Public Board Meeting
16 September 2025, PSA office
10:30-11:30

professional standards authority
for Health and Social Care

Agenda

			Timing
1.	Welcome, introductions and declarations of interest		10:30-10:30
2.	Apologies		10:30-10:30
3.	Minutes of the meeting on 15 July 2026 (for approval)	(Paper 1)	10:30-10:30
4.	Actions and Matters Arising from the meeting on 15 July 2026		10:30-10:35
5.	Chair's report	(Paper 2)	10:35-10:40
6.	Executive report and project dashboard	(Paper 3)	10:40-10:55
7.	EDI Advisory Group update	(Paper 4)	10:55-11:05
8.	Finance report	(Paper 5)	11:05-11:10
9.	Committee Reports		
	• Nominations Committee	(verbal)	11:10-11:15
10.	Risk register and Risk Management Policy	(Paper 6)	11:15-11:25
11.	Board annual workplan	(Paper 7)	11:25-11:25
12.	Any other business		11:25-11:25
13.	Agree actions		11:25-11:25
14.	Questions from the Public		11:25-11:30

The next Board meeting is scheduled for Wednesday 18 November in Cardiff.

Unapproved Public Board meeting minutes

15 July 2026

Present	**In Attendance**
Caroline Corby (CC - Chair)	Jane Carey (JC)
Alan Clamp (AC - Chief Executive)	Graham Mockler (GM)
Candace Imison (CI)	Melanie Venables (MV)
Juliet Oliver (JO)	Douglas Bilton (DB)
Nick Simkins (NS)	Marija Hume
Ali Jarvis (AJ)	Dinah Godfree
Geraldine Campbell (GC)	Akua Dwomoh-Bonsu
Eleanor Marks (EM)	
Ododo Ediagbonya (OE)	Oyinkan Onile-Ere
	Melanie Hueser (Secretariat)
	Observers
	See below

1. Welcome and Declarations of Interest

1.1. The Chair opened the meeting and welcomed everyone to the Board meeting. Observers included members of staff and external observers: Anisah Chowdhury (GMC)

2. Apologies

2.1. There were no apologies.

3. Minutes of meeting held on 20 May 2026

3.1. The minutes of the meeting held on 20 May 2026 were approved as an accurate record.

4. Actions and matters arising from the meeting on 20 May 2026

4.1. The Board reviewed the action log.

5. Chair's report

5.1. The Chair introduced the item.
5.2. On under-regulation, the Chair asked MV for an update later in the item on consultation relating to non-surgical cosmetics.

5.3. The Chair asked for an update on the Independent Oversight Group meeting held on 6 July. The group had looked mainly at the delayed second and third NMC reports, FtP data and survey results on how assured group members felt about the NMC's progress. The group will discuss in September how long the Independent Oversight Group should continue, as it had been set up as a task-and-finish group and September would mark two years. It was also noted that from January the NMC would be subject to the new governance standard, giving further routes for oversight through performance review.

5.4. The Board asked whether the PSA had sufficient resource and capacity for the Mann review and Scottish Commission work. It was confirmed that the Scottish Commission would require management time and headspace but should be manageable, supported by additional fixed-term resource. The Mann review did not currently appear to be a major resource issue, unless DHSC or regulators expected the PSA to do more than currently anticipated. It was noted that the upcoming year would be busy, but the PSA could control some elements of its workload and may revisit resource questions during business planning.

5.5. There was discussion of the General Osteopathic Council not meeting standard 3. There was some concern that the GOsC might not be clear why it had failed the standard or what it needed to do. It was explained that the PSA had met the GOsC before finalising the report and had amended it to make the reasoning clearer. The issue related partly to gaps in data held by the GOsC, which limited its ability to demonstrate fairness. It was noted that other regulators were watching the decision and were concerned about whether the PSA had effectively "moved the goalposts" through the new stretch indicators. The Board agreed there was a communication point to address with the GOsC and potentially more broadly with regulators.

5.6. The Board **noted** the report.

6. Executive report and project dashboard

6.1. The Chief Executive introduced the item, noting the new standards going live, the Mann review recommendations, the Scottish Government commission and the ongoing issue of Fitness to Practice (FtP) backlogs.

6.2. **Performance Review:** It was highlighted that more detail had been included in the performance review section than in previous reports and hoped this was helpful. Positive outcomes in relation to Social Work England were noted.

6.3. **Section 29:** It was explained that the PSA had sought permission to appeal to the Court of Appeal regarding the Hughes case, with the process expected to take several months. Once permission was determined, there would be a further decision point on whether and how to proceed.

6.4. There had been an increase in GMC appeals of MPTS decisions, and the PSA would discuss this with the GMC to understand its perspective. The PSA's current policy is to undertake a detailed case review when the GMC appeals. Historically, low numbers meant this had not had a major resource impact, but if appeal numbers increased significantly, the PSA may need to consider whether the policy should be reviewed on a risk basis.

6.5. In response to a question about whether the shape of the Section 29 data had changed, it was clarified that initial reviews were actually lower in the period covered by the report. Some of this may be timing-related, and that June data appeared to be moving back towards the usual level of around 70% of initial reviews compared with decisions received. Two-month data periods can be volatile and are better understood over a longer timeframe.

6.6. **Non-surgical cosmetics and under-regulation:** There was an update on the consultation for England on non-surgical cosmetics. The report had noted that the consultation was expected in June, but it had not happened. The Department of Health and Social Care still appeared prepared to launch it imminently, including potentially during the summer recess, and that the delay appeared to be technical rather than a change in policy direction.

6.7. The PSA would review the position again in a couple of months if the consultation still had not appeared, as that would then represent a more significant delay. Scotland's proposals, including preparations for implementation in September 2027, were continuing to move forward. There had been less movement in Northern Ireland and Wales. The PSA had written to the new Cabinet Secretary to highlight the issue and intended to continue pursuing it, involving devolved administration Board members as appropriate.

6.8. The stakeholder survey for the **Healthcare science commission** was due to go out later that week, allowing the PSA to start gathering information and evidence. It was confirmed that the new roles supporting the work would be fixed-term contract roles, including a clinical adviser and data analyst for three months. Arrangements had been finalised, with the aim of having people in post by the end of August. Although the Commission was Scotland-focused, the PSA would consider wider UK developments in parallel.

6.9. There was an update on work with the MHRA, which was leading the **National Commission on regulation of AI in healthcare**. The PSA had been working closely with MHRA to provide a conduit for professional regulation input into recommendations expected in mid-September. Joint workshops had been delivered, and chief executives had agreed to establish a task-and-finish group to develop a joint statement in September supporting the recommendations and setting out what professional regulators and accredited registers would do. The group would also work on principles for AI use, due to be completed by December.

6.10. The **Accredited Registers Quality Mark campaign** was continuing, including the use of influencers. Scripts were being reviewed to ensure they aligned with PSA messaging, with launch planned later in the month.

6.11. The Board asked how the PSA would evaluate the campaign and whether it would help answer broader questions about what the Quality Mark means to users, consumers and patients. It was explained that there was baseline data, including Ipsos polling on general awareness of Accredited Registers, and would compare future data against that. The campaign would measure both reach and what people did after seeing the material, such as click-throughs.
Action: MV to bring the final Quality Mark report to the March 2027 Board meeting.

6.12. **Research conference:** Brunel University, through Professor Anne Gallagher, Head of Health Sciences, was keen and committed to hosting it. Discussions with Brunel and the PSA communications team were ongoing to ensure the facilities would meet requirements. Dates in February and March 2027 were being explored, and it was expected to confirm a date soon.

6.13. **ICT:** The first stage of the business continuity plan testing had been carried out successfully. The team had rebuilt the necessary IT systems on the first day of testing, and JC was awaiting a detailed report.

6.14. There had been significant recruitment activity and since the executive report was drafted, the Head of Policy post was now being advertised.

6.15. The TIDE evaluation had been audited by Onvero, (a sample are audited every year), and the PSA's score had increased to 76%. The PSA remained at stage four of five, but the outcome was very positive. Onvero, had been impressed, particularly with the organisation's detailed record keeping. The PSA had initially undersold itself in the self-assessment but had been able to evidence more during the audit. Follow-up work would be incorporated into the people strategy and equality objectives.

7. Finance report

7.1. The Director of Corporate Services introduced the first full finance forecast for 2026/27.

7.2. The PSA had refunded £168,000 to regulators in the budget, meaning the year began with a forecast deficit of £168,000. That deficit had increased, mainly because of Section 29 costs, but this was largely a timing issue. The previous year had ended with a £151,000 underspend because some appeals were still ongoing, and that expenditure had effectively shifted into the current year.

7.3. The Board was asked to approve use of £35,000 of unrestricted reserves, carried over from the previous year's Accredited Registers surplus, to fund Accredited Registers communications activity. The Board **approved** the use of £35k for this purpose. They also agreed to leave the drawdown at £35,000 rather than approving a larger amount upfront, as there may be other calls on unrestricted reserves later in the year, including business planning and potentially research.

7.4. Questions were raised about the Section 29 legal costs and whether the PSA had sufficient control or assurance over the financial position. It was explained that Section 29 forecasting is done case by case, but number of cases, timings and outcomes are uncertain. It was also noted that the PSA does not have a policy of declining to appeal cases solely because they may be expensive.

8. Committee updates

8.1. **Audit and Risk Committee:** The Chair of the Audit and Risk Committee introduced the item. The Annual Report and accounts had been reviewed by the committee and subsequently approved by AC as Accounting Officer. The audit had been clean and had gone much more smoothly than the previous year. Thanks were recorded to everyone involved in the audit process.

8.2. The Committee had reviewed PSA's first annual report on cyber security, which is one of the key risks. The cyber report assessed the organisation against national benchmarks, including the national cyber security assessment framework. The conclusion was that current arrangements looked robust, although the Board was cautioned that cyber security is an area where the organisation cannot be complacent.

8.3. The Committee's overall conclusion, set out in its annual report, was that the PSA had appropriate frameworks, governance, risk management and controls in place as a whole.

8.4. **Scrutiny Committee:** The Committee had had a lengthy and useful discussion about Section 29 work, particularly legal costs. The discussion recognised that the legal costs being charged were reasonable for the work being done. The main issue was not necessarily the level of cost but the certainty and predictability of costs, especially for forecasting.

8.5. The team was asked to consider whether more could be done through greater standardisation of costs across counsel and solicitors, possible fixed-fee arrangements, better cost recovery, maximising recovery of costs through the process. The team would look at these issues and report back to the Committee.

8.6. The Committee had received an interesting presentation on sexual misconduct in Section 29 cases. There had been an increased profile of sexual misconduct cases within Section 29 work. This was also reflected in statistics discussed at a recent stakeholder meeting. The Committee heard about the broader impact of Section 29 work in this area, including the ability to identify themes and trends and share them with regulators.

8.7. The recent Section 29 conference had been well received and had generated positive feedback. There was a view that the PSA should take more opportunities to showcase the value and impact of its work in this area. This will be covered in the associated publication in September 2026.

8.8. The Committee also discussed implementation of the new standards, reviewing readiness for implementation, communications going out to different audiences and how the message about the standards' substantive impact would be conveyed.

9. Governance and Assurance Frameworks

9.1. The Director of Corporate Services introduced the item, noting that the Audit and Risk Committee had reviewed the frameworks in detail and made helpful changes, which were summarised in the paper. The Committee was recommending both frameworks to the Board for approval.

9.2. It was noted that the Scrutiny Committee terms of reference had been updated significantly and were particularly different and had needed to be built into the Governance framework. Because there were so many changes, they had been listed in detail so Board members could see exactly what had been amended.

9.3. The Chair thanked the governance team for keeping the frameworks up to date and "watertight" so that Audit and Risk could review it properly.

9.4. The Board was being asked to review and approve the frameworks.

9.5. The Board asked in what circumstances additional subcommittees might be created. It was explained that the only current subcommittee was the Business Plan Review Committee. It was due to meet the following week and again at the end of August to help pull together the business plan and budget for the next year, ahead of the September fee consultation.

9.6. There had previously been a Finance Committee, which had been wound up because the Board felt finance matters could be handled at Board level. The wording was intended to give flexibility to determine whether another committee might be needed in future. Setting up any new committee would be a Board decision.
Action: JC to update the wording of the governance framework so that it was clear any new committee would be established by the Board.

9.7. Subject to that clarification, the Board **agreed** the frameworks.

10. Risk discussion

10.1. The Chief Executive introduced the item, explaining that it followed recommendations from the external Board evaluation. Those recommendations were to introduce a revised risk register and to hold a Board discussion on risk tolerance. The new risk register had already been considered by the Audit and Risk Committee, which was generally pleased with it but had suggested some improvements.

10.2. Key changes included a new heat map, recommended through the external review; a revised scoring system, based on internal audit advice; a clearer commentary column to make the register more live and current; a new indication of the degree of PSA control over each risk; and an explicit view on whether each risk was within or outside current risk tolerance.

10.3. The Board agreed the dashboard/heat map was useful and easy to read. It was noted that the risk register would come to every Board meeting as an annex to the executive report, so members could track movement over time.

10.4. **Risk 1: Fitness to practise backlogs.** The first and most detailed discussion was on fitness to practise backlogs. The overall position was not improving, and regulators were generally "running to stand still". More was needed, whether through greater investment by regulators, improved processes, more innovative or different approaches.

10.5. The PSA could shine a light on the issue, provide data and analysis, and convene discussion, but it did not directly run regulators' processes. PSA's control was assessed as medium, and the risk was not within tolerance.

10.6. Board members supported the PSA's focus on thinking differently with regulators rather than simply accepting the position as normal.

10.7. The Board agreed that the word "unacceptable" was important. There was a danger that persistent backlog problems could become normalised simply because they were difficult to fix.

10.8. The Board queried whether some of the planned actions, such as analysis of sexual misconduct cases and Section 29 concerns, were directly linked to reducing backlog risk. It was explained that these were linked more to the impact of backlogs than the backlog itself — for example, whether delay could compromise regulatory effectiveness, cause cases to fall away, or lead regulators to cut corners to speed things up.

10.9. There was agreement that the register needed to distinguish between different types of backlog. Some delays may be unavoidable or justifiable, such as cases affected by registrant health issues or criminal justice processes, while others may be unacceptable, such as delays caused by expert witness availability or avoidable process problems. The Board felt both the PSA and regulators needed better analysis of the reasons behind backlogs, not just headline numbers.

10.10. **Risk 2: Performance review and regulatory underperformance.** The second risk concerned the PSA failing to identify risks in regulators' performance, or regulators underperforming against standards. The overall risk was increasing because two regulators were significantly underperforming in terms of standards met.

10.11. The Board noted that the wording should be amended because the paper appeared to say that poor fitness to practise by regulators was "not identified by the PSA", whereas in fact the PSA had identified it.

10.12. The Board raised the question of issues not spotted by the PSA, referring in particular to maternity-related findings and concerns about how regulators communicated with families and responded to harm. The Board asked whether the PSA processes were picking up these kinds of significant policy and public protection issues. In relation to Nottingham, the PSA was aware of earlier poor engagement by the regulator, although later feedback suggested improvements had been made. There could be timing issues, and the policy team was looking across maternity reviews to identify what they mean for professional regulation. While professional regulation may only be a small part of many inquiry recommendations, it may still be part of the solution.

10.13. Some ongoing work to improve the PSA's ability to identify issues was not fully reflected in the risk actions. This included performance review becoming more risk-based and forward-looking; work to make the process more agile; November Scrutiny Committee consideration of the action plan following the lessons learned review on the NMC.

10.14. **Risk 3: Accredited Registers.** The Accredited Registers area was generally working well, with a number of new registers in the pipeline. However, the scheme was now testing areas outside the "natural market" captured in its early days, including whether some applicants were genuinely in health and care, and the possibility of larger social care-related developments in future.

10.15. The Board raised the issue of applicants where no register was actually in place. This could expose the PSA to considerable risk if it appeared to be evaluating public safety in relation to something that did not yet exist. Updated processes under the new standards now make the public interest test clearer at the outset, including that there must be an actual register for the PSA to review. It was agreed that this improvement should be reflected in the register.

10.16. **Risk 4: Regulatory reform.** The PSA was more comfortable than previously with the legislation on regulatory reform, particularly the latest order, though it still believed improvements could be made and was feeding that back.

10.17. The main risks now related to delays, slow progress, whether regulators have sufficient resources to deliver reform well. The PSA was increasingly concerned about the resources regulators would need. The GMC was committing significant resource, but other regulators might struggle, especially if they were already dealing with performance issues. The NMC and HCPC were identified as particularly relevant forthcoming examples, because they would need both to improve current performance and deliver major change programmes over several years.

10.18. **Risk 5: PSA relevance, impact and doing things differently.** This risk was linked to several others, especially FtP backlogs. There were positive indicators in terms of commissions, engagement, reviews, and being asked to lead work related to the Mann review. However, the current wording described activity more than impact. The Board's concern was not simply whether the PSA was busy or useful, but whether its work was adding value and helping create a more cohesive, coherent and preventative system.

10.19. **Risk 6: Cyber security.** This was described as a continuing area of focus for the Audit and Risk Committee. The PSA had had a detailed internal audit, had implemented actions, and would continue testing. Business continuity testing had also been completed successfully. Cyber risk would probably never be a decreasing risk because it is an "arms race" and the PSA has to keep on top of it. There was nothing obvious more to do beyond maintaining vigilance and avoiding complacency. Cyber risk is not just an IT team issue. Risks can arise from staff and Board members leaving documents on trains, mishandling access to documents, or clicking phishing links. Annual training and phishing tests were in place; a small number of people had clicked on test links and had been required to undertake further training.

10.20. The Board felt that a low residual score did not instinctively feel right for cyber, given the ongoing threat. This would be reviewed.

10.21. **Risk 7: Safeguarding and criminal records checks.** This risk had been around for a long time. It initially focused on Accredited Registers but had now widened to include regulators. The new standards ask more questions about how risks are managed in this area, which gave the PSA more assurance. However, the PSA still had limited direct control. Once assessments under the new standards had taken place, the organisation would have a better understanding and might identify additional risks or areas of concern.

10.22. **Risk 8: Public confidence, underperformance and under-regulation.** This risk covered two related issues: public confidence being affected because regulation is not working well and public confidence being affected where there is no regulation in areas that may pose risks.

10.23. Cosmetics was highlighted again as a concern, especially given delay to the England consultation. The Scottish Commission was also seen as useful because it may identify issues in Scotland that are likely to apply elsewhere in the UK.

10.24. The Board asked whether the register should reflect fallout and follow-up from major inquiries, including maternity-related inquiries. The concern was that even where areas are ostensibly regulated, members of the public may ask why harm keeps happening and what the regulatory system is learning from it.

10.25. There is a gap between what the public may expect regulation to do to prevent harm, what regulation is actually designed to do, and what it actually delivers in practice. The PSA has a clear role in trying to close the gap between regulatory design and delivery, but there is also a wider question about whether the regulatory model itself should be expected to do more.

10.26. The PSA needed to engage with patients and the public about this without sounding defensive. Regulation cannot eliminate all risk, and adverse outcomes do not always mean that an individual professional should be blamed or that a referral will result in action. However, the public is entitled to say that the system needs to work better.

10.27. Regulatory effectiveness depends heavily on collaboration across the system. A regulator acting alone is unlikely to succeed; effectiveness depends on working with professionals, providers and the public.

10.28. A general point was raised that, given the changes to the risk register format and approach, the risk management policy would need updating. It was confirmed that this would be done.

11. Website project benefits realisation report

11.1. The Director of Policy and Communications introduced the item, explaining that the new website had been introduced at the beginning of 2025 and had been a significant project for the PSA, involving support across the organisation, including IT services. The project board had recently reviewed implementation, and the paper drew on that review to assess the project against the three main benefits originally identified.

11.2. The paper also set out further actions and next steps. It was presented to the Board for information, but the team wanted the Board to be assured and to capture any further actions members wanted taken forward.

11.3. In preparing the review, the team had learned lessons, particularly around accessibility, changes in how people use websites, changes in search behaviour and the impact of AI on how online information is found and used.

11.4. The Board had tested the website search function and found it not very easy to use or bringing up the most relevant content. Overall the Board was disappointed with the practical user experience and felt some usability and optimisation work was needed.

11.5. There was agreement that future work needed to consider how users now search for information; whether the website's internal search algorithm can be improved; how the website content is scraped or interpreted by AI tools; whether information is structured so that both users and AI-generated summaries find the right, most current material.

11.6. The Board felt that the PSA needed to think more broadly about how it engages users, rather than assuming the website would remain the main route.

11.7. The Board welcomed the work done to make the website accessible. Accessibility is a significant challenge for all websites and can be complex because what improves accessibility for one user may make things harder for another.

11.8. It was also highlighted that referrals from other relevant websites appeared to be an area of growth. The PSA should ensure it is visible and properly linked from regulators' websites, Accredited Registers websites and other relevant related websites.

11.9. It was confirmed that despite stepping back from Twitter/X, other social media channels, especially LinkedIn remained an important channel because it fits the PSA's corporate and professional audience. BlueSky and Facebook are also being used. The influencer campaign will use channels where the PSA does not necessarily maintain its own corporate presence, including Instagram and TikTok. The approach would allow the PSA to reach consumer-facing audiences on those platforms through influencers, with links directing people back to the PSA website, without requiring the PSA to maintain a permanent corporate account on every channel.

11.10. It was confirmed that AI optimisation work was already one of the planned actions. The team was scoping potential partners to support that work, which would lead to a programme of activity.

11.11. The internal search function was already part of the ongoing development programme with the website developer. The team could adjust search algorithms based on what people are looking for and how the search function performs. Staff feedback will be sought on what people search for and whether they can find it easily.
Action: MV to bring an update on next steps for website optimisation to the September Board meeting.

12. Board annual workplan

12.1. The Director of Corporate Services introduced the item, and the Board **noted** the workplan.

13. Any other business

13.1. There was no other business discussed.

14. Questions from Members of the Public

14.1. There were no questions.
14.2. The Chair thanked the observers for their interest in the PSA.

Signed by Chair..... Date.....

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Action Log

On track (including not started) Delayed (or medium risk of delay for projects) Overdue (or high risk of delay for projects) Complete

Mtg. Date	Item No.	Action point	Owner	Date required	Action progress	Status
14 January 2026	6.17	Schedule deeper review of the Fitness to Practise system for the Scrutiny Committee and report back to the Board.	JO/GM	November 2026	Previously identified for June, however moved to the Scrutiny Committee meeting in November 2026 to allow full exploration of the issue	
20 May 2026	5.4	Organise Board workshop on AI.	MV	October 2026	In progress.	
20 May 2026	6.12	Review and refine the Wales engagement model, including options beyond a single annual seminar, and report back to the Board.	MV	September 2026	In progress. Survey to stakeholders in Wales has been issued. Proposals will be taken to November Board meeting (Cardiff).	
20 May 2026	6.18	Review and propose revisions to communications KPIs and reporting approach, including AI-related impacts.	MV	September 2026	Completed. Revised KPIs	

					proposed as part of the draft 27/28 business plan. Executive Report provides further context.	
15 July 2026	6.11	Bring the final Quality Mark report to the March 2027 Board meeting.	MV	March 2027		
15 July 2026	11.12	Bring an update on next steps for website optimisation to the September Board meeting.	MV	September 2026	Completed – please see Executive Report.	

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Chair's report

1.1 Our Board last met on 15 July 2026 in London. As it has been the summer period, this report will be shorter than usual.

1.2 Since we last met, our policy and comms teams have had a real push on a campaign called Look Before You Book which highlights the lack of regulation of non-surgical cosmetic interventions and the benefits of using an Accredited Register.

1.3 A poll undertaken by the PSA of 1,000 UK adults found that 46% believed that all aesthetic practitioners were regulated by law. The survey also revealed that 29% of those seeking non-surgical cosmetic treatments relied on before-and-after photographs or testimonials on social media when choosing a practitioner.

1.4 As you will be aware, last year the government promised to develop a licensing system for England, but it is yet to be introduced. Scotland does have a licensing regime. The Northern Ireland and Wales regimes are even more lax than England.

1.5 The PSA Look Before You Book campaign has been picked up by several media outlets including Marie Claire, BBC Radio London, BBC News Manchester, HELLO! And ITV Anglia.

1.6 Well done to everyone involved. This sort of campaign fits squarely with one of the key aims of our new strategic plan which is to move upstream and reduce harm before it happens.

1.7 We held our first Business Plan Review Committee meeting in July. A second will be held on 3 September. Following this, we should be in a position as a Board to approve a business plan and budget for 2027/28 which allows us to fulfil our remit at a reasonable cost.

1.8 Alan and I have had our usual catch ups with the chairs and CEOs of the PSNI and the HCPC. Further details will be shared in the private session.

1.9 I look forward to seeing you all in London on 16 September 2026.

Caroline Corby
2 September 2026

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Executive report

1. Summary

1.1. In addition to our statutory duties, the key priorities for the organisation at this point in time are: (1) the Business Plan 2027/28 and Fees Consultation; (2) addressing the recommendations from the Mann Review; (3) delivering the commissioned work for the Scottish Government; and (4) working with regulators to address fitness to practise volumes and backlogs.

2. Recommendations

2.1. The Board is asked to note the Executive report and to ask any questions of the Chief Executive and Directors.

3. CEO stakeholder engagement

3.1. Between the July 2026 and September 2026 Board meetings, the Chief Executive attended a number of stakeholder engagement events, including the following.

- Attending the Health and Social Care Regulators Forum.
- Together with the PSA Chair, meeting the Chair and CEO of the HCPC.
- A meeting with the CEO of the GMC.
- Attending a quarterly information-sharing meeting of the PSA, DHSC and officials from the Devolved Administrations.
- A meeting with the CEO of the NMC.
- Attending the first meeting of the Institute of Regulation Regulators of Professions Group.
- Meeting the Department of Health in Northern Ireland (with the Board member for Northern Ireland) to discuss the performance of the PSNI.
- Chairing a meeting of the NMC Independent Oversight Group.

3.2. Looking forward, the Chief Executive will attend further stakeholder engagement events before the next Board meeting, including the following.

- A meeting of the regulator Chief Executives Steering Group.
- Attending a meeting of the Advisory Group to the Patient Safety Commissioner for England.
- Making a keynote presentation at the Canadian Network of Agencies for Regulation (CNAR) International Symposium in Montreal (‘Successful regulation in a dynamic world’); plus being a panel member discussing the theme ‘Leading through change: Regulatory leadership in a dynamic world’.

- Recording two podcasts: on right-touch regulation; and, together with the Chair of the Legal Services Board, on oversight regulation.
- Attending the Health and Social Care Regulators Forum.
- Chairing a quarterly information-sharing meeting of the PSA, DHSC and officials from the Devolved Administrations.
- Together with the PSA Chair, meeting the Chair and CEO of the HCPC.
- Chairing a meeting of the NMC Independent Oversight Group.

Summary of risks

3.3. We have assessed the top three known risks facing the PSA as: (1) the backlogs of fitness to practise cases in some regulators – this situation is not improving and we are convening a cross-regulator group in the autumn to discuss opportunities for improvement; (2) underperformance of the NMC and PSNI – we are reviewing options for interventions in line with our new Strategic Aim 2; and (3) the perception of under-regulation in some sectors, which may undermine public confidence – being taken forward by commissioned work under Strategic Aim 3.

Regulation and Accreditation

4. Performance Review

Reporting

4.1. We have not published any Performance Review reports in this reporting period.

Pharmaceutical Society of Northern Ireland

4.2. We have moved the PSNI's annual reporting cycle from January–December to April–March by extending the 2027 review period to cover January 2027 to March 2028. The key benefits are:

- Aligning the PSNI's review period with the financial year will enable us to assess a full year of data. As the PSNI has a small register, its quarterly data is particularly prone to fluctuation, so a larger dataset should support more detailed analysis.
- The extended period, from January 2027 to March 2028, will be covered by a periodic review. This may enable us to examine more areas in detail than would normally be possible and, through increased engagement with the PSNI during the year, provide enhanced oversight.
- The PSNI is due to appoint a new Chief Executive in March 2027. The revised cycle will allow the review to consider their first full year in post and any resulting changes, which we will also monitor throughout the periodic review.

Nursing and Midwifery Council – Independent Oversight Group

4.3. At the last meeting on 6 July 2026, the Independent Oversight Group (IOG) considered the NMC's response to two independent reports that were published in September 2025. These reports were commissioned by the NMC. One is focused on the NMC's handling of a number of fitness to practise cases, the other reviewed how the NMC managed a whistleblower's disclosures. The IOG also received an update from the NMC on its fitness to practise data.

4.4. The next meeting of the IOG will take place on 9 September 2026. At that meeting, the IOG will receive a comprehensive update from the NMC in relation to its progress completing recommendations arising from all the three independent reports.

Fitness to practise – regulator workshop

4.5. As we recognise that fitness to practise timeliness and backlogs are among the most significant challenges facing many regulators, the PSA is convening a workshop for regulators on 5 October. The session will enable regulators to discuss current challenges, barriers to resolving those challenges and explore innovative solutions.

Standards for Regulators – Council session

4.6. On 16 October, we will hold a session to introduce regulator Council members to the new Standards, explain the PSA's role and responsibilities, and provide an opportunity for discussion and questions.

5. Section 29

5.1. The table below sets out the key statistics for this financial year, compared to the previous financial year.

	1 April 2026 – 31 July 2026	1 April 2025– 31 July 2025
Decisions received by the PSA	768	747
Initial reviews completed	438	491
Detailed Case Reviews (DCRs) completed	17	30
Statutory deadline decisions	0	4
Case meetings held (including S40B case meetings)	9	12

Appeals lodged	6[1]	10
Learning Points	95 on 69 cases	84 on 56 cases

5.2. Between 1 April and 31 July 2026, we received 2.8% more final fitness to practise panel decisions than the same period last year.

5.3. We completed fewer initial reviews than in the same period last year overall, with a decrease of 53 reviews. However, this decrease only occurred in the first two months of the reporting period (as identified in the July Executive Report). In the second two months (June / July 2026), the number of initial reviews completed was higher than in the equivalent period last year (254 in June / July compared with 225 in the same period last year).

5.4. In the July Executive Report, we advised that we would interrogate our data to try to identify the reasons for fewer initial reviews being carried out over April / May 2026 compared to the same period last year, despite the increased number of decisions received. However, analysis of the data did not bring back any significant reasons for this discrepancy. We can see that there was an increase in administrative case closures before an initial review for April / May 2026 (43% / 44% compared to 36% / 35% for 2025). This is due to an increase in these months of the types of cases we close without review (strike off cases etc).

5.5. In May and June, Lawyers in the S29 team completed between 14% and 38% of initial reviews due to capacity restraints in the initial review team. We anticipate the recruitment of an additional Legal Review and Operations Officer (see below) will address capacity gaps over the next twelve months without having to seek lawyer support.

5.6. We have seen a significant decrease in the number of DCRs carried out compared to the same period last year (17 compared to 30). We have completed DCRs on 3.9% of initial reviews completed this year, compared to 6.1% last year.

5.7. We also reduced the number of outsourced DCRs in comparison to the same period last year (18% compared to 60% last year). However, with the departure of one of our two lawyers in July, this figure may increase until such time as our new lawyer begins (see 5.16).

5.8. We have held seven fewer case meetings so far this year, with no statutory deadline meetings yet being held (compared to four in the same period last year). We held case meetings in 53% of cases on which we undertook a DCR this year (compared to 40% for the same period in 2025). This, aligned with the decrease in DCR numbers, suggests continued improvement in our scrutiny processes to ensure that only those cases where there are clear concerns are progressed to the latter stages of our processes.

5.9. We have appealed four fewer cases compared to this period last year. As a proportion of cases on which we undertook an initial review, this was slightly less in comparison to the same period last year: we appealed 1.4% of cases on which we undertook an initial review compared to 2% in the same period last year.

[1] Including joining as a party to one GMC appeal under S40B of the Medical Act 1983.

5.10. Six appeals were lodged between 1 April and 31 July (NMC/Haugh, NMC/Lole, GDC/Rahman (review hearing), GPhC/Jones, NMC/Campbell, and we joined as a party to the GMC appeal of Elwan). One appeal lodged since 1 April has since been withdrawn owing to our success in the substantive appeal (Rahman review).

5.11. We received judgments in three appeals during this period. We were successful in two of these appeals (GMC/Grajn and GDC/Rahman) and unsuccessful in another (GMC/Hughes). Due to our concerns with the Court's decision in GMC/Hughes, we sought permission to appeal to the Court of Appeal. However, our application was unsuccessful. A review of recent dismissed appeals (including GMC/Hughes) has been provided separately to the Board.

5.12. Settlements are being explored in several other appeal cases, and all other Section 29 litigation is progressing.

5.13. We have asked all our panel solicitor firms to provide us with Counsel fee estimates on all appeal cases at the outset of proceedings going forward, to enable us to better predict total costs in appeal cases and retain more control over those costs.

5.14. We have sent 53 learning points on 39 cases to the NMC so far between 1 April and 31 July in comparison to 47 on 27 cases in the same period last year. 11 of these learning points relate to poor investigation, in comparison to four in the same period last year. In July we reported to the board that we had engaged in correspondence with the NMC regarding our concerns in relation to the increase in evidence of poor investigations. The NMC have responded but we have requested further information, as we continue to see a significant number of these concerns.

5.15. GMC cases: We carried out seven DCRs (41% of all DCRs) in relation to GMC cases between 1 April and 31 July (last year this was 8 DCRs, 27% of total). All seven of these cases were considered at GMC executive panel meetings, and six resulted in the GMC bringing an appeal. Between 1 April and 31 July, we joined one GMC appeal under Section 40B. As a comparison to previous financial years, the GMC lodged one appeal in the same period in 2025/26, and none in 2024/25, or in 2022/23. The GMC lodged only one appeal in the same period in 2023/24. This continues to have an impact on the section 29 team's capacity as, in accordance with our policy, we carry out a DCR of every case which the GMC appeal. Enquiries have been made with the GMC, and they have not identified a single cause for this increase, noting many of these appeals remain ongoing.

5.16. We have successfully recruited for the vacant Legal Review and Operations Officer 12-month fixed term role, and they are due to start on 2 September. Following the departure of one of our two lawyers, we have since completed a recruitment round, with an offer made to the successful candidate. Their start date is yet to be confirmed.

Review of dismissed appeals

5.17. At Annexe B of the Executive Report, we have provided a paper outlining our review of recently dismissed Section 29 appeals. While we have not identified any issues or errors that would mean that we should have made different decisions, we have recommended some improvements to processes identified through the review.

6. Appointments

6.1 Since the last update to the Board, we have provided the Privy Council with

advice about two completed appointments processes. These were the GDC's process to find a registrant candidate to recommend to the Privy Council for appointment and the GOsC's process to select a lay candidate to recommend. We were able to advise the Privy Council it could have confidence in both processes.

6.2 During this period, we scrutinised an advance notice from the NMC. We were satisfied with its plans to run a process to select four candidates (two lay and two registrant) to recommend for appointment to its Council. We also imminently expect an advance notice from the GPhC.

7. Accredited Registers

7.1. At the end of July 2026, all six KPIs were achieved.

KPI	Met / Not Met	Performance	Direction of Change since March Board meeting
90% of full reassessments within three years	**Met**	**93% (26/28)**	
90% of annual checks within one year	**Met**	**100% (28/28)**	
95% of conditions are reviewed within two months of due date	**Met**	**100% (67/67)**	
100% of targeted reviews completed within four months:	**Met**	**100% (2/2)**	
90% of decisions on new Standard One applications made within four months	**Met**	**100% (3/3)**	
90% of decisions on full accreditation made in eight months of receipt	**Met**	**100% (2/2)**	

7.2. Performance across almost all KPIs has been maintained or improved since the Board's last report. We remain within KPI on completion of full renewal assessments within three years, but owing to an agreed late submitted renewal and one complex reassessment of the public interest test for nine roles, we have seen a slight dip in performance against this KPI. We do not anticipate any further challenges to meeting this KPI over this assessment year and therefore expect we will see no further degradation in performance.

Accreditation Decisions

7.3. The application for the International Foundation for Therapeutic and Counselling Choice (IFTCC) has received an outcome that Standard One is provisionally not met. The decision was published in July 2026.

7.4. The Association of Traditional Chinese Medicine (ATCM) full application was considered by an Accreditation Panel in March 2026. The Panel adjourned to allow the applicant to provide further evidence against some Standards. We are awaiting a response from the applicant before reconvening an Accreditation Panel.

7.5. We have completed the first stage of review of submitted documents for the full application for the Care Professions Organisation's (CPO) register of social care workers in England. We anticipate a decision on this application to be made in February 2026.

7.6. We have reached a decision in respect of the application from the Society of Health Play Specialists (SOHPS) that the Eligibility and Public Interest Standard is met. We originally planned publication in November 2026 but are likely to bring this forward given how quickly a decision was reached.

7.7. The application for Eye Movement Desensitisation and Reprocessing UK (EMDRUK) is progressing after a short delay while we awaited payment. We anticipate a decision in December 2026.

8. Standards Review Project – progress update

8.1. The Standards Review Project has been formally closed and all activities transferred to business-as-usual activity.

Policy, Communications and Engagement

9. Policy

Regulatory reform

9.1. The Legislative Reform Programme Board met on the 28 August. The programme remains on track. All workstreams are progressing to schedule in terms of PSA activities, though there are delays against the Government's timelines for the GMC Order and for non-surgical cosmetics in England.

9.2. The programme continues to operate in a context of external dependency, and the position will need to be kept under review as government timetables, consultation activity and legal proceedings develop. Key areas being monitored include the potential impact of the BMA legal action on GMC reform, further consultation on Mann related reforms, including proposals for the PSA, and the pending DHSC consultation on the highest-risk non-surgical cosmetic procedures.

9.3. Programme level risks and dependencies are being actively managed, monitored and recorded, with mitigations in place where required where these are within the PSA's control.

Regulating for AI use by health and care professionals

9.4. Following agreement at the Chief Executives Steering Group, the AI Regulatory Principles Task and Finish Group has been established. The group met for the first time on 21 July and then again on 18 August. It has agreed its Terms of Reference and a plan for collaborative work, with the PSA providing secretariat and co-chairing alongside the MHRA. The group is working to develop a shared statement of intent and a set of high-level principles for regulating AI use by health and care professionals. The current focus is on finalising the joint statement of intent for organisational approval, with publication planned to align with the Commission's recommendations and the wider government response. The Group is also beginning work on the high-level principles, which are intended to support greater consistency across regulators while recognising their different statutory remits.

Healthcare Science commission for Scottish Government

9.5. Project documentation, including the Equality Impact Assessment, has been approved. Additional resources (Data Analyst and Policy Advisor) joined the PSA on fixed term contracts in August 2026. Initial stakeholder surveys to establish interest and data availability have been completed and analysed, and stakeholders now being approached for primary data requests.

PSA prevention research commission

9.6. At the time of writing, we are in the process of finalising an invitation to tender for a piece of research on how pre-qualifying education curricula, teaching methods and learning environments could more effectively uphold professionalism, encourage positive working cultures and prevent future misconduct across regulated and registered health and care professions.

9.7. This research would support delivery of Strategic Aim 3, in trying to find ways in which professional regulators and registers can further support positive working cultures, and prevention of harm.

9.8. We aim to go out to tender by the end of September 2026.

PSA Mann review action plan

9.9. The PSA has continued to develop its response to the Lord Mann Review recommendations. A high-level action plan has been established, setting out the PSA's role, proposed actions and reporting milestones across the recommendations where the PSA has a lead, coordinating or contributory role. The action plan provides the framework for monitoring progress, coordinating activity with partners and supporting reporting internally and to DHSC and the Health and Social Care Committee against the Review's six-month and one-year milestones.

9.10. Following discussions with DHSC on implementation expectations and respective roles, the PSA shared its proposed approach and action plan with the professional regulators and invited feedback on priorities, coordination arrangements and individual recommendations. A cross-regulator meeting was held in August to discuss regulators' emerging plans, identify shared risks and dependencies, and consider how work can be coordinated proportionately across the sector. Discussions highlighted strong support for collaborative working, while also underlining the importance of aligning activity with existing programmes of work and avoiding duplication of reporting requirements. The PSA

will continue to work closely with DHSC, regulators and other partners as implementation activity develops, including ahead of the planned Secretary of State roundtable and forthcoming reporting milestones.

Parliamentary events in Westminster and Stormont

9.11. Work continues on the PSA's programme of parliamentary engagement events across the four UK nations, which is intended to strengthen relationships with parliamentarians and stakeholders and raise awareness of the contribution that effective professional regulation can make to improving patient safety and supporting wider health and care priorities. The programme remains structured around events in Westminster, Stormont, the Senedd and Holyrood over 2026-27.

9.12. The Northern Ireland event, originally planned for October 2026 at Stormont, has been developed substantially, with a draft agenda, parliamentary venue arrangements and prospective speakers identified. The event is intended to explore the role of good regulation in supporting safer care in Northern Ireland and to bring together parliamentarians, regulators, patient representatives and system leaders. Due to a range of factors beyond our control, the decision has been taken to reschedule the event, and work is now focused on identifying a revised date and maintaining engagement with key stakeholders and parliamentary sponsors.

9.13. Planning for the PSA's joint Westminster parliamentary reception with the All-Party Health Group (APHG) on 11 November 2026 is progressing well. The event will focus on how professional regulation can support delivery of the Government's priorities for health and care in England, with particular emphasis on patient safety, workforce transformation and learning from failures in care. A draft programme has been developed, speaker invitations have been issued, and engagement is underway with parliamentarians and key stakeholders to support attendance. The event will be held in the House of Commons and is expected to provide a significant opportunity to raise the PSA's profile and strengthen relationships with policymakers, regulators and patient groups.

PSA November Board meeting in Wales

9.14. The November Board meeting will take place in Cardiff on 17 and 18 November. Practical arrangements for the meeting and wider stakeholder programme are being finalised. The visit forms part of the PSA's wider engagement activity in Wales and will provide an opportunity for the Board to engage directly with Welsh stakeholders on areas of shared interest under the PSA's Strategic Plan 2026–2029.

9.15. A meeting involving the PSA Chair, CEO and Board member for Wales will be held with the Cabinet Minister for Health and Care. This will focus on the PSA's role and how we can support the Welsh Government's work on professional regulation and public protection, as well as the Minister's priorities for health and care in Wales and any areas where the PSA's expertise may be of assistance.

9.16. Stakeholder roundtables will be held on how professional regulation can support more proportionate, preventative and equitable approaches to handling concerns in Wales, with a particular focus on complaints processes and fitness to practise pressures. This will create opportunities to consider how regulation can better support change, strengthen learning and prevention, and reduce harm within the wider health and care system.

10. Communications and engagement

PSA website

10.1. Following the website benefits realisation discussion at the July Board meeting, the actions were to improve the search functionality on the website and undertake AI optimisation.

10.2. Discussions are underway with our web developers to explore the changes needed to the algorithm of the website search function. This work is not straightforward and requires significant scoping and development time. The timescale for the work is still being worked out but will take several months at minimum.

10.3. Discussions with external agencies on how they can support us with AI optimisation will begin in September with the aim of identifying the most suitable agency and agreeing on an appropriate scope of work. We will need to work within budget constraints in planning the AI optimisation work which may mean we only undertake an aspect of it in this financial year. Budget for this work has been included as part of business planning for 2027/28. Updates on timing for both the search function improvements and AI optimisation will be provided when available.

10.4. In reviewing the website and taking account of the impact of AI on website traffic, we agreed to review the communications KPIs which are presented to the Board at each meeting. Given the global trend we are seeing, we believe it would be most useful to set our KPIs against benchmarks rather than against the previous year's metrics, as is currently the case. Given our specific remit, our goal is not to reach large numbers of stakeholders but to engage well with our strategically important stakeholders. Therefore, the new KPIs being proposed for 2027/28 (to be considered by the Board as part of business planning) focus on engagement rates which will tell a clearer story about how well we are delivering quality content to our key audiences. As well as reviewing the KPIs presented to the Board, the Communications team also hold regular evaluation meetings internally where we look at a range of additional metrics across our social media, media, events, newsletter and website activities. These include, among other things, likes, shares, coverage, sentiment, satisfaction, open rates, click-throughs and downloads.

Making our Standards accessible for all

10.5. We have published Easy Read versions (English and Welsh) of the new PSA's Standards for regulators and Accredited Registers. These have been developed to make the Standards more accessible to a wider audience by presenting complex information in a clearer, more straightforward format. The new versions support our wider commitment to accessible communications and help more people understand how we assess regulators and Accredited Registers, and what they should be able to expect from them. The Easy Read Standards have been promoted through our website and social media channels.

Accredited Registers *Look Before Your Book* campaign

10.6. The *Look Before You Book* campaign has now launched, promoting the Accredited Registers Quality Mark to the public and encouraging people to look for it when choosing health and care practitioners. The campaign focuses initially on counselling and psychotherapy, private baby scans (sonography) and non-surgical cosmetic procedures, using content created with a range of influencers alongside digital advertising, public relations/media activity and supporting communications. Campaign content and dedicated landing pages are now live, with further activity being released in phases over

the coming weeks. We will monitor reach, engagement, website traffic and media coverage to assess performance and inform future activity.

10.7. Early indications are positive. Influencer content is gaining good traction and engagement, helping the campaign reach audiences through trusted and relevant voices. The media campaign is also performing well, with coverage already secured by BBC Online and a number of regional titles. Further media opportunities are being pursued, including potential coverage in a national women's lifestyle publication, which would provide valuable additional reach among a relevant consumer audience. We are also seeing support from Accredited Registers and other stakeholders in sharing social media content to their audiences. We will continue to monitor the campaign as it progresses, using the results to assess performance and inform future activity.

11. Intelligence and Insight

11.1. In collaboration with the Section 29 team and the Director of Regulation and Accreditation, and supported by the Communications Team, a report has been developed for publication in the week commencing 7 September on *Improving the handling of sexual misconduct cases in fitness to practise*. The report draws on S29 reviews, the webinar series on tackling and preventing sexual misconduct, research, and expert contributions on the impacts of sexual misconduct on victim-survivors including those featured at our S29 conference in May. The document highlights key challenges in the handling of fitness to practise cases involving sexual misconduct and sets out practical measures that regulators and Accredited Registers can consider when reviewing their own approaches.

11.2. The research conference is scheduled for 24 February 2027 at Brunel University. Professor Ann Gallagher, Head of Department of Health Sciences at Brunel, and Professor Robert Jago, Associate Dean (Research and Knowledge Exchange), Faculty of Business and Law at RHUL will be our research partners for the event. At the time of writing, we are working with the partners to develop the scope and themes, with a view to issuing a call for content proposals in early October.

11.3. The process for internal reporting on horizon scanning has been further developed during August and a proposed format was discussed at a meeting of Executive and Board members on 4 September. In future this will become a part of routine reporting to the Audit and Risk Committee.

11.4. The prevention project has begun. The first phase is a review of previous work on the issue. This project will run until the end of the financial year and aims to identify principles for good preventative regulation, identify good practice examples, and identify commonly encountered challenges to successful preventative initiatives and how they have been overcome.

Corporate Services

12. IT

New Teams meetings kit has been installed in the Small Meeting Room so all meeting rooms now have Microsoft Teams Rooms systems, enabling hybrid meetings and making it easier for staff to join meetings without needing their own device.

13. Finance

13.1. The latest Finance Report is on the agenda.

14. People

14.1. Rebecca Senior-Carroll returned from Maternity Leave on 3 August 2026 to take up the role of Head of Legal (maternity cover).

14.2. Recruitment for two Scrutiny Officers has now concluded. Catherine Manning joined us on 29 July 2026 (maternity cover) and Anna Lyne will be starting on 23 September (permanent).

14.3. Folusho Akinkunmi joined us on 2 September 2026 as a Legal Review and Operations Officer. Rachael Martin began a 12-month fixed term contract as Legal Reviewer on 16 September 2026.

14.4. Eloise Le Santo (Lawyer) left on 10 August 2026. A successful candidate has been appointed to the position, subject to pre-employment checks and paperwork.

14.5. Dinah Godfree (Head of Policy) will be leaving on 18 September 2026. A successful candidate has been appointed to the position, subject to pre-employment checks and paperwork.

14.6. Shama Master and Haylie Page joined us on secondment from GMC on 17 August 2026 as Data Analyst (3-month fixed-term contract) and a Policy Adviser (9-month fixed-term contract) to work on the Scottish Government commission.

15. Governance

15.1. We have received the Internal Audit report of Performance Management – Standards.

15.2. The audit on the s29 Case Management System is currently ongoing.

15.3. The payroll internal audit recently took place and has now concluded, subject to agreeing the final report.

15.4. The scope for the internal audit on Internal Communications has been agreed and will start shortly.

16. EDI

16.1. We previously reported that after completing the inclusive work culture self-assessment and benchmarking tool from Onvero called TIDE (Talent Inclusion and Diversity Evaluation) the PSA were selected for audit. Following completion of the audit our final score increased from 71% to 76%; this means we remain working at the 'Embed' stage of the TIDE inclusion journey towards building a sustainable inclusive workplace culture. Actions from the evaluation report are being developed and will be included in the EDI action plan.

16.2. We continue reviewing and updating our EIA (equality impact assessment) toolkit with ELT sign off for this expected in September 2026.

16.3. We continue work on our 2025/26 self-assessment against Performance Review (EDI) Standard 3. All teams have completed their self-assessments, taking a proportionate approach focussed on updating the indicators rated amber or red for 2024/25. An additional step this year aimed at strengthening the robustness of our self-assessment process by introducing an element of triangulation, required Directors to peer assess

another Directorate. A workshop to consider the PSA's overall position against Standard 3 is due to take place in September 2026.

KPIs up to 31 July 2026

Our performance against our KPIs is set out below:

Area of work	Key performance indicators	Performance to date in 2026/27
Section 29 and S40B decisions	Number of cases received [compared with same period last year]	768 [747]
	Number of Cases considered at a s29 case meeting or statutory deadline meeting [compared with same period last year]	9 [16]
	Appeals lodged [compared with same period last year]	6 [10]
	100% of relevant decisions considered within statutory deadline	100% [100%]
Performance Reviews	100% of 2025 performance reviews published within three months of end of review period	2/2 to date [100%]
Public concerns about Regulatory bodies	100% of concerns acknowledged within five working days since 1 April 2026	100% (130/130)
Accredited Registers – current processes	90% of Registers have a full assessment within three years of the previous assessment.	93% (26/28)
	90% of decisions about the annual check within one year of the previous assessment.	100% (28/28)
	95% of Conditions are reviewed within two months of when they were due.	100% (67/67)
	100% of targeted reviews are completed within four months of the date initiated.	100% (2/2)
	90% of decisions about new Standard 1 applications are made within four months of receipt.	100% (3/3)

	90% of decisions about full accreditation (Standards 2-9) are made within eight months of receipt.	100% (2/2)
Finance	Budgeted income / expenditure variance less than 5%	6.83% (1,791/1,923)
IT	85% of helpdesk calls to be closed within 1 day System unavailability below 10 hours	100% (137/137) 0 hours
Information security	No incidents reported to the Information Commissioner's Office	0
Information requests (FOI / SAR / EIR)	All (100%) Subject Access Requests dealt with within statutory deadlines All (100%) Freedom of Information Act requests dealt with within statutory deadlines	2/2 [100%] 11/11 [100%]
Complaints	100% of complaints acknowledged in five days Response to all complaints to be completed within 28 days	2/2 [100%] 2/2 [100%]
Social media (1 June – 31 July)	Total number of followers across our social media channels (compared with same period last year in brackets) Number of new followers across our social media channels (compared with same period last year in brackets) Number of engagements with our social media posts (compared with same period last year in brackets). *Engagements include likes, reactions, comments, replies and shares.*	9, 567 [8,303] 305 [247] 515 [679]

	NB: All data in this section based on most recent reporting period.[2]	
Website usage (1 June – 31 July)	Data on website usage since last reporting period with same period last year in brackets • Total page views across the website • Check a Practitioner landing page and practitioner specific pages • Accredited Registers home page and related Accredited Registers pages NB: All data in this section based on most recent reporting period.	66, 859 [95, 313] 15, 416 [26, 171] 8,120 [13, 520]

[2] In previous reports, website and social media KPIs were presented cumulatively from 1 April to the end of the month preceding the meeting. From September 2025, metrics instead cover only the period since the last report (a two-month period ending in the date identified in KPI title). This change ensures each report reflects performance for the most recent reporting period rather than building cumulatively from April. This helps to identify performance peaks and troughs more accurately. We will continue to provide year-on-year figures to show a comparison with the same period last year.

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Annexe A: Project Status Dashboard

Status Date	09/09/2026

Overall Project Portfolio RAG	GREEN

Overall Status Commentary
Standards review – On 19 March 2026, we published our new and combined Standards for regulators and Accredited Registers on our website, supported this with a multi-channel communications approach. On 1 July the Standards came into effect, and we issued further communications to mark this milestone. We have closed the project, and the Scrutiny Committee will continue to oversee operational readiness. **Healthcare science commission for Scottish Government** – The project has commenced, with additional resources in place. Analysis of initial stakeholder survey underway. Principal risk reflects importance of accessing primary data sources, which we are in the process of requesting access to, and which is being mitigated through proactive stakeholder management.

Project Portfolio Status Summary

Project / Programme	Owner / Lead	Start Date	Baselined End Date	Current End Date	Planned Budget	Current Expend.	Project RAG	Project Status Commentary
Standards Review	Graham Mockler & Melanie Venables	01/05/24	31/03/26	31/07/26	£0	£22,080	G	• **September 2026 –** The Standards came into effect on 1 July. Launch was accompanied by stakeholder communications. Work is underway to close the project and no further reports from the development project will be made.
Healthcare Science (HCS) Right-touch assurance assessment - commission for the Scottish Government	Melanie Venables	26/08/26	29/04/27	29/04/27	£0[1]	£0		• **September 2026 –** Project documentation, including EIA,

[1] Project is fully funded by the Scottish Government. Expenditure is covered by the agreed commission income, therefore budget monitoring is focused on delivery within the commissioned resource envelope rather than against a separate PSA project budget.

Project / Programme	Owner / Lead	Start Date	Baselined End Date	Current End Date	Planned Budget	Current Expend.	Project RAG	Project Status Commentary
								approved. Additional resources (Data Analyst and Policy Advisor) joined the PSA on fixed term contracts in August 2026. Initial stakeholder survey to establish interest and data availability completed and being analysed. Individual stakeholders now being approached for primary data requests.

Key Risks	Mitigations
HCS Commission: Lack of / difficulties with accessing primary data	• Close working with Scottish Govt officials to access primary data held by Health Boards in particular • Proactive stakeholder management • Clarity on data protection and application of Freedom of Information (FOI) • Appropriate IT software in place

Status Key: On plan / budget | On / late to plan and / or within 10% of budget but with manageable risk | Late to plan and / or > 10% budget variance. Requiring re-plan or scope change

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Review of dismissed appeals

This paper considers three dismissed PSA Section 29 appeals, which were heard March 2026.

1 Introduction

1.1 In March 2026, three PSA S29 appeals were dismissed by the High Court. This paper considers each of these three cases, and follows an action from the May Private Board meeting to: '*Bring the analysis of themes emerging from recent Section 29 appeal outcomes to the Board for information after the Scrutiny Committee has discussed it'*. The action was originally scheduled for the July Board meeting, but postponed to September to allow for Scrutiny Committee consideration of this report.

1.2 As a reminder, the S29 process consists of multiple assessment and decision-making stages. It is, in effect, a three-stage process:

- **Stage 1:** Initial review of the determination. If no concerns are identified, the case is closed.[1] If concerns are identified, further information is sought and a detailed case review (DCR) is undertaken.[2]
- **Stage 2:** DCR undertaken on the case documentation. If there are issues identified that may render the decision insufficient for public protection, a case meeting is recommended. If such issues are not identified, the case is recommended for closed. The Head of Legal decides whether to accept the DCR recommendation.[3]
- **Stage 3:** Case meeting. This is a meeting of a panel of two or three members of PSA staff to determine whether to appeal the case. The meeting has two decision stages: whether the outcome is sufficient for public protection, public confidence and/or upholding professional standards; and if it is deemed insufficient, whether the PSA should exercise its discretion to appeal. The second stage of the decision is made after taking advice from Counsel in attendance on prospects of success.

1.3 The purpose of this paper is not to reinvestigate the decisions made, but to identify any themes and any learning that can be identified from the decisions made at different stages of the process.

[1] A proportion of cases closed at initial review are automatically selected by the Case Management System (CMS) for a second check by the Lead Lawyer.
[2] A case may be closed upon receipt of further information if it is determined that a DCR is not required. In 2025/26, further information was requested on 109 cases and 91 DCRs were completed.
[3] This was the process at the time of the cases in this paper. Subsequently, this process was changed so that the Lead Lawyer considers DCR recommendations. The Head of Legal becomes involved if the Lead Lawyer disagrees with the DCR recommendation or if the case is complex and/or high profile.

2 Cases

2.1 The three cases are summarised below.

Hughes, General Medical Council

2.2 The registrant engaged in an inappropriate relationship with a highly vulnerable (physically and mentally) patient when she was 13 years old, then used his position to pursue an improper emotional relationship when she was 16, sought to pursue a sexual relationship before she turned 18 years old, and then entered into a sexual relationship from the age of 18 years. The Tribunal imposed a sanction of 12 months suspension with a review.

2.3 The PSA's grounds included that the sanction was insufficient given the seriousness of the allegations as found proven, the panel failed to adequately apply the sanctions guidance and the panel failed to have proper regard for the patient's vulnerability and erred in finding that the registrant had not exploited Patient A's vulnerability (see Annex A).

2.4 The appeal was heard on 10 March 2026 and the judgement handed down on 19 May 2026. The PSA was unsuccessful on each of its grounds as the judge considered the panel's decision was overall sufficient, had made adequate reference to the sanctions guidance and evidenced that they had taken the patient's vulnerability into account. Ultimately, the Court found that it was open to the Tribunal to conclude that erasure was not required. We sought permission to appeal to the Court of Appeal (which could then have been the basis for a separate decision on whether or not to appeal), which was refused.

McClean, Pharmaceutical Society of Northern Ireland

2.5 This case included allegations that the Registrant, a Pharmacist, had issued, without clinical indication, a large number of prescription/Class C drugs to friends and family members over a period of two and a half years, attempted to conceal her actions by deleting records/cancelling prescriptions. This was described by the panel as 'dishonest actions by the Registrant which involved a huge element of concealment' and that 'it required a great deal of effort by investigators to uncover the nature and extent of her dishonest activities'. The panel imposed a nine-month suspension order with a review.

2.6 The PSA appealed on grounds which included that the sanction did not reflect the gravity of the misconduct, and that the panel failed to adequately follow the sanctions guidance and failed to provide adequate reasons (see Annex B). The regulator and registrant defended the appeal.

2.7 The appeal was heard on 19 March 2026. The PSA was unsuccessful on each of its grounds as the judge considered the panel's decision was overall sufficient. The judgement was handed down verbally (*ex-tempore*) at the hearing, so we do not yet have full reasons for its dismissal. We are in the process of seeking the transcripts.

Lord, General Dental Council

2.8 In this case, allegations arose concerning the registrant's treatment of 13 patients over an 11-month period. Additionally, it was alleged that the registrant dishonestly misappropriated monies from the practice where he worked and made himself out to be the owner of a practice when this was not yet the case. The registrant only began repaying the money when he was investigated several months later. A GDC panel imposed a six-month suspension order without a review.

2.9 The PSA's grounds included material errors in the panel's findings, including but not

limited to: erring when considering dishonesty and failing to have regard to the sanctions guidance, and a failure to give adequate reasons (see Annex C). The regulator and registrant defended the appeal.

2.10 The appeal was heard on 25 March 2026. The judgment was handed down *ex-tempore,* and we are in the process of ordering a transcript of this. The PSA was unsuccessful on each of its grounds of appeal as the judge considered the panel's decision was overall sufficient.

3 Analysis

Overview

3.1 Having three cases dismissed in quick succession is unusual for the PSA. This is equal to the number of cases dismissed from 2019/20 to 2024/25. We therefore need to consider whether any factors have led to this.

3.2 All three cases dismissed in 2026 were dismissed as the Court did not find that the PSA had successfully argued that the outcomes were insufficient to protect the public. All grounds of appeal were dismissed in each case. We do not have written judgements for the Lord or McClean cases, which significantly limits our understanding and therefore ability to undertake an analysis of the reasons for dismissal of these cases. This is particularly the case for McClean, where we were not in attendance in person at the High Court of Northern Ireland. We have therefore considered other elements where possible in our considerations and when seeking to identify potential improvements to processes.

3.3 **Recommendation:** PSA lawyers should attend all hearings in person to ensure full understanding of the reasons for court decisions in the event that written judgements are not provided.

3.4 The three cases are individually different, with grounds of appeal being specific to each case. However, there is a similarity in outcome, in that in all three cases, the registrants were suspended (for between six and 12 months, 12 months being the maximum possible suspension for these regulators). In Lord, the panel did not direct a review hearing at the conclusion of the suspension, whereas in Hughes and McClean a review hearing was directed. This is an important distinction as the order automatically lapses on expiry if a review hearing is not directed.

3.5 Of the 133 appeals closed since 2019/20, 62 (47%) have been suspension cases. The only sanction higher than suspension is erasure, and so for these to be considered insufficient, the PSA's position in each case will be that erasure was the only sanction reasonably available to a panel.

3.6 However, the courts recognise that a suspension is a serious sanction in and of itself[4] and that the regulator's panel is the body which is best equipped to determine questions as the sanction. Such decisions are afforded a high degree of deference. To overcome this, the PSA will need to establish that there was an error of approach in carrying out the evaluation or establish that for any other reason the evaluation was wrong and fell outside the bounds of what the tribunal could properly and reasonably decide.[5] The prospects of

[4] *R (on the application of council for the regulation of healthcare professionals) v GMC and Khanna [2009] EWHC 596 (Admin*) [27]. It was also stated in this case (at [34]) that a review hearing is 'a significant element' of the sanction imposed to protect the public.
[5] *Bawa Garba v GMC [2018] EWCA Civ* 1879 at [67]

success we receive from Counsel will take deference into account, and so will inform whether we take forward an appeal at the second stage of a case meeting.

3.7 **Recommendation:** New and refresher panellist training should reiterate decision-making in relation to suspension cases, and the outcome the PSA will be seeking in these cases. This report should also be shared with all panellists.

3.8 Of the three appeals dismissed from 2019-2025, the sanctions were:

- Suspension
- Warning
- Not impaired

3.9 Given the small numbers and lack of pattern over time, aligned with the commonality of appealing suspension cases, we have not drawn any further conclusions on the type of sanction and dismissal of appeal.

Decision-making

3.10 We referred the cases to the relevant court in July (McClean, Lord) and August (Hughes) 2025.

Initial stages

3.11 The below table outlines the decisions made at initial review and DCR.

Case	Initial review decision	Second check	DCR
Hughes	Case closed. The initial review recommended that a 12-month suspension is a serious sanction and that erasure was not the only appropriate outcome available in this case.	Case closed without a second check as it was not randomly selected by the CMS for a second check. Complaint received outlining issues with the case that were not apparent in the determination. The case was reopened and second check undertaken by the Lead Lawyer. Further information requested to assess the case in more detail, including the complainant's concerns.	Case meeting recommended. Recommendation approved and case meeting held. DCR undertaken by external Counsel.
McClean	The initial review identified concerns with the sufficiency of the decision. Second check by Lead Lawyer	Second check agreed with the concerns identified at initial review. Further information requested.	Case meeting recommended. Recommendation approved and case meeting held.

	requested.		DCR undertaken by S29 lawyer.
Lord	Further information requested.	N/A	Case meeting recommended. Recommendation approved and case meeting held. DCR undertaken by external Counsel.

3.12 Each case took a different path to the completion of a DCR, although the only difference between McClean and Lord at the initial stage was a requested second check, which agreed with the concerns of the initial reviewer.[6] The standout point is the reopening of the Hughes case following receipt of a complaint. We do occasionally receive such correspondence, and while relatively rare, this can result in further consideration of cases where it raises concerns that are not apparent from the determination and which require further exploration.

3.13 Our process outlines that if the case is still within the statutory deadline (regardless of whether it has already been reviewed by the team and closed without having requested further information from the regulator), the Concerns and Appointments Officer provides the concern received to the initial reviewer of the case or the lawyer (depending on the which stage of the process the case has reached). If the case is complex and/or high-profile, the Lead Lawyer (at the first stage) and/or Head of Legal (at the second/third stage) should be cc'd into any emails and reviews carried out of the information, and they are likely to need to review the initial reviewer or lawyer's advice. We undertake our own analysis and do not base our decisions solely on the concerns raised with us. If we decide to undertake a DCR following receipt of a complaint, this is done in line with normal processes.

3.14 Having re-reviewed the second check and decision to request further information in the Hughes case, this decision-making appears appropriate. The concerns raised in the complaint are serious and required further investigation. The Lead Lawyer undertook the second check as requested by the Head of Legal as it was a complex and high-profile case. While this was appropriate given the nature and complexity of the case, we consider that we can improve the wording of our internal process documentation to be clearer on who undertakes the second check in this scenario.

3.15 **Recommendation:** Clarify who undertakes the second check following receipt of concerns within the S29 process documentation.

Decisions to proceed to appeal

3.16 We identified concerns in each of the three cases that may render the decision insufficient for public protection. These issues were explored through our usual decision-making processes. Each decision was made by a panel of two (McClean) or three (Lord,

[6] For clarity, a second check is its own assessment of the case, which may agree with the issues identified in the initial review, identify additional concerns, or disagree with the initial review.

Hughes), in line with our process.

3.17 The case meeting note for each meeting outlines the reasons for each decision taken. These explain the reasons why each panel considered the outcome of the case to be insufficient and as such why each case was progressed to appeal. There are no obvious errors in this decision-making process.

3.18 Each appeal had its own merits. We do not record prospects of success provided by Counsel in the case meeting note. Counsel are generally cautious when it comes to prospects, and we accept that this process is an estimation based on a range of factors. It is not a formal predictor of success. While this review has not identified issues with this process, we will consider whether there is learning to be had more broadly in relation to how we seek and receive prospects of success. While recording prospects in a published case meeting note would not be appropriate, we should record this more systematically elsewhere on the case management system.

3.19 **Recommendation:** Record prospects of success on the case management system.

Hughes – High Court appeal outcome

3.20 In this case, the High Court Judge was not persuaded by either of the PSA's two grounds of appeal.

- In relation to Gound 1, the Judge found no error of fact in the approach by the tribunal. They noted that it was a difficult, factually nuanced case, which the Tribunal had found. They rejected the PSA's submission that the tribunal had failed to have due regard to the sanctions guidance, and were not persuaded that the tribunal had given undue weight to mitigating factors, or to the public interest of Dr Hughes remaining on the register.

- The Judge was not persuaded that the tribunal had reached the wrong conclusion on whether Dr Hughes had exploited Patient A's vulnerability.

Hughes – Court of Appeal

3.21 We had concerns that the High Court decision was inadequate. We had concerns that this could potentially impact future cases. This point of principle and wider applicability is a key factor in determining whether to progress a case at this point, and we will generally not pursue further action following an unsuccessful appeal unless this factor is present. This is also part of the test for granting permission to appeal in the Court of Appeal (alongside real prosects of success and if there is some other compelling reason for the Court to hear the appeal). The decision was finely balanced, and we were aware that it would be difficult to overturn the decision of the High Court. However, we considered that there may be wider implications if the judgement was not challenged.

3.22 Permission to take the case to the Court of Appeal was refused and therefore the case did not meet the relevant threshold. While the PSA can, and at times should, take forward cases that it determines pose potential risks in terms of wider application to future cases, this must be done on an exceptional basis, particularly noting the high bar for taking a case to the Court of Appeal.

3.23 While these decisions do not arise regularly, learning from this appeal should be taken forward to inform any future decisions on whether to appeal to the Court of Appeal, and the thresholds for doing so. This should be distilled into a more formal process for doing so. Given the infrequency of such decisions, a formal process for decision-makers is

important.

3.24 **Recommendation:** Take learning from the Hughes referral to the Court of Appeal to develop processes and inform future decisions.

4 Conclusion

4.1 The analysis of why cases were dismissed has been frustrated by not having judgements for the Lord and McClean cases. We will, on occasion, have our appeals dismissed. If we were successful in 100% of cases, we consider this may indicate that we are being overly risk averse in our approach to appeals. Including these three dismissed appeals, our success rate since 2019/20 is 95%, which remains very high. In comparison, the GMC's success rate at appeal from January 2016-January 2026 was 82%.[7]

4.2 It is, however, highly unusual for three appeals to be dismissed in quick succession, and so it is right to consider whether there are any issues that have led to these outcomes, or whether the decisions we took were plainly wrong.

4.3 While not intending to reinvestigate these cases, particularly as we do not have written judgements for two of the cases, which has limited analysis for the reasons for dismissal, we have reviewed our decision-making stages to identify any issues in the processes followed. While we have not identified any issues or errors that would mean that we should have made different decisions, we have identified some areas where processes could be improved, as outlined in the recommendations.

4.4 We will continue to report to the Board on the outcomes of our appeals and will continue to review any dismissed cases.

5 Recommendations and next steps

5.1 Within the report, we have identified a number of recommendations for strengthening processes. An action plan with dates for completion is provided below. This will be monitored by the Scrutiny Committee.

Recommendation	Action and completion date
PSA lawyers should attend all hearings in person to ensure full understanding of the reasons for court decisions in the event that written judgements are not provided.	Head of Legal and/or Lead Lawyer to attend all hearings in person, including those outside of London. To be implemented for upcoming case in NI in September 2026 and ongoing.
New and refresher panellist training should reiterate decision-making in relation to suspension cases, and the outcome the PSA will be seeking in these cases. This report should also be shared with all panellists.	Training documentation to be updated by end of December 2026. Report to be shared with all panellists by end of September 2026.
Clarify who undertakes the second check following receipt of concerns within the S29 process documentation.	Process documentation to be updated by end of October 2026.

[7] We have excluded withdrawn appeals from these figures as cases may be withdrawn for a number of reasons.

Record prospects of success on the case management system.	Record this on the 'Meeting' tab of the case management system for each relevant case meeting. From September and ongoing.
Take learning from the Hughes referral to the Court of Appeal to develop processes and inform future decisions.	Internal guidance on determining whether to appeal to the Court of Appeal to be developed by end of October 2026.

5.2 We will return to our analysis of these cases once we have the transcripts of the McClean and Lord judgements to consider if there is further learning for the PSA in relation to these cases. We will take any further analysis to the Scrutiny Committee and report to the Board through the Scrutiny Committee meeting reports.

Annex A: Hughes grounds of appeal

1: The Panel erred by finding a suspension order was a sufficiently serious sanction.

2: Alternatively, the Panel made erred by finding the Registrant had not exploited Patient A's vulnerability and, had it not made such error, an erasure order would have been the only reasonable sanction.

Annex B: McClean grounds of appeal

1. The imposition of a Suspension Order for a period of 9 months is insufficient for the protection of the public, the maintenance of public confidence and the need to uphold and declare standards.

2. The Statutory Committee of the First Respondent failed to adequately consider whether the misconduct of the Second Respondent was fundamentally incompatible with her continued registration as a pharmacist.

3. The Statutory Committee of the First Respondent failed to provide any adequate reasoning as to why they found that the misconduct of the second Respondent was not fundamentally incompatible with continued registration as a pharmacist.

4. The Statutory Committee of the First Respondent failed to have any, or any adequate, regard to the First Respondent's "Interim Sanctions Guidance" document in particular the guidance on cases involving dishonesty at paragraphs 2.26 – 2.32 of the document

5. The Statutory Committee of the First Respondent took a flawed approach to the question of mitigating and aggravating features in respect of the Second Respondent's case

6. The decision of the Statutory Committee of the First Respondent is internally inconsistent in that at the impairment stage there was a finding of a lack of "demonstrable insight" whilst at the sanction stage it was noted that the Committee had found "developing insight" at the impairment stage

7. The Committee also failed to have regard to paragraph 2.20 of the Interim Sanctions Guidance which provides that "insight and remediation may carry less weight in cases where public confidence in the profession is seriously undermined, than in cases related to clinical errors or incompetence".

Annex C: Lord grounds of appeal

1: The Panel erred in finding that a suspension order was sufficient for the protection of the public

2: Alternatively, the Panel made material errors in its findings and, had it not made such errors, an erasure order would have been the only reasonable sanction.

3: In the further alternative, the decision is unjust because of a serious irregularity, in that the Panel failed to give adequate reasons for its decision in respect of sanction.

professional standards authority
for Health and Social Care

EDI Advisory Group

Date: Sept 2026

Title: EDI Advisory Group – update

Author: Sarah Fox and Melanie Hueser

Paper for Information

Open paper

How does this work contribute to our Strategic Plan: Our Strategic Plan sets out that Equality, Diversity and Inclusion runs through our strategic aims and is embedded in all our work.

1. Issue

1.1. This paper provides an update to the Board on the activity of the PSA's EDI Advisory Group – focused on the discussions the EDI Advisory Group have had since October 2025.

2. Recommendation

2.1. The Board is asked to note this paper and provide any feedback to the EDI Advisory Group.

3. Background

3.1. The EDI Advisory Group (the Group) has been in place for six years at the PSA. This paper provides a high-level summary of some of the issues the Group has discussed in the last ten months and some of our future plans.

4. Analysis

Co-Chairs and updated Terms of Reference

4.1. In October 2025 Melanie Hueser and Sarah Fox took over as Co-Chairs of the EDI Working Group. This prompted a review of the Terms of Reference in consultation with Group members which resulted in some small changes and clarifications in respect of the role of the Group. Group members also agreed that the name of the Group should be amended to Advisory rather than

Working Group in order to more accurately reflect the role, responsibilities and capacity of Group members.

4.2. As outlined in the Terms of Reference, the EDI Advisory Group's role is to support and promote equality, diversity, and inclusion across the PSA. The aim is that the Group will do this by sharing and discussing EDI matters of relevance to the PSA in safety and with openness. The Group does not take decisions on behalf of the PSA but can provide advice to inform the PSA's decisions, activities, and policies with a focus on internal EDI matters.

Raising awareness of the EDI Advisory Group

4.3. The EDI Advisory Group has also discussed raising awareness across the organisation of the Group, its purpose and how to get involved / raise issues. There are plans for a poster advertising the Group, membership and its role in the office.

4.4. The Group also discussed the staff survey results that showed a significant proportion of respondents answered 'don't know' when asked whether they were satisfied with the Group's work. The Group noted that this may partly reflect the number of newer staff who have not yet had much exposure to the Group. However, it agreed that meeting minutes should continue to be shared with all staff and that EDI must be a standing item on team meeting agendas, enabling representatives to update colleagues and gather feedback. All new starters continue to have an EDI induction with the EDI Manager and one of the Group co-chairs and in addition are invited to observe an EDI Advisory Group meeting.

4.5. The Group agreed to review staff awareness again following the next staff survey. The Group will also consider whether to poll staff members following the days we have planned in October and December 2026 – see paragraph 4.8 below.

Board member attendance

4.6. At its meetings since September 2025 the EDI Advisory Group has welcomed Board members to its meetings. Eleanor Marks, Juliet Oliver, Ali Jarvis and Caroline Corby have each attended a meeting to discuss EDI issues relevant to their external roles or previous experience. Group members have found these discussions interesting, and they have provided useful insights / prompts for the Group on how we might see our role going forward – particularly in allowing a forum for discussion and diversity of thought through an EDI lens.

Staff recognition awards

4.7. Following a recommendation from the Group, a representative of the EDI Advisory Group has continued to be involved in the panel discussing and agreeing the PSA's staff recognition awards. The next set of awards are due to be given out at the all staff half day awayday in September.

Marking events

4.8. The Group remains the primary way that the PSA organise the internal marking of EDI events. At its January 2026 meeting the EDI Advisory Group held a discussion about which key EDI events to

mark during 2026-27.

4.9. The Group discussed and agreed to mark World Mental Health Day – this falls on Saturday 10 October. The Group plan to focus on the link between money and mental health as part of this event. We think this is relevant given the recent findings of the cost of living survey on staff.

4.10. The Group also agreed to mark World Human Rights Day on 10 December. As part of that event we are hopeful that one of our former lawyers who recently left the PSA will return to give a talk on their experience of human rights law.

4.11. The Group have also agreed to identify a relevant event to mark / focus on in the New Year. Board members are welcome to attend any of these events should they wish.

Future areas of focus / work

4.12. The EDI Advisory Group have several substantive areas of focus in the coming 6-12 months including:

- Increasing our understanding of social mobility and socioeconomic background within the organisation.
- Intersectionality and being more explicit about how this can be an opportunity, particularly in relation to events, communications and discussions about Fitness to Practise.
- Reviewing the PSA's Strategic Plan/EDI Action plan to help identify possible workstreams that the Group could contribute / advise on given its remit / Terms of Reference.
- Reviewing the updated self-assessment of the PSA's adherence to Standard 3 of the Standards of Good Regulation.

5. Finance and resource

- The EDI Advisory Group is resourced by volunteers. In line with the Terms of Reference the aim is that each area of the organisation is represented at the Group.

- It is noted that in the last update provided to the Board there was a reference to Group members logging their time in order to assess how much resource is being used for this area of work. Following the review of the Terms of Reference it was agreed that we shift our focus from Working Group – and so in effect delivering EDI related pieces of work – to Advisory Group. This was largely to reflect the capacity of Group members and a need to be realistic on what we could achieve. The Group will review achievements and how much resource it has required in May 2027.

6. EDI implications, including Welsh Language

- The purpose of the Group is that it will have a positive impact on EDI for PSA staff and support the delivery of the PSA's EDI Action Plan.

7. Timescale

- Ongoing. The EDI Advisory Group does not have a set timeframe or expiry date. The aim is for the Group to meet every two months; provide input on the PSA's EDI Action Plan; and to

provide regular (likely twice yearly) updates to SMT and (annual) the Board.

8. Communications

- The Group communicates regularly with all staff through circulating meeting agendas, minutes and presenting at all-staff meetings. Group representatives liaise with colleagues in a number of ways, including raising EDI issues at team meetings and feeding back to the Group. There are no external communications requirements arising from this work, however, thought could be given to referencing the Group in the annual report and accounts.

9. Internal stakeholders

- All staff and Board members. As noted above, all staff are sent the agenda for the upcoming EDI Advisory Group meetings and are welcome to attend or raise questions either via a member of the Group or one of the Co-Chairs. The minutes of each meeting are also shared with all staff so they can see the discussions that the Group have held and the actions. Board members are also invited to join a meeting to discuss issued related to EDI.

10. External stakeholders

- The Group has an internal focus, and its work is not likely to affect external stakeholders. However, thought could be given to mentioning the Group in the annual report / annual plans / external newsletters.

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Finance report

1. Executive summary as at 30 July 2026

Regulatory Activity

1.1. Regulatory Activity is forecast to close the 2026/27 financial year with a deficit of £305k compared with a budgeted deficit of £168k. The budgeted deficit reflects the planned refund to regulators through fee reductions.

1.2. The forecast position is primarily driven by higher than budgeted Section 29 legal costs. As reported last financial year, a number of Section 29 hearings have taken place later than originally anticipated, resulting in a higher level of costs being incurred in 2026/27. The forecast also includes two unsuccessful cases where PSA is liable for both its own legal costs and the costs of the regulator and registrant.

1.3. The forecast also includes additional £65K for Commissioned research project that was postponed from 2025/26.

Accredited Registers

1.4. The Accredited Registers programme is currently forecast to perform broadly in line with budget, apart from communications costs due to a number of projects. As set out in the sectoral summary, approval has been sought to utilise unrestricted reserves to support planned activity during the year.

Commissions

1.5. The DHSC Rapid Policy Commission undertaken in March 2026 generated income of £13k which has been recognised in 2026/27 following completion of the commission and invoicing in May 2026. In addition, PSA has commenced work on the Scottish Government Healthcare Science Commission. Income associated with this commission is currently expected to be £138k, with associated costs, primarily staff costs, estimated at £106k. These figures are based on current estimates and may change as the commission progresses and actual staff time allocations become clearer.

Recommendations

1.6. The Board is asked to note the financial position as at the end of July 2026

2. Sectoral Summary – Regulatory Activity

2.1. Income and Expenditure breakdown

Income and Expenditure	2025/2026 Actual	2026/2027 Budget	2026/2027 Forecast	2026/2027 Budget vs Forecast
Income				
Fee Income from regulators	5,461	5,603	5,603	0
Operating Income				
S29 cost recoveries	125	221	350	129
Investment interest	139	100	118	18
Conferences income	8	0	8	8
Total income	5,733	5,924	6,079	155
Staff costs	3,796	4,106	4,063	43
Recruitment costs	27	15	15	0
Training and Conferences	73	77	77	0
HR and payroll costs	22	61	61	0
Staff travel	7	10	10	0
Occupancy costs	356	334	355	(21)
Audit costs	67	80	76	4
IT costs	159	223	213	10
Board appointments	3	0	0	0
Board remuneration/expenses	140	154	171	(17)
Depreciation/Capital costs	54	50	50	0
Conferences	30	52	51	1
Commissioned Policy advice and research	7	90	155	(65)
Comms	19	16	16	0
Other policy costs	79	125	129	(4)
Direct S29 legal costs and case review	506	607	872	(265)

Other costs	95	92	70	22
Total admin costs	**1,644**	**1,986**	**2,321**	**(292)**
Surplus/(deficit)	**293**	**(168)**	**(305)**	**(137)**

2.2. £21k overspend in occupancy costs due to an increase in business rates. The rates are reviewed every three years and the final rates liability notified by the City of London was higher than originally assumed in the budget.

2.3. £17k overspend in Board remuneration and expenses due to timing differences between forecast and actual costs incurred, including costs associated with the Board effectiveness review.

2.4. £265k overspend in Section 29 legal costs and case reviews due to the timing of hearings, with a number of cases progressing later in the year than originally anticipated, resulting in higher costs being incurred during the year. The overspend also reflects increased Section 29 activity and includes two lost cases (PSNI and GMC) where PSA is liable for both its own legal costs and the costs of the regulator and registrant (cost totalling approx. £150k).

2.5. £129k favourable variance in Section 29 recoveries due to higher anticipated recoveries based on historical recovery rates and current case activity. The increased recoveries are consistent with the higher level of Section 29 expenditure incurred during the year.

2.6. £65k overspend in commissioned policy and research are additional funding for research that has been approved by board.

3. Sectoral Summary – Accredited Registers

Income and Expenditure	2025/2026 Actual	2026/2027 Budget	2026/2027 Forecast	2026/2027 Budget vs Forecast
Registers Income	773	798	800	2
Staff costs	466	494	502	(8)
Comms Costs	13	80	114	(34)
Overheads	193	206	206	0
Other costs	3	11	12	(1)
Surplus/(Deficit)	**98**	**7**	**(34)**	**(41)**

The Quality Mark campaign is a key element of our work to raise public awareness of Accredited Registers (AR) and help people make safer choices when accessing private health and wellbeing services. Having kicked off the campaign with digital marketing activity in 2024/25, the influencer campaign was originally planned for delivery in 2025/26, but due to

procurement delays will now be delivered this financial year. Having not spent the funds allocated for this last year (an underspend of £53k), the programme has sought Board's approval for this additional spend in July 2026.

3.1. Moving the influencer campaign to this financial year presents an opportunity for us to run it at the same time as other campaign activity planned for 2026/27- public relations activity, a paid Meta and Google advertising campaign and outdoor advertising in the form of digital banners. This layering of communications means we can provide more channels where our campaign content can be seen, reinforcing our messages, increasing our visibility and giving the whole campaign more impact.

4. Sectoral Summary – Commissions to Government

Income and Expenditure	2025/2026 Actual	2026/2027 Budget	2026/2027 Forecast	2026/2027 Budget vs Forecast
Income	0	0	151	151
Staff costs	10	0	106	(106)
Other Costs	0	0	0	0
Surplus/(Deficit)	**10**	**0**	**45**	**45**

4.1. The PSA undertook a DHSC Rapid Policy Commission in March 2026. The costs associated with this commission were incurred in 2025/26; however, as the commission was not finalised and invoiced until 2026/27, the related income of £13k has been recognised in 2026/27.

4.2. The PSA has been commissioned by the Scottish Government to undertake a Healthcare Science Commission. Income associated with this commission is currently expected to be £138k, with associated costs, primarily staff costs, estimated at £106k. These figures are based on current estimates and may change as the commission progresses and actual time allocations become clearer.

5. Total staff costs

Income and Expenditure	2025/2026 Actual	2026/2027 Budget	2026/2027 Forecast	2026/2027 Budget vs Forecast
Salaries	3,163	3,446	3,426	20
Social Security	407	481	414	67
Pension	597	673	633	40
Temp/Agency/Secondments	211**	0	92	(92)
Total staff costs	**4,378***	**4,600**	**4,565**	**35**

*This matches statutory accounts and includes £87k of AR overheads costs that are classed as staff costs in statutory accounts

**Two Secondments and legal associate costs

6. Capital

Capital Expenditure	2025/2026 Actual	2026/2027 Budget	2026/2027 Forecast	2026/2027 Budget vs Forecast
Intangible assets	0	0	0	0
IT equipment	16	40	40	0
F&F	1	10	10	0
Total capital costs	**17**	**50**	**50**	**0**

7. Statement of Financial Position

Income and Expenditure	2025/2026 Actual	2026/2027 Budget	2026/2027 Forecast	2026/2027 Budget vs Forecast
Intangible assets	42	42	42	0
Property, plant & equipment	47	47	47	0
Right of use asset – property lease	320	160	160	0
Total	**409**	**249**	**249**	**0**
Trade and other receivables	1,724	1,724	1,724	0
Cash and cash equivalents	7,910	9,458	9,325	(133)
Total assets	**10,043**	**11,431**	**11,298**	**(133)**
Trade and other payables	(6,842)	(8,558)	(8,558)	0
Lease liability	(197)	(197)	(197)	0
Provisions	(102)	(132)	(132)	0
Total	**(7,141)**	**(8,887)**	**(8,887)**	**0**
Lease liability	(215)	(18)	(18)	0

Net Assets	**2,687**	**2,526**	**2,393**	**(173)**
Reserves				
Unrestricted	972	979	983	4
Restricted	1,715	1,547	1,410	(137)
Total Reserves	**2,687**	**2,526**	**2,393**	**(133)**

8. Cashflow

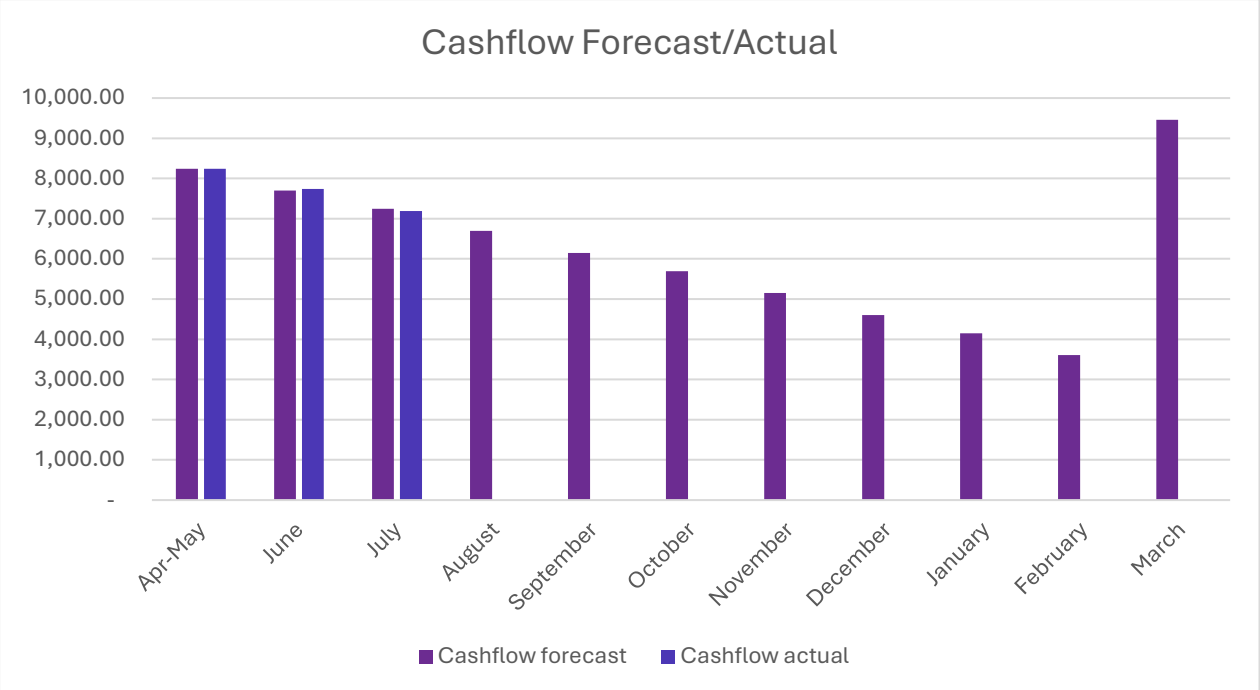
Cash and investments as at 01/04/2026	7,910	7,910
Income	**Projected (Full year)**	**Actual (year to date)**
Fees Income	7,030***	1,430*
Accredited Registers	1,080****	77
Interest	100	39
S29	221	106**
Other	0	0
Total Income	**8,431**	**1,652**
Outgoings		
Payroll	4,600	1,464
Other costs	2,283	910
Total Outgoings	**6,883**	**2,374**
	31/03/2027	**30/07/2026**
Cash and investments	**9,458**	**7,188**

*Five regulators have not paid fee invoices as at 31 March 2026 (amounting to £1.4m)

**Partly for the recovery relating to previous year

*** assuming similar fee income for 2027/28, received in March 2027 and £1.4m of fee income not paid as at 31st of March 2026

****£282k fees unpaid as at 31st of March 2026 and assuming similar level of income for 2027/28 received in March



professional standards authority
for Health and Social Care

Strategic risk register

Date: 16 September 2026

Title: Strategic risk register

Author: Alan Clamp

Paper for Information

Open paper

How does this work contribute to our Strategic Plan: All objectives as the paper relates to risks of not achieving the objectives.

1. Issue

1.1. In line with the PSA Risk Management Policy, the organisation's main risks are reviewed: monthly by the Senior Management Team; at each meeting by the Audit and Risk Committee (ARC); twice each year by the full Board. In addition, the risk register is provided to the Board for information at every meeting, as an annexe to the Executive Report.

1.2. This paper has the August 2026 Strategic Risk Register at Annexe A and the revised Risk Management Policy (with changes highlighted to reflect the new format of the risk register) at Annexe B.

2. Recommendation

2.1. The Risk Management Policy is reviewed annually by the Audit and Risk Committee. In addition, the Board formally reviews the PSA Strategic Risk Register twice each year. Risks are also escalated to the Board as necessary.

2.2. Operational risk registers are managed within the directorates. Major projects also have their own risk registers.

3. Background

3.1. The EDI Advisory Group (the Group) has been in place for six years at the PSA. This paper provides a high-level summary of some of the issues the Group has discussed in the last ten months and some of our future plans.

4. Analysis

4.1. We have assessed the top three known risks facing the PSA as: (1) the backlogs of fitness to practise cases in some regulators – this situation is not improving and we are convening a cross-regulator group in the autumn to discuss opportunities for improvement; (2) underperformance of the NMC and PSNI – we are reviewing options for interventions in line with our new Strategic Aim 2; and (3) the perception of under-regulation in some sectors, which may undermine public confidence – being taken forward by commissioned work under Strategic Aim 3.

5. Finance and resource

5.1. The work is funded from existing resources for 2026/27.

6. EDI implications, including Welsh Language

6.1. No Equality Impact Assessments are required, but this may change as a result of discussions on the Risk Register.

6.2. The risk register can be made available in Welsh if requested.

7. Timescale

7.1. Any amendments will be made immediately to the Strategic Risk Register and this will be monitored by ARC and the Senior Management Team.

8. Communications

8.1. This paper will be used for internal discussion within the Board. Any changes made will be shared with all staff.

9. Internal stakeholders

9.1. All Board members and staff.

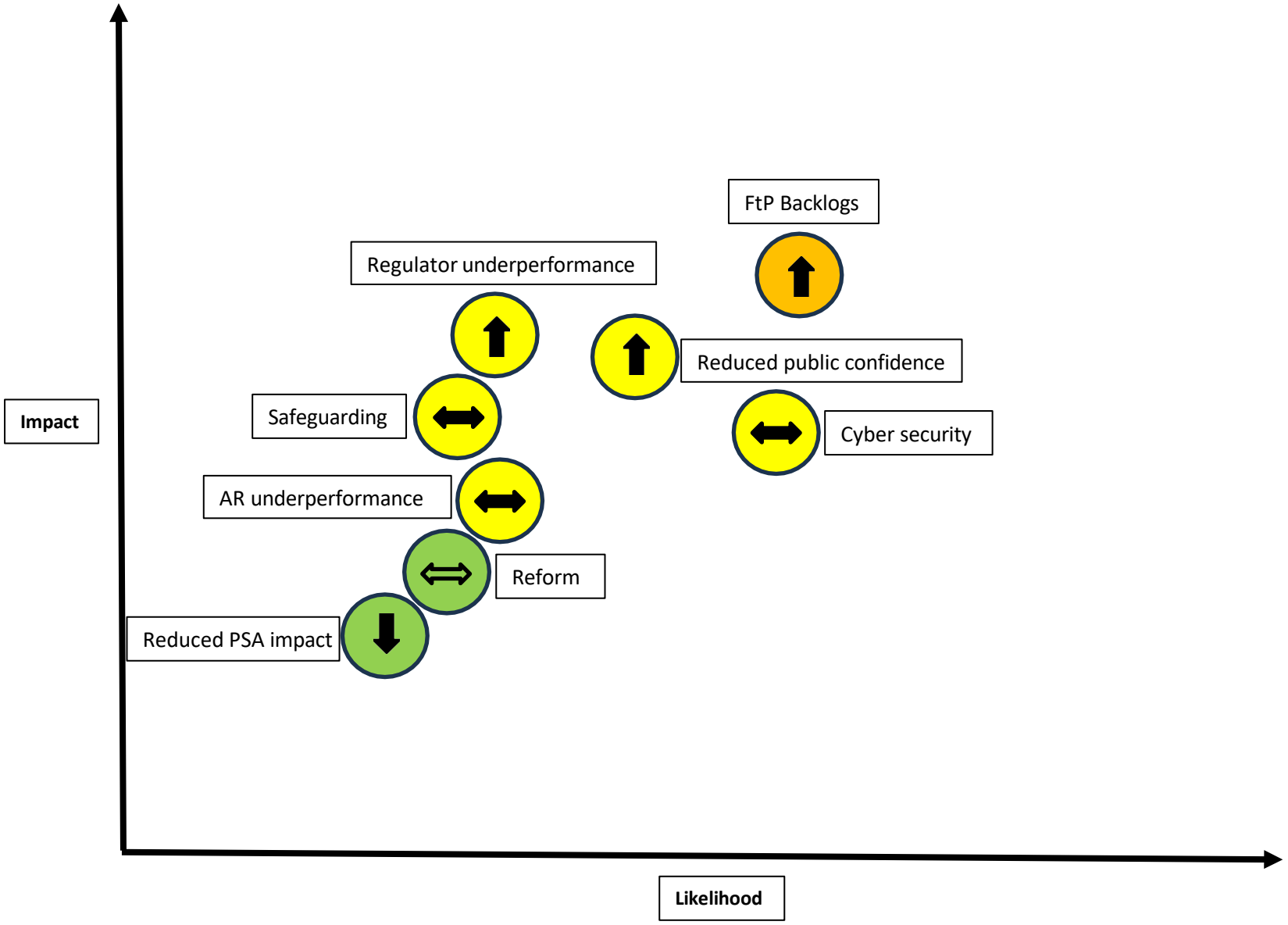
10. External stakeholders

10.1. There are currently no external stakeholders.

11. Annexes list

Annexe A: Strategic Risk Register (as at August 2026)
Annexe B: PSA Risk Management Policy

PSA Risk Dashboard (Residual Risk): September 2026



PSA Strategic Risk Register: September 2026

Risk Description	Causes and Effects	Inherent Score	Existing Controls	Assurance and Level	Residual Score	Target Score	Planned Actions	Commentary
Risk description **[1]** Fitness to practise backlogs compromise regulatory effectiveness. **Risk Owner**: GM **Risk Lead:** AD-B **Last Updated:** 31 August 2026 **Last Reviewed:** 24 August 2026	**Causes** • Increasing referrals • Ineffective FtP processes • Lack of resources • Third party delays **Effects** • Negative impact on complainants, witnesses and registrants • Increased costs • Reduced public protection • Reduced public confidence in regulation	**I = 4** **L = 3** **18** **HIGH**	Monitoring by the PSA, including engagement with registrant and patient bodies as part of the performance review process	Performance data and stakeholder feedback Assurance level: **moderate**	**I = 3** **L = 3** **13** **MEDIUM**	**I = 2** **L = 2** **5** **VERY LOW**	Section 29 report on sexual misconduct cases to be published in **September 2026** to support improvements in quality. **[Head of Legal]** S29 publishing blogs and LP bulletins on areas of concern identified and/or appeals. **[Head of Legal; ongoing]** Convening regulators to consider what radical changes are needed to help address backlogs. **[Director of R&A; September 2026]** Further analysis of the different causes of backlogs through the PR process. **[Director of R&A; ongoing]**	Issues not being addressed; risk increasing and existing controls having limited impact due to increases in referrals to regulators. PSA outputs emphasise the importance of quality. Additional interventions needed in 2026/27 to try to reduce backlogs. Degree of PSA control: **medium.** Within risk tolerance: **no – further action needed.**
			Escalation process to highlight poor performance to the Secretary of State and HSC Committee	Action by SoS and/or HSC Committee Assurance level: **low**				
			Section 29 process can identify concerns about FTP quality	Tracking issues in individual cases and across cases. Assurance level: **high**				
			Information from our Concerns function discussed regularly with the PR/s29 teams and quarterly at SMT	Analysis of volume and nature of concerns; follow up by PR/s29 teams. Assurance level: **medium**				
			Monitoring of regulator Council meetings to ensure continued focus on dealing with any backlogs	Council papers, clarity of data presentation, scrutiny by council members. Assurance level: **low**				

Risk Description	Causes and Effects	Inherent Score	Existing Controls	Assurance and Level	Residual Score	Target Score	Planned Actions	Commentary
Risk description **[2]** Risks to the public arising out of poor practice by the regulators are not identified by the PSA and/or not addressed by regulators. **Risk Owner**: GM **Risk Lead:** AD-B **Last Updated:** 31 August 2026 **Last Reviewed:** 24 August 2026	**Causes** • Regulator poor performance • Performance information not shared with PSA • PSA analysis does not identify performance risks **Effects** • Performance issues not addressed. • Reduced confidence in PSA • Issues with registrant competence and/or conduct • Reduced public protection • Reduced public confidence in regulation	**I = 3** **L = 3** **13** **MEDIUM**	Monitoring and reporting by the PSA, including performance reviews and associated stakeholder feedback	Performance data, standards met and stakeholder feedback Assurance level: **moderate**	**I = 3** **L = 2** **9** **LOW**	**I = 2** **L = 2** **5** **VERY LOW**	Changes to standards, including a new Standard on governance from **July 2026**. An audit of the PR process as part of the programme of internal audits for 2026/27 completed in **June 2026 [actions TBC]**. PR processes undergoing changes to be more risk-based. **[Head of PR; ongoing]**	Increasing risk due to major underperformance at the NMC (and, to a lesser extent, the PSNI). Degree of PSA control: **high.** Within risk tolerance: **no – further action needed.**
			Section 29 process can identify concerns about registrants and processes	Section 29 collaborative work with PR team; plus direct feedback to regulators via appeals and learning points. Assurance level: **moderate**				
			Monitoring of concerns raised about regulator performance	Concerns Officer liaison with PR and s29 teams; plus quarterly analysis of concerns and reporting to SMT. Assurance level: **moderate**				
			Media and stakeholder monitoring	Possible issues at regulators identified via media. Assurance level: **low**				
			Establishment and chairing of the Independent Oversight Group (IOG) for the NMC from September 2024.	Additional oversight for largest and most underperforming regulator, involving a wide range of stakeholders. Assurance level: **moderate**				

Risk Description	Causes and Effects	Inherent Score	Existing Controls	Assurance and Level	Residual Score	Target Score	Planned Actions	Commentary
Risk description **[3]** Risks to the public arising out of poor practice by the Accredited Registers are not identified by the PSA and/or not addressed by AR. **Risk Owner**: GM **Risk Lead:** OA **Last Updated:** 31 August 2026 **Last Reviewed:** 24 August 2026	**Causes** • AR poor performance • Performance information not shared with PSA • PSA analysis does not identify performance risks **Effects** • Performance issues not addressed. • Reduced confidence in PSA • Issues with registrant competence and/or conduct • Reduced public protection • Reduced public confidence in AR	**I = 3** **L = 3** **13** **MEDIUM**	Monitoring and reporting by the PSA, including the (re)accreditation processes (including powers to set conditions and recommendations)	Performance data, standards met, conditions and/or recommendations addressed, and stakeholder feedback Assurance level: **moderate**	**I = 3** **L = 2** **9** **LOW**	**I = 2** **L = 2** **5** **VERY LOW**	From July 2026 we introduced clearer tests for the eligibility and public interest test related to unlawful practice and more inclusive of the ongoing management of the risks related to Practitioners (including the requirement for a register to be in place). We are also introducing greatest standardisation of risk management for practitioners so we can report with more confidence and greater speed on the measures in place to manage risk to the public across all Accredited Registers. **[HoA; ongoing]**	Currently stable, although expanding the AR Programme may increase the risk due to possibly including a more diverse range of therapies; and/or less 'accreditation ready' registers. Degree of PSA control: **high.** Within risk tolerance: **yes.**
			Standard 1(b): public interest test.	Assessment of whether the AR comes under the remit of the PSA and if accreditation would be in the public interest. Assurance level: **moderate**				
			Media and stakeholder monitoring	Possible issues at ARs identified via media. Assurance level: **low**				
			Monitoring of concerns raised with AR team about AR performance	Possible issues at ARs identified via concerns. Assurance level: **low**				

Risk Description	Causes and Effects	Inherent Score	Existing Controls	Assurance and Level	Residual Score	Target Score	Planned Actions	Commentary
Risk description **[4]** The reform of regulation is not continued for all regulators, is implemented poorly and/or reduces effective oversight of the regulators' work, reducing protection of the public. **Risk Owner**: MV **Risk Lead:** DG **Last Updated:** 31 August 2026 **Last Reviewed:** 24 August 2026	**Causes** • Not a government priority • Insufficient DHSC and/or regulator resources • Poor quality legislation • Slow and ineffective implementation • Insufficient resources **Effects** • Very slow pace of reform • Challenges in oversight of regulators at various stages of reform • Reduced regulatory effectiveness with too few corrective safeguards	**I = 3** **L = 2** **9** **LOW**	The PSA has a clear view on the risks associated with reform and prioritises those that pose greatest risk to the public.	Clear PSA position on reform and public protection opportunities and risks Assurance level: **moderate**	**I = 2** **L = 2** **5** **VERY LOW**	**I = 2** **L = 2** **5** **VERY LOW**	Regulatory Reform Programme Board monitoring developments and engaging with DHSC/DA and regulators to shape future reform. **[HoP; ongoing]**	Had been declining. The GMC Order is improved on the previous reform legislation, although the rationale and expectations relating to reviewing interim order decisions require clarification. The biggest risk at the moment is the slow pace of reform, with further delays to GMC Order.
			Communications to encourage understanding of PSA's work and support stance on regulatory reform. Contributing to decisions on reform for the GMC through response to DHSC consultation (June 2026)	Presentations, consultation responses, stakeholder engagement present consistent position on reform. Assurance level: **low**				Degree of PSA control: **low.** Within risk tolerance: **yes.**
			Published guidance to support the effective implementation of reform.	Guidance published in 2025; further guidance will be considered in the light of the GMC Order. Assurance level: **moderate**				

Risk Description	Causes and Effects	Inherent Score	Existing Controls	Assurance and Level	Residual Score	Target Score	Planned Actions	Commentary
Risk description **[5]** PSA is not seen to be relevant and beneficial, or any benefits are outweighed by costs and administrative burdens. **Risk Owner**: AC **Risk Lead:** AC **Last Updated:** 31 August 2026 **Last Reviewed:** 24 August 2026	**Causes** • PSA misses performance issues in regulators and AR • PSA not seen to be driving improvements in regulators and AR • Appeals not taken forward; declining success rates in appeals; s29 feedback does not improve FtP • Research, policy and comms work deemed to add little value • Processes burdensome; costs too high **Effects** • Fees not approved • Challenge and scrutiny from parliament, DHSC, DA and media • Changes to PSA oversight role	**I = 3** **L = 2** **9** **LOW**	Strategic and business planning to focus on: statutory oversight functions; driving improvements in regulation and registration; and collaboration to make the overall system of healthcare regulation more cohesive, coherent and preventative. Horizon scanning and media monitoring to keep abreast of emerging issues. Communications and Engagement Strategy and associated plans.	Consultation on strategic plan, business plans and fees to seek feedback on PSA priorities. Assurance level: **moderate** Quarterly horizon-scanning in place to inform business plan priorities and in-year reaction to emerging issues. Assurance level: **moderate** PSA priorities, actions and positive impact shared with all stakeholders. Assurance level: **moderate**	**I = 2** **L = 2** **5** **VERY LOW**	**I = 2** **L = 2** **5** **VERY LOW**	Business planning to be kept under review in the light of external events which may change PSA priorities. **[CEO; ongoing]** Standards Review and use of Right-Touch Regulation in our work (including developing new risk assessment tools for PR). **[DoRA; ongoing]**	Declining. New Strategic Plan in place with good support from stakeholders. Commissions from DHSC and Scottish Government. Contributions to (and some actions from) the Review of Social Work Regulation and the Mann Review. Key stakeholder on reform. Degree of PSA control: **high.** Within risk tolerance: **yes.**

Risk Description	Causes and Effects	Inherent Score	Existing Controls	Assurance and Level	Residual Score	Target Score	Planned Actions	Commentary
Risk description **[6]** A cyber-attack leads to: IT system unavailability leaving PSA unable to operate BAU; or loss of sensitive information. **Risk Owner**: JC **Risk Lead:** AB **Last Updated:** 31 August 2026 **Last Reviewed:** 24 August 2026	**Causes** • Direct cyber-attack on PSA systems • Human error permits attack (such as phishing) or loss of information **Effects** • System or parts of system unavailable or corrupted, impacting functions • Ransomware costs • Loss of information causing harm to individuals, reputational damage and/or ICO referral.	**I = 4** **L = 3** **18** **HIGH**	Cyber security controls in place and tested and reviewed regularly.	Control score reported quarterly to SMT as part of IT Report. Controls include multi-factor authentication, device and endpoint security, vulnerability scanning, access reviews, backups, monitoring and incident response. Level of assurance: **moderate**	**I = 3** **L = 2** **9** **LOW**	**I = 2** **L = 2** **5** **VERY LOW**	**Schedule next Pen Testing September 2026**	Steps taken since the internal audit in 2025 are managing this risk. It is stable but it is unlikely to reach the position of decreasing. Degree of PSA control: **medium.** Within risk tolerance: **yes.**
			Annual information security training for all staff and the Board	Quality of training (including assessment) verified by DPO. Annual compliance checked by HR. Level of assurance: **low**				
			Regular attack simulation emails sent to staff to increase cyber awareness	Variety of approaches used. Non-compliance followed up with informal training and re-assessment. Level of assurance: **low**				
			Annual Penetration testing and Cyber Essentials Plus Assessment	Penetration test report plus Cyber Essentials Plus accreditation. Level of assurance: **high**				
			Weekly monitoring of data loss prevention audit logs by the IT team	Weekly reports and mitigating actions. Level of assurance: **moderate**				

Risk Description	Causes and Effects	Inherent Score	Existing Controls	Assurance and Level	Residual Score	Target Score	Planned Actions	Commentary
Risk description **[7]** Inconsistent approaches to accessing criminal record checks by the regulators and AR could lead to an individual who poses a risk to the safety of the public being able to register. **Risk Owner**: GM **Risk Lead:** AB-D/OA **Last Updated:** 31 August 2026 **Last Reviewed:** 24 August 2026	**Causes** • No consistent direct checking by regulators and AR • Assumptions about checks invalid (e.g. done by employers or agencies) • Insufficiently frequent/robust checking • Inappropriate persons exploit loopholes **Effects** • Public exposed to risks of harm from professionals with criminal convictions.	**I = 3** **L = 3** **13** **MEDIUM**	Escalation of this risk with DHSC and other stakeholders.	Regular reporting of risk. Assurance level: **low**	**I = 3** **L = 2** **9** **LOW**	**I = 2** **L = 1** **3** **VERY LOW**	New Standard 11 from **July 2026** on 'Continuing suitability for registration' addresses this risk directly and supporting evidence frameworks makes clearer our expectations for assessment and mitigation of this risk. Permit checks of self-employed practitioners undertaking regulated activity and change the definition of regulated activity in safeguarding legislation to include activities related to children and young people who are not supervised **[expected to come into force in summer 2026]**	Risk remains unchanging and relatively high prior to introduction of new standard, new processes and assurance from data analysis. Degree of PSA control: **low.** Within risk tolerance: **no – further action needed.**
			New standards have changed our expectations on criminal convictions checks.	Seeking assurance from regulators and AR that appropriate and proportionate checks are carried out as part of admission and ongoing suitability to remain on registers. Assurance level: **moderate**				
			Collecting data to support our analysis of the extent of risks arising from failure to disclose convictions.	PR, s29 and AR data being used to assess issues arising from failure to disclose. Assurance level: **low**				
			Engagement with the Home Office and Ministry of Justice, and national agencies, on developing mechanisms for all self-employed registrants to access enhanced checks (England and Wales)	Focus on potential higher-risk group of self-employed. Assurance level: **low**				

Risk Description	Causes and Effects	Inherent Score	Existing Controls	Assurance and Level	Residual Score	Target Score	Planned Actions	Commentary
Risk description **[8]** Public confidence in regulation and the healthcare system undermined as a result of perceived regulatory failures and/or over- or under-regulation. **Risk Owner**: MV **Risk Lead:** DG/OO **Last Updated:** 31 August 2026 **Last Reviewed:** 24 August 2026	**Causes** • Issues of significant harm associated with regulator poor performance • Public assumptions about regulatory coverage and the impact of regulation on risk • Perceptions of under-regulation in certain sectors, such as cosmetics • Changing job roles **Effects** • Reduced public confidence in, and support for, regulation and services. • Calls for changes in regulation (that may or may not be based on an objective assessment of risk) • Ineffective regulation of new roles	**I = 3** **L = 3** **13** **MEDIUM**	Standard One for AR allows for an assessment of the risks of unregulated roles, and for escalation to the Government where voluntary registration may not be sufficient.	Standard One assessment provides useful evidence but may not result in further work to manage the risks. DHSC commission (March 2026). Level of assurance: **low**	**I = 2** **L = 3** **8** **LOW**	**I = 2** **L = 2** **5** **VERY LOW**	Supporting the implementation of additional safeguards for non-surgical cosmetics. **[DoPC; ongoing]** We are aware of increasing concerns about counselling and psychotherapy, audiology, sonography and some healthcare science roles, and are working with stakeholders to understand the current risks and to identify whether further actions are required. **[DoPC ongoing]** Scottish Government Commission **[2026/27] [DoPC; ongoing]**	Increasing risk due to underperformance of NMC and PSNI. Under-regulation beginning to be assessed via commissioned work. Additional safeguards on cosmetics not yet in place. Degree of PSA control: **low.** Within risk tolerance: **no – further action needed.**
			The PSA has a Right-touch Assurance (RTA) tool which it can be commissioned by the Government to use to determine the inherent risk of a health or care related profession.	Tool in use; requires further development; may not lead to steps to mitigate risks. Level of assurance: **low**				
			Share Your Experience submissions, AR and regulator engagement and horizon scanning/media monitoring provide insight into service user experiences where regulation may not be proportionate to public protection	Feedback useful for PR and AR, but quality of evidence may be variable. Level of assurance: **low**				
			Better reporting of performance to identify required areas for improvement.	Improvements made to reports in recent years; greater use of recommendation from April 2026. Level of assurance: **low**				
			Right-touch regulation includes an explanation of the role (and limits) of regulation.	Awareness of regulation among the general public remains low. Level of assurance: **low**				

Scoring Matrix

5 - Almost Certain	11 Medium	16 High	20 Very High	23 Very High	25 Very High
4 - Likely	7 Low	12 Medium	17 High	21 Very High	24 Very High
3 - Possible	4 Very Low	8 Low	13 Medium	18 High	22 Very High
2 - Unlikely	2 Very Low	5 Very Low	9 Low	14 Medium	19 High
1 - Rare	1 Very Low	3 Very Low	6 Low	10 Medium	15 High
↑ Likelihoods → Impacts	1 - Negligible	2 - Minor	3 - Moderate	4 - Significant	5 - Major

Assurance level definitions

High: strong evidence controls are effective

Moderate: controls working but under pressure

Low: weak evidence or clear gaps

Uncertain: not enough evidence

Degree of PSA control: defined as **high** if relating to our operational processes; **medium** if subject to PSA public reporting or if the risk is changing quickly; and **low** if controlled by third parties and PSA may only have limited influence.

11

professional standards authority for Health and Social Care

1. Purpose

1.1 The purpose of this document is to define the Professional Standards Authority's (PSA's) strategic intent for risk management and set out the roles and procedures for risk management at the PSA now and in the future. It will be reviewed by the Audit and Risk Committee and updated formally by the Board on an annual basis.

1.2 PSA strives to be an organisation that demonstrates good governance practices. The environment that we operate within requires us to have in place a proportionate and strategic approach to the day-to-day management of risk. The objective is to ensure that when risks arise, they will be dealt with in a manner that is consistent with the principles and processes outlined in this document.

1.3 This document applies to all employees of the PSA and those seconded to work here. There should be an active lead from managers at all levels to ensure that risk management is a fundamental part of the overall approach to regulation, service delivery and corporate governance.

2. What is risk management?

2.1 His Majesty's Treasury, in The Orange Book Management of Risk - Principles and Concepts describes risk as follows:

> *'Risk is defined as the uncertainty of outcome, whether a positive opportunity or a negative threat, of actions and events. The risk has to be assessed in respect of the combination of the likelihood of something happening, and the impact that arises if it does actually happen. Risk management includes identifying and assessing risks (the "inherent risks") and then responding to them.'*

2.2 Risk management is essentially about identifying and managing key obstacles to the achievement of strategic and business objectives. It is a tool that is an integral part of effective and efficient management and planning.

Types of risk	
Strategic	Those current business risks that, if realised, could fundamentally affect the way in which we exist or provide services in the next one to five years. These risks will have a detrimental effect on the achievement of our strategic objectives. The risk realisation will lead to failure, loss or lost opportunity.
Operational	Those current business risks that, if realised, could affect the way in which we operate or provide services in the new year. These risks will have a detrimental effect on our achievement of our business plan. The risk realisation will lead to failure, loss or lost opportunity.
Project	Those business risks that, if realised, could affect the way in which we deliver any specific project. The risk realisation will lead to failure, loss or lost opportunity.

3. Strategic intent

3.1 We recognise that risk management is an integral part of good governance and management practice and to be most effective should be part of our culture. We are committed to ensuring that risk management forms an integral part of our philosophy, planning and practice, rather than being viewed or practised as a separate activity, and that responsibility for risk management is accepted at all levels of the organisation.

3.2 PSA aims to take all reasonable steps in the management of risk with the overall objective of achieving its strategic and business objectives and protecting staff, stakeholders, the public and assets.

3.3 We recognise that the outcome of a risk management will not eliminate risk totally. Rather it provides the means to identify, prioritise and manage the risks and provide a balance between the cost of managing and treating risks, and the anticipated benefits that will be derived from doing so. Risk management should not be so rigid that it stifles innovation and the imaginative use of limited resources in order to achieve objectives.

4. Risk appetite and tolerance

4.1 Our risk appetite is the total amount and types of risk we are willing to take in the achievement of our objectives. Our risk appetite is set by the Board and it will regularly review the amount of risk that it is prepared to accept, depending on the prevailing circumstances at the time.

4.2 PSA will evaluate factors such as the activity and developments in those we oversee; our culture and the nature of the strategic objectives we are trying to achieve. The PSA's financial strength and organisational capabilities are also taken into account.

4.3 The PSA has a risk averse position on matters relating to fraud, cyber security and health and safety.

4.4 We acknowledge that zero cyber risk is practically unattainable and so it is difficult to avoid risk in this area, but we consider it is still appropriate to take maximum precautions possible on cyber risk.

4.5 Financial investments, compliance with IT policies, key governance controls and matters of policy with a direct impact on public protection are categorised as 'minimalist' for risk appetite.

4.6 The appetite for risk is higher (but remains cautious) for oversight judgements in core functions, budgeting , the use of AI, and statutory HR policies.

4.7 Risk appetite is "open" for other HR policies, the development of the Accredited Register (AR) programme, general policy positions that are not critical for public protection and most communication activities.

4.8 The PSA has an 'eager' risk appetite in relation to IT and communications innovations that may help the PSA to perform its role more effectively, whilst being conscious of weighing the potential benefits of innovations against the risks to the organisation.

4.9 PSA is not willing to accept risks (without appropriate mitigation) that may result in compromising the protection of patients or the public.

5. Accepted risks

5.1 We consider that any risk with no further action planned to address it is an accepted risk, providing assurance is received that the controls relied upon to manage it are in place. It is reasonable to accept a risk that under normal circumstances would be unacceptable if the risk of all other alternatives, including doing nothing, were even greater.

6. Duties and responsibilities

Role of the Board

6.1 The Board has ultimate responsibility for the management of PSA's risks. It monitors PSA's approach to the management of risk, and its effectiveness in managing risk. Predominantly, it considers the risks facing the PSA at the strategic level. Its role includes:

- Instilling a culture of risk management:
  - Determining PSA's 'risk appetite' across the whole organisation or on any relevant single issue, and reviewing this periodically as part of the strategic planning cycle
  - Determining which risks are acceptable and which are not
  - Determining the appropriate level of risk exposure.
- Satisfying itself that risks are managed appropriately:
  - Considering the external environment and identifying emerging strategic risks, including an annual risk-identification exercise
  - Approving the overall risk management arrangements
  - Approving decisions which have a major impact on the PSA's risk profile or exposure and satisfying itself that the PSA's actual level of risk exposure does not exceed that agreed
  - Monitoring the management of significant risks and assuring itself that risks are tolerable
  - Satisfying itself that the less significant risks are being actively managed, and that the appropriate controls in place are working effectively
  - Reviewing the approach to risk management (including the annual review of this policy) and approving key changes or improvements to processes and procedures.

6.2 In addition, the Board will:

- Review the strategic risk register at every Board meeting
- Receive a report at each meeting on risks as part of the Executive Report, with the latest strategic risk register as an annexe to the Executive Report
- Receive a report from the Audit and Risk Committee after each of its meetings via minutes or a summary report
- Consider serious and emerging risks as separate items at its meetings.

Role of the Audit and Risk Committee

6.3 The Audit and Risk Committee reviews and tests the establishment and maintenance

of an effective system of internal control and risk management. This process is underpinned by the internal audit function, which provides an opinion on internal control.

6.4 It is the Audit and Risk Committee's role to advise the Board on the effectiveness of the PSA's internal control arrangements. As part of this role, it will advise the Board:

- Annually on our approach to risk management and overall risk management arrangements, approving the Risk Policy
- Periodically on the management of significant risks (following discussion with the Executive Leadership Team (ELT) on specific risks)
- On the implications of internal audit reports
- On the implications of the recommendations made by the external auditors
- On the assurance the Board can take from the PSA's approach to risk management.

6.5 In addition, the Audit and Risk Committee will:

- Review the strategic risk register at each meeting
- Review areas of the PSA's work that are identified as posing particular risks to ensure that mitigations are in place and identify possible changes
- Commission 'deep dives' into particular areas of risk
- Report to the Board on significant risks or key concerns.

Role of the Executive Leadership Team

6.6 As ELT is the authoritative decision-making body within PSA's executive management structure, it has the management responsibility for risk and implementation of the PSA's risk management strategy and reporting requirements.

6.7 ELT takes the lead in ensuring that the strategy and practice remain appropriate and fit for purpose. ELT ensures that assessment and management of risk are an integral feature when authorising and managing existing and new work. ELT members are risk owners of strategic risks.

6.8 Specifically, ELT is responsible for:

- Establishing and maintaining a coherent and practical PSA -wide approach to the management of risk, using the procedures set out in this document
- Maintaining the PSA's Risk Policy
- Identifying and managing the strategic risks faced by the PSA for consideration by the PSA (in this role the ELT takes advice from the wider Senior Management Team)
- Take the lead role in reviewing strategic risks on a monthly basis
- Periodic review of the effectiveness of the PSA's risk management arrangements
- Delegating responsibility to staff for identifying and managing the operational and project risks faced by the PSA.

Director of Corporate Services

6.9 The Director of Corporate Services acts as central reference point for all risk management issues within the PSA. The Director facilitates and oversees the risk management processes but does not act as the "risk manager" for all risks, as the PSA recognises that risk management forms an integral part of all functions.

6.10 The Director is responsible for the maintenance of the strategic risk register.

7. Procedures

Approach to risk management

7.1 The starting point for risk management is a clear understanding of what the organisation is trying to achieve. Risk management is about managing the threats that may hinder delivery of priorities and core functions, and maximising opportunities that will help to deliver them. It should take into account the environment within which the PSA operates.

7.2 The risk management process should be kept as simple and straightforward as possible. It should:

- Start from objectives
- Put the primary focus on significant risks and related controls
- Record details in risk registers
- Regularly monitor progress
- Allocate risk management responsibilities to individuals
- Link actions to manage risks to personal and business plans.

7.3 Risk management involves a 5-stage process, as shown below:

Stage 1 – Risk identification

7.4 The first step is to identify the 'key' risks that could have a significant adverse effect on us or prevent key strategic or business objectives from being met. It is important that those involved with the process clearly understand the service or organisation's key business objectives i.e. 'what it wants to achieve' in order to be able to identify 'the barriers to achievement'.

7.5 Details of any new risks should be raised with the Director concerned to be considered for recording on the Risk Register. Project risks are recorded by the project manager or project team, using the system in place for specific projects, and are escalated to the strategic risk register through ELT as necessary.

7.6 ELT should consider the current portfolio of risk in coming to a decision whether to accept a new risk. ELT will also confirm or make changes to the new risk, assign a risk owner and agree any further action to be taken to manage the risk.

7.7 Risk identification also includes identifying opportunities, where the outcome is uncertain, and these may be managed using the process set out here but will not be reported in the strategic risk register. Strategic considerations about whether to exploit opportunities are made by the Board.

Stage 2 – Risk analysis

7.8 There are three important principles for analysing risk:

- Consider the likelihood and impact for each risk
- Be clear about the difference between inherent and residual risk
- Record the assessment of risk in a way that facilitates monitoring and the prioritisation of risks.

7.9 Having identified new risks, the following details should be provided to ELT so that they can be recorded in the strategic risk register. The implications of project risks should be considered, and significant ones included in the register. The details should include:

- A description of the risk, its owner and executive lead, and the dates of last review and last update.
- The causes and the effects of the risk (if the risk materialised)
- An assessment of the inherent[1] impact of the risk if there were no mitigation in place to manage the risk. This should be measured on a scale of 1 to 5
- An assessment of the inherent likelihood of the risk materialising. This should also be measured on a scale of 1 to 5. The combined impact and likelihood score is calculate using a scoring matrix displayed on the risk register.
- A summary of the controls in place, the assurance these provide and any additional mitigating actions
- An indication of the residual impact and likelihood using the same scoring system shown above. The residual score indicates the level of the risk once the controls have been put in place and action has been taken
- A target residual score for the risk
- A commentary on movement of the risk over time, the degree of PSA control over the risk and whether the residual risk is currently within tolerance (if not, additional mitigating actions are needed)
- A summary 'heat map' of risks will be provided with each new version of the risk register.

Stage 3 - Risk prioritisation

7.10 Once risks have been identified and analysed, they require a priority to be applied.

7.11 Once risks have been assigned a score they will fall into one of the following three groups which will determine the manner in which they will need to be managed:

- Primary Group (red) – Where risk management should focus most of its time. Risks that fall into this group will require immediate attention. Both the inherent and residual status of the risk will need to be monitored with regard to any effect on the organisation's activities and the progress of any action taken to ensure its effective completion.
- Contingency Group (amber) – Where risk management will ensure that contingency plans are in place. Risks that fall into this group may require immediate action but will need to be monitored for any changes in the risk or control environment, which may result in the risk attracting a higher score.
- House Keeping Group (green) – Basic mechanisms should be in place. Risks that fall into this group will need to be monitored by management.

7.12 New risks that are classified as primary should be bought to the attention of ELT and the Board immediately to enable the risk to be reviewed and actions to be quickly identified.

Stage 4 - Risk Management

[1] The concept of inherent and residual impact and likelihood is taken from the Orange Book.

7.13 Once a risk has been identified, analysed and prioritised, it will be possible for the organisation to decide whether to take further action to address the risk and if so what type of action. When deciding how best to manage risks, it is useful to ask the following questions:

- How to prevent it from happening - either by putting some controls/countermeasures in place or putting the project or activity in a position where it would have no impact
- How to reduce the risk - what action is needed to reduce the probability of the risk happening
- What to do to if the risk does occur - outline some contingent activities
- What are the implications of accepting the risk - ensuring that all the stakeholders are aware of the possible impact.

7.14 There are several response options that can be taken to address the risks that have been identified. These are set out in the following table.

Response options to risks and opportunities	Description
Terminate or avoid	An informed decision not to be involved in, or to withdraw from, an activity, in order not to be exposed to a particular risk. Used if risks are not acceptable or outweigh the benefits.
Treat - reduce or mitigate	Take action to reduce the likelihood of a risk, or its impact if it does arise.
Transfer or share	This option aims to pass at least part of the risk to a third party. Insurance is the classic form of transfer, where the insurer picks up the cost if the risk materialises, but the insured retains the impact on other objectives. Contracting or working in partnership are other means.
Tolerate	Tolerated risks are risks that the organisation lives with and keeps under review. The risks have been managed as far as is considered to be reasonably practicable and have adequate control mechanisms in place.
Accept	Here the organisation "takes the chance" that the risk will occur, with its full impact if it did. There is no change to residual risk, or no actions, with this option, but neither are any costs incurred now to manage the risk, or to prepare to manage the risk in future.

Stage 5 - Monitoring

7.15 The strategic risk register should be monitored regularly to be able to close risks down when their likelihood has passed or to add new risks in the light of new information. Additionally, levels of inherent and residual risk should be assessed, and controls added or amended as appropriate.

7.16 The strategic risk register serves as an essential tool for monitoring and reporting on the actions selected to address risks. Some of the actions may have only been to monitor the identified risk for signs of a change in its status. Monitoring risks will also consist of:

- Checking that execution of the planned actions is having the desired effect
- Watching for the early warning signs that a risk is developing
- Modelling trends, predicting potential risks or opportunities
- Checking that the overall management of risk is being applied effectively.

7.17 It should be noted that as risk management is an on-going and iterative process, the status of existing risks will change, and new risks will arise. This means it will be necessary from time to time to return to any one of the five stages of the process as outlined above in relation to a particular risk.

8. Operational and project management risk

8.1 Directorate Operational risk registers have been developed to enable us to better monitor operational risks and manage the escalation to (or de-escalation from) the strategic risk register.

8.2 These are reviewed within each Directorate on a monthly basis, and updates are provided to the Head of Governance who includes these in the monthly Governance Report to Senior Management Team, for oversight.

8.3 Our project management policy requires all projects to have a risk register in place. This is reviewed by the project management group for that project, and necessary issues are escalated to ELT for consideration.

Annexe A: risk appetite summary

Risk appetite	Description	Examples
Averse	Avoidance of risk and uncertainty in achievement of key deliverables or initiatives is key objective. Activities undertaken will only be those considered to carry virtually no inherent risk.	Finance: fraud. IT: cyber security. Governance: health and safety.
Minimalist	Preference for very safe business delivery options that have a low degree of inherent risk with the potential for benefit/return not a key driver. Activities will only be undertaken where they have a low degree of inherent risk.	Finance: investments. IT: policies. Policy: public protection. Governance: assurance framework.
Cautious	Preference for safe options that have low degree of inherent risk and only limited potential for benefit. Willing to tolerate a degree of risk in selecting which activities to undertake to achieve key deliverables or initiatives, where we have identified scope to achieve significant benefit and/or realise an opportunity. Activities undertaken may carry a high degree of inherent risk that is deemed controllable to a large extent.	Finance: budgeting. Section 29: decision reviews and appeals. PR: judgements on regulator performance. AR: judgements on AR performance. Governance: statutory HR policies.
Open	Willing to consider all options and choose one most likely to result in successful delivery while providing an acceptable level of benefit. Seek to achieve a balance between a high likelihood of successful delivery and a high degree of benefit and value for money. Activities themselves may potentially carry, or contribute to, a high degree of residual risk.	Policy: general. Communications: learning from PSA activities; perspectives on health and social care issues; media engagement; sharing expertise. Governance: non-statutory HR policies. AR: programme development.
Eager	Eager to be innovative and to choose options based on maximising opportunities and potential higher benefit even if those activities carry a very high residual risk.	Communications: innovations to further increase awareness and impact. IT: innovations to increase productivity.

Document Control

Version Control

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Version	Description of Version	Date Completed
1.0	Risk Management policy	25 November 2020
1.1	Endorsed by ARC subject to removal of the Assurance section, which is covered in the Assurance Framework and an update on proposed Operational and Project Risk Registers	7 October 2021
1.1	Reviewed by Board – No changes made.	November 2021
1.2	Endorsed by ARC subject to updating the section on Operational and Project Management risks.	October 2022
1.3	Risk appetite updated after May 24 Board discussion And annexe added.	June 2024
1.4	Reformatted onto the new PSA template	Sept 2025
1.4	ARC review	October 2025
1.5	Amended following external board evaluation by MSK.	July 2026

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Board work programme 2026/27

Date	Work programme
May 2026	• Delegate authority to ARC to approve the Annual Report and Accounts • Committee update reports
July 2026 (Manchester)	• Annual People Report • Business Planning 2027/28 • Committee update reports • Risk Register review • Annual review of Governance and Assurance Frameworks
July/August 2026	• Subset of Board (Business Plan Review Committee) to consider 2027/28 Regulated Activity and Accredited Registers business plans and budgets.
September 2026	• Business Plan 2027/28 and Fees Consultation approval • Board member appointments/renewals (Nominations Committee) • Risk register review
November 2026 (Wales/Cymru)	• Mid-year review of 2026/27 Business Plan
January 2027	• Staff Survey 2026 • Scrutiny Committee update report
March 2027	• Annual report from Nominations, Scrutiny and Audit and Risk Committees including review of terms of reference • Devolved Administration Board member reports (Wales, Scotland and Northern Ireland) • Risk Register Review • Optional item – If AR 27/28 forecast agreed in Business Plan is not as anticipated and gives a lower income level rather than higher, revisit the business plan and return to Board in March.