

PART 13

CROSS BORDER ISSUES

Provisional Proposal 13-1: The statute should require the regulators to specify in rules which qualifications would entitle an applicant to be registered, including overseas qualifications.

- 13.1 A large majority agreed with this proposal.¹ For example, the Pharmaceutical Society of Northern Ireland said the proposal was an “essential consideration within any new statute”.
- 13.2 Whilst most consultees did not explain why they agreed, those that did stressed that the rules are too detailed to be the subject of primary legislation and that this was an appropriate role for the regulator rather than Government.
- 13.3 In addition, the General Dental Council felt that this proposal would enable the regulators to stop a course or prevent graduates registering if the course was found to be inadequate. The Professional Standards Authority felt that the proposal would allow for “greater flexibility and agility in specifying the entitling qualifications as these change with time”.
- 13.4 However, some consultees thought that the proposal was too rigid. An individual consultee (Anonymous) said:

This is too prescriptive – it should be open to regulators to state in any way they see fit the standard of practice and/or competence that is expected rather than exactly which qualifications are relevant. In the case of multi-professional regulators and for non-EEA qualifications it would be too cumbersome to state in rules all the qualifications which might be relevant.

- 13.5 The General Optical Council thought it would be “more appropriate for rules to set out the process for assessment and recognition of applicants’ qualifications”.
- 13.6 Several consultees were of the view that the proposal should only apply to the sectoral professions, while the general systems professions require a case by case assessment. For example, the General Pharmaceutical Council commented that it could see:

significant challenges in implementing this proposal for those professionals exercising free movement rights under the general system as these applications are required to be assessed on a case by case basis, taking into consideration not only an applicant’s qualifications, but also their work experience and continuing professional development/continuing education.

- 13.7 The Department of Health and the Scottish Government questioned the practicality of specifying qualifications in rules, especially given the requirement for consultation each time the rules are amended. The Department also felt that

¹ Of the 192 submissions which were received, 40 expressed a view on this proposal: 30 agreed, 7 disagreed, and 3 held equivocal positions.

there should be an express duty on the regulators to ensure compliance with the Directive in any rules they make.

13.8 Other concerns raised by consultees included the following:

- (1) the rules would have to be updated frequently (the Medical and Dental Defence Union of Scotland);
- (2) the regulators may lack access to comprehensive information on overseas qualifications (Allied Health Professions Federation);
- (3) the proposed system might not be workable as regards non-EEA qualifications (the General Medical Council); and
- (4) there needs to be greater consistency between the regulators on this matter (UNISON).

13.9 The Department of Health, Social Services and Public Safety for Northern Ireland argued that in relation to nursing “entry should be based on meeting standards set for entry to the register, not on qualifications alone”.

13.10 Action Against Medical Accidents also criticised the consultation paper for not going further. It felt that:

The new arrangements should address the problems resulting from the freedom accorded to EEA registered health professionals to practise in the UK without the normal checks and balances which the regulators apply to all other health professionals from overseas, including checks on competence and English language skills. Health professionals from the EEA area make up an increasing proportion of the healthcare community in the UK and without closing these gaps a large number of health professionals will simply not be covered by the system of regulation which the Law Commission is considering.

Language testing

13.11 A number of consultees raised the question of a language check for EEA nationals, arguing that this was a crucial issue which should be clarified and tackled by the regulators. For example, NHS Greater Glasgow and Clyde expressed concerns that this issue had been devolved inappropriately to local employers, even though it raises concerns relating to patient safety. Pharmacy Voice considered that “health care professionals from overseas must be able to communicate effectively in the language of the country in which they wish to practise”.

13.12 The Royal Pharmaceutical Society of Great Britain argued that “language/communication must be assessed before a professional can register and practise”. Pharmacy Voice added that language testing should be “an automatic issue” which is addressed by the regulator.

13.13 Several consultees, including the Chartered Society of Physiotherapy, pointed to a need for all regulators to apply “profession-specific language tests”, instead of a “generic language test”.

Provisional Proposal 13-2: The default powers of the Government should include the ability to intervene in cases where there is likely to be or has been a failure to implement the Qualifications Directive properly.

- 13.14 An overwhelming majority agreed that the default powers of the Government should include the ability to intervene in cases where there is likely to be or has been a failure to implement the Qualifications Directive properly.² For example, the Association of Regulatory and Disciplinary Lawyers agreed that the proposal “is an essential safeguard that should reside with the Government for use in exceptional circumstances”.
- 13.15 The Department of Health agreed with intervention powers but felt these should rest with the Privy Council and not Government. It also argued that:
- The power should go wider than just the Qualifications Directive and extend to circumstances in which the regulators are failing to properly discharge any of their duties under a European Treaty to which the UK is party. The rationale for such a power would be to seek to prevent an infraction of the UK’s treaty obligations from occurring.
- 13.16 The Allied Health Professions Federation agreed with the proposal, and thought it “should also include the failure to adhere to the code of conduct for regulators relating to the Professional Qualifications Directive”.
- 13.17 Some consultees called for further clarity as regards the role of the Government in the interpretation and implementation of EU law. The General Osteopathic Council suggested that the Government should take the advice of the Professional Standards Authority before exercising this power.
- 13.18 Although the General Medical Council accepted that “it is reasonable that a Government would wish to avoid costly infraction proceedings in the event that the regulator’s actions would be in conflict with EU law”, it argued that the Localism Act 2011 already meets this concern. It also considered that this provision grants too much power to the Government and that “when EU issues raise interpretation issues, the regulator’s views aiming to protect public interest should prevail”.
- 13.19 The Professional Forum of the Pharmaceutical Society of Northern Ireland commented that “all default powers should only be used in conjunction with the devolved administrations”.

² Of the 192 submissions which were received, 35 expressed a view on this proposal: 33 agreed with the proposal, 1 disagreed, whilst 1 held an equivocal position.

Provisional Proposal 13-3: The statute should include broad powers for the regulators to register those from non-EEA countries, including powers to set requirements as to the language, practice and education requirements.

13.20 The vast majority agreed with this proposal.³ For example, the Royal College of Nursing said it supported this approach:

in recognition that the UK regulators already carry out these functions, that the UK has traditionally been a destination country for large numbers of health professionals from outside the EU, and because it is important that migrants are treated fairly and transparently.

13.21 Many consultees, for example, the Academy of Medical Royal Colleges, stressed the need to set up similar checks for EEA nationals. The Association of Regulatory and Disciplinary Lawyers argued that in order to ensure transparency, the rules must be made public.

13.22 The Chartered Society of Physiotherapy and NHS Education for Scotland also stressed the need for consistent rules across the regulators. The Allied Health Professions Federation agreed that consistency was required, “given the common issues involved regardless of profession, and with regulators’ criteria and processes having evident transparency, fairness and rigour”.

13.23 The British Association and College of Occupational Therapists argued that the regulators should ensure that all health professionals who qualified abroad have “access to an adaptation course”. The Patients Association supported a minimum provision on language skills.

13.24 The National Clinical Assessment Service considered that “assessment of communicative competency in a professional and context specific setting is vital to ensure appropriate skills for maintaining and protecting patient safety”.

13.25 UNISON stated that although it supported the proposal, it is “the primary responsibility of employers to ensure that their employees have the requisite skills”. It added that the proposal should not lead to further controls, “as it risks feeding the media’s often negative perception of immigration”.

Question 13-4: Would there be benefits in the same regulatory arrangements applying in the Channel Islands and the Isle of Man? If so, would the best way to achieve this be parallel legislation or a single statute?

13.26 A large majority felt there would be benefits in the same regulatory arrangements applying in the Channel Islands and the Isle of Man. These benefits were said to include assisting professional mobility, avoiding duplication and providing a

³ Of the 192 submissions which were received, 41 expressed a view on this proposal: 40 agreed, whilst 1 disagreed.

simpler framework.⁴ A majority argued that the best way to address this would be through a single statute covering the UK and the British Islands.⁵ For example, an individual consultee (Jacqueline A Wier) said that:

As these Islands are part of the UK it is important that they have access to the same regulatory arrangements so that consistency of regulation and health care professionals' standards is maintained. This should be included in a single statute to limit bureaucracy.

13.27 Optometry Scotland also agreed that "the preferred option would be to apply a single statute".

13.28 However, the Patients Association and the British Association for Counselling and Psychotherapy considered that parallel legislation would be the best way to implement the same regulatory arrangements.

13.29 The General Medical Council disagreed that regulation should be extended because there is "a significant number of British citizens living on the islands", since "the same argument could logically be extended to a number of other jurisdictions around the world". Furthermore, the Council argued that it can already take fitness to practise action against a registered doctor regardless of where the alleged offence has taken place. It felt that the more relevant concern "is the fact that some UK medical trainees undertake their training in the Channel Islands". In addition, doctors in the islands are not subject to the Responsible Officer provisions. As a result, the Council had to develop special provisions covering the revalidation of licensed doctors practising on the islands.

13.30 The Health and Care Professions Council stated:

For most of the professions we regulate, legislation passed by the Isle of Man Government ensures that professionals are appropriately ... registered and means that we can deal effectively with concerns about an individual's conduct and/or competence. However, the Isle of Man legislation has not caught up with professions brought into regulation by more recent UK legislation.

13.31 The General Dental Council stated that :

Concerns have been raised that certain professions are left unregulated in these jurisdictions and that fitness to practise regimes are insufficiently comprehensive and robust. In relation to dental care professionals, this has occurred because Jersey law has not been amended to reflect recent amendments to the Dentists Act 1984, for example the introduction of new dental care professionals groups in 2006. In addition, Isle of Man legislation refers to dental auxiliaries

⁴ Of the 192 submissions which were received, 28 expressed a view on this question: 25 said that there would be benefits, whilst 3 said that there would not. Of those who said that there would be benefits: 5 said that it would aid mobility of professionals, 2 said that it would avoid duplication and 2 said that it would provide a simpler framework.

⁵ Of the 192 submissions which were received, 14 expressed a view on this question: 10 said that there should be a single statute, 3 said that there should be parallel legislation and 1 said that there should be partnership arrangements.

established by regulations under section 45 of the Dentists Act 1984 – section 45 made provision for hygienists and therapists only and was repealed in 2006.

13.32 The General Osteopathic Council argued that the respective Channel Islands and Isle of Man jurisdictions should formally require practitioners to register, through “parallel legislation or even administratively”.

13.33 The Professional Standards Authority stated that:

the point of principle is that the same standards of professionalism and the same standards of care should apply irrespective of where in the British Islands treatment is being provided. This could be achieved through either one regulatory framework extended to the Islands or parallel legislations working closely together.

13.34 The Health and Social Services Department of Guernsey noted that doctors, dentists and pharmacists cannot practise unless they are registered by the UK regulators, and similar arrangements apply to the professions regulated by the Health and Care Professions Council. However, different arrangements apply to chiropractors and osteopaths who need to satisfy the Department that they have the equivalent competence to practise. It stated that it wishes to continue the current arrangements which apply in Guernsey and Alderney (Sark has its own arrangements). However, it expressed interest in extending some of its regulations, mainly in relation to premises regulation, and developing a memorandum of understanding with the Professional Standards Authority to ensure close working relations.

Question 13-5: How could the new legal framework address the interface between the regulatory systems in the UK and the Channel Islands and the Isle of Man?

13.35 A large majority felt that the statute should address the interface through joint working arrangements.⁶ For example, the General Dental Council considered that “the issuing of joint standards or codes would be the preferred option that would most effectively address the interface between the regulators”. Optometry Scotland also supported joint standards and codes.

13.36 The General Medical Council thought that the “general duties of cooperation that are discussed elsewhere in the consultation document should be applicable without the need for additional measures in the statute”. The Health and Care Professions Council agreed that the proposed legal framework was “sufficient”.

13.37 The Local Supervising Authority Midwifery Officers Forum UK thought that the legal framework should “make the Nursing and Midwifery Council the regulator for the Isle of Man and Channel Islands”.

⁶ Of the 192 submissions which were received, 8 expressed a view on this question: 6 said that joint working arrangements would address the interface, 1 said that the interface should be managed as with any other jurisdiction, whilst 1 said that the current legal framework is sufficient.

Provisional Proposal 13-6: The regulators should be given an express power to approve and accredit overseas education institutions and courses and issue rules and guidance for the purpose of such activity.

- 13.38 A majority agreed that the regulators should be given an express power to accredit overseas courses and institutions.⁷ For example, the Patients Association felt this proposal “would make it clear from the outset which qualifications are acceptable for registrants who are seeking to work in the UK”, “clearer for patients and service users who may rely on these as an indication of skill and ability”. It would also “protect the UK regulatory system from fraudulent medical schools passing themselves off as competent”.
- 13.39 The Scottish Government agreed with the proposal but only “to the extent that overseas courses are attached to a UK provider”. The Institute of Medical Illustrators agreed that the proposal should only apply where “the overseas institutions were formally linked with UK based and regulated institutions”.
- 13.40 The Health and Care Professions Council supported the proposal but noted that its existing legislation does not allow the approval of “programmes delivered outside of the UK by a non-UK institution” or “where a programme is delivered under a collaboration or franchise agreement between UK and non-UK education providers”.
- 13.41 The General Medical Council and the Nursing and Midwifery Council supported the permissive nature of the proposal. The General Optical Council noted that it already has the proposed power, and said it would “appreciate flexibility in our approach in this area, including possibly the option of appointing others to perform quality assurance functions”.
- 13.42 Several consultees questioned why UK registrants should fund such activity. The General Dental Council and General Osteopathic Council argued there must be a power to charge the overseas institution. The Department of Health, Social Services and Public Safety for Northern Ireland commented that “this could be a very expensive process” and it was:
- uncertain that existing registrants should be required to cover the costs of this exercise. It would appear that free movement ... in the EU eclipses the proposed recommendation.
- 13.43 The Professional Standards Authority felt that the statute should avoid:
- allowing the development of UK accreditation as an international brand or mark of good quality if there is no clear evidence of a direct link back to the regulator’s fundamental responsibility for public protection.
- 13.44 The Chartered Society of Physiotherapy said:

⁷ Of the 192 submissions which were received, 36 expressed a view on this proposal: 26 agreed, 3 disagreed, whilst 7 held equivocal positions.

There is ... the potential for confusion about the relationship between programme approval and graduates' registration with a UK regulator. More fundamentally, all these factors could undermine the standing and credibility of UK regulators' approval and therefore transparency and public understanding of its role. This could clearly have a significant and concerning impact on public protection

13.45 UNISON argued that due to the costs associated with accreditation of overseas education institutes, the regulators should work together on these matters.

13.46 The Council of Deans of Health felt it was questionable whether further UK regulatory activity overseas is necessary when those health courses are already subject to the regulation and quality assurance processes of the country in which these courses are delivered.

13.47 The Department of Health expressed concerns about the regulators approving and accrediting overseas institutions and programmes. It said that:

On the one hand, they have significant expertise in this area, which might be of benefit overseas. On the other hand though, quality assurance is undertaken against the standards and outcomes required of UK graduates who will be practising within the UK health care system - the delivery of education and training overseas can be delivered in a very different context to the UK and, consequently, we consider that it might be difficult for the regulators to properly quality assure institutions overseas.

13.48 However, the UK-wide Nursing and Midwifery Council Lead Midwives for Education Group was strongly opposed to the proposal. In addition to being concerned about costs and the proper scope of the regulators' remit, the Group felt that the focus needs to be on getting regulation "right in the UK first".

Question 13-7: What are the practical difficulties which arise as a result of the requirement to quality assure UK qualifications which are awarded by institutions based overseas?

13.49 A number of practical problems were highlighted in respect of quality assuring UK qualifications which are awarded by institutions based overseas.⁸

13.50 The General Medical Council identified the following practical challenges:

- (1) curricula taught and assessed in non-English speaking countries;
- (2) difficulties of ensuring that students gain an equivalent understanding of the organisational and economic framework of the UK health care system;

⁸ Of the 192 submissions which were received, 28 expressed a view on this question: 12 cited cost, 7 cited quality assurance, 6 cited the different practical environments of overseas institutions, 4 cited language difficulties, 1 cited different cultural values, whilst 1 cited the risk that approval is withdrawn from the parent provider.

- (3) the risk that students will not get a UK equivalent experience in primary care and mental health because of the different overseas systems;
 - (4) differences in ethical and legal issues, including the concept of professionalism;
 - (5) different approaches to equality and diversity, including the rights of gay people and those with mental health problems;
 - (6) differences in cultures that impact on clinical skills, for example some students may not be comfortable examining patients of the opposite sex; and
 - (7) diverting regulatory resources towards quality assurance activities which may bring little or no benefit for patients and the public in the UK.
- 13.51 The Council also noted that it is currently exploring whether its legislation should be amended to enable the award of a UK primary medical qualification overseas which would be different to a UK based qualification and would “reflect the different circumstances and context in which students were being educated and trained overseas”.
- 13.52 The General Osteopathic Council noted similar issues to the General Medical Council:
- (1) language differences;
 - (2) ethical and legal differences;
 - (3) cultural contexts of healthcare delivery; and
 - (4) cost of quality assurance activities and cost recovery.
- 13.53 The Professional Standards Authority felt that the main challenges for the regulators included:
- (1) meeting the cost of quality assurance activity overseas from UK registration fees;
 - (2) the risk that poor performance on a single programme may threaten the recognition of UK institutions when it is the institution that is the holder of the approval, not the programme or an individual course; and
 - (3) confusion may arise when an overseas regulator accredits a programme but this does not convey automatic registration rights on individuals who successfully complete the course.
- 13.54 The British Psychological Society felt that the key issues included that “quality assurance is increasingly based on self report and monitoring of processes”, overseas institutions may not have “access to peer contacts and support for new initiatives” and the difficulties of putting in place remedial measures.
- 13.55 The General Dental Council pointed to problems relating to “speed of response, intelligence and communications”. It said:

We can respond rapidly to a whistleblower in the UK. Reports of problems at dental schools may appear in the local press and are noted by students and others. This may be less likely in respect of overseas institutions.

- 13.56 The Department of Health noted the risk “that approval is withdrawn from the parent provider as there is not provision to just approve a local education provider”.
- 13.57 Rescare thought that a lack of knowledge of overseas institutions and their staff was a challenge for the regulators. The Local Supervising Authority Midwifery Officers Forum UK suggested that the system could be “open to fraudulent activity and entry under false purposes on the register”.

Question 13-8: How might our statute enable the regulators to manage the issues that arise from distance service provision?

- 13.58 Opinion was divided on this question.⁹
- 13.59 The Nursing and Midwifery Council felt that a “clear definition” of distance service provision was an important starting point. It considered that:

It would also be helpful to clarify whether distance service provision includes educational services or clinical services or both because these would require different management approaches

- 13.60 The General Medical Council doubted it was “practical, desirable or enforceable” to require that overseas practitioners who provide telemedicine services from outside the UK must be registered and licensed with the UK regulator. It noted that:

The more practical approach has been to put responsibility on UK health care providers and commissioners to ensure that any organisations or individuals with which they contract to provide services have arrangements in place to maintain the quality of the care provided. UK providers are then accountable to the systems regulators for ensuring that the appropriate arrangements are in place.

- 13.61 Similarly, the General Pharmaceutical Council stated that:

If the individual providing the service is not based in the UK they still must be appropriately qualified and regulated in the country in which they are based for the specific service they are providing across borders. It should be the responsibility of the organisation that

⁹ Of the 192 submissions which were received, 32 expressed a view on this question: 8 cited joint-working arrangements with international regulators and other bodies such as the Medicines and Healthcare products Regulatory Agency, 8 said that the regulators should seek to impose regulatory standards on those providing services from overseas, 4 said that UK providers should be obliged to contract with overseas providers only if they achieve the standards of the UK regulatory system, whilst 5 said that this issue is beyond the remit of our statute.

contracts with the service provider to ensure that this is the case and inform service users of the checks they have undertaken.

13.62 The Department of Health also argued that “it should be for the commissioner of any service to ensure that the provider was using appropriately qualified practitioners” but “there may be scope for giving the regulators power to advise commissioners”.

13.63 However, the Academy of Medical Royal Colleges disagreed with this approach, saying that:

Whilst contractual arrangements with overseas providers should specify standards and the system regulator has a responsibility for the quality of service, we believe there must be a locus for the professional regulator. In this case the legal framework has been overtaken by technological advances and this must be addressed.

13.64 The Pharmaceutical Society of Northern Ireland also argued for a role for the professional regulators. It thought:

There should be a provision in the statute to ensure that the provision of services outside the UK should, as a minimum, meet UK standards. Where these standards are not met then the regulator will make a referral to the competent authority in the state of establishment of the service.

13.65 Some consultees argued that regulatory standards should be imposed on overseas practitioners. The British Medical Association argued that:

Distance service provision must be regulated to the same standards. Those providing teleradiology, for example, for UK patients must be subject to the same regulatory standards, irrespective of where they might reside.

13.66 The Royal College of Radiologists argued that all doctors who provide care to NHS patients, even if they are providing those services from outside the UK by telemedicine, should be subject to the same regulation as those within the UK.

13.67 The Scottish Government argued that the new statute should ensure that:

the person making individual clinical decisions is appropriately qualified to give advice and suggest certain treatments. This would link with the increasingly high profile requirement to ensure that all healthcare providers act, behave and conduct themselves in a professional manner irrespective of their discipline, location or mode of healthcare delivery.

13.68 The British Psychological Society thought that:

It may be necessary for the statute to include specification of more aspects of the management of the relationships such as regularity and frequency of contacts, as well as clarification of what balance could be local and autonomous and what would mirror the host institution.

- 13.69 Some felt that more public information was needed. For example, the Professional Standards Authority stated that:

For those patients who seek to consult an overseas health professional directly, an element of *caveat emptor* applies. We wonder whether targeted public communications about the importance of using the systems that apply to check the registration of overseas health professional are used; and that the regulators in the UK, who are accustomed to using systems such as the Internal Market Information system to check the registration of professionals overseas (in this case, within Europe), make clear to the public that they will advise on how to check the status of an overseas professional.

- 13.70 The Health and Care Professions Council felt that the provision of joint guidance in this area might be appropriate. It suggested that:

For example, this might include working with others to produce cross-jurisdiction guidance on internet advertising or working appropriately with other agencies, such as the Medicines and Healthcare Products Regulatory Agency on ensuring compliance.

- 13.71 The General Optical Council noted that its existing accreditation and quality assurance powers are sufficient for it to “manage distance learning provision and [that there are] many such courses”. The Patients Association agreed that no additional specific provision is currently required, but that regulation-making powers for the Secretary of State would future proof the legislation.

- 13.72 The General Dental Council did not think that a “broad legal framework could be expected to deal with the practical difficulties” identified in the previous section. The Professional Forum of the Pharmaceutical Society of Northern Ireland was also unable to “see how any statute which is enacted in the UK will be able to successfully regulate health care services provided outside the jurisdiction”. The Medical Protection Society thought it might be “more pragmatic to rely on local regulation”.