

## Results of the HPCB Survey on Information Sharing and the implementation of the Portugal Agreement

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### Introduction

1. This paper reports on the by Healthcare Professional Crossing Borders' (HPCB)<sup>1</sup> survey on information sharing and the implementation of the [Portugal Agreement](#)<sup>2</sup>. The survey received a good response and some significant successes can be reported including: the number of respondents that have a list of registered practitioners publicly available on their website, the adoption of the Certificate of Current Professional Status (CCPS) format, as well as the number of organisations that publish their standards publicly on their website. It also provides information on areas where future action is needed.

2. HPCB would like to thank competent authorities for their assistance in responding to the survey and would welcome feedback from HPCB participants on the follow-up actions proposed by the HPCB Steering Group (see [paragraph 68-69](#)). Please forward any comments to [hpcb@gmc-uk.org](mailto:hpcb@gmc-uk.org).

### Survey objectives and content

3. The survey was developed following discussions at the HPCB Spring conference held in Dublin in March 2009. The survey was developed by the HPCB Secretariat and launched in August 2009. It was disseminated to healthcare regulators through the HPCB network, and member states representatives on the European Commission's Coordinators Group and Implementation Committee for Directive 2005/36/EC. It included questions in the following areas:

- A. [Transparency and access to information](#)
- B. [Proactive and reactive information exchange](#)
- C. [Notification of hearings and disciplinary decisions](#)
- D. [Competence assurance of healthcare professionals](#)
- E. [Professional standards](#)

<sup>1</sup> HPCB is an informal partnership of professional healthcare regulators from within Europe that works collaboratively on a range of regulatory issues. The purpose is to contribute to patient safety in Europe through the effective regulatory collaboration in the context of cross-border healthcare and free movement of healthcare professionals. For more information visit: [www.hpcb.eu](http://www.hpcb.eu)

<sup>2</sup> The Portugal Agreement is a collaborative voluntary work programme for professional healthcare regulators from within Europe. It was achieved at the 2007 HPCB Autumn Meeting, in Lisbon. The Agreement sets out a range of actions that provide a framework for voluntary cooperation and the development of professional healthcare regulation in Europe

## **Survey limitations**

4. As the survey was published in English only, it has become apparent in interpreting the data that there have been difficulties in comparing some of the technical terms (in some instances the same term has different meanings in other jurisdictions).
5. Additionally, in some cases the terms used are not relevant to individual competent authorities (for example only some competent authorities can place restrictions on practice, issue fines, or agree undertakings with a doctor).
6. Some caution should therefore be used in the interpretation of these results.

## Key survey findings

### A. Transparency and access to information

#### A.1 Respondents' demographics

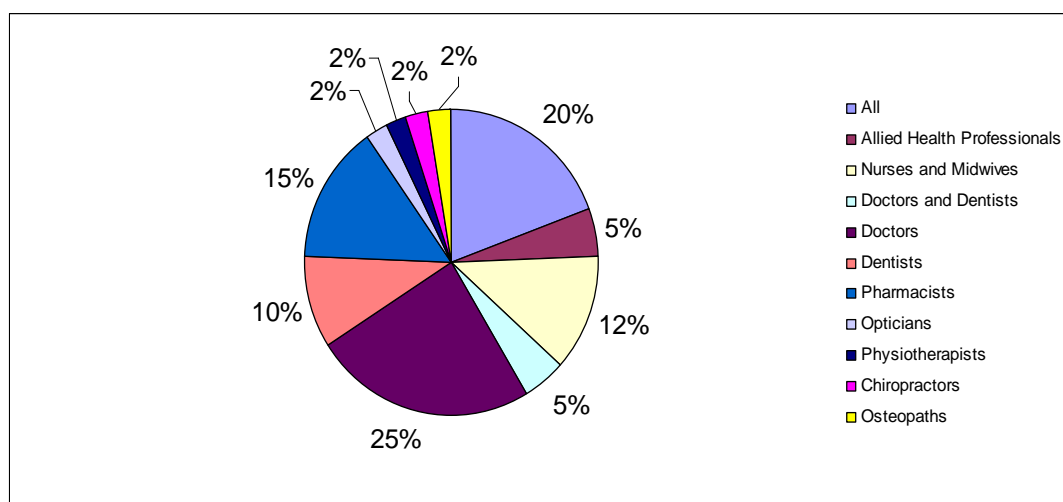
7. The survey received responses from 41 organisations from 22<sup>3</sup> European countries.

8. 39 of the respondent organisations have national authority or are the national federal organisation of regional bodies. Only one respondent has a regional regulatory remit and only one respondent a local regulatory remit.

9. Organisations regulating only doctors make up the largest proportion of respondents with 25%. A further 5% of respondents regulate both doctors and dentists. Organisations that regulate pharmacists accounted for 15% of respondents and organisations that regulate nurses and midwives accounted for 12%.

10. Organisations that regulate only Opticians, Chiropractors, Osteopaths, or Physiotherapists were under-represented in the survey with only one respondent for each of these professions. Some caution should therefore be exercised in interpreting the results into broader conclusions for these professions.

**Figure 1** – Breakdown of healthcare professions regulated by survey respondents.



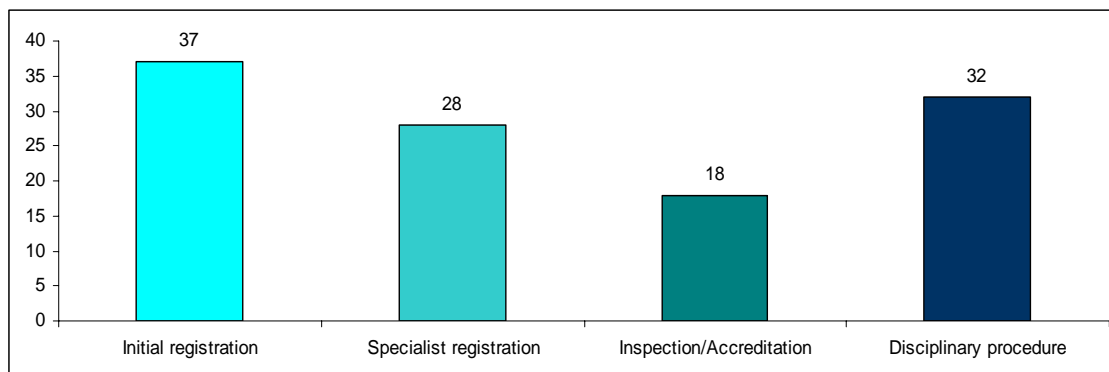
'All' indicates organisations regulating at least doctors, dentists, nurses, midwives and pharmacists. 'Allied Health Professionals' indicates organisations that regulate more than one profession including physiotherapists, psychologists, radiographers, dieticians, speech and language therapists, and others, but not doctors, dentists, nurses, midwives and pharmacists.

<sup>3</sup> Responses were received from competent authorities in: Austria, Belgium, Croatia, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Hungary, Ireland, Italy, Malta, the Netherlands, Norway, Poland, Portugal, Slovakia, Spain, Sweden, and the UK.

11. In the survey we asked more information about the profile of the respondent organisations and these were the organisations' responsibilities:

- i. 38% (15)<sup>4</sup> for initial and specialist registration of healthcare professionals, inspection or accreditation and disciplinary procedures;
- ii. 25% (10) for initial and specialist registration and disciplinary procedures;
- iii. 15% (6) for initial registration and disciplinary procedures;
- iv. 5% (2) for initial registration only and;
- v. a further 5% (2) for initial registration and specialist registration with a further organisation for initial and speciality registration and inspection or accreditation;
- vi. One organisation for specialist registration only and two organisations for initial registration, inspection or accreditation and disciplinary procedures.
- vii. Two organisations did not indicate for which function they are responsible.

**Figure 2** – Breakdown of the respondents' functions



## A.2 Competent authorities' websites

12. 39 of the 41 respondent organisations have a website, 26 of which are linked through Health Regulation Worldwide ([healthregulation.org](http://healthregulation.org)) and 9 of which reported being also linked through the European Commission site<sup>5</sup> ([ec.europa.eu/internal\\_market/qualifications/compauth\\_en.htm](http://ec.europa.eu/internal_market/qualifications/compauth_en.htm)).

<sup>4</sup> Throughout this paper, percentages indicate a proportion of total respondent organisations unless they are presented in parenthesis in which case they represent a percentage of a subgroup of organisations specified in the preceding text.

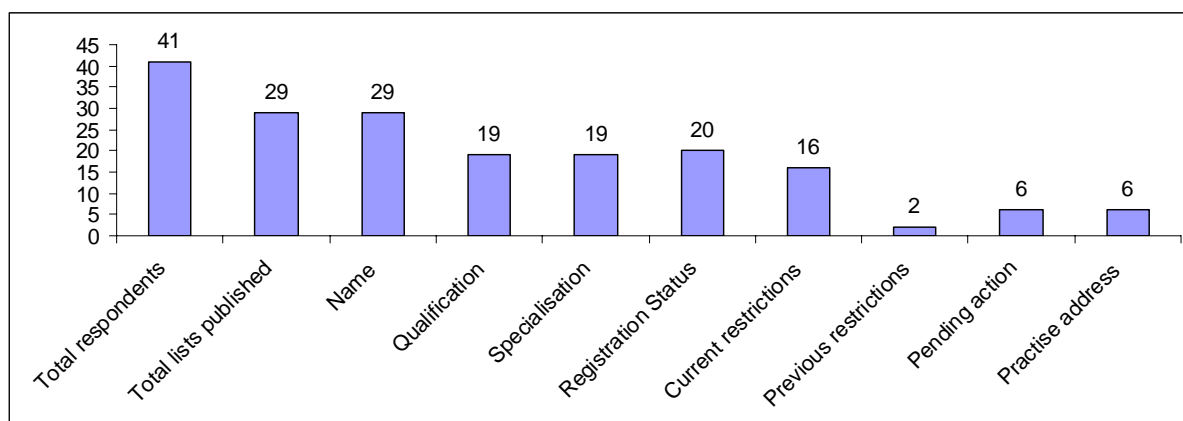
<sup>5</sup> The Commission site currently displays only an 'under construction' message.

### A.3 Lists of registered healthcare professionals

13. 71% (29) of respondent organisations make available a list of registered healthcare professionals on their website and a further 2 organisations are currently constructing such a facility.

- i. All of the 29 organisations list the name of the healthcare professional;
- ii. 20 (69%) list the registration status of the professional;
- iii. 19 (66%) list their qualifications and 19 (66%) their specialty;
- iv. 6 (20%) also list the professional's practice address;
- v. 2 (7%) list the complete history of a healthcare professional including current restrictions on practice, previous restrictions on practice and any pending action;
- vi. 14 (48%) do not list any of the items mentioned in paragraph 13.v above;
- vii. a further 9 (31%) list only current restrictions on practice;
- viii. while 4 (13%) list current restrictions and pending action.

**Figure 3** – Breakdown of the fields published in publicly available lists by number of organisation



14. 13 organisations (46%) update their lists for new registrations, when a decision is made about a professional or when a professional is suspended or erased either automatically or on a daily basis. For erasures alone, 16 organisations (55%) update their lists automatically or on a daily basis.

15. In terms of search criteria:

- i. 26 lists (90%) are is searchable by the name of the healthcare professional;

- ii. 19 (66%) are searchable by the professional identification number;
- iii. 11 (37%) by specialty;
- iv. 11 (37%) by address of practice;
- v. 2 (7%) by gender;
- vi. 1 (3%) by the date of birth of the professional; and
- vii. 1 (3%) was arranged in alphabetical order by name so although it did not have an active search function it would be possible to locate the professional on the list.

16. Professionals can request their details to be amended or removed from 12 (41%) of the lists in certain circumstances. It is not clear from the answers provided whether these requests are always granted.

17. The responses to the survey indicate that there is wide variation in the information that is contained in various lists. It is encouraging to note most of the lists were searchable. It is therefore possible for employers, other competent authorities and members of the public in most instances to assure themselves relatively quickly and easily of a practitioner's right to practise ensuring transparency and contributing to patient safety.

18. The frequency with which the lists are updated also varies substantially between competent authorities.

## **B. Proactive and reactive information sharing**

### **B.1 Proactive information exchange<sup>6</sup>**

19. Of the 21 respondent organisations that proactively share information, the following share information when a professional's practice has been restricted:

- i. 19 (90%) do so for issues arising from conduct;
- ii. 16 (76%) when there are health concerns;
- iii. 12 (57%) when there has been a criminal investigation; and
- iv. 13 (61%) when clinical performance has given rise to concerns.

20. Responses also show that the following share information when a professional's practice has been removed:

<sup>6</sup> The concept of proactive information exchange was set out in Agreement 5.2.1 of the Edinburgh Agreement: "Proactive exchange of information is competent authorities taking the initiative and circulating information to other competent authorities without a request. This becomes important for patient safety where individuals who pose a risk seek to evade regulatory procedures".

- i. 19 (90%) do so for issues arising from conduct;
  - ii. 17 (80%) when there are a health concerns;
  - iii. 16 (76%) when has been a criminal investigation; and
  - iv. 13 (61%) when clinical performance has given rise to the concern.
21. Of the 21 organisations that proactively share information:
- i. 10 (48%) share information if they suspect that identity fraud has occurred and a further organisation indicated they would share information if they had proof that identify fraud had occurred although there were a number of incomplete responses to this question.
  - ii. 16 (76%) routinely notify the jurisdictions where a healthcare professional has been known to have worked previously or is currently working if a sanction had been made against them.
  - iii. 13 organisations (61%) said that if they were aware that a healthcare professional was intending to work or obtain registration in another jurisdiction they would also notify that jurisdiction.
  - iv. 7 (33%) produce a decisions circular to a range of European regulators. As a percentage of total respondents this represents only 18% of organisations. Only 4 (19%) organisations reported that they produce a decisions circular to a range of international regulators (both EEA and non-EEA) and a further 4 organisations reported that they produce a decisions circular to HPCB signatories. 3 (14%) organisations reported using an accumulated list system.
  - v. 17 (80%) share information on a case-by-case basis as the information becomes available. 2 (10%) organisations said they shared information on a monthly basis and one organisation said it shared information on a yearly basis.

## **B.2 Reactive information exchange**

22. Of the 38 organisations that reactively share information:
- i. All do so by hard-copy and 17 (45%) exchange information electronically as well.
  - ii. When a request for further information is received, 31 (82%) organisations reported that they routinely confirm the identity of the healthcare professional in question. 17 (45%) reported that they would share details of any current criminal convictions.
  - iii. In terms of sanctions, 29 (76%) would disclose that a healthcare professional has been removed from the register, 23 (60%) that a license has

been withdrawn and 28 (74%) that the professional has been suspended. 20 (52%) organisations would disclose any conditions that had been imposed on a professional's registration or license and 19 (50%) would disclose any warning or reprimand.

iv. Few organisations have the authority to impose a fine but 9 organisations reported that they would disclose if a fine had been imposed.

v. Similarly of those organisations that accepted undertakings from a professional, 12 would disclose this.<sup>7</sup>

vi. 17 (45%) reported that they would acknowledge receipt of a request for more information within five working days while 63% (24) reported that they normally respond to requests within 15 days or less. This is in line with the service delivery targets for reactive information exchange included in the HPCB Memorandum of Understanding on Case-by-Case and Proactive Information Exchange.

23. The responses indicate that, at the more serious end of the spectrum, where the maximum sanction of erasure or a suspension has been imposed, some organisations do seem to be sharing information proactively placing patient safety and the public interest ahead of data protection and personal privacy laws. However gaps remain in the way that respondents routinely share information about decisions with regulators in other jurisdictions.

#### *The Certificate of Current Professional Status*<sup>8</sup>

24. Of the 38 organisations that reactively share information, 11 (29%) said they would only issue a certificate if the professional was in good standing with no outstanding concerns; 12 (32%) said they would still issue a Certificate of Current Professional Status (CCPS) or equivalent if the professional has disciplinary action pending, 14 (37%) said they would issue a certificate if there was a sanction on registration. Of these organisations 14 (37%) would list any current sanctions against a practitioner on the certificate and a further 8 (21%) would list any previous sanctions but only 4 (1%) would list any pending action while 6 (16%) would not list details of any sanctions. A further organisation indicated that policy was still in development following a recent legislative change.

25. If an organisation decided not to issue a certificate:

i. 9 (24%) organisations indicated that they would share information with the recipient competent authority as to why the certificate could not be issued;

<sup>7</sup> These findings should be interpreted with caution as not all competent authorities have the legal power to take certain actions against a registrant.

<sup>8</sup> The European template for a Certificate of Current Professional Status (CCPS) is set out in the 2005 Edinburgh Agreement. The European template contributes to increased consistency of information exchange between regulatory authorities and provides a range of information about the current status of a healthcare professional who is seeking registration with a regulator in another country. See: [http://www.hpcb.eu/activities/documents/80615\\_The\\_Edinburgh\\_Agreement.pdf](http://www.hpcb.eu/activities/documents/80615_The_Edinburgh_Agreement.pdf)

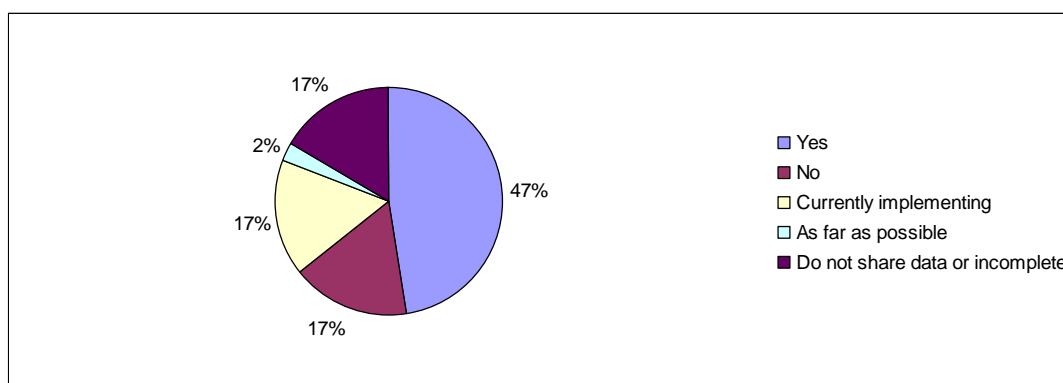
- ii. 10 (26%) would inform the requesting competent authority of the outcome of any proceedings;
- iii. 4 (11%) indicated that, if they made a judgement to not issue a certificate, they would be unable to share any further information with the recipient competent authority as to why the certificate could not be issued.

26. Most organisations seem to be sharing information reactively. However the 4 organisations which are unable to share any further information following a request from another competent authority represent a risk to patient safety.

27. With regard to the implementation of the CCPS template

- i. 47% (19) of respondent organisations reported that they have implemented the CCPS;
- ii. 17% (7) reported that they are in the process of implementing the CCPS.
- iii. 1 organisation reported that it has implemented the CCPS as far as it is able to.
- iv. 17% (7) organisations indicated they do not use the CCPS format; and
- v. 17% (7) either do not share data or did not submit a response to this question.

**Figure 4** – breakdown of respondents using the CCPS



28. Of the 7 organisations that indicated they were in the process of implementing the CCPS, 6 anticipated that they would have the CCPS implemented during 2010 and one organisation stated that it would do so by 2012.

29. The survey indicates that the CCPS initiative has been successful in providing a framework template for the reactive exchange of information. Even though the survey revealed some discrepancies with regard to the template fields in use, it is clear that the missing fields are not critical to the identification of the professional and his/her fitness to practise. It has also become apparent that implementation of the complete CCPS format is constrained by national data protection and privacy

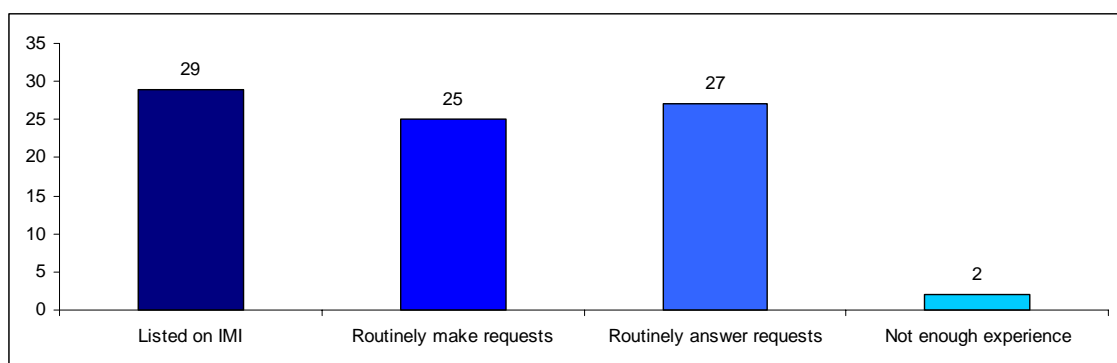
laws as well as technical issues such as some data fields not being contained in national databases.

30. Survey respondents also indicated that that the CCPS template is fit for purpose and should not be revisited to include any additional information.

#### *Internal Market Information (IMI) System*

31. 70% (29) of all respondents reported being listed on IMI. 27 of these (93%) reported that they routinely respond to requests for information through IMI and 25 (86%) said they routinely issue requests for information.

**Figure 5** – Organisations listed on IMI and their use of the system



32. Only one organisation reported that it uses IMI for every applicant for registration while 12 organisations (41%) indicated they use IMI if there was a query about information contained in a CCPS. 18 organisations (62%) stated that they use IMI if they had any queries about any of the information provided by an applicant.

33. 25 organisations (86%) indicated that they found IMI to be a very useful tool for confirming information.

34. Survey respondents indicated that useful IMI features include the easier identification of the correct competent authority in any given country and the ease with which competent authorities can receive information in their own language.

35. IMI users identified a number of obstacles including:

- i. The requirement for staff to be trained to operate a complicated system;
- ii. Restrictive questions format and difficulty of obtaining information outside of the system;
- iii. Inability to transfer request for information if the organisation was not the correct competent authority;
- iv. Difficulties related to the fact that some competent authority are not listed on IMI;

- v. Difficulties with comparing the information provided as each country has different standards, sanctions and terminology;
  - vi. The lack of sanctions for competent authorities that do not comply with information requests was also observed; and
  - vii. Data protection laws preventing the exchange of some information in some countries.
36. A number of suggestions were made to improve the system including:
- i. Making IMI compulsory for all competent authorities subject to Directive 2005/36/EC;
  - ii. Allowing for more flexibility in the system for free text questions and answers and allow for an exchange of information so that questions and answers can go back and forth rather than a 'one-off' exchange;
  - iii. Adding an alert functionality that would allow for proactive information exchange. This would further enhance the system, provide a secure channel for those competent authorities operating under more restrictive data protection and privacy laws, and facilitate the sharing of sensitive information more easily.

*HPCB Memorandum of Understanding on Case-by-Case and Proactive Information Exchange*

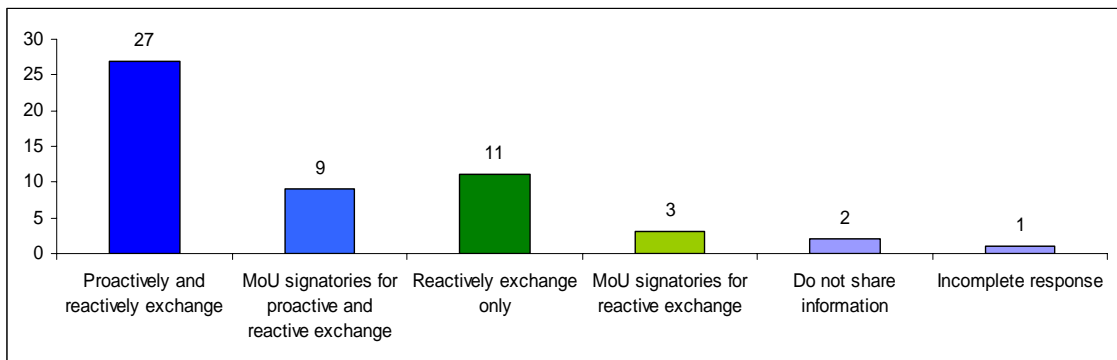
37. 29% of respondent organisations (12) have signed the [HPCB Memorandum of Understanding on Case-by-Case and Proactive Information Exchange](#)<sup>9</sup> (MoU). Of these:
- i. 9 (75%) have signed for both proactive and reactive information sharing; and
  - ii. 3 (25%) have signed for reactive information exchange only.
38. The remaining 70% (29) of respondents have not signed the MoU. Of these:
- i. 11 (37%) intend to sign for both proactive and reactive information exchange.
  - ii. 7 (24%) already proactively and reactively exchange information; and
  - iii. a further 8 (27%) reactively exchange information;

<sup>9</sup> The 'Memorandum of Understanding on Case by Case and Proactive Information Exchange' (MoU) between a number of European healthcare regulators was developed in October 2007. The MoU details how case by case information requests and responses should be handled by regulators and provides a framework for the sharing of information proactively, and by establishing guiding principles.

- iv. only 2 (7%) do not share information; and
- v. There was one incomplete entry

39. In total 65% (27) of respondent organisations both proactively and reactively share information. 27% (11) of respondent organisations share information on a reactive basis only. 93% (38) of respondents therefore exchanged information in some form.

**Figure 6** – Number of organisations that proactively and reactively share information compared to those who have signed the MoU



40. The high number of respondents who exchange reactive information in some form is a positive finding. It is interesting to note that a number of organisations already share information reactively and proactively but are not signatories to the HPCB Memorandum of Understanding.

### C. Hearings and decisions

41. Out of all the respondent organisations, 32 are responsible for disciplinary procedures (see [Figure 2](#)). And an additional 3 organisations that are not responsible for disciplinary procedures but that do publish details of hearings and decisions in some form of another (for example because they are responsible for the register).

#### C.1 Advance information about hearings

42. 20 (57%) out of 35 organisations (that have disciplinary powers and those that publish hearing and decisions) do make details of disciplinary hearings public in advance while 13 (37%) do not. One (3%) organisation does sometimes dependent on the case and a further organisation indicated policy for making information about hearings public was in development following a recent legislative change.

43. Of the 20 organisations that do make the information public in advance:

- i. 10 (50%) issue a press release;
- ii. 5 (25%) notify the professional's employer;

- iii. 7 (35%) notify the complainant;
- iv. 12 (60%) provide the information on request;
- v. 11 (55%) place the information on their website.
- vi. 2 (10%) organisations indicated that they make the information available on billboards in the office of the jurisdiction.

44. A number of reasons were cited as to why some organisations do not make hearings public which include data protection laws, the principle of innocent until proven guilty, specific national legislation prohibiting publishing this information and no legal basis to publish the information. The responses clearly indicate that this is a very difficult legal area.

## **C.2 Information about decisions**

45. 28 (80%) out of 35 organisations make their decisions public once they have been made, while 6 (18%) of organisations do not. A further organisation (3%) stated that it makes the decision public in certain circumstances.

46. Of the 28 organisations that publish decisions:

- i. 18 (64%) publish the information on their website;
- ii. 14 (50%) issue a press release;
- iii. 17 (61%) notify the professional's employer;
- iv. 13 (46%) notify the complainant;
- v. 10 (35%) provide the information on request;
- vi. 17 (60%) notify their national Ministry of Health, this included one organisation that has a legal duty to report to their Ministry of Health and is currently developing policy on the wider publication of decisions; and
- vii. 11 (28%) write a circular letter informing all major employers.
- viii. 1 further organisation informs the employer, complainant, and one national newspaper but only for those cases where the decisions allows the information to be made public.

47. Reasons cited for not publishing decision information included data protection and personal privacy laws. Additionally one organisation stated that it can publish the details of a case but only in an anonymised format.

48. Given the higher number of organisations making information publicly available once a decision has been made about a healthcare professional's right to

practise, it is clear that competent authorities have less difficulties publishing information when the over-riding consideration is the need to protect the interests of patients and the public, both within their own jurisdictions and elsewhere.

### **C.3 Information received from a foreign competent authority**

#### *Suspensions and erasures*

49. 34% (14) of all respondent organisations indicated that if they receive information from another competent authority that one of their registrants has been suspended or removed from the register in that jurisdiction then the recipient competent authority would initiate an investigation to ascertain whether similar action was required on their part.

50. 10% (4) of organisations indicated that they do not have any legal power to take account of activity outside of their jurisdiction and a further 5% (2) of organisations indicated that they do not currently have the power but domestic legislative changes are in progress which would potentially allow them to do so.

51. 7% (3) of organisations indicated that if the registrant was primarily registered outside of their jurisdiction and a foreign competent authority suspended or removed that practitioner from their register then they would follow suit. However if the practitioner was primarily registered in their jurisdiction they would conduct their own investigation. A further organisation indicated that only holders of a foreign degree could be removed from the register and if their suspension ended in their home jurisdiction they could reapply. One organisation also reported that when a practitioner's annual renewal is due they have to take into account any decisions made against them in another jurisdiction.

52. One organisation reported that taking disciplinary action is not their responsibility, 2 organisations reported that they have no experience of this situation and further 2 organisations indicated they are awaiting a change in domestic legislation. There was incomplete information for 21% (9) of organisations.

#### *Investigations*

53. 34% (14) of respondent organisations reported that if they received information that a healthcare professional registered with them was being investigated in another jurisdiction they would await the outcome of that investigation before taking any action. A further 4 organisations would consider interim sanctions while awaiting the outcome of the foreign investigation.

54. 12% (5) of respondent organisations indicated they would initiate their own investigation while a further organisation said that it depended on the situation and the severity of the alleged offence.

55. 5% (2) of respondent organisations indicated they had no legal basis to act and a further organisation said it does not yet have a legal basis to act but legislative changes would potentially allow them to do so.

56. 5% (2) of organisations reported that they did not have an operational register yet and were thus not in a position to investigate healthcare professionals while a further organisation reported that its policy was currently in development following a recent legislative change. One organisation said that they are not responsible for disciplinary procedures and one organisation has no experience of this occurring. Information was incomplete for 17% (7) of respondents in this respect.

#### *Evidence*

57. 37% (15) of respondent organisations indicated that they can use evidence provided by another competent authority and a further 7% (3) of organisations said that they can only take into account the judgement of a court following criminal proceedings. 5% (2) of organisations do not currently have the power to take into account evidence provided by another competent authority but said that legislative changes are currently in train which would potentially allow them to do so. One further organisation indicated that it can take the evidence from another competent authority into account but it would have to be delivered orally.

58. 5% (2) of respondent organisations reported that it would depend on the information provided but said that they would not routinely consider evidence provided by another competent authority. 2 organisations did not have a legal basis to consider evidence of events that occurs outside of their jurisdiction.

59. 5% (2) of respondent organisations had no experience of this and a further organisation reported that its policy was still under development following a recent legislative change. One organisation indicated that it was not responsible for disciplinary proceedings. Information was incomplete in 23% (10) of instances.

60. The survey results demonstrate a wide variation in approach to dealing with information about suspensions and erasures, investigations and evidence received from other competent authorities. It is clear that the recognition of decision is problematic for many competent authorities due to domestic legal constraints.

#### **D. Competence Assurance of Healthcare Professionals**

61. 53% of organisations (22) reported that registration is not dependent on a successful assessment of any kind although one of these organisations had a voluntary scheme. 3 organisations indicated that successful acquisition of Continuing Professional Development points or credits was necessary to renew registration and a further 11 organisations indicated they had plans to bring in a system of assessment before registration would be renewed.

#### **E. Professional Standards**

62. 78% (32) of respondent organisations reported that they made their standards available on their website. 17 of these organisations would also send registrants a copy of their standards on registration while 21 would send them to registrants on request. 8 organisations made the standards and guidance available through healthcare provider organisations and further 17 would make the standards and guidance available to members of the public on request.

## Conclusion

63. The objective of this survey was to measure the implementation of the Portugal Agreement and the level of information sharing at European level.

64. The outcomes have demonstrated that significant progress has been made in regard to the sharing of reactive information and the implementation of the CCPS across competent authorities in many European jurisdictions. The survey has also indicated a significant level of support for the IMI system and presented a number of options to develop the system in a constructive way.

65. The survey also highlighted a number of risk areas, including the inability of some competent authorities to share detailed information or to consider evidence about a healthcare professional's fitness to practise produced by another competent authority.

66. The difficulties competent authorities face with the recognition of decisions about healthcare professionals taken in other jurisdictions also represents a significant patient safety risk.

## HPCB follow-up activity

67. The survey produces useful information for HPCB participants in terms of progress in implementing the Portugal Agreement as well as identifying areas where more action is required.

68. Following the results of the survey, HPCB plans the following activities:

- a. To continue to disseminate information about EU policy and legislative developments as well as regulatory news through the HPCB website and the *Crossing Borders Update* newsletter;
- b. To continue to encourage competent authorities to implement the Portugal Agreement;
- c. To continue to encourage competent authorities to list their website link on [healthregulation.org](http://healthregulation.org);
- d. To encourage competent authorities to hold a register of the healthcare professionals they regulate and make that register publicly available; and in line of agreement 2b of the Portugal Agreement, to draw up good practise and guidance on the establishment and maintenance of publicly available lists of healthcare professionals (registers);
- e. To continue to promote the HPCB MoU to all competent authorities in Europe and in particular encourage those respondent organisations that have signalled their intention to sign the MoU, and those organisations

that have implemented the CCPS, to sign the MoU for reactive information exchange;

- f. To promote the secure exchange of CCPS and encourage competent authorities to exchange CCPS directly and electronically;
- g. To continue to support IMI and explore whether it could be enhanced to allow for the [proactive exchange of information](#) and provide a tool for those competent authorities that currently cannot share information because of privacy concerns;
- h. In line of agreement 3c of the Portugal Agreement, to continue to encourage competent authorities to develop appropriate competence assurance and performance enhancement initiative and share experience in this area;
- i. To organise an event on Directive 2005/36/EC in 2010 for healthcare professional regulators to share views and experiences on the Directive in light of its upcoming review;
- j. In the context of the European Commission's efforts to create an area of freedom security and justice, to explore engagement with the EU Stockholm Programme and the mutual recognition of decisions imposing some kind of disqualification and or prohibition from carrying out certain professions;
- k. To try and collate examples of healthcare professionals that have been suspended/erased in one European jurisdiction but continue to practise in another.