

To note

Implementing the revised recognition of professional qualifications Directive

Issue

- 1** The revised recognition of professional qualifications Directive 2013/55/EU was adopted in November 2013. We have been working closely with government officials, the European Commission and other regulators in the UK and elsewhere in Europe to ensure the implementation of the new provisions in the Directive do not compromise patient safety in the UK and our statutory functions.

Recommendations

- 2** Council is asked to note:
 - a** The impact of the recently adopted recognition of professional qualifications Directive on the GMC.
 - b** Action taken so far to prepare for its implementation and to mitigate any risks identified in that process.
 - c** The proposed next steps.

Implementation of the revised recognition of professional qualifications Directive

Issue

- 3** The recognition of professional qualifications (RPQ) Directive was first adopted in the 1970s and revised most recently in 2013.
- 4** The Directive is legally binding on the UK and has a direct impact on the Medical Act 1983 (as amended) and on the GMC's rules and procedures. It provides a legal definition of a primary medical qualification, setting out minimum requirements for basic medical training and a system of equivalence for certain specialist qualifications, governs the rules for the recognition of EEA doctors who wish to practise in the UK and defines the rules on language competency for these doctors.
- 5** If the recent changes to the Directive are not fully implemented into UK law by 18 January 2016, the UK is at risk of EU infraction procedures. The UK Government can recover from the GMC any infraction costs if it can demonstrate that the fault lies with us.

Background

- 6** Our engagement has shaped many of the proposals the European Commission (EC) considered during its review. These include:
 - a** The introduction of a legal duty on healthcare professional regulators to share fitness to practise decisions proactively.
 - b** Substantially stronger language requirements for migrating healthcare professionals and powers to assure language competency for regulators on which we are seeking legal advice.
 - c** A European 'Professional Card' (EPC) that takes the form of an online recognition process and certificate rather than a physical card. Doctors are not included in the first implementation phase but are likely to be part of the second phase from 2018.
 - d** A new definition of basic medical training that safeguards UK graduate entry programmes.

The new Directive

- 7** The revised Directive has new elements which will impact across the GMC:

- a** A revised recognition and registration procedure, linked to the EPC, for those wishing to provide both permanent and temporary and occasional services in the UK.
 - b** Partial access, which gives individuals qualified to undertake certain medical professional activities the right to undertake these activities in another member state under certain conditions.
 - c** The possibility of common training frameworks and tests for new medical specialties.
 - d** A fitness to practise alert mechanism mandating the exchange of information between regulators.
 - e** Partial exemptions from UK specialist training if the doctor has already undertaken parts of that training outside the UK.
 - f** A requirement to make application procedures available online.
 - g** Clearer language requirements for healthcare professionals which will build on the powers we introduced in 2014 and will allow us to ask for evidence of language knowledge on a systematic basis.
 - h** A new procedure for adding new medical specialties to automatic recognition.
 - i** A requirement to share experience on approaches to Continuous Professional Development.
 - j** A new definition of basic medical training of '5,500 hours and 5 years'.
- 8** All of the above provisions, with the exception of the EPC and the common training frameworks and tests, need to be implemented into UK law by 18 January 2016.
- 9** The revised Directive contains reforms that will improve patient safety and that we were instrumental in bringing about, notably clearer rules on language proficiency and the fitness to practise alert mechanism. But it also contains some risks that are associated with partial access, the EPC and the new temporary and occasional procedure. We will act to mitigate these risks associated and we will update Council on these later this year.

Our activities and engagement to date

- 10** Since the adoption of the Directive at the end of 2013, we have:
- a** Responded to a number of consultations by Department of Health (DH), Department of Business, Innovation and Skills (BIS) and the European Commission. We have provided regular feedback and observations to the EC on

secondary legislation, directly resulting in clarifications to proposals that support patient safety and regulators' operational requirements.

- b** We have prepared impact assessments for each GMC Directorate and sought legal advice to ensure we are ready for transposition by January 2016. Concerns identified in these assessments and the legal advice are being brought to DH, BIS and the EC's attention to try and resolve issues in advance of implementation.
- c** Met Commission officials on a number of occasions including the new Head of Unit at the EC, Martin Frohn, and attended and actively participated in three EPC expert group meetings in Brussels organised by the Commission.
- d** Continued to coordinate the European Network of Medical Competent Authorities (ENMCA). This has met 12 times since its creation in 2010 and twice in 2014 to discuss common challenges surrounding the implementation of the Directive. ENMCA has also responded jointly to EC proposals on the EPC.
- e** Continued to convene the Alliance of UK Health Regulators on Europe, which meets regularly, with BIS and the DH(E) officials in attendance.

Next steps

11 Our work on the Directive has two main strands:

- a** UK implementation ahead of the January 2016 deadline.
- b** Engaging with the EU to influence further initiatives that the EC will take forward via secondary legislation

12 On the former, we plan to:

- a** Respond to DH(E) and BIS consultations, planned for 2015 after the general election, on draft regulations transposing the Directive into UK law seeking further legal advice as required.
- b** Continue working with the AURE and ENMCA groups to address common concerns.
- c** Assure the proposed Law Commissions Bill is aligned with the requirements of the Directive.

13 On the latter, we will seek to:

- a** Respond to EC secondary legislation as GMC, ENMCA and AURE bringing any concerns to the attention of DH(E), BIS, the EC, and the Group of Coordinators before the adoption of any secondary legislation.

- b** Seek to build alliances and common approaches with European umbrella organisations representing the medical profession and other health professions.

Supporting information

How this issue relates to the corporate strategy and business plan

- 14** Strategic aim one: to make the best use of intelligence about doctors and the healthcare environment to ensure good standards and identify risks to patients requires us to engage with the development and implementation of legislation that impacts on patient safety.
- 15** The implementation of the revised Directive also relates to strategic aim five: to work better together to improve our overall effectiveness, our responsiveness, and the delivery of our regulatory functions.

If you have any questions about this paper please contact: Shane Carmichael, Assistant Director - Strategy and Communication, scarmichael@gmc-uk.org, 020 7189 5259.