PART 12
OVERLAP ISSUES

Question 12-1: How could the legal framework establish clearer interfaces between the various regulatory systems?

12.1 A number of views were expressed on how the legal framework might encourage clearer interfaces between the regulatory systems.[1]

12.2 Many pointed to the need for greater co-operation. For example, the General Medical Council said "there is growing recognition among regulators of the importance of better co-operation and joint working" and recognised that "more work is required for the various systems to interface effectively". The Medical Defence Union agreed "that working between the different health care regulatory systems and other procedures such as the Ombudsmen is to be encouraged".

12.3 Many consultees made general statements that relationships between professional and systems regulators were particularly complex and would benefit from clarification. The Parliamentary and Health Service Ombudsman "was particularly interested in securing collaborative working". It said:

> It is only by having a coherent and complete picture that decisions – whether about a particular health body, a particular service or, indeed, an individual health professional – can deliver a coordinated and effective response … we view this consultation as an opportunity for introducing significant measures to strengthen the existing framework around joint working and information sharing.

12.4 Some gave examples of practical measures that could assist, such as public awareness campaigns and an improved central website. The British Pharmaceutical Students' Association said:

> Whilst the Professional Standards Authority has a central website whereby visitors can learn about the individual regulators it would require the public to know what the Professional Standards Authority is. A central website containing information on the individual regulators and which ones the public should contact regarding their concerns may be more acceptable to the public. This could well be integrated into another commonly used healthcare website.

12.5 Optometry Scotland said "a significant effort" would be required to "educate the public on the role and responsibilities of the various professions, especially when there are close working relations such as in primary care".

[1] Of the 192 submissions which were received, 25 expressed a view on this question: 5 said that managing interfaces was a matter of good practice between the regulators, 10 said that the statute could define the interfaces such as through duties to co-operate, 11 said that interfaces would be clearer with a simpler system that did not have duplication.

12.6 The General Social Care Council felt that a practical solution would be for the Government to "provide guidance and a policy steer on how it envisages that each part of the regulatory framework should fit together".

12.7 Several consultees, such as the British Dental Association and the British Association for Counselling and Psychotherapy, thought that the "removal of duplication" was a priority. The Department of Health and the Scottish Government agreed, and also identified poor information sharing as a problem in the current system, and argued for a "duty of cooperation". The Scottish Government considered:

> that there could be a place in the new statute for clearly defining those matters which legitimately lie with the professional and systems regulators to address, and their respective roles and responsibilities.

12.8 It also called for a single body to deal with "allegations/complaints against all the regulators". It felt that:

> This would enable any patterns of poor performance to be identified, including any team/systemic failures rather than focusing attention on individuals and their performance, and could enable organisational solutions to be identified. This could also provide efficiencies in terms of human and administrative costs, duplication of time, effort and resource (including providing repeated copies of documents/records and statements from staff) and would assure patients that, where necessary and required, appropriate steps (involving multiple agencies where relevant) are being taken to address concerns.

12.9 However, the Medical Defence Union was concerned that the rights of registrants should be protected in any moves towards closer cooperation, "especially when information is being exchanged between different regulatory systems". It raised a specific concern "about the passing on of 'soft information' about registrants", stating that "any sharing of information must take into account the rights of registrants and this must be clear in the legislation".

12.10 The Professional Standards Authority suggested three ways in which the legal framework could establish clearer interfaces between regulatory systems:

(1) by requiring regulators to take "reasonably practicable steps" to identify agencies with similar or overlapping remits;

(2) by requiring regulators to consult on the scope of their activities and to agree the means by which they will conduct operational activity where an interface exists, for example by the use of a memorandum of understanding; and

(3) by being clear on the roles and responsibilities of the regulators, and avoiding the possibility of extending functions into non-core areas.

12.11 The Patients Association also said that it would "like to see a clearer definition of where the regulators' powers sit within the current and emerging healthcare landscape".

12.12 The Nursing and Midwifery Council argued that the statute should require the regulators to "proactively share information" and "work together in a coordinated and targeted manner" where public safety is at risk. An individual consultee (Anonymous) felt that the "statute should make it clear that regulators must pass on information where public safety may be at risk even when the information does not fall under that regulator's remit". An individual consultee (Don Brand) considered that "effective links and joint working arrangements" were "particularly important in social work".

12.13 The Department of Health, Social Services and Public Safety for Northern Ireland supported "the need for joint working to enable efficient and effective working practices". It also felt that there needs to be a rigorous review of the costs of regulation and queried if it would be more efficient at a more corporate level.

12.14 However, the Medical Protection Society felt that clarity was unlikely due to regulators' resistance and the risk of "protracted legal arguments regarding the jurisdiction". It suggested that statutory guidance may be useful on the extent of a regulator's responsibility.

12.15 Several argued that changes to the law would not provide a solution. The General Medical Council disagreed that "the issue here is fundamentally a problem of legal boundaries and jurisdiction", but felt there was "a case for creating a clear and shared purpose for professional regulation in the new legislative framework". The General Osteopathic Council agreed that it was:

> not obvious that the legal framework is the best way to improve cooperation and interface between regulatory systems; many of the problems appear to derive from professional, organisational and individual, cultures and behaviours.

12.16 The Health and Care Professions Council thought that this issue was "largely a matter of policy and practice for the regulators rather than a matter for statute", and had "no suggestions to make for improvements to the proposals in this area".

12.17 The General Optical Council considered "that the duties to cooperate and act transparently set out in the proposals in the consultation would be sufficient".

12.18 NHS Greater Clyde and Glasgow suggested that "memoranda of understanding between various bodies may be the best way forward".

12.19 The British Medical Association said that it was not sure that the interfaces required clarification.

Question 12-2: What practical difficulties arise as a result of parallel criminal and fitness to practise proceedings?

12.20 Various views were expressed about the practical difficulties that arise as a result of parallel criminal and fitness to practise proceedings.[2]

12.21 Delay was the most widely reported problem. Several consultees referred to delay in the context of not being able to obtain information. The General Medical Council said that it "sometimes experiences difficulties getting access to evidence as a result of the primacy of criminal proceedings and this can lead to delay in progressing our case".

12.22 The Nursing and Midwifery Council made this point more strongly. It said that:

> The agencies responsible for the criminal proceedings are very reluctant to share the information needed by us for our fitness to practise proceedings, which can mean that cases are delayed and that interim orders are not sought as early as they should be, through want of information.

12.23 Some pointed to the effect of delays caused by the primacy of criminal proceedings. For example, the General Optical Council commented that "the impact of this on registrants can be significant given the length of time of criminal cases". Coventry and Warwickshire Partnership Trust feared that lengthy suspensions pending criminal proceedings do "not support a presumption of innocent until proven guilty".

12.24 Several regulators reported widespread use of interim orders to manage such cases. The General Osteopathic Council stated that:

> It is also likely that an interim suspension order will have been imposed on the registrant, which helps to protect the public but does – especially where the registrant is self employed – result in a loss of livelihood for the duration of the suspension order and there could in theory (though it does not happen often) be no conviction at the end of the process.

12.25 The Nursing and Midwifery Council also reported:

> very long delays in being able to reach a substantive outcome in these cases which can lead to problems in proving current impairment at the fitness to practise hearing, and in maintaining or extending interim orders.

12.26 An individual consultee (Jacqueline A Wier) also commented on a:

[2] Of the 192 submissions which were received, 29 expressed a view on this question: 17 said that delay was a problem, 5 said that sharing information was a problem, 4 said that different evidential regimes was a problem, whilst 3 said that different outcomes were a problem.

> propensity that information will not be shared and that communication will not be effective which could jeopardise outcomes to both criminal and fitness to practise proceedings.

12.27 Some consultees commented on the different evidential regimes between the two systems. The Health and Care Professions Council stated that:

> As more restrictive rules of evidence will apply in criminal proceedings, there is a risk that evidence which has not been admitted at that trial may enter the public domain by being admitted in the course of the regulatory proceedings.

12.28 The Department of Health recognised that parallel criminal and fitness to practise proceedings often lead to delay, duplication, and "witness overload and confusion". The Association of Regulatory and Disciplinary Lawyers also commented on the increased demands on witnesses required to participate in two sets of proceedings.

12.29 The General Dental Council and General Pharmaceutical Council both cited the financial implications of the regulators duplicating criminal investigations. However, the Professional Standards Authority suggested that waiting for the outcome of the criminal proceedings could actually have a cost benefit for regulators since they could "rely upon a conviction, rather than trying to re-prosecute any underlying misconduct".

12.30 The General Pharmaceutical Council set out its approach to criminal cases:

> At an operational level we have already moved away from an assumption that all fitness to practise cases should wait until relevant court cases have concluded, to considering on a case by case basis whether proceedings could be taken forward in an appropriate manner without undue risk to other proceedings.

12.31 Unite endorsed this approach, and said that "regulators should retain their own integrity and act as necessary in the circumstances".

12.32 The Nursing and Midwifery Council and the UK-wide Nursing and Midwifery Council Local Midwives for Education Group both cited the possibility of different outcomes as a practical difficulty resulting from parallel criminal and fitness to practise proceedings. The Royal College of Obstetricians and Gynaecologists noted that "fitness to practise issues could easily follow criminal acquittal".

12.33 The Professional Standards Authority said that "criminal investigations may take a long time to complete, be discontinued, or may only focus on some of the issues with which the regulator is concerned". However, it felt that "these risks do not outweigh the importance of criminal investigations and prosecutions being allowed to proceed without interruption". The Scottish Government also acknowledged that delay was appropriate in certain circumstances, as criminal convictions are subsequently often relevant to the fitness to practise proceedings.

Question 12-3: What are the practical and legal difficulties associated with joint working?

12.34 A number of consultees identified practical and legal difficulties associated with joint working.[3] For example, the Scottish Government identified the following potential issues:

> Difficulties would include data protection issues and the sharing of panellists who may have been trained differently, different education and training standards, and different levels of remuneration that may have been paid to panellists. There may also be difficulties in ensuring that there are no potential conflicts of interest.

12.35 The General Osteopathic Council said that:

> A major disincentive appears to be that that the marginal gains in cost savings often appear to be outweighed by the upheaval involved in securing those gains. Another significant reason why we think that it has been difficult to secure effective joint working is around governance and the focus in legislation on the role of the Council and its duties.

12.36 The General Dental Council also stated that:

> The duties of the systems regulators are different to those of the professional regulators and even within professional regulation there are sufficient differences which could militate against joint working eg different approaches to quality assurance of education.

12.37 Some consultees said that poor communication was a problem, and the General Social Care Council stressed the:

> importance of developing personal relationships between key personnel, understanding the different cultures which exist between different organisations and ensuring that there is a clear mechanism for resolving disputes.

12.38 The Care Quality Commission noted that the lack of a "common information sharing portal" was a barrier to joint working.

12.39 The Association of Clinical Biochemistry referred to "individual regulators' suspicions of their own independence being compromised". Optometry Scotland also felt that "defensive professional posturing has proven to be a barrier in the past when trying to establish joint ventures between various professions, even for those closely aligned".

12.40 A number of consultees commented that difficulties arise from a lack of clarity about the division of legal functions and responsibilities in joint working

[3] Of the 192 submissions which were received, 12 identified practical issues such as the different working practices of each regulator and poor communication. 12 identified legal difficulties such as data sharing and uncertainty about legal responsibility.

arrangements. The Health and Care Professions Council felt that "each regulator would need to ensure that any joint working was appropriate and did not jeopardise their independence or the delivery of their regulatory functions".

12.41 The Professional Standards Authority pointed to practical barriers to joint working:

> There can be operational difficulties in terms of aligning work timetables, aligning different processes and in the training and working practices of staff. There can also be contractual issues relating to fitness to practise panellists, and sharing costs, responsibilities and liabilities.

12.42 Similarly, the British Association for Counselling and Psychotherapy noted that "practical difficulties could involve redundancies and other employment issues".

12.43 However, several consultees felt that the difficulties were "not insurmountable where there is value in joint working" (General Medical Council).

Provisional Proposal 12-4: The statute should include a permissive statement to the effect that each regulator may carry out any of its functions in partnership with another organisation.

12.44 An overwhelming majority agreed with this proposal.[4] For example, the Association of Regulatory and Disciplinary Lawyers considered that "joint working … is to be encouraged and promoted".

12.45 The Pharmaceutical Society of Northern Ireland welcomed the "permissive nature" of the proposal. Similarly, the General Social Care Council said that:

> The provisions within the legislation should be enabling provisions and should not require regulators to enter into partnership arrangements. Again, flexibility is important in such matters to take into account changed circumstances.

12.46 The British Pharmaceutical Students' Association argued that:

> Pharmacists work with other health care professionals and therefore some proceedings may involve multiple professions and would therefore require the cooperation of different regulators.

12.47 A number of consultees suggested particular partnerships that would be beneficial. For example, the British Chiropractic Association felt that:

> Given the similarities in statute and function of some regulators, for example, the General Chiropractic Council and the General Osteopathic Council, it seems sensible to introduce measures to permit functions being carried out in partnership.

[4] Of the 192 submissions which were received, 41 expressed a view on this proposal: 39 agreed, whilst 2 held equivocal positions.

12.48 The Department of Health argued that partnership arrangements could be particularly helpful to clarify the interface between the General Pharmaceutical Council and the Care Quality Commission. The National Clinical Assessment Service said that it would welcome "opportunities to work in partnership with regulators such as currently happens with the General Dental Council".

12.49 Some emphasised that any decision to carry out functions in partnership with another organisation could not affect the regulators' liability for the discharge of their statutory functions. The Local Supervising Authority Midwifery Officers Forum UK said that joint working must "not be to the detriment of the core function of the regulators". The General Social Care Council considered "that it is important that the statute is clear that any such arrangements do not affect the liability of the regulator for the exercise of any of its statutory functions". The Professional Forum of the Pharmaceutical Society of Northern Ireland also "did not see any reduction in the legal liability of any regulator for the discharge of their functions".

12.50 A small number disagreed with the proposal. For example, NHS Greater Glasgow and Clyde preferred to limit the power to joint working between the regulators and statutory organisations.

Provisional Proposal 12-5: The statute should enable formal partnership arrangements to be entered into between any regulator and one or more other organisations (including the other professional regulators) in relation to the exercise of their statutory functions. The statute should provide that any such arrangements do not affect the liability of the regulator for the exercise of any of its statutory functions.

12.51 All those who expressed a view agreed that the statute should enable formal partnership arrangements to be entered into between any regulator and one or more other organisations.[5]

12.52 The Nursing and Midwifery Council felt that our proposal should go further and "encourage" the formation of certain partnerships in the public interest. The Council also suggested that the statute "should require regulators to have regard to certain considerations when selecting partners".

12.53 The Medical Protection Society felt there were many areas in which formal partnership arrangements could be beneficial, such as joint consultations on new guidance and rules, joint training of panellists, the production of a consolidated set of procedural rules and shared hearing rooms.

12.54 An individual consultee (Dr Susan Blakeney) argued it would be appropriate for the General Optical Council and General Medical Council to have a formal partnership arrangement "when investigating a case of alleged impaired fitness to practise of a registered medical practitioner who is providing one or more of the protected optical functions".

12.55 Other consultees were slightly more cautious in their support. The Osteopathic Alliance maintained its position that partnership should only be permitted in

[5] Of the 192 submissions which were received, 37 submissions expressed a view on this proposal: all agreed.

respect of certain functions. The Professional Standards Authority suggested that further work might be beneficial in order to consider "whether any potential for conflict of interests might exist and how these would be managed". The British Association for Counselling and Psychotherapy suggested that partnership arrangements "may lead to more cost and complexity rather than less". The British Pharmaceutical Students' Association was "wary of the ability to move actual regulatory functions to another body that does not have an in-depth knowledge of the pharmacy profession". The General Dental Council noted that the proposal was "not necessarily a complete solution to the problems of regulatory overlap and potential gaps".

12.56 The Department of Health queried whether formal partnership arrangements are necessary if there is already a joint working power in the statute. The Scottish Government agreed, and also noted the regulators should be required to consult before entering any partnership arrangements.

12.57 The regulators' liability for the discharge of their statutory functions was seen by many as a key issue. The Medical Defence Union used the example of the keeping of registers. It said:

> We assume that such an arrangement would be an administrative one and that even if one regulator held and updated a register for another regulator, the responsibility for accuracy etc of information within that register would remain with the initial regulator and not the "host". That is, if a registrant wished to complain about information that was available on his or her regulator's register that was hosted by another regulator, the registrant should be able to complain to his or her regulatory body and not the host regulator.

Provisional Proposal 12-6: The statute should impose a general duty on each regulator to make arrangements to promote cooperation with other relevant organisations or other persons, including those concerned with the:

(1) employment of registrants;

(2) education and training of registrants;

(3) regulation of other health or social care professionals;

(4) regulation of health or social care services; and

(5) provision/supervision/management of health or social care services.

12.58 A significant majority of consultees supported the proposed general duty to promote cooperation.[6]

12.59 An individual consultee (Jacqueline A Wier) welcomed the proposal on the basis that "collaboration is a fundamental aspect which improves patient outcomes". The Patients Association agreed that improved cooperation, notably between the

[6] Of the 192 submissions which were received, 46 expressed a view on this proposal: 40 agreed, 2 disagreed, whilst 4 held equivocal positions.

regulators and the Care Quality Commission, could "play a huge part in protecting patients from poor care".

12.60 The Nursing and Midwifery Council was concerned that a failure to engage on the part of other organisations would prevent regulators complying with the duty. It concluded that it:

> would favour permissive or encouraging provisions that could be overseen by the Professional Standards Authority, who could hold regulators to account through performance reviews.

12.61 The General Optical Council also considered that the statute should permit cooperation, but not impose a duty. It said:

> We would possibly favour more a permissive statement in the statute rather than a specific requirement to make arrangements for cooperation. We would be wary of a substantial bureaucracy of partnership working arrangements that are either resource-intensive to maintain or are not supported by concrete activity.

12.62 The General Pharmaceutical Council expressed reservations about the proposed general duty. However, it concluded that:

> There are opportunities and risks to setting out a general duty to cooperate. On the one hand it provides a clear requirement to work with others. On the other hand it could become mechanistic and artificial. On balance we think this suggestion is worthwhile.

12.63 Some consultees did not support the proposal in its current form. The General Social Care Council felt that the duty would not be effective unless the organisations and persons referred to were subject to a reciprocal duty. The Medical Protection Society was concerned that "there could be no obvious way to enforce [the duty to cooperate]".

12.64 The British Association for Counselling and Psychotherapy queried whether the imposition of a general duty was feasible in light of what it considered would be "very heavy" resource implications. The Pharmaceutical Society of Northern Ireland felt that the "proposal has the capacity to create unnecessary duties particularly when specified to this extent"

12.65 Some consultees disagreed with the proposal, on the basis that cooperation was not a matter for statute. The General Chiropractic Council thought that:

> there is a danger here of trespassing by statute into areas which should best be worked out by the regulators themselves. Our view is that there is a danger of over prescription.

12.66 An individual consultee (Anonymous) said:

> I would hope this could all be established by good practice overseen by the Professional Standards Authority rather than needing to be said in statute. In particular the phrase "promote co-operation" could be interpreted as creating co-operation for its own sake rather than for public protection and if that took the regulators' eye off their core functions this would be regrettable.

12.67 The Local Supervising Authority Midwifery Officers Forum UK thought that an imposition of the duty in statute could make the required cooperation "lengthy and burdensome".

12.68 There were a number of comments about the proposed list of organisations with whom regulators would be required to promote cooperation. The Care Quality Commission felt that any list should not be exhaustive, whilst some consultees wanted to extend it to cover:

(1) professional bodies and unions (Unite and Guild of Healthcare Pharmacists);

(2) those involved in the registration of other professionals and occupations (Professional Standards Authority);

(3) bodies responsible for commissioning NHS services (Department of Health); and

(4) those involved in education and training of potential registrants (General Dental Council and Dental Schools Council).

12.69 The Department of Health also commented that any duty should apply to any "queries raised by other European competent authorities to the extent required by Directive 2005/36/EC".

12.70 Action Against Medical Accidents stated that:

> At the moment, there is no statutory requirement on employers (including, for example, GP or dentist practices) to share information about concerns or indicators of poor practice with potential new employers or other key stakeholders such as the regulators themselves. This means that bad health professionals can simply be passed on to another employer without issues being addressed and employers not notifying the regulator so that they can investigate and use their powers to protect patients.

12.71 It warned that this issue has been outstanding for some time, and that a "continued failure to address these issues will continue to undermine the capacity of the regulators to protect patients and therefore puts patients at risk".

Question 12-7: Should the statute specify or give examples of the types of arrangements that could be made under provisional proposal 12-6?

12.72 A small majority agreed that the statute should specify or give examples of the types of arrangements that could be made under the general duty.[7]

12.73 The Scottish Social Services Council suggested that a "specific provision allowing the sharing of personal data" would "facilitate information sharing and obviate some of the practical difficulties currently experienced by regulators" when they are considering whether information should be shared. The National Clinical Assessment Service suggested that "examples could include provision of initial, expert, clinical, screening and provision of assessment and record review".

12.74 The General Medical Council said that examples must not "on the one hand impose mandatory requirements or, on the other, represent an exhaustive list which would prevent co-operation in other areas where appropriate". The Medical Schools Council agreed that any examples should be "illustrative".

12.75 Some consultees said that providing examples would inhibit cooperation. The Professional Standards Authority felt that examples "may limit the way in which this general duty is developed within and across the regulators". The Medical Defence Union thought that "regulators should be free to explore opportunities to co-operate as they consider it appropriate to do so".

12.76 The Nursing and Midwifery Council felt that examples could be created under guidance. The General Osteopathic Council suggested that it may be "preferable for the regulators to be given a duty to publish an up to date scheme which sets out with whom and how they cooperate". The Professional Forum of the Pharmaceutical Society of Northern Ireland agreed that it would be sufficient to require regulators to "consult upon and publish any formal schemes of cooperation".

12.77 The Scottish Government stressed that "such examples should take account of any differing considerations in the devolved administrations".

Provisional Proposal 12-8: The statute should impose a specific duty to cooperate, which would apply when the regulator in question is:

(1) considering registration applications and renewals;

(2) undertaking the approval of education and training;

(3) ensuring proper standards of practice and conduct; and

(4) undertaking an investigation into a registrant's fitness to practise.

This duty would apply to the same list of organisations and persons contained in provisional proposal 12-6. The requested authority would be required to give due consideration to any such request made by the regulator, and if it refuses to cooperate, must give written reasons.

12.78 A significant majority supported the proposed specific duty to cooperate.[8]

[7] Of the 192 submissions which were received, 33 expressed a view on this question: 19 said that examples should be given, 13 disagreed, whilst 1 held an equivocal position.

12.79 The Scottish Government particularly welcomed the requirement of written reasons in support of any refusal to cooperate, and called for the statute to specify "the potential negative consequences associated with any failure to cooperate that may be deemed to be unreasonable (as judged from an objective standpoint)".

12.80 The Association of Regulatory and Disciplinary Lawyers suggested that the duty "could extend to the joining of proceedings for different regulated professionals, with the aim of achieving consistent outcomes". The British Pharmaceutical Students' Association felt that the proposal would be beneficial in respect of education and training due to the increase in multi-disciplinary learning.

12.81 The General Dental Council noted that the general duty would only apply to regulators, whilst the specific duty could apply to bodies "not within the legislative competence of the Westminster Parliament". In light of this, the Council felt that there must be a clear distinction between the two duties.

12.82 Some consultees reiterated their concerns in respect of the general duty, namely the risk of significant and unnecessary bureaucracy. The General Optical Council queried whether it would be preferable to have "a permissive statement in the statute rather than a specific requirement to make arrangements for cooperation".

12.83 Some consultees were concerned about how the specific duties would be enforced. The General Social Care Council felt "it would be useful if greater sanctions were available to regulators in the event that, say an employer was unwilling to co-operate". The UK-wide Nursing and Midwifery Council Lead Midwives for Education Group also queried the role of the legal system in the event of a failure to cooperate by an independent organisation.

12.84 The British Association for Counselling and Psychotherapy commented that the proposed duty could extend to "a very large number of organisations", and did not consider that the "desired outcome of such cooperation" was clear.

12.85 However, others thought that it was beyond the scope of the statute to impose duties on other organisations. The General Medical Council said that:

> It appears that this proposal imposes an absolute duty on the regulator to cooperate in the specified area, but a lesser duty on the requested authority merely to consider whether it wishes to cooperate ... We think it unwise for the statute to prescribe in absolute terms on operational matters as needs will vary according to circumstances and will also change over time. It may therefore, be more appropriate and balanced for the statute to impose a duty on regulators to consider the need for cooperation in the specified areas.

12.86 The Medical Defence Union was also:

> not sure how the statute would be able to make it a requirement that requested authorities give due consideration to the regulator's

[8] Of the 192 submissions which were received, 44 expressed a view on this proposal: 36 agreed, 3 disagreed, whilst 5 held equivocal positions.

> request to co-operate because this would presumably need to be enshrined in the legislation. We do not object to the principle, but we think it may be difficult to give it legislative force given the number and variety of the authorities and the potential for any "list" of such authorities to change regularly or for authorities to be left off any list.

12.87 The Council of Deans of Health was particularly concerned about the impact of the proposed duties on universities as "information requested by regulators is not always held within the university, but within a trust or practice setting".

Question 12-9: Are there any other circumstances in which the specific duty to cooperate contained in provisional proposal 12-8 should apply?

12.88 A small majority felt there were no other circumstances in which the duty should apply.[9] For example, the Medical Defence Union felt that the legislation is worded "widely enough to allow the regulators to request co-operation with other authorities as they think appropriate" even if the authorities or activities are not those listed by the statute.

12.89 However, a number of consultees did identify additional circumstances. The Professional Forum of the Pharmaceutical Society of Northern Ireland suggested that the statute should require information sharing about dual registered individuals. Similarly, the Medical Protection Society stated that:

> As it is possible for an individual to be a member of more than one regulated healthcare profession, there should be a specific duty on each regulator, when considering an application for registration, to make enquiry of the other regulators as to whether or not there are any fitness to practise concerns.

12.90 The General Osteopathic Council identified "the investigation and prosecution of breaches of protected titles" as "another area where cooperation is required". The General Dental Council suggested that the duty should include "considering continuing professional development submissions". An individual consultee (Jacqueline A Wier) thought that the duty to cooperate should apply "when a service is being provided to vulnerable adults and children". The Patients Association proposed that "undertaking action to prevent the compromise of service user safety or dignity" should be added to the proposed list of activities. The Professional Standards Authority felt that there should be greater cooperation "in specification of a common data set of regulatory metrics" in order to identify trends and support strategic planning. The Nursing and Midwifery Council suggested that the consideration of "fraudulent or incorrect entries in the register" should be included for completeness.

[9] Of the 192 submissions which were received, 20 expressed a view on this question. 11 said that there were no other circumstances in which the duty should apply, whilst 9 said that there were other circumstances.