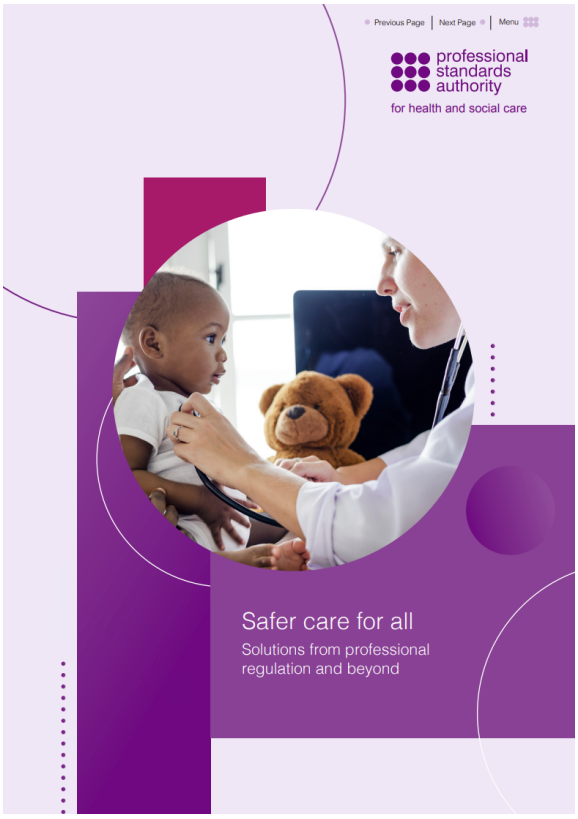
professional standards authority
for Health and Social Care

Safer care for all

a summary of progress to date

In 2022 the Professional Standards Authority for Health and Social Care (PSA) published *Safer care for all: solutions from professional regulation and behond*, outlining the biggest challenges to the quality and safety of health and social care, and explaining how professional regulation can help drive change. It also showed that real change will only happen if the whole health and care system works together.



The report's recommendations are grouped under four key themes:

- **Tackling inequalities**
- **Regulating for new risks**
- **Facing up to the workforce crisis**
- **Accountability, fear and public safety**

Examining these themes identified a sector-wide problem, **structural flaws in the safety framework**.

Safer care for all was a call to action. It invited those in health and care to work together, break down barriers, and deliver safer care for everyone. There has been progress against the recommendations and commitments since publication, but these are complex issues and, in many areas, further work is required.

Read ***Safer care for all: solutions from professional regulation and beyond***

Key initiatives and achievements as of 2026

Tackling inequalities

> "We found that the very inequalities we were trying to tackle were being hampered by the culture which sustains such inequalities." ***Racism embedded in NHS organisational culture and norms prevents progress on healthcare staff inequities,*** Kings College London (2022)

- The PSA is now in the third year of its strengthened approach to assessing Equality, Diversity and Inclusion (EDI) for regulators, launched in 2023/24, with clearer indicators that raise expectations – including that senior leadership, councils, committees, decision-makers and fitness to practise panellists should reflect the diversity of both professionals and the public.
- The PSA's EDI Standards are improving how regulators collect and use data, including encouraging cross-organisation working, though success varies.
- A requirement for regulator processes to address racist and discriminatory behaviour is now built into the PSA's Standards. As of 2025/26, eight of the 10 regulators the PSA oversees, have already updated their guidance, and two are working through improvement plans.
- The PSA has introduced an enhanced EDI Standard for Accredited Registers.
- Accredited Registers are required to make it easier for people to take part in complaints processes.
- 27 out of 28 Accredited Registers met the EDI requirements without any conditions attached in 2025/26.
- Most regulators are now meeting the EDI Standard, with eight out of 10 doing so in 2023/24 and seven out of 10 in 2024/25.
- New unified Standards for regulators and Accredited Registers came into effect from July 2026 and provide greater consistency of expectations on EDI.
- The PSA's ***Barriers to Complaints*** research seeks to encourage further improvements to regulators' complaints processes.
- The PSA has proactively supported regulators in dealing with hate speech, including issuing a public statement affirming that while preserving freedom of speech is important, hate speech is unequivocally unacceptable.
- The PSA has reviewed its own processes to make sure it does not unintentionally worsen inequalities.

Regulating for new risks

> **"Innovation is a key enabler of improvements in health and social care. Many of the things we now think of as essential to high-quality care were once considered new and innovative, and today's innovations will be tomorrow's best practice."** ***State of care report,*** Care Quality Commission (2018)

- The UK Government has committed to reforming professional regulation, including updating legislation for the General Medical Council, Nursing and Midwifery Council and Health and Care Professions Council during the 2024–2029 Parliament. These changes are intended to give regulators more flexibility to respond to new and emerging risks.
- The Medicines and Healthcare products Regulatory Agency has set up a National Commission into the Regulation of Artificial Intelligence in Healthcare at the request of the Government, tasked with developing a regulatory framework for AI use in healthcare. The PSA is working with the Commission.
- Work is ongoing across governments, regulators and Accredited Registers to clarify who is responsible for overseeing new technologies.
- The General Optical Council has launched a focused review of how commercial practices affect patient safety, with findings expected in 2026.
- The *People* working group, as part of the 10-Year Health Plan, has highlighted that the future workforce must be broader and more fluid, spanning the NHS, private sector, social care, volunteers, and unpaid carers.

Facing up to the workforce crisis

> **"The UK healthcare workforce needs to double, and care quadruple its growth over the next decade. At current rates of growth, there will be too few, too late."** The Health Foundation (October 2021)

- The *10 Year Health Plan for England: fit for the future* sets out regulation as an important tool for improving how health and care services work.
- Regulators and Accredited Registers are working together to increase workforce supply, prepare practitioners for future care needs, reduce safety risks, and protect patients and service users. This is ongoing, and further actions are being developed.
- Progress is being made to embed the Accredited Registers programme as a proportionate alternative to support workforce development and manage risk.
- The PSA's call for a regulatory strategy to help manage and address workforce risks is increasingly being recognised and supported by key stakeholders in England.
- The PSA's new Standards will encourage organisations to work more closely with others, helping them to improve how they identify and manage risks to the public which should help support action on workforce objectives.

Accountability, fear and public safety

> **"When things do go wrong and cause harm, it is very rare that this is because individuals deliberately depart from good practice or act maliciously. However, if that were the case, the individuals would need to be held to account." *A vision of what a 'just culture' should look like for patients and healthcare staff*, AvMA (2021)**

- Regulators are becoming clearer about how they handle cases where professionals are involved in patient or service user safety incidents. For example, the Nursing and Midwifery Council has adopted a "culture of curiosity" to better understand the context surrounding patient safety incidents and the General Dental Council is fostering a learning culture, promoting and encouraging continuous improvement.
- The *Patient Safety Incident Response Framework* has been rolled out, and the NHS England *Just Culture Guide* has been updated, taking account of the role of professional regulation.
- Following the recommendation from the Dash Review in 2025, the Health Services Safety Investigations Body will become a discrete investigations unit within the Care Quality Commission.

Structural flaws in the safety framework

> **"The patient safety landscape is fragmented and complex. Concerns raised often fall between organisations.... Large-scale failures of care still occur frequently, and inquiries and reviews highlight similar themes and issues, with the system seemingly unable to prevent their recurrence." *Safer care for all*, PSA (2022)**

- The role of Patient Safety Commissioner was established in 2021 for England and in 2023 for Scotland, with the first appointments made in England in 2022 and Scotland in 2025.
- The Dash Review recommended revamping, revitalising and significantly enhancing the role of the National Quality Board for England with a remit covering the safety and quality of care including considering recommendations from previous reviews and inquiries.
- The Health Services Safety Investigations Body report *Recommendations but no action* identified the high volume of safety recommendations hinders implementation in the NHS, leading to a "no action" scenario for many, which increases patient risk.
- The Thirlwall Inquiry reviewed inquiries and reviews conducted in England and Wales over the last 30 years to evaluate why past healthcare warnings often failed to produce lasting change.

There is more work to do and the PSA and others are pushing for action across these areas

Nearly 800 inquiry recommendations over the last decade or so (and that is just for maternity services).

Non-surgical cosmetic procedures have become increasingly popular across the UK. As demand has grown, so have reports of botched procedures and unsafe practices.

- Drive improvements in how demographic data on complaints made to health and care services across the UK is recorded and shared, where progress has so far been limited.
- Extend and build on the healthcare professional regulator reform programme beyond the largest three regulators, so that, if progressed for other regulators, it can review regulator powers over businesses, consider extending business regulation to those with high street registrants, and ensure regulators are equipped to respond to new care models and technologies.
- Put in place a clear, formal process for deciding which roles should be regulated, supported by an overall regulatory strategy to manage risk and support workforce development.
- Create a unified process and accountability mechanism so that learnings from every major review across the UK leads to real, measurable change.
- Push for a level playing field for the PSA's Accredited Registers Programme, including a legislative and policy framework to help manage risk, and consider mandatory registration in high-risk areas such as mental health and healthcare science.
- Ensure appropriate safeguards are in place for non-surgical cosmetics across the UK.
- Take forward a cross-sector review of financial conflicts of interest.
- Respond to concerns about the balance between accountability and blame. As highlighted by James Titcombe in the HSJ (2026) "If we fail to disentangle necessary accountability from blame – while being clear about where responsibility truly lies – we risk perpetuating a system that satisfies neither patients nor staff and remains dangerously ill-equipped to prevent the next Yaser Jabbar."
- Continue efforts to improve the overall coherence of the safety system both through the removal of barriers to effective collaboration across different organisations and/or the establishment/enhancement of Patient Safety Commissioner roles across the different parts of the UK.