one-off test of language skills before professionals came into contact with patients.

77. We heard widespread support for allowing regulators to test language at the point of registration.[119] The regulators explained their function as one of 'gatekeepers' to professions and argued that they should be able to satisfy themselves that those they admitted to their register were fit to practise,

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113 GPhC, DH/BIS

114 PA

115 Q 113

116 http://ec.europa.eu/internal_market/qualifications/docs/future/cocon_en.pdf

117 NMC, GMC

118 See for example BMA. Goldplating is where the government transposes requirements into UK law beyond the minimum requirements set out at EU level.

119 EFN, GMC, NMC, BDA, GDC, GPhC, GOsC, MPS, NHS European Office, PA, RCP, Q 127

including with respect to their language competence. They highlighted the fact that their views were shared by their counterparts in other Member States.[120] Alliance Boots, as an employer, also agreed and considered that "the inability of healthcare regulatory bodies to ask for clear proof of high-level fluency in a relevant Member State's official language is a major loophole in the protection offered to patients".[121]

78. Once healthcare professionals are registered with the relevant competent authority, which the Directive states must be done if they have the relevant qualifications, they are free to practise in that Member State. Given the limitations placed on the ability of regulators to test language ability, significant reliance is therefore placed on the employer. We heard concerns that some employers and particularly agencies who take on the responsibilities of employers in this respect may not be sufficiently rigorous in assessing language competence. The GDC suggested that the nature of dental practice as a particularly mixed economy (NHS and private) meant "that complete reliance cannot be placed on employers to identify and act on language skill deficiency".[122] There was particular concern regarding agencies who employ individuals in a locum or temporary capacity. Agencies are responsible for employing significant percentages of professionals in some professions, for example pharmacy, but concern was also raised in other professions. For example the RCS told us that it had "major reservations" and believed that a "lack of stringency could compromise patient safety".[123]

79. The position of self-employed professionals was another argument made in favour of the regulator being able to undertake language testing. There were concerns that giving employers the primary responsibility for ensuring that language requirements are met meant that there were no provisions in place to ensure that self-employed professionals met the required standards. This was of particular concern in professions which had a high proportion of self-employed individuals, for example pharmacy or osteopathy.[124] Even in professions where the risk was perceived to be small, for example those regulated by the HPC where there are few single practitioners with the majority working in a managed environment, it was still acknowledged that the system as it currently stood left the "possibility that somebody could get into the system who does not speak the language".[125] The Commission acknowledged that the position of self-employed professionals was a legitimate matter of concern and acknowledged that a "solution would have to be found".[126]

80. With regard to the options set out in the Green Paper, witnesses felt that greater clarity on the circumstances under which competent authorities are currently able to test language competence would be welcome.[127] However, none of our witnesses made the case that this would be sufficient in itself.

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120 See for example Q 79, Q 99

121 Alliance Boots

122 GDC

123 RCS

124 Q 114, NHS European Office, GOsC

125 Q 47

126 Q 114

127 See for example Q 80, RCP, RCN, GMC

The GDC told us that allowing regulators to test language competence where they believed it to be necessary would be a "safer approach".[128] It was notable that the Commission also conceded that option 1 "may not be sufficiently rigorous".[129]

81. However, a number of witnesses felt that even option 2 was not sufficiently rigorous, limited as it would be to professionals who had direct contact with patients. The GMC felt that this would be "unwise", highlighting that complex language skills which impact on patient safety were not just required in situations with direct contact with patients but also, for example, those with colleagues.[130] Furthermore, given the 'gatekeeper' role of competent authorities there would be nothing to prevent an individual from undertaking a different role in the future which might involve direct patient contact.

82. **We consider that the Directive currently strikes the wrong balance between facilitating mobility and ensuring patient safety, which must be the overriding concern. Furthermore, the current system undermines public and professional confidence in the mobility of healthcare professionals within the EU.**

83. **Language testing should be permitted at the point of registration if deemed necessary for patient safety by the relevant competent authority and changes to this effect should be made to the Directive. The ability of regulators to test language is particularly important in the case of professionals who are self-employed. The current lack of provision to assess the language competence of this group of migrant professionals represents a serious failure of the current system.**

84. **Whilst we consider legislative change to be essential we recognise that achieving this can be a lengthy process. Given the patient safety implications we recommend that the Commission as a matter of urgency clarifies with competent authorities their understanding of what the Directive currently permits in terms of language testing and make changes to the Code of Conduct as necessary.**

85. **We consider that option 2 in the Green Paper, which permits a one-off test of language skills before professionals come into contact with patients, is insufficiently rigorous. Testing should not be restricted to professionals who come into direct contact with patients.**

Proportionality of language testing

86. The Green Paper notes that "systematic language testing can become a means of unfairly preventing foreign professionals from accessing the right to perform a professional activity, if applied disproportionately".[131] Whilst it is important to ensure that language testing does not become a cover for protectionism, it is also, as Emma McClarkin MEP pointed out, important that this should be "tempered by the principal belief that minimum levels of language competence need to be met before employment can commence".

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[128] GDC

[129] Q 113

[130] Q 79

[131] COM (2011) 367

87. Our evidence suggested that different competent authorities had alternative ideas on the type and level of checks they would like to employ, reflecting current differences in practice with regard to non-EEA professionals. The GPhC told us that it "would not suggest a systematic, blanket approach" but wished to have the ability to seek assurances where it had concerns. The GDC similarly told us it did "not seek to undertake systematic language testing, but the ability to test language in certain circumstances at the point of registration". By contrast, the NMC told us it considered the ability to "pass a language test organised by a reputable third party" was the only method which could be both "rigorous and impartial".[132] The GMC agreed, arguing that it would wish to apply the same standards that it currently applies to non-EEA applicants.[133] The difference in requirements reflects the reality that what will be appropriate for one profession will not be appropriate for all. The Government acknowledged that there were different degrees of risk, telling us that they had been focusing much of their efforts on the medical profession for this reason.[134]

88. **Strengthening the rules on language testing to allow a one-off test at the point of registration would potentially strengthen the system of free movement of healthcare professionals by increasing confidence in its provisions for assuring patient safety. The form of the language test should be left to the discretion of the competent authorities, depending on their assessment of the risk for individual professions.**

Role of the employer

89. Many witnesses were at pains to stress the importance of the role of the employer. There was concern that the ability of employers to assess the language competence of an individual for a specific job should not be affected by any changes made to the ability of competent authorities to assess language at the point of registration.[135] However, as Emma McClarkin MEP highlighted, there was also a need to ensure that any changes to the current provisions should not result in a two-tier system where professionals were checked multiple times for exactly the same competence".[136]

90. The NHS European Office was clear that it was "the responsibility of employers to ensure that people they appoint to posts have the necessary skills, including language competence, to perform the tasks for which they are being recruited". The RCS considered the system "to be safe only when the individuals are employed via a properly constituted appointments process ... [which] gives the employer an opportunity at the interview to assess language and communication skills as well as the critical clinical competencies required".[137]

91. The Government and the GMC told us of work they were undertaking jointly to strengthen the current system of testing at employer level. This had involved the appointment of Responsible Officers acting for local employers

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[132] NMC

[133] Q 81

[134] DH/BIS

[135] See for example BMA, GHP

[136] Emma McClarkin MEP

[137] RCS

and given a duty to ensure that medical practitioners have qualifications and experience appropriate to the work to be performed. The Government intended to work with the relevant regulatory bodies and the Commission to explore how a strengthened system of proportionate local checks might be introduced for other healthcare professions.[138]

92. Employers also have an important role in providing ongoing support to professionals, including in the area of language competence and communication. The Government provided the example of understanding the variety of local accents to which a professional may be exposed.[139] The RCP advocated the sharing of models of best practice such as "shadowing attachments" of up to two weeks being used in some UK hospitals to support and assess language competence and to enhance knowledge of the local medical culture, something which some RCN members also advocated.[140]

93. **The nature of language competence and communication skills required will inevitably vary according to the specific role to be undertaken. We consider it unlikely that a one-off test conducted at the point of registration would be sufficient to assure employers. It is therefore vital that changes to the Directive should not restrict the flexibility of the employer to assess applicants proportionately according to the specific requirements of a job. The nature of this assessment is likely to be different and of a less formal kind from that undertaken at the point of registration and we therefore do not believe that this would result in a disproportionate system of dual testing for the same competences.**

94. **We welcome the Government's engagement with the issue of language testing and their work to strengthen assurances of language competence at local level in the UK. We encourage them to press ahead with their work in this area along with working to collate and disseminate best practice.**

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138 DH/BIS

139 DH/BIS

140 RCP, RCN

CHAPTER 5: EUROPEAN PROFESSIONAL CARD

95. Chapters 2–4 of this report have argued for enhanced and more easily available access to information for competent authorities in the interests of patient safety. This chapter considers whether the European professional card proposed in the Green Paper is the best means of achieving these ends before examining some specific risks associated with the concept which would need to be mitigated against.

96. The Green Paper envisages a card being used by all professions covered by the Directive as a tool to facilitate mobility through speeding up the recognition process, and to provide information and proof of status. It is not envisaged that such a card would be mandatory. The Green Paper describes how the card would mobilise both the Member State of origin and the host Member State. Verification of qualifications is currently the responsibility of the host Member State. Under the proposal outlined in the Green Paper this would become the responsibility of the home Member State which would retain proof of qualification and upload details onto the card. This would then be made available to the competent authority in the host Member State. The Green Paper suggests that the card could be particularly useful for those professionals seeking to practise on a temporary basis with all necessary information for competent authorities being either featured on or made available through the card.[141]

97. The card is intended to be used primarily for the purposes of speeding up the process of recognition but it also has potential to be used more widely to share information relating to the professional status of an individual, for example fitness to practise information. The Commission established a steering group on the card in January 2011 composed of representatives from competent authorities across the EU. This group has been charged with examining questions of implementation including the contents and form of a card and the best ways to ensure its reliability. It is expected to put forward proposals later in the year.

98. The majority of our witnesses were unclear as to what a card would look like in practice and the nature of its added value.[142] Indeed, much of the debate was complicated by the vagueness of the concept, with witnesses providing answers on the basis of significantly differing ideas of how the card would function.[143] There was a sense amongst many that the Commission were approaching the issue from the wrong angle. Emma McClarkin MEP told us that it was "clear that this idea is seen by the European Commission as a tangible way to ostensibly prove they are taking action on the issue of mobility" whilst the CHRE considered the proposal failed "the first test of right-touch regulation: it is a solution looking for a problem".[144]

99. We heard limited and, at best, cautious support for the concept of a professional card although some witnesses felt that the idea was at least one

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[141] COM (2011) 367

[142] See for example BDA, CHRE

[143] See for example Q20, GDC, GOsC

[144] Emma McClarkin MEP, CHRE

worth exploring in principle.[145] The Commission told us that despite uncertainty amongst UK stakeholders it was aware of interest from bodies elsewhere in the EU, particularly for doctors and nurses.[146] The NMC explained how cards were currently used for nursing in some Member States, especially those with federal or local regulatory structures where professional registers were not used. Many authorities within these countries therefore looked favourably on the possibility of an EU wide professional card system.[147] The main benefits cited by our witnesses were the potential for an accelerated recognition procedure through mobilising the Member State of departure and its potential to make communication between relevant organisations and access to information easier and more timely.[148] There was also some suggestion that a card might be a useful medium on which to record the CPD of individual professionals.[149] We heard more support for a card being used among those healthcare professions not covered by automatic recognition, and the Government also recognised that it would be easier to see the role a card could play for these professions. The HPC, responsible for regulating many of these professions, considered a card would be useful in speeding up the process of registration and in particular would make the movement of professionals on a temporary basis much easier.[150]

The professional card and the IMI

100. There was no enthusiasm for the idea of a card alone providing a means of entry into practice in a Member State or for a system in which a card would replace the checks undertaken by the competent authorities at the point of recognition. The RCN stressed that this should also be the case for temporary practice and that there should be no suggestion that a card might "water down" requirements.[151] It was notable that even witnesses who were positive about the potential of a card stressed that in order to be successful it would have to work in conjunction with increased use of a strengthened IMI.[152] This was seen as essential in order for competent authorities to be confident of the currency of information, particularly any fitness to practise issues.[153] There was some uncertainty amongst witnesses as to whether a 'live' (i.e. continually updated and web-based) or a 'dead' (i.e. physical) card was being proposed by the Commission but the overwhelming preference was for a real-time system with a physical card seen as a significant risk to patient safety.[154] The proposed nature of any card was not explicit in the Green Paper but the Commission confirmed that it envisaged the card being linked to the IMI.[155]

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145 RPS

146 Q 120

147 Q 94

148 MPS, HPC, EFN

149 Q 26, GHP

150 HPC

151 RCN

152 EFN, RPS, HPC

153 See for example RCP, GMC

154 Q 49, Q 68, Q 92, BMA

155 Q 120

101. Many witnesses questioned what added value a professional card would bring over and above measures to strengthen the IMI, considering that at best it would represent a costly administrative duplication.[156] Emma McClarkin MEP also felt that a professional card should not detract from the "fundamental priority" which should be to improve the IMI system and promote its use.[157] The Government had sympathy with this view, the Minister telling us she was "dubious" and "sceptical" about the idea of the card and "would need a lot of convincing".[158] Instead the Government considered that "more innovative use of the IMI system … might deliver some or most of the same benefits but at more proportionate cost".[159] The NHS European Office summed up the view of many of our witnesses who were "concerned that this proposal has been put forward as a solution without simpler, more cost-effective means of achieving the same objectives being considered first".[160] The disproportionate cost of a professional card was a common concern, both with reference to the cost of establishing and maintaining the system as well as any cost which might fall to individual professionals.[161] Related to this, many witnesses were keen to stress that although there was currently no suggestion otherwise, any card should be strictly voluntary.[162]

Further risks: maintaining confidence and preventing fraud

102. Some witnesses suggested that a professional card could provide a false sense of reassurance, particularly to employers. The NMC explained how it had encountered this issue with a card it used domestically but was considering withdrawing due to such difficulties. It told us that the card served very little purpose and that its "advice to employers is always not to bother to look at the card", instead directing them to a website to ensure that a professional is fit to practise. It was notable that the NMC considered that where professional cards were currently viewed as successful in facilitating mobility this was often in Member States without a register system. Interestingly, it considered the register system was one which a number of Member States were moving towards.[163] The RCP suggested it might provide a false sense of security to professionals. The GMC had related concerns, suggesting it could encourage some "to think that they can wander around without getting registered in another jurisdiction".[164] The HPC felt that a professional card might offer a level of reassurance to patients in some circumstances, for example when making home visits,[165] although we also heard concerns that a professional card might undermine patient confidence, being perceived as a less stringent process, prioritising mobility above safety.[166]

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156 See for example BMA, CHRE, BDA

157 Emma McClarkin MEP

158 Q 166

159 DH/BIS

160 NHS European Office

161 See for example Q20, RCN, Alliance Boots

162 See for example Emma McClarkin MEP, RCP

163 Q 92

164 RCP, Q 68

165 Q 46

166 Q 131, Dr Rory Gray, Dr Stuart Gray

103. Concerns were also raised regarding the potential for fraudulent use of the card.[167] The Commission acknowledged that this was "a problem of all cards" but remained confident that there would be technical solutions to ensure the risks were minimised, although it was not clear what these might be.[168]

104. **The case for the added value of the professional card for the healthcare professions, particularly those covered by automatic recognition, has yet to be made although we acknowledge that the concept may have greater value for those professions covered by the general system. However, it is essential that priority is given to ensuring changes to the Directive are introduced as soon as is possible. If necessary, work on the professional card should be decoupled from this process.**

105. **The aim of increased sharing of information between competent authorities is clearly a laudable one, working both to improve mobility and increase wider confidence in the system. There is much to be welcomed in the Commission's proposals to mobilise home and host Member States, for example the host Member State having automatic electronic access to documents proving qualifications. However, many of these measures would be possible through strengthening of the existing Internal Market Information System (see chapters 3–4) in which significant resources have already been invested.**

106. **We acknowledge that thinking on the professional card has yet to be fully developed but consider there are clear risks associated with the concept. In particular, issues surrounding the accuracy and currency of the data need to be addressed. We believe the idea of a physical card to be incompatible with satisfactorily addressing these. To go down this route would be to adopt an inappropriate 'one size fits all' approach to mobility and we welcome the fact that the Commission's thinking appears orientated towards a 'live', continually updated system. Nevertheless, whilst the idea of a virtual card may have greater potential, the Commission should be alive to the danger that a card would represent, for those professions covered by automatic recognition, a costly and unnecessary measure, failing to command the confidence of professionals and patients alike.**

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[167] See for example Q 71, Q 131, GMC, Emma McClarkin MEP, GOsC, NHS European Office

[168] Q 121

continually updated system. Nevertheless, whilst the idea of a virtual card may have greater potential, the Commission should be alive to the danger that a card would represent, for those professions covered by automatic recognition, a costly and unnecessary measure, failing to command the confidence of professionals and patients alike (paragraph 106).

National Clinical Assessment Service (NCAS)

NHS European Office

North East Scotland Faculty of the Royal College of General Practitioners

⋆ Nursing and Midwifery Council (NMC)

Patients Association (PA)

Royal College of General Practitioners (RCGP)

Royal College of Nursing (RCN)

Royal College of Physicians (RCP)

Royal College of Surgeons of England (RCS)

Royal Pharmaceutical Society (RPS)

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