EU Commission consultation paper on the professional qualifications directive – NMC response

Background

We are the nursing and midwifery regulator for England, Wales, Scotland, Northern Ireland and the Islands. We exist to safeguard the health and wellbeing of the public. We set standards of education, training, conduct and performance for nurses and midwives, and hold the register of those who have qualified and meet those standards. We provide guidance and advice for nurses and midwives and we have clear and transparent processes to investigate and deal with those whose fitness to practise is called into question.

The NMC welcomes the EU Commission's consultation paper on the qualifications directive. We have been heavily engaged in the consultation process, having led the collection of 26 national reports on the implementation of the directive for the profession of nursing in the fall of 2010. We are also active members of the network of European midwifery regulators (NEMIR). We welcome the opportunity to provide the EU commission with additional views on potential changes to the directive.

The NMC processes the applications of about 7,000 EU nurses and midwives every year under the provisions of Directive 2005/36/EC. The directive has been a determining factor in increasing the freedom of movement in the EU and the NMC recognises the positive contribution of EU nurses and midwives to the provision of healthcare in the UK.

However, we must use the opportunity of the directive's revision to enhance patient safety while respecting the rights of migrating professionals.

Answers to the consultation

Q1. Do you have any suggestions for improving citizen's access to information on the recognition processes for their professional qualification in another Member State?

A1. The key to success in this area is making the existence of the directive known to all professionals, by enlisting the aid and mutual cooperation of competent authorities, professional associations and consumer bodies to make the processes open and transparent. To achieve this goal, National Contact Points, national SOLVIT centres, competent authorities and national coordinators must improve their mutual cooperation.

Q2. Do you have any suggestions for the simplification of the current recognition procedures? If so, please provide suggestions with supporting evidence.

A2. The challenge of the current recognition procedures is that they have evolved piece by piece, as EU membership has grown over the years. Complications have tended to

be added both to achieve political agreement and by ad hoc decisions of the European Court of Justice (ECJ). There cannot possibly be a need to recognise 4,700 different 'professions' and 'occupations' as separate entities, or even 800 categories.

Whilst competent authorities should strive to ensure that their processes are fair and transparent it should always be remembered that healthcare regulators such as the NMC have a statutory duty to protect patients and ensure high standards of care. Therefore this should be borne in mind when discussing simplification of procedures.

The NMC believes that core regulated professions especially those in healthcare should be separated from all other categories in order to address their particularities such as their essential role in patient safety. A separate directive which dealt only with the recognition of healthcare qualifications would hence be a useful development.

Q3. Should the Code of Conduct be enforceable? Is there a need to amend the contents of the Code of Conduct? Please specify and provide reasons for your suggestions.

A3. The code of conduct applies to all regulated professions and is thus not specifically designed to address the needs of any one profession. We therefore do not believe that the code of conduct as it exists should be made enforceable. It does not provide enough flexibility for healthcare competent authorities to meet the higher safety procedures necessary to the registration of health professionals.

There is however a role for a 'code of practice' to be developed and updated by those involved in making the system work, which aims to share good emerging practice, and to give mutual guidance on the issues most commonly referred to National Coordinators, National SOLVIT Centres and the European Commission for resolution.

Q4. Do you have any experience of compensation measures? Do you consider that they could have a deterrent effect, for example as regards the three years duration of an adaptation period?

A4. The NMC has significant experience with compensation measures. We understand that when the general system was drafted it was meant to address the rare cases where an applicant did not benefit from either automatic recognition or acquired rights. However, we feel this system has almost become the norm due to the significant shortfalls we experience with certain applicants. This has lead to challenges for the organisation and delivery of adaptation periods in a healthcare system which already suffers from pressure on placements for UK nursing and midwifery students.

We understand that an adaptation of three years nearly equates to retraining entirely. However, reducing the maximum duration of adaptation periods would not be helpful as it does provide maximum flexibility. In any case, adaptations should not be evaluated in terms of their length, but in terms of their scope and should be measured against standards rather than a period of time.

The NMC is designing an aptitude test which will be available for EU applicants to sit for the first time in May 2011 and thereafter will run six times a year. We will closely monitor

the results of this test and are committed to share our best practice with other competent authorities in Europe.

Q5. Do you support the idea of developing Europe-wide codes of conduct on aptitude tests or adaptation periods?

A5. No. Member states have different healthcare higher education systems, and provision and funding of compensation measures are very different across the EU. We believe that we need a framework which would enable comparisons to be criterion-referenced, thereby reducing the need for compensation measures in many cases.

In the case of nursing, no peer review was organised for specialist branches like children's nursing. The result of this is that competent authorities have to devise compensation measures for professions which share little more than their name and have wide differences in their scope of practice. Where there is a need, it should be clear which outcomes need to be achieved, not how long or what kind of training or experiential learning, therefore a code of conduct in this area would not be helpful.

Q6. Do you see a need to include the case-law on 'partial access' into the Directive? Under what conditions could a professional who received 'partial access' acquire full access?

A6. We understand how some special cases like that of civil engineers have given rise to European Court of Justice referrals. However, we strongly believe that "partial access" should not be included into the directive. Doing so would undermine the whole meaning of the directive, making minimum training requirements and compensation measures redundant. If a migrant cannot compensate the shortfalls in their training through an adaptation or an aptitude test, this indicates that they are not fit to practise in the host country.

Furthermore, this would open the question "how many parts are there to a profession?". The NMC believes that competent authorities in member states are the best placed to decide on the standards and the scope of practice of a given profession. Including "partial access" into the directive would undermine the fundamentals of regulation. The NMC relies on self-regulation and partial access would necessitate strong policing of individual nurses, midwives and their employers. Employers would have to check the registration of each nurse and midwife from the EU to ensure themselves that they do not have conditions to their practice. This would create confusion and suspicion from employers and patients, resulting in potential apprehension to employ an EU nurse or midwife. Ultimately this process would increase barriers to nurses' and midwives' free movement.

The ECJ, in the *Collegios de ingenerios* case, ruled that partial access must be granted if two conditions are met; that the differences in activities are so large that they cannot be compensated, and that there are no valid public interest reasons to prohibit such partial access. In the cases of health professions the public interest reason is evident and hence such professions should not be subject to the jurisprudence.

Q11. What are your views about the objectives of a European professional card? Should such a card speed up the recognition process? Should it increase transparency for consumers and employers? Should it enhance confidence and forge closer cooperation between a home and host member state?

A11. Professional cards could help streamline the process of registration and facilitate mobility. However, a card should be a uniform system for the whole of the EU and there needs to be sufficient and effective interoperability between the IT systems of competent authorities. One way of achieving this, rather than creating new systems, would be to link professional cards to the trusted Internal Market Information (IMI) system.

The only way a professional card could speed up the recognition process is if it gave access to an updated database which could satisfy the host member state that the migrant has the necessary qualifications and is fit to practise at the time of the application. Anything less would not be helpful. In order to achieve this goal, competent authorities across the EU would need to have "live registers" which would also contain information on the migrant's qualification. If this was the case though, a professional card would be superfluous; indeed, one would only need to consult the home member state's register through an online connection to obtain all the necessary information.

Q12. Do you agree with the proposed features of the card?

A12. If a card was to be introduced, it would have to be issued by competent authorities. They are the holders of the information necessary to the recognition of professional qualifications.

In the case of temporary provision of services, if the card provided up-to-date details of the migrant's qualifications and fitness to practise information[*], then it could speed up the declaration process. However, it is imperative that a declaration of the intention to practise in the host country remains a compulsory measure.

In the case of establishment, if the card was to be issued on a case by case basis, it would not necessarily reduce the administrative burden on the migrant. The application procedures to obtain a card in the home country might be similar in length as the establishment procedure in the host country, especially in cases of automatic recognition.

Q13. What information would be essential on the card?

A13. The card should contain very limited information, such as name of cardholder and contact details for the home competent authority (although this can be found easily through IMI). Any information regarding the registration status of the cardholder would only be relevant on the day of issue. After that the information would be out of date and of no use to the host competent authority. The card, if it is introduced, should only be a means to direct the host competent authority to an up to date database in the home country, which holds all the necessary information for the recognition of professional qualifications.

[*] That is, if the nurse or midwife has any professional conduct proceedings against them or if they have been suspended or removed from the home competent authority's register.

Q14. Do you think that the title 'professional card' is appropriate? Would the title 'professional passport', with its connotation of mobility, be more appropriate?

A14. If a card was introduced the title "professional passport" may be more appropriate, since its core function is to facilitate the recognition of qualifications in another EU country.

Q15. What are your views about introducing the concept of a European curriculum – a kind of 28th regime applicable in addition to national requirements? What conditions could be foreseen for this development?

A15. The NMC understands that the proposed EU curriculum does not apply to the sectoral professions such as nursing and midwifery and will therefore not comment on this question.

Q17. Should lighter regimes for professionals be developed who accompany consumers to another Member State?

No. Whether the accompanying professional is simply acting as an advisor to their own principal or whether there is an interaction (for example in the need to refer a patient), we would consider their actions as practice. It is illegal to practice as a nurse or midwife in the UK without being registered with the NMC.

Q18. How could the current declaration regime be simplified, in order to reduce unnecessary burdens? Is it necessary to require a declaration where the essential part of the services is provided on-line without declaration?

A18. The NMC has not investigated this issue in detail. However, it seems reasonable to expect that future IT systems could be developed that allow for online notification via IMI linked web-sites, using personal identification numbers etc.

Q19. Is there a need for retaining a pro-forma registration system?

A19. Yes. It is essential that nurses and midwives who wish to work in the UK register with the NMC, even if they provide temporary services. This serves an important public protection function; being on the NMC register gives nurses and midwives the right to practise in the UK.

Employers consult the NMC register online before employing nurses and midwives to satisfy themselves that they have the right to practise. If the registration of temporary providers of services was abolished it would be illegal for the professional to practise, employers would not be able to employ them, and patients would not be able to check the background of their service provider.

Q20. Should Member States reduce the current scope for prior checks of qualifications and accordingly the scope for derogating from the declaration regime?

A20. Nursing and midwifery are professions with public health and safety implications which give the NMC the right to check their qualifications in advance of their temporary provision of service. The view that prior checks are an obstacle to the freedom of movement seems to be an opinion influenced by internal market considerations. As the regulator of nurses and midwives in the UK, the NMC's mission is to safeguard the health and wellbeing of the public. We believe that the prior declaration regime and the prior checks we perform on professionals who wish to practise on a temporary basis are the least we can do to ensure ourselves and the public that they are fit to practise. We would strongly oppose any reduction in our scope for prior checks of qualifications.

Q21. Does the current minimum training harmonisation offer a real access to the professions, in particular for nurses, midwives and pharmacists?

A21. Overall, the current minimum training requirements which give applicants automatic recognition do offer access to the professions. The NMC recognises approximately 2000 qualifications of nurses and midwives every year under the automatic recognition regime. The question is whether they give access to employment. The NMC does not hold formal evidence but we have indications that employers are confused by the wide difference in the scope of practice of EU nurses and midwives, even those whose training meets the requirements for automatic recognition. The situation applies especially to the midwifery profession. This can reduce confidence in the qualifications of foreign professionals. Some employers helpfully run courses aimed at helping international nurses and midwives to the British health system. However, many of these issues could be resolved by including output competences to the requirements and by updating Annex V to reflect modern practice based on evidence.

The NMC, as chair of the network of EU competent authorities for nurses is willing to lead discussions on the issue and suggest possible updates to the European Commission.

Q22. Do you see a need to modernise the minimum training requirements? Should these requirements also include a limited set of competences? If so, what kind of competences should be considered?

A22. Yes, as explained in question 21 the NMC believes that the minimum training requirements need updating to encourage a more holistic and outcomes-based learning and assessment. The requirements set out in Annex V of the directive date back three decades. They do not reflect contemporary practice, new roles and scientific and academic progress anymore and are thus not fit for purpose. The majority of national reports for the professions of nursing and midwifery which were submitted in September 2010 called for an update. In addition, we feel that the separation of theory and practice is not helpful as it does not provide for modern ways of learning such as simulation.

We also believe that a set of competences should be included along with the minimum training requirements. The Tuning project and the European Qualification Framework can indicate the types of competences which could be considered for use in new

specifications of requirements. However, we believe that competent authorities, in their regulating role, should lead on the discussions. The NMC, as chair of the network of EU competent authorities for nurses, is committed to lead the work on the identification of necessary competences in partnership with programme providers.

Q23. Should a Member State be obliged to be more transparent and to provide more information to the other Member States about future qualifications which benefit from automatic recognition?

Q24. Should the current scheme for notifying new diplomas be overhauled? Should such notifications be made at a much earlier stage? Please be specific in your reasons.

A 23-24. Yes, mutual confidence in other Member States' systems is vital. This is best achieved by transparent, cooperative arrangements. The directive is unclear as to the procedure to follow when a member state devises a new qualification which benefits from automatic recognition. Article 21.7 provides that member states shall notify the European Commission and other member states of future evidence of formal qualifications. Experience has shown that the procedures are not satisfactory.

We believe that when a member state adopts a new qualification which benefits from automatic recognition, it should consult other member states at least one academic year before its implementation. This would give other competent authorities the opportunity to satisfy themselves that the programme meets the minimum training requirements. It would also assure students that, upon completion, the programme they are entering will give them access to the profession in other member states.

We do not suggest that new qualifications should be accredited by all other member states; this would be too burdensome. However, in the name of mutual confidence, it would be beneficial that other competent authorities be presented with complete and transparent information about the qualifications which they will be asked to recognise automatically in the future. This could be organised as an informal peer assessment group.

Q27. Do you see a need for taking more account of continuing professional development at EU level? If yes, how could this be reflected in the Directive?

A27. The need for continuous professional development (CPD), either to keep up to date in the current area of practice or to move into new areas, should be a professional obligation. It is already a requirement for nurses and midwives in most EU countries. However, some countries do not require CPD and this can put their professionals at a disadvantage when they seek employment in another member state.

Nurses and midwives on the NMC register are asked to undertake CPD in order to maintain their registration. This system guarantees that all nurses and midwives who practise in the UK keep their practice up to date. However, in the absence of CPD requirements in the directive, we have had to automatically register EU nurses and midwives who had not practised for 20 years, without the power to require them to undergo a return to practice programme. This is wholly unsatisfactory.

We ask for CPD to be made compulsory at EU level. A minimum definition of CPD should be agreed on by competent authorities and reflected in a code of conduct. This would help harmonise the professions across the EU and help those professionals whose home member state does not require CPD find employment in other member states. It would also give competent authorities the ability to ask migrants who have not practised in a long time to update their skills and knowledge, thus enhancing patient safety.

Q28. Would the extension of the IMI to the professions outside the scope of the Services Directive create more confidence between Member States? Should the extension of the mandatory use of IMI include a proactive alert mechanism for cases where such a mechanism currently does not apply, notably health professions?

A28. The NMC supports the extension of the IMI; we have used this tool since 2009 and find it very useful to communicate with respective competent authorities. Other competent authorities have also commended its success. Although some technical improvements may still be necessary, the IMI needs to be made to work and be mandatory for use by all competent authorities, and with appropriate response times. A smooth working IMI might take some pressure off the need for a comprehensive real-time system of professional cards.

We strongly support the introduction of a proactive alert mechanism for health professions. Patient protection would benefit from competent authorities being able to proactively share information; it would give us the means to prevent the very small yet damaging number of professionals who use the limitations of the directive to commit harm with impunity.

We understand that data protection legislation may discourage some competent authorities from proactively sharing information on professionals. An alert mechanism imbedded in IMI would alleviate these concerns as the information would only be shared between competent authorities.

Q29. In which cases should an alert obligation be triggered?

A29. An alert must be triggered whenever a home competent authority suspends or deregisters anyone for reasons relating to their fitness to practise. The alert should be targeted to avoid inundating all competent authorities. It would be the sanctioning competent authority's responsibility to decide which competent authorities might benefit from being alerted. These could, for example, be the competent authority in the home country of a migrant professional, the competent authority of a country which shares the same language, or where there are reasonable doubts that the professional may decide to emigrate. Competent authorities should decide amongst themselves on a code of best practice regarding proactive alerts.

It must be noted that the information shared through the alert would not necessarily prevent a migrating professional from registering in another member state. It would be up to the host competent authority to judge the case on its merits and evaluated against its national standards. The alert mechanism should never be viewed as a barrier to the mobility of professionals. It is a means to protect the public by giving competent

authorities all the information they need to satisfy themselves that the people they register are fit to practise.

Q30. Have you encountered any major problems with the current language regime as foreseen in the Directive?

A30. The current language regime as foreseen in Article 53 is not helpful for competent authorities. The implementation of Article 53 and the interpretation of case law prevent competent authorities from systematically language testing applicants. The ambiguous guidance obtained from the European Commission and national authorities suggest that the NMC can language check on an ad-hoc basis when we have reasonable doubts. But this logically implies that we must evaluate all applicants' knowledge of English in order to identify those about which we have doubts. Even so, there is no clarity on whether registration can be dependant on the applicant demonstrating that they possess sufficient knowledge of English.

We believe that this lack of clarity puts patients at risk and is unfair to applicants because competent authorities may not be the best placed to individually evaluate their knowledge of language. The NMC requires all non-EU applicants to pass a language test organised by a reputable third party. This is the only way that is both rigorous and impartial. We would therefore welcome the possibility to systematically language check all EU applicants.

The NMC understands that rigorous language requirements may not be necessary for some professions and that they may be an obstacle to freedom of movement. However, we call on the EU commission to recognise that health professions such as nursing and midwifery are singular because the quality of the service they perform is dependant on a high knowledge of the national language.

Further information

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