To consider

Implementing the revised recognition of professional qualifications Directive

Issue

1. Following the adoption of the revised recognition of professional qualifications Directive 2013/55/EU 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. The Strategy and Policy Board is asked to:

a. Note the impact of the recently adopted recognition of professional qualifications Directive on the GMC.

b. Note action taken so far to prepare for its implementation and to mitigate any risks identified in that process.

c. Agree 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 and on the GMC’s rules and procedures. It provides a legal definition of a primary medical qualification (PMQ), 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 EC considered during its review. These include:

   a The introduction of a legal duty on healthcare professional regulators to proactively share fitness to practise decisions.

   b Substantially stronger and clearer language requirements for migrating healthcare professionals and powers to assure competency for regulators.

   c A professional card that takes the form of an online recognition process and certificate rather than a physical card.

   d A new definition of basic medical training that safeguards UK graduate entry programmes.

The new Directive

7 The revised Directive contains a number of new elements which will impact across the organisation. They are:

   a Recognition to be obtained through an online system called the European Professional Card (EPC).
b A revised recognition and registration procedure, linked to the EPC, for those wishing to provide temporary and occasional services in another member state.

c Partial access, which gives doctors qualified to undertake certain professional activities the right to do so in another member state under certain conditions.

d Common training frameworks and tests for new medical specialties.

e A fitness to practice alert mechanism mandating the exchange of information between regulators.

f Partial exemptions for parts of specialist training undertaken outside the UK.

g A requirement to make application procedures available online.

h Clearer language requirements for healthcare professionals which will build on the powers we introduced in 2014.

i A new procedure for Annex V notifications when new medical specialties are added to automatic recognition.

j A requirement for member states to share experiences on their approaches to Continuous Professional Development.

k A new definition of basic medical training of ‘5500 hours and 5 years’.

8 We have established that the main risks to patient safety and our statutory responsibilities are linked to the EPC, the new temporary occasional procedure the EPC would introduce, and partial access. We are undertaking a number of actions (at Annex A) to mitigate the risks associated with these.

Our activities and engagement to date

9 Since the adoption of the Directive at the end of 2013, we have:

a Responded to a number of informal and formal consultations by DH, BIS and the European Commission (EC) to ensure transposition of the Directive minimises the risk to patient safety in the UK.

b Provided regular feedback and observations to the EC on forthcoming secondary legislation (Implementing and Delegated Acts), via UK government officials and directly, to feed into the RPQ Coordinators Group.

c Established an internal, cross-Directorate working group that meets on a monthly basis. The group has prepared Directive impact assessments for each GMC Directorate on the basis of which it has sought legal advice to ensure we are ready for transposition by January 2016. Concerns identified in these impact
assessments and the legal advice are being brought to DH, BIS and the EC’s attention to ensure that any potential issues with implementation are resolved in advance of the implementation deadline.

d Met Commission officials on a number of occasions including the new Head of Unit, Martin Frohn and attended and actively participated in three EPC expert group meetings in Brussels organised by the Commission.

e 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.

f Continued to convene the Alliance of UK Health Regulators on Europe, which meets regularly, with BIS and the DH(E) officials in attendance.

Proposed next steps

10 Our work on the Directive can be broadly categorised into two strands:

   a UK implementation of the new provisions in time for the transposition deadline.

   b EU engagement to influence those initiatives that the EC will take forward via Implementing and Delegated Acts and which are expected to be published in early 2015.

11 On the former, we plan to:

   a Respond to DH(E) and BIS consultations, planned for 2015, on draft regulations transposing the Directive into UK law.

   b Continue working with the AURE group to address common concerns

   c Assure the proposed Law Commissions Bill is aligned with the requirements of the Directive.

12 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 Implementing and Delegated Acts

   b Seek to build alliances and common approaches with European umbrella organisations representing other professions.
13 Both of these strands of work will entail working across the organisation to ensure that systems and processes are introduced or modified in time for the implementation deadline of January 2016.

14 We will also provide an update on the Directive and our work to prepare for its implementation to GMC Council at a time to be confirmed in 2015.
Supporting information

How this issue relates to the corporate strategy and business plan

15 Strategic aim 1: 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.

16 The implementation of the revised Directive also relates to strategic aim 6 of the Corporate Strategy and our commitment in the 2014 Business Plan to work in partnership with key interest groups across the UK, Europe, and internationally, to develop appropriate, more effective relationships that will enhance patient safety.

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

Issue
1. This paper outlines three of the key risks to the organisation from the revised Directive and details the mitigating actions that we have taken.

2. The three key risks identified for the revised Directive are:
   - European professional card
   - Partial access
   - Temporary and occasional practice
## Key risk 1: European professional card

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<th><strong>Risks</strong></th>
<th><strong>Mitigation</strong></th>
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<tr>
<td>• Ultimate aim: removal of all barriers EC deems unnecessary &amp; trust robustness of checks done elsewhere</td>
<td>• Ongoing dialogue and joint working with other UK regulators affected: NMC, GPhC, PSNI &amp; HCPC</td>
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<td>• Reliance on home regulator to verify documents</td>
<td>• UK regulators met the EC to discuss our concerns on the card (13/10)</td>
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<td>• Recognition fees – unclear if host regulator can charge for scrutiny of applications</td>
<td>• Sent information to the EC on regulators’ documentary and translation requirements</td>
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<td>• Official translations – only permitted for certain documents</td>
<td>• Niall Dickson met Martin Frohn, the EC Head of Unit for the Directive, and Vicky Ford MEP on 15/10</td>
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<td>• Type/form of evidence for general systems – reduced flexibility</td>
<td>• AURE wrote to DH about concerns on the recognition fees host regulators can charge (November)</td>
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<td>• Impact on fraud detection &amp; ID checking practices</td>
<td>• AURE wrote to DH to suggest a 6 month transition period between EPC adoption and implementation (December)</td>
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<td>• Tacit recognition if deadlines missed</td>
<td>• Ongoing sharing of our concerns with regulators across Europe encouraged them to feed their comments to the EC via their government coordinators</td>
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<td>• Likely to increase T&amp;O applications</td>
<td>• Ongoing sharing of our concerns with the British Medical Association and encouraged them to use their influence within the Standing Committee of European Doctors to engage with the EC</td>
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- The European Network of Medical Competent Authorities discussed the EC’s proposals, in the presence of the EC, at its meeting in Malta on 24 November
- ENMCA coordinators have agreed to try and adopt a common position on the draft Implementing Act for the EPC once published.
## Key risk 2: Partial access

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<th><strong>Risks</strong></th>
<th><strong>Mitigation</strong></th>
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<tr>
<td>• No blanket exemption for sectoral professions (this includes doctors)</td>
<td>• Sought clarification from DH, BIS and EC on applicability for medical profession</td>
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<td>• Separate medical register or annotations of the current register suggested by DH</td>
<td>• EC confirmed (ND meeting on 15/10) that:</td>
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<td>• Cannot foresee how this would ever apply to doctors as minimum training requirements are set out in the Directive</td>
<td>- Refusal on a case-by-case basis acceptable</td>
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<td>- Separate medical registers or annotations of the current register not required</td>
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<td>- Partial access should not undermine minimum training requirements</td>
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<td>• Responded to DH draft amendments to Medical Act (Sept 2014)</td>
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<td>• Responded to BIS consultation (Nov 2014)</td>
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<td>• Commissioned legal advice to explore options for alternative means to legislate outwith Medical Act</td>
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<td>• Wrote to Gavin Larner to suggest way forward via overarching BIS implementing regulations (Nov 2014)</td>
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<td>Mitigation</td>
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| • T&O doctors are not required to:  
  • pay registration fees  
  • meet our revalidation requirements, thereby demonstrating on-going fitness to practise  
  • have in place appropriate cover under an indemnity arrangement  
  • comply with our language controls  
  • European professional card likely to result in increase in T&O applications  
  • Under the EPC the home regulator will grant T&O recognition – role of host regulator is limited  
  • EPC also extends validity to 18 months  
  • Unclear as to what documents we can request from T&O applicants | • Ongoing policy work in R&R to establish a corporate position on T&O  
• Commissioned legal advice to clarify documentary requirements  
• Engaged with EC, DH and BIS to call for exclusion of T&O from European professional card  
• Contact with other regulators (e.g. Medical Council of Ireland, General Dental Council) on how they are handling T&O |