Call for evidence submission
February 2026

professional standards authority
for Health and Social Care

Professional Standard Authority response to All Party Health Group call for evidence on improving access to primary care

1. About us

1.1. The Professional Standards Authority for Health and Social Care (PSA) is the UK's oversight body for the regulation of people working in health and social care. Our statutory remit, independence and expertise underpin our commitment to the safety of patients and service-users, and to the protection of the public.

1.2. There are 10 organisations that regulate health professionals in the UK and social workers in England by law. We audit their performance and review their decisions on practitioners' fitness to practise. We also accredit and set standards for organisations holding registers of health and care practitioners not regulated by law.

1.3. We collaborate with all of these organisations to improve standards. We share good practice, knowledge and our right-touch regulation expertise. We also conduct and promote research on regulation. We monitor policy developments in the UK and internationally, providing guidance to governments and stakeholders. Through our UK and international consultancy, we share our expertise and broaden our regulatory insights.

1.4. Our core values of integrity, transparency, respect, fairness, and teamwork, guide our work. We are accountable to the UK Parliament. More information about our activities and approach is available at **www.professionalstandards.org.uk**

2. Key points

- "Good access" to primary care must include safety and quality, not just speed or availability, with equal emphasis on patient experience, continuity of care and clinical outcomes
- Patient safety remains a concern in primary care, with avoidable harm still occurring, particularly related to diagnosis, medication and delayed referrals, highlighting the need for stronger safety-focused approaches to widening access
- Reducing health inequalities must be central to reforming access to primary care, as barriers linked to ethnicity, socio-economic status, discrimination and poor patient experience can deter engagement with primary care services

- Strong mechanisms for patient voice are needed, especially if local and national Healthwatch bodies are abolished, with complaints playing a larger role in identifying access problems and inequalities
- Learning from patient safety incidents and complaints is critical, but participation in learning systems and the availability of robust demographic complaints data remain limited, constraining improvement efforts
- A clear, proactive regulatory strategy is essential to support workforce transformation in primary care, ensuring new and expanded roles are introduced safely, transparently and retaining public and stakeholder confidence
- Lessons learned from the rollout of new roles (e.g. Physician Associates and Anaesthesia Associates) demonstrate the risks of insufficient clarity, planning and regulatory oversight, particularly for "first contact, right professional" models
- Changes proposed in the *10 Year Health Plan for England: fit for the future* including greater use of reception and administrative staff to improve access and triage and the utilisation of new roles and voluntary organisations could provide benefits, but appropriate training, support and regulatory assurance is needed for these to be fully realised
- Accredited Registers offer a proportionate way to manage risk for unregulated or expanding roles in primary care, supporting public protection while enabling workforce innovation
- AI and digital tools have huge potential in primary care but require clearer governance, including accountability, professional responsibilities and regulatory safeguards, to maintain safety and public trust.

3. Detailed comments

Theme 1. Reducing Health Inequalities and Access Barriers

1) What patient-centred indicators (experience, continuity, clinical outcomes etc.) should define "good access" across:

a) General Practice,
b) Community Pharmacy,
c) Dentistry, and
d) Optometry?

3.1. Safety is also an important indicator of "good access" across the healthcare settings specified as part of the overall picture on quality of care.

3.2. A 2021 study suggests that the rate of significant harm considered at least probably avoidable in primary care in England was 35.6 per 100 000 patient-years (57.9, 95% CI 42.2 to 73.7, per 100 000 based on a sensitivity analysis). Overall, 74 cases of avoidable harm were detected, involving 72 patients. Three types of incidents accounted for more than 90% of the problems: problems with diagnosis, medication-related problems and delayed referrals.[1]

3.3. The *Primary care patient safety strategy* suggests there are 20,000 – 30,000 incidents of avoidable significant harm in primary care each year, although highlights that this

[1] **Incidence, nature and causes of avoidable significant harm in primary care in England: retrospective case note review | BMJ Quality & Safety**

may be an underestimate as reporting systems in primary care are underdeveloped.[2] The proportion of GP practices participating in the *Learn from patient safety events (LFPSE)* service operated by NHS England is low (7.2% for Q2 25/26).[3] This demonstrates that despite limited data, safety remains a clear and present consideration for patients within primary care and should be taken seriously.

2) What population groups remain under-represented or face significant barriers in accessing primary care services, why do these barriers occur and in which regions are they most prevalent? Please outline the contributing factors, together with any evidence of effective approaches that have improved access for these groups.

3.4. Health inequalities linked to ethnicity and socio-economic status are widely acknowledged.[4,5] In addition, research published recently by the NHS Race and Health Observatory has highlighted that certain groups of patients face discrimination in primary care.[6] The report also found that poor patient experiences including discrimination or lack of cultural awareness/competence can impact on trust in primary care services and can potentially lead patient to disengage from healthcare.

3.5. The PSA highlighted the need to prioritise tackling inequalities as part of the shift toward prevention within its response to the 10 Year Workforce Plan call for evidence.[7] Primary care will play a crucial role in supporting the move to prevention and it is therefore important that patients across all demographics are able to access the care that they need.

3.6. Although others will be best placed to provide specific details on initiatives to help improve access to primary care, providers have a key role to play. NHS England has developed a *Patient and carer race equality framework (PCREF)*, for all NHS mental health trusts and mental health service providers to embed across England.[8] This mandatory framework will support trusts and providers on their journeys to becoming actively anti-racist organisations by ensuring that they are responsible for co-producing and implementing concrete actions to reduce racial inequalities within their services. It will become part of Care Quality Commission (CQC) inspections and helps to demonstrate the actions that can be undertaken by providers in combatting inequalities.

3.7. Training for healthcare professionals will also be a key part of any action. For example, the North London Integrated Care Board has created and piloted cultural competence training to ensure GPs are equipped to deliver care to diverse communities.[9]

3.8. There is an important role for professional regulators in ensuring that professionals have the necessary education and training to provide care to patients with diverse

[2] **NHS England » Primary care patient safety strategy**
[3] **Statistics » Quarter 2 2025/26 (July, August, September 2025)**
[4] **What Are Health Inequalities? | The King's Fund**
[5] **Health inequalities in health protection report 2025 - GOV.UK**
[6] **Patients face discrimination in primary care, survey finds | The BMJ**
[7] **Response to call for evidence on the NHS 10 year workforce plan | PSA**
[8] **NHS England » Patient and carer race equality framework**
[9] **CPD: How to develop a culturally competent practice - Pulse Today**

needs through their quality assurance of education and training.

3.9. The PSA encourages the regulators we oversee to take a proactive approach in this area through our Standards of Good Regulation which have included a focus on EDI since 2019. Our detailed EDI indicators, introduced in 2023/24 cover this area, specifically: *'In terms of EDI, the regulator ensures that students and registrants are equipped to provide appropriate care to all patients and service users, and have appropriate EDI knowledge and skills.'*[10] Our good practice report published in 2025 outlines a range of examples of action across the regulators we oversee.[11]

3.10. Another key method of improving access to and experience of care is through learning from and acting on complaints. The case for this is two-fold. Complaints can in themselves provide important insights into the areas of weakness within services and therefore provide the opportunity to bring about improvements. In addition, a poor experience compounded by a poorly handled complaint may deter patients from using services again in the future perpetuating problems of uneven, unequal access.

3.11. Research, including recent research commissioned by the PSA on barriers to complaints to the professional regulators highlights that patients and service users are still experiencing significant challenges in raising concerns.[12] The PSA will shortly be introducing a new unified set of Standards for both the regulators and Accredited Registers it oversees, which will include enhanced expectations in relation to EDI and will promote a consistent approach across regulated and unregulated roles. The new Standards will also cover expectations on professional regulators to understand the diversity of people interacting with them (including through complaints/referrals) and provide appropriate support.

3.12. However, there remains a lack of robust demographic data relating to complaints about health and care provision which may hamper efforts to understand and improve the experience of particular groups. For primary care, the GP Patient Survey[13] collects some demographic information, however, there remains a gap in terms of the complaints data needed to properly address access barriers and the wider reforms needed to the complaints system, see further detail at 3.25 below.

3) What single policy change would most immediately improve patients' ability to be directed to the right primary care professional at their first point of contact…?

3.13. In its response to the 10 Year Workforce Plan call for evidence, the PSA recommended that Government develops a regulatory strategy as an integral part of workforce transformation.[14]

3.14. Regulation should be used as an enabler of workforce transformation – a key partner in ensuring the right professions/ roles/ skills are available and safe to practise – but this requires proactive planning. The ongoing controversy around the introduction of Physician Associates (PAs) and Anaesthesia Associates (AAs) into the workforce

[10] **Professional Standards Authority Standard 3 evidence matrix**
[11] **Lessons from meeting our EDI Standard for regulators - good practice guide | PSA**
[12] **New research reveals need for clearer, more accessible complaints systems for healthcare professional regulators | PSA**
[13] **GP Patient Survey**
[14] **Response to call for evidence on the NHS 10 year workforce plan | PSA**

demonstrates that decisions on risk management and regulation cannot be an afterthought.

3.15. The *Independent review of the physician associate and anaesthesia associate roles* undertaken by Professor Gillian Leng found that: *'A clear vision communicated effectively is required in all change processes, and this was largely missing in the rollout of PAs and AAs. There was no nationally described vision for the integration of the new roles into existing teams and services and, as the workforce expanded, confusion about the roles' purpose and respective remits grew among both patients and professionals."*[15]

3.16. This example illustrates the challenges that can arise when key decisions about the implications of a particular workforce change lack transparency and robustness. The Secretary of State noted when presenting the findings of the Leng Review to Parliament: *'The lessons learned in the Review will be embedded into the upcoming workforce plan to improve how we effect change in the NHS, and ensure the mistakes of the past are not repeated in the future."*[16]

3.17. A regulatory strategy would set out principles, objectives and options to guide current and future decisions about regulation; explain how workforce changes will be implemented safely; and provide tools for decisions not anticipated in the plan. This is directly relevant to "first contact, right professional" because it underpins safe role redesign, triage models, and accountability that will be integral to realising the ambition for primary care outlined in the 10 Year Health Plan for England.

3.18. It would outline how risks will be managed for new roles, broadening the scope of existing roles or expanding numbers within a profession at pace. This would include innovations proposed in the 10 Year Health Plan including greater utilisation of reception and administrative staff as first points of contact with patients (see answer at 3.31-3.33 below), use of new roles such as community health workers and peer support workers and wider utilisation of volunteers and/or voluntary organisations within the NHS.

3.19. A proactive strategy would ensure the roll-out of changes required is much smoother and retains the buy-in of the relevant stakeholder groups.

5) With the proposed abolition of 153 local Healthwatch across the country, as well as the national body Healthwatch England, what mechanisms should be put in place to ensure meaningful patient voice and feedback are embedded in the design, delivery, and evaluation of neighbourhood health hubs and wider access reforms? What specific metrics and accountability frameworks should be developed to monitor and proactively respond to regional disparities in access to primary care?

3.20. Patient feedback is vital to ensuring that healthcare services meet the needs of the local population. As highlighted in *Safer care for all*, the legacy of the Covid-19 pandemic was that many users of health and care services were left feeling isolated and unsupported as well as reducing patient and public involvement in policy-

[15] **The Leng review: an independent review into the physician associate and anaesthesia associate professions**

[16] **Written statements - Written questions, answers and statements - UK Parliament**

making and service delivery.[17]

3.21. In the absence of local Healthwatch groups, learning from complaints will become an increasingly important method of learning when things have gone wrong and bringing about improvements. The commitment in the 10 Year Health Plan for England to: *'reform the complaints process and improve response times to patient safety incidents and complaints'* is welcome.[18]

3.22. However, the scale of the challenge when it comes to complaints should not be underestimated. The PSA has highlighted the gap in relation to the limited demographic data available in complaints made to health and care services. In 2024, we ran a joint event with the Parliamentary and Health Service Ombudsman (PHSO) which shone a light on the broader barriers patients and service users face when trying to make a complaint about care. This highlighted that as well as smaller scale improvements, radical changes may be needed to make the complaints system work better for those that it serves.[19]

3.23. The PSA's revised Standards (soon to be published) will promote a greater focus on harm prevention and a more compassionate, joined-up approach to complaints handling by professional regulators, including clearer information about where to go with different complaints and promoting effective local resolution where appropriate. This is informed by research the PSA commissioned last year on barriers to complaints.[20]

3.24. It will be important that improvements to complaints processes are progressed across different parts of the health service including primary care. Uptake of the PHSO's complaints standards which set out how NHS and UK central government organisations should approach complaints handling in a clear and consistent way should be a powerful tool to bring about improvements.[21] Healthwatch has also called for demographic complaints data to be collected as standard and for use of the PHSO complaints standards to be made mandatory for NHS organisations as well as making a range of wider recommendations to improve the complaints system in their 2025 report: *A pain to complain: Why it's time to fix the NHS complaints process*.[22]

3.25. In addition, the promised strengthening of mechanisms for the patient voice within Integrated Care Boards (ICBs) will also need to materialise if the changes outlined in the 10 Year Health Plan for England are to be realised.[23]

Theme 2. Harnessing Digital Transformation and System Integration

[17] **Safer care for all - solutions from professional regulation and beyond | PSA**
[18] **NHS England » Fit for the Future: 10 Year Health Plan for England**
[19] **Barriers to complaints: what are they and how can we break them down? | PSA**
[20] **New research reveals need for clearer, more accessible complaints systems for healthcare professional regulators | PSA**
[21] **Complaint Standards | Parliamentary and Health Service Ombudsman (PHSO)**
[22] **A pain to complain: Why it's time to fix the NHS complaints process.**
[23] **Patient voice must be embedded into 10 Year Health Plan to maximise technology benefits | Medical Technology Group**

8) How should transparency, safety, and public trust be maintained when deploying AI or virtual tools in primary care, and what governance and regulatory safeguards are required?

3.26. Whilst AI has huge potential to improve efficiencies and patient experience within primary care, the regulatory framework for it is still relatively under-developed and as such caution is required when seeking to make use of such technologies. The work being undertaken by the National Commission into the Regulation of AI in Healthcare through the Medicines and Healthcare Products Regulatory Authority (MHRA) will be important in helping to shape the wider regulatory approach.

3.27. To ensure the safe use of AI and virtual tools in primary care (and healthcare more widely), greater clarity and consistency are needed around expectations for healthcare professionals when using AI, including on matters of responsibility and liability when things go wrong. This will help to inform guidance for professionals when making use of such tools.

3.28. The PSA is in a unique position, overseeing regulators and registers, to help coordinate across both regulated and unregulated groups and is working with other organisations including the MHRA, regulators, Accredited Registers, professionals and patients to support the delivery of the benefits that can come from adopting medical devices that use AI, while maintaining patient safety.

3.29. While existing professional regulatory standards already cover aspects such as transparency and consent, which are important to trust, the novel nature of AI means that professionals will be encountering new ethical scenarios. Developers and providers therefore have a role in equipping professionals with the appropriate training and technologies to deliver care safely.

Theme 3. Securing Long-Term Sustainability in Primary Care

13) d) Aside from funding, what system-wide reforms or policy levers would have the greatest impact on improving access to primary care and which should be prioritised?

3.30. As outlined in our answer to question 3, a regulatory strategy would be a key development to help improve access to primary care by providing a structured approach to manage risks arising from the workforce changes required.

20) How can reception and administrative staff in general practice, including those involved in NHS 111 and GP redirection, be better trained and supported to act as effective first points of contact and triage as digital access expands? What policies, training frameworks, or support systems are needed to help them guide patients through digital tools, care navigation, and appointment systems?

3.31. It is important that anyone who may have contact with patients including providing advice and support on health matters operates within the appropriate regulatory framework. As highlighted in previous answers, a regulatory strategy would be a major step forward in outlining the governments approach to management of risk in line with changes proposed for the workforce in the 10 Year Health Plan for England including the expansion of scope for non-clinical staff which could be both a key area of opportunity but also risk.

3.32. There are a range of tools available to ensure a robust framework to support staff employed in such roles in taking on greater responsibility in supporting and guiding patients. The Accredited Registers programme for groups of unregulated

practitioners provides proportionate, independent assurance of registers of roles not subject to statutory regulation.[24] The public and those commissioning services can be assured that those on an Accredited Register meet standards of competence and conduct and that there is access to robust complaints mechanisms.

3.33. The AR Programme should be considered as an option for assurance of unregulated staff within primary care whose role is expanding and where new public protection risks may be emerging.

Theme 4. Additional Considerations

22) Has the Government overlooked any significant issues in its approach to improving access to primary care? What additional priorities should be considered to ensure the 10-Year Health Plan is effective?

3.34. As highlighted in our answer to question 3, in our view a regulatory strategy is an essential element of putting in place a robust approach to management of the new risks that will emerge alongside the workforce changes required to improve access to primary care.

Submissions permissions

1. Do you give permission for the report to quote your submission?

3.35. a. Yes

2. May we attribute the submission to the organisation you belong to?

3.36. a. Yes

3.37. b. Name of organisation: The Professional Standards Authority for Health and Social Care

3. May we attribute the submission to you personally, listing your job role?

3.38. a. No

3.39. b. Full name: Daisy Blench

3.40. c. Job role: Policy Manager

4. Would you be interested in providing further evidence via a short call or online interview?

3.41. a. Yes

[24] **Our work with Accredited Registers | PSA**